Lancashire Health and Wellbeing Board

Lancashire County Council

Lancashire Health and Wellbeing Board
Monday, 13 June 2016, 10.00 am,
Cabinet Room 'C' - The Duke of Lancaster Room, County Hall, Preston

AGENDA

Part I (Open to Press and Public)

Agenda Item	Item for	Intended Outcome	Lead	Papers	Time
1. Appointment of Chair	Information	The Board is asked to note that in accordance with the Terms of Reference, County Councillor J Mein, Leader of the County Council, is appointed as the Chair for the remainder of the 2016/2017 municipal year.	Dr Sakthi Karunanithi, Director for Public Health Lancashire		10.00-10.05am
2. Appointment of Deputy Chair	Action	The Board to appoint a Deputy chairman for the municipal year 2016/2017 as set out in the Terms of Reference.	Chair		10.05-10.10am
3. Membership and Terms of Reference of the Board	Information	To note the membership and terms of reference.	Chair	(Pages 1 - 8)	10.10-10.15am

Sam Gorton: sam.gorton@lancashire.gov.uk 01772 534271

Agenda Item	Item for	Intended Outcome	Lead	Papers	Time
4. Welcome, introductions and apologies	Action	To welcome all to the meeting, introduction and receive apologies.	Chair		10.15-10.20am
5. Disclosure of Pecuniary and Non-Pecuniary Interests	Action	Members of the Board are asked to consider any Pecuniary and Non-Pecuniary Interests they may have to disclose to the meeting in relation to matters under consideration on the Agenda.	Chair		10.20-10.25am
6. Minutes of the Last Meeting	Action	To agree the minutes of the previous meeting.	Chair	(Pages 9 - 12)	10.25-10.30am
7. DPH Annual Report	Action	To note the report and support the recommendations.	Dr Sakthi Karunanithi, Director for Public Health Lancashire	(Pages 13 - 40)	10.30-10.50am
8. Sustainability and Transformation Plan	Information	Progress to date.	Samantha Nicol, Director, Healthier Lancashire	(Pages 41 - 44)	10.50-11.15am
9. Closure of Chorley A & E	Information	To note progress on this issue and identify any action, if needed. Links to agendas/minutes for Healthy Scrutiny Committee to note what has been discussed previously: 26 April 2016 24 May 2016 14 June 2016	Karen Partington, Chief Executive of Lancashire Teaching Hospitals Foundation/Jan Ledward, Chief Officer, Chorley, South Ribble and Greater Preston CCG	(Verbal Report)	11.15-11.45am

Agenda Item	Item for	Intended Outcome	Lead	Papers	Time
10. Lancashire CYP Emotional Wellbeing and Mental Health Transformation	Information	To note the verbal report and support the recommendations.	Julie Haywood, NHS Midlands and Lancashire Commissioning Support Unit	(Verbal Report)	11.45-12.05pm
11. Development of Pan Lancashire Health and Wellbeing Board	Action	To note progress to date.	Dr Sakthi Karunanithi, Director of Public Health Lancashire	(Verbal Report)	12.05-12.20pm
12. Urgent Business	Action	An item of Urgent Business may only be considered under this heading, where, by reason of special circumstances to be recorded in the minutes, the Chair of the meeting is of the opinion that the item should be considered at the meeting as a matter of urgency. Wherever possible, the Chief Executive should be given advance warning of any Members' intention to raise a matter under this heading.	Chair		12.20-12.25pm
13. Date of Next Meeting	Information	The next scheduled meeting of the Board will be held at 10am on Friday, 2 September 2016 in the Henry Bollingbroke Room (formerly Cabinet Room 'D' at County Hall, Preston, PR1 8RJ.	Chair		12.25-12.30pm

I Young
County Secretary and Solicitor

County Hall
Preston

Lancashire Health and Wellbeing Board
Meeting to be held on 13 June 2016

Electoral Division affected: All

Membership and Terms of Reference of the Lancashire Health and Wellbeing Board.
(Appendix A refers)

Contact for further information: Samantha Gorton 01772 532471, Office of the Chief Executive, sam.gorton@lancashire.gov.uk

Executive Summary

The current Membership and Terms of Reference of the Board.

Recommendation

The Lancashire Health and Wellbeing Board is asked to:

i. note the current membership and Terms of Reference for the 2016/17 municipal year, as set out in the report and at Appendix 'A'.
ii. appoint a Deputy Chair for the year 2016/2017 municipal year

Background and Advice

The Health and Wellbeing Board was initially established by the Urgency Committee of the Full Council on the 29 March 2013.

The current membership of the Board is set out below.

Position/Representing	Name
Leader of the Council (Chair)	County Councillor Jennifer Mein
Cabinet Member for Health and Wellbeing	County Councillor Azhar Ali
Cabinet Member for Children and Schools	County Councillor Matthew Tomlinson
Cabinet Member for Adult and Community Services	County Councillor Tony Martin
County Councillor	County Councillor David Whipp

Lancashire County Council

Position/Representing	Name
Corporate Director, Operations and Delivery (LCC)	Louise Taylor
Director of Public Health (LCC)	Dr Sakthi Karunanithi
Director of Adult Social Care (LCC)	Tony Pounder
Director for Education, Schools and Care (LCC)	Bob Stott
Six Clinical Commissioning Group Network Members	Dr Dinesh Patel (Greater Preston) Dr John Caine (West Lancashire) Dr Gora Bangi (Chorley and South Ribble) Dr T Naughton (Fylde and Wyre) Mark Youlton (East Lancashire) Dr Alex Gaw (Lancashire North)
Director of Commissioning Operations, Lancashire and Greater Manchester, NHS England	Graham Urwin
Three District Councillors (appointed by the Lancashire Leaders Group for Central, East and Fylde Coast)	Cllr Bridget Hilton (Central Lancashire) Cllr Viv Willder (Fylde Coast) ?
1 District Chief Executive (nominated by the Lancashire Chief Executives Group)	Gary Hall (Chorley Borough Council)
Third Sector Representative	Sarah Swindley
Chairperson of Healthwatch	Michael Wedgeworth
Providers (two representatives)	Karen Partington, Chief Executive of Lancashire Teaching Hospitals Foundation Trust Professor Heather Tierney-Moore, Chief Executive of Lancashire Care Foundation Trust
Five Chairs of Health and Wellbeing Partnerships in Lancashire	Cllr Tony Harrison (East Lancashire) Cllr Hasina Khan (Central) David Tilleray (West Lancashire) ? ?
Independent Chair of Lancashire Safeguarding Children Board	Jane Booth
Independent Chair of Lancashire Safeguarding Adult Board	Vacancy (currently covered by Jane Booth)
Lancashire Constabulary	Assistant Chief Constable Mark Bates

A copy of the current Terms of Reference of the Board are set out at Appendix 'A' for information.

The Terms of Reference also require that the Board appoint a Deputy Chairman annually from amongst the membership on an annual basis, and the Board is invited to make this appointment.

Consultations

N/A

Implications:

This item has the following implications, as indicated:

Risk management

There are no risk management implications arising from this report.

Local Government (Access to Information) Act 1985
List of Background Papers

Paper Date Contact/Directorate/Tel

Reason for inclusion in Part II, if appropriate
N/A

Lancashire Health and Wellbeing Board
Terms of Reference

1. Purpose

To enable people in Lancashire to achieve the best possible health and wellbeing outcomes through better partnership working and service integration.

2. Functions

To achieve the purpose outlined above the Health and Wellbeing Board will deliver the following key functions:

Leadership – to lead and direct the health and wellbeing system to ensure we improve services and make the best use of resources that deliver better outcomes for people.

Assurance – to ensure a collective awareness of the major changes, pressures and risks across health and wellbeing services and provide opportunity to review, comment and consider the opportunities for collaborative approaches to address or manage these.

Challenge – to monitor and evaluate all parts of the health and wellbeing system in Lancashire and where necessary provide appropriate and effective challenge.

Accountability – to be able to demonstrate and evidence that the decisions of the Board, and their subsequent outcomes, are clearly focussed on protecting the health and wellbeing of people in Lancashire.

Strategy – to agree a Health and Wellbeing Strategy and ensure plans and priorities, both through collaboration and within individual organisations/sectors, are aligned and support the delivery of this Strategy.

Commissioning - to enable collaboration between commissioners, joint commissioning and pooled budgets, where this provides better integrated service delivery and outcomes.

Understanding – to be clear about the needs and opportunities for people's health and wellbeing in Lancashire and to lead the development of a Joint Strategic Needs Assessment. To ensure that data, intelligence and evidence (for example through the Joint Strategic Needs Assessment) is informing and driving the development of plans and priorities. To listen to and understand the needs of local people.

Engagement – to ensure there is effective dialogue, engagement and joint working between county and local health and wellbeing structures and partnerships and with other key strategic partnerships and networks.

Integration – to promote integration and partnership working between the NHS, social care, public health and other services.

3. Principles

The Health and Wellbeing Board members recognise shared values as the foundation of a strong partnership and through trust, openness, equality and fairness will ensure a strong and sustainable partnership that delivers improved health and wellbeing outcomes for people in Lancashire.

Trust – to have confidence in the integrity and ability of all partner organisations working collaboratively through the Health and wellbeing Board.

Openness – demonstrating transparency and openness between partners in how decisions are made and in sharing activities, plans and ambitions.

Equality – each partner organisation/sector has an equal standing within the Health and Wellbeing Board.

Fairness – commitment throughout the Health and Wellbeing Board that the behaviour and actions of partners is equitable, impartial and objective.

4. Membership

The membership of the Lancashire Health and Wellbeing Board is comprised of the following:

- The Leader of the County Council, LCC (Chairperson)
- The Cabinet Member for Health & Wellbeing, LCC
- The Cabinet Member for Children and Schools, LCC
- The Cabinet Member for Adult and Community Services, LCC
- A County Councillor to be nominated by the Liberal Democrat Group, LCC
- Corporate Director, Operations and Delivery, LCC
- Director of Adult Social Care, LCC
- Director of Public Health, LCC
- Director of Children's Services, LCC
- Six Clinical Commissioning Group (CCG) Network Members (1 member to be nominated by each CCG)
- The Director of the Lancashire Area Team (National Commissioning Board)
- Three District Councillors (one from each of the sub areas of Lancashire, to be nominated by the Lancashire Leaders Group)
- One District Council Chief Executive (to be nominated by the Lancashire Chief Executives Group)
- A Third Sector Representative (to be nominated by One Lancashire)
- The Chairperson of Healthwatch
- Two Providers (to be nominated by Chief Executives of NHS Foundation Trusts)
- Five Chairs (or a nominated representative) of the Health and Wellbeing Partnerships in Lancashire (one to be nominated by each Health and Wellbeing Partnership)
- Independent Chair of the Lancashire Safeguarding Children Board
- Independent Chair of the Lancashire Safeguarding Adult Board
- A Lancashire Constabulary representative

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All Board members to have one vote each.

5. Meeting Arrangements

The Health and Wellbeing Board is a committee of the County Council and unless specified below, meeting arrangements are subject to the County Council's procedural Standing Orders:

- The Leader of the County Council will be the Chair of the Board.
- The Board will appoint the Deputy Chair annually.
- The Board will meet bi monthly.
- Every other meeting will have a clear thematic focus to enable wider discussion, understanding and decision making around priorities areas.
- Decisions will be made by consensus where possible, or when appropriate by a majority vote.
- The quorum at a meeting of the Board shall be a quarter of the whole number of voting members of the Board with at least one Cabinet Member being present.
- Substitutes for Board members are permitted with written notification being given to the Clerk by the relevant nominating body in advance of the meeting.
- Meetings of the Board are open to the public but they may be excluded where information of an exempt or confidential nature is being discussed – see Access to Information Rules set out at Appendix 'H' in the County Council's Constitution.
- The Board cannot discharge the functions of any of the Partners.

Lancashire Health and Wellbeing Board

Minutes of the Meeting held on Thursday, 28th April, 2016 at 2.00 pm in Cabinet Room 'D' - The Henry Bolingbroke Room, County Hall, Preston

Present:

Chair

County Councillor Jennifer Mein, Leader of the County Council

Committee Members

County Councillor Azhar Ali, Cabinet Member for Health And Wellbeing (LCC)
County Councillor Matthew Tomlinson, Cabinet Member for Children, Young People and Schools (LCC)
Dr Sakthi Karunanithi, Director of Public Health, Public Health Lancashire
Louise Taylor, Corporate Director Operations and Delivery (LCC)
Tony Pounder, Director of Adult Services
Councillor Bridget Hilton, Central Lancashire District Councils
Karen Partington, Chief Executive of Lancashire Teaching Hospitals Foundation Trust
Dr Tony Naughton, Fylde & Wyre CCG
Dr Alex Gaw, Lancashire North Clinical Commissioning Group (CCG)
Dr Dinesh Patel, Greater Preston CCG
Sarah Swindley, CEO, Lancahire Women's Centres, VCFS Rep
Gary Hall, Lancashire District Councils
Jane Booth, Independent Chair, Lancashire Safeguarding Children's Board
Dee Roach, Lancashire Care NHS Foundation Trust (on behalf of Heather Tierney-Moore)
David Tilleray, Chair West Lancs HWB Partnership
Dr John Caine, West Lancashire CCG
Councillor Tony Harrison, East Lancs HWB Partnership
Clare Platt, Health Equity, Welfare & Partnerships
Cllr Viv Willder, Fylde Borough Council
Jan Ledward, Chorley and South Ribble CCG

Apologies

County Councillor Tony Martin	Cabinet Member for Adult and Community Services (LCC)
Dr Gora Bangi	Chorley and South Ribble CCG
Michael Wedgeworth	Healthwatch Lancashire Interim Chair
Graham Urwin	NHS England, Lancashire and Greater Manchester
Mark Bates	Assistant Chief Constable, Lancashire Constabulary
Mark Youlton	East Lancashire CCG

1. Apologies

Apologies for absence were noted as above.

The Board were informed of a number of new members as follows:

- Councillor Viv Willder – Fylde Borough Council (replacing Councillor Cheryl Little)
- Mark Youlton – East Lancashire CCG (replacing Dr Mike Ions)
- Dr John Caine – West Lancashire CCG (replacing Dr Simon Frampton and Lucinda McArthur)

2. Disclosure of Pecuniary and Non-Pecuniary Interests

Dr Tony Naughton declared a non-pecuniary interest as Chair of Fylde and Wyre Health and Wellbeing Board Partnership.

3. Minutes of the Last Meeting

Minutes from the meeting held on 22 February 2016 were agreed as a true and accurate record.

4. Better Care Fund 2016/17 Submission

Paul Robinson spoke to this item. The purpose of the report is to inform the Lancashire Health and Wellbeing Board on the progress of and rationale around the development of the Lancashire Better Care Fund (BCF) Plan for 2016/17 and to seek the Board's approval of the plan. On page 2 of the report in the sentence: *"The plan therefore includes all schemes of the 2015/16 plan, with some minor name changes, along with an additional scheme of Carer support in Fylde and Wyre".* The reference to the additional scheme in Fylde and Wyre should be removed. The sentence reflected where the plan was at when the report was written. Fylde and Wyre CCG will be managing that activity outside of the BCF.

The Lancashire BCF Plan for 2016/17 will build upon that for 2015/16 and take an approach that ensures stability and consolidation. The schemes within the plan will vary little in outward appearance from those seen in 15/16 but will be stronger in how they deliver.

This is an approach agreed across all BCF partners. It reflects the changing planning environment, and a central government desire for BCF focus on addressing the issues around hospital admission avoidance and safe, timely discharge. It also enables partners to best manage resources at a time of continuing financial uncertainty and increased system pressures.

The Lancashire BCF plan 2016/17 aligns with all CCGs (Clinical Commissioning Groups) and Lancashire County Council's operating plans being now part of "business as usual" planning.

Further ambitions expressed for the BCF have not been lost but redirected into the Healthier Lancashire and Lancashire and South Cumbria Sustainability Transformation Plan work programmes. The BCF will continue to be a core part of the move to greater integration and as part of the work within the BCF plan in 2016/17 lay the ground for a plan for integration of Health and Social Care.

The BCF plan 2016/17 sees significant strengthening of the input of the City and Borough Councils and Voluntary sector that will bring a whole new set of skills and resources into delivering its priorities and schemes. Built into the plan is the early refresh of delivery plans for schemes and this will reflect that wider view of who can contribute and the prospect of greater coordination/integration.

The centrally prescribed format of the BCF plan for 2016/17 has been slimmed down to a high level narrative, which refers to supporting documents, and a spreadsheet template submission of management information and financial plan detail.

The Board noted that Gary Hall was now a member of the BCF Steering Group.

The financial arrangements for the Better Care Fund are based around a centrally defined level of minimum contributions that CCGs will make to the BCF pooled fund. In addition Lancashire County Council contributes against agreed schemes. Also added to the pooled fund is an amount for the provision of Disabled Facilities Grants which is then distributed to City and Borough Councils so that they can fulfil their statutory duties. This is £11,476,00 in 2016/17.

The total BCF pooled fund for 2016/17 is £91,419,000. The detailed allocation of this is set out in the BCF plan.

The agreement to pool these funds is set out in a Section 75 agreement between Lancashire County Council and all Lancashire CCGs. Lancashire County Council has agreed to host the pooled fund and manages the financial processes required.

Resolved: that as the Lancashire Better Care Fund accountable body the Health and Wellbeing Board agreed to:

- Endorse the approach taken in developing the Lancashire Better Care Fund plan 2016/17
- Approve the Lancashire Better Care Fund Plan 2016/17 and its submission to NHS England
- A BCF quarterly reporting schedule to the board based upon that required by NHS England and an evaluation of the BCF Plan for 2015/16 be brought to the next meeting on 13 June 2016
- Amend the new plan as and when necessary

Further information on the BCF Fund Submission is attached as requested at the meeting.

5. Urgent Business

There were no items of urgent business.

6. Date of Next Meeting

The next scheduled meeting of the Board will be held at 10.00am on Monday, 13 June 2016 in the Duke of Lancaster Room (formerly Cabinet Room 'C'), County Hall, Preston, PR1 8RJ.

I Young
Director of Governance,
Finance and Public Services

County Hall
Preston

Securing our Health and Wellbeing

Report of the Director of Public Health and Wellbeing
2016

Lancashire County Council

www.lancashire.gov.uk

Contents

Preface

It is a well-known fact that Lancashire is the birthplace of the industrial revolution that began in the 18th Century. Our ancestors include some of the most hardworking and innovative people in the world. We have a rich and diverse heritage, culture, social capital and assets on which we have built our economy and health.

The responsibilities for protecting and improving the public's health were transferred back to Lancashire County Council in 2013. This means the public health functions have come home to the local government, since they left in 1974. Local government has an opportunity to embed public health objectives in everything it does – to address not just ill health prevention and influence the NHS but also promote what determines good health and wellbeing – education, skills, jobs, homes, healthy environments, transport, to name a few. We have already seen some success stories. For example, all the play areas in Lancashire have become smoke free in 2016 and there are many similar exemplars of good practice.

At the same time, there are new challenges. Our county is ageing and the burden of disease is on the rise. The economic downturn at the beginning of this century, the political choices being made by the UK government in allocating the scarce public resources to address the structural deficit in our economy, and the impact this could have on our lives, and on the sustainability of public services including the NHS is a key concern.

Traditionally, the Directors of Public Health report progress on the recommendations made in their previous reports. As this is my first report covering 2013 – 2015, I have described what determines our health and wellbeing and made recommendations to protect and improve it. **I hope to draw your attention on three main issues – we have been adding years to our lives but not necessarily life to our years; addressing health inequalities needs action across the social gradient within our county and not just in the most deprived communities; and that protecting and promoting good health is not just a social issue but also crucial for our local and national economy.**

It is common knowledge that the financial resources within the public

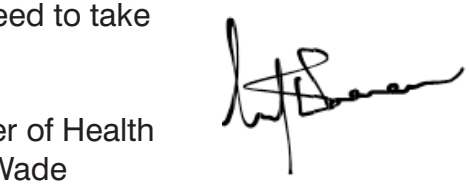
sector, both nationally and within our county are not going to increase to meet the needs and demands of our changing demography. Having the focus on financial savings alone can distract organisations from improving health and wellbeing. Therefore, we need to relentlessly pursue the 'Triple Aim' of improving outcomes, enhancing quality of care and reducing costs at the heart of everything we do.

In order to pursue the 'Triple Aim' in our county, we need a strong and longer term political will to radically upgrade our efforts on prevention; we need fully engaged individuals, families, communities and businesses in improving wellbeing; and a workforce that embraces innovation and puts people and the places they live at the centre of everything they do. This report focusses on key actions we need to take on these areas.

The last County Medical Officer of Health Dr. Charles Henry Townsend Wade said in his annual report in 1973 "… my grateful thanks to all the staff… who have continued to co-operate in the maintenance and advancement of the various services, whilst undertaking much work involved in the reorganisation". I'd like to echo his words and add that I am proud and privileged to be working with so many motivated and inspiring individuals across the county – politicians and professionals across various sectors alike.

My vision is to develop Lancashire into a safer, fairer and healthier place for our residents. I invite your feedback, debate, and ideas to shape this further and make the vision into a reality for the current and future generations. Together, let us make Lancashire the birth place for a wellbeing revolution in the 21st Century.

Yours sincerely,



Dr. Sakthi Karunanithi MBBS MD MPH FFPH
Director of Public Health and Wellbeing

1 About Lancashire

Lancashire has an estimated population of 1.18 million spread over 2,900 km^2. The average population density (people per km^2) is 408, compared to the North West average of 506 and an England and Wales average of 380[1].

The population is projected to increase 5.8% by 2037, with the number expected to reach 1.24 million. The estimated increases are lower than the average for the North West (7.9%) as a whole, and well below the expected increase for England of 16.2%.

At the district level, Hyndburn and Burnley are actually predicted to see small population decreases between 2012 and 2037, whilst Rossendale and Chorley are the only Lancashire authorities with projected increases in excess of 10%.

Analysis by age reveals that most of the age-groups between 0 and 64 years are predicted to decrease between 2012 and 2037. A substantial increase of over 50% is predicted in the over 65 age group. The number of people aged 90 years and older is projected to increase from around 10,000 in 2012 to around 32,000 in 2037[2].

2011 census showed that the largest ethnic group is white (90%). The black and minority ethnic group (BME) makes up 8% of the population, the majority of this group were Asian/Asian British. Numerically, there were over 90,000 black minority ethnic people in the county. Three-quarters of the BME population reside in Preston, Pendle, Burnley and Hyndburn. Across England and Wales, the white population accounted for 86% and BME accounted for 14%.

There are wide variations in levels of income, wealth and health across the county. In more rural areas social exclusion exists side-by-side with affluence and a high quality of life. Several districts have small pockets of deprivation, but there are also larger areas of deprivation, particularly in east Lancashire, Morecambe, Skelmersdale and parts of Preston.

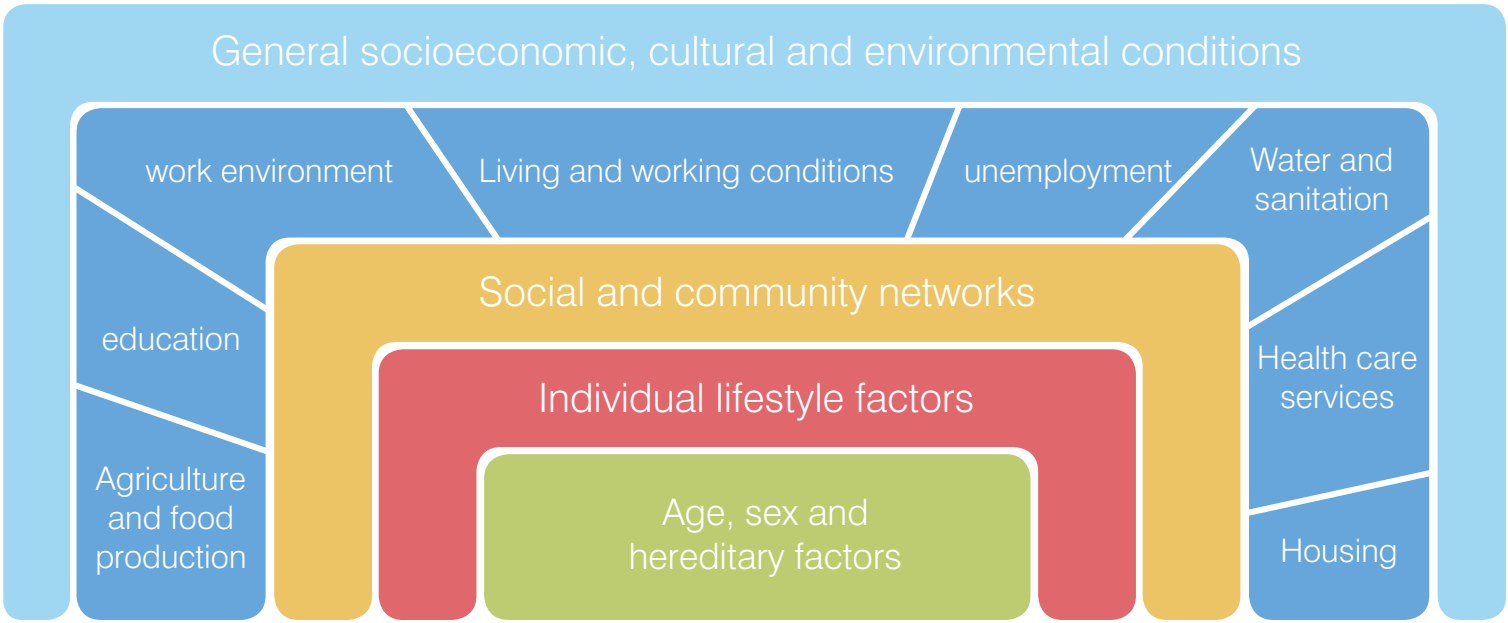
Further details of the demography and population projections can be accessed by clicking on Lancashire Insight - www.lancashire.gov.uk/lancashire-insight.aspx

Lancashire county has 12 district councils and neighbours the two unitary authorities of Blackpool and Blackburn with Darwen. There are six NHS clinical commissioning groups (CCGs) in the council area with one in each of the unitary councils. Lancashire is also served by five key NHS Trusts, over 250 GP practices and a similar number of pharmacies and a wide range of social care providers. A single fire and rescue service, constabulary and police and crime commissioner cover the whole of Lancashire. Key strategic partnerships in the county council area include a Health and Wellbeing board, a Children and Young People Trust Board, a Safeguarding Adults Board, a Safeguarding Children Board, and a Lancashire Enterprise Partnership. There are three main university campuses in the county and specialist agriculture and maritime college facilities.

1 ONS, Mid-2014 Population Estimates
2 ONS, 2012-based Sub-National Population Projections

2 The state of our health and wellbeing

Our health and wellbeing is determined not only by the quality of health and care services and lifestyle factors but also by a range of good health promoting factors including the conditions in which we are born, live and work – which are referred to as the socioeconomic and environmental determinants (SEEDs) or root causes of health. An illustration of the determinants of health by Dahlgren and Whitehead (1992) is provided below. Therefore, it is all these determinants that we need to act on to improve our health and wellbeing. Many of these are influenced by local and national government policies and programmes and not just by the NHS.



The Determinants of Health (1992) Dahlgren and Whitehead

An analysis of key measures of health and wellbeing and its determinants are presented in this report.

2.1 Life Expectancy and Healthy Life Expectancy

Life Expectancy (LE) and Healthy Life Expectancy (HLE) are well known global measures of health and wellbeing. The slope index of inequality in life expectancy and healthy life expectancy is a measure of variation between most deprived and least deprived areas.

The table below shows the female and male LE and HLE in Lancashire.

In summary, the life expectancy at birth for both females and males have been increasing over the years. However, there is a gap of 7.1 and 10.2 years between our least and most deprived areas for females and males respectively.

The gap between the female LE and the national average has also widened. None of the districts are significantly better than the national average. South Ribble, Ribble Valley, West Lancashire, and Fylde are similar to the national average and the rest are significantly worse than national average.

Male LE in Fylde, West Lancashire, and Chorley is similar to the national average. While South Ribble and Ribble Valley have better male LE than the national average, the rest of the districts have significantly worse male LE than the national average.

The average number of years a female child can expect to live in good health, otherwise called healthy life expectancy, is 62.4 years, meaning they will spend 19.7 years in not so good health.
The average number of years a male child can expect to live in good health, otherwise called healthy life expectancy, is 61.3 years, meaning they will spend 17.2 years in not so good health. HLE has been decreasing since 2009. It is significantly worse than England average.

	Female	Male
Life expectancy at birth in years (Lancashire)	82.1	78.5
Life expectancy at birth (England)	83.2	79.5
Gap between most and least deprived MSOAs in Lancashire	7.1	10.2
Healthy life expectancy at birth (HLE) in Lancashire	62.4	61.3
Healthy life expectancy at birth in England	63.9	63.3
Gap in HLE between most and least deprived MSOAs in Lancashire	15.6	15.8

We have been adding years to our lives but not necessarily life to our years. Healthy life expectancy in males has decreased since 2009. If not addressed, this is likely to affect the economy and productivity of our workforce.

2.2 Social, Economic, Environmental Determinants (SEEDs) of Health and Wellbeing

An independent review, led by Sir Michael Marmot examined the most effective evidence-based strategies for reducing health inequalities in England. The final report, 'Fair Society Healthy Lives', was published in February 2010, and concluded that reducing health inequalities would require action on six policy objectives:

- Give every child the best start in life.
- Enable all children, young people and adults to maximise their capabilities and have control over their lives.
- Create fair employment and good work for all.
- Ensure healthy standard of living for all.
- Create and develop healthy and sustainable places and communities.
- Strengthen the role and impact of ill-health prevention.

A framework of indicators, called Marmot Indicators, are published regularly for Local Authorities in England. Analysis of data published in December 2015[3] has identified that Lancashire is significantly better than the national average in the following areas:

- Good level of development at age 5 (%)
- Good level of development at age 5 with free school meal status (%)
- Long term claimants of Jobseeker's Allowance (rate per 1,000 population).

The analysis also identified that Lancashire is significantly worse than the national average in the following areas:

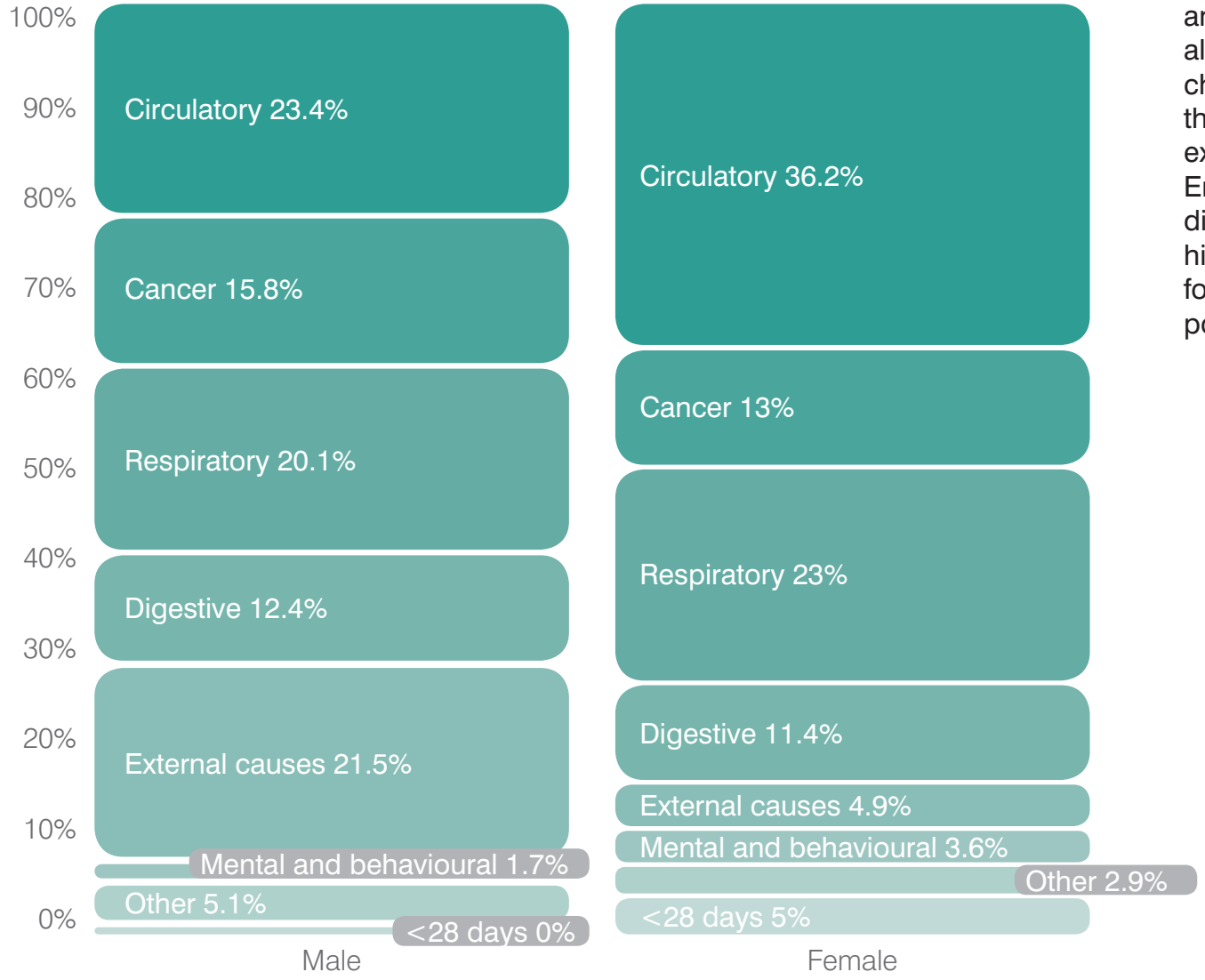
- Life expectancy and healthy life expectancy for females and males
- GCSE achieved 5A*-C including English & Maths with free school meal status (%)
- Fuel poverty for high fuel cost households (%).

It should be noted there is a significant variation between the districts within Lancashire. Any action to address the SEEDS of wellbeing need to focus on the areas that need the most support as well as improving them across the whole of Lancashire.

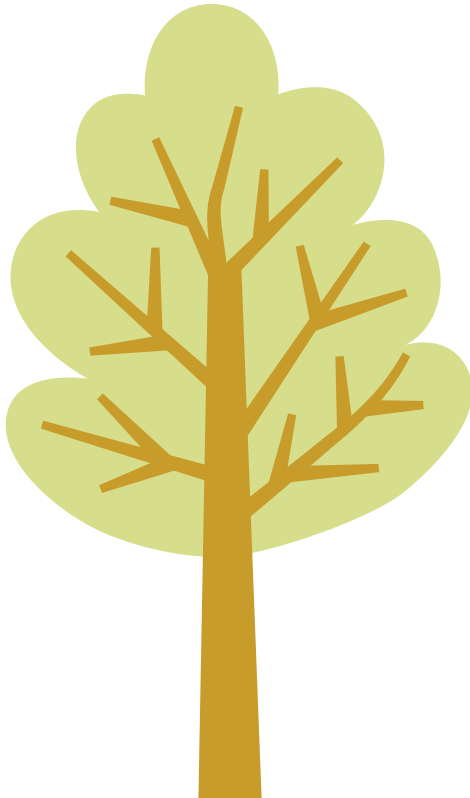
Analysis of causes of excess deaths (The Segment Tool) has been developed by Public Health England (PHE) to provide information on the causes of death that are driving inequalities in life expectancy at local area level. Targeting the causes of death which contribute most to the life expectancy gap should have the biggest impact on reducing inequalities. The following chart provides further information on the causes of death that are driving inequalities in life expectancy at Lancashire level. The tool also allows analysis at a district level.[4]

3 https://neighbourhood.statistics.gov.uk/HTMLDocs/nessgeography/superoutputareasexplained/output-areas-explained.htm
4 https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015

Chart showing the breakdown of the life expectancy gap between Lancashire as a whole and England as a whole, by broad cause of death, 2010-2012



The chart shows that circulatory diseases (includes coronary heart disease and stroke), cancer, respiratory and digestive diseases (includes alcohol-related conditions such as chronic liver disease and cirrhosis) are the major reasons for the gap in life expectancy between Lancashire and England. Of particular concern is the difference in gap caused by significantly higher proportion of external causes for men (include deaths from injury, poisoning and suicide).



The Table below shows further breakdown of the life expectancy gap between Lancashire as a whole and England as a whole, by broad cause of death, 2010-2012.

	Male			Female		
Broad cause of death	**Number of deaths in local authority**	**Number of excess deaths in local authority**	**Contribution to the gap (%)**	**Number of deaths in local authority**	**Number of excess deaths in local authority**	**Contribution to the gap (%)**
Circulatory	5,044	364	23.4	5,444	637	36.2
Cancer	5,183	211	15.8	4,533	80	13.0
Respiratory	2,492	334	20.1	2,819	385	23.0
Digestive	918	134	12.4	985	131	11.4
External causes	829	128	21.5	466	17	4.9
Mental and behavioural	880	23	1.7	1,875	74	3.6
Other	1,430	-69	5.1	2,101	-40	2.9
Deaths under 28 days	68	-2	..	65	12	5.0
Total	**16,844**	**1,124**	**100**	**18,289**	**1,296**	**100**

This means there were at least 2420 excess deaths in Lancashire between 2010 and 2012 compared to England average.

2.3 Analysis of inequalities within Lancashire[5]

Further local analysis of the inequalities within Lancashire is aimed to target specific actions in the areas causing the most inequalities. The table below describes the ten worst health inequalities in Lancashire.

	The ten worst inequalities in health outcomes	
1	Diabetes	Those in the most deprived areas are over seven times as likely to die prematurely from diabetes as those in the least deprived areas.
2	Respiratory disease	Those in the most deprived areas are over four and a half times as likely to die prematurely from chronic obstructive pulmonary disease as those in the least deprived areas.
3	Digestive disease	Those in the most deprived areas are over three times as likely to die prematurely from chronic liver disease as those in the least deprived areas.
4	Mental health problems	Those in the most deprived areas are three times as likely to suffer from extreme anxiety and depression as those in the least deprived areas.
5	Lung cancer	Those in the most deprived areas are over two and a half times as likely to die prematurely from lung cancer as those in the least deprived areas.
6	Circulatory disease	Those in the most deprived areas are over two and a half times as likely to die prematurely from coronary heart disease, and over twice as likely to die prematurely from stroke as those in the least deprived areas.
7	Accidents	Those in the most deprived areas are over twice as likely to die prematurely as a result of an accident as those in the least deprived areas.
8	Quality of life	Those in the most deprived areas are over twice as likely to experience extreme pain and discomfort and over one and a half times as likely to have problems with mobility, self-care and performing usual activities as those in the least deprived areas.
9	Unplanned hospital admissions	Those in the most deprived areas are over one and a half times as likely to be admitted to hospital in an emergency as those in the least deprived areas Those in the most deprived areas are over one and a half times as likely to be admitted to hospital in an emergency as those in the least deprived areas.
10	Narrow the gap in infant mortality	In the most deprived areas, babies up to one year old are over one and a half times as likely to die as those in the least deprived areas.

5 Based on new health inequalities analysis JSNA 2014. http://www3.lancashire.gov.uk/corporate/web/?siteid=6117&pageid=35405&e=e

2.4 Economy, Ill Health, Disability and State Pension Age

It is estimated that more than 130 million days are still being lost to sickness absence every year in Great Britain and working-age ill health costs the national economy £100 billion a year[6]. This is greater than the annual budget for the NHS in 2013/14 and comparable to the entire GDP of Portugal. The costs to the taxpayer – benefit costs, additional health costs and forgone taxes – are estimated to be over £60 billion.

It is estimated that the state pension age for children born in 2015 will be 68 years. It is therefore important to have as much a healthy and disability free life expectancy as possible during working age and before reaching the state pension age. Using raw data available at middle super output area (MSOA) level, it is estimated that a disability free life expectancy of over 68 years can be achieved in only 18 out of 154 MSOAs for females, and in 12 out of 154 MSOAs for males. This is an important consideration for having a healthy and productive workforce in the future. We need to act now to create the conditions to have healthy working life for our population, particularly for our children.

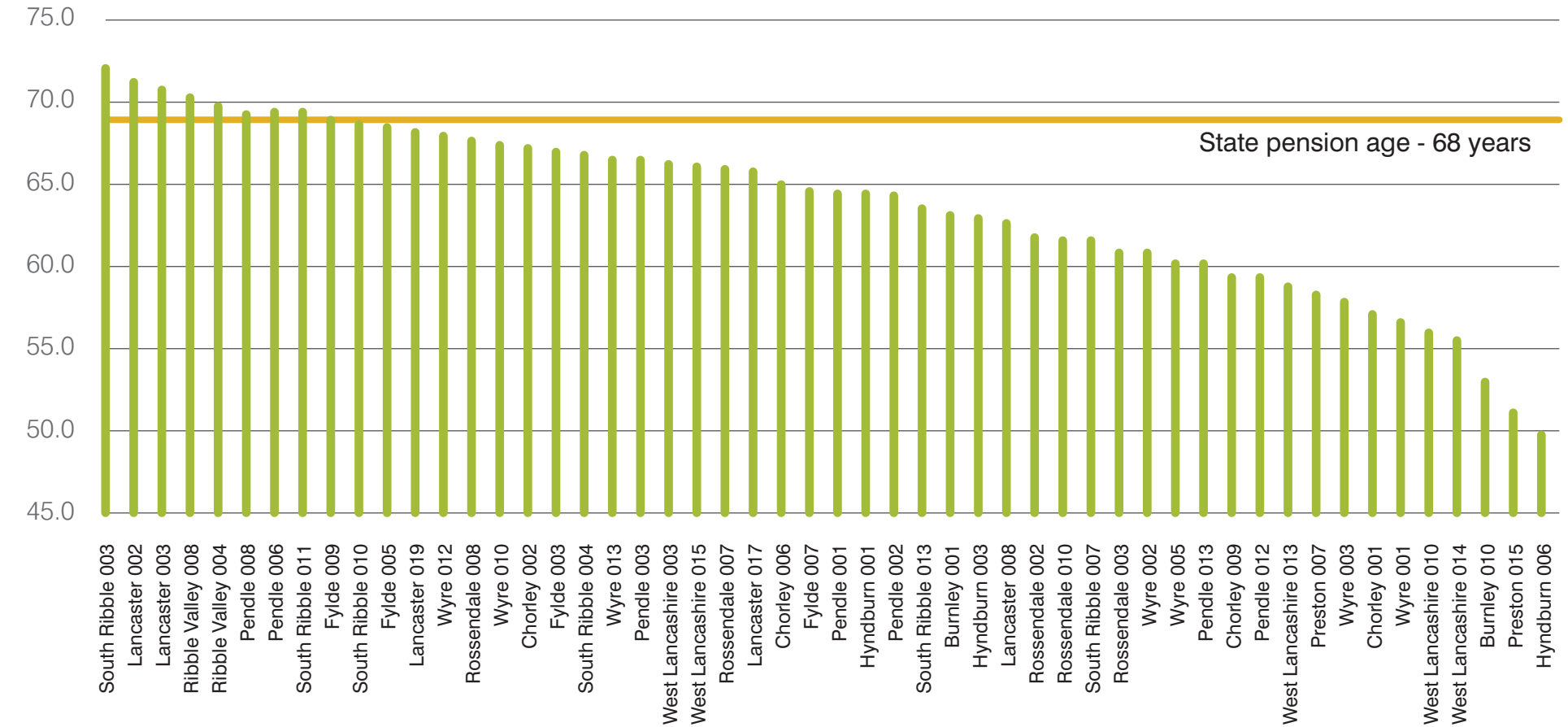
2.5 Inequalities across the social gradient

Another important consideration is that these inequalities are not just present within the most deprived and the rest of Lancashire. There is a gradient across the county based on the indices of deprivation. As an illustration, the bar chart shows the gradient female healthy life expectancy across the 154 MSOAs in Lancashire. Hence, improving the outcomes only in the most deprived areas of Lancashire will not be enough to improve the outcomes across the county. We need a response proportionate to the need in each of these geographical areas. In other words, we need proportionate universalism as described in the Fairer Society, Fairer Lives report by Sir Michael Marmot.

These inequalities are not just between the most deprived areas and the rest. In fact they exist across our social gradient. We need to up our game across all sections of our society.

6 https://www.gov.uk/government/news/a-million-workers-off-sick-for-more-than-a-month

Distribution of Female Healthy Life Expectancy across Lancashire



There is a strong commitment to tackle health inequalities in Lancashire. This was demonstrated by the Joint Strategic Needs Assessment of Health Inequalities conducted in 2009 and then repeated in 2014. Analysis of change in the gap show that the gaps in early deaths from diabetes has widened between 2009 and 2012 and the gap in some of the important causes of health inequalities such as income, fuel poverty and drinking alcohol at levels hazardous to health have also widened over the last three years. On the other hand, the gaps in anxiety and depression and early deaths from heart disease and stroke had narrowed; with rates in the most deprived parts of the population improving faster than the least deprived. This shows that it is possible to narrow the health gap with concerted co-ordinated efforts across partner organisations.

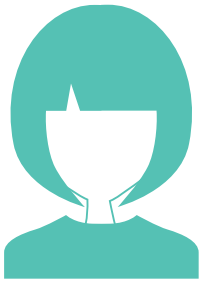
In addition, The Lancashire Fairness Commission was set up to provide an independent perspective on inequality in Lancashire and to make recommendations to increase fairness to Lancashire County Council and its partners. The commission reported in March 2015 and its recommendations can be found at http://www.lancashire.gov.uk/media/584910/4000-Fairer-Lancashire-Fairer-Lives.pdf

3 Healthier Lifestyles

It is estimated that around 40% of all deaths in England are related to lifestyles. The NHS spends more than £11bn a year on treating illnesses caused by the effects of diet, inactivity, smoking and drinking alcohol.

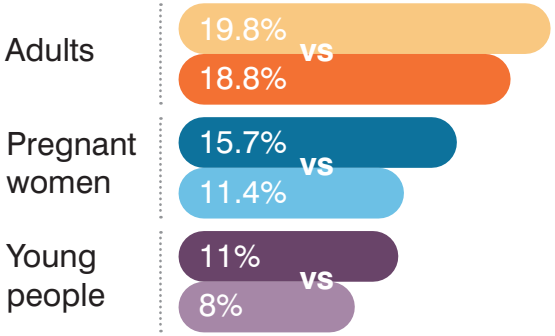
Key facts about lifestyles in Lancashire[7]

3.1 Tobacco



Tobacco smoking kills **1,673** adults aged 35 years and over in Lancashire each year

Smoking rates remain higher in Lancashire than nationally:

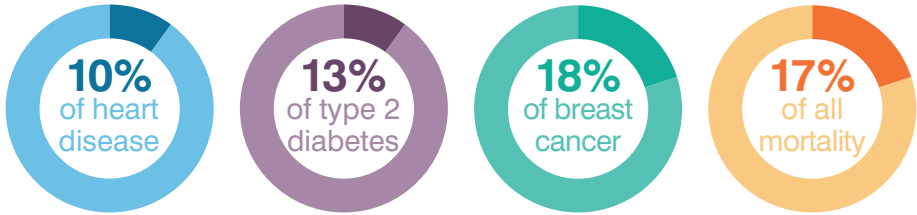


- Cost of smoking to society in Lancashire is £291.7 million each year, including £50 million NHS care
- A smoker of 20 cigarettes a day spends £2,800 a year, family where both parents smoke spend £5,600 a year
- Two-thirds of smokers (63%) want to quit and welcome support to do so.

3.2 Physical activity

Inactivity, described by the DH as a "silent killer," directly costs the NHS across the UK an estimated **£1.06 billion**

Estimates suggest that in England, physical inactivity causes



- Six districts in Lancashire are significantly worse than the national average in terms of children's activity levels (England average 55.13%)
- In Lancashire, at a county level, the level of inactivity is 30.41% in adults.
- This amounts to 284 premature deaths per annum at a cost of £19,937,814.
- This percentage of inactivity in adults is significantly higher than the national average for England.

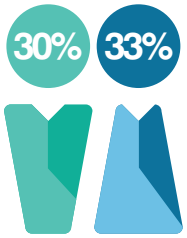
7 Various sources, including www.lancahire.gov.uk/JSNA

3.3 Overweight and Obesity

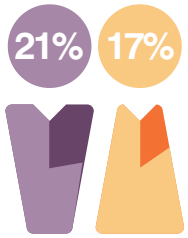
Each year, an estimated **£5.1 billion** is spent on obesity related health problems

- In Lancashire, the percentage of overweight and obese adults is higher than the national average by 0.9% (Lancashire, 64.7% compared to England 63.8%).
- Similarly, the percentage of overweight and obese children in reception (aged 4-5 years) is higher than the national average by 1.3% (Lancashire, 23.5% compared to England 22.2%).

Obesity is known to be related to social disadvantage.

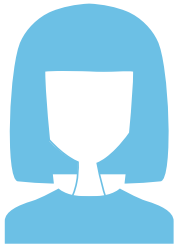


Nationally, around 30% of men and 33% of women with no qualifications are obese...



...compared to 21% of men and 17% of women with a degree or equivalent.

3.4 Alcohol



Alcohol misuse costs **£21 billion** per year in England (Lancashire £495m).

7.8% of Lancashire population are estimated to be high risk drinkers

24% are estimated to be binge drinking

4% are dependent

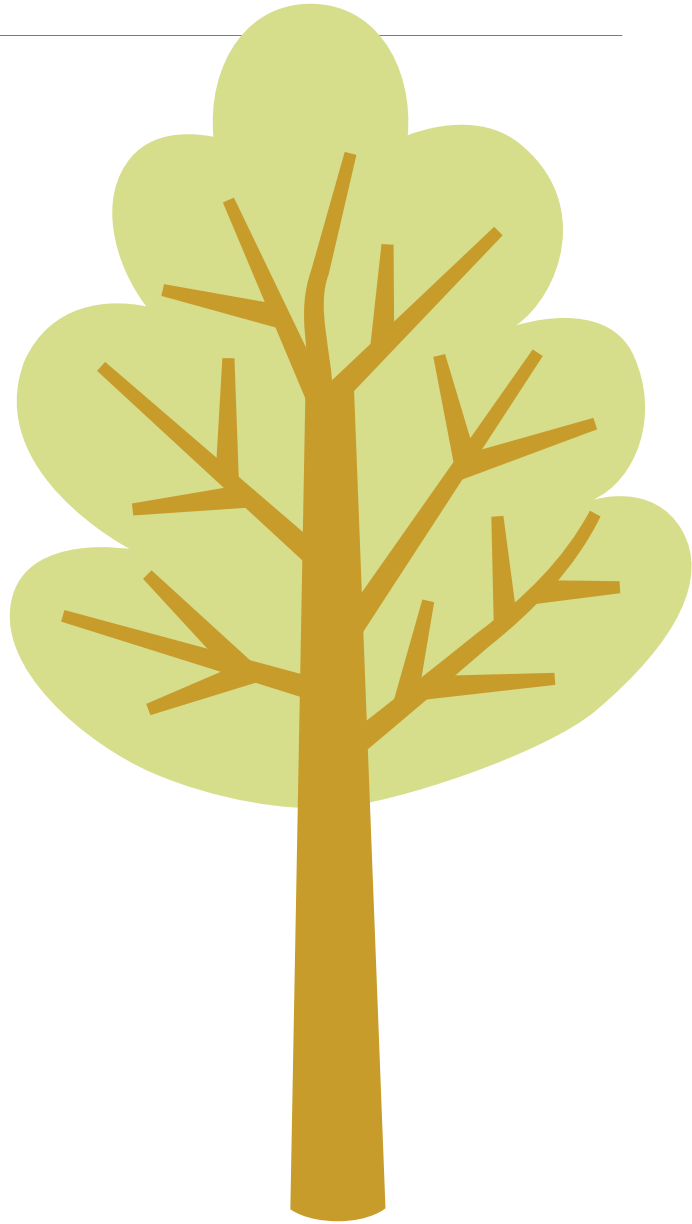
21.3% have increasing risk due to alcohol misuse

4 Economic case for prevention and early intervention

The National Institute for Health and Care Excellence (NICE) has examined the costs of ill health and advices that public health activities do save money by preventing premature death and reducing preventable diseases can boost the economy.

CIPFA estimates that £1 spent on prevention leads to savings of £5-6 to the public purse. It argues that this kind of "public pound multiplier" is due to the relatively inexpensive interventions that can mitigate the spiralling costs of acute care down the line. If this could be replicated throughout the NHS, the health service would eventually see a reduction in financial pressure.

Another study done by the Early Intervention Foundation shows that picking up the pieces from damaging social problems affecting young people such as mental health problems, going into care, unemployment and youth crime costs the Government almost £17 billion a year[8]. Their analysis finds that almost a third of this bill came from the annual £5 billion cost of looking after children in care. An estimated further £4 billion a year is spent on benefits for 18-24 year-olds not in education, employment or training (NEET) with another £900 million spent helping young people suffering from mental health issues or battling drug and alcohol problems.



8 http://www.eif.org.uk/publication/spending-on-late-intervention-how-we-can-do-better-for-less/

5 Opportunities for improving quality of care

The variation in quality of care across the NHS and the tools to address them have been published by the NHS Right Care programme. Together with the New Care Models, they are aimed to support the vision set out in the Five Year Forward View[9] with its focus on the transformation of healthcare services to drive improvements in quality and efficiency.

The table provides a list of common areas of improvement across a range of disease pathways in Lancashire. The data packs for individual CCGs in Lancashire can be accessed here: https://www.england.nhs.uk/resources/resources-for-ccgs/comm-for-value/nth-2016/#lan

Disease pathway	Common themes for improvement across Lancashire
Cancer (Breast, Colorectal and Lung)	Breast screening, Bowel Cancer screening, early diagnosis and starting definitive treatment within 2 months.
Diabetes	Control of blood pressure and cholesterol Retinal screening
Common mental health conditions	Improving access to psychological therapy completion and demonstrating reliable improvement
Heart disease	Control of hypertension and high cholesterol
Stroke	Treatment of Transient Ischaemic Attack within 24 hours Patients with stroke spending 90% of the stay in a stroke unit Emergency readmissions within 28 days of discharge
COPD	Improving the identification of people with COPD on GP registers Measuring FEV1 to assess COPD
Asthma	Emergency admissions for children and young people (0-18)
Musculoskeletal	Management of osteoporosis EQ5D health gain for people undergoing hip and knee replacement Emergency readmissions within 28 days of discharge following hip replacement
Trauma	Falls in elderly, emergency readmissions within 28 days of discharge following hip fracture
Renal	Percentage of people with chronic kidney disease on home dialysis Percentage of people with renal replacement therapy who have renal transplant
Maternity and early years	Many areas have worse outcomes e.g. under 18 pregnancy, smoking during pregnancy, breast feeding at 6-8 weeks, childhood obesity at reception age, AE attendances for under 5s

9 https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

5.1 Analysis of resources utilised in managing complex patients

Complex patients are individuals with multiple comorbidities that are likely to utilise most resources across programmes of care and the urgent care system. Understanding them can support local discussions in managing this cohort of the population via integrated care planning and supported self-management arrangements.

Nationally, it is estimated that 2% of patients comprise 15% of spend on inpatient admissions in 2013/14. Nationally the most common conditions of admissions for complex patients are circulation; cancer; and gastro-intestinal problems. Whilst this analysis only focuses on secondary care due to availability of data, it is expected that these patients are fairly representative of the type of complex patients who will require the most treatment across the health and care system. It is not possible to include analysis on mental health patients as they are not captured fully in these datasets.

Other key facts about the complex patients include:

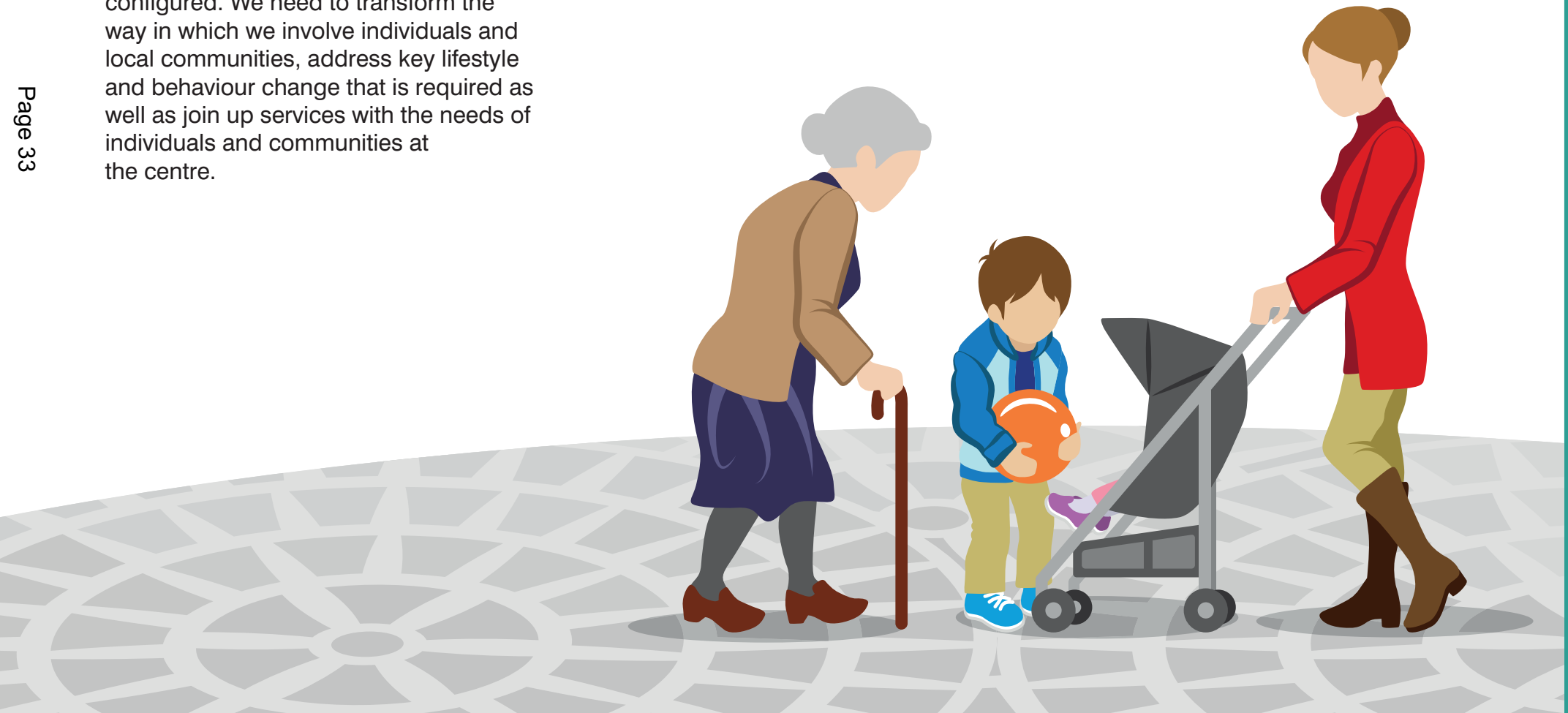
- The average complex patient has 6 admissions per year for three different conditions (based on programme budget categories).
- 59% of these complex patients are aged 65 or over; 37% of these complex patients are aged 75 or over
- 13% of these complex patients are aged 85 or over; 92% of the complex patients also had an outpatient attendance during the year. Those patients had 13 attendances a year on average.
- 81% of the complex patients also had an A&E attendance during the year. Those patients had 4 attendances a year on average.
- The proportion of CCG spend on the 2% of their most complex patients is provided in the table below:

CCG	Number of patients	Proportion of CCG spend on their 2% most complex patients	CCG Spend in £'000
Lancashire North	498	16.5%	10,299
Fylde and Wyre	522	15.6%	10,233
Greater Preston	689	16.4%	13,444
Chorley and South Ribble	589	16.5%	12,167
East Lancashire	1,249	16.8%	25,775
West Lancashire	393	16.4%	7,635
Total	3,940		79,553

6 The funding and efficiency gap

It is estimated that there will be a gap between patient needs and NHS resources of nearly £30 billion a year by 2020/21. In Lancashire, there is an estimated funding gap in excess of £805 million between NHS, adult social care and public health budgets. This gap means that we cannot continue to deliver the services as they are organised and configured. We need to transform the way in which we involve individuals and local communities, address key lifestyle and behaviour change that is required as well as join up services with the needs of individuals and communities at the centre.

The NHS Five Year Forward View focusses on preventing ill health, redesigning more productive services, harnessing innovation and technology, transparency in understanding the spending patterns and maximising the value of the NHS budget as the main ways of closing the funding gap.



7 Strategic Opportunities in Lancashire

In spite of the challenges in outcomes, quality and costs, there are positive developments happening across Lancashire to address these challenges. For example:

The NHS Five Year Forward View and the Sustainability and Transformation planning guidance has put prevention, a place based approach, and integration of health and social care at the centre. This is already emerging in the two Vanguard programmes (Lancashire North and Fylde and Wyre CCG areas) and similar programmes in other local health care economies.

Local Authorities and the wider public sector agencies are working more closely together. The formation of a Combined Authority will enhance the momentum in improving transport, housing and economic regeneration opportunities. This is a significant development towards reducing health inequalities.

Lancashire Constabulary, Office of the Police and Crime Commissioner, Lancashire Fire and Rescue Service, and the Lancashire schools forum have prioritised prevention and early intervention.

There is an enthusiastic VCFS sector and various new business models to mobilise individuals and communities for collective action on health and wellbeing are already emerging e.g. Lancashire time credits programme.

Lancashire County Council has put improving health and life chances of its residents at the heart of its evolving corporate strategy

8 Enabling innovation through our workforce and digital technology

8.1 A 21st Century workforce

As the public services reform and health and care integration takes hold, it is important to consider the skills and attributes of our workforce in Lancashire and beyond. The workforce needs to be enabled to make every contact with our residents count towards their wellbeing. This is particularly relevant for staff working with vulnerable and complex individuals and families where they need to act as the lead professionals. Research conducted by the Birmingham University has identified a series of characteristics which are associated with the 21st Century Public Servant[10].

We need to embrace these attributes when considering our workforce development plans across the public sector.

8.2 The 21st Century Public Servant

1 is a municipal entrepreneur, undertaking a wide range of roles
2 engages with citizens in a way that expresses their shared humanity and pooled expertise
3 is recruited and rewarded for generic skills as well as technical expertise
4 builds a career which is fluid across sectors and services
5 combines an ethos of publicness with an understanding of commerciality
6 is rethinking public services to enable them to survive an era of perma-austerity
7 needs organisations which are fluid and supportive rather than silo-ed and controlling
8 rejects heroic leadership in favour of distributed and collaborative models of leading
9 is rooted in a locality which frames a sense of loyalty and identity

10 http://www.birmingham.ac.uk/Documents/college-social-sciences/public-service-academy/21-century-report-28-10-14.pdf

8.3 Harnessing the power of digital technology

Personalised Health and Care 2020 is a framework for action by the National Information Board to use data and technology to transform outcomes for citizens and patients. It describes that in the airline industry 70% of flights are booked online and 71% of travellers compare more than one website before purchasing. A paper ticket was once a critical 'trusted' travel document, yet today around 95% of tickets are issued digitally as e-tickets. In Britain we use our mobile phones to make 18.6 million banking transactions every week; automation of particular services has helped cut costs by up to 20% and improved customer satisfaction. More than 22 million adults now use online banking as their primary financial service[11].

In 2014 59% of all citizens in the UK have a smartphone and 84% of adults use the internet; however, when asked, only 2% of the population report any digitally enabled transaction with the health and care services. There is also evidence that people will use technology for health and care, given the opportunity. There are 40 million uses of NHS Choices every month, of which some 5 million are views by care professionals who regard this service as a trusted source of information and advice. The internet-based sexual and general health service, Dr Thom (now part of Lloyds online), has seen 350,000 individuals sign up as users.

In Airedale, West Yorkshire, care home residents have quickly embraced an initiative that gives them the opportunity to tele-access clinicians from the local hospital over a secure video link. A reduction in local hospital admissions of more than 45% has been reported among that group of people.

Used appropriately, technology could help transform care via telehealth, telecare, mobile applications and social media, and by timely information sharing between care professionals. NHS FYFV and the Sustainability and Transformation Plan requires each area to develop a digital road map by June 2016.

11 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/384650/NIB_Report.pdf

9 Key actions to secure our health and wellbeing

We need to develop Lancashire as a County of Wellbeing. It involves addressing the wider determinants of health and wellbeing, mobilising individuals and communities to develop resilience, achieving sustainable behaviour and lifestyle changes, and joining up our services at neighbourhood level with the needs of the individuals and families at the centre.

The following recommendations are based on the analysis of the health outcomes and their determinants in Lancashire. They are aimed to promote wellbeing, prevent ill health and prolong quality of life. They cannot be solely achieved by a single organisation and therefore requires partnership working across Lancashire. They are intentionally broad and complement the start well, live well and age well elements of Lancashire's Health and Wellbeing strategy. They form the basis for public health action and the prevention efforts across the public services.

Implemented alongside other initiatives in the context of NHS Five Year Forward View and the Sustainability and Transformation Plan, they are highly likely to help achieve the Triple Aim in Lancashire. Progress on the recommendations will be reported in the subsequent reports of the Director of Public Health.

Create the conditions for wellbeing and health	
A	Ensure a best start in life for our children and young people, including systematically implementing the healthy child programme[12] across Lancashire.
B	Achieve year on year improvement on all the Marmot indicators for socioeconomic and environmental determinants of health.
C	Systematically proliferate the grass roots community development approaches that we have already got to mobilise and build community capacity to improve our resilience, health and wellbeing.
D	Promote healthy living environments by addressing the variation in road safety (particularly for children), housing standards and fuel poverty, and access to green space, cycling and walking paths across Lancashire.
E	Facilitate the development of a Dementia Friendly Lancashire by supporting the dementia friendly communities and programmes to support raising awareness, early detection and supporting people with dementia.

12 https://www.gov.uk/government/publications/healthy-child-programme-rapid-review-to-update-evidence

Enable Sustainable behaviour and lifestyle changes	
F	Continue to enable the citizens of Lancashire to adopt healthier lifestyles through a comprehensive behaviour change approach to tackle smoking, physical inactivity, obesity, alcohol consumption.
G	Promote workplace wellbeing by encouraging the businesses and other public sector bodies in Lancashire to adopt the workplace wellbeing charter.
Ensure we have a joined up public service to provide right care at the right time at the right place	
H	Adopt a neighbourhood based approach to identify and deliver care, paticulary in supporting the most vulnerable and complex individuals and families across all ages through a joined up targeted early help and crisis support across the public services sector.
I	Improve access to support emotional wellbeing of our children and young people and social isolation/loneliness in older people.
J	Support individuals with long term conditions and their carers with self-management tools to promote their independence and reduce emergency admissions.
K	Achieve continuous improvement on the quality of care and savings opportunities across the care pathways from prevention to end of life care, and supporting complex individuals as identified by the NHS Right Care programme.
Develop the right environment for public service innovation and improvement	
L	Develop a digital roadmap that embraces the opportunities presented by the digital technologies, internet and the social media to achieve the Triple Aim.
M	Support the development of core competencies for place based working across the public sector workforce, including their ability to make every contact count to improve the wellbeing of the residents and communities they serve.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Lancashire Health and Wellbeing Board
Meeting to be held on 13 June 2016

Lancashire and South Cumbria Sustainability & Transformation Plan update
Contact for further information:
Samantha Nicol, Healthier Lancashire, 01253 951613, samanthanicol@nhs.net

NOTE - If Part II item insert (Not for Publication - Exempt information as defined in Paragraph (X) of Part 1 of Schedule 12A to the Local Government Act, 1972. It is considered that in all the circumstances of the case the public interest in maintaining the exemption outweighs the public interest in disclosing the information) - delete if not applicable

Executive Summary

In January 2016, Healthier Lancashire, which now incorporates South Cumbria was tasked with coordinating and facilitating the development of the Lancashire and South Cumbria Sustainability and Transformation Plan. Throughout the development, having the HWB engagement and support of the STP has always been important, therefore robust feedback continues to be sought, in order to ensure that the STP is covering the priority areas for Lancashire and South Cumbria and has the necessary reach and ambition required.

The purpose of this report is to provide the Health and Wellbeing Board with an update on the development of the Lancashire and South Cumbria Sustainability and Transformation Plan (STP). The original NHS England guidance regarding the STP which was published in December 2015, advised that STPs are approved by the Health and Wellbeing Board prior to the 30 June 2016 submission deadline. However, on Friday 20 May 2016, NHS England issued new guidance. An extract from this guidance is as follows:

"The plans that you submit on 30 June will form the basis for a face to face personal conversation with the national leadership in the NHS throughout July, and will be a key part of a subsequent managerial process to inform decisions about the geographical targeting of growth in the intervening years to 2020. Your submissions will therefore be work in progress, and as such we do not anticipate the requirement for formal approval from your boards and/or consultation at this early stage. We will, however, wish to be assured that your plans reflect a shared view from your leadership team where possible, based upon the needs of patients and taxpayers, and a robust plan to engage more formally with boards and partners following the July conversations."

Therefore, this report is an update of the system wide co-designed activities to develop the STP since December, rather than a final version of the STP requiring endorsement.

Recommendation/s

The Health and Wellbeing Board is recommended to:

- Note the contents of this report
- Provide any relevant comment on the Lancashire and South Cumbria STP

Lancashire County Council

Background

Introduction

NHS England in December 2015 issued their planning guidance '*Delivering the Forward View: NHS Planning Guidance 2016/17-2020/21'.* This document was authored by six national NHS bodies and sets out a clear list of national priorities for 2016/17 and longer term challenges for local systems, together with financial assumptions and business rules. The guidance reflects the settlement reached with the Government through its new Mandate to NHS England and that the Mandate, for the first time, is not solely for the commissioning system, but sets objectives for the NHS as a whole.

NHS England asked every health and care system to come together to create their own ambitious local plan for accelerating its implementation of the 5 Year Forward View. STPs are expected to cover the period between October 2016 and March 2021 and will be subject to formal assessment in July 2016. The NHS was asked to focus between December 2015 and June 2016 on delivering core access, quality and financial standards (ensuring sustainability), while planning properly for the next five years (sustainable transformation).

The Footprint and Accountable Leadership

On 29 January 2016 the Lancashire and Cumbria Clinical Commissioning Groups agreed to develop a Sustainability and Transformation Plan on a Lancashire and South Cumbria footprint and recognised Healthier Lancashire as the vehicle, through which the planning activities would be undertaken. Dr Amanda Doyle, Chief Clinical Officer, Blackpool CCG had already been nominated as the Chief Officer for Healthier Lancashire and as such, was supported by the organisations of the Lancashire and South Cumbria footprint to be one of the 44 STP leads nationally. The announcement of this was made by NHS England in March 2016.

First Iteration of the STP

On 15 April 2016, the first draft of the Lancashire and South Cumbria STP was submitted to NHS England and subsequently circulated to the Healthier Lancashire and South Cumbria stakeholder organisations, for information. It is appended to this report for completeness.

The information contained in the first draft submission was taken from the Alignment of the Plans Report and the Healthier Lancashire Five Year Forward View, in addition to other documents or sources of information that had already been collaborated on and agreed by the stakeholder organisations.

NHS England Review

At the beginning of May, the 44 STP leads were invited to face to face meetings with NHS England and NHS Improvement, amongst other national arm's length bodies. Dr Doyle attended the meeting in Leeds and was supported by a mix of health and social care colleagues across the footprint.

The initial feedback was supportive, particularly in relation to the collaborative work already undertaken through Healthier Lancashire. NHS England however, emphasised the need for the STP to clearly set out the shared ambition for radical change across the footprint to bring about sustainable and financially viable health and care services by 2020/21.

Second Iteration of the STP

This feedback will be reflected in the next iteration of the STP, which is due to be drafted and submitted to NHS England by 30 June. It had been expected that this would be the final version of the STP, but it has been recognised by NHS England that an agreed Case for Change will further strengthen the STP submission and will enable us to clearly articulate the radical ambitions across the patch for a future health and care system by 2020, therefore there will be a further update to the STP in October 2016.

As a consequence, the Health and Wellbeing Boards and stakeholder organisations are now continuing to be engaged and involved in the discussion and development of the STP, rather than, at this stage, being asked to support, or endorse it.

Update on the development of the Case for Change

The Healthier Lancashire and South Cumbria Programme are facilitating the development of the Case For Change and the Lancashire and South Cumbria system is being supported by Ernst Young to undertake this work and will ensure that there is a robust evidence based description of the challenges (and causes) across the system and that includes the disconnect currently between organisations, the local system and STP footprint objectives and those challenges. The Case for Change will also begin to set out where the opportunities are and to provide a robust evidence base of hypotheses and how these fit together, as a way of establishing the potential options for radical change to improve the health outcomes of our population(s) and to ensure sustainable health and care services.

Priorities for the future

These hypotheses will be used to set the scope of the Healthier Lancashire and South Cumbria Programme and as a basis on which to undertake the co-design and co-production of solutions. The areas of focus are:

- Primary Care
- Urgent and Emergency Care and 7 day hospital services
- New Care Models
- Cancer
- Mental Health
- Learning Disabilities
- Digital health
- Prevention
- Supporting people to manage their own health, wellbeing and care
- Provision of acute care

A key principle of the Healthier Lancashire and South Cumbria Programme is co-design, once the Case for Change has set out the main hypotheses then the Programme will ensure the solution designs focus on co-designing proposed solutions based on achieving required quality standards and fitting within agreed guidelines. There is an urgent need to speed up the pace of change and focus on delivery in these areas, in addition to a national ambition for us to come up with radical and significant solutions to address the triple aims (care and quality, finance and efficiency and health and wellbeing gap).

The STP submitted in June will reflect the outcomes of the Ernst Young Case for Change work and it will assure NHS England of the robust process that the Case for Change will be used to engage not only the NHS, local authority and voluntary organisations in agreeing

that radical change is necessary, in respect of a clear set of shared and consistently owned challenges. It will be the opportunity to engage the staff and the wider public and their political representatives in being involved in working together, bringing their perspectives to the production of solutions, that can be robustly aligned around a single set of collaborative objectives. These objectives will include ensuring that the health outcomes of the population are measurably improved by 2020; that the health and care system is able to do this within their given financial resource envelope and that these are enabled through focus on agreed, evidenced care quality standards that drive and guide the redesign of the health and care system.

Ongoing review and challenge by NHS England

During July, the STP Chief Officers and their footprint colleagues will again have the opportunity to discuss the scale of ambition set out in their STPs with NHS England and NHS Improvement.

Next steps

It is now expected that the third, and final, iteration of the STP will be required in October 2016. The Case for Change will be utilised at pace to agree a future system model and to mobilise the work required, with a strong focus on delivery of our ambitions set out in the STP and surrounding the 10 priority areas.

Conclusions

The STP continues to be an iterative process between the Lancashire and South Cumbria footprint and NHS England. The development of the detailed content through the collaborative work of the Healthier Lancashire and South Cumbria Programme, will be built around the 10 areas of focus as outlined in section 5.7, focusing on both health and social care services.

List of background papers

N/A

Reason for inclusion in Part II, if appropriate

N/A

This report should be no more than **two** pages in total but may provide links to more detailed information and papers.