Public Document Pack

Executive Board

Thursday, 14 October 2021
Time: 6.00 pm
Venue: Blackburn Library

AGENDA

Information may be provided by each Executive Member relating to their area of responsibility

1. Welcome and Apologies

2. Minutes of the Previous Meeting

Executive Board Minutes September 2021 **4 - 9**

3. Declarations of Interest

DECLARATIONS OF INTEREST FORM **10**

4. Equality Implications

The Chair will ask Members to confirm that they have considered and understood any Equality Impact Assessments associated with reports on this agenda ahead of making any decisions.

5. Public Forum

To receive written questions or statements submitted by members of the public no later than 4pm on the day prior to the meeting.

6. Questions by Non-Executive Members

To receive written questions submitted by Non-Executive Members no later than 4pm on the day prior to the meeting.

7. Youth MPs Update

To receive an update from the Youth MPs along with any issues they would like to raise.

8. Executive Member Reports

Verbal updates may be given by each Executive Member.

Leader

8.1 NHS Health and Social Care Integration Update on Partnerships and Governance

NHS and Social Care Governance **11**
AppendixALancashireSouthCumbrial **-**
AppendixBPLICPDevelopmentDeliveryProposition202122 **49**
AppendixCPenninеLancashirePartnershipAgreement202122v2

Adult Services & Prevention

Children, Young People & Education

Environmental Services

Public Health & Wellbeing

8.2 Investment in Health and Fitness Facilities at Witton Park Arena and Blackburn Sports and Leisure Centre
Investment in health and fitness facilities **50 - 53**

Under provisions outlined in the Constitution and referred to in the report, it has been agreed that this decision is not subject to Call-in.

8.3 Oral Health Improvement Strategy 2021

OralHealthImprovementStrategy.doc **54 - 100**
BwD OHI Strategy 2021_26 Appendix 1
Appendix 2

8.4 Procurement process for Substance Misuse Services

Procurement Process Substance Abuse **101 -**
Appendix 1- Substance Abuse **137**

Digital & Customer Services

Growth & Development

Finance & Governance

9. Corporate Issues

10. Matters referred to the Executive Board

PART 2 – THE PRESS AND PUBLIC MAY BE EXCLUDED DURING CONSIDERATION OF THE FOLLOWING ITEMS

11. Investment in Health and Fitness Facilities at Witton Park Arena and Blackburn Sports and Leisure Centre
Investment in health and fitness facilities P2 **138 - 142**

Under provisions outlined in the Constitution and referred to in the report, it has been agreed that this decision is not subject to Call-in.

Date Published: Wednesday, 06 October 2021
Denise Park, Chief Executive

EXECUTIVE BOARD
Thursday 9th September 2021

PRESENT

COUNCILLOR:	PORTFOLIO:
Councillor Mohammed Khan CBE	Leader of the Council
Councillor Mustafa Desai	Adult Services & Prevention
Councillor Jim Smith	Environmental Services
Councillor Vicky McGurk	Finance and Governance
Councillor Phil Riley	Growth and Development
Councillor Damian Talbot	Public Health and Wellbeing
Councillor Quesir Mahmood	Digital and Customer Services
Councillor Julie Gunn	Children, Young People and Education

EXECUTIVE MEMBER	NON PORTFOLIO
Councillor John Slater	Leader of the Conservative Group

ALL IN ATTENDANCE:

Muhammed Bapu	Deputy Youth MP

	Item	Action
1	**Welcome and Apologies** The Leader of the Council, Councillor Mohammed Khan, welcomed all to the meeting. Apologies were received from Youth MP Zara Hayat.	**Noted**
2	**Minutes of the Previous Meeting** The Minutes of the Meeting held on 12th August 2021 were agreed as a correct record.	**Agreed**
3	**Declarations of Interest** Councillor Damian Talbot declared an interest in regard to the complaints report in relation to his work at the constituency office of the MP for Blackburn.	**Noted**
4	**Equality Implications** The Chair asked Members to confirm that they had considered and understood any Equality Impact Assessments associated with reports on the agenda ahead of making any decisions.	**Confirmed**
5	**Public Forum** No questions had been received from members of the public.	
6	**Youth MPs Update**	

	Item	Action
	The Deputy Youth MP verbally reported on recent events and activities including : • Work to progress and establish Youth Mental Health First Aid Champions and on Suicide Prevention. • Muhammed's recent nomination for Young Person of the Year by One Voice. • Work with the NHS to identify wellbeing support for students and improved uptake of vaccines by young people. • Team Building Activities with the Youth Forum. Executive Board Members reflected on the continued excellent work of the Youth MPs and Youth Forum.	**Noted**
7.1	**<u>Executive Member Reports</u>**. **<u>Leader's Update</u>** Councillor Khan verbally reported on the Success at the Local Government Innovation Awards where the Council had won the gold award. He drew attention to the proposed ending of the Universal Credit uplift and the detrimental effect this would have on the many residents of the Borough who depended on this. Councillor Slater echoed the sentiments of the Leader and efforts would be made to seek the reversal of the decision. The recent announcement relating to Health and Social care funding was highlighted and although there was little detail at present concerns were expressed that this may not replace the money already lost by the care sector in previous years. The annual suicide awareness day was to be held on Friday 10th September and the leader invited members of the Board to take part and raise awareness of the effects suicide has on families and the community.	**Noted**
7.2	**<u>Coroners Service-Update Report and Cost Sharing Agreement.</u>** Members received a report which advised them of the cost sharing agreement that existed between the Council and Lancashire County Council. The revised arrangements had been introduced in 2018 and merged the service for Blackburn with Darwen, Hyndburn and Ribble Valley, Preston and West Lancashire and East Lancashire. Under the agreement Lancashire County Council were the Relevant authority under the Coroners and Justice Act 2009. The initial term of the agreement had now expired and Lancashire County Council and Blackburn with Darwen were seeking to extend the term of agreement.	

	Item	Action
	RESOLVED- That the Executive Board: - Notes the contents, reporting on the Lancashire and & Blackburn with Darwen Coroner's Service during 2020-21. - Notes the proposed use of Blackburn Town Hall facilities by the Coroner to hold routine inquests for Blackburn with Darwen cases, once the refurbishment works have been completed. - Delegates authority to the Strategic Director of Resources in consultation with the Leader to agree the terms for extending the Cost Sharing Agreement with Lancashire County Council.	**Noted** **Noted** **Approved**
8	**<u>Adults Services and Prevention</u>** Councillor Desai verbally reported on the financial pressures that the portfolio was facing and the need to press for funding of social care.	**Noted**
9	**<u>Children, Young People and Education.</u>** Councillor Julie Gunn verbally reported to the Board on the return to school and the positive attitudes that had helped this happen. No Data was available as yet but would be reported when available.	**Noted**
9.1	**<u>Strategic Youth Alliance Update</u>**. The Board were informed that the Strategic Youth Alliance had been first convened and chaired by the Head of Adolescent Services in May 2019 in response to the national and local financial reductions which led to the youth sector becoming significantly at risk. The Board were updated on the development of the first two years of the alliance and future plans. **RESOLVED-** That the Executive Board: • Notes the report and continues to offer support to the SYA • Continue to support the local youth sector via commissioned funding	**Noted** **Noted** **Approved**
9.2	**<u>Schools Capital Programme 2021/2022</u>** Members received a report presenting the Capital Programme for Schools 2021/22. The Council received capital funding from the Government to meet the responsibilities placed upon it by the Education Acts and the School Standards and Framework Act. The capital programme was	

	Item	Action
	driven by capital priorities raised from the condition, suitability and sufficiency sections of individual schools asset management plans. In addition the boroughs information on pupil place sufficiency is used to understand the demand for any required school place growth. The Council retained the responsibility for capital improvements valued at over £10,000 in all schools. **RESOLVED-** That the Executive Board: 1. Approve the attached list of projects as detailed in Appendix 2 for inclusion in the 2021/22 Schools and Education Capital Programme funded from Basic Need, School Condition allocation, Development Formula Capital, Healthy Pupil Capital Fund and SEN Capital Fund. 2. Approves the variations to the 2020/21 capital programme for: • Lower Darwen Primary School • Roe Lee Primary School • Shadsworth Infant School. 3. Delegate authority to the Strategic Director of Children's & Education in consultation with the Executive Member for Children, Young People and Education to undertake procurement for the works in accordance with the Contracts & Procurements Procedure Rules in the Council's Constitution. 4. Approves expenditure to be incurred on individual projects, in line with the Council's Financial Procedure Rules. 5. Notes that reports will be provided for the Executive Member detailing any variations/amendments to programmes of works and seeking necessary approvals where these are required to ensure compliance with financial instructions and the Constitution.	**Approved** **Approved** **Approved** **Approved** **Noted**
10	**Digital and Customer Services**. Councillor Quesir Mahmood drew attention to the hard work that had gone into the winning of the Local Government Innovation award and congratulated the team on their achievement.	**Noted**
10.1	**Annual Complaints Monitoring 2020/21** Members considered a report monitoring the complaints and compliments received by the Council for the period 1st April 2020 to 31st March 2021. The information was compared to data collected from previous years to allow reasonable comparison. **RESOLVED** That the report be noted.	**Noted**

	Item	Action
11	**Corporate Revenue Budget Monitoring Quarter 1 2021/22** A report was submitted which detailed the overall revenue position of the Council, highlighting significant issues and explaining variations in the first quarter of the financial year. **RESOLVED -** That the Executive Board approves: • the portfolio budget adjustments outlined in Appendix 1. • the earmarked reserves position shown in Appendix 2 • the variations to revenue expenditure, as listed in Section 6, thereby giving rise to a balance of £8.818 million in the unallocated General Fund revenue reserve.	**Approved** **Approved** **Approved**
11.1	**Manxman Road Petition.** Members were informed that a petition had been submitted signed by local residents of the Manxman Road area requesting additional parking on Manxman Road, opposite the shops, on the grounds of safety. **RESOLVED -** That the Executive Board: • Notes the petition. • Notes that the service had already committed to providing a new area of on street parking opposite the shops, following a request from Cllr Vicky McGurk, also supported by fellow Ward Councillor's Cllr Jim Shorrock and Cllr Tony Humphrys • Supports the new parking scheme designed to create more parking capacity at this location, improve road safety and address poor visibility caused by parked cars • Request that works are added to the capital programme (once funding confirmed) • Request that officers inform the lead petitioner of the decision	**Noted** **Noted** **Approved** **Approved** **Approved**

Signed at a meeting of the Board

on 14th October 2021

	Item	Action
	(being the ensuing meeting on the Board) Chair of the meeting at which the Minutes were confirmed	

DECLARATIONS OF INTEREST IN

ITEMS ON THIS AGENDA

Members attending a Council, Committee, Board or other meeting with a personal interest in a matter on the Agenda must disclose the existence and nature of the interest and, if it is a Disclosable Pecuniary Interest or an Other Interest under paragraph 16.1 of the Code of Conduct, should leave the meeting during discussion and voting on the item.

Members declaring an interest(s) should complete this form and hand it to the Democratic Services Officer at the commencement of the meeting and declare such an interest at the appropriate point on the agenda.

MEETING: **EXECUTIVE BOARD**

DATE: **14TH SEPTEMBER 2021**

AGENDA ITEM NO.**:**

DESCRIPTION (BRIEF):

NATURE OF INTEREST:

DISCLOSABLE PECUNIARY/OTHER (delete as appropriate)

SIGNED :

PRINT NAME:

(Paragraphs 8 to 17 of the Code of Conduct for Members of the Council refer)

EXECUTIVE BOARD DECISION

REPORT OF:	Leader
LEAD OFFICERS:	Strategic Director of Adults and Health (DASS)
DATE:	Thursday, 14 October 2021

PORTFOLIO(S) AFFECTED:	ALL
WARD/S AFFECTED:	(All Wards);
KEY DECISION:	**Y**

SUBJECT:

EB NHS Health and Social Care Integration Update on Partnerships and Governance

1. EXECUTIVE SUMMARY

This report and associated appendices, provide the Executive Board with an update on key matters in relation to health and care system reform and provide an overview of how these relate to the Pennine Lancashire Integrated Care Partnership (ICP). The aims, ambitions and delivery priorities for the ICP in 2021-22 have been articulated, in the form of a Development and Delivery Proposition and the Board is asked to endorse this Proposition, along with a revised Partnership Agreement, to reaffirm its commitment to supporting the on-going development of partnership arrangements in Pennine Lancashire, throughout this period of Health and Care reform.

2. RECOMMENDATIONS

That the Executive Board:

a) Note the update on health and care system reform as outlined in this paper
b) Note the Lancashire and South Cumbria ICP Narrative (Appendix A) which confirms the role and remit of ICPs in Lancashire and South Cumbria
c) Endorse and provide their support to the Pennine Lancashire Development and Delivery Proposition, as contained at Appendix B
d) Note that the Proposition is intended to be iterative, and it is likely that as our collaborative delivery arrangements evolve and national guidance is received, further amendments will be required
e) Endorse the Pennine Lancashire ICP Partnership Agreement 2021-22

3. BACKGROUND

For the past few years, health and care organisations in Lancashire and South Cumbria have worked together as the Healthier Lancashire and South Cumbria Integrated Care System (ICS). The ICS is a partnership of organisations working together to improve services and help the 1.8 million people in Lancashire and South Cumbria live longer, healthier lives. The partnership is made up of Local Authority, Public Sector, NHS and voluntary and community organisations coming together to improve outcomes and care. The aims of the ICS partnership are to join up health and care services, to listen to the priorities of local communities, citizens and patients and to tackle some of the biggest challenges we are all facing.

Within Lancashire and South Cumbria ICS, there are five local areas, including Pennine Lancashire, that provide a way in which all organisations and groups involved in health and care can join up locally. These are called Integrated Care Partnerships (ICPs).

Pennine Lancashire Integrated Care Partnership has operated formally since 2016, it represents all of the health and care organisations in the Pennine Lancashire region as well as local councils and the voluntary, community and faith and social sector. The Partnership serves to connect health and care services across Pennine Lancashire and create 13 neighbourhoods of 30,000 to 50,000 people registered to a GP. Integral to these neighbourhoods are services that support the health and wellbeing of the Pennine Lancashire residents, including those provided by our local government and Voluntary, Community, Faith and Social Enterprise (VCFSE) partners.

Health and care services are about to embark on a nationally driven programme of reform, that aims to simplify how services are planned and delivered, encourage great collaboration between services (as opposed to historical competition driven approaches) and put people, population health and reducing inequalities firmly at the heart of everything we do. This paper is intended to provide a brief overview of these reforms and offer an update on what this means for the Pennine Lancashire ICP and its partners during 2021-22.

Health and Care Reform Update

In February 2021 the Government published a White Paper outlining how the NHS in England needs to change to enable health and care to work more closely together. It has long been our aspiration to improve the way services work together and to be excellent partners to each other, but bureaucracy has sometimes got in the way. In summary, the White Paper and the subsequent Health and Care Bill (currently on second reading in the House of Commons) outlines how:

a. Change is needed to enable health and care systems to further build on innovation born from the pandemic.
b. The NHS, local authorities and other partners will come together legally as part of integrated care systems (ICSs) to plan health and care services and focus on prevention.
c. ICSs will become statutory and will be accountable for the health and wellbeing outcomes of the population.
d. The current functions of Clinical Commissioning Groups (CCGs) will move into the ICS.
e. Legislation that hinders collaboration and joint decision-making will be removed.
f. A 'duty to collaborate' will apply to NHS organisations and local authorities. This will promote joint working across healthcare, public health and social care.
g. A shared duty to have regard for the 'triple aim' of better health and wellbeing for everyone, better care for all people and sustainable use of NHS resources is proposed.
h. NHS England's main role will be to support improvements in health outcomes, the quality of care and the use of NHS resources.

The proposals and guidance that has followed, are designed to be flexible and will allow our health and care system to continue to evolve in a way which best suits us locally. It is recognised that the Health and Care Bill does not address adult social care or public health reforms, which will be critical to ensure ambitions for integrated care are achieved, proposals for these areas are expected later in the year.

Key points for Pennine Lancashire in 2021-2022

Whilst legislation and detailed guidance relating to health and care reform is slowly emerging, place-based partnerships are recognised as the arena where NHS organisations will continue to forge deep relationships with each other, alongside local government, VCFSE and communities to join up services, support Primary Care Networks (PCNs) delivery and tackle the wider social and economic determinants of health.

Within Lancashire and South Cumbria, we have clarity that our place-based partnerships/ICPs of the future will be a collaborative of providers and planners, working together to simplify and modernise care and implement service models that are grounded in neighbourhoods and communities, which deliver improved outcomes for our residents through a whole population health approach.

Through September to December 2020, the ICP Directors from each of the Lancashire and South Cumbria ICPs, collaborated and engaged with stakeholders from across the breadth of the system, to produce a common Strategic Narrative for the ICPs in Lancashire and South Cumbria. This ICP Strategic Narrative was agreed with the ICS Board in December and sets out the blueprint for future working at place level, within our system. This is attached at Appendix A for information.

Through January to March 2021, further whole system engagement in the scoping and production of an ICP development programme took place, this included the development of an ICP Maturity Matrix, which was undertaken to baseline each ICP against the core aspects of the Strategic Narrative. The outcomes of the maturity baseline and engagement events resulted in recommendations being identified in relation to key activities ICPs could undertake, some collectively and some individually, to progress the maturity of their ICPs in 2021-22. The recommendations were tested with a wide range of system leaders, via a workshop in April with c.70 attendees, and were formally agreed by the Lancashire and South Cumbria ICP Development Advisory Group and ICS Board in May. The agreed actions now form the basis of a development plan for each ICP and have been supplemented by additional, locally relevant actions.

Through discussions with all partners, alongside a review of recent national publications (namely the ICS Design Framework and the System Development Progression Tool), a Pennine Lancashire ICP Development and Delivery Proposition which sets out the core purpose, aims and objectives for the Pennine Lancashire ICP in 2021/22. This document is intended to be used to guide the further development of our collaborative work streams and for the purposes of stakeholder engagement. The ICP Development and Delivery Proposition 2021-22, attached at Appendix B, seeks to clarify what our ICP is and what it will work to collectively deliver, it clearly articulates our purpose, ambition and functions, drawn from the Lancashire and South Cumbria ICP Strategic Narrative, but localised to reflect our own arrangements, partners and priorities.

The Development and Delivery Proposition has been endorsed by the ICP Partnership Leaders' Forum and is recommended now for endorsement by the Board. Blackburn with Darwen BC are represented on that Forum by the Leader and Chief Executive.

As part of Pennine Lancashire a key feature of our ICP development work in 2021-22 will be to develop closer working with our district councils, particularly through the district health partnership/action groups that have continued to evolve throughout the pandemic. The contribution of our district councils and their networks to vital issues such as population health & wellbeing and community asset development is widely acknowledged across our Partnership. We have now seized the opportunity within our Proposition document, to signal clear intent to support the evolution of these partnerships to be a key part of our infrastructure, working together to ensure that local needs and priorities are understood and inform the delivery of our integrated services moving forward.

In line with the national direction of travel, there is clear recognition now within our ICP, that addressing health inequalities, through a concerted focus on population health improvement and collective action on the wider determinants of health, must be at the heart of our collaboration moving forward. To this end, we are working to establish a Population Health Board for Pennine Lancashire, that will bring together all relevant partners to coordinate a whole system approach to improving population health. Whilst the full remit of the Board is still to be scoped with partners, it is envisaged that this will inform on priorities for health outcomes, inequalities and improvement and oversee delivery of key system actions to address inequalities.

The ICP Development and Delivery Proposition also outlines the key programme areas which will form the focus of our collaborative delivery. BwDBC officers will be actively engaged in these workstreams, as relevant to their portfolios. The workstreams are:

- Primary, Community and Social Care
- Intermediate Care
- the Care System
- Urgent and Emergency Care
- Children and Maternity
- Learning Disabilities and Autism
- Restoration and Recovery
- Mental Health

The governing group for the ICP, for the remainder of 2021-22, will be the Partnership Leaders' Forum and Blackburn with Darwen BC representation on the Forum is through the Leader of the Council, Chief Executive and Strategic Director Adults and Health.

Pennine Lancashire Partnership Agreement 2021-2022

The Pennine Lancashire ICP has operated under a Memorandum of Understanding since its formal inception in 2016. The Memorandum of Understanding was signed by all the key partners during that year, outlining their commitment to working together to integrate health and care services. The Memorandum was endorsed by the Council's Executive Board in 2016.

Through collaborative working across all of the ICPs in Lancashire and South Cumbria, it has been agreed that revised partnership agreements would be put in place for each ICP, which outline the role and responsibilities of partners within the place during the 2021-22 transition phase. In support of this, a common draft Partnership Agreement developed by the ICP leads was endorsed by the ICS Board in May 2021, with a view that ICPs would then build on the common draft with content relevant to their own partnership arrangements.

The draft Agreement has now been adapted to reflect arrangements within Pennine Lancashire and was endorsed by our Partnership Leaders' Forum on the 21 July. The Pennine Lancashire Partnership Agreement is not designed to be a legally binding document, but rather an agreement that sets out principles, behaviours and ways of working and a reaffirmation of commitment to work in partnership, to improve health and care. It is recognised that a formal Memorandum of Understanding or other such agreement, will be required as the ICPs and the Lancashire and South Cumbria Health and Care Partnership/NHS Body develop throughout 2021-22 and as national guidance/legislation is released.

The Pennine Lancashire ICP Partnership Agreement 2021-22 is attached at Appendix C for the endorsement of the Board.

4. KEY ISSUES & RISKS

Given the NHS reforms the council needs to mitigate and manage the change of current Clinical Commissioning Groups (CCGs) into a single Lancashire and South Cumbria CCG under the ICS. There is a risk of the administration and commissioning of the NHS becoming too remote and distanced from the people we serve.

Lancashire and South Cumbria is a very diverse area and different areas have particular characteristics, needs and capacity. Therefore it cannot be a one size fits all approach.

It is therefore about strategic fit and being able to demonstrate value at the right levels and the ability to delegate and empower to make a difference at the Place based level. In the case of this council we should be considered as a locality under the technical definition, have defined neighbourhoods

and be part of Pennine Lancashire ICP. We also need to engage in specialist provision and commissioning at the ICS system level where is makes sense e.g. Brain and spinal surgery, specialist heart and stroke units etc.

This council has always believed in Partnership and collaboration. Working at a Pennine Lancashire level is not new. Many Partnerships exist and have worked well on a Pennine Lancashire basis.

It is important to ensure that Local Government, particularly upper tier authorities are involved in the Governance and decision making for the ICS and ICP. This will help ensure democratic representation and our ability to influence and advocate for the improvement of our communities and residents.

5. POLICY IMPLICATIONS

None with this report.

6. FINANCIAL IMPLICATIONS

No direct financial implications. However the council will need to work with the ICP and ICS on defining how it works on programmes that are based on joint commissioning and the Better Care Fund.

7. LEGAL IMPLICATIONS

The Partnership agreement is non-legally binding and therefore is a proposal of 'principles' that we will voluntarily sign up to at this stage.

The Health and Social Care Bill, which sets out a number of legislative proposals for integrated health and social care is currently in the parliamentary process. The Partnership Agreement will prepare for when the legislative changes come in force, but formalised governance arrangements for the partnership will need to be reviewed set up in accordance with new legislation.

8. RESOURCE IMPLICATIONS

The main strain on resource will be officer and elected Member time for meetings and collaborative working with the ICS and ICP.

There are no further resource implications at this stage.

9. EQUALITY AND HEALTH IMPLICATIONS

Please select one of the options below.

Option 1 ☒ Equality Impact Assessment (EIA) not required – the EIA checklist has been completed.

Option 2 ☐ In determining this matter the Executive Member needs to consider the EIA associated with this item in advance of making the decision.

Option 3 ☐ In determining this matter the Executive Board Members need to consider the EIA associated with this item in advance of making the decision.

10. CONSULTATIONS

Consultation has been undertaken by the ICS through the ICP meetings.

11. STATEMENT OF COMPLIANCE

The recommendations are made further to advice from the Monitoring Officer and the Section 151 Officer has confirmed that they do not incur unlawful expenditure. They are also compliant with equality legislation and an equality analysis and impact assessment has been considered. The recommendations reflect the core principles of good governance set out in the Council's Code of Corporate Governance.

12. DECLARATION OF INTEREST

All Declarations of Interest of any Executive Member consulted and note of any dispensation granted by the Chief Executive will be recorded in the Summary of Decisions published on the day following the meeting.

CONTACT OFFICER:	Sayyed Osman, Ailsa Smith, Strategic Director of Adults and Health (DASS), sayyed.osman@blackburn.gov.uk, ailsa.smith@blackburn.gov.uk
DATE:	08/09/21
BACKGROUND PAPER:	Appendix A – Lancashire and South Cumbria NHs narrative Appendix B – PL ICP delivery and development proposition Appendix C – PL ICP Partnership Agreement

Lancashire and South Cumbria
Health and Care Partnership

Developing Integrated Care Partnerships in Lancashire and South Cumbria

Bay Health & Care Partners delivering
bettercare together
Fylde Coast Integrated Care Partnership
OUR Central Lancashire
Healthier Pennine Lancashire
WEST LANCASHIRE PARTNERSHIP

What do we mean by an 'Integrated Care Partnership'?

An Integrated Care Partnership (ICP) is a collaboration of planners and providers across health, local authority and the wider community, who take collective responsibility for improving the health and wellbeing of residents within a place, with a population of up to 500,000. Most people's day to day care and support needs will be met within a place and delivered in neighbourhoods of 30,000 to 50,000 people.

Our partnership will create a feeling of belonging to a place, where all partners are valued and respected, and mutual support is offered to all partners. This will be particularly significant in challenging times. It is important to acknowledge that residents are co-partners in the continued evolution of ICPs, and that social movements in communities can increase people's ownership of their own health and wellbeing and mobilise communities to support each other.

The common purpose of an ICP is to enable collaboration that will address specific place-based challenges and deliver within each place the component parts of the Integrated Care System (ICS) strategy.

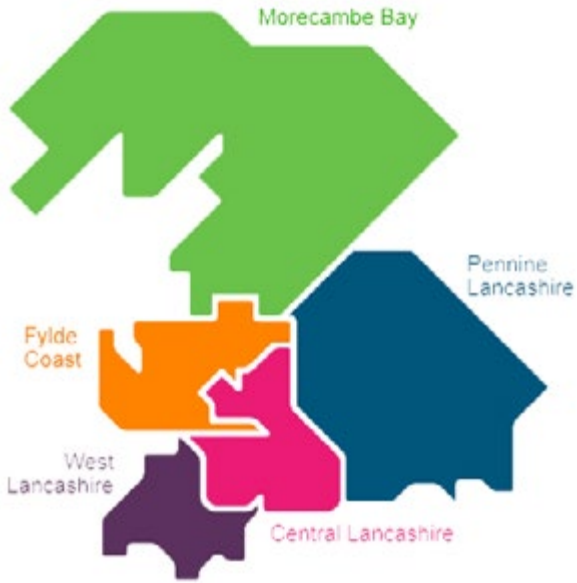
The document entitled "***Integrating care: Next steps to building strong and effective integrated care systems across England***", published by NHSEI in November 2020 states that:

> "Every area is different, but common characteristics of the most successful are the full involvement of all partners who contribute to the place's health and care; an important role for local councils (often through joint appointments or shared budgets); a leading role for clinical primary care leaders through primary care networks; and a clear, strategic relationship with health and wellbeing boards."

Take a look at our glossary for a list of terminology we are using in Lancashire and South Cumbria: www.healthierlsc.co.uk/glossary

The core aims of an ICP are to:

- Improve the health and wellbeing of the population and reduce inequalities.
- Provide consistent, high quality services that remove unwarranted variation in outcomes.
- Consistently achieve national standards / targets across the sectors within the partnership.
- Maximise the use of a place-based financial allocation and resources.



What will happen within ICPs?

As a minimum, each ICP will have the following all age service provision at place level, working together to simplify and modernise care and implement service models which deliver improved outcomes:

- Public health and wider community development.
- Community-based wellbeing support, including social prescribing activities, VCFSE provision and local access to green spaces, and leisure facilities.
- GP and wider primary care, delivered through Primary Care Networks.
- Community health care.
- Community mental health care (including for those with learning disabilities).
- Urgent and emergency care, including physical and mental health (noting that some emergency services will be provided in a networked model across Lancashire and South Cumbria.
- Ongoing management of long term conditions, including the use of skills, expertise and resources that have historically been accessed via referral to acute care services.
- Local acute hospital services (noting that some services will be provided in a networked model across Lancashire and South Cumbria, and there will be tertiary services provided in some places for the system-wide population).
- Social care, education, housing, employment and training support.
- The wider care sector within the place.

The providers of these services will be partners within the ICP working alongside place-based commissioning and planning teams.

Several providers will be working collaboratively at more than one level; for example, NHS Trusts who provide acute and community services will be collaborating within neighbourhoods through the provision of community services, within places through the provision of specialist expertise to support the ongoing management of long term conditions, and across the system in the networked provision of elective care.

In the future, it is expected that the NHS will move towards organisations within each ICP receiving a financial allocation for the place, based on capitation; the principle that money is allocated per person in each place.

This, along with the potential for increased use of pooled budgets, will mean that partners within the ICP will make collective decisions on how best to invest financial resources in order to deliver neighbourhood-based, place-based, regional and national requirements and ambitions across health, care and wellbeing. Partners will need to be clear on their own role in delivery and will need to hold each other to account to ensure collective achievement of their place-based objectives.

What will we need to do collectively as partners within an ICP?

To achieve the common purpose of an ICP, there are several areas where collaborative working will be needed:

Place-based leadership and collaboration

Effective, collaborative leadership – with a clear, common purpose, and drawn from all parts of the system including democratic, clinical and professional teams – has been shown to be essential to developing the partnership culture needed to create and sustain system-wide improvement. ICPs will:

- Co-create a vision for the place that delivers the system and place strategies through a partnership of equals.
- Provide a 'system management' function that connects the partners within the place, as well as influencing key priorities across the Lancashire and South Cumbria Health and Care Partnership and connecting each place to the wider system. This function will include shaping the culture of the partnership through a population health management approach to the planning and delivery of services; holding each other to account for delivery; acting as place-based and system-wide integrators and catalysts for change; brokering challenging conversations between partners; and ensuring that decisions are made in the best interests

of the place. It will need to encompass the expertise and experience of place-based commissioning and provision.

- Use this system management approach to support a collaboration of providers across different sectors and multiple organisations to build seamless, integrated services that respond to the health and wellbeing needs of local residents.
- Promote social value in our communities by employing a workforce that is drawn from, and representative of, the population in the place; by offering fair pay and conditions of employment; by offering employability programmes that support people to acquire the skills needed to work in health and care; and by offering apprenticeship programmes which assist in providing employment now and creating the workforce of the future.
- Promote, embed and demonstrate compassionate leadership across all services within the place.
- Build a culture of rapid improvement with a shared, consistently applied methodology; a management system that aligns improvement activity to priorities and ways of working; and a set of leadership behaviours which supports an engaged and empowered workforce.
- Implement accountability frameworks that incentivise evidence-based care provision and improved outcomes for individuals and for the population as a whole, shaping priorities and decision-making.
- Support effective place-based organisational development programmes, recognising the need for increased support during large-scale and/or sustained periods of change.
- Ensure systems are in place to provide comprehensive organisational development, coaching and mentoring support for leaders to facilitate the transition from organisational to place-based leadership behaviours and decision-making.

Listening to the voice of our communities

Our residents and communities are a fundamental part of our partnerships and their voice and lived experience is vitally important in creating the culture of a social movement in our neighbourhoods and places, in ensuring that residents' needs are heard and understood, and in shaping services that meet local needs. ICPs will:

- Ensure local engagement is culturally appropriate, in line with the demographics of the place.
- Engage with residents to ensure co-production in health and wellbeing needs assessments, delivery plans, operating models and service redesign / transformation activities.
- Listen to feedback from patients, carers, service users and residents to ensure that services are evaluated from quantitative and qualitative perspectives, and that this feedback is used to inform future service provision.
- Engage with residents (and our workforce, many of whom are residents themselves) to encourage a social movement that fosters and enhances an increased responsibility for health and wellbeing and mobilises communities to support each other better.
- Proactively work with communities to create a greater sense of accountability to the local population for the quality of services provided and the resultant outcomes.
- Seize the short-term benefits in restoration and incentivise change to build the culture and capability for the medium and long term.

Planning integrated services

A more integrated approach to the planning of services across all sectors will support more efficient and effective use of resources. ICPs will:

- Lead the creation of a fully integrated, place-based delivery plan that is able to respond to:
  - National strategies, plans, standards/targets
  - The requirements of national and regional regulators
  - Lancashire and South Cumbria Health and Care Partnership strategies
  - Existing place-based strategies
  - Place and neighbourhood-based health and wellbeing/joint strategic needs assessments
- Join up population intelligence capability, and health and local authority planning, including joint commissioning, transformation and at-scale change programmes, quality improvement, service delivery and empowered communities.
- Ensure that actual and potential inequalities are identified and addressed in all aspects of service planning and provision.

Delivering integrated services

Patients, service users and our own workforce often describe their frustrations at the fragmented nature of our service provision. A key shift in the transition to significantly increased partnership working should be the removal of unnecessary boundaries between services and professions. ICPs will:

- Work with partners to ensure the delivery of high quality, safe, affordable integrated services, tailored across the differing needs within the place footprint at neighbourhood/PCN, district and place.
- Ensure that all partners work together so that services will be predominantly focused on improving health and wellbeing through a population health management approach which will include self-care, preventative action, vulnerability reduction, anticipatory care, community-based models of care and support, long term condition management using digital technology, and addressing the wider determinants of health and wellbeing with clinicians and professional groups working at the top of their licence to support complex care in the community.
- Ensure that all partners work together so there is an operating model for the place that includes standard service offers and minimum standard specifications within a place to reduce health inequalities and unwarranted variation within the place and, where appropriate, across the places within the Lancashire and South Cumbria Health and Care Partnership. These service offers and standard specifications will be outcome focused in order to allow for necessary flexibility in delivery and eliminate asynchronous care. The operating model will include:
  - Primary, community, acute, mental health and social care working as self-directed teams across organisational boundaries, to deliver for populations of 30,000-50,000, driven by data, mobilising prevention and anticipatory care. PCNs will be at the core of these teams.
  - Joining up of civic and community assets, providing partnership multi-disciplinary teams (MDTs) which will include housing, Department for Work and Pensions, voluntary sector support and access to community assets to support people to maintain independence.
  - Long term condition management where the focus of specialist/consultant led support is on holistic continuous condition and exacerbation management, aimed at keeping people at home.
  - More intensive community support when required to keep people at home, including at times of crisis.
  - Elective care, urgent and emergency care, including physical and mental health, providing timely and appropriate access.

- Ensure that all partners work together to provide fully integrated health and care records that are available to all staff involved in the provision of care across the place, with information governance agreements that support and enable integrated working. The ambition is to move towards records that are resident owned.
- Make best use of digital solutions that will support residents staying in their own homes wherever safe and effective, predict need and support effective mobilisation of the workforce, and promote multi-disciplinary working to deliver seamless care.

Population health management

Moving towards a preventative, proactive and holistic approach to the health and wellbeing of our residents is key to improving outcomes and reducing inequalities. ICPs will:

- Ensure plans are in place to implement a population health management infrastructure and culture.
- Ensure that the ICP uses a population health management approach to service planning, i.e. making use of holistic data from multiple sources to identify the health and wellbeing needs of the population (place and neighbourhood).
- Ensure that a risk stratification approach is used to plan how services can meet health and wellbeing needs and reduce inequalities, including addressing the wider determinants of health and wellbeing such as housing, environmental quality and access to good employment and training.
- Use population data to mobilise the workforce, working to accountability frameworks that demonstrate delivery on outcomes and incentivise prevention and anticipatory care.
- Build a collaborative decision-making process that prioritises investment in anticipatory and preventative care to reduce specific risks and vulnerabilities within the local population.
- Ensure the creation of integrated population health management units in neighbourhoods by building on existing neighbourhood working, community hubs and PCNs, whilst also drawing in acute care specialists who focus on long term conditions and the elderly.

Improving quality of services

We know that many services in our system provide good quality care which is rated highly by patients and services users. It is important for us to build on that and learn from these teams / organisations to provide consistent, high quality care across each place. ICPs will:

- Ensure all partners work together so that actual and potential inequalities are identified and addressed in all aspects of service planning and provision.
- Ensure place-based performance and assurance is focused on delivering the required improvements in population health, outcomes and inequalities.
- Ensure all partners use an evidence-based approach to care planning and provision, simplifying and standardising pathways across the place and within neighbourhoods.
- Lead the deployment of improvement science at pace and scale to support rapid cycles of change, allowing freedom to act and promoting innovation.
- Create an integrated, place-based plan for the provision of high quality services that meets the requirements of the regulators across the sectors within the partnership.

- Create and maintain an open and transparent culture that encourages incident reporting, management of serious incidents and the implementation of associated learning from incidents across all sectors within the partnership.
- Ensure there is sufficient capacity and that services are of the highest quality to meet required national standards / targets
- Design and deliver culturally competent personalised care services.

Maximising the use of resources

Resources within each place are scarce and it is therefore important that we use these wisely in order to gain the maximum benefit for our residents. It is therefore proposed that the actions set out below will accelerate the next stage of development. ICPs will:

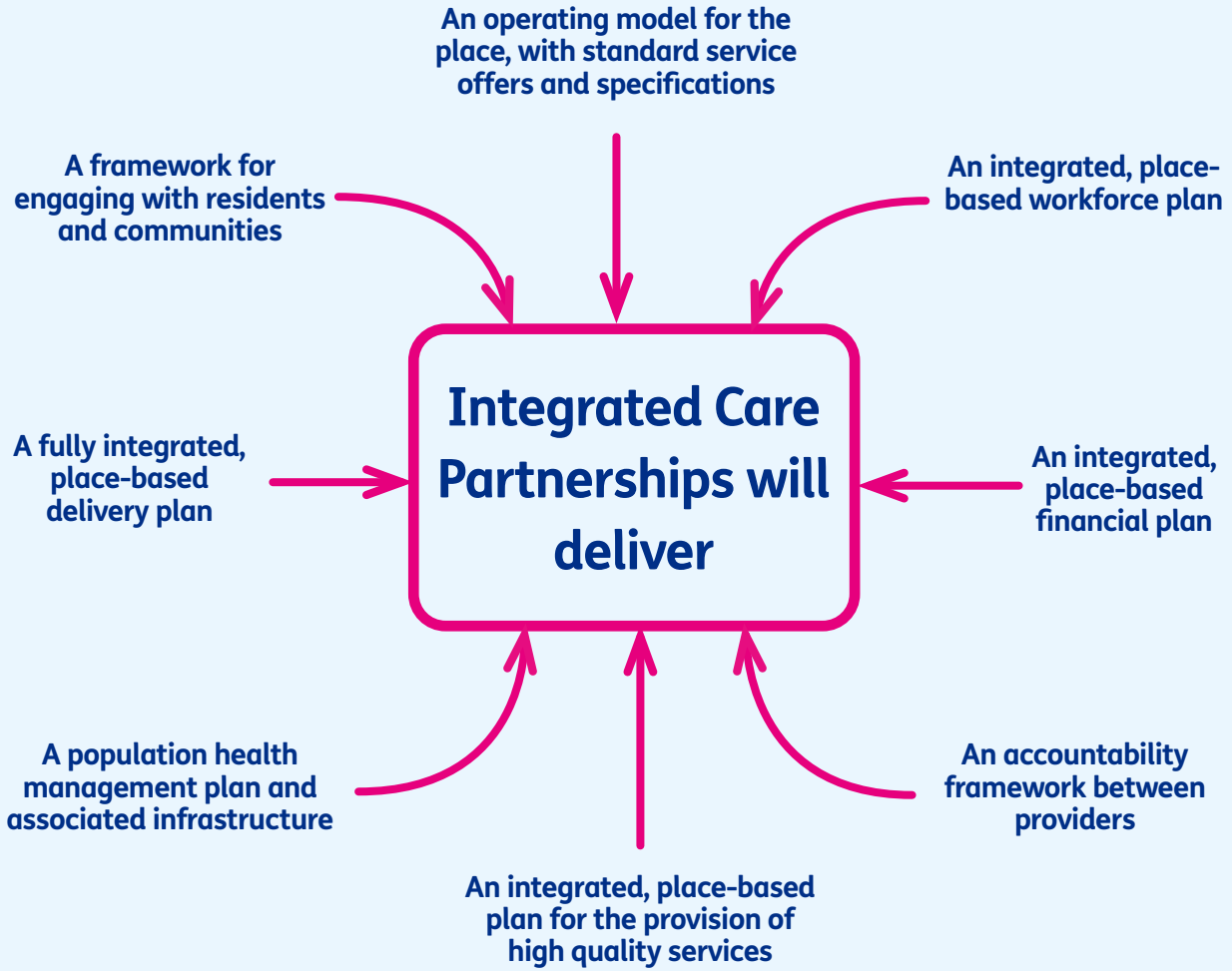
- Be collectively accountable for a place-based capitated NHS budget within an agreed Lancashire and South Cumbria financial framework along with any pooled budgets across the NHS and other partners within the ICP.
- Use a place-based collective prioritisation and decision-making framework to agree the allocation of these financial resources within the place.
- Work with partners to create an integrated, place-based financial plan that supports population-based budgets and demonstrates best value for the 'place pound' whilst maximising impact on population health, health inequalities, quality of service provision and outcomes.
- Use contracting and payment mechanisms within the place that are based on incentives, with agreed shared risk / gain models and aligned financial processes, building on the PCN Directed Enhanced Services and local quality schemes.
- Plan and deliver local cost improvement schemes to ensure best value for money.
- Ensure local understanding of community-based physical assets and influence their collective use across partners within the place.
- Make best use of business intelligence / health informatics resources across the ICP partners, and as appropriate with wider partners across Lancashire and South Cumbria Health and Care Partnership, to provide real time information for use across the place and a single suite of performance / assurance reports.
- Integrate corporate teams to work across the place rather than maintaining separate teams in individual organisations.

Valuing and developing the workforce

The partners within each ICP employ a significant number of people, many of whom are also residents within the place where they work. Partners have a duty to support their workforce and to contribute to the socioeconomic development of the place. There are a significant number of volunteers in each place who make invaluable contributions that should be supported and recognised. ICPs will:

- Recognise that key partners are anchor institutions in each place, acknowledging the fundamental role they have in advancing the welfare of the populations they serve and the way in which they can support local community wealth and development.
- Be a partnership of employers that proactively supports the employment of our local people by providing equity of access to opportunities and employing a workforce that is drawn from, and representative of, the population served by the place.
- Support fair and equitable pay and conditions of employment including paying a living wage and providing stable employment which offers fair working conditions and promotes the health and wellbeing of all staff.

- Ensure that partners develop and offer employability programmes that provide training and support to help local people acquire the skills needed to work in health and care, and work with community partners to support residents who might otherwise face barriers to work.
- Work with local Academies, schools, Further Education colleges and Higher Education institutions to offer apprenticeship programmes which assist in providing employment for the local community and in supporting the creation of the workforce of the future.
- Work with partners to create a place-based people plan for the recruitment, retention and ongoing development of an integrated workforce.
- Integrate the workforce to support seamless service provision and minimise handovers between individuals and organisations across the partners within the place.
- Provide joint appointments and rotational posts across multiple care settings in order to make best use of, and/or further enhance, skills and experience.
- Support professional development and career progression to staff at all levels and across all aspects of provision.



How will we need to work together as partners within an ICP?

It must be recognised that without legislative change, certain types of organisations are accountable to specific regulators, with ring-fenced budgets, and will be held to account for delivering certain services and/or functions.

Therefore, we need to consider what can and cannot be undertaken collectively, how we will organise ourselves to manage this locally, and how we will respond to our respective regulators. This will require liaison with regional and national teams to support the shift from organisational accountabilities to place-based accountabilities.

This is likely to require a new and explicit mechanism for holding ICPs to account for what is in scope of place-based, collective delivery.

Partners within an ICP will share responsibilities, risks and resources. This will require some delegation of decision-making to the place rather than organisations, clarity on which partners are delivering which services / functions within the ICP, and changes to current organisational-based leadership structures and governance arrangements.

Delegated decision making

Each ICP will require a framework that defines the scope within which decision-making happens by place-based system leaders operating within parameters agreed by the partner organisations.

This is likely to be achieved via a scheme of delegation that is explicit about what will be managed via organisations and what will be managed via the ICP. This will include decision-making across all of the functions of the ICP, and all partners within the ICP.

Supporting governance arrangements

Each ICP will require a structure where it can exercise this delegated decision-making, ensuring that partners deliver what has been agreed, and maintaining appropriate levels of lay/non-executive oversight and clinical engagement.

As part of this process each ICP will need to consider the following requirements:

- The use of formal memoranda of understanding, partnership agreements or alliances to provide clarity on the role and responsibilities of each partner organisation within the ICP.
- A place where delegated decision making from the statutory bodies can be discharged, i.e. a place-based ICP Board that is the decision-making group of the ICP, as outlined by a scheme of delegation and enacted by the members of the ICP Board. This may need to be supported by other place-based committees, which could function using a Committees in Common approach.
- A cross-organisational, multi-professional clinical and professional leadership body that allows senior clinicians / practitioners from across the partners within health, social care and third sector within the ICP to make decisions / recommendations on clinical practice, pathways, etc.
- Meaningful clinical, professional and democratic leadership and engagement, to ensure that there is appropriate representation and engagement across neighbourhoods, districts and the place.
- A mechanism for identifying and managing risk for the ICP, with proportionate distribution of risk across partners, and clarity on which partner within the ICP owns the risk along with which partners contribute to the mitigations.
- Systems and processes for partners in the place to hold each other to account for performance and support each other where necessary. These will need to align to the accountability framework within the Lancashire and South Cumbria Health and Care Partnership and the approach agreed with regulators.

It should be noted that effective implementation of these governance arrangements may require changes to current organisational constitutions and Terms of Reference of existing organisational groups.

Supporting leadership arrangements

Each ICP will require a leadership team for the place that will be acting independently of any single organisation (albeit that they may continue to hold organisational leadership roles) working to deliver the core aims of an ICP.

Each ICP will need to consider the following:

- An ICP Chair who will be responsible for creating productive collaborative relationships within the ICP and across the Lancashire and South Cumbria Health and Care Partnership, and for effective leadership of the ICP Board and its role in ensuring delivery of the core aims of the ICP.
- An executive leadership team with members who have responsibilities across the place (albeit that they may continue to hold organisational leadership roles).
- High levels of clinical and professional leadership and influence, where leaders are acting as a collective voice on behalf of the health and care system.
- Shared purpose and values that have been adopted by the ICP partners.
- Leaders who demonstrate high levels of trust, collectively overcome challenges, celebrate shared success and drive continuous improvement to shared objectives through adaptive change and a learning culture.
- Leaders who role model values and behaviours and cascade down through their teams.
- Leaders who respect that the voice of all partners has equal weight and value.

It is suggested that there will be a need for an 'Integration Lead' within each ICP. It is intended that this role will work alongside the senior executives from the partners within the ICP and local communities to:

- Ensure effective integrated approaches are taken to the health needs of the local population – using population health management techniques and building on the experience and expertise within communities.
- Support the development of integration across all services (primary / community / care / hospital / VCFSE) in the place and ensuring that PCNs work effectively to support each neighbourhood of 30,000 to 50,000 residents.

Work with health partners and local authorities to identify joint opportunities for health and care services to be transformed, building on lessons learned through the response to the Covid-19 pandemic and the potential to use new technology.

Coordinate local contributions to health, social and economic development – set as appropriate within the context of wider system strategies.

Next steps

We will continue to keep colleagues, partners and members of the public informed about any developments as early as possible.

If you have any questions, please contact healthier.lsc@nhs.net.

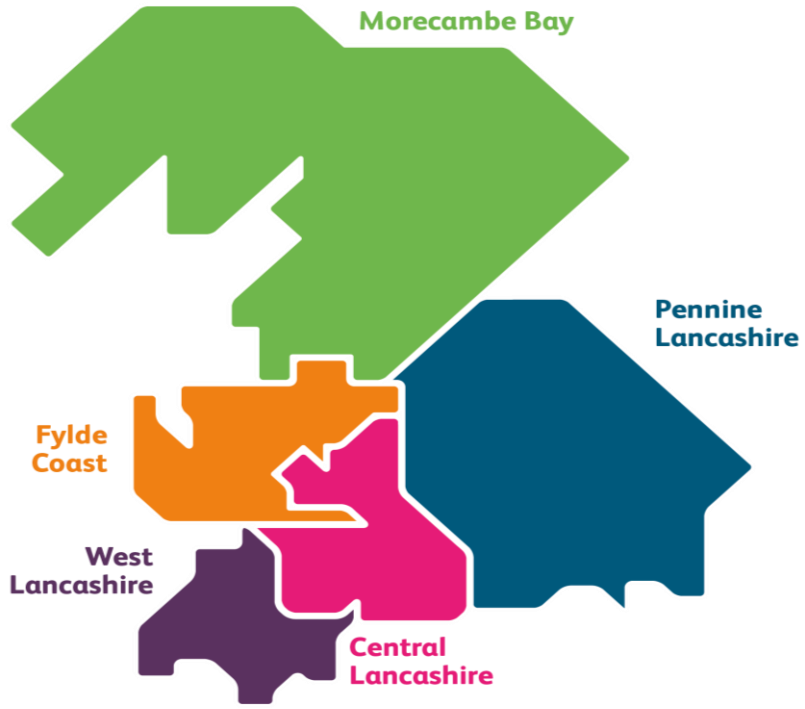
To find out more about how we are developing integrated care in Lancashire and South Cumbria please visit: healthierlsc.co.uk/IntegratedCare.

Healthier Pennine Lancashire

Pennine Lancashire ICP

Development and Delivery Proposition for 2021/22

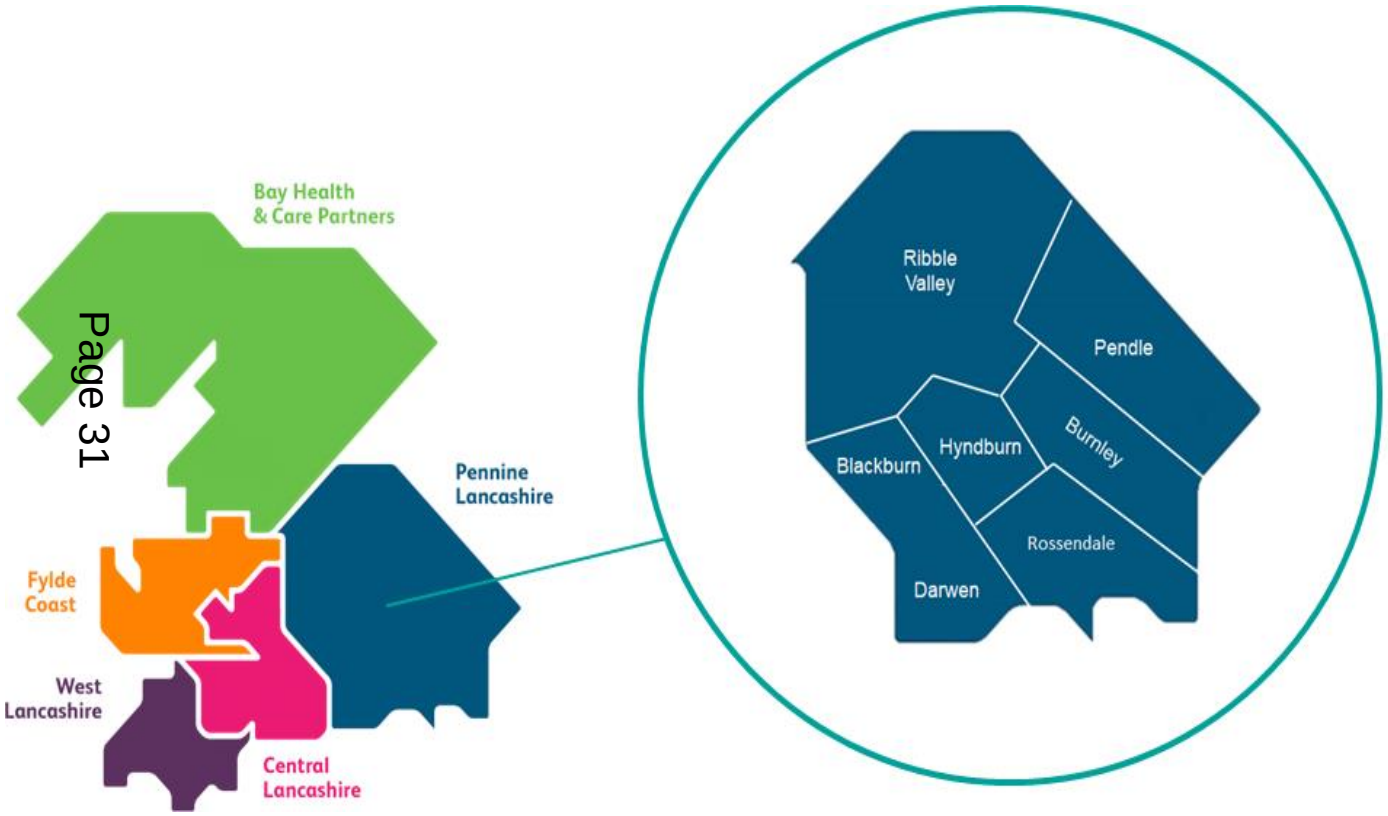
Health and Care System Reform – What we know



While legislation can help to create the right conditions, it will be our hard work that will make the biggest difference.

- **Integrated Care System (ICS) NHS Body serving 1.8m people** - will become a legal body and receive government funding for health services
- Accountability for the **health and wellbeing outcomes** of the population in Lancashire and South Cumbria
- **Lancashire and South Cumbria Health and Care Partnership –** brings together health, local authorities, VCFSE and other partners to address health, social care and public health
- **Health and wellbeing boards (HWBs)** will remain in place and will continue to develop the joint strategic needs assessment and joint health and wellbeing strategy, which both HWBs and the ICS will have to regard.
- **Five Place Based Partnerships (ICPs) -** between local authorities, the NHS and between providers of health and care services, incl. VCFSE these will be left to local partners to arrange
- 42 **Primary Care Networks** – most care will be delivered here. Health and care services will be built around local communities, with services responsive to local need.
- Population health approaches will increasingly be used to **improve health outcomes and reduce inequalities**.
- **Providers of health, care and support services** will increasingly collaborate at all levels of the system and different providers will collaborate at different levels

Pennine Lancashire Integrated Care Partnership



- Healthier Pennine Lancashire represents all of the health and care organisations in the Pennine Lancashire region as well as local councils and the voluntary, community and faith and social sector
- We have worked together for many years with a focus on improving care and support for the people that live here
- Our population across Pennine Lancashire is 531,000 and we have the largest population of all the Lancashire and South Cumbria ICPs
- We have 13 Primary Care Networks (PCNs) serving 30-50,000 people encompassing 76 GP practices
- Our workforce includes anyone who plays a role in the health and care sector including clinicians, nurses, social services, community services, regulated care and volunteers.

Pennine Lancashire Integrated Care Partnership – Our purpose

In February 2021 the Government published a White Paper outlining how the NHS in England needs to change to enable health and care to work more closely together. It has long been our aspiration to improve the way services work together and to be excellent partners to each other, but bureaucracy has sometimes got in the way. The reforms therefore support our local ambitions by removing some of the current legal rules that can get in the way of joined up working.

The reforms outline the need for Place Based Partnerships to be established in local areas, to coordinate care for up to 500,000 people who live there. In Lancashire and South Cumbria we call these Integrated Care Partnerships.

Collectively, we have agreed that the common purpose of our Integrated Care Partnerships (ICPs) is to be a collaboration of people who plan and provide services across health, local authority and the wider community, who take collective responsibility for improving the health and wellbeing of residents within their place.

In Pennine Lancashire our ICP will oversee all age service provision and all partners will work together to simplify and modernise care and implement service models which deliver improved outcomes.

It is our ambition to ensure that our residents are co-partners in the continued evolution of ICPs, and that social movements in communities can increase people's ownership of their own health and wellbeing and mobilise communities to support each other.

The services and partners who work within our ICP include:

- Public health and wider community development
- Community-based wellbeing support, incl. social prescribing activities, VCFSE provision and local access to green spaces, and leisure facilities
- GP and wider primary care, delivered through PCNs
- Community health care and mental health care (including learning disabilities)
- Urgent and emergency care physical and mental (noting some emergency services will be provided in a networked model across ICS, e.g. trauma)
- Services providing ongoing management of long-term conditions, incl. use of skills, expertise and resources historically been accessed via referral to acute care services
- Local acute hospital services (some hospital based services will be provided in a networked model across Lancashire and South Cumbria, and there will be some specialist tertiary services provided in a single place for the whole population of Lancashire & South Cumbria)
- Social care, education, housing, employment and training support
- The wider care sector within the place

Our Vision

Our Vision was developed through discussions with our residents and our workforce and reflects what they told us they wanted care and support to be like in the future.

What our vision means for local people and their families

Better health and wellbeing

People will:

- have longer, healthier lives;
- be more active in managing their own health and wellbeing, maintaining their independence for longer;
- be supported to keep well both physically and mentally, with mental health and physical health being equally important;
- be central to decision making

Better care for all

People will have:

- consistent, high quality services across Pennine Lancashire
- joined up services and support which are easier to navigate and access;
- services and support responsive to local need;
- equal access to the most effective support, with reduced waiting times.

What our ICP will do

Within our Integrated Care Partnership we will continue to work together so that services will be predominantly focused on improving health and wellbeing through a population health management approach which will include promoting self-care, preventative action, vulnerability reduction, anticipatory care, community-based models of care and support, long term condition management using digital technology, and addressing the wider determinants of health and wellbeing with clinicians and professional groups working at the top of their licence to support complex care in the community.

We will ensure that our service offers are outcome focused and delivered flexibly to meet the needs of our residents in a way that avoids duplication of support offers.

Through working together we aim to:

- Improve the health and wellbeing of the population and reduce inequalities
- Provide consistent, high quality services that remove unwarranted variation in outcomes
- Consistently achieve national standards / targets across the sectors within the partnership
- Maximise the use of our Pennine Lancashire financial allocation and resource

Together we will plan and deliver care and support for people of all ages, which will include:

- Joining up of civic and community assets, providing whole partnership support for residents, which will include housing, Department for Work and Pensions, voluntary sector support and access to community assets to support people to maintain their independence.
- Primary, community, acute, mental health and social care working as self-directed teams across organisational boundaries, to deliver services to 30-50k populations, driven by data, mobilising prevention and anticipatory care. Our Primary Care Networks will be at the core of these teams.
- Aiming to support people who suffer from long term conditions, to remain within their own home for as long as possible, by ensuring that the focus of any specialist/consultant led support is on holistic continuous condition and exacerbation management
- More intensive community support when required to keep people at home, including at times of crisis
- Providing timely and appropriate access to planned care and urgent and emergency care, including physical and mental health

The transitional structure of our Place Based Delivery Collaborative has been agreed as below, it is noted that this will be iterative and that we will revise as we need to over the next six to twelve months

Healthier Pennine Lancashire

Place Based Partnership Board

Agrees high level, shared ambitions for place

Confirms the place-based budget and provides shared oversight of the Pennine Pound

Ensures a focus on population health and outcomes

Ensures mutual accountability for delivery

Empowers the collaborative to deliver

Population Health

Informs on priorities for health outcomes, inequalities and improvement

Oversees delivery of strategic actions to improve outcomes and address inequalities

Role and remit to be developed

PCNs with District Partnerships

Networks with primary care and other providers

Enabling greater provision of proactive, personalised, coordinated and more integrated health and social care for their population

District partnerships wrap LAs, VCFSE and others around PCNs, to address district priorities holistically

Collaborative Workstreams

Primary, Community & Social Care

Intermediate Care

Urgent & Emergency Care

Restoration & Recovery

Mental Health

Learning Disabilities & Autism

Care System

Children & Maternity

Clinical, Professional & Civic Leadership

Full engagement and system leadership. Connectivity between neighbourhoods, place and ICS

Role and remit to be developed

Supporting functions

A People Board to oversee workforce development and redesign

Collaborative working around estates, business intelligence and digital solutions

Our ICP delivery arrangements will involve all key stakeholders and as a minimum will include:

- ***Public health & wider community development***
- ***Local authorities***
- ***VCFSE & Healthwatch***
- ***General practice***
- ***Community health care incl. mental health***
- ***Social care***
- ***Urgent and emergency care services***
- ***Local acute hospital***
- ***CCG leaders will remain throughout the transition***

Legal Framework

How we make decisions, share resources/pool budgets and ensure accountability (to be developed prior to end of March 2022). Assurance likely through a Quality & Safeguarding & Finance and Performance Committee

Communication, engagement & co-design

Staff, stakeholders, residents and communities

Organisational Development

Behaviours, culture and ways of working

Leadership for mobilisation

Nominated leads to oversee and coordinate the mobilisation of the ICP and its component parts, including an interim senior leader for place. (NB these will not be substantive roles and not part of any formal leadership structures that will be implemented to support the new ways of working and/or new organisational structures that are outlined in the White Paper (all of which are subject to legislation).

Leadership for development

National legislation and guidance is expected to confirm formal leadership roles for our place based partnership and these roles will be subject to full and open recruitment processes.

Whilst we wait for this guidance, it is important that we have people working together to oversee the continued development of our collaborative working arrangements. As such, over the next two months, we will be working to establish clear leadership for our collaborative delivery.

The ICP Chairs and Chief Officers Group will take on the role of the **ICP Senior Leadership Team –** to take collective responsibility for developing our collaborative arrangements.

We will also work to establish a Leadership Triad for each of our agreed collaborative delivery workstreams, which will ensure there is chief officer level sponsorship, along with clinical/professional and executive level leadership

These are not “new jobs”, but instead people will take on these responsibilities on behalf of the ICP, in addition to the responsibilities they already have to their organisations. Where such arrangements already exist for a workstream, these arrangements will continue.

Delivering on our development

Over the next 3-6 months we will:

- Conduct further engagement on our governance and delivery and identify any additional changes
- Begin to mobilise our new arrangements, particularly working with the agreed collaborative delivery workstreams to identify key delivery priorities for the remainder of 2021-22 and bring forward workstream plans
- Confirm our clinical and professional leadership model
- Agree the role and remit of our Population Health Board
- Begin delivery against our agreed development priorities to in order to test new ways of working and develop a greater understanding of the changes we need to make to support collaborative delivery
- Work to communicate with and engage our key stakeholders and workforce, planning in greater detail for resident engagement towards the latter part of the year.
- Work collaboratively with the other ICPs in Lancashire and South Cumbria to identify frameworks for finance, decision making, accountability and clinical/professional leadership

Most importantly, in doing all of this, we will continue to work together to respond to the on-going impacts of Covid-19, address inequalities and deliver an integrated service offer for all of our residents

Appendix

Roles and Functions

Place Based Partnership Board - functions

The Place Partnership Board is likely to oversee budget delegated from NHS Lancashire and South Cumbria. It could also have other budgets directly aligned to it from local organisations.

Ultimately it is likely that the Partnership Board, with the Place Leader, would delegate spend to the place based delivery collaborative and ensure accountability for delivery against requirements. This delegation could be to the delivery collaborative as a whole, or it could be to a thematic delivery collaborative. As such transparent and robust, yet effective, governance will be required in order to ensure all partners are able to influence decisions.
The Partnership Board will have representation from all local partners and an appropriate balance of executives / officers, clinicians / professionals, non-executives and elected members.

The role and functions of the Board will evolve during 2021/22 as we further understand the future financial flows, subsequent required delegations and the evolution of commissioning reform. Within this evolution it will be important to ensure transparency of prioritisation, accountability for delivery and avoid overly complex or duplicative commissioning arrangements.

The role of ICP Partnership Board in 2021/22 will be fulfilled by the current Partnership Leaders' Forum in the interim period. This will be reviewed again in quarter 3 to ensure this remains fit for purpose in 2022/23.

Population Health and Reducing Inequalities

Healthier Pennine Lancashire

Population Health Board

Informs on priorities for health outcomes, inequalities and improvement.

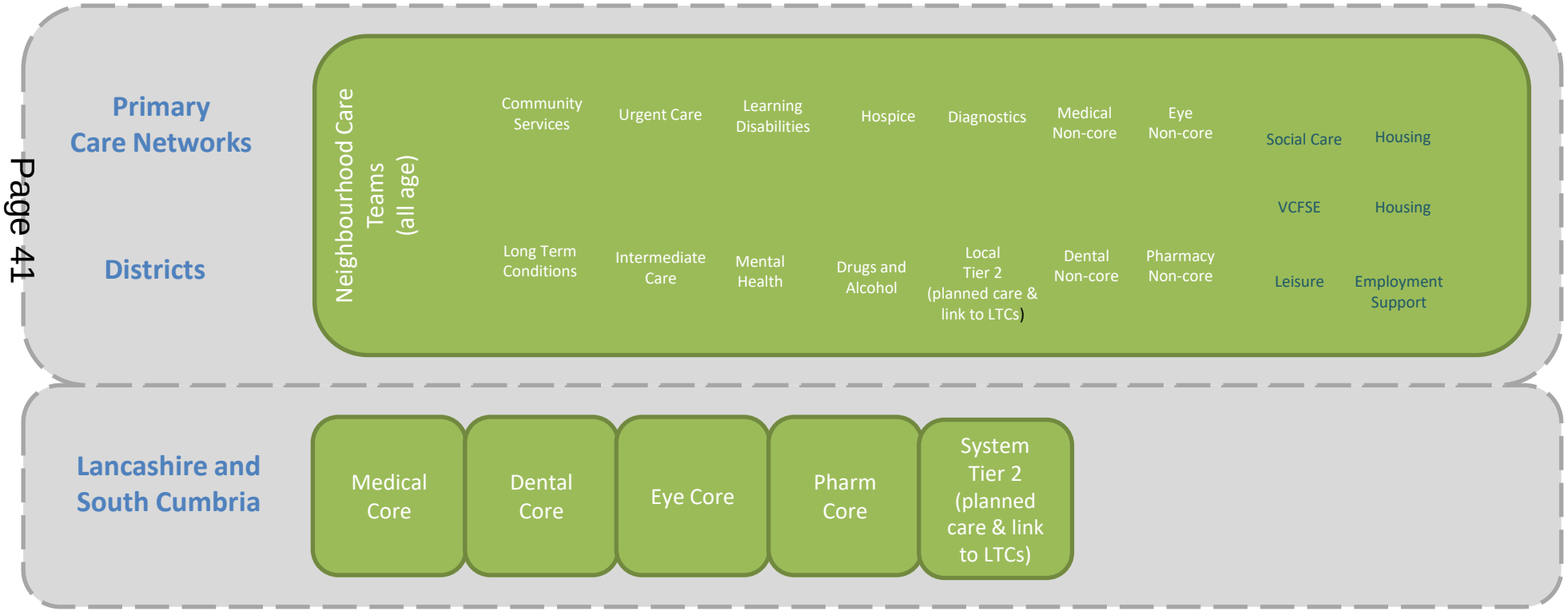
Oversees delivery of strategic actions to improve outcomes and address inequalities.

Influences and learns from the collaborative delivery workstreams to ensure best impact on outcomes and inequalities.

The full role, remit and scope of this Board is currently being developed.

Primary Care Networks and Neighbourhood Care Teams

Primary Care Networks enable greater provision of proactive, personalised, coordinated and more integrated health and social care for their population. The outline below identifies current thinking on the scope of neighbourhood care teams by the ICS Primary Care Sub Cell, alongside our own ambitions for wider service inclusion from our local authorities and other partners.



Our neighbourhood accelerator pilots are currently testing out new ways of joint working to wrap care around local people who are in greatest need.

The learning from these pathfinders can help shape our model.

Our ambitions for District partnerships

- Build on the partnership working that has flourished between our local authorities, VCFSE and PCNs through the COVID response
- Develop and deliver partnership plans that take account of local needs and assets, based on local council geography which is more readily understood by residents
- Create a shared community and partner owned vision of the future state for each area, which aims to align local ambitions with those of the ICP and ICS – critically engages local politicians in creating this
- Align short term operational delivery with longer term transformation plans
- Recognise and build on existing local district and community plans, assets and initiatives
- Re-define the relationship between the community and partners, supporting genuine community engagement and local calls to action, which are best coordinated by local authorities and VCFSE

The evolution of our district partnerships will be iterative and will be informed and guided by close engagement with our district councils.

Healthier Pennine Lancashire

Functions

- Takes a localised approach to population health management and reducing inequalities, engaging all partners relevant to that district
- Agrees priorities based on local needs, assets and inequalities
- Holds a delegated and capitated budget devolved from ICP (for population health in the first instance)
- Joins up civic and community assets, providing partnership MDTs which will likely include housing, Department for Work and Pensions, voluntary sector support and access to community assets to support people to maintain independence
- Supports PCNs to deliver the agreed operating model for out of hospital health, care and wellbeing
- Implements agreed Pennine Lancashire delivery plans and enacts 'top down' requirements, tailored to the relevant local populations e.g. extra care, economic developments, UTCs
- Manages local community engagement work and call to action.
- Develops and delivers local partnership plans that aim address the wider determinants of health
- Work to strengthen and empower local community assets
- Delivers community development initiatives
- Monitors delivery against plan, unblocking where needed
- Provides assurance on delivery and outcomes to Place Based Delivery Board and local constituents

Place Based Delivery Collaborative – functions

Functions
• Brings together health, local authority and VCFSE providers, alongside commissioners to undertake collaborative strategy, planning and transformative delivery
• Sets overall strategy (3-5 year) and annual business plan for place based delivery and coordinates delivery against this
• Determines how local services should be organised and delivered to achieve best value and improved outcomes – maximising the collective skills of providers within the place
• Involves all providers required to deliver the agreed service provision and create the conditions for effective neighbourhood working
• Leads on public and patient engagement and communications strategy
• Focused on delivering population health improvement and person-centred care, overseeing a delegated Population Health Budget
• Reviews investment/disinvestment cases
• Develops and delivers system wide savings/efficiency programme
• Enacts agreed risk share mechanisms (potentially developed at ICS level)
• Delivers against the agreed integrated quality assurance approach
• Identifies and delivers against system quality improvement priorities, deploying the ICP improvement approach to achieve them
• Develops its social value strategy and delivers this to contribute to wider economic recovery

Our priority workstreams

The workstreams identified here reflect our key priorities for collaborative strategy, planning and transformative delivery between providers and place teams (i.e. retained CCG resource in place) to deliver the agreed service model.

These workstreams will be focused around addressing challenges / driving improvements that can only be achieved by integrated working.

Each workstream will also clearly identify actions they will take to improve health outcomes and reduce inequalities.

Accountability for delivery will be through the ICP Partnership Board (Partnership Leaders' Forum).

Pennine Lancashire Integrated Care Partnership

Partnership Agreement 2021-2022

1. Purpose of the Partnership Agreement

The purpose of the Partnership Agreement is to:

- Strengthen collaborative relationships and understanding between decision makers and partners
- Enable and encourage the development of better integration across local health, wellbeing and care systems in Pennine Lancashire, helping to improve quality and financial efficiency
- Enable a system that is robust in its delivery of population health approaches that support long term well-being for the population and help to delivery greater financial sustainability
- Take advantage of all interdependencies and opportunities offered through greater collaborative and partnership working to drive a life-long learning and development, culture and economic improvement
- Enable decision making to take place as close to the citizen or neighbourhood community as possible.

2. Key aims of our Integrated Care Partnership

The key aims of a place-based partnership are:

- Improve the health and wellbeing of the population and reduce inequalities
- Provide consistent, high quality services that remove unwarranted variation in outcomes
- Consistently achieve national standards / targets across the sectors within the partnership
- Maximise the use of a place-based financial allocation and resources and help the NHS to support broader social and economic development.

3. Our partners

The partners within our Integrated Care Partnership are:

- Blackburn with Darwen Borough Council
- Blackburn with Darwen Clinical Commissioning Group
- The District Councils of Pennine Lancashire - Burnley, Hyndburn, Pendle, Ribble Valley, Rossendale
- East Lancashire Clinical Commissioning Groups
- East Lancashire Hospitals NHS Trust
- Healthwatch Together, as represented by Blackburn with Darwen Healthwatch
- Lancashire County Council
- Lancashire and South Cumbria Foundation Trust
- The Pennine Lancashire Primary Care Networks
- The Pennine Lancashire Voluntary, Community, Faith and Social Enterprise Sector

4. Our principles of working together

4.1. Put our residents at the heart of what we do

We will…

- Create a sense of belonging to a place, working on behalf of residents rather than organisations
- Engage with, and work alongside communities to understand and address what matters most to them
- Increase our engagement with residents to create a greater sense of local accountability
- Collaboratively design new cost-effective health and social care processes that place people at the centre, improve the quality of service provision and improve outcomes for individuals and communities
- Make decisions as close as possible to the place where the impact of that decision will be felt
- Put the needs of our residents before the individual interests of professionals and organisations.

4.2. Address inequalities

We will…

- Ensure that we understand, acknowledge and address inequalities for individuals and communities across all aspects of health and care
- Ensure that our collaborative delivery has a clear focus on reducing health inequalities and improving population health
- Ensure that we understand and address our role in the social and economic development of our place and use this to address inequalities for individuals and communities.

4.3. Be good partners to each other

We will…

- Treat all partners with parity of esteem and respect the voice of all partners
- Work together, have joined up conversations and influence wider leadership (across organisations, neighbourhoods, other places and the system) on future ways of working
- Ensure collective decision making, transparency and a culture of co-production
- Where decision-making is not collective, each organisation will be mindful of the impact of its decisions on other partners and will involve partners in consideration of options, impact assessments, etc
- Adopt an open-door policy across organisational committees / groups.

4.4. Adhere to our agreements and hold each other to account

We will…

- Be clear on our individual and collective roles in delivery of actions to achieve the key aims
- Ensure that we have a clear understanding of risks and impact assessments

- Spend within our means and ensure that investment decisions are values-based and transformative.

4.5. Distributed leadership model

We will…

- Ensure that our leadership demonstrates a real sense of purpose for the place
- Create a leadership model that is collaborative, distributed and democratic, creating equity of voice from all partners and engendering high levels of trust
- Ensure we have the right people with the right skills and abilities, undertaking the right work to benefit our communities.

4.6. Recognise our role in the wider Lancashire and South Cumbria system

We will…

- Be active members of our Lancashire and South Cumbria health and care system, recognising that we are all members of our health and care partnership with common aims
- Understand that our Lancashire and South Cumbria system will only be successful when all partners are successful – we will support all organisations and partnerships to be the best that they can be.

5. The behaviours and values we expect to see from each other

We will…

- Act with honesty, integrity and authenticity and trust each other to do the same
- Be compassionate leaders, willing to listen and understand different perspectives
- Foster a reflective and learning culture
- Be ambitious and bold, encouraging risk-taking and experimentation within the confines of clinical and professional safety
- Have a ‘can do’ approach, focusing on opportunities and possibilities rather than barriers or difficulties
- Be an inclusive team, ensuring that we respect the opinions of all our partners and the needs of our diverse workforce and local population
- Challenge constructively when we need to do so
- Lead by example, adhering to behaviours that are reflective of our commitment to collaborative working, and encouraging these behaviours in our wider workforce.

6. Our commitments to each other

We will…

- Put time, energy and focus into developing our partnership and delivering service improvements through collaboration
- Shift our collective focus from episodic treatment of illness / disease to long-term prevention, wellness and wellbeing
- Work as a team, respecting and recognising each other’s experience, knowledge and skills and strengths, whilst supporting appropriate development opportunities for individual members and the partnership as a whole

- Develop and use a common language and support the use of plain English, avoiding the use of jargon, acronyms and other terms that are profession or organisation specific.

7. How partners will come together to do this

The Pennine Lancashire Partnership Leaders' Forum (PLF) will act as our place-based partnership board setting strategic direction, agreeing priorities and coordinating collaborative planning and delivery for Pennine Lancashire's health, social care and wellbeing services. The PLF will oversee the progress of delivery and ensure that partners hold each other mutually accountable for the implementation of the agreed ICP Delivery Plan and the continued development of the ICP.

The Pennine Lancashire Partnership Leaders' Forum will have appropriate representation from partners, with members who are able to represent the views of their organisations/sectors and who take responsibility for cascading messaging in and out of their organisations / sectors.

It is anticipated that formal delegation for decision making within ICPs will be developed and agreed during the course of 2021-22 and at which point more formal agreements will be put in place. Until formal agreements are in place, the PLF recognises that individual organisational Boards and Governing Bodies retain statutory status (where applicable) and existing accountability. The PLF will, therefore, be a forum where partners will agree recommendations to statutory organisations, for those matters that require financial, service or workforce changes that are essential for the furthering of the aims and the vision of the ICP as outlined within this Agreement.

The ICP will work with organisational bodies to identify opportunities for joint decision making processes to be delegated to ICP groups, to enable programmes to progress at pace and facilitate the delivery of the agreed ICP plan and further develop the arrangements for integrating care.

We will have formal place-based groups that have responsibility for planning and delivering an integrated approach to:

- Population health
- Primary care and community-based services delivered in neighbourhoods, including long-term condition management and social care
- Urgent and emergency care (via an A&E Delivery Board)
- Workforce / People (via a People Board)
- Improving quality
- Children and Maternity
- Intermediate Care
- Restoration and Recovery
- Care Sector (including regulated care and wider care)
- Mental Health
- Learning Disabilities and Autism

We will adopt an open-door policy within our Partnership. As outlined above, we now have many collaborative system forums in which we share ideas, information and data. We will expand on this partnership approach by welcoming all of our partners to attend organisational committees which are currently held in public, in line with existing individual

organisational administrative arrangements. For those meetings not held in public, this request will be considered through a conversation with the Chair of the committee in the spirit of openness and transparency.

Functional support

We will have agile and responsive functional support from our Pennine Lancashire Business Intelligence Leadership Team and our network of estates leads and digital leads. These teams/networks will act in an advisory capacity and influence the development of change proposals with intelligence and latest national requirements and developments, in order to ensure robust, viable delivery plans are developed. Should formal groups/meetings need to be established to support collaborative planning and delivery, then proposals for establishing these groups will be agreed with the Partnership Leaders' Forum.

Relationship to Primary Care Networks (PCNs)

It is intended that the ICP and its agreed sub-groups will work closely with and deliver through, the thirteen PCNs in Pennine Lancashire. As such, this Partnership Agreement is not intended to preclude or supersede the requirements on PCNs, which are agreed through the PCN Network Contract DES Specification for 2021/22 and any locally defined Supplementary Network Services.

It is envisaged that furthering the development of the ICP will support the PCNs and particularly the PCN Clinical Directors to fulfil some of the requirements of the Network Contract, by providing an environment where collaborative, multi-organisational delivery, can be planned, influenced and coordinated.

8. How we will manage areas of conflict that require resolution

Partners will attempt to resolve in good faith any dispute between them in respect of Partnership Board (or other Partnership-related) decisions, in line with the Principles, Values and Behaviours as set out in the Partnership Agreement.

Where necessary, place or sector-based arrangements will be used to resolve any disputes which cannot be dealt with directly between individual Partners.

The Partnership may need to apply a dispute resolution process to resolve any issues which cannot otherwise be agreed through these arrangements; any such process should be convened and overseen by the partnership Chair.

EXECUTIVE BOARD DECISION

REPORT OF:	Executive Member for Public Health and Wellbeing
LEAD OFFICERS:	Strategic Director of Place
DATE:	Thursday, 14 October 2021

PORTFOLIO(S) AFFECTED:	Public Health and Wellbeing
WARD/S AFFECTED:	(All Wards);
KEY DECISION:	**Y**

SUBJECT:

Investment in health and fitness facilities

1. EXECUTIVE SUMMARY

Witton Park Arena (WPA) opened in 2014 and Blackburn Sports and Leisure Centre (BSLC) opened in 2015. Both leisure centres still have their original gym equipment in place, which has become outdated and has reached the end of its practical life span.

Gym equipment is breaking down on a more frequent basis and is out of order for longer than necessary as parts are becoming more difficult to obtain. The leisure centres are facing increasing maintenance and repair costs and receiving increasingly negative comments from frustrated customers.

The leisure centres were closed for extended periods of time in 2020 and 2021 due to national and local Covid-19 restrictions. The closures have had a significant impact on health and fitness memberships and customer confidence.

When the leisure centres reopened in June 2021, income from Direct Debit memberships was 51% lower than in June 2019. By September 2021, direct debit income had improved by 9% but was still 43% lower than in September 2019, which is the equates to c.2100 direct debit memberships.

In order to recover the income to pre-Covid levels and achieve income targets, the leisure centres need to provide modern, fit for purpose health and fitness facilities which support membership retention and growth. To achieve this, it will be necessary to replace the gym equipment at both WPA and BSLC.

2. RECOMMENDATIONS

That the Executive Board:

- Approves investment in health and fitness facilities at Witton Park Arena and Blackburn Sports and Leisure Centre for new gym equipment, new flooring and new lighting.

- Gives approval to the Director of Place in consultation with the Executive Member for Public Health and Wellbeing and the Head of Contract and Procurement to place an order with Precor (UK) through the ESPO framework.

3. BACKGROUND

Witton Park Arena (WPA) opened in 2014 and Blackburn Sports and Leisure Centre (BSLC) opened in 2015. At the time of opening both WPA and BSLC were state of the art facilities, with gym equipment to match.

WPA & BSLC have not replaced any of their gym equipment since opening over 7 years ago. The equipment has been extremely well used, it is out of warranty and now incurring increased repair and maintenance costs due to the age of the equipment and frequency of breakdowns. During the past 7 years customer trends and expectations have also changed and gym equipment manufacturers have reflected these changes in the design and 'look and feel' of new equipment.

Private sector competition for health and fitness has also increased in Blackburn with Pure Gym operating in the town centre and JD Gym opening in May 2021 at The Peel Centre in Whitebirk. These operators are competing against WPA and BSLC for health and fitness memberships.

The pandemic has had a major impact on people's physical health and wellbeing, a significant number of gym memberships nationally, have been cancelled or frozen. The pandemic has also changed people's exercise habits with the expansion of on line virtual exercise classes, the boom in the sale of home fitness equipment and the increase in walking, running and cycling outdoors. Whether these exercise habits will permanently replace the "live experience" of exercising in a gym or group fitness studio remains to be seen, but if we are to attract more customers to our facilities, we have to offer people an activity experience which is welcoming, entertaining, engaging and socially interactive.

In 2019, Darwen Leisure Centre (DLC) benefited from £165,000 investment in health and fitness. The whole gym area was redesigned and refurbished and new gym equipment was purchased. Prior to the pandemic, DLC accounted for 43% of direct debit memberships. In September 2021, the DLC accounted for 51% of direct debit memberships which demonstrates that the recently refurbished DLC is recovering at a much faster rate than either WPA or BSLC. If we are to achieve income targets and recover the income to pre-Covid levels, it is vital that we replace the ageing gym equipment at WPA and BSLC.

Leisure Services has successfully promoted a 'join one, join all' health and fitness offer as a unique selling point over the competition. In order to maintain this approach, we need to invest in the same branded gym equipment at all three sites so that customers can train at any site and be familiar with and know how to use the gym equipment. In 2019, DLC installed gym equipment manufactured by Precor (UK). Precor is one of the world's largest commercial gym equipment suppliers, with CV and strength machines installed in thousands of gyms in over 90 countries. It is therefore proposed that Precor gym equipment is also installed in WPA and BSLC.

4. KEY ISSUES & RISKS

The warranties for the existing gym equipment have expired therefore repairs and maintenance costs are increasing and difficult to predict and pose an ongoing pressure to revenue budgets.

The investment in new health and fitness facilities will transform and modernise our health and fitness offer at WPA and BSLC to meet the needs of current and prospective customers and encourage increased levels of participation.

This is the first major investment in gym equipment since the centres opened in 2014 and 2015. The investment will provide customers with a vibrant, new gym environment that encourages increased participation and protects income levels.

The purchase of new equipment with a 5 year warranty in place will ensure repair and maintenance costs are controlled and are predictable, assisting with effective budget management at the sites.

Nationally, c.40% of health and fitness members join a gym between January and March each year. The installation of new gym equipment needs to take place at the earliest opportunity to support improved financial performance in 2022 and recover income to pre-covid levels.

Precor (UK) has confirmed that they can manufacture and install the new gym equipment by the end of December 2021 if they receive a purchase order from the Council before the end of October 2021.

The key decision is urgent as the manufacturer of the gym equipment has confirmed that they can manufacture and install the new gym equipment by the end of December 2021 if they receive a purchase order from the Council in October 2021. If the key decision is delayed, the centres will be operating with ageing and unreliable gym equipment during the busiest quarter of the year for membership sales which will affect the financial performance of the centres and their ability to recover income to pre-covid levels in 2022/23.

5. POLICY IMPLICATIONS

Providing modern fit for purpose health and fitness facilities is an important part of the Council's commitment to improving health and wellbeing through increased levels of participation

6. FINANCIAL IMPLICATIONS

When WPA and BSLC were built, all the gym equipment was purchased as part of the capital projects so there was no provision in the revenue budget for the sites for the replacement of gym equipment in future years.

The purchase of new equipment for WPA and BSLC with a 5 year warranty in place along with new gym flooring at both sites and new lighting at BSLC will enable the centres to develop and grow the membership base.

The capital investment is to be funded from the budget the Council has allocated to COVID support and recovery, and subject to it being agreed, it will need to be funded by way of a contribution from reserves to the Revenue Account and an RCCO to the Capital Programme.

Over the next five years, a leasing budget will be established within each sites revenue budget to fund the lease purchase of gym equipment in the future years.

7. LEGAL IMPLICATIONS

The Corporate procurement team have reviewed procurement framework agreements and after carrying out due diligence, the team obtained agreement with ESPO that the Council could purchase any items from Precor (UK) through the ESPO framework, at prices quoted to us directly by the supplier allowing us to benefit for our existing customer discounts, with warranties negotiated direct from Precor (UK).

This report is recommending a key decision which requires publication of a 28-day notice (the Forward Plan). However, this report is to be considered under the Special Urgency provisions - rule 16 Access to Information Procedure Rules. This report is also to be considered under Rule 15 of the Overview and Scrutiny and Procedure Rules, which waives the call-in procedure due to the urgency as stated above.

8. RESOURCE IMPLICATIONS

The refurbishment of the gyms at WPA and BSLC can be project managed internally using the existing knowledge and skills within the leisure management team.

9. EQUALITY AND HEALTH IMPLICATIONS

Please select one of the options below.

Option 1 ☒ Equality Impact Assessment (EIA) not required – the EIA checklist has been completed.

Option 2 ☐ In determining this matter the Executive Member needs to consider the EIA associated with this item in advance of making the decision.

Option 3 ☐ In determining this matter the Executive Board Members need to consider the EIA associated with this item in advance of making the decision.

10. CONSULTATIONS

11. STATEMENT OF COMPLIANCE

The recommendations are made further to advice from the Monitoring Officer and the Section 151 Officer has confirmed that they do not incur unlawful expenditure. They are also compliant with equality legislation and an equality analysis and impact assessment has been considered. The recommendations reflect the core principles of good governance set out in the Council's Code of Corporate Governance.

12. DECLARATION OF INTEREST

All Declarations of Interest of any Executive Member consulted and note of any dispensation granted by the Chief Executive will be recorded in the Summary of Decisions published on the day following the meeting.

CONTACT OFFICER:	Martin Eden, Director of Environment and Operations martin.eden@blackburn.gov.uk
DATE:	29 September 2021
BACKGROUND PAPER:	

EXECUTIVE BOARD DECISION

REPORT OF:	Executive Member for Public Health and Wellbeing
LEAD OFFICERS:	Director of Public Health and Wellbeing
DATE:	14th October 2021

PORTFOLIO/S AFFECTED:	Adult Services and Prevention Children's Young People and Education
WARD/S AFFECTED:	All
KEY DECISION:	**YES** ☒ **NO** ☐

SUBJECT: BLACKBURN WITH DARWEN'S ORAL HEALTH IMPROVEMENT STRATEGY

1. EXECUTIVE SUMMARY

1.1 Blackburn with Darwen has the highest proportion of five year olds experiencing decay in England, with 51% of our five year olds having at least one decayed missing or filled teeth (dmft). The rate for the North West is 31.7% and for England it is 23.4% (Public Health England (PHE) 2018/19).

1.2 Good oral health has an important role in positive general health and wellbeing for children, vulnerable adults and the elderly.

1.3 Prevention is a multifaceted approach involving education, healthcare, dental services, young people's services, the community, voluntary and faith sector (CVF) and Public Health.

1.4 Vulnerable adults who misuse substances or are homeless or those with a severe mental illness or learning disability require additional targeted oral health intervention, as identified in a PHE report *Inequalities in oral health in England (March 2021*). The strategy also includes elderly residents in care homes as a target group requiring improved oral health care support.

1.5 The oral health strategy has been developed in consultation with partners such as NHS England (NHSE), PHE, the CVF sector, and the Food Resilience Alliance. The strategy includes data showing the scale of the oral health problems in the Borough, effective evidence based interventions, best practice and recommendations for collective action to improve the oral health of our residents.

1.6 The main focus of the strategy is on prevention, with a key recommendation to deliver targeted preventative interventions in our early years' settings as the best return on investment. With sustained investment and focussed resourcing, the impact of these interventions will be evident in the next two to five years, measured by the surveys of five year olds in 2023 and 2025 and evaluation of the recommended interventions.

2. RECOMMENDATIONS

That the Executive Board:

2.1 Note the contents of this report

2.2 Approve the Blackburn with Darwen Oral Health Improvement Partnership Strategy 2021 - 2026
2.3 Approve and support the oral health recommendations and action plan for local implementation.
2.4 Approve the recommendation to tender for an Oral Health Improvement Service, commencing April 2022

3. BACKGROUND

3.1 The oral health of children living in the Borough has been poor for over thirteen years. In 2007/08 the dental epidemiology survey found that the proportion of five year olds experiencing decay was 51%, the highest in England. For the next dental epidemiology survey in 2011/12, the rate fell to 41% probably due to a large 'exposure to fluoride' programme led by the then primary care trust. By 2014/15 the rate had again risen to its highest level of 56% and by the 2016/17 survey, the proportion again dropped to 43% before the latest increase to 51% in the 2018/19 survey. This fluctuation infers a long term strategy is needed to improve the oral health of our children year on year. The rate of decay is also significantly higher in our South Asian Heritage children than in our white children[1].

3.2 Few long term interventions have taken place across pan Lancashire due to changes in funding priorities since the Health & Social Care Act 2012. In 2013, the responsibility for improving the oral health of the local population transferred to local authority Directors of Public Health from NHS Primary Care Trusts. Due to year on year reductions to the Public Health grant, a number of health improvement services were reviewed and scaled back, including local oral health improvement services. Based on the most recent data, Blackburn with Darwen now has the highest rate of 5 year olds with tooth decay in England, which is a call to action as a priority for sustainable investment.

3.3 There is now an urgent need for a cross departmental and partnership response to reduce the rate of decayed teeth in the Borough's young children, and the high number of tooth extractions under general anaesthetic which puts additional pressure on hospital services. The Oral Health Improvement Strategy outlines a number of evidence-based recommendations that would support a reverse in this enduring trend.

3.4 For the average person's time, approximately 5% is spent on accessing health care, including dentistry. The prevention of dental disease, therefore, is achieved in the main during the other 95% undertaking our daily lifestyle routine. Preventing common dental diseases such as tooth decay and gum disease can be achieved through the development of daily habits of self-care, such as regular brushing of teeth with a toothpaste containing fluoride and keeping all sugar-containing drinks and snacks to meal times. However, the Covid-19 pandemic has exacerbated children's oral health outcomes further partly due to restricted access to dentists for routine check-ups and the lack of application of fluoride varnish.

3.5 Poor oral health can affect the ability of children to sleep, eat, speak, play and socialise with other children. Other impacts include pain, infections, poor diet, and impaired nutrition and growth which affect the ability of the child to learn, thrive and develop. To benefit fully from education, children need to be in attendance, be healthy and ready to learn. Taking time off school due to tooth ache or being hospitalised due to tooth extraction, is also disruptive to both the child and their parents. The two main oral diseases, dental decay and periodontal disease, share the same risk factors as other chronic diseases and conditions such as heart disease, cancer, strokes, diabetes and obesity. The latter two conditions are also risk factors for severe Covid-19, so prevention is key.

3.6 Adult dental health is also a concern, as during a recent PHE dental survey[2], Blackburn with Darwen's rate was 36% of patients having visible decay at their appointment (4th worst in the North

[1] PHE 2020
[2] Oral health survey of adults attending general dental practices 2018

West behind three Merseyside Local Authorities). Vulnerable adults are said to have worse oral health, such as substance misuse service users, the Authority's care leavers, the homeless, those struggling with poor mental health, people with learning disabilities and the elderly in receipt of care (see *Inequalities in oral health in England, PHE March 2021*). Therefore, working with our commissioned substance misuse services and care providers is vital to ensure staff in these services receive training on why oral health matters.

3.7 The Framework for Enhanced Health in Care Homes (Version 2) was published in March 2020 and good oral health plays a part. The Care Quality Commission (CQC) 2019 report indicated that too many people living in care homes are not being supported to maintain and improve their oral health and as a result, older people living in care homes are more likely to have experienced tooth decay and the majority of residents with one or more natural teeth will have untreated tooth decay.

3.8 Evidence shows that poor oral health can lead to pain and discomfort, leading to mood and behaviour changes, particularly in those who cannot communicate their experience. There can also be problems with chewing and swallowing, including as a consequence of dysphagia, which limit food choices and can lead to impaired nutritional status. Care staff can find it difficult at times to provide good mouth care, particularly when there are challenges such as advanced dementia or complex dental conditions. There is also a higher risk of 'aspiration pneumonia' which is an infectious pulmonary process that occurs after abnormal entry of fluids into the lower respiratory tract and is also caused by poor oral health and poor oral hygiene. Scientists have found that bacteria growing in the oral cavity can be aspirated into the lung to cause respiratory diseases such as pneumonia, especially in people with periodontal disease.

3.9 PHE have produced guidance for local authorities[3] containing evidence based recommendations, and these form part of the strategy. Examples of some interventions already being delivered include:

- Distribution of toothpaste, brushes and sippy cups by Health Visitors to every child at their 8-12 month check
- Distribution of toothpaste and brushes to every young person leaving our care
- Distribution of toothpaste and brushes to each vulnerable adult in substance misuse services living in homes of multiple occupancy
- A full census survey of every child in reception has been completed where every child in reception had their teeth checked. This will provide evidence to inform targeted interventions in areas with greatest need
- Food Active are piloting a Parent Champion's 'Kind to Teeth' peer support campaign in Blackburn with Darwen and Knowsley Borough Councils. They will work with the children's centres and nurseries to recruit at least two parent champions each. These volunteers will undergo training in September and will form their own parent networks to share good oral health messages
- The Community Voluntary and Faith sector are also recruiting 'Grandparent Champions' in the South Asian communities

4. KEY ISSUES & RISKS

[3] Local authorities improving oral health: commissioning better oral health for children and young people; An evidence-informed toolkit for local authorities

4.1 Due to the current high levels of dental disease in Blackburn with Darwen, there continues to be a demand for dental treatment. However, in March 2020, dental practices received a national directive to cease all treatment provision until Standard Operating Procedures (SOPs) could be put in place to ensure the safe provision of dental treatment during the COVID-19 pandemic. Urgent dental care centres continued to provide emergency care until June 2020, following which dentists resumed the delivery of treatment with additional Covid-19 related infection prevention and control SOPs in place. However, dental treatment capacity remains restricted due to the ongoing impact of the pandemic.

The risks going forward are:

- The number of children being seen regularly by a dentist may be reduced
- Families in need may be unable or unwilling to re-attend once restrictions are lifted and greater capacity is re-established
- The impact of less fluoride varnish being applied to children's teeth as part of NHS funded practice-based prevention
- The number of dental check-ups undertaken may be reduced
- Many care home residents / vulnerable older people in receipt of care are reliant on carers to support their daily oral hygiene care and access to dentistry

If developing daily habits of self-care is done right, through the interventions set out in the oral health strategy, then accessing dentistry for treatment should/will be less of an issue.

4.2 Public Health England have established a link between high rates of tooth decay and being overweight *(The relationship between dental caries and body mass index, 2019)*. Therefore, by addressing poor oral health, the current obesity issue can also be tackled, and vice versa, with both diseases being a risk factor for poor child and adult health. This has resulted in the Council's Eat Well Move More Shape Up strategy group including oral health within its agenda.

4.3. Aim

The aim of the oral health improvement strategy is to improve the oral health of children, vulnerable adults, and the elderly in supported living or in care homes.

The long term vision is to see an increase in children starting school with a full set of healthy teeth who will then grow into adults with healthy strong teeth.

4.4 Governance

The oral health improvement strategy group will oversee and monitor the strategy's recommendations and deliver the action plan.

The oral health improvement strategy group is accountable to the Health & Wellbeing Board and will report to the Children's Partnership Board, Live Well Board and the Age Well Board.

4.5 Recommendations:

Start Well:

Recommendation 1: Make oral health a core component of a joint strategic needs assessment and the health and wellbeing strategy. Review it as part of the yearly update.

As part of this a full census dental survey in reception class has been completed.

Recommendation 2: Ensure all staff working with children in early years settings receive e-learning for oral health each year. Other key staff such as health visitors to receive face to face oral health training on an annual basis, from a commissioned provider.

Recommendation 3: Peer support in early years' settings to form parent champion networks.

Recommendation 4: Continue to purchase toothpaste, toothbrushes and sippy cups for our health visitors to distribute to every child at their 8-12 month check and continue to purchase and distribute a supply of adult brushes and toothpaste for our care leavers each year.

Recommendation 5: Source a provider to deliver and monitor a universal supervised brushing scheme in Reception classes, children's centres and nurseries.

Recommendation 6: Explore with NHS England how dental practices can apply fluoride varnish to children in areas found to have high rates of decay and also make sure every child is registered with a dentist by one year old.

Recommendation 7: Update and reinstate the Smile 4 Life award scheme in all early years' settings; Give Up Loving Pop (GULP) to be rolled out across 20 primary schools with highest rates of decay.

Recommendation 8: Develop and deliver a targeted communications campaign between council and partners to promote good oral health. This will use the intelligence from the full dental census survey to pinpoint wards with the highest rates of decay.

Live Well

Recommendation 9: Purchase toothbrushes and toothpaste for our commissioned services to deliver to clients in houses of multiple occupancy (hostels) and request an evaluation of this intervention from the provider each year.

Recommendation 10: Services working with vulnerable adults' access oral health e-learning on induction and is refreshed annually.

Age Well

The NHS guide 'Framework for Enhanced Health in Care Homes' recommends the following:

Recommendation 11: Every person's oral health should be assessed as part of the holistic care home / domiciliary care assessment of needs and personalised care and support planning process.

Recommendation 12: Care homes should have an oral health policy in place with one staff member taking responsibility for this policy within the home. This should be clearly aligned to NICE guidance 48 Oral Health for Adults in Care Homes.

Recommendation 13: Every person's oral health should be enquired after and/or observed regularly by care home staff as part of their usual hygiene routine, and they should have access to routine dental checks and specialist dental professionals as appropriate. Local systems should work collaboratively to provide access to appropriate clinical dental services for people living in care homes.

Recommendation 14: Staff employed by care home providers should undertake training in oral healthcare to support delivery of oral health assessments and daily mouth care for individuals, and maintain this knowledge and skill through ongoing professional development.

Recommendation 15: Adult Social Care to co-ordinate oral health e-learning for all staff working in care homes or who support our vulnerable elderly residents who live in their own homes. This will take place on induction and as annual refresher training. The oral health champion identified in recommendation 2 above will receive more in depth annual training from the commissioned oral health improvement training provider.

5. POLICY IMPLICATIONS

There are no policy implications.

6. FINANCIAL IMPLICATIONS

A commitment of £120,000 per annum has been ring fenced for an Oral Health Improvement Service for a two year contract with the option to extend for a further two years pending satisfactory performance. The Oral Health Improvement Service will commence April 2022.

The public health grant will be used to fund universal and some targeted oral health improvement interventions.

LEGAL IMPLICATIONS

The Health & Social Care Act 2012 amended the NHS Act 2006 to transfer dental public health functions from primary care trusts to Local Authorities. Statutory Instrument 2012/3094 confirms that Blackburn with Darwen Borough Council is statutorily required to provide or commission oral health promotion programmes to improve the health of the local population (as appropriate for our area). It also requires the Local Authority to provide or commission oral health surveys.

To fulfil our statutory responsibilities, the local authority's public health team commission interventions and programmes to tackle poor oral health and reduce inequalities. The Local Authority public health team monitors oral health and undertakes health needs assessments relating to oral health.

8. RESOURCE IMPLICATIONS

The Public Health team are co-ordinating all interventions. An oral health improvement strategy group has been formed, which includes elected member representation. It will oversee the oral health improvement strategy and will be kept informed of progress made of the oral health improvement action plan (quarterly meetings).

9. EQUALITY AND HEALTH IMPLICATIONS

Please select one of the options below. Where appropriate please include the hyperlink to the EIA.

Option 1 ☒ Equality Impact Assessment (EIA) not required – the EIA checklist has been completed.

Option 2 ☐ In determining this matter the Executive Member needs to consider the EIA associated with this item in advance of making the decision. *(insert EIA link here)*

Option 3 ☐ In determining this matter the Executive Board Members need to consider the EIA associated with this item in advance of making the decision. *(insert EIA attachment)*

10. CONSULTATIONS

- Adults & Prevention Senior Policy Team (Sep 2021) - presentation of findings and recommendations
- BwD Food Resilience Alliance group (Sep 2020) - presentation of findings and recommendations
- Care Network (Aug 2021) – feedback on recommendations
- Change Grow Live / Inspire BwD (June 2021) - feedback on recommendations
- Children & Education Senior Policy Team (Feb 2021) - presentation of findings and recommendations
- Children's Partnership Board (July 2021) - presentation of findings and recommendations

- East Lancs & BwD CCG, Pennine Lancashire Children and Young Peoples Transformation Programme, Priority scoping workshop, Oral Health (July 2021) - presentation of findings and recommendations
- Eat Well Move More Shape Up group (Sep 2020) – presentation of findings and recommendations
- Gypsy Traveller Liaison Officer (June 2021) - feedback on strategy and recommendations
- Healthwatch public consultation (July 2021) - feedback on recommendations
- IMO (Apr 2021) – feedback on strategy and recommendations
- Lancashire & South Cumbria NHS Foundation Trust (June 2021) - feedback on strategy and recommendations
- One Voice (Apr 2021) – feedback on strategy and recommendations
- Parents in Partnership (July 2021) - feedback on strategy and recommendations
- Public Health & Wellbeing Senior Policy Team (Feb 2021) - presentation of findings and recommendations

11. STATEMENT OF COMPLIANCE

The recommendations are made further to advice from the Monitoring Officer and the Section 151 Officer has confirmed that they do not incur unlawful expenditure. They are also compliant with equality legislation and an equality analysis and impact assessment has been considered. The recommendations reflect the core principles of good governance set out in the Council's Code of Corporate Governance.

12. DECLARATION OF INTEREST

All Declarations of Interest of any Executive Member consulted and note of any dispensation granted by the Chief Executive will be recorded in the Summary of Decisions published on the day following the meeting.

VERSION:	**0.6**

CONTACT OFFICER:	**Gillian Kelly / Shirley Goodhew**
DATE:	12/08/2021
BACKGROUND PAPER:	Blackburn with Darwen Oral Health Improvement partnership strategy (2021 – 2026) Oral Health Improvement action plan Equality Impact Assessment toolkit

Blackburn with Darwen Oral Health Improvement Partnership Strategy 2021 - 2026

BLACKBURN with DARWEN BOROUGH COUNCIL

Contents

Foreword

Good oral health has an important role to play in our general health and wellbeing. Oral diseases are common and their impact on both society and the individual is significant. Poor oral health in young children can affect their ability to sleep, eat, speak, play and socialise with other children. Although this is the same for older adults it can also affect their overall quality of life, self-esteem, social confidence, and mental wellbeing, often resulting in reduced engagement in community life, leisure and cultural activities, education and learning, volunteering and employment.

Oral health is an emerging issue amongst vulnerable older people. National data shows an increase in the retention of natural teeth which are often heavily filled and require complex dental or oral care. Alongside this, oral cancer is on the increase with evidence suggesting that tobacco, not eating enough fruit and vegetables, and drinking alcohol, all increase the risk of poor oral health. Other factors also have an impact, such as an increase in the prevalence of Alzheimer's and other dementias and long-term conditions.

Blackburn with Darwen's Oral Health Improvement Strategy aims to promote initiatives and actions across the life course to tackle a broad range of inequalities in oral health, which reflect broader health inequalities. The strategy recommends whole population and behaviour change approaches in an attempt to address some of the common risk factors associated with poor oral health. The recommendations for action in the strategy involves upstream, midstream and downstream interventions based on the best available evidence that use both targeted and universal approaches. These are weighted towards communication, culture and behaviour change, outlined in the accompanying action plan.

Tackling children's oral health is complex and bound up with issues of culture, lifestyle and deprivation. Far too many of our youngest children are having to undergo avoidable and preventable tooth extractions to remove painful and rotten teeth. A whole 'place based approach' to oral health promotion action is required, involving sustained effort, resource and commitment from all partners and residents to tackle this long standing public health issue.

Our health and wellbeing partners are committed to improving the oral health of our children and vulnerable adults, both now and over the long term, as we face the unenviable challenge of reversing our position of having the highest rate of tooth decay in our 5 year old children in England (2018/19).

Through our collective efforts, we are determined to reduce the oral health inequalities associated with access to a healthier food and drink, oral health promotion, literacy and self-care resources, and regular dental health checks for our most vulnerable children, adults and the elderly. This strategy serves as a clear call to action to all of our partners, from the public, private, voluntary community and faith sectors to focus our resources to support and enable our residents to improve the overall oral health and wellbeing of children, families and vulnerable adults.

Professor Dominic Harrison
Director of Public Health

Jayne Ivory
Strategic Director of Children's Service and Education

Councillor Julie Gunn
Executive Member for Children Young People & Education

Councillor Damian Talbot
Executive Member for Public Health & Wellbeing

Aim of the strategy

The aim of the oral health improvement strategy is to improve the oral health of children, vulnerable adults, and the elderly who live in supported living or in care homes.

The Vision

The long term vision is to see an increase in children starting school with a full set of healthy teeth who will then grow into adults and older adults with healthy strong teeth and gums.

The rate of decayed missing and filled teeth (dmft) will also fall year on year, with a target for Blackburn with Darwen Borough Council to match the North West rate by 2026 when the second Public Health England (PHE) commissioned survey of five year olds will have taken place.

Executive summary

Blackburn with Darwen Borough Council is one of the more deprived local authorities in England. Poor oral health is closely linked to deprivation, and this is seen in the data for decayed missing or filled teeth (dmft) for the Borough.

Our five year olds have the highest rate of decay in England, this time by a significant margin. This is a call to action to provide long term interventions to reverse the trend year on year.

Good oral health has an important role in positive general health and wellbeing for children, vulnerable adults and the elderly, and prevention of poor oral health is a multifaceted approach involving education, healthcare, dental services, young people's services, the voluntary, community and faith sector (VCFS) and Public Health.

This strategy has been developed in consultation with partners such as NHS England (NHSE), Public Health England (PHE), the Community Voluntary and Faith sector and the Borough's Food Resilience Alliance. It includes data showing the scale of the oral health problems in the Borough, effective evidence based interventions, best practice and recommendations for collective action to improve the oral health of our residents.

The impact of these interventions will be evident in the next two to five years, measured by the surveys of five year olds in 2023 and 2025 and evaluation of the recommended interventions which are set out across the three life courses of Start Well, Live Well and Age Well. They should go a long way to improve the oral health of all our residents.

Recommendations:

Start Well:

1. Make oral health a core component of a joint strategic needs assessment and the health and wellbeing strategy. Review it as part of the yearly update.
2. Ensure all staff working with children in early years settings receive e-learning for oral health each year. Other key staff such as health visitors will receive face to face oral health training on an annual basis, from a commissioned provider.
3. Peer support in early years' settings to form parent champion networks.

4. Continue to purchase toothpaste, toothbrushes and sippy cups for our health visitors to distribute to every child at their 8-12 month check and continue to purchase and distribute a supply of adult brushes and toothpaste for our care leavers each year.
5. Source a provider to deliver and monitor a universal supervised brushing scheme in reception classes, children's centres and nurseries.
6. Explore with NHS England how dental practices can apply fluoride varnish to children in areas found to have high rates of decay and also make sure every child is registered with a dentist by one year old.
7. Update and reinstate the Smile 4 Life award scheme in all early years' settings; Give Up Loving Pop (GULP) to be rolled out across 20 primary schools with highest rates of decay.
8. Develop and deliver a targeted communications campaign between council and partners to promote good oral health. This will use the intelligence from the full dental census survey to pinpoint wards with the highest rates of decay.

Live Well

9. Purchase toothbrushes and toothpaste for our commissioned services to deliver to clients in houses of multiple occupancy (hostels) and request an evaluation of this intervention from the provider each year.
10. Services working with vulnerable adults access oral health e-learning on induction and this training will be refreshed annually.

Age Well

The NHS guide 'Framework for Enhanced Health in Care Homes' recommends the following:

11. Every person's oral health should be assessed as part of the holistic care home / domiciliary care assessment of needs and personalised care and support planning process.
12. Care homes should have an oral health policy in place with one staff member taking responsibility for this policy within the home. This should be clearly aligned to NICE guidance 48 Oral Health for Adults in Care Homes.
13. Every person's oral health should be enquired after and/or observed regularly by care home staff as part of their usual hygiene routine, and they should have access to routine dental checks and specialist dental professionals as appropriate. Local systems should work collaboratively to provide access to appropriate clinical dental services for people living in care homes.
14. Staff employed by care home providers should undertake training in oral healthcare to support delivery of oral health assessments and daily mouth care for individuals, and maintain this knowledge and skill through ongoing professional development.
15. Adult Social Care to co-ordinate oral health e-learning for all staff working in care homes or who support our vulnerable elderly residents who live in their own homes. This will take place on induction and as annual refresher training. The oral health champion identified in recommendation 2 above will receive more in depth annual training from the commissioned oral health improvement training provider.

Introduction

People living in deprived communities consistently have poorer levels of oral health than people living in more affluent areas[1]. The prevalence of tooth decay, tooth loss, oral cancer and gum disease follows this social gradient. Blackburn with Darwen Borough council has an Indices of Multiple Deprivation (IMD) poverty deprivation score of 42, which is the highest of any upper tier local authority (UTLA) in the North West. The Borough also has the 2nd highest proportion of children <16 years (31.4%) living in absolute poverty in the North West.

Blackburn with Darwen Borough Council now has the highest proportion of its five year olds experiencing decay, in the whole of England.

Poor oral health can affect the ability of children to sleep, eat, speak, play and socialise with other children. Other impacts include pain, infections, poor diet, and impaired nutrition and growth which affect the ability of the child to learn, thrive and develop. To benefit fully from education children need to be healthy and ready to learn. Children with special educational needs and disabilities (SEND) need extra support.

Oral health among children aged five years attending mainstream schools is a useful indicator to measure the impact of interventions to improve general health and wellbeing (including parenting, weaning and feeding practices and nutrition) and school readiness. This metric is currently measured every two years and is commissioned by local authorities as a statutory requirement.

Older people's oral health is determined by behaviour and choices but also vulnerability, and good oral health improves quality of life. Older adults, especially the homeless, substance misuse clients, those with a learning disability or mental illness and the elderly living in care homes or with home help, need to have extra help maintaining a healthy mouth.

The two main oral diseases, dental decay and periodontal disease, share the same risk factors as other chronic diseases and conditions, such as heart disease, cancer, strokes, diabetes and obesity – the latter two being risk factors for severe COVID-19, so prevention is key.

The Pennine Lancashire Integrated Care Partnership have also prioritised oral health and their Business Intelligence Leadership Team have produced a NHS Right Care 'Where To Look Pack' 2019/20 (see Appendix 3) focusing on dental caries in children. Their recommendations are integrated into the Start Well recommendations later in this report.

A life-course approach to chronic disease development therefore highlights the importance of early childhood factors in the development of chronic ill-health, including oral diseases.

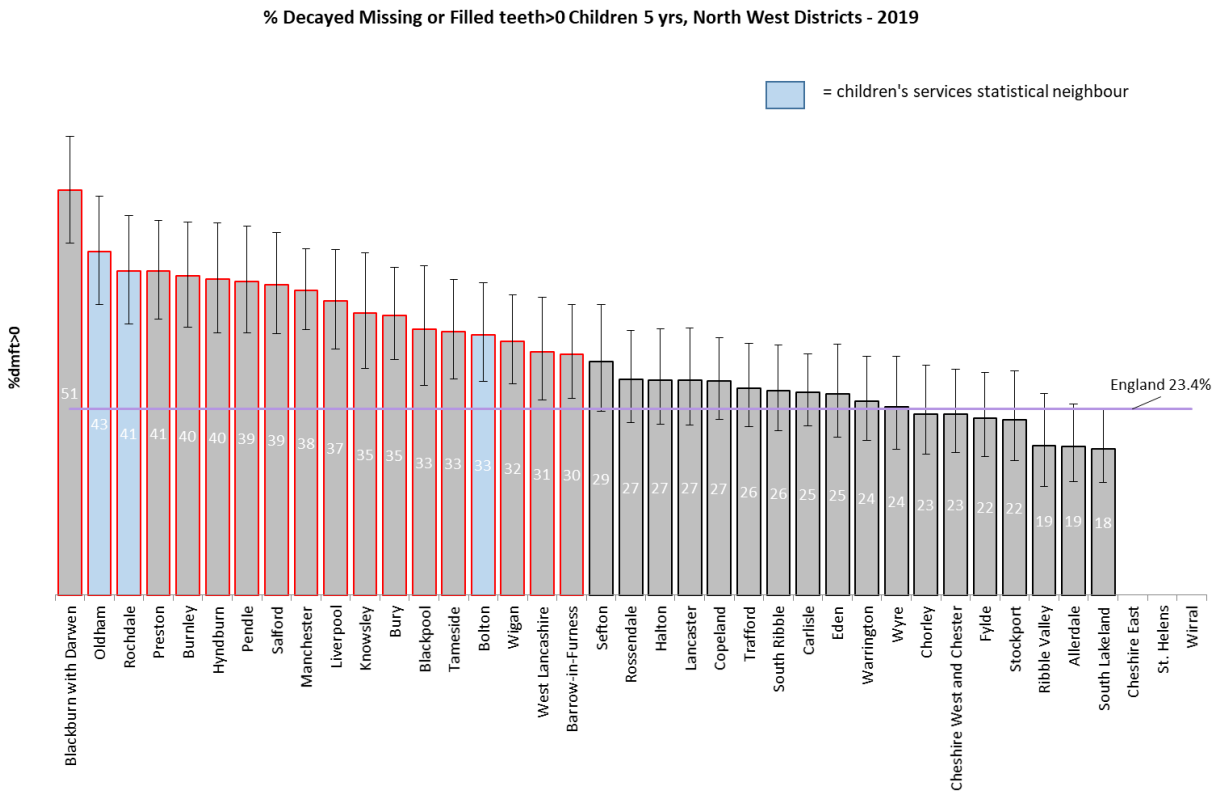
[1] Health Matters: Child dental health - Public health matters (blog.gov.uk)

Part 1 – Start Well

Current Situation

Blackburn with Darwen now has the highest % of five year olds with decayed missing or filled teeth in England, with 51% of five year olds having at least one decayed missing or filled teeth (see Figure 1). This data is taken from the 2019 Public Health England (PHE) dental epidemiology survey in which 282 other local authorities in England took part (43 provided no data). The survey is completed each year, and is a function of the oral health responsibilities transferred to local authorities from the NHS as part of the Health and Social Care Act 2012. Blackburn with Darwen Borough Council commissions the University of Central Lancashire to perform this statutory function. Whilst five year olds are surveyed every two years, each subsequent year is pre-determined by PHE (it has previously been adults seen in a dental practice, 3 year olds, 10 year olds and 12 year olds). See Oral Health - Roles and responsibilities for further details.

Figure 1: Proportion of 5yr olds with decayed, missing or filled teeth, North West, 2019



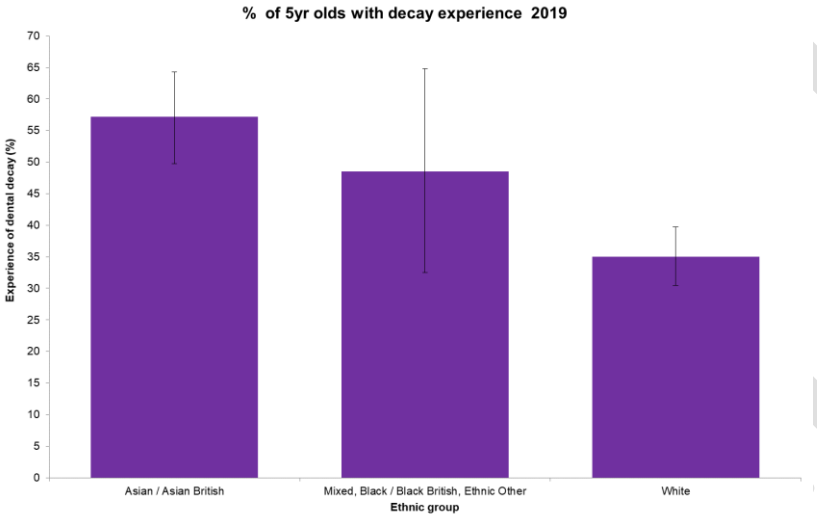
Source: PHE Fingertips 2020

Dental decay occurring in the first two or three years of life can affect the smooth surfaces of upper front teeth and can affect many other teeth as well. This type of decay (early childhood caries) occurs more often in some ethnic groups and is usually associated with long term use of a baby bottle containing sugared drinks, especially if given at night (NICE, 2008). The 2013 survey of three year olds found that 9% had early childhood caries across Blackburn and Darwen, which was higher than the North West (5%) and England (4%) averages. Higher proportions of children from Pakistani and Bangladeshi heritage groups experienced early

childhood caries in some of our statistical neighbour local authorities. The numbers were too low for Blackburn with Darwen Borough Council to show any significance, but higher proportions of children from Pakistani and Bangladeshi heritage groups also experienced early childhood caries here too.

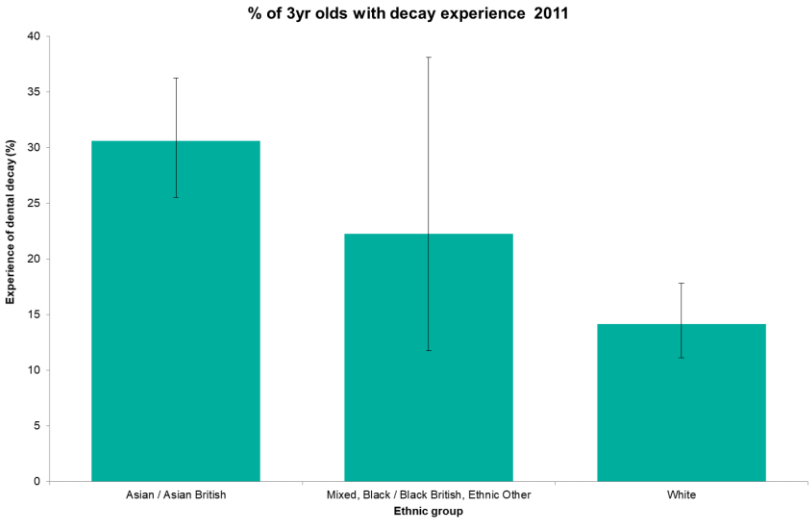
To allow for statistical analysis by ethnicity, the dental survey data was requested from PHE for Pendle and Burnley. The data for these boroughs and Blackburn with Darwen Borough Council's was combined to give a much bigger sample size for more accurate findings. This analysis by ethnicity showed that Asian children living in Blackburn with Darwen, Burnley and Pendle borough councils (combined) have a statistically significantly higher proportion of three and five year olds experiencing decay than white children.

Figure 2 % of five year olds experiencing decay by ethnicity, Blackburn with Darwen, Burnley & Pendle combined.



Source: PHE Dental epidemiologist 2020

Figure 3: % of three year olds experiencing decay by ethnicity, Blackburn with Darwen, Burnley & Pendle combined

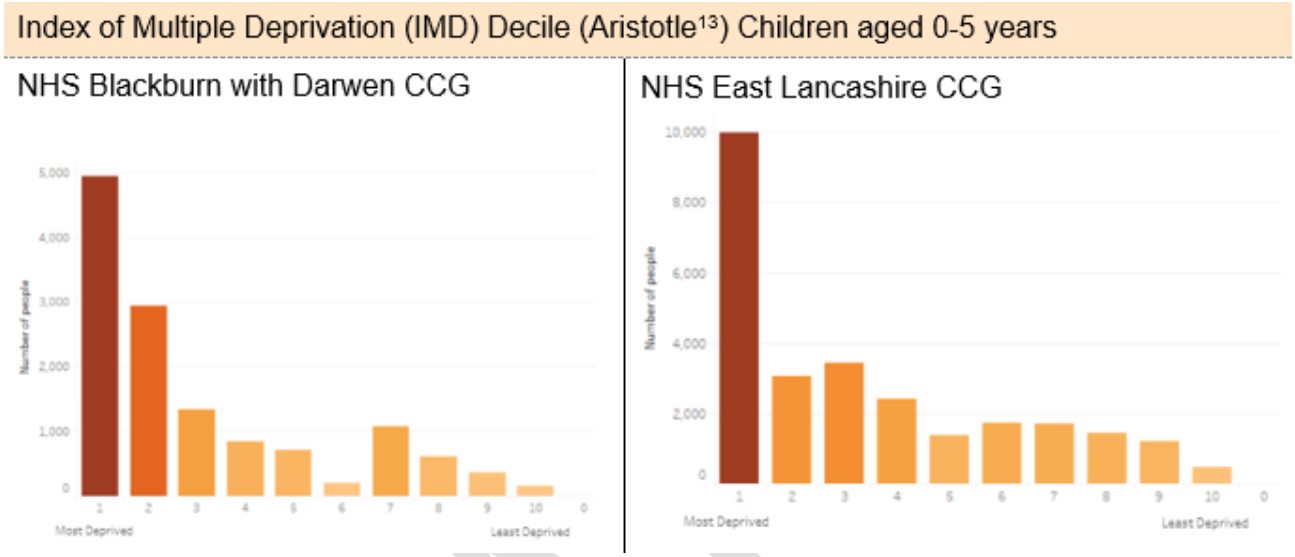


Source: PHE dental epidemiologist 2020

Deprivation

Analysis by the commissioning support unit shows that most children aged 0-5 in Blackburn with Darwen live in the most deprived decile (as is the picture for Pennine Lancashire) so the link between poverty and decay is strong.

Figure 4: % of the population by age band by deprivation decile



Source: Commissioning Support Unit Aristotle Population Health Management tool 2019/20

Hospital episodes for tooth extraction

Dental extractions are the most extreme result of poor oral health, and the most common single reason for hospital admissions for young children aged 5 to 9 years of age in England[2]. Blackburn with Darwen Borough Council has the second highest rate for hospital admissions for dental caries for 0-5 year olds in the North West with 905 admissions per 100,000 children aged 0-5 (crude rate) – see Figure 5.

Children have extractions carried out in hospital mainly because they need general anaesthetic for the procedure. They may be very young or uncooperative, have multiple teeth requiring extraction or have very broken down teeth or infection.

[2] Hospital Episode Statistics (HES) 2019

Figure 5: number and crude rate of hospital admissions for 0-5 year olds for dental caries, north west – 2017/18 -2019/20

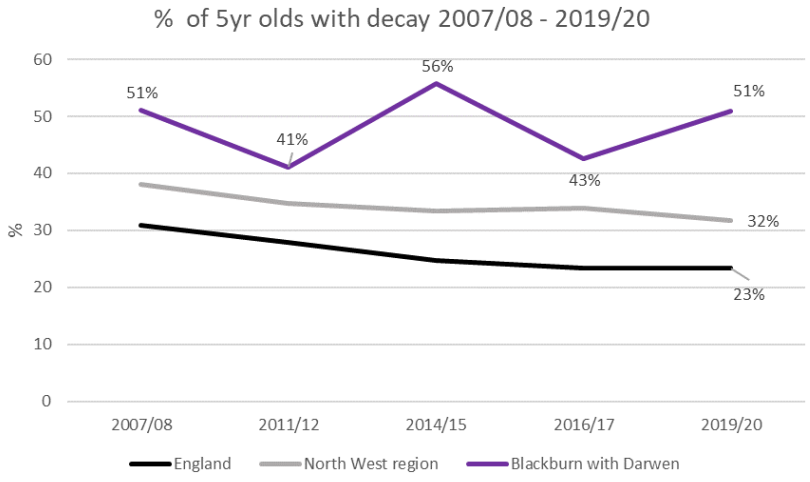
Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	34,771	286.2	283.2	289.3
North West region	–	7,045	446.8	436.4	457.3
Blackpool	–	320	1,055.1	948.8	1,184.2
Blackburn with Darwen	–	350	905.6	808.3	1,000.1
Liverpool	–	770	726.7	676.3	779.9
Wigan	–	485	725.2	659.2	789.5
Bolton	–	485	692.7	631.1	755.7
Lancashire	–	1,600	654.8	623.1	687.7
Manchester	–	720	529.1	491.8	569.9
Tameside	–	260	495.5	433.5	555.5
Oldham	–	280	462.4	409.8	519.9
Rochdale	–	250	455.9	399.4	514.1
Salford	–	285	450.1	400.8	507.2
Knowsley	–	160	446.0	377.0	517.7
Stockport	–	270	420.8	373.6	475.7
Bury	–	175	404.5	342.5	464.2
Sefton	–	180	342.6	297.9	400.6
St. Helens	–	85	228.7	182.6	282.8
Trafford	–	120	223.8	183.8	265.6
Cheshire East	–	90	122.0	96.9	148.4
Warrington	–	45	103.5	75.5	138.4
Halton	–	25	89.2	60.6	135.9
Cheshire West and Chester	–	55	81.2	59.9	104.1
Wirral	–	20	30.3	18.5	46.8
Cumbria	–	20	22.8	14.8	36.6

Trend

Figure 6 shows Blackburn with Darwen Borough Council having the same proportion of five year olds experiencing decay as thirteen years ago, with the proportion of children experiencing decay back up to 51% - from a high of 56% in 2014/15.

Evidence suggests the dip in 2012 was as a result of a large Primary Care Trust-funded fluoride varnish scheme involving the then dental nurse teams based in Accrington and Burnley. There was a Keep Smiling Scheme, Smile for Life and an active oral health promotion scheme with a fluoride toothpaste distribution programme.

Figure 6: The proportion of five year olds experiencing >0 dmft, 2007/08 – 2019/20



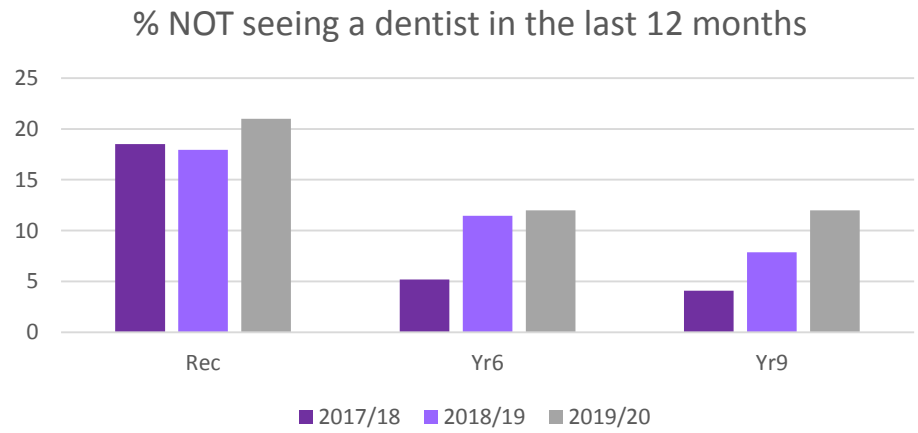
Source: PHE fingertips 2020

School Health Needs Assessment questionnaire

Dental visits

The school health needs assessment questionnaire was a paper questionnaire sent to parents of children in reception, and is completed by children in years 6 and 9. It asks many questions to determine need for a one to one visit from the school nurse, but also asks if the child has been to the dentist in the last 12 months. Figure 7 shows the situation is getting worse with over 20% of five year olds not seeing a dentist in the previous 12 months and an increasing proportion of year 9 students not visiting the dentist. One Voice surveyed some of its members in 2019 and found that a proportion of parents from South Asian heritage didn't feel you needed to register your child with a dentist until they started school.

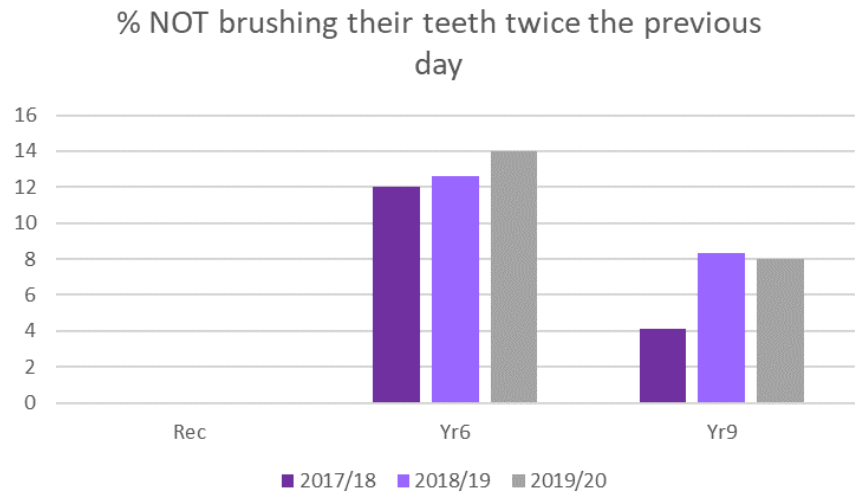
Figure 7: % of children not seeing a dentist by school cohort over time



Tooth Brushing

The proportion of school children informing the school nurse team they did not brush their teeth twice the previous day is also increasing, with the figure doubling from 4% for our year 9's to 8% and increasing for year 6's each year. Results from the One Voice survey also showed some parents believed tooth brushing was only necessary in the morning.

Figure 8: % not brushing their teeth twice the previous day



Oral Health - Roles and responsibilities

The Health and Social Care Act 2012 redistributed resources and responsibilities previously held by Primary Care Trusts. Since April 2013 the roles and responsibilities of Local Authorities, NHS England and PHE in relation to oral health and care are:

Local Authorities have responsibility for improving oral health in the population and there is a Public Health Outcomes Framework (PHOF) measure that relates to this (dental decay among five year olds). We are therefore responsible for commissioning actions and programmes to tackle poor oral health and reduce inequalities. Some of these involve services provided and commissioned by the Local Authority such as Health Visiting and School Nursing Services. In addition local authorities are responsible for monitoring general and oral health and undertaking health needs assessments relating to oral health. This responsibility is supported by the PHE Dental Public Health Epidemiology Programme which facilitates national surveys of a variety of population groups and aims to provide estimates of oral health at local authority level. This programme usually requires local authorities to commission local fieldworkers to undertake local surveys according to a national protocol. Blackburn with Darwen Borough Council have commissioned the dental school at the University of Central Lancashire to provide this service, and the council are in the process of determining an oral health improvement service, as per our responsibilities under the Health & Social Care Act 2012.

NHS England (NHSE) are responsible for commissioning all primary, specialist and hospital preventive and clinical care for oral conditions. This covers general dental practices, access centres and community dental services for primary care, a range of providers for specialist care and dental and general hospitals for inpatient and outpatient care.

Public Health England has a responsibility to provide high level expertise on oral health to support and add value to local authorities and NHS England teams. For example, PHE facilitates and supports the Lancashire and South Cumbria Oral Health Improvement group.

Other Local Authorities - our statistical neighbours' children's oral health interventions

Bradford is one of the most deprived areas in England, with a high prevalence of dental disease in 5 year olds. The local authority recently revised its oral health strategy to highlight areas for improvement and interventions include a community-based fluoride varnish programme, supervised tooth brushing in early year's settings and training for the early years and dental workforce. In addition there is a targeted programme with children attending mosque study classes and Islamic schools.

https://publichealthmatters.blog.gov.uk/2017/06/19/health-matters-tackling-child-dental-health-issues-at-a-local-level/

Oldham

The 2016/17 Public Dental Health Epidemiology Programme for England, oral health survey of five-year-old children living in Oldham showed that dental decay levels decreased significantly to three in ten (34.8%). Oldham has an early years tooth brushing programme called 'Smiles Matter' with nurseries and reception classes taking part in supervised tooth brushing programmes to improve their children's oral health. Children are given a free toothbrush and helped each day to brush their teeth with toothpaste containing the correct amount of fluoride. All children receive a free pack to take home with a toothbrush, fluoride toothpaste and an information leaflet.

Oldham also run an annual 'Big Brush' in November when they encourage all parents in Oldham to back a borough-wide dental campaign to help local children brush up on their tooth care. Throughout the month, children's centres and many nurseries are involved in the Big Brush campaign and some children receive oral health packs containing toothpaste, toothbrushes, timers and written information.

Rochdale

The rate of decay in Rochdale's five year olds has fallen from 47% in 2017 to 41% in 2019. They had commissioned:

1. Borough wide fluoride varnish programme for children aged 3-5 yr. old in both private and Local Education Authority (LEA) nurseries and reception classes.
2. Public Health England transformation fund programme for tooth brushing in schools, taking place in LEA and private day nurseries for children aged 2-5 yr. olds.
3. "Brushing for Life", a Health Visitor led family fluoride tooth brushing scheme for children aged 9 month and 2 yrs. delivered during child assessment visits.
4. "Bump to Baby", a maternity family fluoride toothpaste scheme which helped to create links to promote dental attendance during the ante natal and post-partum periods.
5. Tooth Time, within both LEA and private nurseries. A family fluoride toothpaste scheme which children took home promoting good oral hygiene habits with family or significant carer.
6. The Golden Grin Award scheme designed for all early years settings based on healthy snacking and none food rewards.
7. Referral programme to Living Well Oral Health specialist, for children and families with additional needs. It delivered 1:1 support to improve oral health and support dental attendance.
8. The design and delivery of oral health learning packages for LEA staff and private day nurseries to roll out in class.
9. The loan of resources to support the training packages and delivery of programmes in both LEA and private early years settings.
10. Learning packages in oral health for child minders.

Bolton

The proportion of five year olds with decay in Bolton is 33%, down from 38% in 2017 (and has been declining every survey since 2008). Bolton also has an oral Health Improvement Department based within Bolton NHS Foundation Trust.

The Council has a number of oral health improvement schemes:

1. Brushing for Life (Children aged 8mths) is a health visitor led programme, designed to promote regular brushing of children's teeth. Health visitors provide oral health advice and support for parents and babies at the eight month assessment, along with giving them a toothbrush, toothpaste and an information leaflet.
2. The oral health improvement team offer information and support within a number of children's centres across Bolton. Parent and baby Sessions give early advice for parents on preventing dental decay. The oral health improvement team also explain the importance of early dental attendance and supply a dental access voucher if required.

a. The Dental Access Voucher Scheme aims to ensure that vulnerable children, including looked after children and children on a safe guarding plan are able to access care with a local dentist quickly. The programme has been running in Bolton since 2005 with support from a number of local dental practitioners.

3. Brush Bus - since 2007, children in Bolton have benefited from a supervised Brush Bus programme with many schools, nurseries and special schools taking part. Schools are still posting their Brush Bus activities on their websites.

Evidence based Interventions for consideration for Blackburn with Darwen Borough Council

NICE produce a full list of recommendations for oral and dental health in many settings, outlined in Appendix 2.

PHE's Commissioning Better Oral Health is a guide for local authorities. The Health and Social Care Act (2012) amended the National Health Service Act (2006) to transfer responsibilities to local authorities for health improvement, including oral health improvement, in relation to the people in their areas. Local authorities have specific dental public health functions and are statutorily required to provide or commission oral health promotion programmes to improve the health of the local population, to the extent that they consider appropriate in their areas.

Appendix 1 details the interventions that PHE say local authorities should consider commissioning that are recommended. It also shows those interventions with limited or no value.

Return on investment

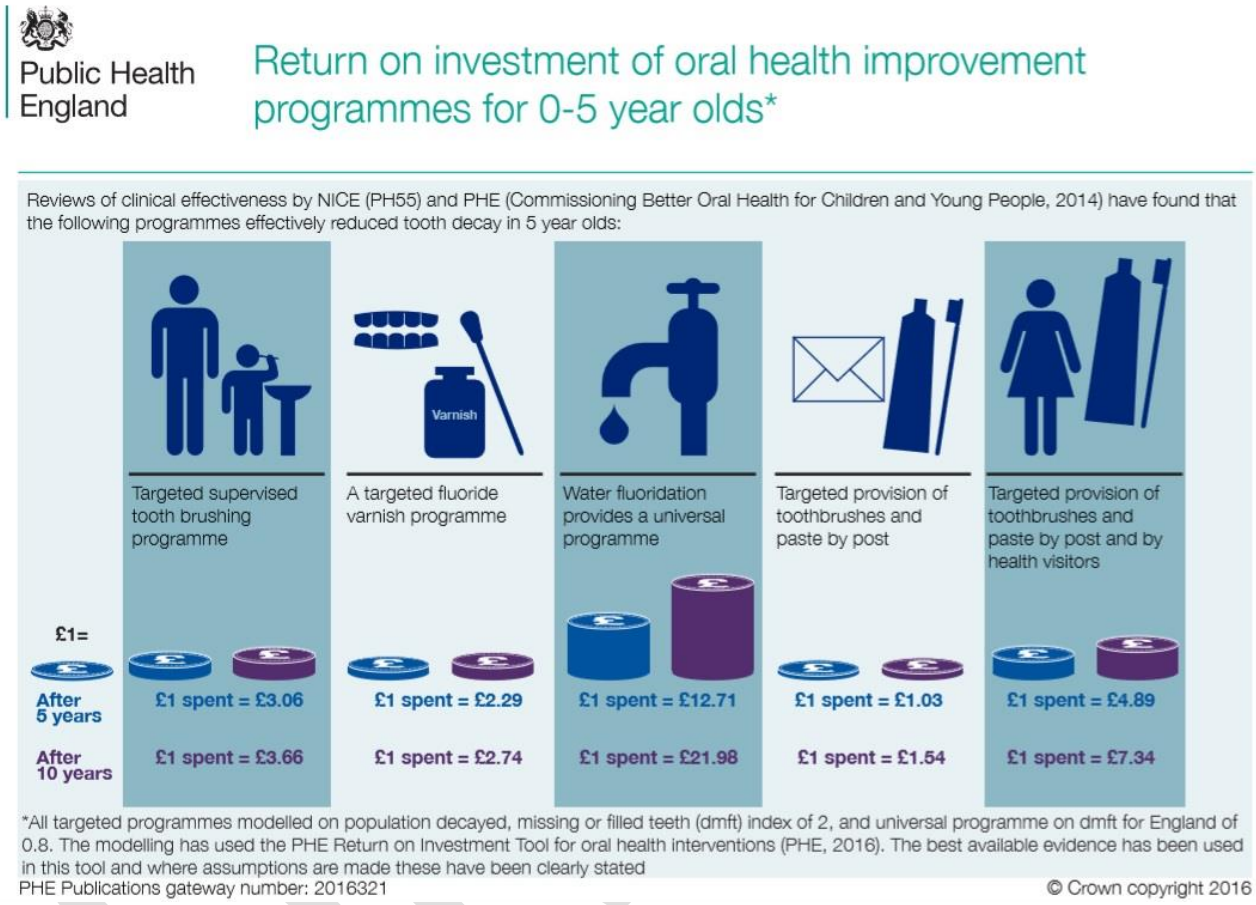
The responsibility for providing oral health improvement interventions falls on Local Authorities and the benefits of better oral health to us as a community are:

1. Improved school attendance due to fewer absences due to tooth ache / tooth extraction hospital episodes.
2. Better long term health due to the links between poor oral health in childhood and adulthood and chronic illness (Anja Heilmann, 2015)

3. Improved Public Health Outcomes Framework (PHOF) indicators for the council.

Figure 9 highlights those interventions that are cost effective:

Figure 9: PHE return on investment – reviews of clinical effectiveness by NICE and PHE, 2016



Recommendations to improve the oral health of children and young people across Blackburn with Darwen Borough Council

(also aligns the Pennine Lancashire recommendations – see Appendix 3 for details)

Recommendation 1: Make oral health a core component of a joint strategic needs assessment and the health and wellbeing strategy. Review it as part of the yearly update.

Sub recommendations to improve intelligence are:

Recommendation 1a: Discuss with our epidemiology provider (UCLan dental school) the cost of a full census survey of five year olds across the Borough (planned for school term 2020/21) to pinpoint wards with high rates of decay, and to allow full analysis by ethnicity, to enable targeted interventions at the right population (currently only 250 children per district are randomly selected across the Borough).

Recommendation 1a has now been completed.

Recommendation 1ai: discuss with the provider a contract variation for the 2023/24 survey to again conduct a full census survey of five year olds.

Recommendation 1b: Set up a group that has responsibility for an oral health JSNA and who will monitor the oral health improvement action plan that aligns with this strategy.

Recommendation 1b is now established

Recommendation 1c: Blackburn with Darwen Borough Council's 'Eat Well, Move More, Shape Up' (EWMMSU) strategy is to include oral / dental health improvement and the oral health improvement action plan will be approved by the board and monitored as part of the EWSUMM strategy action plan.

Recommendation 2: Ensure all staff working with children in early years settings receive e-learning for oral health each year. Other key staff such as health visitors to receive face to face oral health training on an annual basis, from a commissioned provider.

a) Ensure the 0-19 service and our early years' services, including child minders and foster carers, create an account and undertake annually the NHS Health Education England's oral health training for the wider professional workforce, to ensure they convey healthy oral health messages appropriately to the community / children in care / when they visit vulnerable people / families, especially those in more deprived areas and South Asian Heritage communities.
b) For more in depth continuing professional development, the council will commission an oral health improvement training provider to deliver bespoke face to face training across the three life courses Start Well, Live Well and Age Well. The main target audiences for Start Well will be health visitors, early year's staff in our children's centres and key workers in nurseries and social care staff working with children in our care.

Recommendation 3: Peer support in early years' settings to form parent champion networks.

Blackburn with Darwen Borough Council will participate in the Food Active 'Kind to Teeth' parent champion's pilot.

Training for parents champions to start September 2021

Recommendation 4: Continue to purchase toothpaste, toothbrushes and sippy cups for our health visitors to distribute to every child at their 8-12 month check and continue to purchase and distribute a supply of adult brushes and toothpaste for our care leavers each year.

Blackburn with Darwen

Continue to fund the purchase of toothpaste, toothbrushes and sippy cups for our health visitors to distribute to all of our young children at their 8-12 month old check and purchase toothbrushes for our children in care and our care leavers. The provider will at the same time deliver oral health improvement messages at these visits.

Pennine Lancashire

The Pennine Integrated Care Partnership also recommend The Children and Young People Commissioning Team explore the current NHSE work of Starting Well and other opportunities with partner organisations, to increase awareness amongst parents and action/communicate services that support young children in the prevention and early detection of dental caries. CCGs have opportunities to communicate advice and commission maternity and child-health services, both directly and with partner healthcare organisations.

Recommendation 5: Source a provider to deliver and monitor a universal supervised brushing scheme in Reception classes, children's centres and nurseries.

Blackburn with Darwen

Commission a provider to support the delivery of a targeted supervised brushing scheme (Brush Bus) in Reception classes, children's centres and nurseries, including special schools. Note there is a link between being overweight, poor nutrition and subsequently poor oral health in children (PHE, 2019) so the Recipe for Health scheme is also running in these settings.

(Note we have 6000 children in N1, N2 and reception across 112 settings)

Pennine Lancashire

The Pennine Integrated Care Partnership also recommend the CCGs' Children and Young People Commissioning Team explore opportunities with local Public Health partners to increase the regularity of tooth-brushing amongst young children.

Recommendation 6: Explore with NHS England how dental practices can apply fluoride varnish to children in areas found to have high rates of decay and also make sure every child is registered with a dentist by one year old.

Blackburn with Darwen

NHS England commission dentistry. The oral health strategy group will develop and deliver a targeted fluoride varnish scheme for 2-5 year olds using the clinical rooms in children's centres. NHSE are also discussing restarting the Start Well Scheme for dental practices. This scheme funds NHS dentists to attract more children under five year to register with a dental practice and will help towards making sure every child is registered with a dentist by aged 1 year old.

Pennine Lancashire

The Pennine Integrated Care Partnership also recommend using a Population Health Management approach to supplement their original Right Care data. The paper highlights that there are health inequalities in respect to NHS Dentist attendance across many of the districts that make up Pennine Lancashire. Rural populations in both CCGs show lower percentage attendance at NHS Dentists than non-rural areas (for children aged between 0 and 9 years old).

Low dental access rates for young children is thought to be a contributing factor to the poor state of child oral health. NHS Digital report that currently only 13% of children under 2 years of age are visiting a NHS Dentist each year. They recommend the Population Health Management Group explore opportunities to include dental caries prevention and oral health awareness for young children and families, as part of any holistic approach to mitigating health inequalities aligned with high deprivation.

Recommendation 7: Update and reinstate the Smile 4 Life award scheme in all early years' settings; Give Up Loving Pop (GULP) to be rolled out across 20 primary schools with highest rates of decay.

Blackburn with Darwen

Work with PHE and early years' settings to help plan and coordinate a Smile 4 Life programme across all early years' settings. This will help these settings satisfy the statutory framework for the early years' foundation stage 'safeguarding and welfare requirements for health' (food and drink policies)

Blackburn Rovers Football Club will support Food Active and their Healthier Stadia programme to deliver the GULP campaign to 20 primary schools with highest rates of decay (determined using the full oral health census survey data).

Pennine Lancashire

The Pennine Integrated Care Partnership also recommend: Both CCG populations have a higher percentage of children recorded as obese compared to the English rate (26% of East Lancs children aged 4 to 11 years and 19% of children in BwD – 4.6). They recommend the Children and Young People Commissioning Team and the Population Health Management Group explore opportunities (with partner organisations) to promote improved diets for children with reduced sugar intake, and the importance of good oral hygiene.

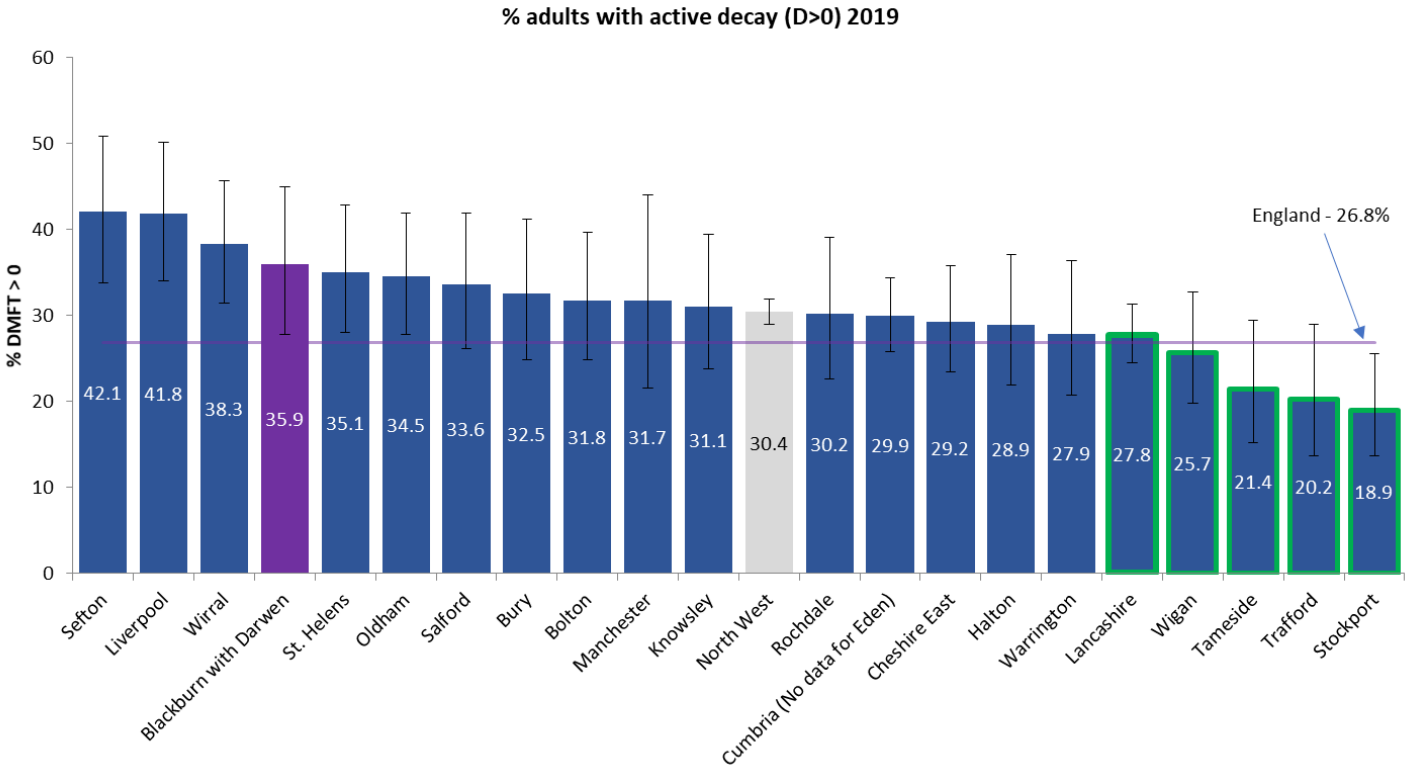
Recommendation 8: Develop and deliver a targeted communications campaign between council and partners to promote good oral health. This will use the intelligence from the full dental census survey to pinpoint wards with the highest rates of decay.

Part 2: Live Well

Adults

Intelligence to support interventions to support adults' and the elderly's mouth care is scarce. However in 2019 PHE informed local authorities that they were to commission a survey of adults in dental practices. Not all authorities took part, and in many, the sample was too small to publish, but what we have is interesting (all bars except those with a green highlight (statistically better than the England rate) are not statistically different from the England rate). Blackburn is ranked 4th behind three Merseyside local authorities. The sample was just 100 adults hence why it is no different to the England rate. Still, 36% had active decay on their visit to the dentist.

Figure 10: % of adults checked in a dental practice with active decay



Source: PHE March 2020

Oral Health Improvement Activity - gaps

Black and Asian populations

Barriers to access: Several qualitative studies have explored the barriers to accessing dental services by people from black and minority ethnic groups. Barriers identified included: language issues, a mistrust of dentists, organisational issues for those in large families, cost, anxiety, cultural misunderstandings and concern about standards of hygiene (Newton J T, 2001),

(Scambler, 2010). The type of barrier identified differed between ethnic groups, though mistrust of dentists was common to all groups (Newton J T, 2001).

Cost: In terms of cost, while NHS dental services for children are free, adults pay for dental care unless they are exempt from payment. Those who wish to apply for exemption must complete a number of lengthy forms which may be difficult for patients with language and literacy difficulties.

Language: Language problems have been cited as a barrier to black and minority ethnic groups accessing dental services. Language barriers may exacerbate the complexities of issues including the charging and appointment system, use of technical terminology, and the need for dentists to obtain both a medical history and informed consent from patients. While interpreting services for use by dental practices are available in some areas, in others there is a lack of resources for interpreting services. Where an interpreter is not available dentists may have to turn patients away or communicate through their friends, families or other patients (Thalassis, 2009). Whilst anxiety is a barrier to accessing dental treatment for both black and minority communities and the general population (Croucher, 2006) Gibbons et al 2000, cited in (Mullen, 2007) such problems may be exacerbated by communication problems.

Mistrust of dentists: Again, mistrust of the dentist occurs in the general population as well as across black and minority ethnic groups. A study of people from black and minority ethnic groups in London found that participants felt that they received a poorer service as a result of their background and believed that dentists did not respect them, listen to them or care about them as much as they did other patients. In turn, they perceived this as the cause of clinical errors, pain, teeth being extracted without all other treatment being exhausted, treatment being rushed and a lack of thought to the true cause of oral problems (Thalassis, 2009).

Culture and religious influences: Little research has been conducted on the cultural and religious barriers to people from black and minority ethnic groups accessing a dentist and the impact this has on oral health. An impact for some patients may come from the gender of the dentist. For example, one study found that some Indian and Pakistani women did not want to visit a male Indian or Pakistani dentist, although they were happy to visit a white British male dentist (Mullen, 2007). A potential impact for dentists may be that for those who work in areas with a high proportion of Muslim patients they will experience a reduction in the use of dental services during the fasting month of Ramadan (Darwish, 2005). This is because dental treatment may result in breaking the fast as water may be swallowed during treatment.

Adult groups prone to poor oral health

PHE have compiled a report on Inequalities in oral health in England. Overall, the available evidence suggests high levels of need among our vulnerable populations.

Substance misuse

Many drugs can cause a craving for sugar, such as sweets and fizzy drinks, which can cause tooth decay.

Drugs such as Methamphetamine and Heroin can also cause you to have a dry mouth. Because there is a reduced saliva flow in the mouth, this can also lead to tooth decay and gum disease.

Some drugs, such as Ecstasy and Cocaine can lead to jaw-clenching and tooth grinding. This can result in cracked or broken teeth, as well as headaches and jaw pain.

Alcoholic drinks such as white wine, beer and cider can be very acidic. This will cause erosion of the enamel on your teeth, possibly leading to pain and sensitivity. Unmet alcohol need in BwD is 83%[3]. Mouth cancer is also at increased risk by some of the above behaviours, and dentists now routinely screen their patients more so if they admit to the above, to detect mouth cancer early.

The Homeless

Homeless people tend to experience very poor health[4]. Sex workers in the Borough are also generally homeless. There are high incidences of physical illness, mental-health problems and substance misuse among the homeless population (including sex workers). These forms of ill health often combine with each other, and are both causes and consequences of homelessness.

Research shows high levels of oral and dental disease among homeless people, both in absolute terms and relative to the rest of the population. This is attributable to the following risk factors:

- Chaotic lifestyle, with no established routines of eating and oral hygiene
- Low priority given to healthy eating and oral hygiene
- Acceptance of poor dental health and poor dental appearance as the norm
- Limited access to hygiene facilities
- Low disposable income
- Lack of awareness of diet and oral hygiene issues
- Mental-health problems
- Substance misuse

The main clinical conditions encountered among homeless people are:

- caries (decay), particularly around the necks of teeth
- deep periodontal (gum) disease
- trauma (damage due to accidents or violence)
- a need for dentures
- broken or ill-fitting dentures
- soft tissue conditions - mostly infections but also cancerous, or potentially precancerous, lesions

For this particular service group, a more flexible approach is required especially in regards to any dental appointments. Appointments with consequences of no attendance (such as being removed from the service or an 'opt-in' system) act as a deterrent for accessing future treatment, as does perceived stigma and stereotyping from professionals/services. Frequently there is non-attendance from individuals for a variety of reasons e.g. the service user did not have the means

[3] National Drug Treatment Monitoring System

[4] 'The dental health of homeless people' – British Dental Association

to attend the appointment be this due to lack of transport, the cost of transport, because the distance is too far to the clinic or because the service user forgot about the appointment because of their chaotic lifestyle.

When discussing their oral hygiene, the homeless population also mention a lack of self-confidence and self-esteem. This often leads people to believe they are not 'worthy' of treatment and so they feel they have no choice but to accept this.

PHE have published a quick guide to a healthy mouth in adults.

People with Learning Disabilities

PHE identified several individual level barriers for people with disabilities in their report 'Inequalities in Oral Health' these being:

INDIVIDUAL BARRIERS

- Inability to tolerate treatment
- Lack of knowledge of accessing oral healthcare services
- Lack of social support

ORGANISATIONAL BARRIERS

- Difficulties in finding a dentist willing to provide treatment
- Shortage of dentists with adequate knowledge, training and confidence in caring for people with disabilities
- Lack of perceived need for training
- Lack of awareness of legal responsibilities as service providers towards overcoming barriers
- Communication barriers
- Poor patient management skills and perceived negative attitudes of dental staff
- Dental professionals perceive the additional time and effort required to treat patients is not fairly compensated by the remuneration system
- Lack of availability of domiciliary equipment
- Lack of information on oral health and oral healthcare services in the appropriate format
- Physical barriers to accessing dental services such as finding suitable transport along with the lack of availability of accessible waiting areas and toilet facilities
- Oral health knowledge and oral health beliefs of carers and their expectations of dentists
- Oral health perceived as a low priority among other health problems
- Lack of continuity of care and a lack of collaboration between and within

These lead people with disabilities to experience inequalities accessing services, experiencing caries and tooth loss and trauma induced dental injury.

Recommendations to improve the oral health of vulnerable adults across Blackburn with Darwen Borough Council

Recommendation 9: Purchase toothbrushes and toothpaste for our commissioned services to deliver to clients in houses of multiple occupancy (hostels) and request an evaluation of this intervention from the provider each year.

9a: NHSE to link with substance misuse services and pharmacies to distribute toothpaste and tooth brushes to certain service users on prescription.

Recommendation 10: All services working with adults with substance misuse problems, homeless and learning disabilities access oral health e-learning every year (requires a free Health Education England account). Targeted face to face training will be commissioned and delivered to some key adult social care staff.

Part 3 – Age Well

Older people with good oral health can eat and drink properly and actively take part in life. This means that they can often stay independent for longer and can recover from episodes of frailty more quickly. Older people living in care homes are however more likely to have experienced tooth decay and the majority of residents with one or more natural teeth will have untreated tooth decay[5].

Poor oral health can cause pain and discomfort and can impact on a person's quality of life by affecting their behaviour and self-confidence as well as their ability to smile, communicate, eat and swallow. Poor oral health is also linked with pneumonia, diabetes, coronary heart disease, strokes and peripheral vascular disease. Also some prescription medicine can cause mouth problems especially when taken in combination, such as mouth thrush and dry mouth, affecting the ability to swallow – which in its worst case scenario, can lead to malnourishment.

Effective daily mouth care can maintain and/or improve oral health in older people, as such, all care providers have an essential role in assessment, care planning and ensuring good daily mouth care.

The Care Quality Commission (CQC) 2019[6] report indicated that too many people living in care homes are not being supported to maintain and improve their oral health.

Further, every residents / client's hydration and nutrition should be reviewed regularly and included in their care plan. The care home should have a nutritional screening policy in place with one staff member taking responsibility for this policy within the home. Staff employed by social care providers should undertake clinical training and professional development, which is critical in promoting good nutrition for older people. Further, every care home should have an oral health policy in place with one staff member taking responsibility for this policy within the home. This should be clearly aligned to NICE guidance 48 Oral Health for adults in care homes.

PHE has a toolkit for care homes e-learning is available free for all staff.

Recommendations to improve the oral health of the elderly:

The Framework for Enhanced Health in Care Homes, Version 2 March 2020 recommends the following for older adults:

Recommendation 11: Every person's oral health should be assessed as part of the holistic assessment of needs and personalised care and support planning process in care homes / domiciliary care.

[5] Public Health England, (2015) What is Known About the Oral Health of Older People in England and Wales

[6] CQC (2019) Smiling Matters: oral healthcare in care homes https://www.cqc.org.uk/publications/major-report/smiling-matters-oral-health-care-care-homes

Recommendation 12: Care homes should have an oral health policy in place with one staff member taking responsibility for this policy within the home. This should be clearly aligned to NICE guidance 48 Oral Health for Adults in Care Homes.

Recommendation 13: Every person's oral health should be enquired after and/or observed regularly by care home staff as part of their usual hygiene routine, and they should have access to routine dental checks and specialist dental professionals as appropriate. Local systems should work collaboratively to provide access to appropriate clinical dental services for people living in care homes.

Recommendation 14: Staff employed by care home providers should undertake training in oral healthcare to support delivery of oral health assessments and daily mouth care for individuals, and maintain this knowledge and skill through ongoing professional development.

Recommendation 15: Adult Social Care to co-ordinate oral health e-learning for **all** staff working in care homes or who support our vulnerable elderly residents who live in their own homes. This will take place on induction and as annual refresher training. The oral health champion identified in recommendation 12 above will receive more in depth face to face annual training from the commissioned provider (see Start Well recommendation 2b).

Governance

The five year Blackburn with Darwen oral health improvement partnership strategy will be monitored by the oral health improvement strategy group which is a multi-agency / partnership group established in April 2021. Its main purpose is to determine how to tackle the causes of poor oral health and improve, in the long term, oral health outcomes across the life course.

Membership includes PHE, NHS England, Health Watch BwD, several community voluntary and faith sector organisations representing our South Asian heritage communities and vulnerable adults, dental practices, early years' settings and the council's elected members for Children, Young People & Education, Adults Social Care and Public Health & Wellbeing.

The group meet quarterly and is chaired by the Public Health team's lead on oral health. Actions are minuted and reported on at subsequent meetings until completed. Reporting arrangements will be via the Public Health & Wellbeing senior policy team (led by the elected member for Public Health & Wellbeing).

The Chair will also feed back to the Children's Partnership Board, the Eat Well Move More Shape Up group (including the Food Resilience Alliance group), Live Well, Age Well and the Lancashire & South Cumbria oral health improvement group led by PHE.

Acknowledgements:

The following council departments and external organisations have contributed to the development of this report through feedback and consultation, for which the Council extends its gratitude:

- Adults & Prevention Senior Policy Team (Sep 2021) - presentation of findings and recommendations
- BwD Food Resilience Alliance group (Sep 2020) - presentation of findings and recommendations
- Care Network (Aug 2021) – feedback on recommendations
- Change Grow Live / Inspire BwD (June 2021) - feedback on recommendations
- Children & Education Senior Policy Team (Feb 2021) - presentation of findings and recommendations
- Children's Partnership Board (July 2021) - presentation of findings and recommendations
- East Lancs & BwD CCG, Pennine Lancashire Children and Young Peoples Transformation Programme, Priority scoping workshop, Oral Health (July 2021) - presentation of findings and recommendations
- Eat Well Move More Shape Up group (Sep 2020) – presentation of findings and recommendations
- Gypsy Traveller Liaison Officer (June 2021) - feedback on strategy and recommendations
- Healthwatch public consultation (July 2021) - feedback on recommendations
- IMO (Apr 2021) – feedback on strategy and recommendations
- Lancashire & South Cumbria NHS Foundation Trust (June 2021) - feedback on strategy and recommendations
- One Voice (Apr 2021) – feedback on strategy and recommendations
- Parents in Partnership (July 2021) - feedback on strategy and recommendations
- Public Health & Wellbeing Senior Policy Team (Feb 2021) - presentation of findings and recommendations

Appendices:

Appendix 1: PHE recommendations

Commissioning better oral health for children and young people

Table 3.3. Summary of the oral health improvement programme's overall recommendations

Nature of intervention	Intervention classification	Target population	Strength of evaluation and research evidence	Impact on inequalities	Cost/resource considerations	Implementation issues	Overall recommendation
SUPPORTIVE ENVIRONMENTS							
Fluoridation of public water supplies	Upstream	Preschool, school children, young people (whole population)	Strong evidence of effectiveness	Encouraging/ uncertain	Good/uncertain	Deliverable	Recommended
Provision of fluoridated milk in school settings	Midstream/ downstream	Preschool, school children	Inconclusive	Uncertain	Uncertain	Uncertain/ major challenge	Limited value
COMMUNITY ACTION							
Targeted peer (lay) support groups/peer oral health workers	Midstream	Preschool, children, young people	Sufficient evidence of effectiveness	Encouraging	Good	Deliverable/ uncertain	Recommended
School or community food co-operatives	Midstream	Preschool, school children, young people	Weak evidence of effectiveness	Encouraging	Good	Deliverable/ uncertain	Emerging
HEALTHY PUBLIC POLICY							
Influencing local and national government policies	Upstream	Preschool, school children, young people	Some evidence of effectiveness	Encouraging/ uncertain	Good	Deliverable/ uncertain	Recommended
Fiscal policies to promote oral health	Upstream	Preschool, school children, young people	Some evidence of effectiveness	Uncertain	Good	Deliverable/ uncertain	Emerging
Infant feeding policies to promote breastfeeding and appropriate complementary feeding practices	Midstream/ upstream	Preschool	No evidence of effectiveness	Encouraging/ uncertain	Good	Deliverable	Emerging

Table 3.3. Summary of the oral health improvement programme's overall recommendations (continued)

Nature of intervention	Intervention classification	Target population	Strength of evaluation and research evidence	Impact on inequalities	Cost/resource considerations	Implementation issues	Overall recommendation
COMMUNITY-BASED PREVENTIVE SERVICES							
Targeted community-based fluoride varnish programmes	Downstream	Preschool, school children	Strong evidence of effectiveness	Encouraging/ uncertain	Uncertain/costly	Deliverable/ uncertain	Recommended
Targeted provision of toothbrushes and tooth paste (ie. postal or through health visitors)	Downstream	Preschool, school children	Some evidence of effectiveness	Encouraging	Good use of resources	Deliverable	Recommended
Targeted community-based fissure sealant programmes	Downstream	Preschool, school children	Sufficient evidence of effectiveness	Uncertain	Costly	Uncertain/major challenges	Limited value
Targeted community-based fluoride mouth rinse programmes	Downstream	School children	Sufficient evidence of effectiveness	Uncertain	Uncertain	Deliverable/ uncertain	Limited value
Facilitating access to dental services	Downstream	Preschool, school children	Weak/inconclusive	Uncertain / unlikely	Uncertain	Uncertain/major challenges	Limited value
Using mouth guards in contact sports	Midstream	School children	Some evidence of effectiveness	Uncertain	Uncertain	Uncertain	Limited value
SUPPORTIVE ENVIRONMENTS							
Supervised tooth brushing in targeted childhood settings	Midstream	Preschool, school children	Strong/sufficient evidence of effectiveness	Encouraging/ uncertain	Good/uncertain	Deliverable/ uncertain	Recommended
Healthy food and drink policies in childhood settings	Midstream/ Upstream	Preschool, school children, young people	Some evidence of effectiveness	Encouraging	Good	Deliverable	Recommended

Appendix 2: NICE guidelines - Oral health: local authorities and partners health guideline

- Recommendation 1 Ensure oral health is a key health and wellbeing priority
- Recommendation 2 Carry out an oral health needs assessment
- Recommendation 3 Use a range of data sources to inform the oral health needs assessment
- Recommendation 4 Develop an oral health strategy
- Recommendation 5 Ensure public service environments promote oral health
- Recommendation 6 Include information and advice on oral health in all local health and wellbeing policies
- Recommendation 7 Ensure frontline health and social care staff can give advice on the importance of oral health
- Recommendation 8 Incorporate oral health promotion in existing services for all children, young people and adults at high risk of poor oral health
- Recommendation 9 Commission training for health and social care staff working with children, young people and adults at high risk of poor oral health
- Recommendation 10 Promote oral health in the workplace
- Recommendation 11 Commission tailored oral health promotion services for adults at high risk of poor oral health
- Recommendation 12 Include oral health promotion in specifications for all early years services
- Recommendation 13 Ensure all early years services provide oral health information and advice
- Recommendation 14 Ensure early years services provide additional tailored information and advice for groups at high risk of poor oral health
- Recommendation 15 Consider supervised tooth brushing schemes for nurseries in areas where children are at high risk of poor oral health
- Recommendation 16 Consider fluoride varnish programmes for nurseries in areas where children are at high risk of poor oral health
- Recommendation 17 Raise awareness of the importance of oral health, as part of a 'whole-school' approach in all primary schools
- Recommendation 18 Introduce specific schemes to improve and protect oral health in primary schools in areas where children are at high risk of poor oral health
- Recommendation 19 Consider supervised tooth brushing schemes for primary schools in areas where children are at high risk of poor oral health
- Recommendation 20 Consider fluoride varnish programmes for primary schools in areas where children are at high risk of poor oral health
- Recommendation 21 Promote a 'whole school' approach to oral health in all secondary schools
- Finding more information and resources

Appendix 3

Pennine Integrated Care partnership's dental caries data pack

PL BILT 2021 Where To Look Packs Dent

References

Anja Heilmann, G. T. (2015). *A Life Course Perspective on Health Trajectories and Transitions; Chapter 3, Oral Health Over the Life Course.* London: Springer.

Croucher, R. a. (2006). *Improving access to Dental care in East London's ethnic minority groups: community based, qualitative study.* Community Dental Health, 23:95-100.

Darwish, S. (2005). *The Management of the Muslim Dental Patient.* British Dental Journal.

Mullen, K. C. (2007). *Exploring issues related to attitudes towards dental care among second-generation ethnic groups.* Diversity in Health and Social Care, 4, 2, pp.91-99.

Newton J T, T. N. (2001). *Barriers to the use of dental services by individuals from minority ethniccommunities living in the United Kingdom: findings from focus groups.* Primary Dental Care, 8(4):157-61.

NICE. (2008). *National Institute for Health and Care Excellence. Maternal and child nutrition. NICE public health guidance 1.* NICE.

PHE. (2019). *The relationship between dental caries and BMI.* London: PHE.

Scambler, S. K. (2010). *Insights into the oral health beliefs and practices of mothers from a north London Orthodox Jewish community.* BMC Oral Health, 10:14. doi: 10.1186/1472-6831-10-14.

Thalassis, N. (2009). *Commissioning World Class Dentistry in Kensington & Chelsea and Westminster: A race equality impact assessment of how the current approach to the provision of dental services is affecting BME communities.* BME Health Forum.

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Oral Health Improvement action plan

VISION: For all Blackburn with Darwen Borough Council's residents to achieve a standard of oral health that enables them to feel physically, mentally and socially well and socially engaged. This will be achieved through improving overall oral health and reducing oral health inequalities with a particular focus on those children and young people who experience the worst oral health

Recommendation 1: Influencing local (and national) government policies).				
Key Actions	**Key Deliverables**	**Progress Indicators**	**Organisation/ Lead**	**Timescale**
1. Make oral health a core component of a joint strategic needs assessment and the health and wellbeing strategy. Review it as part of the yearly update				
1a. Discuss with UCLan, our dental epidemiology provider, the cost of a full census survey of our five year olds (n = 2200, 2018 MYE) to gather data for a JSNA to support decision making for the H&WBB	CV agreed for one year (COVID dependent)	CV signed	GK / CAPS / Jane Pearson (UCLan)	April 2021
	Opt out consent with parents agreed	Letters sent and opted out children not checked	UCLan	April 2021
	Full survey completed for one year	Data received	UCLan	Jul 2021
1b OHI strategy group established that has responsibility for an oral health needs assessment that can report back to the H&WBB	Invite key partners that include: ○ The PHE consultant in dental public health ○ A BwD public health representative ○ The NHS England commissioner of local dental services ○ A representative from a local professional dental network	Group established and first meeting date agreed	GK	April 2021

	○ A representative from the local dental committee ○ Representatives from children and adult social care services ○ A local Healthwatch representative ○ The Portfolio Holder for Children and Young People and the Portfolio Holder for Public Health & Wellbeing ○ Representatives from relevant community groups.			
	Key actions forwarded to H&WBB		GK	Aug 2021
	Oral health needs assessment completed including data on BAME and actions for South Asian community (currently based on Pennine data showing a significantly higher rate of decay in Asian / British Asian children than for white children (PHE June 2020))		GK	Sep 2021
1c. The Council's 'Eat Well, Move More, Shape Up (EWMMSU) strategy is to include oral / dental health improvement	This cross body group can influence and monitor all aspects of a healthy diet incorporating healthy weight, healthy teeth and being active and in shape	Monthly meeting updates	GK	Ongoing
1d. Lobby for a water fluoridation scheme	• Provide the evidence base to the elected member for Public Health & Wellbeing for water fluoridation	• Labour party group meeting presentation • Exec Board decision • NW network feedback • Research on anti-fluoridation	GK	July 2021

	• Liaise with colleagues in the Greater Manchester, Lancs & South Cumbria and CHAMPS areas for their support • Determine the anti-fluoridation argument			

Recommendation 2: Make available oral health training for the wider professional workforce including foster carers, early years' teaching staff and our children's centre staff as well as staff linked to our vulnerable adults such as care home staff, care workers, substance misuse workers and those working with the homeless				
Key Actions	**Key Deliverables**	**Progress Indicators**	**Organisation/ Lead**	**Timescale**
e-learning completed by all staff as per above	All relevant staff create an account and undertake the NHS Health Education England's oral health training for the wider professional workforce, to ensure they convey healthy oral health messages appropriately to the community / children in care when they visit vulnerable families / LAC	Monitor of HEE completion rates across BwD organisations	GK / CSC / CCs / LSCFT / Adult social care / CGL / Inspire	July 2021
Source a provider to deliver face to face / virtual training	• Source a training provider <£5k • TP co-ordinates sessions across healthy settings / early years' settings	• Training provider in post • 90% of staff supporting young children achieving accredited training / CPD in OHI	GK / CAPS	Sep 2021 Oct 2021
Evaluate training	Follow up al staff for evaluation	As many staff contacted and asked for their feedback	GK / CSC / CC / training provider	Dec 2021

Recommendation 3: Children's Centres recruit parent champions as part of the Food Active 'Kind to Teeth' strategy				
Key Actions	**Key Deliverables**	**Progress Indicators**	**Organisation/ Lead**	**Timescale**
Each Children's Centre (CC) recruits at least one parent champion (PC) to attend training with Food Active	At least 8 PCs recruited and trained	Follow up with PCs to determine their confidence to peer support with oral health messages Complete oral health training	PCs / Food Active / CCs	May 2021
Peer support network up and running using social media	Oral health improvement messages shared	At least 8 networks created and OHI awareness increases	CCs / Food Active	June 2021
Evaluation	Focus groups / surveys sent to all networks	Measure of before and after knowledge improved	Food Active	Nov 2021

Recommendation 4: Approval for the purchase of toothpaste, toothbrushes and sippy cups our young children at their 6-8 month old check and for our children in care, our care leavers and substance misuse clients resident in homes of multiple occupation				
Key Actions	**Key Deliverables**	**Progress Indicators**	**Organisation/ Lead**	**Timescale**
Based on stock, purchase another years' supply to cover each new birth the previous year (=n)	Stock ordered and delivered to CCs	Monitor at LSCFT quarterly review meetings	PH / LSCFT	Each April

Purchase a years' supply for all LAC and CGL clients	Stock ordered and delivered to children's social care (CSC)	Feedback from CSC / foster carers / CGL (Inspire)	PH / CSC	Mar 2021

Recommendation 5: Source a training provider to support the delivery of a targeted supervised brushing scheme in al CCs, Reception classes and nurseries				
Key Actions	**Key Deliverables**	**Progress Indicators**	**Organisation/ Lead**	**Timescale**
Identify the targeted primary schools and nurseries	Schools / nurseries with children likely to suffer more decay identified	School / nursery list available for provider	GK / PHE	Sep 2021
Determine a provider (service spec to also include on-going support; new toothbrushes, cleaning the stands; infection control etc.)	Provider sourced and cost agreed	Contract in place (no funding available from NHSE)	GK / CAPS	Sep 2021
Schools, CCs and nurseries contacted and staff members identified for training	Staff attend training with provider	Number of staff trained and ready to undertake supervised brushing	GK / provider / nurseries / CCs & schools	Oct 2021
Brush Busses purchased for 112 schools, nurseries and children's centres (7000 pupils)	Brush busses forwarded to schools, CCs and nurseries	Feedback from all they have received their busses / brushes and have hygienic storage facilities	GK / schools	Oct 2021

Reception supervised brushing starts	Opt out letters sent	1. Opt out letters delivered and received from parents 2. Supervised brushing starts	Provider / Schools /	Nov 2021

Recommendation 6: Work with NHSE to deliver a targeted fluoride varnish scheme for 2-5 yr. olds (this is a free service from NHSE)				
Key Actions	**Key Deliverables**	**Progress Indicators**	**Organisation/ Lead**	**Timescale**
Discuss with NHSE a targeted delivery from our children's centres	• Liaise with CCs to determine likely numbers of children needing fluoride varnish • £cost agreed across x 8 CCs and BwD (pro rata) with provider if a cost is required for dental provider	• Numbers estimated • Cost agreed	PH /PHE / NHSE / CCs / provider	Sep 2021
Children's centres contacted for a schedule	CCs agree with provider a schedule across 8 x CCs	Schedule in place CC staff aware of schedule Social media and in house advertising of sessions	Provider / CCs	Oct 2021
Families contacted for opt in consent	• Opt in letters sent to parents (CC to identify) • Opted in children attend sessions	Aim for 70% return of opt in letters 70% of children having fluoride varnish applied	Provider / CCs / GK	Nov 2021

Recommendation 7: Reignite a healthy food accreditation scheme across our early years and children's centres – called TBC				
Key Actions	**Key Deliverables**	**Progress Indicators**	**Organisation/ Lead**	**Timescale**
Eat Well group discuss a Blackburn Smiles scheme – (to support the Sugar Smart City) and a project co-ordinator role	Blackburn Smiles approved Co-ordinator role advertised • Sticker books purchased • Activities agreed to run across our 8 x CCs and early years' settings • BwD social media utilised • Link with dental practices for social media promotions	• Number of CCs, early years' and LAC settings identified and on board • Co-ordinator role in place • Supplier identified and supplies purchased for our 8 x CCs / early years' settings and LAC	Eat Well strategy group	Sep 2021
Blackburn Smiles live	All early years' settings signed up and monitored by Blackburn Smiles co-ordinator	Register of status and recommendations for each setting	Blackburn Smiles co-ordinator	Oct 2021

Recommendation 8: Work with the BwD Age Well Partnership to develop a set of recommendations to support good oral health in older adults				
Key Actions	**Key Deliverables**	**Progress Indicators**	**Organisation/ Lead**	**Timescale**
Consult with partners, stakeholders and older adults in developing recommendations and actions.			BwD Age Well Partnership	

Determine what issues commonly affect older adults			BwD Age Well Partnership	
Collate any local intelligence/evidence to support issues affecting older adults			BwD Age Well Partnership	

EXECUTIVE BOARD DECISION

REPORT OF:	Executive Member for Public Health and Wellbeing
LEAD OFFICERS:	Director of Public Health & Wellbeing
DATE:	Thursday, 14 October 2021

PORTFOLIO(S) AFFECTED:	Public Health and Wellbeing
WARD/S AFFECTED:	(All Wards);
KEY DECISION:	**Y**

SUBJECT:

EB Procurement process for Substance Misuse Services

1. EXECUTIVE SUMMARY

To note to the provision of substance misuse services across Blackburn with Darwen will be retendered due to the current contract coming to an end. The substance misuse service (including alcohol) incorporates a range of service contracts, covering both young people's services through to adulthood and criminal justice. There is a need to ensure that the service is dynamic and innovative to respond to emerging challenges and trends, whilst becoming more efficient, value for money with improved quality and outcomes.

The new commissioning model will incorporate a more effective Recovery Orientated Integrated System (ROIS). This model goes beyond the clinical and medical model to incorporate employment, training, education and support within family life, and takes a life course approach.

The costs of alcohol and drug misuse to society are significant. Estimates show that the social and economic costs of alcohol related harm amount to £21.5bn, while that of illicit drug use costs £10.7bn. These include costs associated with deaths, NHS, crime and, in the case of alcohol, lost productivity. Alcohol treatment reflects a return on investment of £3 for every pound invested. Drug treatment reflects a return on investment of £4 for every pound invested.
This is a statutory service that must be provided as a condition of the Public Health Ring Fenced Grant Allocation under the Health and Social Care Act (2012) since 1st April 2013.

2. RECOMMENDATIONS

That the Executive Board:

1. To note the commencement of a tendering and procurement activity to offer this service to the wider market, with revised contractual and commissioning arrangements to be in place from 1st April 2022. This contract will encompass both adults and young peoples' services and provide advice, prevention, support and interventions across the life course. The contract will be procured for 3 years with an option to extend for up to 2 year's subject to satisfactory delivery which will be monitored via robust contract review processes.

2. Approves the strategy for the service as set out in this report.

3. BACKGROUND

Since 1st April 2013 upper tier and or unitary Local Authorities (LA's) have had responsibility under the Health and Social Care Act (2012) for improving the health of their local population and for public health services including those aimed at reducing drug and alcohol misuse.
Each local authority has responsibilities under the Public Health Grant to commission community based substance misuse services. Blackburn with Darwen currently commission the following service provision for substance misuse locally:

- Adult substance misuse services including criminal justice provision from CGL, operating under the brand 'Inspire'.
- Young Peoples service from CGL under the branding Go2
- Inpatient detox and rehabilitation services from a range of providers (Out of scope for this tender).

Adult Community Substance (Drug and alcohol) Misuse Services:

- The underpinning service specifications are substantial documents outlining the requirements across a range of interventions under three broad areas, Prevention and Wellbeing, Treatment and Recovery, Development and Support including:
    - Training
    - Information and Brief Advice
    - Assessment
    - Harm reduction
    - Case management
    - Psycho-social interventions
    - Clinical interventions including prescribing
    - Criminal Justice interventions
    - Families
    - Recovery Support

Young Peoples Substance Misuse Service:

- BwD commissions service for young people up to the age 21 across their footprint.
- The underpinning service specifications is a substantial document outlining the requirements across a range of interventions under three broad areas, links to CYP mainstream (0-19) services, Treatment and Life Skills, Life Transitions and Support including:
    - Training
    - Information and Brief Advice
    - Assessment
    - Harm reduction
    - Case management
    - Psycho-social interventions
    - Clinical interventions including prescribing
    - Families
    - Life transition Support

Alcohol and drug misuse impacts on a wide range of cross cutting priorities across health, wellbeing, social care, prosperity and attainment and criminal justice. There is extensive research and evidence in terms of the economic and social benefits and return on investment of funding for drug and alcohol service interventions. Please see a summary below of the rationale to retain investment into these commissioned services:

- Acquisitive crime, violent crime and domestic abuse are particularly associated with drug and alcohol misuse. Analysis of Ministry of Justice and drug & alcohol treatment data has shown that drug and alcohol specialist treatment results in significant reductions in offending behaviour in dependent drug and alcohol users. Drug/alcohol treatment results in

a 44% reduction in the number of individuals re-offending in the 2 years after starting treatment for dependency, with a 33% decrease in the number of offences committed.

- Alcohol misuse has been estimated to cost £7bn in lost productivity nationally. Most individuals seeking drug or alcohol treatment are unemployed and treatment/recovery services actively seek to provide opportunities and support to individuals to find meaningful activities and employment. Employment and recovery are mutually reinforcing.
- Drug and alcohol problems can be both a cause and a symptom of homelessness. Significant proportions of homeless people have drug or alcohol problems. Providing support to address housing need is vital and can have a positive impact on motivation to change.
- The costs of alcohol and drug misuse to society are significant. Estimates show that the social and economic costs of alcohol related harm amount to £21.5bn, while that of illicit drug use costs £10.7bn. These include costs associated with deaths, NHS, crime and, in the case of alcohol, lost productivity.
- Drug and alcohol treatment results in savings in a number of areas, such as Crime, QALY improvements and health & social care.
- Quality-adjusted life years (QALYs) are measures of life expectancy and quality of life, fundamental in health economic evaluations and resource allocations.
- Alcohol treatment reflects a return on investment of £3 for every pound invested
- Drug treatment reflects a return on investment of £4 for every pound invested

Please see Appendix 1 with links to further evidence and details on this issue.

Substance use services across the ICS are under significant strain following the financial climate over recent years which has led to reductions in funding for both these services and wider support structures for those who use the services. This has been further enhanced by the COVID19 pandemic and the need to alter working practice in order to keep services open, adapt to changing demands (e.g. rapid support of accommodated rough sleepers, shielded populations etc.) and operate in a COVID secure manner.

The current Independent review of drugs by Professor Dame Carol Black has included national surveys of commissioners and providers of substance misuse services to ascertain the current spend and reductions, with a view to support a request to the Treasury to reinvest in the delivery of substance misuse services.

4. KEY ISSUES & RISKS

The substance misuse service provision was last reviewed in 2014/15. The current contract will expire on the 31st March 2022. A tender waiver form has been submitted in order to extend the existing arrangements until 31st March 2022, in order for a full consultation, procurement and safe transition to be managed. Whilst performance has progressed and efficiencies have been made, procurement regulation and the contract term mean that a refreshed model should be considered following a period of consultation and engagement with various stakeholders including service users and also non service users. In conjunction with strategic commissioning, appropriate and relevant processes will be adhered to. This will ensure that any risks will be identified throughout the process and improved monitoring can be explored.

The tender documentation (and subsequent contract/specifications) will incorporate details to ensure that any successful provider will adhere to our quality standards. This includes learning from recent safeguarding cases, clinical governance, national and local standards, NICE and CQC compliance.

Conversations have been undertaken to explore opportunity to further integration elements of service delivery from a CCG and a primary care perspective within the Blackburn with Darwen footprint, and also consideration of a wider delivery across the Pennine Lancashire ICP footprint. At present while the service provider is CGL for both BwD and East Lancashire, models and

specifications are slightly different in each area. The new process and exercise can be mindful of the specification requirements and contract lengths and terms in order to allow for future alignment at a time suitable for the ICP and other stakeholders such as Lancashire County Council in terms of the substance misuse provision across East Lancashire.

TUPE transfer implications will be considered as part of the process. Transfer of estate leases and other assets linked with the PHE Alcohol capital funding projects will also be considered as part of the procurement exercise.

A detailed tender project plan has been determined.

5. POLICY IMPLICATIONS

This process will be aligned to both local and national Drug and Alcohol Strategy recommendations, Dame Carol Black review recommendations, the Health and Wellbeing Strategy, local Transforming Lives strategy, local Vulnerable People Strategy, the Early Help Strategy, and will also consider implications with regards to a number of other developing strategic agendas.

The NHS long term plan and also local Pennine Lancashire prevention plans will also be considered.

6. FINANCIAL IMPLICATIONS

The currently proposed allocation of funding in relation to this tender and future contract arrangements has been kept in line with the public health budget for substance misuse services for 2020/21 equating to £2,713,107. This amount is fully contained from within the current year's allocation of the Public Health England (PHE) grant. However, PHE funding for future years remains to be confirmed. Consideration should be given to the budget setting strategy for the Council in finalising the contract financial envelope for these services.

It should also be recognised that this is the only Public Health commissioned service where the financial value is inclusive of the drug costs for clinical pharmacological treatment of service users. The budget is also inclusive of the Local Improvement Scheme (LIS) value for supervised consumption and needle exchange across the Borough and spend where needed to primary care for the delivery of these sub contracted services. Substance misuse services provide a wide range of support and treatment including training, harm reduction, clinical and psychosocial interventions across communities and residential based provision.

Consideration of PHE Universal work stream funding and the comprehensive spending review should be given in terms of the financial value that could be commissioned via this opportunity, equally delays in financial clarity makes it difficult to finalise a tender value. Recent discussions including additional Changing Futures and Probation Service funding may also need to be considered as part of this commissioning process.

7. LEGAL IMPLICATIONS

An open tender process will be followed to ensure this tender attracts providers with sufficient knowledge and expertise to enable quality delivery. The tendering process will need to comply with the Public Contracts Regulations and the Council's Contract and Procurement Procedure Rules. Contract will be in a form approved by legal officers in the Contracts and Procurement team.

8. RESOURCE IMPLICATIONS

The management and implementation of the tender will be actioned within BwD team resources including input from Legal, Finance, Integrated Strategic Commissioning and Public Health.

9. EQUALITY AND HEALTH IMPLICATIONS

Please select one of the options below.

Option 1 ☐ Equality Impact Assessment (EIA) not required – the EIA checklist has been completed.

Option 2 ☐ In determining this matter the Executive Member needs to consider the EIA associated with this item in advance of making the decision.

Option 3 ☒ In determining this matter the Executive Board Members need to consider the EIA associated with this item in advance of making the decision.

10. CONSULTATIONS

A series of consultation and engagement events are planned from September to December 2019 relating to different themes and elements of the integrated treatment system such as YP service provision, adult provision, shared care, Tier 4 interaction etc. The views of providers, key stakeholders and service users will be taken into account and their comments and feedback will influence the service design recommendations and service specification. There is a provider event planned to take place shortly before the commencement of the tender to allow the market place the opportunity to better understand the local need and the proposed process. This will also allow opportunities for them to raise significant queries via the CHEST procurement system.

11. STATEMENT OF COMPLIANCE

The recommendations are made further to advice from the Monitoring Officer and the Section 151 Officer has confirmed that they do not incur unlawful expenditure. They are also compliant with equality legislation and an equality analysis and impact assessment has been considered. The recommendations reflect the core principles of good governance set out in the Council's Code of Corporate Governance.

12. DECLARATION OF INTEREST

All Declarations of Interest of any Executive Member consulted and note of any dispensation granted by the Chief Executive will be recorded in the Summary of Decisions published on the day following the meeting.

CONTACT OFFICER:	Jodene Bibby, Lee Girvan, , jodene.bibby@blackburn.gov.uk, lee.girvan@blackburn.gov.uk
DATE:	29.09.2021
BACKGROUND PAPER:	

Public Health England

Alcohol and drugs prevention, treatment and recovery: why invest?

Public Health England

Alcohol problems are widespread

Estimates show that

10.4 million

adults drink at levels that increase their risk of health harm

Of these

595,000

may need treatment for alcohol dependence

120,000

of whom are living with children (200,000 children in these households)

The impact of harmful and dependent drinking is greatest in deprived communities

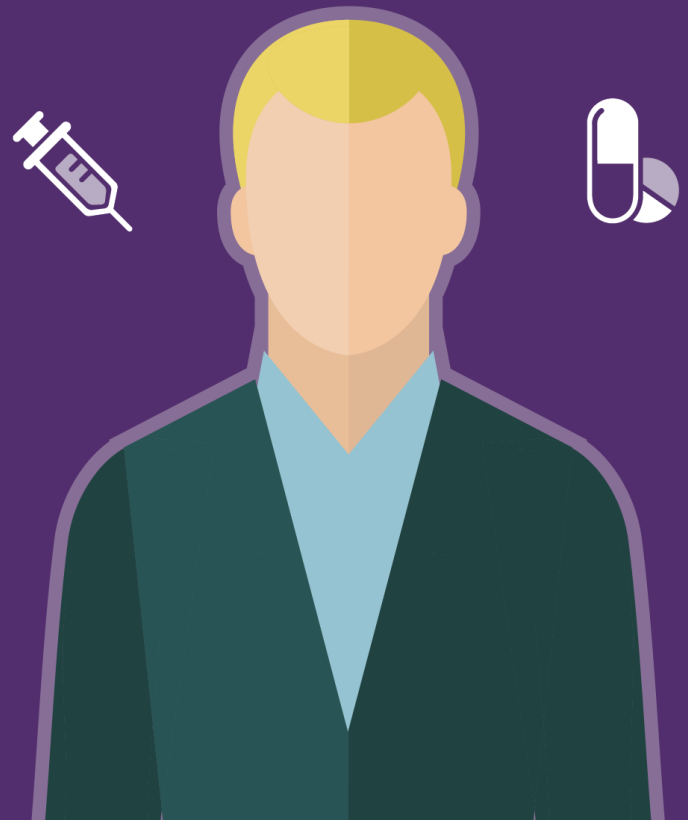
Public Health England

Drug use is widespread but dependence is concentrated

Estimates show that

2.7 million

adults took an illicit drug in the last year



Around

301,000

people in England are opiate and/or crack cocaine users

The most deprived local authorities have the highest prevalence of problematic drug users

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41%

of women and

27%

men reported problematic drug use on arrival at prison

Public Health England

The prevalence of drug and alcohol harm for families

Around **20%** of children 'in need' are affected by drug misuse

Around **18%** are affected by alcohol misuse

Parental drug or alcohol misuse features in a quarter of cases on the child protection register

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Drug misuse is involved in **38%** of serious case reviews

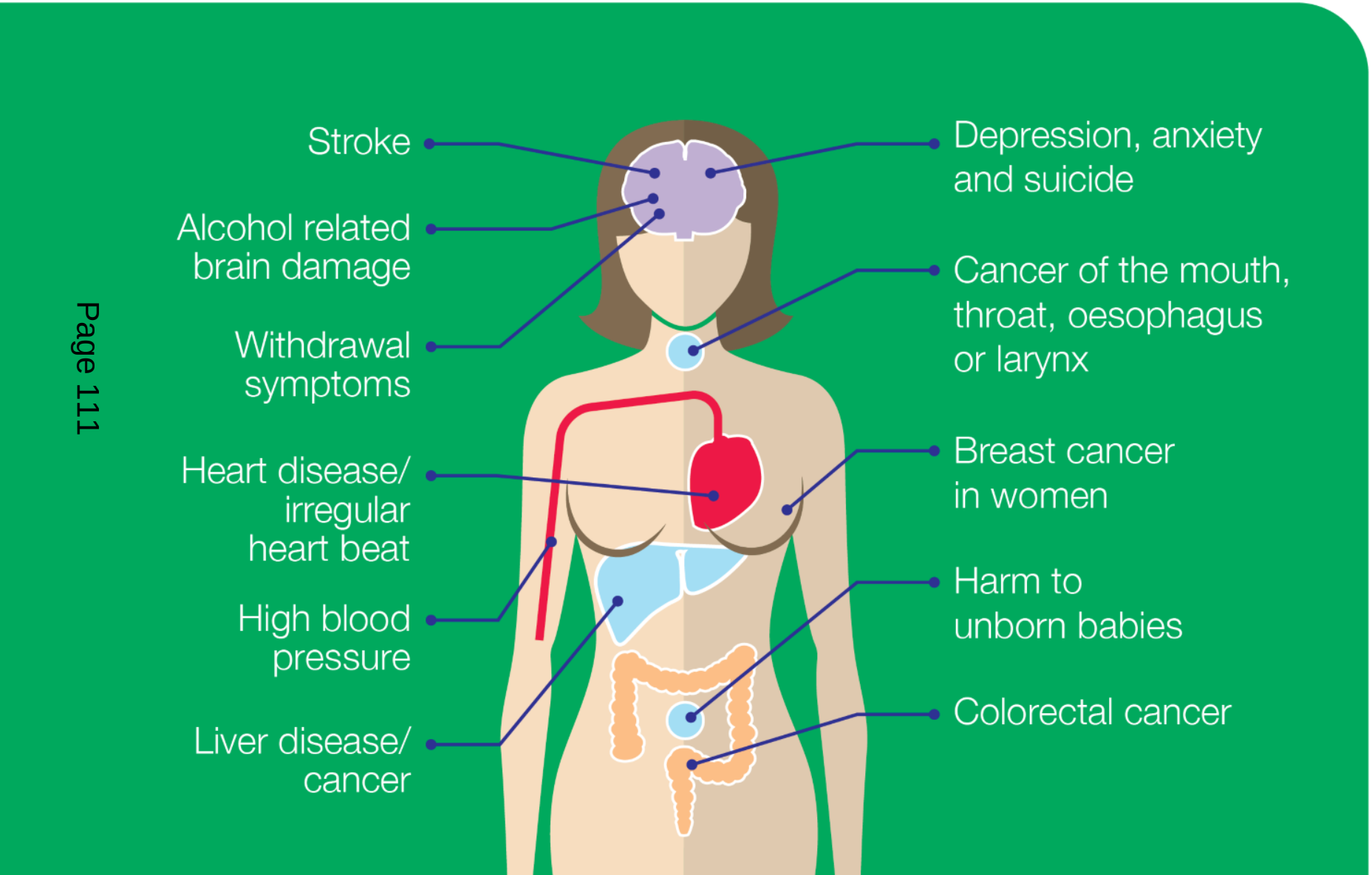
Alcohol misuse is involved in **37%**

Public Health England

The impact on health, mortality, families and communities

Public Health England

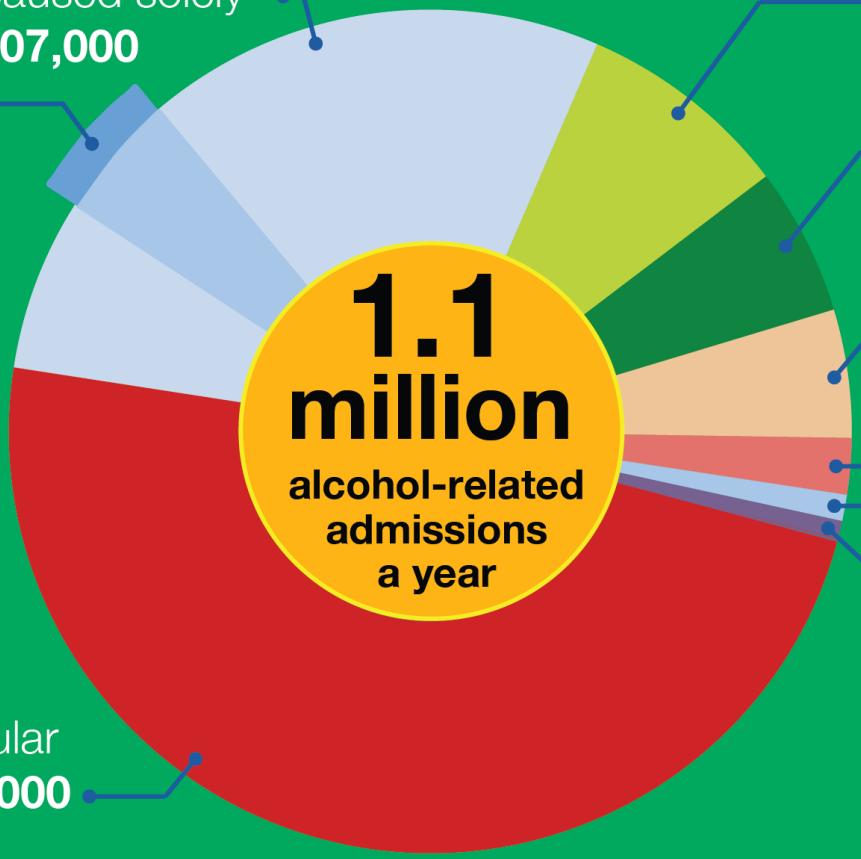
Alcohol use damages health



Public Health England

Alcohol impacts on a wide range of conditions

Proportions of alcohol-related hospital admissions by disease group



Conditions caused solely by alcohol **307,000** including **59,000** for liver disease

Cancers **92,000**

Injuries **60,000**

Epilepsy **55,500**

Digestive diseases **27,500**

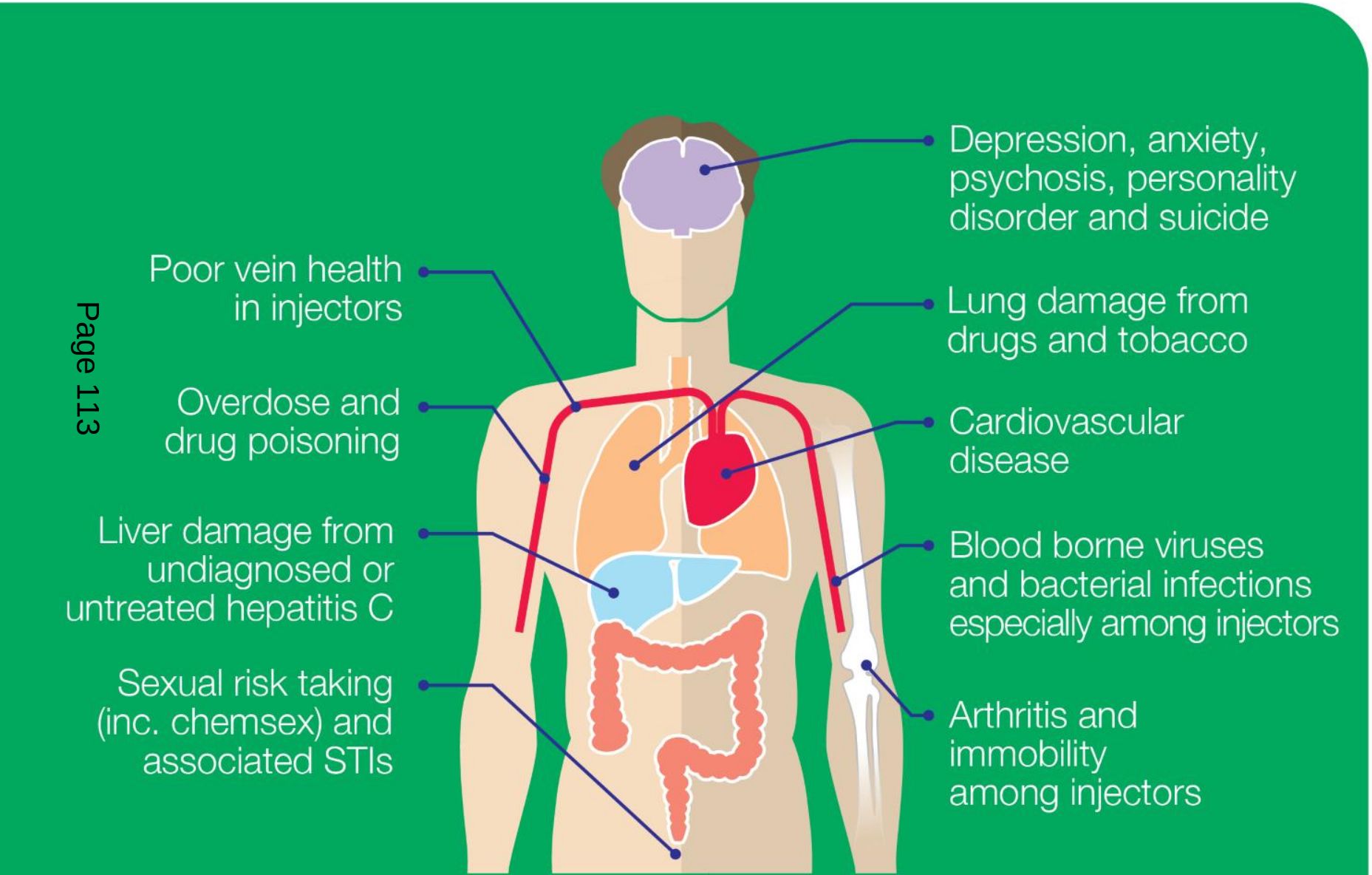
Respiratory infections **13,000**

Pregnancy & childbirth **6,500**

Cardiovascular **557,000**

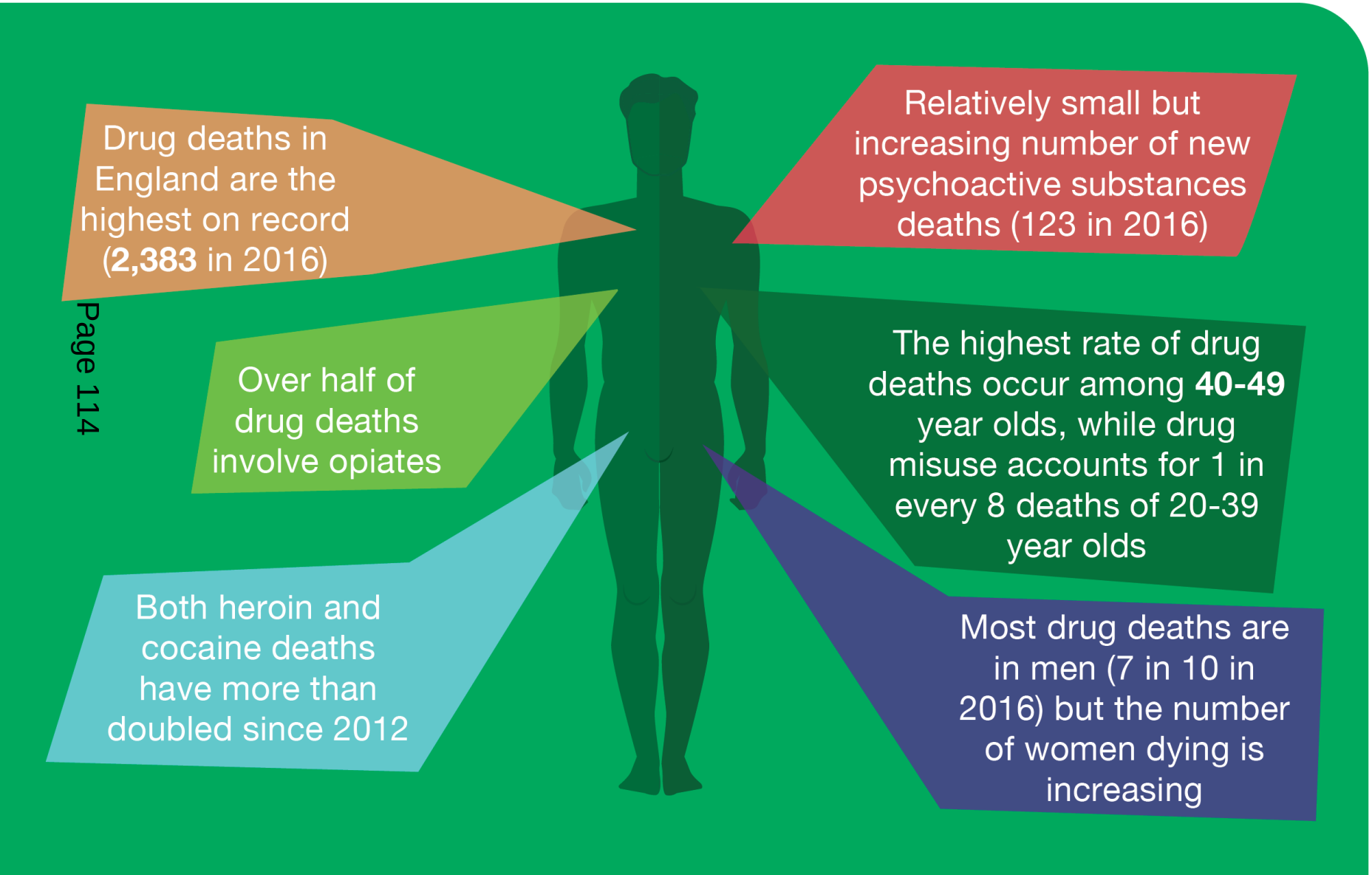
Public Health England

Drug misuse damages health



Public Health England

Drug deaths



Public Health England

Alcohol deaths

Around **24,000** people died from alcohol related causes in 2016, average age 54

Between 2004 and 2014, **45%** of all mental health patient suicides in England had a history of alcohol misuse; this proportion is increasing

Deaths from liver disease have increased **400%** since 1970

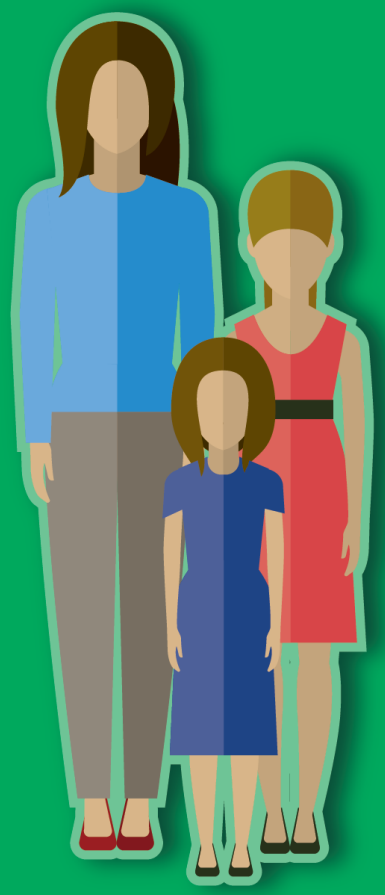
- Death rates from chronic liver disease in men is almost double that of women

More than a fifth of all deaths in young men aged between 16 and 24 years are alcohol related

Public Health England

The impact of drug and alcohol misuse on families

Parental alcohol and drug dependence significantly harms the wellbeing of children



Misuse can impact on health & wellbeing, education, risky behaviours, and result in inappropriate caring roles

Drug and alcohol misuse can be part of a complex set of co-existing health and social problems

Public Health England

Drug and alcohol misuse harms communities

Crime

Drug & alcohol treatment in England in 2016/17 resulted in 4.4m fewer crimes

- **44%** reduction in the number of dependent individuals re-offending
- **33%** decrease in the number of offences committed

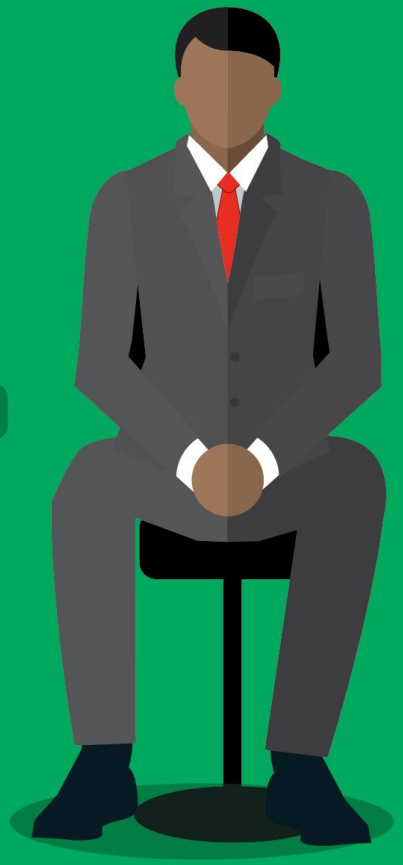
Around **45%** of acquisitive offences are committed by regular heroin/crack users

40% of victims of violence believed perpetrators to be under the influence of alcohol

48% of convicted domestic abuse perpetrators had a history of alcohol dependence; **73%** had consumed alcohol prior to the event

Public Health England

Drug and alcohol misuse and employment



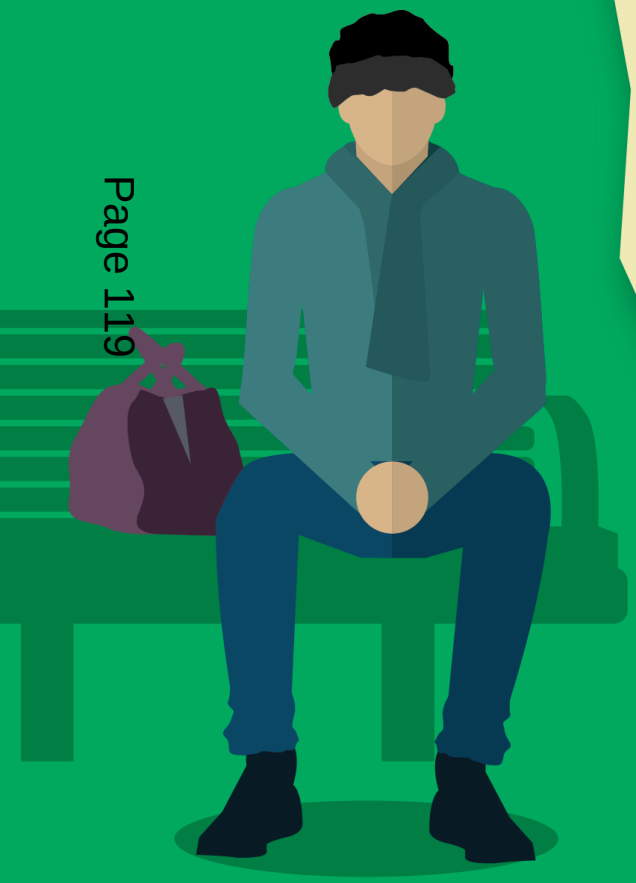
Up to **£7bn** in work productivity is lost due to alcohol misuse in the UK

72% seeking alcohol treatment and around **80%** seeking drug treatment are not in paid employment

There is a mutually-reinforcing relationship between employment and recovery

Public Health England

Drug and alcohol misuse and homelessness



In services for homeless people

- **39%** said they take drugs or are recovering from a drug problem
- **27%** have or are recovering from an alcohol problem

Alcohol and drug problems are both a cause and a symptom of homelessness. Rough sleeping, has increased by **134%** since 2010

Assistance may be needed to access and sustain appropriate housing

Access to housing can have a positive impact on motivation to change

Public Health England

The costs

Public Health England

Annual costs of drug misuse and alcohol related harm

Annual cost of illicit drug misuse in the UK is around ...

£10.7bn

Annual cost of alcohol related harm to society in England is around ...

£21.5bn

these costs include lost productivity, crime, policing, and NHS

Public Health England

The challenge

Public Health England

Delivering a multi-component approach

1 Strong leadership

2 Sharing data and analysis to inform partnership responses to local problems

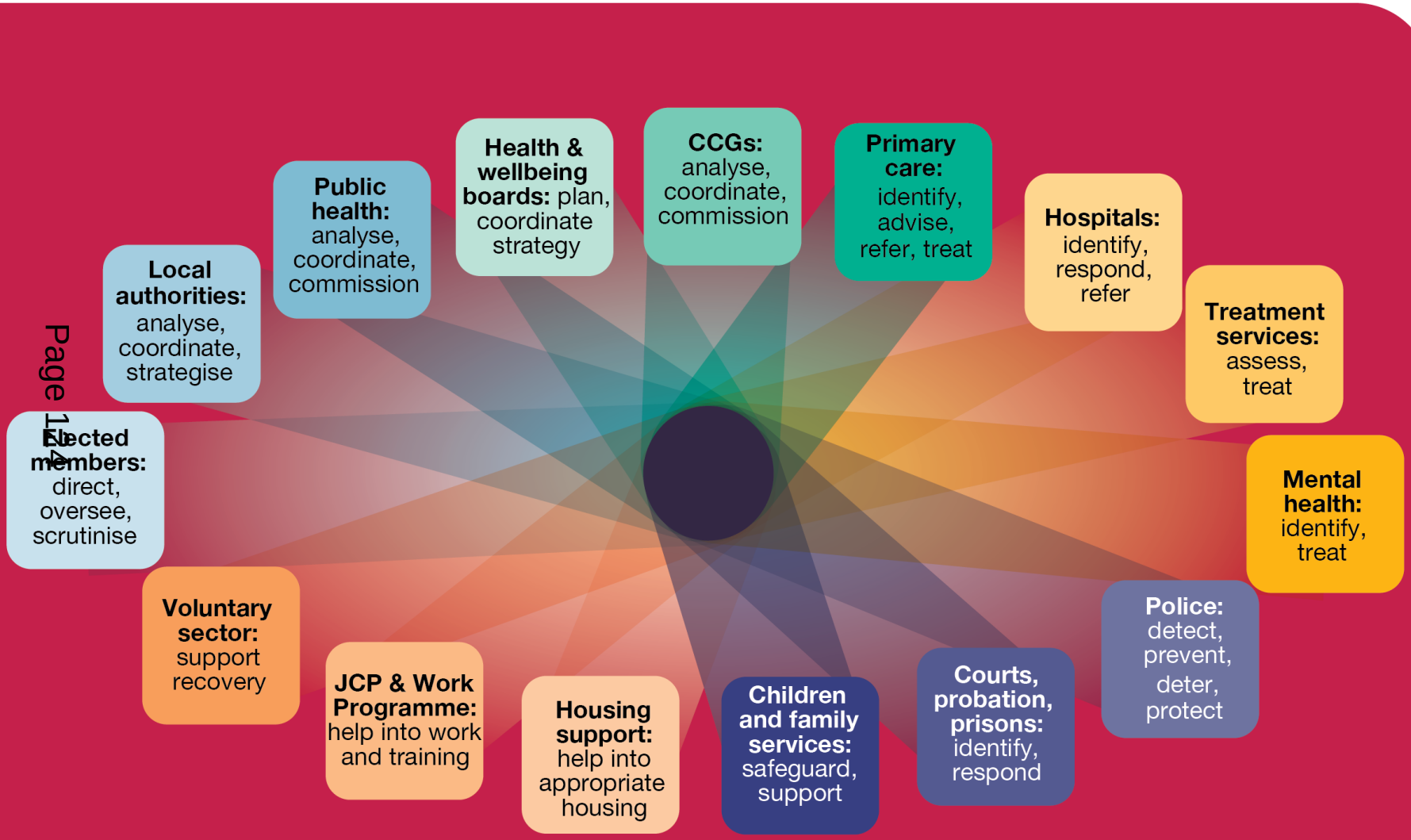
5 A competent workforce delivering evidence based treatment & recovery services

3 Population level prevention – best start in life, a broad approach to prevention and to building resilience

4 Targeted prevention interventions for those at higher risk

Public Health England

Partnership: the key to success



Public Health England

What works? Elements of a multi-component approach

Public Health England

Local population-wide prevention

Alcohol

Full use of licensing powers

Manage the accessibility and availability of alcohol

Drugs & alcohol

Data sharing to inform local partnership enforcement activity

Build resilience and confidence in young people, complemented by drug & alcohol specific resources

Public Health England

Targeted prevention – alcohol

Identification and brief advice in primary and secondary care reduces weekly drinking by **12%**

which reduces risk of alcohol related illness (by **14%**)

and absolute risk of lifetime alcohol-related death (by **20%**)

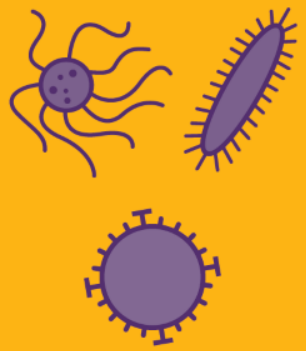
Hospital alcohol care teams can reduce overnight stays in hospital and readmissions (by **3%**) and A&E attendances (by **43%**) related to alcohol.

Public Health England

Targeted prevention and harm reduction – drugs

Needle and syringe programmes to prevent infection and spread of blood-borne viruses

Target at risk groups. eg homeless, sex workers, men who have sex with men



Advice, testing, vaccination and treatment for blood borne viruses

Prevent overdose deaths; provide take-home naloxone to reverse the effects of opioid overdose

Public Health England

Specialist treatment and recovery (alcohol & drugs)

Recovery focussed services that address housing, employment, offending and health & wellbeing

Services address dependence at different severity levels, and address changing patterns of use

Services address parenting and children's needs. Parental treatment has major benefits for the child

Support sustained recovery: develop peer support, build relationships, make use of community resources

NICE compliant, community based, inpatient and residential treatment based on assessed need

Ensure recovery plans integrate psychological with pharmacological interventions where needed

Public Health England

Interventions and outcomes for families

For the children of alcohol or drug misusing parents, treatment and joint work with children's services is protective

Safeguarding is a core component of what drug and alcohol treatment services do

Drug and alcohol treatment, children and families services, health visitors and other support services all work together

Treatment has major benefits for parents and their children. Parents lives become more stable, they can address their wider problems and get help to look after their family better

With the right support, most parents can recover from their alcohol and drug problems and become better parents

Public Health England

The benefits of investing in interventions

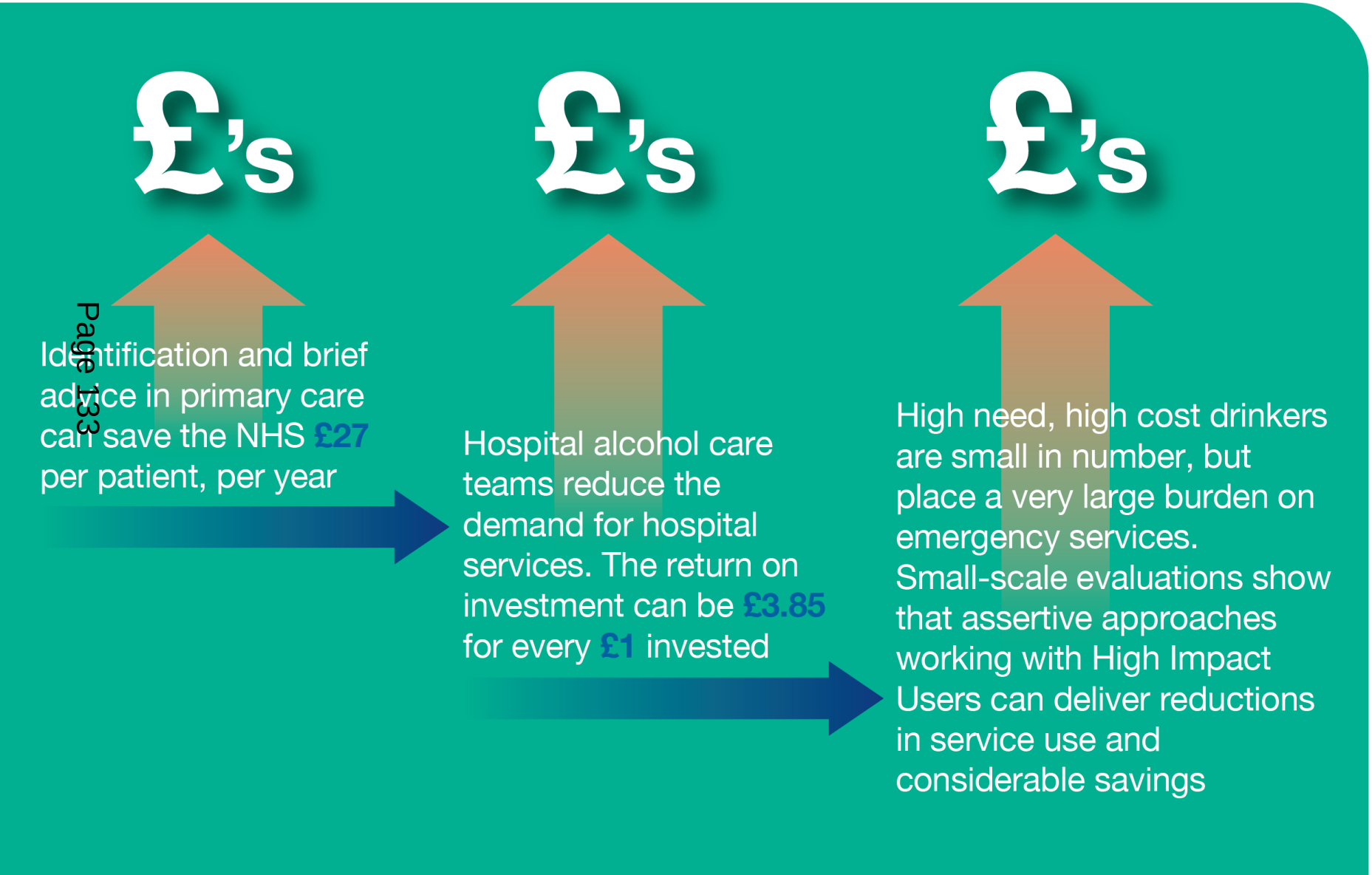
Public Health England

Specialist interventions for young people work and save money

Specialist interventions contribute to improvements in health and wellbeing, educational attainment, absence from school or training, and risky behaviours

Public Health England

Investing in alcohol interventions saves money



Public Health England

Investing in drug harm reduction saves money

Needle and syringe programmes cost around £200 a year per injector and can provide the following savings:

- **£22,000-£41,000** a year for every prevented case of hepatitis C treatment
- **£10,000-£42,000** a year for every prevented case of HIV treatment
- Reduced spending on A&E attendance and hospital stays for injecting site injuries and infections

Public Health England

Investing in drug & alcohol treatment saves money

£2.4 billion

Combined benefits of drug and alcohol treatment

£4

Social return on every **£1** invested in drug treatment

a total of **£21** over 10 years

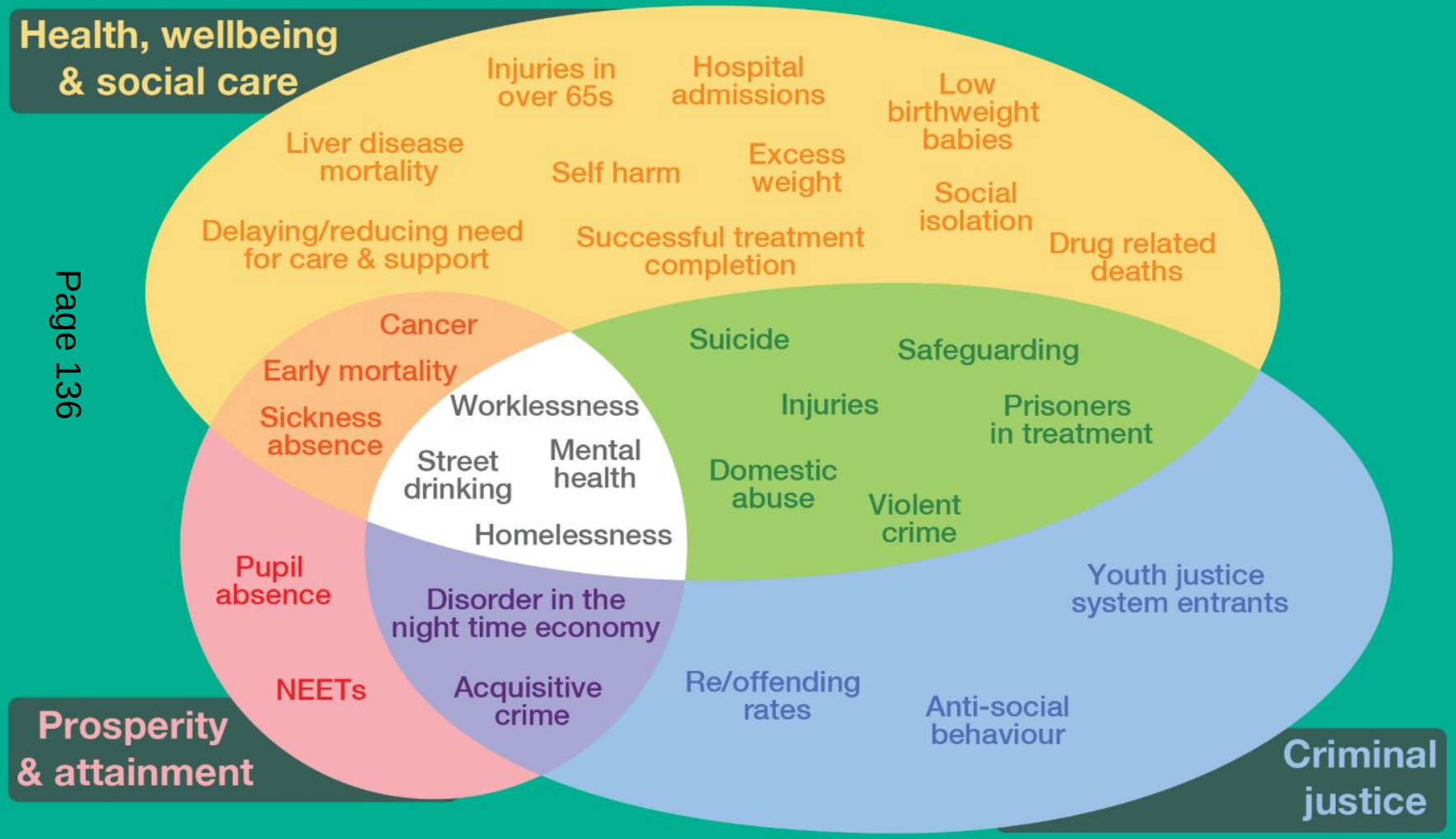
£3

Social return on every **£1** invested in alcohol treatment

a total of **£26** over 10 years

Public Health England

Alcohol and drug misuse impacts on a wide range of local priorities



Public Health England

Find out more…

Local alcohol profiles for England
https://fingertips.phe.org.uk/profile/local-alcohol-profiles

www.gov.uk
Alcohol and drug misuse prevention and treatment guidance
https://www.gov.uk/government/collections/alcohol-and-drug-misuse-prevention-and-treatment-guidance

Drug and alcohol treatment data
National Drug Treatment Monitoring System
https://www.ndtms.net/default.aspx

Health and wellbeing indicators PHE fingertips
https://fingertips.phe.org.uk/

Local PHE centres
https://www.gov.uk/guidance/contacts-phe-regions-and-local-centres

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