NHS
Lancashire and South Cumbria
Integrated Care Board

DIGITAL AND DATA STRATEGY

→ 2024-2029

TABLE OF CONTENTS

FOREWORD

The Lancashire and South Cumbria Integrated Care System (ICS) brings together partners from across the health, social care, Voluntary, Community, Faith and Social Enterprise (VCFSE), academic and industry sectors to tackle health inequalities and improve health and care outcomes for the 1.8m population of Lancashire and South Cumbria.

This ICS Digital and Data Strategy builds on 'Our Digital Future,' the digital strategy co-produced and published in 2018, and has been developed in conjunction with all these key partners from across our system and reflects and aligns with our strategic ambition and direction of travel as outlined in our system wide Integrated Care Partnership (ICP) strategy and the 6 strategic ICB objectives. It also strongly supports our plans over the next three years to address challenges around clinical, operational and financial sustainability as a system whilst improving the quality, effectiveness and efficiency of care delivery in the future, as being addressed by our System Recovery and Transformation work.

Our collective view, as an ICS, is that digital and data is more than an enabler of improved care, but is critical to the transformation of services, improved experience of health and care by our population and delivery of our system wide priorities and wellbeing outcomes.

In the short term, we have to get the basics right and ensure we 'level up' the digital maturity of systems, make better use of the data we already have and improve inclusion through digital skills and accessibility, whilst setting out an ambitious agenda to innovate and 'lead the way' in digital and data as we look to the future.

At ICS level we will focus on what is best done 'at scale' to support all our Places and Neighbourhoods, drive transformational and cultural change at local level and meet the specific needs of their local population. Supporting our local communities to become healthier, wealthier and happier is our ultimate goal as a system and digital and data are integral to achieving this. We will support our system partners' move from siloed to shared and on to truly integrated care for our population, underpinned by integrated teams focussed on the specific health and care needs of everyone.

I look forward to working with partners, our incredibly hard-working staff who deliver excellent health and care services to individuals and families such as my own, and our local population to make this Digital and Data Strategy a reality for the benefit of all our local communities.

Asim Patel
Chief Digital Officer,
Lancashire and South Cumbria ICB

FOREWORD

Lancashire & South Cumbria has a strong historical record pioneering the use of digital technology to transform clinical and professional services, while working in partnership across all care settings – from public health and prevention, through primary, secondary and tertiary care services and with the support of voluntary, community, faith and social enterprise partners, social care and wider local government services.

With the formation of Integrated Care Boards (ICBs) in 2022, and the subsequent evolution of the Lancashire and South Cumbria Provider Collaborative Board (PCB) and wider Integrated Care System, digital and data play an even greater part in fulfilling our potential to meet the quintuple aim of healthcare – to provide an excellent patient experience, with the best possible health outcomes, accessibility and equitability, making the best use of available resources, while maintaining an excellent workforce experience.

Achieving these aims also gives us the opportunity to shift the dial and move care upstream, preventing people becoming unwell, reducing the burden of illness, and reducing demand on health and care services – allowing the people of Lancashire and South Cumbria to live healthier, happier lives.

This will transform when, where and how health and care services are delivered, and our workforce need the intelligence about our patients and communities, along with the knowledge, skills and confidence to do things differently.

Digital and data skills will play a significant part in how our public interact with health and care services, and how our professionals respond – by giving our staff and population the necessary information, tools and skills, we will release more time for care.

There is an increasing need to take a single strategic approach across our health and care partners to the planning, execution and evaluation of transformation programmes.

This single system approach affords us the best opportunity to maximise the availability and proactive use of the collective data we hold about the people we serve, our wider communities and the services available to support people to stay well. A single collaborative approach where providers also share the same digital systems allows us to maximise the potential benefits from available funding, reduce system numbers, reduce duplication and complexity, reduce the management burden and increase the support required to achieve digital transformation.

A single delivery approach, building on the OneLSC model and developing workforce capabilities and competencies will give us the best opportunity to attract, develop and retain a world-class digital, data and technology team across our system.

Lancashire & South Cumbria ICB has seen significant success partnering to deliver against digital strategy and, despite limited resources, has successfully established itself as a capable digital leader over several metrics. This refreshed Digital & Data Strategy provides the fundamental principles that will underpin a consolidated, prioritised, system-owned and delivered digital portfolio. It will enable the system to best manage resources and funds with digital, and to have the flexibility to evolve plans over time. I believe this will facilitate transformation in the delivery of NHS services in Lancashire & South Cumbria.

Stephen Dobson
Chief Information Officer,
OneLSC

NHS
Lancashire and South Cumbria
Integrated Care Board

CONTEXT AND STRATEGY OVERVIEW

1. INTRODUCTION - system/local context

There are over 1.8 million people living in Lancashire and South Cumbria, with almost a third of our population living in some of the most disadvantaged communities in England. The geography also contributes to our unique combination of challenges, covering densely populated urban conurbations as well as rural and coastal environments, requiring our health and care services to be able to respond to widely differing needs across our varying local communities. We must increase our focus on early prevention as opposed to treating ill health to really support those communities. This improvement in health and care outcomes can be achieved through dealing with the wider determinants of health and addressing inequalities at the local level, while supporting delivery of the ICB Joint Forward Plan priorities.

By working through our Provider Collaborative, our four integrated Place partnerships and their constituent Neighbourhoods, we are best able to support our health and care partners deliver sustainable services that meet local need and create a tangible shift upstream toward preventative healthcare and promotion of health and wellbeing.

Our Neighbourhoods, where communities come together to shape and join up health and care services, are critical to understanding and delivering to local nuanced needs.

This valued variation has to be provided across services and this requires widespread collaboration through partner organisations in all sectors, shared insight as to need and best practice as well as our skilled workforce being able to provide care where they are most needed.

ICB JOINT FORWARD PLAN PRIORITIES

The NHS Lancashire and South Cumbria is committed to working with health and care partners on five priorities.

1. We must strengthen our foundations by changing how organisations work together and how the NHS provides services to improve our financial situation.
2. We must take urgent action to reduce the level of long-term disease, working with partners to prevent illness and reduce inequalities.
3. We must move care closer to home wherever possible, strengthening primary and community care and integrating health and care services.
4. We must make sure there is more consistent and high-quality care. We will standardise, network and improve our pathways of care.
5. We must take targeted action to deliver world-class care for priority diseases and conditions, population groups and communities.

The health and well-being of our population

We face a number of challenges in Lancashire and South Cumbria which have a direct impact on people's health and well-being.

Approximately 40% of ill health in Lancashire and South Cumbria is caused by **smoking, not enough exercise, being overweight and taking illegal drugs.**

13% of people live in fuel poverty and are unable to afford to heat their homes, which is **higher than the national average of 10.6%**

Nearly a third of our residents live in some of the **most deprived areas** across England

18.5% of adults smoke. **The National average for England is 17.2%**

Only around **a fifth of adults** are meeting the recommended levels of physical activity

Between **12% and 38% of children** are living in poverty compared with the **national average of 30%**

1. INTRODUCTION - system/local context contd.

The Lancashire and South Cumbria Integrated Care Partnership (ICP) has developed an **Integrated Care Strategy (2023 – 2028)** that sets out a clear vision and a set of priorities to address the needs of the population over their whole life course - see next page.

The ICB Strategic Objectives provide an over-arching guide to the considerations we must take and the principles we must adopt while addressing the needs of the ICP Strategic Priorities.

The **L&SC Green Plan** also provides an important NHS led framework for digital developments to drive greater efficiencies and effectiveness seen through the environmental lens. This encompasses a significant increase in virtual appointments across all appropriate services, reducing travel impact and non- attendance through to reducing paper waste through digitising of administrative process.

Digital and Data has a key role in supporting the Joint Forward Plan requirements of 'Getting the Basics Right' and 'Working Differently' across the system.

This strategy is therefore primarily focussed on supporting the delivery of the strategic priorities for Lancashire and South Cumbria as outlined in the ICP strategy and the JFP alongside the high impact programmes of work over the next three years being progressed through the System Recovery and Transformation work.

In the short term the system must see increased sustainability but also provide tangible benefit for individuals as they support the long-term changes in digitally enabled care alongside the ten-year roadmap for the **New Hospitals Programme.**

For the essential overarching long term prevention agenda, this strategy seeks to lay out the foundational tools to support the necessary earlier access to services and care, increased insight and a better empowered population for a step change in population health to happen.

ICB Strategic Objectives:

1. **Quality:** improve quality, including safety, clinical outcomes and public experience
2. **Reduce inequality:** equalise opportunities and clinical outcomes across all places, through integrated partnership working
3. **Finance and value for money:** meet financial targets and deliver improved productivity
4. **People and culture:** make working in L&SC an attractive and desirable option for existing and potential employees
5. **Performance:** meet national and locally determined performance standards and targets
6. **Strategic oversight:** develop and implement ambitious, deliverable strategies

1. INTRODUCTION - system/local context contd.

ICP STRATEGIC PRIORITIES

Our priorities reflect the different stages of life that everyone goes through. We know that many people will be living their lives across several different parts of this life course at the same time. It is important that we make sure the connections between these are easy to navigate.

Give our children the best start in life, supporting them and their families with problems that affect their health and well-being, and getting them ready to start school

Reduce ill health and tackle inequalities across mental and physical health for people of all ages by understanding the cause of these unfair differences.

Encourage all our residents to feel comfortable in talking about planning for dying, and to be well-supported when a loved one dies.

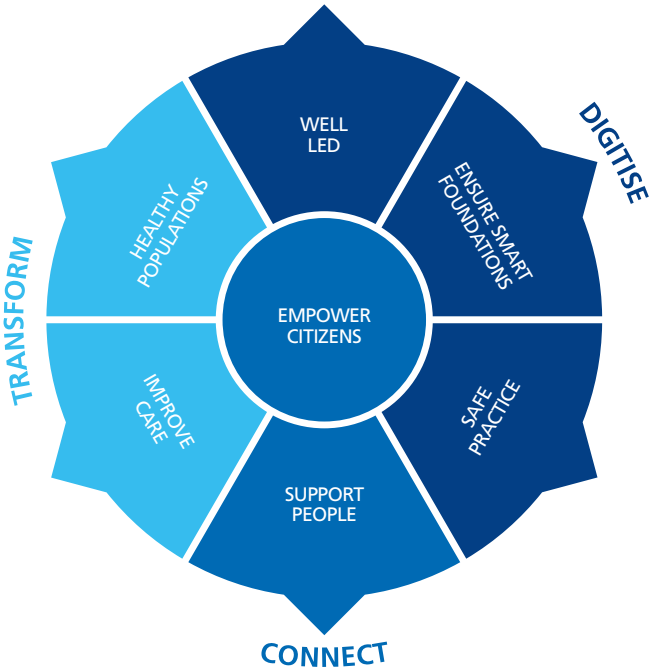
Increase ambition, aspiration and employment, with business supporting a healthy & stable workforce & employing people who live in the local area.

Support people to stay well in their own home with connections to their communities and more joined up care.

1. INTRODUCTION - national context

This Digital and Data Strategy also reflects the requirements and guidance set out in national digital and data policies, plans and priorities to ensure that the regional and national health and care digitisation agenda is advanced. This includes:

- Progressing our overall digital maturity as a set of individual health and care providers and as an ICS system as a whole in line with the requirements of the **'What Good Looks Like' framework**



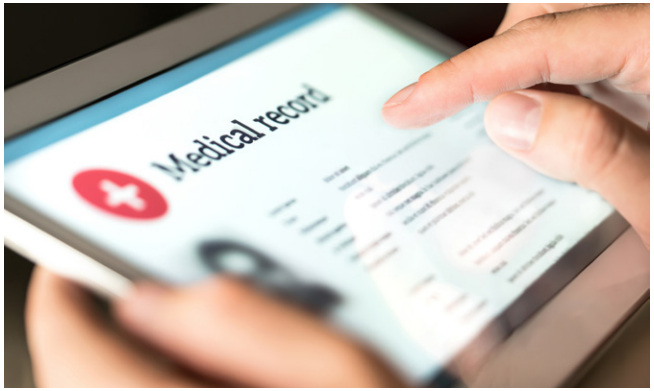
- Meeting the requirements for digital and data developments as outlined in the **Plan for Digital Health and Social Care** and updated in the annual **NHS Operating Plan framework** and through any additional specific in year ministerial priorities.
- Working in alignment with the four key purposes set out in **Data Saves Lives** in order for our strategy to drive forward the use of data for:
  - the direct care of individuals,
  - the improvement of population health through the proactive targeting of services,
  - the planning and improvement of services, and for
  - research and innovation that will power new medical treatments.
- Meeting the requirements of other more specific national digital and data strategies such as those related to the **use of data for direct care** and **research, cyber security, system interoperability, cloud hosting** and **information governance** (as key examples).

The functionality and opportunity from digital and data initiatives evolve faster than we can implement solutions and as a result the strategic roadmap has to maintain implementation flexibility and a clear focus on the outcomes that need to be achieved in both the short and long term. In implementation, whether that is at a system, place or local level we need to ensure that digital enables us to transform hoe we do things and not just digitise existing process.

At a system level the need is to ensure we have the core building blocks to be able to maximise effectiveness from future tools and be able to respond and adapt to the direction of new technologies that can add real value for our staff and population, while simultaneously creating a data-informed, intelligence-driven culture that promotes innovation.

This strategy sets out to capture the key digital and data requirements of the system within the specific local context of the challenges faced by our organisations and our local people in improving their health and well-being.

It then explores how four core digital and data strategic priorities can provide the sustainable building blocks and support the wider enablers for digitally enabled improvements in both service design, delivery and outcomes for the benefit of all our communities but particularly those most disadvantaged.



2. OUR CURRENT STATE - successes and challenges to date

Digital and data tools and services are already supporting system transformation across Lancashire and South Cumbria and are well embedded into direct care delivery, corporate services, commissioning, planning and evaluating impact across our health and care providers.

There have been several key successes from the previous system wide digital strategy ('Our Digital Future') and through developments at both organisational level and system wide collaboration. These include:

- Development of a system wide Shared Care Record solution that is accessed over 14,000 times per day by care professionals across provider organisations to support direct care delivery
- Technology platforms to support nearly 400 virtual ward beds with plans to expand to over 700 beds
- Implementation of a remote monitoring service for care home and house bound people with COPD, heart failure or diabetes in Fleetwood
- Development of a digital catalogue of voluntary, community, faith and social enterprise services to link knowledge of and access to services connecting to health and social care
- Implementation of a single maternity clinical system across Lancashire and South Cumbria
- Development of the System Intelligence Service as an open platform to access system wide health, social care and wider social determinants of health data down to individual level to inform deep analytics and a population health management approach to long term service design
- Implementation of a wide area network (COIN)
- Implementation of digital passports that enable staff to move between organisations and utilise shared systems in a seamless way.
- Almost 3000 vulnerable people supported with the knowledge, skills and confidence to use digital devices, apps and tools.

However, despite significant progress in a number of key areas, several significant challenges remain, e.g.:

- Siloed data and systems, and a lack of clarity as to what is being used where, makes it difficult to share and ultimately integrate care and drive transformation at system level across all health and care partners
- It is difficult to deliver system wide efficiencies with siloed digital and data services and duplication of tools and systems across health and care organisations
- There is currently a high degree of variation in digital maturity across the ICS partners, in particular a lack of historic investment in the social care and VCFSE sectors
- Innovative use of technology at an organisational level has proved difficult to scale up to enable consistent use and benefit across the wider system
- Digital and data informed solutions are not always fully embedded into the requirements and design work for large scale, high impact system recovery and transformation programmes (e.g., new models of care for out of hospital service delivery and elective recovery)
- Our workforce are operating significantly below establishment across both the provision of care services and in the core digital and data functions, meaning the resourcing to drive and support design and implementation of a change of digital and data tools, process and systems is significantly challenging
- Enabling early engagement between digital and significant estate infrastructure development (such as the New Hospitals Programme).
- Sustaining a balance in our approach to support both the need to level up the basic provision of digitally enabled services and the health outcomes experiences by our disadvantaged populations, alongside the need to create more effective solutions in multiple clinical and service areas
- Actively supporting our workforce to innovate despite the challenges of immediate care provision by creating a space to understand the challenges of the front line and enabling staff to be part of co-designing solutions

As a result, this strategy sets out the strategic priorities to ensure digital and data developments support Lancashire and South Cumbria's overall strategic health and care ambitions to 'work differently' and deliver truly transformational change.

2. OUR CURRENT STATE - key digital & data requirements from the system

This strategy has been developed based on extensive engagement with key system partners and builds on the previous digital strategy for Lancashire and South Cumbria, the digital strategy for the Provider Collaborative ('Digital Northern Star') and the work put in by over 150 stakeholders from across disciplines, organisations and sectors to develop a detailed Digital Transformation Investment Plan in 2022. The key high-level requirements for digital and data over the next five years have been identified as:

Having a reliable, fit for purpose **digital and data infrastructure** that enables our staff and partners to access the systems and tools to deliver high quality and efficient health and care services wherever that may be in our geography. This will need to flex and expand as new or different providers, services or facilities come on stream, and/or new working patterns are deployed.

Having a smaller number of **digital and data systems** that together comprehensively support the ambition of delivering truly integrated care and seamless flow of people and information across the full range of health and care providers now and into the future. Creation of and access to a single source of consistent health and care information about an individual is key here and included data from all partners including the care and VCFSE sectors. Common systems need to interoperate with each other to create the opportunity for shared best practice across key clinical pathways and approaches to care delivery.

Making our **digital and data support services** more efficient and easier to access for our staff across the system as care delivery becomes more integrated

Developing the **digital and data skills** in our workforce so that they feel confident and competent in using digital tools and data driven insight to deliver high quality and efficient services today, and design increasingly effective services for the future

Turning **connected data into actionable intelligence** to drive transformation of services, focus more on upstream prevention and provision of more effective and outcomes driven services through shared best practice, reduced unwarranted variation and increased quality across both physical and mental health and care provision for local communities

A simplified and consistent approach to **common reporting requirements and analysis** through shared data capture and learning

Enabling world class **innovation and research** through the provision of high-quality, real-world data sets to support clinical trials and translational research, and continuing to build on some of the locally developed innovative digital tools to benefit the whole of Lancashire and South Cumbria (and beyond)

Increasing **population empowerment** through support for individuals to better utilise digital and data tools to actively support and improve their own health and well-being and that of their family / community

Ensuring the **voice of the population is heard and understood** and that the impact of lived experience is used to inform future design

Significantly **reducing digital exclusion** through targeted support into our local communities to ensure economic or digital skills / experiential disadvantage is not precluding access to health and care services. This must also include ensuring new initiatives do not inadvertently exacerbate the existing "digital divide" and further exclude or disadvantage those most in need.

Ensuring the **safety and security of the data** held by organisations in our system and having the appropriate mechanisms in place to support shared information for those who need access whilst maintaining agreed levels of privacy for person identifiable data

Managing expectations about the **level at which implementation needs to be executed.** Large scale single approach programmes should be undertaken at scale by the system, but it is crucial to leave flexibility and space for local requirements to be led by Place or Neighbourhood where they are better placed to add value for specific local need.

Ensuring we have the **digital and data maturity** (tools, infrastructure and expertise) to maximise benefit for our teams and services users through our systems and then also gradually move the focus of care provision toward prevention and increased population agency in their own well being.

3. DIGITAL & DATA STRATEGY OVERVIEW

The Lancashire and South Cumbria Digital and Data strategy consists of a number of key components

Our **digital and data mission and vision** reflect our focus on alignment with and supporting the delivery of the ICP integrated care strategy and ICP strategic priorities and the ICB strategic objectives

Our **digital and data strategic priorities** set out our direction of travel and indicative end point, taking into account that this will take time to achieve. These strategic priorities also consider our starting point, the requirements for digital and data from our wider system and the system challenges introduced previously in this strategy

Our **digital and data strategic journey** sets out how we will deliver the digital and data strategic priorities over the next five years and illustrates how this supports the system to work differently by moving from the delivery of siloed to shared to integrated care

Our **digital and data strategic enablers** set out how we are going to do this and the areas we will focus on that cross-cut the digital and data priorities and underpin achievement of overall system success

Our **measures of success** that demonstrate clearly the impact that digital and data has on supporting delivery of whole system ambitions outlined in the ICP strategy and the JFP.

Our **Digital and Data Vision** sets out the mid-long term impact of the strategy:

Our Population: Our population are empowered in their own improved health and wellbeing journey and supported by innovative and effective service provision

Our People: Our people are digitally skilled and data informed to confidently design and deliver agile and effective care across the health and care environment

Our Partners: Our partners are fully integrated into a coherent set of systems that enable shared understanding and focused action to increase the health and well being of our whole population

3. DIGITAL & DATA STRATEGY SUMMARY

ICS MISSION

We are committed to improving the health and well-being of the 1.8m population of Lancashire and South Cumbria, by working collaboratively with partners to reduce health inequalities, secure better health and care outcomes and provide the best care at the right time to enable our population to live healthy and fulfilling lives

DIGITAL AND DATA MISSION

Improve the health and well-being of the 1.8 million population of Lancashire and South Cumbria through the supported adoption and use of consistent, increasingly powerful digital and data systems, tools and services accessible in all our communities.

DIGITAL AND DATA VISION

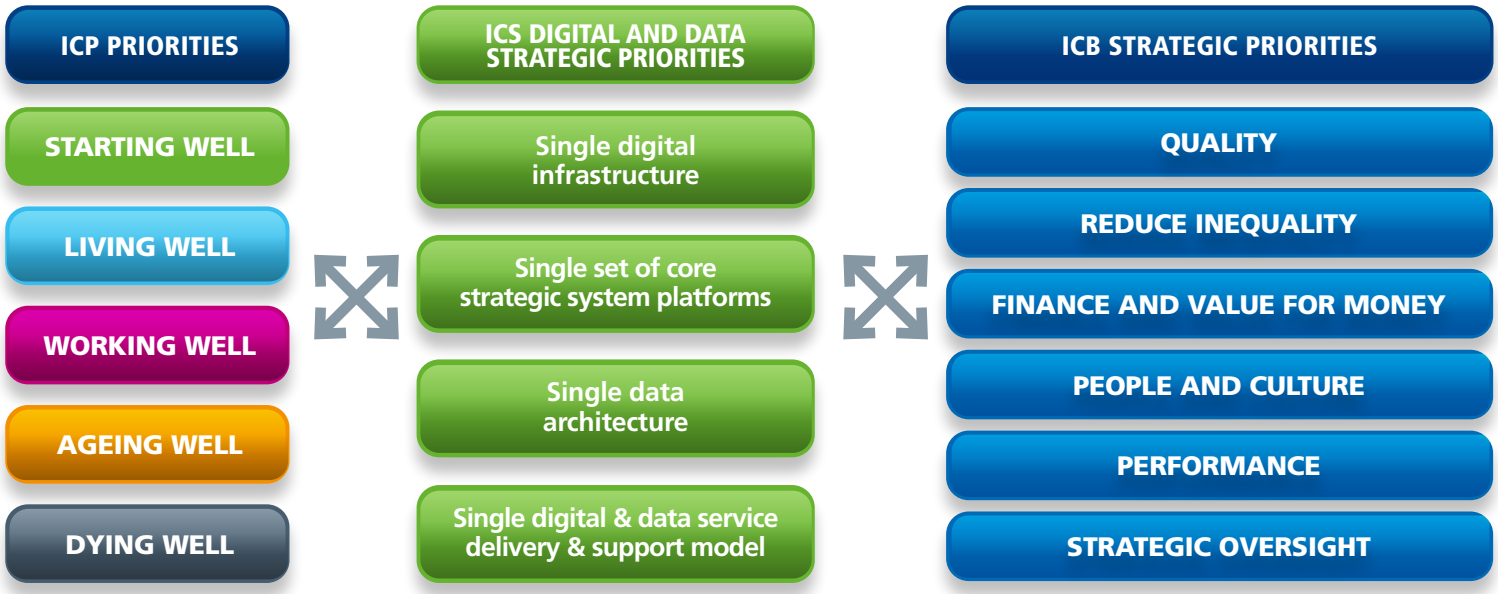
Digital and data underpin the transformation of care and care pathways to improve the health and care outcomes throughout Lancashire and South Cumbria.

The vision is seen through the lenses of our system enablers:

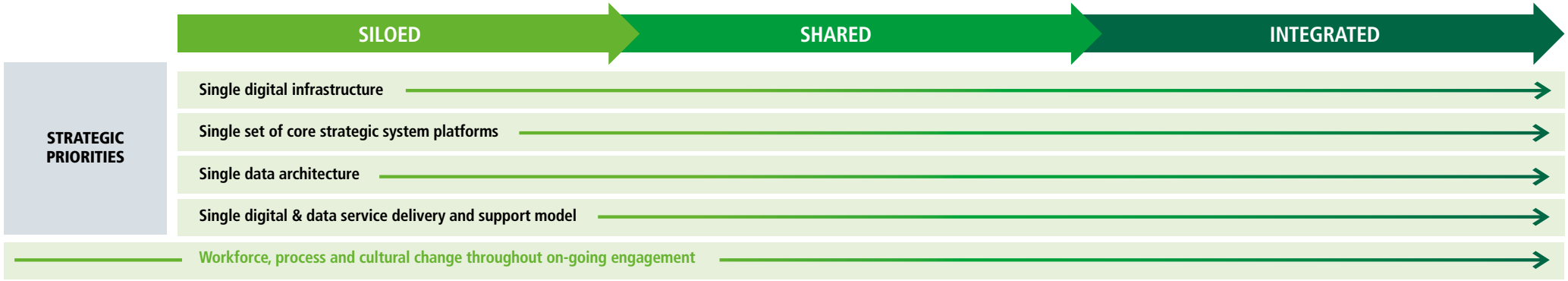
- **Our population** are empowered in their own improved health and well-being journey and supported by innovative and effective service provision
- **Our people** are digitally skilled and data informed to confidently design and deliver agile and effective care across the health and care environment
- **Our partners** are fully integrated into a coherent set of systems that enable shared understanding and focused action to increase the health and well being of our whole population

SYSTEM WORKING PRINCIPLES

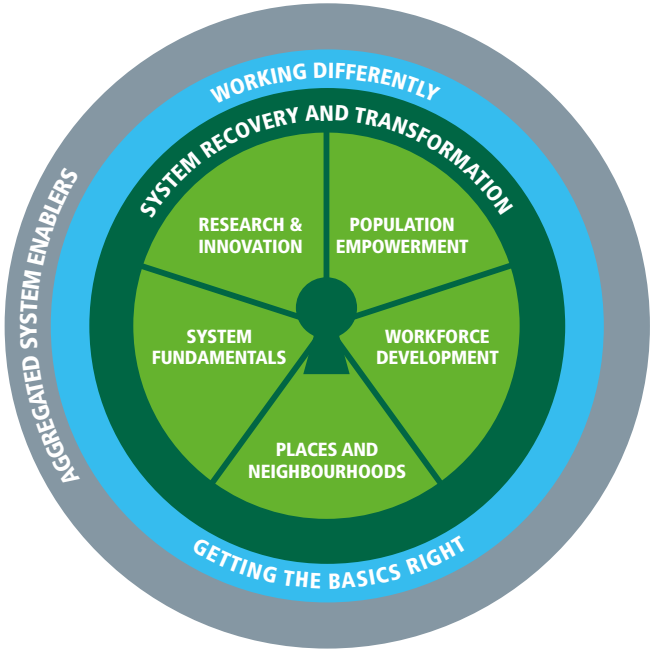
STRATEGIC PRIORITIES - ALIGNMENT



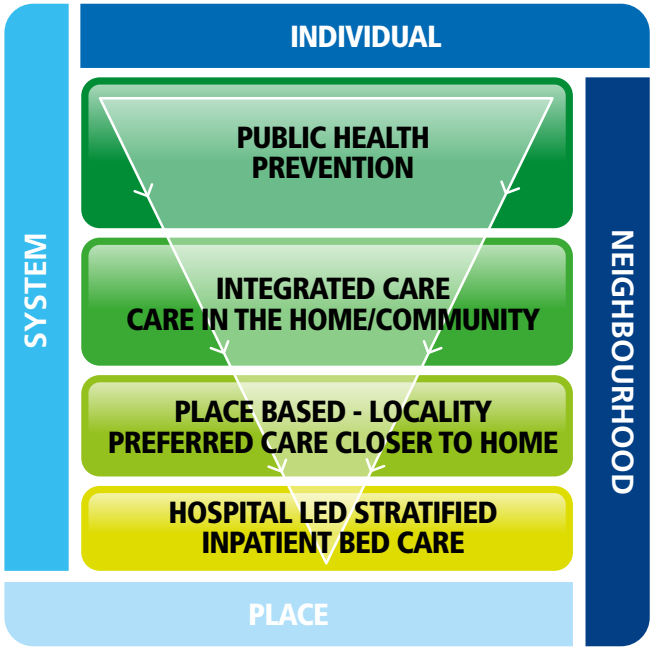
3. STRATEGIC PRIORITIES - JOURNEY



SUPPORTING KEY SYSTEM ENABLERS



MEASURING SUCCESS LENSES OF IMPACT



MEASURING SUCCESS SYSTEM METRICS

- IMPROVED HEALTHY LIFE EXPECTANCY AT PLACE & SYSTEM & A REDUCED GAP IN HEALTH LIFE EXPECTANCY ACROSS THE SYSTEM
- IMPROVED FINANCIAL POSITION
- INTEGRATED PROVISION ACROSS THE WHOLE LIFE COURSE
- ENHANCED AND INTEGRATED PRIMARY AND COMMUNITY CARE PROVISION
- IMPROVED QUALITY OF SERVICES
- IMPROVED PATHWAYS OF CARE FOR PRIORITY AREAS
- CQC GOOD RATINGS
- NHSE SYSTEM OVERSIGHT FRAMEWORK

3. DIGITAL & DATA STRATEGY OVERVIEW - System Working Principles

Development and execution of the Digital and Data Strategy are underpinned by three key working principles which will inform decision making, prioritisation and ultimately how the strategy will be delivered.

These principles are built from the earlier digital memorandum of understanding in the system and reflect how organisations and individuals want to engage to support achieving the system mission and vision for the whole of Lancashire and South Cumbria. The principles are:

WE WILL FOCUS ON OUR POPULATION NEED:

A deep and evolving understanding of the needs of our population (from both extensive engagement, involvement in co-design and analysis of data from a wide range of sources) will underpin all our decision making and inform how and when we prioritise initiatives. This will ensure we are enhancing the population healthy life expectancy over the longer term through a focus on prevention and addressing the wider determinants of health.

Digital inclusion must be increased through focussed activity and non-digital communication channels maintained to support those who remain unable to access digital channels. Measures must be taken to ensure that digital and data developments do not further exacerbate health inequalities.

WE WILL SET OUR PEOPLE UP FOR SUCCESS:

At a system level we will embed digital in transformation programmes by co-designing with our workforce and ensuring that they have relevant digital and data skills, knowledge and experience to confidently deploy tools to support care which is aligned to the strategic system priorities. Our people will be digitally-enabled and supported to work collaboratively across teams, services and organisations in all our health and care sectors.

Our digital, data and technology workforce will increasingly collaborate across the system, and be offered relevant skill and career development opportunities to enable a sustainable, industry-leading digital and data transformation and service support function.

WE WILL PRIORITISE OUR SYSTEM PARTNERSHIP OUTCOMES:

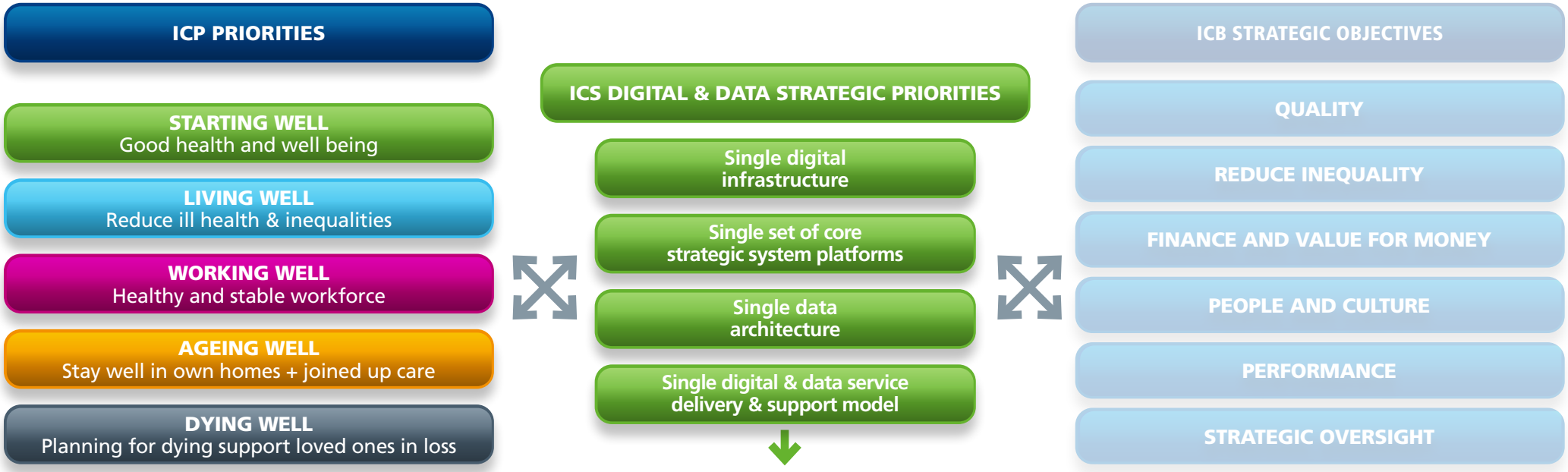
Our behaviours will enable sustainable success across the system, and be in service of the system first, so that co-operation, openness and good faith are the corner stones of our embedded culture of collaborative working and shared outcomes-based impact.

Across organisations, shared information, best practice, reporting and mutual pro-active support enables wider and more sustainable success than local organisational need.

Development and delivery of the Lancashire and South Cumbria Digital and Data Strategy is underpinned by three key working principles focussed through the lenses of our population, our people and our partners. These will inform decision making, prioritisation and ultimately guide the focus of implementation to ensure realisation of benefit at a whole system level

3. DIGITAL & DATA STRATEGY OVERVIEW

Alignment with ICP Priorities



DIGITAL AND DATA PRIORITIES SUPPORT ACROSS THE ICP WHOLE POPULATION LIFE COURSE APPROACH

Good health and well being

A single set of core care systems will include maternity, neonatal and child health services that enables the delivery of high quality services to children, young people and their families focused on their specific health and well-being needs.

As many of these services are delivered in community, a single integrated digital infrastructure enables high speed access to systems from any location

Reduce ill health and inequalities

A unified approach to data architecture, platforms, skill sets and services will allow the system, Places and Neighbourhoods to use population health data and intelligence to increasingly understand the cause and effect of health and care challenges faced by different communities, and share solutions that can be effective in the long term in prevention

Healthy and stable workforce

Utilising data in the single data warehouse and information from core care systems will enable proactive health and well-being services to be offered to working age adults and young people through primary care, VCFSE and local employers.

Stay well in own homes + joined up care

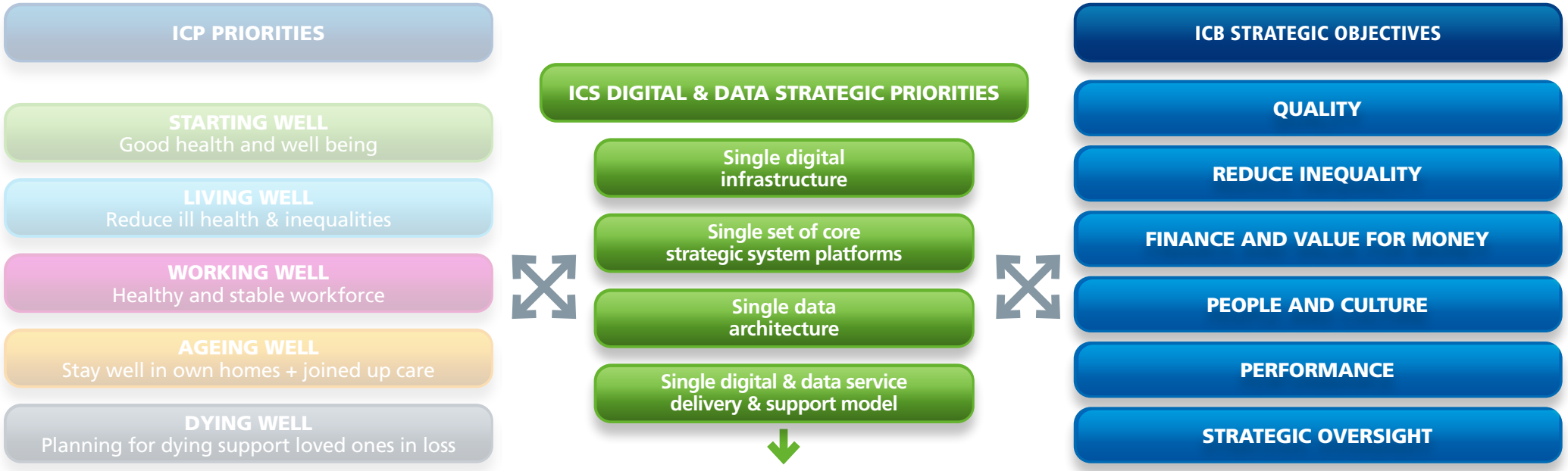
Our core platforms (such as telehealth and shared care record) will enable older people to remain independent for longer through reduced deterioration and support delivery of a coordinated package of care across multiple services focused on their specific needs.

Planning for dying support loved ones in loss

Our core care systems will support sharing of appropriate information across services, including end of life care choices, to reduce repeat requests for information at this difficult time for individuals and their families

3. DIGITAL & DATA STRATEGY OVERVIEW

Alignment with ICB Strategic Objectives



DIGITAL AND DATA PRIORITIES ENABLE THE ICB STRATEGIC OBJECTIVES

Quality

A single set of common care systems, adoption of standardised processes and the implementation of a single data warehouse will drive a reduction in unwarranted variation across care pathways, increase and smooth flow between organisations and improve the overall experience, quality, safety and outcomes of care delivered.

Reduce inequality

A single data platform and associated tools will enable truly integrated care delivery across organisational boundaries, including proactive and preventative interventions, targeted toward areas of greatest disease burden and inequalities. Our population, particularly those at greatest risk of exclusion, will be supported to access digital empowerment tools.

Finance and value for money

Development of a single digital and data delivery and support model and the implementation of a core set of platforms and infrastructure will create significant efficiencies across the system and ultimately reduce existing digital and data expenditure. In addition, digital tools (such as Robotic Process Automation and other types of Artificial Intelligence) can support delivery of savings in administrative processes within both clinical and corporate functions.

People and culture

Our common digital infrastructure, core system platforms and single data architecture will significantly enhance the employee experience across our health and care partners. Our digital, data and technology workforce will be supported to maintain and develop skills and expertise, and talent management will support career progression.

Performance

Our single data architecture will support system partners to meet national and locally determined performance standards and targets. Furthermore, the adoption of automation and emerging technologies will support a shift in energy and time requirements from statutory reporting to proactive and preventative analytics, developing clinical and operational insights that help delivery improved quality, safety and outcomes of care – ultimately improving performance.

Strategic oversight

The Digital and Data Strategy, along with workforce and infrastructure strategies, is a fundamental enabler of other clinical and professional strategies, including the New Hospital Programme strategy. In turn, this strategy will be supported by more granular strategies (such as cybersecurity, population empowerment, DDaT workforce development, interoperability and integration) from within the digital and data function.

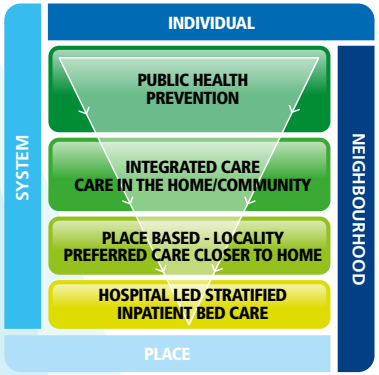
3. DIGITAL & DATA STRATEGY OVERVIEW

The four individual Digital and Data Strategic Priorities are fully aligned to the wider strategic context of both the ICB Objectives and the Lancashire and South Cumbria ICP Life Course Approach. They provide the consistent long term digital and data building blocks for the system to strengthen sustainability, reduce health inequalities and drive increased quality of life outcomes across the population.

SPOTLIGHT ON PREVENTION

The long-term prevention agenda encapsulates the ambition of the system to reduce incidence of preventable disease and ultimately increase focus and investment upstream. This will ensure the population increases the quality and duration of good health and is able to sustain such a change.

The inverted triangle overlaid on the diagram below illustrates the intended shift in focus of energy and resource from more intense hospital-focused care toward public health and prevention, which can be supported through use of digital and data intelligence.



The four digital and data strategic priorities have to focus on the current and emerging needs of the system over the next five years as well as the immediate system recovery and transformation requirements.

But the initiatives underway also provide the building blocks to support the prevention agenda and the ability to support the population to become increasingly empowered in managing their own health and wellbeing.

The Digital and Data strategic priorities are a key part of the longer-term levers to support empowering the population to proactively manage their own health and well-being as well as drive an increase in significantly earlier intervention and focussed prevention strategies.

SINGLE DIGITAL INFRASTRUCTURE

An increase of more reliable and timely data creation and easy access for all health and care service users as well as health and care provider teams, especially in the community and rural settings, can drive better efficiency and effectiveness that can ultimately enable earlier intervention and release investment to move upstream.

SINGLE SET OF CORE STRATEGIC SYSTEM PLATFORMS

A large cohort of single consistent care and support system platforms can enable a reduction in cost that could be reallocated elsewhere. This can also drive a significant reduction in unwarranted variation that can increase quality and improve the ability to accurately move service intervention earlier in preventable disease progression. A Patient Engagement Portal (PEP) and app platform can increase the engagement of the individual in anticipating their own health and care needs and then being able to act on them before professional services are needed.

SINGLE DATA ARCHITECTURE

A system wide warehouse and 'data lake' can enable a reliable rich source of information that can be made available to wider partners. This enables collaboration and innovation in (predictive) analytics, Population Health Management, risk assessment and intervention design that should inform the longer-term creation of services that can better prevent need in local communities and/or enable earlier identification and risk mitigation of ill health.

SINGLE SERVICE DELIVERY & SUPPORT MODEL

An increase in the deep and shared expertise of the digital, data and technology workforce across the system supports the creation of maximum value from the other strategic priorities. This includes both the ability to generate better cross-sectoral insight to inform decision making in the prevention agenda, the ability to do this consistently and effectively across the system and the ability of the frontline teams to work with those in their care to utilise the digital tools available.

NHS
Lancashire and South Cumbria
Integrated Care Board

OUR STRATEGIC PRIORITIES

4. DIGITAL & DATA STRATEGIC PRIORITIES - Introduction

Our four digital and data strategic priorities set out our direction of travel and indicative end point for the most important areas of work to underpin delivery of the ICP priorities and meet the ICB strategic objectives.

They explicitly encompass bringing together both the people and the tools of the system so that support for the population can flow seamlessly through the system partners including the health, social care and VCFSE organisations.

These priorities are implementation of a:

- **Single digital infrastructure**
- **Single set of core strategic system platforms**
- **Single data architecture**
- **Single digital and data service delivery and support model.**

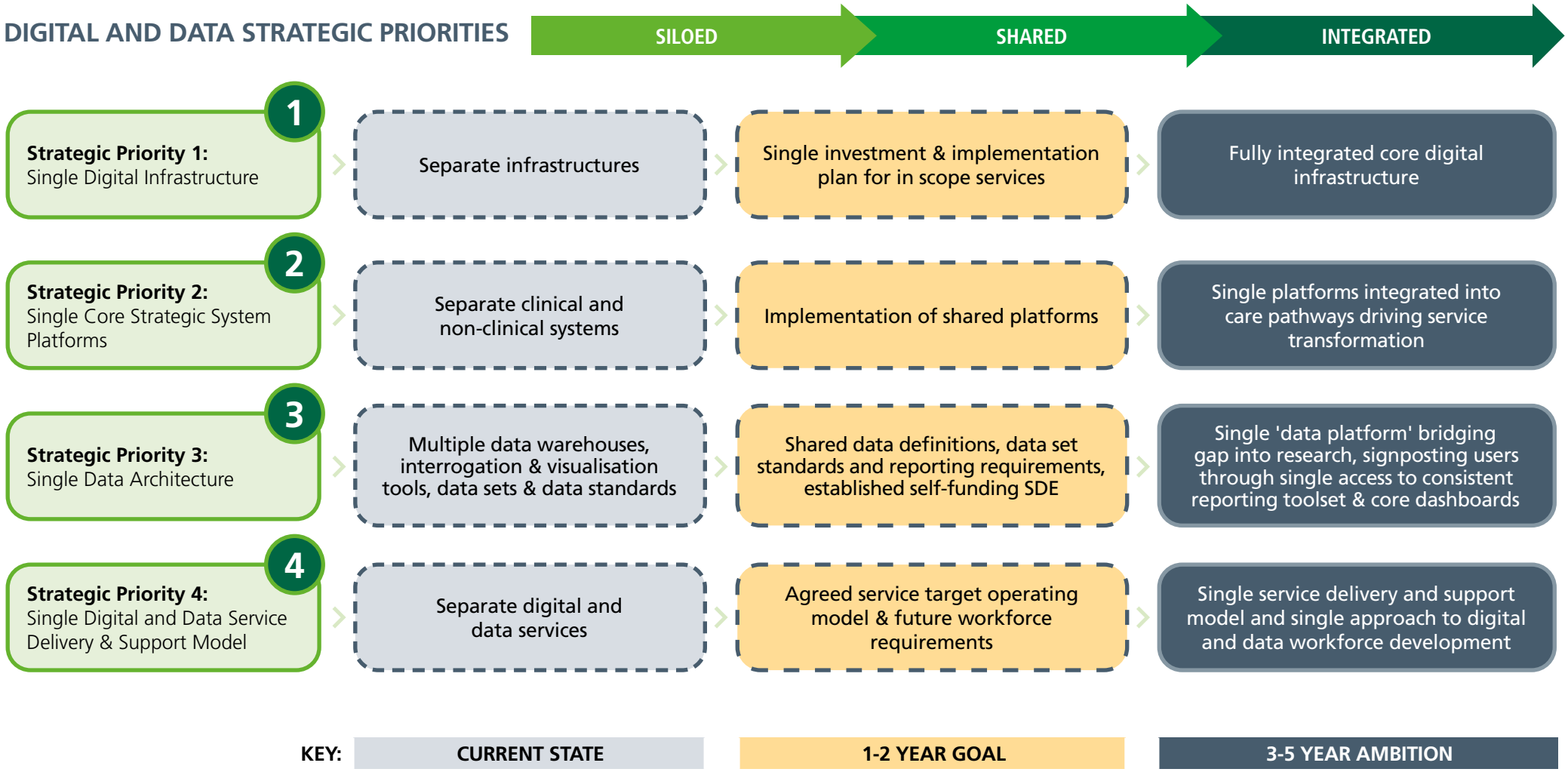
The four Strategic Priorities for Digital and Data seek to actively bring together and harmonise people, information, skills and tools throughout the system to enable support for the population to flow seamlessly across the provider partners in the health, social care and VCFSE sectors.

Throughout this document the term "single" implies best effort toward a unified approach to delivery – this may mean a single digital system (such as Electronic Patient Record) or it may indicate a single approach whereby interoperable components adopt single data and other standards to ensure a seamless end-user experience.

Although the digital and data strategic priorities will be in place for the duration of the strategy period, the key elements making up those priorities will iterate and develop over time and continue to remain aligned to the evolving needs of the system.

More details on each of the strategic priorities are then given to clearly demonstrate the ambition, what the 'future state' will look like for each priority in terms of 'working differently', and what this means specifically our population, people and partners. These strategic priorities also underpin future ambitions for digital maturity as required through the 'What Good Looks Like' framework.

4. DIGITAL & DATA STRATEGIC PRIORITIES - Journey Map



5. STRATEGIC PRIORITY 1 - Single Digital Infrastructure

Our Ambition

By 2029 we will have implemented a single set of core digital infrastructure components across the whole of Lancashire and South Cumbria

What the 'future state' will look like:

- Consistent, reliable, safe and secure access to high-speed networks across the whole of the Lancashire and South Cumbria footprint, providing seamless connectivity of managed devices to the network across the health and care estate
- All staff have access to reliable and fit for purpose digital devices to fully undertake their role, bought from a single, system wide product catalogue
- Single data centre for core care and corporate systems, with a move to all applications adopting a 'cloud first' approach
- A single infrastructure strategy will set out an agreed set of infrastructure workstream priorities, which will be service-wrapped with appropriate, unified cyber and security support (see supporting Cybersecurity Strategy)
- Single approach to intelligent and flexible networks with technology defined by user needs, building on the existing well-established wide area networks.

What this will mean in practice for our people, partners and population:

Population

- Improved service experience and transfer between services as staff are using reliable devices and networks to access relevant information
- More focussed quality time from their care providers due to reduced administrative burden and frustrations with digital devices, network and subsequent information access

People

- Enjoying a more effective and efficient day when no longer dealing with aged or unsuitable devices and/or unreliable network access, increasing staff morale
- More time to care, increased opportunity for collaboration and focus on quality
- Creating more reliable and insightful data for service development as a result of positive experience in utilising digital and data systems

Partners

- Increased efficiency and effectiveness of service delivery across the system through adoption of shared infrastructure across all partners including VCFSE and social care
- Partners with historic underinvestment in infrastructure can access at scale, up to date solutions to drive 'levelling up' at pace.

5. STRATEGIC PRIORITY 1 - Single Digital Infrastructure

Our Ambition

By 2029, we will have implemented a single set of core digital infrastructure components across the whole of Lancashire and South Cumbria

Where are we now:

- Regional wide area networks well developed and implemented across the system
- Some shared system wide working already in place around end user device procurement
- A number of core infrastructure elements are unnecessarily duplicated across organisations providing opportunities for rationalisation
- Collaborative design work in progress for shared data centre hosting, cloud migration, on-going development of the existing wide area networks toward intelligent, flexible networks with software-defined technology, and unified communications (e.g., telephony and video)

What we need to do	How we will do it	1-2 Years	3-5 Years
Complete any outstanding implementation whilst optimising and planning next stage development of intelligent and flexible networks with software--defined technology, building on the existing well-established wide area networks	We will work with all system partners (including VCFSE and social care) to ensure that current network and devices are optimised to deliver the best experience for staff and best value for money, whilst also capturing requirements for the future (including estate development and reconfiguration)	✓	→
Develop a costed, rolling investment plan to ensure that our staff have reliable and fit for purpose digital access devices	We will work with partners to identify any existing 'technical debt' in organisations and support development of business cases for investment and applications for national funding to help address any identified gaps	⚙	✓
Develop a roadmap and implementation plan to move from organisational data centres, networks and telephony solutions to a single ICS wide core infrastructure	We will work with partners to agree the phasing of deployment of each shared infrastructure element to ensure that there is minimal impact on existing 'business as usual' developments, as well as maximising the opportunity to deliver individual organisation and system wide efficiencies	⚙	✓

KEY ⚙ In Progress → Embed Ongoing ✓ Completed ✗ Not yet started

5. STRATEGIC PRIORITY 1 - Single Digital Infrastructure

An accessible Digital Infrastructure for all those providing services to the population ensures a more effective and efficient day, maximising use of digital tools and enabling more time to be spent with those who need it most whilst contributing to the creation of a richer, more insightful data set on population need.

5. STRATEGIC PRIORITY 2 - Single Set of Core Strategic System Platforms

Our Ambition : By 2029 we will have implemented a single set of core strategic care and corporate system platforms across system partners

What the 'future state' will look like:

Care Systems

- Single comprehensive Connected Care Record (ConCR) solution to share all relevant information between care sector information systems in Lancashire and South Cumbria and beyond.
- Single GP record system across primary care.
- Single system for electronic bed capacity management for all bedded environments
- Single system for electronic discharge from acute care settings
- Single child protection information system across the whole health and care partnership
- Single digital record approach for care homes and hospices.
- Single solution for diagnostics image sharing, orders and results reporting.
- Single approach to supporting telehealth / telecare and virtual wards.
- Single set of shared specialty systems across providers (e.g. maternity)
- Single Patient Engagement Portal (PEP) across all health and care providers integrated with and accessed through the NHS app.
- Single online / video consultation solution running through the shared infrastructure platform.
- Single platform for access to accredited and recommended health and care apps for the population.
- One acute and one community and mental health Electronic Patient Record (EPR) system promote better staff experience, safer patient care and more timely patient flow

Other Systems

- Single Robotic Process Automation (RPA) solution for reducing replicable tasks
- Single tenant for MS Teams / Office / SharePoint
- Single identity management solution / 'digital passport' across all Providers.

What this will mean in practice for our people, partners and population:

Population

- Comprehensive and consistent information available through the Patient Engagement Portal for all relevant appointments and care conversations for individuals and their families
- Quicker and more reliable access to diagnostic results to aid individual decision making on next steps for their care
- Increased access to care closer to or at home through virtual wards and telehealth where suitable, and enable those who cannot use digital services to benefit from suitable alternatives
- Improved flow through and between services that meet needs in a timely way
- Increased engagement with their care, service providers and self-management support through portal and app technologies.

People

- Single reliable and consistent core care information set across services with common access
- Streamlined workflows, care record creation and potential to develop common pathways through single EPR
- Increased quality of information and shared insight driving identification of shared best practice and reducing unwarranted variation
- Accessible cross sector information sharing for timely and shared decision making
- Reliable central access to diagnostic tests and results information
- Working with individuals who feel closer to their own information and better engaged in the care process
- Reduced administrative burden and increased time to care / focus on complex work.

Partners

- Increased consistency of cross-sectoral data to support transformation, benefits realisation, performance monitoring and quality improvement
- Improved investment in system level consistency for the creation and sharing of data across all partners
- Single core system platforms and derived intelligence underpinning whole system care pathway transformation across health, care and VCFSE sectors - improving quality, safety, equity and outcomes of care delivered
- Increased ability to flex resources and staff across services and organisations
- Reduced administrative costs burden
- Shared communications and collaboration between organisations.

5. STRATEGIC PRIORITY 2 - Single Set of Core Strategic System Platforms

Our Ambition

By 2029, we will have implemented a single set of core strategic care and corporate system platforms across system partners

Where are we now:

- Single acute EPR procurement underway.
- Significant work on Shared Care Record (ShCR) in place already, building on previous national investment and support.
- Plans in place to build on existing local Patient Engagement Portal (PEP) solution and expand and adopt across other Providers
- Single programme approach to digital diagnostics
- Single system in place for maternity care across Lancashire and South Cumbria.
- Early stage planning in place for other single specialty systems in acute care such as electronic bed management solutions
- A number of systems are unnecessarily duplicated across organisations and have the potential to be rationalised

What we need to do	How we will do it	1-2 Years	3-5 Years
Complete the implementation of a single EPR across acute providers	We will build on the existing collective procurement programme and implement a single deployment, stabilisation and optimisation programme for EPR across Lancashire and South Cumbria	⚙	✓
Specify, procure and implement other 'at scale' care and corporate platforms across the system	We will set up processes and systems and utilise learning so that we can engage with stakeholders to confirm priorities, identify requirements and intended benefits and outcomes from future core platforms. We will build on existing arrangements to procure and implement at scale and pace where possible	✓	→
Confirm funding sources for investment	We will work with system partners and regional / national NHS England teams to identify and confirm capital and revenue funding, ensuring that any investment delivers significant value for our system	⚙	✓
Expand on and connect together existing system wide platforms	We will look at continually develop the breadth and depth of our strategic platforms (such as ConCR) and ensure that these systems are fully interoperable with other solutions both inside and outside L&SC	✓	→
Integrate strategic platforms into mainstream transformation activity	We will work with system partners to ensure the digital and data capabilities provided through these platforms support individual and population outcomes as defined in the ICP strategy, and meet the ICB objectives, as well as the requirements of the System Recovery and Transformation programme	✗	✓

KEY ⚙ In Progress → Embed Ongoing ✓ Completed ✗ Not yet started

5. STRATEGIC PRIORITY 2 - Single Set of Core Strategic System Platforms

KEY SYSTEM PLATFORMS:
Single acute Electronic Patient Record (EPR) system

The challenge:

Our acute provider trusts have varying levels of digital maturity, from having a long-established EPR to working on a mostly paper-based approach.

Therefore, investing in digitising the acute environment is an agreed strategic priority for the ICS, with a commitment to aligning our clinical systems, in keeping with the principles of the 'Digital Northern Star' vision of the Provider Collaborative.

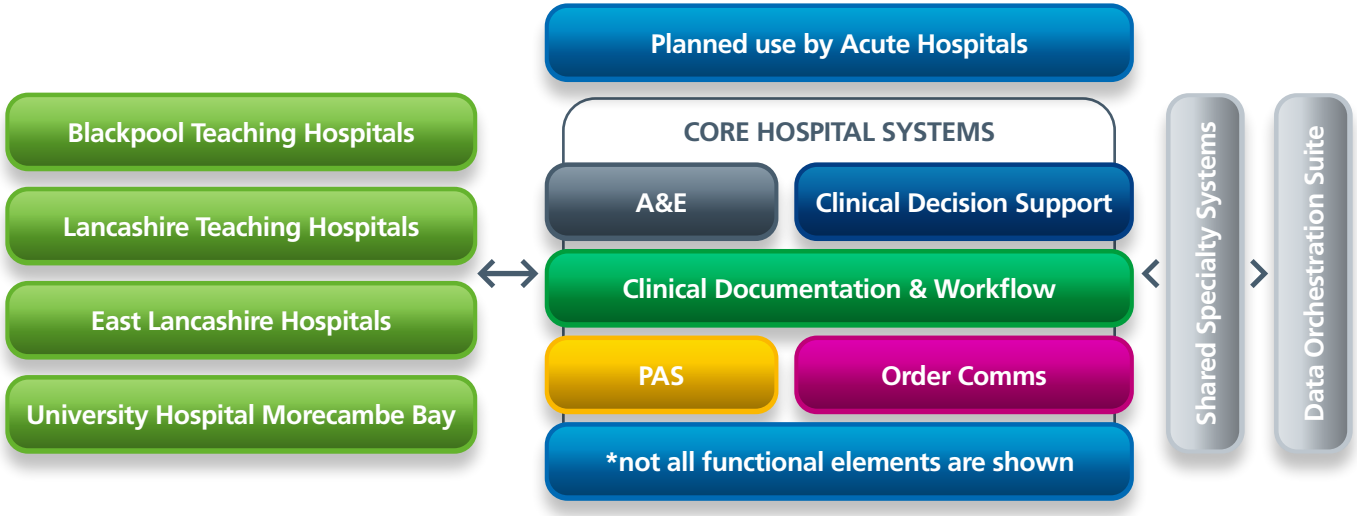
A single EPR system is a fundamental building block to system transformation and reform. It is recognised that there is a need to level up across L&SC and to establish a strong minimum digital foundation to enable new models of care and the transformation work across the ICS.

What the future state will look like:

The aim is to implement a core Acute Electronic Patient Record across the ICS and add a core set of clinical functionalities that are fully integrated to provide end-to-end seamless functionality from the moment that a patient comes into any Trust to their final discharge. The EPR will be a single record accessible whenever and wherever it is needed across the ICS acute trusts and its partners.

The benefit we will experience:

Investing in EPR will improve the digital maturity across the ICS and will:



For our Population:

- Enhance patient care and experience by empowering clinicians, providing them with the right information at the right time, improving flow and reducing unwarranted length of stay variation with any service (bedded / non bedded)
- Enable data collated through wearables to be potentially integrated with records, benefitting patient service and clinician access to information

For our People:

- Remove specialty-specific digital silos
- Create the opportunity for whole-system, clinically-led, operationally-delivered and digitally-enabled transformation of care pathways - enabling our clinical and care workforce to offer timely, relevant, high-quality care
- Provide clinicians with a 'single source of truth', making sharing information across pathways much simpler
- Maximise efficient working and reduce errors when making decisions, thus improving patient safety, quality of care and patient experience. It will also improve mobile working, transfers of care and working seamless across organisational "boundaries"

5. STRATEGIC PRIORITY 2 - Single Set of Core Strategic System Platforms

KEY SYSTEM PLATFORMS:
Single acute Electronic Patient Record (EPR) system (2)

- Provide embedded clinical decision tools to support informed decision-making at the point of care and increase the opportunity to release time to care through AI and "robots" to identify patterns in work and automate appropriate scheduling

For our Partners:

- Facilitate significantly greater clinical information sharing with our partners in other acute Trusts, primary care, community care, mental health, ambulance service and in the private and VCFSE sectors
- Rationalise our complex IT systems estate with, as far as possible, a common integrated platform and look and feel, improving the user-experience and enabling us to meet our regulatory requirements such as technical standards and NHS contractual compliance.

How we will get there:

The "Plan for Digital Health and Social Care 2022" states that 100% of trusts should have electronic health records in place and NHS England have set the ambition for the majority of health and social care services to have digital foundations in place or in implementation, including electronic records, by March 2026.

Currently there is a mixed picture in the Lancashire and South Cumbria ranging from primarily paper based to high EPR functionality in widespread use. Staff at these organisations, and within the ICS as a whole, have identified that moving to a core acute EPR would support national policy direction. It would also support many aspects of local strategy.

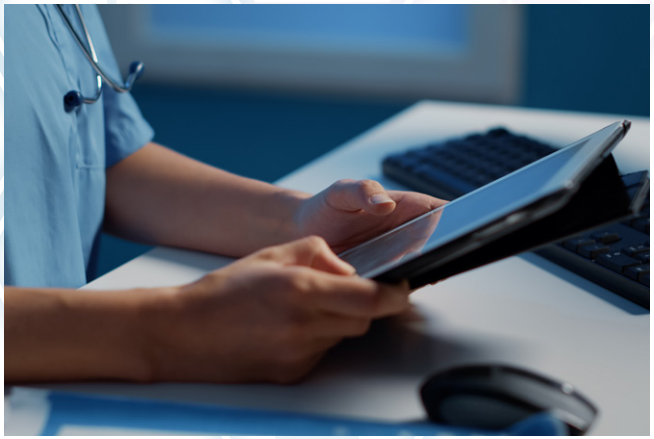
The ICS EPR Strategic Outline Case (SOC) considers the case for such a system and reviews how best it could be implemented and has identified a single instance multi-tenanted EPR with a commercial data platform as the preferred path for our ICS.

How we will continue to make progress:

The Trusts have partnered on this SOC and are working together on their business cases to procure the EPR.

They have started work on their readiness activities for the EPR focusing on clinical pathway development in preparation for the conclusion of the EPR procurement process.

This readiness work is a transformative overhaul of healthcare delivery and processes, and will also support the Patient Engagement Portal, Shared Care Record and Whole System Flow programmes and other developments.



5. STRATEGIC PRIORITY 2 - Single Set of Core Strategic System Platforms

KEY SYSTEM PLATFORMS:
Connected Care Record (ConCR)

The Challenge:

How do we ensure our health and care staff have access to the full set of health and care information relevant to the assessment and decisions they are making with you about our patient population and their health and care needs? Lancashire and South Cumbria have five separate NHS Trusts on separate clinical systems, 200 GP Practices using another system and four local councils also using different systems. Other numerous providers of care (such as care homes, hospices, pharmacies and charities) also have different digital or even paper-based systems.

As our population becomes more empowered, they too may have digital information that is relevant to supporting shared decision-making about their care. Ineffective or slow sharing of information and data between organisations can lead to delayed, duplicated or even inappropriate care.

What the 'future state' will look like:

Wherever and whenever our people access health and social care services across Lancashire and South Cumbria all relevant health and care information will be available at point of care. Providers of health and social care services will be able to access information easily and without delay so they can provide the right care and support at the right time in the right place. We will avoid duplication of effort and provide efficient and effective care delivery to support improved outcomes and experience.

The benefit we will experience:

For our population: Access to a ConCR across multiple care settings means that our patients and people only need to tell their story, which may include sensitive information, once – reducing the emotional burden/ toil and increasing their confidence in the level and personalisation of care being offered to them.

For our people: Benefits of the ConCR include real time access to relevant comprehensive information for our health and care staff, which has been shown to support safer, more effective care delivery and more timely decision making. We have evidenced reduced unnecessary investigations or treatment and reduced prescribing errors. Staff also report reduced administrative and time burden and repeat appointment usage due to timely access to relevant information.

For our partners: Clinical and care insight is derived from a more complete set of information, eliminating geographical boundaries and enabling improved continuity of care across organisational boundaries. The ConCR is a fundamental enabler of Whole System Flow, allowing our population to move around the system between relevant organisations and services, with the minimum of friction and delays.

How we will get there:

Working collaboratively with our health and care providers, citizens and VCFSE community we will work to continuously enhance our current Shared Care Record accessibility and data flows, agreeing with system-wide clinical and care stakeholders what information and types of data will add most value and transform our existing ShCR into a truly Connected Care Record

How we will continue to make progress:

As the data increases in source (organisations and sectors), richness and type (structured and unstructured), it will support the single data architecture approach - in turn improving secondary use opportunities such as Population Health Management and research. Advanced analytics and tools such as AI will help us turn patient information into actionable insights.

5. STRATEGIC PRIORITY 2 - Single Set of Core Strategic System Platforms

KEY SYSTEM PLATFORMS:
Single Patient Engagement Platform

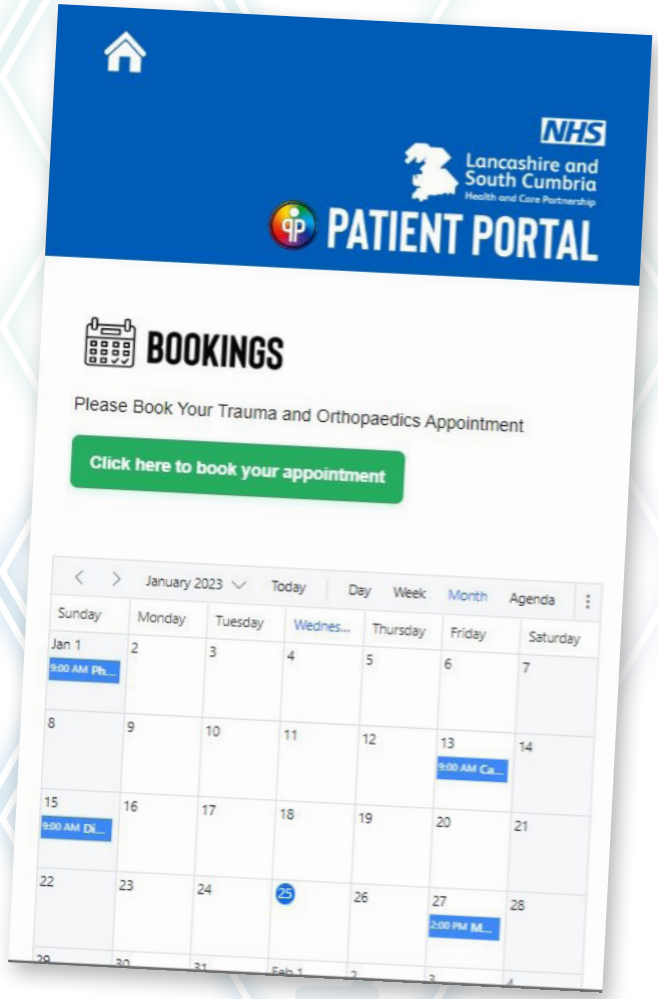
The Challenge

Patients receiving hospital care have traditionally received all communications by post and had very limited choice or control of the date and time of their appointments. In a move to create a more personalised approach, a digital tool was required to put capabilities in the hands of the patient, giving them easy and immediate access to key information about their health and care plan and a point of contact for their care.

University Hospitals of Morecambe Bay Trust, one of our 4 acute trust providers, developed an appointment booking tool that could be utilised by booking staff and patients alike, which has since evolved to offer the options to book, cancel or re-arrange both new and follow-up appointments, receive local guidance on attending an appointment as well as multi-media self-management resources to support aftercare, send a message to a single point of contact for the service, view clinic letters, and to complete questionnaires that can provide initial information toward an assessment, information about monitoring a condition, and supporting information to determine whether a follow up appointment is required under a Patient-Initiated Follow-Up (PIFU) pathway.

What the 'future state' will look like:

The solution, now known as PEP+, is now being integrated with systems in our other provider trusts to give patients attending hospital appointments anywhere across Lancashire and South Cumbria the same ability to be more involved in the planning of their care. As part of the national Wayfinder programme, the PEP+ solution is integrating into the NHS App so that patients can access information relating to their primary care and secondary care in one place. Digitising processes such as appointment booking and sharing of information is a building block for further transformation, and PEP+ provides us with a platform to truly transform how patients interact and transact with health and care services.



5. STRATEGIC PRIORITY 2 - Single Set of Core Strategic System Platforms

KEY SYSTEM PLATFORMS:
Single Patient Engagement Platform

What benefit will we experience:

For our population: Patients already using PEP+ report an enhanced experience of booking and changing appointments, resulting in increased patient satisfaction. As further capabilities are added, patients will experience more personalised care and feel more empowered and involved in their care, with ease of access to relevant information, self-management tools and a point of contact for their care pathway.

For our people: Staff satisfaction and efficiency has also improved due to an improved, more effective system and process for booking teams. As the solution becomes more widely adopted, it will enhance clinical and operational interactions with patients, facilitating better two-way communication, including data capture, patient recorded outcome and experience measures and sharing of multi-media resources to support patients along a care pathway.

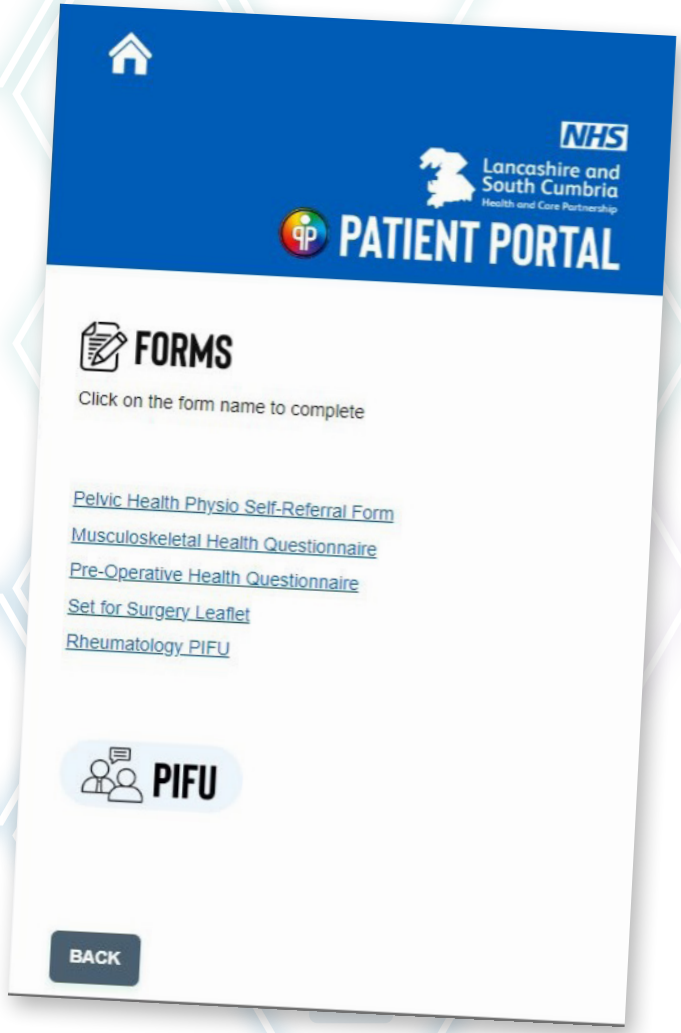
For our partners: The system has increased efficiencies in Morecambe Bay since it was first rolled out: particularly reduced costs and a reduction in our carbon footprint due to less printing and postage of clinic letters, and a reduction in the number of missed appointments (known as DNAs – Did Not Attends) due to empowering patients to have more choice and control of when they are seen. Along with the EPR and ConCR, PEP+ will support pathway transformation and consolidation and enable a more streamlined approach to Whole System Flow.

How we will continue to make progress

A rollout programme will continue through 2024-2026 to ensure that patients on all possible pathways have access to the same capabilities. Meanwhile, the product and its integrations are being further developed to support waiting list validation, the Set 4 Surgery service, Patient-Initiated Follow-up appointments and some peri-operative care.

How we will continue to make progress

We will continue to evolve the solution by co-designing with our patients, clinical and operational staff, to ensure that as care pathways undergo continuous improvement, the engagement portal is adapting and digitally supports capabilities which enhance those pathways. We will also ensure that digital onboarding support is made available to patients who may not feel equipped with the knowledge, skills or confidence to adopt digital tools.



5. STRATEGIC PRIORITY 2 - Single Set of Core Strategic System Platforms

KEY SYSTEM PLATFORMS:
Single Whole System Flow system

The Challenge

Transitions of care from one part of the health and care ecosystem to another can create points of friction and delay, causing waste in the system and more importantly, a frustrating and poor patient and staff experience. Examples of such transitions include ambulance handoff to hospital care, out-patient care to an in-patient episode, GP referral to community support from voluntary, community, faith or social enterprise organisations or hospital discharge to social care.

Effective flow ensures that inefficiencies are understood and removed to enable better outcomes for patients and service users, reduces the current frustration for people working in health and social care and values our collective time and finances. Most flow-related initiatives to date have focused on a small segment of the service user or patient's journey, often within hospitals. There is a need to look beyond the hospital and to give attention to every team, service and organisation that patients and service users encounter within their communities.

What the 'future state' will look like:

Whole System Flow is described by the Health Foundation as the coordination of all systems and resources across a health and social care economy, to deliver effective, efficient, person-centred care in the right setting at the right time and by the right person.

There is a prioritised need to digitise flow across the extensive services within our health and care system. Digital flow will build upon existing tools we have already deployed and introduce new tools, including:

- High quality single electronic health and care records
- A comprehensive, data-rich Connected Care Record, accessible to all, reducing the amount of data we need to transition.
- Patient Engagement Portal capabilities included in the architecture to support 'left-shift' efficiencies by enabling citizen pathway insights and self-service – essentially supporting people earlier in their health journey to prevent illness or exacerbation, manage their illness better and seek support when needed.
- Insights from Population Health Management at scale supports a reduction in health inequalities which is driving an increase in demand amongst our most challenged populations.

The benefit we will experience:

For our population: If we wish to be the world's best healthcare system, we need to start with the best quality structured data collected at the point of care. We will create a world where the citizen can tell their story once and is empowered to manage their own health and care; when assistance is sought or needed, it is competency based, digital by design, creating uniformity of experience, and where waiting is by mutual agreement/design with real-time visibility of activity.

For our people: This in turn means that the requirement for assistance is minimised: wherever the patient enters the health or care eco-system will be the right place because all staff will be empowered and informed to understand what care is needed and can facilitate the transition to that care setting on a competency-based right of access. This will reduce frustrating duplication and improved relationships across health and care services.

5. STRATEGIC PRIORITY 2 - Single Set of Core Strategic System Platforms

KEY SYSTEM PLATFORMS:
Single Whole System Flow system

For our partners: Digital and data will enable a consistent alignment with pathways, with the intentional inclusion of all partners across sectors. People can move seamlessly between and within services or organisations, both as recipients and providers of services, and structured data will be accessible, streamlined and move in a real-time, frictionless manner. This will reduce non-value adding time and improve experience of care for our citizens and workforce.

Ultimately, with the use of high-quality whole system flow solutions and practices, we can measure everything and use real-time data to model theoretical changes in demand or service provision and the predicted impact of those changes on the wider system – e.g. increased demand on emergency response due to a major incident. There are also financial benefits, with an anticipated minimum 2% real cash return on total budget with a shift in investment of resources. Further economic impact will result from a 'pathway shift to the left,' toward preventative care, resulting in care closer to home and lower demand on costly hospital-centric services.

How we will get there:

We will adopt improvement methodology with an agreed suite of measures to achieve this ambition, creating whole system visibility of the need and benefits of optimised patient and data flow. We will focus initially on transitions of care – finding, defining and optimising all transitions, including the 'missing millions,' i.e. we know from recent data that there are approximately 4.4 million transitions of care annually in Lancashire & South Cumbria, with 2.3 million of those being poorly detailed (therefore considered 'missing').

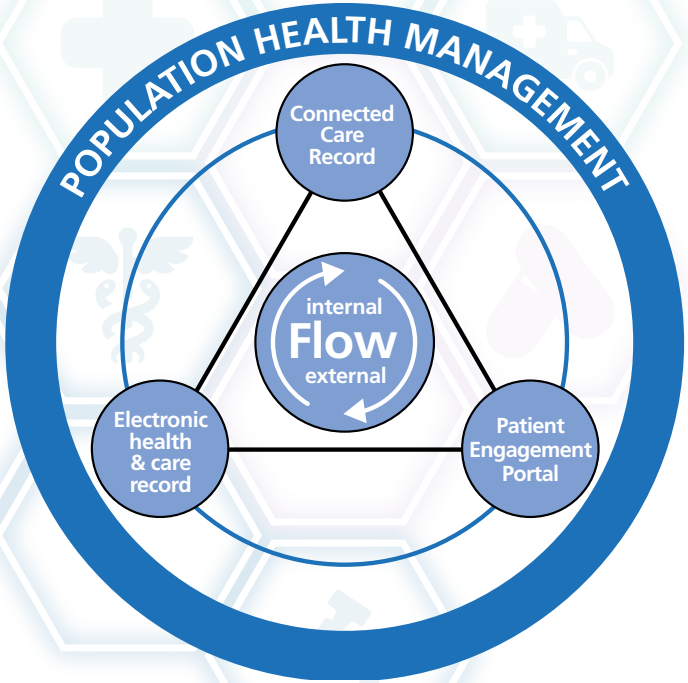
We will work with all system partners to understand the realities of our starting position and ensure appropriate engagement and involvement of operational, care and clinical teams throughout.

We will adopt the following principles of Whole System Flow, focusing initially on the 100 highest volume/impact clinical pathways:

1. Connect everything together flexibly
2. Architect services around the individual service user
3. Design flow around care pathways (pathway-delivered care)
4. Identify opportunities for structured data collection at the point of care (thereby reducing the need to 'move' data from one place to another)
5. Inclusivity of all aspects of pathways and services/ sectors, including enabling self-care where appropriate

How we will continue to make progress:

We will design data-rich functionality that enables a learn and reflect model, ensuring that data informs continuous improvement to care pathways and the delivery of high-quality, timely care.



5. STRATEGIC PRIORITY 2 - Single Set of Core Strategic System Platforms

CASE STUDY:
Digital Care Plans for Adult Social Care Providers

- **The Challenge:** In 2021 only 40% of social care providers across Lancashire and South Cumbria were recording their care plans digitally. Paper based care plans will have increasing limitations as health and social care systems become more digitised. The digital transformation of the adult social care sector supports regulated care providers to deliver safe, personalised care by having the most accurate, up-to-date information at their fingertips. Digital social care records (DSCR) ensure a more equal partnership with colleagues in the NHS and the Local Authorities to achieve joined-up care around the individual. Without financial and targeted support, the rate of adoption had been slow at just 3% a year.
- **What we implemented:** At time of writing 82% of adult social care providers record or imminently plan to record their care plans digitally. The Digital Social Care team have provided funding to 275 care providers resulting in over 12,000 people in receipt of digital personalised care plans.
- **Impact:** Moving from paper-based planning to digital social care records lays the foundation for better sharing of information across health and social care systems, joining up care around an individual. Introducing the DSCR enables an increasing number of providers to integrate with and access the GP records. DSCRs reduce the amount of time care professionals need to spend on administrative tasks as records can be updated and accessed in real time, releasing time to care. It also means that care workers have access to the most up to date information on an individual when and where they need it supporting a more personalised approach to care.
- Moving away from paper to digital ways of working also releases cash savings from the reduction of money spent on stationery and records storage. They also enable more time to deliver care due to reduction in paperwork and admin burden. Care plan audits were originally taking 3-4 hours on average, now they take an average of 30 mins. Care plans are required to be completed within 7 days of admittance and digital care plans are now being completed within 48hours. There is a noticeable increased confidence in using other technologies and upskilling of staff. The Care Quality Commission support the use of a DSCR within the context of the single inspection framework.
- **How my day has changed:** "Recently I have visited a number of care providers with significant issues that have also recently started recording their care plans digitally. I can't tell you how valuable access to a digital care plan has been. A three-hour visit becomes a 30 minute review and phone call; I can see in real time the improvements being made to care and documentation. Access to the record has afforded myself and system partners a greater level of confidence when lifting suspensions and ensured adequate oversight and resident safety." Registered Nurse Care Sector Clinical Lead.

  "Since starting my digital journey in my care home, the system has had a massive impact on my working day, as well as on the residents and staff. Using an electronic system allows staff much more time to spend with residents and to complete other duties. It gives staff clear prompts in residents' care to ensure all aspects of the individual's needs are met. The system allows me to have instant access to an individual's care plan and daily notes, to search a record for the information I need, without having to go through endless paperwork. Since using the system the richness of data that my staff now record on individual residents' daily notes is amazing, it's much more person-centred than when we recorded on paper. The system also highlights areas of concerns that I need to follow up." Registered Care Home Manager
- **How we will continue to make progress:** Further developments will increase access data publishing to and consumption from the Connected Care Record, promoting the use of secure mail, and ensuring that at least 80% of care providers are compliant to the Data Security Protection Toolkit (DSPT).

5. STRATEGIC PRIORITY 2 - Single Set of Core Strategic System Platforms

CASE STUDY:
Single Digital Maternity Record

- **The Challenge:** Across the system we had four hospitals providing maternity care, all using different records. In order to improve care and outcomes, we needed an electronic maternity record that would enable clinical staff to record care activities in real time, and to access the record and test results from anywhere a woman presented for care across the Local Maternity and Neonatal System (LMNS) footprint. We also needed to enable women to view their own maternity record (including scans and test results) on a phone or tablet and access the most up to date evidenced based information and e-leaflets recommended. Having separate recording systems meant that data collected was not comparable, having a single system would allow data to be standardised and validated, contributing to the measurement of outcomes and better targeting of support where it is needed most.

- **What we implemented:** Following a system wide procurement process, which involved clinicians, digital and informatics colleagues, and leadership representation from all units we implemented Badgernet, a maternity information system with a personal health record (patient-held record). This product had the benefit of being a single pregnancy record, ensuring that any maternity record stays complete, regardless of the location within the LMNS where the care episode took place.

- **Impact:** Women now have access to their own, and their baby's record on a personal device (phone or tablet), improving access to important information to enable them to make choices in care that is most appropriate to them and reduces the risk of lost records. Maternity clinicians can have access to the woman's record when they provide care, knowing that it contains the all details of the woman's pregnancy, including her history, any risk factors and importantly her choices. This is particularly important if a woman goes into labour a distance from the hospital she is registered at. Data entry to the record is identical in all our the providers and staff have been able to move between unit to provide care and not need to learn a new system. This also means the record provides an audit trail, and the data can be utilised for planning purposes across the system.

- **How my day has changed:** "The new BadgerNotes are really good. In my last pregnancy I had so many bits of paper to keep track of, this time everything is on my phone – which I always have with me. I can also use it as a diary, for appointments and things that happen to me. It even has all of the scan pictures of my baby" Mother-to-be.

  "The BadgerSystem is really useful to me as a clinician. I recently looked after a mum who had been transferred from another hospital. We were able to look at her record, which looked the same as if she'd had her care with us. Everything was there, results etc. We could see her history straight away, which meant that we didn't need to keep asking her lots of extra questions and could focus on reassuring her and providing care." Midwife

- **How we will continue to make progress:** We will be rolling out the neonatal badger system to University Hospitals of Morecambe Bay and Blackpool Teaching Hospitals. Digital Midwives will also work closely with the wider digital teams to support the future single EPR, and where possible, supporting integration with Badgernet to create a seamless record of care. There is ongoing improvement of the woman's digital health record, and this work is enabling the development of Local Maternity and Neonatal System clinical and equity dashboards, helping us monitor performance, introduce improvement initiatives and further transform service delivery.

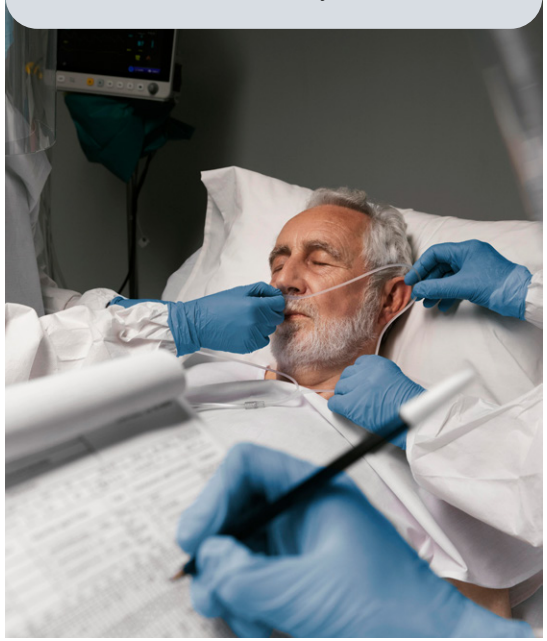
6. STRATEGIC PRIORITY 2 - Single Set of Core Strategic System Platforms

USER STORY:
Charlie, Male, 78 years old, Terminal cancer, End of life plan in place

Charlie

Charlie is a gentleman who has terminal cancer. He has a supportive and caring family and has made the decision that he would prefer to die at home with his family present.

Charlie's wishes need to be documented and available for all care professionals to see so that they know how to support and care for him and his family.



DISTRICT NURSES

After Charlie was diagnosed with terminal cancer an appointment was arranged for the district nurses to visit him at home. Charlie and his family discussed the care he wanted in his final months of life. As part of the discussion Charlie advised that he would prefer to die at home. The district nurses documented Charlie's plan of care and preferred place of death in the shared care record.

999 – NORTH WEST AMBULANCE SERVICE

Charlie had a seizure at home and his family phoned 999. The ambulance service looked at Charlie's shared care record and were able to see his plan of care. The ambulance service did not need to take Charlie to the Emergency Department as they knew what care was needed and how to access this.

HOSPICE AT HOME

The ambulance service contacted the Hospice at Home team who visited Charlie and gave in him appropriate medication to keep him comfortable and provided support to his family.

PATIENT EXPERIENCE

Charlie died peacefully at home 2 days later surrounded by his family as he had wished.

IMPACT OF THE CONNECTED CARE RECORD

As care providers were able to see Charlie's connected care record it meant that he did not have to go to hospital unnecessarily when he had the seizure. This freed up ambulance and emergency department staff time and avoided any distress to both Charlie and his family.

Connected Care Record

In the future, a fully Connected Care Record will ensure that information from all services will be visible, and the capture of structured data will ensure that any recent changes to the health or care record, or patient choices, are immediately visible and can be acted on.

6. STRATEGIC PRIORITY 2 - Single Set of Core Strategic System Platforms

USER STORY:
Iris, Female, 64 years old

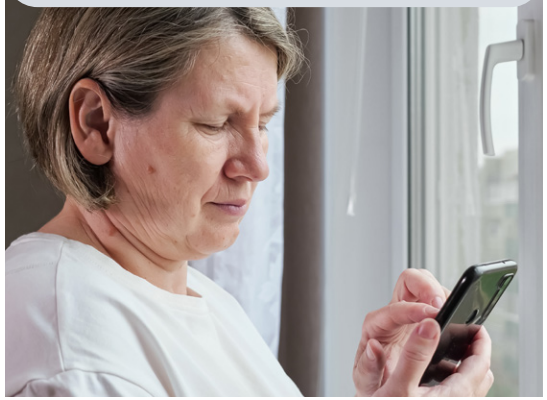
Iris

Following some abnormal test results Iris was referred for a specialist cardiology appointment. Due to a delay in receiving the appointment Iris was sent a text message asking she still needed this and was asked to respond using a text messaging service.

As Iris still needed the appointment, she arranged this herself using the Patient Engagement Portal.

Following the appointment, it was decided that Iris needed surgery but this would take place at a specialist hospital in Blackpool.

Following surgery Iris needed some further check ups to make sure everything was ok and she was recovering as planned.



IRIS CONFIRMS SHE NEEDS A CARDIOLOGY APPOINTMENT

Iris uses the Patient Engagement Portal (PEP) to send a text message to confirm that she still want to attend a cardiology appointment.

IRIS BOOKS A CARDIOLOGY APPOINTMENT

Using the PEP, Iris chose the date and time of her appointment, that was convenient for her to attend. This meant she did not have to cancel or rearrange the appointment.

IRIS ATTENDS CARDIOLOGY APPOINTMENT

Iris is told that she needs surgery at a specialist hospital. The specialist hospital has access to all of Iris's health information as all acute hospitals use the same electronic patient record system to document information.

IRIS COMPLETES PRE OPERATIVE QUESTIONNAIRE

Before her surgery, Iris completes a pre-operative questionnaire using the Patient Engagement Portal. She is able to view information (clinical letters, appointments and instructions from her care providers) from both the referring hospital and the hospital the surgery will take place in through the single Patient Engagement Portal.

IRIS ARRANGES FOLLOW UP APPOINTMENTS

Following successful surgery, Iris was required to attend some follow – up appointments to check on her recovery, Iris made the appointments using the Patient Engagement Portal.

IRIS DISCHARGED FROM CARDIOLOGY

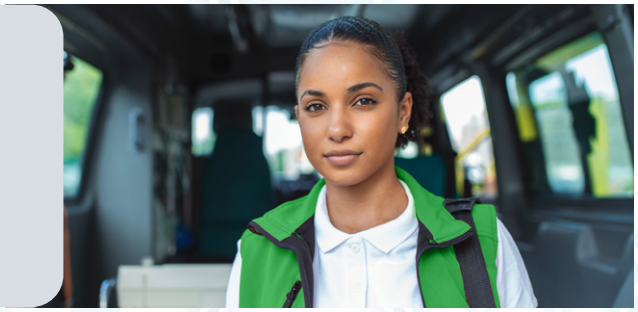
Iris was nervous about being discharged in case something happened and she needed to see the team again. Iris was offered Patient Initiated Follow Up (PIFU) which meant she could request an appointment with the cardiology team if she felt she needed this. This meant she did not have to be re-referred by her GP.

6. DIGITAL AND DATA SUPPORT FOR STRATEGIC ENABLERS

USER STORY:
Robyn, Paramedic

Robyn

Robyn is a paramedic for the North West Ambulance Service and provides urgent care to patients in Lancashire and South Cumbria. When she sees patients she can access the Connected Care Record which means she can see health information about patients from lots of different health care professionals. This means that Robyn has accurate and up to date information to decide the best way to help and care for patients at a time when they need help urgently. Robyn can access the information in one place without the need to go into different systems or speak to different people which would normally be time consuming and may delay the care she needs to give to patients.



USER STORY:
Ayesha, ED doctor

Ayesha

Ayesha, a junior doctor, was asked to help a young lady in her twenties who arrived at the emergency department unaccompanied and unable to communicate effectively due to disorientation. She displayed symptoms of vomiting, flushing, deep and rapid breathing, and laboured breathing. Concerned by her condition, Ayesha accessed the Connected Care Record to gather more information about her health and care history. The Connected care record provides health information from all care providers that have been involved with the patient. By looking at the Connected care record, Ayesha found out that the patient is a type 1 diabetic, leading her to suspect that she had Diabetic Ketoacidosis (DKA), a suspicion later confirmed by additional blood tests.

Due to having access to the patients Connected care record, Ayesha was able to provide the care and treatment to the patient needed much quicker. As a result the patient did not need to be admitted to hospital and was allowed to go home later that day. The patient was also told about how to access diabetes information on her mobile phone which would help her manage the condition better to try and prevent her from becoming unwell in the future.

6. STRATEGIC PRIORITY 2 - Single Set of Core Strategic System Platforms

A consistent set of system platforms will enable the enhanced flow of individuals, information and knowledge across organisations. Each organisation and system platform builds timely and accurate insight into the needs of the individual, enhancing care and maximising the effectiveness of health and care services.

7. STRATEGIC PRIORITY 3 - Single Data Architecture

Our Ambition: By 2029 we will have a single set of data platforms and tools to support reporting, service planning, population health management, continuous improvement, research and innovation

What the 'future state' will look like:

- Standardised clinical pathways using the same tools in each provider will reduce unwarranted variation and increase the power and quality of our data
- With a single shared EPR there will be a single provider clinical data warehouse supporting national, local and board reporting
- National and regional architecture in the form of the Federated Data Platform (FDP) and the ICS wide data lakehouse will support access to an application store/ marketplace for waiting list optimisation, population health management, patient flow and other direct care applications and support creation of AI and machine learning based algorithms. This will include clinical and operational data (including finance and workforce)
- Data for analysis and secondary uses pipelined into a single ICS wide data lakehouse will be accessed through a single North West wide secure data environment (SDE) to support research, development and innovation and partnerships with industry and academia both nationally and internationally
- Internationally standardised data sets (with agreed common definitions, e.g. Observational Medical Outcomes Partnership Clinical Data Model – OMOP CDM) will accelerate research and innovation
- Access to standardised data and core dashboards together with improved data literacy of front line clinical, operational staff and leaders will increase availability and use of intelligence by all teams enhancing operational efficiency, deepening clinical comprehension, and fostering stronger industry partnerships
- Information governance (IG), research ethics and public and patient involvement and engagement (PPIE) will ensure appropriate and acceptable use of data
- Academic partnerships - including student placements and joint NHS/academic positions for data engineers, technologists and clinical researchers - and increased academic rigour will lead to enhanced analytical quality, capability and opportunities

What this will mean in practice for our people, partners and population:

Population

- Services will focus more 'upstream' on prevention and addressing wider determinants of health. As a result, our population will see improved services, meeting more of its health and care needs. This will be due to more insightful analytics informing innovative research and service design
- Our population will be empowered to help us make decisions about the use of health and care data via a Patient and Public Involvement and Engagement programme, and will be given the assurance that their data can contribute safely and anonymously to health care research as well as service improvement.

People

- Standardised high-quality pathways, will be informed clinically and operationally via analytics, resulting in improved experience and outcomes
- Comprehensive access to reliable system data to inform service strategy development, improvements in operational delivery, service planning and service transformation as a system
- Coherent analytical approach across the system will ensure consistency and shared insights. Together with evolving tools and emerging technologies will support self service
- Standard data models (e.g. OMOP) will ensure that dashboards and algorithms created for one trust can be re-used instantly on another
- Digital and data specialists increasingly able to focus on deep dive analytics, continuous improvement and the creation of clinical and operational insights, outcomes, safety and preventative indications and actions

Partners

- A single data architecture will support information integration for direct care, e.g. use of risk stratification or rapid identification of unmet clinical needs
- Increased opportunity for developing research and innovation partnerships through a single secure data environment
- Access to comprehensive data set to inform population health management including data from VCFSE and local government sources
- Opportunity to access industry and academic partners to explore and drive service innovation and system level outcome improvements
- Aligned maturity across organisations and services as against the NHS Digital Population Health Management (PHM) maturity matrix to support equity in provision and outcomes

7. STRATEGIC PRIORITY 3 - Single Data Architecture

Our Ambition: By 2029 we will have a single set of data platforms and tools to support reporting, service planning, population health management, continuous improvement, research and innovation

Where are we now:

- Multiple data warehouses and interrogation tools in place across local health and care providers and the integrated care system more generally (from a variety of different solution providers). System wide data analysis and linked data is very limited or non-existent. Every provider supports its own board, local and national reporting.
- An EPR procurement process has been agreed which will result in a single ICS wide EPR and provider data warehouse for board, local and national reporting
- The Federated Data Platform (FDP) platform has been agreed as a strategic tool to support access to the national marketplace applications
- An ICS wide data lakehouse architecture has been created and population of this with provider and primary care data will commence from 2024 onwards. This includes creating standardised data pipelines per trust and transforming data into the international OMOP CDM standards. This will support direct care, secondary uses and research, including population health management, health inequalities, and continuous improvement.
- A North West regional Secure Data Environment (SDE) for sharing of research ready datasets is in development and will eventually support access to research ready datasets covering a population of up to 7M patients.

What we need to do	How we will do it	1-2 Years	3-5 Years
Complete and implement the ICS wide EPR/data warehouse procurement Complete implementation of the ICS wide FDP supporting national applications for direct care including single patient treatment lists.	Continue to support the existing ICS wide EPR programme Engage with and support the national FDP team to create the appropriate data links and canonical datastore	⚙	✓
Complete initial data population of the ICS wide lakehouse, including primary and secondary care. Ensure maximum shared value through use cases.	Agree that the ICS lakehouse will be the sole source of ICS wide longitudinal data with full ICS wide backing, support and resource. Ensure all information governance, PPIE and ethics are in place. Ensure primary care buy in. Ensure data mapping/pipelines are complete and active. Ensure all BI/data science teams are working together to achieve the shared vision	⚙	✓
Complete the secure data environment platform (SDE) ensuring L&SC research ready data can contribute to NW wide research attracting innovation and funding to the NorthWest.	Engage and lead on the North West SDE programme.	⚙	✓

KEY ⚙ In Progress → Embed Ongoing ✓ Completed ✗ Not yet started

SPOTLIGHT ON POPULATION HEALTH MANAGEMENT

A Population Health Management System gives us the data and intelligence to:

- take a targeted population health approach with our partners
- to identify and reduce health inequalities
- in doing so, we improve the health outcomes for our population

Domain	Ambition
Data	• A single validated, high-quality source of data for Population Health insight • Trusted source of data for ICB and ICP partners • IG compliant management and sharing of data from multiple agencies across the ICB/ICP
Access	• Provision of strategic, tactical, and operational data through a range of digital reporting tools • Patient level insights for public facing staff so that we can support and target our actions • Rich, flexible, and intuitive tools that empower staff and colleagues to deliver
Training and literacy	• Front line staff trained on how to access, interpret, and use PHM data • Training on PHM tools, data availability and methodologies • The development of super users and champions within ICB wide teams • Embedding a culture of data driven, population health centred decision making
Analysis and insight	• Business Intelligence skills, capacity and intelligence at system, place, neighbourhood level • PHM analytical capacity, knowledge and skills at a system and place level • Application of best practice analytical, statistical and data science methodology • Alignment of expertise between partners inc. Public Health, NHS, Council, Social Care etc. • Managed processes for receiving, prioritising, and delivering information and analysis requests • Workforce development plan to grow our PHM BI capacity and skills across the ICB
Prediction and automation	• An ICB approach to machine learning in PHM that ensures we understand non-linear relationships • Increased capacity for predictive analytics • Develop our actuarial modelling and impactability modelling, better understanding not only those at risk but those that will benefit from interventions and potential impact
Knowledge	• Evidence and learning on PHM collated and shared within the ICB • Creation of an ICB wide knowledge base for capturing learning, evidence, best practice, and the development of strategy

SINGLE DIGITAL INFRASTRUCTURE

A single digital infrastructure will support the ability to capture data at the point of care and the seamless movement, collation, aggregation and stratification of that data in order to provide actionable insights to improve patient care and health outcomes, and reduce inequalities.

SINGLE SET OF CORE STRATEGIC SYSTEM PLATFORMS

A unified suite of tools (analytical, dashboard, visualisation) with a user-centric single interface will be available to clinical and operational staff and leaders to help them interrogate a rich, high-quality, cross-sectoral data set and develop intelligence-driven plans for continuous improvement of health and care pathways, identifying and reducing health inequalities.

SINGLE DATA ARCHITECTURE

The unified data architecture described above will build on existing developments to understand our population better through the lens of various datasets from health, local government, housing and other sources. This will enable us to better describe our population needs and understand the health inequalities experienced, as well as better target interventions and model and measure impact of those interventions.

SINGLE SERVICE DELIVERY & SUPPORT MODEL

Training and development for clinical and operational staff and leaders will empower them to self-serve where appropriate, asking intelligent questions of data to provide targeted, multi-agency coordination and intervention for the most complex needs, and to take intelligence-led preventative actions, joining up care to improve patient experience and outcomes. This ability to self-serve, and a more unified approach to data management across the ICS, will allow our data analysts, business intelligence specialists and data science teams to dedicate more of their expertise to more complex analyses, providing predictive and preventative insights.

Achieving these future states will help us to move through the NHS PHM Maturity Matrix – an evaluation framework to compare and benchmark our current levels of functionality and ways of working - to become a Thriving ICS

7. STRATEGIC PRIORITY 3 - Single Data Architecture

KEY SYSTEM PLATFORMS:
Population Health Management System – L&SC System Intelligence Service

What the 'future state' will look like:

L&SC SIS comprises a combination of technical infrastructure and iterative analytical approaches to drive the creation of deep insight into the ongoing needs of the system. The infrastructure includes a core centralised intelligence platform that acts as a single point of access for users and a mechanism for the development of a comprehensive, consistent suite of best practice analytics, reporting and data visualisation tools.

In the future, this analytical capability will be build upon the rich data lakehouse as part of the Secure Data Environment programme, offering even greater Population Health Insight. Our analytical capabilities will support the development of a Learning Health System approach, and the OneLSC model will enable our analytical teams to develop enhanced and specialised skills and expertise.

What benefit will we experience:

The core aim of our System intelligence Service is to enable the improved use of digital and data on an ongoing basis to provide the actionable intelligence on our population's health needs to drive a reduction in health inequalities and ultimately improvement in the healthy life expectancy of all. Through harnessing the power of data analytics and insights, we can gain a deeper understanding of both the many factors that contribute to disparities in health outcomes among our different populations, which account for some of the most deprived in England.

This also informs where to focus resource across the system to best support those in most need in the medium and long term. We will ensure that our skilled resources can invest time into the continued development of this knowledge and collaborate closely and consistently with system partners as well as wider experts utilising the trusted research environment. And day to day users will have a single point of entry to an approved suite of common interactive analytical tools and reports providing population segmentation, risk stratification and modelling techniques.

LSC System Intelligence Service Development :

7. STRATEGIC PRIORITY 3 - Single Data Architecture

KEY SYSTEM PLATFORMS:
L&SC Secure Data Environment (SDE) for direct care and secondary uses including research.

The Challenge:

Imagine 200 doors with 200 different locks and you need a key for each one; that is how accessing data currently works across the health and care system. To transform how health and care is delivered, and ultimately improve health equity and health outcomes, we need to base our intelligence and insights on data that comes from a variety of sources – primary care, secondary care, ambulance, social care, other local government, VCFSE sector – and there is often a time-lag in the aggregation, analysis and interpretation of siloed data sets.

What the 'future state' will look like:

The SDE will support bringing data together and making it available for analysis in real or near-real time. It will complement the national Federated Data Platform (FDP - which may well be a major source of information into the lake-house). It will change our ability to work with and our relationship to industry and academia and via integration with the NW SDE will support combined research across the NW population of up to 7.4 million people. Integration with similar architecture built by the councils will also support wider population insights.

Data will be accessible from the lake house for workforce who would normally access data for direct care providing a whole system view of information and insight. This solution will become a clinically-led centre for AI supporting system validation and generation and regulation of new tools.

The benefit we will experience:

For our population: Our patients will ultimately be in receipt of improved care based on intelligence and local insights. They will be empowered to safely and anonymously contribute their health and care data for research purposes and will have the opportunity to become involved and help shape how their data be used to improve services, via a robust Patient and Public Involvement and Engagement programme.

For our people: Clinicians will be able to use intelligent insights from their own service/speciality as well as from other parts of the health and care system to improve the quality and nature of care delivered. Controlled access to the SDE through Data Access Committees and analysis at scale will help drive up data literacy in our workforce and ensure questions asked and analytical methodology are rigorous and robust.

Business Intelligence and Data Science teams across L&SC will be able to use tools they are familiar with to write analyses valid for all partners and not just their own, increasing their efficiency several fold while also providing greater power for system wide insight, including operational and clinical understanding, population health, health inequalities and continuous improvement. The program will support the development of a highly skilled analytical and technical workforce and a robust CPD programme will support and enable career progression.

For our partners: We expect to see much greater health, care and academic partnership working, students supporting our workforce and NHS staff taking up academic lectureships. The health and care system will be better able to collectively understand and work on system-wide pressures such as patient flow, ageing and health inequalities. The SDE will be a system for all, with primary care, secondary care and other sectors all benefiting while the capabilities it brings will attract new skills to L&SC and support recruitment and retention.

How we will get there:

The SDE is composed of several parts. Firstly, a cloud-based data store (lake house) has been built that all providers will be able to connect to. This can hold both structured (e.g. biometric measurements) and unstructured (e.g. images, streaming, free text) data. Data pipelines are being built to create a constant feed of data, from any source of interest, into the lake-house, which will be joined and pseudonymised to create a longitudinal record of primary and secondary care. Where possible data will be standardised into OMOP CDM (Observational Medical Outcomes Partnership Clinical Data Model) supporting national and international research. Data access rather than data sharing will take place via a L&SC trusted research environment allowing industry, academia and other professions to analyse data in a controlled way within our environment.

7. STRATEGIC PRIORITY 3 - Single Data Architecture

KEY SYSTEM PLATFORMS:
L&SC Secure Data Environment (SDE) for direct care and secondary uses including research (2).

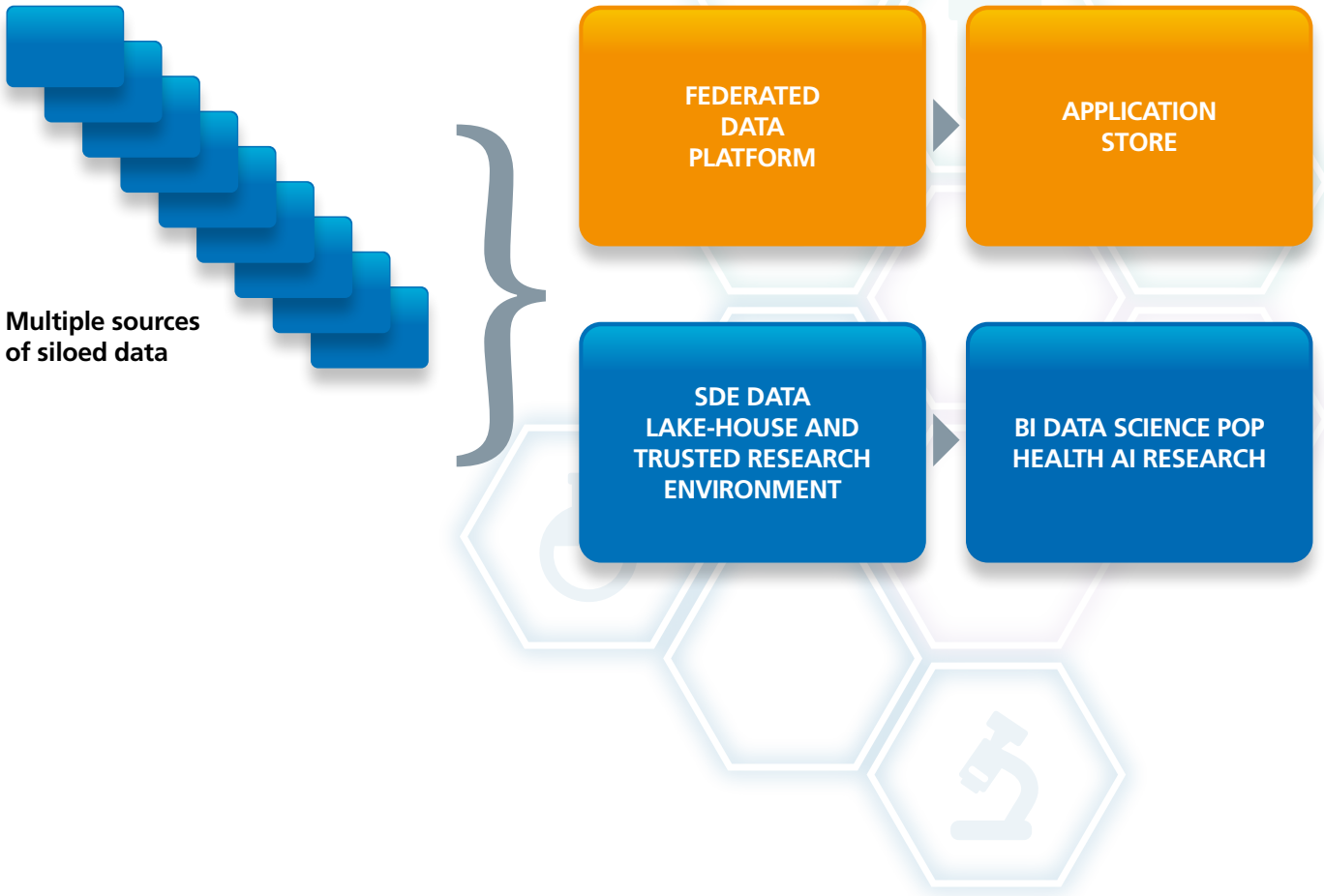
The programme will be supported by:

- appropriate governance and privacy including ethics, information governance, Confidentiality Advisory Group applications, a data access committee, and data and technical design authorities
- the ongoing development of a highly skilled analytical workforce, and
- Patient and Public Involvement and Engagement (PPIE).

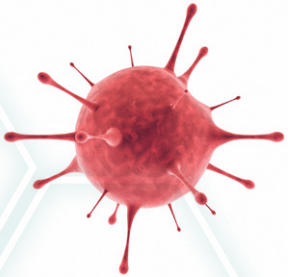
It will also follow the Five Safes Framework of data access.

How we will continue to make progress:

The SDE will become a clinically-led centre for AI, supporting system validation and generation and regulation of new tools. The SDE will continue to build upon the existing strong expertise in research/information governance, public and patient involvement and engagement and academic/clinical oversight.



7. STRATEGIC PRIORITY 3 - Single Data Architecture



CASE STUDY:
Lancashire & South Cumbria System Intelligence Service supporting Covid-19 management

- **The challenge:** As the Covid-19 virus spread rapidly through the population it became clear that some cohorts of people were at greater risk of serious illness if contracting the disease and that there was a need for closer monitoring of outbreaks in these specific population groups in a way that did not overwhelm the acute services but still kept people as safe as possible.

- **What we implemented:** An analytical platform with a suite of applications, supported by data science teams, which allowed the Digital Intelligence Unit for Lancashire and South Cumbria to scale at pace and deliver several supporting responses to the pandemic, including Outbreak Mapping, COVID-19 Population Health Intelligence and a Virtual Ward Console to manage pulse oximetry at home for those patients on that service pathway.

- **Impact:** Public health teams and local authorities used outbreak mapping tools to geographically monitor COVID virus spread, with the ability to run outbreak detection models in as near real time as data was made available. This combined with local intelligence enabled identification of how the virus was spreading through communities to narrow it down to areas or other specific shared spaces with greater risk and / or more vulnerable individuals.

- Commissioned primary care services used a combination of Public Health England (PHE) infection data linked to local data sets to create a patient specific view focussed on assessment of likely care needs of those who had contracted the virus. The safely shared data enabled visibility of the three pathway markers of self-management / oximetry at home / admission to hospital and tracked the outcomes and treatment needs. This insight created immediate learning to inform real time clinical decision making and risk assessment during the identification of COVID-19 positive patients for clinical review and referral into the most appropriate pathway.

- Using the nationally mandated Standard Operating Procedure (SOP), pulse oximetry monitoring through a virtual ward was made available to anyone in that cohort who contracted Covid-19. This then enabled any significant but symptom free drop in blood oxygen levels to be identified immediately and treatment delivered straight away (including admission to hospital if required). In addition to this, our local platform also applied further risk stratification for patients who were at greater vulnerability due to long term conditions or complex co-morbidities. General practitioners and their supporting multi-disciplinary teams then used the interactive population health intelligence tools to identify demographics with both clinical and social vulnerabilities and ensured this was built into the local pulse oximetry monitoring at home model, keeping a greater cohort of patients under close supervision and so able to see the early signs of hospital admission being required and make additional prevention interventions.

- **How my day has changed:** "This analytical platform provided patient data in a clear systematic way to be able to support clinicians with patients who were being diagnosed with covid 19. The data came through each day at a similar time and if there was ever a delay we could contact the team who would support and drive the data in the same day. Patient details would arrive, split into locality, adding benefit as we could see if there were spikes in proximal postcodes despite being classed as two different areas - Blackpool and Fylde & Wyre.

  Information was shown in a clear way and the symbols to show the high-risk categories proved helpful to clinicians as well as the date of testing positive to be able to contact patients in a timely but structured manner. From this clinicians would contact patients to make them aware of their diagnosis to then make a clinical plan of what was best for them from home monitoring to hospital admission. The system was immediately easy to implement with a very supportive team behind it."
  Clinical Head of Primary and Community Care, Fylde Coast Medical Services

- **Opportunity:** Learning from the operationalisation of shared data and risk management to guide pathway management between self-management / virtual ward monitoring and hospital admission could be applied into other long term condition management services such as cardiology and asthma pathways.

- **How we will continue to make progress:** Continued development of the capabilities and common best practice tools as part of the wider SDE programme will support Population Health intelligence to enable increased meaningful segmentation and insight into the health and care needs of the population that can drill down to the individual level. This can support immediate risk management and also inform medium to long term service design and direct care prioritisation. In combination with ward / Lower Layer Super Output Area (LSOA) level aggregated Place-based data sets (such as housing profiles), this can also develop additional understanding and actionable insight into the cause and effect of the complex social / environmental determinants of health and well-being.

7. STRATEGIC PRIORITY 3 - Single Data Architecture

CASE STUDY:
Digital Catalogue of voluntary, community, faith and social enterprise (VCFSE) sector services

- **The challenge:** There are multiple but ever-changing services provided by VCFSE organisations that are available to people in need across the system. Up to date records of them are critical to underpin any prevention ambition to be able to refer people into community support. However, it is a significant overhead to create and maintain multiple up-to-date and accurate views.

  Historically, up to half of on-line service information is inaccurate and there is significant effort invested by individuals and teams networking mainly via emails to remind each other and source specific advice on what is available. Our population were missing out on services that could support them and resources are wasted tracking down what is available and to whom, at any given point in time.

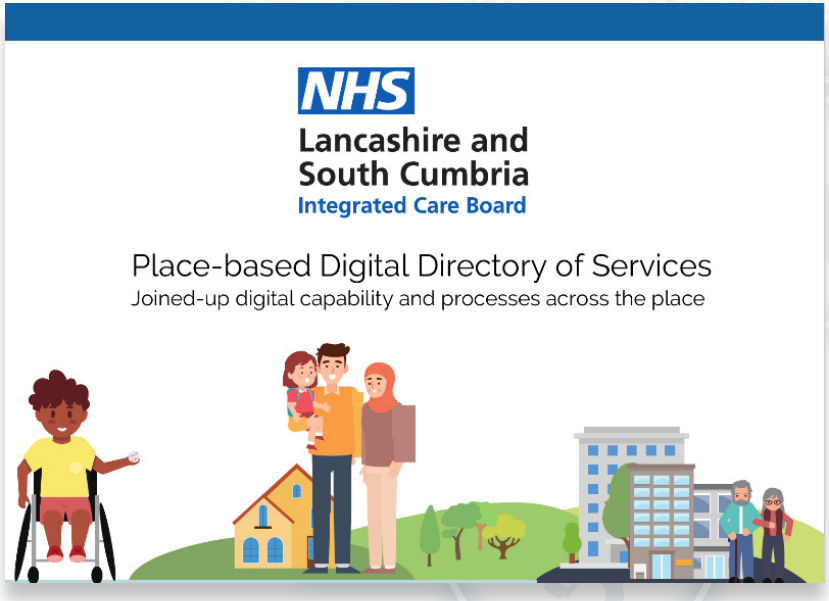
- **What we implemented:** A Digital Catalogue, accessible by any frontline team through various digital mechanisms, which provides a single searchable up to date source of services and contact information. The information is maintained, standardised with an open data standard (Open Referral UK) and assured through a central function – thus sharing this overhead between partners. There is also standardised reporting to enable monitoring and maintenance of data quality and identification of potential gaps in service provision, informing future commissioning decisions.

- **Impact:** 3500 service records have been created from 350 providers – with this information being updated / checked every two months. The information is being re-used by employees from over 15 separate service areas and organisations, with the information also being used to update 3 other Directory solutions. Accuracy has improved from 56% to 97% and 80% of users report a better experience. More people (both care providers and service users) can find out about current local services, increasing their support networks and access to early interventions, increasing their positive experience and ultimately supporting better long-term outcomes.

- **How my day has changed:** "The greatest value of the Digital Catalogue programme is knowing that the information is being checked and maintained. It is a more efficient process to search for and find appropriate support and the team feel confident to signpost people into identified support offers because they know the service information is still relevant and accurate." Social Prescribing Team Coordinator

- **How we will continue to make progress:** Information can be re-used into any process or tool as required. This could include therefore re-using the information to support chatbots, new apps, online triage, as well as updating any web-pages (where these are currently updated manually). and can be embedded into PEP functionality. The model can expanded to cover "Information and Advice" as well as referring to local groups and services.

  A big focus for 2024-2025 is considering how the tools can be direct citizen-facing. A pilot version related to Childrens Services is in development for Summer 2024, alongside planned linkages to clinically governed best practice advice related to family and child issues.



7. STRATEGIC PRIORITY 3 - Single Data Architecture

CASE STUDY:
Data enabling prevention and patient empowerment

- **The challenge:** Work by Professor Chris Bentley (2021) identified a number of electoral wards within Lancashire and South Cumbria that have high levels of deprivation, and higher than expected rates of emergency admissions for ambulatory care sensitive (ACS) conditions, even accounting for the level of deprivation. These admission rates place increased demand on the emergency services and raise concerns over the local incidence of serious conditions and the underlying causes of the same in those wards
- **What we implemented – obtaining our data:** A deep dive assessment (A Priority Ward Report) was undertaken for the two identified wards in Barrow-in-Furness to investigate the causes of these high admission rates, and to help local service leads direct a cross-agency response to reducing rates. A project team was convened consisting of health, local authority, and voluntary sector representatives. Extensive analysis of the datasets brought together by the project organisations was conducted to establish the main causes of ACS admissions. To support development of robust outcomes and recommendations we explored the causes for non-ACS admissions in parallel. And we also complimented the data analysis with consultation through community engagement events with the local population to obtain feedback and understand stories of lived experience. To add immediate value for those communities the clinical case management team also offered ad hoc health checks including blood pressure, pulse oximetry and temperature and provided supplementary packs of hygiene products and service access information where useful.
- **What we implemented – the analysis:** Initial analysis identified 6 priority areas, of which 2 were chosen to focus on initially – self-harm and COPD. Using a combination of data, published literature and engagement feedback, a comprehensive list was compiled to indicate all factors that are likely to contribute towards high levels of activity for these conditions. These included health and wider socioeconomic issues. These potential factors were iteratively tested, through data interrogation and through conversation with subject matter experts to refine a full hypothesis of what the project group believed were causing these issues in this area. The final hypotheses were described using a life-course approach, laying out which issues were believed to be the responsibility of each agency sector and where aligned actions across sectors could be taken to reduce these high admission rates and improve outcomes for the population cohorts examined.
- **Impact - COPD services:** Ensure respiratory "rescue packs" are being provided and accessible to all COPD patients, increased understanding of variation in inhaler / technique prescribing, developing better data on smoking prevalence and that cessation services reach fully into these communities.
- **Learning:** Data and analysis have to be part of a collaborative approach to tackling health inequalities. Data can provide a steer, as can tacit knowledge from those closer to the front line. These two elements can support and enhance each other. In order to truly impact the lives of disadvantaged groups we need to work with partner organisations in a purposeful manner in both analysis and aligned initiatives.
- **How we will continue to make progress:** The detailed outcomes are shared with local service leads to support further action planning to sustainably address the issues identified. The final approach that was developed is being shared with senior ICB leads with a view to being sponsored as a product that can be iterated and used widely in comparable investigations

7. STRATEGIC PRIORITY 3

A single data architecture across the system will enable enhanced access to data to support system level pathway design and service transformation together with a Secure Data Environment that will support research and development of innovation partnerships with industry and academia to drive further innovation.

8. STRATEGIC PRIORITY 4 - Single Service Delivery and Support Model

Our Ambition

By 2029, we will have implemented a single, integrated operating model for digital and data service delivery and support

What the 'future state' will look like:

- Single service desk / initial point of contact for all digital related incidents and service requests
- Single, integrated teams to enable all key elements of digital service support following service desk contact
- Single, integrated teams to deliver digital deployment, upgrade and change programmes
- Standardised set of operational process (based on industry standards such as the ITIL model for services and MSP / PRINCE2 for programmes)
- Single, integrated business intelligence function with appropriate expertise embedded in Providers and Places to deliver specified local requirements and enable workforce self-service
- Single approach to digital, data and technology talent acquisition and development.
- Digital and data delivery and support sitting within the one LSC framework of central services
- Enhanced and consistent service provision to support the single common infrastructure and platforms used by partners

What this will mean in practice for our people, partners and population:

Population

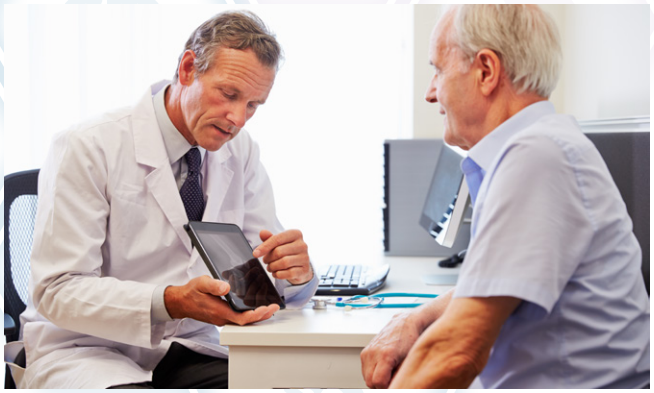
- Improved services, flow through services and increased meeting of health and care needs through more consistent and reliable digital services being deployed for the health and care professionals involved in their care delivery.

People

- Consistent and reliable user experience for those seeking support from digital services
- Focused and insightful support from digital and data professionals into wider programmes of work within the system
- Increased development opportunities for the digital and data specialist workforce and a framework for their development
- Greater ability for collaboration and shared provision of services and skills

Partners

- Consistent digital and data service provision across the system partners
- Improved retention and skills enhancement within the digital and data specialist workforce
- Improved ability to service wider partners such as VCFSE and social care and share skills, insight and opportunity



8. STRATEGIC PRIORITY 4 - Single Service Delivery and Support Model

Our Ambition

By 2029, we will have implemented a single, integrated operating model for digital and data service delivery and support

Where are we now:

- Work has started on defining, for each key digital and data service line, what elements of service would be included in a single service delivery model, and what would be excluded
- High level operating models for limited scope shared service delivery, such as out of hours support for service desk, are in development
- Plans to share resources and adopt a unified approach for single system mobilisation and deployment (such as acute EPR) are in development
- Operating models for system wide business intelligence function are in development
- Further opportunities to reduce service duplication are being investigated
- OneLSC senior leadership recruited and plans under way to develop full system Target Operating Model

What we need to do	How we will do it	1-2 Years	3-5 Years
Design and implement the future target operating model for all elements of in scope digital and data services and describe how this service supports local organisations digital and data needs	We will consult with a wide range of stakeholders from digital and data, operational management and care delivery teams to ensure that the single service delivery and support model delivers highly effective and efficient services to key end user groups We will support organisations in transitioning from localised to shared support arrangements	⚙	✓
Digital, Data and Technology (DDaT) workforce strategy and plan	We will build on existing 'good practice' talent acquisition schemes across the system and 'scale up' where appropriate We will work with partners to set out a plan to ensure that appropriate digital and data skill capacity and capability is available to support the ambition and priorities outlined in this strategy	✗	✓
Ensure alignment with the development of One LSC, the provider approach to developing a new system wide central services function	We will work closely with the strategic and operational development team in One LSC to ensure a consistent approach to the development of the single digital and data services offer alongside the other proposal central services	✗	✓

KEY ⚙ In Progress → Embed Ongoing ✓ Completed ✗ Not yet started

8. STRATEGIC PRIORITY 4 - Single Service Delivery and Support Model

CASE STUDY:
North West Shared Infrastructure Services

- **The challenge:** The growing demands on Integrated Care requires health and care organisations providing acute care, primary care, community, mental health, social care and public health to operate in a collaborative manner. Core technologies must help to support a culture change, enabling these organisations to work together in order to achieve common strategic goals. New approaches for delivering underpinning digital services were required to encourage collaboration, the sharing of knowledge and adoption of innovative working practices. Underpinning and new care pathways would require an integrated technology platform spanning the historic geographic and organisational boundaries.

- **What we implemented:** A consortium of NHS organisations in the North West of England, collectively known as North West Shared Infrastructure Services (NWSIS), recognised that independently procured and deployed technologies limited the scope for collaborative working with their neighbours and concluded that a solution was required to provide common services to a wider community.

  NWSIS provides proven and tested infrastructure services and a governance model that allows each IT provider to retain autonomy for their own assets and service users whilst providing deep levels of integration with their business partners. The cornerstone of this environment is a network directory service (Microsoft Active Directory) which spans all member organisations and locations. Established in May 2002, the Active Directory service has enabled numerous inter-organisation functions ranging from basic file shares to advanced communication services.

- This has been fundamental in fostering a unique spirit of co-operation between the stakeholder organisations. In addition, NWSIS operates a regional wireless network mobility solution allowing staff to securely access applications and data using portable devices whilst working remotely. Access to the network is brokered via the central network directory service regardless of location. This capability enables seamless interaction with the right information, in the right place, at the right time.

- **Impact:** The collaborative approach of the NWSIS has enabled us to

  - Provide a better user experience with fast, reliable and secure access; regardless of time, location or corporate device.
  - Drive quality of care and patient experience improvements through the secure access and sharing of patient information across the health and care community
  - Deliver high-quality, reliable and easy to manage network access for staff
  - Leverage both existing infrastructure investment and future-proofed regional industry-leading regional architecture.

- **How we will continue to make progress:** The establishment and success of the NWSIS collaborative delivery vehicle has set a precedent for a single model of working across Lancashire & South Cumbria.

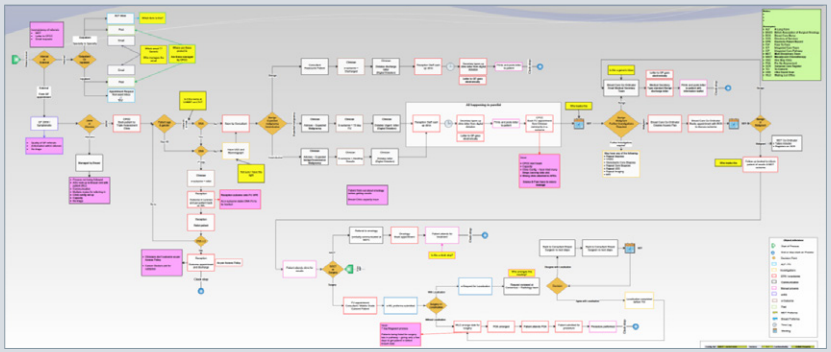
  As OneLSC becomes established, a revised Target Operating Model and governance structure will support the creation of unified teams, equipped with the necessary skills and expertise, to deliver the best digital and data support to the health and care services across Lancashire & South Cumbria.

8. STRATEGIC PRIORITY 4 - Single Service Delivery and Support Model

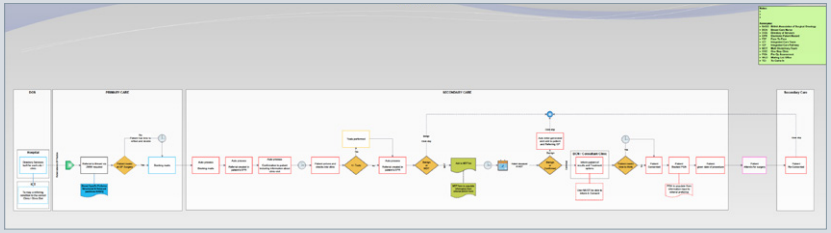
CASE STUDY:
Breast 2-week wait clinical pathway redesign across the health ecosystem

- **The challenge:** A significant amount of our transformation effort is and will focus on the implementation of a single shared electronic patient record (EPR) across four acute trusts. In readiness for that deployment, there is a recognition of the need to harmonise clinical pathways (focusing on providing the best quality care and eliminating any inefficiencies) and improve the patient journey and experience for patients in our care. This pilot initiative aimed to revolutionise patient and clinical engagement, enhance system efficiency, and foster effective collaboration among healthcare providers across the provider trusts. Ultimately, implementing a shared EPR across four NHS trusts isn't a digital project; it's a clinically-led, operationally-delivered and digitally-enabled transformative overhaul of healthcare delivery and processes.
- **What we implemented:** The pilot aimed to bring together stakeholders from the trusts and community services to collectively map out the current state and envisage a future state for a single breast 2-week wait (2WW) pathway, using this experience as the benchmark for future shared pathway sessions. The goal was to establish a unified approach to patient flow, leveraging the shared EPR and building collective trust and collaboration.
- **Impact:** The complexity of the 'As Is' pathways presented in the image was thoroughly understood, and the 'Future State' ideal pathway revealed invaluable common themes and outputs.

The diagrams shown are for illustration purposes only, and highlight the complexity of the current pathways in two trusts, and the improvement that can be made to a patient journey in the future.



Proposed future state pathway (across all provider trusts):



8. STRATEGIC PRIORITY 4 - Single Service Delivery and Support Model

CASE STUDY:
Breast 2-week wait clinical pathway redesign across the health ecosystem

- Key issues identified included challenges in the quality of referrals, time-consuming triaging processes, and a desire for comprehensive referral forms. Participants envisioned the potential use of AI in streamlining processes, from clinic appointments to radiology requests. The focus shifted towards the importance of accurate data capture at the pathway's entry point to enhance downstream elements of the EPR.
- **Opportunity:** Lessons learned emphasised the importance of cross-organisational clinical and operational collaboration in the mapping and re-design of clinical pathways" (to replace all highlighted) and the need for dedicated transformation specialists. Stakeholders for future meetings were highlighted, emphasising the need for diverse representation, including service managers, community/GP representatives, patient representatives, radiology, admin staff, and more – from all four ICS acute Trusts.

  Recommendations include incorporating AI, robotics and EPR technology awareness sessions, securing broad stakeholder involvement, and establishing a central team of transformation specialists. The pilot emphasised the importance of proactive communication, a shared intranet for information repository, and the creation of high-level principles to guide the program. It also underscores the potential benefits of an EPR beyond digital record-keeping, advocating for a comprehensive EPR transformation strategy with dedicated facilitators for pathway sessions.
- **How we will continue to make progress:** A roadmap was established to roll this work out across other pathways of care, undertaking the following tasks:

1. Establish a Dedicated Transformation Team to lead future meetings and ensure alignment with the shared EPR programme's objectives.
2. Conduct awareness and educational sessions for all stakeholders on the potential of AI, Robotics, and EPR technology in streamlining healthcare processes.
3. Secure broad stakeholder involvement to ensure diverse representation from all participating trusts and community services in future pathway meetings.
4. Develop high-level principles to steer the shared EPR programme and pathway development.
5. Enhance communication, awareness and understanding of the shared EPR programme among stakeholders.
6. Formalise a structured approach for reviewing, approving, and managing shared pathways.
7. Foster collaboration and knowledge sharing among participating trusts and community services.
8. Continuously monitor program progress and adapt strategies based on feedback and evolving requirements.

By following this roadmap, the Lancashire and South Cumbria Integrated Care System can advance its shared EPR initiative and realise its vision of transforming patient care delivery and system efficiency across participating trusts and community services.

NHS
Lancashire and South Cumbria
Integrated Care Board

SYSTEM IMPACT

9. DIGITAL & DATA SUPPORT FOR STRATEGIC ENABLERS

The Lancashire and South Cumbria Integrated Care System is working on a wide range of activities to deliver against the ICP strategy and in alignment with the ICB objectives. Some of the key strategic system enablers cross-cut the system priorities and enable delivery of overall system success. There is also a key intersection here with the System Recovery and Transformation Programme needs.

These strategic enablers fall into two general categories articulated in our JFP:

- **Getting the basics right:** Ensuring essential infrastructure and services are in place and can be equitably accessed across the whole footprint
- **Working differently:** Transforming service delivery across multi-organisational care pathways that deliver higher quality services with better outcomes more efficiently.

This section sets out how digital and data can drive the success of these high level strategic system enabling areas. The aggregated system enablers cover a breadth of initiatives and definitions for the purposes of this strategy can be found below, followed by the digital and data response to deliver this system level need.

A core function of the Digital and Data Priorities is to align with and support delivery of wider system strategic developments across Lancashire and South Cumbria. This includes the critical System Recovery and Transformation Plan but also the enabling of Places, Workforce and Population Empowerment as critical to system wide improvement.

9. DIGITAL & DATA SUPPORT FOR STRATEGIC ENABLERS

Defining the Digital and Data support to System Strategic Enablers

Through the **System Recovery and Transformation** programme, driving system level clinical, operational and financial stability and sustainability, ultimately creating robust governance, stronger contracting and commissioning, and transforming delivery of care through New Models of Care and the New Hospitals Programme.

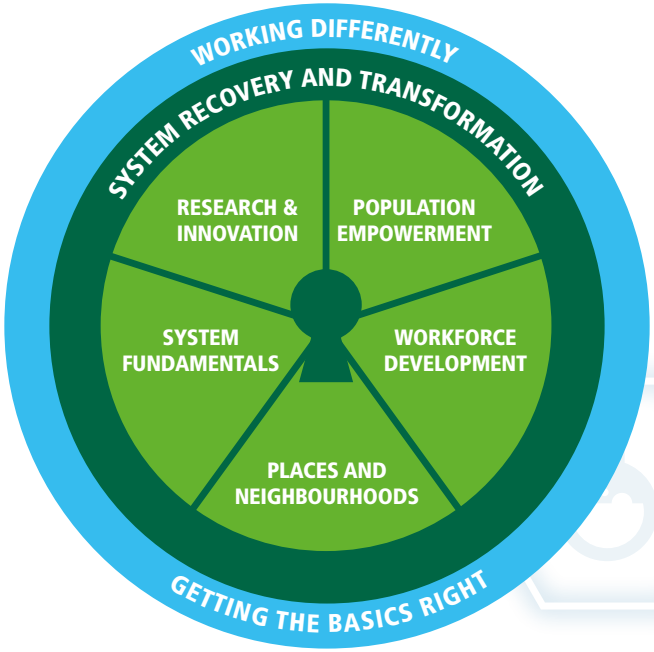
Active facilitation & promotion of **Research and Innovation** to better work with new and existing academic and commercial partners to identify, test and adopt new products and approaches to better meet need, significantly reduce inequalities and drive economic growth.

Creating increased integration through partnership working, vertically and horizontally to increase consistency and equity. Ensure appropriate development through **Places and Neighbourhoods** for local decision making and levelling up outcomes whilst utilising the NHS anchor institutions.

Provision of system essentials to protect and provide a safe, consistent and sustainable environment for our people and our data on an ongoing basis including **System Fundamentals** of cyber security, standards, safe-guarding, information governance and net-zero.

Redefining our relationship with the population and working increasingly in partnership and co-designing new models of care & tools that **Empower our Population** to pro-actively increase their overall health and well-being and thus healthy life expectancy. Actively increasing digital inclusion and ensuring digital tools do not disadvantage.

Taking a system level view of **Workforce Development**, resource capacity and capability to build flexible and expert resourcing possibilities for direct delivery and scaled programmes of work whilst ensuring fulfilling career opportunities through sustainable people investment.



9. DIGITAL AND DATA SUPPORT FOR STRATEGIC ENABLERS

Strategic System Enablers: Digital and Data Response

SYSTEM FUNDAMENTALS

Summary:

- Delivery of safe, high quality 24/7 available care services for our local population requires a set of core digital and data services and safeguards to be put in place to ensure our staff and partners have access to the quality information they need, at the time they need it, to deliver high quality care to all
- The ICS has a duty to ensure these foundational tools and services are in place to protect and provide a safe, consistent and sustainable environment for our people on an on-going basis.

The Need:

- Our systems are at risk of a cyber attack if we do not invest in robust cyber security protection and incident response measures
- Our future core systems risk being siloed if we are not robust in our approach to the adoption of data and interoperability standards
- We risk introducing care delivery risks and further unwarranted variation into services if our care systems are not designed and implemented with digital clinical safety standards in mind
- Information Governance should be seen as an 'enabler' to appropriate sharing of health and care information and provide an appropriate legal 'safety net' to protect all involved in the information sharing process
- Digital and data has a key role to play in addressing the Net Zero ambitions of the system through rigorous adoption of systems, tools and services that reduce the environmental impact of health and care service delivery.

Digital and Data response:

In line with the digital maturity requirements of the 'What Good Looks Like' framework we will:

- Develop and implement a set of system wide cyber security tools and services across the ICS 'at scale' and in line with the requirements of the national Health and Care Cyber Security strategy (see Lancashire & South Cumbria Cybersecurity Strategy)
- Adopt nationally agreed data, technical and clinical architecture standards and ensure that all our system wide and local digital and data developments meet these requirements
- Ensure that our systems are 'secure by design' and meet all relevant care safety standards in their development and implementation
- Ensure that data sharing across all partners (including VCFSE and social care) is undertaken in line with 'Five safes' model to ensure data safety wherever possible, whilst ensuring the relevant information is shared wherever possible to do so to protect the most vulnerable in our society
- Support ICS Green Plan delivery through adoption of digital and data solutions that meet the environmental sustainability ambitions of the system.
- Ensure the digital and data programme of work is part of a socially responsible approach to development of services and support for the local workforce and wider population. We need to enable a wider contribution by the NHS as an anchor institution in all our communities but with greater focus where our populations are experiencing health inequalities and reduced health outcomes.

9. DIGITAL AND DATA SUPPORT FOR STRATEGIC ENABLERS

Strategic System Enablers: Digital and Data Response

SYSTEM RECOVERY & TRANSFORMATION

Summary:

- Ensure a clinical, operational and financially sustainable system of health and social care provision for our local population
- Recurrent financial stability (through quality and efficiency improvements) must form our initial focus as this can underpin investment and ongoing transformation through new models of care and the new hospitals programme across the system (the 'virtuous circle')
- Digital and Data innovation enables both insight into and monitoring of performance alongside enabling tools that can support reductions in variation, drive population health management based service redesign, deliver consistent and reliable data & analysis plus enable more efficient and effective care for our population using the services through shared platforms and systems.

The Need:

- The financial performance needs to be rebalanced over the next three years so that the overspend of previous years including through Covid-19 is in part recouped. This has to come from both ICB supported and Provider led savings across the system
- Our system needs to provide services to meet the increasing demand from an ageing population, population growth and the negative health and care outcomes impact of long covid, poverty and health and care inequalities
- Delivery of high quality services in the same ways as pre Covid cannot meet both the needs of the population and the budget. We need to innovate and develop new solutions that provide improved outcomes (as defined through CQC and SOF ratings) and combat the effect of inequalities.

Digital and Data response:

- We will enable quality through access to a reliable set of core standard systems and tools for our staff, robust data and analytics to drive improved outcomes and better support for our population so that digital and data can drive improved individual health and well-being.
- We will enable efficiencies through data safety and integrity, consistent insight to drive transformational and cultural change, reduction in unwarranted variation, implementation of common infrastructure, platforms and systems (leading to cost reductions and reduced rework and variation), and tools to support automation of manual processes. We will also enable efficiencies through the use of analytics that can identify additional opportunities for cost reduction (e.g., improved medicines management)
- We will enable innovation through access to data to support translational research and clinical trials, closer working with academic and commercial partners and development of an increasingly curious, innovation minded and skilled workforce
- We will enable transformation through improved access to insight to underpin service and care pathway redesign across all system partners (including VCFSE and social care)

REDUCE WASTE AND DUPLICATION

IMPROVE QUALITY

TRANSFORM

9. DIGITAL AND DATA SUPPORT FOR STRATEGIC ENABLERS

Strategic System Enablers: Digital and Data Response

PLACES AND NEIGHBOURHOODS

Summary:

- The ICS operates on the principle of 'subsidiarity', with decisions around planning and delivery of health and care services being devolved to Places and Neighbourhoods where most appropriate, and the ICS delivering services and support 'at scale' where it most makes sense to do so
- Tools, systems, resources and training will be required by Places and Neighbourhoods in order to increasingly collaborate to deliver integrated care to individuals in their communities and plan services that meet specific local population health and care needs.

The Need:

- Health and care delivery teams require access to core, shared care solutions to provide truly integrated care around a person's holistic health and care needs
- Health and care staff in Places and Neighbourhoods require access to high quality, wide ranging and standardised data sets to develop plans to address health and care inequalities and the wider determinants of health
- Appropriately skilled analytical and data science resources are required to interrogate data and provide insight in line with Place and Neighbourhood population health and care needs and create shared learning across the system
- Place and Neighbourhood staff require training and support to utilise the insights provided to transform health and care service delivery for their local population.

Digital and Data response:

- Detailed health and care records will be made available to multi-sector care delivery teams to support integrated care delivery.
- A single ICS wide 'data lake' (incorporating health, care and wider social determinants data) and a single set of analysis and reporting tools will be provided to Places and Neighbourhoods to interrogate and gain locally determined insights
- Skilled analytical resources will be embedded into Places to support Place and Neighbourhood based staff develop their capacity and capability in insight driven planning and decision making.
- Improved digital access for teams across VCFSE and community care outside of traditional environments to enhance collaboration and shared working.

WORKFORCE DEVELOPMENT

Summary:

- A sustainable and skilled workforce is essential for achieving a step change in population health and care outcomes, and ongoing use of digital and data tools and insight is a key part of this.
- Developing fundamental digital and data skills for the wider workforce and ensuring increased capacity, capability and career progression for our digital and data specialists means that the value from investment in our digital and data strategic priorities can be maximised through both service delivery and enhanced staff experience on a sustainable and continuous learning basis

The Need:

- Our front-line staff are under significant pressure, resources are scarce and change can be uncomfortable. This applies across all our system partners
- Digital tools are increasingly seen as an efficient part of both quality care delivery and in the creation of complex data insight to benchmark, improve and transform services. This requires specific skill sets that requires investment in current and future staff
- Our Digital, Data and Technology (DDaT) specialists operate in a highly competitive market, and we are struggling to train and keep people in the public sector as demand for this expertise continues to grow in other industries
- Leverage of maximum value from the investment in large scale system wide digital and data initiatives rests on those systems and tools being used increasingly effectively by the whole workforce over the longer term.

Digital and Data response:

- Front-line staff (across system partners) will be provided with and trained on digital tools as they become available or are significantly upgraded. There will also be increased focus on data literacy to enable staff to take advantage of the significant insight to be gained from analytics and support for embedding new ways of working will be provided. This will be in line with ICS wide 'people digital' developments
- For our DDaT specialists, we will develop a comprehensive workforce plan across system partners to enhance skills, develop future capacity and capability and ensure an attractive opportunity can be created that provides ongoing career development and job satisfaction within the local health and care sector. This will build on the forthcoming national NHS DDaT workforce strategy, once released.

9. DIGITAL AND DATA SUPPORT FOR STRATEGIC ENABLERS

Strategic System Enablers: Digital and Data Response

RESEARCH & INNOVATION

Summary:

- Lancashire and South Cumbria has a highly active academic and commercial research and innovation community that is seeking to utilise digital and data for academic and translational research, clinical trials and the development of local innovation to support the health, economic and job prosperity ambitions of the system.

The Need:

- A unified approach for front line challenges to be consistently better understood so that resources and tools are better deployed and scaled where available, and subsequently innovative solutions are sought that meet local identified needs
- Access to core, standardised data sets in a secure manner to support a wide range of research and commercial 'use cases'
- Access to investment to test and scale up local digital innovations with a view to potential future commercialisation
- Regular 'horizon scanning' of future technologies and solutions that may address key system problems and meet population need in a higher quality, lower cost and/or more efficient manner.

Digital and Data response:

- Develop a common approach to understand service delivery challenges and where /how to prioritise research and innovation
- We will work with our local academic and commercial partners to ensure that high impact research and innovation data sets are identified and made available easily and securely to support translational research, clinical trial delivery and innovative product and service development. This will be enabled through a Secure Data Environment (SDE)
- We will work with key local partners (most notably the North West Coast Health Innovation Network and Local Enterprise Partnerships) to develop a pipeline of local innovation for potential development, adoption and commercialisation through investment
- We will work with academia, the Health Innovation Network and commercial partners to identify and impact assess innovative digital and data solutions that are potentially coming to market that can make a 'step change' in improving outcomes, reducing inequalities and/or increasing efficiencies for our system
- More locally focussed work will be enabled through insight generated from quality translational research data that enables increased sharing of best practice and reduced unwarranted variation.

POPULATION EMPOWERMENT

Summary:

- Our local population is becoming increasingly digitally connected, confident and competent, and health and care services have an opportunity to build on this to deliver more highly personalised support for individuals around engagement in future service design, prevention of illness, management of long-term conditions and improved overall health and well-being
- However, there are individuals who understandably struggle to access and engage with digital, and the ICS has the responsibly to help those people to have the opportunity to do so and / or provide an alternative means of service that the 'digital divide' is not exacerbated across Lancashire and South Cumbria.

The Need:

- Digital access (through equipment, connectivity and skills) is highly variable across our system and unless this is addressed, there is a risk that as services become more digitally enabled, key groups in our population will get further left behind and health inequalities exacerbated
- Access to health and care information for an individual is currently too fragmented and difficult, making it only accessible to the most determined and 'digitally savvy'
- There are a plethora of apps available to support the health and care needs of individuals, and it is difficult for our local population to know which ones are safe and most appropriate to support their specific health and care needs

Digital and Data response:

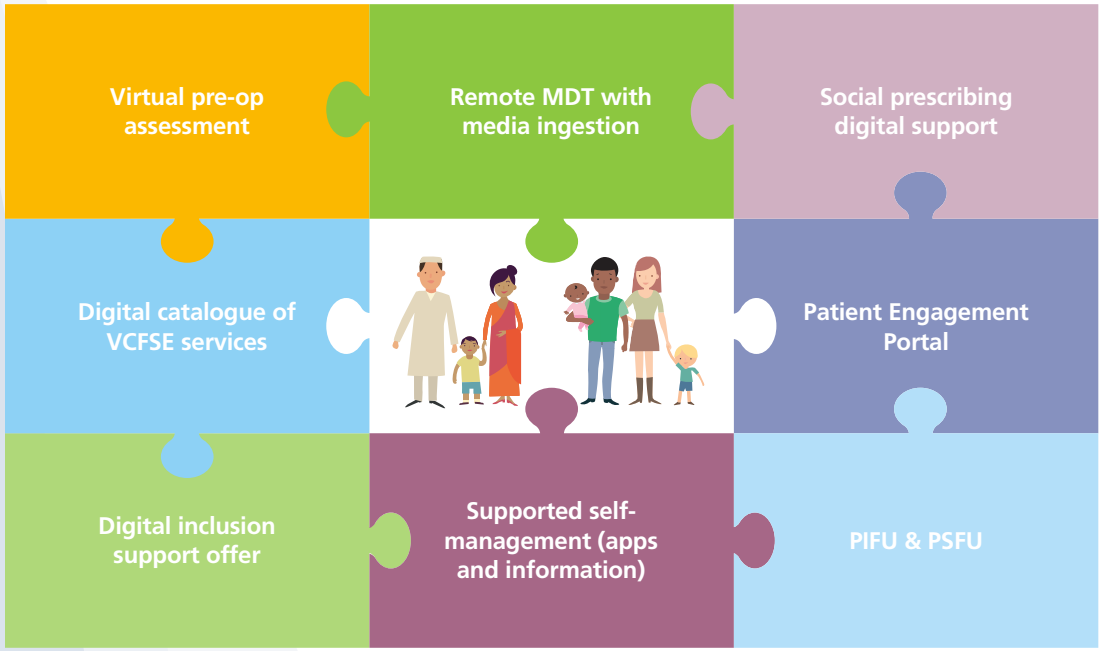
- We will work with local partners (including VCFSE and social care) to improve digital access in the most 'digitally excluded' groups in our local population and help all our communities to engage in co-design of future digitally enabled services
- Our population will be provided with a single 'digital front door' (available through the NHS App) to their detailed health and care records, approved advice and guidance and management of their interactions with health and care services and staff (such as appointments)
- Our population will be provided with a set of accredited apps to support disease prevention and management, improvements in overall health and well-being and a single way of reporting on their experiences with health and care services
- People in our local communities will be given training and support to utilise these digital tools to support management of their care in a highly personalised manner.

SPOTLIGHT ON POPULATION EMPOWERMENT

Increased population empowerment in using digital tools and data insight together with increased engagement in their own health and well-being journey is seen as fundamental to improved system level outcomes in the coming years. This needs to include the most technology savvy but also be mindful that non-digital channels must always remain available for those who need them. The 2023-24 **NHS Priorities and Operational Planning Guidance** specifically references the need for increased direct access, a reduction in unnecessary appointments and greater emphasis on information and prevention.

The Digital Empowerment Programme sets out to create a step change in the ease and effectiveness of the population's engagement with the health and care system through increased support in building and using digital skills, better access to better quality information using digital tools and an increased ability to interact with their care providers and engage in their own health and well-being journey. It aligns with the **NHS England Digital Inclusion Framework** requirements and its future direction will be informed by the creation of a Digital Empowerment strategy, complementary to this overarching strategy.

Key building blocks for the L&SC population



Digital Inclusion is a particular priority given the risk of exclusion increasing health inequalities.

The goal is to target **4** main issues :

1. **Device Accessibility**,
2. **Connectivity**,
3. **Digital activation** (knowledge, skills and confidence) and
4. **Digital Health Literacy** (awareness of and access to the relevant online information and digital health technologies).

9. DIGITAL AND DATA SUPPORT FOR STRATEGIC ENABLERS

Digital Inclusion Support

CASE STUDY:
Digital Inclusion Support

- **The challenge:** As we increasingly digitise our health and care ecosystem, we are in turn often asking our patients to engage with us using digital tools and to adopt such tools to manage their wellbeing and health conditions. However, many of our patients lack the devices, connectivity, or the knowledge skills and confidence to use digital technology. We know that people who might be at risk of health inequalities (due to gender, age, ethnicity, language, education, employment status, etc.) are often also digitally excluded, and digital exclusion can both a symptom and a cause of health inequalities.

- **What we implemented:** NHS England provided us with access to a national platform to support the training of digital health navigators (volunteers and/or staff) and project management tools to monitor impact of such services. We used this opportunity to support 13 organisations from the VCFSE sector we had commissioned to provide digital skills support and confidence building to our excluded populations, particularly those considered to have protected characteristics.

- **Impact:** 43 Digital Health Navigators (mostly volunteers) were trained on the platform and supported to help others to develop digital knowledge, skills and confidence. This helped to build some sustainability within VCFSE organisations, as some volunteers went on to secure paid employment.

  Improved skills were self-reported in almost 2500 citizens across five areas that were important to them (one of which was primary health related) improving their health and wellbeing. Many individual case studies and bitesized videos were created to raise awareness of digital exclusion among health and care staff.

- **How my day changed:**

  "This project provided opportunities for our citizens to improve knowledge, skills and confidence in digital technology, reducing barriers to health, social care and wider services and observing improvements in our citizens health and wellbeing. In listening to their stories, we gained insight for our workforce on local diverse and digital challenges. I'm proud to be part of this transformation!" Digital Inclusion Senior Project Manager

  "I was looking for a volunteering option and unexpectedly became a Digital Health Navigator. I have worked with a diverse range of people in our community, most with chaotic lifestyle experiences. I learned to work with them at their pace, starting with the basics, to make sure they gain a good understanding and walk away feeling they have achieved something." Digital Health Navigator, The Intact Centre, Preston

- **How we will continue to make progress:** This project helped us identify opportunities in the wider system, particularly working with our voluntary, community, faith & social enterprise partners (VCFSE). It also led to the initial development of a Digital Impact Assessment, that will be finalised and adopted to ensure that all transformation projects involving digital and data consider the impact that might be felt among our population and patients.

  Priorities for 2024 onward are to develop a Population Empowerment Strategy imminently that will lay the foundations for partnership working to mitigate against digital exclusion. This will outline how the 4 Digital and Data Strategic Priorities can support this important agenda.

9. DIGITAL AND DATA SUPPORT FOR STRATEGIC ENABLERS

Digital and data supporting System Fundamentals

CASE STUDY:
Digital and Data Supporting the Sustainability Agenda

- **The challenge:** The climate emergency is a health emergency. Climate change threatens the foundations of good health, with direct and immediate consequences for our patients, the public and the NHS. The situation is getting worse, with nine out of the 10 hottest years on record occurring in the last decade and almost 900 people killed by heatwaves in England in 2019. Without accelerated action there will be increases in the intensity of heatwaves, more frequent storms and flooding, and increased spread of infectious diseases such as tick-borne encephalitis and vibriosis. Over the last 10 years, the NHS has taken notable steps to reduce its impact on climate change. As the biggest employer in this country, there is more that the NHS can do. Action must not only cut NHS emissions, currently equivalent to 4% of England's total carbon footprint, but also build adaptive capacity and resilience into the way care is provided.

- **What we implemented:** The covid-19 pandemic enforced change for employees, seeing them predominantly work from home and forced changes in primary care, accelerating plans to digitise healthcare. This means projects to implement Digital Front door Online Consultation Video Consultation (DFOCVC) platforms and Accelerated Citizens Access to GP Data (ACAGPD) for General Practice were delivered at scale. This meant GP practices could communicate with patients, provide information, and conduct appointments digitally, as well as patients having access to their prospective records. This coincided with greater development in NHS App functionality.

- **Impact:** We can categorise our sustainability impact by listing what we have done, what we are currently doing and what still needs to be achieved, into 3 core themes: Better Procurement, Technical Development and Digital Healthcare. There is no doubt that there has already been a significant impact on our carbon production throughout Primary Care. Implementing digital contact with patients has meant a significant reduction in patients driving to practices.

  Patients no longer need to attend practices to order prescriptions, manage referrals, access their medical record or manage ongoing monitoring. Practices no longer need to print full medical records and send them via the post.

  Advancements in digital meeting tools has meant there is no longer a requirement for ICB employees to drive to offices every day. And cloud computing has exponentially reduced energy consumption whilst improving online collaborative working.

- **Opportunity:** Sustainable healthcare is an important concept that focuses on meeting the needs of the present without compromising the ability of future generations to meet their own healthcare needs. It involves finding a balance between providing high-quality care while also being mindful of the environmental impact and resource consumption involved in delivering healthcare to an increased population size.

  Sustainable IT initiatives aim to reduce waste, promote efficiency, and prioritize preventive measures to create a healthier and more sustainable future for all

  By investing in sustainable healthcare practices, we can not only improve the health and well-being of individuals but also contribute to a healthier planet for future generations to enjoy. Therefore, it is crucial for healthcare providers and organizations to embrace sustainability as a core value to ensure a healthier world for all. By focusing on sustainability in Primary Care, we can create a more resilient and equitable healthcare system that benefits both current and future generations. Let's work together to build a healthier and more sustainable future for all!

- **How we will continue to make progress:** There doesn't have to be a choice between delivering healthcare, saving time, saving costs and being more eco-friendly. The optimum result involves finding the perfect balance between leveraging technology and enhancing patient care. By fostering a sustainable culture and encouraging creative thinking, we can ensure everyone is thinking about their sustainability plan and contributing towards NHS 2040 Net Zero target.

9. DIGITAL AND DATA SUPPORT FOR STRATEGIC ENABLERS

Digital and data supporting population empowerment

USER STORY: NOELENE

Neuro Rehabilitation Online (NROL) – online rehabilitation group therapy

On her way to work in March 2023, Noelene suffered a ruptured brain aneurysm. She had urgent emergency surgery at Royal Preston Hospital and following this suffered a brain infection which led to ongoing neurological issues post operatively. Spending 6 months in hospital it was a long journey for Noelene. She had to learn to walk again and suffered significant memory and cognitive issues and on discharge home was still very disorientated.

Once home things started to settle and Noelene's Physiotherapist and Occupational therapist referred her to NROL for ongoing online rehabilitation to help with her ongoing mobility and cognition issues. She reports this was the 'best decision' she had made! and feels she wouldn't have made the progress she had without NROL.

She explained how NROL gave her much needed structure once she left hospital. The tech support staff within the service allowed Noelene to easily access the service and with piece of mind that if she was struggling to get online he was on hand to support her. She stated 'you knew you could contact them and that you weren't taking someone's time up. 'She completed weekly exercise sessions online, explaining how the exercises were simple but effective in achieving her goals and even managed to incorporate some of the exercises into her daily routine. Explaining that having the therapists supporting her live on screen took the 'fear away' and they were always there to help and advise as needed.

Being able to discuss her problems and create strategies to overcome these issues during the cognitive rehab group was really helpful to her, especially around memory as it was so important to her. Explaining how it was presented without 'feeling stupid' as others in the sessions were going through the 'same thing,' but also having expert therapists to support them along the way. Utilising educational booklets helped Noelene as this allow her to prepare for sessions but also look back on sessions to continue to progress independently. Noelene explained how NROL had 'exceeded' the rehab goals she had set with her therapy team. Things such as being able to move around the home, pick things up off the floor, and using useful strategies to improve her memory, as she is now able to read a book and 'enjoy it'.

Her main feeling coming out of NROL is that it allowed her to 'stop feeling so isolated' and somewhere she could go to where people 'understood' what she was going through and support her through it. She actually preferred doing her rehab online compared to face to face as having so many people together at once was 'really good', explaining the patients didn't have to get out to the same place each week especially those with mobility issues, also how much easier it was being in the comfort of your own home but still being able to interact with other people.

Noelene had to finish full time employment due to her brain injury but NROL has given her the confidence to start some voluntary work in her spare time. Improvements were also noted in measures taken before and after the program with her independence to complete certain activities improving significantly along with improvements in her quality of life scores.

9. DIGITAL AND DATA SUPPORT FOR STRATEGIC ENABLERS

Digital and data supporting population empowerment

USER STORY: RUTH

Smart technology reducing falls and improving wellbeing in a residential home

Ruth, an active woman of 90 years with no mobility restrictions, came to live at Hartland House Residential Home. Before the smart lamp - a technology designed to detect and prevent falls - was installed Ruth would frequently wake during the night often getting dressed around 2-3 am ready to go shopping. As a result, Ruth would often be lethargic during the day showing signs of confusion raising concern to the staff. Her daughter was closely involved with Ruth's care and, due to the confusion during the day and concern over her wellbeing overall, it impacted her personal life spending extra time visiting her Mum daily.

Night staff at Hartland House routinely visit all residents' rooms every 2 hours to check the residents have all their needs met and haven't had a fall. The smart lamp was installed into Ruth's room 2 years after she moved in, and it became clear from data and images that Ruth was getting out of bed 18-20 times a night, often stumbling in the bathroom, fortunately immediately getting up. Since installing the lamp, staff can respond immediately to Ruth moving around, provide reassurance that it's still night time and settle Ruth back to sleep.

The technology has not detected any further falls to date and Ruth's night time movements have reduced significantly. She is more alert and more settled during the day. Her daughter is pleased with the improvement and reassured sufficiently to be able to move home to a location that is further away. The Board of Trustees of Hartland House have been so impressed with the improvement of support that the lamps offer, they have been installed in all rooms throughout the home.

Our smart lamps detect and can prevent further falls using radar technology to monitor movement and other parameters without physical contact, and acoustic technology to detect activity such as coughing. It replaces usual ceiling lights, provides a welcome message and automatically lights up the room when the person wakes up and gets out of bed. Out-of-bed detection notifies care staff so they can proactively provide help when needed, and images are analysed in the lamp, providing sleep analysis. In 2024-2025 we will be deploying smart lamps in 50 care homes to support approximately 500 residents

9. DIGITAL AND DATA SUPPORT FOR STRATEGIC ENABLERS

Digital Empowerment as a Priority for Population Empowerment

Lancashire and South Cumbria are not just providing improved digital systems and tools prioritised in the strategy - we will be enabling a step change in the ease and effectiveness of the population's engagement with the health and care system utilising those tools. This means increased support in building and using digital skills, better access to better quality information using digital tools and an increased ability to interact with their care providers and engage in their own health and well-being journey.

10. MEASURING AND DEMONSTRATING SUCCESS

It is important that as a system we are able to show how delivery of the digital and data strategic priorities and enablers impact system success, which can be viewed through a number of different 'lenses', for example what this means for:

- Individuals (at different life stages), our Neighbourhoods, our Places and our system as a whole
- Enabling the measures of success outlined in the Joint Forward Plan
- Delivery of the key outcomes required by our System Recovery and Transformation activity (namely recurrent financial balance, CQC rating of Good or better for our Providers and a Single Oversight Framework score of 2 or more)
- Being able to deliver and demonstrate delivery against the prevention agenda as outlined in the ICP strategic ambition of creating a healthier, happier and wealthier population.

This section of the strategy will explore how we show we have been successful in delivering the required outcomes through these key 'lenses of success' and the associated metrics

METRICS OF SUCCESS

- Financial Sustainability
- CQC (Target Good+)
- SOF (Target Level 2)
- System Recovery & Transformation Metrics

ICB METRICS FOR SYSTEM SUCCESS

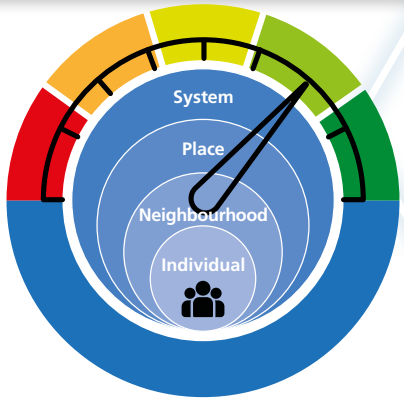
- Improved health of our population, including reduced inequalities
- Financial sustainability and value for money
- Better outcomes and experiences for our people
- Strong and sustainable community model underpinned by integrated service delivery
- Improved quality of services
- New clinical and care models
- LSC a great place to work and live

LENSES OF SUCCESS

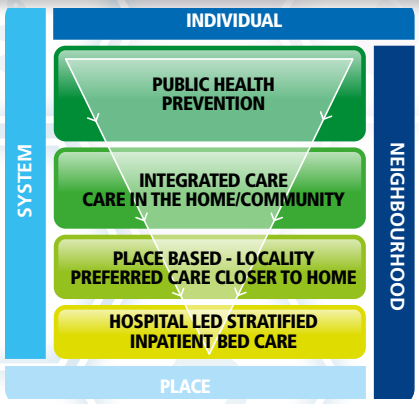
LIFE COURSE PHASES

- STARTING WELL
- LIVING WELL
- WORKING WELL
- AGEING WELL
- DYING WELL

SYSTEM COMPONENTS



LONG TERM CARE SETTING IMPACT



10. MEASURING AND DEMONSTRATING SUCCESS

Demonstration of success in our system requires both the depth and breadth of data to measure progress through multiple lenses, particularly those of our more vulnerable communities together with clearly identifying how digital and data investment supports improved operational performance and health outcomes across the system.

10. MEASURING AND DEMONSTRATING SUCCESS

Supporting the Metrics aligned with the ICB Objectives

Cost savings directly attributable to consolidation of digital infrastructure spend across the system (e.g., data centre consolidation and move to the cloud)

Cost savings attributable to consolidation of core care, corporate and data warehousing systems (e.g., savings through turning legacy and duplicate systems off etc.)

Cost savings attributable to digital and data solutions supporting care service delivery and corporate service efficiencies (e.g., through remote monitoring for care service delivery and robotic process automation for admin efficiencies)

Cost savings associated with consolidation of digital and data delivery and support services into a single service model (i.e. OneLSC).

A single data architecture, incorporating wider determinants of health data, will make it easier to identify and support those at risk of health inequalities.

Improved health of our population, including reduced inequalities

Financial sustainability and value for money

Better outcomes and experiences for our people

Strong and sustainable community model underpinned by integrated service delivery

Improved quality of services

New clinical and care models

LSC a great place to work and live

Our workforce will have a more connected, digitally-enabled experience, reducing keyboard and administrative burden - resulting in improved retention of staff. Increased productivity will support a reduction in agency requirements and release more time to care.

All the above metrics will contribute to better health outcomes for the people we serve, and digital tools and better information (and wraparound support where required) will empower our patients to play a more proactive part in their health management and care journeys.

Digital and data solutions drive consistent delivery of person centred, integrated care throughout all life stages and across the multiple simultaneous care providers to create historically informed decision making and holistic service design through single electronic record systems, multi-disciplinary team support tools and deep analytics to anticipate need and design effective responses. All supporting a shift to the left in terms of care delivery.

Digital and data solutions support improving individual organisations Care Quality Commission and the overall system System Oversight Frameworks (SOF) ratings (e.g., through single electronic record systems and single speciality systems driving improvements in care outcomes, insight from data driving out unwarranted variation etc.)

Digital and data solutions support improving NHS Long Term Plan outcome measures for key NHS operating plan target areas such as cancer, urgent and emergency care, elective care, diagnostics and maternity. Whole system care pathway re-design that is clinically led, operationally-delivered and digitally enabled.

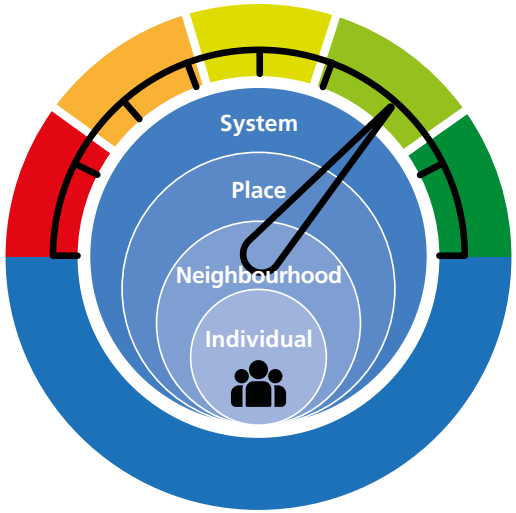
10. MEASURING AND DEMONSTRATING SUCCESS

Supporting the Success Metrics aligned with ICB Objectives

Each of the Digital and Data Strategic Priorities drives short and long-term positive impact on the denominators through which the ICB measures success – finance, service quality and integration, health inequalities, workforce satisfaction, new models of care and ultimately outcomes and experience for the people we serve.

10. MEASURING AND DEMONSTRATING SUCCESS

Supporting delivery of the ICP Strategy



Improved outcomes within each of the life phases set out in the ICP strategy are supported through the digital and data priorities and implementation impact as outlined previously Section 3.

But equally as important, the digital and data strategic priorities also create visibility of success through quality and consistent data building the outcomes picture through the key lenses of success - **Individual, Neighbourhood, Place and System.** This ensures that positive impact at each of these levels can be identified and replicated and that local and/or nuanced disadvantage is not being lost in the overall aggregated picture.

ICP PRIORITIES	Ensure the best start in life through good health and wellbeing and ready to start school	Reduce ill health and tackle inequalities across mental and physical health in all ages	Increase ambition, aspiration & employment with businesses supporting a local, healthy and stable workforce	Support people to stay well in own homes, connected to communities and receive joined up care	Encourage talking and planning for dying and to be well supported when a loved one dies
Digital & Data Strategic Priorities	**STARTING WELL**	**LIVING WELL**	**WORKING WELL**	**AGEING WELL**	**DYING WELL**
Single Digital Infrastructure	Seamless access to high-speed networks across the system enables adherence for reliable and consistent data capture. All interactions can then create timely data to inform insight creation				
Single Set Core Platforms & Systems	Connected Care Record captures consistent individual data throughout the life course of an individual across partner organisations. Single platform for access to accredited apps can ensure quality that meets the needs through each of the lenses				
Single Data Architecture	A "single version of the truth" through standardised data sets reduces the risk of local community needs being lost. The 'data lake' can create increased opportunity for identifying and more deeply understanding need / response at local levels				
Single Service Delivery & Support Model	Single integrated business intelligence function embedded locally creates deep expertise in understanding more local impact. Single integrated teams enables shared deep expertise in Population Health analytics to inform insight creation				

10. MEASURING AND DEMONSTRATING SUCCESS

Supporting delivery of the ICP Strategy

The Digital and Data Strategic Priorities provide capabilities that will improve the effectiveness of health and care delivery in all parts of the individual's heath and care journey – but critically they will also provide the infrastructure to better capture rich data and create innovative insight to ensure visibility of impact across all communities, through all life course stages.

11. LOOKING FORWARD

This strategy document has outlined our strategic mission and vision for digital and data across Lancashire and South Cumbria. It details how we will achieve this ambition through delivering against four key strategic digital and data priorities and taking forward a series of critical digital and data enablers that support achievement of the system wide ICP Strategic Priorities, in alignment with the ICB Strategic Objectives. It also establishes a framework of principles to guide decision making and prioritisation that should keep focus on the three key stakeholder groups of our population, our staff and the system wide partners.

This combination of strategic priorities, principles and enablers also supports work to underpin delivery of the System Recovery and Transformation programme in both the short and longer term. Short term action will go to the immediate sustainability of the system whilst the long-term journey supports the overall goal to deliver better outcomes and experience for our local population at lower cost. This drives the system forward in the transition from siloed to shared to integrated care, underpinned by increasingly collaborative and integrated teams focussed on the specific health and care needs of individuals.

We will need to quickly move from an agreed strategy to an agreed investment and delivery plan to ensure the strategy is implemented and achieves the impact on the population, people and partners in our system as outlined in this strategy document. This will build on the existing Digital Transformation Investment Plan developed in 2022, with a clearly measurable trajectory over the five-year period. It should also be aligned with and inform the ongoing iteration of the JFP and System Recovery and Transformation Plan.

This delivery plan will be developed in conjunction with all partners across the system (including VCFSE and social care) and underpinned by the establishment of resourced high impact programmes of work and appropriate governance and assurance mechanisms to:

- Establish a transparent prioritisation approach and decision accountability
- Ensure delivery of the agreed digital and data capabilities and the realisation of the targeted benefits for our population, people and partners
- Ensure on-going alignment with other initiatives supporting delivery of the overall system transformation ambition
- Provide appropriate frameworks for aligned Place-led plans and implementation where system level scaled solutions are not best placed to serve local needs. The newly evolving Place-led Digital and Data plans are where the local requirements more deeply inform prioritisation and implementation.

We will also ensure on-going engagement with key stakeholders (including our local population) to refresh the Digital and Data strategy (and associated delivery plan) on annual basis to make sure it continues to support delivery of a wide range of system stakeholder needs, evolving recovery and transformation delivery plans and emerging technologies as they develop over time.

With investment of time and money, through this approach, it is anticipated that Lancashire and South Cumbria will see a step change in:

- Digital maturity
- Reduction of health inequalities
- Reduction of unwarranted variation of services
- Improved care outcomes
- Improved service experience
- More efficient and cost-effective care service delivery
- Increased research and commercial funding into the system as a result of increased focus on innovation
- A more confident and competent workforce.

We look forward to seeing implementation of this strategy deliver a happier, healthier and wealthier population across the whole of Lancashire and South Cumbria.

NHS
Lancashire and South Cumbria
Integrated Care Board

DIGITAL AND DATA STRATEGY

→ 2024-2029

lancashireandsouthcumbria.icb.nhs.uk

@LSCICB

@LSCICB