Lancashire County Council

Lancashire Health and Wellbeing Board

Tuesday, 15th October, 2013 at 2.00 pm in Cabinet Room 'C' - The Duke of Lancaster Room, County Hall, Preston

Agenda

Part 1 (Open to Press and Public)

No.	Item	
1.	**Apologies for Absence**	
2.	**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.	
3.	**Minutes of the Meeting held on 24 July 2013** To approve the minutes of the meeting held on 24 July 2013.	(Pages 1 - 10)
4.	**Appointment of Deputy Chair** A nomination has been received from the CCGs for Dr Ann Bowman to be appointed as Deputy Chair, the Lancashire Health and Wellbeing Board are asked to approve this nomination.	
5.	**Health Care Strategy for Lancashire** Report attached, Richard Jones, NHS England, to present.	(Pages 11 - 46)
6.	**Winter Planning** Report attached, Richard Jones, NHS England, to present.	(Pages 47 - 54)
7.	**Marmot Approach to Addressing Health Inequalities in Lancashire - Implementation of the Recommendations and Support from the Institute of Health Equity** Report attached, Debs Harkins, Lancashire County Council, to present.	(Pages 55 - 64)

Lancashire County Council

8. Reports from the Lancashire Safeguarding Children Board: (Pages 65 - 150)

(a) Lancashire Safeguarding Children Board's Annual Report 2012/13
(b) Pan Lancashire Child Death Overview Panel Annual Report 2012/13

Report attached, Louise Taylor, Lancashire County Council, to present.

9. Child Sexual Exploitation (Pages 151 - 162)

Report attached, Ian Critchley, Lancashire Police, to present.

10. CCG Allocations Fundamental Review of the NHS Allocations Policy (Pages 163 - 166)

Report attached. Sakthi Karunanithi to present.

11. Report from the Joint Officers Group meeting held on the 4th October 2013 (Pages 167 - 180)

Report attached. Sakthi Karunanithi to present.

12. Suggested Future Items for the Health and Wellbeing Board to Consider

Board Members are asked to suggest any future items that they would wish the Board to consider.

13. 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 Chairman of the meeting is of the opinion that the item should be considered at the meeting as a matter of urgency. Wherever possible, the Chief Executive should be given advance warning of any Members' intention to raise a matter under this heading.

14. Date of Next Meeting

The next meeting of the Board will be held on Tuesday 28th January 2014 at 2pm, venue to be confirmed.

I M Fisher
County Secretary and Solicitor

County Hall
Preston

Lancashire Health and Wellbeing Board

Minutes of the Meeting held on Wednesday, 24th July, 2013 at 2.30 pm in The Duke of Lancaster Room (Formerly Cabinet Room 'C'), County Hall, Preston

Present:

Chair

County Councillor Azhar Ali, Cabinet Member for Health And Wellbeing (LCC)

Committee Members

County Councillor Matthew Tomlinson, Cabinet Member for Children, Young People and Schools (LCC)
Helen Denton, Interim Executive Director for Adult Social Care and Public Health (LCC)
Louise Taylor, Interim Executive Director for Children and Young People (LCC)
Dr Ann Bowman, Greater Preston Clinical Commissioning Group (CCG)
Dr Simon Frampton, West Lancashire Clinical Commissioning Group (CCG)
Dr Peter Benett, Fylde and Wyre Clinical Commissioning Group (CCG)
Dr Mike Ions, East Lancashire Clinical Commissioning Group (CCG)
Andrew Bennett, Lancashire North Clinical Commissioning Group (CCG)
Richard Jones, Director NHS England – Lancashire
Gail Stanley, Chairperson of Healthwatch
Councillor Julie Cooper, East Lancashire District Councils
Councillor Cheryl Little, Fylde District Councils
Lorraine Norris, Lancashire District Councils (Preston City Council)
Professor Heather Tierney-Moore, Provider (Clinical State) - Chief Executive of Lancashire Care Foundation Trust

Apologies

County Councillor David Whipp, Lancashire County Council
Dr Gora Bangi, Chorley and South Ribble CCG
Councillor Bridget Hilton, Central Lancashire District Councils
Michael Wedgeworth, Chair Third Sector Lancashire
Karen Partington, Provider (Clinical State) - Chief Executive of Lancashire Teaching Hospitals Foundation Trust

1. Welcome and Introductions

The Chair welcomed all to the meeting, round table introductions were made.

2. Welcome from the new Chair of the Lancashire Health and Wellbeing Board - County Councillor Azhar Ali

The Chair, County Councillor Azhar Ali, welcomed all to the Health and Wellbeing Board, and outlined his aspirations for the Board.

3. Apologies for Absence

Apologies for absence were received from County Councillor David Whipp, Councillor Bridget Hilton, Dr Gora Bangi, Dr David Wrigley (Andrew Bennett attended on his behalf), Michael Wedgeworth and Karen Partington.

4. Disclosure of Pecuniary and Non-Pecuniary Interests

None declared.

5. Appointment of Chair, Membership and Terms of Reference of the Lancashire Health and Wellbeing Board

Resolved: The Board noted the appointment of County Councillor Azhar Ali as Chair of the Health and Wellbeing Board, and noted their Terms of Reference and Membership for the 2013/14 municipal year.

The Chair invited nominations for the role of Deputy Chair, and it was suggested that the Deputy Chair should be a none Councillor.

Resolved: The Board agreed that the Clinical Commissioning Groups should decide upon a Deputy Chair and report back to the next meeting of the Health and Wellbeing Board.

6. Proposed Amendment to the number of County Councillor Representatives on the Board

Resolved: The Health and Wellbeing Board resolved to:

i. Endorse the increase of County Councillor representatives from three to four.
ii. Recommend that the County Council amend the terms of reference accordingly.
iii. Note that, subject to approval by the County Council, that the four Councillor representatives will be:

- County Councillor Azhar Ali (Cabinet Member for Health and Wellbeing – Chair)
- County Councillor Matthew Tomlinson (Cabinet Member for Children, Young People and Schools)
- County Councillor Tony Martin (Cabinet Member for Adult and Community Services)
- County Councillor David Whipp

A report will now be submitted to the next Full Council meeting of Lancashire County Council to request agreement to this amendment.

7. Minutes of the Meeting held on 25 April 2013

Resolved: The minutes of the meeting held on 25 April 2013 were agreed as an accurate record.

8. Health and Wellbeing Strategy Delivery Plan

Dr Sakthi Karunanithi, Public Health, Lancashire County Council gave a presentation on this item and explained the background to this Strategy Delivery Plan.

In its considerations of the joint health and wellbeing strategy, the shadow Health and Wellbeing Board identified the need to turn the priority areas and interventions into an action plan. A task and finish group was set up to consider the current position and existing plans of board members, identify the evidence base behind high impact actions and consider how we would know if we have been successful.

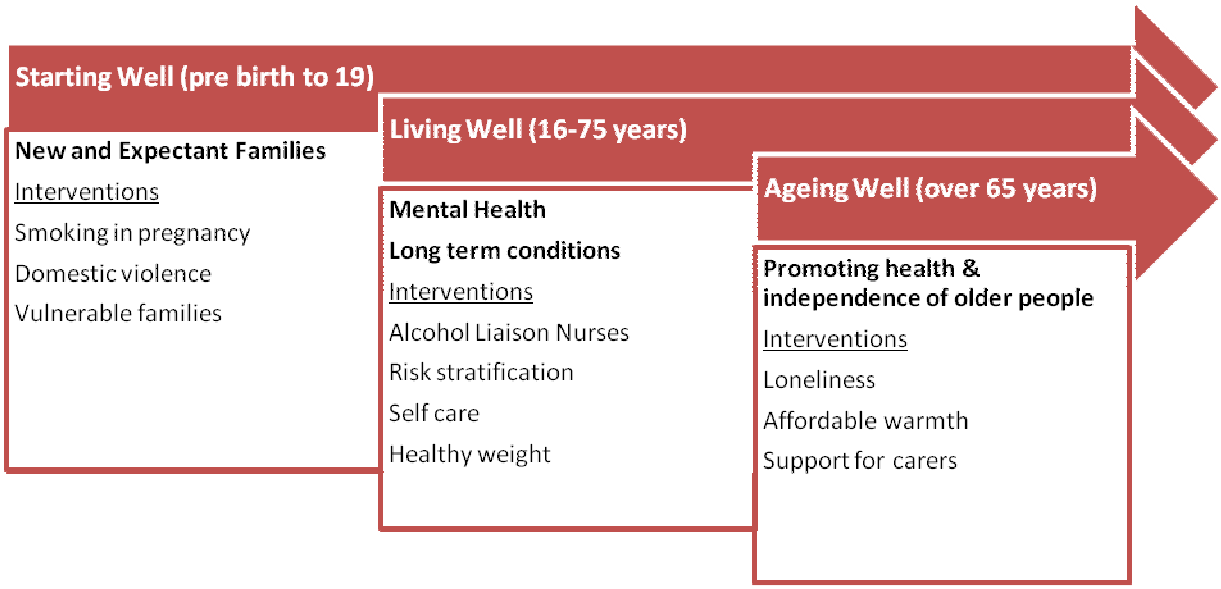
When the Board met on the 25th April 2013, it also identified the need to develop a delivery structure to support the operational aspects of the functions of the board including undertaking a joint strategic needs assessment, developing a joint health and wellbeing strategy, coordinating the commissioning plans and promoting integration between health and care systems.

With the new administration in place and further emerging evidence on the health and care needs through recent reports like Longer Lives from Public Health England, Francis inquiry, lessons from Winterbourne view, and the rising urgent care demand on health and care, there is an opportunity to reflect these priorities in the action plan.

Programmes to deliver the health and wellbeing strategy

Sakthi explained that the report proposed that the health and wellbeing strategy is implemented through three programmes that span the life course. The three programmes are Starting Well, Living Well and Ageing Well. The intention of the programmes is to address the priorities and interventions already identified and also include actions to address the wider determinants, healthy lifestyles, and equitable access to high quality services. Further detail was highlighted in Appendix 'A' to the report.

The alignment of the programmes with the four priorities and the ten interventions was presented to the Board as shown below:



Framework for Delivery
Sakthi also explained that the report proposed that the Board sets the system aims for improvement in health and wellbeing, and mobilises resources to deliver the strategy through the leadership of the locality health and wellbeing partnerships at the CCG/Districts level along with support from other relevant statutory partnerships at the county level. The board should also consider engaging with wider stakeholders e.g. the Local Enterprise Partnership, the Office of the Police and Crime Commissioner, the North West Ambulance Service, Lancashire Fire and Rescue Service, through two annual stakeholder conferences to collaborate and align plans as well as develop a communications strategy to ensure adequate communication with stakeholders.

It was recommended to the Board that a joint officer group be established to support and coordinate the implementation of the action plan agreed by the Health and Wellbeing Board. This officer group would also provide operational leadership to the other functions of the board i.e. developing the JSNA, coordinating the commissioning plans and promoting health and care integration based on the decisions and approvals provided by the board. The draft terms of reference for the joint officers were presented to the Board at Appendix 'B' to the report.

Resolved: The Lancashire Health and Wellbeing Board:

i. Noted the presentation and the report as presented.
ii. Endorsed the action plan.
iii. Approved the formation of a Joint Officer Group, on the Terms of Reference as set out, with Officers authorised to determine the membership as appropriate

9. Integration for Health and Adult Social Care - Spending Review

Steve Gross, Director of Adult Social Care Commissioning, Lancashire County Council presented the report.

Steve explained that as a result of the Spending Round 2013 it was stated "The Government will introduce a £3.8 billion pooled budget for health and social care services, shared between the NHS and local authorities, to deliver better outcomes and greater efficiencies through more integrated services for older and disabled people".

The investment will strengthen incentives for local authorities and the NHS to work together and deliver integrated services more efficiently, including:

- Ensuring that health and social care work more effectively together – through better sharing of information so people only need to explain their problems once;

- Intervening early so that older and disabled people can stay healthy and independent at home - avoiding unnecessary hospital admissions and reducing A&E visits;

- Delivering care that is centred on the individual needs, rather than what the system wants to provide – social care and NHS staff working together, with families and carers, to ensure people can leave hospital as soon as they're ready; and

- Provision of integrated support to carers so that they don't feel they are struggling to cope alone and can take a break from their caring responsibilities

Based on a communication from the LGA to top tier Local Authorities the £3.8bn pool could potentially comprise of the following:

Funding stream	Funding sum	Comments
Continuation of existing NHS transfer to social care	£900m	As set out in the 2010 Spending Review
Funding to accelerate transformation	£200m	Made available in 2014/15, as an addition to the above
New NHS funding for integration	£2bn	We understand this funding includes money to cover demographic pressures. £1bn of this pot will be linked to the delivery of outcomes as per plans pre-agreed with the HWB
'Further funds for carers and people leaving hospital who need support to regain their independence'	c. £350m	We are looking to receive more detail about this, but understand that this includes money for reablement and carers' breaks.
Capital funding	£350m	As per the SR document, "available for projects to improve integration locally, including IT funding to facilitate secure sharing of patient data between the NHS and local authorities and to improve

		facilities for disabled people".
Total funding	**£3.8bn**	
Funding for preparation for reforms to the system of social care funding	£335	One-off - 2015/16 only. We understand this funding is for covering costs associated with, for example, assessments and reviews, information and advice, and deferred payments.

NB. All elements of the entire £3.8bn pot will be subject to Section.75 agreements.

There is an expectation that part of the funding to be conditional on performance. Further details are yet to be announced.

On the 26th June, a joint letter from the LGA and the DoH was sent to all Chairs of Health & Wellbeing Boards which states Access to the pooled budgets will be conditional on agreeing plans with local health and well-being boards to protect access and drive integration of services, to improve quality and prevent people staying in hospital unnecessarily.

Following a discussion, the Board agreed to a proposal that Sakthi Karunanithi facilitate a session to discuss integration for Health and Social Care for Board members.

Resolved: The Lancashire Health and Wellbeing Board:

i. Noted and agreed that the plans for health and social care integration will be agreed at the Lancashire Health and Wellbeing Board, and;
ii. Agreed that a session be arranged to discuss integration. With Sakthi Karunanithi to facilitate.

10. NHS Keogh Review/Next Steps

Richard Jones, Director of Lancashire Area Team, National Commissioning provided an update on the NHS Keogh review and next steps.

Richard explained that on February 6 2013, the Prime Minister announced that he had asked Professor Sir Bruce Keogh, NHS Medical Director for England, to review the quality of care and treatment provided by those NHS trusts and NHS foundation trusts that were persistent outliers on mortality indicators. A total of 14 hospital trusts were investigated as part of this review. You can download the final report (PDF, 1.18Mb) here.

Although the 14 hospital trusts covered by the review were selected using national mortality measures as a "warning sign" or "smoke-alarm" for potential quality problems, the investigation looked more broadly at the quality of care and treatment provided within these organisations. The review considered the performance of the hospitals across six key areas:

- mortality
- patient experience
- safety
- workforce
- clinical and operational effectiveness

- leadership and governance

Findings and recommendations of the Keogh Mortality Review

The review of all 14 trusts has been completed. At both a local and national level, key findings have been collated and examined and recommendations have been made.

As well as the national overview report (PDF, 1.18mb), which outlines all key findings and recommendations, final reports for each individual hospital trust were also published (and circulated as links in the report). These include:

- **Rapid Responsive Review (RRR) report**
  This report details the findings from the announced visits, the unannounced visits and other hard and soft data collected on the trust.
- **Risk Summit action plan**
  This report details the actions and recommendations that were agreed at the Risk Summit. It also details the next steps in the process.
- **Risk Summit video**
  This shows the first part of the Risk Summit where members of the RRR panel summarised the results of the review to the Risk Summit panel.

Richard stated that with regard to East Lancashire Hospitals NHS Trust concerns were raised in the Keogh report regarding quality and assurance. Also additional concerns were raised regarding the complaints process. In total 10 key lines of enquiry were identified as requiring urgent or high priority action.

The review of Blackpool Teaching Hospitals NHS Trust was similar to the East Lancashire review, although Blackpool was not placed in special measures. In total seven key lines of enquiry were identified as requiring urgent or high priority action. One of the key lines was a lack of direction for the Trust in terms planning for the next six months.

Following a discussion the Board noted the report and concerns raised and agreed to, where possible, work closely with the Trusts to improve service delivery.

Resolved: The Lancashire Health and Wellbeing Board agreed to note the report and the next steps to be taken.

11. Winterbourne Update

Steve Gross, Director of Commissioning, Adult and Community Services, Lancashire County Council presented the report.

Steve explained that the Winterbourne Investigations revealed appalling abuse and a culture where this behaviour was allowed to flourish with warning signs unnoticed. Whilst people with a learning disability or autism may sometimes need specialist hospital care, hospitals are not places where people should live. Closed institutions, far from home and family may deny people appropriate care and as is evident can present the risk of poor care and abuse. Most individuals should be able to live in community based settings close to family and friends. The report (circulated) set out the current position in Lancashire, raises wider issues and proposes further action for the consideration by the Health and Wellbeing Board as follows:

Lancashire Position

There are **74** people from across Lancashire in specialist hospital settings, referred to as assessment and treatment services. People use these services when they are disturbed or when there is a crisis and they are in danger putting themselves or others at significant risk.

62 are supported at Calderstones Partnership NHS Foundation Trust Hospital. **7** people are in placements in the North West and **5** are supported outside of the North West. Most are male and the length of time in assessment and treatment services is considerable. **18** of the **74** people are supported in settings requiring significant environmental security or Ministry of Justice approval to manage their treatment plans.

56 of the **74** people are in hospital primarily because they have challenging behaviours and/or autism, sometime compounded by mental health issues.

Reviews on all **74** people were completed by 1 June 2013. The majority are appropriately placed in their current placements at the present time but **21** will be discharged by June 2014.

Issues for Consideration by the Health and Wellbeing Board

Whilst activity to date has ensured that Lancashire has complied with the Concordat requirements, there are risks both in respect of this cohort of 74 people and a wider population for whom there may be the need for a specialist assessment and treatment placement in the future.

Risks

- We focus only on the 74 people currently support in assessment and treatment services, and fail to address the wider system issues.
- The focus on local delivery leads to inconsistent approaches and poor outcomes.
- As responsibility is shared across numerous organisations, governance and accountability may not be sufficiently clear.
- Expertise is split across organisations. There may be a risk of poor coordination, unclear leadership and skill deficit.
- Costs may be shunted between organisations, not only in relation to the 'Winterbourne' cohort but to a wider population with complex needs.
- We do not have a shared view about capability of service providers, service gaps and shortfalls.
- Current configuration of services may not be adequate to manage family and service breakdowns and crisis without escalation to specialist services and then a failure to support individuals back into community services in a timely way.
- Procurement approaches vary across organisations and may be influenced by very different factors such as provider sustainability or the emphasis put on individual choice and control.

A Way Forward

The majority of people with a learning disability have lifelong needs. They are a relatively small but particularly vulnerable section of the population. Evidence over many years has shown that people with a learning disability often have poorer health and shorter life

expectancy than the general population. But whilst outcomes for some are poor, total spend is very high and growing as demand increases particularly from individuals with very complex needs. So whilst the Winterbourne work is focused on a tiny part of the population, this work provides an opportunity to reshape how we support this population. Subject to the agreement of the HWB officers will develop detailed proposals for consideration.

Following a discussion the Board agreed that it would be helpful, from a population perspective, to receive a further report outlining the key outcomes and key standards in response to the Winterbourne Concordat. It was agreed that Sakthi Karunanithi would prepare this report.

Resolved: The Lancashire Health and Wellbeing Board:

i. Noted the report and endorsed the approach to be taken, as detailed, and;
ii. Requested that from a population perspective **Sakthi Karunanithi** produce Key Outcomes and Key Standards in response to the Winterbourne Concordat and report back to the Board at the next meeting to be held in October 2013.

12. Opportunities and Challenges in the Next 12 - 18 Months

Habib Patel, Lancashire County Council, gave an update on responses received in relation to Board members views on the opportunities and challenges for the next 12-18 months. It was agreed to defer consideration of this item and hold a specific development day to go through this item in more detail.

Resolved: The Lancashire Health and Wellbeing Board agreed that that a development day be arranged as soon as possible by Habib Patel to discuss the opportunities and challenges for the next 12-18 months and create a detailed action plan.

13. Urgent Business

None.

14. Date of Next Meeting

The Chair, County Councillor Azhar Ali, reported that the next meeting of the Board is currently scheduled for Wednesday 9th October 2013, however this date is likely to change due to clashes with other meetings, and the Chair would like to rotate the meeting around Lancashire to appropriate venues where there are topical Health issues which would be of interest to the work of the Board. Therefore the date and venue of the next meeting is subject to change.

I M Fisher
County Secretary and Solicitor

Lancashire County Council
County Hall
Preston

Lancashire Health & Wellbeing Board
Meeting to be held on 15 October 2013

Electoral Division affected:
All

Draft Development and Implementation of the Health and Care Strategy for Greater Lancashire
Appendices 'A', '1', '2', '3', '4' and '5' refer

Contact for further information:
Richard Jones – Area Director, Lancashire Area Team, NHS England
Tel No: 01772 214528 Email: richard.jones32@nhs.net

Executive Summary

This report presents a draft Development and Implementation of the Health and Care Strategy for Greater Lancashire to the Lancashire Health and Wellbeing Board for their consideration.

Recommendation

The Lancashire Health and Wellbeing Board is asked to endorse and develop and implementation of an overarching health and care strategy for Lancashire as detailed in this report.

Background and Advice

As detailed in the appendices.

Consultations

As detailed in the appendices.

Implications:

This item has the following implications, as indicated:

Risk management

There are no risks identified in the presentation of this report to the Lancashire Health and Wellbeing Board.

Lancashire County Council

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

Paper	Date	Contact/Directorate/Tel

N/A

Reason for inclusion in Part II, if appropriate

N/A

NHS England

Development and Implementation of the Health and Care Strategy for Greater Lancashire

October 2013

THE NHS CONSTITUTION
the NHS belongs to us all

NHS England (Lancashire Area Team)

Development and Implementation of the Health and Care Strategy for Greater Lancashire

First published: 30 September 2013

Updated:

Prepared by Dr Jim Gardner, Medical Director

1. Introduction

1.1 This paper, prepared during September 2013, is to be presented to the three Health and Wellbeing Boards across Lancashire, the Lancashire Leadership Forum, the Lancashire Clinical Commissioning Group Chairs Network and to other organisations as appropriate. It is intended to capture the current multi-agency thinking about the importance of developing an integrated health and care strategy for Lancashire and help with agreeing and co-ordinating the mechanisms for on-going progress and, ultimately, implementation.

2. Background

2.1 The need for an overarching Health and Care Strategy for Greater Lancashire is now widely agreed[1]. The case for a strategy has been promoted by the Lancashire Leadership Forum in the first half of 2013 and developed by a multi-professional group (Appendix 1). This thinking builds on work undertaken through the Lancashire Level 3 QIPP programme through 2011-12 and has included iterative presentations to the Lancashire Leadership Forum and a workshop led and facilitated by Sir Muir Gray[2]. The arrival of NHS England's *A Call to Action*[3] and the announcement of the requirement to integrate a proportion of NHS funding with Local Authority spending (Statement on the health and social care Integration Transformation Fund, 8 August 2013)[4] add to the sense of urgency and importance.

2.2 Dr Chris Clayton, Clinical Chief Officer, NHS Blackburn with Darwen Clinical Commissioning Group (CCG) and Chair of the Lancashire Network of CCGs said:

"The commissioners of health services across Lancashire are keen to undertake the development of a "Health & Care" strategy across the county which will build upon the work undertaken by the Lancashire Improving Outcomes Board and more recently, the Lancashire Transition Group. We recognise the need to bring together the shared ambitions of both commissioners and providers from both health and social care together with the voluntary sector and other agencies. It recognises the need to prioritise the strategies across the county based upon our current knowledge however, does not undervalue or underestimate the need for local ownership and implementation. The strategy shall be brought together by the Lancashire Leadership Forum but shall be shaped and implemented by those organisations allied to it, including the Health and Wellbeing Boards of Lancashire."

3. National Drivers for Change

3.1 NHS England's *A Call to Action* cites a number of national drivers for change across the health service. They include:

- an ageing and increasing population
- an increase in the number of people with one or more long-term health conditions
- a recognition that there is still a lot of unidentified, and therefore untreated, disease
- increasing demand for services
- rising costs and constrained financial resources

- unexplained and unwarranted variation
- evidence of unacceptably poor standards in certain areas
- increasing public expectation
- lifestyle risk factors.

In suggesting 'solutions', the Call to Action cites:

- harnessing technology to fundamentally improve productivity
- putting people in charge of their own health and care
- integrating more health and care services
- providing more care outside of hospitals
- refocusing on prevention
- matching services more closely to individual's risk
- moving towards more routine services being available 7 days per week[5].

3.2 The Local Government Association and NHS England's joint publication: *Statement on the health and social care Integration Transformation Fund* (Appendix 4) is described as : "a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities". Whilst the Integration transformation Fund (ITF) doesn't come into full effect until 2015/16 there is a requirement to have plans in place by March 2014. Nationally, there is an additional £200m transferring from the NHS to social care in 2014/15, in addition to the £900m already planned, and in 2015/16 the figure rises to a pooled budget of £3.8 billion. The conditions for full receipt of the money and implementation include:

- Plans to be jointly agreed
- Protection for social services (not spending)
- 7-day working in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
- Bette data sharing between health and social care, based on the NHS number
- Joint approaches to assessments and care planning
- Risk-sharing principles and contingency plans if targets are not met
- Agreement on the consequential impact of changes on the acute care sector

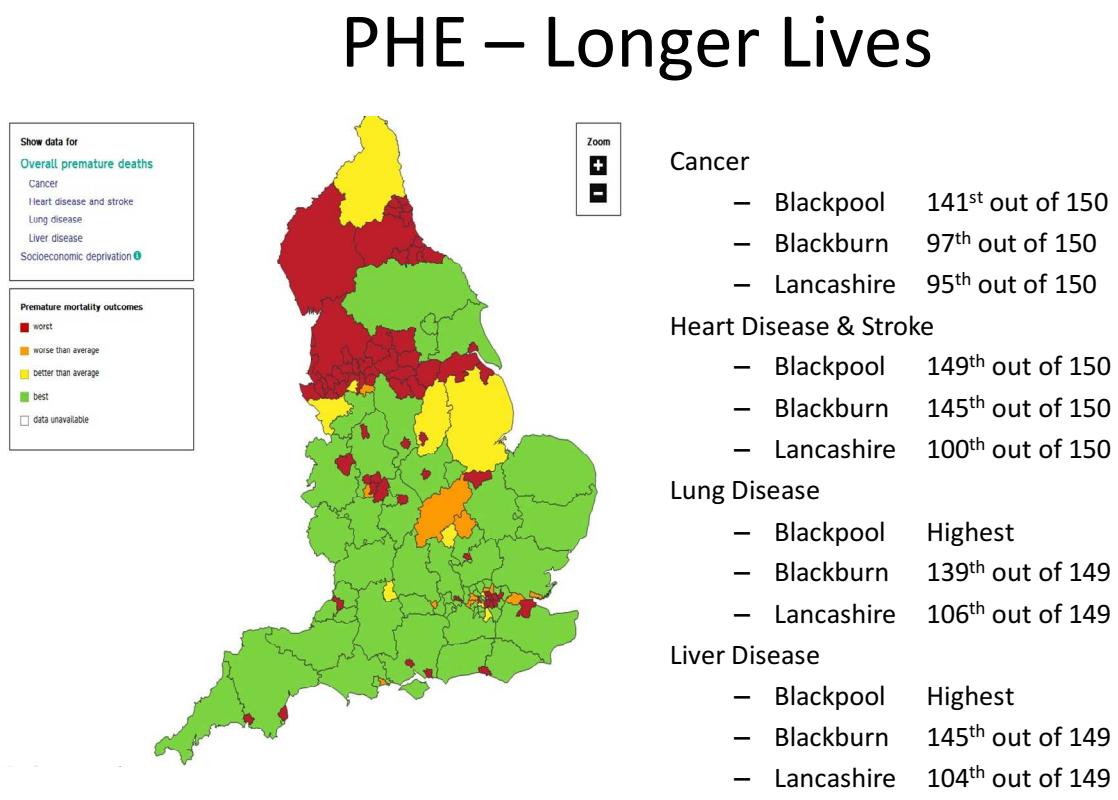
4. Local Drivers for Change

4.1 The work so far across Lancashire has recognised all of the drivers mentioned above. In addition, recent publications showing poor outcomes[6] and hospital reviews(Keogh)undertaken as a result of outlying Summary Hospital Mortality Indices (SHMI) and Hospital Mortality Ratios (HMR) add further impetus.

The National rankings for overall premature deaths rated by the 150 local authorities in England[6] show our three LAs in the bottom third: Lancashire at 103/150, Blackburn with

Darwen at 143/150 and Blackpool at 149/150. Further evidence of poor outcomes is shown in the Public Health England, Longer Lives data set.

Graphic 1. Ranking of Premature Deaths - From Public Health England – Longer Lives.



4.2 There are common themes in the commissioning intentions of the 8 Lancashire CCGs that chime with the aspirations of the 3 Upper Tier Authority Health and Wellbeing Boards. The Lancashire CCG Network, facilitated by the Staffordshire and Lancashire Commissioning Support Unit, undertook further scoping work over the summer of 2013. They produced and ranked a 'long list' of 46 opportunities for consideration within the strategy by referencing the CCG Spend and Outcomes Tool, CCG Commissioning Plans, the Joint Strategic Needs Assessments (JSNAs), CCG Indicators against Outcomes Framework Domains (from HSCIC), National Strategy, Emerging Health Technologies, the AQUA Clinical Inventory for Lancashire and the AQUA Improving Lancashire's Outcomes work. The format of the work is show below:

Table 1.

The Lancashire CCG Network – Summary of commissioning priorities June 2013 – Top 10 of 46.

LANCASHIRE CCG NETWORK - Long list of opportunities for consideration with Greater Lancashire Clinical Strategy										
Area	Detail	CCG Spend and Outcomes Tool	CCG Commissioning Plans	JSNA	Health and Social Care Information Centre: CCG Indicators against Framework Domains	National Strategy	Emerging Health Technologies	AQuA Lancashire Clinical Inventory	AQuA Improving Lancashire's Outcomes	RANK
Problems of the Respiratory System	Mortality from bronchitis and emphysema and COPD:Under 75	H	H	H	H	H		M	H	1
Cancers & tumours	Mortality from all cancers: Under 75	H	H	H	H	H			H	2
	Mortality from all cancers: All ages	H	H	H	H	H			H	2
	Mortality from lung cancer: Under 75	H	H	H	H	H			H	2
Problems of the Circulatory System	Mortality from all circulatory diseases: Under 75	H	M	H	H	H			H	5
	Mortality from coronary heart disease: Under 75	H	M	H	H	H			H	5
	Mortality from acute MI: Under 75	H	M	H	H	H			H	5
Cancers & tumours	Mortality from colorectal cancer: Under 75	M	H	H	H	H			H	5
	Mortality from breast cancer: Under 75	M	H	H	H	H			H	5
Problems of the Circulatory System	Mortality from stroke: Under 75	H	H	H		H	H			10

The full list is shown at Appendix 5.

4.3 The detailed work undertaken by the Advancing Quality Alliance (AQUA) in 2011-12 on behalf of Lancashire is referenced in the CCG Network's long list. In the Summary Paper (February 2012) Appendix 3, a number of clear priorities were identified which included:

a. Implementation of an agreed Cardiac and Stroke strategy for Lancashire with particular attention to the prevention projects within the strategy.
b. Implementation of the agreed cancer programmes with particular attention to prevention and early diagnosis.
c. Continuing prioritisation of work around myocardial infarction, heart failure and pneumonia with additional work focussing on Chronic Obstructive Pulmonary Disease (COPD).
d. Full roll out across the county of prevention projects operating well in certain parts, such as affordable warmth, smoking cessation, alcohol liaison etc.
e. Improving the quality of life for patients with long-term conditions paying particular attention to implementing the principles set out by Sir John Oldham: Early diagnosis and improved disease registers in primary care, risk profiling of populations, integrated health and social care teams, developing self-care, investing in tele-health and tele-monitoring where the evidence is strong.

f. Improve the care of patients with dementia. Reduce the number of specialised in-patient beds with a concomitant increase in community capacity.

4.4 The AQUA Report models substantial reductions in acute hospital bed capacity as a result of (and in part driven by) successful implementation of the initiatives. This constitutes a significant re-balancing of the structure and function of the local health economy in favour of up-stream interventions with increased focus on prevention, self-care and out of hospital based care (which includes social and health care).

4.5 Many of the initiatives described above are already taking place in parts of Lancashire, so there is almost certainly merit in using the strategy to 'main stream' these across the county. In addition, there are county-wide reconfigurations already in the late stage of development. These include the Implementation of the recommendations of the Lancashire and Cumbria Vascular Services review[7], moving to a clinical network based on two arterial surgery sites at Preston and Blackburn to serve the population of Lancashire, South Cumbria, Wigan and Bolton; the reconfiguration of dementia-care beds with a proposal to move to a single intensive-care in-patient unit for patients with dementia coupled with enhanced community services; and the reconfiguration of Rehabilitation Services across the Fylde Coast.

4.6 Finally, it is clear that the financial pressures facing the health and social care economy across Lancashire are severe and set to intensify. In addition to financial pressures there are significant work-force challenges in various clinical areas across the county. These include apparent shortages of midwives, neonatal nurses, GPs, Practice nurses, consultant grades in many specialities. The Chief Executive of the NHS, Sir David Nicholson, has stated that the NHS will need to make efficiency savings of as much as £30 billion by 2021. This equates to £762 million across Lancashire and, overall, the health economy of the County is expected to lose about £833 million by 2021, which represents 35% of the current total NHS allocation. Lancashire Health's share of the £3.8 billion Integrated Transformation Fund is £57.6m, which represents 3% of the commissioning budget of CCGs which will transfer to Local Government in 2015.

5. Developing the Strategy

5.1 In summary, there are compelling national and local reasons to develop and implement a *Health and Care Strategy for Lancashire*. Within this programme it will be essential to engage with service users and the public to identify priorities and test options and this work will necessarily take time. Nevertheless, there are quality and service improvements that can be implemented immediately on a county-wide basis if the will exists to do so. These initiatives can improve outcomes within the short and medium term whilst at the same time laying the foundations for more strategic developments in the future.

5.2 Within this context, in developing *the Health and Care Strategy for Lancashire*, we propose to:

5.2.1 Develop a governance framework which links the developing strategy to the three Health and Wellbeing Boards across Lancashire and their Health and Wellbeing Strategies.

5.2.2. Share ownership of the strategy, the solutions and the outcomes.

5.1.3 Revisit the work already undertaken under the banner of Level 3 QIPP, including detailed analysis of capacity and efficiency in the acute hospital sector.

5.1.4 Implement recommendations of the Vascular Service Review and monitor and consider impact as this unfolds.

5.1.5 Implement the mental health service reconfiguration previously agreed by statutory boards.

5.1.6 Reflect national initiatives and requirements, including *A Call to Action* and the *Health and Social Care Integration Transformation Fund.*

5.1.7 Engage with staff, patients and the public to raise awareness of the challenges we face and to develop shared solutions to meeting our challenges and the aspirations the people have for their future health and care services.

5.1.8 Engage with key stakeholder organisations across the Lancashire health and care economy and use the developing strategy to align initiatives.

5.1.9 Pay particular attention to a primary care (out of hospital care) strategy. A two-day event is planned for 23rd and 24th October at the Dunkenhalgh Hotel. Day 1 is for commissioners and Day 2 for a wide group of stakeholders.

5.1.10 Develop two work streams to explore the changes needed to be secured in our of hospital care and to undertake a review of Acute provision.

5.1.11 Use best evidence where that exits

6 Recommendations

6.1 That the constituent organisations that make up the Lancashire Leadership Forum, the various board, groups and fora in receipt of this paper are asked to endorse the development and implementation of an overarching health and care strategy for Lancashire and the proposals set out at 5.2 of this report.

6.2 That the paper is presented to the three Lancashire Health & Wellbeing Boards to develop the engagement strategy in line with the Health & Wellbeing Strategies.

Dr Jim Gardner
Medical Director

Richard Jones
Area Director

Notes

1. Minutes of the Lancashire Leadership Forum
2. Muir Gray Presentation (See slide Appendix 2).
3. *The NHS belongs to the people*. A call to Action. August 2013.
4. *Statement on the health and social care Integration transformation Fund*. August 2013. Gateway Reference No. 00314.
5. *Improving General Practice – A call to Action*. August 2013.
6. *Longer Lives*. Public Health England. www.longerlives.phe.org.uk
7. *Reconfiguration of Vascular Services for Cumbria and Lancashire.* Independent Reconfiguration Panel. April 2013. www.irpanel.org.uk

Some supporting facts:

- Average life expectancy 78.2 for males and 82.3 for females. Largest growth in older age groups.
- 22% GPs over 55 compared to 17% in 2000. Increased number of GPs are salaried or part-time.
- First attendance at A+E increased from 10.6 million in 2008-9 to 11.6 million in 2010-11. DoH Hospital Episode Statistics.
- 55% people report that they have a long-standing health condition.
- 12% of people with a long-standing health condition feel they do not have enough support from local services to help manage their health.
- 5 in every 1000 people are in a nursing home.
- 51 in every 1000 claim disability allowance
- Lancashire continues to show a high level of unplanned admissions for chronic ambulatory care sensitive conditions – a group of diagnoses, including long-term conditions, for which there is evidence that care can be effectively managed outside hospital.
- There is very little difference in Quality and Outcomes Framework for General Practice (QOF) achievement across the country.
- In general, GPs are referring more patients to hospital for a consultant opinion. However, GPs are seeing more patients and the conversion rate of patients seen to referral has actually been falling (now 1:12).
- Emergency pressures are increasing – Attendances at type 1 A+ E units appear relatively static, whilst attendances in type 2 and 3 are increasing.
- Conversion rates from A+E attendance to admission are increasing.
- General and Acute emergency admissions are increasing.

Appendix 1

Membership of the Strategy Development Group

Richard Jones – Director, Lancashire Area Team, NHS England

Mark Brearley – CEO, East Lancashire Acute Hospitals NHS Trust

Delyth Curtis - Head of Adult Services, Blackpool Council

Jim Gardner – Medical Director, Lancashire Area Team, NHS England

Sally McIvor – Executive Director for People, Blackburn Council

Mike Ions – Chief Clinical Officer, East Lancashire CCG

Jan Ledward – Chief Officer, Chorley South Ribble CCG

Andrew Bennett – Chief Officer, Lancashire North CCG

Kathy Blacker – Assistant Director, Clinical Strategy, Lancashire Area Team, NHS England

Lauren Butler – Programme Manager, Lancashire Area Team, NHS England

Appendix 2

Anticipated changes to the health and social care system in the 21st Century – From Sir Muir Gray's presentation to the Lancashire Leadership Forum -

20th Century Health Care	➔	**21st Century Health Care**
Clinician-centred		Patient Centred
Patient as passive complier		Citizen as co-producer of wellbeing
Focus on cure and effectiveness		Focus on prevention, care and harm
Increase quantity and quality		Reduce waste and increase value
More is better		More is not always better
Good care for known patients		Equitable care for populations
Hospital as focus		Focus on systems
Public sector bureaucracy		Pluralistic networks
Driven by finance		Driven by knowledge
High carbon usage		Low carbon usage
Challenges met by growth		Challenges met by transformation

Improving Lancashire's outcomes (Draft)

Summary paper

February 2012

AQuA Observatory

Summary

It is estimated that across England the NHS treats 1 million people every 36 hours. Many of these people have their lives saved or improved because of the care they receive from dedicated NHS staff. The NHS is there when we need it most providing round the clock, compassionate care and comfort. It plays a vital role in ensuring that as many of us as possible can enjoy good health for as long as possible – one of the things that matters most to us and to our family and friends.

However, there is always more that we could and should do to provide care of the highest quality and holds true at every level of the system. High quality care should be as safe and effective as possible, with patients treated with compassion, dignity and respect. As well as clinical quality and safety, quality means care that is personal to each individual. It also needs to improve health outcomes.

As we enter a period of tougher economic circumstances this focus on quality and outcomes is particularly important. There is a body of evidence to suggest that poor quality care is often inefficient care and that releasing efficiencies will lead to higher quality, innovation and prevention. Therefore, productivity should be driven by the desire to improve quality.

The Lancashire Health and Social Care system, provider and commissioner have joined forces to reframe their approach to QIPP to focus on both Improving Outcomes and saving cost. All organisations, at Board level, have agreed to 'A Strategy for improving Outcomes for the People of Lancashire health economy'. Lead by the Lancashire Improving Outcomes Partnership (LIOP) Board, this change in emphasis from saving to improvement in a way that creates more engaging, broader ownership and moves the approach from predominantly transactional one to a more Transformational.

As part of this work AQuA has been commissioned to undertake an analysis of the improvement priorities and to suggest – for further discussion and refinement – the scale of the improvement aims and the priories for action. In this context this paper sets out:

- The baseline position and trends for the Lancashire health economy at an organisational level for each of the five domains of the National Outcomes Framework.
- Areas for improvement that are quantified where possible.
- Suggested priorities for the Lancashire health economy Improving Outcomes Strategy and associated outcome measures.

Reducing Avoidable Mortality

The evidence suggests that across the Lancashire health and social care economy there is potential to reduce the number of avoidable deaths, including taking action to prevent people becoming ill in the first place. Based on our analysis – and for further discussion and debate – suggested outcome measures lie in the following areas:

a. Reducing premature mortality from the major cause of death (i.e. cancer, cardiovascular disease and respiratory disease) saving 1500 lives by 2015 from a 2009 baseline:
    i. Implement the agreed Cardiac and Stroke strategy for Lancashire health economy with particular attention to prevention projects in that strategy.
    ii. Implement agreed cancer programmes of work with a particular attention to the national priority around prevention.

iii. Continuing to support the Advancing Quality Programme's in AMI, Heart Failure and Pneumonia.
iv. Working with AQuA and the regional Respiratory Leads to develop a new Advancing Quality Programme on COPD.
v. Implement local prevention projects across all of Lancashire health economy that have already been implemented fully in one CCG area focused on areas such as affordable warmth, smoking, alcohol liaison etc.

b. Reduce premature mortality from causes amenable to healthcare saving a further 300 lives by 2015:

    i. Tackling areas such as, perinatal deaths, whooping cough and measles, asthma (ages 0-44 years), diabetes mellitus (0-49 years), CHD (0-74 years), maternal deaths (all ages) and areas where misadventure during surgical and medical care (all ages) are considered most likely to occur. Reduced premature mortality in adults with serious mental illness will also need to be considered.

c. Reduce in-hospital mortality. All four main acute providers to Lancashire health economy have HSMRs over 100 (only one has an SHMI under 100). Working with AQuA's Reducing Mortality Team the aim should be to achieve a combination of:

    i. Reducing avoidable in-hospital mortality by a further 300 deaths by 2013/14 from the 2011 baseline.
    ii. Reduce SHMI to 100 in all providers by 31 March 2015 at the very latest.

d. Reduce levels of smoking, obesity and alcohol consumption as a result of increased surveillance of preventable 'social' factors

Achieving these improvement outcomes will mean that Lancashire health economy will close the gap for preventable deaths against the expected trend for England over the same period. Anything less would lead to a widening of that gap. They are not mutually exclusive and are chosen to reflect that improvement action to reduce avoidably mortality is a complex subject and needs to reflect a number of interlinked issues. Further reducing health inequalities should also be factored in.

Improving the quality of life for patient with long term conditions

The evidence suggests that across the Lancashire health economy health and social care economy has potential to improve the quality of life for patients with long term conditions. Based on our analysis – and for further discussion and debate – suggested outcome measures lie in the following areas:

a. Reduce beds from emergency admissions associated with long term conditions by 300 by 2014/15 resulting in reductions from the 2011/12 baseline of:

a. Reduction in demand from long term conditions by 20%. This equates to a reduction in non-elective spells of 9000 spells.
b. Reduction in long term conditions LOS by 25%. This equates to a total reduction in LOS from long term conditions emergency spells of 1.4 days.

    This pays particular attention to implementing the principles set out by Sir John Oldham which include: Risk profiling of populations, Integrated health and social care teams and self-care. Investment in tele-health and tele-monitoring is also known to be important enablers.

It is also expected that the further work that is in hand to quantify the impact of reducing admissions from acute, chronic and paediatric conditions usually managed in primary care that are known to result in high emergency admissions will provide evidence of the potential for further bed and activity reductions.

b. Dementia beds will be reduced by at least 50 by March 2015 based on 2011 baseline with appropriate community facilities being in place.

    i. Good quality early diagnosis and intervention for all.
    ii. Improved quality of care in general hospitals by reducing LOS for patients with dementia by 1.5 days by 31 March 2013 with further reductions expected after that.
    i. Living well with dementia in care homes and the community by reducing unplanned admissions for dementia patients by 8% through the development of integrated neighbourhood teams targeting patients in the community who are assessed as being at high risk of admission.
    ii. Continue to achieve compliance with a national directive to reduce the use of antipsychotic drugs for people with dementia.

Make further improvements in Primary care management by

a. Increasing the % of relevant patients recorded on the Long term conditions QOF registers (and, possibly in time, the COF), narrowing the gap between actual and expected rates. Priority appears to be conditions relating to CHD.
b. Increasing the rates of diagnosis, initial and on-going management of patient with long term conditions so that all GP Practices are at least as good as the mean figure for the North West and/or England whichever is the highest.

Efforts should also be made to improve the quality of life (as measured by the EQ-5D, GP Practice Survey and Labour Force Survey metrics to improve the quality of life for patient with long term conditions and those that care for them. Working with Health & Well Being Boards and Local Authorities to provide employment opportunities for patients with mental health and long term conditions should form part of this work. Further reducing health inequalities should also be factored in.

Making ill people better

The evidence suggests that across the Lancashire health economy health and social care economy has potential to make progress in reducing cases in which recovery has been interrupted by emergency admissions with those that measure positive progress in recovery provide a picture of the NHS's contribution to minimising the adverse impact of ill-health and injury upon the quality of life of those affected.

However, in reality, both the elective and the emergency care pathway needs to be considered together as both have a bearing on preventing conditions from becoming more serious. Based on our analysis – and for further discussion and debate – suggest that outcomes measures lie in the following areas:

a. Ensure effective recovery from illnesses and injuries requiring hospitalisation by:

    i. Reducing unnecessary outpatient appointments so the 5000 less clinics are held each year freeing up doctors and nurses for other clinical priorities. Greater use

of Shared Decision Making has an important part to play here as do schemes such as pharmacist home-based medication review.

ii. Reduce unnecessary admissions via A&E by the ensuring that a senior clinical opinion is given as early as possible and that access to diagnostics and testing are equitable throughout the day and night. Consideration of the effectiveness of out-of-hours primary care arrangements and the support provided to nursing homes are also important.

iii. Reducing length of stay for elective patients by a range of interventions including greater use of Enhanced Recovery and minimally invasive surgical techniques.

iv. Reducing length of stay for emergency patients by a range of interventions structured approach to discharge planning and the implementation of early Supported Discharge schemes and community-based case management for generic conditions.so that patients can return to their normal lives as quickly as possible. This is particularly important for patients with heart attacks, heart failure, hip fractures, pneumonia and COPD.

As a result the Lancashire health economy could reduce beds in the acute sector by 600 during the planning period (this is in addition to the 300 beds identified within the long term condition work stream).

Improving the patient experience

The evidence suggests that across the Lancashire health economy health and social care economy has potential to further improve the patient experience thereby providing a positive experience of care for patients, service users and carers. Patient feedback has an important role to play in driving improvements in the quality of service design and delivery. When analysed alongside a range of additional information sources (including complaints and operational data), this data can provide local clinicians and managers with intelligence on the quality of local services from the patients' and service users' point of view.

Based on our analysis – and for further discussion and debate – suggest that outcomes measures lie in the following areas:

- Patients will be seen and cared for in clean, friendly, comfortable environments. This will mean respecting privacy, protecting meal times, delivering 'Essence of care'/Nursing High Impact actions and clinical engagement.
- Improving End of Life planning. This will include the systematic introduce gold standard pathway across Lancashire with options provided regarding respite care, interface with hospices, choice of location of death discussed with patients and their families and carers in a timely fashion.
- Access to care and waiting times. This will mean delivering the minimum level of standards set out in the NHS Constitution. This includes a range of indicators relating to timely access to care including maximum waiting time, access to GP hours and out of hours provision. Access to NHS dentistry also form a key part of this.
- Acute and chronic pain management. This will mean improving access to pain management advice and drug therapy using a family centred approach that includes where possible self- management.
- Improved information. This means continuing to improve access to health records, information at point of care and GP discharge letters. It also means ensuring that education and training is provided for clinical professionals and, by listening to

complaints that organisations take the necessary steps to ensure compliance with the proposed Duty of Candour.

The impact on quality of service provision through innovation and rolling out of best practice is expected to be very high. Some productivity gains will be accrued through use of telehealth, telecare and telemedicine.

Safer Care

The evidence suggests that across the Lancashire health economy health and social care economy quality and outcome improvement opportunities lie in the following areas:

- A zero tolerance approach to serious harm and never events.
- Reducing the incidence of Venous Thromboembolism (VTE), CAUTI, falls and pressure ulcers in all settings, including those that occur in the usual pace of residence as well as hospitals and other temporary accommodation.
- A reduction in medical reconciliation errors tackled through a range of ways that include clearer labelling, training, governance and policies/procedures and patient information.
- A focus on the need for a safety culture delivered through awareness of the impact of hand off and other communication errors.
- Year on year reduction in rates of MRSA, C Diff, MSSA and E Coli.
- Safe guarding vulnerable adults and children

Reducing avoidable mortality		
Suggested Outcome	**Suggested Improvement action**	**Suggested Metrics**
Reducing premature mortality from the major cause of death (i.e. cancer, cardiovascular disease and respiratory disease) saving 1500 lives by 2015	• Implement the agreed Cardiac and Stroke strategy for Lancashire health economy with particular attention to prevention projects in that strategy. • Implement agreed cancer programmes of work with a particular attention to the national priority around prevention. • Continuing support the Advancing Quality Programme's in AMI, Heart Failure and Pneumonia. • Working with AQuA and the regional Respiratory Leads to develop a new Advancing Quality Programme on COPD. • Implement local prevention projects across all of Lancashire health economy that have already been implemented fully in one CCG area focused on areas such as affordable warmth, smoking, alcohol liaison etc. • Tackling areas such as, perinatal deaths, whooping cough and measles, asthma (ages 0-44 years), diabetes mellitus (0-49 years), CHD (0-74	• Under 75 mortality from all causes (YLL, SMR, DSR and crude rate). • Under 75 mortality from cardiovascular disease (SMR, DSR and crude rate). • Under 75 mortality rate from respiratory disease (SMR, DSR and crude rate). • Under 75 mortality rate from cancer (SMR, DSR and crude rate).

	years), maternal deaths (all ages) and areas where misadventure during surgical and medical care (all ages) are considered most likely to occur. • Reduced premature mortality in adults with serious mental illness will also need to be considered.	
Reduce premature mortality from causes amenable to healthcare saving a further 300 lives by 2015	• Tackling areas such as, perinatal deaths, whooping cough and measles, asthma (ages 0-44 years), diabetes mellitus (0-49 years), CHD (0-74 years), maternal deaths (all ages) and areas where misadventure during surgical and medical care (all ages) are considered most likely to occur. • Reduced premature mortality in adults with serious mental illness will also need to be considered.	• Under 75 mortality rate from causes amendable to healthcare (SMR, DSR and crude rate). • *Mortality rates for adults with serious mental illness will follow once the national definitions have been released.*
Reduce in-hospital mortality.	• Working with AQuA's Reducing Mortality Team the aim should be to achieve a combination of: – Reducing avoidable in-hospital mortality by a further 300 deaths by 2013/14 from the 2011 baseline. – Reduce SHMI to 100 in all providers by 31 March 2015 at the very latest.	• SHMI • Actual number of death in hospital.
Reduce levels of smoking, obesity and alcohol consumption.	• Increase surveillance of preventable 'social' factors:	• Quit rates for 16+ for smoking and reductions in levels of adult obesity. • Take up of NHS Health Check. • The difference in life expectancy and years of life lost between the most affluence and the least affluent areas

Improving the Quality of life for patients with Long Term Conditions

Suggested Outcome	Suggested Improvement action	Suggested Metrics
Reduce beds from emergency admissions associated by LTCs by 300 by 2014/15 resulting in reductions from the 2011/12 baseline of: i. Reduction in demand from LTC by 20%. This equates to a reduction in non-elective spells of 9000 spells. ii. Reduction in LTC LOS by 25%. This equates to a total	• This pays particular attention to implementing the principles set out by Sir John Oldham which include: Risk profiling of populations, Integrated health and social care teams and self-care. • Investment in tele-health and tele-monitoring is also known to be important enablers. • It is also expected that the further work that is in hand to quantify the impact of reducing admissions from acute, chronic and paediatric conditions usually managed in primary care that are known to result in high emergency	• Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults) • Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s • ALOS for chronic ambulatory care sensitive conditions (adults) • ALOS for asthma, diabetes and

reduction in LOS from LTC emergency spells of 1.4 days.	admissions will provide evidence of the potential for further bed and activity reductions.	epilepsy in under 19s • Emergency readmissions within 28 days of discharge from hospital • Investment in telemedicine/ health
Dementia beds will be reduced by at least 50 by March 2015 with appropriate community facilities being in place	• Good quality early diagnosis and intervention for all • Improved quality of care in general hospitals by reducing LOS for patients with dementia by 1.5 days by 31 March 2013 with further reductions expected after that. • Living well with dementia in care homes and the community by reducing unplanned admissions for dementia patients by 8% through the development of integrated neighbourhood teams targeting patients in the community who are assessed as being at high risk of admission. • Continue to achieve compliance with a national directive to reduce the use of antipsychotic drugs for people with dementia	• Unplanned admissions for patients aged 65+ with a dementia co-morbidity by March 2013 • Average length of stay for patients aged 65+ with a dementia comorbidity • Readmission rate for patients aged 65+ with a dementia comorbidity • Increase number of patients on QOF Dementia related registers • Prescribing levels and costs of anti-psychotic prescribing drugs
Make further improvements in Primary care management	• Increasing the % of relevant patients recorded on the Long term conditions QOF registers (and in time the COF), narrowing the gap between actual and expected rates. Priority appears to be conditions relating to CHD. • Increasing the rates of diagnosis, initial and on-going management of patient with long term conditions so that all GP Practices are at least as good the mean figure for the North West and/or England whichever is the highest.	• Increase number of patients on QOF registers relating to patients with Long Term Conditions
Efforts should also be made to improve the quality of life (as measured by the EQ-5D, GP Practice Survey and Labour Force Survey metrics to improve the quality of life for patient with long term conditions and those that care for them	• Working with Health & Well Being Boards and Local Authorities to provide employment opportunities for patients with mental health and long term conditions should form part of this work. • Further reducing health inequalities should also be factored in	• Proportion of people feeling supported to manage their condition • Employment rates for people with mental health and long term conditions
Helping ill people to get better		
Suggested Outcome	**Suggested Improvement action**	**Suggested Metrics**
Ensure effective recovery from illnesses and injuries requiring hospitalisation As a result the Lancashire	• Reducing unnecessary outpatient appointments so the 5000 less clinics are held each year freeing up doctors and nurses for other clinical priorities.	• % A&E Attendances/ median time to departure from A&E (admitted)

health economy could reduce beds in the acute sector by 600 during the planning period (this is in addition to the 300 beds identified within the long term condition work stream).	Greater use of Shared Decision Making has an important part to play here as do schemes such as pharmacist home-based medication review. • Reduce unnecessary admissions via A&E by the ensuring that a senior clinical opinion is given as early as possible and that access to diagnostics and testing are equitable throughout the day and night. Consideration of the effectiveness of out-of-hours primary care arrangements and the support provided to nursing homes are also important. • Reducing length of stay for elective patients by a range of interventions including greater use of Enhanced Recovery and minimally invasive surgical techniques. • Reducing length of stay for emergency patients by a range of interventions structured approach to discharge planning and the implementation of early Supported Discharge schemes and community-based case management for generic conditions.so that patients can return to their normal lives as quickly as possible. This is particularly important for patients with heart attacks, heart failure, hip fractures, pneumonia and COPD.	• Emergency and elective length of stay • Emergency readmissions within 30days of discharge from hospital • Emergency admissions for acute conditions that should not usually require hospital admission, including the % of children admitted to hospital with serious lower respiratory tract infections (LRTI) • % patients offered rehabilitation (indicator being developed nationally) following a stroke and fragility fractures • Patient reported outcome measures (PROMS) for Hip replacement, Knee replacement, Groin hernia and Varicose veins • Progress towards compliance with all Advancing Quality bundles of care • Take up of Share Decision Making techniques • Take up of Enhanced Recovery techniques/ % day case rates

Improving the patients experience

Suggested Outcome	Suggested Improvement action	Suggested Metrics
Patients will be seen and cared for in clean, friendly, comfortable environments	• Respecting privacy, protecting meal times, delivering 'Essence of care'/Nursing High Impact actions and clinical engagement.	• Delivery of the Essence of Care Benchmarks/ Nursing High Impact actions and other measures of privacy and dignity such as single sex accommodation, protected meal times, score as awarded in PEAT inspections. • National staff survey results

Improving End of Life planning.	• The systematic introduce gold standard pathway across Lancashire with options provided regarding respite care, interface with hospices, choice of location of death discussed with patients and their families and carers in a timely fashion.	• Take up of the Gold Standard and Liverpool Care pathways for patients nearing the end of their lives
Access to care and waiting times.	• Delivering the minimum level of standards set out in the NHS Constitution. This includes a range of indicators relating to timely access to care including maximum waiting time, access to GP hours and out of hours provision. • Access to NHS dentistry also form a key part of this.	• Adherence with the minimum standards set out in the NHS Constitution • Patient experience of a number of care settings including: GP services, GP Out of Hours services, NHS Dental Services, outpatient and inpatient care in acute, mental health can community settings
Acute and chronic pain management	• Improving access to pain management advice and drug therapy using a family centred approach that includes where possible self- management.	• Access to pain services • Patient survey information on pain
Improved information.	• Improving access to health records, information at point of care and GP discharge letters. • Providing education and training for clinical professionals and, by listening to complaints that organisation take the necessary steps to ensure compliance with the proposed Duty of Candour.	• Timeliness of GP discharge letters

Safer patient care

Suggested Outcome	Suggested Improvement action	Suggested Metrics
A zero tolerance approach to serious harm and never events	• Root cause analysis of all serious harm events and	• % serious harm • % same harms repeated
Reducing the incidence of Venous Thromboembolism (VTE), CAUTI, falls and pressure ulcers in all settings, including those that occur in the usual pace of residence as well as hospitals and other temporary accommodation.	• Introduction of risk assessment for at risk patients, • Introduction of established care bundles for VTE, catheter acquired urinary tract infections (cauti), falls and pressure ulcers.	• Delivery of the Essence of Care Benchmarks/ Nursing High Impact actions and other measures of privacy and dignity such as single sex accommodation, protected meal times, score as awarded in PEAT inspections.
A reduction in medical reconciliation errors	• Tackled through a range of ways that include clearer labelling, training, governance and policies/procedures and patient information	• % serious harm relating to med rec errors in all healthcare settings
Year on year reductions in infection rates	• Hand hygiene, early screening and isolation	• Rates of MRSA, C Diff, MSSA and E

		Coli • Orthopaedic surgical site infection
A focus on the need for a safety culture delivered through	• Increased awareness of the impact of hand off and other communication errors	• Increases in harm reporting
Safe guarding of vulnerable children and adults		• Incidence of harm to children due to 'failure to monitor' / National CAS measures • Admission of full term babies to neonatal care • Deaths from suicides and incidence of self harm

Statement on the health and social care Integration Transformation Fund

Summary

1. The June 2013 Spending Round was extremely challenging for local government, handing councils reduced budgets at a time of significant demand pressures on services. In this context the announcement of £3.8 billion worth of funding to ensure closer integration between health and social care was a real positive. The money is an opportunity to improve the lives of some of the most vulnerable people in our society. We must give them control, placing them at the centre of their own care and support, make their dignity paramount and, in doing so, provide them with a better service and better quality of life. Unless we seize this opportunity to do something radically different, then services will get worse, costs to taxpayers will rise, and those who suffer the most will be people who could otherwise lead more independent lives.

2. The funding is described as: "a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities". We are calling this money the health and social care Integration Transformation Fund (ITF) and this note sets out our joint thinking on how the Fund could work and on the next steps localities might usefully take.

3. NHS England, the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS) are working closely with the Department of Health and Department for Communities and Local Government to shape the way the ITF will work in practice. We have also established a working group of CCGs, local authorities and NHS England Area Teams to help us in this process.

4. In '*Integrated care and support: our shared commitment*' integration was helpfully defined by National Voices – from the perspective of the individual – as being able to "plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me". The ITF is a means to this end and by working together we can move toward fuller integration of health and social care for the benefit of the individual.

5. Whilst the ITF does not come into full effect until 2015/16 we think it is essential that CCGs and local authorities build momentum in 2014/15, using the additional £200m due to be transferred to local government from the NHS to support transformation. In effect there will need to be two-year plans for 2014/15 and

2015/16, which must be in place by March 2014. To this end we would encourage local discussions about the use of the fund to start now in preparation for more detailed planning in the Autumn and Winter.

Context: challenge and opportunity

6. The ITF provides an opportunity to transform care so that people are provided with better integrated care and support. It encompasses a substantial level of funding and it will help deal with demographic pressures in adult social care. The ITF is an important opportunity to take the integration agenda forward at scale and pace – a goal that both sectors have been discussing for several years. We see the ITF as a significant catalyst for change.

7. There is also an excellent opportunity to align the ITF with the strategy process set out by NHS England, and supported by the LGA and others, in *The NHS belongs to the people: a call to action*[1]. This process will support the development of the shared vision for services, with the ITF providing part of the investment to achieve it.

8. The ITF will support the aim of providing people with the right care, in the right place, at the right time, including through a significant expansion of care in community settings. This will build on the work CCGs and local authorities are already doing, for example, as part of the integrated care "pioneers" initiative and Community Budgets, through work with the Public Service Transformation Network, and on understanding the patient/service user experience.

Background

9. The June 2013 Spending Round set out the following:

2014/15	2015/16
An additional £200m transfer from the NHS to social care, in addition to the £900m transfer already planned	£3.8 billion pooled budget to be deployed locally on health and social care through pooled budget arrangements.

10. In 2015/16 the ITF will be created from the following:

£1.9 billion existing funding continued from 14/15 - this money will already have been allocated across the NHS and social care to support integration
£130 million Carers' Breaks funding.
£300 million CCG reablement funding.

[1] http://www.england.nhs.uk/2013/07/11/call-to-action/

c. £350 million capital grant funding (including £220m of Disabled Facilities Grant).
£1.1 billion existing transfer from health to social care.
Additional £1.9 billion from NHS allocations Includes funding to cover demographic pressures in adult social care and some of the costs associated with the Care Bill. Includes £1 billion that will be performance-related, with half paid on 1 April 2015 (which we anticipate will be based on performance in the previous year) and half paid in the second half of 2015/16 (which could be based on in-year performance).

11. To access the ITF each locality will be asked to develop a local plan by March 2014, which will need to set out how the pooled funding will be used and the ways in which the national and local targets attached to the performance-related £1 billion will be met. This plan will also set out how the £200m transfer to local authorities in 2014/15 will be used to make progress on priorities and build momentum.

12. Plans for the use of the pooled monies will need to be developed jointly by CCGs and local authorities and signed off by each of these parties and the local Health and Wellbeing Board.

Conditions of the full ITF

13. The ITF will be a pooled budget which will can be deployed locally on social care and health, subject to the following national conditions which will need to be addressed in the plans:

- plans to be jointly agreed;
- protection for social care services (not spending);
- as part of agreed local plans, 7-day working in health and social care to support patients being discharged and prevent unnecessary admissions at weekends;
- better data sharing between health and social care, based on the NHS number (it is recognised that progress on this issue will require the resolution of some Information Governance issues by the Department of Health;
- ensure a joint approach to assessments and care planning;
- ensure that, where funding is used for integrated packages of care, there will be an accountable professional;
- risk-sharing principles and contingency plans if targets are not met – including redeployment of the funding if local agreement is not reached; and
- agreement on the consequential impact of changes in the acute sector.

14. Ministers have agreed that they will oversee and sign off the plans. As part of achieving the right balance between national and local inputs the LGA and NHS England will work together to develop proposals for how this could be done in an efficient and proportionate way.

Conditions of the performance-related £1 billion

15. £1 billion of the ITF in 2015/16 will be dependent on performance and local areas will need to set and monitor achievement of these outcomes during 2014/15 as the first half of the £1 billion, paid on 1 April 2015, is likely to be based on performance in the previous year. We will be working with central Government on the details of this scheme, but we anticipate that it will consist of a combination of national and locally chosen measures.

Delivery through Partnership

16. We are clear that success will require a genuine commitment to partnership working between CCGs and local authorities. Both parties need to recognise the challenges they each face and work together to address them.

- Finding the extra NHS investment required: Given demographic pressures and efficiency requirements of around 4%, CCGs are likely to have to re-deploy funds from existing NHS services. It is critical that CCGs and local authorities engage health care providers to assess the implications for existing services and how these should be managed;
- Protecting adult social care services: Although the emphasis of the ITF is rightly on a pooled budget, as with the current transfer from the NHS to social care, flexibility must be retained to allow for some of the fund to be used to offset the impact of the funding reductions overall. This will happen alongside the on-going work that councils and health are currently engaged in to deliver efficiencies across the health and care system.
- Targeting the pooled budget to best effect: The conditions the Government has set make it clear that the pooled funds must deliver improvements across social care and the NHS. Robust planning and analysis will be required to (i) target resources on initiatives which will have the biggest benefit in terms outcomes for people and (ii) measure and monitor their impact;
- Managing the service change consequences: The scale of investment CCGs are required to make into the pooled budget cannot be delivered without service transformation. The process for agreeing the use of the pooled budget must therefore include an assessment of the impact on acute services and agreement on the scale and nature of changes required, e.g. impact of reduced emergency activity on bed capacity.

Assurance

17. Local Health and Wellbeing Boards will sign off the plans, which will have been agreed between the local authority and CCGs. The HWB is best placed to decide whether the plans are the best for the locality, engaging with local people and bringing a sector-led approach to the process. The plans will then go through an assurance process involving NHS England to assure Ministers.

Timetable and Alignment with Local Government and NHS Planning Process

18. Plans for use of the pooled budgets should not be seen in isolation. They will need to be developed in the context of:

- local joint strategic plans;
- other priorities set out in the NHS Mandate and NHS planning framework due out in November/December. (CCGs will be required to develop medium term strategic plans as part of the NHS Call to Action)
- the announcement of integration pioneer sites in October, and the forthcoming integration roadshows.

19. The outline timetable for developing the pooled budget plans in 2013/14 is broadly as follows:

• August to October:	Initial local planning discussions and further work nationally to define conditions etc
• November/December:	NHS Planning Framework issued
• December to January:	Completion of Plans
• March:	Plans assured

Next Steps

20. NHS England and the LGA and ADASS will work with DH, DCLG, CCGs and local authorities over the next few months on the following issues:

- Allocation of Funds
- Conditions, including definitions, metrics and application
- Risk-sharing arrangements
- Assurance arrangements for plans
- Analytical support e.g. shared financial planning tools and benchmarking data packs.

Carolyn Downs
Chief Executive
Local Government Association

Bill McCarthy
National Director: Policy
NHS England

8 August 2013

NHS England Publications Gateway Ref. No.00314

Appendix '5' - Lancashire CCG Network - Summary of commissioning priorities June 2013

LANCASHIRE CCG NETWORK - Long list of opportunities for consideration with Greater Lancashire Clinical Strategy

Area	Detail	CCG Spend and Outcomes Tool	CCG Commissioning Plans	JSNA	Health and Social Care Information Centre: CCG Indicators against Framework Domains	National Strategy	Emerging Health Technologies	AQuA Lancashire Clinical Inventory	AQuA Improving Lancashire's Outcomes	RANK
Problems of the Respiratory System	Mortality from bronchitis and emphysema and COPD:Under 75	H	H	H	H	H		M	H	1
Cancers & tumours	Mortality from all cancers: Under 75	H	H	H	H	H			H	2
	Mortality from all cancers: All ages	H	H	H	H	H			H	2
	Mortality from lung cancer: Under 75	H	H	H	H	H			H	2
Problems of the Circulatory System	Mortality from all circulatory diseases: Under 75	H	M	H	H	H			H	5
	Mortality from coronary heart disease: Under 75	H	M	H	H	H			H	5
	Mortality from acute MI: Under 75	H	M	H	H	H			H	5
Cancers & tumours	Mortality from colorectal cancer: Under 75	M	H	H	H	H			H	5
	Mortality from breast cancer: Under 75	M	H	H	H	H			H	5
Problems of the Circulatory System	Mortality from stroke: Under 75	H	H	H		H	H			10
Problems of the Respiratory System	Mortality from asthma	L	H		H	H		M	H	11
Mental Health	Mortality from suicide and injury undetermined: All Ages	H	H	M		H			H	12
Maternity	% low birth weight births (live and still)	H	H	H					H	13
Musculoskeletal	Hip replacement, EQ-5D, Health Gain 10/11	H	M	M	L			M		14
Clinical pathways	End of life care.		H			H			H	15
Musculoskeletal	Knee replacement, EQ-5D, Health Gain 10/11	M	M	M	L			M		16
Trauma and injuries	Mortality from accidents	H		H				M		17
	Mortality from accidental falls	H		H				M		17
	Mortality from skull fracture and intercranial injury	H		H				M		17
Neurological	Deaths within 30 days admission:neurological problems. Admissions excluding day case	H				H				20
Conditions of neonates	Neonatal infant mortality per 1,000 births (infants aged less than 28 days)	H		H						20
Genitourinary	Deaths within 30 days admission, all genito urinary admissions excluding daycases	H		L				M		20
Primary care	Peer review and benchmarking		H			H				20
Alcohol & liver	Liver disease				H	H				20
Urgent care system	Emergency admissions.				H		M		M	20
System productivity	Support for LTCs.						H		H	20
Genitourinary	Emergency readmission to Hospital within 28 days discharge, all genito urinary admissions excluding daycases	M		L				M		27
Maternity	Teenage conception rate per 1000, 15-17 years	M		H						27
Prevention	Premature mortality				H				L	27
New technologies	Telehealth and Telecare					M	H			27
New technologies	Electronic Consultations					M	H			27
Neurological	Percentage of patients with epilepsy on drug treatment and convulsion free, 18+ yrs	H								32
System and Integrated working	Prevention and early intervention.			H						32
Clinical pathways	Infromation system integration.		H							32
New technologies	Genomics					M	M			32
New technologies	Nanotechnology					L	L			32
Productivity	Improved productivity.							H		32
	Improved productivity - action areas.							H		32
Children	Perinatal deaths.								H	32
Patient safety	Unplanned events								H	32
System productivity	Early discharge.								H	32
System productivity	Seven day working.					H				32
Primary care	Patient experience (GP out of hours)				L					43

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Lancashire Health and Wellbeing Board
Meeting to be held on 15 October 2013

Electoral Division affected:
All

Planning and Reporting on Health & Social Care System Resilience ahead of Winter 2013/14
(Appendix 'A' refers)

Contact for further information:
Jane Higgs, 07825 319614, Director of Operations & Delivery, NHS England, Area Team (Lancashire) Email: jane.higgs@nhs.net

Executive Summary

This report describes the roles and responsibilities of Health and Social Care organisations in relation to preparation, planning and actions to be taken to ensure system resilience ahead of winter 2013/14; and to identify potential risks regarding winter resilience plans across Lancashire.

Recommendation

The Lancashire Health and Wellbeing Board are asked to:

i. Approve the overall approach to preparing for winter 2013/14.
ii. Note actions to date along with plans and progress in preparations to support NHS resilience over winter.
iii. Note risks and mitigation in plans to ensure all services across the local health and social care systems are well coordinated and well placed to respond appropriately to the demands of winter.

Background and Advice

As detailed in Appendix 'A'

Consultations

As detailed in Appendix 'A'

Implications:

This item has the following implications, as indicated:

Lancashire County Council

Risk management

There are no risks identified in the presentation of this report to the Lancashire Health and Wellbeing Board.

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

Paper	Date	Contact/Directorate/Tel

N/A

Reason for inclusion in Part II, if appropriate

N/A

Appendix 'A'

Executive Team Meeting - Lancashire

1 October 2013

Report title	Planning and Reporting on Health & Social Care System Resilience ahead of Winter 2013/14

Author	H Crombie / J Higgs

Presented by	J Higgs

Purpose of the report	To inform and assure SMT and HWBs of progress in preparation and planning for winter and to seek approval of overall approach.

Actions / decisions required	To approve the overall approach to preparing for winter 2013/14. To note plans and progress in preparation to support NHS resilience over winter. To note risks and mitigation in plans to ensure all services across the local health and social care systems are well coordinated and well placed to respond appropriately to the demands of winter.

Summary	This report describes the roles and responsibilities of Health and Social Care organisations in relation to preparation, planning and actions to be taken to ensure system resilience ahead of winter 2013/14; and to identify potential risks regarding winter resilience plans across Lancashire.

Planning and Reporting on Health & Social Care System Resilience ahead of Winter 2013/14

Purpose
This report describes the roles and responsibilities of Health and Social Care organisations in relation to preparation, planning and actions to be taken to ensure system resilience ahead of winter 2013/14; and to identify potential risks regarding winter resilience plans across Lancashire.

Background
NHS England has been working with CCG colleagues and health care providers along with Social care to ensure that the system is prepared ahead of the winter period. This work has begun earlier this year than in previous years due to the on-going A&E pressures challenging the delivery of a sustainable A&E 4 hour standard to populations across Lancashire.

The national group on A&E (NHS England, Monitor, NHS Trust Development Authority (TDA) and Association of Directors of Adult Social Services (ADASS)) was set up to review the planning, oversight and reporting requirements of the health and social care system needed over the winter period in addition to the on-going work to deliver sustainable A&E standard performance.

Plans have been compiled by each health economy to support NHS resilience over winter so that patients can get swift access to safe services in line with the NHS Constitution.

Three strands of work are being taken forward. These are:
- System planning ahead of winter
- Allocation of non-recurrent funds to specific A&E's
- Winter reporting

System Planning Ahead of Winter

The management of winter pressures is an integral part of the current system recovery planning and assurance process that is now underway for achieving sustainable delivery of the A&E standard.

Plans for Winter resilience have been developed by the end of September, with approval and ownership from all members of local health economy Urgent Care Networks/Groups; assured by NHS England utilising the winter plan assurance framework and peer review across Area Teams within the North of England to be completed by 21 Oct 2013.

Preparation and assurance processes need to be in place with the aim that all services across local health and social care systems being well coordinated and well placed to respond appropriately to the demands of winter 2013/14 including:
- handover of patient care from ambulance to trust
- operational readiness (bed management, capacity, staffing and New Year elective "re-start")
- primary care, especially out of hours arrangements

- NHS/Social Care joint arrangements including work with local authorities to prevent admission and speed discharge
- Ambulance service/primary care/A&E links
- critical care services
- preventative measures including flu campaigns and pneumococcal immunisation programmes for patients and staff.

The expectation is one of a whole system approach to preparing for and managing winter, seasonal flu and other pressures across each local hospital system, as well as the NHS and social care system.

Urgent Care Networks/Groups

Across Lancashire 4 Urgent Care Networks/Groups are in place, albeit at differing levels of maturity. These networks are intended as a local mechanism for bringing together each of those organisations with individual accountability and resource for elements of local services, and who, working together, can ensure delivery of good quality services for patients. The Urgent Care Network/Group has an important role in promoting collaborative working and consensus building, but has no statutory decision making powers.

Winter Planning Submissions

All Urgent Care Networks/Groups have been involved in overseeing submission of Winter Resilience plans, with submissions provided to NHS England Lancashire Area Team on 20 September 2013. These plans should focus on Avoidance on Hospital Admission Schemes, and Supported Safe Discharge from Hospital for those patients admitted and requiring timely discharge. A substantial component of all submitted plans should be evidence of collaborative working between Health and Social Care, provision of appropriate Intermediate Care and evidence of supported care in the community. This will require a concerted 7 day service approach by all organisations and support services including social care and voluntary groups to ensure patient flow through the urgent care pathway.

Consideration over critical care services and preventative measures, including flu campaigns and pneumococcal immunisation programmes for patients and staff are identified as important areas in both preparation and monitoring arrangements for winter preparedness.

A&E Improvement Plans

The NHS England A&E Improvement Plan letter issued on 9 May 2013 articulated the expectation that local approaches to the management of winter should be in place sooner this year, building on the system plans established in relation for A&E delivery. NHS England Lancashire Area Team facilitated a review of winter 2012/13 in May 2013 with all stakeholders involved at a local health economy level to support the system to identify lessons learned and develop robust plans with actions and priorities that would mitigate risks and be included in A&E recovery and improvement plans.

Further support in the form of Urgent and Emergency Care Reviews have been undertaken across all local health economies by the national Emergency Care Intensive Support Team (ECIST) and in West Lancashire this also incorporated a review of vulnerable frail older people.

In addition, specific funding has been identified for three organisations within Lancashire identified as priority trusts to receive non recurrent funding as part of targeted support to deliver recovery and sustained achievement of the NHS Constitutional right of access and treatment within 4 hours at A&E. These organisations are:

- East Lancashire Hospitals Trust
- Lancashire Teaching Hospitals Foundation Trust
- University Hospitals of Morecambe Bay Foundation Trust

A sharing of initiatives in place in individual health economies and lessons learned event was held in September facilitated by NHS England Lancashire Area Team to encourage shared learning across Lancashire of initiatives aimed at improving the urgent care pathway for patients.

Winter Reporting –SITREP and Teleconference Calls
Plans have been communicated across Lancashire regarding the implementation of both a daily monitoring process, continuing the well-established process of winter sit-rep reporting, along with weekly winter resilience teleconference calls. This will provide an opportunity for challenge and assurance in relation to escalation processes across the system so escalation levels within each organisation in a health economy is understood by all stakeholders; and inform overall pressure at county level. Due to risks identified across the system, Lancashire Winter Resilience teleconferences commence on 3 October 2013 and will include all stakeholders across the urgent care pathway including representatives from primary and community care, CCG commissioners of acute services, mental health, social services, ambulance services, 111 services and public health.

System Wide Risks
The following risks have been identified as part of the winter resilience planning and mitigating actions as described below need to be implemented to ensure system resilience and high quality patient outcomes:

- Delivery of sustained A&E access within the 4 hour standard.
  - NHS 111 services as an integral part of delivering a whole resilient health system.

- Primary Care and Community service access for the two weeks around Christmas and New Year Public Holidays (including GPs, pharmacy, dentists and also GP Out of Hours services).
  - Norovirus outbreak control measures in care homes.

- Social Care access for the two weeks around Christmas and New Year Public Holidays (7 day working).
- Timely residential home assessments for discharging patients from hospital within 24 hrs.
  - Business continuity including mortuary capacity and Local Authority Highways Agency gritting arrangements.
  - Effective communication protocols between partners, staff, patients and the public with consistent key messages.

Mitigation actions include:

- Structured forecast of emergency and elective demand to ensure efficient utilisation of capacity and optimise patient flow by implementing estimated Date of Discharge on admission, access to diagnostics and proactive management of discharge at regular intervals throughout the day.

- Regular daily ward rounds and bed meetings embedded and involving key members of multidisciplinary team including social care.

- Ensure consultants are available to discharge patients throughout weekends and the two week period across the festive holiday.

- Ensure key partners are able to provide pharmacy, transport and social care services to support the agreed discharge process.

- All partners agree staff rotas in November for the two week festive period to match projected peaks in demand including rostering plans for 111 services.

- Local commissioners to ensure that the Directory of Services (DOS) is maintained and up to date with opening times of services.

- Agree with local authorities anticipated levels of home care packages that are likely to be required over winter (especially the festive period) and utilise rapid response teams to facilitate discharge. Given the continuing financial pressures that health and social care are facing both the NHS and Local Authorities need detailed engagement around the capacity of social care services to accommodate predicted discharge levels.

- Sustain primary care services including what cover is available at key times such as Christmas Eve and New Year's Eve; practices to schedule enough free appointments on days immediately before or after bank holidays.

- Advance planning in care homes to manage and monitor outbreaks of Norovirus supported by the whole health and social care system to ensure Norovirus patients are well cared for in care homes and their usual place of residence.

- NHS and Local Authority staff ensure arrangements in place to manage short term increases in demand on mortuary capacity and that funeral directors have been included as appropriate.

- Develop relationships with Local Authority Highways departments to ensure agreed priorities are in place for gritting arrangements so services are not adversely affected by severe weather.

- Ensure effective communication protocols between key partners, particularly across Local Authority social services, highways departments, mental health services, blood transfusion services including key contact details together with level of services over the festive period and weekends.

- Ensure communications with the public, patients and staff make use of all mediums including social media and ensure key messages are consistent across the local health economy and link into any national campaigns such as "Choose Well" and "Warmer Homes".

These risks have been identified in each paper along with plans to address them and for mitigation where ever possible however considerable concern remains for areas where multiple agencies are involved in care pathways.

Conclusion

This report has provided an overview of system planning ahead of winter and actions by NHS England Lancashire Area Team along with identifying the risks and recommended mitigations.

Whilst it provides assurance that plans are in place to support NHS resilience over the winter so that patients get swift access to safe services in line with the NHS Constitution, it is unable to provide total assurance that the required constitutional rights will actually be delivered, and does highlight the need for all partners within health and social care to appreciate the need for total commitment and preparedness to be available in any potential state of escalation.

Recommendation

The Senior Management Team (SMT) and Health & Wellbeing Boards (HWB) are asked:
To approve the overall approach to preparing for winter 2013/14.
To note actions to date along with plans and progress in preparations to support NHS resilience over winter.
To note risks and mitigation in plans to ensure all services across the local health and social care systems are well coordinated and well placed to respond appropriately to the demands of winter.

Lancashire Health and Wellbeing Board
Meeting to be held on 15th October 2013

Electoral Division affected: All

Marmot Approach to Addressing Health Inequalities in Lancashire - Implementation of the Recommendations and Support from the Institute of Health Equity
(Appendices 'A' and 'B' refer)

Contact for further information:
Gill Milward, (01772) 533381, Adult Services, Health and Wellbeing Directorate,
gill.milward@lancashire.gov.uk

Executive Summary

Following the Marmot Review and due to the complexities of addressing health inequalities in a two tier authority, Lancashire was chosen alongside five other authorities to form a network and receive bespoke advice and support over a two year period from the Marmot Team. A Partnership event took place on 13th June 2013 facilitated by the Institute of Health Equity to identify actions to address health inequalities using the Marmot approach focussing on the social determinants of health. This event was very well received with a wide range of partners attending.

Recommendation

Members of the Health and Wellbeing Board are asked to:

(i) Receive the report from the Partnership event which took place on 13th June 2013
(ii) Note the next steps for Lancashire County Council as a partner, agreed and endorsed by Lancashire County Council's Cabinet and Management Team.
(iii) Lead the development of plans within their own organisations and to continue to work in partnership to develop actions to support the top priorities as identified at the partnership event.

Background and Advice

1. The History of the Marmot Review in Lancashire

The Marmot review, Fair society; Healthy lives states that reducing health inequalities is a matter of fairness and social justice. There is a social gradient in health, meaning that, the lower a person's social position, the worse his or her health, with those people in the most deprived areas experiencing poorer health than those in the least deprived areas. Action to mitigate this should focus on reducing the gradient in health; this should also consider equity of access for groups who find it difficult to access the resources and services they need to thrive.

Lancashire County Council

Marmot's six policy objectives to address health inequalities are:-

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

A Lancashire 'call to action' event looked at the Lancashire Joint Strategic Needs Assessment (JSNA) review of health inequalities; this review identified 10 goals for health equity and looked at the causal pathways and wider determinants of health. The Marmot team refers to these as 'the causes of the causes' of poor health. They include factors such as income, employment status and the living and working environment which all have a part to play in determining the health and wellbeing of individuals and the population as a whole.

Stakeholders identified 6 priorities as means to achieve the goals. Along with the recommendations from the Marmot review this formed the basis for the 2010/11 Lancashire Directors of Public Health Report.

2. Support from the Marmot team

2.1 Background

Following the Marmot Review and due to the complexities of addressing health inequalities in a two tier authority, Lancashire was chosen alongside five other authorities to form a network and receive bespoke advice and support over a 2 year period from the Marmot Team. Working with Mike Grady from the Institute of Health Equity, University College London, a series of workshops are currently underway to help identify actions to address health inequalities using the Marmot approach focussing on the social determinants of health. In line with all the other Local Authorities participating in the network a charter defining the support offered was developed. This is set out in Appendix 'A'.

2.2 Identifying Actions to Address Health Inequalities 13 June 2013 Workshop

Building on the first workshop held last October which looked at how Lancashire was performing against the Marmot policy objectives, a second event took place on 13 June at the University of Central Lancashire and was facilitated by Mike Grady and Sue Holden from the Institute of Health Equity.

Who Attended?

Whilst the support offered from the Marmot team is based around a network of six local authorities to facilitate the programme, it has always been recognised that addressing health inequalities is complex and no one organisation can tackle it alone. The Health & Wellbeing Board is key to this agenda and representatives from all organisations represented were invited. Attendees included the County Council's newly appointed Cabinet Member for Health and Wellbeing, the Lead Member for

Health and the Lead Member for Families. Also in attendance were representatives from:-

- District Councils
- Clinical Commissioning Groups (CCGs)
- Third Sector Lancashire
- UK Healthy Cities
- County Council representation from
    - Public Health Service
    - Commissioners
    - Equality and Cohesion
    - Senior Directors and Managers from Adult and Community Services and Children and Young People

Workshop Challenge

Groups were asked to agree a small number of actions to be taken in Lancashire to narrow the health gap. Whilst doing so participants were challenged to consider the following:-

- How comfortable are we about giving things up for a greater purpose
- What are we doing about sharing good practice?
- What works?
- Why is it not equitable?
- How strong are our grass roots connections between health and literacy
- Who knows what our community assets are; and how do we share this knowledge?
- As we refine our focus, clearly define the measures that will show if we can been successful

All actions were collated and attendees were given 5 votes each to choose their top priorities.

Key actions were identified which would help reduce Health Inequalities and then they were voted on. The top 5 actions were:-

Action	**Votes**	**B.E.S.T***
Look at our public sector supply chains. We should influence contracts to include wellbeing and community, local organisations etc. weightings to contracts. Recognise our responsibility to smaller organisations. Don't make them into mini organisations that mirror us.	23	S
The Health and Wellbeing Board explore ways to pool and align resources to maximise the use of both financial and human resources to deliver the priorities in the Joint Health and Wellbeing Strategy	22	B
Reduce silos across directorates and across sectors. Improve intersectional work that sees people as people.	13	T
Identify and engage communities, listen and learn about	10	E

their current and future needs		
Enable our employees to volunteer	9	E

*Build, Empower, Sustain, Together

There were 51 actions in all; these fell into the following themes. A full list of actions and votes is set out at Appendix 'B'.

Build – capacity for health equity
Empower – communities to address health equity and take action to improve health
Sustain – develop sustainable business processes to build health equity

Each of the above is underpinned by working **Together** to pool skills and resources and align our plans by breaking down organisational boundaries and professional barriers for the greater good.

Next Steps for Lancashire County Council as a partner.

A report was submitted to cabinet on 5th September setting out options for LCC that would provide the greatest opportunities to reduce Health Inequalities in Lancashire. Cabinet fully endorsed the report and tasked LCC's Management team with developing a way forward across the organisation.
This will ensure that the county council is doing all it can across all of its services to ensure that the life chances of all Lancashire's citizen are maximised.

Next Steps for the Health and Wellbeing Board.

Narrowing the health gap is one of the six shifts within the Health and Wellbeing Strategy. Therefore it is proposed that the Health and Wellbeing Board holds a strategic discussion on implementing Marmot recommendations to address health inequalities.

Health and Wellbeing Board partners are also encouraged to consider the action that they can take to address health inequalities in Lancashire, to contribute to the priorities identified at the partnership event.

Consultations

N/A

Implications:

This item has the following implications, as indicated:

Risk management

N/A

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

Paper	Date	Contact/Directorate/Tel
The Marmot Review Fair Society Healthy Lives	2010	Gill Milward, Adult Services; and & Wellbeing Directorate, (01772) 533381

Reason for inclusion in Part II, if appropriate

N/A

Appendix 'A'

Agreement between Lancashire County Council

&

The Institute for Health Equity

Act as a critical friend to challenge and hold us to account

Help us to develop a can do culture to turn strategy in to action by sharing the learning on ‘what works’ from the Marmot review

Support Lancashire to develop an effective plan of action to improvement in one of the marmot indicators on which it currently performs less well than expected

Support Lancashire to develop an assets approach to commissioning which empowers our communities

Share the learning and experiences from the other local authority networks and facilitate a ‘peer mentor’ approach to maximise the support available from the IHE

Support Lancashire to take a Marmot approach to the Health and Wellbeing Strategy priorities including identifying outcomes to be achieved through the English Partnership Programme

Act as an advocate nationally for the work we are doing in Lancashire and enable us to ‘fly the Marmot flag’ to raise the profile of the work we are doing locally

Provide support, representation and input to high profile stakeholder events aimed at reducing health inequalities particularly across two tier working structures and a complex partnership landscape

Appendix 'B' - Actions and Votes

Action	Support /votes	B.E.S.T = Build, Empower, Sustain, Together
Look at our Public Sector supply chains. We should influence contracts to include wellbeing and community, local organisations etc. weightings to contracts. Recognise our responsibility to smaller organisations. Don't make them into mini organisations that mirror us.	23	T
Joint/pooled contribution from all partners to support capacity building	22	S
Reduce silos across directorates and across sectors. Improve intersectional work seeing people as people.	13	T
Identifying and engaging communities, listening and learning about their current and future needs	10	E
Enabling Employees to volunteer	9	E
Change the mind set of staff and communities	7	T
Commissioning and procurement - integrate social values, mental wellbeing, localism and sustainability	7	T
Support voluntary sector	6	E
Commitment / dedication	5	B
Co-ordinate a total place approach to community engagement across organisations, pooling budgets.	5	T
Services to be advertised / promoted on a "what can we do for you" basis rather than "this is what we do" so that public can tap into services to enable them to achieve their goals. (accountancy, legal)	4	E
Assets - maximise use of schools and buildings	4	S
Maximise the opportunities of our Public sector staff who have other roles such as school governors. Use these staff as champions to get out the health and wellbeing messages	3	B
Devolution to communities to have responsibility for their own budgets	3	E
Local developments - enable new people moving into an area to be able to access where they can volunteer or access groups to join ie South Ribble - cycling membership for new homes.	3	E
Train staff to better understand the wider determinants and emotional wellbeing for children and young people	3	S
Large government contracts to include social value elements	3	T
Supporting people to connect with each other and take responsibility for their neighbourhoods.	2	E
Lead by example and provide positive role models	2	T
Developing a vision for Lancashire that celebrates our success and assets	1	B
Keep local jobs for local people and inspire local children to understand employment opportunities	1	B

Action	Support /votes	B.E.S.T = Build, Empower, Sustain, Together
GP's plans should highlight what they have done for the community, what has been given back - this can be used by other services	1	B
Use links with other champions such as those connections to sports training / coaches etc to promote wellbeing. Is there a need to train champions?	1	B
Supporting people to connect with each other and take responsibility for their neighbourhoods.	1	E
Our green spaces	1	S
Use HR to promote C.S.R as part of contracted hours / PDR	1	S
Listen to people close to and in our local communities	1	T
Remember to be enablers - get out of the way, don't be a barrier by identifying what we can't do and putting obstacles in the way.	1	T
Use the skills our staff have	0	B
Recognise LCC as a healthy workplace, 90% of LCC workforce are Lancashire residents. Public sector is one of the biggest employers in Lancashire.	0	B
Good connections with the private sector	0	B
Share best practice "bright ideas" worth reporting good stories to change culture	0	B
Share our skills, individual and organisational	0	B
Retail environment - access to good quality healthy food	0	B
Time bank - share skills	0	B
Culture change at the top level	0	B
Find and define communities and neighbourhoods	0	E
Listen to people - show a commitment from all organisations to empower staff and listen	0	E
Devolution to local communities	0	E
Community buildings / access	0	E
See our workforce as an asset and give permission to use skills and expertise.	0	E
Lifestyle impact assessment for all policies	0	S
Ensure Mental wellbeing is embedded in all commissioning policies	0	S
Advertise the good points of commissioning contracts to public - highlight social value of commissioning principles of local public sector organisations	0	S
Maximise our knowledge of local communities and good partnership connections	0	T
Use our influencing skills with GP's and Councillors	0	T
As Lancashire is 4th largest council, use collaborative with Districts to have a strong lobbying voice and use this more effectively	0	T
Alignment of existing action	0	T

Action	Support /votes	B.E.S.T = Build, Empower, Sustain, Together
Understand how asset work can be better used to inform decision making	0	T
Pool together skills	0	T
Develop links - connect to the public	0	T

Lancashire Health and Wellbeing Board
Meeting to be held on 15th October 2013

Electoral Division affected: None

Reports from the Lancashire Safeguarding Children Board:

(a) Lancashire Safeguarding Children Board's Annual Report 2012/13
(b) Pan Lancashire Child Death Overview Panel Annual Report 2012/13

(Appendices 'A' and 'B' refer)

Contact for further information:
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richard.matthews@lancashire.gov.uk

Executive Summary

This report is presents the Lancashire Safeguarding Children Board's (LSCB) Annual Report for 2012/13 and the Pan Lancashire Child Death Overview Panel (CDOP) Annual Report for 2012/13. Statutory guidance Working Together To Safeguard Children (2013) places a duty on the LSCB to share its annual report with the Lancashire Health and Wellbeing Board.

Recommendation

The Lancashire Health and Wellbeing Board are asked to:

(i) note the LSCB Annual Report for 2012/13 attached at Appendix 'A', consider the key issues and priorities identified in the LSCB Annual Report for 2012/13, and therein inform HWB planning and service development, and;

(ii) note and comment on the CDOP Annual Report attached at Appendix 'B'.

Background and Advice

The Annual Reports are attached at Appendices 'A' and 'B' respectively.

Consultations

All LSCB partner agencies have been consulted before publication

Implications:

See recommendation above.

Lancashire County Council

Risk management

Failure to consider the report and implement the recommendation above could lead to partnership inefficiencies and poorly coordinated services or commissioning.

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

Paper	Date	Contact/Directorate/Tel

N/A

Reason for inclusion in Part II, if appropriate

N/A

LANCASHIRE SAFEGUARDING CHILDREN BOARD

ANNUAL REPORT 2012/13

Published: August 2013

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Foreword

From Nigel Burke, Independent Chair of Lancashire LSCB

I am pleased to present the Annual Report from Lancashire Safeguarding Children Board.

This report is different from its predecessors as the Government has published its statutory guidance 'Working Together 2013' which came into effect on the 15th of April 2013; and amongst other things this sets out the requirement for Local Safeguarding Children Boards (LSCBs) to publish an annual report. The guidelines explain that the report should cover the effectiveness of child safeguarding and promoting the welfare of children in our area. It should provide a rigorous and transparent assessment of the performance and effectiveness of local services.

The safeguarding of children and young people is challenging. It remains the responsibility of everyone in the community but it is a particular responsibility for all those organisations and individuals who work with children and young people. The challenge has been to maintain that relentless focus on safeguarding in times of financial stringency. Success is entirely dependent on motivated, well trained and highly skilled staff. Wherever I go in Lancashire I find such people. This has not lead to complacency, key decision makers come together in the LSCB to identify how we can all work better together, to identify any weaknesses and put in place improvements.

I believe that partnership working in the LSCB has been exemplary and despite significant challenges for all our partners there has, if anything been a greater willingness to work actively together to find efficiencies whilst maintaining the high standards we set ourselves.

There have been notable successes, the consolidation of the Multi Agency Safeguarding Hub has seen staff coming together in one place to support the safeguarding effort, our Child Sexual Exploitation strategy has national prominence and Health representation has remained strong despite the major reorganisation in the sector. Voluntary, community and faith organisations continue to play a vital role, as do the other organisations represented on the Board, and our lay member led the production of a report on a key area of interest.

Safeguarding is challenging and no more so when dealing with child deaths, now undertaken by the Child Death Overview Panel that spans the local authority areas (Blackpool and Blackburn with Darwen as well as Lancashire), and serious case reviews where a child has died or been seriously harmed through abuse or neglect. The impact on all the professionals involved cannot be underestimated. We do have to learn from where there have been failings in systems or procedures but at the same time staff working with these most challenging cases need our support.

The LSCB has in place robust systems for setting strategy, planning and quality assuring both its work and that of its partners. The work of the Board is well supported by a very able business management team and the Board sub-groups.

I am optimistic that we can continue to improve the safeguarding of children and their welfare and hope that you will find in this report the evidence to help you share that optimism.

Once again my wholehearted thanks to all those who work with our children for their effort and commitment.

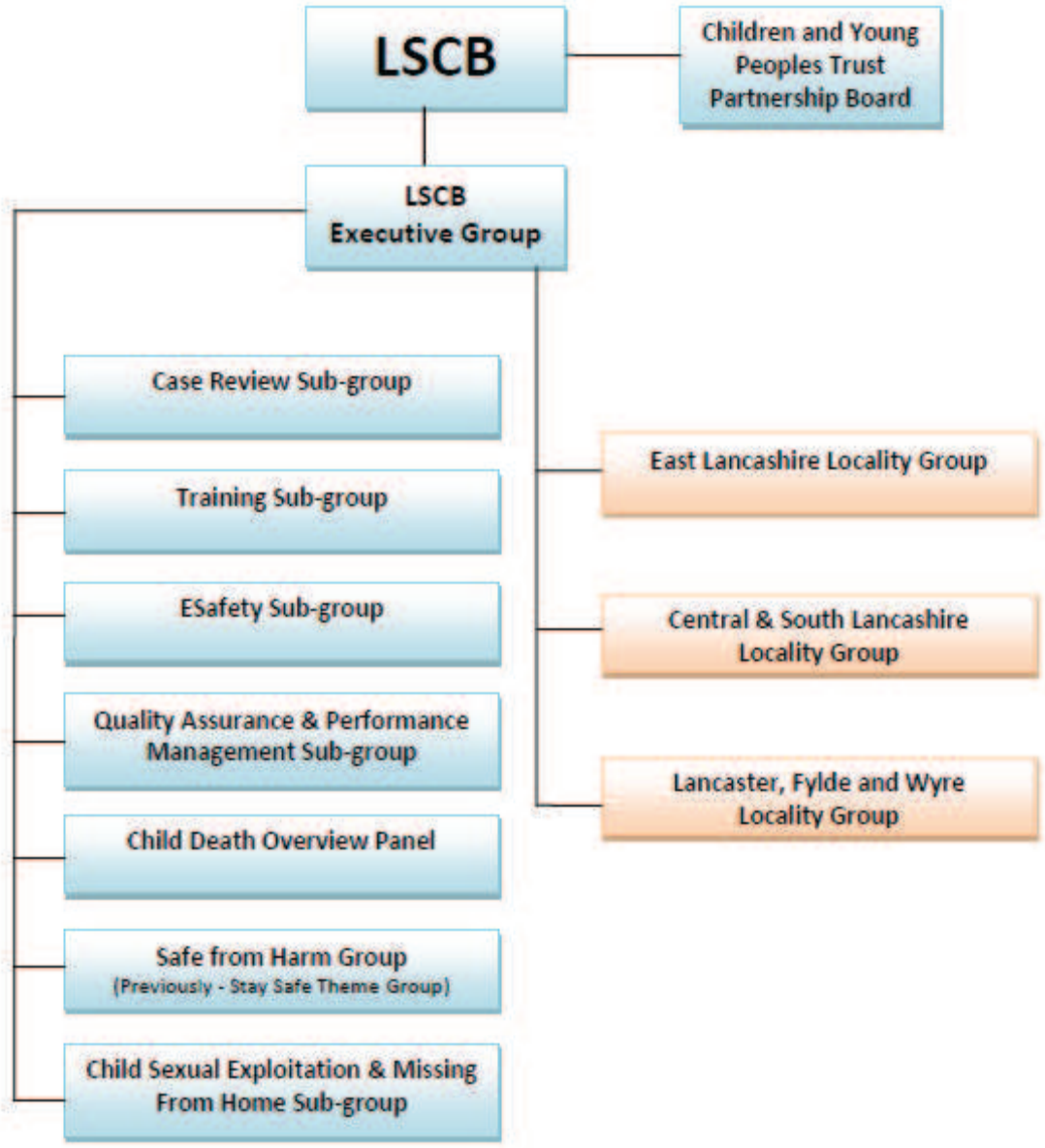
LSCB Members

AGENCY	REPRESENTATIVE
Independent Chair	**Nigel Burke**
NHS Central Lancashire	**Jean Rollinson (Vice Chair)** Associate Director Safeguarding (also Locality Group Chair – South & Central)
NHS North Lancashire	**Barbara Campbell** Head of Standards, Health and Effectiveness
NHS Central Lancashire	**Dr Ruth O'Connor (up to October 2012)** **Dr Diah Mahmood (October 2012 onwards)** Consultant Paediatrician / Designated Doctor for Child Protection
NHS East Lancashire	**Jane Carwardine** Lead/Designated Nurse for Safeguarding Vulnerable Adults & Children
Lancashire Constabulary	**Ian Critchley** Detective Superintendant
Lancashire County Council	**County Councillor Susie Charles** Cabinet Member for Children and Schools
	Helen Denton Executive Director for Children and Young People
	Louise Taylor Director of Specialist Services
	Ann Pennell Director of Targeted and Assessment Services
	Paul Armitage Head of Children's Social Care (Locality Group Chair - East)
	Paul Hegarty Children's Social Care, District Manager (Locality Group Chair - North)
	Mike Banks County Head of Active Intervention and Safeguarding (Adult Safeguarding Board Representative)
Lancashire Probation Trust	**Linda Lock** Assistant Chief Executive
Children and Family Court Advisory and Support Service (CAFCASS)	**Collette Dutton** Head of Service, Cheshire, Merseyside & Lancashire
Lancashire Care NHS Foundation Trust	**Gill Frame**

	Network Director, Children and Families Network
Lancashire Teaching Hospitals NHS Foundation Trust	**Sue Reed** Nursing Director
Secondary Schools	**Roddy McCowan** Head Teacher, Baines School
Voluntary, Community & Faith Sector	**Debbie Fawcett** HARV Outreach, Project Manager
Voluntary, Community & Faith Sector	**Amanda Forshaw** Caritas Care, Director of Services - Children's Services
Lay Member	**Abdul Haleem**
District Councils **Burnley Borough Council** **Chorley Borough Council** **Fylde Borough Council** **Hyndburn Borough Council** **Lancaster City Council** **Pendle Borough Council** **Preston City Council** **Ribble Valley Borough Council** **Rossendale District Council** **South Ribble Borough Council** **West Lancashire District Council** **Wyre Borough Council**	**Lorraine Norris** Chief Executive Preston District Council

LSCB Structure

The LSCB is structured as illustrated in the diagram below. The Executive group is now well established and continues to take forward the day to day business of the Board.



Provision of policies, procedures and guidance for multi-agency arrangements, to protect children and promote their welfare

Lancashire LSCB is now working in collaboration with Blackpool and Blackburn with Darwen LSCBs to provide Pan-Lancashire multi-agency safeguarding policies and procedures. These are available in an interactive e-manual (produced and administered by an external service – Tri-x) which is reviewed and updated three times per annum to account for:

- Changes in national guidance
- Themes emerging from local and national research
- Recommendations from case reviews

- Recommendations from quality assurance
- Learning from best practice

  The procedures are accessible for free, via the LSCB website at the following link:
  http://www.lancashire.gov.uk/corporate/web/?siteid=3829&pageid=20741&e=e

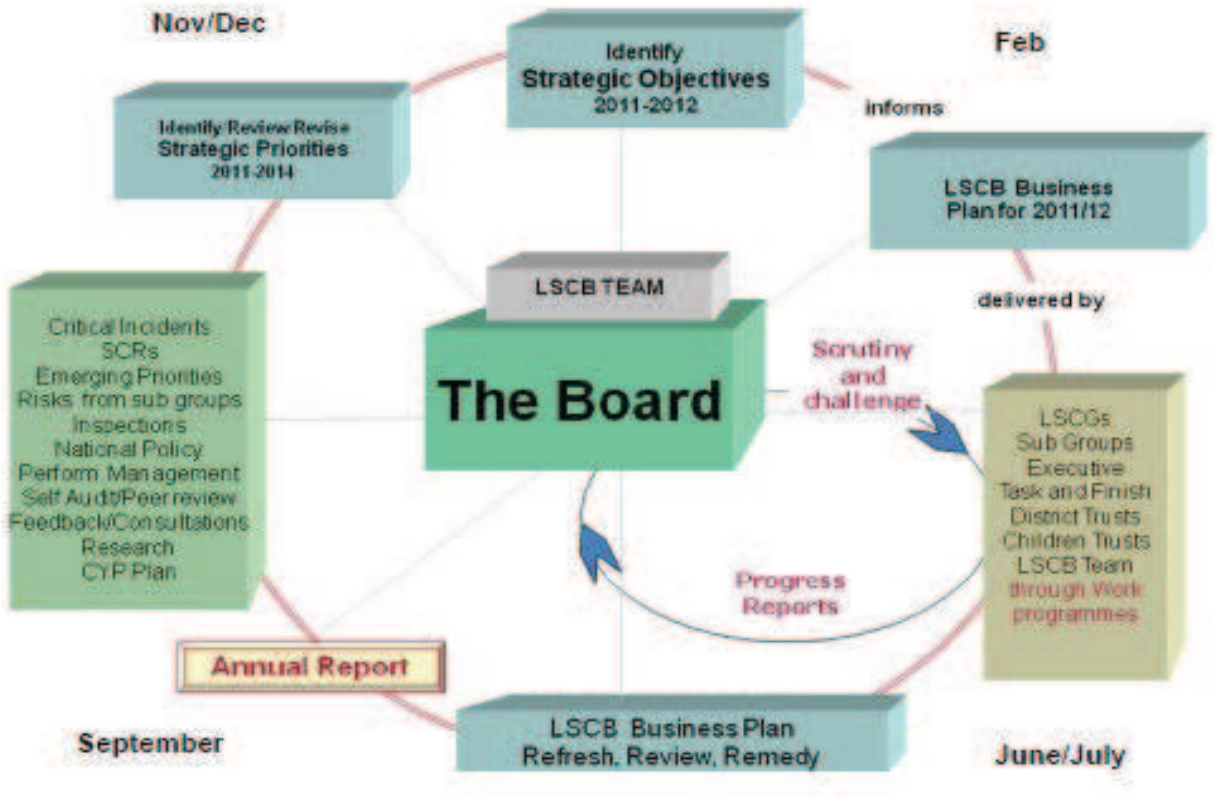
Where possible all procedures are discussed across the 3 LSCBs and agreed on a pan-Lancashire basis to assist partner agencies who work on footprints which are not co-terminus with the 3 local authority areas. However it is recognised that there will inevitably be some LSCB specific variation and this is recognised within the procedures manual.

During 2012/13 the following additional procedures/guidance have been developed or updated and agreed for inclusion within the manual:

- Multi-agency Supervision Standards
- Guidance for supporting staff following the death of a child
- Multi-agency Pre-birth Protocol
- Sexually Active Under 13s
- Procedure for the assessment of young people who exhibit sexually harmful behaviour

The LSCB Business Planning Cycle

The LSCB has developed a robust business planning cycle to ensure strategic priorities and their subsequent delivery plans are effectively monitored, managed and reviewed. This is illustrated in the diagram below.



It is important to note that each sub-group of the LSCB has its own work programme based on the LSCB business plan, but also including specific priorities within the group, which is monitored on a regular basis via formal bi-monthly reports to the LSCB. These reports are discussed in detail and any subsequent corrective action agreed. At

the end of the year the LSCB reviews its strategy and objectives based on feedback from the sub-groups and other areas of activity as detailed above.

Single and Multi Agency training provision

Update from Learning & Development Sub-group

Chair: Jane Carwardine

Summary of Key Functions

The principal purpose of LSCB learning & development sub-group is to promote learning and development which leads to:

- Improved practice in safeguarding Children in their context
- Reduced incidence of harm to children
- Better outcomes for children

The Learning & development sub Group is accountable to the LSCB and contributes to the aims of the LSCB and supports its business plan through the development of staff and organisations on a multi-agency basis.

The strategic aims of the group are:

1. Identifying training and development needs for Inter-agency learning
2. Commissioning, quality assuring and evaluating Inter-agency learning opportunities, to enable staff and agencies to access appropriate learning in line with current National guidance:
    a. That promotes a shared understanding of the tasks, processes, principles, roles and responsibilities and local arrangements for safeguarding children and young people and promoting their welfare
    b. Improves communications between professionals, including developing a common understanding of key terms, definitions and thresholds for action
    c. Promotes effective working relationships, based on respect and an understanding of the role and contribution of different disciplines, including an ability to work in multi-disciplinary groups or teams
    d. Promotes sound child focussed assessments and decision making
    e. Promotes learning from Serious Case Reviews, Critical Incident Reviews and Reviews of Child Deaths
    f. Uses the available resources in the most effective way

Key actions to deliver these aims are as follows:

- Develop a workforce Training Needs Analysis in line with 'Working Together 2010' guidance
- Develop and review a learning and development programme that is established within the context of local and national policies, research and practice developments
- To commission the design, planning, organisation and implementation of the training/learning programme via the LSCB strategic training co-ordinator, based on inter-agency priorities and learning from SCRs and reviews of child deaths
- To maintain links with all other LSCB sub groups in order to ascertain learning needs
- Ensure that the LSCB learning programme is monitored and evaluated for quality and impact on practice
- To recruit, support, develop and monitor the training pool
- To ensure membership attendance of learning & development sub group is in accordance with LSCB guidance

Key priorities for 2012/13

- Develop a pan Lancashire approach to Child Sexual Exploitation training
- Implement and embed revised e-learning programme
- Develop a reporting process with all partners to assure LSCB that all partners comply to national guidance regarding group 1 & 2 safeguarding training
- Implement and embed on line access to LSCB training

- Review membership to the LSCB training sub considering organisational transition
- Review the training needs of all agencies, including the voluntary and independent sector in respect of safeguarding training
- Run a core training programme of approximately 75 events covering at least 20 topics, potentially adding further events required by the LSCB

Were the priorities achieved effectively?
The review of the plan is attached (see appendix 1). As can be seen, most objectives were achieved. The one objective which was not, was part of a large review and the system has been changed.

How has the work of the sub-group contributed to the LSCB's priorities in 2013/14
L& D Sub-group contributes to the work of the LSCB by developing the workforce and informing key members of the workforce about the latest developments. Through the business planning cycle above the work of the sub-group informs future LSCB priorities and development.

Key Successes and Achievements for 2012/13
- 1378 professionals attended LSCB training events, and 2097 completed e-learning, making a total of 3475 professionals who came through the LSCB learning programme
- In 2012-13, L&D sub planned 80 training events. Of those, 59 ran, and 21 were cancelled. In addition, three Critical Incident Reviews, each lasting two days were facilitated.
- Held SCR briefings, jointly with Blackburn with Darwen and Blackpool LSCBs, which were evaluated and found to provide excellent learning
- Provided advice to 58 organisations which approached the LSCB Training Unit
- Recruited new members to the training pool to replace the members who left
- Successfully engaged the 12 District Councils in the safeguarding agenda, with the result that all now have a safeguarding policy and most have training for their staff
- Planned on-line sign up for training events, which will happen in 2013-14
- Pilot tested an electronic feedback system, initially for three months to ascertain viability and response rates
- Revised e-learning course and separated it into Group 1 and group 2
- Ensured AIM training delivered was in line with the new AIM policy and procedures
- Involved Children and Young people as well as parents in the delivery of the Neglect Conference in October 2012.
- Successfully delivered a group 8 course in June 2012
- Developed a new Quality Assurance programme to receive feedback from the workforce on how learning has been used following attendance at courses to influence positive outcomes on children and families.
- Expanded the programme to include more ways of learning to ensure we offer a diversity of learning opportunities which make learning and development accessible for the workforce across agencies in Lancashire. Shorter workshops have proved to be in demand.
- Developed a proposal for inter-agency, case based reflection for front line practitioners.
  Contributed to the Learning and Improvement Plan, which was approved by LSCB
- Wrote a Child Sexual Exploitation e-learning course, which was agreed across the three LSCBs
- Wrote two new e-learning courses which are now on line
- Delivered a Neglect conference
- Brought new learning and research into SCR learning seminars
- Provided three System-based Critical Incident Reviews (now renamed), this has included training up three facilitators
- Met six times in the year, L & D sub membership healthy and the sub works well
- Contributed to the regional learning by membership and contributions to the North West Interagency Trainers (NWIAT)group
- Wrote seven new courses
- Developed new ways of getting messages over, for example by bookmarks and 'best advice' cards
- Proposals for practitioner forums and group supervision written

Quality and Effectiveness of Arrangements and Practice

Update from the Quality Assurance and Performance Management Sub-group

Chair: Barbara Campbell (up to December 2012), Tony Morrissey (December onwards)

Summary of Key Functions

- To provide the LSCB with a qualitative and quantitative evidence base to demonstrate how effective multi-agency safeguarding practices and arrangements are
- To coordinate completion and quality assurance of the LSCB Section 11 audit across all partner agencies
- To develop and deliver a quality assurance work programme based on priorities and methods specified in the LSCB Quality Assurance Framework – namely Neglect and Child Sexual Exploitation
- To oversee any improvements arising from multi-agency inspections, peer reviews or mock inspections and inform the LSCB of any significant risks or issues

Key Priorities for 2012/13

- Co-ordination and quality assurance of section 11 audits for all member agencies
- Development of a strategic quality assurance framework (QAF)
- Delivery of the Neglect quality assurance work programme (as specified in the QAF)
- Delivery of the Child Sexual Exploitation quality assurance work programme (as specified in the QAF)
- Development of a framework to assess the effectiveness of Early Intervention and the Common Assessment Framework (CAF)
- Oversight of the action plan following the safeguarding and looked after children inspection
- Review of health performance data to ensure consistency and quality

Were the priorities achieved effectively?

All priorities were commenced and progressed effectively during 2012/13. A new QAF was developed based on recognised best practice guidance from the pan-London model. This was ratified by the LSCB and implementation led to the agreement of priorities and work programmes with regard to Child Sexual Exploitation and Neglect as detailed below. There was some slippage on delivery of the Neglect work programme and the final activity, a multi-agency case file audit, has just been completed at the time of writing (June 2013). The development of effective QA pathways with regard to Early Support and the use of the Common Assessment Framework is still ongoing due to the current wholesale review of the Common Assessment Framework and development of the Early Support core offer. This activity will continue into 2013/14 and its conclusion reported in next year's annual report.

Neglect work programme:

A summary of conclusions from the neglect work programme is as follows:

- The Local Authority has comprehensive monitoring and recording processes in place around Child Protection Plans, referrals, children missing education and some very informative auditing has taken place engaging with families subject to statutory intervention

- It is a concern that there are no systems in place across agencies to capture, collate and analyse information about neglect lower down the continuum of need

- Health indicators around immunisations, missed appointments and GP registration have proved difficult and problematic to evidence

- The Lancashire housing economy is complex and diverse and seeking assurance from housing providers is a significant challenge. Work is ongoing to engage with housing providers and develop effective quality assurance pathways

- Planned multi-agency auditing over the coming months will provide further evidence of how effectively agencies are intervening with families and children

- Findings shared with the training sub-group to inform the training priorities for next year

The LSCB will be considering how to address these issues following finalisation of the current audit, and will be reported in full next year's annual report. It is also worth noting that the LSCB has developed a Neglect Strategy which has been informed by the findings of this work – delivery of the strategy will be overseen by the Safe From Harm sub-group and reported fully in next year's annual report

Child Sexual Exploitation work programme

A summary of conclusions from the Child Sexual Exploitation work programme is as follows:

- Child Sexual Exploitation practices and procedures are very well developed in Lancashire and all aspects of the frame work have been evidenced to a good standard with any areas for future development identified. A number of local and national action plans have been delivered and the strategy and operating protocol effectively embedded

- Child Sexual Exploitation is a high priority locally and nationally and Lancashire Police are leading the way in partnership with other agencies. The children's commissioner on a recent visit commended the work in Lancashire as a 'beacon of excellent practice'

- There are no identified areas of weakness or gaps to note from this analysis. The areas for development are recognised and planned for implementation in due course

The LSCB has been assured that this area of practice is being effectively addressed by partner agencies in Lancashire. Following this quality assurance activity and implementation of the Child Sexual Exploitation strategy a programme of E-learning has been developed through the Learning and Development Sub-group.

Practitioner Survey

A survey of over 700 practitioners across all LSCB agencies was completed to ascertain how effective they felt their agencies were in dealing with safeguarding issues and how confident they personally felt at dealing with a range of specified safeguarding issues. The results have been shared with all LSCB agencies who have been asked to consider how they will respond to issues raised. A copy of the report can be accessed at the following link:
http://www.lancashire.gov.uk/corporate/web/view.asp?siteid=3829&pageid=31195&e=e

How has the work of the sub-group contributed to the LSCB's priorities in 2013/14

As detailed above the work of the sub-group informs the LSCBs priorities through the robust business planning cycle and regular progress updates to the LSCB on priorities specified in the work programme. The 'Toxic Trio', which refers to the combination of parental drug misuse, domestic abuse and parental mental ill health, has been identified through the QAF as a priority for 2013/14 which follows on from issues raised through the work on Neglect and shared learning from the Case Review Sub-group.

Key Successes and Achievements for 2012/13

- Development and implementation of a new quality assurance framework
- Development of a new section 11 audit tool
- Completion of all section 11 audits by partner agencies
- Completion of the neglect audit work programme
- Completion of the Child Sexual Exploitation work programme
- Development of a health performance dataset
- Completion of a multi-agency practitioner survey of over 700 practitioners
- Development of LSCB multi-agency safeguarding practice inspections

LSCB Section 11 Audit

The Section 11 Audit is a self assessment tool which the LSCB requires all statutory agencies to complete to evidence compliance with section 11 of the Children's Act 2004 – the duty to safeguard. (See appendix 2)

The LSCB section 11 audit follows a triennial business cycle as follows:

- Year 1 – All agencies complete section 11 audit and receive feedback following quality assurance with any improvements required clearly specified using a 'RAG' rating (Green=compliant, Amber=partially compliant, Red=non-compliant)
- Year 2 – Update on areas for improvement
- Year 3 – Update on areas for improvement

September 2012/13 marked the start of year 1. At this point the LSCB had been assured that any areas for development / improvement for all applicable agencies from the previous audit had been effectively addressed or were progressing. A new audit tool was developed to ensure information captured was more concise and relevant with regard to the requirements for organisations specified in the guidance. The previous tool was felt by agencies to be rather unwieldy and overly prescriptive. The audit tool can be viewed at appendix 2.

All statutory agencies completed the audit tool. This includes the following agencies:

- Central Lancashire PCT (provider & commissioner)
- North Lancashire PCT (provider & commissioner)
- East Lancashire PCT (provider & commissioner)
- Lancashire Care NHS Foundation Trust
- East Lancashire Hospital NHS Foundation Trust
- Lancashire Teaching Hospitals NHS Foundation Trust
- Calderstones NHS Foundation Trust
- Blackpool Victoria Hospital NHS Foundation Trust
- University Hospitals of Morecambe Bay NHS Foundation Trust
- Southport & Ormskirk Hospital NHS Foundation Trust
- NHS East Lancashire Community Health Services
- Lancashire Constabulary
- Probation
- Cafcass
- Lancashire County Council
- Chorley BC
- West Lancs BC
- Wyre BC
- Fylde DC
- Lancaster CC
- Preston CC
- Rossendale DC
- Burnley DC
- Pendle DC
- Hyndburn DC
- Ribble Valley DC
- South Ribble BC

The LSCB Quality Assurance sub-group maintained oversight of the submission of returns and a process of quality assurance was agreed as follows:

- LSCB Business Coordinator to make an initial screening of returns to identify any obvious issues or omissions
- 3 key statutory agencies to be randomly selected to receive a site visit from a small multi-agency team of peers to look at supporting documentation and speak to key members of staff about the audit
- LSCB Business Coordinator to visit 3 randomly selected District Councils for a site visit to check supporting documentation and speak to key staff about the audit

These site visits are planned for completion in 2013/14 and results from these will be reported in the next annual report.

<u>Themes from the returns</u>

Within the S11 audit returns agencies identify a number of issues to address, progress in resolving these will be tested through annual updates to the QA Sub-group as well as the QA site visits referred to above. Key themes from the screening exercise have revealed the following:

- All organisations have a designated senior officer
- All organisations can demonstrate policies and procedures are in place
- Safeguarding Supervision arrangements are often not in place – statutory agencies (especially health agencies) recognise this is an area for development
- Evidence of staff training to the required 'levels' is variable – few organisations can demonstrate all staff have received the appropriate training
- Use of the Common Assessment Framework (where referred to) appears inconsistent and patchy
- All organisations appear to have at least the essential safe recruitment practices in place, links to the Local Authority Designated Officer for Allegations (LADO) not always robust
- All agencies understand the need to share information and all appear to have appropriate arrangements with key partners, though this varies depending on the nature of the organisation

LSCB Case Reviews

Update from the Review Group

Chair: Louise Taylor

Summary of Key Functions:

- To consider, at the request of the Chair of Lancashire LSCB, whether a Serious Case Review should take place, and make recommendations to the LSCB Chair who has ultimate responsibility for deciding whether or not such a Case Review should be conducted
- To consider, in the light of each case, the scope of the review process and draw up clear terms of reference and identify any specific expertise needed for the Overview Panel including nomination for independent Chair and Author
- To monitor the SCR process and to oversee changes to this process
- The review group will be required to have over sight of all multi-agency action plans and will need to have a scrutiny role in relation to all single agency action plans. Recommending to LSCB when a SCR can be signed off as being completed
- Advising and facilitating the QA Sub group's role in distilling key learning and audit

Key priorities for 2012/13

- To undertake serious case reviews and multi agency learning reviews when appropriate
- To ensure that there is an effective system is in place for the monitoring of action plans and dissemination of learning from case reviews
- To adopt any new methods and processes for completing SCRs and CIRs that may come from revised statutory guidance
- To enable and support practitioner development in light of SCR and CIR findings
- To develop process of completing good practice reviews and link into best practice panels

Were the priorities achieved effectively?

All cases that potentially met the criteria for a serious case review or multi agency learning review were referred into the SCR group in a timely manner. All those cases were considered by the group and a decision reached by the chair of the LSCB within one month of referral.

The group considers the progress of all single and multi agency action plans on a bi-monthly basis and takes necessary action when there are felt to be unacceptable delays in implementing learning. The findings from all reviews are also shared with the Learning and Development sub group and Quality Assurance sub groups in order that they reflect them in their work programmes.

The SCR group has developed more effective and inclusive models of learning from reviews and has been involved in developing these on a regional basis. The feedback from practitioners about these models has been overwhelmingly positive; they all believe their future practice has changed for the better.
The dissemination of lessons from reviews has continued throughout the year. There are regular newsletters that are widely shared throughout Board agencies and the Children and Young People's Trust. The large scale multi-agency SCR briefings continue to be updated and delivered and the actions practitioners take as a result of their attendance at these events continues to be monitored.

How do these reflect learning and developments from the previous year?
The review group felt that the process for completing reviews was not as effective as it could be and welcomed the findings in the Munro report that suggested a different approach to learning from cases. The group was keen to ensure that practitioners were much more involved with the process of reviewing cases and therefore volunteered to be part of a pilot of a systems methodology being undertaken by the Social Care Institute for Excellence (SCIE).

As a result of learning that came from this pilot, the SCR group developed a new model of reviewing cases that didn't meet the criteria for an SCR. This involved practitioners coming together to discuss a case and reflecting on what worked well and what could be improved. They then help to develop that learning to share more widely with other practitioners. The SCR group has completed a number of multi agency learning reviews over the last twelve months and used the findings to develop training and learning events for all staff. The new Working Together guidance will now allow us to develop this successful model of learning to serious case reviews too, and we have been working with neighbouring authorities to develop a consistent framework for this.
The monitoring of actions emerging from SCRs and other learning reviews has ensured that the messages and learning are being shared widely across partner agencies.

How has the work of the sub-group contributed to the LSCB's priorities in 2013/14
Building on the success of these new models of reviewing cases, the LSCB has developed a proposal for group reflection which is now being piloted.

The issue of the 'toxic trio' (combined effect of parental substance misuse, domestic violence and mental health issues) has been present in a number of reviews locally and nationally and has been adopted by the QA sub group as their topic for QA activity for the coming year.

The findings from case reviews have assisted in the development of the training programme for the coming year, in that all the lessons are built into existing training courses and new ones are developed where necessary. In addition, a programme of 'bite-sized' briefings around topics that emerge from case reviews will be delivered, and larger conferences around specific topics, such as neglect are also planned.

The issue of assessment quality has been incorporated into the LSCB Business Plan for the coming year as a result of potential inconsistencies revealed through case reviews.

Key Successes and Achievements for 2012/13
The SCR group continued to hold agencies to account to demonstrate that they learn from cases when appropriate, meaning that there is a continual process of improvement in working with children and young people across agencies. For example, new supervision guidance has been developed as a result of a serious case review, and the LSCB tests the implementation of this through the s11 audit process.

The new method of reviewing cases has been a huge success for practitioners and they believe their practice with children and young people has changed for the better. Their engagement in the process has made the learning far more effective which in turn will benefit all children and young people that come into contact with professionals across all partner agencies.

This in turn has led to the development of other new ways of engaging with practitioners to ensure the best learning outcomes for them, such as reflective practice sessions and bite-size briefings. The ongoing briefings of staff, on a single and multi-agency basis, has led to a wider understanding of the themes from case reviews, and has given staff tools to use in their practice.

Themes from Case Reviews concluded during 2012/13
Lancashire Safeguarding Children Board concluded two serious case reviews (SCRs) during this year and four multi agency learning reviews (for cases that didn't meet the criteria for an SCR but offered a learning opportunity). The LSCB has also undertaken a number of best practice reviews, and the learning from all these processes has been brought together to inform the training programme for the current year, implement improvements in processes and procedures and drive improvements to practice across the County.

The findings from all of these review processes can be grouped into broad themes; the first of which is around human behaviour. All the reviews found that practitioners were hard working, committed and really cared about outcomes for the children and young people they worked with. The time and energy that people put into their work is commendable. The LSCB wants to build on this passion and help practitioners to develop their practice even further.

Some of the' human themes' that have emerged are natural human behaviour; such as wanting parents to do their best for their children, and believing people when they state their commitment to parenting their children properly. The LSCB has done a great deal of work with practitioners about sceptical curiosity and hypothesising (a tool for practitioners to use to challenge their assumptions about what they see). In addition, the LSCB has worked hard to provide an environment in which practitioners are comfortable in being challenged by others, and comfortable to challenge other practitioners when they don't believe a decision is right for a child. Supervision standards have been developed, and reflective practice is encouraged through the use of multi agency learning reviews, best practice panels and the soon to be operational practitioner forums.

There have also been areas for development identified in the tools that practitioners have available to them in their work. The LSCB has become involved in the Graded Care Profile pilot, in the hope that this will deliver an effective way of assessing neglect and its impact on children. The Common Assessment Framework and Continuum of Need are being refreshed, alongside new Thresholds Guidance for practitioners and the LSCB will monitor the roll-out and use of these refreshed processes. The single assessment framework is being developed and will take account of the findings from reviews around the quality of assessments and the use of historical information to judge risk to children.

Update from the Child Death Overview Panel (CDOP)

Chair: Dr Shelagh Garnett

Summary of Key Functions

- To review all child deaths pan-Lancashire
- To identify themes and trends and make recommendations to try and prevent future child deaths
- Monitor the Sudden Unexpected Death in Infancy (SUDI) Prevention Group and the Safer Sleep Campaign
- Ensure there is a coordinated response to each unexpected child death

Key priorities for 2012/13

1. The Panel will review cases and make recommendations regarding themes to the Board
2. CDOP will develop links with other Local Safeguarding Children Board Sub-Groups particularly the Safe from Harm Group
3. With Public Health department investigate apparent disparity in numbers of deaths between CDOP and ONS data
4. Further detailed review work to identify themes / trends in deaths categorised as caused by perinatal /neonatal events
5. The Panel will monitor the re-launch of the Give Me room to Breathe (GMRTB) Campaign
6. CDOP will ensure the Safer Sleeping Guidance is reviewed
7. Ensure and monitor the review of the SUDC Protocol
8. Finalise the multi-agency e-learning and make available to professionals front line multi-agency professionals
9. Develop a Pan-Lancashire communications strategy for disseminating messages and information on a multi-agency basis
10. Monitor Multi-Board CDOP Budget and develop action plan for utilising the under spend

11. Update the data recording/analysis systems to improve reporting on specific modifiable factors identified by the Panel

How do these reflect learning and developments from the previous year?
In the 2011/12 annual report it was identified a significant proportion of children died as a result of a perinatal/ neonatal event; consequently further research into this cohort of child deaths was identified as needing an in depth review. When Public Health started this review it was identified they would be best placed to investigate the disparity in data between CDOP and ONS.

The data from the previous year identified that for children under one year of age who died unexpectedly, one of the largest categories was sudden unexpected, unexplained death; the risk factors identified within this group were related to safer sleep – which features as a key priority for 2012/13 as above.

The SUDC Protocol was approved by the three Boards in 2011, it was suggested it should be for review after 1 year this has been delayed pending the release of the new guidance. In this time, the SUDC Service has had a number of staff changes, system and service developments and consequently the SUDC Protocol review still remains a priority for the Panel going into 2013/14.

It was identified that e-learning would be the best method for reaching the multi-agency workforce. The e-learning will inform professionals of CDOPs systems and processes but more importantly, raise awareness to the themes and trends emerging and provide additional contacts and resources for further information.

One of the Panel's main functions is to identify themes and trends; the Panel were aware that they collate a large amount of detailed data without the ability to efficiently extract the information and report on it. As a consequence, it was identified a database (rather than excel spreadsheets) would significantly improve the reporting mechanisms of the CDOP particularly in relation to modifiable factors.

Were the priorities achieved effectively?
(See Appendix 3) Most priorities were achieved effectively. The review of the SUDC Protocol was delayed pending the release of Working Together 2013 and is now a priority for 2013/14.

How has the work of the sub-group contributed to the LSCB's priorities in 2013/14
The Panel has regular reporting to the Boards which informs future planning, gaps in service or areas for update/ improvement. The reporting is bimonthly (includes themes and trends from case discussions and issues, recommendations from the business meeting), quarterly statistics are provided and an annual report identifies themes and trends from aggregated data. The CDOP Chair attends and contributes to the annual Board development day.

Key Successes and Achievements for 2012/13
The SUDI Prevention Group, a sub group of CDOP, updated and re-launched the Safer Sleep Campaign (previously Give Me Room To Breathe). The Campaign will provide professionals with a consistent message and materials to give parents/ carers for discussing safer sleep. The Campaign aims to inform parents/ cares of the risks associated with safer sleep for babies to help them make an informed decision in relation to bed sharing and consequently make children within pan-Lancashire safer.

The CDOP monitored the update and review of the Safer Sleeping Guidance which has been ratified by the three LSCBs and has informed the development of the Safer Sleep Campaign. This was a challenging piece of work which provides frontline staff across pan-Lancashire with clear and consistent evidence based information to support them in having open and honest discussions with parents/ carers about safer sleeping choices.

The Panel set up and monitored the Suicide Thematic Task and Finish Group which completed an in depth review of the child deaths which were deemed to be as a consequence of the child/ young person's own actions. The group identified recommendations to be considered by the LSCBs and the report has been shared widely on a multi-agency basis.

The CDOP developed posters for professionals and GPs to advise them who to contact to initiate the rapid response and who to notify should a child die in a manner that was expected. This will improve the notification process, ensure relevant systems are initiated and parents/ carers/ families are supported in a timely manner.
The Panel has completed a survey of available bereavement services within the pan-Lancashire area; this information is being distributed to GPs and will be included in the updated SUDC Protocol.

The CDOP have successfully completed their first year as a tri-partite Panel utilising a rota system for Acute Trusts professionals, Community Health colleagues, Public Health, Children's Social Care and Education representatives.

Update from the eSafety Sub-group

Chair: Graham Lowe (Schools ICT Manager)

Summary of Key Functions:

- To develop and oversee delivery of the LSCB eSafety Strategy and Action Plan (including review and monitoring)
- To provide specialist advice to the LSCB on eSafety issues
- To provide a forum for sharing single agency practice and developments and provide mutual support
- To act as a central point of contact and advice for strategic eSafety issues
- To share resources and take forward actions as agreed by the group
- To provide regular reports to the LSCB on progress with the Action Plan and contribute to the LSCB Annual Report
- To take forward initiatives and projects as directed by the LSCB

Key priorities for 2012/13

- Continue eSafety Group as a forum for sharing good practice and developing eSafety provision across member agencies
- Enhance awareness of Online Safety issues across stakeholder groups
- Maintain and develop the eSafety Group and network of colleagues
- Establish a conference activity to engage stakeholders across the region and raise awareness of Online Safety
- Facilitate activities to engage with C&YP on Online Safety activities
- Establish and develop links with related agencies and groups (local, regional and national)
- Support stakeholder groups in developing Online Safety practices and procedures
- Review the existing 2009-2013 eSafety Strategy
- Establish definitive local evidence re: Online Safety issues and areas where stakeholders require support
- Engage with C&YP to establish concerns and areas requiring further development
- Establish overview of current activity across region
- Investigate potential for Pan-Lancashire approach to Online Safety with Blackpool, Cumbria and BwD colleagues
- Develop links into national representative forums to promote Lancashire issues
- Improve safe access for C&YP in non-school environments

How do these reflect learning and developments from the previous year?

- Additional support pathways from national developments
- Awareness raising continues to be a priority for all key agencies
- Key agencies and individuals continue to provide the most effective support and expertise. More strategic leadership needs to be developed going forward

Were the priorities achieved effectively?

2012/13 has been the most challenging year to-date for the group, particularly as a result of organisational change (majority of eSafety-related activity historically achieved through Schools' ICT Centre which was ceased and disaggregated in 2012) – current and future position of the various functions is still awaiting clarification though much of the existing provision (e.g. LGfL eSafety) currently remains available as a legacy of the previous service.

The majority of the priorities identified above have been achieved to varying extents. Particular successes identified under Key Successes and Achievements below.

How has the work of the sub-group contributed to the LSCB's priorities in 2013/14
Whilst much will be dependent on the results of organisational changes, there is significant potential to effectively progress Online Safety on a much greater and more effective scale, particularly if a co-ordinated approach with associated multi-agency partners and wider regional colleagues can be established.

However, since its inception, the LSCB eSafety Group has achieved its successes predominantly as a result of committed individuals and local priorities. In order to maintain and build upon these successes, there is a need to formalise the position of Online Safety as a priority area for partners which will require strategic leadership.

Subject to approval of the revised Strategy and Action Plan, forthcoming priorities for the Group for 13/14 and beyond will include:

- Commitment from partner agencies and senior members to progress Online Safety as a defined priority area
- Development of the Pan Lancashire & Cumbria eSafeguarding Strategy
- Establish the Pan-Lancashire eSafeguarding Group (existing eSafety Group will continue during interim) with agreed ToR/Key Functions
- Review of Lancashire membership to ensure appropriate representation
- Development of respective Action Plans to address local priorities (e.g. reflect ESL event findings)
- Identify appropriate support and resourcing to implement Action Plan priorities
- Increased co-ordination of activities across the region
- Increase engagement with related internal partners and external agencies to enhance and support the progression of Online Safety for C&YP across the region

Key Successes and Achievements for 2012/13

- Continuation of LSCB eSafety Group in challenging organisational circumstances
- Support and participation in Cover-IT-Live sessions
- Support for Safer Internet Day 2013 through themed advice and guidance
- Links established with Pan-Lancashire partners
- Maintain Lancashire presence on National eSafeguarding Group
- Progression towards cohesive Pan-Lancashire & Cumbria approach to Online Safety
- Raising Lancashire issues at National level (e.g. AskFM Tip sheet)
- Progression and raising awareness of eSafety agenda into related areas and stakeholder groups
- Provision of expertise and experience to colleagues looking to address eSafety in respective organisations
- Increased networking with recognised expertise to support the successful progression of specific Lancashire issues
- Continuation of eSafety presence at locality events (e.g. Chorley Clockwise)
- Increasing number of eSafety 'marketplace' at related events and conferences
- Continuation of Y6 transition activities re: Information Privacy
- Raising awareness of eSafeguarding issues with senior figures in related agencies
- Involvement in supporting the updating/development of Online Safety resources for related partners
- Planning and preparation for eSafety Live (ESL) in Lancashire 2013 sessions to take place on 25th April 2013

Update from Child Sexual Exploitation Sub-group

Chair: Ian Critchley

Summary of Key Functions:
To set a strategic approach to CSE across the County, to quality assure and monitor agencies compliance of CSE policies and procedures. To respond to emerging threats and reduce the risk of exploitation and abuse of our children and young people

Key priorities for 2012/13

- Quality Assurance framework around CSE
- Increased work with all diverse communities regarding awareness of CSE and confidence in
- the service provided
- Develop approach to targeted organised criminal groups committing CSE
- Develop public safety awareness campaigns re CSE
- Undertake activity to obtain feedback from young people who have been exploited regarding
- the service they received in order to continually seek to develop service improvement
- Review and Develop training for all frontline professionals re awareness of CSE

How do these reflect learning and developments from the previous year?

Child Sexual Exploitation remains a significant issue in Lancashire for the Safeguarding Board. There has been national media focus on this area of our protecting people strategy. In Lancashire across our 6 policing divisions we have led the way in terms of the approach we have taken to tackling the issues with our partners. We must continue to review our approach to safeguarding and preventing children from abuse and exploitation and ensure we bring all perpetrators to justice.

Were the priorities achieved effectively?

Increased work with all diverse communities regarding awareness of CSE and confidence in the service provided

The Deter team - Preston, has benefitted by identifying and establishing community contacts through the local Police and Communities Together (PACT) meetings and the City Council's Community Engagement Team. These community contacts work with the team to prepare and present briefings to promote awareness of CSE within their own communities. The next step in this initiative to increase the knowledge and skills of 'Community Champions' to inform the way in which vulnerable young people are identified and supported within the community.

There are a number of projects across the county which have identified concern about the tolerance to exploitive behaviour amongst individuals, groups and communities. The following are just some examples of the awareness raising work being undertaken in our communities to tackle these issues.

The Children's Society **-** provide a service known as 'Respect U & Me' in a Lancashire school where two groups of young men of Asian heritage were identified as displaying demeaning behaviour towards females (both their peers and women in general) and there was evidence of some elements of exploitative behaviour in their personal relationships. The Children's Society worked with the groups on 'respect and healthy relationships' which culminated in the group producing a leaflet on key messages about respecting others this leaflet will be shared with other young men.

Streetlink - an established, voluntary organisation in Preston, provides street based services for sex workers and young people at risk of being involved in prostitution. Their local knowledge and ability to communicate on the street enable their workers to identify and provide targeted intervention to children at risk of CSE being drawn into street sex work.

Develop approach to targeted organised criminal groups committing CSE

The Constabulary continue to target all those suspected of sexually exploiting children and young people. An investigation into individuals associating in an organised criminal group has been successfully prosecuted at Crown Court. The lessons learned from this case will enable police and their partners to refine the targeting, investigation and prosecution of organised groups.

Develop public safety awareness campaigns re CSE

September 2012 - The sub group co-ordinated a week long CSE awareness campaign between the 17th September and the 21st September 2012. This campaign was designed to raise awareness and inform and empower the public, especially young people about Child Sexual Exploitation. Events arranged during the week including the use of the media and social media highlighted how successful collaborative working of agencies addresses and tackles the issue of CSE within Lancashire.

Undertake activity to obtain feedback from young people who have been exploited regarding the service they received in order to continually seek to develop service improvement

The Lancashire co-located teams include statutory and third sector providers. The co-located model provides an essential hub, in which the partners identify the needs of the victim and their family and work together to safeguard, support, investigate and bring offenders to justice. Our VCFS partners are crucial members of the teams and include Brook, The Children's Society, PACE, and Barnardos.

Intensive outreach workers, in the Children's Society's Street Safe Lancashire (SSL), provide valuable support to children and young people, at risk of or involved in sexual exploitation, from report through to the court process. They are co-located in 5 of our divisional teams, where they provide support to victims as part of an integrated package of multi-agency intervention.

Between October 2012 and March 2013, SSL supported 172 children and young people with interventions which raised awareness of grooming, CSE, healthy relationships and protective behaviours. These continued whilst they were needed by the victim and for varying periods from between 2-3 months and a few years, where young people struggled to cope and build resilience. They have also delivered 151 group sessions in children's homes, schools, colleges and youth groups.

Parents Against Child Sexual Exploitation (PACE) parent support workers provide independent, non-judgmental and confidential support to parents, they understand the rights of parents and carers. They listen to concerns, give information on statutory agencies, court procedures and pass on advice from other affected parents. PACE workers help find the best solution for each family. They are co-located in 3 of our teams and have supported 25 families during October 2012 – March 2013.

Both The Children's Society and PACE are positioned to feedback to the teams the views and opinions of young people and their families of the service they were given and how we, as professionals could improve this experience.

Review and Develop training for all frontline professionals re awareness of CSE

The members of the LSCB have developed a CSE training package for practitioners; the one day training is delivered by experienced staff who work in the CSE Arena on a daily basis. The feedback from participants of the course has been excellent. A course for Managers is now being written and will be rolled out in autumn 2013.

The LSCB CSE E-Learning package received agreement in February and is now 'live' this resource is available for all agencies and is aimed at staff who come in to contact with children during their daily work not necessarily as their primary role.

Update from Safe from Harm Sub-group

Chair: Louise Taylor

Summary of Key Functions:

- Overseeing partner agencies contribution to the CYPP regarding Safe From Harm outcomes
- Support development of policies, procedures and strategies in relation the Safe From harm outcomes
- Identify cross cutting countywide procedures and developments and work towards a more integrated approach and work with other groups and partners to ensure integration.
- Ensure policies and procedures are developed and revised to enable delivery of priorities in the CYPP
- Link with the three other priority groups to identify safeguarding concerns and evidence of good practice.
- Identify opportunities for preventative work and early intervention

Key priorities for 2012/13

- Neglect
- Missing Children
- Domestic Abuse

- Bullying
- Fewer Children are killed or seriously injured in road traffic accidents
- Children who sexually offend

How do these reflect learning and developments from the previous year?

Neglect

Following the report on the Safeguarding Quality Assurance Framework on Neglect brought to the group and an audit to take place on 65-70 case files in May 2012, it was agreed that some actions and outcomes should be added to the 2012/2013 action plan

Missing Children

It was agreed that the outcome relating to this priority should remain with the group as it is a high profile area of work

Domestic Abuse

After discussion of a pilot perpetrator programme in Blackpool the group agreed that focus needs to be on what support is given to children pre CP plan threshold as per the safeguarding and looked after children inspection report. A sub group will be set up to look at what support is available and where there are gaps to ensure consistency of provision. The outcomes will inform the action plan.

Bullying

Following discussions on cyber bullying and the problem of bullying which occurs outside of school where perpetrators attend the same school further developmental work will be carried out and will therefore remain a priority for the coming year

Road Traffic

The strategy is being revised and the outcomes will inform the action plan

Children who sexually offend

A thematic inspection will take place in June 2012 and links have been made to identify four young people who meet the criteria. It was appropriate therefore that this should remain on the action plan

Were the priorities achieved effectively

- Pupil Attitude Questionnaire shows an improving picture of bullying. An anti bullying charter has been developed
- There has been a significant reduction in children killed or seriously injured on Lancashire roads
- The number of incidents of domestic violence involving children has reduced
- Good feedback was received around the Neglect conference
- Where signs have been installed on the 20's project and there is still a speeding issue, a number of systems have been put in place, these include smiley faces, banners for school gates and school road watch where those caught speeding have been asked to attend a Q & A session with the schoolchildren
- A flowchart around protocols for children missing from care, missing from home and missing education was drawn up to look at any duplication across the services, this shows that there is good partnership working and minimal duplication and overlap

How has the work of the sub-group contributed to the LSCB's priorities in 2013/14

Informative presentation of the statistical data for Children Missing (previous concern of disparity between CSC and Police Data) The anomaly addressed and further work now planned to review arrangements for conducting "return home interviews" will be picked up by the LSCB Task and Finish Group. Work streams around domestic abuse or substance abuse links into the LSCB neglect strategy, which will be linked to the toxic trio as well as workforce development.

Key Successes and Achievements for 2012/13

- Development of the anti bullying strategy and charter
- Development of a multi-agency neglect strategy and successful conference

- 108 schools using the road safety products on Moodle
- Successful campaign on the 20's speed limit across Lancashire
- Reduction in the number of children and young people being seriously injured in road traffic collisions
- Implementation of a Pan Lancashire procedure for children/young people who display sexually harmful behaviour
- Missing from home strategy finalised
- The initial feedback from the YOT inspection around young people who sexually offend showed a strong and overarching strategy and good communication between services alongside excellent multi-agency working

Update from Local Safeguarding Children Sub-Groups (LSCGs)

The LSCB has 3 Local Safeguarding Children Sub-groups which cover the following districts of Lancashire

- Lancaster, Fylde and Wyre
- East Lancashire (Hyndburn, Rossendale, Burnley, Pendle and Ribble Valley)
- Central & South Lancashire (Preston, Chorley, West Lancashire and South Ribble)

The LSCGs discharge LSCB functions at a local level and advise the LSCB of local issues and developments to ensure the LSCB reflects the diversity of need across the whole of Lancashire.

East Chair: Paul Armitage
Central Chair: Jean Rollinson
LFW Chair: Paul Hegarty

Summary of Key Functions

a. Develop a work programme to ensure effective delivery of specified Strategic Objectives in LSCB annual plan
b. Build and sustain local partnerships within LSCGs to ensure the effective delivery of that programme
c. Report as required to LSCB, on progress on all aspects of the LSCG work programme, identifying any risks or barriers which may impact on the achievement of identified objectives
d. Assist and contribute to the production of the LSCB annual report on the effectiveness of safeguarding in Lancashire by giving a local perspective on operational issues and emerging themes.
e. Provide a named person to link with each of the District Trusts in their area and ensure regular reporting and discussion around safeguarding issues
f. Participate in discussions around the local planning and commissioning of children's services to ensure that they take safeguarding and promoting the welfare of children into account
g. Ensure that lessons emerging from any local or county case reviews are well disseminated and partner agencies are implementing actions plans effectively
h. Undertake local multi-agency audits and peer reviews of child protection processes to ensure practice is effective and improving outcomes for children
i. To scrutinise Performance Management and Quality Assurance data at a local level to identify good practice and areas for further development

Key Priorities for 2012/13

- Identify local consultation channels and mechanisms
- Develop and implement consultation plan at county and local level
- Review of thresholds re: Child Protection & Common Assessment Framework
- Review the understanding of thresholds across agencies
- Review the implementation of thresholds across agencies
- Reporting arrangements between LSCGs and DCTs are agreed and implemented
- LSCGs to create a local communications strategy to include:
    - Serious Case Review Learning
    - CDOP Case Reviews and learning
    - Improve and update Website
    - Scope new communication mechanisms / social networking

    - Publicising LSCB and Safeguarding
    - Specific Campaigns
    - Engaging with diverse communities
    - Ensure themes inform single and multi-agency planning
- Improve governance and function of LSCGS
- Assurance that local arrangement for private fostering are effective
- Develop methods of learning from best practice

How do these reflect learning and developments from the previous year?
LSCGs were re-launched in the previous year to bring activity into line with the new strategy and business planning framework. Learning and activity was collated into the production of the new business plan and a more focused SMART work programme developed for this year with priorities informing and being informed by the LSCB Business Plan.

Were these priorities Effectively Achieved
A review of the work programmes for each sub-group has provided evidence that each LSCG has largely achieved most of the priorities specified. There has been some local variation in how these have been implemented, especially around learning from best practice, which continues to be developed in 2013/14. The Local Authority has provided a wealth of locally reflective performance information and data which has informed a number of discussions and provided assurance around the application of thresholds and CP processes.

How has the work of the sub-groups contributed to the LSCB's priorities in 2013/14
As stated above the sub-groups report bi-monthly to the LSCB on progress with their work programmes which are reviewed annually in line with the business planning cycle to inform priorities for the next year.

Key Successes and Achievements for 2012/13
- Completion of local audit in relation to private fostering
- Completion of local audit of CP referrals (Central Lancashire)
- CDOP annual report presented and discussed at all LSCGs
- Case reviews considered at a local level and learning disseminated
- Best practice panels successfully established at North and East LSCGs
- Membership refreshed
- Regular updates and assurance provided from CART Manager re thresholds and referral process

Engagement with and participation of children and young people

The LSCB identified participation and engagement with young people as a priority for 2012/13 and has now established effective links with the local Children and Young People's Participation Officer who meets regularly with the LSCB Coordinator to identify where the LSCB can be involved in planned activity and vice versa. The LSCB has involved young people in a number of initiatives throughout 2012/13 as follows:

Engagement in national 'take over day' via Lancaster Young Advisors - a young person co-chaired the LSCB meeting which proved a rewarding and useful experience and challenged LSCB members to ensure dialogue is meaningful and accessible to young people.

Inclusion of 2 young people, via Chorley Youth Council, on the 'Cover it Live' panel which was established by the eSafety sub-group to answer live questions (via Twitter) regarding cyber-bullying and acceptable behaviour on line.

Commissioning Lancaster Young Advisors to complete a research project and produce a suite of resources for gaining the views of primary school age children with regard to safeguarding issues. This work is currently ongoing and a full report will be available for the next annual report.

Involvement of a group of young people in the Neglect Managers Conference to raise awareness of the impact on children and young people. This presentation was particularly well received by participants.

Completed a survey involving over 100 young people through district youth councils to ascertain their views on safeguarding and what they feel LSCB priorities should be. The results of this informed the review of the LSCB strategy and were shared with locality groups so locally specific issues could be addressed – for example the district councils in East Lancashire noted the number of young people who did not feel safe in parks or leisure centres and this will inform future service planning and development. The report can be viewed at the following link: http://www.lancashire.gov.uk/corporate/web/view.asp?siteid=3829&pageid=31195&e=e

Equality and diversity

The LSCB and it members recognise that Lancashire is a large and diverse county with huge local variation in need and the composition of local populations. The LSCB has a lay-member who also provides a BME perspective to the business of the Board and all members are required to comply with equality requirements as laid out in statutory guidance and legislation.

Recognition of the diverse needs of different groups of children is central to all areas of LSCB business. Every effort is made to ensure the views of all groups are gathered to inform service developments and business planning.

Priority groups of children

The following groups of children are recognised by the LSCB as potentially experiencing greater vulnerability:

- Children in Custody
- Children who are privately fostered
- Children experiencing neglect (see QA sub-group update)
- Children who are sexually exploited (see QA sub-group update)
- Children with disabilities
- Children Looked After, particularly those moving out of or into Lancashire

The LSCB receives an annual report from the County Youth Justice manager to be assured that young people in custody are being effectively safeguarded. This report was considered and accepted by the LSCB in May 2012. The report assured the LSCB that 100% of YOT assessments were completed within timescales for young people prior to detention, during and post release. The LSCB was also assured that effective arrangements were in place to identify and respond to any safeguarding issues within the secure estate.

The LSCB also receives an annual report from the Local Authority on privately fostered children. This was received in July 2012 and accepted by the LSCB. The following key points were noted:

- All cases related to social care issues
- Publicity activity continues to raise awareness effectively
- There has been an increase in notifications
- All statutory visits have taken place in line with national standards
- There were no disqualifications or significant concerns with regard to carers suitability

With regard to children with disabilities (CWD), a report from the local authority CWD Service Manager was presented to the LSCB in January 2013 which concluded that that arrangements for safeguarding Children with Disabilities are robust and effective which was supported through key findings from the recent Ofsted inspection. It was agreed an audit of cases should be carried out in relation to the current practice guidance recommendations which is progressing through the QA Sub-group due for completion in 2013/14.

In addition to these priority groups the LSCB receives an annual report from the Local Authority Designated Officer (LADO) with regard to the management of allegations against people working with children and young people. The report was presented to the LSCB in November 2012 and the following key points noted:

- More initial considerations and requests from the Police were impacting on capacity
- Health referrals are very low – the LADO is looking into this to establish why
- Little change in referrals from other agencies

Overall it was felt the service is effective and robust and there were no concerns expressed.

LSCB effectiveness, contribution and challenge

The LSCB determines its own effectiveness largely through the business planning cycle referred to above. The business plan is developed and monitored by the LSCB Management Team and presented to each LSCB Executive and Board meeting for scrutiny and challenge and to agree any corrective action where tasks or activities are not progressing as planned. The LSCB business plan showing the end of year position for 2012/13 can be viewed at appendix 4.

In addition the LSCB also has a basket of performance indicators which are monitored by the LSCB through a quarterly performance report. The indicators which relate to the effectiveness of the LSCB, with the year end returns, are as follow:

Indicator	EoY 2011/12	Q1 Actual	Q2 Actual	Q3 Actual	Q4 Actual	Target	Direction of Travel (at Q4)
Number of cases reviewed by CDOP	Not Available	30	33	31	30	26	Worse
SCRs referrals considered within timescale	100%	100%	100%	100%	100%	100%	Same
Attendance at LSCB Meetings	73%	80%	75%	68%	79%	80%	Improved
Percentage of Business Plan Actions completed within timescales	90%	90%	80%	90%	90%	90%	Improved

The LSCB also has in place, a risk management framework and risk register which is reviewed twice a year to ensure the appropriate controls are in place to mitigate against key risks to the delivery of LSCB business and the effectiveness of the partnership. There are currently no risks that are felt to be 'high' given the controls in place at present. The full register can be viewed at appendix 5.

All LSCB members are required to sign a 'Compact' setting out their responsibilities as a Board member and highlighting the expectation that LSCB work should take priority over single agency responsibilities when acting on Board business. All members are provided with an induction pack containing all necessary information.

LSCB Attendance

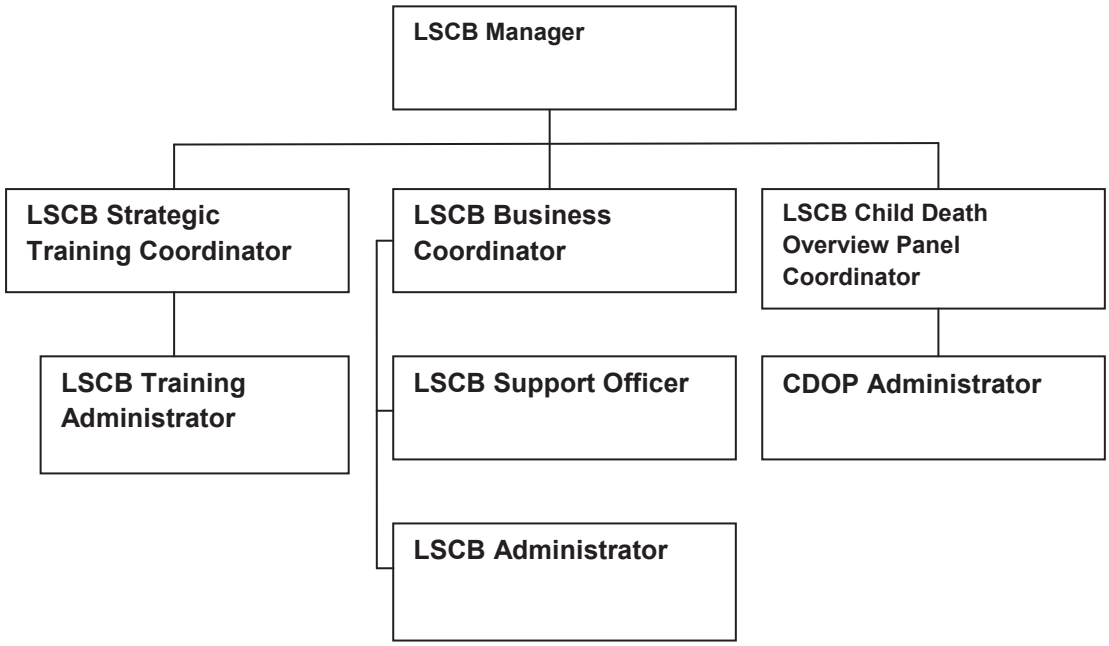
Attendance by agency for all Board meetings in 2012/13 is shown below

Agency	% Attended	No Attended	No Invited
East Lancashire LSCG Chair	100	6	6
LCC (Adult SB)	67	4	6
North Lancashire PCT (Chair QA)	83	5	6
East Lancashire PCT	67	4	6
LCC (member)	83	5	6
LCC (DCS)	83	5	6
Designated Doctor	33	2	6
Probation	83	5	6
Police	83	5	6

Central Lancashire PCT (Vice Chair & LSCG Chair)	100	6	6
Preston City Council	67	4	6
LCC (Director of Specialist Services)	67	4	6
Independent Chair	100	6	6
LCFT NHS	67	4	6
VCFS	67	4	6
VCFS	100	6	6
North Lancashire LSCG Chair	83	5	6
Cafcass	83	5	6
LTHT NHS	83	5	6
LCC (SCR Group Chair)	83	5	6
Schools Rep	33	2	6
Lay Member	50	3	6
OVERALL	**79**		

LSCB Management Team

The LSCB Management Team coordinates and drives forward the work of the LSCB and is currently structured as follows:



All posts are hosted by the local authority and individual performance appraisal is in line with the Local Authority procedure. Individual performance plans are in place for all members of the team which are based on the business plan of the LSCB and monitored on a monthly basis through formal supervision.

An independent review of the team has taken place in 2011/12 in order to identify any efficiency savings or improved ways of working. The recommendations of this review are currently being finalised and further capacity for the team in light of the new guidance is being considered, especially around the Case Review function. Any changes from this will be reported in next year's Annual Report.

LSCB Budget

The LSCB is funded from a pooled partnership budget which is monitored via a bi-monthly report to the LSCB and Executive Group. Accountancy assistance is provided through the Local Authority finance team and expenditure is administered through the Local Authority electronic financial management system (Oracle). A scheme of delegation is also in place which determines the level of expenditure that can be authorised at different levels of seniority. The LSCBs statement of account for end of year 2012/13 is as follows:

INCOME	Actual £
Contributions to Board	
Central Lancs PCT	37,835
East Lancs PCT	37,835
North Lancs PCT	37,835
Police	43,938
Probation Service	13,488
CAFCAS	550
LCC - CYP Directorate Funding	112,000
LCC - CYP Directorate Funding	-3,181
	280,300
Child Death Overview Panel	
Lancashire Safeguarding Children Board	55,000
Blackpool	11,500
Blackburn with Darwen	11,500
Miscellaneous Income	265
Funding from Reserves	29,596
	107,861
Serious Case Review	
Funding from LCC CDOP	20,000
Funding from LCC	51,000
Funding from Main Contributions	3,181
Funding from Reserves	36,319
	110,500
Other income	**12,332**
TOTAL LSCB INCOME	**510,993**
EXPENDITURE	**£**
LSCB General	**143,129**
Child Death Overview	**87,248**
Serious Case Review	**34,807**
Training	**134,520**
TOTAL LSCB EXPENDITURE	**399,704**
Carry Forward to 2013/14	**(111,289)**

Safeguarding and Looked After Children Inspection

During 2011/12 Lancashire was inspected by Ofsted under the framework for Safeguarding and Looked After Children. Within the inspection the role and effectiveness of the LSCB was assessed as follows:

"The performance of the LSCB is good. The independent chair provides good leadership and partners effectively support the board. Partner agencies are challenged and held to account and performance is closely monitored."

In addition to the effectiveness of the LSCB a number of recommendations for improvement were made for partner agencies and an action plan developed. The high priority actions which the LSCB maintained a close scrutiny over (see business plan at appendix 4) are as follow:

a. LSCB is assured that gaps in Designated Health roles are effectively addressed
b. LSCB is assured that CAMHS resources for ADHD, ASD and 16-18yr olds are adequate
c. LSCB is assured that substance misuse services are accessible and effectively commissioned
d. LSCB is assured that safeguarding arrangements across out of hours, walk-in and accident and emergency health services across Lancashire to ensure children are effectively safeguarded

The inspection also highlighted a number of concerns about the effectiveness of safeguarding arrangements at University Hospitals Morecambe Bay NHS Trust. In response to this a multi-agency 'expert panel' was convened, involving a number of LSCB members, and an action plan developed. The LSCB maintained a regular dialogue with the panel through its members and was provided with regular progress reports with implementation of the action plans which is continuing into 2013/14. At the end of year it was felt all improvement plans were established and corrective action progressing. The LSCB will continue to maintain oversight of this action plan both directly and through the North Lancashire Local Safeguarding sub-group.

Issues and challenges facing safeguarding – statement of effectiveness of safeguarding arrangements in local area

The LSCB has faced additional challenges in 2012/13 due to a number of significant external factors and developments as follows:

- Emerging revision of statutory Guidance (Working Together 2013)
- The Munro Review of Child Protection
- High profile media interest in local Child Sexual Exploitation cases
- Reconfiguration of the Health Economy
- Ofsted inspection of Safeguarding and Looked After Children
- Organisational restructuring in response to austerity measures

The LSCB's robust business planning cycle has enabled the LSCB to regularly review its business plan and priorities in response to these emerging and issues and developments, as can be evidenced at appendix 4. In summary the LSCB has responded to these effectively through the following actions and initiatives:

- Consideration of the draft Working Together guidance and collation of a comprehensive LSCB response to the consultation
- Piloting the systems methodology for the completion of SCRs using the SCIE model on a live case (See Case review Sub-group Update)
- Recognising Child Sexual Exploitation as a priority area for quality assurance and receiving regular reports from the Constabulary and Child Sexual Exploitation sub-group re operational and strategic activity
- Requesting regular updates from key health personnel with regard to ongoing reconfiguration of health services
- Inviting all CCG leads to a special extended LSCB to agree how safeguarding will be embedded across the 6 CCGs and how they will be represented through the LSCB and its sub-groups
- Providing all necessary support, information and engagement for the SLAC inspection and taking an active role in implementing and overseeing subsequent improvements

- Requesting all organisations to provide assurance that service re-structuring will not compromise the safeguarding of children and young people

Most of these issues and developments are ongoing into the next financial year and can be clearly evidenced through the 2013/14 business plan and subsequent sub-group work programmes.

Conclusion and recommendations for future priorities and Business Plan

2012/13 has been an extremely challenging year for the LSCB. The pace of organisational change as a result of continuing national and local governmental austerity measures and wholesale revisions to national guidance has required careful planning and horizon scanning to enable the LSCB to meet these challenges head on. In addition to this, the area inspection by Ofsted of Safeguarding and Looked After Children services, while recognising much good and excellent practice has also raised a number of issues and gaps in services resulting in substantial national media interest around issues at University Hospital Morecambe Bay Hospital Trust. There has also been significant challenges in responding to the threat of Child Sexual Exploitation, which has also been widely reported in the media and Lancashire has now been recognised as a beacon of excellent practice for its response.

The LSCB has taken an active role in addressing and overseeing many of these improvements and recognising the wealth of good practice and innovative developments. The robust business planning cycle will ensure key issues and areas for further development are continued into next year's business plan. A brief summary of these are as follows :

- Implementing Working Together 2013
- Relationships with the new:
    - Health Economy & CCGs
    - Health & Well Being Board
    - Police and Crime Commissioner
- Revised Case Review Methodology (systems model)
- Quality Assurance around the 'Toxic Trio'
- Implementing the new Learning and Improvement Framework
- Revision of LSCB Performance Information
- Responding to increased risks from the use of Social Media and online behaviour
- Continued evaluation of practice through Audits/Mock Inspection
- Continued activity to support the victims of Child Sexual Exploitation and bring offenders to justice

Appendices

Appendix 1: Learning and Development Plan

LSCB Business Plan Objective	LSCB Business Plan Task	Actions Sub-group will take to deliver this:	Lead Person/Agency	Completion Date	Progress since last meeting
3e. A Multi-agency training programme is in place which meets the identified priorities of the LSCB.	- Conduct Gap / Fit analysis to ensure training programme meets LSCB priorities	Liaise with LSCB and all LSCB sub-groups to ascertain training needs Consult within own agency to ascertain training needs	Training sub members	September 2012	completed
		To establish, via employing organisations, who in the workforce requires multi-agency training to safeguard children	Training sub-group members	Ongoing	Review done
		Plan the training programme to meet the needs, within the resources given	Training sub group	September 2012	completed
		To have the training programme agreed by LSCB to ensure it meets LSCB priorities	Jane Carwardine & LSCB	January 2012	completed
		Work towards the inclusion of all agencies (statutory, voluntary & independent) in LSCB training programme	Training sub-group, Ane Freed-Kernis	Ongoing	Places to Vol. Orgs. On each event
	- Provide regular progress reports to Executive	Provide a report to each Executive meeting	Jane Carwardine & Ane Freed-Kernis	Ongoing	completed
3f. Single agency training being delivered across the county can be evidenced as complying with Working Together	- Develop and implement programme of audit	To ensure standards are set for single agency basic training/learning and evaluate and review single agency provision	Training sub		Standards set. S.11 used to QA
		To plan and execute a programme of quality assurance of single agency training	Ane Freed-Kernis	Ongoing	s.11
	Provide regular progress reports to Executive	To provide half-yearly reports	Jane Carwardine	Ongoing	Done
		Providing limited children's safeguarding training consultancy service	Ane Freed-Kernis	Ongoing	58 requests done
6c. LSCB member's can effectively	Identify suitable training for	Questionnaire designed for LSCB members regarding	Ane Freed-Kernis	November 2011	Done

LSCB Business Plan Objective	LSCB Business Plan Task	Actions Sub-group will take to deliver this:	Lead Person/Agency	Completion Date	Progress since last meeting
challenge each other.	members with regard to challenge	their needs/wishes for training			
		Questionnaire distributed and returned for analysis	LSCB members	February 2012	Done
		Suitable facilitator identified and date booked	Nigel Burke/Ane Freed-Kernis	April 2012	Not needed, LSCB
Ensure training sub-group is will informed about practice issues in the LSCB	To maintain links with Quality Assurance subgroup, child death overview panel and serious case review panel	Have overlapping members of all the sub-groups	Training sub-group	Ongoing	Done
To ensure membership of training sub group is in accordance with LSCB guidance	Update terms of reference for training sub-group	Have terms of reference agreed by LSCB annually	Jane Carwardine	April 2012	Done
To commission the design, planning, organisation and implementation of the training/learning programme via the LSCB strategic training co-ordinator, based on inter-agency priorities and learning from SCRs and reviews of child deaths.	Run a core training programme of approximately 75 events covering at least 20 topics, potentially adding further events required by the LSCB	Create a training plan for the year Manage the plan responding to feedback from LSCB should priorities change	Ane Freed-Kernis And Freed-Kernis	October 2011 March 2013	Done. 77 events were planned. 56 ran, 21 were cancelled
	To recruit, support, develop and monitor the training pool.	Request trainers from individual agencies Devise and run a development programme for the training pool development	Training sub-group, Ane Freed-Kernis	Ongoing	Done
	Ensure the programme that is run reflects national and local policy and research	Keep abreast of national research Develop the training pool members Use experts to keep us updated	Ane Freed-Kernis, training pool members, Training sub-group	Ongoing	Done
To implement quality assurance measures across	Monitor and evaluate the quality and	Training sub-group members to observe a LSCB course each year	Training sub-group members	Ongoing	Method changed, will

LSCB Business Plan Objective	LSCB Business Plan Task	Actions Sub-group will take to deliver this:	Lead Person/Agency	Completion Date	Progress since last meeting
the learning programme	effectiveness of the LSCB learning programme				happen in 2013-14
To support the LSCB by providing up to date information in relation to the learning programme	Maintaining records of all delegates and trainers on courses, for statistical use	Maintain and update training database to keep this information and provide statistical information to the LSCB and others on request	Louise Wilson	Ongoing	done

Appendix 2

LSCB Section 11 Audit Tool 2012

Section 11 of the Children Act 2004 places a duty on key people and bodies to make arrangements to ensure that their functions are discharged with regard to the need to safeguard and promote the welfare of children. The application of this duty will vary according to the nature of each agency and its functions.

Agency	Name & Designation of Person Completing (include email address)	Date Completed

1 - LEADERSHIP

Senior managers will need to demonstrate leadership, be informed about, and take responsibility for the actions of their staff who are providing services to children and their families.

Minimum Requirements

- Designated Senior Officer for Safeguarding in place and visible
- Senior Managers can evidence effective monitoring of service delivery

Evidence Statement: *(max 200 words, please attach / embed appropriate policies or documents)*	**Quality Assurance** (office use only) Red – Not Compliant Amber – Partially Compliant Green – Fully Compliant **Comments**

2 – COMMITMENT

The agency's responsibilities towards children is clearly stated in policies and procedures that are available for all staff.

Minimum Requirements

- Statement of responsibilities (as per section 11 guidance) is visible in policies & guidance
- This is accessible and understood by all staff

Evidence Statement: *(max 200 words, please attach / embed appropriate policies or documents)*	**Quality Assurance** (office use only) Red – Not Compliant Amber – Partially Compliant Green – Fully Compliant **Comments**

3 – ACCOUNTABILITY & GOVERNANCE

It should be clear who has overall responsibility for the agency's contribution to safeguarding and promoting the welfare of children and what the lines of accountability are from each staff member up through the organisation to the person with ultimate accountability for children's welfare.

Minimum Requirements

- All staff know who to report concerns about a child to
- Staff at all levels know and understand their responsibilities

Evidence Statement: *(max 200 words, please attach / embed appropriate policies or documents)*	**Quality Assurance** (office use only) Red – Not Compliant Amber – Partially Compliant Green – Fully Compliant **Comments**

4 – SERVICE DEVELOPMENT/REVIEW

In developing local services, those responsible should consider how the delivery of these services will take account of the need to safeguard and promote the welfare of children.

Minimum Requirements

- The views of children and families are sought and acted upon when developing services
- The need to safeguard children has informed decision making about any developments

Evidence Statement *(max 200 words, please attach / embed appropriate policies or documents)*	**Quality Assurance** (office use only) Red – Not Compliant Amber – Partially Compliant Green – Fully Compliant

	Comments

5 - TRAINING

Staff should have an understanding of both their role and responsibilities, and those of other professionals and organisations.

Minimum Requirements

- All staff have received level 1 safeguarding training
- All appropriate staff have received level 2 and above single agency training (include %)
- All appropriate staff have received level 2 and above multi agency training (include %)

Evidence Statement: *(max 200 words, please attach / embed appropriate policies or documents)*	**Quality Assurance** (office use only) **Red – Not Compliant** **Amber – Partially Compliant** **Green – Fully Compliant** **Comments**

6 – SUPERVISION

Safeguarding Supervision should be effective and available to all

Minimum Requirements

- Supervision Policy in place and meets LSCB guidance standards
- All staff working with children receive appropriate regular supervision

Evidence Statement: *(max 200 words, please attach / embed appropriate policies or documents)*	**Quality Assurance** (office use only) **Red – Not Compliant** **Amber – Partially Compliant** **Green – Fully Compliant** **Comments**

7 – SAFE RECRUITMENT

Robust recruitment and vetting procedures should be put in place to prevent unsuitable people from working with children.

Minimum Requirements

- All recruitment staff are appropriately trained in safe recruitment
- All appropriate staff receive a CRB check that is regularly updated
- Legal requirements are understood and in place
- Role of LADO understood and procedures in place
- All staff know who the Named Senior Officer for their agency is

Evidence Statement: *(max 200 words, please attach / embed appropriate policies or documents)*	**Quality Assurance** (office use only) Red – Not Compliant Amber – Partially Compliant Green – Fully Compliant **Comments**

8 – INTERAGENCY WORKING

Agencies and staff work together to safeguard and promote the welfare of children.

Minimum Requirements

- Evidence of leadership to enable joint working
- Evidence of practitioners working together effectively
- Evidence that CAF is being used appropriately and effectively

Evidence Statement: *(max 200 words, please attach / embed appropriate policies or documents)*	**Quality Assurance** (office use only) Red – Not Compliant Amber – Partially Compliant Green – Fully Compliant **Comments**

9 - INFORMATION SHARING

Effective information sharing by professionals is central to safeguarding and promoting the welfare of children.

Minimum Requirements

- Evidence of robust single agency protocols and agreements*
- Evidence of robust multi agency protocols and agreements*

- Evidence that practitioners understand their responsibilities and when to share information

*** The lack of an information sharing agreement between agencies should never be a reason for not sharing information that could help a practitioner deliver services to a child.**

Evidence Statement: *(max 200 words, please attach / embed appropriate policies or documents)*	**Quality Assurance** (office use only) Red – Not Compliant Amber – Partially Compliant Green – Fully Compliant **Comments**

Appendix 3

CDOP Work Plan

Priority	Status (RAG rating)	Comments
1. The Panel will review cases and make recommendations regarding themes to the Board		The Panel has an ongoing responsibility to review cases and make recommendations as appropriate; the CDOP reports to the Boards bimonthly, quarterly (with statistics) and annually.
2. CDOP will develop links with other Local Safeguarding Children Board Sub-Groups particularly the Safe from Harm Group		The CDOP Coordinator sits on the pan-Lancashire Infant Mortality Group, has presented the Annual Report and Suicide Thematic Report to the Safe from Harm Group, the annual report has also been shared with the CYPT Chairs Meeting, the LSCB locality groups and the JSNA manager.
3. With Public Health department investigate apparent mis-match in numbers of deaths between CDOP and ONS data.		Mismatch of data identified inherent problems with the comparison of the two datasets because they work on different parameters – gestation viability, pending inquest/ criminal investigation.
3b. Further detailed review work to identify themes / trends in deaths categorised as caused by perinatal / neonatal events.		The initial findings have been presented to CDOP the final report is awaited.
4. The Panel will monitor the re-launch of the Give Me room to Breathe (GMRTB) Campaign		The SUDI Prevention Group have updated and re-launched the Campaign; the Boards have approved funding for the second/ third phase of the Campaign.
5. CDOP will ensure the Safer Sleeping Guidance is reviewed		The Guidance was approved by the Board in March 2013 and is being widely disseminated to all frontline professionals.
6. Ensure and monitor the review of the SUDC Protocol		The review of the Protocol was delayed pending the release of the new statutory guidance. This is a priority for 2013/14.
7. Finalise the multi-agency e-learning and make available to front line multi-agency professionals		The e-learning has been re-written to be more user friendly; this remains a priority for 2013/14.
8. Develop a Pan-Lancashire communications strategy for disseminating messages and information on a multi-agency basis		The CDOP developed a task and finish group to look at this; however, it was decided a specific sub-group/ strategy was not required and the CDOP would develop an 'events calendar' to enable CDOP to recommend to the Boards time press releases.
9. Monitor Multi-Board CDOP Budget and develop action plan for utilising the under spend. (suggested ideas: CDOP database, Give Me Room To Breathe Campaign, commissioning a piece of research into Neonatal/ Perinatal deaths and/ or deaths due to genetic, chromosomal and congenital abnormalities)		The Boards approved funding for the safer Sleep campaign. The CDOP still has a budget for 2013/14 which has some under spend from 2012/13 but the under spend from 2011/12 has been utilised. The CDOP now monitor their budget at each bi-monthly Business Meeting.

10. Update the data recording/ analysis systems to improve reporting on specific modifiable factors identified by the Panel		The current reporting spreadsheet has been updated to enable some reporting on modifiable factors while a CDOP database is scoped out.

Appendix 4

LSCB Business Plan 2012/13

Objective *(what do we want to achieve)*	***Tasks to be completed*** *(to achieve the objective)*	***Lead Person/Group***	***Completion Date***	***Update to LSCB March 2013***
Strategic Priority 1. *We will improve the way we work by listening to and responding to the views and experiences of children and young people*				
a. All existing channels and forums for consulting with children and young people have been identified	- Identify countywide consultation channels and mechanisms - Identify local consultation channels and mechanisms	LSCB Business Team LSCGs	October 2012 October 2012	Completed. Discussed at LSCGs and identified where appropriate
b. Key business priorities incorporate the views of children and young people	- Develop and implement consultation plan at county and local level - Facilitate safeguarding events (x2) with Youth Councils and/or existing groups (11 – 18 year olds. Possibly use North West regional group)	LSCB Business Team LSCB Business Team	December 2012 December 2012	Completed To be considered as part of YP involvement plan 2013-14
c. All agencies can evidence that they consult with children and young people as appropriate	Continued section 11 activity to confirm agency engagement with young people	QA Group	March 2013	Completed. New audit tool now gone out including this criteria.

Objective *(what do we want to achieve)*	***Tasks to be completed*** *(to achieve the objective)*	***Lead Person/Group***	***Completion Date***	***Update to LSCB March 2013***
Strategic Priority 2. *We will make sure that services work well together, taking and sharing responsibility, to keep children and young people safe*				
a. The LSCB is assured that the application of thresholds is safeguarding children	- Monitoring Common Assessment Framework (CAF) performance – data and links to outcomes - Monitoring system for implementation of thresholds to be developed - LSCB assured current proposals are fit for purpose - Develop reporting mechanism to monitor the effectiveness of the Common Assessment Framework and Early Support - Establish involvement of LSCB in development of Multi Agency Safeguarding Hub (MASH) - Development of a local assessment framework in line with National Guidance	QA Group QA Group QA Group QA Group Executive Group Pan Lancs Group	October 2012 December 2012 January 2013 March 2013 March 2013	Completed Report to Feb Exec re CAF and CoN As above Ongoing Progressing – to continue next year.
b. Effective arrangements are in place to monitor, evaluate and influence the work of the Children's Trust, Health and Wellbeing Board (HWB) and the Police Commissioner	- Reporting arrangements between LSCGs and District Children and Young People's Trusts (CYPT) are agreed and implemented - Effective links are established between HWBs and Police and Crime Commissioner - LSCB has established a role / process to	LSCGs chairs meeting Executive Group	October 2012	Chairs have met DCT chairs, awaiting outcome of this Completed

Objective *(what do we want to achieve)*	***Tasks to be completed*** *(to achieve the objective)*	***Lead Person/Group***	***Completion Date***	***Update to LSCB March 2013***
	influence/monitor commissioning - Annual report to CYPT Partnership Board, Lancashire County Council (LCC) Chief Executive and Leader	Executive Group LSCB	March 2013 October 2012 July 2012	KG attending commissioning groups Completed
c. Effective strategies are in place regarding the issues of: - Bullying - Domestic Abuse - Neglect - Child Sexual Exploitation/missing persons - E safety - Child and Adolescent Mental Health - Rape	- Review current provision regarding these issues and conduct gap analysis - Commission development of any new strategy and ensure monitoring arrangements are in place - Hold a conference on neglect to raise awareness of recognition and how to deal with it - Rape group to report into LSCB regarding development of strategies and work	Specific sub groups Specific sub groups Business Team Strategic Rape group	October 2012 December 2012 July 2012 October 2012	Ongoing activity. Ongoing Completed Completed

Objective *(what do we want to achieve)*	***Tasks to be completed*** *(to achieve the objective)*	***Lead Person/Group***	***Completion Date***	***Update to LSCB March 2013***
d. LSCB is assured that the refreshed continuum of need is widely understood by practitioners and families and is working well. The LSCB is also assured that the approach to working together with families is making a difference	- Work with CYPT to progress implementation of new continuum of need and the approach to working together with families. - Attend and participate in all workshops with CYPT regarding these issues - Complete any actions for the LSCB from these workshops	LSCB LSCB LSCB Business Team and LSCB	September 2012 As and when required As and when required	Work progressing through strategic group, regular updates to Exec.
e. LSCB is assured that multi-agency assessments are effective and robust	Quality Assurance framework to be progressed, to ensure findings from audits are acted upon	QA Group	March 2013	Planned
f. The LSCB is assured that arrangements for the safeguarding of privately fostered children are effective	- Annual Report to be presented by LCC - Audit findings to be presented to LSCB and necessary actions undertaken	Paul Armitage/LSCGs Paul Armitage	July 2012 July 2012	Completed Completed
g. Develop effective relationships with the 'new' Health Economy	- Establish connectivity to Clinical Commissioning Groups and Health and Well Being Board - Re-establish Health sub-group	Executive Group Health leads	March 2013 October 2012	Completed, Ongoing

Objective *(what do we want to achieve)*	***Tasks to be completed*** *(to achieve the objective)*	***Lead Person/Group***	***Completion Date***	***Update to LSCB March 2013***
h. LSCB to receive assurance that issues identified through Safeguarding and Looked After Children Inspection are being/have been addressed effectively	- Full action plan in place which will be monitored by 'continuous improvement' multi-agency group - LSCB will monitor progress of action plan via QA group	QA Group QA Group and LSCB	July 2012 Ongoing	Regular update reports now being provided.
i. LSCB is assured that all single agency areas for improvement identified through Safeguarding and Looked After Children Inspection have been addressed effectively	Multi-agency 'Continuous improvement group' to monitor progress of Inspection Action Plan Business Manager to keep the LSCB informed	Jane Higgs	Update to every Exec	Group continuing to meet and action plan update can be provided at the Exec if required.
j. LSCGs are well attended by all key local agencies and services and are effectively identifying local issues and needs	- LSCGs to report to LSCB what local needs and priorities are in line with Board priorities and act upon them through their action plans - Annual report on attendance from LSCGs	LSCGs LSCGs	October 2012 March 2013	Ongoing Attendance reported at every meeting
Strategic Priority 3. *We will make sure that the way we recruit, train and supervise those who work with children and young people will keep children and young people as safe as possible*				
a. Multi-agency supervision standards are in place	Develop multi-agency safeguarding supervision standards	LSCB Business Team	October 2012	Completed
b. Effective supervision policies are implemented across all agencies and compliance evidenced	Seek assurance from agencies on concerns identified in 2010 section 11 audit in relation to	QA Sub-group	March 2013	Completed

Objective *(what do we want to achieve)*	***Tasks to be completed*** *(to achieve the objective)*	***Lead Person/Group***	***Completion Date***	***Update to LSCB March 2013***
	this issue			
c. LADO role has been reviewed with regard to function and capacity	- Improve awareness of LADO, including regular newsletters and increased access to website - Review effectiveness of LADO role - LSCGs to assure all members know about LADO and LSCB	LADO LADO and Executive LSCG chairs	October 2012 March 2013 October 2013	Completed ?? Completed
d. Recruitment practices of LSCB agencies are demonstrably effective and robust	Seek assurance from agencies on concerns identified in 2010 section 11 audit in relation to this issue	QA Sub-group	March 2013	Completed
e. A Multi-agency training programme is in place which meets the identified priorities of the LSCB	- Implement revised programme - Commission specific programmes in response to Munro review using funding provided	Training Sub-group Training Sub-group	July 2012 October 2012	Completed Completed
f. Single agency training being delivered across the County can be evidenced as complying with Working Together	- Develop and implement programme of audit - Provide regular progress reports to Executive	Training Sub-group Training Sub-group	October 2012 Ongoing	Currently being developed. As and when required
g. LSCB Members have a suitable pack of induction material	Keep induction pack updated as required	LSCB Business Team	Ongoing	Completed

Objective *(what do we want to achieve)*	***Tasks to be completed*** *(to achieve the objective)*	***Lead Person/Group***	***Completion Date***	***Update to LSCB March 2013***
h. LSCB has a Learning and Improvement Framework	Develop Framework	LSCB Business Team	March 2012	Completed
Strategic Priority 4. *We will make sure that everybody who works with children and young people knows that keeping them safe is an important part of their job*				
a. LSCB Safeguarding policies and procedures are up to date and effective	- Existing pan-Lancashire group to continue to meet regularly and consider priorities - Set task and finish groups to develop specific procedures as and when required - Monitor Tri-X updates and improvements to procedures and ensure they are completed	Pan-Lancs & Cumbria procedures group Pan-Lancs & Cumbria procedures group Pan-Lancs & Cumbria procedures group	Ongoing Ongoing	Ongoing, new procedures being developed as and when required.
b. The LSCB is assured that all agencies are meeting their requirements under section 11	- Section 11 Audit has been completed by all member agencies, quality assured and key findings acted upon - Seek assurance from agencies that areas for improvement are progressing as planned - Revise S11 Tool to ensure effectiveness	QA Sub-group QA sub-group QA sub-group	March 2013 March 2013 October 2013	Progressing as planned Completed Completed
Strategic Priority 5. *We will assist children, young people, their families and communities to keep themselves safe and know how to get help*				
LSCB have an effective communications strategy	*To include:* - Serious Case Review Learning - CDOP Case Reviews and learning – especially around overlay	Specific sub-groups to manage specific	July 2012	

Objective *(what do we want to achieve)*	***Tasks to be completed*** *(to achieve the objective)*	***Lead Person/Group***	***Completion Date***	***Update to LSCB March 2013***
	- Improve and update Website - Scope new communication mechanisms (Social - Networking etc) - Publicising LSCB and Safeguarding - Specific Campaigns - Engaging with diverse communities - Rapid response to increase incidence of overlay	issues LSCB Business team to develop overarching communications strategy		Completed
Strategic Priority 6. *We will continue to make sure that people who work with children and young people are doing their jobs well, and will challenge them when they don't*				
a. The LSCB is robust in its challenges of agencies that are not safeguarding children in the way they should do	- LSCB member's can effectively challenge - Review responses to challenge questionnaire and develop action plan - Offer individual training sessions to individuals that want it	Training sub	October 2012	Training offered questionnaire completed
b. The LSCB be assured that all agencies are meeting the needs of children and young people across Lancashire, specifically with regards to neglect and Child Sexual Exploitation	- Embed Quality Assurance Framework and feedback to the LSCB - Deliver priorities as specified in Quality Assurance Framework for this year	QA Sub-group	March 2013	Largely completed, some activity to continue into next year.
c. The LSCB is assured that health agencies are meeting the needs of children and young people across Lancashire	Review of Health performance data : existing and provision of data as per example from Manchester LSCB (include acute trusts and safeguarding standards)	QA sub group	July 2012	Completed. End of year data to be requested as agreed.

Objective *(what do we want to achieve)*	***Tasks to be completed*** *(to achieve the objective)*	***Lead Person/Group***	***Completion Date***	***Update to LSCB March 2013***
d. LSCB is assured that gaps in Designated Health roles are effectively addressed [1]	Health action plan to be progressed and monitored by QA sub-group	QA sub group	October 2012	Expert Panel now in place and update reports provided.
e. LSCB is assured that CAMHS resources for ADHD, ASD and 16-18yr olds are adequate [1]	Health action plan to be progressed and monitored	QA sub group	October 2012	Progressing through inspection improvement group.
f. LSCB is assured that substance misuse services are accessible and effectively commissioned [1]	Health action plan to be progressed and monitored	QA sub group	Update to every Exec	Progressing through inspection improvement group.
g. LSCB is assured that safeguarding arrangements across out of hours, walk-in and accident and emergency health services across Lancashire to ensure children are effectively safeguarded [1]	Health action plan to be progressed and monitored	QA sub group	Update to every Exec	Progressing through inspection improvement group.

[1] Relates to Inspection findings

Objective *(what do we want to achieve)*	***Tasks to be completed*** *(to achieve the objective)*	***Lead Person/Group***	***Completion Date***	***Update to LSCB March 2013***
h. LSCB has a robust plan and is prepared for any future inspection	Plan and arrangements to be developed and scrutinised.	QA Sub-group	March 2013	Carried over to next year.
Strategic Priority 7. *We will make sure that we use our money and staff to give the best results for children and young people*				
a. LSCB Business Team is effective, efficient and provides value for money	Review of establishment to be completed through LCC Business Analysts	Executive Group	October 2012	Progressing but significant slippage.
b. LSCB has effective and efficient ways of working	- Budget management process to be further refined and improved - Review training function and all sub-groups for efficiency savings	Executive Group	October 2012	Completed Largely completed
c. Ensure closer joined up working with other LSCBs on cross cutting / Sub-regional issues	LSCB Business Teams and Chairs to develop cross boundary working when possible	Pan –Lancs and Cumbria Chairs group	Ongoing	Ongoing meetings and developments.
d. LSCB Membership has the right representation from all necessary agencies	Review membership to ensure the following are linked in:	Executive	March 2012	Discussed at Nov LSCB and felt to be

Objective *(what do we want to achieve)*	***Tasks to be completed*** *(to achieve the objective)*	***Lead Person/Group***	***Completion Date***	***Update to LSCB March 2013***
	- Faith Community - Armed Forces - Transport Police - Another lay-member?			adequate.
Strategic Priority 8. *We will make changes that come from research, serious case reviews and any national policy guidelines.*				
a. Serious Case Reviews and Critical Incident Reviews are undertaken where appropriate	- Consider referrals against criteria for Serious Case Reviews - Commission Serious Case Reviews as appropriate - Commission Critical Incident Reviews as appropriate - Complete Critical Incident Reviews and feedback learning to SCR Group and local agencies	SCR Group SCR Group SCR Group LSCGs	Ongoing	Systems in place and effective.
b. An effective system is in place for the monitoring of action plans and dissemination of learning from case reviews	- Maintain system to monitor action plans - Ensure messages from case reviews are widely disseminated within all agencies	SCR Group SCR Group	Ongoing	Systems in place and effective.
c. That good practice is recognised and disseminated	- Learning from best practice cases in the north and the east be shared and any learning is acted upon	LSCGs	Ongoing	Systems in place and effective.

Objective *(what do we want to achieve)*	***Tasks to be completed*** *(to achieve the objective)*	***Lead Person/Group***	***Completion Date***	***Update to LSCB March 2013***
d. LSCB members are up to date with developments in policy, guidance and research	- Ensure members are made aware of relevant information and developments - Plan development day for LSCB to examine new Working Together when available	LSCB Business Team	Ongoing	Systems in place and effective.
e. Themes from the review of Child deaths have been recognised and acted upon	- Review all child deaths in Lancashire - Themes from child deaths to be identified - Ensure themes inform single and multi-agency planning; especially overlay given recent 'spike' in numbers - Specific activities and projects commissioned in response to identified themes and issues	CDOP	Ongoing September 2012 December 2012 As and when required	Systems in place and effective.

Appendix 5

Risk Register

Theme 1 – Integrity & Reputational Risks

No	Description of Risk	Inherent Risk Rating	Current Controls	Residual Risk Rating	Further Controls Required	By When	By Whom	Retained Risk	Current Status	Review Date
1a	Inability to evidence improved outcomes for children and families	12	Performance Reports, QA framework, scrutiny of single agency inspections / evidence, Mock Inspections	8	None	NA	NA	8		September 2013
2a	Negative media exposure	9	Media planning around key issues and SCRs. Scrutiny of key reports and info. Communication with agency media liaison staff	6	None	NA	NA	6		September 2013
3a	Information security breaches.	8	Robust procedures and governance. Training and supervision.	6	None	NA	NA	6		September 2013
4a	Poor inspection judgement – of LSCB or key partner	9	Peer review feedback, business planning, intelligence gathering from other areas, links to inspection planning groups, assurance from partners	6	None	NA	NA	6		September 2013

Theme 2 – Risks to Partnership & Engagement

No	Description of Risk	Inherent Risk Rating	Current Controls	Residual Risk Rating	Further Controls Required	By When	By Whom	Retained Risk	Current Status	Review Date
1b	Insufficient contribution from partners - financial or in kind (Failure of duty to cooperate)	9	Review at regular intervals, operation of Compact, regular reports, accountability and governance arrangements,	6	None	NA	NA	6		September 2013
2b	Failure to effectively hold a partner agency to account who is failing	8	Publish attendance stats, quality assurance of sec 11, peer review, chair has a clear mandate, LSCB compact , calendar of peer reviews	6	None	NA	NA	6		September 2013
3b	Disengagement of key partners from the LSCB	8	Governance arrangements, secured commitment, LSCB Compact, shared priorities	3	None	NA	NA	3		September 2013
4b	Impact of Health reforms resulting in potential loss of focus and leadership around safeguarding	9	Regular updates from Health members, engagement with CCGs	6	?			6		September 2013

Theme 3 – Risks to Delivery of LSCB Business Objectives

No	Description of Risk	Inherent Risk Rating	Current Controls	Residual Risk Rating	Further Controls Required	By When	By Whom	Retained Risk	Current Status	Review Date
1c	Insufficient resources to deliver key business priorities.	12	Financial monitoring, review of team structure, Effective business planning	8	Establish long term capacity in LSCB Team	September 2013?	Exec	8		September 2013
2c	Changes in government policy impacting upon resources and priorities	12	Regular updates from members on policy issues, forward planning and horizon scanning	9	Response to finalised revised WT	September 2013?	Exec	9		September 2013
3c	Severe staff absence in	8	Formal absence	8	Contingency	September	LSCB	8	No	September

	management team – business continuity		management procedure.		planning for additional resources if required	2013	Manager		business continuity plan in place	2013
4c	Severe weather restricting business activity	**9**	Electronic information systems, forward planning	**6**	None	NA	NA	**6**		September 2013
5c	Legal challenge or substantial liability claim	**8**	Close links with legal team, scrutiny of key business.	**6**	None	NA	NA	**6**		September 2013
6c	Very high profile and complex SCR, or several required simultaneously	**8**	Close scrutiny of referrals, improved processes, additional staff resources to support SCRs	**6**	Establish long term capacity to support SCRs	September 2013	Exec	**6**		September 2013
7c	Competing Priorities from supporting LASB?	**9?**	Being developed – clear mandate for resource allocation / level of support	**?**				**?**		September 2013
8c	Failure to evidence effective monitoring of single agency training	**9**	Process being developed through L&D Group	**9**	Assurance from all key agencies that processes are in place	September 2013	L&D Sub Chair	**9**		September 2013

Pan-Lancashire Child Death Overview Panel
Annual Report
2012/13

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Introduction

At the start of the 2012/13 reporting year the Lancashire and Blackburn with Darwen Child Death Overview Panel (CDOP) merged with the Blackpool Panel to become a pan-Lancashire tripartite CDOP. The pan-Lancashire CDOP is a sub-group of the three Local Safeguarding Children Boards (LSCBs) with responsibility for reviewing the deaths of all children resident within the local area.

The deaths of all live-born children under 18 years (excluding infants live-born following planned, legal terminations of pregnancy) were reviewed by the panel in line with Working Together to Safeguard Children (2010). This report will provide information on trends and patterns in the deaths reviewed during this reporting year (2012-13) and also on all deaths reviewed since the panels began in April 2008. It will also provide assurance to the LSCBs that the CDOP is meeting its statutory obligations.

The first section of the report provides updates in relation to CDOP priorities 2012/13, successes during 2012/13, updates from the sub-groups of CDOP and outlines the 2013/14 priorities for CDOP and the rapid response service. The second section focuses on the deaths reviewed in 2012-13 including data on the timeliness of the reviews completed in the period. The third section analyses all deaths reviewed between April 2008 – March 2012 by year of death in an attempt to provide a more meaningful and useful approach to looking at the trend data. The fourth section analyses all deaths reviewed by the panel between April 2008 and March 2013 and reviews the causes of death, whether any modifiable factors were identified, and considers the broader context of the child death data such as demographic and population characteristics. The final section documents emerging themes, trends and recommendations to the respective Boards.

Changes in Statutory Guidance

March 2013 saw the publication of the revised statutory guidance *Working Together to Safeguard Children* (HM Government 2013). Although there are no significant changes in respect of the Child Death Overview Panel (CDOP) processes, as anticipated, the rapid response to unexpected deaths in childhood remains a paediatrician led model. The pan-Lancashire rapid response service has operated very effectively using a nurse-led model since its inception in September 2008; therefore, a priority for the CDOP for 2013/14 is to commission a review of the model to evaluate its effectiveness in delivering on the requirements detailed in *Working Together* (HM Government 2013).

Members and Attendance

During 2012/13 the panel had representation from Lancashire Constabulary, Children's Social Care the Local Safeguarding Children Boards, Community Health Services, Midwifery, Paediatrics, Education (Blackpool and Lancashire), Early Years (Blackburn with Darwen), Public Health, SUDC Service and Neonatology & Obstetrics (co-opted for review of early neonatal deaths).

In an attempt to ensure equal representation across the three areas a rota system has been utilised for case discussion meetings which aims to ensure:

1. All three areas are represented
2. All agencies are represented
3. It is equitable for all: number of meetings attended is based on number of child deaths per area

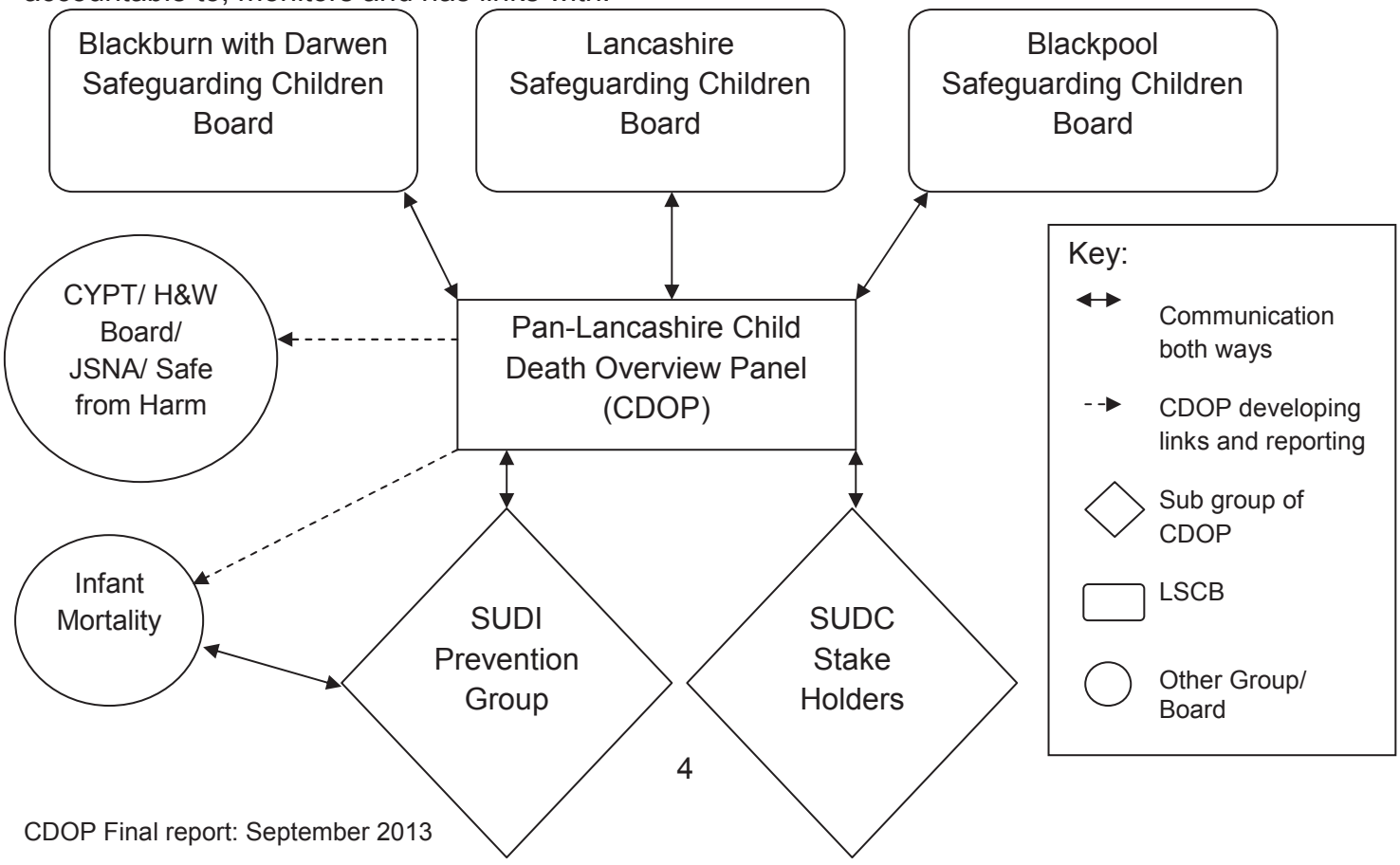
The table below documents the attendance by each agency/ area of expertise for business and case discussion meetings.

	Business Meetings			Case Discussion Meetings			
Agency	**Invited**	**Attended**	**% attendance**	**Agency**	**Invited**	**Attended**	**% attendance**
Chair	6	6	100	Chair	12	12	100
Lancashire Constabulary	6	5	83	Lancashire Constabulary	12	12	100
Children's Social Care	6	4	67	Children's Social Care	12	11	92
Public Health	6	3	50	Public Health	12	10	83
Midwifery	6	6	100	Midwifery	12	12	100
SUDC Service	6	6	100	SUDC Service	12	10	83
Paediatrics	6	3	50	Paediatrics	12	12	100
SUDI Prevention Chair	4	1	25	Neonatology & Obstetrics	5	3	60
SUDC Stake Holders Chair	6	5	83	Community Health Services	12	12	100
Community Health Services	6	3	50	Education	5	4	80
LSCBs	6	6	100	Early Years	2	1	50
Designated Nurses	6	5	83				

Table 1, annual attendance at Business and Case discussion meetings from April 2012 – March 2013

CDOP Structure

Below is the CDOP structure chart which shows which Boards and/or Groups CDOP is accountable to, monitors and has links with.



CDOP priorities for 2012/13

CDOP Priority	Status (RAG rating)	Comments
1. The Panel will review cases and make recommendations regarding themes to the Board		The Panel has an ongoing responsibility to review cases and make recommendations as appropriate; the CDOP reports to the Boards bimonthly, quarterly (with statistics) and annually.
2. CDOP will develop links with other Local Safeguarding Children Board Sub-Groups particularly the Safe from Harm Group		The CDOP Coordinator sits on the pan-Lancashire Infant Mortality Group, has presented the Annual Report and Suicide Thematic Report to the Safe from Harm Group, the annual report has also been shared with the CYPT Chairs Meeting, the LSCB locality groups and the JSNA managers for the 3 local authority areas.
3. With Public Health department investigate apparent mis-match in numbers of deaths between CDOP and ONS data.		Mismatch of data identified inherent problems with the comparison of the two datasets because they work on different parameters – gestation viability, pending inquest/ criminal investigation.
3b. Further detailed review work to identify themes / trends in deaths categorised as caused by perinatal / neonatal events.		The initial findings have been presented to CDOP the final report is awaited.
4. The Panel will monitor the re-launch of the Give Me room to Breathe (GMRTB) Campaign		The SUDI Prevention Group have updated and re-launched the Campaign; the Boards have approved funding for the second/ third phase of the Campaign.
5. CDOP will ensure the Safer Sleeping Guidance is reviewed		The Guidance was approved by the Board in March 2013 and is being widely disseminated to all frontline professionals.
6. Ensure and monitor the review of the SUDC Protocol		The review of the Protocol was delayed pending the release of the new statutory guidance. This is a priority for 2013/14.
7. Finalise the multi-agency e-learning and make available to front line multi-agency professionals		The e-learning has been re-written to be more user friendly; this remains a priority for 2013/14.
8. Develop a Pan-Lancashire communications strategy for disseminating messages and information on a multi-agency basis		The CDOP developed a task and finish group to look at this; however, it was decided a specific sub-group/ strategy was not required and the CDOP would develop an 'events calendar' to enable CDOP to recommend to the Boards time press releases.
9. Monitor Multi-Board CDOP Budget and develop action plan for utilising the under spend.		The Boards approved funding for the safer Sleep campaign. The CDOP still has a budget for 2013/14 which has some under spend from 2012/13. The CDOP now monitor their budget at each bi-monthly Business Meeting.
10. Update the data recording/ analysis systems to improve reporting on specific modifiable factors identified by the Panel		The current reporting spreadsheet has been updated to enable some reporting on modifiable factors while a CDOP database is scoped out.

Table 2, CDOP priorities for 2012/13

CDOP Key Successes for 2012/13

Safer Sleep Campaign
The SUDI Prevention Group, a sub group of CDOP, updated and re-launched the Safer Sleep Campaign (previously Give Me Room to Breathe). The Campaign will provide professionals with a consistent message and materials to give parents/ carers for discussing safer sleep. The Campaign aims to inform parents/ carers of the risks associated with safer sleep for babies to help them make an informed decision in relation to bed sharing, and consequently make children within pan-Lancashire safer.

Safer Sleeping Guidance
The CDOP monitored the update and review of the Safer Sleeping Guidance which has been ratified by the three LSCBs and has informed the development of the Safer Sleep Campaign. This was a challenging piece of work which provides frontline staff across pan-Lancashire with clear and consistent evidence based information to support them in having open and honest discussions with parents/ carers about safer sleeping choices.

Suicide Thematic Review
The Panel set up and monitored the Suicide Thematic Task and Finish Group which completed an in depth review of the child deaths which were deemed to be as a consequence of the child/ young person's own actions. The group identified recommendations to be considered by the LSCBs and the report has been shared widely on a multi-agency basis.

CDOP Posters
The CDOP developed posters for professionals and GPs to advise them who to contact to initiate the rapid response and who to notify should a child die in a manner that was expected. This will improve the notification process, ensure relevant systems are initiated and parents/ carers/ families are supported in a timely manner.

Bereavement services
The Panel has completed a survey of available bereavement services within the pan-Lancashire area; this information is being distributed to GPs and will be included in the updated SUDC Protocol.

Tri-partite CDOP
The CDOP have successfully completed their first year as a tri-partite Panel utilising a rota system for Acute Trusts professionals, Community Health colleagues, Public Health, Children's Social Care and Education representatives.

Neonatal Research
CDOP commissioned a piece of research to provide an analysis of modifiable risk factors associated with neonatal mortality in pan-Lancashire using routine data collected by CDOP of children that died between April 2008 and March 2011. Modifiable risk factors were broadly defined as those factors that may be changed through lifestyle choices. 110 records were included as meeting the study' criteria. The research has identified the following initial findings and recommendations pending the final report, CDOP could:

- Consider further analysis and explore evidence base around pre-term births including late preterm
- Review definitions used by CDOP for cause of death and look at other ways of providing more detail
- Look at the feasbility of reporting the weight for gestational age for infant mortality cases

- Look at ways of calculating neonatal mortality rates adjusted for maternal age and deprivation
- Explore the apparent excess of mortality associated with consanguinity in Blackburn with Darwen as part of the larger scale public health genetics programme of work
- Review local weight management pathways and initiatives
- Examine the factors that may contribute to low recording of maternal weight.
- Examine factors that may contribute to low recording of substance misuse issues.

The research also took into consideration data quality and means to extract statistics from the information CDOP collates. The initial findings noted that although individual case records contained a wealth of information around maternal health and obstetric notes this level of information is not included in the current CDOP spreadsheets. Furthermore, it was noted that data quality is improving over time; however, there are still significant gaps and there is significant under-reporting across a number of data fields. The following recommendations have also been identified:

- Reporting agencies should be reminded of the importance of completing all data fields
- CDOP may consider a data validation exercise to provide assurances that all infant deaths are reviewed. This would involve data matching with another routine mortality data source such as death registration records
- Most importantly CDOP should consider investing in a comprehensive database that can be used to analyse trends and generate hypotheses for further study

CDOP Sub Group Updates

SUDC Service

The Sudden Unexpected Death in Childhood (SUDC) service is nurse-led and has been providing the health element of the multi agency rapid response process to sudden unexpected deaths of infants and children across pan-Lancashire since September 2008.

With the publication of Working Together (March 2013) the Pan–Lancashire SUDC Protocol is currently under review, with the SUDC Nurses working closely with the CDOP Coordinator and partner agencies to ensure a document 'fit for purpose' that fulfils the requirements of chapter 5.

In November 2012, the SUDC Service successfully, alongside the Lancashire Constabulary, developed and delivered a multi-agency Continuous Professional Development (CPD) event for police staff. This was well evaluated and the feedback was impressively positive with many staff reporting that they had learnt something new about the rapid response and CDOP processes and would definitely change their practice. This hopefully will improve better information sharing and practices.

The SUDC service co-ordinates the end of case discussion meetings (ECDM). Challenges remain in ensuring these are undertaken within the required timescale; the service will continue to monitor and explore solutions. As part of the ECDM process the service has developed a more formal way of collating parent and multi-agency feedback on their experience of the rapid response process and is giving practitioners and parents an expectation that any feedback regarding the response will be welcomed as a means of improving the service further. The lessons learnt from ECDMs and the rapid response process now formally feed into the CDOP case reviews and are recorded on the AB forms.

An increasing demand on the SUDC service has been generated by the number of notifications they receive in respect of expected deaths. Although the service is only commissioned to respond

to unexpected deaths, they are often informed of child deaths where the referrer is unsure of the classification of the death. After discussion and information gathering these deaths are then classified as expected. The initial response into these deaths consumes a significant amount of the SUDC Nurse's time and capacity.

The SUDC Lead Nurse and the CDOP Coordinator organised a 'Suicide Thematic Task and Finish Group' on behalf of CDOP to review data available on the children and young people taking their own lives across Lancashire. This resulted in the publication of, a 'Suicide Thematic Review Report' identifying themes/ trends, gaps in service provision and recommendations. Although the review did not evidence a 'spike' in the numbers of children dying as a result of their own actions, issues were raised about gaps in service on offer to young people 16-18 year olds suffering emotional distress.

The number of unexpected deaths reported to the SUDC service has seen an increase year on year since the service started in 2008 (2009/10 – 50; 2010/11 – 58; 2011/12 – 65), however, for the period 2012/13 the service has seen a reduction reporting 46 unexpected deaths in this period. 25 of these were infants and 21 children, compared to the year before when the number of children (40) far exceeded the number of infants (25) that died unexpectedly. Figure 1 below shows the number of unexpected child deaths by Clinical Commissioning Group (CCG) area for April 2012 – March 2013.

The number of infants dying in pan-Lancashire where co – sleeping or where unconventional sleeping arrangements were a factor was slightly less than the previous year, less than 5 in 2012-13, compared to 5 in 2011-12. Whether this can be attributed to the raised profile of the 'Safer Sleep for Baby' campaign can be debated. However, the SUDI prevention group (SUDC Nurses being members of this group) has worked with LCC Media department to market the safer sleep campaign and develop resources to be used with families.

The SUDC Service has utilised their insight and knowledge gained from responding to these deaths, and has contributed to reviewing and revising the LSCB 'Safer Sleep for Infants – guidelines for professionals' which is being disseminated across Lancashire integrated workforce.

Figure one removed to maintain confidentiality

CCG	SUDC rates per 10,000 child population
Chorley & South Ribble	1.62
East Lancs	1.58
Blackpool	1.24
Lancashire North	1.22
Blackburn with Darwen	1.18
Greater Preston	0.56
Wyre & Fylde	0.26
West Lancs	0

Figure 1 and Table 3, number of unexpected child deaths between April 2012 and March 2013 by CCG area and Sudden Unexpected Death in Childhood rates per 10,000 child population

SUDI Prevention Group

The pan-Lancashire SUDI Prevention Group is a sub group of CDOP and has responsibility for planning and coordinating the 'Safer Sleep for Baby' campaign.

During 2012/13 the SUDI Prevention Group held a large multi-agency workshop to review the Give Me Room to Breathe Campaign, Safer Sleeping Guidance and information currently provided to parents/ carers on a pan-Lancashire basis. The Group also coordinated a number of focus groups held at children's centres within different localities across pan-Lancashire to review the Give Me Room to Breathe materials with parents/ carers.

The feedback from the workshop with professionals and focus groups was invaluable in updating the Campaign. Particularly with the current climate of financial constraint and constant change which has required the SUDI Prevention Group to develop strategies to effectively get key messages to our audiences such as utilising twitter and our internet page at Christmas received 185 unique visitors and 353 visits.

The Campaign heavily relies on frontline professionals to disseminate the information to parents/ carers in a way that is understood; in an attempt to help professionals have these crucial conversations with parents' new materials and designs (following feedback from focus groups) have been developed (see images below).

The revised Campaign was renamed to Safer Sleep for Baby and is underpinned by the Safer Sleeping Guidance for professionals. The SUDI Prevention Group is aware of the complex nature of the safer sleep information and therefore, the key messages for the general public are simply the Six Steps to Safer Sleep. These are:

1. Keep baby away from smoke, before and after birth.
2. Put baby in a cot, crib or moses basket to sleep - never fall asleep with them on a sofa or chair.
3. Never fall asleep with baby after drinking or taking drugs/medication.
4. Put baby to sleep on their back with their feet to the foot of the cot.
5. Keep baby's head and face uncovered and make sure they don't get too hot.
6. Breastfeed your baby - support is available if you need it.

The secondary message for the campaign is:

- We know that every baby is different and if you have any questions, you can speak to your:
  - Midwife
  - Health visitor
  - Local Children's Centre
  - Or you can call the Lullaby Trust Helpline.

The Group plan to have a more targeted approach to disseminating materials for the 2013/14 phase of the Campaign, resulting in more parents/carers receiving consistent messages from the integrated workforce across pan-Lancashire at key contacts.

New Safer Sleep Campaign Materials

CDOP priorities for 2013/14

CDOP Priority	Task	Lead	Timescale
1. Review cases and make recommendations regarding themes to the Board	Continue to gather information in relation to all child deaths in pan-Lancashire.	CDOP Team	Ongoing
	Identify themes / patterns in these reviews	CDOP Meeting	Ongoing
	Discuss 13/14 Annual Report content Prepare draft Annual Report Final Annual Report ratified by Panel	CDOP Coordinator/ Vice Chair	April Business Meeting June Business Meeting August Business Meeting
	Share Annual Report and themes identified with LSCB to inform planning.	CDOP Meeting	Sep-13
	Upload the Annual report to the LSCB websites and share with Safe from Harm Theme Group, HWB, CYPT and establish how it will link with the JSNA	CDOP Co and Chair	Dec-13

2. Undertake a detailed review to identify themes / trends in deaths categorised as caused by perinatal / neonatal events.	Public Health Specialty Registrar to present initial findings to CDOP Business meeting	Public Health Specialty Registrar	April Business Meeting
	Final report to be shared with CDOP Business Meeting	Public Health Specialty Registrar	October Business Meeting
3. Monitor Safer Sleep Campaign	SUDI Prevention Group to plan 2013/14 Campaign and request funding from CDOP.	SUDI Prevention Group	April Business Meeting
	LSCBs to approve CDOP funding recommendation	LSCBs	May Boards
	Summer Campaign to be started and planning for Winter to be initiated	SUDI Prevention Group	May-13
	Monitor development of training materials for Safer Sleeping Guidance	Cath Topping	Dec-13
4. Ensure and monitor the review of the SUDC Protocol	SUDC Nurses to update the Protocol in line with new guidance	SUDC Nurses	May-13
	6 week consultation period	CDOP Co	Jul-13
	Task and Finish Group to be developed to review the feedback	CDOP Co and SUDC nurses	Aug-13
	Guidance to be updated, draft document to be circulated to agencies and presented to SUDC Stake Holders Group	CDOP Co and SUDC nurses	Oct-13
	(Pending agreement by CDOP to agree evaluation of SUDC Service) The SUDC Service evaluation report to be considered and SUDC Protocol to be updated as appropriate.	SUDC Stake Holders	Nov/ Dec - 13
	Final Draft SUDC Protocol to be presented to CDOP	CDOP Co and SUDC nurses	Dec-13
	Final SUDC Protocol to be ratified by the 3 Boards	CDOP	Jan-14
	SUDC Protocol training and awareness raising	CDOP	Jan- 14 onwards
5. Finalise the multi-agency e-learning and make available to professionals front line multi-agency professionals	E-learning slides to be updated with Training Co-ordinator to put into appropriate language	CDOP Co	Jun-13
	E-learning to be approved by CDOP	CDOP Business Members	Jun-13
	CDOP Coordinator to request e-learning is uploaded Moodle and 10 volunteers to be identified to test the e-learning, any further amendments to made.	CDOP Co, LCC project officer and CDOP Business Members	October Business Meeting
	E-learning package live on the Children's Trust web site.	CDOP Co & LCC project officer	Nov-13
	CDOP Members to disseminate message to relevant professionals e-learning is now available.	CDOP Business Meeting	Nov-13 onwards
	Regular reports will be provided to CDOP Business Meetings to enable CDOP to monitor which agencies are completing the training.	CDOP Business Meeting	December 13 onwards

6. Disseminate messages and information to the multi-agency workforce and public (as appropriate)	CDOP Business Meeting to develop 'events calendar' of key multi agency campaigns	CDOP Co	June Business Meeting
	Business Meeting to identify campaigns and time press releases to raise awareness to particular issues.	CDOP Business Members, CDOP Co, LCC Media Team	Ongoing
	CDOP to share themes/ trends with the Health and Wellbeing Boards and CYP Trusts	CDOP & LSCBs	As and when appropriate
7. CDOP to implement a new database/ IT system which will improve reporting particularly in relation to specific modifiable factors identified by the Panel	CDOP Coordinator to scope out a costing for a database and present options to Panel	CDOP Co	Apr-13
	Request for funding to be approved by the Boards	CDOP Busi Meeting	May-13
	CDOP Coordinator to meet with Sentinel and confirm no licence contract term.	CDOP Co	Jun-13
	CDOP Coordinator to clarify with all agencies Vantage Technologies IT governance and security levels are sufficient.	CDOP Co	Aug-13
	CDOP Coordinator to initiate development of database with Sentinel following June Business Meeting update.	CDOP Co	Sept-13
	Development of the database, progress monitored by CDOP	CDOP Co/ Busi Meeting	Apr-13 onwards
8. CDOP Development Day	LSCBs to appoint new CDOP Chair	LSCBs	URGENT
	Date to be decided and draft programme to be developed.	CDOP Chair, CDOP co and Training Co	TBD
	Hold Development Day	CDOP Chair, CDOP co and Training Co	TBD

Table 4, CDOP priorities for the 2013/14 reporting year

Analysis of deaths reviewed in 2012/13

During the 2012/13 reporting year CDOP was notified of 129 child deaths (8 Blackpool residents, 11 Blackburn with Darwen (BwD) residents, 93 Lancashire residents and 17 out of area). In the same reporting year the Panel completed 150 reviews (15 BwD reviews, 11 Blackpool reviews and 124 Lancashire reviews).

In the figure below it can be seen that the number of notifications received this reporting year is significantly less than in previous years (this graph does not include out of area notifications).

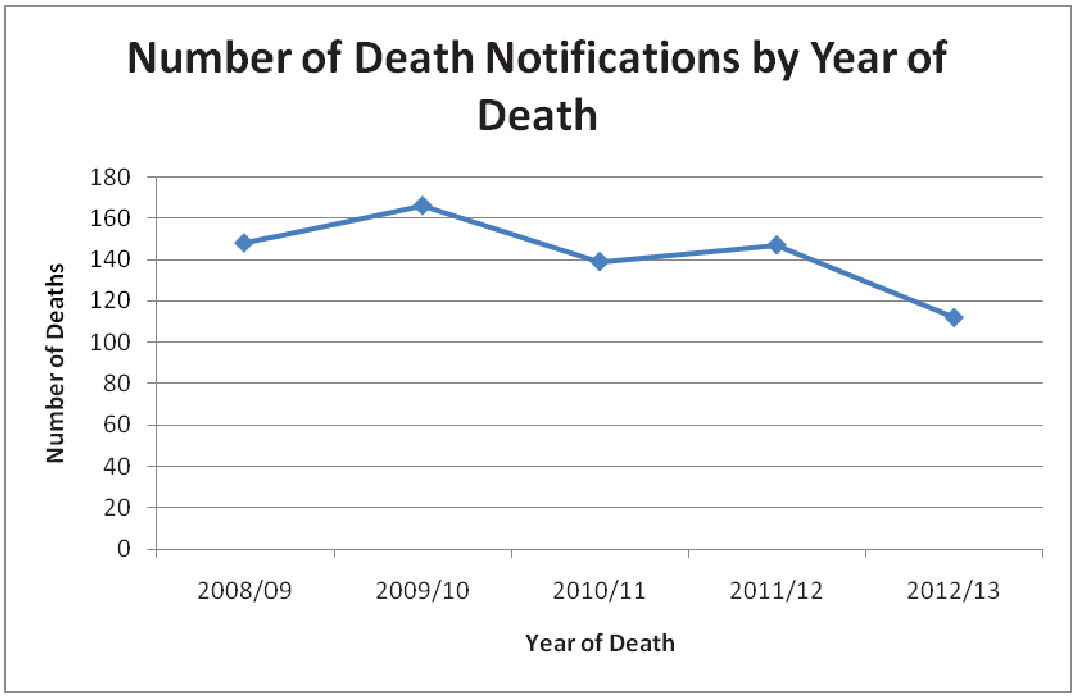


Figure 2, number of death notifications each reporting year from April 2008 – March 2013

Modifiable Factors

Of the 150 child deaths reviewed this reporting year table 5 below shows the number of deaths that were deemed to have modifiable factors and whether the deaths were expected or unexpected.

Expected?	Locality	Modifiable factors	No modifiable Factors	Grand Total
Expected	Blackburn with Darwen	<5	9	10
	Blackpool	0	<5	<5
	Lancashire	5	66	71
Expected Total		6	79	85
Unexpected	Blackburn with Darwen	<5	<5	5
	Blackpool	5	<5	7
	Lancashire	23	30	53
Unexpected Total		30	35	65
Grand Total		36	114	150

Table 5 Total number of deaths reviewed by expected/ unexpected and whether modifiable factors were identified

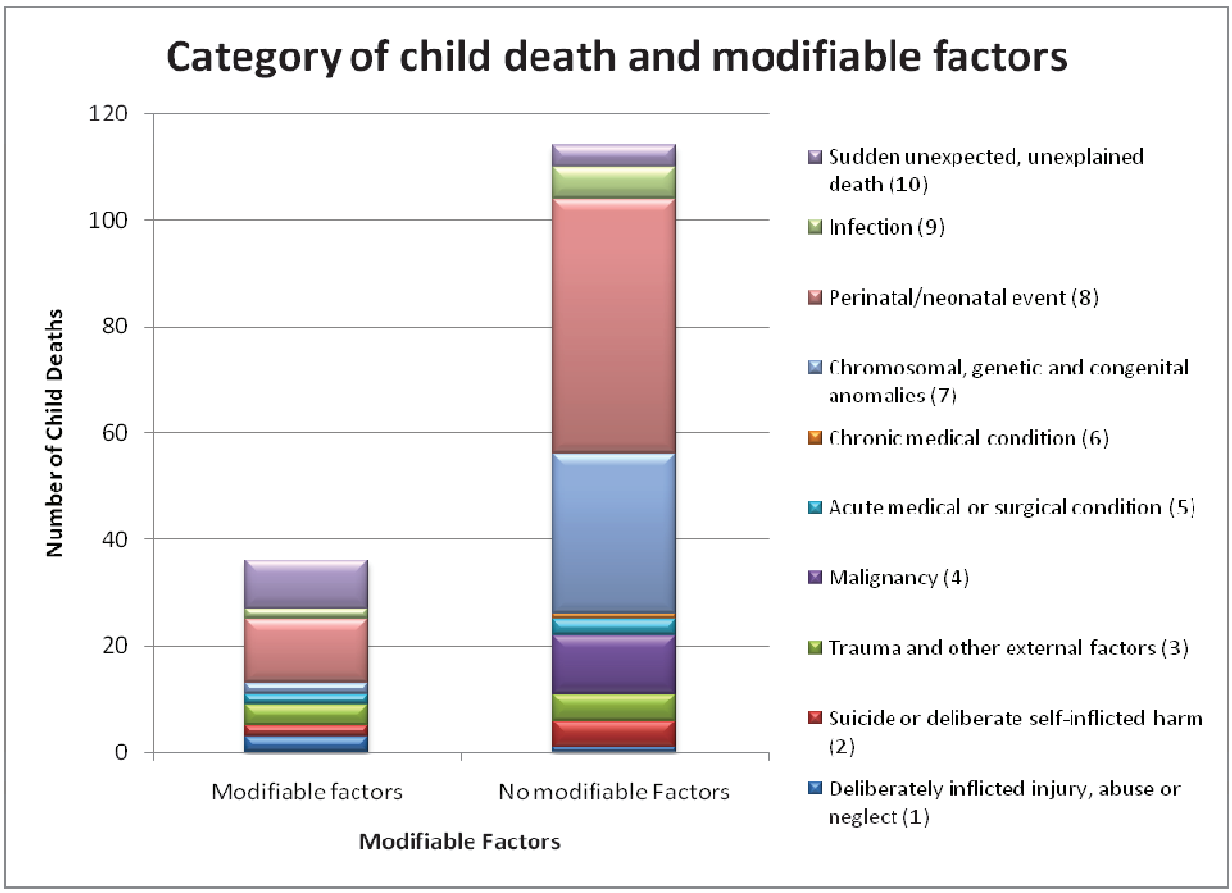


Figure 3, category of the child's death as defined by the Department for Education and whether modifiable factors were identified in reviews completed between April 2012 and March 2013

Of the cases reviewed in 2012/13 the largest categories of death which were deemed to have modifiable factors were perinatal/ neonatal event (33%) and sudden unexpected, unexplained death (25%) (figure 3). This was also seen nationally with 26% of deaths identified as having modifiable factors were due to perinatal/ neonatal event and a further 23% due to sudden unexpected, unexplained deaths.

Malignancy and chronic medical condition did not have any deaths where modifiable factors were identified.

Length of time to complete the review

Nationally, of the deaths notified to Panels in the year ending 31st March 2013, 62% of reviews were on-going at the end of the reporting year. In the same reporting year the pan-Lancashire Panel completed 44% of reviews and the remaining 56% were on-going at 31st March 2013.

The figure below (4) shows that the number of reviews completed in less than 6 months has reduced in comparison to the 2011/12 reporting year. Although, over half of reviews were still completed in 7 months or less; during 2011/12 137 reviews were completed whereas 150 reviews have been completed this reporting year. During 2011/12 and 2012/13 approximately 16% of cases took over 12 months to review, this is less than the national average of 25%.

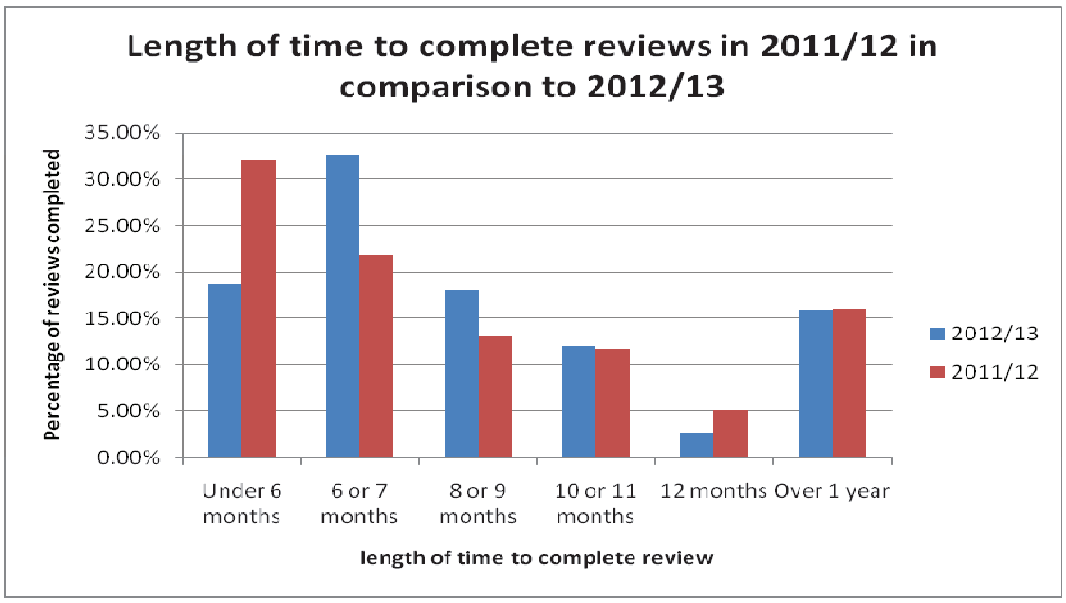


Figure 4, time taken to complete reviews in 2011/12 in comparison to 2012/13

Figure 5 shows the length of time taken for reviews to be completed this reporting year for each area; this information reflects the timeliness of information returned to the Panel by different agencies such as NHS, Lancashire Constabulary, Children's Social Care and the Coroner's. During 2012/13 the Panel completed 47% of Blackburn with Darwen reviews in under 6 months; in comparison 9% of Blackpool's cases were able to be reviewed in the same time period, 12% in North Lancashire, 16% in East Lancashire and 19% in Central Lancashire.

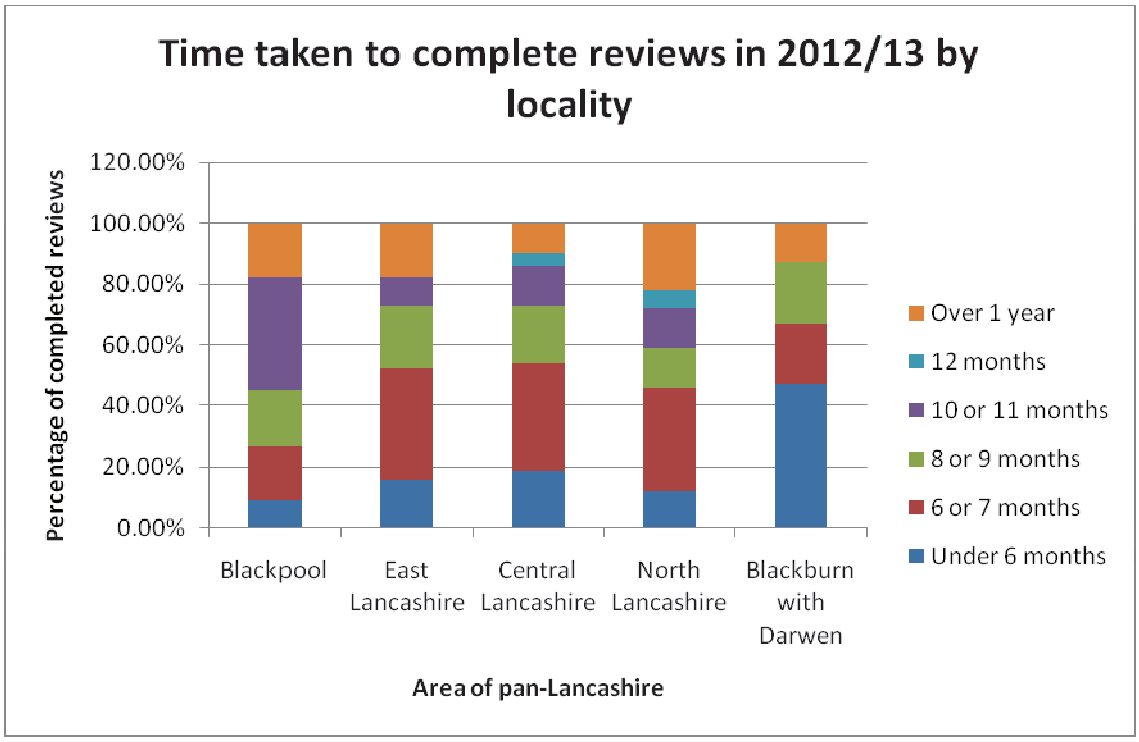


Figure 5, time taken to complete reviews during 2012/13 by are of pan-Lancashire

Analysis of data April 2008 – March 2012

This section of the report will consider the data by the year the child died which provides a more useful and meaningful approach for looking at trend data. 583 child deaths will be used in this section of the report and as 55% of child deaths which occurred in 2012/13 have yet to be reviewed, this section only contains data from April 2008 – March 2012. The Panel have recorded 148, 166, 138 and 131 child deaths in 2008/09, 2009/10, 2010/11 and 2011/12 respectively.

Child Deaths by Locality

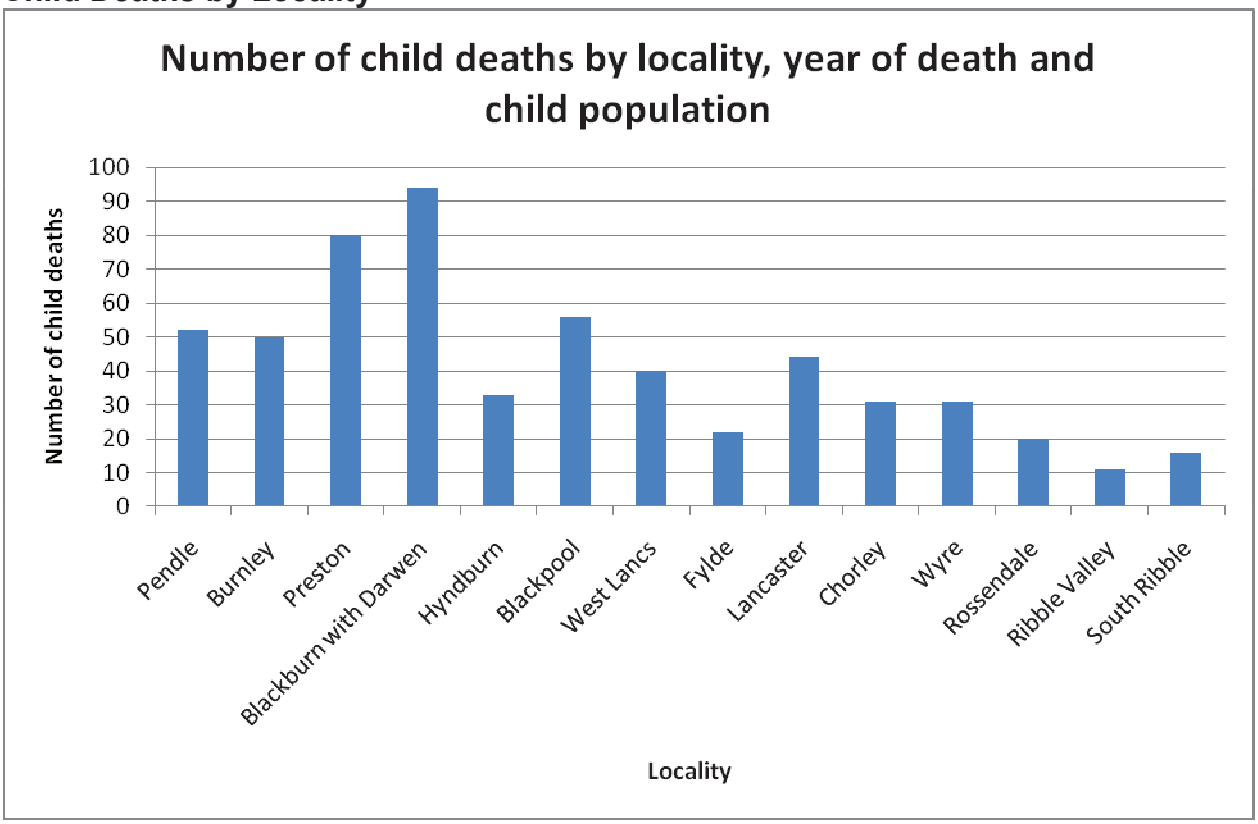


Figure 6, the number of child deaths per locality by year of death (this figure has been modified to maintain confidentiality)

It can be seen from figure 6 that Blackburn with Darwen, Preston, Pendle, Blackpool and Burnley have the highest number of deaths. Blackburn with Darwen, Hyndburn and Chorley had an increase in the number of deaths in 2009/10 with Ribble Valley not having any child deaths in 2010/11 and Preston having a relatively consistent number of deaths year on year.

Child Deaths by Gender and Age

From table 6 below it is seen that year on year more male children die than female children.

Gender	2008/09	2009/10	2010/11	2011/12
Female	41% (60)	39% (65)	42% (58)	42% (55)
Male	59% (87)	61% (100)	58% (80)	58% (76)

Table 6, child death by gender and year of death

The scarf charts on the next page represent child deaths between April 2008 and March 2012 by gender, age at death and year of death; the pattern of deaths by age, is what would be expected based on previous annual reports and the national data. The largest number of deaths occurred in

children aged 0-27days with the fewest deaths in children aged 5-9 years. This pattern is also seen on a year by year basis in the same figure.

Nationally, 66% of reviews completed in the year ending 31st March 2013 were for children aged under 1 year. Similar to the pan-Lancashire data, nationally there were more males (57%) children's deaths reviewed in comparison to females (43%).

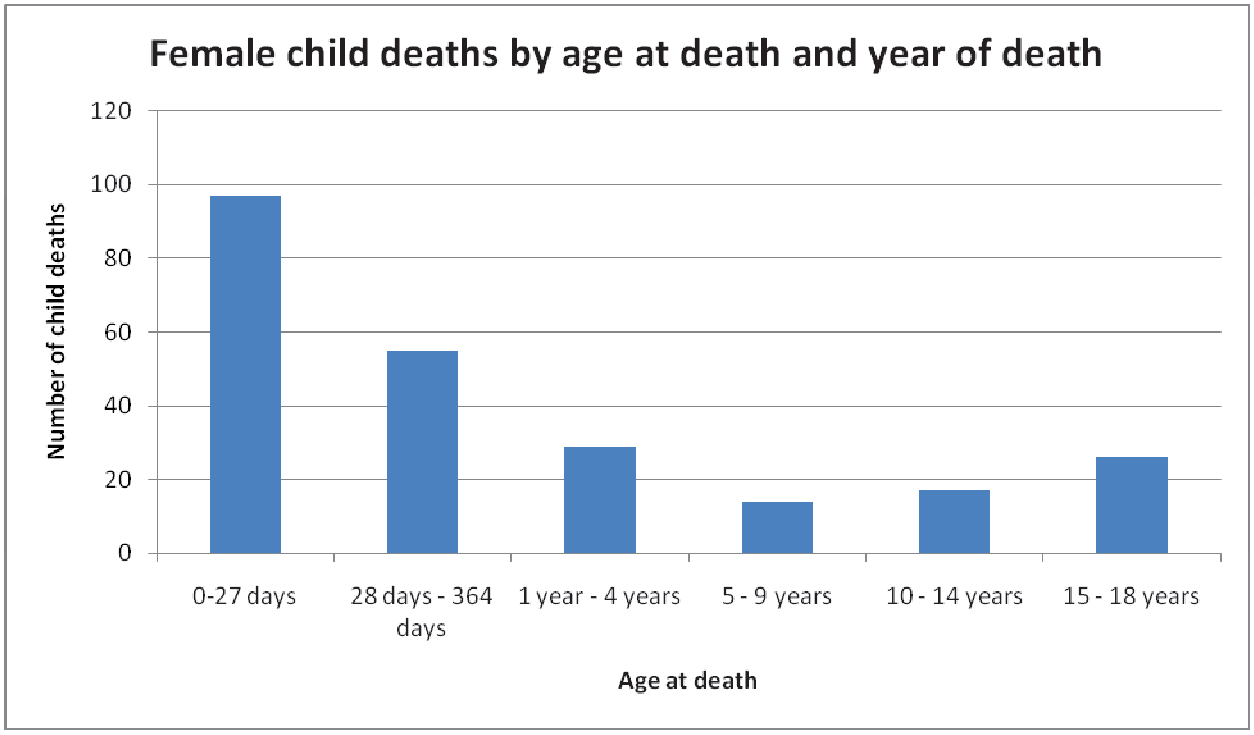


Figure 7, female child deaths by age at death and year of death (this figure has been modified to maintain confidentiality.)

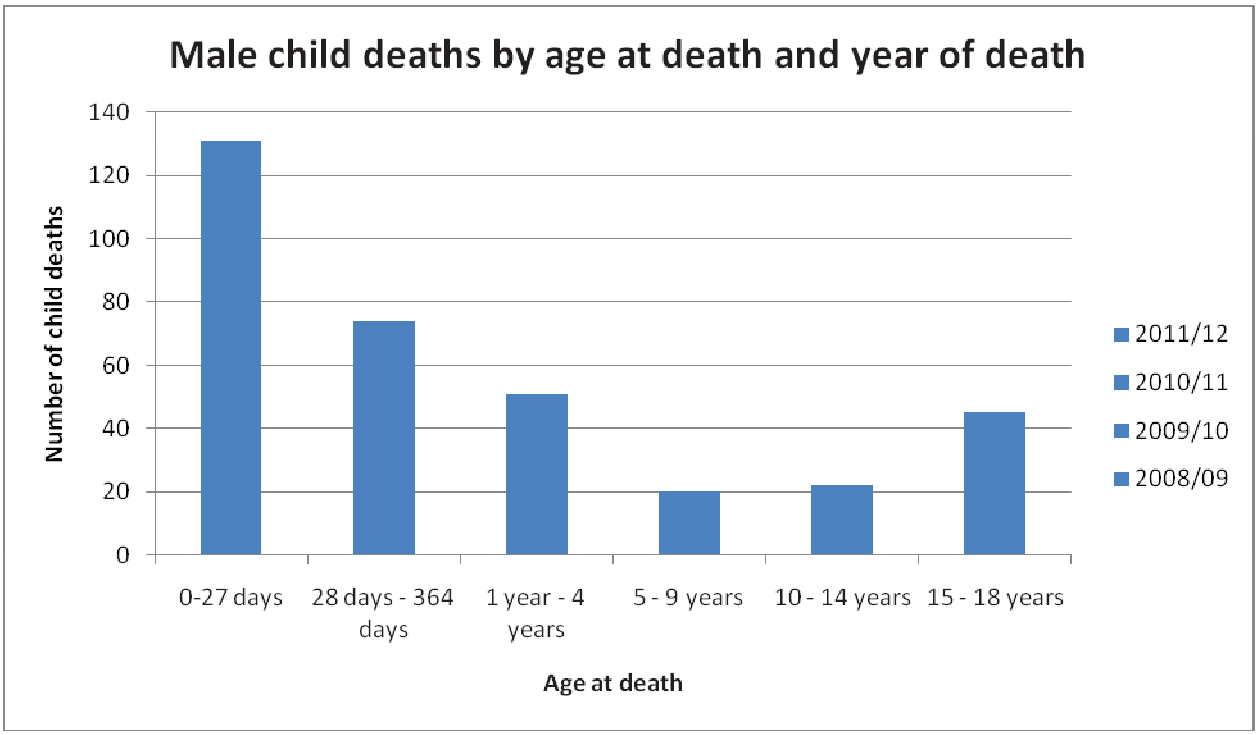


Figure 8, male child deaths by age at death and year of death (this figure has been modified to maintain confidentiality.)

Figure 9 removed to maintain confidentiality

Figure 9, child deaths in 2008/09 by age and category of death

Figure 10 removed to maintain confidentiality

Figure 10, child deaths in 2009/10 by age and category of death

Figure 11 removed to maintain confidentiality

Figure 11, child deaths in 2010/11 by age and category of death

Figure 12 removed to maintain confidentiality

Figure 12, child deaths in 2011/12 by age and category of death

Category of Child Death

Figures 9-12 above show age at death by category of death by the year of death; as anticipated a large number of deaths occurred in children aged 0-27days with the majority due to perinatal/ neonatal events. 62% of all the child deaths between April 2008 and March 2012 were in children under 1 year and of these 76% died of chromosomal, genetic and congenital abnormalities or perinatal/ neonatal events. The increasing impact of trauma and other external factors and suicide is apparent in young people; with sudden unexpected, unexplained deaths particularly noticeable in children aged 28- 364 days old. See page 21 table 7 for all data reviewed by the Panel between April 2008 and March 2013 by category of death.

The analysis of the data by year of child death between April 2008 and March 2012 identified there were fluctuations in the number of deaths per category for each year as detailed below:

2008/09:

- Fewer deaths due to chromosomal, genetic and congenital abnormalities
- Increased number of deaths due to acute medical or surgical condition and chronic medical condition
- Slight increase in suicide or self inflicted harm and deaths due to infection

2009/10

- Similar number of deaths caused by perinatal/ neonatal events and chromosomal, genetic and congenital abnormalities
- Slightly higher number of deaths due to trauma and other external factors
- Fewer deaths as a consequence of suicide or self inflicted harm

2010/11

- The highest number of deaths due to perinatal/ neonatal events and chromosomal, genetic and congenital abnormalities
- Increased number of sudden unexpected, unexplained deaths
- Reduce number of deaths due to malignancy and suicide or deliberate self harm

2011/12

- Increased number of deaths due to perinatal/ neonatal events
- Fewer deaths due to chromosomal, genetic and congenital abnormalities and sudden unexpected, unexplained death
- Slight increase in deaths due to malignancy and suicide or deliberate self harm

The chart (figure 13) on the next page identifies the different causes of child death by the year the child died. Perinatal/ neonatal events and deaths as a consequence of chromosomal, genetic and congenital abnormalities are the main causes of child death from April 2008 – March 2012. See page 21 table 7 for all data reviewed by the Panel between April 2008 and March 2013 by category of death.

Figure 13 removed to maintain confidentiality
Please see page 21 table 7 for all data reviewed by the Panel between April 2008 and March 2013 by category of death.

Figure 13, number of child deaths by category of death and year the child died

Figure 14 depicts the number of child deaths with modifiable factors identified by category of death and year of death. During 2009/10 there was an increase in the number of deaths in which modifiable factors were identified this is likely due to the increased number of child deaths for this year; moreover there were specific increases in deaths due to trauma and other external factors and sudden unexpected, unexplained death during 2009/10.

There appears to be an increase in 2009/10 and 2010/11 in the deliberately inflicted injury, abuse or neglect; however, this type of death usually takes over a year to be reviewed by Panel. This is due to other investigations such as Serious Case Reviews (SCRs) or criminal investigations needing to be complete before the CDOP can review the information, therefore, the data for 2011/12 should be treated with caution. More deaths as a consequence of suicide or deliberate self-inflicted harm during 2008/09 were deemed to have modifiable factors.
It seems as though there are increasing numbers of deaths due to perinatal/ neonatal events being categorised as having modifiable factors. The Panel has commissioned further research into perinatal/ neonatal deaths and the final report will be released in 2012/13.
The differences in the number and category of deaths identified as having modifiable factors in 2008/09 and 2009/10 in comparison to 2010/11 and 2011/12 may be as a result of the following factors:

1. In March 2010 the statutory guidance was amended from each review being categorised as either 'not preventable', 'potentially preventable' or 'preventable' to 'modifiable factors identified' or 'no modifiable factors identified'. Therefore the category for 'modifiable factors identified' includes all deaths which were previously categorised as 'preventable' or 'potentially preventable.
2. The Panel has developed experience and understanding of the review process and discussions
3. The Panel members have changed which may have affected the decisions made

Figure 14 removed to maintain confidentiality

Figure 14, child deaths identified as having modifiable factors by category and year of death

Analysis of child deaths reviewed from April 2008 – March 2013

Since April 2008 – March 2013 the Child Death Overview Panel (Blackpool, Lancashire and Blackburn with Darwen) has been notified of 712 child deaths (excluding out of area children) and has completed 633 reviews (88.9%), nationally 81% of reviews have been completed since the statutory responsibility to review deaths was introduced in April 2008. Of the 633 cases reviewed 44% were unexpected deaths, 59% were male and 22% had modifiable factors.

From table 7 below it can be seen that perinatal/ neonatal events (8) and chromosomal, genetic and congenital anomalies (7) are the cause for the majority (58%) of child deaths within pan-Lancashire. Similar to last year, sudden unexpected, unexplained deaths (10) is the third most common category but it is a much smaller group than category 7 and 8 and has similar numbers to categories 3 and 4.

Category of Death	Number of Child Deaths	Percentage
Deliberately inflicted injury, abuse or neglect (1)	12	1.8%
Suicide or deliberate self-inflicted harm (2)	19	3.0%
Trauma and other external factors (3)	44	7.0%
Malignancy (4)	40	6.3%
Acute medical or surgical condition (5)	22	3.5%
Chronic medical condition (6)	36	5.7%
Chromosomal, genetic and congenital anomalies (7)	154	24.3%
Perinatal/neonatal event (8)	213	33.6%
Infection (9)	31	4.9%
Sudden unexpected, unexplained death (10)	57	9.0%

Table 7, number of child death by category of death

Expected/ Unexpected Deaths and Modifiable Factors

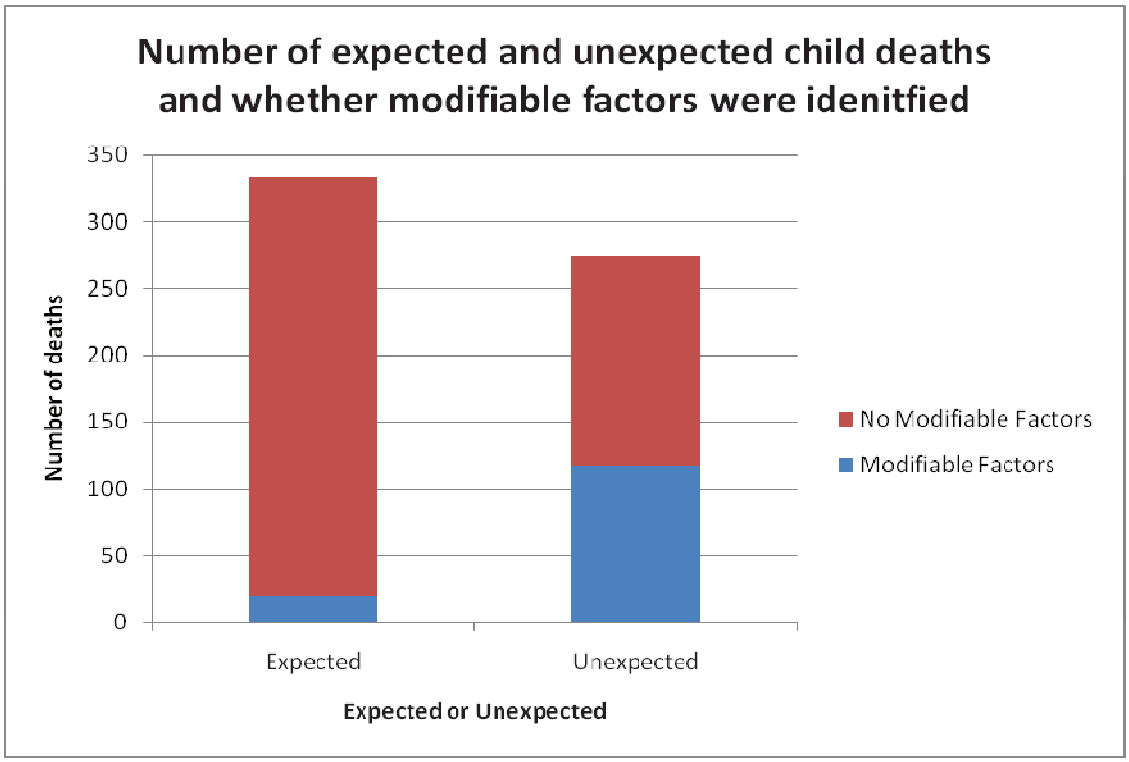


Figure 15, number of child expected and unexpected child deaths reviewed between April 2008 – March 2013 and whether modifiable factors were identified.

74% of the child deaths were deemed to have no modifiable factors; of the cases identified to have modifiable factors (22%) the majority were unexpected child deaths. No modifiable factors were identified in 94% of expected deaths and 57% of unexpected deaths. In 4% of the deaths there was either insufficient information to determine whether there were modifiable factors/ no modifiable factors or if the death was expected/ unexpected (figure 15).

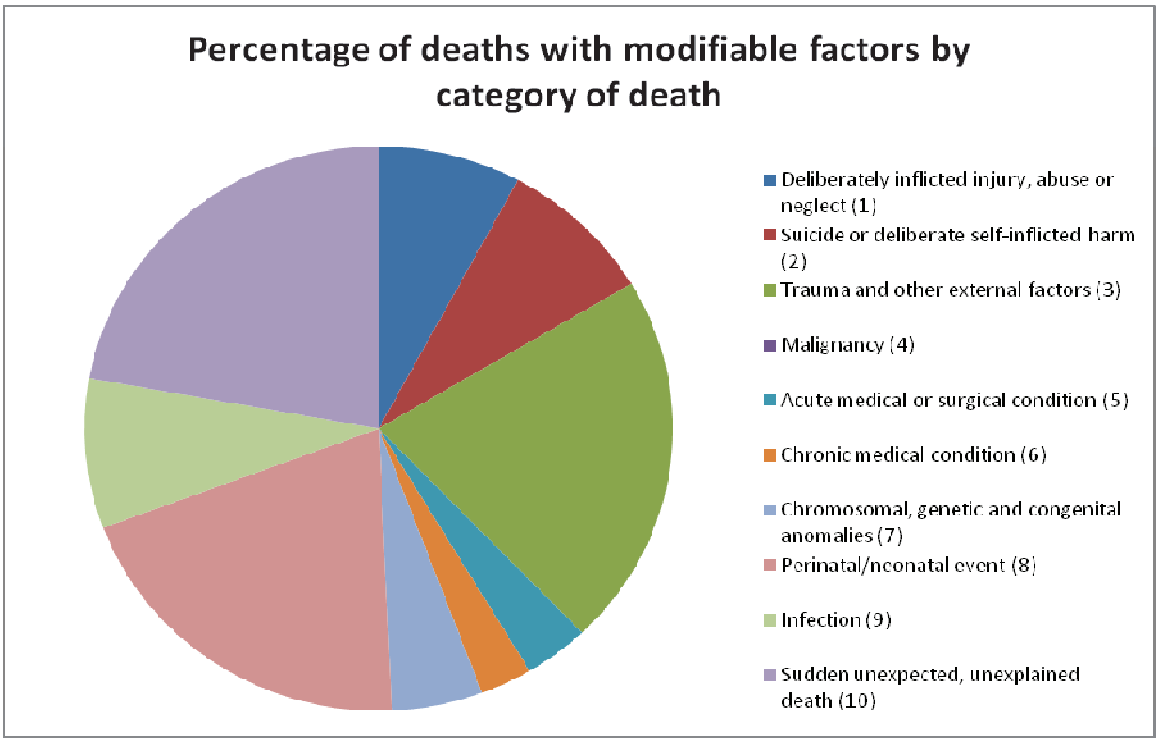


Figure 16, percentage of child deaths with modifiable factors identified by cause of death (this figure has been modified to maintain confidentiality.)

Figure 16 above shows 22% of deaths identified as having modifiable factors were sudden unexpected, unexplained deaths, 21% were due to trauma and other external factors and 20% were caused by perinatal/ neonatal event. No deaths due to malignancy were identified as having modifiable factors. Examples of modifiable factors relating to sudden unexpected, unexplained deaths, trauma and other external factors and perinatal/ neonatal events are issues relating to safer sleep, risk taking behaviours and smoking in pregnancy respectively.

The most common risk factors identified from the 140 cases deemed to have modifiable factors were:

- 32% of cases identified issues in relation to service provision including engagement with services, language barriers or access to services
- 28% of cases identified alcohol/ substance misuse by a parent or carer
- 24% of cases identified smoking by a parent/ carer
- 21% of cases identified issues relating to safer sleep for baby (80% also had either smoking, alcohol and/or substance misuse as risk factors)
- Other factors noted by CDOP included mental health of a parent/ carer, domestic violence, chaotic lifestyles and housing issue

Locality and Ethnicity

Figure 17, represents child deaths reviewed between April 2008 and March 2013 by locality and ethnicity. It can be seen that Blackburn with Darwen, Preston, Pendle and Burnley have the most diverse populations within pan-Lancashire and also have some of the highest numbers of deaths. Of the 633 deaths reviewed between April 2008 and March 2013 the two largest ethnicities were White British 60% and 12% of children and young people were of an Asian or Asian British (Pakistani) ethnic origin. 13% of the child deaths reviewed did not have an ethnicity listed because it was either not known or not stated.

Figure 14 removed to maintain confidentiality

Figure17, child deaths reviewed between April 2008 and March 2013 by locality and ethnicity

Figure 14 removed to maintain confidentiality

Figure18, child deaths reviewed between April 2008 and March 2013 by category and ethnicity
*the numbers on the y axis refer to the categories of death as follows: Deliberately inflicted injury, abuse or neglect (1), Suicide or deliberate self-inflicted harm (2), Trauma and other external factors (3), Malignancy (4), Acute medical or surgical condition (5), Chronic medical condition (6), Chromosomal, genetic and congenital anomalies (7), Perinatal/neonatal event (8), Infection (9), Sudden unexpected, unexplained death (10)

Figure 18 above depicts the child deaths reviewed between April 2008 and March 2013 by category of death and ethnicity. Each category of death has children of a White British heritage with the majority due to perinatal/ neonatal events. Of the children and young people who were of an Asian or Asian British (Pakistani) ethnic origin 52% died due to chromosomal, genetic and congenital anomalies and 28% perinatal/ neonatal events.

Analysis of the two largest ethnicities across pan-Lancashire by age of the child at death is seen in the table (8) below. Interestingly, the White British ethnicity follows a similar pattern to the combined data with 62% all the child deaths reviewed between April 2008 and March 2013 aged under 1 year, with fewest deaths in the 5-9 year category, and numbers increasing again in over 10 year olds. Comparatively, of the child deaths reviewed between April 2008 and March 2013 79% of Asian, Asian British (Pakistani) were under 1year of age and numbers plateau in the older age categories.

	0-27 days	28- 364 days	1-4 years	5-9 years	10-14 years	15-18 years	Totals
White British	155 (41%)	80 (21%)	49 (13%)	21 (6%)	27 (7%)	46 (12%)	378
Asian, Asian British (Pakistani)	33 (44%)	26 (35%)	6 (8%)	<5 (5%)	<5 (4%)	<5 (4%)	75

Table 8, two most common ethnicities across pan-Lancashire by the age of the child

Deprivation

From figure 19 below it can be seen that a high child population does not predispose an area to increased numbers of child death; therefore other social, economic and biological factors must be considered. Figure 20 identifies the areas which have the most deprivation also have far more child deaths than the least deprived areas of pan-Lancashire. This section of the report will look at mapping deprivation and child deaths reviewed between April 2008 and March 2013.

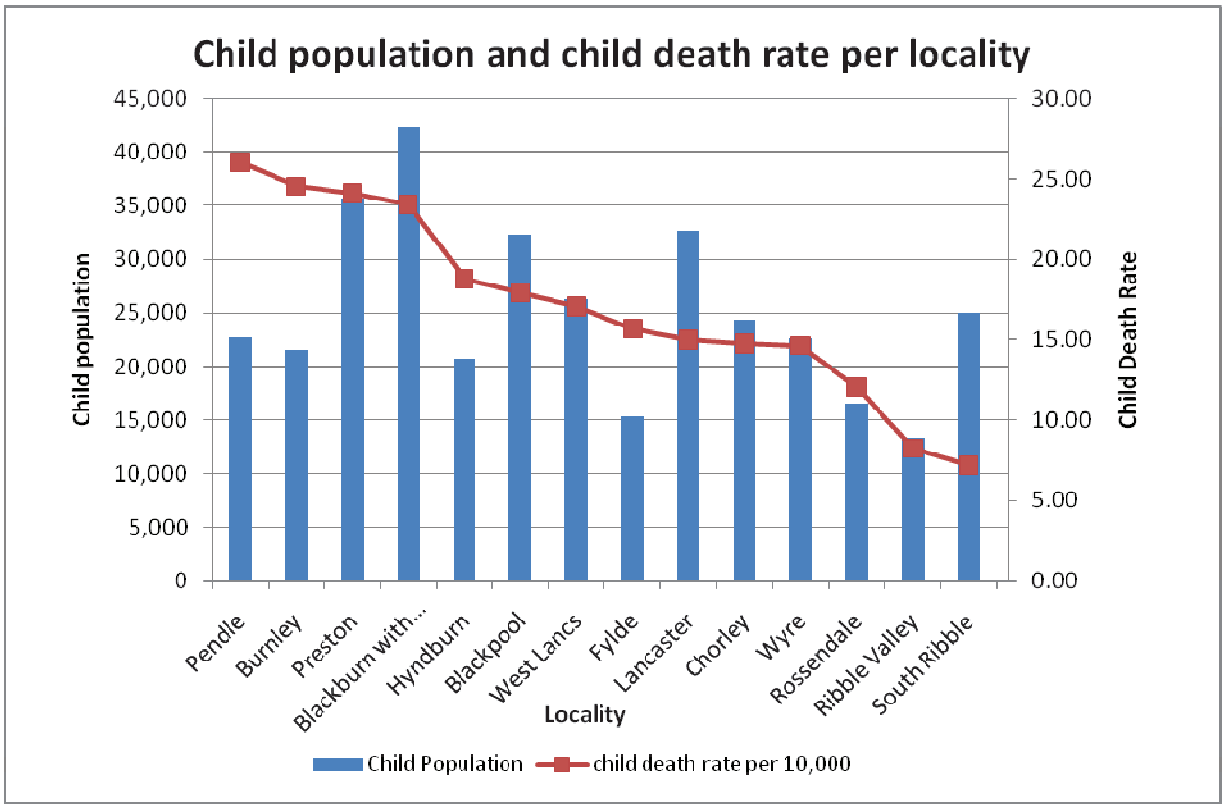


Figure 19, Child death rate per 10,000 of under 18 population

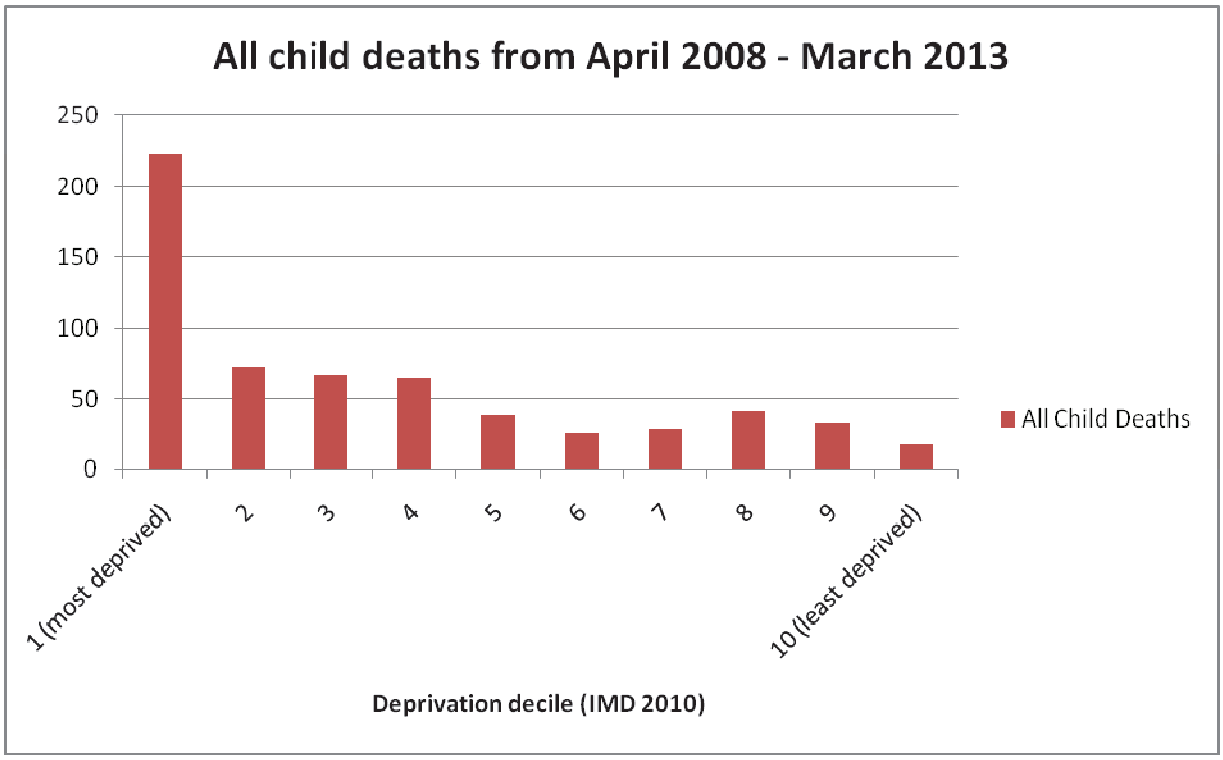


Figure 20, child deaths reviewed between April 2008 and March 2013 by deprivation decile.

Experian Mosiac Public Sector was used to profile all the child death data, it was identified that families from the following socio-economic backgrounds suffered more child deaths:

- lower income workers in urban terraces in often diverse areas
- families in low-rise social housing with high levels of benefit need

Further analysis idenified the following specific groups of being more at risk of child deaths :

- South Asian communities experiencing social deprivation
- Families living in older town centre terraces with transient, single populations
- Low income families occupying poor quality older terraces
- Vulnerable young parents needing substantial state support

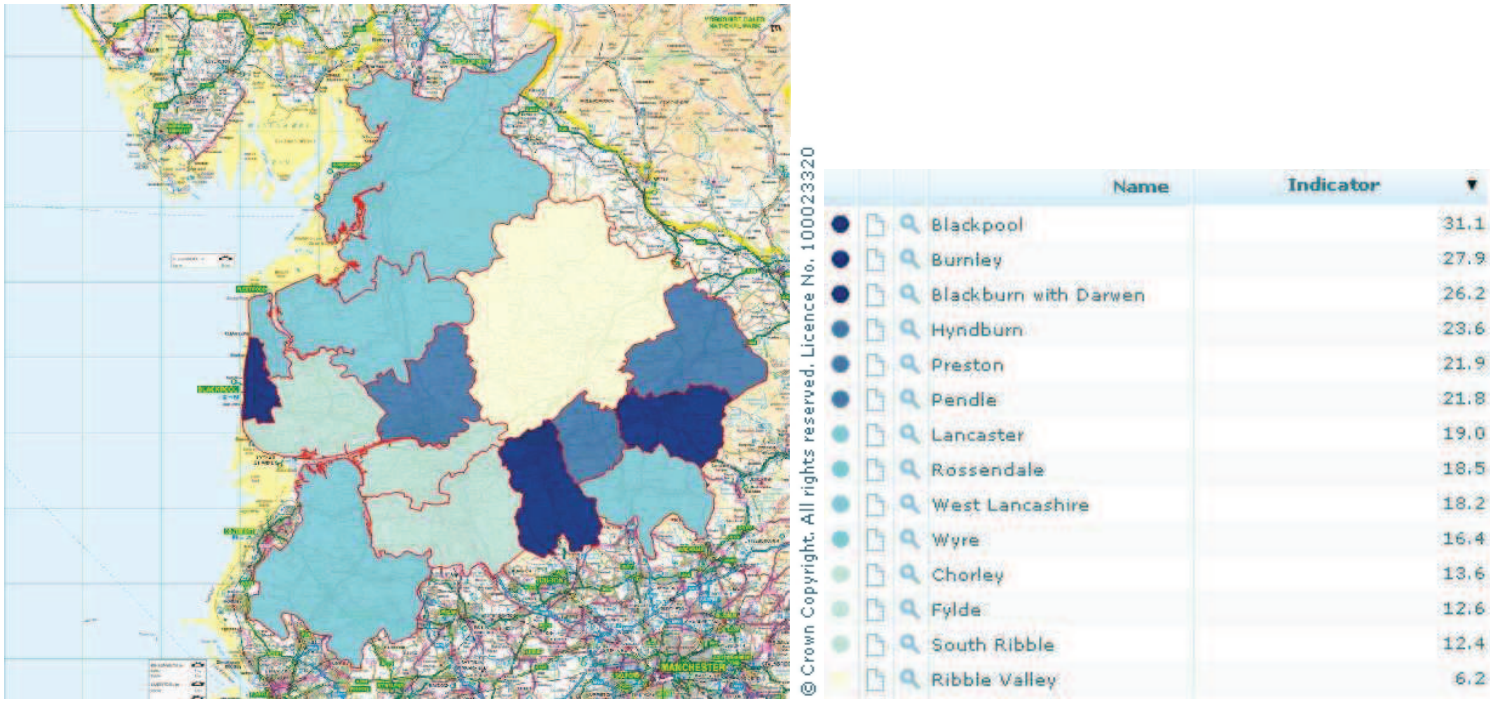


Figure 21, poverty of children and young people under 16 years old

When looking at the figure above (21) and the locality and ethincity scarf chart on page 23 the following trends/ themes can be seen:

- There are more child deaths in the districts with increased child poverty
- Ribble Valley, South Ribble and Fylde are the areas with the least child poverty also tend to have fewer child deaths.
- More diverse areas tend to have high levels of child deaths. However, Blackpool which has a large White British population also has high child death numbers, although this may be explained by the high deprivation rate for Blackpool.
- When looking at Lower Super Output Area (LSOA) and Ward level at the index of multiple deprivation 2010 and hotspot areas of under 18 conception rates per 1000 females aged 15-17 (2003-2005) (LCC interactive maps) there are higher conception rates in under 18s in areas of higher deprivation and there are also clusters of child deaths in these areas (CDOP Annual Report 2011/12).

Based on the mosiac analysis and the discussion above relating to deprivation/ child poverty, ethnicity and locality, families from BME communities experiencing social deprivation and families living in more deprived areas are more likely to experience a child death.

Identification of themes and trends

- The most common cause of all child deaths is perinatal/ neonatal events and chromosomal, genetic and congenital anomalies
- There are significantly more deaths with no modifiable factors identified; of the deaths deemed to have modifiable factors the largest categories of death are sudden unexpected, unexplained deaths, trauma and other external factors and perinatal/ neonatal events
- There are more expected deaths then unexpected deaths
- More male children die than female children
- 62% of all the child deaths between April 2008 and March 2012 were in children under 1 year and of these 76% died of chromosomal, genetic and congenital abnormalities or perinatal/ neonatal events
- The increasing impact of trauma and other external factors and suicide is apparent in young people; with sudden unexpected, unexplained deaths particularly noticeable in children aged 28-364 days old
- 60% of children who have died between April 2008 and March 2013 are White British
- Of the deaths reviewed 79% of Asian, Asian British (Pakistani) children were under 1year of age
- 80% of Asian, Asian British (Pakistani) child deaths were due to perinatal/ neonatal events and chromosomal, genetic and congenital anomalies
- Blackburn with Darwen, Burnley, Pendle and Preston have the most diverse populations within Pan-Lancashire, these areas also have the highest child death rates
- There are more child deaths in the districts with increased child poverty
- Families from BME communities experiencing social deprivation and families living in more deprived areas are more likely to experience a child death

Recommendations for 2013/14

- The three LSCBs should reiterate to all agencies, who provide CDOP with information, the importance of completing AB forms as fully as possible, particularly ethnicity, asylum seeker and parental demographic details
- The three LSCBs should recommend to the Health and Wellbeing Boards in their area to note the information contained within this report and ask them to clarify whether any research and/or planning of services work is being undertaken on any of the themes/trends or issues raised, in particular for:
  - The Blackpool LSCB to consider research and/or planning of services on the theme of deprivation identified in child deaths under 28 days;
  - The Lancashire and Blackburn with Darwen Boards to consider the themes of ethnicity and deprivation linked with deaths categorised under the category of 'chromosomal, genetic and congenital anomalies'.

  In seeking the clarifications from the Health and Wellbeing Boards, the LSCBs should be assured that local action is being taken, and that this action is effective, in preventing future such deaths
- The three Boards should be mindful that although the majority of cases do not have modifiable factors, this does not mean there were no risk factors identified. It may be appropriate to review in depth all the cases with no modifiable factors to identify common risk factors
- The LSCBs should recommend to the Health and Wellbeing Boards that representatives should attend the CDOP development day
- CDOP to explore learning opportunities with other CDOPs across the country
- All three Boards should continue to support the Safer Sleep Campaign
- The three LSCBs should circulate the anonymised report widely

Links

To access the Safer Sleeping Guidance for the integrated workforce, thematic reports and SUDC Protocol please follow this link LSCB - CDOP page
Please follow this link for the Safer Sleep for Baby Campaign

CHILD SEXUAL EXPLOITATION
THE MORE YOU KNOW THE MORE YOU SEE

G Division PPU Development and Compliance Unit

Briefing Paper

Child Sexual Exploitation Awareness Week
Op Toledo

Originator: DS 2468 Paul Burnside
Date: Friday 20th September 2013

OVERVIEW

The Constabulary, the Police and Crime Commissioner for Lancashire and many partner organisations worked closely together through Op. Toledo to achieve a highly effective CSE Week of Action, which commenced on Monday 9th September. Our main objectives for Op Toledo were to keep children in Lancashire safe from abusers, provide our communities with confidence in the service and protection we provide and focus attention on our commitment and effective, innovative approaches to tackling CSE & bringing offenders to justice.

To achieve these objectives during Awareness Week, we delivered a range of activities focusing on prevention, awareness, enforcement and community engagement. These included a major conference held at the Dunkenhalgh Hotel, attended by 200+ Partners/Police, at which experts in their field identified and shared best practice. We also engaged with a diverse range of communities to raise awareness about CSE and focused on making sure the information reached young people. We did this through an innovative marketing campaign designed by the office of the PCC. In addition we arrested 22 individuals for offences of using the internet to view, share and distribute indecent images and these arrests identified many further safeguarding concerns.

Overall, the many and wide ranging activities highlighted how collaborative working in effective partnerships provides powerful tools with which to successfully tackle CSE across Lancashire.

I would like to thank everyone involved in planning, organising and undertaking the many varied actions and activity that took place during the week. We now have a further opportunity to build on what we do well in Lancashire in tackling CSE and protecting children from being exploited and abused , whilst recognising there is more we can all do.

Ian Critchley

Results

Each dedicated CSE team collated information about their daily core activity. These statistics were then disseminated to all partners and to the media via our corporate communications department.

The County figures collated from the six CSE teams between 09th - 13th September are as follows:-

Number of Children Missing from the family home	**17**
Number of Children Missing From Care	**8**
New CSE Referrals	**26**
Safeguarding Measures	**27**
Section 2 /49 Notices8 (S2) 1 (S49)	
Warrants	**7**

CEOP Packages	**6**
Arrests (not relating to above)	**10**
Persons Charged	**4**
CII Arrests	**22**
Court Cases	**2**

The 10 CSE related arrests included investigations into the following;-

1 – Sexual activity with Child 12yrs**4 –** Downloading indecent images of children **1 –** Rape/Sexualtouching (2 victims 14yrs) **1 –** Rape**. 2 -** Physical Assault of 2 CSE victims**. 1 -**Grooming Offence

(*See arrest area on page 8*)

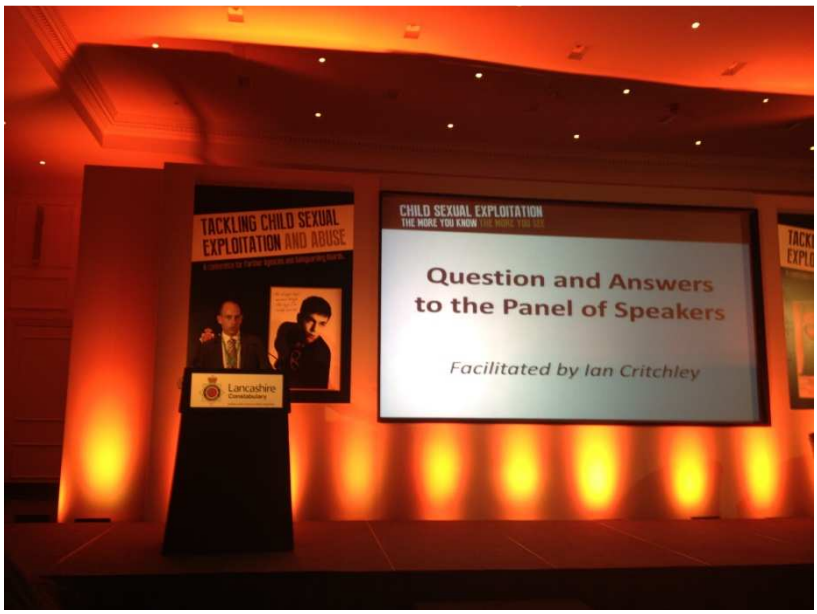
Lynne Asbridge PPU Compliance Manager facilitated a 'Cover it Live' session supported by Lancashire Constabulary Corporate Communications at Police HQ. A number of Partners attended the session, where they were able to receive typed messages from schools / public/ parents / children, asking questions on the area of E-Safety. The group then discussed the questions and prepared replies. All questions and answers will remain on the Constabulary site for a period of a few days after the event and the Media Unit are able to provide stats on how many reviews we have received.

DS Paul Burnside PPU Compliance Manager arranged 2 events delivered by Parents Against Child Sexual Exploitation (PACE) at the Legacy International Hotel, Preston. The events were attended by 87 partners from across Lancashire and the 2 Unitary Authorities. The speakers included the mother of a victim, who portrayed very openly the wider/distressing effects of one of your own children succumbing to CSE.

Evaluation comments snapshot:

- ***The case was excellent. I'm a student social worker. CSE is a new topic area for me and this was a very important viewpoint from a parent's perspective. Thank you.***
- ***Very powerful to hear directly from a parent about how CSE affected them.***
- ***The parent experiences shared and the personal account given by the parent of K was so powerful and something I will never forget. Thank you very much.***

Det. Supt Ian Critchley,Head of Public Protection, Lancashire Constabulary, facilitated a conference which was attended by over 200+ multi - agency delegates. The event was arranged through CJS events and was deemed a great success. The speakers included, **ACC Andy Rhodes**, **Ibrahim Master**, Deputy Police and Crime Commissioner, Lancashire Constabulary, **Louise Taylor**, Interim Executive Director of Children and Young People, Lancashire County Council, **Nazir Afzal OBE**, Chief Crown Prosecutor, CPS North West, a former v**ictim** from Children's Society, **Sue Berelowitz**, Deputy Children's Commissioner, **Stephanie McCourt**CEOP**, DCI Sion Hall**Lancashire Constabulary**, Det. Supt Neil Esseen**Lancashire Constabulary**, Naomi Walker**, Head of Communications and Engagement, Lancashire Police and Crime Commissioner, **Nick McPartlan**, Team Manager, Engage Team, **Emma Jackson**Victim's Story, **DCI Jonathan Holmes**Lancashire Constabularyand**Alyas Karmani**, Co-Director, STREET UK.



A fully joined up approach to the development and implementation of a new and impactive communications campaign for CSE in Lancashire was delivered by the Constabulary and the Office of the Police and Crime Commissioner. This covered all aspects of communication, both traditional and digital, and saw a new brand emerge with the focus on creating a long standing message which would resonate with not only young people but also the wider communities of Lancashire.

The brand itself, which carried the strapline 'The More You Know The More You See' and the hashtag**#** 'Know the Signs', was developed in consultation with young people, enabling the right look and feel to be created and the young person's voice to be heard clearly. The aim is as to provide an overarching call to action about pan Lancashire agencies working together to tackle CSE, specifically concentrating on internet safety, MFH, groups and gangs and trafficking.

Conference evaluation comments snapshots:

- ***All very interesting especially real life cases and police investigations, great conference!***
- ***Both victims were extremely brave in sharing their stories in their own words: (e.g. not young people but kids) I agree! Excellent speakers overall. All passionate about the topic. We need to meet CSE head on, not be afraid, call it what it is Child Abuse and deal with it very strongly. Well done - this information needs to get into Schools to educate the children, make them aware as they don't recognise this as abuse. Get the message to them and hopeful you may also target some of the potential offenders.***
- ***An excellent informative thought provoking conference. Emma Jackson's courage is inspirational. Her journey has been harrowing so brave. Thank you for sharing and giving us an insight. I wish her well in her life. Thank you for today.***

A significant communications strategy and action plan was developed and included a wide range of products and tactics. Highlights included:

- Branded products including posters, leaflets, business cards, mouse mats and stickers provided to all partner agencies for use and dissemination;
- Refreshed web banners and content;
- A full media plan, utilising all operational activity to encourage press interest and reporting. This was complemented by a wider internet safety piece which had been months in development with the BBC;
- The production of a new DVD which included comments from Tim Laughton MP, ACC Rhodes, Det Supt Critchley, Louise Taylor and a young man, who was a victim of CSE at the age of 15;
- A full social media plan, with pre-agreed Facebook and Twitter messages being published daily across all partner accounts;
- Webchats and on-line discussions on the issue of CSE and internet safety;
- A daily update of activity using the digital app, Storify;
- Messages on library screens across the county;
- Delegate packs for the conference and pull up banners;

- A video produced by Burnley Football Club outlining the signs of CSE which is played on game days and is available on YouTube, complemented by information in match programmes.

The full evaluation of this activity is still being developed but early indications show that the following was achieved;

- Media coverage was extensive, positive and accurate. Coverage was secured across all outlets nationally, regionally and locally both prior to and during the week and included a significant piece on the BBC 6 o'clock news, Radio 4 and 5 Live;

- An estimated digital audience of hundreds of thousands with the Constabulary alone achieving over 87,000 individual views of its Facebook postings, a daily Twitter audience of over 27,000 (with shares and retweets greatly increasing this basic figure) and a web audience in the region of 46,000 people at least. Content was replicated across most partner websites and via the media's digital outlets so the potential reach is hugely significant given the amount of messages and information used.

The range and diversity of awareness ranging activity during the week attested to the strong commitment by partnership organisations and helped to disseminate important information to frontline workers. It is clear that there is now a much greater opportunity to forge stronger working relationships, for example awareness briefings to bus station security staff in Preston resulted in intelligence about CSE concerns being provided to Deter. The more established areas of support for operational activity were also covered in divisions and joint visits to follow up on support to victims, work around licensing activity and the nighttime economy and awareness raising events amongst the community all featured in the week's activity. A number of good examples highlighted below.

Awaken- The Awaken Team delivered a number of CSE presentations to Partners from Health and CSC.

Three males from the Blackpool area were arrested for offences under the Protection of Children Act 1978.

A total of 8 S2 Abduction Notices were executed on potential perpetrators.

Breakthrough- Lancaster Policing area did a Facebook live Q & A session with DS Simon Coates and intensive support worker Wendy Croston relating to issues of internet safety and CSE.

PCSO's spent a shift stood in the foyers of Sainsbury's and ASDA in Lancaster and Morecambe distributing leaflets and posters and advice to members of the public.

Numerous Visits to CSE visor nominals living in Lancaster and Morecambe made and suitable advice/ checks made.

Partnership presentation given to staff and residents at Ashdean children's home regarding internet safety.

Q & A session held at the Dallas Road Mosque, over 100 people present.

Cherish – A number of visits to key stakeholders/local businesses informing them of CSE concerns in the area.

NHPT officers distributed posters and leaflets for display at local retail outlets. Officers also visited Taxi ranksand handed out Op Toledo cards.

Deter – A number of partners and the Deter team patrolled the Moor Park Area and engaged with young people. The team were accompanied by a reporter from the Daily Mirror. The evening generated a number of intelligence reports and disruption opportunities.

MAPS/Early Action Teams together with Lancashire Fire and Rescue Service conducted licensing/safety visits to hotels on Fishergate Hill and takeaways that have been linked with CSE.

The Deter Team and partners delivered a number of CSE presentationsat Preston Railway Station to Northern Rail, Virgin and British Transport Police, none of whom had any previous input on CSE. CSE presentations also given to Scout Club Leaders.

Media interview given with Rock FM to raise awareness.

Engage– Assembliesdelivered to Year 7 and Year 8 at Norden High School around internet safety, about 250 young people in total. This coincided also with the NSPCC Child abuse national launch. Awareness delivered to professionals in the health sector to encourage early identification of risk to CSE and promote referrals.

Neighbourhood officers, with Media Representatives from the BBC, Granada & Lancashire Evening Telegraph, conducted a high visibility initiative around Blackburn Bus Station. The officers displayed posters on all bus shelters and entered into dialogue with bus drivers and passengers in respect of raising awareness around child vulnerability and sexual exploitation. A total of 12 bus drivers and approximately 20-30 passengers were spoken to during this initiative.

Awareness material delivered to Brook, Sexual Health Clinic in Blackburn and Accrington. Partnership agreement signed between Engage and The Children's Residential Network in BWD to plan joint activity in respect of Children in Care in the Blackburn with Darwen Policing Area.

EngageTeam conducted a vast amount of activity within Eastern Division. Of note 54 children were open to Engage at the start of the week with a further 7 referrals received in the 5 days. All referrals responded to and allocated within 24 hours, 47 (87%) of children were visited during the week, with all high risk children visited on at least 2 occasions. Parents of 28 children visited and supported during this week.

Engage Officers attended Darwen Vale High School and completed an awareness raising presentation to approximately 200 Year 10 students. The presentation involved providing an understanding of CSE and vulnerability of young people, including internet awareness.

Multi agency mini can safe operation. High risk CSE located. At the time of the young person, she was not in immediate risk of CSE, however the intervention of calling parents and getting her home prevented a CSE opportunity for any potential perpetrator. In addition the parents of 6 further children were visited following previous referrals and all agreed to Section 2 notices being served on risky peers, with whom their daughters are associating.

Freedom- All Neighbourhood Offices within Pennine Division were visited and given posters and leaflets. Neighbourhood staff distributed this documentation to local schools, libraries, youth groups and doctors surgeries.

All secondary schools were revisited during the week by the Youth PCSO's who distributed CSE awareness material and gave information/spoke to teachers and pupils around CSE related

matters/concerns. A CSE presentation was also completed to Early Break staff to increase awareness of CSE related issues.

Awareness briefings were given to staff in the park rangers department and joint patrols were completed with park rangers with further documentation relating to sexual exploitation being distributed. Photographs were taken and shared with local media and passed out on Lancashire Constabulary's twitter feed.

Care homes were visited by Operation Freedom staff and Donna Horsfall Pennine Divisions Missing Person Coordinator to outline issues regarding sexual exploitation and care homes responsibilities to protect vulnerable residents from the risk of exploitation and reducing missing episodes involving care home residents.

Presentation completed by Op Freedom staff at St Mary's chambers Rawtenstall to SWIIS foster carers highlighting issues faced by young people in foster care and the link to CSE. Details passed to the media and photographs of the course were circulated to the media and on Lancashire Constabulary's twitter page.

Operation Toledo

Operation Toledo was a Lancashire based week of activity aimed at protecting those at risk from Child Sexual Exploitation. It ran from the 9th – 13th September 2013 inclusive and consisted of four stands of activity; publicity, education, prevention and enforcement.

In order to prepare for the operation, and the week of enforcement activity, Public Protection Unit officers worked alongside officers from the Special Operations Department to produce in excess of twenty investigative packages for subjects throughout Lancashire. These packages identified paedophiles who prey on the most vulnerable that are unable to protect themselves, the main thrust of the operation was identify those children at risk from sexual harm and initiate immediate safeguarding measures along with identifying contact offences. During the recent investigations into the tragic murders of Tia Sharp and April Jones it was identified that the perpetrators had viewed child pornography hours before committing the murders.

The investigative packages were of an extremely high standard which identified 'every move' of the offender. The quality was such that the majority of offenders have already admitted their involvement.

The operational week proved to be a huge success which was professional executed by officers throughout the county. Colleagues from 'H' Division planned the entry, arrest and search side of the operation, with the planning being meticulous throughout the week and all warrants executed in a robust and professional manner, highlighting the quality work carried out by the H Division staff who worked on the planning side of the operation.

Result

Twenty warrants executed throughout Lancashire resulting in 22 arrests and over 1000 exhibits seized. Many offenders made admissions on arrest which will ease the post arrest investigation.

Below are some of examples from Operation Toledo and other internet investigations –

- ***AG 14/05/1966 , Colne.***

This male was arrested on 04/09/13 for possession of indecent images of children and as a result the following PVP referral has been made:

Referral was made from social services after they were contacted by Airedale hospital that one of their patients KE (1 year) requires a blood transfusion. KE was taken into care 2 Days ago and has been presented at Airedale by Foster parents and it has been found that his Haemoglobin levels are extremely low and he needs an urgent blood transfusion. The Consultant is describing the requirement for a transfusion as a near miss and he wants to know why medical attention was not sought sooner .There are no safeguarding concerns as the child had been taken to a place of safety after a warrant was executed at the home address for indecent images. KE Is currently under the supervision of Dr Maudsley for anaemia. 10/09/13.

Although the plan of the local authority was to initiate proceedings due to the risk of sexual harm KE health has made this all the more important. We received the medical report from Dr Mawdsley yesterday in which 'severe neglect' is mentioned and that had the foster carer not sought medical attention KE could have died.

- **MB 25/07/86 Lancaster.**

During Operation Toledo a warrant was executed at the home address of MB where computer equipment was seized and examined. The examination revealed images of SAP levels 1 to 4. MB is so severely disabled it was not appropriate to arrested him and so special measures for his arrest have been put in place. During the course of the investigation it was identified that MB had been visited on a regular basis by a female from the West Yorkshire area, during the visits she was accompanied by her two children. Safeguarding was instigated regarding the children who have now disclosed contact offences. Investigation ongoing.

- **JE22/05/89 Fulwood.(live abuse detected)**

Initial interaction was on 07/04/11 where JE engaged with whom he believed to be a 13yr old female and attempted to groom the same. An intelligence package was forwarded to Preston Division and as a result of a warrant and subsequent protracted investigation JE was charged on 02/05/2012 with 15 x offences relating to inciting children (one 9yrs old) to engage in sexual activity and making indecent images of children. JE appeared at Preston Crown Court on 14/08/12 and was convicted for making indecent images of children and inciting a child under 13 years to engage in sexual activity. On 14/09/12 JE was sentenced to 3 years imprisonment, SOPO for 5 years and is disqualified from working with children.

- **AW 11/10/1962 Preston.(Dentist)**

Initial interaction was on 16/03/11 whereby over a period of time AW engaged with whom he believed was a 13 year old female over the internet and arranged to meet the female outside Blockbuster Video on Corporation Street, Preston. He was arrested at the meeting point and subsequently charged with inciting a female to engage in sexual activity. AW was a Dentist based at the clinic at Preston. On 18/01/2013 AW was found guilty by unanimous decision of attempting to arrange or facilitate the commission of a child sex offence. He was sentenced on 08/03/13 to 12

months imprisonment suspended for two years, disqualified from with working with children and has to sign the Sex offenders Register.

Divisional Arrests

Awaken (Western Division) **3**

Breakthrough (Northern Division)**2**

Cherish (Southern Division)**2**

Deter (Central Division)**1**

Engage (Eastern Division)**1**

Freedom (Pennine Division) **1**

A total of **32** arrests were made during the week as part of Op Toledo.

Finally……..

Some comments from officers/Police staff that were involved in the week long activity:

I'm sure everyone is aware that over the past week the Constabulary has come together with partners to undertake a week of action aimed at preventing child sexual exploitation. I have been fortunate enough to work with Divisional searchers and colleagues from DASOU, Special Operations and the High-Tech Crime Unit throughout this week undertaking enforcement activity against suspected offenders, and at risk of sounding overly sentimental it has done my heart good this week to see colleagues taking such delight in their work. This is not because we have enjoyed turning suspected child sex offenders out of bed at 5am (although that has been a bonus…..), but because it has reminded us all of the reason why we joined the police service in the first place- to protect the people who cannot protect themselves. Recently there has been a pleasing move away from a target-driven culture toward one which puts those most at risk of harm at the top of our agenda and activity such as this has been a timely reminder of the need to ensure we best align our resources to protect those most at risk of harm.

Having worked the full week on Op Toledo executing the warrants and completing the searches has been for me a very rewarding week and no doubt for everyone else involved, I hope there will be more weeks like this and would be first in line to volunteer my services. A great week great results and great teams.

I worked as a member of the search team for Operation Toledo, even though at times this was a challenging experience, this was an immensely worthwhile operation which I was proud to be part of and hopefully will continue on and in my opinion should continue with a dedicated team.

I was lucky enough to be involved in the search aspect of this operation and I have to say that it was one of the most rewarding and best-run operations that I've been involved in. The feeling of satisfaction we got from targeting high-end offenders, who would otherwise have been completely undetected, more than made up for the early starts. I would happily volunteer my services for any further operations that the force runs.

Having worked the full week as part of the search team on Op Toledo, I found the experience very rewarding and worthwhile, targeting offenders who prey on innocent victims causing a lifetime of hurt.

It has been very emotional seeing the effect that this has on the families of the offenders and despite the early starts and late finishes I would jump at the opportunity to volunteer for future operations

Good idea to hear from people on Toledo how they thought it went because of the threads on the performance culture and the negative aspect of 'chasing the numbers'. Toledo isn't about a numbers game it's about tackling sexual abuse of vulnerable children, wherever in the world they may be. So nobody is asking or demanding that we put effort into this apart from ourselves. We are never going to stop locking up burglars etc., nobody wants to be burgled - my point here is that this type of work IS performance - high quality, victim impact performance that everyone joined the job to do. It's purposeful and it's what protecting vulnerable people is all about. We don't need to hit any reds or greens with this type of work but our staff need to know how much we value what they are doing in this area of work just as much as locking up burglars and prolific criminals etc. . Personally I've enjoyed being told at 7am every morning this week that we've locked up paedophiles, I would like to hear that every day. Glad you enjoyed being on the op there are more planned.

Report to the Health and Wellbeing Board
Meeting to be held on the 15th October 2013

Electoral Division affected:
All

Briefing on the CCG Allocations - Fundamental Review of the NHS Allocation Policy

Contact for further information:
Dr. Sakthi Karunanithi, (01772) 539846, Adult Services, Health and Wellbeing
sakthi.karunanithi@lancashire.gov.uk

Executive Summary

NHS England is currently reviewing the formula for allocation of resources across the full range of its responsibilities, covering both allocations to CCGs and the budgets available for direct commissioning functions in area teams. We do not know whether there will be a change in the formula. The effect of any potential changes to the formula will also be dependent on the pace of change policy that will be put into place. However, compared to the existing allocations to the CCGs, if the proposed new formula comes into place it appears that the allocations to Lancashire County Council linked CCGs will decrease by £29m. Nationally, this would reduce NHS funding in the parts of the country with the worst health outcomes by £30 per head and increasing the funding in areas with the best outcomes by the same amount. This is on top of the £200 per head that has been cut from local authority budgets in those same areas with the worst health outcomes.

Recommendation

It is recommended that the Lancashire County Council Health and Wellbeing Board:

1. Seek to establish a shared understanding of the impact of the fundamental review of allocations policy on the joint NHS resources available for Lancashire, including the allocations for the CCGs and NHS England's direct commissioned and specialised commissioned services.

2. Agree to respond to NHS England's review that
   - the proposed funding formula will adversely affect the health outcomes and inequalities in Lancashire,
   - the impact of future NHS allocations should be considered in the context of wider local government funding allocation process, and
   - further consultation should be done before the pace of change policy is established

Lancashire County Council

1. Background and Advice
Context

NHS England is currently reviewing the local allocation of resources across the full range of its responsibilities, covering both allocations to CCGs and the budgets available for direct commissioning functions in area teams. A series of workshops are being held across the country with a view to agree the policy at the Board meeting in December.

Implications for Lancashire

With the fundamental review of the NHS allocation policy still on-going, the implications for Lancashire health economies are not entirely clear. We do not know whether there will be a change in the formula. This will also be dependent on the pace of change policy that will be put into place. However, compared to the existing allocations to the CCGs, if the proposed new formula comes into place it appears that the allocations to Lancashire County Council linked CCGs decrease by £29m. The Fylde coast and West Lancashire health economies will see a rise of approximately £4m and £7.5m. Feedback from West Lancashire CCG suggests that their allocation might only rise by £1m following the technical adjustments for specialised commissioning. For all other health economies, the funding will decrease over a period of time that is yet to be established. For example, the allocation for East Lancashire CCG will decrease by £20m; Lancashire North and Chorley, South Ribble and Greater Preston CCGs will see a decrease of at least £13m and £2m respectively.

Although there is some clarity on CCG allocations, further information is needed on how the allocation for NHS England's directly commissioned services, including the specialised commissioning services, is set to change as a result of the allocation policy.

Further clarify is also needed on the potential impact of tariff reductions to the provider organisations and its impact on the health services in Lancashire.

Wider implications

The new allocation formula that was proposed by the resources allocation group (ACRA), now being reviewed by NHS England, would severely disadvantage poorer parts of the country. It would reduce NHS funding in the parts of the country with the worst health outcomes by £30 per head and increasing the funding in areas with the best outcomes by the same amount. This is on top of the £200 per head that has been cut from local authority budgets in those same areas with the worst health outcomes[1].

[1] Source: Ben Barr, Senior Clinical Lecturer in Applied Public Health, University of Liverpool.

Recommendations

It is recommended that the Lancashire County Council Health and Wellbeing Board consider the following:

1. Seek to establish a shared understanding of the impact of the fundamental review of allocations policy on the joint NHS resources available for Lancashire, including the allocations for the CCGs and NHS England's direct commissioned and specialised commissioned services.

2. Agree to respond to NHS England's review that

- the proposed funding formula will adversely affect the health outcomes and inequalities in Lancashire,
- the impact of future NHS allocations should be considered in the context of wider local government funding allocation process, and
- further consultation should be done before the pace of change policy is established

Consultations

N/A

Implications:

N/A at this stage

Risk management

There are no risk management implications arising from this report at this stage.

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

Paper	Date	Contact/Directorate/Tel
Working paper on 2013/14 CCG allocations, Indicative Target Allocations and Distance from Target – Available from http://www.england.nhs.uk/2013/08/15/rev-all-wrkshp/	15th August 2013	Sakthi Karunanithi/ Adult Services, Health and Wellbeing/01772 539846
Reason for inclusion in Part II, if appropriate		

Lancashire Health and Wellbeing Board
Meeting to be held on 15th October 2013

Electoral Division affected: All

Report from the Joint Officers Group meeting held on the 4th October 2013
(Appendices 'A' 'B' and 'C' refer)

Contact for further information:
Dr. Sakthi Karunanithi, (01772) 539846, Adult Services, Health and Wellbeing Directorate,
Sakthi.karunanithi@lancashire.gov.uk

Executive Summary

The joint officers group met on the 4th October 2013. This paper reports the key actions from the meeting.

Recommendation

The Lancashire Health and Wellbeing Board are asked to:

(i) Endorse the communications and engagement strategy for the Health and Wellbeing Board.
(ii) Agree that JSNA analysis on health behaviours and Health and Wellbeing Strategy 'shifts' be undertaken within the 2013/14 work programme.
(iii) Support the process to conclude the funding transfer from NHS England to Lancashire County Council adult social care services.

1. Background and Advice

The Health and Wellbeing Board, at its meeting on 24th July 2013 established the Joint Officers Group to support the operational delivery of its core functions. These include developing proposals for the Joint Strategic Needs Assessment, supporting the implementation of the Health and Wellbeing strategy, coordinating the commissioning plans, and developing health and care integration plans to be agreed by the Board.

2. Key actions from the Joint Officer Group

The joint officers group met on the 4th October. Key actions following the meeting include:
1. Agreed to review and update the progress being made on the health and wellbeing strategy delivery plan
2. Develop the Board's communications and engagement plan (please refer to Appendix 'A')

Lancashire County Council

3. Propose the topics for the JSNA analysis to be undertaken in 2013/14 (please refer to Appendix 'B')
4. Developed the process to conclude the funding transfer from NHS England to Lancashire County Council to support adult social care services that also benefit the NHS. (Please refer to Appendix 'C')

Consultations

N/A

Implications:

This item has the following implications, as indicated:

Risk management

N/A

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

Paper	**Date**	**Contact/Directorate/Tel**
Minutes of the Health and Wellbeing Board – 24th July 2013-10-11	24th July 2013	Andy Milroy / OCE / 01772 536050

Reason for inclusion in Part II, if appropriate

N/A

Communications Strategy for Health and Wellbeing Board

Date: September 2013

Author: Ginette Unsworth, Communications Account Director

Lancashire County Council

www.lancashire.gov.uk

Background

The Health and Social care Act 2012 established health and wellbeing boards as a forum where key leaders from the health and care system would work together to improve the health and wellbeing of their local population and reduce health inequalities.

Each top tier and unitary authority has its own health and wellbeing board. Board members collaborate to understand their local communities' needs, agree priorities and encourage commissioners to work in a more joined up way. As a result, patients and the public should experience more joined-up services from the NHS and local councils in the future.

Health and wellbeing boards are a key part of broader plans to modernise the NHS to:

- ensure stronger democratic legitimacy and involvement
- strengthen working relationships between health and social care, and,
- encourage the development of more integrated commissioning of services.

As such, Lancashire's health and wellbeing board will help give communities a greater say in understanding and addressing their local health and social care needs.

Objectives

- To increase awareness amongst the public of the outcomes achieved through the work of the board
- To publicise the progress of the Health and Wellbeing Board to all relevant partners both within and outside the NHS
- To present the board as a campaigning/lobbying body for the health and wellbeing of the people of Lancashire

Target Audience

The board has a principally strategic role; therefore the majority of communications activity will be targeted at health professionals, partners and key influencers, to convey the board's vision for improving health and wellbeing across Lancashire and explain the role they have to play in helping to deliver it. Only high level messages will be communicated to the public when relevant and will be used to update on how Lancashire is achieving against its objectives for better Health& Wellbeing.

Key stakeholders will include;

<u>Member organisations of the board</u>

- Clinical Commissioning Groups

- NHS trusts
- County Council (elected members, officers)
- District councils (elected members/officers)
- Healthwatch
- Health providers
- Third sector

Other key stakeholders

- Health & Wellbeing Partnerships
- District Health Leads
- Lancashire Economic Partnership
- Community Safety partnership
- Children's Trust Partnerships
- MPs

Members of the public

- General public
- In particular those who are affected by health & wellbeing issues that form part of the board's priorities

Key Messages

- The Health and Wellbeing Board aims to be the driving force for health& Wellbeing in Lancashire, acting as the focal point for health and social care organisations and professionals to agree goals and lead change
- Our strategy to join up services will help avoid duplication amongst other health professionals and provide more efficient services to our communities
- We will listen to our communities' and patients' feedback to help ensure they have access to appropriate services that can help them improve their health

Strategy and Approach

The content of the communications will primarily be produced and delivered by colleagues supporting the Health and Wellbeing board, while the Communications Service will set up and provide the tools to enable this to happen and lead on media activity. The following channels will be used to communicate with stakeholders and the general public:

Brand

A new brand will be required to be used across all materials and distinguish the board as a separate body. This will be designed by the Communications Service and will need to be agreed by the board.

The agreed brand will flow across all visual materials included on-line and hard copy publications. Templates will be produced for an electronic newsletter, report document etc.

Newsletter

A quarterly electronic newsletter will be produced to be sent to all key stakeholders and be added to the website. The electronic template will be designed by the Communications Service but the content of the newsletter will be produced and disseminated by officers providing direct support to the Health and Wellbeing board.

A six monthly electronic/hardcopy newsletter should also be considered for the public, which communicates the key performance/changes to frontline services, which has a local feel and is very much front line service focused.

Media

Proactive media relations will be used at regular intervals throughout the year to highlight improvements and changes to the health &wellbeing of Lancashire residents, calls to action on how people can help themselves improve their health, and changes in services that will benefit communities. The work of the board will also be cross referenced in media relations carried out around campaigning activities where the link between the two stories is relevant.

The Communications Service will coordinate all proactive media activity and also handle reactive media enquiries, calling on members of the board to act as spokespeople when required.

Events

Different events throughout the year could be held with key stakeholders to share ideas and update on progress. This could involve holding the Board meeting at different locations throughout the year and linking in with other activity happening in a particular area, that could also be used as a media opportunity.

Bite sized briefings will be arranged for councillors to update them on progress a couple of times a year.

Speaking opportunities for Board members could be identified and used as a channel to communicate the work of the board to different target groups.

Materials using the brand will be created to support such activity as and when required.

Website

The website will be updated to convey the new brand and will be used to share relevant documents to the public and professionals. The website will also provide access to the archived quarterly newsletter updates. The website will be updated to reflect the new Lancashire County Council website style which is currently being implemented.

Social media

A 'thought leader' on the Health and Wellbeing board will be identified to utilise Twitter as a means of updating professionals on the work of the board. Guidance will be provided on the use and set up of the account. The corporate Facebook and Twitter accounts will be used for general public messages in line with any media relations.

Engagement of MPs

It is recommended that the Chair of the Board along with other key Health & Social Care influencers has a regular dialogue with Lancashire MPs on the progress of the board and challenges faced by Lancashire on the Health & Wellbeing issues. MPs could be included in the update newsletter but it is also recommended that a face to face meeting is arranged once a year.

Assumptions

This strategy assumes a co-ordinated communications approach amongst professionals that represent the Board. Core scripts will created for key issues to ensure a consistent message.

Campaigns that are delivered by the representative organisations on the Board, will be used as examples of the overall Board's achievement in a strategic context.

Targets

- Four electronic newsletters issued annually
- £100k of media coverage (advertising equivalent) achieved annually for Health and Wellbeing Board messages

Budget

TBC

Contact Information

Please do not hesitate to contact us should you have any questions or would like to discuss any element of this strategy.

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Appendix B - Lancashire Joint Strategic Needs Assessment - Proposals for bespoke analyses 2013/14

1. Introduction

This paper sets out proposals to the Health and Wellbeing Board for bespoke thematic analysis to be undertaken in 2013/14 as part of Lancashire's Joint Strategic Needs Assessment.

2. Background to Lancashire's JSNA

Lancashire's Joint Strategic Needs Assessment (JSNA) aims to enable partners to set intelligence based commissioning priorities. The JSNA approach has three main strands: the web platform to share intelligence and insight; thematic JSNA projects to provide depth and understanding; and ongoing support.

Thematic JSNAs are delivered each year and are commissioned, strategic analytical projects that deliver prioritised recommendations to decision-makers and commissioners. The projects are done in partnership, with both analysts and specialists, and with decision makers. Every thematic JSNA has a project sponsor and lead. Following a scoping exercise with stakeholders, a project group delivers the analysis and interpretation, whilst a wider reference group is used to shape the recommendations and priorities. Literature reviews are undertaken during the project to inform direction and to identify best practice in the topic area. Finally stakeholders are consulted on the recommendations to ensure they are appropriate.

Each thematic JSNA provides a county-level report, along with summaries for CCGs and district council areas. The timings of each JSNA fit into the commissioning and budgeting cycle.

3. Developing a programme for 2013/14

An item on the JSNA work programme was discussed at May's Health and Wellbeing Board. At that meeting it was agreed that a Joint Officer Group should be established to ensure the implementation of the decisions that the Health and Wellbeing Board makes. One of the responsibilities for that group will be developing proposals for the JSNA annual work programme. Lessons over the previous five years tell us that the people that need to use JSNA intelligence should be fully engaged in deciding what intelligence is needed and the Joint Officer group is ideally placed to develop proposals for thematic JSNA projects. The proposals for the JSNA work programme have been developed by the JSNA team and the three Directors within public health. The Joint Officers Group was informed of the proposal for this year. For the future years, the Joint Officers is ideally placed to recommend the topics for bespoke JSNA analyses to the Health and Wellbeing Board.

4. Proposals

There have been three proposals for bespoke JSNA analyses for 2013/14. These are summarised below.

I. Health behaviours

Healthy behaviours such as sensible drinking of alcohol, being physically active, eating well and managing stress are known to prevent a wide range of health problems across the life course. Behaviours such as smoking tobacco, misusing drugs and alcohol and unsafe sex put people at particular risk of ill health. In Lancashire we have very limited intelligence about the prevalence of different health behaviours across population groups or the characteristics of people with different health behaviours. We don't know what assets there are in our communities that enable and support healthy behaviours. Neither do we know how many people participate in more than one risk taking behaviour or the scale of the various combinations of unhealthy behaviours. Health and Wellbeing Board partners have committed to invest a greater proportion of their resources in prevention as one of the 'shifts' within the strategy. A greater understanding of health behaviours would help us identify where resources invested in prevention can most effectively be deployed.

The intelligence that partners currently hold on health behaviours largely comes from our services and is therefore limited as indicators of needs or assets. This work would therefore utilise intelligence from a proposed population health survey which is being explored by the County Council in collaboration with partners from Blackpool and Blackburn with Darwen Councils (subject to necessary approvals), and which would ask people about their own health behaviour.

Work is planned to develop integrated services and pathways to support healthy behaviours and a JSNA analysis on health behaviours would be able to influence the priorities for this work.

II. Intelligence to inform delivering the health and wellbeing strategy shifts

The Health and Wellbeing Board has committed to delivering six 'shifts' within the Health and Wellbeing Strategy. These represent significant changes in how we will deliver better health outcomes, improve citizen's experience of our services and provide the best possible value. The shifts are:

- Invest a greater proportion of our resources to prevent ill health
- Build and utilise the assets of our citizens and communities
- Promote greater self-care and responsibility for health
- Deliver accessible services within communities

- Make joint working the default option
- Narrow the gap in health and wellbeing and its determinants

Health and Wellbeing Board Partners do not have an accurate picture of the current position in relation to these 'shifts' or intelligence about what the priorities are in actually delivering these changes within our commissioning and service development plans. We don't have a full understanding how the health and wellbeing strategy delivery plan will impact on these 'shifts' and therefore what else we will need to do together to make these changes happen between now and 2020.

Work is already underway to develop the JSNA to include intelligence about community assets and this could be captured formally in this analysis. JSNA analysis on health inequalities will be published in the next two months. Additional intelligence provided through this work could include partner spend, activity and outcomes in relation to prevention and integration, levels of health literacy and perceptions about self-care and understanding more about the needs and assets in relation to services in community settings. This intelligence could then influence the on-going delivery of the Health and Wellbeing Strategy.

III. Sexual health analysis

An additional proposal has been submitted to undertake a JSNA analysis on sexual health which will inform the commissioning of sexual health services. Commissioning of sexual health services is largely the responsibility of public health within local government and the CCGs and it is proposed that a health needs assessment of sexual health be undertaken within the public health team and be published on the JSNA website, rather than undertaken as a thematic JSNA.

5. Recommendations

The Health and Wellbeing Board is asked to agree that JSNA analysis on health behaviours and Health and Wellbeing Strategy 'shifts' be undertaken within the 2013/14 work programme.

Report Author:

Deborah Harkins, Director of Health Improvement, Lancashire County Council.

Appendix C - Funding Transfer from NHS England to social care 2013/14

1. Context

In the 2011/12 Operating Framework for the NHS in England, the Department of Health set out that PCTs would receive allocations in 2011/12 and 2012/13 for transfer to local authorities to support adult social care services that also benefit the NHS.

For 2013/14, the NHS England Lancashire Area Team has been allocated £19,750,385 to transfer to Lancashire County Council to support adult social care services.

2. Legal basis for the transfer

NHS England is to enter into an agreement with the local authority to be administered by the NHS England Area Team. The payments are to be made via an agreement under Section 256 of the 2006 NHS Act.

3. Use of the funding

The funding must be used to support adult social care services in the local authority, which also has a health benefit. However, beyond this broad condition, flexibility is provided for local areas to determine how this investment in social care services is best used.

4. Role of the Health & Wellbeing Board

The joint local leadership of Clinical Commissioning Groups and local authorities, through the Health and Wellbeing Board, is at the heart of the new health and social care system.

Local authorities should agree with local health partners how the funding is best used within social care, and the outcomes expected from this investment. The Health and Wellbeing Boards are expected to be the forum for discussions between the Area Team, CCGs and the local authority on how the funding should be spent.

5. Recommendation

The County Council will engage in local discussions with CCG partners in order to achieve local agreement of spending plans in the coming weeks, after which the agreed spending plans will be submitted to the NHS England Lancashire Area Team in the form of a completed section 256 template. The NHS England Lancashire Area Team will then be asked to sign this agreement on behalf of NHS England to authorise the funding transfer.

It is recommended that the Health & Wellbeing Board endorse the process outlined above in order to conclude the funding transfer.

Report Author: Khadija Saeed, Senior Business Partner, County Treasurer's office, Lancashire County Council