Lancashire Health and Wellbeing Board

Lancashire County Council

Lancashire Health and Wellbeing Board
Monday, 24 October 2016, 10.00 am,
Cabinet Room 'C' - The Duke of Lancaster Room, County Hall, Preston

AGENDA

Part I (Open to Press and Public)

Agenda Item	Item for	Intended Outcome	Lead	Papers	Time
1. Election of Chair for the Meeting	Action	To elect the Chair for the meeting.	Clare Platt		10.00am-10.05am
2. Welcome, introductions and apologies	Action	To welcome all to the meeting, introduction and receive apologies.	Chair		10.05am-10.10am
3. Disclosure of Pecuniary and Non-Pecuniary Interests	Action	Members of the Board are asked to consider any Pecuniary and Non-Pecuniary Interests they may have to disclose to the meeting in relation to matters under consideration on the Agenda.	Chair		10.10am-10.15am
4. Minutes of the Last Meeting	Action	To agree the minutes of the previous meeting.	Chair	(Pages 1 - 86)	10.15am-10.25am

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

Agenda Item	Item for	Intended Outcome	Lead	Papers	Time
5. LSAB Annual Report	Information	To receive and discuss the Annual Report.	Jane Booth	(Pages 87 - 120)	10.25am-10.35am
6. LSCB Annual Report	Information	To receive and discuss the Annual Report.	Jane Booth	(Pages 121 - 122)	10.35am-10.40am
7. Lancashire CYP Emotional Wellbeing and Mental Health Transformation	Information	To receive the quarterly update on the transformation.	Dave Carr, Policy, Information and Commissioning (Start Well)/Shirley Waters, NHS Commissioning Support Unit	(Verbal Report)	10.40am-10.55am
8. CQC Report and Action Plan	Information	To discuss the report and the action plan.	Sakthi Karunanithi	(To Follow)	10.55am-11.10am
9. Emergency Care Crisis - Chorley: report of the Health Scrutiny Committee	Action	To note the request from Health Scrutiny.	CC Steven Holgate	(Pages 123 - 148)	11.10am-11.25am
10. Health and Care Integration	Information	To receive the report.	Sakthi Karunanithi	(Verbal Report)	11.25am-11.40am
11. Managing Demand	Discussion	To discuss progress on utilising the Better Care Fund (BCF) to support and fund more preventive activity.	Louise Taylor	(Verbal Report)	11.40am-11.50am
12. Development of the Pan Lancashire Health and Wellbeing Board	Information	To receive an update and discuss the report.	Clare Platt	(To Follow)	11.50am-12.05pm

Agenda Item	Item for	Intended Outcome	Lead	Papers	Time
13. Urgent Business	Action	An item of Urgent Business may only be considered under this heading, where, by reason of special circumstances to be recorded in the minutes, the Chair of the meeting is of the opinion that the item should be considered at the meeting as a matter of urgency. Wherever possible, the Chief Executive should be given advance warning of any Members' intention to raise a matter under this heading.	Chair		12.05pm-12.10pm
14. Date of Next Meeting	Information	The next scheduled meeting of the Board will be held at 10.00am on 13 December 2016 in Cabinet Room 'D' – Henry Bollinbroke Room at County Hall, Preston.	Chair		12.10pm-12.15pm

I Young
County Secretary and Solicitor

County Hall
Preston

Lancashire Health and Wellbeing Board

Minutes of the Meeting held on Friday, 2nd September, 2016 at 10.00 am in Cabinet Room 'D' - The Henry Bolingbroke Room, County Hall, Preston

Present:

Chair

County Councillor Jennifer Mein, Leader of the County Council

Committee Members

Dr Sakthi Karunanithi, Director of Public Health and Wellbeing, LCC
Louise Taylor, Corporate Director Operations and Delivery (LCC)
Bob Stott, Director of Education, Schools and Care, LCC
Councillor Bridget Hilton, Ribble Valley Council representing Central Lancashire District Councils
Michael Wedgeworth, Healthwatch Lancashire Interim Chair
Gary Hall, Chief Executive, Chorley Council representing CEOs of Lancashire District Councils
Councillor Hasina Khan, Chorley Borough Council
David Tilleray, Chair West Lancs HWB Partnership
Clare Platt, Health Equity, Welfare & Partnerships
Cllr Viv Willder, Fylde Borough Council
Mark Youlton, East Lancashire CCG
Jacqui Thompson, North Lancashire NHS
Jan Ledward, Chief Officer - Chorley & South Ribble and Greater Preston CCG
Paul Kingan, West Lancashire CCG

Present

Clare Platt, Head of Health, Equality, Welfare and Partnerships, LCC
Mike Kirby, Director of Corporate Commissioning, LCC
Roger Baker, Lancashire and South Cumbria Change Programme, NHS
Sam Nicol, Director, Lancashire and South Cumbria Change Programme, NHS
Gemma Jones, JSNA Manager, LCC
Sam Gorton, Clerk, Legal and Democratic Service, LCC

Apologies

County Councillor Azhar Ali	Cabinet Member for Health And Wellbeing (LCC)
County Councillor Tony Martin	Cabinet Member for Adult and Community Services (LCC)
County Councillor Matthew Tomlinson	Cabinet Member for Children, Young People and Schools (LCC)
County Councillor David Whipp	Lancashire County Council
Tony Pounder	Director of Adult Services
Dr Tony Naughton	Fylde & Wyre CCG
Sarah Swindley	Third Sector Representative

Jane Booth	Independent Chair, Lancashire Safeguarding Children's Board
Mark Bates	Assistant Chief Constable, Lancashire Constabulary
Dee Roach	Lancashire Care NHS Foundation Trust (on behalf of Heather Tierney-Moore)

1. Welcome, introductions and apologies

Welcome and introductions were made.

Apologies were noted as above.

Replacements were as follows:

Jan Ledward for Dr Gora Banghi (Chorley and South Ribble Clinical Commissioning Group (CCG)) and Dr Dinesh Patel (Greater Preston CCG)
Jacqui Thompson for Dr Alex Gaw (Lancashire North CCG)
Paul Kingan for Dr John Caine (West Lancashire CCG)
Paul Havey for Karen Partington, Lancashire Teaching Hospitals

2. Disclosure of Pecuniary and Non-Pecuniary Interests

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

3. Minutes of the Last Meeting

The Board were asked to agree the minutes with the following additional paragraph to Item 10 – Lancashire CYP Emotional and Mental Health Transformation, being inserted after the paragraph beginning 'Following on from the CQC Inspection… on page 5.

'The Board welcomed the progress report. It challenged the pace of change, particularly in improving access and the care of the most vulnerable. Specific concerns will be highlighted to the programme via the LSCB. The Board requested further updates on a regular basis'.

Resolved: that the Board agreed the minutes of the meeting held on 13 June 2016 with the addition of the amendment as detailed above.

Matters Arising from the Minutes

Following on from the CQC Inspection, the final report was issued on 17th August, following which, 20 days are given to present the action plan to the CQC for them to agree it, which makes the submission date for the plan, 15 September 2016.

The action plan is currently being drawn up from the report and this will be presented to the Board at the next meeting on 24 October.

Resolved: the Board to receive the action plan at the next meeting in October.

4. Amendments to JSNA Leadership Group terms of reference

The Board were asked to agree the suggested amendments as detailed in the report.

Discussion ensued as to whether there was a need for a Safeguarding representative on the Joint Strategic Needs Assessment (JSNA) Leadership Group. The Director of Adult Services is on the group so safeguarding is represented, however it was felt that someone from the Lancashire Adult Safeguarding Board (LASB)/Lancashire Children's Safeguarding Board (LSCB) should also be a member of the JSNA Leadership Group

Resolved: i) that the Board approve the amendments to the Terms of Reference for the Joint Strategic Needs Assessment (JSNA) Leadership Group.

ii) that Gemma Jones presents the suggestion to the JSNA Leadership Group, as made by the HWBB, that a member from LASB/LSCB be added to the membership.

5. Q1 Better Care Fund (BCF) Report

Paul Robinson presented to the Board the attached Powerpoint.

In terms of Delayed Transfers of Care (DTOC) it was noted that:

- A DTOC Plan (with targets) was required.
- Five plans to be drawn into one.
- A pan Lancashire planning group has been set up including Blackburn with Darwen and Blackpool and met in June and are due to meet again in September.
- Connections are being made to existing activities e.g. 90 day DTOC Rapid Improvement programme.
- Coordination with the NHS England NHS Improvement and Association of Adult Social Services (ADASS) 2016/17 Accident and Emergency Improvement Plan was required.

District Councils are also reviewing the Disabled Facilities Grant (DFG) activity and are engaged in the BCF Governance. A meeting will be held on 22 September where all District Councils will look at what they can offer to the BCF and this will also include the Voluntary, Community and Faith Sector (VCFS).

Blackpool and Blackburn with Darwen are doing some BCF work which is overlapping and feeding into the STP programme.

Concern was raised over what discussions were being had with the Morecambe Bay health/social care economy.

It was recognised that performance of individual schemes needs to be reported on too, so that what is working can be rolled out.

Resolved: i) Paul to report back on Quarter 2 at the December meeting and include information about individual schemes in the reporting, in particular reablement/rehabilitation schemes.

ii) Paul agreed to speak with Lancashire North CCG and have discussions around Morecambe Bay on the BCF.

6. Better Care Fund (BCF) Evaluation

Paul Robinson presented the evaluation as requested by the HWBB as attached in the agenda.

Discussion following the presentation was around the perceived lack of progress/change as a consequence of BCF scheme activity. It was pointed out that the BCF relates only to adults over 65 years of age. There still needs to be better joint working between CCGs, District Councils, NHS and Lancashire County Council.

I Performance information needs to be compared in terms of the planned savings from Non-Elective Admissions (NEA) and Delayed Transfers of Care (DTOC) against the actuals. While it appears to demonstrate a lower level of saving than anticipated, it does not take into account factors such as increase in demand and complexity of need, which may underplay the level of financial savings made through BCF scheme activity.

There was consensus about the need to work more effectively in collaboration in order to transform the system, moving resources into preventive activity. There was discussion about reablement as a means of reducing demand, but where more resources are needed, to scale up activity.

Similarly Disabled Facilities Grant (DFG) activity helps keep people safe and health at home, but need to be used more effectively. Funding from the BCF pool could be used to support reablement and DFG activity, and linking to other services such as home improvement services.

Resolved: i) The BCF schemes need to be reviewed and then recommendations about those which are most effective and provide value for money identified for progression by the BCF Steering Group.

ii) Representatives of district councils on the Board need to ensure that relevant information is passed on to other district council colleagues.

7. Lancashire and South Cumbria Change Programme (LSCCP) and Sustainability Transformation Plan (STP) Update

Sam Nicol was welcomed to the meeting along with Roger Baker, Involvement Communications and Engagement Director who was introduced to the Board for the first time.

Sam spoke to the report that was circulated with the agenda. It was noted that the Lancashire and South Cumbria Change Programme Board (LSCCPB) had met twice and a third meeting was planned. The Board welcomed the offer of an update following each meeting of the LSCCPB.

The detailed STP narrative needs to be submitted by 21 October 2016. Discussion ensued around the narrative that needs to be submitted before the next HWBB meeting and whether a joined up approach would be more effective with Blackpool, Blackburn with Darwen and South Cumbria going forward. The Board welcomed this suggestion along with Sam and Roger, and it was agreed that Sam Gorton look to arrange a special meeting, Pan-Lancashire including South Cumbria where an update will be provided prior to submission.

The Board requested an update at the next meeting on solutions and workstreams.

It was noted that the CCGs have agreed a Joint CCG Group to help design the offer across the localities.

Resolved: i) that the Board agree the recommendations as set out in the regular report back to HWBB.

ii) As agreed by the HWBB, Sam Nicol to provide a Director's report from the LSCCPB meetings.

iii) To receive an update at the meeting in December on solutions and workstreams.

iv) To hold a special meeting to ensure the STP narrative is shared ahead of submission on 21 October 2016.

Roger stated that there was ongoing engagement and work in Lancashire is consistent with that across Blackpool and Blackburn with Darwen. If anybody feels that there are any gaps that need addressing to contact Roger direct, email roger.baker3@nhs.net.

8. Development of Pan Lancashire HWBB

Following on from the Pan Lancashire HWBB Summit meeting that was held on 26 July 2016, there was an agreement that this was the way forward and discussions were held around the model, democratic and governance issues around the Terms of Reference and Memorandum of Understanding.

A Pan Lancashire approach will strengthen local delivery and enable better planning with the BCF for 2017/18. The JSNA is currently developed on a Pan-Lancashire footprint, then drills down to the five health economy areas and then further still to districts.

Legislative requirements are currently being considered by legal officers.

The next steps are that a report will be presented to Lancashire Leaders on 15 September 2016 and the final framework will be agreed in October.

A paper will come back to the HWBB on 24 October with a further update. It is anticipated that a report will then be presented to Cabinet on 10 November 2016 and to Full Council on 15 December 2016; with powers transferred to the Pan Lancashire HWBB in May 2017.

Members of the Board were advised to look at the proposals and participate in the discussions going forward.

Resolved: that the Board receive an update at the next meeting on 24 October 2016.

9. Urgent Business

There were no matters of urgent business received.

10. Date of Next Meeting

The next scheduled meeting of the Board will be held at 10.00am on Monday, 24 October 2016 in the Duke of Lancaster Room – Cabinet Room 'C', County Hall, Preston.

Details of the special meeting which will take place before the next scheduled meeting to discuss the STP will be forwarded as soon as possible.

I Young
Director of Governance,
Finance and Public Services

County Hall
Preston

Lancashire Health and Wellbeing Board
Meeting to be held on *24 October 2016*

Lancashire's Local Digital Roadmap

Contact for further information:
Declan Hadley, Digital Health Lead, Healthier Lancashire & South Cumbria Change Programme
Tel: 0750 785 7000. Email: declanhadley@nhs.net

Appendix 'A' refers

Executive Summary

Lancashire's Local Digital Roadmap (LDR) is a Clinical Commissioning Group (CCG) lead process, hosted by East Lancashire. Within the Lancashire LDR, five delivery themes have been outlined that build on the established Lancashire & South Cumbria Digital Health Board programme:

- *Electronic record sharing* - Supporting safe, effective and efficient care by sharing healthcare records across organisational boundaries
- *Empowered Citizen* – Giving people access to their healthcare records, to new online services and seeking to improve digital health literacy
- *Enabled Citizens* – Using technology to enable care closer to / in the home, supporting new models of care that allow patients to avoid admission or to get home sooner and to deploy technology that allows professionals to test patients in the community, potentially offering early diagnosis and disease management
- *Learning healthcare system* – Making better use of our data to predict need and manage our population's health. Creating capability within the workforce to use data and a collaborative to approach to how we store and process it
- *Enabling IT* - ensuring IT works for our staff and supports new models of care, where people can work seamlessly across organisational boundaries and within the patient's home

Recommendation/s

The Health and Wellbeing Board is recommended to:

- Endorse the strategic direction of Lancashire's Local Digital Roadmap (LDR).

Background

In June 2016, the CCGs were required to submit a Local Digital Roadmap (LDR) alongside our Sustainability and Transformation Plan. Lancashire's LDR covers eight CCGs, six provider trusts (including Southport and Ormskirk), three councils and the North West

Lancashire County Council

Ambulance Service. Cumbria has a separate LDR, however the direction of travel is well aligned through the Better Care Together Programme.

The LDR has been developed through the Digital Health Board and wide ranging consultation with both clinical and non-clinical leaders. The document sets out our baseline digital maturity (as measured against national criteria), a vision for the future and an outline plan for delivery of specific targets associated with electronic record sharing.

The LDR is a working document and will be subject to further stakeholder input and revision.

List of background papers

https://www.england.nhs.uk/digitaltechnology/info-revolution/digital-roadmaps/

This report should be no more than **two** pages in total but may provide links to more detailed information and papers.

Lancashire's Local Digital Roadmap

Digitally Enabled Transformation:

Helping to make healthcare

faster, easier & more engaging for citizens

2016-2021

Note to the reader:

This document builds on the previous digital health strategy documentation and incorporates specific national requirements for Local Digital Roadmaps. This document will be subject to further iteration.

Index

Foreword

It is a well-known fact that Lancashire is the birthplace of the industrial revolution that began in the 18th Century. Our ancestors include some of the most hardworking and innovative people in the world. We have a rich and diverse heritage, culture, social capital and assets on which we have built our economy and health.

Today we are living in the midst of a technological revolution, one which has the potential to transform lives for the better. Our county is ageing and the burden of disease is on the rise. We have been adding years to our lives but not necessarily life to our years; addressing health inequalities needs action across the social gradient within our county and not just in the most deprived communities; and that protecting and promoting good health is not just a social issue but also crucial for our local and national economy.

It is common knowledge that the financial resources within the public sector, both nationally and within our county are not going to increase to meet the needs and demands of our changing demography. Having the focus on financial savings alone can distract organisations from improving health and wellbeing. Therefore, we need to relentlessly pursue the 'Triple Aim' of improving outcomes, enhancing quality of care and reducing costs.

We need a strong and longer term political will to radically upgrade our efforts on prevention; we need fully engaged individuals, families, communities and businesses in improving wellbeing; and a workforce that embraces innovation and puts people and the places they live at the centre of everything they do. I believe that technology has a key part to play in supporting this vision.

Personalised Health and Care 2020 is a framework for action by the National Information Board to use data and technology to transform outcomes for citizens and patients. It describes that in the airline industry 70% of flights are booked online and 71% of travellers compare more than one website before purchasing. A paper ticket was once a critical 'trusted' travel document, yet today around 95% of tickets are issued digitally as e-tickets. In Britain we use our mobile phones to make 18.6 million banking transactions every week; automation of particular services has helped cut

costs by up to 20% and improved customer satisfaction. More than 22 million adults now use online banking as their primary financial service.

In 2016, 71% of all citizens in the UK have a smartphone and 84% of adults use the internet; however, when asked, only 2% of the population report any digitally enabled transaction with the health and care services. There is also evidence that people will use technology for health and care, given the opportunity. There are 40 million uses of NHS Choices every month, of which some 5 million are views by care professionals who regard this service as a trusted source of information and advice. The internet based sexual and general health service, Dr Thom (now part of Lloyds online), has seen 350,000 individuals sign up as users. In Airedale, West Yorkshire, care home residents have quickly embraced an initiative that gives them the opportunity to tele-access clinicians from the local hospital over a secure video link. A reduction in local hospital admissions of more than 45% has been reported among that group of people.

Used appropriately, technology can transform care via telehealth, telecare, mobile applications and social media, and by timely information sharing between care professionals. My vision is to develop Lancashire into a safer, fairer and healthier place for our residents. Over coming years we will work collaborative with our partners to harness the technological revolution and make Lancashire the birth place for a new revolution in wellbeing in the 21st Century. Lancashire's local digital roadmap is a significant step in that journey.

Dr. Sakthi Karunanithi, MBBS MD MPH FFPH

Chair of the Digital Health Board

Executive Summary

The NHS is undoubtedly in the midst of a formidable challenge brought about by a combination of static investment, an ageing population and a high prevalence of chronic disease. Lancashire, like many other parts of the country will see significant demographic and public health changes over the next five years. There will be a 13% increase in the number of people aged over 70, whilst at the same time the health inequalities gap will rise. Meaning that more people in Lancashire are likely to die prematurely from chronic illness, in part caused by the wider determinants of health, such as low income, poor education and housing. This gives us a sense of urgency in responding to the challenges set out in the Five Year Forward View and in reforming our public services for the future.

All across the country, communities are digitally transforming to respond to increasing demand and less money. In Lancashire, this transformation has started with the introduction of a new approach to electronic record sharing. However, going forward more will need to be done to meet local need and the expectations of Government[1], who set out a clear direction for the healthcare system to:

- Seek a radical upgrade in public health
- Put patients in control of their own care
- Use technology to improve patient experience and access
- Improve local partnerships with greater integration across the system

In October 2015, NHS England issued new guidance to Clinical Commissioning Groups (CCGs) to establish Digital Roadmaps[2]; mapping out how communities will harness technology to support sustainability and transformation. For Lancashire, the CCGs have agreed to create a single countywide roadmap, coordinated through the existing Lancashire Digital Health Board. This builds on the established programme to:

- Improve the digital maturity of healthcare providers to enable them to be paper-free at the point of care by 2020
- Share electronic records across organisations to support safe, effective & efficient care

[1] https://www.england.nhs.uk/ourwork/futurenhs/
[2] https://www.england.nhs.uk/digitaltechnology/info-revolution/digital-roadmaps/

- Empower the patient to be an active participant in their care by giving them access to their health records
- Enable citizens to harness the power of assistive technology to live independent, healthy lives
- Make better use of our data to predict need and inform future service delivery
- Create a robust, affordable IT infrastructure that supports integrated working and new models of care across the public sector workforce
- Create opportunities for economic growth within the region in the digital life sciences sector

In our community, the health and wellbeing outcomes for our population are amongst the worst in the country. If we do nothing different, demand for healthcare services will continue to outstrip the available resources and more importantly, our health outcomes will remain poor or possibly deteriorate.

We need to seek out opportunities to improve efficiency, reduce variation and achieve higher quality standards. New technology and specifically digital health can help to achieve these objectives.

Across Lancashire we have a wealth of expertise and a rich asset base to harness digital health if we choose to work together. Having identified the scale of our challenge, we must now work collectively to describe how technology can help to transform the system. Making it **faster, easier and more engaging for citizens** to take charge of their health and wellbeing.

1. Introduction

1.1. The NHS is undoubtedly in the midst of a formidable challenge brought about by a combination of static investment, an ageing population and a high prevalence of chronic disease. The scale of this challenge has been documented by Simon Stevens, CEO for NHS England, who paints a clear picture on what we all need to do if we want to continue having a universal healthcare service that offers high quality care for all. In the Five Year Forward View[3], he sets out a clear direction for the healthcare system to:

- Improve local partnerships with greater integration across the system
- Seek a radical upgrade in public health
- Put patients in control of their own care
- Use technology to improve patient experience and access

1.2. For Lancashire, the challenge is manifesting itself in the form of a financial gap; the exact scale of which is yet to be determined. However, it could be in excess of £700m by 2020, if left unchecked. Tackling this mammoth problem is going to require bold solutions, effective leadership and purposeful collaboration across health, social care and the third sector. In response to the Five Year Forward View, NHS England have published a framework called 'Personalised Health and Care 2020: a framework for action'[4] , which outlines examples of how the application of technology can improve health outcomes, transform quality and reduce costs. Also contained within the framework are proposals to help, such as:

- Increasing the use of remote diagnostics and telecare
- Increasing the use of consumer health technology
- Empowering citizens to use their own health data

1.3. Stemming from the 2016/17 NHS planning guidance, there is now a requirement for CCGs to develop local digital roadmaps and define a collaborative footprint in which organisations will work together. Thus, harnessing the potential of technology and data to work for citizens and the caring professionals who serve them. Crafting a NHS that is sustainable for at least another sixty five years.

3 https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

4 https://www.gov.uk/government/publications/personalised-health-and-care-2020/using-data-and-technology-to-transform-outcomes-for-patients-and-citizens

2. A citizen's perspective

Michael Harding's Story

My diagnosis with COPD came after I was admitted into hospital suffering from pneumonia, that was about five years ago. I'm 81 now and I've been active all through my life; I still swim 3 times a week and in my younger days I served in the military. I guess I've led a normal and happy family life.

Along with my COPD I suffer from sleep apnoea, arthritis and I have a trapped nerve which runs from my spine and down the inside of my leg; a legacy of a hernia operation a few years back. I take lots of different tablets and require oxygen from a tank for 16 hours a day which can be a pain, it's certainly put an end to foreign holidays – the high pressure on the flights ruins me for days. It can also be difficult to sleep at night, it's quite noisy and obviously it's not that comfortable either!

I see a consultant at the local hospital once a year. It's quite a quick appointment where they check how I am getting-on and monitor any change in my symptoms. They still use paper records and so it sometimes seems like they have a lot of information to wade through. I don't think they have a complete history of my health and information about my other conditions like my GP does.

I didn't realise that all of the information that the GP holds about me, like the medication I am taking and a complete list of my health problems couldn't be shared with the consultant at the hospital. How can they properly help if they don't have all your information? That doesn't make sense to me.

I would certainly be happy for all of the health professionals that I interact with to see my medical history, at the end of the day they are there to help and treat patients and that's the most important thing. I understand that some people have concerns about the privacy of their health information but I'm sorry, I don't see it that way.

I have a computer at home and go online to order repeat prescriptions. It's great. Very useful and convenient and I've never had any problems at all. If I could access my medical records online I would, I think that's a good idea because that way I can make sure that the information about me is correct and up-to-date.

I don't use my mobile phone for anything other than a phone but I've been told about some of the new ideas that the health service is currently trying out. I take a mountain of tablets and I'm always forgetting about them so if there was a way that I could receive a reminder, like a text message or something telling me it was time to take my tablets that would be great. I don't forget on purpose so little improvements like that could make a big difference.

Innovation Agency North West Coast, Connected Health Cities

2.1. Michael's story gives a personal perspective on how technology is and can be used in healthcare, potentially dispelling some of the perceptions inside the public sector about the demand for new digital services. Technology has the potential to offer all parts of our society new, more convenient ways to access health and care services and potentially reduce health inequalities.

2.2. Across Lancashire our three Health and Wellbeing Boards have set out clear plans for starting well, living well and ageing well. Digital solutions can play a significant part in helping to achieve these plans by:

- Providing online information for citizens to improve their health literacy
- Providing technology for citizens to manage their health conditions
- Providing a platform for citizens to connect with their communities
- Providing a mechanism to improve access to traditional services

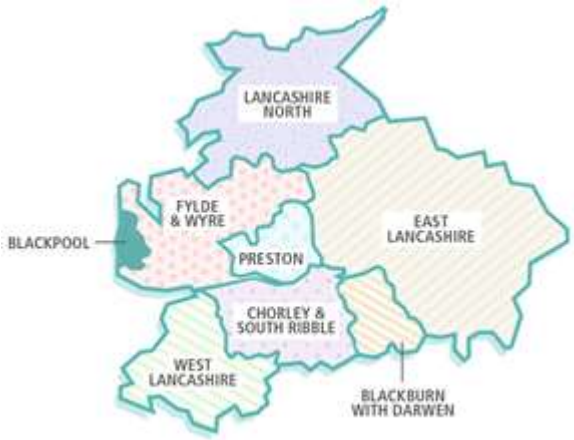
2.3. In summary, the digital ambition for Lancashire is to create a new relationship between citizens and their healthcare system, which uses digital solutions to make it **faster, easier and more engaging** to take charge of your own health and wellbeing.

3. Strategic Context

3.1. The Lancashire LDR forms part of the Lancashire and South Cumbria Change Programme and encompasses the eight CCGs outlined in the map below. The LDR covers the following health and care partners:

- Blackpool Teaching Hospitals NHS Foundation Trust (Acute & Community)
- East Lancashire Hospitals NHS Trust (Acute)
- Lancashire Care NHS Foundation Trust (Mental Health & Community)
- Lancashire Teaching Hospitals NHS Foundation Trust (Acute)
- Southport and Ormskirk Hospital NHS Trust (Acute)
- University Hospitals of Morecambe Bay NHS Foundation Trust (Acute)
- Blackburn with Darwen Council
- Blackpool Council
- Lancashire County Council

Map 1 – Lancashire LDR Footprint



3.2. Beyond these core partners, Lancashire's LDR will also take account of the need for service integration beyond geographic and organisation boundaries to ensure there is continuity of care for our patients, particularly with pan-regional organisations, such as the North West Ambulance Service. This means we will seek to collaborate with stakeholders in Bradford Districts, Calderdale, Cumbria, Greater Manchester and Liverpool. Our approach will enable the integration of Calderstones Partnership NHS Foundation Trust into Mersey Care NHS Foundation Trust later this year. It also reflects the need for the health and care system to

harness the potential of third sector providers and other regional assets, such as our borough councils and our academic institutions.

3.3. Across the North West Coast we have access to a wealth of expertise and a world-class infrastructure that we intend to harness in delivering our LDR, for example:

- Intense, cognitive computer facilities at STFC Daresbury
- Expertise in flow and capacity modelling at Liverpool John Moores University
- A thriving technology enterprise zone at Baltic Creative in Liverpool
- Digital Creative Fab Labs in Blackburn with Darwen
- Leading edge sensor technology at Sensor City, Liverpool
- A Rural Health Forum in Cumbria
- Internet of Things research hub at Lancaster University
- A learning healthcare system testbed with NWC Connected Health Cities
- A frail elderly technology testbed at Lancaster University
- A healthy ageing village at Lancaster University
- A Healthy New Town on the Fylde Coast
- A digital health park at Chorley
- A Genomic Medicine Centre in Liverpool

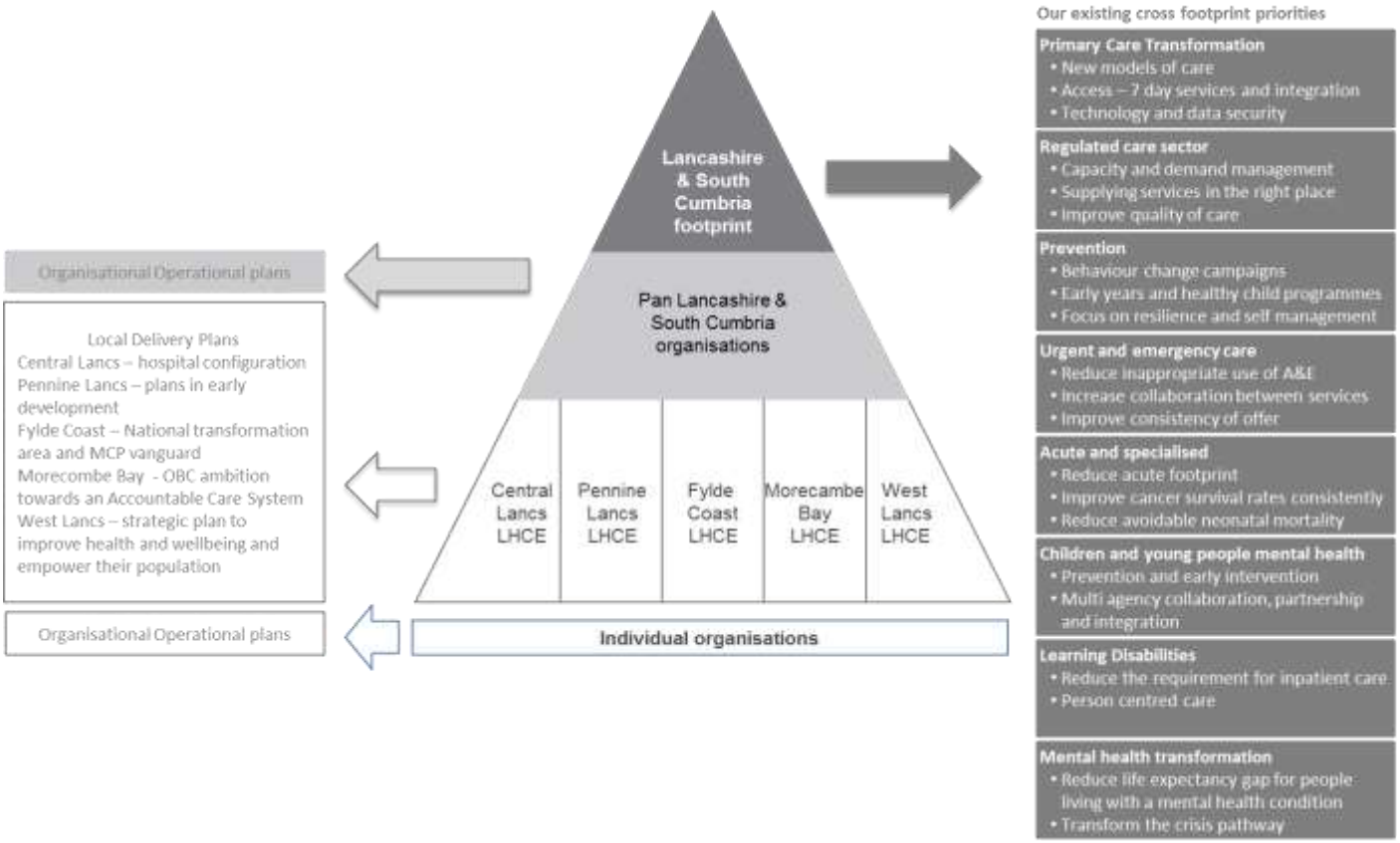
3.4. Lancashire, like many other parts of the country will see significant demographic and public health changes over the next five years. There will be a 13% increase in the number of people aged over 70, whilst at the same time the health inequalities gap will rise. Meaning that more people in Lancashire are likely to die prematurely from chronic illness, in part caused by the wider determinants of health, such as low income, poor education and housing. Unfortunately, parts of the county demonstrate some of worst deprivation in the country. This gives a sense of urgency in responding to the challenges set out in the Five Year Forward View. Typically, for Lancashire this will mean finding effective solutions to respond to:

- Twice as many people with cancer
- A 70% increase in obesity
- 175,000 more people with diabetes

3.5. To address these and other systemic challenges, organisations across Lancashire and South Cumbria (L&SC) have agreed to come together to co-design, implement and deliver the changes required to transform the health and care services within

our shared footprint. This ambition is set out in the Sustainability and Transformation Plan (STP). Alongside this, each of our five localities are developing their local delivery plans (LDPs) to drive through the underpinning changes that are required to deliver success. This digital roadmap is a key enabler to both. The diagram below outlines the relationship between local, locality and regional planning.

Diagram 1 – Relationship between LDP & STP



4. Baseline Position

4.1. The Lancashire health and social care system spends in excess of £3 billion annually to provide services for its citizens, with most provider organisations typically spending an average of 2% of their revenue on provisioning their information communication technology (ICT) infrastructure. Whilst our LDR partners have made good progress, in many areas (of digital maturity) over the last few years, there is still a long way to go in delivering the ambition of the Five Year Forward view. In Lancashire today:

Our Citizens

- Very few have access to their electronic care records
- Very few can access on-line booking or virtual clinics
- Very few use technology as part of their care needs

Our Workforce

- Struggle to understand the potential of technology
- Still capture large amounts of clinical documentation on paper
- Do not have all the information they need at the point of care

Our Systems

- Are not interconnected or standardised
- Are not maximising the value of our data to improve health outcomes
- Are not as cost effective as they could be

4.2. In reality, Lancashire is not that different from any other part of the health and social care system in how it operates. It is anticipated that the success of this LDR in addressing the current state will be determined by our citizen's demand for new digital-enabled services and our workforce's ability to deliver them.

4.3. All of our secondary care providers have reported a level of digital maturity (see Table 2) that is broadly in-line with the national average, except Calderstones Partnership which will integrate with another Trust later this year.

4.4. All providers have plans in place to improve their digital maturity through the implementation of electronic health records (EHR). Whilst each acute provider has a different solution, there may be scope for some consolidation within the timeframe of this LDR. The provision of primary care and community systems is less complex,

with EMIS Health Solutions in use across all GP practices, half of the county's community services and its planned use as the county-wide child health information system (CHIS). Medicines management and e-prescribing are also largely delivered through EMIS solutions. In addition to EMIS, other key systems in use are:

- IMS Maxims in Fylde Coast
- CSC Lorenzo in North Lancashire
- CSC Continuum In East Lancashire
- Harris Quadramed in Central Lancashire
- System C Medway in West Lancashire
- Servelec Rio pan-Lancashire for mental health (& some community)

Table 2 - Summary of baseline digital maturity in secondary care

Question																
	Average Score	Average Score	Score	Answer	Score	Answer	Score	Answer	Score	Answer	Score	Answer	Score	Answer	Score	Answer
Organisation Demographics																
Strategic Alignment	76%	75%	90%		44%		75%		70%		90%		85%		65%	
Leadership	76%	71%	70%		30%		85%		70%		100%		70%		75%	
Resourcing	66%	58%	80%		35%		75%		55%		75%		35%		55%	
Governance	74%	65%	85%		20%		80%		50%		85%		60%		75%	
Information Governance	74%	73%	94%		71%		72%		70%		66%		57%		85%	
Records, Assessments & Plans	44%	46%	43%		71%		24%		52%		36%		49%		49%	
Transitions Of Care	48%	43%	29%		47%		56%		18%		44%		74%		33%	
Orders & Results Management	51%	52%	77%		30%		55%		46%		62%		30%		58%	
Medicines Management & Optimisation	27%	25%	11%		5%		40%		30%		29%		24%		28%	
Decision Support	35%	27%	6%		39%		17%		19%		19%		63%		25%	
Remote & Assistive Care	32%	38%	25%		33%		17%		58%		25%		17%		33%	
Asset & Resource Optimisation	41%	50%	30%		65%		40%		60%		65%		45%		45%	
Standards	40%	39%	42%		17%		49%		29%		25%		56%		54%	
Enabling Infrastructure	68%	71%	70%		84%		61%		80%		70%		64%		68%	

4.5. In social care, councils use:

- Servelec CoreLogic in Blackburn with Darwen and Blackpool
- System C Liquidlogic within Lancashire County Council

4.6. The provision of diagnostics is delivered through a range of solutions and suppliers. However, within the timeframe of the LDR it is anticipated that clinical experts will

drive forward consolidation to support new models of care and increased operational efficiency. One example being the development of 'lab in a bag', which is exploring near-patient testing alongside a review of pathology services in general.

5. Key achievements

5.1. Prior to arrival of the LDR, Lancashire already had a strong record of collaboration on enabling technology. Through a collaborative partnership called the North West Shared Infrastructure Service, health and social care providers have delivered:

- A health information exchange[5] to allow organisations to share relevant data for the benefit of citizens and frontline staff
- Created a new information governance tool that improves the transparency of record sharing and reduces bureaucracy
- A community of interest network that provides a sustainable infrastructure to support all forms of digital technology
- Used telemedicine for new models of care with stroke and renal patients
- A shared staff Wi-Fi system that operates throughout Cumbria and Lancashire
- Established a number of proof of concepts to test new digital health tools for managing remote and complex care
- Mapped out the digital health assets that exist across South Cumbria and Lancashire and supported the development of regional growth schemes
- A shared free public access Wi-Fi service across all our hospitals
- A shared Active Directory Service that is the largest of its kind in the NHS
- Enabled around 10,000 staff to use tablet and smartphone technology to deliver paper-free solutions at the point of care
- A number of collaborative service contracts

5.2. Within our individual organisations, providers have successfully delivered:

- Video and messaging technology, clinician to clinician or patient to clinician, in North Lancashire to improve access to specialist advice and overcome problems caused by rurality

5 https://en.wikipedia.org/wiki/Health_information_exchange

- Real-time reports and dashboards supporting direct care and underpinning the changes being implemented through the Vanguard - Project Better Care Together
- A patient observations system successfully deployed in West Lancashire, to all Acute Wards to monitor fluid balance, nutrition, infection control and many other aspects of care
- Integrated primary and community electronic records throughout large parts of Lancashire, supporting transitions of care across organisational boundaries and enabling real-time information sharing
- A Trust-wide clinical portal integrating the hospital PAS, GP record, Clinical Correspondence and results reporting in East Lancashire and on the Fylde Coast.
- An integrated electronic patient tracking system with ward based electronic displays supporting clinical review and observation management.
- Electronic medicine administration and medicines management systems in all our providers, improving patient safety and reducing pharmacy costs
- Widespread use (2/3^{rds} of the workforce) of mobile technology and agile working across community-based staff in Lancashire Care
- Mature utilisation of skype (video) for business for clinical consultations in Adult Mental Health and Speech and Language Therapy

"*The structure of the health and social care health informatics 'family' has meant that Lancashire has been able to draw on the skills and knowledge of experienced individuals from a variety of organisations around the county. This has resulted in a shared vision of how we should use information technology to help deliver care and support health to the citizens of our county. I have also been lucky to work alongside and learn from experienced and helpful colleagues in health informatics to support my role as Chief Clinical Information Officer. This collaborative approach is echoed in the attitude to delivering a solution to record sharing in our health and social care economy*."

Nick Wood, Consultant Gynaecological Oncologist & CCIO, Lancashire Teaching Hospitals

6. Vision for the future

6.1. So what might a digitally enabled future look like? The innovation charity, Nesta recently published a vision for the NHS in 2030[6] that sets out how technology might underpin delivery of healthcare in the future. The report highlights key themes, such as:

- Precision care from precision medicine, using genome mapping to deliver more precise interventions
- Real-time telemetry from biometric and passive sensors, which constantly monitor people for signs of disease
- Patients and their carers actively involved in their care, using easily accessible knowledge to inform their decision making
- More health professionals actively engaged in research, utilising automated diagnostic tests and health analytical tools to inform their practice

6.2. Whilst the healthcare system in 2030 might seem intangible, there are clear indicators emerging today that suggest Nesta's predictions maybe a reality sooner than we think. For example, the use of mobile and tablet technology is growing exponentially in the UK. This year Ofcom reported[7] that 93% of UK adults have a mobile phone, of which 71% are smartphones. This has increased 27% since 2012. This year the smartphone has overtaken the tablet or PC as the preferred device to access the Internet. With this proliferation of access, public attitudes and behaviours are changing:

- Seven in ten (69%) internet users say that technology has changed the way they communicate and six in ten (59%) say these new communication methods have made life easier
- More than seven in ten adult internet users (72%) have a social media profile
- A quarter of adults with a Twitter account use it to air complaints or frustration
- 78% of households have access to the internet, with 30% being superfast

6.3. Undoubtedly citizens are becoming digitally enabled and subsequently expectations around digital services in the public sector are growing. Accordingly, Lancashire's

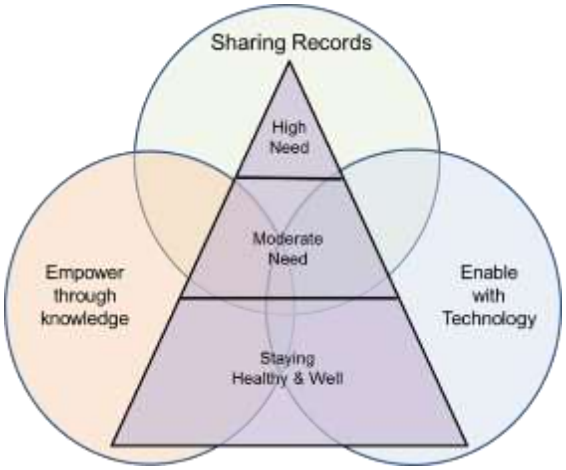
[6] http://www.nesta.org.uk/publications/nhs-2030-people-powered-and-knowledge-powered-health-system
[7] http://stakeholders.ofcom.org.uk/binaries/research/cmr/cmr15/CMR_UK_2015.pdf

LDR needs to address the ongoing societal change and the anticipated exponential growth and convergence of technology that is anticipated over the next 10-15 years.

6.4. In context of this roadmap, there are three broad themes for digitally-enabled transformation, the Venn diagram below outlines how these initiatives align to population health need.

- ***Sharing*** of electronic records is primarily focused on supporting safe, integrated care for those with the highest need. Typically, this is the same group of people who have the most interaction with healthcare services. In a more general sense, record sharing underpins all digitally enabled services.
- ***Empowering*** people through the sharing of knowledge is aimed at helping those people with moderate to low need. These people may have one or more long-term condition but are otherwise well. Here technology is used to give them access to information about their condition and allow them to be actively involved in managing their own care, as Michael describes in his story.
- ***Enabling*** people with technology is utilising a range of technologies, including lifestyle and consumer devices to help people stay healthy and well, access services in new ways and to bring care closer to home. Whilst there will be many scenarios for technology to support those with the highest need, the transformational priority here will be to use technology to promote health literacy, prevent illness and improve the accessibility of healthcare.

Diagram 2 – The alignment of digital health technology to population need



6.5. Encompassed within these themes, Lancashire's LDR specifically aims to respond to the three national challenges (the triple aim[8]) through county-wide collaboration on:

Addressing Care Gap

- Ensuring we have a standardised approach to electronic clinical / care documentation based on professional standards where they exist.
- Ensuring our systems & processes will support new models of care.
- Ensuring our workforce is able to work across organisational boundaries and provide care closer to home.
- Ensuring we have the capability to share electronic care records across organisational boundaries.
- Ensuring the workforce have access to and can use data in the context of a learning healthcare system[9]
- Ensuring technology-enabled care is deployed to the maximum benefit of the patient / citizen
- Ensuring we harness innovation in precision medicine, new sensor technology, predicative analytics & cognitive computing to support new models of care

Health & Wellbeing Gap

- Ensuring patients / citizens can access and use their care data to be active partners in managing their health and wellbeing
- Ensuring our workforce has the necessary skills to deliver digital care in partnership with patients / citizens
- Ensuring we have a standardised approach to patient-held records
- Ensuring we maximise the potential of our care data to improve health outcomes for the whole population

Finance Gap

- Ensuring the L&SC transformational programme effectively exploits technology to manage capacity and demand
- Ensuring we consolidate and share IT systems to reduce cost and complexity
- Ensuring we utilise cost effective cloud-based solutions
- Ensuring we leverage procurement through scale and standardisation
- Ensuring we collectively maximise the benefits of technology

6.6. The logic model below summarises the vision of Lancashire's LDR as an integral part of a system-wide transformation programme.

8 https://www.england.nhs.uk/2015/12/long-term-approach/

9 http://healthaffairs.org/blog/2013/01/14/new-approaches-to-learning-in-the-learning-healthcare-system/

Table 3 – Logic Model for Lancashire's Local Digital Roadmap

Rationale for Intervention

Lancashire must harness the potential of digital health to help meet the triple aim of creating a health service that delivers improved quality of care, better health outcomes for its citizens and is financially sustainable: through electronically sharing healthcare records to deliver safe, effective care; using digital tools to empower patients to do more for themselves; deploying technology enabled care that helps people to be more independent; improving health outcomes by using our data to target our resources effectively.

Inputs

Involvement of **Patients, citizens & Front line staff** co-creating solutions.

Organisational commitment to partnership working across Lancashire.

System governance and leadership to oversee the delivery of solutions and to realise benefits

Collaboration partnerships with external agencies, clinical networks & business to innovate at pace & scale

Funding to pump-prime new collaborative solutions

Activities

Standardise clinical and care documentation in use across Lancashire.

Use electronic systems to **capture all clinical and operational data.**

Create unified clinical and care records **available at the point of care.**

Give **patients and their carers access** to their electronic healthcare records.

Deploy technology to **support patients & citizens** to manage their health & wellbeing.

Use healthcare data to improve health outcomes and service efficiency.

Short Term Outcomes
(Meeting the financial gap)

A **digital roadmap** is in place

Organisations are **sharing data** using an agreed set of **document standards.**

All front-line staff have **access to a summary care record** and electronic transfer of care documentation.

Patients are increasingly accessing their healthcare records and **new online services.**

Information technology operations are becoming **more efficient** across Lancashire.

Data is being used to **prevent hospital admissions**

Medium Term Outcomes
(Meeting the care gap)

Front line staff have online access to a comprehensive **healthcare record at the point of care.**

Services are **safer** by sharing data and outcomes are improving.

Patients have a greater **understanding of their health and wellbeing** by using technology and data.

It is **easy for patients** to access healthcare through online services.

Real-time data is **improving the efficiency and effectiveness** of services

Long Term Impacts
(Meeting the health & wellbeing gap)

The people of Lancashire live **longer, healthier lives** and use technology to access services when they need to.

People feel empowered to manage their health & wellbeing by using technology.

Our workforce is harnessing technology to delivery **safe, effective care** closer to patient's homes.

Data is providing new insight into our population's health and is being used to **improve health outcomes.**

Key Enablers

- New workforce skills, capability & capacity
- Robust security and information governance
- Common shared ICT infrastructure
- Data interoperability is in place for all our partners

Key Assumptions

Our workforce have the skills and tools needed to capture clinical and operational data. Patients and carers actively engage with front line staff in the development of digital solutions and go on to use them to manage their health & wellbeing. Organisations accept the need to collaborate and where necessary share technical solutions. There is an agreement in place between citizens & organisations to share data.

7. Roadmap development process

7.1. Prior to the launch of the LDR process, Lancashire had already established a collaborative approach for digital health that has overseen many of the achievements described above. The LDR will build on the endorsed initiatives that were agreed by the Digital Health Board in late 2014 – see below:

Table 4 – Digital Health Board Scope:

Enabling outcomes, experience, empowerment, efficiency, sustainability and innovation			
SIS stakeholder board	E prescribing	Online access	Shared records platform
Sharing good practice	Exploring patient held records	Promoting a digital first approach	Assisted independent living
E-Growth & commercial partnerships	Promoting digital literacy	Infrastructure	Telehealth/Telecare

7.2. In the context of the existing Healthier Lancashire Digital Health Programme , this first iteration of the LDR aims to:

- Refine and reframe the current Digital Health Board agenda based on the feedback and insight gained from stakeholders over past 12 months.
- Ensure there is a mechanism to allow the roadmap to respond to the emerging transformation agenda
- Identify opportunities within digital health to address the wider determinants of health, including economic growth in the digital sector across the region
- Ensure there is a robust governance structure in place that oversees the delivery of the LDR and meets the needs of the L&SC transformation programme
- Enable Digital Health Board members to effectively prioritise initiatives going forward
- Ensure there is a shared understanding of what digital health is and the opportunities it presents to transform the system
- Ensure the LDR continues to be developed and is supported by partners

7.3. Also influencing the development of Lancashire's LDR has been an analysis of current (both provider and commissioner) strategic plans, highlighting a number of common themes that are relevant to the LDR:

- Holistic person-centred care, in-part utilising personal budgets
- Supporting a broad health and wellbeing agenda
- Ensuring right care, first time, every time
- Self-management with care closer to home or available digitally from home
- Seamless care, shared records and partnerships across agencies
- Enabling 7-day services and extended services
- Easy access to the most services, using signposting and information
- Telehealth, remote diagnostics / consultations and patient decision aids
- Simple processes and systems to improve productivity
- Using data to target resources, improve quality and reduce variation
- Creating safer communities

7.4. The engagement process, post publication of the LDR guidance has been intense and will continue beyond the submission date on the basis that the LDR is a living document. Numerous meetings have been convened, bringing together clinical and non-clinical professionals and other LDR stakeholders. In summary, the LDR has been developed through engagement with the following groups:

- Members of the Digital Health Board
- Members of the Digital Health Clinical Advisory Group
- Provider Chief Information Officers Group
- Provider Executive Teams
- CCG GP IT Leads
- Chief Finance Officers & Directors of Finance Group
- Local Transformation Leads
- Council CIOs & Leaders
- Healthwatch Lancashire
- The Innovation Agency North West Coast
- Several strategic supplier forums
- North West Coast Connected Health Cities Partnership

8. Governance Structure, Leadership & Clinical Engagement

8.1. The proposed governance structure supporting delivery of the roadmap will be integrated into the L&SC STP governance model. There will be three tiers within this structure reflecting the need for broad community engagement in developing our strategic direction whilst at the same time managing the delivery of a complex and technical agenda. The broad function of each tier is as follows:

The Digital Health Board

- Set the strategic direction though engagement with a wide range of stakeholders
- Provide programme oversight and ensure there is alignment with the STP
- Set the priorities for the programme, establish partnership commitment and monitor risks, escalating where necessary to the L&SC Programme Board
- Representation is drawn from health, social care, police, fire and rescue, academic institutions, the academic health science network, third sector and business partnerships

Chief Clinical Information Officers (CCIO) & Chief Information Officers (CIO) Group

- Drive the delivery of the LDR within and across organisations, ensuring opportunities for collaboration to close the finance gap are seized
- Setting and implementing standards and performance metrics, drawing on professional guidelines where they exist
- Establish mechanisms for meaningful co-creation with the frontline workforce
- Advise the Digital Health Board and acting as a catalyst for change within the STP work streams
- Contribute to the case for change and ensure the LDR's solutions are aligned for the benefit of the whole system
- Representation is drawn from both the public and private sectors and represents primary, secondary and social care

The Shared Infrastructure & Services Group

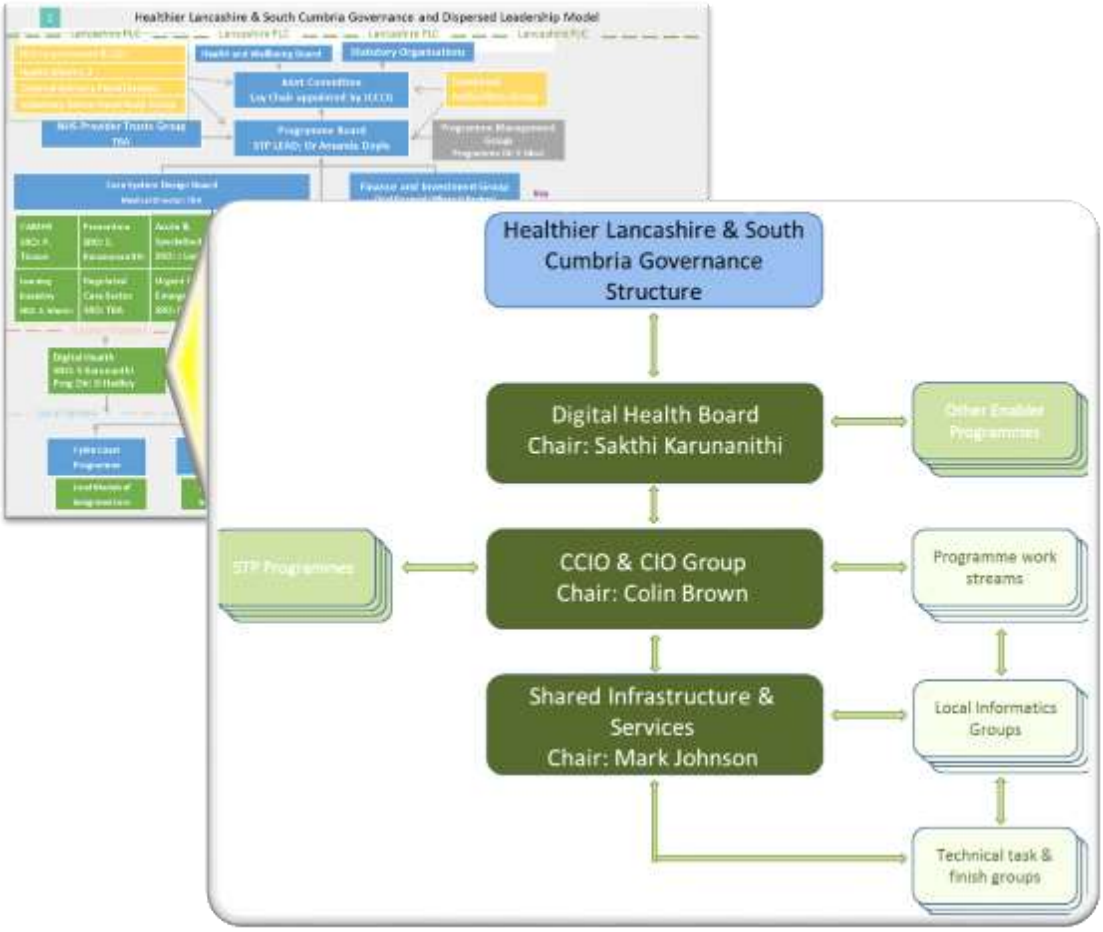
- Identifying and scoping collaborative opportunities, building on previous successes and driving forward the Carter recommendations
- Deploying technical solutions and enforcing standards
- Working in partnership with suppliers to bring innovations into the LDR

- Engaging with the Informatics workforce to co-create collaborative solutions
- Representation is drawn from primary, secondary and social care

8.2. The CCIO & CIO Group will also act as the aggregation point for work stream activities led at a Lancashire level, delivered through a series of task and finish groups, which will be led by clinical representatives wherever possible (see Diagram 3).

8.3. Implementation work which is relevant to the digital roadmap but not delivered at a pan-Lancashire and South Cumbria level will report into the Digital Health Board as appropriate and in line with the leadership approach for the LDR.

Diagram 3 – LDR Governance model integrated into the STP



8.4. Both the Digital Health Board and the CCIO & CIO Group will aim to meet quarterly, the Shared Infrastructure and Services group will meet monthly. The terms of reference and membership of all three committees will be reviewed annually. The constitution of task and finish groups will be determined on a case-by-case basis by the governing committees above.

8.5. The implementation of pan-Lancashire activities within the roadmap will be coordinated and managed through a Digital Programme Team aligned / integrated with the Lancashire and South Cumbria Programme Management Office.

8.6. To avoid the potential pitfalls of top-down planning, the preferred collaborative approach for the LDR and the Digital Health Board can be defined as:

- **Aligning** initiatives across the partners to ensure delivery of the LDR
- **Supporting** local organisations to drive forward their plans
- **Facilitating** collaboration across organisational boundaries on common issues
- **Leading** pan-Lancashire initiatives where there is a clear mandate from stakeholders

8.7. In addition to this approach, there is a firm commitment from system leaders in digital health to ensure that this roadmap embeds a principal of co-creation[10] with citizens, clinicians and the wider workforce from the outset. Whilst some mechanisms are already in place to fulfil this principle, further work is required over the coming years to really achieve meaningful engagement.

8.8. All three of the committees described above have strong clinical leadership and are chaired by either a practicing clinician or someone with a clinical background. Going forward, the aim is to further strengthen clinical and other professional leadership in the LDR by seeking to engage more frontline workers; threading the LDR into the STP transformation work and by offering a mechanism for developing digital skills and capabilities within the workforce.

10 http://www.stakeholderdesign.com/co-production-versus-co-design-what-is-the-difference/

9. Workforce development

9.1. The success of Lancashire's LDR will be fundamentally determined by our workforce's ability to adapt and change working practices. Having a roadmap document alone will not bring about change. What it can do is act as a catalyst to bring people together to start the dialogue about what the future could look like. The scale of the challenge that lies ahead requires us all to commit to bold, effective, large-scale change. However, first and foremost we need to achieve a common understanding of what we want to change and why.

9.2. With the support of Lancashire's Workforce and Education Group (LWEG) and the Innovation Agency North West Coast we have established a digital skills development framework to engage the frontline workforce in the digital agenda. Although still in its infancy, a first cohort of people have started to learn how to deliver technology-enabled change and will be embarking on work-based projects later this year. The course is run by the University of Cumbria as part of a consortium of delivery partners, including the North West Informatics Skills Development Network.

9.3. Over the life of the LDR we will be seeking to expand and develop this programme into a Virtual Digital Academy (VDA), that offers blended learning opportunities to a range of stakeholders and brings together the technical (informatics) and non-technical (care) professionals in to a space where they can:

- Improve their digital skills and knowledge
- Undertake continued professional development in digital transformation
- Co-create new digital solutions with both industry and academia
- Identify and adopt translational research in digital at pace and scale
- Create a peer support network to share good practice in digital innovation across the North West Coast – Linked to the Innovation Agency's Scout Network

9.4. The consortium is led by Lancaster University, which over the last two years has forged strong links with Lancashire's digital agenda and will play a key role in driving digital innovation over the next five years through the VDA. The University offers academic expertise in:

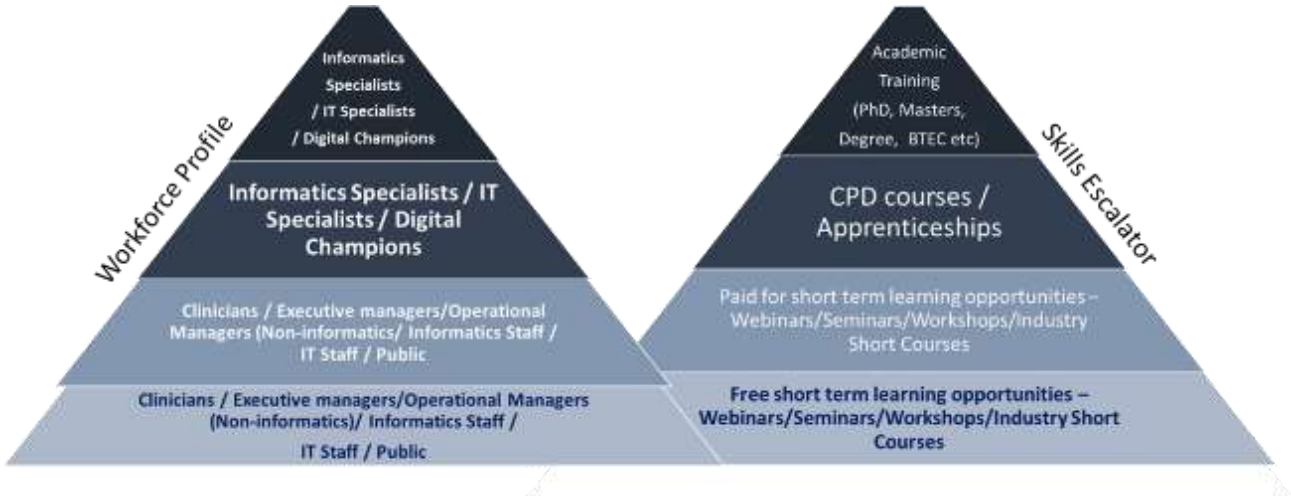
- Data science, cybersecurity & digital health

- Information systems, operational research & management
- Whole systems design
- Human computer interface
- Data analytics, forecasting & simulation
- Partnerships for funding (ESIF Digital impact)
- Health innovation, design & evaluation

9.5. In addition to Lancaster, we will be actively seeking to engage with the University of Central Lancashire and other academic institutions to join the VDA and play a part in co-creating the digital transformation of healthcare.

9.6. The diagram below outlines the skills framework and its target audience within our workforce.

Diagram 4 – Digital Skills Framework



9.7. Alongside our focus on 'bottom-up' capability building and service-led redesign, the VDA will seek to raise awareness and understanding at board level. This builds on recent experience of a board development programme run by Mersey Care NHS Trust, in partnership with NHS England. Through the VDA, all the senior leaders engaged in the STP will be invited to participate in a digital health development programme that aims to:

- Help leaders understand the 'art of the possible'
- Encourage leaders to think creatively about digitally-enabled transformation
- Describe how simple, effective 'off the shelf' solutions can be utilised
- Build confidence around digital transformation

9.8. Ideally, this would be externally facilitated to bring in perspectives from other industry sectors[11].

9.9. In summary, workforce development (top to bottom) is critical to the success of the LDR. Attitudes and behaviours around digital will dictate how quickly we adopt paper free at the point of care and how quickly we see citizens using technology as part of their care. Through the development of the VDA we are seeking to ensure the L&SC healthcare system:

- Is at the forefront of science, research and digital innovation
- Is learning from combinatorial innovation in the testbed and other schemes
- Is embracing breakthroughs in genomics, precision medicine and diagnostics

11 https://leadingedgeforum.com/what-can-lef-do-me/

10. Change Management & Benefit Realisation

"Healthcare organisations cannot continue to do more of the same and remain viable. Clinical transformation of clinical services and cross-organisational care pathways need to be transformed and linked up across organisations. This should be a clinically-led planning process:

- *Clinical information needs to be presented at different care points along those clinical pathways, so that we have "Better Information" to support "Better Decisions" at point of care or other clinical decision points such as MDT's, and lead to Better Outcomes for patients.*
- *We need better electronic records, connected up and supporting pathways of care.*
- *We need organisations to be brave, with collaborative, strategic leadership to put patients first and not persist in organisation-centric thinking.*

All of this will support safer patient care, good clinical decisions and lead to more affordable care across a large footprint.

Agreeing on a Digital Roadmap Strategy will support the development of cohesive electronic health and social care records, which are securely linked and underpinned by IT infrastructure which supports sharing and helps to break down technological and electronic 'walls' "

Colin Brown, Consultant Gastroenterologist & CCIO, University Hospitals of Morecambe Bay

10.1. To succeed in bringing about change, Helen Bevan suggests ten key principles[12]:

- Move towards a future vision that is fundamentally different from the status quo
- Identify and communicate key themes that people can relate to and that will make a big difference
- Do lots of things and seek to amplify these small changes ('lots of lots')
- Frame the issues in ways that engage and mobilise a lot of different people
- Mutually reinforce change across different parts of the system
- Continually refresh the story and attract new, active supporters
- Adopt an emergent planning and design process, adapting as you go
- Enable many people to contribute to the leadership of change, moving beyond organisational boundaries
- Transform mind-sets to deliver sustainable change

[12] http://www.institute.nhs.uk/leading_large_scale_change/general/leading_large_scale_change_homepage.html

- Maintain and refresh leaders energy to sustain them over the long-haul

10.2. Lancashire's LDR change management approach will link that of the broader STP, that is:

- Everything we will do together will be for the benefit of all of the people of Lancashire. We will build upon the collaborative change programmes that we are already delivering, within which we have undertaken extensive engagement on planning changes to service delivery. However, we are now looking for a step-change in that involvement so that our people become part of the change. Collectively we will co-create strategies, working towards a radically different, people-centric preventive system, addressing the wider determinants of health and so become less reliant on costly infrastructure.
- We recognise that changes over the next five years can only be made by common consent with patients, the public, staff, local media and system partners – so everyone will need to be fully engaged to collectively develop the system-wide solutions needed to tackle system-wide problems. Consequently, we have designed a L&SC involvement communications and engagement (ICE) programme.
- Our ICE programme will create widespread understanding of the need for radical change; raise awareness of what individuals and communities can do to improve their health, resilience and behaviours;

10.3. In addition to the ICE programme, we will seek specific support from external agencies such as, the Strategic Clinical Networks, Health Education England and the Innovation Agency North West Coast to:

- Engage clinical leaders and networks
- Learn from other areas
- Increase the diversity and creativity of our thinking
- Accelerate change

10.4. Benefits within the LDR will be managed using the principles and tools associated with the Management of Portfolios (MoP) and the Managing Successful Programmes (MSP) methodologies. A Benefits Management Strategy will outline the framework for how benefits will be quantified and measured, the roles and

responsibilities for benefits management and the associated governance arrangements. To manage the complexity of Lancashire's partnership, the approach will outline:

Who will benefit from the change

- This is about being clear who the stakeholders are in the project, what is the current issue that they are trying to solve, are there also associated dis-benefits of the change that will affect other stakeholders?

How will they benefit from the change

- Look at current and potential future states, where does the organisation see the most benefits coming from, where are the points in the service that implementing this change will impact on and will this change make the service more efficient , increase productivity and save the stakeholder money.

What are the defined high level benefits

- Once the stakeholder fully understands who will benefit and how, they can be more specific about the benefit they want to measure and this can form the case for change.

When will the benefits be realised for the client or wider community

- Some benefits are immediate and some benefits can take more than a year to show. Looking at all the benefits a stakeholder wishes to realise will identify quick wins and which benefits are likely to be longer term gains.

10.5. A Benefits Register will be developed at the start of each project that will contain details of all the quantitative cash releasing and non-releasing benefits, as well as the qualitative benefits associated with the project. Each benefit will contain (as a minimum):

- A description of the benefit and when it is expected to occur, and over what period of time
- Details of benefits ownership
- Measurement criteria
- Any dependencies and risks

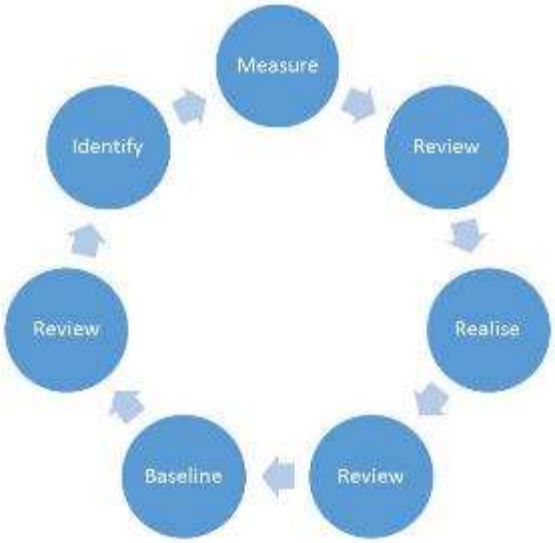
10.6. The broad definition of benefit outcomes for the LDR will be:

- Cash Releasing = Financial returns that can be legitimately put back in the budget, e.g. Staff costs

- Non Cash Releasing = Financial returns that are put back into the system e.g. Clinical time saved that can be put into other areas such as developing a new system or clinic.
- Qualitative = A benefit to the patient or staff that cannot be quantified in financial terms e.g. improved clinical interventions for a patient or improved work life balance for staff

10.7. The approach we would take when managing benefits across the programme would follow the diagram below, starting at Identify.

Diagram 5 – The LDR benefits realisation process



10.8. Within the LDR the list of benefits is expected to be substantial, and therefore the programme will focus on a small number of key benefits that will be pro-actively tracked and managed throughout the LDR lifecycle. These key benefits will be reported through the Benefits Realisation Plan which will show how benefits are realised, measured and delivered. It will also show appropriate milestones when benefits reviews will be carried out to ensure the project benefits delivery remains on track. This will be supported by a Benefits Tracker tool which outlines on a month by month basis progress for each benefit against its planned target.

10.9. This list will be regularly reviewed and updated to ensure that all benefits arising as a result of the programme are captured and reported through the governance described above and aligned to the wider L&SC programme.

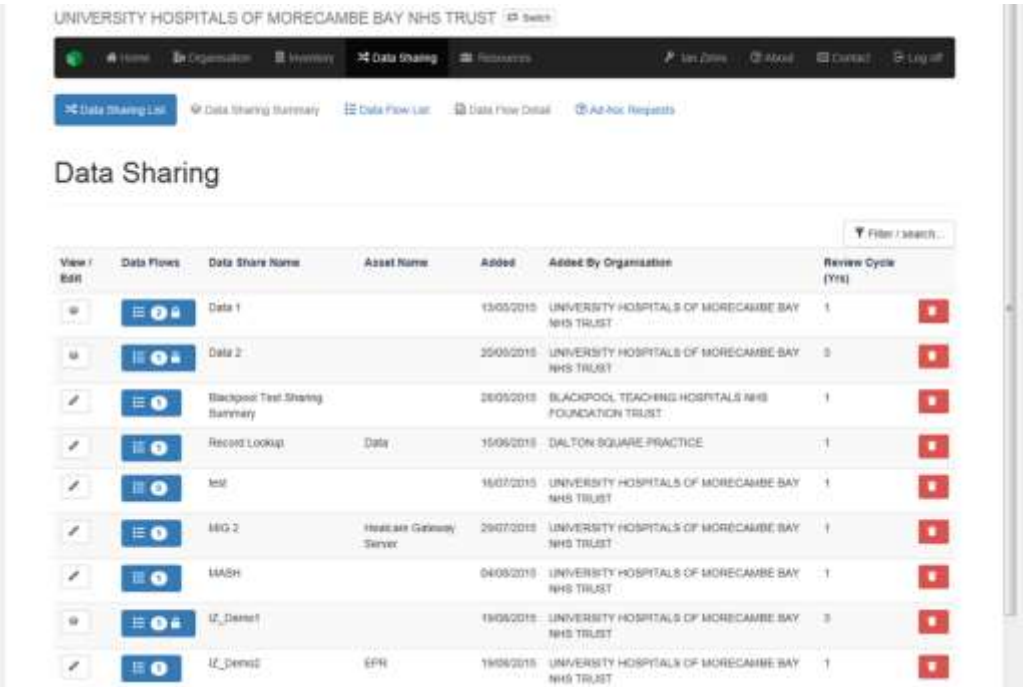
11. Information Sharing

11.1. Back in April 2015, the Cumbria and Lancashire Information Governance Group began work on the development of an electronic information sharing platform that would underpin the introduction of an Integrated Digital Care Record (IDCR).

11.2. For Lancashire, this IDCR solution is based on an international standard called Integrating the Healthcare Enterprise (IHE)[13]. This technology allows organisations to retain control of their data and *publish* records for others to *consume*. This creates a mechanism to allow the real-time viewing of care documents within local systems without frontline staff having to access multiple systems.

11.3. To support the IDCR, our information governance experts created a common information sharing mechanism that ensures the flow of documents is governed appropriately. The solution is called the Information Sharing Gateway (screenshot below). The online tool, creates a trusted network which forms a tier 1 information sharing agreement. Linked to this, organisations can register the types of data they are publishing (sharing) and request details of the types of data they wish to access (consume). In doing so, organisations have to demonstrate they have complied with legislation.

Screenshot – Information Sharing (IS) Gateway summary screen



[13] http://www.ihe.net/

11.4. The tool has been incredibly successful to date, with over 400 organisations registered. During 16/17, resources have been committed to further develop the functionality of the IS Gateway, linking it electronically into Lancashire Person Record Exchange Service (LPRES), which is the local name for our IDCR. This creates three layers of automated control for our information sharing approach:

- Access control via our shared active directory
- Legitimate use via a transactional flag, referral or other assignment
- Electronic information sharing agreement in place between both parties

11.5. In response to CCG maturity assessment (Line 13, Annex D), work has started to bring on all GP practices onto the IS Gateway by Q4, 16/17. As of June 2016, six CCGs are now actively engaged in migrating legacy information sharing agreements.

11.6. Over the next couple of years a fourth layer will be developed in partnership with the Innovation Agency's Connected Health Cities Programme. This seeks to create an electronic mechanism for federating a citizen's explicit 'consent to share' preferences. Whilst it is acknowledged that this is ambitious, it is undoubtedly something we should aspire to, as more sensitive personal data is captured digitally and processed for secondary uses. In addition to building a technical solution, this particular development will require significant investment in communications and engagement with the public to build confidence, inform and educate. Lancashire's LDR would see Healthwatch and similar agencies playing a pivotal role in this process.

11.7. LPRES is key to the success of Lancashire's LDR, it provides an enterprise approach to sharing information between our stakeholders and with our citizens. The solution will be deployed to all our LDR partners by Q3 16/17, with an expectation that police, fire and rescue and borough councils join in 17/18 (as part of transforming lives). Once connected an organisation can:

- Share tests, documents and images
- Pull data together to create an integrated shared record view
- Replace legacy integration solutions to reduce cost and complexity
- Send and receive data with patient-held records / applications
- Send and receive data with patient-held technology (BMI, blood glucose etc)

11.8. Over the life of the LDR, LPRES will transact 90% of the record sharing requirements for Lancashire. To fulfil the remaining 10%, we will link into the Connected Health Cities Programme, which is developing an inter-regional patient information exchange to federate data across the North of England. The LPRES solution has been part-funded by NHS England's IDCR Technology Fund.

11.9. Beyond our technical solutions, stakeholders have expressed a need to establish a formal agreement (known locally as the Watling St. Agreement) between organisations that sets out the principles of our information sharing ambition. This would be a memorandum of understanding signed by stakeholder boards, committing to:

- Ensure shared care documents are:
  - Timely
  - Accurate
  - Relevant
  - Fit for purpose
  - Captured electronically
- Ensure the processes for sharing information are aligned to new models of care

11.10. This agreement will be in place by Q3 16/17 and will commit organisations to the delivery of their paper-free trajectory and to uphold the principles of sharing.

11.11. In summary our information sharing approach is central to the delivery of our LDR. We have made good progress to date in harmonising our information governance processes onto the IS Gateway and we have deployed a regional health information exchange. Going forward we intend to accelerate the use of these strategic initiatives to underpin paper-free at the point of care, to enhance our universal capabilities and most importantly, to empower citizens to access and contribute to their healthcare records. The timeline for our information sharing capabilities is set out in Annex F.

12. Resources

12.1. It is anticipated that significant investment will be required to meet the full ambition of this LDR in delivering transformational change at pace and scale. The application of this resource will primarily be in the areas of business change, citizen and clinical engagement. Fortunately, most of our secondary care providers already have plans or solutions in place to improve their digital maturity. However, all have identified potential gaps. Typically in the areas of business change capacity (to meet new timescales), meeting regional interoperability standards and providing digital solutions for citizens.

12.2. Current levels of investment in digital vary between organisations. In total Lancashire has over 1100 people working across the professions associated with health informatics.

12.3. Secondary care providers spend in excess £37m on the provision of ICT related services and have a planned capital spend of £14m in 16/17. The total recurrent spend on ICT in secondary care equates to just under 2% of the total spend on healthcare for those organisations. A figure which has remained largely unchanged for several years and is broadly in-line with other parts of England. This falls someway short of the historic expectations outlined in Wanless'[14] fully engaged model

12.4. In primary care we spend approximately £4m providing ICT systems and services, with a further £1.3m spent on equipment (15/16 capital spend). In addition, the Lancashire health system benefits from two Prime Minister's Challenge Fund projects (which have digital elements) and two Vanguard sites bringing in a further £3m of non-recurrent investment into the LDR footprint.

12.5. Beyond our health partners, there are many other institutions with collaborative schemes operating in Lancashire that we can draw on to support our LDR. These schemes typically have elements of translational research, academic evaluation and supplier partnerships that if connected together through the LDR will drive innovation within the broader STP. Typical examples being:

[14] http://si.easp.es/derechosciudadania/wp-content/uploads/2009/10/4.Informe-Wanless.pdf

Test Bed

- The Lancashire and Cumbria Innovation Alliance (LCIA) Test Bed will be delivered through two neighbouring Vanguard sites (Fylde Coast Local Health Economy and Morecambe Bay Health Community) supported by Lancaster Health Hub (LHH), an established NHS/University partnership comprising 10 local organisations. Over 2 years, this £1.7m initiative will implement and evaluate a combination of innovative technologies and practices aimed at supporting the frail elderly, people with dementia and other long term conditions to remain well in the community, avoiding unnecessary hospital admissions.

Health Innovation Campus (HIC)

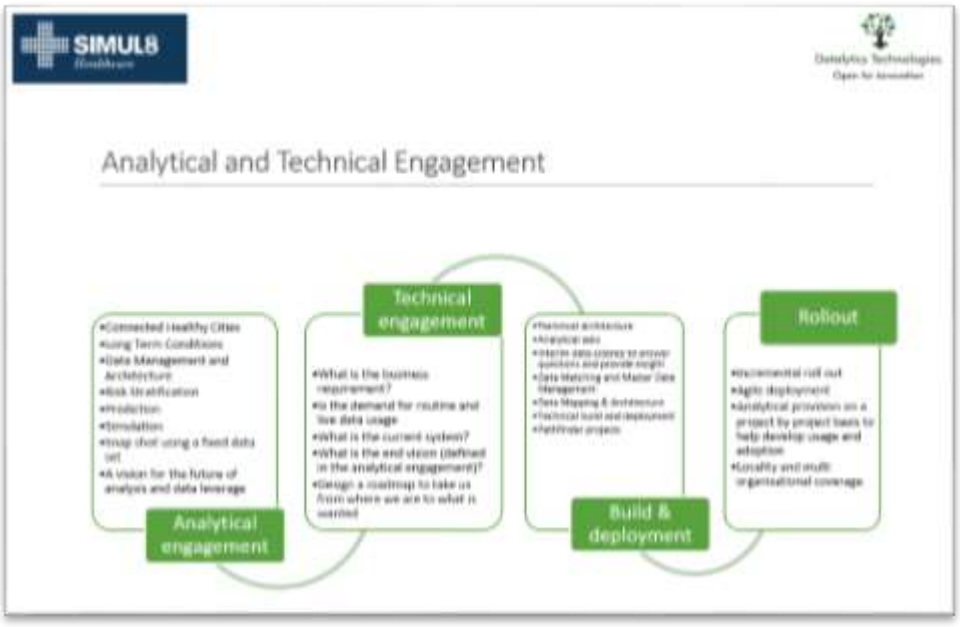
- The HIC based at Lancaster University creates a distinctive national centre of excellence focused on innovation for health and healthcare. The HIC £41m Phase 1 investment includes an 8000m2 new signature building and the enabling works and infrastructure. Four distinctive features of the HIC will include:
    - Innovation in processes and services at scale, with digital solutions as an initial theme. Drawing particularly on health and social science (rather than laboratory science) it will concentrate on driving macro-level system-wide innovation.
    - Stakeholder engagement and collaboration to enable co-creation and co-evaluation ('doing with' rather than 'doing to'), including a particular emphasis on effective engagement and involvement of the public
    - Bringing a wide range of perspectives to address health problems (not just biomedical solutions) and creating market opportunity across a broad spectrum of key sectors – creative & digital, design, advanced manufacturing, construction, environmental, health & care
    - Supporting SMEs through knowledge exchange and innovation programmes to create transformational economic impact, growth and new jobs, through collaboration on product, process and service development and delivery, allied to support for enhanced leadership, management and organisational development.

Connected Health Cities (CHC) North West Coast

- The CHC is a £20m Northern Powerhouse initiative. At its heart is a programme of innovation to use data to deliver new insight and a more connected health system for the benefit of staff and citizens. Led by the Innovation North West Coast, the programme has been awarded £4 million to deliver the CHC in the North West Coast. Locally, Lancaster University leads on the 'People Ark' component of the project. The People Ark will:
    - Develop our region's Health Service by enhancing the capacity of frontline staff to utilise digital tools and data analysis in their day to day work
    - Engage with industry to create a better supply of relevant product offerings to the Health Service.
- The initial areas of clinical focus for the programme are urgent unplanned care associated with Chronic Obstructive Pulmonary Disease and alcohol misuse, both of which have a high prevalence in Lancashire.

Wider Ark Partnerships

- Through collaborative contracts and partnerships created locally or leveraged through the CHC programme, Lancashire is attracting significant investment from industry, such as the example below; two data analytical companies are working with the Vanguards to develop new population health tools. This and other partnerships, represents matched investment in the millions.



- European Social Investment & Innovation Funds
  - Digital Impact (Di3) is a 4 year, £10m European Structural and Investment Fund (ESIF) initiative led by Lancaster University with the Innovation Agency as a delivery partner. The underlying ambition is to increase the growth and absorptive capacity of Lancashire's priority sector SME's, including those wishing to develop digital solutions for the NHS. It supports SMEs to develop new or improved high quality digital and data-driven products, processes and services, centred on three thematic areas:
    - Data exploitation (relevant to all sectors)
    - Cyber security (relevant to all sectors)
    - Digital Healthcare

12.6. In 16/17, the focus of effort around LDR resources will be to firm up the governance structure (see section 8), ensuring that digital resources are encapsulated into new STP governance arrangements. Plus, contributing to the STP Case For Change to describe:

- What changes digital (LDR) will deliver to citizens
- How technology will be used
- How we intend to operate & structure digital solutions
- How stakeholders will interact with digital solutions
- What resources will be required
- What benefits 'digital first' is likely to bring

12.7. To deliver progress on the LDR in 16/17, an investment of £577k is sought to:

- Back fill clinical and informatics resource to coordinate delivery of the universal capabilities
- Engage STP stakeholders in the co-creation of the case for change
- Deliver the enabling activities outlined in section 15
- Finesse the LDR plans for 17/18 & 18/19

12.8. Approximately £220k of this investment could be met through contribution in-kind from our partner organisations and in-part, through the reassignment of resources currently supplied through the Commissioning Support Unit contract. However, the balance will require cash for the procurement of products and services. It should

be noted that there is a potential risk of contributions in-kind, in that individuals often struggle to free up their time to deliver the additional tasks.

12.9. Over the life of the LDR, the level of investment required to deliver the full vision is anticipated to be well in excess of £50m. However, a proportion of this spend is already accounted for within existing budgets. To deliver the LDR over the next four years will require a mix of new non-recurrent funding (STP & grant funds) and re-allocation of existing budgets, although not necessarily exclusively from the current ICT spend.

12.10. During 16/17, we will seek agreement between the LDR partners to put in place a mechanism to align major capital and revenue expenditure to the delivery of the LDR plan, this will leverage procurement opportunities. We will also explore opportunities for pooling a proportion (up to 10%) of ICT spend (across the system) into an LDR Transformation Fund and bid for moneys from the Driving Digital Maturity Investment Fund.

12.11. Once the scope and scale of the L&SC STP is fully agreed a more detailed LDR resource and applications profile will be established. This will be informed by Case for Change and will seek to identify how a 'digital first' approach will contribute to meeting the triple aims and more specifically, the £700m financial gap outlined in section 4.

Chart 1 – Developing the business case for digital transformation

12.12. In summary, by the end of 16/17, L&SC will have described (see Chart 1) how the effective utilisation of digital solutions will empower citizens and care professionals to have the capability to radically transform services, thus delivering long-term sustainability.

13. Building Capability

13.1. Over the next three years secondary care providers are planning to substantially improve their digital maturity from their baseline positions (see section 4, table 2) through deployment of new or existing functionality within their electronic health record (EHR) systems. All of our secondary care providers are at different points in their system refresh strategies; meaning some EHRs are firmly embedded in to an organisations, while others are planning replacements or embarking on a new deployment. This presents a degree of risk to the planned deployment trajectories across the LDR. The tables below outlines the pan-Lancashire targets for the next three years:

Table 5 - LDR Digital Maturity Trajectory

Lancashire Revised Trajectory	Average scores across providers			
Capability group	Baseline score (Feb 16)	Target (end 16/17)	Target (end 17/18)	Target (end 18/19)
Records, assessments and plans	42%	52%	68%	93%
Transfers of care	**42%**	**75%**	**90%**	**100%**
Orders and results management	55%	68%	87%	100%
Medicines management and optimisation	27%	45%	79%	99%
Decision support	27%	32%	54%	83%
Remote care	29%	38%	57%	87%
Asset and resource optimisation	48%	57%	73%	94%

13.2. This trajectory profile has been risk adjusted based on LDR discussions with CCIOs and GP IT Leads. The baseline trajectory and risk profile can be seen in Annex C.

13.3. In delivering these ambitious targets on digital maturity LDR partners will be:

- Agreeing document standards to be implemented into EHRs
- Aligning their deployment strategies to the STP & new models of care
- Seeking opportunities to consolidate clinical support systems
- Identifying funding sources to accelerate deployment
- Using LPRES to publish care documentation
- Linking deployment activities across the provider landscape to the LDR
- Engaging with independent & the third sector providers to incorporate their records into the Lancashire Share Care Record (via LPRES)
- Seeking opportunities to optimise the record sharing process

13.4. For the Universal Capabilities (UC) outlined in Annex B most of the supporting technical solutions are in place. The challenge for the next three years will be driving uptake and adoption. From a technical perspective Lancashire has already achieved:

- All GP practices have patient online services activated
- All have practices and pharmacies able to transact electronic prescribing
- All secondary care providers accessing the summary care record & an enhanced local summary care record
- A pan-Lancashire deployment of free public access Wi-Fi
- A single workers Wi-Fi network that spans from Ormskirk to Sedbergh

13.5. Consequently the emphasis of the UC delivery plan, is primarily centred on sharing good practice, building stakeholder confidence in the technology and driving demand for on-line services with citizens.

13.6. The maturity of social care providers is broadly aligned with that of our secondary care providers. Improvements in paper-free systems on either side of the partnership will have a positive impact on the overall level of digital maturity across Lancashire. Going forward, the implementation of LPRES will significantly improve the flow of data between organisations and increase the coverage of the NHS number in social care.

13.7. From patient risk perspective the deployment of Child Protection Information is an area that Lancashire needs to address promptly, with central Lancashire being the only area currently actively using the solution. To respond to this challenge, the LDR will seek to align ongoing work on the Child Health Information System with the child protection agenda.

13.8. Another area that requires significant improvement is sharing End of Life (EOL) preferences (UC8). Whist there are pockets of good practice across Lancashire, there is still considerable work to do in mapping out processes and ensuring any care professional along the pathway can view and contribute to the record. There is also a desire to ensure the patient and their carers are involved in the process and can contribute to the electronic shared record. The CCG maturity assessment (Annex D) highlights in question 7, that only 4 out of the 8 CCGs have a working system in place.

13.9. To maximise the use of our resources and accelerate delivery of the LDR, secondary care organisations have formally agreed to collaborate by signing up to a Memorandum of Understanding (MoU) that covers:

- Sharing quality indicators
- Liberating data and putting it to work
- Adopting shared digital health record systems
- Shared digital infrastructures
- Shared learning
    - promoting the exchange of expertise and organising events
    - sharing procurement knowledge and expertise
    - sharing knowledge and capability in design, architecture and standards
    - collaboration to ensure effective capability for work stream efficiency
    - conference and showcasing
    - formation of joint working groups and networks
    - shared Health Informatics Operational Plans and Digital Roadmaps

13.10. The MoU is intended to improve working relationships between provider teams and enshrine the following principles:

- Promoting best practices, patient safety and high quality care
- Respecting each other
- Using our resources efficiently and effectively
- Keeping each other fully informed about developments

13.11. Key to delivering success on digital maturity and the universal capabilities is being able to monitor progress against the delivery of key milestones. The development of this initial LDR has highlighted the challenge of getting robust performance monitoring data. Whilst many of the data discrepancies have been ironed out through the development of this document, there is still more to do in the coming months, typically in the following areas:

- Building a LDR delivery dashboard for automated performance monitoring
- Aligning local referral booking slots to national eRS reporting
- Working with the CSU to improve practice level reporting on
    - Patients with active live accounts
    - Patient online appointments transacted vs bookable
    - Repeat prescriptions transacted outside EMIS

- EPS transaction data
- End of Live EPaCCS

13.12. In 16/17, in addition to delivering improved digital maturity and the Universal Capabilities described above, Lancashire will continue to progress a number of ongoing enabling activities that will support the objectives of the LDR and the emerging STP. These are described in the next section; the relationship between these activities and the new LDR requirements is outlined in the table below:

Table 6 - Alignment of enabling activities to LDR & STP

LDR & STP Capabiilties	16/17 Enabling Activities				
	Record Sharing	Empowered Citizen	Enabled Citized	Learning Healthcare System	Enabling IT
LDR Paper free at the point of care					
Records, assessments and plans	✓	✓			✓
Transfers of care	✓	✓			
Orders and results management	✓				✓
Medicines management and optimisation	✓				
Decision support	✓	✓		✓	
Remote care	✓	✓	✓		✓
Asset and resource optimisation	✓				✓
LDR Universal Capabilities					
C1 - Access to GP Information	✓				✓
C2 - Access to GP data for high risk patient	✓			✓	✓
C3 - Patient can access their GP record	✓	✓			
C4 - GPs Can refer electronically to secondary care	✓				✓
C5 - GP receive timely electronic discharges	✓				✓
C6 - Social care receive electronic ADWN	✓				✓
C7 - Clinicians can access CPIS in unscheduled care	✓				
C8 - Professionals can access EOL preferences	✓	✓			✓
C9 - Electronic Prescriptions in place	✓	✓			
C10 - Patients can book appointments / meds online	✓	✓			
STP Universal Capabilities / Workstreams					
Acute care transformation	✓	✓	✓	✓	✓
Integrated place-based out of hospital care	✓	✓	✓	✓	✓
Prevent & rehabilitation	✓	✓	✓	✓	✓
Supporting placed-based care / Multispecialty Community Providers	✓	✓	✓		✓
Sample workstream 1 - Urgent Care Transformation	✓	✓		✓	✓
Sample workstream 2 - Children & Young People's Health & Wellbeing	✓	✓	✓		

14. Enabling activities

14.1. As stated previously, this LDR will require further iterations over the coming months as new requirements emerge from the L&SC programme and elsewhere. Nevertheless, there are enabling activities already taking place or being planned that will underpin these emergent requirements. Principally, these activities have been initiated under the banner of the Digital Health Board to either tackle current operational issues or develop new approaches for future transformation. The funding for these activities is either in place or will need to be addressed in the coming months as part of the STP planning process.

14.2. Once this LDR is approved the activities below will form a baseline programme for 16/17, including delivery of the universal capabilities and aspects of paper-free at the point of care not already incorporated. These are cross-cutting activities spanning LDR partners and in addition to organisational activities. Alterations or amendments to the programme will be subject to a change control process.

Record Sharing

- Continue to roll out Local Person Record Exchange Service (LPRES) to stakeholders, expanding the portfolio of standardised documents for exchange within the system
- Explore solutions for using technology to support adherence to clinical guidelines and workflow
- Work with stakeholders to seek opportunities for clinical systems consolidation and to expand the breadth / depth of digital records
- Continue to support collaboration and further development of the Cumbria & Lancashire Information Sharing Gateway Tool
- Explore opportunities to develop a federated data sharing model that allows data to be shared with tertiary and specialised services outside of Lancashire

Empowering Patients / Citizens

- Explore an approach to use LPRES as a mechanism to provide citizens with unified access to their care records
- Map out clinical App usage and identify any common approaches.
- Explore mechanisms to standardise App usage in clinical pathways (see portal mock-up below)
- Establish a common set of clinical standards and protocols for App usage

- Learn from others and test out solutions with patients, clinicians and citizens

Screenshot – Example of a Clinical App Portal

Enable Patients / Citizens

- Develop care professionals' skills in delivering digital care in partnership with Lancashire's workforce development network
- Create a 'digital first' resource kit for teams seeking to transform their services, based on a proof of concept with sexual health and obesity services
- Promote digital literacy for citizens by supporting doteveryone and similar
- Support stakeholders developing digital channels for generating, collating and acting on patient feedback (Twitter, Facebook & Skype etc.)
- Engage the public, patients and staff in testing new digitally enabled services, particularly solutions that harness third sector community-based assets. Evaluate tests of Rallyround[15] and online patient participation groups
- Develop digital solutions that improve health literacy and empower patients to be active participants in their care. Engage with Public Health leads to develop the design principles
- Encourage peer to peer support amongst patients using social media, supported by clinicians.
- Explore the potential for digital social prescribing

15 https://www.rallyroundme.com/welcome

- Exploit new technologies that help deliver care closer to home and near patient testing. Test, evaluate and where appropriate link to transformation initiatives

A Learning Healthcare System

- Map out the use of patient decision aids and clinical decision support tools with a view to sharing good practice across Lancashire
- Coordinate / integrate with regional initiatives and groups, such as the Lancashire Testbed[16] and the Connected Health Cities programme[17]
- Work with the Information Governance network to develop a consent to share model with citizens that supports secondary uses
- Work with Lancashire's workforce development network to improve the informatics skills within the workforce

Enabling IT Infrastructure

- Continue to expand the availability of public access Wi-Fi across Lancashire
- Collaborate and optimise across the stakeholder's IT estate, to reduce cost and share expertise. In particular, collaborate on solutions that support workforce mobility, such as:
    - Simple, fast logons using shared Wi-Fi
    - Consolidated data centre compute & store facilities
    - Expand the use of open source solutions
    - Expand the use of cloud-based solutions (e.g Office 365)
    - Link telephone, instant message and video solutions
- Explore opportunities to rationalise clinical support and operational systems in line with emerging new models of care, for example - pathology, radiology and workforce rostering
- Explore collaborative opportunities for the procurement and accelerated deployment of patient identification technology using GS1 standards
- Expand the use of solutions that allow multidisciplinary teams to work seamlessly, e.g. the Advice & Guidance App developed in North Lancashire
- Create a common catalogue of telehealth / care solutions for stakeholders

16 https://www.lancashirecare.nhs.uk/test-bed

17 http://connectedhealthcities.com/

14.3. The list above contains a mix of projects, large and small. Some projects will be delivered at an organisational level, others across a community and a few at a Lancashire level and beyond. Further work will be required to define specific resource requirements and to align investment being made elsewhere in the system. The primary outcomes for these projects are to:

- Support safe, effective care
- Share knowledge and experience
- Co-create design principles and common standards
- Create capacity for innovation and service redesign in the digital space
- Build relationships and trust around digital innovation
- Reduce cost where possible

15. Managing risks and opportunities

15.1. All health and social care partners have achieved a satisfactory rating for their information governance assessment in 15/16. This demonstrates they have policies and procedures in place to manage data in a safe and secure manner.

Table 7 - Information Governance Assessment 2015/16

Organisation Name	Score	Rag Rating
Blackpool Teaching Hospitals NHS Foundation Trust	83%	
East Lancashire Hospitals NHS Trust	71%	
Lancashire Teaching Hospitals NHS Foundation Trust	81%	
Southport and Ormskirk Hospital NHS Trust	76%	
University Hospitals Of Morecambe Bay NHS Trust	78%	
Lancashire Care NHS Foundation Trust	78%	
Blackpool Borough Council	66%	
Blackburn with Darwen	79%	
Lancashire County Council	95%	
M& L Commissioning Support Unit	77%	
Blackpool CCG	91%	
Blackburn with Darwen CCG	91%	
Chorley & South Ribble CCG	92%	
Fylde & Wyre CCG	91%	
Greater Preston CCG	92%	
East Lancashire CCG	91%	
North Lancashire CCG	91%	
West Lancashire CCG	91%	

15.2. The established LDR governance structure described in section 8 will monitor compliance with current and emerging standards for security and patient safety associated with technology (including addressing the gap identified in CCG Maturity Assessment Line 8, Annex D). The governance groups will also:

- Oversee accessible information standards through the LPRES programme
- Oversee the application of new data security and encryption standards across common infrastructure (e.g. WAN, Active Directory & Cloud)
- Seek out opportunities to improve business continuity through collaboration

15.3. All risks and issues associated with the delivery of the LDR will be managed using an enterprise risk management methodology, meaning the programme will not only seek to manage and mitigate risk, it will also seek out opportunities. All projects delivered within the LDR will:

- Identify risks
- Allocate an owner
- Evaluate the impact of the risk
- Plan and implement mitigation
- Assess effectiveness

15.4. High-level risks will be reported through the LDR governance structure to the Digital Health Board and where appropriate on to the STP Programme Board. Individual organisations will manage their own risks associated with delivery of digital maturity. Except where a risk impacts on the cross-organisational delivery of the LDR, in which case it will be reported on the LDR risk register.

15.5. All provider organisations have committed to the deployment of GS1 Standards and are exploring collaborative approaches to accelerate deployment of solutions. This work falls into the Enabling Infrastructure work stream outline in section 14.

15.6. By far the biggest opportunity presented by the LDR is working together. By the very nature of our current state, our working practices and approach are not achieving a sufficient pace of change.

16. Measuring the success of our Local Digital Roadmap

16.1. Going forward into the next three years this roadmap will create a number of work streams that will support the strategic ambitions of the stakeholders. The exact definition and scope of these will form through continued discussion with stakeholders. At this stage in the process, the foundation of the roadmap is based on the following broad themes:

Table 8 – Capabilities deployment success metrics by theme

LDR Theme	Measures of success
Sharing records across organisations to support direct care giving: • Working with stakeholders to deliver paper-free at the point of care, building the capability and coverage of systems that capture healthcare data • Establishing standards that enable the flow of data between organisations and to the patient • Ensuring record sharing meets legislative standards and that the citizen is actively involved in any decision to share • Seeking out opportunities to reduce the burden of administration for our workforce	• A process is in place adopt standard care documentation across our STP footprint (16/17) • All LDR partners have signed up to the Watling St. Agreement (16/17) • All LDR primary & secondary care organisations have signed up to Information sharing Gateway (16/17) • Citizens will be able to manage their consent to share preferences online (18/19) • All health & care organisations (Inc. NWAS & 111) are connected & sharing care documents via LPRES (17/18) • We have plans in place for connecting police, fire & rescue, independent providers, local councils and third sector to LPRES (16/17) • An electronic shared care record is in use by health & care professionals (16/17) • LDR partners are publishing 80% of relevant care documents to LPRES (17/18) • We will have demonstrated improved administration processes freeing up more time to care (17/18) • All relevant care documentation is captured electronically (18/19) • All relevant electronic care documentation has been standardised (18/19)

LDR Theme	Measures of success
Empowering the patient to be an active participant in their care: • Creating a mechanism for patients to readily access and contribute to their electronic care records in a consistent and meaningful way • Promoting the use of patient health applications in a standardised way using both mobile and web technologies • Exploring how technology can be used to help improve health literacy across the population • Utilising digital health technologies to support the prevention and the health promotion agenda	• Citizens in Lancashire with a long term condition will have accessed their online primary care record, booked an appointment online or ordered a prescription (30% Q1 17/18, 75% Q1 18/19) • Citizens can access their documents published on LPRES (Q4 17/18) • All citizens with a long term condition can access applications to help manage their health and wellbeing (20% Q2 17/18, 75% Q4 18/19) • All citizens have online access to personalised health promotion information (17/18) • Citizens can access on-line health and wellbeing tools that are linked to their care records (17/18)
Enabling citizens through the use of technology to live independent, healthy lives: • Harnessing care professionals' skills in designing and delivering technology-enabled care • Engaging with, and involving, the public and service users of health & social care in service design of technology-enabled care services • Expanding the use of technology-enabled care in a safe and consistent manner • Encouraging peer to peer support networks for patients, that harness the power of communities and use social media and other tools (supported by frontline workers)	• All residents in care homes have access to remote telemedicine to prevent unnecessary admission to hospital (17/18) • All new services offer a 'digital first' approach, where appropriate, that encourages citizens to use technology as part of the their self-care and to interact with care professionals online (17/18) • Patients with long term care needs are offered technology that allows them to be treated / use services in their home or near to home (25% 17/18, 75% 18/19) • Care professionals managing long-term conditions understand the potential of and routinely offer technology-enabled care (18/19) • Digital solutions are in place to support peer networks and social prescribing (17/18)

LDR Theme	Measures of success
Using data to create a Learning Healthcare System: • Building skills and capability in the analysis and interpretation of healthcare data • Create an approach that allows data to be brought together for the purpose of improving health outcomes • Increasing the breadth and scope of patient decision aids and clinical decision support tools • Working with academic partners to accelerate the diffusion of research into practice • Developing a citizen consent to share model that supports appropriate secondary uses for healthcare data	• Agreed plan for the consolidation of our data and the associated business intelligence resources (Q4 16/17) • New analytical tools in regular use to support families with complex needs and other multi agency initiatives (17/18) • A regional (nationally compliant) child health information system is in place supporting a multi-agency children & young people's health & wellbeing (17/18) • Frontline professionals can use predictive analytical tools to manage citizens with long term care needs (17/18) • Frontline professionals can access real time analytical tools to monitor professional standards, manage capacity and demand (17/18) • Citizens actively engaged in managing their consent preferences to share data for healthcare research (18/19) • A mechanism is in place to systematically analyse cross-agency population data in near real-time (18/19)
Creating a robust, affordable technical infrastructure that supports the clinical and operational workforce: • Ensuring stakeholders exploit opportunities to reduce costs on ICT infrastructure • Designing ICT that allows the workforce to deliver care closer to home and across organisational boundaries • Exploiting technology to improve communications between organisations and to the patient	• All staff can seamlessly access online systems and services from any public sector building (16/17) • Telephony, instant messaging and video consultation is ubiquitous, with clinicians using it for multidisciplinary meetings / advice (& guidance) and citizens using it to contact care professionals (17/18) • All staff have the ability to access care records at the point of care (17/18) • All care record systems, including departmental solutions are linked to the shared care record (18/19)

LDR Theme	Measures of success
Creating a robust, affordable technical infrastructure that supports the clinical and operational workforce - continued	• All LDR partners have an agreed approach for Cloud Service Adoption where applicable to the LDR (16/17) • All providers have deployed a patient identification technology, to GS1 Standards (17/18) • All LDR partners align major ICT capital investments to the LDR plan (16/17) • All LDR partners seek to align major ICT service contracts to the LDR plan (16/17) • All opportunities for collaboration and consolidation of internal ICT services are actively pursued (16/17)
Exploring how the LDR can support economic growth within the region: • Connecting and aligning our regional digital health assets • Exploring opportunities for collaboration between the public sector in Lancashire and local businesses (*see example below) • Creating an environment for digital innovation to flourish in the region • Working collaboratively across public, private and third sectors to seek out digital solutions that address the wider determinants for health	• LDR partners support regional growth schemes in partnership with the Local Enterprise Partnership (16/17) • LDR partners actively engage local businesses in the co-creation of new digital solutions to support the STP (17/18) • LDR partners work with regional universities and the Innovation Agency NWC actively engaging researchers in the service transformation process (16/17) • LDR partners working in partnership with universities and businesses to successfully bid for innovation grants (16/17)

*"*A specific example of how digital health can support economic growth in the region is the proposed Digital Health Village development at Chorley. This innovative project, aimed at creating over 700 jobs, will bring together office and data centre provision with a 40 bed step down care home, a mix of 125 affordable and private houses, and the adjacent district hospital to create a hub focused on supporting start-ups and small companies developing and testing digital health solutions. "*

Gary Hall, Chief Executive, Chorley Council

17. Sign-off and next steps

17.1. Having a roadmap document alone will not bring about change. What it can do is act as a catalyst to bring people together to start the dialogue about what the future could look like. The scale of the challenge that lies ahead requires us all to commit to bold, effective large-scale change. However, first and foremost we need to achieve a common understanding of what we want to change and why.

17.2. Alongside our commitment to change, we also need to be united in our desire to use technology, which has the potential to transform the way we do things. If we choose to embrace it, it will improve services and empower our citizens to live longer, healthier lives. To make it happen, going forward we need to:

- Continue to develop the vision for the future and closely align it with stakeholder strategies
- Determine the scope and scale of our collaboration
- Have a shared understanding of what activities are best done at scale and those that are best delivered locally
- Ensure we invest time and resources across our partnership to achieve true and meaningful co-creation
- Frame and reframe the roadmap, communicating the vision in a clear and concise way to the citizens and the workforce
- Build partnerships with business that maximise our investment and sustain regional growth
- Seek out a diverse range of stakeholders with a view to incorporating and aligning our transformational agendas
- Be bold in our ambition and harness the creativity and diversity of our workforce
- Make sure we have a clear case for change, including a shared understanding of the realisable benefits, and ultimately ensure that the programme is financially viable

17.3. The mechanism for signing off this LDR has been aligned with the local STP process. It is a working document that will be subject to change as new requirements emerge from the STP work streams. This first iteration has been approved by the all the partners through the following process:

- ✓ Publication of draft versions to all stakeholder organisations inviting comment

- ✓ Sign-off by CCIOs, CIOs and CCG GP IT Leads
- ✓ Sign of at Lancashire's Digital Health Board
- ✓ Sign-off at Lancashire & South Cumbria STP Programme Board

18. Summary

18.1. The Lancashire care system is facing a formidable challenge, one which leaders must rise up to. New technology and specifically digital health, has the potential to transform the way we deliver services.

18.2. Across our community we have a wealth of expertise and a rich asset base to harness digital health if we choose to work together. Having identified the scale of Lancashire's challenge we must work collectively to describe how technology can help and set about to transform the system.

18.3. Over the coming years through delivery of this LDR, L&SC community aims to ensure:

- Its citizens are able to use technology to actively manage their health and wellbeing.
- Its workforce is able to harness technology to deliver new online services and provider care remotely
- Its systems support safe, high quality and cost effective care

18.4. To quote Rosabeth Moss Kanter from Harvard Business School:

> ''*Leaders must wake people out of inertia. They must get people excited about something they've never seen before, something that does not yet exist'.*

18.5. This first iteration of our LDR refines and reframes the existing digital health agenda, moving us forward towards a unified digital roadmap for Lancashire. One that leads to a true digital transformation making the healthcare system faster, easier and more engaging for citizens.

Annex A - Capability Deployment Schedule

The table below brings together all the elements of this LDR. The table provides timeframe for the delivery of new capabilities. It is envisaged this will develop significantly as the STP plans mature in the coming months. The capabilities have been categorised in relation to paper free at the point of care and represent the system rather than specific organisations.

Who	What	Year	Capability group
Frontline staff	Will have access to new analytical tools to support families with complex needs and other multi agency initiatives	16/17	Decision support
Frontline staff	Can access a shared record view from LPRES	16/17	All Care Documentation
All LDR partners	Will have an agreed approach for Cloud Service Adoption	16/17	Enabling Infrastructure
Citizens	Will have access to free public access Wi-Fi in hospital buildings	16/17	Enabling Infrastructure
Citizens	Can access their primary care record	16/17	Online access
Citizens	Will be able to order their repeat prescriptions online and have them delivered electronically to their pharmacy of choice	16/17	Online access
All LDR Partners	Have an electronic information sharing agreement in place	16/17	Standards
Urgent care staff	Will be able to identify high risk patients and access a relevant case management plan electronically	17/18	Records, assessments and plans
Urgent care staff	Will be able to access and update child protection notifications electronically	17/18	Records, assessments and plans
Frontline staff	Will be able to access End of Life Preferences at the point of care	17/18	Records, assessments and plans
GPs	Will receive timely electronic discharge notices for their patients receiving in-patient care in Lancashire	17/18	Transfers of care
GPs	Will receive timely electronic notifications of care given in secondary care	17/18	Transfers of care
All LDR Partners	Will use the NHS number on electronic document exchanges	17/18	Transfers of care
Frontline staff	Will be able to access a range of diagnostic test results at the point of care	17/18	Orders and results management
Frontline staff	Will have access to regional child health information system to support children & young poepl's health & wellbeing	17/18	Decision support
Frontline staff	Can use predictive analytical tools to manage citizens with long term care needs	17/18	Decision support
Citizens	Care homes will have access to remote telemedicine to prevent unnecessary admission to hospital	17/18	Remote care
Citizens	25% of patients with long term care needs are offered technology that allows them to be treated / use services in their home or near to home	17/18	Remote care
Frontline staff & Citizens	Will use telephony, instant messaging and video consultation for multidisciplinary meetings / advice (& guidance) and consultations	17/18	Remote care
Frontline staff	Will be able to access an App portal for the selection of appropriate technology solutions	17/18	Remote care
Police, Fire and Rescue & Others	Can access a shared record view from LPRES	17/18	All Care Documentation
All LDR partners	80% of relevant care documentation is published to LPRES	18/19	All Care Documentation
Frontline staff	Will have the ability to access care records at the point of care	17/18	Enabling Infrastructure

Annex A - Capability Deployment Schedule - Continued

Who	What	Year	Capability group
All Secondary care partners	Will have deployed a patient identification technology, to GS1 Standards	17/18	Enabling Infrastructure
Citizens	Can access secondary care records	17/18	Online access
Citizens	20% can access applications to help manage their long-term care needs	17/18	Online access
Citizens	Have access to personalised online health promotion information	17/18	Online access
Citizens	Can access online health and wellbeing tools that are linked to their care record	17/18	Online access
Citizens	Digital solutions are in place to support peer networks and social prescribing	17/18	Online access
Citizens	Will be able to book appointments online to see practice-based staff	17/18	Online access
Citizens	Will be able to conduct appointments online (web, chat, skype, email etc.)	17/18	Online access
All LDR Partners	All new services offer a 'digital first' approach, where appropriate, that encourages citizens to use technology as part of the their self-care and to interact with care professionals online	17/18	Policy Framework
Healthcare professionals	Will use electronic systems to correctly identify patients based on GS1 Standards	17/18	Standards
Citizens	Will be able to access and amend their online palliative care record and share it with others as they see fit	18/19	Records, assessments and plans
Social Workers	Will receive timely electronic notifications of care given in secondary care (ADWNs)	18/19	Transfers of care
Healthcare professionals	Will routinely order standardised diagnostic tests online	18/19	Orders and results management
Citizens	Will be able to undertake certain diagnostic tests close to /in the home	18/19	Orders and results management
Citizens	Will be able to access diagnostic test results (in a meaningful way) relating to them through online tools	18/19	Orders and results management
Healthcare professionals	Will be automatically alerted to abnormal test results through their EHRs	18/19	Orders and results management
Citizens	75% of patients with long term care needs are offered technology that allows them to be treated / use services in their home or near to home	18/19	Remote care
Healthcare professionals	Will be able to access telemetry from monitoring devices both in the hospital and within the patient's home	18/19	Asset and resource optimisation
All LDR partners	Relevant care documentation has been standardised	18/19	All Care Documentation
Citizens	75% can access applications to help manage their long-term care needs	18/19	Online access
Citizens	Will be able to book appointments online to see secondary care staff	18/19	Online access
Citizens	Will be able to actively engaged in managing their consent preferences to share data for healthcare research	18/19	Standards
Healthcare professionals	Will be able to access a complete online view of a patients medications / prescriptions	19/20	Medicines management and optimisation
Healthcare professionals	Will use digital solutions to help prescribe and administer medications and prescriptions	19/20	Medicines management and optimisation
Healthcare professionals	Will be prompted by electronic solutions to monitor and report adverse prescribing events	19/20	Medicines management and optimisation
Healthcare professionals	Will be able to order and allocate hospital beds electronically	19/20	Asset and resource optimisation
All LDR partners	Will have enabled care record systems, including departmental solutions to be linked to the shared care record	20/21	Enabling Infrastructure

Annex B – Universal Capabilities Delivery Plan

Capability 1

Professionals across care settings can access GP-held information on GP-prescribed medications, patient allergies and adverse reactions.

Baseline

The Summary Care Record (SCR) is active in 100% of GP Practices. All secondary care providers have the ability to view the SCR. Uptake is typically highest in Pharmacy and the Emergency Care Departments. All providers are able to use Healthcare Gateway's MIG Viewer, which is believed to be more accurate and complete for summary data. Access to these data by all professionals is estimated to be at 30%. A constraining factor on uptake is accessibility to data at the point of care. Generally data is not embedded within clinical systems. The data is not currently accessible to social care.

Ambition

- To improve the quality of shared data
- To improve the accessibility of data at the point of care
- To improve the coverage

Activities

- Establish a reciprocal partnership agreement between primary and secondary care (The Watling St. Agreement). To set local standards for the timeliness, accuracy and quality of shared records. Complete & signed off by Q4 16/17
- Improve the mechanisms for monitoring the uptake of SCR & MIG access by Q3 16/17
- Publish summary view in LPRES to all providers by Q4 16/17
- Get all GP Practices registered on the IS Gateway by Q4 16/17

National Services / Infrastructure / Standards

- Lancashire will continue to use the national solution and Healthcare Gateway's MIG whilst developing capability within LPRES to surface relevant GP data into health and care systems in real-time. The LPRES programme will also oversee the implementation of national and local document standards.

Evidencing Process

- An LDR dashboard will be developed to present traffic analysis from LPRES
- Traffic Data will be sought from SCR & the MIG
- Audit of service / departmental access
- Auditing frontline staff to seek their perspective and opinion on progress

Annex B – Universal Capabilities Delivery Plan - Continued

Capability 2

Clinicians in urgent and emergency care settings can access key GP-held information for those patients previously identified by GPs as most likely to present (in U&EC)

Baseline

As stated previously, the technical capability exists for the urgent and unplanned workforce to be able to view GP data, however this is not universally deployed. Also the identification of patients with particular conditions likely to present in U&EC is not federated into secondary care EHRs. Some work has been undertaken to share condition flags for frail elderly and mental health patients. This has not been scaled-up across the system

Ambition

- To have a consistent risk stratification mechanism in order to appropriately identify patients with specific conditions
- To have a mechanism for federating condition flags across systems
- To identify appropriate data related to each condition flag and make it accessible at the point of care

Activities

- Identify and prioritise the relevant patient groups for condition flags through discussion with the U&EC STP work stream by Q3 16/17
- Establish data sets / anticipatory care document standards associated with condition flags Q4 16/17
- Through LPRES, federate two condition flags and the anticipatory care documents by Q4 16/17
- Seek to integrate with the North West Ambulance Service by Q4 16/17

National Services / Infrastructure / Standards

- Lancashire will continue to use the national solution and Healthcare Gateway's MIG whilst developing capability within LPRES to surface relevant GP data into health and care systems in real-time. The LPRES programme will also oversee the implementation of national and local document standards.

Evidencing Process

- An LDR dashboard will be developed to present traffic analysis from LPRES
- Traffic Data will be sought from SCR & the MIG
- Audit of service / departmental access
- Auditing frontline staff to seek their perspective and opinion on progress

Annex B – Universal Capabilities Delivery Plan - Continued

Capability 3

Patients can access their GP record

Baseline

All GP Practices in Lancashire have the capability to make patient's records accessible on line. However at the start of 16/17, only 14% of the population had an active on-line account.

Ambition

- To significantly improve the uptake of patients accessing their GP Record
- To establish the reasons why uptake is low and establish any remedial actions
- To educate the public around the benefits of on-line access
- To ensure all patients with long-term care needs are aware of, and offered use of, online services, including accessing their GP record and associated secondary care documents

Activities

- Improve the process for monitoring uptake with EMIS & CSU by Q2 16/17
- In partnership with Healthwatch(s) to better understand the reasons why access is low by Q3 16/17
- Engage GP Practices to identify any barriers to improvement by Q3 16/17
- Align the LDR requirements within the primary care transformation work stream by Q2 16/17
- Seek to increase uptake to 30% by Q1 17/18 for patients with a long term condition
- Establish an approach for publishing all LPRES records to patients by Q2 17/18
- All patients with long-term care needs are made aware of and routinely offered online services by Q4 17/18

National Services / Infrastructure / Standards

- Lancashire will continue to use the EMIS Access solution and seek the support of the national team to improve access
- Lancashire will harness LPRES to enhance to content of online records for patients, ultimately to encompass all published documents

Evidencing Process

- LDR dashboard will monitor access
- Data extracts form EMIS enterprise reporting
- Healthwatch audit to gauge patient opinion

Annex B – Universal Capabilities Delivery Plan - Continued

Capability 4

GPs can refer electronically to secondary care

Baseline

All GP Practices in Lancashire have the capability and make electronic referrals. During 2015/16, an average of 67% of referrals from primary care were made electronically. During March 2016, approximately 55% of the available (secondary care) 1st out-patient appointments were directly booked electronically.

Ambition

- To improve the quality of information exchanged between care providers at the point of referral
- To establish a mechanism to reduce unnecessary referrals
- To reduce the administrative burden of frontline workers
- To make 90% of referrals electronic by 17/18

Activities

- Improve the mechanisms for monitoring progress by Q2 16/17
- Align the LDR requirements within the out of hospital transformation work stream by Q3 16/17
- Identify barriers preventing all referrals being made electronically by Q3 16/17
- Build on the experience of North Lancashire's Advice & Guidance tool in reducing unnecessary referrals. Seek to scale by Q4 16/17
- Identify opportunities for streamlining the e-referral process by Q4 16/17
- Work with hospital out-patient providers to identify mechanisms to achieve a 20% increase in e-referrals by Q416/17

National Services / Infrastructure / Standards

- Lancashire will continue to use the e-Referral Service and explore the use of the Strata application deployed in Cumbria for community and other services. The use of LPRES will be explored for exchanging referrals not currently in scope for e-Referral Service (eRS)

Evidencing Process

- LDR dashboard to monitor access
- Data extracts from eRS & local validation process
- Audit work to gauge progress and identify new issues

Annex B – Universal Capabilities Delivery Plan - Continued

Capability 5

GPs receive timely electronic discharge summaries from secondary care.

Baseline

Across Lancashire providers have deployed a mix of solutions for delivering electronic discharge summaries and have achieved varying degrees of maturity. On average 50% of discharges are sent electronically. Recent work in Central Lancashire with LPRES has created an opportunity for a county-wide approach which overcomes issues with boundary GP Practices. It has also highlighted issues with the MIG and EMIS that means summaries can easily be missed.

Ambition

- To improve the quality of information exchanged when transferring care
- To ensure the mechanisms for electronic discharge summaries are safe and effective
- To make 90% of discharge summaries electronic by 17/18

Activities

- Improve the mechanisms for monitoring progress by Q2 16/17
- Align the LDR requirements within the acute / specialised care and mental health transformation work streams by Q3 16/17
- Establish a reciprocal partnership agreement between primary and secondary care (The Watling St. Agreement). To set local standards for the timeliness, accuracy and quality of shared records. Complete & signed off by Q4 16/17
- To establish LPRES as the standard mechanism for sending discharge summaries, integrating with Messaging Exchange for Social Care and Health (MESH) and other services, as appropriate
- Identify opportunities for streamlining the discharge summary process by Q4 16/17
- Work with hospital providers to identify mechanisms to achieve a 25% increase in discharge summaries by Q416/17

National Services / Infrastructure / Standards

- Lancashire will continue to develop (& incorporate) the document standards for discharge summaries
- LPRES will seek to federate with other regional exchanges through an inter-regional exchange to achieve 100% uptake. This work is being developed through the Connected Health Cities Programme

Evidencing Process

- LDR dashboard to monitor transactions with data from secondary care providers
- Audit work to gauge progress, data quality and identify issues

Annex B – Universal Capabilities Delivery Plan - Continued

Capability 6

Social care receive timely electronic Assessment, Discharge and Withdrawal Notices (ADWN) from acute care.

Baseline

A process for exchanging electronic Care Act 2014 compliant ADWN is not in place in Lancashire. Hospitals largely rely on paper-based processes and secure email. Work has started through the LPRES programme to create interoperable links between health and social care systems.

Ambition

- To have standard electronic exchange process in place for ADWN
- To improve the quality of information exchanged when transferring care
- To ensure the mechanisms for electronic ADWN are safe and effective
- To achieve 100% uptake by 17/18

Activities

- Align the LDR requirements within the care homes transformation work stream by Q2 16/17
- Identify opportunities for streamlining the ADWN process by Q3 16/17
- Improve the mechanisms for monitoring progress by Q3 16/17
- Establish a reciprocal partnership agreement between health and social care (The Watling St. Agreement). To set local standards for the timeliness, accuracy and quality of shared records. Complete & signed off by Q4 16/17
- To establish LPRES as the standard mechanism for ADWN, with integration in place with the three care providers by Q1 17/18
- Utilise LPRES to federate (fill gaps) the NHS number into social care systems Q1 17/18
- Work with hospital providers to achieve 50% electronic ADWNs by Q2 17/18

National Services / Infrastructure / Standards

- Lancashire will comply with the Care Act 2014 standards when deploying electronic ADWNs

Evidencing Process

- LDR dashboard to monitor transactions with data from LPRES
- Audit work to gauge progress, data quality and identify issues

Annex B – Universal Capabilities Delivery Plan - Continued

Capability 7

Clinicians in unscheduled care settings can access child protection information with social care professionals notified accordingly.

Baseline

Only Lancashire County Council and Lancashire Teaching Hospitals have deployed the national Child Protection Information System (CPIS). The two unitary authorities and Blackpool Teaching Hospitals are either committed to, or planning to go live. All other organisations have not started implementation.

Ambition

- To ensure all vulnerable children have a child protection plan and information relevant to their care is shared appropriately
- To align deployment work on CPIS with the deployment of Lancashire's Child health Information System (CHIS)
- To align CPIS plans into our broader Children & Young Persons digital plans
- To achieve 100% deployment in all urgent care centres by March 2018

Activities

- Explore options for connecting LPRES with CHIS & CPIS by Q4 16/17
- Work with Child Protection Teams to ensure child protection plans are timely and accurate Q4 16/17
- Establish a deployment plan for all providers currently not planning to deploy
    - Complete provider implementation checklists by Q3 16/17
    - All providers deployed by Q4 17/18

National Services / Infrastructure / Standards

- CPIS & Mini Services for PDS

Evidencing Process

- Readiness Assessments Complete
- NHS Digital CPIS data reported through the LDR Dashboard
- Audit work with Child Protection Teams

Annex B – Universal Capabilities Delivery Plan - Continued

Capability 8

Professionals across care settings made aware of end-of-life (EOL) preference information.

Baseline

The availability of EOL preferences at the point of care varies considerably across the county. Communities in North Lancashire and the Fylde Coast have in place good mechanisms for sharing EOL preferences. However, even in these places the aspiration of sharing a full electronic palliative care co-ordination plan has not yet been achieved, largely down to technical delays with the GP system supplier in Lancashire.

Ambition

- To ensure EOL preferences are shared with all those who need them
- To ensure care plans accurately reflect patients & carers preferences and are updated as required
- To have a fully populated electronic care plan in place for anybody receiving palliative care
- To enable patients and their carers to access their care plans on-line

Activities

- Conclude the EOL current and future state mapping work by Q3 16/17
- Ensure the EOL plan is accessible across primary and secondary care Q4 16/17
- Integrate the EOL plan into LPRES by Q4 16/17
- Connect North West Ambulance Service to LPRES by Q4 16/17
- Ensure Hospice and other relevant 3rd sector partners can access relevant EOL data by Q2 17/18
- Work with the Strategic Clinical Network to effectively deploy solutions by Q2 17/18

National Services / Infrastructure / Standards

- SCCI1580 Palliative Care Co-ordination: core content
- Use of LPRES to federate data

Evidencing Process

- Audit work with the SCN
- Provider systems can share an EOL data set based on SCCI1580
- LDR dashboard to monitor transactions with data from EMIS & LPRES

Annex B – Universal Capabilities Delivery Plan - Continued

Capability 9

GPs and community pharmacists can utilise electronic prescriptions.

Baseline

All GP Practices in Lancashire have the capability to issue electronic prescriptions. However 10 practices (5%) have not yet gone live. Across the county approximately 67% of prescriptions are issued electronically through the electronic prescription service (EPS). Uptake in Lancashire is higher than the national average (59%).

Ambition

- To ensure that every patient who wants an electronic prescription has one
- To ensure patients can easily order a repeat prescription online
- To ensure patients have choice about where there electronic prescription is sent

Activities

- To promote EPS within Lancashire through Healthwatch(s) by Q4 16/17
- To ensure all practice are live by Q4 16/17
- Explore options for increasing uptake by Q4 16/17

National Services / Infrastructure / Standards

- Electronic Prescription Service

Evidencing Process

- LDR dashboard to monitor uptake and activity with data from NHS Digital
- Audit work from Healthwatch

Annex B – Universal Capabilities Delivery Plan - Continued

Capability 10

Patients can book appointments and order repeat prescriptions from their GP practice.

Baseline

All GP Practices in Lancashire are able to offer online appointments and repeat prescriptions. In 2015/16, approximately 40,000 appointments and 60,000 repeat prescriptions were transacted online through EMIS Patient Access. However this figure excludes the transactions that GP Practices enabled through practice-based online solutions. While there has been progress made in offering online transactions, the availability varies dramatically between practices. Although it is difficult to determine the exact number of appointments on offer in GP Practices, it is likely to be in the region of 6m per year based on national statistics.

Ambition

- To offer every patient the opportunity to book appointments online
- To offer every patient the opportunity to order repeat prescriptions online
- To make available 25% of all appointments bookable by 17/18
- To encourage patients to order repeat prescriptions online
- To ensure all patients with long-term care needs are aware / offered online services
- To routinely offer and conduct appointments online (web, chat, skype, email etc)

Activities

- To improve the monitoring mechanisms for both metrics by Q2 16/17
- To work with Healthwatch(s) to communicate the benefits of online services for patients
- Establish a local team to help practices publish more online appointment slots by Q3 16/17
- To quantify the number of appointments that are offered through unified communications (webchat, video consultation, instant message, email and telephone) by Q3 16/17
- To share good practice and develop a common approach by Q4 16/17
- Continue to drive uptake throughout 17/18

National Services / Infrastructure / Standards

- Professional Standards, seeking support from the national Patient Online Team

Evidencing Process

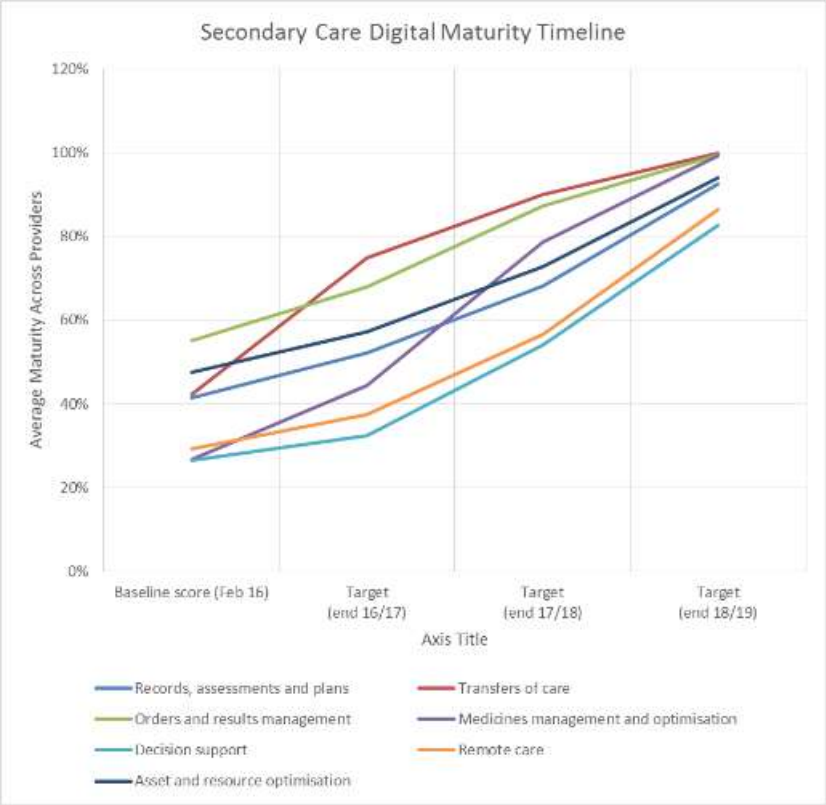
- Audit work and patient engagement
- LDR dashboard to monitor transactions from EMIS
- Monitoring other data sources

Annex C – Capability deployment trajectory (secondary care)

The table below shows the assessed risk against each capability. This assessment was made by local, digital clinical leads based on local knowledge. This means Lancashire will be prioritising the digital maturity in Transfers of Care first and foremost.

Capability Risk Profile

Baseline	Average scores across providers				Risk Profile			
Capability group	**Baseline score (Feb 16)**	**Target (end 16/17)**	**Target (end 17/18)**	**Target (end 18/19)**	**Care Gap**	**Health & wellbeing Gap**	**Finance Gap**	**Gross Risk**
Records, assessments and plans	42%	52%	68%	93%	2	3	2	14
Transfers of care	42%	52%	72%	94%	3	2	2	15
Orders and results management	55%	68%	87%	100%	3	1	2	13
Medicines management and optimisation	27%	45%	79%	99%	3	1	3	14
Decision support	27%	32%	54%	83%	2	2	3	13
Remote care	29%	38%	57%	87%	1	3	2	11
Asset and resource optimisation	48%	57%	73%	94%	1	1	3	8



Annex D – CCG Digital Maturity

		Clinical Commissioning Group							
	Questions	West Lancs	Bwd	Gtr. Preston	E. Lancs	Chorley	Blackpool	Fylde & Wyre	Lancs. North
1	All practices have access to SMS	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
2	All NHS owned GP IT equipment is recorded in an accurate asset register	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
3	All NHS owned GP IT equipment is subjected to an approved IT reuse & disposal policy and procedure	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
4	There is a locally agreed WES (Warranted Environment Specification) for GP IT equipment	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
5	All health & care organisations (including GPS) can access their principal record systems from all local commissioned provider locations.	100%	<95%	<95%	<95%	<95%	100%	100%	<25%
6	The CCG commissioned service provider for GP IT services will have an annually reviewed tested Business Continuity Plan and validated IT Disaster Recovery Plan for services critical to GP service continuity	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
7	A local Electronic Palliative Care Co-ordination System (EPaCCS) supporting the recording and sharing of people's care preferences and key details about their care at the end of life which is integrated with principal primary care clinical systems and meets the requirements of ISB 1580 (End of Life Care Co-ordination: Core Content) is available	Yes	No	Yes	No	Yes	No	No	Yes
8	The practices have access to a formal Clinical Safety System (ISB 160) and qualified clinical safety office	No	No	No	No	No	No	Yes	No
9	All local providers of health & social care sharing patient digital information have systems which maintain a full automated audit of read and write access to individual patient records	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
10	The CCG completes a formal review of the IT Services with each Practice at least once a year	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
11	The commissioned GP IT services include formal P3M (Project, Programme and Portfolio Management) methodologies which are recognised and used in the deployment of GP Clinical systems, local implementation of national solutions and major primary care IT infrastructure changes or upgrade	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
12	Formal governance arrangements are established which ensure the effective mapping and provision of digital enablers that will support delivery of locally identified health and care priorities. Business cases (where necessary) are shared with, and agreed with relevant partners in the local area. Business cases where required for Informatics-enabled programmes with cross-community impact are approved by a relevant cross-community Board	Yes	No	Yes	No	Yes	Yes	Yes	Yes
13	All local GPs and providers of health & social care sharing patient digital information agree to a consistent information sharing model	No	No	No	No	No	No	Yes	Yes
14	All software (including operating systems) used on NHS owned GP IT infrastructure by the practice must be approved and recorded on an software asset & licence register which must confirm the software is appropriately and legally licenced for such use	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
15	The CCG has appointed a Chief Clinical Information Officer (CCIO) or equivalent accountable officer who will provide (clinical) leadership for the development of local IT strategy including the development of primary care IT services.	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes

Annex D – CCG Digital Maturity – Part 2

		Clinical Commissioning Group							
	Questions	West Lancs	Bwd	Gtr. Preston	E. Lancs	Chorley	Blackpool	Fylde & Wyre	Lancs. North
16	There is a local GP IT strategy and programme with roadmap annually reviewed and aligned with local commissioning priorities	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
17.1	There is a comprehensive ongoing training and clinical system optimisation service to support GP Principal clinical systems and national clinical services available to all practices	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
17.2	There is support available to all practices for deployment, training, technical issues, tracking database maintenance and supplier liaison and escalation for GPSoC (lot 1) clinical systems	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
18	GP IT services are commissioned and contracted with robust and clear service specifications	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
19	All CCG commissioned GP IT support services are supported with KPI reports (at least 4/year) and there are annual service performance and contract review meetings	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
20	There is a clear agreed local (CCG) budgeted plan for the full funding of all core GP IT requirements for the next 2 year	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
21	The GP IT infrastructure estate supporting core GP IT (includes desktop, mobile, server and network equipment) has a fully documented plan for refresh and replacement. This must include a local WES (Warranted Environment Specification) for such equipment which as a minimum will meet the WES for the principal clinical systems used and any NHS mandated national systems and infrastructure	Yes	Yes	Yes	N/A	Yes	Yes	Yes	Yes
22	All general practices have secure data storage services available for all electronic data other than that stored in their GPSOC clinical systems and NHS Mail to a standard not less than tier 3 data centre	<95%	100%	<75%	<95%	<95%	<50%	100%	100%
23	CCG Commissioned GP IT support provides consistent support for core GMS contracted hours	No	Yes	No	No	No	No	Yes	Yes
24	The GP IT support service desk has current formal accreditation through a recognised (industry or NHS) scheme or meets the requirements for GPIT service desk in the GP IT Schedule of Services	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
25	GP IT services available include IT Security advice and oversight, including configuration support, audit, investigation and routine monitoring	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
26	Where there is a local community network wholly or part funded through GPIT and used in addition to, or in place of, N3 by general practices AND other locations and care settings the costs are shared between these organisations	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
27	CCG Commissioned GP IT support Service supports general practice to provide extended hours (DES) services	Rest	Rest	Rest	Rest	Rest	Rest	Rest	Rest
28	CCG Commissioned GP IT support Service supports general practice to provide 7 day week services to patients where these are offered	Rest	Rest	Rest	Rest	Rest	Rest	Rest	Rest
29	There is an agreed local strategy and plan for core GP IT infrastructure & software investment to meet the needs of (i) practice organic/incremental growth (ii) practice developments eg mergers (iii) significant primary care developments e.g. new builds	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
30	Within primary care locations Wi-Fi access is available to GPs and primary care delivery staff.	<95%	<95%	<75%	<95%	<95%	<95%	<75%	100%

Annex D – CCG Digital Maturity – Part 3

		Clinical Commissioning Group							
	Questions	West Lancs	Bwd	Gtr. Preston	E. Lancs	Chorley	Blackpool	Fylde & Wyre	Lancs. North
30	Within primary care locations Wi-Fi access is available to GPs and primary care delivery staff.	<95%	<95%	<75%	<95%	<95%	<95%	<75%	100%
31	Access to Wi-Fi services is available to general practice clinical staff across local commissioned provider locations	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
32	There is clearly defined Executive Leadership (CCG) to ensure that digital technology maturity is recognised as a key enabler to achievement of core objectives in the effective commissioning and delivery of quality health and care and future service transformation	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
33a	Formal governance and accountability arrangements clearly articulated and embedded, which effectively engage strategic partners, with terms of reference and reporting responsibilities clearly defined, including the following forums/structures	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
33b	The commissioner (CCG) owns the strategic digital direction and ensures that this is driven by local commissioning objectives	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
34.1	Commissioning of clinical services, routinely includes clinical (CCIO) consideration of digital technologies/systems, together with associated benefits	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
34.2	Service specifications for commissioning of clinical services, include core digital requirements, including, but not limited to data management and reporting, data security, data sharing, systems access, digital technology requirements	Yes	Yes	Yes	NO	Yes	Yes	Yes	No
35	Clear standing financial instructions must be established between commissioners and delivery organisations. Clear reporting, monitoring and review arrangements established to ensure CCG oversight of GPIT funding and expenditure, with clear escalation points agreed	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
36.1	CCG has secured a service that meets or exceeds the 'core' standards outlined in the GPIT Operating model/framework with clearly define local IM&T requirements in the form of a detailed service specification that will ensure local IM&T delivery partners are clear on service needs	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
36.2	Negotiate and contract for IM&T services ensuring value for money through effective use of national framework contract (e.g. Lead Provider Framework - LPF) and procurement mechanisms in accordance with NHSE procurement rules	Yes	Yes	Yes	No	Yes	Yes	Yes	No
37.1	The CCG ensures that appropriate IG and information standards/requirements are clearly specified within any local IM&T service specification and associated service level agreement (SLA) and contractual arrangements with IM&T delivery partners. Able to evidence level 2 compliance for commissioned GPIT delivery partners	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
37.2	Currently NHS England are responsible for commissioning a local IG support service as described in section 6.4 - GPIT Operating Model. GP Practice IGT compliance is being monitored locally to ensure effective delivery of GP IGT support services	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
37.3	IGT compliance is assured through the standard contractual routes with wider health economy providers	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
38.1	The CCG as local commissioner, through formal local governance arrangements, is responsible for ensuring benefit realisation from local investment in digital technology	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
38.2	Benefits are explicitly defined, tracked and captured within individual projects	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
39	CCGs have appropriate mechanisms in place to effectively manage risks and issues in accordance with system wide procedures to help ensure the safe and successful delivery of outcomes associated with digital investment	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
40	CCGs actively promote take up and utilisation of national strategic systems, such as SCR, e-Referrals, GP2GP, EPS2, Patient Online, to enable more integrated care across all care settings and achieve operational benefits for patients and clinicians	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
41.1	There is a comprehensive data quality advice and guidance service is available to all GPs, including training in data quality, clinical coding and information management skills	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
41.2	A formal and structured data quality accreditation programme is commissioned by the CCG and available for GP sites to ensure continuous review and improvement of data quality within General Practice	No	No	No	No	No	No	No	Yes
41.3	Calculating Quality Reporting Service (CQRS), General Practice Extraction Service (GPES), A proactive support service is in place locally to support Quality and Outcomes (QOF) data collection and reporting, which includes review, report management and remedial action planning, particularly around exception reporting, to ensure appropriate data quality within GP sites to enable effective QOF reporting	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Annex E – Social Care (Local Authority) Digital Maturity Assessment

The table below represents a local comparison of capabilities. The RAG assessment is assessed locally and **not** against any national benchmark scores (the assessment is drawn from a PDF output). Summary findings from the assessments are:

- Social care providers are broadly aligned with secondary care providers digital maturity
- The delivery of LDR paper-free trajectories will support increased digital maturity in social care
- Deployment of the LPRES solution will help improve maturity and propagation of the NHS number
- Blackburn with Darwen has identified gaps in the NHS number (standards section) for adults

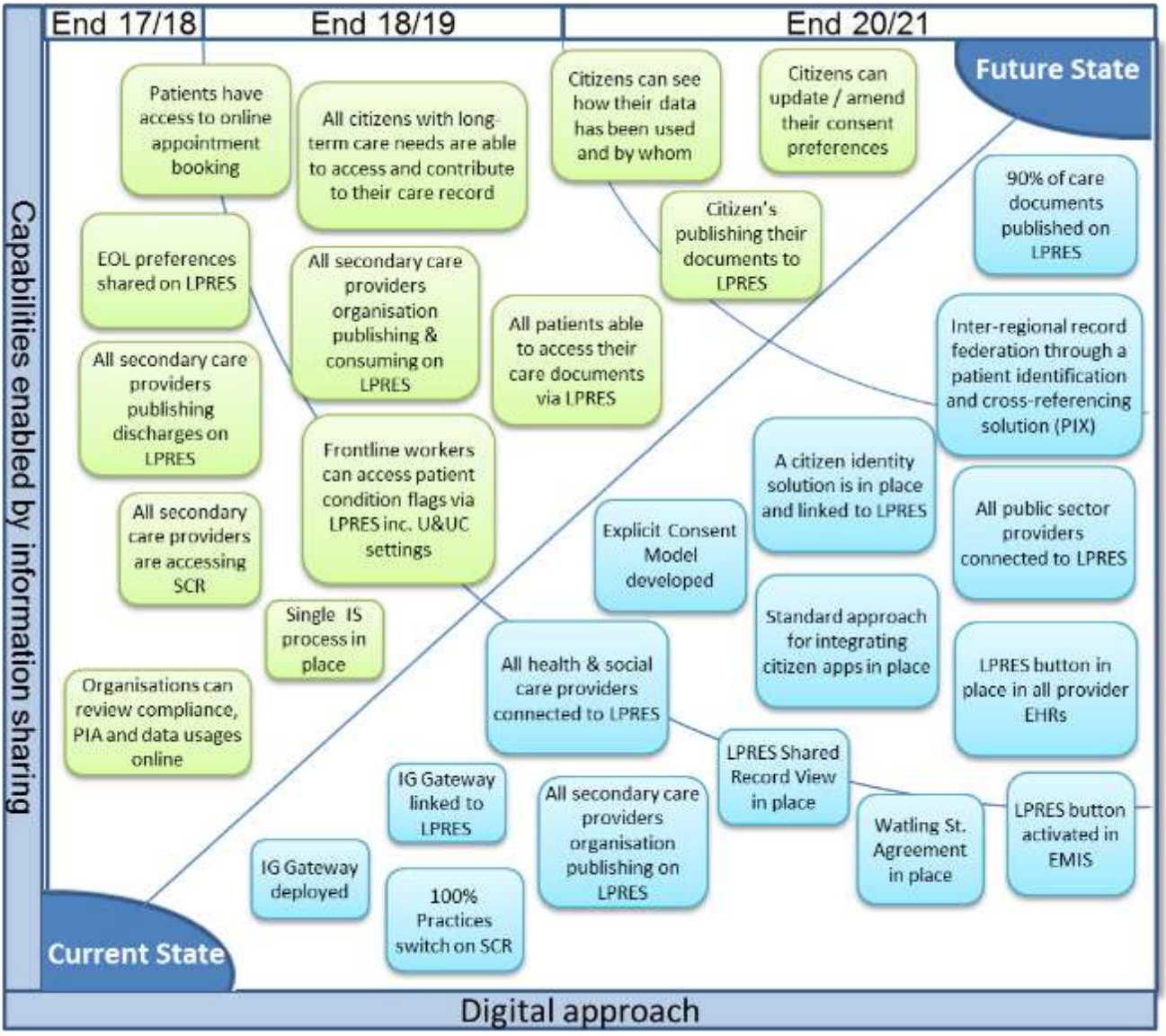
*RAG Rating

Maturity Domain	Blackpool	Blackburn with Darwen	Lancashire CC
Strategic Alignment			
Leadership			
Resourcing			
Governance			
Information Governance & Management			
Records, Assessments & Plans			
Transfers of Care			
Decision Support			
Remote Assistive Technology			
Standards			
Infrastructure			

Key
Satifactory level of maturity
Gaps in maturity or seeking to improve

Annex F – Information Sharing Approach - Lancashire

The table below outlines the capabilities trajectory associated with information sharing. It represents the on-going deployment of Lancashire's Health Information Exchange (LPRES), which is the enterprise solution for sharing records across public sector bodies, independent healthcare providers and directly with the citizen through apps and other online tools.



Local Digital Roadmap on a page

Sustainability & transformation

- Providing technology that works for frontline staff
- Harnessing business intelligence to plan effectively
- Using technology to avoid hospital admissions
- Supporting new models of care
- Offering near patient testing
- Delivering remote care

Collaboration & Co-creation

- Harnessing innovation from vanguards, testbed & health new towns
- Finding out what works from the people who use our services
- Using agency partners, the Innovation Agency & clinical networks
- Developing the digital skills of our frontline workforce
- Maximising the 1000+ Health Informatics workforce
- Building partnerships with academia & business
- Sharing knowledge and expertise
- Building on our regional assets

People focussed

Digital Health

Ecosystem

Four themes, underpinned by record sharing

Collaboration at scale

Back office efficiency

Activated Citizens	Enabled Citizens
Literacy through online access	Technology Enabled Care
Record sharing for safe, effective care	
Learning Healthcare System	Enabling Infrastructure
Data to knowledge	Supporting new models of care

Supporting regional economic growth

Faster, easier & more engaging

Paper-free at the point of care

- Improving clinical systems maturity
  - Records, Assessment & Plans
  - Transfers of care (a priority area)
  - Orders & results management
  - Medicines management & optimisation
  - Decision support
  - Remote & assistive care
  - Asset & resources optimisation
- Capturing & sharing care documentation
- Clinical systems to support safe, effective care

Core capabilities

- Access to GP summary information
- Access to GP data for high risk patients
- Patient's online access to their GP record
- GPs able to refer electronically to hospitals
- Social care can receive electronic notifications
- GPs receive timely electronic referrals
- Clinicians can access child protection data in U&UC
- Professionals can access end of life preferences
- Electronic prescriptions are offered and used
- Patients can book appointments and repeat prescriptions online

Lancashire Health and Wellbeing Board
Meeting to be held on *24 October 2016*

Lancashire Safeguarding Adults Board Annual Report 2015-16

Contact for further information:
Jane Booth, Independent Chair, or Victoria Gibson, Business Manager.
(jane.booth@lancashire.gov.uk or Victoria.gibson@lancashire.gov.uk)

Appendix 'A' refers

Executive Summary

This report sets out the Annual Report of the Lancashire Safeguarding Adults Board (LASB) for 2015-16.

The report is attached as an Appendix. The main body of the report has been written by the previous Chair of the Board, who resigned earlier in 2016 and an Interim Independent Chair has been in place since March 2016.

The report draws attention to the impact of changes in legislation which have put the Board on a statutory footing; it provides a brief local context and information about the Board's priorities in 2015-16, together with analysis of data, it reports on coordination and collaboration between services and draws conclusions re adult safeguarding. The report concludes with a review of news during the year which highlights issues in safeguarding.

What is clear from the report is that adult safeguarding is challenging. Adult vulnerability is complex. The demographic profile of the community will continue to include increasing numbers of people who fall into service user groups that are more vulnerable to risk of abuse or neglect (including self-neglect) because of their health or social care needs or issues of mental capacity, abuse and neglect. The challenge will be, at a time of reducing resources, making a proportionate response and delivering a personalised service.

Recommendation

The Health and Wellbeing Board is recommended to:

- Consider the content of the Annual Report and identify any areas it may wish to comment on and any action it may wish to take.

Background and Advice

Since April 2015 the LSAB has a statutory responsibility to ensure the effectiveness of work undertaken by its members and partner agencies to safeguard adults in Lancashire. This Annual Report reflects on the work undertaken in this regard in Lancashire for the 2015-16 financial year. The report is appended to the end of this report for information. The Lancashire Board has an Independent Chair who has the responsibility, amongst others, to promote good practice and collaborative working. The Chair of the Board is accountable to the Council's Chief Executive who is, in turn, responsible for ensuring its effectiveness.

Lancashire County Council

Protocols are in place which establish the relationship between the LSAB, the health economy, Police and other partners. The Director of Adult Services is a member of the LSAB, as is the Lead Member.

The report draws the following conclusions:

Lancashire's Safeguarding Adults Board has benefitted from the learning arising from members' association with such pan-Lancashire and national activities as work concerning the Mental Capacity Act 2005 and Prevent, the Chair's North West network and the English network of Safeguarding Adult Board Chairs.

Rearranging tasks into more integrated processes has been critical during 2015-16 in Lancashire. Feedback concerning the provision of consistent business support and coordination from the Business Unit (since September 2015) has made a significant and positive difference to the work of the Board and its subgroups. The Action Monitoring Log has sharpened the distinction between the Board's expectations and the actions of individuals.

The previous Chair expressed disappointment that agencies have required prompts to share information about the outcomes they are achieving with, and on behalf of, adults at risk. A further concern was the decision not to commission a Safeguarding Adult Review following the death of a Continuing Health Care funded patient in a nursing home. New arrangements for review of cases and decision making about such reviews have now been developed.

The level of referrals to Adult Social Care Services is impacting on the ability of social care staff to manage the associated enquiries and case work. Necessarily there is a dependency on providers to undertake a greater volume of enquiries which may presents risks in terms of oversight and potential for challenge regarding objectivity.

Critically, this report is not able to provide information about Safeguarding Adult Reviews – none were undertaken during 2015-16. The Chair of the sub group stepped down during 2015 and did not forward any information to the Board.

Although the County is large, the case for hosting three leadership groups is becoming less credible, particularly since attendance at these is reported as uneven and diminishing. Lancashire's investment in place-based commissioning and initiatives to improve neighbourhoods and public spaces is being led by Public Health.

Website development is essential, not least in terms of prompting all agencies to respond to events which feature in the media in Lancashire and nationally. This is not a new concern. The annual report of 2014-15 noted that, "*a website that is tuned into the media is likely to tell a better story and speak in a language that the public can follow instead of processes, acronyms and claims about lessons learned ……..".* Development of a more effective web-site is being progressed and will be published over the coming months.

List of Background Papers

LSAB Annual Report 2015/16, published September 2016 as attached at Appendix A.

This report should be no more than **two** pages in total but may provide links to more detailed information and papers.

Lancashire's Safeguarding Adults Board

Annual Report 2015-2016

Published September 2016

Chair's Foreword

For the last eight years the Lancashire Adult Safeguarding Board has been chaired by Margaret Flynn and our gratitude is due to her for the work she has done in highlighting Adult Safeguarding as worthy of high priority and in championing the needs of adults with care and support needs who are vulnerable to abuse and neglect. She has worked hard to establish the Board as an independent body and saw it through transition onto a statutory footing.

It falls to me as the current Chair of the Board to present this report which covers the last year of Margaret's tenure and I can take no credit for the work that has been done. The report reflects a range of activity designed to ensure that those with care and support needs are as safe as they can be in Lancashire and I want to thank all those who have played a part in this.

The required contents of the Adult Safeguarding Board Annual Report are set out in government guidance and the report must set out how the Board is monitoring progress against its policies and intentions to deliver its strategic plan. We have also sought to explore what we know about the vulnerabilities of people in Lancashire and how well-placed services are to respond to them.

Safeguarding adults at risk of abuse and neglect is a challenging agenda and will become ever more so as the impact of reduced budgets for public services continue to increase. We are given to understand that spending on public services will reduce by around £800 million and it would be naïve to assume this will not impact on services for the most vulnerable. One of the tasks of the Board will be to challenge agencies about service re-design to ensure the impact on those in need of safeguarding is mitigated as far as is possible.

A positive development during 2015-16 has been the development of a single business unit to support the work of both the Adult and Children safeguarding Board. This will enable us to work more closely together and approach safeguarding on a "whole family" basis. We have already agreed some joint work programmes and will undoubtedly discover more opportunities to enrich our work and make it more effective by working together.

Jane Booth

Independent Chair

Lancashire Adult Safeguarding Board

Contents Page

Context – The Care Act and Adult Safeguarding

Care Act legislation became statutory on 1st April 2015.

The Government has set out six principles to underpin all work when safeguarding adults:

- Empowerment – taking a person-centred approach, whereby users feel involved and informed.
- Protection – delivering support to victims to allow them to take action.
- Prevention – responding quickly to suspected cases.
- Proportionality – ensuring outcomes are appropriate for the individual.
- Partnership – information is shared appropriately and the individual is involved.
- Accountability – all agencies have a clear role.

Safeguarding is described as protecting adults from abuse and neglect. The Care Act is a response to the recognition that the law and practice around this issue had become increasingly complex. The Care Act has made the following changes in regard to safeguarding adults:

- Safeguarding Adults Boards are now statutory;
- The Board must have an independent chair;
- The statutory members are the Local Authority, the Police and the CCG.
- The board is required to have a safeguarding plan and to publish annual reports detailing what it has done during the year to achieve its main objectives and implement the strategic plan; and
- In specified circumstances the Board must conduct Safeguarding Adult Reviews (SAR) and subsequent actions and these must be published.

As a result the Lancashire Safeguarding Adults Board is on a journey – the previous arrangements resulted in the Local Authority leading the work of the Board and the Board's independent identity, and indeed its role in championing safeguarding and challenging poor practice was often confused with the role of the statutory agencies. The statutory footing and independent status of the Board is now clear and paves the way for future developments.

The local context - what do we know about vulnerable adults in Lancashire[1]

- There are an estimated 1.2 million people in Lancashire (Lancashire-12 footprint) of whom more than 900,000 are adults;
- The population of those aged over 65 is predicted to increase from around 10,000 recorded in 2010 to 34,000 by 2039;
- There are wide variations in levels of income, wealth and health across the county;
- The population is served by over 250 GP practices and five key NHS trusts;
- People receive support from a single police constabulary and fire and rescue service;
- Life expectancy has been increasing but there is a gap between those living in the most deprived areas and those in the more affluent areas;
- On average women will spend 19.7 years at the end of their lives in not so good health and the figure for men is 17.2 years (set against a lower level of life expectancy.

The data below relates to safeguarding enquiries or concerns:

	Age 18-64	**Age 65-74**	**Age 75-84**	**Age 85 - 94**	**95+**	**Not known**
Safeguarding concerns	1936	823	1563	1773	274	2
Safeguarding enquiries under Section 42	494	220	439	570	82	0
Other safeguarding enquiries	223	95	191	188	30	1

Note: Section 42 is the statutory response to an allegation abuse or neglect.

The gender balance in respect of the above is female dominated which reflects the higher longevity rates of women.

[1] Report of the Director of Public Health - 2016

The remainder of this report is presented on behalf of the previous Chair:

2015-16 has been an interesting and busy year for Lancashire's Safeguarding Adults Board and consequent on the implementation of the Care Act 2014, this report is set out as required by the *Care and Support Statutory Guidance* (March 2016).

The Guidance headlines concerning safeguarding are:

- adult safeguarding;
- abuse and neglect, understanding what they are and spotting the signs;
- reporting and responding to abuse and neglect;
- carers and adult safeguarding;
- adult safeguarding procedures;
- local authorities' role and multi-agency working;
- criminal offences and adult safeguarding;
- safeguarding enquiries;
- safeguarding adults board;
- safeguarding adults reviews;
- information sharing, confidentiality and record keeping; and
- roles, responsibilities and training in local authorities, the NHS and other agencies.

The Guidance also proposes somewhat muted expectations concerning self-neglect. The earlier Guidance (of October 2014) acknowledged the fact that self-neglect had been inconsistently addressed by safeguarding adults boards and mental health services throughout England.

Maintaining confidence in how the Safeguarding Adults Board goes about its work matters a great deal. Lancashire is a large county with a population pan Lancashire of 1.5 million, of which 1.2 million reside within the Lancashire-12 footprint. They are supported by 12 districts (Burnley, Chorley, Fylde, Hyndburn, Lancaster, Pendle, Preston, Ribble Valley, Rossendale, South Ribble, West Lancashire and Wyre) and six Clinical Commissioning Groups (CCGs). During the period of reporting 2015-2016 the Lead Nurse represented North Lancs and Fylde & Wyre CCGs, Head of Safeguarding Adults and Mental Capacity Act Lead represented East Lancs CCG and Head of Safeguarding up to her retirement in December 2015 replaced by Designated Lead Nurse for Safeguarding Adults and Mental Capacity Act in January 2016 for Chorley and South Ribble & Greater Preston and West Lancs CCGs. The CCGs are grouped into three areas, North, Central and East, with a single safeguarding lead representing two CCGs on the Board. There are over 300 residential homes and residential with nursing homes in the county, almost 200 home care providers and over 30 assisted living and extra care housing providers. The Care Act 2014 states that the principal responsibility for creating local arrangements for adult protection/safeguarding adults resides with local authorities in partnership with the NHS and the police.

Abuse comes in many guises and the forms of harm and distress that people experience may overlap with criminal acts, with some people requiring medical attention. The Safeguarding Adults Board knows that typically, safeguarding/adult protection professionals across sectors have to deal with incomplete information – perhaps because a person does not have the capacity and/or is too traumatised to recall what has happened; or too loyal to a relative who is physically assaulting them; or too embarrassed and humiliated to tell someone. There are also services and agencies which deny and evade accountability since they do not want to be exposed to prosecution. Their services may be poor, ineffective or abusive but it is unlikely that they set out to be so.

This report includes some real, and some anonymised, "case studies" which have affected the thinking and practice of safeguarding/ adult protection practitioners in Lancashire. They highlight the complexity of the tasks facing practitioners, the settings in which abuse occurs and the challenges of identifying preventive measures.

The expectation of Lancashire's Safeguarding Adults Board during its transition to becoming a statutory body in April 2015 was that all members of the Board, its networks, associated groups and partners would contribute fully to adult safeguarding priorities and activities within the county. This expectation has been broadly realised – even though the recession, sustained austerity and a contracting economy are the stark backdrop. Councils have been cut harder than the rest of the public sector and Lancashire County Council has had to make extensive "efficiency savings" by re-thinking the structure of its public services and management. Major organisational changes across all sectors have witnessed both management and staffing reductions which have impacted on safeguarding/ adult protection as key professionals have left. Necessarily this has impacted on the membership of the Board, on attendance and on the structures connected to the Board, for example its sub-groups (see Appendix 1).

There were some significant currents and eddies during 2015-16: neither the prison nor probation service was represented at Board meetings, irrespective of previous membership/contributions; the Multi-Agency Safeguarding Hub (MASH)[2] got into difficulties when a "backlog" emerged and it ceased to be multi-agency; Tri-X, the organisation which hosts Lancashire's "bespoke" safeguarding policy and procedures (with Blackburn with Darwen and Cumbria) now requires the considerable input of practitioners from these authorities to ensure they are updated and the Safeguarding with Providers Group has described accessing the procedures as "problematic;" it is increasingly difficult for commissioners to be "smart buyers" where competition is elusive; the flourishing of collaborative arrangements has resulted in parallel deliberations concerning adult safeguarding/protection; the unfamiliar discipline of a new (to adult safeguarding) focused administrative team requiring timely contributions from Board members has exposed weaknesses, most particularly in distinguishing processes from outcomes; domestic violence and Domestic Homicide Reviews are

[2] A single point of contact for professionals to report safeguarding concerns

increasingly being brought to the attention of adult safeguarding; and extensive coverage of the carnage resulting from acts of terrorism and the government's flagship anti-radicalisation strategy, Prevent,[3] are impacting on Muslim communities in Lancashire and elsewhere.

Case Study 1 concerns Alice and Bernard, an elderly couple. Both are living with dementia. When support staff noticed that Alice had a lot of bruises which neither Alice nor Bernard could explain, it was suspected that her mobility had become so compromised that she was falling. In spite of input from Occupational Therapy there was continuing concern about Alice's unexplained bruises. Eventually an application was made to the Court of Protection and a residential placement was identified for Alice. Once there, it was discovered that her body was covered in bruises which were consistent with multiple physical assaults. Options for her future remain under consideration and enquiries about the couple's history continue.

During December 2015, the Independent Chair stood down after eight years in the post. She chaired the January 2016 safeguarding board meeting and requested sight of the minutes of the March 2016 board meeting in order to write this report.

Our Priorities

The safeguarding/adult protection of Lancashire's citizens is a high priority in care planning, commissioning and delivering services. Abusive and harmful acts may happen once or repeatedly in services that are regularly inspected as well as in our own homes. Since Lancashire's SAB is responsible for steering adult protection/safeguarding activity across the county it has identified **four long-term priorities:**

1) **To provide strategic leadership** and **seek assurance of safeguarding quality and performance activity** across Lancashire, that is, our interventions are appropriate, proportionate and person-centred
2) **To work closely with all multi-agency partners and strategic boards** to **reflect our learning,** provide strategic vision across Lancashire and set clear and achievable aims and priorities
3) To ensure that SAB members, partners and agencies **share a common understanding** of what constitutes abuse and can recognise risk factors and the situations that should be reported
4) To ensure that the SAB has strategic links to **promote early intervention** to prevent harm and supports the creation of vigilant services and communities

History confirms that without a constantly renewed sense of purpose and direction, things fall apart. History confirms also that a transformed landscape of dispersed responsibility and accountability within a reducing public sector changes the nature of relationships and creates uncertainty. Adult safeguarding/protection cannot address some of the fallout arising from changes to the public sector including the changes in public policy. For example, at a Pan Lancashire level – with safeguarding practitioners in Blackburn and Cumbria, and nationally with Safeguarding Adult Board Chairs – attention was focused on the role

[3] Preventing vulnerable people from being drawn into terrorism

of the Designated Safeguarding Adults Manager, which the Department of Health abandoned during May 2015. Similarly, work was progressed with Lancashire Fire and Rescue concerning people who self-neglect and hoard and yet this group of citizens have been demoted in terms of the expectations of safeguarding practitioners in the revised Department of Health Guidance.

Lancashire Care Association has been tenacious in alerting the Board to the challenges its members face, for example, being overwhelmed by the information requirements of Local Authority contract monitoring, Clinical Commissioning Groups' contract monitoring, the Care Quality Commission's inspections, adult safeguarding and Healthwatch Lancashire. There has been modest progress in terms of facilitating a mechanism for doing this. Although the shortage of nurses and Registered Care Managers within the residential and nursing care sector is a long-standing concern (not least because it is a factor associated with failing homes), attention to this is out with the scope of adult safeguarding and the contracted provider sector. Similarly, although older people developing avoidable pressure ulcers has been a consistent concern in Lancashire, there are not enough Tissue Viability Specialist Nurses, thus rendering some homes without any assistance.

In the light of home closures and homes subject to safeguarding attention a helpful rule of thumb during 2015-16 has been to ask the question: will scrutiny of the circumstances in this particular home add to the learning arising from the *Learning Review of Incidents of Significant Harm?* This was published during 2014 and it concerned the harmful behaviour of staff towards older people with dementia at Hillcroft Nursing Home in Slyne with Hest. Similarly, the review of homes in south east Wales investigated as Operation Jasmine[4] has been an illuminating backdrop to the work of the Quality and Improvement Planning (QIP) practitioners.

There are thriving networks in the county. For example, Lancashire Care Association is engaging with NHS England, Clinical Commissioning Groups and Commissioning Support Units, with the Home Improvement Group and with the RADAR[5] and the Quality Improvement Planning (QIP) processes, and yet, in the absence of a functional market (that is, one that is not just set up to compete on price) there are endemic dangers as Kennedy (2014)[6] noted: *If a care home is under financial pressure, there is a significant danger that corners will be cut and quality reduced…the opportunity cost of an impoverished care sector is huge for the NHS and the economy…The market is one that we have created but it doesn't work. The market should be managed to create what we want – good, viable care homes in the right places…care homes with the skills and capacity to support our ageing communities and our NHS.* At the close of 2015, the Safeguarding Adults Board was challenged by the LCA: *"When*

[4] http://gov.wales/topics/health/publications/socialcare/reports/accountability/?lang=en

[5] Receive, Advise, Develop, Act, Refer

[6] Kennedy, J. (2014) *John Kennedy's Care Home Inquiry* York: Joseph Rowntree Foundation and Joseph Rowntree Housing Trust

does underfunding, particularly informed underfunding, become a safeguarding issue?"

Finally, people who lack the mental capacity to attend to their needs are among the most vulnerable in our communities. Crucially, their rights may be infringed by the nature of the health or social care with which they are provided. If this amounts to a deprivation of liberty in breach of Article 5 of the European Convention on Human Rights, then there are safeguards for their protection. However, the safeguarding provisions are the subject of complex primary and subordinate legislation and interpretation by senior courts. In consequence, these provisions place onerous responsibilities on local authorities, social workers, home managers, hospitals and doctors. The complexities of the law, emergent case law and practice led to the creation of a new Pan Lancashire group which is a 2016 addition to the Board's sub-groups.

Delivering our priorities

The Safeguarding Adults Board provides assurance on the governance of safeguarding activities. It does not provide governance for all organisations and businesses working to deliver adult safeguarding. Each organisation is accountable for its own activities, including reporting, most particularly with regard to matters of risk. The Safeguarding Adults Board is not a substitute for the responsibilities of commissioned services and the services of public bodies. It is for commissioned services and public bodies to ensure that their business is conducted in accordance with the law, the requirements of regulation and the expectations of the Board.

Evidence of community awareness of adult abuse and neglect and how to respond

Adult Social Care disseminates information to commissioned services and agencies supporting adults who may be "at risk," including learning disability forums, carers' groups and housing providers for example. The Leadership Groups involve Victims' Voice, Trading Standards, Citizens Advice and members of Community Safety Partnerships. The existence of such groups acknowledges the interest of individual professionals and agencies keen to contribute to adult safeguarding and learn about emergent concerns and practice.

The **CCGs** engage in "Quality walk arounds" in NHS services. These are occasions for CCG personnel to witness and discuss patients' experience and ensure that the mechanisms for raising concerns are known. **NHS Choices** is monitored by each CCG to identify local concerns which are raised by the local community which could indicate potential safeguarding referrals.

Case Study 3 - at University Hospitals Morecambe Bay NHS Trust the Named Nurse facilitates a full day work shop for all of the Trust's registered professionals. This reflects the implementation of the Care Act, 2014, changes within the MCA/DoLS case law, raising awareness of services and resources available locally for individuals with a diagnosed learning disability. The workshop also incorporates the PREVENT training, raising the awareness of vulnerable adults susceptible for radicalisation. The session aims also to embed into all areas within the Trust that "*Safeguarding is Everybody's Business*." As of January 2016, 74% of staff have attended Level 2 Safeguarding Adults Workshop training. As a direct reflection of the impact of the training, there has been an increase in the number of reported Patient Safety Incidents, and referrals into the Local Authority where abuse or neglect has been identified. Also, the Trust has seen a significant rise in the number of Deprivation of Liberty Safeguard applications.

Lancashire Police proactively engages with partners at all levels with the aim of preventing crime, developing and enhancing confidence within communities, identifying and reporting adult safeguarding matters and preventing and detecting crime by bringing perpetrators to justice.
Vulnerable Adult training is provided 'in house' and is supported by multi-agency partners.
To support the commitment to protect vulnerable citizens, Lancashire Police's Engagement and Media Units work alongside the Public Protection Units to promote initiatives such as "*In the Know*,"[7] which is a free messaging system where the public can be informed about coastline crime, rural crime and neighbourhood watch news, for example.

During 2015, a pilot 'Banking Protocol' was set up in Preston City Centre. This involved the Police, Trading Standards and Age UK Lancashire to train bank counter staff. The training included the raising of awareness around coercion and deception, and in particular the pressure placed on vulnerable individuals to release their monies for the unlawful gain of others. This pilot has been a real success and is now set to be rolled out across Lancashire. The benefits include the police receiving direct calls from banks regarding suspicious activities and concern about specific customers. This has not only safeguarded individuals but it has also raised confidence with other bank customers and staff.

Dedicated Single Points of Contact (SPoC) are assigned to investigation areas such as Missing from Home, Human Trafficking and Sex Workers. All these areas are connected to the people who are at an increased risk of becoming victims of crime. These Single Points of Contact work with external partners to raise community awareness of potential risks.

Lancashire Fire and Rescue (LFRS) proactively engages with partners at all levels with the aim of preventing harm and making Lancashire safer.

LFRS during their home fire safety visits identify and report adult safeguarding matters. LFRS have a training programme that delivers Fire Safety training to care and health providers, which helps to ensure safety of their service users. LFRS are an active partner within the Multi Agency Safeguarding Hub (MASH) which provides useful

[7] http://www.lancashire.police.uk/help-advice/in-the-know.aspx (accessed 12 January 2016)

opportunities for multi-agency safeguarding. LFRS audit premises to ensure that the fire safety requirements of the Regulatory Reform (Fire Safety) Order 2005 are in place and managed to keep vulnerable adults safe. LFRS complete arson assessments and fit safety equipment to households where the occupiers are identified as being at risk.

Lancashire Care Association as a member body is contributing as a partner to safeguarding activities; as the joint Chair of the Health and Social Care Partnership; and via membership of the 'Care Home Quality Assurance and Improvement Board.' Also, the LCA is seeking to help providers at crisis point by working with the QIP process to (a) identify 3rd party expertise from the independent sector (b) help QIP health and LA staff and (c) help the provider.

Analysis of safeguarding data to better understand the reasons that lie behind local data returns and use the information to improve the strategic plan and operational arrangements

Between January 2015 and 29 February 2016, there were 9,879 referrals to the MASH – an average of 705 a month. Of these, 3,377 proceeded to a safeguarding enquiry, that is, it was determined that 6,502 did not merit a safeguarding enquiry and individuals were directed elsewhere. Scrutiny of the figures concerning residential care shows that physical assaults ("service user on service user") and neglectful care are exercising care homes and their commissioners, after which, the management of medicines in care homes is an enduring theme. Associated proactive and responsive work includes the development of safer professional practice in working with medicines and the development of a sample safeguarding policy for care homes.

Since the introduction of the MASH, low level safeguarding alerts have been managed through a risk management and prioritising process. Lancashire has been keen *not* to develop and promote "threshold criteria" because safeguarding practitioners want people to get in touch about their concerns irrespective of the apparent seriousness. This has enabled the local authority to be proactive and consider such avenues as the Quality Improvement Planning process. However, the following table confirms that a review is overdue.

Table 1: **Mash backlog data**

29.5.2015 423	02.6.2015 469
19. 6.2015 435	10.7. 2015 383
17.7.2015 439	31.7.2015 439
7.8.2015 444	28.8.2015 480
11.9.2015 469	9.10.2015 496
16.10.2015 477	2.11.2015 516
6.11.2015 554	15.11.2015 549
20.11.2015 546	27.11.2015 541
4.12.2015 528	11.12.2015 523
23.12.2015 461	15.1.2016 483

29.1.2016 493	05.02.2016 476
13.2.2016 473	

Care and nursing home provision in Lancashire has received a lot of negative media coverage as a result of poor practices and home closures. **NHS England**, the **Clinical Commissioning Groups**, **adult social care** and **Public Health** developed a programme of work around "benchmarking quality" and providing support to nurses in the sector.

All **CCGs** hold assurance meetings with their providers to discuss the local themes and data from safeguarding concerns.

All providers are required to report on their safeguarding data which is scrutinised and challenged by CCGs. This is fed in to **NHS England** systems to review and monitor across the County. This information is shared with service commissioners to support redesign and re-commissioning of services to meet patients' needs more safely.

The **Lancashire Care Foundation Trust** shared a Serious Incident Board report during December 2015. This states that "*Lancashire is identified as the highest geographical area for suicide in the National Confidential Inquiry into Suicide and Homicide*" with 68 suicides occurring between April 2014 and September 2015.

Data has a key role in the planning and resourcing of **policing teams**. Police analysts pay particular attention to such data as: the number of recorded crimes; ages and gender of victims and offenders; the location of crimes; and the associated factors, for example – drugs and alcohol; the rates of crime over designated timeframes which highlight emerging trends and issues; the victim/offender relationship; and protecting vulnerable people (PVP) submissions via the Multi-Agency Safeguarding Hub (MASH). Such data enable targeted policing to focus resources where they are most needed, with the potential to predict crime patterns.

Case study 4 –during 2015 a social worker made 30 safeguarding alerts about a single home on the basis of one visit. These included residents being locked in their rooms and staff sleeping when they should have been working. So serious were the concerns that the transfer of residents was considered by social care, the CQC, the police and the CCG. A QIP meeting set out the improvements required and identified the professionals willing to support these. Within four months, improvements were confirmed:

"*There's a different feel to it*"

"*They're more co-operative and proactive*"

"*They're receptive to help and support."*

The suspension of places was lifted and a valued nursing and residential home was retained in the County.

One of the recent adaptations to the Vulnerable Adult risk is the utilisation of an Adult Care Environment (ACE) tag. This is employed by the initial call taker, who 'flags' incidents that involve Adult Care Establishments for example. This searchable feature provides data to allow the identification of potential '*resource intensive locations'* which may indicate criminal issues through to internal staffing /management concerns. This data permits pro-active intervention in the identified establishments.

What adults who have experienced the process say and the extent to which the outcomes they wanted (their wishes) have been realised

Lancashire has not developed a consistent means of capturing the experience of adults known to safeguarding practitioners. Although it is encouraging that mini case studies are shared at Board meetings, at RADAR discussions and those identified during the Quality Improvement Planning process – including the part played by families, advocates and services supporting them – safeguarding practitioners have yet to identify a consistent means of bringing people's experience to life. It is understood that those most at risk of abuse are likely to be the least able to speak for themselves. Similarly, the limited articulacy of people with learning disabilities or neurological impairments means that they may have difficulties in making themselves understood, and it is through the discussion of case studies that the Board is aware of such impacts as sleep problems, self-harm, aggression, reliving the experience and exaggerated "startle" responses, for example. Although case study examples and accounts of people's behaviour are helpful in terms of illustrating particular points, evidence remains to be gathered systematically.

Lancashire Police has received feedback from individuals who have used the Sexual Assault Forensic Examination (SAFE) Centre at Royal Preston Hospital. Typically these people have been the victims of serious sexual crimes. Each month their feedback is received and reviewed. Most of the feedback is positive and it has been constructive in identifying areas for learning and development:

"*Excellent Service that took my feelings and emotions into consideration*"

"*They were really comforting and explained everything really well*"

During January 2016 the Home Secretary made it mandatory for all forces to collate data concerning domestic abuse victim 'experiences' as part of the annual data returns

commencing. Lancashire Constabulary has a dedicated survey team which is working with and on behalf of domestic abuse victims.

Ongoing Care Quality Commission concerns regarding Calderstones[8] Foundation Trusts' quality of care resulted in "enhanced surveillance" by NHS England. Extended contact with adults with learning disabilities and their relatives during 2014 (following a visit by the Department of Health) had identified concerns about safeguarding practice and people's health care. This resulted in a social worker being located there for four weeks, a programme of visits by NHS England, Clinical Commissioning Groups and Healthwatch Lancashire. Since so few people had discharge plans, the aim of contact with Calderstones was "*to put in as much effort as needed*" in the light of prospective in-patient bed closures. This included the reduction of "*unnecessary admissions*."

The "*Making Safeguarding Personal*" agenda is still in its infancy across **Lancashire's health services**. There is work planned to begin addressing how to capture people's views when alerts are being made on their behalf. Feedback to referrers remains inconsistent.

What front line practitioners say about outcomes for adults and about their ability to work in a personalised way with those adults

Adult social care staff are conscious that "*making safeguarding personal*" and helping to turn a deteriorating situation around takes time. These important tasks may be compromised by the volume of safeguarding activity. Many practitioners report frustration that they cannot invest more time with individuals. There is concern that the focus on care home providers during 2015-16 means that NHS providers are "*under the radar*." Also, their internal reporting is inconsistently shared with the Safeguarding Adults Board.

NHS staff state that they often feel disconnected from the safeguarding enquiry process. They report that on occasion they are asked to work beyond their skill set and role, whilst at other times their clinical skills and expertise are not fully utilised.

Lancashire Police acknowledges that although the parallel referral pathways are well used (for example concerning domestic violence and adult safeguarding/protection) modifications are required, since clarity of process is important for all safeguarding practitioners, as well as recognition of the limits and reach of each agency. The MASH has enabled knowledge, information and skills sharing and an understanding of respective roles. However, a review is merited.

Lancashire Care Association, through the Registered Care Managers, is attempting to 'map' the various groups that Registered Care Managers are involved with that are directly associated with or overlap with Safeguarding. From these meetings the LCA has learned of lots of groups with changing titles and uncertain function. Also, the LCA

[8] Calderstones is the only specialist learning disability trust in England

is concerned that the act of suspending placements in care homes means that independent sector providers are prevented from taking local authority funded and CCG funded residents. This compromises business viability and the LCA would like the suspension process to be reviewed. The LCA would favour some independent scrutiny of the information held and shared in RADAR meetings because the use of 'grey' information needs safeguards for those who are the subjects of discussions. While there will always be a need for discussions 'in camera' – as for example when there is a clear situation of safety for a care user, the response to which would be compromised if a provider were in the know - there nonetheless need to be the proper checks and balances to ensure that what happens is the exchange of necessary 'intelligence,' not gossip and prejudice.

Better reporting of abuse and neglect

In order to achieve consistency in raising concerns about tissue viability and the prevention of pressure ulcers, **health** members of the Safeguarding Adults Board developed "*best practice guidance*." Although 10% of pressure ulcers are unavoidable, some homes have struggled to deal with residents' painful ulcers in the absence of Tissue Viability nurses.

The **CCGs** provide strategic leadership as a statutory partner of the SAB and as with all other NHS bodies have a duty to ensure that it makes arrangements to safeguard and promote the welfare of adults at risk of abuse. The CCGs monitor commissioned services including independent providers, voluntary, community and faith sector (VCFS), against clear service standards to ensure that all service users are protected from abuse and the risk of abuse. The CCGs are committed to achieve effective joint working with constructive relationships at all levels, promoted and supported by:

- Clear lines of accountability within the CCG for safeguarding
- Service developments which take account of the need to safeguard all service users, and informed, where appropriate, by the views of service users
- Staff training and continuing professional development so that staff have an understanding of their roles and responsibilities in regard to safeguarding adults at risk, implementation of the Mental Capacity Act and implementation of the Prevent agenda
- Appropriate supervision and support for staff in relation to safeguarding practice
- Safe working practices including recruitment and vetting procedures
- Effective interagency working, including effective information sharing.

NHS England has been working closely with GPs and Primary Care around their own compliance and has devised and implemented a system to secure safeguarding assurance through e-declarations around competency and understanding.

Lancashire Police has completed safeguarding CPD days (Child Sexual Exploitation/Domestic Abuse/ Female Genital Mutilation/Honour Based

Violence/Adults at Risk) in 2015 and have scheduled further events concerning Coercive Control for 2016.

During January – February 2016, two Rape Workshops were held, that provided valuable guidance on the revised requirements for file submission to CPS. The delivery of WRAP training (Workshop to Raise Awareness of Prevent) to police staff in MASH has been completed and 'Adult at Risk' training is currently being developed.

Human Trafficking Training has also been provided to all Contact Management, and Public Enquiry Assistants and the SPOCs have delivered training to front line staff. In addition the Police and Crime Commissioner's office is committed to supporting this area of work and has funded a series of external training sessions to both Police and the multi-agency workforce.

Lancashire Care Association is exploring how to work jointly, in preventative mode, to identify and help providers who are 'at risk' pre QIP.

Evidence of success of strategies to prevent abuse or neglect

The **Safeguarding Adults Board** discussed and shared briefings concerning modern slavery, domestic violence, forced marriage and self-neglect since these featured in the Guidance as being within the purview of adult safeguarding/ protection. These materials were shared with partner agencies, including the Lancashire Action Against Domestic Abuse.

The **CCGs** have also been key partners in the development of the quality improvement process to support care providers in the improvement of quality and safety in care home settings. This has included providing significant support for failing care homes and service providers by NHS staff. Provision of additional wrap around services to support failing providers has been integral to being able to keep some services safe and functioning whilst they are closing down; alternatively it has also been instrumental in supporting providers to recover and prevent the need for closure.

The **police's** Quality and Compliance Managers are responsible for ensuring all Public Protection policies are accessible and understood by staff. Three managers have responsibility for (1) child protection/ child sexual exploitation/Missing From Home; (2) domestic abuse/honour based violence/female genital mutilation/vulnerable adult; and (3) rape/human trafficking /sex work/adults at risk

Lancashire Constabulary supports the National 'Ugly Mugs' scheme. This is the pro-active sharing of intelligence that relates to violence against sex workers. The SPOCs and Intelligence Units work with partner support agencies to ensure that this information is circulated to safeguard sex workers whilst raising awareness both in the Constabulary and out in the wider area.

Claire's Law gives members of the public a '*right to ask'* police where they have a concern that their partner may pose a risk to them or where they are concerned that the partner of a family member or a friend may pose a risk. Police and partner agencies will carry out checks and if they show that a partner has a record of abusive offences, or where there is other information to indicate that there may be a risk, the police will consider sharing this information.

Domestic Violence Protection Notices/Orders will be issued in circumstances where no enforceable restrictions can be placed upon a perpetrator. The principal aim of the process is to provide some respite and allow agencies to safely engage and work with the victim.

Feedback from Healthwatch Lancashire, adults who use care and support services and carers, community groups, advocates, service providers and other partners

Healthwatch Lancashire submits written information to each Safeguarding Adults Board meeting including its work programmes concerning learning and development activities, public involvement and evidence of ensuring effectiveness. It embeds within its recruitment practices of staff, volunteers and Board the principles of safeguarding. Also, its Work Plan is focused on staff and volunteers obtaining feedback of service users, carers and relatives about health and adult social care services across Lancashire.
Drawing from:

- Community engagement - in health, social care and community settings
- Patient Engagement Days – including surveys in healthcare settings
- Care circles – forms of group work
- Mystery shopping
- Campaigns
- Patients' Stories
- Membership of patient voice groups and strategic quality performance committees
- Working with health and social care providers to offer a 'lay person' perspective at events such as: Mock Inspections, quality improvement activities and events, and annual Patient Led Assessment of the Care Environment (PLACE)

With its statutory powers of Enter and View, Healthwatch Lancashire obtains first hand feedback about the experiences of people using health and adult social care services. The feedback is presented in a report form, initially presented to the service provider for consideration and comment prior to publication and sharing with relevant stakeholders. Every month Healthwatch Lancashire provides an update to RADAR on the visits and ratings of its Enter and View visits to care homes across Lancashire.

How successful adult safeguarding is at linking with other parts of the system, for example children's safeguarding, domestic violence, community safety

Adult social care has operational links with children's safeguarding and e-learning packages are shared between the services, not least because honour based violence, forced marriage and domestic abuse occur over the life course. There are joint learning opportunities. Collaboration with the Community Safety Partnerships is a critical means of developing problem-based learning.

Lancashire Police: Adult Safeguarding Leads and Adult Social Care staff are key members of the MARAC steering group. The Multi-Agency Risk Assessment Conference (MARAC)[9] protocol now includes Adult Safeguarding and wider links to other support services. The Review of MASH during 2016 will seek to improve safeguarding, processes and outcomes for those who are vulnerable.
Membership of Lancashire's Safeguarding Adults Board was extended to include the Children's Head of Safeguarding, Inspection and Audit.

The impact of training carried out in this area and analysis of future need

Adult social care receives broadly positive feedback concerning its learning events and e-packages. Similarly, its "learning circles" for staff are valued opportunities for discussing risk assessments and management, individual and home/ward level safeguarding outcomes and ways of averting potential safeguarding issues. Five learning and development priority areas have been identified during 2015-16: statutory responsibilities consequent on the MCA 2005 and the Care Act 2014; safeguarding in residential homes; safeguarding adult reviews; and the safeguarding challenges arising from preventing radicalisation and modern slavery, for example.

NHS England funded a Female Genital Mutilation Conference; various Child Sexual Exploitation events; the provision of Court of Protection skills and mock court skills training for safeguarding practitioners; a GP safeguarding toolkit; MCA/DoLS training via e-learning package; MCA/DoLS training for community based staff delivered by Afta-Thought (a theatre group); and MCA/ DoLS training for GPs delivered by a local barrister.

CCGs have been working with **NHS England** and with **Lancashire CC** in delivering these events and where needed, hosting them.

Prevent training has been significantly invested in across all health services, and the North West continues to be seen as a hub of good practice. Due to Burnley being considered a priority area, the local health provider, with the CCG, has made the

[9] Meetings about the high risk domestic abuse cases involving the police, health, child protection and housing practitioners for example

decision to make WRAP training mandatory for all staff. This significant investment is showing a much greater awareness and knowledge.

CCGs are key stakeholders in the RADAR process across Lancashire. This ensures that there is health information being provided around early warning signs of failing services. This early intervention supports quality improvement and the prevention of further harm.

NHS England and the CCGs are all heavily involved in media use to share messages of safeguarding and best practice. Recently NHS England produced pocket books on the Care Act and one on Safeguarding Adults which are being distributed through the CCGs to providers and communities. These highlight responsibilities and give clear guidance on what to do when people are concerned around potential safeguarding alerts.

Also, the Safeguarding Adults Board is developing "Seven Minute Briefings" to which the CCGs are key contributors. These are addressing topics such as Prevent, the MCA, safer recruitment, the use of agency staff and fire prevention (see Appendix 2). They are distributed through health and social care services and providers and are displayed in patient areas to help spread awareness of safeguarding adults.

How well agencies are cooperating and collaborating

There is encouraging evidence of the willingness of all parties to explore the phenomena of abuse and harm from the perspectives of victims and those responsible for the harm; to understand why it is under-reported; to understand contexts; and to be cautious about "explaining" it as a result of the onset of dementia for example.

Through a collaborative approach, the **CCGs** and the **Local Authority** have launched a Safeguarding Adults and Mental Capacity Act (MCA) champion model across the care home sector. This has been a significant development with 'sign up' from partner agencies to share best practice.

The champion's model approach seeks to strengthen safeguarding and MCA arrangements and has the capacity to improve practitioner confidence and competence in supporting adults at risk and in understanding their safeguarding responsibilities.

There has been a significant programme of work in seeking to address the challenges facing the care home sector. Part of this work has resulted in the decision by **Lancashire CC** and the **CCGs** to invest in a pilot for a new contracting monitoring mechanism. The current system fails to give assurance around the quality of the care across the sector. The pilot has been designed to look in detail at how we can both

streamline the contract monitoring process, whilst also making it more robust and relevant, with a focus on quality and safety indicators.

The **CCGs** have been key partners in the development of the quality improvement process to support care providers in the improvement of quality and safety in care home settings. This has included providing significant support for failing care homes and service providers by NHS staff. The provision of additional 'wrap around' services to support failing providers has been integral to being able to keep some services safe and functioning whilst they are closing down. Alternatively it has been instrumental in supporting providers to recover and prevent the need for closure.

The **CCGs** chair both the MCA sub-group and the Safeguarding Adult Review sub-group, and vice chair the Learning and Development sub-group, the Quality Assurance sub-group and all three Safeguarding Area Leadership Groups. There is active representation from the CCGs at all sub-group meetings and they lead on multiple "task and finish" work streams.

Lancashire Care Association is committed to the principle that Safeguarding is "Everybody's Business" and through its role as a membership body, through its input to the LSAB and subgroups, its work as a registered body for criminal records to help providers recruit properly and safely, and through its strategic role on the Health and Social Care Partnership Steering Group. It seeks to work effectively with health and local authority partners and service providers to ensure a whole-systems approach to delivering safe care.

Conclusions

Lancashire's Safeguarding Adults Board has benefitted from the learning arising from members' association with such pan-Lancashire and national activities as work concerning the Mental Capacity Act 2005 and Prevent, the Chair's North West network and the English network of Safeguarding Adult Board Chairs. While modelling collaboration is essential to addressing adult abuse, there is concern that this may be undermined by capacity, staff time, structures and processes. Bringing together public health, patient safety and safeguarding adults in Lancashire is pragmatic and ambitious.

Looking over 2015-16, the Quality Improvement Planning process, which is triggered when information is received which causes concern about a particular setting to support people safely, has involved 76 providers during 1 April 2015- 29 February 2016. The process is securing valued results for residents and staff. One case study concluded:

The proprietor and manager have expressed their gratitude for the support they have been given during the quality improvement planning process and have confirmed their ongoing commitment to driving up quality.[10]

Rearranging tasks into more integrated processes has been critical during 2015-16 in Lancashire. Feedback concerning the provision of consistent administrative support from the Business Unit (since September 2015) has made a significant and positive difference to the work of the Board and its subgroups. The Action Monitoring Log has sharpened the distinction between the Board's expectations and the actions of individuals insofar as it offers concrete information about what individuals/ agencies are doing. However, given the Board's tolerance of the subgroups developing and promoting a Compact, revising governance arrangements and refreshing the Terms of Reference for the sub-groups, it is disappointing that agencies have required prompts to share information about the outcomes they are achieving with, and on behalf of, adults at risk. For example, the disquiet concerning the decision not to commission a Safeguarding Adult Review following the death of Continuing Health Care funded patient in a nursing home, suggests that a disclosure of *conflicts of interest* should be added to the Compact. This necessary addition should remove individuals/ agencies from the discussion or determination of matters in which their interest might suggest a danger of bias.

The increase in referrals is impacting on the ability of social care staff to manage the associated enquiries and case work. Necessarily there is a dependency on providers to undertake a greater volume of enquiries which presents risks in terms of oversight and potential for challenge regarding objectivity.

Critically, this report is not able to provide information about Safeguarding Adult Reviews in terms of the number undertaken during 2015-16. There was no business support for this sub-group at this time and the Chair of the sub group stepped down during 2015[11].

Although the County is large, the case for hosting three leadership groups is becoming less credible, particularly since attendance at these is reported as uneven and diminishing. Lancashire's investment in place-based commissioning and initiatives to improve neighbourhoods and public spaces is being led by Public Health.

[10] This is one of the 14 providers no longer subject to the QIP process

[11] *Further enquiry has shown that within the reporting period a total of eleven referrals were received for consideration by the group. Of the referrals five were recommended for a single agency review, five were recommended for a look back and learn review and one case did not meet the criteria due to no evidence of multiagency failings. Identified themes reflect those nationally focusing on areas of practice including record keeping, supervision, consent / application of the principles of the MCA, recognition of family and their needs, risk management of complex situations, accountability, complex funding arrangements and the recognition of the responsible agency, responsibility around continued reviews and assessments, self-funding service users, leadership, joint working, training, risk assessment and understanding in what constitutes abuse and self-neglect.*

Website development is essential, not least in terms of prompting all agencies to respond to events which feature in the media in Lancashire and nationally. This is not a new concern. The annual report of 2014-15 noted that, *a website that is tuned into the media is likely to tell a better story and speak in a language that the public can follow instead of processes, acronyms and claims about lessons learned, for example. Ensuring that Lancashire's Safeguarding Adults website reflects and enlarges on information featuring in the local press, region and national news broadcasts should begin with a consideration of what is going to better inform the public and professionals.*

News headlines[12] in Lancashire and England

The following sample of what is published and broadcast reveals a great deal about the matters that safeguarding/adult protection practitioners are addressing: medication errors; failing care homes; harm in hospitals; rogue cold callers; scamming; the use of deception in relationships and marketing; exploitation; alcohol abuse; suicide; institutional models of service provision; domestic abuse; and hate crime. All of these are taking place at a time when services are being cut, legislation enacted and its guidance being amended. The media play an opportunistic role in describing adult abuse, neglect and cruelties such as human trafficking. However, because broadcast and print journalists decide what to report, the onus is on services and commissioners to assure Lancashire citizens of the immediate actions taken and the actions which may reduce the likelihood of their recurrence. It will be seen that variety and complexity are the norm in adult safeguarding.

During **April 2015:**

- The Network Director for Specialist Services at Lancashire Care Foundation Trust reported that: "*Over the weekend it has transpired that a small group of service users have ingested medication not prescribed to them. Our main concern at the moment is ensuring that those thought to have taken the substances receive medical attention and preventing further misuse. As such, service user movements have been limited on site so that the situation can be contained and managed accordingly*." The outcome is unknown at the time of writing.

During **May 2015:**

- The Deputy Chief Inspector of the Care Quality Commission wrote to local authorities about the CQC's new regulatory duty of Market Oversight, the purpose of which is "*to protect people who may be placed in vulnerable circumstances due to the failure of a 'difficult to replace' adult social care*

[12] During May 2015's Safeguarding Adults Board meeting, the Chair reminded members that giving the SAB advance notice of events is preferable to learning about these via the media

provider." The CQC's monitoring of the "financial sustainability" of a sample of providers would enable it to determine "*where we believe business failure is likely and that service delivery may be affected to the extent that Local Authorities may need to step in to ensure continuity of care, we will notify the relevant Local Authorities of this*."

- The Safeguarding Adults Board and the Children's Safeguarding Board proposal to merge key business and support functions was agreed. It was acknowledged that the adults' board and its sub-groups had been disadvantaged by limited administrative support – most particularly in terms of commissioning resource intensive Safeguarding Adult Reviews (SARs).[13]

- The Department of Health opted to abolish the role of the "Designated Adult Safeguarding Manager" as set out in the *Care and Support Statutory Guidance* of October 2014.

- Lancashire Libraries and Museums promoted a weeklong series of events to support Dementia Awareness Week.

- The Chair circulated a briefing concerning self-neglect to the Board for onward distribution and discussion.

During **June 2015:**

- East Lancashire Hospital Trust identified a "*significant safeguarding issue*" on a unit for older patients. As a result a "*group safeguarding alert was raised on behalf of 24 patients*." The outcome is unknown at the time of writing.

- A patient at Calderstones Medium Secure Unit was attacked by two other patients.[14] The safeguarding referral was substantiated and one of the men was subsequently prosecuted, albeit for assaulting another person. An investigation led by a psychiatrist recommended that there should be: compliance with stated levels of observation; well-structured handovers; changes to supervision levels; and that staff should not leave observation duties without being replaced. The safeguarding board also learned that Calderstones was facing staff recruitment challenges.

[13] The Guidance states: *SABs **must** arrange a SAR when an adult in its area dies as a result of abuse of neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult…a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults.*

[14] http://www.lancashiretelegraph.co.uk/news/13347033.Probe_into_attackson Calderstones_patient_by_two_men/ (accessed 17 July 2015)

- A patient whose care home placement was funded by NHS Continuing Health Care died having been assaulted by a resident. Although it was believed that a Safeguarding Adult Review was necessary, and the Independent Chair set out a series of questions for the sub-group to consider, the Sub-Group asserted that scrutiny by a Strategic Executive Information System (StEIS) would suffice. The outcome had not been shared with the Safeguarding Adults Board at the time of writing.

- A nursing home in Freckleton was judged to be "inadequate" in every inspection area. It was warned that unless changes were made, it could face the possibility of closure.[15]

- NHS England published *Safeguarding Vulnerable People in the NHS – Accountability and Assurance framework; Managing Safeguarding Allegations against Staff Policy and Procedure; Safeguarding Alerts Policy and Procedure;* and *Safeguarding Policy.*

During **July 2015:**

- The first Conservative budget introduced the National Living Wage. Although this was welcomed by the health and social care sectors because of its potential to improve the status of careers in caring for people, the implications for residential, nursing and domiciliary care are stark: are there the resources to fund their service delivery?

- The Chair shared the findings/executive summary of *In Search of Accountability: the review of the neglect of older people living in care homes investigated as Operation Jasmine.*

- The County Council reflected on ways of "*preventing people from being drawn into terrorism*" - a duty under the Counter Terrorism and Security Act 2015. This involved the provision of learning opportunities for Advanced Practitioners and Principal Social Workers and the production of Practice Bulletins, for example.

- Lancashire Police advised people not to do business with people on their doorstep, most particularly with people offering to undertake "*free, no obligation roof surveys*."[16]

- Lancashire County Council Trading Standards backed a campaign "*to encourage more people to speak up and report a scam.*" It is believed that nationally, only 5% of people who have been scammed report what happened to them. Hence the theme of "*Don't be rushed, don't be hushed*" for National Scams Awareness Month.

[15] http://www.lep.co.uk/news/local/inspectors-slam-freckleton-home-as-inadequate-1-7290705 (accessed 15 January 2016)

[16] http://www.lancashiretelegraph.co.uk/news/pendle/nelson/13409702.Police_issue_warning_over_roof_repair_scam/ (accessed 15 January 2016)

- There was imprisonment of a care worker who had plundered £71k from her clients' accounts.[17] She had been the manager of a charity supporting adults with learning disabilities and was responsible for managing their money, yet over a period of six years she stole from them. As the relative of one of her victims reported, *"…we feel so incredibly hurt and betrayed. She was welcomed into our home and was like one of the family, considered a friend…we put our complete trust in her.*"

- The safeguarding board considered two cases: one concerning a former Anglican Bishop who was assaulted by a care worker at a home in Chorley.[18] She humiliated him, forced him to have cold showers and slapped him; and a patient at a privately run psychiatric unit hanged himself.[19] He had been detained under the Mental Health Act.

During August 2015:

- A pensioner was jailed at Preston Crown Court for sexually abusing a woman with learning and physical disabilities. The judge stated that the pensioner had "*exploited her vulnerability*" to his "*own advantage*."[20]

- A 60 year old man was jailed at Preston Crown Court for defrauding four adults, three with dementia and one with a learning disability.[21] Using his working knowledge as a financial advisor this man defrauded the four of £400k. At his trial it was acknowledged that he had deliberately "*targeted*" his victims.

- In addition, the owner of a care home in Lostock was told to "*expect a prison sentence*" after being convicted of ill-treating elderly residents in her care.[22] The home was closed during June 2014 after it was discovered that residents had been force-fed and that one resident was denied medical treatment after she sustained scalds to her legs, feet and buttocks from a bath.

- A "failing" nursing home in Bamber Bridge closed after a damning CQC inspection. It resulted in residents having only days to find alternative accommodation. The owners attributed their decision to close to the shortage of nurses willing to work in the nursing home sector.[23]

[17] http://www.lep.co.uk/news/local/carer-stole-71k-from-vulnerable-people-she-had-been-trusted-to-look-after-1-7377013 (accessed 8 November 2015)

[18] http://www.mirror.co.uk/news/uk-news/cruel-carer-jailed-after-forcing-5132029 (accessed 1 July 2015)

[19] http://www.lancashiretelegraph.co.uk/news/13436949.Patient_at_secure_mental_health_unit_found_hanged_by_staff_member/

[20] http://www.lep.co.uk/news/local/pensioner-jailed-for-sexually-abusing-disabled-woman-1-7411166

[21] http://www.lancasterguardian.co.uk/news/crime/man-jailed-for-defrauding-elderly-and-vulnerable-victims-out-of-400k-1-7416201 (accessed 30 August 2015)

[22] http://www.lep.co.uk/news/local/care-home-boss-convicted-of-ill-treating-elderly-residents-1-7416165

[23] http://www.lep.co.uk/search?query=Cuerden+grange&p=header (accessed 12 September 2015)

- Also during August, a report for Lancashire County Council's Cabinet revealed that it will have to save "*an additional £223m by April 2020…on top of the £152m…agreed in February…between 2011 and 2020 the council will have delivered savings of £685m*."

During September 2015:

- A roofer was jailed for poor work for which he charged extortionate prices. Home owners were targeted during "cold calling" and once a job had begun they were persuaded that because the roofing problems were so serious it would cost several thousands of pounds.

- It was in early September that the Safeguarding Adults Board learned that five care home closures had impacted on the lives of around 100 people. These included three nursing homes, the re-provision of which was challenging because of the difficulties in recruiting nurses to the sector. The resulting resident reviews and reflections on the adverse consequences for the Multi-Agency Safeguarding Hub have exercised safeguarding practitioners throughout the year.

- NHS England: Lancashire and Greater Manchester hosted an event for almost 200 people: *Resilience in the Care Home Sector – Vital to NHS success.* This underlined the vital learning that there is nothing resource efficient about a failing care home if people's mental and physical health is compromised. The event highlighted valued practice from around the County, including pathways for older people living with frailty, tele-health work, ways of looking after staff as well as residents and more general ways of enhancing quality.

- East Lancashire CCG was proactive and assertive in addressing the challenge by a private psychiatric unit that it was not obligated to share personal staff information for the purposes of adult safeguarding.

During October 2015:

- **I**t was determined that Calderstones is to close. This is four years after the BBC's broadcast concerning Winterbourne View Hospital, *Undercover Care: the Abuse Exposed* which illustrated the long-term detention of adults with learning disabilities believed to be too challenging to live in ordinary neighbourhoods. *Calderstones, which has 223 beds, is seen as symbolic of the NHS's reluctance to abandon entirely the institutional model of care and support for learning disabled people.*[24]
- Lancashire Police hosted a "Vulnerable Adult" conference which addressed the learning arising from the review of incidents of significant harm at Hillcroft Slyne with Hest Care (Nursing Home); partnership working with Trading Standards; Operation Jasmine; and "Think Jessica."[25]

[24] http://www.theguardian.com/society/2015/oct/30/nhs-hospital-england-people-learning-disabilities-to-close-calderstones-winterbourne-view (accessed 8 November 2015)
[25] http://www.thinkjessica.com/

- The Chair circulated information concerning two Serious Case Reviews published by Suffolk's Safeguarding Adults Board.
- The Institute of Alcohol Studies surveyed nearly 5000 police officers, ambulance staff, NHS medics and firefighters.[26] It turns out that dealing with alcohol related incidents is hazardous. At a time when alcohol takes a disproportionate share of emergency services time and resources, there is the ever present fear of being attacked. Over half of the ambulance staff surveyed reported that they have been sexually harassed or assaulted by drunken patients. Alcohol and drugs play very significant roles in safeguarding/adult protection referrals.

In November 2015:

- The *Journal of Epidemiology and Community Health* published an article concerning the correlation between the Work Capability Assessment, increases in suicide and people's worsening mental health.[27]
- Lancashire County Council's MCA practitioners responded to the Law Commission's consultation concerning Deprivation of Liberty Safeguards. This reflected learning from all sectors in Lancashire.

During December 2015:

- Norman Lamb led a debate in the House of Commons concerning out-of-area mental health placements at times of crises.[28] The Health and Social Care Information data indicates that Lancashire is one of four localities which send their patients out of their area most often because there are too few beds in the County. The former health minister is campaigning for equality of access to treatment for people with mental health problems.[29]
- A UK accountancy firm, Mazars, published its *Independent review of deaths of people with a learning disability or mental health problem in contact with Southern Health Foundation NHS Trust April 2011 to March 2015.* This showed that the NHS had failed to investigate an astonishing number of the 700+ '*unexpected deaths*' within a single trust; only 30% were investigated. Less than 1% of deaths in learning disability services were investigated compared with 60% of the unexpected deaths in adult mental health services,

- Lancashire County Council, Collaborations for Leadership in Applied Health Research and Care (CLAHRC) and other partners led work on engaging with care home residents. *Closer to home, the Way We Were...NOW!* is one example of improvement work in Lancashire's care homes. The work was presented at the CLAHRC *Evidence for Change* event during December 2015 and is available at:

https://www.youtube.com/watch?v=7oNinI_YXLc&feature=youtu.be

[26] http://www.theguardian.com/society/2015/oct/26/violence-against-emergency-services-prompts-police-call-for-end-to-24-hour-licensing

[27] http://jech.bmj.com/content/early/2015/10/26/jech-2015-206209 (accessed 8 November 2015)

[28] http://www.theyworkforyou.com/debates/?id=2015-12-03a.591.0 (accessed 8 November 2015)

[29] Interview in *Primary Care Today: Supporting Integration in Primary Care* issue 35

However, an estimated 20% of care homes were delivering inadequate care across Lancashire, according to the CQC.

- At the end of December 2015, the Chair circulated notes for the Safeguarding Board – and for onward distribution – concerning (i) Safeguarding Adult Reviews and (ii) an anonymised summary of the review of death by suicide. The former reflect the Board's concern regarding its open-ended responsibility to undertake SARs in an era of austerity. Conducting a Serious Case Review (which pre-dated SARs) concerning the suicide of a person at a mental health in-patient unit was atypical at the time since there had been a Serious Untoward Incident (SUI) report commissioned which claimed that the psychiatric service was not at fault. The review contained lessons which the SUI had not considered.

During January 2016:

- Monitor and the NHS Trust Development Authority issued the instruction to reduce staffing even though this will have a detrimental effect on patient safety.[30] Nurses and other frontline medical workers are anticipated to be in the firing line. This is just three years after Robert Francis' report in Mid Staffs which underlined the importance of safe staffing. A Department of Health spokesperson sidestepped the concern noting, "*We expect all parts of the NHS to have safe staffing levels – making sure they have the right staff, in the right place, at the right time*."
- At the end of 2015 and the beginning of 2016, flooding devastated parts of the County, December 2015 having been the wettest month ever recorded. Storms Eva, Frank and Desmond prompted astonishing emergency service responses and, from adult social care, a sustained programme of visits to people who were known to social care services, including those with cognitive and/or physical impairments, mental illness and final illnesses. Many such people live alone and some live with carers who may be frail themselves. They are at different stages of their lives – from young adults to very frail older people. Contacts involved staying with people waiting to be rescued; ensuring that those who wished to remain in their homes had the means to stay warm, had enough food, clean water and their medications; helping people to move their furniture and belongings; checking that the residents of care homes were safe from the floods and that the staff were supported to move people's belongings and beds to upper floors. People living close to care homes were extraordinarily attentive – they arrived wanting to help tackle damage arising from floods and lost power supplies. In spite of the closed roads and suspended rail services, many people made their way to stricken localities with food, water, clothes and gifts as well the means to help people dispose of sodden furniture and white goods and clean what was left.

[30] www.politicshome.com/health-and-care/articles/story/hospitals-told-cut-staff-tackle-nhs-funding-crisis (accessed 9 February 2016)

Case Study 2 concerns Maureen who is 75. Since having a stroke she has lived in a residential home. When a dietician visited to review Maureen's nutrition she was informed that although Maureen had enjoyed a lunch of sausage, mashed potatoes and peas, she had choked afterwards. Maureen had recovered but since her care plan stipulated that she should have a pureed diet, the dietician was concerned. A safeguarding alert was raised by the dietician and this triggered an enquiry, which established that staff supporting Maureen did not understand what was meant by a pureed diet or why this was important to Maureen's care. The dietician contributed to the safeguarding enquiry and the resulting multi-agency work. There had been a high turnover of staff which had compromised their skill mix and communications.

During February 2016:

- Lancashire County Council and Greater Together supported a campaign to raise awareness of domestic abuse. "*Be a lover not a fighter*" encouraged people to talk about the fact of violence in the home: on average, two women are killed every week and two men are killed every month in the UK.
- An anti-abuse Muslim helpline was launched in Lancashire.[31]

During March 2016:

- The Department of Health published its revised adult safeguarding guidance.[32] Unfortunately, key sections which contain conflicting guidance have not been amended, that is:

14.2 The safeguarding duties apply to an adult who:

- *has needs for care and support (whether or not the local authority is meeting any of those needs [S1])*
- *is experiencing, or at risk of, abuse or neglect*
- *as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect*

14.5 Where someone is 18 or over but is still receiving children's services and a safeguarding issue is raised, the matter should be dealt with through adult safeguarding arrangements. For example, this could occur when a young person with substantial and complex needs continues to be supported in a residential educational setting until the age of 25 (see also chapter 16). Where appropriate, adult safeguarding services should involve the local authority's children's safeguarding colleagues as well as any relevant partners (e.g. the Police or NHS) or other persons relevant to the case. However, the level of needs is not relevant, and the young adult does not need to have eligible needs for care and support under [S2] the Care Act, or be receiving any particular service from the local authority, in order for the safeguarding duties to apply – so long as the conditions set out in paragraph 14.2 are met.

14.6 Local authority statutory adult safeguarding duties apply equally to those adults with care and support needs regardless of whether those needs are being met, regardless of whether the adult lacks mental capacity or not, and regardless of setting, other than prisons and approved premises where prison governors and National Offender Management Service (NOMS) respectively have responsibility.

- The pan Lancashire Mental Capacity Act 2005 practice group, a multi-agency group with health and social care colleagues from commissioning and provider organisations, drew from their collective experience to produce an excellent

[31] http://www.briefreport.co.uk/news/anit-abuse-muslim-helpline-launched-in-lancashire-3955502.html
[32] https://www.gov.uk/guidance/care-and-support-statutory-guidance/safeguarding (accessed 16 March 2016)

learning resource which will be available on the website of the Social Care Institute for Excellence:

http://pub.lucidpress.com/MCABLBNetwork/ [33]

The resource includes a video and e-book; the video illustrates the key elements of the MCA and professional actors take viewers through a number of scenarios/practical demonstrations. The e-book provides additional information with links to complementary resources.

- The Safeguarding Enquiry Service transferred to Public Health.

[33] Accessed 24 March 2016

Lancashire Health and Wellbeing Board
Meeting to be held on *24 October 2016*

Lancashire Safeguarding Children Board Annual Report 2015-16

Contact for further information:
Jane Booth, Independent Chair, or Victoria Gibson, Business Manager.
(jane.booth@lancashire.gov.uk or Victoria.gibson@lancashire.gov.uk)

Executive Summary

The report is available here.

The production of this report fulfils a statutory requirement and its contents are, to a large extent, determined by the legal framework and this results in a document of some size. A group of young people have been working on an alternative version with a target audience of children and young people themselves, which will be published in November.

The report reflects on a challenging year. In the Autumn of 2015 Ofsted inspected services for children in need of help and protection, children looked after and care leavers. The inspectors judged services overall as inadequate. While the inspection focussed largely on Children's Social Care the judgement reflects on all agencies as safeguarding requires agencies to work together to be effective.

This Annual Report provides information about services and their effectiveness. The LSCB shares the concerns set out in the Ofsted report. The LSCB is working as part of the Improvement Board set up to ensure an effective response and has seen evidence of plans to restructure services, reduce caseloads of social workers and improve quality assurance. These things will take time to show an impact and at the end of 2015-16 it was not possible to identify significant improvement in practice. In addition the LSCB is particularly concerned about the quality and availability of appropriate Child and Adolescent Mental Health where the resource allocation is too low and progress towards improved services too slow.

The report sets out the priorities of the LSCB and the areas identified for future work.

Recommendation

The Health and Wellbeing Board is recommended to:

- Consider the content of the Annual Report and identify any areas they may wish to comment on and any action they may wish to take.

Background and Advice

The LSCB has a statutory responsibility to ensure the effectiveness of work undertaken by agencies to safeguard children in Lancashire. This Annual Report reflects on the work undertaken in this regard in Lancashire for the 2015-16 financial year. The Board is required to have an Independent Chair and has the responsibility to promote and protect

Lancashire County Council

the welfare and interest of children, young people and their families. The Chair of the Board is accountable to the Council's Chief Executive who is, in turn, responsible for ensuring its effectiveness.

Protocols are in place which establish the relationship between the LSCB, the Children and Young People's Trust Board and the Health and Well-being Board and to strengthen this link the Independent Chair of the LSCB has recently joined the Health and Well-being Board.

The Director of Children's Services is a statutory member of the LSCB along with the Cabinet Member for Children, Young People and Schools who is a 'participating observer' on the Board. It is clear that a great deal of work to safeguard children has taken place during the last twelve months. However, there are several areas that the LSCB remains concerned about:

- Ensuring services reach an appropriately high standard on a timely basis;
- Ensuring equality of services given the complexity and diversity of the administrative area especially in relation to deprivation rates;
- Poor health outcomes, especially infant and child death rates, alcohol and substance use and self-harm;
- Increasing numbers of Children Looked After from other local authorities (around 1000) and issues around levels of need and incidents of missing from home;
- Significant increases in children subject to Child Protection Plans;
- Increasing number of Child Sexual Exploitation referrals but no increase in recorded crime;
- Continuing development of effective early intervention and preventative.

The level of concern regarding services for children experiencing emotional and mental health issues resulted in the LSCB reporting its concerns to the Health and Well-being Board who responded by requiring a comprehensive review with the intention re-commissioning services from April 2016. While some additional services have been commissioned the outcome of the review in terms of service re-design is yet to be completed and has now been rolled into a broader transformation agenda with timescales running up to the end of 2020. The LSCB has expressed its serious concerns and is now receiving regular update report at its meetings.

The LSCB will continue to work with partner agencies to address all relevant concerns identified in the Annual Report and Lancashire County Council is a key organisation in all this work.

Priorities identified in the current Business Plan are set out in detail in the report.

The Health and Wellbeing Board will also note that the business functions of both the adult and children safeguarding boards have been aligned to achieve greater efficiency and improved synergy with shared functions and responsibility.

List of Background Papers

LSCB Annual Report 2015/16, published 9 September 2016.

This report should be no more than **two** pages in total but may provide links to more detailed information and papers.

Lancashire Health and Wellbeing Board
Meeting to be held on Monday, 24 October 2016

Emergency Care Crisis - Chorley: report of the Health Scrutiny Committee
(Appendix A refers)

Contact for further information:
Wendy Broadley, Lancashire County Council, Senior Democratic Services Officer (Overview & Scrutiny) wendy.broadley@lancashire.gov.uk

Executive Summary

The Health and Wellbeing Board is presented with the report of the Health Scrutiny Committee into the emergency care crisis at Chorley Hospital. The report was approved by the Committee at its meeting on 20 September.

The report identifies a number of recommendations, two of the recommendations require a formal response from the Board.

County Councillor Steve Holgate will present the report.

Recommendation

The Health and Wellbeing Board is recommended to:

i) Produce a formal response to the relevant recommendations contained with the report by 22 November.

Background

On 13 April Lancashire Teaching Hospitals Trust notified a number of stakeholders and the public that they had taken the decision to temporarily close the A&E Department at Chorley and South Ribble Hospital and introduce an Urgent Care Service which would only be open between the hours of 8am and 8pm with a GP Out-of-Hours service overnight. The reason given by the Trust for the decision was due to insufficient numbers of middle grade doctors required to deliver a safe service.

The temporary change came into effect on Monday 18 April 2016.

The Health Scrutiny Committee consequently held a series of meetings to establish how the situation came to be, what steps needed to be taken by the Trust to resolve the situation, and what lessons could be learnt for the NHS for the future. Committee meetings took place on 26 April, 24 May and 14 June 2016 during which evidence was presented by a number of stakeholders and additional information had been gathered to support the members in their consideration of the issues identified.

Lancashire County Council

A report was subsequently presented to the Committee on 20 September 2016 which set out the findings and conclusions identified through their previous meetings and highlighted a number of recommendations. The Committee approved the recommendations subject to a few minor amendments and attached at Appendix A is the revised final version of the report.

CC Holgate will present the report and seek a commitment from the Board to provide a formal response to Recommendations 7 and 10.

List of background papers

Reason for inclusion in Part II, if appropriate

N/A

This report should be no more than **two** pages in total but may provide links to more detailed information and papers.

August 2016

Emergency Care Crisis - Chorley

Overview & Scrutiny Review

County Councillor Steve Holgate, Chair of the Health Scrutiny Committee

For further information about this report please contact
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Principal Overview & Scrutiny Officer
07825 584684
wendy.broadley@lancashire.gov.uk

Executive Summary

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The recommendations made by the Committee are:

1. The Trust should provide the Committee with a transparent, sustainable, realistic and achievable plan for the provision of services at Chorley by 22 November 2016
2. The Trust should provide the Committee with detailed information on how they are addressing their inability to meet the 4 hour target for A&E attendance at Royal Preston Hospital
3. The Clinical Commissioning Group to provide the Committee with evidence that it is supporting the Trust to explore all methods to recruit and retain staff
4. NHS Improvement should undertake a review of the national issues identified within this report, namely:
    a. The discrepancy between substantive and locum pay
    b. The need for clear guidance relating to the application and/or removal of the agency cap
    c. The number of emergency medicine trainee places
5. In the light of the failure of the Trust to communicate in a timely and effective manner with the public and their representatives in this case, NHS commissioners be asked to demonstrate how they will effectively engage and involve local residents in future service design

6. The System Resilience Group should develop a plan that identifies the lessons learnt from this situation, in particular how communication and resource planning is managed. It should then be shared with wider NHS and social partners and stakeholders.
7. That the developing crisis in Emergency Care is given the required priority in the development of the Lancashire and South Cumbria Sustainability and Transformation Plan, and a plan for Emergency Care across Lancashire is developed as a key priority, and that the Lancashire Health and Wellbeing Board be asked to take responsibility for the implementation and monitoring of this priority.
8. The Trust should make every effort to increase the Urgent Care Centre opening hours on the Chorley site to 6am – midnight as additional staff are appointed. In addition the Health Scrutiny Committee require the Trust to provide evidence of the public promotion of the Urgent Care Centre including information available on the services it delivers.
9. The Trust should actively seek best practice from other Trusts regarding staffing on A&E Departments
10. For the future, a more open approach to the design and delivery changes to the local health economy needs to take place, working with wider public services through the Lancashire Health and Wellbeing Board to make our hospitals more sustainable and better able to serve the needs of residents. Partners must also demonstrate robust engagement with local residents on the proposed location of future services.

Background and methodology

Lancashire Teaching Hospitals Trust provides a range of district general hospital services to the 390,000 local population of Preston, Chorley, and South Ribble. Services are provided mainly from Royal Preston Hospital and Chorley and South Ribble Hospital.

- Royal Preston Hospital is designated as the major trauma centre for Lancashire which is where the majority of the Trust's specialist services are provided, as well as trauma pathway services including neurosurgery, vascular, plastics, and trauma orthopaedics.
- Any patient who presents at Chorley who requires a specialist review is transferred to Royal Preston Hospital, including children and young people as there is no longer a paediatric service at Chorley and South Ribble Hospital.
- In 2015, around 79,000 patients attended Royal Preston Emergency Department a year, and around 50,000 patients attended Chorley Emergency Department.

Prior to 18 April 2016, both hospitals provided a 24 hour emergency department service, with consultant cover at Royal Preston Hospital until midnight (on call thereafter). There was no consultant presence at Chorley and South Ribble Hospital after 6pm.

On 13 April the Trust notified a number of stakeholders that they had taken the decision to temporarily change the service provision at Chorley from an A&E Department to an Urgent Care Service, operating between the hours of 8am and 8pm with a GP Out-of-Hours service overnight. The decision was made due to insufficient numbers of middle grade doctors required to deliver a safe service. The change would take effect from 18 April 2016.

Considering the evidence

The subject of A&E services is always extremely controversial and emotive. Services can be, literally, a matter of life and death. Decisions around A&E must always be taken solely on the grounds of patient safety and ensuring the best outcomes for people who present to A&E. In considering this sensitive subject, the Committee has sought to separate out the facts from the emotions, whilst recognising the strong feelings that the decision generated.

It is well understood that the nature of health and social care services are changing, and that, due to the increasing specialisation of healthcare and the better outcomes this brings, that it is no longer possible for all hospitals to offer all services. However, it is essential that any such decisions are made on the grounds of delivering the best outcomes, and not for purely financial

or other non-health reasons. The concern in this case was that the closure, albeit temporary, happened so quickly, with so little communication, that there has been, at least in the public's mind, doubt about the motivation, and a clear lack of clarity about the impact of the change.

The first in a series of the Health Scrutiny Committee meetings was held on 26 April to which Lancashire Teaching Hospitals Trust and Chorley South Ribble & Greater Preston Clinical Commissioning Group were invited to present.

At the meeting the Committee heard from the Trust as they provided details of their actions and the events that had led up to their decision to make the temporary changes. It was evident that the key factor for the Trust was their inability to recruit adequate numbers of staff to provide a safe service and they cited a number of underlying reasons for this which included

- the lack of actual trainee doctors provided by Health Education North West compared to the number of training posts in the Trust's structure
- a lack of sufficiently experienced, qualified and available locums
- the Trust's reluctance to break the 'agency cap', guidance introduced by the NHS in November 2015 which limits the hourly rate that can be paid for agency staff with the intention that it should only be breached on "exceptional safety grounds"

The next meeting held on 24 May therefore concentrated on the issue of recruitment and further investigation was undertaken to explore the factors identified by the Trust. Members were provided with comments and opinion from:

- Health Education North West regarding the system in place for the training of consultants and the allocation of trainee doctors to the Trust
- Medacs UK, a healthcare recruitment company employed by the Trust to help source locum doctors from a number of agencies and across all services.
- NHS Improvement in relation to the "agency cap", and the Trust's application of it, specifically the timing of the decision by the Trust to break the cap
- Rt Hon Lindsay Hoyle MP regarding local opinion and the impact on neighbouring Trusts

The final meeting held on 14 June subsequently focused on the long term sustainability of acute health services within Chorley, the wider CCG footprint and also at a county wide level.
Members were provided with presentations from:

- The CCG, on their "Our Health, Our Care" Programme which would take a medium to long term view on how future models of care will need to operate, and plans for implementation in addition to
- Healthier Lancashire & South Cumbria Change Programme which is the overarching strategy for the county to identify how sustainable health and care services can be delivered.
- The Committee also heard from a representative from the Protect Chorley Hospital Against Cuts and Privatisation campaign group and acknowledged the strength of feeling of local residents and their efforts to ensure that local people were at the centre of local service design and delivery

The Committee received direct contributions from	Additional evidence was obtained from
• Lancashire Teaching Hospitals Trust • Chorley South Ribble & Greater Preston CCG • System Resilience Group • Health Education England North West • Medacs UK • NHS Improvement • NHS Employers • Rt Hon Lindsay Hoyle MP • Mark Hendrick MP • Seema Kennedy MP • Local Campaign Group - Protect Chorley Hospital Against Cuts and Privatisation • Healthier Lancashire & South Cumbria Change Programme	• Wrightington, Wigan & Leigh NHS Trust • University Hospitals Morecambe Bay • North West Ambulance Service • General Medical Council • College of Emergency Medicine • Chorley Council • NHS England • Local residents

Findings

What the evidence told us

The Committee heard a lot of evidence, some of it contradictory, and much of it requiring further analysis and examination. However, the very clear message that emerged is that there is a very real and serious problem with emergency care services and A&Es. This does not appear to be limited to Lancashire, as regular news stories about queueing ambulances, Trusts missing the four hour target for dealing with A&E attendees set by government, and regular campaigns and requests by the NHS through the media to the public to make sure they are using A&E appropriately.

What is also true is that often A&Es are where the problems in our health services show most obviously, but that this does not mean that the problems are with the A&Es themselves. People present at A&Es if the right alternatives are not available. People get stuck in A&E departments if there are no beds available for them because other services aren't operating effectively. More people need emergency treatment if their day to day health and care needs aren't met, until they end up in a crisis situation.

The investigation by the scrutiny committee cannot begin to consider all of these issues and the general problem with Emergency Care in Lancashire. However, the Chorley A&E closure has highlighted that this is a system under massive pressure, and that things can very easily go wrong. There are also clearly some specific actions or issues in Chorley that the Committee have sought to identify and address.

In relation to Chorley, throughout the evidence gathering sessions a number of key areas of concern emerged which included:

a) The impact on surrounding hospitals
b) Policies and practices relating to recruitment
c) How the developing situation had been communicated
d) What the future holds

The impact on surrounding hospitals

- One crucial area for consideration is the impact on the A&E departments of neighbouring Trusts, and their capacity to take on any additional patients. Statements made by Lancashire Teaching Hospitals Trust claimed that the situation at Chorley was only having a 'minimal impact' on neighbouring hospitals. However, anecdotal evidence was that there was an impact, especially at Royal Preston.

- The Committee established that the following Trusts had been included within data analysis by the System Resilience Group and North West Ambulance Service to consider what level of impact the changes may have had:
    - Blackpool Teaching Hospitals Trust
    - University Hospitals Morecambe Bay Trust
    - East Lancashire Hospitals Trust
    - Wrightington, Wigan & Leigh Trust
- Many local Trusts have recently made media statements identifying the current pressures on their A&E Departments and whilst is was acknowledged that there were several reasons for these pressures, at least one of those Trusts said that the change to services at Chorley was one of the contributory factors resulting in them struggling to meet demand.
- The data provided identified the increase in patient attendance at six neighbouring hospital A&E Departments. It was clear that Royal Preston Hospital had the most significant increase both month on month and in comparing 2015 to 2016 data (see Appendix A). The other Trust that experienced an increase in attendance was Wrightington, Wigan & Leigh. The table below is an excerpt from Appendix A.

  It provides numbers of ambulance attendances at A&E Departments for the Royal Albert Edward and Royal Preston Hospitals for April to June during 2015 and 2016, specifically identifying those patients presenting from a postcode served by the Chorley and South Ribble CCG, who would, for the most part, have had the Chorley A&E as their nearest. It should be acknowledged that the data is a snapshot of a three month period and does not identify what increase in attendances took place in the months previous to the change to services in Chorley.

	2015	2016
	A&E Department attendance	
Royal Albert Edward Infirmary Wigan Greater Manchester	**24**	**157**
April	5	19
May	10	73
June	9	65
Royal Preston Hospital Lancashire	**1064**	**2598**
April	386	665
May	343	1029
June	335	904

- These tables, at first glance, demonstrate a significant impact, with the number of patients from Chorley and South Ribble presenting at Royal Preston almost trebling following the closure. The number of extra patients at the Royal Albert Edward, although the percentage increase was large, is not especially significant in the context of the overall numbers. However, when systems are already under pressure, small numbers can sometimes make a significant difference.
- It is also clear that the A&E at Royal Preston is struggling to cope with demand. Appendices B & C show the outcome of further analysis by the CCG. The data shows that ambulance attendances have increased by an average of 24 per day and severe handover delays (over 60 minutes) occurred 141 times in May 2016, which is more than double that of any neighbouring A&E Department. The Trust have also failed to achieve their performance target of 95% for dealing with attendances within a four hour period. The figure for May 2016 is 82.2% compared to 97.2% for the same period last year. Even accepting the general increase in patient numbers of 26% it was felt that the significant deterioration in the four hour target performance was unacceptable.

- The figures show that the increase in attendance at Royal Preston is significantly greater than simply the difference between the attendance at Chorley and Preston this time last year. If there were no other pressures, then the extra demand at Preston would have halved. Again, this highlights that this was already a system under massive pressure when the Chorley decision was made, and raises serious questions about the Trust's understanding of the problem and preparedness for the impact.
- The figures for patients being seen within the four hour target show that there is a major problem at Royal Preston, but that at the Chorley UCC 100% of patients are seen within the timescale. This suggests that either staffing ratios at the two sites are wrong, and that there is possibly spare capacity at the UCC, or that the public don't understand when they can go to the UCC and when they need to go to the full A&E. It would be interesting to establish how many presenting at Royal Preston could have been satisfactorily seen at Chorley. This is, perhaps, again a matter of communication from the Trust not properly explaining what the UCC is for and when it should be used.
- This analysis places a spotlight on when failures within A&E are identified, it is clear however that the concerns around the provision of primary care and social care also need to be addressed to produce long term sustainable solutions to a whole system approach.

Policies and practices relating to recruitment

- The Committee acknowledged that the changes implemented at Chorley were based on clinical safety and accepted this fact. However, they had serious concerns that the situation had been allowed to get to the stage where patient safety was a problem, that the staffing issue was not shared with partners earlier, and the committee felt that a 'crisis management' approach had been used over a sustained period of time.
- The Committee have seen little evidence that the Trust implemented alternative recruitment processes at an early enough stage which indicates a perceived reliance on traditional methods to source potential staff. Additionally there is a lack of robust engagement with other Trusts to explore different ways of working or seeking best practice procedures. A reactive rather than proactive approach seems to have been adopted. This assumption is reinforced by the admission of the Trust that they did not lift the agency cap until 16 March. This then enabled the Trust to pay enhanced rates for locum doctors to increase their ability to attract potential staff.

- A cap on the hourly rate paid for agency staff was introduced by the NHS in November 2015, in an attempt to reduce the cost of locum doctors to the NHS. The "agency cap" was introduce on a phased basis across the NHS in England, and the intention that this cap would be adhered to and only breached in exceptional circumstances - the provision was for Trusts to override the cap only on ' *exceptional safety grounds'*. The Committee heard that LTHT followed the guidance strictly, and was one of the only Trusts in the country to do so and act in accordance with the government's intention. Whilst on one hand the Committee acknowledged the Trust's stance to adhere to the guidance relating to the agency cap could be perceived as commendable, members were of the opinion that in the circumstances it was a naïve approach to take when staffing levels put at risk the viability of an A&E Department being able to provide a safe service and therefore continue to remain open, and that the circumstances were "exceptional" much earlier than the Trust acknowledged. The Trust, in short, did not act quickly enough to tackle the problem.
- The significance of the Trust not breaching the cap when other Trusts did, was simply that other Trusts were willing to pay more for the services of locums. The Trust obviously therefore would not attract as many suitably qualified locum doctors.
- NHS Improvement confirmed they were aware of potential gaps in the system around the enforcement of the agency cap and they were currently unable to monitor this as effectively as they would like. It is a matter of concern that such an important and commendable government initiative to reduce the costs of locums was not being properly monitored to ensure fairness.
- Many reasons were cited by the Trust explaining how multiple factors had compounded their inability to adequately staff the A&E Department at Chorley such as the application of the agency cap, lack of trainees and the unreliability of locum doctors. However the Committee felt these considerations were universal across the NHS, and being dealt with more effectively elsewhere. There was a concern that the Trust was attempting to shift the responsibility onto other organisations for the current position.
- Even though it was acknowledged that the Trust held the agency cap until the 11th hour it is unclear what the underlying reasons are for staffing issues being at crisis point at Lancashire Teaching Hospitals whilst other Trusts such as University Hospitals Morecambe Bay are able to maintain an A&E provision on more than one site.
- The Trust seem to place an over reliance on trainee posts to supplement their staffing structure for the A&E Department and the reduction in actual number of trainees available has not been adequately addressed. The Committee felt that the Trust just cited the inability to confirm exact trainee numbers without providing any assurances that alternative

methods were being developed. Health Education North West were of the opinion that a sufficient number of trainee posts had been allocated to the Trust and nationally there was not the demand from doctors for an increase in emergency medicine placements.

- The national issues of discrepancy between substantive and locum staff pay, the adherence to the agency cap by Trusts and the number of available emergency medicine training places are significant factors that would benefit from a fundamental review.
- Because of the way that Emergency Departments are run in the UK it was agreed that challenges exist around the ability to identify staff from overseas who are able to be recruited on the basis that their knowledge and experience of an emergency department system is similar to that in the NHS. This effectively narrows the places from which potential staff can be sourced.
- It was acknowledged by Medacs, the managed recruitment service used by the Trust, that there were challenges to recruiting to Chorley A&E, due to the lack of trauma and intensive care units at the site, which made it less attractive to specialists in emergency care

How the developing situation had been communicated

- The Trust must take the responsibility for the poor management of the issue in terms of communicating concerns early enough to partners and formulating an action plan to deal with such an event.
- Taking the decision based on clinical safety does not mitigate the fact that Lancashire Teaching Hospitals and the wider health system should have taken action earlier to address staffing issues and to communicate with other partners and stakeholders
- It was apparent from several sources, including the Trust itself, that the emerging issue of staffing levels reaching crisis point at Chorley had been known and documented for a significant period of time and the Committee were dismayed that the information had not been shared with stakeholders sooner nor an active action plan developed and implemented.
- It also appears that the Trust may not have adequately communicated the services for which the UCC could be used, and when the public should attend the full A&E

What the future holds

- Members were always sceptical that the potential re-opening date of August subject to staffing levels was unlikely to be achieved and that the A&E Department would not re-open. The latest communication from the System Resilience Group (dated 28 July) has borne this out, and it now appears that the A&E will not re-open until 2017 at the earliest.
- The Committee felt that the Urgent Care Centre opening hours are not adequate even as a temporary measure. It was felt that a 24 hour service was necessary, and at the very minimum it should be 6am – midnight. The Committee also considered that the Trust should begin to reintroduce extended hours on an incremental basis for the Urgent Care Centre as soon as additional staff became available as an interim measure and to demonstrate their commitment to the service.
- The Clinical Commissioning Group should take more of a lead role in driving a resolution forward by insisting the Trust look at different ways of service delivery by comparing the actions of other Trusts.
- Health Education North West stated that for a centre to offer the required training element for doctors it needed to provide at least 2 of the following 3 specialisms; an A&E, Paediatrics and Intensive Care – Chorley no longer has these facilities. Some members expressed the view that the long term future use of Chorley Hospital overall appears to be unclear in light of key service areas withdrawn over recent years. This needs to be addressed within the Sustainability and Transformation Plan for Lancashire and South Cumbria to determine what role the hospital will play in the transformative plan for health and care services in the county.
- The local 'Our Health, Our Care Programme' being designed by the Clinical Commissioning Group and the wider 'Healthier Lancashire & South Cumbria Change Programme' need to demonstrate how they will consider the views and ideas of the local population. It is recognised that as the Sustainability and Transformation Plan for Lancashire and South Cumbria is developed it will outline how health and care services are built around the needs of the local population and therefore bring about significant changes to the patient experience and substantial improvements in health outcomes.

- The Trust have failed in its attempts to convince the local community that there is a genuine commitment to re-open the A&E Department at Chorley. Regular and well attended public protests at Chorley hospital demonstrate great local concern at the

position. Evidence, especially from MPs and local campaigners, suggests a lack of trust by a large section of the public and there is even a view that has been expressed that the handling of the situation has amounted to "closure by stealth". The Trust therefore need to make a very clear statement that they are fully committed to reopening a full A&E service at Chorley. Clearly, if that is not the case, and the intention is to close Chorley A&E permanently, that must not be done until there is the full consultation, in accordance with legal requirements, where the Trust can openly set out its reasoning for closure and the public and its representatives can have their say as part of a proper democratic process.

Conclusions

There is a major problem in Lancashire and the rest of the country in Emergency Care. The reasons for this are complex, wide ranging and the subject of much debate amongst health and social care professionals, politicians and the public. The Committee can't solve this problem, it can only acknowledge that it exists, and try to understand the situation in Chorley in this context.

It would be unfair to simply say that all of the problems in Emergency Care in central Lancashire are the fault of the Trust. The Committee also accepts that, at the point the announcement was made, the situation at Chorley A&E would have become unsafe for patients if it had been allowed to remain open.

However, it would equally not be reasonable to say that the Trust is a simple victim of circumstances, nor that the Trust could not have acted to prevent the situation at Chorley becoming unsafe.

Simply put, it has been clear for some time that there has been a growing problem in Emergency Care. The Trust could and should have seen that coming, and should have taken action to ensure that the problem did not become a crisis.

The Trust failed to act soon enough to tackle the problems with recruitment. It failed to recognise that the situation was "exceptional" and justified breaking the agency cap much earlier. The Trust did not appear to have actively sought other options or engage with other Trusts to identify creative solutions, and when, finally, the Trust acted, it was too late.

The Trust also failed to communicate with key partners and the public about the developing situation. There were rumours which the Trust did not either confirm or effectively put a stop to. The Health Scrutiny Committee, who the Trust have a statutory duty to engage with, were kept in

the dark. If the position had been explained, if the Trust had been more open, then conversations and consultations could have been held and a solution could possibly have been found.

The position at Chorley is still unresolved, and it has recently been confirmed that the Trust has not recruited sufficient staff to reopen in August, as originally suggested might be the case. The latest information is that the A&E will not reopen until 2017, indicating that whatever actions the Trust is taking are insufficient, and giving fuel to the fire of those who believe that it is the Trust's intention, and perhaps has always been the Trust's intention, to close Chorley A&E permanently. If this is not the case then the Trust needs to make a clear public statement to that effect.

The Committee, and the public, understand that the NHS is under great pressure, and that NHS services have to change to reflect demand, clinical developments, better integration, improved technology and the financial pressures it is under. However, any changes must be done in a co-ordinated, planned, open and transparent way, looking at the whole system of health and social care. Until actions are taken in primary care, other acute services and social care to reduce demand on A&E, reducing capacity in emergency care and piecemeal and emergency closures will only make a bad situation worse.

The Trust, by their actions and in some cases inaction, have regrettably made an already difficult situation worse.

Recommendations

1. The Trust should provide the Committee with a transparent, sustainable, realistic and achievable plan for the provision of services at Chorley by 22 November 2016
2. The Trust should provide the Committee with detailed information on how they are addressing their inability to meet the four hour target for A&E attendance at Royal Preston Hospital
3. The Clinical Commissioning Group to provide the Committee with evidence that it is supporting the Trust to explore all methods to recruit and retain staff
4. NHS Improvement should undertake a review of the national issues identified within this report, namely:
    a. The discrepancy between substantive and locum pay
    b. The need for clear guidance relating to the application and/or removal of the agency cap
    c. The number of emergency medicine trainee places
5. In the light of the failure of the Trust to communicate in a timely and effective manner with the public and their representatives in this case, NHS commissioners be asked to demonstrate how they will effectively engage and involve local residents in future service design
6. The System Resilience Group should develop a plan that identifies the lessons learnt from this situation, in particular how communication and resource planning is managed. It should then be shared with wider NHS and social partners and stakeholders.
7. That the developing crisis in Emergency Care is given the required priority in the development of the Lancashire and South Cumbria Sustainability and Transformation Plan, and a plan for Emergency Care across Lancashire is developed as a key priority, and that the Lancashire Health and Wellbeing Board be asked to take responsibility for the implementation and monitoring of this priority.
8. The Trust should make every effort to increase the Urgent Care Centre opening hours on the Chorley site to 6am – midnight as additional staff are appointed. In addition the Health Scrutiny Committee require the Trust to provide evidence of the public promotion of the Urgent Care Centre including information available on the services it delivers.
9. The Trust should actively seek best practice from other Trusts regarding staffing on A&E Departments
10. For the future, a more open approach to the design and delivery changes to the local health economy needs to take place, working with wider public services through the

Lancashire Health and Wellbeing Board to make our hospitals more sustainable and better able to serve the needs of residents. Partners must also demonstrate robust engagement with local residents on the proposed location of future services.

Appendix A

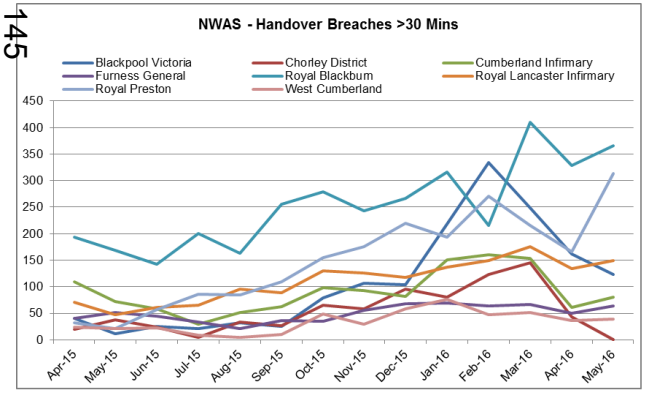
Number of ambulance attendances at individual hospitals from residents with a Chorley South Ribble CCG postcode for April-June in 2015 and 2016

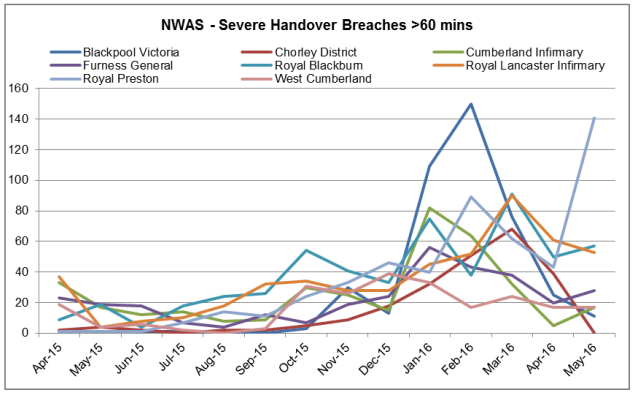
Attendances	Year						
Month	2015 Non AE Department	AE Department	2015 Total	2016 Non AE Department	AE Department	2016 Total	Grand Total
Royal Albert Edward Infirmary Wigan Greater Manchester		**24**	**24**	**9**	**157**	**166**	**190**
April		5	**5**	3	19	**22**	27
May		10	**10**	3	73	**76**	86
June		9	**9**	3	65	**68**	77
Royal Blackburn Hospital Lancashire	**5**	**11**	**16**	**9**	**33**	**42**	**58**
April	1		**1**	6	12	**18**	19
May	2	4	**6**	3	12	**15**	21
June	2	7	**9**		9	**9**	18
Royal Bolton Hospital Greater Manchester	**3**	**8**	**11**	**2**	**30**	**32**	**43**
April	2		**2**		7	**7**	9
May	1	1	**2**	1	13	**14**	16
June		7	**7**	1	10	**11**	18
Royal Preston Hospital Lancashire	**259**	**1064**	**1323**	**405**	**2598**	**3003**	**4326**
April	86	386	**472**	165	665	**830**	1302
May	99	343	**442**	132	1029	**1161**	1603
June	74	335	**409**	108	904	**1012**	1421
Grand Total	**267**	**1107**	**1374**	**425**	**2818**	**3243**	**4617**

NHS Chorley and South Ribble CCG (CSRCCG) - ED Attendance Impact Assessment

- **Ambulance Handover Delays (Data Source: NWAS Portal – HAS Reports, excludes exceptions)**

Trust Site	Breaches (Excluding Exceptions)	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16
Blackpool Victoria	Handover Breaches >30 Min	40	11	25	21	32	25	79	106	104	218	334	248	162	123
	Severe Handover Breaches >60 Min	1	1	1	1	0	0	3	30	13	109	150	76	25	11
Chorley District	Handover Breaches >30 Min	20	37	24	4	34	27	65	59	95	80	123	145	43	0
	Severe Handover Breaches >60 Min	2	4	2	0	2	2	5	9	18	32	51	68	39	0
Cumberland Infirmary	Handover Breaches >30 Min	110	72	58	30	52	63	99	93	82	151	160	153	61	81
	Severe Handover Breaches >60 Min	33	17	12	14	8	9	30	25	15	82	64	32	5	17
Furness General	Handover Breaches >30 Min	40	52	44	34	21	36	35	55	68	69	64	67	50	64
	Severe Handover Breaches >60 Min	23	19	18	7	4	12	7	19	24	56	43	38	20	28
Royal Blackburn	Handover Breaches >30 Min	193	168	143	200	163	256	279	243	266	316	216	410	329	366
	Severe Handover Breaches >60 Min	9	19	4	18	24	26	54	41	33	75	38	91	50	57
Royal Lancaster Infirmary	Handover Breaches >30 Min	71	47	61	65	96	88	130	126	117	137	150	176	134	150
	Severe Handover Breaches >60 Min	37	4	8	10	18	32	34	28	28	45	52	90	61	53
Royal Preston	Handover Breaches >30 Min	32	21	57	86	84	110	155	175	220	193	270	215	166	313
	Severe Handover Breaches >60 Min	1	1	1	7	14	11	24	33	46	40	89	62	43	141
West Cumberland	Handover Breaches >30 Min	24	21	23	9	4	10	49	29	58	76	48	51	36	39
	Severe Handover Breaches >60 Min	19	4	6	2	0	3	31	26	39	33	17	24	17	17
Cumbria & Lancashire	**Handover Breaches >30 Min**	**530**	**429**	**435**	**449**	**486**	**615**	**891**	**886**	**1010**	**1240**	**1365**	**1465**	**981**	**1136**
	Severe Handover Breaches >60 Min	**125**	**69**	**52**	**59**	**70**	**95**	**188**	**211**	**216**	**472**	**504**	**481**	**260**	**324**





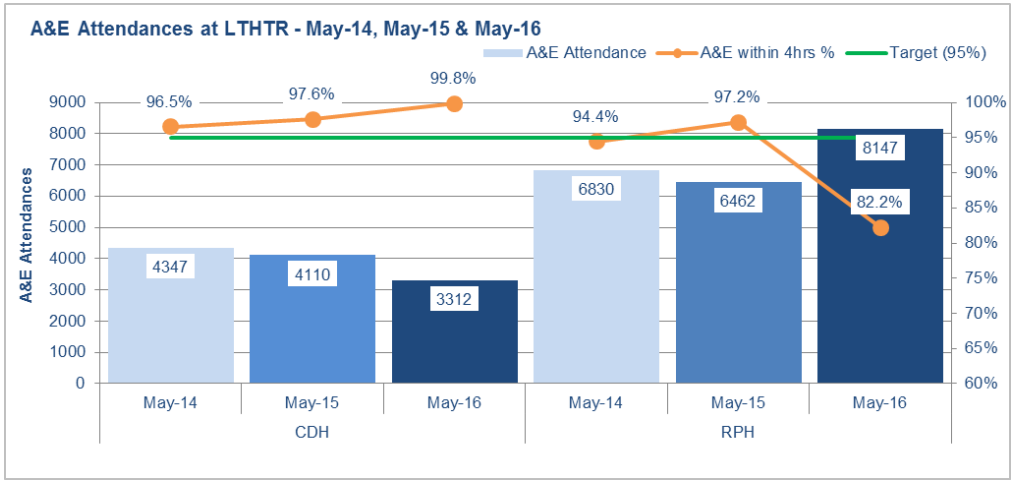
- The table left displays all breaches reported by NWAS (excluding exceptions) for all Trusts within the Cumbria and Lancashire area since Apr-15.
- The charts below show the handover breaches by Trust for both >30 minutes and >60 minutes.
- There has been an increasing trend for most Trusts over the reported period with the greatest growth for > 30 min breaches for Royal Blackburn.
- The greatest increases for severe handover breaches >60 mins can be seen for Royal Preston with increases during months Jan-15 and Feb-15 for Blackpool Victoria.

Weekly analysis from NWAS shows that number of ambulances arriving at RPH have seen an increase of 24 on average a day since temporary closure of ED at Chorley

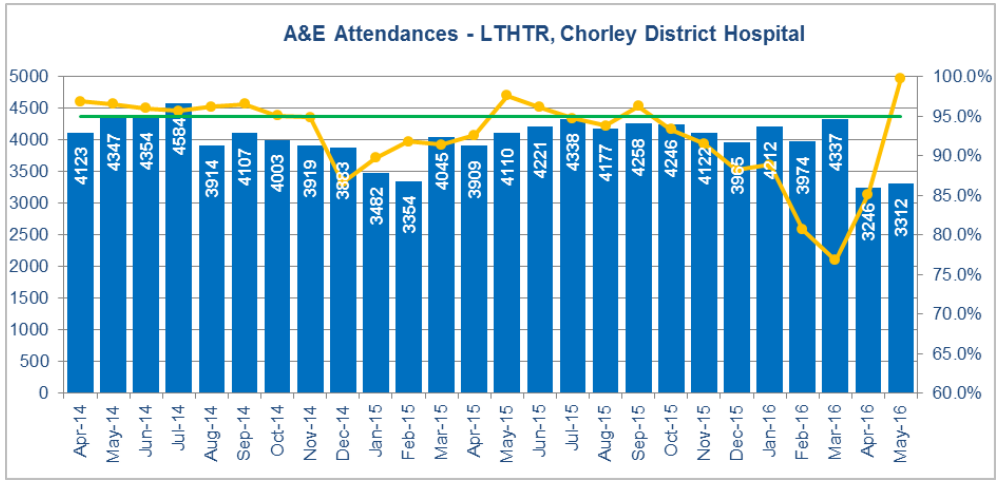
NHS Chorley and South Ribble CCG (CSRCCG) - ED Attendance Impact Assessment

Follow-up Data Requirement – July 2016

- **A&E Attendance Activity at LTHTR (Data Source: LTHTR Monthly 'Sitrep')**



- The chart left shows the volumes of A&E attendances at LTHTR by site for the month May for the last three years 2014/15, 2015/16 and 2016/17.
- The 4 hour performance is also shown against the target of 95%.
- Attendances have reduced by 19% at CDH comparing May-16 with May-15.
- Attendances have increased by 26% at RPH comparing May-16 with May-15.
- Performance of the 4 hour target has improved at CDH and has deteriorated at RPH to 82.2%.



- The chart left shows volumes of A&E attendances at CDH since Apr-14 with the 4 hour performance (yellow line).
- Year to date 2016/17 there has been an 18% reduction in attendance volumes at CDH.
- During May-16 the 95% target has been met for the first time since Aug-15 at 99.8%.