Lancashire Health and Wellbeing Board

Lancashire County Council

Lancashire Health and Wellbeing Board
Tuesday, 28 January 2020, 2.00 pm,
Committee 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. Welcome, introductions and apologies	Action	To welcome all to the meeting, introduction and receive apologies.	Chair		2.00pm
2. 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		
3. Minutes of the Last Meeting held on 19 November 2019	Action	To agree the minutes of the previous meeting.	Chair	(Pages 1 - 8)	
4. Action Sheet and Forward Plan	Update	To note the action updates from the previous meeting and the forward plan for future meetings.	Chair	(Pages 9 - 12)	

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

Agenda Item	Item for	Intended Outcome	Lead	Papers	Time
PART A					
5. Review of Lancashire Health and Wellbeing Board	Discussion	To receive a verbal update further to the evaluation of questionnaire feedback, discuss and agree a way forward on strengthening the role of the Health and Wellbeing Board and its' relationship with the Integrated Care System Board.	Clare Platt	(Verbal Report)	2.10pm
6. Integrated Care System, including Population Health Priorities	Decision	To receive, discuss and endorse the Integrated Care System Strategy and confirm commitment to the Population Health Plan priorities.	Andrew Bennett Dr Sakthi Karunanithi	(Pages 13 - 54)	2.40pm
7. Advancing Integration by Delivering the Intermediate Care Strategy	Decision	To receive an update on progress on Intermediate Care and confirm joint commitment.	Louise Taylor	(Pages 55 - 58)	3.20pm
8. Director of Public Health Report 2019/20 - Investing in our Health and Wellbeing	Decision	To receive, discuss and endorse the annual report of the Director of Public Health and confirm joint commitment to reduce levels of infant mortality in Lancashire.	Dr Sakthi Karunanithi Ruksana Sardar-Akram	(Pages 59 - 110)	3.50pm
PART B					
9. Lancashire Special Educational Needs and Disabilities Improvement Programme - Progress Report	Information	To receive a progress report on the Special Educational Needs and Disabilities Improvement Plan 2019.	Sian Rees	(Pages 111 - 114)	4.20pm

Agenda Item	Item for	Intended Outcome	Lead	Papers	Time
10. 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		4.25pm
11. Date of Next Meeting	Information	The next scheduled meeting of the Board will be held at 2pm on 17 March 2020 in the Duke of Lancaster Room – Committee Room 'C' at County Hall, Preston.	Chair		4.30pm

L Sales
Director for Corporate Services

County Hall
Preston

Lancashire Health and Wellbeing Board

Minutes of the Meeting held on Tuesday, 19th November, 2019 at 2.00 pm in Committee Room 'C' - The Duke of Lancaster Room, County Hall, Preston

Present:

Chair

County Councillor Shaun Turner, Lancashire County Council

Committee Members

Denis Gizzi, Chorley and South Ribble CCG and Greater Preston CCG
County Councillor Keith Iddon, Lancashire County Council
County Councillor Phillippa Williamson, Lancashire County Council
Dr Sakthi Karunanithi, Public Health, Lancashire County Council
Ian Crabtree, Adult Social Care, Lancashire County Council
Sian Rees, SEND, Lancashire County Council
Dr John Caine, West Lancashire CCG
Kelly Short, Morecambe Bay CCG
Roger Parr, East Lancashire CCG
Suzanne Lodge, North Lancashire Health & Wellbeing Partnership
Adrian Griffiths, Lancashire Teaching Hospitals Foundation Trust
Gary Hall, Lancashire Chief Executive Group
Stephen Ashley, Lancashire Children's Safeguarding Assurance Partnership, Lancashire Adult Safeguarding Board
Councillor Bridget Hilton, Central District Council
Cllr Viv Willder, Fylde Coast District Council
Councillor Margaret France, Central Health and Wellbeing Partnership
Adrian Leather, Third Sector
Tammy Bradley, Housing Providers
Joanne Moore, Lancashire Care Trust
David Blacklock, Healthwatch
Clare Platt, Health, Equity, Welfare and Partnerships, Lancashire County Council
Sam Gorton, Democratic Services, Lancashire County Council

Apologies

County Councillor Graham Gooch	Lancashire County Council
Stephen Young	Growth, Environment, Transport and Community Services, Lancashire County Council
Greg Mitten	West Lancashire Health and Wellbeing Partnership
David Russel	Lancashire Fire and Rescue Service
Peter Tinson	Fylde and Wyre CCG

1. Welcome, introductions and apologies

The Chair welcomed all to the meeting.

Apologies were noted as above.

Replacements for the meeting were as follows:

County Councillor Keith Iddon for County Councillor Geoff Driver CBE, Lancashire County Council
Roger Parr for Julie Higgins, East Lancashire Clinical Commissioning Group
Ian Crabtree for Louise Taylor, Lancashire County Council
Sian Rees for Edwina Grant OBE, Lancashire County Council
Kelly Short for Dr Geoff Jolliffe, Morecambe Bay Clinical Commissioning Group
Adrian Griffiths for Karen Partington, Lancashire Teaching Hospitals Foundation Trust

Apologies were also received from Dominic Harrison and Councillor Mohammed Khan from Blackburn with Darwen Council.

2. Disclosure of Pecuniary and Non-Pecuniary Interests

There were no disclosures of interest in relation to items appearing on the agenda.

3. Minutes of the Last Meeting and Matters Arising

Resolved: That the Board agreed the minutes of the last meeting.

4. Action Sheet and Forward Plan

Resolved: That the Board noted the actions from the last meeting, along with items for the Board's consideration at future meetings as detailed on the forward plan.

5. Healthwatch Lancashire

Sue Stevenson, Chief Operating Officer, Healthwatch Lancashire provided a summary of the findings from the Focus Groups on the NHS Long Term Plan. Lancashire and South Cumbria Integrated Care System wanted to ensure that the needs of those with complex health conditions were being addressed by recent developments within the healthcare system. Healthwatch Cumbria, Healthwatch Lancashire, Healthwatch Blackburn with Darwen and Healthwatch Blackpool were asked to conduct focus groups that targeted certain priority groups. The priority groups were identified by the local Integrated Care Partnership and Clinical Commissioning Groups.

The presentation demonstrated how the individual views and experiences of people gathered by Healthwatch could provide rich intelligence and real insight into how services could be improved from the perspective of service users.

The Focus Groups took place between June and September 2019. The priority groups were:

- Aged 18-65 with a mental health condition
- Living in areas of high deprivation
- Living in rural areas
- Of working age

- With a long term medical condition
- Who were military veterans
- Who were older, transgender persons
- Suffering from frailty
- With dementia
- One group of older residents and one group of younger residents

The groups were asked to focus on the following key areas:

- Changes and developments to the health care system
- Feedback on Associate Physicians
- Inclusion
- Communication
- Links between different services
- Mental health
- Primary Care Networks
- Community Services

The Board received the feedback on the key areas that were discussed by the priority groups and discussed ways forward. The Board agreed it needed to hold the Integrated Care System to account and be aware of what each service was doing with regarding this. Communication was still a major issue within organisations and how residents were communicated with, should be more user-friendly. Again the biggest challenge was financially and decisions were still being made within individual organisations unaware of the consequences across the piste and learning needed to be shared across the system. Communities also needed to come together and help each other and organisations should be offered to communities to help them set this up.

Resolved: That the Health and Wellbeing Board:

i) Noted the key messages from the Focus Groups including:
   - The level of understanding about the health and care system and its on-going changes.
   - What was working well and less well.

ii) Considered how Healthwatch could further assist Lancashire Health and Wellbeing Board ensure that more people were engaged and involved more people in shaping local services. As a consequence it was agreed that the Chair, on behalf of the Board, engage with the Integrated Care System and Integrated Care Partnerships to request their response to the report and identify actions they intended to take; with a view to bringing findings back to a future Board meeting and that the Health and Wellbeing Strategy be revisited in light of the report to inform Board agendas and activity going forward.

6. Transforming Care - In Patient Provision and the Learning Disabilities Mortality Review (LeDeR)

Rachel Snow-Miller, Director of Commissioning – All Age Mental Health and Learning Disability Services, Lancashire and South Cumbria Integrated Care System and Sue Hastewell-Gibbs, Clinical Lead for Transforming Care, NHS England and NHS Improvement (North) presented to the Board an update on Transforming Care – Learning Disabilities Mortality Review (LeDeR).

The report updated the Board on the findings of the 3rd Annual National Mortality Review report and this had been implemented locally and to highlight the health inequalities suffered by people with Learning Disability and/or Autism across Lancashire and South Cumbria.

The Learning Disability Mortality Review (LeDeR) programme was established in June 2015 in response to significant ongoing concerns about the likelihood of premature deaths of people with learning disabilities.

In Lancashire and South Cumbria the estimated number of deaths of people with learning disabilities is 102 per year. The local challenges include a lack of reviewers across health and social care, lack of awareness of the Learning Disability Mortality Review programme and provider sign up.

To date, Blackpool Teaching hospital has implemented learning disability awareness training within the Adults Community division as a direct consequence of the learning from some Learning Disability Mortality Reviews together with development of two, seven minute briefings on reasonable adjustments and capacity/consent for sharing with all staff in the division/trust. There were also plans to review the Speech and Language/dysphagia processes in place in the Trust.

Priorities for Lancashire and South Cumbria going forward are:

- Commence and complete the backlog project by March 2020.
- Develop a communication plan to raise awareness of the Learning Disability Mortality Review programme across the Integrated Care System.
- Support learning into action.
- Work with Public Health England to explore key focus areas for action.

Resolved: The Health and Wellbeing Board:

i) Supported the implementation of learning into action across Lancashire and South Cumbria.
ii) Supported the focus on reasonable adjustments being made in relation to people with Learning Disability and/or Autism across the region.
iii) Supported communication of the Learning Disabilities Mortality Review (LeDeR) programme across the region.

7. Lancashire Special Educational Needs and Disabilities (SEND) Partnership

Sian Rees, Improvement Partner, Special Educational Needs and Disabilities presented the Board with an update report on the assessment of progress on the Improvement Plan and Accelerated Plans.

Following the inspection which was carried out by Ofsted and the Care Quality Commission in November 2017 there were two fundamental failings and twelve areas of significant concern identified.

Partners in Lancashire were required to produce a Written Statement of Action, setting out the immediate priorities for action. Progress on the implementation of these actions had been monitored by the Department for Education (DfE) and NHS England. The Written Statement of Action had been updated and any ongoing actions included in the Special Educational Needs and Disabilities Partnership Improvement Plan for the period April 2019 to December 2020.

On the Improvement Plan, there were five delayed actions. Of these the review of the Personal Budget policy was expected to be completed in November 2019; the improved Local Offer site was soft launched on 10 October 2019; the development of a Special Educational Needs and Disabilities Sufficiency Strategy and work with post-16 providers to develop Special Educational Needs and Disabilities provision had commenced.

Of those actions yet to commence there was risk of delay with one action due in January 2020 i.e. to review the access criteria for support from the Children with Disabilities Social Work team. This was as a result of capacity.

On the Accelerated Plans, there were five plans in total; four were on track. These were focused on: improving the quality of Education Health and Care Plans; improving education outcomes; implementing the Neuro-developmental Pathway and the process of transition from Children's Social Care to Adult Services. The fifth plan to improve the accessibility of and information on the Local Offer was delayed - the soft launch of the new site took place on 10 October 2019 and information continued to be updated and revised. The full launch, supported by promotion, would take place in January 2020 followed by user testing.

Resolved: The Health and Wellbeing Board:

i) Noted the delay in the re-visit from Ofsted.
ii) Considered the report on progress to date in delivering the actions in the Special Educational Needs Improvement Plan and the Accelerated Plans.

8. Pan-Lancashire Health and Wellbeing Board

The Local Government Association facilitated an event on 9 October 2019 at Winter Gardens, Blackpool on the possible collaboration between Lancashire, Blackpool and Blackburn with Darwen Health and Wellbeing Boards. The event was attended by a range of key Board members from all three Health and Wellbeing Boards.

Overall, there was no consensus in terms of either developing a single Health and Wellbeing Board or coming together as an alliance or collaboration.

The facilitators identified two key actions:

i) That a smaller representative group across the Pan Lancashire system come together to explore the transformational opportunities that could be achieved by working at a Pan Lancashire level with clear proposals that could then be tested with partners to establish commitment to take the next steps.
ii) That development work takes place in each of the three Health and Wellbeing Boards to help identify the strengths of current working and identify where there might be areas for improvement. This would include looking at how each partnership board was clear about its role, purpose and focus and how this would be communicated and owned.

Subsequently, County Councillor Turner had had discussions with Councillor Khan (chair of Blackburn with Darwen Health and Wellbeing Board) and Councillor Cain (chair of Blackpool Health and Wellbeing Board). Although there was no consensus in terms of function of form or any pan Lancashire arrangements and commitments to retain current structures, it was agreed that:

i) Officers be requested to map out current health and wellbeing partnership arrangements, to understand how they related to each other.
ii) Officers be requested to organise a meeting of the three Boards to consider a joint response to the Integrated Care System Strategy Delivery Plan (including population health plan) once it had been agreed by the Integrated Care System Board.

In terms of the Lancashire Board, members had been sent a questionnaire by County Councillor Turner, to consider the strengths of the current arrangements and opportunities for improvement.

Cumbria were also involved in talks in working together on a Pan-Lancashire basis and wished to be linked in however, wanted the Pan-Lancashire Board establishing first.

Resolved: That the Board be requested to complete the questionnaire by 30 November 2019.

9. Urgent Business

There were no items of urgent business received.

10. Date of Next Meeting

The next scheduled meeting of the Board would be held on Tuesday, 28 January 2020 in the Duke of Lancaster Room – Committee Room 'C', County Hall, Preston.

L Sales
Director of Corporate Services

County Hall
Preston

Lancashire Health and Wellbeing Board

Actions, November 2019

Action topic	Summary	Owner
Healthwatch Lancashire	The Board: • Considered how Healthwatch could further assist Lancashire Health and Wellbeing Board ensure that more people were engaged and involved more people in shaping local services. As a consequence it was agreed that the Chair, on behalf of the Board, engage with the Integrated Care System and Integrated Care Partnerships to request their response to the report and identify actions they intended to take; with a view to bringing findings back to a future Board meeting and that the Health and Wellbeing Strategy be revisited in light of the report to inform Board agendas and activity going forward.	Chair
Pan-Lancashire Health and Wellbeing Board	The Board: • Requested to complete the questionnaire by 30 November 2019.	Health and Wellbeing Board members

Lancashire Health and Wellbeing Board

Forward Planner

Date of Meeting	Topic	Summary	Owner
March 2020	Individual Patient Activity Programme	To receive the Individual Patient Activity Programme Board report from the Joint Commissioning Clinical Commissioning Group.	Jerry Hawker
March 2020	Voluntary Community and Faith Sector Strategy	To receive the VCFS Strategy.	Lynne Johnstone
March 2020	Commissioning Reform	To receive a report on the Commissioning Reform.	Louise Taylor
March 2020	Better Care Fund	To receive an update on the Better Care Fund.	Paul Robinson
March 2020	Child Death Overview Panel	To receive a summary of the Annual Report.	Dr Sakthi Karunanithi
March 2020	Lancashire Special Educational Needs and Disabilities Partnership – SEND Improvement Plan **(Standing Item)**	To receive a progress update on the Special Educational Needs and Disabilities Improvement Plan 2019 (updated Written Statement of Action).	Sian Rees
March 2020	Quality Assurance Reports **(Standing Item)**	To receive reports from external audit agencies with multi-agency County wide implications	Various
May 2020	Residential and Nursing Home Markets in Lancashire	To receive a report on the capacity, quality and challenges.	Lisa Slack Louise Taylor
TBC	Review Morecambe Bay Plan: Improving Health, Care and Wellbeing	To receive an update about the Integrated Care Partnership plan	TBC
TBC	Review Fylde Coast Plan: Improving Health, Care and Wellbeing	To receive an update about the Integrated Care Partnership plan	TBC

Appendix A

Lancashire Health and Wellbeing Board
Meeting to be held on 28 January 2020

Integrated Care System Strategy and Population Health Plan Priorities

Contact for further information:
Andrew Bennett, Executive Director for Commissioning, Integrated Care System, Lancashire and South Cumbria, andrew.bennett5@nhs.net
Dr Sakthi Karunanithi, Director Public Health and Wellbeing, Lancashire County Council,
Tel: 01772 537065, sakthi.karunanithi@lancashire.gov.uk;

Executive Summary

The draft Integrated Care System (ICS) Strategy (Appendix A) has recently been discussed by the Integrated Care System Board. The draft strategy identifies the Population Health Plan priorities:

- Best start in life
- Healthy Behaviours
- Zero Suicides
- Neighbourhood Development
- Work and Health

These are aimed at improving the health and wellbeing outcomes of our communities. A system wide approach to develop the Implementation Plan is under way, managed through the Population Health Steering Group of the Integrated Care System.

Recommendations

The Health and Wellbeing Board is requested to:

(i) Receive, discuss and endorse the draft Integrated Care System Strategy.
(ii) Confirm commitment to the Population Health Plan priorities identified in the draft Strategy.
(iii) Engage with and support the development of the Integrated Care System Population Health Implementation Plan.
(iv) Endorse the alignment of the existing population health and prevention activity across the Integrated Care System work streams and Integrated Care Partnership/Multispeciality Community Provider plans.

Background

1. Draft Strategy and Population Health Priorities

1.1 The draft Integrated Care System (ICS) Strategy (Appendix A) has recently been discussed by the Integrated Care System Board. The vision identifies the following ambitions:

- Healthy communities

Lancashire County Council

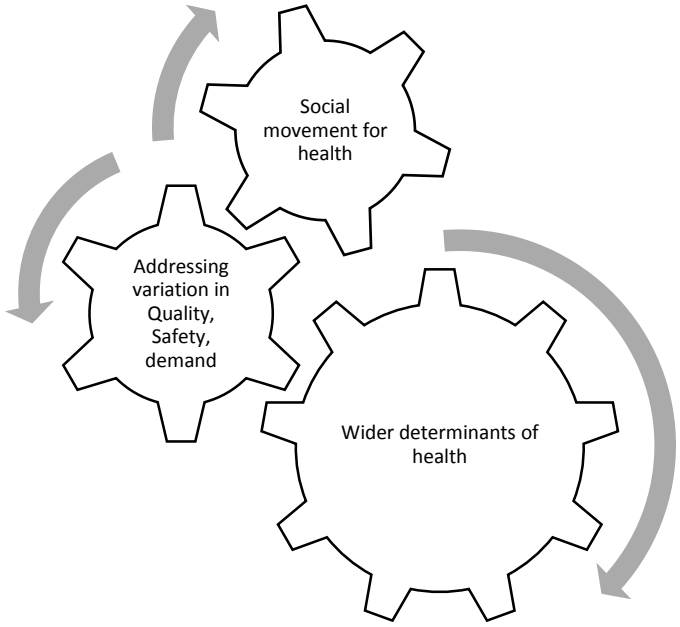
- High quality and efficient services
- Health and care service that works for everyone, including our staff

The strategy also identifies the Population Health Plan priorities, which are aimed at improving the health and wellbeing outcomes of our communities. Our overarching Population Health ambition is to achieve best health for all, with a focus on reducing health inequalities. The ambitions and objectives are informed by the latest national and local data and evidence based practice of what good looks like. The strength is our focus in places and neighbourhoods. We are building on a range of successful collaborations we already have across our system.

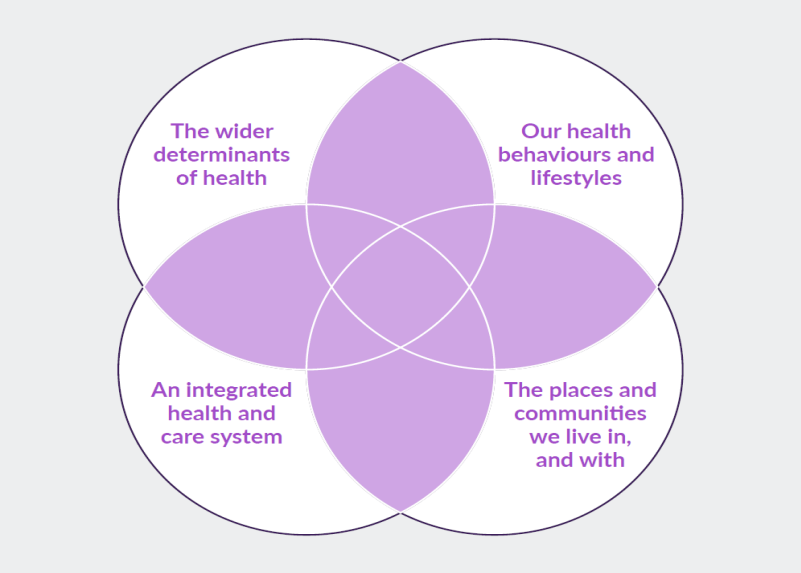
1.2 The Lancashire and South Cumbria Integrated Care System Board signed off our population health framework that incudes our organising principles, strategic objectives and theory of change for improving health and care at scale in February 2018. These are aligned to the priorities identified by the four Health and Wellbeing Boards.

1.3 Our organising principle is to embed prevention in everything we do and provide place based, person centred care, by working with our residents.

1.4 Our theory of change for improving health and care outcomes at scale is illustrated below.



1.5 Our framework for population health is based on The Kings Fund Population Health Framework as well as Public Health England's (PHE) toolkit for place-based approaches to reduce health inequalities. This includes action to improve the wider determinants of health, healthy behaviours and lifestyles, the places and neighbourhoods we live in, and delivering person centred care.



The King's Fund. A vision for population health: Towards a healthier future. 2018. Available from: https://www.kingsfund.org.uk/publications/vision-population-health.

The Population Health approach will be embedded across every level of our system level as follows:

- Integrated Care System – whole system setting of quality, standards and population level health and wellbeing campaigns.
- Integrated Care Partnerships/Multispeciality Community Provider – develop integrated population level prevention programmes tackling key health and care inequalities.
- Primary Care Networks – extend the Population Health Management accelerator to improve health outcomes and maximise the neighbourhood and community assets for local communities.

2. Five Key Population Health Priorities

Based on our analysis and building on our strengths, we have identified five key Population Health priorities for implementation in the next five years. We are in the process of developing robust delivery plans during 2019/20 in the following areas:

- Best start in life
- Healthy Behaviours
- Zero Suicides
- Neighbourhood Development
- Work and Health

Further details on each of these priorities can be found in the Integrated Care System Strategy (Appendix A).

3. What are we doing next?

3.1 Engaging with each Integrated Care Partnership (ICP)/Multispecialty Community Provider (MCP) and local authority teams, together with the Integrated Care System work streams, in developing the Population Health Implementation Plan, with the support from NHS England, Public Health England, Local Government Association and partners e.g. Innovation Agency and Universities.

3.2 As part of this a planning workshop on 'place based approaches to reducing inequalities' is being organised with support from Public Health England in February 2020.

3.3 Reviewing the governance, programme management capacity and coordination arrangements so that the Population Health programme is reset and aligned to the NHS Long Term Plan implementation.

3.4 Developing the first draft of the implementation plan by April 2020.

List of background papers

N/A

Healthier Lancashire & South Cumbria

DRAFT VERSION

Our Integrated Care System Strategy

Published January 2020

Working together to improve services and help people in Lancashire and South Cumbria live longer, healthier lives

Appendix A

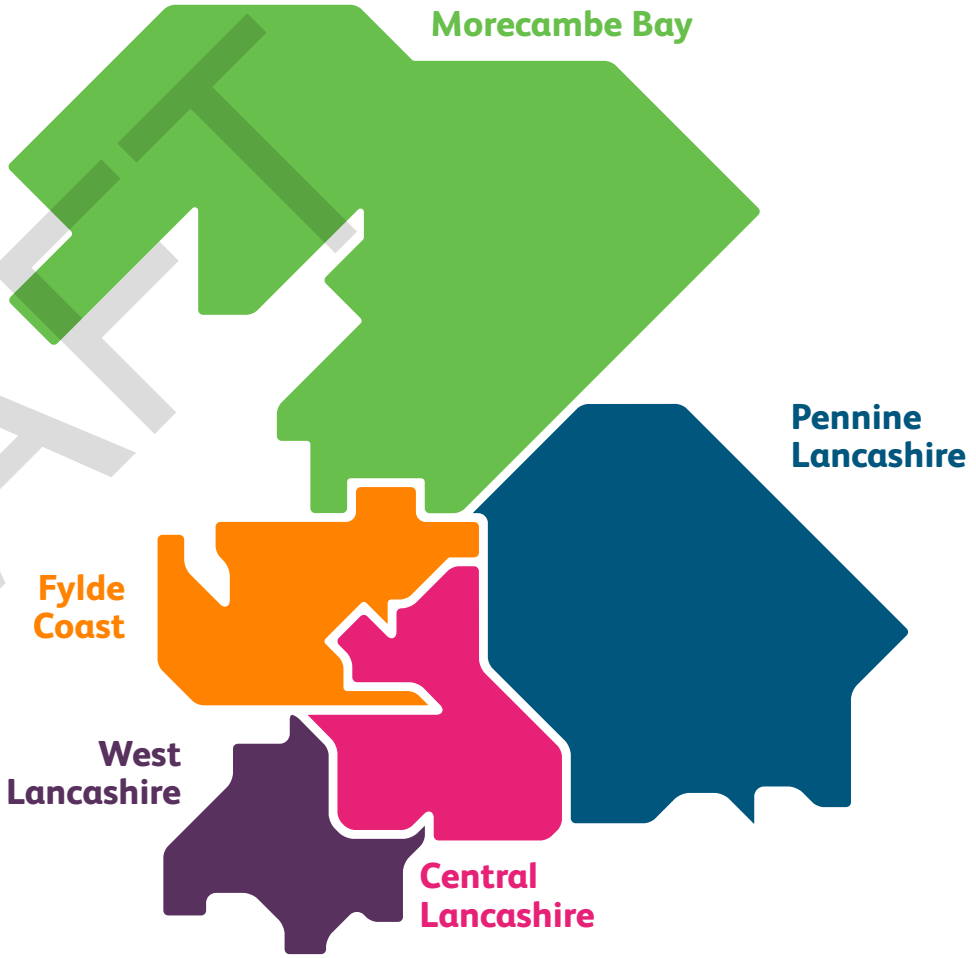
Welcome

We have an ambitious vision to empower and support healthy local communities, so that local people have the best start in life and can live and age well.

We are Lancashire and South Cumbria Integrated Care System (ICS), a partnership of NHS, local authority, public sector, voluntary, faith and social enterprise and academic organisations. We work together to join up health and care services, listen to the priorities of our communities, local people and patients and tackle some of the biggest challenges we are all facing.

Healthier Lancashire and South Cumbria is the name of our shared vision and five-year strategy for improving health and care services and helping the 1.8million people in Lancashire and South Cumbria live longer, healthier lives. To achieve this we will need to make difficult decisions about how and where our services are delivered and how we organise ourselves to achieve our aims as a partnership.

We have listened to local people and worked together to set out how we will deliver the aims of the NHS Long Term Plan and address the most urgent needs of our population.



Contents

This document is written for local people interested in developments in our health and care system, our staff and partners. It describes our plans for the future.

Our purpose – together we can make things better

The partnership of organisations working across the Integrated Care System have agreed a clear purpose for our work together.

This will happen in neighbourhoods, local places and across the whole of Lancashire and South Cumbria.

Our vision for Lancashire and South Cumbria is that communities will be healthy and local people will have the best start in life, so they can live longer, healthier lives.

Healthier Lancashire & South Cumbria

At the heart of this vision are the following ambitions:

We will have healthy communities

We will have high quality and efficient services

We will have a health and care service that works for everyone, including our staff

In your neighbourhood and community

- Health and social care will work together to support your social needs, physical and mental health and wellbeing
- You will be supported to care for yourself where you can, including using digital technology
- Community groups and local teams, including your GP, will work with you
- You will be encouraged to take an active role in managing your own health and wellbeing and to support others in your community

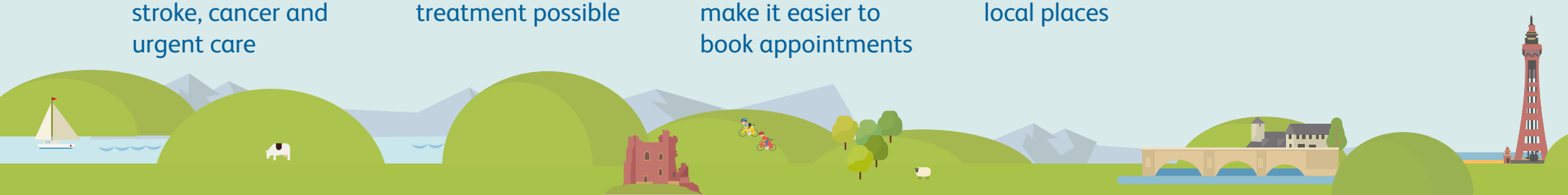
In your local area

- Most care will be locally delivered, managed and planned
- We will make the best use of all the expertise and staff skills available to us
- We will talk to you and your community about how best to provide care
- You know best what you and your community needs

Our vision for Lancashire and South Cumbria

Across Lancashire and South Cumbria

- We will work together on issues like mental health, stroke, cancer and urgent care
- Our hospitals will work together so you have the best treatment possible
- We will use technology to share health records and make it easier to book appointments
- As much of our finances as possible will be spent in local places
- We will manage our spending better



Tackling our biggest challenges together

Our partners across Lancashire and South Cumbria are committed to taking coordinated action to improve health and wellbeing, provide clinically sustainable services and to do this within available resources.

We need to accelerate changing the way we provide services across Lancashire and South Cumbria over the next four years.

We will take action as a partnership to:

- Reduce health inequalities
- Improve our performance on national targets, particularly for waiting times for urgent treatment, cancer services and routine surgery
- Provide more consistent, high quality care for everyone
- Deliver more care in our local communities
- Ensure good care at the end of life
- Make better use of our collective resources and stop overspending on our budgets.

To tackle these challenges, the partners across Lancashire and South Cumbria recognise that we need to change how services are provided to offer more joined-up, proactive care that is organised in neighbourhoods.

This change needs to be led by clinicians – including doctors, nurses and health professionals, who know that tailored and personalised care will support local people, carers and families to live healthier lives within their communities. We will fully involve local people and patients in changes to services.

This cannot be done without significantly changing the way organisations invest in, provide and manage the whole health and care system including GPs, A&Es, specialist centres, hospitals and care services.

A change in the way we use our resources is required to enable us to increase our focus on promoting good health and preventing illness as we work with local residents, as well as ensuring we can provide safe and effective treatment when people do become unwell. There are already dynamic examples of this starting to happen in Lancashire and South Cumbria.

There are currently a number of fragile services, which are unsustainable in their current form. The required workforce for the service structures simply does not exist. Despite a number of national and local workforce initiatives, the likelihood is that for the medium term the prospects for filling staffing vacancies remains poor. If the partnership does not change the way in which these services are organised, they will fail.

The evidence for financial unsustainability in some services is also clear. NHS trusts in Lancashire and South Cumbria are spending more than the income they receive, meaning that they are increasing their level of debt and spending money that should go to other parts of England.

Key facts about our population and communities

We now have a good understanding of our population's health and care needs.

It will enable us to provide the right services, in the right place, at the right time to improve care and ensure the best use of resources.

This will help us to plan care more effectively and deliver better results for local people.

Our population

National average

Population over 65 **19.9%**

Percentage of population over 65 is **19.9%**, national average for England is **18.2%**

One person households with people age 65+ **14%**

Number of one person households with people aged 65 or over is **14%**, national average for England is **12.4%**

Rural communities **20.4%**

Percentage of population in rural communities is **20.4%**, national average for England is **17%**

Reference details to be added here

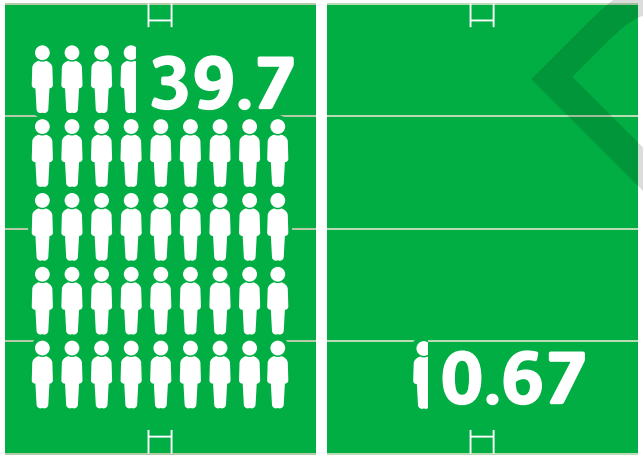
Our geography is varied across Lancashire and South Cumbria

The number of people per hectare (the size of a rugby pitch) is high in:

- Blackpool: **39.7**
- Hyndburn: **11.03**
- Blackburn with Darwen: **10.73**
- Preston: **9.99**

Compared to more rural areas:

- Wyre: **3.91**
- West Lancashire: **3.27**
- Lancaster: **2.49**
- South Lakeland: **0.67**



Deprivation

Nearly a third of our residents live in some of the most deprived areas across England.

The percentage of people living in fuel poverty and unable to afford to heat their homes, is higher than the national average: **13% for Lancashire and South Cumbria**, national average is 10.6%.

A significant proportion of children experience **adverse living conditions**, including child poverty. This leads to significant variation in their development and school readiness.

The percentage of children living in poverty ranges from a low of 12% to **as high as 38% in Lancashire and South Cumbria**, the national average is 30%.

13%

of people in Lancashire and South Cumbria are living in fuel poverty.

The national average is 10.6%.

Between

12 to 38%

of children in Lancashire and South Cumbria live in poverty.

The national average is 30%.

Reference details to be added here

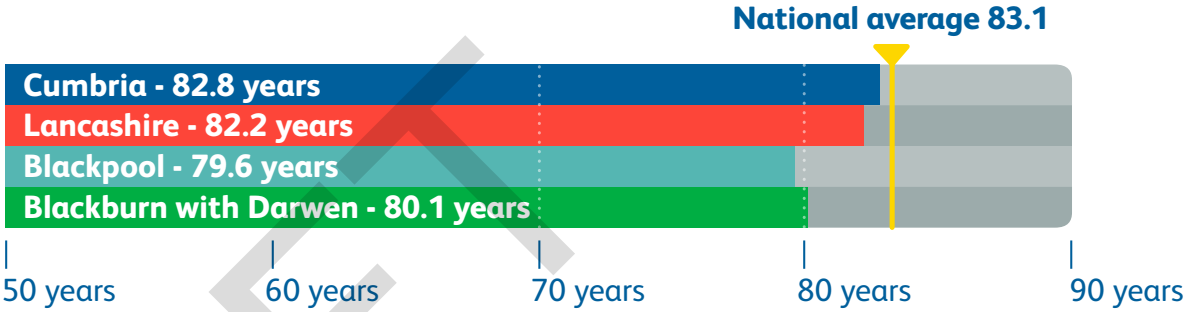
Life expectancy in Lancashire and South Cumbria is lower than the national average

There is a significant level of unwarranted variation in the number of years people can expect to live a healthy life.

Healthy life expectancy and disability-free life expectancy is predicted to be less than the expected state pension age of **68 years** for children born today.

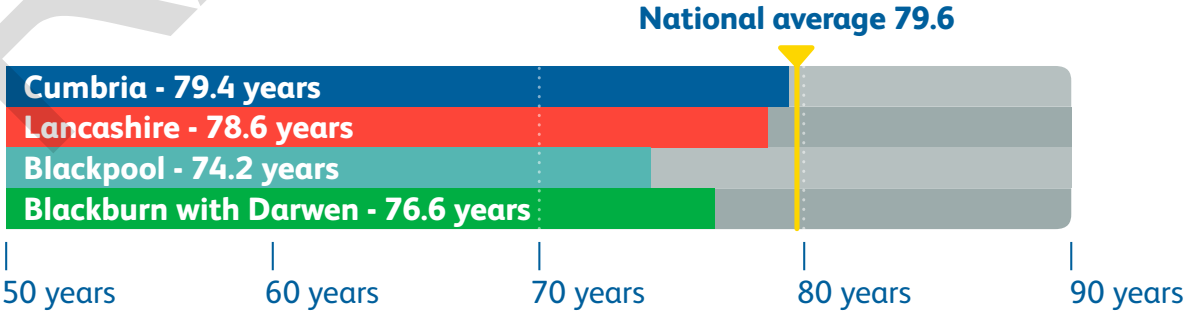
In some neighbourhoods, healthy life expectancy is just **46.5 years**.

Female life expectancy by council area



The number of years females **live in good health** is above the national average of **63.8 years** in Cumbria (**65.4 years**) and Lancashire (**64.5 years**). It is below the national average in Blackburn with Darwen (**58.6 years**) and Blackpool (**57.8 years**).

Male life expectancy by council area

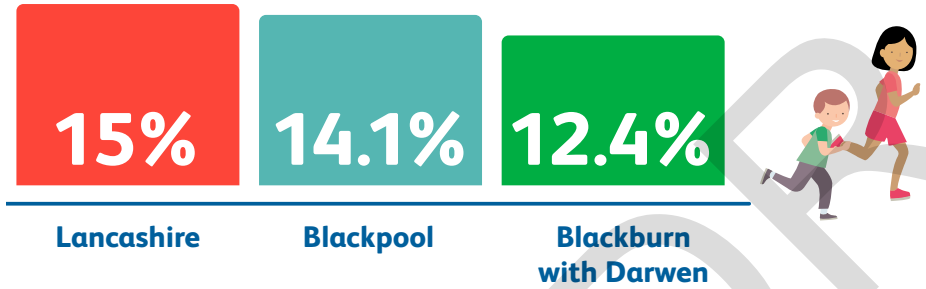


The number of years males **live in good health** is above the national average of **63.4 years** in Cumbria (**64.4 years**). It is below the national average in Lancashire, (**61.2 years**), Blackburn with Darwen (**57.3 years**) and Blackpool (**54.7 years**).

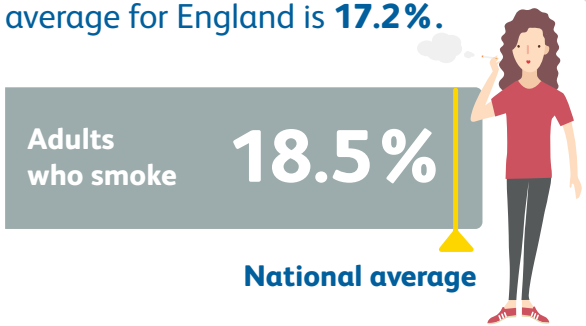
Health and wellbeing

Only around **a fifth** of adults are meeting the recommended levels of physical activity.

Much more needs to be done to encourage children to be active: just **15%** of young people aged 15 in Lancashire are meeting the recommended levels of physical activity, **14.1%** in Blackpool and **12.4%** in Blackburn with Darwen.



18.5% of adults smoke, the national average for England is **17.2%.**



The main causes of ill-health are cancer, cardiovascular, respiratory, mental health, and neurological conditions.

Suicide rates are significantly higher than average in Lancashire and South Cumbria, particularly in Barrow in Furness, Blackpool, Chorley and Wyre.

The estimated prevalence of common mental health disorders is higher than the England estimate.

Approximately

40%

of ill-health in Lancashire and South Cumbria is due to **smoking, physical inactivity, obesity** and **substance misuse**.

Reference details to be added here

Lancashire and South Cumbria health service performance

In 2018/19, we had:

358,590
NHS 111 calls

More than
7.5million
GP appointments

More than
330,000
attendances at A&E

281,173
local planned admissions for treatment or surgery

2,880,582
outpatient appointments

...with more than
697,022
missed appointments

211,315
emergency admissions

Reference details to be added here

The NHS in Lancashire and South Cumbria is spending more than the budget available to it

In 2020/21, the total budget for health services in Lancashire and South Cumbria is **£3,525million**.

Lancashire and South Cumbria receives around **10%** more per person in funding compared to the average for England because of the higher level of need in our communities.

Lancashire and South Cumbria will receive an average growth in funding of around **£150million** per year between 2019/20 and 2023/24.

In contrast, local authority funding for county councils and unitary authorities has reduced by **around 40%** over the last decade and growth for social care and public health budgets is uncertain.

Further work needs to be completed to create a plan that will see the health services in Lancashire and South Cumbria return to financial balance.

Our neighbourhoods and local areas

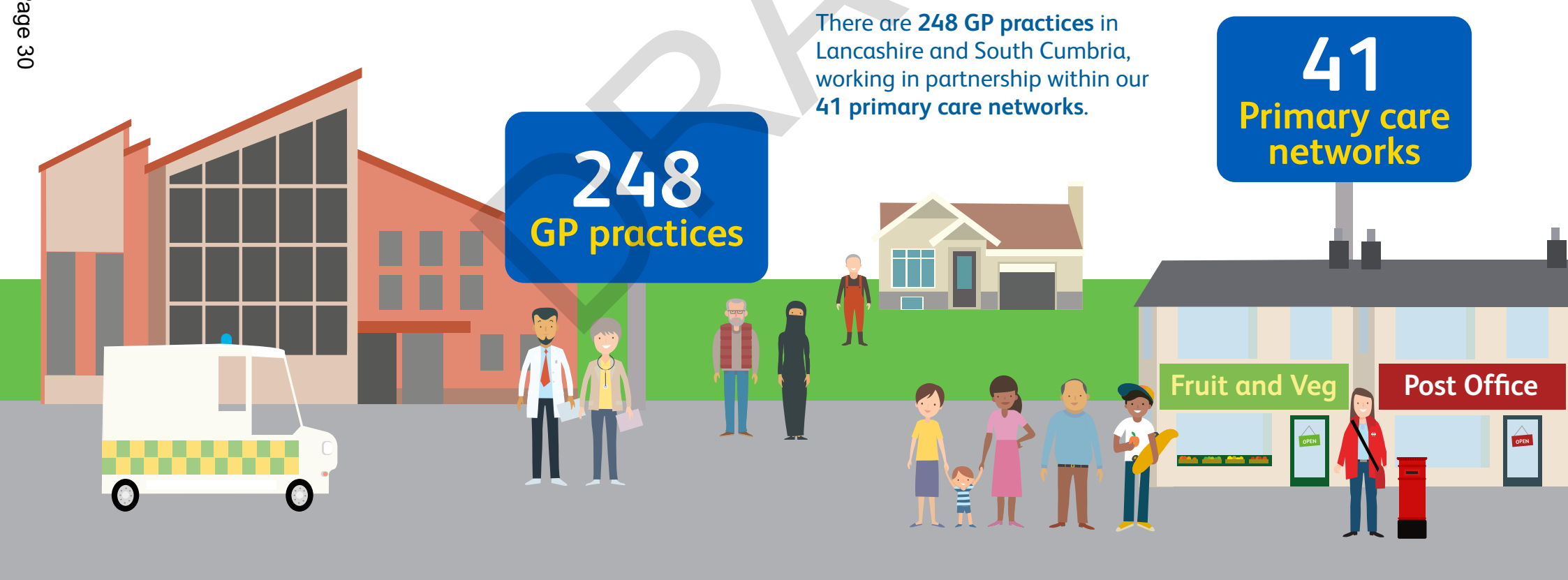
To respond to what we can see in our population statistics, we have looked at how we can address the needs of our local populations within our five local areas and all of our neighbourhoods.

About our neighbourhood approach

We are defining neighbourhoods as communities where all aspects of health and care services will come together: with local people, local authorities and voluntary and community organisations.

Within each neighbourhood is a primary care network, these are a key part of the NHS Long Term Plan and are based on populations of between 30,000 and 50,000. They build on the core of current primary care services and enable greater provision of proactive, personalised, coordinated and more joined-up health and social care within neighbourhoods.

There are **248 GP practices** in Lancashire and South Cumbria, working in partnership within our **41 primary care networks**.



Five local partnerships

There are five local health and care partnerships: Central Lancashire, Fylde Coast, Morecambe Bay, Pennine Lancashire and West Lancashire.

These local partnerships include primary care networks linked together with other care providers such as hospitals, care homes, mental health and community providers, local government, voluntary and community organisations – alongside health and care commissioners.

Together, these partnerships assess local need, plan how to use their collective assets and join up what they offer – including how to make best use of overall public and community resources.

You can find out more about the work of our five local partnerships at: **healthierlsc.co.uk/Local**

Numbers of people living in each area
Morecambe Bay: 352,000 people
Pennine Lancashire: 566,000 people
Fylde Coast: 354,000 people
Central Lancashire: 399,000 people
West Lancashire: 114,000 people
Total: 1,785,000 people live in Lancashire and South Cumbria

Source: NHS Digital. Figures as of December 2019.

Lancashire and South Cumbria Integrated Care System

The Integrated Care System is a partnership, which provides strategic leadership across our whole population.

The partnership includes:

- Local authorities
- NHS organisations
- Voluntary, community, faith and social enterprise organisations
- Academic institutions, such as our universities
- Public sector organisations, such as police and other emergency services
- Our local communities.

Involving local people

Our partners continue to work with, engage and involve local people in changes and new ways of delivering services in neighbourhoods, in local partnerships and across Lancashire and South Cumbria. We have listened to the feedback of local people as we have developed this five-year strategy.

Local people have told us

- They were not aware and did not recognise the changes and developments that are being made to the health and care system
- They are positive about the inclusivity of the vision but raised concerns over a focus on the elderly at the expense of younger people
- Opinion was divided over whether changes to the health and care system were a positive development, although it was evident that understanding of primary care networks and local partnerships and how they work is low
- They felt positive about links being formed between different healthcare services
- They felt positive about work taking place in some of our neighbourhoods where communities, health and care services and local organisations are working together
- They are positive about intentions to improve community services
- They feel there is a lack of support for mental health issues and lengthy waits for referrals.

Read more about our engagement with local people at **healthierlsc.co.uk/GetInvolved**

We value this feedback and have used it to shape this strategy and how we will deliver partnership working across Lancashire and South Cumbria. We are committed to continue to involve people and put them at the centre of everything we do as a partnership.

To get involved and find out what is happening in your local area, visit **healthierlsc.co.uk/Local**

Integrating health and care

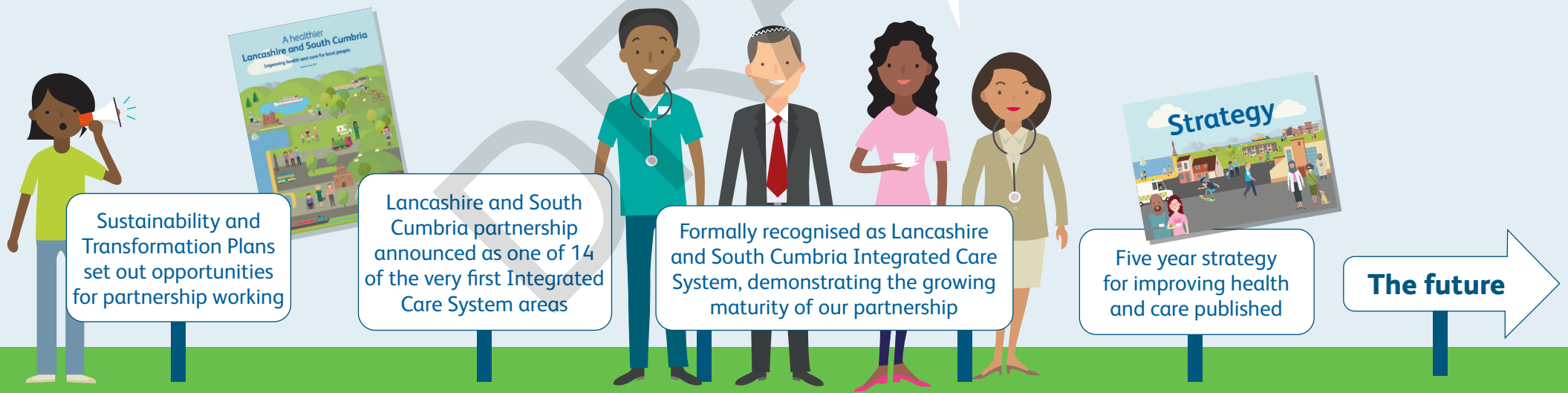
The NHS Long Term Plan, published in January 2019, set out an ambitious programme of service improvement for health and care in England. It describes how Integrated Care Systems will work in new, more coordinated ways to:

- Join up health and care for local people – especially those with multiple and long term conditions
- Be proactive about prevention – stopping people getting ill in the first place
- Make the very best use of the whole health and care resource across an area

This document builds upon the foundations of partnership working which have been developing over the past four years.

We have listened to local people and worked together with colleagues across the health and care sector to develop a five-year strategy to deliver the aims of the Long Term Plan and to address the most urgent needs of the 1.8million people living in Lancashire and South Cumbria.

Examples of how we are already successfully working in partnership are available on pages 32 to 35



Our journey towards partnership working

Improving the health and wellbeing of local communities

Delivering better, joined-up care, closer to home

How we will deliver our strategy

Delivering safe and sustainable, high quality services

Improving the health and wellbeing of local communities

We will take action to improve the underlying issues that impact health, healthy behaviours, the lifestyle choices we make and the places and neighbourhoods we live in. We will deliver care tailored to meet the needs of individuals.

Five key priorities will be our focus to improve the health of the population and to reduce health inequalities.

Giving the best start in life

National evidence tells us that development begins before birth and that the health of a baby is crucially affected at this early stage. We need to make changes to policies to eradicate health inequalities and make sure children and families receive support in the first 1,000 days after birth.

To do this, we will:

- Focus on reducing infant mortality
- Close the gap in communication skills between disadvantaged children and their classmates when they start school
- Address child poverty and its impact on the health and wellbeing of children and families
- Develop plans to get every child ready to learn at the age of three.

Healthy behaviours

Tobacco use, obesity, alcohol consumption and inactivity are issues which can result in disability and early death and directly affect physical and mental health.

We will work with communities to:

- Deliver our ambition to become smoke free in our premises across Lancashire and South Cumbria
- Reduce childhood obesity, learning from partnership work in Pennine Lancashire and spreading the learning to support local residents to have a healthy weight throughout their lives
- Improve oral health in all age groups
- Put in place alcohol care teams where they are needed
- Support the voluntary, community, faith and social enterprise sector (VCFSE) and wider partners to strengthen and expand the social prescribing offer available in communities.

Zero suicides

We have an ambitious goal of working towards having zero suicides in Lancashire and South Cumbria. The impact of suicide is far-reaching and remains with family, friends, colleagues and many others long after the individual has gone.

The bereavement is often detrimental to personal relationships, behaviour, wellbeing and work.

To achieve our ambitious goal, we will:

- Put policies and services in place to improve mental wellbeing, identify people at risk of suicide and better support families with specialist bereavement services
- Use real-time intelligence from the police, local authorities and NHS to support the partnership in taking action in the right areas to reduce suicides to zero over a number of years.

Neighbourhood development

People should be able to live, work and prosper in their neighbourhoods. Understanding what matters to people where they live and by working with them on the challenges they face can help find creative solutions to seemingly insurmountable problems.

Neighbourhoods are where people spend most of their time. We will work with local communities to co-create solutions through local partnerships where people live. In these areas, people will be supported to manage their own health and wellbeing and receive social support by integrating health and care services with local authorities and other voluntary and community groups.

To achieve this all 41 of the primary care networks will be supported to deliver care centred around the person and detect and diagnose conditions such as diabetes, cancer and heart disease early.

Work and health

Having a healthy and capable working age population has major positive benefits for local people, organisations, the local economy and wider society.

This means it is important to support people to achieve their potential in life by enabling them to work, maintain financial independence and security for themselves and their families, especially as they age. This includes people with long term conditions and disabilities, a large number of whom, want to work and live independent lives.

To achieve this, the partnership is already working with local economic partnerships, wider public sector leaders and universities to create opportunities through the development of a local industrial strategy and sharing good employment practices between large organisations in Lancashire and South Cumbria.

We will support our current and future workforce to have the best possible health, and in turn improve the local economy.

Delivering better, joined-up care, closer to home

Our neighbourhood approach aims to deliver better care planning and outcomes for local people. This builds upon positive local and national examples where GPs, community nurses, therapists, social workers, voluntary, community, faith and social enterprise sector partners and the communities themselves have worked together more closely.

This approach to working in neighbourhoods allows partners to make use of a multidisciplinary workforce and offer opportunities to create a sustainable future for primary and community services, which have been under significant pressure in recent years.

We want to use neighbourhood working to continue learning about how best to engage with local people about their health and wellbeing, using the assets of each community to do so. The aim is to make this approach one of the most recognisable characteristics of the partnership in Lancashire and South Cumbria.

We are supporting the development of the **41 primary care networks** at the heart of wider public and voluntary sector integrated neighbourhoods.

Primary care networks are a vital component of the neighbourhood model, with ambitions to:

- Stabilise general practice
- Help solve the capacity gap and improve the skills mix by growing the wider workforce
- Invest in our local communities
- Be the connection point between primary and community care
- Deliver new service improvements and achieve clear, positive, quantified impacts that benefit people.

The five local health and care partnerships are where:

- Local authorities can take an active, lead role in system redesign
- System redesign can be built on community approaches
- Integration between health and care and other sectors can be best delivered
- Political engagement and democratic input can be undertaken most effectively
- Partners can determine how they can best work together to achieve outcome improvement and system change.

You can find out more about the work of our five local partnerships at: **healthierlsc.co.uk/Local**

Each local health and care partnership is developing an integrated model of:

- Primary and community services
- Physical and mental health services
- Integration of health and social care services.

Where things are best undertaken once, we will do them in partnership across Lancashire and South Cumbria.

Delivering safe and sustainable, high quality services

It is clear that the way local NHS hospital services are delivered is both clinically and financially unsustainable. Across the four providers of acute services, there is significant variation in the quality, access and outcomes of services received by people living in Lancashire and South Cumbria. System leaders recognise that variation exists and that plans are now needed to address this.

Clinical leaders will be supported to work beyond the boundaries of their organisations to set out what the future of service delivery will look like and work together to influence how services will be delivered over the next four years and beyond.

Integrated Care System partners are working together to overcome these challenges through three key programmes:

1. **Increased collaboration between providers**
2. **Efficient and sustainable service delivery**
3. **Integrated pathways.**

1. Increased collaboration across providers

We will explore the benefits of our hospitals and community services working together as a Provider Collaborative and describe what this will mean for local people and staff. This will be to enable services to deliver the highest quality, safe and sustainable care to people in Lancashire and South Cumbria.

To achieve this, the four NHS trusts providing acute services will increasingly work more closely together, transforming the ways in which some more specialised services and patient pathways are organised. This could involve changes to current models of care, locations of care, or the number of hospitals which provide care. Local communities and stakeholders will be involved in shaping these models of care and, where appropriate, further engagement and formal consultation will take place.

Examples of early work are redesigning how services are delivered for head and neck, cancer, and vascular services, paediatrics and diagnostics.

2. Efficient and sustainable service delivery

In line with the expectations of the NHS Long Term Plan and more local analysis of unwarranted variation and efficiency opportunities, partners have identified a range of potential schemes to improve the clinical and financial sustainability of services. It is recognised that these opportunities can only be realised with the leadership and support of clinical and other professional leaders working together across the system.

The following areas will be prioritised as they demonstrate the greatest opportunities for improving efficiency:

- Outpatient appointments
- Musculoskeletal (MSK) services
- Theatre efficiency
- Back office functions
- Management of medicines
- Interventions of limited clinical value
- Innovation and quality.

3. Integrated pathways

The NHS Long Term Plan identifies integrated pathways across a number of services that are intended to enhance clinical outcomes for local people. As well as working towards the implementation of these pathways, ICS partners have identified a number of local priority pathways for redesign across Lancashire and South Cumbria.

Our priority pathways for improvement are:

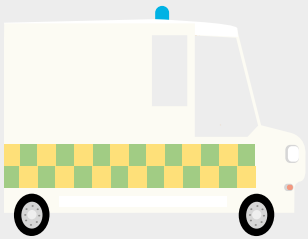
- Mental health – adults and children and young people
- Learning disabilities and autism
- Urgent and emergency care
- Cancer
- Stroke services
- Planned care
- Maternity services.

Urgent and emergency care

We are committed to providing highly responsive services for adults and children with urgent care needs, which deliver care as close to home as possible and are high quality, safe and sustainable.

This will be achieved by:

- Using the same approach across partners to collecting and using intelligence about how services are working
- Improving how ICS partners and the ambulance service share information
- Improving patient safety and experience due to quicker response times
- Using resources and teams appropriately, so that paramedic crews are able to respond to life threatening emergencies.



Cancer

We aim to improve early diagnosis for patients with cancer, offering greater opportunities to make personal decisions about cancer treatment.

We are taking forward bold actions to improve lung cancer screening, introduce rapid diagnostic centres and increase our workforce.

Stroke services

We plan to improve stroke services – right across the pathway from prevention through to rehabilitation. Our aim is to reduce the number of people having a stroke in our population, but for those who do, we need to reduce variation in the outcomes of the care that we provide.

We will work in partnership with care professionals, public health and wider partners such as the Stroke Association, and local people to reduce the likelihood of experiencing a stroke.

Mental health – adults and children and young people

Working with communities to improve the mental health, resilience and wellbeing of people in Lancashire and South Cumbria is one of our partnership priorities.

Our ambition is that mental health and wellbeing is considered of equal importance to physical health in all of our communities. When local people require more support, they should be able to access an effective range of age-appropriate mental health services. At present, there is variation in access, provision and clinical outcomes.

Learning disabilities and autism

We will redesign and deliver effective, streamlined community services and develop specialist assessment and treatment beds, community admission avoidance placements and alternatives to hospital admission for people with learning disabilities and/or autism.

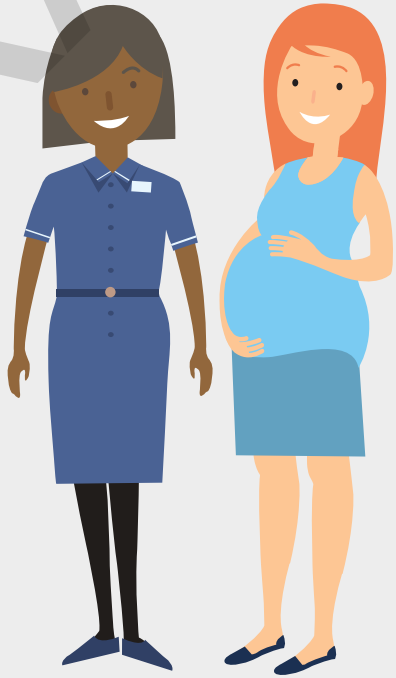
The partnership will:

- Ensure the safe and effective discharge of people who do not require the use of inpatient services
- Ensure that the right number of beds are delivered in the right places, meeting the needs of individuals
- Ensure that public sector resources are being used effectively to support people with a learning disability or autism
- Ensure that action is taken to reduce health inequalities.

Planned care

We have reviewed how all our hospital operating theatres are used to improve efficiency and reduce waiting times for patients. Across the ten specialties with the highest volume of activity, we have identified an opportunity for an additional 18,000 theatre hours per year, but recognise that there are significant challenges in achieving all of this.

We will enable earlier and more accurate diagnosis to make sure we get patients on the right planned pathway first time. To do this, we will work in partnership to deliver improved diagnostic services, which use tests and evaluations to help detect, diagnose and treat diseases, injuries and other physical conditions.



Maternity services

We aim to better deliver consistent care for families. As a partnership, we are committed to removing boundaries, improving choice, safety and experience of maternity services and improving outcomes.

This will result in:

- Reduced number of stillbirths and neonatal deaths
- Reduced number of brain injuries between labour and delivery of the placenta
- Personalised care records
- Most people receiving continuity of carer during pregnancy, birth and postnatally
- Reduced number of newborn babies separated from their parents
- Reduction in people smoking during pregnancy and at the time of delivery
- Improved support and education around infant feeding.

Making this happen

This strategy will be enabled by our plans to:

- Create a great place to work and develop
- Use technology and innovation to deliver great care
- Make the most of public sector investment
- Inform, involve and engage local people, staff, partners and stakeholders

Creating a great place to work and develop

- We are committed to developing employment opportunities for local communities within health and care services
- We will develop the volunteer workforce, which includes partnership working with the voluntary, community, faith and social enterprise sector
- We will recruit new members of staff – we want to attract new staff to the region
- We will improve the experience of staff currently working within the partnership
- We will develop new roles and skills and use technology to better support staff
- We will create stable and sustainable clinical and frontline teams working across more than one trust/site in order to ensure that there are sufficient staff to deliver quality and safety for patients.

Using technology

We will mobilise our workforce to harness the technology revolution and bring about a radical transformation, that will:

- Empower people to be more active in managing their health and wellbeing
- Enable more patients to self-care and live independently for longer
- Pinpoint, predict and prevent disease through better use of data
- Increase the amount of time for care on the frontline
- Create a flexible working environment that helps retain the workforce
- Improve operational efficiency across back office services.

Innovating to deliver great care

- The partnership will contribute to the development of the Lancashire and South Cumbria economy, promoting a wide range of benefits to the population from this approach to collaboration, mutual learning and investment in new ideas. This allows us to respond locally to the global impacts of technological, social, scientific and environmental changes.
- The partnership will establish a public service enterprise and innovation alliance, bringing together the health and care sector across Lancashire and South Cumbria with universities and economic development partners.

Making the most of public sector investment

We will significantly change the way organisations invest in, provide and manage the whole health and care system including GPs, A&Es, specialist centres, hospitals and care services.

To achieve this, we will:

- **Develop a more radical approach** to planning and making changes to services across providers. This needs to result in much faster change than partners have been able to do in the past
- **Increase our collective ability** to achieve efficiencies and services changes. We need a higher level of ambition, peer support and challenge, leadership and the application of the right techniques
- Ensure we are quick to **adopt best practice** across the whole system
- **Make the most of new ideas and opportunities**, which lead to faster change and improve the efficiency of our services.

Inform, involve and engage local people, staff, partners and stakeholders

We will involve people when designing how we deliver services and work together to improve people's experience of health and care locally.

What this means for communities and our staff

In five years' time…

Local people will be:

- More active in managing their health and wellbeing and decisions they make that affect them
- Supported to improve their long-term health and wellbeing
- Living well before they die, in the place of their choice in peace and dignity
- Using technology to manage their health
- More involved in decision making in their area
- Making best use of local housing and leisure services by connecting with integrated community teams
- Living in dynamic, empowered communities where people can live, work and thrive
- Benefiting from more coordinated and joined-up care
- Receiving care from hospitals, which provide networks of services, with sustainable staffing levels and consistent pathways
- Supported to live longer, healthier lives with earlier diagnosis of conditions and advice on prevention.

Staff will be:

- Happier, healthier and more resilient
- Provided with a wider range of roles and support to develop new skills and capabilities
- Working in integrated community teams, delivering targeted and coordinated physical and mental health care to their local neighbourhoods
- Better able to support people they care for, through greater access to data shared by partners
- Attracted into working and living in Lancashire and South Cumbria.

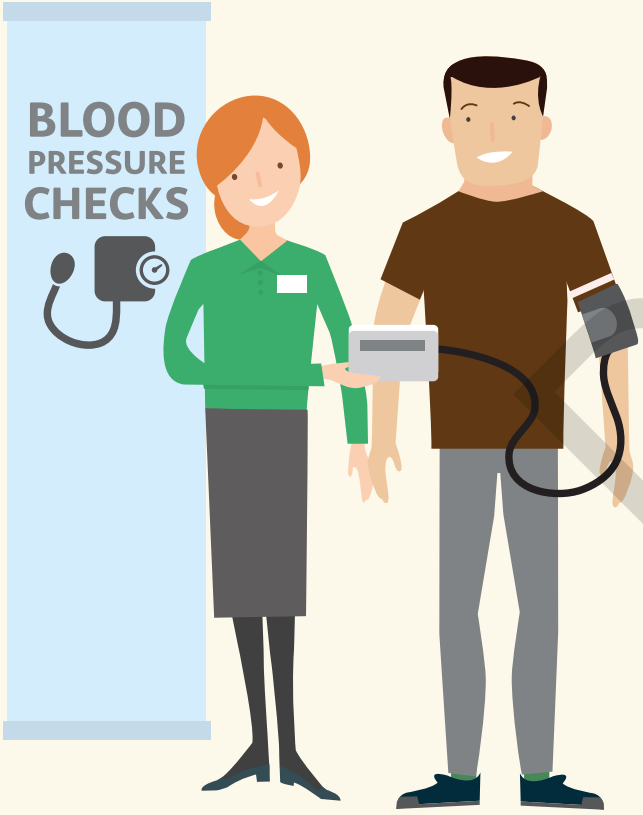
Partners will be:

- Able to demonstrate how public sector organisations have supported economic development and innovation, resulting in employing local people into new and different jobs in health and care
- Able to demonstrate that they are getting the best value health and care
- Confident in the evidence of improving life expectancy and reducing inequalities in the most deprived neighbourhoods through our approach to population health
- Able to demonstrate how health and wellbeing has been considered in public policies such as education, housing, economic development, transport and retail.

The impact of working in partnership

Lancashire and South Cumbria Integrated Care System is seen as a maturing partnership.

There is much that has already been achieved, which health and care system partners are proud of.



Early detection and prevention

- **£7.6million funding** from NHS England and NHS Improvement (NHSE/I) will help to diagnose lung cancer earlier in Blackpool and Blackburn with Darwen. Lung health checks will begin in early 2020, targeting smokers or ex-smokers between 55 and 74 years of age. In addition, **£9million** is being invested in early diagnosis of other types of cancer.
- Partners are working with the British Heart Foundation to deliver **12,000 blood pressure tests in local communities by 2021** with football clubs, leisure centres and pharmacies so that people know their numbers and what they mean. This is identifying individuals much earlier who are at risk of a heart attack, kidney disease and stroke.
- A partnership approach to **reduce suicides** has seen the development of a dashboard of live intelligence on suspected suicides. The insight is helping to identify trends, which is being used to deliver a campaign to reduce suicides by encouraging people to talk, create stigma free working environments where people can seek help and reach out to colleagues and to provide support for those bereaved by suicide.

Developing partnerships with the voluntary, community, faith and social enterprise (VCFSE) sector

- The VCFSE sector, local authorities and NHS in Lancashire and South Cumbria have worked together to develop better relationships. This has seen **consistent models of VCFSE engagement** within and across all local health and care partnerships and the development of a VCFSE leadership group across Lancashire and South Cumbria.

Supporting thriving local communities

Leading the way nationally in developing a population health management approach resulted in five neighbourhoods tackling issues in their communities:

- In **Blackpool**, people living in houses of multiple occupancy have been provided help related to issues with where they live and empowered to become more actively engaged in managing their own health and wellbeing.
- In **Skelmersdale**, people with respiratory conditions often have other health conditions such as diabetes or depression and anxiety. More personalised care has been provided to a group of patients by looking at the whole person rather than just one condition at a time, as well as developing group consultations to provide peer support.
- In **Chorley**, it was identified that residents known to the GP surgeries as living with frailty also needed help to have their bins collected. People have been connected with link workers who visited and interviewed them in their own homes to provide support for their mental health, physical and social needs in one assessment. This has resulted in connecting people with local groups to help combat loneliness or obtain support and tips for healthy eating.
- In **Barrow and Millom**, people most at risk of serious mental health conditions have been supported by improving the consistency and quality of the Severe Mental Illness (SMI) checks they receive.
- In **Burnley**, a group of people aged 50 and over living with frailty have benefited from their neighbourhood team using a peer-to-peer model of support. This has helped individuals to meet people with a similar condition and learn from each other how best to manage and self-care as well as getting the best from services.
- In **Fleetwood,** partners have joined initiatives together, which have contributed to a significant reduction in the number of residents attending Blackpool's A&E, down **11.5%** in a year. There has also been a reduction of **9.4%** in the number of people being admitted to hospital in an emergency. The primary care network has received multiple awards.

Strengthening the health and care workforce

- A programme called **EPIC** has been established to share and adopt best practice; celebrate the achievements of staff; and connect individuals and teams across the partners of Lancashire and South Cumbria Integrated Care System. **More than 500 staff and volunteers** from health, social care, public sector and community organisations have participated in the first two events in 2019. EPIC stands for **E**ngaging communities, **P**romoting partnerships, **I**nnovation for improvement and **C**ollaborating to develop services.
- Nurse recruitment is being developed through the Global Health Exchange Programme to attract new staff from overseas. All trusts have taken part in an initial recruitment exercise with more than **200 nurse** posts filled.

Joining up health and social care services

- **78% of our care homes** are actively using a tool that allows bed vacancies to be tracked. This is helping to reduce avoidable and unnecessary lengthy stays in hospital.
- A Lancashire-wide joined-up **response and falls lifting service** has been launched. This is designed to divert calls from ambulance services in cases where older and vulnerable people have fallen within their own home (this includes care/nursing homes and extra care sheltered housing). The service has teams based in every locality and is averaging a response time of around 30 minutes, comparing favourably to what was often a four hour plus wait.
- Partnership work across **maternity** services has resulted in **29.2%** of people being booked onto pathways, which can offer continuity of carer, exceeding the national target of 20%.

Innovations in digital health

- Almost **500,000 people** across Lancashire and South Cumbria have **downloaded an app** that helps them connect with their GP surgery. **More than one million** local people have been enabled to use **online consultation**. Patients are now able to contact their practice online to ask about a new or ongoing problem and get advice or an appointment if needed. **More than four fifths** of all GP practices across Lancashire and South Cumbria are now offering online consultations.
- A **shared care record** is now fully operational across Lancashire and South Cumbria, supporting clinical staff to deliver care to patients. Thousands of clinicians use it routinely to ensure continuity and consistent care for the people they treat. There are currently more than **2.5million care documents** available to view, with more than **100,000 new documents** published every month. This means that patients do not have to repeat information to different care teams and more joined-up care can be provided thanks to easier access to an individual's medical history.

Thank you

We would like to say a huge thank you to all the local people, staff and partners who have been involved in developing this strategy and our plans for the next five years.

We are also grateful to our universities, voluntary, community, faith and social enterprise sector, police and local Healthwatch who have all actively contributed to this strategy for the partnership.

Our next steps

We will continue to work together across health and care to develop and deliver these priorities in partnership.

This version of our strategy is a draft because we would like to get further feedback from local people and stakeholders.

To find out how to share your comments, please visit:

healthierlsc.co.uk/Strategy

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Our partners

Lancashire and South Cumbria Integrated Care System is a partnership of the following organisations:

NHS organisations

- NHS Blackpool CCG
- NHS Blackburn with Darwen CCG
- NHS Chorley and South Ribble CCG
- NHS East Lancashire CCG
- NHS Fylde and Wyre CCG
- NHS Greater Preston CCG
- NHS Morecambe Bay CCG
- NHS West Lancashire CCG
- NHS Midlands and Lancashire Commissioning Support Unit
- 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
- North West Ambulance Service NHS Trust
- NHS North West Regional Specialised Commissioning Team
- The Innovation Agency, the Academic Health Science Network (AHSN) for the North West Coast

Local authorities

Upper tier/unitary councils

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

District councils

- Preston City Council (Central Lancashire ICP)
- Chorley Council (Central Lancashire ICP)
- South Ribble Borough Council (Central Lancashire ICP)
- Fylde Council (Fylde Coast ICP)
- Wyre Council (Fylde Coast ICP)
- West Lancashire Borough Council (West Lancashire MCP)
- Barrow-in-Furness Borough Council (Morecambe Bay ICP)
- Lancaster City Council (Morecambe Bay ICP)
- South Lakeland District Council (Morecambe Bay ICP)
- Burnley Borough Council (Pennine Lancashire ICP)
- Hyndburn Borough Council (Pennine Lancashire ICP)
- Pendle Borough Council (Pennine Lancashire ICP)
- Ribble Valley Borough Council (Pennine Lancashire ICP)
- Rossendale Borough Council (Pennine Lancashire ICP)

Voluntary, Community, Faith and Social Enterprise (VCFSE)

The ICS has established strong partnerships with the VCFSE sector. A Voluntary Sector Partnership Alliance has been formed by the sector comprising chairs of VCFSE networks in each of the five local health and care partnerships.

Accessibility

If you would like this document in an alternative format, please email us at **healthier.lsc@nhs.net**

Glossary

For definitions of health and care words and phrases used in this document, please visit **healthierlsc.co.uk/glossary**

Lancashire County Council

Cumbria County Council

Blackpool Council

Blackburn with Darwen Borough Council

NHS

Lancashire Health and Wellbeing Board
Meeting to be held on Tuesday, 28 January 2020

Advancing Integration by Delivering the Intermediate Care Strategy

Contact for further information: Victoria Tomlinson, Advancing Integration Programme Lead, Lancashire County Council, Tel: 01772 530897, victoria.tomlinson2@lancashire.gov.uk

Executive Summary

This report is supplemented by a presentation around the progress of work following the review of Intermediate Care in 2019.

The Better Care Fund (BCF) requires the NHS and local government to create a single pooled budget and plan to incentivise closer working around people, placing their wellbeing as the focus of health and social care services, with a strong emphasis on community based services.

To date, the Better Care Fund in Lancashire has been used mainly in a transactional way to commission services at the interface between health and social care with a significant amount of funding linked to short term 'intermediate care' provision.

Following the Intermediate Care review, it is clear that opportunities have been missed to take full advantage of the transformational opportunity to:

- Improve quality and level of provision for individuals and their carers/families closer to home,
- Manage demand in both health and social care, and
- Maximise the impact of funding across health and social care.
-

The Intermediate Care Programme is the first test of working in an integrated manner across health and social care, implementing a single set of recommendations across both sectors with accountability, financial reform and risk management being managed through the Advancing Integration Board (formerly Better Care Fund Steering Group).

Recommendations

The Health and Wellbeing Board is asked to:

(i) Note the progress of the Intermediate Care Programme to date.
(ii) Act as the accountable body for this programme.
(iii) To hold the Integrated Care System to account for implementing via the Integrated Care Partnerships.
(iv) Consider working with the other Health and Wellbeing Boards (Blackburn, Blackpool and Cumbria) to undertake that assurance role akin to a committee in common approach.
(v) Agree to a review of the Advancing Integration Board membership that will function as programme board.

Lancashire County Council

(vi) To provide the check and challenge to the programme at key intervals linked to decision gateways.
(vii) Recognise and lend support for the need for this programme to be properly resourced at Integrated Care Partnership and Integrated Care System levels.
(viii) To link with population health management and Continuing Health Care programmes of work.

Background

This document sets out the changes in approach to joint commissioning between the Clinical Commissioning Groups and local government and updates on the work in progress. The Better Care Fund (BCF) requires the NHS and local government to create a single pooled budget and plan to incentivise closer working around people, placing their wellbeing as the focus of health and social care services, with a strong emphasis on community based services.

The Health and Wellbeing Board is the accountable body for the Better Care Fund approving spending plans and receiving reports on performance against nationally specified targets.

The Better Care Fund comprises the nationally legislated minimum contribution from Clinical Commissioning Groups across Lancashire and the improved Better Care Fund which has continued but is not guaranteed long term. As a consequence of uncertain funding, services have emerged to some degree in an ad-hoc fashion and fragmented picture across the county.

In recognition of this, recent changes to the way in which the Better Care Fund is managed and administered have generated the following actions:

- Creation of an evidence base to bring precision to transformation opportunities - the review of intermediate care services by Carnall Farrar has outlined a strong case for change and a proposed strategy for improvement. This has been supplemented by a hospitalisation review by the Oak Group around appropriate place of care and work by Newton Europe, around establishing HomeFirst principles and strengthening reablement services across Lancashire to support admission avoidance and hospital discharges. It is also important to note that a review of this scale and encompassing all provision which falls under this aspect of health and care has never been completed at a national level previously.
- The Intermediate Care review, led by Lancashire County Council with full support and engagement from health colleagues, sought to unpick the current state of services and pathways within Intermediate Care across Lancashire and South Cumbria, with additional strength in the fact that the council were able to also include information from Blackpool Council, Blackburn Council and Cumbria County Council to gain a full picture of the provision across Lancashire, our unitary authority colleagues and South Cumbria.

Previously, the board agreed that a proportion of the funding to be spent on a review of Intermediate Care which is a range of social care and NHS services which are short term in provision and aimed at increasing people's level of independence through reablement, rehabilitation, recuperation and/or recovery. Intermediate Care provision incorporates health and social care services which are short term in their provision. These services are aimed at helping people to increase their independence and reduce the risk of admission to hospital or residential care. Services include, but are not limited to, rapid response therapy and nursing, crisis care hours, residential intermediate care beds and night time support.

Today, the Lancashire and South Cumbria system spends an estimated £43m per year on Intermediate Care which equates to around 45,000 episodes of care across a range of bed and home based health and care services.

This review has entailed a detailed examination of spend, activity and outcomes across the different geographies. It has signalled some strengths in the current arrangements eg reablement which is a therapy-led service working with care providers to support people to regain skills which they may have lost due to injury or illness and has achieved consistently good outcomes and home first which is both an approach to service as well as a provision in itself, supporting the early discharge of people from hospital through undertaking assessments in the home which were previously done in a hospital setting.

It has also identified areas to improve and change shifting focus more towards improving quality of provision by supporting people in the community to avoid hospital admission than regarded only as a 'step down' from hospital.

This outcome was supported by additional cost avoidance and better use of existing resources. The greatest opportunity is to shift care from the acute setting to intermediate care, increasing intermediate care requirements by 36%, over and above the increase required to meet growth in the current system. This would support a 23% reduction in demand for acute bed days and a 45% reduction in the use of short-term care beds.

Managing growth under the existing model of care would increase cost in intermediate care by £27.5m (66%) in ten years' time. The additional cost of treating patients in acute care who could be managed in intermediate care would be a further £51m (14%), and in short-term care beds a further £6.3m (55%) making a **total cost to manage growth of £84.8m.**

Implementing the new care model, assuming a four year phase in, would generate significant savings and cost avoidance for the system against the predicted cost of managing growth under the current model. The greatest impact is seen in acute care, where there would be a 10% reduction in ten years, saving £37.9m, and a £33.8m (78%) increase in cost in intermediate care. This represents a total increase in cost of £28.1m in 10 years, **saving £87.3m of predicted additional cost.**

The shift represents a 23% increase in intermediate care beds and a 123% increase in staff delivering care in home-based intermediate care services compared to today, against an increase in demographic demand of 26%.

Progress to date

The Advancing Integrated Board has identified a set of principles to build trust and ensure we have a system-wide approach to ways of working and behaviours that will enable the delivery of the Intermediate Care strategy and cement our approach to joint working in the Integrated Care Partnerships by:

- Actively sharing information and knowledge;
- Clear system agreement on how resources and incentives support the whole system, in particular how we jointly agree changes to funding methodologies and flow of funding across the system to enable change;
- Agreement on which 'enabling' activities should be undertaken at a Lancashire level;
- System leaders hold themselves mutually accountable, collectively measuring results and providing feedback;
- One trusted assessment and referrals process meaning that appropriate people receive intermediate care;
- A no-blame culture and feedback loops established for continuous improvement.

To date, our joint working has achieved the following:

- A detailed Intermediate Care Review and a robust Implementation Strategy (including Blackpool, Blackburn and South Cumbria).
- Budgets for Intermediate Care are available for each Integrated Care Partnership, enabling transparency with work in progress to enable 'in-view' budgets.
- The conversation between partners has shifted into a more trusting approach with an agreement for budgets to move towards being ‘in view’ and in time to move to aligned and possibly pooled budgets in Integrated Care Partnerships.
- Building support within local authorities for advancing integration by using intermediate care as a proof of concept for effective joint plans at Integrated Care Partnership and Integrated Care System levels, including positive discussions with the unitary authorities.
- Change in the governance structure of the Better Care Fund Steering Group resulting in the formation of the Advancing Integration Board (AIB). This Board has responsibility for the programme management of the intermediate care strategy and implementation plan.

Next Steps

The Programme Initiation Document has been drafted, which articulates the transformation plan, resource requirements and benefits for the system. The next steps within this programme are to:

- Create a detailed Intermediate Care Strategy, with aligned commissioning standards.
- Consider options for high level implementation and resource phasing.
- Develop an Integrated Care System-wide financial and risk management strategy for Intermediate Care provision

List of background papers

Carnall Farrar (2019) –Lancashire Intermediate Care Review
Accessible at:
http://council.lancashire.gov.uk/documents/s149994/Presentation.pdf

Lancashire Health and Wellbeing Board
Meeting to be held on Tuesday, 28 January 2020

Director of Public Health Report 2019/20 - Investing in our Health and Wellbeing
(Appendices 'A' and 'B' refers)

Contact for further information: Dr Sakthi Karunanithi, Director of Public Health, Lancashire County Council, Tel: 01772 537065, sakthi.karunanithi@lancashire.gov.uk

Executive Summary

The Director of Public Health report 2019/20 entitled 'Investing in our Health and Wellbeing' (Appendix 'A') follows on from the last report in 2016 on Securing our Health and Wellbeing. The report refocuses on three main issues:

1. We have been adding years to our lives but not necessarily life to our years;
2. Addressing health inequalities needs action across the social gradient within our county and not just in the most deprived communities; and
3. That protecting and promoting good health and wellbeing is not just a social issue but also crucial for our local and national economy.

Health outcomes for our residents living in many areas of our county are not improving in line with national trends. Health inequalities in Lancashire are widening and if we fail to focus on prevention and wellbeing, it is likely to be even more challenging in improving measures such as life expectancy and healthy life expectancy. Crucially this will have an impact on the productivity of the local economy, employers and our workforce.

To address these challenges, the report recommends addressing four key public health priority areas:

- Investing in giving children the best start in life.
- Investing in our communities.
- Investing in our working age population.
- Investing in our own health and wellbeing.

Recommendations

The Health and Wellbeing Board is asked to:

(i) Support the key messages and dissemination of the Director of Public Health annual report (Appendix 'A') within partner organisations.
(ii) Continue to ensure that our collaborative prevention and population health investments are optimised for improving the health and wellbeing of communities across Lancashire.
(iii) Endorse the action plan to reduce infant mortality across Lancashire (Appendix 'B').

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Background

The Health and Social Care Act 2012, sets out a requirement for all Directors of Public Health to produce a report on the health of their local population and for their local authority to publish it.

The Director of Public Health report (Appendix 'A') is a professional statement about the health of local communities, based on sound epidemiological evidence, and interpreted objectively. The report is an important opportunity by which the Director of Public Health can identify key issues, flag up trends in health status, report progress and thereby serve their local populations.

The report acts as a key resource to inform stakeholders of priorities and recommend actions to improve and protect the health of the communities. It is also a mechanism for advocacy as well as a statement of needs, current priorities and action and continuing progress.

List of background papers

Lancashire County Council Corporate Strategy -
https://www.lancashire.gov.uk/council/corporate-strategy/ .

Lancashire Health & Wellbeing Strategy -
https://www.lancashire.gov.uk/media/907203/lancashire-health-and-wellbeing-strategy.pdf .

Lancashire Joint Strategic Needs Assessment (JSNA) -
https://www.lancashire.gov.uk/lancashire-insight/jsna/.

Appendix A

Investing in Our Health and Wellbeing

Report of the Director of Public Health, 2019/20

Lancashire County Council

comms: 6574

www.lancashire.gov.uk

Contents

Thank you to all contributors without which this report would not have been possible:
Davina Hanlon, Gill Millward, Charlotte Cuddihy, Matthew Stanton, Andrea Smith, Abdul Razaq, Aidan Kirkpatrick, Farhat Abbas, Donna Gadsby

Public Health leadership and report editorial team

Foreword

"Investing in our health and wellbeing" follows on from my last report in 2016 on securing our health and wellbeing. The report presents evidence and highlights three main health and wellbeing issues facing our county. They are:

1. We have been adding years to our lives but not necessarily life to our years.
2. Health inequalities are widening in our county compared to national trends, and require systematic action across the public, private and voluntary sectors in partnership with local communities.
3. Protecting and promoting good health and wellbeing is not just a social issue but is also becoming a critical factor for our local and national economic productivity.

If we fail to focus on prevention and keeping people well, it is likely to be even more challenging in improving key wellbeing measures such as healthy life expectancy. Crucially, this will have an impact on our ability to make Lancashire the best place to live, work, visit and prosper.

In the current context of increasing budgetary pressures in health, social care and other public services, the need to invest in prevention of ill health is stronger than ever. Only 20% of our health is determined by access to good quality services in the NHS. Although the NHS Long Term Plan sets out a strengthened focus on preventing poor health, including action on smoking, obesity and Type 2 diabetes, alcohol and air pollution, we also need community level grass roots social movement for health. New and innovative cross sectoral partnerships across education, housing and business sectors across the county can make a positive difference to the lives of our residents. This includes embedding health in our local industrial strategy, promoting more inclusive growth through our local enterprise partnership, and pursuing a carbon neutral economy.

This report identifies health as our best wealth, and recommends key evidence based opportunities for action across four themes. They are:

1. Giving our children the best start in their life,

2. Investing in our communities,

3. Focussing on health as an economic asset, and

4. Looking after our own health and wellbeing

A system wide response to addressing health inequalities must now be our collective priority. I remain committed to our original vision to develop Lancashire into a safer, fairer and healthier place by working with our residents and all our stakeholders.

Best wishes

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

1. About Lancashire

Lancashire[1] has a population estimate of approximately 1.21 million spread over 2,900 km^2. The average population density (people per km^2) is 413, compared to the North West average of 512 and an England and Wales average of 387.

The population is projected to increase by 3.5% in the 25 year period, 2016-2041, with the number expected to reach 1.23 million by 2041. The estimated increases are lower than the average for the North West (6.4%), and well below the expected increase for England of 12.1%. At a district level, Burnley, Hyndburn, Pendle and Preston are predicted to see small population decreases between 2016 and 2041, whilst Chorley is the only Lancashire authority with a projected increase higher than the North West or England average.

Analysis by age shows the number of children aged 0 to 15 in Lancashire will rise for the next eight years before beginning to decline. The working-age population is predicted to start to decline within five years and the older population is predicted to continue to increase. There will be more people in the 85+ age range each year as life expectancy increases over the period. The old age dependency ratio (number of people on state pension per 1,000 people of working age), is predicted to increase in every district over the period of the projection, with Fylde seeing the largest increase (496 in 2016 to 685 in 2041).

The 2011 census showed that the largest ethnic group in Lancashire is white (92%), with Black, Asian and Minority Ethnic (BAME) groups making up 8% of the population. Of these, the majority of this group were Asian/Asian British. Numerically, there were over 90,000 BAME people in the county. Three-quarters of the BAME population reside in Preston, Pendle, Burnley and Hyndburn. Across England and Wales the white population accounted for 86% and BAME 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 found on the Lancashire Insight webpages. There are six NHS clinical commissioning groups (CCGs) in the county council area and one in each of the unitary councils. Lancashire is also served by several key NHS Trusts, 173 GP practices (August 2019), over 270 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 (the 12 district councils and the two unitary authorities).
Key strategic partnerships in the county council area include a health and wellbeing board, adult and children safeguarding boards, and the Lancashire Enterprise Partnership. There are three main university campuses in the county, and specialist agriculture and maritime college facilities.

2. Our Health, Our Wealth

There is an inextricable link between our health and wealth and this report draws attention to the main areas for joint collaboration and action to achieve inclusive growth across Lancashire.

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 data for Lancashire is shown in the table below.

Table 1: Life expectancy and Healthy Life Expectancy (in years), females and males in Lancashire compared to England (2015-17).

Indicator	Female	Male
Life expectancy at birth in years (Lancashire)	82.2	78.6
Life expectancy at birth (England)	83.1	79.6
Gap between most and least deprived areas in Lancashire	8.1	10.2
Healthy life expectancy at birth (HLE) in Lancashire	64.5	61.1
Healthy life expectancy at birth in England	63.8	63.4
Gap in HLE between most and least deprived areas in Lancashire*	15.6	15.8

*This indicator is for 2009-2013 Source: Lancashire Insight – life expectancy

The life expectancy at birth for both females and males has been increasing over the past ten years. However, there is a gap of 8.1 and 10.2 years between our least and most deprived areas for females and males respectively.

Within Lancashire the gap in female LE between most and least deprived areas has widened (7.8 years in 2010-12 to 8.1 years in 2015-17)

The average number of years a female child can expect to live in good health, (healthy life expectancy), is 64.5 years, meaning they will spend 17.7 years in poor health.

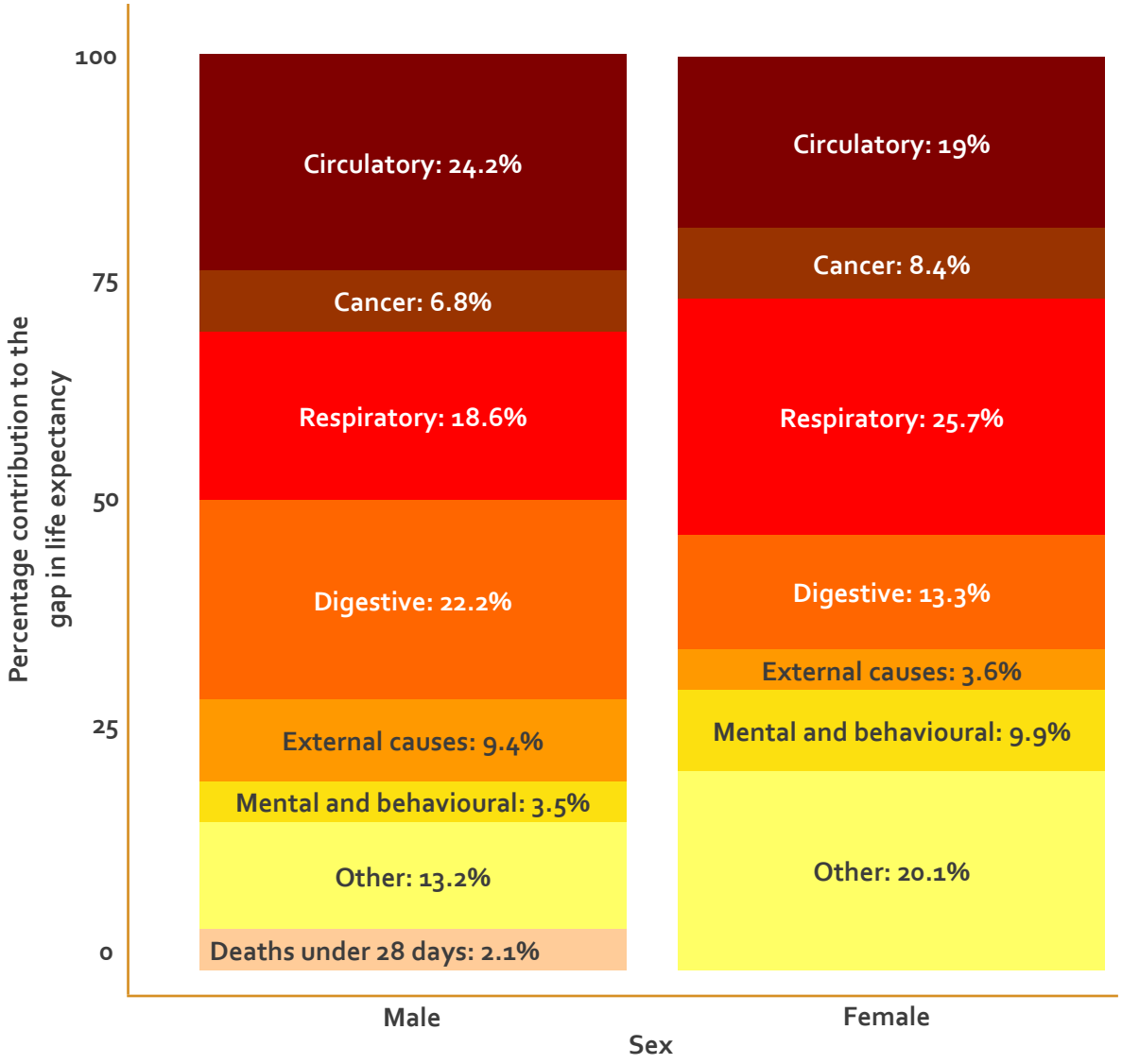
We have added life to years but not necessarily years to life. Healthy life expectancy in males has decreased since 2009. If not addressed, this is likely to affect the economy and productivity of our workforce

The average number of years a male child can expect to live in good health, (healthy life expectancy), is 61.1 years, meaning they will spend 17.5 years in poor health. Male HLE has been decreasing since 2009-11 and is significantly worse than the England average.

2.2 Causes of excess deaths

A 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. The causes of death that are driving inequalities in life expectancy at Lancashire level are shown in the chart below. Targeting the causes of death which contribute most to the life expectancy gap should have the biggest impact on reducing inequalities.

Chart 1: Breakdown of the life expectancy gap between Lancashire as a whole and England as a whole, by broad cause of death, 2015-17.



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 the gap caused by a significantly higher proportion of external causes for men (including deaths from injury, poisoning and suicide). The table overleaf shows the absolute numbers of excess deaths.

Table 2: Breakdown of the life expectancy gap between Lancashire as a whole and England as a whole, by broad cause of death, 2015-2017

	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	4,937	360	24.2	4,567	241	19.0
Cancer	5,314	91	6.8	4,565	45	8.4
Respiratory	2,655	303	18.6	2,907	423	25.7
Digestive	1,002	185	22.2	955	115	13.3
External causes	770	- 1	9.4	481	- 5	3.6
Behavioural	1,540	95	3.5	3,075	235	9.9
Other	1,928	114	13.2	2,479	225	20.1
Deaths under 28 days	67	5	2.1	47	-	-
Total	18,213	1,152	100	19,076	1,279	100

Source: Public Health England Segment Tool

This means there were at least 2,430 excess deaths in Lancashire between 2015 and 2017 compared to the England average.

2.3 Inequalities within Lancashire

Public Health England has produced an 'at a glance' profile, which give a snapshot of the health of the population in Lancashire. The profile includes key indicators around the wider determinants of health, health improvement, health protection, and healthcare and premature mortality. The profile includes the recent trends and changes from previous values. To view the profile please click on the link here.

A framework of indicators known as the Marmot indicators are another measure of inequalities published for local authorities in England. Analysis of the most recent published data shows that Lancashire is significantly better than the national average in some areas such as long-term claimants of Jobseeker's Allowance but significantly worse than the national average in other areas such as:

- GCSE achieved 5A*- C including English and maths with free school meal status (%).
- Good level of development at age 5 (%) (improving based on recent trend).
- Good level of development at age 5 with free school meal status (%) (improving based on recent trend).
- Fuel poverty for high fuel cost households (%) (getting worse based on recent trend).

It should be noted that there is also significant variation between the districts within Lancashire.

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'[2], was published in February 2010, and concluded that reducing health inequalities would require action on six policy objectives, which are still relevant in 2019:

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

The policy objectives 1, 3, 5 and 6 form the basis for this year's public health report.

3. Investing in giving children the best start in life

A key recommendation in the previous public health annual report[3] was to ensure the best start in life for our children and young people, including systematically implementing the Healthy Child Programme across Lancashire. A lot has been achieved since the last report, including a new partnership between Lancashire County Council and Virgin Care which will see health visiting and school nursing services across Lancashire transformed over the next three years. Running alongside this is a refresh of the council's approach to early help, with the early years as a key focus, ensuring that families and carers receive the right support at the right time in the right way. Lancashire is committed to ensuring services are offered as early as possible and are coordinated, integrated, accessible and personalised to the needs and strengths of individual children, young people and families.

3.1 Why it matters

The Marmot Report on health inequalities cited evidence that development begins before birth and that the health of a baby is crucially affected by the health and wellbeing of the mother. Key factors for poor development outcomes include:

- Parental depression
- Parental illness or disability
- Smoking in pregnancy
- Parent at risk of alcoholism
- Domestic violence
- Financial stress
- Parental worklessness
- Teenage mother
- Parental lack of basic skills, which limits daily activities
- Household overcrowding

The Marmot report states:

'The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid in early childhood. What happens during these early years (starting in the womb) has lifelong effects on many aspects of health and wellbeing.'

Marmot showed that of about 700,000 children born in 2010, if policies could be implemented to eradicate health inequalities, then each child could expect to live two years longer.

Child poverty has short, medium- and long-term consequences for individuals, families, neighbourhoods, society and the economy. These consequences relate to health, education, employment, behaviour, finance, relationships and subjective wellbeing. Therefore, there are economic and social arguments for investing in childhood. The Family Nurse Partnership estimated savings five times greater than the cost of the programme in the form of reduced welfare and criminal justice expenditures; higher tax revenues and improved physical and mental health.

3.2 What is the current picture in Lancashire?

Overall, comparing local indicators with England averages, the health and wellbeing of children in Lancashire is mixed.

Key issues (from the Lancashire Child Health Profile 2019):

- The infant mortality rate is worse than England with an average of 62 infants dying before the age of one year each year. Recently there have been 33 child deaths (1-17-year olds) each year on average.
- The teenage pregnancy rate is worse than England (now showing signs of improvement), with 440 girls becoming pregnant in a year.
- 13.4% of women smoke while pregnant which is worse than England (2018/19).
- The Measles, Mumps and Rubella (MMR) immunisation level does not meet recommended coverage (95%). By age two, 91.4% of children have had one dose (2018/19 data).
- Dental health is worse than England. 34.0% of 5-year olds have one or more decayed, filled or missing teeth.
- Over a fifth of reception children (23.5%) aged 4-5 are overweight or obese, higher than England (22.6%). This rises to one in three for year six children (34.5%), similar to England (34.3%) (2018/19).
- The rate of child inpatient admissions for mental health conditions at 98.8 per 100,000 is worse than England.
- The rate for self-harm at 439.3 per 100,000 is similar to England.
- Over a three-year period, 224 children were killed or seriously injured on the roads. This gives a worse rate than England.

Monitoring infant deaths remains a priority and the Child Death Overview Panel 2018-2019 annual report provides information on trends and patterns in the deaths reviewed in the last reporting year (2018-2019) and on all deaths since the panel began in 2008, across the Lancashire-14 area. The Lancashire-14 area incorporates the two additional unitary authorities of Blackburn with Darwen and Blackpool.

Investing in new partnerships

The new partnership between Lancashire County Council and Virgin Care which launched on Monday 1 April 2019, will see health visiting and school nursing services across Lancashire transformed over the next three years.

More than 400 health visitors, school nurses and other health professionals are part of the new partnership, which will be known as the "Lancashire Healthy Young Person and Family Service", delivering the three year transformation programme which will give new families and young people access to additional support, free up professionals from their desks to spend more time in the community and mean extra help for the most vulnerable.

The new partnership will see most of the key foundations of the new service – such as new 'hub' and 'spoke' bases for staff based around Preston, Burnley and Lancaster, and new technology to support mobile working – live from the very start.

3.3 What makes a difference?

The most effective interventions are often those that are preventive instead of reactive. Preventive interventions address risk factors (mentioned earlier in this chapter) likely to result in future problems for particular families, without waiting for those problems to emerge.

- A joined-up approach "whole system around the child / family, less fragmented".
- Helping children, families and communities to secure outcomes for themselves, laying the foundations for good parenting including a healthy pregnancy.
- Breaking cycles of poverty, inequality and poor outcomes in and through early years (substance misuse; debt; poor housing, low income, poverty, worklessness, domestic abuse).
- Focus on engagement and empowerment of children, families and communities – e.g. through motivational interviewing to build skills and resilience.
- Using the strengths of universal services to deliver prevention and early intervention – identify needs and risks early.
- The safer sleep for baby campaign aims to raise awareness of safer sleeping for babies and focuses on six easy. steps for parents/carers to follow to make sleep safer, and potentially reduce the risk of Sudden Infant Death Syndrome (cot death).
- Putting quality at the heart of service delivery – skills, knowledge, attitudes and qualifications of the workforce.
- Services that meet the needs of children and families across the social gradient – integrated education and childcare services.
- Reducing barriers to access, particularly transport, improving outcomes and children's quality of life through play.
- Multi-agency pathways of care, based on robust evidence including strategic leadership.
- More effective collaboration between public, private and third sector.

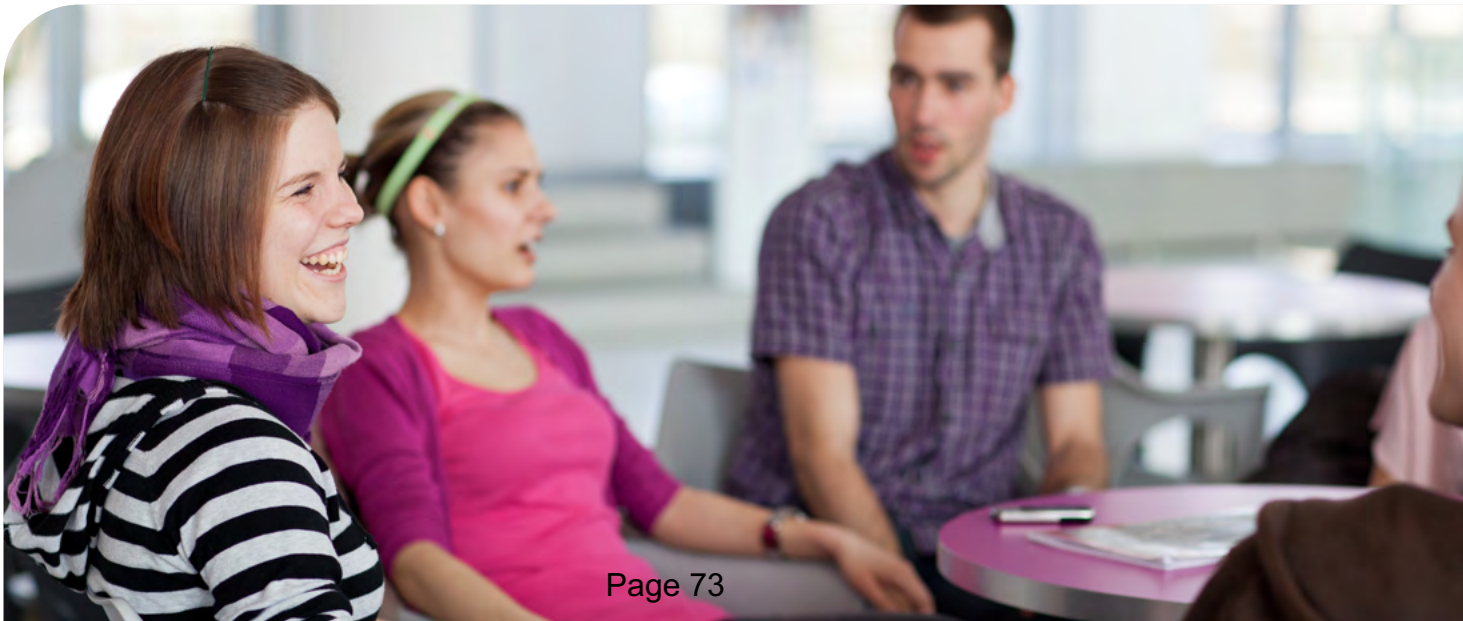
3.4 Recommendations / future challenges

1. Joining up commissioning within the Local Authority for children's public health, early years and wider family services including education.

2. Joint commissioning between Local Authority, CCGs (which commission NHS children services) for services around the child and family.

3. Refreshed early help and early years strategies and delivery plans.

4. A renewed focus to help families, children and communities build skills, local capacity and resilience to be able to secure positive outcomes for themselves and each other.



4. Investing in our communities

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. Place based planning is based on key actions to strengthen community action, civic service integration and service engagement with communities[4].

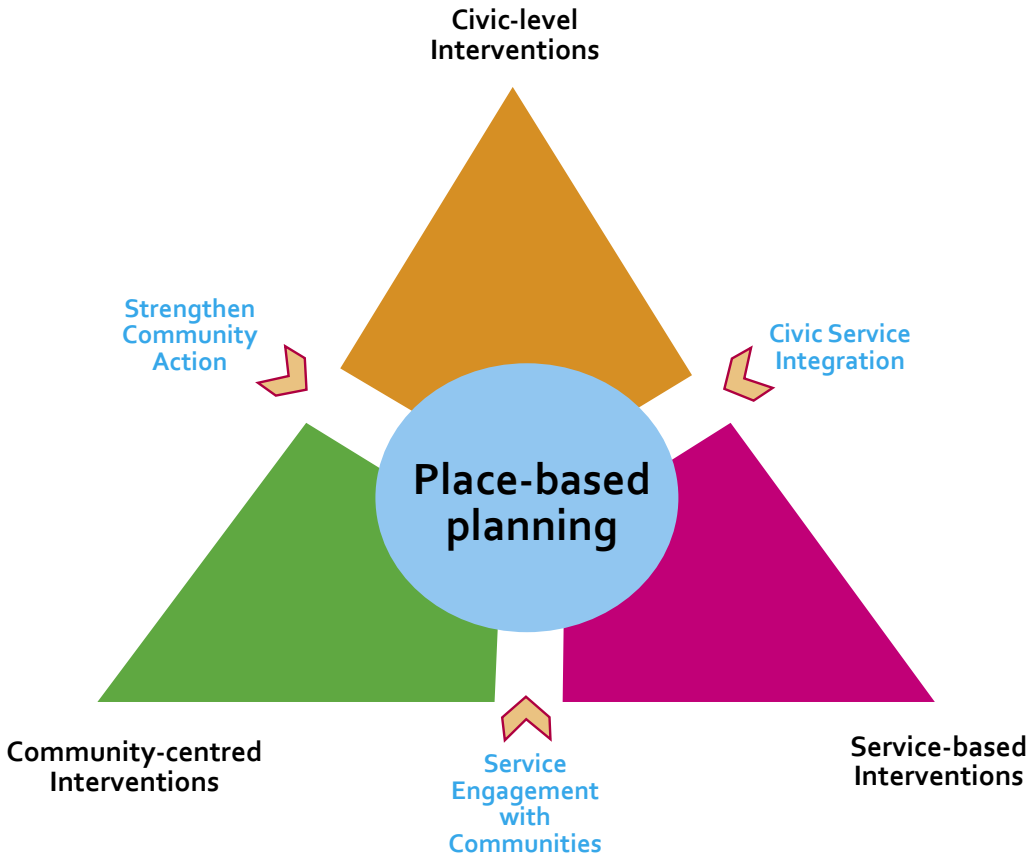
Lancashire County Council is ranked as the most deprived out of the 26 two-tier county council areas in England, and 78th out of all 151 upper-tier local authorities. The county council has 24.7% (187) of its 756 Lower Super Output Areas (LSOAs) in the 20% most deprived nationally, an increase from the 22% (166) in the 2015 indices. 18.3% (138) of county council's LSOAs are in the 20% least deprived nationally, a fall from 18.8% (142) in the 2015 indices.

Burnley is the most deprived lower-tier authority area within the county council area, with an IMD rank of average rank of 11, where one is the most deprived, and 317 is the least deprived in England. Hyndburn, Pendle and Preston are also in the 20% most deprived areas in England on this measure. Ribble Valley is the only Lancashire district in the least deprived 20% of authority areas.

Burnley, Hyndburn, Lancaster, Pendle and Preston are also ranked in the 20% most deprived areas in England for the health deprivation and disability rank of average rank measure and the living environment rank of average rank measure. For the employment deprivation rank of average rank, Burnley, Hyndburn, Pendle, Preston and Rossendale are in the 20% most deprived areas in England for this measure.

Effective place-based action requires action on civic, service and community interventions, along with system leadership and planning.

Figure 1: The Population Intervention Triangle model (PIT)



4.1 Why it matters

Place matters.
We live our lives in neighbourhoods – so it makes sense for them to be the starting point for how we think about services. Working at a neighbourhood level – with communities who understand both the challenges local people face and the strengths they have to overcome them – can help find creative solutions to seemingly insurmountable problems.

Quite simply where you live affects your health, people living in the most deprived areas spend nearly a third of their lives in poor health, compared with only about a sixth for those in the least deprived areas. Not only are health inequalities socially unjust they are preventable. They cut people's lives short and lead to avoidable years living with impaired health and wellbeing. In addition to this personal cost there are also costs the NHS, local authorities and our national and local economies which amount to billions of pounds each year.

The causes of health inequalities are a complex mix of environmental and social factors which play out in a local area, or place – this means that local areas have a critical role to play in reducing health inequalities. Many of the solutions to challenges such as improving the public's health need to be much more rooted in local circumstances. We often identify groups of people that need extra help and target them – we do that less well with places. If we are to invest in our communities to maximise the benefits to health we should focus on the neighbourhoods which are doing less well and target our resource and effort there. This needs to be firmly embedded in the neighbourhood and start from a position of what does this place have that's good.

The 'asset approach' is an approach which builds on the assets and strengths of specific communities and engages citizens in taking action for themselves, not only is this empowering it is also cost-effective and sustainable.
It harnesses the resources of citizens, community groups and the third sector to complement the work of the public sector. Given the growing financial pressures these are important benefits. In short – we all win, communities and citizens take control of what makes them well, which frees up public sector resource for those who simply are not able to take personal responsibility and need our help.

This approach does not come for free, we must invest time, resources and support in our communities to help them to thrive. Healthy and resilient communities which are strong and supportive of each other do not depend on the support of statutory services. However creating and sustaining this approach does require organisations to work differently, and will only be achieved through services collaborating with communities on what will help them to flourish. An important, pressing issue facing communities and statutory services is the climate emergency on which we are working together to harness our mutual assets.

4.2 What's the picture in Lancashire?

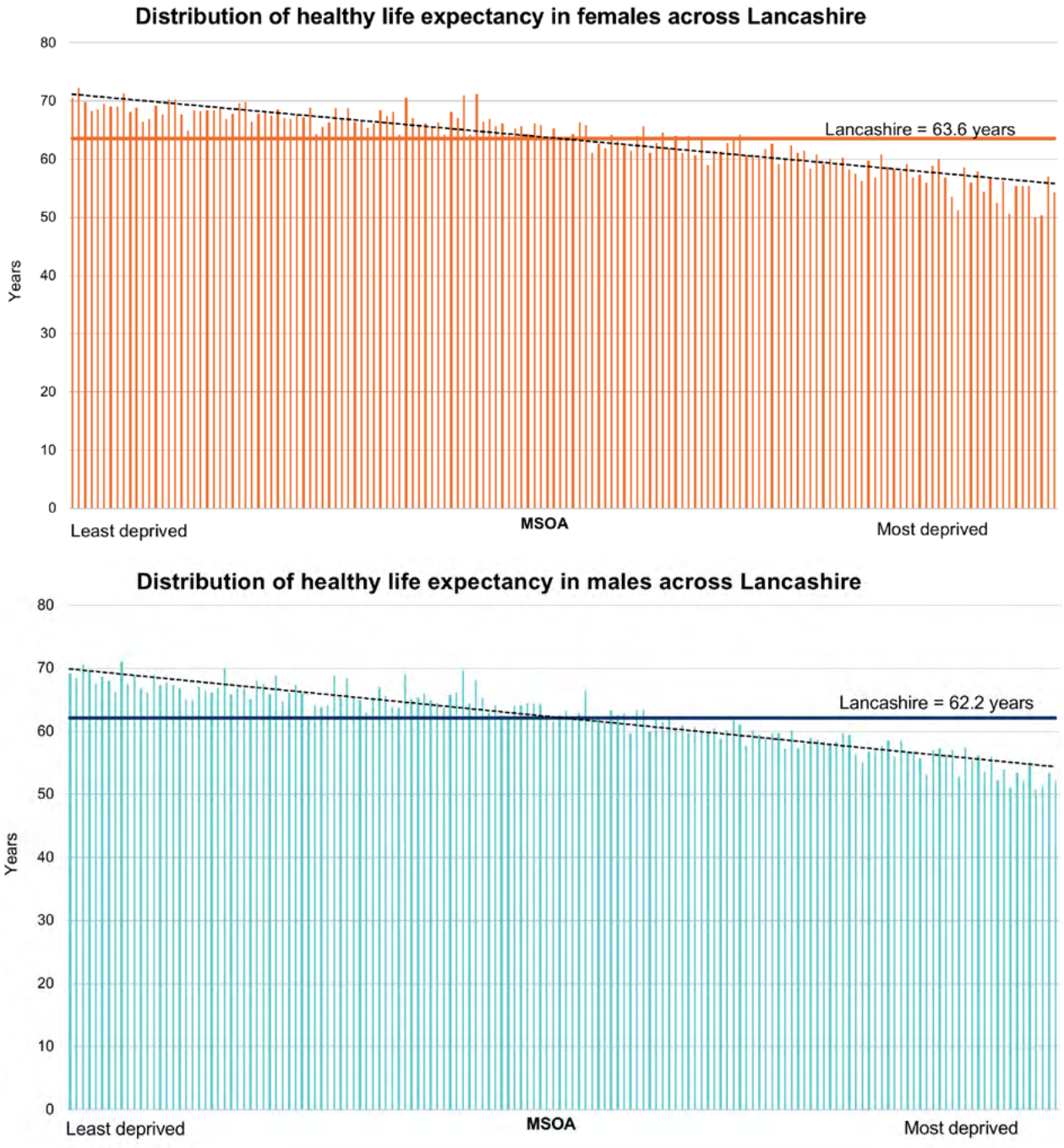
As we saw above the increasing gap in life expectancy between the most and least deprived areas gives us cause for concern.

Extreme inequalities can be found across a range of indicators; the percentage of year 6 children who are overweight or obese in Lostock Hall, South Ribble is 25.9% (2015/16-17/18), whereas the percentage is 45.8% in Daneshouse with Stoneyholme (Burnley). In University ward, Preston, the percentage of young people (16-18) not in education, employment or training is 16.4%, while in Eccleston and Mawdesley, Chorley, the figure is only 0.2%.[5]

> 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.

An important consideration is that these inequalities are not just present between the most deprived areas and the rest of Lancashire. As an illustration, the bar charts show the distribution in female and male healthy life expectancy across the 154 middle-layer super output areas (MSOAs) in Lancashire.

Chart 2: Distribution of female and male healthy life expectancy across Lancashire (2009-13)



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.

There is a strong commitment to tackle health inequalities in Lancashire. This was demonstrated by the completion of the health inequalities joint strategic needs assessment (Health Inequalities JSNA) in 2009, repeated in 2014 and now being undertaken again in 2019 with an expected publication date in March 2020 following the Marmot 10 years on review publication in February 2020.

4.3 What makes a difference

Good neighbourhoods help people have good lives.
Understanding what matters to people where they live and by working with them on the challenges they face can help find creative solutions to seemingly insurmountable problems. Neighbourhoods are where people spend most of their time so it seems obvious that is where the solutions must be. We need to work with our communities to co-create solutions.

In Lancashire we are developing an approach to neighbourhood working, which we call Total Neighbourhoods. We have been working with our health, district council and other partners in the constabulary and Lancashire Fire and Rescue service, as well as the voluntary, community and faith sector (VCFS). We are working together as one team, but this isn't just about how we work better together as organisations, it's about listening to our communities and shaping our services to meet their needs.

We are really starting to make a difference by working in this way with one of our communities, in Fleetwood. Watch this video to see what a difference this is making to the people who live and work there.

Investment in our communities is vital. Living and working conditions and (un)employment are important determinants of health, but healthy, resilient communities are also a vital determinant of a thriving economy. We need to invest in our workforce and commit to working differently 'with' people to change the system in which health and wellbeing is created rather than one which treats and manages conditions. This requires commitment from system leaders. The investment needed is not financial we need to repurpose our all our investment in our communities and work with them to build a sustainable new approach which creates resilience.

4.4 Recommendations / future challenges

5. System leaders should commit to new models of working across the public sector to develop asset based approaches to service delivery, that enhances the capacity and capability within our citizens and communities.

6. Public sector partners should work hard to align and even pool budgets wherever possible to maximise their capacity to improve outcomes for people including tackling the climate emergency and investments in social prescribing.

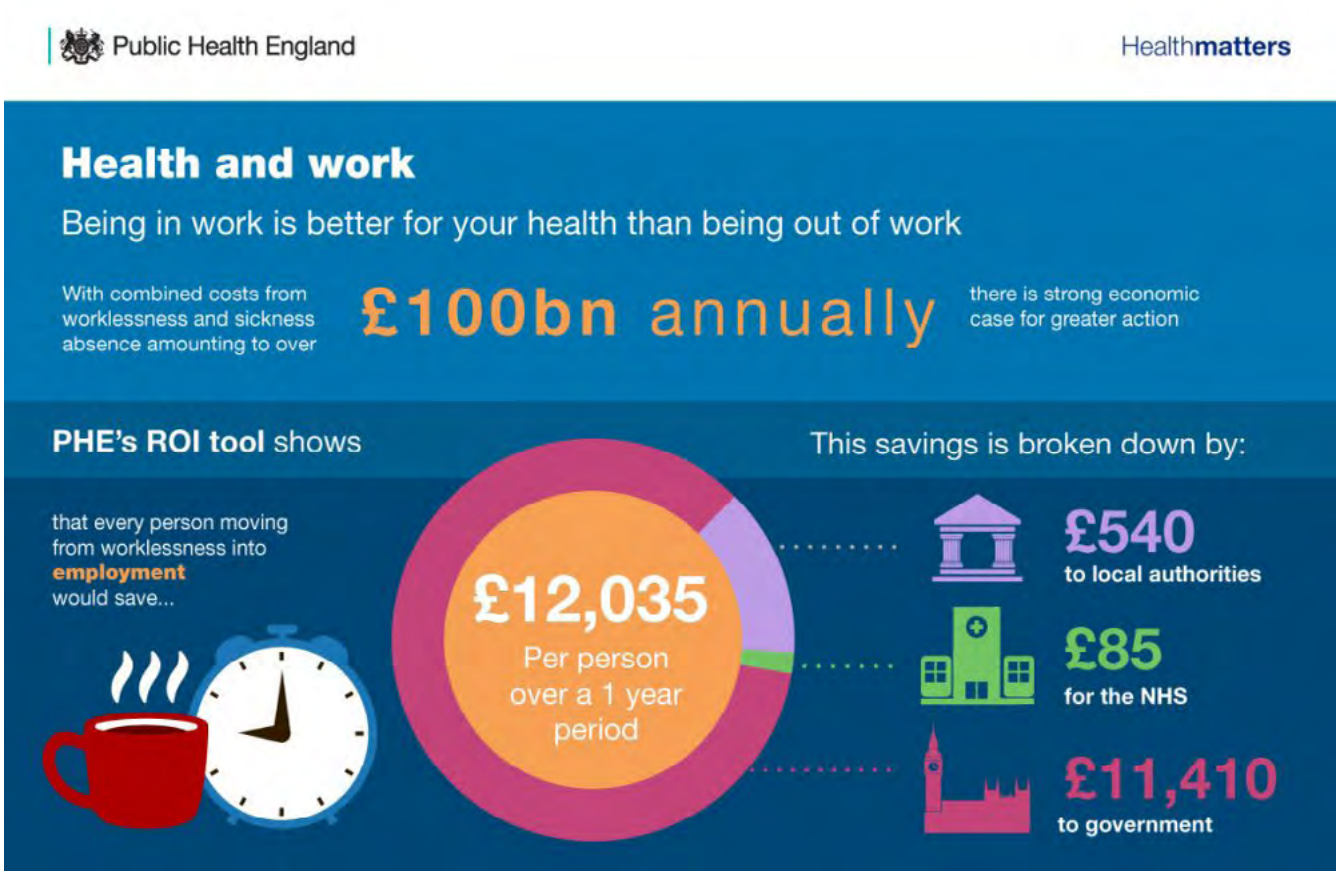
7. Use our engagement processes to have open conversations with our citizens to develop strong and resilient communities that take responsibility for creating and maintaining their own health and wellbeing that is supported by effective services which they co-create.

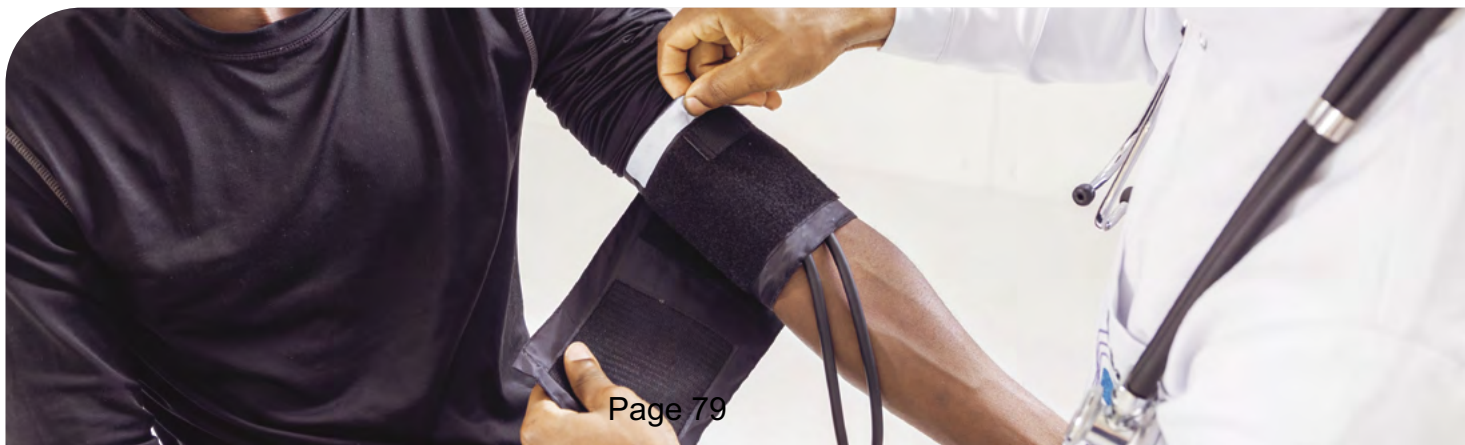
5. Investing in our working age population

5.1 Why it matters

Having a healthy and capable working age population (WAP) has major positive impacts at an individual level, for organisations, the local economy and wider society. This means supporting people to achieve their potential in life by enabling them to enter the employment market and maintain financial independence and security for themselves and their families, especially as they age. This is particularly important for people with long term conditions and disabilities, a large number of whom want to work and live independent lives. Additionally, for those in work, it means being able to access fair employment and good work to maintain healthy behaviours, to get the support to stay in work and in the case of sickness absence, return to work promptly.

Infographic 1: Health and financial benefits of moving individuals into employment in the UK





Fundamentally, a healthy place is one that has the potential to be a healthy and productive workforce for the local economy. It also drives improvements in wellbeing and narrows the gap in health inequalities. The evidence that unemployment is bad for your health is clear, and keeping people in work or getting people back to work also reduces the number of working-age people claiming out of work benefits and lessens the impact of poverty and social exclusion.

Achieving this will require collaborative, strong and effective management in workplaces, and engagement and communication with communities and individuals, particularly around understanding the impact of the wider determinants of health, personal resilience, health promotion and training and the support for the management of long-term conditions. It is established that many causes of ill health are attributed to modifiable lifestyle factors, such as smoking, physical inactivity, obesity, poor diet, excessive alcohol consumption, and substance use. Other contributory factors include the cumulative impact of living/working conditions. As a person ages they are more at risk of developing debilitating health conditions. Alongside the main causes of mortality, many other conditions can also have a profound impact on individuals, such as musculoskeletal conditions and diabetes, and result in poor health, comorbidity and long-term disability

Infographic 2: The cost of an unhealthy workforce

5.2 What is the current picture nationally and in Lancashire?

The impact of long-term conditions and disability in the WAP is huge, with economic and social costs to both the individual and society in the form of lost productivity and increased health and social care demands.

It is estimated that more than 131.2 million days were lost to sickness absence in the UK in 2017 and working-age ill health could cost the national economy up to £100 billion a year.[5,6] The costs to the taxpayer – benefit costs, additional health costs and forgone taxes – are estimated to be over £60 billion.[7] Since 2003, there has been a general decline in the number of days lost to sickness absence, with the figure falling to a low of 131.7 million days in 2013, but there were increases in 2014 and 2015.

Nationally, it is estimated that 2% of patients comprise 16% of spend on inpatient admissions (2015/16), with the most common conditions of admission for complex patients being circulatory, 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.

In Lancashire key facts about complex patients include:

- The average complex patient has seven admissions per year for three different conditions (based on programme budget categories).
- 61% of these complex patients are aged 65 or over; 38% of these complex patients are aged 75 or over.
- 14% 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 four attendances a year on average.

Table 3: The proportion of CCGs spend on the 2% of their most complex patients is provided in the table below:

CCG (2015/16)	Number of patients	Proportion of CCG spend	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	595	16.8%	12,424
East Lancashire	1,249	16.8%	25,775
West Lancashire	393	16.4%	7,635
Total	3,940		79,553

Source: NHS Clinical Commissioning Group (2015/2016 data)

It is estimated that the state pension age for children born in 2019 will be 68 years. It is therefore important to have as much of 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 for Lancashire, 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 a healthy working life for our population, and particularly our children.

5.3 What makes a difference

Evidence shows that work, education, training and volunteering are contributors to good physical and mental health and wellbeing. Conversely unemployment, poor quality employment and long-term sickness absence have a harmful impact, with higher rates of mortality, morbidity and a lower quality of life. There also may be fewer opportunities for development and growth, and for people to reach their full potential.

Examples of effective interventions include musculoskeletal (MSK) prevention and supporting employers to help staff improve their health and wellbeing.

Infographic 3: Effective interventions for MSK prevention

Infographic 4: Employer actions to improve workforce health and wellbeing

5.4 Recommendations / challenge

8. Collaborate with leaders in economic growth and local employers across the sectors to develop strategies to promote and deliver a Lancashire Offer for workplace health to promote and manage the health and wellbeing of staff and so support Lancashire businesses to be productive and be able to retain and recruit staff. Encourage employers and staff to adopt carbon neutral modes of transport (e.g. walking, cycling) and work environments.

9. Strategically support employers using what we know works to improve the health and wellbeing of employees (guidance from National Institute for Health and Care Excellence , Local Government Association, Public Health England, Health and Safety Executive). Having an emphasis on organisational culture, engagement, role of line managers and the wider determinants of health is essential to this.

10. Support communities and workplaces in creating and implementing pathways to good jobs, especially for those who want to work and live independent lives. Inclusive growth should be achieved by working together with partners from across the private, public, voluntary sector, primary and community care services.

6. Investing in our own health and wellbeing

6.1 Why it matters

The strong evidence to support investment in preventative interventions has previously been referenced earlier in this report. The potential impact of such interventions cannot be understated as it is estimated that nationally around 40% of all deaths in England are related to the individual behavioural and societal opportunities to make healthier choices. The NHS spends more than £11bn a year on treating illnesses caused by the effects of diet, inactivity, smoking and drinking alcohol.[8]

Strategically it is important to acknowledge that the potential range of preventative interventions to address this is wide ranging and needs to be planned across the life course using an evidence based, needs based approach whilst ensuring that the full range of civic, community and service interventions are appropriately integrated.

In terms of local context it is therefore important to not only highlight the significant impact that empowering communities and individuals to adopt healthier choices can have on broader health and well being as well as focus in on some of the key challenges and opportunities within Lancashire.

6.2 What is the current picture in Lancashire?

The following sections provide some key facts about lifestyle behaviours in Lancashire.

Tobacco

Tobacco use is the biggest risk factor for disability and death globally and continues to present significant harm to the population of Lancashire.

- Tobacco smoking kills over 2,000 adults (aged 35+) in Lancashire each year.
- Smoking prevalence remains slightly higher in Lancashire (14.2% in 2018) compared to England (14.4%), although this figure continues to fall (current smokers aged 18+).
- Just over 13% of women were smoking at the time of delivery, significantly worse than England (10.6%) (2018/19).
- The proportion of young people smoking (9.0%) is similar to England (8.2%) (2014/15).
- The cost of smoking to society in Lancashire is estimated at £269.8m; of this £59m is the cost to the NHS.[9]
- A person smoking 20 cigarettes a day will spend between £3,200 and £4,000 per year (depending on brand).

Excess weight

Obesity is the second leading cause of premature death in Europe and a contributor to a number of non-communicable diseases such as some cancers, cardiovascular disease and type 2 diabetes.[10]

- In Lancashire, the percentage of overweight and obese adults (64.6%) is significantly higher than England (62.0%), with the trend showing a small increase year on year (2015/16 to 2017/18).
- Over a fifth of reception children (23.5%) aged 4-5 are overweight or obese, higher than England (22.6%). This rises to one in three for year six children (34.5%), similar to England (34.3%) (2018/19).
- In England, 71% of people with no qualifications have excess weight (overweight and obese combined), compared to those with a level 4 and above qualification (a degree or higher).[11]
- Estimates indicated the cost of obesity to the NHS was likely to be approximately £6.3bn by 2015, rising to £9.7bn by 2050.

Physical activity

Inactivity, described by the Department of Health as a "silent killer," directly costs the NHS across the UK an estimated £1.06 billion annually and is the fourth leading risk factor for death and disability.

- The health benefits of activity include a 30% lower risk of early death; a 20% lower risk of breast cancer; up to a 35% lower risk of coronary heart disease and stroke; and up to a 50% lower risk of type 2 diabetes.
- Two-thirds of adults (19+ years) in Lancashire are meeting moderate physical activity recommendations, in line with the England proportion (66.3%).
- Just over a fifth of adults (22.0%) are classed as inactive in Lancashire, similar to England (22.2%).
- 664 deaths could be prevented if adults (40-79 years) were engaged in the recommended levels of activity.
- The cost of inactivity to Lancashire is £22.6m per year.[12]

Alcohol

Alcohol consumption can directly affect physical and mental health, and also have wider impact on individuals and society, through increased risk of accidents, and crime and violence for example:

- Alcohol misuse costs almost £21 billion per year in England (Lancashire £495m).
- Of Lancashire's population 1.5% are dependent drinkers, 17.8% are binge drinkers and 22.9% have increasing risk due to alcohol misuse.[13]

6.3 What makes a difference

Investing across the life course is a central tenant of the Government's recent Green paper on Prevention[14]. This paper crucially acknowledged that when considering factors that shape our health and wellbeing, whilst these are indeed likely to vary from person to person and from disease to disease, most people agree that the choices we make, shaped by the conditions in which we live, have the biggest impact. These considerations have been central in formulating our recommendations over how best we invest our energies, time and resources in order to maximise individual behavioural and societal opportunities to make healthier choices.

6.4 Recommendations / future challenges

Drawing on some of the emerging national consultation on how we should best achieve this, it is therefore recommended that within Lancashire:

11. Strategically we align our collaborative approaches to prevention with partners across Lancashire ensuring they are able to be predictive, proactive and personalised while ensuring they still maintain their strong focus on our biggest lifestyle challenges referenced above.

12. Continue to develop our 'Health in All Policies' approach to help create environments that support individuals' opportunities to adopt healthy behaviours.

13. Embed further preventative interventions into mainstream service delivery across our range of commissioned services on an integrated basis across both the NHS, social care and the voluntary sector whilst also systematically embedding a culture of 'Make Every Contact Count'.

14. Continue to incorporate a behavioural science approach to some of our biggest challenges around promoting and embedding a culture of healthy lifestyles.

Summary of Recommendations/ Future Challenges

Best start in life

1. Joining up commissioning within the local authority for children's public health, early years and wider family services including education.

2. Joint commissioning between local authority, CCGs (which commission NHS children services) for services around the child and family.

3. Refreshed Early Help and Early Years Strategies and delivery plans.

4. A renewed focus to help families, children and communities build skills, local capacity and resilience to be able to secure positive outcomes for themselves and each other.

Investing in our communities

5. System leaders should commit to new models of working across the public sector to develop asset based approaches to service delivery,that enhances the capacity and capability within our citizens and communities.

6. Public sector partners should work hard to align and even pool budgets wherever possible to maximise their capacity to improve outcomes for people including tackling the climate emergency and investments in social prescribing.

7. Use our engagement processes to have open conversations with our citizens to develop strong and resilient communities that take responsibility for creating and maintaining their own health and wellbeing that is supported by effective services which they co-create.

Working age population

8. Collaborate with leaders in economic growth and local employers across anchor institutions to develop strategies to promote and deliver a Lancashire Offer for workplace health to promote and manage the health and wellbeing of staff and so support Lancashire businesses to be productive and be able to retain and recruit staff. Encourage employers and staff to adopt carbon neutral modes of transport (e.g. walking, cycling) and work environments.

9. Strategically support employers using what we know works to improve the health and wellbeing of employees (guidance from National Institute for Health and Care Excellence , Local Government Association, Public Health England, Health and Safety Executive). Having an emphasis on organisational culture, engagement, role of line managers and the wider determinants of health is essential to this.

10. Support communities and workplaces in creating and implementing pathways to good jobs, especially for those who want to work and live independent lives. Inclusive growth should be achieved by working together with partners from across the private, public, voluntary sector, primary and community care services.

Our own health and wellbeing

Drawing on some of the emerging national consultation on how best we should best achieve this, it is therefore recommended that within Lancashire:

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12. Continue to develop our 'Health in All Policies' approach to help create environments that support individuals' opportunities to adopt healthy behaviours.

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14. Continue to incorporate a behavioural science approach to some of our biggest challenges around promoting and embedding a culture of healthy lifestyles.

References

1 'Lancashire' in the context of this report refers to the twelve local authority districts in the county council area and does not include the two unitary authorities of Blackburn with Darwen and Blackpool.

2 Fair Society Healthy Lives. Marmot 2010 - http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review

3 Securing our Health and Wellbeing. Lancashire Director of Public Health Report 2016 - https://www.lancashire.gov.uk/media/898725/securing-our-health-and-wellbeing-report-of-the-dphw-2016.pdf

4 Place Based Approach to Inequalities. Public Health England 2019 - https://www.gov.uk/government/publications/health-inequalities-place-based-approaches-to-reduce-inequalities

5 Sickness absence in the UK labour market. Office For National Statistics: Sickness absence in the UK labour market - https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/datasets/sicknessabsenceinthelabourmarket

6 A million workers off work for more than a month, 2014 - https://www.gov.uk/government/news/a-million-workers-off-sick-for-more-than-a-month

7 Health and Work Infographics. PHE and The Work Foundation - https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/618541/Health_and_work_infographics.pdf

8 One You: A step towards better health and more sustainable services. PHE, 2016 - Public Health Matters blog - https://publichealthmatters.blog.gov.uk/2016/03/07/one-you-a-step-towards-better-health-and-more-sustainable-services/

9 ASH 'Ready Reckoner', 2019 - http://ash.lelan.co.uk/

10 World Health Organization: Obesity factsheet, 2018 - https://www.who.int/news-room/fact-sheets/detail/obesity-and-overweight

11 House of Commons Library briefing paper, August 2019 - https://researchbriefings.files.parliament.uk/documents/SN03336/SN03336.pdf

12 Sport England, Lancashire Profile, 2016 - https://public.sportengland.org/Shared%20Documents/Map%20Library/LA%20mini%20sport%20profiles%20-%20Aug%202016/Lancashire.PDF

13 Public Health England Local Alcohol Profiles for England - https://fingertips.phe.org.uk/profile/local-alcohol-profiles

14 HM Government (2019), Advancing our health: prevention in the 2020's - https://www.gov.uk/government/consultations/advancing-our-health-prevention-in-the-2020s


Lancashire
County
Council

Appendix B

Health and Wellbeing Board

Lancashire Infant Mortality Report by Director of Public Health

January 2020

www.lancashire.gov.uk

Lancashire County Council

1. Introduction

1.1 This report provides information about infant mortality and outlines our proposed plan to reduce the number of infant deaths in Lancashire.

1.2 Infant mortality is an indicator of the overall health of a population. It reflects the relationship between the causes of infant mortality and upstream determinants of population health such as economic, social and environmental conditions.

1.3 Reducing infant mortality is an important part of the Population Health Plan First 1000 Days priority.

1.4 Infant mortality is also a key priority area for the Children, Young People and Families Partnership Board as part of a broader approach in the Early Years Strategy (see Appendix 1).

1.5 Infant mortality has been highlighted as a key part of the Director of Public Health report and is also a major part of the ICS work.

2. Definitions

2.1 Infant mortality is defined as deaths that occur in the first year of a child's life.

2.2 The infant mortality rate is the number of deaths at ages under 1 per 1,000 live births. Stillbirths are not normally counted as infant deaths and are not included in the calculation of the infant mortality rate. Some of the factors that contribute to a stillbirth may also be contributing factors in infant deaths.

2.3 Infant deaths can be divided into three broad stages, each with a different set of risk factors and determinants:

- Deaths under 7 days of life (perinatal mortality)
- Deaths to infants aged under 28 days (neonatal mortality)
- Deaths to infants aged 28 days to 1 year (post-neonatal mortality)

3. Data sources and limitations

3.1 There are three main sources of data and information on infant deaths in the UK:

3.1.1 Vital Statistics i.e. information supplied when infant deaths are certified and registered as part of the civil registration process. This is a legal requirement and the information that is collected is prescribed in the relevant legislation. The data collected through this process is managed by the Office for National Statistics (ONS) and is usually reported based on the local authority within which the deceased was usually resident at the time of death.

3.1.2 Child Death Overview Panels (CDOP) collect and review information about each child death in a local area in order to build a picture of emerging themes and patterns and inform local strategic planning on how to best safeguard and reduce harm and promote better outcomes for children in the future. Each CDOP collects data in a common format and also submits information to the Department for Education on an annual basis to inform the national picture.

3.1.3 Surveillance reporting systems, notably the Mothers and Babies Reducing Risk through Audits and Confidential Enquiries (MBRRACE) system. MBRRACE is part of the national Maternal, Newborn and Infant Clinical

Outcome Review Programme, the aim of which is to provide robust national information about the causes of maternal deaths, stillbirths and infant deaths.

3.2 The information collected by each of these sources is different. For example, the restrictions on the data collected as part of the deaths registration process means that the ONS dataset contains limited information on key risk factors, such as ethnic group, mother's country of birth, maternal lifestyles and family circumstances.

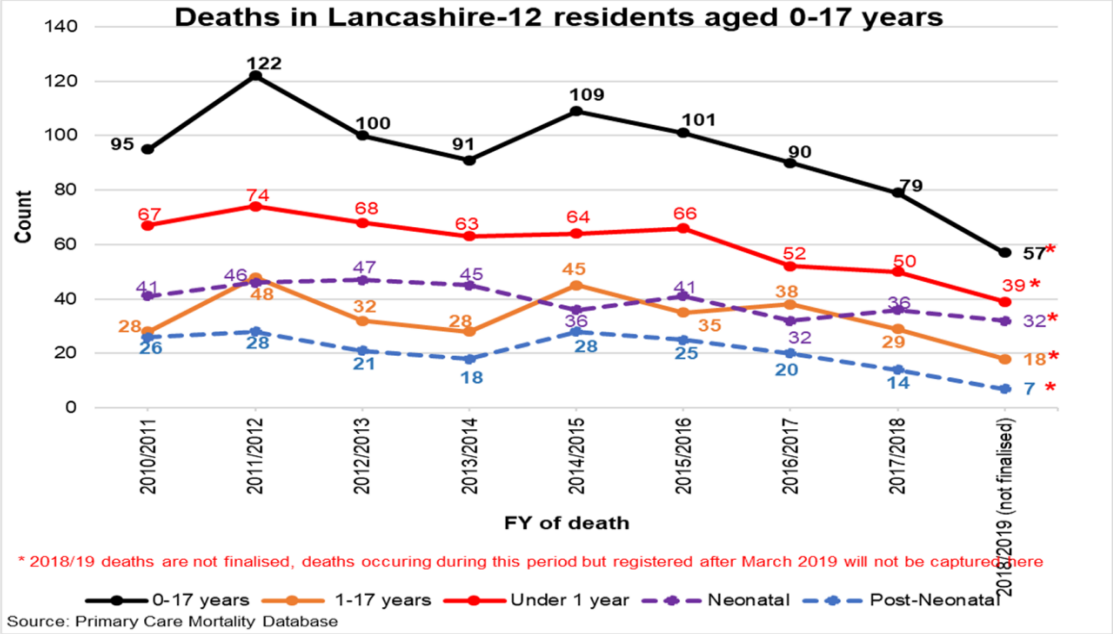
However, data on some of these factors is collected as part of the CDOP process. Used together, the ONS and CDOP data provide a rich and powerful picture of infant deaths in Lancashire.

3.3 The CDOP Annual Report for Lancashire is also produced on an annual basis and supports the context for this report and the action plan.

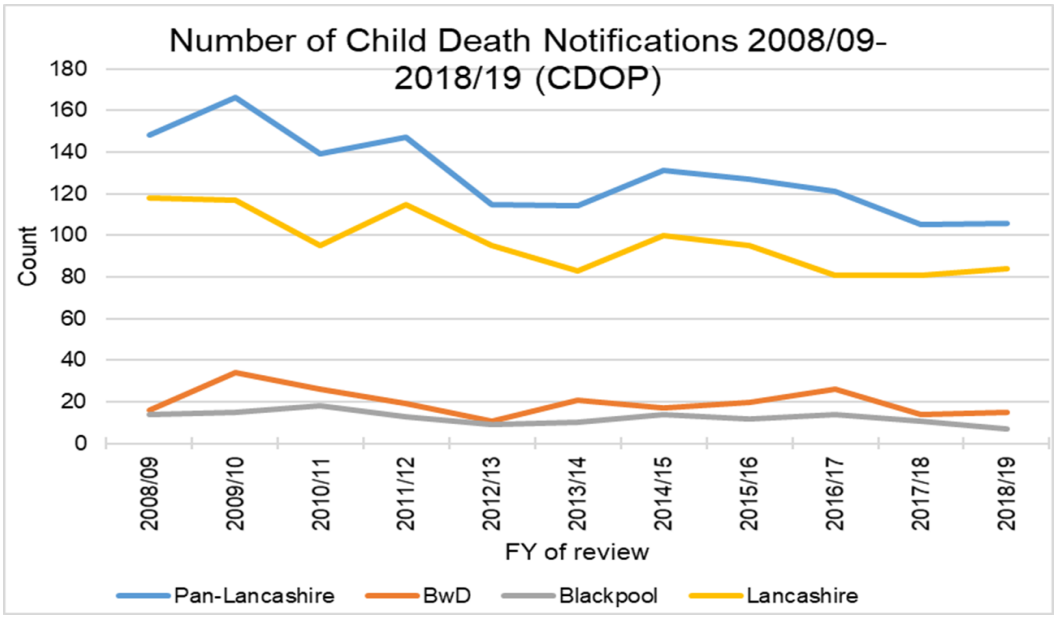
4. Trends and patterns of infant deaths in Lancashire

4.1 Infant Mortality rates

- The overall child mortality rate (age 0-17) in Lancashire has been falling as can be seen below. However child mortality remains significantly worse than the England rate (coverage over the period 2010-12 to 2015-17).
- According to recent published figures (2015-17) infant mortality and post-neonatal mortality remain worse than the England rate (2010-12 to 2015-17).
- Neonatal mortality has been similar to the England rate (coverage between 2012-2014 and 2015-2017).



4.2 According to Child death notifications from 2008/9 to 2018/19, there are inequalities between geographical areas where Lancashire has the highest number of deaths compared to Blackburn and Darwen and Blackpool.



4.3 The infant mortality rate for Lancashire is 4.7 per 1,000 compared to 3.9 per 1,000 England 2015-17. Lancashire after Staffordshire is ranked worst compared to its neighbours.

4.01 - Infant mortality New data 2015 - 17 Crude rate - per 1000

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	7,734	3.9	3.8	4.0
Neighbours average	–	-	1,623	3.7*	-	-
Staffordshire	–	2	141	5.5	4.6	6.5
Lancashire	–	-	185	4.7	4.1	5.5
Northamptonshire	–	6	122	4.5	3.7	5.4
Warwickshire	–	7	75	4.2	3.3	5.2
Worcestershire	–	9	74	4.1	3.2	5.2
Nottinghamshire	–	1	104	4.0	3.3	4.8
Kent	–	8	199	3.8	3.3	4.4
Derbyshire	–	5	86	3.7	3.0	4.6
Leicestershire	–	15	77	3.7	2.9	4.6
Lincolnshire	–	10	75	3.3	2.6	4.1
Cumbria	–	12	46	3.3	2.4	4.3
Gloucestershire	–	4	65	3.3	2.5	4.1
Norfolk	–	13	86	3.2	2.6	4.0
Essex	–	3	153	3.1	2.6	3.6
West Sussex	–	14	72	2.7	2.1	3.4
Suffolk	–	11	63	2.7	2.1	3.4

Source: Office for National Statistics (ONS)

4.4 There are also local variations and inequalities in infant deaths within areas of residence in Lancashire. As can be seen in the period 2015-2017 Burnley stands out as having the highest number of deaths, followed by Pendle, Wyre, Fylde, Chorley and Hyndburn. Ribble Valley and Lancaster have lowest number of deaths.

Infant mortality (2015 - 17), crude rate per 1,000 live births

Area	Count	Rate per 1,000	95% Lower CI	95% Upper CI
England	**7,734**	**3.9**	**3.8**	**4**
Lancashire	**185**	**4.7**	**4.1**	**5.5**
Burnley	28	7.8	5.2	11.2
Chorley	19	5.1	3.1	8
Fylde	10	5.3	2.6	9.8
Hyndburn	16	5	2.9	8.1
Lancaster	11	2.6	1.3	4.6
Pendle	21	5.7	3.5	8.7
Preston	26	4.7	3	6.8
Ribble Valley	3	2.2	0.4	6.3
Rossendale	8	3.4	1.5	6.7
South Ribble	14	3.9	2.2	6.6
West Lancashire	13	4.2	2.2	7.1
Wyre	16	5.5	3.2	9

4.5 There are clear links between socioeconomically deprived areas and infant mortality. When broken down into deprivation using IMD, the infant mortality rate is highest in most deprived areas compared to least deprived areas.

IMD Decile	Count of infant deaths	IMR	
1	218	6.7	-0.90
2	91	5.5	
3	63	4.2	
4	51	4.1	
5	33	3.9	
6	45	4.1	
7	37	3.1	
8	39	3.3	
9	27	2.7	
10	19	2.9	

4.6 As can be seen from the table below the majority of the births occur in the most deprived quintile includes Hyndburn, Burnley and Pendle.

Births in 2017						
District	**IMD 2015 Quintile (1=20% most deprived, nationally) - % of total births**					
	1	**2**	**3**	**4**	**5**	**Total**
Burnley	**58.8%**	**24.8%**	5.6%	7.5%	3.3%	100.0%
Chorley	13.5%	25.7%	16.3%	26.6%	17.9%	100.0%
Fylde	4.4%	10.2%	30.6%	34.1%	20.7%	100.0%
Hyndburn	**62.6%**	**16.8%**	6.7%	12.0%	1.9%	100.0%
Lancaster	30.0%	19.6%	19.7%	21.5%	9.1%	100.0%
Pendle	**50.1%**	**22.0%**	14.7%	10.7%	2.5%	100.0%
Preston	44.2%	24.4%	10.6%	9.7%	11.0%	100.0%
Ribble Valley	0.0%	3.1%	28.9%	30.0%	38.0%	100.0%
Rossendale	15.4%	43.3%	17.6%	15.5%	8.2%	100.0%

South Ribble	5.1%	10.6%	35.4%	23.6%	25.4%	100.0%
West Lancashire	31.8%	13.9%	20.9%	14.8%	18.7%	100.0%
Wyre	22.6%	10.1%	28.1%	24.6%	14.6%	100.0%
Lancashire	32.1%	19.7%	18.0%	17.6%	12.6%	100.0%

4.7 There are also links with low birth weight and areas of deprivation. The following table shows the areas with highest IMD scores also have the highest rates of low birth weight babies. Burnley, Hyndburn, Pendle and Preston are worse when compared to England Average.

Low birth weight of term babies, five year aggregate, 2011-2015 (same period as ward data)

District	%	Lower CI 95.0 limit	Upper CI 95.0 limit	Count	Denominator	Compared to England value
Burnley	3.8	3.3	4.3	204	5412	Worse
Chorley	2.4	2.0	2.8	137	5677	Similar
Fylde	2.0	1.6	2.6	59	2944	Better
Hyndburn	3.4	2.9	3.9	174	5108	Worse
Lancaster	2.6	2.2	3.0	181	6999	Similar
Pendle	3.3	2.9	3.8	193	5882	Worse
Preston	3.6	3.3	4.1	314	8615	Worse
Ribble Valley	2.5	1.9	3.3	51	2043	Similar
Rossendale	2.8	2.3	3.4	104	3741	Similar
South Ribble	2.1	1.8	2.6	120	5593	Better
West Lancashire	2.4	2.0	2.8	121	5061	Similar
Wyre	1.9	1.5	2.4	83	4342	Better

5. Causes and underlying factors of infant deaths

5.1 National data shows a correlation between deaths and deprivation, and as can be seen from the table analysis of local data highlights an obvious correlation locally between IMD and the infant mortality rate.

5.2 National data shows that of babies with known gestational age, babies born in the White Other ethnic group (White Irish and any other White background) had the lowest infant mortality rate. In contrast, Pakistani and Black African babies had the highest infant mortality rates. Further analysis is required on ethnicity locally.

5.3 There are a range of factors that contribute to infant mortality. These are low birth weight, Under 18 conceptions, smoking in pregnancy and breast feeding initiation.

5.4 In Lancashire various modifiable factors have been identified which contribute to the infant mortality rate. This can increase the risk of prematurity, meaning the infant will not be born in the best possible condition, or make sudden infant death more likely.

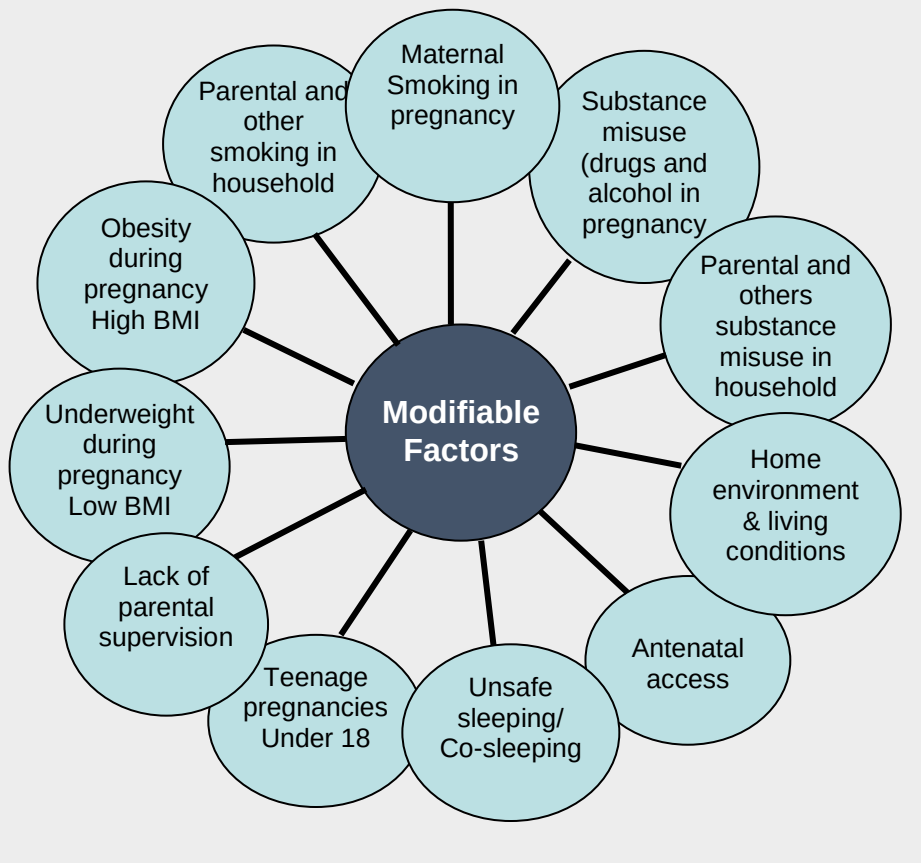
5.5 Modifiable factors act as a multiplier effect. Where there are two or more factors present, the vulnerability of the child increases. The modifiable factors that occur most frequently, and therefore where most impact can be made, include maternal smoking in pregnancy, maternal obesity in pregnancy and Parental/household smoking and substance misuse.

5.6 In part, this can be linked to the fact that the prevalence of some lifestyle factors known to increase the risk of infant mortality are higher in certain ethnic groups. For example, the prevalence of obesity is known to be higher among some South Asian communities.

5.7 Maternal obesity during pregnancy can lead to increased health risks for mother and baby.

5.8 Smoking in pregnancy is the single biggest risk factor for infant mortality.

5.9 Those modifiable factors identified in the CDOP for Lancashire are highlighted in the diagram below.



5.10 As well as these modifiable factors there are a number of protective factors against infant deaths. These include vaccinations including flu vaccination for pregnant women, breastfeeding and safe sleeping practices.

6. What is the data telling us about these factors and the associated risks in Lancashire?

6.1 The following table highlights the risk factors and the associated risk, with data on numbers in Lancashire.

Risk Factor	Local data for Lancashire (2016)	%/Number
How maternal age is associated with increased risk	The risks of birth complications, congenital anomalies and stillbirth increase with age. Multiple births are also more common in older women, particularly as the result of assisted conception. However, the exact age at which these risks increase is uncertain and co-existence of additional risk factors such as smoking will increase the chance of adverse birth outcomes.	In this area, **17.4%** of women giving birth in 2016/17 were aged 35 years or above: **2,227 women**
How teenage pregnancy is associated with higher risk	In 2016 babies born to mothers under 20 years had a **24% higher rate of stillbirth** and a **56% higher rate of infant mortality.** Teenage pregnancy is associated with a higher risk of smoking, of late booking antenatally, lower birth weight babies, stillbirth and infant mortality	In this area, **1.0%** of women giving birth in 2016/17 were aged under 18 years: **132 women**
Low birth weight of <u>all</u> babies	Babies born with a low birth weight are almost **9 times more likely to die in infancy**. Smoking is linked to low birth weight. Evidence suggests reducing and quitting smoking is associated with increased birth weight. Babies which are part of a multiple birth are also more likely to have a low birth weight	In this area, **7.9%** of babies (including pre-term) were born with a low birth weight in 2016: **1,038 babies**
Low birth weight of <u>term</u> babies	This indicator is included in the Public Health Outcomes Framework and looks at the number of babies born live with a low birth weight at full term (37 weeks or more) as a percentage of all babies born at full term. At a population level, a higher percentage for this indicator might suggest that women's lifestyles during pregnancy could be improved	In this area, **2.8%** of term babies were born with a low birth weight in 2016: **338 babies**

6.2 What is the data telling us about Lancashire locally and what do we need to do to make a difference?

The following summary provides information on where we are currently in relation to the areas identified and provides a benchmark against England and Regional data. This will help to prioritise areas of need and inform action planning in order to make a difference in reducing infant mortality from baseline data so we either improve compared to a regional or national benchmark. The data is taken from a toolkit by PHE.

Factor	Outcome of risk factor	England	Region
Stillbirths	In 2014-2016, there were on average 58 stillbirths per year, with a rate of 4.4 stillbirths for every 1,000 live births and stillbirths		
Infant Mortality	In 2014-2016, there were on average 59 infant deaths per year, with a rate of 4.5 infant deaths for every 1,000 live births.		
Smoking	In 2017/18, 13.9% of women in this area smoked when pregnant: **1,619 women**. Approximately **130** fewer women smoking during pregnancy in this area could reduce infant mortality rate to match the North West average. ❖ Reducing smoking during pregnancy alone to 0% would not be enough to reduce the stillbirth rate to be among the 25% best performing local authorities ❖ Any reduction in smoking during pregnancy will have a positive impact on health and help to reduce stillbirth rates. You should consider taking action on other factors as well.		
Obesity	**51.0%** of women in this area in 2017 were obese in early pregnancy: 6,190 women. Approximately **181 fewer women obese in pregnancy** in this area could reduce your infant mortality rate to match the North West average. ❖ Approximately 2,593 fewer women obese in pregnancy in this area could reduce your stillbirth rate to be among the 25% best performing local authorities ❖ Achieving these reductions in the short term may be challenging but at an individual level having a normal weight during pregnancy is beneficial for mother and baby. ❖ Over time year-on-year reductions in maternal obesity should be reflected in reduced stillbirth and infant mortality rates		
Immunisations	In 2017/18, **86.1%** of children in this area were vaccinated against diphtheria, pertussis (whooping cough), tetanus, Haemophilus influenzae type b (an important cause of childhood meningitis and pneumonia) and polio at age 1.		

Low birth weight	In 2016, 7.9% of babies (including pre-term) were born in this area with a low birth weight: 1,038 babies		
	In 2016, 2.8% of term babies were born in this area with a low birth weight: 338 babies		
Mothers aged under 18	In 2016/17, 1.0% of women giving birth in this area were aged under 18 years: 132 women		
Mothers aged 35+	In 2016/17, 17.4% of women giving birth in this area were aged 35 years or above: 2,227 women.		

7. What are the key priority areas for action in Lancashire?

7.1 Given the inequalities mentioned above, the public health intelligence data, CDOP findings and serious case reviews, to make a difference in reducing infant mortality we need to take action on the following priority areas:

Key Priority Area	Objective
1. Wider determinants	❖ To address the wider determinants such as poverty, poor housing, overcrowding knowing there is a link between infant mortality and socioeconomic status and a factor on affecting sleeping habits in the home, as well as other risks such as low birth weight.
2. Sudden infant deaths	❖ To reduce the number of sudden infant deaths caused by co-sleeping in unsafe situations
3. Access to services	❖ To ensure equal access to all aspects of pre-conception, maternal and infant health care
4. Social and emotional support	❖ To improve social and emotional support for vulnerable parents, especially those living in areas of social disadvantage, including maternal mental health and wellbeing and attachment
5. Smoking in pregnancy	❖ To reduce the numbers of women (and partners/families) smoking during pregnancy
6. Substance misuse	❖ To reduce the numbers of women with high levels of use of alcohol and/or non-prescribed drugs in pregnancy
7. Women, infant nutrition and breastfeeding	❖ To improve the health and nutrition of pregnant women, babies and infants by promoting a healthy food culture, and tackling obesity
8. Performance, data and intelligence	❖ To ensure appropriate performance and data intelligence to monitor infant mortality
9. Communications	❖ To ensure effective communication so these plans are implemented and shared widely with individuals, communities and professionals

A proposed draft of the action plan can be found in Appendix 2.

8. About the Infant Mortality Plan

8.1 Implementation and delivery

8.1.1 It is proposed the Reducing Infant Mortality Action plan will be over three years from 2020 to 2023 to allow time for outcomes to be realised.

8.1.2 A Strategic Partnership Group will be developed with key internal and external partners who will have a key role in the monitoring and implementation of the plan.

8.1.3 There is already a strong network of organisations and programmes in Lancashire that are supporting healthy pregnancy and the first years of a baby's life.

8.1.4 The approach therefore will be to map and embed priorities in the provision of existing services so they target areas of inequality and develop work programmes and new approaches to improve the health and wellbeing of mothers and infants based on areas of greatest need.

Key thematic groups will be established to oversee the delivery of these priority areas.

8.2 Performance and outcomes

8.2.1 Performance will be measured against the strategic outcomes identified in the Early Years Strategy and the Children and Young Peoples Plan (Appendix 1)

8.2.2 This will be benchmarked against the Public Health outcomes framework (PHOF) which will provide all the indicators and the most recent data that is recorded (https://fingertips.phe.org.uk/profile/public-health-outcomes-framework)

8.2.3 We will be ambitious in setting our targets so that we improve health outcomes overall but using public health intelligence to target areas identified as deprived or achieving below the regional and national average outcomes.

8.2.4 The service will be monitored against the outcomes highlighted for children, young people and families and will be submitted quarterly demonstrating activity against these outcome areas as highlighted in Appendix 3.

8.3 Governance and Reporting

8.3.1 Delivering and measuring progress against this plan will be through the establishment of a Best Start Strategic Group who will monitor progress as part of the wider Early Years Strategy highlighted in Appendix 1.

8.3.2 The Health and Wellbeing Board will have oversight of the Strategic Plan as part of a collaborative and shared leadership approach.

8.3.3 Progress towards achieving the outcomes will be reported through the Children and Young People's and Families Partnership Board, chaired by the Executive Director of Education and Children's Services.

8.3.4 This strategy will link and support as appropriate other wider plans such as the Early Help Strategy; Safeguarding; SEND Strategy; Managing Behaviour Strategy and Emotional Wellbeing and Mental Health Transformation Plan.

8.3.5 The plans will deliver and support key national and local plans in relation to the priority areas identified within the NHS Plan and the Integrated Care Partnership.

9. Next steps

9.1 To establish a Strategic Partnership Group comprising of key partners to oversee the implementation of the Plan.

9.2 To consult, engage and agree with key partners so a robust action plan and performance framework is developed under the key priority areas proposed.

9.3 A detailed Infant Mortality Action plan to be launched in March with regular updates to the Children, Young people and Families Partnership Board and Health and Wellbeing Board.

10. Conclusion and recommendations

The Board to:

- ❖ Acknowledge the report
- ❖ Approve the Key Priority areas being proposed

APPENDIX 1: Early Years Strategy Plan on a page


KEY ACTIONS
Develop Infant Mortality Action Plan
Deliver Better births Action Plan
Deliver 1001 critical days action plan
Develop pathways to support early detection of speech delay
Implementation of a Lancashire speech, language and communication plan
Promote Home Learning Environment
Develop parenting Strategy
Develop an Integrated care pathway
Delivery of high impact areas
An integrated workforce development plan
Ensure all families receive mandated developmental reviews
Ensure a clear reporting and governance structure
Develop a Lancashire outcomes framework for CYP
Develop a performance dashboard
Safeguarding, Leadership, Evidence Base-Practice, Accountability

APPENDIX 2: Draft Infant Mortality reduction

Key Priority Area	Objectives	Actions
1. Addressing the wider determinants to health	1.1 To support efforts to reduce poverty in families	• To ensure we raise awareness of the links between child poverty and infant mortality targeting services in areas of greatest need based on deprivation and infant mortality data
	1.2 To tackle child poverty as a priority	• To consider the development of a child poverty strategy and action plan/embed the importance of this as a priority across everything we do
	1.3 To improve the availability of good quality and affordable housing	• To work with housing services to ensure the needs of pregnant mothers, babies and children are prioritised so we address inequality in housing through improved living conditions and assessment of need and risk of overcrowding
	1.4 Take ensure take up of benefits in most deprived areas	• To support and advice individuals and communities at risk who are eligible for welfare benefits and support with their family and child's needs
	1.5 To establish links with Health and Social care so we target vulnerable Families	• To work with early help, safeguarding and Health and Social care services so we target vulnerable communities at risk
	1.6 To target anti-social behaviour, violence and domestic abuse in pregnant women and families with babies and infants	• To ensure safeguarding of vulnerable women, babies and families by using a partnership approach to address some of these wider determinants linking with youth services, anti-social behaviour and safeguarding teams
2. To reduce the number of deaths caused by co-sleeping in unsafe situations (see case Review Recs)	2.1 To improve professional advice about co-sleeping in unsafe situations and reduce SIDs	• To develop and implement an individualised safer sleep assessment tool as part of the 6 safer sleep steps programme.
		• To strengthen and clarify the safer sleep messages for parents as well as the criminal consequence should they ignore professionals' advice.
		• To continue with the Train the Trainer Sessions so members of the health/ social care/ education professions receive training.
	2.2 To improve public awareness of infant death	• Public campaign on the risks of co-sleeping in line with the Pan-Lancashire safer sleep guidance including a broader approach to reducing SIDS using social media, marketing and a communications plan as well as the development of a workforce development plan.
		• Training carers and parents in rescue and resuscitation techniques to minimise the severity of outcomes from.

	2.3 To raise awareness of deaths and life limiting injuries sustained through shaking an infant and causing Abusive Head Trauma (AHT)	• To implement the ICON (Abusive head Trauma) Campaign as set out in Hampshire's ICON Campaign with additions from UNICEF BFI and signed off by CDOP: • To consider Phase 2 of the ICON campaign • Links with schools/GPs/Digital Screens and the use of the full length film.
	2.4 To ensure adequate support to affected parents and families	• To support families who have been bereaved and ensure appropriate care of next infant (CONI)
3 To ensure equal access to all aspects of pre-conception, maternal and infant health care	3.1 To ensure engagement with antenatal services and promote the benefits of preconception, antenatal care	• To ensure equal access to midwifery services so that every woman receives the appropriate level of antenatal care, assessment and targeted support where needed
		• To develop an integrated care pathway from birth to ensure consistency and evidence based approach across Lancashire so maternity services are engaged and there are clear pathways and a streamlined approach to maternity and other services such as health visiting and early year's services.
		• To align public health and early years services with the Better Births Programme Action Plan
	3.2 To deliver core offer of Health Visiting mandated services	• To ensure all women are offered the mandated visits as part of the core health visiting offer and an assessment of need is carried out at all visits especially the antenatal and birth visit
	3.3 To focus prevention programmes on families most at risk	• To prioritise the needs of those with social circumstances that expose infants to more risk and promote parental behaviour change, including more vulnerable and at risk women and families such as for teenage mothers
		• Communications and raising awareness with so called hard to reach groups - Consider targeted health promotion messages (e.g. ESOL classes, family and neighbourhood centres, nurseries, schools)
	3.4 To ensure timely and complete immunisations and vaccinations	• To increase access to immunisations and vaccinations for pregnant mothers (pertussis, flu) and babies and children (DTaP/IPV/Hib/ HepB, Pneumococcal conjugate vaccination (PCV), MenB, gastroenteritis Rotavirus
		• To ensure screening tests during pregnancy including for infectious diseases, Sickle cell and thalassaemia, Down's syndrome, Edwards' syndrome and Patau's syndrome, 20-week scan and Newborn screening
	3.4 To provide genetic counselling/genetic literacy for	• To ensure clear pathways for genetic counselling when family history is identified or where families have been affected by genetically inherited conditions

	individuals and communities with a need	• To provide training for midwives and obstetricians to improve knowledge of genetics and consanguinity • To raise community awareness of genetics
4 Improve social and emotional support for vulnerable parents	4.1 To improve social and emotional support for vulnerable parents, especially those living in areas of social disadvantage	• Early identification of women and appropriate pathways in place for vulnerable women including younger (teenage mothers) and vulnerable mothers addressing issues such as domestic violence, antisocial behaviour or abuse in families
		• To ensure fathers/partners are provided with appropriate support where social and emotional support is required
		• To provide an enhanced Health Visiting service to vulnerable women with additional visits as well as the core offer which will identify and support women at risk who need more targeted support
	4.1 To ensure early identification of women with perinatal and post-natal depression through universal mood assessment	• To ensure maternal mood and emotional health and wellbeing issues are assessed through antenatal access and maternal mood assessments by Health visitors, including monitoring of referrals and follow up
5 To reduce the numbers of women (and families) smoking during pregnancy (and after	5.1 To ensure commissioning and delivery of Public Health Harm reduction services include a focus on smoking in pregnancy	• To ensure commissioning and delivery of Public Health Harm reduction and other services recognise the importance of the impact smoking on pregnancy has on infant mortality and stillbirths and to include this as part of specifications
	5.2 To ensure all women are offered CO monitoring at their antenatal appointments	• To ensure all midwives have accessed training to use CO monitors and that all women are CO monitored at booking appointments with support to identify and refer women as necessary
		• To ensure smoking cessation clinics for women attending ante-natal ‘high risk’ obstetric clinics and ongoing improvements to CO monitor use, referral system and CO levels recorded
	5.3 To ensure reducing smoking in pregnancy is a core part of the Children and family centres	• To ensure reducing smoking in pregnancy is part of the core offer for Children/family/neighbourhood centres and have trained advisers and brief intervention training on-going with early year's staff with targeted interventions where there is highest need
	5.4 To use public health intelligence data to identify trends and hot spots	• Need to consider the hot spots for smoking using public health data and intelligence as well as linking into key partnerships such as the ICP
	5.5 To reduce smoking in pregnancy and parents and	• Promote smoke free homes and support staff with the training and skills to have conversations about smoke-free homes, with clear, constructive and supportive

	exposure to tobacco smoke in the home and cars	messages and communications.
6. To reduce the numbers of women with high levels of use of alcohol and/or non-prescribed drugs in pregnancy	6.1 To raise awareness of the risks associated with substance misuse in pregnancy	• To ensure that available alcohol and substance-misuse services are communicated more effectively to health professionals and other relevant agencies
		• To ensure that health professionals are aware of the safeguarding risks associated with drug and alcohol use
		• To raise awareness of Foetal alcohol syndrome and the impact of alcohol on the developing foetus, and how children are affected at different ages
	6.2 To ensure referral pathways are up to date and effective	• To ensure existing pathways target pregnant women who have issues with substance misuse and poor mental health as a result
	6.3 To identify substance misuse in pregnancy	• To ensure all women receive the Audit C screening to identify women and signpost to appropriate services and treatment.
		• To consider specialist Substance Misuse Midwife and champions in centres
		• To ensure social workers understand the vital role in their daily practice - effective working with and parenting affected children
	6.3 To ensure appropriate training and resources	• To ensure basic Awareness through Alcohol and Drug courses and consider on-line e-learning Basic Awareness Course
		• To promote this through Every Contact Count so that we embed alcohol screening, smoking cessation and sexual health awareness
7. To improve the health and nutrition of pregnant women, babies and infants	7.1 To reduce maternal obesity and improve nutrition in pregnancy and before	• To raise awareness of the importance of healthy weight for a healthy pregnancy and work with partners to consider maternal obesity that focuses on prevention and earlier intervention
		• To train more health professionals to confidently identify, provide consistent advice, and refer where required.
	7.2 To ensure obesity pathways in place	• To revisit what pathways we have for obesity and faltering growth and ensure that maternal obesity is treated as a priority and that referrals to appropriate services take place as early as possible (family-planning and booking stages).
		• To ensure links are established between Women and Infants Nutrition and Child Poverty so priority areas are targeted as appropriate
	7.3 To develop and policies and guidelines for maternal and early years nutrition	• To ensure we have a strategy on maternal and Early Years nutrition which is developed with key partners
		• To develop guidelines and training on nutrition for maternal and infant health

		including weaning
		• To consider the development of a model food policy for children's centres to use to quality check their provision of food activity including a Food and nutrition toolkit for early year's settings.
	7.4 Community awareness and training	• Consider nutrition training programme for 2020
		• Healthy Start Programme – increase community awareness and uptake of vitamin D supplements • Development and production of a guide to weaning in appropriately culturally sensitive languages
	7.5 To encourage and support breastfeeding	• To take a collaborative approach to breastfeeding and nutrition, ensuring the benefits of breastfeeding and maternal Body Mass Index (BMI) are understood • To ensure consistent advice provided by all health professionals to ensure women are able to make an informed choice • To explore options for increasing the provision of peer support delivering evidence based care • To increase in the number of GPs accessing breastfeeding training • To consider Breastfeeding Champions being in Children/community Centres • UNICEF Baby Friendly Initiative adopting across the area and increase in the number of Organisations working towards Baby Friendly initiative standards
8. Performance, Data and Intelligence	8.1 To ensure appropriate performance and data intelligence is used to monitor infant mortality.	• To ensure work is systematically being undertaken and monitored to reduce local area infant mortality rates. • To improve the focus and understanding of infant mortality rates in the local area • To measure inequalities and progress in areas of greatest need • To ensure relevant performance data is available in the areas identified so we can monitor progress
		• To work closely with CDOP to inform planning and monitoring of infant mortality • To ensure this clear governance and accountability through the CYP and families partnership board, health and wellbeing board and ICS where appropriate
	8.2 To develop a dashboard for infant mortality	• To develop a dashboard as part of the Early Years strategy with a key focus on infant mortality so this can be monitored and benchmarked according to national and regional targets.

9	**Communication plan**	To ensure these plans are shared widely and understood by communities, professionals across Lancashire	▪ To ensure communities are better informed ▪ To develop a website (review what we have) ▪ To ensure Infant mortality is embedded within midwifery, health visiting and early years through development and dissemination of an integrated care pathway. ▪ To ensure consultation and engagement with communities via CCG maternity service user groups ▪ To use social media to raise awareness of modifiable factors mentioned above

Ruksana Sardar-Akram
9th January 2020

APPENDIX 3: OUTCOMES AND PERFROMANCE FRAMEWORK (Example – to be agreed)		
Priority 1: Best Start in Life		
Objective	**Performance Measure**	**Indicator ref**
1.1 Reduce Infant mortality	1.1.1 Rate of infant mortality	
1.2 Reduce Low birth weight of term babies 37 weeks	1.2.1 Low birth weight of term babies 37 weeks gestational age at birth	2.01
1.2 Increase breastfeeding rates	1.2.1. Breastfeeding initiation All ages	2.02i
	1.2.2 Breastfeeding prevalence at 6-8 weeks after birth - current method	2.02ii
1.3 Reduce smoking status at time of delivery	1.3.1 Smoking status at time of delivery All ages	2.03
1.5 Reduce under 18s conception rate	1.5.1 Under 18s conception rate / 1,000 <18 yrs.	2.04
	1.5.2 Under 16s conception rate / 1,000 <16 yrs.	2.04

Ruksana Sardar-Akram
9th January 2020

Lancashire Health and Wellbeing Board
Meeting to be held on 28 January 2020

Lancashire Special Educational Needs and Disabilities (SEND) Partnership – assessment of progress on the Special Educational Needs and Disabilities Improvement Plan and Accelerated Plans

Contact for further information: Sian Rees, Improvement Partner SEND, Lancashire County Council, Tel: 01772 535162, sian.rees@lancashire.gov.uk

Executive Summary

Lancashire local area Special Educational Needs and Disabilities services were inspected by Ofsted and the Care Quality Commission (CQC) in November 2017 to judge how effectively the special educational needs and disability (SEND) reforms had been implemented, as set out in the Children and Families Act 2014. The inspection identified two fundamental failings and twelve areas of significant concern.

Partners in Lancashire were required to produce a Written Statement of Action, setting out the immediate priorities for action. Progress on the implementation of these actions has been monitored by the Department for Education (DfE) and NHS England. The Written Statement of Action has been updated and any ongoing actions included in the Special Educational Needs and Disabilities Partnership Improvement Plan for the period April 2019 to December 2020. The Health and Wellbeing Board received an update on progress at their last meeting in November.

Recommendations

That the Health and Wellbeing Board:

(i) Note the continued delay in the re-visit from Ofsted.
(ii) Consider the report on progress to date in delivering the actions in the Special Educational Needs and Disabilities Improvement Plan and the Accelerated Plans.

1. Background

1.1 The Lancashire Special Educational Needs and Disabilities Partnership Board is responsible for ensuring the delivery of the Written Statement of Action and the updated version known as the Special Educational Needs and Disabilities Improvement Plan.

1.2 Progress on these plans has been reported bi-monthly to the Health and Wellbeing Board and the Special Educational Needs and Disabilities Partnership Board using a red, amber, green rating. Completed actions and those not yet started are also recorded.

1.3 A re-visit by Ofsted and the Care Quality Commission to assess whether the local area has made sufficient progress in securing improvement was expected to take place before the end of October 2019. At the time of writing this report there has been no notification of inspection; it is understood that this is due to a shortage of inspectors.

Lancashire County Council

1.4 The self-assessment and associated paperwork required for this revisit continue to be updated with focus maintained on delivering the Improvement Plan.

1.5 All other arrangements are in place, including the draft presentation, named participants for discussion with inspectors, the draft timetable and data/evidence.

2. Progress Report

2.1 The Special Educational Needs and Disabilities Improvement Plan and the Accelerated Plans are subject to bi-monthly review, for which detailed information is provided by action leads. The latest review took place in December 2019.

2.2 The Improvement Plan was approved by the Special Educational Needs and Disabilities Partnership Board in March 2019 for the period April 2019 to December 2020; it includes action carried forward from the Written Statement of Action. The Plan has 27 action areas supported by 94 specific actions, each with a specified lead and clear deadline. The plan is organised under four key priorities aligned with the Special Educational Needs and Disabilities Partnership Strategy. The report provides a summary of progress and by exception highlights action where there is significant delay or risk of delay.

2.3 The status in relation to each action at the end of December 2019, is as follows:

Rating	Status	October Actions	December Actions	Total
Blue	Action completed and signed off	33	52	94
Green	Action will achieve completion deadline	17	14	
Amber	Action underway	32	20	
Red	Action delayed and at risk	5	5	
Grey	Action yet to commence	7	3	

2.4 There are five delayed actions. Of these, the improved Local Offer site was launched on 13 January 2020 and reporting to the Special Educational Needs and Disabilities Partnership Board will commence in March 2020; the implementation of the revised Occupational Therapy Service Specification is not being implemented by all providers and is currently being negotiated and the Special Educational Needs and Disabilities Sufficiency Strategy will be considered by the Council's Cabinet in January.

2.5 As indicated in the last report to the Board, the risk of delay to a review of the access criteria for support from the Children with Disabilities Social Work team has been borne out, due to a lack of capacity, however this work has commenced.

2.6 All other actions are completed, on track or in train. Those with amber ratings include ongoing actions, such as increasing the skills base of staff, expanding the membership of the Parent Carer Forum and the representation of young people with special educational needs and disabilities in participation activities. Where the implementation of completed action is ongoing, such as the development of the Neuro Developmental Pathway there is also an Amber rating.

2.7 The Accelerated Plans provide greater detail than the Special Educational Needs and Disabilities Improvement Plan about the work taking place in areas where there was concern about pace. They are being closely monitored by the Special Educational Needs and Disabilities Operational Group.

2.8 There are five plans in total; four are on track. These are focused on: improving the quality of Education Health and Care Plans; improving education outcomes; implementing the Neuro-developmental Pathway and the process of transition from Children's Social Care to Adult Services. The fifth plan to improve the accessibility of and information on the Local Offer has two delayed actions. This was reported to the Special Educational Needs and Disabilities Partnership Board at their meeting on 16 January 2020. The soft launch of the new site took place on 10 October 2019 and the full launch, supported by promotion, on 13 January 2020. Phase two development, to include the implementation of a directory facility, have commenced and action taken to identify ongoing resources for the maintenance/development of the site. This plan will be on track when resources are agreed.

3. Conclusion

Since the implementation of the Special Educational Needs and Disabilities Improvement Plan to update the Written Statement of Action in April 2019, 52 actions have been completed with a further 14 scheduled to be completed by the deadline and 20 underway. This represents 91% of the actions, compared with 87% when last reported, across a large programme of improvement work. The remaining eight actions are either delayed/at risk or not yet started, with deadlines from April to December 2020 for the latter.

List of background papers

Handbook for the inspection of local areas' effectiveness in identifying and meeting the needs of children and young people who have special educational needs and/or disabilities - Part 3