Blackpool Council

16 June 2023

To: All Member of the Health and Wellbeing Board

The above members are requested to attend the:

HEALTH AND WELLBEING BOARD

Tuesday, 27 June 2023 at 3.00 pm
in Conference Room 3A and 3B, Bickerstaffe House

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 8 MARCH 2023 (Pages 1 - 6)

To agree the minutes of the last meeting held on 8 March 2023 as a true and correct record.

3 BLACKPOOL JOINT LOCAL HEALTH AND WELLBEING STRATEGY UPDATE (Pages 7 - 16)

To provide the Board with an update on the development of a new Blackpool Joint Local Health and Wellbeing Strategy.

4 LANCASHIRE AND SOUTH CUMBRIA INTEGRATED CARE SYSTEM - JOINT FORWARD PLAN 2023 ONWARDS (Pages 17 - 80)

To provide the Health and Wellbeing Board with an overview of the Joint Forward Plan for the Lancashire and South Cumbria Integrated Care Board (ICB) and system partners.

5 TOBACCO FREE LANCASHIRE AND SOUTH CUMBRIA STRATEGY 2023-2028 (Pages 81 - 132)

To summarise the progress of the Tobacco Free Lancashire and South Cumbria Strategy 2023-2028 and how the strategy will assist with progress toward the Smokefree 2030 agenda.

6 JOINT STRATEGIC NEEDS ASSESSMENT WORKING GROUP (Pages 133 - 154)

To consider the re-establishment of a Joint Strategic Needs Assessment (JSNA) Working Group.

7 DATE OF NEXT MEETING

To note the date of next meeting as the 18 October 2023.

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, 8 MARCH 2023

Present:

Councillor Farrell (in the Chair)

Councillors

Hobson Mrs Scott

Dr Arif Rajpura, Director of Public Health, Blackpool Council
Karen Smith, Director of Adult Services, Blackpool Council and Director of Health Integration, Lancashire and South Cumbria Integrated Care Board

Roy Fisher, Non-Executive Director, Lancashire and South Cumbria Integrated Care Board
Professor Sarah O'Brien, Chief Nursing Officer, Lancashire and South Cumbria Integrated Care Board

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

Tracy Hopkins, Blackpool Citizens Advice Bureau, Voluntary Sector Representative

Beth Martin, Healthwatch Blackpool Representative

In Attendance:
Lennox Beattie, Executive and Regulatory Manager, Blackpool Council
Stephen Boydell, Principal Epidemiologist, Blackpool Council
Dianne Draper, Consultant in Public Health, Blackpool Council
Liz Petch, Consultant in Public Health, Blackpool Council

Lee Kenworthy and Fiona Williams, Council for Voluntary Services for Item 3

Craig Harris, Lancashire and South Cumbria Integrated Care Board
Karen Tordoff, Lancashire and South Cumbria Integrated Care Board

1 DECLARATIONS OF INTEREST

There were no declarations of interest on this occasion.

2 MINUTES OF THE LAST MEETING HELD ON 14 DECEMBER 2022

The Health and Wellbeing Board considered the minutes of the last meeting held on 14 December 2022.

Resolved:

That the minutes of the last meeting held on the 14 December 2022 be approved and signed by the Chairman as a correct record.

3 SOCIAL PRESCRIBING PRESENTATION

The Board received a presentation which raised awareness of Social Prescribing and how it could link to the priorities of the Health and Wellbeing Board.

Lee Kenworthy and Fiona Williams from Let's Connect a team split between Citizens Advice and the Volunteer Centre gave the presentation. Mr Kenworthy and Ms Williams explained the client pathway and how it started from a simple conversation with somebody about what mattered to them. It was noted that it was important that within social prescribing, decision making remained with the client with them being able to choose what support they needed and how they would access support.

It was explained that currently social prescribing had dealt with around 161 new referrals a month with these numbers continuing to rise due to cost of living issues. The benefits of the linkages with the Citizens Advice service was emphasised with the importance of access to financial and support advice underpinning to ensure clients were accessing the right support, maximising income and minimising outgoings. This model of service was considered to be superior to alternative options and it was noted that often where social prescribers were embedded within primary care linkages with other support was often not well-defined.

The Board expressed positive feedback on the role that social prescribing could play meet the practical, social and emotional needs that affected their health and wellbeing. It emphasised the need for continuity and certainty of funding for the community and voluntary sector.

Resolved:

To note the content of the presentation.

4 LANCASHIRE AND SOUTH CUMBRIA INTEGRATED CARE PARTNERSHIP: DEVELOPMENT OF THE INTEGRATED CARE STRATEGY 2023-2028

The Board received a presentation providing it with information on the development of the draft Lancashire and South Cumbria Integrated Care Strategy and the next steps for further engagement and finalisation of the document.

The Board noted the work undertaken since September 2022 and the broad support received from consultation for the draft priorities of Living Well, Starting Well, Ageing Well and Dying Well. The Board further noted the next steps for approval. The Board noted that elsewhere on the agenda

The Board expressed a view that the strategy needed to be clear on how it would be implemented and the linkages with other plans including the Blackpool Health and Wellbeing Strategy and the Integrated Care Partnership Forward Plan, on which reports were brought to this meeting.

The Board highlighted the need to ensure that suitable workforce development and the importance that staff retention and recruitment would play in delivering the strategy's key priorities.

Resolved:

1. To endorse the current version of the Lancashire and South Cumbria Integrated Care Strategy, noting that this will be further updated in the coming weeks to reflect feedback from partners and residents.

2. To note that the final version of the Lancashire and South Cumbria Integrated Care Strategy will be presented to the Integrated Care Partnership in April 2023 for formal agreement.

5 LANCASHIRE AND SOUTH CUMBRIA INTEGRATED CARE BOARD - DEVELOPMENT OF A JOINT FORWARD PLAN FOR 2023-2028

The Board received a presentation giving an overview of the emerging Joint Forward Plan for the Lancashire and South Cumbria Integrated Care Board (ICB). The Board noted that the joint forward plan development process to produce a shared delivery plan for the integrated care strategy so supported that

The Plan had been developed to address three broad principles as required by statutory guidance.

- Principle 1: Fully aligned with the wider system partnership's ambitions.
- Principle 2: Supporting subsidiarity by building on existing local strategies and plans as well as reflecting the universal NHS commitments.
- Principle 3: Delivery focused, including specific objectives, trajectories and milestones as appropriate.

The five strategic objectives remained strengthen our foundations, improve prevention and reduce health inequalities, integrate and strengthen primary and community care, improve quality and outcomes and world class care. The plan would identify long term success indicators for each strategic priority. The Board broadly supported the key themes.

The Board noted the linkages between

Resolved:

1. To endorse the key themes highlighted within the emerging Joint Forward Plan for Lancashire and South Cumbria Integrated Care Board.

2. To note that a draft version of the Joint Forward Plan will be circulated to members of the Health and Wellbeing Board for information, after the plan is approved by the Integrated Care Board (this is intended to be at the end of March 2023).

3. To note that a final version of the Joint Forward Plan will be presented to the Health and Wellbeing Board prior to its sign off by the Integrated Care Board the end of June 2023.

6 BLACKPOOL JOINT LOCAL HEALTH AND WELLBEING STRATEGY UPDATE

To provide the Board with an update on the Blackpool Joint Local Health and Wellbeing Strategy.

The Board was reminded that at its meeting on the 5 October it had agreed 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. The Board noted that this group had been supplemented by the inclusion of Tracy Hopkins, Third Sector Representative.

The Board noted the outline timeline for the development of the strategy as highlighted in Paragraph 6.7 of the report. The Board endorsed the need for an Informal session with Adult Social Care and Health Scrutiny Committee to take place in September 2023 followed by a period of consultation with the intention for the final version to be approved by the Council in February 2024.

Resolved:

To note the update report.

7 BLACKPOOL PLACE-BASED PARTNERSHIP DEVELOPMENT

The Board receive a brief verbal update

The Board noted the strategic aims of the Integrated Care Board are to:

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience and access
- Enhance productivity and value for money
- Help the NHS support broader social and economic development

The Board was reminded that in July 2022, the Integrated Care Board had realigned its place boundaries with the upper-tier and unitary local authorities within the footprint:

- Blackpool Council
- Lancashire County Council
- Blackburn with Darwen Council
- South Cumbria

This had the aim of providing more support for the deeper integration of health and social care services across the now 4 Lancashire and South Cumbria places.

There is a long-term vision for developing, and delegating responsibility to Place-based Partnerships such as Blackpool. It was noted that The place-based partnership is currently in the early stages of this journey.

The focus on key areas was noted including with examples given of the sort of work that would address outcomes and grow visibility:

- The First 1,000 days with the focus example given of further work to reduce smoking in pregnancy.
- Living Well with the focus example given of developing workforce aspirations
- Long Term conditions with focus on improving housing conditions, reducing smoking and ensuring mild conditions did not further detiorate.

Along with a general focus on mental health and wellbeing. An emphasis was also placed on the desire to avoid duplication and the Board noted that further regular updates would be given to the Board.

Resolved:

To support the Blackpool place-based partnership implementation and current developments, including its alignment with other strategies and work programmes.

8 HEALTH PROTECTION DRAFT STRATEGY UPDATE

To summarise progress with Blackpool's first Health Protection Strategy and how it assisted the Council's statutory duty for Health Protection. Dianne Draper, Consultant in Public Health presented the progress update to the board. Ms Draper reminded members about the Health Protection Strategy summit that had taken with representatives from the Council, NHS, Healthwatch and UK Health Security Agency on 21 September 2022 which had reviewed strengths and weaknesses and fixed the direction for the new strategy. Feedback from the session had then been analsyed thematically. Once the evidence for each recommendation had been reviewed, priority actions were written into a strategic approach to addressing critical health protection issues for Blackpool.

The strategy summarised the Health Protection purpose and vision, supported by four priority outcomes and two priority activities to enable the outcomes.

The Board endorsed the four priority outcomes namely: protect our children by increasing vaccination rates, protect our vulnerable residents and reduce inequalities, enhance the way we communicate risk to our residents and visitors, and work together to address outbreaks and incidents. The two ways of working together namely shared data and intelligence platform and governance and learn from other and our residents. The Board expressed its view that strong, robust and evidence-led health protection interventions could support all other health based objectives.

Resolved:

To endorse the approach outlined in the report and draft strategy at Appendix 8a

Chairman

(The meeting ended at 5.10pm)

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

Report to:	**HEALTH AND WELLBEING BOARD**
Relevant Officer:	Liz Petch, Consultant in Public Health
Relevant Cabinet Member:	Councillor Jo Farrell, Cabinet Member for Levelling Up People
Date of Meeting:	27 June 2023

BLACKPOOL JOINT LOCAL HEALTH AND WELLBEING STRATEGY UPDATE

1.0 Purpose of the report:

1.1 To provide the Board with an update on the development of a new Blackpool Joint Local Health and Wellbeing Strategy.

2.0 Recommendation(s):

2.1 To note the report and any verbal update.

3.0 Reasons for recommendation(s):

3.1 The report is for information to ensure that the Board is kept aware of progress in developing the new Blackpool Joint Local Health and Wellbeing Strategy.

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

3.3 Is the recommendation in accordance with the Council's approved budget? 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 Following the Health and Wellbeing Board meeting on 5 October 2022, the Board had agreed the need to write a new Joint Local Health and Wellbeing Strategy (JLHWS) for Blackpool as the previous Joint Health and Wellbeing Strategy 2016-2019 had elapsed.

6.2 Health and Wellbeing Boards have been a key mechanism for driving joined up working at a local level since they were established in 2013.

The new Health and Care Act 2022 introduced new architecture to the health and care system, specifically the introduction of Integrated Care Boards (ICBs) and Integrated Care Partnerships (ICPs). In this new landscape, Health and Wellbeing Boards continue to play an important statutory role in instilling mechanisms for joint working across health and care organisations and setting strategic direction to improve the health and wellbeing of people locally.

Health and Wellbeing Boards have a statutory function to:

- Assess the health and wellbeing needs of the local population and publish a Joint Strategic Needs Assessment (JSNA);
- Publish a Joint Local Health and Wellbeing Strategy (JLHWS) which sets out the priorities for improving the health and wellbeing of its local population and how the identified needs will be addressed, including addressing health inequalities, and which reflects the evidence of the Joint Strategic Needs;
- The Joint Local Health and Wellbeing Strategy should directly inform the development of joint commissioning arrangements (see section 75 of the National Health Service Act 2006) in the place and the co-ordination of NHS and local authority commissioning, including Better Care Fund plan

6.3 It is expected that all partners – the Health and Wellbeing Board, Integrated Care Board (at Lancashire and South Cumbria level) and Integrated Care Partnership - adopt a set of principles in developing relationships, including:

- Building from the bottom up
- Following the principles of subsidiarity
- Having clear governance, with clarity at all times on which statutory duties are being discharged
- Ensuring that leadership is collaborative
- Avoiding duplication of existing governance mechanisms

In line with this guidance, we are working together at a Blackpool system level to ensure alignment of priorities and work programmes.

6.4 Work on developing a new Joint Local Health and Wellbeing Strategy has begun with a review of existing strategies, systems and structures and a review of Joint Strategic Needs Assessment data having taken place during March and April 2023.

6.5 A stakeholder workshop was then held on 6 June 2023 where the review work was presented alongside an update on the development of the Integrated Care Partnership (ICP) and NHS Joint Forward Plan.

It was agreed at this first workshop with Health and Wellbeing Board partners that the overarching goal for the new Joint Local Health and Wellbeing Strategy would be to close the gap in life expectancy and healthy life expectancy with England. This is however a long term goal and further work will be needed to think about what existing or new actions are needed to achieve this goal.

6.6 A summary of the workshop discussions, with agreements and next steps are attached as an Appendix, this includes details on the agreed key priorities for action: -

- Starting Well – First 1001 days to include smoking in pregnancy and childhood obesity
- Education, employment and training – particularly year round economy and jobs to tackling seasonality, and valuing core community
- Living Well – to include smoking, drugs and alcohol, and physical and mental wellbeing
- Wider determinants of health – particularly housing

6.7 Leadership from existing Partnership Forums and Boards will be key in taking this work forward. There is no need to create new structures and governance if this work is already in train.

The Board should be guided by topic expert's knowledge and experience on what, how and who is needed to tackle the health harms that are associated with each of these priorities.

6.8 Monitoring of progress against agreed work programmes, with appropriate performance indicators will be key; as will key decisions on prioritisation of resources and evidence of what has been done or what has changed because of the Joint Local Health and Wellbeing Strategy.

6.9 Key next steps for this work, include: -

- Develop a rationale to explain why certain priorities have been chosen and address why certain priorities were not chosen. This will help to build a shared understanding among stakeholders.

- Identify and engage wider stakeholders who have not yet been involved in the strategy development process, to ensure a more comprehensive and inclusive approach.
- Develop a framework for action that outlines short, medium, and long-term evidence based actions for each identified priority.

6.10 Does the information submitted include any exempt information? No

7.0 List of Appendices:

7.1 Appendix 3a: Joint Local Health and Wellbeing Strategy Workshop Notes - Tuesday 6 June 2023

8.0 Financial considerations:

8.1 There may be financial resources needed to facilitate an inclusive consultation and development process for a new Joint Local Health and Wellbeing Strategy. These will be identified as the strategy is developed and approval sought through the appropriate decision making processes.

8.2 There may also be financial resources needed to take forward some aspects of new work of identified in the Joint Local Health and Wellbeing Strategy. This will be considered as part of the development and implementation phase of the process and presented back to Board at a future meeting.

9.0 Legal considerations:

9.1 None.

10.0 Risk management considerations:

10.1 None.

11.0 Equalities considerations:

11.1 Health and wellbeing boards must meet the Public Sector Equality Duty under the Equality Act 2010, and consideration will be given to this throughout strategy process. This includes consideration about how the community is involved, the experiences and needs of people with relevant protected equality characteristics, (as well as considering other groups identified as vulnerable in Joint Strategic Needs Assessments); and the effects decisions have or are likely to have on their health and wellbeing.

11.2 The underlying theme of the strategy is to improve people's health and wellbeing, and reduce health inequalities that exist in Blackpool. It is not anticipated that the strategy would adversely impact on key protected equality groups. An Equality Analysis will be completed as part of the strategy development process.

12.0 Sustainability, climate change and environmental considerations:

12.1 Reducing Blackpool's contribution to the climate crisis and creating resilience to respond to the worst impacts of climate change is an opportunity to protect health.

Dependent upon the priorities of the strategy, the Joint Local Health and Wellbeing Strategy could contribute to the delivery of the council's climate emergency declaration in the following ways:

- Climate mitigation (efforts to limit the emission of greenhouse gases): the strategy could incorporate actions which improve health as well as reduce greenhouse gas emissions. For example, by improving the energy efficiency of housing this would mean houses would use less energy, thereby reducing greenhouse gas emissions. Improving housing energy efficiency would help to address issues such as fuel poverty and the physical and mental health issues associated with cold homes. This shows how incorporating climate mitigation considerations into the strategy could positively impact models of care by reducing inequalities in health and reducing avoidable hospital admissions.

- Climate adaptation (actions taken to reduce the negative consequences of climate change): the strategy could address the expected health impacts as a result of climate change and incorporate actions to prepare for and be equipped to respond to the climate crisis. For example, increasing education on the health impacts and risks associated with heat can enable people to cope more effectively. This shows how incorporating climate adaptation considerations into the strategy could increase community resilience to climate change and provide support to vulnerable residents to reduce the impact of climate change.

Other examples of how the strategy could promote healthy living while reducing environmental impacts include promoting active travel, reducing the carbon footprint of healthcare facilities, and ensuring that new programmes support the local environment.

13.0 Internal/external consultation undertaken:

13.1 As detailed in the attached Appendix 3a as a result of a multi-agency workshop on 6 June 2023.

14.0 Background papers:

14.1 None.

Blackpool Council

Appendix 3a

NHS Lancashire and South Cumbria Integrated Care Board

Joint Local Health & Wellbeing Strategy Workshop – Notes

Tuesday 6th June 2023

This document offers an overview of the Joint Local Health & Wellbeing Strategy workshop and summarises key points and considerations discussed. The document also outlines the proposed next steps for the further development of the Joint Local Health & Wellbeing Strategy.

Presentations

The workshop consisted of presentations on:

- Lancashire and South Cumbria Integrated Care Strategy
- Blackpool Joint Strategic Needs Assessment, and
- Blackpool Place-Based Partnership Priorities

Key Questions

Participants were then divided into groups to work on the following key questions:

1. What is the overarching goal that we want to achieve with the Joint Local Health and Wellbeing Strategy?
2. What are the key priorities that we should focus on in the Joint Local Health and Wellbeing Strategy?
3. What needs to be the focus within each priority area?
4. Which group/board/forum will take ownership of driving improvement in each priority area?

Overarching goal of the strategy

Discussions about the overarching goal of the strategy, included considerations such as:

- Considering the current state of life in our communities and identify areas for improvement
- Improving overall health and healthy life expectancy
- Building hope and aspiration with the resident population
- Narrowing health inequalities gap
- Addressing wider determinants of health
- Aspire for improvements in employment, education, parental roles and school settings
- Emphasise a person centred approach and personalised care
- Fostering collaboration
- Recognising the impact of the foundational elements for success
- Stabilising the present situation to enhance future lives

Key priorities

Participants actively worked towards identifying key priorities to be addressed within the strategy. These priorities spanned across various areas, including:

- Housing
- Smoking (respiratory)
- The first 1001 days

- Starting well
- Living Well
- Childhood obesity
- Wider determinants of health
- Education, employment and training
- Drugs and alcohol
- Wellbeing (physical and mental)
- Year round economy, tackling seasonality and valuing core community

Focus within each priority area

It was recognised that each priority area required specific focuses in the short, medium and long term.

- **Short term action**: Immediate or near term action such as health interventions
- **Medium term action:** Addressing lifestyle choices and behaviours that contribute to health outcomes
- **Long term action:** Target the wider determinants of health (the social, economic and environmental factors that influence health outcomes)

The table below illustrates an example of short, medium, and long-term actions for several priority areas identified during the workshop.

Priority Area	Short Term	Medium Term	Long Term
Smoking	Targeting illegal tobacco	Education about the risks of smoking in schools	Increase levels of resilience within individual and communities
Alcohol	Implement interventions for first admission	Address lifestyle factors, including education and support for individuals with alcohol-related issues	Target prevention activity
Physical activity	Introduce health interventions through social prescribers	Physical activity programs in schools, after school activities and gyms	Address barriers to physical activity e.g. financial constraints, access to recreational space, perceptions etc.

Ownership of driving improvement in the strategy

Finally, considerations were given to determine which groups/boards/forums would take ownership of driving improvement in the strategy. Key points included:

- Assessing current enabling factors
- Establishing clear links to the ICS strategy
- Identifying treatable ill health related for each priority area and involving the NHS in addressing these issues
- Assessing the availability and quality of provision related to the priorities and addressing any gaps
- Engaging relevant statutory organisations in efforts to "grow our own" workforce

- Considering commitments for longer contracts, especially in the Voluntary, Community, Faith, and Social Enterprise (VCFSE) sector
- Clarifying the roles and responsibilities of each organisation in driving improvement within the strategy

Next steps post workshop

- **Identify and engage stakeholders:** Identify and engage stakeholders who have not yet been involved in the strategy development process to ensure a more comprehensive and inclusive approach.
- **Understand community perspectives**: It is important to gain a deep understanding of what is important to the local populations and how the strategy will be received, in order to ensure that the strategy is tailored to meet the community's specific needs.
- **Agree on priorities**: A consensus on the identified priorities within the strategy needs to be reached. This will require further discussions and inputs from relevant stakeholders to ensure that the chosen priorities align the community's needs.
- **Focus on key strategic priorities:** It is important to recognise that this is not about taking action on everything at once, but about setting a small number of key strategic priorities for action, that will make a real impact on people's lives.
- **Provide rationale for priority selection**: Rationale should be developed to explain why certain priorities have been chosen and address why certain priorities were not chosen. This will help to build a shared understanding among stakeholders.
- **Communicate the priorities:** Clear communication of the identified priorities is vital to ensure transparent and accountability.
- **Develop a framework for action**: Develop a clear framework that outlines short, medium, and long-term action for each identified priority.
- **Agree on collective resources**: It is necessary to agree on how resources will be allocated to support the identified priorities and actions.

Thank you

Thank you to all who participated in the workshop.

For further information and next steps contact: liz.petch@blackpool.gov.uk

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Report to:	**HEALTH AND WELLBEING BOARD**
Relevant Officer:	Carl Ashworth, Director of Planning, Lancashire and South Cumbria Integrated Care Board
Relevant Cabinet Member:	Councillor Jo Farrell, Cabinet Member for Levelling Up People
Date of Meeting:	27 June 2023

LANCASHIRE AND SOUTH CUMBRIA INTEGRATED CARE SYSTEM – JOINT FORWARD PLAN 2023 ONWARDS

1.0 Purpose of the report:

1.1 To provide the Health and Wellbeing Board with an overview of the Joint Forward Plan for the Lancashire and South Cumbria Integrated Care Board (ICB) and system partners.

2.0 Recommendation(s):

2.1 To consider and comment upon the attached draft version of the Joint Forward Plan and offer Board members' reflections on the content and particularly on whether they feel that the plan takes proper account of the Blackpool Health and Wellbeing Strategy. After taking account of these comments, a final version of the plan will go sign off by the Integrated Care System Board at its 5 July 2023 meeting.

3.0 Reasons for recommendation:

3.1 This approach to system planning provides an opportunity to strengthen the Health and Wellbeing Board's influence in the work of the new Integrated Care Board for Lancashire and South Cumbria, particularly on prioritising prevention of ill health and ensuring provision of high-quality community services; promoting integrated funding/commissioning to ensure best value; and delivering improved outcomes.

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 Expectations of national guidance

Integrated Care Boards are encouraged to use the Joint Forward Plan development process to produce a shared delivery plan for the Integrated Care System (developed by the Integrated Care Partnership) and the Joint Local Health and Wellbeing Strategy (developed by local authorities through Health and Wellbeing Boards) that is supported by the whole system, including local authorities and voluntary, community and social enterprise partners.

As a minimum, the Joint Forward Plan should describe how the Integrated Care Board and its partner trusts intend to arrange and/or provide NHS services to meet their population's physical and mental health needs. This should include the delivery of universal NHS commitments; address the Integrated Care Systems' four core purposes and meet legal requirements.

The following principles describing the Joint Forward Plan's nature and function, these have been co-developed nationally with Integrated Care Boards, trusts and national organisations representing local authorities and other system partners.

- **Principle 1:** Fully aligned with the wider system partnership's ambitions.
- **Principle 2:** Supporting subsidiarity by building on existing local strategies and plans as well as reflecting the universal NHS commitments.
- **Principle 3:** Delivery focused, including specific objectives, trajectories and milestones as appropriate.

Joint Forward Plans should build on and reflect existing Joint Strategic Needs Assessments Joint Local Health and Wellbeing Strategies and NHS delivery plans, along with previous local patient and public engagement, as such it is not anticipated that their development will require full formal public consultation, unless a significant reconfiguration or major service change is proposed, which is not the case for Lancashire and South Cumbria at this time.

6.2 How the plan matches up against national guidance

In the main, the expectations of the national guidance have been met within the text of the draft Joint Forward Plan. However, it should be noted that, as 2022/23 is a transition year for Integrated Care Boards, national guidance anticipates that the breadth and depth of the initial Joint Forward Plan will be constrained, with an expectation that a more comprehensive plan will be developed for 2024/25 onwards.

A review against the national guidance can be summarised against the three Joint Forward Plan principles set out above:

Principle	Description	Position in draft JFP
1	Fully aligned with the wider system partnership's ambitions	GREEN - Full alignment with Integrated Care Strategy and previous Long Term Plan ambitions
2	Builds on existing local strategies and plans as well as reflecting the universal NHS commitments	GREEN – strategic priorities reflect Integrated Care Strategy, Long Term Plan and operational plan objectives
3	Delivery focused	AMBER – narrative focuses on need for delivery – however, full detail of accountability frameworks and delivery plans will be worked up alongside the development of the system recovery plan

The draft Joint Forward Plan sets out five strategic priorities:

<table>
<tr><th colspan="3">OUR LONG-TERM STRATEGIC PRIORITIES</th></tr>
<tr><td colspan="3">STRENGTHEN OUR FOUNDATIONS</td></tr>
<tr><td colspan="3">Improve our long-term financial sustainability and value for money, through transformation with providers.</td></tr>
<tr><td>IMPROVE PREVENTION</td><td colspan="2">IMPROVE AND TRANSFORM CARE PROVISION</td></tr>
<tr><td>Prevent ill-health and reduce inequalities by collaborating with partners.</td><td>Integrate and strengthen primary and community care with partners and providers.</td><td>Improve quality and outcomes through standardisation & networking with providers.</td></tr>
<tr><td colspan="3">WORLD CLASS CARE</td></tr>
<tr><td colspan="3">Deliver world-class care for priority disease areas, conditions, population groups and communities.</td></tr>
</table>

The 'improving prevention' priority is where the key link to delivery of the Integrated Care Partnership's Integrated Care Strategy – which in turn was built upon the health and wellbeing plans of the Health and Wellbeing Boards in Lancashire and South Cumbria – can be found, although there are clearly connections across all priorities:

Since the review of the draft Joint Forward Plan document by the Integrated Care Board March, there have been further amendments made to the contents – most notably, the alignment of the plan's narrative to the developing system recovery and transformation approach, aimed to deliver system financial balance over the next three years. The details of this approach are being finalised - the attached document should be considered therefore as work in progress prior to the final version being presented to the Board in early July.

6.3 Next steps

A final version of this plan – amended to take account of feedback from partners and the public – will be received by the Integrated Care Board at its 5 July 2023 meeting.

A detailed system delivery plan with measurable goals, annual milestones, targets, performance ambitions and trajectories for providers, places and neighbourhoods is under development, aligned with the System Recovery and Transformation plan. The system delivery plan will inform a clear accountability framework for delivery between organisations and residents and patients and will support clear governance and oversight arrangements.

The Integrated Care Board will work with partners to develop a more comprehensive updated plan for 2024/25 onwards with the opportunity for further engagement and collaboration and for the most appropriate delivery mechanisms and actions of partners to be included.

6.4 Does the information submitted include any exempt information? No

7.0 List of Appendices:

7.1 Appendix 4a Lancashire and South Cumbria Joint Forward Plan 2023 v7.1 for Board engagement

8.0 Financial considerations:

8.1 There are no financial implications resulting from this report.

9.0 Legal considerations:

9.1 Under section 14Z54 of the National Health Service Act 2006 (as amended by the Health and Care Act 2022) the Health and Wellbeing Board must respond to any draft Joint Forward Plan it receives from the Integrated Care Board by providing its opinion on whether the draft Joint Forward Plan takes proper account of Health and Wellbeing Board's Joint Local Health and Wellbeing strategy. The Integrated Care Board must include the final statement of the Health and Wellbeing Board's opinion in their Joint Forward Plan when it is published.

10.0 Risk management considerations:

10.1 Risk of non-compliance with statutory duty as described at section 9.

11.0 Equalities considerations:

11.1 Full equality impact analysis to be undertaken as part of the implementation of the Joint Forward Plan once agreed.

12.0 Sustainability, climate change and environmental considerations:

12.1 The Joint Forward Plan references the Integrated Care Strategy Green Plan and the ambition for the NHS emissions to be net zero by 2040.

13.0 Internal/external consultation undertaken:

13.1 All Health and Wellbeing Boards and health and care partner organisations in Lancashire and South Cumbria are being engaged as part of the development of the Integrated Care Board's Joint Forward Plan.

There is no requirement on the Integrated Care Board to conduct formal public consultations as part of its Joint Forward Plan development process, however feedback from public engagement is being considered to support the development.

14.0 Background papers:

14.1 None.

NHS
Lancashire and South Cumbria
Integrated Care Board

Appendix 4a

Lancashire and South Cumbria Integrated Care System

Our NHS Joint Forward Plan for 2023 onwards

V7.1 For engagement prior to Board

31.05.23

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Foreword

Kevin Lavery
Chief Executive of the Lancashire and South Cumbria Integrated Care Board

David Flory CBE
Chair of the Lancashire and South Cumbria Integrated Care Board

The Lancashire and South Cumbria Integrated Care Board (ICB) is responsible for developing a Joint Forward Plan for the NHS over the next five years. The ICB forms part of the Integrated Care System across Lancashire and South Cumbria, the formal partnership of organisations tasked with improving the health and wellbeing of our population.

Our plan describes how the NHS will meet the health needs of our population, by working jointly with partners on prevention, and by working with all organisations within the NHS family to transform the way healthcare services are provided.

Our plan has been developed at a time of enormous challenges for health and care services. The demands and expectations on services are ever increasing, alongside significant financial and workforce constraints.

We know that we have faced many of these challenges for some time and we acknowledge that we can't solve them without changing the way we work as a health and care system. ***We are clear on the 'what' and the 'why' but up until now we have not grasped the 'how'.*** *We are ready to take action and work very differently.*

There are significant health and well-being issues within Lancashire and South Cumbria, and the COVID-19 pandemic has exacerbated these, with health inequalities widening in some areas. The cost-of-living crisis is expected to worsen the position further still.

The pressures we face are not unique to us, but their impact on our communities is affected by our local demographics. Almost a third of our residents are living in some of the most deprived areas of England, with poor health outcomes and widening inequalities. There are significant differences in the number of years people can expect to live a healthy life across our area. We know that many people in Lancashire and South Cumbria could be living longer, healthier, happier lives than they currently do.

We need to work with partners and local communities to prevent people from becoming ill in the first place by tackling the wider determinants of health and supporting people to make positive health and well-being choices, while also improving access to health and care services.

The establishment of our Integrated Care Board is an opportunity to make a real difference to the health and lives of the people who live here and the quality of care in Lancashire and South Cumbria. This Joint Forward Plan outlines, at a high level, how we will work alongside our providers and other partners to meet the challenges set out above. It builds upon existing system strategies and activity that is already underway and provides an overarching narrative about what it is that we are all trying to change and improve together.

Be assured that the hard work has already begun.

We have developed an Integrated Care Strategy with our partners in local government, the voluntary, community, faith, and social enterprise sector and local people. The strategy details a joined-up work programme, across the whole life course of our population, to improve prevention and integrate health and social care. It will drive integrated working at system, place, and neighbourhood, to improve the health and well-being of our population. This Joint Forward Plan responds to the commitments made by the NHS within this Strategy.

Our system finance colleagues are developing a financial framework for the next three years that sets out the context for the difficult decisions that we will need to make under harsher financial conditions, including the establishment of our formal recovery and transformation programme. This Joint Forward Plan describes our financial framework and how it will influence our work over the coming years.

Our communities will be at the centre of everything we do. With our partners, we have agreed on how we will work with people and communities to listen, involve, and co-produce our plans together. This will help to develop ways of working that focus on local people and their lived experience, putting our population's needs at the heart of all we do.

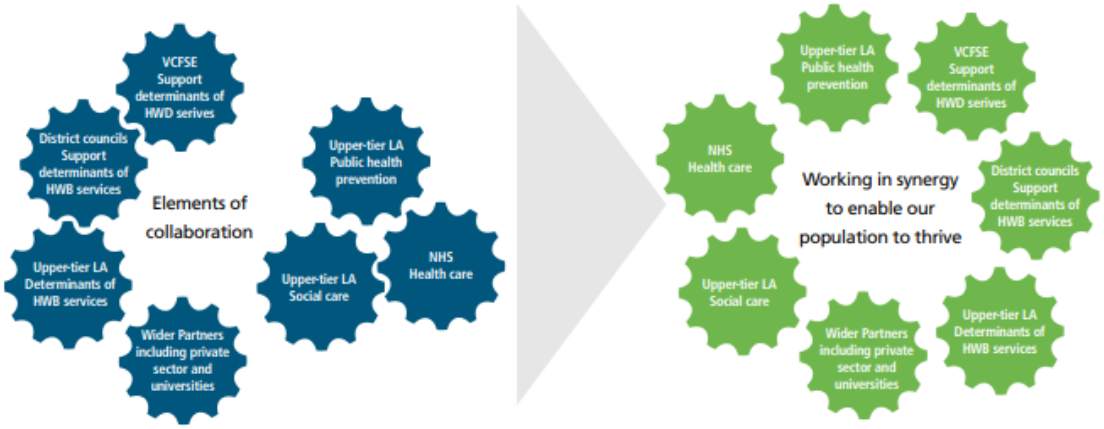
Together, we will achieve our vision of longer and healthier lives for our population across Lancashire and South Cumbria.

1. Introduction

When the NHS was established, it mainly focused on treating single conditions or illnesses. Since then, the health and care needs of our populations - and their demands and expectations of the NHS - have changed.

More people than ever are living longer with multiple, complex, long-term conditions and often need support from many different services, sectors, and professionals. Unfortunately, people often receive care from different services that aren't joined-up and are not effectively centred around their needs. This is not a good use of vital NHS time and resources and can mean that patients have a poorer experience of health and care; take longer to recover from illness or injury; and have to 'tell their story' to lots of different teams.

In the past, whilst there have been connections between the organisations that have a role in health and well-being, often they have not formally worked in a joined-up (integrated) way. This is because many organisations were encouraged to compete for resources, rather than collaborate.



The Health and Care Act 2022 marks a change from this competitive way of working. It sets out in law that the NHS must work in an integrated way with other organisations and partners.

Integrated Care Systems (ICSs) are geographically based partnerships that bring together providers and commissioners of NHS services with local government and other local partners to plan, coordinate and commission health and care services.

ICSs are tasked with improving the health and well-being of the whole population by harnessing the knowledge, skills and talents of all partner organisations.

Together, all the partners in the ICS are responsible for improving outcomes, tackling inequalities, improving productivity and helping the NHS support broader social and

economic development. This new structure expects and encourages collaboration at every level.

The Health and Care Act offers an opportunity for partners across Lancashire and South Cumbria to understand the important contribution that each organisation makes to people's health and well-being and therefore how creating shared plans and forging new relationships will really benefit our population.

We intend to connect services across councils, the NHS, Voluntary, Community, Faith and Social Enterprise (VCFSE) organisations and beyond, to provide seamless and integrated services for our population.

This Joint Forward Plan for the NHS includes joint working between health and social care and within the NHS family of providers, including hospitals, primary care, community, mental health, and acute providers.

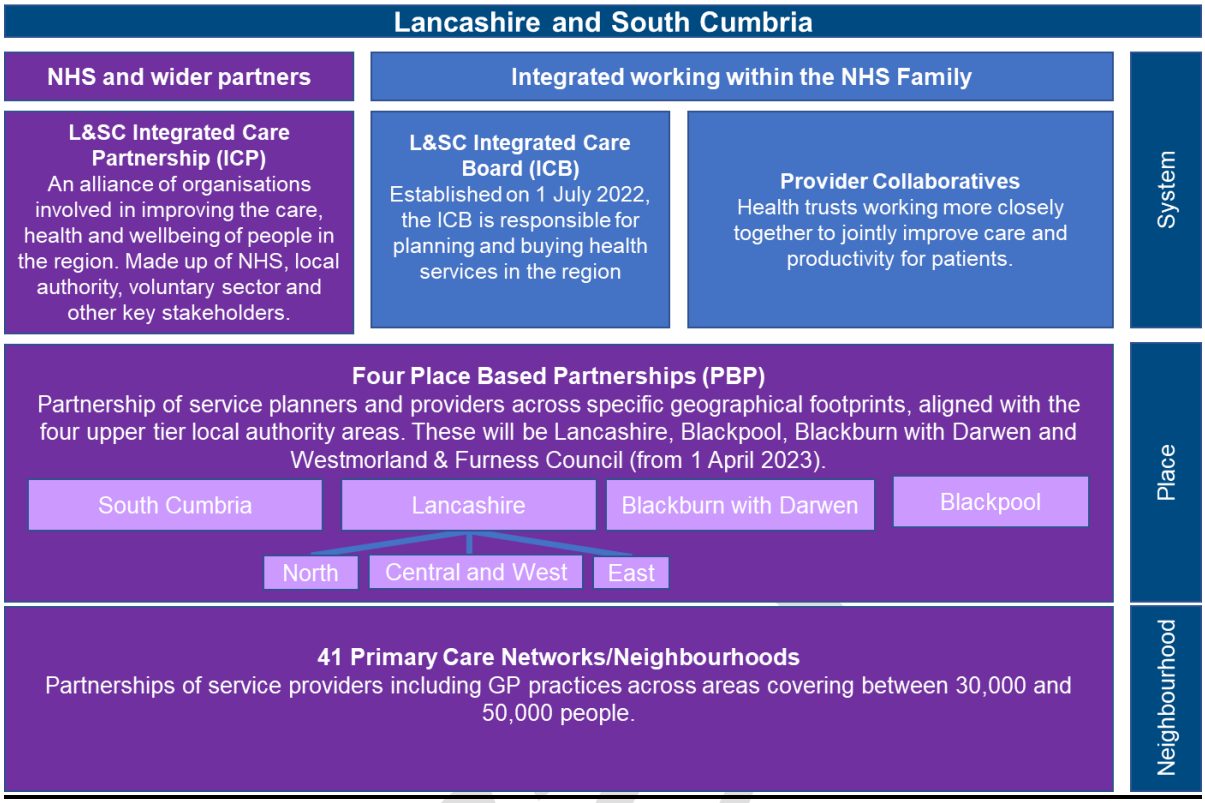
A new way of working

To deliver improved health and well-being for our population by working in an integrated way, we need to have the right structures in place to support and drive change. This means we must work in different ways at three levels - across the Lancashire and South Cumbria System; within our four places; and at neighbourhood level – to organise and deliver services at the most appropriate level and closest to the residents we serve.

Our places and neighbourhoods put our residents, their families, their carers, and wider communities at the centre of our integrated working. Most people's day-to-day care and support needs will be planned and delivered within a place and its neighbourhoods.

- **System**: Integrated working across Lancashire and South Cumbria.
- **Places**: Integrated working in the areas covered by our four place-based partnerships, covering Lancashire, Blackburn with Darwen, Blackpool and South Cumbria.
- **Neighbourhoods**: Integrated working in the areas covered by our 41 primary care networks, and local neighbourhood teams.

Components of the Lancashire and South Cumbria Integrated Care System



The structure of the ICS

The Integrated Care System in Lancashire and South Cumbria was established as a legal entity under the Health and Care Act 2022, with statutory powers and responsibilities and made up of two formal parts:

- **The Lancashire and South Cumbria Integrated Care Board** (ICB) is the statutory body responsible for commissioning (planning and buying) NHS services for the 1.8 million people living in Lancashire and South Cumbria. The ICB must work in partnership with local authorities and wider organisations and integrate services wherever possible to deliver the greatest possible improvement in health and well-being. Members of the ICB Board include representatives from NHS providers, primary medical services, and local authorities.

- **The Lancashire and South Cumbria Integrated Care Partnership (ICP)** is a statutory committee formed jointly between the NHS ICB and all upper-tier local authorities in Lancashire and South Cumbria (councils with responsibility for children's and adult social care and public health). The ICP brings together partners that have a role in improving the health and well-being of the population, with membership determined locally. The ICP is responsible for producing an Integrated Care Strategy which details how the local health and well-being needs of the population will be met.

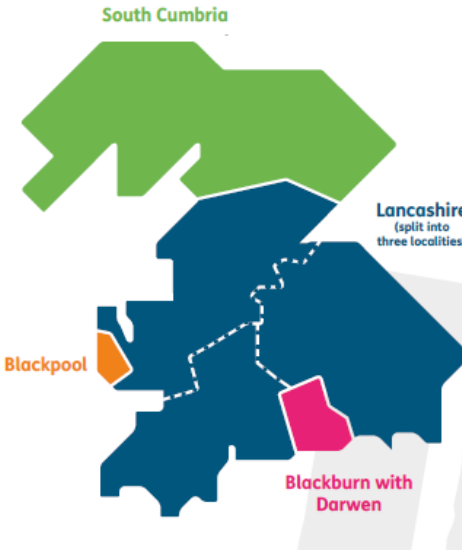
- **The Provider Collaborative** sees five acute, mental health and community providers in Lancashire and South Lancashire work together as one. They are:
    - Blackpool Teaching Hospitals NHS Foundation Trust
    - East Lancashire Hospitals NHS Trust
    - Lancashire and South Cumbria NHS Foundation Trust
    - Lancashire Teaching Hospitals NHS Foundation Trust
    - University Hospitals of Morecambe Bay NHS Foundation Trust

Our provider collaborative will be the engine room for improving sustainability and transforming the delivery of acute care across the system.

Our system

Local Authorities	**Six upper-tier local authorities** *Lancashire County Council, North Yorkshire Council (unitary), Cumberland Council (unitary), Westmorland and Furness Council (unitary), Blackpool Council (unitary), Blackburn with Darwen Council (unitary).* **Twelve district councils** ***Lancashire**: Preston City Council, Chorley Council, South Ribble Borough Council, Fylde Council, Wyre Council, West Lancashire Borough Council, Lancaster City Council, Burnley Borough Council, Hyndburn Borough Council, Pendle Borough Council, Ribble Valley Borough Council, Rossendale Borough Council.*
NHS	**Provider Collaborative -** *All five of the foundation trusts below, work together as part of the provider collaborative.* **Four acute / community service providers** *Blackpool Teaching Hospitals NHS Foundation Trust (acute and community services), East Lancashire Hospitals NHS Trust (acute and community services), Lancashire Teaching Hospitals NHS Foundation Trust (acute services), University Hospitals of Morecambe Bay NHS Foundation Trust (acute and community services).* **One mental health/community provider** *Lancashire and South Cumbria NHS Foundation Trust*
	One ambulance service provider *North-West Ambulance Service NHS Trust (NWAS).* **Primary care** *41 primary care networks (PCN) covering 248 GP Practices.*
VCFSE	**Seven collectives of community voluntary services or councils for voluntary services** (CVS) *Blackburn with Darwen CVS, Burnley, Pendle and Rossendale CVS, Cumbria CVS, Hyndburn and Ribble Valley CVS, Lancaster District CVS, Blackpool, Wyre, and Fylde CVS.*
Wider	**Four local independent organisations that champion the views of patients and service users** ***Healthwatch:** Blackburn with Darwen, Blackpool, Cumbria, and Lancashire. All four Healthwatch organisations work collaboratively as Healthwatch Together* **Other partners** *This includes our local universities, colleges, hospices and community and faith organisations.*

Our places



There are four places within the Lancashire and South Cumbria Integrated Care System: South Cumbria, Lancashire, Blackpool, and Blackburn with Darwen. We are forming place-based partnerships in each of these places. These are collaborations of health, local authority, VCFSE organisations, independent sector providers and the wider community, working in a joined-up way and taking collective responsibility for planning and delivering services. By working in partnership and with local communities, organisations can better address the biggest and most challenging issues that affect people's health and well-being.

Our places will be the engine room for driving delivery of the Integrated Care Strategy.

- **South Cumbria** has a resident population of around 311,000 people.
  - A mixture of coastal and rural areas, with some wealthy and some disadvantaged communities.
  - The area stretches from Barrow-in-Furness, a busy shipbuilding town and port, and Millom on the west coast, through South Lakeland with its rural, land-based and thriving visitor economy, across to the area around Bentham in North Yorkshire.
  - This is England's most sparsely populated local authority area, which makes it hard to deliver services, and to provide public transport and transport connections.

- **Lancashire** has a resident population of around. 1.2 million people.
  - It is a varied place from the high moorland of the South Pennines to the flat expanse of the Fylde Coast and the countryside of the Ribble Valley and Forest of Bowland.
  - A combination of urban areas including Preston and Lancaster, former textile towns such as Burnley, coastal resorts, and market towns.
  - A mixture of wealthy and disadvantaged communities. In the more rural areas, poverty and social exclusion happen alongside people living in luxury. Large areas of deprivation can be found in East Lancashire, Morecambe, Skelmersdale and Preston.

- **Blackpool** has a resident population of around 153,000 people.
    - An urban coastal area, with a thriving tourist economy and a strong sense of community.
    - With high levels of deprivation and a transient population, Blackpool residents have some of the most difficult health needs in the country.

- **Blackburn with Darwen** has a resident population of around 163,000 people.
    - A semi-rural borough with small urban areas around the towns of Blackburn and Darwen, and several small rural villages and hamlets.
    - A multicultural borough, the area is home to many people with diverse ethnicities and identities.

2. Scope and development of our Joint Forward Plan

This Joint Forward Plan for 2023 onwards outlines how the Lancashire and South Cumbria ICB will work with NHS providers of care, local government, VCFSE organisations and other partners to deliver our mission.

Mission	*We are committed to improving the health and well-being of the 1.8 million people of Lancashire and South Cumbria, by working collaboratively with partners to:* • *Reduce health inequalities* • *Secure better health and care outcomes* • *Provide the best care at the right time, to enable people to live healthy and fulfilling lives.*

We will deliver our mission by taking targeted action with partners across the four priority aims for Integrated Care Systems.

Our Four Pillars			
Tackling inequalities *in outcomes, experience, and access*	***Improving outcomes*** *in population health and healthcare*	***Enhancing productivity and value for money***	***Helping the NHS to support broader social and economic development***

We will also consider the effects of all our decisions on the three triple aims of Integrated Care Systems, as outlined below:

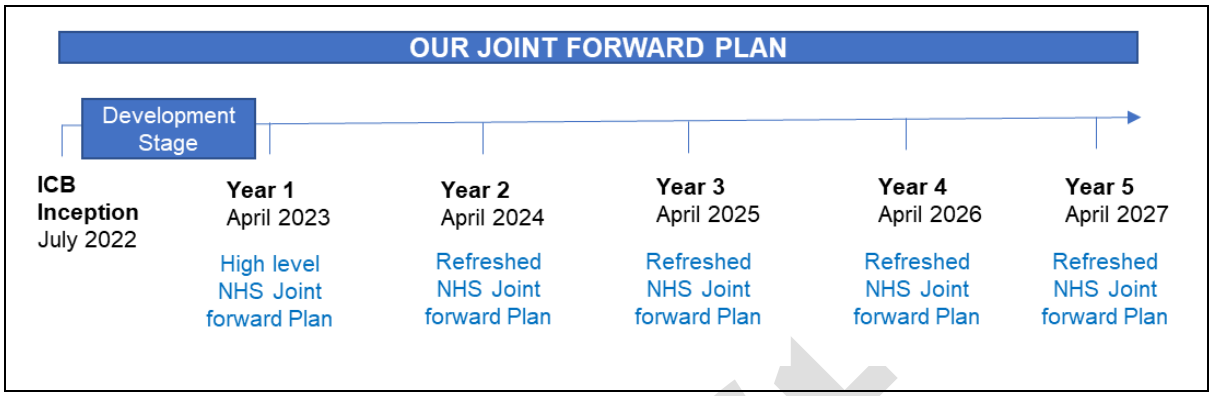
The health and well-being of our population *(including inequalities)*	***The quality of services provided*** *(including inequalities in benefits from those services)*	***The sustainable and efficient use of resources***

The NHS services that the ICB is responsible for are shown in the table below.

In Scope				Out of Scope
Primary Care *including dentistry, optometry, and community pharmacy.*	**Community Care**	**Acute Care**	**Mental Health and Learning Disability services**	**Specialised Commissioned** (Currently Commissioned by NHS England)
Our services cover all the healthcare needs of our population, from cradle to grave. Our valued service providers include the NHS, the independent sector, and the voluntary sector.				

Specialised commissioned services may be impacted by decisions taken by the ICB - where necessary, due consideration and involvement of these services will take place.

Our development journey



This first ICB Joint Forward Plan is intentionally high-level because the ICB is a newly-formed organisation and so many of our plans, priorities and relationships are continuing to be developed.

This plan sets out our intended vision, strategy and priorities for action. Working as a system provides a huge opportunity to work differently to tackle the urgent challenges that we face. However, this will also be a significant programme of change.

The final version of the Joint Forward Plan for the ICB Board in July will provide a summary of our statutory responsibilities and how we intend to deliver them.

We will work through the detail and consult with our partners, our workforce, and our population to ensure our plans, infrastructure and systems and processes are sustainable and provide the right foundations for integrated working.

This document builds on existing strategies and plans and sets out our aspiration to engage with our partners, staff and population to refresh and further develop this plan for 2024/25 and beyond.

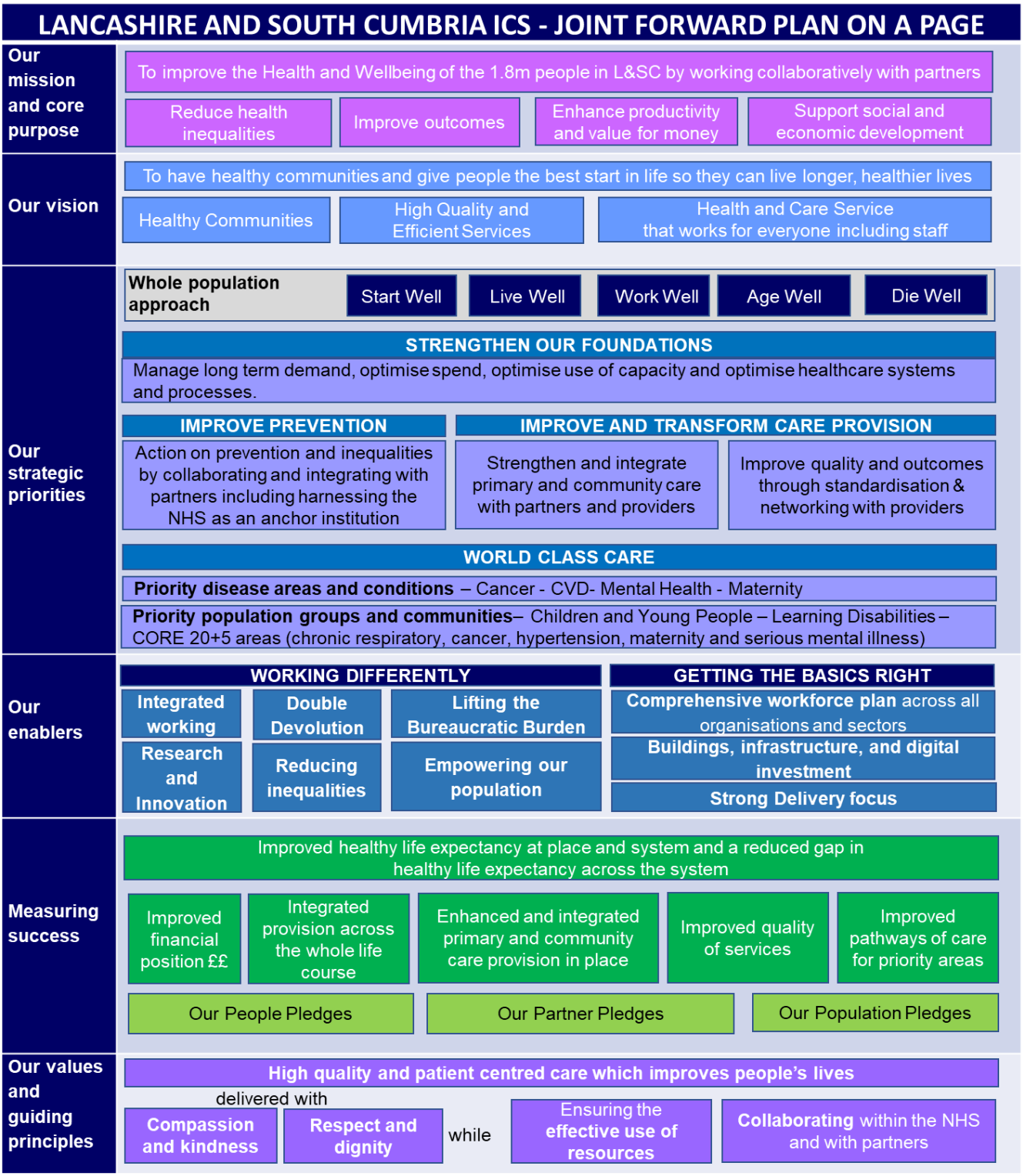
This Joint Forward Plan should be considered alongside the following documents:

- The **Integrated Care Strategy** has been developed through our Integrated Care Partnership and proposes how the ICB will work with local authorities and other partners to meet the health and well-being needs of our population.

- The **State of the System report** was published by ICB Chief executive, Kevin Lavery, and sets out his early views on the challenges facing the health and care system in Lancashire and South Cumbria and the steps we need to take to overcome them.

3. Our Joint Forward Plan on a page

The diagram below summarises the Joint Forward Plan for improving the health and well-being of the people of Lancashire and South Cumbria.



4. Our current challenges

There is a mismatch between the demand for healthcare in Lancashire and South Cumbria and the available capacity – indeed, this gap is widening over time. It is impacting on our population, our patients, our staff, and our finances. As demand grows, so do waiting times for care - it also creates additional pressure on our valued workforce. As a system, we are spending more money on health and care services then we receive in income, and this situation has got significantly worse since the COVID-19 pandemic.

In the financial year 2019/20, five of the six hospital trusts were overspending. During the pandemic, funding was provided to cover all the costs in the system, but this masked the true underlying position that has not been addressed. The CCGs also had underling deficits that were being covered each year through non-recurrent means. The underlying system financial risk is significant and the additional funding we have been receiving is being reduced over the next three years.

However, the finance challenges are merely the symptom. We must take urgent action to improve the long-term sustainability of the Lancashire and South Cumbria health system by managing increasing demand on our services and transforming the way we use services, staff, and buildings to provide services.

Factors driving an increase in demand	Factors limiting our capacity
More people living with diseases (the disease burden) • High levels of deprivation, unhealthy lifestyle choices and variability in community resources and access to care, is affecting people's health. • There are significant differences in life expectancy and healthy life expectancy between communities. • More people than ever are living with more serious, long-term conditions. This is often also linked to deprivation. **A population with varied levels of engagement with their health and well-being** • There are varied levels of understanding in how to maximise positive health and wellbeing. • Advancements in health innovation are creating increasing demand for services. • People have become used to accessing healthcare on demand.	**Workforce gaps** • Hospital workforce gaps mean we are spending more on agency staff. • There are gaps in the primary and community care workforce which reduce our ability to support patients outside of hospital. • Increasing numbers of people are choosing to leave the healthcare workforce. • Some staff are feeling exhausted and low, particularly after the COVID-19 pandemic. **Quality of physical infrastructure** • There are issues with the quality of our physical buildings. **Inconsistent quality and outcomes** • There are differences in the quality of care across our system. **The delivery model** • Focused on hospitals • There are barriers which impact upon providers working together, and the NHS working with its partners.

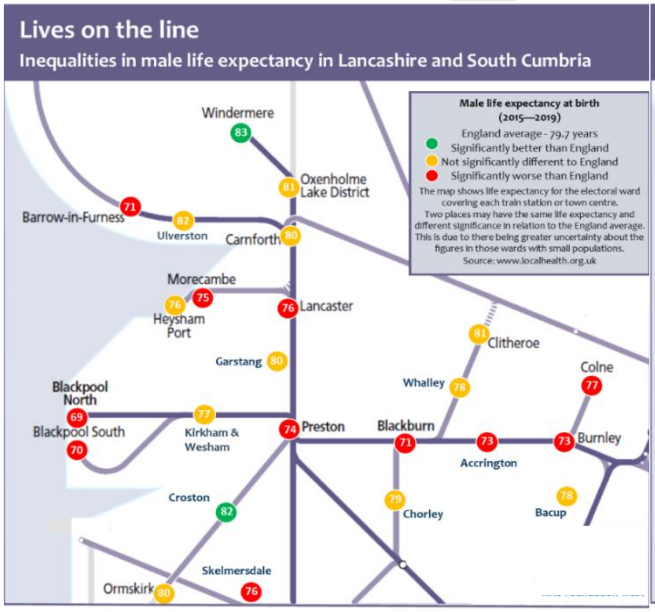
To ensure that our strategic priorities over the next ten years are the correct ones, it is critical that we have a detailed understanding of all the issues that are driving our financial position and how the issues are interconnected.

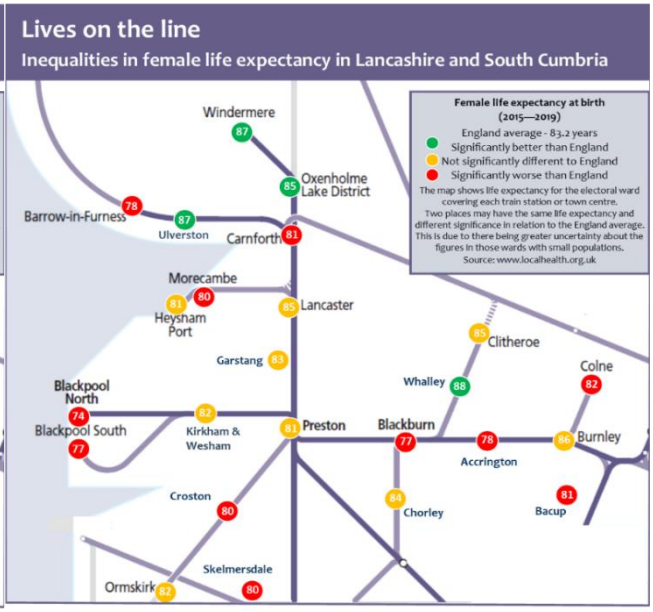
Increasing demand

Some 1.8 million people live in Lancashire and South Cumbria and this number is expected to rise to 2.05 million by 2033. The health and well-being of our population is variable, depending on the neighbourhood and place in which people live. We have a significant number of people living with complex long-term diseases (sometimes called the disease burden) and the demand for healthcare is rapidly increasing. This is being driven by unhealthy lifestyle choices and deprivation and is also affected by ways of working that often see the NHS largely working separately from the other organisations which support health and well-being.

Life expectancy

Life expectancy in Lancashire and South Cumbria is lower than the national average – by almost a decade in some areas. There is also a large variation in the number of years people can expect to live a healthy life. Babies born in this area today have a healthy life expectancy that is lower than the expected state pension age of 68. In some areas, healthy life expectancy is as low as 46.5 years, although this varies significantly across our communities. The health of our communities also varies significantly.





Driven by

Disease burden

The main causes of the lower healthy life expectancy in Lancashire and South Cumbria are cancer, conditions relating to the heart and lungs, mental health, and conditions relating to the brain and nervous system. Around 21,000 people in the area have five or more long-term health conditions. The number of people living with common mental health disorders is higher than the rate across England. In addition, nine per cent of our population are from ethnically diverse backgrounds. Ethnicity can affect people's health differently, for example, South Asian people are more likely to develop heart disease at a younger age and have a higher risk of stroke, than the general population.

Impacted by

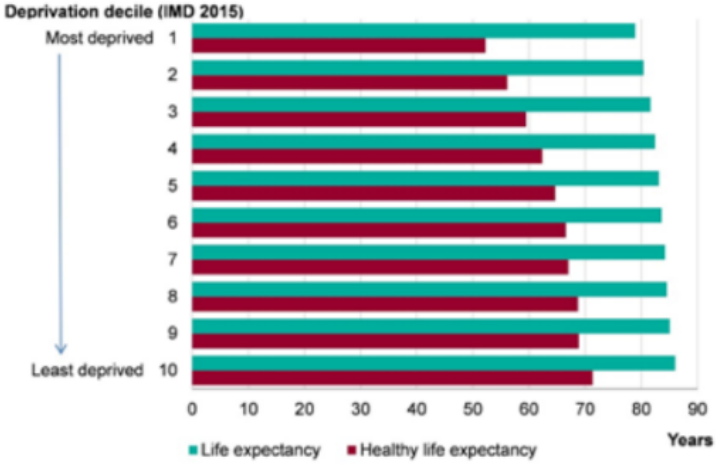
Lifestyle choices

One of the biggest factors that affect people's healthy life expectancy is their lifestyle choices. Around 40 per cent of ill health is seen in people who smoke, do little physical activity, are obese or abuse substances such as drugs and alcohol. In Lancashire and South Cumbria, 18.5 per cent of adults' smoke, compared with the national average for England of 17.2 per cent. Plus, only around a fifth of adults do the recommended levels of physical activity. These statistics vary markedly by place and neighbourhood.

Driven by

Demographics and deprivation

The healthy life expectancy across Lancashire and South Cumbria is affected by the levels of deprivation and poverty within our communities. Factors such as housing, the quality of the living environment, levels of education, crime and employment all have an impact on health. The level of deprivation in an area is measured by the Index of Multiple Deprivation (IMD).



The effect of deprivation on health is shown very powerfully on this chart. At the top of the chart is IMD decile one, representing the most deprived areas in England, and it shows the healthy life expectancy is only around 50 years, whereas those in the least deprived areas or IMD decile 10, can expect to live in good health until they are over 70. This is important because almost a third of people in Lancashire and South Cumbria live in some of the most deprived areas of England.

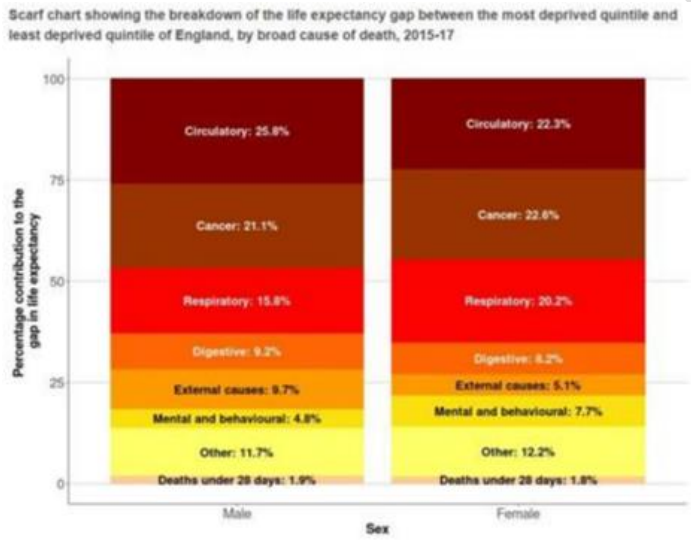
The table below shows the levels of deprivation across the wider Lancashire area, including Blackpool and Blackburn with Darwen. The decile shows the level of deprivation in each area, with a lower decile indicating higher deprivation; Blackpool, Blackburn, Hyndburn, and Burnley are all within decile one. The percentile shows their relative position, with Blackpool being the most deprived area within decile one, at 1.2%. Within Lancashire there are four areas within decile one, and a further two areas within deciles two and three.

Area	2015		2019		2015 to 2019	2015 to 2019
	Percentile	Decile	Percentile	Decile	Change in percentile	Change in decile
Burnley	5.2%	1	3.5%	1	-1.7%	0
Chorley	57.1%	6	60.6%	7	3.5%	1
Fylde	66.9%	7	62.5%	7	-4.4%	0
Hyndburn	8.6%	1	5.7%	1	-2.9%	0
Lancaster	38.3%	4	35.3%	4	-3.0%	0
Pendle	12.9%	2	11.4%	2	-1.5%	0
Preston	22.1%	3	14.5%	2	-7.6%	-1
Ribble Valley	89.0%	9	89.0%	9	0.0%	0
Rossendale	30.1%	4	28.7%	3	-1.4%	-1
South Ribble	71.8%	8	66.2%	7	-5.5%	-1
West Lancashire	50.3%	6	56.2%	6	5.8%	0
Wyre	51.2%	6	46.4%	5	-4.9%	-1
Blackburn with Darwen	7.4%	1	4.4%	1	-2.9%	0
Blackpool	1.2%	1	0.3%	1	-0.9%	0

Our areas of significant deprivation include wards within Blackpool, Blackburn with Darwen, Burnley, Hyndburn, and Barrow. It's a real concern that eleven of the fourteen areas in Lancashire became more deprived between 2015 and 2019. At ward level,

17 (or six per cent) of the wards in the Lancashire area are in the one per cent most deprived of all the 7,408 wards in England. These include six wards in Blackpool, eight in East Lancashire and one each in Preston, Lancaster, and Wyre.

The level of deprivation can have a real, daily impact on people's lives and their ability to feed their families, heat their homes and support their children. The percentage of children living in poverty across Lancashire and South Cumbria ranges from a low of 12 per cent to a high of 38 per cent, compared with the national average of 30 per cent. Our health inequalities were starkly exposed during the COVID-19 pandemic - people from our deprived communities had a higher-than-average likelihood of being admitted to hospital with the disease. A significant proportion of children in these communities, experience poor living conditions which can affect their development, readiness for school and their future life chances. This can also have long-term impacts on their health and well-being and leave them more likely to need healthcare in future.



The diseases that contribute to the gap in life expectancy between the most and least deprived areas is shown in the chart. Circulatory diseases (ones that affect the heart and circulation, like stroke) cancer and respiratory conditions that affect your lungs and breathing all play a significant role for both men and women.

Rising numbers of older people

In Lancashire and South Cumbria, we have more people aged over 50 than the national average. This increases the demand for healthcare in the area. There is also expected to be an increase in the number of people aged 85 and older which will further increase pressure on services.

Carers

Carers are every day, invisible heroes, who support family members, friends, and neighbours with their additional day-to-day needs. They play a hugely valuable and vital role in the lives of the people they care for and their contribution supports our health and care system.

They play a major role in the care of people with long-term conditions and can help prevent unnecessary stays in hospital. With increasingly limited resources and difficulties in recruiting staff, it is often family and friends who step in to bridge the gap. Therefore, carers must be known to and supported by the health and care system. There are approximately 175,000 unpaid carers in Lancashire and South Cumbria according to the 2021 Census, and Carers UK estimates the true number may be double that. Our carers range from children aged five to elderly people. As the proportion of older people and the number of people living with long-term conditions grows, the impact on carers will increase further.

There are approximately 63,000 people across Lancashire and South Cumbria who provide more than fifty hours of unpaid care a week. Caring can take a heavy toll on individuals, affecting their physical and mental health. Yet many carers are not registered with a local authority or GP practice and miss out on vital help and support.

Our operating model

The NHS has played an important role in primary prevention but there is an opportunity to extend this further and fully harness the benefits of integration by working more closely with the significant range of partner organisations that support the determinants of health. While the NHS and local authorities have collaborated on joint health and well-being strategies, more could be done to formally integrate approaches, teams and pathways.

The table on the next page highlights the range of organisations which are involved in supporting our population's health and wellbeing and the role of the NHS. This diagram illustrates very powerfully the huge potential benefit for our population, of the NHS working in an integrated way with partners at system, place and neighbourhood.

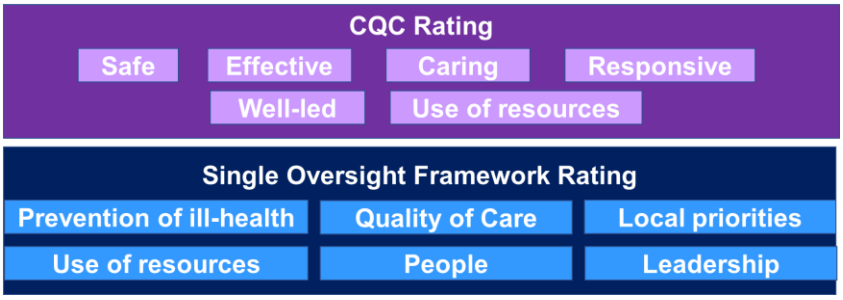
Health and well-being roles						
Organisation		Determinants of health	Health education	Social care	Healthcare	Well-being
Council *Provision varies depending on whether the council is upper tier* or district level.*		Education * Employment Housing Family Support Environment	Disease prevention *	Social Care*		Libraries * Physical environment Culture Creativity
NHS		Anchor Institutions Greener NHS	Prevention NHS Awareness Campaigns Making Every Contact Count		Care provision	
VCFSE	Charities Faith Sector Community Groups	Support services				Services
	Social Enterprises	Supporting Business Childcare Education Community Environment		Services	Services	Sports and Leisure
Private/independent sector		Services		Care provision	Care provision	Provision

Capacity issues

The quality and outcomes of our healthcare in Lancashire and South Cumbria are affected by the availability of a skilled and talented workforce, the size and quality of our buildings and spaces, our underpinning system and processes around care and our operating model. The amount of care we can provide is limited by the capacity we have available, and our capacity is reduced by gaps in our workforce, the quality of our estate and our historic operating model which has not enabled us to share limited resources across our providers. Poor quality also impacts costs - where patients wait longer, their conditions deteriorate and are more expensive to treat; where there are inconsistent care processes and blockages, there are more errors and wastage; and where there are gaps in highly skilled clinicians, very expensive agency staff must be sought.

The quality of our care

The quality of care can be measured via access and waiting times, care processes, patient safety and patient experience. The overall quality of our main providers is assessed by two bodies: the Care Quality Commission (CQC) and NHS England & NHS Improvement via the Single Oversight Framework (SOF).



The quality of care at the main providers in Lancashire and South Cumbria is shown in the table below, highlighting significant room for improvement. The standard of care people receive in our area varies depending on where they live. Four of our five hospital trusts are rated as 'requires improvement', while one – East Lancashire Teaching Hospitals NHS Foundation Trust – is rated 'good'. This difference in standards also has an impact on our health inequalities.

Trust	CQC Rating	Single Oversight Framework
North -West Ambulance Service (NWAS)	Good	2 Plans in place to meet the challenges
East Lancashire Hospital Trust (ELHT)	Good	2 Plans in place to meet the challenges
Blackpool Teaching Hospital (BTH)	Requires improvement	3 Significant support required
Lancashire and South Cumbria Foundation Trust (LSCFT)	Requires improvement	3 Significant support required
Lancashire Teaching Hospital NHS Foundation Trust (LTH)	Requires improvement	3 Significant support required
University Hospitals Morecambe Bay (UHMB)	Requires improvement	4 In actual or suspected breach of licence

The table below outlines the rating for each provider against the key domains within the CQC assessment. Whilst all the providers offer a caring environment for our population, urgent action is needed to ensure improvements are secured in the other domains.

CQC Ratings						
Trust	Safe	Effective	Caring	Responsive	Well-Led	Use of resources
NWAS 2020						-
ELHT 2019						
BTH 2022						
LSCFT 2019						-
LTH 2019						
UHMB 2021						

Waiting times for planned care have increased markedly over the past two years due to the cessation of routine surgery during COVID-19. The demand and waiting times for urgent care have also increased, and the patients presenting have greater acuity. Alongside this, our care processes and clinical pathways vary by geographical area, due to the level of available workforce in each location and the quality of the estate; all of this has a consequential impact on patient safety and experience. The historic operating model of the NHS which has encouraged providers to work in competition and isolation rather than working collaboratively to share scarce resources has been a huge barrier to improving quality. These are challenges shared across the country.

Workforce

A significant factor which impacts the quality of our care is the quality and availability of the workforce, and we have significant gaps within our hospitals which are also predicted to rise. Across Lancashire and South Cumbria, NHS hospitals employ around 40,000 people. We have higher vacancy rates than the national average, at 9per cent compared with 6.9per cent across England and some of the highest levels of sickness absence in England. Furthermore, more than 20 per cent of our staff, approximately 8,000 people, are over the age of 55 and will therefore retire in the not-too-distant future. Alongside this, our ability to recruit is impacted by the condition of our infrastructure and the reputation and quality of our services. The consequence is a high level of agency staff usage, which comes at a considerable financial cost to the system and impacts the quality of care. The workforce gaps are shared by hospitals across the country which means that hospital Trusts often compete for the same staff. We face significant problems with recruiting the people we need and retaining them.

Our primary care workforce also faces significant challenges, with the number of GPs falling and half of the current GP workforce expected to have retired within the next two decades. The number of GPs reduced by 5.2 per cent from September 2019 to September 2022 and a quarter of the general practice workforce is aged 55 and older with a similar proportion aged 45 to 54.

Estates

Our health estate needs both significant investment and radical reimagining if we are to deliver quality care and improved health outcomes for the future.

The condition of our hospital estate has a marked impact on the quality of care we can provide and also impacts our ability to recruit and limits our ability to transform care.

Our capital allocation is being spent on maintaining our ageing estate and equipment rather than on innovative transformation projects. All our hospitals were built many years ago, developed for far fewer patients and developed to meet historic care standards. This impacts overcrowding, risks around infection and patient experience.

Royal Lancaster Infirmary emergency department is seeing 50 per cent more patients than it was designed for, while Furness General Hospital is seeing 44 per cent more patients. The rate of bed occupancy recommended by the National Institute for Care Excellence (NICE) is 85 per cent and across north and central Lancashire, 95 per cent of beds are occupied. This impacts the frequency of elective surgery being cancelled and contributes to the stress levels within our workforce.

Patients have a poorer experience of care than elsewhere due to limited facilities such as single rooms and the number of toilets and showers, this also increases the risk of infections spreading. Standards of care for mental illness across emergency departments are also not good enough, due to a lack of space.

Driven by

Operating model

The cultural and legislative landscape of the NHS has been underpinned for over 30 years by competition within an 'internal market' rather than collaboration – whilst initially competition drove productivity gains and innovation, more recently it has been recognised nationally that the market model has created waste and inefficiency. Despite the challenges around workforce being shared across Lancashire and South Cumbria, the legislative framework has actively discouraged working collaboratively, and this has been a huge barrier to improving quality and has contributed to a significant cost burden for providers. This has proved very expensive and has adversely affected quality across Lancashire and South Cumbria and starved services of much-needed investment. Only in recent years have hospitals started to collaborate across geographical areas to address these issues, establishing regional centres of excellence and working together, rather than against each other.

The long-term sustainability of the system depends on reducing the reliance on delivering health care within hospitals, which consumes a significant amount of our healthcare spend. Whilst providing economies of scale, acute hospital care is still expensive and we have patients being cared for in a hospital setting because there is no other local community alternative. This is not an optimum model of care delivery either in terms of achieving best outcomes or securing value for money from the Lancashire and South Cumbria healthcare pound. Critical to increasing sustainability will be strengthening primary and community care while also integrating the provision of primary and community care with social care, wider local authority services and the

VCFSE sector into Integrated Neighbourhood Teams and harnessing the use of digital technology.

However, this will not be easy.

Both primary and community care are struggling under the strain of the ever-increasing demand for care, whilst also experiencing capacity challenges including significant workforce gaps and estates issues. These issues are driven by a lack of integrated work with partners to support prevention upstream, which is driving demand for primary and community care through an ever-increasing burden of disease, alongside our population having low levels of engagement in managing their health and well-being.

We have significant pressures across our primary care and community health estate. Whilst there has been some past localised investment, there is still a huge geographical disparity in the quality of community estate which impacts the ability to deliver quality care, locally. In addition, we are not always sufficiently connected with partners across places and neighbourhoods in a way that enables us to maximise the value of the collective public sector land and estate (and wider infrastructure).

Digital, data and technology

The maturity of Digital, data and technology is variable across Lancashire and South Cumbria. Two of our acute provider trusts do not have a mature electronic patient record system and still rely on paper-based processes. Good progress has been made in the development of Lancashire and South Cumbria shared care record, but data flows and access from out-of-hospital settings need to be developed further.

The use of data is largely fragmented and is predominantly used for retrospective performance reporting rather than supporting predictive analytics and insights leading to early intervention and action.

There are some good examples of the usage of innovative technology to support care for our population but there are opportunities to scale these across Lancashire and South Cumbria such as remote monitoring, tele-care, technology-enabled virtual wards and patient-initiated follow-ups.

Digital and data provide significant opportunities in supporting improvements in the outcomes of our population's health and in tackling inequalities, experience and access. Digital and data can also play a pivotal role in increasing productivity and supporting financial sustainability.

The implications

In conclusion, the analysis of our current issues tells us that, to improve the health and well-being of our population, and to reduce the inequalities, we need to:

	Where our Joint Forward Plan needs to focus
1	**Ensure we are spending our £4 billion of healthcare resources wisely by exploring opportunities to work differently and reduce costs.** • *Explore opportunities to reduce costs and increase value for money* across the NHS by working differently including moving care closer to people's homes where possible. • *Explore opportunities to share resources* across the NHS family • *Reduce long-term healthcare demand* by supporting people to stay well for as long as possible, reducing the pressure on the healthcare system (as below). • *Optimise the quality of care across Lancashire and South Cumbria* this will also reduce costs (as below). • Variation in the quality, consistency, and processes for care, can create additional demands for care such as re-admissions.
2	**Reduce and manage the unsustainably increasing demand for care** **Take action on prevention and address inequalities** • *Provide targeted support for communities and demographics with the greatest health issues* by undertaking targeted action at system, place, and neighbourhood. • *Take joined-up action with partners on the social determinants of health such as unpaid care* • *Support our population to make healthy lifestyle choices* by offering NHS support services and connecting them to the wider service offers from our partners. • *Screen our population for diseases and intervene early* to keep people well for as long as possible. • *Empower our population to actively manage their health and well-being* • *Work with our population to understand the drivers of their health choices* and co-produce the development of any solutions. ***Proactive disease management*** • *Implement evidence-based standardised care pathways* for our most significant disease areas, population groups and communities. ***Integration*** • *Support the health needs of our ageing population and those with long-term conditions*, by working in partnership • *Integrate teams across the NHS and wider partners* at neighbourhood, place, and system.
3	**Improve the Quality of care** ***Work collaboratively across providers to:*** • *Address the workforce gaps* • *Improve the quality of the hospital estate* • *Improve access to care* • *Standardise care and clinical pathways* • *Deliver world-class pathways* for priority disease areas, conditions, population groups and communities.

5. Our future vision

The ICS's long-term vision for our population is outlined below, together with our long-term aims. Our vision can only be achieved by working in partnership with all the organisations that contribute to the health and well-being of our population. These include upper and lower-tier local authorities, the NHS, the VCFSE sector, our universities and local people and communities. This vision is about health and well-being in its widest sense This requires the NHS and all its partners, to work very differently from how they have in the past.

Our Vision

We want our population to live longer and healthier lives which will be enabled by:

- Healthy communities
- High-quality and efficient services
- Health and care services that are centred around the needs of our communities and offer high-quality employment opportunities for our workforce

Together, we will measure our long-term success over the next 7-10 years, by our ability to increase the healthy life expectancy of our population. We will track this across the system and within each of our places and communities, to ensure inequalities are reduced.

Our Values

We are committed to delivering high-quality, patient-centred care which improves people's lives with compassion, humanity, kindness, respect, and dignity. We will make the most efficient and effective use of the healthcare resources across Lancashire and South Cumbria.

Our Pledges to our key stakeholders

Our pledges to our population		
1	**You will have healthy communities**	You will *be supported to keep well both physically and mentally* by health and well-being services that are connected across organisations and at system, place, and neighbourhood level.
2	**You will have high-quality and efficient services**	You will: ○ *Have access to high-quality, and patient-centred services*. We will ensure our providers work collaboratively to share their resources and expertise, offering access to the care that gives the best outcomes for patients. ○ *Have access to joined up and coordinated services and support,* which is easier to navigate and access. ○ *Be treated with compassion, humanity, kindness, respect, and dignity.*
3	**A health and care service that works for you**	You will *be provided with opportunities to make choices about your healthcare and have greater opportunities to design and co-produce local services, to ensure they meet your needs.*

Our pledges to our partners	
We will work together in partnership	○ *We will work collaboratively with you* at every level of the system and co-produce our plans. ○ *We are committed to widening our understanding* of the role, and hugely valuable contribution of all our partners in health and well-being to ensure that the programmes of work we jointly develop, can meet the challenges our population faces, and we can collectively make the biggest difference to the health and well-being of our population. ○ *We are committed to developing a sense of 'esprit de corps'* across our system. A shared spirit of comradery, enthusiasm, and devotion to a very important cause.

Our pledges to our people	
You will have access to more opportunities and more support for your health and well-being.	We aspire to be a system that people want to work for. We want to attract and keep the best people to create high-performing teams with a strong, collaborative, can-do culture. We intend to work together with you to ensure we can build and strengthen our workforce. We welcome your suggestions, and ideas, as we recognise that the last few years have taken a heavy toll on our hugely valuable workforce. ✓ *You will have access to a wider range of job opportunities* and routes for development as we develop new roles across our system. ✓ *You will have the opportunity to share your expertise* and make a difference across a wider geographical area. ✓ *You will be supported via digital tools* to focus more time on patient care and less time on unnecessary bureaucracy. ✓ *You will be offered more flexible working opportunities* where possible to enable you to balance your work and home life. ✓ *You will be provided with more added value health and well-being support* including assistance with financial issues and mental health.

The importance of partnership working

Our work to support local people to live longer and healthier lives will rely on strong relationships between the NHS and all our partners which impact upon health and well-being.

The Lancashire and South Cumbria Integrated Care Partnership has developed an ambitious vision; it will work to harness the collective knowledge, skills, and talents of partners to improve our population's health, wealth, and happiness. The Partnership has already agreed on outline priorities for collective action, to enable our population to start well, live well, work well, age well and die well, as detailed in the Integrated Care Strategy. This joint programme of work has built upon a review of health equalities by the Health Equity Commission and the Joint Strategic Needs Assessments (JSNAs) for each of the places across the system: Lancashire, South Cumbria, Blackpool, and Blackburn with Darwen.

Engagement on our plans

This initial ICB Joint Forward Plan is high-level and recognises that we are on a developmental journey. It builds upon previous strategies and plans which are, in turn, built upon engagement with our partners and our population.

Most recently, we have engaged with partners and with targeted sections of our population in the development of our 2023 Integrated Care Partnership Strategy, with support from local Healthwatch and VCSFE organisations.

Before this, as part of the development of our system response to the national ten-year Long-Term Plan in 2020, we engaged with our partners and some of our local communities. This engagement revealed that more work was needed on health inequalities, access to care, the quality of care and sustainability. All these elements are integral to our Joint Forward Plan and form part of our strategic priorities.

Although our current plan is fully aligned with the 2019/2029 Long-term Plan, much has changed in the health and care sector since COVID-19: the challenges our system faces are now greater, with more significant gaps in terms of inequality, access, quality, outcomes, and sustainability.

Having laid out the foundations of our draft Joint Forward Plan in March 2023, we are undertaking further engagement with partners and the public on elements of this plan to gain more detailed and informed views and feedback from our population, staff, partners and other stakeholders. The final version of the plan – taking account of this feedback – will be received by the ICB Board in July 2023, alongside a public facing summary of the plan.

6. Our system strategy

We want our population to live longer and healthier lives. This will be enabled by healthy communities, high-quality and efficient services and a health and care service that is centred around the needs of our communities and offers high-quality employment opportunities for our workforce.

To deliver this vision we must address the root cause of our problems. We must vastly improve the cost, quality, and value for money of our services, while also acting earlier, and through closer working with our partners to prevent people from getting ill and to prevent their illness deteriorating.

The problem

There is a mismatch between the demand for healthcare in Lancashire and South Cumbria, and the available capacity.

The cost of the healthcare we provide in this system is greater than our level of income, and the gap is widening.

We have identified five strategic priorities which will together enable our population to live longer and healthier lives.

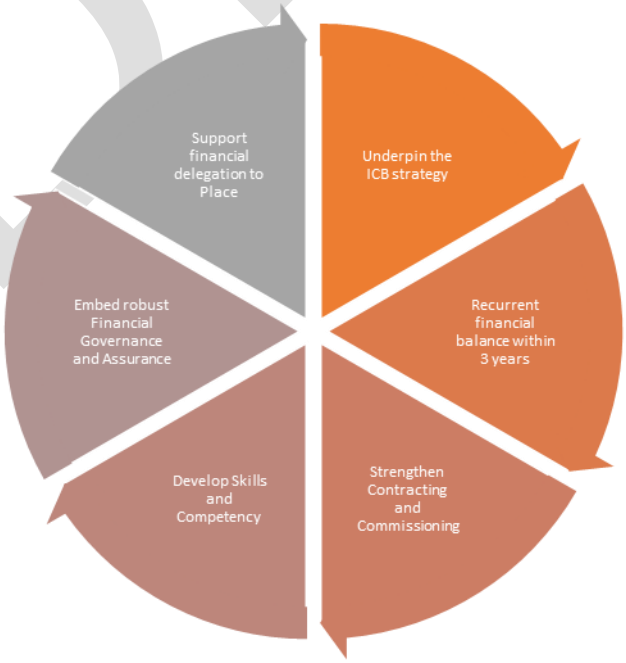
1. We must strengthen our foundations by improving our financial situation with a fully-fledged financial recovery programme
2. We must take urgent action to reduce the unsustainable level of long-term disease, working with partners to prevent illness and reduce inequalities.
3. We must move care closer to home wherever possible, strengthening primary and community care and integrating health and care service delivery.
4. We must ensure there is more consistent and high-quality care among our providers. We will standardise, network, and optimise our pathways of care.
5. We must take targeted action to deliver world-class care for priority disease areas and conditions, population groups and communities.

OUR LONG-TERM STRATEGIC PRIORITIES		
1. STRENGTHEN OUR FOUNDATIONS		
Improve our long-term financial sustainability and value for money, through transformation with providers.		
2. IMPROVE PREVENTION	**IMPROVE AND TRANSFORM CARE PROVISION**	
Prevent ill-health and reduce inequalities by collaborating with partners.	**3. Integrate and strengthen primary and community care** with partners and providers.	**4. Improve quality and outcomes** through standardisation & networking with providers.
5. WORLD CLASS CARE		
Deliver world-class care for priority disease areas, conditions, population groups and communities.		

Our urgent priority is to take immediate action to reduce our costs and work very differently across the NHS to share our resources. We have sought external expertise to ensure we make rapid progress is this area. The underlying financial risk that was forecast for 2023-24 was significant – in agreeing our system financial target for the year, we have accepted the need to take urgent joint action on recovery across the whole NHS and with our partners, overseen by the establishment of our Recovery and Transformation Board.

Our financial strategy

Our highest priority in the short to medium term is to improve our financial sustainability. A financial strategy is being developed to underpin the Joint Forward Plan. Principles for the strategy have been developed as follows:



The ICB capital plan for 2023/2025 is fully aligned with our strategic aims. It is focused on maintaining our current equipment and buildings so that our providers can make the best use of equipment and space. Due to issues with the quality of some of our hospital buildings, we have higher estates costs than other ICBs. The consequence is that we have less money to spend on capital projects which focus on transformation. When there is additional national capital money available for transformation, the ICB will take all necessary steps to apply for it, to improve healthcare in Lancashire and South Cumbria.

Our Enablers

To deliver our strategy, we must work differently at system, place, and neighbourhood and take action to get the basics right, including action to improve our buildings, systems, and workforce. Underneath all this, we need a comprehensive delivery plan that sets out which organisations are responsible for delivering results and how improvement will be measured.

Working differently			
Research and Innovation	**Reducing inequalities** using population health management and public health expertise	**Integrated working** within the NHS and with our system partners	**Lifting the bureaucratic burden** longer-term partnerships with high-performing providers
	Empowering our population including public and patient engagement and personalised care	**Double devolution** strengthening places and neighbourhoods	**Harnessing our role as an anchor institution**

Getting the basics right		
Comprehensive workforce plan across all organisations and sectors	**Buildings, infrastructure,** and digital investment	**A strong focus on delivery** with clear plans, joint accountability frameworks and performance metrics

Measuring Success

We will measure our success for each of our five strategic priorities using the measures in the table below. Our system delivery plan will detail the programmes of work and key performance metrics for system, place, and neighbourhood, for each of our priority areas.

MEASURING OUR LONG-TERM SUCCESS – AMBITIONS FOR 2033		
STRENGTHEN OUR FOUNDATIONS		
Improved sustainability of the system as measured via the overall financial position.		
IMPROVE PREVENTION	**IMPROVE AND TRANSFORM CARE PROVISION**	
Improved healthy life expectancy at system and place.	Enhanced and seamless care provision within our neighbourhoods.	Improved quality of care across all our providers as measured via their CQC and Single Operating Framework assessments.
WORLD CLASS CARE		
Improved pathways of care across the system as measured via our adherence to national recommendations for World-class Care within the NHS Long Term Plan.		

Delivering the aims of the ICB

The strategic priorities can be mapped to delivery of the four key ICB strategic aims:

Contribution to our four key strategic aims					
		Reduce Inequalities	Improve Outcomes	Enhance Productivity	Support broader social and economic development
1	Strengthen our foundations			✓	
2	Improve prevention and reduce inequalities	✓	✓	✓	✓
3	Integrate and strengthen primary and community care	✓	✓	✓	
4	Improve Quality and Outcomes	✓	✓	✓	
5	Deliver world class care for priority areas	✓	✓	✓	

Our new Operating Model

Working in an integrated way with all our partners means the NHS must work in a different way than it has before. The ICB is not simply a combination of the eight separate Clinical Commissioning Groups (CCGs) that existed before - it has a different role and scope. The NHS will now be working holistically with partners to improve health and well-being at system, place, and neighbourhood; as well as providing healthcare. Each organisation across the health and well-being landscape has its own culture and ways of working, and to really benefit from working together, all organisations need to be open-minded and willing to learn from each other.

To achieve true integration, we need an operating model which clearly defines the rules of engagement with our partners and all organisations within the NHS family, at system, place, and neighbourhood levels.

An essential part of this new way of working will be making the best use of all our combined assets: our people, our partners, our infrastructure, and our resources. We need to make this change in our ways of working quickly, and this will require innovation, commitment, and collaboration, together with a great deal of enthusiasm. We must look for opportunities to innovate while being realistic about which factors are within our control. The table below outlines our historic operating model and the opportunities that we must urgently harness as we move forward.

	Our historic operating model	Our opportunity
Our people *Workforce across the NHS and partners* 	Organisations working largely independently with a fragile workforce across providers and partners.	• To collaborate with providers and partners at system, place, and neighbourhood level, to share knowledge, skills, and expertise. • To develop shared teams, shared systems, and shared processes.
Our partners *Our system partners and our population* Local Government NHS VCFSE and wider	**Our partners** Historically, there has been some joint working and some joint plans. **Our population** Largely the consumers of healthcare have had low involvement in their care, with some choices and some opportunities to engage and co-produce service developments.	**Our partners** • To develop a shared strategy for prevention across all partners with a focus on the communities which need targeted support. **Our population** • To enable and empower our population and our patients to take a lead in choices about their health and care. • To harness local knowledge to co-produce initiatives and service developments to respond to the increasing demand for care.

	Our historic operating model	Our opportunity
Our infrastructure *Our Estates and digital infrastructure* 	**Buildings** The way we deliver healthcare is expensive. It is mostly face-to-face, and in ageing hospitals with costly parking. **Anchor role** As a major employer, the NHS is an 'anchor institution', however our contribution to the local economy could be greater. **Digital** Historically, there has been little sharing of information and data between organisations. This can prevent patients from being able to easily 'flow' between one organisation to another. Data isn't being used to its maximum potential to help prevent ill health early on. There is also real potential for technology to improve the way we work and give more choice to the people we serve.	**Estates** • To use our facilities and buildings differently to improve quality. This may include separate sites for planned (elective) and acute care and moving care closer to patients' homes where possible. **Anchor** • To utilise our anchor status to support the local economy, including working with schools and colleges to encourage careers in health. **Digital** • To use digital tools to enable patients to safely leave hospital sooner and improve their experience of healthcare. • To bring together clinical and corporate information systems across NHS providers and better share information across local authorities and VCSFE organisations and to support population health intelligence, research, and service evaluation. • To develop and use technologies to prevent ill health and offer care closer to, or in, the home.
Our resources 	In the past, our focus has been on treating illness, usually in hospital. This is not sustainable as the demand for care increases. Organisations work in isolation and there is little sharing of resources and functions.	• To focus on preventing ill health, reducing the number of people living with long-term conditions and improving healthy life expectancy. • To increase value for money by moving care delivery into the community and using digital tools. • To increase efficiency, by sharing programmes and administrative work across providers.

7. Our strategic priorities

Strategic priority one - Strengthening our foundations

We will strengthen our foundations by improving our financial sustainability and value for money, through a transformation programme with providers

The underlying financial risk that was forecast for 2023/24 was significant - in agreeing our system financial target for the year, we have accepted the need to take urgent joint action on recovery across the whole NHS and with our partners.

We will eliminate our system's financial deficit over the next three years. However, our financial position is merely a symptom of how our services are delivered.

To strengthen the long-term sustainability of the NHS within Lancashire and South Cumbria, we need to manage demand for healthcare services over the long-term and make the best use of our budget, our capacity to deliver care and our systems and processes. Some of the promises detailed below also cross over into the other five priority areas.

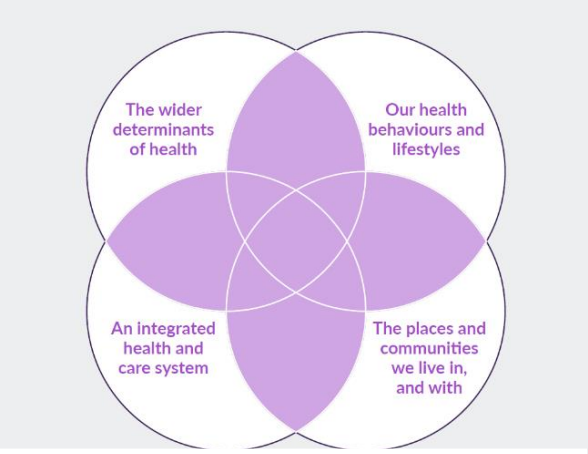
A formal System Recovery & Transformation Board will be established to oversee the work plan and provide assurance to the ICB board. A five-year plan will outline how the financial gap will be closed.

The strategic priorities		Our promises
1	**Reduce and manage demand for healthcare services over the long-term**	✓ We will work with our partners to prevent ill health and reduce the long-term demand for healthcare. This will include integrating health and social care teams and working closely with our wider partners at system, place, and neighbourhood. ✓ We will work with local people to empower them to take more responsibility for their health and well-being, signposting them to services and providing coaching.
2	**Optimise the spend and value for money of the system's £4 billion budget**	✓ We will develop programmes to make the ICB and our providers more efficient ✓ We will secure the expertise of a regional turnaround team and 'leave no stone unturned' in the search for efficiency and effectiveness. ✓ We will take tight control of spending and remove any unfunded costs. ✓ We will reduce duplication, combine back-office functions across providers and reduce administrative costs wherever possible. ✓ We will reduce the ICB back-office costs and our carbon emissions, by enabling our workforce to work in an agile way. ✓ We will work with our local authorities to ensure the use of Better Care Funding is used to enable patients to be discharged from hospital when they no longer need to be there.

The strategic priorities		Our promises
3	**Make the best use of our capacity to deliver health and care healthcare**	✓ We will network and reconfigure our clinical teams to increase their resilience and reduce costs. ✓ We will reduce the environmental impact of our buildings and vehicles. ✓ We will improve patient experience and reduce the cost of delivering healthcare by moving care closer to home wherever possible: ○ expanding and strengthening primary and community care including integrated neighbourhood teams. ○ enhancing intermediate care including the use of remote monitoring and virtual wards
4	**Make the best use of our systems and processes**	✓ We will increase the efficacy of clinical and care pathways ✓ We will develop seamless pathways across providers and partners.

Strategic Priority two - Preventing ill health and reducing inequalities

We will improve prevention and reduce inequalities by collaborating with our partners



(2018), Buck et al, A vision for population health: Towards a healthier future, The King's Fund

To improve the health and well-being of our population we will connect and integrate health and well-being services across the system. This will improve our ability to prevent illness, and over the long term, it will reduce the burden of disease, increase healthy life expectancy, and reduce inequalities. As the level of disease in our population reduces, this will impact upon the level of healthcare spending although this is reliant on our population making positive lifestyle choices. To prevent ill-health the NHS needs to increase its contribution to population health and well-being. Underpinning this is the intention to level-up health and well-being for our population and to address with partners, systemic inequalities in their life chances.

We know that we need to work together with our partners to improve the overall health of the Lancashire and South Cumbria population. As the diagram above shows, to

make a real difference, action is needed across the wider determinants of health, health behaviours, communities, and the healthcare system.

As well as taking a holistic approach to health and well-being, we will take targeted action within communities and population groups where there are significant health inequalities. Critical to this will be using population health data and intelligence to understand the health challenges faced by different communities and the causes of varying outcomes, alongside evidence-based research on what makes a difference. This will enable us to level-up the health and well-being playing field.

A priority focus for support to encourage healthier behaviour is to address tobacco usage. A joint plan has been developed in collaboration with the L&SC Public Health Collaborative with the intention of making a concerted effort to reduce tobacco usage in all areas of L&SC to less than 5% by 2030.

We will measure success in the long-term by the extent to which we have added life to years in terms of healthy life expectancy at system and place. We will also measure the extent to which we are reducing the variation in healthy life expectancy across our system. In the medium term, we will monitor disease prevalence and admissions. In the short term, we will ensure that seamless and integrated provision is in place within every community.

The strategic priorities		Our promises
1	**Develop a joint programme of work across all partners to improve health and well-being**	✓ We will review the joint strategic needs assessments for each place in Lancashire and South Cumbria to identify the areas we could collaborate on, so we can improve the life chances of our population. ✓ We will implement an Integrated Care Strategy across all partners, detailing joint programmes of work across the whole life course of our population, integrating services, and improving people's experiences of health and care ✓ We will act at system, place, and neighbourhood levels, responding to different communities' needs, to ensure health inequalities are addressed. ✓ We will harness the role of the NHS as an anchor institution to make a difference in our communities. ✓ We will use population health management expertise to understand the reasons for differences in health across Lancashire and South Cumbria and use it to design innovative ways to improve health and well-being in our communities.
2	**Support healthy lifestyles**	✓ We will work with local people and communities to provide additional support to encourage our population to stay well for as long as possible, including services for smoking, drinking and obesity.
3	**Improve prevention**	✓ We will undertake targeted action within priority pathways to help prevent the progression of key diseases. The priority work programmes as identified nationally in the NHS Long Term Plan, are cancer, mental health, and cardiovascular disease. ✓ We will sign the NHS Smokefree Pledge as endorsed by the NHSE Chief Executive and various other esteemed organisations including the Association of Directors of Public Health. We will support regional models for tobacco control

4	**Reduce Inequalities**	✓ We will undertake targeted work to support a reduction in health inequalities at system, place, and neighbourhood. This will include initiatives to support those with the greatest health inequalities including specific population groups with poorer than average access, experience and/or outcomes. This work is supported by the national Core20PLUS5 programme. ✓ We will undertake targeted work to improve outcomes for adults within five nationally identified clinical pathways, including maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis and hypertension. ✓ We will undertake targeted work to improve outcomes for children within five nationally identified clinical pathways, including asthma, diabetes, Epilepsy, oral health, and mental health. ✓ We will apply the outcomes from the Learning Disability - Learning from Lives and Deaths review (LeDeR) to inform improvements to the clinical pathway such as cancer, diabetes, epilepsy, respiratory alongside impact and learning from the dynamic support register and Annual Health Checks.
5	**Support broader social and economic development**	✓ We will harness the role of the NHS as an anchor institution to make a difference in our communities. ✓ We will drive social value and inclusive economic development via the commissioning and procurement of goods and services. ✓ We will work with educational establishments and local employment services, to encourage people to take up health careers.

Our Integrated Care Strategy, as outlined below, sets out our intention to take joined-up action with our partners to enable our population to thrive by starting well, living well, working well, ageing well, and dying well.

Lancashire and South Cumbria Integrated Care Strategy priorities	
Start Well	**Together with our partners, we will support our population to start well.** ✓ **Integrated support for families**: we will develop family hubs across Lancashire and South Cumbria, providing integrated and joined-up support for children and their families, including carers who are parents, and young carers. This will include a comprehensive start-for-life offer. ✓ **Supporting those with the poorest health**: we will reduce health inequalities and vulnerabilities by taking targeted action to address differences in access to services and improve health and well-being outcomes for children and their families, including parental carers and young carers. We will provide support for breastfeeding, reduce childhood obesity, promote safer sleeping, and reduce smoking during pregnancy. ✓ **Support for children to achieve their potential at age three**: we will support all our children to be as healthy as they can be by their third birthday including joined-up child health and development services, support for all pre-school children with additional needs and support for school readiness. It will include support for families, parental carers, and young carers.
Live Well	**Together with our partners, we will support our population to live well.** ✓ **Support for the unwell:** we will support people with existing mental and physical ill health with a particular focus on those who face the greatest inequalities in access, experience, and outcomes. ✓ **Support for healthy lifestyles**: we will support our residents to make healthy lifestyle choices, with the greatest focus on those experiencing the biggest health inequalities. ✓ **Support for the causes of ill health**: we will address the causes of poor health and care – working together to address the things that can have an impact on health and well-being.
Work Well	**Together with our partners, we will support our population to work well.** ✓ **Career support for young people:** we will support young people to feel more interested in their future careers, helping them to gain the life skills needed for work and encouraging them into jobs with good career opportunities. ✓ **Skills development:** we will support our working-age population into stable and healthy workplaces, helping individuals, particularly from disadvantaged communities, to gain confidence and skills that enable them to compete for jobs as equals. ✓ **Support for well-being at work**: we will create workplaces and cultures that encourage good health and well-being, identifying the signs of ill health and well-being early and offering support where needed. ✓ **Support for local development**: we will encourage large organisations and local businesses to support social and economic development in their area.
Age Well	**Together with our partners, we will support our population to age well.** ✓ **Integrated support for frail older people**: we will provide joined-up, wrap-around support for our most vulnerable and frail residents, their families, and carers. This will include the development of older people's hubs. ✓ **Choice and control over care**: we will make sure support is in place when circumstances change for an individual or their carers, supporting people to be as independent as possible. ✓ **Keeping older people active**: we will keep our maturing population mentally and physically active as well as involved and contributing to their communities.
Die Well	**Together with our partners, we will support our population to die well.** ✓ **Talking about dying**: We will encourage our residents to feel comfortable talking about death and dying. ✓ **Personalised end-of-life planning**: We will ensure end-of-life care is made more personal, regardless of where they live or their condition. ✓ **Bereavement support:** we will provide outstanding support for people who have lost a loved one, their families and carers with an approach that meets their individual needs.

Strategic Priority three – Integrating and strengthening primary and community care

Strengthening primary and community care with partners and providers

The long-term sustainability of the system depends on reducing the reliance on delivering healthcare within hospitals, which is an expensive way to care for people. To become more sustainable as a system, we will need to strengthen primary and community care, integrating them further with social care, wider local authority services and the VCFSE sector to create Integrated Neighbourhood Teams that harness the use of digital technology.

Enhancing and strengthening community care supports hospitals by:

- Reducing the number of people needing to enter the 'front door' – helping patients to be cared for at, or closer to home and avoid unnecessary hospital admissions.
- Increasing the flow of patients out of the back door – working in the community to ensure there are safe and suitable places for people to move on to when they no longer need to be cared for in hospital.

By better using digital technology and enhancing the care we provide out of hospital for people with long-term conditions, we can keep people well for longer. It also has a role in supporting acute-based planned care services, some elements of which could be moved into the community via a hub and spoke model.

We will measure success by the extent to which the current primary and community care provision has been strengthened, and in the longer term, the extent to which enhanced primary and community care provision is in place, including integrated neighbourhood teams.

The strategic priorities		Our promises
The foundations		
1	**Strengthen primary care**	✓ We will strengthen the existing primary care provision and improve access to primary care. ✓ We will integrate primary care with community services into primary care networks.
2	**Strengthen community services**	✓ We will review community services to understand the gaps.
Transformation		
3	**Transform primary and community care provision**	✓ We will develop integrated neighbourhood teams that support proactive prevention and provide integrated care within the community, reducing downstream demand on hospitals, by September 2025. ✓ We will empower people to take greater control over their health and well-being by offering them personalised choices about their care.

4	**Transform intermediate care provision**	✓ We will coordinate care and enhance services to avoid patients being admitted to hospital where it can be avoided and help them leave hospital faster when they are ready ✓ We will transform intermediate care provision

Strategic Priority 4 - Improving Quality and Outcomes

Improving quality and outcomes through standardisation and networking with providers

Our vision is that people in Lancashire and South Cumbria will have equal access to joined- care that is consistently safe, delivered with compassion and on a par with regional and national averages.

Where health and care services are not as good as they should be, there is a real impact on patients' recovery and long-term health. This, in turn, means people often need more healthcare which is negative for the patient and costly for the system.

Our quality of care across Lancashire and South Cumbria is variable as evidenced by the NHS SOF ratings of our providers. As our financial situation shows, the way the system currently works is expensive and unsustainable. Our action in this area has the potential to improve quality and reduce spending in the medium term.

We will measure success in the short term via an improvement in the CQC and the SOF ratings of our six trusts. In the medium and longer term it will be measured by better healthcare and experience for our patients, as measured through the implementation of optimised pathways, an improved healthcare estate and an enhanced workforce.

Trust	CQC rating		Single Oversight Framework	
	2022-23	Plan	2022-23	Plan
North-West Ambulance Service NHS Trust (NWAS)	Good	Maintain Good	2	Maintain SOF 2
East Lancashire Hospitals NHS Trust (ELTH)	Good	Maintain Good	2	Maintain SOF 2
Blackpool Teaching Hospitals NHS Foundation Trust (BTH)	Requires improvement	Good during 2024/25	3	SOF 2 by 2025-26
Lancashire and South Cumbria NHS Foundation Trust (LSCFT)	Requires improvement	Good during 2024/25	3	SOF 2 and maintain during 2023/24
Lancashire Teaching Hospitals NHS Foundation Trust (LTH)	Requires improvement	Good during 2024/25	3	SOF 2 by 2025/26
University Hospitals of Morecambe Bay NHS	Requires improvement	Good during 2024/25	4	SOF 3 by 2023/24 and SOF 2 by

Foundation Trust (UHMBT)				2025/26

The strategic priorities		Our promises
1	**Enhance the consistency of the pathways and processes around care including access**	✓ We will enhance clinical and care pathways across providers. ✓ *We will take action to ensure our pathways of care for key disease areas, conditions, population groups and communities are world-class (see in the next section).* ✓ We will improve our urgent care pathways including access to urgent care and better intermediate care. ✓ We will improve our planned care pathways • We will optimise referrals • We will reduce waiting times for care • We will redesign planned care pathways to improve quality, outcomes and patient experience and move care closer to home. • We will reduce clinical variation and low-value activity.
2	**Improve the estate/physical care environment**	✓ We will significantly improve the quality of our estates via the new hospitals programme *(subject to confirmation of national funding).* ✓ We will reduce the NHS carbon emissions and reduce our use of single-use plastics.
3	**Increase the productivity and resilience of our workforce**	✓ We will build a workforce plan for the system which includes workforce networks across providers.
4	**Robust governance and oversight**	✓ We will ensure there is robust governance and oversight of our providers to support the improvement of access, safety, quality, outcomes, and patient experience at our acute trusts.

Strategic Priority five – World class care for priority areas

The NHS Long-term Plan highlighted areas where resources and efforts needed to be targeted to improve the health outcomes for our population, these are detailed in the table below together with the core outcomes. There are national resources to support improvement in these areas. Achieving the desired outcomes will depend on workforce availability.

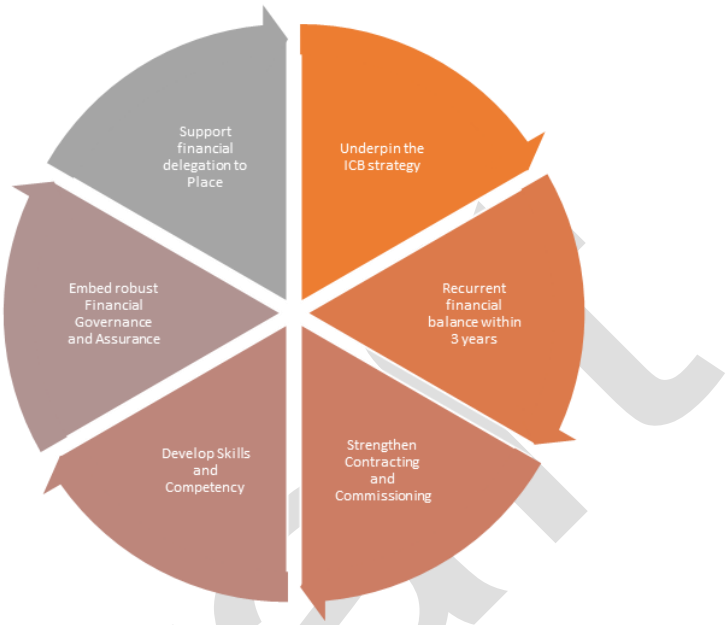
Improving pathways and care for priority disease areas, conditions, population groups and communities

The strategic priorities	Our promises

1	***Priority disease areas and conditions*** – *Cancer - mental health – maternity- Cardiovascular disease*	✓ **Pregnancy:** We will improve the quality of care for women who are pregnant ○ We will improve the support for pregnant mothers including continuity of carer and perinatal mental health support. ○ We will reduce the number of stillbirths ✓ **Cardiovascular disease**: We will improve care for people with cardiovascular disease. ○ We will improve prevention by providing access to cardiac rehabilitation and defibrillators. ○ We will improve the outcomes after a stroke including access to thrombectomy and thrombolysis. ○ We will improve prevention for diabetes by offering structured education and improved monitoring. ○ We will improve support for those with respiratory conditions. ✓ **Mental health:** We will improve the care we provide to those who need mental health support. ○ We will improve the support for those in a crisis including a single point of access, and support within acute hospital emergency departments. ○ We will improve early intervention for people with psychosis ○ We will provide more support for people with depression and anxiety ○ We will improve the support for those with serious mental illness ✓ **Cancer:** We will improve outcomes for those with cancer ○ We will increase the proportion of people diagnosed early ○ We will increase the level of lung cancer spotted early via lung health checks.
2	***Priority population groups*** – *Children and Young People – Learning Disabilities*	✓ **Children and young people**: We will improve healthcare outcomes for children ○ We will support children who are obese to improve their health. ○ We will provide more access to mental health services including eating disorder services ○ We will ensure there is support for victims of abuse ○ We will provide access to more cancer treatments for children including CAR-T and proton beam therapy. ✓ **Learning disabilities and autism:** We will improve healthcare outcomes for people with learning disabilities ○ We will improve the quality of life for those with learning difficulties by moving people out of hospitals ○ We will improve the health of people with learning difficulties and autism by ensuring they are registered with a GP, and we regularly monitor their health via regular checks.
3	***Reducing inequalities*** - *CORE 20 per cent and others as identified via PHM*	✓ **We will reduce inequalities by improving the healthy life expectancy of our population in the areas of greatest need including the most deprived 20 per cent.** ○ We will undertake evidenced-based interventions within these communities to improve the health outcomes in key disease areas such as severe mental illness, chronic respiratory disease, early cancer diagnosis, and hypertension.

8. Our financial strategy

A financial Strategy is being developed to underpin the ICB strategic direction. Principles for the strategy have been developed and the full strategy will be in place by September 2023. The principles are shown in the diagram below.



The key areas of work within each of these principles is described as follows:

Our financial strategy principles	
Underpin the ICB strategic priorities	✓ *Place devolution* ✓ *Community redesign and vertical integration* ✓ *Strong out of hospital offer* ✓ *Investment in population health through place* ✓ *Available Capital aligned to strategy*
Recurrent financial balance within 3 years	✓ *Recovery approach to transform the system finances – joint ICB and Provider 3-year recovery plan* ✓ *Tight spending controls governance and process in line with national protocols firmly in place for ICB and Providers* ✓ *Effective efficiency delivery each year*
Strengthen Contracting and Commissioning	✓ *Strong commissioning strategy and contract review* ✓ *Greater openness and transparency in working collaboratively with partners* ✓ *Mechanisms and governance to review acute contracts at place level*
Develop Skills and Competencies	✓ *Strong focus on Finance Skills development and financial controls across the system* ✓ *Ensure the highest level of Finance staff Development accreditations* ✓ *Ensure all opportunities to attract and retain the best talent with a strong focus on Equality and Diversity* ✓ *Financial Training, development and tools for Senior Leaders and Clinicians across the system*
Embed robust Financial	✓ *High level of assurance in audit opinions* ✓ *Strengthen financial governance in maturing ICB*

	Governance and Assurance	✓ *Ensure HFMA Governance Handbook recommendations in place across the system* ✓ *Develop the financial assurance framework for system working* ✓ *Memorandum of Understanding in place between organisations*
	Support financial delegation to Place	✓ *Senior Financial Leadership in each place* ✓ *Develop a clear financial framework for allocations and devolution to place* ✓ *Devolve Primary Care Population health and community budgets by 2024*

9. Our enablers

To tackle the significant health issues our population faces – and to enable delivery of all of our strategic priorities - we will work differently and effectively at system, place, and neighbourhood. We will work together with local people, ensuring that communities are at the heart of our plans and will vary our approach based on local needs.

Key enablers are as follows:

<table>
<tr><th colspan="4">Working differently</th></tr>
<tr><td rowspan="2">Research and Innovation</td><td>Reducing inequalities using population health management and public health expertise</td><td>Integrated working within the NHS and with our system partners</td><td>Lifting the bureaucratic burden longer-term partnerships with high-performing providers</td></tr>
<tr><td>Empowering our population including public and patient engagement and personalised care</td><td>Double devolution strengthening places and neighbourhoods</td><td>Harnessing our role as an anchor institution</td></tr>
</table>

<table>
<tr><th colspan="3">Getting the basics right</th></tr>
<tr><td>Comprehensive workforce plan across all organisations and sectors</td><td>Buildings, infrastructure, digital and environment</td><td>A strong focus on delivery with clear delivery plans, joint accountability frameworks and performance measures</td></tr>
</table>

Working Differently

Research and Innovation

To enhance our sustainability and ensure we are delivering optimum pathways of care, we will review best practice research and innovation and look at the national and international evidence base. We are fortunate to have the Health Innovation Campus for a prestigious university within our patch, and we fully intend to harness this opportunity. We also recognise that this system has untapped research potential in terms of our diverse population. A system approach to attract prominent research studies, trials, and projects, both commercial and non-commercial is of paramount strategic importance.

We also recognise that our trusts currently have a lack of dedicated research time due to the competing demands of rising demand and capacity shortfalls. To address this,

it is our intention to be a pilot region for the Academy of Medical Sciences (AMS) review proposal of providing dedicated research time for staff (20% of consultants with 20% of their time protected for research in each NHS Trust). The heads of research and innovation from across our five key providers have agreed priority areas of focus: innovation and digital, workforce development, academia, and working with industry to increase sustainability. There is a joint commitment across providers to advancing individual and regional research, innovation and development functions, capacity, and capabilities.

Reducing inequalities

To reduce inequalities, we will use population health data and intelligence to understand our communities' differing health. This will be combined with research, innovation, and best practice on what makes a difference. This population health management expertise will be critical to our strategic priority on prevention and inequalities. It will work hand in hand with expertise from our public health colleagues in the local authorities.

Empowering our population

We want to completely change the relationship between our healthcare services and our population. Traditionally, our services have informed local people of how to access services and how they can provide feedback on their patient experience. To improve the long-term sustainability of our system we will develop a completely different relationship with our most important stakeholders – patients and the public. We want to *involve* and work in *partnership* with our population to design new models of integrated healthcare delivery. We want to *empower* people to feel that they are in the driving seat of their health and well-being; to understand what they can do to improve their lives and to be able to make choices about their care.

We have agreed on principles across our partners for how we will work with people and communities to listen, involve, and co-produce our plans together. This will help to develop ways of working that really are focused on local people, their lived experiences and have our population's needs at the heart of all we do.

Integrated working and double devolution

To improve health and well-being across the system, we will harness the opportunities of working in collaboration with all organisations within the NHS and all our wider partners. It will involve integrated working at system, place, and neighbourhood, across all our partners, and integrated working across the NHS family.

Our key vehicles to achieve this are:

- The provider collaborative

- Lancashire and South Cumbria Health and Care Partnership
- Place-based partnerships
- Neighbourhood teams

Effective integration will also require a leadership and organisational development programme across all organisations to facilitate a 'systems mindset' and a shared culture.

Provider collaborative

The aim of the provider collaborative is to pool the collective knowledge, skills, and talent from across the system to quickly deliver a small number of high-priority Lancashire and South Cumbria-wide projects. At the same time, the providers will continue to improve the quality of their services at a local level. These projects will be underpinned by a joint turnaround team, with progress reported to the system recovery and transformation board, alongside the devolution programme and place-based investments.

Lancashire and South Cumbria Health and Care Partnership

The Lancashire and South Cumbria Health and Care Partnership is tasked with working across organisational boundaries to improve health and well-being. It has developed a strategy to improve our population's health, wealth, and happiness by taking collective action to enable our population to start well, live well, work well, age well and die well. The delivery of services will be transformed by collaboration and integration between teams, and the reorientation of resources towards prevention. To facilitate partners working differently, we will review how we invest, provide, and manage services. Critical to the delivery of our system strategy is our plan for double devolution to places and neighbourhoods, to ensure services are delivered as close to patients as possible.

Place based partnerships

Our long-term plan is for place-based partnerships to be at the forefront of the design of local health services, with only those things that are best done on a larger scale, being led at system level, across Lancashire and South Cumbria. This will enable local authorities and the VCFSE sector to play a greater role in improving the health and well-being of their local population. Our local authority colleagues in unitary, district and county councils, have vast knowledge, experience and understanding of the needs of their communities which is a huge asset to improving the life chances of our population.

Our commitment to the development of our places can be summarised as follows:

The strategic priorities		Our promises
	Place development priorities	✓ We will develop a phased devolution programme in July 2023. It will include the following functions – continuing healthcare, primary care, community services, the Better Care Fund, and population health. A critical element of the plan will be double devolution. It will include the adoption of neighbourhood working across the ICB area. ✓ We will develop a three-year phased investment programme to strengthen community services, it will include proposals to expand virtual wards (hospital at home), intermediate care, domiciliary care, prevention priorities, a proactive approach to primary care to reduce unnecessary hospital admissions and integration between health and care. ✓ We will develop an operating framework for place. It will include budget delegation, staffing, operating rules, roles and functions, and the culture needed to work well together and succeed.

Getting the basics right

Workforce strategy

To meet our ambitions for the next five years, we need to enhance and strengthen our workforce and ensure the health and care system in Lancashire and South Cumbria is a great place to work. There is a shortage of health and care staff, which will not be resolved without working very differently than we have in the past.

Our workforce strategy
✓ **We will develop new roles within our providers**, to help with staff shortages. This includes roles such as nursing associates, physician associates and assistant practitioners, which can support GPs, nurses, and other health professionals to look after lower-risk patients, freeing them up to spend more time with their most complex cases. ✓ **We will network our staff across a wider geographical area** to enable skills and expertise to be shared on a wider footprint. The new roles which will develop will cover a wider remit in terms of geography and the service they provide which will support gaps in the workforce. The national additional roles reimbursement scheme (ARRS) allows primary care networks to fund staff that work across all GP practices within their network. We will also explore the possibility of networking clinical teams across more than one trust to fill vital gaps and optimise care provision. This approach already exists for some services where there are clear opportunities for better use of a smaller number of people, such as stroke and maternity. ✓ **We will harness digital technology** to reduce the amount of time clinical staff have to spend on administrative tasks. ✓ **We will create job opportunities** within the NHS for those within our communities, harnessing the role of the NHS as an anchor institute. It will include careers and employment programmes designed to reach out to many different groups of people. ✓ **We will explore how we can make our employment offer more attractive**. This will include flexible and portfolio career packages and agile working patterns for many support services, where appropriate. ✓ **We will take action to bring the nursing vacancy rate** down to five per cent. This will involve working closely with chief nurses across the NHS and investing in developments to address the shortage of nurses both in hospitals and in care homes. ✓ **We will provide additional health and well-being support** for our staff, to enable a reduction in sickness absences. The rates in Lancashire and South Cumbria are higher than the national

average for England. Services include support with financial issues and workplace health issues, particularly focusing on mental health and musculoskeletal conditions that can be brought on or affected by work.

- ✓ **We will support staff retention** via our involvement in and learning from, a national programme which has an agreed consistent approach to agency and 'bank' staff.
- ✓ **We will improve our long-term workforce planning.** We have undertaken a review of our current and future workforce including discussions with training providers and higher education institutions to understand the numbers of candidates expected to join the system, alongside leavers' data, staff turnover and future demand profiling.
- ✓ **We will strengthen our approach to equality, diversity, and inclusion** to ensure we have a diverse and representative workforce at all levels, and across all parts of our system. We are implementing a comprehensive *Belonging Strategy* in conjunction with the inclusion networks from across our provider trusts, local authority, and wider partner agencies.
- ✓ **We will take innovative approaches** to the recruitment, retention, development, and support of our staff.
- ✓ **We will take an integrated approach to demand and capacity planning** for our future workforce.
- ✓ **We will provide education, training, and development opportunities** for our people.

Estates infrastructure, environment and digital strategy

We are updating our health infrastructure strategy to 2040. It will help us to address our key challenges in terms of our ageing buildings, issues with specific sites and our aim of keeping up with the best healthcare facilities across the globe. It will explore the radical way in which our infrastructure will need to evolve in the future and how we can make better connections across the local ecosystem to sustainably improve buildings and accommodation.

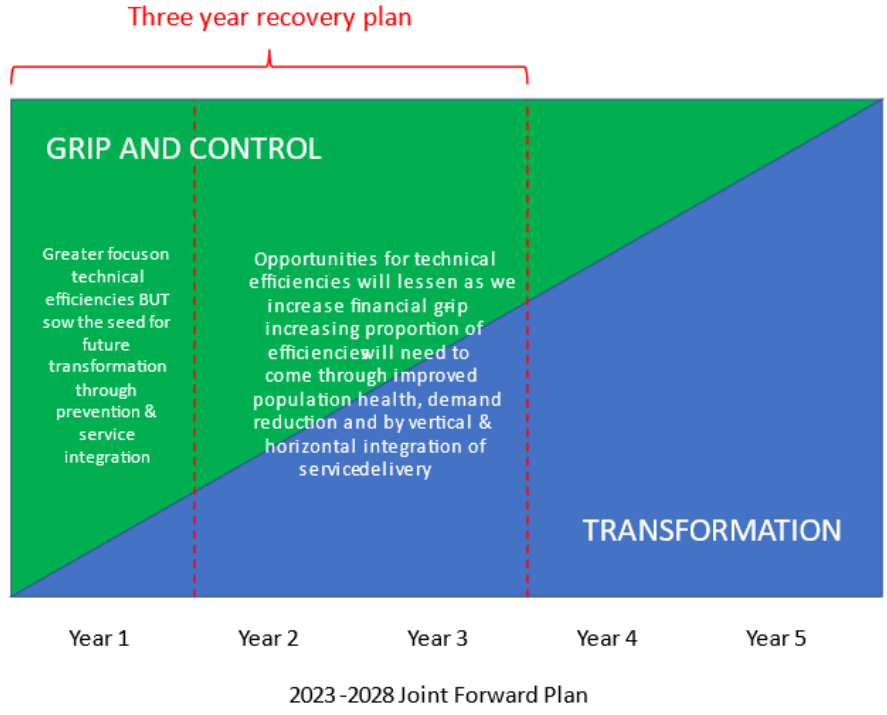
Our estates, Infrastructure, and digital strategy	
Estate	✓ **We will reduce and consolidate the estate** which housed our corporate and management staff, in line with changes to working practices which commenced during the COVID-19 pandemic. Many of our staff now work either from home or in a hybrid or 'agile' way, without a permanent desk in an office building. This will reduce unnecessary costs. ✓ **We have developed plans to significantly improve the quality of our hospital sites** through the New Hospitals Programme. This has the potential to make Lancashire and South Cumbria a world-leading centre of excellence for hospital care. It offers us a once-in-a-generation opportunity to transform some of our oldest and most outdated hospital buildings and develop new, cutting-edge hospital facilities. It will help us to offer the absolute best in modern healthcare, providing patients with high-quality, next-generation hospital facilities and technologies. The hospital buildings will be designed in a way to meet demand while remaining flexible and sustainable for future generations. They will also be aimed at helping to support local communities, bringing jobs, skills and contracts to Lancashire and South Cumbria businesses and residents. ✓ We are developing plans to understand our requirements for health **accommodation and infrastructure across our places and neighbourhoods** and will identify our investment requirements to improve the quality of our out-of-hospital estate. ✓ We will consider how our **estate needs will change** and be shaped by advances in technology, digital services, and new models of care. We will consider less-traditional approaches to both the development and use of accommodation, as well as increasingly focus on the role of infrastructure in prevention and reducing health inequalities.

Digital	✓ **We will improve the responsiveness of services** by utilising real-time information to change how care is provided, where resources are coordinated and plan future care. ✓ We will develop a common electronic patient record (EPR) across the system to enable Lancashire and South Cumbria to be a digitally mature system. Other work includes the ongoing development of tele-health and tele-care and an assessment of the possibilities surrounding virtual and augmented reality, machine learning and Artificial Intelligence. ✓ **We will enable care to be integrated across organisations** by providing shared records to all partners involved in patient care. For example, medication history and information on long-term conditions, so information from one organisation will directly benefit care provided by another. ✓ **We will transform how patients interact with services**, technology will support timely messaging and improve the experience for patients. We are developing a digital front door for people in Lancashire and South Cumbria to engage with health services. This portal will build on the capability of the NHS app.
Green	✓ **We will review the carbon emissions from our hospital sites** and work with NHS property companies to develop plans to meet the NHS commitment of being net zero carbon by 2040. This will include a plan for decarbonising buildings A standardised review of all of Lancashire and South Cumbria hospital sites is underway to help understand the complexity and cost of this target.

10. A strong delivery focus

Our plan to improve the health and well-being of our population is ambitious and we are confident it will deliver over the long term, but it will require patience, tenacity and enthusiasm. It is vital that financial grip and control are maintained in the early phasing of delivery of our recovery plan - our focus will then move fully to the vital transformation work that we need to do to improve the quality of our care and support improvements in population health and reductions in demand on services.

Considering the expectations of our three-year recovery plan alongside this phasing shows that in year 1 we would expect most savings to come from technical efficiencies with increasing contributions from transformation and integration in years 2 and 3, at the end of which we should have achieved financial balance.



This will allow us to close the financial gap and create a sustainable system where we can operate within our budget and provide access to high-quality services.

Delivering our five strategic priorities

The table below shows how we will measure the delivery of our five strategic priorities. We will do more work through the development of our system delivery plan to identify the delivery implications for system, place, and neighbourhood.

Strategic priorities		Short-term 1-3 years	Medium-term 4-6 years	Long-term 7-10 years
1	Strengthen our foundations	Three-year system financial plan	Financial balance across the NHS system	
2	Improve prevention and reduce inequalities	Seamless and integrated provision is in place within every community.	Reduced admissions and disease prevalence	Seamless and integrated provision is in place within every community.
3	Integrate and strengthen primary and community care	Strengthened primary and community care Reduced demand on hospital services	Enhanced and integrated primary and communicate care provision in place	
4	Improve Quality and Outcomes	Improved CQC and SOF ratings for the six providers	• Optimised care and clinical pathways • Improved quality of estates • Enhanced workforce	
5	World-class Care	Short term actions on priority areas	Medium term actions on priority areas	Short term actions on priority areas

Further work will be undertaken to develop the underpinning performance framework; this will incorporate metrics from the NHS constitution, the 2023/24 national priority metrics, the National Oversight Framework metrics, and others. There will be careful consideration of which metrics should be monitored at which level, system, place, or neighbourhood.

The 2023/24 operational plan objectives – and the commitments we made as a system to achieving them – can be mapped to the JFP strategic priorities as follows:

L&SC Joint Forward Plan Strategic Priorities		23-24 core objectives of the NHS	
		Recovering core services	LTP and transformation
Strengthen our foundations		Use of resources	
Improve prevention and reduce inequalities			Prevention and health inequalities
Integrate and strengthen primary and community care		Primary care Community health services	
Improve Quality and Outcomes		Urgent and emergency care Diagnostics Elective care	Workforce
World Class Care	Priority care and disease pathways	Cancer Maternity	Mental health
	Priority population groups		People with a learning disability and autistic people

These objectives and associated metrics and trajectories will be aligned within the development of the system delivery plan.

Our Risks

Our most significant risk is that the demand and capacity mismatch increases, leading to further increases in costs and a wider gap between our allocation and our spend. We will have a three-year financial framework and a clear programme of work across our providers and the ICB to reduce our costs, but there are many factors, which are outside of our control.

Within our control	Within our influence	Outside our control
Our plan Our strategy to address our challenges and the underpinning governance structure to support our programmes of work and enable collaborative working. **The way we choose to operate** In collaboration with providers and partners across the whole system, at place and within neighbourhoods. **Our behaviours and values** A culture built on pragmatism, collaboration, learning, enthusiasm, and compassion. **Our mindset** We can play our cards to the best of our ability, harnessing the collective expertise, talent, knowledge, and skills across the system to find innovative and transformative solutions.	**The level of demand** • The action we take to reduce the pressure on services including action to support the prevention of ill-health. • Action to help people to take better care of themselves and make positive lifestyle choices. • Action to ensure patients are seen in the most appropriate, cost-effective, location. **How we use our capacity** • Action with partners to make the best use of our resources including staff, financial resources, buildings, and action to attract and retain staff.	**Available resource** • The amount of money we receive • Laws which limit our ability to work differently **Demand** • The impact of inflation on our population's basic life conditions which drives demand for health care. **Capacity** • The impact of inflation on the cost of running services • The size of the workforce pool nationally and locally that we can draw from. • The levels of recruitment we can achieve.

What we can do

- ✓ We can ensure that every penny of the allocated Lancashire and South Cumbria healthcare pound is being used in the best possible way.
- ✓ We can ensure that the quality and outcomes from our care are the best they can be, that they are provided in the right place and are as high-quality and sustainable as possible

11. Next steps

This initial Joint Forward Plan is described at an intentionally high level – nonetheless, we hope that it provides a clear overview of our future vision, strategy, and priorities for action. Our new system offers an opportunity to work differently to tackle the urgent challenges that we face. The next stage of implementation of our plan will include working through the detail with our partners to ensure our plans, infrastructure and services are sustainable and joined-up.

A final version of this plan – amended to take account of feedback from partners and the public – will be received by the ICB Board at their July meeting.

The detailed system delivery plan with measurable goals, annual milestones, targets, performance ambitions and trajectories for providers, places and neighbourhoods is under development, aligned with the System Recovery and Transformation plan. The system delivery plan will inform a clear accountability framework for delivery between organisations and residents and patients and will support clear governance and oversight arrangements.

We will work with partners to develop a more comprehensive updated plan for 2024/25 onwards with the opportunity for further engagement and collaboration and for the most appropriate delivery mechanisms and actions of partners to be included.

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Report to:	**HEALTH AND WELLBEING BOARD**
Relevant Officer:	Sarah Kipps, Public Health Registrar. Blackpool Council
Relevant Cabinet Member:	Councillor Jo Farrell, Cabinet Member for Levelling Up People
Date of Meeting:	27 June 2023

TOBACCO FREE LANCASHIRE AND SOUTH CUMBRIA STRATEGY 2023-2028

1.0 Purpose of the report:

1.1 To summarise the progress of the Tobacco Free Lancashire and South Cumbria Strategy 2023-2028 and how the strategy will assist with progress toward the Smokefree 2030 agenda.

2.0 Recommendation(s):

2.1 To endorse the approach outlined in the report and approve the Strategy attached at Appendix 5a with effect until the 31 December 2028.

3.0 Reasons for recommendation(s):

3.1 To inform Health and Wellbeing members of the approach taken to develop the strategy and how its contents will be beneficial to reduce tobacco related harm in Blackpool's population.

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 strategy has been produced by the Tobacco Free Lancashire and South Cumbria group supported by the Public Health Collaborative and the Integrated Care Board Population Health Team.

Tobacco Free Lancashire and South Cumbria is a multi-agency alliance working together towards the smokefree agenda across Lancashire and South Cumbria and includes representatives from local authority public health, NHS, providers, Office for Health Improvement and Disparities (OHID) and Trading Standards. This group was previously known as Tobacco Free Lancashire however since the implementation of Integrated Care Systems (ICSs), the footprint of the group has been expanded to match that of the Integrated Care System.

The purpose of this strategy is to provide clear direction for commissioners, strategic leads and policymakers across Lancashire and South Cumbria around how we can together make Smokefree a reality for Lancashire and South Cumbria and reduce the harm to our population from smoking and tobacco.

6.2 **Context**

Smoking is the number one cause of preventable death across England, resulting in more deaths than the next five causes combined (obesity, alcohol, road traffic accidents, drug abuse and HIV infection). Smoking affects each of the domains in the CORE20PLUS5 agenda and is a huge driver of health inequalities.

In 2019 the government set an ambition for England to be Smokefree by 2030. This would mean that by this time less than 5% of the population would smoke.

Currently in Lancashire and South Cumbria we are not on track to meet this ambition. An estimated 15% of our population currently smoke, and huge inequalities exist both in prevalence of tobacco use and tobacco related harm. As stipulated in the Khan Review published in 2022, considerable upscaling of intervention for tobacco control is needed to meet the Smokefree 2030 ambition and national action announced will not be enough alone to improve outcomes. A sustained and comprehensive effort is needed from the whole of Lancashire and South Cumbria Integrated Care System.

6.3 **Development of the Strategy**

This strategy has been developed collaboratively with tobacco leads and commissioners from each local authority area alongside colleagues from the NHS and Office for Health Improvement and Disparities.

An initial analysis was performed with local commissioners against the previous Tobacco Free Lancashire 2018-2023 strategy. This was presented back at a joint stakeholder engagement event with the Public Health Collaborative and Integrated Care Board Population Health team to assist in agenda and priority setting for the new strategy, alongside the latest data, evidence, policy and guidance on tobacco control. Wider stakeholder engagement was also conducted with Acute Trusts and the Mental Health NHS Trust.

The strategy has been socialised at the Public Health Leadership Collaborative and shared with commissioners, tobacco leads and the population health team with a deadline for the final round of comment of Monday 5 June 2023.

The strategy will now be finalised and formatted with a plan for presentation and final approval by each of the Health and Wellbeing Boards (Blackpool, Lancashire County Council, Blackburn with Darwen and Westmorland and Furness) and the Integrated Care Board by the end of September 2023.

6.4 **Strategy Priorities**

The strategy has been built around 4 key priorities for tobacco control:

1. Working together as a system for a smoke free tomorrow
2. Action to address health inequalities
3. Making Smoke Free the new normal
4. Lancashire and South Cumbria - A United Voice against tobacco harm

An additional separate priority was also identified around vaping and the need for consensus and clarity on the Lancashire and South Cumbria position on nicotine vapes.

6.5 Does the information submitted include any exempt information? No

7.0 List of Appendices:

7.1 Appendix 5a: Tobacco Free Lancashire and South Cumbria Strategy 2023-2028
Appendix 5b: Equality Analysis Record Form

8.0 Financial considerations:

8.1 Full implementation of strategy recommendations is likely to require additional investment across the Integrated Care System to ensure delivery of an equitable service that addresses areas of greatest need. A key recommended action within the strategy is to assess options regarding financial resource from local authorities and the Integrated Care Board to determine the best course of action.

9.0 Legal considerations:

9.1 None.

10.0 Risk management considerations:

10.1 None.

11.0 Equalities considerations:

11.1 An equality impact analysis has been conducted. Strategy includes specific foci with ambitions and recommendations for groups who experience inequalities in tobacco use and tobacco related harm, including: smoking in pregnancy, smoking in people with mental health conditions, socio-demographic inequalities, smoking in routine and manual occupations, smoking in those with multiple addictions, shisha and smokeless tobacco and children and young people.

12.0 Sustainability, climate change and environmental considerations:

12.1 Considered within specific strategy section around smokefree places, smoking waste and e-cigarettes.

13.0 Internal/external consultation undertaken:

13.1 Developed collaboratively with tobacco leads and commissioners across Lancashire and South Cumbria, Office for Health Improvement and Disparities and NHS colleagues. Current draft presented back to steering group 14/06/23. To be presented to Integrated Care Board Prevention and Health Inequalities Steering Group 15 June 2023 with a view for Integrated Care Board approval by September end. Consultation to also be held with Health and Wellbeing boards at Blackburn with Darwen, Lancashire and Westmorland and Furness.

14.0 Background papers:

14.1 None.

Appendix 5a

Tobacco Free Lancashire & South Cumbria Strategy 2023-2028

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Foreword

Over recent decades, much work has been done in Lancashire and South Cumbria to reduce the harm from smoking and tobacco in communities. However, tobacco continues to cause a significant level of harm to our population. In fact, smoking is the number one cause of preventable death across England, resulting in more deaths than the next five causes combined (obesity, alcohol, road traffic accidents, drug abuse and HIV infection) and is a huge driver of health inequalities. [1].

The single best action that an individual can take to improve their health is to stop smoking. Therefore it is imperative that we provide our population with a comprehensive tobacco control strategy to provide the best support possible, not only support individuals to stop smoking, but also to prevent the uptake of smoking and reduce exposure to dangerous second hand smoke.

The development of Integrated Care Systems across England provides a fantastic opportunity to work together as Lancashire and South Cumbria to stamp out tobacco harm. It is our hope that by working together as a system we can generate a whole that is more than just the sum of our parts.

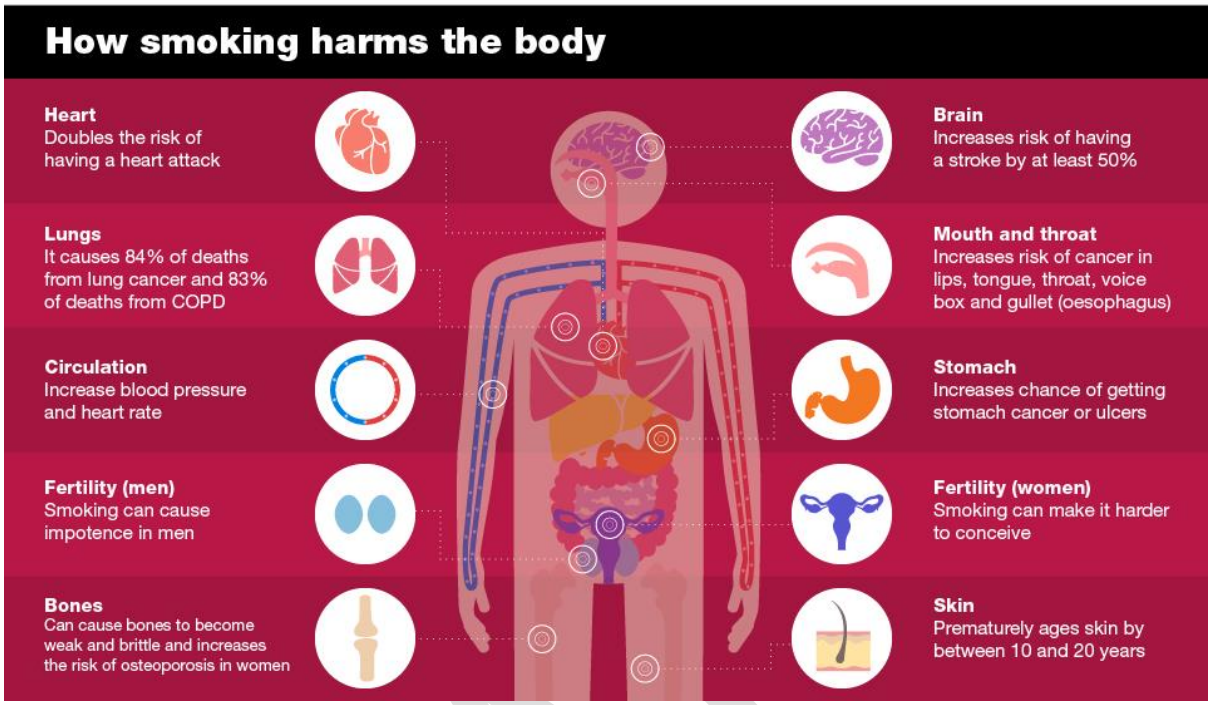
We want to create a future in Lancashire and South Cumbria where every person is able to breathe clean air, free from the harmful effects of tobacco smoke. In order to do this, we are working toward the Smoke Free 2030 ambition of lowering smoking prevalence in every neighbourhood to less than 5% by 2030. This ambitious vision cannot be made possible by one organisation alone, and will require a sustained and comprehensive effort from local authority public health, the NHS, our service providers and communities.

Councillor Brian Taylor, Blackburn with Darwen

Introduction

Why is smoking such a big concern?

Smoking is linked to over 100 different conditions, including at least 15 types of cancer, 9 mental health conditions and numerous respiratory, cardiovascular and other disorders. Prevalence of smoking in England has been gradually declining for a number of years, with around 13% of the adult population estimated to be current smokers in 2021 compared to 45% in 1974. However, this still equates to over 6 million people who smoke in England and smoking continues to kill almost 75,000 people per year.



Source: [Health matters: stopping smoking - GOV.UK (www.gov.uk)]

Tobacco use is also the largest driver of health inequalities in England and is perhaps the most significant public health challenge that we face today. Recorded life expectancy for smokers is at least 10 years shorter than for non-smokers with a disproportionate impact on those from poorer backgrounds where smoking prevalence is higher, as well as those suffering from mental health conditions[2].

Many of the local authorities with the highest proportions of smokers rank among the most deprived in England. In 2016, people living in the most deprived areas of England were four times more likely to smoke than those living in the least deprived areas. This is reflected in the outcomes for diseases such as lung cancer and chronic obstructive pulmonary disease (COPD) where smoking is the biggest risk factor. Deaths from respiratory diseases are more than twice as common in the most deprived places in England as in the least deprived places[3].

Tobacco use in Lancashire and South Cumbria

Tobacco use remains a significant public health challenge in Lancashire and South Cumbria. It is estimated that currently around **15% of adults in Lancashire and South Cumbria smoke** (APS, 2021) which is significantly higher than the 13% smoking prevalence estimate for England.

Figure 1.1 Smoking prevalence (%) in adults (18+), 2011-2021, Annual Population Survey (APS), by local authority

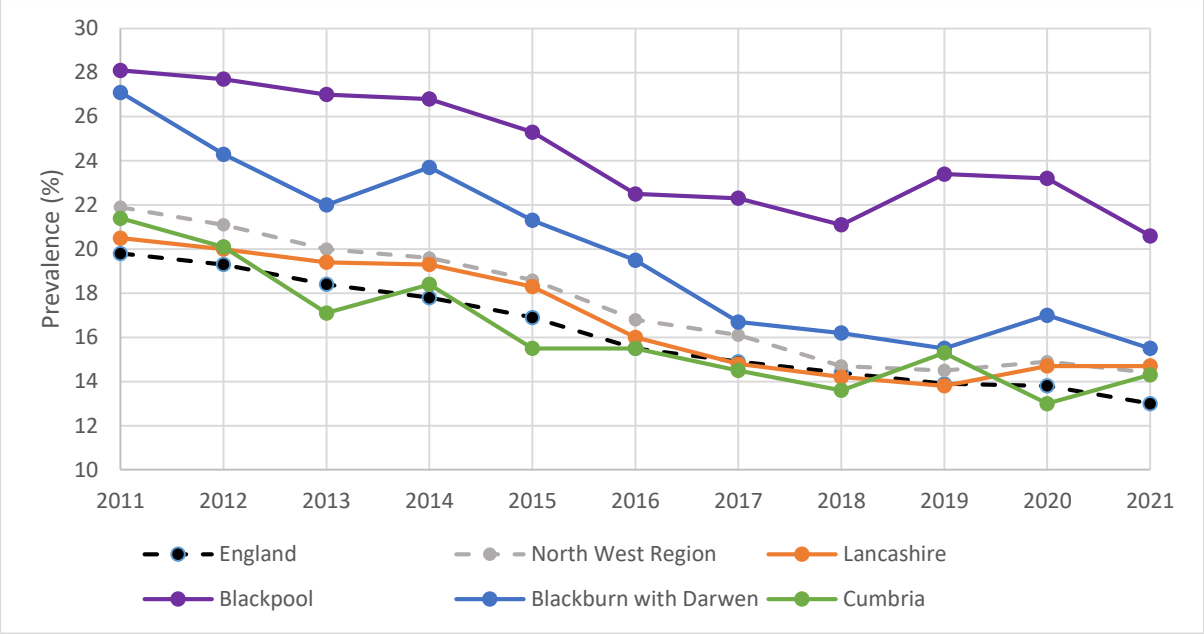
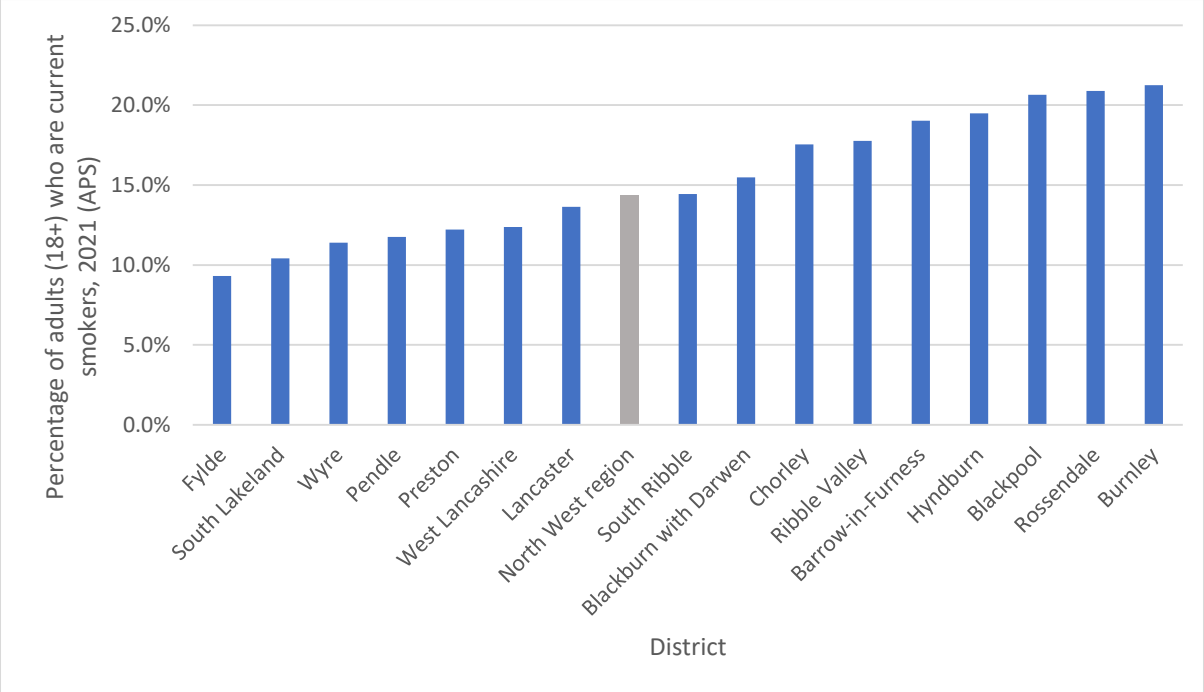


Figure 1.1 shows the trends in smoking prevalence in adults (18+) within England, the North West region and within the local authorities in our footprint using data from the Annual Population Survey- the largest household survey in England. Smoking can be seen to have declined in the past decade in each of our local authority areas, with decline starting to slow in more recent years. In 2021, it is estimated that 14.7% of adults in Lancashire smoke, 15.5% in Blackburn with Darwen, 14.3% in Cumbria, and 20.6% in Blackpool.

Smoking also varies within local authority areas, and this can be illustrated when we look at smoking prevalence by district (Figure 1.2). In 2021, the lowest smoking prevalence was seen in Fylde where 9.3% of adults are current smokers, and the highest prevalences are seen in Rossendale (20.9% current smokers) and Burnley (21.2% current smokers). Yet all three of these areas sit within Lancashire county council local authority. This demonstrates the importance of looking at the drivers of smoking at district and neighbourhood levels.

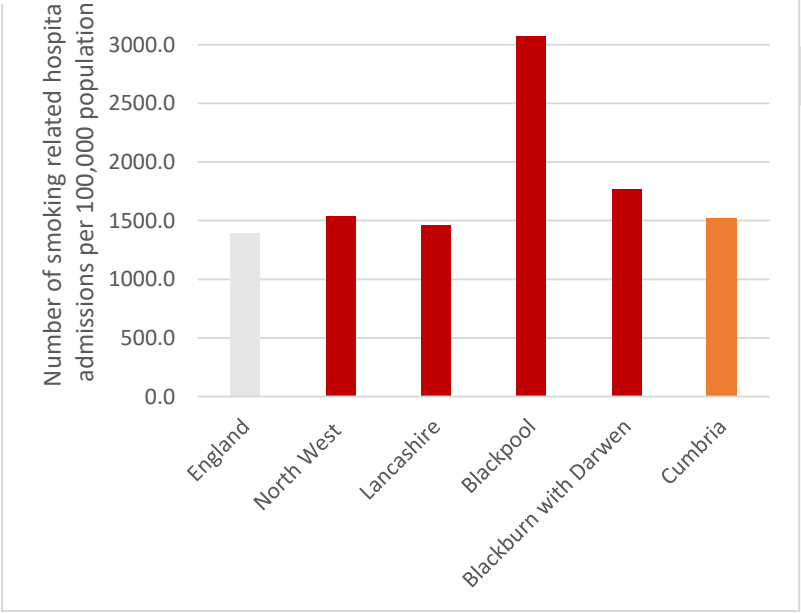
Figure 1.2 Smoking prevalence in adults by district (APS 2021)



Mortality and Morbidity from smoking

Across Lancashire and South Cumbria, smoking is responsible for **around 7,600 premature deaths** and **over 17,000 hospital admissions** each year.

Figure 2.1 Smoking attributable hospital admissions 2019/20, per 100,000 population, by local authority

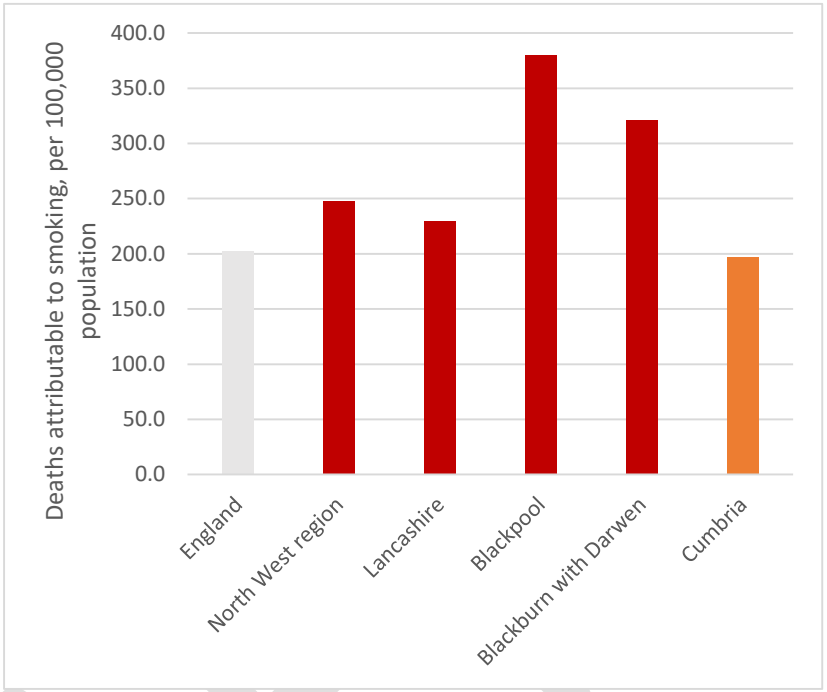


Source: Fingertips, OHID

Looking at smoking attributable hospital admissions acts as a proxy to give an idea about how much ill-health from smoking is suffered in our communities. In England, there are around 1398 hospital admissions per 100,000 of the population per year which can be attributed to smoking. In the North West as a whole, the smoking attributable admissions are higher than England with around 1540 admissions per 100,000 population per year. Figures for each local authority in Lancashire and South Cumbria can be seen in Figure 2.1. In Blackpool, smoking attributable admissions are over double that seen across England with around 3071 admissions per year due to smoking.

Smoking is also a major preventable cause of death, contributing to deaths from cancers, COPD, cardiovascular disease and many other conditions. Across England around 202 deaths per 100,000 population each year are caused by smoking. This is higher in the North West as a whole with around 247 deaths per 100,000 population each year. In Cumbria, the levels of smoking related deaths are similar to that seen across England. However, in Lancashire, Blackburn with Darwen and Blackpool, smoking related deaths are significantly higher than that seen across England. The highest levels being in Blackpool where around 380 people per 100,000 population die due to smoking each year.

Figure 2.2 Smoking attributable mortality by local authority, 2017-19



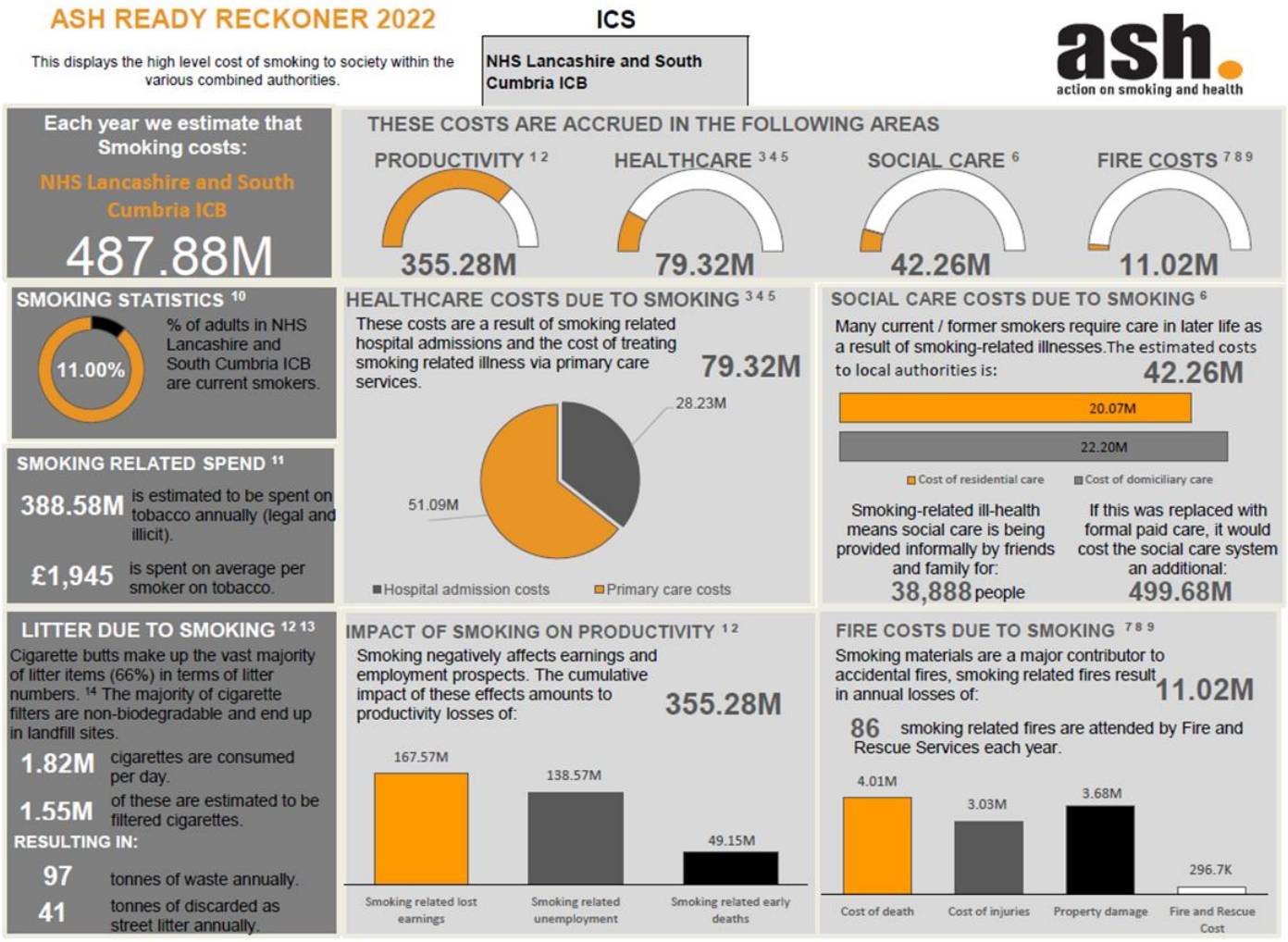
Source: Fingertips, OHID

Wider effects of Smoking on Lancashire and South Cumbria

Smoking not only impacts on the health of our population but also has wider economic costs to our society.

There are almost 200,000 people who smoke in Lancashire and South Cumbria, who on average spend £1945 per year on tobacco (legal and illicit). This gives Lancashire and South Cumbria residents a total spend of over £388 million per year on tobacco products. Stopping smoking could save each person currently smoking 10-20 cigarettes per day around £2000 - £4000 every year.

In addition to this, smoking also accrues wider costs due to its impact on productivity, healthcare, social care and costs of managing smoking related fires. . The Ready Reckoner tool created by Action on Smoking and Health (ASH) allows us to estimate the extent of these effects in Lancashire and South Cumbria[4].



National policy and guidance

In 2019 the government set a target for England to be smokefree by 2030 which would mean that by 2030 less than 5% of the population will smoke. In order to achieve this target, considerable upscaling of current tobacco harm interventions is required as very few areas of the country are on track to meet this target. Summarised below are key national policy, strategy and guidance on tobacco control that inform our approach in Lancashire and South Cumbria.

The national Tobacco Control Plan 2017-2022

Between 2017 and 2022 action has been guided by the National Tobacco Control Plan 2017-2022 [5]. This plan set out a variety of ambitions to achieve by the end of 2022, including reducing inequalities in smoking between routine and manual occupations, improving support for smokers with mental health conditions and encouraging innovation to help smokers quit. Part of these ambitions included targets for lowering smoking prevalence in key groups:

- Reduce smoking prevalence amongst adults in England from 15.5% to 12% or less.
- Reduce the prevalence of 15 year olds who regularly smoke from 8% to 3% or less.
- Reduce the prevalence of smoking in pregnancy from 10.7% to 6% or less.

To achieve these targets the Tobacco control plan set out the below actions:

1. Prevention first

To achieve a smokefree generation we will:

- Ensure the effective operation of legislation such as proxy purchasing and standardised packaging designed to reduce the uptake of smoking by young people.
- Support pregnant smokers to quit. NICE has produced guidance on how pregnant smokers can be helped to quit. Public Health England and NHS England will work together on the implementation of this guidance.

2. Supporting smokers to quit

To achieve a smokefree generation we will:

- Provide access to training for all health professionals on how to help patients - especially patients in mental health services - to quit smoking.
- NHS Trusts will encourage smokers using, visiting and working in the NHS to quit, with the goal of creating a smokefree NHS by 2020 through the 5 Year Forward View mandate14.

3. Eliminating variations in smoking rates

To reduce the regional and socio-economic variations in smoking rates, we need to achieve system-wide change and target our actions at the right groups so we will:

- Promote links to "stop smoking" services across the health and care system and full implementation of all relevant NICE guidelines by 2022.
- Support local councils to help people to quit by working with Directors of Public Health to identify local solutions, particularly where prevalence remains high.

4. Effective enforcement

To reduce the demand for tobacco and continue to develop an environment that protects young people and others from the harms of smoking we will:

- Maintain high duty rates for tobacco products to make tobacco less affordable.
- Ensure that sanctions in current legislation are effective and fit for purpose,

The next iteration of the National Tobacco Control Plan has not yet been released at time of writing this strategy.

The Khan Review

Link: [The Khan review: making smoking obsolete - GOV.UK (www.gov.uk)]

This independent review by Dr Javed Khan OBE was published on the 9th June 2022, commissioned by Secretary of State for Health and Social Care to inform the government's approach to tackling the wide health disparities associated with tobacco use[6]. In the absence of a new National Tobacco Control Plan at time of strategy development, the findings from this review, have provided key evidence and recommendations to inform our local plans.

Khan finds in his review that without further action, the national smokefree 2030 target would be missed by at least 7 years, with the poorest areas of England not meeting this target until 2044. Indeed, Khan suggested that to meet the 2030 target the decline in smoking rates would have to accelerate by 40%.

In order to achieve this Khan set out 15 recommendations to be implemented at national and local levels. Four of these recommendations were described as "critical recommendations" needing urgent action if we are to meet the 2030 Smokefree target:

Khan's critical recommendations

- **Urgently invest £125m per year in interventions to reach smokefree 2030.**
- **Raise age of sale of tobacco by one year, every year**
- **Offer vaping as a substitute for smoking, alongside accurate information on the benefits of switching, including to healthcare professionals.**
- **The NHS needs to prioritise prevention, with further action to stop people smoking, providing support and treatment across all its services, including primary care**

The Khan Review: Independent review into smokefree 2030 policies

Four critical recommendations are boxed in red. These are 'must dos' for the government to achieve a smokefree England by 2030 , around which all other interventions are based.

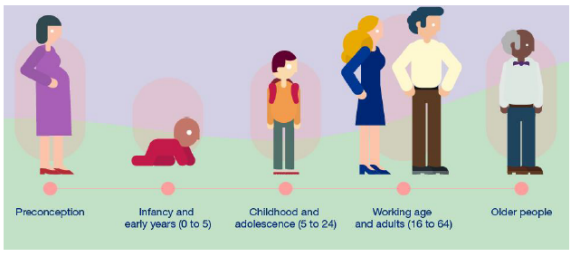
Part 1: Invest Now

REC 1: Urgently invest £125m per year in interventions to reach smokefree 2030.

Option 1: Additional funding from within government
Option 2: A 'polluter pays' industry levy
Option 3: A corporation tax surcharge

Part 2: Stop the Start

REC 2: Raise age of sale of tobacco by one year, every year.



The image above shows **the lifecycle of a smoker**. From smoking in pregnancy and the impact on the unborn baby, to old age, where 2/3 lifetime smokers will likely die from smoking. Interventions are needed at all stages of a person's life.

REC 3: Substantially raise the cost of tobacco duties (more than 30%) across all tobacco products, immediately. Abolish all duty free entry of tobacco products at our borders.

REC 4: Introduce a tobacco licence for retailers to limit where tobacco is available.

REC 5: Enhance local illicit tobacco enforcement by dedicating an additional funding of £15 million per year to local trading standards.

REC 6: Reduce the appeal of smoking by radically rethinking how cigarette sticks and packets look, closing regulatory gaps and tackling portrayals of smoking in the media.

REC 7: Increase smokefree places to de-normalise smoking and protect young people from second-hand smoke.

Part 3: Quit for Good

REC 8: Offer vaping as a substitute for smoking, alongside accurate information on the benefits of switching, including to healthcare professionals.

REC 9: Invest an additional £70 million per year into 'stop smoking services', ringfenced for this purpose.

REC 10: Invest £15 million per year in a well-designed national mass media campaign, supported by targeted regional media.

Part 4: System Change

REC 11: The NHS needs to prioritise prevention, with further action to stop people smoking, providing support and treatment across all its services, including primary care

REC 12: Invest £15m per year to support pregnant women to quit smoking in all parts of the country.

REC 13: Tackle the issue of smoking and mental health.

REC 14: Invest £8m to ensure regional and local prioritisation of stop smoking interventions through ICS leadership.

REC 15: Invest £2 million per year in new research and data, including investing £2 million in an innovation fund.

A number of these recommendations require national policy decisions and cannot be implemented on a local scale without national action. This includes raising the age of tobacco sale, increasing central investment for interventions and services, increasing taxes and levies on the tobacco industry, developing regulations around how cigarette packers should look and introducing tobacco licenses. Therefore it is important that we use our voice in Lancashire and south Cumbria to lobby national government for actions that would be beneficial for our population.

The NHS Long Term Plan

The NHS Long Term Plan was published in 2019 and is a 10-year plan which outlines steps to be taken to improve the health of the population and maintain and develop the NHS to provide the best possible care to patients[7]. A key part of this plan involves increasing prevention within the NHS and addressing inequalities. For smoking cessation this has meant the introduction of a new NHS funded treating tobacco dependency service in:

- **Inpatient settings**
- **Maternity services**
- **Mental health and learning disability services**.

Smoking cessation commitments in the NHS long term plan:

- "By 2023/24, all people admitted to hospital who smoke will be offered NHS-funded tobacco treatment services.
- The model will also be adapted for expectant mothers, and their partners, with a new smoke-free pregnancy pathway including focused sessions and treatments.
- A new universal smoking cessation offer will also be available as part of specialist mental health services for long-term users of specialist mental health, and in learning disability services."

NHS Core20PLUS5

Core20PLUS5 is a national NHS England approach to reduce healthcare inequalities. This approach targets the 20% of England's population living in the most deprivation as identified using the Index of Multiple Deprivation (IMD), as well as population, groups at local levels who experience inequalities such as those from ethnic minority backgrounds, people with long term conditions, and other vulnerable groups.

The approach defines 5 clinical areas where focus is required to accelerate improvement. These are:

- Maternity
- Severe mental illness
- Chronic respiratory disease
- Early cancer diagnosis
- Hypertension

Each of these areas are impacted heavily by smoking, further demonstrating the need to incorporate strong action to tackle smoking moving forward.

5: Five clinical areas of focus are all impacted by smoking

1. Maternity	2. Severe Mental Illness	3. Chronic respiratory illness	4. Early cancer diagnosis	5. Hypertension
Smoking is the leading modifiable risk factor for poor birth outcomes In your ICS 13%[14] of women smoke at time of delivery ~ 2,034 women annually[15]	Smoking is the leading cause of the 10-20 year reduction in life expectancy for people with SMI. In your ICS 44% of people with SMI smoke[16]	Around 86% of all COPD deaths are caused by smoking In your ICS 1,123 people a year die from COPD[17]	Smoking is the leading preventable cause of cancer responsible for 27% of cancer deaths In your ICS 1,086 people a year die from cancer caused by smoking[18]	Smoking cessation is embedded in NICE guidelines on hypertension because smokers' CVD risk is double that of non-smokers. In your ICS 394 people a year die from CVD caused by smoking[19]
Find out more	Find out more	Find out more	Find out more	Find out more

Source: Briefings for Integrated Care Systems - ASH

NICE Guidance

The National Institute for Health and Care Excellence (NICE) is an independent public body who provide guidance and advice to improve health and social care in England. NICE have published guidance on the public health approach to smoking cessation in **NG209 "Tobacco: preventing uptake, promoting quitting and treating dependence"** [8]. This was published in November 2021 and replaces previously published guidelines for smoking harm reduction (PH45), stop smoking interventions and services (NG92) and guidance for smoking cessation in acute settings, pregnancy and mental health (PH48).

This comprehensive guideline covers support to stop smoking for anyone aged 12 and over, how to reduce harm from smoking for those not ready to quit, and preventing uptake of smoking.

New and updated recommendations can be found in this guideline regarding adult-led interventions in schools, stop smoking interventions, e-cigarettes, support to stop smoking in secondary care, identifying and supporting pregnant women who smoke and commissioning and designing of services. It also includes best practice guidance on preventing uptake, promoting quitting, treating tobacco dependence, policy, commissioning and training.

This evidence based guidance plays a key role in our strategy, in determining the what works and how to support our population to stop smoking, reduce harm from smoking and prevent the uptake of smoking.

Smokefree 2030: Government action

On the 11th April 2023 Neil O'Brien MP gave a ministerial speech regarding the 9 next steps by the government to work towards their 2030 Smokefree ambition:

1. Youth vaping: A call for evidence

A call for evidence has been published to explore evidence related to youth vaping. This is to collect information and explore issues such as accessibility of vapes to children and young people, regulation, marketing, promotion and environmental impacts of disposable vapes.

2. Swap to stop: 1 million smokers

A two year "swap-to-stop" scheme has been announced that will see nationally funded vaping kits being distributed to a million smokers to be used as quit aids to stop smoking. It has been announced that this will target the most at-risk communities first- including job centres, homeless centres and social housing providers.

3. Illicit products: A new national "flying squad"

£3 million of funding is being used to develop a new "flying squad" to tackle underage and illicit vape sales through trading standards.

4. Smoking in pregnancy: A national incentive scheme

Financial incentive schemes for pregnant women to quit smoking are to be funded centrally and will be offered to all pregnant women who smoke by the end of 2024.

5. Smoking in mental health: Quit support in Mental Health services

All mental health professionals to be trained to at minimum signpost to services.

6. Licensed medicines: Unblocking supplies

There have been issues regarding supply of some evidence based medications to help smokers quit such as Varenicline and Cystisine. Action is planned to improve access and unblock supply chains.

7. Tobacco packaging: Mandatory pack inserts

Consultation is planned on introducing mandatory inserts inside cigarette packs that promote the benefits of stopping smoking and signpost to support.

8. The Major Conditions Strategy: Smokefree at the core

As stated above, the next iteration of the National Tobacco Control Plan has not yet been delivered at the time of writing. It has been announced however, that the Major Conditions strategy will have Smokefree at its core.

Although these announcements were welcomed by the Public Health community, the consensus is that the actions do not go far enough. Many of the recommendations from the Khan review have not been discussed and there appears to be no plans for the substantial additional central investment recommended, or for policy change such as raising the age of tobacco sales and increasing tobacco industry taxes. Many questions still remain as to whether the announced measures will have enough impact and influence on smoking levels, particularly in areas where smoking is most prevalent.

Our priorities for Smoke-Free Lancashire and South Cumbria 2023-2028

The purpose of this strategy is to provide clear direction for commissioners, strategic leads and policymakers across Lancashire and South Cumbria around how we can together make Smokefree a reality for Lancashire and South Cumbria, and reduce the harm to our population from smoking and tobacco.

In order to achieve this our strategy is built around four key priorities;

1. **Working together as a system for a smoke free tomorrow**
2. **Action to address health inequalities**
3. **Making Smoke Free the new normal**
4. **Lancashire and South Cumbria - A United Voice against tobacco harm**

Priority 1: Working together as a system for a smoke free tomorrow

To effectively move towards a smokefree 2030 in Lancashire and South Cumbria, it is essential that we provide our population with effective support to stop smoking. One of the most effective and cost-effective ways to do this is through provision of evidence based treating tobacco dependence services.

Where are we now?

Community stop smoking support is currently commissioned and funded through local authorities. However in addition to this, as part of the NHS Long Term Plan commitment to prevention, new specialist stop smoking support should now be in place for in-house inpatient, maternity and mental health services at NHS acute trusts across Lancashire and South Cumbria. Despite this progress, availability of funding and equity of service provision remains an issue as need and complexity in the levels of intervention needed to successfully treat tobacco addiction means there remain unacceptable levels of variation of support within Lancashire and South Cumbria. What services you have access to very much depends on where you live.

Comprehensive evaluation of different stop smoking models and interventions over the years provide us with robust evidence that the most effective provision for stop smoking support is a specialist treating tobacco dependence service, providing a universal offer with pharmacology alongside behavioural support. This must be provided by a service whose primary role is the provision of stop smoking support[9]. Despite financial pressures on Local Authority's the 2021/22 survey by ASH found that 67% of local authorities still provided community treating tobacco dependence services using this model of delivery with some areas of the country having tried alternative approaches to delivery and having gone back to the specialist approach[10].

Lancashire and South Cumbria Integrated Care Partnership (ICP) was created with the ambition and purpose to harness the collective efforts of all partners to improve the health and wellbeing of the Lancashire and South Cumbria population. This presents a great opportunity to come together to tackle tobacco addiction across the footprint equitably, with the collective efforts of partners to enable a whole that is more than just the sum of our parts.

Ambitions:

- **We will work towards reducing smoking prevalence in every district of Lancashire and South Cumbria to 5% or below by 2030, taking a targeted neighbourhood approach where appropriate**
- **We will work together as a system across Lancashire and South Cumbria to ensure that there is consistent, fair access to stop smoking support at every touch point within health, and care services**
- **We will ensure that the level of investment needed to tackle tobacco addiction is appropriate to the needs and circumstances of our communities, to allow provision of evidence based effective interventions and to address variations in levels of provision**
- **We will use local and national intelligence to understand smoking and nicotine use in our populations and provide support that meets the unique needs of populations in each locality**

Recommendations for Action:

- **Each area within the ICS footprint should have access to a specialist community treating tobacco dependence service that provides a universal offer of support to its population**
- **Development of an options appraisal to look at what steps can be taken at an ICS level to work together towards achieving a Smokefree Lancashire and South Cumbria, and to determine levels of financial investment required to level up progress in line with the Smokefree 2030 ambition**
- **Smoking status should be recorded for all patients visiting health and care services and this information should be available to treating tobacco dependence services so that support to stop smoking can be offered.**
- **Training in Very Brief Advice (VBA) should be mandatory for all frontline health and care staff, and be available for key individuals and organisations that work with residents who smoke. This training should be consistent across Lancashire and South Cumbria and include information on how to refer patients to treating tobacco dependence services.**
- **Delivery of very brief advice and the outcome of encounters should be recorded and monitored to understand how training is translated into practice and how this impacts service use.**
- **All resources for training, education and public engagement should be used and developed collaboratively across the footprint. This will ensure that consistent messages are delivered with a shared vision. It will also allow more effective use of resources.**
- **Treating tobacco dependence services should work collaboratively with partners who can signpost and refer into services such as: acute trusts, mental health trusts, primary care, social care, schools, colleges and workplaces to ensure that it is clear how individuals can be referred or refer themselves to access support and what that support entails.**

How will we measure success?

Equity of service provision will be monitored and reviewed through the Smoke free Lancashire and South Cumbria group.

Success will also be measured through improvements in the following indicators:

- Local smoking prevalences
- Treating tobacco dependence service referrals
- Recording of patient smoking status by services
- Treating tobacco dependence service quit rates
- VBA training compliance

Priority 2: Action to address health inequalities

Smoking in Pregnancy

Stopping smoking during pregnancy is one of the best things that a mother can do to ensure a healthy start in life for their child. Smoking cigarettes and exposure to second hand smoke during pregnancy increases the risk of a variety of problems including, increased likelihood of low birth weight, stillbirth, miscarriage, pre-term delivery and heart defects. Adverse health effects can also be seen after delivery with children of mothers who smoke being 3 times more likely to experience sudden infant death syndrome (SIDS).

A summary of the impacts of smoking in pregnancy is displayed below in Table 1.

Table 1: Impacts of smoking in pregnancy.

	Maternal smoking	Second-hand smoke exposure
Low birth weight	Average 250g lighter	Average 30-40g lighter
Stillbirth	Double the likelihood	Increased risk
Miscarriage	24-32% more likely	Possible risk
Preterm birth	27% more likely	Increased risk
Heart defects	50% more likely	Increased risk
Sudden infant death	3 times more likely	45% more likely

Source: NHS Long Term Plan

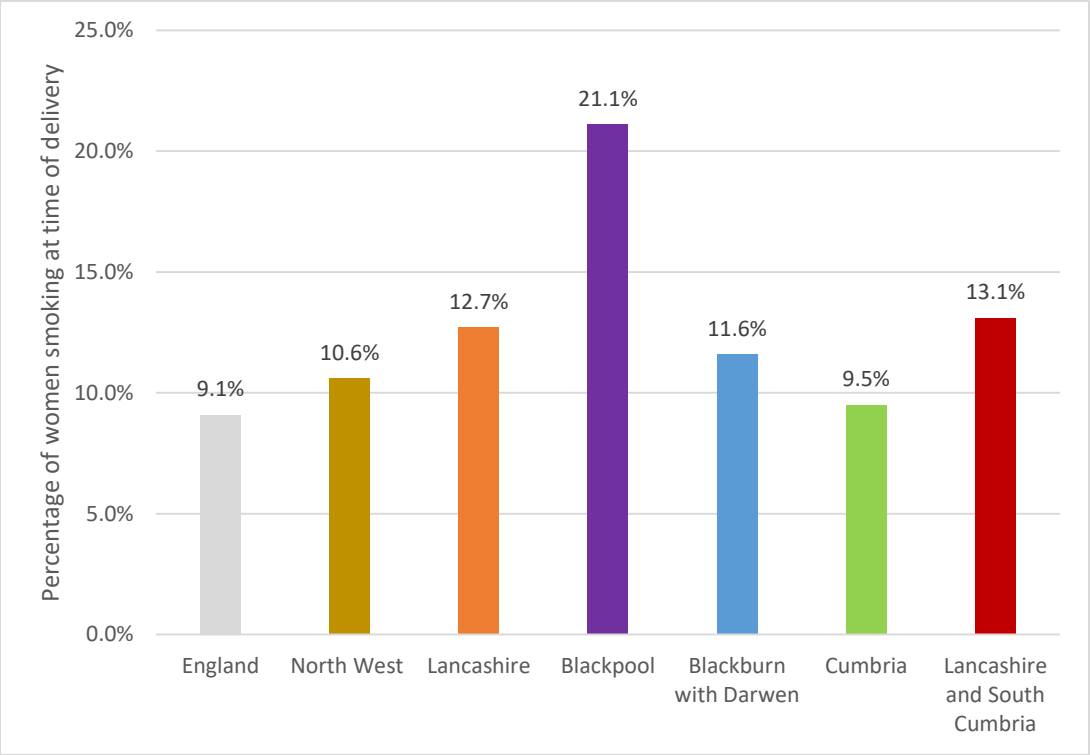
Rates of smoking in pregnancy are strongly linked to age and social economic deprivation. Mothers aged 20 or under are five times more likely than those aged 35 and over to have smoked throughout pregnancy (45% and 9% respectively)[26]. Women in routine and manual occupations are more than five times as likely to smoke throughout pregnancy compared to those in managerial and professional occupations. As a result, those from lower socio-economic groups are at much greater risk of complications in pregnancy[27].

For these reasons, smoking in pregnancy has been a key component of plans to reduce smoking at national and local levels and is a key area of focus in the NHS Long Term Plan, under which specialist in-house maternity treating tobacco dependence services are being rolled out across England. Prevalence of smoking within pregnancy is measured by collecting data on smoking status at time of delivery (SATOD) for pregnant women and the Government Tobacco Control Plan for England 2017-2022 set an ambition to reduce smoking in pregnancy to below 6% by the end of 2022.

Where are we now?

Rates of smoking at time of delivery (SATOD) have been gradually declining over the past decade, and vary considerably across England (Figure 4). Prevalence remains above national targets with the latest annual figure from NHS Digital in 2021/2022 year showing that 9.1% of women in England are smoking at time of delivery. This compares to 13.1% within Lancashire and South Cumbria, however there is great variation in this within the patch. The highest rates of smoking at time of delivery are seen in Blackpool, where 21.1% of women were still smoking at time of delivery.

Figure 3- Smoking at time of delivery (%) in 2021/22, by location



In order to further reduce smoking in pregnancy in Lancashire and South Cumbria, more action is needed to support pregnant women and their families. The new in-house specialist maternity treating tobacco dependence services, introduced as part of the NHS Long Term Plan is a key step forward and will ensure all pregnant women have the option of a combination of nicotine replacement therapy (NRT) and psychological support from trained professionals to help them stop smoking.

There is good evidence that the use of financial incentive schemes for smoking cessation in pregnant women works, with those receiving incentives being twice as likely to stop smoking [11]. Financial incentive programs for pregnant women are now being rolled out as part of a national, centrally funded scheme announced in the April 2023 ministerial speech on tobacco and should be available for all pregnant women by the end of 2024.

Currently, not all women who report as smokers at booking with maternity services are referred and engage with treating tobacco dependence services. As it is an opt-out pathway, some women choose to stop smoking independently, some try to stop smoking but don't succeed and others do not feel able to engage with services. Some local insight work has been conducted previously in Lancashire and South Cumbria to understand the reasons behind different smoking behaviours in pregnancy, and smoking in pregnancy has also been a key focus in the recent qualitative research conducted by Bluegrass and ASH around smoking behaviours [12]. Further developing, utilising reviewing this work is imperative to understand how we can best support pregnant mothers.

Ambitions:

- **All pregnant women will have access to a specialist in-house maternity treating tobacco dependence service offering both NRT and behavioural support as part of standard care**

- **To work towards a smoking at time of delivery prevalence of 6% of less in every neighbourhood**
- **To ensure all evidenced based best practice is adopted in maternity services so that women are given the best opportunity to stop smoking during pregnancy and beyond**
- **To better understand why women in Lancashire and South Cumbria smoke during pregnancy and how they can be best supported to quit**

Recommendations for action:

- **Regular training with consistent messaging and up to date information should be made available for midwives, maternity health trainers and midwifery support workers on the importance on stopping smoking during pregnancy, with a specific focus on how to counsel pregnant women**
- **Supporting significant others on the women's pregnancy journey should include them also having access to stop smoking support in all areas of Lancashire and South Cumbria. Where this support is to be delivered by community services, pathways and the referral process should be simple, clear and robust.**
- **All pregnant women who smoke should have access to a stop smoking incentivisation programme to support their quit attempt.**
- **Carbon monoxide monitoring should be performed and documented in all pregnant women, occurring as a minimum at booking and 36 weeks with regular monitoring and auditing of these figures.**
- **Data should be systematically collected and analysed regarding reasons why stop smoking support is declined by pregnant mothers and why quit attempts do not succeed. This will allow a better understanding of the wider challenges faced by our pregnant mothers and inform public health action on wider determinants of health.**
- **Prominence of messages around why stopping smoking in pregnancy is important, and how to access support should be increased through campaigns across the ICS and wider region.**

How will we measure success?

Success will be measured through monitoring of action plan implementation in the Tobacco Free Lancashire and South Cumbria group and through improvements in the following indicators:

- Smoking at time of delivery rates
- Maternity treating tobacco dependency service quits
- Maternity reating tobacco dependence service referrals
- Incentivisation scheme offer and quit rates
- CO monitoring compliance
- Referrals of significant others into services and subsequent quits

Mental health and Smoking

Those with mental health conditions die, on average, 10-20 years earlier than the general population with smoking the single largest cause of this gap in life expectancy. There is evidence that smoking prevalence is higher across a range of mental health conditions and that smoking rates increase with the severity of illness. In addition to this, people with mental health conditions smoke significantly more, have increased levels of nicotine dependency, and are therefore at even greater risk of smoking-related harm [2].

Smoking causes the release of a chemical called dopamine in the brain. When someone smokes they begin to crave this dopamine release and feel more stressed when levels of nicotine decrease in the bloodstream between cigarettes. The relief felt when this craving is finally satisfied is the feeling that smokers commonly describe as 'relaxing'.

For smokers with a mental health condition, the association between smoking and feeling relaxed is more pronounced and this can lead some to believe that smoking is good for their mental health[13]. However, the relief from nicotine withdrawal is only temporary and there is evidence that smoking can exacerbate problems. Smokers with a mental health condition tend to be more heavily addicted to smoking; and the higher the number of cigarettes smoked per day, the greater the likelihood of someone developing a mental health condition[14].

Where are we now?

Data from the GP Patient Survey estimates that in 2020/21 26.3% of adults (18+) with a long term mental health condition in England smoke. A similar prevalence can be seen across most areas of Lancashire and South Cumbria. However in Blackpool, 41.7% of those with a mental health condition are recorded as smoking.

Since July 2008, mental health facilities in England have been required by law to be smokefree indoors. Since this time, more mental health facilities have offered stop-smoking support to patients who express an interest in quitting. Currently, as part of the NHS Long Term Plan, a specialist inpatient treating tobacco dependence service is being implemented in all Mental Health NHS Trusts in England.

However, many people with mental health conditions receive support from mental health services in their communities. Therefore it is imperative that support is also available in outpatient settings. People with a mental health conditions often anticipate the difficulty of stopping smoking, which can make quitting the habit harder. However, motivation to quit smoking is often high in these groups and it is therefore important to ensure that an adequate level of specialist support is available to meet their needs[15,16].

Ambitions:

- **Individuals with mental health conditions will have access to specialist stop smoking support, both in inpatient settings and in the community**
- **Pathways between mental health and community treating tobacco dependence services will be strengthened with all staff appropriately trained to manage the unique needs of those with mental health conditions**
- **We will work with partners across the footprint to dispel myths around smoking and mental health to ensure a change in culture in mental health settings**

Recommendations for Action:

- **Lancashire and South Cumbria mental health inpatient specialist stop smoking support service should be appropriately resourced to support all those with mental health conditions. This should include adequate provision of pharmacotherapy and behaviour support for patients to make abstinence from smoking extend beyond their inpatient stay.**
- **Specialist stop smoking support should be made available for patients with mental health conditions as an outpatient, in the community.**
- **Evidenced based training for staff on smoking, access to treating tobacco dependence services (inpatient, outpatient and community) need to be available for all involved with the patient. This must include dispelling the myths around mental health and smoking and detailed guidance on medications.**
- **Work needs to be developed to engage all in a drive towards culture change which challenges the current social norms around smoking and mental health.**

How will we measure success?

Success will be measured through improvements in the following indicators:

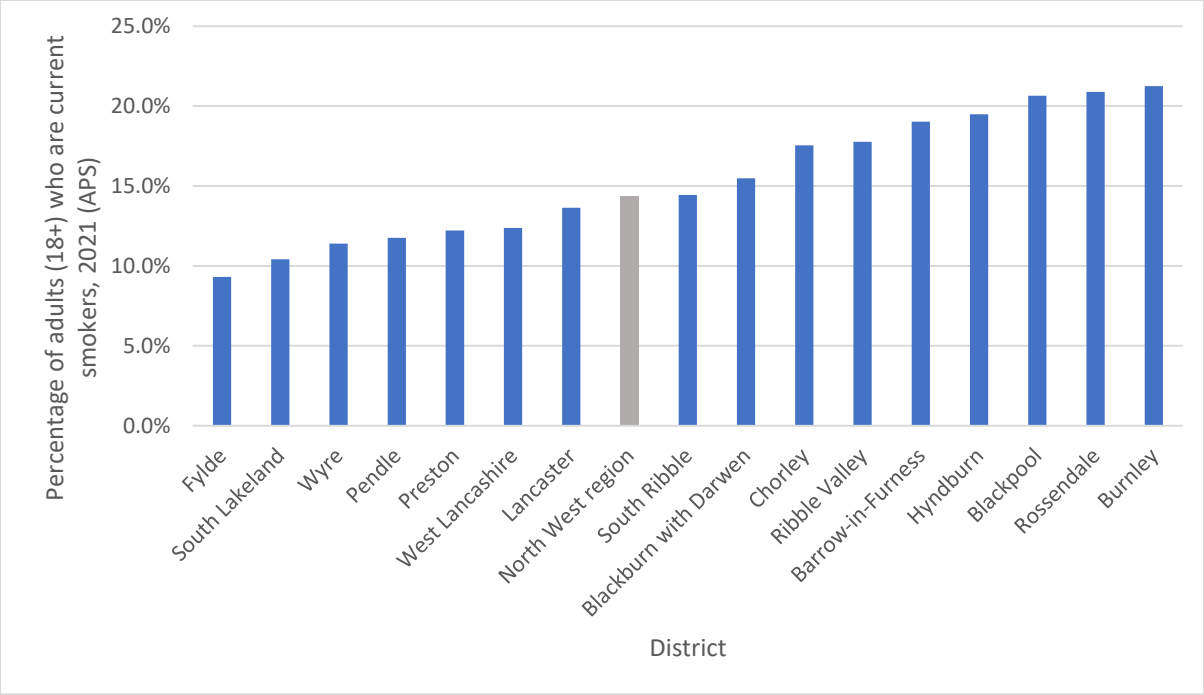
- Referrals and quits in specialist mental health treating tobacco dependency services
- Smoking prevalence in patients with mental health conditions and severe mental illness

Sociodemographic inequalities in Smoking

Smoking not only varies between local authority areas, but variation in prevalence can also be seen between and within our districts and neighborhoods.

Figure 1.2 shows the smoking prevalence across Lancashire and South Cumbria at a district level. Within Lancashire County Council, prevalence ranges between 5.5% in Fylde to almost 23% in Burnley, therefore it is important when striving for targets around smoking levels, that we monitor habits and behaviours at district and neighbourhood levels and target additional interventions to reduce inequalities. Attention also needs to be paid to sociodemographic groups where smoking is more prevalent, including: routine and manual occupations and in those with multiple addictions. Specific interventions may also need to be considered in some areas tackle smokeless tobacco products and shisha.

Figure 1.2 Smoking prevalence(%) in adults (18+) by district (APS 2021)



Source: Annual Population Survey (2020), via Fingertips

Ambitions:

- **We will ensure that treating tobacco dependence service provision is equitable and services are able to provide support appropriate to the varying needs within our communities across Lancashire and South Cumbria**

Recommendations for Action:

- **Develop local data and intelligence to understand the reasons behind variations in smoking prevalence at district and neighbourhood levels**
- **Target additional support at groups where prevalence is high (see below)**

Routine and manual occupations

In England, around 1 in 4 people working in routine and manual occupations (for example, as labourers, bar staff, lorry drivers, receptionists or care workers) smoke, compared to just 1 in 10 of those in managerial and professional occupations (for example, as lawyers, architects, nurses or teachers). In some areas of Lancashire and South Cumbria, the proportion of routine and manual workers who smoke is even higher. Data from the Annual Patient Survey estimates that in Burnley almost 46% of those in routine and manual occupations smoke, and in Blackpool 36% of these workers smoke.

Supporting this group to stop smoking is not only imperative to prevent the long term health consequences that smoking causes, but is also important to ensure that we have a healthy and productive workforce to economically support our area.

Recommendations for Action:

- **Stop smoking campaigns should be developed to targeting those in routine and manual occupations**
- **Work should be undertaken with employers and workplaces that provide these routine and manual occupations, especially in areas where smoking prevalence in this group is highest.**
- **Workplaces should be supported to promote a smokefree culture through development and implementation of smokefree policies**
- **All ICS partners should set a clear, strong example in their workplaces by ensuring that they have clear smokefree policies in place and pathways to treating tobacco dependence services and support for all employees and contractors**

How will we measure success?

Success will be measured through monitoring of action plan implementation in the Tobacco Free Lancashire and South Cumbria group and through improvements in the following indicators:

- Reduction in variation of smoking prevalence in routine and manual occupations from from general population smoking prevalence, at place level

Shisha and Smokeless Tobacco

Shisha smoking involves the smoking of tobacco through a shisha pipe, also known by the names water-pipe, hookah and narghile. This practice is traditionally more common in the Middle East and in some areas of Asia and Africa. However, shisha has become more popular in the UK in the last decade, with shisha lounges opening in many UK towns and cities.

Smokeless tobacco is a term which encompasses a range of tobacco products that are not smoked but may instead be chewed, inhaled through sniffing or placed in the mouth. Examples include tobacco pouches, paan and naswar.

Both shisha and smokeless tobacco are most commonly used in minority ethnic, particularly groups of South Asian descent[17]. In Lancashire and South Cumbria, prevalence of shisha and smokeless tobacco use varies, and is most common in areas with a higher South Asian populations such as Blackburn.

There are a number of commonly held misconceptions around the health risks of shisha and smokeless tobacco. Some mistakenly believe that the process of passing tobacco through water in a shisha pipe filters the tobacco making it safer than smoking or believe that shisha is less addictive. Whilst shisha is not as extensively researched as cigarette smoking, there is considerable evidence that smoking shisha constitutes similar health risks to smoking, including exposure to tar, nicotine and various carcinogens.

Whilst smokeless tobacco is not associated with the same risk for lung cancer and respiratory diseases as smoking, there are still considerable associated health risks to this practice, including risks of oral and pharyngeal cancers, ischaemic heart disease and stroke.

Recommendations for Action:

- **Increase awareness of the harms caused by smokeless/niche tobacco products, targeting specific communities, utilising health harm awareness campaigns**
- **Develop and implement treating tobacco dependence services and care pathways for smokeless tobacco users, and find sustainable mechanisms to embed these pathways in targeted communities, (such as through faith groups and community leaders)**
- **Trading standards should be supported to ensure that shisha premises comply with laws and regulations**
- **Organisations should ensure to consider niche tobacco, such as shisha and smokeless tobacco when developing local guidance and policy. This can be supported by use of the OHID niche tobacco self-assessment tool.**

How will we measure success?

Success will be measured through trading standards intelligence on shisha establishments and improvements in the following indicators:

- Quit rates through services in users of niche and smokeless tobacco products
- Referrals into services for users of niche and smokeless tobacco products

Smoking in those with Multiple Addictions

Smoking rates in those with alcohol and other drug dependencies are between two and four times higher than rates seen in the general population.

Sometimes treating tobacco dependence services and support may not seem like a priority in these settings but it presents a good opportunity to quit and improve their health outcomes. Evidence shows that by providing support to stop smoking to individuals in treatment for alcohol and other drug dependencies increases the likelihood of successfully quitting[18].

Recommendations for Action:

- **Strengthen pathways of support between stop smoking and substance misuse services**
- **Provide further training for all staff within our drug and alcohol treatment services to highlight the importance of stopping smoking alongside treatment for other dependencies, and dispel myths around smoking, mental health and stress relief**
- **Provision of a support offer for staff who are regular smokers to drive towards a shift in culture**
- **Collaboration with alcohol and drug services to provide co-located support offers to individuals with multiple addictions**

How will we measure success?

Success will be measured through monitoring of action plan implementation in the Tobacco Free Lancashire and South Cumbria group and through improvements in the following indicators:

- Quits in individuals receiving support for other addictions
- Referrals into services for individuals receiving support for other addictions

Priority 3: Making Smoke Free the new normal

Smoking and the environment

Smoking not only impacts our population negatively, but also has negative effects on our environment. Cigarette butts make up 66% of all litter items in the UK and the majority of cigarette filters are made of non-biodegradable material that ends up sitting in our landfill sites.

In Lancashire and South Cumbria approximately 1.8 million cigarettes are consumed each day, with over 1.5 million estimated to be filtered cigarettes. This results in approximately 41 tonnes of street litter from cigarettes alone each year [4].

Smokefree places

A key part of become smokefree is to denormalize smoking and create more smokefree spaces. Smoke from tobacco does not only cause harm to the smoker. Second hand smoke (SHS) comprised "mainstream smoke" which is exhaled by the smoker, and also "sidestream smoke" from the lit end of the cigarette. There is no safe level of exposure to second hand smoke and inhalation by those around individuals who smoke increases the risk of a number of diseases commonly experienced by smokers, including lung cancer, heart disease, stroke and COPD[19].

Second hand smoke is especially dangerous in children and babies. Exposure increases the risk of sudden infant death syndrome (cot death), asthma, glule ear and respiratory problems in later life such as emphysema[20]. It is therefore extremely important to minimise exposure to cigarette smoke as much as possible.

The biggest step forward in the UK to reduce the impact of second hand smoke on our population came in 2007 when the smoking ban in public and work spaces was implemented following the Health Act 2006 [21]. This made smoking illegal in enclosed public spaces such as restaurants and bars, and workplaces such as offices. This law was extended in 2015 to also include a ban on smoking in cars where children under the age of 18 are present. This legislation has been imperative in reducing exposure to second hand smoke, especially in children and young people. Media campaigns around the benefits of smokefree homes have also meant that far fewer children are now exposed to second hand smoke at home. In ASH's Youth Smokefree 2019 survey, 90% of young people aged 11-18 across the UK said that people are never allowed to smoke inside their house, 7% lived in houses where people can smoke, and 3% said that they didn't know.

However, there is still room for further progress. Smoking is still common in outdoor public spaces and can expose nearby individuals to similar levels of second hand smoke as indoor settings[22]. This can be combatted by the creation of Smokefree places, where individuals are asked to refrain from smoking.

This is beneficial in helping us move towards a Smokefree generation in a number of ways:

- Reducing exposure to dangerous second hand smoke
- Denormalising smoking to younger generations by reducing the visibility of smoking
- Supporting those trying to quit smoking by reducing their exposure to others who are smoking
- Helping to reduce cigarette litter and waste

Ambitions:

- **We will ensure that all health and care settings are smokefree**
- **We will reduce the prevalence of smoking within family homes**
- **We will work with partners to develop and implement smokefree parks and public places in Lancashire and South Cumbria**
- **We will support partners to ensure compliance with smokefree policies**
- **We will encourage businesses to develop smokefree policies and support staff to stop smoking**
- **We will reduce the impact of cigarette litter on our environment**

Recommendations for action:

- **All Local Authorities and NHS trusts should be signed up to the latest smokefree pledge**
- **NHS Trusts should monitor and review implementation of their smokefree policies regularly in collaboration with frontline staff and treating tobacco dependence services**
- **Development of co-ordinated action is needed on the development and implementation of outdoor smokefree places such as parks, children's play areas and other services across Lancashire and South Cumbria**
- **Joint resources need to be developed to support businesses and organisations to implement smokefree policies and support staff to stop smoking**
- **Campaigns should be developed to include focussed messaging on the importance of smoke free homes and the dangers of second hand smoke**
- **We need to ensure that all Social Housing providers in Lancashire and South Cumbria work towards the ambition to have their homes smokefree**
- **Trading Standards and the Police should be supported to enforce smokefree legislation; particularly smoking in cars and littering of tobacco and e-cigarettes**
- **Management of tobacco products and e-cigarettes should be incorporated into local authority strategies around the environment and sustainability**

How will we measure success?

Success will be measured through monitoring of action plan implementation in the Tobacco Free Lancashire and South Cumbria group

Smoking in Children and Young People

Smoking often begins at a young age with around two thirds of our current adult smokers report that they took up smoking before the age of 18 [23]. If we are to become a smokefree society, a key part in this is preventing the uptake of smoking in children and young people.

The younger an individual starts smoking, the greater the risk to their health. Starting smoking young is associated with higher levels of dependency and a lower chance of successfully quitting[24]. Moreover, smoking can stunt the development of children's respiratory systems, making them more susceptible to COPD in later life and also putting them at greater risk of coronary heart disease and lung cancer [25].

The latest data from the 2021 smoking, drinking and drug use survey shows that across England, there has been a decrease in the prevalence of smoking cigarettes in young people aged 11-15 with 12% of pupils having ever smoked (16% in 2018), 3% being current smokers (5% in 2018), and 1% regular smokers (2% in 2018).

This decreasing trend is positive, but more work is needed to reduce these figures further. To do this it is important to understand why children and young people smoke. Parental smoking is a key influencing factor, further strengthening the need to support adult smokers to quit the habit. Peer pressure, stress and the media also contribute to this picture.

Ambitions:

- **We will reduce the uptake of smoking in children and young people**
- **We will reduce underage sales of tobacco and nicotine products to children and young people**
- **We will provide support to children and young people who smoke to stop smoking**
- **We will reduce exposure to second hand smoke for children and young people**
- **We will reduce the culture of smoking across our footprint with further development of smokefree places**

Recommendations for Action:

- **All schools and colleges should have smokefree policies in place and be supported to design and implement these**
- **Resources for delivery of education around smoking, e-cigarettes and stopping smoking should be developed collaboratively across Lancashire and South Cumbria to deliver a consistent message**
- **Children, young people, schools and youth organisations should be engaged in the development of resources to ensure accessibility and relevance of accurate, evidenced based materials**
- **Insight work should be undertaken with schools, children and young people to understand and address reasons why they choose to start smoking; this may include discussion on whether e-cigarettes are a gateway to smoking**
- **Community specialist treating tobacco dependence services should be accessible and appropriate to children and young people who wish to stop smoking (and/or vaping)**
- **Trading standards should receive further investment to increase their ability to tackle underage sales of tobacco, e-cigarettes and nicotine product sales; including illicit products**

How will we measure success?

Success will be measured through monitoring of action plan implementation in the Tobacco Free Lancashire and South Cumbria group and through improvements in the following indicators:

- Smoking prevalence in children and young people
- Trading standards intelligence on illicit and underage sales

Priority 4: Lancashire and South Cumbria - A United Voice against tobacco harm

Evidence shows that media and campaigns can be an effective way to influence tobacco use behaviours in both young and adult audiences [26]. However, the prominence of campaigns around smoking and tobacco use has decreased over the past decade both locally in Lancashire and South Cumbria, and nationally.

Digital and social media have huge potential to influence our population, especially in children and young people. Therefore it is important that these are utilised to communicate unified messages around smoking and tobacco across Lancashire and South Cumbria.

It is also important that Lancashire and South Cumbria's voice is heard at a national level. There are some important actions around tobacco that we do not have the power to implement at local levels. For example, as recommended in the Khan Review, we feel that gradually increasing the age of sale of tobacco products, increasing duties on tobacco with a "polluter pays" approach, and increased funding for preventative services and trading standards are key components needed to help us reach the 2030 Smokefree ambition. Where we cannot implement measures locally, we as Lancashire and South Cumbria will use our voice, expertise and local intelligence to lobby national government and campaign for measures that will benefit our population.

Ambitions:

- **We will work together to raise the prominence of stop smoking and smokefree messaging across the footprint with joint media campaigns**
- **We will work with key partners in Local Authority (including Trading Standards and Environmental Health), NHS Trusts, schools, businesses and the voluntary, community, faith sector to ensure prominence of action and messaging around Smokefree**
- **We will use our voice as a Lancashire and Cumbria system to lobby government around national policy and legislation changes needed to help us move towards our smokefree goals**

Recommendations for action:

- **Launching of a united campaign across Lancashire and Cumbria ICS to highlight the dangers of smoking, engage vulnerable and excluded groups and signpost to specialist stop smoking support**
- **All ICS organisations should work towards a shared smokefree policy to ensure consistency in patient experience across the region**
- **Increase the prominence of stop smoking messages across the ICS using both physical and digital media**
- **Lancashire and South Cumbria should use its combined voice as a system to lobby national government on legislation and policy that we are not in a position to change at regional and sub-regional levels. This should include:**
    - **Increased national investment in specialist treating tobacco dependence services in order to allow high quality, effective support to smokers to help them quit**

- **Substantial increases to cost of tobacco duties across all tobacco products**
- **Increasing the age of sale for tobacco and nicotine containing products**
- **Introduction of tobacco licencing for retailers**
- **Increasing ring-fenced funding for Trading Standards to ensure additional capacity and resource to tackle illicit tobacco, e-cigarettes and smokeless tobacco products, and to tackle underage sales of products**

How will we measure success?

Success will be measured through monitoring of action plan implementation in the Tobacco Free Lancashire and South Cumbria group.

Vapes and vaping

Vapes, also known as e-cigarettes or electronic nicotine delivery systems (ENDS), are battery powered devices that deliver nicotine by heating a liquid solution containing nicotine, flavourings and other additives into a vapour. These devices have become increasingly popular across the UK in the last decade, with prevalence of vaping continuing to increase. Vaping prevalence in England in 2021 was between 6.9% and 7.1%, depending on the survey, which equates to between 3.1 and 3.2 million adults who vape.

Many people now use vapes as a quit aid when stopping smoking. In treating tobacco dependence services across England in 2020 to 2021, quit attempts involving a vaping product were associated with the highest success rates (64.9% compared with 58.6% for attempts not involving a vaping product).

However, there are concerns around vaping. Prevalence of vaping is also increasing in children and young people with national data estimating that around 8.6% of children and young people aged 11 to 18 are vaping regularly or occasionally, more than doubling estimates from 2021. Local intelligence tells us that in reality vaping prevalence in young people may be even higher. In Blackpool, the 2022 SHEU survey found that 17% of children in years 8 and 10 used vapes regularly (at least once per week).

Moreover, single-use or "disposable vapes", which low cost vaping devices that are pre-filled with a vaping liquid and contain a single use lithium battery are also increasing in popularity. These devices cannot be recharged or refilled, therefore once used they are often thrown away. In adults who vape, around 15.2% use single-use devices, compared to 2.2% in 2021. In children and young people this increase is even more marked with 52.8% of under 18s who vape using single-use vapes compared to 7.8% in 2021. Concerns are held regarding both the environmental impact of these products and their accessibility to children and young people.

Balancing the potential benefits that vapes can bring in reducing smoking related harm, whilst also managing concerns around wider use of vapes is a highly complex and contentious issue. It was clear when developing this strategy that work also needed to be done to develop consensus in Lancashire and Cumbria on vaping. To provide clarity on our position in Lancashire and South Cumbria, a position statement on nicotine vaping has been developed. This can be found in **Appendix 1.**

Ambitions:

- **We will continue to use research evidence alongside local and national intelligence to inform a united stance on the place of vaping and e-cigarettes**
- **We will support where appropriate, the use of vapes as a quit aid to stop smoking**
- **We will work together to reduce the uptake of vaping in children and young people**
- **We will work to minimise the negative impacts of vapes on our environment**

Recommendations for action:

- **To continue to monitor and review the evidence around vaping, using local and national intelligence to inform our position on vapes.**
- **Where services choose to commission vapes as part of smoking cessation programs they should:**

    - **Encourage vape use as a quit aid rather than as a long term replacement for cigarettes.**
    - **Ensure that quitters are provided with a supporting regime to gradually reduce and ultimately stop vape use.**
    - **Ensure that advice is given on how to effectively use vapes to satisfy nicotine cravings.**
    - **Ensure that suppliers of vapes do not have links with the tobacco industry in line with Article 5.3 of the WHO Framework Convention on Tobacco Control. This can be ensured using the OHID national vaping portal.**
    - **Avoid using suppliers who market products to children and young people or encourage long-term vape use in their marketing.**
    - **Use plain packaging where possible.**
- **Close working with trading standards should be ensured to tackle underage sales and illicit products**
- **We advocate for further regulation around marketing of vapes and more severe sanctions for establishments who do not adhere to regulations, in order to better protect our children and young people.**
- **Schools and colleges should be both smokefree and vaping-free places. Schools and colleges should be supported to manage vaping, including disposal of confiscated devices, and ensure that policy is in place regarding how to manage vaping.**
- **Schools and colleges should be supported to provide further education around vaping.**
- **Further work is needed to understand and address the drivers of vaping behaviours in children and young people.**
- **Services commissioning vapes for use as a quit aid should choose reusable devices where possible. Where single-use vapes are used as a quit aid by services, it should be ensured that facilities are in place to appropriately recycle devices.**
- **Management of e-cigarette litter should be incorporated into local authority strategies around the environment and sustainability**

Measures:

Success will be measured through monitoring of action plan implementation in the Tobacco Free Lancashire and South Cumbria group and through improvements in the following indicators:

- Reduction in vaping prevalence in children and young people
- Increasing numbers of vape supported quits in adults

Governance and Accountability

Tobacco Free Lancashire and South Cumbria is a multi-agency group which has individual lines of reporting to each of the partner organisations. Overall accountability for the work of the group is however to each of the Health and Wellbeing Boards (HWBs); Lancashire, Blackpool, Blackburn with Darwen, Westmorland and Furness, and to Lancashire and South Cumbria Integrated Care Board (ICB).

Links are made with national and regional expert advisors and good governance dictates that latest evidence, policy and practice are regularly reviewed to ensure that work continues to be relevant and current in the context of local needs and circumstances.

How will this strategy be delivered?

Implementation of this strategy includes a variety of actions at both individual local authority and integrated care system levels. A system wide action plan will be monitored and reviewed through the Tobacco Free Lancashire and South Cumbria multi-agency group and this should be supplemented by local tobacco action plans for each local authority area.

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Appendices

Appendix 1

FINAL COPY OF POSITION STATEMENT

Appendix 5b: Equality Analysis (EA) Record Form
Formerly Equality Impact Assessment

Revised February 2015

Department: Public Health

Team or Service Area Leading Assessment: **Public Health**

Title of Policy/ Service or Function: **Tobacco Free Lancashire and South Cumbria Strategy 2023-2028**

Proposals to introduce/ alter/ delete policy, service, expenditure etc:

Date of proposals: 13/06/ 2023 Committee/Team: **Public Health**

Lead Officer: **Sarah Kipps/Liz Petch**

STEP 1 - IDENTIFYING THE PURPOSE OR AIMS

1. What type of policy, service or function is this?

Existing ☐ New/ proposed ☐ Changing/ updated ☒

2. What is the aim and purpose of the policy, service or function?

To reduce tobacco related harm across Lancashire and South Cumbria and work towards the Smokefree 2030 agenda.

3. Please outline any proposals being considered.

Tobacco Free Lancashire and South Cumbria is a multi-agency alliance working together towards the smokefree agenda across Lancashire and South Cumbria and includes representatives from local authority public health, NHS, providers, Office for Health Improvement and Disparities (OHID) and Trading Standards. This group was previously known as Tobacco Free Lancashire however since the implementation of Integrated Care Systems (ICSs), the footprint of the group has been expanded to match that of the ICS.

The purpose of this strategy is to provide clear direction for commissioners, strategic leads and policymakers across Lancashire and South Cumbria around how we can together make Smokefree a reality for Lancashire and South Cumbria and reduce the harm to our population from smoking and tobacco.

The strategy has been built around 4 key priorities for tobacco control:

1. Working together as a system for a smoke free tomorrow
2. Action to address health inequalities
3. Making Smoke Free the new normal
4. Lancashire and South Cumbria - A United Voice against tobacco harm

An additional separate priority was also identified around vaping and the need for consensus and clarity on the Lancashire and South Cumbria position on nicotine vapes.

4. What outcomes do we want to achieve?

Reduce the prevalence of smoking in every neighbourhood to below 5% by 2030. Improve equity in stop smoking service provision

5. Who is the policy, service or function intended to help/ benefit?

All users of tobacco across Lancashire and South Cumbria, families of smokers, children and young people

6. Who are the main stakeholders/ customers/ communities of interest?

The strategy is universal aiming to benefit all in the population by reducing tobacco related harm. Key groups requiring support are:

- Smokers,
- Families of smokers
- Children and young people
- Pregnant smokers,
- Smokers with mental illness,
- Users of niche tobacco products
- Smokers with multiple addictions
- Smokers in routine and manual occupation

Stakeholder organisations include:

- Blackpool Council
- Lancashire and South Cumbria ICB
- Lancashire and South Cumbria NHS Foundation Trust
- Acute NHS trusts
- Lancashire County Council
- Blackburn with Darwen Council
- Westmorland and Furness Council
- Addiction services

- Primary care
- Community, acute and maternity stop smoking services
- Trading standards
- Schools

7. Does the policy, service or function have any existing aims in relation to Equality/ Diversity or community cohesion?

Previous strategy had focus on managing inequities in smoking in pregnancy, mental health and smoking and long term conditions. This is built on in the new strategy with additional foci on niche tobacco, multiple addictions and routine and manual occupations.

STEP 2 - CONSIDERING EXISTING INFORMATION AND WHAT THIS TELLS YOU

8. Please summarise the main data/ research and performance management information in the box below.

Data/ information

Key resources include:

- Smoking prevalence data – Local Tobacco Control Profiles https://fingertips.phe.org.uk/profile/tobacco-control/data#page/0
- NHS Digital. Statistics on Smoking, England 2020. Statistics on Smoking, England 2020 - NDRS (digital.nhs.uk)
- Action on Smoking and Health (ASH), 2022. ASH Ready Reckoner. https://ash.org.uk/resources/view/ash-ready-reckoner
- Stakeholder engagement

Research or comparative information

The strategy is informed by evidence based practice, guidelines and policy, most notably:

- Department of Health and Social Care, 2017. Towards a Smokefree Generation, A Tobacco Control Plan for England
- Khan, J, 2022. Making smoking obsolete.
- National Institute for Helath and Care Excellence, 2021.Tobacco: preventing

uptake, promoting quitting and treating dependence.

- Public Health England, 2017. Models of delivery for treating tobacco dependence services: options and evidence

Key findings of consultation and feedback

Stakeholder engagement gave rise to the below themes:

1. Communication/ campaign as one voice
2. Voice as a region to lobby National Government – Khan Report
3. Targeted approach for health inequality e.g pregnancy, mental health
4. Agreed shared vision on e-cigarettes and vaping

Enablers
Shared Resources/ shift resources*
Shared data – systems talk *

This was used to develop and build strategy priorities collaboratively with multiple oppurtunities for input by tobacco leads and commissioners.

9. What are the impacts or effects for Key Protected Characteristics?

Age

We do not anticipate that this strategy will adversely impact individuals according to their age.

The strategy incorporates elements to ensure accessibility of services to individuals of all ages.
Children and young people are an important age group to incorporate as it is in teenage years that most individuals begin smoking and therefore the strategy includes ambitions and recommendations around educating children and young people, ensuring support for children and young people and denormalising smoking and tobacco use to reduce the uptake of tobacco.

Disability

We do not anticipate that this strategy will adversely impact individuals according

to whether or not they have a disability.

The implementation of secondary care stop smoking services will ensure that stop smoking support is avaialbe at all touch points for individuals accessing secondary care and accessibility of services is considered throughout. Special consideration is given to groups with mental health conditions as there are considerable inequities in smoking prevalence and tobacco related harm for these groups. Support should be specialised to meet the additional needs of this group and a section of the strategy focusses on addressing this,

Gender Reassignment

We do not anticipate that this strategy will adversely impact individuals according to their gender reassignment status.

Marriage and Civil partnership

We do not anticipate that this strategy will adversely impact individuals according to their marriage or civil partnership status.

Living in a household where others smoke not only increases the likelihood that family members may take up smoking but risks are also accrued from second hand smoke. Smokefree environments is a key component of the strategy, as is ensuring support for the supporting others of pregnant women.

Pregnancy and Maternity

We do not anticipate that this strategy will adversely impact individuals according to their pregnancy/maternity status.

Smoking in pregnancy is extremely important to tackle, and smoking in pregnancy is especially prevalent in Blackpool's population. A core part of the strategy discusses support of and services for pregnant women to stop smoking and for their families to stop smoking. The speicialist maternity stop smoking service is also already operating for Blackpool.

Race

We do not anticipate that this strategy will adversely impact individuals according to their ethnicity.

It is noted that certain methods of consuming tobacco are more prevalent in minority ethnic groups such as chewing tobacco, tobacco pouches and shisha. The strategy has a a dedicated section to address this.
Religion and Belief
We do not anticipate that this strategy will adversely impact individuals according to their religion and/or beliefs. We recognise that religious belief can impact decisions made around smoking and tobacco and the importance of appropriate support being available for indivudal of all backgrounds. Services are available to support those with all religious beliefs and strategy considers use of community and faith leaders in signposting support to stop smoking.
Sex
We do not anticipate that this strategy will adversely impact individuals according to their sex.
Sexual Orientation
We do not anticipate that this strategy will adversely impact individuals according to their sexual orientation.

10. What do you know about how the proposals could affect community cohesion?

By ensuring equitable and accessible services across the patch we hope to increase community cohesion. Increased prominence of campaigns and education can help promote a joint vision with our communities towards the Smokefree agenda.

11. What do you know about how the proposals could impact on levels of socio –economic inequality, in particular Poverty?

Many of the local authorities with the highest proportions of smokers rank among the most deprived in England. In 2016, people living in the most deprived areas of England were four times more likely to smoke than those living in the least deprived areas. This is reflected in the outcomes for diseases such as lung cancer and chronic obstructive pulmonary disease (COPD) where smoking is the biggest risk factor. Deaths from respiratory diseases are more than twice as common in the most deprived places in England as in the least deprived places. In addition to this, smoking also accrues wider costs due to its impact on productivity, healthcare, social care and costs of managing smoking related fires. .

STEP 3 - ANALYSISING THE IMPACT

12. Is there any evidence of higher or lower take-up by any group or community, and if so, how is this explained?

Epidemiology of smoking, inequities and strategy to combat inequities is considered for each of the following groups in which smoking prevalence is higher: Routine and manual occupations Smoking in pregnancy Smoking in those with mental health conditions Smoking in those with multiple addicitions Shisha and smokeless tobacco

13. Do any rules or requirements prevent any groups or communities from using or accessing the service?

There are inequities in the service provision between different local authority areas in the ICS. This strategy works towards addressing these with more equitable services and sharing of resources.

14. Does the way a service is delivered/ or the policy create any additional barriers for any groups of disabled people?

No specific barriers have been identified.

15. Are any of these limitations or differences “substantial” and likely to amount to unlawful discrimination?

Yes ☐ No x

If yes, please explain (referring to relevant legislation) in the box below

NA

16. If No, do they amount to a differential impact, which should be addressed?

Yes ☐ No x

If yes, please give details below.

STEP 4 - DEALING WITH ADVERSE OR UNLAWFUL IMPACT

17. What can be done to improve the policy, service, function or any proposals in order to reduce or remove any adverse impact or effects identified?

It is not felt that the strategy will adversely impact any particular groups.

A key theme within the Tobacco Free Lancashire and South Cumbria strategy is around reducing pre-existing inequities in tobacco related harm. This can be actioned through implementation of strategy recommendations

18. What would be needed to be able to do this? Are the resources likely to be available?

To achieve the ambitions in this strategy, a systems approach across the ICS should be used with sharing and pooling of resource to provide an equitable service for all. To achieve this, the ICB have been engaged throughout development and will also be signing off on the strategy

19. What other support or changes would be necessary to carry out these actions?

Collobaration across local authority areas, servies and stakeholders through the TFLSC group with each area developing their own action plan for strategy implementation.

STEP 5 - CONSULTING THOSE AFFECTED FOR THEIR VIEWS

20. What feedback or responses have you received to the findings and possible courses of action? Please give details below.

Stakeholder engagement carried out throughout development process with feedback incorporated. There was key ffedback noted around pre-existing inequities for those with multiple addictions and those using niche tobacco and therefore specific sections to address these issues were developed.

21. If you have not been able to carry out any consultation, please indicate below how you intend to test out your findings and recommended actions.

NA

STEP 6 - ACTION PLANNING

Please outline your proposed action plan below.

Issues/ adverse impact identified	Proposed action/ objectives to deal with adverse impact	Targets/Measure	Timeframe	Responsibility	Indicate whether agreed

STEP 7 - ARRANGEMENTS FOR MONITORING AND REVIEW

Please outline your arrangements for future monitoring and review below.

Agreed action	Monitoring arrangements	Timeframe	Responsibility	Added to Service Plan etc.

Date completed: 13/06/2023 Signed: 

Name: Sarah Kipps Position: Public health registrar

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Report to:	**HEALTH AND WELLBEING BOARD**
Relevant Officer:	Stephen Boydell, Principal Epidemiologist, Public Health
Relevant Cabinet Member:	Councillor Jo Farrell, Cabinet Member for Adult Social Care, and Community Health and Wellbeing
Date of Meeting:	27 June 2023

JOINT STRATEGIC NEEDS ASSESSMENT WORKING GROUP

1.0 Purpose of the report:

1.1 To consider the re-establishment of a Joint Strategic Needs Assessment (JSNA) Working Group.

2.0 Recommendation(s):

2.1 To re-establish a Joint Strategic Needs Assessment Working Group that meets three times a year, chaired by Blackpool's Director of Public Health with a membership as outlined in Appendix 6a. The group would be representative of the organisations that contribute to the Health and Wellbeing Board and report progress to the Health and Wellbeing Board.

3.0 Reasons for recommendation(s):

3.1 A Joint Strategic Needs Assessment (JSNA) is an essential tool for identifying and addressing the health and wellbeing needs of the local population. It is a responsibility of the Health and Wellbeing Board and its member organisations.

To support the production of an effective Joint Strategic Needs Assessment, a working group should be established to oversee current Joint Strategic Needs Assessment projects, manage the future work plan, and identify colleagues who can contribute to different topics within the Joint Strategic Needs Assessment.

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 The latest statutory guidance regarding JSNA can be found here:
Statutory guidance on joint strategic needs assessments and joint health and wellbeing strategies (publishing.service.gov.uk)
The document is also attached at Appendix 6b.

This explains who is responsible for undertaking a Joint Strategic Needs Assessment, what a Joint Strategic Needs Assessment is and its purpose and how it should inform the Local Health and Wellbeing Strategy and local decision making.

6.2 A proposal is included as an appendix that sets out in more detail the purpose of the group, the terms of reference and potential group membership.

6.3 Does the information submitted include any exempt information? No

7.0 List of Appendices:

7.1 Appendix 6a Proposal for the re-establishment of a Joint Strategic Needs Assessment Working Group
Appendix 6b: Statutory Guidance on Joint Strategic Needs Assessment.

8.0 Financial considerations:

8.1 No direct implication. Staff time to contribute towards production of JSNA projects.

9.0 Legal considerations:

9.1 None.

10.0 Risk management considerations:

10.1 Producing an up to date JSNA is a statutory duty of the Health and Wellbeing Board.

11.0 Equalities considerations:

11.1 The establishment of the group does not have an equalities considerations in itself, however the Joint Strategic Needs Assessment is an important tool in understanding health inequalities and how they impact different communities.

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 Statutory guidance on joint strategic needs assessments and joint health and wellbeing strategies (publishing.service.gov.uk)

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Appendix 6a

Proposal for the Re-establishment of a Joint Strategic Needs Assessment Working Group

Joint Strategic Needs Assessment (JSNA) is an essential tool for identifying and addressing the health and wellbeing needs of the local population. To support the production of an effective JSNA, a working group should be established to oversee current JSNA projects, manage the future work plan, and identify colleagues who can contribute to different topics within the JSNA. This proposal outlines the terms of reference and potential members of this working group.

Terms of Reference: The JSNA working group will be responsible for overseeing the production of the JSNA and ensuring it identifies the health and wellbeing priorities of the population of Blackpool. The working group will:

- Oversee the progress and quality of JSNA projects and ensure they are aligned with local and national policies and strategies
- Manage the future work plan for the JSNA, including identifying topics that need to be covered and the timelines for completion
- Allocate resources and personnel. In particular by identifying colleagues who can contribute to the writing of different topics within the JSNA, ensuring a diversity of perspectives and expertise
- Review and provide feedback on the JSNA draft documents, ensuring accuracy and quality
- Foster engagement and collaboration between the various stakeholders involved in the JSNA process
- Ensure the JSNA is inclusive, equitable, and reflective of the diversity of the local population
- Oversight of any Key Performance Indicators to track the progress against ambitions stated in the Blackpool Joint Local Health and Wellbeing Strategy

The JSNA Working Group should consist of members with diverse expertise and perspectives to ensure comprehensive understanding and assessment of health and wellbeing needs. Suggested job roles for members of the working group include:

- Chair (**Director of Public Health – Arif Rajpura**) - responsible for leading the working group and ensuring it operates effectively
- Consultant in Public Health (**Liz Petch**) - responsible for advising on the health and wellbeing needs of the local population
- Public Health Intelligence Analysts (**Stephen Boydell, Christine Graham, Donna Gadsby**) – responsible for project managing the JSNA, some content creation, advising on the needs assessment process, analysis, oversight of the JSNA website
- Adult Services Representative (**Karen Smith, Kate Aldridge**)- responsible for advising on the social care needs of the local population
- Children's Services Representative (**Joanne Stewart???**) - responsible for advising on the needs of children
- NHS Business Intelligence Lead (**???**) – responsible for analysis of NHS generated data to inform the JSNA
- Local Authority Business Intelligence Manager (**Sara Coombs**) – responsible for analysis of local authority generated data to inform the JSNA

- NHS Place Based Partnership Representative (**Karen Smith, Karen Tordoff**) - responsible for advising on the healthcare needs of the local population
- NHS Population Health Management Representative (**Paul Hegarty, Pete Smith**) – Responsible for linking NHS generated population intelligence and programmes with the JSNA
- Blackpool Health Determinants Research Collaboration (HDRC) Representative (**Reuban Larbi)**
- HealthWatch Representative (**Beth Martin**) – To link in public and patient engagement

Some Roles will be invited to the group as topic areas are covered within the JSNA or as required. For example:

- Education Representative
- Voluntary Sector Representative
- Housing Representative
- Communications Officer

Meetings: The JSNA working group will meet every four months, or more frequently if required. Meetings will be chaired by the Director of Public Health, with agendas and minutes circulated in advance. The working group will report regularly to the Health and Wellbeing Board on progress and recommendations.

The establishment of a JSNA working group will ensure that the JSNA process is managed effectively. The working group will provide a valuable source of oversight, support, and guidance to the JSNA process, ensuring that it reflects the priorities and concerns of Health and Wellbeing Board members.

Note on this guidance: 24 August 2022

Following the implementation of the Health and Care Act 2022 on 1 July 2022, clinical commissioning groups (CCGs) have been abolished and their functions have been assumed by integrated care boards (ICBs).

The Health and Care Act 2022 also amends section 116A of the Local Government and Public Involvement in Health Act 2007, renames ‘joint health and wellbeing strategies’ to ‘joint local health and wellbeing strategies’ and replaces references to ‘clinical commissioning groups’ with ‘integrated care boards’.

Health and wellbeing boards continue to be responsible for the development of joint strategic needs assessments and joint local health and wellbeing strategies. However, they must now have regard to the integrated care strategy when preparing their joint local health and wellbeing strategies in addition to having regard to the NHS Mandate and this guidance, as previously.

These changes will be made to the guidance at its next update.

Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies

DH INFORMATION READER BOX		
Policy	Clinical	Estates
HR / Workforce	Commissioner Development	IM & T
Management	Provider Development	Finance
Planning / Performance	Improvement and Efficency	**Social Care / Partnership Working**

Document Purpose	Best Practice Guidance
Gateway Reference	18840
Title	Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies
Author	Department of Health
Publication Date	**26 March 2013**
Target Audience	NHS Trust CEs Foundation Trust CEs , Directors of PH, Local Authority CEs, Directors of Adult SSs, Allied Health Professionals, GPs, Communications Leads, Directors of Children's SSs, Healthwatch England, Public Health England, LINks, CCG pathfinders shadowHWBs, voluntary and community sector orgenisations
Circulation List	
Description	The purpose of this publication is intended to support health and wellbeing boards and their partners in understanding the duties and powers in reation to Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs).
Cross Ref	The Health and Social Care Act 2012, Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013. Joint Strategic Needs Assessments and joint health and wellbeing
Superseded Docs	N/A
Action Required	N/A
Timing	**N/A**
Contact Details	Freya Lock Department of Health People, Communities and Local Government Richmond House Room 330 79 Whitehall London SW1A 2NS
For Recipient's Use	

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1. Purpose

The Health and Social Care Act 2012[1] ('the Act') amends the Local Government and Public Involvement in Health Act 2007 ('the 2007 Act') to introduce duties and powers for health and wellbeing boards in relation to Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs).

This statutory guidance explains the duties and powers relating to JSNAs and JHWSs. This guidance does not cover the wider membership of health and wellbeing boards, or what services should be commissioned in response to local JSNA findings and JHWS priorities – these decisions need to be made locally, depending on circumstances, and subject to duties to have regard to the relevant JSNAs and JHWSs. Further supporting materials, including advice on good practice will be published alongside this statutory guidance.

2. Context

In the Act, the Government has set out a new vision for the leadership and delivery of public services, where decisions about services should be made as locally as possible, involving people who use them and the wider local community. The Act supports the principle of local clinical leadership and democratically elected leaders working together to deliver the best health and care services based on the best evidence of local needs. JSNAs and JHWSs are an important locally owned process, through which to achieve this. As such, and with duties that fall upon local parts of the system, each health and wellbeing board is likely approach them according to their own local circumstances. It would not therefore be appropriate for central Government to be prescriptive about the process or to monitor the outputs.

The purpose of JSNAs and JHWSs is to improve the health and wellbeing of the local community and reduce inequalities for all ages. They are not an end in themselves, but a continuous process of strategic assessment and planning – the core aim is to develop local evidence-based priorities for commissioning which will improve the public's health and reduce inequalities. Their outputs, in the form of evidence and the analysis of needs, and agreed priorities, will be used to help to determine what actions local authorities, the local NHS and other partners need to take to meet health and social care needs, and to address the wider determinants that impact on health and wellbeing[2].

In preparing JSNAs and JHWSs, health and wellbeing boards must have regard to guidance issued by the Secretary of State[3] (this guidance, and any future revisions issued), and as such boards have to be able to justify departing from it.

[1] The relevant parts of which are expected to come into force on 1 April 2013.

[2] More information can be found in *Fair Society, Healthy Lives (the Marmot Review)*, 2010

[3] The 2007 Act – section 116 (as amended by the Act – section 192) and section 116A (as inserted by the Act – section 193).

3. Duties and powers under the 2007 Act (as amended by the Act)[4]

3.1 Who is responsible for JSNAs and JHWSs?

Local authorities and clinical commissioning groups (CCGs) have equal and joint duties to prepare JSNAs and JHWSs, through the health and wellbeing board[5]. The responsibility falls on the health and wellbeing board as a whole and so success will depend upon all members[6] working together throughout the process. Success will not be achieved if a few members of the board assume ownership, or conversely do not bring their area of expertise and knowledge to the process. As the duties apply across the health and wellbeing board as a whole, boards will need to discuss and agree their own arrangements for signing off the process and outputs. What is important is that the duties are discharged by the board as a whole.

Two or more health and wellbeing boards could choose to work together to produce JSNAs and JHWSs, covering their combined geographical area[7]. Some health and wellbeing boards may find it helpful to collaborate with neighbouring areas where they share common problems as this can prove to be more cost effective than working in isolation.

Local authorities and health and wellbeing boards can decide to include additional members on the board beyond the core members[8]. Additional members, such as service providers (NHS, private or voluntary and community sector), health and care professionals, representatives of criminal justice agencies, fire and rescue services, local voluntary and community sector organisations, universities, or representatives of military populations, can bring expert knowledge of the local community to enhance JSNAs and JHWSs. Membership of the board is not the only way to be involved in or influence JSNAs and JHWSs – boards will need to work with a wide range of local partners and the community beyond the board's membership. Working with local partners will support boards not only to undertake a thorough and broad assessment of local needs by using evidence and expertise these partners can provide; but it

[4] The duties imposed by, and the powers conferred by the Act, the 2007 Act (as amended by the Act), and the NHS Act 2006 (as amended by the Act) relating to the preparation of JSNAs and JHWSs are summarised and referenced throughout. Where 'must' is used, this indicates something required by one or other of the Acts. Where 'can' is used, this indicates a power in one or other of the Acts. Where 'could' is used, this indicates an example of how that power could potentially be used. Where 'should' is used it indicates something that is not required by the Acts, but it is recommended in order to achieve the spirit of the Acts or in accordance with sector-led best practice, and to which there is a statutory duty to have regard.

[5] The 2007 Act – section 116 (as amended by the Act – section 192 require a "responsible local authority" and each of its partner CCGs to prepare JSNAs and JHWSs; and section 116A (as inserted by the Act – section 193); and the Act – section 196 provides that these functions are to be exercised by the health and wellbeing board established by the local authority. Section 103 of the 2007 Act provides that each of the following is a "responsible local authority": a county council in England, a district council in England other than a council for a district in a county for which there is a county council; a London borough council, the Council of the Isles of Scilly and the Common Council of the City of London in its capacity as a local authority.

[6] The Act – section 194: each "responsible local authority" in England (see footnote 4) must set up a health and wellbeing board, with a core membership of: a) at least one elected representative – a councillor(s) nominated by the leader or the mayor of the local authority (and / or the leader or mayor themselves), or in some cases by the local authority; b) a representative of each clinical commissioning group (CCG) whose area is within or partly within, or coinciding with the local authority area – CCGs will be required to appoint representatives to more than one health and wellbeing board if their area falls within more than one local authority area; c) the directors of public health, adult social services, and children's services; and d) a representative of the local Healthwatch organisation. Other members may be appointed by the local authority or health and wellbeing board.

[7] The Act – section 198(a) allows two or more health and wellbeing boards to make arrangements for any of their functions to be exercisable jointly.

[8] 'Core members' is a reference to the members referred to on the face of the Act (section 194) – see Footnote 5. A local authority or health and wellbeing board can appoint other members to the board – section 194.

will also provide an opportunity to influence the work of these partners to support addressing the identified needs.

Although the NHS Commissioning Board (NHS CB) is not a core statutory member of health and wellbeing boards, prescribed by the Act, it must participate in JSNAs and JHWSs. If the health and wellbeing board agrees, the NHS CB may be represented by someone who is not from the NHS CB; such as from a CCG or a local Commissioning Support Unit (CSU)[9] .

3.2 What are Joint Strategic Needs Assessments (JSNAs)?

JSNAs are assessments of the current and future health and social care needs of the local community. – these are needs that could be met by the local authority, CCGs, or the NHS CB[10]. JSNAs are produced by health and wellbeing boards[11], and are unique to each local area. The policy intention is for health and wellbeing boards to also consider wider factors that impact on their communities' health and wellbeing, and local assets that can help to improve outcomes and reduce inequalities. Local areas are free to undertake JSNAs in a way best suited to their local circumstances – there is no template or format that must be used and no mandatory data set to be included.

A range of quantitative and qualitative evidence should be used in JSNAs. There are a number of data sources and tools that health and wellbeing boards may find useful for obtaining quantitative data[12]. Qualitative information can be gained via a number of avenues, including but not limited to views collected by the local Healthwatch organisation or by local voluntary sector organisations, feedback given to local providers by service users; and views fed in as part of community participation within the JSNA and JHWS process.

JSNAs can also be informed by more detailed local needs assessments such as at a district or ward level; looking at specific groups (such as those likely to have poor health outcomes); or on wider issues that affect health such as employment, crime, community safety, transport, planning or housing. Evidence of service outcomes collected where possible from local commissioners, providers or service users could also inform JSNAs. Boards will need to ensure that staff supporting JSNAs have easy access to the evidence they need to undertake any analysis they needed to support the board's decisions.

Health and wellbeing boards are also required to undertake Pharmaceutical Needs Assessments (PNAs)[13]; and although many may choose to combine the process with JSNAs,

[9] The duty on the NHS CB to appoint a representative to participate in JSNAs and JHWSs is in section 197(1) and (2) of the Act. Section 197(5) provides that the representative may be someone who is not a member or employee of the NHS CB, with the health and wellbeing board's agreement.

[10] The 2007 Act – section 116 (as amended by the Act – section 192). Section 116 requires an assessment of "relevant needs" – a "relevant" need is a) a need capable of being met to a significant extent by the local authority's exercise of functions; and which could also be met or affected, to a significant extent, by the partner CCG or NHS CB's exercise of functions; or b) a need which is capable of being met to a significant extent by the partner CCG or NHS CB's exercise of functions; and which could also be met or affected, to a significant extent by the local authority's exercise of functions.

[11] The duty falls on local authorities and CCGs but must be discharged by health and wellbeing boards (the Act – section 196(1)). Where the guidance refers to something that health and wellbeing boards must do in relation to JSNAs, the source of this is a duty imposed on the local authority and CCG.

[12] Links to existing sources and tools for quantitative data will be available within the suite of resources to support health and wellbeing boards. This will be hosted on the Knowledge Hub.

[13] Section 128A of the NHS Act 2006, as amended by Section 206 of the 2012 Act. DH has laid regulations for undertaking PNAs - please refer to Regulations 3 - 9 and Schedule 1 of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013.

the duties for these are separate, and distinct PNAs need to be produced to inform the NHS CB's decisions on commissioning pharmaceutical services for the area.

Health and wellbeing boards can request relevant information to support JSNAs from organisations represented on the board (core members and others)[14] – and when asked, they have a duty to supply the requested information, if they hold it[15]. Health and wellbeing boards may find it useful to develop a dialogue with their local Healthwatch organisation over time to understand what information it intends to collect. Unless the NHS CB is a board member, it is not subject to the duty to provide evidence when asked. However, as it must base its commissioning plans on JSNAs (and JHWSs) it does have an interest in the process and may wish to co-operate in sharing evidence. Boards can also request evidence they would expect other organisations (such as regulators or other local commissioners) to hold, although again unless they are members of the board, they will not have a duty to comply with the request.

Local authorities will need to interpret and analyse data and information for a number of their functions, including giving public health advice to CCGs. They may choose to use this expertise to support health and wellbeing boards; however, as the primary JSNA (and JHWS) duties sit jointly on local authorities and CCGs, they will want to discuss and agree what resources and expertise they will each provide to support their health and wellbeing board.

Public Health England (PHE) will support local authorities to deliver locally appropriate interventions and services. They will provide data, interpretation and evidence to enable local public health teams to improve the public's health. PHE is also developing clear processes for stakeholders to be able to discuss their knowledge and intelligence support needs[16]. From 1 April 2013, public health professionals in PHE and the wider public health system in local authorities will have access through a single portal[17] to a suite of indicators, analyses and evidence to support decision-making. Through this portal local authorities will continue to be able to access the knowledge and information products currently available from the agencies coming together to form PHE on 1st April 2013, including the Public Health Observatories, Health Protection Agency, National Treatment Agency, Cancer Registries and others. PHE will be a key partner to support public health within local authorities to use these resources to increase capacity to identify local issues and make the best decisions (including prioritising local resources), to reduce inequalities and help improve the health and wellbeing outcomes of the local community, including vulnerable groups.

JSNAs must assess current and future health and social care needs[18] within the health and wellbeing board area and it is important to cover the whole population, and ensure that mental health receives equal priority to physical health. This includes health protection, and upstream prevention of ill health; and it could include looking at the role of personal budgets and universal advice. Therefore health and wellbeing boards will need to consider:

[14] The Act – section 199. Health and wellbeing boards have the power to request information from the local authority, or the CCGs and local Healthwatch organisations represented on the board. They also have the power to request information from members (or those organisations represented by members) beyond the core members. The request must be made in order to enable or assist health and wellbeing boards to perform their functions – in this context, to enable or assist health and wellbeing boards to undertake JSNAs and JHWSs.
[15] Organisations will need to ensure that the supply of this information does not this does not override the common law duty of confidentiality and the requirements of the Data Protection Act 1998.
[16] Information on the process of interacting with local authority stakeholders will be available via the PHE website.
[17] The web-portal will be available via the PHE website.
[18] See Footnote 10 as to the needs that are covered.

- demographics of the area, and needs of people of all ages of the life course including how needs vary for people at different ages;
- how needs may be harder to meet for those in disadvantaged areas or vulnerable groups who experience inequalities, such as people who find it difficult to access services; and those with complex and multiple needs such as looked-after and adopted children, children and young people with special educational needs or disabilities, troubled families, offenders and ex-offenders, victims of violence, carers including young carers, homeless people, Gypsies and Travellers, people with learning disabilities or autism who also have mental health conditions or behaviours viewed as challenging[19];
- wider social, environmental and economic factors that impact on health and wellbeing – such as access to green space, the impact of climate change, air quality, housing, community safety, transport, economic circumstances, employment; and
- what health and social care information the local community needs, including how they access it and what support they may need to understand it.

Health and wellbeing boards may find that there is a lack of evidence about some issues, and some seldom heard and vulnerable groups, which could be indicative of unmet needs and deprivation. Local partners such as voluntary sector organisations or local Healthwatch may be able to help where such evidence is lacking as they are well-placed to collect both quantitative and qualitative evidence and have good specialist knowledge of the community. They can also help boards to directly engage with some of these seldom heard and vulnerable groups. Other public sector organisations in the area can also provide relevant evidence on deprivation which may help boards develop a detailed understanding of deep inequalities in the area, such as the association between health and employment inequalities.

Supporting active communities and encouraging people to improve their health and wellbeing is central to achieving the Government's vision. When undertaking JSNAs, health and wellbeing boards should also consider what assets local communities can offer in terms of skills, experience, expertise and resources[20] that could help local authorities and the NHS to address the identified needs and impact on the wider determinants of health. This could be a range of assets including formal or informal resources, social networks, community cohesion, capacity or skills in organisations or the community; such as the ability of groups to take greater control of their own health or manage long-term conditions. Local partners, especially in the voluntary sector, can help boards understand the strengths and assets within local communities.

3.3 What are Joint Health and Wellbeing Strategies (JHWSs)?

JHWSs are strategies for meeting the needs identified in JSNAs[21]. As with JSNAs, they are produced by health and wellbeing boards[22], are unique to each local area, and there is no

[19] This is not an exhaustive list, but an example of some vulnerable groups and health and wellbeing boards may wish to consider – boards will need to develop their understanding of the vulnerable groups in their area and the issues that affect them.

[20] Strong communities can improve health and wellbeing, and reduce inequalities *(Foot, J., What makes us healthy? The asset-based approach in practice: evidence, action, evaluation, 2012).* There are a number of methods of assessing assets being developed, (Local Area Co-ordination, Connected Care or Asset-Based Community Development) – these examples may be useful to health and wellbeing boards.

[21] The 2007 Act – section 116A (as inserted by the Act – Section 193).

[22] The duty falls on responsible local authorities and partner CCGs but must be discharged by health and wellbeing boards (the Act – section 196(1)). See Footnote 4. Where the guidance refers to something that health and wellbeing boards must do in relation to JHWSs, the source of this is a duty imposed on the local authority and partner CCGs.

mandated standard format. In preparing JHWSs, health and wellbeing boards must have regard to the Secretary of State's mandate[23] to the NHS CB[24] which sets out the Government's priorities for the NHS.

They should explain what priorities the health and wellbeing board has set in order to tackle the needs identified in their JSNAs. Again, it would not be appropriate to specify or dictate issues which should be prioritised. This is not about taking action on everything at once, but about setting a small number of key strategic priorities for action, that will make a real impact on people's lives. JHWSs should translate JSNA findings into clear outcomes the board wants to achieve, which will inform local commissioning – leading to locally led initiatives that meet those outcomes and address the needs.

3.4 Using JSNAs and JHWSs

The importance of JSNAs and JHWSs lies in how they are used locally – as well as identifying the local community's needs, they also provide a significant opportunity to tackle and make a real impact on extreme inequalities experienced by some vulnerable and seldom heard groups, and to integrate local services around their users.

CCGs, the NHS CB, and local authorities' plans for commissioning services will be expected to be informed by relevant JSNAs and JHWSs. Where plans are not in line with JSNAs and JHWS, CCGs, the NHS CB and local authorities must be able to explain why[25]. The policy intention is that local services which impact upon health and wellbeing will be based on evidence of local health and wellbeing needs and assets, including the views of the community; meaning that services and the way in which they are provided meet local needs.

CCGs must involve the health and wellbeing board in preparing (or making significant changes to) their commissioning plans[26]. This includes consulting health and wellbeing boards on whether the plans take proper account of the JSNAs and JHWSs[27]. When consulted, boards must give a view, and their final opinion must be included in the published plan[28]. It would also be good practice for local authorities and the NHS CB to involve boards when developing their commissioning plans, to ensure that they are properly informed by the relevant JSNAs and JHWSs. By their nature, commissioning plans will need to cover a broad range of services – plans for services which meet addition needs to those prioritised in JHWSs, does not in itself mean the plans do not take proper account of those JHWSs.

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[23] The first Mandate between the Government and the NHS Commissioning Board, setting out the ambitions for the health service for the next two years, was published on the 13th November 2012. The Board is legally required to pursue the objectives in this document.

[24] The 2007 Act – section 116A (as inserted by the Act – section 193).

[25] The 2007 Act – section 116B (as inserted by the Act – section 193) requires local authorities and CCGs, in exercising any functions and the NHS CB, in exercising its commissioning functions in relation to the local area, to have regard to any JSNA and JHWS which is relevant to the exercise of those functions.

[26] The NHS Act 2006 – section 14Z13 inserted by section 26 of the Act. The duty on the CCG is to involve each relevant health and wellbeing board. A relevant health and wellbeing board, in relation to a CCG, is one which is established by a local authority whose area coincides with, or includes the whole or any part of, the area of the CCG – the NHS Act 2006 - section 14Z11 (as inserted by the Act - section 26).

[27] The NHS Act 2006 – section 14Z13 inserted by section 26 of the Act. The duty on the CCG is to consult each relevant health and wellbeing board on whether the draft commissioning plan takes proper account of each JHWS published by the board which relates to the period (or any part of the period) to which the plan relates.

[28] The NHS Act 2006 – section 14Z13 (as inserted by section 26 of the Act). The CCG must include a statement of the final opinion of each relevant health and wellbeing board consulted upon publication of the plan

If a health and wellbeing board thinks a CCG has not taken proper account of the relevant JSNAs and JHWSs it can make this clearly known to the CCG when consulted, and also to the NHS CB[29]. As mentioned above, the CCG must be able to justify any parts of their plans which are not consistent. The NHS CB can take action if it believes that the plan is not in line with the JHWSs, without a good reason[30]. If a health and wellbeing board thinks that the NHS CB has not taken proper account of the relevant JSNAs and JHWSs, it can raise this directly with the NHS CB, or in extreme circumstances it could escalate this to Secretary of State[31].

Under the Act, in relation to their public health functions, upper-tier local authorities are required to take appropriate steps to improve the health of their population[32]. This is an opportunity for local authorities to embed health improvement in all policy and decision-making, which will also help address needs identified in JSNAs and priorities agreed in JHWSs. If the health and wellbeing board does not believe that a local authority has taken proper account of the JSNAs or JHWSs, it can raise its concerns with the local authority[33]. This could be raised in a number of ways, such as with the leader of the council, the full council, council members with relevant portfolios, or with any relevant scrutiny committees or arrangements.

3.5 Timing

JSNAs and JHWSs are continuous processes, and are an integral part of CCG and local authority commissioning cycles [34]. Health and wellbeing boards will need to decide for themselves when to update or refresh JSNAs and JHWSs or undertake a fresh process to ensure that they are able to inform local commissioning plans over time. They do not need to be undertaken from scratch every year; however boards will need to assure themselves that their evidence-based priorities are up to date to inform the relevant local commissioning plans. To be transparent and enable wide participation, boards should be clear with their partners and the community what their timing cycles are and when outputs will be published.

4. Promoting integration between services

JHWSs can help health and social care services to be joined up with each other and with health-related services[35], such as housing, transport, the economy or the environment.

Health and wellbeing boards must encourage integrated working between health and social care commissioners, and provide appropriate support to encourage partnership arrangements

[29] See Footnote 26 as to the duty to consult under the NHS Act 2006 – section 14Z13 (as inserted by the Act - section 26).
[30] Action could be taken if the NHS CB has reason to believe that the CCG might fail, have failed, be failing to discharge any of its functions. The NHS CB could require documents, information or an explanation (the NHS Act 2006 – sections 14Z17 or 14Z19).
[31] The Secretary of State for Health has intervention powers in relation to the NHS CB where the NHS CB is not exercising its functions properly or at all or is at risk of failing to do so. The NHS Act 2006 – section 13Z2 (as inserted by the Act - section 23). The Secretary of State can also request information from the Board (The NHS Act 2006 - Schedule 1A paragraph 14).
[32] The NHS Act 2006 – section 2B (as inserted by the Act - section 12) requires responsible local authorities (see footnote 5) to take such steps as they consider appropriate to improve the health of their populations.
[33] The Act – section 196.
[34] The NHS Act 2006 – sections 14Z11 to 14Z14, and 14Z24 (as inserted by of the Act – section 26). CCGs must develop commissioning plans to be in place before the beginning of each financial year (or before a date directed by the NHS CB as regards the financial year of establishment) and most local authorities also plan yearly.
[35] The 2007 Act – section 116A (as inserted by the 2012 Act – section 193). In the context of health and wellbeing boards' powers to encourage close working between certain commissioners, health-related services are those that are not health or social care services, but may have an effect on health outcomes, as defined in the Act – section 195; such as transport, planning or environmental services insofar as they may have an effect on health.

for health and social care services[36], such as pooled budgets, lead commissioning, or integrated provision[37]. In JHWSs, health and wellbeing boards must consider how far needs can be met more effectively by working together in this way[38].

Health and wellbeing boards can encourage close working between commissioners of health-related services and themselves; and commissioners of health and social care services[39]. This could potentially involve considering the commissioning of health-related services either with or by a broad range of local partners, such as district councils, local authority housing commissioners, local community safety partnerships, Police and Crime Commissioners, local probation trusts, prisons, children's secure estates and schools. In this way health and wellbeing boards can use the priorities agreed in JHWSs to influence other services that also affect health to improve outcomes and also to encourage the integration of services.

The NHS CB must encourage partnership arrangements between CCGs and local authorities[40] where it considers this would ensure the integrated provision of health services and this would improve the quality of services or reduce inequalities[41]. CCGs also have a duty to aim to achieve such integration to improve the quality of services or reduce inequalities[42]. Combined, these duties should help encourage joint working between CCGs and local authorities in order to tackle the priorities jointly agreed in JHWSs.

The Act supports joint working by allowing local authorities to delegate functions to the health and wellbeing board[43]. This could result in boards taking on health-related functions, such as preparing housing strategies; which could help to take action on the agreed local priorities. To avoid potential conflicts of interest, the power to delegate functions does not include health scrutiny functions[44], as boards will be subject to scrutiny by the local authority. This is an important way that the local authority (and through it, local people) can hold some organisations represented on the board to account for their role in delivering health services, or consider how the JSNA and JHWS process and its outputs are used to plan services.

JHWSs could be used to consider how services might be reshaped and redesigned to address needs identified in JSNAs, and reduce inequalities. Using local JSNA evidence and agreed JHWS priorities means local service change and commissioning plans should complement other; and this will encourage greater integration across health and social care services.

[36] The Act – section 195.
[37] The NHS Act 2006 – section 75.
[38] The 2007 Act – section 116A (as inserted by the Act – section 193).
[39] The Act – section 195.
[40] And also between CCGs where this would lead to improvements and integrated services, which may be prioritised in JHWSs. The NHS Act 2006 - section 13N (as inserted by the Act – section 23).
[41] The NHS Act 2006 – section 13N (as inserted by the Act – section 23). This also applies where the NHS CB considers that partnership arrangements would lead to integrated provision of health services with social care or health-related services, and that this would improve the quality of services or reduce inequalities. "Reducing inequalities" in this section of the Act is specifically "reducing inequalities in relation to access to or outcomes from services".
[42] The NHS Act 2006 – section 14Z1 (as inserted by the Act – section 26). Again this specifically is "reducing inequalities in relation to access to or outcomes from services".
[43] The Act – section 196.
[44] The Act – section 196.

5. Working in partnership to carry out JSNAs and develop JHWSs

Health and wellbeing boards for county councils must involve the relevant district councils in developing JSNAs[45]. Although it is not required by the Act, they should also seek to work with district councils when preparing JHWSs, and to agree with district councils how they will do this – this should form part of the inclusive way that boards work with their partners. District councils can bring expertise on community engagement, gathering and using useful evidence to input into JSNAs; as well as providing services which can improve health and wellbeing as part of contributing to delivering JHWSs, such as housing, planning and leisure services.

Health and wellbeing boards must involve the local Healthwatch organisation[46] and the local community[47], and this should be continuous throughout the JSNA and JHWS process. When involving the local community, boards should consider inclusive ways to involve people from different parts of the community including people with particular communication needs to ensure that differing health and social care needs are understood, reflected, and can be addressed by commissioners. This should recognise the need to engage with parts of the community that are socially excluded and vulnerable[48]. Involvement should aim to allow active participation of the community throughout the process – enabling people to input their views and experiences of local services, needs and assets as part of qualitative evidence; and to have a genuine voice and influence over the planning of their services.

Health and wellbeing boards should also work closely with other local partners such as Police and Crime Commissioners, criminal justice agencies, youth justice services, troubled families co-ordinators, local authority housing services, local professional representative committees such as Local Medical Committees, schools, voluntary sector organisations, Local Nature Partnerships[49], Environmental Health Officers, local planning authorities representatives of military populations; and Department for Work and Pensions local partnership teams[50]. Such partners can both input evidence into JSNAs to get a thorough understanding of local needs and how to address them, as well as take action to contribute to meeting aims of JHWSs.

Local Healthwatch and voluntary sector organisations (including organisations that represent specific groups) can provide insight and information to help JSNAs better reflect the needs and views of people in vulnerable circumstances and this can support the development of JHWSs to meet those needs. Such organisations can bring great value to the process and should be

[45] The 2007 Act – section 116 (as amended by the Act – section 192). A "relevant district council" means : (a) in relation to a responsible local authority (the authority which established the health and wellbeing board in question), any district council which is a partner authority of it; and (b) in relation to a partner CCG of a responsible local authority, any district council which is a partner authority of the responsible local authority and whose district falls wholly or partly within the area of the CCG. Section 104 of the 2007 Act sets out who are partner authorities in relation to responsible local authority. These include a district council (which is not a responsible local authority) who acts or is established for an area which, or any part of which, coincides with or falls within the responsible local authority's area.

[46] The 2007 Act – section 116 (as amended by the Act – sections 192) and section 116A (as inserted by the Act – section 193). The duty to involve the local Healthwatch organisation for the area is separate to (i.e., not discharged only by) local Healthwatch being represented on the health and wellbeing board.

[47] The 2007 Act – section 116 (as amended by the Act – sections 192) and section 116A (as inserted by the Act – section 193). The duty to involve the local community is a requirement to involve the people who live or work in the area, and does not distinguish between children and adults and therefore should be inclusive of both.

[48] Such as people with disabilities, homeless people, offenders, victims of crime, or Gypsies and Travellers.

[49] Local Nature Partnerships are broad partnerships designed to work at a strategic scale to help manage the natural environment to produce multiple benefits for people, the economy and the environment - www.defra.gov.uk/environment/natural/whitepaper/local-nature-partnerships/

[50] Serving both working age (through Jobcentres), and pension age clients.

seen as a critical friend. Most local areas will have a Compact agreement[51] setting out how local authorities and the NHS will work with voluntary organisations for mutual benefit and these Compacts should be considered, and recognised within the JSNA and JHWS process.

Service providers[52], from the NHS, voluntary or private sector; hold a wealth of information which can also provide important evidence about local needs. They can also take action to improve outcomes through the services they deliver, although health and wellbeing boards will need to consider how any conflicts of interest will be managed when working with local providers.

6. Transparency and accountability

Local communities and partners can hold health and wellbeing boards to account in a number of ways. Statutory membership of elected members and local Healthwatch will be important in ensuring that the voice of local communities are heard and taken into account within JSNAs and JHWSs. Health and wellbeing boards will also be subject to scrutiny by the local authority.

JSNA and JHWS outputs must be published[53]. Making them public will explain to the local community what the board's assessment of the local needs (and if they choose to include them, assets) is and what its proposals to address them are. It should also provide clear measures of progress to hold the board to account over time. Publication will show what evidence has been considered, and what priorities have been agreed and why. It should include a summary of community views, how they have been used; and also whether any other views have been considered. To increase transparency it would be good practice to include in the publication an explanation of how concerns can be raised with the board or its members.

Sharing the analysis behind JSNAs, and (if appropriate) making the data they have used accessible in a safe way, will help health and wellbeing boards make their decision-making processes transparent to their community and to be held to account[54].

The modernised health and care system will be underpinned by greater local transparency of how well health and social care services are improving people's lives through the separate NHS, Adult Social Care and Public Health Outcomes Frameworks[55], the CCG Outcomes Indicator Set and various outcome strategies. The evidence-based outcome measures set out in the frameworks and strategies will be useful to feed into the evidence base for health and wellbeing boards and inform their joint priorities; although this should not overshadow local evidence. They can also be used by boards as a way of demonstrating progress in working together to improve health and care outcomes. However, they are not performance management tools, and are primarily designed to provide transparent measurement of progress, and focus the system on improving outcomes for everyone. Boards may also wish to consider developing local measures to demonstrate progress against their JSNAs and JHWSs.

[51] More information is provided by Compact Voice.
[52] For instance Foundation Trusts, care homes; and providers of domiciliary care services.
[53] The 2007 Act – section 116 (as amended by the Act – section 192) and section 116A (as inserted by the Act – section 193).
[54] Government Open Data policies provide more information.
[55] The Department of Health intends to republish the Public Health Outcomes Framework as statutory guidance to which relevant local authorities must have regard to within their public health responsibilities and function.

7. Other duties

Health and wellbeing boards must meet the Public Sector Equality Duty under the Equality Act 2010, and consideration should be given to this throughout the JSNA and JHWS process. This applies to boards both as a local authority committee, and due to the fact that both local authorities and partner CCGs on whom the primary JSNA and JHWS duties fall have duties under the Equality Act in their own right. This is not just about how the community is involved, but includes consideration of the experiences and needs of people with relevant protected equality characteristics , (as well as considering other groups identified as vulnerable in JSNAs); and the effects decisions have or are likely to have on their health and wellbeing[56]. Integrating equality considerations into the JSNA and JHWS process can help public sector organisations to promote equality and discharge their responsibilities under the Public Sector Equality Duty[57], which is something boards should routinely do as part of their work.

Preparing JSNAs and JHWSs can support other legal duties, for example, in relation to the reduction of crime (including antisocial behaviour)[58]. They can also contribute to other local partnerships such as Community Safety Partnerships (CSPs)[59] or where they exist, Local Enterprise Partnerships (LEPs)[60].

8. Conclusion

By having full engagement of all health and wellbeing board members, wider local partners and the local community, JSNAs will provide a unique picture of local needs, and if boards choose to include them, assets. By agreeing joint local priorities in JHWSs to inform joint action to tackle these needs, health and wellbeing boards will be able to lead action to improving people's lives, integrate services and reduce inequalities.

To support health and wellbeing boards in undertaking JSNAs and developing JHWSs, a suite of supportive resources will be published on the LGA Knowledge Hub from April 2013. These resources will contain case studies, as well as signposts to useful resources. They will be organised under the following categories: cross cutting good practice, assessing needs and assets, engagement and involving specific groups, process and product development and commissioning and integration. They have been developed in response to views heard during the development of this guidance, including through engagement with emerging health and wellbeing boards, and the public consultation.

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[56] The relevant protected characteristics consist of age, disability, gender reassignment, pregnancy and maternity, race (includes ethnic or national origins, colour or nationality), religion or belief (includes lack of belief), sex, and sexual orientation.

[57] As public authorities, both local authorities and CCGs have general and specific duties under the Equality Act 2010, designed to integrate consideration of advancing equality; eliminating discrimination and fostering good relations into the day-to-day business of public authorities; and to help them improve their performance on the general equality duty by improving their focus and transparency. These duties will apply to health and wellbeing boards as a committee of the local authority, including when discharging functions on behalf of the local authority and CCGs. Local authorities remain responsible for ensuring that the general and specific equality duties are met.

[58] The Crime and Disorder Act 1998 ('the 1998 Act') – section 6 places a statutory duty on responsible authorities (including local authorities, the Police, Probation Trusts, Fire and Rescue Authorities, and CCGs) to formulate and implement strategies for the reduction of crime and disorder (including anti-social behaviour); for combating the misuse of drugs, alcohol and other substances; and for the reduction of reoffending.

[59] CSP is a term used to refer to the group of responsible authorities under section 5 of the 1998 Act (Schedule 5 paragraph 84) which have duties to prepare the strategies referred to in footnote 55. These strategies offer a way for all partners to focus on improving health and wellbeing, and crime outcomes together.

[60] LEPs are non-statutory partnerships between local authorities and business, – *Local Growth White Paper*, 2010

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