Lancashire Health and Wellbeing Board

Lancashire County Council

Lancashire Health and Wellbeing Board
Tuesday, 18 September 2018, 10.00 am,
Committee 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. Welcome, introductions and apologies	Action	To welcome all to the meeting, introduction and receive apologies.	Chair		10.00am
2. 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		
3. Minutes of the Last Meeting held on 17 July 2018	Action	To agree the minutes of the previous meeting.	Chair	(Pages 1 - 10)	
4. Action Sheet and Forward Plan	Update	To note the action updates from the previous meeting and the forward plan for future meetings.	Chair	(Pages 11 - 14)	

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

Agenda Item	Item for	Intended Outcome	Lead	Papers	Time
5. Review of Central Lancashire Plan - Improving Health Care and Wellbeing in Central Lancashire	Information	To receive a presentation about the Integrated Care Partnership plan, including the future of acute services in Central Lancashire. **PowerPoint presentation** by Sarah James and Gerry Skailes.	Sarah James Gerry Skailes		10.05am
6. Review Pennine Plan - Improving Health Care and Well Being in Pennine Lancashire	Information	To receive a report about the Integrated Care Partnership plan in Pennine Lancashire.	Mark Youlton	(Pages 15 - 62)	10.30am
7. Lancashire Adult Learning - Opportunities for collaboration and partnership to support Health and Wellbeing strategies in Lancashire	Information	To receive information on opportunities available through Lancashire Adult Learning.	Andrew Parkin Nicola Hall Sarah Howarth	(Pages 63 - 66)	10.50am
8. Better Care Fund (BCF) and Active Ageing Alliance	Action	To receive and update including Quarter 1 performance, Delayed Transfers of Care diagnostic, BCF planning requirement and the Active Ageing Alliance work.	Paul Robinson Adrian Leather	(Pages 67 - 104)	11.10am
9. Mental Health and Wellbeing - Time to Change Hub	Action	To consider the establishment of a Time to Change hub for Lancashire as a way of influencing, long-term local strategies relevant to mental health and wellbeing.	Dr Sakthi Karunanithi Darren Bee	(Pages 105 - 110)	11.40am

Agenda Item	Item for	Intended Outcome	Lead	Papers	Time
10. Lancashire Special Educational Needs and Disabilities (SEND) Partnership - Update on the implementation of the Written Statement of Action	Action	To receive an update on the SEND Improvement Plan.	David Graham	(Pages 111 - 114)	11.50am
11. Lancashire Safeguarding Boards Annual Report 2017/18	Information	To receive the annual reports from the Lancashire Safeguarding Children Board and the Lancashire Safeguarding Adults Board	Jane Booth	(Pages 115 - 220)	12.00 noon
12. Role of Lancashire Fire and Rescue Service on the Board	Information	To receive a presentation on the role of the Lancashire Fire and Rescue Service to the Health and Wellbeing Board and outline future opportunities through collaborative working.	David Russel	(Pages 221 - 222)	12.15pm
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		

Agenda Item	Item for	Intended Outcome	Lead	Papers	Time
14. Date of Next Meeting	Information	The next scheduled meeting of the Board will be held at 10.00am on 20 November 2018 in Committee Room 'C' – Duke of Lancaster Room at County Hall, Preston.	Chair		12.30pm

L Sales
Director for Corporate Services

County Hall
Preston

Lancashire Health and Wellbeing Board

Minutes of the Meeting held on Tuesday, 17th July, 2018 at 10.00 am in Committee Room 'C' (The Duke of Lancaster Room) - County Hall, Preston

Present:

Chair

County Councillor Shaun Turner, Lancashire County Council

Committee Members

County Councillor Graham Gooch, Lancashire County Council
County Councillor Mrs Susie Charles, Lancashire County Council
County Councillor Geoff Driver CBE, Lancashire County Council
Dr Sakthi Karunanithi, Director of Public Health, LCC
John Readman, Interim Executive Director of Education and Children's Services
Councillor Bridget Hilton, East Lancashire Health and Wellbeing Partnership and Central District Councillor
Gary Hall, Chief Executive, Chorley Council representing CEOs of Lancashire District Councils
Jane Booth, Independent Chair, Lancashire Safeguarding Children's Board and Adult Board
Cllr Viv Willder, Fylde Coast District Council Rep
Mark Youlton, East Lancashire CCG
Councillor Margaret France, Central HWBP
Adrian Leather, Third Sector Representative
Greg Mitten, Interim Chair of West Lancashire HWBP
Tammy Bradley, Housing Providers
David Russel, Lancashire Fire and Rescue Service
Dr Tom Marland, Fylde and Wyre CCG and Fyle and Wyre Health Partnership
Helen Curtis, NHS Chorley and South Ribble CCG & NHS Greater Preston CCG

Apologies

Louise Taylor	Executive Director of Adult Services and Health and Wellbeing
Stephen Young	Director of Growth, Environment, Transport and Community Services, LCC
Karen Partington	Chief Executive of Lancashire Teaching Hospitals Foundation Trust
Dr Alex Gaw	Morecambe Bay Clinical Commissioning Group (CCG)
Graham Urwin	NHS England, Lancashire and Greater Manchester
Dr John Caine	West Lancashire CCG
Jacqui Thompson	North Lancashire HWB Partnership
Chief Inspector Ian Sewart	Lancashire Constabulary
Professor Heather Tierney-Moore	Lancashire Care NHS Foundation Trust
Councillor L Pate	East Lancashire District Council Rep

1. Appointment of Chair

Resolved: That in accordance with the Terms of Reference, County Councillor Shaun Turner, as the Cabinet Member for Health and Wellbeing, was appointed as Chair for the remainder of the 2018/19 municipal year.

2. Appointment of Deputy Chair

Resolved: That the Clinical Commissioning Groups nominate a Deputy Chair for the municipal year 2018/19 and that the Board be updated of the appointment at the next meeting.

3. Membership and Terms of Reference of the Lancashire Health and Wellbeing Board

Resolved: i) That the Board noted the current membership and Terms of Reference for the 2018/19 municipal year, as set out in the report and at Appendix 'A'.

ii) To appoint a Deputy Chair for the year 2018/2019 municipal year at the next meeting of the Board in September from Health as discussed at Item 2.

4. Welcome, introductions and apologies

All were welcomed to the meeting and round table introductions took place.

Apologies were noted as above.

New members were noted as follows:

Stephen Young, Director of Growth, Environment, Transport and Community Services, Lancashire County Council
Tammy Bradley, Progress Housing, representing Housing Providers
Councillor Lian Pate for Councillor Tony Harrison, East Lancashire District Council
David Russel, Lancashire Fire and Rescue Service

Replacements were as follows:

Dr Tom Marland for Jennifer Aldridge, Fylde and Wyre Clinical Commissioning Group and Fylde and Wyre Health and Wellbeing Partnership
Helen Curtis for Dr Goran Bangi and Dr Sumantra Mukerji, Chorley and South Ribble Clinical Commissioning Group and Great Preston Clinical Commissioning Group

5. Disclosure of Pecuniary and Non-Pecuniary Interests

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

6. Minutes of the Last Meeting held on 20 March 2018

Resolved: That the Board agreed the minutes of the last meeting.

7. Action Sheet and Forward Plan

Updates on actions from the 20 March 2018 meeting were received.

New membership had already been reported to the Board at Item 4.

The Board were still awaiting the query on how many people the 3,479 delayed days affected. As Paul Robinson was on leave, this information would be shared at the next Board meeting.

With regards the specific Better Care Fund planning session, this would be discussed further when the new guidance had been issued.

If there were any items for the forward plan, these should be sent to Sam Gorton, email sam.gorton@lancashire.gov.uk who would then bring them to the Chair's attention for consideration.

8. Better Care Fund and Delayed Transfers of Care Update

The year 2017/18 saw considerable activity and change across the Lancashire Better Care Fund (BCF). The performance against metrics was good for both reablement and reducing the numbers of permanent admissions to residential and nursing homes. It was also so for the number of non-elective admissions that were slightly below the target.

The main area of focus for the year was the level of Delayed Transfers of Care (DToC) across hospitals in Lancashire and the split of responsibility for these across health and social care. There was an overall reduction during the year that saw a convergence towards the revised and highly challenging targets. The greater reduction was seen in social care attributable delays.

There was a high level of cooperation and challenge across the whole health and social care system that has resulted in improved Delayed Transfers of Care performance and a continuing improvement in collaborative working that includes the voluntary sector and district councils.

The level of funding via the Better Care Fund increased overall and was then supplemented by the Improved Better Care Fund (iBCF). This required and ultimately enabled better joint working and decision making across health and social care and targeting of new and enhanced services at shared priorities.

Such was the challenge around Delayed Transfers of Care that national resources were allocated to provide currently ongoing Delayed Transfers of Care diagnostic work that has presented its findings and is now shaping up how the improvement themes will be applied.

As there is a two year Better Care Fund and an Improved Better Fund plan in place there is no need for further detailed planning at present. The NHS plan and social care green paper due in Autumn will provide detail of the nature and purpose of the Better Care Fund beyond 2019/20 although it has been indicated that there will be an increased emphasis

on integration and the Better Care Fund will be at the centre of this. A report will be provided to the board when the information becomes available.

The Disabled Facilities Grant funding at Wyre District Council had been used in innovative ways and this had been shared with other Districts.

It was reported that, notwithstanding progress made, parts of the Better Care Fund resources are non-recurrent and ending in two years' time. It was noted that there were schemes funded by the local authority and the NHS that were not included in the Better Care Fund but were intended to achieve same outcomes as the Better Care Fund. The Board agreed to scope and review the overall health and care budget that fund these schemes to inform planning beyond the Better Care Fund period.

Resolved: That the Health and Wellbeing Board:

i) Noted the Better Care Fund annual summary provided at Appendix 'A'.
ii) Requested a further report on the outcomes of the Delayed Transfers of Care diagnostic work once this is completed.
iii) Requested a report on future planning requirements for the Better Care Fund once this was known.
iv) Organise a workshop to scope and review the total system budget and develop an integration plan beyond 2019/20.

9. Fylde and Wyre Local Delivery Plan

The Board received an update on the Fylde Coast Local Delivery plan and not the Wyre Local Delivery Plan. Peter Tinson, NHS Fylde and Wyre Clinical Commissioning Group presented the attached PowerPoint presentation to the Board.

Within the Fylde Coast, 11 neighbourhoods had been in operation for over four years. The Clinical Commissioning Group was working closely with Lancashire County Council and Dr Sakthi Karunanithi in planning for neighbourhood level integration.

Links were being made with Lancashire County Council's proposed priorities on neighbourhood level integrated care systems, improving delayed transfers of care, improving stroke outcomes, addressing variation in diabetes care and reducing suicides.

Excellent progress was being made already within the Integrated Care Plan system across clinical and non-clinical areas.

Clinical Senate had been established to drive vision forward and brings together a range of professionals to share best practice including GPs, Consultants, Nurses, Therapists and Public Health practitioners which would provide leadership, guidance and input.

Delayed Transfers of Care have significantly reduced since last year and were beneath the 3.5% target.

Peter Tinson was thanked for his presentation.

10. Prevention and Population Health Plan and Neighbourhood Working

Dr Sakthi Karunanithi, Director of Public Health, Lancashire County Council presented the report and PowerPoint to the Board that were attached to the agenda.

At the Lancashire Health and Wellbeing Board (HWBB) workshop held on the 15 May 2018, it was agreed that the single next focus for integration (alongside the existing activity on hospital flow and Delayed Transfers of Care (DTOC) was the whole system approach to health and care at neighbourhood level.

A task and finish group comprising of the Cabinet Member for Health and Wellbeing and officers from the NHS and local government met on the 29 June 20218. The working title for this programme of work was 'Total Neighbourhoods'. The task and finish group discussed the offer and ask from the County Council to progress this work and agreed two key activities.

They included:

1. ‘Operational alignment’ of NHS, district council and Voluntary, Community and Faith Sector services at neighbourhood level, starting with public health and preventative services and then to consider adult social care and other relevant services of the County Council as as the programme develops.

2. 'Strategic design' work to further develop integrated care including pooled budgets, joint commissioning, risk and gain share agreements and regulation.

Discussion ensued around the Neighbourhood Operating model and looking at this on an integrated care system level which was aligned to the Council's footprint. Each neighbourhood could be unique and it includes services for all ages and not just physical health.

The Board agreed that they would stand to make some huge gains with neighbourhood working and that this had to be a whole system approach to keep people safe and well in their own homes and communities. The Board needed to align itself operationally and be innovative.

Lancashire Adult Learning could offer support with this, and the Board were informed that they had been invited to present at the next meeting in September 2018.

The active ageing proposal being developed by the Voluntary, Community and Faith sector will also support this.

Some work was already being done in certain neighbourhoods so would look to them to design and lead as first wave of neighbourhoods starting in Autumn 2018 with a view to scale up and spread the neighbourhood level integration of services during 2019/20 and the year after.

It was requested that Lancashire's Health and Wellbeing Board asks the five Health and Wellbeing Partnerships to develop plans to support the neighbourhood level working in

their respective areas. It was noted that this will also support the priorities of Lancashire and South Cumbria Integrated Care System.

Resolved: That the Health and Wellbeing Board agreed to:

i) Support the 'offer' and 'ask' from the County Council to integrate services at the neighbourhood level.
ii) Support a detailed design of this programme with NHS, districts and partner organisations to invite first wave of neighbourhoods, starting in Autumn 2018.
iii) Endorse the implementation of this programme via Lancashire and South Cumbria Integrated System and its associated Integrated Care Partnerships
iv) Support the ongoing discussions between local authorities to develop an alliance of Health and Wellbeing Boards across Lancashire and South Cumbria.
v) Receive regular progress reports to provide ongoing support to this programme.
vi) Receive a report on the Acting Ageing Alliance at a subsequent meeting.

11. Special Educational Needs and Disabilities Improvement Plan

Lancashire local area Special Educational Needs and Disabilities services were inspected by Ofsted and the Care Quality Commission (CQC) in November 2017 to judge how effective the special educational needs and disability (SEND) reforms had been implemented, as set out in the Children and Families Act 2014. The inspection identified areas of significant concern and required a written statement of action to be developed to address these.

The Lancashire SEND Partnership had produced a written statement of action and this had been accepted and signed off by Ofsted and CQC. Actions had been organised into working groups and delivery had commenced. Activity on these actions was monitored by the Department for Education (DfE) and NHS England. An initial monitoring visit had been held and feedback received had been positive. The next monitoring visit is on 25 July 2018.

Key achievements of the working groups to date were listed in the report.

As part of this work a series of parent/carer engagement events were taking place across the county.

It is hugely important that partners and commissioners were involved with SEND Services, so that the required outcomes were achieved.

Resolved: That the Health and Wellbeing Board:

(i) Noted the detail of the written statement of action.
(ii) Noted the progress of delivery on the written statement of action.
(iii) Will receive an update to the next Board meeting.

12. Transforming Care - In Patient Provision

Rachel Snow Miller and Sharon Walkden, Midlands and Lancashire Commissioning Support Unit, Andrew Simpson, NHS England and Ian Crabtree, Lancashire County Council gave an update of the current status, progress and upcoming plans for specialist Learning Disability and Autism inpatient provision within the Lancashire and South Cumbria Transforming Care Programme.

Updates were provided on Medium Secure Units (MSU) and Low Secure Units (LSU) provision including the determined location of the MSU and the options for future provision of the LSU.

The paper also outlined plans for the future model of care for non-secure, Clinical Commissioning Group commissioned beds and the upcoming consultation process.

The current provision of CCG commissioned beds was through the Enhanced Support Service (ESS) based on the Mersey Care Foundation Trust (MCFT) Whalley site (Calderstones). This was supplemented by a number of spot-purchased, out of area beds from independent providers. At the start of the Transforming Care Partnership programme in 2016/17 Lancashire and South Cumbria were required to discharge 61 patients from Specialised Commissioning (SC) Beds and 46 patients from CCG commissioned beds. Any patients who were admitted to ESS/out of area beds in the meantime were also added to the numbers counted.

Papers detailing transformational proposals and project timelines, in line with national requirements were presented and approved at the Collaborative Commissioning Board (CCB) and the Joint Committee of Clinical Commissioning Groups (JCCCG) in November 2017. The initial plan approved a two staged approach that incorporated an interim solution and the development of a long-term, permanent model.

Interim Solution - It was proposed that during 2018-19, care would be delivered through the optimisation of the existing ESS service on the MCFT Whalley Site. This would enable patients from out of area placements to return to Lancashire and South Cumbria and help retain a highly skilled learning disability workforce.

Permanent Model – was developed by clinical experts within the North West Learning Disability and Autism Operational Delivery Network (ODN). Their proposed model satisfies the Building the Right Support (BRS) target for the Lancashire and South Cumbria footprint. The model incorporates:

- Provision of 14-16 beds in a specialist in patient unit (a mix of rehabilitation and Assessment and Treatment beds) co-located / in close proximity to a hospital site and on a bus route and close to amenities/community.

- 10 step-up / step-down placements (homes not beds). It was proposed that these placements were Care Quality Commission registered as Domiciliary Care and **not** as hospital beds. These placements would offer short term placements with a clear pathway into supported living once appropriate.

In addition there would be a need for a number of individual tenancies for service users who would be provided with the necessary packages of support in their own homes. Initially it was suggested that 10 such tenancies would be required.

Based on this approach the total model would take up to 2021 to deliver. It was now clear that this time line would not be acceptable to NHS England and that all learning disability patients must be relocated from the Whalley site by July 2019. On that basis it was now recommended that the Transforming Care Partnership move directly to implement the permanent model without an interim solution with the ambition to move all patients off the site at Whalley by April 2020.

A plan for public, patient and stakeholder consultation on the model of care was in development, this would comply with NHS England's Four Tests for Service Change:

- Strong public and patient engagement;
- Consistency with current and prospective need for patient choice;
- A clear clinical evidence base; and
- Support for proposals from clinical commissioners.

For the consultation a six step process would be undertaken, underpinned by engagement and involvement with patients and carers, public, clinicians, staff and stakeholders.

The Board also noted the higher mortality rate for people with learning disability compared to the general population. The Learning Disabilities Mortality Review (LeDeR) programme was aimed at making improvements to the lives of people with learning disabilities. Reviews were being carried out with a view to improve the standard and quality of care for people with learning disabilities. It was really important in supporting individuals, parents and families with complex difficulties and will support the Total Neighbourhoods programme discussed earlier.

Resolved: That the Health and Wellbeing Board:

i) Noted the update for Secure Inpatient Services.
ii) Noted the update for the CCG Commissioned Inpatient Service.
iii) Noted the update on the CCG commissioned beds consultation process.
iv) Would receive a further update in relation to life expectancy and health and wellbeing outcomes for people with learning and disabilities and their carers.

13. Clinical Commissioning Groups (CCGs) Annual Report 2017/18

Consultation had taken place on the Clinical Commissioning Group (CCG) Annual Reports 2017/18, as part of the statutory requirement outlined in guidance. Reports from four CCGs had been received.

Resolved: That the Health and Wellbeing Board:

i) Acknowledged the receipt of CCG Annual Reports, as per the Boards request.

ii) Noted the contribution and continued delivery of the joint Lancashire Health and Wellbeing strategy priorities.

14. Urgent Business

There were no matters of urgent business received.

15. Date of Next Meeting

The next scheduled meeting of the Board will be held at 10am on Tuesday, 18 September 2018 in Committee Room 'C' – Duke of Lancaster Room at County Hall, Preston.

L Sales
Director of Corporate Services

County Hall
Preston

Lancashire Health and Wellbeing Board

Actions, July 2018

Action topic	Summary	Owner
Appointment of Deputy Chair	• The Board to be updated on the appointment of Deputy Chair for the municipal year 2018/19	Clare Platt
Better Care Fund	• The Board to receive information on how many people the 3,479 delayed days affected. Paul Robinson was on leave in July so it was agreed this information would be shared at the next Board • That a further report be presented on the outcomes of the Delayed Transfers of Care diagnostic work once this is completed. **(Report attached at Item 8 of the agenda)** • That a report be presented on future planning requirements for the Better Care Fund once this was known. **(Report attached at Item 8 of the agenda)** • That a workshop be held to scope and review the total system budget and develop an integration plan beyond 2019/20.	Paul Robinson
Prevention and Population Health Plan and Neighbourhood Working	• The Board to receive regular progress reports to provide ongoing support to this programme. **(Included on forward plan)** • The Board to receive a report on the Acting Ageing Alliance at a subsequent meeting. **(Report attached at Item 8 of the agenda)**	Dr Sakthi Karunanithi Adrian Leather

Special Educational Needs and Disabilities Improvement Plan	• The Board to receive an update to the next meeting **(Report attached at Item 10 of the agenda)**	David Graham
Transforming Care - In Patient Provision	• The Board to receive a further update in relation to life expectancy and health and wellbeing outcomes for people with learning and disabilities and their carers. **(included on forward plan)**	Ian Crabtree

Lancashire Health and Wellbeing Board

Forward Planner

Date of Meeting	Topic	Summary	Owner
November 2018	Care Home Collaborative Working	Board to receive an update on activity.	Lisa Slack/Louise Taylor
November 2018	Data Sharing	To develop a data sharing agreement between Primary Care/Hospitals/Local Authorities for planning purposes.	Dr Sakthi Karunanithi
November 2018	Transforming Care – In Patient Provision	To receive a further update in relation to life expectancy and health and wellbeing outcomes for people with learning and disabilities and their carers.	Rachel Snow-Miller
November 2018	Prevention and Population Health Plan and Neighbourhood Working in the Integrated Care System	To receive update and provide ongoing support to this programme.	Dr Sakthi Karunanithi
November 2018	Digital Health Board	To receive the strategy.	Amanda Thornton/Declan Hadley
November 2018?	Review Morecambe Bay Plan: Improving Health, Care and Wellbeing in Morecambe Bay	To receive an update about the Integrated Care Partnership plan	TBC
November 2018?	Review Fylde Coast Plan: Improving Health, Care and Wellbeing on the Fylde Coast	To receive an update about the Integrated Care Partnership plan	Dr Sakthi Karunanithi
November 2018?	Review West Lancashire Plan: Improving Health, Care and Wellbeing in West Lancashire	To receive an update about the Integrated Care Partnership plan.	TBC

Date of Meeting	Topic	Summary	Owner
November 2018	Central Lancashire Integrated Care Partnership Development and Future of Acute Services	To provide an update on the future of acute services in the Central Lancashire area detailing the case for change, process and next steps.	TBC
November 2018	Healthy Living Pharmacy Campaigns	To receive an update on the campaigns.	Dr Sakthi Karunanithi
November 2018	Children and Young People Emotional Wellbeing and Mental Health	To receive an update on Lancashire's Children and Young People Emotional Wellbeing and Mental Health transformation programme.	Dave Carr
November 2018	Ofsted Improvement Plan	To receive the improvement plan.	John Readman
November 2018	Lancashire Volunteer Partnership	To receive an update and explore a social action network for Lancashire.	Ian Sewart
November 2018	Motor Neurone Disease Association Charter	To request that the Council adopt the MND Charter.	Julie Compton

Lancashire Health and Wellbeing Board
Meeting to be held on Tuesday, 18 September 2018

Pennine Plan: Improving Care, Health and Well Being in Pennine Lancashire
(Appendix A refers)

Contact for further information:
Tony Pounder, Lancashire County Council, Tel: 01772 536287

Executive Summary

This paper provides an overview of how the proposals for improving health, care and wellbeing across Pennine Lancashire have been developed and recommends the Pennine Plan for consideration and approval.

Recommendation/s

The Health and Wellbeing Board is recommended to:

(i) Approve the Pennine Plan as the blueprint for health and care transformation in Pennine Lancashire.

(ii) Seek assurance from the Pennine Partnership that in its delivery of the Pennine Plan it will also take account and ensure delivery of the emerging priorities of the Lancashire and South Cumbria Integrated Care System.

(iii) Agree any further requirements, aspirations or expectations that should be communicated on behalf of the Lancashire Health and Well Being Board in relation to the future development of the Pennine Partnership and the delivery of the Pennine Plan.

Background

For the purposes of this report, the Pennine area covers the population and organisations operating within the east of Lancashire County Council's boundaries, in each of the five district council areas of

- Ribble Valley
- Hyndburn
- Burnley
- Pendle
- Rossendale (excluding Whitworth)

Pennine also includes the area covered by the unitary council of Blackburn with Darwen. Its population and the organisations serving it are also therefore partners to this plan.

In 2016, the health and care organisations in Pennine Lancashire agreed to work together to address the greatest issues of challenge in relation to health, care and wellbeing, and to work together as a single public sector economy for Pennine Lancashire.

Lancashire County Council

The Pennine Plan sets out the response to these issues. A wide range of health and care professionals and patient and community representatives were involved in developing the blueprint for a 'New Model of Care' for Pennine Lancashire.

In December 2017, the Pennine Integrated Health and Care Partnership published a draft of the Pennine Plan to test proposals for change with a broad range of stakeholders, and to gather feedback and insight to inform more detailed service specifications and implementation plans.

This report provides an overview of the engagement approach undertaken to test the Draft Pennine Plan and a summary of responses received during the engagement. These have been used to shape the final version of the Pennine Plan, which is attached for consideration at Appendix A.

Publication and Stakeholder Engagement

Publication of the Draft Pennine Plan was accompanied by a significant programme of communications and engagement to promote, explain and discuss the content of the plan and elicit views from the public, stakeholders and staff about the draft plan.

Building on considerable public and stakeholder engagement undertaken since the inception of "Together a Healthier Future" in 2016, this engagement programme included:

- Promotion of the plan online and through social media. The Facebook story about the draft plan reached 44,709 individuals and on Twitter promotion of the draft plan reached 36,127 users. A total of 13,751 visitors visited the "Together A Healthier Future" website over this period of engagement.
- A programme of public relations and media engagement resulting in positive and accurate coverage in all print media of the draft Pennine Plan and our call for views about it.
- Workforce engagement via staff newsletters, public bulletins, features on their social media pages, intranet and websites.
- A specific targeted engagement exercise with the Gypsy, Romany and Traveller community in Pennine Lancashire.
- An open invitation from the partnership to every known stakeholder group within the voluntary, community and faith sector, patient interest groups, and staff groups and networks to attend, present and discuss the Draft Pennine Plan.
- Market stalls in key locations across Pennine. In East Lancashire these were as follows
    - 7th December 2017 – Burnley Central Library with Burnley Care to Chat members
    - 14th December - Hanson Cement training centre with Ribble Valley Seniors
    - 14th December – Old Colne Library with the Asian Carers Forum
    - 10th January – Blind Society shop Accrington with Hyndburn Older People's Forum
    - 10th January – Irwell Medical Centre
    - 12th January – Clitheroe Hospital
    - 17th January – St Andrews Church Hall, Colne with the Fun 4 Stroke group
    - 18th January – Rawtenstall Primary Care Centre
    - 22nd January – Burnley General Hospital
    - 5th February - Nelson Town Hall with Pendle Older People's Forum

- Co-production of an “easy read” version of the draft Pennine Plan with representatives of the learning disability community which was well received and accessed by a large number of people.

Summary of Feedback

Substantial feedback on the Draft Pennine Plan was received. This included formal responses from 377 individuals, alongside the key messages from the market stalls and meetings which are occurred.

The responses and feedback clearly support the proposals set out in the Draft Pennine Plan. While there was some concern expressed about financial viability and sustainability, people recognised the ambitions outlined for Pennine Lancashire.

A significant proportion of the feedback sought to highlight key considerations for the mobilisation and implementation of the proposals. This feedback will be used to inform the development of detailed delivery proposals.

A detailed report of this Communications and Engagement programme is available at www.togetherahealthierfuture.org.

Final Version

The final version of the Pennine Plan has now been produced.

Key changes from the published draft version are summarised below:

- Updating of terminology such as replacing references to accountable care systems and partnerships with integrated care systems and partnerships

- Simplification of the language used where engagement highlighted particular concerns, for example in relation to food poverty and finance

- Included further detail which more accurately reflects the scale of opportunities and ambition for Pennine, for example in relation to digital developments

- Explained how key areas of work will be taken forward through agreed or developing strategies and framework such as the Pennine Lancashire Volunteer Strategy

- Updated figures and dates as appropriate

- Included reference to making sure we support people to be more aware of what services can support them, to help people to make the right choices, particularly by promoting the NHS Choose Well campaign.

A detailed list of changes is available on request.

Publication of the Pennine Plan and Delivery Plan

Alongside the Pennine Plan there will also be published a Delivery Plan, which will set out to stakeholders how we are already progressing and delivering key elements of the New Model of Care. This will address queries raised by some stakeholders, regarding the mobilisation and implementation and provide an important opportunity to highlight the significant work already underway across partner organisations to progress the vision.

Collaboration between Health and Social Care agencies in Pennine Lancashire has a substantial history already. However, this is being given new impetus by emerging national policy developments regarding integration of health and social care services. There is also considerable local momentum in Pennine Lancashire to move progressively but decisively towards even closer and ultimately formal legal partnership arrangements.

List of background papers

None

Appendix A

TOGETHER
A HEALTHIER FUTURE
The Integrated Health and Care Partnership for Pennine Lancashire

The Pennine Plan:

Improving Health, Care and Wellbeing in Pennine Lancashire

Summer

2018

FOREWORD

We are proud of the health and care services we have in Pennine Lancashire. Our doctors, nurses, and wider health and care staff provide high quality care for people who live and work here. We are equally proud of our communities and how residents across the area come together to provide friendship, encouragement and support to each other. Around 114,000 residents volunteer at least once per month, providing support and care to individuals and families across our communities.

People in Pennine Lancashire are more likely to experience ill health compared with people living in other parts of the country. We have high levels of deprivation, poor health outcomes and greater demand for health and care services. The good news is that we can prevent many of our illnesses and, by working together, we can help improve people's health and wellbeing, whilst continuing to provide effective and efficient health and care services.

In delivering Together A Healthier Future we want to harness everything that is good about Pennine Lancashire; our people, our communities, our volunteers, our open spaces and our services. We want to put you and your family at the centre of everything we do and provide health and care around your needs, and not those of organisations.

Over the past 18 months we have worked with residents, volunteers, doctors, nurses, health and care professionals, community workers and others to develop our plans for change. We have listened to what people have had to say and we set out our proposals in our Draft Pennine Plan which we published in December 2017. Thank you to everyone who has taken the time to let us know what you think of our proposals.

On the whole, you support our drive, ambitions and proposals to improve health and wellbeing in Pennine Lancashire. Many of you recognise the need for everyone to play a role in looking after their own health and using services responsibly. You gave us lots of ideas and food for thought, which will help us shape our services for the future.

We all have a part to play in achieving a Healthier Future and making our services the best they can be. We need everyone to look after their own health as much as they can, to make healthy choices in their lives, use services appropriately and support their families and friends to live healthy lives. Our doctors, nurses, pharmacies and other health care professionals are already working better together in our neighbourhoods and we are continuing to improve hospital and urgent care services.

We are proud of our ambition for Pennine Lancashire, and whilst we acknowledge that the challenges are great, we are committed to improving the health and wellbeing of our residents, transforming the quality of care delivery and ensuring that health and care organisations operate within their financial means. We hope that you will all continue to be involved in helping us achieve these ambitions.

Graham Burgess
Chair, Pennine Lancashire Integrated Health and Care Partnership.

EXECUTIVE SUMMARY

We know we face a number of challenges that contribute to increasing demands for service provision and mean that local people are more likely to experience ill health than people living in other areas of the country:

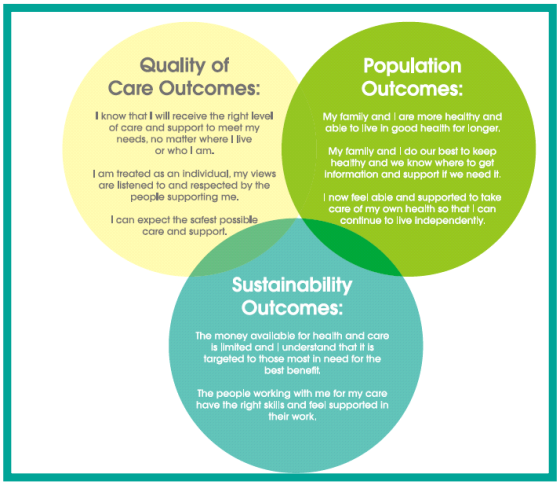
- **Children and young people are not getting the best start in life**
- **Mental illness is more common than in other areas of the country**
- **Many people have diseases and health conditions that are preventable**
- **Many more people attend accident and emergency than in other areas of the country**
- **People are living longer but with more complex needs**
- **Increasing pressures are being placed on our services and demand for services is out-stripping the money we have to pay for health and social care.**

Together A Healthier Future represents all the health and care organisations in Pennine Lancashire, along with local councils and voluntary, community and faith sector services. As organisations who are responsible for, or have an interest in delivering health and care services, we have agreed to work together to take a more preventative approach to health and wellbeing, aiming to ensure people live as healthy as they can for as long as they can. We also want to make health and care services easier for people to access, understand and work with.

We have agreed a shared vision which is:

"For all of us in Pennine Lancashire to live a long and healthy life. Any extra help and support we need will be easy to find, high quality and shaped around our individual needs."

We believe that working together is the best way to deliver real improvements for local people, and we have worked with staff and members of the public to identify eight statements that reflect how we want our shared future to be.



Our Partnership has achieved a lot already, but we want to go further and work together as the Pennine Lancashire Integrated Health and Care Partnership, to ensure we provide care in the right place, at the right time and as one team, to deliver our agreed outcomes. This means we will:

- Take shared responsibility for delivering our agreed performance goals and improving on our shared outcomes
- Manage funding for our population together through a financial system 'control total' across Clinical Commissioning Groups (CCGs) and service providers

- Create an effective collective decision making and governance structure, aligning the ongoing and continuing individual statutory accountabilities of our partner organisations
- Demonstrate how our provider organisations will work together to integrate their services Partner with local GP practices, formed into clinical hubs serving 30,000-50,000 populations
- Ensure we have the skills to understand the health needs of our population and that we are commissioning and delivering services to respond to these needs in the most effective way
- Establish clear mechanisms by which our residents will still be able to exercise patient choice
- Take shared responsibility for continuing to improve the efficiency, effectiveness and quality of our health and care services.

We have identified **Health and Wellbeing Improvement Priorities** where Pennine Lancashire is performing poorly compared to other similar areas for these issues, either in terms of population outcomes, quality of care, or spend on services. We know that a lot of work has taken place in recent years to improve services and outcomes for patients but we need to do more.

Working together with our staff and our communities, we have developed and agreed a **Prevention Framework** which will embed prevention across every aspect of our future plans and a **New Model of Care** which we believe is the best approach to improving the health and wellbeing of all who live and work in Pennine Lancashire.

Our **New Model of Care** puts people, their families and communities at the heart of everything, aiming to put them in control of their own health and wellbeing, so they can remain as healthy as possible for as long as possible. If people do become ill, our New Model of Care aims to ensure they receive the right level of support within their home or local area. When specialist or acute support, in hospital, is needed, people will receive care that is safe, effective and shaped around their individual needs.

The successful delivery of Together A Healthier Future will depend on ensuring we can manage our financial challenges together. We also know that we need to design and provide a workforce equipped to deliver new services, have buildings that are fit for purpose and affordable and use technology to its full potential.

We are focussed on striving to achieve the best health and wellbeing outcomes for our population and making a positive difference to people's lives.

CONTENTS

For more information on how we developed our Pennine Plan please visit:

www.togetherahealthierfuture.org.uk.

1.0 Introduction

"We are committed to changing our health and care system here in Pennine Lancashire for the better. We have some of the worst health in the country. We can and must do better and we can do this by everyone – staff, residents, businesses, elected representatives, community groups and organisations - working together. Of course, there is not an endless pot of money to achieve this and there is a significant financial challenge but we can change the way things are done for the better."

Dr Phil Huxley, Chair of East Lancashire Clinical Commissioning Group

1.1 Our Pennine Plan sets out how we will work together to transform health and care and improve the health and wellbeing of everyone in Pennine Lancashire.

1.2 Nationally the Government has asked health and care leaders in each area to come together to transform services and ensure they are affordable. These are called Integrated Care Systems. Pennine Lancashire is one of five Integrated Care Partnership (ICP) areas that make up the Healthier Lancashire and South Cumbria Shadow Integrated Care System (SICS). More details about the Lancashire and South Cumbria SICS can be found at www.lancashiresouthcumbria.org.uk.

1.3 We are already working together as an Integrated Health and Care Partnership in Pennine Lancashire, we call it 'Together A Healthier Future.' This means all health and care organisations are working together to achieve the best health and wellbeing outcomes for our population and make a positive difference to people's lives.

1.4 Our Vision for Together A Healthier Future is:

"For all of us in Pennine Lancashire to live a long and healthy life. Any extra help and support we need will be easy to find, high quality and shaped around our individual needs."

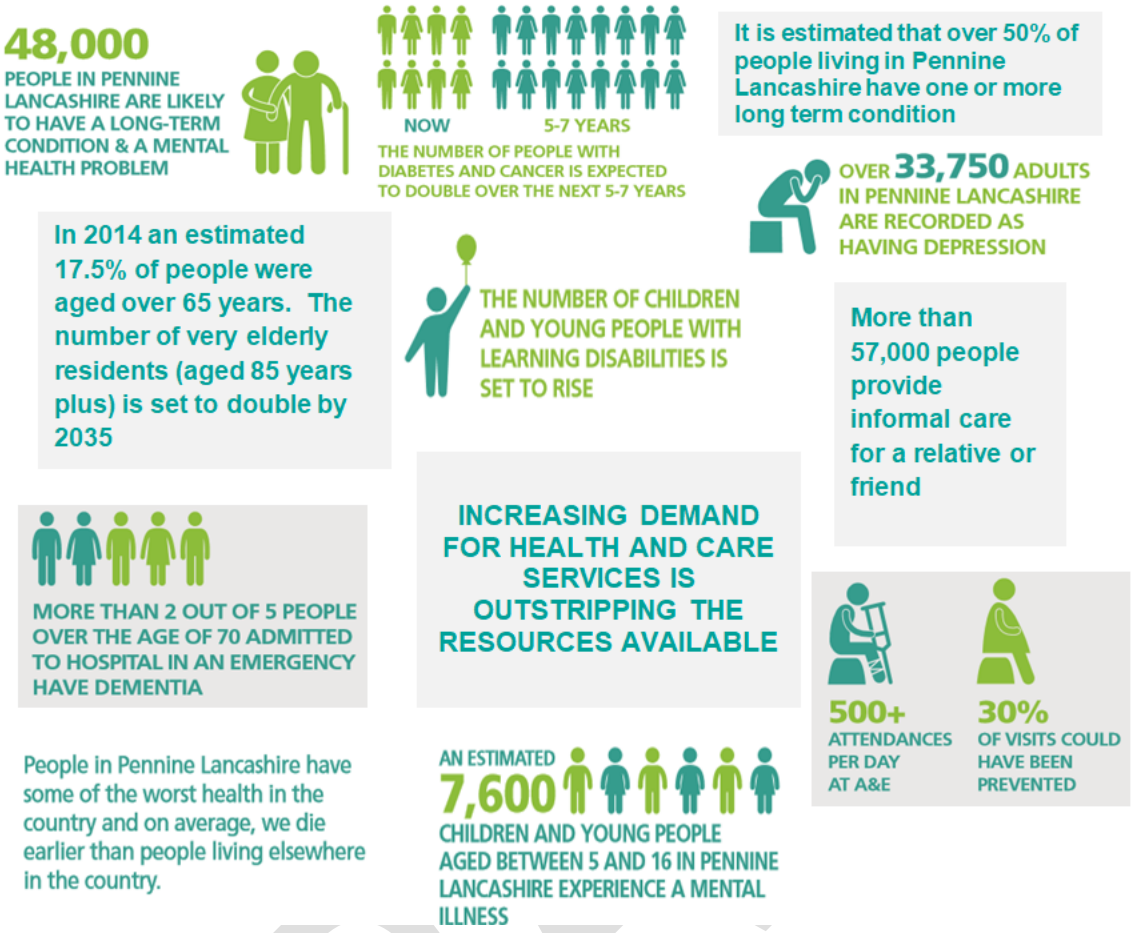
1.5 Pennine Lancashire is a large geographical area comprising the six boroughs of Blackburn with Darwen, Burnley, Hyndburn, Pendle, Ribble Valley and Rossendale.

1.6 We have a resident population of over 531,000, 21% of whom are under 16 years old and more than 17% of residents are from Black or Minority Ethnic Groups. One of the boroughs, Blackburn with Darwen, has one of the youngest populations in England, and half of all school-age children belong to BME communities. The Pennine Lancashire population will grow a little over the next ten years. By 2035 the proportion of people aged 65+ will increase from 13% to 17% and the number of residents aged 85+, currently almost 11,000 people (2.1% of the population), is set to double.

1.7 Pennine Lancashire is a great place to live and work. Public services are of high quality, and have delivered significant improvements to people's lives, but there is always room for improvement. Additionally, there are increasing pressures being placed on these services and demand for services is out-stripping the money we have to pay for health and social care. But we also know about the excellent work that goes on in our neighbourhoods by people and communities working together.

1.8 We know we face a number of challenges that contribute to increasing demands for service provision and mean that local people are more likely to experience ill health than people living in other areas of the country:

- **Children and young people in Pennine Lancashire are not getting the best start in life**
- **Mental illness is more common in Pennine Lancashire than in other areas of the country**
- **Many people in Pennine Lancashire have diseases and health conditions that are preventable**
- **Many more people in Pennine Lancashire attend accident and emergency than in other areas of the country.**
- **People in Pennine are living longer but with more complex needs.**



Note: An in-depth analysis of the issues which drive our need for change is set out in the Pennine Lancashire Case for Change which is available on our website www.togetherahealthierfuture.org.uk.

1.9 At the core of Together A Healthier Future is a commitment to embed prevention (see section 2.0) right across every aspect of our future plans and a New Model of Care (see section 3.0) which places individuals and families at its heart.

1.10 As we have developed our New Model of Care, we have worked hard to ensure that we deliver on our Commitments to the people of Pennine Lancashire and our Vision for the future.

Pennine Lancashire Commitments

We will create an effective, integrated, person and family centred Locality Services Model, incorporating NHS, Social Care, Primary Care and the voluntary, community and faith sector. This will be capable of managing the escalation of demand in neighbourhood and community settings, keeping people safe and well in their own homes.

We will transform urgent and emergency care to ensure that the people of Pennine Lancashire with urgent care needs will receive a highly responsive service that delivers care as close to home as possible. Those with serious or life-threatening conditions will be treated in centres with the very best expertise and facilities in order

to maximise their chances of survival and a good recovery.

We will improve on all of our key 'Variations in Care' through standardisation of pathways and best practice interventions and improve the health and wellbeing outcomes of our population overall.

We will develop a comprehensive health promotion and wellbeing programme focussing on community resilience, disease prevention, citizen empowerment and the development of volunteering, through a single public sector approach working with the voluntary, community and faith sector.

We will deliver the enablers of change for an Integrated Care System:

- Workforce transformation: One workforce
- Better use of technology
- Consistent and clear communication and engagement with our public and workforce
- Optimise the use of public estate across all organisations: one public estate.

1.11 Our Principles are the way in which we will deliver our Vision and Commitments and are aligned with the Lancashire and South Cumbria Shadow Integrated Care System. Our thinking, analysis and design work have all been guided by these principles.

Pennine Lancashire Principles

Place based – transformation will bring about an integrated 'place based health system', that shifts the service model to one that spans organisational boundaries and has more health and social care focussed on prevention and promoting wellbeing.

People centred – people are considered in terms of their strengths; they are empowered to improve their own health and wellbeing, and manage their care. Care and support is shaped around individual needs, coordinated, and empowering.

People as partners - in developing services and in providing care and support to others, as carers or volunteers are identified, supported and involved

Health and wellbeing is everyone's business – health, wellbeing and health improvement is everyone's business. Whole system transformation requires a 'whole of society' approach.

Equity before equality - recognising that some people will need more help and support to ensure they can access the same opportunities as others.

Digital first or digital only – maximising technological developments to give people greater control over their health, care and lifestyle choices.

Safe and effective care – delivery of evidence-based services and interventions which maximise clinical safety and effectiveness.

Shared outcomes – the focus will be on ensuring quality and narrowing inequalities. Voluntary, community and social enterprise and housing sectors are involved as key partners and enablers. People will be given the opportunity to shape their care and support and work towards the outcomes they want to achieve.

One workforce – there will be one workforce, made up of different services, including voluntary; community and faith sector services, who are all working to the same principles and values, to achieve improved outcomes.

Accessible and safeguarded information – for people, patients and professionals when they need it.

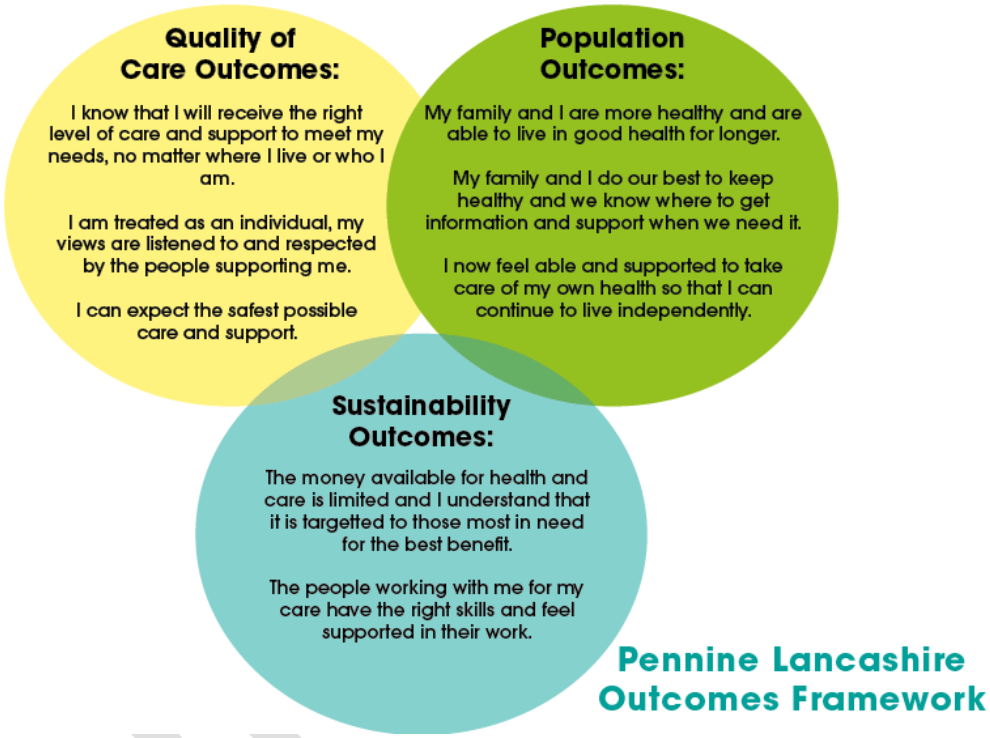
1.12 We have identified the Health and Wellbeing Improvement Priorities below because Pennine Lancashire is performing poorly compared to other similar areas for these issues, either in terms of population outcomes, quality of care, or spend on services. We know that a lot of work has taken place in recent years to improve services and outcomes for patients but we need to do more.

Pennine Lancashire Health and Wellbeing Improvement Priorities	
Healthy Lungs – including a focus on: ○ Chronic Obstructive Pulmonary Disease ○ Respiratory illness for children and young people **Healthy Hearts** – including a focus on: ○ Stroke ○ Diabetes **Healthy Minds** – including a focus on: ○ Crisis mental health ○ Mental health and substance misuse ○ Psychological support for long term conditions **Cancer** – including a focus on: ○ Prevention and earlier diagnosis ○ Treatment and care ○ Living with and beyond cancer ○ Patient experience ○ Pathway redesign and waiting times **End of life** – including a focus on: ○ Providing high quality palliative and end of life care	**Healthy Children and Young People** – including a focus on: ○ Accidents and injuries (including road traffic accidents) ○ Nutrition and physical activity (incorporating dental health, obesity and low weight) ○ 0-25s complex physical needs and long term conditions ○ 0-25s complex psychological/social needs ○ Infant mortality **Musculoskeletal** – including a focus on: ○ Osteoporosis and bone frailty ○ Pain Management ○ Osteoarthritis **Frailty** – including a focus on: ○ Falls ○ Effectively identifying and supporting people who are frail

1.13 We are proud of our ambition for Pennine Lancashire, and whilst we acknowledge that the challenges are great, we are committed to improving the health and wellbeing of our residents, transforming the quality of care

delivery and ensuring that health and care organisations operate within their financial means.

1.14 At the heart of Together A Healthier Future is the idea that we can all work together as individuals, communities, neighbourhoods, volunteers, health and care workers and organisations to improve our health and wellbeing. We have used a series of events with people and staff, to design and refine eight statements that we believe will help us achieve our vision. These set out both how as individuals we can help ourselves and our families and, as organisations, how health, care and wellbeing services should be delivered in the future. This is shown in the diagram below:



Note: Full details of the how we will measure progress towards achieving these outcomes are set out in our Outcomes Framework which can be viewed at www.togetherahealthierfuture.org.

1.15 We are very proud of the partnership work that has taken place with the public, workforce and partner organisations to produce a joint response to the health and care challenges we face here in Pennine Lancashire and are truly thankful to everyone who has taken the time to work with us, talk to us and offer us their opinions. Our Solution Design approach, engagement work and the feedback we have received and considered in developing our Pennine Plan, is described on our website www.togetherahealthierfuture.org.

1.16 In this Plan we set out our proposals in more detail:

- **Our Prevention Framework:** focuses everyone to take preventive action across our place and our lifetime, to enable us all to lead

healthier lives.

- **Our New Model of Care:** places individuals and their families at its heart and recognises the importance of people living in Healthy Homes and Healthy Communities. The New Model of Care also reflects the different elements of care and support that people need dependent on their circumstances, from when they have no health problems, to when they have multiple health problems and need coordinated support.
- **Finance and Investment:** Outlines the amount of money we currently spend on health and care in Pennine Lancashire, along with the future financial challenges and how we can meet these.
- **System Enablers:** The successful delivery of Together A Healthier Future will depend upon being able to design and provide a workforce equipped to deliver new services, buildings that are fit for purpose and affordable, information and communications technology, and the development of a thriving Pennine Lancashire care culture. We call these elements our 'system enablers' because they are essential to enabling the changes and improvements we need to make in Pennine Lancashire.
- **Next Steps:** Outlines what we want to do next and how you can continue to be involved in Together A Healthier Future.

2.0 The Pennine Lancashire Place-Based Prevention Framework

"Preventing avoidable illness, hospital admissions, long-term loss of independence and poorer quality of life, is not just common sense, in the long run it's the only way to balance the books."

Dominic Harrison, Director of Public Health, Blackburn with Darwen

2.1 If we are serious about achieving our Vision, for all of to us to have healthy and long lives, we must invest significantly in prevention activities which we know work. Our approach is to create healthy communities, both placed-based communities and communities where people share a common identity or like-minded interest. We will also ensure we take preventive action across all stages of life and all stages of both wellness and illness, for us all to lead healthier lives. We will do this through The Pennine Lancashire Prevention Framework (also referred to as The Framework), which underpins the New Model of Care.

2.2 Evidence tells us that if we invest in prevention, we will save money, not just in the health and care system, but across the whole of society including criminal justice, children's services and wider welfare support systems. We know that local prevention activity pays back around £4 for every £1 invested in it.

Place Based Prevention

Healthy Communities are created when:

- Every individual, community group, neighbourhood and locality agree to work together to promote good health

And where:

- Every organisation (voluntary, private and public)
- Every management group, governance system, decision making body and scrutiny organisation
- Every public policy (especially those without a health label)

are mobilised
to support
good health for all

2.3 The Framework is based on five key principles of Place-Based Prevention which outline that prevention:

1. **Requires a 'whole of society' approach**: Research shows that the biggest impact on people's health and wellbeing comes not from formal health and care services, but from other organisations and the community and environment around them. We need to take action outside of the health and care system to improve the health and wellbeing of our communities.

2. **Is a co-operative and collective activity that mobilises support for change**: Creating healthy communities, through place-based prevention, requires collective action aimed at generating resilience to health risks at both individual and community level.

3. **Involves mobilising all of society's resources in a 'place'**: Healthy communities in healthy places will not happen by themselves. We will need a programme of social mobilisation to get everyone working together for the common good. The health and care system has a key role to play in this but we need everyone to play their part using their own energy, skills, capacities and resources.

4. **Involves creating a culture for health that actively enables individuals to take care of themselves and their communities**: Creating a social movement for health that supports people to act to improve wellbeing and re-directs the health and care systems towards prevention is critical to the future sustainability and transformation of health and care systems.

5. **Is aimed at promoting equity of outcomes and equal life chances for all residents:** Creating equity of outcomes may sometimes involve inequalities of inputs - providing more resources to those whose need is greatest, and actively challenging social inequalities that are unjust, unfair and avoidable.

2.4 The Pennine Lancashire Prevention Framework has ten Domains for Action which will be incorporated into our proposed New Model of Care, these are:

- **Social Movement for Health**
- **Healthy Neighbourhoods and Localities**
- **Health in All Policies**
- **Healthy Settings**
- **A Health Promoting Health and Care System**
- **Healthy Citizens**
- **A Health Promoting Workforce**
- **Health Governance**
- **Volunteering and Building Community Capacity**
- **Digital Health**

Domains and Actions are included visually within final published document.

3.0 A New Model of Care for Pennine Lancashire

"We want to look at how we change the way we live to improve our health as well as how we work together to improve health and care services. There's never been a more important time to change the way we work in Pennine Lancashire. This is something we can and will change. Together we will find ways of living better and longer lives."

Graham Burgess, Chair of Blackburn with Darwen Clinical Commissioning Group and Chair Pennine Lancashire Integrated Health and Care Partnership

3.1 Our New Model of Care places individuals and their families at its heart and recognises the importance of people living in Healthy Homes and Healthy Communities.

3.2 There are seven different elements to our New Model of Care, each of which describe how we will work differently to enable people in Pennine Lancashire to live healthier and for longer:

- **Me and My Family:** Putting each of us in control of our own health and wellbeing, enabling us to live in good health for as much of our life as possible and to manage any illnesses we might have.

- **My Healthy Home:** Enabling a positive home environment, wherever we live, including the physical quality, suitability and stability of our homes. Having a healthy home can protect and improve our health and wellbeing, and prevent physical and mental ill-health throughout life.
- **My Healthy Community:** Empowering and supporting people within our communities to take more control over their health and lives and strengthen volunteering and support networks to improve the health and wellbeing of others.
- **Living Happy, Healthy and Well:** Encouraging and enabling us all to maintain healthy lifestyles, in environments that promote health and that will help to prevent us from becoming unwell.
- **Keeping Happy, Healthy and Well:** Supporting everyone to stay well and helping people manage their own health and care better.
- **Joined-Up Care and Support:** Bringing services together to improve standards of care and reduce duplication of activity. Providing seamless links between services, such as hospital and residential care services, and linking people into support within local communities. Ultimately delivering better outcomes for people.
- **In-Hospital Care and Support:** Ensuring that when we need specialist or acute support, in hospital, we receive the best, most effective care possible.

3.3 Our Health and Wellbeing Improvement Priorities look at how our services work at the moment and consider what could be improved through the New Model of Care. In particular, we know we need to do more to prevent people getting these illnesses in the first place, but if people do become ill, we need to provide clear and consistent advice to empower people to manage their own care.

3.4 Hearing from, and working with, people who have experience of these illnesses, either themselves or their family and friends, is a key part of our work. We are involving people, patients and their family/carers in shaping how we address our priorities together.

4.0 Me and My Family

4.1 Me and My Family lies at the heart of our New Model of Care. We want to put each of us in control of our own health and wellbeing, enabling us to live in good health for as much of our life as possible and to manage any illnesses we might have. You have told us how important it is for all of us to take care of ourselves, make healthier lifestyle choices, use services appropriately and support others around us to live healthier lives. We will support people to do this by:

Encouraging and Promoting the Five Ways to Wellbeing

4.2 We want to encourage everyone to follow the Five Ways to Wellbeing, so that we are able to take simple steps to improve our own health and wellbeing and support others.

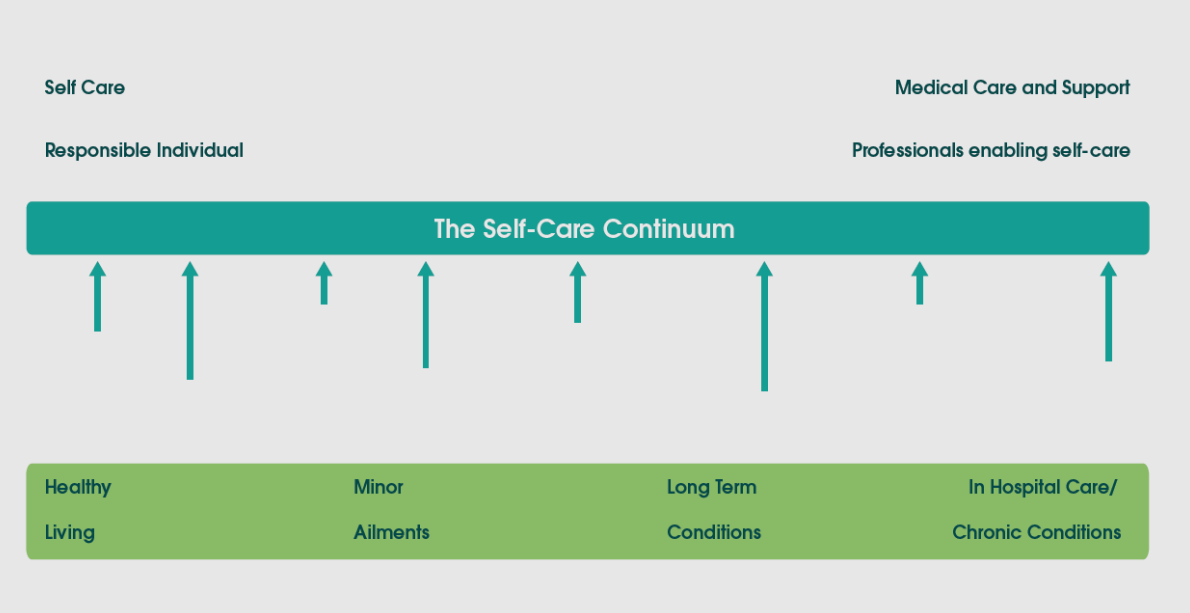
Promoting and Enabling Self Care

4.3 Self-care is so important because it puts people in control of their own health and wellbeing, enabling people to protect their health and manage any illnesses they may have.

4.4 There are plenty of opportunities for people to take care of themselves, by taking responsibility and making daily choices about their health, such as brushing their teeth to prevent cavities or eating healthy options and choosing to be physically active. People can also take care of themselves when they have common symptoms, such as sore throats, and sneezes, many of which can be treated with over-the-counter medicines, and with advice from local pharmacists. Self-management is a way in which people with long term conditions can also self-care and be enabled to deal with their symptoms, treatment and the physical and mental consequences of their illness.

4.5 We want to promote and enable self-care at every opportunity and you will see us talk about self-care throughout our plan.

4.6 The diagram below, which was developed by the Self-Care Forum, helps to show this.



4.7 **Improve Personal Health Literacy:** Health literacy is when we are able to obtain, process and understand basic information about our health and services, so that we can take responsibility and control of our own health. We know that having good personal health literacy encourages healthy behaviours, thereby preventing ill health in the longer term.

4.8 Our whole workforce, whether it be carers, volunteers, or health and social care professionals, is vital to the success of Me and My Family. We will actively involve our workforce in helping us shape new relationships with you, to enable self-care, and improve personal health literacy. To achieve this we will promote:

- Shared values between patients, carers and health care workers
- An acceptance that people have a responsibility for their own health and can positively contribute to improving their health and wellbeing
- An understanding of the benefits of self-care, in particular the preventative and long term approach
- A belief that health behaviours can be changed, that there is a need for motivation and self-discipline and, to know the best advice and support for this change to happen
- Help for people to feel in control of their own health and work together to set self-care goals / pledges. We will enable people to access and utilise digital resources, such as Up and Active, and gain a knowledge and understanding of the range of offers available within communities
- People's self-care pledges as a key part of their care plan if they have one.

5.0 My Healthy Home

5.1 My Healthy Home is about having a positive home environment, wherever we live, and includes the physical quality, suitability and stability of our homes. Having a healthy home can protect and improve our health and wellbeing, and prevent physical and mental ill-health throughout life.

5.2 My Healthy Home will reduce health risks that are associated with living in a damp, cold or unsafe home by working with those at greatest risk of poor housing and those in the greatest need. We will ensure that people receive timely and relevant information and support to improve their health by improving their home environment.

5.3 Building on existing local services, we will look to provide support across Pennine Lancashire that will:

- Help everyone to understand the effect of housing on health and wellbeing and raise awareness of local support available
- Deliver timely and appropriate advice, signposting and assistance
- Providing home safety risk assessments and advice for the most vulnerable
- Deliver the most cost effective improvements to the poorest housing occupied by the most vulnerable people
- Ensure our workforce makes every contact count for housing and health
- Embed a programme of Health Promoting Care Homes, through our delivery of the Enhanced Health in Care Homes Vanguard
- Support and develop volunteer roles.

5.4 Through My Healthy Home we will also work together to develop:

- Improvements in hospital discharge processes so that we improve the home environment in a timely manner
- Landlord Accreditation and Selective Licensing Schemes as appropriate
- Pre-tenancy and tenancy support to enable people to maintain a tenancy agreement.

6.0 My Healthy Community

Political, civic and managerial leadership in public services should focus on creating the conditions in which people and communities take control, to lead flourishing lives, increase healthy life expectancy and reduce inequalities across the social gradient".

Professor Sir Michael Marmot, Fair Society Healthy Lives

6.1 We know that community life, social connections and having a voice in local decisions all have a positive impact on health and wellbeing. We want to empower and support people within their communities to take more control over their health and lives, and strengthen volunteering and support networks to improve the health and wellbeing of others.

6.2 Our communities across Pennine Lancashire are full of great people, who really care about each other. They want to do the best they can for each other and their neighbourhoods and there are so many examples of great things happening. We have 114,000 formal volunteers, and we know that there are thousands more informal volunteers and many people who support each other within communities. We want to build on this strong community spirit, and:

- Make sure community-focused approaches, which build on individual and community strengths, become more central to our local plans for health and care
- Improve access to, and funding, for community resources, so that we are able to better connect people to practical help, group activities and volunteering opportunities, to promote good health and wellbeing and increase social participation
- Recognise the excellent work already undertaken by our communities in delivering health improvement and preventative services across our New Model of Care and help grow these further
- Develop new and innovative ways to increase participation and involve individuals and families, particularly those at risk of social exclusion, in designing and delivering solutions that address inequalities in health
- Celebrate, support and develop volunteering
- Work in collaboration and partnership with our local communities and proactively involve them and listen to them at all stages of planning and designing of services.

6.4 Within our communities social movements can be nurtured and grown. They are an integral part of a healthy and thriving society and can enable really positive outcomes. Social movements for health have the potential to:

- Bring about change in the experience and delivery of health care
- Improve people's experience of disability or ill health
- Promote healthy lifestyles

- Address the wider determinants of health
- Democratise the production and dissemination of knowledge
- Change cultural and societal norms
- Bring about new health innovation and policymaking process.

6.5 It is often challenging for established organisations, such as the NHS or local government, to work alongside social movements. Public sector organisations are not always used to more fluid ways of working and may be seen to pressure social movements to change or 'burden them with bureaucracy'. To make sure we can work with, nurture and support social movements we want to:

- **Understand social movements for health and recognise their value.** We will improve our collective understanding of social movements and their potential, so that we are able to generate the necessary appreciation, appetite, enthusiasm and ambition across communities and organisations in Pennine Lancashire

- **Build and support communities of interest which are safe havens for social movement innovation.** It is important that we nurture local activists who will influence their peers and form a critical mass of support for sustained change

- **Develop new models of engagement for Social Movement:** We want to go beyond traditional community development approaches and work outside of our usual geographic and organisational boundaries. We must also seek to understand and work with the desires of our workforce and communities

- **Leadership and culture change for social movement:** We will work together to listen and respond effectively and will be willing to hear new ideas and do things differently. We know that new approaches are required that draw effectively on both the efficiency and scale of institutions and the dynamism and agility of movements.

6.6 We will publish a Community Development Framework setting out how we will work alongside our communities, later in 2018.

6.7 We recognise that, for the health and care system to be able to respond appropriately to emerging social movements, we need to enable and empower our workforce to be able to grow and work with social movements. We will ensure that this is a shared ambition across organisations.

7.0 LIVING HAPPY, HEALTHY AND WELL

7.1 **Living Happy, Healthy and Well** means encouraging and enabling us all to maintain healthy lifestyles, in health promoting environments that will help to prevent us from becoming unwell. Our Prevention Framework (section 2.0) sets out some of the steps we need to take to achieve this, we will also work to deliver the following:

Early Years, Children and Young People

7.2 Giving every child the best start in life is our highest priority and provides the biggest opportunity for future improvement of health and economic outcomes in Pennine Lancashire. We will improve the life chances for our children by enabling them to grow into healthy and resilient adults.

7.3 Evidence shows that the earlier in life we invest in children, the greater the financial return - for every £1 spent on early years' education, £7 has to be spent to have the same impact in adolescence.

7.4 To give our children the best start in life we want to:

a) Join up health and care provision through the **Healthy Child Programme** to have a positive impact on a wide range of health, education and social care outcomes for children, young people and their families. This will be achieved by expanding programmes that are known to be cost effective and successful and community capacity building across a range of settings, such as children's centres, health centres and GP practices.

b) Ensure parents and carers get the best support possible, through **evidence-based parenting programmes,** as well as through peer support and community groups. This support will be there from before birth through into adolescence.

c) Develop **health promoting education settings**, through delivering activities such as:

- Physical activity in education settings, such as "mile a day"
- Emotional health, wellbeing and resilience for example 'Youth Mental Health First Aid' training
- Life skills such as cooking, financial literacy, citizenship, skills for employment
- Dental health, such as 'smile4health', toothbrush/paste distribution and fluoride varnish.

Physical Activity Promotion, Active Travel and Nutrition

7.5 There is strong and consistent evidence that increasing physical activity will help us live longer and improve our mental wellbeing. It has also been shown

to reduce the risk of many long term conditions, including heart disease and stroke, diabetes, cancer and dementia.

7.6 We want to support a wide range of initiatives including:

a) Physical Activity and Active Travel

- Physical activity promotion
- Strengthening and expanding subsidised leisure opportunities
- Active Travel and the promotion of walking and cycling.

b) Food and Nutrition

- **Promoting healthy and sustainable food choices for all**: Building on local examples of good practice we will develop an 'Out of Home' food provision action plan

- **Supporting families to have access to healthy and affordable food:**
    - Investing further in ante and postnatal support for breastfeeding, healthy introduction to solid foods and expand nutritional advice in early years settings, to ensure the best nutritional start in life
    - Develop an Affordable Food Network to identify and support families, of all ages, to have access to healthy, affordable food
    - Developing a Pennine-wide food growing programme, accessible for everyone within their local community to support people to access healthy sustainable food, teach life skills and encourage inter-generational activity.

- **Building community food knowledge, skills and resources** – Further investment in cookery clubs, based in community buildings and run by local volunteers, which will target all ages and will include support for vulnerable adults. Investment in achieving 'Sugar Smart Pennine' status using a Pennine-wide campaign, promotions and competitions.

Adverse Childhood Experience

7.7 A public health study in 1998 identified a range of stressful or traumatic experiences that children can be exposed to whilst growing up, collectively termed Adverse Childhood Experiences (ACEs). These ten ACEs range from direct harm to a child, that is physical, verbal and/or sexual abuse and, physical or emotional neglect, to those that affect the environment in which a child grows up, including parental separation, domestic abuse, mental illness, alcohol abuse, drug abuse or incarceration.

7.8 There is a strong relationship between these ten ACEs and the onset of chronic diseases such as diabetes, stroke and heart disease, in adulthood, and health harming behaviours, such as smoking and substance misuse.

7.9 To address and respond to ACEs we propose to:

a) Build **ACE informed communities** where children have the opportunity to develop intellectually, socially and emotionally. We will ensure that every adult who interacts with children understands ACEs, the impact they can have and knows how to best to provide support.

Pennine Lancashire aims to become the UKs first 'ACE Informed area' by:

- Developing strategies for raising awareness and understanding of ACEs, resilience and the associated science
- Creating environments for people to share and support each other in addressing their own experiences of ACEs
- Creating an ACE informed workforce including education; health and social care; criminal justice; voluntary, community and faith sector
- Strengthening a collective response to ACEs by engaging local community members in developing effective and novel solutions.

b) To build **ACE informed organisations** where we are able to prevent ACEs, mitigate the consequences of ACEs through early identification and intervention and to enable our workforce to take an ACE informed approach to:

- Develop and implement ACE informed training and digital assessment tools to identify children, young people and adults who have increased ACE scores
- Understand the distribution of ACEs across different population groups and understand the potential paths for recovery
- Integrate and incorporate knowledge of ACEs into existing strategies, policies, procedures and practice
- Develop ACE Informed provision, so that there is appropriate support for and management of the consequences of ACEs.

8.0 KEEPING HAPPY, HEALTHY AND WELL

8.1 Keeping Happy Healthy and Well means supporting everyone to stay well and to help people manage their own care better. We will do this by:

- Creating new relationships between health and care professionals and the public and by having greater integration across primary care (GP practices, dental practices, community pharmacies and optometrists) and within the community
- Ensuring we all know how to access the advice and resources we need to look after ourselves, enabling self-care and scaling up the non-medical advice and support that is available (social prescribing)
- Taking steps to identify and act early on specific health conditions, such as heart disease, diabetes or cancer
- Implementing across all neighbourhoods, preventive interventions that are known to work well.

Creating New Relationships and Integrating Across Primary Care within Communities

8.2 Looking after ourselves, and keeping ourselves as healthy as we can be, helps us from becoming ill and can also prevent existing conditions from worsening. To support self-care and to support healthier lifestyle choices, we must develop better links between our local community and community groups and primary care. This will help us to work together to identify the most appropriate health or social care support when we need it. To do this we will:

- Work together to develop innovative ways of encouraging healthy lifestyles from bump, birth and beyond, which includes improving vaccination uptake, life course skills to support healthy choices and, emotional health and wellbeing
- Ensure children and young people have a voice in, and influence over, service developments, as often their voice is not as prominent as adults
- Support the expansion of a range of community initiatives, such as expert patient programmes, self-management educational programmes for specific conditions, peer-to-peer support and personalised self-management plans
- Ensure that community pharmacies, dental practices and optometrists are aligned to our thirteen neighbourhoods and become integral to our Neighbourhood Health and Wellbeing Teams.

Access to Advice and Resources to Look After Ourselves

8.3 We want to empower people to understand their health and wellbeing and any conditions they may have. We will focus on removing barriers and making health information easier for all to of us to understand. We will work to ensure our services are easier to navigate and that our workforce check that people have understood the information given.

8.4 As described in Me and My Family (Section 4.0), self-care is vitally important to enabling us to Keep Happy, Healthy and well. We will work with primary care, the neighbourhood health and wellbeing teams, community pharmacies and people and patients to provide preventative self-care through a range of measures and interventions. Our proposals for physical activity and healthy nutrition (see Section 7.0) will be important in helping us to self-care.

8.5 We will promote healthy living pharmacies and 'pharmacy first' to enable people to receive safe and effective advice and treatment for non-emergency health matters, such as minor ailments, injuries and self-limiting conditions. We will also support community pharmacies to act as facilitators for personalised care for those of us with long term conditions.

8.6 We will enable more people to access additional advice and support that can enhance their medical care and improve their health and wellbeing. This is known as Social Prescribing. Social Prescribing enables any health and care professional to refer people to a range of local, non-clinical, community-based services, providing the link between medical and social support. Examples of activities that are often linked to social prescribing include volunteering, arts activities and gardening, as well as more formal types of activities, such as exercise referral schemes.

8.8 Through our proposals we will build on the social prescribing models that we have across Pennine Lancashire. This will be strengthened by a digital tool, which will provide links to all of the activities and groups that are available in our neighbourhoods or other places in Pennine Lancashire.

8.9 Community Connectors will form part of our Neighbourhood Health and Wellbeing Teams to assist in providing wellbeing support and helping us to identify and access the activities that they feel will most benefit our health and wellbeing. Connectors will engage across primary care, local community groups and other public services to ensure we get the best support.

Identify and Act Early on Specific Health Conditions

8.10 Screening programmes that detect cancer early are known to be cost-effective if lots of people take-up the service. Unfortunately, take-up of screening services remains low across Pennine Lancashire. We will work to increase the number of people accessing screening services particularly those people who are less likely to use them, incentivise specific schemes and develop intensive targeted programmes.

8.11 We will continue to support and develop the emotional health and wellbeing programme for children and young people, by improving access to appropriate support and care, working specifically with education and the criminal justice system to reduce mental illness in adults and to improve outcomes for our children and young people.

8.12 We will develop a more targeted approach to the detection and reduction of heart disease risk through NHS Health Checks, with particular focus on hypertension and atrial fibrillation and link to the Type 2 diabetes prevention programme for those at high risk. Access to, and the up-take of, structured patient-education for all patients newly diagnosed with diabetes will be enhanced.

Preventive Interventions That Are Known to Work Well

8.13 In Pennine Lancashire we have already worked together on a range of existing local strategies that aim to support us to make more positive lifestyle choices, such as those that tackle obesity, substance misuse (including alcohol), accidents and falls, child maltreatment and those that improve mental wellbeing, screening, vaccinations, sexual health. But we know we can do more and we will work to expand prevention programmes that are known to be cost effective and successful, such as stop smoking services and support for people with a drug and/or alcohol dependence.

8.14 Through the integrated approach of the Healthy Child Programme, we will support children and young people to have their full course of vaccinations. We want to achieve a 95% uptake for all childhood vaccinations, because this will mean we are able to reduce the associated illnesses and establish an effective level of immunity within all our communities.

8.15 We will work together to understand and capture the impact that various prevention activities have on our health and wellbeing. We will use this information to continually improve our services and help us invest in activities that we know have the best impact.

9.0 JOINED-UP CARE AND SUPPORT

9.1 Pennine Lancashire has a strong history of delivering integrated health, wellbeing and care services to communities. We have worked with local residents, patient groups and our workforce to develop our ideas about how we can build on our past successes and deliver improved and consistent services across Pennine Lancashire.

9.2 We want to bring more services together to improve care pathways, provide seamless links to other services (such as acute and residential care services) and, importantly into community groups and support. We want to reduce duplication of service provision and the number of times that people have to tell their story. Ultimately we want to deliver better outcomes for people.

9.3 Our proposals for Joined-Up Care and Support are about:

- **Integrating health and wellbeing care at neighbourhood level**, bringing together primary care (GP practices, dental practices, community pharmacists and optometrists), community healthcare, social care, wellbeing services, and the voluntary, community and faith sector

- Keeping people at home for as long as possible by providing a range of **specialised and enhanced community services**. An enhanced offer will be provided to people with long term conditions, bringing additional support to the neighbourhood health and wellbeing led care plans

- Delivering **intermediate care**, which is an extended model of community care which helps people to stay out of hospital following deterioration in their health and circumstances (known as step up services), as well as those that support people to get back home after spending time in hospital (known as step down services)

- **Transforming urgent and emergency care** to ensure that people with urgent care needs receive highly-responsive services that delivers the right care as close to home as possible.

Integrating Health and Wellbeing Care at Neighbourhood Level

9.4 We will bring services together, ensuring that care and support is focused around people's needs and that access to various services is seamless and easy. We want this care to be provided as close to a person's home as possible, whilst ensuring that quality is not compromised.

9.5 Neighbourhood Health and Wellbeing care will be developed around everyone who is registered with local GP practices, regardless of age. There will be a core level of service delivered across all neighbourhoods, with flexibility to meet the specific needs of local populations. General Practitioners will be the foundation of the neighbourhood-based service, supported by the wider primary care and community teams, including nurses, mental health practitioners, social care, community connectors and a community, voluntary and faith sector lead, who will all work to provide continuity of care.

9.6 Neighbourhood Health and Wellbeing Teams will provide care and support for people in their community to help them stay well and independent for as long as possible. They will also encourage and enable people to play an active role in their own health and wellbeing. This will enable the individual to lead a purposeful and healthy life, maintain their independence, often with a personalised shared support plan and ensure that they have positive mental wellbeing.

9.8 The Neighbourhood Health and Wellbeing Teams will actively seek to support individuals and their families whose situation can be described as complex, and where a co-ordinated approach is required to minimise the risk of deterioration and prevent crisis situations occurring. When a person requires an increase in support rapidly, they will be immediately assessed and an agreed plan will be implemented to prevent an unnecessary hospital stay. Teams will have responsibility for improving communication and connections between hospital inpatient services and with bed and home-based Intermediate Care, to reduce hospital stays and support timely discharges.

9.9 Specifically our Neighbourhood Health and Wellbeing Teams will offer:

- Fully integrated and improved access to psychological therapy (IAPT) services at a neighbourhood level, with specific support for people with long term conditions
- Mental health link workers to provide specialist support for adults
- Universal services for children and young people (aged 0-25), as well as targeted services that are coordinated and integrated, building on the Healthy Child Programme and from the other components within the New Model of Care
- Support, at home wherever possible, for frail older people, and people with complex needs, including those at the end of their lives, to maximise their quality of life
- Improved relationships and communication between primary care and specialist services will enable a more co-ordinated approach to care.

9.10 Enhanced care will be provided to meet the needs of patients residing in short or long term nursing or residential care. This will include access to a named GP and the wider primary care service, comprehensive assessment and care planning support, support for the most vulnerable and those with complex needs, support to promote independence and access to expert and specialist advice.

Primary Care as the Cornerstone for Our Neighbourhoods

9.11 Primary Care Networks (PCNs) are being promoted by NHS England to develop integrated teams, across primary care, working to support 30,000-50,000 patients, within a specific location. Through our PCNs in Pennine Lancashire we will look to build on our strong history of collaborative working and further develop our offer of support.

9.12 We will align our PCNs to the Neighbourhood Health and Wellbeing teams, and put working arrangements in place to allow them to develop a plan for joined-up delivery of community based services.

9.13 Seven day access to urgent and routine general practice will be supported by wider primary care services including dentistry, pharmacy and optometry.

9.14 System wide information, advice and signposting will be supported in primary care by Primary Care Navigators, which will create capacity within GP Surgery times. This will result in longer appointment times being available for people with long term conditions and/or for those with higher levels of need.

Specialised and Enhanced Community Services

9.15 Whilst the majority of health and care services will be delivered at a neighbourhood level, more specialised and enhanced community services will be available at a wider geographical footprint or district level. These will provide an enhanced offer to people with long term conditions, such as diabetes and heart failure. Our proposals for these services are outlined below.

9.16 Development of **early supported community rehabilitation** across all sectors and conditions to provide assessments and support for people who need it.

9.17 **Intermediate Care services** help people to stay out of hospital following deterioration in their health and circumstances (known as step up services) and they also support people to get back home after spending time in hospital (known as step down services). These services are short-term in nature, providing support for six weeks or less. The services offer a link between hospitals and people's homes, and between community services, hospitals, GPs and social care services. There are three main aims of intermediate care:

- Helping people avoid going into hospital unnecessarily
- Helping people be as independent as possible after a stay in hospital
- Preventing people from having to move into a residential home until they really need to.

9.18 **Specialist therapy, nurses, social workers and doctors.** There is an on-going need for specialist skills to deliver effective care for specific conditions. These specialists will interface with our Neighbourhood Health and Wellbeing

Teams and provide case management for those people with more complex needs, for short periods of time, until comprehensive support plans are developed. These specialist roles could include for example Gastroenterology services and Diabetes Specialist Nurses.

9.19 We will work closely with the Lancashire and South Cumbria Shadow Integrated Care System to effectively align **specialist services**, currently provided across Lancashire and South Cumbria, to our New Model of Care. This will include:

- Specialist community-based mental health support including access and crisis, community mental health and drug and alcohol services
- Children's mental and emotional health services
- Learning disability specialist support teams.

9.20 We will work with **wider support services**, such as specialist safeguarding, employment support and specialist social work, to consider how these can be developed to provide a specialist response to neighbourhood health and wellbeing care.

Developing a High Quality and Sustainable Urgent and Emergency Care Service

9.21 We often discuss Urgent and Emergency Care as a single part of the health system, but there are two distinct tiers of need:

- **Urgent Care** is treatment for injuries or illnesses requiring immediate or same day care but not serious enough to require an Emergency Department visit or to result in the need for a hospital admission. It can be required to prevent serious deterioration of health following the onset of an unforeseen condition or injury.

- **Emergency Care** is treatment for serious or life-threatening conditions and will always require the back up of further hospital services such as in-patient treatment or surgery, though this may not be required for every patient that attends.

9.22 Improving Urgent and Emergency Care is one of the main NHS priorities. There is a clear aim to transform the system into one that allows patients quick and efficient access to the help they need. Patients have often voiced the view that they find the current system confusing and that it is difficult to know how to access the most appropriate sources of help and support, at what, for them, are critical moments in their lives. Therefore both nationally and locally we aim to transform the system across seven key priority areas.

9.23 When you or your family need to access urgent or emergency care services you are able to ring NHS 111 to speak to an advisor, who will quickly be able to direct you to the most appropriate service for your needs. In the future you will still be able to do this, but you will also be able to access a similar system on-line, via your smart phone or computer. Your information will be passed seamlessly, and securely, between all of the services that need to know your

details eg between 999 and 111 and 111 and your GP. The intention is that one call will do it all and if you need to speak to someone different, you (with your details) will be passed smoothly and swiftly to the correct place.

9.24 Through these proposals, the options for you to receive the help and support you need will be expanded. Access to GP services will be extended so that weekend and evening appointments will be able to be booked directly through your initial call to 111. Urgent Treatment Centres will also be developed that can be booked into as well as being available for walk in treatment. These will operate at least 12 hours a day, be staffed by doctors, nurses and other staff and will have access to key testing and diagnostic services.

9.25 Developments will also take place within ambulance services to enhance the way that they work. Over time their services will be able to deal with more patients over the phone, directing them to appropriate services and they will be able to treat many more patients at home. Key to this will be linking with other services in the community. The result should mean that a lower proportion of people are taken to hospital.

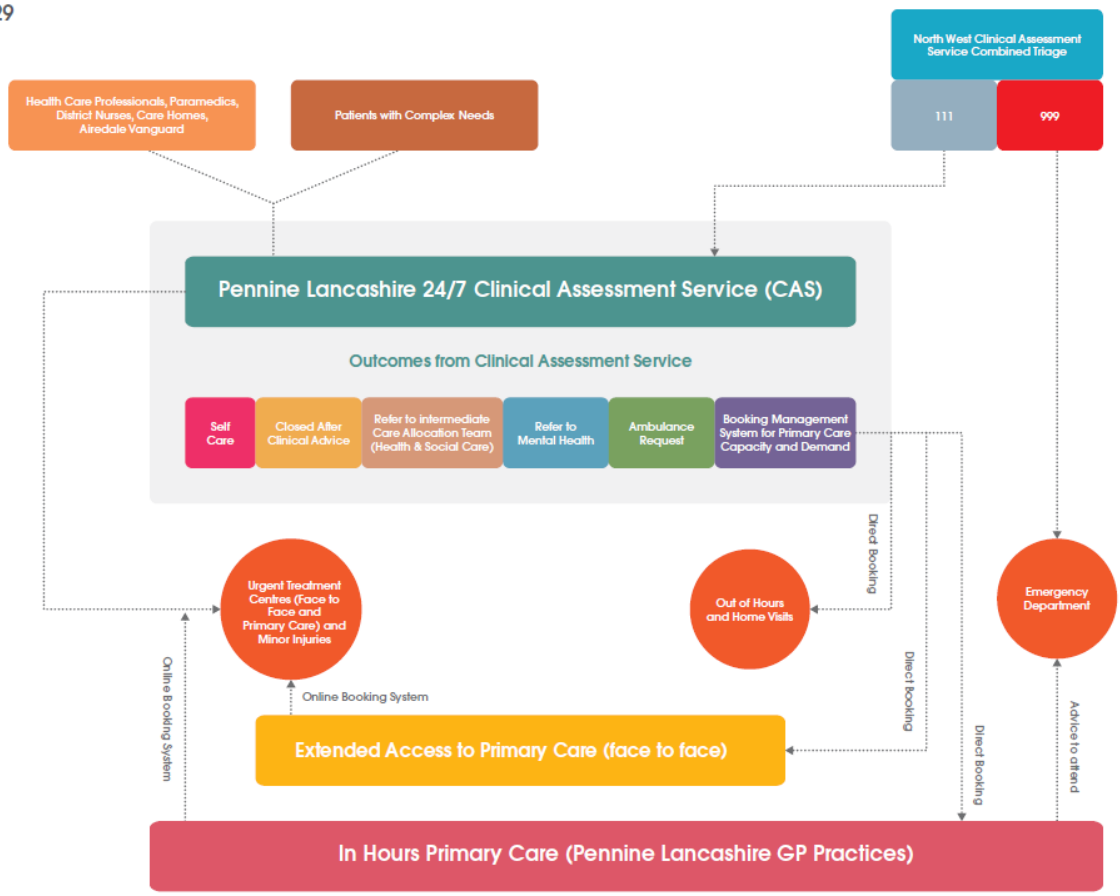
9.26 We will also:

- Put in place Primary Care and Minor Injuries streaming models so that people attending A&E or Urgent Treatment Centres can be directed to the service they need
- Develop a workforce model that will meet both existing and future patient care needs and demand
- Make sure we understand our current demand and capacity requirements
- Consolidate our acute assessment areas within Royal Blackburn Teaching Hospital
- Deliver a Medical Triage Unit which will include an enhanced Ambulatory Emergency Care function which will include a review of the existing Ambulatory Emergency Care model
- Review and improve existing emergency care pathways, particularly for mental health and orthopaedics.

9.27 During our engagement activity in Winter 2017, many people suggested that we should do more to help people make the right choice in relation to urgent and emergency services. We will continue to promote this message particularly through the “NHS Choose Well” campaign.

9.28 All of these improvements should free up A&E to treat only those people who need to be there. The way that people get back out of hospital, if they need care and support at home, will also be a priority for change with joint working across health, social and other sectors being key.

9.29


North West Clinical Assessment Service Combined Triage
111
999
Health Care Professionals, Paramedics, District Nurses, Care Homes, Airedale Vanguard
Patients with Complex Needs
Pennine Lancashire 24/7 Clinical Assessment Service (CAS)
Outcomes from Clinical Assessment Service
Self Care
Closed After Clinical Advice
Refer to intermediate Care Allocation Team (Health & Social Care)
Refer to Mental Health
Ambulance Request
Booking Management System for Primary Care Capacity and Demand
Direct Booking
Urgent Treatment Centres (Face to Face and Primary Care) and Minor Injuries
Out of Hours and Home Visits
Emergency Department
Online Booking System
Online Booking System
Extended Access to Primary Care (face to face)
Direct Booking
Direct Booking
Advice to attend
In Hours Primary Care (Pennine Lancashire GP Practices)

10.0 IN-HOSPITAL CARE AND SUPPORT

10.1 We all want to know that when we need specialist or acute support, in hospital, that the care we receive will be the best it can be.

10.2 At times we will need access to hospital services in an emergency situation, for example because of an accident, whilst at other times this will be a planned admission to hospital, for example because a routine operation is required.

10.3 We recognise that if we do have to be admitted to hospital, then it is important that we stay there for the shortest time needed and that any after care and support is provided within our home or as close to our home as possible.

10.4 Our proposals below outline, in more detail, what we plan to do to achieve these ambitions.

Emergency Department at the Royal Blackburn Hospital

10.5 Currently there is a single Emergency Department covering Pennine Lancashire situated at the Royal Blackburn Hospital. We don't envisage that this will change. The Emergency Department will continue to be staffed by a highly-skilled workforce delivering life-saving care for our most sick patients. Our proposals for Urgent and Emergency Care (Section 9.29) outline the key steps we are going to take to improve care and support for people in an emergency situation.

Improving Patient Flow

10.6 The Government now requires every hospital and its local health and social care partners to have "adopted good practice to enable appropriate patient flow". This means that people can be admitted to a hospital bed when they need to be, including from the Emergency Department, and that they are discharged from hospital in a timely and safe manner. To do this we will:

- **Optimise Ward Processes** and transform medical, surgical and community wards. The aim is to roll out an improvement programme across all adult wards (post-assessment unit) which will include assessment and diagnostics, care planning, admission, welcome and introduction, delivery and review of care plans (multi-disciplinary working) and transfer of care. This will improve performance and patient experience

- Implement a **Home of Choice** policy. An acute hospital is not an appropriate setting for ongoing care once a patient has completed treatment. Through implementing a Home of Choice Policy, those awaiting a care placement or care provider while in hospital will be

supported to make a timely choice to minimise the risks associated with remaining longer in hospital

- Develop a **Single Discharge from Hospital Service** which will support people to be discharged from hospital as soon as they can be. Our current Pennine Lancashire Integrated Discharge Service (IDS) commenced in 2015 and brings together a number of disciplines within the hospital setting including complex case managers, social care and therapies. The service supports individuals in discharge planning and arranging care and support needed upon discharge, including social care packages, reablement and rehabilitation, dependant on individual needs. We will strengthen this service and ensure that our Integrated Discharge Service will be responsible for the full implementation of system-wide Trusted Assessment, consistent and effective use of integrated discharge pathways across Pennine Lancashire and the development of a single performance dashboard

- **Discharge to Assess** is a principle of effective intermediate care delivery. It means that future assessments will take place in a community setting, rather than in a hospital setting. This is because it is more effective to assess an individual's needs in their home and surrounding community environment so that the right level of support can be identified and provided. We will ensure a seamless offer of support between hospital and Intermediate Care services to ensure that the assessment of any ongoing support takes place in a suitable environment outside of hospital (preferably in our own homes).

Elective (Scheduled/Planned) Care

10.7 Our proposals aim to ensure the delivery of efficient and effective elective (planned) care services, delivered in a timely manner, as close to the patient as practicable, and that are linked to primary care and community and intermediate services in a seamless manner.

10.8 Some of our elective (planned) care is currently provided at Burnley General Teaching Hospital. In the future we want to provide all our planned care from this site, or others within the community. This will build upon the previous development of Burnley General Teaching Hospital as an elective centre, where the Trust is able to provide a high quality elective experience for patients on a site which has been configured to optimise patient experience and quality and maximise productivity of elective services.

10.9 This innovative unit will see elective work, both medical and surgical carried out side by side in a fit for purpose environment streamlining staffing, resources and skills. The proposal focuses on hospital based services where elective (planned) care centre provision would be desirable and beneficial. It would not involve Gynaecology, Paediatrics, Urgent Care, or Orthopaedic services, and it would not include the care of long stay patients

10.10 Within Pennine Lancashire we already have successfully transferred a number of other elective services, for example ophthalmology (eye) and dermatology (skin) services out of hospital and into the community, closer to people's homes. Given the success of the work completed to date, we want to deliver more scheduled care within our community settings which could include:

- Providing support closer to home, particularly for people with long term conditions, with specialist nurse/therapist support linked to Primary Care, in particular Gastroenterology
- Services being provided through virtual clinics
- A Single Point of Access for secondary care services within primary care would allow all referrals to be triaged and the most appropriate pathway be sourced reducing the amount of inappropriate referrals and empowering primary care to manage demand in partnership with secondary care
- Providing diagnostic services at district level.

Working within Lancashire and South Cumbria

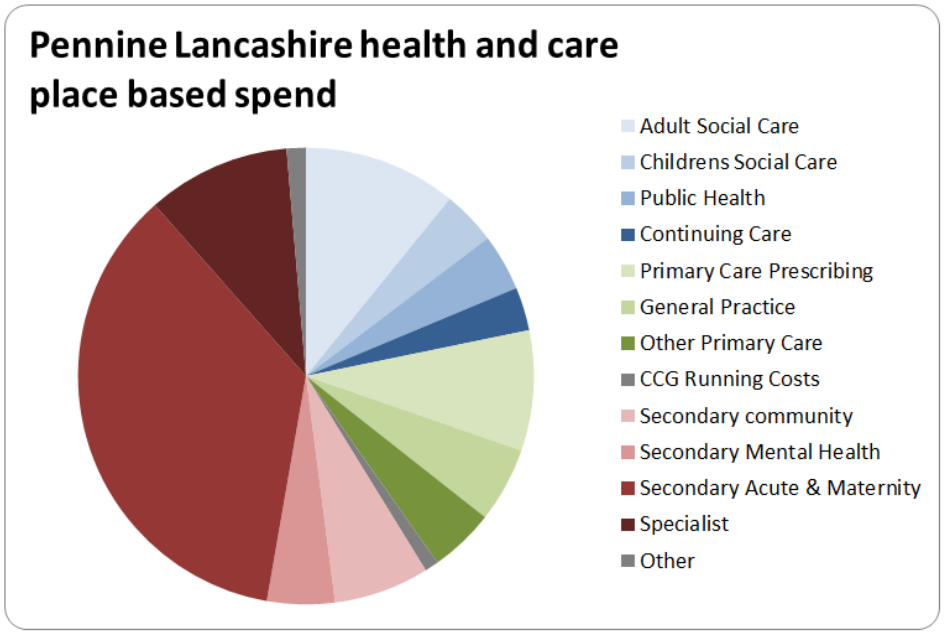
10.11 The future provision of in-hospital care and support services (acute and specialist) will also be shaped and influenced by discussions across Lancashire and South Cumbria Shadow Integrated Care System.

10.12 East Lancashire Hospitals Trust will be recognised as a centre of excellence for certain key clinical services, taking referrals from a wide geography across the North West (for example certain urology and hepatobiliary surgery and neonatology) and be a networked provider of key specialist services with other Trusts across all of Lancashire (including stroke services, maxillofacial services, vascular services, radiology services and cancer services).

11.0 Finance and Investment

The Challenge

11.1 Each year public sector spending on health and social care for the residents of Pennine Lancashire is around £1.1billion and over the next five years there will continue to be a significant amount of money spent on health and care interventions for the 531,000 people living in Pennine Lancashire. The diagram below shows how this money is spent.



11.2 In June 2018 the Prime Minister announced a new multi-year funding plan for the NHS, which will bring an increase in expected funding available (the financial settlement will be confirmed later in 2018). However, we know that even after taking account of the resources that are likely to be made available, the increasing complexity of people's health needs and demand for services, coupled with the need for a radical uplift in investment in prevention, means we still need to work together to make the best use of our resources.

11.3 Whilst the size of the financial challenge cannot be underestimated, we recognise that there are significant opportunities for us to address this challenge and deliver value for money for every 'Pennine Pound' that is spent.

11.4 Significant work is already underway in developing plans to address how we can do this. These include:

Improving efficiency of services we deliver

11.5 Whilst we always work hard to deliver the best care possible for our population, we know that health and social care providers in Pennine Lancashire can do more to reduce costs and run services more efficiently.

11.6 Benchmarking performance of our services nationally and locally has identified opportunities where savings can be made. Areas identified for

improvement include for example, improving the efficiency of Accident and Emergency and outpatient activity, reducing lengths of stay in hospital for certain procedures and reducing unwanted variation in care through RightCare. Our partner organisations are working hard to deliver efficiencies and productivity improvements to address these challenges.

11.7 A specific programme of work is underway with a team consisting of clinical and specialist expertise, working together to identify areas for improvement specifically related to discharge pathways and community services across Pennine Lancashire. The results of this work will identify the potential capacity which could be released through improved service delivery and inform the development and delivery of improvement plans to realise these savings.

Investment in Prevention and Population Health

11.8 Evidence tells us that, if we invest in prevention, we will save money, not just in the health and care system, but across the whole of society including criminal justice, children's services and wider welfare support systems. We know that local prevention activity pays back around £4 for every £1 invested in it.

11.9 We have a strong foundation of Prevention throughout our New Model of Care as well as some specific new Prevention programmes, which we believe based on evidence of returns on investment, will save money in the long term.

New Model of Care

11.10 The New Model of Care described in detail throughout this document has been, and continues to be, designed to address the triple aim outlined in our Pennine Lancashire Outcomes Framework; to improve population health and wellbeing, provide safe, effective and high quality care and support, and ensure a sustainable health and care system.

11.11 By focussing on and investing in prevention, supporting people and communities to care for themselves and each other, providing high quality out of hospital services and in doing so, freeing capacity in our hospitals to focus on acute and specialist services, we can make best use of our resources and drive real improvements for local people.

One Public Sector Estate

11.12 Savings can be made by making sure we use the buildings we own effectively, across the whole public sector, and where we no longer need some of our buildings, we sell or share these with other organisations. Partners from health and social care, as well as other estate providers, are already working together to improve how our buildings are used and where services and workforces can be co-located.

11.13 The next phase of this work will be to review all of the buildings we own and some of those we don't, across the Pennine Lancashire footprint (public

sector and wider) with a view to identifying how we can maximise the use of our buildings to deliver the New Model of Care and how we can release some estate to free up valuable funds.

Digital and Technological Innovation

11.14 Digital and technological innovation has the potential to radically empower people to play a more active role in their care and fundamentally change how we deliver services. The Lancashire Local Digital Roadmap identifies three broad themes all of which if delivered effectively will improve care and save money; sharing of electronic records, empowering people through the sharing of knowledge and enabling people with technology.

11.15 Within these themes and to directly address the financial challenge the following commitments have been made:

- Ensuring we exploit 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.

Next Steps

11.16 Following public engagement the New Model of Care will move into a detailed design phase which will further clarify the benefits and costs of each of the proposals, with a view to decisions being made regarding the affordability of the New Model of Care and any prioritisation that is required.

11.17 A System Control Total has been agreed on behalf of the Pennine Lancashire Integrated Health and Care Partnership which details how we will manage our money together and a financial strategy to support this is being completed and includes in its core principles, delivering the best value for “the Pennine Pound” and “One Public Estate”.

11.18 The Estates and Digital opportunities will continue to be refined through the detailed design of the New Model of Care as well through other emerging developments.

11.19 As we continue to move forward as an Integrated Health and Care Partnership and develop our financial strategies and plans to support this, we are also seeking confirmation of Pennine Lancashire’s ability to access the following:

- Fair share of the additional transformation funding
- Funding to support social care activity
- Access to capital resources to invest in Information Management and Technology.

12.0 One Workforce

One Workforce

12.1 We have set our aspiration for One Workforce which is ***"to have in place a workforce which is fit for the future and is able to meet the challenges of a changing health and social care landscape across Pennine Lancashire which will create working conditions that enable the paid workforce to provide care where it is needed irrespective of organisational boundaries"***.

12.2 We have a highly committed and professional health and care workforce across Pennine Lancashire, supporting residents, patients and carers in a range of settings and in a wide range of roles. This workforce is made up of people who are passionate about the jobs they do whether they are providing care in an employed role or whether they are a vital volunteer working on behalf of one of the many charities or community groups in the area.

12.3 Working in health and care is incredibly rewarding, although demanding, and with our vision for One Workforce, we will work with all our colleagues, across all organisations, to shape the delivery of our services and also ensure we make best use of our people and the skills they bring, in delivering these services.

12.4 We know that our ambitions for Together A Healthier Future will mean changes for our workforce – from embedding the principles of self-care, to having the flexibility and agility to deliver care closer to patients' homes. A number of specific workforce priorities have been identified within the New Model of Care, including:

- **Securing future workforce supply** – increase the workforce in specific clinical and nursing roles to ensure safe levels of staffing both in primary and secondary care
- **Upskilling** – upskill staff in particular training to ensure that they are able to make the most of every interaction with a patient whether that be linking to other services or promoting health and wellbeing messages – we call this Making Every Contact Count
- **New roles** – increase in new and different roles to enable individual professional groups to have more time to do the work that only they are trained to do. We will also consider greater and most effective use of the voluntary, community and faith sector to support people in their communities
- **New ways of working** – consider new employment and contracting models to attract future workforce and offer current staff greater flexibility and balance, avoiding burnout and subsequent turnover.

Current Workforce Profile

12.5 Services are provided through a number of organisations including NHS providers, Local Authority, GP Federations, VCF Sector and Care Homes.

12.6 We estimate that the employed workforce in health and social care, including primary care, stands at around 13,500 and alongside staff working in the 178 local care homes there is a huge volunteer workforce estimated at around 14,000.

12.7 Alongside the New Model of Care, there are a number of other workforce challenges that we need to address. These include significant difficulty in recruiting and retaining certain key roles including medical and nursing roles in both primary and secondary care. An ageing workforce and an expectation of different employment models that offer greater flexibility, means that we face difficulties in maintaining services as they currently are and in realising the ambition of transformation.

12.8 We are planning what our future workfoce needs to look like based on required skills and competencies, enabling exploration of potential new roles, working differently and identification of any upskilling required. We will work with health and care education and training providers to make sure that the number of staff, and the skills and capabilities, we need can be met.

12.9 We know we want our staff to work together across the many different organisations in Pennine Lancashire. This means we will need to think about how we reflect and address differences in culture and practice and differences in the national frameworks for terms and conditions, if we are to achieve true integration.

12.10 There is also a significant unpaid workforce of volunteers and carers who need to be considered to ensure we fully understand how all aspects of care and support is currently delivered and how this supports our drive towards social prescribing and promotion of self-care. Our Volunteer Strategy sets out how we will maximise opportunities for volunteers and organisations to support the health and wellbeing of residents.

Achieving One Workforce

12.11 Workforce design events have taken place with input from colleagues across the system, to shape the One Workforce agenda and develop activity plans for delivering this.

12.12 A comprehensive workforce engagement plan has been developed and has commenced ensuring that colleagues are both kept informed of progress as well as having the opportunity to be meaningfully involved in shaping services. There are many other activities we now need to complete and our proposals are set out below.

12.13 In order to deliver the New Model of Care and meet the gaps in current workforce, significant remodelling will be required in line with population needs, moving away from task and role based provision to needs based. It is likely that there will be a requirement for new roles which are much more generic in nature with the aim of developing the current workforce into these

roles with new generic competencies, working with education providers to ensure they are able to meet the needs of the future workforce.

12.14 In order to help us attract, recruit and retain staff, we will also develop an education and training approach and organisational development strategy that will enable new and existing staff from across the local health economy to effectively carry out the New Model of Care.

12.15 We have worked with our leaders and our staff to co-design and begin delivery of a comprehensive leadership and organisational development programme, to enable large scale change and a culture that will support transformation. The key elements of this programme are:

- System Leadership Approach - to develop the relationships and behaviours required to work outside organisational boundaries
- Shared Culture, Values and Behaviours
- A culture of innovation and creativity
- Managing and coping with change
- Development of skills, knowledge and experience
- High performing individuals, teams and organisations
- Communication and engagement.

12.16 The key steps we believe we need to take to allow us to achieve our vision of One Workforce are outlined below. We believe these activities will move Pennine Lancashire from collaboration between individual organisations, to a more joined up way of working, with single management arrangements and integrated working:

- **Leadership, Organisational Development (OD) and Workforce Engagement including:**
  - Develop leadership strategy based on compassionate leadership model
  - Build on successful organisation development programme for leaders and Neighbourhood Health and Wellbeing Teams
  - Develop shared values and behaviours
  - Implement joint induction
  - Produce engagement toolkit
  - Identify and train engagement ambassadors
  - Deliver roadshows
  - Undertake a baseline staff survey
  - Engage staff in workforce modelling workshops.

- **Streamlining and Alignment Activities including:**
  - Establish a formal Partnership Forum with Trades Union colleagues
  - Agree a single approach to managing organisational change
  - Establish an agreement for a shared training and development programme
  - Agree a single Occupational Health provision
  - Consider provision of Human Resources and Organisational Development activity, under shared management arrangements

- Develop a single recruitment and retention strategy
- Develop a single health and wellbeing strategy for our workforce.

- **Workforce Transformation Activities including**:
  - Undertake workforce modelling across the New Model of Care and our health and wellbeing improvement priorities
  - Develop use of Insight tool for General Practice
  - Work with education providers to create a Care Academy
  - Appoint a Volunteer Project role to develop volunteer workforce
  - Explore opportunities to utilise new roles such as physician associates, community pharmacists, advanced nurse practitioners
  - Participate in the Global Exchange as part of the Lancashire and South Cumbria Sustainability and Transformation Partnership
  - Create a digital workforce through use of technology
  - Explore new employment models.

13.0 Conclusion and our Next Steps

"I think, in the future, we've got some challenges, I just think we need to work together we need to look at the social capital, we need to make it work. I think what we need to do now, maybe at a more strategic level, when we're developing these plans we need to make sure everybody is consulted and everyone's getting a say. I just think that times' hard, yes they really are hard, but together we can really make a difference."

Rick Wilson, community leader, Blackburn.

13.1 The Pennine Plan draws to a close our solution design work and reflects the contributions you as our residents, patients and staff have made to the future design of health and care in Pennine Lancashire.

13.2 We've come a long way over the past two years, and we would like to thank all our residents, community and voluntary groups, health care professionals and wider staff who have contributed their support, ideas and opinions to help us get this far. We hope that you will continue to provide us with your thoughts as we move forward in delivering our ambitions.

13.3 As we undertook our detailed engagement, you told us you were keen to hear more details about how and when health and care services will be changing. Alongside this plan we have published a delivery plan to provide more information. This can be found on our website www.togetherahealthierfuture.org.

13.4 We still have a long way to go, but we are confident that together, we can make the difference needed for Pennine Lancashire. If you haven't already joined the conversation about the future for health, care and wellbeing in Pennine Lancashire, then take a look at our website, Twitter and Facebook accounts.

Join the Conversation

www.togetherahealthierfuture.org.uk

@ahealthyfuture_
#ahealthyfuture

together a healthier future

Elccg.Togetherahealthierfuture@nhs.net

Lancashire Health and Wellbeing Board
Meeting to be held on 18 September 2018

Lancashire Adult Learning – Opportunities for collaboration and partnership to support Health and Wellbeing strategies in Lancashire

Contact for further information:
Andy Parkin, Lancashire Adult Learning, 01282 508 278, a.parkin@lal.ac.uk

Executive Summary

Lancashire Adult Learning is the second largest adult community learning provider in the country and provides exceptional learning opportunities across Lancashire. The primary objective of Lancashire Adult Learning is to deliver a wide range of high quality 'targeted' programmes, which focus on the needs of disadvantaged people and those least likely to participate in learning. These include those furthest away from the job market, people on low incomes, and adults with low skills who lack 'first rung' qualifications.

Recommendation/s

The Health and Wellbeing Board is recommended to:

(i) Raise awareness of Lancashire Adult Learning and its curriculum offer within Lancashire County Council and Public Health in order to identify opportunities for collaboration and partnership.

(ii) Make recommendations to Clinical Commissioning Groups and locality managers to identify opportunities for Lancashire Adult Learning to support and contribute to health initiatives within districts and localities.

(iii) Support Lancashire Adult Learning to ensure that the learning offer is directly linked to Lancashire's strategies to support adults.

Background

The offer reflects the needs of local communities, and regional and national priorities. Delivery is aligned to Lancashire County Council's strategic objectives and priorities for example, 'Digital Inclusion' and 'Starting Well, Living Well and Ageing Well'. We also work to meet national agendas and these include the Department for Work and Pensions' Fuller Working Lives and the Troubled Families programme.

As a result of a thorough understanding of the profile of people living and working in Lancashire, the College offer is defined around the following curriculum areas: Health and Wellbeing; Preparation for Life (Basic Skills); Employability; Digital Inclusion and ICT; Family Learning; Arts, Modern Foreign Languages and Humanities; Volunteering.

In addition to the 'targeted' learner offer, Lancashire Adult Learning provides an extensive range of engaging and interesting lifelong learning courses through its publicly advertised

Lancashire County Council

programme. In 2017-18, Lancashire Adult Learning engaged with 13,500 learners, 2500 of which were learners who completed a Health and Wellbeing course.

The majority of Lancashire Adult Learning's Health and Wellbeing courses are delivered in partnership with community organisations across Lancashire, who work to improve their lives. This provision is delivered in the heart of communities and is shaped to meet the bespoke needs of the groups. These courses are provided free of charge and are delivered by teachers who are highly skilled at meeting the needs of learners in order to support them to move forward with their lives.

The Health and Wellbeing curriculum provides a range of taster sessions and longer courses in a variety of health related topics which offer learners the chance to improve their health and overall wellbeing whilst developing key skills that will enable them to progress onto further learning and employment opportunities.

There is a small amount of accredited provision within the offer which includes Level 2 and 3 qualifications in: First Aid and Level 2 qualifications in Food Safety and Health and Safety. The vast majority of the curriculum is unaccredited and has been developed in line with the documents stated below.

The key priorities within Health and Wellbeing are:

- Align the curriculum with the three programmes of work as detailed in the Lancashire Health and Wellbeing Strategy: Start Well, Live Well, and Age Well in order to support the wider Lancashire vision "that every citizen in Lancashire will enjoy a long and healthy life".

- Ensure the curriculum offer is responsive to the 7 key health behaviours in Lancashire as identified in the LCC JSNA (Joint Strategic Needs Assessment) – Alcohol, Drug/substance use, Healthy eating, Mental health, Physical activity, Sexual health, Smoking/tobacco use.

- Respond to identified local and national significant health issues in an effort to reduce health inequalities across Lancashire (District Health Profiles).

- Across Lancashire, the consistent significant health issues are: Mental health, Obesity, Physical Inactivity, Alcohol, Drug/Substance use and Smoking. Working in partnership with LCC's Public Health Team and the NHS, we aim to support partners across Lancashire who are working to educate the public and reduce the prevalence of these issues.

- Reduce the number of premature deaths by improving how people live their lives.

- Work with partners to plan provision that responds to local needs and provides opportunities to engage learners who are disadvantaged and least likely to participate, including those in rural areas and people on low incomes with low skills.

- Provide robust Information, Advice and Guidance to support learners to progress onto appropriate and relevant learning opportunities, including English, Mathematics, ICT and Employability.

Health and Wellbeing courses are targeted at a range of learners, some of which are the most vulnerable in Lancashire. Examples include; unemployed adults, people who are recovering from alcohol and substance misuse, people suffering from mental ill health,

people with long-term health conditions, offenders / ex-offenders and blind / partially sighted adults. Feedback from learners tells us that attending courses such as Chair Based Exercise has greatly improved their long-term health, confidence and ability to live independently whilst across all areas of the provision 75% of learners reported that by attending a course they had reduced their dependency on health care services. Lancashire Adult Learning aims to continue to have a positive impact on the residents of Lancashire by working with a range of partners. By engaging with members of the Health and Wellbeing Board we aim ensure that the learning offer is directly linked to Lancashire's strategies to support adults.

List of background papers

None

Lancashire Health and Wellbeing Board
Meeting to be held on 18th September 2018

Lancashire Better Care Fund Update

Mark Youlton, East Lancashire Clinical Commissioning Group, 01282 644684
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Executive Summary
The recent publication of the Integration and Better Care Fund guidance 2017/19 has set out the continuing role for the BCF and confirmed the ongoing conditions and requirements that vary little from those set out at the creation of the current Lancashire BCF plan in September 2017.

The role of the Health and Wellbeing Board is reaffirmed as overseeing strategic direction and delivery of the BCF.

While there is an option to revise three of the four national metrics the recommendation of the BCF steering group is that these remain as originally planned.

The fourth metric, Delayed Transfers of Care, is the subject of revised nationally imposed expectations which current performance trajectories show Lancashire should be able to achieve in 2018/19. It is important to emphasise that this is only achievable because of the combined efforts across the Lancashire health and social care system that have resulted in significant improvement in performance and a drop of total delayed days from 4643 in June 2017 to 2758 in June 2018.

The guidance indicates a shift of emphasis towards impacting on and monitoring length of stays in hospital. For now, the BCF is expected to support reducing these through its efforts around DToC and the implementation of the High Impact Change Model although further requirements may be identified in coming months.

There is no requirement to create a revised BCF plan but any revisions have to be reported and must continue to meet the BCF / iBCF conditions. There have been a number of required changes identified in the Lancashire plan and these are set out in Appendix B.

Recommendation/s

The Health and Wellbeing Board is recommended to:

1. Note the guidance and its implications for the Lancashire BCF and Health and Wellbeing Board.
2. Approve the revisions to the BCF/iBCF plan, for 2018/19, as set out in Appendix B.
3. Approve the maintenance of the BCF metrics for Non Elective Admissions, Residential and Nursing Home Admissions and reablement at the original 2017/19 plan levels.
4. Note the expected performance for Delayed Transfers of Care for 2018/19.
5. Note the success of joint working across health and social care in significantly improving DToC performance and enabling the expectations to be met.

Lancashire County Council

Background

The Lancashire Better Care Fund Plan 2017/19 was approved by the board and subsequently by NHS England in September 2017.

The intention of having a two year plan was to achieve a period of stability in delivery and reduce the bureaucracy of the planning process.

To continue to support this and to allow for flexing of the plan the Integration and Better Care Fund Operating Guidance was jointly published by the Department of Health and Social Care, Ministry of Housing, Communities and local Government and NHS England on 18th July 2018. The full guidance document is available via the link here. A summary is attached at Appendix A.

This report focuses on the key points of the guidance, revisions to the Lancashire Better Care Fund plan for 2018/19 and the revised expectations of the BCF delayed transfers of care (DToC) metric.

Please note that the Better Care Fund Plan includes both the original and "improved" (iBCF) plans.

List of background papers

Lancashire Better Care Fund Plan 2017/19

The Integration and Better Care Fund Operating Guidance 2017/19 18th July 2018

Revisions to the Lancashire Better Care Fund plan 2018/19 (Appendix B)

Operating Guidance 2017/19

The guidance reiterates much of what has been given in previous versions. Key points include:

1. The role of Health and Wellbeing Boards is confirmed; they are expected to continue to oversee the strategic direction of the BCF and the delivery of better integrated care, as part of their statutory duty to encourage integrated working between commissioners.

2. The conditions for approval of BCF plans remain the same.
    a. The four national metrics remain the same.
    b. For Non-elective admissions, Residential and Nursing homes admissions and 'Reablement' metrics there is an option to revise the targets. This option has been considered by the BCF partners and specifically by the BCF steering group. The conclusion reached was that no revision was required as sufficient challenge was built into the original targets.
    c. The Delayed Transfers of Care DToC metric will be subject to revised centrally set expectations. Further detail is provided below.

Amended Plans

3. Health and Wellbeing Boards are not required to undertake any revision of their plans except to reflect the revised DToC expectations. They can amend plans, though, to:
    - Modify or decommission schemes.
    - Increase investment, including new schemes

    The resulting amended plans must be jointly agreed by the Local Authority and CCGs.

    Lancashire CCGs and LCC have been working together to review all schemes to ensure that they are fit for purpose and value for money. Where necessary this has

led to amended or replaced schemes. The summary of these changes is set out in Appendix B.
Each amendment has been tested to ensure that the conditions and requirements of the BCF and iBCF continue to be met. This has been confirmed and it is recommended that the board supports these revisions.

The County Council has retained an iBCF allocation of £800K for commissioning DToC related diagnostics during the two years.

A significant sum of this has now been allocated to cover the cost of work that is being commissioned with Carnall Farrer as agreed by the BCF steering group (date). Carnell Farrer is an approved improvement partner with experience in working with health systems .Their work will particularly look at the operation of the intermediate care system across the whole of Lancashire with a particular focus on the use of community beds in LCC residential care homes due to the increasing challenge of managing the complex needs of people admitted and identify areas of potential improvement. The final price of this work is still under negotiation but it is unlikely to exceed 50% of the iBCF allocation.

Given the current levels of activity and financial pressures already faced within the older people's area of adults social care, the county council proposes to allocate any underspend in this areas towards mitigating the costs of those budget pressures. This will contribute towards ensuring that capacity in social work, occupational therapy, domiciliary care and residential admissions can be sustained throughout the coming winter 2018/19, and hence contribute towards continuing to reach the mandated DTOC targets.

Length of Stay

4. While there will continue to be significant attention paid to the performance against the DToC metric the guidance references a shift of emphasis to reducing length of stays (LoS) in hospital. The guidance sets out a supporting role for the BCF in reducing long stays by 25% through continued delivery against the DToC expectations and implementation of the High Impact Change Model for managing transfers of care.
   There are no additional requirements, on LoS, for the BCF at this time, but the guidance does state: “National partners will consider applying additional requirements for 2019/20, including through the BCF where appropriate, for local areas and NHS bodies that have made insufficient progress in reducing the number of people experiencing long stays in hospital during 2018/19”.
   NHS England and NHS Improvement wrote to all Community provider Chief Executives, CCG Accountable Officers, Acute provider Chief Executives on 3rd August 2018 to set out the key recommended features of voluntary local incentive schemes to reduce excess bed days, through collaboration between CCGs, acute and community providers. This letter is attached at Appendices C and D for information.
   How the BCF is contributing to supporting reducing LoS and the voluntary local incentive schemes to reduce excess bed days will be reported to a future Health and Wellbeing Board meeting.

Delayed Transfers of Care

5. As from November 2017 all Health and Wellbeing Board level health and social care systems were subject to nationally imposed DToC targets. For Lancashire these were extremely challenging but, as previously reported, significant progress was made in 2017/18 in narrowing the gap between actual and target performance.

The guidance has been accompanied by revised national set expectations for DToC. These are more realistic than those set previously and actual performance and forecast trajectories indicate that the requirement to meet them by September 2018 will be achieved, in Lancashire.

That this will be achieved is as a result of successful joint working across health and social care and continued prudent investment of BCF and iBCF monies over the last year. Initiatives to address DToC have resulted in a major shift in DToC performance. The table below gives a selection of data to provide an over view of the change during the last 12 months.

Month	NHS Days	Social Care Days	Joint Days	Total Days
Jun-17	1953	2436	254	4643
Nov-17	2216	1936	395	4547
Dec-17	1661	1811	431	3903
Apr-18	2221	995	207	3423
May-18	1855	1147	154	3156
Jun-18	1508	1093	157	2758

The expectation for September 2018 is 3,054 total days. Appendix E gives a more detailed breakdown of actual, expected and trends of performance.

Lancashire Better Care Fund
The Integration and Better Care Fund Operating Guidance For 2017-19

The Integration and Better Care Fund Operating Guidance For 2017-19 was published on 18th July 2018.

It is available in full here: Operating guidance

This should be read along with an accompanying letter (attached) from Neil Permain, Director of NHS Operations and Delivery and SRO for the Better Care Fund and the extract of Lancashire data from the Provisional DToC ambitions spreadsheet. (attached).

The document:

- …is for local partners that agree and administer Better Care Fund 2017-19 plans – Clinical Commissioning Groups (CCGs), local authorities (LAs) and Health and Wellbeing Boards (HWBs).
- … sets out refreshed operating guidance for approved Better Care Fund (BCF) plans for 2017-19.
- …sets out:
  - accountability structures and funding flows for 2017-19 plans
  - refreshed metric plans for 2018-19
  - guidance on amending BCF plans
  - guidance on reporting on and continued compliance with BCF 2017-19 conditions
  - the support, intervention and escalation process
  - the legislation that underpins the BCF

Summary

1. HWBs are expected to continue to oversee the strategic direction of the BCF and the delivery of better integrated care, as part of their statutory duty to encourage integrated working between commissioners.
2. Arrangements for monitoring delivery, accounting and audit should be governed by the local s.75 agreement.
3. Where a risk sharing arrangement linked to the Non-Elective Admissions (NEA) activity is put in place by the HWB through the planning process for 2017-19, local areas should ensure that arrangements for this are clear and there is a process in place for monitoring this locally.
4. For the purposes of the BCF, there should be a partnership board with minimum representation across the relevant CCG(s) and LA(s). This needn't be solely to manage the BCF.
5. The conditions for approval of BCF plans remain the same:
6. The four national metrics remain the same.
   For NEAs and Residential admissions' and 'Reablement' metrics there is an ***option*** to revise the targets.
   Non Elective Admissions (NEAs)
   For 2018-19, areas can consider and submit revisions to these additional reductions or apply additional reductions where none are in place currently.
   For the '**Residential admissions'** and '**Reablement'** metrics, local areas can submit revisions to the planned metrics for 2018-19 on their planning templates with an accompanying note summarising the rationale for this revision.

Delayed Transfers of Care (DToC)
The Government's mandate to the NHS for 2018-19 has set an overall ambition for reducing delays to around 4,000 hospital beds occupied by patients delayed without discharge by September 2018.
There are centrally set expectations for DToC performance based upon this ambition and local performance as at Q3 2017/18.

The baseline used is Q3 DToC metric data. Any dispute with the use of or accuracy of the baseline used must be submitted to the BCST by 3rd August. The baseline used does match the actual Q3 reported internally by the Lancashire BCF so there is no case for dispute. However, partners need to consider this

Areas will be expected to ***agree*** a DToC metric for 2018-19 that meets the nationally set HWB level expectations for 2018-19. The document refers to adopting the level set in the expectations and there is a clear assumption that this will happen.
Areas should plan based on the assumption that the expectation will be met from September and that this level will be maintained or exceeded thereafter.
A revised guide on counting DToC will be published in the coming months for implementation in October 2018. The guidance will provide greater clarity on the process for recording and attributing delayed transfers, with a view to reducing the degree of variation in recording that currently exists across the country.
NB As a system can we agree the whole Lancashire target / trajectory for 2018/19
Attached is a spreadsheet setting out a graphic interpretation of Lancashire 2018/19 DToC expectations and a comparison of these against published monthly DToC bed days for NHS, Social Care, Joint and Total.

This appears to show that, bearing in mind the assumption that the expectation will be met from September:

- NHS attributable is close
- Social Care is there now
- Joint is already much better
- Total is there already

However, we need to be confident in these assumptions and agree that the expected trajectory is accepted by all partners.
It should also be borne in mind that this is a whole HWB position.

This can be broken down to an AEDB level for AEDBs to decide / agree what proportion of improvement should be allocated to them. This will support local planning and enable local monitoring and reporting.

Attached is a AEDB/Provider breakdown of expectations based upon AEDB breakdown of the Q3 baseline. This will require local consideration.

7. Amending BCF plans
Better Care Fund plans were agreed for two years (2017-18 and 2018-19). Places are ***not***, therefore, required to revise their plans for 2018-19 other than in relation to metrics for DToC as set out above. Places can, if they wish, amend plans to:

- Modify or decommission schemes.
- Increase investment, including new schemes.

Any changes to plans that impact on schemes or spending in the assured BCF planning template must be jointly agreed between the LA and the CCGs that are signatory to the plan and be accompanied with an updated Planning Template and brief rationale. Amended plans must continue to meet all planning requirements and conditions. Amended plans should be submitted by 24 August 2018.

8. Reducing Length of Stay

NHS England and NHS Improvement have recently set out their ambition for reducing long stays in hospital by 25% to reduce patient harm and bed occupancy. NHS England and NHS Improvement have asked trusts and CCGs to work with local government partners to agree local sectoral ambitions to achieve this reduction.

BCF plans will support delivery of this reduction through the continuing focus on delivery of the local DToC expectations and through the implementation of national condition four – the High Impact Change model. Particular focus in relation to length of stay should be given to the implementation of the HICM in relation to systems to monitor patient flow, seven day services and trusted assessors (changes two, five and seven).

National partners will consider applying additional requirements for 2019/20, including through the BCF where appropriate, for local areas and NHS bodies that have made insufficient progress in reducing the number of people experiencing long stays in hospital during 2018/19.

There is no stated requirement for BCF reporting of LoS or additional BCF actions. LoS will though be built into BCF metric reporting and expected to be referenced in scheme planning and progress monitoring.

Actions required:	**By who**	**By when**
BCF Partners to agree whether any change to NEA, Residential and Nursing Care Admissions and Reablement targets is required for 2018/19	BCF steering and programme managers group members	17th August
BCF partners to agree or dispute the 2017/18 Q3 baseline used to set DToC expectations is correct/ acceptable. Any objection to be lodged by 3rd August.	BCF steering and programme managers group members	3rd August
BCF partners to agree or dispute the DToC expectations set for Lancashire 2018/19. *	BCF steering and programme managers group members	17th August
BCF partners and AEDB to agree or dispute the DToC expectations set at AEDB level *	BCF steering and programme managers group members / AEDB	TBC
To identify any amendments to BCF/iBCF plans for 2018/19 i.e. for changes to schemes and/ or spending plans	BCF programme managers /PR	17th August
Any amendments to be considered and agreed by BCF steering group and submitted for approval by Health and Well-Being Board under chair's delegated powers.	BCF steering group/ PR	24th August

Amended plans to be included in an updated BCF Planning Template along with a brief rationale and submitted to the Better Care Support Team by 24th August.	BCF steering group / PR	24th August
Final position / agreement of Lancashire DToC expectations for confirmation with BCST	BCF steering group /PR	24th August

* There is no specified timescale for agreeing or disputing the DToC trajectory expectations, but it seems reasonable that the final date for this should be 24th August hence the earlier deadlines set for local agreement /dispute.

The actions above are only those that immediately fall out of the guidance requirements. Full requirements will be built into ongoing planning.

Appendix B
Lancashire Better Care Fund

Lancashire Better Care Fund and improved Better Care Fund revised plans for 2018/19

East Lancashire BCF	2017/18	2018/19 Original plan	2018/19 Revised plan	Comments
	£1000s	£1000s	£1000s	
Transforming Lives, Strengthening communities - Building capacity in the voluntary sector	206	210		No change
Re-design of Dementia Services East Lancashire	1,346	1,371		No change
Redesigned Intermediate Care supported by: a) Intensive Home Support b) Integrated Discharge Function c) Intermediate Care Allocation and Navigation	13,904	14,168		No change
Total	15,456	15,749		

Fylde and Wyre BCF	2017/18	2018/19 Original plan	2018/19 Revised plan	Comments
	£1000s	£1000s	£1000s	
Intermediate Care Redesign	1,969	2,006		No change Planned to these established programmes
Admissions Avoidance	3,857	3,930		
Total	5,826	5,936		

Chorley / South Ribble and Greater Preston BCF	2017/18	2018/19 Original plan	2018/19 Revised plan	Comments
	£1000s	£1000s	£1000s	
Health and Social Care Community Access Point CATCH	6,433	6,555	0	Now iBCF.
Ambulatory Care Pathways	906	924	840	
Intermediate Care			6,868	Investment in intermediate care has been increased from core CCG funding following a review of bed based care that identified we have a shortfall.

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Lancashire Better Care Fund

Chorley / South Ribble and Greater Preston BCF	2017/18	2018/19 Original plan	2018/19 Revised plan	Comments
	£1000s	£1000s	£1000s	
Integrated Care Teams			10,132	As GPs have moved into collaboratives the funding streams for the integrated care teams that sit around them have been re aligned to the collaboratives through core CCG funding
Total	7339	7479	17480	In order to better achieve the outcomes of the BCF core CCG funding has been realigned to these key schemes, hence the increase in spend.

Morecambe Bay BCF	2017/18	2018/19 Original plan	2018/19 Revised plan	Comments
	£1000s	£1000s	£1000s	
Intermediate Care Services to Support Care Coordination	3,618	3,687		
Self-Care	43	44		No Change
Community Specialist Services	2,712	2,764		No Change
Total	6,383	6,495		No Change

West Lancashire BCF	2017/18	2018/19 Original plan	2018/19 Revised plan	Comments
	£1000s	£1000s	£1000s	
Building for the Future	5,066	5,162		This scheme is delivering care co-ordination, MDTs and integrated Neighbourhood teams; so will remain unchanged
Total	5,066	5,162		

Lancashire County Council BCF			2017/18	2018/19 Original plan	2018/19 Revised plan	Comments
			£1000s	£1000s	£1000s	
		Extra Care Housing	0	0	0	
		Integrated offer for Carers	7,327	7,468	7,468	
		Reablement	5,239	5,338	5,338	
		Transforming Community Equipment services	10,967	11,175	11,175	
		Telecare	551	562	562	
		Care Act	3,183	3,244	3,244	
		Disabled Facilities Grants	12,565	13,652	13,652	
		Integrated Neighbourhood/ Care Schemes	14,039	14,306	14,306	

Improved Better Care Fund

East Lancashire iBCF	2017/18	2018/19 Original plan	2018/19 Revised plan	Comments
	£1000s	£1000s	£1000s	
Pennine - Multi-Disciplinary Discharge Team: Support joined up leadership to ensure consistent and effective discharge pathways.	220	220		No Change
Pennine - Home First: Support delivery of discharge to assess to admit; facilitating step up and down.	849	849		No Change
Total	849	849		

Fylde and Wyre iBCF	2017/18	2018/19 Original plan	2018/19 Revised plan	Comments
	£1000s	£1000s	£1000s	
Fylde and Wyre - Aligned Social Work: Neighbourhood and A&E deployment of F&W social workers/wellbeing	150	150		Both services are under ongoing

workers to support discharge and cover in A&E working 7 days.				review. Any changes in spending plans, in year, will being reported once finalised.
Fylde and Wyre - Reablement Hours: Hospital discharge and reablement service to provide individuals with a single service specification that meets health and social care needs of communities.	274	274		
Fylde and Wyre - CHC process review (trusted assessment): Trusted assessment, better screening, and better home of choice compliance.	150	150		Staff in post; DTOC performance currently <3.5%
Fylde and Wyre - Trusted Assessor (Care Homes): Targeted locality Trusted Assessor support.	54	54		Staff in post, working with care homes directly
Fylde and Wyre - Set-up costs.	8	8		
Total	636	636		

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Chorley/South Ribble iBCF	2017/18	2018/19 Original plan	2018/19 Revised plan	Comments
	£1000s	£1000s	£1000s	
Social Work Assessment Capacity - 7 Days: Increase social work capacity in the Integrated Discharge Service at both hospital sites and in the community across 7 days.	159	159	0	This service is now provided by LCC
Allocation team for Care and Health: Single point of access for intermediate care, managing capacity and demand in services, with additional crisis support capacity.	533	533	533	
Care Home Support Model: Proactive, preventative service to wrap around residents in a care home setting, working to prevent inappropriate visits to A&E, avoidable admissions, reduce delayed transfers of care and length of stay.	517	517	1,120	As this service has been scoped out it has become apparent that the original funding was not sufficient to provide it. These monies have come from core CCG funding
Social work support to GP Practice Collaborative: Social work support embedded with Mental Health and Physical Health service to support patients with social care needs presenting at GP practices. Proposed to align with a better resourced out of hours Adult Mental Health Practitioner (AMHP) resource.	43	43	0	This service is now provided by LCC
Home First	0	0	201	This service is being rolled out in Central in line with the agreement made by the integrated care system
Total	1252	1252	1854	Additional spend is from CCG core funding

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Morecambe Bay iBCF	2017/18	2018/19 Original plan	2018/19 Revised plan	Comments
	£1000s	£1000s	£1000s	
Altham Meadows Intermediate Care Centre: Integrated nursing and rehabilitation service as an alternative to hospital care.	750	750	750	
Crisis Hours: Expedite discharge work with patients and reduce re-admission to an acute setting.	210	210	141.5	Identified that Crisis hours were being provided through 18/19 slippage and could push funds into scheme below.
Implementation Team: Funding for a system wide Discharge lead with a specific focus on delivering a reduction in DTOC through Discharge to Assess. Also recruitment of complex case managers for D2A Pathway 1 and 2.			68.5	Appointed a system wide Discharge to Assess Lead and additional Complex Case Managers to facilitate flow through both health and social care to improve DTOC rate.
Total	960	960	960	

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West Lancashire iBCF	2017/18	2018/19 Original plan	2018/19 Revised plan	Comments
	£1000s	£1000s	£1000s	
Community Hub: One place, flexible hub for intermediate care, reablement and rehabilitation. Increased capacity for discharge to assess.	175	175	85	Continue to develop the Community Hub option. Utilising S&O unused ward space to develop the model for winter 2018/19, this could then be transferred once new building is ready.
7 day integrated discharge pilot (intermediate care) Integrated working between 2 current teams. Move to 7 day working.	72	72	115	The timescales for this project slipped due to recruitment. Team now in place and will continue for 2018/19 – LCC are holding this budget on behalf of the CCG.
Home First Workforce Development: Generic therapy and Nursing assistant. Training posts.	81	81	140	This is a two-year apprenticeship scheme which will run until 2020 using the total 2 - year funding BCF monies. Apprentices have commenced and will be used to support discharge and home first.
Home First Pathway development			90	Proposed costs are £226,00 for Additional Social Care and Crisis hours required for home first pilot planned Sept 18 to March 19. £136K already allocated, therefore CCG propose to split Community Hub Fund to make up the funding and enable Home first in time for Winter.
Total	328	328	430	Includes £102K additional investment for 2018/19

Appendix B
Lancashire Better Care Fund

Lancashire County Council iBCF			2017/18	2018/19 Original plan	2018/19 Revised plan	Comments
			£1000s	£1000s	£1000s	
		High Impact Changes Fund additional spend				
		HIGH IMPACTS CHANGES FUND: Including Peripatetic Team; Acute team 7 day working across hospitals; Trusted Assessors - Trusted Assessor Training; Seven Day Service - 24 hour AMHP service (Mental Health); System to Monitor Patient Flow - DTOC tracking - additional hospital resource.	2,095	2,095	2,095	
		Learning from Passport to independence: To resource the development and implementation of granular level implementation plans for each of the six Lancashire Hospitals, on the basis of agreed best practice.	600	600	400	iBCF allocation of £800K for commissioning DToC related diagnostics during the two years 50% allocated to review operation of the intermediate care system across the whole of Lancashire and identify areas of potential improvement.
		HIGH IMPACT CHANGES FUND ADDITIONAL SPEND	**2,695**	**2,695**	**2,495**	
		Additional spend on existing BCF schemes				
		Reablement contract	3,670	3,975	3,975	
		Reablement & Occupational Therapy Team (excludes senior management currently)	2,778	2,806	2,806	
		Care Act (carers Personal budgets, training, Advocacy)	234	234	234	
		Carers support (Respite & block contract spend)	0	235	235	
		Urgent Care (Crisis & residential rehab)	0	62	62	
		Equipment & Adaptations	0	151	151	
		Intermediate Care Services	369	379	379	
		Telecare	1,952	2,040	2,040	

Appendix B
Lancashire Better Care Fund

Lancashire County Council iBCF			2017/18	2018/19 Original plan	2018/19 Revised plan	Comments
		ADDITIONAL SPEND ON EXISTING BCF SCHEMES	**9,002**	**9,882**	**9,882**	
		Spend on schemes previously outside of BCF				
		Transformational support relating to the Passport to Independence Programme	1,440	0	0	
		Additional reablement costs - as part of the reablement opportunity - supporting Passport to Independence	208	208	208	
		Wellbeing worker service	2,636	2,636	2,636	
		Home Improvement Agency	880	880	880	£912K expected spend additional cost funded via LCC budgets
		Hospital aftercare	304	304	304	
		Roving nights – County-wide service	304	804	804	£815K expected spend additional cost funded via LCC budgets
		Additional Fee and Demand pressures	4,582	15,738	16,138	allocate underspend towards mitigating the costs of domiciliary care and residential admissions
		Additional package costs through improved DTOC rates	1,000	1,000	1,000	
		Homecare implementation costs	800	0	0	
		SPEND ON SCHEMES PREVIOUSLY OUTSIDE BCF	**12,154**	**21,570**	**21,970**	

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03/08/2018

To: Community provider Chief Executives
CCG Accountable Officers
Acute provider Chief Executives

Cc: STP leaders
Regional Directors

Publications Gateway Reference: 08330

Dear colleague

Excess bed day incentive scheme

We are writing to set out the key recommended features of voluntary local incentive schemes to reduce excess bed days, through collaboration between CCGs, acute and community providers. Local areas are expected to adopt an excess bed day incentive scheme to improve patient experience and improve efficiency across the local health economy. This is particularly important for the CCGs with the highest excess bed day spend per head of weighted population.

There is clear evidence that staying in hospital for longer than required drives adverse outcomes for patients. It is also costly to keep patients in hospital for longer than is necessary. Local areas should seek to reduce lengths of stay across the inpatient setting by following best practice guidance on discharging patients. NHS Improvement has published the "*Good practice guide: Focus on improving patient flow*"[1] which may be used as the starting point for a best practice discussion.

Whilst for some patients an extended length of stay will be clinically appropriate, there is significant variation across the country – the highest quartile of CCGs have almost three times the rate of excess bed days compared to those in the lowest quartile. This indicates that there are opportunities to reduce length of stay by transferring these patients to a more appropriate setting, including in the community. If all CCGs had an excess bed day rate per head of weighted population equal to the average of the upper quartile of performers, around 1 million bed days would be freed up from acute hospitals, equating to £0.2bn.

The onward transfer of patients to a more appropriate setting requires acute and community providers to work together with their local CCG. To encourage this further,

[1] https://improvement.nhs.uk/resources/good-practice-guide-focus-on-improving-patient-flow

we have developed the attached document on local incentive schemes to reduce excess bed days. It recommends that community and acute providers agree a baseline level of excess bed days with their local CCG and a plan to reduce them below that level. All the savings to the CCG from this reduction should be transferred to the community provider, unless the local partners agree to share the savings in a different way. This will ensure that the funding follows optimal patient flows.

We are aware that some health systems have already implemented a scheme of this nature; where this has happened we are not seeking changes to the existing arrangements. However, where there is not a scheme in place for excess bed days and community investment, we encourage STP and ICS leaders to support this being rolled out in every system.

Yours sincerely

Matthew Swindells
National Director: Operations and Information
NHS England

Dr Kathy McLean OBE
Executive Medical Director and Chief Operating Officer
NHS Improvement

Excess bed day incentive scheme

Summary

1. This document sets out the key recommended features of voluntary local incentive schemes to reduce excess bed days, which will in turn:

    - Improve patient flow and efficiency in acute hospitals to improve patient outcomes and experience
    - Help acute hospitals reduce super-stranded patients by 25% to reduce the patient harm that comes from excessive stays in hospitals and create the extra capacity needed for elective and emergency care
    - Recognise that community providers need to be appropriately reimbursed if they are to care for more patients
    - Share the benefits across participating organisations
    - Encourage more integrated working on delayed discharges, 'stranded' patients and reducing length of stay

2. **Annex 1** provides background information.

3. Local areas are expected to adopt an excess bed day incentive scheme to improve patient experience and improve efficiency across the local health economy. This is particularly important for the CCGs with the highest excess bed day spend per head of weighted population. The CCGs which lie in the highest quartile of CCGs ranked by excess bed days per head of weighted population, are shown in Annex 2.

Proposed key features of local incentive schemes

4. Community and acute providers should agree with the CCG a baseline level of excess bed days that the CCG will have to fund if the status quo remains and a target for the reduction of this number in the local acute provider that will result from focused management and investment in community services. The community provider, CCG and acute provider should then agree a plan to reduce the number of excess bed days and transfer patients to the most appropriate setting.

5. If the total number of excess bed day payments by the CCG to the acute provider falls, then all the savings to the CCG should be transferred to the community provider, unless the local partners agree to share the savings in a different way. If the CCG and/or acute provider agree to invest in community services in advance to share the upfront risk with the community provider, they should expect to recover their investment and a share of any additional savings if the programme is successful.

6. Most of the service changes necessary to deliver the reduction in excess bed days should be achievable through targeted management within the community services, with any additional investment in staff and services funded by the resulting reduction in excess bed days and a monthly transfer of resources from the CCG.

7. The CCG, acute provider and community provider should agree a series of KPIs for any investment in community services, such as:

    a. A specified number of community beds and community teams available
    b. The planned growth in beds or non-inpatient staff
    c. Community bed occupancy to remain below a set percentage and domiciliary productivity to go up through more efficiency work
    d. Community discharge planning team available 7 days per week
    e. Admissions are accepted by the community provider 7 days per week

8. Where there are multiple community providers supporting the same acute provider, local agreement will be required on how funds will be distributed and how risk will be shared.

9. The reduction in excess bed days should contribute to freeing up capacity in the acute setting and continued improvements in patient flow through the hospital. Most parts of the country are currently not meeting waiting time standards or reducing their emergency bed occupancy to the required levels to confidently prepare for winter. As a result, it may be possible to use this freed up capacity to provide elective activity that is covered by existing contracts without an adverse impact on CCG finances.

10. Where acute providers are able to over-perform their elective contract, the provider and commissioner should discuss the affordability of using any freed capacity to further increase levels of activity.

11. It is likely that in taking targeted action to reduce excess bed days, there will also be some reductions in length of stay for some patients who are current long stayers but below the excess bed day trim point. This will help to offset the loss of income for the acute provider and improve patient flow to help meet the 4-hour A&E standard.

Local and national monitoring

12. Local areas should set clear and specific targets for the reductions in excess bed days that they are seeking to achieve from targeted action – with clarity about the specialties (some or all) to which these targets apply.

13. Routine monitoring of these metrics, along with regular local performance reviews, should identify early on where actions are having the desired effect and where they are not. Discussions about any remedial action to return to plan should happen regularly and with reference to performance in peer organisations.

14. Nationally, we will regularly publish statistics of excess bed days by CCG and provider.

National tariff payment system

15. Where local areas have agreed contracts using national prices as specified in the National Tariff Payment System (NTPS), the commissioner will need to submit a

local variation to NHS England and NHS Improvement to confirm any new arrangements. To help reduce burden locally, NHS England and NHS Improvement will produce some exemplar templates that can be used to submit this information.

16. Areas of the country that have already agreed local variations to prices specified in the national tariff should still agree a local incentive scheme if it is likely to reduce length of stay in the acute provider by an amount greater than planned. Where areas are operating with some form of block or fixed payment, the published national prices for excess bed days could be used as a starting point for local negotiation.

Annex 1 - Background

1. Some patients stay in hospital longer than others, even if they have similar characteristics and receive similar treatment. In order to fairly reimburse hospitals when patients remain in hospital longer than expected, the national tariff payment system requires that CCGs pay an additional amount to the provider per day after a pre-determined length of stay[1], which varies by HRG – an excess bed day payment. In 2017/18 commissioners paid providers £0.6bn[2] in excess bed day payments. However, the number of excess bed days varies across the country, and the highest quartile of CCGs pay for almost three times the rate of excess bed days compared to the ones in the lowest quartile. This is after controlling for each CCG's weighted population and so cannot be explained by casemix alone.

2. If all CCGs had an excess bed day rate per head of weighted population equal to the average of the upper quartile of performers, around 1 million bed days would be freed up from acute hospitals, offering better patient experience and improved patient flow across the hospital. This offers the potential to free up around £0.2bn of the £0.6bn paid in excess bed days to be invested in community services to provide care closer to home for tens of thousands of patients.

Patients with long lengths of stay

3. There are likely to be three main reasons that patients stay in hospital for a longer than expected period triggering these excess bed day payments:

    - Even within the same HRG, the complexity of patients' needs varies. Some patients will stay in hospital for good medical reasons, probably within specialist centres.
    - In some cases, patients could be discharged sooner with more consistent clinical practice and organisation within the hospital.
    - Some patients will be medically fit for discharge but cannot be discharged because of delays in setting up the health and care support packages needed to support them at home.

4. Some stranded patients (patients with a length of stay of 7 days or more) and super stranded patients (patients with a length of stay of 21 days or more) could be discharged from hospital earlier with better service integration between acute and community organisations. Some of these stranded and super stranded patients will have stayed in hospital for a period of time which triggers excess bed day payments.

[1] This 'trimpoint' is calculated for each HRG as the upper quartile plus 1.5 times the interquartile range. Each trimpoint is published in the national tariff payment system document.

[2] Providers reported they incurred £1.4bn of excess bed day costs in 2016/17 reference costs (£1.2bn relating to non-elective admissions). For payment purposes, the tariff is calculated on a spell basis rather than an episode basis (as in reference costs) and a floor of 5 days is introduced which prevents an incentive to keep very short staying patients in one extra day to trigger an excess bed day payment, which may be a relatively high amount compared to the cost of the spell. Taken together, the payment system explicitly reimburses around half of the provider self-reported excess bed day costs in reference costs through excess bed day payments.

New local incentive schemes

5. By creating a local incentive scheme which aims to reduce the number of stranded and super stranded patients, resources which were being used by commissioners to pay for long staying patients in hospital (the excess bed day payments) can be redeployed to other parts of the health system to provide more opportunities to discharge patients in a more timely manner, when medically fit to do so.

6. Local areas should seek to reduce lengths of stay across the inpatient setting by following best practice guidance on discharging patients and with regard to levels in peer organisations. NHS Improvement has published the "Good practice guide: Focus on improving patient flow[3]" which may be used as the starting point for a best practice discussion.

7. The guide sets out:

"The outcome of following best practice is that patients are discharged as soon as they no longer benefit from acute hospital care and in most cases, discharge is to a person's usual place of residence. The core principles to follow to achieve such an outcome are:

- *Therapy and social work teams should work at the front of the acute care pathway, routinely collecting information on how patients have been managing at home before becoming acutely unwell.*
- *On admission, the expectation should be that people will be discharged to their usual place of residence, with additional support if required, and assessment of their longer term needs undertaken there rather than in hospital.*
- *A clear clinical care plan must be set for all patients within 14 hours of admission, which includes an expected date and time of discharge that are linked to functional and physiological criteria for discharge.*
- *There should be a strong focus on 'simple' discharges. The SAFER patient flow bundle and 'Red2Green days' tools should be used routinely to ensure the most appropriate care for patients on all hospital wards.*
- *Board rounds should take place on all hospital wards each morning. The multidisciplinary team should review the clinical plan (including the discharge elements) on the board rounds and any decisions communicated to the patient.*
- *Duplication of assessment should be minimised using trusted assessors, building on the functional information collected on admission (see below).*
- *There should be a single point of access for health and social care to support 'discharge to assess'. Integrated discharge teams should be linked to an integrated intermediate tier of local services."*

8. Local areas should focus on how better use of community and out of hospital services can improve patient flow in the hospital. This may require investment in additional community capacity or redesigning how existing community services interact with patients who are in hospital.

[3] https://improvement.nhs.uk/resources/good-practice-guide-focus-on-improving-patient-flow

Variations in levels of excess bed days

9. CCG commissioned activity data shows that there were around 2.3m excess bed days in 2017/18, around 38 excess bed days per 1,000 population, but this hides variation at CCG level. The lowest quartile CCGs had on average 21 excess bed days per 1,000 weighted population, compared to 57 in the highest quartile. Table 2 shows the summary by quartile, ranking CCGs from highest to lowest number of excess bed days per head of weighted population.

10. Annex 2 shows each CCG ranked by excess bed days per 1,000 weighted population.

11. Specialty level data also shows variation, with paediatric specialities incurring the highest proportions of bed days classed as excess bed days. In raw numbers, nervous system, digestive system and respiratory system accounted for around 0.8 million excess bed days, around one third of the total number of bed days including non-CCG commissioned activity. Annex 3 shows the differences between specialties.

Table 2 – summary excess bed days by CCG quartile and reduction opportunity

Quartile	Excess bed days	Weighted Population	Excess bed days per head of weighted population	Reduction if everyone at the lowest quartile rate
1	921,041	16,126,731	57.1	575,363
2	630,676	16,794,551	37.6	270,683
3	395,553	13,067,381	30.3	115,452
4	272,896	12,731,257	21.4	-
All	2,220,166	58,719,921	37.8	961,498

12. Local incentive schemes could be targeted at the specialties with the largest number of excess bed days and/or specialties where the number of excess bed days appears to be a significant problem compared to peer organisations.

Annex 2 – Variation in the number of excess bed days January-December 2017

CCG Name	Excess Bed Days	Weighted Population	Excess bed days per 1000 weighted population
NHS City and Hackney CCG	26,517	217,080	122.2
NHS Trafford CCG	23,002	255,599	90.0
NHS Manchester CCG	46,861	570,358	82.2
NHS Lewisham CCG	19,781	250,728	78.9
NHS Portsmouth CCG	15,174	203,159	74.7
NHS South Sefton CCG	13,620	189,449	71.9
NHS Dorset CCG	62,622	897,136	69.8
NHS Bath and North East Somerset CCG	13,850	198,603	69.7
NHS Cumbria CCG	26,023	381,336	68.2
NHS West Hampshire CCG	40,777	602,187	67.7
NHS Nene CCG	42,067	651,154	64.6
NHS Lancashire North CCG	28,491	443,878	64.2
NHS Southampton CCG	15,743	264,745	59.5
NHS East Lancashire CCG	25,974	442,508	58.7
NHS Fareham and Gosport CCG	12,521	214,680	58.3
NHS Leeds CCG	47,638	841,070	56.6
NHS Dartford, Gravesham and Swanley CCG	13,854	253,318	54.7
NHS South Eastern Hampshire CCG	12,342	226,776	54.4
NHS North Hampshire CCG	11,913	219,566	54.3
NHS North East Hampshire and Farnham CCG	11,873	219,039	54.2
NHS Oxfordshire CCG	34,264	635,244	53.9
NHS Buckinghamshire CCG	26,687	496,338	53.8
NHS Sutton CCG	9,286	178,215	52.1
NHS Cannock Chase CCG	8,093	155,613	52.0
NHS Corby CCG	3,961	76,311	51.9
NHS Surrey Heath CCG	4,900	95,014	51.6
NHS Doncaster CCG	18,298	361,467	50.6
NHS Stockport CCG	18,131	359,726	50.4
NHS Fylde & Wyre CCG	9,703	196,564	49.4
NHS Swindon CCG	10,431	212,607	49.1
NHS Norwich CCG	10,624	219,904	48.3
NHS Somerset CCG	31,515	652,509	48.3
NHS Tameside and Glossop CCG	13,772	285,253	48.3
NHS Wiltshire CCG	25,080	521,815	48.1
NHS Bexley CCG	10,783	231,344	46.6
NHS Greenwich CCG	11,064	238,883	46.3
NHS Blackburn with Darwen CCG	8,780	190,599	46.1
NHS Herefordshire CCG	9,244	202,417	45.7
NHS North Norfolk CCG	9,653	211,415	45.7
NHS West Leicestershire CCG	17,059	373,722	45.6
NHS West Kent CCG	21,099	466,097	45.3
NHS East Surrey CCG	8,031	177,628	45.2
NHS Eastbourne, Hailsham and Seaford CCG	10,297	229,883	44.8
NHS Surrey Downs CCG	12,813	287,086	44.6
NHS Lambeth CCG	12,333	279,652	44.1
NHS Ealing CCG	14,725	335,225	43.9
NHS Sheffield CCG	25,691	588,192	43.7
NHS Bromley CCG	14,081	325,636	43.2
NHS Newcastle Gateshead CCG	24,591	573,862	42.9
NHS Southport and Formby CCG	6,699	158,608	42.2
NHS Blackpool CCG	9,155	217,079	42.2

NHS High Weald Lewes Havens CCG	7,465	177,500	42.1
NHS Liverpool CCG	24,663	586,438	42.1
NHS Berkshire East CCG	15,704	378,345	41.5
NHS Stafford and Surrounds CCG	6,846	167,613	40.8
NHS Bristol, North Somerset and South Gloucestershire CCG	38,730	953,317	40.6
NHS Greater Preston CCG	9,308	230,302	40.4
NHS Hillingdon CCG	10,943	273,940	39.9
NHS Stoke on Trent CCG	12,475	313,471	39.8
NHS Wandsworth CCG	10,204	256,506	39.8
NHS Southwark CCG	9,295	234,166	39.7
NHS Milton Keynes CCG	10,054	254,054	39.6
NHS North Tyneside CCG	10,563	270,230	39.1
NHS Brighton & Hove CCG	10,028	258,192	38.8
NHS Kernow CCG	27,017	697,744	38.7
NHS Scarborough and Ryedale CCG	5,358	138,940	38.6
NHS Walsall CCG	11,800	306,479	38.5
NHS Merton CCG	6,515	169,756	38.4
NHS Harrogate and Rural District CCG	6,469	169,512	38.2
NHS Lincolnshire East CCG	11,767	308,392	38.2
NHS Birmingham and Solihull CCG	48,050	1,266,141	37.9
NHS West Lancashire CCG	5,004	133,970	37.4
NHS Great Yarmouth & Waveney CCG	10,639	287,302	37.0
NHS South Norfolk CCG	8,857	240,043	36.9
NHS Haringey CCG	8,833	240,267	36.8
NHS Guildford and Waverley CCG	7,218	198,026	36.4
NHS West Norfolk CCG	8,090	223,153	36.3
NHS Horsham and Mid Sussex CCG	8,223	228,204	36.0
NHS Coventry and Rugby CCG	17,274	479,962	36.0
NHS Lincolnshire West CCG	8,660	243,831	35.5
NHS Herts Valleys CCG	20,601	580,985	35.5
NHS South East Staffs and Seisdon Peninsular CCG	8,594	242,721	35.4
NHS Northumberland CCG	14,485	409,423	35.4
NHS East Leicestershire and Rutland CCG	11,731	332,164	35.3
NHS North Staffordshire CCG	8,582	243,080	35.3
NHS Gloucestershire CCG	22,916	650,153	35.2
NHS North East Lincolnshire CCG	6,444	183,472	35.1
NHS Enfield CCG	9,976	285,730	34.9
NHS West Cheshire CCG	10,372	297,504	34.9
NHS North, East, West Devon CCG	35,991	1,038,992	34.6
NHS Thurrock CCG	5,473	158,695	34.5
NHS North Durham CCG	10,004	290,923	34.4
NHS South Tyneside CCG	6,948	203,511	34.1
NHS Hounslow CCG	7,974	234,920	33.9
NHS Tower Hamlets CCG	6,915	203,725	33.9
NHS Berkshire West CCG	14,641	431,535	33.9
NHS Durham Dales, Easington and Sedgefield CCG	12,532	371,673	33.7
NHS Cambridgeshire and Peterborough CCG	28,784	857,008	33.6
NHS Croydon CCG	11,593	345,575	33.5
NHS Harrow CCG	7,354	220,364	33.4
NHS Hastings & Rother CCG	7,095	212,725	33.4
NHS Waltham Forest CCG	8,052	242,212	33.2
NHS Airedale, Wharfedale and Craven CCG	6,069	184,522	32.9
NHS Coastal West Sussex CCG	19,690	601,829	32.7
NHS Eastern Cheshire CCG	7,334	225,743	32.5
NHS Halton CCG	5,136	158,601	32.4
NHS Thanet CCG	5,370	166,617	32.2
NHS Crawley CCG	3,888	121,615	32.0

NHS Central London (Westminster) CCG	4,640	146,412	31.7
NHS South West Lincolnshire CCG	4,572	144,550	31.6
NHS Wirral CCG	13,473	426,931	31.6
NHS Calderdale CCG	6,950	220,868	31.5
NHS Ipswich and East Suffolk CCG	13,290	424,469	31.3
NHS Hartlepool and Stockton-on-Tees CCG	10,887	347,891	31.3
NHS Isle of Wight CCG	5,103	163,266	31.3
NHS Wakefield CCG	13,217	424,899	31.1
NHS Brent CCG	8,820	283,808	31.1
NHS Leicester City CCG	10,273	331,199	31.0
NHS South Lincolnshire CCG	5,728	185,709	30.8
NHS Basildon and Brentwood CCG	8,317	271,765	30.6
NHS Bradford City CCG	3,320	109,441	30.3
NHS North Derbyshire CCG	10,190	336,867	30.2
NHS East Staffordshire CCG	4,423	146,462	30.2
NHS North Lincolnshire CCG	5,804	192,201	30.2
NHS Knowsley CCG	6,361	213,757	29.8
NHS Warrington CCG	7,128	241,459	29.5
NHS Redditch and Bromsgrove CCG	5,322	183,574	29.0
NHS Bradford Districts CCG	10,444	360,291	29.0
NHS Luton CCG	5,879	203,911	28.8
NHS West London (Kensington and Chelsea, Queen's Park and Paddington) CCG	5,172	181,041	28.6
NHS Redbridge CCG	7,142	250,020	28.6
NHS Richmond CCG	4,537	159,232	28.5
NHS Hammersmith and Fulham CCG	4,484	157,434	28.5
NHS Sandwell and West Birmingham CCG	15,232	536,637	28.4
NHS Ashford CCG	3,511	123,723	28.4
NHS South Worcestershire CCG	9,240	326,281	28.3
NHS Islington CCG	5,488	195,959	28.0
NHS Salford CCG	8,016	290,402	27.6
NHS Bedfordshire CCG	12,597	458,656	27.5
NHS Chorley and South Ribble CCG	5,717	209,310	27.3
NHS Bury CCG	5,939	218,292	27.2
NHS Warwickshire North CCG	5,528	204,482	27.0
NHS South Kent Coast CCG	6,163	228,072	27.0
NHS West Essex CCG	8,189	304,993	26.8
NHS Vale of York CCG	9,300	346,418	26.8
NHS Barking & Dagenham CCG	4,792	179,892	26.6
NHS Darlington CCG	3,288	123,586	26.6
NHS Bolton CCG	8,688	328,539	26.4
NHS Dudley CCG	9,790	371,654	26.3
NHS South Devon and Torbay CCG	9,255	351,400	26.3
NHS Sunderland CCG	8,617	329,794	26.1
NHS North Kirklees CCG	5,058	196,381	25.8
NHS Havering CCG	7,299	283,904	25.7
NHS Swale CCG	2,926	114,915	25.5
NHS Greater Huddersfield CCG	6,051	239,249	25.3
NHS East and North Hertfordshire CCG	13,982	558,094	25.1
NHS South Warwickshire CCG	7,405	296,467	25.0
NHS Oldham CCG	6,401	260,361	24.6
NHS Hambleton, Richmondshire and Whitby CCG	3,907	161,553	24.2
NHS Nottingham City CCG	8,059	333,680	24.2
NHS Barnet CCG	8,155	338,916	24.1
NHS Heywood, Middleton & Rochdale CCG	6,182	262,159	23.6
NHS Shropshire CCG	8,182	358,388	22.8
NHS Camden CCG	4,453	195,156	22.8
NHS Medway CCG	6,642	292,570	22.7

NHS Barnsley CCG	6,917	307,646	22.5
NHS Newham CCG	5,925	264,411	22.4
NHS Erewash CCG	2,412	108,765	22.2
NHS Telford & Wrekin CCG	4,158	188,294	22.1
NHS Wolverhampton CCG	6,538	297,820	22.0
NHS Rushcliffe CCG	2,772	128,065	21.6
NHS Hardwick CCG	2,737	127,828	21.4
NHS North East Essex CCG	8,273	388,378	21.3
NHS Wyre Forest CCG	2,769	130,900	21.2
NHS East Riding of Yorkshire CCG	7,485	356,864	21.0
NHS Southern Derbyshire CCG	11,560	555,118	20.8
NHS Canterbury and Coastal CCG	4,574	223,349	20.5
NHS St Helens CCG	5,102	251,202	20.3
NHS Nottingham North & East CCG	3,369	169,926	19.8
NHS South Cheshire CCG	4,109	207,657	19.8
NHS Kingston CCG	3,080	155,975	19.7
NHS Wigan Borough CCG	7,668	391,934	19.6
NHS Mansfield & Ashfield CCG	4,374	224,984	19.4
NHS Rotherham CCG	5,525	290,655	19.0
NHS Nottingham West CCG	1,890	102,169	18.5
NHS Vale Royal CCG	2,193	118,826	18.5
NHS North West Surrey CCG	5,889	344,291	17.1
NHS South Tees CCG	5,893	347,079	17.0
NHS Newark & Sherwood CCG	2,579	153,507	16.8
NHS Bassetlaw CCG	2,272	135,283	16.8
NHS Southend CCG	2,917	193,739	15.1
NHS Mid Essex CCG	5,413	381,847	14.2
NHS Castle Point and Rochford CCG	2,791	198,962	14.0
NHS Hull CCG	4,020	315,368	12.7
NHS West Suffolk CCG	3,352	273,650	12.2
All CCG commissioned	2,220,166	58,719,921	37.8

Annex 3 – Variation in the number of excess bed days by specialty (including CCG and specialised commissioned activity)

HRG Subchapter	Total bed days	Excess bed days	Excess bed days as a proportion of all inpatient bed days
Paediatric Immune System Disorders	1,731	1,106	64%
Eyes and Periorbita Procedures and Disorders	96,841	23,429	24%
Pain Management	1,371	274	20%
Paediatric Nervous System Disorders	70,126	13,035	19%
Paediatric Non-Malignant Haematological Disorders	21,982	3,795	17%
Paediatric Rheumatology Disorders	23,642	4,049	17%
Paediatric Gastroenterology Disorders	119,025	19,854	17%
Skin Procedures	60,807	10,112	17%
Ear, Nose, Mouth, Throat and Neck Disorders	346,181	57,235	17%
Paediatric Diabetology, Endocrinology and Metabolic Disorders	26,071	4,200	16%
Paediatric Hepatobiliary Disorders	6,623	937	14%
Spinal Procedures and Disorders	683,256	95,454	14%
Poisoning, Toxic Effects, Special Examinations, Screening and Other Healthcare Contacts	956,443	129,901	14%
Paediatric Cardiology Disorders	26,991	3,478	13%
Paediatric Haematological-Oncology Disorders	67,756	8,104	12%
Musculoskeletal and Rheumatological Disorders	688,994	80,579	12%
Diabetic Medicine	209,172	24,189	12%
Neurological Imaging Interventions	36,156	4,157	11%
Paediatric Medicine	139,142	15,918	11%
Haematological Procedures and Disorders	608,126	61,917	10%
Nervous System Procedures and Disorders	2,991,163	302,863	10%
Paediatric Ear Nose and Throat Disorders	50,630	5,084	10%
Orthopaedic Disorders	833,615	83,338	10%
Ear, Nose, Mouth, Throat and Neck Procedures	176,954	17,354	10%
Paediatric Renal Disorders	24,532	2,392	10%
Multiple Trauma	623,473	57,529	9%
Renal Procedures and Disorders	1,730,942	159,258	9%
Endocrine System Disorders	70,829	6,493	9%
Paediatric Dermatology Disorders	14,528	1,330	9%
Paediatric Trauma Medicine	34,270	3,135	9%
Skin Disorders	699,627	61,183	9%
Metabolic Disorders	280,312	23,838	9%
Vascular Imaging Interventions	170,515	14,095	8%
Breast Procedures and Disorders	105,453	8,661	8%
Urological and Male Reproductive System Procedures and Disorders	752,575	61,741	8%
Paediatric Respiratory Disorders	233,874	19,038	8%
Infectious Diseases and Immune System Disorders	1,970,442	158,291	8%
Digestive System Procedures and Disorders	3,582,366	287,780	8%
Musculoskeletal Imaging Interventions	11,005	875	8%
Cardiac Disorders	1,865,677	145,736	8%
Open and Interventional Procedures for Congenital Heart Disease	60,733	4,678	8%
Vascular Open Procedures and Disorders	524,473	39,186	7%
Orthopaedic Non-Trauma Procedures	1,213,890	77,436	6%
Interventional Cardiology for Acquired Conditions	776,441	48,485	6%
Female Reproductive System Disorders	146,553	8,919	6%
Paediatric Infectious Diseases	200,595	11,159	6%
Respiratory System Procedures and Disorders	4,722,526	249,535	5%
Hepatobiliary and Pancreatic System Disorders	749,115	37,558	5%
Hepatobiliary and Pancreatic System Endoscopic Procedures	205,721	10,228	5%
Hepatobiliary and Pancreatic System Open Procedures	204,133	9,940	5%
Orthopaedic Trauma Procedures	1,335,230	62,952	5%
Neonatal Disorders	475,117	22,196	5%
Thoracic Imaging Interventions	3,706	155	4%
Gastrointestinal Imaging Interventions	46,727	1,801	4%
Hepatobiliary and Pancreatic Imaging Interventions	40,962	1,383	3%
Female Reproductive System Procedures	231,193	7,796	3%
Obstetric Medicine	1,444,971	47,356	3%
Paediatric Ophthalmic Disorders	8,346	250	3%
Open Cardiac Procedures for Acquired Conditions	218,727	4,370	2%
Urological Imaging Interventions	5,498	64	1%
Dental and Orthodontic Procedures	4,315	-	0%
Breast Imaging Interventions	2,128	-	0%

Better Care Fund: Expectations for reducing DToC for 2018/19

APPENDIX E

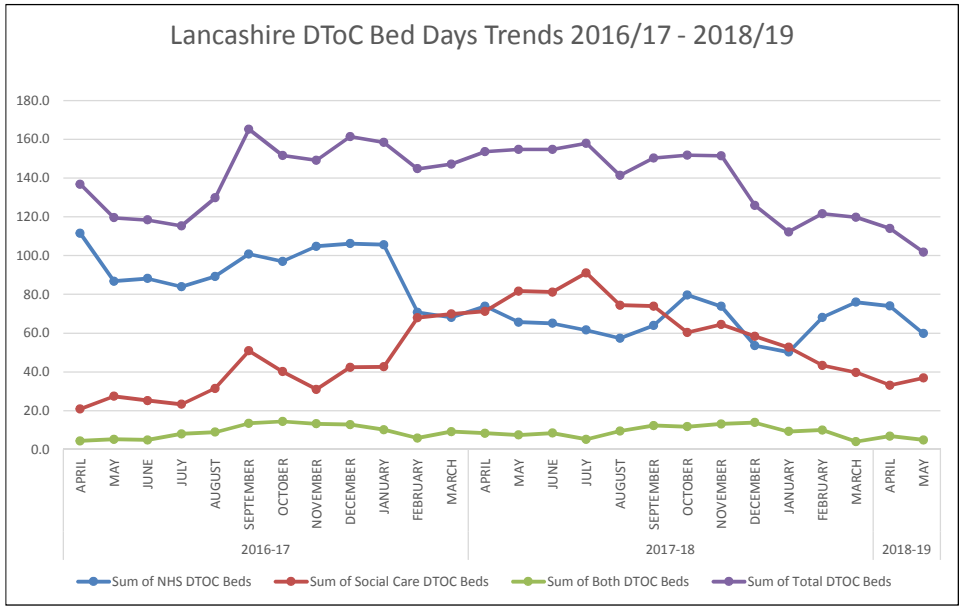
This table sets out expectations, agreed with MHCLG and DHSC for reducing DToC in Lancashire. These expectations are split into NHS, Social care and Joint Delays and are expressed as average daily delays.

Region	HWB		Original 2016 population mid-estimates	Revised 2016 population mid-estimates	2017/18 Q3 Per day				2017/18 Q3 Rate (Per 100k Population, per day)				**2018/19 expectations Per day**				2017/18 previously agreed plans Per day			
					NHS	ASC	Joint	Total	NHS	ASC	Joint	Total	**NHS**	**ASC**	**Joint**	**Total**	NHS	ASC	Joint	Total
North	E10000017	Lancashire	952,006	948,866	69.0	61.1	12.9	143.0	7.3	6.4	1.4	15.1	**52.2**	**36.6**	**12.9**	**101.8**	42.6	24.9	5.9	73.4

The table and chart below focus on Lancashire DTOC Bed Day Trends 2016/17 - 2018/19

Local Authority N LANCASHIRE

Year	Period Name	Sum of NHS DTOC Beds	Sum of Social Care DTOC Beds	Sum of Both DTOC Beds	Sum of Total DTOC Beds
2016-17	APRIL	111.5	20.9	4.4	136.8
	MAY	86.9	27.5	5.2	119.6
	JUNE	88.2	25.3	5.0	118.4
	JULY	84.0	23.4	8.0	115.4
	AUGUST	89.3	31.5	9.0	129.8
	SEPTEMBER	100.9	50.9	13.5	165.3
	OCTOBER	97.0	40.2	14.5	151.6
	NOVEMBER	104.8	31.0	13.3	149.2
	DECEMBER	106.2	42.5	12.8	161.5
	JANUARY	105.6	42.6	10.2	158.4
	FEBRUARY	70.9	68.0	5.9	144.8
	MARCH	68.2	69.9	9.2	147.3
2017-18	APRIL	73.9	71.3	8.4	153.6
	MAY	65.6	81.6	7.5	154.8
	JUNE	65.1	81.2	8.5	154.8
	JULY	61.6	91.1	5.2	158.0
	AUGUST	57.4	74.4	9.6	141.4
	SEPTEMBER	64.1	73.9	12.4	150.4
	OCTOBER	79.7	60.4	11.8	151.9
	NOVEMBER	73.9	64.5	13.2	151.6
	DECEMBER	53.6	58.4	13.9	125.9
	JANUARY	50.2	52.7	9.3	112.2
	FEBRUARY	68.1	43.4	10.1	121.6
	MARCH	76.0	39.7	4.1	119.8
2018-19	APRIL	74.0	33.2	6.9	114.1
	MAY	59.8	37.0	5.0	101.8



Better Care Fund: Expectations for reducing DToC for 2018/19

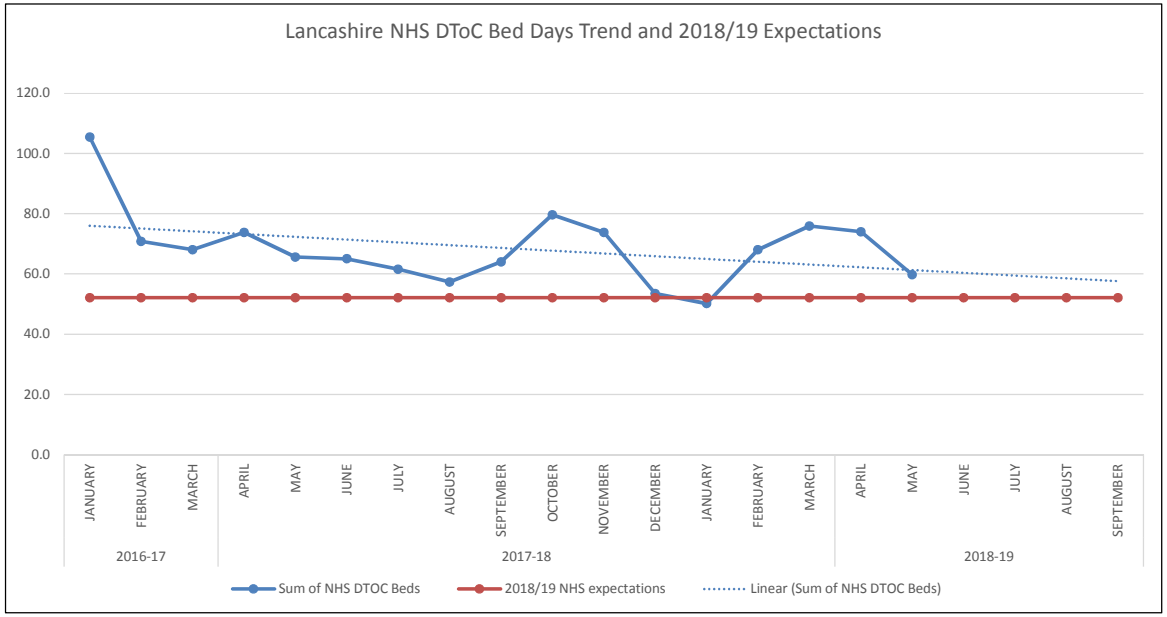
This table sets out expectations, agreed with MHCLG and DHSC for reducing DToC in Lancashire. These expectations are split into NHS, Social care and Joint Delays and are expressed as average daily delays

Region	HWB		Original 2016 population mid-estimates	Revised 2016 population mid-estimates	2017/18 Q3 Per day				2017/18 Q3 Rate (Per 100k Population, per day)				**2018/19 expectations Per day**				2017/18 previously agreed plans Per day			
					NHS	ASC	Joint	Total	NHS	ASC	Joint	Total	**NHS**	**ASC**	**Joint**	**Total**	NHS	ASC	Joint	Total
North	E10000017	Lancashire	952,006	948,866	69.0	61.1	12.9	143.0	7.3	6.4	1.4	15.1	**52.2**	**36.6**	**12.9**	**101.8**	42.6	24.9	5.9	73.4

The table and chart below focus on the current Lancashire NHS DTOC Bed Days trend and 2018/19 Expectations

Local Authority N LANCASHIRE

Year	Period Name	Sum of NHS DTOC Beds	2018/19 NHS expectations
2016-17	APRIL	111.5	**52.2**
	MAY	86.9	**52.2**
	JUNE	88.2	**52.2**
	JULY	84.0	**52.2**
	AUGUST	89.3	**52.2**
	SEPTEMBER	100.9	**52.2**
	OCTOBER	97.0	**52.2**
	NOVEMBER	104.8	**52.2**
	DECEMBER	106.2	**52.2**
	JANUARY	105.6	**52.2**
	FEBRUARY	70.9	**52.2**
	MARCH	68.2	**52.2**
2017-18	APRIL	73.9	**52.2**
	MAY	65.6	**52.2**
	JUNE	65.1	**52.2**
	JULY	61.6	**52.2**
	AUGUST	57.4	**52.2**
	SEPTEMBER	64.1	**52.2**
	OCTOBER	79.7	**52.2**
	NOVEMBER	73.9	**52.2**
	DECEMBER	53.6	**52.2**
	JANUARY	50.2	**52.2**
	FEBRUARY	68.1	**52.2**
	MARCH	76.0	**52.2**
2018-19	APRIL	74.0	**52.2**
	MAY	59.8	**52.2**
	JUNE		**52.2**
	JULY		**52.2**
	AUGUST		**52.2**
	SEPTEMBER		**52.2**



Better Care Fund: Expectations for reducing DToC for 2018/19

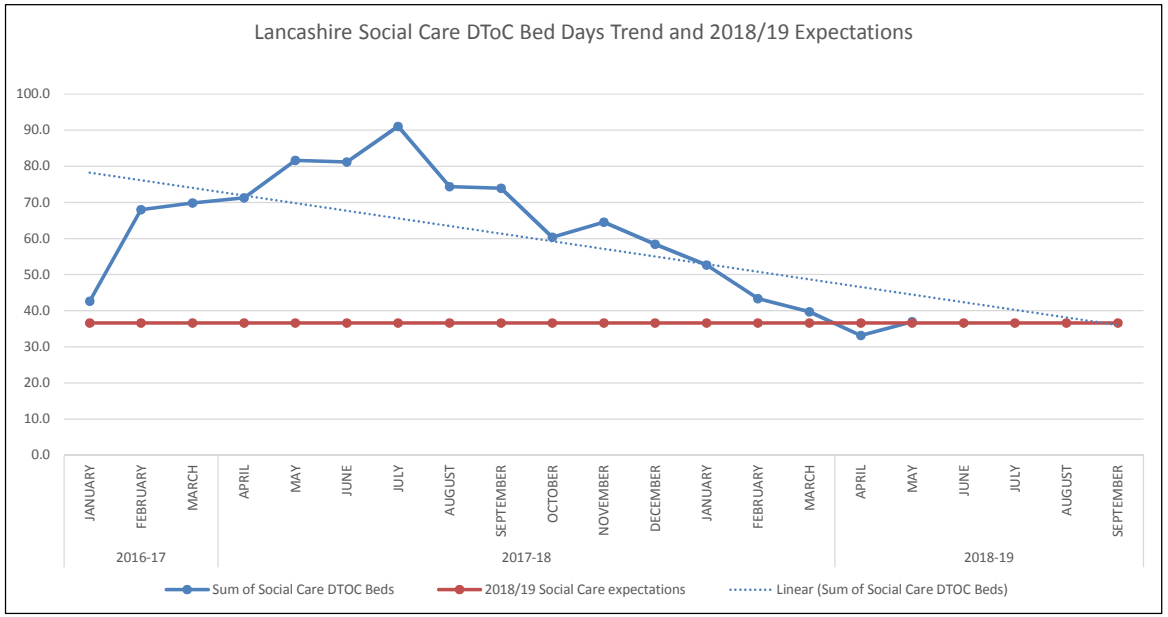
This table sets out expectations, agreed with MHCLG and DHSC for reducing DToC in Lancashire. These expectations are split into NHS, Social care and Joint Delays and are expressed as average daily delays

Region	HWB		Original 2016 population mid-estimates	Revised 2016 population mid-estimates	2017/18 Q3 Per day				2017/18 Q3 Rate (Per 100k Population, per day)				**2018/19 expectations Per day**				2017/18 previously agreed plans Per day			
					NHS	ASC	Joint	Total	NHS	ASC	Joint	Total	**NHS**	**ASC**	**Joint**	**Total**	NHS	ASC	Joint	Total
North	E10000017	Lancashire	952,006	948,866	69.0	61.1	12.9	143.0	7.3	6.4	1.4	15.1	**52.2**	**36.6**	**12.9**	**101.8**	42.6	24.9	5.9	73.4

The table and chart below focus on the current Lancashire Social Care DTOC Bed Days trend and 2018/19 Expectations

Local Authority N LANCASHIRE

Year	Period Name	Sum of Social Care DTOC Beds	2018/19 Social Care expectations
2016-17	APRIL	20.9	**36.6**
	MAY	27.5	**36.6**
	JUNE	25.3	**36.6**
	JULY	23.4	**36.6**
	AUGUST	31.5	**36.6**
	SEPTEMBER	50.9	**36.6**
	OCTOBER	40.2	**36.6**
	NOVEMBER	31.0	**36.6**
	DECEMBER	42.5	**36.6**
	JANUARY	42.6	**36.6**
	FEBRUARY	68.0	**36.6**
	MARCH	69.9	**36.6**
2017-18	APRIL	71.3	**36.6**
	MAY	81.6	**36.6**
	JUNE	81.2	**36.6**
	JULY	91.1	**36.6**
	AUGUST	74.4	**36.6**
	SEPTEMBER	73.9	**36.6**
	OCTOBER	60.4	**36.6**
	NOVEMBER	64.5	**36.6**
	DECEMBER	58.4	**36.6**
	JANUARY	52.7	**36.6**
	FEBRUARY	43.4	**36.6**
	MARCH	39.7	**36.6**
2018-19	APRIL	33.2	**36.6**
	MAY	37.0	**36.6**
	JUNE		**36.6**
	JULY		**36.6**
	AUGUST		**36.6**
	SEPTEMBER		**36.6**



Better Care Fund: Expectations for reducing DToC for 2018/19

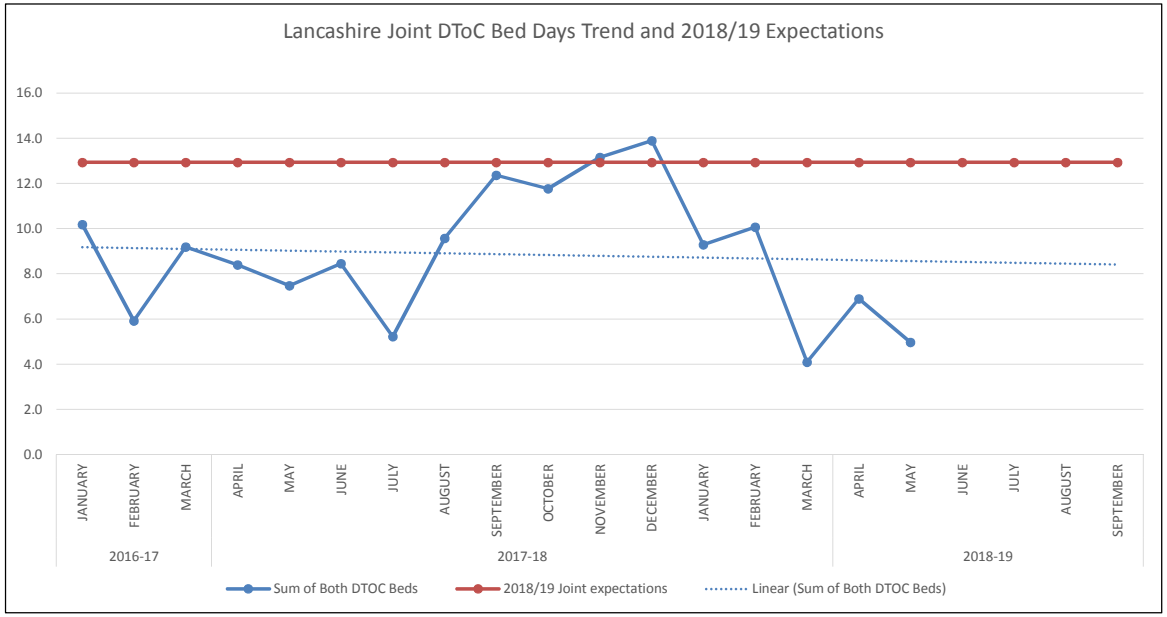
This table sets out expectations, agreed with MHCLG and DHSC for reducing DToC in Lancashire. These expectations are split into NHS, Social care and Joint Delays and are expressed as average daily delays

Region	HWB		Original 2016 population mid-estimates	Revised 2016 population mid-estimates	2017/18 Q3 Per day				2017/18 Q3 Rate (Per 100k Population, per day)				**2018/19 expectations Per day**				2017/18 previously agreed plans Per day			
					NHS	ASC	Joint	Total	NHS	ASC	Joint	Total	**NHS**	**ASC**	**Joint**	**Total**	NHS	ASC	Joint	Total
North	E10000017	Lancashire	952,006	948,866	69.0	61.1	12.9	143.0	7.3	6.4	1.4	15.1	**52.2**	**36.6**	**12.9**	**101.8**	42.6	24.9	5.9	73.4

The table and chart below focus on the current Lancashire Joint DTOC Bed Days trend and 2018/19 Expectations

Local Authority N LANCASHIRE

Year	Period Name	Sum of Both DTOC Beds	2018/19 Joint expectations
2016-17	APRIL	4.4	**12.9**
	MAY	5.2	**12.9**
	JUNE	5.0	**12.9**
	JULY	8.0	**12.9**
	AUGUST	9.0	**12.9**
	SEPTEMBER	13.5	**12.9**
	OCTOBER	14.5	**12.9**
	NOVEMBER	13.3	**12.9**
	DECEMBER	12.8	**12.9**
	JANUARY	10.2	**12.9**
	FEBRUARY	5.9	**12.9**
	MARCH	9.2	**12.9**
2017-18	APRIL	8.4	**12.9**
	MAY	7.5	**12.9**
	JUNE	8.5	**12.9**
	JULY	5.2	**12.9**
	AUGUST	9.6	**12.9**
	SEPTEMBER	12.4	**12.9**
	OCTOBER	11.8	**12.9**
	NOVEMBER	13.2	**12.9**
	DECEMBER	13.9	**12.9**
	JANUARY	9.3	**12.9**
	FEBRUARY	10.1	**12.9**
	MARCH	4.1	**12.9**
2018-19	APRIL	6.9	**12.9**
	MAY	5.0	**12.9**
	JUNE		**12.9**
	JULY		**12.9**
	AUGUST		**12.9**
	SEPTEMBER		**12.9**



Better Care Fund: Expectations for reducing DToC for 2018/19

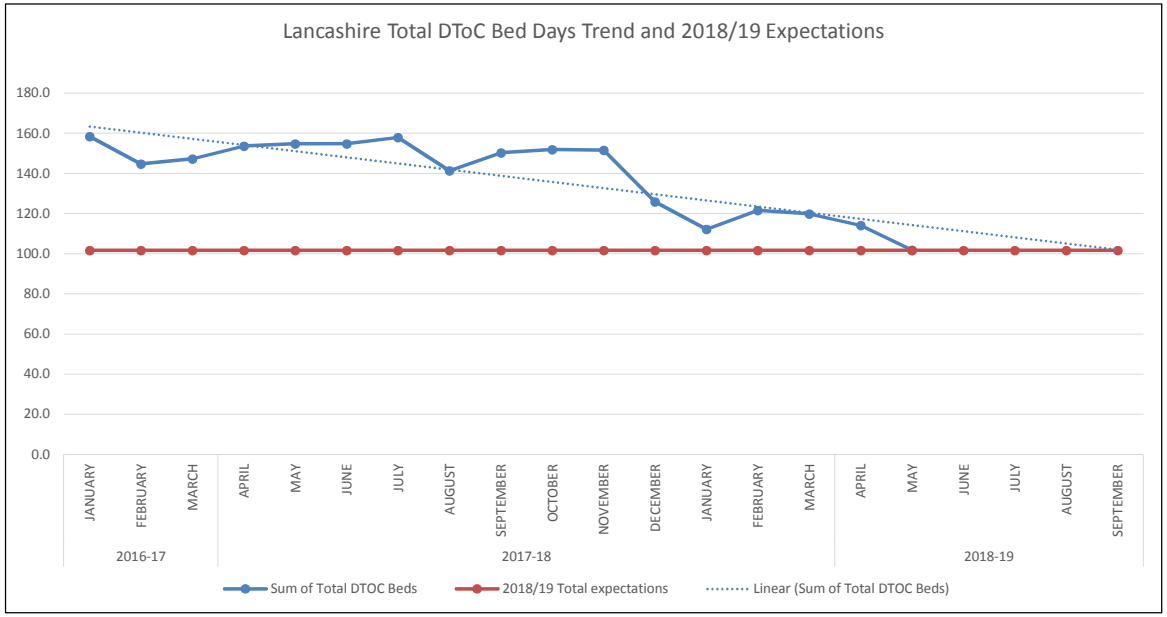
This table sets out expectations, agreed with MHCLG and DHSC for reducing DToC in Lancashire. These expectations are split into NHS, Social care and Joint Delays and are expressed as average daily delays

Region	HWB		Original 2016 population mid-estimates	Revised 2016 population mid-estimates	2017/18 Q3 Per day				2017/18 Q3 Rate (Per 100k Population, per day)				**2018/19 expectations Per day**				2017/18 previously agreed plans Per day			
					NHS	ASC	Joint	Total	NHS	ASC	Joint	Total	**NHS**	**ASC**	**Joint**	**Total**	NHS	ASC	Joint	Total
North	E10000017	Lancashire	952,006	948,866	69.0	61.1	12.9	143.0	7.3	6.4	1.4	15.1	**52.2**	**36.6**	**12.9**	**101.8**	42.6	24.9	5.9	73.4

The table and chart below focus on the current Lancashire Total DTOC Bed Days trend and 2018/19 Expectations

Local Authority N LANCASHIRE

Year	Period Name	Sum of Total DTOC Beds	2018/19 Total expectations
2016-17	APRIL	136.8	**101.8**
	MAY	119.6	**101.8**
	JUNE	118.4	**101.8**
	JULY	115.4	**101.8**
	AUGUST	129.8	**101.8**
	SEPTEMBER	165.3	**101.8**
	OCTOBER	151.6	**101.8**
	NOVEMBER	149.2	**101.8**
	DECEMBER	161.5	**101.8**
	JANUARY	158.4	**101.8**
	FEBRUARY	144.8	**101.8**
	MARCH	147.3	**101.8**
2017-18	APRIL	153.6	**101.8**
	MAY	154.8	**101.8**
	JUNE	154.8	**101.8**
	JULY	158.0	**101.8**
	AUGUST	141.4	**101.8**
	SEPTEMBER	150.4	**101.8**
	OCTOBER	151.9	**101.8**
	NOVEMBER	151.6	**101.8**
	DECEMBER	125.9	**101.8**
	JANUARY	112.2	**101.8**
	FEBRUARY	121.6	**101.8**
	MARCH	119.8	**101.8**
2018-19	APRIL	114.1	**101.8**
	MAY	101.8	**101.8**
	JUNE		**101.8**
	JULY		**101.8**
	AUGUST		**101.8**
	SEPTEMBER		**101.8**



Lancashire Health and Wellbeing Board
Meeting to be held on Tuesday, 18 September 2018

Mental Health and Wellbeing - Time to Change Hub

Contact for further information: Andrea Smith, Public Health Specialist, Health Equity, Welfare & Partnerships Mobile: 07876 844 093 Email: Andrea.Smith@lancashire.gov.uk

Executive Summary

Time to Change is a growing movement of people changing how we all think and act about mental health. Since 2007, Time to Change have been working to create major changes in national attitudes and behaviours, raising awareness and reducing the stigma associated with mental health. Its aim is to empower communities to lead and embed local change, and to do this it has established 'Time to Change Hubs'. Mental health and wellbeing is identified in the Lancashire Health and Wellbeing Board Strategy as a priority for addressing health inequalities in Lancashire, especially for children and young people.
This paper, and presentation by Darren Bee, Time to Change regional co-ordinator, explains the proposed approach for developing a Time to Change Hub in Lancashire

Recommendation/s

The Health and Wellbeing Board is recommended to:

i. Endorse an application and acknowledge the external funding stream associated with this, to become the Host for the Lancashire Time to Change Hub and support the Time to Change social movement to end the stigma and discrimination experienced by people with mental health problems
ii. Oversee the local Hub Partnership and uphold the responsibilities of the Host as described
iii. Nominate and endorse the organisation proposed to fulfil the role of the Hub Co-ordinator
iv. Delegate the responsibility for submitting the application to the Chair of Lancashire Health and Wellbeing Board, in consultation with the Director of Public Health and Wellbeing.

Background

Time to Change Hub

A Time to Change Hub is a partnership of local organisations and people who are committed to ending mental health stigma and discrimination. Collectively and independently they initiate and run regular local activities to challenge mental health prejudice, coming together to align and maximise the impact of their combined activity.

They provide encouragement, support and tools to those that are already campaigning locally and to those that aspire to join the campaign, as well as seeking to encourage anti-

stigma and discrimination policies and best practice within both their own organisations and relevant local strategies. Hubs are partnerships of local organisations and communities; they are not a physical resource based in one location.

Each Hub will receive 18 months direct support from Time to Change from the date of their appointment. Following this period there is an expectation that Hubs commit to continuing to work around mental-health anti-stigma and discrimination independently for a reasonable period, approximately two years, to ensure local changes in attitude and behaviour are robust and sustainable.

Each Hub consists of five main elements;

- **Hub Host** (usually the Local Authority or Health and Wellbeing Board)
- **Hub Coordinator** (usually a local mental health community organisation)
- **Local Authority** (if not nominated as the Hub Host)
- **Local Champions**
- **Wider Hub members**

The 'Host' and 'Coordinator' organisations make up the 'core members' of local Hub partnerships, together with the relevant Local Authority.

The Application Process and Timeline of Events

The table below sets out the key stages and timings of the application process to host a local Time to Change Hub;

Stage / Timing	Outline
Application window *July – 16th November*	Applications are expected to be jointly developed between the core Hub members; Hub Host, Coordinator and the Local Authority. Applications should be endorsed by an appropriate executive of each core member organisation to signal their commitment to the Hubs proposal at a senior level. **The deadline for applications is 5.00pm, Friday 16th November.**
Shortlisting *November*	A shortlisting panel will review all applications and shortlist proposals for interviews with the Decision Panel. Applications will be scored against the criteria set out in the application form and accompanying guidance. **Applicants will be notified if they have been successfully shortlisted or not by Friday 7th December**.
Interviews **North West Region** *22nd January 2019*	The Decision Panel will decide which area are to be appointed as the funded Time to Change Local Hub in their region. The panel will score applicants based on; ▫ The original application ▫ A one hour interview, conducted either face-to-face or by video conference

	Applicants will be told the outcome of interviews and offered feedback in the week ending 1st February 2019
Regional inductions North West Region *28th March*	Areas successfully appointed through the interview process will be invited to host a regional Local Hubs induction day for all interested areas, delivered by Time to Change. **The Date for the North West Region is 28th March.** The purpose of the regional induction is to; ▫ Set out expectations of Hub areas and Time to Change ▫ Introduce Hubs to the work of the individual Time to Change teams, key contacts and the training Time to Change can provide ▫ Enable introductions and networking between partners from all regional Hubs ▫ Provide some key starting points and next steps

Time to Change Funding
If successful, the organisation acting as Hub Coordinator will receive;

- £15,000 contribution from Time to Change towards the staff time required to coordinate and support the Hub partnership, including the administration of a Champions Fund to support local activity.
- £10,000 Champions Fund pot

The Health and Wellbeing Boards' Role as Hub Host
The role of the Hub Host is that it must be able to bring together the organisations likely to be engaged in local partnerships and own, or be able to influence, long-term local strategies relevant to mental health and wellbeing. For this reason, either Local Authorities or Health and Wellbeing Boards are best placed to fulfil the role, although any other organisation also able to meet these requirements may be nominated.

The Hub Host holds the overall partnership agreement with Time to Change. Supported by the other core members and Time to Change, the Host is responsible for setting up and establishing the Hub partnership, including engaging relevant local partners and establishing the partnerships terms of reference.

It is ultimately the Host's responsibility to oversee the local Hub partnership, holding other partners to account and ensuring that they fulfil their roles in the Hub. If high level issues arise it is the Hub Host who will be primarily responsible for ensuring they are effectively resolved, working alongside Time to Change if required.

Together with the two other core members, the Hub Host is expected to;

- Oversee and endorse the Time to Change Hub application
- Ensure the collective production and ownership of the Local Hub action plan
- Ensure mental health anti-stigma and discrimination work and policies are embedded within their own organisation, including signing the Time to Change employer's pledge, by the end of the 18 month period of support.

- Commit to ensuring sufficient staff-time, including the necessary level of senior management buy-in, is available to effectively facilitate delivery of the Hubs objectives
- Enact the core principle of Lived Experience Leadership at the heart of Hub governance and programme planning and delivery

Other responsibilities of Hub hosts include;

- Using their position and influence to ensure both public-facing and local strategic prioritisation of mental health anti-stigma and discrimination work remains a longer-term objective for the local area.
- Nominate and endorse the organisation proposed to fulfil the role of Hub coordinator.
- Identify appropriate local organisations to form the wider Hub partnership, working alongside the other core members.
- Ensuring the Hub partnership reflects all of the local community, including the engagement of minority and marginalised groups.
- Ensuring people with experience of mental health are at the heart of Hub activity, including through the active representation of local Champions on the local partnership group.
- Attend and contribute to all Hub partnership meetings
- Support, promote and attend local Time to Change events

Time to Change Hub for Lancashire – Proposed Approach.

The Health and Wellbeing Board's ability to bring together leaders from the health and care system across Lancashire and its ambition within its strategy to work better together to deliver improvements in health and wellbeing for the people in Lancashire means it is ideally placed to fulfil the role of 'Host'. Around one in four people will experience a mental health problem this year yet the shame and silence can be as bad as the mental health problem itself. With mental health and wellbeing being one of the top ten inequality gaps in health and wellbeing outcomes in Lancashire, its impact cuts across all three programmes of the Health and Wellbeing Board's strategy work across the life course.

The Hub's high-level objectives will aim to mirror those of the national Time to Change campaign to change behaviour and attitudes towards people with mental health problems, reduce levels of reported stigma and discrimination and, to empower people with experience of mental health problems to be at the heart of activity whilst also being rooted in local agendas and priorities.

To do this our proposed approach is to look at the following areas of work and work to our local strengths in these areas:

1. To align with and support the Total Neighbourhood approach:
    - Working with the pilot areas this strategy will enable change and identify community champions to work alongside the host and hub co-ordinator to deliver local anti-stigma events, activities and campaigns.
    - Community champions will be appointed from these communities to support this campaign. They will be connected and integrated into local pilot work to embed and sustain the approach, and included in the development of social prescribing.

2. To support Lancashire employers with their workplace wellbeing approaches:
    - Building on the endorsement of the recent Well@Work Healthier Lancashire and South Cumbria event, the public sector health economy organisations

which make up the newly formed workplace wellbeing network will be encouraged to take the Time to Change pledge and maximise the impact of its combined efforts to reduce stigma and improve workplace mental health. This will include sharing of information and activities and combined campaigns across the workforce at key dates such as World Mental Health Day and Time to Change Day.

- Ensure mental health anti-stigma and discrimination work and policies are embedded within their own organisation, including signing the Time to Change employer's pledge, by the end of the 18 month period of support

3. Children and Young People's Emotional Health and Wellbeing in Schools
    - Unique support for educational establishments to build resilience and skills to cope with developing mental health issues in young people and take preventative action in the establishment is currently commissioned from Lancaster University. This plan will maximise the impact of this unique service and extend provision to cover the transition between primary and secondary education, enhance the skills of in school practitioners and develop peer to peer support to key stage 3 and 4. Time to Change will be promoted with schools as part of this contract and the additional materials which are available on the website, reducing stigma and changing conversations around mental health.

4. Suicide and Self Harm:
    - The Time to Change campaign can attribute to the cultural shift of more people talking about their own mental health and seeking help.
    - Training is currently commissioned by LCC across the Lancashire twelve districts including Youth Mental Health First Aid, Safe Talk and Assist. Time to Change can be promoted while delivering these courses providing a further outreach into communities.
    - The suicide prevention logic model (Outcome 5) includes improved mental health and wellness which can be supported by the Time to Change campaign, encouraging people to talk about mental health and reducing stigma.
    - Digital Technology can be used to promote the campaign via the Digital Thrive platform which is being designed to be utilised across the Integrated Care System footprint.

List of background papers

None

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Lancashire Health and Wellbeing Board
Meeting to be held on 18 September 2018

Lancashire Special Educational Needs and Disabilities (SEND) Partnership – Update on the implementation of the Written Statement of Action

Contact for further information:
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Executive Summary

Lancashire local area Special Educational Needs and Disabilities services were inspected by Ofsted and the Care Quality Commission in November 2017, to judge how effectively the special educational needs and disability reforms had been implemented, as set out in the Children and Families Act 2014. The inspection identified two fundamental failings and twelve areas of significant concern.

The partners in Lancashire were required to produce a written statement of action, setting out the immediate priorities for action; the progress on implementing these actions is monitored by the Department for Education and NHS England.

The Health and Wellbeing Board had requested regular updates on progress at their bi-monthly meetings; this is the second update to the Board.

Recommendation/s

The Health and Wellbeing Board is recommended to:

(i) Note the progress of delivery on the written statement of action.

(ii) Receive an update on progress at the November Board meeting.

Background

As described in the report to the Health and Wellbeing Board in July 2018, the Lancashire Special Educational Needs and Disabilities Partnership Board is responsible for ensuring the delivery of the written statement of action and for reporting on progress bi-monthly to the Health and Wellbeing Board. John Readman, Executive Director for Education and Children's Services and Mark Youlton, Clinical Commissioning Group Chief Officer are the accountable officers for SEND and have been appointed as Chair and Vice-Chair of the Board.

1. Progress since the 17 July 2018 report

- ✓ SEND Partnership brand/identity agreed
- ✓ Delivery plans completed to drive partnership activity in the short and longer term
- ✓ Meetings held with all Head Teacher Associations; representation agreed for Board and Working Groups

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- ✓ Feedback from 'Your Child, Your Voice' engagement events collated and informing vision and strategy
- ✓ Parent/carer volunteers taken up roles within the partnership
- ✓ Review of Local Offer undertaken and website specification developed with parents and young people
- ✓ Joint Strategic Needs Assessment scope finalised and data set determined
- ✓ 2016/17 data dashboard published end of July and updated in August
- ✓ Commissioning Framework for Children and Young People's Services agreed
- ✓ Autism Spectrum Disorder diagnostic pathway for Morecambe Bay agreed
- ✓ Consultation on Pan-Lancashire Neurodevelopmental Assessment and Diagnostic pathway completed
- ✓ Achievement data analysed by phase/district/need and updated in August
- ✓ SENCO Cluster Meetings held across the county

2. Key action over the next reporting period

- ➢ Agree SEND Partnership Vision and Strategy
- ➢ Agree joint commissioning function, including for SEND
- ➢ Appoint supplier for build of SEND Local Offer website
- ➢ Work with Department for Education contractor to facilitate new Parent Carer Forum
- ➢ Define quality standards for Education Health and Care Plans
- ➢ Deliver shared training for SENDO's and SENCO's
- ➢ Agree targets for improvements in Exclusion and Attainment outcomes
- ➢ Implement the Designated Clinical Officer service with partners
- ➢ Target support for those with Education Health and Care Plans at risk of permanent exclusion

3. Monitoring progress

Internal monitoring of delivery takes place monthly by the SEND Partnership team and is reported to the SEND Partnership Board at every meeting; initially monthly and from September 2018 on a bi-monthly basis.

External monitoring by the Department for Education and NHS England takes place at quarterly review meetings; the first review took place on 20th April 2018 and the second on the 25th July 2018.

The overall 'amber' assessment by the Department for Education/NHS England on the progress the Lancashire SEND Partnership is making concurs with our own view. All deadlines were met, apart from one in May and two in June and activity is underway to progress these three actions to a satisfactory conclusion.

Conclusion

Initial progress to develop and implement the foundations for change has been timely. Delivering the required actions by the end of September deadlines, in readiness for the October Department for Education/NHS England review, will be challenging however mitigating action is in place to accelerate progress.

List of background papers

Lancashire Special Educational Needs and Disability Written Statement of Action (May 2018)
https://www.lancashire.gov.uk/media/905171/lancashire-send-partnership-written-statement-of-action.pdf

Lancashire Health and Wellbeing Board
Meeting to be held on Tuesday, 18 September 2018

Lancashire Safeguarding Boards Annual Report 2017/18
(Appendix 'A' refers)

Contact for further information:
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Executive Summary

This report is being presented to the Health and Wellbeing Board prior to publication of the Lancashire Safeguarding Adults Board/Lancashire Safeguarding Children Board Annual Report, to allow for comment on the draft report before it is finalised.

The draft Annual Report is attached at Appendix 'A'.

Recommendation/s

The Health and Wellbeing Board is recommended to:

(i) Note the contents of the report.

(ii) Comment on any key issues and consider the implications for the conduct of business.

Background

Current statute requires that in every local authority administrative area there must be both an Adult Safeguarding Board and a Children Safeguarding Board. Key local agencies are represented on the Boards at a senior level, but the Boards have an Independent Chair. At present in Lancashire, both Boards have the same Chair.

Both Boards are required to produce and publish an annual report which reflects on safeguarding practice and issues in the area. The draft Annual Report which covers the period from April 2017 to end of March 2018 is attached at Appendix 'A'. The Health and Wellbeing Board is asked to note that Appendix 'A' includes a number of embedded documents which have not been printed for the purposes of this agenda. These documents can be made available on request.

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Additionally a separate Annual Report is prepared by the LSCB's Child Death Overview Panel (CDOP). A brief summary of key issues is included in this report, and the full report will be shared with Health and Well-being Board later this year.

The report begins with contextual information drawn from Public Health data. The data highlights the complexity of the population in Lancashire, with higher incidence of poor health and well-being indicators being seen in the areas of highest deprivation. The report then seeks to set out what we know about the vulnerability of the people in terms of safeguarding, what we know about the quality of safeguarding activity in local services, and how the Board has sought to make a positive impact on services.

In Lancashire, a single business unit supports both Boards and every attempt is made to maximise the potential benefits this brings. Common approaches have been developed for the conduct of business and, as far as possible, we strive to do things once. As was the case last year, the Annual Report will be published as a single report covering both Boards. If required, for example by Ofsted, it can be split into a Children's or Adults report.

1.1 Positive progress has been evidenced in the course of the year in respect of the following:

Adult Services:

- High quality practice tools and guidance have been developed in respect of when to raise a safeguarding alert; covert medication; cardiopulmonary resuscitation; and pressure ulcerations. Guidance in relation to Self- Neglect and Hoarding have recently been agreed by the Lancashire Safeguarding Adults Board and will be launched in the coming months, and pan-Lancashire guidance for the management of allegations against people in a position of trust is also nearing completion.
- Funding has been identified to develop and deliver multi-agency Safeguarding Adult Training. Recruitment to a multi-agency training pool is in progress for delivery of the training programme.
- A Leadership programme has been launched to support registered managers in the care home sector to improve quality of care in Lancashire. This programme has been provided by a nationally recognised leadership programme 'My Home Life'.
- Further progress has been made in respect of the implementation of the Mental Capacity Act. This includes research into practitioner experiences of working with the Mental Capacity Act and Deprivation of Liberty Safeguards; development of an Mental Capacity Act Learning and Development Framework and resources; awareness raising with carers and the public; development of a best practice sample Mental Capacity Act and Deprivation of Liberty Safeguards policy for use across agencies; and a multi-agency audit against the Association of Directors of Adult Social Services Improvement Tool.
- Some investment has been made against the Multi-Agency Safeguarding Hub for Adults but the backlog of referrals, although reduced, remain highs. A review of the Adult Multi-Agency Safeguarding Hub has been commissioned in order to improve efficiency and effectiveness.

Children's Services:

- Through membership of the Children's Services Improvement Board the Lancashire Safeguarding Children Board has seen and supported continuous improvement.
- Significant positive change has been evident in the Children's Multi- Agency Safeguarding Hub and continues to progress.
- Improvements in range and timeliness of services is evident in respect of Child and Adolescent Mental Health Services, though there is more to do.
- Communication with looked after children has been improved through the introduction of Mind of My Own– a mobile phone app for participation.
- Pathways for responding to Female Genital Mutilation have been improved and rolled out via a multi-agency conference.
- A pathway for identifying and offering timely support to children with a parent or carer in prison has been implemented and actions taken to capture and record this information through case management systems.
- A review of the Standard Operating Procedures for Child Sexual Exploitation has been initiated during reporting year and has made good progress in bringing procedures up to date and suitable for working practice across the Pan-Lancashire area. This is due to be finalised and formally agreed shortly.

Some examples of impact from Audit and Review:

- A Child Protection Strategy meetings re-audit shows actions implemented and improved practice.
- An audit of Under 65s mental health case Safeguarding Investigations initially showed very poor practice. This led to immediate changes and a re-audit showed improvement.
- An audit of domestic abuse referrals and a Safeguarding Adult Review highlighted specific issues for elderly dementia sufferers and their carers, which has resulted in the development of guidance for those working with adults with care and support needs.
- A number of Serious Case Reviews raised concerns about practitioners' confidence in assessing the potential impact of drug use on parenting. A new course was developed and delivered to over 600 multi-agency practitioners. The course content is currently being transformed into an e- learning module, and a supporting resource pack is in development. Articles in the press also highlighted this issue to the public.
- Serious Case Reviews also raised concerns around concealed and denied pregnancy. A multi-agency protocol has been in development during the reporting year and has recently been formally agreed for roll out.
- The Boards' audit process requires agencies to complete a self- assessment to establish the extent to which they meet the safeguarding requirements and standards set out in Section 11 of the Children Act 2004 and the Care Act 2014. This has been a welcome change and allows the collection of information regarding all-age safeguarding compliance. Additional time is also being invested in quality assuring the returns receiving and offering challenge to single agencies.

1.2 At the end of the 2016/17 reporting period, we reported that the following areas were of concern and presenting as challenges to the Lancashire Safeguarding Adults Board in respect of Adults Safeguarding:

- Backlog of Deprivation of Liberty Safeguards applications and safeguarding referrals;
- Understanding of thresholds to ensure adults with care and support needs receive the correct service at the correct time;

- Ensuring “Making Safeguarding Personal” underpins all adult safeguarding work throughout all settings.

At the end of 2017/18, the position is as follows:

- The backlog of Deprivation of Liberty Safeguards applications remains an issue of concern with the local authority unable to respond to all cases falling within the Association of Directors of Adult Social Services highest priority. It should be noted that this problem is not specific to Lancashire and is common to other authorities. The Lancashire Safeguarding Adults Board has received assurance in regard to revisions made to the prioritisation tools when applications are received but, whilst this enables a proportion of the highest priority cases to be considered, the underlying issue is one of capacity. During 2018-19, the Lancashire Safeguarding Adults Board plans to support the Local Authority in engaging in a Peer Review with a high performing council; is conducting an audit of cases to test the appropriateness of the revised prioritisation tools; and encouraging the care sector to ensure users rights are protected by continuing to make appropriate applications.
- With regard to the Multi-Agency Safeguarding Hub backlog of safeguarding referrals, the Lancashire Safeguarding Adults Board receives monthly data relating to the number of cases outstanding and there is evidence that improvements have been made and appropriate monitoring is in place. Whilst the "multi-agency" hub is in place to address adult safeguarding referrals, it should be noted that it is currently resourced and staffed by the local authority only and is not strictly "multi-agency" function as it stands. The Lancashire Safeguarding Adults Board is supporting agencies to undertake a further review which will be reported to the Board in the Autumn.
- Referrals into the Multi-Agency Safeguarding Hub continue to be high. The Lancashire Safeguarding Adults Board launched a thresholds guidance tool in 2016/17, to assist practitioners in making appropriate referrals in response to safeguarding concerns. After a year of implementation, feedback on the use of the tool has been gathered and provided positive findings, highlighting that the tool has been well received and well regarded by practitioners. Some minor changes are currently being made based on the feedback provided, which will further strengthen the tool.
- Compared to other areas, Lancashire has a high percentage of people in residential and nursing care and a significant number of homes which do not get good or outstanding ratings on inspection. In order to improve both leadership and safeguarding in these homes, the Lancashire Safeguarding Adults Board is supporting the council in delivering a targeted development programme designed to improve standards.

The following areas were of concern and presenting as challenges to the Lancashire Safeguarding Children Board in 2017-18 in respect of Children's safeguarding:

- Embedding access to early help as the first response;
- Ensuring the redesign of the Child and Adolescent Mental Health Service results in a more accessible and equitable service;
- Ensuring the improvements made in Children’s Social Care are sustained;
- Piloting new approaches to the Multi-Agency Safeguarding Hub and developing a locality based service;
- Embedding the lessons from audit and Serious Case Reviews into practice.

During 2017/18, the following activity has taken place in order to address such issues:

- Early help approaches remain a priority for the Lancashire Safeguarding Children Board with a number of mechanisms in place to strengthen the approach. Following the roll out of an updated Common Assessment Framework, the Board commissioned a number of Train the Trainer events, providing training to over 160 multi-agency staff to roll out further training across the county. A school engagement project was commissioned in January 2017, with a key objective around strengthening the links between school and Early Help/Early Action Teams and Children's Social Care. The Continuum of Need was reviewed in July 2017, to provide a consistent pan-Lancashire approach to strengthen assessment levels across the local authority areas. This led to Lancashire undertaking a further review of the supporting Thresholds Guidance which is now nearing completion.
- The Lancashire Safeguarding Children Board receives regular updates from the Children and Young People's Emotional Wellbeing and Mental Health Transformation Programme, with regard to the activity being undertaken to improve service provision. We are pleased to be able to report that progress demonstrates clear improvements and it is evident that positive changes are being made in ensuring a more accessible, timely and equitable service provision for children and young people. Overall, however, financial investment in this service still does not compare well nationally.
- Improvements in Children's Social Care continue to be made, with substantial investment and capacity increase made by the local authority, particularly for the reorganisation of the Child Sexual Exploitation Teams. Whilst reorganisation has brought a period of intense change, the Lancashire Safeguarding Children Board is confident that progress has been, and continues to be made. At the time of writing this report, Ofsted published the findings of the recent inspection, with an overall inspection judgement of "Requires Improvement" meaning the local authority is no longer subject to Department for Education intervention.
- Following a service redesign, a locality-based model has been introduced into the Multi-Agency Safeguarding Hub, with multi-agency partners co-locating on a North, Central and East footprint in one large office. The implementation of this model has strengthened relationships between partner agencies; increased the understanding of roles and responsibilities; and made improvements in information sharing and decision making between partner agencies. The Multi-Agency Safeguarding Hub is now the single point of contact for any concerns relating to a child who is not open to Children's Social Care. The Multi- Agency Safeguarding Hub Strategic Board continues to further develop the model, reporting into the Lancashire Safeguarding Children Board regularly. A refreshed plan is in place for the Strategic Board, focusing on quality of practice.
- Audit and case review activity often present reoccurring themes for learning, which results in a challenge for the Boards in ensuring our methods to embed learning are effective in preventing the same issues arising over time. The Board has recently commissioned a specialist in impact measurement workshop to provide briefing sessions to Board and Sub Group members to refresh our approaches.

The Board completes a range of quality assurance activities which are reflected in the Annual report. Serious Case Reviews concerning children and Safeguarding Adult reviews are published (where there are no legal constraints) and the Boards always publish learning briefings. A programme of audits is completed each year on subjects linked to the Boards' priorities. Partner agencies which provide services for children and families complete an annual self-assessment against a Lancashire Safeguarding Children Board template and a proportion are subject of detailed challenge.

The governance arrangements for the Boards is set out in the annual report, as is the work of the sub-groups. Lessons from case reviews and audits are outlined. Partner agencies

have also provided a summary of their work in respect of safeguarding and these are embedded in the report.

Revised governmental guidance around the arrangements for safeguarding children was published on 5 July 2018. The guidance removes the current arrangements for a Local Safeguarding Children Board, and requires the three 'safeguarding partners': the local authority; the police; and the Clinical Commissioning Groups to agree future Multi Agency Safeguarding Arrangements. The guidance also brings changes to current approaches for Serious Case Reviews, which will be replaced with Child Safeguarding Practice Reviews; and changes to Child Death Overview Panels which become Child Death Reviews led by the local authority and Clinical Commissioning Groups.

Safeguarding partners must agree and implement arrangements for Multi Agency Safeguarding Arrangements on or before 29 September 2019. New processes for Child Practice Reviews should be followed from 29 June 2018, with a grace period of up to 12 months to publish existing Serious Case Reviews. Existing Child Death Reviews should be published within four months.

Provide a brief narrative that outlines the background to the report and supports the recommendations proposed.

Consultations

All Board partner agencies have been consulted during the preparation of the Annual Report. The report reflects comments made and includes information directly provided by the agencies.

Implications:

While there is evidence of good practice, significant challenges remain in ensuring services that provide safeguards for vulnerable children and adults are sufficiently resourced to meet demand on a timely basis.

List of background papers

Paper	Date	Contact/Tel
Working Together to Safeguard Children The Care Act 2014	2015/18	Jane Booth/Victoria Gibson
Board Minutes and Reports	2017/18	Victoria Gibson
Member Agency Feedback Reports (section 3.1 of Appendix A refers)	2017/18	Laura Parkinson
Service Area Annual Reports (section3.5 of Appendix A refers)	2017/18	Laura Parkinson

Reason for inclusion in Part II, if appropriate

N/A

Annual Report 2017/18
DRAFT

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1. Foreword by the Independent Chair

It is a great privilege to Chair both the Adult and Children Safeguarding Boards in Lancashire. As financial pressures and human resource issues continue to be a significant challenge in all agencies, I get to see at first hand the commitment and hard work which leads to better and safer services.

The scale, levels of diversity and complexity of the population in Lancashire create a challenging environment. As at the end of quarter four, agencies were supporting 6,097 children in need of early help; 1,243 children on a Child Protection Plan; and the council looks after almost 2,000 children in care. There are almost 1,000 children living in Lancashire who are looked after and placed here by other councils; we have 1,210 educated at home; and 363 missing from education. Almost 6,000 adults with care and support needs are supported in residential or nursing homes; approximately 11,000 adult safeguarding alerts are dealt with in a year; significant numbers of people need support with their mental health; and the population of the very elderly is growing year on year.

None of the services in Lancashire would claim to be perfect but the value of the work managers and practitioners do often goes unrecognised. To them I say thank you – their skills and dedication make a difference to the lives of some of the most vulnerable people every day.

The Boards offer both support and challenge to the agencies and our performance and audit framework continues to develop. This report covers the year from April 2017 to end of March 2018. It seeks to set out the context within which agencies work, what we know about the range of services and what we have found out through our audits and review about the quality of agency performance.

The year has seen the local authority continue its improvement journey following an adverse inspection two years ago and additional challenge for the police and one of our health providers following criticism in this year's round of inspections. We have seen changes in responses to those referred for services with more emphasis on early help but in children's services there are still too many children in need of protection or looked after by the local authority. Child and adolescent mental health services are showing improvement in range and timeliness of services. For older people we have proportionately more people in care settings and too many homes not rated as good.

Responses to exploitation - sexual, financial, criminal, online – continue to develop. The local authority has increased the resources to manage child sexual exploitation and all agencies are sighted on the increasingly complex nature of exploitation. Better identification of exploitation of adults via modern slavery and human trafficking is a developing pressure area.

The two Safeguarding Boards continue to be supported by a single business unit and this has enabled us to take a much more coordinated approach to the work. Wherever possible the Boards work together, doing things just once! We have also applied this as a principle in our work with

neighbouring Boards – Blackpool, Blackburn with Darwen and Cumbria – and have developed joint adult safeguarding procedures and completed a number of joint initiatives.

We have seen some turnover of staff during the year but have a strong team and they have completed a challenging workload. The volume of work is high and we have had a significant number of cases requiring a formal review. As a result we have developed new ways of working and this has been shared at a regional level as a model of good practice.

In July 2018 the government issued new guidance around the arrangements for safeguarding children. These will require the establishment of a new "Multi-agency Safeguarding Partnership" to replace the LSCB. Plans are in development and the three lead partners, the council, the police and the Clinical Commissioning Groups will need to reach a decision in the coming months with a final implementation deadline of September 2019. There are a range of options but strong commitment to ensuring that the new arrangements will be at least as robust as current arrangements.

I expect the coming year to be just as challenging as the last one but look forward to playing a part.

Jane Booth, Independent Chair

2. Local Context and Background

Lancashire is a large Shire County in the North West of England, with one County Council (LCC) and 12 District Councils, in addition there are 2 Unitary Authorities within the geographic region of Lancashire; Blackpool and Blackburn with Darwen. Lancashire Safeguarding Boards are primarily concerned with the Lancashire-12[1] area, hence data within the Annual Report relates to Lancashire excluding the unitary authorities unless otherwise stated. The most current data available has been used to inform this report and data for 2017-18 used whenever possible, however this is not always possible especially for indicators which are submitted nationally and include regional and national comparators. At the time of writing, mid-year 2017 population estimates had not been released, hence mid-year 2016 population estimates have been used to provide the local context and background.

Mid-year 2016 population estimates indicate that Lancashire local authority area is the fourth largest in the United Kingdom, with a population of 1,195,418; the three local authority areas with larger populations being Kent, Essex and Hampshire respectively.

As the data in the table below illustrates, Lancashire's mid-year population estimate has increased by 0.55% compared to 2015, in contact North West and England population estimates have increased by 0.68% and 0.88% respectively. With regards to the English population, it is estimated that 2.16% reside in Lancashire. The population estimates also indicate that approximately 16.55% of the North West population reside in Lancashire.

Mid-year population estimates	**2015 estimate**	**2015 % Lancs**	***Annual % change***	**2016 estimate**	**2016 % Lancs**
England	54,786,327	2.17%	*+0.88%*	55,268,067	2.16%
North West	7,175,178	16.57%	*+0.68%*	7,223,961	16.55%
Lancashire	1,188,875	100.00%	*+0.55%*	1,195,418	100.00%

In contrast to the 1,195,418 estimated to live in Lancashire, the unitary authorities have much smaller populations, with an estimated 148,462 in Blackburn with Darwen (which equates to 12.5% of population within the Lancashire-12 area) and 139,983 Blackpool (11.7% of Lancashire-12 area).

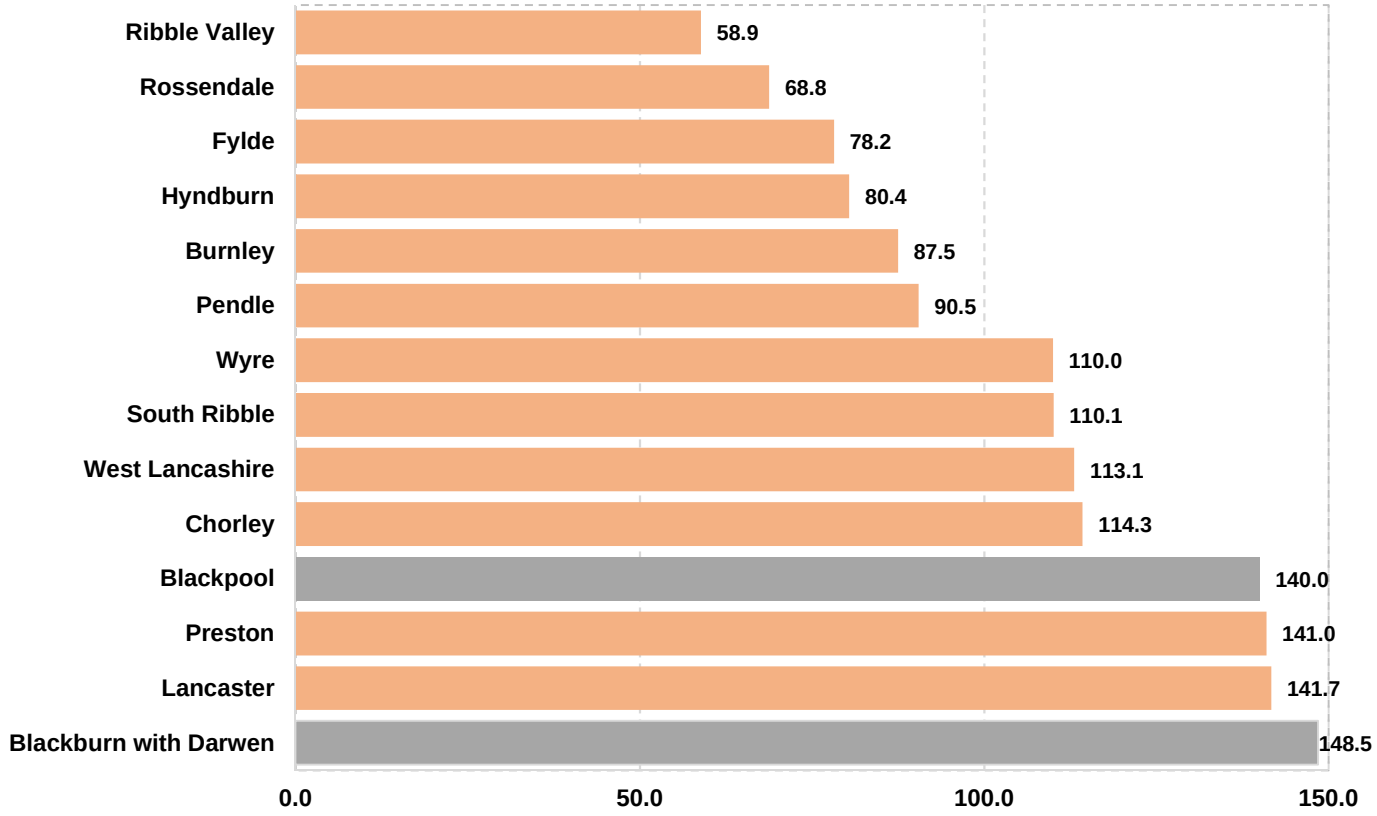
With regards to the individual districts within the Lancashire-12 area, each of these are distinctly diverse with significant difference in many aspects including population, demography, geography, ethnic composition and indices of deprivation.

As the graph below shows, the populations for each district within Lancashire vary considerably. Lancaster district continues to have the largest population in the Lancashire-12 area (141,723) closest followed by Preston (141,023). These numbers are likely bolstered by the fact that both

[1] "Lancashire-12" refers to the 12 District Councils within the County Council footprint: Burnley, Chorley, Fylde, Hyndburn, Lancaster, Pendle, Preston, Ribble Valley, Rossendale, South Ribble, West Lancashire and Wyre

districts are centred on a city and both have University's. Ribble Valley (58,864) and Rossendale (69, 787) remain the two districts with the lowest population totals.

2016 mid-year population estimates (thousands) for local authorities with the Lancashire-12 authority area and unitary authorities



Source: Office for National Statistics (ONS) 2016 mid-year population estimates

The 2016 birth and death rates indicate that the Lancashire-12 area overall continues to register more live births than deaths each year. There are however differences between the districts; in 2016 Fylde, Lancaster, Ribble Valley, West Lancashire and Wyre recorded more deaths than births. This can be explained in part at least by the fact that these districts have a high proportion of older residents, thus leading these districts to have a higher mortality rate and also a lower proportion of the population are children or adults of child bearing age.

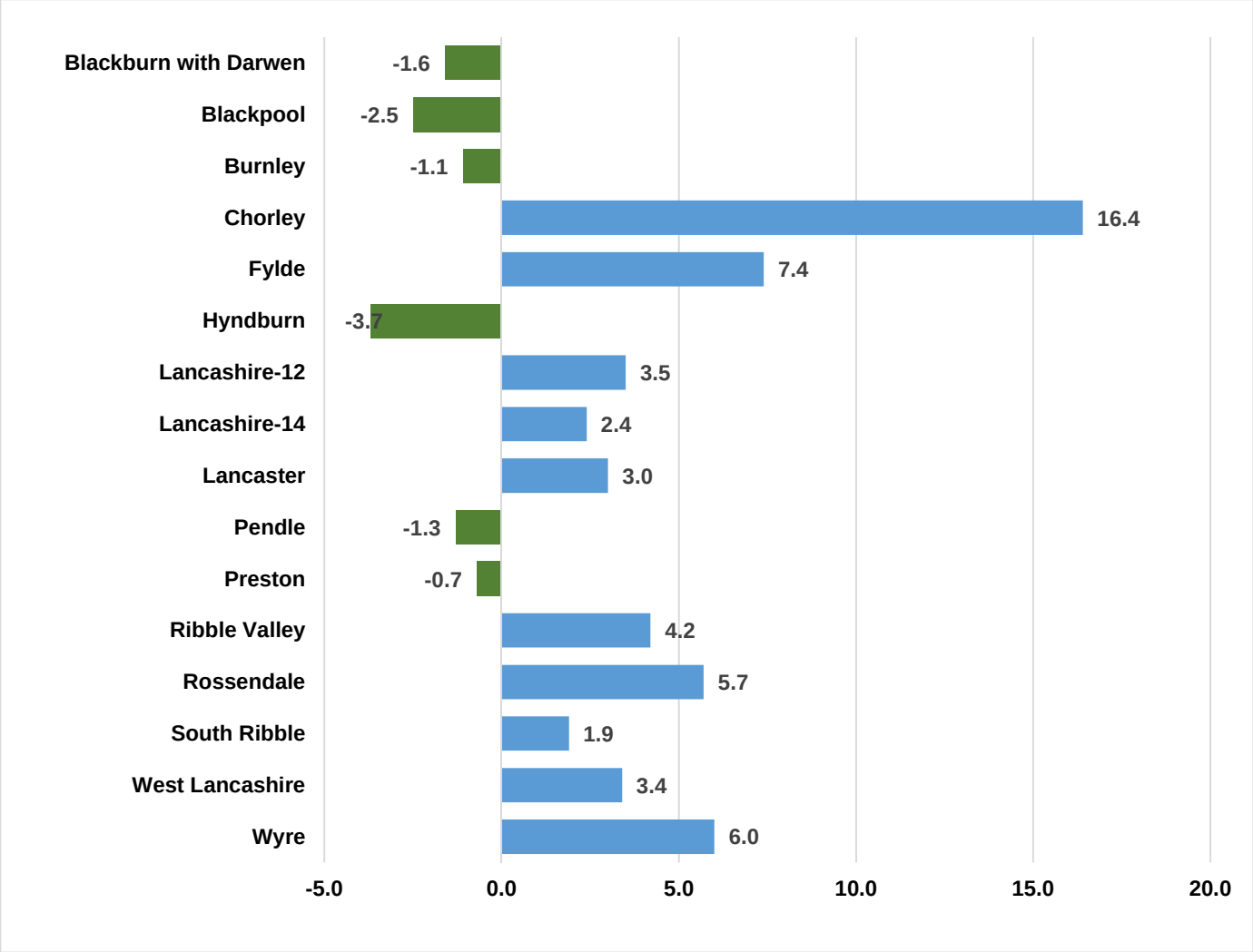
Population Projections

According to data available via the Lancashire Insight2 site, the latest population projections for the Lancashire-12 area project a population increase of 3.5% with the population expected to reach 1.23 million by 2041. This increase is lower than the North West projection of 6.4% and expected increase of 12.1% for England.

[2] Lancashire Insight provides statistics and intelligence regarding Lancashire, including Lancashire's Joint Strategic Needs Analysis - http://www.lancashire.gov.uk/lancashire-insight

Burnley, Hyndburn, Pendle and Preston are expected to experience small population decreases between now and 2041. As illustrated below, the only Lancashire-12 district which is anticipated to experience a significant increase in population is Chorley, with an expected increase of 16.6% by 2041.

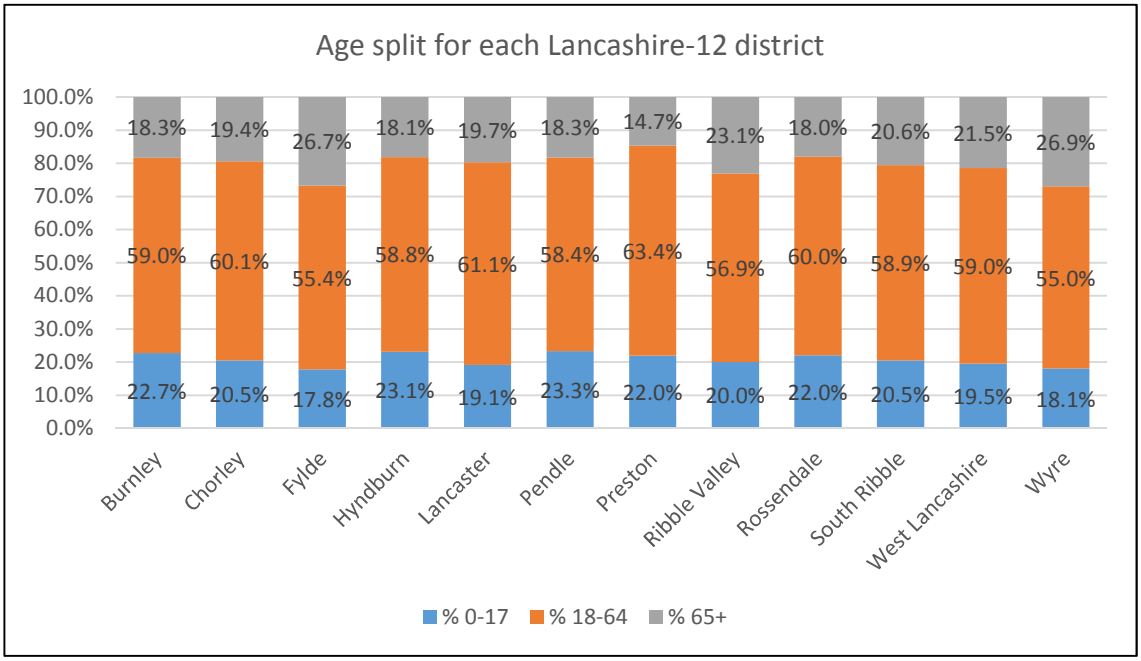
Lancashire population projection by district



Age Profile of Lancashire

	all ages	0-17	18-64	65+		% 0-17	% 18-64	% 65+
Lancashire-12 total	1,195,418	246,552	707,268	241,598		20.6%	59.2%	20.2%
North West	7,223,961	1,533,440	4,368,604	1,321,917		21.2%	60.5%	18.3%
England	55,268,067	11,785,277	33,599,949	9,882,841		21.3%	60.8%	17.9%

Mid-year population information (all ages) estimates there to be 246,552 children (aged under 18), this accounts for 20.6% of the total population in Lancashire-12 area. 59.2% of the total population were of working age (59.2%) and 20.2% of the total population (241,598) were aged 65+.



In comparison with the North West and England percentages, the Lancashire-12 area overall has an extra 2-3% older adults. As mentioned above the demographic structure varies between the districts, this is illustrated by the bar chart (above) which shows that Wyre & Fylde had the highest percentage aged 65+ (26.9% and 26.7% respectively). In contrast, only 14.7% of the Preston district were aged over 65.

Based on the 2016 mid-year population estimates, the Lancashire age profile shows that the gender split remains equal across all age groups until aged 65+, at this point the percentage of females exceeds males. This remains true within the North West and National comparator lines and is presumably due to females having an increased life expectancy.

The age profile also supports the fact that Lancashire has a higher number of people aged 65+ compared to North West and National comparators. It is also evident that Lancashire has a below average 'young adult population' (i.e. age 25-40).

Deprivation

There are some areas of Lancashire which are considered to have severe social and economic deprivation. Deprivation is measured by the indices of deprivation (IMD), which provides detailed results for very small areas. As the table above indicates, there are 7 domains of deprivation, which each contributing to the overall index score.

Of 152 upper tier local authorities the Lancashire-12 area is ranked 87, which puts the county in the middle nationally, (57%) however within this data there are significant variations between the districts. 3 of the 12 Lancashire-12 districts are considered to be within the top 20% most deprived areas in the country. Burnley (ranked 17th), Hyndburn (ranked 28th) and Pendle (ranked 42nd). Conversely, Ribble Valley (ranked 290th is considered within the top 20% of least deprived areas in

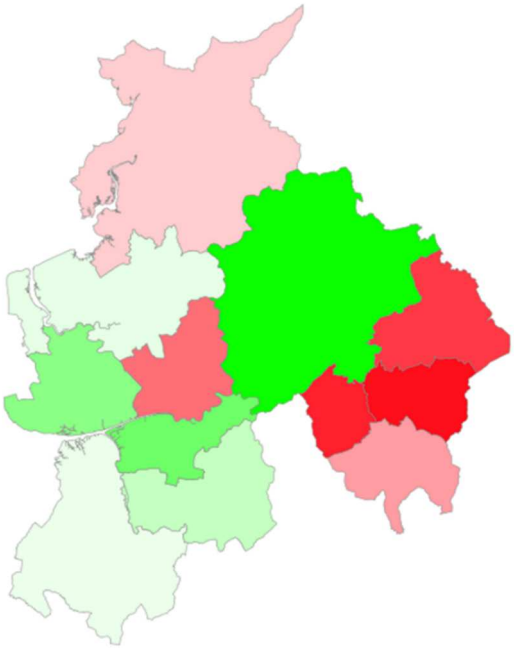
the country). This information is best represented by the district map of Lancashire below, clearly showing the differences between district (red areas show the most deprived and green the least deprived districts).

Based on 2015 information, this is the most recently available data with regards to Deprivation

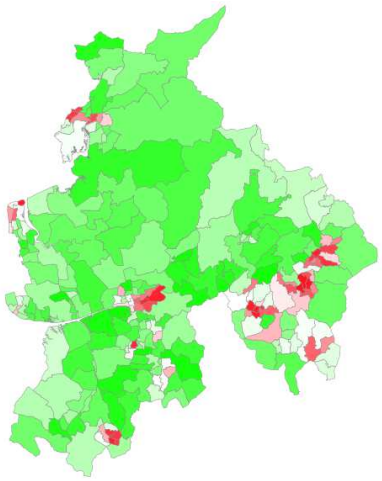
Rank of 326 local authorities

District	IMD rank	IMD Perc	Employment Perc	Health Perc	Income Perc	IDACI Perc	Education Perc	Crime Perc
Burnley	17	5.2	4.0	1.8	10.4	10.7	8.9	7.7
Hyndburn	28	8.6	7.7	2.1	14.7	22.1	18.4	16.3
Pendle	42	12.9	16.6	7.4	17.8	28.8	16.6	27.6
Preston	72	22.1	30.4	7.1	28.2	30.7	37.4	21.8
Rossendale	98	30.1	21.2	13.8	27.6	38.7	50.9	35.0
Lancaster	125	38.3	48.8	19.0	50.0	45.1	73.3	35.3
West Lancashire	164	50.3	39.3	24.8	45.1	52.5	65.0	50.6
Wyre	167	51.2	38.7	23.3	48.2	54.9	62.9	58.9
Chorley	186	57.1	48.2	24.2	60.1	65.3	75.2	51.5
Fylde	218	66.9	46.6	33.4	62.0	76.4	89.3	76.1
South Ribble	234	71.8	59.8	42.0	71.2	73.9	75.8	69.9
Ribble Valley	290	89.0	82.2	66.9	96.6	99.7	96.9	89.6

Source: Lancashire Insight: deprivation dashboard



It is also useful to note that even within the district areas, there is considerable variances within local neighbourhood deprivation, within severe deprivation most noticeable within the urban centres; specifically in East Lancashire. The second map illustrates that there is considerably variation in deprivation even within individual districts.



2.1 What do we know about Adults in Lancashire?

The following information is based on the Adult Health and Social Care profiles, which are available via the NHS Public Health profiles. In addition, reference is also made to data from the LSAB's multi-agency dataset; this information is routinely analysed by the LSAB's Quality Assurance, Audit and Performance sub-group and shared with board on a quarterly basis.

2.1.1 Public Health Profiles

The key indicators illustrated in the Health Profiles table include a key list of health and social indicators. Information can be extracted for the Lancashire Local Authority area and compared regionally, nationally and with previous year's data. The data is RAG rated against the benchmark set by Public Health and an indication of the direction of travel is included which enables comparison for Lancashire compared to the previous time period. It is important to note that the Public Health profiles' information provides data for the Lancashire-12 area, this means that district variations in the data will not be evidenced (it is however possible for each indicator to be broken down to district level if required).

Red = worse, Amber = similar, Green = better
Benchmark RAG – Lancashire compared with the Public Health England benchmark
Direction of Travel – most recent Lancashire data compared with previous
Most recently available data as of June 2017.

Health Profiles **Life expectancy and causes of death**		England	NW	Lancashire			
				Current	Previous	Direction of Travel	Benchmark RAG
1	Life expectancy at birth (males) *2014-16 data*	79.5	78.2	78.7	78.5	Stable	
2	Life expectancy at birth (females) *2014-16 data*	83.1	81.7	82.2	82.1	Stable	
3	Suicide Rate - per 100,000 population *2014-16 data*	9.9	11.0	11.4	11.6	Stable	
5	Under 75 mortality rate: cardiovascular – per 100,000 population *2014-16 data*	74.6	88.5	82.0	85.5	Better	
6	Under 75 mortality rate: cancer – per 100,000 population *2014-16 data*	136.8	151.4	138.3	143.4	Better	
7	Excess Winter Deaths (%) *Aug13-Jul16 data*	17.9	18.0	18.1	18.8	Better	

Data relating to life expectancy at birth for males and females in Lancashire remains stable. Male life expectancy in Lancashire is 78.7 and for females, slightly higher at 82.2. For both males and females, the Lancashire figure exceeds the North West average but lower than the National life expectancy; thus the red RAG benchmark. Interestingly there is significant variation in the life expectancy across the Lancashire districts, for example the life expectancy in Ribble Valley is 81.8, whilst Chorley had a rate of 76.7.

The suicide rate remains stable with a marginal drop in the Lancashire rate (11.4 per 100,000 population, compared with 11.6 previously). Lancashire remain RAG rated red compared to the NHS England rate of 9.9.

In the previous year's Annual Report, the LSAB drew attention to the significant district variation with regards to the suicide rate, highlighting specifically Preston district which had a suicide rate of 16.8 per 100,000 in 2013-15. As the table below illustrates, the suicide rate continues to differ considerably amongst the Lancashire-12 districts. Preston's rate has improved from 16.8 to 13.7, however other areas have seen a noticeable increase. Chorley's rate has seen an increase of 2.6 (increasing from 8.7 in 2013-15 to 11.3 in 2014-16). Hyndburn's suicide rate has also increased, going up to 15.3 per 100,000.

Suicide rate 2014 - 16 — Directly standardised rate - per 100,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	14,277	9.9	9.8	10.1
Lancashire	–	352	11.4	10.2	12.6
Burnley	–	18	8.2	4.9	13.0
Chorley	–	34	11.3	7.8	15.8
Fylde	–	27	12.4	8.1	18.1
Hyndburn	–	32	15.3	10.5	21.6
Lancaster	–	46	12.8	9.3	17.1
Pendle	–	23	10.0	6.4	15.1
Preston	–	50	13.7	10.1	18.2
Ribble Valley	–	18	12.0	7.0	19.1
Rossendale	–	16	8.7	4.9	14.1
South Ribble	–	33	11.7	8.0	16.4
West Lancashire	–	24	7.9	5.0	11.8
Wyre	–	31	11.5	7.7	16.4

Source: Public Health England (based on ONS source data)

District Suicide Rate	2013-15 count	2014-16 count	count diff	2013-15	2014-16	rate diff
England	14429	14277	-152	10.1	9.9	-0.2
Lancashire	357	352	-5	11.6	11.4	-0.2
Burnley	26	18	-8	11.5	8.2	-3.3
Chorley	26	34	8	8.7	11.3	2.6
Fylde	26	27	1	11.7	12.4	0.7
Hyndburn	28	32	4	13.7	15.3	1.6
Lancaster	44	46	2	12.2	12.8	0.6
Pendle	29	23	-6	12.4	10.0	-2.4
Preston	58	50	-8	16.8	13.7	-3.1
Ribble Valley	17	18	1	*	12.0	N/A
Rossendale	21	16	-5	*	8.7	N/A
South Ribble	32	33	1	11.3	11.7	0.4
West Lancashire	25	24	-1	8.7	7.9	-0.8
Wyre	25	31	6	9.2	11.5	2.3

There are many factors which may have contributed to the variations in the district suicide rates. Changes in the suicide rate may be affected by socio-economic factors such as deprivation, poverty, access to healthcare, drug/ alcohol misuse.

LCC Public Health completed a Suicide Audit in 2017/18, this piece of work explored some of the factors contributing to suicide cases in Lancashire over the last 3 years.

Disease and Poor Health	England	NW	Lancashire			
			Current	Previous	Direction of Travel	Benchmark RAG

8	Hospital stays for self-harm - per 100,000 population *2016-17 data*	185.3	231.2	194.7	235.0	Better	
9	Admission episodes for alcohol related conditions - per 100,000 population *2016/17 data*	575	612	645	669	Better	
10	Hip fractures in people aged 65 + - per 100,000 population *2016/17 data*	575	612	583	564	Worse	

Public health information relating to disease and poor health shows that the rate of hospital stays for self-harm and alcohol related conditions has improved within Lancashire. Despite the improvement in both indicators Lancashire remains benchmarked red with regards to hospital stays for self-harm.

Adult Social Care **People with care and support needs**		**England**	**NW**	**Lancashire**			
				Current	**Previous**	**Direction of Travel**	**Benchmark RAG**
11	Dementia: QOF Prevalence % (all ages) *2016/17 data*	0.8	0.8	0.9	0.9	Stable	
12	Prevalence of learning disabilities – proportion % (all ages) *2014-15 data – more recent data not available*	0.44	0.46	0.45	No data		

Prevalence of dementia within Lancashire is 0.9%, this is stable compared to the previous year. Lancashire's rate remains marginally higher than the North West and National average of 0.8%.

Data relating to the prevalence of learning disabilities has not yet been updated. 2014-15 data indicates that 0.45% of the population are diagnosed as having a learning disability. This indicator is all age.

Safeguarding Vulnerable Adults *2015/16 – most recently available data*		**England**	**NW**	**Lancashire**			
				Current	**Previous**	**Direction of Travel**	**Benchmark RAG**
15	Emergency hospital admissions due to falls in people aged 65 or over (per 100,000) *2016-17 data*	2114	2373	1882	1969	Better	
16	Hip fractures in people aged 65 and over (per 100,000) *2016-17 data*	575	612	583	564	Worse	
17	Excess winter deaths index (single year, all ages) ratio - % Aug15-Jul16	15.1	15.3	15.8	13.0	Worse	

18	Statutory Homelessness: rate per 1000 households	2.5	1.3	0.5			

Lancashire's emergency hospital admissions due to falls in people aged 65+ have improved again from 1969 to 1882 per 100,000, this is consistently lower than the National and North West figures. The rate of the population aged 65+ with hip fractures has worsened from 564 in 2016/17 to 583 in 2016/17. This rate is higher than the National figure, but lower than the North West benchmark. Data for excess winter deaths also shows a worsening trend in Lancashire, with the ratio increasing from 13.0 to 15.8, which now exceeds the National and North West figures.

Delayed Transfers of Care

Total delayed transfers of care per 100,000

Indicators regarding delayed transfers of care (ASCOF 2C) were revised in 2017, with new definitions published in December 2017. The table below illustrates the total delayed transfers of care per 100,000 for the last 3 years. The final 3 columns of the table illustrate how Lancashire ranked Nationally (1 best, 151 worst). In 2017/18, Lancashire's total delayed transfer of care rate was 14.8. This is on a par with the previous year, however the ranking in 2017/18 worsened from 104 in the previous year to 120 in 2017/18 – this means that Lancashire fall into the third quartile having previously been in the second. Lancashire is below the North West and National averages.

ASCOF 2C Part 1 (total delayed transfers)	Indicator Scores			Ranking (best=1, worst=151)		
Calculations	2015/16	2016/17	2017/18 (Apr-Mar)	2015/16	2016/17	2017/18 (Apr-Mar)
Minimum value	2.3	2.3	2.6	1	1	1
First quartile	6.6	7.5	6.6	39	39	39
Second quartile	9.1	10.8	9.5	76	76	76
Third quartile	12.7	16.1	14.0	114	114	114
Maximum value	30.3	41.3	33.3	151	151	151
Average value NW	10.3	15.3	13.5	76	87	97
Average value England	10.2	12.8	11.1	76	76	76
Average value comparator gp	13.4	18.0	14.6	105	108	103
Lancashire	12.7	14.9	14.8	113	104	120

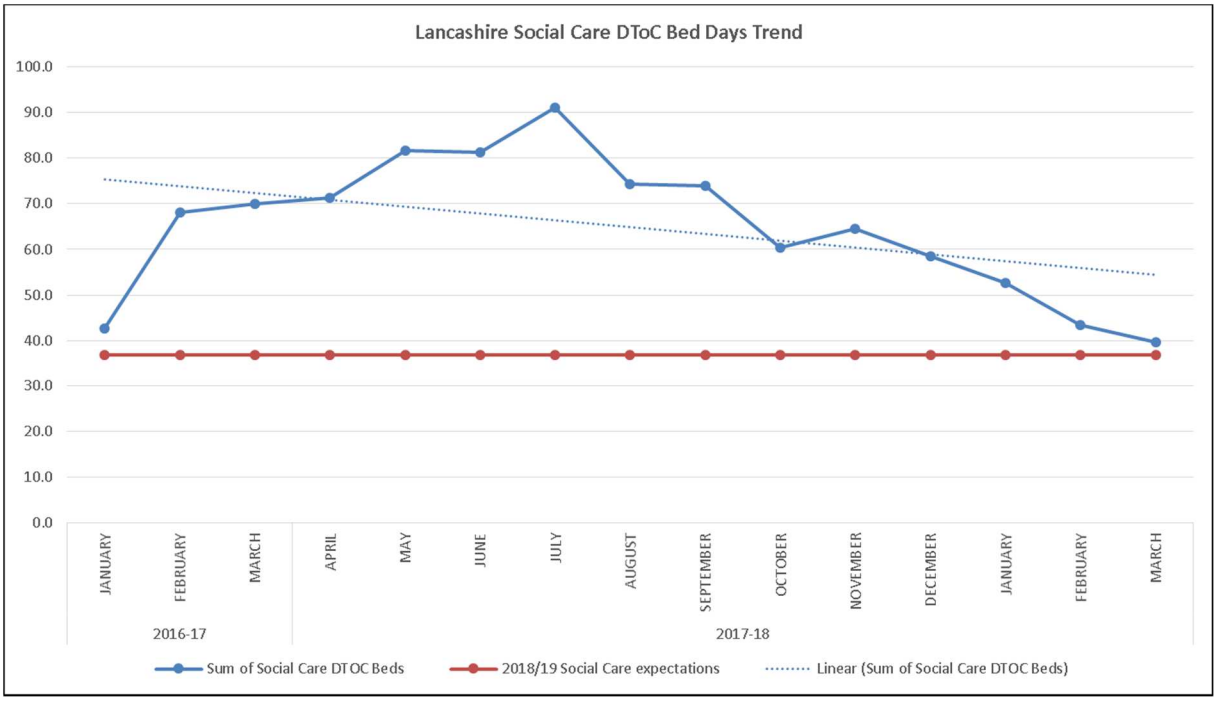
Social Care delayed transfers of care per 100,000

With regards to Social Care specific Delayed Transfers of Care. Lancashire's rate has increased from 4.1 to 6.9 in 2017/18. This has led to the ranking increasing from 86 to 134 as the table below indicates. Lancashire is now in the third quartile and is below the North West and National averages.

ASCOF 2C Part 2 (social care delayed transfers)	Indicator Scores			Ranking (best=1, worst=151)		
Calculations	2015/16	2016/17	2017/18 (Apr-Mar)	2015/16	2016/17	2017/18 (Apr-Mar)

Minimum value	0.0	0.2	0.2	1	1	1
First quartile	1.3	1.9	1.6	39	39	39
Second quartile	2.6	3.2	2.9	76	76	76
Third quartile	4.3	6.0	4.9	114	114	114
Maximum value	12.6	20.4	17.7	151	151	151
Average value NW	3.3	5.8	5.6	71	89	101
Average value England	3.2	4.3	3.7	76	76	76
Average value comparator gp	3.6	6.2	5.7	86	100	102
Lancashire	1.2	4.1	6.9	37	86	134

The Local Authority monitor and interrogate this data on a monthly basis. They also use the above information to determine what the rate means in terms of number of 'bed days' lost in Lancashire. The Local Authority advise that since the middle of 2017/18 the Lancashire Delayed Transfer of Care performance has consistently improved and they are now on track to achieve the national average – this is supported by the graph below, which shows month on month decreases.



ASCS Adult Social Care Outcomes Framework (ASCOF) Scores

The table below provides Lancashire's 2017/18 ASCOF scores. Please note, the whole dataset has not been provided, instead a selection of indicators are included which it is felt clearly relate to safeguarding. At the time that this report was written, comparative data was not available. Therefore Lancashire's scores are compared with 2016/17 benchmark standards).

Performance Indicator	Good is: H/L/C (NB C=Comparative	2013/14	2014/15	2015/16	2016/17	**2017/18**	Direction of travel		Comparative Performance 16/17 (published Oct 17)	
							Lancashire compared with national average	Lancashire compared with previous year	NW Average	England Average
1A: Social care related quality of life (NB this is not a percentage, it is a composite indicator comprising 8 questions and the maximum score is 24)	H	19.1	19.5	19.5	18.8	**19.6**	Better	Improving	**19.0**	**19.1**
1B: The proportion of people who use services who have control over their daily life	H	76.3%	81.4%	77.4%	78.7%	**78.1%**	Better	Declining	**77.4%**	**77.7%**
1Ii: Proportion of service users who report that they have as much social contact as they would like.	H	49.2%	44.9%	47.1%	42.8%	**49.0%**	Better	Improving	**44.5%**	**45.4%**
3A: Overall satisfaction of people who use services with their care and support	H	64.9%	70.3%	68.3%	67.7%	**67.9%**	Better	Improving	**64.9%**	**64.7%**
3D Part 1: The proportion of people who use services and carers who find it easy to find information about services (**service users only**).	H	69.2%	71.8%	70.8%	68.8%	**74.1%**	Better	Improving	**72.6%**	**73.5%**
4A: The proportion of people who use services who feel safe	H	66.4%	72.9%	74.5%	69.6%	**76.1%**	Better	Improving	**70.7%**	**70.1%**
4B: The proportion of people who use services who say that those services have made them feel safe and secure.	H	73.0%	88.9%	88.4%	86.9%	**87.9%**	Better	Improving	**85.8%**	**86.4%**

Local authorities in England with responsibility for providing adult social care services are required to conduct an annual postal survey of their service users. The Personal Social Services Adult Social Care Survey (ASCS) asks questions about quality of life and the impact that the services they receive have on their quality of life. It also collects information about self-reported general health and well-being. Responses are gathered from a range of service users in a range of service settings. Data is also used to populate several measures in the Adult Social Care Outcomes Framework (ASCOF).

The 2017/18 ASCS ASCOF results show improving performance in Lancashire performance for all indicators listed except "1B: The proportion of people who use services who have control over their daily life". This indicator has fallen from 78.7% to 78.1%. Although this is reduction compared to the previous year, Lancashire's figure is above the North West and National comparators (2016/17 benchmark).

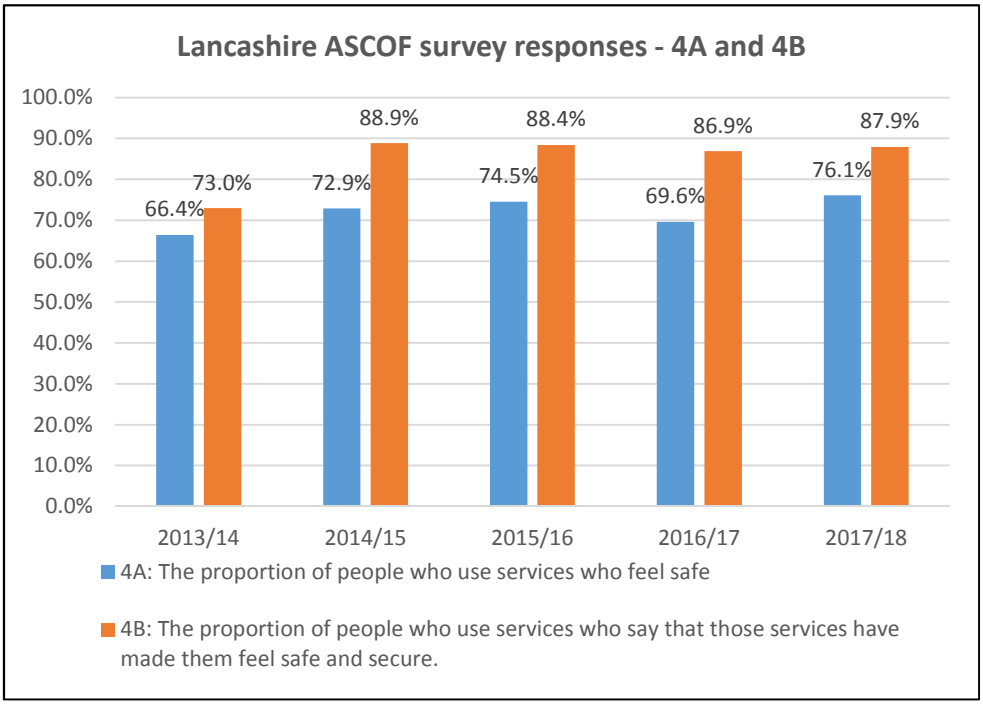
For all indicators listed, Lancashire's performance is better than the North West and National figures (although these are 2016/17 comparators since 2017/18 benchmarked data is not yet available). Lancashire's performance in 2017/18 compared to the previous year has also improved for all indicators (other than 1B).

Indicators 1B and 1Li relate to enhancing the quality of life for people, these are included in the annual report in order to provide some measure of the voice of the service user. Indicator 1B indicates that 78.1% of Lancashire people who use services feel they have control over their daily life. The percentage of people who use services, and reported sufficient social contact is 49.0% in Lancashire, this is an improvement of 6.1% compared to the previous year (2016/17 – 42.9%). This indicator is included as there is said to be a strong link between loneliness, and poor mental and physical health and tackling loneliness and social isolation is a priority for the Government.

Indicator 3A has shown a marginal improvement (67.7% to 67.9%) and is an indication of how satisfied service users are with their care and support. Indicator 3D has improved by 5.3% (68.8% to 74.1%) and implies that improvements have been to how easy it is for service to find information about services.

The indicators highlighted yellow in the table above relate directly to safeguarding. For 4A: 'The proportion of people who use services who feel safe', Lancashire has experienced an increase of 6.3% (from 69.6% to 76.1%). As mention above, this better than the North West and National averages.

For the second indicator involving safeguarding; 4B ' the proportion of people who use service who say that those services have made them feel safe and secure', Lancashire has this year experienced an increase of 1.0% (from 86.9% to 87.9%), again this is above the North West and National averages.



It is clear that an improvement has been seen across most of the indicators listed above, both in terms of Lancashire data and the regional and National benchmarks. In 2016/17 the direction of travel for most of the indicators above was generally worsening. It will be interesting to whether Lancashire compares with regional and National data when the 2017/18 comparator data is released (anticipated to be available October 2018).

2.1.2 LSAB Multi-agency dataset

The following tables of information are extracted from the LSAB's multi-agency dataset; this is updated quarterly and a quarterly performance report is received by the LSAB board, highlighting key fluctuations within the dataset. The dataset is modelled against the Care Act Priorities and work continues to ensure the dataset is more reflective of multi-agency safeguarding and the quality assurance, audit and performance sub-group to the board continue to work hard to source meaningful analysis to help explain the data.

Empowerment and Proportionality

Deprivation of Liberties (DoLS)	2015/16	2016/17	2017/18	Comments
DoLS applications received	4432	4256	3425 Reduced	The number of DoLS applications received has reduced by 19.5% from 3425 in 2016/17 to 3425 in 2017/18.
Number of DoLS applications authorised	397	433	495 Increased	The number of DoLS applications authorised has increased by 14.3% from 433 in 2016/17 to 495 in 2017/18.

The LSAB's quality assurance, audit and performance sub-group regularly report data regarding DoLS (Deprivation of Liberties) to board. The board have been concerned throughout 2017/18 regarding the number of DoLS applications that the Local Authority continue to receive, the lack of a timely response, and the number that the team are able to authorise on a quarterly basis. Nationally almost all local authorities struggle to process the volume of DoLs applications and as result the Association of Directors of Adult Services issued guidance around prioritisation of applications with bandings of Red, Amber and Green. In Lancashire the Local Authority are not able to respond in line with this guidance and process only a proportion of the “red” cases. There is still a lengthy backlog of cases, including significant numbers of high priority work. The LSAB has sought assurance from the Local Authority with regards to the prioritisation method used to handle the large number of cases received. Recently the sub-group have spent some time analysing Lancashire's DoLS data in comparison to data for England, regional neighbour and statistical neighbours.

It is anticipated that regular analysis of the DoLS data will need to continue in light of the high number of cases waiting to be processed by the DoLS team and potential safeguarding implications for the individuals concerned.

Partnership and Accountability

The LSAB Quality and Performance sub-group receives Care Quality Commission (CQC) information on a monthly basis. The information received shows CQC rating for all establishments in Lancashire, with North West and National figures included for comparative measures. Data from last year has been included for comparison and illustrates that the proportion of Lancashire establishments graded 'good' is increasing over time, whilst those that are considered to require improvement or are deemed inadequate is falling. This suggests that quality of health and social care establishments graded by CQC is improving across the county. Although there is an increasing improvement, and Lancashire is comparable with regional and national figures, there remains almost a fifth of establishments where services are rated by CQC as requiring improvement or inadequate and Lancashire would want a significant reduction in this position.

CQC Position as of 01/04/2017 April 2017 Grade	CQC Ratings - All establishments					
	Lancs.	Lancs. %	North West	NW %	England	Eng. %
Outstanding	17	2.3%	96	2.6%	657	2.3%
Good	543	74.2%	2718	74.8%	22332	78.5%
Requires Improvement	160	21.9%	735	20.2%	4975	17.5%
Inadequate	12	1.6%	87	2.4%	484	1.7%
Total	**732**	**100.0%**	**3636**	**100.0%**	**28448**	**100.0%**
CQC Position as of 01/04/2018 **April 2018 Grade**	**CQC Ratings - All establishments**					
	Lancs.	Lancs. %	North West	NW %	England	Eng %
Outstanding	25	3.3%	129	3.4%	941	3.2%
Good	599	80.0%	3031	79.3%	24072	80.8%
Requires Improvement	118	15.8%	584	15.3%	4328	14.5%
Inadequate	7	0.9%	77	2.0%	441	1.5%
Total	**749**	**100.0%**	**3821**	**100.0%**	**29782**	**100.0%**

As of April 2018 there were a total of 749 establishments in Lancashire that had a CQC rating. At this point in time, 25 (3.3%) were outstanding, 599 (80.0%) were good, 118 (15.8%) required improvement and 7 (0.9%) were inadequate. These figures were comparable with North West and National figures.

Prevention

Fire	15/16	16/17	17/18	Comments
Number of accidental dwelling fires	680	617	718 Worse	718 accidental dwelling fires occurred in Lancashire in 2017/18, this is 16.4% higher than in the previous year when there were 617 accidental dwelling fires.
Number of dwelling fires where no smoke alarm fitted	145	127	136 Worse	In 2017/18 there were 136 dwelling fires in Lancashire where no smoke alarm was fitted. This is broadly comparable with last year where there were fewer ADF's and is the same as 2015/16.
Fire deaths in accidental dwelling fires	4	3	5 Worse	There have been 5 fire related deaths in accidental dwelling fires during 2017/18.
Number of completed home fire safety checks	10,979	8,143	9,223 Increase	The number of completed home fire safety checks undertaken by Lancashire Fire & Rescue has increased by 13.3% from 8,143 to 9,223 in 2017/18.

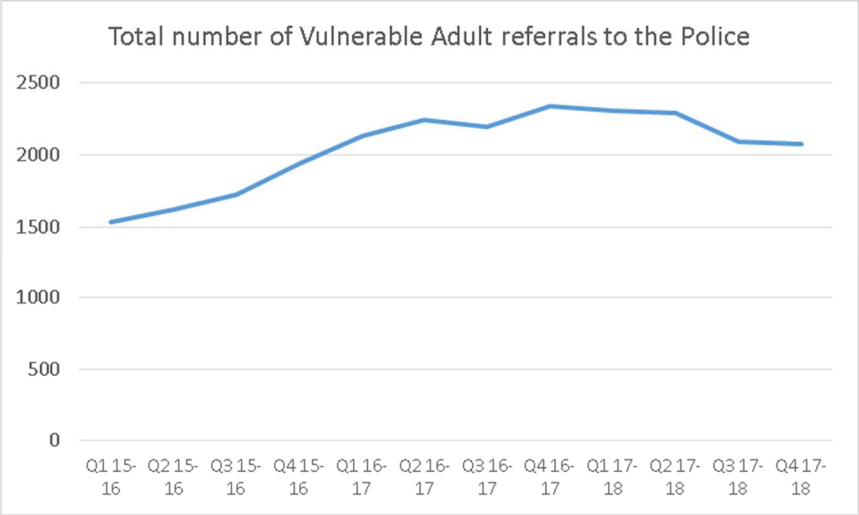
There have been 5 deaths in accidental dwelling fires in 2017/18, whilst this is an increase on the previous year's data, the number of accidental dwelling fires has increased by 16.4%. With regards to the number of completed home fire safety checks, the number conducted in 2017/18 was 9,223, which is a 13.3% higher than the previous year. Lancashire Fire and Rescue service continue to prioritise requests for home fire safety checks based on need and vulnerability.

Safeguarding Adult Reviews (SARs) – these are conducted in response to death or significant harm where abuse and neglect are suspected and multi-agency working has been a concern.									
	2016/17				**2017/18**				
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Comments**
Number of safeguarding adult reviews referred in		4	4	3	2	2	4	4	In 2017/18 the LSAB have received 12 referrals for safeguarding adult reviews. In the previous year, 11 were referred.
Number of safeguarding adult reviews commissioned		1	2	1	1	1	1	1	In 2017/18 the LSAB commissioned 4 safeguarding adult reviews. The same number were commissioned in the previous year.

The quality assurance, audit and performance sub-group receive data from the Safeguarding Adult Review (SAR) sub-group in relation to the number of SAR referrals received and commissioned on a quarterly basis. In addition the key themes and recommendations from SARs are fed through to the quality assurance, audit and performance sub-group in order that we can ensure that the learning from SARs is reflected in the multi-agency dataset and audit priorities.

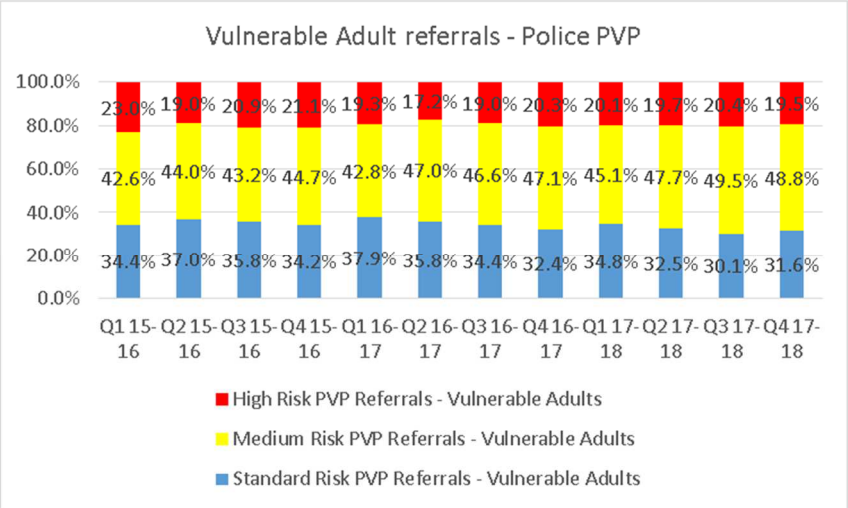
Protection

Police Protecting Vulnerable Person (PVP) referrals	**15/16**	**16/17**	**17/18**	**17/18 diff**	**Comments**
Total PVP referrals – vulnerable adults (VA)	6813	8908	8758	-150 (-1.7%)	The number of PVP referrals for vulnerable adults has reduced by 1.7% from 8908 in 2016/17 to 8758 in 2017/18.
High risk PVP referrals – VA	1429	1688	1746	58 (3.4%)	The number of high risk PVP referrals for vulnerable adults has risen by 3.4% from 1688 referrals in 2016/17 to 1746 in 2017/18.
% High risk PVP referrals - VA	21.0%	18.9%	19.9%	1.0%	In 2017/18 high risk referrals accounted for 19.9% of PVP referrals.
Medium risk PVP referrals – VA	2977	4092	4177	85 (2.1%)	The number of medium risk PVP referrals for vulnerable adults has risen by 2.1% from 4092 in 2016/17 to 4177 in 2017/18.
% Medium risk PVP referrals - VA	43.7%	45.9%	47.7%	1.8%	In 2017/18 medium risk referrals accounted for 47.7% of PVP referrals.
Standard risk PVP referrals – VA	2407	3124	2833	-291 (9.3%)	The number of standard risk PVP referrals for vulnerable adults has risen by 9.3% from 3124 in 2016/17 to 2833 in 2017/18.
% Standard risk PVP referrals - VA	35.3%	35.1%	32.3%	-2.8%	In 2017/18 standard risk referrals accounted for 32.3% of PVP referrals.



Protecting Vulnerable Persons (PVP) referrals are flagged for 'Vulnerable Adults' and are categorised according to risk level (high, medium or standard). The quality assurance, audit and performance sub-group use this data as an indication of the number of Vulnerable Adults which the Police come into contact with.

The data and line graph above illustrate that there are quarterly fluctuations in the number of referrals received by the Police. In the last 12-15 months the number of referrals has plateaued with a slight decrease experienced in quarter 2 of 2017/18.



The bar chart to the left illustrates the risk level associated with the PVP referrals. As indicated by the colours, there is minimal change in the percentage of referrals for each risk level. Broadly speaking, 20% of the PVP referrals received in the quarter are classified as high risk, 50% are medium risk and 30% standard risk.

MARAC	15/16	16/17	17/18	diff	Comments
Total volume of MARAC cases discussed	2179	2140	2401	261 (12.2%)	In 2017/18 there were 2401 MARAC cases discussed. This has reduced by 12.2% compared to the preceding year.
Number of MARAC cases heard that are repeats	635	542	634	92 (16.9%)	Of the 2401MARAC cases heard, 634 were repeat cases.
% MARAC cases heard which are repeats	29.1%	26.2%	26.4%	0.2%	The percentage of MARAC cases heard which are repeats has dropped marginally. In 2017/18 26.4% MARCH cases heard were repeats.

Multi-agency Risk Assessment Conferences (MARAC) take place in respect of high risk domestic abuse cases. Annual data (as above) shows a 12.2% reduction in MARAC cases discussed and a 35.4% reduction in repeat MARAC cases heard. The increase in repeat MARAC cases heard would be expected considering the fact that the total MARAC cases discussed had increased.

Multi-agency Safeguarding Hub referrals (MASH) – the single point of access in Lancashire for all safeguarding concerns across all service areas for adults with care and support needs.					
	16/17	**17/18**	**diff**	**% % diff**	**Comments**
Total MASH referrals received	10761	11341	580	5.4%	In 2017/18, 11341 Adult cases were received by the MASH, this is 5.4% higher than the previous year.

MASH referrals received by source	**16/17**	**17/18**	**diff**	**% diff**	**Comments**
Care Quality Commission	270	231	-39	-14.4%	Of the 11341 referrals received by MASH in 2017/18:- - 44.2% were from social care staff - 27.1% were from health staff - 10.1% were classed as 'other' - 7.8% were from family members Referrals from educations/training/work have increased by 230.8% Self-referrals have increased by 118.8%
Education/training/workplace	13	43	30	230.8%	
Family member	657	889	232	35.3%	
Friend/neighbour	110	146	36	32.7%	
Health staff	2344	3074	730	31.1%	
Housing	123	164	41	33.3%	
Other	1401	1146	-255	-18.2%	
Other Service User	5	7	2	40.0%	
Police	308	457	149	48.4%	
Self-referral	80	175	95	118.8%	
Social Care Staff	5450	5009	-441	-8.1%	

MASH referrals received by abuse type	**16/17**	**17/18**	**diff**	**% diff**	**Comments**
Discriminatory	68	49	-19	-27.9%	In 2017/18, 15011 abuse types were recorded against the MASH referrals received. This figure is higher than the total MASH referrals received since some referrals will have multiple abuse types attributed to them. In comparison with last year, there was an increase of 14.4% in terms of the number of abuse types. The fact that MASH referrals increased by 5.4% implies that a greater proportion of referrals in 2017/18 had multiple abuse types attributed to them.
Domestic Abuse	149	466	317	212.8%	
Emotional/psychological	1795	2751	956	53.3%	
Financial and material	1362	1941	579	42.5%	
Modern slavery	8	22	14	175.0%	
Neglects and acts of omission	4949	5272	323	6.5%	
Organisational	326	151	-175	-53.7%	
Physical	3919	3582	-337	-8.6%	
Self-neglect	107	234	127	118.7%	
Sexual (incl. sexual exploitation)	436	543	107	24.5%	

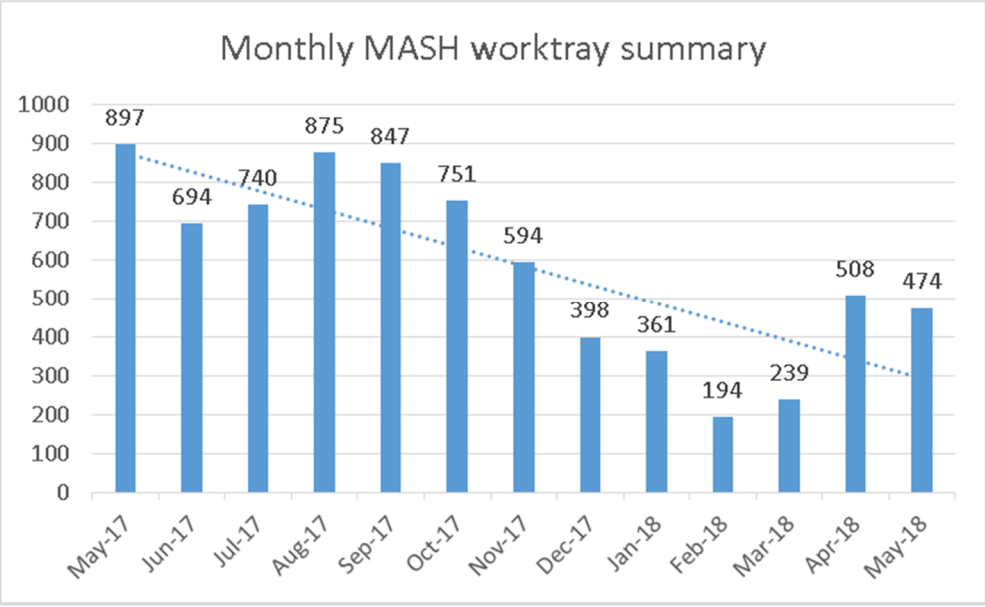
Of the 15011 abuse types recorded by MASH in 2017/18:-
- 35.1% were neglects and acts of omission
- 23.9% were physical abuse
- 18.3% were emotional/psychological abuse
- 12.9% were financial and material abuse

As indicated in the table directly above, 2017/18 has seen an increase in the most abuse types; specifically Domestic Abuse, Modern Slavery and Self-Neglect.

MASH referrals for emotional/psychological abuse have increased by 53.3%, financial and material has increased by 42.5% and MASH referrals for sexual abuse have increased by 24.5%. There has been an 8.6% reduction in MASH referrals for physical abuse and referrals for organisational abuse have more than halved (-53.7%).

MASH Backlog data

In recognition of concerns which were raised last year regarding the length of time taken for a case to be dealt with by MASH, the quality assurance, audit and performance sub-group now receive monthly data detailing the number of cases in the MASH work trays on a set date each month. This information is intended as an indicator of the level of work outstanding within the MASH, it is important to make clear that cases in the 'MASH backlog' will have already been through initial prioritisation in order to ensure that any urgent cases are dealt with in a timely manner. Based also on the fact that high priority cases should be dealt with quickly it is likely that those cases in the work trays are not deemed high priority.



As the graph above shows, there has been a general downward trajectory with regards to the number of cases in the MASH work trays. At the highest point (May 2017), there were 897 cases in the MASH work trays, by February 2018 this had dropped to 194. The sub-group are

currently monitoring the increase which has been since February and will continued to challenge the Local Authority with regards to this information.

Referrals to the Safeguarding Enquiry Team

Referrals to the LCC Adult Care Safeguarding Enquiry Team	15/16	16/17	17/18	diff	% diff	Comments
Number of referrals opened in the reporting period	9842	11481	11006	-1691	-4.1%	In 2017/18, 11006 referrals were opened to the safeguarding enquiry team, this is a decrease of 4.1% compared to the previous year.
Number of repeat referrals opened in the reporting period	No data	2243	3468	1225	54.6%	Of the 11006 referrals opened in 2017/18, 3468 were repeat referrals in the reporting period, which equates to 31.5% of referrals in the year being repeats.
Percentage of all safeguarding enquiries which are repeat referrals	No data	19.5%	31.5%	12.0%		
Individuals for whom a referral was opened in the reporting period	8709	10361	10127	-234	-2.3%	10127 individuals had referrals opened for them in 2017/18, this is a decrease of 2.3% on the previous year. The decrease in the number of individuals is to be expected considering the 4.1% reduction in the referrals opened.
Number of referrals proceeding to an assessment	4027	4632	4322	300	-6.5%	In 2017/18 4322 referrals proceeded to an assessment, this is 6.5% lower than the previous year. There is a correlation between the reduction in the number of referrals opened and the number of proceeding to an assessment, as is demonstrated by the fact that the percentage of referrals proceeding to an assessment remains relatively static at just less than 40% (39.3%).
Percentage of referrals proceeding to an assessment	40.9%	40.3%	39.3%	-1.0%		

Outcome of Safeguarding Enquiries

With regards to the outcome of Safeguarding Enquiries, the following data provides the percentage of safeguarding enquiries resulting in the outcomes listed. 24.7% of safeguarding enquiries resulted in no further action, 22.0% led to increased monitoring and 25.7% had an outcome which is recorded on the system as 'other'. These percentages are very similar to those reported in previous quarters.

The LSAB continue to also receive referral information from the Safeguarding Enquiry Team which breaks down referral information by age, gender, district and referral source. Such

information is provided to the quality assurance, audit and performance sub-group and shared with board as necessary.

Description	Q1 17-18	Q2 17-18	Q3 17-18	Q4 17-18
% Application to change appointee-ship	0.0%	0.1%	0.1%	0.1%
% Application to Court of Protection	0.1%	0.1%	0.1%	0.2%
% Civil Action	0.0%	0.0%	0.0%	0.0%
% Community Care Assessment & Services	12.1%	11.1%	10.9%	7.0%
% Guardianship/Use of Mental Health Act	0.3%	0.2%	0.5%	0.1%
% Increased Monitoring	23.8%	21.4%	22.0%	21.0%
% Management of access to finances	1.2%	1.1%	1.6%	0.9%
% Moved to Increased/Different Care	4.0%	4.3%	4.9%	5.5%
% No Further Action	31.5%	26.6%	24.7%	31.8%
% Other	19.4%	23.9%	25.7%	13.4%
% Referral to advocacy scheme	0.1%	0.3%	0.1%	0.3%
% Referral to Counselling/Training	0.0%	0.2%	0.0%	0.2%
% Referral to MARAC	0.0%	0.2%	0.0%	0.1%
% Restriction/Management of access to alleged perpetrator	1.1%	1.8%	1.7%	0.8%
% Review of Self Directed Support (IB)	0.0%	0.0%	0.0%	0.0%
% Vulnerable Adult removed from property/service	0.6%	0.4%	0.4%	0.5%
% (blank)	5.6%	8.2%	6.9%	18.0%

2.1.3 Summary

The information within this data supplement provides Lancashire's local background and context and specific data relating to the Health and Social Care needs of vulnerable adults within Lancashire. The demographic detail provides context and demonstrates that Lancashire is a diverse county. The Lancashire population is ageing, with population projections indicating that some districts will see a significant shift in their demographic composition over the next few decades. Changes in population composition will have an impact on those statutory organisations which provide Lancashire residents with services. Deprivation is also a key contributory factor to the population's health and wellbeing and this is seen in varying degrees depending on which district of Lancashire is considered.

The Public Health data presented illustrates that Lancashire has challenges compared to the local authorities that we are benchmarked against, with many indicators in relation to life expectancy showing Lancashire to be RAG rated red. However, Lancashire's current position compared to the previous timeframe does generally show that improvements are occurring. It is pleasing that hospital stays for self-harm and due to alcohol have improved. With regards to the ASCOF survey data, it is noted that the proportion of adults who use services and feel safe has decreased and is now below the North West average.

In terms of local data, the LSAB is now in a stronger position to be able to understand the needs of resident in Lancashire who have care and support needs. The sub-group receive regular data and analyse and challenge this in order to ensure that the board are fully cited on current need and potential areas of concern.

2.2 What do we know about Children in Lancashire?

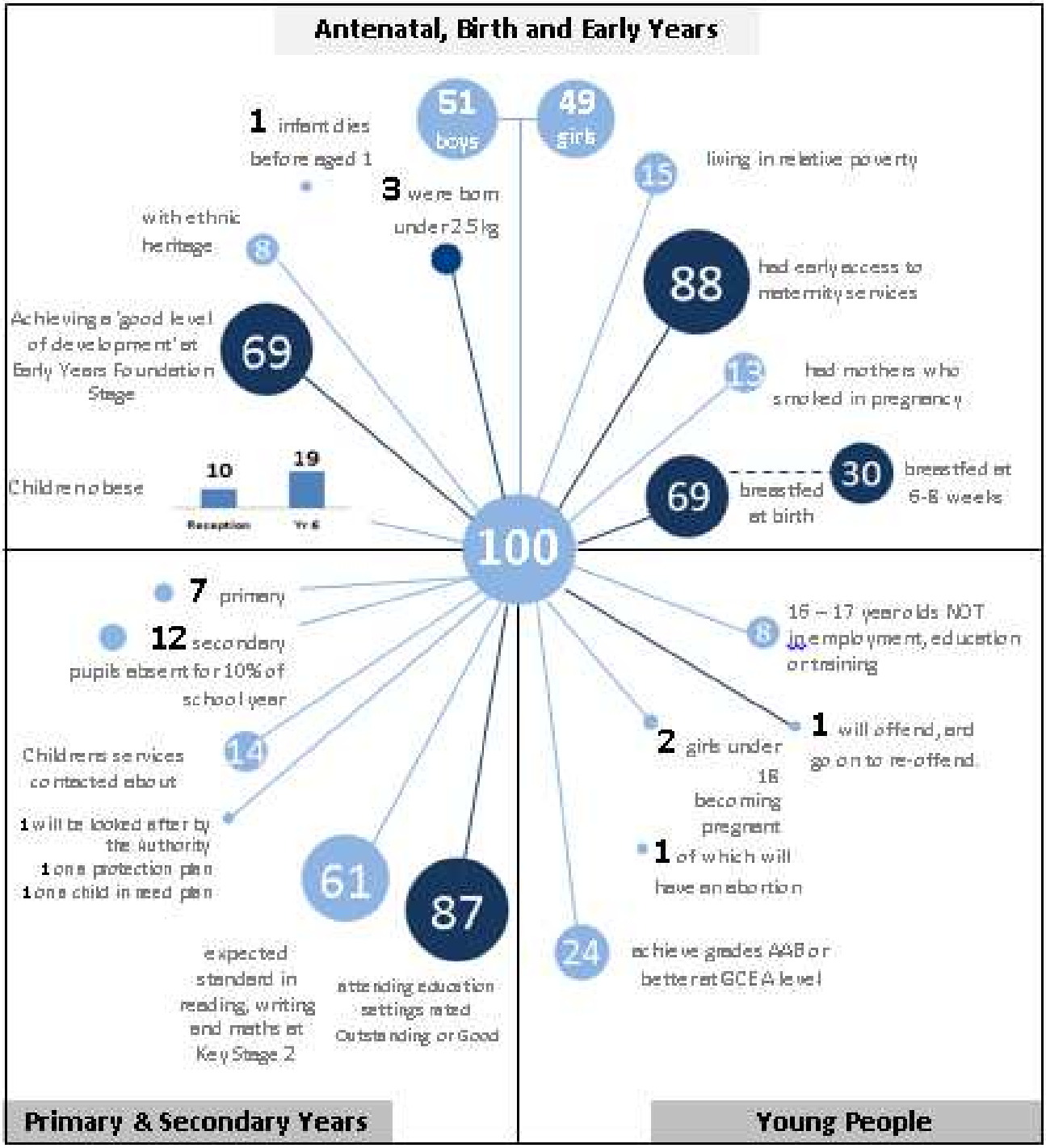
Lancashire has a child population of approximately a quarter of a million (245,516 – 2015 mid-year estimate), this has increased by 0.4% compared to the mid-year estimate for the previous year (245,516 – 2015 mid-year estimate for population aged 0-18). According to the 2016 mid-year estimates 20.6% of the population were children.

The following diagram, provided by LCC Business Intelligence, illustrates the diverse range of needs and demographic factors for children within Lancashire.

If Lancashire were a village of 100 children…

Source: - LCC Business Intelligence, updated April 2018

What do we know about the health and well-being of Children in Lancashire?



The following information is based primarily on the Child Health Profiles (Public Health England) these provide an indication of children's health and wellbeing for each local authority in England; some of these indicators can also be analysed at district level which enables greater local understanding. North West and National benchmark information is also published, which allows for comparisons to be made locally, nationally and over time. Below figures are provided for the Lancashire-12 area, with North West and National comparator data provided also. Data is RAG rated according to the benchmarked information provided by Public Health England, with direction of travel also included which gives an indication of the direction of change compared to the previous time period. As mentioned within the Adult's section of the data supplement above, it is important when considering the information presented to remember that Lancashire is a large area with 12 distinct and diverse districts. Different areas of the county have a different demographic composition and unique local issues to contend with; these should be considered when analysing the child health profiles information for the Lancashire-12 area.

Red = worse, Amber = similar, Green = better
Benchmark RAG – Lancashire compared with the Public Health England benchmark
Direction of Travel – most recent Lancashire data compared with previous
Most recently available data as of June 2018.

Child Health Profiles		England	NW	Lancashire			
				Current	Previous	Direction of Travel	Benchmark RAG
Premature mortality							
1	Infant mortality rate (Rate per 1,000 live births) *2014-2016 data*	3.9	4.5	4.5	4.6	Stable	
2	Child mortality rate (Rate per 100,000 1-17 year olds) *2014-2016 data*	11.6	14.3	16.0	16.8	Better	
Most recently available information in relation to premature mortality is 2014-16 data. Lancashire's Infant Mortality rate is stable; improved by 0.1 from 4.6 to 4.5 per 1000 live births. This matches the North West rate but exceeds the National figure of 3.9 per 1000 live births. Lancashire's Child Mortality Rate has improved from 16.8 to 16.0 per 100,000 of the 1-17 year old population. This improvement is welcomed, though Lancashire is still benchmarked red and a figure of 16.0 for 100,000 is considerably higher than the National and North West figures; 11.6 and 14.3 respectively.							
Wider determinants of ill health							
3	Percentage of children achieving a good level of development at the end of reception	70.7%	67.8	69.4%	69.2%	Stable	
4	Percentage of 16-18 year olds not in education, training or employment (or whose whereabouts are not known) – *new method indicator (2016)*	6.0%	6.6%	8.6%			

5	First Time Entrants to the youth justice system (rate per 100,000 of 10-17 population)	327.1	293.7	228.3	306.0	Better	
6	% of children in low income families (under 16 years)	16.8	16.7	15.6	19.1	Better	
7	Family homelessness (per 1000 households)	1.9	1.0	0.4	0.3	Stable	
8	Children in care (rate per 10,000 of under 18's)	62	86	75	68	Worse	

With regards to the wider determinants of health, the data above indicates that Lancashire is performing better than the benchmark in relation to First Time Entrants to the Youth Justice System and the percentage of children in low income families. The family homelessness rate is stable and remain much lower than the National and North West comparator.

The rate of children in care in Lancashire has worsened, this is supported by local data which shows the children looked after rate continues to increase. Lancashire's rate for children in care remains higher than the National rate but lower than the North West rate.

Health Improvement		**England**	**NW**	**Lancashire**			
				Current	**Previous**	**Direction of Travel**	**Benchmark RAG**
9	Percentage of 4-5 year olds classed as obese	9.6	10.3	9.6	9.3	Worse	
10	Percentage of 10-11 year olds classed as obese	20.0	20.8	18.9	18.9	Stable	
11	Percentage of children (aged 5) with decayed, missing or filled teeth	23.3	33.9	34.0	32.0	Worse	
12	Hospital Admissions due to alcohol specific conditions (rate per 100,000 under 18 year olds)	34.2	49.6	49.8	56.0	Better	
13	Hospital Admissions due to substance misuse (rate per 100,000 15-24 year olds	89.8	131.0	120.3	137.6	Better	

Hospital admissions for children due to alcohol specific conditions has improved for Lancashire compared to the previous year, however the rate per 100,000 still remains much higher than the National figure. Hospital admissions from young people due to substance misuse shows a similar pattern, the Lancashire rate has improved but is still much higher than the National figure.

With regards to the percentage of children in Lancashire considered obese, the percentage of 10-11 year olds considered obese is stable compared to the previous year's data and is also lower than the National and North West percentages; hence Lancashire is benchmarked green.

Dental health is an area which Lancashire score poorly on, the percentage of Lancashire children with decayed, missing or filled teeth has increased and is much higher than the National figure.

Prevalence of ill health							
14	Accident and Emergency attendances for children aged 0-4 (rate per 1000)	601.8	748.3	570.4	564.0	Worse	
15	Hospital admissions caused by unintentional and deliberate injuries in children aged 0-14 years (rate per 10,000)	101.5	136.5	141.6	148.6	Better	
17	Hospital admissions for asthma (under 19 years, rate per 100,000)	202.8	286.4	299.6	342.2	Better	
18	Hospital admissions for mental health conditions (rate per 100,000)	81.5	106.7	108.6	120.6	Better	
19	Hospital admissions as a result of self-harm (10-24 years, rate per 100,000)	404.6	474.0	419.0	549.8	Better	

The rate of Accident and Emergency attendances of children aged 0-4 in Lancashire have increased compared to last year, however in terms of National and North comparisons, Lancashire's rate is considered low.

It is encouraging to note that hospital admissions in terms of unintentional and deliberate injuries, asthma, Mental health conditions and self-harm have all reduced compared to the previous year. Lancashire's benchmark for these indicators shows that there is still a void between Lancashire's figures and the National benchmark. That being said it is positive to see an improvement in the Lancashire data especially since indicators relating to self-harm and mental health were highlighted in last year's Annual Report as areas of challenge for Lancashire.

Despite the improvement evidenced with regards to hospital attendance for self-harm and Mental health, the fact that Lancashire still remains benchmarked red for indicators relating to substance misuse, alcohol, self-harm and mental health implies that there is scope for further attention to be given to these areas.

Source – Public Health England. Child Health Profiles 2018

2.2.1 Safeguarding and supporting children in specific conditions

The information contained within the following table provides annual data for some of the LSCB's key performance indicators relating to supporting children with specific needs/in specific conditions.

Indicator	2015/16	2016/17	2017/18	Comments
Number of Police vulnerable child referrals with a CSE marker	1220	1190	968	The number of vulnerable children referred to the Police with a CSE marker has reduced by 18.7% compared to the previous year. In 2017/18 there were 968 compared with 1190 in 2016/17. The total number of vulnerable child referrals to the Police overall has decreased by 8.3%.

Indicator	2015/16	2016/17	2017/18	Comments
				In 2017/18, 12.5% of the total vulnerable child referrals were flagged for CSE (13.6% in the previous year).
Number of Domestic Violence notifications from Police where a child is recorded to live at the address	8644	10391	10432	In 2017/18 there were 10432 Domestic Violence notifications from the Police where a children was recorded to be living at the address, this is 0.39% higher than the previous year.
The rate of violent and sexual offences against children aged 0-17 per 10,000 of U18 population	160.6	169.7	203.0	The increase in the rate of violent/sexual offences against children has continued. In 2017/18 the rate was 203.0 per 10,000 of the under 18 population, this is an increase of 33.3 compared to the previous year. The rate has almost doubled since 2013/14 (2013/14 rate – 118.1).
Of those cases discussed at MARAC, the number of children in the household	2519	2566	3551	The number of children in the household for MARAC cases discussed has risen by 38.4% from 2566 in 2016/17 to 3551 in 2017/18.
Privately fostered children	26	26	28	The number of Lancashire children identified as privately fostered has remained relatively stable with an increase of 2. Quarterly figures available throughout the year show slight changes in numbers but no definite increasing/decreasing pattern.
CLA placed in Lancashire from other LA (at year end)	986	970	975	There has been a slight increase in the number of looked after children from out of area placed in Lancashire. At 31/03/18 there were 975 out of area children looked after placed in Lancashire. A high proportion of those placed in Lancashire originate from neighbouring local authorities (i.e. Blackburn, Blackpool)
Local Authority Designated Officer Allegations/ Investigations against professionals	496	547	604	There have been 604 LADO Allegations/Investigations in 2017/18, this is a percentage increase of 10.4%
Independent Reviewing Officer Caseloads	92	75	74.6	The IRO caseload average in Lancashire in 2017/18 was 74.6. This is a minimal reduction compared to the previous year's average of 75 cases per IRO.

Children Missing from Home/Care/Education

	2015/16				2017/18			
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Missing from home	411	425	365	362	413	429	394	289
% of children reported missing who were looked after by the local authority	21.8%	20.6%	20.6%	20.8%	23.2%	23.5%	25.1%	30.4%
Approximation of number of looked after children who go missing in the quarter	*90*	*88*	*75*	*76*	*97*	*101*	*99*	*88*
Number of children confirmed as missing from education (not on school roll or receiving alternative provision)	62	64	59	88	95	110	100	58

The number of missing from home episodes has fallen by 2.4%, from 1563 in 2016/17 to 1525 in 2017/18, although this is a reduction; it is less noticeable than the 24.3% reduction reported last year. There is an increasing percentage of looked after children being reported missing, with 30.4% of those missing from home in Q4 of 2017/18 being looked after; in the same period in 2016/17, 20.8% were looked after.

Information from the children missing from education team confirms that there were 363 children missing from education in 2017/18, this is 32.9% higher than the previous year. This increase is in addition to the 22.4% increase reported last year. It is anticipated that some of this increase is attributable to improved recording of children missing from education, which had led to more accurate reporting.

Referrals to Children's Social Care

Referrals to Children's Social Care refers to the number of referrals which are accepted by Children's Social Care. In 2017/18, the number of referrals accepted by Children's Social Care increased by 4.3% from 9907 in 2016/17 to 10337 in 2017/18. This translates to a rate of 419.4 per 10,000 of the child population in Lancashire.

	2013/14	**2014/15**	**2015/16**	**2016/17**	**2017/18**
Lancashire (number)	19460	12394	12156	9907	10337
Lancashire (rate per 10,000 child population)	799.2	506.4	495.1	412.5	419.4

Data for the last 3 years indicates that referrals to Children's Social Care have been on a downward trajectory, however there are monthly fluctuations and variations between districts in numbers and rate. Burnley district consistently has the highest rate of referrals to Children's Social Care.

Repeat Referrals

The table below shows the percentage of referrals that were repeat referrals to Children's Social Care. A repeat referral is defined as a referral which is received within 12 months of the initial referral. The repeat referral rate in 2017/18 is 19.0% which is 0.1% lower than the previous year.

	2013/14	2014/15	2015/16	2016/17	2017/18
% Re-referrals	15.1%	15.7%	15.7%	19.1%	19.0%

Monthly data for this indicator shows the percentage of repeat referrals on a very slight upwards trajectory through 2016/17, with monthly variations evident. The fact that the rate of repeat referrals has not increased by the same percentage as the overall increase in referrals to Children's Social Care over the last 12 months may imply that Children's Social Care's referrals are more likely to be new cases (i.e. those which haven't been referred in the previous 12 months).

Percentage of assessments completed to timescale

	2013/14	2014/15	2015/16	2016/17	2017/18
Lancashire	96.1%	79.8%	73.2%	75.0%	75.0%
North West	85.1%	82.2%	83.3%	80.9%	Published Nov 18
England	82.2%	81.5%	83.4%	82.9%	Published Nov 18

75.0% of Lancashire's single assessments were completed within timescales (45 working day target); this indicator has remained static. Based on last year's North West and National averages for 2016/17, Lancashire's percentage of assessments completed to timescale remain consistently below the regional and national figures.

Children in Need (per 10,000 of the child population)

	2013/14	2014/15	2015/16	2016/17	2017/18
Lancashire (number)	9,034	8,534	9,316	8,377	Published Nov 18
Lancashire (rate per 10K)	371.5	348.7	380.1	342.3	Published Nov 18
England	346.4	337.3	337.7	330.4	Published Nov 18

The Lancashire number of Children in Need for 2017/18 has not yet been published. Last year's Lancashire rate was 342.3 per 10,000, this is higher than the National rate for 2016/17. As the above data indicates, Lancashire's Children in Need rate is consistently higher than the National rate.

Children subject to a Child Protection Plan (per 10,000 of the child population)

Children subject to a Child Protection Plan								
Area	**2010/11**	**2011/12**	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**
Lancashire rate	27	23	36	44.4	38.9	59.0	57.0	50.4
England Rate	39	38	38	40	42.1	42.9	43.3	Published Nov 18

In 2017/18, the rate of children subject to a Child Protection Plan was 50.4, this rate has decreased by 6.6 compared to the previous year (2016/17 Lancashire rate was 57.0). The Lancashire rate is

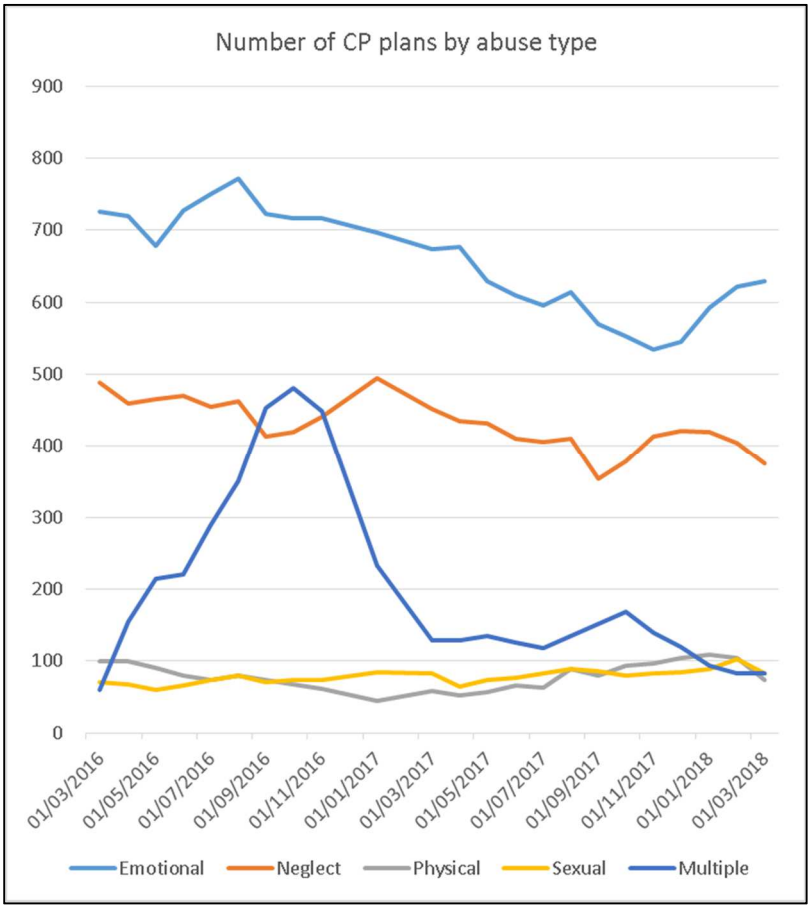
above the 2016/17 National rate, as has been the case since 2015/16. Monthly data for Lancashire's child protection plan rate has been decreasing over the last 18 months.

The reason for a child being subject to a Child Protection Plan is categorised by need and recorded under the following headings: Neglect; Physical Abuse, Sexual Abuse, Emotional Abuse or Multiple Categories. Data to explore this further is included below.

Child Protection Plans by Abuse Type

Lancashire Percentage	Neglect	Physical Abuse	Sexual Abuse	Emotional Abuse	Multiple Categories
2014	40%	11.9%	4.1%	34.6%	9.3%
2015	34%	6.1%	2.5%	48.8%	8.8%
2016	33.8%	6.9%	4.9%	50.3%	4.1%
2017	32.4%	4.2%	6.0%	48.3%	9.3%
2018	30.2%	5.9%	6.7%	50.6%	6.7%

Most recently available data (March 2018) is presented in the table above. In the graph below, there is the monthly breakdown for the previous 2 years which shows fluctuating percentages for each of the abuse types. It is of note that Emotional Abuse is consistently the most prominent, however in 2014, Neglect was the most widespread abuse type with 40% of child protection plans occurring for this reason.



With regards to the monthly data for the last 2 years, emotional abuse remains the most prominent, closely followed by neglect. Physical abuse, sexual abuse and those child protection plans which have multiple abuse types attributed account for 6-7% of the total.

The option of 'multiple abuse types', inevitably means that the data does not give us a full picture of the prominence for each abuse type. It would be interesting to investigate whether there are any specific abuse types which are commonly grouped together under the heading of multiple. This is something which the Intra-familial Sexual Abuse task and finish group have been interested in, with regards to trying to ascertain meaningful data in respect of intra-familial sexual abuse within Lancashire. This group reported back to

the LSCB board during 2017 and the task and finish group has recently been reconvened to consider this subject and investigate further the recording issues surrounding intra-familial sexual abuse.

Child Protection Plans Lasting Two Years or More

This measure highlights the complexity of Child Protection cases held by the Local Authority and provides an indication of whether children or young people and their families are receiving the services they need in order to make required changes in a timely fashion. This measure is of interest to the LSCB because if a child is deemed to require support via a Child Protection Plan for an extended period of time, this may indicate a lack of targeted and effective support and may imply drift within cases. In 2017/18, 4.9% of the Child Protection Plans were lasting 2 years or more, this has increased from 2.9% in 2016/17. Lancashire's most recent rate for this indicator is above the previous year National figure of 3.4%.

Area	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Lancashire rate	4.8%	4.4%	2.4%	1.2%	3.0%	3.7%	2.9%	4.9%
England Rate	6.0%	6.0%	5.2%	3.5%	2.6%	3.7%	3.4%	Published Nov 18

Children Looked After (CLA)

At 2017/18 year end Lancashire had responsibility for 1968 Lancashire looked after children, this equates to a rate of 79.7 per 10,000. This is a 5.6% increase in the number of looked after children compared to the previous year. (2016/17 – 1864 Lancashire looked after children). Assuming that the regional and national averages don't alter drastically from previous years (current benchmarks not yet available), Lancashire's CLA rate looks to remain above the national average and below the North West average.

Rate of CLA	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Lancashire rate	53	54	60.9	66.3	67.2	69.1	75.9	79.7
North West Rate	77	76	79	78	81	82	86	Published Nov 18
England Rate	59	59	60	60	60	60	62	Published Nov 18

In addition, there are almost 1000 looked after children from other local authorities placed in Lancashire, residing in Private/Independent Children's Homes or with foster carers; 975 looked after children from out of area placed in Lancashire at 2017/18 year end, many of whom originate from neighbouring local authorities (including the unitary areas of Blackpool and Blackburn with Darwen).

Social Worker Caseloads

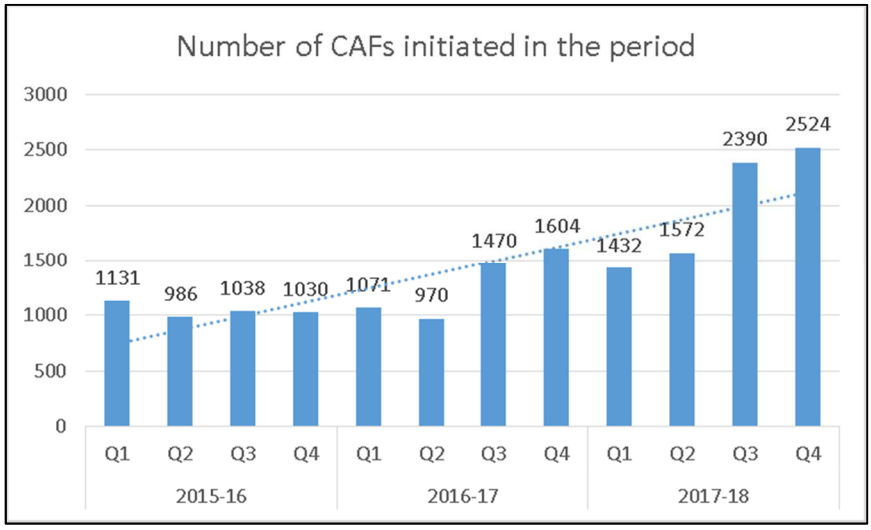
The following table shows the average social worker caseloads within Children's Social Care by month and level of social worker experience. The colour coding is provided for the Ofsted Improvement Board in order to indicate whether the caseload level meets the internally set acceptable caseload level for each experience band.

Whilst the table indicates that caseloads have continued to increase across all level of experience, it is generally accepted that these levels are below those of neighbouring local authorities.

Experience	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
NQSW	17.8	20.3	19.5	19.7	19.3	19.1	19.5	19.5	19.3	20.3	20.9	20.8
1-2 years	19.1	20.9	20.8	21.4	21.1	19.8	21.5	22.2	23.6	22.9	23.5	24.6
2-3 years	20.6	20	20.1	19.9	21.1	21	22.7	21.4	22.7	22.5	22.5	23.6
3-5 years	20.1	20.2	20	21.4	20.8	20.1	22.1	23.1	19.5	22.1	18.2	17.9
5 years +	23.1	22.7	22.5	21.4	21.2	21.8	26.3	24.4	23.1	24.2	20.2	24.5
Grand Total	**19.1**	**20.6**	**20.2**	**20.5**	**20.3**	**19.8**	**21.1**	21.1	21.7	21.9	21.6	22.5

Early Help

Early Help	2016/17				2017/18			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Number of CAFs initiated in the period	1071	970	1470	1604	1432	1572	2390	2524
Number of CAFs open (including SEN) at period end	8510	8041	9253	9285	9234	9360	5720	6097
% of CAFs closed in period due to 'needs met'	57%	64%	60%	64%	62%	66%	71%	62%
% of CAFs closed in period due to escalation to statutory assessment	18%	16%	11%	12%	14%	14%	11%	11%
CAFs closed due to non-engagement				11%	12%	14%	13%	21%

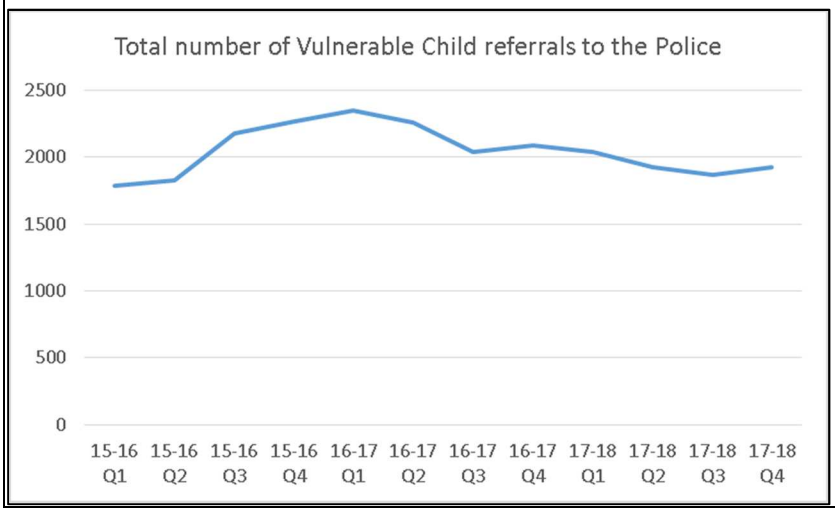


The Common Assessment Framework (CAF) is an assessment and early help framework for children and families in need of help. During 2017/18 a total of 7,918 CAF assessments were initiated, this is an increase of 54.8% on the previous year when 5,115 CAFs were initiated. This increase has been attributed to the promotional activity which the Children and Family Wellbeing service have undertaken (including ensuring agencies know about the services they can offer). The Children and Family wellbeing service continued to encourage the use of CAF, and every case open to them has to have a CAF (or CSC assessment). Additionally, district teams have been promoting the use of CAF.

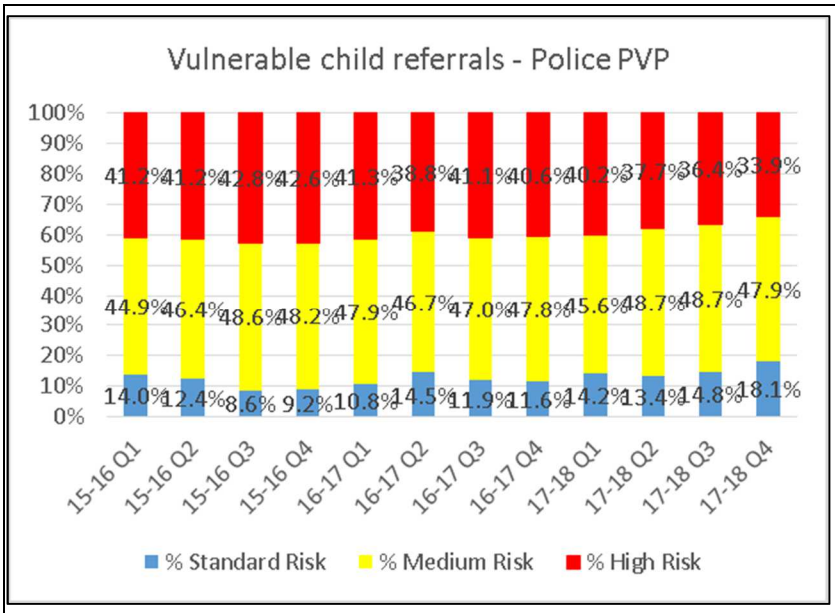
The number of CAFs open at the end of each quarter (including SEN) in 2017/18 peaked at 9360 in quarter 2, but then dropped in quarter 3 to 5720. At the end of 2017/18 (i.e. quarter 4), there were 6097 CAFs open. The reduction in the number of open CAFs has occurred as a result of the Children and Family Wellbeing service implementing a new archiving system. CAFs that have been 'open' for more than 2 years but with no interaction with the database have been archived. This means that the number of CAFs open now is a more accurate reflection of ongoing current CAF numbers.

Police Data – Protecting Vulnerable Persons - Child (PVP - VC) referrals

	15/16	16/17	17/18	diff	Comments
Total PVP referrals – vulnerable children (VC)	8067	8738	7749	- 989	The number of PVP referrals for vulnerable children has decreased by 11.3% from 8738 in 2016/17 to 7749 in 2017/18.
High risk PVP referrals – VC	3391	3535	2877	- 658 *(-18.6%)*	The number of high risk PVP referrals for vulnerable children has fallen by 18.6% from 3535 in 2016/17 to 2877 in 2017/18.
% VC PVP referrals flagged as high risk	42.0%	40.5%	37.1%	-3.4%	In 2017/18 high risk referrals accounted for 37.1% of all PVP referrals for vulnerable children.
Medium risk PVP referrals – VC	3804	4139	3695	-444 *(-10.7%)*	The number of medium risk PVP referrals for vulnerable children has fallen by 10.7% from 4139 in 2016/17 to 3695 in 2017/18.
% VC PVP referrals flagged as medium risk	47.2%	47.4%	47.7%	0.3%	In 2017/18 medium risk referrals accounted for 47.7% of all PVP referrals for vulnerable children.
Standard risk PVP referrals – VC	872	1064	1173	10.2%	The number of standard risk PVP referrals for vulnerable children has risen by 10.2% from 1064 in 2016/17 to 1173 in 2017/18.
% VC PVP referrals flagged as standard risk	10.8%	12.2%	15.1%	(2.9%)	In 2017/18 standard risk referrals accounted for 15.1% of all PVP referrals for vulnerable children.



As is demonstrated by the line chart to the side, there are quarterly fluctuations in the total number of vulnerable children referrals received by the Police, since Q1 2016/17, the number of referrals has been declining.



This second graph indicates the split in terms of risk level for those PVP referrals received over the last 12 quarters (3 years). Although the proportions for each risk level are relatively static, there does seem to be a marginal increase in those considered standard risk and a comparable decrease in those classified as high.

2.2.2 Summary

The figures reported above demonstrate the extent to which children in Lancashire are in need of support and protection. The data needs to be considered alongside the demographic overview analysed above, especially with regards to issues such as deprivation and population composition. Lancashire agencies face a constant challenge to ensure that they are able to provide services which meet the needs of children and young people in need of help and support.

The quality and performance sub-group will continue to have oversight of multi-agency performance indicators, reporting these to board on a regular basis in order to ensure that the LSCB is fully cited on current need and provision of support in Lancashire overall and within each specific district.

3. What do we know about services in Lancashire and their effectiveness?

3.1 Member agencies

The Boards request submission of information about the quality of safeguarding in its member agencies either via external inspection activity or through direct annual feedback. The feedback reports embedded below have been presented to the Board to reflect the work undertaken by the agencies during 2017/18.

Lancashire County Council provides support for vulnerable adults, children and their families through direct services from: Adults Social Care; Adults Disability Service; Domiciliary Care; Older People Services (residential and day care); Public Health services; Children's Social Care; Children and Family Wellbeing Service; Schools and specific support for children involved in the criminal justice system via the Youth Offending Team (YOT).

The Local Authority has strong representation on LSAB and LSCB and its sub groups, with regular attendance. Three of the LSAB sub groups are chaired by LCC Board members: Practice with Providers; Safeguarding Adults Leadership Group; Policies and Procedures.

2017/18 Feedback Reports:	Adults Safeguarding LCC - Adults Safeguarding.pdf	Children's Services LCC - Childrens Services.pdf	Children and Family Wellbeing Service CFWS.docx

Lancashire Constabulary covers the former county area which includes Lancashire County Council, Blackburn with Darwen and Blackpool, delivering its services through three divisions (East, West and South). It provides direct policing across the county and is fully engaged in partnership safeguarding services as part of the Child Sexual Exploitation teams, Multi-agency Safeguarding Hub, Multi-Agency Risk Assessment Conferences and Multi-agency Public Protection Arrangements. Increasingly the force has been moving its focus towards early action and preventative policing.

Lancashire Constabulary is represented on the LSAB and LSCB and its sub groups, with a representative chairing the Lancashire CSE Operational Group during 2017/18.

2017/18 Feedback Report:	Lan Con.docx

Six **Clinical Commissioning Groups** (CCGs) operate across Lancashire and are responsible for commissioning most hospital and community healthcare services. From April 2015 co-commissioning arrangements were brought in which involves CCGs in the commissioning of primary care services. The 6 CCGs in Lancashire are:

- Fylde and Wyre CCG
- Chorley and South Ribble CCG
- Morecambe Bay CCG
- Greater Preston CCG
- East Lancashire GGG
- West Lancashire CCG

All CCGs are well represented on both Boards, attending regularly. A number of our sub groups are Chaired by CCG representatives: LSAB/LSCB Learning and Development Groups; Safeguarding Adult Review (SAR)/ Serious Case Review (SCR) Groups; and Mental Capacity Act (MCA) Implementation Sub Group.

2017/18 Feedback Report:	CCGs collective.docx

Seven **NHS Hospital Trusts** provide a range of community and acute services for children and vulnerable adults. The NHS provider trusts that serve the Lancashire area as follows:

- Blackpool Teaching Hospitals NHS Foundation Trust
- East Lancashire Hospital Trust
- Lancashire Care NHS Foundation Trust
- Lancashire Teaching Hospitals Foundation Trust
- Mersey Care NHS Foundation Trust
- Southport and Ormskirk Hospital Trust
- University Hospital Morecambe Bay NHS Foundation Trust

Lancashire Care Foundation Trust provides inpatient Mental Health; Community Mental Health Services, and Adult and Child Health and Wellbeing Community Services.

With the exception of Mersey Care, all Trusts are represented on the LSCB and attend on a regular basis. The representative for East Lancashire Hospital Trust is the Chair of the LSCB QAPI Sub Group. East Lancashire Teaching Hospitals, Lancashire Care Foundation Trust; Lancashire Teaching Hospitals; Mersey Care, and University Hospital of Morecambe Bay are all represented on the LSAB.

2017/18 Feedback Reports:			
Blackpool Teaching Hospital BTH.docx	East Lancs Teaching Hospital ELHT.docx	Lancs Care Foundation Trust LCFT.docx	
Lancs Teaching Hospital LTHT.docx	Mersey Care Foundation Trust Mersey Care Whalley.docx	Southport and Ormskirk Hospital SOHT.docx	University Hospital of Morecambe Bay UHMBT.docx

NHS England: NHS England leads the National Health Service (NHS) in England, setting the priorities and direction of the NHS, encouraging and informing the national debate to improve health and care. NHS England North is one of five regional teams that support the commissioning of high quality services and directly commission primary care and specialised services. The North regional team covers Yorkshire and The Humber, the North-West and the North-East of England. NHS England North is represented on both Boards and actively engages with our workstreams

2017/18 Feedback Report:	NHSE.docx

Lancashire Probation Trust (now: HM Prison and Probation Service) – The specific duties of the National Probation Service (NPS) are: to provide advice to Courts and deliver pre-sentence assessments; management of all high risk of serious harm offenders; management of all offenders sentenced to 12 months or more for a serious sexual or violent offence; and the management of all offenders who are subject to statutory supervision and are registered sex offenders.

Public protection, including safeguarding children and vulnerable adults is a key priority and thorough and robust safeguarding arrangements are in place. The service work closely with other agencies and make necessary checks and referrals at pre-sentence stage and throughout our period of contact. In Lancashire the service currently supervises around 3,440 cases, predominantly violent and sexual offenders with a high number of domestic violent offenders.

The Probation service is represented on both the LSAB and LSCB, attending regularly and engaging in work of the sub groups and task and finish approaches.

2017/18 Feedback Report:	Probation.docx

Cumbria and Lancashire Community Rehabilitation Company (CLCRC) delivers offender management and rehabilitation services to offenders assessed as presenting a low and medium risk of serious harm. These could be serving community sentences or be sentenced to custody in which case CLCRC will be involved in their rehabilitation both inside prison and in supervising the post release licence. CLCRC delivers a range of programmes to help rehabilitate offenders by providing access to learning new skills, changing and challenging offenders thought processes and managing risky behaviour. In particular, and central to safeguarding, CLCRC delivers 2 specific domestic abuse programmes in addition to modules to address emotional resilience, conflict resolution and stress resilience.

CLCRC is represented on both the LSAB and LSCB with regular attendance and engagement with various workstreams.

2017/18 Feedback Report:	CRC.docx

Children and Family Court Advisory and Support Service (Cafcass) is a non-departmental public body sponsored by the Ministry of Justice. The role of Cafcass within the family courts is: to safeguard and promote the welfare of children; provide advice to the court; make provision for children to be represented; and provide information and support to children and families.

Cafcass is represented on the LSCB, attending on a regular basis.

2017/18 Feedback Report:	CAFCASS.docx

The Children's Society is a charity organisation which provides support and services for 10 to 18 year olds who are especially vulnerable and often experiencing severe and multiple disadvantage. The charity is represented on the LSCB, providing a voice and perspective for the Voluntary Sector.

2017/18 Feedback Report:	 TCS.docx

Lancashire Fire and Rescue Service (LFRS) delivers Prevention, Protection and Response functions across the county of Lancashire, employing staff in a variety of roles operating from 39 operational bases. The service works extensively with partner organisations to allow for a more efficient and effective delivery in order to keep the residents of Lancashire safe.

LFRS joined the membership of both Boards during the reporting year, attending regularly and engaging with various pieces of work.

2017/18 Feedback Report:	 LFRS.docx

There are 12 **District Councils** providing services across the county. All 12 have a nominated safeguarding lead and ensure staff are appropriately trained in respect of safeguarding issues.

Engagement with the Districts has improved further over the reporting year. The Business Manager and Business Coordinators attend meetings of the District Safeguarding Leads (DSLs), and in October 2017, the LSCB facilitated a safeguarding awareness and section 11 feedback session with the DSLs. The aim of the event was to provide district councils with an overview of the Boards; discuss the communication and connections between the Boards and the District Councils; share information regarding case review processes and learning from recent reviews; and provide feedback on the Section 11 returns with an opportunity for review and reflection. All but one of the 12 districts were in attendance at the event, and some positive actions were agreed in order to support district councils in their safeguarding responsibilities.

The actions formed part of a 90 day action plan around the themes below. We're happy to report that good progress has been made in each area and we will continue to make improvements in communication and engagements with the 12 districts.

- Improvements to District Council Section 11 submissions
- Improved understanding of District Council's safeguarding responsibilities
- Improved Engagement and Communication between District Councils and the Safeguarding Boards (Children's and Adult's)
- Improved Engagement and Communication between District Councils and Statutory agencies

The District Councils have historically been represented by one Chief Executive on the LSCB, and has more recently been added to the membership of the LSAB. The current representative is the Chief Executive for Wyre Council, who provides feedback to the other Districts via the Chief Executives Group, and Chairs the Pan-Lancashire Communication & Engagement Sub Group.

Three District Councils have shared their achievements and challenges from the reporting year.

	Wyre Council	South Ribble Borough Council	Pendle Borough Council
2017/18 Feedback Report:	Wyre Council.docx	South Ribble BC.docx	Pendle BC.docx

Schools – There are over 600 mainstream schools (including 29 special schools and 9 short stay schools) of which currently only 11 have been judged to be inadequate as at March 2018. There are also a significant number of schools and organisations providing education outside the public sector. The LSCB is notified if a school is judge to be inadequate in respect of safeguarding when inspected by Ofsted and liaises with the local authority to ensure appropriate steps are taken. Data provided by Ofsted suggests 92.7% of Primary Schools and 75% of Secondary Schools were rated as Good or Outstanding as at March 2018.

Education providers are represented on the LSCB via a Primary School Head teacher; Secondary School Head teacher; Lancashire Association of School Governors; and a representative from Further Education.

During 2017/18, the LSCB commissioned a piece of work in order to improve the interface between schools and multi-agency partners. The project is making good progress which is detailed under section 5.4.2

Healthwatch Lancashire is the public voice for health and social care in Lancashire and exists to make services work for the people who use them.

The Chief Executive represents the organisation on the LSAB.

Lancashire Police and Crime Commissioner (PCC) is responsible for the provision of services for victims of crime (Lancashire Victim Services) and also acts as the lead commissioner for support services for victims of domestic abuse. The support for victims of crime includes a dedicated service offering support to children and young people, delivered under the NEST Lancashire brand, which includes supporting those affected by domestic abuse, sexual abuse and sexual exploitation.

Lancashire Care Association (LCA) is a not-for-profit company representing independent care sector providers (private and third sector; larger groups and small independents; adults and older people care homes and domiciliary care.) LCA supports providers in ensuring the provision of safe

services; quality, performance and inspection monitoring; and partnership working through the Health and Social Care Partnership.

The LCA is represented on the LSAB and a number of its sub groups and task and finish groups to offer a 'provider' voice in safeguarding arrangements.

2017/18 Feedback Report:	LCA.docx

North West Ambulance Service (NWAS) provides 24 hour, 365 days a year accident and emergency services to those in need of emergency medical treatment and transport in Cumbria and Lancashire; Cheshire and Merseyside; and Greater Manchester. Employing over 4,900 staff across the North West region, the service provides emergency response; transport for patients attending hospital appointments; and deals with major incidents. NWAS also delivers the NHS 111 service in the North West.

NWAS are currently compiling an annual report for thee geographical footprint which will be shared with the 46 LSABs and LSCBs in the area on completion.

Private/Independent Sector Providers – There is a wide range of community support services available across Lancashire, including drug and alcohol services, sexual health services and domestic abuse services.

Housing providers – the area is supported by a wide range of private providers, Registered Social Landlords (RSLs), hospices and hostels, sheltered housing provision and local authority housing provide accommodation across the County. Progress Housing represent the sector on the LSAB.

2017/18 Feedback Report:	Progress Housing.pdf

There are over **100 children's homes** in the County with a high percentage of private providers. Many of the children placed are out of area placements. The LSCB receives notification of any provider that is judged to be inadequate by Ofsted with regard to safeguarding.

660 **child minders** provide day care across the County along with, 342 **day nurseries** and **124 pre-school play groups**. As at March 2018, there were 2 Child Minders to have been judged inadequate.

The Board itself exercises challenge and scrutiny of agencies using a number of mechanisms for assessing the quality of local services and agencies commitment to safeguarding. These include:

3.2 Section 11 Audit Process:

Section 11 of the Children Act 2004 sets out agencies responsibilities in respect of safeguarding children and the LSCB conducts an annual audit of all member agencies safeguarding arrangements. The section 11 audit tool has been updated in recent years to encourage agencies to consider their safeguarding arrangements specifically in relation to training for counter terrorism and child sexual exploitation, and to demonstrate how they respond to learning raised through Serious Case Reviews.

In last year's annual report, we reported that the LSAB Quality Assurance, Audit and Performance (QAAP) Sub Group was in the processes of identifying ways to mirror the s11 process in order to gain assurances that adults with care and support needs are appropriately safeguarding. This year we can report that the process was successful and the existing s11 tool was amended to enable the collection of information regarding all-age safeguarding.

Once completed, the audit tool provides the board with assurance that all agencies have the necessary arrangements in place to safeguard adults and children effectively.

3.2.1 Quality Assurance

During the reporting year, quality assurance processes have been made more robust in relation to S11s, in order to provide more effective, constructive challenge. A desk based quality assurance exercise of 2016/17 returns was undertaken to determine whether the level of detail in S11 returns met minimum requirements, as set out in the audit tool. This piece of work was undertaken by QAPI members who worked in pairs to provide critical challenge and reflection for all agencies who submitted a S11 return. Feedback was given to individual agencies with regard to their returns, and an offer of support was made if they felt it necessary. Some common themes were drawn from the quality assurance exercise and a "Top Tips" document was created based on those themes in order to achieve a more standardised approach in future. In addition, the quality assurance exercise allowed the business unit opportunity to learn from the process and find ways to promote consistent quality within future annual returns.

Following the desk based audit, challenge events were offered to four agencies as an opportunity to further explore some of the themes to come from their returns. These agencies were District Councils collectively; NHS England; Fylde and Wyre Clinical Commissioning Group; and North West Ambulance Service. Although North West Ambulance Service were asked to participate, the service declined having undertaken a similar process in Blackpool two years previously.

3.2.2 2017/18 Returns

Agencies have made submissions for the 2017/18 audit collection. Returns are currently being compiled and analysed, and will inform a summary report to be presented to both Boards in the coming months.

3.3 Thematic Audits

3.3.1 S47 Re-Audit

Last year, we reported on an audit completed with regard to child protection (S47) investigations, following areas of concern being highlighted by Ofsted. The original audit identified some issues in respect of timeliness of strategy meetings; recording strategy meetings; multi-agency engagement; and post-qualification experience of allocated social workers. Recommendations were made against each area, and an action plan was developed to address each recommendation which was completed and signed off, however it was agreed that a re-audit would take place late 2017.

The audit was repeated in December 2017, to determine whether progress had been made against the recommendations. This was completed with the same staff members and very similar process to the original audit. The findings of the re-audit clearly demonstrate that improvements have been made in relation to multi-agency engagement and recording of strategy discussions and the LSCB is satisfied that no further re-audit is needed at this stage.

In regard to the experience of social workers, it is acknowledged that recruitment and retention of staff will continue to create instances where newly qualified staff are involved in the S47 process, however the audit findings demonstrate a vast improvement in experience levels. Findings identified some issues where multi-agency involvement is difficult when a strategy discussion takes place 'out of hours' however the cases analysed display evidence of information being sought and responded to appropriately

3.3.2 Cannabis

A number of recent Serious Case Reviews (SCRs) identified key issues around the impact of use of cannabis on parenting, and practitioner awareness of the potential risks and their ability to effectively challenge parents during assessments. The LSCB agreed to allocate some capacity to address these issues and explore the development of a campaign to increase awareness, recognise the risks, and equip practitioners with the knowledge and skills to challenge appropriately.

In order to identify the most effective action to address the above, it was agreed to undertake a survey of practitioners in order to gain an understanding of the level of awareness already held in relation to the issues raised, specifically the risks and effects that cannabis usage can pose, and the likelihood of agencies challenging parental attitude towards drugs and the impact use has on their parenting ability.

An online survey was created, via Survey Monkey, around the issues outlined above and received over 500 responses from multi-agency practitioners. The findings of the survey were presented to Board members via a detailed report, supported by a number of recommendations in relation to awareness raising and training amongst agencies. The recommendations were agreed, resulting in the roll out of 17 briefings sessions, delivering training over 600 practitioners.

The project is still on going and will see the roll out of a resource pack; 7 minute briefing; and an e-learning package in order to further embed learning. The QAPI Sub Group will repeat the staff

survey, once there has been sufficient time for learning to be cascaded and embedded in practice, in order to measure the impact made.

3.3.3 GP Online Survey for Information Sharing

The Boards multi-agency audit activity highlighted a common theme running through a number of audits around barriers and challenges in Primary Care with regard to information sharing with partner agencies. As this was highlighted in a number of audits, the QAPI Sub Group recommended that an online survey of Primary Care practitioners was initiated in order to gather the views directly from GPs themselves.

The overall aim was to identify the barriers faced in sharing information and escalating concerns of safeguarding, in order to consider where additional support may be required in order to improve existing approaches and practice.

The Online Survey ran from August to October 2017, gathering responses from 61 participants on questions relating to:

- Safeguarding responsibilities;
- making referrals;
- identifying and responding to CSE;
- professional disagreement;
- existing approaches to sharing information and any improvements that could be made;
- what stops GPs from sharing information;
- internal processes for flagging concerns; and
- creating a safe environment for patients to share sensitive information.

A draft findings report has recently been considered by the QAPI and QAAP Sub Groups who agreed a Task and Finish Group approach in order to address the issues raised. The findings and progress will be reported in next year's annual report.

3.4 Multi-Agency Audit Framework

In 2016, the Boards introduced a new scheme of multi-agency audit activity which aims to identify good practice and to highlight areas for concern and development both on a single agency and multi-agency basis.

The audit process has been well embedded into the Board's quality and performance functions over the past two years. Following the successful implementation of the tool, and successful completion of various audits, it was agreed by the QAPI and QAAP Sub Groups to audit the tool itself in order to measure its effectiveness and establish if any improvements could be made.

The audit found that there is a clear agreement that the audit tool is successful and provides an effective mechanism to assess multi-agency case involvement. The audits take approximately 4 to 5 weeks to complete and whilst this appears a timely process, partners involved report that it is a valuable exercise and use of time. There is however a need to consider roll out times for future

audits, ensuring sufficient time and capacity is built in between each one. The QAPI and QAAP Sub Groups will take this into consideration for future annual work plans.

The LSAB QAAP Sub Group completed one, and initiated a further two multi-agency audits during reporting year:

LSAB

- Domestic Abuse – audit initiated in January 2017 and concluded with a report to the LSAB in September 2017. Findings can be found in the summary report on the LSAB website;
- Making Safeguarding Personal – audit activity has concluded and findings will soon be presented to key partners via a feedback event in order to identify the most effective method of sharing findings more widely in order to make any necessary improvements;
- Timescales and Information Sharing – a number of case file audits have been completed, however due to inconsistencies in the level of information shared it has been agreed that the information will be reviewed collectively by QAAP members in order to identify key themes and trends for learning.

LSCB

- Child Sexual Exploitation – audit initiated January 2017, and concluded with a report to the LSCB in May 2017. Findings can be found in the summary report on the LSCB website;
- Non-Accidental Injuries – audit initiated September 2017. Agencies are currently considering recommendations and identifying appropriate actions.

3.5 Service Area Annual Reports

The Board also receives a number of annual reports in relation to key multi-agency services. Reports are received regarding the following:

1. Local Authority Designated Officer (LADO)
2. Common Assessment Framework (CAF)
3. Counter Terrorism
4. Domestic Abuse
5. Independent Reviewing Officer (IRO)
6. Multi-agency Public Protection Arrangements (MAPPA)
7. Secure Estate (Young offenders institutes)
8. Private Fostering

All service area annual reports for 2017/18 are available at Appendix 1.

3.6 Themes from Child Death Reviews

The Child Death Overview Panel (CDOP) reviews every child death in the county and analyses any factors that may have contributed to the death in order to identify themes and trends for preventative measures. 70% of deaths reviewed during 2017/18 were completed within 12 months.

A summary of the key findings for 2017/18 are as follows:

- 14% of deaths were of children from an Asian Pakistani heritage, compared with the child population of 6% in the 2011 census
- 62% of children were aged under 1 year (37% 0-27 days and 24% 28 – 264 days)
- 27% of deaths were due to perinatal/ neonatal events, 23% were due to chromosomal, genetic and congenital anomalies. This is to be expected with the majority of deaths being of children under 1 year of age.
- 36% of deaths were identified to have modifiable factors*
- Of the 36% of deaths identified to have modifiable factors the most common category of death was perinatal neonatal events (32%). The second largest category to have modifiable factors was sudden, unexpected, unexplained deaths (15%).
- The most common modifiable factors were smoking by parent/carer, alcohol/substance misuse by parent/carer, safer sleep practices and domestic abuse.

**Factors which could be modified to reduce the risk of future child death*

3.7 Safeguarding Adult Reviews (SAR)/Serious Case Reviews (SCR)

During 2017/18, the SAR and SCR groups have continued to successfully implement the Welsh methodology for undertaking reviews. Both groups have tailored the approach to suit Lancashire's needs. The change includes the addition of a fourth panel meeting which focusses solely on action plan development, following the presentation of the final report to Board. The final report no longer makes recommendations but instead documents clear findings and learning points which multi-agency panel members use to develop an effective outcomes focussed action plan.

An evaluation of the methodology was commissioned and completed during the reporting year in order to measure the effectiveness of the Welsh model when compared with the traditional approach. The findings of the evaluation highlighted that on average, reports are produced in a quarter of the time and at a third of the cost of the traditional reviews, offering a more concise and focussed findings report.

Breakdown of Case Reviews

2017/18	SARs	SCRs
Number of referrals:	14	11
Number converted to reviews:	4	4*
Number converted to Multi-agency learning reviews	0	1

** 1 was agreed in 2016/17 but commissioned in 201718 reporting period*

Two Safeguarding Adult Reviews, Adult A and Adult D, and four Serious Case Reviews: Child LC; LE; LF and LH were published during the reporting year. Final reports are published in full to the LSAB and LSCB websites, for a period of 12 months. Practitioner learning briefs remain published for an extended period.

A further SAR into Adult B was published outside of reporting year and will be referenced in the 2018/19 annual report. Three SARs and four SCRs continue to progress through the review process and, if appropriate, will be published in due course.

Key Learning Themes

The following themes were drawn from the reviews into Adult A and Adult D:

- **Voice of the adult/family**: when undertaking any assessment professionals should always seek to incorporate family member views (particularly if they are actively involved in the care of the service user) and, where appropriate, share with other agencies.
- **Information sharing:** this not only applies to other professionals involved with the service user, but also to the service user and their family members.
- **Domestic Abuse:** should be considered by professionals working with adults and older couples. This includes assessment of controlling and coercive behaviour which could be long standing within a relationship.
- **Mental Capacity**: professionals should always be mindful of completing a mental capacity assessment when working with individuals when there are concerns regarding mental wellbeing and confusion
- **Self-neglect and hoarding:** professionals should identify self-neglect and/or hoarding at the earliest opportunity and consider if a co-ordinated multi-agency approach is required,

A number of common themes were amongst the learning to come from the four SCRs published in the reporting year. The information below highlights such themes and the action taken to address learning:

- **Professional curiosity:** professionals need to exercise an appropriate level of professional curiosity during assessment – it is crucial to understanding family environment and dynamics;
- **Engaging with Fathers:** professionals need to recognise the importance of engaging with fathers and encourage fathers to talk about developing their relationship with their child. Fathers should be included in assessments and their presence/absence recorded;
- **Cannabis**: professionals should understand and recognise the potential seriousness of cannabis use and the risk and impact this can have on parenting capacity and the child. Appropriate assessments and referrals to specialist services should be considered. (See section 3.3.2 regarding actions undertaken by the LSCB to address this issue).
- **Concealed/denied pregnancy**: professionals should always consider a psycho-social assessment and referral to children's social care when a woman has concealed or denied a pregnancy. In July 2018, the LSCB agreed a multi-agency Concealed and Denied Pregnancy Protocol to support professionals. The Protocol will be piloted for a period of 12 months and reviewed as necessary.

The Overview reports and learning briefs for all SARs and SCRs have been shared widely with partners and practitioners, and robust action plans are in place to address the key issues raised by the review. Partners are working to these actions which are monitored regularly by the SAR and SCR Sub Groups.

Putting Learning into Practice

In March 2018, a multi-agency conference was held for frontline practitioners in order to further embed learning from Case Reviews. The "Putting Learning into Practice" event was attended by approximately 130 practitioners who received presentations and contributed to discussion sessions around the learning from 3 SARs and 3 SCRs. Feedback from the event was extremely positive, with attendees recommending that the event takes place on an annual basis.

As part of the event, practitioners were asked to share their views on the style of learning briefs published after each review. Whilst the feedback on the current style was positive, there was some suggestions as to how improvements could be made. This is currently being considered by the Case Review Groups and the Communication and Engagement Sub Group and will be progressed over the coming months.

4. Statutory and Legislative Context

4.1 Lancashire Safeguarding Adults Board

Section 43 of the Care Act 2015 sets out the statutory objectives and functions of an LSAB as follows:

1) Each local authority must establish a Safeguarding Adults Board (an "SAB") for its area.
2) The objective of an SAB is to help and protect adults in its area in cases of the kind described in section 42(1).
3) The way in which an SAB must seek to achieve its objective is by coordinating and ensuring the effectiveness of what each of its members does.
4) An SAB may do anything which appears to it to be necessary or desirable for the purpose of achieving its objective.
5) Schedule 2 (which includes provision about the membership, funding and other resources, strategy and annual report of an SAB) has effect.

The LSAB must promote a culture with its members, partners and the local community that recognises the values and principles contained in 'Making Safeguarding Personal' and ensure all work is underpinned by the six key safeguarding principles:

- 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.

4.2 Lancashire Safeguarding Children Board

At the time of writing this report, the LSCB continues to work to regulations and statutory objectives set out in Section 14 of the Children Act 2004 and Working Together to Safeguard Children 2015 as follows:

a) To coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and

b) To ensure the effectiveness of what is done by each such person or body for those purposes.

Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out that the functions of the LSCB, in relation to the above objectives under section 14 of the Children Act 2004, are as follows:

1a. developing policies and procedures for safeguarding and promoting the welfare of children in the area of the authority, including policies and procedures in relation to:

i. the action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention;
ii. training of persons who work with children or in services affecting the safety and welfare of children;
iii. recruitment and supervision of persons who work with children;
iv. investigation of allegations concerning persons who work with children;
v. safety and welfare of children who are privately fostered;
vi. cooperation with neighbouring children's services authorities and their Board partners;

1b. communicating to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encouraging them to do so;

1c. monitoring and evaluating the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve;

1d. participating in the planning of services for children in the area of the authority; and

1e. Undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

Regulation 5 (2) which relates to the LSCB Serious Case Reviews function and regulation 6 which relates to the LSCB Child Death functions are covered in chapter 4 of the guidance.

Regulation 5 (3) provides that an LSCB may also engage in any other activity that facilitates, or is conducive to, the achievement of its objectives.

2. In order to fulfil its statutory function under regulation 5 an LSCB should use data and, as a minimum, should:

- assess the effectiveness of the help being provided to children and families, including early help;
- assess whether LSCB partners are fulfilling their statutory obligations set out in chapter 2 of this guidance;
- quality assure practice, including through joint audits of case files involving practitioners and identifying lessons to be learned; and
- monitor and evaluate the effectiveness of training, including multi-agency training, to safeguard and promote the welfare of children.

The LSCB has been working to these requirements during 2017-18

4.3 Working Together 2018

In June 2018, the Department for Education (DfE) released the revised version of Working Together to Safeguard Children (2018 new guidance). These will have a significant impact on local arrangements and some of the key changes are set out below:

- Abolishment of LSCBs and the introduction of Multi-Agency Safeguarding Arrangements (MASA);
- Local Authorities, Clinical Commissioning Groups and Police are identified as having the lead – described as the "Safeguarding Partners" whilst other organisations are identified as "Relevant Others"
- Introduction of Child Safeguarding Practice Reviews, replacing existing Serious Case Reviews;
- Changes to Child Death Reviews, led by child death review partners who are identified as the Local Authority and Clinical Commissioning Groups.

4.3.1 Multi Agency Safeguarding Arrangements (MASA)

Working Together 2018 sets out the functions of the MASA as:

1. Local organisations and agencies that work with children and families play a significant role when it comes to safeguarding children.

2. To achieve the best possible outcomes, children and families should receive targeted services that meet their needs in a co-ordinated way. Fragmented provision of services creates inefficiencies and risks disengagement by children and their families from services such as GPs, education and wider voluntary and community specialist support.

3. There is a shared responsibility between organisations and agencies to safeguard and promote the welfare of all children in a local area.

4. As set out in chapter 2, many local organisations and agencies have a duty under section 11 of the Children Act 2004 to ensure that they consider the need to safeguard and promote the welfare of children when carrying out their functions.

5. The responsibility for this join-up locally rests with the three safeguarding partners who have a shared and equal duty to make arrangements to work together to safeguard and promote the welfare of all children in a local area.

The three safeguarding partners are:

a) the local authority
b) a clinical commissioning group for an area any part of which falls within the local authority area
c) the chief officer of police for an area any part of which falls within the local authority area

The responsibilities of the partners, and the new arrangements are set out in detail in the Working Together Guidance (2018)

4.3.2 Transitional Guidance

Local authority areas must begin their transition from LSCBs to safeguarding partner/child death review partner arrangements from 29 June 2018. The agreed approach and arrangements must be completed for implementation by 29 September 2019.

In the case of ongoing serious case reviews and child death reviews, LSCBs have a statutory 'grace period' of up to 12 months to publish SCRs, and up to four months to publish child death reviews. All reviews should seek to be completed as soon as possible.

Initial scoping is now taking place between Lancashire County Council; Clinical Commissioning Groups; and Lancashire Constabulary to consider how the new arrangements may look for Lancashire. Options will be considered during the Autumn 2018 with the decision being the responsibility of the Chief Executive of the Local Authority, the Chief Accounting Officers In the CCGs and the Chief Constable.

5. Governance and accountability arrangements

5.1 Relationship between the LSAB/LSCB

Last year we reported on the first Development Day which took place jointly with the LSAB and LSCB in March 2017. The key theme to come from the session was around more efficient ways of working, with a particular focus on principal of "doing things once" where possible – this not only applies to the two Boards in Lancashire, but also the pan-Lancashire footprint, working more closely with the Boards in our neighbouring authority areas. The following activity has taken place during reporting year, following agreement at the development day, in order to become more efficient and further develop joint working.

- LCSB Executive Group was disestablished in May 2017 to ensure the accountability of the full Board remains as robust as possible. Regular budget meetings and sub group chairs meetings were established in order to allow an alternative forum for the management of financial issues and decisions which don't require agreement at full Board;
- A joint Communication and Engagement Sub Group was established in June 2017 on a pan-Lancashire footprint, addressing both adult and children's safeguarding issues;
- The Welsh Model has been successfully embedded for both SARs and SCRs and an evaluation into the model has been undertaken and shared with the LSAB and LSCB. A joint conference took place to share key learning and discuss future approaches to sharing learning effectively across the adult and children's workforce;
- Common audit processes are in place across both Boards, and the LSCB Section 11 audit has been mirrored to capture safeguarding activity from the adult's workforce;
- The LSAB and LSCB meet together twice a year to discuss joint issues; and the chairs and business managers of adult and children's boards for pan-Lancashire continue to meet on a quarterly basis to address pan-Lancashire issues;
- A second development day took place in February 2018 in order to identify future priorities and effective mechanisms for measuring impact. A number of all-age priorities were agreed for joint working which are detailed 5.4.3.

At the time of writing this report, a number of joint initiatives are in development for the 2018/19 period. Some examples of this are:

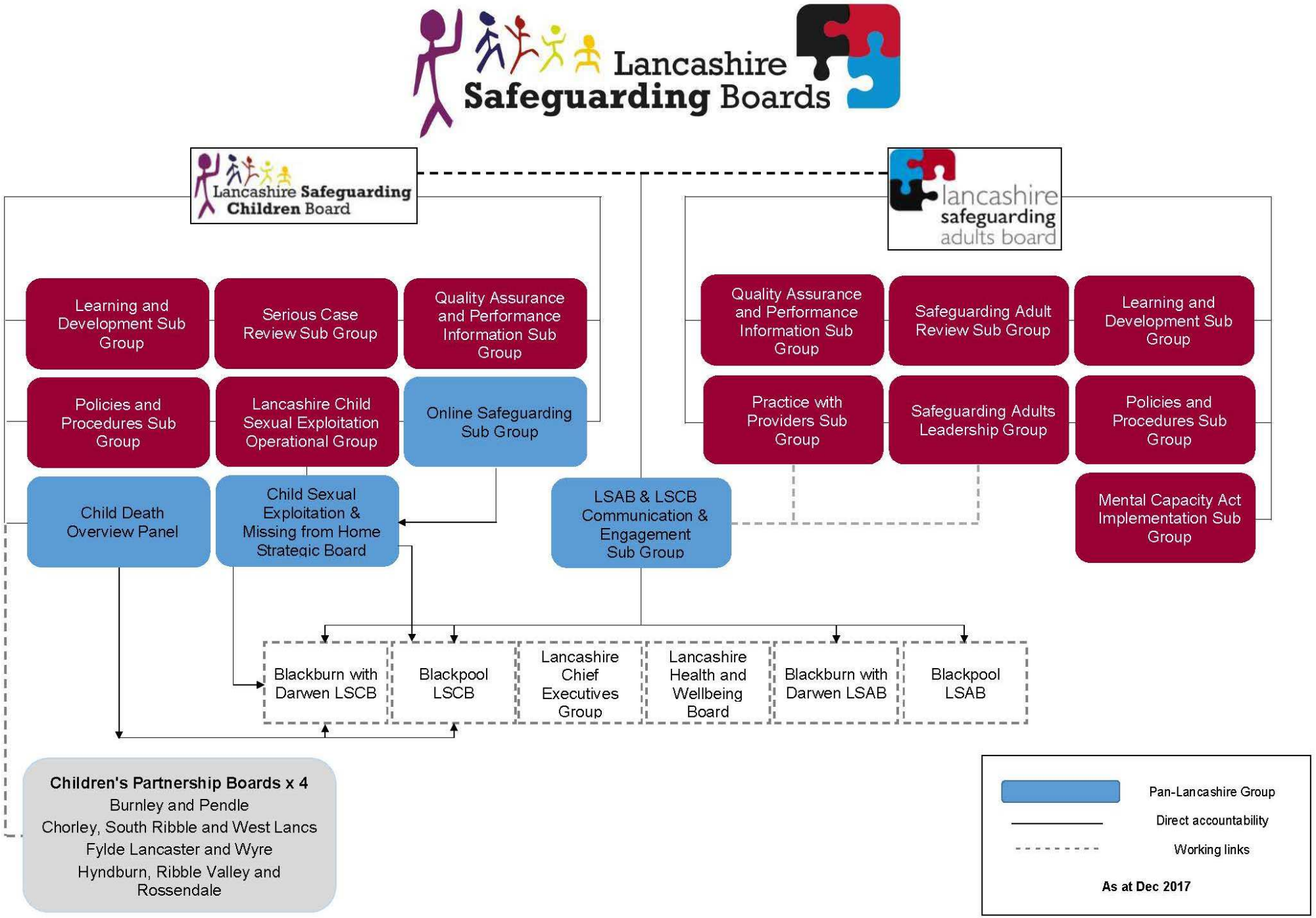
- Joint business plan and priorities;
- Measuring impact briefings are taking place with Board members and sub group chairs to enable the identification of mechanisms to allow us to measure impact effectively;
- Complex Safeguarding conference will take place to consider the continually emerging issue of 'exploitation' in Lancashire
- The Learning and Development Sub Groups are working on a number of joint approaches, including:
    - Multi-agency Workforce Development Plan;
    - Training for Trainers Courses;
    - 7 minute briefings which address all-age themes.

5.2 Board Structure

The Board structure can be found on the next page, illustrating the governance between the Boards, its sub groups, and links with other partnerships.

Changes to the Children's Partnership Board (CPBs) have been under consideration during 2017/18, however the locality based groups have largely continued to meet and the four Business Co-ordinators continue to attend the CPB meetings regularly while this review is taking place, providing updates and direction from a safeguarding perspective.

2017/18 has seen further developments in engagement with the Office of the Police and Crime Commissioner (OPCC). The OPCC is represented on the LSAB and LSCB; Safeguarding Adult Review Group; Communication & Engagement Sub Group; and the CSE Strategic Board, and actively engages with a number of Task and Finish Groups.


Lancashire Safeguarding Boards
Lancashire Safeguarding Children Board
lancashire safeguarding adults board
Learning and Development Sub Group
Serious Case Review Sub Group
Quality Assurance and Performance Information Sub Group
Policies and Procedures Sub Group
Lancashire Child Sexual Exploitation Operational Group
Online Safeguarding Sub Group
Child Death Overview Panel
Child Sexual Exploitation & Missing from Home Strategic Board
LSAB & LSCB Communication & Engagement Sub Group
Quality Assurance and Performance Information Sub Group
Safeguarding Adult Review Sub Group
Learning and Development Sub Group
Practice with Providers Sub Group
Safeguarding Adults Leadership Group
Policies and Procedures Sub Group
Mental Capacity Act Implementation Sub Group
Blackburn with Darwen LSCB
Blackpool LSCB
Lancashire Chief Executives Group
Lancashire Health and Wellbeing Board
Blackburn with Darwen LSAB
Blackpool LSAB
Children's Partnership Boards x 4
Burnley and Pendle
Chorley, South Ribble and West Lancs
Fylde Lancaster and Wyre
Hyndburn, Ribble Valley and Rossendale
Pan-Lancashire Group
Direct accountability
Working links
As at Dec 2017

5.3 Accountability and inspection

Despite having statutory functions, the LSAB does not undergo the same scrutiny processes as the LSCB. However it should be noted that agencies represented on the LSAB are often inspected in terms of quality and compliance around issues of safeguarding.

The LSCB is reviewed as part of the local authority inspection of services for children in need of help and protection, children looked after and care leavers, carried out by Ofsted. The last full inspection took place in 2015 and the LSCB was judged to be 'good' following a separate assessment and judgement of its effectiveness. At the time of writing this report, a re-inspection of the local authority was in progress and whilst the LSCB were not formally scrutinised, the Business Unit and multi-agency partners engaged and supported the local authority throughout the process. Findings are not yet known.

The independent chair is the same for both Boards and is held to account by the Chief Executive of the Local Authority through regular meetings and Board member participation in a process of standardised appraisal.

5.4 Business Planning and Strategic Priorities

5.4.1 LSAB Business Plan

The LSAB and its sub groups have continued to make progress against the key priorities set out in the 2016-18 business plan. Priorities were set based on the 15 Care Act Responsibilities under 6 Key Safeguarding Principles: Empowerment; Prevention; Proportionality; Protection; Partnership; and Accountability.

The information below details the progress made against priorities with completion deadlines during the April 2017 – March 2018 period:

Empowerment

Care Act No. 9 – Develop strategies to deal with the impact of issues of race, ethnicity, religion, gender and gender orientation, sexual orientation, age, disadvantage and disability on abuse and neglect.

Progress update: All sub groups consider issues of diversity throughout work programmes and during development of policy and practice. The Communication and Engagement Sub Group will ensure that diversity is considered and addressed during the roll out of any communication materials, considering easy read formats; additional languages etc.; and alternative platforms and mechanisms

The Mental Capacity Act Sub Group have developed a framework for learning, providing a suite of packages in order to support the implementation of MCA across the workforce. The frameworks has been agreed by the LSAB and is currently being finalised ready for distribution.

Prevention

Care Act No. 5 – Establish mechanisms for developing policies and strategies for protecting adults which should be formulated, not only in collaboration and consultation with all relevant agencies but also take account of the views of adults who have needs for care and support, their families, advocates and carer representatives

Progress Update:

Pan-Lancashire and Cumbria Multi Agency Policies and Procedures
In October 2017, the LSAB launched the new online safeguarding policies and procedures manual, moving away from the traditional method delivered via Tri-X.

The manual is a joint Pan-Lancashire and Cumbria approach to adult safeguarding, including consistent language and commonly used terms. It is intended for the entire adult workforce, aiming to promote multi-agency working and providing information about how to safeguard adults at risk of abuse or neglect, providing practitioners with appropriate guidance in order to respond appropriately to adult safeguarding concerns.

The manual is hosted on the Blackburn with Darwen website and will be updated on a regularly basis to reflect ongoing developments in local, regional and national guidance.

There will of course be various local guidance and policies procedures which are specific to the Lancashire area only. A number of these procedures are currently in development, led by the Policies and Procedures Sub Group as detailed below. Once completed and formally agreed, all guidance documents specific to Lancashire will be made available on the LSAB website.

LSAB Policies and Procedures Sub Group
Established in November 2017 with a clear Terms of Reference which sets out functions including horizon scanning with regard to new legislation and best practice; and the development and review of policies and procedures commissioned by the LSAB. The group is multi-agency, currently consisting of representation from Advocacy Focus, Social Work from LCC, representation from CCG, housing and provider representative.

During the reporting year, progress has been made in reviewing policies in relation to: People in Positions of Trust; Self-Neglect and Hoarding; Making Safeguarding Personal; and Safeguarding Adult Reviews. The reviews will continue to progress during 2018, along with Financial Abuse, Domestic Abuse, and Modern Slavery.

Mental Capacity Act (MCA) Awareness Raising – carer and public engagement
Three events were delivered for carers and the public across Lancashire, led by "Afta Thought" drama group. Approximately 120 people attended the sessions where real life scenarios were played out around the principles of MCA and an understanding of individual rights.
Feedback received was extremely positive with a request for similar sessions to be held in the future.

Care Act No. 6 - Develop preventative strategies that aim to reduce instances of abuse and neglect in its area

Progress Update:

Safeguarding Guidance

Last year we reported on the comprehensive guidance tool, launched in March 2017, which aims to assist practitioners in making appropriate referrals in response to safeguarding concerns. It is intended to assist in the management of risk and making appropriate decisions around the level of support and response required to suspected or recognised abuse.

The guidance and its appendices have been successfully embedded across the workforce during 2017/18 and, as agreed, a review of its first year has recently been undertaken via an Online Survey of practitioners. Overall, the findings of the survey were positive and highlighted that the guidance tool is well received and well regarded by partners. A few suggestions for amendments were raised which have recently been considered by a multi-agency task group and slight amendments agreed. Revised guidance will be published in the coming weeks.

Communication and Engagement Sub Group

The Pan-Lancashire Communication and Engagement Sub group was established in June 2017 and has developed a Communication and Engagement Strategy which was agreed by Boards in May 2018. The strategy provides strategic direction and aims to make improvements in terms of effective communication and engagement of priorities and statutory obligations to further embed "safeguarding" into services, communities and the general public.

An annual work plan is in place to support the implementation of the strategy. Further details can be found at section 6.10.

Safeguarding Adult Reviews

Safeguarding Adult Reviews are undertaken in order to identify any lessons which might prevent similar instances of abuse or neglect from happening in the future. The learning from the reviews is shared widely with Board members and practitioners of our partner agencies.

During 2017/18 connections have been strengthened between the sub groups in order to more effectively address learning and ensure it is shared. This is done via bi-monthly update reports to Board; sharing of learning briefs; creation of 7 Minute Briefing based on common themes coming out of reviews; robust action planning; and the "Putting Learning into Practice" event which is detailed at section 3.7.

Proportionality

Care Act No. 10 - Balance the requirements of confidentiality with the consideration that, to protect adults, it may be necessary to share information on a 'need-to-know basis'

Progress Update: The MASH Strategic Board has been re-established and strengthened during reporting year, agreeing a Memorandum of Understanding and an Information Sharing Protocol across agencies. The service redesign for the Children's MASH has been complete, however further work is required in terms of the Adult MASH. The LSAB has commissioned a review to progress this further during 2018.

The Board receives assurance that "Making Safeguarding Personal" (MSP) is embedded through all agencies and a multi-agency audit has been undertaken to explore this further. Findings of this audit are currently being considered, as detailed at section 3.4. All sub groups work to embed MSP principals and this has been identified as a priority area within the new business plan for 2018-2020.

Protection

Care Act No. 8 – Formulate guidance about the arrangements for managing adult safeguarding, and dealing with complaints, grievances and professional and administrative malpractice in relation to safeguarding adults.

Progress Update:

People in a Position of Trust (PiPoT)

During reporting year the Policies and Procedures Sub Group has developed a pan-Lancashire policy to assist in the management of concerns around People in a Position of Trust. The policy has recently been completed and is due to be signed off formally by the LSAB in August 2018. Once agreed, it will be uploaded to the Online Policies and Procedures for Safeguarding Adults.

Partnership

Care Act No. 3 – Establish how it will hold partners to account and gain assurance of the effectiveness of its arrangements; and

Care Act No. 14 - Evidence how SAB members have challenged one another and held other boards to account

Progress Update: The LSAB has a number of mechanisms in place to enable effective challenge in order to measure effectiveness and hold partners and other Boards to account. This activity includes:

- Section 11 Audit – the existing LSCB s11 process has been amended to enable the collection of information regarding all-age safeguarding. This provides the Board with assurance that arrangements are in place to safeguard adults effectively. The process has been Quality Assured during 2017/18 which is detailed at section 3.2.1;
- The multi-agency audit programme is well embedded within the LSAB and the audit team have completed a range of audit activity during reporting year, as detailed at section 3.4. The audit tool itself has undergone audit activity to ensure it is an effective;

- Annual Feedback Reports are requested from key partners for inclusion in this annual report regarding safeguarding activity which has taken place during 2017/18, and planned priorities for the year ahead. (See section3.1);
- Bi-monthly sub group reports are given at each Board meeting to inform members of the recent progress of each group against individual work plans. The reports also provide the opportunity to raise any issues which require agreement or support from the Board, or other sub groups in order to progress effectively;
- Following a recent review and establishment of new Community Safety Partnership arrangements, a protocol will now be developed between the Lancashire Safeguarding Boards and the CSPs in order to set out how we will work together and hold each other to account.

Accountability

Care Act No. 1 - Identify the role, responsibility, authority and accountability with regard to the action each agency and professional group should take to ensure the protection of adults

Progress update: Membership and structure of the LSAB and its sub groups are regularly reviewed and amended as necessary. All sub groups are well developed with work plans and clear Terms of Reference agreed. Governance arrangements were reviewed and published to the LSAB website in April 2017, setting out the aims, priorities and Terms of Reference of the LSAB; membership and responsibilities of members; and structure and role of sub groups.

Care Act No. 4 – Determine arrangements for peer review and self-audit

In February 2017, an ADASS and LGA Support tool was presented to LSAB members to support agencies in recognising the requirements of MSP and provide assistance in measuring progress against MSP principles. Board members were asked to familiarise themselves with the tool and complete a self-assessment. This was later discussed at a development day and MSP was formally agreed as a key priority moving forward into 2018-20.

A full peer review exercise is planned to take place during 2018/19

- *Care Act No. 13 – Produce a strategic plan and annual report*

  The Business Plan has recently been reviewed, becoming a joint plan with the LSCB. The plan includes both joint priorities with the LSCB, and individual priorities to be addressed by the LSAB. Details of the priorities can be found at section 5.4.3.

  Once formally agreed and presented to other Boards, the annual report is published each year to the LSAB website.

5.4.2 LSCB Business Plan

The Business Plan for the reporting period was develop by the LSCB and has the support of all the Board's partner agencies. It takes account of and is informed by statutory requirement and the implementation of LSCB processes: QA Framework - Section 11 Audit, Multi-Agency case file audits, Performance Indicators. Themes from SCR are inbuilt into our priorities. The plan

incorporates the actions required to ensure the Board itself is efficient and effective in fulfilling its statutory responsibilities.

The key priorities for 2016-18 were agreed at the Board's Development Day on 7th June 2016, as follows:

- *Priority Area 1:* Improve the effectiveness of agencies and the community in preventing Child Sexual Exploitation and addressing other complex safeguarding issues (including female genital mutilation, forced marriage and honour based violence).

- *Priority Area 2:* Improve the effectiveness of agencies in meeting the needs of Children Missing for Home, Care and Education

- *Priority Area 3:* Improve the effectiveness of safeguarding activity for children in specific circumstances:
    - Children placed in Lancashire from other areas, and in other areas from Lancashire
    - Children whose parents are in prison
    - Children in need of support for emotional and mental health issues
    - Children in need of support with regard to online safety

- *Priority Area 4:* Cross cutting themes

- *Priority Area 5:* Ofsted improvement plan

Priority updates for 2017/18:

Child sexual exploitation and complex safeguarding

Child Sexual Exploitation (CSE)

There have been some challenges during 2017/18 largely due to capacity within agencies to release staff to take forward the agenda, therefore resulting in a period of drift in respect of the strategic agenda. It is important to note that this has not impacted on the quality of practice and is now making good progress and getting back on track.

A review of the Standard Operating Procedures (SOPs) for CSE has been initiated during reporting year and has made good progress in bringing procedures up to date and suitable for working practice across the Pan-Lancashire area. There is still some work to be done to further develop and finalise the SOPs which will be a priority of the Pan-Lancashire CSE Strategic Group over the coming months.

Recognition must be given to the substantial investment made by the local authority in relation to the reorganisation of the CSE teams and creation of additional capacity. As with all reorganisations, this comes with a period of intense change which takes time to embed, however the LSCB is confident that positive progress has been made and continues to do so.

Female Genital Mutilation (FGM)

In June 2017, the Boards contributed to and supported the multi-agency "Harmful Practice of Female Genital Mutilation" conference. The event was a joint approach with the Blackpool and Blackburn Safeguarding Boards; the Office of the Police and Crime Commissioner; and NHS England (North Region).

The purpose of the conference was to launch the FGM pathway developed by multi-agency partners, and to build on existing awareness of FGM legislation and the harmful effects it has on an individual and their families. Over 100 partners attended the event, receiving presentations and information from Peggy Mungolo and an FGM survivor from specialist charity NESTAC (Next Step for African Community); CPS North West; Integrate; and Afta-Thought drama group who brought to life anonymised case studies from Lancashire in order to highlight the presence of FGM in the county.

The conference as extremely well attended and received positive feedback from attendees who felt the event was "engaging"; "thought provoking"; and "improved knowledge that can be disseminated and shared in practice".

The FGM pathway is now in place and held on the Pan-Lancashire and Cumbria multi-agency procedures. In addition, an FGM leaflet was developed and published in order to assist individuals in recognising the signs of FGM; the different types of the procedure; and how to report it.

Children missing from home, care and education

The pan-Lancashire CSE/MFH Strategic Board and Operational Group continue to be sighted on the Missing from Home agenda, having reviewed the Strategy and Action Plan in August 2016.

Although the National College of Policing released guidance in relation to the removal of the 'absent' category, the DfE are yet to release guidance for local authorities. The LSCB has previously made contact with the DfE to seek advice regarding potential timescales for the release of the guidance. Once it is made available, the Strategic Board will seek to review the Strategy, and supporting Action Plan, once more to take account for the changes.

Children placed in Lancashire from other areas, and in other areas from Lancashire

In 2015 Lancashire Safeguarding Children's Board conducted an audit of Children Looked After by other Local Authorities placed in Lancashire. The audit activity was undertaken in 2015 and analysed 45 individual cases with key multi-agency findings reported back in the final report. The original report acknowledged that in most cases information was shared appropriately, however notifications were often received from placing local authorities very late; with statutory services not usually knowing that the child has been placed in Lancashire until after the placement has commenced. There were also some concerns identified with regards to the level of information routinely recorded on LCS for out of area looked after children placed in Lancashire.

In 2018, the LSCB QAPI sub-group were required to revisit the original audit in order to ensure that the initial recommendations had been addressed and ascertain whether any further multi-agency work needs to be undertaken. A decision was taken by the sub-group to progress this by conducting a multi-agency focus group. The purpose of the focus group is to map the current process for placing

out of area looked after children in Lancashire, identify the weaknesses in the process and understand whether in reality the process occurs as intended. The group was established just outside of the reporting period and has made progress against this priority, by revisiting the original recommendations and considering to what extent these have been addressed since the audit was undertaken. The findings of this piece of work will soon be reported to the LSCB and referenced in next year's annual report.

Children whose parents are in prison

The Lancashire Safeguarding Children Board (LSCB) recognises that children with a parent in prison are at risk of experiencing poor outcomes comparable with those of looked after children. This cohort of children was made a priority of the Board following a number of awareness raising events held in 2015/16 in partnership with the CYP Trust Board and charity i-Hop. In response to this, the LSCB established a multi-agency Task and Finish Group to order to identify a way of ensuring that this particular cohort of children is recognised and offered an appropriate level of support when a parent/carer is incarcerated.

The work undertaken led to the development of a pathway to ensure an offer of support is made. This was shared with multi-agency partners throughout its development, providing the opportunity for comments and suggestions, with appropriate amendments made along the way.

The LSCB launched the pathway in November 2017 as part of Child Grief Awareness week. The launch was communicated widely and partners asked to ensure staff were appropriately briefed. Children's Social Care and the Children and Family Wellbeing Service were asked to make additions to case management systems in order to capture information accurately and allow monitoring against the cohort moving forward.

The information in the table below was captured by CFWS in the period from the launch in November up to 31 Marcy 2018. Since March (up to 3 July), an additional 8 children and young people have been identified as having a parent/carer in prison, taking the count of families up to 6.

	Numbers identified between November 2017 – March 2018	
District	**Count of CYP**	**Count of Families**
South Ribble	**5**	**1**
Wyre	**1**	**1**
Pendle	**2**	**2**
Total	**8**	**4**
Data Source: *Children and Family Wellbeing Service*		

Partners from the Multi-Agency Safeguarding Hub have confirmed that requests have recently been addressed to allow the case management system to record the primary nature of contact and contact source. Additions are also being made to allow for flags to be added to cases already

open to provide more accurate reporting. Data will be available on referrals to MASH regarding children with parents in prison at the end of August and each month after that

Children in need of support for emotional and mental health issues

The LSCB continues to receive regular updates from the Children and Young People's Emotional Wellbeing and Mental Health Transformation Programme. For a considerable period of time, the LSCB reported concerns regarding the progress made around the programme, however we are happy to report that improvements are now beginning to be seen. It is evident that positive changes are being made in terms of timeliness and equity of service provision for children and young people in relation to emotional wellbeing and mental health though the average overall spend on this activity is still lower than the National average. The LSCB will continue to request regular updates from the Transformation Board and will monitor the progress being made to ensure ongoing improvements are made.

A priority of the LSAB MCA Sub Group is to strengthen awareness of Mental Capacity and Deprivation of Liberty Safeguards for services supporting young people aged 16 and 17 years old. This includes work to improve service user experience of MCA for young people transitioning from child to adult services. The LSCB will work in collaboration with the MCA Group in order to further develop this piece of work during 2018/19.

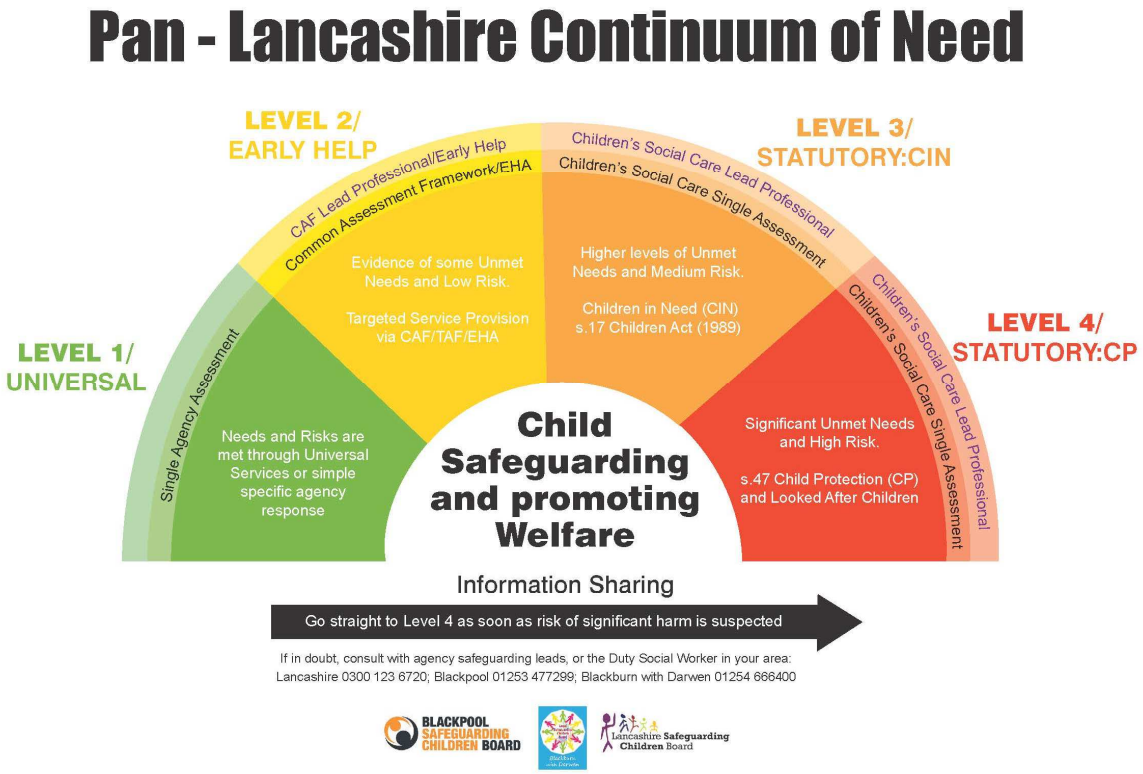
Additional areas of focus:

Risk Sensible assessments and the Continuum of Need

In July 2017 the LSCB launched a Risk Sensible Framework for multi-agency partners in order to align practice during assessments following the roll out of risk sensible assessments within Children's Social Care. The Framework was launched via a number of workshops to multi-agency partners between July and October 2017. During these events, concerns were raised regarding the level of training capacity available for the children's workforce around the risk sensible approach, this has resulted in the LSCB increasing the number of 2-day training courses available from 3 per year to 12 per year in the first instance. Following this, the approach will be further reviewed as necessary.

The Continuum of Need and supporting Thresholds document was reviewed in 2016 in order to align with Risk Sensible. During reporting year 2017/18, a further review has been undertaken, following an agreement of the pan-Lancashire LSCB Chairs and Directors of Children's Service which tasked the three LSCBs with exploring the alignment of the three Continuum of Needs and supporting Thresholds Guidance documents, with the possibility of one single approach being agreed.

Initial exploration took place in July 2017, which resulted in all three areas adopting the same Continuum of Need (see below). Due to some ongoing differences in local working arrangements, the alignment of the supporting Thresholds Guidance is not achievable at this time.



Whilst it was not possible to fully align the supporting Thresholds Guidance, an exercise was undertaken to consider the example 'risk indicators' given against each level across the three local authority areas to ensure there are no contradictions about where the need or risk should sit. This exercise didn't raise too many issues but some minor changes were agreed for each document.

In the case of Lancashire, the exercise highlighted that we have some work to do to move away from the "Every Child Matters" style categories and move towards those referenced in the new CAF: Health; Education; Emotional and behavioural development; Identity; Family and social relationships; Social presentation; Self-care skills and independence. A Task and Finish Group was convened in October 2017 to undertake this work and complete a refresh of the Thresholds Guidance. This work is nearing completion and should be ready for roll out and implementation in the autumn.

Schools Safeguarding

Due to the size of Lancashire and the number of schools in the county, engaging effectively with schools is a challenge for the LSCB and the partner agencies represented. In order to overcome this challenge, a project was initiated in January 2018 with the aim of identifying methods to strengthen the link between Schools; the Police; and Children's Social Care at a local level. A Headteacher from a Lancashire Primary school was commissioned by the LSCB, on a secondment opportunity, to lead this piece of work and develop approaches around the following.

There are two elements to this project. The first includes developing or embedding timely information sharing re Domestic abuse incidents to allow schools to support children appropriately, ensuring that families receive effective early help - project "Encompass".

The second aims to:

- Increase confidence in schools engaging with the CAF process and risk management;
- Review the operation of links between agencies in order to promote improved communication;
- Develop a network of school safeguarding champions;
- Support the development of links between schools and Early Help/Action teams.

At the end of reporting year, good headway has been made in progressing the project. Focus groups have taken place with school representatives across the county to gain an understanding of current processes and future aspirations, and the outcome of the focus groups has been shared with headteacher forums across the county. Models in operation in other areas have also been researched in order to identify best practice.

The focus of the work undertaken so far involves the following:

- Sharing of information around Domestic Abuse incidents – Operation Encompass is a methodology adopted by a number of police forces nationally which ensures the timely sharing of information between police and schools in respect of domestic abuse incidents. This method has been explored in recent months.
- Safeguarding support around risk assessment and management – it is clear that there is a need for a more structured and formalised support framework. Parallels have been drawn with the arrangements in the north of the county in respect of mental health and the benefits that are perceived to have been derived from this. Although direct parallels can't be drawn, there is learning that could be applied elsewhere.
- Confidence in CAF – as part of a wider multi-agency refresh of CAF, the LSCB is training multi-agency Trainers to roll out CAF Training across the networks.

Progress made was reported to the LSCB in May 2018, where an agreement was reached to provide some funding in order to progress the below as a proposed way forward ward:

- Operation Encompass be further explored and considered for a pilot model with the aim to improve inter-agency communication around Domestic Abuse, resulting in the timely provision of support for children and families
- Hub and Spoke Safeguarding Networks to be explored with the aim to improve the quality and reduce the number of referrals to MASH; improve communication and enhance effective multi-agency family support; support professionals in providing early help; and ensure a multi-agency approach to routine enquiry with regard to adverse childhood experiences.

The outcome of this work is due to reported in January 2019.

Adverse Childhood Experiences (ACEs)

ACEs are a complex set of childhood experiences which studies show can increase the likelihood of health-harming behaviours and diseases in adult life. ACEs can relate to multiple types of abuse including emotional, physical and sexual, domestic abuse, parental drug or alcohol use, and loss or imprisonment of a parent.

The LSCB is committed to exploring new ways of working which embed our understanding of the impact of ACEs, which has been identified as a joint priority for the LSAB and LSCB in the 2018-20 Business Plan. Links have been made with Public Health Lancashire with regard to this agenda and the Board will be involved in a scoping meeting in September 2018.

The Pan Lancashire Child Death Overview Panel (CDOP) commissioned a thematic audit to explore the prevalence of ACEs in cases where a child has died, and the potential link between health and behaviours. This audit has recently completed and a summary of findings was presented to CDOP in June 2018. The author of the report was asked to provide a set of recommendations for inclusion in the CDOP Annual Report, with a view to incorporating questions regarding ACEs within CDOP processes to allow for future data collection. The CDOP annual report will be presented to the LSCB in November 2018.

Intra-familial sexual abuse (IFSA)

In May 2017 the LSCB convened a multi-agency Task and Finish Group to investigate the number of IFSA cases that are recorded in Lancashire, following a report of the Children's Commissioner in November 2015.

The multi-agency group consisted of representatives from Health, Education, and Children's Social Care who initiated a data collection exercise based on a 6 month case sample to establish how many IFSA cases were recorded by Children's Social Care during that period.

Analysis of these results suggested that current recording processes on LCS (children's social care case management system) do not allow for IFSA to be identified as a distinct issue. A further search on case notes for the term "intra-familial SA" was performed which yielded no results. It would appear that practitioners do not use this as a term but are more likely to describe the circumstances in their case notes.

Further data provided by Business Intelligence showed that from 2017, 17 cases of sexual abuse were recorded by children's social care in the preceding 6 month period. This is a very low figure when compared with the figures published by the Children’s Commissioner on prevalence.

The Task and Finish Group presented findings to the LSCB in January 2018 and made the following recommendations:

- That Lancashire CSC referral forms are reviewed to ensure that information and referrals where intra-familial abuse has been alleged or identified is recorded.
- That LCS recording practice is reviewed to allow intra-familial abuse to be recorded as a CIN category (more understanding needed of LCS) to support future analysis of prevalence and reporting of intra-familial sexual abuse
- Multi-agency training to support the workforce including staff in schools, children's social care, police and health services and all agencies represented on the LSCB to support identification of sexual abuse, how to create the right environment, remove barriers to communication and

facilitate disclosure; and highlighting the underreporting of sexual abuse by children from hidden groups such those with special needs or disabilities, or from minority communities.

- The Lancashire PHSE curriculum is reviewed to ensure that schools equip all children, through compulsory lessons for life, to understand healthy and safe relationships and to talk to an appropriate adult if they are worried about abuse.
- The Lancashire process of achieving best evidence interviewing is reviewed in line with the Commissioner's recommendations to ensure timely and appropriate support for children.

The Task and Finish Group continues to progress this piece of work and will provide regular updates to the LSCB.

5.4.3 Business Plan 2018-20

The two Boards have recently developed a new Business Plan for 2018-20, which sets out priorities for the given period. Sub Groups are now addressing the agreed plan and will incorporate appropriate actions into individual work plans in order to progress the priorities.

LSAB Priorities

1. Embed Marking Safeguarding Personal to ensure that the voice of service users influences service delivery;
2. Engage and listen to the voice of adults with care and support needs;
3. Further develop the Adult MASH;
4. Engage with diverse communities.

LSCB Priorities

1. Transition to the new Working Together arrangements;
2. Ensure that families where neglect is an issue are supported;
3. Intra-familial Sexual Abuse.

Joint Priorities:

1. Promote awareness of Adverse Childhood Experiences and promote a trauma informed workforce;
2. Work with other Boards and partners to promote good practice with regard to Complex Safeguarding involving exploitation;
3. Promote an all-age approach to Domestic Abuse and to work across agencies;
4. Highlight the need for smooth transitions for children and adults transferring across services;
5. Work with partners/organisations who are managing organisations transition and system change to ensure coordinated responses to safeguarding practice is not compromised;
6. Raise awareness of Online Safety with children/young people and adults with care and support needs.

Progress against the priorities will be monitored throughout the year and reported in the 2018/19 annual report.

5.5 Views of service users

Over the past few years, the Boards have undertaken some effective activities for involving service users in various aspects of its work and seeking their views as appropriate.

The following activity has taken place within 2017/18:

a) What is Safeguarding – a film by young people. In January 2018, a group of children and young people from across the county came together to tell us about what "safeguarding" means to them. The group shared their experiences and what it means to be safe, and helped us to create a film to share their views. The children and young people involved, whose ages range from 7 to 24, are involved in a number of services across Lancashire, some are in care or leaving care, some are young carers or have a disability, and others have a parent in prison or have experienced going missing from home – and much more.

   The film can be viewed on the LSCB website at the link below – this is just a small part of the information the group shared with us, there is much more information for us to share throughout the year.

   http://www.lancashiresafeguarding.org.uk/what-is-safeguarding.aspx

b) MoMo – in 2017/18 the LSCB funded the first year of a participation tool introduced by Children's Social Care. MoMo ("Mind of My Own") is an app which can be used with children and young people who are in care, to allow them to share their views, concerns and good news stories. The implementation of the tool has been very successful, over 200 children and over 500 workers are signed up to the app and Lancashire was recognised for the quickest implementation during 2018.

c) Safeguarding Easy Read – the LSAB engaged with a group of service users to develop an Easy Read Guide: 'What is safeguarding and how to report your concerns', which aims to help vulnerable adults understand what 'safeguarding' is; what 'abuse' is; the different types of abuse, and what to do if they are worried or concerned. This was developed in partnership with the Learning and Disability Partnership Board, and was published to the LSAB website in September 2017.

d) SARs and SCRs – the Boards routinely consult with and seek the views of family members in relation to case reviews and ensures their views are appropriately reflected. Family members are always considered during decision making around publication and any possible effect publishing may have on an individual.

Collecting the views of service users is an ongoing challenge for the Boards and has been built into the Strategy and Workplan of the Communication and Engagement Sub Group who will consider effective methods for development and use in the future.

5.6 Board Performance

The Boards also have performance indicators which relate to its own effectiveness, with the year-end returns as follows:

Indicator	2015/16	2016/17	2017/18	Target	Direction of Travel
Attendance at LSAB Meetings*	Not available	76%	75%	80%	Worse
Attendance at LSCB Meetings*	67%	68%	68%	80%	Same
SCRs referrals considered within timescale	100%	100%	100%	100%	Same
Number of cases reviewed by CDOP	86	68	94	N/A	N/A

*A full breakdown of attendance by agency can be viewed at appendix 2. Where agency representation is poor, this addressed by the Chair.

A risk register is in place for each Board to ensure the appropriate controls are in place to mitigate against key risks to the delivery of Board business and the effectiveness of the partnership.

6. Key Achievements from the Sub Groups

The work of the Boards is delivered through a range of themed sub-groups as illustrated in the structures above. Each sub-group has its own work plan which are drawn from the Business Plans and in turn based around the Boards' strategic priorities. The work plans have been reviewed for the year and key achievements are as follows:

6.1 Safeguarding Adult Review and Serious Case Review Groups

Role – To consider referrals for SARs and SCRs against the criteria, commission reviews and monitor implementation of single and multi-agency learning from case reviews.

SAR/SCR Activity 2017/18

2017/18	**SARs**	**SCRs**
Number of referrals:	14	11
Number converted to reviews:	4	4*
Number converted to Multi-agency learning reviews	0	1

Key Achievements 2017/18

The SAR and SCR Groups have continued to successfully implement the Welsh methodology throughout the year, commissioning new reviews as detailed above, and undertaking 4 SARs and 5 SCRs which were commissioned in the previous year.

In order to improve the effectiveness of action planning, the groups have amended the style of the final reports and amended the review process. The final report no longer includes recommendations but instead the reviewers are asked to document clear findings and learning points. Therefore, following presentation of the final report to the Board, a fourth panel has been added to utilise action plan development. The fourth panel is chaired by the independent chair of the review and attended by panel members. The aim of the meeting is to develop a multi-agency, outcome focused action plan as a result of the findings and learning points identified within the report.

The groups completed an evaluation of the Welsh Methodology compared with the traditional methodology. The evaluation highlighted that on average, the Welsh Model can produce a report in a quarter of the time required and at a third of the cost. The findings from the report have been shared locally and at national conferences. Following agreement from the author, the report shall be published on the Board website.

A Case Review conference: '*Putting Learning into Practice*' was held at the Marriott Hotel in Preston. The event was attended by 130 frontline practitioners and managers. The conference included the sharing of key themes and lessons learnt from 3 SCRs and 3 SARs. The event was very well received and feedback has recommended turning the conference into an annual event.
Furthermore, a retention policy and panel member agreement have been developed. Both are shared with panel members for all SARs and SCRs.

What difference will this make to service users?

As Lancashire has embedded the Welsh methodology for undertaking Case Reviews, practitioners are directly involved in identifying themes; areas for improvements; and good practice. They are given a unique opportunity to reflect on their own safeguarding practice within a multi-agency setting allowing the learning they identify to be implemented immediately.

With the removal of recommendations within reports and the improvement of the action planning phase of the review process, action plans will be more meaningful, robust and achievable and most importantly the learning from Reviews will inform service delivery earlier. Overall, it is envisaged that improvements to the Review process will enable lessons to be learnt earlier and improve outcomes for Lancashire service users sooner.

Priorities for 2018/19

- The SAR Group are to agree a process for all SARs which meet criteria despite a STEIS report already been completed.
- Complete a thematic review of all completed SCRs and SARs.
- Review the key themes from SARs in Lancashire and compare with key themes from National SARs.
- SCR Group will transition into the MASA structures to abide to the new Working Together guidance.
- Undertake a peer review with colleagues from a SCR group in a neighbouring Safeguarding Children Board.
- Liaise with Quality and Performance Information to triangulate information submitted on the section 11 audits in relation to embedding lessons learnt from SCRs.

6.2 Learning & Development Sub Groups (LSAB and LSCB)

Role – The principal purpose of LSAB and LSCB learning & development sub-group is to promote learning and development.

LSAB

The function of the group has improved significantly in the reporting year since the introduction of the Learning Development Coordinator role, Business Support Officer, along with a consistent Chair, introduction of a Vice Chair role and widening of the membership of the group.

Key areas of success include:

- A review of the safeguarding adults E learning basic awareness package
- Continued strengthening of the learning and development repository on the Board website
- Review of the process around the 7 minute briefing series and topics for inclusion
- Inclusion of learning from Safeguarding Adult / Domestic Homicide Reviews as a standardised agenda item
- A review of the Terms of Reference
- Successful development day to plan objectives for 17/18

- Development of a process to cascade multiagency learning following the outcomes of
- SARs and learning briefs

Key Achievements for 2017/18

The Learning & Development group is responsible for the multi-agency response to learning and development across Lancashire. The group's primary function is to facilitate a more integrated approach to safeguarding learning and development to ensure all partner workforces are appropriately skilled to provide a good quality and safe service for adults with care and support needs and their carers.

- **Introduction of a training pool model –** within the reporting year an options paper was presented to the Board with the recommended option of the introduction and development of a training pool model. The board agreed to the proposed model and work has progressed in identifying skilled and motivated trainers across member agencies. Further work is required to develop peer supervision and mentoring for the trainers.
- **Learning and development session to plan business priorities –** the group have been proactive in identifying gaps in practice following local Safeguarding Adult and Domestic Homicide Reviews. Learning priorities have been agreed based on improving multiagency training opportunities which include:
    - Human trafficking and modern slavery
    - Supporting adults with care and support needs experiencing domestic abuse
    - Complex safeguarding and legislation interface
    - Implementation of a MCA train the trainer model

- **Seven minute Briefing series -** briefings have been issued following learning from safeguarding outcomes which include:
    - Information sharing and safeguarding
    - Safeguarding and oral healthcare
    - How to raise a safeguarding alert
    - Safeguarding adult reviews and the Welsh Model
    - The role of advocacy

What difference will this make to service users?

The Safeguarding board is committed to ensuring appropriate arrangements are in place to enable agencies to be skilled and competent in safeguarding. Multi-agency training is highly effective in helping professionals understand their responsibilities in respect of safeguarding practice. By developing a shared understanding of assessment and decision making practices the opportunity to learn together is greatly valued; participants report increased confidence in working with colleagues from other agencies and greater mutual respect. Learning and development is central to ensuring that services are safe and provide high quality care to service users.

Priorities for 2018/19

- Working collaboratively with the LSCB in developing joint learning and development opportunities where appropriate

- Working collaboratively with the other sub groups of the board to support a climate of culture change and learning from safeguarding outcomes
- Development and launch of a Learning and Development Framework for Safeguarding Adults
- Roll out of the training pool model with provision of robust supervision and support for the trainers
- Launch of the multi-agency learning packages in the subjects of modern slavery and human trafficking, complex safeguarding and legislation interface, self-neglect and hoarding, domestic abuse and supporting adults with care and support needs and the introduction of a MCA train the trainer programme
- Development of a programme to quality assure and peer review learning packages
- Embedding the MCA Learning and Development Framework across agencies
- Delivery of a self-neglect and hoarding conference
- Delivery of a modern slavery and human trafficking conference
- Continue to publish the 7 minute briefing series in response to local themes and trends
- Continue to strengthen learning and development opportunities via the Board website
- Incorporation of the NHS England Prevent Wrap 3 E- Learning programme via the Board website

LSCB

Key Achievements in 2017/18

- Recruitment of a new learning and Development Coordinator and Business support officer took place on 2017 following the retirement of the previous post holder in August. The new post holders took up their positions in January 2018.
- Taxi driver booklet published, sent to District Councils, four of which requested hard copies. Shared electronically with all DC's and published on website. Evaluation planned.
- New or updated courses such as Modern Day Slavery, FGM 7mb, online safeguarding and Risk Sensible and SMART planning have been added as a result of Training Needs Analysis
- 63 face to face events planned.
- Increase in course attendance - 1324 (920 in 16-17), but also with 144 non-attenders (11%) (112 in 16-17).
- E-learning was more popular and 17,633 (12.782 in 16-17) completed e-learning courses.
- 4 courses were quality assured externally
- 10 seven minute briefings were published (2 rolled over due to L&D vacancies)

What difference will this make to service users?

The availability of trained staff to deliver services will be beneficial to service users and also beneficial to the confidence of staff to deliver the services within Lancashire. Multi agency training always adds another dimension to the training leading to better role identification within the safeguarding system and understanding of organisational positions.

The process of updating training following SCR's and audit ensures that learning is cascaded to the workforce.

Priorities for 2018/19

- Joint conference with Adult Board focussing upon exploitation across all the age groups
- Re write of identified courses
- Maintenance of the present training availability through the safeguarding partnerships
- Identification of a new system upgrade for delivery of e learning and learning management system
- Continuing to respond to identified need from SCR and national and local agendas
- CAF training to ensure multi agency workforce is trained and able to access support in their locality. CAF training to be cascaded via pool of 160 trainers across Lancashire
- Multi-agency Risk Sensible training– capacity to offer places is increased with one course per month delivered in partnership with AP's

6.3 Quality Assurance and Performance Information Sub Groups (LSAB and LSCB)

LSAB

Role – to ensure that the LSAB is assured that there is an effective and wide spread approach in ensuring the safety of adult citizens of Lancashire.

Key achievements for 2017/18

The following achievements have been made based on priorities set out last year

- **Maintaining the commitment from member organisations in supporting the QAAP** – attendance at QAAP meetings is generally good with deputies sent as appropriate. QAAP have challenged some agencies with regards to non-attendance, which has had a positive impact on group membership
- **Identifying key topics for audit for 2017/18 - the first of these being *'Time scales and information sharing'***. Key topics for 2017/18 were:
    - 1 – Timescales and Information Sharing
    - 2 – Making Safeguarding Personal
    - 3 – Mental Health referrals for U65
    - 4 – Establishing a mechanism for gaining assurance that agencies are fulfilling their safeguarding responsibilities (a process equivalents to the LSCB's 'S11' audit return).
- **Ensuring the sub group maintains its focus on its key priorities** – the group made good progress of the key topics listed above. Focus on these areas of interest continues
    1. Audit report with regards to Timescales and Information Sharing yet to be received by board. A significant amount of time was needed to ensure the audit was robust enough to deal with the complex referral process into the local authority prior to the audit being undertaken. The group also focussed on ensuring that the audit tool was detailed, relevant to as many agencies as possible and included all relevant questions.
    2. MSP Audit. Audit returns have been received. Feedback event planned for Summer 2018.
    3. Mental Health referrals for U65. Initial audit report presented and concerns highlighted to board. Re-audit undertaken April 2018, subsequent audit report due to be presented at next board meeting.
    4. Work undertaken alongside the LSCB QAPI group to develop an all-age safeguarding assurance document. Returns received.

- **To further refine the performance data presented to the group and the board –** Performance dataset extended throughout 2017/18. QAAP group given opportunity to receive all data on a quarterly basis and decide based on group discussions which indicators are included in the quarterly performance report to board
- **To explore how the QAAP will align to the Safeguarding Adult Review (SAR) and the Learning and Development (L&D) sub groups –** links developed between SAR and L&D sub-groups. Several QAAP members (including board Business Manager and chairs for both SAR and L&D sub-groups) attend all 3 sub-groups and act as the conduit for information sharing. We also have a standing agenda item for themes from SAR's and feed information through to the L&D when requested.

Other key achievements include:

- **Domestic Abuse multi-agency audit –** completion of DA audit and presentation at the joint board meeting in September 2017. Considerable progress made in relation to the Action Plan which was formulated based on the recommendations of the DA audit.
- **Making Safeguarding Personal annual assurance document –** QAAP made local amendments to the ADASS MSP assurance tool and distributed to board member agencies for completion. The MSP assurance tool provides agencies with the opportunity to benchmark themselves with regards to the extent to which MSP is embedded within their agency. MSP feedback event planned for Summer 2018 to discuss the findings of the assurance exercise and discuss how the LSAB use this information to improve practice.
- **Timescales and Information Sharing audit –** a significant amount of time was invested in better understanding the process for making a safeguarding referrals prior to commencing the audit. Agencies have completed the audits that are relevant to their organisation.
- **Mental Health audit of U65 –** Audit of mental health referrals for U65's undertaken by members of QAAP sub-group. Findings reported through to board and concerns raised and addressed appropriately via an Action Plan. Re-audit recently undertaken and due to be presented at next board meeting.
- **Performance / dataset –** the sub-group receive an increasing amount of data and have become more involved in discussing what this data means with regards to safeguarding. Interrogation of data has improved in 2017/18 with QAAP members offering challenge and suggesting areas for future consideration.

  Specifically of concern to QAAP sub-group is the backlog of DoLS applications and how Lancashire compare Regionally and Nationally. This will be taken forward as a key priority for 2018/19.

  CQC data relating to CQC Inspections is routinely collated for the sub-group and included in the quarterly reports to board.

<u>What difference will this make to service users?</u>

- The implementation of an 'all-age' assurance document, evidences that agencies are fulfilling their safeguarding responsibilities. Quality assurance of these returns will provide assurance to service users that agencies are being challenged on the content of their return.

- Improvements to the dataset enable the board to be better sighted on potential safeguarding issues, thus putting the board in a better position to respond to any issues/declining performance (i.e. DoLS backlog).
- Making Safeguarding Personal annual assurance – ensures that agencies are considering MSP in detail and making efforts to ensure that the MSP concept is embedded throughout their organisations
- Timescales and Information Sharing audit – investigating this topic should help us to understand whether there are any unnecessary delays in agencies raising and responding to safeguarding concerns. Improvements in this area would have a positive impact on service users with regards to the timeliness of quality of response received from agencies

Priorities for 2019/18

- **Deprivation of Liberties** – to seek assurance from the Local Authority that DoLS Applications are prioritised and actioned appropriately.
- **Performance Dataset** – to continue to develop the LSAB multi-agency performance dataset and to seek meaningful analysis from agencies which can better explain what the data means.
- **Safeguarding Annual Assurance** – working together with the LSAB QAAP sub-group to quality assure and challenge agencies with regards to their S11/Care Act compliance returns
- Setting of the QAAP groups priorities has been delayed until the new joint Business Plan for the Boards is finalised. It is anticipated that future audits will include an audit of current DNA CPR/MCA process, DoLS audit and any other topics which are highlighted for QAAP within the final business plan.

LSCB

Role – to develop QA capacity and test the quality of multi-agency responses to vulnerable children and their families in order to inform service development and training needs.

Key achievements for 2017/18

The following achievements have been made based on priorities set out last year

- **Complete risk register amalgamating risk that currently sit at a sub group level and ensure regular updates to board –** work undertaken in 2017 to agree risk appetite. Risk register recently updated and priority rolled over into 2018/19 due to decision being taken to refresh Business Plan and Risk Register and produce joint documents to cover both Children's and Adult's boards
- **Robust analysis of S11 audits utilising new format and all members of the QAPI group to agree partners to be challenged –** priority addressed in full. Extended QA activity undertaken, including desk based assurance of S11 returns and challenge events to a variety of agencies
- **Undertake agreed multi-agency audits and focus group reviews**
    - Multi-agency audit of non-accidental injuries (this was not received by board until May 2018 – although all the audit work was undertaken in 2017/18), this topic was chosen in response to recommendation from child LE SCR.
    - Cannabis survey (in response to recommendations from 3 Lancashire SCRs).
    - Re-audit of Strategy Discussion / S47 Process

- **Monitor completion of action plans against completed audits** – completion of action plans has progressed throughout the year, QAPI have oversight of the progress made and sign off action plans accordingly. An action plan was also prepared to address additional work needed to ensure District Councils were fulfilling their safeguarding responsibilities.

Other key achievements include:

- **S11 Returns –** extended quality assurance activity of 2017 S11 returns. Desk based quality assurance of every S11 return undertaken by members of the QAPI group and quality assurance visits undertaken to identified agencies.
- **District Council engagement event –** S11 feedback provided to District Councils as a collective via a half day engagement event. This was well received and also gave the LSCB the opportunity to brief the District Councils on recent SCR/SAR publications and to encourage the District Councils to work more closely with the boards.
- **Joint work undertaken with Adults QAAP group to amend S11 template and produce an all-age assurance template –** review of S11 template by members of QAPI and QAAP group. Questions considered and amended to ensure they are applicable to all ages. Annotated version of the template created to assist agencies in completing the return.
- **NAI Audit –** significant planning undertaken prior to NAI audit commencing. Ensuring the cases chosen for audit are appropriate and provide the opportunity to multiple agencies to be involved in the audit. Additional time taken by QAPI to review the audit tool used in order to ensure that the questions included cover all areas of interest and allow us the opportunity to fully address the recommendation made in child LE SCR
- **Cannabis Survey –** Survey Monkey created and distributed to partner agencies to survey staffs understanding of cannabis and their awareness with regards to the effect on parenting capacity. Over 500 returns received and comprehensive report written for board detailing the findings of the survey. Cannabis briefings rolled out across Lancashire and a repeat survey planning for late 2018 to measure the impact of the briefing sessions.
- **Re-audit of strategy discussion/S47 process –** re-audit undertaken to establish whether the recommendations made in response to the original strategy discussions audit (2017) had been embedded. Evidence found within CSC records of improved recording of strategy discussion attendance, multi-agency involvement and improvements with regards to the experience level of the social worker involved in the case.
- **Performance –** ongoing efforts made to improve the LSCB Multi-agency dataset, including adding additional indicators to the dataset in relation to CSE, Missing and Health. Level of analysis included within board report also continues to improve.

<u>What difference will this make to service users?</u>

- S11 process is more robust, providing service users/wider public with assurances that agencies are required to evidence that they are fulfilling their safeguarding responsibilities adequately.
- QAPI priorities are fed by recommendations from SCRs, proving that we are learning lessons from SCRs and taking action to try and prevent future harm.
- Improvements to the dataset enable the board to be better cited on potential safeguarding issues.

- Closer working with District Councils, reinforces the fact that safeguarding is everybody's business.

Priorities for 2018/19

- Working together with the LSAB QAAP sub-group to quality assure the S11/Care Act compliance returns
- Completion of Action Plans relating to multi-agency audits
- Consideration to be given to the Joint Targeted Area Inspection (JTAI) auditing process and JTAI audit topics

6.4 Policies and Procedures Sub Groups (LSAB and LSCB)

Role – to develop local policy and procedures in relation to safeguarding and to scrutinise local arrangements.

LSAB

The sub group was established in November 2017 and developed Terms of Reference to support the governance arrangements and function of the group. The function is to include horizon scanning with regard to new legislation and best practice; to include policies and procedures commissioned by the LSAB; terms of reference to be reviewed every 12 months and current membership to include a Police representative, Advocacy Focus, Social Work from LCC, representation from CCG, housing and provider representative.

Policy review programme agreed as follows:

1. People in Positions of Trust
2. Self-Neglect
3. Hoarding
4. Making Safeguarding Personal
5. FGM (LSCB)
6. Resolving Professional Disagreements (LSCB)
7. SAR Protocol
8. Financial Abuse – *to be looked at in 2018*
9. Domestic Abuse - *to be looked at in 2018*
10. Modern Slavery – *to be looked at in 2018*

Key Achievements for 2017/18

There has been progress made on policies numbered 1-7 with several policies either agreed or in final draft. For these policies to be developed there has been several task and finish groups that have been established where there has been good multi agency working, including challenge and ensuring that each agency were able to raise their issues.

What difference will this make to service users?

Service Users should have a consistent approach from agencies when they have been unable to protect themselves against abuse or harm enabling them to be supported and protected when they are in high risk situations.

Priorities for 2018/19

The group will continue to work on the completion of the policies in draft form and also work on Policies relating to Domestic Abuse, Financial Abuse and Modern Slavery on behalf of the LSAB.

LSCB

Key Achievements for 2017/18

The group has become well established within the reporting year, gaining a clear position and direction in readiness for 2018/19. Key achievements include:

- Review of membership
- Agreement of a clear Terms of Reference
- Review Tri-X Communication and establishment of Pan-Lancashire and Cumbria Adult Safeguarding Procedures
- Prioritise outstanding actions from other sub groups, including SCR.

What difference will this make to service users?

It will help to improve practice to allow for a prompt and appropriate response to safeguarding needs.

Priorities for 2018/19

- To finalise concealed and denied pregnancy guideline.
- Resolving Professional Disagreements process – to be reviewed
- Review pre-birth protocol
- Develop Standard format for presentation to LSCB.

6.5 Mental Capacity Act Implementation (MCA) Sub Group (LSAB)

Role – to advise the LSAB on processes, procedures and outcomes in relation to the implementation of the MCA and Deprivation of Liberty Safeguards (DoLS).

Key achievements for 2017/18

The group have made considerable progress in the reporting year and have achieved the priorities outlined on the work plan. Key areas of success include:

- Providing assurance to the Board on how the MCA is embedded across its member agencies responsible for adults with care and support needs
- Completion of a benchmarking exercise using the ADASS MCA improvement tool
- Development of a suite of learning and development resources
- Completion of the Pan Lancs MCA research project and stakeholder event to disseminate the research findings
- Provision of targeted educational sessions for services

- Raising awareness of the Act with the public and carers
- Development of best practice guidance for professionals on 'do not attempt resuscitation' DNAR CPR
- Incorporation of service improvement initiatives following the outcomes of Safeguarding Adult Reviews
- Development of a best practice sample MCA/ DoLS policy for use across agencies or to benchmark against existing policies
- Implementation of a best practice covert medication pathway

Other headline achievements include:

- **Mental Capacity Act Learning and Development Framework** – the group have developed a MCA Learning and Development framework. The framework is based on the University of Bournemouth competencies and is a forward looking document which sets out a suite of training packages with the aim of supporting the achievement of MCA implementation across the Health and Social Care Economy. The framework will contribute to agency effectiveness over the coming years with the best practice packages being accessible via the Lancashire Safeguarding Adults Board's (LSAB) website.
- **Multi agency audit against the ADASS Improvement Tool** – the group conducted a multiagency audit to assess the quality of services with the aim of identifying and promoting good practice and to highlight areas for further development. The tool is grouped into four main themes and includes:
    - Outcomes and experiences for people using services
    - Leadership, strategy and commissioning
    - Service delivery and performance
    - Partnership working

  An action plan is in progress which is being monitored by the Board. Despite a significant amount of progress over the year in awareness raising and developing best practice to support MCA implementation, there have been a number of challenges demonstrated in learning identified from Safeguarding Adult Reviews. This highlights the need to do more around sharing consistent messages of implementation of the Act and holding agencies to account in the embedding of the Act in practice. Further work is required by the subgroup in the coming year to monitor the effectiveness of MCA implementation and to provide assurance to the Board.

- **Pan Lancashire MCA Research Project –** NHS England North region commissioned a 12 month research project across Lancashire. The aim of the project was to explore the experiences of working with the MCA and DoLS within health and social care settings. Following the conclusion of the research a stakeholder event was held with over 250 people in attendance. The findings demonstrated that:
    - There is a lack of access to expert training/case law updates for MCA leads within the private sector; statutory services are able to access expert training/ case law updates
    - There is awareness of the MCA across agencies but staff have difficulty in applying the principles in practice
    - There are inconsistent messages between the Supervisory Body and the regulator

  The findings were shared with the Safeguarding Board and NHS England with the aim of the recommendations being taken forward from a national, regional and local perspective. The

actions have since been incorporated within the ADASS action plan for the sub group to consider how current arrangements can be strengthened.

- **Multi-agency targeted training opportunities –** using funding provided by NHS England Browne Jacobson were commissioned to deliver four multiagency practice events on case law / MCA & DoLS and court preparation workshops. The sessions were targeted at MCA leads / senior practitioners and were well attended and evaluated well.
- **Public / Carer engagement awareness opportunities** – three carers events were delivered across the Lancashire localities using 'Afta Thought', a drama based educational company. The sessions provided real life scenarios on the principles of the Act and understanding of individuals rights. The sessions were well attended with over 120 people attending across the three localities. The public made the request for 'more sessions like these' with the sub group keen to deliver further training when funding opportunities become available. Key areas of discussion included:
    - DNAR and Lasting Power of Attorney
    - Supporting older parents with capacity and decision making
    - Court Appointed Deputies/ Lasting Power of Attorneys and transition into adult services.
- **Court of Protection (COP) collaborative task group –** a task group was set up to standardise MCA/ DoLS with the aim of improving consistency in approach across the CCGs and Local Authority where application to the Courts are required. The group was initiated to formalise the dialogue between health and social care to ensure involvement in court proceedings is as timely and effective as possible. The group brings together lead professionals with responsibilities for coordinating, overseeing, managing and / or making applications to the COP on behalf of the CCGs and Local Authority. The group reports into the subgroup around areas for development and service improvements. A recent success includes the development of a standardised prioritisation tool to determine individuals who are supported in a domiciliary setting and may need an application to the Court.

<u>What difference will this make to service users?</u>

The Mental Capacity Act 2005 is an important piece of legislation and one that will make a real difference to the lives of people who may lack mental capacity. It empowers people to make decisions for themselves wherever possible and protects people who lack capacity by providing a framework that places individuals at the heart of the decision-making process. It enables individuals to participate as much as possible in any decisions made on their behalf and ensure that these are made in their best interests. The Act also allows people to plan ahead for a time in the future when they might lack the capacity, to make decisions for themselves. All agencies have a responsibility to ensure that the services they provide pay regard to the MCA and the principles outlined within the Act.

The sub group is committed to ensuring that best practice information is available for service users, and the public about the MCA and about the promotion of the rights of individuals who may lack capacity to consent to care and treatment. Service user views are incorporated into practice development initiatives where possible.

Priorities for 2018/19

- Working collaboratively with the LSCB in strengthening awareness of MCA / DoLS for services supporting young people age 16 & 17 years old, including improving service user experience of MCA for young people transitioning into adult services
- Raising awareness across agencies regarding use of Advocacy Services incorporating Care Act requirements and Making safeguarding Personal
- Embedding the MCA Learning and Development Framework across agencies via the Board Learning and Development sub Group.
- Improving experiences and outcomes for people who use services regarding MCA, by the development and implementation of a standardised audit tool for use across board agencies
- In collaboration with the Communication and Engagement Sub Group of the Board to inform the development of consistent customer feedback tools, to gain customer feedback regarding experiences of the MCA/DoLS in practice
- Continue to seek assurance regarding performance and resource management within the Local Authority and Lancashire CCGs around the management of the backlog of unauthorised DoLS and the impact on service user experience
- Continue to support agencies in strengthening arrangements to ensure the embedding of MCA/ DoLS in practice and seeking assurance via the Board

6.5 Practice with Providers Sub Group (LSAB)

Role – a multi-agency forum to discuss the wide safeguarding agenda following amendments to the Care Act, with a view to raising awareness and sharing learning across agencies and providers.

Key achievements for 2017/18

- The LSAB safeguarding guidance and its appendices, referred to above has been shared widely with practitioners and providers alike promoting that safeguarding is everybody's business. Importantly the guidance seeks to support registered providers have confidence and understanding as to when to raise safeguarding alert with the Multi Agency Safeguarding Hub. The purpose is to encourage appropriate alerts with inappropriate alerts reduced
- Appendix 4 to the LSAB concerns guidance – incidents between service users was developed and approved. This guidance promotes services being proactive to prevent incidents in the first place but when incidents occur to increase understanding within provider services as to the actions to be considered including when to raise a safeguarding alert.
- A 7MB on oral health (work commenced in January 2017) was finalised and promoted with providers to promote good oral health in services to reduce the incidence of omission or neglect in this area
- An example of a sample Nursing and Residential Safeguarding Policy which is Care Act compliant has been shared to support providers with this requirement.
- A task and finish group was established to update DNAR CPR guidance for Care and Nursing homes. This work was needed following guidance launched in June 2017 whereby when health professionals discover that a person is dying as an inevitable result of advanced, irreversible disease or a catastrophic event and there is no realistic prospect of a successful outcome, CPR should not be offered or attempted. The updated guidance for Care and Nursing homes is now available.

- Safeguarding Guidance for Providers when completing Internal safeguarding enquiries and a Provider led safeguarding enquiry template has been developed.
- The Residential Champions model was launched in 2015 and these champions meetings have grown in success and in attendance. Concerns identified in safeguarding alerts and through the quality improvement planning meetings highlighted particular difficulty many domiciliary providers have in complying with the MCA, despite having some level of training. A Domiciliary Champions Forum was launched during the year (facilitated by LCC with input from the CCG's) with three meetings taking place each year and commenced in January 2018. (April and October 2018 booked) the Champions forum through the use of case studies and group work is providing an opportunity to gain greater depth of understanding to shape day to day safeguarding practice
- Adverse Childhood Experiences - the group received a presentation on the impact of ACE's into adulthood and the consequences on the adult's health and social wellbeing. Referred to the LSAB for further consideration
- Prescribing for Clinical Need Policy – the Head of Medicines Optimisation from the Chorley and South Ribble CCG attended the sub group to enable discussion and increased understanding of the research and evidence for this low priority prescribing policy. Providers were provided with further written information regarding homely remedies and Q&A information sheet for patients.

What difference will this make to service users?

More than 50% of all safeguarding alerts to LCC are received from residential and nursing home providers. This increases to more than 70% when alerts from domiciliary and supported living services are included.

The sub group of the LSAB promotes and support residential and domiciliary provider in Lancashire to understand their safeguarding duties and responsibilities to mitigate risks and provide safe services so that adults with care and support needs in receipt of these services are protected from abuse and neglect and their care needs are safely met.

Service user 'voice' is heard and directs safeguarding activity to achieve the outcomes that they want to feel safe and protected from abuse.

Through sharing (from SAR's and Complaints) promote a culture of learning from errors and continuous service improvement

Priorities for 2018/19

- The sub group will engage and support Providers to contribute and support the LSAB key priorities for 2018/19
- MSP will continue to be discusses at each meeting to keep this important Board priority high on the agenda and provide the bed rock for all the work that is delivered.
- The LSAB safeguarding concerns guidance approved in April 2017 will be reviewed and amendments made in the light of operational use and re-issued
- Finalise an Easy Read version of the DNAR CPR leaflet

- Develop guidance for practitioners and providers as to the considerations and actions needed when financial abuse is suspected
- A sample Safeguarding Policy for Non-residential services will be developed
- Continue to support and develop the Domiciliary Champions Model
- Raise awareness with Providers and take forward learning from SAR's appropriate to service providers

6.6 Leadership Sub Group (LSAB)

Role – a multi-agency forum to discuss the wide safeguarding agenda following amendments to the Care Act, with a view to raising awareness and sharing learning across agencies and providers.

Key achievements for 2017/18

This year some of the subjects we have explored and shared learning around the following areas:

- Prevent and Channel process (government's strategy on counter terrorism)
- Female Gentile Mutilation
- Advocacy
- Scams and trading standards work
- Financial abuse and safeguarding
- Making safeguarding personal
- MASH and safeguarding service
- Domestic Abuse
- The effects of hoarding on people
- Adult social care policy and procedures for managing service provider and quality and performance in community services
- The importance of advocacy.

What difference will this make to service users?

By sharing knowledge and expertise in the above areas, partners are able to embed this within their organisation and ensure that their staff are aware of how to deal with this broad spectrum of concerns and where they can access support.

Multi agency professionals have a link to the board through this group and provide feedback to the board as appropriate.

Priorities for 2018/19

- Human Trafficking and Modern Slavery;
- Domestic abuse;
- Communication of Board priorities;
- Development of pictorial communication aids;
- Learning around safeguarding adult's reviews
- Self-neglect framework.

6.7 Lancashire Child Sexual Exploitation Operational Group (LSCB)

Role: Operational multi-agency group to ensure a coordinated multi-agency response to CSE.

Key achievements for 2017/18

The work conducted by this group in 2017-18 has been disjointed. This is as a result of several changes to the chair position and some slippage on the action plan for the group. A new chair was appointed in October 2017. Since the appointment of a new chair, the group is meeting regularly and has gained some momentum in relation, focusing on the following:

1. Re-energising the group
2. Assessing the groups purpose and mandate
3. Creating effective governance in the form of priorities, an operational plan and generating actions.

As a result of these priorities the group is in discussion with the Board around a rebranding to take account of the wider mandate for the group than has previously existed and now encompasses child criminal exploitation and human trafficking and modern slavery.

The group has also made significant progress in formulating performance indicators for child safeguarding (particularly within the Police). The intention is to use this progress to create a wider multi-agency performance programme that is built on Microsoft business intelligence and will provide the group with a multi-agency performance dashboard. Of note, the new indicators are more holistic and are focused upon a child centric purpose which is “Keep me Safe. Listen and Believe me. Make it stop”. With this approach we aim to measure impact and evidence outcomes more effectively.

What difference will this make to service users?

Now the group has improved co-ordination and governance it can return to its previously productive state. This will improve the service delivered to victims of exploitation in Lancashire through improved awareness amongst safeguarding practitioners and sharing of best practice.

Immediately, the dash boards being created will serve to enable the group to understand the impact they are creating so future assessments can be more meaningful.

Priorities for 2018/19

- Improving and creating consistent working practices between the various partner agencies that relate to exploitation.
- Conducting bespoke intervention programmes to protect and safeguard children of exploitation.
- Improving performance measurement at a multi-agency level to increase understanding of impact.

6.8 Pan-Lancashire Online Safeguarding Sub Group (LSCB)

Role – To raise awareness and support agencies in protecting young people from the risks associated with the use of the internet and social media.

Key Achievements for 2017/18

- Continued development of (Pan-Lancashire) Online Safeguarding section of LSCB website with increasing use by stakeholders
- 'LSCB Responding to Sexting Flowchart' resource developed to counter mis-information and support Pan-Lancashire schools in appropriately addressing Sexting instances in-line with recommended best practice.
- 'LSCB Making Sense of…Keeping Children Safe in Education', 'LSCB Governor Checklist' and 'LSCB Responding to Sexting Flowchart' resources have received very positive reception from Schools. Resources received positive feedback from Ofsted during school inspections. A number of requests received from other areas of the UK to utilise the Lancashire resources.
- Successful delivery of Keeping Children Safe Online (KCSO) Foster Carer/Adopter course series (c. 300 parents/carers)
- Online Safety Live 2018 successfully delivered attracting highest ever attendance. Feedback immensely positive with increased engagement from primary sector colleagues
- Large cross-sectional dataset developed for children's workforce including evidence to allow historical comparison and inform future support priorities
- P4S (preventforschools.org) – continued maintenance. Continually increasing usage both within and beyond Lancashire region. Highest ever traffic recorded (to-date) in January 2018
- Historical and largely outdated policies and procedures information on Tri.x platform updated to reflect current recommended guidance and best practice
- Continued engagement at national level to inform, influence and develop national progression
- LSCB-produced resources regularly attract broad interest from the wider UK and beyond
- Interpreting strategic/high-level requirements into practical guidance remains popular (e.g. 'Making Sense of…KCSIE', 'Governor SRT Checklist') both at local and national level

What difference will this make to service users?

- Service users have access to quality research on current and future developments as the (often complex) online safety agenda continues to develop (e.g. Impact of Social Media on CYP's Emotional Health & Wellbeing)
- Increased confidence across Children's workforce to support addressing the broadening online safety agenda through an informed approach
- Governors and proprietors have a clearer understanding of responsibilities in relation to Online Safety and best practice recommendations
- Teachers and professionals have access to current, good quality resources to support delivery and inform progression
- Improved consistency of online safety-related activity and core messages across the Lancashire children's workforce
- Improved understanding and acknowledgement that Online Safety is an increasingly important key area of Safeguarding provision

Priorities for 2018/19

- Provide annual Online Safety Live (OSL) event in 2019 as principal Pan-Lancashire engagement event to support Online Safety and provision of workforce dataset
- Build on central Govt focus and forthcoming UK Internet Safety Strategy priorities
- Maximise opportunities provided through UK Council for Child Internet Safety (UKCCIS) 'Connected Framework' guidance to support age-appropriate education beyond historical online safety messages
- Maintain and further develop online web presence as principal engagement resource for Quality Assured Online Safety guidance and recommended best practice
- Progression of Parent/Carer engagement priorities as highlighted in OSL 2018 workforce dataset plus broader key areas for support identified through OSL 2018 dataset
- Maintain, review and develop P4S website to support schools in progression of Prevent duty-related priorities
- Develop securing the views of Lancashire's C&YP re: Online Safety through engagement opportunities to inform future progression and improve effectiveness and education
- Provide opportunities for practitioners to develop 'beyond-awareness' knowledge and skills
- Continued delivery of KCSO for Foster Carers and Adoptive Parents in-line with progressing support for vulnerable groups
- Review and update LSCB 'Making Sense of…KCSIE' guidance to reflect 2018 revisions highlighted in DfE 'Keeping Children Safe in Education'
- Increased engagement across children's workforce partners to address challenges of in-silo activities and outdated approaches
- Reflect LSCB joint-business approach through development of adult-focussed provision including vulnerable groups and associated risk areas

6.9 Pan-Lancashire Child Death Overview Panel (CDOP) (LSCB)

Role – Reviews all child deaths in Lancashire to identify themes and trends to inform preventative developments

Key Achievements 2017/18

- **CDOP Conference –** in May 2017 the SUDC Prevention Group hosted the 'Make Every Contact Count' conference. The aim of the conference was to assist frontline practitioners in preventing infant deaths and to give practitioners more confidence when delivering safer sleep messages to parents and to also challenge parents regarding safer sleep arrangements. The aim of the conference was to also provide information about what happens when a child dies and how they are investigated. Various professionals from across Pan-Lancashire presented including the SUDC team, members from Public Health, LCFT, Lancashire Constabulary and the Blackpool Coroner. The theatre group 'AftaThought' delivered two live performances around infant deaths and safer sleep which were very powerful. The conference was well attended with over 120 delegates in attendance and received excellent feedback.
- **Safer Sleep Campaign** – the Campaign has continued to supply professionals with materials to support them in providing consistent messages to parents/ carers across pan-Lancashire. For the third year running a bulk order of the materials was placed with regional colleagues

(Pan-Cheshire and Merseyside CDOPs). This significantly reduced the cost for pan-Lancashire and provided regionally consistent messages and reduced cross-border differences particularly for acute trusts.

- **SUDC Service Development –** in response to the SUDC Service review that was undertaken in 2016 the SUDC Service with support from CDOP business members explored the most cost efficient ways with commissioners to extend the service. In response, the service is currently in the transition of extending to a 7-day service in order to be more compliant to Working Together 2015 and the Kennedy Principles 2016. Equity of responses will also be improved. It is thought that the service will be fully up and running by September 2018.

What difference will this make to service users?

Under Working Together 2015, Chapter 5, the CDOP is a statutory function of the Local Safeguarding Children Boards that reviews all deaths of children resident across pan-Lancashire from age 0-17 years to prevent future deaths and to analyse themes and trends. By far, one of CDOPs biggest achievements is the safer sleep campaign that outlines the six steps to safer sleep. The campaign is embedded into frontline practice across community and acute trusts, voluntary organisations and children's centres. Since its launch in 2014 the number of safer sleep deaths have decreased. However, this does still remain an issue and CDOP continually looks to improve the campaigns.

Additionally, reviewers on behalf of CDOP have undertaken thematic reviews into deaths due to trauma and other external factors, deaths due to infection and an audit has been undertaken into the CDOP cases to analyse the number of ACEs. Reviews such as these give a greater insight into particular themes with the aim of implementing recommendations to try and prevent similar deaths.

Priorities for 2018/19:

- Transition to the new Child Death Review Guidelines and proposed changes
- Ensure CDOP is integrated into wider networks/partnerships and collaboratives
- Ensure that CDOP is involved in the Strategic Suicide Prevention Group
- Monitor the CDOP database
- Monitor the extension of the SUDC Service
- Implement recommendations from the ACE audit
- Implement recommendations of the reviews into trauma and infection
- Engagement with GPs
- Monitor the SUDC Prevention Group

6.10 Joint Communication and Engagement Sub Group

Role – to enable the effective delivery of key messages and awareness raising around issues of safeguarding for the residents of Lancashire

The Communication and Engagement Sub Group was established in June 2017/18. Whilst initially established as a Lancashire group, members agreed that a pan-Lancashire approach would be more effective and so the membership was extended to reflect the wider footprint and it now covers all three local authority areas.

The group meets on a quarterly basis and the main focus of the reporting year has been around full establishment of the group with Terms of Reference agreed in November 2017, and the creation of a Communication and Engagement Strategy and supporting work plan.

In January 2018, the group agreed 5 key priorities for the year ahead, which was agreed by Lancashire, Blackpool and Blackburn with Darwen Boards. The priorities are:

1. Safeguarding is Everyone's Business;
2. Domestic Abuse;
3. Self-Neglect;
4. Online Safeguarding;
5. Safeguarding in Extremism and Radicalisation.

Key Achievements for 2017/18

- Full establishment of the Sub Group and Terms of Reference;
- Development and agreement of a Strategy and supporting work plan for 2017/18;
- Initiated the development a suite of 'Safeguarding Leaflets' to promote an awareness and understanding of safeguarding in various settings to assist practitioners and members of the public in recognising that safeguarding is everyone's business, and what to do when there is a concern;
- Developed business case and gained agreement to enter a pilot of a secure members area/collaborative workspace for Board members;
- Twitter – both the LSAB and LSCB Twitter feeds have been utilised again during 2017/18 to further promote key safeguarding messages. In June 2018, the decision was taken to merge the two accounts together with a view to sharing joint messages in the future. Over the reporting year, the platform has been used to support many national and local campaigns and signpost users to information and support. Examples of campaigns include:
    - Child Safety Week – June 2017
    - Exam Results support – August 2017
    - Lancashire CSE Awareness Week – November 2017
    - Road Safety Awareness Week – November 2017
    - Safer Internet Day – February 2018
    - National CSE Day – March 2018
    - Safer Sleep Week – March 2018
- Establishment of an annual Safeguarding Awareness Week – the first awareness week took place outside of reporting year in June 2018. The week was a slightly scaled back approach, utilising social media to promote safeguarding messages around "Safeguarding is Everyone's Business" and sharing information on the types of abuse; how to spot the signs; and how to report concerns. The week will become an annual event.

Priorities for 2017/18

- Agree and undertake actions to deliver key messages against the five campaign areas set out above;
- Establish and publish quarterly newsletters regarding safeguarding matters;
- Further develop the LSAB website, and review and update existing content of the LSCB website;
- Establish effective methods of engagement to gain the views and input of service users;
- Identify methods to measure the impact of communication and engagement activity.

6.11 MASH Strategic Board

Role: Implementation of the re-design of MASH, which had been agreed by partners. An Improvement Partner was appointed in May 2017 to provide additional capacity to work with partners to bring about the changes.

Key Achievements for 2017/18

As part of a review of the MASH, multi-agency practitioner events and a multi-agency diagnostic involving the Lancashire Safeguarding Children Board (LSCB) were undertaken and identified there was a need for change. The review considered the purpose of the MASH and the flow of work into the service alongside the processes in operation. This identified duplication and too many steps in the process. It was recognised that multi-agency working practices were required for all referrals into the front door. (At that time the MASH only dealt with Police referrals. All other referrals went into a single agency (local authority – children's services) Contact & Referral Team). As part of this work, the Police Futures Team along with partners undertook a review of referrals into the "front door" using a systems thinking approach. The developments highlighted below came out of a multi-agency recognition that the purpose of the MASH was to focus on timely decisions with the child and family at the forefront.

As a result, a service re-design commenced in May 2017 with the following key developments: -

- Reconfiguration of MASH into a locality model with partners sitting together on a North, Central and East footprint in one large room in Lancashire House, Accrington. This mirrors the structure of the locality social work teams. Police, Children's Social Care, adult safeguarding, health practitioners and MASH early help officers are co-located in each team. Probation, education workers and an Independent Domestic Violence Advisor (IDVA) are sitting in the same room on a centralised basis so they are easily accessible to each MASH locality team. Fire and Rescue, substance misuse and the Youth Offending Team (YOT) are virtual partners. This means there is a consistent group of multi-agency professionals managing the work in one geographical area only. This has enabled relationships to be built within the MASH and with partner agencies outside of the service, including a shared understanding of roles and responsibilities and aims and objectives. Information sharing and decision making has improved because of the close proximity of partner agencies.
- Police vulnerable person (PVP) referrals are triaged by the Police in each MASH locality team prior to entering the MASH and those at level 2 are stepped down to the Children and Family Wellbeing Service (CFWS) in the relevant MASH locality team or to the early help integrated teams/Police Early Action Teams. These are at varying stages of development, with the intention

that they will be fully operational across the county by April 2018. Children's Social Care have implemented a model whereby the triage, information sharing and decision making on contacts and referrals involves one social worker and one manager in the same team from start to finish, preventing unnecessary handovers and delay.

- Dispensed with the distinction between MASH - dealing with Police referrals only and the Contact and Referral Team (CART) - dealing with referrals from any other source. The MASH is now a single point of contact for any concerns relating to a child not already open to Children's Social Care.
- Changes have been made to the role of the Customer Access Service (CAS), with clearly defined roles depending on whether a telephone query relates to an existing open case to Children's Social Care or a new referral. Whereas previously the CAS (unqualified staff) dealt with all telephone calls and where appropriate signposted to other agencies, all calls regarding a child welfare concern are now transferred to a qualified social worker, thereby, bringing expertise closer to the customer. Qualified social workers are therefore undertaking triage and assessment with practice manager oversight.
- A MASH service development plan is in place along with new governance documents and the creation of a MASH Operational Group which reports to the MASH Strategic Board. Partners have been fully engaged with the changes and feedback from them is positive. Following the Ofsted monitoring visit to MASH in February 2018 a refreshed plan is now in place focusing on quality of practice.
- A MASH Operational Manual has been developed and work is taking place to upgrade the Liquid Logic Children's System (LCS) to include the Early Help/MASH module. This will further strengthen multi-agency information sharing and timely decision making via one IT system, which partners will have access to. The MASH module will go live in October 2018.
- As a result of the MASH re-design, there has been an increase in the number of Children's Social Care staff in the service.
- Ofsted Monitoring visit to MASH in February 2018 highlighted a number of positives in relation to the MASH re-design, including good management oversight
- Multi-agency training in relation to domestic abuse is being delivered to all staff in MASH
- All partners have received refreshed training in relation to the CoN and thresholds and also risk sensible
- A tracking tool that tracks the timelines of decision making.

<u>What difference will this make to service users?</u>

The above important changes have provided the necessary foundations to now enable there to be a focus on improving the quality of practice within MASH. We are seeing improved information sharing arrangements between partners and which is contributing to more timely decision making.

Work is taking place with social care staff on the analysis of need and risk including the lived experiences of the child, consideration of relevant historical information and focusing on outcomes.

<u>Priorities for 2017/18</u>

- Continuing to embed improvements in quality of practice and timely decision making for children linked to service development plans

- Implementing the MASH module for all partners to use including new developments involving Lancashire police
- A focus on the MASH re-design relating to adult safeguarding
- Continuing to receive and analyse performance information relating to children and adult safeguarding
- Continued analysis of Contact to Referral conversion rates including volumes.
- Undertaking MASH development day involving partners to reflect on the developments to date and priorities for 2018/19

7. Budget

The below details the contribution and expenditure against the LSAB/LSCB budget during 2017/18.

INCOME	Outturn 17/18
Contributions to Board	
North Lancashire CCG	-33,164
Fylde & Wyre CCG	-33,164
Greater Preston CCG	-28,214
West Lancashire CCG	-14,850
Chorley & South Ribble CCG	-23,265
East Lancashire CCG	-66,329
Police	-76,723
Community Rehabilitation Company 17/18	-4,896
Cafcass	-550
Lancashire County Council	-257,009
Lancashire Teaching Hospitals NHS Trust	-4,000
Training income	-7,000
Miscellaneous Income	-3,150
Transfer from reserves	-88,233
	-640,546
Child Death Overview Panel	
Lancashire County Council	-74,000
Blackburn with Darwen Borough Council	-14,700
Blackpool Borough Council	-9,800
	-98,500
TOTAL LSCB/LSAB INCOME 17/18	**-739,046**
EXPENDITURE	
Staffing Costs	460,724
Transport	7,614
Supplies	134,159
Training	56,160
Other Expenses	7,416
Provision O/s Invoices	72,973
TOTAL LSCB/LSAB EXPENDITURE 17/18	**739,046**

8. Contact Details

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Appendix 1 – Service Area Annual Reports

1. Local Authority Designated Officer (LADO)	LADO Annual Report 2017 2018 F]
2. Common Assessment Framework (CAF)	CAF.pdf
3. Counter Terrorism	Counter Terrorism.pdf
4. Domestic Abuse	Domestic Abuse.pdf
5. Independent Reviewing Officer (IRO)	IRO Annual Report 2017-18 FINAL.pdf
6. Multi-agency Public Protection Arrangements (MAPPA)	Mappa 2018.pdf
7. Secure Estate (Young offenders institutes)	YOT.pdf
8. Private Fostering	Private Fostering.pdf

Appendix 2 – Attendance Breakdown 2017/18

Lancashire Safeguarding Adult Board meetings Member representation	% Atn
Independent Chair	100
LCC – Director of Adult Services	83
LCC – Lead Member	67
LCC – Head of Patient Safety and Quality Improvements	83
LCC – Principal Social Worker	50
LCC – Quality Improvement and Safety Specialist	67
LCC – County Operations Manager	33
Lancashire Constabulary	100
Chorley and South Ribble, West Lancs and Preston CCG	100
East Lancashire CCG	83
Fylde and Wyre CCG	100
Morecambe Bay CCG	67
Lancashire Care Foundation Trust	100
Lancashire Teaching Hospitals	67
Merseycare NHS Foundation Trust	100
NHS England	33
NW Ambulance Service	50
Probation	100
Cumbria and Lancs Community Rehabilitation Company	100
Lancs Fire & Rescue Service	83
Healthwatch Lancashire	100
Prison Services	33
Progress Housing	100
Lancashire Care Association	50
Lancashire Sport	33
Overall	**75**

Lancashire Safeguarding Children Board meetings Member representation	% Atn
Independent Chair	83
LCC – Director Children's Services	100
LCC – Lead Member	67
LCC – Director Public Health	50
Lancashire Constabulary	83
Chorley and South Ribble, West Lancs and Preston CCG	67
East Lancashire CCG	83
Fylde and Wyre CCG	83
Morecambe Bay CCG	100
Blackpool Teaching Hospitals	50
East Lancashire Teaching Hospitals	100
Lancashire Teaching Hospitals	100
Lancashire Teaching Hospitals (GP Rep)	83
Lancashire Care NHS Foundation Trust	83
Southport and Ormskirk Hospitals	83
University Hospital of Morecambe Bay	67
NHS England	33
Probation	83
Cumbria and Lancs Community Rehabilitation Company	83
Wyre Borough Council	100
The Children's Society	50
HARV	17
Cafcass	83
Primary Schools	33
Secondary Schools **No representative was in place during 2017/18*	0
Further Education	67
Lancashire Association of School Governors	50
Lancashire Fire and Rescue Service	33
Overall	**68**

Lancashire Health and Wellbeing Board
Meeting to be held on Tuesday 18 September 2018

Role of Lancashire Fire and Rescue Service on the Board

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Executive Summary
Fire and Rescue Services and health and social care partners operate in the heart of local communities to increase safety, health and wellbeing of the people living and working there. They are concerned with prevention and early intervention. Most importantly, all are reaching out to the same people and families who find themselves at risk of accident or ill health.

On 1 October 2015 NHS England, the Chief Fire Officers Association, the Local Government Association, Public Health England and Age UK published a joint 'Consensus Statement' setting out a national commitment to improve health and wellbeing. The aim being, to support vulnerable people and those with complex needs to get the personalised, integrated care and support they need to live full lives and sustain their independence for longer, thus reducing demand on fire, health and social care services. By working in partnership in the wider health and wellbeing context, Fire and Rescue Services are well placed, to help enhance and improve shared outcomes beyond what could be achieved in isolation.

A presentation will be delivered to Board members at the meeting, the purpose of which is to share Lancashire Fire and Rescue Service progress to date, and to explore further opportunities for the Service to work in partnership going forward.

Recommendation/s
The Health and Wellbeing Board is recommended to:

1. Note the preventative work which Lancashire Fire and Rescue Service currently undertake.

2. Explore [where appropriate] opportunities for Lancashire Fire and Rescue, to undertake preventative work, in partnership, aimed at improving health and wellbeing outcomes across Lancashire.

Background

Lancashire Fire and Rescue Service [LFRS] play a key role in ensuring that communities are safe, through responding to emergencies, and also through their extensive preventative work. This has been hugely successful and has seen fires, in Lancashire, decrease by half

Lancashire County Council

in the last ten years. LFRS continue to seek to explore how they can use their expertise in prevention to improve public health outcomes.

The trust placed in LFRS and the comprehensive access to the public that this provides, means the Service have a unique ability to provide critical interventions, promote health messages and refer to appropriate services.

There is a growing realisation nationally, of the effectiveness Fire and Rescue Services can have, in supporting prevention and wellbeing priorities, particularly in reducing pressure on health and social care systems and improving both fire and health outcomes through the use of data-led approaches.

As a new member to the Board a presentation will be delivered at the meeting. The purpose of which is to explain LFRS progress to date, in respect of the above, and to explore potential opportunities to work with partners in the future, to help improve health and wellbeing outcomes across Lancashire.

A presentation will be delivered to Board members at the meeting which will cover this in more detail.

List of background papers

None

Reason for inclusion in Part II, if appropriate

N/A