Lincolnshire
COUNTY COUNCIL
Working for a better future

County Offices
Newland
Lincoln
LN1 1YL

3 June 2013

Lincolnshire Health and Wellbeing Board

A Meeting of the Lincolnshire Health and Wellbeing Board will be held on Tuesday, 11 June 2013 at 2.00 pm in Committee Room One, County Offices, Newland, Lincoln LN1 1YL

Yours sincerely

Tony McArdle
Chief Executive

MEMBERS OF THE BOARD (*)

Lincolnshire County Council: Councillors: Mrs P A Bradwell (Executive Councillor for Adult Care and Health Services, Children's Services), Mrs S Woolley (Executive Councillor for NHS Liaison, Community Engagement), C N Worth (Executive Councillor for Libraries, Heritage, Culture), D Brailsford, Mrs J P Churchill, B W Keimach, Mrs A M Newton and C R Oxby

Lincolnshire County Council Officers: Debbie Barnes (Executive Director of Children's Services), Glen Garrod (Director of Adult Social Services) and Dr Tony Hill (Director of Public Health)

District Council: Vacancy (1)

GP Commissioning Group: Dr Vindi Bhandal (South West Lincolnshire CCG), Dr Kevin Hill (South Lincolnshire CCG), Dr Sunil Hindocha (Lincolnshire West CCG) and Dr Simon Lowe (Lincolnshire East CCG)

Healthwatch Lincolnshire: Mr Preston Keeling (Healthwatch Lincolnshire)

NHS Commissioning Board: Mr David Sharp (NHS Commissioning Board)

(*) Permanent Membership

LINCOLNSHIRE HEALTH AND WELLBEING BOARD AGENDA
TUESDAY, 11 JUNE 2013

Item	Title	Pages	Estimated Time
1.	**Election of Chairman**		2.05 pm
2.	**Election of Vice-Chairman**		2.10 pm
3.	**Apologies for Absence/Replacement Members**		
4.	**Declarations of Members' Interests**		
5.	**Minutes of the meeting held on 13 March 2013**		2.15 pm
6.	**Action Updates from previous meeting**		2.20 pm
7.	**Chairman's Announcements**		2.30 pm
8.	**Decision/Authorisation Items**		
	8.1 Health and Wellbeing Boards Terms of Reference (TOR) and Operating Procedures *(To receive a report from Martin Wilson (Health and Wellbeing Board Advisor), which invites the Board to agree the Terms of Reference and Operating Processes for the year 2013/14)*	1 - 22	2.40 pm
	8.2 Disabled Children's Charter *(To receive a report from Meredith Teasdale (Assistant Director of Children's Services), which invites the Board to sign up to the Disabled Children's Charter that has been developed by the organisation 'Every Disabled Child Matters')*	23 - 50	2.55 pm

Item	Title	Pages	Estimated Time
9.	**Discussion/Debate Items**		
9.1	**Health and Wellbeing Board - Development Tool** *(To receive a report by Martin Wilson (Health and Wellbeing Board Advisor), which invites the Board to discuss and agree a national tool to assess their progress, using indicators of good practice, on how the Board has and can progress to achieve the outcomes agreed within the Joint Health and Wellbeing Strategy)*	51 - 58	3.05 pm
9.2	**Lincolnshire Public Health Annual Report 2012** *(To receive a report from Dr Tony Hill (Director of Public Health), which invites the Board to receive and discuss the recommendations included in each chapter of the Lincolnshire Public Health Annual Report 2012)*	59 - 92	3.35 pm
10.	**Information Items**		
10.1	**Dementia Strategy Update** *(To receive a report from Glen Garrod (Director of Adult Social Services), which invites the Board to comment on the Lincolnshire Dementia Partnership discussion paper and agree the approach to partnership working)*	93 - 118	3.45 pm
10.2	**Letter inviting Expressions of Interest for Health and Social Care Integration 'Pioneers'** *(To receive a verbal update from Dr Tony Hill (Director of Public Health)*		3.55 pm
11.	**Lincolnshire Health and Wellbeing Board - Forward Plan Items** *(This item provides the Board with an opportunity to discuss potential agenda items for future meetings, which will subsequently be included on a Forward Plan for the Board. Martin Wilson (Health and Wellbeing Board Advisor) to lead on this item)*	119 - 120	4.05 pm
12.	**An Action Log of Previous Decisions**		

Item	Title	Pages	Estimated Time
13.	**Future Scheduled Meeting Dates** *(For the Board to note the following meeting dates:- Tuesday 11 June 2013, Tuesday 10 September 2013, Tuesday 10 December 2013, Tuesday 25 March 2014, Tuesday 10 June 2014,Tuesday 30 September 2014, and Tuesday 9 December 2014. All meetings to commence at 2.00 p.m.)*		4.25 pm

<u>Democratic Services Officer Contact Details</u>

Name:	**Katrina Cope**
Direct Dial	**01522 552104**
E Mail Address	katrina.cope@lincolnshire.gov.uk

Please note: for more information about any of the following please contact the Democratic Services Officer responsible for servicing this meeting

- Business of the meeting
- Any special arrangements
- Copies of reports

Contact details set out above.
All papers for council meetings are available on:
www.lincolnshire.gov.uk/committeerecords

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of Dr Tony Hill, Director of Public Health

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**11 June 2013**
Subject:	**Health and Wellbeing Board's Terms of Reference (TOR) and Operating Procedures**

Summary:

Terms of Reference and operating processes for Lincolnshire's Health and Wellbeing Board to fulfil its statutory obligations.

Actions Required:

Core members of the Board to agree the Terms of Reference and operating processes for the year 2013/14.

1. Background

The Health and Social Care Act 2012 makes provision for the establishment by the Council of a Health and Wellbeing Board which will be an Executive Committee of the Council.

Regulations were issued on 8 February 2013 which removed some of the statutory requirements relating to committees.

The functions of the Health and Wellbeing Board are set out in Sections 195 and 196 of the Health and Social Care Act 2012 as follows:-

- to encourage persons who arrange for the provision of any health and social care services in the area to work in an integrated manner

- provide such advice, assistance or other support as it thinks appropriate for the purpose of encouraging Joint Commissioning

- prepare and publish a Joint Strategic Needs Assessment

- prepare and publish a Joint Health and Wellbeing Strategy

It was agreed at Lincolnshire's full Council meeting on the 22 February 2013 that it would establish a Lincolnshire Health and Wellbeing Board with the following membership:

- the Council's Executive Councillors for Health, Housing and Community, Adult Social Care and Children's Services
- Five further County Councillors
- the Director of Adult Social Services
- the Director of Children's Services
- the Director of Public Health
- a designated representative from Healthwatch
- a designated representative from the NHS Commissioning Board
- a designated representative from each Clinical Commissioning Group in Lincolnshire
- One District Council representative

At the March meeting it was agreed that the Health and Wellbeing Board Advisor would arrange a workshop to look at the draft Terms of Reference, this happened by gathering comments from 1-1 meetings with various members of the Board, attached to this report is the amended final draft.

2. Conclusion,

The attached draft Terms of Reference are based on national best practice with amendments to ensure they reflect the current position in Lincolnshire and it is recommended that Board agree the TOR and operating processes

3. Consultation,

N/A

4. Appendices,

These are listed below and attached at the back of the report	
Appendix A	Terms of Reference and operating processes
Appendix B	Health and Wellbeing agenda process
Appendix C	Health and Wellbeing core members
Appendix D	Part 5 of the Lincolnshire County Council's Constitution

5. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

This report was written by Martin Wilson, Health and Wellbeing Board Advisor, who can be contacted on 01522-554292 or martin.wilson@lincolnshire.gov.uk

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Lincolnshire
COUNTY COUNCIL

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

TERMS OF REFERENCE and PROCEDURAL RULES

June 2013

Terms of Reference
and Procedural Rules
Lincolnshire Health and Wellbeing Board

1. Context

1.1 The full name shall be the Lincolnshire Health and Wellbeing Board. ("The Board").

1.2 The Board is established as a consequence of Section 194of the Health and Social Care Act as a committee of Lincolnshire County Council.

2. Aim

2.1 The Board must, for the purpose of advancing the health and wellbeing of the people in its area, encourage persons who arrange for the provision of any Health or Social Care services in Lincolnshire to work in an integrated manner.

2.2 The Board must provide advice, assistance and support for the purpose of encouraging the making of arrangements under section 75 of the National Health Service Act 2006 in connection with the provision of such services.

2.3 The Board must encourage those involved in arranging the provision of Health-Related Services to work closely with the Board.

3. Objectives

3.1 To provide strong local leadership for improvement of health and wellbeing.

3.2 Monitor the implementation and performance of health and wellbeing outcome targets defined within the Joint Health and Wellbeing Strategy (JHWS).

3.3 Lead on the production and delivery of a Joint Strategic Needs Assessment (JSNA) and ensure that partner agencies use the evidence base as part of their commissioning plans.

3.4 Lead on the implementation of the Joint Health and Wellbeing Strategy (JHWS).

3.5 Confirm and challenge the joint commissioning plans for Health and Social care to ensure they meet the needs identified by the JSNA and in line with the JHWS.

3.6 Review any reconfiguration of Health or Social care services in Lincolnshire to ensure they support the outcomes of the Joint Health and Wellbeing strategy.

3.7 Maximise opportunities and circumstances for joint working and integration of services and make the best use of existing opportunities and processes and prevent duplication or omission within Lincolnshire.

4. Roles and Responsibilities of members of the Board

4.1 To work together effectively to ensure the delivery of the JSNA and JHWS for the benefit of Lincolnshire's communities.

4.2 To work within the Board to build a partnership approach to key issues and provide collective and collaborative leadership for the communities of Lincolnshire.

4.3 To participate in discussion to reflect the views of their partner organisations, being sufficiently briefed and able to make recommendations about future policy developments and service delivery.

4.4 To champion the work of the Board in their wider networks and in the community.

4.5 To ensure that there are communication mechanisms in place within the partner organisations to enable information about the priorities and recommendations of the Board to be disseminated and actioned to ensure the health and wellbeing of the community of Lincolnshire is improved.

4.6 To promote any consequent changes to strategy, policy, budget and service delivery within their own partner organisations to align with the recommendations of the Board.

In particular, it is the Boards expectations that members will act in accordance with Board members/champions responsibilities listed at Appendix A.

5. Accountability

5.1 The Board carries formal delegated authority to carry out its functions under the Health and Social Care Act 2012 from full Council.

5.2 Core Members bring the responsibility, accountability and duties of their individual roles to the Board and provide information, data and consultation material, as appropriate, to inform the discussions and decisions.

5.3 The Board will discharge its responsibilities by means of recommendations to the relevant partner organisations, who will act in accordance with their respective powers and duties to improve the health and wellbeing of the population of Lincolnshire.

5.4 The District Council Core Member will ensure that they keep all Districts advised of the work of the Board.

5.5 The Board will report to the Full Council and the NHS Commissioning Board via the Local Area Team (LAT) by sending meeting minutes and presenting papers as and when requested.

5.6 The Board will provide information to the public through publications, local media, and wider public activities and by publishing the minutes on the Lincolnshire County Council website.

5.7 The members of the Board will also take part in round table discussions with the public, voluntary, community, private, independent and NHS sectors to ensure there is a ‘conversation’ with Lincolnshire communities about health and wellbeing

6. Membership

6.1 The core membership of the Board will comprise the following:

- Executive Councillor – Health, Housing and Community,
- Executive Councillor– Adult Social Care,
- Executive Councillor– Children’s Services including Adult Education,
- Five designated Lincolnshire County Councillors,
- The Executive Director of Public Health,
- The Director of Adults Social Services,
- The Executive Director of Children’s Services,
- Designated representative from each Clinical Commissioning Group in Lincolnshire,
- Designated NHS Commissioning Board (Local Area Team LAT) representative ,
- One designated District Council representative (representing all seven districts),
- A designated representative from HealthWatch

6.2 The Core Members, through a majority vote, have the authority to approve individuals as Associate Members of the Board. The length of their membership will be for up to one year and will be subject to re-selection at the next Annual General Meeting (AGM).

6.3 Each member of the Board can nominate a named substitute. Two working days advance notice that a substitute member will attend a meeting of the Board will be given the Democratic Services Manager. Substitute members will have the same powers as Board members.

7. Frequency of Meetings

7.1 The Board will meet no less than four times per year including an AGM.

7.2 Additional meetings of the Board may be convened with agreement of the Chairman.

8. Agenda and Notice of Meetings

8.1 The agenda for each ordinary meeting of The Board will be against the following headings:

1. Apologies
2. Declaration of members interests
3. Minutes from the previous meetings
4. Action updates from previous meetings
5. Chairman's announcements
6. Decision/Authorisation items
7. Discussion/debate items
8. Information items
9. The work programme of planned future work
10. An action log of previous decisions
11. Date of next meeting

All papers for The Board to be provided to the Democratic Services Manager of Lincolnshire County Council ("the Secretariat") 15 working days before the date of the scheduled meeting, with appropriate template short report for the appropriate agenda item, for the agenda setting meeting with the Chairman. (See process map at Appendix B)

8.2 All finalised agenda items or reports to be tabled at the meeting should be submitted to the Secretariat no later than seven working days in advance of the next meeting. No business will be conducted that is not on the agenda.

8.3 The Secretariat will circulate and publish the agenda and reports at least five working days prior to the next meeting. Exempt or Confidential Information shall only be circulated to Core Members.

9. Annual General Meeting

9.1 The Board shall elect the Chairman and Vice Chairman at each AGM, The appointment will be by majority vote of all Core Members/substitutes present at the meeting and will be for a term of one year.

9.2 The Board will approve the representative nominations by the partner organisations as Core Members.

10. Quorum

10.1 Any full meeting of the Board shall be quorate if not less than a third of the Core Members are present. This third should include a representative from the Clinical Commissioning Groups and a Lincolnshire County Council Executive Councillor and either the Chairman or Vice Chairman.

10.2 Failure to achieve a quorum within thirty minutes of the scheduled start of the meeting, or should the meeting become inquorate after it has started, shall render the meeting adjourned until the next scheduled meeting of the Board.

11. Procedure at Meetings

11.1 Members of the Public may attend all ordinary meetings of the Board subject to the exceptions set out in the Access to Information Procedure Rules set out in Part 4 of the Lincolnshire County Council's constitution.

11.2 Only the Core and Substitute Members are entitled to speak through the Chairman. Associate Members and the Public are entitled to speak only at the invitation of the Chairman.

11.3 With the agreement of the Board, the Board can set up operational/working sub-groups to consider distinct areas of work to support the activities of the Board.

11.4 The operational/working sub-group will be responsible for arranging the frequency and venue of their meetings.

11.5 Any recommendations of the operational/working sub-group will be made to the Board who will consider them in accordance with these terms of reference.

11.6 The aim of the Board is to make its business accessible to all members of the community and partners with special needs. Accessibility will be achieved in the following ways:

- Ensuring adequate physical access to Board meetings,
- Providing signers, interpreters or other specialist support within existing resources on request to the secretariat,
- To include a work programme of planned future work on the agenda,
- Reports and presentations are in a style that is accessible to the wider community, and of a suitable length, so that their content can be understood,
- Enabling the recording of meetings to assist the secretariat in accurately recording actions and decisions of the Board.

12. Voting

12.1 Each Core Member and Substitute Member shall have one vote.

12.2 Wherever possible decisions will be reached by consensus. In exceptional circumstances and where decisions cannot be reached by consensus of opinion, voting will take place and decisions agreed by a simple majority. The Chairman will have a casting vote.

12.3 Decisions of the Board will be as recommendations to the partner organisations to deliver improvements in the Health and Wellbeing of the population of Lincolnshire.

13. Minutes

13.1 The Secretariat shall minute the meetings and produce and circulate an executive summary and action log to all Core Members.

13.2 The Secretariat will send the draft minutes and action log to the Chairman within five working days of the meeting for comment.

13.3 The draft minutes, as agreed by the Chairman, will be circulated to Core Members.

13.4 The draft minutes will be approved at the next quorate minuted meeting of the Board.

13.5 The Secretariat will publish the minutes, excluding Exempt and Confidential Information, on the Lincolnshire County Council website.

14. Expenses

14.1 The partnership organisation's are responsible for meeting the expenses of their own representatives.

15. Declarations of Interest

15.1 At the commencement of all meetings Core Members, members of Lincolnshire County Council, and non councillors (are treated as co-opted members under S27(4) of the Localism Act 2011 for the purposes of the application of the Code of Conduct) and therefore all Core members shall declare any interests in accordance with the Member's Code of Conduct which is set out in Part 5 of the Lincolnshire County Council's constitution. (see Appendix D)

16. Conduct of Core Members at Meetings

16.1 It is important to ensure that there is no impression created that individuals are using their position to promote their own interest, whether financial or otherwise, rather than for the general public interest.

16.2 When at Board meetings or when representing the Board, in whatever capacity a Core Member must uphold the principles of:

- Selflessness
- Honesty and Integrity
- Objectivity
- Accountability and Openness
- Respect for Others
- Cooperation

17. Review

17.1 The above terms of reference will be reviewed at the AGM or earlier if necessary.

17.2 Any amendments shall only be included by unanimous vote.

Definition

Exempt Information
Which is information falling within any of the descriptions set out in Part I of Schedule 12A to the Local Government Act 1972 subject to the qualifications set out in Part II and the interpretation provisions set out in Part III of the said Schedule in each case read as if references therein to "the authority" were references to "Board" or any of the partner organisations.

Confidential Information
Information furnished to, partner organisations or the Board by a government department upon terms (however expressed) which forbid the disclosure of the information to the public; and information the disclosure of which to the public is prohibited by or under any enactment or by the order of a court are to be discussed.

Associate Members

Associate Member status is appropriate for individuals wanting to be involved with the work of the Board, but who not designated core members are. The Board has the authority to invite Associate Members to join and approve their membership before they take their place. Associate Members will not, unless specifically requested, be consulted on dates and venues of meetings, but are invited to submit agenda items, and have a standing invitation to attend meetings if an issue they are keen to discuss is on the agenda. Associate members will not have voting rights at HWBB meetings.

Health Services
Means services that are provided as part of the health service.

Health-Related Services *means services that may have an effect on the health of individuals but are not health services or social care services.*

Social Care Services
Means services that are provided in pursuance of the social services functions of local authorities (within the meaning of the Local Authority Social Services Act 1970).

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Standard agenda item	Item detail	By When
1. **Apologies**	Core members of the Board unable to attend	**Two** working days before Board meeting to Secretariat
2. **Declaration of members interests**	Core members to declare any interest against agenda items listed	Either – **two** working days before Board meeting, or to Chairman on the day of meeting
3. **Minutes from the previous meeting**	Core members to formally amend and agree formal minutes which will be placed on LCC website	At meeting
4. **Chairman's announcements**	Announcements of local, regional or national interest to the delivery of health and wellbeing in Lincolnshire	**Two** working days before Board meeting to Secretariat
5. **Decision/Authorisation Items**	Forward plan items e.g. commissioning plans, service re-configurations, Healthwatch reports, Joint Strategic Needs Assessment, Joint health and Wellbeing Strategy, etc	Draft reports **15** working days before Board meeting to Secretariat for an Agenda planning meeting Final reports (including any presentation) to Secretariat **7** working days before Board meeting
6. **Discussion/ Debate items**	Health and wellbeing themes ideas, national policy changes, items for forward plan, etc.	Draft reports **15** working days before Board meeting to Secretariat for an Agenda planning meeting Final reports (including any presentation) to Secretariat **7** working days before Board meeting
7. **Information items**	Information items to be	Seven working days

	shared with partner agencies from Core members	before Board meeting to Secretariat
8. Work programme for future planned work	Items from Core members for discussion with Board	
9. Action log of previous decisions	Record of activity of the Board and partner activity	
10. Date of next meeting	Dates to be set for full year following AGM	

Lincolnshire Health and Wellbeing Board Responsibilities

Key responsibilities of **ALL** board members:

- Agreement of GP Commissioning plans
- Oversight of Annual Public Health Report/Public Health Issues
- Agreement of Children's commissioning plans
- Oversight of Health Watch Plans/Annual Report
- Agreement of Adult's commissioning plans
- Creation of Joint Strategic Needs Assessment (JSNA), and the Joint Health and Wellbeing Strategy (JHWS)
- Adhere to the Equalities Duty Act 2010, including the Public Sector Duty
- Performance and Quality Monitoring
- Promote integration and partnership across areas
- Undertake a compliance role in relation to major service redesign
- Support joint commissioning plans and pooled budget arrangements to meet the needs identified by the JSNA and to support the implementation of the Health and Well-being Strategy
- Ensure all commissioning plans have been co-produced
- Joint health and wellbeing strategy sponsor members of the Board should also ensure the strategy is developed according to the direction of the Board and to provide assurance to the Board that it is working within agreed timescales

All members of the HWB will be expected to

- **Represent** and **speak** on behalf of their organisation or sector
- Be **accountable** to their organisation or sector when participating in the HWB ensure organisations/sector are kept informed of HWB business and that information from their organisation/sector is reported to the HWB
- **Support** the agreed majority view when speaking on behalf of the HWB to other parties
- **Attend** HWB meetings or ensure that a named deputy is briefed when attending on their behalf
- **Declare** any conflicts of interest should they arise
- **Read** agenda papers prior to meetings so that they are ready to contribute and discuss HWB business
- **Work collaboratively** with other board members in pursuit of HWB business;
- **Ensure** that the HWB adheres to its agreed terms of reference and responsibilities;
- **Listen** and respect the views of fellow Board members;
- **Be willing** to take on special tasks or attend additional meetings or functions to represent the HWB

Key roles and responsibilities of individual core board members:

Executive members

- Report any issues raised by the public to the Board
- Report any issues raised by other councillors to the Board
- Report any issues raised by other members of the Board
- Provide strategic direction in relation to Lincolnshire's Joint Health and Wellbeing Strategy
- Report publicly on the work and progress of the Board
- Report to Executive on the work and progress of the Board
- Promote and ensure co-production of all commissioning plans and proposals

Lincolnshire County Councillors

- Report publicly on the work and progress of the Board
- Report any issues raised by the public to the Board
- Report any issues raised by other councillors to the Board

Executive Director for Public Health

- Update the Board on public health related activity taking place in Lincolnshire
- Report to the Board any relevant information provided from Public Health England (PHE) and report any relevant board matters to PHE
- Ensure Lincolnshire is addressing health inequalities and promoting the health and wellbeing of all Lincolnshire residents
- Lead the revision and publication of the JSNA
- Lead the revision and publication of the Joint Health and Well-being Strategy

Adults and Children's Directors

- Report on commissioning activity to the Board
- Provide relevant information requested by the Board
- Contribute to the creation of the JSNA

- Have regard to the JSNA and the JHWBS when developing commissioning and budget proposals
- Report Board activity to assistant directors and heads of service

Clinical Commissioning Group representative

- Ensure that the Clinical Commissioning Group members/partners directly feed into the JSNA
- Have regard to the JSNA and the JHWBS when developing commissioning and budget proposals
- Report commissioning activity to the Board
- Report Board activity to other Clinical Commissioning Group members

Lincolnshire Healthwatch representative

- Reflect the public's views acting as the patient's voice to report any issues raised by the public to the Board
- Feedback board response to issues raised and activity undertaken
- Promote community participation and co-production in support of activity
- Report on and from Healthwatch England
- Ensure the Joint health and Wellbeing Strategy reflects the need of Lincolnshire's population
- Provide reports to the Board on issues raised by providers or the public of Lincolnshire

District Council representatives

- Promote the Boards intentions to District Council partners
- Feedback any issues raised by partner districts or the public to the Board

Local Area Team representative

- Update the board on any national Commissioning issues which will affect Lincolnshire's Joint Health and Wellbeing Strategy
- feedback on any issues raised by the Board affecting Lincolnshire to the NHS Commissioning Board

SECTION B
MEMBERS CODE OF CONDUCT

PREAMBLE

Lincolnshire County Council Members' Code of Conduct

The County Council have adopted this Code setting out the expected behaviours required of its members or co-opted members, acknowledging that they each have a responsibility to represent the community and work constructively with our staff and partner organisations to secure better social, economic and environmental outcomes for all.

In accordance with the Localism Act provisions, when acting in this capacity all Councillors must be committed to behaving in a manner that is consistent with the following principles to achieve best value for our residents and maintain public confidence in this authority.

SELFLESSNESS: Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family, or their friends.
INTEGRITY: Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

OBJECTIVITY: In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

ACCOUNTABILITY: Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

OPPENNESS: Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

HONESTY: Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

LEADERSHIP: Holder of public office should promote and support these principles by leadership and example.

The Act further provides for registration and disclosure of interests and in Lincolnshire County Council this will be done as follows:
On taking up office a member or co-opted member must, within 28 days of becoming such, notify the Monitoring Officer of any ‘disclosable pecuniary interests’, as prescribed by the Secretary of State.

On re-election or re-appointments, a member or co-opted member must, within 28 days, notify the Monitoring Officer of any ‘disclosable pecuniary interests not already included in his or her register of interests.

If a member or co-opted member is aware that they have a ‘disclosable pecuniary interest’ in a matter they must not participate in any discussion or vote on the matter at a meeting.

If a member or co-opted member is aware of a ‘disclosable pecuniary interest’ in a matter under consideration at a meeting but such an interest is not already on the Council’s register of interests or in the process of entry onto the register having been notified to the Monitoring Officer, the member or co-opted member must disclose the ‘disclosable pecuniary interest’ to the meeting and register it within 28 days of the meeting at which it was first disclosed.

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of Debbie Barnes, Executive Director of Children's Services

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**11 June 2013**
Subject:	**Disabled Children's Charter**

Summary:

Lincolnshire Health and Wellbeing Board are asked to sign up to the Disabled Children's Charter that has been developed by the organisation 'Every Disabled Child Matters'. Lincolnshire County Council has in previous years agreed to sign up to the Charter and work to its principles. The Charter shows our commitment to disabled children, young people and their families.

Actions Required:

That the Health and Wellbeing Board agree to sign up to the Disabled Children's Charter for Health and Wellbeing Boards.

1. Background

The Disabled Children's Charter sets out the shared ambition to improve health outcomes for a key group of its local population.

Disabled children, young people and their families access services across multiple agencies, and therefore are disproportionately affected by poor integration between health, social care and education services and a lack of coordinated commissioning. This results in additional financial costs, poor outcomes, significant health inequities and considerable distress for children and their families. Health and Wellbeing Boards will play a crucial role in tackling these challenges by providing the strategic direction and leadership for local commissioners and services.

Signing the Charter will help Lincolnshire Health and Wellbeing Board to articulate a vision for improving the outcomes experienced by disabled children and young people to the public, commissioners, service providers and local partners including Lincolnshire Parent Carer Forums. It will reassure parent carers that their Health and Wellbeing Board will use its influence to ensure the new health system delivers for disabled children, young people and their families in their area.

Lincolnshire already meets the Charter which is evidenced below;

1. **'We have detailed and accurate information on the disabled children and young people living in our area, and provide public information on how we plan to meet their needs'.**
   Lincolnshire County Council with partners has agreed the Children with Disability Commissioning Strategy which includes a needs assessment and how we plan to meet needs.

2. **'We engage directly with disabled children and young people and their participation is embedded in the work of our Health and Wellbeing Board'.**
   The Shadow Transition Board made up of young people with disabilities ensures participation in service delivery and monitoring of services. This includes representation at the Transition Board and provides and conduit for the Health and Wellbeing Board to ensure effective engagement and participation of children and young people with disabilities.

3. **'We engage directly with parent carers of disabled children and young people and their participation is embedded in the work of our Health and Wellbeing Board'.**
   Parent Carers are engaged in a variety of ways including Parent Carer Forums and the Lincolnshire Parent Carer Partnership. The Health and Wellbeing Board utilises this system to ensure engagement and participation of parent carers of disabled children and young people in the development and commissioning of services.

4. **'We set clear strategic outcomes for our partners to meet in relation to disabled children, young people and their families, monitor progress towards achieving them and hold each other to account'.**
   Lincolnshire's Children with Disability (CWD) Commissioning Strategy set out clear strategic outcomes for all partners to meet in relation to disabled children, young people and families and progress is monitored on a quarterly basis. A report on progress is taken to Children and Young People Scrutiny Panel (CYPSP) on an annual basis.

5. **'We promote early intervention and support for smooth transitions between children and adult services for disabled children and young people'.**
   A range of services for children, young people and their families are provided to support early intervention. Emphasis is also put on smooth transition between children's and adult services. This is monitored by the Shadow Transition Board and the local authority Transition Board previously mentioned.

6. **'We work with key partners to strengthen integration between health, social care and education services and with services provided by wider partners'.**
   There is already good integration between heath, social care and education and with wider partners to provide services to children and young people with disabilities. This is regularly reviewed and strengthened further for example, integration of all occupational therapists for children is being implemented to stop duplication and provide a better integrated service for children and young people with disabilities.

7. **'We provide cohesive governance and leadership across the disabled children and young people's agenda by linking effectively with key partners'.**
   Lincolnshire has good governance with a Shadow Transition Board and Transition Board that feed into the CYPSP who are represented by the Director of Children's Services at the Health and Wellbeing Board. This, with the CWD Commissioning Strategy provides cohesive governance and leadership across the disabled children and young people's agenda and ensures effective links with partners.

2. Conclusion

Lincolnshire Health and Wellbeing Board already fulfil their commitment to the Charter. It is therefore advised that the Charter is signed to reassure parent carers of children and young people with disabilities that we will continue to influence to ensure the new health system delivers for disabled children, young people and their families in Lincolnshire.

3. Appendices

These are listed below and attached at the back of the report	
Appendix A	Disabled Children's Charter for Health and Wellbeing Boards
Appendix B	Why sign the Disabled Children's Charter for Health and Wellbeing Boards?

5. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

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Disabled Children's Charter for Health and Wellbeing Boards

The .... **Health and Wellbeing Board** is committed to improving the quality of life and outcomes experienced by disabled children, young people and their families, including children and young people with special educational needs and health conditions. We will work together in partnership with disabled children and young people, and their families to improve universal and specialised services, and ensure they receive the support they need, when they need it. Disabled children and young people will be supported to fulfil their potential and achieve their aspirations and the needs of the family will be met so that they can lead ordinary lives.

By [date within 1 year of signing the Charter] our Health and Wellbeing Board will provide evidence that:

1. We have **detailed and accurate information** on the disabled children and young people living in our area, and provide public information on how we plan to meet their needs
2. We **engage directly with disabled children and young people** and their participation is embedded in the work of our Health and Wellbeing Board
3. We **engage directly with parent carers** of disabled children and young people and their participation is embedded in the work of our Health and Wellbeing Board
4. We set **clear strategic outcomes** for our partners to meet in relation to disabled children, young people and their families, monitor progress towards achieving them and hold each other to account
5. We **promote early intervention** and support for smooth transitions between children and adult services for disabled children and young people
6. We work with key partners to **strengthen integration** between health, social care and education services, and with services provided by wider partners
7. We provide **cohesive governance** and leadership across the disabled children and young people's agenda by linking effectively with key partners

Signed by .... Date ....
Position: Chair of Health and Wellbeing Board.

For guidance on meeting these commitments, please read the accompanying document: Why sign the Charter?

every disabled child matters

Every Disabled Child Matters (EDCM) is the campaign to get rights and justice for every disabled child. It has been set up by four leading organisations working with disabled children and their families – Contact a Family, the Council for Disabled Children, Mencap and the Special Educational Consortium. EDCM is hosted by the National Children's Bureau, Charity registration number: 258825.

The Children's Trust, Tadworth is a national charity providing specialist services to disabled children and young people across the UK. These services include rehabilitation and support for children with acquired brain injury, expert nursing care for children with complex health needs, and residential education for pupils with profound and multiple learning difficulties at The School for Profound Education. Charity registration number: 288018. Find out more about the work of The Children's Trust, Tadworth at **www.thechildrenstrust.org.uk**

The Children's Trust Tadworth
For children with multiple disabilities

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The Children's Trust
Tadworth
For children with multiple disabilities

every disabled child matters

Why sign the Disabled Children's Charter for Health and Wellbeing Boards?

Benefits to Health and Wellbeing Boards of signing the Charter and meeting its commitments:

- Publicly articulate a vision for improving the quality of life and outcomes for disabled children, young people and their families
- Understand the true needs of disabled children, young people and their families in your local area and how to meet them
- Have greater confidence in targeting integrated commissioning on the needs of disabled children, young people and their families
- Support a local focus on cost-effective and child-centred interventions to deliver long-term impacts
- Build on local partnerships to deliver improvements to the quality of life and outcomes for disabled children, young people and their families
- Develop a shared local focus on measuring and improving the outcomes experienced by disabled children, young people and their families
- Demonstrate how your area will deliver the shared ambitions of the health system set out by the Government in 'Better Health Outcomes For Children and Young People: Our Pledge' for a key group of children and young people[1]

Who are we talking about?

The Disabled Children's Charter for Health and Wellbeing Boards and this accompanying document have been developed to support Health and Wellbeing Boards (HWBs) meet the needs of all children and young people who have disabilities, special educational needs (SEN), health conditions, and their families. In this document, when we talk about disabled children and young people we are referring to all the children and young people in this group.

[1] Department of Health (2013), Better Health Outcomes for Children and Young People: Our Pledge

Commitment 1: We have detailed and accurate information on the disabled children, young people and their families living in our area, and provide public information on how we plan to meet their needs

Statutory drivers

Health and Social Care Act 2012

Duty to prepare assessment of needs (JSNA) in relation to local authority area and have regard to guidance from Secretary of State

Information

The quality of data and information used to underpin the planning, commissioning and delivery of services for children and young people with very complex needs is often poor. The difficulty of developing accurate, robust data in a standard format about disabled children and young people is an enduring issue for local areas and for national agencies. Reliable performance information about the use and value of services is critical to commissioning decisions. The Children and Young People's Health Outcomes Forum identified the lack of accurate data as the single biggest challenge in relation to the development of outcomes for children with long-term health conditions, disabilities and life limiting conditions[2].

In March 2012, the CQC released a report entitled 'Healthcare for disabled children and young people'[3]. This report gave details of primary care trust (PCT) replies to a self assessment questionnaire on services for disabled children.

PCTs demonstrated an extremely worrying lack of awareness of the needs of local disabled children:

- **Five PCTs** claimed that **no disabled children and young people lived in their area**
- **Fifty five** PCTs **did not monitor whether services allocated as a result of Common Assessment Framework were delivered**
- **Sixty three** PCTs **didn't know how many children were referred for manual wheelchairs** and **nine said children were waiting over 51 weeks for wheelchairs**
- **Fifteen** PCTs said they **didn't provide short breaks services**

Due to the lack of reliable data on disabled children and young people, their strategic involvement and that of their parents is essential to gain a good understanding of the profile of this group

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[2] Children and Young People's Health Outcomes Forum (2012), Report of the long term conditions, disability and palliative care subgroup p2

[3] Care Quality Commission (2012), Healthcare for Disabled Children and Young People

and the particular challenges and experiences they face. Their views remain underrepresented in surveys and public and patient involvement in the health service.

Meeting Needs

One of the primary tools Health and Wellbeing Boards have to drive strategic commissioning in their areas is the Joint Strategic Needs Assessment (JSNA). The JSNA will assess the current and future health and care needs and assets of a local population and will underpin a Joint Health and Wellbeing Strategy (JHWS). It will interpret available data to develop an understanding of the causes of health inequalities and a narrative of the evidence.

The JSNA can only be an effective tool for evidence-based decision making if it is based on accurate and meaningful data. The bodies Health and Wellbeing Boards delegate collecting data to as part of the JSNA process, must focus on improving the quality and scope of information on disabled children and young people which they use, including: available national data sets; local information sources such as data from Common Assessment Frameworks; qualitative information from direct engagement with service users.

The JSNA process must develop an understanding of the local population which is sufficiently differentiated to understand the needs of all groups of children, particularly those who face the greatest inequalities or experience multiple disadvantages.

How to meet your Charter commitments

In order to fulfil this commitment, we would expect a HWB to be able to provide the following evidence:

- The full range of sources of information collected on disabled children, young people and their families which will be used to inform the JSNA process
- The quality assurance process used to ensure that information and data on disabled children, young people and their families used to inform commissioning is sufficiently detailed and accurate
- The way in which the JSNA will be used to assess the needs of local disabled children, young people and their families
- The way in which information on any hard to reach groups is sourced, and action taken to address any gaps of information with regard to local disabled children, young people and their families
- The way in which disabled children, young people and their families are strategically involved in identifying need, and evidence and feedback on their experiences is used to inform the JSNA process
- Public information on how the HWB will support partners to commission appropriately to meet the needs of local disabled children, young people and their families

Key resources for meeting this Charter commitment

Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies

> Statutory guidance to support Health and Wellbeing Boards and their partners in understanding the duties and powers in relation to Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies.

NHS Confederation, Operating principles for Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies

> Paper designed to support areas to develop successful Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies.

Child and Maternity Health Observatory: support for commissioners

> Help to find the right tools, data and evidence to review, plan and improve services in your local area.

Child and Maternity Health Observatory: tools and data

> ChiMat provides easy access to a wealth of data, information and intelligence through a range of online tools designed to support decision-making.

Rightcare (2012), NHS Atlas of Variation in Healthcare for Children and Young Adults

> Variations across the breadth of child health services provided by NHS England are presented together to allow clinicians, commissioners and service users to identify priority areas for improving outcome, quality and productivity.

LGA (2011), Joint Strategic Needs Assessment: Data Inventory

> Offers practical help to councils, clinical commissioning groups and other members of health and wellbeing boards.

Children and Young People's Health Outcomes Forum (2012), Making data and information work for children and young people

> Factsheet on making data and information work for children and young people, including resources.

Contact A Family (2012), Health and Wellbeing Boards: making the case to target disabled children services

> Briefing for Parent Carer Forums on the reasons why the Health and Wellbeing board in their area should target disabled children in their Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing strategy (JHWS).

Commitment 2: We engage directly with disabled children and young people and their participation is embedded in the work of our Health and Wellbeing Board

Statutory drivers

Health and Social Care Act 2012

Duty to involve third parties in preparation of the JSNA:

- Local Healthwatch
- people living or working in the area
- for County Councils – each relevant DC

Duty to involve third parties in preparation of the JHWS:

- Local Healthwatch
- people living or working in the area

Article 12 of the United Nations Convention on the Rights of the Child (UNCRC)

- The child has the right to express his or her opinion freely and to have that opinion taken into account in any matter or procedure affecting the child.

Article 7 of the UN Convention on the Rights of Persons with Disabilities (UNCRPD)

- Children with disabilities have the right to express their views freely on all matters affecting them, their views being given due weight in accordance with their age and maturity, on an equal basis with other children, and to be provided with disability and age-appropriate assistance to realise that right.

Health and Wellbeing Boards should ensure that the voice of disabled children and young people is always heard when decisions are being made that affect them. Health and Wellbeing Board members should use their influence to embed engagement with disabled children and young people throughout the health and care system and in the context of a continuous and current partnership.

The benefits of embedding participation of disabled children and young people are huge: better services will be developed driven by feedback from the people who know and use them; resources are not wasted on services that are not taken up or valued; services will be more child and young person friendly and accessible; disabled children and young people will have insight into the diverse needs and barriers faced by marginalised and vulnerable groups; improved accountability to children and young people as stakeholders; and direct benefits to disabled children and young people themselves such as increased knowledge of services, confidence, and skills[4].

It should be recognised that many disabled children and young people may face significant barriers to their involvement, particularly in mainstream settings. Recent research from the VIPER project found that young disabled people's participation is still not embedded at a strategic, service level or individual decision-making. It found barriers to participation including a lack of understanding of what participation is and how you make it happen, lack of funding, inclusive practice, resources, time and training, and lack of consistent systems and structures[5].

All disabled children and young people communicate and have a right to have their views heard and this may require targeted approaches and the involvement of Voluntary Sector Organisations (VSOs).

How to meet your Charter commitments

In order to fulfil this commitment, we would expect a HWB to be able to provide the following evidence:

- Evidence of the way in which the HWB or its sub groups have worked with disabled children and young people in the JSNA process, and next steps for JSNA engagement
- Evidence of the way in which the HWB or its sub groups have worked with disabled children and young people in the preparation and delivery of the Joint Health and Wellbeing Strategy (JHWS), and next steps for JHWS engagement
- Evidence of partnership working with any local groups of disabled children and young people

Key resources for meeting this Charter commitment

The NHS Confederation, Royal College of Paediatrics and Child Health and Office for Public Management (2011), Involving children and young people in health services

This report highlights the key findings and recommendations from an event held in September 2011 to discuss the key priorities for child health.

VIPER (Voice.Inclusion.Participation.Empowerment.Research)

VIPER is a three-year project funded by the Big Lottery Fund, to research young disabled people's participation in decisions about services. It began in Summer 2010.

VIPER (2012), The Viper project: what we found

Findings and key messages arising from the research activities of the VIPER project.

VIPER (2012), The Viper project: what we found from the survey

Summary of the findings and key messages from the research activities. The research summarised in this report was carried out between 2010 and 2012.

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[4] Participation Works (2008), How to involve children and young people in commissioning, p.6.

[5] VIPER (Voice, Inclusion, Participation, Empowerment and Research) (2013), Hear Us Out, p.23.

Participation Works

Enables organisations to effectively involve children and young people in the development, delivery and evaluation of services that affect their lives.

Participation Works (2008), How to involve children and young people in commissioning

An introduction to commissioning from a variety of perspectives. It describes the different parts of the process and ways to support children and young people to participate in all aspects of commissioning.

Participation Works (2008), How to build a culture of participation

Information and practical ideas about how to embed participation throughout your organisation in a way that brings about change.

Participation Works (2010), Listen and Change - a guide to children and young people's participation rights

Aims to increase understanding of children and young people's participation rights and how they can be realised in local authority and third sector settings.

Making Ourselves Heard (MOH)

MOH is a national project to ensure disabled children's right to be heard becomes a reality.

Council for Disabled Children (2009), Making Ourselves Heard

Based on a series of eight seminars with local authorities this book sets out the current policy context for disabled children and young people's participation, outlines the barriers and challenges to effective participation and highlights what is working well.

Franklin, A. and Sloper, P. (2009) Supporting the participation of disabled children and young people in decision-making

Presents research exploring factors to support good practice in participation and discusses policy and practice implications.

DfEs (2003), Building a culture of participation: research report

Many of the case studies in this research are attempting to make participation more integral to their organisation.

Commitment 3: We engage directly with parent carers and their participation is embedded in the work of our Health and Wellbeing Board

Statutory drivers

Health and Social Care Act 2012

Duty to involve third parties in preparation of the JSNA:

- Local Healthwatch
- people living or working in the area
- for County Councils – each relevant DC

Duty to involve third parties in preparation of the JHWS:

- Local Healthwatch
- people living or working in the area

The purpose of parent participation is to ensure that parents can influence service planning and decision making so that services meet the needs of families with disabled children. Effective parent participation happens when parents have conversations with and work alongside professionals, in order to design, develop and improve services[6].

The benefits of effective parent participation are well established: resources are not wasted on services that are not taken up or valued; parent carers' insight can help develop cost-effective solutions to local problems; a shared view can be developed between parents and professionals of how to support families within funding limitations; more costly interventions can be avoided in the future; and complaints can be reduced by Parent Carer Forums monitoring services and alerting commissioners and managers if problems occur. The Contact A Family resources below contain a wealth of evidence and case studies into how effective parent participation has benefited the local areas where it has been implemented.

Health and Wellbeing Boards should ensure that parent carers are involved in decisions that affect them at a strategic and service level. Health and Wellbeing Board members should use their influence to embed engagement with parent carers throughout the health and care system and in the context of a continuous and current partnership.

It should be recognised that parent carers may face significant barriers to their participation in mainstream settings but that this should not prevent their involvement in decision-making.

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[6] Definition from Together for Disabled Children (2010), How to guide to parent carer participation: Section 1 – parent participation as a process, p.2.

How to meet your Charter commitments

In order to fulfil this commitment, we would expect a HWB to be able to provide the following evidence:

- Evidence of the way in which the HWB or its sub groups have worked with parent carers of disabled children in the JSNA process, and next steps for JSNA engagement
- Evidence of the way in which the HWB or its sub groups have worked with parent carers of disabled children in the preparation and delivery of the JHWS, and next steps for JHWS engagement
- Evidence of partnership working with local parent groups, including the local Parent Carer Forum(s)

Key resources for meeting this Charter commitment

Together for Disabled Children (v2.0 2010), Parent carer participation: How to guide.

A guide to support parent carer forums, commissioners and managers to develop parent carer participation. It can be downloaded in the following separate sections:

Section 1 - The Process

Section 2 - producing information

Section 3 - consultation

Section 5a - successful meetings Together for Disabled Children

Section 5b - how to reach and engage parents

Section 5c - supporting parent representatives

Section 6b- for strategic leaders

How parent participation and parent carer forums leads to better outcomes for disabled children, young people and their families 2011

Contact A Family (2012), Parent Carer Participation: An overview

This short guide provides examples of successful parent carer participation

Contact A Family, Improving Health Services

Resources to support the commissioning and management of health services.

Contact A Family, Resources

Resources, case studies and information for professionals to help them improve how services are delivered, so they better meet families' needs.

Contact A Family (2013), Parent carer forum involvement in shaping health services - second report

Report into Parent Carer Forum involvement with the health service in the lead up to the new health system coming into effect.

Commitment 4: We set clear strategic outcomes for our partners to meet in relation to disabled children, young people and their families, monitor progress towards achieving them and hold each other to account

Statutory drivers

Health and Social Care Act 2012

Duty to prepare a JHWS for meeting needs included in JSNA in relation to LA area and to have regard to guidance from Secretary of State

Power of the HWB to give its opinion to the local authority which established it on whether the authority is discharging its duty to have regard to relevant JSNA and JHWS

CCG is under a duty to involve HWB in preparing or significantly revising the commissioning plan – including consulting it on whether the plan has taken proper account of the relevant JHWS

Duty to provide opinion on whether the CCG commissioning plan has taken proper account of the JHWS. Power to also write to NHS England (formerly the NHS Commissioning Board) with that opinion on the commissioning plan (copy must also be supplied to the relevant CCG). Duty to review how far the CCG has contributed to the delivery of any JHWS to which it was required to have regard and to consult HWB on this

Duty in conducting the performance assessment, to assess how well CCG has discharged duty to have regard to JSNA and JHWS and to consult HWB on its view on CCGs' contribution to delivery of any JHWS to which it was required to have regard (when conducting its annual performance assessment of the CCG)

In response to the report of the Children and Young People's Health Outcomes Forum, the Government set out its ambitions for improving health outcomes for children and young people by launching 'Better Health Outcomes For Children And Young People: Our Pledge'[7]. Health and Wellbeing Boards will play a key role in delivering on these ambitions.

Disabled children and young people will provide a crucial test of the effectiveness of the new health system and improving the outcomes they experience, including those in the NHS and Public Health Outcomes frameworks, will require concerted strategic leadership. However, if a Health and Wellbeing Board can improve integration for local disabled children and young people, who frequently test the interface between multiple services and agencies, it can deliver for all children and young people.

For the JSNA and JHWS process to make a positive impact on the outcomes faced by disabled children, young people and their families, it is essential that the evidence collected through the JSNA process reflects the outcomes that are most meaningful to them. Health and Wellbeing Boards should use the JSNA process to develop a shared understanding of the needs of disabled children, young people and their families, and the causes of the poor outcomes and inequalities

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[7] Department of Health (2013), Better Health Outcomes for Children and Young People: Our Pledge

they experience. They should set clear strategic outcomes for partners to meet and ensure that mechanisms are in place to measure and monitor progress towards achieving them.

The JHWS should address how the needs of disabled children, young people and their families should be met and make recommendations on cost-effective approaches to reducing the health inequalities they experience. However, if this group is not identified as a priority in the JHWS, the Health and Wellbeing Board should demonstrate how it is providing strategic direction for partners to meet the needs of disabled children and young people.

How to meet your Charter commitments

In order to fulfil this commitment, we would expect a HWB to be able to provide the following evidence:

- Public information on the status of outcomes for local disabled children and young people based on indicators such as the NHS Outcomes Framework, the Public Health Outcomes Framework, etc.
- Public information on the strategic direction the HWB has set to support key partners to improve outcomes for disabled children and young people. This may be encompassed by the JHWS, but would need to be sufficiently delineated to demonstrate specific objectives and action for disabled children and young people.

Key resources for meeting this Charter commitment

NHS Confederation (2012), Children and young people's health and wellbeing in changing times

The purpose of this report is to support implementation of the health reforms to improve children and young people's health and wellbeing.

Report of the Children and Young People's Health Outcomes Forum (2012)

The Children and Young People's Health Outcomes Forum was established by the Secretary of State for Health and tasked with responding to the challenges set out in Sir Ian Kennedy's report published in 2010 'Getting it right for children and young people'.

Report of the Children and Young People's Health Outcomes Forum - report of the long-term conditions, disability and palliative care sub-group (2012)

Report discussing the challenges around improving outcomes for this group of children.

Report of the Children and Young People's Health Outcomes Forum - inequalities in health outcomes and how they might be addressed (2012)

Report commissioned by the co-chairs of the Children and Young People's Health Outcomes Forum from Maggie Atkinson, Children's Commissioner for England.

Children and Young People's Health Outcomes Forum (2012), Health and wellbeing boards and children, young people and families

Poster produced in June 2012 by the health and wellbeing board learning set for children and young people.

Children and Young People’s Health Outcomes Forum (2012), Commissioning in the new NHS for children, young people and their families

Poster setting out the Children and Young People’s Health Outcomes Forum’s vision for successful commissioning for children, young people and their families in the new NHS.

Department of Health (2013), Improving Children and Young People’s Health Outcomes: a system wide response

The Children and Young People’s Health Outcomes Forum report made recommendations, aimed at DH, DfE and a wide range of health system organisations, to improve health outcomes for children and young people. This document contains the system-wide response setting out the action already undertaken, in progress and planned in response to the recommendations.

Department of Health (2013), Better health outcomes for children and young people: Our Pledge

Government response to the report of the Children and Young People’s Health Outcomes Forum, setting out shared ambitions across the NHS to improve outcomes and services for children and young people.

Contact A family and Strategic Network for Child Health and Wellbeing in the East of England (2012), Principles for commissioning and delivering better health outcomes and experiences for children and young people so that they are comparable with the best in the world

Poster showing 6 principles for commissioning and delivering better health outcomes and experiences for children and young people, developed by the Strategic Network for Child Health and Wellbeing in the East of England.

Department of Health (2010), The NHS Outcomes Framework 2011/12

The outcomes and indicators which make up the first NHS Outcomes Framework, following the consultation Transparency in outcomes – a framework for the NHS.

Commitment 5: We promote early intervention and support smooth transitions between children and adult services for disabled children and young people

The report of the Children and Young People's Health Outcomes Forum emphasised the importance of early intervention and transitions within a life-course approach to reducing health inequalities[8]. This is particularly significant for disabled children and young people and their families, who often struggle to obtain a diagnosis and access appropriate support at an early age and when transitioning to adult services, which affects their outcomes throughout their lives.

It should be emphasised that disabled children and young people may transition to adult services up to the age of 25. Health and Wellbeing Boards should consider the needs of disabled children and young people from 0-25 as well as ensuring smooth transitions to adult services.

How to meet your Charter commitments

In order to fulfil this commitment, we would expect a HWB to be able to provide the following evidence:

- The way in which the activities of the HWB help local partners to understand the value of early intervention
- The way in which the activities of the HWB ensure integration between children and adult services, and prioritise ensuring a positive experience of transition for disabled young people

Key resources for meeting this Charter commitment

Graham Allen MP (2011), Early Intervention: The Next Steps

An independent report to Government, which argues that many of the costly and damaging social problems for individuals can be eliminated or reduced by giving children and parents the right type of evidence based programmes between 0-18 and especially in their earliest years.

Graham Allen MP (2011), Early Intervention: Smart Investment, Massive Savings

Graham Allen MP's second independent report to the Government sets out how early intervention programmes can be paid for within existing resources and by attracting new non-government money.

Child and Maternity Health Observatory, Knowledge Hub: Transitions

The transitions to adulthood hub brings together a range of resources and evidence relating to young people's transition process into the adult world. It is constantly updated with new resources.

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[8] Report of the Children and Young People's Health Outcomes Forum (2012), p.38

Early Support

A way of working, underpinned by 10 principles that aim to improve the delivery ofservices for disabled children, young people and their families. It enables services to coordinate their activity better and provide families with a single point of contact and continuity through key working.

Early Support (2012), Key working: improving outcomes for all - Evidence, provision, systems and structures

A summary of the key evidence and consistent elements of a key working approach. It presents an analysis of the implications of key working that cuts across health, social care and education.

Ofsted (2013), Good practice resource - Early intervention through a multi-agency approach: Sheffield City Council

Sheffield City Council has developed a creative and innovative approach across the children's workforce by introducing a multi-agency perspective in providing preventative services to children and families.

C4E0, Improving the wellbeing of disabled children through early years interventions (age 0–8)

This section contains the following resources in support of improving the wellbeing of disabled children through early years interventions (age 0–8) priority: links to online tools; key online publications from C4EO partners and other organisations.

Institute of Public Care (2012), Early Intervention and Prevention with Children and Families: Getting the Most from Team around the Family Systems

Briefing paper arguing that effective local systems to identify families who would benefit from additional support and to coordinate support from a range of agencies is as important as delivering effective services.

Transition Information Network (TIN)

An alliance of organisations and individuals who come together to improve the experience of disabled young people's transition to adulthood. TIN is a source of information and good practice standards for disabled young people, families and professionals.

TIN Resource Library

You can use the search form to find a range of resources that can help you to improve your provision for disabled young people in transition to adulthood.

Preparing for Adulthood (PfA)

A 2 year programme funded by the Department for Education as part of the delivery support for 'Support and aspiration: A new approach to special educational needs and disability' green paper. It provides knowledge and support to all local authorities and their partners, including families and young people, so they can ensure young people with SEN and disabilities achieve paid work, independent living, good health and community inclusion as they move into adulthood.

Preparing for Adulthood (2012), PfA resource list

> Created for the PfA ‘How are you doing?’ events which took place in June and July, 2012. Resources are listed under: Paid employment; Independent living; Good health; Community inclusion.

Sloper, P., Beecham, J., Clarke, S., Franklin, A., Moran, N. and Cusworth, L. (2011) Transition to adult services for disabled young people and those with complex health needs, Research Works, 2011-02, Social Policy Research Unit, University of York, York

> This research aimed to provide evidence of what works well in developing and implementing multi-agency coordinated transition services for disabled children and those with complex health needs and their families. It also assessed the costs of the services.

Commitment 6: We work with key partners to strengthen integration between health, social care and education services, and with services provided by wider partners

Statutory drivers

Health and Social Care Act 2012

Duty to encourage integrated working:

- between commissioners of health services and commissioners of social care services
- in particular to provide advice, assistance or other support for the purpose of encouraging use of flexibilities under NHS Act 2006

Power to include in the JHWS a statement of views on how the commissioning of health and social care services, and wider health-related services, could be more closely integrated – i.e. the ability for the JHWS to look more broadly than health and social care in relation to closer integration of commissioning

Disabled children and young people access services across multiple agencies, and therefore are disproportionately affected by poor integration between health and social care services and a lack of coordinated commissioning. Health and Wellbeing Boards must work with key partners to meet the needs of disabled children and young people, including: education providers and schools; safeguarding boards, local children's trust arrangements; learning disability partnership boards; and others. Health and Wellbeing Boards should make recommendations to ensure that disabled children and young people experience seamless integration between the services they access.

In particular, Health and Wellbeing Boards should consider how they engage with education services, including schools and colleges, because of the significance of joined up-working between health, education and social care to disabled children and young people's outcomes.

To promote integrated commissioning Health and Wellbeing Boards will also need to consider how specialised health services commissioned by NHS England are joined up with locally commissioned services and ensure they are taken into account by their JSNA and JHWS.

How to meet your Charter commitments

In order to fulfil this commitment, we would expect a HWB to be able to provide the following evidence:

- Details of the way in which the HWB is informed by those with expertise in education, and children's health and social care
- Details of the way the HWB engages with wider partners such as housing, transport, safeguarding and the youth justice system
- Details of steps taken to encourage integrated working between health, social care, education and wider partners in order to improve the services accessed by disabled children, young people and their families

Key resources for meeting this Charter commitment

Together for disabled children (2009), Facilitating integrated practice between children's services and health

> This report contains examples of innovative working practice where services are integrated with health.

Council for Disabled Children (2006), Pathways to success: Good practice guide for children's services in the development of services for disabled children - evidence from the pathfinder children's trusts

> This project ran from April 2004 to March 2006 and set out to work alongside the pathfinder children's trusts in developing new ways of working and to capture the learning from their work. The work covered: stratgeic planning; commissioning services, pooling budgets; joint working and co-location; assessment process and information sharing.

East Midlands, Everybody's learning (2012), Assured safeguarding: GP and Health Leader edition

> Resource to help commissioners and health providers reassure themselves they are doing everything possible to ensure that children within the services for which they are responsible are as safe as possible.

Ofsted (2012), Improving outcomes for disabled children by integrating early support and prevention services: Luton Borough Council

> Luton's services for disabled children and their families bring together practice across health, social care and education services, alongside innovative short break and early support provision. The development of an extensive range of integrated early support and prevention services is improving outcomes for disabled children and preventing situations deteriorating so that child protection or looked after services become necessary.

Commitment 7: We provide cohesive governance and leadership across the disabled children and young people's agenda by linking effectively with key partners

Statutory drivers

Health and Social Care Act 2012

Power to encourage close working (in relation to wider determinants of health):

- between itself and commissioners of health-related services
- between commissioners of health services or social care services and commissioners of health-related services

Power to appoint additional members to the board as deemed appropriate

Power for HWB to request information for the purposes of enabling or assisting its performance of functions from:

- the local authority
- certain members or those they represent with a duty to provide

Children Act 2004

Requirement for each local authority to have a children's trust board which must include representatives of the local authority and each of the children's trust 'relevant partners'

Local safeguarding children's boards put on statutory footing

Children and Families Bill 2012-13 (currently in Parliament)

(Clause 25) Local authorities must promote the integration of special education, health and care provision.

(Clause 26) Local authorities and their partner CCGs must make arrangements for the joint commissioning of education, health and care provision for children and young people with SEN.

(Clause 27) Local authorities must keep under review special education provision and social care provision for children and young people with SEN and consider the extent that it is sufficient to meet their needs.

(Clause 30) Local authorities must publish a Local Offer containing information about services available for children and young people with SEN, including education, health and care provision.

The role of the Health and Wellbeing Board must be understood in relation to new and existing partnerships, including: local children's trust arrangements; local safeguarding children's boards; learning disability partnership boards; and others. A clear local framework on how these partnerships interact needs to be established to avoid the duplication of effort or even competing for resources.

The JSNAs and JHWS need to be aligned with other arrangements, such as: reviewing and commissioning of SEN services via the High Needs Block[9]; safeguarding arrangements; child poverty strategies; and children and young people's plans if they are still used.

Additionally, the Children and Families Bill currently in Parliament contains clauses for promoting integration between special educational provision, health and social care provision (25), making joint-commissioning arrangements (26), keeping education and care provision under review (27), and producing a local offer (30), for children and young people with SEN. These new duties on local authorities all have a clear relevance to the functions of the Health and Wellbeing Board to encourage integrated working, promote close working and undertake a JSNA and JHWS. This is particularly important as CCGs will be under a new duty to secure specific services in education, health and care plans for children and young people with SEN[10]. Indicative regulations also make clear that local authorities must consult Health and Wellbeing Boards when preparing and reviewing its Local Offer[11].

How to meet your Charter commitments

In order to fulfil this commitment, we would expect a HWB to be able to provide the following evidence:

- Information on links to other local integration forums which set strategic direction for disabled children's services, e.g. the local children's trust arrangements, the local safeguarding board, the learning disability partnership board, the school forum, etc.
- Evidence of how the JSNA and JHWS is aligned with other arrangements, such as: reviewing and commissioning of SEN services via the High Needs Block; safeguarding arrangements; child poverty strategies, etc.

Key resources for meeting this Charter commitment

NHS Confederation (2012), Children and young people and health and wellbeing boards: putting policies into practice

> Developed by the health and wellbeing board learning set for children and young people, part of the National Learning Network for health and wellbeing boards, to give HWB members some ideas of how other boards are organising themselves to deliver coordinated services for children and young people.

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[9] See Department for Education (2012), School funding reform 2013-14, pp. 16-20

[10] See Department for Education website (2013), Children and young people with special educational needs to benefit from new legal health duty

[11] The Special Educational Needs (Local Offer) (England) Regulations 2014: http://media.education.gov.uk/assets/files/pdf/c/clause%2030%20draft%20regulations%20sen%20local%20offer.pdf

Children and Young People’s Health Outcomes Forum (2012), Health and wellbeing boards and children, young people and families

Poster produced in June 2012 by the health and wellbeing board learning set for children and young people.

Easton, C.; Hetherington, M., Smith, R., Wade, P., Aston, H. and Gee, G. (2012). Local Authorities’ Approaches to Children’s Trust Arrangements (LGA Research Report)

The Local Government Association commissioned the National Foundation for Educational Research (NFER) to investigate local authorities’ approaches to their children’s trust arrangements and how they are fulfilling their duty to promote cooperation with partners to improve children and young people’s health and wellbeing.

General resources

The Marmot Review (February 2010), Fair Society, Healthy Lives: A Strategic Review of Health Inequalities in England Post-2010

Professor Sir Michael Marmot was asked by the then Secretary of State for Health to chair an independent review to propose the most effective evidence-based strategies for reducing health inequalities in England.

Kennedy, Prof Sir Ian (September 2010) Getting it right for children and young people: Overcoming cultural barriers in the NHS so as to meet their needs

An independent review of services provided by the NHS to children and young people, concentrating on understanding the role of culture in the NHS. It focuses on areas where there are cultural barriers to change and improvement and makes recommendations.

NHS Confederation - Resources for Health and Wellbeing Boards

The NHS Confederation has been working with each health and wellbeing board learning set in collaboration with the NHS Institute for Innovation and Improvement, Department of Health and Local Government Association to produce publications which summarise their key points of learning and which will be shared with other shadow health and wellbeing boards.

NHS Confederation (2012), Children and young people's health and wellbeing review of documents

Briefing summarising the key policy documents on children and young people's health and wellbeing that have been published over the last two years."

NHS Confederation (2012), Support and resources for health and wellbeing boards

Summary of the support available to spread networking and learning opportunities for Health and Wellbeing Boards

NHS Confederation (2012), National learning network for health and wellbeing board publications 2012

A list of publications produced by The National Learning Network for health and wellbeing boards to share learning and support the establishment of well functioning boards.

Local Government Associaton - Resources for Health and Wellbeing Boards focusing on children, young people and family issues

The Health and Wellbeing Board learning set for children and young people looked at the issues important to the development of Health and Wellbeing Boards. The learning sets are a part of the Department of Health's development and support programme for Health and Wellbeing Boards which is supported by the LGA, NHS Confederation and NHS Institute. Nine learning sets focused on a number of themes including governance, resources and public engagement.

Getting the Best Out of Your Health and Wellbeing Board Leadership Development Offer - Health and Wellbeing Board Information Resource

This document brings together information about publications and websites which should be of value to Health and Wellbeing Boards.

Child and Maternity Health Observatory

ChiMat was established in 2008 as a national public health observatory to provide wide-ranging, authoritative data, evidence and practice related to children's, young people's and maternal health.

National Voices

The national coalition of health and social care charities in England. They work together to strengthen the voice of patients, service users, carers, their families and the voluntary organisations that work for them.

Regional Voices

Supports the voluntary sector to successfully influence local strategic decision making in health and social care. This group of pages links to a variety of resources to support you develop strategies to influence in your local area.

About Us

Every Disabled Child Matters is the national campaign to get rights and justice for every disabled child. It is run by four leading organisations working with disabled children and their families: Contact a Family, Council for Disabled Children, Mencap and the Special Educational Consortium.

The Children's Trust, Tadworth is the leading UK charity for children with acquired brain injury, multiple disabilities and complex health needs. The Trust's services include the UK's largest rehabilitation centre for children and young people with acquired brain injury, nursing care for technology-dependent children, and education for children and young people with profound and multiple learning difficulties and complex health needs.

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open report on behalf of Martin Wilson, Health and Wellbeing Board Advisor

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**11 June 2013**
Subject:	**Health and Wellbeing Board – Development Tool**

Summary:

Lincolnshire's Health and Wellbeing Board came into existence on 1 April 2013, this national tool allows the Board to assess their progress, using indicators of good practice, on how the Board has and can progress to achieve the outcomes agreed within the Joint Health and Wellbeing Strategy.

Actions Required:

The Board to discuss and agree the current position within this assessment and to review the progress in March 2014 to inform the 2013/14 Annual Report.

1. Background

Lincolnshire's Health and Wellbeing Board has been developed after 18 months of operating as a 'shadow' Board where its structures and hierarchy developed as the legal background to their role became clear.

It seems then to be an opportune time to assess were the Board currently feels it is and what processes, practices and partnerships it needs to improve to deliver an improved health and wellbeing for the population of Lincolnshire against five areas

- Strategy, purpose and vision
- Leadership, values, relationships, ways of working
- Governance
- Roles and contributions
- Measures and accountabilities

In Appendix A, the Health and Wellbeing Board Advisor has highlighted where, in his opinion the Board currently sits within this national assessment framework and has asked some questions of the Board.

2. Conclusion

It is important that Lincolnshire's Health and Wellbeing Board look at its current position to assess its strengths and opportunities to improve its effectiveness and review, in 2014 whether the Board has been successful with its agreed outcomes for Lincolnshire. This development/assessment tool is one way the Board can show how well it has achieved its agreed aims and objectives for the population of Lincolnshire and also were it has identified areas that will need to be improved.

3. Consultation

N/A

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Lincolnshire's Development Tool for Health
Appendix B	Development Tool for Health and Wellbeing Boards

5. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

This report was written by Martin Wilson, Health and Wellbeing Board Advisor, who can be contacted on (01522 554292) or martin.wilson@lincolnshire.gov.uk

Development tool for Health and Wellbeing Boards

Area	Now - 2013	In 1 Year	In 3 Years	Questions for the Board
Strategy, Purpose, Vision	1. The board understands its unique potential contribution and is ambitious to improve health and wellbeing.	1. The board has agreed a realistic set of priorities on which to focus its efforts.	1. The board has demonstrated achievement against its priorities. The board has a track record of enabling efficient, effective and integrated re-commissioning of service(s).	**How will we show improvement?**
	2. The board has a clear statement of purpose and priorities. Existing JSNA reviewed and JHWS initiated.	2. JSNA and JHWS formally agreed. Individual commissioning plans of CCGs and LA align with JSNA/JHWS.	2. JSNA/JHWS embedded in annual plans of service providers. JSNA and JHWS reviewed and revised and commissioning plans of all relevant partners aligned.	**Does the Board agree?**
	3. HWB has a compelling narrative of its purpose and ambitions for its local community.	3.Partner organisations can describe how HWB will make a difference. A shared and effective communications plan exists (including media handling).	3. Community can describe how HWB has made a difference. The board can describe what	**Does the Board agree?**
Leadership, values, relationships, ways of working	4. Board members understand the concept of shared leadership and communicate effectively and respectfully.	4. Trust has been established, constructive challenge is the norm, a conflict resolution process is in place.	4. Continuous learning (from own experiences and from others) is well established.	**Does the Board agree and how do we move to in 1 year?**
	5. The board has a code of conduct which is explicit about expectations of behaviour, and which describes the values aspired to. The board models appropriate behaviours and has an agreement about minimum attendance at meetings.	5. The board uses both internal and external reviews to test that its code of conduct is effective. Board members attend regularly and make a positive contribution to meetings.	5. The board's annual self assessment incorporates agreed outcome measures against its code of conduct. Stakeholders agree that the board operates on a win-win basis.	**Are the Board comfortable about developing review programmes?**
	6. Members have effective working relationships and are beginning to influence each other's organisations.	6. Board members look for win-win solutions focused on beneficial health outcomes for the community. Relationships enable members to influence beyond their own organisations.	6. Local organisations seek to contribute to the work of the board.	**Does the Board agree?**
	7. The board has interim arrangements in place to engage users and the public pending the establishment of local Healthwatch.	7. The board empowers the local Healthwatch member to act as an independent and effective voice for users and the public.	7. The board can demonstrate that it has considered and acted upon the views of local people.	**Does the Healthwatch member agree?**
	8. The board understands the needs of diverse communities and is clear about its responsibilities under Equalities legislation, and those of its partners.	8. The board can demonstrate that it promotes equality in all its actions including consultation, priority setting and service improvement, and undertakes equality impact assessment on its plans.	8. The board is a beacon of excellence in relation to equality and diversity and can show positive outcomes for the health and wellbeing of minority groups.	**Does the Board have proposals/plans to be a beacon of excellence?**
Governance	9. The board is clear on accountability for decisions and action, and has a scheme of delegation.	9. Decision making is clear and transparent, and effectively communicated to stakeholders and the public.	9. Decisions of the HWB are accepted and acted on by all oragnisations in the local system.	**The Board to review communications plan?**
	10. The board has governance frameworks which align with those of the LA and CCGs.	10. Board membership, operational structures, and mechanisms for engaging partners, are clear.	10. The board has regular updates on the priorities of the wider LA, NHSCB and key local partners.	**The Board Advisor to develop structual plans?**
	11. The relationship between the HWB and the LA scrutiny function is clear.	11. The relationship between scrutiny and external regulators is agreed and an initial effectiveness review has been completed.	11. Scrutiny and regulators work constructively with the HWB.	**The Board Advisor to develop structual plans?**
	12. An agreement re pooling of resources is in place.	12. A risk sharing agreement exists between the LA and CCGs.	12. A risk sharing agreement exists between the LA, CCGs and other relevant partners.	**Does the Board agree?**
Roles and contributions	13. The board knows what each member brings in the way of skills, experience, knowledge and potential contribution.	13. Each board member has a clear role description and acts in accordance with this. An annual board development plan has been agreed.	13. The board regularly reviews its own effectiveness and development needs.	**Members roles to be agreed as part of the Terms of Reference.**
	14. The board knows what's good about its existing partnership working and can describe what has been successful, what hasn't, and why.	14. A stakeholder map exists for external partners and each board member has agreed partners that they work with proactively. A 360 degrees feedback survey with partners has been completed.	14. A 360 degrees feedback survey is completed with stakeholders; with key partners; with the public and an appropriate action plan developed.	**Does the Board agree and are they prepared to participate in 360° survey?**
Measures and accountabilities	15. The board's priorities balance improvements in service provision with improvements in population health and wellbeing.	15. The board has an agreed set of outcome measures, matched to its priorities.	15. The board's annual report demonstrates achievement of outcomes.	**Does the Board agree?**
	16. The board has reviewed the current position as regards service integration, population health and use of resources.	16. The board has identified outcomes with defined early wins in the areas of: A) more intergrated and/or personalised services; B) improved popoulation health; C) better use of resources	16. The board has achieved defined outcomes in the araes of: A) more intergrated and/or personalised services. B) improved population health. C) better use of resources, including community based assets, and identified early wins in reducing health inequalities	**Does the Board agree?**
	17. The board has reviewed its current outcomes against its peer group.	17. The board reviews itself regularly against benchmarks and adapts plans as necessary.	17. The board consistently performs well against benchmarks.	This item is to be reviwed Nationally

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APPENDIX B

Health, adult social care and ageing

Local Government Association

A new development tool for health and wellbeing boards

directors of adass adult social services

ADCS Leading Children's Services

Association of Directors of Public Health

Faculty of Public Health

solace

nhsalliance

The King's Fund

NHS Commissioning Board
A special health authority

NHS Confederation

NHS Leadership Academy

DH Department of Health

Using the development tool

The development tool asks users to assess how their board is performing in relation to 17 key issues. The issues have been identified based on the outcomes from the design events mentioned above. When using the tool it is important to promote dialogue amongst the partners on the board about these issues.

The development tool can be used in a number of ways:

- by board members acting collectively to discuss and agree scores together.
- with the help of an external facilitator, to assist exploration of the issues, and to promote discussion.
- individually completed by members of the board working independently, (however this approach has the significant disadvantage that a useful exchange of views between partners is less likely to occur, and the process may therefore be less helpful to mutual understanding and board development).

Boards are invited to evaluate their position against the suggested criteria that are expected to characterise the achievements of a board now; in one year; and in three years.

It is to be expected that boards in the early stages of development will respond positively to a limited number of the criteria, but as they progress to maturity that position should improve. It is quite possible that a board completing the assessment today may not yet be at the point suggested by all 17 criteria in the 'Now' column. On the other hand, for some criteria it may exhibit advanced behaviour as projected in the 'In three years' column.

The development tool can be found online at http://www.local.gov.uk/web/guest/health/-/journal_content/56/10171/3638628/ARTICLE-TEMPLATE

Next steps

The aim of the development tool is to support boards to discuss challenging issues, to inspire them towards transformational outcomes for their community, and to help them identify what action they need to take. It is expected that boards will wish to use the tool as a stepping stone towards developing an improvement plan to address their next steps. We intend to keep the content of the tool under review to ensure it meets the future needs of boards; we would therefore welcome comments about how the tool might be further improved. Please send your feed back to healthy.admin@local.gov.uk

Support and assistance

Health and wellbeing boards are challenged to develop complex and innovative methods of working that require partnership of a new order. Help is available from several national and regional organisations to assist boards in finding their way.

A good starting place for assistance is with the LGA Health and Wellbeing Board Leadership Offer at healthy.admin@local.gov.uk where advice can be obtained on the development tool and a range of support options for boards.

Area	Now	In 1 year	In 3 years
Leadership, values, relationships, ways of working	4. Board members understand the concept of shared leadership and communicate effectively and respectfully.	4. Trust has been established, constructive challenge is the norm, a conflict resolution process is in place.	4. Continuous learning (from own experiences and from others) is well established.
	5. The board has a code of conduct which is explicit about expectations of behaviour, and which describes the values aspired to. The board models appropriate behaviours and has an agreement about minimum attendance at meetings.	5. The board uses both internal and external reviews to test that its code of conduct is effective. Board members attend regularly and make a positive contribution to meetings.	5. The board's annual self assessment incorporates agreed outcome measures against its code of conduct. Stakeholders agree that the board operates on a win-win basis.
	6. Members have effective working relationships and are beginning to influence each other's organisations.	6. Board members look for win-win solutions focused on beneficial health outcomes for the community. Relationships enable members to influence beyond their own organisations.	6. Local organisations seek to contribute to the work of the board.
	7. The board has interim arrangements in place to engage users and the public pending the establishment of local Healthwatch.	7. The board empowers the local Healthwatch member to act as an independent and effective voice for users and the public.	7. The board can demonstrate that it has considered and acted upon the views of local people.
	8. The board understands the needs of diverse communities and is clear about its responsibilities under Equalities legislation, and those of its partners.	8. The board can demonstrate that it promotes equality in all its actions including consultation, priority setting and service improvement, and undertakes equality impact assessment on its plans.	8. The board is a beacon of excellence in relation to equality and diversity and can show positive outcomes for the health and wellbeing of minority groups.

Area	Now	In 1 year	In 3 years
Measures and accountabilities	15. The board's priorities balance improvements in service provision with improvements in population health and wellbeing.	15. The board has an agreed set of outcome measures, matched to its priorities.	15. The board's annual report demonstrates achievement of outcomes.
	16. The board has reviewed the current position as regards service integration, population health and use of resources.	16. The board has identified outcomes with defined early wins in the areas of: a) more integrated and/or personalised services b) improved population health c) better use of resources.	16. The board has achieved defined outcomes in the areas of a) more integrated and/or personalised services b) improved population health c) better use of resources, including community based assets, and identified early wins in reducing health inequalities.
	17. The board has reviewed its current outcomes against its peer group.	17. The board reviews itself regularly against benchmarks and adapts plans as necessary.	17. The board consistently performs well against benchmarks.

Agenda Item 9.2

Lincolnshire
COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open report on behalf of Dr Tony Hill, Director of Public Health

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**11 June 2013**
Subject:	**Lincolnshire Public Health Annual Report 2012**

Summary: The Annual Report from the Director of Public Health is a statutory report to Lincolnshire County Council as it takes on its new public health responsibilities. The report raises issues of importance to the health of the population of Lincolnshire.

Actions Required: The Board is asked to receive and discuss the recommendations included in each chapter.

1. Background:

This is my third Annual Report as Director of Public Health for Lincolnshire, and my last to the Board of Lincolnshire Primary Care Trust. It is, however, of more significance to Lincolnshire County Council as it takes on its new public health responsibilities and to the four new clinical commissioning groups in Lincolnshire as they take on their new statutory duties for commissioning health care. The next year will be a challenging one for all of us, with new responsibilities, new partner organisations and a whole new set of opportunities to improve the health and wellbeing of the people of Lincolnshire. This annual report tries to shine a light on some of the changes and their implications to help all of us focus on the ways we need to work together. These changes are a big opportunity to improve the way we join up our work.

2. Conclusion:

The Board is asked to receive a presentation and to discuss the recommendations included in each chapter.

3. Consultation:

Much of the detail in the report reflects public engagement on the topics discussed. The report will also be presented to the Executive of Lincolnshire County Council. Many of the recommendations have an implication for other organisations in the County.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Lincolnshire Public Health Annual Report 2012

5. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

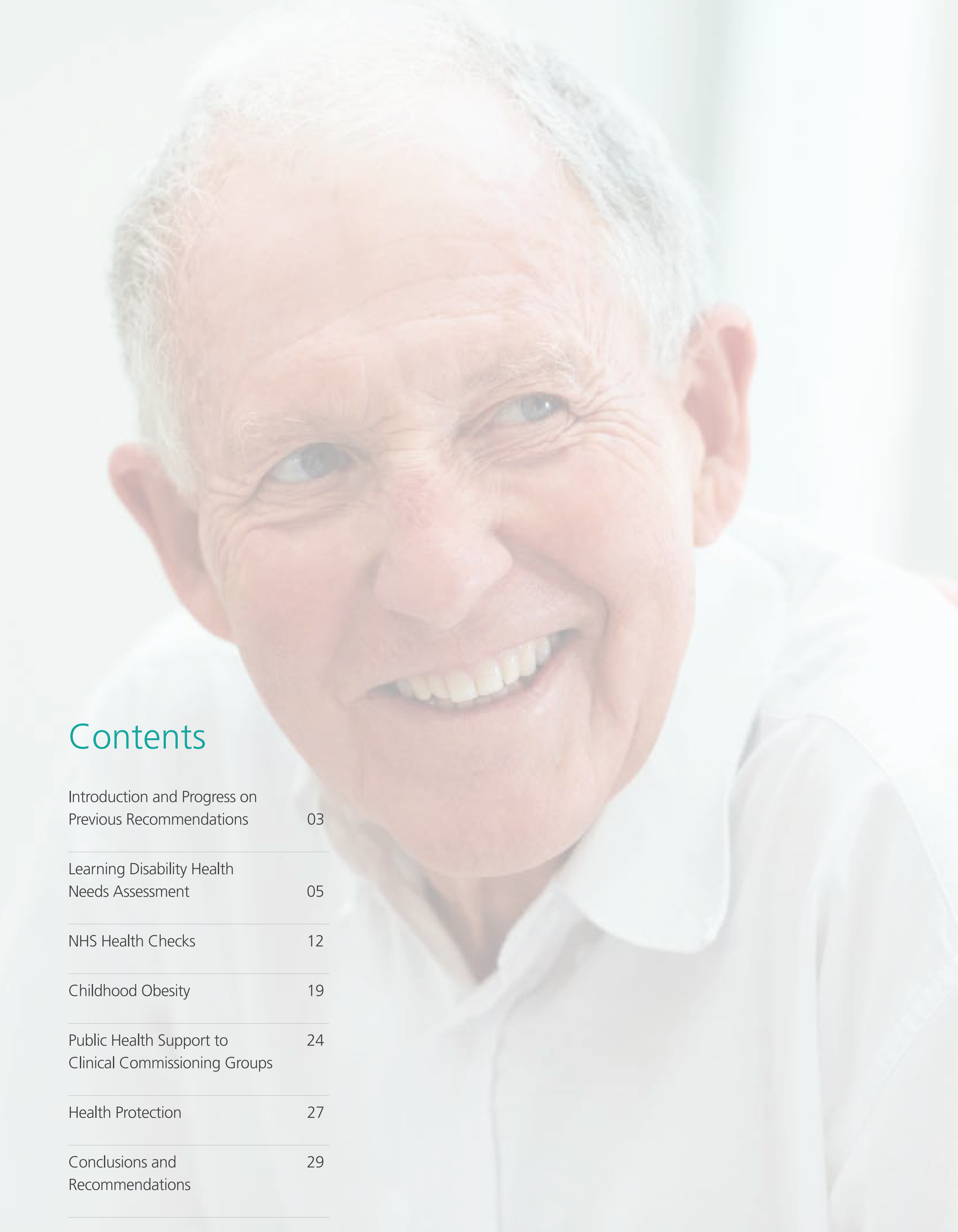
This report was written by Dr Tony Hill, who can be contacted on (01522 552902) or (tony.hill@lincolnshire.gov.uk)

LINCOLNSHIRE PUBLIC HEALTH

Annual Report 2012

NHS
Lincolnshire

Lincolnshire
COUNTY COUNCIL



Contents

Introduction

This is my third annual report as Director of Public Health for Lincolnshire, and my last to the Board of Lincolnshire Primary Care Trust. It is, however, of more significance to Lincolnshire County Council as it takes on its new public health responsibilities and to the four new clinical commissioning groups in Lincolnshire as they take on their new statutory duties for commissioning health care. The next year will be a challenging one for all of us, with new responsibilities, new partner organisations and a whole new set of opportunities to improve the health and wellbeing of the people of Lincolnshire. This annual report tries to shine a light on some of the changes and their implications to help all of us focus on the ways we need to work together. These changes are a big opportunity to improve the way we join up our work. In the maelstrom of reorganisation we must not miss this opportunity. Chapters four and five are the main ones for this.

Population needs assessment is not highly valued in Lincolnshire, but it is a critical component of the commissioning cycle. Relying on routine statistics and performance data does not measure unmet need and you simply get what you have always had, although it may be better quality or better value for money as a result of the commissioning activity. To identify and meet unmet demand in our communities requires painstaking work to look at the whole of the population. The Joint Strategic Needs Assessment requires some specific and focussed work to support the routinely collected data.

Chapter one gives a summary of a population needs assessment for people with learning disabilities. I hope this needs assessment will play a significant part in shaping new jointly commissioned services for this vulnerable group of people.

The Joint Health and Wellbeing Strategy (JHWS) for Lincolnshire places a great emphasis on addressing issues in systematic ways. A systematic, evidence based approach to, for example, cancer care, heart disease programmes and treatment of stroke has been shown to deliver better care and better outcomes. Continued improvement to these is the objective of theme three in the JHWS. The NHS Health Checks programme is designed to identify those with some long-term conditions earlier than they might be found otherwise, so that these people can benefit from earlier treatment and secondary prevention. Chapter two reports on progress with NHS Health Checks in Lincolnshire.

The JHWS also identifies childhood obesity as a major challenge for Lincolnshire. Chapter three explains why this is, and tries to outline some of the changes that need to happen so that our children in Lincolnshire do not grow up to be obese adults with all the increased risks for cancer, diabetes, heart disease, musculoskeletal disease and others.

The 2011 Annual Public Health Report made fourteen recommendations. I think it is helpful to report back on how much progress has been made against these recommendations.

Improved quality of data on the demography and health status of prisoners – The quality of data has recently improved greatly and further improvements are being implemented.

Prison healthcare provider to maintain disease registers and manage healthcare for prisoners on the registers to the required standard – Disease registers are now in place and disease management is improving using an assessment tool to identify prisoners with a learning disability.

Stress testing of each antenatal and new-born screening programme to be carried out – This has been completed.

Improved quality of data on people who do not attend for screening and target evidenced based programmes to address this – Progress has been made in primary care using mosaic profiling within the cervical cancer screening programme. The service provider of the Diabetic Eye Screening Programme has introduced new pathways for inviting people to try and reduce numbers of the people who do not attend.

Increase screening uptake in areas with lowest coverage – The EPOC programme is now working to increase uptake across all three of the cancer screening programmes in areas with the lowest coverage across all CCG areas as appropriate. They are working with staff from the breast and bowel cancer screening units locally.

Roll out abdominal aortic aneurysm screening across Lincolnshire – This has now been agreed and is under way. The Service Provider is working closely with General Practices and Public Health to provide this service for the Lincolnshire population.

Maintain good access to sexual health services within 48 hours of appointment request – This has proved to be a considerable challenge in a wide rural county and a fundamental review is now under way.

Linking chlamydia screening with wider aspects of sexual health – This has been achieved

Increase HIV testing in high risk groups – Work has commenced with GPs to increase awareness of testing, and with organisations which already, work with the ‘at risk’ groups.

Linking Teenage Pregnancy work with wider aspects of sexual health – This has been achieved.

Awareness raising in relation to sexual assault and rape – The police and the Sexual Assault Referral Centre have developed a ‘no means no’ campaign, which has a variety of ways of delivering their key message.

Service redesign of sexual health services to meet population needs – A fundamental review is now under way.

I would like to thanks staff within the Lincolnshire Public Health directorate who wrote parts of the report, reviewed chapters and proof read. I would welcome your comments on the report.

Tony Hill

Dr Tony Hill

Joint Director of Public Health
NHS Lincolnshire and Lincolnshire County Council

Learning Disability Health Needs Assessment

In April 2012, Lincolnshire Public Health published a Health Needs Assessment (HNA) for adults with learning disabilities. This chapter of the Annual Report provides outline information on some of the findings from the HNA.

Introduction

People with a learning disability tend to have worse health than the population as a whole, and they are one of the most socially excluded groups in society. There is evidence indicating greater prevalence of specific diseases amongst people with a learning disability compared with the general population. The learning disability definition used for this HNA is given in the definitions and clinical signs section below.

NHS and Local Authority Commissioners have a responsibility to ensure that mainstream health and social care services address the needs of people with learning disabilities, in addition to ensuring that specialist healthcare is available for people who require it. This HNA aims to support NHS and Local Authority Commissioners and their providers in delivering their responsibilities for the Lincolnshire learning disability population.

Aims of the Health Needs Assessment

The aims of the HNA were to:

- systematically assess the health needs of adults with learning disabilities in Lincolnshire;
- identify gaps in service provision;
- review evidence of effective interventions;
- make recommendations to address unmet health needs and reduce health inequalities.

Methodology

A multi-agency steering group, led by the Public Health team, was established to oversee the HNA. The group used established HNA methodology and approaches to carry out the work. This included:

- Epidemiological – exploring the health status of the learning disability population, and describing the effectiveness of services and interventions.
- Comparative – contrasting local epidemiology or service provision with other geographical areas.
- Corporate – collecting the views of learning disability service users, service providers and other stakeholders.

Findings from the Literature Review

Definitions and Clinical Signs,

For the purpose of the HNA, the learning disability definition in the White Paper, Valuing People: A New Strategy for Learning Disability for the 21st Century[1] is used. This is that learning disability includes the presence of:

a significantly reduced ability to understand new or complex information, or to learn new skills (impaired intelligence), with

- a reduced ability to cope independently (impaired social functioning),
- and which started before adulthood, with a lasting effect on development.

The World Health Organisation International Classification of Diseases divides learning disability into four main categories: mild, moderate, severe and profound, depending on the level of cognitive impairment.

Causes and Risk Factors

The aetiology of learning disability can be subdivided into those conditions that arise at conception, and those that arise during pregnancy, labour and birth. Aetiological agents fall into three main categories: genetic, infective and environmental. However, no known aetiological cause is identified in a high proportion of learning disability cases.

Prevention

Prevention can be divided into primary and secondary prevention. Primary prevention is the implementation of measures to prevent new cases of people with learning disabilities. These occur at various stages, i.e. prior to conception, during pregnancy, during labour and after birth.

Policy Context

Valuing People recognised that people with a learning disability are among the most vulnerable and socially excluded in our society. It has six main priority areas, one of which is to improve the health of people with a learning disability. Valuing People Now[2] further progressed the work of Valuing People, and has an overall objective that all people with a learning disability receive the healthcare and support that they need to live healthy lives.

The Disability and Equality Act 2010[3] gives disabled people important rights of access to everyday services. Service providers have an obligation to make reasonable adjustments to their premises and/or the way that they provide services.

A number of high profile reports have been published in relation to the health of people with learning disabilities. Some of these include Equal Treatment Closing the Gap[4], Promoting Equality[5], Treat Me Right[6], Death by Indifference[7], Six Lives: The Provision of Public Services to People with Learning Disabilities[8] and Healthcare for All[9]. Following a BBC Panorama programme in May 2011 about Castlebeck Care Ltd, the Care Quality Commission (CQC) developed a focussed inspection programme to review the care provided by hospitals for people with learning disabilities.

Health Needs and Inequalities

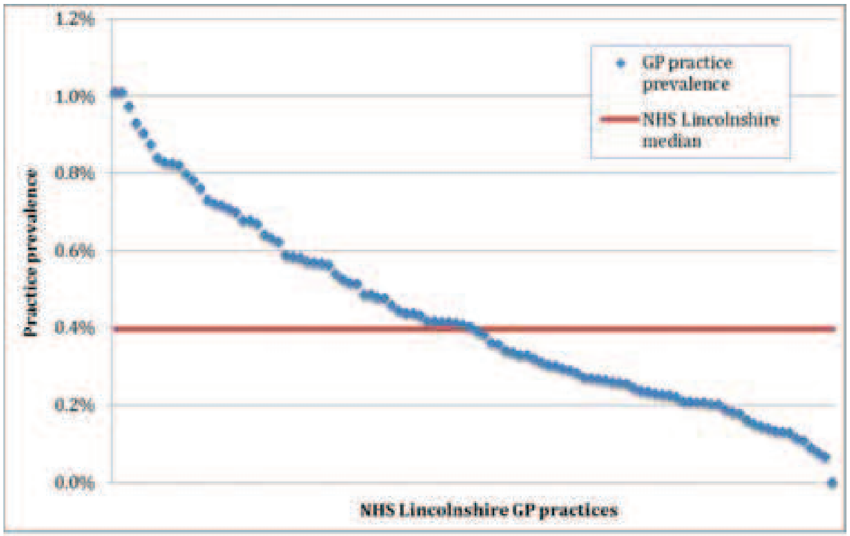
A literature review was carried out to establish the evidence in relation to the mortality and morbidity of people with learning disabilities, and how their health compares with that of the general population. Some of the key findings from the literature review include:

- People with a learning disability, have a shorter life expectancy compared to the general population. The greater the level of learning disability, the greater the reduced life expectancy.
- Difficulties in swallowing are found in people with learning disabilities due to neurological or anatomical problems. In Lincolnshire, 2.7% of adults with learning disabilities are known to have dysphagia, while the overall prevalence is 0.8%.
- Respiratory infections place a significant burden on people with a learning disability, and there is significantly greater risk of mortality compared to the general population.
- The prevalence of epilepsy amongst people with a learning disability is greater than for the general population. In Lincolnshire, 26% of adults with a learning disability have epilepsy, while the overall prevalence is 1.4%.
- Sensory impairments are known to be more prevalent in people with a learning disability.
- People with a learning disability are more likely to have poorer oral health compared to the general population.
- Accidental injuries in the adult learning disability population are known to occur more frequently than in the general population.
- People with learning disabilities are at greater risk of developing mental health and behavioural disorders compared to the general population.

- The prevalence of psychiatric disorders is greater in adults with a learning disability compared to the general population.
- The prevalence of dementia is significantly higher in older adults with a learning disability compared to the general population.
- Adults with a learning disability generally have a poor diet, and a high proportion of adults with a learning disability do not undertake the recommended levels of physical activity.
- Adults with a learning disability are more likely to be obese compared to the general population. Those at greatest risk include women and people with Down's syndrome.
- People with learning disabilities are more frequently exposed to factors that are associated with poor health, such as poverty, poor housing and unemployment.

As part of the Quality and Outcome Framework (QOF), general practices are required to maintain a register of adults with a learning disability. In 2010/11, there were 2685 people in Lincolnshire on the learning disability register. This represents a prevalence of 0.45%, which is close to the England (0.43%) and East Midlands (0.47%) prevalence. Figure 1.1 shows the variation in prevalence amongst the general practices in Lincolnshire, which could be due to the differences in the case mix of general practice lists, as well as the relative completeness of the registers.

Figure 1.1 Age-specific (18 years and over) prevalence of learning disabilities recorded on primary care registers held by GP practices across Lincolnshire, 2010-2011



Source: Primary care registers held by GP practices across Lincolnshire

The national PANSI (Projecting Adult Needs and Service Information) and POPPI (Projecting Older People Population Information) datasets provide information on the predicated number of learning disability cases 10,[11]. Although there are known shortcomings with the evidence on which this data is based, they indicate that there could be in the region of 13000 people with learning disability across Lincolnshire, with 2709 of these being moderate or severe.

In March 2011, 1714 people with learning disabilities were known to Lincolnshire adult social care services. The ratio of males to females was 1.23:1 and 98.4% were of white British ethnic origin. Boston, East Lindsey and West Lindsey had the highest crude rate in their population. The Index of Multiple Deprivation (IMD) 2010 suggests that learning disability service users live in more deprived areas compared to the general population, with more than half residing in the two most deprived quintiles of the county. This may be partly explained by access to services. For example, the distribution of IMD scores for CQC approved care homes is greater in more deprived areas of the county.

POPPI and PANSI project the number of adults with a learning disability from 2011 to 2030. It is estimated that, in Lincolnshire, there will be a 16% increase in the number of cases during this period. It is projected that the proportion of people with profound and multiple learning disabilities will increase, and the greatest increase is anticipated in people aged over 65 years.

Description of Lincolnshire Health Services and Activity

Commissioning arrangements and service provision

People with a learning disability access a wide range of mainstream services that are provided for the general population. NHS commissioning organisations have a responsibility to ensure that these mainstream health services address the needs of people with learning disabilities. Furthermore, specialised learning disability healthcare is commissioned for people who require it. This section of the report provides information on some of the services that are available for the Lincolnshire learning disability population.

Primary Care Services

A wide range of primary care services (general practices, dental practices, opticians and community pharmacies) are available for people with a learning disability. As part of QOF, general practices are required to maintain a register of adults with a learning disability. Annual health checks for people with a learning disability were introduced in 2008 as part of a Directed Enhanced Service (DES).

Community Services

Lincolnshire Community Health Services (LCHS) provide a wide range of health services for the Lincolnshire population, including people with learning disabilities. LCHS provides a Special Care Dentistry Service which addresses oral health for particular individuals and groups in society, such as those with a severe and profound learning disability, who have needs beyond the usual skills and facilities of a general dental practitioner.

Secondary Care Services

United Lincolnshire Hospitals provide a wide range of healthcare from their four main hospitals.

Specialised Learning Disability Service

Lincolnshire Partnership Foundation NHS Trust provides specialist health services for people with a learning disability, for example, an assessment, treatment, and rehabilitation service (Long Leys Court), outpatient clinics and specialist allied health professionals.

Lincolnshire County Council Learning Disability Community Partnership Teams provide integrated health and social care.

East Midlands Specialised Commissioning Group is responsible for commissioning secure (low, medium and high security) mental health and learning disability services for the Lincolnshire population.

Service Activity

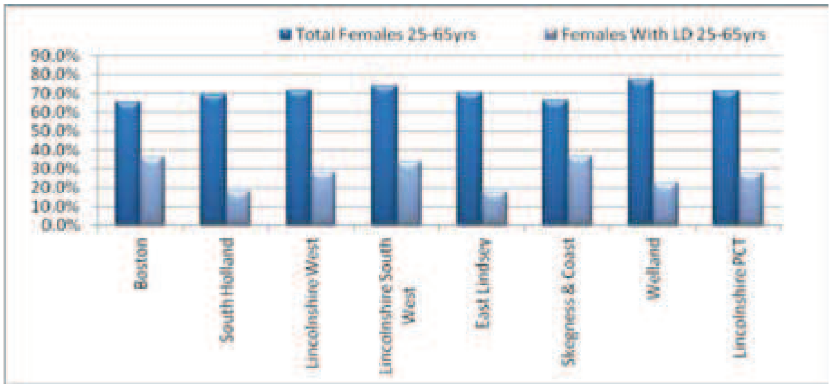
Whilst carrying out the HNA it was difficult to obtain comprehensive information on how far people with learning disabilities are accessing the full range of services that are available to them. This section of the report provides some information about the available data, which, unfortunately, is limited.

Primary Care Activity

Cervical Cancer Screening

The screening uptake amongst women with a learning disability is considerably lower than for the general population. In 2010/11, the uptake amongst the general population was 71%, compared with 28% for the learning disability population (Figure 1.2). Nearly half (48%) of the eligible learning disability population have declined/been 'exception reported' (compared to 12% of the general population), and consequently will not routinely receive invitations for screening.

Figure 1.2 Cervical screening uptake (2010/11)

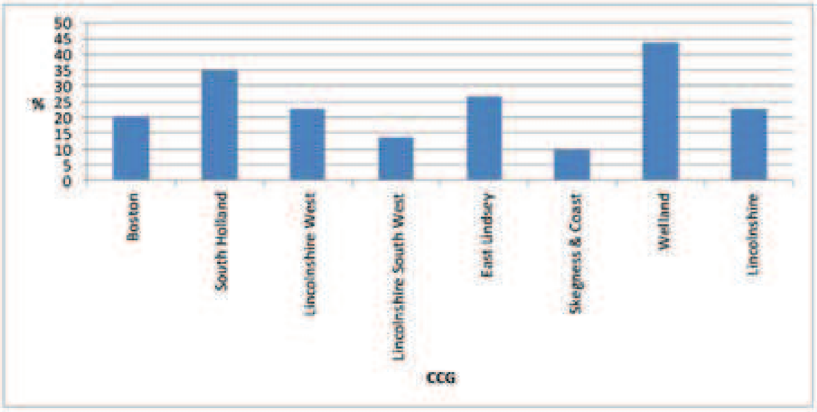


Source: Learning Disability Audit, NHS Lincolnshire

NHS Health Checks

Eighty-two general practices in Lincolnshire provide this service. Figure 1.3 shows the proportion of people with a learning disability who have received an annual health check, both in Lincolnshire as a whole and for each of the initial CCGs.

Figure 1.3 People with a learning disability receiving a health check



Source: Learning Disability Audit, NHS Lincolnshire

Hospital Activity

There was analysis of the levels of inpatient hospital activity for the general population compared to the learning disability population during 2010/11. Because of the relatively small learning disability population, any comparison of the two population groups should be treated with caution. Nevertheless, the analysis does provide some information on the differences in activity between the two groups. Some of the key findings are:

- The emergency hospital admission rate for the learning disability population is over twice that of the general population.
- Injury and poisoning account for 23% of the emergency admissions in the learning disability population compared to 12% in the general population.
- Diseases of the nervous system account for 11% of the emergency admissions for the learning disability population compared to 2% for the general population.
- Mental disorders account for just over 5% of the emergency admissions for the learning disability population compared to less than 2% for the general population.
- The accident and emergency admission rate is almost twice as high amongst the learning disability population compared to that of the general population.

Barriers to Services

The National Primary Care Research and Development Centre[12] carried out a review on access to healthcare for people with learning disabilities. It identified a number of findings in relation to barriers to accessing healthcare. Some of these include:

- problems identifying and communicating health needs.
- problems with carers recognising signs and symptoms.
- physical access difficulties.
- lack of knowledge amongst professionals of how to address the specific health needs of people with learning disabilities.

Effectiveness of Services and Interventions

The literature on the effectiveness of treatments, interventions and service models for people with learning disabilities is mainly limited to descriptive and uncontrolled research studies. Some guidance on how to meet the needs of people with learning disabilities has been produced by the various Royal Colleges. For example, the Royal College of General Practitioners has produced resources to support general practices in delivering high-quality health checks[13]. The Royal College has also been involved in producing commissioning guidance for CCGs[14], in order to achieve better health outcomes for people with learning disabilities. The Royal College of Nursing has produced guidance to support nurses in delivering high-quality healthcare for people with learning disabilities[15].

Corporate Assessment and Qualitative Analysis

A range of approaches was used to gain the views of service users, service providers and commissioners, and other stakeholders:

- Service users. Five small discussion groups for people with learning disabilities, which represented 30 service users, were consulted.
- Service providers/commissioners. An online survey was developed for service providers and commissioners and 19 responses were received.
- Other stakeholders. An online survey was developed and three people responded.

Service users reported that, in general, they are happy with general practices and dental services, and they were very positive regarding some of the specialised learning disability services. Service providers gave feedback on how communication could be improved across agencies to enhance joint working, and on how further training for generic staff could help meet the specific needs of people with learning disabilities.

Recommendations

The HNA report includes approximately 50 recommendations covering a number of themes. Although the full set of recommendations cannot be provided in this chapter, some of the most significant recommendations (with the theme provided in brackets) are listed below:

- The Joint Commissioning Board should ensure joint plans are in place to meet the needs of service users, including increased demand from more adults with learning disabilities (strategy and policy).
- Primary care should be encouraged to identify and record all people with learning disabilities (identification of adults with learning disabilities).
- Preventive healthcare and public health activities should be reviewed to ensure provision across Lincolnshire (prevention of learning disabilities).
- All services should provide the opportunity for adults with learning disabilities to access healthy lifestyle initiatives and services (healthy lifestyle initiatives).
- All GP practices should be encouraged to provide annual health checks (primary care).
- Frontline staff should receive training on learning disability awareness in order to develop their clinical skills, so that they are equipped to meet the health needs of this group (action across healthcare services).

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The full Learning Disability HNA report is available on the Lincolnshire Research Observatory website www.research-lincs.org.uk.

NHS Health Checks

What is the NHS Health Check Programme?

Everyone is at some risk of developing vascular disease. The risk increases with age, and other increases in risk are attributable to being overweight, smoking, not exercising regularly and a poor diet.

The 'NHS Health Check' Programme, offers preventative checks to people aged 40-74 years to assess their risk of vascular disease (heart disease, stroke, diabetes and kidney disease) followed by appropriate management and intervention, e.g. medical intervention and/or referral onto lifestyle services such as weight management.

The NHS Health Check is a 5-year rolling programme, which means that people are invited for a health check every five years. Patients leave the programme if they are diagnosed with vascular disease and therefore will be treated appropriately, or once they reach the age of 75.

In Lincolnshire, those at most risk are being invited for their health check first. Risk is calculated by a software risk tool which uses indicators such as age, gender, BMI, family history of vascular disease and previous blood pressure and cholesterol measurements to give a risk percentage. Where information is not available, for example a cholesterol test has not been conducted in previous years, the software calculates an estimated reading on which to base the risk score. Once a person has been invited and assessed, a new, more accurate, risk score is calculated with the up-to-date information. If any undiagnosed underlying disease is detected, then this can be treated and managed, and general risk can be reduced by discussing where improvements in lifestyle can be made.

The prevention or early identification of vascular disease with this assessment and management programme will lead to a higher uptake of preventative interventions (including statins, anti-hypertensives, brief exercise interventions, weight management and smoking cessation), reduce risk of vascular disease, and increase early detection and treatment of kidney disease and diabetes. The intended effect will be a reduction in vascular disease morbidity and mortality across the population.

Background

Vascular diseases are the biggest cause of death in the UK, and the NHS Health Check programme could, on average, prevent 1,600 heart attacks and strokes and save at least 650 lives, each year. The vascular checks programme could prevent over 4,000 people a year from developing diabetes, and detect at least 20,000 cases of diabetes, or kidney disease earlier, allowing individuals to be better managed and improve their quality of life. (Information from Putting Prevention First, Vascular Checks: Risk Assessment and Management)[1].

Over the past decade there have been significant improvements in the treatment of vascular disease through the National Service Frameworks on coronary heart disease, renal services and diabetes. Nationally there has been a 40% reduction in deaths from cardiovascular disease in people under 75 between 1996 and 2008[1]. During the same period, Lincolnshire had a 43% reduction. However, it remains a major cause of disability and poor health.

A focus is now needed on how vascular diseases can be prevented earlier in life. This will enable people to make informed choices about improving their health, and help them live longer and healthier lives. Vascular disease currently affects the lives of over 4 million people in England. It is responsible for 36% of deaths (170,000 a year in England) and accounts for a fifth of all hospital admissions. It is the largest single cause of long-term ill health and disability, impairing the quality of life for many people[1].

Evidence shows that it is possible to identify the risk factors for these diseases, and also to act to change them. Early intervention to reduce risk can prevent, delay, and, in some circumstances, reverse the onset of vascular disease[1].

How we have performed

NHS Lincolnshire was required to start commissioning the programme from 2009/10, and has done so with a Local Enhanced Service (LES) currently in place with 96% of GP practices. This has prioritised people who are at the greatest risk of vascular disease so they are invited first.

There is a requirement to have the programme rolled out fully by 2012/13, and the programme is a national ‘must be done’. Local Authorities will be expected to ensure NHS Health Checks continue as part of the mandatory responsibilities laid out in the Health and Social Care Act, 2012.

Not everyone aged 40-74 years old is eligible for an NHS Health Check. Only those who have not been diagnosed with a vascular disease will be invited.

From full roll out in 2012/13, where one-fifth of the eligible population in Lincolnshire will be invited, 45,046 patients will be eligible for their NHS Health Check each year. The Department of Health produced an economic modelling document which showed that, of all the options considered to deliver the programme in the most clinically effective and cost effective way, a starting age of 40 was the optimal, with vascular checks every five years[2].

Table 2.1 shows the number of eligible people who have been invited for an NHS Health Check, and the number receiving a health check. The Department of Health requested that PCTs were ‘seen to be doing something’ in 2009/10. From 2010/11 formal trajectories have been agreed and in 2010/11 NHS Lincolnshire was one of only 2 East Midlands PCTs to meet these SHA targets.

Table 2.1: NHS Health Check Target and Actual Uptake in Lincolnshire, 2009-2014

Year	Number to be Invited & (Number to be Assessed)	Actual Number Invited & (Assessed)	% Uptake to be Achieved	Actual % Uptake Achieved
09/10	No target set	13,530 (6,323)	No target set	47%
10/11	21,287 (10,003)	27,151 (12,886)	47%	47%
11/12	32,840 (17,734)	32,897 (22,075)	54%	67%
12/13	45,046 (25,676)		57%	
13/14	45,046 (27,028)		60%	

Data source: Integrated Performance Measures Returns (IPMR) NHS Lincolnshire

Outcomes

Specialist software was introduced in 2010/11 to assist practices in identifying eligible patients, and to enable full reporting of the data set required by the Department of Health.

Since the beginning of the programme (1st August 2009 to 30th September 2012) 50,599 people have received an NHS Health Check in Lincolnshire.

Table 2.2 shows the number of first letter invitations sent to eligible patients, and the number attending as a result of this from the start of the programme.

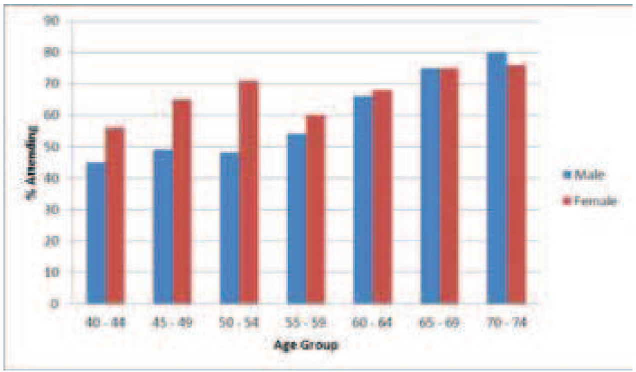
Table 2.2: NHS Health Check Attendance by Gender, 2009-2012

Gender	Number Invited to Attend	Number Attending	% Attending
Male	45,537	26,756	59%
Female	35,020	23,843	68%

Data source: TCR NHS Health Check Database

Figure 2.1 shows the percentage of eligible patients attending for their NHS Health Check after being invited, by gender and age group.

Figure 2.1: NHS Health Check Attendance by Gender and Age Group, 2009-2012



Data source: TCR NHS Health Check Database

Table 2.3 shows the disease diagnosis from the start of the programme, as a direct result of a patient having their NHS Health Check.

Table 2.3: NHS Health Check Disease Diagnosis, 2009-2012

Disease	**Number of Cases Identified**	
Diabetes Type II	415	1 in every 122 patients seen
Hypertension	1281	1 in every 40 patients seen
Chronic Kidney Disease	207	1 in every 244 patients seen
Familial Hypercholesterolaemia	50	1 in every 1,012 patients seen
Atrial Fibrillation	41	1 in every 1,234 patients seen
Peripheral Vascular (Arterial) Disease	13	1 in every 3,892 patients seen

Data source: TCR NHS Health Check Database

The risk tool used to calculate an individual's overall risk of developing vascular disease is called QRISK2. This calculates the risk of having a fatal or non-fatal heart attack or stroke in the next 10 years. A 20% risk in, say, a 50-year old man, means that he has a 1 in 5 chance of having a major vascular disease event before he is 60 years old.

Table 2.4 shows the number and percentage of those estimated (by the risk tool) to be at high risk, the numbers invited for an NHS Health Check and those attending.

Table 2.4: NHS Health Check Attendance by High Risk Patients, 2009-2012

	>20 RISK	**Number Invited**	**Number Invited as a %**	**Number of NHS Health Checks Completed on these High Risk patients**	**Number of NHS Health Checks Completed as a %**
Male	13,601	9,332	69%	7,511	81%
Female	3,539	2,679	76%	2,321	87%
Total	17,140	12,011	70%	9,832	82%

Data source: TCR NHS Health Check Database

It is encouraging to see that, as we enter the first full year of roll out in 2012/13, already 70% of those estimated at high risk have been invited, and 82% have chosen to attend for their NHS Health Check. The uptake rate in this group is much higher than the general uptake rate, even the high 67% achieved in 2011/12.

Where someone has been identified as being at a high risk of developing vascular disease, but no underlying disease has been detected, they are placed on a high risk register. This allows their GP to monitor them with an annual check up, and provide advice on reducing this risk with lifestyle improvements and referrals on to lifestyle services where appropriate.

Identification of undiagnosed disease, which people are often unaware of, is only one half of the NHS Health Check. The other half concentrates on offering people tailored lifestyle advice to equip them with the knowledge to manage their risk of developing vascular disease. There is also assistance in the form of lifestyle, services, such as weight management, smoking cessation, 'exercise on referral', healthy walking clubs and many more, which people can be referred to.

Quotes from GP practices providing the service:

''There is no doubt that the Health Check service has, on many occasions, highlighted potential problems with patients who, because they have been diagnosed early are on treatment early, and thus any serious effects have been avoided. The patient group that are being called in are usually the ones that do not come to the GP very often, so having the ability to give them a full MOT is invaluable.

The patient satisfaction with the service has been excellent, and our nurses who undertake the checks have found them interesting to do from a clinical point of view.

We, as a practice, hope the funding for this vital service will continue."

"The NHS Health Check has identified a number of patients with diabetes who may otherwise have gone undetected. Where the patient is identified in the early stages of diabetes type II, lifestyle changes have been made and the symptoms reduced or alleviated completely.

Having an NHS Health Check has encouraged some patients to make a concerted effort to lose weight. One patient has managed to lose two stone and five inches from around his waist. His cholesterol (LDL) has dropped from 5.7 to 4.8 and in, his own words has 'turned his life around'".

The future of the NHS Health Check Programme

The Public Health White Paper: Healthy Lives, Healthy People[3] highlights that the NHS Health Check remains a priority, and will continue in its current format as a national 'must be done'.

The roll out of the Health Check Programme in Lincolnshire met agreed trajectories for 2011/12. The LES was written in consultation with GP practices and the Local Medical Committee. There are currently 4 GP practices out of 102 which are not signed up to the LES; this will impact on the planned full roll out for the current year (2012/13). As a LES is agreed with each individual practice, currently, practices are not obliged to take part. Each individual practice decides whether they wish to provide the service to their patients.

The inclusion of the NHS Health Check on the NHS Lincolnshire corporate dashboard; quarterly reports written and sent to senior managers, including the Accountable Officers of the newly formed Clinical Commissioning Groups (CCGs); Public Health Assistant Directors raising the profile of the programme with their respective CCGs; and the backing of Lincolnshire County Council's Health Scrutiny Committee, have all had a positive impact on the number of GP practices which have signed up to the LES in 2012/13. We hope by continuing to raise the profile of the programme and reporting on the positive outcomes for patients, that the few remaining practices will see the advantages of offering this service to their patients.

Conclusion

The benefits of the NHS Health Check include:

- enabling more people to be identified at an earlier stage of vascular change, therefore offering a better chance of putting in place positive ways to substantially reduce the risk of premature death or disability;
- preventing the development of diabetes in many of those at increased risk of this disease;
- sustaining the increase in life expectancy and reduction in premature mortality that are under threat from the rise in obesity and sedentary living;
- offering an opportunity to make significant inroads into health inequalities, including socio-economic, ethnic and gender inequalities;
- reducing the number of secondary care admissions due to cardiovasular disease events.

The NHS Health Check programme has been generally well received in Lincolnshire, with an encouraging sign up from GP practices and a 67% uptake rate in 2011/12 by those people sent an invitation.

Now at full roll out in 2012/13, the small service gap of practices choosing not to participate will have some impact on us being able to reach the number of people we would have hoped to, but, on a positive note, we have met our trajectories in previous years, and practices have assessed over 50,000 people and diagnosed over 2000 cases of vascular disease as a result.

The programme is now in its fourth year, and we need to place a real emphasis on promoting the huge part that lifestyle plays on a person's risk of developing vascular disease. As those at highest risk are being seen, those at a lower estimated risk will be getting calls for their assessments, and may feel that the lack of underlying disease means that they will not develop vascular disease in the future. Everyone is at some risk, and this risk can be reduced considerably by making, often quite small, changes in behaviour. For example, if you are overweight or obese, a 5% reduction in weight can bring real health benefits. If you do no exercise, then starting to do just 'some' will bring improvements in health, and stopping smoking can reduce your risk considerably.

Lincolnshire has lifestyle services in place, such as weight management, smoking cessation and 'exercise on referral', to support those wishing to improve their health and lower their risk of developing vascular disease in the future. In 2012/13 we have increased the number of weight-management places available, and will continue to manage these services so that they are best suited to meet the needs of the people of Lincolnshire.

Recommendations

The commissioners, public health teams and providers work together to increase the number of NHS Health checks offered, increase the uptake rate and agree a way to cover the service gaps.

The commissioners, Public Health teams and providers work together to ensure that every eligible individual is offered high quality lifestyle advice and when appropriate, a referral to a lifestyle service.

Appendix - Disease Outlines

Diabetes – Diabetes occurs when the level of glucose (sugar) in the blood becomes higher than normal. There are two main types of diabetes - type 1 diabetes and type 2 diabetes. Type 2 diabetes used to be known as maturity onset, or non-insulin-dependent diabetes. It develops mainly in people older than the age of 40 (but can also occur in younger people). In the UK, about one in 20 people aged over 65, and around one in five people over 85, have diabetes.

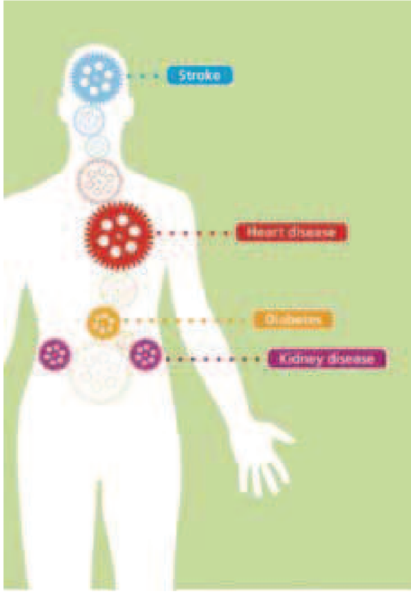
Hypertension – High blood pressure is one of several 'risk factors' that can increase an individual's chance of developing heart disease, stroke, and other serious conditions. As a rule, the higher the blood pressure, the greater the risk. Treatment includes a change in lifestyle risk factors where these can be improved - losing weight if you are overweight, regular physical activity, a healthy diet, cutting back if you drink a lot of alcohol, stopping smoking, and a low salt and caffeine intake. If needed, medication can lower blood pressure.

CKD (Chronic Kidney Disease) – Chronic kidney disease means that your kidneys are not working as well as they once did. Various conditions can cause CKD. Severity can vary, but most cases are: mild or moderate, occur in older people, do not cause symptoms and do not progress to kidney failure. People with any stage of CKD have an increased risk of developing heart disease or a stroke. This is why it is important to detect even mild CKD, as treatment may not only slow down the progression of the disease, but also reduces the risk of developing heart disease or stroke.

FH (Familial hypercholesterolaemia) - Familial hypercholesterolaemia is an inherited condition, in which the level of low-density lipoprotein (LDL) cholesterol in the blood is higher than normal from birth. The condition may be discovered at a routine health check, or by noticing some of the features, such as fatty lumps on the skin or around the eyes.

AF (Atrial Fibrillation) – Atrial fibrillation causes a fast and erratic heartbeat. It is a complication of various diseases. Medication can slow the heart rate back to normal, and ease symptoms. In some cases, treatment can restore the heart back to a normal rhythm. In addition, a drug such as warfarin is usually advised to reduce the risk of having a stroke.

PVD (Peripheral Vascular Disease) - Peripheral Vascular Disease is narrowing of one or more arteries (blood vessels). It mainly affects arteries that take blood to the legs. The condition is also known as peripheral arterial disease. It is also sometimes called hardening of the arteries of the legs.



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Childhood Obesity

What is childhood obesity?

Overweight and obesity are terms used to describe an excess of body fat, which results from an energy imbalance where more energy is taken in compared to what is consumed.

Within the UK, overweight and obesity are assessed among adults using the Body Mass Index (BMI). For children, there are no clearly defined BMI criteria, as weight and height vary considerably depending upon age and stage of development. Instead, overweight and obesity are defined for children using the British 1990 growth reference charts, where the weight status of the child is classified according to their age and sex. Children with a weight at or above the 95th centile are classified as obese, and children between the 85th and 95th centiles are classified as overweight. Because this method of measurement takes into account the age and gender of the child, and matches it with measurements taken from British children before the current high levels of obesity were observed, it is widely acknowledged to be the most accurate way to identify weight problems in children under 12 years of age.

Classification	BMI Centile
Underweight	≤2nd centile
Healthy Weight	2nd centile – 84.9th centile
Overweight	85th centile – 94.5th centile
Obese	≥95th centile
Atrial Fibrillation	41
Peripheral Vascular (Arterial) Disease	13

Classification of children's BMI

Children who are overweight or obese early in life are at greater risk of developing serious health problems. The World Health Organisation states;

'Overweight children are likely to become obese adults. They are more likely than non-overweight children to develop diabetes and cardiovascular diseases at a younger age, which in turn are associated with a higher chance of premature death and disability.'[1]

Being obese or overweight brings significant risks at a range of different points throughout life (NHS Information Centre 2011). The health risks for adults who do not maintain a healthy weight status are somewhat concerning. Evidence from the Department of Health[2] suggests that, when compared with an adult healthy-weight male, an obese male is:

- five times more likely to develop type 2 diabetes;
- three times more likely to develop cancer of the colon;
- more than two and a half times more likely to develop high blood pressure, which is a major risk factor for stroke and heart disease.

Similarly, an obese woman, compared with a healthy weight woman, is:

- almost thirteen times more likely to develop type 2 diabetes;
- more than four times more likely to develop high blood pressure;
- more than three times more likely to have a heart attack.

Antenatal and postnatal risks

Obesity in pregnancy is associated with an increased risk of serious adverse outcomes, including miscarriage, foetal congenital anomaly, thromboembolism, gestational diabetes, pre-eclampsia, dysfunctional labour, postpartum haemorrhage, wound infections, stillbirth and neonatal death. Obese women also tend to contribute to a higher caesarean section rate and lower breastfeeding rates compared with women with a healthy BMI.

The Government's Foresight Project Report, Tackling Obesities: Future Choices[3] highlights the 'generational dimension' of obesity, claiming that children of parents who are overweight or obese are also more likely to have difficulty maintaining a healthy weight.

How do we know what the picture of obesity looks like in Lincolnshire? The National Child Measurement Programme (NCMP).

The NCMP takes place annually between September and June during the school academic year. The children involved are those in reception year (aged 4/5 years of age) and year 6 (aged 10/11 years of age).

Over the past four years, the percentage of children taking part in this process has improved, and we now have a robust set of measurements to give us a snapshot of the numbers of overweight and obese children within the targeted age groups in Lincolnshire.

The numbers of overweight children in both reception and year 6 have demonstrated a slight increase (not statistically significant) over the past 12 months.

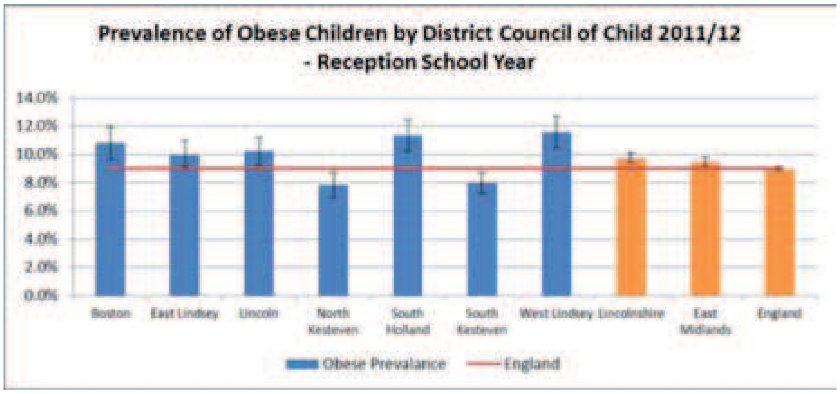
Despite showing a slight decrease over the past 12 months, the numbers of year 6 children identified as obese has remained around 19% of the population. It is clear, looking at these figures for each school year, that there is a consistent doubling of the numbers of obese children during their first seven years of school (Figure 3.1).

Figure 3.1: Prevalence of Overweight and Obese Children in Lincolnshire 2008/09 to 2011/12

Indicator		**2008/9**	**2009/10**	**2010/11** **2011/12**	**2010/11**
Reception (age 4-5 yrs.)	Overweight	15%	15%	14.4% 15.4%	38445
	Obese	9.9%	10.8%	9.4% 9.7%	3625
	Overweight or obese	24.9%	25.8%	23.8% 25.1%	34820
Year 6 (age 10-11 yrs.)	Overweight	**16%**	**15.5%**	**15.1%** **15.7%**	**34199**
	Obese	18.5%	19.5%	20.2% 19.4%	25840
	Overweight or obese	34.5%	35%	35.3% 35.1%	99.0%
		87.5%	79.9%	89.4%	75.6%
		11.8%	10.7%	7.7%	9.4%

Source: NHS Lincolnshire Dataset

Figure 3.2: Reception Year Prevalence of Childhood Obesity by District Council 2011/12

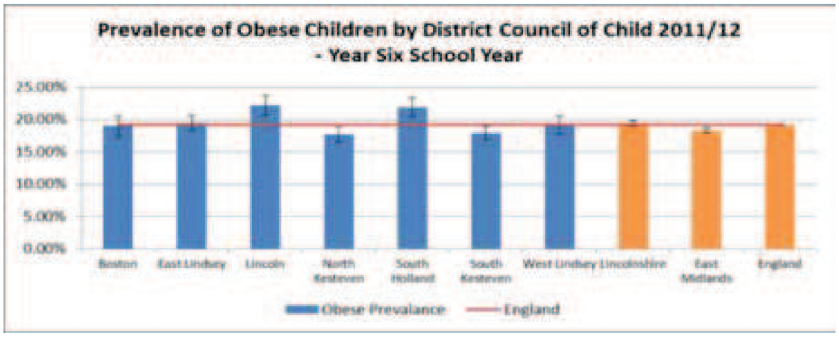


Source: NHS Lincolnshire Dataset

Figure 3.2 shows that reception year children in Lincolnshire exhibit higher levels of obesity than the England and East Midlands average.

The only district councils in Lincolnshire which demonstrate statistically significantly lower numbers of obese reception year children compared to England as a whole are North and South Kesteven.

Figure 3.3: Year 6 Prevalence of Childhood Obesity by District Council 2011/12



Source: NHS Lincolnshire Dataset

The prevalence of obesity in year 6 children continues to be above the England and East Midlands averages.

Two areas of the county, Lincoln and South Holland, demonstrate significantly higher levels than England (figure 3.3). Lincoln and South Holland also have statistically significantly higher prevalence of obesity compared to the Lincolnshire average.

The obesity data for reception and year 6 in 2011/12 continues to demonstrate a doubling of the numbers of children measured as being obese in these year groups.

Nevertheless, in some areas of the county the outcomes exceed this average increase. Lincoln City increased from 10.2% to 22.2%, North Kesteven from 7.8% to 17.7% and South Kesteven from 8.0% to 17.9%.

Childhood obesity and gender

Similar to national trends, the analysis of local Lincolnshire data demonstrates that the prevalence of obesity is higher among boys than girls. In 2011/12, 9% of reception-age girls were obese compared to 10.5% of boys.

The numbers of year 6 girls who are being identified as obese has continued to rise year on year since 2006: reaching 17.7% by 2011/12. Nevertheless, this is lower than the prevalence in year 6 boys which was 21.1% in 2011/12.

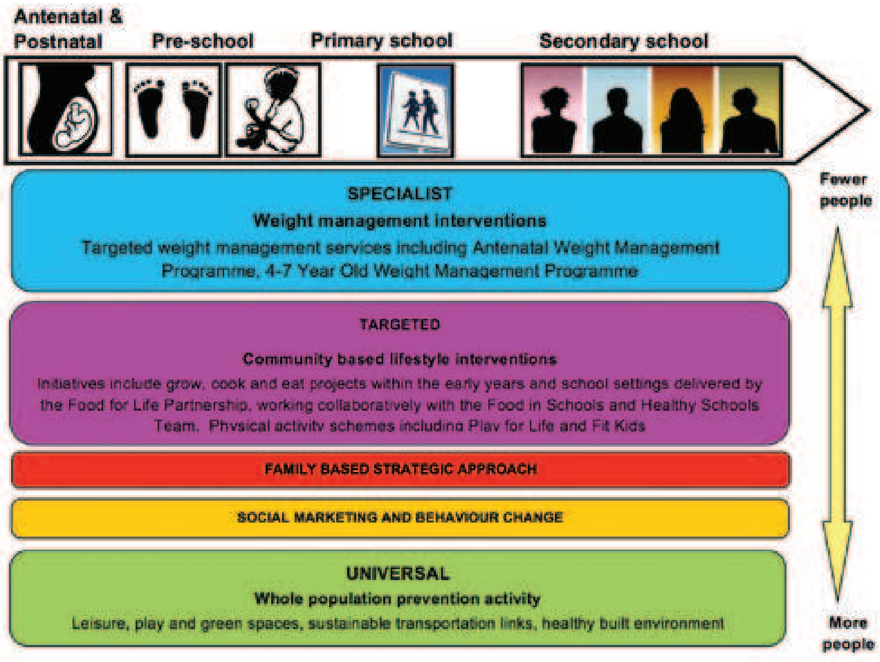
Childhood obesity and deprivation

The prevalence of obesity varies with deprivation. The Index of Multiple Deprivation (IMD 2010) quintile one indicates those who are most deprived, and quintile five those least deprived. The Lincolnshire data demonstrates a correlation between deprivation and overweight/obesity levels. Those in the most deprived groups have a statistically significantly higher prevalence of overweight and obesity compared to those in the more affluent quintiles for both reception and year 6 pupils.

Implementing a 'life course approach' to reduce childhood obesity

The 'life course approach' recognises that there are important stages in peoples lives where they are more likely to change their behaviour or come into contact with health services. We have taken this evidence-based approach as one of the key themes for tackling childhood obesity in Lincolnshire, to ensure we provide a comprehensive map of interventions to target children and their families across their life stages. Figure 3.4 shows the life course approach in Lincolnshire, where a range of interventions are implemented at different tiers (universal, targeted and specialist).

Figure 3.4: Description of the Life Course Approach to reducing Childhood Obesity in Lincolnshire



Conclusion

The health, social and personal costs associated with the consistent increase in the numbers of children and adults who are not maintaining a healthy weight are high. If we don't start to reduce the numbers of overweight or obese children and adults in Lincolnshire, this will undoubtedly overwhelm services, and not just health services, in the future.

Over the past four years, we have observed that the proportion of children identified as being obese at year-6 is double that of reception year pupils. Therefore, the necessity to understand what is affecting our children's ability to maintain a healthy weight during these informative early school years is imperative.

To reverse the childhood obesity crisis in Lincolnshire, we must support families to make healthier food choices, give portion sizes appropriate to the child's age and keep physically active and healthy. It is necessary to do this at home, in pre-school nursery and at school.

We are providing interventions across each area of the child's lifetime: during pregnancy, early years and throughout their school years. This is supported by the following recommendations:

- Raise the profile and implications of childhood obesity with local communities
- Support mothers to effectively breastfeed
- Promote healthy food choices and appropriate portion sizes in the home, nursery and school
- Increase the numbers of children eating healthy school meals and reduce the numbers of those eating unhealthy packed lunches
- Promote active lifestyles in the home, nursery and school
- Increase customer insight and media use to raise the profile of childhood obesity e.g. 'me-sized' plates

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References

1 The World Health Organisation, 10 Facts on Obesity; http://www.who.int/features/factfiles/obesity/facts/en/index2.html accessed 17/12/12

2 The Department of Health, Facts & Figures on Obesity; http://www.dh.gov.uk/health/2012/04/obesityfacts/ accessed 17/12/12

3 Foresight Project Report 2007, Tackling Obesities: future Choices 2nd edition, Government Office for Science, p8

Public Health Support to Clinical Commissioning Groups

Introduction

For over one hundred years, responsibility for public health was a statutory function of local authorities, but since 1974 has been located within the NHS, most recently within Strategic Health Authorities and Primary Care Trusts (PCT). During this time, specialist public health staff have assumed the lead for three major responsibilities on behalf of the NHS and local communities:

- Health improvement eg lifestyle factors and the wider determinants of health;
- Health protection eg preventing the spread of communicable diseases, leading the NHS response to major incidents, and screening programmes;
- Population healthcare eg input to the commissioning of health services, evidence of effectiveness, care pathways.

Under the Health and Social Care Act 2012, on 1st April 2013 primary responsibility for health improvement and health protection will transfer at the national level from the NHS to Public Health England, and at local level from PCTs to upper tier local authorities. Responsibility for strategic planning and commissioning of NHS services will transfer to the NHS Commissioning Board and to Clinical Commissioning Groups (CCGs). Around 60 Public Health staff currently employed by NHS Lincolnshire will transfer to Lincolnshire County Council in April 2013, together with an annual budget of around £27 million.

There will be four CCGs in Lincolnshire:

- Lincolnshire East CCG (East Lindsey, Boston and Skegness)
- Lincolnshire West CCG (nearly all of West Lindsey, City of Lincoln and the northern half of North Kesteven)
- South Lincolnshire CCG (South Holland, Bourne, Stamford and the Deepings)
- South West Lincolnshire CCG (Grantham and Sleaford and surrounding areas)

CCGs will be responsible for improving the health of the population and reducing health inequalities within their area, and the commissioning of many NHS services - effectively, all health services except primary care, public health and specialised services - from NHS and private sector providers. The four Lincolnshire CCGs will, between them, spend around £900 million per year.

CCGs will not directly employ Public Health specialists. Rather, each CCG will obtain its public health advice and support from staff employed by the relevant local authority. The Department of Health has mandated local authorities to provide this support, funded from the ringfenced Public Health grant that they will receive. The Department of Health has indicated that around 40-50% of public health staff time should be allocated to work for CCGs.

In Lincolnshire, a Memorandum of Understanding has been agreed with each of the four CCGs, which sets out in detail what support will be provided for each of the three main areas of public health work: health improvement, health protection and population healthcare. This document will be reviewed annually.

Health Improvement

The Health and Social Care Act 2012 gives Lincolnshire County Council a statutory duty to improve the health of the population of Lincolnshire and reduce health inequalities, from April 2013. Clinical Commissioning Groups will be required to secure continuous improvement in health, and to reduce inequalities in the outcomes achieved by health services. This will require action along the entire care pathway from prevention to tertiary care. In addition, the NHS will only be able to remain within budget in future years if there is successful implementation of preventive measures to reduce the burden of disease that results from, for example, smoking, alcohol, obesity and falls.

Lincolnshire County Council and Lincolnshire's Clinical Commissioning Groups therefore have a collective interest in health improvement. The expectations for 2013/2014 are that:

Lincolnshire County Council's Public Health Directorate will:

- Refresh current strategies and action plans to improve health and reduce health inequalities, with input from Clinical Commissioning Groups.
- Lead on the commissioning of cost effective, equitable lifestyle services based on local needs and evidence of good practice.
- Ensure that lifestyle services are evaluated and monitored, and that they support CCGs in their role of improving health and addressing health inequalities.
- Work with all areas of service of Lincolnshire County Council, and with the seven district councils in Lincolnshire, to embed ownership and leadership of health improvement across the county.

- Lead media campaigns on lifestyle issues, and provide staff who can give media interviews.
- Support primary care to improve health - for example, by offering training opportunities for staff, and through targeted health information campaigns.
- Facilitate partnership working between Clinical Commissioning Groups, local partners and residents to integrate and optimise local efforts for health improvement and disease prevention.

Lincolnshire Clinical Commissioning Groups will:

- Contribute to strategies and action plans to improve health and reduce health inequalities.
- Work with constituent practices to help maximise their contribution to disease prevention – for example, by taking every opportunity to address smoking, alcohol, and obesity in their patients and by optimising management of long-term conditions.
- Ensure that primary prevention and lifestyle services are considered within the commissioning process, and are an integral part of all care pathways.
- Play a full part in the work of the Lincolnshire Health and Wellbeing Board.

Health Protection

The Health and Social Care Act sets out that the Secretary of State for Health is responsible for taking steps for the purpose of protecting the health of the population. Regulation-making powers will be used to require local authorities (through the Director of Public Health on their behalf) to ensure that plans are in place to protect the health of the local population from threats ranging from relatively minor outbreaks to full-scale emergencies, and to prevent as far as possible those threats arising in the first place. The scope of this duty will include local plans for immunisation and screening, as well as the plans acute providers and others have in place for the prevention and control of infection, including those which are healthcare associated.

Thus, as with health improvement, Lincolnshire County Council and Lincolnshire's Clinical Commissioning Groups have a collective interest in ensuring that the arrangements for health protection within the county are robust. The expectations for 2013/2014 are that:

Lincolnshire County Council's Public Health Directorate will:

- Assure that strategic plans are in place for responding to the full range of potential emergencies – for example, pandemic flu, fuel crises, flooding, and other major incidents.
- Assure that these plans are adequately tested.
- Assure that Clinical Commissioning Groups have access to these plans and an opportunity to be involved in any exercises.
- Assure that any preparation required – for example, training, access to resources - has been completed.
- Assure that the capacity and skills are in place to co-ordinate the response to emergencies, through strategic command and control arrangements.
- In conjunction with Public Health England provide specialist advice to Clinical Commissioning Groups and constituent practices on health protection issues.
- Monitor the effectiveness of national screening programmes within Lincolnshire.

Lincolnshire Clinical Commissioning Groups will:

- Familiarise themselves with strategic plans for responding to emergencies.
- Participate in exercises when requested to do so.
- Ensure that any provider contracts they have responsibility for include appropriate business continuity arrangements.
- Work with constituent practices to develop business continuity plans to cover action in the event of the most likely emergencies.
- Assist with co-ordination of the response to emergencies, through local command and control arrangements.
- Ensure that resources are available to assist with the response to emergencies, by invoking provider business continuity arrangements, and through action by constituent practices. Staff employed by CCGs will be made available to assist in the response to emergencies.

Population Healthcare

The Health and Social Care Act establishes Clinical Commissioning Groups as the local commissioners of NHS services, and gives them a duty to continuously improve the effectiveness, safety and quality of services. The Lincolnshire Health and Wellbeing Board has been established to identify the needs of the population, and ensure that these needs are addressed through Clinical Commissioning Groups, public health and social care commissioning plans and activities, and the commissioning plans of the NHS Commissioning Board.

The expectations for 2013/2014 are that:

Lincolnshire County Council's Public Health Directorate will:

- Provide specialist public health advice to Clinical Commissioning Groups.
- Lead the work of the Lincolnshire Health and Wellbeing Board.
- Continuously refresh the Joint Strategic Needs Assessment (JSNA), to specify the needs of the population and ensure that this is relevant at the level of each Clinical Commissioning Group. The production of the JSNA will be complemented by a programme of targeted needs assessments and profiles for each CCG.
- Ensure that insight data, such as Mosaic, is used to help target services appropriately.
- Lead implementation of the Joint Health and Wellbeing Strategy.
- Work on care pathways, including review of the evidence of effectiveness, and work with clinicians.
- Provide specialist support in relation to named patient funding requests.
- Respond to media requests for interviews on topical healthcare issues.

Lincolnshire Clinical Commissioning Groups will:

- Consider how to incorporate specialist public health advice into decision making processes, in order that public health skills and expertise can inform key commissioning decisions.
- Ensure that their commissioning plans are underpinned by the Joint Strategic Needs Assessment, and support the implementation of the Joint Health and Wellbeing Strategy.

Level of Public Health Support to CCGs

Lincolnshire's public health directorate has recently been restructured to ensure that we can meet the needs of our CCGs for public health support. Currently, at a senior level, we employ a Director of Public Health and 5.6 wte consultants in public health, plus trainees and staff at a more junior level.

Three teams will provide public health support to Lincolnshire CCGs, i.e. one for Lincolnshire West CCG, one for Lincolnshire East CCG, and one for South Lincolnshire CCG and South West Lincolnshire CCG. Each team will be led by a Public Health consultant who will normally be a member of the Governing Body and Executive Committee, and input from the team will, as a minimum, consist of:

- Three days per week from Public Health consultants
- One day per week from a Public Health programme manager
- Share of the work of Public Health trainees and other Public Health Directorate staff

Recommendations

1. That Lincolnshire County Council's Public Health Directorate and the four Clinical Commissioning Groups in Lincolnshire cooperate fully to improve health, and reduce health inequalities, across the three domains of Public Health practice: health improvement, health protection and population healthcare.
2. That Lincolnshire's Clinical Commissioning Groups continue to play a full part in the production of the Joint Strategic Needs Assessment, and the implementation of the Joint Health and Wellbeing Strategy.
3. That around half of the staff time of Lincolnshire's Public Health directorate be devoted to work on behalf of NHS commissioners.

Health Protection

Health Protection is one of the three component parts of Public Health. Through this part of our work we seek to prevent or reduce the harm caused by communicable diseases, minimise the health impact of environmental hazards, including chemicals, radiation and physical threats, and identify early disease. We do this in a wide variety of ways, and almost always in partnership with other parts of the NHS or with other agencies. This chapter aims to set out some of this work, and make recommendations on the way forward as these public health responsibilities move from the NHS to upper tier local authorities.

Communicable Diseases

Currently, responsibility for the surveillance and control of communicable diseases is split. Much of the statutory responsibility lies with the Primary Care Trust (PCT), although district councils have responsibilities under a number of statutes. The day-to-day work on surveillance and management of single cases or outbreaks of infections such a salmonellosis, legionella and hepatitis is undertaken by staff within the Health Protection Agency, supported by environmental health officers and community nursing staff. Healthcare acquired infections, such as MRSA, Clostridium difficile and E. coli are a shared responsibility between the Public Health Team and the organisation treating the person affected. This works well with NHS providers, but requires much more Public Health input with primary care and social care providers.

The Director of Public Health has a key role in coordinating and leading this work. The Department of Health wants this coordination role to continue, and has set out in guidance that “the local leadership of the Director of Public Health will play an important part in ensuring the local authority and local partners are supporting preventative services that tackle key threats to the health of local people”. One of the key areas we need to tackle in Lincolnshire is raising awareness of the risks of infectious diseases. This would include blood-borne and sexually transmitted viruses, such as Hepatitis B and C, where excellent vaccines are available, which are not used as much as they should be, and tuberculosis where high risk groups, such as migrant workers and the homeless present a particular risk.

At present Public Health staff lead the development of health protection plans for outbreaks of communicable disease and the prevention and control of infection, and this will continue.

Responsibility for commissioning immunisation programmes will move from the PCT to the NHS Commissioning Board, but the Director of Public Health will have a role in “supporting, reviewing and challenging local plans for, and delivery of, immunisation programmes”. This will particularly consider inequalities in uptake rates and whether the programmes are meeting local needs. Where we identify issues that need addressing we will provide “advice, challenge and advocacy”. This will utilise leadership skills within public health and good relationships with clinicians and Clinical Commissioning Groups (CCGs). Other channels for resolving difficulties will include the DPH annual report and reports to the Health and Wellbeing Board.

The Public Health Team will continue with its role in community infection control, and will continue to give advice on healthcare acquired infection to CCGs.

Environmental Issues and Hazards

The Public Health Team currently has a role in giving advice on the health aspects of environmental issues and hazards. This is both in terms of trying to reduce the health risks in the environment through advice to planners, the Environment Agency and others, and in supporting the multiagency response to a wide range of incidents. These might be air pollution, water pollution including drinking water, chemical leaks, fires, floods and so on. Most of these require multiagency planning and exercising in preparation.

The local authority, through their Director of Public Health will take over responsibility for local initiatives to reduce the public health impact of environmental risks. The position of the Public Health Team within the local authority gives added opportunities to influence environmental issues.

The future of health input to emergency planning and managing emergency situations is more complex. Many of these require specialist Public Health advice, and this will continue to be available through the Director of Public Health and Public Health England. The responsibility for the NHS contribution to emergency planning, and for preparing NHS plans, will now be with the NHS Commissioning Board. The interdependence of these two contributions is the reason why the local Director of Public Health and a director from the Local Area Team of the Commissioning Board will co-chair a new executive level partnership to oversee health emergency planning and link with the multiagency planning. This will be called the Local Health Resilience Partnership.

Screening Programmes

The NHS currently commissions a range of screening programmes, which were described in some detail in chapter 3 of the 2011 Annual Public Health Report. These include a number which relate to pregnancy and very early childhood – screening the mother for Hepatitis B, HIV and syphilis; and new-born hearing screening; some programmes to pick up early cases of cancer – breast, cervix and bowel; and some adult screening programmes for other conditions – diabetic retinopathy and abdominal aortic aneurysm. The actual programmes to be commissioned across the whole country are decided by the National Screening Committee, which is part of the National Institute of Health and Clinical Excellence.

Responsibility for commissioning screening programmes is not transferring to local authorities as part of their public health functions but to the NHS Commissioning Board supported by staff from Public Health England. What is transferring is a role for the Director of Public Health to have an oversight of screening programmes. This role is similar to that with immunisation programmes – ensuring that programmes meet local needs, especially in relation to inequalities, advice to commissioners and providers, and advocacy. There will be a particular role if a serious incident occurs, where the Director of Public Health and the rest of the Public Health Team may need to lead the overall health community response to the incident.

Next Steps

These programmes often involve a large number of provider organisations. For example, cervical screening involves the organisation providing the NHS register for call and recall; GPs, practice nurses, and sexual health services to take the test; pathology services; Public Health staff and voluntary organisations raising awareness; and hospital services. Add to this mix an increased number of organisations involved in commissioning and coordination, and it can be seen that these changes lead to a considerable level of uncertainty in the delivery of some of the most critical public health programmes.

This makes the local Public Health role critical to the safety and success of these programmes. In Lincolnshire we are putting in place a team of experienced staff, led by Public Health consultants to ensure that we deliver these outcomes.

Recommendations

1. That all NHS organisations in Lincolnshire ensure that they have a high-level executive input to the Local Health Resilience Partnership, and give serious consideration to its decisions and recommendations.
2. That a Health Protection Group is established involving commissioners and providers, to assist the Director of Public Health to give advice, challenge and advocacy.
3. That the Local Area Team of the NHS Commissioning Board continue with the current coordination arrangements for each of the screening programmes.

Conclusions and Recommendations

This report highlights some really beneficial improvements which could be made in services for people with learning disabilities. This type of health needs assessment offers objective guidance on the unmet needs of the population which can be used to reconfigure existing services. Very often, meeting these needs now will avoid costly requirements in the future, as well as improving quality of services, and life.

A similar opportunity exists with the NHS Health Check Programme. For example, with a population in this country which is considerably overweight, one difficulty is that being overweight becomes the norm, and people may not even realise that they need to lose weight. Identifying a need to lose weight now, and giving modest help to achieve this, will result in less heart disease, fewer people with diabetes and fewer older people with immobility requiring social and healthcare, amongst other benefits. You can see that this gives better quality of life for many people in Lincolnshire, and better use of the collective resources of organisations in the county.

The NHS reforms present us with many opportunities, and the recommendations below seek to maximise those opportunities and address the potential risks. I hope organisations in Lincolnshire will take these recommendations and use them to improve our collective health.

1. The Learning Disability Joint Commissioning Board should ensure joint plans are in place to meet the needs of service users, including increased demand from more adults with learning disabilities.
2. Primary care should be encouraged to identify and record all people with learning disabilities.
3. Preventive healthcare and Public Health activities should be reviewed to ensure provision across Lincolnshire.
4. All services should provide the opportunity for adults with learning disabilities to access healthy lifestyle initiatives and services.
5. All GP practices should be encouraged to provide annual healthchecks for people with a learning disability.
6. Frontline staff should receive training on learning disability awareness in order to develop their clinical skills, so that they are equipped to meet the health needs of this group.
7. Commissioners, Public Health Teams and providers should work together to increase the number of NHS Health Checks offered, increase the uptake rate and agree a way to cover the service gaps.
8. Commissioners, Public Health teams and providers should work together to ensure that every eligible individual is offered high quality life style advice and, when appropriate, a referral to a lifestyle service.
9. All involved with children should raise the profile and implications of childhood obesity with local communities.
10. Maternity primary care and children's services should support mothers to effectively breastfeed
11. We should all promote healthy food choices and appropriate portion sizes in the home, nursery and school.
12. Schools need to increase the numbers of children eating healthy school meals and reduce those eating packed lunches.
13. We all need to promote active lifestyles in the home, nursery and school.
14. Lincolnshire County Council's Public Health Directorate and the four Clinical Commissioning Groups in Lincolnshire should cooperate fully to improve health and reduce health inequalities, across the three domains of public health practice: health improvement, health protection and population healthcare.
15. Lincolnshire's Clinical Commissioning Groups should continue to play a full part in the production of the Joint Strategic Needs Assessment, and the implementation of the Joint Health and Wellbeing Strategy.
16. Around half of the staff time of Lincolnshire's Public Health Directorate should be devoted to work on behalf of NHS commissioners.
17. All NHS organisations in Lincolnshire should ensure that they have a high-level executive input to the Local Health Resilience Partnership and give serious consideration to its decisions and recommendations.
18. A Health Protection Group involving commissioners and providers should be established to assist the Director of Public Health with the duties of giving advice, challenge and advocacy.
19. The Local Area Team of the NHS Commissioning Board should continue with the current coordination arrangements for each of the screening programmes.

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COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of Glen Garrod, Director of Adult Social Services

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**11 June 2013**
Subject:	**Dementia Strategy Update**

Summary:

A partnership approach to the review of the previous Dementia Strategy and the development of the new Dementia Strategy has been initiated with the launch of a consultation during Dementia Awareness Week, and the introduction of a Dementia Core Group to steer the Lincolnshire agenda. Discussions around a Lincolnshire Dementia Partnership and a resulting Customer Journey and Pathway have begun, alongside a mapping exercise to establish gaps in service and provision.

Actions Required:

For the Board to:

1. Note the launch of the Consultation
2. Comment on the attached discussion document
3. Agree the approach to partnership working

1. Background

The Lincolnshire Joint Commissioning Strategy for Dementia Care 2010 – 2014 was published in June 2010. As part of the continued partnership work between Lincolnshire County Council and the four Lincolnshire CCGs it was decided that the current strategy would be reviewed and a new strategy agreed that supported the national drivers, and considerable national agenda for change and improvement, alongside local drivers and needs.

As part of the review, a consultation has begun that will take place between 20 May and 19 July 2013. This consultation includes a questionnaire (Appendix A) that examines the impact of the current strategy, asks about current services and pathways, and seeks information about service gaps and improvement opportunities. The consultation will also include a number of events held around the County to discuss local issues in more depth and to establish a robust picture of current thoughts and future thinking around dementia in Lincolnshire.

Alongside the work around the consultation, we have also sought to begin a local 'conversation' about dementia. This begun at the Dementia Summit held in February 2013, and has continued through the establishment of a Dementia Core Group with members from CCGs, Health providers, Public Health, the Third sector and Adult Care. This group has been formed to help shape the future direction of dementia services across Lincolnshire, by sharing priorities, opportunities, ideas and risks. A partnership approach to taking forward the dementia partnership in Lincolnshire is being sought and the attached discussion paper on a Lincolnshire Dementia Partnership (Appendix B) has been shared with the group in order to agree the cornerstones of a partnership approach in terms of shared principles, outcomes and actions.

At the heart of the current discussions is an agreed journey and pathway for dementia in Lincolnshire. The journey (based on national best practise models) lays out six phases of a pathway, and we have sought to mirror all discussions around dementia around these phases – for example, the current consultation is constructed around the phases.

Phase 1	• When memory or changing behaviour problems have prompted me, my family or carer to seek help
Phase 2	• Learning that the condition is Dementia
Phase 3	• Learning more about the disease, how to manage, options for treatment & care, and support for me & my family & carers
Phase 4	• Getting the right help at the right time to live with Dementia, prevent crisis and manage together
Phase 5	• Managing at more difficult times, including if possible to live at home
Phase 6	• Receiving care, compassion, and support at the end of life

Although a new strategy is clearly needed for the County, we do not want to wait until we have a new document before making changes. The Dementia Core Group is currently analysing potential 'quick wins' and is sharing knowledge in order to deliver improvements. We are also analysing where potential pilot work can begin in order to demonstrate the potential for change and improvement through adoption of a new journey and pathway

2. Conclusion

It is hoped that through both the Dementia Core Group and the Health and Wellbeing Board, agreement to this partnership approach; the shared principles, outcomes and actions; and the dementia journey and pathway can be achieved. Agreement at this level will allow us to proceed with a joined up approach to strategy, commissioning and development that will deliver Lincolnshire an improved and effective system to support people affected by dementia.

3. Consultation

A Public Consultation has begun and ruins from 20 May to 19 July 2013.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Consultation Paper
Appendix B	Lincolnshire Dementia Partnership Discussion Paper

5. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

This report was written by Richard Collins who can be contacted on 01522 554012 or richard.collins@lincolnshire.gov.uk

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Appendix A

Lincolnshire Joint Strategy for Dementia 2010-2014 Refresh

Consultation Questionnaire

The aim of this questionnaire is to help improve the experience of people living with dementia in Lincolnshire.

It may be completed by anyone who has experience of or an interest in dementia. You may be living with dementia yourself, or living with dementia by caring for a loved one. You might be a professional in the field of health or social care, or working for a care provider or the voluntary sector. You may simply have an interest in promoting better dementia services in the county.

The first section asks questions about the impact of the current Dementia strategy, and your views about priorities for the future.

The sections after that ask questions about your own experiences, using the **Dementia Journey** below as a guide. This deepens our understanding of what is working and helps identify priorities for improvement.

There are opportunities throughout for you to give your ideas.

We recognise that this is a personal and sensitive subject, and ask you to respond in a way that is right for you. We would like to thank you in advance for your time and help.

The Dementia Journey[1]

Phase 1	• **When memory or changing behaviour problems have prompted me, my family or carer to seek help**
Phase 2	• **Learning that the condition is Dementia**
Phase 3	• **Learning more about the disease, how to manage, options for treatment & care, and support for me & my family & carers**
Phase 4	• **Getting the right help at the right time to live with Dementia, prevent crisis and manage together**
Phase 5	• **Managing at more difficult times, including if possible to live at home**
Phase 6	• **Receiving care, compassion, and support at the end of life**

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[1] The Dementia Journey is designed by Dementia Partnerships UK

A refreshed strategy for Lincolnshire

Q1. How aware are you of the current Joint Lincolnshire Dementia Strategy?

	Yes/ No/ Don't Know
I am not aware of it	
I am aware of it	
Has it worked?	

Q.2 Do you think attitudes and awareness towards people living with dementia have changed in the last three years, since the launch of the National Dementia Strategy and Lincolnshire's Joint Dementia Strategy?

Thinking about…	**Yes/ No / Don't Know**
Healthcare professionals (e.g. GP, nurse)	
Social workers	
Care providers	
Voluntary organisations	
Shops, banks, supermarkets	
Employers	
Friends	
General public	
Any other comment – please explain	

Q3. What is most important to help improve attitudes and awareness towards people living with dementia (up to five priorities)?

Q4. Are you aware of some of the following national initiatives in Lincolnshire from the Prime Ministers Challenge?

Tick all that apply	**Yes/ No**	**Involved**	**Would like to know more or be involved**
Dementia Action Alliance			
Dementia Friendly Communities			
Dementia Friends			
Dementia Champions			

Q5. Thinking about the impact of the Joint Dementia Strategy over the last three years, has the experience of people living with dementia in Lincolnshire improved?

What people said was important in 2010	**Rate 1- 5 where 5 is most improved; 1 is least improved and 0 is 'Don't know'**
People with dementia and carers being at the heart of everything	
Easy access to accurate and up to date information	
Early diagnosis and swift follow up	
Easy to access medication and monitoring	
Identifying carers and support for carers	
Easy to access short breaks and respite	
Supportive, enjoyable social and community services	
Flexible, reliable and responsive care at home	
Stimulating and caring residential care	
Active respectful care in hospital and for end of life	

Q.6 Thinking about what needs to be achieved in the next three years, how important do you think are the following?

Thinking about…	**Rate how important this is on a scale of 1-5 where 5 is most important and 1 is least**
Joined up care and support from health, social care and the voluntary sector	
Earlier diagnosis, increased levels of diagnosis	
More support after diagnosis for people and carers living with dementia	

Dementia friendly communities	
Improving skills of families to understand and manage living with dementia	
Reliable, personalised support for people to live well at home	
Knowledgeable, skilful staff working in all sectors	
Reduced use of anti-psychotic medication (e.g. medication to manage behaviour)	
All service providers signed up to deliver the outcomes of the National Dementia Strategy	
Preventing unnecessary hospital admissions and delayed discharge	
Effective support for families when things get difficult	
Ensuring the most effective use of current spending on dementia	
The best possible care at the end of life for the person and carer	
Other priorities or comments (please specify)	

The next sections ask about your experience of getting help and support, and help us understand what is working well at present, and what requires improvement.

Phase 1

Seeking help

Q.7 When you or someone you know began to shows signs of changing behaviour or memory problems, where did you go for information or help? Please tick all that apply.

Source of help	**Yes/ No**	**Rate helpfulness on a scale of 1-5 where 5 is most helpful and 1 is least**
Family		
GP		
Nurse		
Pharmacist		
Voluntary organisation (name):		
Employer		
Friend		
Internet Website (name)		
Other – please explain		

Q.8 What other support would have helped ? Please list up to five priorities.

Phase 2
Learning that the condition is Dementia

Q.9 Have you or a loved one been given a diagnosis of dementia?

Yes	No	Not sure

Q.10 If yes, were you given information to help manage the present and plan for the future? Please tick all that apply.

Thinking about…	**Yes/ No**	**Rate helpfulness on a scale of 1-5 where 5 is most helpful**
Understanding dementia and how it might affect you; learning to manage its symptoms		
Appointments just for you as the carer		
Available treatment options		
Information about local help available		
National helplines and support		
Access to help for family carers		
Access to counselling		
Support groups		
Lincolnshire's online information and advice service www.mychoicemycare.org.uk		
Please tell us about your experience		

Q.11 What would have helped most after a diagnosis? Please tell us your priorities (up to five).

Phase 3
Learning more and planning for the future

Q.12 Have you had an assessment of your needs and a care plan? If so, were any of the following agencies involved? Tick all that apply.

Agency	**Yes/ No**	**Rate helpfulness on a scale of 1-5 where 5 is most helpful**
GP		
Lincolnshire Foundation Partnership Trust		
Psychologist		
Occupational Therapist (OT)		
Neurology		
Old age physician		
Lincolnshire County Council Adult Services		
Carers Team		
Voluntary organisation		
Were your needs as a carer taken into account?		

Q.13 What support have you and your family been offered to live with dementia? Tick all that apply.

Thinking about…	**Yes/ No**	**Rate helpfulness on a scale of 1-5 where 5 is most helpful**
Understanding more about dementia, its impact and managing its symptoms		
Ongoing health appointments and support		
A carer's assessment and carers emergency plan		
Access to counselling		
Dementia Awareness or Carers Education courses for families		
Help for the patient to manage memory loss		
Information about support groups		
Social care assessment		
Help with early onset dementia (under 65)		
Help if you have a learning disability and dementia		
Planning care for the future		
What to do in a crisis		

Information about managing money, lasting power of attorney & wills		
Adapting the home to make it more dementia friendly		
Housing options for the future		
No information and help		
Other (please specify)		

Q.14 What are your top five priorities to help families learn more about managing living with dementia and to plan for the future?

Phase 4
Living well with Dementia

Q.15 Thinking about living day to day with dementia, what helps you and your family to live as well as possible with the condition? Tick all that apply

Thinking about…	**Yes/ No/ Don't Know**	**Rate helpfulness on a scale of 1-5 where 5 is most helpful**
Easy to contact knowledgeable help and support		
Equipment, telecare and telehealth		
Local support group		
Supportive and enjoyable social and community activities		
Day service		
More personalised day time support (please specify)		
Help to maintain paid employment		
Accessible transport		
Support of family & friends		
Activities and support appropriate for someone with early onset dementia (under 65)		
Help if you have a learning disability and dementia		
Personal budget, direct payments or personal assistant		
Accessible short breaks and respite for carers		
Help with housework, shopping or other tasks		
Home care or other paid support in the home		
Other (please specify)		

Q.16 How well do you feel you are managing day to day, living with dementia? Tick all that apply.

Thinking about…	**Yes/ No**
We are managing day to day for now	
We are managing day to day but would like more help	
Some days are very difficult but I have support	
Some days are very difficult and I would like more support	
We feel well supported	
We feel isolated	
We are struggling to cope right now	
We know how to find out about getting more help	
Other (please specify)	

Q.17 How aware are you of what telecare can do to help people with dementia?

	Yes/No
I am aware of how telecare can help people with dementia	
I know how to find about telecare	
I don't know how it can help people with dementia	
For more information see www.lincstelecare.co.uk or call the Lincolnshire County Council Customer Service Centre 01522 782155	

Q.18 What improvements would most help you and your family to live with dementia as well as possible in your part of Lincolnshire? Please list up to five.

Q.19 What improvements would you most like to see to help meet **your** needs as a family carer, to help you manage caring for someone with dementia? Please list up to five.

Q.20 If a break from caring or household tasks is helpful to you, what sort of break do you most value? Please tick all that apply.

What sort of break is most helpful to you?	**Do you receive this now? Yes/ No**	**Can you get this in your area? Yes/ No**	**Rate helpfulness on a scale of 1-5 where 5 is most helpful**
A sitting service for a few hours at home in the day or evening			
Care in your home			
Planned respite in a care home so you can go on holiday			
Help with household tasks/ garden that helps take the pressure off and allows time to make memories with a loved one			
Flexible, personalised & consistent support to suit the needs of your family			
Regular breaks that let you plan and maintain activities & friendships			
Support for your loved one out and about doing things that they enjoy			
Doing enjoyable things together			
Other (please specify			

Phase 5
Managing at more dificult times

Q.21 When things get harder, do you know where to go for information, advice, guidance or support? Tick all that apply.

	Yes/ No	Rank in order of helpfulness 1-5 where 5 is most helpful
No		
Family		
GP		
Community Nurse		
Carers Team or Carers Support		
Support group (name)		
Lincolnshire Partnership Foundation Trust		
Voluntary organisation (name)		
Friend		
Lincolnshire County Council Adult Services		
Website (name)		
Pharmacist		
Palliative Care		
Other – please explain		

Q.22 What would help you most to manage difficult times at home? Please tick all that apply.

Thinking about…	**Yes/ No**	**Rank in order of helpfulness 1-5 where 5 is most helpful**
Community Nurse or GP		
Advice and information about managing challenging behaviour		
A single point of contact I know and trust		
Lincolnshire Partnership Foundation Trust		
Support for you as a carer (please specify)		
Support group (name)		
Regular breaks for you as a carer		
Adult Social Care assessment and support		
Telecare and equipment		
Home care support		
Day centre or other support in the community		

What to do in a crisis		
Advice and information about housing options and residential or nursing care		
Other – please explain		

Q23. If you or a loved one with dementia has had experience of going to hospital, what help - prior to admission, or on discharge - do you consider might have helped prevent or reduce the length of stay in hospital?

	Tick any that apply	**Helped/ Would help/ Didn't help**	**Not aware of this**
This Is Me scheme			
Message in a bottle scheme			
Carers emergency response service			
More intensive home care			
Telecare & equipment			
Falls clinic advice			
Respite care/ break for carer			
Reablement			
Staff skilled in dementia nursing			
Family liaison in hospital			
Help and support when you come home from hospital			
Discharge planning with carer as equal partner and carer needs taken into account			
Other (please specify)			

Q.24 What is most important to you about care in hospital for a patient with dementia? Please list up to five things.

Phase 6
At the end of life

These are delicate questions, and if you are affected by them, there are helplines that are available at the end of this questionnaire.

Q.25 What is most important to you about making decisions around end of life care? Please identify up to five aspects.

(for example advance care planning, or being surrounded by loved ones)

Are you aware of 'The Patient's Journey' – an End of Life Care Pathway?
Yes/ No

Q.26 What is important to you as the carer of a loved one at the end of their life, to help you manage? Please identify up to five points.

Q.27 If there are any further comments you wish to make, please do so here:

Thank you very much for taking the time to complete this questionnaire. Your contribution will help improve support for people living with dementia.

Please fill in the below to help us understand the feedback we receive. Personal contact details are optional.

Please indicate which stage you, or the person you care for, feel you are at in the Dementia Journey (or which stage you provide care at). **Please tick below:**

Phase 1 **Seeking help**	
Phase 2 **Learning that the condition is Dementia**	
Phase 3 **Learning more and planning for the future**	
Phase 4 **Living well with Dementia**	
Phase 5 **Managing at more dificult times**	
Phase 6 **At the end of life**	

About me (please tick all that apply):	
I have dementia	
I care for a loved one with dementia	
I am a health professional. Please state which sector...	
I am a social work/ social care professional	
I am a care provider	
I work for, or support a voluntary organisation	
I am none of the above, but I am a Lincolnshire resident	
Other (please state)	

Monitoring information

Where in Lincolnshire do you live?	
Postcode (first part only)	

Gender

Male ☐ Female ☐

Are you married or in a civil partnership Yes ☐ No ☐

Age 16-24 ☐ 25-29 ☐ 30-34 ☐ 35-39 ☐ 40-44 ☐ 45-49 ☐ 50-54 ☐ 55-59 ☐ 60-64 ☐ 65+ ☐ Prefer not to say ☐

How would you describe your national identity?

English ☐ Welsh ☐ Scottish ☐ Northern Irish ☐

British ☐ Other ☐ Prefer not to say ☐

What is your ethnicity?

Ethnic origin categories are not about nationality, place of birth or citizenship. They are about the group to which you as an individual perceive you belong. Please indicate your ethnic origin by ticking the appropriate box

White English ☐ Welsh ☐ Scottish ☐ Northern Irish ☐

Irish ☐ Gypsy or Irish Traveller ☐ Other White background ☐

Mixed/multiple ethnic groups

White and Black Caribbean ☐ White and Black African ☐

White and Asian ☐ Any other mixed background ☐

Asian/Asian British

Indian ☐ Pakistani ☐

Bangladeshi ☐ Chinese ☐

Any other Asian background ☐

Black/ African/ Caribbean/ Black British

African ☐ Caribbean ☐

Any other Black/African/Caribbean background☐

Other ethnic group

Arab ☐ Any other ethnic group ☐

Prefer not to say ☐

Do you consider yourself to be disabled? Yes ☐ No ☐ Prefer not to say ☐

What is your sexual orientation?

Heterosexual/straight ☐ Gay woman/lesbian ☐

Gay man ☐ Bisexual ☐ Other ☐ Prefer not to say ☐

What is your religion or belief?

No religion ☐ Buddhist ☐ Christian ☐

Hindu ☐ Jewish ☐ Muslim ☐

Sikh ☐ Any other religion ☐ Prefer not to say ☐

Do you have caring responsibilities? If yes please tick all that apply

None ☐

Primary carer of a child/children (under 18) ☐ Primary carer of disabled child/children ☐

Primary carer of disabled adult (18 and over) ☐ Primary carer of older person (65+) ☐

Secondary carer ☐ Prefer not to say ☐

Helplines

If you are affected by any of the issues raised in this questionnaire and would like to talk to someone who can help:

Alzheimers Society Lincolnshire 01522 692681 (Mon-Fri 10-4)

Alzheimers Society UK Helpline 0300 2221122 (Mon-Fri 9-5; Weekend 10-4)

Admiral Nursing Direct UK 0845 2579406 (Tues & Thurs 11-8.45 and Sat 10-1)

Lincolnshire Carers Team 01522 782224 (Mon-Fri 8-6)

Alternative Formats

The information contained in this document can also be provided in other languages as well as other formats including large print, please request on the number below.

Further information about this consultation

If you have any further questions or would like to talk to someone about this consultation please contact Paul.Herniman@lincolnshire.gov.uk on 01522 554219.

The Lincolnshire Dementia Partnership

The Vision

Within Lincolnshire we want to ensure people with dementia and their families work with the statutory sector, third sector organisations and service providers because we know that working together is more effective. We will pursue a single unified approach to supporting people with dementia throughout a journey and pathway that is made as positive as possible. This journey will be assisted by a network of support and opportunities that encourage self-support and independence, and provides the right support at the right time.

We believe that this is best achieved by working in a balanced partnership between people, families, professionals, providers and the public, where everyone has a role and where everyone provides all the support that they can, at the right point within a person's journey.

Our vision moves us away from traditional services and a dependence on Adult Social Care and Health services, to a preventative model that is based on individual needs, wellbeing and choice.

The Principles

In order to enable a partnership to function appropriately, a set of agreed principles are needed. Our principles are:

- People will live well with dementia in Lincolnshire
- People will remain at home for as long as possible
- We will invest in prevention and intervention
- We will undertake joint commissioning and develop pooled budgets
- We will provide a positive journey and a pathway to navigate that journey
- We will create a sustainable network of services
- We will work together in a trusting, equal partnership
- We will reflect the nature and needs of communities in Lincolnshire

The Journey

We think that we need a pathway that links to the dementia journey that has been developed by Dementia Partnerships UK– laid out in figure 1 below – that creates logical steps that are supportive, responsive and effective.

Figure 1 – The Dementia Journey

Phase 1	**When memory problems have prompted me and/or my carer/family to seek help**
Phase 2	**Learning that the condition is dementia**
Phase 3	**Learning more about the disease, how to manage, options for treatment and care, and support for me and my carers/families**
Phase 4	**Getting the right help at the right time to live well with dementia, prevent crisis, and manage together**
Phase 5	**Managing at more difficult times, including if possible to manage at home**
Phase 6	**Receiving care, compassion and support at the end of life**

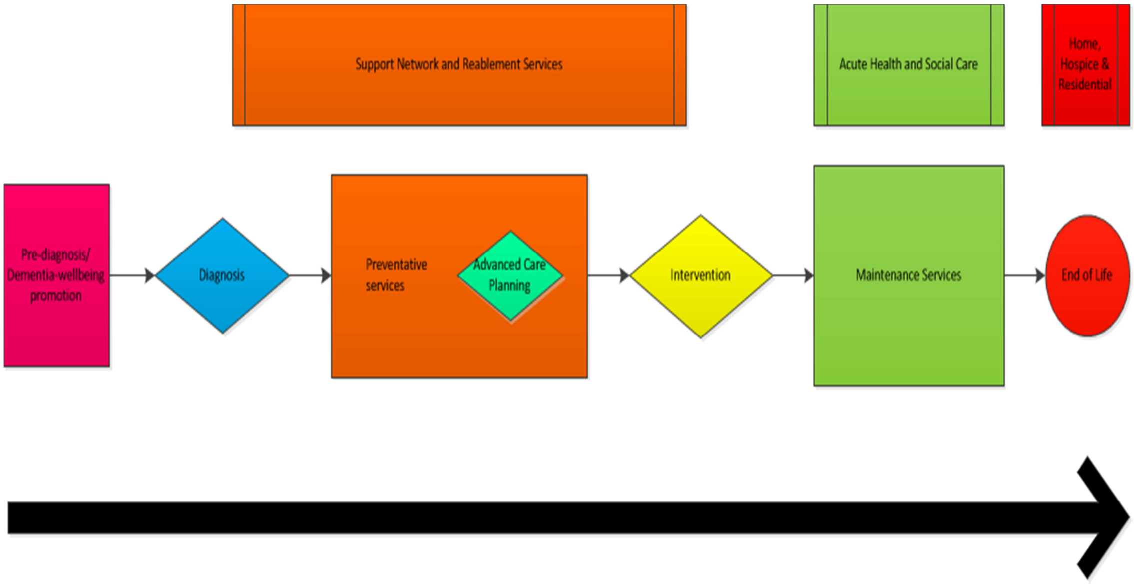
http://www.dementiapartnerships.org.uk/commissioning/models-of-care/the-dementia-journey/

We believe that these phases are understood by people living with dementia, and represent the appropriate points of providing intervention and support.

The Pathway

We see the pathway for people with dementia as being positive, supportive and built on the quality of the relationships we make. Our pathway supports health and well-being prior to a diagnosis of dementia through targeted information, advice and awareness promotion. We see early identification and diagnosis as essential, and backed by a network of support and reablement that will empower people to remain independent, encourage self-support and enable people and their families to care for themselves. We believe that this is possible through the right investment in services and opportunities, appropriate care planning, and the right culture and ethos to care and support that respects and nurtures individuals and their relationships. We know that targeted intervention and crisis support will enable people to remain at home with less support for longer. We also know that the right support will always be needed at the right time, and we believe in the availability of appropriate, high quality services that are available when they are needed. Our pathway ensures that the best services are in place at the end of life, and that people are able to choose where they die.

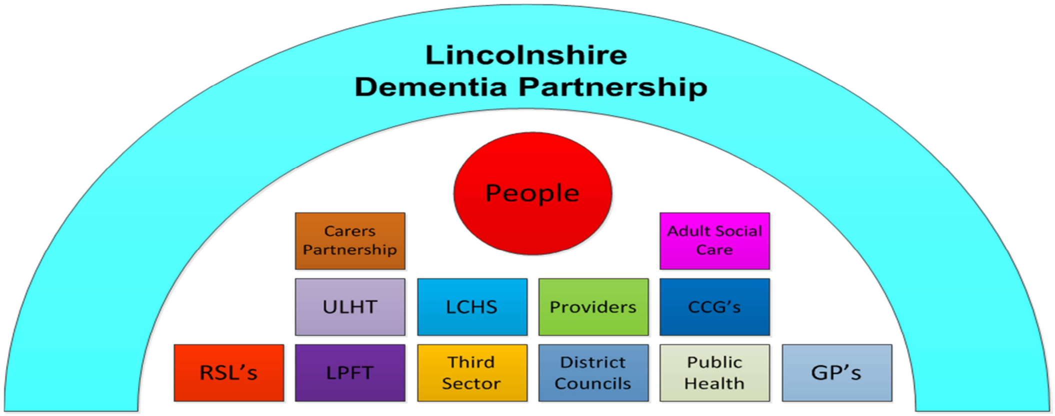
Figure 2 – The Dementia Pathway



The Partnership

We know that there is only one sustainable way that we can achieve our vision for dementia, and that is by working together. This cannot be achieved by one organisation alone, but if we combine resources, efforts, expertise and passion then we can bring about a new way to enable people to live well with dementia in Lincolnshire

Figure 3 – The Lincolnshire Dementia Partnership



The Outcomes

In order to secure a longstanding partnership and to secure a positive result, we agree to a joint set of outcomes:

- Improved public awareness of dementia
- Improved identification and early diagnosis
- Improvement in the quality of diagnosis
- Improved quality of care in hospitals and in the community
- A reduction in the use of anti-psychotic medication
- More people supported away from Adult Social care and Health Services
- Improved and accessible information and to enable people with dementia and carers to plan, manage and live well with dementia
- Reduction in long term care admissions
- Reduction in hospital admissions due to dementia
- Improved customer journey and experience
- Improved support for families/carers that helps preserve relationships
- Improved outcomes at End of Life
- Improved access to alternative care pathways
- Involve people throughout
- Increase self-management

The Actions

In order to deliver these outcomes, we will undertake a number of actions:

- Develop and agree a new dementia Strategy for Lincolnshire in line with the national dementia strategy and local needs
- Develop an action plan to implement the strategy
- Develop a dementia Programme and Programme Board
- Develop a dementia Support Network
- Provision of Intervention and Crisis Support
- Develop integrated approaches to community working for dementia and throughout the journey
- Further develop Dementia Friendly Communities
- Increase the range and diversity of support in consultation with people affected by dementia

Lincolnshire Health and Wellbeing Board – Forward plan items

Meeting date	Decision/Authorisation item	Discussion item	Information item
24th September 2013	**Pharmaceutical Needs Assessment** – Discharge of HWB statutory functions – **David Stacey, Programme Manager**	**Joint Health and Wellbeing Strategy** – Baseline dashboard of items **David Stacey, Programme Manager** **Joint Health and Wellbeing Strategy Implementation Framework David Stacey, Programme Manager** -	**Tobacco Control** – 5 year plan **Ros Watson, Smokefree Lincs Alliance** **NHS to Social care funding** – update report **Glen Garrod, Director, Adult care-**
10th December 2013			
25th March 2014			
10th June 2014			

Agenda Item 11.

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