Lancashire County Council

Health Scrutiny Committee

Tuesday, 24th September, 2019 at 10.30 am in Cabinet Room 'C' - The Duke of Lancaster Room, County Hall, Preston

Agenda

Part I (Open to Press and Public)

No.	Item	
1.	**Apologies**	
2.	**Constitution: Chair and Deputy Chair; Membership; Terms of Reference of the Health Scrutiny Committee and its Steering Group**	(Pages 1 - 10)
3.	**Disclosure of Pecuniary and Non-Pecuniary Interests** Members are asked to consider any Pecuniary and Non-Pecuniary Interests they may have to disclose to the meeting in relation to matters under consideration on the Agenda.	
4.	**Minutes of the Meetings Held on 14 May 2019 and 26 June 2019**	(Pages 11 - 20)
5.	**Lancashire and South Cumbria Integrated Care System - Update on the five year strategy**	(Pages 21 - 114)
6.	**Our Health Our Care Programme - Update on the future of acute services in central Lancashire**	(Pages 115 - 130)
7.	**Report of the Health Scrutiny Steering Group**	(Pages 131 - 144)
8.	**Health Scrutiny Work Programme 2019/20**	(Pages 145 - 158)

Lancashire County Council

9. Urgent Business

An item of urgent business may only be considered under this heading where, by reason of special circumstances to be recorded in the Minutes, the Chair of the meeting is of the opinion that the item should be considered at the meeting as a matter of urgency. Wherever possible, the Chief Executive should be given advance warning of any Member's intention to raise a matter under this heading.

10. Date of Next Meeting and Future Meetings

The next meeting of the Health Scrutiny Committee will be held on Tuesday 5 November 2019 at 10.30am at County Hall, Preston.

Subsequent meetings will be held at 10:30am on Tuesdays as follows:

- 3 Dec 2019
- 4 Feb 2020
- 31 Mar 2020
- 12 May 2020

L Sales
Director of Corporate Services

County Hall
Preston

Health Scrutiny Committee
Meeting to be held on Tuesday, 24 September 2019

Electoral Division affected:
None;

Constitution: Membership; Chair and Deputy Chair; and Terms of Reference of the Health Scrutiny Committee and its Steering Group
(Appendix A refers)

Contact for further information:
Gary Halsall, Tel: (01772) 536989, Senior Democratic Services Officer (Overview and Scrutiny), gary.halsall@lancashire.gov.uk

Executive Summary

This report sets out the constitution, membership, chair and deputy chair and terms of reference (remit) of the Health Scrutiny Committee for the municipal year 2019/20.

Recommendation

The Committee is asked to note:

i. The appointment of County Councillors Peter Britcliffe and Stuart Morris as Chair and Deputy Chair of the Committee for the remainder of the 2019/20 municipal year;

ii. The new Membership of the Committee following the County Council's Annual Meeting on 23 May 2019; and

iii. The Terms of Reference of the Committee.

Background and Advice

i) Constitution and Membership of the Health Scrutiny Committee

The Full Council, at its meeting on 23 May 2019, agreed that the Health Scrutiny Committee shall comprise 12 County Councillors (on the basis of 7 Conservative, 4 Labour and1 from either the Liberal Democrat or Independent groups) and 12 non-voting co-opted members, with each District Council being invited to nominate a representative.

It was also agreed that County Councillor nominations to serve on the Committee should be submitted to the Director of Corporate Services by the respective Political Groups. Accordingly, the membership of the Committee, as confirmed by the Political Group Secretaries and the 12 Lancashire District Councils, is as follows:

Lancashire County Council

County Councillors (12):

P Britcliffe	S Morris
J Burrows	E Pope
S Charles	K Snape
J Fillis	P Steen
N Hennessy	C Towneley
M Iqbal	D Whipp

Non-voting co-opted members (12):

Burnley Borough Council	-	Councillor Gordon Lishman
Chorley Council	-	Councillor Margaret France
Fylde Borough Council	-	Councillor Viv Willder
Hyndburn Borough Council	-	Councillor Glen Harrison
Lancaster City Council	-	Councillor Tim Dant
Pendle Borough Council	-	Councillor Tom Whipp
Preston City Council	-	Councillor David Borrow
Ribble Valley Borough Council	-	Councillor Bridget Hilton
Rossendale Borough Council	-	Councillor Sue Brennan
South Ribble Borough Council	-	Councillor David Haworth
West Lancashire Borough Council	-	Councillor Gail Hodson
Wyre Borough Council	-	Councillor Julie Robinson

The Full Council also appointed County Councillors Peter Britcliffe and Stuart Morris as Chair and Deputy Chair of the Committee for the remainder of the 2019/20 municipal year.

ii) Health Scrutiny Steering Group

The Steering Group is made up of the Chair and Deputy Chair of the Health Scrutiny Committee plus two additional members, one each nominated by the Conservative and Labour Groups as follows:

County Councillors (4):

P Britcliffe	J Burrows
J Fillis	S Morris

The Committee's terms of reference (remit) are set out at appendix A.

Consultations

N/A

Implications:

This item has the following implications, as indicated:

Risk management

There are no risk management implications arising from this item.

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

Paper	Date	Contact/Tel

None

Reason for inclusion in Part II, if appropriate

N/A

Part 2 – Article 5 (Overview and Scrutiny)

The council has established the following Overview and Scrutiny Committees:

Committee	Responsibility	Membership
Internal Scrutiny Committee	Review and Scrutinise decisions, actions and work of the Council	12 County Councillors
Health Scrutiny Committee	Statutory responsibility for scrutiny of adult and universal health services	12 County Councillors, plus 12 non-voting co-opted members, nominated by the 12 district councils
Children's Services Scrutiny Committee	Review and scrutinise children and young people's services including the statutory powers of a scrutiny committee as they relate to the NHS.	12 County Councillors, one non-voting co-opted youth council representative, and five non-voting district council members with one member being nominated by each Children's Partnership Board
Education Scrutiny Committee	Review and scrutinise issues around education services provided by the council including those education functions of a Children's Services authority.	16 County Councillors and 5 co-optees, (comprising three Church representatives and two parent governor representatives) who shall have voting rights in relation to any education functions which are the responsibility of the Executive
External Scrutiny Committee	Review and scrutinise issues, services and activities carried out by external organisations	12 County Councillors

All Overview and Scrutiny Committees have the following Terms of Reference:

1. To review decisions made, or other action taken, in connection with the discharge of any functions which are undertaken by the Cabinet collectively, or in the case of urgent decisions which cannot await a Cabinet meeting by the Leader of the Council (or in his/her absence

(Approved and last updated under the Council's Urgent Business Procedure on behalf of the Urgency Committee, 20 June 2017 Owner – Chris Mather)

the Deputy Leader) and the relevant Cabinet Member, or Cabinet committees.

2. To make reports or recommendations to the Full Council, the Cabinet, the Leader, Deputy Leader or other Cabinet Members as necessary or Cabinet committees with respect to the discharge of any functions which are undertaken by them or in respect of any functions which are not the responsibility of the Cabinet.

3. To hold general policy reviews and to assist in the development of future policies and strategies (whether requested by the Full Council or the Cabinet, individual Cabinet members, Cabinet committees, or decided by the Committee itself) and, after consulting with any appropriate interested parties, to make recommendations to the Cabinet, individual Cabinet members, Cabinet committees, Full Council or external organisations as appropriate.

4. To consider any matter brought to it following a request by a County Councillor or a Co-optee of the Committee who wishes the issue to be considered.

5. To consider requests for "Call In" in accordance with the Procedural Standing Orders – Overview and Scrutiny Rules at Appendix C – Appendix 3 of the Constitution

6. To request a report by the Cabinet to Full Council where a decision which was not treated as being a key decision has been made and the Overview and Scrutiny Committee is of the opinion that the decision should have been treated as a key decision

7. To request the Internal Scrutiny Committee to establish task groups and other working groups and panels as necessary.

8. To request that the Internal Scrutiny Committee establish as necessary joint working arrangements with district councils and other neighbouring authorities

9. To invite to any meeting of the Committee and permit to participate in discussion and debate, but not to vote, any person not a County Councillor whom the Committee considers would assist it in carrying out its functions.

10. To require any Councillor, an Executive Director or a senior officer nominated by him/her to attend any meeting of the Committee to answer questions and discuss issues.

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Internal Scrutiny Committee

1. To review and scrutinise all services provided by the authority, unless specifically covered by the Terms of Reference of another Overview and Scrutiny Committee.

2. To consider matters relating to the general effectiveness and development of Overview and Scrutiny in the authority including training for county councillors and co-optees.

3. To consider requests from the other Overview and Scrutiny Committees on the establishment of task groups, and to establish, task groups, and other working groups and panels as necessary, as well as joint working arrangements with District councils and other neighbouring authorities including joint committees to exercise the statutory function of joint health scrutiny committees under the NHS Act 2006.

4. To determine which Overview and Scrutiny Committee considers a particular matter where this is not clear.

5. To establish arrangements for the scrutiny of member development, and receive reports from the Member Development Working Group.

6. To recommend the Full Council to co-opt on to a Committee persons with appropriate expertise, without voting rights

Children's Services Scrutiny Committee

1. To scrutinise matters relating to services for Children and Young People delivered by the authority and other relevant partners.

   The following provisions relating to scrutiny of health and social care relate to services for children and young people:

2. To review and scrutinise any matter relating to the planning, provision and operation of the health service in the area and make reports and recommendations to NHS bodies as appropriate,

3. In reviewing any matter relating to the planning, provision and operation of the health service in the area, to invite interested parties to comment on the matter and take account of relevant information available, particularly that provided by the Local Healthwatch

4. The review and scrutinise any local services planned or provided by other agencies which contribute towards the health improvement and

the reduction of health inequalities in Lancashire and to make recommendations to those agencies, as appropriate

5. In the case of contested NHS proposals for substantial service changes, to take steps to reach agreement with the NHS body

6. In the case of contested NHS proposals for substantial service changes where agreement cannot be reached with the NHS, to refer the matter to the relevant Secretary of State.

7. To refer to the relevant Secretary of State any NHS proposal which the Committee feels has been the subject of inadequate consultation.

8. To scrutinise the social care services provided or commissioned by NHS bodies exercising local authority functions under Section 31 of the Health Act 1999.

9. To draw up a forward programme of health scrutiny in consultation with other local authorities, NHS partners, the Local Healthwatch and other key stakeholders.

10. To acknowledge within 20 working days to referrals on relevant matters from the Local Healthwatch or Local Healthwatch contractor, and to keep the referrer informed of any action taken in relation to the matter

11. To require the Chief Executives of local NHS bodies to attend before the Committee to answer questions, and to invite the chairs and non-executive directors of local NHS bodies to appear before the Committee to give evidence.

12. To invite any officer of any NHS body to attend before the Committee to answer questions or give evidence.

Education Scrutiny Committee

1. To scrutinise matters relating to education delivered by the authority and other relevant partners.

2. To fulfil all the statutory functions of an Overview and Scrutiny Committee as they relate to education functions of a Children's Services Authority.

(Approved and last updated under the Council's Urgent Business Procedure on behalf of the Urgency Committee, 20 June 2017 Owner – Chris Mather)

Health Scrutiny Committee

1. To scrutinise matters relating to health and adult social care delivered by the authority, the National Health Service and other relevant partners.

2. In reviewing any matter relating to the planning, provision and operation of the health service in the area, to invite interested parties to comment on the matter and take account of relevant information available, particularly that provided by the Local Healthwatch

3. In the case of contested NHS proposals for substantial service changes, to take steps to reach agreement with the NHS body

4. In the case of contested NHS proposals for substantial service changes where agreement cannot be reached with the NHS, to refer the matter to the relevant Secretary of State.

5. To refer to the relevant Secretary of State any NHS proposal which the Committee feels has been the subject of inadequate consultation.

6. To scrutinise the social care services provided or commissioned by NHS bodies exercising local authority functions under the Health and Social Care Act 2012.

7. To request that the Internal Scrutiny Committee establish as necessary joint working arrangements with district councils and other neighbouring authorities.

8. To draw up a forward programme of health scrutiny in consultation with other local authorities, NHS partners, the Local Healthwatch and other key stakeholders.

9. To acknowledge within 20 working days to referrals on relevant matters from the Local Healthwatch or Local Healthwatch contractor, and to keep the referrer informed of any action taken in relation to the matter.

10. To require the Chief Executives of local NHS bodies to attend before the Committee to answer questions, and to invite the chairs and non-executive directors of local NHS bodies to appear before the Committee to give evidence.

11. To invite any officer of any NHS body to attend before the Committee to answer questions or give evidence.

12. To recommend the Full Council to co-opt on to the Committee persons with appropriate expertise in relevant health matters, without voting rights.

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13. To establish and make arrangements for a Health Steering Group the main purpose of which to be to manage the workload of the full Committee more effectively in the light of the increasing number of changes to health services.

External Scrutiny Committee

1. To review and scrutinise issues, services or activities carried out by external organisations including public bodies, the voluntary and private sectors, partnerships and traded services which affect Lancashire or its inhabitants, and to make recommendations to the Full Council, Cabinet, Cabinet Members, Cabinet committees or external organisations as appropriate.

2. To review and scrutinise the operation of the Crime and Disorder Reduction Partnership in Lancashire in accordance with the Police and Justice Act 2006 and make reports and recommendations to the responsible bodies as appropriate

3. In connection with 2. above, to require an officer or employee of any of the responsible bodies to attend before the Committee to answer questions

4. To co-opt additional members in accordance with the Police and Justice Act 2006 if required, and to determine whether those co-opted members should be voting or non-voting

5. To review and scrutinise the exercise by risk management authorities of flood risk management functions or coastal erosion risk management functions which may affect the local authority's area

(Approved and last updated under the Council's Urgent Business Procedure on behalf of the Urgency Committee, 20 June 2017 Owner – Chris Mather)

Lancashire County Council

Health Scrutiny Committee

Minutes of the Meeting held on Wednesday, 26th June, 2019 at 11.00 am in Committee Room 'C' - The Duke of Lancaster Room, County Hall, Preston

Present:

County Councillor Peter Britcliffe (Chair)

County Councillors

J Burrows	S C Morris
Mrs S Charles	E Pope
A Cheetham	K Snape
J Fillis	P Steen
N Hennessy	D Whipp
J Mein	

Co-opted members

Councillor B Aitken, Fylde Borough Council
Councillor David Borrow, (Preston City Council)
Councillor Tim Dant, (Lancaster City Council)
Councillor G Hodson, (West Lancashire Borough Council)
Councillor Gordon Lishman, (Burnley Borough Council)
Councillor Tom Whipp, (Pendle Borough Council)

County Councillors A Cheetham and J Mein replaced County Councillors C Townley and M Iqbal respectively. Councillor B Aitken replaced Councillor V Wilder, representing Fylde Borough Council.

1. Apologies

Apologies were received from Councillors M France (Chorley Council), G Harrison (Hyndburn Borough Council), D Howarth (South Ribble Borough Council) and J Robinson (Wyre Borough Council).

2. Disclosure of Pecuniary and Non-Pecuniary Interests

None were disclosed.

3. Call In Request: Decisions taken by Cabinet on 13 June 2019, in relation to the Cabinet Member for Health and Wellbeing's area of responsibility

Following requests from eleven County Councillors in accordance with the Call In procedures, the Committee considered a report outlining the decisions of the Cabinet on 13 June 2019 in relation to the Lancashire Wellbeing Service, the Health Improvement Service and Integrated Home Improvement Services.

The Chair welcomed County Councillor Shaun Turner, Cabinet Member for Health and Wellbeing; Sakthi Karunanithi, Director for Public Health and Wellbeing and Clare Platt, Head of Service for Health, Equity, Welfare and Partnerships.

Presenting the case for the Call In for decisions made relating to the **Lancashire Wellbeing Service** were County Councillor Azhar Ali, along with Teresa Jennings, chief executive of N-Compass North West and Rhaya Barnes, a Lancashire Wellbeing service user.

County Councillor Ali provided additional information, detailing data and financial information showing the benefits of the Lancashire Wellbeing service. This was pre-circulated to the Committee in advance of the meeting and a copy is set out in the minutes.

The Committee considered a number of issues in connection with the original decision, including: the impact on service users; the potential effect on other Lancashire wide services; the financial information provided; the potential for increased costs in other services; the consultees responses; new models of working supported by partner organisations and budget pressures across the county council.

County Councillor Ali proposed that the service be funded for a further twelve months to ensure a smooth transition to the intended new way of working that would provide an efficient proactive method of wellbeing support for the residents of Lancashire.

It was moved by County Councillor Peter Steen and seconded by County Councillor Eddie Pope that the Committee support the decisions made by Cabinet on 13 June 2019 in relation to the Lancashire Wellbeing Service.

The following amendment was proposed by County Councillor David Whipp and seconded by County Councillor John Fillis:

That the Committee request Full Council to review the decisions in relation to the Lancashire Wellbeing Service and decide whether it should be reconsidered as the additional documentation reviewed at the meeting highlighted that the report to Cabinet did not include the full consequential costs and was therefore contrary to the Budget and Policy Framework set by the Full Council.

On being put to the vote the amendment was LOST.

The substantive motion was then put to the vote and was CARRIED.

It was proposed by County Councillor Eddie Pope and seconded by County Councillor Britcliffe that County Councillor Shaun Turner report back to the Health Scrutiny Committee on the progress and success of the community based approach to providing wellbeing support to the residents of Lancashire in six months.

It was therefore:

Resolved: That

(i) The Committee supported the decisions made by Cabinet on 13 June 2019 in relation to the Lancashire Wellbeing service and therefore should not be called in.

(ii) County Councillor Shaun Turner report back to the Health Scrutiny Committee on the progress and success of the community based approach to providing wellbeing support to the residents of Lancashire in six months.

Presenting the case for the Call In for decisions made relating to the **Health Improvement Service** were County Councillor Azhar Ali, along with County Councillor Steven Holgate.

County Councillor Ali provided additional information detailing the social return on investment in targeted exercise and weight loss programmes. This was pre-circulated to the Committee in advance of the meeting and a copy is set out in the minutes.

The Committee considered a number of issues in connection with the original decision, including: the social impact of the service; the availability of similar replacement services; investment in and suitability of alternative facilities for maintaining a healthy lifestyle; potential longer term cost implications; the suitability of digital pathways and the importance of maintaining face to face interaction to promote healthy living; the re-procurement of drug and alcohol rehabilitation services and responding to the consultation to ensure the reduced budget is spent to best effect.

County Councillor Ali proposed that the service remain in place until December 2020 until the emerging neighbourhood services were established to ensure a positive transition.

It was moved by County Councillor John Fillis and seconded by County Councillor David Whipp that the Committee refer the decisions relating to the Health Improvement service back to Cabinet for reconsideration.

On being put to the vote the motion was LOST. It was therefore

Resolved: That

The decisions made by Cabinet on 13 June 2019 in relation to the Health Improvement Service not be referred back to Cabinet for reconsideration.

County Councillor Azhar Ali presented the case for the Call In for decisions made relating to the **Integrated Home Improvement Services**.

The Committee considered a number of issues in connection with the original decision, including the potential longer term cost impact of ceasing the services; the results of the consultation; the potential of utilising alternative funding streams for the service; district councils' role in funding home adaptations and the necessity of effective pathways to ensure correct referrals are made following a hospital discharge.

It was moved by County Councillor John Fillis and seconded by County Councillor David Whipp that the Committee refer the decisions relating to the Integrated Home Improvement Services back to Cabinet for reconsideration. On being put to the vote the motion was LOST. It was therefore

Resolved: That

The decisions made by Cabinet on 13 June 2019 in relation to the Integrated Home Improvement Services not be referred back to Cabinet for reconsideration.

4. Urgent Business

There were no items of urgent business.

5. Date of Next Meeting

The next meeting of the Health Scrutiny Committee will be held on Tuesday 24 September 2019 at 10.30am in Cabinet Room C – The Duke of Lancaster Room, County Hall, Preston.

L Sales
Director of Corporate Services

County Hall
Preston

Lancashire County Council

Health Scrutiny Committee

Minutes of the Meeting held on Tuesday, 14th May, 2019 at 10.30 am in Cabinet Room 'C' - The Duke of Lancaster Room, County Hall, Preston

Present:

County Councillor Peter Britcliffe (Chair)

County Councillors

J Burrows	E Pope
N Hennessy	M Salter
S Holgate	P Steen
S C Morris	C Towneley
M Pattison	

Co-opted members

Councillor David Borrow, (Preston City Council)
Councillor Bridget Hilton, (Ribble Valley Borough Council)
Councillor Alistair Morwood, (Chorley Borough Council)
Councillor Julie Robinson, (Wyre Borough Council)
Councillor Viv Willder, (Fylde Borough Council)

County Councillor Matthew Salter replaced County Councillor Charlie Edwards for this meeting only.

1. Apologies

Apologies were received from Councillors Margaret Brindle, Burnley Borough Council, Barbara Ashworth, Rossendale Council and G Hodson, West Lancashire Borough Council.

2. Disclosure of Pecuniary and Non-Pecuniary Interests

None were disclosed.

3. Minutes of the Meeting Held on 2 April 2019

County Councillor Towneley requested the following points of accuracy be made to the minutes:

Item 5 Whyndyke Garden Village:

Page 5 in the agenda

It was requested that the paths were made multi-use to incorporate the needs of all non-motorised users **including equestrians,** not just walkers and cyclists.

Page 6 in the agenda

1. c) Ensuring that multi-user paths proposed in future developments cover all non-motorised users, **including equestrians** and also extend to the wider network.

The Chair, County Councillor Britcliffe also requested that the following point of accuracy be made to the minutes:

Item 6 Report of the Health Scrutiny Steering Group:

Page 6 in the agenda

Resolved: That;

1. The report be noted.

2. The factual error in relation to the report of Steering Group presented at the Committee's meeting on 11 December 2018 be noted.

Resolved: That subject to the above amendments the minutes from the meeting held on 2 April 2019 be confirmed as an accurate record and signed by the Chair.

4. Social Prescribing

The Chair welcomed Linda Vernon, Healthier Lancashire and South Cumbria Integrated Care System (ICS); Kathryn Kavanagh, West Lancashire Clinical Commissioning Group (CCG) and Christine Blythe, Burnley Pendle and Rossendale Council for Voluntary Service (CVS).

The report presented provided an overview for developing the digital infrastructure to support local social prescribing programmes across the Lancashire and South Cumbria Integrated Care System (ICS).

The Committee provided feedback regarding the report and sought further clarification as follows:

- It was explained that the Healthier Lancashire and South Cumbria ICS viewed social prescribing as a way of enabling people to access the wider community. NHS England described the process as a patient being referred to a link worker to guide them to resources in their area, such as social groups, in order to treat and prevent health issues. Digital social prescribing referred to the technology that could support the process, such as a robust and accurate directory of trusted services and platforms to assist healthcare professionals to make appropriate referrals.

- The GP determined which services best serve patients in terms of health and the digital model explored how this can be achieved without the face to face interaction, when this is the preferred option for the individual. This would help to develop effective pathways that work well for local communities. The NHS long term plan had pledged to fund more link workers within primary care networks across England and their remit would include tackling motivational issues. GP time was still important to explore the problems presented, the best way to address them and how best to signpost the person. It was confirmed that currently in East Lancashire, the CVS link worker connected with the patient and agreed an appropriate personalised pathway. It was noted that not everyone wanted the GP face to face interaction and the digital platform would enable everyone to access social prescribing. Additional funding from East Lancashire Clinical Commissioning Group had enabled the CVS to promote community services.

- Some members expressed concern that the model built expectations to prescribe to voluntary and community organisations that were not sustainable in the longer term due to lack of funding. The Institute of Fiscal Studies (IFS) had warned in a recent report on inequalities of the impact of social determinants on public mental and physical health. Such issues in society would benefit significantly from social prescribing. It was clarified that the NHS funding focus was on providing link workers, however there had to be community services to connect with to enable the initiative to work. Only 20% of health outcomes were related to health care and the rest were influenced by socio economic factors. The CVS were also concerned regarding the impact on organisations as referrals increased. Grants had been made available to such services from CCGs and from other local businesses for social prescribing and further investment would be required, particularly for voluntary organisations. It was confirmed that the West Lancashire CCG also worked with the local CVS to enable a connection with the third sector and this was critical to the success of the initiative. The CCG were able to directly commission services with organisations that were able to provide a contract.

- Some members expressed concern regarding the description as a sickness model rather than a wellness model, and suggested this initiative was duplicating work already in place at district council level. It was explained that the work had been commissioned as a result of people presenting at the GP with no medical issues and the initiative aimed to find an interface to address issues that couldn't be resolved in a short visit with the GP. The work built on collaboration and aimed to prevent duplication by sharing information, including the good work already in place and presenting this to the public. It was suggested that the information from the report be shared with district councils to enhance collaboration and prevent duplication of work.

In response to further questions it was confirmed that:

- The list of social prescribing initiatives in the report provided an example of what was available but was not exhaustive.

- Social isolation in rural communities and the importance of link workers having a good working knowledge of the community they work in had been considered to ensure effective social prescribing to the smallest groups and services. The model was co-produced with GP's and community groups to support a dual health programme.

- Kendal Town Council had teamed up with Lancaster University to create a mobile device application called the 'Mobile Age App' which mapped the directory of services in the area against bus routes to determine the feasibility of accessing social prescribed services. It was anticipated this would identify any gaps in services and the transport infrastructure currently in place.

- The digital work had been undertaken to empower those who preferred this, however it was clear this was not a viable solution for everyone. The digital platform would free up capacity for link workers and healthcare professionals for those who required face to face interaction. The initiative aimed to provide a spectrum of resources. The platform had been co-designed in conjunction with a consultation with service users representing groups such as Age UK to ensure individual needs were taken into consideration.

- Members recommended building links with other local universities as well as Lancaster, such as the University of Central Lancashire and Edge Hill University.

Resolved: That

1. The report giving an overview of key programmes of work for developing the digital infrastructure to support local social prescribing programmes across the Lancashire and South Cumbria Integrated Care System be noted.

2. The Health Scrutiny Committee receive an update on progress with the programme of work in 12 months.

5. The issue of Period Poverty and how it can best be addressed

Andrea Smith, Public Health Specialist presented a report, providing an outline of the issue of period poverty and how engagement with the national government taskforce would further support a collaborative approach across Lancashire.

It was explained that the council were currently awaiting the outcome of the government taskforce recommendations before formulating its response.

In response to questions it was confirmed that:

- It was not clear if the Council's Corporate Communications Group had been requested to carry out a campaign regarding period poverty or if Lancashire Youth Zone had been asked to assist in any campaigns or education programmes. However it was likely that both service areas

would be involved in taking forward the outcome of the government's taskforce recommendations and a further update would be provided.

- It would be beneficial to have a collaborative approach with district councils and other partners such as the providers of school nursing to the task force recommendations.

Members made the following observations:

- The link between period poverty and pupils in receipt of free school meals was highlighted and a member shared their experience in a school working with students on formulating a plan on how best to address the issue. It was suggested that as central government had pledged funding for both primary and secondary schools an action plan could be presented to the Schools Forum.
- With regard to addressing the stigma of period poverty, this should be with regard to people of all ages and gender.

- Members requested more specific detail and information to enable measurement of success. It was confirmed that there was a link within the report for UK data and that the council would link with other counties to understand the issues around stigma and lack of knowledge. The positive work done in local business and groups to raise awareness was also referenced.

Resolved: That

1. The Leader of the Council and the Cabinet Members for 'Health and Wellbeing' and 'Children, Young People and Skills' give consideration to implement an education programme and campaign to address the issue of period poverty across all schools in Lancashire in partnership with Lancashire YouthZone, Lancashire Care Foundation Trust, Blackpool Teaching Hospitals Trust and VirginCare.

2. CC Hennessy be appointed as rapporteur to report to the Health Scrutiny Committee on the activities of the Government's joint taskforce on period poverty in the UK.

6. Report of the Health Scrutiny Steering Group

The report presented provided an overview of matters presented and considered by the Health Scrutiny Steering Group at its meeting held on 17 April 2019.

Resolved: That the report of the Steering Group be received.

7. Health Scrutiny Committee Work Programme 2018/19

The Work Programmes for both the Health Scrutiny Committee and its Steering Group were presented to the Committee.

Resolved that:

1. The report be noted.

2. The work programming for the 2019/20 municipal year would be undertaken by the Health Scrutiny Steering Group at its meeting scheduled for Wednesday 19 June at 10:30am.

8. Urgent Business

There were no items of Urgent Business.

9. Date of Next Meeting

The next meeting of the Health Scrutiny Committee will be held on Tuesday 2 July 2019 at 10.30am in Cabinet Room C – The Duke of Lancaster Room, County Hall, Preston.

L Sales
Director of Corporate Services

County Hall
Preston

Health Scrutiny Committee
Meeting to be held on Tuesday, 24 September 2019

Electoral Division affected:
(All Divisions);

Lancashire and South Cumbria Integrated Care System - Update on the five year strategy
(Appendices A to E refer)

Contact for further information:
Gary Halsall, Tel: (01772) 536989, Senior Democratic Services Officer (Overview and Scrutiny), gary.halsall@lancashire.gov.uk

Executive Summary

The report at appendix A and accompanying documents at appendices B to E provide a high-level overview of the partnership in Lancashire and South Cumbria which is working as an Integrated Care System (ICS) and the progress towards developing a five year strategy for the system in response to the NHS Long Term Plan.

Recommendation

The Health Scrutiny Committee is asked to provide feedback on the Lancashire and South Cumbria Our Next Steps strategic narrative.

Background and Advice

The Committee last received an update on the Integrated Care System at its meeting held on 5 February 2019. At that meeting it was resolved that the Healthier Lancashire and South Cumbria five year local strategy be presented to the Health Scrutiny Committee at its meeting scheduled on 24 September 2019.

The report from Healthier Lancashire and South Cumbria set out at appendix A and the accompanying documents at appendices B to E, provide an update on progress towards developing a five year strategy for the system in response to the NHS Long Term Plan.

Appendices are as follows:

A. Report with progress of the ICS strategy
B. Lancashire and South Cumbria's Our Next Steps strategic narrative
C. Infographics used with staff and public to describe the Lancashire and South Cumbria vision and partnership priorities
D. Healthwatch report summarising insight from 969 people in Lancashire and South Cumbria

Lancashire County Council

E. Lancashire and South Cumbria: Our Population Health Management Journey report

Healthier Lancashire and South Cumbria are planning to publish their five year strategy in November 2019, in accordance with guidance from NHS England and Improvement.

The Health Scrutiny Committee is asked to provide feedback on the Lancashire and South Cumbria Our Next Steps strategic narrative set out at appendix B.

Consultations

N/A

Implications:

This item has the following implications, as indicated:

Risk management

The report and accompanying documents at appendices A to E represent the views of Healthier Lancashire and South Cumbria and Healthwatch and are not those of Lancashire County Council.

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

Paper	Date	Contact/Tel

None

Reason for inclusion in Part II, if appropriate

N/A

Appendix A

Lancashire County Council Health Overview and Scrutiny Meeting Healthier Lancashire and South Cumbria System update	
Integrated Care System update on five year strategy	**Chief Officer:** Dr Amanda Doyle **Executive Director for Commissioning:** Andrew Bennett **Chief Operating Officer for Fylde Coast CCGs:** Peter Tinson **Head of Communications and Engagement:** Neil Greaves
PERIOD OF REPORT	17 September 2019

FOR INFORMATION

1. Introduction

This report provides a high-level overview of the partnership in Lancashire and South Cumbria which is working as an Integrated Care System (ICS) and the progress towards developing a five year strategy for the system in response to the NHS Long Term Plan.

Healthier Lancashire and South Cumbria covers a region made up of five local health and care partnerships - four integrated care partnerships (ICP) and one multi-speciality community provider (MCP). These are Central Lancashire, Pennine Lancashire, Fylde Coast, Morecambe Bay and West Lancashire. These areas provide a way for organisations and groups involved in health and care to build up their local partnerships.

Partners include:

- Clinical Commissioning Groups: Greater Preston, Chorley and South Ribble, East Lancashire, West Lancashire, Blackpool, Fylde and Wyre, Morecambe Bay, Blackburn with Darwen
- Five acute and community trusts: Lancashire Teaching Hospitals NHS Foundation Trust, University Hospitals of Morecambe Bay NHS Foundation Trust, East Lancashire Hospitals Trust, Blackpool Teaching Hospitals NHS Foundation Trust and Lancashire Care NHS Foundation Trust
- Two upper tier councils (Lancashire and Cumbria) and two unitary councils (Blackpool and Blackburn with Darwen)

The integrated care system is clinically led by Dr. Amanda Doyle with support from senior clinicians and managers from every part of Lancashire and South Cumbria.

Earlier in the year and to underpin the development of the ICS partnership, leaders across the Lancashire and South Cumbria ICS produced a document called “Our Next Steps” (appended to this report). This set out a number of priorities for the partnership and forms a foundation for the development of our response to the Long Term Plan.

Our Next Steps sets out our vision for a healthier Lancashire and South Cumbria. The document explains how working in partnership helps us respond to the challenges our communities and front

line professionals are experiencing and how we can use our resources better. We also commit to building stronger alliances between our organisations to realise our ambition that Lancashire and South Cumbria becomes a great place to live and work.

System partners have agreed the eight partnership priorities for changing the way they work together from the Our Next Steps document. These were co-designed with system leaders and have been tested with staff and patient groups through extensive consultation:

- Maximise the benefits of our work in neighbourhoods
- Deliver an integrated health and social care workforce for the future with the capacity and capability to provide sustainable care and support to our local communities.
- Strengthen the resilience and mental health of people and communities
- Establish a group model for all hospital services in Lancashire and South Cumbria
- Reinvigorate strategic partnerships across the public sector
- Establish a public sector enterprise and innovation alliance with our ICS partners, including academic partners and Local Enterprise Partnerships to deliver inward investment and support job creation
- Bring the entire health and social care system back into financial balance
- Consolidate commissioning so that our arrangements for planning and prioritising our resources improve our population's health and the outcomes of health and social care.

This version of Our Next Steps has been developed for system leaders and senior clinical/programme leads and has been developed through discussions with more than 200 individuals from our partner organisations.

The Lancashire Health Overview and Scrutiny Committee was updated on the progress of partnership working and the development of a shadow integrated care system in February 2019 and a workshop was attended with members of the Health Overview and Scrutiny Steering Group in June.

In the previous briefing the Committee were apprised of the executive leadership for the system, examples of progression in priority areas, a financial update and the introduction of a 20 week programme for population health management.

2. Five-year strategy for Lancashire and South Cumbria

Publication of the NHS Long Term Plan

On Monday 7th January 2019, NHS England published the 133-page NHS Long Term Plan which outlines the priorities for the health service over the next decade.

Health leaders across Lancashire and South Cumbria have welcomed the publication of the NHS Long Term Plan. It describes how the NHS will make sure people get the best start in life, and how patients can expect world-class care for major health problems.

The plan also details how different organisations should work closer together to make sure health and care services are more joined up and delivered in the right place and at the right time for local people and their families.

It outlines how services should be joined up within neighbourhoods – geographical communities with populations of typically between 30,000 to 50,000 – to support people to stay well.

The plan clearly endorses what we have been doing for some time here across Lancashire and South Cumbria in terms of partnership working and bringing services together. We enjoy good working relationships with our local authority partners, as well as those from the voluntary, community and faith sector and the many groups of people who volunteer their time to help shape and improve health and care services.

We are confident that closer integration of services and partnership working is vital to improve the experience of patients and also to support people to keep well. People sometimes experience fragmented care when it is provided by several organisations; bringing services and teams closer together will help to reduce this.

Five Year Strategy

The Committee was informed in February that the next step for Lancashire and South Cumbria as outlined in the Long Term Plan is to develop and implement our own five-year strategy for 2019-24. This will set out how we intend to take forward the ambitions set out in the NHS Long Term Plan , and work together to turn these into local action to improve services and the health and wellbeing of the communities we serve.

Over the summer, additional national guidance was published to support the development of ICS strategies. This set out that the intended focus and expectations of the plans that they should:

- Be clinically-led
- Be locally-owned
- Use realistic workforce assumptions
- Be financially-balanced
- Focus on the delivery of the NHS Long Term Plan commitments
- Be based on local need
- Be focused on prevention, reducing health inequalities and unwarranted variation
- Engaged with local authorities
- Drive innovation

The five year strategy is expected to identify a number of clinical service priorities for the system over the next three years. These will include:

- Out of hospital and the development of Primary Care Networks
- Urgent and Emergency Care (to include Respiratory)
- Cancer
- Mental Health, Learning Disabilities and Autism
- Planned Care
- Better Births
- Stroke
- Fragile services e.g. acute paediatrics

Further work is taking place at the current time to identify more precise areas of focus in these clinical areas.

Involvement of local people, staff and stakeholders
We have been working with partners across the system to involve local people and listen to feedback on the key messages within Our Next Steps. We are committed to involving local people, staff and partners in the development of our shared five year strategy.

In developing and setting a five year strategy for Lancashire and South Cumbria we believe this also needs to be built upon high levels of engagement and involvement at the earliest possible stage with a range of stakeholders and will be influenced by the engagement which takes place throughout its development.

A considerable amount of engagement work has taken place over the past two years on a local level upon which the strategy will be built. We want to make sure people have the opportunity to shape the plans at every stage over the coming weeks and months to make sure we have a strategy for Lancashire and South Cumbria which is fit for purpose.

The following engagement and involvement with local people has been undertaken to support the development of the five year strategy:

- 803 people contributed to a local Healthwatch survey on different components of care
- 166 people contributed to a local Healthwatch survey for people with specific conditions
- A programme of focus groups delivered by local Healthwatch working with the five local partnerships is underway with 16 groups already completed
- 397 staff from partner organisations (including NHS, Local Authority, Voluntary, Community, Faith and Social Enterprise and education) have contributed to a survey on proposed partnership priorities
- Our Next Steps has been discussed in partner governing bodies, trust boards, cabinet meetings and in local public involvement forums
- Discussions have taken place with staff in briefings led by leaders of individual organisations
- An event with clinical leaders from across Lancashire and South Cumbria to develop a clinical strategy is planned for 26 September 2019.

We are planning to publish our five year strategy in November in accordance with guidance from NHS England and Improvement.

3. Commissioning Reform
In August 2017, commissioning leaders from CCGs, NHS England and the CSU committed to a programme of work to respond to the changes taking place in commissioning in the light of the Five Year Forward View.

CCG chairs, chief officers and CSU directors have been working together to agree a road map and statement of intent for commissioning reform, in the light of the work undertaken by commissioners and providers in recent years to introduce models of integrated care and the development of Lancashire and South Cumbria as an Integrated Care System.

The agreed road map outlines a direction of travel to establish by April 2021 a single CCG in Lancashire and South Cumbria to act as a strategic commissioner. The CCG would be established as a consequence of the development work to create four maturing Integrated Care Partnerships (ICPs) and 1 Multi-specialty Community Provider (MCP) and enable the development of Primary Care Networks (PCNs) working in neighbourhoods.

These recommendations endorse our agreed place-based approach to commissioning to maximise the contribution made by commissioners at the most appropriate level of place for the services

under consideration. This includes action to be taken at the Lancashire and South Cumbria level. We expect that commissioning will continue to be clinically led.

Commissioning leaders have a clear intention of building on the best work undertaken with our partners to improve health and join up health and care, health care services and community assets in neighbourhoods, integrated care partnerships (ICPs) and across the whole of Lancashire and South Cumbria.

There is a need to address several examples of fragmented or variable commissioning in the current system. Examples include our approach to complex, individual packages of care, cancer and learning disabilities. There are further opportunities to align decision-making for specialised services commissioning more closely to Lancashire and South Cumbria.

This work aims to create a focus for the health and care system to work very differently, agreeing plans to improve the whole population's health, using partnerships to improve the quality of health services and bringing the system back into financial balance.

A single CCG working on the same footprint as the ICS is the typical model expected in the Long Term Plan. Under current statute, the CCG would be established under a constitutional model as a member organisation.

Leaders have committed to be open and transparent with staff and partners about these proposals for commissioning reforms and intend to provide further information in the autumn. It is important to emphasise that for any changes to be formally agreed, a case for change will need to be submitted to NHS England and a process of consulting member practices and partners will also be required.

4. Focus on prevention and population health management

In February 2019, Committee members were informed that nearly half a million pounds was being invested in local communities across Lancashire and South Cumbria by NHS England and Improvement. This funding aimed to tackle the factors which have the greatest impact on people's wellbeing. The ICS was one of four of the first wave of national exemplar areas testing the use of data and intelligence to support improvements in the health of local areas.

The £471,000 investment from NHS England was used to design better care around our communities' needs, a priority described in the NHS Long Term Plan. This included work in Barrow, Blackpool, Burnley, Chorley and Skelmersdale to look at how data and intelligence can be better used by GPs and community services to help people live longer, healthier lives.

The 20 week programme has completed and work is continuing, led by Dr Sakthi Karunanithi, Director for Public Health and Wellbeing for Lancashire County Council and Senior Responsible Officer for Prevention and Population Health for Lancashire and South Cumbria. Lancashire and South Cumbria is one of four areas in the country to be recognised as leading the way in starting to improve outcomes, reduce inequalities and address the broad range of individual, social and economic factors affecting the wellbeing of local people.

Taking a whole population approach means working collaboratively beyond the boundaries of health and care services to support people to stay healthy and avoid complications from existing illnesses. It will enable care to be delivered in the right place and at the right time for local people and their families.

A Lancashire and South Cumbria: Our Population Health Management Journey report has been enclosed with this briefing.

Videos are available to watch the progress of this work in these five neighbourhoods:

- Barrow: https://www.youtube.com/watch?v=zxrR_NEKUEM
- Blackpool: https://www.youtube.com/watch?v=JGLq4WEAWog
- Burnley: https://www.youtube.com/watch?v=3w3rRPItPmc
- Chorley: https://www.youtube.com/watch?v=lZPgNKJUQb4
- Skelmersdale: https://www.youtube.com/watch?v=wmnXDxD7qHo

5. Glossary of Terms

There can be lots of confusion created when people use the same terms to mean different things. There is not yet a clear and nationally shared approach to defining the new system.

For the purposes of ensuring that developments in the system are understood locally, the following terms are used throughout and their meaning defined simply, as follows:

Healthier Lancashire and South Cumbria	The name for our partnership of NHS, local councils, voluntary sector and community organisations working together to support the 1.7 million people who live in this part of North West England.
Integrated care system (ICS)	An Integrated Care System provides strategic leadership across the whole population of the ICS. This will include overseeing a single plan covering both operational and long-term transformation priorities (building on, and aligning place-level plans), and managing financial performance against a system control total that encompasses CCGs and NHS providers. (Definition from *Designing Integrated Care Systems*, NHS England)
Integrated Care Partnerships (ICP) and Multi-specialty Community Provider (MCP)	These are our five places: Pennine Lancashire, Fylde Coast, Morecambe Bay, Central Lancashire are developing as ICPs and West Lancashire is developing as an MCP. They include clusters of primary care networks, linking these to care providers such as one or more acute hospital, care homes, mental health and community providers, local government and voluntary or community organisations. Together, these will make a shared assessment of local need, plan how to use collective resources and join up what they offer – including beyond traditional health and care services – to make best use of overall public and community resources. (Definition from *Designing Integrated Care Systems*, NHS England)
Primary Care Networks	Primary Care Networks (PCNs) are a key part of the NHS Long Term Plan which typically serve natural communities of around 30,000 to 50,000. Primary care networks build on the core of current primary care services and enable greater provision of proactive, personalised, coordinated and more integrated health and social care.
Neighbourhoods	These areas are local areas based on populations of between 30,000 and 50,000 where all aspects of NHS and Local Authority services come together with the voluntary, community organisations and local people. Examples include Fleetwood, Barrow, Burnley East or Skelmersdale. There are currently 41 neighbourhoods in Lancashire and South Cumbria.

A more detailed glossary of terms is available here: www.healthierlsc.co.uk/about/glossary.

Appendix B

Healthier Lancashire & South Cumbria

Our next steps

26th April 2019

For public Boards/Governing Bodies

Contents

Healthier Lancashire & South Cumbria

Introduction

Healthier Lancashire and South Cumbria is the name we have given to a **partnership** of NHS, local councils, voluntary sector and community organisations working together to support the 1.7 million people who live in this part of North West England.

We are working together as an “integrated care system” or ICS. The aims of the partnership are to join up health and care services, to listen to the priorities of our communities, citizens and patients and to tackle some of the biggest challenges we are all facing.

Our next steps is a strategic document which we have developed as part of our response to the NHS Long Term Plan (published in January 2019). Firstly, we set out our vision for a healthier Lancashire and South Cumbria. Then, we explain how working in partnership helps us respond to the challenges our communities and front line professionals are experiencing and how we can use our resources better. We also commit to building stronger alliances between our organisations to realise our ambition that Lancashire and South Cumbria becomes a great place to live and work.

This version of Our next steps has been developed for system leaders and senior clinical/programme leads. The ICS is asking leaders to endorse the priorities set out here for the ICS partnership and lead the process of sharing our thinking with the public, with our staff and with our local representatives. We will develop additional engagement materials to help us to do this which will be specific for these audiences. We’d like to know what you think about Our Next Steps for working together and delivering safe and sustainable services.

Our Vision for Healthier Lancashire and South Cumbria

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

At the heart of this are the following ambitions:

- **We will have healthy communities**
- **We will have high quality and efficient services**
- **We will have a health and care service that works for everyone, including our staff**

Section 1: A case for changing the way we work

We recognise that there is no single factor, no one organisation that can guarantee the health of every community or person. Our health and wellbeing is heavily influenced by our education and work opportunities, our lifestyle behaviours, our environment including the quality of our homes – as well our ability to maintain our own health and access good clinical care when we are ill.

We understand that members of the public are concerned when they hear about pressures on local health and care services. This may be a consequence of personal experiences of receiving care or hearing that “difficult choices” need to be made about the future of local services.

It is true that we are facing some significant challenges and believe that our ICS partnership provides new opportunities to tackle these, working together with local people. We know that:

- **We are not taking sufficient action to tackle health inequalities**
- **Our services do not always provide consistently high quality care for everyone**
- **Our performance on some national targets is poor**
- **We are spending more money than we receive from government**

The scale of these challenges is illustrated on the next slide:

Healthier Lancashire & South Cumbria

A case for changing the way we work

We are not taking sufficient action to tackle health inequalities

Where you are born can affect how long you live by as much as 10 years in Lancashire and South Cumbria

1:6 of neighbourhoods in Lancashire and 1:10 in Cumbria are in the most deprived decile nationally

Our services do not always provide consistently high quality care for everyone

There is unwarranted variation in outcomes for people with conditions such as Cancer, Coronary Heart Disease and Mental Health

Gaps in the workforce create fragility in hospitals, community and care services

Our performance on some national targets is poor

We struggle to consistently achieve targets for treatment in A&E, cancer services and routine surgery in all of our hospitals

Solving many of these issues requires action by several organisations

We are spending more money than we receive from government

NHS organisations need to reduce spending by £167m over the next few years

Local Authority funding has reduced by an average of 40% over the last 5 years

A case for changing the way we work

We believe that we need to change the way we work together if we are to address these major issues successfully:

- Agreeing the key priorities which all our partner organisations support will help us repair the fragmentation in our current health and care system;
- Simplifying the current complex arrangements for making decisions will ensure faster progress in tackling poor performance and reducing financial deficits in our frontline organisations;
- Sharing good practice across Lancashire and South Cumbria will help us to talk honestly with the public about how we create sustainable services for the future - and enable our staff deliver those changes.

The good news is that we have begun to take action already.

We have some great examples of work taking place in neighbourhoods, in our local Integrated Care Partnerships (ICPs) and across Healthier Lancashire and South Cumbria. For more details about this please see Appendix 1. The infographic on the next slide also helps to summarise how this work is being focused on the needs of our 1.7 million citizens.

Section 2: Our Plans and our partnership priorities

This visual representation of our vision shows how local organisations are already working together. We believe that local people and patients must be at the centre of everything we do.

Our job is therefore to ensure our partnership organisations:

- support people in their neighbourhood and community,
- create shared plans for local areas (ICPs) of 300-500,000 people,
- unite around a set of priorities we have agreed to undertake in partnership across Lancashire and South Cumbria.

Our plans and our partnership priorities

Each year, NHS organisations are required to develop a 1 year “Operational Plan.” This sets out the agreements about activity levels, performance targets and financial commitments between local commissioners and providers. Operational plans are submitted to NHS England and NHS Improvement and must align to the priorities set out in national planning guidance.

In Lancashire and South Cumbria, operational plans for 2019/20 will be connected to existing organisational and ICP-based strategies. These will influence the way the NHS and its partners work together.

Healthier Lancashire and South Cumbria is using this document called Our Next Steps to develop a five year partnership strategy by September 2019. This is part of our response to the NHS Long Term Plan. In so doing, it is understood that the Operational Plans for 2019/20 are considered the first year of this 5 year approach.

The ICS also has a number of existing clinical workstreams through which partners are working to improve quality, performance, resilience and efficiency. Several of these are key national priorities in the Long Term Plan.

It will be necessary to review these workstreams to ensure that they have clear objectives and remain a priority for the ICS partners.

The current clinical workstreams are as follows:

Cancer	Regulated Care	Stroke
Mental Health	Maternity and Paediatrics	Head and Neck Cancer
Urgent Care	Elective Care Diagnostics	Vascular Surgery
Learning Disability	Primary Care	Prevention

Our partnership priorities

The effectiveness of the ICS partnership will be judged by our ability to join up health and care services, to listen to the priorities of our communities, citizens and patients and to tackle some of the biggest challenges we are all facing. Leaders across the system are proposing 8 priorities through which the partners agree to take action over the next 5 years:

1. Maximise the benefits of our work in **neighbourhoods**
2. Deliver an integrated health and social care **workforce** for the future with the capacity and capability to provide sustainable care and support to our local communities.
3. Strengthen the resilience and **mental health** of people and communities
4. Establish a group model for all **hospital services** in Lancashire and South Cumbria
5. Reinvigorate strategic partnerships across the **public sector**
6. Establish a public sector **enterprise and innovation** alliance with our ICS partners, including academic partners and Local Enterprise Partnerships to deliver inward investment and support job creation
7. Bring the entire health and social care system back into **financial balance**
8. Consolidate commissioning so that our arrangements for **planning and prioritising** our resources improve our population's health and the outcomes of health and social care.

These priorities are shown on the following infographic and then set out in more detail in the subsequent slides.

Our partnership priorities

This is an illustration of the partnership priorities we are proposing Healthier Lancashire and South Cumbria should take forward over the next 5 years. Our priorities show how we intend to:

- Support our communities and our staff,
- Strengthen partnerships to improve care and promote innovation
- Plan to improve our population's health and our use of resources

Priority 1

Maximise the benefits of our work in neighbourhoods

Why is this priority important?

Neighbourhood care models are one of the five major practical changes identified in the NHS Long Term Plan to tackle the health challenges faced by the population and provide a sustainable service model for the future.

We also need to tackle significant inequalities of health which exist in different communities.

If we work effectively as partners in each of our neighbourhoods, then we will be able to:

- Manage the health of the community proactively using predictive prevention, screening, case finding and early diagnosis to better support people stay healthy
- Provide more coordinated care for the increasing number of people with long-term health conditions
- Empower individuals, families and communities to become “fully engaged” in their own health and wellbeing,

What are the ICS partners trying to achieve through this priority?

We are building on a number of positive local and national exemplars in which frontline professionals (GPs, community nurses, therapists, social workers, VCFS partners) have improved and integrated the care provided to local neighbourhoods of 30-50,000 residents. As well as delivering better care planning and outcomes for patients, these integrated models of care enable us to maximise the benefits of a multidisciplinary workforce –and offer potential to create a sustainable future for primary and community services which have been under significant pressure in recent years.

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

Priority 1

Maximise the benefits of our work in neighbourhoods

How will we track progress for this priority in our local communities?

Based on our work to date, we will continue to track progress using a number of measures relating to patient activity, the use of resources and the utilisation of technology to support their needs. These may include hospital admission rates, increasing the number of people with full access to their electronic, integrated health and care record and supporting more people with long term conditons with technology to manage their needs.

We will continue to use patient satisfaction surveys to understand if citizens feel they can access the best services for them at the right time. We know that each neighbourhood/ primary care network team will also have to respond to 7 new national service specifications over the next 1-2 years e.g. support to care homes.

It is vital that we discuss with local people which measures of progress are most important to them.

How will we track progress for this priority in front line organisations?

We will use a locally developed maturity matrix to support the continued development of our Neighbourhood/Primary Care Network care teams over the next two years.

Each Neighbourhood will develop a 1 year plan for 2019/20 with their objectives for 2019/20 by the end of March 2019. These plans identify individual priorities, the benefits expected to be realised and how they will be measured.

The work of neighbourhoods will also be evaluated as part of the updated national contract for General Practices. From April 2020 every Primary Care Network will be able to see its relative progress on key metrics contained in a comprehensive new national Dashboard, including population health and prevention, urgent care and anticipatory care, prescribing and hospital use. It will also cover metrics for all the new national service specifications.

Priority 2

Deliver an integrated health and social care workforce for the future with the capacity and capability to provide sustainable care and support to our local communities.

Why is this priority important?

There are significant vacancies in both health and social care and staffing gaps in all professional areas. These include but are not exclusive to nursing, medical, primary care, social work and regulated care staff. Lancashire and South Cumbria represents a huge geographic challenge and opportunity, with diverse services operating from countryside to coastal, urban and rural, highly populated and isolated communities.

Delivering the ambitions in the NHS Long Term Plan is contingent on having the right workforce (skills, experience and numbers) to provide the right care to our local population and support them in preventing ill health and maintaining wellbeing. There are significant health inequalities in our area and we need the workforce to help us address these.

There is a need to improve recruitment processes and cross organisational approaches to fluid and flexible employment; improve the offer in terms of access to careers advice and entry level opportunities, including apprenticeships; and support workforce flexibility and mobility. Alongside this, work is needed on consistent skills and competency development, developing roles at scale and creating new ways of working to support service redesign.

What are the ICS partners trying to achieve through this priority?

We want to develop a system-wide approach to tackle the range of issues affecting our workforce. Foremost of these is our ability to recruit and retain the workforce needed to provide care to our local population. We want to attract the workforce from our local population as well as growing our own workforce so that we can maximise the wider social benefits arising from good employment opportunities.

We are committed to making Lancashire and South Cumbria a positive employment and career choice for health and care staff nationally and internationally.

Priority 2

Deliver an integrated health and social care workforce for the future with the capacity and capability to provide sustainable care and support to our local communities.

How will we track progress for this priority in our local communities?

- Having a clear value proposition and communication plan for why you should live and work in Lancashire and South Cumbria
- Establishment of Health and Social Care Academies to ensure full coverage across Healthier Lancashire and South Cumbria
- Increased access to health and social care work experience programmes (numbers of students/numbers of placements)
- Uptake of NHS Careers Passport (current coverage, targets to achieve this)
- % increase in access to health and social care related Further Education / Higher Education Institutions courses (current position/increase)
- Implementation of joint health and social care apprenticeship programme (numbers/target for future)
- Rollout of volunteer programmes and uptake of these
- Service users and local citizens into employment (e.g. Mental Health support workers, link workers, social prescribing roles)
- Uptake of employment into wider roles (link workers, social prescribing roles)
- New models of employment and rotation schemes across Lancashire and South Cumbria

How will we track progress for this priority in front line organisations?

- Reduction in vacancies at system level for main staff groups
- Target to increase international recruitment by X% (depends on supply/migration rules)
- Target to increase nursing apprenticeships by X% (contingent on funding)
- Reduced turnover levels at system level for main staff groups
- Improved staff satisfaction scores from national staff survey (system level aggregation)
- Reduction in sickness absence rates to England average
- Sustaining talent management programmes across the ICS
- Agreed approach to modelling impacts of new technology on the workforce
- Using technology to improve working conditions for front line staff

Priority 3

Strengthen the resilience and mental health of people and communities

Why is this priority important?

Mental Health problems are experienced by a significant number of people in our communities (e.g. one in ten children between the ages of 5 to 16 has a diagnosable mental health problem; one in four adults experiences at least one diagnosable mental health problem in any given year).

Demand for specialist mental health services has significantly risen in recent years in Lancashire and South Cumbria –raising concerns about the resilience of our communities, gaps in services and the capacity to offer access to care within reasonable time limits.

Increasing investment in all age mental health services at a rate above the overall funding growth for the NHS is also a clear priority in the NHS Long Term Plan. Lancashire and South Cumbria is committed to meeting this Mental Health Investment Standard.

What are the ICS partners trying to achieve through this priority?

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

Improving mental health and wellbeing is also a critical example of our whole approach to population health - we need to ensure we support individuals with their education, access to employment opportunities and good housing as well as improving health care services.

Priority 3

Strengthen the resilience and mental health of people and communities

How will we track progress for this priority in our local communities?

Build resilient community services with a focus on early intervention, ensuring these are responsive to the health and social care needs of children and adults – these services need to be part of our joined up neighbourhood care teams by March 2020.

Work with our local third sector and independent providers to broaden the workforce, making different skill sets and service models available to our citizens in local areas.

Enable individuals, their families and carers to develop resilience in their communities, schools and workplaces and provide locally-facing support within a “recovery college” model.

Neighbourhood care teams and ICPs agree plans to achieve 0 preventable deaths including from suicide from April 2020.

How will we track progress for this priority in front line organisations?

No individual waits more than 12 hours for an inpatient bed (for mental health or detoxification) by March 2020.

50% reduction in the number of out of area placements for acute care and rehabilitation by March 2021 and a 75% reduction by March 2023.

Build robust 24/7 crisis intervention services and community mental health services. This may also involve commissioning bespoke services at a locality level which reduce dependency on NHS specialist services and align to our urgent care pathways.

Ensure that we have no inappropriate admissions to in-patient beds by providing a range of alternatives that provide a greater focus on upstream support.

Priority 4

Establish a group model for all Hospital services in Lancashire and South Cumbria

Why is this priority important?

Our hospitals have identified a number of “fragile” services where workforce gaps or models of care make it difficult for every hospital to deliver comprehensive, sustainable services. Financial deficits add further complexity to the challenges facing the sector.

Although we are working hard to address workforce shortages we now need to think differently about the way we utilise our staff across the ICS, so that they work in the right place to maximise their expertise and availability.

We know that elsewhere in the UK, hospitals have been working together to develop stronger networks of care and tackle variation in the quality, access and treatment available to local citizens –as well as to help make services financially more efficient. It is now essential that we explore these approaches more systematically in Lancashire and South Cumbria.

What are the ICS partners trying to achieve through this priority?

We want our hospitals to continue to deliver the highest quality, safe and sustainable care to the people of Lancashire and South Cumbria. To achieve this, our hospitals will increasingly work more closely together, transforming the ways in which some of our more specialised services and patient pathways are organised. This could involve changes to current models of care, locations of care or the number of hospitals which provide care.

Our ambition is that our hospitals develop further as “centres of excellence,” sharing skills and expertise where appropriate to ensure these is available to all of our citizens as equitably and efficiently as possible.

Our hospitals are willing to explore the opportunities of working as a group to enable them to work systematically on these issues – building on their existing collaborations.

Priority 4

Establish a group model for all Hospital services in Lancashire and South Cumbria

How will we track progress for this priority in our local communities?

We will be really clear with our communities in 19/20 about which services (for routine and urgent care) will be delivered locally (in neighbourhoods/communities) and which would benefit from a group/network-based model of care. We will set out how these service changes can be measured in a quantitative and qualitative way.

To do this we need to urgently prioritise the implementation of a shared dataset supported by ICS-wide digital integration. Local communities will access this to identify, monitor and measure progress on identified clinical patient pathways in terms of access, diagnostics, treatment and outcomes, which are based on national and local standards of care.

Metrics: RTT 18 weeks, Cancer 62 day (and others), Patient and Staff Surveys, DTOC, IAPT etc.

How will we track progress for this priority in front line organisations?

We will agree a small number of priority clinical areas using local, regional and national measures by the end of June 2019.

We will use these to test commitment as to whether a group/network-based model of care could work across Lancashire and South Cumbria by March 2020.

Priority 5

Reinvigorate strategic partnerships across the public sector

Why is this priority important?

Many of our most significant challenges require cross-cutting approaches across multiple public sector partners. We cannot tackle health inequalities, improve poor performance or resolve our financial problems as individual organisations. We also need to demonstrate an ability to remove obstacles pointed out by people who use our services and our own staff – at whatever level in the system these become apparent.

Our approach in Healthier Lancashire and South Cumbria is also to acknowledge that different organisations are best placed to lead on issues such as economic regeneration, workforce innovation and community resilience – our public sector partnerships need to support and drive these priorities forwards.

The NHS Long Term Plan puts significant focus on the delivery of new models of care, promoting shifts of resource from secondary care to more preventative models in the community – this can only be delivered if there are stronger partnerships between NHS and local authority-funded services.

What are the ICS partners trying to achieve through this priority?

We recognise that our communities, staff and organisations are facing a range of complex challenges. Responding effectively to these requires a more coherent, joined-up approaches from public sector organisations than exists at present in Lancashire and South Cumbria.

This priority commits public sector leaders to make sense of their different roles and accountabilities and determine how their organisations will work in partnership, agree joint priorities and improve decision-making – whether this is in neighbourhoods, in local areas or across Lancashire and South Cumbria.

We want to increase the confidence of local communities that our organisations are delivering the right priorities and support to all of our citizens.

Priority 5

Reinvigorate strategic partnerships across the public sector

How will we track progress for this priority in our local communities?

- Partners to identify specific progress measures across the whole of this Next Steps document which illustrate effectiveness of strategic partnership working – this to include impact of neighbourhood care models, inclusive economic growth plans, support for regulated care sector, workforce innovation

How will we track progress for this priority in front line organisations?

- Strengthen collective commitment towards improving population health and wellbeing through a joint review of the governance arrangements for Health and Wellbeing Boards by October 2019
- Use learning from local/national experiences of the Better Care Fund to agree joint NHS/LA investment strategies at ICS and ICP levels by March 2020
- Develop action plan for NHS and LA in Lancashire CC area in response to review of Intermediate Care by July 2019.
- NHS and LA commissioners to agree changes to existing unsatisfactory arrangements for assessing people requiring complex care packages or continuing health care by March 2020.

Priority 6

Establish a public sector Enterprise and Innovation alliance with our ICS partners, including academic partners and Local Enterprise Partnerships.

Why is this priority important?

Public sector partners have a duty to create opportunities for growth, investment, employment, life-long learning and innovation.

Action taken across the partnership can help tackle health and other social problems caused by poverty, poor housing, limited educational attainment and under-investment.

We want to ensure that public sector partners (including the NHS, local authorities, Higher Education) take a full and active role in supporting economic growth, education, research and skills development in all of our communities

Lancashire and South Cumbria must play a full and distinctive role in the ambitions for a Northern Powerhouse – to make this a place in which people want to come to work, learn, grow and invest in jobs and people..

What are the ICS partners trying to achieve through this priority?

We know there are significant and diverse opportunities to develop the Lancashire and South Cumbria economy, promoting a wide range of benefits to the population from this approach to collaboration, mutual learning and investment in new ideas. This allows us to respond locally to the global impacts of technological, social, scientific and environmental changes.

Our organisations also employ a highly trained and motivated workforce with the skills to innovate, research and create opportunities to provide sustainable future services to the people they serve.

Priority 6

Establish a public sector Enterprise and Innovation alliance with our ICS partners, including academic partners and Local Enterprise Partnerships.

How will we track progress for this priority in our local communities?

- Creation of a Strategic Health Commission with the Lancashire LEP and Innovation Alliance
- Identification of 3 actions health sector can take to make best use of NHS spend in L&SC in 2019
- Each ICP to report on a subset of smart objectives as part of ICS/ICP reviews
- Discussion with Economic Development Director in Blackburn with Darwen Council to determine how best to engage the LEP
- Annual partnership assessment of whether there is real and perceived benefit in working collaboratively in this area
- Measure number of programmes or inward funding leveraged through partnership

How will we track progress for this priority in front line organisations?

- Each ICP to report on a subset of smart objectives
- Develop and agree local targets that are place specific as part of ICS/ICP reviews
- Annual partnership assessment of whether there is real and perceived benefit in working collaboratively in this area
- Measure number of programmes or inward funding leveraged through partnership
- Measure reduction in waste and increases in energy efficiency
- Track new jobs created and increase in local workforce
- Track health status and weight reduction in NHS staff
- Continued implementation of the Lancashire and South Cumbria Digital Health Strategy

Priority 7

Bring the entire health and social care system back into financial balance.

Why is this priority important?

Parliament votes a fixed amount of money, sourced from taxpayers, to the NHS each year. Income for Local Authorities is sourced from local council tax as well as from national government. In overall terms, Lancashire and South Cumbria receives its fair share of the national budget for health. However, health organisations in the area spend more on delivering services (that are not fully meeting patients' needs and quality standards) than they are receiving in income, resulting in a deficit of £167m per annum. This cannot continue.

The good news is that there is clear evidence that greater efficiency could be achieved and waste reduced significantly were services to be organised and delivered differently to the way they are now. Moreover, reform of services would also ensure that they better meet the changing needs of our population.

What are the ICS partners trying to achieve through this priority?

Our ambition is that NHS and social care services are able to deliver clinically sustainable services **within** the financial resources available to us by 2022/23. This will be achieved by improving the value for money we currently expend in delivering care, eradicating waste and changing the way we deliver some services.

Priority 7

Bring the entire health and social care system back into financial balance.

How will we track progress for this priority in our local communities?

The difference between the amount we spend on average per person and the average amount of income we receive per person reduces year on year by an amount sufficient to achieve financial balance by 2023/24, with a higher level of savings weighted towards the earlier years.

We are able to identify waste in every setting and agree local ways to reduce it and track progress.

Our status as a national exemplar for population health management is offering early promise in using advanced analytics to increase prevention activity, reducing demand and expenditure as a result.

We are able to achieve a higher level of efficiency in service delivery, measured through national and any locally determined “best value” criteria and also benchmark favourably against RightCare and Getting it Right First Time (GIRFT) metrics.

How will we track progress for this priority in front line organisations?

Organisations will be able to meet their control totals every year.

Organisations will reduce the level of deficit by an agreed amount each year, until they achieve a break even position (the level of annual savings should be weighted towards the earlier years of this strategy).

Organisations will achieve their agreed efficiency schemes each year on a recurring basis.

Organisations are situated in the top half or top quartile for an agreed range of programmes/services as defined in GIRFT, RightCare and CIPFA benchmarking schemes.

Priority 8

Consolidate commissioning so that our arrangements for planning and prioritising our resources improve our population's health and the outcomes of health and social care

Why is this priority important?

We want to improve the health of our communities in our neighbourhoods, ICPs and across the ICS by taking effective and efficient decisions about the use of public funds.

We need to sustain and accelerate the evolution of integrated care models by ensuring that commissioners are combining local decision-making with local providers, councils and other partners.

We also want our commissioners to agree plans and priorities which help to reduce health inequalities and achieve common standards and outcomes from the care provided to our citizens across Lancashire and South Cumbria.

What are the ICS partners trying to achieve through this priority?

The roles of commissioners will evolve to focus on planning and priority-setting to improve the health of the populations served by each of our Integrated Care Partnerships.

There is a clear expectation in the NHS Long Term Plan that the number of commissioning organisations will reduce, releasing funds to be directed into front line care.

Agreeing joint approaches to this between NHS and Local Government partners will also be critical to agree investment plans and achieve better outcomes for many people living in Lancashire and South Cumbria.

This priority also supports our ambition to align both our priorities and decision-making for specialised services between NHS England and the ICS.

Priority 8

Consolidate commissioning so that our arrangements for planning and prioritising our resources improve our population's health and the outcomes of health and social care

How will we track progress for this priority in our local communities?

- Mature neighbourhood (PCN) care models in place across L&SC by March 2021 (see priority 1)
- 5 year plans in each ICP to reduce health inequalities by March 2020
- NHS and Local Authorities will be able to describe how their joint approach to key priorities is impacting on neighbourhoods by March 2020

How will we track progress for this priority in front line organisations?

- Implementation of place-based commissioning at neighbourhood, ICP and ICS levels will continue through 2019/20
- Each ICP will set out their leadership arrangements for population health management/planning/integrated commissioning by September 2019
- Agreement on future configuration of CCGs in L&SC by April 2020 for implementation by April 2021

Section 3: What will be different?

In two years…

Integrated community teams deliver risk stratified and coordinated physical and mental health care to their local neighbourhoods

Improved retention of staff in all sectors

Frontline staff will have greater access to data shared by partners

Joint NHS and Local Authorities working encourage further engagement of communities in their health and wellbeing – and create 500 new jobs through economic development

Group hospital model completes first wave of sustainable service changes with quality and financial improvements

Living and working in Lancashire and South Cumbria has a clear value proposition

In five years…

The Integrated Care System will have matured into an effective group model of integrated care providers working together with an integrated health and care strategic commissioner

Our hospitals will be providing networks of services with sustainable staffing levels and consistent pathways of care

Partners will demonstrate how the Strategic Health Commission has supported economic development and innovation – to benefit citizens, patients and staff

We will demonstrate best value from the Lancashire and South Cumbria pound – and return the system to financial balance

Our future workforce will be attracted into Lancashire and South Cumbria by a creative and innovative offer

Our public sector partnership will lead to organisations sharing power with the asset-based communities we serve

Integrated community teams will work with local citizens to make best use of local housing and leisure services

We will make better predictions of people's needs and personalise care to meet those needs

Our populations will be "fully engaged" in their health and wellbeing, and public sector leaders will have a clear view on what is important to them

Our approach to population health will create confidence in the evidence of improving life expectancy and reducing inequalities in our most deprived neighbourhoods

Section 4: Engagement Process

The Healthier Lancashire and South Cumbria partners are required to share the proposals set out in this document and gain feedback from the public, from our staff and from local representative groups and individuals.

The purpose of the engagement is to galvanise partners and mobilise staff towards working in partnership across Lancashire and South Cumbria and the benefits of this. For our staff and public we want to capture their feedback about how developing stronger partnerships provides opportunities to work differently.

The insights from this process will contribute to a 5 year strategy for the ICS which will be published by September 2019.

Engagement activity will be led locally by organisational leaders to ensure that the connections between existing work in neighbourhoods, local areas (ICPs) and across Lancashire and South Cumbria are clearly explained. This is vital to ensure local issues, networks and relationships are managed sensitively. Our colleagues from Healthwatch are also undertaking an independent assessment of local opinions – this has been supported at a national level as part of the response to the Long Term Plan.

None of the priorities set out in this document remove the statutory duty of NHS organisations to conduct formal public consultation in the context of significant change to services.

The ICS proposes to use a phased approach to engagement which is set out as a timeline on the next slide.

Key messages for our staff and local people

1. Only by working in partnership across Lancashire and South Cumbria do we have a chance to tackle some of our biggest challenges
2. We need to work differently going forwards if we want to deliver the ambitions of the Long Term Plan and deliver integrated care.
3. We want to involve local people and staff in developing our new ways to make sure local people are able to live longer, healthier lives.

Additional materials will be produced to support engagement including:
Slides, a public facing document, a staff facing document, social media toolkit for local teams, website content.

Phases of engagement

1 Development of priorities

Involve wide range of system leaders including from NHS, Local Authority, VCFS, and local Healthwatch to develop existing partnership work into a set of propositions where partnership working at ICS would provide the most impact.

2 Healthwatch local engagement

Local Healthwatch to engage with communities to capture independent intelligence about the NHS Long Term Plan to shape the clinical strategy and provide local insights.

4 Develop 5 Year strategy using insight from engagement

Use the insights from the previous phases to draft a Five Year Strategy for the Integrated Care System and publish for wider comments and involvement from stakeholders.

January - April | **April - July** | **July - August** | **September**

3 Wider engagement with stakeholder groups

Engage with communities on the vision for the ICS and the draft partnership priorities to explain and shape how the system will work together to benefit local people. This will be led locally and include patient groups, patient representatives, Councillors and staff. Includes MPs, Councillors, CCG and Trust Governing Bodies.

5 Publish the Five Year Strategy and demonstrate the impact of involvement

Publish and effectively communicate the strategy. We will demonstrate the impact of the involvement of the public and stakeholders in the previous stages and how this contributed to the strategy.

Section 5: Next Steps for system leaders

The ICS Board is endorsing several actions to take forwards the work set out in **Our next steps**. System leaders are therefore asked to:

- Endorse the 8 priorities personally in advance of endorsing them with organisational boards and leadership teams.
- Indicate to the ICS Chief Officer if you are willing to sponsor one of the ICS priorities
- Support the actions now required to create an effective engagement process across the ICS. This will include the drafting of additional materials which can be used to support engagement with patients, citizens, staff and wider partners. Planning meetings will be arranged with ICP leaders to ensure that the connections between the ICS partnership priorities and existing ICP strategies can be clearly articulated.
- Confirm the highest priorities for the ICS' clinical workstreams.
- Support the further system development work now being arranged in respect of provider collaboration, commissioning and partnerships between local authorities and the NHS.
- Contribute to the current review of ICS governance and decision-making arrangements

Healthier Lancashire & South Cumbria

Appendix 1: what the ICS has achieved already

101,000 people are actively using apps to book their primary care appointments across Lancashire and South Cumbria

Partnership working has maximised our flexibility to enable organisations to reach our financial targets

Our partners are working with parents, children and young people to co-produce and implement a THRIVE model for CAMHS services for 0-19 year olds

A partnership approach to performance against nationally recognised clinical indicators of good acute stroke care (SSNAP) have improved

Five primary care networks are part of a national programme to pilot a population health management approach

A Health and Social Skills Partnership has been re-established in collaboration with the Local Enterprise Partnership

The Healthier Fleetwood model resulted in the Primary Care Network receiving an award from the National Association of Primary Care

78% of care homes are actively using a tool which allows for bed vacancies to be tracked which is helping to reduce avoidable lengthy stays in hospital

Partnership work across maternity services has resulted in 29.2% of women being booked onto pathways which can offer continuity of carer, exceeding the national target of 20%

£7.6million funding from NHS England is facilitating an initiative to diagnose lung cancer earlier in Blackpool and Blackburn with Darwen

Nurse recruitment is being developed through the Global Health Exchange Programme – all Trusts have taken part in an initial recruitment exercise with over 200 offers of employment being made

Healthier Lancashire & South Cumbria

Glossary of terms

We need to create a more consistent dialogue across Lancashire and South Cumbria which requires defining some of the terms we use. A glossary of terms has been developed below:

Healthier Lancashire and South Cumbria	The name for our partnership of NHS, local councils, voluntary sector and community organisations working together to support the 1.7 million people who live in this part of North West England.
Integrated Care System (ICS)	In an integrated care system, NHS organisations, in partnership with local councils and others, take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve. (Definition from the NHS Long Term Plan).
Integrated Care Partnerships (ICP)	These are our five sub Lancashire and South Cumbria level partnerships: Pennine Lancashire, Fylde Coast, West Lancashire, Morecambe Bay, Central Lancashire.
Neighbourhoods	These areas are local areas based on populations of between 30,000 and 50,000 where all aspects of NHS and Local Authority services come together with the voluntary, community organisations and local citizens. Examples include Fleetwood, Barrow, Burnley East or Skelmersdale.. There are currently 41 neighbourhoods in Lancashire and South Cumbria.
Primary Care Networks	Primary Care Networks are the multi-disciplinary care teams working in our neighbourhoods. They will build on the core of existing general practice and other community-based services and enable greater provision of proactive, personalised, coordinated and more integrated health and social care.
A group model for acute services	We have not yet defined the detail of this term. We will work with partners and staff from the acute trusts during the engagement phase to define the meaning for this term.

Appendix C

Healthier Lancashire & South Cumbria

Together we can make things better

Local people will be at the centre of everything we do. Our communities will be healthy and people will have the best start in life, so they can live and age well. We will have high quality and efficient services. We will have a health and care service that works for everyone – both patients and staff.

Health and social care will work together to support your social, physical and mental health

You will be helped to care for yourself, including using digital technology

Community groups and local teams, including your GP, will work with you

You will be seen as equal partners and encouraged to support each other

Care will be locally delivered, managed and planned

We will make the best use of all the expertise and staff skills available to us

We will talk to you and your community about how best to provide care

You know best what you and your community needs

We will work together on issues like mental health, stroke, cancer and urgent care

Our hospitals will work together so you have the best treatment possible

As much of the local health and care pound as possible will be spent in local places

We will manage our spending better

We will use the latest technology, this includes sharing records and booking appointments online

Healthier Lancashire & South Cumbria

Our partnership priorities

We work together as a partnership of NHS services, councils, public sector, voluntary and community organisations to better support the 1.7 million people who live in Lancashire and South Cumbria. By working together on shared health and care system priorities, we are stronger together as an integrated care system.

We will work with local people in their neighbourhoods to join up services and improve wellbeing

We will strengthen the resilience and mental health of our communities

We will invest in the development of our workforce and make Lancashire and South Cumbria a great place to live and work

Our hospitals will work closer together to strengthen fragile services, share efficiencies and offer standardised pathways of care

We will increase joint decision making with public services to combine our resources in local areas

We will build upon existing alliances with business, education and innovation partners to tackle our biggest challenges

The system will return to financial balance through a rigorous approach to investment in transformation and cost reduction

Commissioning will be rationalised to focus on our population's health and the outcomes of health and social care

Appendix D

healthwatch

NHS Long Term Plan

Engagement Report

An insight from people in Lancashire & South Cumbria

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what would you do?

It's your NHS. Have your say.

Executive summary

This project is providing feedback from the public about their views and recommendations on the NHS Long Term Plan. The Long Term Plan sets out what the NHS wants to do better including:

- making it easier for people to access support closer to home and via technology
- doing more to help people stay well,
- and providing better support for people with specific or long term conditions including cancer, mental health conditions; heart and lung diseases; long-term conditions, such as diabetes and arthritis; learning disabilities and autism; for people as they get older and experience conditions such as dementia.

This project shows the findings from each respective Healthwatch within the Lancashire and South Cumbria ICP footprint, which are:

- Healthwatch Lancashire
- Healthwatch Blackburn with Darwen
- Healthwatch Blackpool
- Healthwatch Cumbria (Carnforth, Barrow, Kendal, Ulverston, Millom and Kirby Lonsdale)

Each Healthwatch had a target to fulfil the following:

1. Gain feedback from 250 people in each area on general views about the Long Term Plan or specific conditions (Healthwatch Cumbria was half of this at 125, as the other half falls under a different ICP area)
2. Complete two focus groups in each Healthwatch footprint, one at a general group and one at a group for people with specific conditions

For the generic survey, respondents were asked to state how important different components of care were to them, in order to:

- Live a healthy life, such as being able to easily access good quality health care or having knowledge to prevent ill health
- Managing and choosing the support you need, such as making decisions jointly with professionals and choosing where to receive care
- Keeping your independence and ageing healthy such as being looked after at home for as long as possible or friends, family and communities having the knowledge to support them

For the survey which asked questions to people with specific conditions, respondents were asked a range of questions including:

- If the support they have received met their needs
- Their experience of getting help
- Seeking support for more then one condition at a time
- The amount of time to receive initial assessment, diagnosis and treatment

Overall, Healthwatch in Lancashire and South Cumbria gathered feedback from 969 people, 803 on generic feedback and 166 on specific conditions.

Each Healthwatch engaged with people in two focus group settings, including a day centre in Blackpool, a self advocacy group in Barrow in Furness, a respite care service in Chorley and a women's South Asian group in Blackburn with Darwen.

We also completed a number of more detailed case studies

The following report has identified some significant findings in relation to the NHS LTP and the views of the Lancashire and South Cumbria people regarding their existing services.

Key findings from the general survey

For all of the questions where the respondent was asked to state how important each statement was to their care, a large majority in each question said that all were very important. Those listed below detail those that scored the highest:

- Access to services and being listened to were considered the most important for people to live a healthy life.
- Choosing the right treatment with health professionals and timely communications scored the highest for people to manage and choose the support they need.
- Ensuring their family are supported if they care for them at the end of life and staying at home for as long as possible scored the highest for people to maintain their independence and age healthily.
- In terms of interacting with the NHS, respondents said that having complete confidence that their personal data is managed securely was the most important followed by receiving results quickly. Interestingly, when asked to make once choice from this list, the highest score changed to being able to talk to a doctor or other health care professional wherever they are.
- The majority of respondents said they would go to their GP/doctor to find out how to stay well whilst consulting online sources was the second choice overall.

There is significant differences for individuals travelling the same care pathway in terms of diagnosis, treatment and support/ on-going support provided - this was identified in reference to those on a Dementia Care Pathway in Lancashire.

There was reference to the "inequality (of treating dementia) compared with other long-term condition, for example cancer".

The theme of alternative therapy was raised in all forums, face to face, specific and general groups, through general engagement and it was also apparent on the online survey.

It was highlighted that social prescribing would require a change in position both of cultural views and also a change in service provision for women from a South Asian background to be able to access this alternative form of support for example going forward, but that it would be welcomed.

Prevention and/ or early intervention was identified by more than 90% of respondents as to the level of support the NHS could provide to help people stay healthy. This particular theme identified a range of areas including easy to access nutrition advice, holistic treatments, psychological and talking therapies, specialists to assist with diet and exercise.

This area was also identified as being significantly important for those with existing heart and lung disease diagnosis including;

- *Support groups with health professionals in attendance*
- *Quicker appointments*
- *Provide Specialist health care practitioners*
- *Regular assessments and reviews*
- *Ongoing treatment with a consistent professional medical practitioner*
- *Regular check-ups to see if any change of condition*

Background

With growing pressure on the NHS – people living longer, more people living with long-term conditions, and lifestyle choices affecting people's health – changes are needed to make sure everybody gets the support they need.

The Government is investing an extra £20bn a year in the NHS. The NHS has produced a Long Term Plan, setting out all the things it wants health services to do better for people across the country. The NHS needs to hear from people about what those changes should look like in local communities.

The Long Term Plan sets out what the NHS wants to do better, including making it easier for people to access support closer to home and via technology, doing more to help people stay well, and providing better support for people with cancer, mental health conditions, heart and lung diseases, long-term conditions, such as diabetes and arthritis, learning disabilities and autism, and for people as they get older and experience conditions such as dementia.

Objectives

Long Term Plan Programme Objectives: The Long Term Plan sets out what the NHS wants to do better, including making it easier for people to access support closer to home and via technology, doing more to help people stay well, and providing better support for people with cancer, mental health conditions, heart and lung diseases, long-term conditions, such as diabetes and arthritis, learning disabilities and autism, and for people as they get older and experience conditions such as dementia.

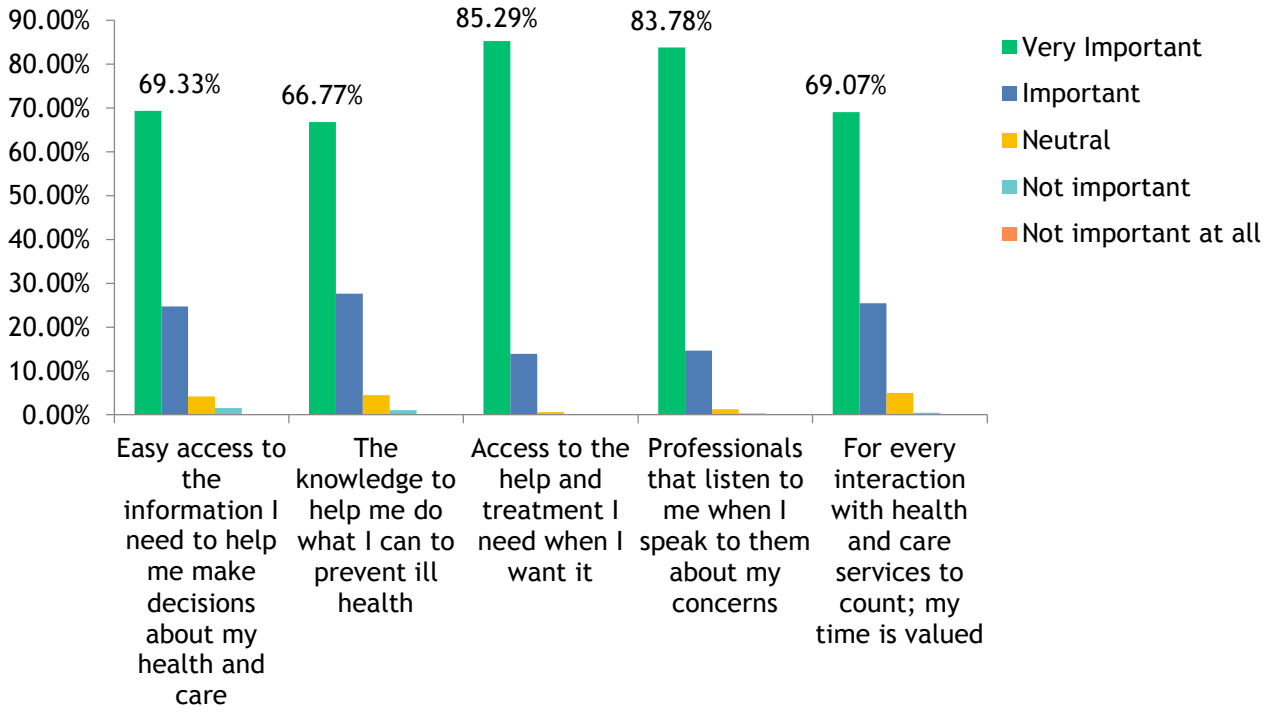
Local Objectives: There are many areas of interest and development locally in Lancashire as well as the specific conditions set out in the long term plan surveys. Some of these areas include stroke, cancer, maternity, and respiratory.

Summary of Findings:

We received 803 responses to the generic survey from people across Lancashire and South Cumbria. All gave Healthwatch their consent prior to completing the survey. 97% of respondents provided feedback about their own views and experiences whilst the remaining 3% was on behalf of someone else.

We asked: "Please rate how important the following things are to you when it comes to living a healthy life"

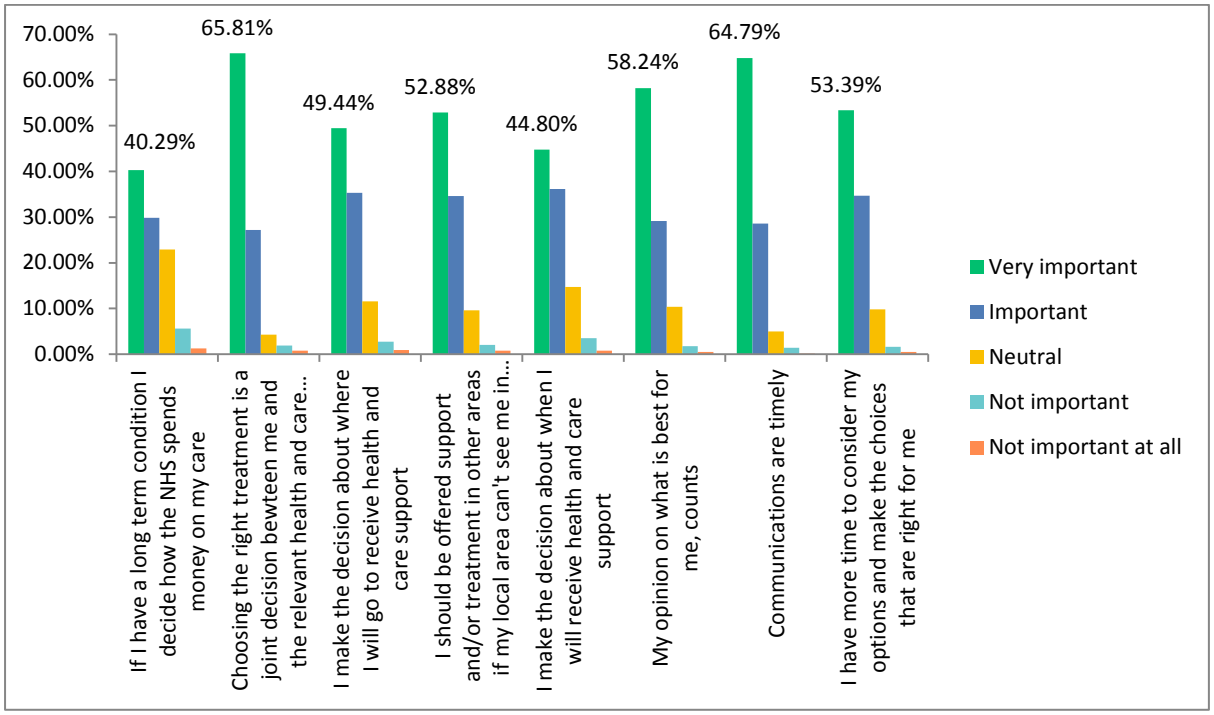
The chart below shows that the majority of respondents felt all statements were very important for them to live a healthy life. Access to services and being listened to were considered the most important.



Following this question, respondents were asked if they had one choice which would be the most important: A large majority at 42% said *access to help and treatment I need.*

We asked: *"Please rate how important the following things are to you when it comes to managing and choosing the support you need"*

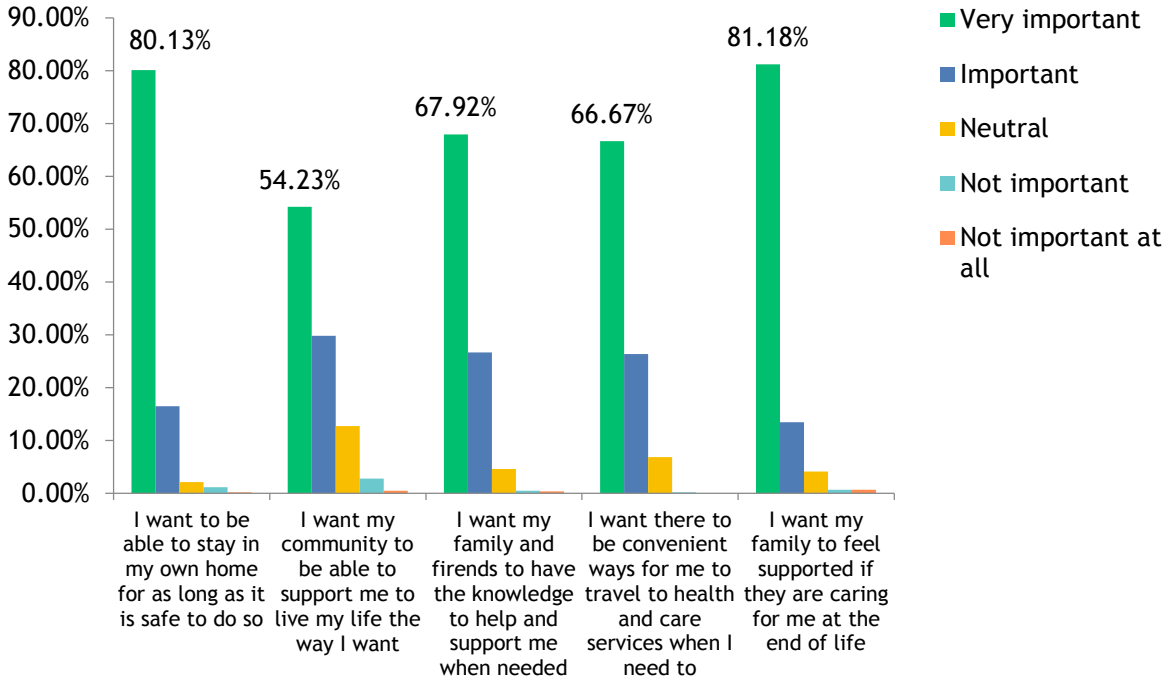
The chart below shows that the majority of respondents felt all statements were very important for them to manage and choose the support they need. Choosing the right treatment with health professionals and timely communications scored the highest.



Following this question, respondents were asked if they had one choice which would be the most important: A large majority at 40% said *choosing the right treatment is a joint decision between me and the relevant health and care professional.*

We asked: *"Please rate how important the following things are to you when it comes to keeping your independence and ageing healthy"*

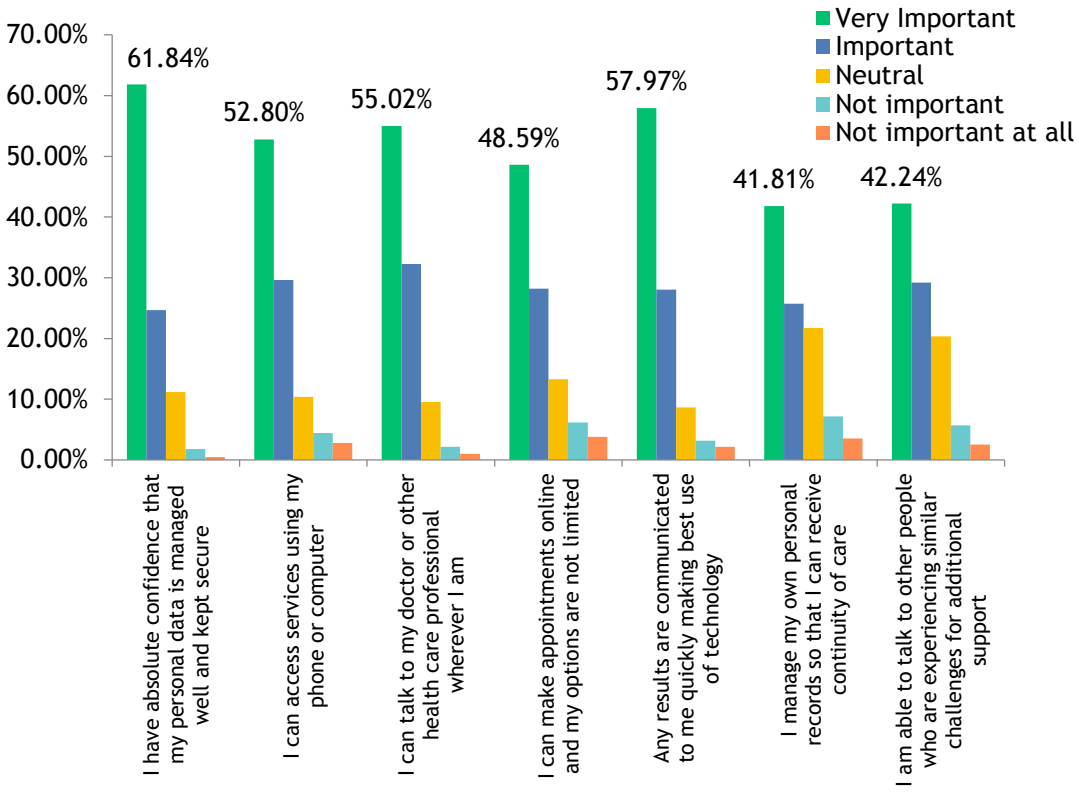
The chart below shows that the majority of respondents felt all statements were very important for them to maintain their independence and age healthily. Ensuring their family are supported if they care for them at the end of life and staying at home for as long as possible scored the highest.



Following this question, respondents were asked if they had one choice which would be the most important: A large majority at 58% said *I want to be able to stay in my own home for as long as it is safe to do so.*

We asked: *"What is most important to you when interacting with the NHS?"*

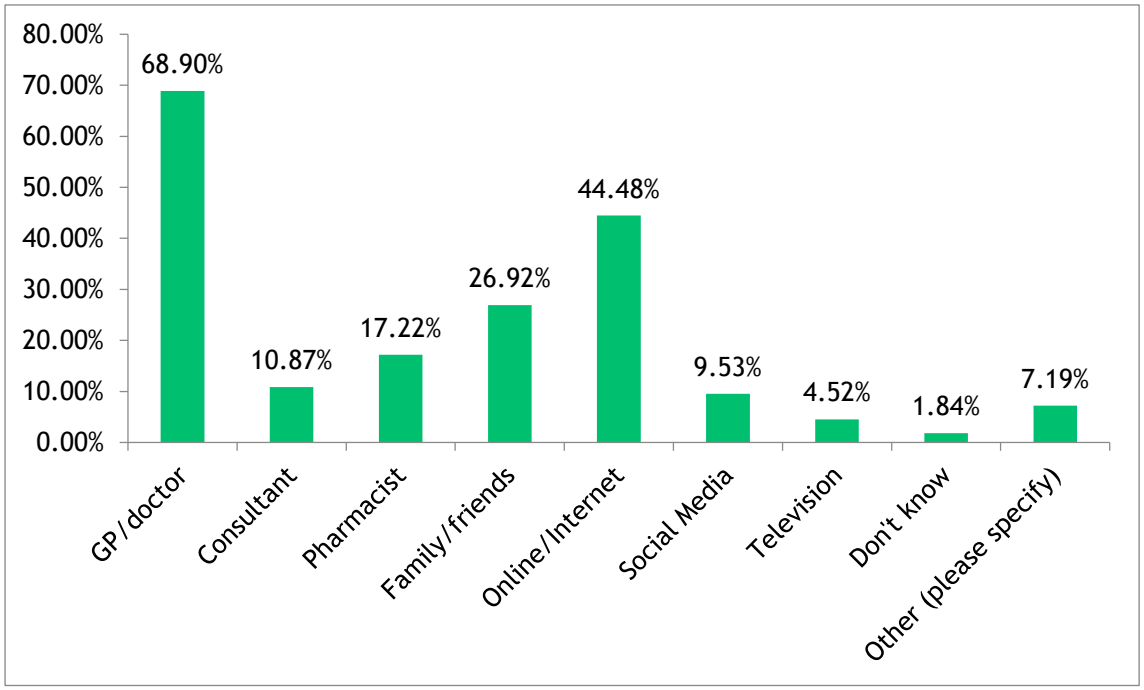
The chart below shows that the majority of respondents felt all statements were very important for them when interacting with the NHS. Having complete confidence that their personal data is managed securely scored the highest followed by receiving results quickly.



Following this question, respondents were asked if they had one choice which would be the most important: A majority at 33% said *I can talk to a doctor or other health care professional wherever I am.*

We asked: *"Where or who would you go to, to find out more information about staying well?":*

The chart shows that the majority would go to their GP/doctor followed by consulting online sources.



What matters most to people in Lancashire and South Cumbria?

During the local engagement, it was clear to see that there were significant differences in how the local people wanted services to be delivered to them depending on the age groups that we engaged with, the location of the groups that we facilitated (geographical barriers were identified in some areas) and the service users past experience of NHS services in their area.

The preferred way in which people wanted to engage with the health services regarding how to get information on how to stay well was face to face with their GP/Health Professional with 97% of those who responded stating that they would still want to speak to someone face to face. This is in stark contrast to those who stated that they would look for information online or via a social media platform, 44% and 10% respectively.

Recommendations

Largely there were three key themes identified throughout the engagement online and at the focus group sessions;

1. ***Areas that the NHS could improve upon going forward to engage with the service users***
   - *Improved, sustainable travel mechanisms, particularly in the 'hard to reach' communities.*
   - *Improved communications across the NHS and Multi-Healthcare network to ensure that the service user does not have to relay their story at every appointment i.e. shared access to service user files.*
   - *Improved waiting times and notice provided to the service user if an appointment has to be cancelled and re-arranged.*
   - *Incorporating the provision of holistic alternative treatments, where applicable, instead of traditional routes*
2. ***Areas that the NHS and Local Authority could work collaboratively on to enable service users to lead a healthier life***
   - *Provide easier/ cheaper access to gyms and exercise classes*
   - *Easily accessible/ easy to understand nutrition advice/ diet plans that are tailored to the individual*
   - *Providing workshops to service users on how to cook healthy, nutritious food on a budget.*
3. ***Preventative measures that could be taken to enable the service user to make better/ healthier choices***
   - *Provide easy to understand nutritional advice that goes beyond the Eat Well plate, including vitamins and minerals and how these work to keep us healthy*
   - *Access to/support from Healthcare professionals in a timely manner to avoid the need to be admitted to hospital*
   - *Quicker access to mental health services for both children and adults to avoid being admitted to*

In terms of identifying what is currently working well and what could be better, based on the feedback provided by respondents, improved communication between Hospital staff but also between the NHS and Social Care services was a prominent theme. When the communication is good and an appropriate care plan has been put in place, with the appropriate level of support, the service user feedback is of a highly positive nature. However, as identified in the focus group sessions, when this is not the case, although individuals may be using the same services, their experience is significantly varied.

In Focus: Diverse Communities

We met 7 women of South Asian (both Indian and Pakistani) background who attend the Kiran Women's Group at Bangor Street Community Centre in Blackburn. The topics discussed with the group focused on their experiences of accessing Primary Care and Community Services, options for treatment and support for long term conditions and use of Technology in communications.

Access to services - Language barriers were raised as an issue in accessing GP services with the length of appointments being a problem if people struggle to understand English well and cannot access a GP who speaks their language. Communication with receptionists was deemed to be harder for the group than with GPs and Language Line was not often used. The group also felt that adjusting to receptionists asking details about conditions was problematic: -

"I just don't feel comfortable telling them what is wrong with me in front of other members of my community"

Alternative Therapy - The group felt that social prescribing could be good, but it would take both a shift in cultural views and a change in services for women from South Asian backgrounds to access this kind of support. They felt that it would need to be tailored to the needs of their community with GPs having knowledge of South Asian groups who could offer support.

Mental health - The group felt that mental health is still taboo within their community and whilst depression is now more accepted, complex issues such as schizophrenia are just not recognised. Improved partnership working between health services and mosques or voluntary organisations would help to make progress in this area.

Dementia care - Communication between services was described as poor and that there were not enough support for families or carers. The community wants more support to help keep family members at home for as long as possible "that's so important in our culture".

Implementing cancer health and care services

Summary

We heard from 26 people in total, more than 80% of those being patients with a first hand experience of accessing cancer support services. More than 60% of these people told us about their experiences within the last three years of being diagnosed with cancer. We also found that more than 30% of these people had other additional conditions.

Generally the feedback we gathered around assessment, diagnosis and treatment was predominantly positive, however, it did highlight some areas of improvement. Similarly, were experiences of ongoing care and support. The feedback highlighted a need for better communication and readily available information for patients, when it matters.

When people first seek help and during diagnosis and treatment they would rather see any appropriate professional who is available immediately. However, for long term support they would rather see a familiar professional even if they had to wait a while.

Assessment, diagnosis and treatment

- 50% of people told us when they tried to access help the support did meet their needs

> *"The oncology unit was outstanding. There was 'joined up' thinking with other departments when co-ordinating both my wife's cancer as well as mine. We were put up in a hotel and had treatment on the same days and at the same time"*

- 25% of people told us when they tried to access help the support did not meet their needs

> *"There was no information whatever available at the oncology department or at my GP surgery related to my kind of cancer. I was given three badly photocopied sheets - two were not about my cancer and the third was links to Macmillan"*

- More than 79% of people described their overall experience of getting help very positive, positive or average

- When reflecting on waiting times for an initial assessment, diagnosis , receiving treatment or seeing a specialist most people felt it was ok, fast or very fast

- After being diagnosed were people offered access to further health and care support?

Yes - More than 40% - people commented how the staff were friendly and helpful and external support such as MacMillan and palliative care services was put in place very quickly.

No – More than 57% - people reported that there was too long of a wait for district nurses to visit when they were in pain. In addition there was little input from Mac Millan nurses, no information given and long waiting times in clinics.

The provision of ongoing care and support

- The majority of people reported that it was ok or easy to find access to ongoing support, however some were unsatisfied with the support they received

"The nursing team did not understand my cancer diagnosis and were confused by my treatment plan. They didn't read my notes and were unprofessional when I was an inpatient"

"The care was OK but I had difficulty with accessing a cancer nurse when I had decisions to make over treatments"

- When considering timely and consistent communication there were conflicting responses

People told us how some phone assessments were planned for a specific time but the oncology unit didn't communicate well regarding when they would be calling. Patients felt that their conditions went un diagnosed due to lack of understanding from their GP. We were told that one patient learnt more information by 'googling' their condition.

Prevention and/or early intervention

- What level of support could the NHS provide to help people stay healthy?

More than 90% of people would want a lot or some support – people suggested a range of medications, holistic treatments, psychological and talking therapies. Others spoke about gaining support close to home by specialist nurses and help with diet and exercise.

"I appreciate there are a team of specialists working together to give me the most effective treatment. However, It can get quite complicated and the nurse specialist had to intervene when I seemed to drop off everybody's radar for about eight weeks. I phoned her up and asked what was happening"

In Focus: Dementia Care Service in Lancashire

We visited Genesis Care, a small not for profit organisation which provides well-being and respite care services for older people. We spoke to 15 people on our visit.

Genesis told us: "Older people deserve respect and dignity as they move towards the end of their lives. For many dementia comes along and changes everything. A loss of identity, thoughts and words, faces become unrecognisable and friends may not always be around as they once were. For the person who cares for them it is often hard for them to find someone to stay with their relative, to go out and have some respite"

"Our aim is to provide person centred care within a homely environment, focusing on strategies for maintaining life skills, building self confidence and self esteem".

Denise's story

Five years ago my Mum had an episode of delirium where she thought people were damaging her plants and trying to break in to her house. One evening when I was working nights the Police contacted me as Mum had called and thought someone was trying to break in, and the next day Mum thought the burglars were at the Magistrates court.I went to the GPs with Mum as she was confused and she was prescribed medication.

Mum went in to hospital with an infection and following her stay went in to Broadfield House in Leyland for rehabilitation to support her return home.

We made adaptations at home such as a keysafe, Mum's medication was put in to blister packs and she had a Lifeline and Mum received 6 weeks of crisis care from Housing 21 on her return home.

Two years ago there was a concern with the safety of Mum's medication, so with Social work support and a carer's assessment from Ncompass a care package of domiciliary care was put in place and other adaptions made at home, to support Mum's independence.

Through Ncompass there was a referral to the British Legion Admiral Nurses, as my Mum had been in the services. "My Admiral nurse was my lifeline". There needs to be support for carers and families.

My Mum is 99 next week and is now living at The Lodge in Buckshaw Village, where I visit regularly.

I am now a volunteer with Dementia UK to help families who face dementia. I would like the Admiral Nurses Dementia help line to be promoted right across health and social care services so that carers and families know there is support available.

Summary of feedback

When you first accessed help, and received diagnosis, did the support meet your needs?

Our initial discussion focused around referral from GPs to Charnely Fold which is the Lancashire Care NHSFT Memory Assessment service for Central Lancashire.

Referral waiting times were not highlighted as an issue and the main concern after diagnosis was being left in "limbo", "being left on their own to just get on with it", "We haven't known who to speak to."

A lack of communication,for example being prescribed medication by Charnley Fold and then told there would be a GP follow up but nothing, no phonecall. You're in a "whirl" coming to terms with this diagnosois, you need support then.

The Community Fire Officer who regularly attends the homes of people with a recent diagnosis stated "people feel very on their own,there should be someone to follow up with people". One of the attendees had received help with her partner post diagnosis from the Alzheimer's Society and advised that an appointment was made at the time for a home visit with a support worker who provided on going support.

Could it be improved and how?

A referral there and then to Ncompass who will arrange a dedicated Carer's Support worker to visit and complete a carer's assessment and put in place a Peace of Mind 4 Carers plan and information about the Carer's Hub to support carers in their caring role. This information needs to be provided as a matter of course.

An information pack to be given out at Charnley Fold with contacts for organisations who can support, for example Genesis care, ncompass, Dementia uk, social services. A named person to follow up with a pre arranged phonecall.

" Information can be a bit of an overload. A person to speak to is more important". "People need to be supported at their own pace."

Eric and Tarnia's story:

"There was just nothing after the diagnosis.

We haven't heard anything in 6 months.

A pack would have been great 6 months ago. We didn't know about Genesis care until yesterday. We haven't known who to speak to.

It's quite frightening at first you are just anxious

We have now gone out and sought support, we were assessed and we've applied to Primrose Gardens which is a supported living scheme, we are waiting so aren't making any changes at home. It's a new development it should have opened in March (LCC and Chorley Council)" So a bit in limbo.

It's reassuring today to hear that others can help.

Tarnia has recently joined a choir it can be beneficial for dementia "I felt relaxed as soon as I got there," "It's really important to be with people"

I'm a people person.

After assessment /diagnosis were you offered access to health and care support:

Experiences of the impact of other medication mixed with dementia medication and the contra indications were highlighted as a real concern. Guidance from the diabetes team regarding diet though very good was not with dementia medication, for example having grapefruit and cranberry juice.

"Medical professionals are tunnel visioned for their particular care pathway"

Food and medication balance is so important for people, it is critical for people with Parkinson's

Regular medication reviews with either the pharmacist or GP.

In terms of further feedback people shared their experiences of social services, their concerns were the waiting times to speak to a social worker, it can take up to 3 weeks to get a response and so much can change in that time.

"You never get to speak to the same person" This was also the experience of the Lancashire Fire and Rescue who refer through to Social services and can speak on behalf of their clients.

"It's that inbetween time from diagnosis and when people hit crisis"

"There seems an inequality compared with other long-term conditions for example cancer - you need some one now not in 3 weeks time or somewhere we can go"

Many people do not go to the Memory Assessment Service until their dementia is quite developed, and depending on what type of dementia they have symptoms can change quite rapidly.

Support for carers was also raised as a priority and being made aware of organisations who can provide support for example Genesis, ncompass, the Alzheimer's Society, Age concern central lancashire

"Experience of cancer treatment was very different with regular follow ups"

Could it be improved and how?

The promotion of Genesis care together with other partner organisations to provide a one stop shop, for example a monthly hub similar to the Bay Dementia Hub or the weekly Carer's café on a Wednesday.

Key in the delivery of the above is communication, to ensure people know what's going on in their local area

Respite support – carers have long stints with their loved ones

Document every condition so that you can reference this when talking to healthcare professionals.

Using the local Dementia Action Alliances as a "voice" for People Living with Dementia and their carers to influence change. The local Parkinson's group exampled the very positive experience of the Parkinson's nurses providing a drop-in at Chorley hospital rather than having to travel to RPH.

A suggestion from the Dementia UK volunteer: "Is there an opportunity for a group of Admiral Nurses to do drop in centres across the locality"

How easy did you find it to access ongoing support?

"People with Parkinson's struggle with communication. Patients weren't eating and drinking because they couldn't be understood, I helped feed a patient because there was no-one to help".

"There was no information that my friend had dementia, so hospital porters don't know a person's needs and whether they can communicate".

"My friend had a water infection and was admitted to a room with 3 other ladies, they didn't know she had dementia, it was very upsetting"

"Volunteers aren't allowed to touch patients – if no response leave them".

The hospital expect patients to feed themselves and to be "independent" however many are too weak and need help to build their strength up

The problems of texture and thickness of drinks in cups and clingfilm not being removed was another issue raised as a reason why patients weren't eating

Menu/ food options that take into account the needs for diabetic patients

Hospital staff ask people living with dementia questions however don't understand their capacity. Carers and family members need to be made aware so they can support and explain.

Reference was made a number of times to ncompass and the Peace of Mind 4 Carers plan, a plan for carers in the event of an emergency with an option of upto 72 hours free replacement care from a care provider in the case of emergencies.

Could it be improved and how?

Training – All staff at Chorley hospital to have an understanding of dementia, including RVS volunteers

"Dementia is a different discipline, they are not looking at the person " you can't put a bandage on it"

The Butterfly scheme is adopted in many hospitals for example Clifton Hospital in Lytham St Annes, this is a whole-hospital care response to people with dementia, but also supports people with other forms of cognitive impairment. The Dementia Champion at Healthwatch Lancashire is supporting the hospital to deliver Information sessions across the healthcare team.

Use of hospital passports, life journals

Identifying patients living with dementia – either butterfly/forget me –not

Regular Dementia Hubs across Chorley and Leyland where information and support is available from health and local authority and Partner organisations for people living with dementia and their families and carers

Support for care homes who don't have available transport to take patients out need people to come in to support activities, volunteers.

Pam and Alan's story

You have to work out "the balance" and it's taken a while.

When we go for appointments for Alan I give them an hour at the hospital, I will give them an hour and then have a word, there's no point shouting. The longer you are in the system the more skilled you become. I keep a notebook of conditions you need to have the facts on and this will help the carers.

You have to fight for the person you love; otherwise you won't get anywhere. You need the facts when you do this. Carers save the community lots of money.

It's been hard for me to see the change in Alan but a great leveller.

The Parkinson's nurses were great especially when first diagnosed and spoke in "plain English". The diagnosis was so impersonal; it's the specialist nurses that give the real everyday support.

If Alan is admitted to hospital I ring the Parkinson's nurses and they go to the ward to support Alan.

Ncompass assessment is really important. As a carer I've signed up to Ncompass Peace of mind 4 carers, just in case anything happens to me.

Implementing Heart and Lung Disease health and care services

Summary

We heard from 11 people in total, more than 80% of those being patients with a first hand experience of accessing support services for heart and lung disease. More than 70% of these people told us their conditions started more than three years ago. We also found that more than 50% of these people had other additional conditions.

Generally the feedback we gathered around assessment, diagnosis and treatment was predominantly positive, however, did highlight some areas of improvement. Similarly, were experiences of ongoing care and support. The feedback highlighted concerns around waiting times to see a specialist as well as the delays in communication between specialists and GP's.

When people first seek help they would rather see any appropriate professional who is available immediately. During diagnosis and treatment they would rather see a familiar professional even if they had to wait a while. For long term support, 55% of people are happy to see anyone appropriate, whilst 44% would rather see someone familiar.

Assessment, diagnosis and treatment

- 90% of people shared that the initial support they received met or somewhat met their needs

> *"I had my first of six heart attacks 42 years ago and a stroke 6 years ago. Support has improved over time. I have benefited from the hospital recommending me to a gym for people with a heart condition. With people who attend having similar problems we talk about our problems and learn from each other"*

- More than 80% of people described their overall experience of getting help very positive, positive or average

- *We asked people what they thought of the length of time waiting on an initial assessment or diagnosis and over 40% reported it was ok.*

- When reflecting on the waiting time between the initial assessment and diagnosis and receiving treatment responses were conflicting

More than 50% of people commented that the waiting times were slow or very slow. 40% of people commented that waiting times were fast or very fast. *Waiting times to*

see a specialist was similar with almost 40% of people reporting it was fast and 50% of people reporting it was slow or very slow.

The provision of ongoing care and support

- More than 40% of people found it easy to find ongoing support after they were diagnosed or assessed but whether the support met expectations was conflicting.

People expressed their disappointment at not being taken seriously until their conditions were fully diagnosed. Others spoke about there being no local support and having to contact a national society to get information.

- When considering timely and consistent communication there were conflicting responses

People commented how it can take a long time for letters from the consultant to reach the GP and at times support was absent

Prevention and/or early intervention

- What level of support could the NHS provide to help people stay healthy?

100% of people would want a lot or some support

Support suggestions were:

Support groups with health professionals in attendance

Quicker appointments

Provide specialist health care practitioners

Regular assessments and reviews

Ongoing treatment with a consistent professional medical practitioner

Regular check-ups to see if any change of condition

Implementing Mental health and care services

Summary

We heard from 36 people in total, more than 70% of those being people with a first hand experience of accessing support services for their ill mental health. 55% of these people told us their conditions started more than three years ago. We also found that more than 60% of these people had other additional conditions.

Unfortunately, in general the feedback we received was negative. People told us about their disappointment with waiting times, ongoing support and lack of communication. In addition people shared how the support they eventually received had not at all been helpful or met their expectations.

When people first seek help there was a difference of opinion in preference to seeing any appropriate professional who is available immediately or someone who is familiar However, during diagnosis and treatment and for long term support they would rather see a familiar professional even if they had to wait a while.

Assessment, diagnosis and treatment

- More than 50% of people reported that when they initially tried to access help the support did not meet their needs

> *"I have been waiting to see someone and I'm classed as urgent. Both my support worker and councillor have written to the mental health nurse and neither have had a reply. I was promised an update at the end of the week, however they never keep to promises. I have now lost all faith in the mental health services in Blackpool and it had taken me years to build up the courage to ask for help"*

- *When people reflected on the time they waited to see a specialist the vast majority felt it was slow or very slow - most commented that they waited over a year.*

The provision of ongoing care and support

- More than 50% of people found it difficult or very difficult to find ongoing support and over 60% of people did not feel the support met their expectations

> *"I wasn't offered any counselling initially and had to pay for private treatment"*

"I've been told that my mental health issue is best treated with talking therapy and although I'm under the care of the mental health team, I have not been offered any therapy"

"I was offered Cognitive Behaviour Therapy, and went for my second session to be told that the therapist was no longer there as he was off sick, and there was no one else who could help me"

- When considering timely and consistent communication more than 60% of people were unhappy

People expressed the lack of communication about waiting times and diagnosis was disappointing. In addition they expressed that appointments were cancelled at very short notice with no explanation.

Prevention and/or early intervention

- What level of support could the NHS provide to help people stay healthy?

More than 80% of people would like a lot or some support

Support suggestions were:

Support through alternative solutions when on a waiting list

Regular appointments to track my progress and help keep me on track

For teams within mental health and physical health services to work together and share information on an individual's overall well being

"Provide timely, helpful and supportive information, without judgement blame or unhelpful attitudes especially around mental health issues which may impact physical health"

"Provide better access to mental health services, and also advertise services better, as I have suffered from depression for 20 years, but didn't know I could self refer to minds matter"

Implementing Long Term Conditions and care services

Summary

We heard from 69 people in total, more than 94% of those being people with a first hand experience of accessing support services for a long term condition (for example, diabetes or arthritis). More than 79% of these people told us their conditions started more than three years ago. We also found that more than 45% of these people had other additional conditions.

Generally the feedback we gathered around assessment, diagnosis and treatment was predominantly positive and waiting times were reported to be ok. The feedback highlighted a need for better communication, especially in relation to professionals sharing notes timely.

When people first seek help and during diagnosis people would rather see an appropriate professional who is available immediately. However, for treatment or long term support they would rather see a familiar professional even if they had to wait a while.

We also completed a focus group in Blackpool where we spoke to 10 people with long term conditions. They provided us with feedback around getting help and support, highlighting areas of improvement. The feedback was also extremely insightful in regards to what support would assist people to have more control over their own care.

Assessment, diagnosis and treatment

- More than 50% of people reported that when they initially tried to access help the support did meet their needs

"Support was very varied depending on who I saw. It was very apparent that professionals didn't share notes so it was a continuous feeling of having to repeat my story over and over. Lots of clinicians also knew very little about the condition and failed to look at me holistically instead trying to fob me off with short interim fixes or 'it will pass' references meaning I spent more and more time trying to access health care support and the impact this had on myself, family, work and social life was huge"

- When reflecting on waiting times for an initial assessment, diagnosis, receiving treatment or seeing a specialist most people felt it was ok.

"Despite some initial confusion at my GP practice when I initially came requesting a diagnosis, the response was then very rapid (1

hour later they rang me back to get me in). I was then seen by a diabetic nurse the next day and set up on an insulin regime"

"My Symptoms started when I was about 10 years old and I finally received a diagnosis at the age of 31. Since then I have been passed around from professional to professional and eventually I sought support online and found out about a specialist place in a different locality over 200 miles away. The service they provided has been fantastic but within my Borough professionals did not appear to t be aware of them or what they offered and don't offer anything similar"

- When considering timely and consistent communication there were conflicting responses

People told how they got all the support they required, there was good communication and their experience could not have been improved.

However, others told how they had difficulties chasing test results and there was a huge delay in separate professionals getting access to individual care notes.

Prevention and/or early intervention

- What level of support could the NHS provide to help people stay healthy?

More than 66% of people would like some support

Support suggestions were:

- ***Regular contact with a specialist nurse or other expert in my condition***
- ***Prescriptions for specialist gluten-free flour***
- ***Referrals to Slimming World to help weight loss***
- ***More staff, money and resources***
- ***No parking charges at any hospitals or clinics or walk in centres***
- ***Useful ongoing support***
- ***Ongoing physiotherapy treatment***
- ***Education about my condition.***
- ***Knowledge of a long term condition changes***
- ***Help to access fitness/be healthy and have an active lifestyle***

"My own condition and life circumstances change and it is very helpful to be in a group of people who have similar experiences. The professionals, with the best will in the world, do not always understand the realities of living with a long term condition. Often it is small things that make managing difficult and a suggestion from

someone else who has struggled can change the way you do something and makes life easier, or can change your outlook on life"

Focus Group Feedback

We visited Warren Manor Day Centre in Blackpool and spoke with 10 people, aged between 20-80 years old presenting with the following single or multiple conditions:

- Muscular Skeletal
- Arthritis
- Learning Disabilities

Summary of findings:

Experience of getting help and support

"It's a postcode lottery getting a GP appointment"

"Ten minute GP appointments are a nightmare when you have multiple health conditions"

"The GP and consultant do not refer to my notes therefore I have been prescribed unsuitable medication"

"I waited over three months to see consultant and feel this is unacceptable"

The health and care support you received after initially seeking help

- There were varying experiences in the length of time that people had to wait to receive an initial assessment and depending on the consultant, waiting times between initial assessments and treatment varied. After assessment a number of people said they had to fight for all of the things they needed for ongoing support "Continuity of care does not exist". We heard that there is an over reliance on technology and a need to have a more positive, person centred approach. In general people felt they did not receive consistent and timely communication from services.

"It took a long time from the initial assessment to receive a formal diagnosis and then due to the persons Attention Deficit Hyperactive Disorder it took a long time for them to understand the diagnosis and its implications"

"As a person with mental health issues and long term health complaints I needed to access support from a charity organisation to get continued support rather than NHS based support"

"As a person with multiple complex support needs the NHS has not met my expectations"

Time spent travelling to access support and care

The majority of the group reported that they are willing to travel if it meant getting access to treatment sooner or if it was a critical situation. Others would be willing to travel with the support of hospital transport, or were not willing to travel beyond their local hospital at all.

Expectations at each stage of your care

A number of people said that they would be willing to wait to see the same doctor as long as their condition was not serious. Some said they would see an alternative health professional if they took the time to read and digest their notes.

What can the NHS do to support people to have more control over their own care?

- **Effective person centred communication needs to be in place to enable patients to be involved in their care and not to feel helpless and frightened**
- **The system needs to consider different capabilities of the patient and their families in supporting them to stay healthy**
- **The NHS needs to resolve the issue of handling and sharing of medical records and generate trust and faith with patients and their families by demonstrating they have read patient records**
- **There is a need for people with cognitive impairments to have ongoing support to understand their diagnosis and treatment**

Implementing Autism & Learning Disability health and care services

Summary

We heard from 11 people with disabilities who provided some valuable feedback regarding health and care services.

In addition to this, we also completed a focus group in South Cumbria, speaking to 12 adults with learning disabilities. They discussed what the NHS could do to help people keep healthy, what good care looks like and how they would like to interact with the NHS.

Assessment, diagnosis and treatment

People told us how it can take years to obtain a full diagnosis, with there being little or no post diagnosis support offered. Some felt this was due to pre diagnosis concerns not being believed. Most support came from privately funded psychological support and from charity groups

"There needs to be earlier diagnosis and support through transition into clinical medical adult services"

There were concerns around the quality of support offered to people, with people commenting how the Child and Adult Mental Health Service were not useful.

"There needs to be more psychological support to understand how that persons Autism affects them and strategies to ameliorate some of the difficulties"

"They should provide access to Autism knowledgeable psychological support which presently does not exist and is very much needed. I'm against psychiatric input"

The provision of ongoing care and support

"I felt that my case was not taken seriously, despite the severity of it. The team did not treat me with understanding and one specialist would not explain my condition to me, even when asked. I could not access the specialist nurse, which is how I was advised to contact the department. I saw a different member of the team each team, where I had to re-explain what had happened to me and received mixed messages about my care"

"The whole issue of support for adults with Autism needs to be revised for those that do not meet the LD or Elderly criteria, too many of our loved ones are being let down by lack of appropriate and timely support"

Focus Group Feedback

We visited a Self Advocacy Group in Barrow-in-Furness, Cumbria and met 10 adults with learning disabilities. The discussion was focussed around three main areas:

- What could the NHS do to keep you healthy?
- What is good care?
- How would you like to interact with the NHS?

Summary of findings:

Keeping Healthy

The group spoke about their concerns for NHS dentists and many members said they were not able to get an NHS dentist as there were no places available without travelling quite far. They also said they would like more information to be made available in an easy read format about how they can care for their teeth.

Easy read formats were discussed further with many of the members saying that they believed that there was a lot of information available from the NHS on keeping healthy, though this wasn't always easily available in large font or easy read formats. We discussed where the group would like to see this information and they suggested having more information available at GP surgeries or at day centres so that staff members, who know them well can make sure they have access to information that might be relevant to them.

One of the members raised the issue of weight and healthy eating, the group mainly agreed that they had little knowledge of healthy foods and did not use the internet to access information in this area. They discussed the idea of having food workshops for people with learning difficulties so that they can try different healthy foods and recipes in a safe and friendly environment that they could re-create at home.

What makes good care?

- Give us plenty of time
- Let us get to know the environment
- Explain what you are doing

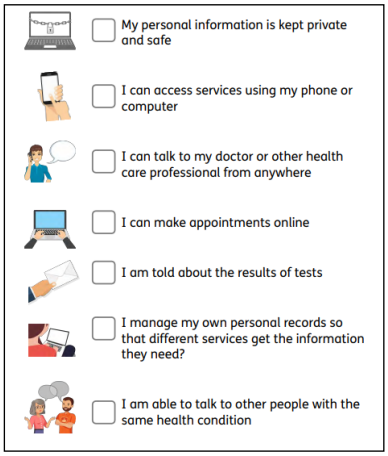
- Talk to us, not to our carer

GP experiences – feedback included: “my doctor listens to me” and “it is a nice place to be and people are friendly”. One person described their experience as being scary, reporting that “they didn’t fully understand what was happening to them” and “they had to wait for a long period of time before their appointment”.

Hospitals - All members of the group felt that they were treated with respect whilst in hospital and that staff showed an interest in them. Some members of the group commented about the experience being positive because they were able to take a family member or, carer with them to the appointment.

Dentists - positive experiences included: “the dentist did not rush me” and “they told me what they were doing”. Negative Feedback included: “feeling rushed” and feeling “scared of the procedure and un-informed about what the appointment would entail”.

Interacting with the NHS



The group shared how it is important for them that:

- Medical information is kept safe and secure
- Being told about the results from any tests
- Carers able to make appointments online
- Carers to be able to easily access their doctor

“preferably, test results should come as soon as possible, by letter so that they can read the results or ask someone to read them for them”

The group also shared what is less important to them:

- Accessing their own personal records – no-one expressed an interest to see their own personal records and they were all confident that professionals would use and manage these appropriately
- Speaking to other with the same condition – people preferred to talk to a family member or carer
- Accessing services using a phone or computer – no-one had access to a mobile phone and had very limited knowledge of using computers. They would not feel confident using digital methods to discuss their health

People want to feel respected and listened to, though they mainly trust their health professionals to make decisions about their care and so do not always need to be involved in this decision making process

Next steps

Response from Lancashire and South Cumbria Integrated Care System:

Lancashire and South Cumbria Integrated Care System is a partnership of NHS, local councils, voluntary sector and community organisations working together to support the 1.7 million people who live in this part of North West England. We call this partnership Healthier Lancashire and South Cumbria.

This report from the collaboration of local Healthwatch organisations provides valuable insight from more than 900 people across our area and we would like to thank Healthwatch for their work in capturing this feedback and for presenting this in a way which will contribute to improving services across our integrated care system.

The NHS Long Term Plan states that each ICS must produce a five year strategy which will cover both operational and long-term priorities. The effectiveness of the ICS partnership will be judged by our ability to join up health and care services, to listen to the priorities of our communities, local people and patients and to tackle some of the biggest challenges we are all facing. We can only do this by making sure patients are at the centre of everything we do as a partnership.

We are committed to involving local people, patients, staff and partners in the development of our shared five year strategy. We are already working with partners across our system to capture feedback from each of these groups which will contribute to the development of this strategy and this report will help to make sure local people's views are used to shape plans for working together and delivering safe and sustainable services. The feedback in this report has already been shared with teams working on specific areas referenced in the report along with those in each of our five areas which make up Lancashire and South Cumbria.

We are pleased that the collaborative of the four local Healthwatch in Lancashire and South Cumbria is continuing to support engagement with local people over the coming weeks to make sure local people have contributed to a strategy for our integrated care system. This engagement will see a programme of focus groups delivered within each of our five areas which are supporting local priorities.

For more information on the development of our five year plans please visit healthierlsc.co.uk

Methodology

The methodology used to collect and collate this report for the people of Lancashire adheres as closely as possible to the guidance contained within the research quality framework. Prior to engagement commencing a local engagement plan was created that would look to engage with the population of Lancashire to identify what really matters to them as part of the response to the NHS Long Term Plan and how improvements could be made during local service transformation. This was undertaken by various methods including local online surveys looking at those in the population who have a long term condition(s) already diagnosed and also by engaging with the wider population. There were also Focus Groups and general engagement undertaken to ascertain this information.

Acknowledgements

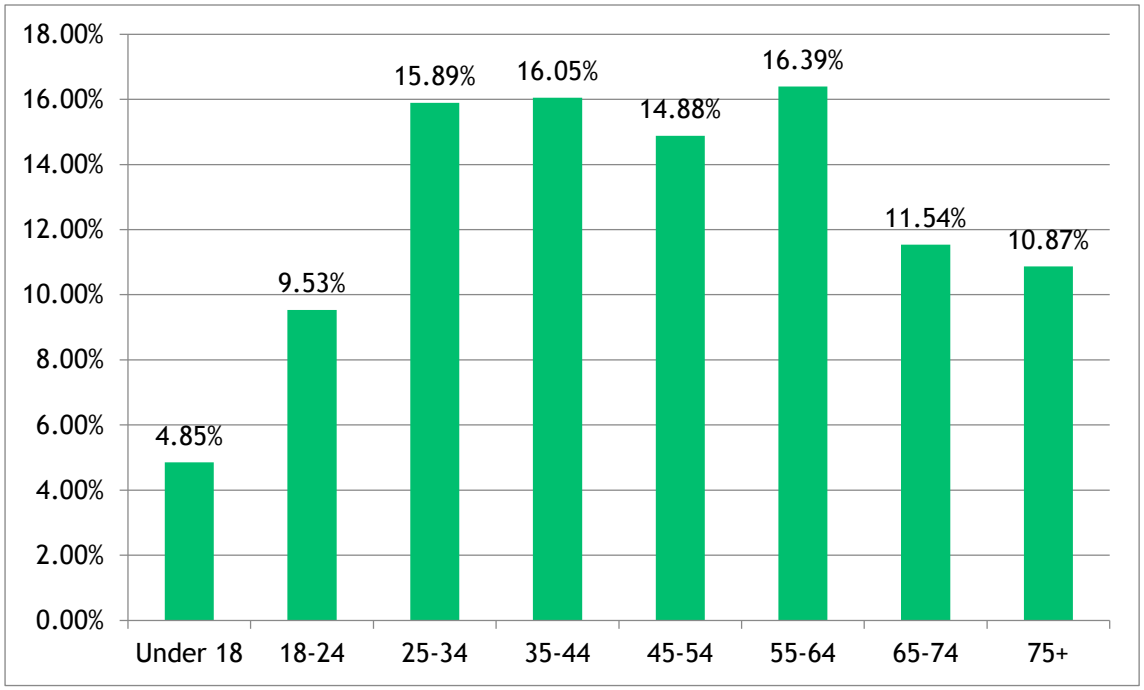
With many thanks to all who have contributed to making this report possible:

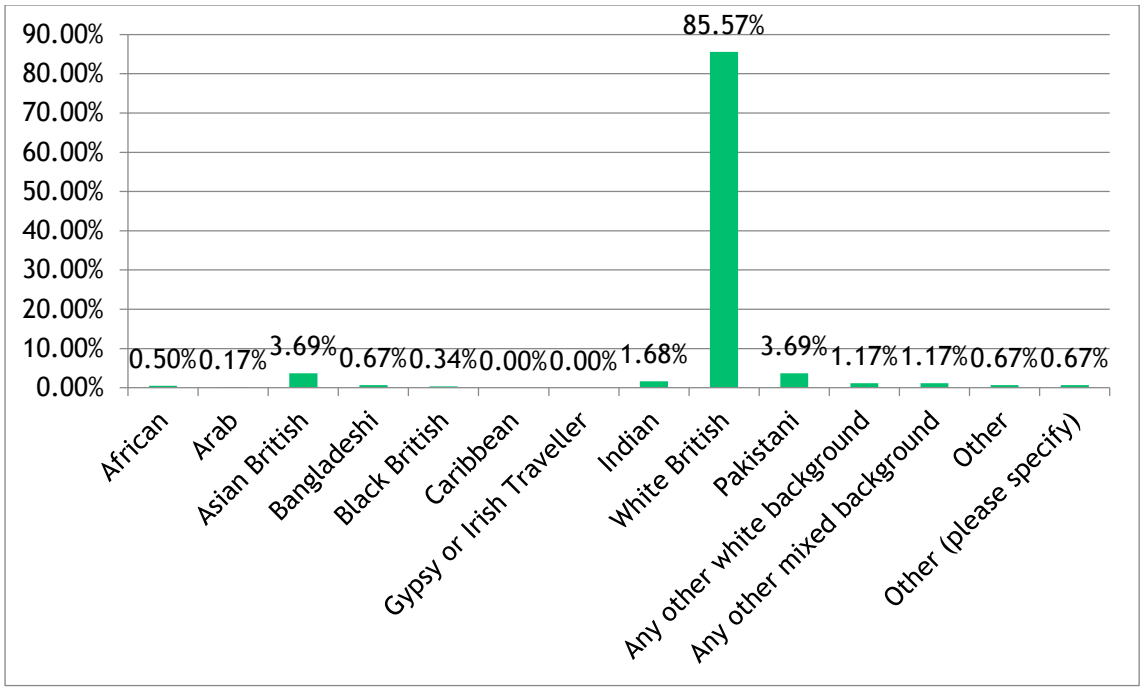
- *To all of the service users of Lancashire who have engaged with us either online or in person.*
- *Barrow-in Furness Self-Advocacy Group*
- *Healthwatch Blackburn and Darwen*
- *Healthwatch Blackpool*
- *Genesis Care*
- *Kiran Women's Group*
- *Warren Manor Day Centre, Blackpool*

Appendix1 Demographics

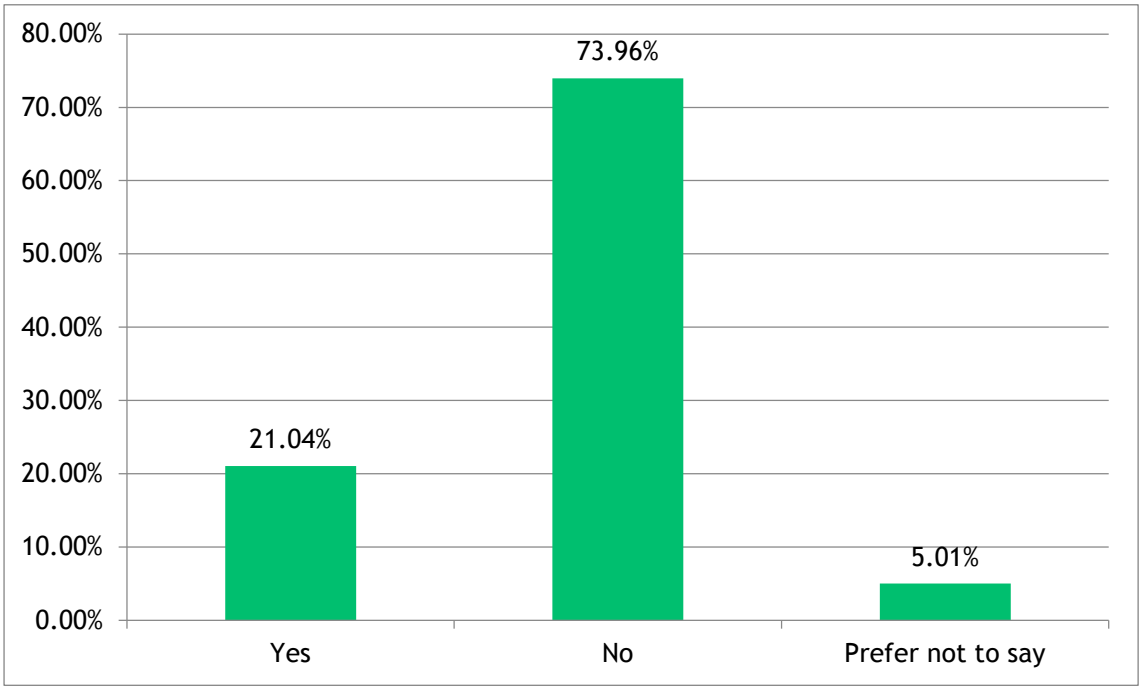
Below detail the demographic characteristics of respondents across Lancashire and South Cumbria

Age

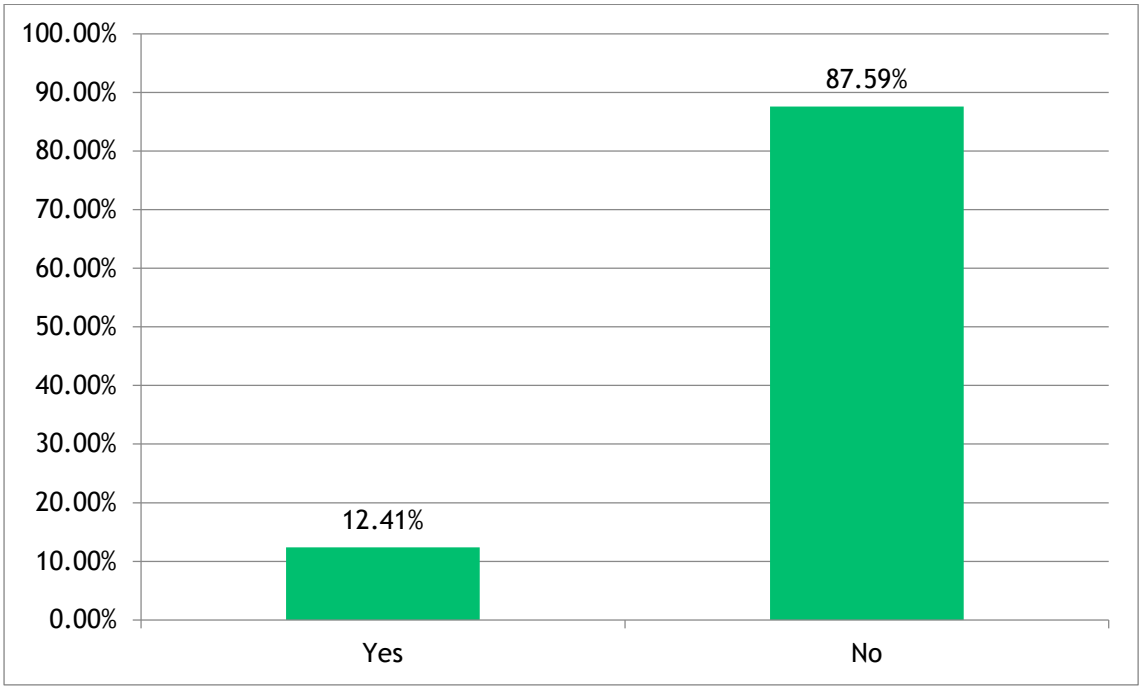




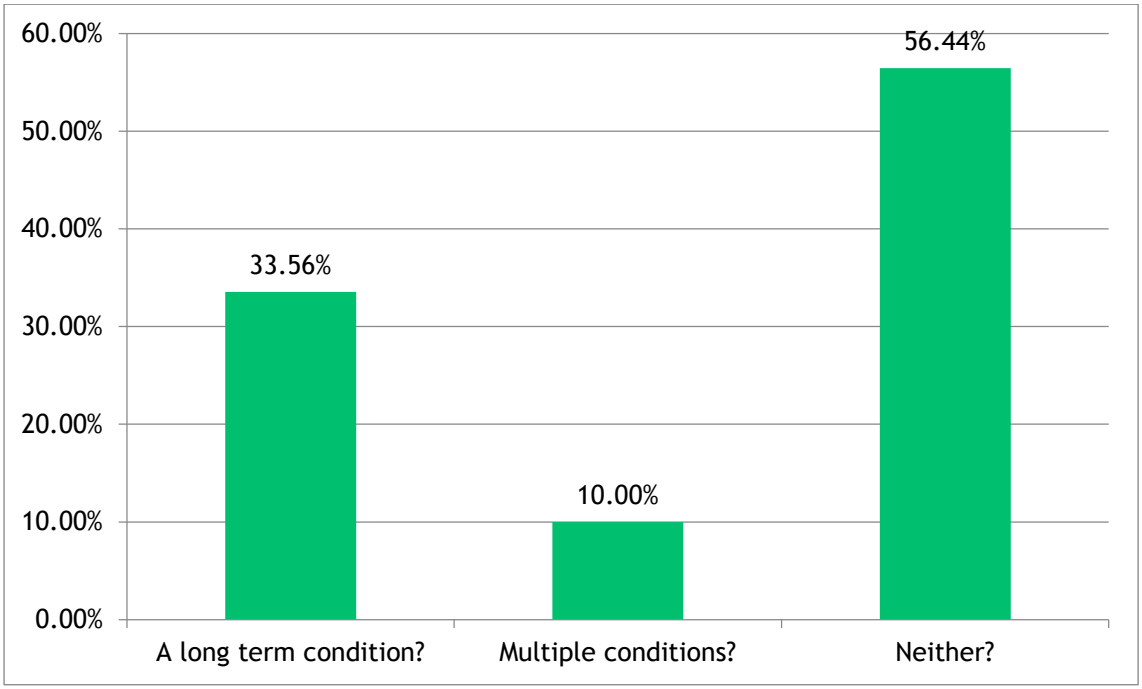
Ethnicity



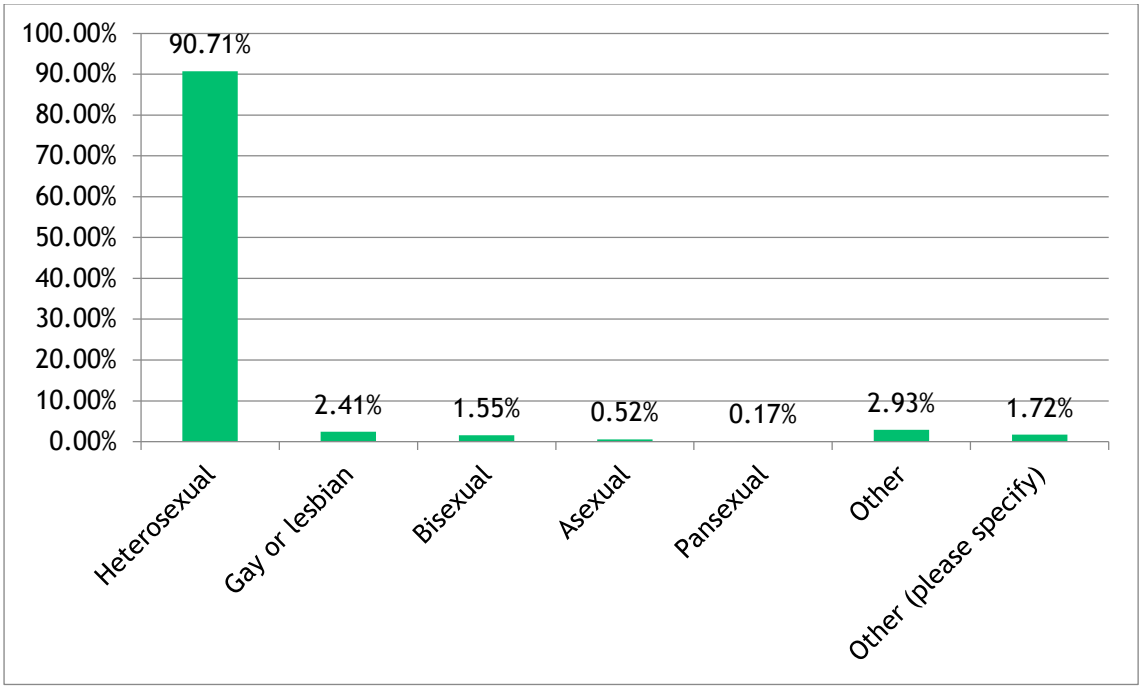
Carers



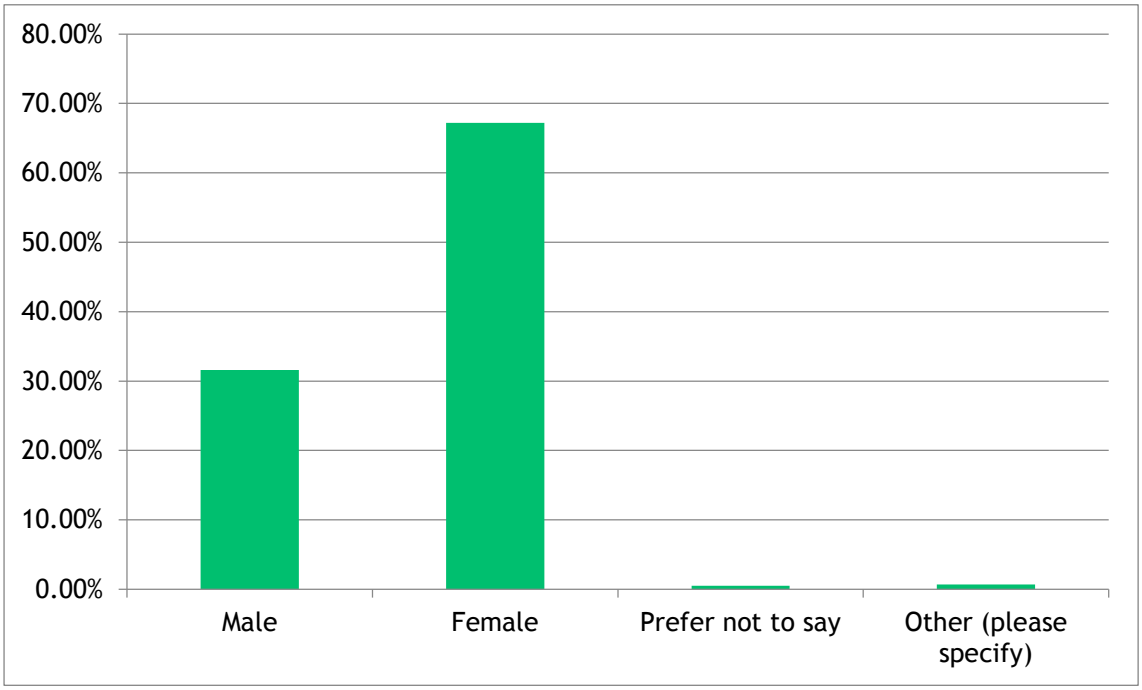
Disability or long term conditions



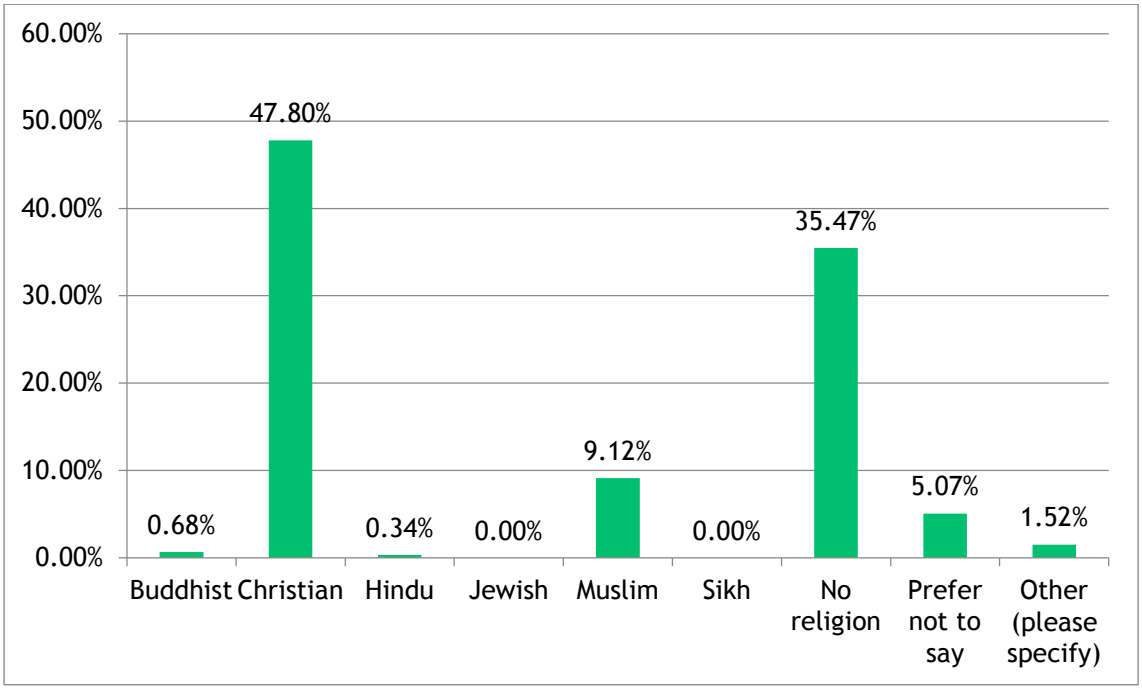
Sexuality



Gender



Religion



Appendix E

Lancashire and South Cumbria: Our Population Health Management Journey

Progress and early lessons

September 2019

Case study prepared as part of the Population Health Management Development Programme

The NHS England and Improvement (NHSE/I) Population Health Management (PHM) Development Programme

The PHM Development Programme is helping health and care systems to improve patient care and outcomes, informed by data and analysis. It helps clinicians target those groups of people and individual patients who can most benefit from more personalised or proactive care.

The programme is co-designed between local systems, NHSE/I and Optum. It runs intensively for 20 weeks and provides systems with analysis, support, coaching and workshops to build their PHM capability. Local clinicians are crucial to success, deciding which patients to focus on and how to care for them proactively and sustainably. Local areas are supported to develop plans to build PHM capability and infrastructure systemwide.

Key factors in choosing participating systems such as Lancashire and South Cumbria were the strength of clinical leadership and sufficient data infrastructure to support analysis and segmentation.

Lancashire and South Cumbria

Population: 1,700,000

Lancashire and South Cumbria is an integrated care system (ICS) composed of five integrated care partnerships (ICP). The area has some of the poorest neighbourhoods in the country, including Blackpool, the second most deprived local authority nationally. For most of the area, the quality of life for people with long term health conditions is worse than the average across England.

Lancashire and South Cumbria identified one neighbourhood from each ICP to participate in the programme. Primary Care Networks (PCNs) were emerging at the time of the programme, but five emerging PCNs of approximately 30,000-50,000 population were identified: **Barrow, Blackpool, Burnley Chorley and Skelmersdale.**

What Lancashire and South Cumbria gained through the development programme

A culture change for the system and PCNs

The PCNs worked together to understand the health and care needs of their populations. They were supported by data analysts who brought insights from data on their populations to inform discussion. Lancashire and South Cumbria was able to start seeing how data could change what they do, and think differently about their population as a whole.

Moving from improving health care to improving health

The expertise and understanding of PCNs' own populations led them beyond traditional health care. While the initial programme insights were focussed on health care, the iterative conversations with analysts led PCNs to look more broadly at the health of their population. They used their links with the community and borough councils to consider the wider determinants of people's health.

Personalised care, informed by data

The programme helped PCNs to find, from the data, people with needs not met by existing models of care. These people received a tailored offer from their clinical teams, including support for their health, psychological and social needs. Jennifer, who is approaching 60, has multiple illnesses and is a full-time carer for her daughter (see page 10). Programme analysts found Jennifer in the data because she lives with moderate frailty and has had more than 10 GP appointments in the past year. A link worker visited Jennifer and helped her reschedule surgery that had been cancelled. The link worker then put her in touch with support in the community to help her care for her daughter and look after herself as well.

A focus on measuring what matters to PCNs and patients

The programme encouraged Lancashire and South Cumbria PCNs to consider their desired outcomes while designing their interventions. Given the focus on personalised care in these interventions, this meant that PCNs asked themselves what improvements they wanted to see in their patients that goes beyond improved outcomes. PCNs designed data collection that reflected what they and their patients wanted to improve, including a focus on the patient's ability and confidence to manage their health.

Summary: lessons learned in Lancashire and South Cumbria

NHSE/I three core PHM capabilities

Infrastructure
What are the basic building blocks that must be in place?

Intelligence
Opportunities to improve care quality, efficiency and equity

Interventions
Care models focussing on proactive interventions to prevent illness, reduce the risk of hospitalisation and address inequalities

PHM Infrastructure

Lesson 1 PHM is 90 per cent culture, 10 per cent data.

Progress has been made by recognising that each of the neighbourhoods were starting from different places and with a broad mix of maturity, they have all accelerated through the programme and developed their understanding of PHM. Key to this was recognising that effective PHM is built on positive relationships between analysts, system leaders and clinicians. Bringing people together to talk about their population is informed by data, but it only leads to change if the right culture is in place.

When faced with the data there was more joined up decision making. As commissioners, we make them alone, incurring a sense of responsibility. They [the clinicians] got involved, dived in."
(System leader)

PHM Intelligence

Lesson 2 The data can help tell a story about real people

Teams can make progress without the data being perfect and they should start with what they have access to. In Lancashire and South Cumbria, programme analysts and clinicians worked to piece together what the data was telling them about their populations. Visualisations, like theographs, were able to tell a compelling story about where there were gaps in care for some patients. It was then up to the clinicians to decide what they were going to do about it.

"The clinicians really engaged in the data sets… clinical engagement in data sets has been essential and fully embraced."
(System leader)

PHM Interventions

Lesson 3 Personalisation means seeing people as people

Each PCN took personalisation seriously and built this into their interventions – with several PCNs committing to measuring changes in patient activation (see page 9). This helped interventions to be designed around people as people with health, psychological and social needs. This was supported by data that gave a full picture of individuals - partnering across health and local authorities to do so. And where the data was not enough, PCNs supplemented it with patient and community voices.

"We know this is a data driven process to find areas to improve individual and community health. We also have an underlying core vision to improve individual and community resilience."
(GP)

Summary: the Lancashire and South Cumbria PHM journey

Why were Lancashire and South Cumbria successful *(page 5)*

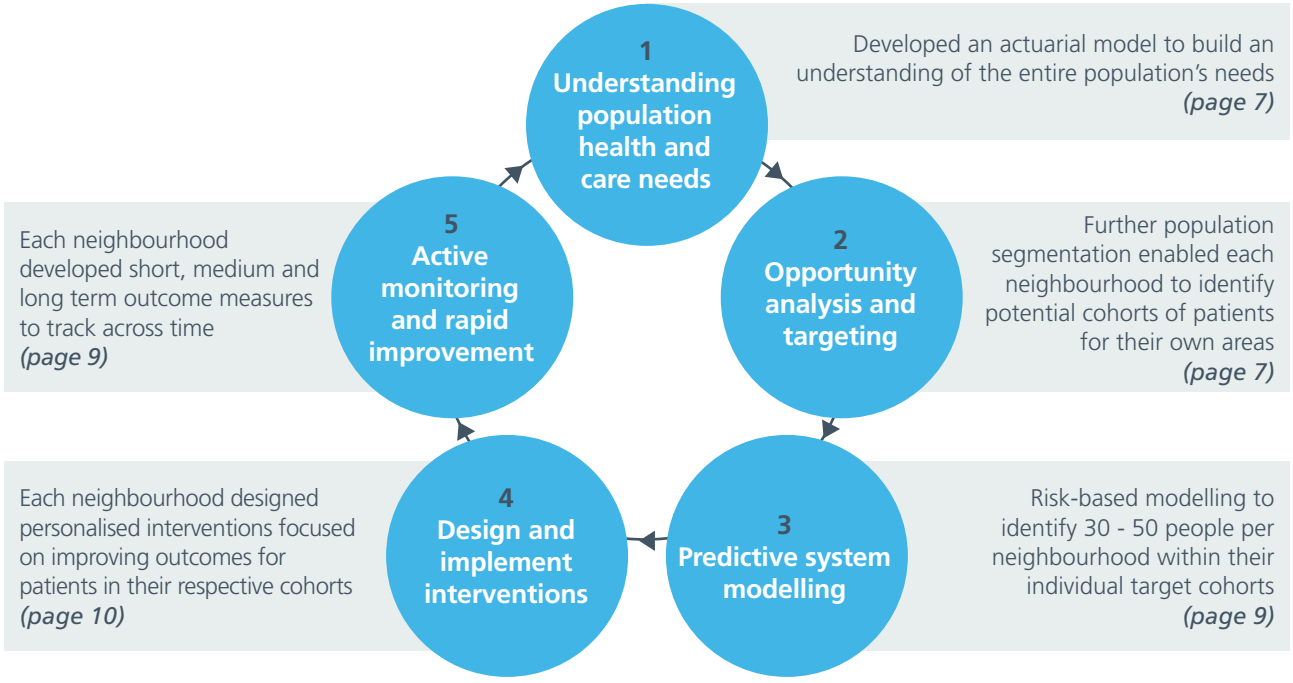
Work had been done in Lancashire and South Cumbria to provide a good foundation for PHM to develop:

Infrastructure: Collaborative system leadership in place taking a population health approach with PHM embedded in the overall Healthier Lancashire and South Cumbria ICS plans.

Intelligence: Mobilised and developed a culture of using data to inform resource prioritisation and system planning.

Interventions: Data was already being used to inform care model redesign. Meetings were already using PHM principles as a framework for focussing changes to how patients were being cared for.

What did Lancashire and South Cumbria do during the programme? *(pages 6-11)*



What is Lancashire and South Cumbria doing next? *(page 12)*

Short Term: Continue to develop and spread the learning from the programme. A new set of PCNs are to go through a locally-led 20-week PHM programme.

Medium Term: Build a cross-organisational approach to share analytics skills, expertise and training. Develop and align PHM strategies and priorities across places and the system, with senior buy-in and support.

Longer Term: Begin to develop aligned incentives that will support frontline behaviour change and a population health approach across all organisations.

The technical terms used in this case study are detailed in a Glossary *(page 13)*

Why were Lancashire and South Cumbria successful?

Population health was already bringing system leaders together

System leaders were already collaborating in considering population health – across their health and care organisations. This approach had strong support from the ICS board. PHM capabilities were already being strengthened in the ICPs across the system and having an impact. Significant progress had already been made in each ICP towards developing a systematic PHM approach.

A culture of using data to drive planning and clinical improvements – Lancashire and South Cumbria had an existing culture of using data and insights to inform decisions and planning. Work had already been done to identify information governance (IG) issues that might arise from linking data together and using it for PHM. This meant the programme was able to get started quickly on overcoming any issues.

Improving Health and Care at Scale (iHACS) had been adopted as a framework for understanding and monitoring population health – this framework was developed to give the ICS a way of understanding their collective population and coordinating action across Lancashire and South Cumbria. Taking this approach is encouraging a more holistic approach to looking after the population, including personalised care and digital health programmes as well as focussing on wider determinants of health. iHACS developed into a monthly meeting across the system, chaired by a senior public health representative. The regularity of this meeting and its senior buy-in meant that it was able to keep initiatives around prevention and PHM moving. Shortly after the programme began, this monthly meeting became a primary way of keeping a diverse range of stakeholders linked in to the PHM and development programme agenda.

Read more about population health in Lancashire and South Cumbria here.

Infrastructure: how was success enabled?

Identifying the right stakeholders to build robust infrastructure

In Lancashire and South Cumbria it was important to undertake engagement with stakeholders to confirm what data is available and what IG arrangements exist.

Gaining support from the local Data Services for Commissioners Regional Offices (DSCRO) was also essential. These organisations release data on patients in line with data access requests that NHS Digital have approved. In Lancashire and South Cumbria, progress happened much more quickly when an IG lead was identified that had a good relationship with the DSCRO. The IG lead had a detailed knowledge of IG and credibility with the DSCRO and the system. This, together with focused support from the programme, helped Lancashire and South Cumbria to navigate IG concerns.

In the long term, these good relationships have provided the groundwork for more data linking to take place. Lancashire and South Cumbria are planning to extend use of the data beyond the programme. This will enable a sustainable data set to be available across the system for the purposes of PHM.

Engaging PCNs, clinical leaders and analysts

Engagement with PCNs and public health teams began early in the process. System leaders had been working collaboratively already and knew that they wanted more than just clinical teams around the table. This was to be a wider conversation, including public health and other community groups. Initial workshops were an opportunity for a wide range of stakeholders to discover more about the programme and the PHM approach. They also began to raise with local teams how they might start to think about their population as a whole, outside of an organisational approach, and design interventions to target groups that need support.

Lancashire and South Cumbria also sought to build its analytics community. Business intelligence workshops brought together a wide range of analysts that could begin to share learning and network. Most importantly, these workshops also brought clinicians and analysts together in a way that had not happened before. This cemented links between these two communities and began to spark ideas for how analysts and clinicians could work together more consistently.

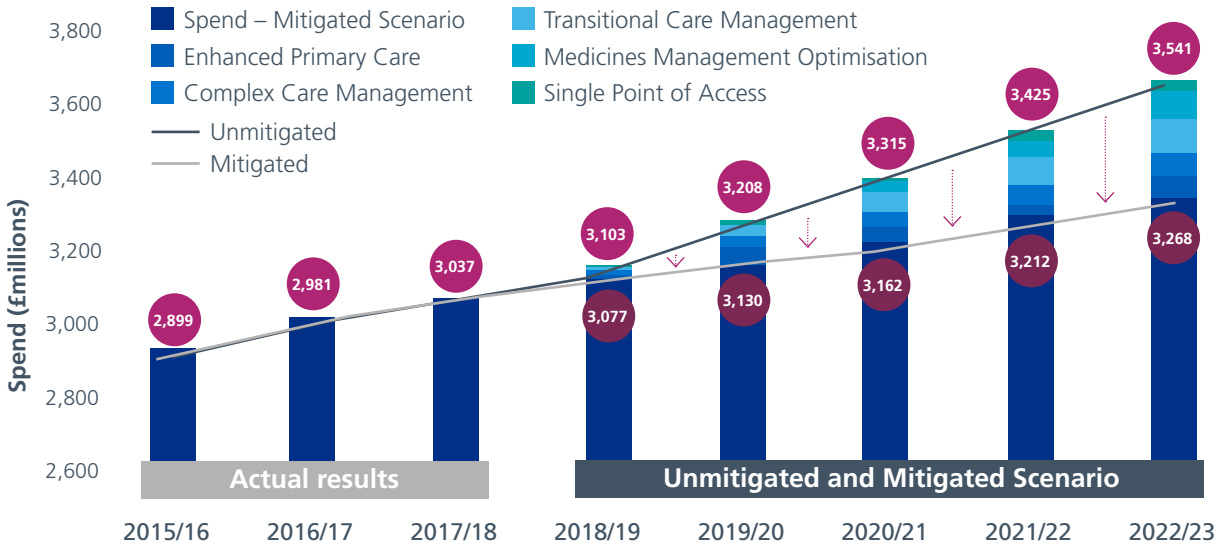
The PHM journey as described by one of the PCNs – Skelmersdale

Intelligence: using data to inform focus areas

Actuarial modeling is data analysis that calculates the probabilities of healthcare events happening in the future and the associated impact on system finances. These predictions are used to calculate the patterns of future care for all people in a system.

An actuarial model was developed for Lancashire and South Cumbria at the start of the programme. System leaders began to use this modelling to move away from an organisation-specific view of their patients. The actuarial model allowed system leaders to understand the future demand on the system based on a holistic view of the population. It is based off aggregate data from primary and secondary care. The programme also provided a mitigated future projection. This displayed how future use of resources could be different if they change their model of care.

Savings per Intervention in the Mitigated Scenario



Lancashire and South Cumbria's actuarial model shows who the highest users of the health system will be over the next few years and which groups of patients are growing most quickly. The projection visualised here shows how growth could be mitigated. This was developed further after the programme ended.

Locally, the focus was on developing an accurate view on the projected growth rate if services remain the same - the unmitigated growth rate. To do this the team built from previous models that had been developed.

Support was then provided to show local leaders how to project what the mitigated future might be. This involved engaging with local clinical staff about which interventions they might meaningfully adopt, and then projecting how these might impact people's use of health care. This helped leaders to understand how much of their cost and activity growth might be reduced. Only local teams know how well current interventions are working, what interventions are already planned and their realistic impact. The team was also provided with the actuarial model so that they could input the resulting changes and refresh the model as often as required. Analytical teams were upskilled in use of the model so that in the future it can be a basis for more advanced workforce modelling and contracting changes. Further development of this model will include understanding more about how different possible scenarios could have an impact for different parts of the system.

Intelligence: moving from data to action

The programme helped PCNs to think through the data on their populations, and ask analysts further questions to help narrow to a specific cohort of patients for initial action. Analytical teams and PCNs chose areas to focus on that were of particular relevance or concerns to their individual PCNs.

In Lancashire and South Cumbria, in particular, there was a real focus on how their population's health might be affected by wider issues in their life. Community approaches, social prescribing and patient activation were all focus areas that the PCNs adopted, encouraged by the system.

Barrow

Barrow chose to focus on geography and access to services when considering their interventions. The data indicated that just 19 per cent of patients with severe mental illness were attending their physical health check – a finding that corroborated staff's understanding. They looked at how patients were contacted and redesigned the appointment letter and the information leaflet to encourage patients to attend. This was tested with a small group of patients. This involvement of patients in the PHM process allowed through investigation into a known issue. One patient commented that the only reason they had come was because the letter said they could bring someone – otherwise they would not have been comfortable leaving the house.

Blackpool

Blackpool is the second most deprived borough in the country. Staff knew that patients living in houses of multiple occupancy - where multiple tenants live in a single residence - needed more support. However, this group is traditionally hard to find in NHS data as the information is not recorded in health care. The programme worked with council data to identify who these people were and whether their health was also at risk. Using this analysis, clinicians could identify people that would benefit from further support. Initiatives were designed and tested to support these individuals with health coaching and signposting into the community. A read code helped to find individuals in houses of multiple occupancy in the future.

Burnley

Burnley already had an interest in connecting with communities and building community resilience. The programme worked closely with local data analysts to identify the patients with moderate frailty. This group was offered an holistic assessment and follow-up support to understand their health needs. At the same time, GP leads identified existing forums that were popular in the community, starting with local church lunch clubs, to build community awareness of frailty and the services on offer. Patients and communities now have a much better understanding of the services available to them and how they can be accessed through the use of local community connectors. The team has seen the benefit in taking an holistic approach, pairing data and analytics with community-asset based approaches. Improvements in patient activation scores are being tracked to measure impact.

Chorley

Chorley had already begun working across practice boundaries and with other stakeholders, including Chorley Council. These prior interests encouraged Chorley to think wider than traditional healthcare data. A lightbulb moment came when realising that people who were receiving assistance with bin collections – data held by the council – could help clinicians find frail people who had fewer social links. Interventions reflected these links between health and social needs. They used a social prescriber to provide care coordination and outreach for patients identified from this data. Patient activation scores were collected from patients. Patients are starting to see improved activation levels and reduced use of their GP practices.

Skelmersdale

Skelmersdale successfully used the programme to build a solid grounding in PHM. They used data insights from the programme to consider the complexity of their patients. A multi-disciplinary team was set up to focus on those with chronic pulmonary obstructive disorder (COPD) and additional complexity. This group was identified from the data as being particularly in need of additional support. Patients were found in the data and received interventions like being invited in to see a social prescriber and attend group consultations. A more comprehensive COPD template was also developed, helping with identifying complexity of COPD patients in the future.

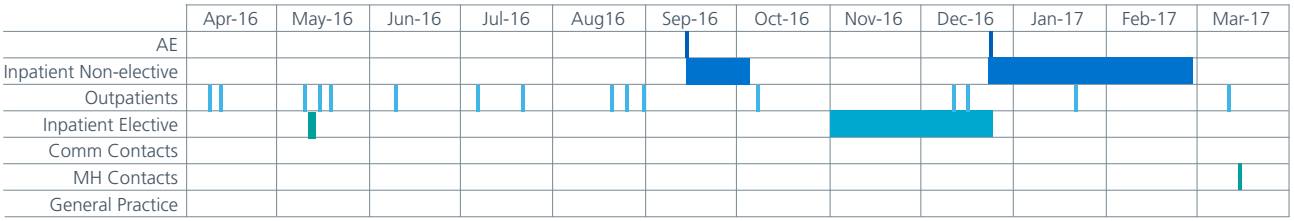
Intelligence: identifying individuals to take action with

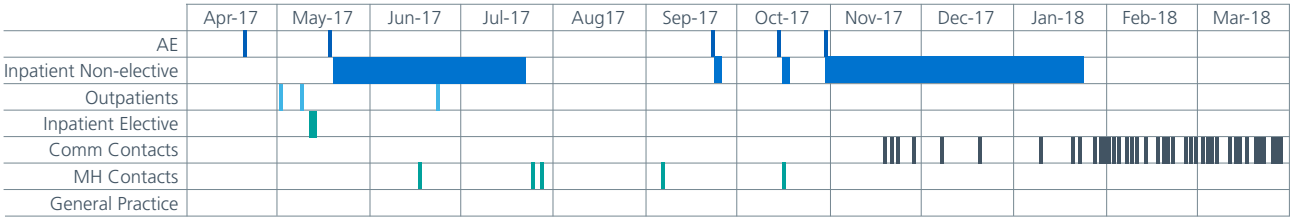
Visualisations used to bring out the patient story in the data

Once the PCN had agreed on an initial cohort to target, programme analysts conducted further analysis on the PCN's request. The aim was to identify the first 35 to 50 patients to target and following interventions, identify ways to extend this approach. They could then target proactive and personalised care for this group.

To aid this, teams were given heatmaps that looked at the factors that drive complexity within their cohort. These showed system cost – a measure of how much people in different categories are using services. PCNs were able to use this information to identify which groups of patients might be receiving poor value care.

Teams also received **theographs**. These visualisations show how individuals have used care services and show where the system is not working for patients as it should. In Lancashire and South Cumbria theographs particularly resonated with staff who used them to understand the data in a way that also reminded them of the patients at the heart of that data. Clinicians used the theographs to have a discussion on how to better coordinate care for their patients and prevent unnecessary hospital visits. Read more about theographs.





Estimated system cost of care:
2016/17 – £14,000
2017/18 – £19,000

High quality, linked data is vital for PHM. However, PCNs in Lancashire and South Cumbria could start developing their approach to the PHM linked data that was available. The theograph is an example of how the programme helped PCNs see their own data local data and enrich their understanding of their patients. Locally sourced data, coupled with local knowledge, allowed teams to make progress in areas they would not have been able to if they had to wait for all data sources to be linked.

Measuring the outcomes that matter

Measurement is a critical part of the PHM cycle. Each PCN developed specific outcome measures that they could track in the short, medium and longer-term. This was achieved by adding specific codes to the records of patients who had received the new models of care developed in the programme.

A specific focus in Lancashire and South Cumbria was on collecting patient activation measures (PAM) from patients. Patient activation describes the knowledge, skills and confidence a person has in managing their own health and care. The PAM is a validated way of capturing this and is administered as a survey with patients. People are then described as being anywhere from level 1 to level 4 – with level 1 individuals being passive and overwhelmed by managing their own health and level 4 individuals having adopted many of the behaviours needed to support their own health. Read more about the Patient Activation Measure.

In Lancashire and South Cumbria, the PCNs had a shared objective of improving patient activation. Some PCNs designed processes to capture patients' activation levels before and after interventions.

Intervention: how did this make a difference to patients?

While the PCNs all chose different cohorts of patients to target they all implemented interventions that impacted on patients in different ways. Interventions in Lancashire and South Cumbria took an holistic view of the population and were developed with input from NHSE/I's personalised care team. This supported the development of interventions that were in line with NHSE/I's Universal Personalised Care guidance.

A patient story from Lancashire and South Cumbria: **'Jennifer from Chorley'**

Chorley PCN identified a series of patients who were under 60, living with moderate frailty who also had a high number of primary care appointments in the last year. One of these people was Jennifer, who lived with hypertension, cataracts and had recently had a knee operation. A link worker (Irene) visited Jennifer and had a conversation to talk through her needs and complete the PAM (see slide 9) to determine her current level of activation. Jennifer was assessed as lacking some knowledge and confidence in managing her health (level 2). She was also a full-time carer for her disabled adult daughter. She was linked in with community services, but only had two appointments left. Irene worked with the GP surgery to reschedule vital cataract surgery and put Jennifer in touch with additional support services, particularly those who could help her as a carer. Irene visited again four weeks later: the patient had her cataract operation and a health care worker was helping arrange future care for her daughter. A Special Educational Needs and Disability worker had helped liaise with her daughter's school. Jennifer was also signposted to opportunities to volunteer for a parent and toddler course, and she enrolled in a cooking course to help with her goal of losing weight. Her patient activation rose to a level 4.

PCN cohort identified through the analytics:

- The Chorley team identified patients aged between 45-60 years, who were moderately frail (9 or more Electronic Frailty Index deficits) and had 10 or more primary care appointments in the previous year.

Locally-designed intervention:

- Face to face meetings with moderately frail patients aged 45-60 who have high utilisation of primary care. These patients are identified, and then representatives from the practice meet with them to help coordinate access to appropriate care options and provide additional support and education.
- Tracking patient engagement and monitoring the impact on patient outcomes.

A patient story from Lancashire and South Cumbria: **'Barbara from Blackpool'**

The Blackpool team used data on health and housing to find Barbara. She lived in a one bedroom flat, in a house of multiple-occupancy in Blackpool town centre. Barbara lived in poor quality housing, suffered from depression, was unemployed and recently experienced a bereavement. She was in rent arrears and turned to alcohol to help her relax. The PCN arranged for a health and wellbeing worker to visit Barbara. During their visit, the health and wellbeing worker identified severe risks in the quality of Barbara's building and was concerned for her welfare and safety. The worker supported Barbara to call her letting agent and strengthen the locks on the door to help her feel safer. The worker now visits Barbara regularly, building up a picture of her health and social needs. Barbara was referred to a local charity to support her with her bereavement. Other support around her housing was provided by organisations in the Blackpool area, and she found support for finding employment and building her skills and confidence. Barbara's patient activation rose from a level 2 to a level 4 during this time, demonstrating how confidence in managing her health changed with this social support. She is eating healthier and drinking more water and she looks to alternatives to alcohol for socialising.

PCN cohort identified through the analytics:

- Blackpool identified residents of houses of multiple occupancy, with depression and other health issues.

Locally-designed intervention:

- Holistic and proactive health assessments by health coaches in the PCN.
- Follow-up assessments of social situation by health and wellbeing workers in the council. This included assessment of particular risks to health.
- Signposting individuals to other psychosocial services – counselling, peer support and other social support.

Intervention: how did the care model change in each PCN?

Barrow

Patient cohort: Patients living with severe mental health issues and other physical health issues.

Initial List Size: 12 people

Intervention: Followed a quality improvement approach to improving uptake of health checks among patients living with severe mental health issues. An improved information leaflet for patients to outline why they are having a follow up post review.

Impact: Understanding what motivates people is key to delivering successful interventions. *"This project pulls together what have traditionally been segregated services."* (System Lead)

Blackpool

Patient cohort: Residents of houses of multiple occupancy with depression and other health issues.

Initial List Size: 41 people

Intervention: Work jointly to develop health coaching focusing on holistic assessment, counselling, peer support and sign-posting to support groups.

Impact: Bringing together multiple stakeholders is important to make and sustain change. *"The programme brought together people who have the same purpose" building a sense of camaraderie."* (GP)

Burnley

Patient cohort: Over 65s with a moderate frailty score.

Initial List Size: 48 people

Intervention: Created a dashboard as a baseline for face-to-face health coaching, holistic assessment and signposting to other services. Community engagement sessions aimed at bringing people together to discuss improvements to their health and wellbeing.

Impact: Utilising existing community assets builds resilience. *"I was very surprised that the clinicians really engaged in the data sets… clinical engagement in data sets has been essential and fully embraced."* (System Lead)

Chorley

Patient cohort: Patients aged between 45-60 years identified as being moderately frail. Patients having 10 or more primary care appointments

Initial List Size: 144 people

Intervention: Providing care coordination along side social prescribing. A new data collection was designed for assessing patient activation before and after the intervention.

Impact: *"Our council leader has had a strong vision about collaborative working across health and social care. This executive interest and vision to drive towards breaking down barriers has been hugely important, and means we are way ahead of most other localities in our area."* (GP)

Skelmersdale

Patient cohort: Respiratory (COPD) and additional complexity. **Initial List Size:** 40 people

Intervention: Individual COPD review and holistic assessment. Patients invited in to see a social prescriber and attend group consultation. A new COPD template was designed to record patient information.

Impact: *"The programme helped push clinician thinking from disease management to holistic patient and population management. This programme has been going on as PCNs and neighborhoods take more shape. The sense of team helped the PCN development get onto a good footing."* (System Lead)

How is PHM being taken forward in Lancashire and South Cumbria?

At the end of the development programme, Lancashire and South Cumbria developed a **roadmap** (see below) to further develop and commit to a PHM approach.

Significant up front effort is needed to ensure IG and linked data is in place. The system is looking to implement a sustainable linked data set solution and potentially establishing an ICS analytics hub. The programme helped build a consensus that all parties should be working from one agreed data-source and that a wider range of stakeholders should have access to this. There are also plans to build on the actuarial modelling to understand more about how different scenarios can be modelled to understand the impact of different interventions.

Lancashire and South Cumbria wants to understand the patient impact of PHM. Each PCN has committed to collecting data on their agreed cohorts to measure the effectiveness of interventions, particularly around patient activation. They will be reviewing their outcome measures over the next 6 to 12 months to understand what has improved. There is also going to be another 20 week local PHM programme, with new PCNs.

Lancashire and South Cumbria's roadmap for PHM

PHM capability	Next steps
Infrastructure	
Leadership	• Develop consistent understanding and vision of PHM across ICP and ICS leadership. • Identify project management office resources to support PHM.
PCN development	• Develop ongoing support to embed approach to deliver targeted impact in five existing PCNs. • Next priority PCNs identified for new local wave of PHM programm. • Continue ALS format to develop clinical skill in applying PHM approach.
Analytics capacity and capability	• Work with partners to release resources to support analytics at all levels of the system, including supporting PCN MDTs in interpreting data.
Data infrastructure and maturity	• Continue to integrate wider data sources (social care, County Council, community mental health, fire service, assisted bin collection) and move to long term hosting arrangement. • Work with PCNs and partners to ensure data and analytics tools are actionable and meaningful to all levels of the system.
Intelligence	
Impact modelling and outcomes measurement	• Develop skills for long term actuarial modelling and planning purposes. • Implement structures to support impact measurement in line with the PHM cycle. • Ensure structures in place to support measurement at patient level.
Tools to target those in need	• Sophisticated predictive models, consistently applied, tailored to local needs. • Developing own predictive models and adopt a data driven approach to modelling.
Interventions	
Implementation of effective interventions	• Multi-professional teams resourced and skilled to apply the PHM approach. • Personalised care team engaged and measures being taken to ensure maximum patient activation. • Wider stakeholders being engaged to share data and support interventions.
Workforce	• Workforce assessed to ensure all staff are working to the "top of license" and in line with PHM methodology.
Transitions of care	• All parts of the system being engaged to support transitions of care.

Glossary

Term	Definition
Actuarial modeling	Actuarial modeling is data analysis that calculates the probabilities of healthcare events happening in the future and the associated impact on system finances. These predictions are used to calculate the patterns of future care for all people in a system.
Neighbourhoods	Lancashire and South Cumbria's precursor to primary care networks (PCNs) was neighbourhoods. These varied in size but were approximately 30-50,000 patient population. This case study refers mainly to PCNs for simplicity.
Personalised care	Personalised care means people have choice and control over the way their care is planned and delivered, based on 'what matters' to them and their individual strengths, needs and preferences. It is a new way of delivering NHS care in which people have options, better support and more joined-up care. **Read more about the universal personalised care model**
Population health management (PHM)	PHM is a means of improving population health by using data driven planning and delivering of proactive and personalised care to achieve maximum impact.
Segmentation	Segmentation is grouping the local population by what kind of care they need as well as how often they might need it. This can be done at a population level, by identifying different segments in a population, or at an individual level, by identifying which segment an individual fits into. **Read more about segmentation**
Theograph	'Theographs' are a way of visualising an individual patient's use of health and care services. It allows clinicians to see how individuals have used care services and any gaps or duplication. **Read more about theographs**

Introducing the Lancashire and South Cumbria PHM team

The following individuals have been instrumental to the success of PHM across Lancashire and South Cumbria.

For more information about Lanchasire and South Cumbria PHM Journey, please contact Sakthi Karunanithi at sakthi.karunanithi@lancashire.gov.uk

For more information about the National PHM Programme, please contact england.stgphm@nhs.net

PHM Role	Name	Title
Senior Responsible Officer	Andrew Bennett	ICS Executive Sponsor & Executive Director of Commissioning
Senior Responsible Officer	Dr Sakthi Karunanithi	Senior Responsible Officer (SRO) for Population Health and Development Programme Director
Consultant Public Health	Eleanor Garnett-Bentley	Consultant Public Health
Data and Analytics Lead	Declan Hadley	ICS Digital Lead
Programme Manager	Lindsey Roome	ICS Population Health Programme Manager
Communications and Engagement Lead	Louise Barker	Senior Communications & Engagement Manager, Lanchasire and South Cumbria ICS
Integrated Care Partnership (ICP) Lead	Donna Roberts	Central Lancashire ICP Lead
ICP Lead	Jackie Moran	West Lancashire MCP Lead
ICP Lead	Collette Walsh	Pennine ICP lead
ICP Lead	Peter Tinson	Fylde Coast ICP Lead
ICP Lead	Helen McConville	Morecombe Bay ICP Lead

Health Scrutiny Committee
Meeting to be held on Tuesday, 24 September 2019

Electoral Division affected:
(All Divisions);

Our Health Our Care Programme - Update on the future of acute services in central Lancashire
(Appendix 'A' refers)

Contact for further information:
Gary Halsall, Tel: (01772) 536989, Senior Democratic Services Officer (Overview and Scrutiny), gary.halsall@lancashire.gov.uk

Executive Summary

An update from the Our Health Our Care programme on the future of acute services in Central Lancashire. This update describes the progress made relating to the formal assurance process required by NHS England relating to proposals for significant service change (Stage 2).

Recommendation

The Health Scrutiny Committee is asked to:

1. Note the update and in particular the outcome of the Our Health Our Care Joint Committee meeting held on 28 August 2019.

2. Identify the areas of analysis which it would like to see stand part of the next stage of the programme, to support its consideration of the proposals being in the interests of the health service in the local area.

Background and Advice

The paper at appendix A provides an update from the last presentation formally received by the Committee at its meeting held on 25 September 2018, and updates members further from the elected members informal meeting provided on 7 December 2018. The paper also reflects the outcome of the Our Health Our Care Joint Committee meeting on 28 August 2019.

A senior team of Our Health Our Care programme stakeholders will attend the meeting to present an update on the future of acute services in the Central Lancashire area, providing details of the progress being delivered with respect to the assurance milestones required by NHS England.

The Health Scrutiny Committee is asked to:

Lancashire County Council

1. Note the update and in particular the outcome of the Our Health Our Care Joint Committee meeting held on 28 August 2019.

2. Identify the areas of analysis which it would like to see stand part of the next stage of the programme, to support its consideration of the proposals being in the interests of the health service in the local area.

Consultations

N/A

Implications:

This item has the following implications, as indicated:

Risk management

The report at Appendix A represents the views of the Our Health Our Care programme and are not those of Lancashire County Council.

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

Paper	Date	Contact/Tel

None

Reason for inclusion in Part II, if appropriate

N/A

Health Scrutiny Committee

Meeting to be held on Tuesday, 24 September 2019

Our Health Our Care Programme – Update on the future of acute services in Central Lancashire.

1.0 NHS England Assurance Gateways:

The Our Health Our Care programme cleared the Stage 1 “strategic sense check” gateway of the NHS England process for assuring proposals which could constitute major service change in July 2018.

This process triggered “Stage 2” which involves the production of four key assurance documents – developed in turn:

- An updated Case for Change,
- An updated Model of Care,
- A defined list of service options, including shortlisted options,
- A Pre-Consultation Business Case.

In short, the documents developed in Stage 2 should take account of the outcomes from clinical, service user and broader stakeholder engagement activities which have previously taken place; the requirement to meet the assurance conditions set by the regulator; and the duties to respond to the programme objectives and the delivery of safe, effective and affordable healthcare.

Upon the completion of the above four key assurance documents and the direction provided by the Health Scrutiny Committee, the regulator determines if the documentation is of the required quality, depth, and alignment with the necessary standards so as to enable clearance to be provided for a consultation activity to take place. Prior to approaching the regulator, the programme should consider options (if available) which may not trigger the need to consult, as part of an open-minded approach to option generation, modelling and appraisal.

More detail about the NHS England guidance is included in Annex 1. A full electronic version of the guidance can be found by following this link:

https://www.england.nhs.uk/wp-content/uploads/2018/03/planning-assuring-delivering-service-change-v6-1.pdf

For clarity, Clinical Commissioning Groups (CCGs) are under a statutory duty to have regard to this guidance.

With respect to the Our Health Our Care programme, the above documents are presented to a Joint Committee of the Clinical Commissioning Groups for Chorley and South Ribble and Greater Preston, known as the OHOC Joint Committee. The OHOC Joint Committee comprises the membership of the two clinical commissioning group governing bodies, including Executive Directors, GP Directors, Lay Members and Professional Leads.

2.0 Headline Progress:

The programme is currently developing the third of these four assurance documents – a defined list of options, including shortlisted options. These matters were presented to a the Our Health Our Care Joint Committee in a meeting in public on Wednesday, 28th August. A copy of the report can be found by following this link.

https://www.chorleysouthribbleccg.nhs.uk/download.cfm?doc=docm93jijm4n7363.pdf&ver=13593

This report considered the process by which these options were developed, the assumptions, the viability criteria, the options themselves, and those which will now be developed for further detailed modelling (the shortlist). All options are "on the table" and the opportunities to seek further capital investment in Central Lancashire are to be explored expeditiously.

Only when the detailed modelling and shortlisting has taken place, and the approval from regulators achieved, will a public consultation on the options considered to be viable will then take place. This will also incorporate any opinions and recommendations received relating to the options from the North West Clinical Senate, who visited both Royal Preston and Chorley and South Ribble hospitals on Monday 16th and Tuesday 17th September respectively.

Any public consultation will be open, honest, and fair - providing sufficient and transparent information to the public so as to enable them to form a reasoned response to the proposals. The length of a consultation process is likely to be at least twelve weeks and may be extended such the period of consultation overlap with a planned holiday season.

The programme has undertaken extensive public engagement to date but will further take the advice of the Consultation Institute relating to the form and manner of a consultation. The programme continues to benefit from the expertise of its Stakeholder Reference Panel and partners such as Healthwatch to ensure that the materials it is developing, and the communication approaches proposed will enable the programme to communicate effectively with the public. The programme, relating to its Stakeholder Reference Panel, and existing patient liaison forums including the Patient Voice Committee and the Patient Advisory Group have also supported the implementation of a proactive media/engagement strategy so as to build public awareness around the options. This work has already commenced with an engagement strategy covering print, social and website-based media approaches. A political briefing has also been offered to all local members of parliament.

Consultation processes will also include all statutory consultees, local stakeholders and neighbouring commissioning and provider organisations. The programme also wishes to maintain effective communication and co-working with the Health Scrutiny Committee throughout all remaining stages of Our Health Our Care.

2.1 Programme Background:

The mandate to develop the report containing programme options arose from the approval of the Case for Change (13th December 2018) and Model of Care (13th March 2019) respectively. More information about the Case for Change and Model of Care can be found in Appendices 2 and 3 of this paper respectively.

As discussed above, the report containing programme options was presented to a meeting in public of the Our Health Our Care Joint Committee on 28th August 2019. The outcome from the Joint Committee on the 28th August enabled the programme to continue detailed modelling activities relating to all of the options, as part of its work in proceeding with the development of the Pre-Consultation Business Case. This included a proposal to revisit the opportunity for a new build site in at an unspecified Greenfield site in Central Lancashire.

2.1.1 Supporting the options development process:

To support its work in the development of the report containing the programme options, the programme also engaged additional assurance during this process, details as follows:

1. The **Royal College of Emergency Medicine** conducted an Invited Service Review on Wednesday, 3rd April and Thursday, 4th April. The terms of reference for this review can be found in Annex 4. The report received from the Royal College is intended for future publication as part of the Pre-Consultation Business Case in the programme, citations were also provided in the report containing the programme options. The review team from the Royal College included expert clinicians from across the country, also including Lay representation and the Registrar.

2. The **Care Professionals Board** is an independent, multi-disciplinary panel covering Lancashire and South Cumbria. The membership of this group, including external representatives and a separate reviewer team drawn from clinicians beyond the Lancashire and South Cumbria geography, will review the options for Our Health Our Care on the 19th July and will provide a report shortly afterwards. The report received from the Care Professionals Board is also intended for future publication as part of the Pre-Consultation Business Case in the programme.

3. At a formal level, the Health Scrutiny Committee has received representations from the North West Clinical Senate manager, Caroline Baines, relating to the function, role, and objectivity of clinical review provided by the Clinical Senate. The Stage 2 external review from the **North West Clinical Senate** took place on 16th and 17th September. The Senate process required the programme to develop detailed information relating to all options and the supporting Model of Care. This group also received details of the opinions from the other assurance functions; the previous report commissioned by NHS England in 2016; and the correspondences and action plans arising from the Committee's consideration of these matters in 2017. The final report from the North West Clinical Senate will not be received until 25th November. The report received from the North West Clinical Senate is also recommended (by them) to be made public. The report will be published as part of the Pre-Consultation Business Case in the programme.

2.1.2 The Options Development Process:

Within the report, the options development process and described followed has reflected a three-stage approach, indicated below. All stages were clinically led. The options process itself has been split in to three consecutive stages, known as Stages A to C. The work continuing with the options represents an extension of Stage C.

2.1.3 Stage A: Agreeing the approach and methodology

This stage included defining the approach by which options will be generated in the programme, making sure that the approach is objective and clinically led. The approach taken with the Our Health Our Care programme has included developing relevant assumptions, constraining the options to those which could reasonably respond to the issues cited in the Case for Change and Model of Care, but also, at the same time, including possibilities which appear unlikely, or outside the frame of current thinking.

Options, as developed, must outline the full breadth of changes which are required to deliver improved population health and clinical outcomes, but equally must be clear in terms of the points where they differentiate. In short, this also mean that the options under consideration in the process must not avoid describing choices which are not easy, potentially controversial, or unlikely to attract universal levels of support.

2.1.4 The assumptions within the programme include:

- The need to maintain access to emergency care in Central Lancashire as a core requirement for population health.
- To maintain access to two acute hospitals serving the Chorley and South Ribble and Greater Preston CCG populations in Central Lancashire.
- Restricting the scope to the clinical activities directly commissioned by the two clinical commissioning groups in Central Lancashire.
- Not assuming that enabling capital will be made available to develop any of the options.
- With the exception of a “do nothing” option, the programme assumes that the requirements for effective prevention activities and an out of hospital strategy must stand part of any of the options.
- With the exception of a “do nothing” option, the programme assumes that the engagement responses – to deliver more care closer to home where safe and clinically effective, must stand part of any of the options.

2.1.5 The three main outcomes from the approach followed in Stage A were as follows:

1. An agreed methodology for generating and assessing options.
2. A benefits and outcomes framework against which options can be identified.
3. A theoretical long list of options being developed.

2.1.6 Outcomes of the Stage A process:

In total, thirteen options were generated as a result of this process, including a “do nothing” option, and a further possibility (option 2) of focussing exclusively on transforming services across primary and secondary care, without delivering reconfiguration of acute services. This option considers retaining services in their existing set up but focussing on schemes employed by the trust to improve flow and patient experience. This includes schemes focussing on improving length of stay for admitted patients, improving the utilisation rates for theatres, improving urgent care access, and improved working with partner agencies such

as social care, mental health, and the North West Ambulance Service. This option also considers the benefits which can be delivered by the clinical commissioning group in terms of developing primary care networks, delivering more care closer to home, and avoiding unnecessary referrals to the acute system for outpatient services.

All further options (11) include the benefits available from the above. This is based on the principle tested in Stage B namely, can this option deliver the necessary benefits for patients and the broader health economy or is a form of structural change, which is likely to require consultation (subject to the view taken by the Health Scrutiny Committee), also required? Of the remaining 11 options, it was considered likely that at least 10 of the variants would be likely to trigger the need to consult and with the decision to proceed with consideration of all options, this is more likely. Please refer to Annex 1 or the service change guide (see previous hyperlink) for details.

The exception to the above, around the need to consult, is Option 3 – the creation of a Type 1 Accident and Emergency facility at Chorley and South Ribble District General Hospital. Based on guidance received from the Royal College of Emergency Medicine and the content of the national service specification developed by NHS England, such an option would require levels of service access at that site to be in excess of those provided prior to the closure in 2016. Such an option is unlikely to be considered to require consultation because, extraneous to any clinical or financial viability assessment, the requisite impact on local access to healthcare would be positive and more care would be delivered closer to home overall than in the current service model. The likely level of sensitivity of the option would be low. Therefore, such an option would be unlikely to require consultation. However, such a decision, in the event that such an option was proceeded with by the OHOC Joint Committee, would also rest with the Health Scrutiny Committee. However, it should be pointed out that if Option 3 were to stand part of a shortlist comprising one or more other alternative options then consultation would still be required.

The remaining options (4a-e and 5a-e) differentiate based on how the site at Chorley and South Ribble District General Hospital can be best utilised to deliver safe and effective clinical care to patients. The assessment of safe and effective clinical care relates to the clinical standards relating to the Model of Care and the co-dependency framework (which services need to be co-located), contained also within that document.

The service models, access standards, and workforce delivery approaches reflect those prescribed by NHS England. A short guide to Urgent Treatment Centres (reference options 5a-e), based on the direction set nationally (and required for services of this type), was published in July 2017 and can be found on the hyperlink below. The Urgent Treatment Centre guidance applies to all urgent and emergency care services which do not meet the service access standards described in the Type 1 specification (and are not site-specific or specialist Type 2 A&E departments).

https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres%E2%80%93principles-standards.pdf

Remaining variants of options (4a-e) describe service models significantly enhanced beyond the Urgent Treatment Centre specification but incorporating all elements; and options which create varying access thresholds to elective surgery and critical care, depending on the type and case mix of patients using the facility.

2.1.7 Developing Options Without Enabling Capital:

The Scrutiny Committee are advised that the options have been developed without the assumption of enabling capital. The reason for taking this approach is that the programme was declined access to enabling capital from Wave 4 of the NHS England bidding process in December 2018 and neither an alternative source of capital funding has yet been agreed, or another wave of funding announced. Whilst this development was and remains disappointing, it remains an objective of all partners in the Our Health Our Care programme to maximise access to capital investment for the benefit of patients in Central Lancashire, and those who would also benefit more broadly across the Integrated Care System, should a realistic opportunity materialise within the development timescales for the programme.

In this context, the options have also been developed with the perspective of the urgent need to act, as defined in the Case for Change in mind. In short, this means that the issues identified in the Case for Change require a solution, and an option, which is capable of being developed towards implementation in the short to medium term, as part of a longer-term transformation of services.

For clarity, it is a requirement of the regulator to have confirmed support for capital to be in place before any option which is contingent on capital funding can be consulted upon. This means that the approach being developed by the programme is the only one permissible within the rules set by NHS England. The concept of enabling capital to support any future option, but not a particular one option, was declined as part of the Wave 4 outcome. As the awarding body, NHS England have also indicated that no further capital funding routes of this scale are forecast to be open. However, as part of the Joint Committee outcome, the Committee resolved to continue pursuing this route.

This means that the options for the programme have been developed from the perspective of what can be improved without enabling capital in the short term, and further represent a framework which could be developed to accelerate benefits and improved outcomes for patients, should enabling capital become available at a later stage, from whatever source.

2.1.8 Stage B: Alternatives to major service change

This stage involved the Governing Body considering, from the long list of options, whether or not an option which would be unlikely to require consultation could be developed successfully – see references to Options 1, 2 and 3 discussed above.

To make this assessment, there were two forms of high-level review:

- A **clinical assessment** – led by the Clinical Oversight Group. This comprises clinical representatives from each partner in the Our Health Our Care programme and is chaired by the Director of Transformation from the CCG. The clinical assessment comprises a review of the given option against the clinical standards and the co-dependency framework, also taking in to account the external assurance information available.

- A **financial assessment** – led by the Finance, Investment and Activity Group. This comprises representatives from across the Integrated Care Programme and comprises a view of the option from modelled outcomes looking at how far clinical activity would be able to fit, relating to inpatient/admitted and theatre-based activity. Each of the options reviews how far it may be specifically possible to improve resource utilisation via that option and so identify if the option is more likely, or not, for the system to operate within the financial resources available. The Finance, Investment and Activity Group is chaired by the Chief Finance Officer from the CCG.

The outcomes and recommendations from the Clinical and Finance groups respectively are reviewed by the Programme Oversight Group, before being presented to the Governing Body. The recommendations arising are subject to the external and independent scrutiny of the assurance processes listed above, including the Care Professionals Board and the North West Clinical Senate.

2.1.9 Stage C: Consideration of Remaining Options

Beyond those matters already referred to in the programme's report around options, the outcomes of the additional modelling and the external assurance opinions received will influence whether or not the options remain on the short list.

If they do not remain on the short list, then they will not stand part of a future Pre-Consultation Business Case and the spectrum of options upon which the programme would intend to commence a consultation activity with the public. The public will be able to express comments around the whole programme and indeed to suggest possibilities which they may feel have not been fully considered.

2.2 Determination of the OHOC Joint Committee – 28th August

The determination of the OHOC Joint Committee, by unanimous approval, varied from the initial recommendation presented in the report. The decision, providing clarity and direction to the programme, can also, as referred to above, be summarised as an extension of Stage C:

1. **All options on the table:** All 13 options would be considered further, and this position will be outlined to the Health Scrutiny Committee on the 24th September. No final decisions on any of the options was made and an open-minded approach was maintained.

2. **New Build option:** The feasibility study previously undertaken for a new build acute site in central Lancashire and referred to in the background section of the options paper, would be subject to a request for funding from the Chief Officer of the CCGs and Senior Responsible Owner of the OHOC programme to the Department of Health and Social Care.

3. **Preferred approach – significant capital investment to transform care outcomes:** With respect to this preferred approach for significant capital investment in a new build site in central Lancashire, the Committee reflected on the position outlined in the background section of the report, namely:

   "Local commissioners will continue earnestly, and in an open-minded way, to work with others to build the case for significant capital investment across both primary, community and acute care. Local commissioners believe that such an approach will improve patient experience, quality, and care outcomes and for the benefit of people in Central Lancashire. Such an approach will support the delivery of a long-term sustainable solution to the planning and delivery of healthcare services of a growing population with changing needs.

   Local commissioners will continue to work in partnership across Healthier Lancashire and South Cumbria to identify how capital funding may be acquired and the

conditions upon which a future application for investment is more likely to be successful.

Local commissioners stand ready to review and revisit all options should significant capital investment routes become open.

Local commissioners agree that, in the circumstances of the present Case for Change and the Model of Care developed by the programme, it must consider options at this stage which are based around the resources currently available to the health economy, seeking to deliver the best outcomes for patients."

In taking the decision to outline and pursue further the case for significant capital investment in central Lancashire, it should be emphasised that the Committee agreed that, at this stage, there appeared to be neither a funding route for enabling capital, nor a confirmed funding stream for capital of this scale.

However, the purpose of exploring this option further was to improve confidence in the process overall and to evidence that this preferred approach would be given primary consideration alongside all other options for change. The Committee continues to recognise that consultation can only occur if it can be demonstrated that an option is viable. In addition to clinical criteria, this assessment also considers other factors, including funding streams and affordability, as specified by the regulator, NHS England.

4. **Enhanced clinical scrutiny** would take place relating to all of the options, further ensuring that no alternative route has been omitted in Stages A and B. This would take place via a number of routes, namely:

   - **Clinical Summit:**

   A Clinical Summit, drawing together primary care network leads, partners, and secondary care clinicians and others, such that the options for acute change could be fully discussed, scrutiny be applied, and the links/dependencies with the out of hospital workstream of the programme be adduced. This has been arranged for the evening of the 3rd October.

   This forum will present the opportunity for an ongoing dialogue and process of scrutiny to ensure that the appropriate options are generated and that best clinical outcomes for the people of central Lancashire result. This will involve significant close working with the Wellbeing and Health in Integrated Neighbourhood (WHiN) platform and a discussion around how the system economic and financial reform strategies may act as enablers to successfully and sustainably redesign care across the whole central Lancashire system.

   - **Clinical Oversight Group – scrutiny role:**

   An enhanced and extended role for the Clinical Oversight Group for the programme, additionally comprising of greater primary care network clinician engagement; secondary care clinicians and the role of other non-medical professional groups, such as nursing and allied health professionals.

   - **Independent Clinical Director:**

   The planned appointment of an independent clinical director for OHOC who will oversee the clinical scrutiny and support the programme through the remaining stages.

- **Primary Care network – engagement and scrutiny:**

Further engagement with each primary care network leadership team and the Peer Groups in Chorley and South Ribble and Greater Preston respectively. In the case of the former group, this will take account of the recent formal establishment of primary care network leadership teams and in the latter reflect the ongoing partnership working with the Peer Groups which has taken place over the past 18 months to 2 years.

- **Independent Clinical Senate:**

The independent clinical senate will visit both LTH sites on 16th and 17th September to provide a report on the options and the scope of work undertaken with respect to developing a sustainable Model of Care. The independent clinical senate is satisfied that it has received sufficient information from the programme relating to the Model of Care, such that it can provide assurance at this stage and usefully add to the information which will be relied upon by the OHOC Joint Committee in determining which of the options are viable.

The formal report from the clinical senate will be received by the end of November. Part of the role of the independent clinical senate will be to test the rigidity of proposals which could see more care delivered outside of the acute sector. They will also receive the opinions outlined in the reports published by the Royal College of Emergency Medicine and the Healthier Lancashire and South Cumbria Care Professionals Board forum.

- **Activity and Impact Modelling:**

Detailed activity modelling will take place relating to the options. This work is currently being developed and will be shared in the public domain when complete and accepted as part of the Pre-Consultation Business Case for the programme.

This modelling will project planned patient movements across each outpatient, elective and emergency care categories, across specialties and the existing operational sites used by patients in central Lancashire. This work will also include a detailed Equality Impact and Patient Impact Analysis, also incorporating an analysis of travel and access considerations relating to the options.

3.0 Next Steps:

The programme remains keen to maintain its constructive and open relationship with the Health Scrutiny Committee, and its membership. The programme team will endeavour to respond to the concerns of the Committee to ensure that the process is correctly followed. Assuming that the steps indicated in section 2.2 hold as planned and the Clinical Senate's report is received as indicated, the programme team would propose to update the Scrutiny Committee again in December, whilst the programme remains at this formative stage,

Jason Pawluk

OHOC Programme Director

16th September 2019

Annex 1: The Major Service Change Guide

The NHS England guidance "*Planning, assuring and delivering service change for patients (March 2018)"* is designed to be used by those considering and involved in service change to navigate a clear path from inception to implementation of decision made. It supports commissioners and their partners to consider how to take forward their proposals, including effective public involvement, enabling them to reach robust decisions on change in the best interests of their patients. Clinical Commissioning Groups (CCGs) are under a statutory duty to have regard to this guidance.

There is no legal definition of service change but broadly it encompasses any change to the provision of NHS services which involves a shift in the way front line health services are delivered, usually involving a change to the range of services available and/or the geographical location from which services are delivered.

There is also no legal definition of 'substantial development or variation' and for any particular proposed service change commissioners and providers should seek to reach agreement with the local authority on whether the duty is triggered. Regular local authority engagement should continue through the lifecycle of service change. Service reconfiguration and service decommissioning are types of service change. Change of site from which services are delivered, even with no changes to the services provided, would normally be a substantial change and would therefore require consultation with the local authority and public consultation.

Effective service change involves full and consistent engagement with stakeholders including (but not limited to) the public, patients, clinicians, staff, neighbouring ICSs and Local Authorities.

<u>All service change should be assured against the government's four tests:</u>

- Strong public and patient engagement.
- Consistency with current and prospective need for patient choice.
- A clear, clinical evidence base.
- Support for proposals from clinical commissioners.

Prior to public consultation NHS England will assure proposals for substantial service change in accordance with the process set out within the guidance. For any service change requiring public consultation which also requires capital funding, NHS England and NHS Improvement will assess any proposals to provide assurance that they do not require an unsustainable level of capital expenditure and that they will be affordable in revenue terms. Not all substantial service changes require capital expenditure.

<u>There are a number of other key points made in the guidance:</u>

- Service changes should align to local Integrated Care System plans and the service, sustainability and investment priorities established within them.
- NHS commissioners and providers have duties in relation to public involvement and consultation, and local authority consultation. They should comply with these duties when planning and delivering service change.
- The public involvement and consultation duties of commissioners are set out in s.13Q NHS Act 2006 (as amended by the Health and Social Care Act 2012) for NHS England and s.14Z2 NHS Act 2006 for CCGs.

- NHS trusts and foundation trusts are also under a duty to make arrangements for the involvement of the users of health services when engaged with the planning or provision of health services (s.242 NHS Act 2006).
- The range of duties for commissioners and providers covers engagement with the public through to a full public consultation. Public involvement is also often referred to as public engagement.
- Where substantial development or variation changes are proposed to NHS services, there is a separate requirement to consult the local authority under the Local Authority (Public Health, Health & Wellbeing Boards and Health Scrutiny) Regulations 2013 ("the 2013 Regulations") made under s.244 NHS Act 2006. This is in addition to the duties on commissioners and providers for involvement and consultation set out above and it is a local authority which can trigger a referral to the Secretary of State and the Independent Reconfiguration Panel.
- Where a proposal for substantial service change is made by the provider rather than the commissioner, the 2013 Regulations require the commissioner to undertake the consultation with the local authority on behalf of the provider.
- Both commissioners and providers need to ensure that they have satisfied their statutory duties to involve and consult. In general, where there is commissioner led consultation with the local authority on a substantial service change, full public consultation will also be required.

The Our Health Our Care programme has been developing proposals in receipt and knowledge of this guidance and has substantive relationships developed with the regulator for information sharing purposes.

Annex 2: The Case for Change

The updated Case for Change for the programme was presented and approved by the OHOC Joint Committee on 13th December 2018.

The document identified five main reasons why change to health services is required, based on a system approach:

1. Workforce:

We do not have the workforce we need in critical staffing areas. Our urgent and emergency care system workforce is stretched — a symptom of the issues with recruitment and retention being experienced right across our health system and more widely in the NHS.

2. Flow:

We are not delivering effective patient flow in our hospitals. In short, this means that too many patients are waiting too long for their care, whether their care is either planned or unplanned. Too many patients are experiencing delays to be discharged. Our hospitals are struggling to balance the needs of patients with urgent and emergency care issues (including critical care) with those receiving planned care, including day cases and outpatients. They are not running as efficiently as they could do.

3. Lack of alternatives:

We do not have a comprehensive range of alternative options available to using the urgent and emergency care system at all times. This means that too many patients are using urgent and emergency care services because they either do not know the best alternative to use, or because that alternative is not available to them at a time and place to best meet their needs. This is a problem right across our health system – we recognise that the problem does not start at the front door of our hospitals' Emergency Departments.

4. Demographics:

We are serving a growing and ageing population which continues to experience inequalities in health status, reflected in different clinical outcomes. This means some local people have worse life expectancy than others; some people are more likely to have chronic and complex long-term conditions than others; and some people are making additional use of urgent and emergency care services because they do not know the best alternative to use. This includes community-based and self-care alternatives.

5. Effective use of Resources:

To build a sustainable healthcare model, we must use the resources as an integrated health and social care system. We are not currently doing this well enough. This is because we have yet to fully develop an asset-based approach to healthcare, particularly where this impacts on the best use of our urgent and emergency care system. We can also do more in terms of delivering a neighbourhood care model, and we will need to deliver more care closer to home where this is safe and practical.

The full Case for Change can be reviewed by following this link:

https://www.greaterprestonccg.nhs.uk/download.cfm?doc=docm93jijm4n6397.pdf&ver=12217

Annex 3: The Model of Care

The Model of Care sets out a clear, clinically led vision to protect and improve the NHS services which our patients rightly care about in Central Lancashire. It is based around the principle of delivering better, joined up (or integrated) care which will provide the best opportunity for the services provided by our local hospitals to improve for the benefit of the people who use them.

The Model of Care has been developed in relation to the acute sustainability ('in hospital care') element of the Our Health Our Care (OHOC) programme. It is based on the rich learning and engagement that the programme has undertaken with the public, clinicians and wider stakeholders and creates an exciting and compelling agenda for action, which seeks to resolve the issues identified in the Case for Change.

Our aim for the population of Chorley, South Ribble and Greater Preston is for them to be supported to stay healthy, but where care is needed, for them to receive this joined up care. By this we mean where a person's care needs are co-ordinated, their support and interventions are connected, and their pathways of care are seamless. For the professionals delivering this care, their contributions are co-ordinated, regulated for quality, and measured against performance and quality standards. The aim of providing joined up or Integrated Care is to put patients at the heart of what we do and in doing so, avoid duplication and unwarranted clinical variation.

Our Vision and OHOC Ethos:

The OHOC programme has a central delivery ethos – our number one priority always remains simple and crystal-clear – taking the right actions now which will transform patient experience and clinical outcomes. All of the lead partners in the Our Health Our Care programme are united in delivering this common purpose for the future. The lead partners are Chorley and South Ribble and Greater Preston Clinical Commissioning Groups, Lancashire Teaching Hospitals NHS Foundation Trust; Lancashire Care NHS Foundation This Model of Care focusses on how we can deliver sustainable hospital services in the future and what enabling changes will be required across the whole care pathway in Central Lancashire to deliver this. They are based around the principle of delivering joined up or integrated care with partners coming together to deliver better care for the benefit of patients.

This Model of Care will be used to develop open-minded options for change which are clinically led, patient-centred and focus on dealing with the issues addressed in the Case for Change.

The full Model of Care, including the clinical standards and co-dependency framework can be accessed by following this hyperlink.

https://www.greaterprestonccg.nhs.uk/download.cfm?doc=docm93jijm4n6620

Annex 4: Terms of Reference for the Royal College of Emergency Medicine review

The Royal College of Emergency Medicine were engaged by the Our Health Our Care programme to deliver an Invited Service Review. The Invited Service Review provided an opportunity for the urgent and emergency care service at both sites to be reviewed in the light of the previous report commissioned by NHS England and the actions taken arising. The Terms of Reference for the review were agreed by the Programme Oversight Group and the decision to engage the review was agreed by the Governing Body. The terms of reference for the review are shown below.

To conduct a service review of the departments provided at Chorley and South Ribble Hospital and Royal Preston Hospital, linked to the objectives specified on the next page. The service review has been requested with a view to providing recommendations which can be used by the trust to support existing transformation schemes and to the clinical commissioning groups (Chorley and South Ribble CCG and Greater Preston CCG) who are considering future service models as part of the Our Health Our Care programme.

The Our Health Our Care programme is currently developing a Model of Care for future service provision at Stage 2 of the NHSE assurance cycle. The request to engage the Royal College also emanates from a recommendation made to the programme by the Stage 1 strategic sense-check service review in Summer 2018 and equivalent discussions with the North West Clinical Senate.

1. Our current transformation plans: *The NHSI ECIST transformation activities and out-of-hospital strategies seek to improve the usage of emergency care services in Central Lancashire, complementing plans to expand the use of urgent care. To what extent do you feel that these plans are robust and complete, in terms of them helping us to transform outcomes on a "whole pathway" basis? In particular, what is the RCEMs opinion on the emerging model of care for the urgent and emergency services under the remit of the acute hospital services – are we taking sufficient account of best practice, new service models and emerging thinking from the NHS 10 Year Plan?*

2. Sustainability and Quality: *The previous NHSE service review of emergency care in Central Lancashire resulted in the Accident and Emergency department re-opening at Chorley and South Ribble Hospital on a 14/7 basis. Based on your present assessment of safety/sustainability, service quality, and the available workforce, do you feel that the circumstances which led to that recommendation are still valid?*

3. Emergency Department service adjacencies: *In terms of enhancing service quality and sustainability, what is the RCEMs opinion on service integration and structures in the critical adjacencies to the emergency departments, in particular relating to acute medicine?*

4. Focus*: In terms of reducing unnecessary demand for urgent and emergency care services, what is the RCEM's opinion on the clinical pathways which should be prioritised for transformation activity based on an "end to end / whole pathway" approach.*

5. Future Proofed: *The NHS Ten Year Plan describes the NHS Clinical Standards Review due out in the spring, developing new ways to look after patients with the most serious illnesses. To what extent would the proposed model support any new standards that are likely to result.*

For clarity, the review team did not examine issues around the specifics of quality of care or governance structures in place within the Emergency Department at the Trust, nor did they specifically examine issues around training and education.

Health Scrutiny Committee
Meeting to be held on Tuesday, 24 September 2019

Electoral Division affected: (All Divisions);

Report of the Health Scrutiny Steering Group

Contact for further information:
Debra Jones, Tel: (01772) 537996, Democratic Services Officer,
Debra.jones@lancashire.gov.uk

Executive Summary

Overview of matters presented and considered by the Health Scrutiny Steering Group at its meetings held on 14 May, 11 July and 11 September 2019

Recommendation

The Health Scrutiny Committee is asked to receive the report of its Steering Group.

Background and Advice

The Steering Group is made up of the Chair and Deputy Chair of the Health Scrutiny Committee plus two additional members, one each nominated by the Conservative and Labour Groups.

The main purpose of the Steering Group is to manage the workload of the Committee more effectively in the light of increasing number of changes to health services which are considered to be substantial. The main functions of the Steering Group are listed below:

The main functions of the Steering Group are listed below:

1. To act as a preparatory body on behalf of the Committee to develop the following aspects in relation to planned topics/reviews scheduled on the Committee's work plan:
   - Reasons/focus, objectives and outcomes for scrutiny review;
   - Develop key lines of enquiry;
   - Request evidence, data and/or information for the report to the Committee;
   - Determine who to invite to the Committee

2. To act as the first point of contact between Scrutiny and the Health Service Trusts and Clinical Commissioning Groups;

3. To liaise, on behalf of the Committee, with Health Service Trusts and Clinical Commissioning Groups;

Lancashire County Council

4. To make proposals to the Committee on whether they consider NHS service changes to be 'substantial' thereby instigating further consultation with scrutiny;

5. To act as mediator when agreement cannot be reached on NHS service changes by the Committee. The conclusions of any disagreements including referral to Secretary of State will rest with the Committee;

6. To invite any local Councillor(s) whose ward(s) as well as any County Councillor(s) whose division(s) are/will be affected to sit on the Group for the duration of the topic to be considered;

7. To develop and maintain its own work programme for the Committee to consider and allocate topics accordingly.

It is important to note that the Steering Group is not a formal decision making body and that it will report its activities and any aspect of its work to the Committee for consideration and agreement.

Meeting held on 14 May 2019:

- **Transforming Hospital Services and Care for People in Southport, Formby and West Lancashire**

Silas Nichols presented his report and clarified the following points for the Steering Group:

- The last Care Quality Commission (CQC) inspection in 2017 rated the Trust as requires improvement (close to inadequate). It was reported that the Trust had been set objectives by the former Secretary of State for Health Jeremy Hunt in order to prevent it from falling into special measures. The targets, based on the primary concerns raised in the inspection, were regarding patient safety, emergency care; improving staff engagement; establishing stable leadership and preventing further financial issues.

- A priority was to improve patient flow through the hospital. Accident and emergency (A&E) waiting times were previously among the worst in the country. Initiatives undertaken to address this included: investment in facilities - new clinical decisions and triage units and a discharge lounge; investment in medical staff which had now increased by just under 8% since April 2018, and the Trust was now at full establishment for A&E doctors. As a result performance in A&E had improved dramatically and was now in the top third in the country. There was a direct correlation between long waiting times in A&E, crowding and safety and a number of patients had come to harm or a significant level of harm. All these cases were being investigated and the patients had been written to and would be advised of the outcome.

- A critical care outreach team had been formed to identify patients who were deteriorating. In such cases the team would initiate bedside care and if necessary move the patient to critical care.

- Trusts' hospital standardised mortality rates were benchmarked against others, with 100 being the baseline number used to compare performance. Southport and Ormskirk Hospital NHS Trust score was 124 and over the last year had reduced to 110. It was anticipated that this would continue to fall.

- A stable leadership team had been established and all last year's financial objectives had been fulfilled in some part by reducing numbers of high cost agency staff and by generating significant savings on procurement.

- An improvement in staff engagement was evident through the results of regular staff surveys. Data received from the independent 'freedom to speak up' service had received 75 concerns compared to 7 the previous year which indicated that staff were now at ease with raising concerns. Staff could now also confidentially contact the CEO by e-mail. Concerns raised and survey results were cross referenced to identify any emerging trends which were proactively investigated when necessary.

Members sought clarification on the following issues:

- In response to a question it was confirmed that the Trust had a current nurse vacancy rate of 9% and the gap was mainly for band 5. There were no issues in recruiting non-qualified nurses. It was necessary to ensure the staffing establishment was set correctly. Currently £2 million was being invested to address staffing shortages, the expenditure was linked to risks and staffing was a high risk. Members asked if the Trust had established links with local universities to address staffing and it was confirmed that the Trust was keen to sponsor individuals through their education and was forging a stronger relationship with Edge Hill University and already had a good link with the University of Central Lancashire. There were national issues recruiting radiologists and the same pattern was emerging with geriatricians. The Trust was looking to set up joint appointments with another hospital to reduce the impact of this.

- A number of discussions had been held with the head of the new Medical School at Edge Hill University. The Trust was keen to create joint posts for consultants with an interest in teaching, which would make vacant posts at the Trust more attractive.

- Members asked what the Trust would do differently to improve recruitment and it was confirmed that they would continue to pursue links with other organisations in order to provide staff with opportunities to be involved with different areas of work. In terms of nurses, the Trust would continue to recruit and train. When advertising vacant posts the benefits of living in the area would be emphasised.

The Trust would also advertise for groups of consultants which sent a positive signal. The Trust would continue to ensure good educational experiences for trainees, making them more likely to apply for a post. Weekly meetings were held with junior doctors and the common area environment had been made more pleasant – such simple low cost initiatives made juniors feel more valued.

- Members asked how many services would be transferred out of West Lancashire and it was confirmed that the Trust were investigating different models for the following, although it was emphasised that these were all subject to further consultation:

    - Acute strokes: 24 hour specialised treatment at Aintree hospital followed by step-down care at Southport and Ormskirk Hospital Trust.
    - Consolidation of oncology services.
    - Women and children's services – more treatments and complex births at Liverpool.

    Currently the Trust operated over two sites, which wasn't efficient and the possibilities to improve this would be explored. Members asked if this would include linking with Lancashire Teaching Hospitals and it was confirmed that links with other Trusts were predominately with Aintree, St Helens and Knowsley and Wigan. However Lancashire Care Foundation Trust did provide some local services.

- Currently there were three separate organisations providing services to the area, including Virgin Care for community provision. The Trust had made it clear to commissioning colleagues that it would be more efficient if this was reduced to one.

- The Trust currently operated radiology services over two sites which stretched the workforce. Emergency care also needed to be reviewed as currently paediatric and adult emergencies were directed separately over the two sites. It was not clear what the impact would be on other Trusts if emergency services were to be consolidated. Southport hospital had seen sustained increases for demand for A&E and there were very few alternatives. However more could be done such as therapy in homes and improved management of health issues in nursing homes to reduce this.

- In response to a question it was confirmed that the key targets for the next 12 months would be to reduce mortality rates to be at or below the standard; achieve optimum staffing levels and develop the strategic direction of the organisation. This would be heavily influenced by the Clinical Commissioning Groups (CCGs) and NHS England but the Trust would steer the strategy as much as possible. It was anticipated that by 2020 it would be achievable that the Trust be rated as good.

Resolved: That

1. The report regarding the transforming hospital services and care for people in Southport, Formby and West Lancashire be noted.

2. An update on the Trust's key targets be provided in 12 months to the Steering Group.

Meeting held on 11 July 2019:

- **Our Health Our Care: Update on the future of acute services in central Lancashire**

Jason Pawluk, Delivery Director and Kelly Bishop, Head of Nursing from the NHS Transformation Unit presented a report providing an update on the future of acute services in central Lancashire.

In response to questions the following information was clarified:

- The seven options remaining from the list of thirteen, would be discussed in a meeting open to the public on 28 August 2019 and the approach and methodology of the options would be shared. The Clinical Senate report would not be available until November. The timeline was based on the assumption that there would be no general election.

- Members expressed concern that the public meeting would be a public relations exercise rather than an open discussion.

- The bid for capital funding in excess of £50 million to develop options for increasing existing capacity within the programme was unsuccessful as the current national parameters for funding was focussed on mental health. There was no additional budget allocated for expenditure on the programme and no reserve funding that could be accessed as the Trust and the CCGs were in a deficit financial position.

- There were no plans to approach third party providers for capital investment. It was emphasised that great work could be achieved by working differently, for example by reducing referrals to hospital and rework options that were capital dependent. The Trust was not in a position to make any assumptions within the available options that funding would be available.

- Systems to reduce admissions and options for outpatient care would be explored to support the programmes. For example, telephone appointments, remote monitoring and empowering patients to take responsibility for their own health. It would be made clear that the developments may involve being serviced by a different hospital than the current arrangements.

- Members queried exploring the potential involvement of housing associations for community support for health. It was confirmed that there would be an emphasis on outreach roles, virtual wards and wrap around care to encompass both health

and social care. This would involve enabling more proactive work with consultants/specialists in to the community to deliver care and train community staff in working with the public to prevent illness.

Members made the following comments in response:

- It was important to educate service users that the best care needed was not necessarily in hospital.

- Trained professionals needed to be available to give the correct advice and a reliance on information available on the internet was not always appropriate.

- The public don't necessarily see new ways of working as improvements.

- A potential barrier could be consideration of who takes responsibility for paying for preventative care by a specialist, as the funding should follow the patient. It was clarified that the vision was that it would be the hospital as it would be their staff going out. The aim was to respond to the NHS long term plan by developing outreach community services. It was necessary to ensure that hospitals and GPs provided joined up care and communicated effectively and this was part of all the options being considered.

Resolved: That

1. The update provided be noted.

2. A further update on the seven options for the future of acute services in central Lancashire be provided to the Health Scrutiny Committee at its meeting on 24 September 2019.

❖ **Delayed Transfers of Care in Lancashire - Interim Report**

Margaret France declared an interest as a Public Governor for Lancashire Teaching Hospitals NHS Trust.

Sue Lott, Head of Service Adult Social Care and Emma Ince, Interim Associate Director of Transformation and Design, NHS Chorley and South Ribble Clinical Commissioning Group and NHS Greater Preston Clinical Commissioning Group, presented a report detailing Delayed Transfers of Care (DToC) performance since the last report in November 2018 and the continued development of new hospital discharge arrangements.

A video showing service users and staff's positive experiences of the Home First service was shared. It was explained that Home First was a joint initiative between the NHS and Lancashire County Council facilitating a prompter and safe discharge to home, reducing the need for discharge to a nursing home and eased delayed transfers of care.

Members sought clarification on a number of issues as follows:

- Members asked that with regard to the pressure on accident and emergency services, had any investigations taken place as to why they had presented there and what alternatives were available. It was confirmed that repeat visitors to A and E were monitored and targeted for alternative services. These were predominately people with mental health issues. The board was exploring other courses of action with the North West Ambulance Service (NWAS) rather than taking patients to A and E. Same day care was a focus in the A and E long term plan.

- The Home First initiative included the installation of essential equipment on the same day as discharge. Patients with complicated needs requiring specialised equipment wouldn't be supported through Home First.

- In response to a question regarding the shortage of physiotherapists and occupational therapists (OT), it was explained that the service had evolved so that the patient had an initial assessment in their home to establish what support was needed. Dependent on the needs identified, the appropriate staff would visit within one day, utilising the staff resources available.

- Members commented on delays by the ambulance service to calls and it was confirmed that they categorised their response times depending on the availability of ambulances according to clinical priority. Hospitals worked to release ambulance staff as soon as possible.

- Members highlighted that the use of nursing home beds in Lancashire was greater than other areas and the work to reduce this was very welcome. Delays in issuing Disabled Facilities Grant (DFG) for necessary home adaptations was a concern. It was confirmed that the OT team had doubled resulting in the backlog for assessments being reduced from 1000 to 300, with the longest wait time being 8 weeks. This enabled requests for home adaptions via the DFG to be fast tracked to the district council, however it is was a means tested grant and this process caused delays.

- As the funding that had supported services such as Home First that had mitigated delayed transfers of care ended, it was anticipated that the offset in reduction of costs in other areas would support its continuation.

Resolved: That

1. The challenges across the Lancashire system during winter 2018/19, and the significant level of partnership work between Lancashire County Council and local NHS organisations to meet the demands of urgent care and avoidance of delays to hospital discharge be noted.

2. The continuing actions to improve the DToC performance, balancing the challenges of demand increases and financial pressures be noted.

❖ **Head and Neck progress update**

Tracy Murray, Senior Programme Lead Vascular, Head and Neck, Healthier Lancashire and South Cumbria and Sharon Walkden, Project Manager, NHS Midlands and Lancashire Commissioning Support Unit presented a report regarding the background for change that had led to the establishment of a Lancashire and South Cumbria Head and Neck Steering group and the progress made to date.
In response to questions it was clarified that:

- A high calibre workforce would be secured by creating a high performing service that met the standards, therefore attracting the right candidates. They would also make working patterns more attractive.
- The head and neck service didn't include neurological provision. They worked with dental services to deflect unnecessary cases and to avoid overlapping and duplication of work.

- The plan was to establish a hub and spoke method of delivery. The hub would provide the specialist work and diagnostics and outpatient appointments would be fulfilled in the 'spokes'. The aim was to standardise the services offered and address the logistic issues of specialist staff being available and mitigate any risks identified. Discussions were ongoing with human resources to communicate to staff how covering a large area would be managed. The preferred clinical model should be decided by September 2019, with the preferred models of care being shared around October/November.

Resolved: That the Health Scrutiny Steering Group noted background and drivers for change that led to the establishment of a Lancashire and South Cumbria Head and Neck Steering Group and the progress made to date.

Meeting held on 11 September 2019:

❖ **Membership and terms of reference**

Gary Halsall, Senior Democratic Services Officer confirmed the membership of the Health Scrutiny Committee Steering Group and presented the committee terms of reference for the 2019/20 municipal year. Members' attention was drawn to the additional responsibility of the committee at point 5 in the terms of reference.

Resolved: That

1. The membership and terms of reference of the Steering Group be noted.

2. The new additional role set out at point 5 in the terms of reference be noted.

❖ **Social Prescribing - Central Lancashire**

Joan Burrows declared an interest as retired chief officer for the Council for Voluntary Service (CVS), Central Lancashire. It was noted that Central Lancashire CVS ceased operating in May 2014.

Joe Hannett, Partnership Manager at Community Futures presented a report providing an update on how volunteer partnerships contributed to the Social Prescribing agenda in Central Lancashire without the existence of a local Council for Voluntary Service (CVS) in the area.

In response to questions from members the following information was clarified:

- The Central Lancashire Voluntary Community and Social Enterprise Leaders Partnership (CLLP) was established May 2018. The partnership represented a range of individual voluntary organisations, city and district councils, 2 clinical commissioning groups (CCGs) and Lancashire County Council. The developing group was a formalisation of networks between chief officers representing the various organisations across the Central Lancashire Integrated Care Partnership area at the request of the Lancashire and South Cumbria Integrated Care System (ICS) to provide a peer support specialised network across the area.
  It was confirmed that the relationship and engagement between the primary care networks and district councils was being developed.

- The partnership was progressed from ICS work that took place in September 2017, when inconsistencies in a joined up approach from voluntary, community and faith organisations across the ICS were identified. The aim was to provide a more collaborative approach by April 2020, to align with the plans to merge CCGs across the ICS.

- Funding from the ICS to develop the partnership was held by Community Futures as the most independent organisation.

- It was anticipated that the partnership would fit in with the Social Prescribing agenda by providing a link to primary care networks to enable them to prescribe events and opportunities in the voluntary sector and identify gaps according to the health needs of their specific population. The CCGs would be supporting an upcoming event which would bring voluntary organisations, link workers and CLLP partners to discuss how to move this forward. The aim was to support primary care networks using a test and learn approach in the Central Lancashire Integrated Care Partnership (ICP) area before widening the approach to ensure Social Prescribing was a success across the ICS. There was a budget of £1.2 million to support the development of primary care networks and part of this would be the personalised care which could be provided by Social Prescribing. The delivery would be based on learning from successes in other areas. It was hoped that a person would receive an intervention without knowing which individual sector the support had come from.
  It was noted that it was an explicit expectation in the NHS long term plan that the voluntary sector be supported and collaborated with and as such they would be represented on the ICS board.

- Members enquired about the potential of duplication of provision and it was confirmed that once the digital element of Social Prescribing was embedded it would be easier to identify any areas of duplication and where any gaps were.

Prior to the establishment of the CLLP there was no sharing of information between partners and the peer support network would help raise awareness of any unnecessary duplication of provision and identify ways to mitigate this.

- It was confirmed that Social Prescribing aimed to connect people with their community and it was anticipated that eventually this would lead to self-referrals. Social Prescribing was a holistic, person centred approach rather than a condition driven means of treating individuals.

- The CLLP aimed to improve communications and visibility to link such programmes as blood pressure tests funded by the British Heart Foundation with voluntary organisations and work in a co-ordinated way.

- Members asked how the success of Social Prescribing would be measured. It was clarified that once the use of digital tools was in place to support the programme, the impact on areas such as reducing appointments and morbidity would be evidenced.

- The CLLP was currently working on a joint set of principles between the NHS, the ICP, Lancashire County Council and the voluntary sector and implementation should be within the next 6 months. The work had been compared to the approaches in other ICS's nationally to review what progress had been made over the last 18 months and it was noted that the bottom up approach to developing neighbourhood collaboration had proved more successful.

- It was noted that the ICS was hoping to launch a pilot directory of services in October, utilising crowdsourcing techniques to help maintain the database and keep it active. Ways of sharing information about services via libraries was also discussed.

Resolved: That

1. The update on how volunteer partnerships contributed to the Social Prescribing agenda in Central Lancashire, as discussed be noted.

2. The Health Scrutiny Committee be updated on the progress of the Central Lancashire Voluntary Community and Social Enterprise Leaders Partnership at its meeting on 13 May 2020 as part of the Social Prescribing update.

❖ **Draft Terms of Reference for the appointment of a Joint Health Scrutiny Committee for the Lancashire and South Cumbria Integrated Care System (ICS)**

Gary Halsall, Senior Democratic Services Officer presented draft terms of reference for the appointment of a Joint Health Scrutiny Committee for the Lancashire and South Cumbria Integrated Care System (ICS). It was highlighted that once the responses to the draft from the three relevant local authorities were received, the final draft would be circulated for each authority to arrange for their respective governance procedures to establish the Joint Committee.

Resolved:

1. That the update regarding the establishment of the Joint Health Scrutiny Committee for the Lancashire and South Cumbria Integrated Care System (ICS) be noted.

2. Representatives from each area be invited to the 16 October 2019 Health Scrutiny Steering Group meeting to finalise the terms of reference.

❖ **Stroke Programme - Position Statement**

Claire Kindness-Cartwright, Senior Programme Manager, NHS Midlands and Lancashire Commissioning Support Unit and Jack Smith Deputy Director - Acute and Specialised Services, Midlands and Lancashire Commissioning Support Unit, presented the current Stroke Programme position statement.

The following points were highlighted from the report:

- A requirement for change had been identified to provide consistency and to align services across the ICS, due to the current unjustified variation in service provision for stroke survivors. The change would enhance current services and provide an optimum number of hyper acute services to improve outcomes. The programme supported the NHS long term plan for stroke. The impact of the strokes impacted on physical, cognitive, vision, psychological wellbeing, work and social aspects of life, and rehabilitation services needed to address all these areas. There was currently a vast variation regarding stroke rehabilitation services available across Lancashire and the CCGs and the ICS were focussed on addressing this by the consistent commissioning of high intensity rehabilitation services. It was noted that this would need to be approved via the appropriate governance processes before this was confirmed.

- Following an analysis of the pilot, the ambulatory pathway had been approved by the ICS stroke programme board as the most appropriate model to expedite the best outcomes.

- There was currently no hyper acute service in the Lancashire and South Cumbria ICS and it was acknowledged that during the first 72 hours following a stroke, high intensity care was required at such a unit to ensure the best outcomes for patients. The board had followed national guidance when proposing the sites for hyper acute provision. The recommendations were for Preston and Blackburn as they treated the nationally recognised number (600 or over a year) of stroke patients for consideration for an acute provision and Preston currently provided the regional thrombectomy service. It was noted that the work of a hyper acute unit had to be provided in conjunction with the discharge team and ambulatory care model.

- The programme had been shared with patients and partners such as the Stroke Association, who agreed this was the right model. However wider engagement was required.

In response to a request for recommendations, engagement at libraries, with parish and town councils, with Healthwatch and by attending local public events was suggested by members.

- In terms of rehabilitation the availability of psychological and orthoptic support would be addressed. Following a stroke 75% of survivors would suffer from cognitive impairment and a third with depression. Stroke sufferers typically experienced ongoing fatigue and rehabilitation should focus on how this could be self-managed. An analysis of the rehabilitation workforce revealed that half of the services did not have access to a psychologist. The expertise and ability to work with stroke patients in the longer term was not currently available. It was anticipated that depending on the level of need, the stroke programme could collaborate with other neurological rehabilitation services. In terms of orthoptics, the board was looking at undertaking a skills audit of what was currently available and looking at other referral services for stroke patient interventions.

In response to questions from members the following information was clarified:

- The first treatment for a stroke caused by a clot was thrombolysis, which disperses the clot and is most effective if administered within an hour of the stroke. Thrombectomy is the mechanical extraction of a clot on the brain.

- The national guidelines for the amount of clinical psychologist time was 1 day a week for 100 referrals and the service currently had 1 across the Trusts. As data showed that there were 2000 stroke survivors in 2018 and in the region of 75% of which would need assessment due to cognitive impairment, in addition to those requiring support for emotional and psychological difficulties, further recruitment would be required. However some support could be accessed via other routes such as the Stroke Association.

- The Integrated Stroke Delivery Network (ISDN) referred to Trusts and hospitals working together to deliver a service that was accountable to a board. It was noted that collaborative working was already in place and the establishment of the ISDN formalised this.

- In terms of national comparisons for stroke services, the ICS had been initially poor but was now improving. The majority of CCGs had agreed business cases for rehabilitation for implementation from April 2020. It was acknowledged that this area had concentrated on the complete pathway, whereas other areas, such as London, concentrated on hyper acute provision only. Members were advised that full comparison data across regions and hospitals could be found on the Stroke Sentinel National Audit Programme (SSNAP) website.

- The stroke programme was also including prevention within its remit of work.

- Members asked what work was in place to standardise the discharge process for stroke patients and it was confirmed that this was included in the continuous improvement plan. It was noted that NHS Digital continued to work on the transfer of information on a wider scale to enable shared care records which would support this.

- Digital indicators would track and show improvements and the impact of the programme.

Resolved: That the August 2019 position statement for the Lancashire and South Cumbria Stroke programme, as presented, be noted.

Consultations

N/A

Implications:

This item has the following implications, as indicated:

Risk management

This report has no significant risk implications.

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

Paper	Date	Contact/Tel

None

Reason for inclusion in Part II, if appropriate

N/A

Health Scrutiny Committee
Meeting to be held on Tuesday, 24 September 2019

Electoral Division affected:
(All Divisions);

Health Scrutiny Committee Work Programme 2019/20
(Appendix A refers)

Contact for further information:
Debra Jones, Tel: 01772 537996, Democratic Services Officer,
Debra.Jones@lancashire.gov.uk

Executive Summary

The work programme for both the Health Scrutiny Committee and its Steering Group is set out at appendix A.

Recommendation

The Health Scrutiny Committee is asked to note and comment on the report.

Background and Advice

A statement of the work and potential topics to be undertaken and considered by the Health Scrutiny Committee and its Steering Group for the remainder of the 2018/19 municipal year is set out at appendix A, which includes the dates of all scheduled Committee and Steering Group meetings. The work programme is presented to each meeting for information.

The work programme is a work in progress document. The topics included were identified by the Steering Group at its meeting held on 19 June 2018.

Consultations

N/A

Implications:

This item has the following implications, as indicated:

Risk management

This report has no significant risk implications.

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

Paper	Date	Contact/Tel

None

Reason for inclusion in Part II, if appropriate

N/A

Health Scrutiny Committee Work Programme 2019/20

The Health Scrutiny Committee Work Programme details the planned activity to be undertaken over the forthcoming municipal year through scheduled Committee meetings, task group, events and through use of the 'rapporteur' model.

The items on the work programme are determined by the Committee following the work programming session carried out by the Steering Group at the start of the municipal year in line with the Overview and Scrutiny Committees terms of reference detailed in the County Council's Constitution. This includes provision for the rights of County Councillors to ask for any matter to be considered by the Committee or to call-in decisions.

Coordination of the work programme activity is undertaken by the Chair and Deputy Chair of all of the Scrutiny Committees to avoid potential duplication.

In addition to the terms of reference outlined in the Constitution (Part 2 Article 5) for all Overview and Scrutiny Committees, the Health Scrutiny Committee will:

- To scrutinise matters relating to health and adult social care delivered by the authority, the National Health Service and other relevant partners.
- In reviewing any matter relating to the planning, provision and operation of the health service in the area, to invite interested parties to comment on the matter and take account of relevant information available, particularly that provided by the Local Healthwatch
- In the case of contested NHS proposals for substantial service changes, to take steps to reach agreement with the NHS body
- In the case of contested NHS proposals for substantial service changes where agreement cannot be reached with the NHS, to refer the matter to the relevant Secretary of State.
- To refer to the relevant Secretary of State any NHS proposal which the Committee feels has been the subject of inadequate consultation.
- To scrutinise the social care services provided or commissioned by NHS bodies exercising local authority functions under the Health and Social Care Act 2012.

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- To request that the Internal Scrutiny Committee establish as necessary joint working arrangements with district councils and other neighbouring authorities.

- To draw up a forward programme of health scrutiny in consultation with other local authorities, NHS partners, the Local Healthwatch and other key stakeholders.

- To acknowledge within 20 working days to referrals on relevant matters from the Local Healthwatch or Local Healthwatch contractor, and to keep the referrer informed of any action taken in relation to the matter.

- To require the Chief Executives of local NHS bodies to attend before the Committee to answer questions, and to invite the chairs and non-executive directors of local NHS bodies to appear before the Committee to give evidence.

- To invite any officer of any NHS body to attend before the Committee to answer questions or give evidence.

- To recommend the Full Council to co-opt on to the Committee persons with appropriate expertise in relevant health matters, without voting rights.

- To establish and make arrangements for a Health Steering Group the main purpose of which to be to manage the workload of the full Committee more effectively in the light of the increasing number of changes to health services.

The Work Programme will be submitted to and agreed by the Scrutiny Committees at each meeting and will be published with each agenda.

The dates are indicative of when the Health Scrutiny Committee will review the item, however they may need to be rescheduled and new items added as required.

Health Scrutiny Committee work programme

Topic	**Scrutiny Purpose** **(objectives, evidence, initial outcomes)**	**Lead Officers/organisations**	**Proposed Date(s)**	**Recommendations**	**Progress**
Committee					
Healthier Lancashire and South Cumbria Integrated Care System - five year local strategy	Feedback on draft five year strategy	Dr Amanda Doyle, Healthier Lancashire and South Cumbria	24 September 2019		
Our Health Our Care Programme	Update on the future of acute services in central Lancashire	Dr Gerry Skailes, Lancashire Teaching Hospitals; Denis Gizzi, Greater Preston and Chorley and South Ribble CCGs and Jason Pawluk, NHS Transformation Unit	24 September and 3 December 2019		
Delayed Transfers of Care (DToC)	Update on performance as a whole system and preparations for winter 2019/20	Sue Lott, LCC and Faith Button, Ailsa Brotherton, Lancashire Teaching Hospitals, Emma Ince, GPCCG and CSRCCG.	5 November 2019		

Topic	Scrutiny Purpose (objectives, evidence, initial outcomes)	Lead Officers/organisations	Proposed Date(s)	Recommendations	Progress
Committee					
Urgent Mental Health Pathway	Improvement journey of LCFT…	Caroline Donovan, Chief Executive, LCFT (incl. LCC officers)	5 November 2019		
North West Ambulance Service (NWAS)	Trust wide rota review	tbc	5 November 2019		
Transforming Care (Calderstones)	Model of care for CCG commissioned learning disability beds To receive a written report and action plan on performance against targets for the trajectory for discharge rates, annual health checks (AHC) and Learning Disabilities Mortality Reviews (LeDeR).	Rachel Snow-Miller, Director for Commissioning for All-age Mental Health, Learning Disabilities and Autism, Healthier Lancashire and South Cumbria	3 December 2019		
Impact of recruitment of additional Occupational Therapists	Update on the recruitment of additional OTs and impact on waiting times	Tony Ponder, LCC	3 December 2019		
			4 February 2020		

Topic	Scrutiny Purpose (objectives, evidence, initial outcomes)	Lead Officers/organisations	Proposed Date(s)	Recommendations	Progress
Committee					
Housing with Care and Support Strategy 2018-2025	Update on the implementation of the strategy	Cabinet Members S Turner and G Gooch, Louise Taylor, Joanne Reed, Craig Frost, Julie Dockerty, LCC	31 March 2020		
Social Prescribing	Update on progress with the programme of work	Linda Vernon, Healthier Lancashire and South Cumbria and Michelle Pilling, East Lancs CCG	13 May 2020		
Cessation of the Lancashire Wellbeing Service	Impact of decommissioning the service. Tracking of service users	Dr Sakthi Karunanithi, CC Shaun Turner, LCC	13 May 2020		
Tackling period poverty	To report back on the activities of the Government's joint taskforce on period poverty in the UK	CC Nikki Hennessy (rapporteur)	tbc		

Future meeting dates:
Meeting dates for 2020/21 will be agreed by Full Council at its meeting scheduled for 17 October 2019.

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Other topics to be scheduled

- Improved/Better Care Fund – and the transformational impact
- Vascular Service Improvement – New Model of Care for Lancashire and South Cumbria (Joint Committee)
- Pooling health and social care budgets (Joint Committee?)
- Continuing Healthcare Assessments

Health Scrutiny Steering Group work programme

Topic	Scrutiny Purpose (objectives, evidence, initial outcomes)	Lead Officers	Proposed Date(s)	Recommendations	Progress
Steering Group					
Work programming workshop	workshop on the priorities of the ICS and work programming for 2019/20	CCs S Turner and G Gooch, and Dr Sakthi Karunanithi, LCC (10:30am), Healthier Lancashire and South Cumbria (11:30am) and Oliver Pearson, Healthwatch	19 June 2019	-	-
Delayed Transfers of Care	Progress update and learning from ECIST event.	Sue Lott, LCC Faith Button and Emma Ince, GPCCG and CSRCCG	17 July 2019 (11:15am)	-	-
Head and Neck	Improving quality and access to head and neck services	Tracy Murray, Healthier Lancashire and South Cumbria, and Sharon Walkden, NHS Midlands and Lancashire Commissioning Support Unit (CSU)	17 July 2019 (12noon)	-	-
Our Health Our Care	Update on the future of acute services in central Lancashire	Jason Pawluk, NHS Transformation Unit	17 July 2019 (10:30am)	-	-

Topic	Scrutiny Purpose (objectives, evidence, initial outcomes)	Lead Officers	Proposed Date(s)	Recommendations	Progress
Steering Group					
Social Prescribing	Council for Voluntary Services across Lancashire	Linda Vernon, Healthier Lancashire and South Cumbria; with Christine Blythe, BPR CVS, Joe Hannett, Community Futures and Lynne Johnstone, LCC	11 September 2019		
Joint Health Scrutiny Committee for the Lancashire and South Cumbria Integrated Care System (ICS)	Draft Terms of Reference	Gary Halsall, LCC	11 September 2019		
Stroke Programme	Improvement, and the position on Hyper Acute Stroke Services	Gemma Stanion, Healthier Lancashire and South Cumbria and Elaine Day, NHS England	11 September 2019		
Fylde Coast ICP	Primary and Community Care Transformation Planning - Priorities for delivery in 2019/20	Peter Tinson, FWCCG and Stephen Gough, NHS England?	16 October 2019 or 20 November 2019		
Joint Health Scrutiny Committee for the Lancashire and South Cumbria Integrated Care System (ICS)	Draft Terms of Reference	Members and scrutiny support officers from Lancashire, Cumbria, Blackburn and Blackpool Councils	16 October 2019		

Topic	Scrutiny Purpose (objectives, evidence, initial outcomes)	Lead Officers	Proposed Date(s)	Recommendations	Progress
Steering Group					
Suicide Prevention in Lancashire	Progress report/annual update on outcomes set out in the Logic Model	Dr Sakthi Karunanithi/Clare Platt and Chris Lee, LCC	20 November 2019		
NHSE – Quality Surveillance Group	Overview and relationships with scrutiny	Sally Napper, NHSE, Lisa Slack, LCC	20 November 2019		
Cessation of the Lancashire Wellbeing Service	Exit plan to identify possible mitigating actions for service users (schedule before 31 December 2019)	Dr Sakthi Karunanithi, CC Shaun Turner, LCC	18 December 2019		
Quality Accounts Preparations for responding to NHS Trusts Quality Accounts (incl. early involvement)	Continued focus on Lancashire Care Foundation Trust and Lancashire Teaching Hospitals Foundation Trust	Oliver Pearson, David Blacklock, Sue Stevenson, Healthwatch Lancashire	18 December 2019 **and** 16 April 2020		
			15 January 2020		

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Topic	Scrutiny Purpose (objectives, evidence, initial outcomes)	Lead Officers	Proposed Date(s)	Recommendations	Progress
Steering Group					
			19 February 2020		
			11 March 2020		
			16 April 2020		
Transforming hospital services and care for people in Southport, Formby & West Lancs	Update on the Trust's key targets	Silas Nicholls, Southport and Ormskirk Hospital Trust	? May 2020		
Health in All Policies Briefing note	Embedding spatial planning and economic determinants	Dr Aidan Kirkpatrick and Andrea Smith, LCC	-		Pending

Other topics to be scheduled:

- Neighbourhoods/Primary Care Networks – reviewing impact at local level and accessibility of health care services and provision of local facilities (capital and estates strategy – opportunities and constraints) – theme for steering Group?
- Sexual health – commissioning LCFT and Young Person's Clinics

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- Integrated Care Partnerships (ICP) – Central Lancashire; Fylde Coast; Morecambe Bay; Pennine; West Lancashire
- Chorley A&E, GTD Healthcare and CCGs - performance

Standing items:

- Health and Wellbeing Board update
- Adult Social Care update
- Lancashire Safeguarding Boards Annual Report
- Adult Social Care Complaints Annual Report