Public Document Pack

Health & Wellbeing Board

Tuesday, 5th September, 2023
6.00 pm
Meeting Room A
Meeting Room A

AGENDA

1. Welcome and Apologies

2. Minutes of Previous Meeting

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3. Declarations of Interest

Declaration of Interest Form **12**

4. Public Questions

5. Tobacco Free Lancashire and South Cumbria Strategy 2023-2028

TOBACCO FREE LANCASHIRE AND SOUTH CUMBRIA STRATEGY 2023- 2028 **13 - 52**
Tobacco Free Lancashire & South Cumbria Strategy 2023-2028

6. Climate Emergency Action Plan

For the Board to receive a presentation about the Climate Emergency Action Plan

7. Place Based Partnership

Developing Blackburn with Darwen Place Based Partnership – Update on progress **53 - 81**
Blackburn with Darwen Place Based Partnership Board (Interim) Terms of Reference
The Place Integration Deal
Lancashire and South Cumbria Integrated Care System - Proposals for a Place Integration Deal

8. ICB Joint Resource Capital Plan annual report

ICB Joint Capital Plan 23-24 **82 - 89**
Joint capital resource use plan
LSC Joint ICB Capital Plan 2022-23

9. Joint Local Health and Wellbeing Strategy: Life Boards Update

For the Board to receive a presentation on Joint Local Health and Wellbeing Strategy: Life Boards Update

10. Children's Partnership Board Update

For the Board to receive a presentation on Children's Partnership Board Update

11. Any other Business

12. Proposed Items for Next meeting

Proposed Items for next meeting:
- Age Well Annual Update
- CDOP Annual Report

13. Date & time of Next Meeting

Date & time of Next Meeting
5th December 2023 6.00pm – 8.00pm

Date Published: Friday 25th August 2023
Denise Park, Chief Executive

Health & Wellbeing Board

Start well | Live well | Age well

BLACKBURN WITH DARWEN HEALTH AND WELLBEING BOARD
MINUTES OF A MEETING HELD ON TUESDAY, 20th June 2023

PRESENT:

Councillors	Damian Talbot
	Mustafa Desai
	Derek Hardman
Integrated Care Board (ICB)	Claire Richardson
	Carl Ashworth
East Lancashire Hospitals NHS Trust	Emma McGuigan
Voluntary Sector	Dilwara Ali
	Vicky Shepherd
	Sarah Johns
	Angela Allen
Council	Abdul Razaq
	Mark Warren
	Michelle Holt
	Rabiya Gangreker
	Gill Kelly
	Catherine Taylor
	Shima Ahmed
	Tina Kuczer

1. Welcome and Apologies

The Chair welcomed everyone to the meeting.
Apologies were received on behalf of Councillor Julie Gunn, Jo Siddle, Sam Proffitt and Katherine White.

2. Declarations of Interest

There were no Declarations of Interest received.

3. Minutes of the Meeting held on Tuesday, 7th March 2023

The Minutes of the Meeting held on 7th March 2023 were submitted for approval.

RESOLVED – That the Minutes of the Meeting held on 7th March 2023 be agreed as a correct record.

4. Public Questions

The Chair informed the Board that no public questions had been received.

5. Joint Strategic Needs Assessment

The Consultant in Public Health, Catherine Taylor, presented an overview of the JSNA Summary and delivered a supporting presentation.
The Board was asked to approve the 2023 JSNA Overview Documents as a key component of Blackburn with Darwen's Joint Strategic Needs Assessment.

The Board was informed that the 100 page document was not designed to be read cover to cover – but to be dipped into as and when required.
Subject to approval by the Health and Wellbeing Board, the JSNA Summary Review would be the main component of Blackburn with Darwen's JSNA 2023. It began with a profile of the Borough's population and local economy ('setting the scene') and was then arranged under the three themes reflected in the Borough's Joint Local Health and Wellbeing Strategy: 'Start Well', 'Live Well', and 'Age Well'. Whilst 'Dying Well' was not one of the major themes in the JSNA Overview, it would be reflected in a separate themed chapter. The Board was informed that further work on the 'Die Well' Strategy was required but that it was meeting ICB priorities The Board were advised that the Sexual Health Strategy would be shared in due course.

There was a discussion following Catherine Taylor's presentation regarding ethnic group indicators. The Board was advised that Thematic Chapters may be utilised going forward. The Board agreed that data should be translated into supporting BAE minority needs. Diversity within the borough was growing, longer standing settled communities need to be recognised more specifically.

The Chair, Cllr Damian Talbot and Director of Public Health, Abdul Razaq both thanked Catherine Taylor for her hard work in preparing the JSNA and agreed it was a great piece of work.

The Board was recommended to approve uploading of the Joint Strategic Needs Assessment 2022-2023 to the Website.

RESOLVED – That the Board approved the 2023 JSNA Overview documents as a key component of Blackburn with Darwen's Joint Strategic Needs Assessment.

6. Lancashire and South Cumbria Integrated Care Strategy 2023-2025

The Director of Health and Care Integration, Claire Richardson, presented the final version of the Lancashire and South Cumbria Integrated Care Strategy.
Claire Richardson asked the Board to endorse the final version of the Strategy and recognise the changes following feedback through content and layout of the strategy from all stakeholders ie. Sectors / organisations who are members of our integrated care system, residents board and engagement with partners. The final document was more visual than the draft document. It had a better summary of geography and places, with updates of vision and inclusion and would be a digital resource for all. The ICB endorsed the ICS on 17th April 2023. The ICP was in consultation with the JSNA to align with their Strategy.

In direct response to feedback from residents, a short summary of the Strategy had been produced. This aimed to identify the key points from the integrated care strategy in simple language.

There was a discussion following Claire Richardson's presentation. It was agreed that elements had been strengthened and it would be beneficial to consistently reflect the aims with strategic priorities. It was also agreed that the achievements were clear and in terms of aspirations going forward we know what we want to achieve over the next 12 months, 2 to 10 years and beyond. It was acknowledged that the ICP with Place Based Boards were key drivers in the joint partnership arrangements. A Live Well/Die Well board had yet to be set up.

Claire Richardson advised there was a further workshop planned in July 2023.

RESOLVED – That the board noted and endorsed the Lancashire and South Cumbria Integrated Care Strategy 2023-2025.

7-8. Lancashire and South Cumbria Integrated Care Board – Development of a Joint Forward Plan for 2023-2028

The Director of Planning - LSC ICB, Carl Ashworth, presented the Joint Forward Plan for 2023-2028 (version 7). The Board were asked to consider and comment upon the Draft Version of the Joint Forward Plan, particularly whether it took proper account of the Blackburn with Darwen Health and Wellbeing Strategy.

There was a discussion following Carl Ashworth's presentation - Topics included:
Smoking Cessation; Colleagues felt the document should reflect the partnership.
Workforce Gap; There has been a significant piece of work re Workforce strategy and how to retain staff. Development within the National Workforce Strategy should be a priority. Recruitment is being outstripped by retention of staff, strengthening would be welcome.
Healthy Life Expectancy; figures for the Borough were concerning (46.5yrs healthy years before decline). Residents were living longer but not living well. Place is going to be important to help focus / target our vulnerable communities.
re:fresh offer; The value of free / reduced cost leisure to improve Health and Wellbeing.
The complexities of linking strategies; working within individual providers rather than integrated / collaborative means across health and care sectors. The board recognised it is a key gap that needs further exploration. The aim should be to provide a clear link between ICBMs and strategic policies / health and wellbeing processes. Conversations need to be had with local trust boards who have their own strategies.

Lack of public engagement; interaction is limited amongst local residents. The Board agreed residents need to be reminded of the basic key themes / aims as this seems to have become very complex over the past 12 months.
Mental Health; Request that the report be more ambitious in regards to Mental Health Services. Concerns that Mental Health had been kept separate and should be considered as integrated with other services. Children's Mental Health had not been highlighted. Mental Health and links to physical health / wider determinants need to be considered and this support could be within the gift of other partners / housing / planning – updates are needed within the place based partnership board.

Carl Ashworth advised there would be additional narrative available regarding Mental Health and Integration. He recognised the challenges within the document and reported the systems consume more finances than received. There is high demand with reduced capacity. One of the many challenges is inconsistent outcomes for the population of Blackburn with Darwen. This will not be a one off process – the intention is to revisit the plan every year; focussing on delivering financial sustainability, prevention with delivery and greater efficiencies. The intention is to close the loop from the ICP feeding back into development plans.
Carl Ashworth advised the report will be more robust in the next iteration but you can already see the direction of travel.

The Board agreed that there was already lots of work in the document in less than 12 months and it would have been difficult to produce a really robust document. The Board agreed an Annual refresher / review would be a welcome idea. Investing in prevention was the way forward as National Statistics indicate we are not in a good place, particularly when resources are tight. Looking back to ICP consultations they were limited due to timescales.

The Board was recommended to acknowledge the Joint Forward Plan for 2023-2028 (V.7)

RESOLVED – That the Board recommended comments be taken into account in the Final Version of the Plan – to be signed off by the Integrated Care Board at their meeting on 5th July 2023.

9. Better Care Fund 2022/23 Quarter 4 End of Year position and Quarter 1 2023-24 Budget Update

Strategic Director of Adults and Health, Mark Warren, presented the Better Care Fund 2022/23 Quarter 4 End of Year position and Quarter 1 2023-24 Budget Update.

Mark Warren advised the service was currently looking to identify where money has been invested but not yet delivered properly on, particularly in respect of the Intermediate Care facility at Albion Mill. There were 31 beds and 4 flats that needed to be brought on line. As the industry in itself was providing the metrics, if projects are not delivered funding will stop. The complexity of people being discharged is increasing – Albion Mill can be step up and step down facility.

There are also plans to transfer 3500 residents using Better Care / Telecare from to a digital framework.

As outlined in previous reports the Health and Wellbeing Board is accountable for the delivery of the Better Care Fund Plan and managing performance against the required metrics and schedule of mandatory reporting. The management of the plan is undertaken through Blackburn with Darwen's joint commissioning arrangements and governance structures.

The report provided an account of the progress made against each of the performance metrics, scheme priorities and financial expenditure throughout the year.

All of the statutory planning and reporting requirements had been met through 2022/23.

The formal Section 75 Agreement detailed the pooled budget arrangements between the Local Authority and CCG (now ICB) and was updated for 2022/23. No substantial changes were made to the agreement.

The Better Care Fund Policy Framework and Planning Requirements for 2023/25 had been published with a submission deadline of 28th June 2023. This was a 2 year plan. As part of the review process a workshop was undertaken on 25th Ma 2023 which was well attended by colleagues from across the partnership. The Outputs from the workshop would support priority setting and the development of the scheme going forward.

There was a discussion following Mark Warren's presentation regarding the sustainability of DFG and the criteria for access. Mark Warren advised that grants can be discretionary but there is no direct criteria for access / eligibility. Considerations need to be made regarding the suitability of properties for adaptation and the longevity of the service users needs. No two applications are the same and this is a difficult discussion to be had with applicants.

Questions were asked regarding Intermediate Care and BwD residents being discharged and / or displaced to other areas of the UK. It was agreed that residents should not be sent direct from hospital to Care Home facilities as progress is difficult to monitor. Most residents are able to relocate to local Residential Care or their home of choice.

RESOLVED – That the Board acknowledged the Better Care Fund 2022/23 Quarter 4 End of Year position and Quarter 1 2023-24 Budget Update as recommended

10. <u>Health Watch Update</u>

The Chief Executive Officer of Health Watch BwD, Sarah Johns, shared a presentation and update of the Health Watch Service 2023/2024 Work Plan.

Slides included:
Start Well –

- Youth Healthwatch engagement across the year with a focus on:-
- mental health
- supporting Public Health in the development of the Child Poverty
- and delivering level 2 Royal Society of Public Health Young Health Champions accreditation in schools and youth settings

Live Well –

- Engagement to understand people's experiences of accessing support for substance misuse, covering all age groups and with a focus on vulnerable/seldom heard groups
- Engagement to understand how adults with learning disabilities can best be supported through the use of hospital passports, annual health checks and pilot programmes such

as the red bag scheme and Bubble app to engage with health services as independently as possible and manage their own health better.

Age Well –

- Engagement to understand residents' experiences of support in the community for dementia, particularly in the early stages – both individuals and families/carers.
- Monthly Enter and View visits into residential care homes and working closely with the Council's Quality Assurance team to support a multi-disciplinary team approach to action planning for homes

All Age –

- Enter and View visits into GP practices and pharmacies
- Information and signposting – in community venues and via telephone and email
- Supporting Public Participation Panel at ELHT and lived experience roles within the Pennine Health Equity Alliance
- Volunteering opportunities with Healthwatch BwD

There was a discussion following Sarah Johns' presentation. The Board agreed there was a need for understanding residents' expectations of GP services and the role of Receptionists as a triage service, not a blocker to accessing the GP. There is work to do around Communication and informing people of the new roles and how they can give better care than the GP. Communication needs to be a regular driver as it is very hit and miss, with little continuity. This lack of communication is driving people to A&E, if we can get the understanding out there it may help us with A&E targets. Telephone consultations need promoting as there is a collective push back to have a triaged call. Negative narrative has built up. As a board we should be smarter in combining and building on what people want to hear and use to support their H&WB and their priorities using strategies and plans.

Questions were asked regarding the Primary Care Model. There are half million new GP appointments than pre-covid but due to workforce challenges, access is still an issue. Communication and expectation needs to be turned into a strategic conversation. What are we going to be telling our residents? Are we still wedded to the old model? Do we need to move the conversation forward?

Joined up working needs to be done in regards to resident's care home experience. Quality needs to be driven up and resident experiences need to be pushed upwards. One place strategy would help improve and drive standards.

Further discussions took place regarding Lancashire Health Watch and external services. Questions were asked about how residents' feedback can be incorporated when being supported by external services. It was agreed that families and residents would welcome closer scrutiny. The board were informed that each Health Watch area does things differently. When placed out of borough it is difficult to manage quality for our residents. For those placed within BwD from outside the borough they are far away from their usual support networks. Many external services do not have a quality and assurance scheme to protect residents and all this comes back to good commissioning services.

Chair Cllr Damien Talbot advised that a full report is due to be received by the Board at the end of 2023.

RESOLVED – That the Board noted the Health Watch Work Plan Presentation as recommended.

11. Health Protection Annual Assurance Report

Public Health Development Manager, Rabiya Gangreker, presented the Health Protection Annual Assurance Report. The Health and Wellbeing Board were provided with an update on health protection assurance arrangements in Blackburn with Darwen and health protection activities undertaken during 2022.

In 2022 the Priority Objectives were:

- Manage outbreaks of communicable disease, including respiratory & new and emerging infections
- Maintain and progress with an IPC audit programme of settings
- Increase uptake of flu vaccinations amongst all priority groups and manage outbreaks effectively
- Provide support to prevent and reduce risks associated with HCAI and AMR
- Increase uptake and reduce inequalities in uptake across all immunisation programmes

During 2022, the Board also considered:

• Covid vaccinations and booster programmes, supporting the uptake of vaccinations in the borough and increasing engagement activities to increase uptake in the borough which was supported by the community champions' programme.
• Climate and Health needs assessment which has supported the Climate Emergency action plan.
• Regular updates on food borne infections in the borough as part of the quarterly IPC update
• Actions to reduce winter pressures on Council and partner services
• Discussion on local actions to reduce damp housing conditions in the borough

In 2023 the Planned Activities are:

- Continue to work with UK Health Security Agency (UKHSA) to monitor risks and respond to outbreaks in local settings
- IPC Team will be offering IPC audits to all Council-run and maintained nurseries and will continue with the rolling programme of care home IPC audits
- Task and finish groups to meet prior to the start of the next flu season to address learning shared at the regional flu evaluation
- Bwd Seasonal Flu group will meet during the 22/23 flu season to promote uptake and circulate comms messages as wide as possible
- To continue to deliver regular IPC forums and promote attendance. To continue to work in collaboration with the Integrated Care Board to reduce risk and prevent HCAIs

The Director of Public Health, Abdul Razaq thanked Rabiya for the report – noting previous work by Laura. A discussion took place regarding the Hydration Heroes pilot and the positive effect it was having on Care Home residents with a reduction of UTIs in vulnerable groups. The board were advised there are plans to extend the pilot to Day Centres. It was agreed that the project could have a huge impact on hospital attendances.
Antibiotic resistance was flagged as a concern in the local population. Work is ongoing between the IPCT and pharmacies in regards to this.

The Board was recommended to:

RESOLVED – That the Board noted the information within this report as recommended and that the report provided assurance that effective processes are in place to protect population health.

12. OHI Strategy One Year On

Public Health Development Manager, Gill Kelly, shared a presentation on the Oral Health Improvement Strategy.

The Board was recommended to acknowledge and approve the presentation, key highlights of which are presented below;

Achievements to Date:

- Reduce rate of DMFT- Now 40% down from 51% and ranked 5th from 1st (worst)
- Launch event at Ewood Park May 2022
- Oral Health Improvement Service commissioned
- GULP (Give Up Loving Pop)
- Madrassah pilot
- Kind to Teeth Parent Champions
- Max's Not So Sweet Dream book reading and dental nurse assemblies
- Oral health communications campaign
- Lift the Lip in primary care
- Start, Live and Age Well training

Other OHI Work:

- Linking with Baby Friendly Team
- Supporting other food and nutrition agendas
- Strong leadership and governance at BwD Oral Health Strategy Group
- Re-established stronger L&SC OHI group
- New L&SC Dental Public Health Consultant
- New DMFT data released 23rd March (full census (different MO) reduced DMFT by 10%)

Priorities for 2023/2024

- Exec Board paper (update on 15 approved recommendations; risks etc.)
    - SLT 13/03/23
    - Exec Board 13/04/23
    - H&WBB 06/06/23
- Looked After Children's oral health (Start Well)
- Homeless people's oral health (Live Well)
- Oral Health Champions in care homes and care services (Age Well)

A discussion took place following the presentation. Topics discussed were as follows:
Hydration and dental care needs to be supported; priority for SLCC was a priority at a local level.

The positive impact in schools; one reception class within the pilot reported no one has had time off due to toothache.
Capacity; Was still an issue - There is no registration process to access a dentist and they are only commissioned for 60% of the population. This has always been the case – a lot of NHS dentists have transferred to private practice. It is a difficult and challenging situation but there is an active piece of work being led by the ICB.
Care homes and access to mouth care; Staff found it very difficult to get people to a dentist. Poor dental health links strongly to poor nutrition. A Toolkit was sent out to all care homes. The ICB can occasionally fund dentists to attend particular projects.
Historically, PCTs and CCGs had a GP with a special interest in care homes incl. dental health. Funding hadn't increased in the last 15yrs and the whole system required reform. The older age groups are a focus for the next year.

Gill Kelly was thanked for her hard work and excellent report.

The Board was recommended to acknowledge and approve the presentation.

RESOLVED – That the Board approved the presentation.

13. Any Other Business

There was no other business.

NOTED: 24hrs notice must be given for any other business to be included as an item in the Health and Wellbeing Board Agenda.

NOTED: Facilitates staff to be present at the back entrance reception desk 15 minutes before and 15 minutes after a meeting has commenced where external partners are expected to attend a particular meeting – to be reported to the appropriate Manager.

13. Proposed Items for Next Meeting

The proposed items for the next meeting to include:

- Start Well Annual Update
- Climate Emergency Action Plan Update
- Place Based Partnership Update
- Live Well Board – monitoring and reporting
- Health and Wellbeing Strategy

14. Date and Time of Next Meeting

The next meeting was scheduled to take place on 5th September 2023 at 6pm.

Signed……..

Chair of the meeting at which the Minutes were signed

Date……

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: **Health and Wellbeing Board**

DATE:

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)

HEALTH AND WELLBEING BOARD

TO:	Health and Wellbeing Board
FROM:	Abdul Razaq – Director of Public Health, BwD Liz Petch – Consultant in Public Health, Blackpool
DATE:	5th September 2023Tuesday, 5 September 2023

SUBJECT: TOBACCO FREE LANCASHIRE AND SOUTH CUMBRIA STRATEGY 2023- 2028

1. PURPOSE

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

2. RECOMMENDATIONS FOR THE HEALTH & WELLBEING BOARD

2.1 To inform Health and Wellbeing members of the approach taken to develop the strategy and how its contents will be beneficial to reduce tobacco related harm in Blackburn with Darwen population.

2.2 To endorse the approach outlined in the report and approve the Strategy document attached with effect until the 31 December 2028.

3. BACKGROUND

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

Tobacco Free Lancashire and South Cumbria is a multi-agency alliance working together towards the smokefree agenda across Lancashire and South Cumbria and includes representatives from local authority public health, NHS, providers, Office for Health Improvement and Disparities (OHID) and Trading Standards.

This group was previously known as Tobacco Free Lancashire however since the implementation of Integrated Care Systems (ICSs), the footprint of the group has been expanded to match that of the Integrated Care System.

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

4. RATIONALE

Smoking is the number one cause of preventable death across England, resulting in more deaths

than the next five causes combined (obesity, alcohol, road traffic accidents, drug abuse and HIV infection). Smoking affects each of the domains in the CORE20PLUS5 agenda and is a huge driver of health inequalities.

In 2019 the government set an ambition for England to be Smokefree by 2030. This would mean that by this time less than 5% of the population would smoke. Currently in Lancashire and South Cumbria we are not on track to meet this ambition. An estimated 15% of our population currently smoke, and huge inequalities exist both in prevalence of tobacco use and tobacco related harm.

As stipulated in the Khan Review published in 2022, considerable upscaling of intervention for tobacco control is needed to meet the Smokefree 2030 ambition and national action announced will not be enough alone to improve outcomes. A sustained and comprehensive effort is needed from the whole of Lancashire and South Cumbria Integrated Care System.

5. KEY ISSUES

This strategy has been developed collaboratively with tobacco leads and commissioners from each local authority area alongside colleagues from the NHS and Office for Health Improvement and Disparities. An initial analysis was performed with local commissioners against the previous Tobacco Free Lancashire 2018-2023 strategy.

This was presented back at a joint stakeholder engagement event with the Public Health Collaborative and Integrated Care Board Population Health team to assist in agenda and priority setting for the new strategy, alongside the latest data, evidence, policy and guidance on tobacco control. Wider stakeholder engagement was also conducted with Acute Trusts and the Mental Health NHS Trust.

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

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

6. POLICY IMPLICATIONS

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

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

An additional separate priority was also identified around vaping and the need for consensus and clarity on the Lancashire and South Cumbria position on nicotine vapes. A Lancashire & South Cumbria Directors of Public Health vaping consensus statement has been developed. Similar vaping consensus vaping statements are in development in Cheshire & Merseyside and Greater Manchester.

7. FINANCIAL IMPLICATIONS

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

8. LEGAL IMPLICATIONS

The Council's legal power to adopt such initiatives falls within section 2B National Health Service Act 2006 which provides that local authorities must take such steps as they consider appropriate for improving the health of the people in its area.

9. RESOURCE IMPLICATIONS

Current investment to support the Blackburn with Darwen population is available through a local authority community pharmacy offer and promoted via Re-Fresh.

Development of an extended specialist smoking cessation service with Primary Care Networks (PCN) is under consideration funded through the Public Health grant allocation 2023/24.

NHS ICB funding commitments in the NHS Long Term Plan (LTP) for tobacco in NHS settings is subject to national direction and NHS Lancashire & South Cumbria ICB prioritisation.

10. EQUALITY AND HEALTH IMPLICATIONS

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

11. CONSULTATIONS

Developed collaboratively with tobacco leads and commissioners across Lancashire and South Cumbria, North West Office for Health Improvement and Disparities and NHS colleagues. Presented to Integrated Care Board Prevention and Health Inequalities Steering Group 15 June 2023 with a view for Integrated Care Board approval by September 2023.

Approved at Blackpool Health and Wellbeing Board June 2023 and to be presented at Health and Wellbeing boards at Blackburn with Darwen, Lancashire and Westmorland and Furness at September 2023 meetings.

VERSION:	**1**

CONTACT OFFICER:	Mr Abdul Razaq – Director of Public Health
DATE:	22nd August 2023

BACKGROUND PAPER:	None.

Tobacco Free Lancashire & South Cumbria Strategy 2023-2028

Contents

Foreword

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

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

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

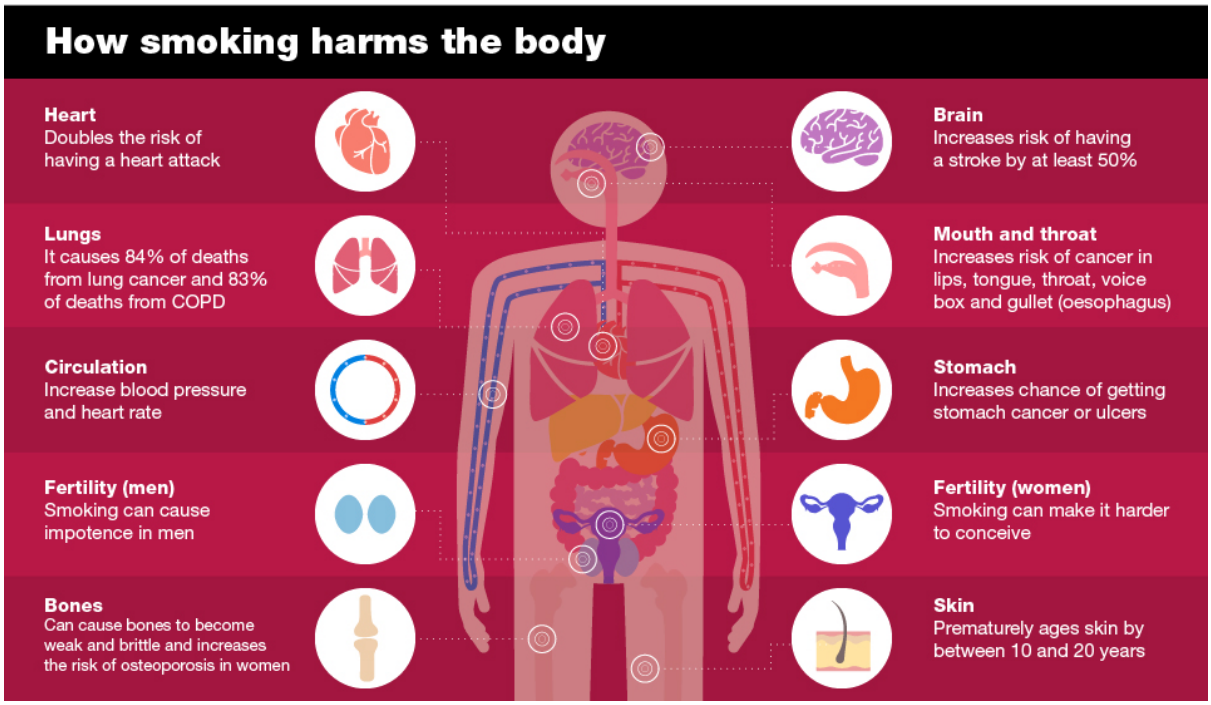
We want to create a future in Lancashire and South Cumbria where every person is able to breathe clean air, free from the harmful effects of tobacco smoke. In order to do this, we are working toward the Smoke Free 2030 ambition of lowering smoking prevalence in every neighbourhood to less than 5% by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

Councillor Brian Taylor, Blackburn with Darwen

Introduction

Why is smoking such a big concern?

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



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

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

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

Tobacco use in Lancashire and South Cumbria

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

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

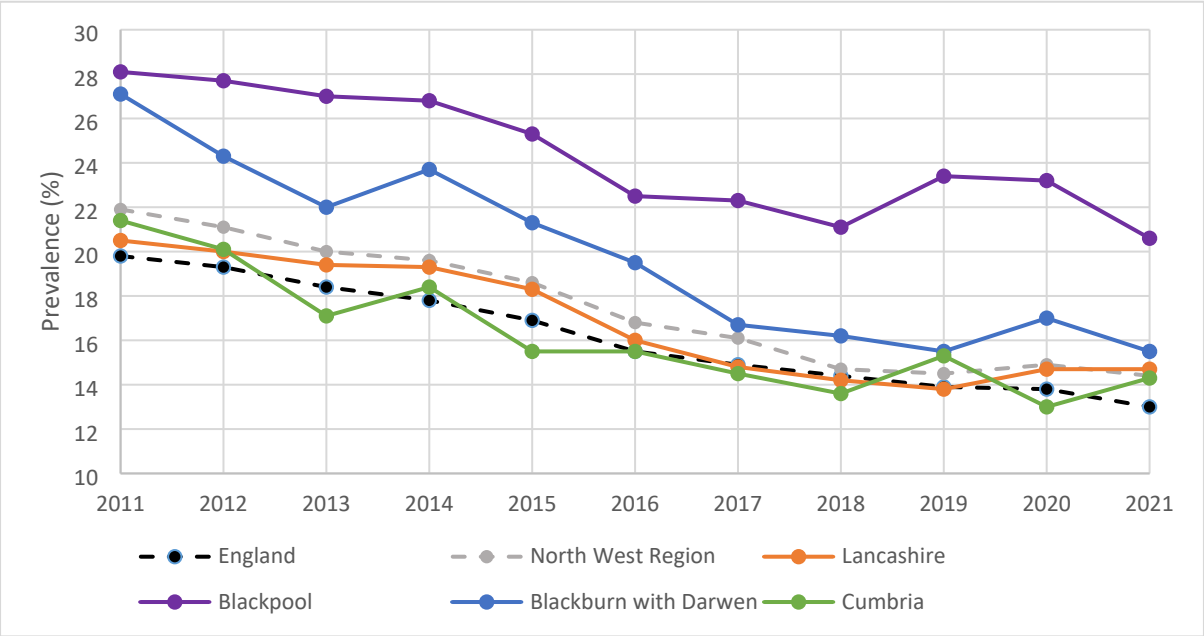
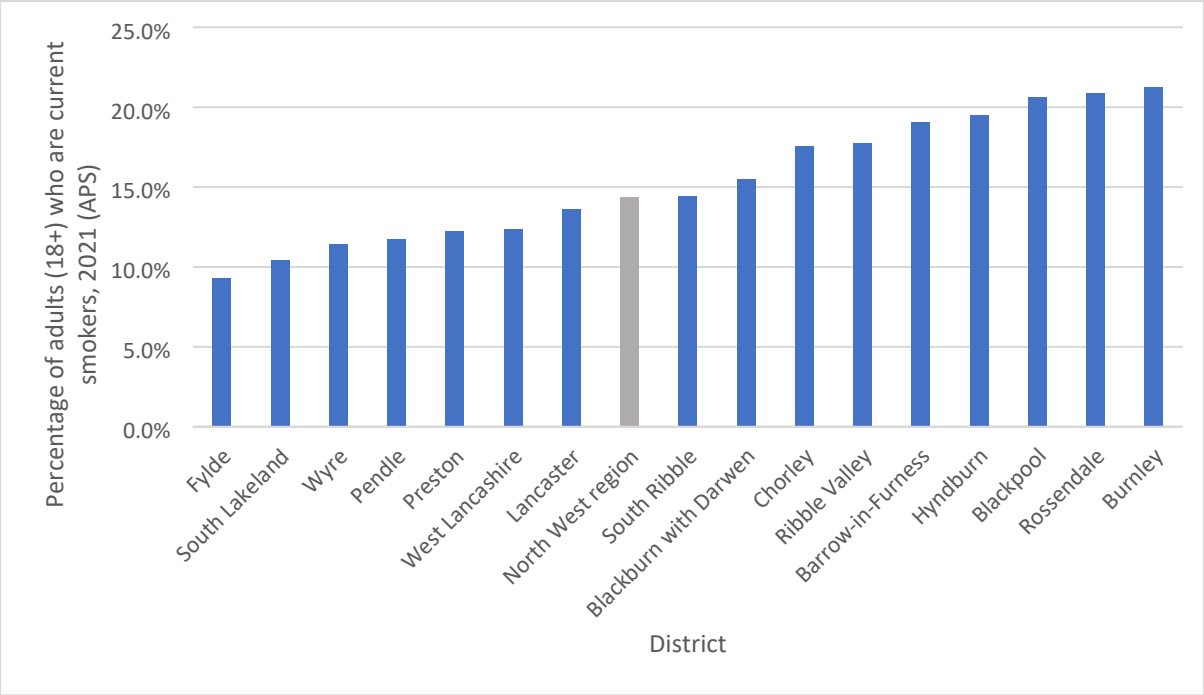


Figure 1.1 shows the trends in smoking prevalence in adults (18+) within England, the North West region and within the local authorities in our footprint using data from the Annual Population Survey- the largest household survey in England. Smoking can be seen to have declined in the past decade in each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

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

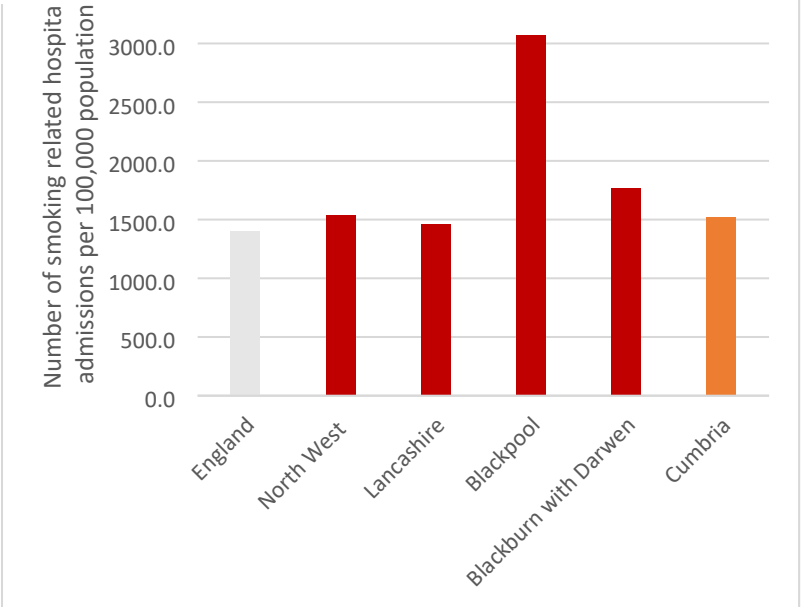
Figure 1.2 Smoking prevalence in adults by district (APS 2021)



Mortality and Morbidity from smoking

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

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

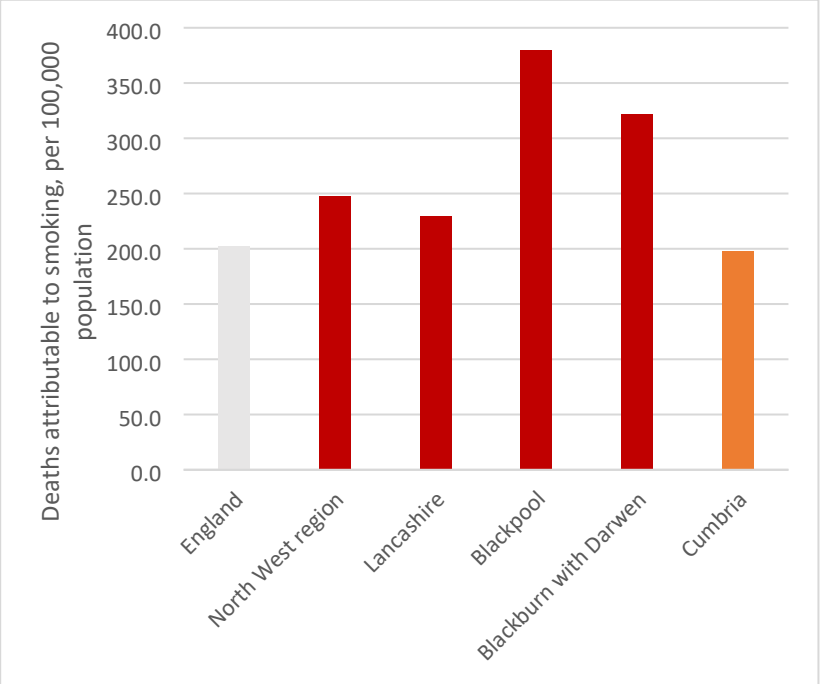


Source: Fingertips, OHID

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

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

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



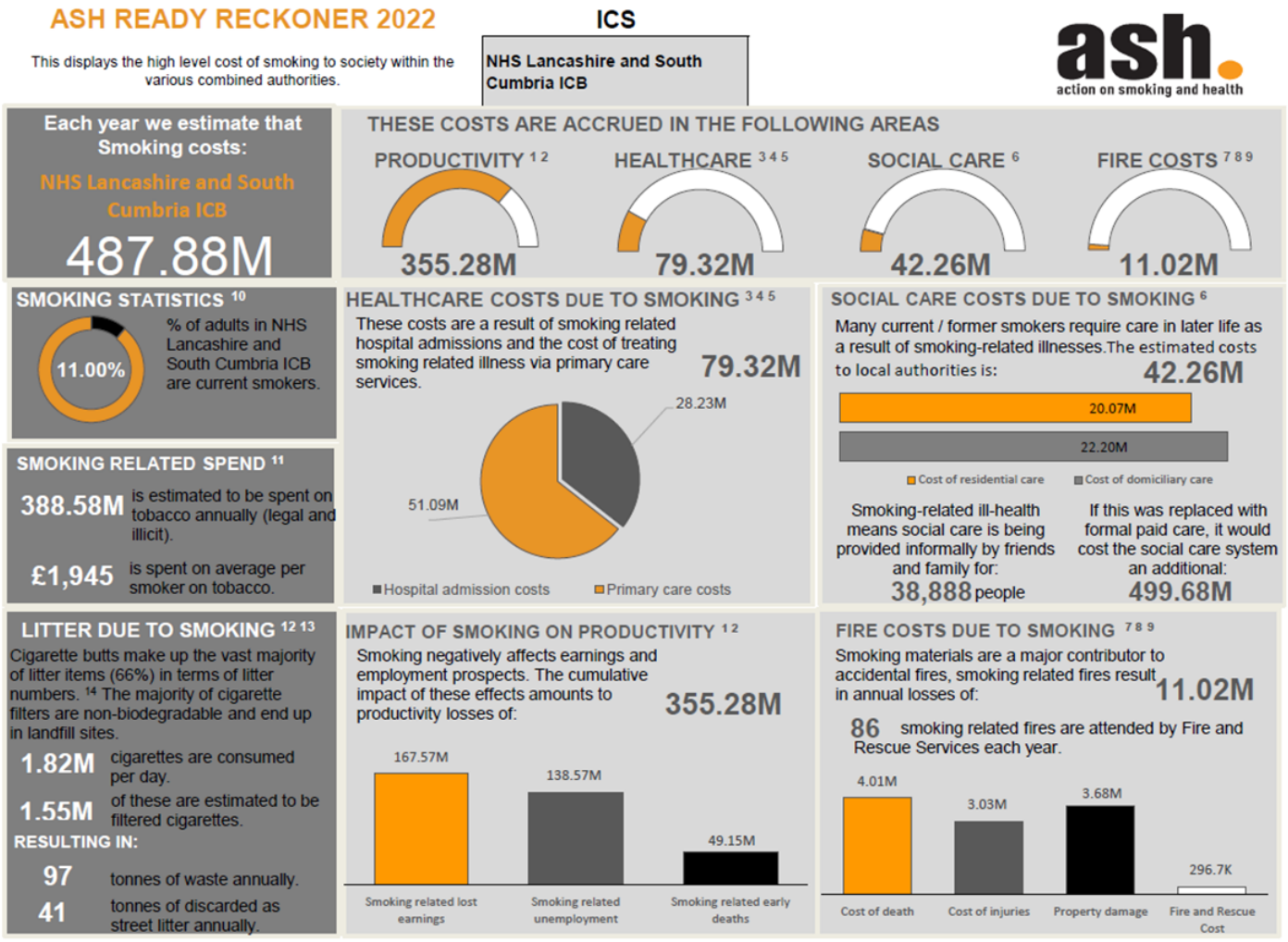
Source: Fingertips, OHID

Wider effects of Smoking on Lancashire and South Cumbria

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

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

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



National policy and guidance

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

The national Tobacco Control Plan 2017-2022

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

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

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

1. Prevention first

To achieve a smokefree generation we will:

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

2. Supporting smokers to quit

To achieve a smokefree generation we will:

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

3. Eliminating variations in smoking rates

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

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

4. Effective enforcement

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

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

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

The Khan Review

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

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

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

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

Khan's critical recommendations

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

The Khan Review: Independent review into smokefree 2030 policies

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

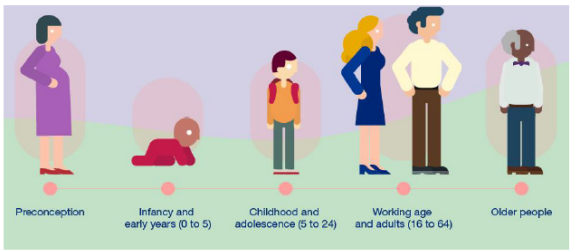
Part 1: Invest Now

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

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

Part 2: Stop the Start

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



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

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

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

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

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

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

Part 3: Quit for Good

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

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

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

Part 4: System Change

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

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

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

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

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

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

The NHS Long Term Plan

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

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

Smoking cessation commitments in the NHS long term plan:

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

NHS Core20PLUS5

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

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

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

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

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

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

Source: Briefings for Integrated Care Systems - ASH

NICE Guidance

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

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

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

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

Smokefree 2030: Government action

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

1. Youth vaping: A call for evidence

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

2. Swap to stop: 1 million smokers

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

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

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

4. Smoking in pregnancy: A national incentive scheme

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

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

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

6. Licensed medicines: Unblocking supplies

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

7. Tobacco packaging: Mandatory pack inserts

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

8. The Major Conditions Strategy: Smokefree at the core

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

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

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

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

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

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

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

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

Where are we now?

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

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

Lancashire and South Cumbria Integrated Care Partnership (ICP) was created with the ambition and purpose to harness the collective efforts of all partners to improve the health and wellbeing of the Lancashire and South Cumbria population. This presents a great opportunity to come together to

tackle tobacco addiction across the footprint equitably, with the collective efforts of partners to enable a whole that is more than just the sum of our parts.

Ambitions:

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

Recommendations for Action:

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

How will we measure success?

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

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

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

Priority 2: Action to address health inequalities

Smoking in Pregnancy

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

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

Table 1: Impacts of smoking in pregnancy.

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

Source: NHS Long Term Plan

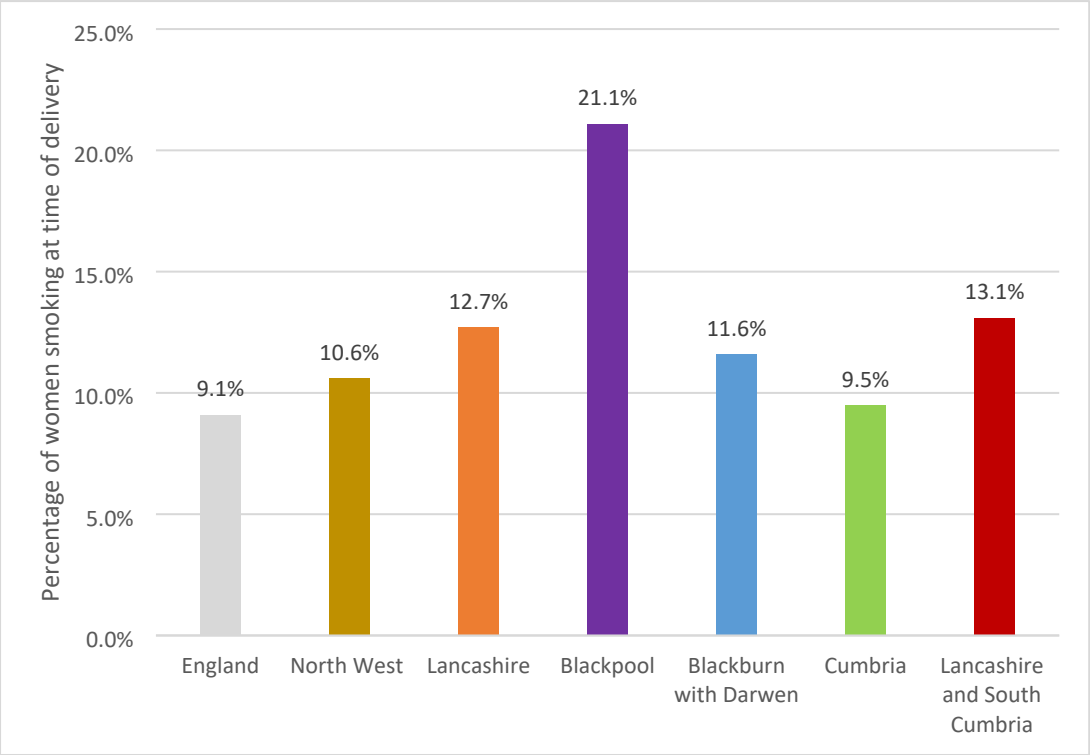
Rates of smoking in pregnancy are strongly linked to age and social economic deprivation. Mothers aged 20 or under are five times more likely than those aged 35 and over to have smoked throughout pregnancy (45% and 9% respectively)[26]. Women in routine and manual occupations are more than five times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

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

Where are we now?

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

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



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

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

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

Ambitions:

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

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

Recommendations for action:

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

How will we measure success?

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

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

Mental health and Smoking

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

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

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

Where are we now?

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

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

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

Ambitions:

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

Recommendations for Action:

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

How will we measure success?

Success will be measured through improvements in the following indicators:

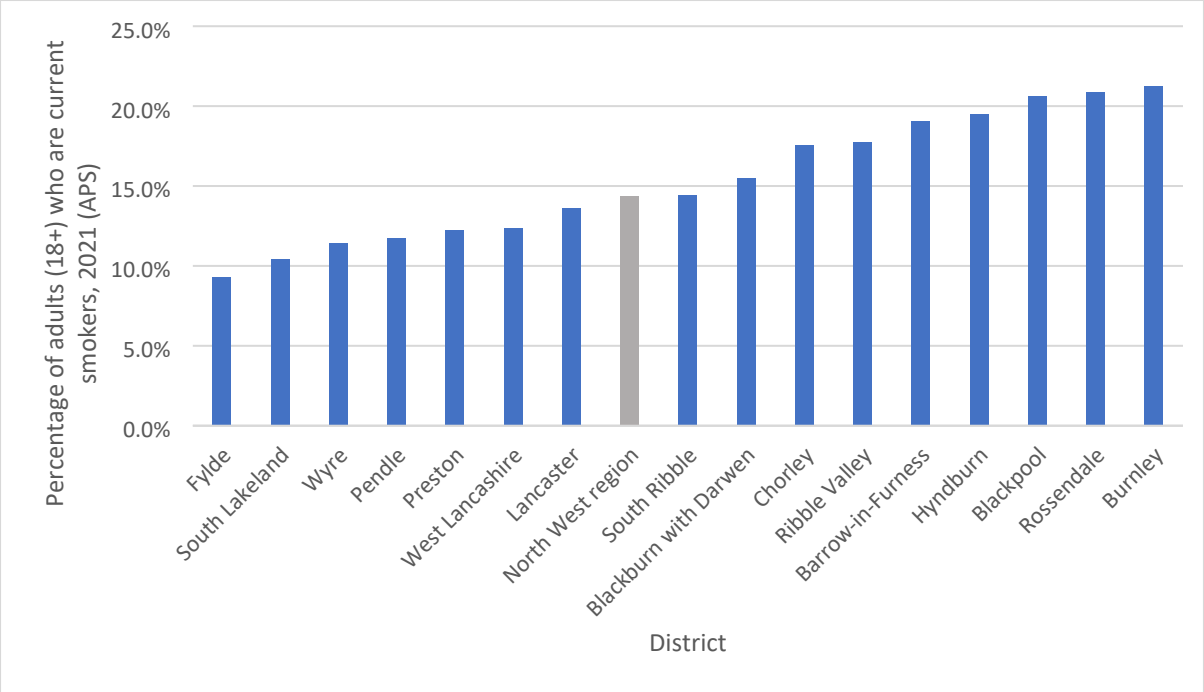
- Referrals and quits in specialist mental health treating tobacco dependency services
- Smoking prevalence in patients with mental health conditions and severe mental illness

Sociodemographic inequalities in Smoking

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

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

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



Source: Annual Population Survey (2020), via Fingertips

Ambitions:

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

Recommendations for Action:

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

Routine and manual occupations

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

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

Recommendations for Action:

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

How will we measure success?

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

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

Shisha and Smokeless Tobacco

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

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

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

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

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

Recommendations for Action:

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

How will we measure success?

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

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

Smoking in those with Multiple Addictions

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

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

Recommendations for Action:

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

How will we measure success?

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

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

Priority 3: Making Smoke Free the new normal

Smoking and the environment

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

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

Smokefree places

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

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

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

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

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

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

Ambitions:

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

Recommendations for action:

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

How will we measure success?

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

Smoking in Children and Young People

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

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

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

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

Ambitions:

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

Recommendations for Action:

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

How will we measure success?

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

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

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

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

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

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

Ambitions:

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

Recommendations for action:

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

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

How will we measure success?

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

Vapes and vaping

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

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

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

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

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

Ambitions:

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

Recommendations for action:

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

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

Measures:

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

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

Governance and Accountability

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

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

How will this strategy be delivered?

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

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Appendices

Appendix 1

Lancashire South Cumbria DPH Positio

HEALTH AND WELLBEING BOARD

TO:	Health and Wellbeing Board
FROM:	Claire Richardson, Director of Health and Care Integration Blackburn with Darwen, Lancashire and South Cumbria Integrated Care Board
DATE:	5th September 2013

SUBJECT: Developing Blackburn with Darwen Place Based Partnership – Update on progress

1. PURPOSE

This paper provides the Health and Wellbeing Board with an update on progress in developing Place Based Partnership arrangements for Blackburn with Darwen. It intends to ensure that the Health and Wellbeing Board are fully sighted on our progress during the development and subsequent phases of the partnership arrangements.

2. RECOMMENDATIONS FOR THE HEALTH AND WELLBEING BOARD

The Health and Wellbeing Board is recommended to:

a) Consider and provide feedback on this progress report on the development of the Blackburn with Darwen Place Based Partnership
b) Note the Place Integration Deal for the Lancashire and South Cumbria places that was agreed by the Lancashire and South Cumbria Integrated Care Board in July and offer reflections, during the course of their meeting, as regards to their ambitions for integration in Blackburn with Darwen
c) Agree to receive a further report at their meeting in December, outlining options and recommendations for governance of the joint planning, delivery and commissioning arrangements that will enable the implementation of the Place Integration Deal in Blackburn with Darwen.

3. BACKGROUND

The Health and Care Act 2022 introduced radical changes to the NHS health and care commissioning landscape, the key change being the formal creation of Integrated Care Systems across the country. They are made up of two parts – an Integrated Care Board (ICB) which is an NHS organisation with responsibility for allocating the NHS budget and commissioning services for the population, taking over the functions previously held by clinical commissioning groups (CCGs) and an Integrated Care Partnership (ICP) which is a statutory joint committee of the ICB and local authorities in the area.

The Act and subsequent national commentary (Thriving Places Guidance, Sept 2021; Hewitt Review of ICSs, April 2023) also paved the way for collaborative working arrangements between partners, of all sectors, to be convened in “places”, in the form of Place based Partnerships (PBPs).

Within the Lancashire and South Cumbria Integrated Care System, it has been agreed that there will be four “places”, where commitment has been made to grow and support thriving PBPs, aligned to Upper Tier Local Authority boundaries - Blackburn with Darwen, Blackpool, South Cumbria and Lancashire.

The HWBB have previously received verbal updates in relation to the development of a Place Based Partnership for Blackburn with Darwen and through their development session in March, members had opportunity to input into key delivery priorities and an operating model for the Partnership. The developing Place Based Partnership arrangements have been supported via partner organisations across Blackburn with Darwen.

This paper sets out the progress made in establishing local arrangements over the past six months and provides HWBB members the opportunity to input into the next phases of development.

4. RATIONALE

The approach to collaborative planning and delivery of health and care services, through a Blackburn with Darwen Place based Partnership, provides an opportunity to strengthen the Board's influence in prioritising prevention of ill health and ensuring joined provision of high-quality community services; promoting integrated funding/commissioning to ensure best value and deliver improved outcomes.

5. KEY ISSUES

Partnership Development

Health and care partners in Blackburn with Darwen, including the Voluntary, Community, Faith and Social Enterprise sector (“VCFSE”) and Healthwatch, have a long history of working together to improve service delivery for residents, with a BwD Local Integrated Care Partnership (LICP) being established in 2018 to oversee such collaborative working. This Partnership, amongst other things, drove the development of strong, cohesive, multi-agency neighbourhood working arrangements, which have since been recognised as good practice within Lancashire and South Cumbria.

When considering and discussing future PBP operating arrangements for Blackburn with Darwen, partners felt strongly that existing partnership infrastructure should be utilised and evolved, where it was relevant to do so. It was therefore agreed that the existing LICP infrastructure would be reviewed and evolved to form a PBP Board and that the existing life course boards, operating under the Health and Wellbeing Board, would become key focal points for driving forward collaborative delivery.

The Health and Wellbeing Board members considered and offered input into the operating framework for the PBP at their development session in February and suggestions from Board members were reflected within revised iterations.

The terms of reference for the interim PBP Board have been developed to reflect this operating framework and also to reflect a line of accountability to the Health and Wellbeing Board for the delivery of health and care services to improve health outcomes for Blackburn with Darwen residents. The terms of reference for the PBP Board are attached at Appendix C for the information of HWBB members. These terms of reference will be further developed as and when delegations are made to the PBP.

The current operating structure for the PBP is outlined below in Figure 1.

Figure 1.

Collaborative delivery

When considering initial priorities for the Place-based Partnership, existing Blackburn with Darwen strategies, priorities and plans were considered and cross referenced with the emerging priorities for the Lancashire and South Cumbria Integrated Care Partnership and Integrated Care Board. The refresh of the Joint Local Health and Wellbeing Strategy earlier in 2023, provided an ideal opportunity to develop priorities in tandem with the Health and Wellbeing Board and members contributed to the development of the PBP priorities at their development session in February. The initial priorities identified by the PBP are outlined below in Figure 2.

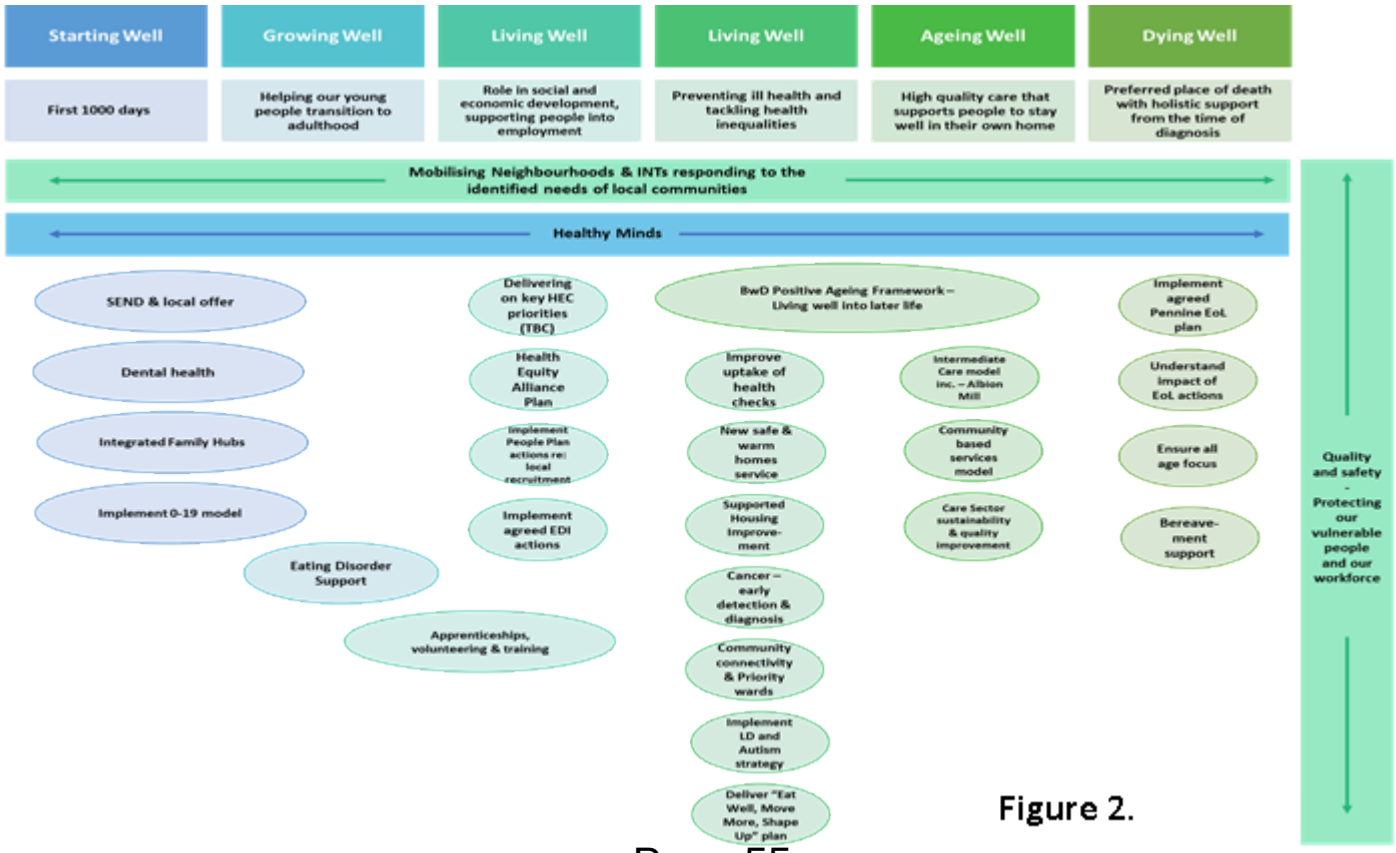


Figure 2.

Aligned to these priorities a number of key workstreams were subsequently agreed for delivery during 2023-24, these are outlined below.

Delivering integrated services:

- **Neighbourhoods** – review and re-energise, launch October
- **Community health and care** (incl. mental health) – transaction and transformation of adult health provision, improvement of community mental health offer, opportunities to align 0-19 provision
- **Intermediate Care** – maximising Albion Mill facility
- **Care Sector quality** improvements – opportunities for joint working
- Growing and supporting our **workforce** – local recruitment for health and care jobs, school leavers, care academy, opportunities to link with growth and skills development programme

Delivering improvements across the life course using population health approaches:

- **Start Well** – family hubs, dental health, vaccinations, emotional and mental health and wellbeing
- **Live/Work Well** – mental health and wellbeing, health checks/enhanced health checks, linking to skills, economic development and economic inactivity
- **Age Well** – Positive Ageing, frailty and falls prevention, dementia friendly BwD
- **Dying Well** – learning from Healthwatch engagement, focus on early identification and care planning in primary care

Knowing our people:

- Working effectively with **people and communities** – growing our co-production approaches consistently across all our partners
- **Population health** intelligence and insights – targeting specific areas to keep people well at home this winter; using our knowledge to plan and deliver better to meet the needs of local communities

Developing our partnership:

- **Partnership arrangements** for effective collaborative planning and delivery
- **Finance, Performance and Reporting** – demonstrating impact to our Health and Wellbeing Board
- Evolving **commissioning governance**
- **Clinical and care professional** leadership
- Working with VCFSE to establish **BwD Community Network**
- **Workforce and organisational development** – integrated induction, leadership and culture change

Delivery against all of these workstreams is now underway and progress will be reported through to the Health and Wellbeing Board.

Developing a Place Integration Deal

There is a long-term vision, both nationally and locally, for delegating responsibility for elements of health care planning, delivery and commissioning to Place-based Partnerships and thinking on this is on-going within Lancashire and South Cumbria.

Work has been undertaken within the ICB and across Place partnerships, to consider what a 'Place Integration Deal' could look like and achieve from an NHS perspective and the Integrated Care Board agreed the high-level Deal at their meeting on 5th July.

The Place Integration Deal aims to ensure the effective delivery of the ICB's aims through its implementation where resources from the ICB (and other partners over time) are embedded further

into our neighbourhoods and places. Over time, delegated decision making will support further aligning and/or pooling of resources with local authorities, ensuring better targeting to local need and making better use of our collective resources.

The Deal outlines several common priorities of focus for the four places over the remainder of 2023/24:

- Population health – addressing inequalities
- Primary care – development of Integrated Neighbourhood Teams (INTs) and transformation
- Scope of the Better Care Fund (BCF) and Section 75/256 agreements regarding pooling of resources/payments
- Community health services – transaction and transformation
- Continuing Health Care

This clear set of common priorities align to those already adopted by the Blackburn with Darwen PBP, which, in turn, align to a number of priorities set out within the Blackburn with Darwen Joint Local Health and Wellbeing Strategy.

The Directors of Health and Care Integration (DsHCI) hold responsibilities as convenors of partners in places around agreement and delivery of shared priorities. It is the intention that they will be empowered further, through a clear set of delegations, which will ensure agile and responsive decision making for the ICB in place.

The details of the Place Integration Deal are available for members to consider in the attached appendices A and B.

The Deal offers an opportunity to enable delivery of improved experiences and outcomes for our residents, through moving resources and decision-making closer to our communities, and having greater involvement of our communities in decision-making. This will enable deeper integration and allow us to achieve better value from our collective resources.

Following agreement with the ICB Board in July, more detailed engagement is now commencing with place partners, particularly the local authority, in order to understand their specific ambitions for integration in Blackburn with Darwen and opportunities for delegations to be made into the Partnership.

<u>Evolving Place governance to implement the Place Integration Deal</u>

Effectively managing the responsibility and budgetary allocations associated with the Place Integration Deal will require robust governance to be in place. The target date for phase one of the NHS delegations (Better Care Fund and Population Health Fund) into Place is 1st April 2024. As such, the governance option for management of those responsibilities and budgets needs to be pragmatic and deliverable within this timescale.

In Blackburn with Darwen, these arrangements will draw on the existing good practice for joint commissioning of the Better Care Fund, through the section 75 agreement that has operated under the auspices of the HWBB, for almost a decade. Due diligence will be given to evaluating the options that exist for governing the joint arrangements, with legal and governance leads from both the local authority and the ICB. A report will be brought back to the HWBB at their meeting in December, to outline the options and recommendations.

5. POLICY IMPLICATIONS

Driving integration, the key remit of the Place-based Partnership, is an ambition which aligns with the key statutory functions of the Health and Wellbeing Board and which includes setting the

strategic direction to improve health and wellbeing (Department of Health and Social Care (2022) Health and Wellbeing Boards – Guidance. Available at: Health and wellbeing boards – guidance - GOV.UK (www.gov.uk)).

The proposals and next steps outlined within this report, offer the Health and Wellbeing Board greater influence over the planning, delivery and commissioning of health and care services within Blackburn with Darwen, in order to ensure the achievement of the Joint Local Health and Wellbeing Strategy.

6. FINANCIAL IMPLICATIONS

There are no financial implications resulting from this report.

Any subsequent financial matters relating to the Better Care Fund, section 75 Agreement or 256 agreements will be discussed with, and taken through, the relevant governance channels of the Health and Wellbeing Board and/or relevant partner organisations, prior to any action being undertaken.

7. LEGAL IMPLICATIONS

There are no legal implications resulting from this report requiring any explanation and the legislative background has already been set out in the report.

Any subsequent legal matters relating to the Better Care Fund, section 75 Agreement or 256 agreements will be discussed with, and taken through, the relevant governance channels of the Health and Wellbeing Board and/or relevant partner organisations, prior to any action being undertaken.

8. RESOURCE IMPLICATIONS

There are no resource implications resulting from this report.

Any subsequent resourcing matters relating to the Better Care Fund, section 75 Agreement or 256 agreements will be discussed with, and taken through, the relevant governance channels of the Health and Wellbeing Board and/or relevant partner organisations, prior to any action being undertaken.

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.

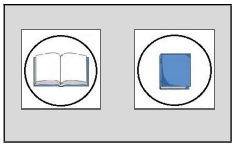
10. CONSULTATIONS

Members of the Health and Wellbeing Board have been engaged as part of the Place-based Partnership development, particularly through their own development sessions in February and June. An update on health and care integration was also presented to BwD Health Oversight Scrutiny Committee in August.

Senior leads from health, care, local authority and voluntary, community, faith and social enterprise sector have and continue to be, engaged in the work of the PBP; in the development and implementation of the Place Integration Deal and the more detailed engagement that is now commencing with place partners, particularly the local authority, in order to understand their specific ambitions for integration in Blackburn with Darwen and opportunities for delegations to be made into the Partnership.

VERSION:	**0.2**

CONTACT OFFICER:	Philippa Cross, Head of Partnership Development, Blackburn with Darwen
DATE:	10.08.23
BACKGROUND PAPER:	Lancashire and South Cumbria Integrated Care Board Place Integration Deal 5th July 2023



Blackburn with Darwen Place Based Partnership Board (Interim)

Terms of Reference

1. PURPOSE OF THE BOARD

The purpose of the Board is two-fold:

1) To provide a vehicle for collaborative working and delivery of health and care services within Blackburn with Darwen, connecting all partners to make joint recommendations as to the effective deployment of resources to drive integration and improved health outcomes.

2) To promote collective responsibility across all partners for the planning and delivery of health and care services within Blackburn with Darwen, in order to achieve the following aims:
    - Improve the health and wellbeing of the population and reduce inequalities
    - Provide services that are of consistently high quality, and that remove unwarranted variation in outcomes
    - Achieve national standards / targets consistently across the sectors within the partnership
    - Maximise the use of a place-based financial allocation and resources

The Board will provide regular assurance updates to the ICB, the Health and Wellbeing Board and partner organisations in relation to activities and items within its remit.

2. DELEGATED AUTHORITY

In this development phase the Place Based Partnership Board (Interim) has no formal delegations in terms of decision making or resources and, at all stages of its operation, individual organisational Boards and Governing Bodies retain statutory status (where applicable) and existing accountability. The Place Based Partnership Board (Interim) 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 Partnership.

3. MEMBERSHIP AND ATTENDANCE

The Board members shall be appointed by the constituent partner organisations, to act as their nominated representatives.

The Board will have seniority of representation so that Members may hold each other and constituent organisations to account for delivering the agreed objectives of the Place Based Partnership.

When determining the membership of the Board, active consideration will be made to equality, diversity and inclusion, including:

- the perspectives of all sectors and types of provider within the place area
- the views and perspectives of patients, carers and the public, along with those from clinical and professional groups, under-represented communities and different geographical perspectives.

The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

Members

- Place based Partnership Board (Interim) Chair
- Director of Health and Care Integration, LSC Integrated Care Board
- Place-based Partnership Clinical and Care Professional Lead, LSC Integrated Care Board
- Director of Adult Social Care, Blackburn with Darwen Borough Council
- Director of Children's Social Care, Blackburn with Darwen Borough Council
- Director of Public Health, Blackburn with Darwen Borough Council
- A Voluntary, Community and Faith Sector Member
- A Primary Care Member drawn from Primary Care Providers or PCN clinical directors
- A Community Services Provider Member
- An Acute Trust Member
- A Mental Health Provider Member
- A Healthwatch Member
- Place Finance Lead, LSC Integrated Care Board

The Board may invite specified individuals to be participants at its meetings in order to inform its recommendations and the discharge of its functions as it sees fit. Such participants will receive advanced copies of the notice, agenda and papers for Board meetings. They may be invited to attend any or all of the Board meetings, or part(s) of a meeting by the Chair. Any such person may be invited, at the discretion of the Chair to ask questions and address the meeting but may not vote.

A Vice-Chair will be nominated and confirmed by the Board at the start of each annual meeting cycle. If the Chair is not in attendance, the Vice-Chair will take on the responsibility of Chair, if neither the Chair nor Vice-Chair are in attendance, then a Chair will be appointed from the floor of those Members present.

4. MEETING QUORACY AND DECISIONS

The Place Based Partnership Board (Interim) shall meet every month. Additional meetings may be convened on an exceptional basis at the discretion of the Chair.

Quoracy

There will be a minimum of one Local Authority member, the Chair or the Director of Health and Care Integration, plus at least one VCFSE Member and one provider representative from either primary, community or acute care.

Where members are unable to attend they should ensure that a named and briefed deputy is in attendance who is able to participate on their behalf.

Decision making

Decisions will only be undertaken within a Board meeting if they are within the scope of the delegated powers given to those Chief/Senior Officers present at the meeting, in line with those officer's organisational delegation frameworks.

Formal decision making on those matters that require financial, service or workforce changes, that sit outside of those delegated powers given to the Chief/Senior Officers present, must be taken through the agreed decision-making process for the relevant organisation(s).

As efficiently as possible following the meeting, for those decisions which are outside the scope of individual officer powers, it is the relevant Chief/Senior Officers who will take responsibility for expediting the decision through their organisational decision-making process.

It is recognised that it is not always possible for those Members who attend on behalf of a whole sector or network, e.g. the VCFSE and primary care, to take decisions on behalf of their network/sector. In instances where decisions are required which would have a direct impact on such a sector/network, the Place Based Partnership and its Members commit to undertaking engagement with a broader range of representatives in order to canvas views and opinions prior to any decision being taken.

Voting

The Board will ordinarily reach conclusions and agree its recommendations by consensus. When this is not possible the Chair may call a vote. Only members of the Board may vote, each member will be allowed one vote and a majority will be conclusive on any matter.

Where there is a split vote, with no clear majority, the Chair of the Board will hold the casting vote. The result of the vote will be recorded in the minutes.

If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

5. RESPONSIBILITIES OF THE BOARD

It is the responsibility of the Place Based Partnership Board, working as a collective of member organisations, to oversee seek assurances of the development and delivery of the following, within the Blackburn with Darwen place:

Collaborative leadership – Creation of a collaborative leadership culture, bringing partners together and building strong working relationships, respecting and valuing unique abilities and contributions, holding each other to account for delivery of agreed outcomes

Collaborative planning – Creation of a shared vision, shared ambitions/objectives and joint delivery plans, aligned to the needs of the communities and the required delivery targets/standards and the Integrated Care Strategy. Enacting the principle of subsidiarity, with decisions taken as close to local communities as possible

Prevention, population health and wellbeing - Ensuring a population health and care based culture, with increased emphasis on wellbeing and prevention. Using a population health and care management approach to address current needs and inequalities, predict future challenges and design anticipatory support

Integrated delivery and transformation - Integrate, with redesign and change where needed, community-based health creation and service delivery across sectors, organisations and professions, improving quality and outcomes, and maximising the use of resources (physical and financial)

Listening to our communities - Listening to the voice of communities to understand their diverse health and care needs, concerns, aspirations and 'what good looks like' from their perspective. Embedding the lived experience of our residents and our workforce and ensure a co-production approach to design, delivery and transformation of all our programmes

Developing our workforce - Ensuring an integrated workforce plan for community-based service delivery across the place. Supporting the development of our workforce as we move to a population health and care based culture, with increased emphasis on wellbeing and prevention

Collective use of resources - Maximising opportunities for collective use of resources through aligning and pooling of budgets to support integrated delivery and maximise the use of community assets. Proactively manage place resources within an agreed financial envelope, moving resources into wellbeing and prevention

Monitoring our progress - Monitoring performance and quality, with a clear focus on outcomes, inequalities and resident experience of health and care services. Being proactive in making use of data and intelligence from all partners to ensure we know where we are making a difference and to support collaborative decision-making.

The Board will also ensure that adequate provision is made to secure the breadth of clinical and care professional leadership advice and influence across the discharge of its functions, in line with the agreed Clinical and Care Professional Leadership Framework for Lancashire and South Cumbria.

6. ACCOUNTABILITY and REPORTING ARRANGEMENTS

The Place Based Partnership Board (Interim) is established locally and jointly by the relevant local organisations as equal partners and accountability is maintained through statutory and local frameworks.

It will report regularly to the Blackburn with Darwen Health and Wellbeing Board and the LSC Integrated Care Board, on its activities relating to collaborative delivery and on-going partnership development. Update reports will be made available to other organisational Boards and networks as required.

The Board will receive scheduled assurance report from its delivery groups, which include but are not limited to:

- Children's Partnership Board
- Live Well Board (TBC)
- Age Well Partnership
- Dying Well Board (TBC)
- PCN Delivery Group

The Board will also assure itself that adequate arrangements are in place to involve people and communities in the work of the Place Based Partnership and that such arrangements are in line with the ICB Working with People and Communities Strategy.

7. BEHAVIOURS AND CONDUCT

In acting as a Member of the Place Based Partnership Board (Interim) each member will share accountability for the delivery of the responsibilities, priorities and plans of the Partnership. Members will create a leadership model that is collaborative, distributed and democratic, ensures equity of voice from all partners and engenders high levels of trust.

It is expected that Members will ensure they have access to and have appropriately engaged with, relevant networks, in a timely manner so as to ensure they are able to take informed decisions as part of the Board.

Members will also commit to conducting their business in line with the values, objectives and ways of working in line with the Nolan Principles of Public Life and in accordance with their own professional or clinical Codes of Conduct.

Members will put the interests of residents, patients, carers first and be prepared to challenge and change organisational, or individual, role restrictions where this is required to secure the greatest benefit whilst observing the current legal framework and their statutory obligations.

Equality and diversity

Members must demonstrably consider the equality, diversity and health equity implications of decisions they make.

8. DECLARATIONS OF INTEREST

Members are expected to declare any interests in line with the Partnership's Management of Conflicts of Interest Guidance (Appendix A).

Anyone with a relevant or material interest in a matter under consideration may be excluded from the discussion at the discretion of the Board Chair.

9. ADMINISTRATION

The Board shall be supported with an administration function which will include ensuring that:

- The agenda and papers are prepared and distributed in a minimum of one week prior to the meeting date, having been agreed by the Chair with the support of the relevant executive lead
- A forward plan of up-coming decision and discussion items is maintained and provided to Members, so as to ensure Members have advance awareness of future business, in order to most effectively consider their input alongside that of the networks or organisations they may represent
- Good quality minutes are taken and agreed with the Chair and that a record of matters arising, action points and issues to be carried forward are kept;
- The Board is updated on pertinent issues/ areas of interest/ policy developments;
- Action points are taken forward between meetings by the nominated Member and progress against those actions is monitored and recorded.

10. REVIEW

The Board will review its effectiveness at least annually and complete an annual report submitted to the Integrated Care Partnership, the Integrated Care Board, and the Health and Well Being Board, alongside the Boards of member organisations and other relevant bodies.

In the development phase of the Partnership, the Board will review these terms of reference prior to moving into its next phase of maturity (approximately six months) and then at least annually, or more frequently if required.

The Board will utilise a continuous improvement approach in its delegation and all members will be encouraged to review the effectiveness of the meeting at each sitting.

Date of approval: 23rd May 2023

Date of review: 1st April 2024

NHS
Lancashire and South Cumbria
Integrated Care Board

Integrated Care Board

Date of meeting	5 July 2023
Title of paper	The Place Integration Deal
Presented by	Kevin Lavery, Chief Executive Claire Richardson, Director of Health and Care Integration (Blackburn with Darwen)
Author	Dr Victoria Ellarby, Programme Director – System Reform Claire Richardson, Director of Health and Care Integration (Blackburn with Darwen)
Agenda item	9
Confidential	No

Executive summary

This paper sets out a vision for our four Lancashire and South Cumbria places and puts forward a Place Integration Deal (Appendix A) describing the way places will operate as part of the Integrated Care Board (ICB).

The report outlines the key content of the Place Integration Deal:

- **Why** the Place Integration Deal is key to meeting national and local expectations and ambitions, and in delivering our vision
- **What** will be planned and delivered in places
- **How** the Place Integration Deal could be implemented through a phased approach

It sets out how the Place Integration Deal will enable delivery of improved experiences and outcomes for our residents through moving resources and decision-making closer to our communities, and by greater involvement of our communities in decision-making.

Implementation of the Place Integration Deal is likely to be a 2-to-3-year journey for our places and key partners. A phased approach to implementation of the Place Integration Deal, and the high-level risks and mitigations associated with this programme of work are outlined for the Board.

Once agreed, this Deal will pave the way for further innovations in integrated working with local government and wider partners in place, which will be critical to ensuring our residents have healthy communities, high quality services and a health and care service that works for them.

Recommendations

The Board is requested to:

1. Note the content of the report.

2. Approve the proposed Place Integration Deal including the direction of travel, the scope in relation to the ICB and early priorities for delivery in places
3. Note that the next steps following Board approval will be to develop a phased approach to implementation of the Place Integration Deal.
4. Note the associated risks and mitigations.
5. Receive a further report on progress on delivery of place priorities and implementation of the Deal in September 2023.

Which Strategic Objective/s does the report contribute to		**Tick**
1	Improve quality, including safety, clinical outcomes, and patient experience	✓
2	To equalise opportunities and clinical outcomes across the area	✓
3	Make working in Lancashire and South Cumbria an attractive and desirable option for existing and potential employees	✓
4	Meet financial targets and deliver improved productivity	✓
5	Meet national and locally determined performance standards and targets	✓
6	To develop and implement ambitious, deliverable strategies	✓

Implications

	Yes	**No**	**N/A**	**Comments**
Associated risks	✓			*High level risks identified with associated mitigations*
Are associated risks detailed on the ICB Risk Register?	✓			*Risk ICB-016 – a key mitigation for this risk is the implementation of the Place Integration Deal*
Financial Implications	✓			*Initial financial implications identified. Further work to determine impact will be undertaken during 2023/4*

Where paper has been discussed (list other committees/forums that have discussed this paper)

Meeting	**Date**	**Outcomes**
Current place-based partnership forums	April – June 2023	Feedback used to support iterations of Place Integration Deal
ICB Executive Team	23 May 2023 06 June 2023	Supported direction of travel
ICB/Local Authority CEOs	12 June 2023	Supported direction of travel and priorities
ICB Board Development session	21 June 2023	Provided feedback. Supported direction of travel and priorities

Conflicts of interest associated with this report

Not applicable

Impact assessments

	Yes	**No**	**N/A**	**Comments**
Quality impact assessment completed		✓		

Equality impact assessment completed		✓		
Data privacy impact assessment completed		✓		

Report authorised by:	Kevin Lavery, Chief Executive

The Place Integration Deal

1. Introduction

1.1. Delivering improvements in health and wellbeing and putting our population's needs at the heart of everything we do requires the Integrated Care Board (ICB) to organise and deliver care at the most appropriate level and closest to the residents we serve. Our four places are at the heart of this and will be a key driving force in ensuring our residents have healthy communities, high quality services, and a health and care service that works for them.

1.2. This paper sets out a vision for our places and puts forward a Place Integration Deal (Appendix A) describing the way places will operate as part of the ICB. Once agreed, this Deal will pave the way for further innovations in integrated working with local government and wider partners in place.

1.3. Implementation of the Place Integration Deal is likely to be a 2-to-3year development journey for our places, our partners, and our system. It is our intention to move forward with a common ambition, a clear direction of travel and, most importantly, a clear articulation of the impact on improving experience and outcomes for our residents.

2. Our vision for places as part of the integrated care system

2.1 It is our ambition in Lancashire and South Cumbria to have a world class, all age, community centric, integrated care system which has our four places at its heart, driving the transformation and changes that we need to see to improve health and care outcomes and experiences for our population.

2.2 Our aims are:

- A **much stronger focus on prevention**, transforming health and care services from being reactive to proactive, and designing new and improved prevention strategies.

- A **step change in community-based services**, with much greater integration of planning and provision between the NHS and local councils.

- **Delivering world class care** for priority diseases, conditions, population groups and communities.

- **Getting better value from our collective resources** – money, people, buildings and digital assets.

- **Using data and intelligence to focus on local needs**, making better use of what is available across different organisations to inform planning and delivery

- **Strengthening of places and neighbourhoods** to ensure decision-making happens closer to and with local people, moving resources and changing the way organisations invest in, provide and manage services.

2.3 These aims will be delivered more effectively through the implementation of the Place Integration Deal, where resources from the ICB and other partners over time are embedded further into our neighbourhoods and places. In the future, delegated decision making will support further aligning and/or pooling of resources with local authorities, ensuring a targeted approach to local need and making better use of our collective resources.

2.4 Our places will continue to deliver against a number of common priorities during the remainder of 2023/24:

- Population health – addressing inequalities
- Primary care – development of Integrated Neighbourhood Teams (INTs) and transformation
- Scope of the Better Care Fund (BCF) and Section 75/256 agreements regarding pooling of resources
- Community services – transaction and transformation
- Continuing Health Care

These workstreams reflect the Transforming Community Services element of the ICB recovery and transformation plan, encompassing community services, integrated neighbourhood teams and enhanced care at home, ensuring a strong interface remains across the ICB and each place.

2.5 This clear set of common priorities will ensure our ICB ambitions are better targeted to meet the needs of local populations, to be more effective in improving outcomes and reducing inequalities.

2.6 The Directors of Health and Care Integration (DsHCI) hold responsibilities as convenors of partners in places around agreement and delivery of shared priorities. Empowering them further, through a clear set of delegations, will ensure agile and responsive decision making for the ICB.

3. The Place Integration Deal

3.1 The Place Integration Deal sets out the way in which places will operate as part of the integrated care system, specifically in relation to the ICB. It describes:

- **Why** the Place Integration Deal is key to meeting national and local expectations and ambitions, and in delivering our vision

- **What** will be planned and delivered in places

- **How** the Place Integration Deal could be implemented, through a phased approach

Why the Place Integration Deal is key to meeting national and local expectations and ambitions, and in delivering our vision

3.2 Many recent national publications set out expectations and ambitions regarding the role of places. Our own vision, local expectations and ambitions as an ICB and wider system are fully aligned with these. The Place Integration Deal embodies these ambitions. It will enable deeper integration of all age health and care; improvement of experiences, outcomes, and population health; and reduce inequalities, by ensuring that decision making and spend on public services is as close to people and communities as possible.

What will be planned and delivered in places

3.3 Key to the Place Integration Deal is the principle that the majority of planning and delivery will happen in our places, with most day-to-day care for individuals and families being delivered in neighbourhoods. The document sets out the way in which places will operate as part of the integrated care system, specifically in relation to the NHS via the ICB, and also outlines which NHS functions / services will be planned and delivered at place.

3.4 These services range from health creation, through to community-based crisis intervention, with a strong focus on those services providing on-going support to allow individuals to remain at home.

3.5 Phasing for the transition to place-based planning and delivery will be structured to ensure those service areas fundamental to the delivery of key operational priorities for our places happen first. Each of the 4 places have agreed a number of integration priorities which will be delivered during 2023-4.

What will be the impact of place integration

3.6 Aligned to the scope of place delivery, our key operational priorities and the phased approach to delegations, a set of core metrics will be used to measure successful integration and delivery in places. An example of what the impact of place integration will mean for local people is outlined within the Place Integration Deal and it is proposed that a set of metrics be developed alongside this, that allow all partners, including residents, to gauge the impact of their collaboration and integrated working.

3.7 A performance reporting framework will also be implemented to enable places to track local progress, and for the ICB to understand how delivery through the four places is contributing to collective achievement across the ICB as a whole.

How the Place Integration Deal will be implemented

3.8 To enable successful implementation of our place-based working, we will need to be clear on what resources (people and funding) are available to support

planning and delivery, and what our governance and decision-making arrangements will be. The Place Integration Deal proposes that a phased approach to the further alignment of people, finances and decision making to our places be developed once the Board has agreed the premise of the Deal.

3.9 Leadership throughout implementation will be driven by the DsHCI, working closely with other ICB teams and partners including the Voluntary, Community, Faith and Social Enterprise (VCSFE) Sector and our residents.

People employed by the ICB working in place

3.10 Initially a core team would be deployed into place which, in the first phase, will lead place development and delivery of operational priorities, population health planning and delivery, and place-based communications and engagement. Wider ICB team members will then be aligned, in line with the agreed scope and phasing plan. Opportunities for greater alignment with people/teams from partner organisations will also be explored during implementation.

Financial allocations to place

3.11 The financial allocations to places will be defined by the agreed scope of the Place Integration Deal. The following are proposed to be implemented by April 2024, with accountability / responsibility being to the DsHCI in the first instance:

- BCF (already jointly managed with local authorities)
- Population Health

3.12 Further work is required to identify budgets that are most appropriate to be managed at place level (or in neighbourhoods) and timeframes for delegation. Detailed work is needed to determine allocation methodologies, with various options for consideration including historic budgets (based on CCG footprints/spend), population size (resident / GP registered), and/or health inequality/deprivation adjusted. Any risks and mitigating actions associated with financial allocations in place will be considered as part of this work.

3.13 A key ambition of the Place Integration Deal is to further develop pooled budget arrangements, bringing together spend across the NHS, local authority and wider partners and building on existing Section 75 agreements aligned to the BCF. We will ensure provider involvement in these developments, including the Voluntary, Community, Faith, and Social Enterprise sector, in pathway redesign and system flow in places, aligning incentives where necessary, through our place-based partnership arrangements.

Effective governance and decision-making arrangements

3.14 Robust and inclusive partnership arrangements at each place will be required to a point where they are capable of holding delegations from the ICB and enacting place-based decision-making. The Place Integration Deal sets out the intention to evolve from having place partnership arrangements that act as a

consultative forum to support the DsHCI to becoming committees holding formal delegations.

3.15 Governance arrangements would be developed in a way that allows for differing arrangements in each place, whilst ensuring decisions are taken across places or a system level where it makes sense to do so. Over time, decision-making would be increasingly focused on local population need and create greater transparency and accountability to the public through involvement, engagement, and co-production.

3.16 Further work is required to determine how the transition to place-based arrangements will be enacted through governance and decision-making arrangements in the ICB, and what amendments will need to take place to the existing Scheme of Reservation and Delegation. A task and finish group, led by the ICB Director of Corporate Governance has been established to lead this work.

4. Key risks and mitigations

4.1 The ICB Corporate Risk Register contains the following risk:

ICB-016: There is a risk that places will not develop with sufficient speed and/or with sufficient resources allocated from the ICB directorates because the operating model for the ICB is not yet clear, and therefore the delegations to places/ responsibilities of places are not yet defined, nor the resources to match these. This will result in Places being unable to deliver on the needs of the population as set out in the Integrated Care Partnerships (ICP) Integrated Care Strategy, the ICB's Joint Forward Plan and their own locally defined priorities.

Development and implementation of the Place Integration Deal is a key mitigating action to minimise both the consequence and likelihood of this risk.

4.2 Related to the above, a number of areas of risk have been identified in the course of engaging on the Place Integration Deal, these can be categorised as risks for people (staff and residents), financial risks and potential risks around variation in provision. The phased approach to implementation, as outlined within this report, allows for specific risks to be captured relevant to each theme and mitigations agreed through implementation planning. The Board will be sighted on these risk and mitigations development of Place Integration plans.

4.3 Feedback during engagement has also identified that the Place Integration Deal will benefit from an aligned programme of organisational development to support the transition to place-based ways of working and mitigate risks for our staff. This will be beneficial for the evolving place-based teams as they become more established and take on greater responsibilities for delivery and local decision-making, and senior leaders across key organisations who will be shaping the future of deeper integration, pooled use of resources and joint decision-making.

5. Conclusion

5.1 The paper sets out the vision for places as part of the Lancashire and South Cumbria integrated care system and summarises the key content of the Place Integration Deal (provided as Appendix A). It describes how the Place Integration Deal will enable delivery of improved experiences and outcomes for our residents through moving resources and decision-making closer to our communities, and greater involvement of our communities in decision-making. This will enable deeper integration and allow us to achieve better value from our collective resources.

6. Recommendations

6.1 The Board is requested to:

1. Note the content of the report.
2. Approve the proposed Place Integration Deal including the direction of travel, the scope in relation to the ICB and the early priorities for delivery in places
3. Note that the next steps following Board approval will be to develop a phased approach to implementation of the Place Integration Deal.
4. Receive a further report on progress on delivery of place priorities and implementation of the Deal in September 2023.

Dr Victoria Ellarby, Programme Director – System Reform
Claire Richardson, Director of Health and Care Integration (Blackburn with Darwen)
23rd June 2023

Lancashire and South Cumbria Integrated Care System
Proposals for a Place Integration Deal

ICB Board Meeting
5 July 2023

Our vision for places as part of the LSC system

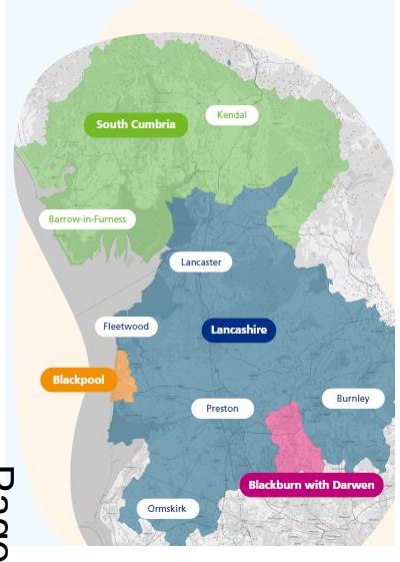
It is our ambition in Lancashire and South Cumbria to have a world class, all age, community centric, integrated care system which has our four places at its heart, acting as the engine room for driving the transformation and changes that we need to see to **improve health outcomes and experiences, responding to the needs of our population.**

Our aims

- A much stronger focus on prevention
- A step change in community-based services to a more integrated approach across health and care
- Delivering world class care for priority diseases, conditions, population groups and communities
- Getting better value from our collective resources
- Using data and intelligence to focus on local needs
- Strengthening places and neighbourhoods to ensure decision-making happens closer to people and with local communities

The impact for our people

What is the Place Integration Deal?



The 'Place Integration Deal' sets out the way in which places will operate as part of the Lancashire and South Cumbria integrated care system, specifically in relation to the NHS Lancashire and South Cumbria Integrated Care Board (ICB).

It describes:

Why
- Why the Place Integration Deal is key to meeting national and local expectations

What
- What will be planned and delivered in places

How
- How the Place Integration Deal will be implemented

This is the first stage of the Place Integration Deal. It sets out the way in which the ICB will work with places at the centre of our integrated care system and lays the foundations for more integrated working with local government.

In line with our strategic narrative for places and the Directors of Health and Care Integration holding shared roles across the NHS and our local authorities, **the next stage will be to consider the '*what*' and the '*how*' from the perspective of local authorities, thus enabling deeper integration in each place**. This will mean agreement to joint leadership, decision making and financial arrangements between the ICB and partners in our places. Detailed design and implementation of the Place Integration Deal is likely to be a 2- to 3-year development journey for our places and those organisations that are key partners in places and across the system.

Year 1 — Increasing maturity of places, the ICB,
- Begin delivery of operational priorities in places as DsHCI act as convenors of place partnerships
- Agreement of Place Integration Deal and start of delegations from ICB to places through DsHCI

Year 2 — and local authorities with earned autonomy
- Formalised delegations from ICB to places, with place-based governance arrangements
- Agreement of local authority delegations to places
- Increased pooling of funding across NHS and local authority

Year 3 — freedom and flexibility for places
- Formalised delegations from local authorities to places, with local decision-making
- Further pooling of funding across NHS and local authority
- Integration of NHS and local authority teams

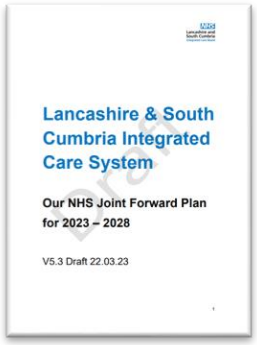
Implementation of the Place Integration Deal will enable delivery of key commitments…

Why

Integrated Care Strategy (April 2023) – five long-term measures of success for our system

Development of this strategy included review and inclusion of key elements from the local authority Health and Wellbeing strategies.

- Early years development
- Years in good health
- Avoidable mortality
- Unemployment rate for the working age population
- Life satisfaction



Joint Forward Plan (March 2023 – in draft) – sets out six long-term measures of success for the NHS

- Improved financial sustainability
- Improved healthy life expectancy
- Enhanced and seamless care provision within our neighbourhoods
- Improved quality of care across all providers
- Improved pathways of care across the system

'Turning challenges into opportunities – The state of our system report' (March 2023) and the ICB financial recovery programme – set out key ambitions for a sustainable system

- All trusts will be high performing
- Maximise efficiency across emergency and elective care
- Rationalize our system for greater efficiency
- Invest in community services
- Reconfigure the ICB itself to support this approach.

The scope in relation to the ICB – key areas of NHS planning and delivery in our places

This is the first stage of the Place Integration Deal. It sets out the way in which places will operate as part of the Lancashire and South Cumbria integrated care system, specifically in relation to the NHS via the ICB and working with key partners. Therefore, we have set out the NHS functions / services where we envisage planning and delivery to happen at place, but recognise that this will evolve over time as places and the ICB mature, and as delegations happen from other partners in place.

What

Health creation	Prevention, self help and care navigation	Anticipatory neighbourhood based care	Ongoing support to remain at home	Community based, short term crisis intervention
• All age population health and wellbeing	• All age population health and wellbeing, including health checks, smoking cessation, healthy weight, etc. • Secondary prevention • Care navigation • Social prescribing	• Population health management approach • Primary care (non-core) • Integrated neighbourhood teams (all age) • Community nursing and therapies (all age) across physical and mental health, learning disabilities and autism • Pharmacy / medicines management	• Long term condition management for specific programmes / specific pathways (e.g., frailty, mental health) • Enhanced care at home – bed and non-bed based	• Falls • Community stroke services • Discharge to Assess • 2-hour urgent community response • Virtual wards • Primary Care Enhanced Access and Out-of-Hours • Mental health initial response service • Continuing Health Care • Care market sustainability • Winter operational schemes

Greater use of a population health management approach to planning
Joint commissioning in place, including VCFSE commissioned services and the scope of the Better Care Fund
Engagement, coproduction and evaluation with our communities

Maintaining clear focus on delivery - priorities across our places

Lancashire and South Cumbria Integrated Care Partnership

NHS Lancashire and South Cumbria Integrated Care Board

What

Operational delivery

From 2023/24

Common priorities for operational delivery through leadership in places from 2023/24

- Population health – addressing inequalities
- Primary care – development of Integrated Neighbourhood Teams (INTs) and transformation
- Scope of the Better Care Fund (BCF) and Section 75/256 agreements
- Community services – transaction and transformation
- Continuing Health Care (CHC)

	Phase 1	Phase 2	Phase 3
Blackburn with Darwen	• Integrated neighbourhoods incl. Physical, Mental, Family Hubs & Fuller * • Improve care sector quality * • Focused interventions based on need – start, live, age, die well – frailty • Community services (incl. enhanced care at home) • Population health • Winter operational schemes (*inc meds optimisation)	• CHC and Personal Health budgets – roll out wider • Discharge to assess and effective step-up care • Local primary care quality and access improvement (GP) • Joint commissioning opportunities with Council • Focused interventions based on need – start, live, age, die well – mental health	• Local primary care quality and access improvement (dental, optometry, pharmacy) • Focused interventions based on need – start, live, age, die well – children and young people
Blackpool	• Continuing Health Care / Personalised Health Budgets • Community services – transaction / transformation (including enhanced care at home) • Focused interventions based on need – specific cohorts	• Long term conditions pathways • Personal Health budgets – roll out wider (offer to host on behalf of all areas)	
South Cumbria	• Community wellness centre • Enhanced Care at Home programme • Workforce model – Local workforce analysis • Whole System Flow Programme • Thriving Communities - alignment of Community Development; Population Health & Public Health priorities and programmes	• Community wellness centre • MBRN roll out south Cumbria (subject to investment proposal) • Whole System Flow programme • Joint governance arrangements between ICB and Local Authority (to oversee the BCF and Section 75/256 agreements) • Focussed interventions based on need – reflecting JSNA	• Community wellness centre • Whole System Flow Programme • Focused interventions based on need – reflecting JSNA
Lancashire	• Integrated Commissioning of Care at Home Services • Alignment of Care Navigation/ Brokerage of Care Sector • ASC and ICB workforce-agreed approach to recruitment and rostering of agency workers • Discharge to Assess (D2A)	• Learning Disabilities Pooled Budgets	• Urgent Care Services (such as out of hospital emergency care, including Urgent Treatment Centres, and on the day urgent Primary and Community Care) • TBC following engagement with District Council Chief Execs

Impact for our people

Lancashire and South Cumbria Integrated Care Partnership

NHS Lancashire and South Cumbria Integrated Care Board

Considering the scope of place, the phased approach to delegations, and the priority areas for delivery, we envisage that a core set of metrics could be adopted to measure successful integration and the impact of integration in our places. These will evolve as our places increase in maturity and further work will be undertaken with residents and partners in order to scope what these metrics could be.

What

People will live in a places that actively supports economic development and has a culture of enabling them and their families to take care of themselves and their communities

People will have to access help, advice and signposting when they need it

People will get more help or support in the community to help them remain at home

People get the right care, from a trained professional, in the right place, when they need it

People will receive intensive, short term care or longer term support in the community, which enables them to maintain their independence, or in some cases remain safe

Initial Metrics

Smoking cessation rates

Annual health checks for people with a learning disability

Access to mental health support for children & young people

Access to GP appointments

People 65+yrs with a recorded frailty score have a care plan

Use of 2hr urgent community response

Lengths of hospital stays

Phased approach to governance arrangements

We recognise that delegation of decision-making to places will evolve as as our places and the ICB mature, and as confidence grows in place-based ways of working. Our decision making arrangements in place will evolve across three stages of maturity – 'in development', 'in shadow' and 'ready for delegation'.

In development

- Interim Place-Based Partnership Board established as a 'consultative forum'
- Partners come together to undertake the core responsibilities of each place
- This may be through:
  - Members of the board having delegated decision-making from their own organisation;
  or
  - The consultative forum making recommendations for approval by individual organisations

In shadow

- Place-Based Partnership Board confirmed as a 'shadow board' and operates as if it has delegations
- DHCI has delegated authority from the ICB around any NHS budget allocated to place
- Some DsHCI may also have delegated authority from the upper tier/unitary local authority, depending on their role
- DHCI exercises some/all delegations via the Place-Based Partnership Board to support collective decision-making between partners in place

Ready for delegation

- Place-Based Partnership Board fully constituted as a committee of the ICB (or a joint committee of the ICB and local authority if local authority delegations are also included)
- There is an appointed chair of the Place-Based Partnership
- Terms of Reference are formally agreed by all place partners
- The ICB SORD (and local authority Constitution if relevant) confirm any delegations
- Over time, wider partners may delegate into the committee.

We anticipate all places should have reached this phase by April 2024

Our governance will be an enabler to achieving:

- Improved experiences and outcomes for our local people
- Joined up care and delivery
- Bringing decision-making closer to our local people
- Making decision-making more focused on local population needs
- Creating greater transparency and accountability to the public

HEALTH AND WELLBEING BOARD

TO:	Health and Wellbeing Board
FROM:	Gareth Jones, NHS Lancashire & South Cumbria Integrated Care Board (ICB)
DATE:	5th September 2023

SUBJECT: ICB Joint Capital Plan 23-24 2023

1. PURPOSE

To update the Health and Wellbeing Board NHS Lancashire & South Cumbria ICB Joint Resource Capital Plan Annual Report 2023/24.

2. RECOMMENDATIONS FOR THE HEALTH & WELLBEING BOARD

To note the NHS Lancashire & South Cumbria ICB Joint Resource Capital Plan Annual Report 2023/24.

3. BACKGROUND

The National Health Service Act 2006, as amended by the Health and Care Act 2022 (the amended 2006 Act) sets out that an Integrated Care Board (ICB) and its partner NHS trusts and foundation trusts:

- must before the start of each financial year, prepare a plan setting out their planned capital resource use
- must publish that plan and give a copy to their integrated care partnership, Health & Well-being Boards and NHS England
- may revise the published plan - but if they consider the changes significant, they must re-publish the whole plan; if the changes are not significant, they must publish a document setting out the changes.

In line with the amended 2006 Act, ICBs are required to publish these plans before or soon after the start of the financial year and report against them within their annual report.

The template for the 2023/24 plan was provided by NHS England, with a requirement to submit this to NHSE alongside the finance system and provider planning templates by the final plan submission date of 30 March 2023 which was done to the deadline specified.

4. RATIONALE

The Health and Care Act 2022 established ICBs with effect from 1 July 2022. Under sections 14Z56 and 14Z57, systems are required to publish the joint capital resource use plan before the start of the year and publish any significant amendments to that plan. They are also required to share the final plan with the Integrated Care Partnership's Board, each relevant Health and Wellbeing Board and NHS England.

5. KEY ISSUES

In 2022/23 the ICB incurred capital expenditure of £212m; £209m in providers and £3m in primary care. This was funded by £95m of trust internal resources, £23m of approved loans and lease liabilities and £94m of national Public Dividend Capital (PDC) funding. Of the £94m PDC funding £19m was spent on community diagnostic centres and a further £24m went to supporting recovery of elective activity. The key priorities for 2023/24 are the completion of the elective recovery and community diagnostic centre schemes as well as the eradication of Reinforced Autoclaved Aerated Concrete (RAAC) from Trust premises. Further priorities are the implementation of electronic patient record systems where these are not currently present or fit for purpose as well as reducing backlog maintenance in Trust estates. Funding is also anticipated for the development of the business case to develop the Royal Preston and Lancaster Royal Infirmary sites as part of the New Hospital Program.

6. POLICY IMPLICATIONS

Community Diagnostic Centres and Elective Recovery schemes represent a prioritisation process that was operated by the system. EPR funding has been directed towards those organisations with the lowest digital maturity. Capital funding was allocated between providers based on their need to replace existing assets by using depreciation as the basis allocating funding.

7. FINANCIAL IMPLICATIONS

The main risk to capital plans in 2023/24 is the risk of inflation creating an in-year pressure on budgets. The risk will be managed through tight monitoring of spend in-year. Given the ICB and provider track records of spending within capital allocations the risk is considered as low risk.

8. LEGAL IMPLICATIONS

The ICB Joint Capital Plan 2023/24 is provided to the Health and Wellbeing Board as required by s.14Z56(5)(c) Health and Care Act 2022. If the ICB Joint Capital Plan 2023/24 is subsequently revised, a copy will be provided to the Health and Wellbeing Board as required by s.14Z57(3)(ii) Health and Care Act 2022.

9. RESOURCE IMPLICATIONS

The main business case expected to be submitted in 2023/24 is for a new Electronic Patient Records (EPR) system at Blackpool Foundation Trust with £14.8m planned to be spent in 2022/23 (£23.4m in total). Work will also continue on the NHP business case with £1.2m planned to be spent in year.

10. EQUALITY AND HEALTH IMPLICATIONS

Northwest Ambulance Service NHS Trust (NWAS) operates across all ICBs in the Northwest region and as such the capital expenditure incurred by them directly impacts these systems. The ICB works closely with Cheshire and Merseyside ICB on capital plans for Southport and Ormskirk Hospitals NHS Trust.

11. CONSULTATIONS

None.

VERSION:	**1**

CONTACT OFFICER:	Gareth Jones - NHS Lancashire & South Cumbria ICB
DATE:	5th September 2023
BACKGROUND PAPER:	None

Joint capital resource use plan – 2023/24

REGION	**North West**
ICB / SYSTEM	**NHS Lancashire and South Cumbria ICB**

Introduction

Figures based on M11 forecast outturn and exclude the impact of IFRS16.

In 2022/23 the ICB incurred capital expenditure of £212m; £209m in providers and £3m in primary care. This was funded by £95m of trust internal resources, £23m of approved loans and lease liabilities and £94m of national Public Dividend Capital (PDC) funding. Of the £94m PDC funding £19m was spent on community diagnostic centres and a further £24m went to supporting recovery of elective activity.

The key priorities for 2023/24 are the completion of the elective recovery and community diagnostic centre schemes as well as the eradication of Reinforced Autoclaved Aerated Concrete (RAAC) from Trust premises. Further priorities are the implementation of electronic patient record systems where these are not currently present or fit for purpose as well as reducing backlog maintenance in Trust estates. Funding is also anticipated for the development of the business case to develop the Royal Preston and Lancaster Royal Infirmary sites as part of the New Hospital Program.

Assumed Sources of Funding for 2023/24

As shown in Annex A, the total capital programme for 2023/24 is £184.6m. Excluding the impact of IFRS 16 the plan is £174m with the funding for this being as follows:

- Trust own resources £107m
- Pre-approved loan funding £1m
- PDC £63m
- Primary care £3m

This is considered to be low risk as all the funding has been confirmed.

Overview of Ongoing Scheme Progression

In 2023/24 several large schemes which started in previous years will continue the main ones being:

- Elective Recovery £25m
- Community Diagnostic Centres £10m
- Eradication of RAAC £3m
- Front line digitisation £15m
- New Hospitals Programme (NHP) - ongoing development of the business case

Risks and Contingencies

The main risk to capital plans in 2023/24 is the risk of inflation creating an in-year pressure on budgets. The risk will be managed through tight monitoring of spend in-year. Given the ICB and provider track records of spending within capital allocations the risk is considered as low risk.

Business Cases in 2023/24

They main business case expected to be submitted in 2023/24 is for a new Electronic Patient Records (EPR) system at Blackpool Foundation Trust with £14.8m planned to be spent in 2022/23 (£23.4m in total). Work will also continue on the NHP business case with £1.2m planned to be spent in year.

Cross System Working

Northwest Ambulance Service NHS Trust (NWAS) operates across all ICBs in the Northwest region and as such the capital expenditure incurred by them directly impacts these systems.

The ICB works closely with Cheshire and Merseyside ICB on capital plans for Southport and Ormskirk Hospitals NHS Trust.

Capital Planning & Prioritisation

Community Diagnostic Centres and Elective Recovery schemes represent a prioritisation process that was operated by the system.
EPR funding has been directed towards those organisations with the lowest digital maturity.
Capital funding was allocated between providers based on their need to replace existing assets by using depreciation as the basis allocating funding.

NHS
Lancashire and South Cumbria
Integrated Care Board

Annex A – NHS Lancashire and South Cumbria ICB 2023/24 CAPITAL PLAN

	CDEL	Lancashire and South Cumbria ICB £000	Blackpool Teaching Hospitals NHS Foundation Trust £000	East Lancashire Hospitals NHS Trust £000	Lancashire and South Cumbria NHS Foundation Trust £000	Lancashire Teaching Hospitals NHS Foundation Trust £000	Northwest Ambulance Service NHS Trust £000	University Hospitals of Morecambe Bay NHS Foundation Trust £000	Total Full Year Plan £000
Provider	Operational Capital		21,139	14,011	14,353	22,370	23,787	19,215	114,875
ICB	Operational Capital	3,113							3,113
	Total Op Cap		21,139	14,011	14,353	22,370	23,787	19,215	117,988
Provider	Impact of IFRS 16		0	4,970	0	362	4,672	0	10,004
ICB	Impact of IFRS 16	504							504
Provider	Upgrades & NHP Programmes		0	0	0	880	0	350	1,230
Provider	National Programmes (diagnostics, Front line digitisation, Mental Health, TIF)		22,748	4,924	1,408	12,708	0	10,667	52,455
Provider	Other (technical accounting)		0	2,375	1	0	0	0	2,376
	Total system CDEL	3,617	43,887	26,280	15,762	36,320	28,459	30,232	184,557

Lancashire & South Cumbria

ICS Total **QE1**

CDEL		Total Plan Months 1-12	Total Expenditure Months 1-3	Total Budget Months 4-12	Narrative on the main categories of expenditure Period covered M1 - M12
Provider	Operational Capital	110,539	12,142	98,397	Main areas of spend include backlog maintenance (£11m), Routine maintenance (£15m), Equipment (£14m), IT (£16m), Fleet and Vehicles (£12m) and various new build schemes (£34m). Sources of funding £6.4m of RAAC Plank remiedial works funded by PDC. £2.7m pre-approved emergency loan funding. Remainder is self financed.
ICB	Operational Capital	3,117	0	3,117	Primarily Gp IT (£2.9m).
	Total Op Cap	**113,656**	**12,142**	**101,514**	
Provider	Impact of IFRS 16	9,121	0	9,121	New equipment leases (£3m), new vehicle leases (£3.5m) and new building leases (£1.4m). Remainder is lease re-measurements
ICB	Impact of IFRS 16	0	0	0	
Provider	Upgrades and NHP Programmes	9,060	1,158	7,902	£1m NHP and £8m pathology collaboration. Pathology scheme still awaiting approval.
Provider	National Programmes (diagnostics, Front line digitisation, Mental Health, TIF)	51,918	1,175	50,743	Elective recovery (£30m), CDC (£7m), Frontline digititisation (£1.6m)
Provider	Other (technical accounting)	2,294	573	1,721	PFI capital charges (residual interest)
	Total system CDEL	186,049	15,048	171,001	