Lincolnshire COUNTY COUNCIL
Working for a better future

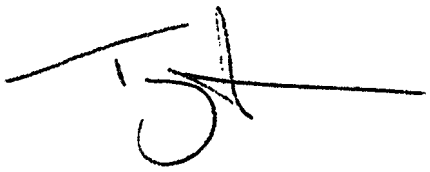
County Offices
Newland
Lincoln
LN1 1YL

17 March 2014

Lincolnshire Health and Wellbeing Board

A Meeting of the Lincolnshire Health and Wellbeing Board will be held on Tuesday, 25 March 2014 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 S Woolley (Executive Councillor for NHS Liaison, Community Engagement) (Chairman), Mrs P A Bradwell (Executive Councillor for Adult Care and Health Services, Children's Services), C N Worth (Executive Councillor for Libraries, Heritage, Culture), D Brailsford, J P Churchill, B W Keimach, C R Oxby and S M Tweedale

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

District Council: Councillors Marion Brighton OBE (District Councils)

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 Malcolm Swinburn (Healthwatch Lincolnshire)

NHS England: Mr Andy Leary (NHS England)

(*) Permanent Membership

LINCOLNSHIRE HEALTH AND WELLBEING BOARD AGENDA
TUESDAY, 25 MARCH 2014

Item	Title	Pages	Estimated Time
1	**Apologies for Absence/Replacement Members**		
2	**Declarations of Members' Interests**		
3	**Minutes of meetings of the Lincolnshire Health and Wellbeing Board**		
3a	**Minutes of the meeting held on 10 December 2013**	1 - 10	
3b	**Minutes of the Extraordinary meeting held on 28 January 2014**	11 - 14	
4	**Action Updates from the previous meeting** *(For the Health and Wellbeing Board to consider the actions arising from the previous meeting)*	15 - 16	
5	**Chairman's Announcements**	Verbal Report	
6	**Decision/Authorisation Items**		
6a	**Better Care Fund Final Submission** *(To receive an update report from Glen Garrod, Director of Adult Social Services, concerning the final submission of the Better Care Fund to NHS England)*	17 - 80	
6b	**Commissioning Plans** *(For the Health and Wellbeing Board to consider the following Commissioning Plans:* • *West Lincolnshire Clinical Commissioning Group* • *Lincolnshire East Clinical Commissioning Group* • *South West Lincolnshire Clinical Commissioning Group* • *South Lincolnshire Clinical Commissioning Group* • *NHS England Local Area Team)*	81 - 164	

Item	Title	Pages	Estimated Time
7	**Discussion/Debate Items**		
7a	**Annual Report of the Director of Public Health on the health of the people of Lincolnshire 2013** *(To receive the Annual Report of Dr Tony Hill, Director of Public Health on the health of the people of Lincolnshire 2013)*	165 - 206	
7b	**Lincolnshire Sustainable Services Review** *(To receive a verbal update from Dr Tony Hill, Director of Public Health with regard to the current position of the LSSR)*	Verbal Report	
8	**Information Items**		
8a	**The Lincolnshire Safeguarding Children's Board** *(To receive a report from Andrew Morris, Lincolnshire Safeguarding Children Board Business Manager, which* provides *the Board with an update on the work currently being undertaken by the Lincolnshire Safeguarding Children Board (LSCB) and its Sub-Groups. Chris Cook, Independent Chairman of the Lincolnshire Safeguarding Children Board will be attending the meeting to present the report to the Board)*	207 - 228	
8b	**Review of Health Services for Children Looked After and Safeguarding in Lincolnshire** *(To receive a report from Jan Gunter, Consultant Nurse Safeguarding, South West Lincolnshire Clinical Commissioning Group, which provides the Board with Care Quality Commission information concerning the review of Health Services for Children Looked After and Safeguarding in Lincolnshire)*	229 - 266	
8c	**Autism Self- Evaluation 2013** *(To receive a report from Richard Collins, Head of Service Policy and Development, which provides the Board with an update on the Autism Self-Evaluation 2013)*	267 - 312	
8d	**Support and Aspiration** *(To receive a report from John O'Connor, Head of Service School Administration, which provides an update for the Board on the progress of the SEN Implementation Project designed to implement the reforms to Special Educational Needs (SEN)*	313 - 318	

Item	Title	Pages	Estimated Time
	support set out in Part 3 of the Children and Families Bill, draft SEN Code of Practice and draft regulations)		
8e	**An Action Log of Previous Decisions** *For the Health and Wellbeing Board to note decisions taken since the 11 June 2013)*	319 - 324	
8f	**Lincolnshire Health and Wellbeing Board - Forward Plan** *(This item provides the Board with an opportunity to discuss potential agenda items for future meetings, which will subsequently be included on the Forward Plan for the Board. Martin Wilson, Health and Wellbeing Board Advisor to lead on this item)*	325 - 330	

Democratic Services Officer Contact Details

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 COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD
10 DECEMBER 2013

PRESENT: COUNCILLOR MRS SUSAN WOOLLEY (CHAIRMAN)

Lincolnshire County Council: Councillors Mrs P A Bradwell (Executive Councillor for Adult Care and Health Services, Children's Services), C N Worth (Executive Councillor for Libraries, Heritage, Culture), D Brailsford, J P Churchill, B W Keimach 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 (Executive Director of Public Health).

District Councillors: Councillor Jeff Summers.

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 Malcolm Swinburn.

NHS Commissioning Board: Mr Andy Leary (Leicestershire & Lincolnshire Area Team).

Officers in Attendance: Katrina Cope (Team Leader Democratic and Civic Services) and Martin Wilson (Health and Wellbeing Board Advisor).

Others in Attendance: Annette Laban (Lincolnshire Sustainable Services Review Programme Director), May Mengyui-Li (PricewaterhouseCoopers), Rose Taylor (PricewaterhouseCoopers) and Colin Warren (Head of Commissioning, Mental Health NHS South West Lincolnshire).

30 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

Apologies for absence were received from Councillor Mrs M Brighton OBE (District Council representative) and Mr David Sharp (NHS England Area Team).

It was noted that Councillor Jeff Summers (District Council representative) and Mr Andrew Leary (Leicestershire & Lincolnshire Area Team) had replaced Councillor Mrs M Brighton OBE (District Council representative) and Mr David Sharp (NHS England Area Team) for this meeting only.

31 DECLARATIONS OF MEMBERS' INTERESTS

There were no declarations of members' interests declared at this stage of the meeting.

32 MINUTES OF THE MEETING HELD ON 10 SEPTEMBER 2013

RESOLVED

That the minutes of the meeting held on 10 September 2013 be confirmed and signed by the Chairman as a correct record.

33 ACTION UPDATES FROM THE PREVIOUS MEETING

RESOLVED

That the completed actions as detailed be noted.

34 CHAIRMAN'S ANNOUNCEMENTS

The Chairman advised the Board that an announcement sheet had been tabled which made reference to:-

- That photographs of all Board members had been published on the website www.lincolnshire.gov.uk/hwb;
- Informal Meeting dates had been identified for the rest of the year;
- That any members of the Board who had not already provided substitute information should email the generic email address (as detailed above);
- Members were provided with an easy read version of the JSNA Overview Update Report 2013; and
- That the Chairman had attended a Public Health England East Midlands Event – 'Working Together to protect and improve health and reduce health inequalities across the East Midlands' at which the Chairman had been asked to provide closing remarks to system leaders from across the East Midlands which had included to agree PHE East Midland's priorities and local prospectus; identify opportunities to further support and develop system leadership; and develop and agree formal governance arrangements for the new public health system.

DECISION/AUTHORISATION ITEMS

35 LINCOLNSHIRE SUSTAINABLE SERVICES REVIEW

A joint presentation from the Lincolnshire Sustainable Review Programme Board Chairman, Dr Tony Hill, Annette Laban, Lincolnshire Sustainable Review Programme Director and Rose Taylor from PricewaterhouseCoopers provided the Board with a high level blueprint document which had been developed over the last several months. The blueprint considered radical change and best practice and focussed on

the challenges that had been raised across Lincolnshire. In order to develop the document the board had created four Care Design Groups which had been divided into core delivery areas, these groups had then been tasked with agreeing an overall vision and then developing a series of interventions, that if implemented would make the vision achievable.

It was noted that the four Care Design Groups were:-

- Proactive ideas;
- Urgent Care (reactive);
- Elective Care; and
- Women and Children's.

These interventions were then tested at the recent Care Summit which had been attended by in excess of 200 delegates from across Lincolnshire to showcase "Lincolnshire's Brave Ideas" and future model of care. A vote taken at the summit confirmed that the blueprint options being put forward had been accepted to progress further to design planning, subject to executive and Health and Wellbeing Board approval.

The Board were advised that representatives from all providers and commissioner organisations; the Local Area Team; designated patient representatives; carers; Healthwatch; the voluntary sector and District council colleagues had all been involved in care design; and the development of the blueprint.

It was highlighted that the quality of services; workforce issues and financial issues had all been reasons for the review. Particular reference was made to the fact that if nothing was done under the current system there was already a system deficit of £20.8 million; this figure would rise to £105 million in five years if current services were to continue.

The review would provide for a person centred approach to services provided within the four identified categories as detailed on slide four of the presentation. What was proposed was a radical reconfiguration of services being delivered by neighbourhood teams using local resources such as community hospitals.

It was highlighted that approval had been received from all the respective executive boards, prior to being considered by the Health and Wellbeing Board at its meeting today. During December the procurement process for Phase two had commenced and supplier interviews would be taking place on 10 January 2014. Then, from January to April detailed planning for Phase two would commence, and the Phase one blueprint would be evaluated and some pilot schemes would be commencing, some preparation work would also be done around implementation planning and preparing materials for the consultation. The consultation process would then follow during May to July 2014. During August to October 2014 updates would then be made to the detailed plans and implementation planning would then follow the consultation. Phase three 'Implementation' to deliver the changes would then commence in October 2014.

During discussion, the following points were raised:-

- Working with neighbouring authorities – reassurance was given that the review was about the people of Lincolnshire and that a model of care included working across boundaries;
- To ensure that the review encompassed the requirements of the GP contracts;
- The need to ensure that there was plenty of time for engagement with the general public;
- The need to ensure that neurological services were included. Reassurance was given that although there was nothing specific in the blueprint, neurological conditions would be included as part of the work of the neighbourhood teams;
- The need to ensure that the terminology contained within the consultation document was plain English, as it was very important to get the public involved;
- Success of the radical changes would depend on the implementation, commissioning and contracting of service providers. It was noted that there was proposals for joint commissioning across the county;
- It was highlighted that presenting the information to the public had and would continue to be done through different mediums, so that information was readily available to the general public;
- Members agreed that this was a very exciting time for Lincolnshire, having the opportunity to tailor health and social care needs for the people of Lincolnshire; and
- It was agreed that theme leads currently working on projects should continue their work on these, as this would ensure that some momentum was maintained and with some tweaking, the projects could then be included in the overall plan. It was highlighted that there were lots of pockets of good work and practise being undertaken in Lincolnshire and therefore any one working on a project should be encouraged to continue to do so.

RESOLVED

That approval be given to the blueprint document presented and that further reports during phase two of the programme be received by the Board.

36 INTEGRATED TRANSFORMATION FUND AND PROPOSALS TO DEVELOP A STRUCTURE TO SUPPORT JOINT COMMISSIONING

Pursuant to Minute no 27 (3) of the meeting held on 10 September 2013, consideration was given to a report from the Director of Adult Social Services, which provided the Board with an update as to the use of the Integrated Transformation Fund (ITF) in 2013/14; and to advise the Board how plans were developing to meet the national requirements for the use of funds in 2014/15 and 2015/16. The report also highlighted proposed joint governance arrangements which would govern how the Council and Lincolnshire Clinical Commissioning Groups (CCG's) would work

together to improve the health and social care outcomes for Lincolnshire communities.

Appended to the report were the following:-

- Appendix A provided information on the Integrated Transition Funding for 2013/14;
- Appendix B provided information about the Section 256 funding transfer from NHS England to social care 2013/14;
- Appendix C provided the Board with a copy of the Section 256 Agreement between NHS England to Lincolnshire County Council;
- Appendix D provided a proposed joint commissioning structure, further information was detailed on pages 185 to 187 of the report; and
- Appendix E provided information relating to the Integrated Transformation Fund LCC/Health.

It was highlighted that four CCG's and the Corporate Management Team of Lincolnshire County Council had been involved in the production of the report. A condition of the ITF two year plan submission was that Providers (health and social care) were engaged and that this would be a matter of priority for social care providers given early the involvement of the three NHS providers in Lincolnshire.

Page 183 of the report outlined the proposed priorities (from the Task Group) for investment as 'early implementers' these were as follows:-

- Development of neighbourhood teams;
- Development of an Intermediate Care Layer and consequential pooled budget;
- Seven-day Hospital working, which was a requirement in guidance as to the use of ITF;
- Prevention, this would incorporate a number of short term projects currently funded by the ITF; and
- Enablers such as estates, organisational development and IT.

In conclusion, the Board were requested to agree a range of activities that included the priorities and the joint commissioning structures which would begin to underpin the longer term ambitions of the Lincolnshire Sustainable Services Review and at the same time satisfy the requirements of the two year detailed plan in the use of the Integration Transformation Fund.

A discussion ensued, from which the following items were raised:-

- The amount of the Integrated Transformation fund for 2013/14. The Board were advised that Appendix A to the report provided a breakdown of the funding. Members received clarity that this was not all new money, the whole principle was that through working together with providers and CCG's would ensure that the funding was utilised better;
- Seven day working – The Board were advised that this required careful consideration and might require additional resources in some areas; and

- Reassurance was given that the Integrated Transformation Fund fitted into the Lincolnshire Sustainable Services Review.

RESOLVED

1. That the content of the report and Appendices be noted.

2. That the agreement previously reached in March 2013, on the use of allocated funds in 2013/14 be noted, in order that money can be transferred from the Area Team to Lincolnshire (Appendices A, B and C).

3. That the 'special. Meeting of the Health and Wellbeing Board meeting on 5 February 2014 to formally agree the two year plan to spend the Integration Transformation Fund in 2104/15 and 2105/16 be noted.

4. That the five 'early implementers' priorities be agreed.

5. That the outline structure for joint commissioning arrangements as detailed at Appendix D be agreed.

DISCUSSION/DEBATE ITEMS

37 THE LINCOLNSHIRE CHILDREN AND YOUNG PEOPLE'S PLAN

The Executive Director of Children's Services presented a report which asked the Board to consider and note the Lincolnshire Children & Young People's Plan, which was a strategic plan for services which supported children and young people in Lincolnshire.

The plan demonstrated how the local authority and its partners would work collaboratively and in partnership to improve the wellbeing of every child, young person and family in Lincolnshire over the next three years.

It was highlighted that the statutory duty to produce a Children and Young Peoples Plan had been revoked in October 2010 and; that local areas were now no longer required to produce a plan. Local Partnerships were now free to publish their own strategic plan as they saw fit. It was highlighted that the plan circulated had been as a result of consultation undertaken and development days with partners.

A copy of the Lincolnshire Children and Young People's Plan was tabled at the meeting. An Executive Summary of the Plan was detailed at Appendix A to the report presented.

RESOLVED

That the Children and Young People's Plan 2013 – 2016 be noted.

38 LINCOLNSHIRE JOINT COMMISSIONING STRATEGY FOR DEMENTIA CARE 2014 - 2017 : THE WAY FORWARD

Consideration was given to a report from the Director of Adult Social Services, which provided the Board with an update on the plans to improve the 'Dementia Journey'.

It was reported that over 750,000 people in the UK were affected by dementia, with an estimated 10,500 people in Lincolnshire. Dementia is primarily a disease that comes on in later life, but there were at least 15,000 people in the UK under 65 who had been reported as having the illness.

A major feature of the new Dementia Strategy was to move away from high cost maintenance services and to look at investment in prevention, early intervention (including higher rates of diagnosis) and support mechanisms within the community.

Appended to the report were the following:-

- Appendix A - the Consultation and Evaluation Report;
- Appendix B - the Lincolnshire Joint Commissioning Strategy for Dementia Care – 2014 – 2017 – The Way Forward; and
- Appendix C – Initial Action Plan.

During discussion the following points were raised:-

- The importance of the piece of work;
- Use of Dementia champions in the community;
- The good work done by LCC around the welfare of carers;
- The importance of providing dementia training;
- Page 234, why not all District Councils were listed, members were advised that the group listed were those who had participated in the consultation and had offered their views;
- Page 241 the inclusion of Phase 2; and
- Page 254 typographical error, the date in the first paragraph should read 2010 -2014.

RESOLVED

1. That the Consultation Evaluation Report detailed at Appendix A be endorsed and that agreement be given to its publication.

2. That the draft Joint Commissioning Strategy 2014 – 2017 be endorsed; and that the planned timetable for further County Council sign-off through the Adult Scrutiny Committee on 29 January 2014; and the Executive on 4 February 2014 (Appendix B); and Health sign-off via Mental health Lead Officer, Allan Kitt through the four CCG Governing Bodies in December and January, following endorsement by the Board be agreed.

3. That the draft Initial Action Plan (Appendix C) be noted.

4. That the proposed approach to manage strategy delivery via the Joint Dementia Core Group be endorsed.

INFORMATION ITEMS

39 HEALTHWATCH LINCOLNSHIRE

Consideration was given to a report from The Healthwatch representative, which provided the Board with a summary update on the Healthwatch Lincolnshire activities.

The report detailed the current, medium and long term plans for Healthwatch along with informational relating to organisational development; Engagement Activities; and Board and company status.

Members were advised that since the report had been produced, Healthwatch had become a charity which was a first for Lincolnshire. Members were advised further that Healthwatch was in the process of moving into new offices in Swineshead, Boston. It was noted that once the move was completed, interviews would be taking place to recruit additional staff needed to cover the County.

RESOLVED

That the report be noted.

40 AN ACTION LOG OF PREVIOUS DECISIONS

RESOLVED

That the Action Log of previous decisions of the Board be noted.

41 LINCOLNSHIRE HEALTH AND WELLBEING BOARD - FORWARD PLAN

The Health and Wellbeing Advisor presented the Boards current forward plan.

It was highlighted to the Board that the meeting scheduled for the 5 February 2014 would be an additional meeting of the Board to consider the Integrated Transformation Fund item. It was noted that this meeting would be taking place at the Johnson Community Hospital, Pinchbeck Road, Spalding at 12:15 pm.

Members were also reminded that some informal workshops dates had been arranged for the Board the first one being on 28 January 2014, which would be looking at Commissioning Plans, the next one being on 25 February 2014, which would be dedicated to the Health and Wellbeing Strategy.

RESOLVED

That the forward plan for formal meetings and informal workshop sessions as presented be accepted.

The meeting closed at 3.45 pm

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Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD
28 JANUARY 2014

PRESENT: COUNCILLOR MRS S WOOLLEY (CHAIRMAN)

Lincolnshire County Council: Councillors Mrs P A Bradwell (Executive Councillor for Adult Care and Health Services, Children's Services), C N Worth (Executive Councillor for Libraries, Heritage, Culture), J P Churchill, B W Keimach and S M Tweedale.

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

District Councillor: Councillor Jeff Summers.

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 Malcolm Swinburn.

NHS Commissioning Board: Mr Jim Heys (Leicestershire & Lincolnshire Area Team.

Officers in Attendance: Katrina Cope (Team Leader, Democratic and Civic Services) and Martin Wilson (Health and Wellbeing Board Advisor).

42 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

Apologies for absence were received from Councillors D Brailsford, C R Oxby, Mrs M Brighton OBE and Mr Andy Leary (Leicestershire & Lincolnshire Area Team).

It was noted that Councillor Jeff Summers (District Council representative) and Mr Jim Heys (Leicestershire and Lincolnshire Area Team) had replaced Councillor Mrs M Brighton OBE (District Council representative) and Mr Andy Leary (Leicestershire and Lincolnshire Area Team) respectively, for this meeting only.

43 DECLARATIONS OF MEMBERS' INTERESTS

Dr's Vindi Bhandal, Sunil Hindocha, Kevin Hill and Simon Lowe, wished it to be noted that they had an interest in the Better Care Fund, as independent providers of services.

Also, Dr Simon Lowe wished it to be noted that his wife was a Director of a medical provision company and Dr Sunil Hindocha wished it to be noted that his wife was a GP.

44 BETTER CARE FUND SUBMISSION DOCUMENT: 'FIRST-CUT'

Consideration was given to a revised report from the Director of Adult Social Services, which provided the Board with a copy of the Better Care Fund (BCF) document, which was the first-cut submission in accordance with national guidance. The document represented the collective ambition of the health and social care community in Lincolnshire to further improve services and establish a more sustainable financial base in an integrated environment.

The report highlighted the core elements of the BCF, the connection between the BCF document and the Lincolnshire Sustainable Services Review (LSSR) and the process and timetable for production. Members were advised that it was necessary for the Health and Wellbeing Board to agree a 'first-cut' submission as that described how Lincolnshire intended to meet the national requirements in terms of:

- The spend of the BCF allocation in 2014/15, 2015/16;
- The performance expected to be achieved; and
- The level of pooled budget (health and social care) expected to be reached.

Appended to the report was:-

- Appendix A – A copy of the NHS England Planning Guidance;
- Appendix B – A copy of the Better Care Fund Planning Template – Part 1 (V12), which detailed the overall plan details, provided an agreed vision and schemes for Early Implementers and explained how the submission met the national conditions and identified any strategic risks; and
- Appendix C – A copy of the Better Care Fund Part 2 – which described the performance measures and agreement on the use of the BCF in 2014/15 and 2015/16. The appendix also reflected the level of ambition to pool budgets across both health and social care.

Full details of the governance arrangements were shown on page three of the agenda presented. The Director of Adult Social Services highlighted that the 'first-cut' was to satisfy national prescribed requirements and that this had to be with NHS England for 15 February 2014, and that the final version needed to be submitted to NHS England by 4 April 2014.

During discussion, the Board raised the following issues:-

- The inclusion in the background to the report (on page two) further information relating to the role of Local Area Team;
- How to deal with changes to the document up to 14 February 2014. The Director of Adult Social Services advised that the document was evolving and although the Board were agreeing the document presented, it would

continue to evolve up to the submission date. The Board agreed that once the Director of Adult Social Services felt that he had incorporated all subsequent amendments, that the document should be emailed to members for comments/information, prior to it being submitted to NHS England on 15 February 2014;

- Some members stressed the importance of the BCF and highlighted that a lot was depending on it for Lincolnshire and the LSSR. The Director of Adult Social Services highlighted that if the submission was not successful, Lincolnshire would not lose the money, but would be offered peer support and challenge from NHS England;
- Members discussed the potential of having further opportunity to look at the document, prior to its submission; and
- The Health and Wellbeing Board Advisor circulated to members at the meeting a copy of the latest forward plan for forthcoming informal/formal meetings of the Board. Members' attention was brought to a planned informal meeting date of 25 February 2014. This informal meeting would enable the Board to look at Commissioning Plans, and receive an update in relation to the Better Care Fund.

RESOLVED

1. That the content of the Better Care Fund submission document as presented be noted.

2. That the Better Care Fund 'first-cut' submission document to NHS England be agreed, and that a copy of any subsequent amendments be emailed out to Board members for comments/information prior to the documents submission to NHS England by 15 February 2014 to meet the national conditions.

3. That a further report concerning the Better Care Fund final submission be received at the next meeting of the Lincolnshire Health and Wellbeing Board on 25 March 2014, prior to submission to NHS England.

4. That the Better Care Fund be added as an item for discussion for the informal meeting scheduled to be held on the 25 February 2014.

The meeting closed at 3.55 pm

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Lincolnshire Health and Wellbeing Board – Actions from the previous meeting

Meeting Date	Minute No	Agenda Item & Action Required	Action by
11.06.2013	1 and 2	**Election of Chairman** – Records to be updated Councillor Mrs S Woolley elected as Chairman and Dr Sunil Hindocha elected as Vice-Chairman.	Katrina Cope
	7	**Chairman's Announcements** – The Chairman to send a response on behalf of Board with regard to the Letter from Norman Lamb MP Minister of State for Care and Support – Delivery of the Winterbourne View Concordat and review commitments.	Dr Tony Hill
	8	**Health & Wellbeing Boards Terms of reference and operating procedures -** The Health & Wellbeing Board Advisor to present membership information of other Health & Wellbeing Boards to the September meeting of the Board.	Martin Wilson
	9	**Disabled Children's Charter** The Disabled Children's Charter for Health was agreed subject to the wording of the Charter being Amended to read 'engaged with'.	Martin Wilson/ Sheridan Dodsworth
	10	**Health & Wellbeing Board – Development Tool** The Health & Wellbeing Board Advisor to have a discussion with Andrew Leary concerning functions discharged at a local level and that this information should be presented to the next meeting of the Board.	Martin Wilson
	13	**Letter inviting expressions of interest for Health and Social Care Integration 'Pioneers'** – Expression of interest to be made by the Executive Director of Public Health.	Dr Tony Hill
	14	**Lincolnshire Health & Safety Wellbeing Board – forward plan Items** – That the items raised at the minute numbers 8 and 10, and those detailed above be included on the work programme for the Lincolnshire Health and Wellbeing Board	Martin Wilson/Katrina Cope
10.09.2013	21	**Chairman's Announcements** Communications – All members to forward a photograph to the generic email address HWB@lincolnshire.gov.uk for the attention of the Health and Wellbeing Board Advisor, Martin Wilson Substitute Members - Members who had not provided the name of a designated substitute were asked to forward the name of their substitute to the generic email address (As above). Membership of other Boards – The Health and Wellbeing Board Advisor to send a copy of the regional board information to members following the meeting.	All Members All Members Martin Wilson
	23	**Terms of Reference** The Health and Wellbeing Board Advisor to amend the Roles and Responsibilities of NHS England following the meeting.	Martin Wilson

		That this item should be included on the forward plan for review at the June 2014 meeting.	Martin Wilson
	24	**Joint Health and Wellbeing Board Statement of Intent** That this item should be included on the Forward Plan for review at the June 2014 meeting.	
	26	**Lincolnshire Sustainability Review** That this Item needed including on the Forward Plan for future meetings.	Martin Wilson
	27	**Social Care and Health Funding** That this item needed including on the forward plan for the 10 December 2013 meeting.	Martin Wilson
10.12.2013		**No Actions**	
28.01.2014	44	**Better Care Fund Submission Document 'First-Cut'** That a copy of any subsequent amendments should be emailed to all members prior to the documents submission to NHS England.	Katrina Cope

Lincolnshire 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:	**25 March 2014**
Subject:	**Better Care Fund Final Submission**

Summary:

The Better Care Fund (BCF) represents a profound shift in emphasis towards integration between health and social care services in England. The form this took was financial, and announced by the Chancellor in June 2013 when he created a £3.8b integrated budget for health and social care. The antecedents were previously described to Health and Wellbeing Board at their meeting on 28th January 2014. A first cut submission was made as required on 15th February 2014 endorsed by the County Council, all four Clinical Commissioning Groups and the Health and Wellbeing Board. Since that time the group tasked with completing a final submission by the deadline of 4th April 2014 has continued to meet. This report details the final BCF submission for the health and social care community in Lincolnshire.

Unfortunately, given the reporting timetable for this Board and the national timetable for the BCF Assurance Process the final submission document and formal feedback from NHS England related to first cut submission is not available. It will be circulated as soon as possible in advance of the Board meeting 25th March 2014.

Actions Required:

1. Members are asked to note and comment on the content of the attached BCF final submission.

2. Agree the document as attached.

3. Note that further updates concerning this submission and tracking of progress will be managed through the LSSR Governance Board in the first instance and ultimately Health and Wellbeing Board.

1. Background

The value of the BCF in Lincolnshire in 2014/15 is £15.4m. In 2015/16 the value of the fund will reach just under £53m. This incorporates an allocation to help underwrite the costs of implementing both the Care Bill from 2015, and the 'Dilnot Reforms' (how people will be charged for adult social services for which they are eligible).

The Task Group identified below has senior representatives from each of the four CCGs and includes their Chief Finance Officers. It is chaired by the Director of Adult Social Services with other colleagues from LCC covering Children's Services, Public Health, Performance and Finance.

DATE	GOVERNANCE PROCESS
12.11.2013	Task Group
28.11.2013	Task Group
10.12.2013	Health and Wellbeing Board
18.12.2013	Task Group
06.01.2014	Task Group
13.01.2014	Task Group
14.01.2014	Informal Executive of LCC
16.01.2014	Task Group
21.01.2014	Task Group
22.01. 2014	South West CCG Board
22.01.2014	West CCG Board
23.01.2014	East CCG Board
30.01.2014	South CCG Board
28.01.2014	Informal Health and Wellbeing Board
05.02.2014	Health and Wellbeing Board
06.02.2014	Task Group
15.02.2014	**First cut submission of Lincolnshire BCF to NHS England**
20.02.2014	Task Group
07.03.2014	Task Group
19.03.2014	West CCG Board
25.03.2014	Task Group (last one in the diary)
25.03. 2014	Health and Wellbeing Board
26.03.2014	South West CCG Board
27.03.2014	South CCG Board
27.03.2014	East CCG Board
27.03.2014	Overview and Scrutiny Management Committee
01.04.2014	Formal Executive of LCC
04.04.2014	**Final version submitted to NHS England**

2. Conclusion

This final BCF submission represents the combined and shared ambition across the health and social care community in Lincolnshire. The consequence of this BCF is that

shared and improved performance, an extensive level of pooled budget and significant service integration will follow commensurate with the intentions of the LSSR.

Governance is proposed to be through the Health and Wellbeing Board.

3. Consultation

Key aspects of the BCF are subsumed within the LSSR programme. During Phase 1 of the LSSR a degree of consultation took place with representative bodies from the health and social care community and those representing groups of service users and the wider public. Phase 2 of the LSSR will provide more extensive consultation later this spring.

At the Health and Wellbeing Board presentation on 28th January 2014 an informal meeting of the Board and wider interested parties took place. This included wider representation from District Councils and social care providers.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Lincolnshire BCF first cut submission
Appendix B	Assessment by NHS England regarding first cut submission
Appendix C	Additional guidance produced by NHS England and the LGA dated 24th February 2014
Appendix D	Final BCF submission

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 Glen Garrod who can be contacted on 01522-550808 or Glen.garrod@lincolnshire.gov.uk.

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Lincolnshire
COUNTY COUNCIL
Working for a better future

My ref: SW/JMW
Your ref:

11 February 2014

County Offices
Newland
Lincoln
LN1 1YL
Tel: 01522 552094
Fax: 01522 552072
Email: cllrs.woolley@lincolnshire.gov.uk

David Sharp
Director
NHS England (Leics & Lincs Area Team)
Fosse House
6 Smith Way
Grove Park
Enderby
Leicestershire
LE19 1SX

Dear David

The attached Better Care Fund (BCF) document is the 'first-cut' submission from the health and social care community in Lincolnshire. It represents our collective ambition to further improve services and establish a more sustainable financial base in an integrated environment.

This report illustrates the core elements of the BCF, the connection between this BCF document and the Lincolnshire Sustainable Services Review and the process and timetable for production. The report builds upon previous presentations to the Health and Wellbeing Board that detailed early versions of the submission document. It describes how Lincolnshire intends to meet the national requirements in terms of:

1. Spend of the BCF allocation in 2014/15, 2015/16;
2. The performance we expect to achieve;
3. The level of pooled budget (health and social care) we expect to reach.

The document as attached has two parts provided as a national template: Part 1 describes the overall **Plan Details**, an agreed **Vision and Schemes** – 'Early Implementers', how the submission meets **National Conditions** and finally, identified strategic **Risks**.

Part 2 describes the **performance measures** to be used and the agreement on the use of the BCF in 2014/15 and 2015/16. Critically it also seeks to reflect the level of ambition to **pool budgets** across both health and social care.

The connection between this BCF document and the Lincolnshire Sustainable Services Review (LSSR) is critical. In other words, if the LSSR is a five year plan to transform health and social care in Lincolnshire then the BCF describes the first two years of that plan. It is also where national policy and local ambition coalesce.

NHS England provides a representative from the Area Team who participates in both the Health and Wellbeing Board and the LSSR Governance Board, where both BCF and LSSR have been presented and discussed. The Area Team representative also agreed to act as a critical friend in the development of the BCF submission attached. Furthermore, we are currently negotiating with the Area Team details of primary care spend so that this can be considered for inclusion in pooled budget arrangements supporting neighbourhood team development. As such we will need NHS England to support the level of ambition described in the attached Part 1 and 2 submissions.

The value of the BCF in Lincolnshire in 2014/15 is £15.4m. In 2015/16 the value of the fund will reach just under £53m. This incorporates an allocation to help underwrite the costs of implementing both the Care Bill from 2015, and the 'Dilnot Reforms' (how people will be charged for adult social services for which they are eligible).

The Task Group charged with constructing this BCF submission has senior representatives from each of the four CCGs and includes their Chief Finance Officers. It is Chaired by the Director of Adult Social Services with other colleagues from LCC covering Children's Services, Public Health, Performance and Finance. Colleagues in Public Health lead on engagement with the seven District and City Councils in Lincolnshire to ensure their contribution is both recognised and incorporated.

The following timeline describes the stage of evolution this document has arrived at and, what is expected to happen next.

DATE	GOVERNANCE PROCESS
12.11.2013	Task Group
28.11.2013	Task Group
10.12.2013	Health and Wellbeing Board
18.12.2013	Task Group
06.01.2014	Task Group
13.01.2014	Task Group
14.01.2014	Informal Executive of LCC
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27.03.2014	East CCG Board
27.03.2014	Overview and Scrutiny Management Committee
01.04.2014	Formal Executive of LCC
04.04.2014	**Final version submitted to NHS England**

We believe that this BCF submission meets the requirement to reflect the aims and objectives in the Health and Wellbeing Strategy and respective CCG planning documents. The level of 'read-across' is therefore high.

This BCF submission represents a cornerstone upon which the LSSR builds. It also further facilitates the shared ambition across health and social care organisations and more firmly bind us together in a way not previously seen in the county.

The Lincolnshire Health and Wellbeing Board are fully supportive of this 'first-cut' submission and commend it to you.

Yours sincerely

Cllr Sue Woolley
Chairman
Lincolnshire Health & Wellbeing Board

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Better Care Fund planning template – Part 1 (Final version)

Please note, there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Lincolnshire County Council**
Clinical Commissioning Groups	**West CCG**
	East CCG
	South West CCG
	South CCG
Boundary Differences	**The population of Lincolnshire is 740,158. The GP registered population of the four CCGs combined is 761,002. The distribution of the CCG population is as described below in boundary details**
Date agreed at Health and Well-Being Board:	**28/1/2014**
Date submitted:	**12/02/2014**
Minimum required value of ITF pooled budget: 2014/15	**£15.4m**
2015/16	**£48.4m**
Total agreed value of pooled budget: 2014/15	**£70.8m**
2015/16	**£197.3m**

Boundary Details - how we propose to deal with the different populations between CCGs and LCC
As part of the work supporting the Blueprint detailed analysis suggests there are significant issues to address across Lincolnshire but also across the four Clinical Commissioning Groups. Modelling has taken place to understand current utilisation of service but more significantly what will be required in five years' time. Demographic trends lead us to believe that the population will age rapidly, with the West and South

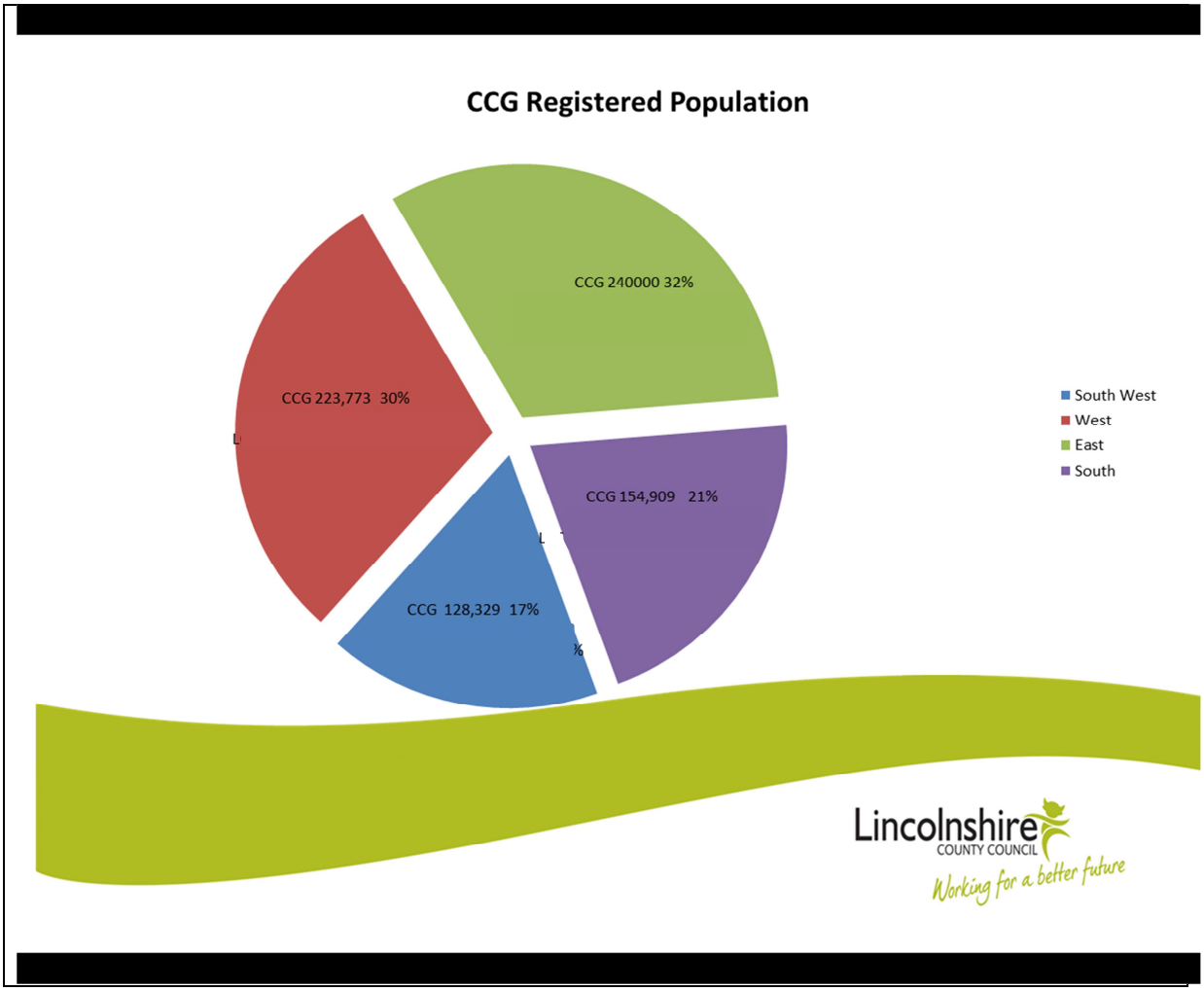
West ageing most.

The number of children in Lincolnshire is projected to grow by 10%, most in the East, at the same time the number of births is projected to fall, particularly in the West. We also know that the volume of patients leaving the County for inpatient treatment is significant and therefore Lincolnshire is dependent on out of area providers, such as Peterborough, for inpatient services. There are also no significant net inflows of patients from outside the county into Lincolnshire.

Whilst the LSSR Blueprint is described as an overarching clinical and social care strategy for consistent outcomes, quality and safety of services, some services will have to be enhanced further to support demographic changes in differing areas or provided slightly different in the operation delivery. These will be most profound in the care of the elderly and children's care, dependent on the area especially around the model for proactive care.

Consideration of the interface with other reviews outside Lincolnshire is being undertaken especially with the knock on effect of the Peterborough, North and North East Lincolnshire and North Nottinghamshire reviews to ensure they read across.

Finally, the LSSR is also building on the current initiatives that Lincolnshire is undertaking, especially Shaping Health for Kesteven, to ensure that both patients and the wider population recognise one health and care system but with local issues within it, and that no one falls through any gaps that might appear due to boundary difficulties and the impact that the LSSR has with other reviews.



b) Authorisation and sign-off

Signed on behalf of the Clinical Commissioning Group	South West Lincolnshire
By	Allan Kitt
Position	Chief Operating Officer
Date	28/01/2014

Signed on behalf of the Clinical Commissioning Group	West Lincolnshire
By	Sarah Newton
Position	Chief Operating Officer
Date	28/01/2014

Signed on behalf of the Clinical Commissioning Group	East Lincolnshire
By	Gary James
Position	Chief Operating Officer
Date	28/01/2014

Signed on behalf of the Clinical Commissioning Group	South Lincolnshire
By	Gary Thompson
Position	Chief Operating Officer
Date	28/01/2014

Signed on behalf of the Council	Lincolnshire County Council
By	Tony McArdle
Position	Chief Executive
Date	28/01/2014

Signed on behalf of the Health and Wellbeing Board	Lincolnshire Health & Wellbeing Board
By Chair of Health and Wellbeing Board	Cllr Sue Woolley
Date	28/01/2014

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

The Lincolnshire Sustainable Services Review (LSSR) included the three NHS Provider Trusts within Lincolnshire as stakeholders from the beginning. They are United Lincolnshire Hospitals NHS Trust, Lincolnshire Community Health Services NHS Trust, and Lincolnshire Partnership NHS Foundation Trust. In addition, the East Midlands Ambulance Service NHS Trust have been involved throughout. The review document is attached below in Related Documentation.

Social Care providers, housing providers and third sector providers have also been involved in the production of the LSSR. Additionally, an approach to securing ongoing engagement with the large and diverse independent social care and housing provider market is under discussion that will utilise the Executive Board of Social Care providers (called 'Linca') to support the work of delivering the LSSR which subsumes this two year plan. It is also intended that these delivery vehicles will also incorporate local preparations for the advent of both the 'Care Bill' and social care funding reforms.

Primary Care Providers are represented on the LSSR Programme Board by the Chairs of the four Clinical Commissioning Groups, South West, South, East and West. The ambulance service is represented by East Midlands Ambulance Services who also have a seat at the Board. Each provider organisation has two representatives at the Board to ensure both organisational leadership as well as clinical, this is usually the Trust Chief Executive and the Trust Medical Director.

Everyone in the Health and Social Care economy needs to understand, believe and support the delivery of the LSSR Blueprint and a model of integrated care for the future. All service provider organisations are expected to cascade information of what is happening at the LSSR Board as well as to be able to discuss the Blueprint to ensure transparency and consistency of message and also get feedback or concerns from their staff and share with the programme team and Board.

In the development of the blueprint, constituent organisations tasked professionals and representatives from 3rd sector and carer groups across Lincolnshire to work together to

co-design, how care will be delivered in the future.

Over 80 Health and Care professionals have been involved in co-design by taking part in three workshops providing their inputs and sharing their experience and insights on the four care design groups. These came together with a Health and Care Summit early in October 2013 where nearly 200 attendees met to bring the blueprint together. Social Care providers and third sector providers attended the Care Summit in addition to the health organisations identified above.

d) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

The LSSR Blueprint document is now at the end of Phase 1 (design stage). Phase 2 will develop a more detailed planning model. The LSSR Board is keen to have strong levels of engagement.

Health Watch Lincolnshire is a member of the LSSR Programme Board and the care design groups also included Lincolnshire Carers and the Young Carers Partnership. Stakeholder engagement has included inviting a range of designated patient organisations to take part in the four care design groups as well as a large presence at the Health and Social Care Summit. Staff from the programme team have attended service user meetings, discussions have taken place with St Barnabas Hospice (as the leading third sector provider of 'end of life care') and visits have been undertaken to all the District Councils across Lincolnshire. The key objective of Phase 1 was to be open and transparent about the process but not to discuss in depth the outputs. These will become more detailed in Phase 2. Communication teams have worked hard to brief as many of the population as possible with weekly proactive media briefings and newsletters.

At the end of further design work in Phase 2 - anticipated for April 2014, there will follow a formal process of public engagement for three months (May, June, July). We are currently seeking options on how best to ensure this period of public engagement will satisfy a level of scrutiny across both health and social care communities.

e) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
Attachment 1 - Lincolnshire Sustainable Services Review.	 LSSR_Blueprint_1111 2013.pdf
Attachment 2 – LSSR JHWS Matrix Summary	 LSSR JHWS Matrix Summary.docx

2) VISION AND SCHEMES

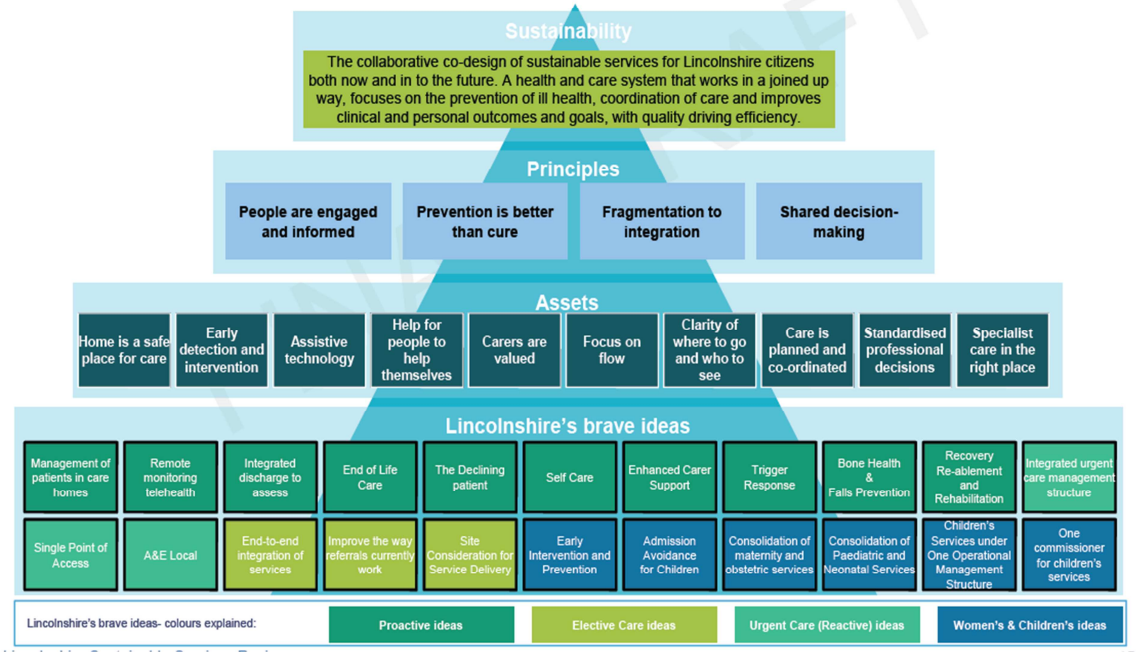
a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

We have drawn on best practice both within the UK and further afield.The following diagram best represents our collective ambition to transform health and social care services in Lincolnshire. We will build services that better serve the people of Lincolnshire, improves health and social care outcomes and the 'customer' experience. In doing this we will be organisationally agnostic so that form will truly follow function. This will be our collective mindset from which we will secure a sustainable financial base into the long term.

The diagram below provides on one page the golden thread between Lincolnshire's goal of the design of sustainable services in the future model through key principles, use of assets and brave ideas:



Aims and objectives
Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

There is already significant congruence between the priority themes, objectives and measures in Lincolnshire's Joint Health and Wellbeing Strategy (JHWS) and the objectives and outcomes being pursued through the LSSR and this Better Care Fund Programme.

Our JHWS was developed on the basis of priorities identified during the comprehensive stakeholder engagement undertaken by the local Health and Wellbeing Board in developing its JSNA. The table below identifies the degree of existing congruence across the JHWS, LSSR and BC programme.

Lincolnshire Sustainable Services Review (LSSR) mapped to Lincolnshire Joint Health and Wellbeing Strategy (JHWS)

	Promoting Healthier Lifestyles	Improve the health and wellbeing of older people	Delivering high quality systematic care for major causes of ill health and disability.	Improve health and social outcomes for children and reduce inequalities	Tackling the social determinants of health.
Proactive Ideas	X	X	X		X
Elective Care Ideas	X	X	X	X	
Urgent Care Ideas		X	X		
Women's and Children's Ideas				X	X

A fuller analysis of the congruence described above is included as Attachment number 2 (see above).

The Health and Wellbeing Board already has influence and oversight of the extent to which the commissioning plans of all the health and social care commissioners, and other public bodies like district councils, are driving towards the outcomes, objectives and measures within the JHWS. The tracking of delivery of these intentions is supported by a suite of measures selected from the national outcomes frameworks for the NHS, Adult Social Care and Public Health. The Board performance manages achievement in the short term against these measures.

A summary of the mapped measures as they stand is provided in the table below, it is proposed that measures identified in this BCF proposal would be added to the outcomes pursued through JHWS and JSNA once agreed.:

Joint Health and Wellbeing Strategy Outcomes mapped to LSSR Themes and National Outcomes Frameworks

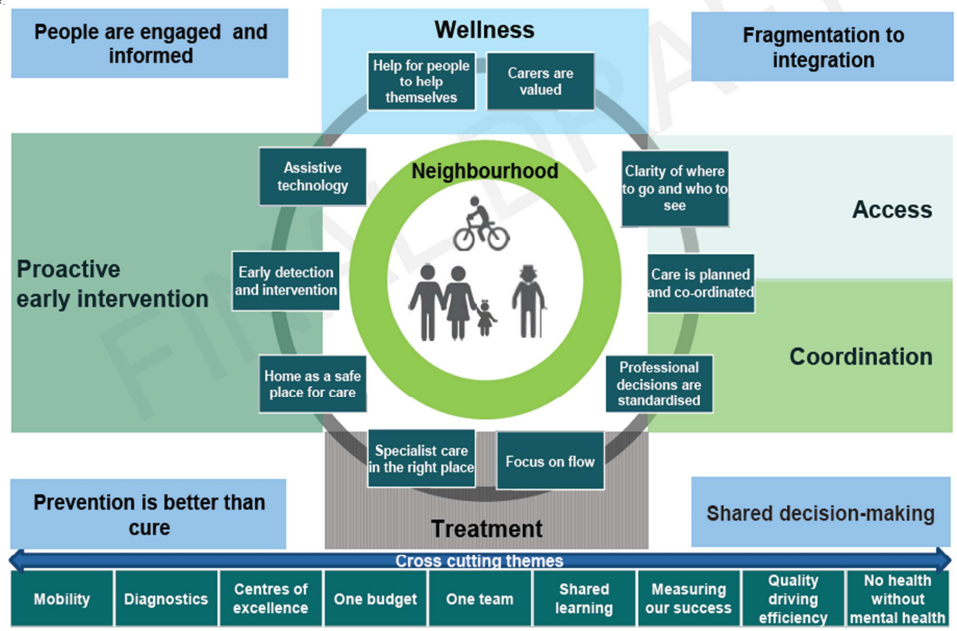
JHWS - Theme	JHWS - Priority	LSSR Overlap	Outcome Measures
Promoting Healthier Lifestyles	Reduce the number of people who smoke	Proactive, Elective Care	PH 4.7 / NHS 1.2 Mortality from respiratory diseases
Promoting Healthier Lifestyles	Reduce the number of people who are overweight or obese	Proactive, Elective Care	PH 4.4 / NHS 1.1 Mortality from all cardiovascular diseases
Promoting Healthier Lifestyles	Support people to drink alcohol sensibly	Proactive, Elective Care	PH 4.6 / NHS 1.3 Mortality from liver disease
Improve the health and wellbeing of older people	Change how we spend our money to enable more older people to stay safe and well at home	Proactive, Elective Care, Urgent Care	ASC 2B / NHS 3.6i Older people still at home 91 days after discharge from hospital
Delivering high quality systematic care for major causes of ill health and disability	Reduce unplanned hospital admissions for people with Chronic Obstructive Pulmonary Disease	Proactive, Elective Care, Urgent Care	PH 4.7 / NHS 1.2 Mortality from respiratory diseases
Improve health and social outcomes for children and reduce inequalities	Increase access for parents to good information and support throughout their child's life	Elective Care, Women's and Children's	PH 4.1 / NHS 1.6i Infant mortality
Tackling the social determinants of health.	Support more vulnerable people into good quality work	Proactive, Women's and Children's	PH 1.8 / NHS 2.2 Employment for those with a long term health condition

Each theme of the JHWS has a named Board sponsor who is supported by a consultant level public health specialist and these individuals are tasked with supporting implementation planning and delivery of their themes across the complex commissioning and delivery systems that exist in Lincolnshire. The LSSR and BCF activity that will support JHWS delivery have already been accepted by the Health and Wellbeing Board and LSSR implementation is accepted as a key mechanism by which the planned JHWS benefits will be delivered for local people.

As the BCF proposals are based on the LSSR work already completed, the Board will 'absorb' the BCF activity into its expectations and performance management of the delivery of the JHWS and bend its weight and influence to actively align its other programmes of work to this as a key delivery vehicle for wider strategy. A key feature of this would be the adaptation of our IT based and inherently dynamic approach to JSNA to move to providing the intelligence for planning and performance management of the activities and interventions within the BCF programme.

Our JSNA constantly evolves and adoption of the BCF activity into the delivery programme for the JHWS as described above will ensure that the JSNA moves to support the activity. See also Attachment 2.

The diagram below details, on one page, the elements which have been described across all four care design groups and reviewed by the Programme Board to form the proposed future model of care. This model is intended to encompass the full spectrum of physical, mental health and social care services across Lincolnshire.



b) Description of planned changes
Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

The timeframe in which we plan to begin to deliver transformation to health and social care services in Lincolnshire takes place over three years and has already begun with Phase 1 and the publication of the Lincolnshire Sustainability Review. Phase 2 will see further detailed planning before a formal period of public consultation takes place around May 2014 for a period of three months. Please see the diagram below for further detail.

We have carefully selected five 'Early Implementers' that are seen as central to securing early progress against the LSSR. They will also help ensure we are well placed to meet the requirements for performance improvement against the BCF national targets and our locally selected target. In addition these Early Implementers are intended to build on some of the pre-existing infrastructure that exists and which require further development if they are to secure profound improvement to outcomes, quality and sustainability – as such they provide early momentum and opportunity for learning. Finally, they have been chosen as pre-requisites to creating the opportunity for substantial reductions in acute beds which in turn frees-up resources for further primary/community based capacity – with the expectation that this will produce a virtuous cycle.

The Early Implementers are:

1. The development of **'neighbourhood teams**' at a number of locations reflecting GP clusters.

Mr A is 27 and has low level needs not eligible for social care support, but is identified through our triggers that he could benefit from a brief spell of support. Mr A will be assessed to identify what support and equipment he could benefit from.

Mr A feels isolated and alone, often having episodes of low self-esteem and depression, his GP referred him to the Wellbeing Service to receive support from a worker that would give him confidence to improve his social connection with his peers and community.

Mr A's assessment noted he sometimes struggled to take his medication as prescribed and the Wellbeing Service sourced some assistive technology that could aide him in taking his medication.

Mr A identifies caring for his ageing mother as a particular stress for him. The Wellbeing Service assess Mrs B and notes she has early stages of dementia and is becoming increasingly frail. Mrs B receives assistive technology that:

- *Helps her remember to take her medication;*
- *Installs a monitored fire safety sensor that connects to the Wellbeing Service Monitoring Centre and assure a proportionate and timely response is made to any alarms.*

2. The Development of a pooled budget and jointly commissioned **Intermediate Care Layer**.

Case Study: Admission Avoidance. GP Out of Hours Referral.

Mrs A is visited by the Out of Hours GP on a Saturday. She is an 84 year old lady with a recent history of falls. The GP identifies a need for support to avoid hospital admission, and contacts the Combined Independent Living team.

An Assessor visits the same day and makes a full assessment of Mrs A. The following day, Sunday, a bed lever, raised toilet seat and toilet surround are delivered. A zimmer frame is also provided, and 16 days after commencement Mrs A is discharged, recorded as feeling much better with improved appetite and one call a day from a home care provider. She is advised to contact the local team if she needs further help.

3. **Seven-Day Working** which will begin in the Acute Sector but be developed into community where appropriate.

4. **Prevention** which will incorporate a number of short term projects funded by the BCF and the developing 'Wellbeing' service led by Public Health colleagues. It will also need to include young people – notably regarding the implications of 'Support and Aspiration'.

5. **Enablers** notably estates, organisational development and IMT. We consider organisational development and indeed workforce development as critical enablers to successful integration. To this end the Lincolnshire Education and Training Board (LETB) will be approached to secure additional support outwith this BCF allocation.

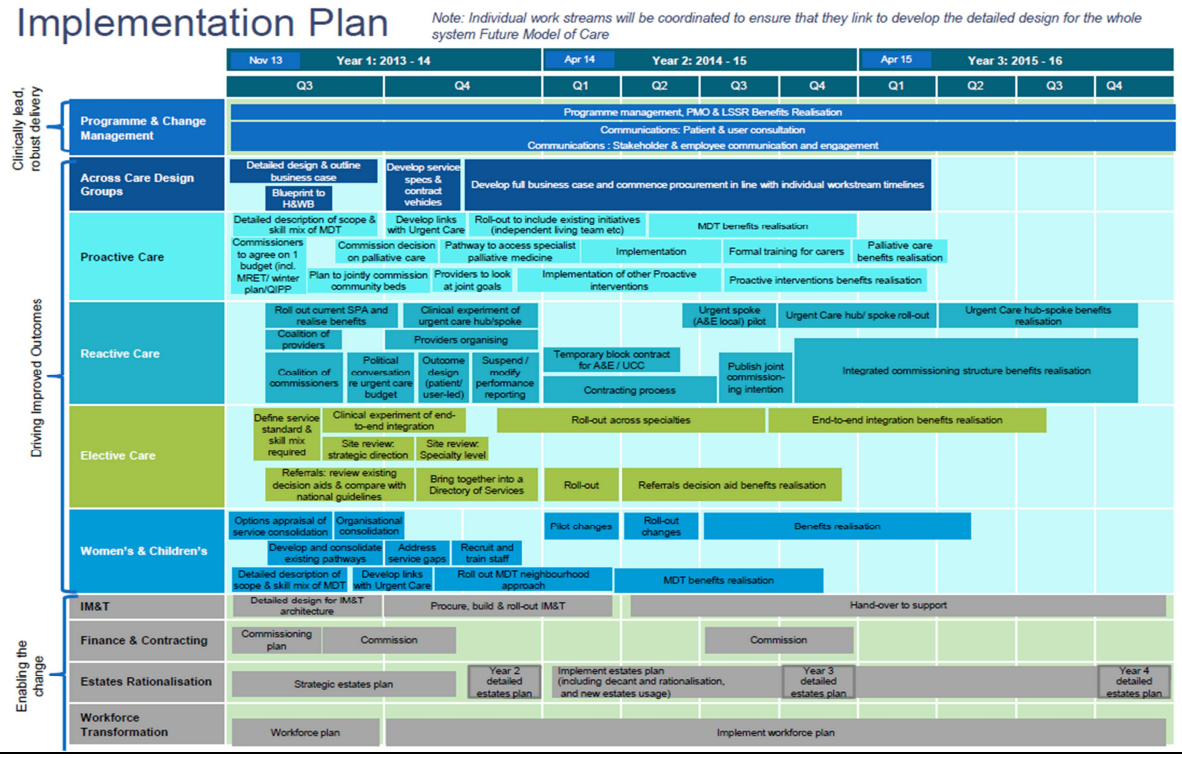
Part 2 of this submission details the allocation of BCF funds against each of the above. They will also facilitate further pooling of budgets beyond what we have already achieved.

The examples given above describe a number of new and pre-existing initiatives. However, our ambition is to increasingly combine services, based on a clear understanding of what works best and where synergies can be obtained. This will mean the merging of currently disparate services that may exist across several organisations. We will progress single service configurations through a collective approach to commissioning, for example in creating shared access points and in the further development of intermediate care services. We will remain organisationally agnostic.

The Joint Strategic Needs Assessment, Health and Wellbeing Strategy and current plans are fully embedded within our Sustainability Review, there is evidence for this assertion in the documentation attached to this BCF Plan. In addition a thorough analysis of Adult Social Care was undertaken during 2012/13 entitled '14Forward'. The resulting analysis was incorporated into the Sustainability Review. Furthermore, any plans in production such as for people with autism and, those with dementia will be shaped to reflect the ambition of our Sustainability Review and what we intend to achieve collectively.

The Health and Wellbeing Board will have overall responsibility for ensuring a high degree of consistency and congruence between our developing knowledge of local

communities, their needs, wishes and aspirations, coupled with a clear understanding of what good looks like. The Health and Wellbeing Board will be supported by a small number of Delivery Boards for aspects of this plan. Led by senior officers from both health and social care organisations and with dedicated programme support to ensure resources and skills are brought together for best effect.



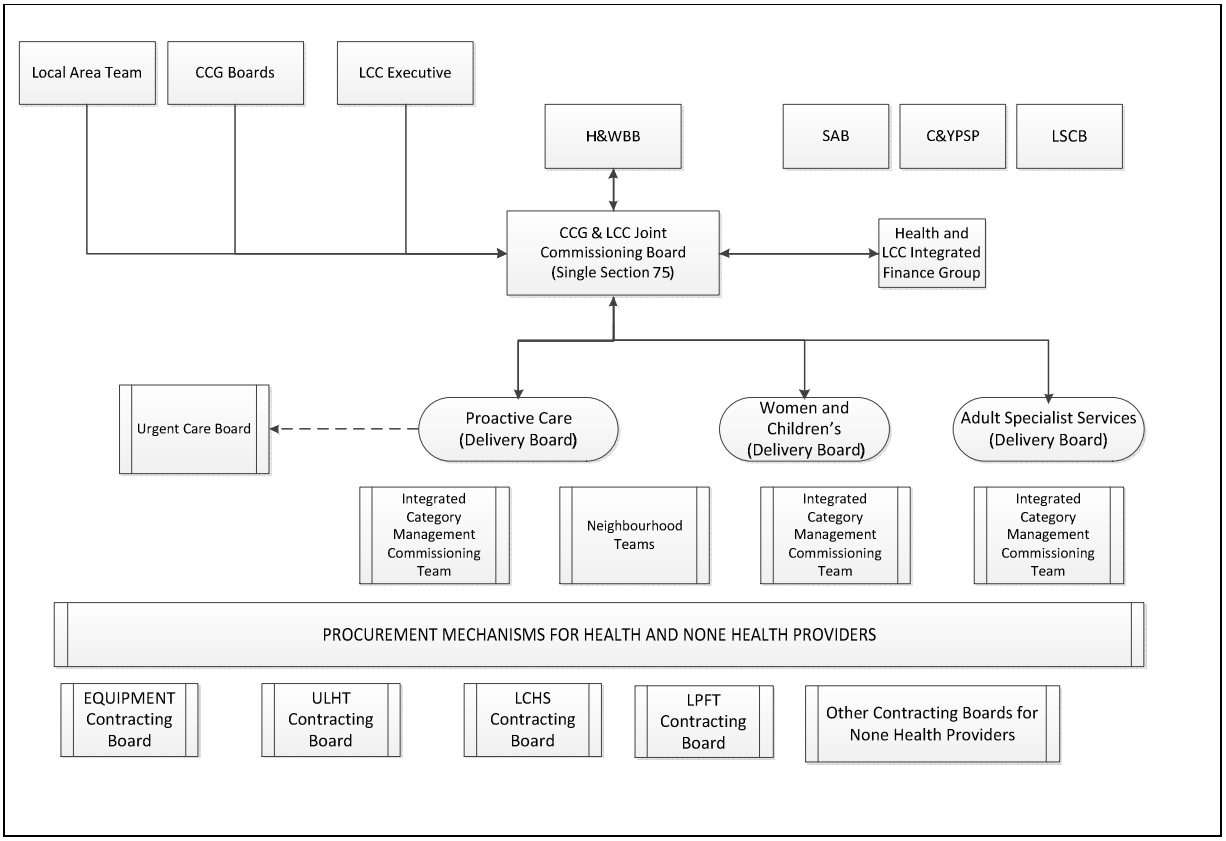
c) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

The LSSR Blue print defines Lincolnshire's vision for service reconfiguration including very significant reduction in acute bed capacity from the acute sector by 2016/17 and the strengthening of community based services with extended 7 day working wrapped around Neighbourhood teams. This objective is consistent with the national requirement to reduce emergency admissions by 15%. Performance metrics for this are in Part 2 and will be completed once the national dataset is available. Years 2014/15 and 2015/16 are key transitional years during which time momentum for change must be galvanised into targeted delivery. Failure to deliver will result in a significant financial gap across Lincolnshire Health and Social Care Services. For the two transitional years focus is being given to commencing a reduction of acute hospital bed capacity by further preventing avoidable acute hospital admissions, reducing delayed transfers of care and ensuring that the valuable acute sector facilities are utilised to best effect for those most in need of specialised acute hospital care. Implementation of the Urgent Care Board strategy will be critical to support the delivery of targets. Due consideration is being given to the acute sector clinical strategy which is currently undergoing early clinical consultation.

d) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes



ALIGNING LEAD RESPONSIBILITY TO DELIVERY BOARDS

Topic Area	Pro-active Care	Women and Children's	Adults Specialist Services
BCF Early Implementers:			
Neighbourhood Teams	✓	✓	
Seven Day Working	✓	✓	✓
Prevention	✓	✓	
Intermediate Care	✓		
Enablers	✓	✓	✓
Joint Dementia Strategy			✓
Joint Autism Strategy			✓
Joint Carers Strategy	✓		
Pooled Budget Targets (2015/16) – estimated	79.7m	5.5m	112.1m
BCF Performance Targets:			
Permanent Admissions of Older People to Residential Care	✓		
Proportion of Older People	✓		

still at home following Reablement/Rehabilitation			
Delayed Transfers of Care	✓	✓	✓
Avoidable Emergency Admissions	✓	✓	✓
Patience Service User Experience	✓	✓	✓
Proportion of People feeling supported to manage their Long-term Conditions	✓		

The above table begins to provide additional clarity concerning which Delivery Board in the governance structure previously described would take lead responsibility for the five "early enablers" within the BCF, the pooled budget figure to be achieved in 15/16 and relevant BCF performance targets described in Part 2 of this submission. Furthermore, lead responsibility for current strategy development is detailed.

The design phase of LSSR will see the creation of a number of design groups. These groups will liaise with relevant Delivery Boards as described above.

Each Delivery Board is expected to work with colleagues in other boards to ensure where overlaps exist these are collectively managed.

3) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services.

Our working definition has several elements to it. These are:

1. That the current eligibility to Adult Social Care will be maintained at substantial and critical.
2. Section 75 agreements, whether existing or new, will not reduce or impact negatively on performance or quality of adult social care services in securing agreed levels of future funding and performance.
3. The design of new models for commissioning and supplying social care services will not detrimentally affect performance against ASCOF (notably those detailing hospital discharge, personalisation and reviews); from the baseline of March 2013.

Each Delivery Board and ultimately the Health and Wellbeing Board will monitor progress to ensure this definition is observed.

Please explain how local social care services will be protected within your plans.

We recognise that there is little protection for either Health or Social Care services unless we take a profound step towards integration as detailed in our Sustainability Review. Only in this way are we likely to secure services to meet Health & Social Care needs in Lincolnshire. The Executive of the County Council expect that Social Care Services will be maintained as we develop more pooled budget arrangements based on agreed and shared outcomes. The County Council will continue to monitor performance and outcomes using benchmarking data, trend analysis and ASCOF. Adult Care has a robust and comprehensive quality assurance system in situ that will also ensure services are not impaired as the proposed changes in this plan and the Sustainability Review progress. Our approach to transformation is to ensure that there is stability in areas of core health and social care provision. Through the Sustainable Services Review we will implement transformation in an incremental way so there is a risk management approach to change management and social care services will be protected. To enable us to plan change whilst protecting vulnerable clients, we will utilise some ITF funding to protect services so there is stability through change management.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

The Lincolnshire health and social care community, is fully committed to working in partnership to secure sustainable high quality seven day services, in line with the LSSR Blue Print.

The multi-agency Lincolnshire Urgent Care Group will oversee the development of 7 day services. It is recognised that any move to seven day working within Lincolnshire hospitals will bring greatest benefit if it is part of a move to seven day working across all organisations and agencies that provide care to the people of Lincolnshire either in

hospital, their own homes. The approach being taken by each of our main providers is set out below.

United Lincolnshire Hospital Trust

In order to make the move to seven day working in unscheduled care, across all ULHT sites a number of actions have already been taken these. In November 2013 a broad cross section of clinical leaders (supported by senior managers) met to outline which medical, diagnostic, therapeutic and support services need to be available to support seven day unscheduled care. Building upon this dialogue and taking account the draft standards for 7 day working published by NHS England; guidance from learned bodies (eg Royal colleges and Professional organisations), and experience elsewhere across the NHS, a framework is being developed setting out the services required to deliver unscheduled care services across ULHT. In turn each hospital site within the Trust providing unscheduled care will be required to develop proposals for the delivery of those elements of service on their site. This will ensure consistent standards of service across the Trust whilst allowing for site-specific approaches to delivery.

Once proposals for delivery have been developed they will then be the subject of scrutiny by a multi-disciplinary group. This will ensure:-

- the model of delivery is capable of delivering the benefits in terms of mortality reduction, improved patient experience and reduction to length of stay
- Ensuring that any proposed increase to the cost of delivery is justifiable.

The Trust is committed to at least one site within the Trust commencing the delivery of seven day unscheduled care services in April 2014, with all other sites operational by the end of June 2014.

Lincolnshire Community Health Services

LCHS are committed to delivering high quality, safe services throughout the 7 day working week. To achieve this in the longer term, the organisation intends to undertake significant transformational change in the way services are delivered.

In the shorter term, immediate actions have been taken to restructure elements of the community nursing resource to work across both the 7 day and 24 hour periods in support of the programme of admission reduction schemes being trialled in the county. The recruitment drive supporting these schemes has been based on a seven day working week, signalling a shift in the organisation's commitment towards a goal of standardising all future clinical appointments throughout the trust.

In addition the organisation has introduced an attendance management tool which supports front-line staff to maximise their capacity and performance manage attendance across a 7 day period, 365 days of the year. This has been supported by the implementation of a roster policy which embeds the principles of improving working lives, whilst ensuring that safe levels of staffing are available to maximise and sustain the delivery of services in the community. Performance management of attendance across community teams is now being formally monitored via internal processes, with significant challenge being applied to areas where there is evidence of in- efficient utilisation of available resource. This is particularly pertinent in times of predicted peak activity.
A review of our existing community work force is being undertaken. The aim of this review is to ensure a baseline for safe staffing levels are established in the community.

Pending the outcome of the review, there may be the potential for some movement of key clinical personnel around the county or indeed evidence of additional investment being required to support a robust community service provision.

In parallel work is being under taken to review current and future workforce planning, to recruit and retain a much more flexible workforce which can be fully utilised according to need such as; maximising bed occupancy, reducing length of stay and the management of increasingly complex patients being cared for in the community. The organisation also intends to implement new ways of working which require employees to work across a number of geographical areas as well as over seven days per week. This will ensure the future workforce is able to deliver the ambitions of the organisation's clinical strategy and be underpinned by the introduction of annualised hours contracts as well as the availability of a more robust bank system to supplement the existing workforce in times of increased need.

Lincolnshire Partnership Foundation Trust

LPFT has an on-going commitment to ensuring high quality, easily accessible and timely health and social care service provision across Lincolnshire. This is currently being achieved by a combining a number of established and newly developed services with continued innovation and partnership working always high priorities. The Single Point of Access for LPFT now provides one dedicated contact number for all Trust services and is available 24 hours a day, 7 days a week. 7 day services are provided by the Crisis and Home Teams, Rapid Response Teams and the Lincoln HIPs team to both provide care in the community, early discharge and admission avoidance. These services closely link to on-call medical staff, the wider Trust services such as the Integrated Community Mental Teams (7 days a week when required) and the wider health and social care community including the Emergency Duty Team.

Primary Care

The walk in Centre in Lincoln provides 7 day a week 8am to 8pm access to primary care. Out of hours GP access is commissioned from Lincolnshire Community Health Servicers. A number of Community Pharmacies throughout Lincolnshire provide services 7 days a week. There are also a number of dental practices that provide 7 day a week services.

The CCG will work closely with NHS England's Leicester and Lincolnshire Area Team who commission primary care services, to ensure the emerging Primary Care Strategy, is fully aligned and supports the implementation of the Lincolnshire Strategic Services Review.

Lincolnshire County Council

Adult Care will continue to meet the demand for assessment activity over seven days a week. This will be delivered by the Council's Customer Service Centre (CSC), neighbourhood teams, Emergency Duty and Hospital based staff who are able to work weekends and bank holidays to meet varying demands. LCC supports a joint reablement service with health partners working across the whole county 7 days a week this supports hospital avoidance and discharges. This has easy links to all providers and their access points to ensure a seamless health and social care response.

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

The NHS number is used as the primary identified for correspondence between health and social care.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

We can confirm that we are committed to adopting systems based on Open APIs and Open Standards. In social care we have procured a new case management system from Core Logic for implementation in January 2015. The software solution will implement a multi-agency case management system for social care that will act as an enabler to countywide, joint service delivery and empower greater flexibility and efficiency via secure, shared data services.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

There is an overarching Information Sharing Protocol agreed between the Health and Social Care Community in Lincolnshire which includes consent, access and security procedures, subject access requests, protocol management procedures, data protection and Caldicott requirements. The Local Authority uses GCSX e-mail in all patient identifiable exchanges of information. Mandatory training must be completed before individual accounts are authorised and managers are required to complete an Information Sharing Agreement audit providing details of the information to be shared. The Local Authority also completes the IG Toolkit self-assessment on an annual basis.

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

In Lincolnshire we have a pooled budget agreement between Lincolnshire CCGs and Lincolnshire County Council from which an integrated Assessment and Care Management Team is funded and hosted by LCC for Adults with a Learning Disability

aged 18+. Each case is open to a lead officer who is responsible for assessing the Health and Social Care needs of citizens. As at 30/11/2013 there were 1,700 open cases for adults with a learning disability aged 18+, representing 12% of the total number of adults supported in Lincolnshire (14,000 current adult clients – all ages and client groups).

LCC also has a section 75 agreement in place with Lincolnshire Partnership Foundation Trust (LPFT) that enables LPFT to deliver LCC's Social Care Assessment and Care Management Function. This is delivered as part of an integrated Community Mental Health Team (CMHT). This is predominately for people aged 18 to 64 at this point. LPFT have also developed a Single Point of Access (SPA) for Mental Health Services and there are opportunities to expand this initiative to all clients groups across Lincolnshire. Currently there are 600 open cases to the LPFT CMHT which represents 4% of total cases in Lincolnshire" (expressed as a % of 14,000 from above).

In Lincolnshire a new pathway was created in November 2013; all adults at risk of a hospital admission are referred to a multi-agency contact centre where the adult is assessed based on all available information by an appropriate health / social care professional into a pathway for the right support to enable the person to remain in their own home or as close as possible. In Lincolnshire; for this winter, the commissioners have in place 2 contact centres based on the prime need of the person being either Physical or Mental health. The contact centres provide a 24 hour a day, 7 day service across the County to all Health and Social Care Professionals.

The lead professional will remain involved until either the adult is no longer in need of support at which point the Lead professional role would transfer to the Adult's GP Practice; or the lead professional role is passed to an Adult Care practitioner to undertake a statutory Adult Social Care assessment of need.

The Lincolnshire Urgent Care Working Group has oversight of the overall quality assurance and performance for this new pathway and support systems will be provided from contact centre data which includes response times, waiting times, abandoned calls. Customer experiences are gathered ongoing by all providers with some individual patient experiences shared across Health and Social Care to demonstrate the effectiveness and monitor the outcomes for each patient.

The special educational needs reforms which come into place in September 2014 require health, education and social care to radically transform and streamline the system for SEN assessments. Statements will be replaced with an aligned assessment process and an integrated education, health and so vial care plan from birth to 25 years

The BCF will support improved cooperation between the social, education and health system so there is a shared understanding and integrated processes for delivering our statutory services under the new legislation.

4) RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

We have undertaken a Risk Assessment which is detailed below. We would highlight the level of resource invested in securing adequate capacity to ensure progress in both this BCF (notably with respect to the "Early Implementers") and the LSSR. Specifically, three senior appointments have been made to add capacity to the Delivery Boards identified in Section 2d (this included two jointly appointed Assistant Director grades). Health and Social Care commissioners along with the Area Team have added to this capacity by commissioning highly respected and skilled organisations to work alongside us. In phase 1 for example, PWC were commissioned to provide support and expertise.

Better Care Fund Risk Assessment

Risk No	Risk Description		Inherent Risk Score		
	Risk Source	Risk Consequences and mitigation	Probability	Impact	Score
001	Lack of capacity to transform and integrate will result in failure to maintain current performance and customer satisfaction, or failure to achieve integration	Investment in phase one of a county-wide review of the Health and Social Care Economy (Lincolnshire Sustainable Services Review) is completed and has provided an holistic view of key areas and high level models for integration. Non-recurrent funding for phase two will provide the necessary investment in capacity and infrastructure to support detailed mapping and impact analysis of models identified in phase one. Funding for phase 2 and phase 3 has been identified and the external consultancy has now been sourced which will provide additional capacity. The County Council has also added capacity to secure necessary progress.	1	4	4
002	An improved integrated pathway focused on prevention and keeping people safe in their homes is achieved but fails to deliver key performance improvements across health and social care economy resulting in reduced funding and an insufficient financial envelope to support core activity	Modelling from phase one of the services review considered key data, but includes a number of assumptions. This data will be further detailed in phase two allowing develop development of co-directed detailed business case and informed decision making. Phase 2 which will provide the necessary design is shortly to commence. Public Health has commissioned a new Well Being Service that will form part of the overall prevention 'offering'. This is due to begin 1/04/14.	2	4	8
003	Service providers, voluntary sector and community groups are unable to respond adequately to the re-modelling of commissioned services to achieve the vision	Phase two of the sustainable services review has a strong focus on consultation and collaboration and will build on the co-design of phase one across the provider and community landscape to fully understand and plan for the required level of support and investment to deliver an integrated vision. A robust governance structure with joint commissioning responsibilities will assist in securing necessary service levels and quality. Further, both NHS and Social Care Providers are engaged in the phase 2 work and overall governance of LSSR.	2	4	8
004	The anticipated financial impact of the care bill which has planned Royal Ascent in 2014 in not fully quantifiable although financial modelling and planning have been undertaken to an extent. This has potential to impact on the delivery and sustainability of current plans	An initial impact assessment has been completed and has been considered during phase one of the sustainable services review by Adult Care. Future planning needs to consider the risks and benefits of the bill to ensure a sustainable model is developed. The financial effect of new legislation has been reported. The government have indicated that the full cost of implementation will be fully funded.	2	4	8
005	The model chosen for an integrated health and social care system in Lincolnshire does not deliver sufficient whole systems base budget savings and the forecast deficit is not mitigated	The health and social care system re-design planned for in the Lincolnshire Sustainable Services Review has to demonstrate not only improvements for customer outcomes and experience, but sufficient radical re-engineering to deliver a balance budget across the Health and Social Care Economy. The earlier analysis in phase 1 and the detailed design work in phase 2 are supported by an external consultancy which provides a level of analysis and modelling based on best practice elsewhere.	2	4	8

Outcomes and metrics

For each metric other than patient experience, please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

Metrics	Metrics measurement	Delivery Board Responsible	Metrics outcome / benefit
Admissions of older people to residential care	Based on admissions to council funded permananent long term care and will be monitored through both the proactive care board	Proactive Care Delivery Board	There will be a reduction in admissions to permanent long term care over and above estimated growth in population through integrated intermediate care, neighbourhood teams, 7 day working and prevention schemes
Proportion of older people still at home over 91 days	Measures the benefit to individuals from reablement, intermediate care and rehabilitation following a hospital episode. Data is available on an annual basis and will be monitored through the proactive care board	Proactive Care Delivery Board	An increasing number of people will be maintained to live at home through integrated intermediate care, neighbourhood teams and 7 day working schemes
DTOC from ULHT acute hospital (including health and social)	This is based on ONS Population stats for 18 years over and is measuring health and social care reasons for DTOC from main acute hospital (ULHT). The monitoring will be undertaken on a monthly basis via the unscheduled care board	Unscheduled Care Delivery Board	There will be a reduction in the DTOC over and above estimated growth in population. This will support an easing of pressures on acute hospital beds.
Avoidable Emergency Admissions	Awaiting national baseline information	Unscheduled Care Delivery Board	Although the baseline figure is not yet available intermediate care, neighbourhood teams and 7 days working should support a reduction in emergency avoidable admissions
Patient Experience Metrics	Awaiting National Metrics publication	Proactive Care Delivery Board	All the schemes should support an improvement in patient experience of health and social care
Local metric - Proportion of people feeling supported to manage their (long term) condition	This measure is based on the GP patient survey question 'In the last 6 months, have you received enough support from local services/ organisations to help manage your long term condition	Proactive Care Delivery Board	All the schemes should support an increase in the proportion of people who feel that they are supported to manage their long term conditions

Area	Delayed Transfers of Care	Emergency Admissions	Effectiveness of Reablement	Admissions to residential and nursing care	Patient and service User experience	Proportion of people feeling supported to manage their (long term) condition
Intermediate Care	x	x	x	x	x	x
Neighbourhood Teams	x	x	x	x	x	x
7 day working	x	x	x	x	x	x
Prevention				x	x	x

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical

It is the intention to use the National Metrics once it has been published

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

The monitoring and assurance of delivery will be undertaken by the Joint Commissioning Board and the under-pinning delivery Boards as outlined within the Governance section of the BCF plan. This

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB and for the multiple-

N/A

Metrics		Current Baseline (as at....)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	784.6	N/A	733.1
	Numerator	1215		1214
	Denominator	155115		165597
		(April 2012 - March 2013)		(April 2014 - March 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*	72.40%	N/A	76%
	Numerator	653		761
	Denominator	902		1000
		(April 2012 - March 2013)		(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	262.99	247.67	247.79
	Numerator	1523	1476	1493
	Denominator	579100	595943	602520
		Oct 12 - March 13	(April - December 2014)	(January - June 2015)
Avoidable emergency admissions (composite measure)	*Metric Value*	1220.44	1190.69	1190.79
	Numerator	8773	8813	8913
	Denominator	718838	740158	748490
		Oct 12 - March 13	(April - September 2014)	(October 2014 - March 2015)
Patient / service user experience		Pending national publication	N/A	Pending national publication
Proportion of people feeling supported to manage their (long term) condition - ***Query on baseline data o/s with CCG's***	*Metric Value*	63%		64%
	Numerator	9418		9600
	Denominator	14933		15000
		July 2012 - March 2013	*N/A*	*July 2014 - March 2015*

(Leicestershire & Lincolnshire Area)
Fosse House
6 Smith Way
Grove Park
Enderby
Leicestershire
LE19 1SX

Tel: 0116 295 7500
Fax: 0116 295 7599

From the office of: David Sharp, Area Director (Leics & Lincs)
Telephone: 0116 295 7293
Email address: david.sharp5@nhs.net
Our ref: DS/ER/Letters/2014/Mar/10032014

10 March 2014

By email

Accountable Officers, East Midlands Clinical Commissioning Groups

Dear All

Better Care Fund (BCF) Assurance Update

Following the regional assurance for the BCF which assessed the draft BCF plans submissions as at 14 February and the self-assessment from each Health and Wellbeing (HWB) Board submitted on 27 February 2014, I would like to extend my thanks for all the ongoing work on the BCF and for your support in meeting the challenging timescales. Please also convey this message to your colleagues.

Each HWB Board was asked to submit a RAG rated BCF self-assessment, which showed its view of BCF plan completeness and risks at this stage, per the categories in the BCF assurance template. This also assessed if any gaps and further work would resolve matters before the 4 April 2014 final submission.

Regional assurance took place on 28 February 2014 with representatives from local government and NHS England. Those from local government were Cheryl Davenport, the Programme Adviser for HWB Boards in the East Midlands, and Lee Harrison, the ADASS Regional Lead, who works to Cath Roff and David Pearson. Cheryl Davenport works mainly to John Sinnott but also to me. Trish Thompson, Director of Ops & Delivery, NHS England was also involved in the assurance process.

The regional assurance process involved:

- A confirm and challenge on the HWB Board self-assessments and BCF draft plans.
- Reviewing analysis provided by NHSE on the metrics, baselines and trajectories.
- Overall assurance on national conditions (such as 7 day working and adopting the NHS number).
- Information from the NHS Local Area Team on the assurance on CCG operational plan drafts.
- Intelligence from local government about the local context affecting BCF plans in each council.

We have 3 products to share from this work:

1. From NHS England, a list of specific queries on metrics and baselines which need following up.
2. A RAG rated high level summary of BCF assurance showing the position across the East Midlands.
3. Individual feedback on findings per BCF plan with suggested actions to improve evidence/plans ahead of the 4 April 2014 submission.

The Regional Leadership Group* for the East Midlands HWB Board programme is meeting on 11 March 2014 to receive these products formally and we will circulate individual queries/feedback as soon as possible.

*Regional Group members: David Sharp (NHS England), Mark Edgell (LGA), Cath Roff (ADASS), Tony Hill (ADPH), Meng Khaw (PHE) and Rachel Holynska (DH).

I have enclosed some notes that were made by Cheryl and Trish following the submission of the draft plans and self-assessments, for information.

I hope this update is helpful.

David Sharp
Director (Leicestershire & Lincolnshire Area)
NHS England

Enc: Draft Plans and Self-Assessment Analysis

Council	Self-Assessment	NHSE Metrics / Finance Analysis	CCG Op Plan Draft Analysis	Local Govt Areas of Concern / Positives	Position at 28.02.14	Actions	Self-Assessment Adjustment
Lincolnshire	Received	£197m proposed (us £53m minimum).	Lincs West - Medium Risk / Low Deliverability	Good on joint commissioning with NHS	HWB sign off (letter if support - 11.02.14 and 28.01.14 meeting (no sigs)	More details -Explicit figure on social care protection.	ASC Protection - AMBER
	Amber: 7 day working Acct prof / Join assessment (no reds) Provider Impact Risk Plan Patient / Public	Residential care metrics (-6%).	South Lincs - Medium Risk / Medium Deliverability	Geographically challenged re provision / market development	National conditions, NHS number commitment	Implementation plan / op detail NHS number and 7 day wokring.	
		Trajectory of DTOC improvement (-407). LTC local metric no baseline.	South West Lincs - Medium Risk / Medium Deliverability		Provider engagement - via LSSR, not on BCF task group, 7 day working in LSSR, sustainability services review, Keogh trust, reconfiguration	Use modelling data and explain how care and support bill implications will be addressed in the BCF - including Financial assumptions.	
		plus tracjectory of improvement EM admissions also queried.	Lincs East - Medium Risk / Medium Deliverability		Care and Support bill - not explicitly referenced		
					Provider (impact on acute) - suggests 400 less acute beds, 15% less acute activity, PWC doing further impact analysis		
					Protection Social Care - No figure stated in narrative but have pooled budget.		

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Better Care Fund
Supplement to the assurance process guide

24 February 2014

Introduction

1. This note is a supplement to the guidance on the assurance process for Better Care Fund plans issued to Area Teams and Local Government peer review leads on 13 February.

2. The supplement is being provided following early discussion between government, NHS, and local government colleagues on some of the common risks and concerns which have emerged through the process of developing and submitting the first drafts of local plans. It is intended to provide further advice and clarification on the kinds of issues which should be considered in assessing the completeness and robustness of Better Care Fund Plans, and should be read in conjunction with the earlier guidance.

Principles of the Assurance Process

3. Some concern has been expressed that the assurance process is too top-down and driven by central concerns and requirements. The emphasis should be on the local assurance of plans, starting with the central role of the Health and Wellbeing Board, supported by the role of Area Teams and local government peer reviewers in assessing whether plans meet the national conditions and provide a firm basis to begin the process of service transformation.

4. This guidance should be used as one tool to support the assurance process. Area teams and local government peer reviewers should consider the content of the plan together with their knowledge of the area, its resource context, the quality of local relationships and leadership and the track record of delivering improvement, to consider whether there is a reasonable prospect of delivering transformational integration through the plan.

5. Officials from central government will not intervene directly with CCGs and councils in the details of the continuing process of developing plans (although ministers may, of course, wish to discuss progress with this or any other policy issue with local political leaders). Similarly, officials from the NHS England national support centre will continue to engage through regional and area teams, rather than intervening directly with individual CCGs.

6. It should be emphasised that the first draft of plans submitted in February are not expected to be complete in every detail. They should be assessed on the extent to which they provide a basis for completing a robust revised submission on 4 April.

Key national milestones

7. The revised submissions in April must be sufficiently complete and detailed in terms of metrics and financial plans to be signed off, and to provide a basis for the agreement of contracts with service providers. However, it is recognised that the details of planned

service changes may be subject to ongoing refinement through 2014/15. This will ensure that plans remain aligned with the ongoing process of developing five-year strategic plans and whole system savings targets.

Provider Engagement

8. The planning guidance for the Better Care Fund emphasised the importance of engaging service providers in the process of developing local plans and achieving a detailed shared view of the future requirements for service provision.

9. Early indications are that the quality and extent of this engagement has been very variable so far. The assurance process should have a clear focus on the evidence of provider alignment demonstrated by the plan, including how well the plan addresses the implications for provider activity, capacity and workforce requirements (providing a basis for discussion with LETBs about workforce numbers).

10. NHS England will work closely with Monitor and the NHS Trust Development Authority to assess the extent of alignment between providers' own plans and Better Care Fund and CCG operational plans. It is therefore in the interests of both providers and Health and Wellbeing Boards to ensure that providers engage with the Better Care Fund plans at an early stage. Councils and CCGs should speak to their Area Teams if they are having difficulties engaging with service providers.

Alignment with wider local strategic context

11. It is expected that in signing off draft plans Health and Wellbeing Boards will have considered the extent of alignment with both the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy. This alignment should be considered as part of the assurance process.

12. It will also be important to consider how well aligned the plan is with local plans for housing, and plans for the use of technology as an enabler for closer service integration and joint working.

Care and Support

13. Initial feedback suggests that there has been some confusion about the requirement for the Better Care Fund to meet the costs of support for carers and costs associated with the Care Bill. The requirements were set out in paragraphs 13-14 of the Better Care Fund planning guidance in December. The assurance process should consider how clearly the plan articulates the amount of money identified for Care Bill costs, and whether this is proportionate to the £135m allocated nationally. It should also consider where the plan is sufficiently clear on:

    - What level of resource will be dedicated to carer-specific support, including carers' breaks, and how the chosen methods for supporting carers will help to meet key outcomes. (This element of the plan should develop as local estimates the financial impact of the carers' element of the Bill are refined, and the eligibility criteria are published);

- How the Disabled Facilities Grant and the provision of adaptations can be incorporated in the strategic consideration and planning of investment to improve outcomes for service users.

Meeting National Conditions

14. The following points have emerged from local queries raised about the requirements of the national conditions for the Better Care Fund, and should be taken into account in the overall assessment of the evidence provided in plans on meeting these conditions.

Protection for Social Care Services

15. Does the plan set out how eligibility criteria will be protected and provide a rationale for any service changes?

16. Does the plan describe an increased focus on preventative services?

Joint Approach to Assessment and Care Planning

17. Evidence to date suggests that integration works best when there are single teams coordinating care, organised virtually or physically. While areas do not always need to co-locate teams or put in place complex joint funding of posts it is important to people that they know who they contact when they need to, that the person can facilitate a decision about their care in a timely manner and that they do not need to tell their story more than is necessary. Consideration should be given to how well plans demonstrate this approach to person-centred care planning.

18. Consideration should also be given to whether:

- the plan adequately considered the impact for people with Dementia in the local area; and

- the plan set out how GPs will be supported in being accountable for co-ordinating patient-centred care for older people and those with complex needs.

Quantitative Summary

19. To support the assurance process, Area Teams and Local Government regional peers, will be provided with a summary of the quantitative data from completed part two plan templates submitted on 14 February. Using RAG ratings, this will provide a high level view of the completeness of the plans submitted by each HWB. Area Teams and Local Government regions peers may want to refer to, and build on, this basic data as part of their more detailed assessment of the quality of plans.

Further Guidance

20. Further supplementary guidance may be provided as the process of plan development and assurance progresses, in response to any substantive issues which emerges from the early experience of the process.

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Appendix A (Part 1)

Better Care Fund planning template – Part 1 (Final Submission)

Please note, there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Lincolnshire County Council**
Clinical Commissioning Groups	**West CCG**
	East CCG
	South West CCG
	South CCG
Boundary Differences	**The population of Lincolnshire is 740,158. The GP registered population of the four CCGs combined is 761,002. The distribution of the CCG population is as described below in boundary details**
Date agreed at Health and Well-Being Board:	**25/3/2014**
Date submitted:	**4/04/2014**
Minimum required value of ITF pooled budget: 2014/15	**£15.4m**
2015/16	**£48.4m**
Total agreed value of pooled budget: 2014/15	**£70.8m**
2015/16	**£197.3m**
Boundary Details - how we propose to deal with the different populations between CCGs and LCC	
As part of the work supporting the Blueprint detailed analysis suggests there are significant issues to address across Lincolnshire but also across the four Clinical Commissioning Groups. Modelling has taken place to understand current utilisation of	

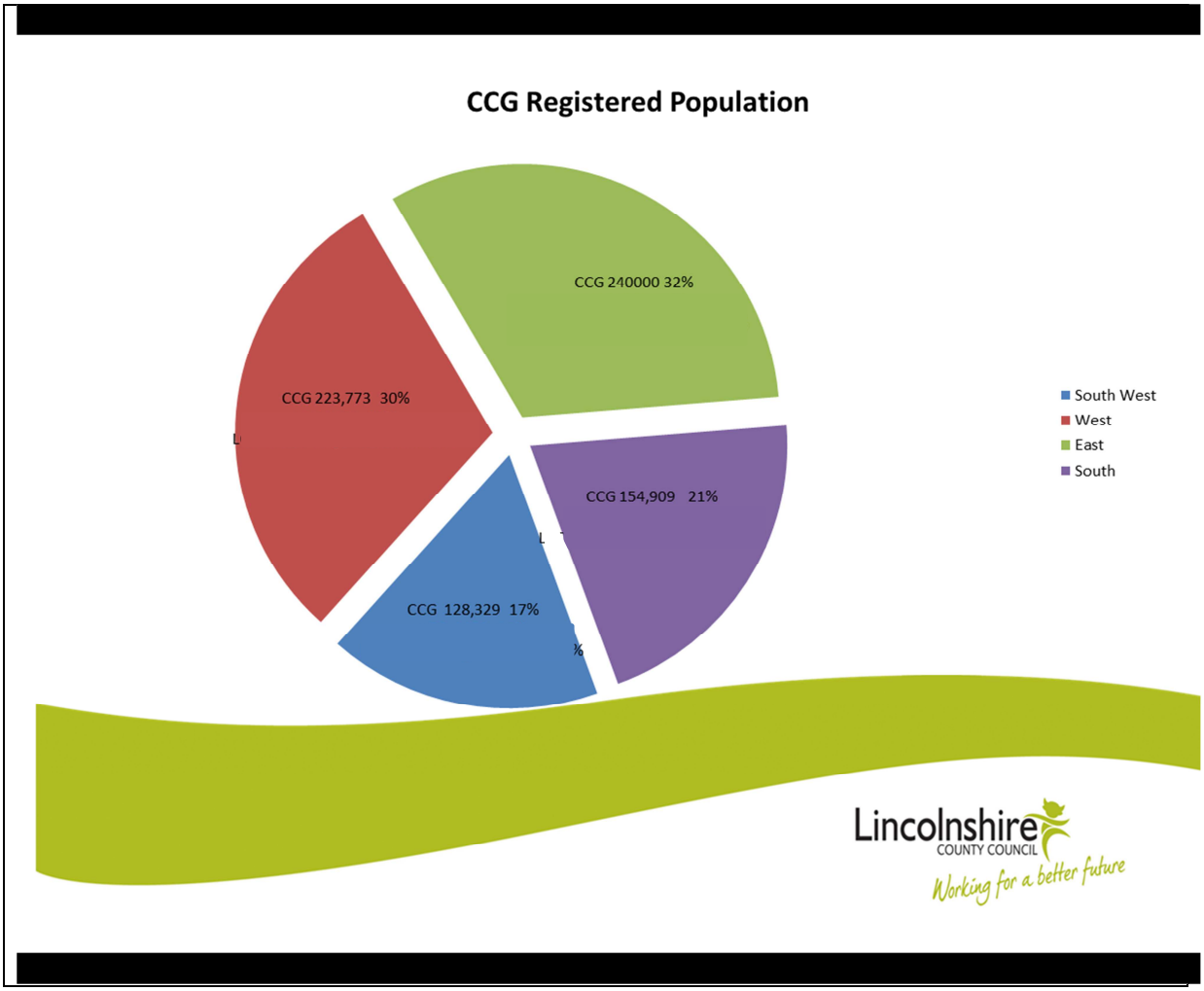
service but more significantly what will be required in five years' time. Demographic trends lead us to believe that the population will age rapidly, with the West and South West ageing most.

The number of children in Lincolnshire is projected to grow by 10%, most in the East, at the same time the number of births is projected to fall, particularly in the West. We also know that the volume of patients leaving the County for inpatient treatment is significant and therefore Lincolnshire is dependent on out of area providers, such as Peterborough, for inpatient services. There are also no significant net inflows of patients from outside the county into Lincolnshire.

Whilst the LSSR Blueprint is described as an overarching clinical and social care strategy for consistent outcomes, quality and safety of services, some services will have to be enhanced further to support demographic changes in differing areas or provided slightly different in the operation delivery. These will be most profound in the care of the elderly and children's care, dependent on the area especially around the model for proactive care.

Consideration of the interface with other reviews outside Lincolnshire is being undertaken especially with the knock on effect of the Peterborough, North and North East Lincolnshire and North Nottinghamshire reviews to ensure there is an appropriate level of 'read across'.

Finally, the LSSR is also building on current initiatives under way in Lincolnshire such as Shaping Health for Kesteven. This will ensure that both patients and the wider population recognise one health and care system but with local issues within it, and that no one falls through any gaps that might appear due to boundary difficulties and the impact that the LSSR has with other reviews.



b) Authorisation and sign-off

Signed on behalf of the Clinical Commissioning Group	South West Lincolnshire
By	Allan Kitt
Position	Chief Operating Officer
Date	25/03/2014

Signed on behalf of the Clinical Commissioning Group	West Lincolnshire
By	Sarah Newton
Position	Chief Operating Officer
Date	25/03/2014

Signed on behalf of the Clinical Commissioning Group	East Lincolnshire
By	Gary James
Position	Chief Operating Officer
Date	25/03/2014

Signed on behalf of the Clinical Commissioning Group	South Lincolnshire
By	Gary Thompson
Position	Chief Operating Officer
Date	25/03/2014

Signed on behalf of the Council	Lincolnshire County Council
By	Tony McArdle
Position	Chief Executive
Date	01/04/2014

Signed on behalf of the Health and Wellbeing Board	Lincolnshire Health & Wellbeing Board
By Chair of Health and Wellbeing Board	Cllr Sue Woolley
Date	25/03/2014

c) Service provider engagement
Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

The Lincolnshire Sustainable Services Review (LSSR), during Phase 1, included the three NHS Provider Trusts within Lincolnshire as stakeholders. These are also heavily involved in Phase 2 which is currently underway. They are United Lincolnshire Hospitals NHS Trust, Lincolnshire Community Health Services NHS Trust, and Lincolnshire Partnership NHS Foundation Trust. In addition, the East Midlands Ambulance Service NHS Trust have been involved throughout. The LSSR Phase 1 review document is attached below in Related Documentation.

Social Care providers, housing providers and third sector providers have also been involved in the production of the LSSR. An approach to securing ongoing engagement with the large and diverse independent social care and housing provider market has been concluded. This will utilise the Executive Board of Social Care providers (called 'LinCA') to support the work of delivering the LSSR which subsumes this two year plan. LinCA has designed a series of events during the next phase (Phase 2) of the LSSR to ensure a wide level of engagement. It is also intended that this work (LSSR and BCF) will also incorporate local preparations for the advent of both the 'Care Bill' and social care funding reforms.

In addition, colleagues in Public Health have engaged with District and City Councils and third sector providers to ensure their participation in key elements of this BCF and the LSSR. Specifically, in developing the Wellbeing Strategy which forms the core of the preventative work that we are progressing in Lincolnshire. This, in time, will subsume both the Integrated Community Equipment Services (ICES) and the DFG component of the BCF.

Primary Care Providers are represented on the LSSR Programme Board by the Chairs of the four Clinical Commissioning Groups, South West, South, East and West. The ambulance service is represented by East Midlands Ambulance Services who also have a seat at the Board. Each provider organisation has two representatives at the Board to ensure both organisational leadership as well as clinical, this is usually the Trust Chief

Executive and the Trust Medical Director.

In the development of the LSSR Review document – described as 'the blueprint', constituent organisations tasked professionals and representatives from 3rd sector and carer groups across Lincolnshire to work together to co-design, how care will be delivered in the future.

Over 80 Health and Care professionals have been involved in co-design by taking part in three workshops providing their inputs and sharing their experience and insights on the four care design groups. These came together with a Health and Care Summit early in October 2013 where nearly 200 attendees met to bring the blueprint together. Social Care providers and third sector providers attended the Care Summit in addition to the health organisations identified above.

We are now engaged in Phase 2 of the LSSR programme and have secured Price Waterhouse Coopers to support our work. Provider and public engagement is a critical component of this and we are in the process of securing additional capacity at a strategic and operational level. We anticipate being on schedule for formal public engagement later this spring.

d) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

The LSSR Blueprint document is now at the end of Phase 1 (design stage). Phase 2 will develop a more detailed planning model. The LSSR Board is keen to have strong levels of engagement.

Health Watch Lincolnshire is a member of the LSSR Programme Board and the care design groups also included Lincolnshire Carers and the Young Carers Partnership. Stakeholder engagement has included inviting a range of designated patient organisations to take part in the four care design groups as well as a large presence at the Health and Social Care Summit. Staff from the programme team have attended service user meetings, discussions have taken place with St Barnabas Hospice (as the leading third sector provider of 'end of life care') and visits have been undertaken to all the District Councils across Lincolnshire. The key objective of Phase 1 was to be open and transparent about the process but not to discuss in depth the outputs. These will become more detailed in Phase 2. Communication teams have worked hard to brief as many of the population as possible with weekly proactive media briefings, a dedicated website and newsletters.

As mentioned in Section C above Phase 2 has now commenced and "care design groups" have been formed to develop the detail of health and social care services. At the end of further design work in Phase 2 - anticipated for April 2014, there will follow a formal process of public engagement for three months (May, June, July). We are currently seeking options on how best to ensure this period of public engagement will satisfy a level of scrutiny across both health and social care communities.

e) Related documentation
Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
Attachment 1 - Lincolnshire Sustainable Services Review (Phase 1).	 LSSR_Blueprint_1111 2013.pdf
Attachment 2 – LSSR JHWS Matrix Summary	 LSSR JHWS Matrix Summary.docx

2) VISION AND SCHEMES

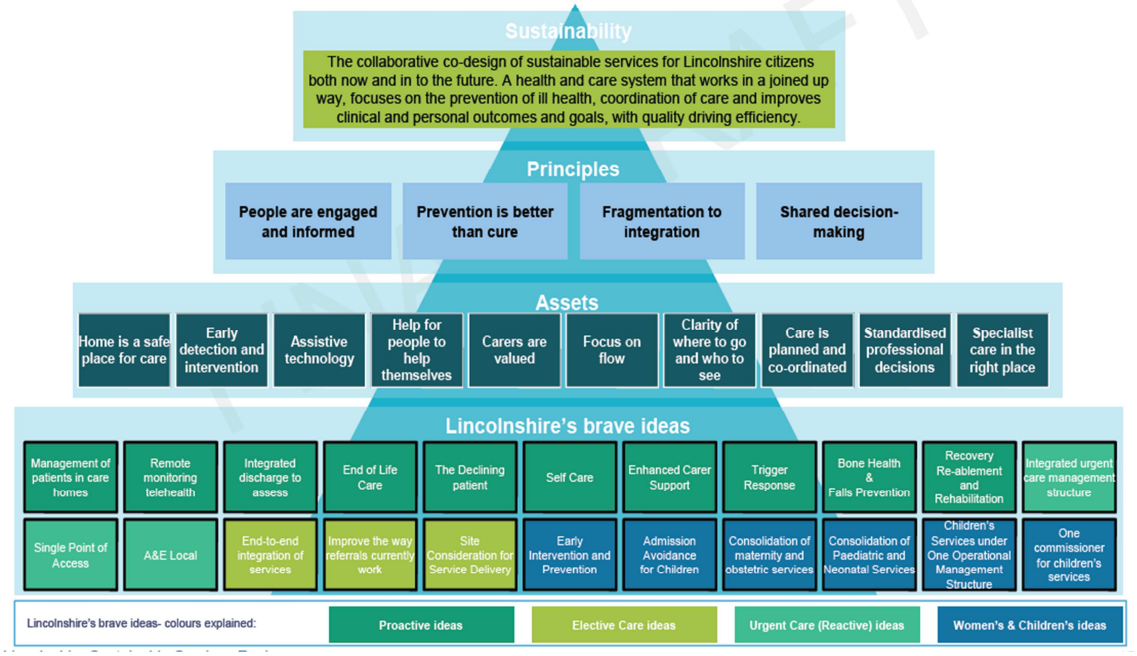
a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

We have drawn on best practice both within the UK and further afield.The following diagram best represents our collective ambition to transform health and social care services in Lincolnshire. We will build services that better serve the people of Lincolnshire, improves health and social care outcomes and the 'customer' experience. In doing this we will be organisationally agnostic so that form will truly follow function. This will be our collective mindset from which we will secure a sustainable financial base into the long term.

The diagram below provides on one page the golden thread between Lincolnshire's goal of the design of sustainable services in the future model through key principles, use of assets and brave ideas:



Aims and objectives
Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

There is already significant congruence between the priority themes, objectives and measures in Lincolnshire's Joint Health and Wellbeing Strategy (JHWS) and the objectives and outcomes being pursued through the LSSR and this Better Care Fund Programme.

Our JHWS was developed on the basis of priorities identified during the comprehensive stakeholder engagement undertaken by the local Health and Wellbeing Board in developing its JSNA. The table below identifies the degree of existing congruence across the JHWS, LSSR and BC programme.

Lincolnshire Sustainable Services Review (LSSR) mapped to Lincolnshire Joint Health and Wellbeing Strategy (JHWS)

	Promoting Healthier Lifestyles	Improve the health and wellbeing of older people	Delivering high quality systematic care for major causes of ill health and disability.	Improve health and social outcomes for children and reduce inequalities	Tackling the social determinants of health.
Proactive Ideas	X	X	X		X
Elective Care Ideas	X	X	X	X	
Urgent Care Ideas		X	X		
Women's and Children's Ideas				X	X

A fuller analysis of the congruence described above is included as Attachment number 2 (see above).

The Health and Wellbeing Board already has influence and oversight of the extent to which the commissioning plans of all the health and social care commissioners, and other public bodies like district councils, are driving towards the outcomes, objectives and measures within the JHWS. The tracking of delivery of these intentions is supported by a suite of measures selected from the national outcomes frameworks for the NHS, Adult Social Care and Public Health. The Board performance manages achievement in the short term against these measures.

A summary of the mapped measures as they stand is provided in the table below, it is proposed that measures identified in this BCF proposal would be added to the outcomes pursued through JHWS and JSNA once agreed.:

Joint Health and Wellbeing Strategy Outcomes mapped to LSSR Themes and National Outcomes Frameworks

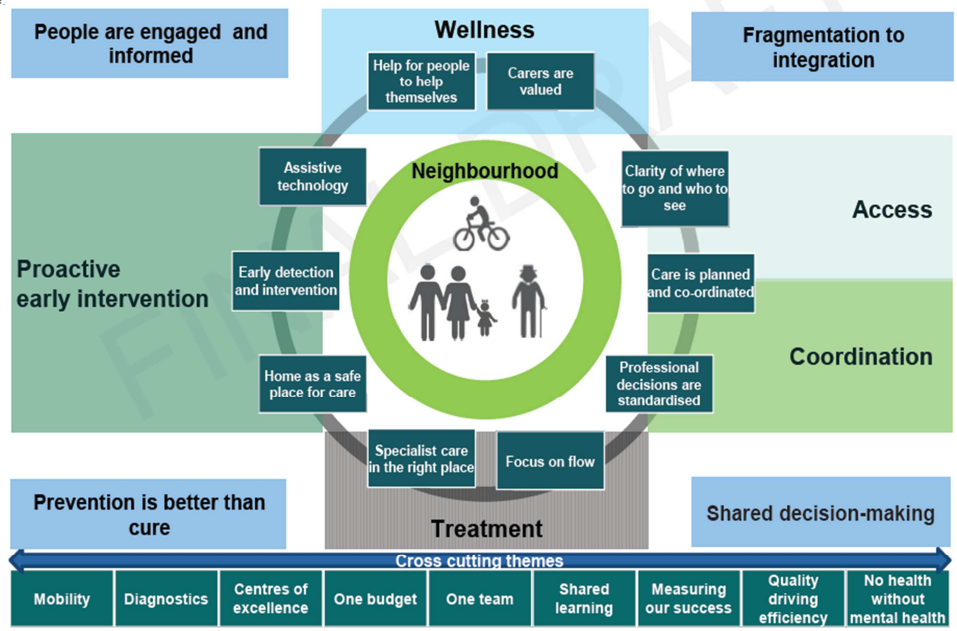
JHWS - Theme	JHWS - Priority	LSSR Overlap	Outcome Measures
Promoting Healthier Lifestyles	Reduce the number of people who smoke	Proactive, Elective Care	PH 4.7 / NHS 1.2 Mortality from respiratory diseases
Promoting Healthier Lifestyles	Reduce the number of people who are overweight or obese	Proactive, Elective Care	PH 4.4 / NHS 1.1 Mortality from all cardiovascular diseases
Promoting Healthier Lifestyles	Support people to drink alcohol sensibly	Proactive, Elective Care	PH 4.6 / NHS 1.3 Mortality from liver disease
Improve the health and wellbeing of older people	Change how we spend our money to enable more older people to stay safe and well at home	Proactive, Elective Care, Urgent Care	ASC 2B / NHS 3.6i Older people still at home 91 days after discharge from hospital
Delivering high quality systematic care for major causes of ill health and disability	Reduce unplanned hospital admissions for people with Chronic Obstructive Pulmonary Disease	Proactive, Elective Care, Urgent Care	PH 4.7 / NHS 1.2 Mortality from respiratory diseases
Improve health and social outcomes for children and reduce inequalities	Increase access for parents to good information and support throughout their child's life	Elective Care, Women's and Children's	PH 4.1 / NHS 1.6i Infant mortality
Tackling the social determinants of health.	Support more vulnerable people into good quality work	Proactive, Women's and Children's	PH 1.8 / NHS 2.2 Employment for those with a long term health condition

Each theme of the JHWS has a named Board sponsor who is supported by a consultant level public health specialist and these individuals are tasked with supporting implementation planning and delivery of their themes across the complex commissioning and delivery systems that exist in Lincolnshire. The LSSR and BCF activity that will support JHWS delivery have already been accepted by the Health and Wellbeing Board and LSSR implementation is accepted as a key mechanism by which the planned JHWS benefits will be delivered for local people.

As the BCF proposals are based on the LSSR work already completed, the Board will 'absorb' the BCF activity into its expectations and performance management of the delivery of the JHWS and bend its weight and influence to actively align its other programmes of work to this as a key delivery vehicle for wider strategy. A key feature of this would be the adaptation of our IT based and inherently dynamic approach to JSNA to move to providing the intelligence for planning and performance management of the activities and interventions within the BCF programme.

Our JSNA constantly evolves and adoption of the BCF activity into the delivery programme for the JHWS as described above will ensure that the JSNA moves to support the activity. See also Attachment 2.

The diagram below details, on one page, the elements which have been described across all four care design groups and reviewed by the Programme Board to form the proposed future model of care. This model is intended to encompass the full spectrum of physical, mental health and social care services across Lincolnshire.



b) Description of planned changes
Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

The timeframe in which we plan to begin to deliver transformation to health and social care services in Lincolnshire takes place over three years and has already begun with Phase 1 and the publication of the Lincolnshire Sustainability Review. Phase 2 will see further detailed planning before a formal period of public consultation takes place around May 2014 for a period of three months. Please see the diagram below for further detail.

We have carefully selected five 'Early Implementers' that are seen as central to securing early progress against the LSSR. They will also help ensure we are well placed to meet the requirements for performance improvement against the BCF national targets and our locally selected target. In addition these Early Implementers are intended to build on some of the pre-existing infrastructure that exists and which require further development if they are to secure profound improvement to outcomes, quality and sustainability – as such they provide early momentum and opportunity for learning. Finally, they have been chosen as pre-requisites to creating the opportunity for substantial reductions in acute beds which in turn frees-up resources for further primary/community based capacity – with the expectation that this will produce a virtuous cycle.

The Early Implementers are:

1. The development of **'neighbourhood teams'** at 4 locations across Lincolnshire reflecting GP clusters.

2. The Development of a pooled budget and jointly commissioned **Intermediate Care Layer**.

Case Study: Admission Avoidance. GP Out of Hours Referral.

Mrs A is visited by the Out of Hours GP on a Saturday. She is an 84 year old lady with a recent history of falls. The GP identifies a need for support to avoid hospital admission, and contacts the Combined Independent Living team.

An Assessor visits the same day and makes a full assessment of Mrs A. The following day, Sunday, a bed lever, raised toilet seat and toilet surround are delivered. A zimmer frame is also provided, and 16 days after commencement Mrs A is discharged, recorded as feeling much better with improved appetite and one call a day from a home care provider. She is advised to contact the local team if she needs further help.

3. **Seven-Day Working** which will begin both in the Acute Sector to reflect recent policy exhortations to help reduce mortality in hospitals (which rise at the weekend) and to facilitate improved operation of discharge – notably for frail elderly. Furthermore, we anticipate that all 'early implementers' will develop to reflect the necessity of 7 day working for improved outcomes for people.

4. **Prevention** which will incorporate a number of short term projects funded by the BCF and the developing 'Wellbeing' service led by Public Health colleagues. It will also need to include young people – notably regarding the implications of 'Support and Aspiration'.

   Lincolnshire is on a clear trajectory for the implementation of a population level prevention and early intervention service, starting initially with a Wellbeing Service that includes virtually limitless capacity for assistive technology expansion, 24/7 monitoring and response management and on the ground proactive and reactive service capacity of 2500 rising to 3500 service users in the first year. Phase two will see an ongoing expansion of the reach of this service into self-funding populations and the addition of community equipment and housing adaptation (DFG) interventions into a unified system by 2016.

   We see improved support to carers as a key component of our preventative work. An additional £200k has been allocated from the BCF to support targeted groups of carers such as those elderly carers supporting profoundly learning disabled individuals and those supporting a relative with dementia. Additionally, a revised carers strategy and reconfiguration of existing services is expected to further improve "our offer" to carers in Lincolnshire. As noted previously the Lincolnshire Carers and Young Carers Partnership (LC&YCP) was involved in the production of Phase 1 of the LSSR and is involved in Phase 2.

Case Study – Preventing an escalation of need.

Mr A is 27 and has low level needs not eligible for social care support, but is identified through our triggers that he could benefit from a brief spell of support. Mr A will be assessed to identify what support and equipment he could benefit from.

Mr A feels isolated and alone, often having episodes of low self-esteem and depression, his GP referred him to the Wellbeing Service to receive support from a worker that would give him confidence to improve his social connection with his peers and community.

Mr A's assessment noted he sometimes struggled to take his medication as prescribed and the Wellbeing Service sourced some assistive technology that could aide him in taking his medication.

Mr A identifies caring for his ageing mother as a particular stress for him. The Wellbeing Service assess Mrs B and notes she has early stages of dementia and is becoming increasingly frail. Mrs B receives assistive technology that:

- *Helps her remember to take her medication;*
- *Installs a monitored fire safety sensor that connects to the Wellbeing Service Monitoring Centre and assure a proportionate and timely response is made to any alarms.*

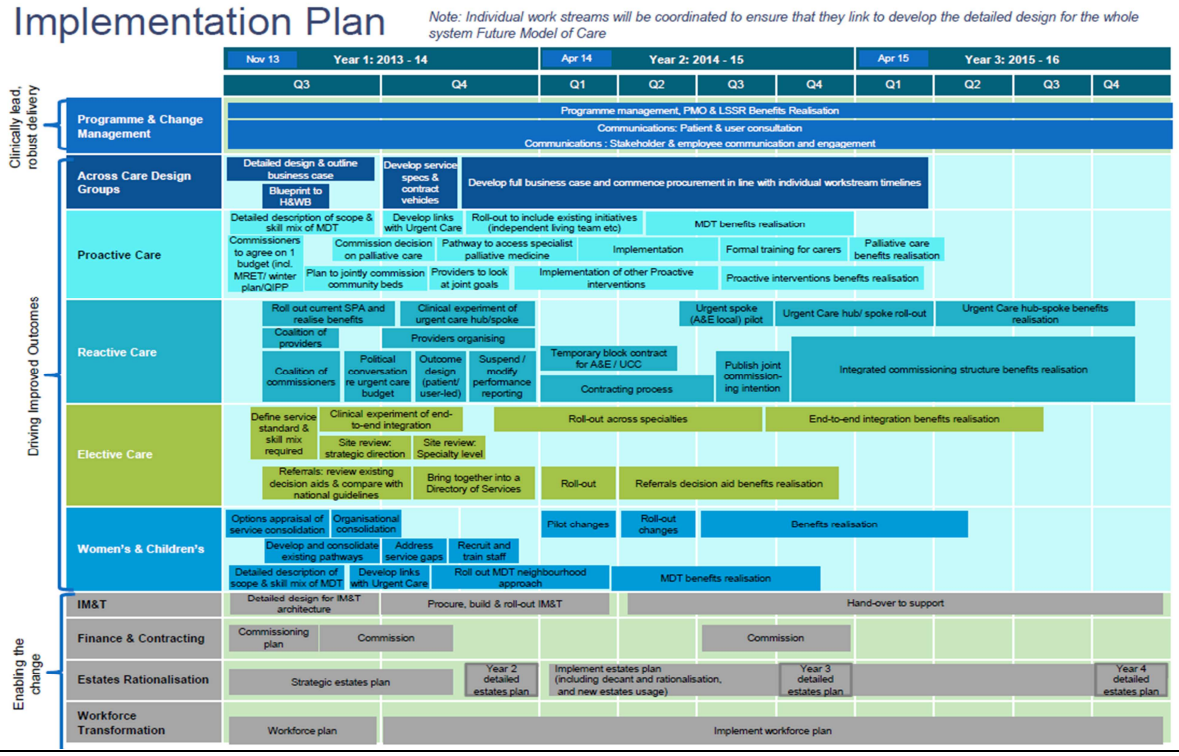
5. **Enablers** notably estates, organisational development and IMT. We consider organisational development and indeed workforce development as critical enablers to successful integration. To this end the Lincolnshire Education and Training Board (LETB) will be approached to secure additional support outwith this BCF allocation.

Part 2 of this submission details the allocation of BCF funds against each of the above. They will also facilitate further pooling of budgets beyond what we have already achieved.

The examples given above describe a number of new and pre-existing initiatives. However, our ambition is to increasingly combine services, based on a clear understanding of what works best and where synergies can be obtained. This will mean the merging of currently disparate services that may exist across several organisations. We will progress single service configurations through a collective approach to commissioning, for example in creating shared access points and in the further development of intermediate care services. We will remain organisationally agnostic.

The Joint Strategic Needs Assessment, Health and Wellbeing Strategy and current plans are fully embedded within our Sustainability Review, there is evidence for this assertion in the documentation attached to this BCF Plan. In addition a thorough analysis of Adult Social Care was undertaken during 2012/13 entitled '14Forward'. The resulting analysis was incorporated into the Sustainability Review. Furthermore, any plans in production such as for people with autism and, those with dementia will be shaped to reflect the ambition of our Sustainability Review and what we intend to achieve collectively.

The Health and Wellbeing Board will have overall responsibility for ensuring a high degree of consistency and congruence between our developing knowledge of local communities, their needs, wishes and aspirations, coupled with a clear understanding of what good looks like. The Health and Wellbeing Board will be supported by a small number of Delivery Boards for aspects of this plan. Led by senior officers from both health and social care organisations and with dedicated programme support to ensure resources and skills are brought together for best effect.



c) Implications for the acute sector

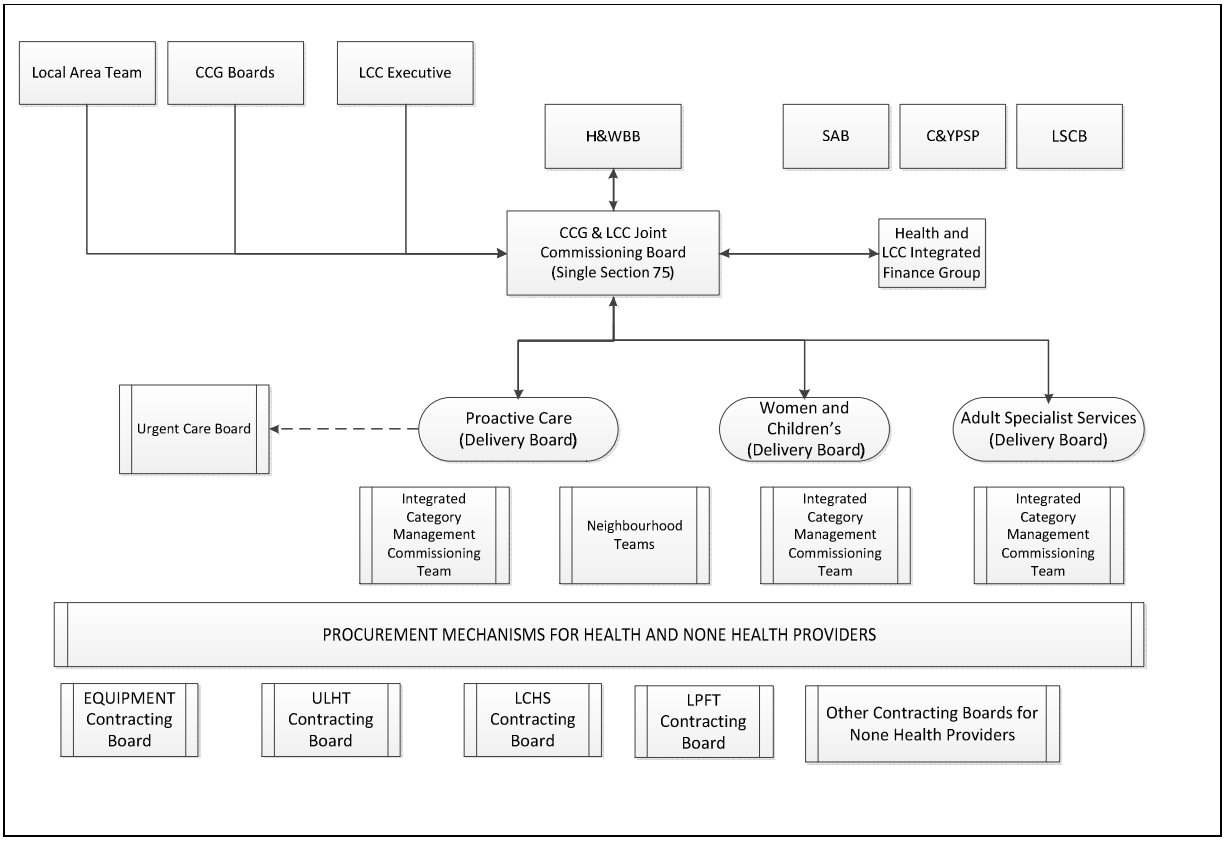
Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

The LSSR Blue print defines Lincolnshire's vision for service reconfiguration including very significant reduction in acute bed capacity from the acute sector by 2016/17 and the strengthening of community based services with extended 7 day working wrapped around Neighbourhood teams. This objective is consistent with the national requirement to reduce emergency admissions by 15%. Performance metrics for this are in Part 2. Years 2014/15 and 2015/16 are key transitional years during which time momentum for change must be galvanised into targeted delivery. Failure to deliver will result in a significant financial gap across Lincolnshire Health and Social Care Services as identified in LSSR Phase 1. For the two transitional years focus is being given to commencing a reduction of acute hospital bed capacity by further preventing avoidable acute hospital admissions, reducing delayed transfers of care and ensuring that the valuable acute sector facilities are utilised to best effect for those most in need of specialised acute hospital care. Implementation of the Urgent Care Board strategy will be critical to support the delivery of targets. Due consideration is being given to the acute sector clinical strategy which is currently undergoing early clinical consultation.

In 2014/15 ULHT will begin the progress of reducing beds so that a fundamental shift from acute to primary can begin. It is expected that a minimum of 78 beds will be permanently removed from acute provision in Lincolnshire to be built on in subsequent years as the effects of the early enablers and LSSR Phase 2 begin to take effect along with a review of A&E provision and the clinical pathways, for example frail elderly where we anticipate generating greatest efficiencies.

d) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes



ALIGNING LEAD RESPONSIBILITY TO DELIVERY BOARDS

Topic Area	Pro-active Care	Women and Children's	Adults Specialist Services
BCF Early Implementers:			
Neighbourhood Teams	✓	✓	
Seven Day Working	✓	✓	✓
Prevention	✓	✓	
Intermediate Care	✓		
Enablers	✓	✓	✓
Joint Dementia Strategy	✓		✓
Joint Autism Strategy			✓
Joint Carers Strategy	✓		
Pooled Budget Targets (2015/16) – estimated	79.7m	5.5m	112.1m
BCF Performance Targets:			
Permanent Admissions of Older People to Residential Care	✓		
Proportion of Older People still at home following Reablement/Rehabilitation	✓		
Delayed Transfers of Care	✓	✓	✓
Avoidable Emergency Admissions	✓	✓	✓
Patient/ Service User Experience	✓	✓	✓
Proportion of People feeling supported to manage their Long-term Conditions	✓		

The above table provides additional clarity concerning which Delivery Board in the governance structure previously described would take lead responsibility for the five "early implementers" within the BCF, the pooled budget figure to be achieved in 15/16 and relevant BCF performance targets described in Part 2 of this submission. Furthermore, lead responsibility for commissioning strategies is detailed.

The design phase of LSSR will see the creation of a number of design groups. These groups will liaise with relevant Delivery Boards as described above.

Each Delivery Board is expected to work with colleagues in other boards to ensure where overlaps exist these are collectively managed.

3) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services.

Our working definition has several elements to it. These are:

1. That the current eligibility for Adult Social Care will be maintained at substantial and critical.
2. Section 75 agreements, whether existing or new, will not reduce or impact negatively on performance or quality of adult social care services in securing agreed levels of future funding and performance.
3. The design of new models for commissioning and supplying social care services will not detrimentally affect performance against ASCOF (notably those detailing hospital discharge, personalisation and reviews); from the baseline of March 2013.
4. Agreement has been reached with the 4 CCGs concerning the allocation of the BCF in 2015/16 which helps secure the necessary level of investment in adult social care services. Of the monies available £20m will be allocated for this purpose which represents approximately 40% of the total revenue available.
5. We estimate the cost of the Care Bill and future funding reforms will be £2.8m in 2015/16. The sum agreed in 4 above includes this requirement. However, beyond 2015/16 there is no clarity of future funding. See also 'Risks' below.

Each Delivery Board and ultimately the Health and Wellbeing Board will monitor progress to ensure this definition is observed.

Please explain how local social care services will be protected within your plans.

We recognise that there is little protection for either Health or Social Care services unless we take a profound step towards integration as detailed in our Sustainability Review. Only in this way are we likely to secure services to meet Health & Social Care needs in Lincolnshire. The Executive of the County Council expect that Social Care Services will be maintained as we develop more pooled budget arrangements based on agreed and shared outcomes. The County Council will continue to monitor performance and outcomes using benchmarking data, trend analysis and ASCOF. Adult Care has a robust and comprehensive quality assurance system in situ that will also ensure services are not impaired as the proposed changes in this plan and the Sustainability Review progress. Our approach to transformation is to ensure that there is stability in areas of core health and social care provision. Through the Sustainable Services Review we will implement transformation in an incremental way so there is a risk management approach to change management and social care services will be protected. To enable us to plan change whilst protecting vulnerable clients, we will utilise some ITF funding to protect services so there is stability through change management.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

The Lincolnshire health and social care community, is fully committed to working in partnership to secure sustainable high quality seven day services, in line with the LSSR Blueprint.

The multi-agency Lincolnshire Urgent Care Group will oversee the development of 7 day services. It is recognised that any move to seven day working within Lincolnshire hospitals will bring greatest benefit if it is part of a move to seven day working across all organisations and agencies that provide care to the people of Lincolnshire either in hospital, their own homes. The approach being taken by each of our main providers is set out below.

United Lincolnshire Hospital Trust

In order to make the move to seven day working in unscheduled care, across all ULHT sites a number of actions have already been taken these. In November 2013 a broad cross section of clinical leaders (supported by senior managers) met to outline which medical, diagnostic, therapeutic and support services need to be available to support seven day unscheduled care. Building upon this dialogue and taking account the draft standards for 7 day working published by NHS England; guidance from learned bodies (eg Royal colleges and Professional organisations), and experience elsewhere across the NHS, a framework is being developed setting out the services required to deliver unscheduled care services across ULHT. In turn each hospital site within the Trust providing unscheduled care will be required to develop proposals for the delivery of those elements of service on their site. This will ensure consistent standards of service across the Trust whilst allowing for site-specific approaches to delivery.

Once proposals for delivery have been developed they will then be the subject of scrutiny by a multi-disciplinary group. This will ensure:-

- the model of delivery is capable of delivering the benefits in terms of mortality reduction, improved patient experience and reduction to length of stay
- Ensuring that any proposed increase to the cost of delivery is justifiable.

The Trust is committed to at least one site within the Trust commencing the delivery of seven day unscheduled care services in April 2014, with all other sites operational by the end of June 2014.

Lincolnshire Community Health Services

LCHS are committed to delivering high quality, safe services throughout the 7 day working week. To achieve this in the longer term, the organisation intends to undertake significant transformational change in the way services are delivered.

In the shorter term, immediate actions have been taken to restructure elements of the community nursing resource to work across both the 7 day and 24 hour periods in support of the programme of admission reduction schemes being trialled in the county. The recruitment drive supporting these schemes has been based on a seven day working week, signalling a shift in the organisation's commitment towards a goal of standardising all future clinical appointments throughout the trust.

In addition the organisation has introduced an attendance management tool which supports front-line staff to maximise their capacity and performance manage attendance

across a 7 day period, 365 days of the year. This has been supported by the implementation of a roster policy which embeds the principles of improving working lives, whilst ensuring that safe levels of staffing are available to maximise and sustain the delivery of services in the community. Performance management of attendance across community teams is now being formally monitored via internal processes, with significant challenge being applied to areas where there is evidence of in- efficient utilisation of available resource. This is particularly pertinent in times of predicted peak activity.
A review of our existing community work force is being undertaken. The aim of this review is to ensure a baseline for safe staffing levels are established in the community. Pending the outcome of the review, there may be the potential for some movement of key clinical personnel around the county or indeed evidence of additional investment being required to support a robust community service provision.

In parallel work is being under taken to review current and future workforce planning, to recruit and retain a much more flexible workforce which can be fully utilised according to need such as; maximising bed occupancy, reducing length of stay and the management of increasingly complex patients being cared for in the community. The organisation also intends to implement new ways of working which require employees to work across a number of geographical areas as well as over seven days per week. This will ensure the future workforce is able to deliver the ambitions of the organisation's clinical strategy and be underpinned by the introduction of annualised hours contracts as well as the availability of a more robust bank system to supplement the existing workforce in times of increased need.

Lincolnshire Partnership Foundation Trust

LPFT has an on-going commitment to ensuring high quality, easily accessible and timely health and social care service provision across Lincolnshire. This is currently being achieved by a combining a number of established and newly developed services with continued innovation and partnership working always high priorities. The Single Point of Access for LPFT now provides one dedicated contact number for all Trust services and is available 24 hours a day, 7 days a week. 7 day services are provided by the Crisis and Home Teams, Rapid Response Teams and the Lincoln HIPs team to both provide care in the community, early discharge and admission avoidance. These services closely link to on-call medical staff, the wider Trust services such as the Integrated Community Mental Teams (7 days a week when required) and the wider health and social care community including the Emergency Duty Team.

Primary Care

The walk in Centre in Lincoln provides 7 day a week 8am to 8pm access to primary care. Out of hours GP access is commissioned from Lincolnshire Community Health Servicers. A number of Community Pharmacies throughout Lincolnshire provide services 7 days a week. There are also a number of dental practices that provide 7 day a week services.

The CCG will work closely with NHS England's Leicester and Lincolnshire Area Team who commission primary care services, to ensure the emerging Primary Care Strategy, is fully aligned and supports the implementation of the Lincolnshire Strategic Services Review.

Lincolnshire County Council

Adult Care will continue to meet the demand for assessment activity over seven days a week. This will be delivered by the Council's Customer Service Centre (CSC), neighbourhood teams, Emergency Duty and Hospital based staff who are able to work weekends and bank holidays to meet varying demands. LCC supports a joint reablement service with health partners working across the whole county 7 days a week this supports hospital avoidance and discharges. This has easy links to all providers and their access points to ensure a seamless health and social care response.

Generally

We recognise the need for a step change in seven day working across the health and social care community in Lincolnshire. This necessary development will proceed through the care design groups detailed earlier as part of the LSSR Phase 2 work. In particular there is an expectation that neighbourhood teams and intermediate care (both early enablers) will operate on this basis. The wellbeing service which forms the bedrock of our preventative 'offer' is being re-commissioned on this basis and will commence across Lincolnshire on 1 April 2014.

It is also expected that the provider landscape will change to improve the level of integrated provision where several providers working more closely together can deliver a much stronger, more efficient, customer-centric response. As such commissioners and providers are working together to ensure our approach is 'organisationally agnostic'. This will be a feature in a number of early-implementers such as a new integrated care layer and neighbourhood teams.

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

The NHS number is used as the primary identified for correspondence between health and social care.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

We can confirm that we are committed to adopting systems based on Open APIs and Open Standards.

In social care we have procured a new case management system from Core Logic for implementation in January 2015. The software solution will implement a multi-agency case management system for social care that will act as an enabler to countywide, joint service delivery and empower greater flexibility and efficiency via secure, shared data

services.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

There is an overarching Information Sharing Protocol agreed between the Health and Social Care Community in Lincolnshire which includes consent, access and security procedures, subject access requests, protocol management procedures, data protection and Caldicott requirements.

The Local Authority uses GCSX e-mail in all patient identifiable exchanges of information. Mandatory training must be completed before individual accounts are authorised and managers are required to complete an Information Sharing Agreement audit providing details of the information to be shared.

The Local Authority also completes the IG Toolkit self-assessment on an annual basis.

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

In Lincolnshire we have a pooled budget agreement between Lincolnshire CCGs and Lincolnshire County Council from which an integrated Assessment and Care Management Team is funded and hosted by LCC for Adults with a Learning Disability aged 18+. Each case is open to a lead officer who is responsible for assessing the Health and Social Care needs of citizens. As at 30/11/2013 there were 1,700 open cases for adults with a learning disability aged 18+, representing 12% of the total number of adults supported in Lincolnshire (14,000 current adult clients – all ages and client groups).

LCC also has a section 75 agreement in place with Lincolnshire Partnership Foundation Trust (LPFT) that enables LPFT to deliver LCC's Social Care Assessment and Care Management Function. This is delivered as part of an integrated Community Mental Health Team (CMHT). This is predominately for people aged 18 to 64 at this point. LPFT have also developed a Single Point of Access (SPA) for Mental Health Services and there are opportunities to expand this initiative to all clients groups across Lincolnshire. Currently there are 600 open cases to the LPFT CMHT which represents 4% of total cases in Lincolnshire" (expressed as a % of 14,000 from above).

In Lincolnshire a new pathway was created in November 2013; all adults at risk of a hospital admission are referred to a multi-agency contact centre where the adult is assessed based on all available information by an appropriate health / social care professional into a pathway for the right support to enable the person to remain in their own home or as close as possible. In Lincolnshire; for this winter, the commissioners

have in place 2 contact centres based on the prime need of the person being either Physical or Mental health. The contact centres provide a 24 hour a day, 7 day service across the County to all Health and Social Care Professionals.

The lead professional will remain involved until either the adult is no longer in need of support at which point the Lead professional role would transfer to the Adult's GP Practice; or the lead professional role is passed to an Adult Care practitioner to undertake a statutory Adult Social Care assessment of need.

The Lincolnshire Urgent Care Working Group has oversight of the overall quality assurance and performance for this new pathway and support systems will be provided from contact centre data which includes response times, waiting times, abandoned calls. Customer experiences are gathered ongoing by all providers with some individual patient experiences shared across Health and Social Care to demonstrate the effectiveness and monitor the outcomes for each patient.

The special educational needs reforms which come into place in September 2014 require health, education and social care to radically transform and streamline the system for SEN assessments. Statements will be replaced with an aligned assessment process and an integrated education, health and so vial care plan from birth to 25 years

The BCF will support improved cooperation between the social, education and health system so there is a shared understanding and integrated processes for delivering our statutory services under the new legislation.

It is recognised that the advent of the Care Bill and funding reforms affecting adult social care are best addressed through the development of robust integrated services. The alternative would be for Adult Care to consider these changes in isolation. In this way we expect 'early implementers' to address for example the increased capacity requirements arising from these national initiatives. One example would be in the development of neighbourhood teams to ensure they can accommodate the anticipated growth in assessments required.

See also the section above regarding seven-day working.

4) RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

We have undertaken a Risk Assessment which is detailed below. We would highlight the level of resource invested in securing adequate capacity to ensure progress in both this BCF (notably with respect to the "Early Implementers") and the LSSR. Specifically, three senior appointments have been made to add capacity to the Delivery Boards identified in Section 2d (this included two jointly appointed Assistant Director grades). Health and Social Care commissioners along with the Area Team have added to this capacity by commissioning highly respected and skilled organisations to work alongside us. In phase 1 for example, PWC were commissioned to provide support and expertise.

Further work is underway to identify how financial risk will be shared across the health and social care community. However, the detail for this is not available prior to publication of this final submission document.

We have already detailed the costs falling to Adult Care as a result of the Care Bill and future funding reforms. We estimate for 15/16 approximately £2.8m will be needed though the true figure in Lincolnshire over 10 years is likely to reach in excess of £100m. For 15/16 the allocation of £20m to protect Adult Care will incorporate the £2.8m.

We are currently working with the County Councils Network to reinforce the point to Government that the funding figures currently being used are not sufficient to cover the true costs of these new legislative requirements..

Better Care Fund Risk Assessment

Risk No	Risk Description		Inherent Risk Score		
	Risk Source	Risk Consequences and mitigation	Probability	Impact	Score
001	Lack of capacity to transform and integrate will result in failure to maintain current performance and customer satisfaction, or failure to achieve integration	Investment in phase one of a county-wide review of the Health and Social Care Economy (Lincolnshire Sustainable Services Review) is completed and has provided an holistic view of key areas and high level models for integration. Non-recurrent funding for phase two will provide the necessary investment in capacity and infrastructure to support detailed mapping and impact analysis of models identified in phase one. Funding for phase 2 and phase 3 has been identified and the external consultancy has now been sourced which will provide additional capacity. The County Council has also added capacity to secure necessary progress.	1	4	4
002	An improved integrated pathway focused on prevention and keeping people safe in their homes is achieved but fails to deliver key performance improvements across health and social care economy resulting in reduced funding and an insufficient financial envelope to support core activity	Modelling from phase one of the services review considered key data, but includes a number of assumptions. This data will be further detailed in phase two allowing develop development of co-directed detailed business case and informed decision making. Phase 2 which will provide the necessary design is shortly to commence. Public Health has commissioned a new Well Being Service that will form part of the overall prevention 'offering'. This is due to begin 1/04/14.	2	4	8
003	Service providers, voluntary sector and community groups are unable to respond adequately to the re-modelling of commissioned services to achieve the vision	Phase two of the sustainable services review has a strong focus on consultation and collaboration and will build on the co-design of phase one across the provider and community landscape to fully understand and plan for the required level of support and investment to deliver an integrated vision. A robust governance structure with joint commissioning responsibilities will assist in securing necessary service levels and quality. Further, both NHS and Social Care Providers are engaged in the phase 2 work and overall governance of LSSR.	2	4	8
004	The anticipated financial impact of the care bill which has planned Royal Ascent in 2014 in not fully quantifiable although financial modelling and planning have been undertaken to an extent. This has potential to impact on the delivery and sustainability of current plans	An initial impact assessment has been completed and has been considered during phase one of the sustainable services review by Adult Care. Future planning needs to consider the risks and benefits of the bill to ensure a sustainable model is developed. The financial effect of new legislation has been reported. The government have indicated that the full cost of implementation will be fully funded.	2	4	8
005	The model chosen for an integrated health and social care system in Lincolnshire does not deliver sufficient whole systems base budget savings and the forecast deficit is not mitigated	The health and social care system re-design planned for in the Lincolnshire Sustainable Services Review has to demonstrate not only improvements for customer outcomes and experience, but sufficient radical re-engineering to deliver a balance budget across the Health and Social Care Economy. The earlier analysis in phase 1 and the detailed design work in phase 2 are supported by an external consultancy which provides a level of analysis and modelling based on best practice elsewhere.	2	4	8

*A **ppendix A (Part 2)***

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please expand the table if necessary.

BCF Investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits	
		Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent
		£'m	£'m	£'m	£'m	£'m	£'m	£'m	
Scheme 1 - Neighourhood Teams - led by the Proactive Care Delivery Board			*1.6*				*49.5*	*2.1*	
led by the Proactive Care Delivery Board			*4.3*				*14.1*	*0.5*	
Scheme 3 - Seven Day Working - led by the Urgent Care Delivery Board			*0.5*				*0.8*		
Scheme 4 - Prevention -led by the Proactive Care Delivery Board			*3.3*				*10.7*		
Scheme 5 - Enablers e.g. Capital, IMT, Organisational Development, Communications			*1.0*				*3.5*		
Learning Disabilities and Mental Health led by the Specialist Care Delivery Board			*4.3*				*117.6*	*0.8*	
Others			*0.4*				*1.1*		
Total			***15.4***				***197.3***	***3.4***	

Notes

The spend has been attributed as non-recurrent to align with LSSR strategic intentions where the health and social care landscape will look very different. In line with LSSR there will be a shift of resources from acute hospitals to support re-investment in the community across health and social care.

The front sheet of the BCF submission notes 14/15 total spend of £70.8m. This is compiled from the £15.4m non-recurrent schemes and the value of the existing pooled funds arrangements under S(75) which are noted in part one of the BCF submission

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Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of Lincolnshire West Clinical Commissioning Group

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**25 March 2014**
Subject:	**Lincolnshire West Clinical Commissioning Group Operational Plan 2014/15-2015/16**

Summary:

The CCG is required by NHS England to produce a 5 year strategic plan 2014/15- 2018/19 and an Operational Plan for 2014/15- 2015/16. CCGs in Lincolnshire agreed a Lincolnshire wide footprint for the 5 year strategic plan to support collaborative working across CCGs, the Lincolnshire Health and Wellbeing Board and Lincolnshire County Council and to facilitate transformation and strategic planning with our 3 main healthcare provider trusts. The Lincolnshire Sustainable Services Review (LSSR) is in essence the 5 year strategic plan.

The NHS Lincolnshire West Clinical Commissioning Group Operational Plan 2014/15 - 2015/16 is the key document that presents our organisation's plans to address health inequalities and improve the health of our population, in response to the population's health needs.

The Operational Plan sets out our intention to transform quality and access to services within the financial resource we have available. The plan has been developed to support the implementation of in the Lincolnshire Sustainable Services Review (LSSR,) and in the context of the national reforms set out in the Health and Social Care Act 2012, and National guidance 'Everyone Counts: Planning for patients 2014/15 to 2018/19.

There are significant health inequalities in Lincolnshire West, linked to a mix of lifestyle factors, deprivation, access and use of healthcare, and significant variation in healthcare need between and within localities. For example, women in our most deprived communities on average die on average 17 years earlier than those in our least deprived, whilst men die 12 years earlier.

In developing the plan we have identified nine strategic programmes that encapsulate what is required, to address the most significant challenges facing us, and to deliver our

strategic goals.

The CCG Operational Plan outlines local operational delivery of the Lincolnshire Sustainability Services Review and all of our programmes are aligned to LSSR work streams and the Lincolnshire Joint Health and Wellbeing Strategy. These are;

CCG Programmes	LSSR Work Stream	Joint Health & Wellbeing Strategy Theme
• Reducing Inequalities and Improving Life Expectancy • Long Term Conditions and Frail Older People • Improving Outcomes in Cancer • Mental Health & Learning Disabilities	Proactive care	• Promoting healthier lifestyles • Improving lives of older people • Delivering high quality systematic care • Tacking social determinants of health
• Integrated Urgent (Reactive) Care	Urgent Care (Reactive)	• Delivering high quality systematic care
• Elective Care	Elective Care	• Delivering high quality systematic care
• Women & Children	Women & Children	• Improving Outcomes for children
• Quality and Safety • Primary Care Strategy	Cross Cutting Themes	• Delivering high quality systematic care

The Operational Plan outlines high level summaries of our programmes, and detailed programme summaries are included in the appendices.

Priorities

Focus on quality

Focus on quality is integrated across all programmes. In addition national and local CQUINs will be used to incentivise quality improvements

CQUINs

The list of nationally developed CQUINs applicable to Acute, Primary Care and Mental Health Services was published at the end of December 2013, these may be summarised as:

National CQUIN Scheme	Acute services providers	Community services providers & care homes	Ambulance services providers	Mental health providers
Friends and Family Test	✓	✓(community services only)	✓	✓
NHS Safety Thermometer	✓	✓	n/a	✓
Dementia and delirium	✓	n/a	n/a	n/a
Improving physical healthcare to reduce premature mortality in people with severe mental illness (SMI)	n/a	n/a	n/a	✓

In addition the following local CQUIN targets have been agreed with providers:-

Local CQUIN Schemes	Acute services providers	Community services providers	Mental health providers	Ambulance services providers (waiting confirmation from Erewash CCG)
Workforce Expectations	✓	✓	✓	
Care Bundles	✓			
Medication Safety Thermometer	✓			
Clinical Escalation	✓			
Falls Reduction	✓			
Development of PROMS (End of Life)	✓			
7 day working,	✓			
Development of PROMS (End of Life)	✓			
Autism (Training & Awareness)			✓	
Development of PROMs for Dementia			✓	
Medication Safety Thermometer,			✓	
Cultural Barometer		✓		
Care rounding on virtual wards		✓		
End of Life Care		✓		
Medication Safety Thermometer		✓		
Co-ordinated discharge planning with GPs		✓		
Train the Trainer / palliative care eol' champions		✓		

Quality Premium 2014/15

The quality premium is intended to reward CCGs for improvements in the quality of services that they commission and for associated improvements in health outcomes and reduction in inequalities. Quality premiums are divided into national measures, all of which are based on measures in the NHS Outcomes Framework:

- Reducing potential years life lost through amenable mortality
- Reducing avoidable emergency admissions
- Ensuring the roll-out of the friends and family test and improving patient experience of hospital services
- Preventing healthcare associated infections

And local a local measure which should be based on local priorities identified in the Joint Health and Wellbeing Strategy. Lincolnshire West CCG local quality premium priority is described below.

Local Quality Premium : Appropriate treatment of Atrial Fibrillation

Measure:

- **To increase by at least 5% from current baseline of AF patients who are prescribed optimum preventative therapy.**

Rationale.

- Atrial fibrillation (AF) is the most common sustained dysrhythmia, affecting at least 600,000 (1.2%) people in England alone. It is also a major cause of stroke. Uniquely it also is an eminently preventable cause of stroke with a simple highly effective treatment.

- Clinical discussions with the stroke consultant have identified a problem with prescribing of appropriate medications for patient who are admitted with a stroke

- Clinical peer pressure created by selecting AF a local target will be used to help improve the lower performing localities and in doing so help to reduce health inequalities.

- This target will help reduce the number of stroke admissions to hospital

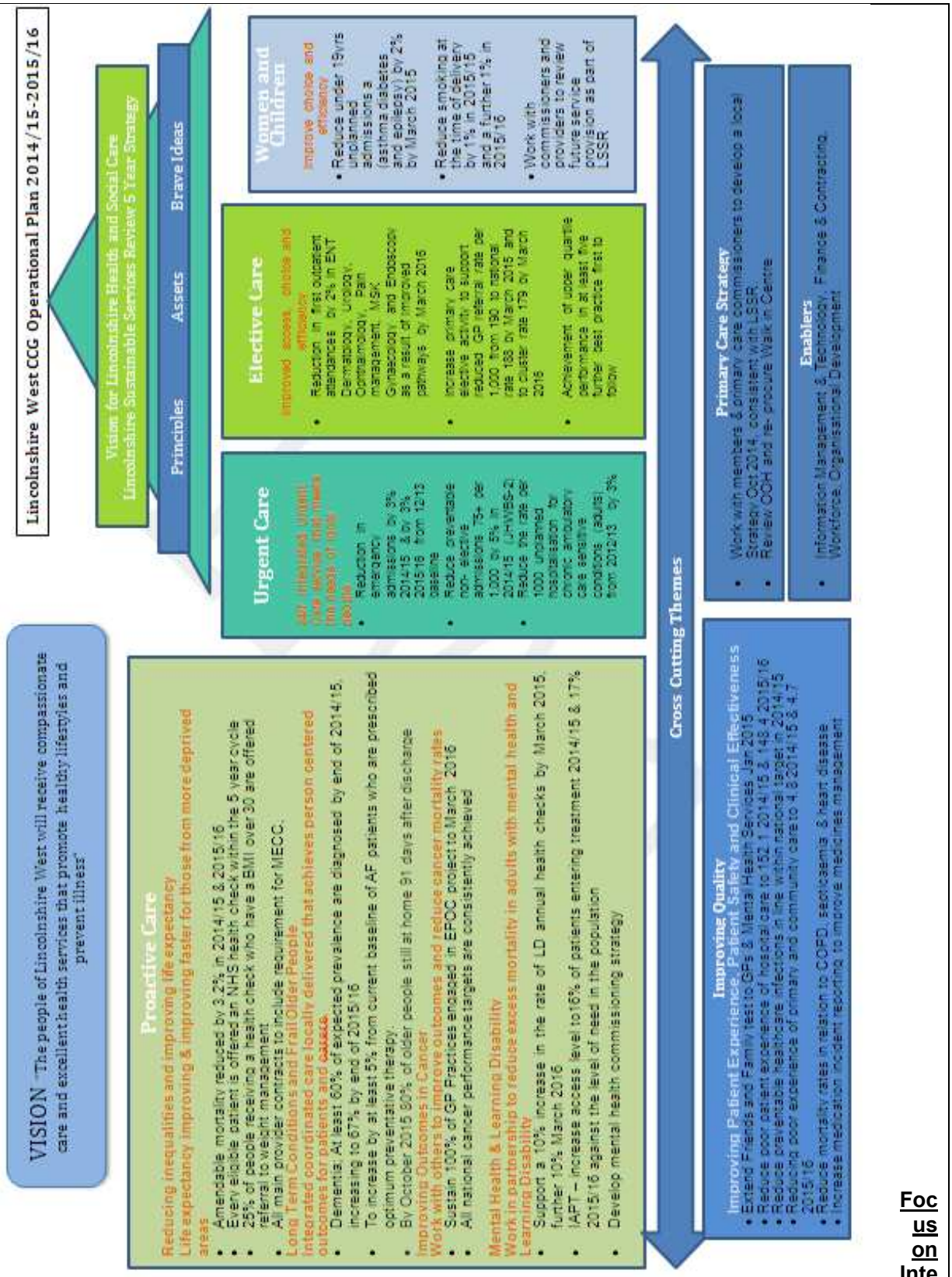
Focus on outcomes

The table below outlines how the CCG local ambitions support NHS England Ambitions

	NHS England Ambitions

LWCCG Local Ambitions	Securing additional years of life for people with treatable mental health and physical conditions	Improving the health related quality of life of people with one or more long- term conditions, including mental health conditions	Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital	Increasing the proportion of older people living independently at home following discharge from hospital	Increasing the number of people with mental and physical health conditions having a positive experience of hospital care	Increasing the number of people with mental and physical health conditions having a positive experience of care outside of hospital, in general practice and the community	Making a significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care	Improving health through ensuring every contact counts -promote a healthy lifestyle and healthy environment	Reducing health inequalities, ensuring the most vulnerable in society get better care and better services	Moving towards parity of esteem
Reducing inequalities and improving life expectancy	✓							✓	✓	✓
Long Term Conditions and Frail Older People		✓	✓	✓	✓	✓		✓	✓	✓
Integrated Urgent (Reactive)Care			✓		✓		✓		✓	✓
Elective Care		✓	✓			✓				
Quality			✓	✓	✓	✓	✓		✓	✓
Primary Care Strategy	✓	✓	✓	✓		✓		✓	✓	✓
Mental Health & Learning Disability	✓	✓	✓	✓	✓	✓		✓	✓	✓
Improving Outcomes in Cancer	✓				✓	✓		✓	✓	
Maternity and Paediatrics		✓	✓		✓	✓		✓		

Metrics have developed for all programmes to measure progress in achieving ambitions and are summarised on the plan on a page



Focus on Integration

The Better Care Fund (previously referred to as the Integration Transformation Fund) was announced in June 2013 as part of the 2013 Spending Round. It provides an opportunity to

transform local services so that people are provided with better integrated care and support. The Fund will be an important enabler to take the integration agenda forward at scale and pace, acting as a significant catalyst for change.

The Fund will support the aim of providing people with the right care, in the right place, at the right time, including through a significant expansion of care in community settings. This will build on the work Clinical Commissioning Groups (CCGs) and councils are already doing. Summary funding arrangements in Lincolnshire are listed in the table below.

Organisation	Spending on BCF schemes in 14/15	Minimum contribution (15/16)
	£'m	£'m
Local Authority Social Services	£15.40	
Lincolnshire East CCG		*£16.19*
Lincolnshire West CCG		*£14.50*
South Lincolnshire CCG		*£9.81*
South West Lincolnshire CCG		*£7.90*
BCF Total	**£15.40**	**£48.40**

Alignment to the LSSR

The Lincolnshire West Operational Plan is the local implementation of the first two years of the LSSR. The CCG has

- Prioritised and designed local ambitions, interventions and metrics that align to and have a measurable impact on delivery of LSSR ambitions (and further metrics will be developed)
- Prioritised financial and human resources
- Worked with partners to ensure investment of the Better Care Fund supports delivery of the LSSR

The CCG has developed four priorities to support the LSSR, that will be implemented in 2014/15, these are

1. **Develop Neighbourhood Teams**
2. **Re-procure the intermediate layer by winter 2014/15**
3. **Focus on improving prevention, early detection and delivery of cancer services**
4. **Management of atrial fibrillation (AF) in general practice**

Finances

Local and national economic conditions will influence the availability of resources and requirements for all public services. The financial allocations for Lincolnshire West CCG are as follows, (2013/14 allocation included to provide context):

CCG Allocation	13/14	14/15	15/16
Allocation (£'000)	253,509	258,934	263,336
Population	228,278	230,271	232,199
Total Growth		2.14%	1.70%
- Population		0.87%	0.84%
- Price		1.27%	0.86%

Impact of Engagement Activity on development of the Operational Plan

Engagement Activity	Outputs	Influence on Operational Plan
Commissioning Intentions Stakeholder Event (circa 100 stakeholders) July 13	• Test CCG's vision, mission and goals • Rank CCG priorities for transformational change for 2014/15	Informed themes of: • Patient-centred care • Integrating services around the patients' needs • Improving access, choice and efficiency • Improving consistency of high quality care
LSSR Stakeholder Event October 13	• Draft Blueprint reviewed with stakeholders	• Format and content of plan updated and aligned to draft LSSR • Integrated Community teams reviewed against the draft blueprint for Neighbourhood Teams
GP Member Practice Think Tank Event October 13	• Identify workable solutions to key challenges around A&E, IHD, Breast Cancer, Friends and Family Test and Integrated Services	• Ideas fed into planning, e.g. improving access to prevention, improving integrated working • Different ways of delivering urgent care in Primary Care
Clinical leaders content development groups October –November 2013	• Think tank ideas reviewed • Long list of potential projects reviewed and shortlist produced • Review of draft commissioning intentions	• Improved sharing of clinical information and Integration of clinical notes • Higher profile of mental health in the plan and production of Mental Health Commissioning Strategy • Short list of elective projects • Recommendation to produce a Primary Care Strategy to support implementation of plans
Provider Event	• Share draft	• Providers' inputs to draft

November 13	commissioning intentions with providers	commissioning intentions • Able to link draft commissioning intentions to emerging LSSR themes and provider plans
Strategy Group briefing December 13	• Share outline Plan, including local innovations, with Member Practices	• Informed development of local innovations, including neighbourhood teams
Keogh Listening Event December 13	• Identify main issues impacting on individual patient experiences	Main issues informed themes of: • Patient-centred care • Integrating services around the patients' needs • Improving access, choice and efficiency
Content Development Event January 14	Secure engagement of Local Authority partners to: • Identify level of ambition for trajectories • Agree local priorities	• Informed trajectory targets • Informed development of five local priority measure options for wider consultation
Public and stakeholder consultation on draft priority measures January 14	• Feedback on five local priority measure options from public, stakeholders and Member Practices	• Informed development and inclusion of local priority measure: Management of atrial fibrillation in general practice
Informal meeting of Health and wellbeing Board and CCGs to review draft CCG operational plans	• Discussion of operational plans across 4 CCGs. CCG plan could have more focus on addressing childhood obesity.	• CCG to explore opportunities to support any public health initiatives
Consultation on draft plan February- March 11th 2014	• To follow	• To follow
Equality Impact Assessment of the Plan February- March 11th 2014	• To Follow	• To follow
Member practice Strategy Group March 2014	• Shared draft plan	• Ideas for development of localities to support implementation of the plan including delegation of responsibilities

Actions Required:

To agree the Lincolnshire West Clinical Commissioning Group operational Plan 2014/15-2015/16

From 5pm on Wednesday 12th March the full Draft Lincolnshire West Operational Plan will be accessible form the Lincolnshire west CCG homepage www.lincolnshirewestccg.nhs.uk

1. Appendices

These are listed below and attached at the back of the report	
Appendix A	Lincolnshire West Clinical Commissioning Group Operational Plan on a Page 2014/15-2015/16

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 Annette Lumb who can be contacted on (01522 513355) or (annette.lumb@lincolnshirewestccg.nhs.uk)

Lincolnshire West CCG Operational Plan 2014/15-2015/16

VISION "The people of Lincolnshire West will receive compassionate care and excellent health services that promote healthy lifestyles and prevent illness"

Vision for Lincolnshire Health and Social Care
Lincolnshire Sustainable Services Review 5 Year Strategy

Principles | Assets | Brave Ideas

Proactive Care

Reducing inequalities and improving life expectancy

Life expectancy improving & improving faster for those from more deprived areas

- Amendable mortality reduced by 3.2% in 2014/15 & 2015/16
- Every eligible patient is offered an NHS health check within the 5 year cycle
- 25% of people receiving a health check who have a BMI over 30 are offered referral to weight management
- All main provider contracts to include requirement for MECC,

Long Term Conditions and Frail Older People

Integrated coordinated care locally delivered that achieves person centered outcomes for patients and carers.

- Dementia; At least 60% of expected prevalence are diagnosed by end of 2014/15, increasing to 67% by end of 2015/16
- To increase by at least 5% from current baseline of AF patients who are prescribed optimum preventative therapy.
- By October 2015 80% of older people still at home 91 days after discharge

Improving Outcomes in Cancer

Work with others to improve outcomes and reduce cancer mortality rates

- Sustain 100% of GP Practices engaged in EPOC project to March 2016
- All national cancer performance targets are consistently achieved

Mental Health & Learning Disability

Work in partnership to reduce excess mortality in adults with mental health and Learning Disability

- Support a 10% increase in the rate of LD annual health checks by March 2015, further 10% March 2016
- IAPT – increase access level to 16% of patients entering treatment 2014/15 & 17% 2015/16 against the level of need in the population
- Develop mental health commissioning strategy

Urgent Care

24/7 Integrated Urgent Care service that meets the needs of local people

- Reduction in emergency admissions by 3% 2014/15 & by 3% 2015/16 from 12/13 baseline
- Reduce preventable non-elective admissions 75+ per 1,000 by 5% in 2014/15 (JHWBS-2)
- Reduce the rate per 1000 unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults) from 2012/13 by 3%

Elective Care

Improved access, choice and efficiency

- Reduction in first outpatient attendances by 2% in ENT Dermatology, Urology, Ophthalmology, Pain management, MSK Gynaecology and Endoscopy as a result of improved pathways by March 2016
- Increase primary care elective activity to support reduced GP referral rate per 1,000 from 190 to national rate 188 by March 2015 and to cluster rate 179 by March 2016
- Achievement of upper quartile performance in at least five further best practice first to follow

Women and Children

Improve choice and efficiency

- Reduce under 19yrs unplanned admissions a (asthma diabetes and epilepsy) by 2% by March 2015
- Reduce smoking at the time of delivery by 1% in 2015/15 and a further 1% in 2015/16
- Work with commissioners and providers to review future service provision as part of LSSR

Cross Cutting Themes

Improving Quality

Improving Patient Experience, Patient Safety and Clinical Effectiveness

- Extend Friends and Family test to GPs & Mental Health Services Jan 2015
- Reduce poor patient experience of hospital care to 152.1 2014/15 & 148.4 2015/16
- Reduce preventable healthcare infections in line within national target in 2014/15
- Reducing poor experience of primary and community care to 4.8 2014/15 & 4.7 2015/16
- Reduce mortality rates in relation to COPD, septicaemia & heart disease
- Increase medication incident reporting to improve medicines management

Primary Care Strategy

- Work with members & primary care commissioners to develop a local Strategy Oct 2014, consistent with LSSR.
- Review OOH and re- procure Walk in Centre

Enablers

- Information Management & Technology, Finance & Contracting, Workforce, Organisational Development

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Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of Lincolnshire East Clinical Commissioning Group

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**25 March 2014**
Subject:	**Lincolnshire East Clinical Commissioning Group Operational Plan 2014/15 and 2015/16**

Summary:

As part of NHS governance, all NHS Clinical Commissioning Groups must produce an annual rolling programme, their 5 year Strategic Plan 2014-19 and their Operational Plan for 2014/15 and 2015/16. The Strategic Plan must be agreed and finalised by June 2014 and will be a significant output of the Lincolnshire Sustainable Services Review. The 2 year operational plans must be finally submitted to the NHS Executive by 4th April 2014, but with a directive that they must be formally approved and signed off by the Lincolnshire Health and Wellbeing Board on the basis that the plans take account of and support the five core themes of the Joint Health and Wellbeing Strategy 2013 -18 (JHWS), through the CCGs programmes and projects.

The purpose of this paper is to assure the Board that the JHWS is supported by the Lincolnshire East CCG plans and to request the Board to formally support the CCG plans.

Actions Required: To formally support the Lincolnshire East Clinical Commissioning Group Operational Plans 2014/15 and 2015/16.

1. Background

All NHS Clinical Commissioning Groups (CCGs) are required to develop their 5 year strategic and 2 year operational plans on an annual, rolling basis. For the operational plans 2014-16 the deadline is 4th April 2014 and for the strategic plans 2014-19 the deadline is June 2014. Ideally, strategy should preceed operational plans deadlines, however, because of the recent restructuring within the NHS, the need to ensure operations continue to move forward and the timetable and the likely impact of the Lincolnshire Sustainable Services Review, this timetable is the pragmatic way to proceed

and the LSSR Blueprint produced in October 2013 gives enough substance to inform how the first 2 years of operations may contribute to the strategy.

Significant expectations have been established by the planning guidance issued by the NHS Executive in December 2013, regarding the content and level of the plans, not least the assurance shown within plans that all partners and stakeholders have been consulted in the plans development and in particular, that the plans complement and support the 5 core themes established within the Joint Health and Wellbeing Strategy 2013-18, to the extent that the Operational Plan can be formally approved and supported by the Health and Wellbeing Board. The integration of care the development of accessible services closer to home, avoidance of unnecessary hospital admission and the maintenance of people in their homes are key components within CCG plans and the mantra of '**quality and safety first**' flows through all considerations.

In line with both national and local drivers, the Lincolnshire East CCG have established 4 key programmes of work, each of which is underpinned by a series of projects (all identified in programmes and projects – see section 3 of attached plan).

LECCG programme	**Anticipated impacts**	**LSSR workstream**	**JHWS theme**
Wider primary care provided at scale	• Reduced unnecessary referrals • Increase capacity in community • Effective prescribing • Reduced CVD mortality • Improved dementia pathway • Healthy lifestyle programmes	Proactive care Women and children	• Promoting healthier lifestyles • Delivering high quality systematic care • Improving lives of older people • Tackling social determinants of health • Improving outcomes for children
A modern model of integrated care	• Improved pathways for long term conditions and frail elderly • Integrated neighbourhood teams • Supporting patients at home • Improved continuity of care • Falls prevention • Better access to psychological services	Cross cutting	• Promoting healthier lifestyles • Delivering high quality systematic care • Improving lives of older people • Tackling social determinants of health • Improving outcomes for children
Access to the highest quality urgent and emergency care	• Integrated urgent care and reduced hand offs • Care home support • GPs in A&E and single point of access • Rapid response • Appropriate reduced admissions	Urgent care	• Delivering high quality systematic care • Improving lives of older people
Productive elective care	• Cardiovascular disease • Improving access and outcomes in cancer • Appropriate repatriation to home localities • Improved intensive psychiatric care	Elective care Women and children	• Delivering high quality systematic care • Improving outcomes for children

2. Conclusion

Lincolnshire East Clinical Commissioning Group contend that their draft operational plans for 2014/15 and 2015/16 and the core themes expressed with the Joint Health and Wellbeing Strategy are mutually supportive in addressing the health needs and inequalities across the served, Lincolnshire population and that the Boards formal support for the CCGs Operational Plan would be appropriate.

3. Consultation

The CCG plans, as presented, have been extensively consulted upon in their development. No further formal consultation is anticipated prior to publication in April 2014.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Lincolnshire East CCG's Plan on a Page

5. Background Papers

Draft Lincolnshire East Clinical Commissioning Group 5 year Strategic Plan 2014-19 and 2 year Operational Plan 2014-16 www.lincolnshireeastccg.nhs.uk

This report was written by Andrew Rix who can be contacted on 01205 366273 ext. 226 or Andrew.rix@lincolnshireeastccg.nhs.uk

Lincolnshire East CCG website – www.lincolnshireeastccg.nhs.uk
The final *Lincolnshire East Clinical Commissioning Group 5 year Strategic Plan 2014-19 and 2 year Operational Plan 2014-16* will be available on the website when complete

Appendix A

NHS
Lincolnshire East
Clinical Commissioning Group

Strategic Priorities and key measures of success

Reducing early deaths

We will increase life expectancy

- Detecting cancer earlier (Local Priority 1)
- Finding and managing patients with a high risk of stroke (Local Priority 3)

In 2013/14 we will increase, by 3%, the number of people who are screened for cervical cancer (25-49) and improve treatment to reduce strokes to move us closer to the UK median

Talking and listening to Patients

We will improve engagement with our patients

- By continuously listening to patients in our GP practices to improve services
- Consult with our patients about our priorities and ask them how we are doing
- Improve our links with hard to reach groups

In 2013/14 we will achieve this by holding two Stakeholder events per year and implement the Family & Friends Test in 50% of our GP Practices

GP and Community Services

We will drive improvements

- Our GPs will review each other's practice
- Improve the effectiveness of our prescribing and achieve a 1% financial reduction (Local Priority 2)
- Continue to provide dementia training and support to care homes
- Improve care for people with diabetes, providing 90% of the care in the community
- Reduce the harm from falls
- Improve palliative and end of life care

Quality and Safety

We will put quality at the centre of all we do

- Zero tolerance of pressure sores
- Improve patient experience when using our general practices and other providers
- Reduce the number of patients who get preventable infections in hospital (CDiff reduce by 19 cases)
- Learning and acting upon the recommendations of the Francis Report
- Contract assurance of national and local quality and safety standards
- Ongoing monitoring of complaints and incidents and ensuring there is a systematic gathering and use of soft intelligence via continuous listening

Alternatives to Hospital Admissions

We will care for more people at home and in the community, admitting less people to hospital

- Increase the number of patients being looked after at home
- Improve how Community Nurses, GPs and Social Services work together
- Work with the Ambulance Service and GPs to reduce the need to go to A&E
- Improve how GPs and A&E work together

In 2013/14 we will reduce non-elective admissions by 600 and will deliver 2500 diverted A&E attendances

Using Hospitals Well

We will improve access, choice and efficiency

- Get prompt access to a consultant when patients need it
- Improve treatment options for ENT, Ophthalmology and Dermatology
- Reduce number of times patients go back to hospital
- Provide as much service choice as we can to patients
- Develop and use our community hospitals in Louth and Skegness

In 2013/14 we will reduce our follow-ups by 2%

Mental Health and Learning Disabilities

We will improve patient experience

- A minimum of 15% of patients with need will access psychological therapy (IAPT)
- Provide better treatment pathways for patients with dementia
- Improve rates of health checks by 20% for people with Learning Disabilities (LD) by March

In 2013/14 the commissioning of LD and vulnerable adults placements will reflect the learning form Winterbourne review.

Working together for better care

We will work with our partners in Lincolnshire to deliver the Health and Well Being Strategy and work together with other CCGs in commissioning high quality services for our population.

Our Values

Quality – safety, effectiveness & patient experience will guide our decisions
Clinical Leadership – clinicians will be our key leaders and primary influence
Patients – patient's views will be sought and taken into account in what we do
Integration & Partnership – will be used as keys to success
Fairness – we believe investment should reflect need
Equality – we will strive for equality of patient experience, opportunity and outcome
Good Value – we will use NHS resources to best effect

NHS Outcomes Framework	Preventing premature death	Quality of life for people with long term conditions	Help recover from ill health or following injury	Ensure positive experience of care	Care delivered in a safe environment

Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of South West Lincolnshire Clinical Commissioning Group

Report to:	**Lincolnshire Health and Wellbeing Board**
Date:	**25 March 2014**
Subject:	**Strategic and Operational Plan**

Summary:

In December 2013 NHS England published two-year financial allocations to all CCGs in England for the two-year period.

CCGs are required to submit both a two-year operational plan and a five-year strategic plan. The plan sets out the local priorities as determined through the Members' Council and the CCG executive.

Actions Required:

- To receive the first cut of the Operational Plan 2014 – 2019
- Note and comment on the content of the first cut submission of the CCG Strategic and Operational Plan.
- Receive a subsequent and final version of the plan in March prior to final submission to NHS England on 4th April 2014.

1. Background

In December 2013 NHS England published two-year financial allocations to all CCGs in England for the two-year period.

The accompanying planning guidance sets out the parameters and expected contents of the Operational and Strategic commissioning plans of CCGs, which are to be assured by NHS England. The planning guidance encompasses the national expectations of the NHS Mandate and the priorities of the NHS outcomes framework and the NHS constitution.

CCGs are required to submit both a two-year operational plan and a five-year strategic plan. The plan sets out the local priorities as determined through the Members' Council and the CCG executive.

The first draft was submitted to the NHS England Area team on 29 January 2014 and revised following feedback. This draft was submitted to NHSE regional and Area Team on 14th February with a further iteration in March and a final submission on 4 April with the final 5 year Strategic Plan being submitted on 20 June.

The planning guidance also confirm the creation of a "Better Care Fund" transferring resources from the NHS and local authorities into a single pool at national level to act a driver for increasing integration between the NHS and Social care only around 30% is new resource therefore recurrent resources will be transferred from the CCG to the BCF. The link to the planning guidance is detailed below:
http://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf

2. Conclusion

Key priorities for the operational plan and the use of non-recurrent resources in the next 2 years are as follows:

- Establishment of Neighbourhood teams across the CCG as early in 2014/15 as possible (this will also incorporate the outstanding actions for Shaping Health for Mid Kesteven.
- Specification and Procurement of intermediate care in partnership with the County Council and other Lincolnshire CCGs in time for Winter 2014/15
- Key priorities for the longer terms Strategic plan will be as follows:
- Development of the Sleaford and District Health and Social Care Hub
- Development of an integrated care hub in Grantham to support Shaping Health for Mid Kesteven.

The planning guidance also stresses the priority given to moving to 7 day working at both community service and hospital level; whilst provision has been made by Monitor in the agreed Tariff uplift for providers it is likely that this will cause significant tensions with providers, as overall the Tariff changes for 2014/15 actually reduce prices overall and include a further 4% efficiency saving built in.

A key issue for the plan is the need for it to be potentially revised to reflect the outcome of contract negotiations, it is likely that in the light of the very substantial structural deficit at ULHT there will be considerable pressure to use resources earmarked to support change to manage the deficit in the short term.

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 Clair Raybould, Head of Delivery and Development who can be contacted on 01476 406578 or Clair.Raybould@southwestlincolnshireccg.nhs.uk

3. Consultation

N/A

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Draft Strategic and Operational Plan

5. Background Papers

The link to the planning guidance is detailed below:
http://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf

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NHS
South West Lincolnshire
Clinical Commissioning Group

Operational and Strategic Plan 2014-2019

CONTENTS

SECTION 1: STRATEGIC DIRECTION

1.1 MISSION

The mission of NHS South West Lincolnshire Clinical Commissioning Group is to be a CCG for the whole community, striving for the continued improvement in health and wellbeing for all residents in our locality. We want to achieve this in partnership with the local population so that we make the right decisions to ensure the best healthcare is provided and needs are met.

1.2 VALUES

In South West Lincolnshire CCG we believe that high quality services need to be accessible to the whole community. Our clinicians are well placed to lead the development of commissioning and quality improvement in the locality – but we can only do this by close working with councils, local people, allied health professionals and care providers to design the very best services. We intend to maximise input and engagement in improving the quality of local health services.

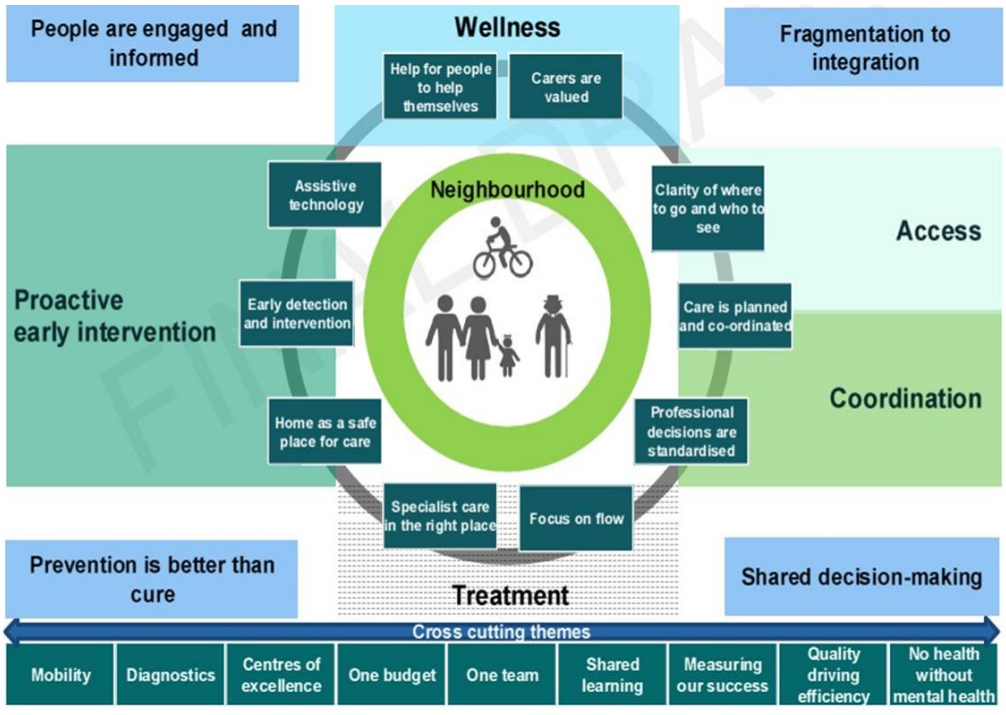
We believe that:

- Patient safety and quality is paramount
- We need to be realistic in our expectations and accept that our resources will never allow us to provide everything for everyone all of the time. We will be open and transparent about the difficult decisions we will have to make and always strive to do the most good for the benefit or our population;
- Services should be local where viable and safe, centralised and accessible where necessary;
- Patients should be at the heart of their health care;
- We will work in an open, honest and transparent manner.
- Integration between primary, community and secondary care services and social care services is critical to the success of health provision;
- Services start at home and our carers are an important part of this.

1.3 STRATEGIC AIMS AND PRIORITIES – PLAN ON A PAGE

The Plan on a Page, below, has been developed by the Lincolnshire Sustainable Services Review Group (LSSR) and has therefore being signed up to and agreed across all Health and Social Care partners in Lincolnshire.

STRATEGIC PLAN ON A PAGE



SECTION 2: HEALTH PROFILE

2.1 HEALTH INEQUALITIES

- South West Lincolnshire CCG has relatively low levels of deprivation, poverty and unemployment compared to other areas in Lincolnshire.
- There is a high proportion of population of people aged 40-49 and significantly lower proportion of people in their 20s then the England average.
- Life expectancy within the CCG is slightly better than the England average.
- Prevalence of cancer, diabetes, coronary heart disease and stroke are higher than the England rates.
- The GP referrals to outpatients and elective admissions are above the England average, but the rate of emergency admission is below the rate for England

Under 75 mortality rates from cancer and cardiovascular disease in South West Lincolnshire CCG are below the rates for England, but the mortality rate from respiratory disease is slightly higher than the national rate. Please note that there are discussions around how those rates are being calculated and the methodology may change in the near future.

Under 75 mortality rates, DSR per 100,000 (2011):

Cardiovascular disease = England (65.6), SW Lincs CCG (55.4)

Respiratory disease = England (27.3), SW Lincs CCG (28.7)

Cancer = England (121.5), SW Lincs CCG (111.8)

The figures below show the average life expectancy for both males and females within South West Lincolnshire CCG and England. It can be seen that the average life expectancy is slightly higher in this CCG compared to England overall.

Average Life Expectancy (2006-2010):

Male = England (78.3), SW Lincs CCG (79.5)

Female = England (82.3), SW Lincs CCG (83.5)

2.2 MAJOR DISEASE

In order to establish the key health problems affecting practices within South West Lincolnshire CCG we have examined the data from the APHO website. If you would like to view the spine charts for each individual indicator they can be accessed via www.apho.org.uk/PracProf/Profile .

Long Term Conditions – Key Points (2011/2012 data):

- Diabetes prevalence is slightly higher than the England average. The prevalence of diabetes has increased compared to 2010/2011 following National trends (6% from 5.6%).
- Coronary Heart disease prevalence is above the England average: 4.3% within South West Lincolnshire compared to 3.4% for England.
- Stroke prevalence is higher than the England rate: 2.2% within South West Lincolnshire compared to 1.7% within England.
- Hypertension prevalence is above the England average: 16.2% within South West Lincolnshire CCG compared to 13.6% in England.
- Psychoses prevalence is below the England average: 0.5% in South West Lincolnshire CCG compared to 0.8% in England. However depression prevalence is above the England average: 13.4% in South West Lincolnshire CCG compared to 11.7% in England.
- Cancer prevalence is above the England average: 2.2% (CCG) – 1.8% (England).The number of Cancer admissions per 1000 is also above the England average, 40.9 (CCG) – 28.6 (England).

Lifestyle – Key Points:

- Obesity prevalence is above the England average, 11.8% (CCG) compared to 10.7% (England), but it's lowest in comparison to the other Lincolnshire CCGs.
- Smoking prevalence cannot accurately be found for individual CCG areas. However according to the Integrated Household Survey by Department of Health, smoking prevalence in South and North Kesteven does not exceed national average (17.3% and 20.0% respectively compared to 20.0% in England).
- The Health and Wellbeing Strategy 2013-2018 stated that "It is estimated that a higher percentage of adults in Lincolnshire smoke than in the East Midlands and England. However, the percentage of people quitting smoking is higher in Lincolnshire than in England."
- Priorities within Lincolnshire according to the Health Profile 2012 (www.apho.org.uk) are obesity, alcohol and tobacco.

2.3 REFERRALS AND ADMISSIONS

- The number of GP referrals to outpatients (1st attendance, per 1000) is above the England average: 195.8 (CCG) compared to 191.7 (England).
- The number of elective admissions (per 1000) is above the England average: 145.5 (CCG) compared to 121.0 (England).
- The number of emergency admissions (per 1000) is slightly below the England average, 85.1 (CCG) compared to 89.0 (England).

SECTION 3: SYSTEM VISION

3.1 LINCOLNSHIRE SUSTAINABLE SERVICES REVIEW (LSSR)

Since August 2013 the Lincolnshire Sustainable Services Review (LSSR) has brought together the health and social care community in Lincolnshire to establish a vision for health and social care provision and to focus on how the people of Lincolnshire can achieve the best health and social care outcomes for the resources available and what care should look like in 3 to 5 years' time.

The overall objective is to collaboratively design and implement a future model of integrated care that will allow the Lincolnshire health and social care system to deliver high quality services within a sustainable financial model.

The partner organisations are: Lincolnshire East CCG, Lincolnshire West CCG, South Lincolnshire CCG, South West Lincolnshire CCG, NHS England (Leicestershire and Lincolnshire Area), Lincolnshire County Council, Lincolnshire Partnership NHS Foundation Trust, Lincolnshire Community Health Services NHS Trust, United Lincolnshire Hospitals NHS Trust and East Midlands Ambulance Service and Health Watch Lincolnshire.

The Plan on a Page shown above provides a pictorial of the direction of travel in terms of the model we will be collectively developing for the provision of health and social care services in Lincolnshire.

3.2 WORK STREAMS & TIMESCALES

The LSSR involves two phases of work:

Phase 1 was carried out between July and October 2013 and produced a Blueprint Design focused on 4 main areas:

- Establishing a vision and objectives, mobilising the team
- The current model of care: agreeing a baseline for how the health and social care economy currently operates:
- The future model of care: engaging clinicians, health and social care professionals and patients and carers in four Care Design Groups to develop design options, followed by modelling to understand

the financial and activity impact of the proposed changes.
- The creation of a roadmap to deliver the changes proposed for consideration.

The Blueprint was approved by the health and Wellbeing Board in December 2013.The Blueprint is only a first step – but will act as a unifying guide against which the planning and performance of each consistent organisation will be held to account.

Phase 2 of the LSSR runs from February 2014 to December 2014, and includes developing robust models for all 4 care groups along with enablers for implementation. There will be a comprehensive pre-consultation and full consultation. Some of the 22 interventions do not need consultation and implementation can therefore begin during 2014/15, the catalyst being the **piloting of a range of 5 to 6 Neighbourhood Teams and the further development of the Urgent Care Plan and seven day working**, which are seen as the key elements of the model of integrated care to avoid unnecessary admission and enable an integrated approach across all providers to care in the community and closer to home.

3.3 KEY VALUES AND PRINCIPLES

To provide a structure for understanding the future model of care developed by the CDGs, the programme team have considered the future model of care in terms of:

- The overall goal – sustainability in Lincolnshire's health and care economy
  - The principles of how the overall goal will be delivered
    - People are engaged and informed
    - From fragmentation to integration
    - Prevention is better than cure
    - Shared decision-making

  - The assets needed to achieve these outcomes. The Future Model of Care will include ten assets designed to drive our four principles and overall benefits:
    - Home is a safe place for care
    - Early detection and intervention
    - Assistive technologies
    - Carers are valued
    - Focus on flow
    - Clarity of where to go and who to see
    - Care is planned and co-ordinated
    - Standardised professional decisions
    - Specialist care in the right place
    - ideas required to achieve the future blueprint

  - The 22 improvement interventions within the following categories
    - Proactive Care
    - Urgent Care
    - Elective Care
    - Women and Children's

3.4 IMPROVING QUALITY AND OUTCOMES

Currently, Health and social care services are commissioned and provided by a number of separate organisations. Service models have developed and evolved based on these partial views of the system, with services being fragmented by organisation boundaries, traditional professional distinctions and separate funding, regulation, physical locations and IT systems.

Care professionals across Lincolnshire have strived to deliver the best possible care within this framework – but it has led to duplication, "hand-offs" of people between organisations, and a lack of clear end-to-end accountability for people's health and social wellbeing. To many patients and members of the public this brings confusion and uncertainty.

The current configuration not only constrains care professionals, but through duplication and uneven

distribution of resources is not financially sustainable and particularly not given the expected growth in the population and increasing older people. Some recent service quality issues also indicate a system under pressure and that reform is required.

The leaders of health and social care across Lincolnshire have come together to focus on defining the right services for Lincolnshire to improve quality and outcomes and deliver services that the population will value and care professionals can be proud of.

3.5 SUSTAINABILITY AND COMMITMENT TO DELIVER

The LSSR does not fully close the affordability gap, but the interventions described and the benefits they will deliver are intentionally realistic, in order to ensure that the proposed service model is achievable and sustainable. There is significant opportunity for the benefits realised to go beyond what is described. In addition it is anticipated that the implementation phase will allow for identification of new possibilities that will help to further close the financial gap.

Integration is national policy and it is essential we get services working together, especially community care, social care, primary care and prevention and early intervention. In light of this, the organisations involved in the delivery of health and social care in Lincolnshire have agreed to work together to design a blueprint for the future delivery of services that would meet the needs of the population both now and in the future, and do so whilst operating under the financial constraints that exist to make the right choices for sustainability, particularly where these choices are difficult and contentious.

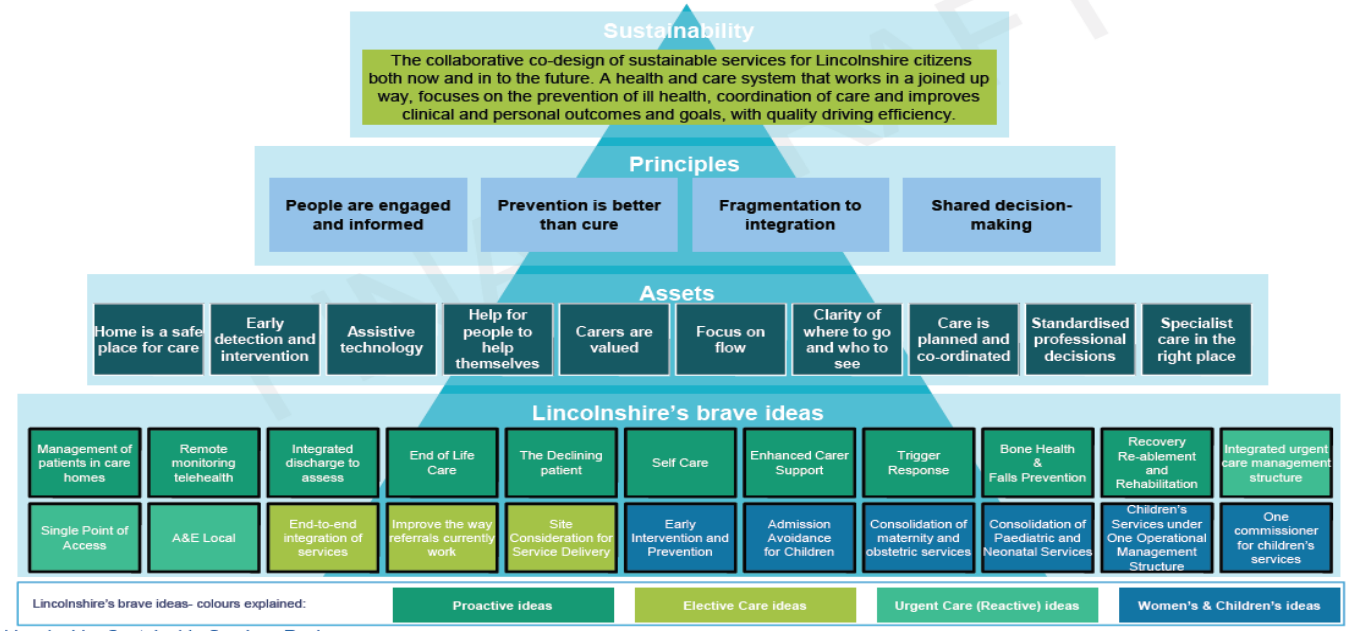
3.6 IMPROVEMENT INTERVENTIONS

In order to achieve the future model of care and the proposed capabilities 22 interventions (as proposed by the Care Design Groups) have been proposed (see diagram below), which include:

- Proactively managing people, particularly those with long term conditions and the frail elderly thereby
- Avoiding unnecessary hospitalisation
- A clear simple response to an urgent need and
- Aligning all urgent care response services under a single operational management
- More consistent access to urgent care thus protecting specialist services
- No longer setting up hospital services in competition with community services
- Safety and quality as the main focus

These will be supported by some key enablers, such as Estates, IM&T, Contracting and Workforce Planning.

The diagram below provides on one page the golden thread between Lincolnshire's goal of the design of sustainable services in the future model through key principles, use of assets and brave ideas:



SECTION 4: OPERATIONAL PLAN

4.1 DELIVERY AGAINST THE FIVE DOMAINS

We want to **prevent people from dying prematurely**, with an increase in life expectancy for all sections of society
We want to make sure that those people with long-term conditions including those with mental illnesses get the **best possible quality of life**
We want to ensure patients are able to **recover quickly** and successfully from episodes of ill-health or following an injury
We want to ensure patients have a **great experience** of all their care
We want to ensure that patients in out care are **kept safe** and protected from all avoidable harm

4.1.1 Performance Against the Five Domains

During 2013/14, performance during the year is reported as follows against the 5 domains of the Outcomes Framework:

Domain 1 Preventing people from dying prematurely (5 Indicators)			
Green – 2	Amber – 0	Red – 3	Blue – 0
Domain 2 Enhancing quality of life to people with long term conditions (5 Indicators)			
Green – 0	Amber – 0	Red – 0	Blue – 5
Domain 3 Helping people recover from episodes of ill health or injury (7 Indicators)			
Green – 4	Amber – 0	Red – 0	Blue – 3
Domain 4 Ensuring people have a positive experience of care (5 Indicators)			
Green – 3	Amber – 0	Red – 2	Blue – 0
Domain 5 Treating and caring for people in a safe environment and protecting from harm (2 Indicators)			
Green – 1	Amber – 0	Red – 1	Blue – 0
Key: Green – achieving, Amber – at risk, Red – not achieving, Blue – where no data is available in 2013/14			

4.1.2 Improvement Intentions

3 out of the 5 Domains have areas of non-achievement, further details are as follows along with intended remedial action.

Domain 1 Preventing people from dying prematurely:

PYLL from Cases Considered Amenable to Health
There has been no improvement and no decline in the figure.
The measures contained within the LSSR Blueprint around prevention will undoubtedly have an impact on reducing the PYLL, for example: Plans for early intervention, alarm systems, self-care, falls prevention, neighbourhood teams and generally much better access to care in the community, to mention some

Under 75 Mortality Rate from Cardiovascular

The CCG's Governing Body has agreed that CVD is a priority for the next 2 years. Based on the performance data, there is significant evidence that improvement is required

The CCG have commissioned a 'deep dive' piece of working, drilling down into the performance data to identify targeted areas for improvement. One of the areas already identified is Diabetes. A project has already commenced to identify issues within the current
Diabetes service and to identify improvements taking into consideration the national model for Diabetes care that has recently been made available.

Under 75 Mortality Rate from Cancer

As for CVD, it has been agreed that there will be a 'deep dive' into the cancer performance information in order to inform further review.

Domain 4 Ensuring people have a positive experience of care:

Patient Experience of Primary Care – GP Out of Hours
We will undertake further analysis of the data and will work with practices and the Out of Hours provider to agree actions required.
Friends and Family Test – Score – Provider 2 – (NUH)
Whilst there has been no improvement in this score, there has been no deterioration either. However, this area clearly needs attention and will be managed through the formal contract management process with NUH and through the CCGs Quality and Patient Experience Committee.

Domain 5 Treating and caring for people in a safe environment and protecting from harm:

Healthcare Acquired Infection Measure (MRSA)
Figure currently sitting at 2 with a target of zero. There has been improvement but clearly needs further improvement. Actions have been identified and the CCGs have appointed a new Infection Prevention and Control lead who will be working directly with providers.

ULHT has a specific action plan in place to manage the risk of patients acquiring MRSA bloodstream infection. Key actions include:

Multi-disciplinary post infection reviews undertaken as per national standard
Root Cause Analysis undertaken to ensure that lessons learned are identified, actions are put in place to address any issues and learning is disseminated throughout the trust.
Invasive device supply company representatives visiting all sites to provide training

The CCG federated IP&C has also produced a service plan (currently out to exec nurses for review) which will ensure that the appropriate assurance is obtained from ULHT regarding their MRSA action plan.

4.2 DELIVERY ACROSS THE SEVEN OUTCOMES MEASURES

The seven outcome measures will be delivered and improved upon through the implementation of the LSSR and the local areas of service development that have been identified as local priority projects over the next 2 years. Some of the projects will be conducted on behalf of the Planning Unit.

The table below shows the projects and identifies the links of each of these to the seven outcome measures.

The LSSR interventions and local service development projects will improve health and reduce health inequalities across Lincolnshire and specifically within South West Lincolnshire.

Ref No.	IMPROVEMENT INTERVENTION	Ambition 1 Securing additional years of life for the people of England with treatable conditions	Ambition 2 Improving health related quality of life of the 15 million+ people with one or more long-term condition	Ambition 3 Reducing the amount of time people spend avoidably in hospital	Ambition 4 Increasing the proportion of older people living independently at home following discharge from hospital	Ambition 5 Increasing the number of people having appositive experience of hospital care	Ambition 6 Increasing the number of people having a positive experience of care outside hospital	Ambition 7 Making significant progress towards eliminating avoidable deaths in our hospitals
Current Level of Achievement – South West Lincs CCG only		2012 Baseline of 1978.8. 3.2% reduction year on year target. CVD primary contributor	12/13 figure 74.1. 2nd best CCG in County (best 82.3). Above England average 73.1. Target 1% year on year	12/13 Baseline 2075.7. 2nd poorest CCG in County. Above England average. 15% reduction in 5 years. 50% of target to be achieved by end of year 2	Proportion of older people still at home 91 days after discharge from hospital into reablement/rehab services :12/13 Baseline 72.40%. Oct 2015 target 80%	12/13 Baseline 155.8. 2nd highest performing CCG in County. Above England average (reducing target – England 142, our target 142)	12/13 Baseline 6.8. Poorest performing CCG in County. Above England average (reducing target – England 6.1, our target 5.8)	MRSA YTD figure is 2. Target zero.
SOUTH WEST LINCS CCG								
1	CVD Deep Dive	√	√	√	√	√	√	
2	AF Stroke – GRASP Tool	√	√	√			√	
3	Palliative Care Hospice Beds Provision			√		√		
4	Re-commission Diabetes Model of Care	√	√	√	√		√	
5	Mobile Outreach Team		√	√	√		√	
6	Re-Commission Intermediate Care layer for intervention not requiring acute bed			√	√		√	
7	Commission Community Dermatology Service		√				√	
8	Pilot Complex Back/Spinal Opinion Service		√				√	

Ref No.	IMPROVEMENT INTERVENTION	Ambition 1 Securing additional years of life for the people of England with treatable conditions	Ambition 2 Improving health related quality of life of the 15 million+ people with one or more long-term condition	Ambition 3 Reducing the amount of time people spend avoidably in hospital	Ambition 4 Increasing the proportion of older people living independently at home following discharge from hospital	Ambition 5 Increasing the number of people having appositive experience of hospital care	Ambition 6 Increasing the number of people having a positive experience of care outside hospital	Ambition 7 Making significant progress towards eliminating avoidable deaths in our hospitals
9	Implementation of Care Home Education Project	√	√	√	√		√	
10	Commission movement disorder service, currently a pilot for Parkinson Disease		√	√			√	
11	Shaping Health – Integrated Urgent Care at Grantham inc Children			√		√		
12	Shaping Health - Grantham Ambulatory Care Unit			√		√		
13	Shaping Health - Kingfisher Hub for Children's Services		√	√		√	√	
14	Shaping Health - Repatriation of elective care, development of day case unit (Grantham)			√		√		
PLANNING UNIT LEVEL								
15	Commissioning Cancer Services	√		√		√	√	
16	Improving Access to Psychological Therapies (IAPT)		√					

Ref No.	IMPROVEMENT INTERVENTION	Ambition 1 Securing additional years of life for the people of England with treatable conditions	Ambition 2 Improving health related quality of life of the 15 million+ people with one or more long-term condition	Ambition 3 Reducing the amount of time people spend avoidably in hospital	Ambition 4 Increasing the proportion of older people living independently at home following discharge from hospital	Ambition 5 Increasing the number of people having appositive experience of hospital care	Ambition 6 Increasing the number of people having a positive experience of care outside hospital	Ambition 7 Making significant progress towards eliminating avoidable deaths in our hospitals
17	Dementia Pathway Development	√	√	√		√	√	
LSSR								
	PROACTIVE CARE MODEL – NEIGHBOURHOOD TEAM							
1	Management of Patients in Care Homes	√		√			√	
2	Remote monitoring telehealth	√	√		√		√	
3	Integrated discharge to assessment				√	√	√	
4	End of Life Care					√	√	
5	The Declining Patient	√	√				√	
6	Self Care	√	√		√		√	
7	Enhanced Carer Support				√		√	
8	Trigger Response	√	√	√	√		√	
9	Bone Health & Falls Prevention			√	√		√	
10	Recovery, re-ablement and Rehabilitation		√	√	√		√	
	URGENT CARE DESIGN							
11	Integrated Urgent Care Management Structure			√		√		
12	Single Point of Access					√		
13	A&E Local			√		√		

Ref No.	IMPROVEMENT INTERVENTION	Ambition 1 Securing additional years of life for the people of England with treatable conditions	Ambition 2 Improving health related quality of life of the 15 million+ people with one or more long-term condition	Ambition 3 Reducing the amount of time people spend avoidably in hospital	Ambition 4 Increasing the proportion of older people living independently at home following discharge from hospital	Ambition 5 Increasing the number of people having appositive experience of hospital care	Ambition 6 Increasing the number of people having a positive experience of care outside hospital	Ambition 7 Making significant progress towards eliminating avoidable deaths in our hospitals
	ELECTIVE CARE							
14	End to End Integration of Services					√	√	
15	Improve the Way Referrals Currently Work					√		
16	Site Consideration for Service Delivery					√		
	WOMEN'S AND CHILDRENS							
17	Early Intervention and Prevention			√			√	
18	Admission Avoidance for Children			√			√	
19	Consolidation of maternity and obstetric services					√		
20	Consolidation of Paediatric and Neonatal Services					√		
21	Children's Services Under One Operational Management Structure		√			√		
22	One Commissioner for Children's Services		√					

4.3 PARITY OF ESTEEM

Child and Adolescent Mental Health Services (JHWBS-theme 4)

There is a current section 75 agreement in place between Lincolnshire County Council and Lincolnshire CCGs for the provision of Tier 2 and 3 services. Tier 2 CMHS has been fully integrated into local Children's services, however in 2014/15 pilot work will take place in Grantham on the wider integration of children's services including Tier 3 CAMHs.

In 2014/15 Lincolnshire County Council as the lead partner will undertake a re-specification and procurement exercise for tier 3 services to ensure a stronger focus on urgent response and 7 day working.

Parity of Esteem (JHWBS-theme 1,2,3)

CCGs and LCC will review provider contracts over the next 12 months and update contracts to ensure that they contain explicit requirements to ensure parity of esteem including a review of:

Eligibility criteria for services;
Education, training and skills of staff;
Open book accounting with clear understanding of activities that support parity of esteem.

Patients with schizophrenia will on average die 14.6 years earlier, bipolar 10.1 and patients with schizoaffective disorder eight years earlier than the general population. The CCG is working with partners to reduce the health inequalities between people with serious mental illness and the general population including

Making Every Contact Count; pick up patients with physical health conditions that need assessment and treatment early;

Putting in place a local CQUIN to ensure that experts support people on complex medications for severe mental health conditions in the primary health care setting to ensure the effects and side effects of psychotropic medications are routinely monitored and addressed;

Improved access to healthcare and talking therapies;
Ensuring suicide prevention policies are effectively implemented;
Ensuring the Care Programme Approach supports people with severe mental health conditions;
And ensuring positive mental well-being is recognised as being a central part of an individual's good health and care

4.4 IMPROVEMENT INTERVENTIONS – PATIENT SERVICES

4.4.1 Action Plan

The Action Plan below provides further detail on each of the proposed interventions at LSSR level, SWLCCG level and Planning Unit level. Some of the SWLCCG interventions currently underway and ongoing over the next 2 years will feed into the delivery of some of the interventions committed to within the LSSR.

Ref No.	IMPROVEMENT INTERVENTION	Progress to Date	Implementation Targets Next 2 Years	Quality/Outcomes Impact
SOUTH WEST LINCS CCG				
1	CVD Deep Dive	CCG identified opportunities for improvements in quality and outcomes for CVD from the Commissioning for Value Pack. Informed by prevalence in: CVD primary prevention Coronary heart disease Heart failure Heart failure due to LVD (left ventricular dysfunction) Hypertension Obesity in age 16+	Deep dive has been commissioned from GEM. Timescale to be complete by end of quarter one.	Tell us 'what' we need to do in order to achieve: Financial - Savings on elective and day case admissions, non-elective admissions and prescribing Quality – improve mortality rates for CVD patients under 75 (11 patients per year) Reduce the number of patients with high blood pressure and high cholesterol (reduce by 185 with high blood pressure and 165 with high cholesterol) Reduce TIA's by 19 Length of stay reduced by 53 patients where patients are spending 90% of their time in hospital rather than in the community
2	AF Stroke – GRASP Tool	GRASP AF tool has been adopted by 18 out of 19 practices. Educational seminars in Jan 2013 and Dec 2013 for clinical practice staff.	The screening and methodology for identification adopted by clinical staff will continue and will feed into the CVD project identified above. Statistics will be obtained to demonstrate impact on prevention	Enabled early identification of patients with AF through routine and opportunistic screening, using recommended methodology and monitoring through the GRASP tool. Resulting in reduction of AF patients who could potentially progress to having a stroke or heart failure. Reduction in prescribing costs through appropriate administration of medication. Avoiding emergency admissions for stroke of 12 per year. Ability to manage AF in primary care setting without referral into acute. QIPP Plan was to reduce stroke admissions by £19,000. Achievement is £12,500 at month 8. Reduction in number by 6 less strokes this year.
3	Hospice Palliative Care Provision	St Barnabas and ULHT are jointly providing 6 nurse-led palliative care beds on the hospital site; supported by GP's – a Hospice in a Hospital. This has stimulated much interest from NHS England due to the unique concept. Building work started	The beds will open in July 2014. Running concurrently is a review of all EOL community services to identify the money flow. Identified that there needs to be changes in clinical behaviour in	Invest to save – initial investment of £109,800 in 13/14. Will remove 50% of deaths in hospital on the Grantham site. Improve patient experience and quality of care

		Jan 2014 and is on schedule for completion to meet opening date of July. Staff selection timetabled for end Feb 2014. Training programme developed to ensure staff are prepared before opening date. Training timetabled in June for GP practice clinical staff.	order to release savings, including earlier identification of palliative care patients. If this is achieved the beds will be self- sustaining in 2015/2016. Work will feed into the LSSR Proactive Care EOL work.	– avoiding patients dying on wards. Patients currently unsupported, along with their carers, in the community or in hospital, will receive a much improved level of support. Ensure dignity of patients at end of life. Will also support patients who require stabilisation during palliative phase but not close to death. Hospice nursing team will be able to outreach to patients within the hospital who still require acute bed based treatment.
4	Re-commission Diabetes Model of Care	Framework review of services undertaken in 2013 to establish current position and to identify gaps and issues with current service provision/model. Diabetes has also been identified in the Commissioning for Value Packs. Identification of LLR model as example of best practice – up-skilling primary care clinical staff to provide level 2 care	Reconfigure services at a countywide level with the recently issued outcome based National Specification (aligned to NICE clinical standards). This work will also integrate with the LSSR Neighbourhood Team implementation. Final approval of the business case will be quarter 1 with implementation in quarter 2. The model is similar to the LLR model Investment in up-skilling practice staff. This work will link into the CVD work as a large proportion of the CVD patients will also have diabetes.	The National Specification is outcome based. Less use of secondary care. The Commissioning for Value Pack identifies: Change of prescribing practice. Resulting in a reduction of costs. Quality improvement for over 500 patients. Reduction in non-elective admissions. Reduction in length of hospital stay. Reduction in outpatient's appointments. Care closer to home through community based provision. Enable and educate patients in relation to self-care, in order to avoid/reduce complications further down the line.
5	Mobile Outreach Team	7 day working 11/2013 as part of community services Rapid Response service Team expanded to 5 03/2013 CCM team aligned to care homes to undertake care home support and education 01/2014	MOT to be included as part of Neighbourhood Team	The MOT has already avoided 206 admissions to acute hospital sites. Future reduced A&E attendances/admissions from care homes as a result of the CCM alignment. More patients referred to appropriate care settings More patients remaining at home with appropriate support packages
6	Re-Commission Intermediate Care layer for intervention not requiring acute bed	Identified that we should have 24 intermediate care beds. We currently have 16. There is an identified lack of capacity in Grantham. Looked at a number of options. Now in	By April we will have commissioned a pilot for an additional 8 beds in Grantham that will not exclude dementia patients.	Plan not to re-open 34 beds currently closed as a result of the Keogh Review at Grantham Hospital resulting in reduction of acute beds and acute admissions.

		discussion with new care home opening in Grantham.		To support the ongoing bed reduction at ULHT on the Lincoln County and Pilgrim Sites. Flow within the hospital will be improved by enabling a step-up into intermediate care and facilitate step-down out of acute hospital beds into intermediate care. Improved patient care and patient experience. Re-ablement and rehabilitation of these patients will enable them to continue to live more independently and avoid/delay the need for social care intervention. Reduce impact on long term placements in nursing or residential care homes.
7	Commission Community Dermatology Service	The CCG have identified due to performance issues with meeting Constitutional standards that there is an opportunity to commission a service in the community.	Complete a business case by end of first quarter for implementation by the end of 2014/15.	Early work identifies that we could reduce Outpatients, follow ups and some treatments in secondary care. Opportunity to use tele-medicine. Care Closer to home
8	Pilot Complex Backs / Spinal Opinion Service	Local services have been explored whilst countywide discussions on a unit level service have not developed in the way the CCG would like locally. The CCG has audited the existing services for MSK and determined the true gap. Spinal Injections have been reviewed and actions taken to ensure these obtain prior approval from all providers.	Sheffield back pain service has been highlighted as best practice and the CCG wishes to adopt similar pathways. Currently discussions underway with a provider regarding a pilot service for 12 months as the current spinal service will cease at the end of May 2014 and that will allow analysis of other linked services.	The CCG CFV pack identifies savings (1.2M) and improvements for MSK services. Since the baseline the CCG has reviewed the LIMMS and AQP MSK service and identifies that the remaining opportunity for improvement will be delivered by a Complex back and Spinal Opinion pathway. This will impact upon prescribing, elective and day case admissions.
9	Implementation of Care Home Education Project	CCM team increased to 3 in March A number of homes identified as having gaps in training demonstrated by higher levels of use of 999 services. (Report available)	By April CCMs are aligned with care homes to conduct Falls, UTI, respiratory assessment and training, ward rounds and advice to staff. All CCMs will be part of the Rapid Response Team so that EMAS crews only have one number to dial 24/7.	To increase the numbers of patients treated at home and decrease ambulance call outs and A&E attendances and admissions. Reduce the number of unscheduled admissions from Care Homes Reduce the number of falls – including recurrent falls Reduce the number of UTI Improvement of quality of care due to increase in staff skills levels Reduce the number of pressure sores occurring (Grade 2-4)

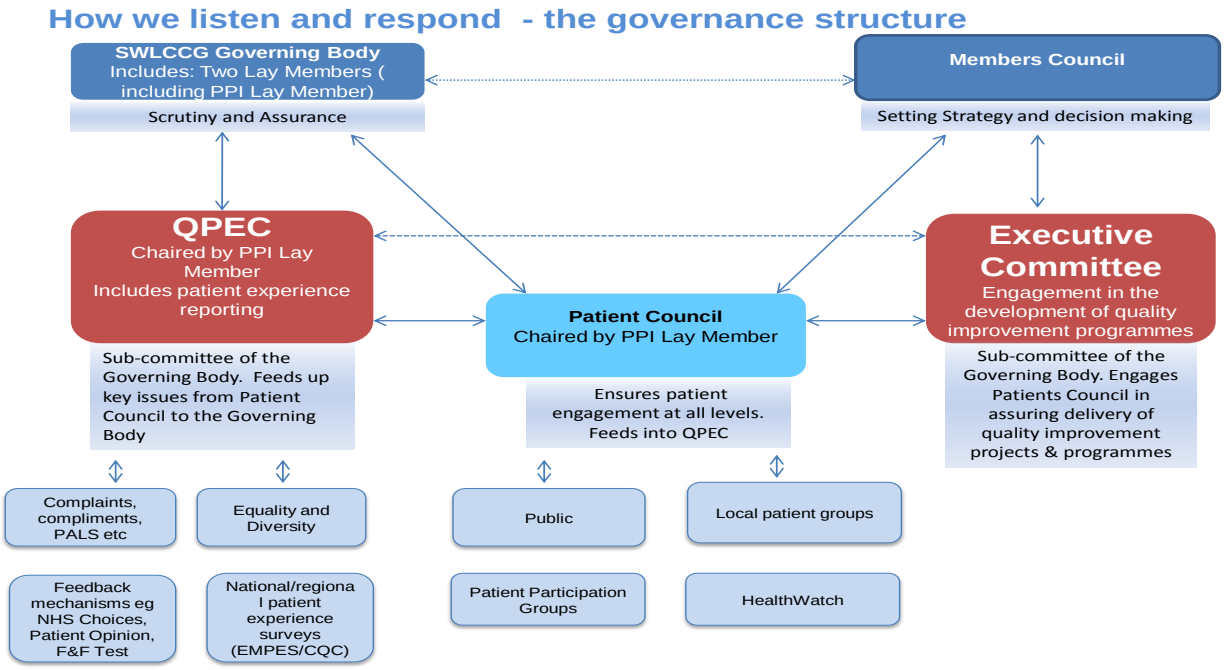
10	Commission movement disorder service, currently a pilot for Parkinson Disease(PD)	PD service started 09/2012 in partnership with Parkinson's UK. CCG agree to continue funding 09/2014 – 03/2015 Review of movement disorder services undertaken by Public Health student	03-09/2014 Identify and agree movement disorder service model Prepare business case for funding for service and to fund PDNS to cover transition period Possible staged implementation to embed the service and ensure it is within the CCG financial envelope	PDNS brought CCG PD services up to NICE standards delivery better quality of care for people with PD. Movement disorder service will bring care closer to home to a wider range of patients with neurological conditions. In the CCG CFV pack there is an opportunity to reduce non elective admissions and prescribing but it is very difficult to quantify the nurse impact due to coding. However we know from national work that by proactively managing PD patients they are less likely to be admitted. Common admissions are falls as a result of medication changes.
11	Shaping Health – Integrated Urgent Care at Grantham inc Children	In order to deliver the integrated front door model building works need to be undertaken at Grantham. Department design is underway and due to complete by the end of March. During 2013/14 there has been a pilot running of a GP in A&E to support A&E staff with decisions to admit, see and treat children with minor illness and treat other patients as a member of the A&E team. Current avoided at month 8 is 299 Dedicated observation/treatment space for children with urgent care needs has been completed and Paediatric nurses will be moved into A&E in March.	Integrated front door department design is underway and due to complete by the end of March. The timeframe for the building work is dependent on the design selected. Work is ongoing to develop operational policy / referral processes / cross organisational working alongside contract discussions.	Reduced emergency admissions for children of 35 per month. Less Ambulance transfers Improved quality of care as children are seen and treated in one department. Multi-Disciplinary Team working to ensure patients are treated by the right professionals first time will enable achievement of A&E Constitution targets.
12	Shaping Health - Grantham Ambulatory Care Unit	In order to deliver the full Ambulatory Care service building work is required. In the meantime to cover winter pressure the first phase of the ambulatory care pathways started in Nov 2013 within the existing A&E and EAU footprint at Grantham Hospital.	Building work due to commence in April 2014 and is to be completed by Aug 2014. Currency and payment regime to be agreed. Operational policy / referral processes / training programme to be developed by a task and finish group during the build time.	Reduce avoidable Emergency admissions and national evidence base by up to 40% The CCGs CFV identifies opportunities for improvements in quality and savings for non-elective admissions in patients that would have an ambulatory sensitive care condition Where patients do need to be admitted early diagnosis provides for better outcomes
13	Shaping Health - Kingfisher Hub for Children's Services	Staff consultations to move nurses to the Integrated Urgent Care Centre and it is planned to move those staff in March.	It is planned to have a 3 phase approach to the children's hub and this would be: Phase 1 – Reconciling all	One stop care for children including the most vulnerable. Better care Coordination

			ULHT activity that was currently going into Boston Health Clinic and could be brought into the Grantham unit. An invitation was to be extended to the other ULHT specialities such as Orthopaedics, ENT to encourage them to hold their Paediatric clinics within the hub. Phase 2 – MDT from LCHS, LPfT. Phase 3 – Lincolnshire County Council – Fully integrated Health and Social Care facility – April 2015	Reduced Waiting times Reduced hospital stays Major contribution to special education needs reforms (SEND)
14	Shaping Health – Development of elective capacity at Grantham including development of a day case unit (Grantham)	Options appraisal undertaken and preliminary work to develop business case completed by ULHT. Awaiting ULHT Investment Programme Board decision for capital investment funding in March,	Once IPB has confirmed the timeline will be agreed.	Improve access, availability and productivity of outpatient and elective care services at Grantham Hospital, where possible offering one stop clinics and day case surgery. This will reduce the numbers of patients required to travel outside of the area and will also reduce the financial burden of paying increased market forces factor for care outside of the county. These services will be available 7 days a week. This will support hospital re configuration as part of LSSR enabling greater concentration on emergency care on one or more of the other Lincolnshire sites.
PLANNING UNIT LEVEL				
15	Commissioning Cancer Services	Current performance in Cancer services and outcomes has been identified by the CCG as an area that requires further analysis and support. The CCG practices have undertaken a review of all breaches of targets and a report is to be completed in March. The CCG has commissioned a deep dive into Cancer to be completed by April 2014.	• Ensure access to treatment (14, 31 & 62 day measures • Individual funding reviews • Access to cancer drugs fund • Adherence to best practice (e.g. chemo protocols) • Prevention through screening achieved and sustained • Breast Screening – Age extension implemented offering screening to 47 to 73 year olds	The CCG CFV pack identifies opportunities in spend and quality that will be tested through the deep dive. Survival rates will be increased owing to early detection and treatment

			• Cervical screening – HPV and test of cure • Bowel Cancer – Age extension has been increased to men and women age 60 to 75	
16	Improving Access to Psychological Therapies (IAPT)	There has been a performance improvement plan in place with LPFT. Performance remains above the national average. Recruitment and retention of staff is challenging but training programmes are in place. Single point of access for mental health services has been implemented as has self-referral.	Service for people with common mental health problems will initially be aligned and then integrated into neighbourhood teams. We will be engaging the market across Lincolnshire to secure additional capacity and increase patient choice.	We expect a 1% per year improvement in uptake of the service and continued improvement in recovery rates.
17	Dementia Pathway Development	Lincolnshire is developing a new Dementia Strategy which will be complete by end of April 2014. Lincolnshire County Council have led a public consultation on the Strategic Priorities for Dementia care.	Following agreement of the final strategy commissioning intentions will be confirmed covering the diagnosis, ongoing support and integration with social care. Diagnosis made either as a GP or memory assessment service pathway Navigator / support worker person attached to patient at time of diagnosis Signposting to network of agencies who provide help and support Advanced care planning and management of difficulties via the memory service at a point when the need becomes apparent	Increase Dementia Diagnosis to 67% Improved Public awareness of dementia Improved identification and early diagnosis Improved Quality of diagnosis Improved support for families/carers Increased self-management CCG CFV pack identifies savings in prescribing and reduction in emergency admissions for over 74 with secondary diagnosis of dementia.

4.4.2 Citizen Participation in Service Design, Change and Own Care

As a leading local healthcare commissioner, South West Lincolnshire Clinical Commissioning Group (CCG) is committed to ensuring that our patients and citizen drive decisions about their health care. The CCG has appointed a Patient and Public Engagement Lay Member and established a Patients Council to act as a diverse reference group to enable the citizens of South West Lincolnshire to make an effective contribution to the prioritisation, design, planning and commissioning of health care services in alignment with the CCGs strategic objectives. The Patients Council ensures that mutually advantageous relationships develop between the CCG, Healthwatch and local Patient Participation Groups to help shape the most effective health services for the local population. The PPG representatives, as part of the governance arrangements for the CCG, hold listening events within their respective groups and wider practice populations and real time report any issues, ideas or experience of local health care. The Patients Council reports directly to the Governing Body.



Through its Shaping Health for Mid-Kesteven programme the CCG has already made significant progress consulting and involving the local communities in decisions about care and getting public feedback on a range of issues including treatment choices. To ensure a sustained and meaningful dialogue a continuous listening model has been developed based on the patient engagement methodology employed by Keogh in response to 'Transforming Participation in Health and Care'. The CCG webpage has also been developed to encourage real time feedback, 166 tweets issued – 43,993 potential impressions, 37 new followers on Twitter – 38%increase since Quarter 1 and 71 Facebook posts issued – 29,900 potential impressions. Patient choice, involving patients and carers in decisions about care and the duty of candour are mandatory measures through the quality schedule in place with providers and are monitored through a programme of annual quality visits. The CCG monitors NHS Choices Patient Opinion at GP, Mental Health & Learning Disability & Acute Care level.

4.4.3 Wider Primary Care, Provided at Scale

Primary care has huge potential to contribute to the delivery of our ambitions, particularly relating to proactive care. The Director for Primary Care Direct Commissioning at the Area Team has joined the Lincolnshire Joint Commissioning Group with all CCGs and Lincolnshire County Council which is leading the Strategic Commissioning to underpin the LSSR.

The LSSR is absolutely clear that primary care and general practice is at the centre of the neighbourhood team model. This will mean that new models of joint commissioning and new contractual frameworks and increased strategic coordination will be needed across the CCG, Area Team and County Council.

The CCG has historically; using Quality Premium (QP QOF), enabled primary care to focus on pathway changes that improve the quality of care in which primary care has a role. Over the years, this has moved from small scale to larger scale projects which have directly improved quality and cost.

The CCG has met with member practices to start the discussion about the role that primary care could have and their response to the Call to Action. In recognition of their role and its importance in the overall system, the practices wished to develop a strategy for primary care.

In 2013 the Sleaford and District GPs have been working on a vision for primary care that not only covers core general practice but more broadly that of urgent care, diagnostics, neighbourhood team and shift from secondary care to community for appropriate services. This vision is well placed to meet the needs of the neighbourhood team approach for the area and supports the proactive, urgent and elective part of the LSSR. The vision is currently being developed into a model/blueprint for Sleaford and will be enabled by non-recurrent transformation money. This ensures suitable estate is available in conjunction with the local district council and NHS England from the services it commissions. As part of the development a pilot of non-emergency urgent care in primary care based on the learning from the Corby model will be implemented in 2014/15 to evaluate the impact particularly on ambulance conveyance to Lincoln County Hospital.

The strong message from the public during our Shaping Health consultation was that they wished us to focus on care closer to home and that for Sleaford area services could be delivered as a satellite of Grantham Hospital.

In 2013 the NHSE Area Team (AT) communicated with CCGs regarding 7 day working in Medical practices to support winter pressures. This has supported work the CCG was undertaking to pilot services to support winter pressures delivered by primary care such as the Urgent Care Hub Sleaford; self-management of care home patients with care planning at the heart.

Apart from dental services, the AT only commission ‘core’ services from primary care contractors. CCGs and Local Authorities commission any additional services. We have been working closely with NHS England on the development of Sleaford and ensuring that it fits the emerging strategy for primary care.

The GMS Contract Changes for 2014/15 include some that may impact in this area, particularly the named co-ordinating GP. There will also be a new DES to cover admission avoidance/pro-active case management etc. The CCG has planned two events across all practices to facilitate the planning work required for this.

4.4.4 A Modern Model of Integrated Care

The LSSR has determined that when aggregated, the 22 interventions create a strategically different integrated model of care, a greater proportion of which is provided out of acute hospital settings, with care professionals working across organisational and professional boundaries.

The CCG formally consulted with the public through its Shaping Health Programme in 2013. Some elements of the models of care focus on integration in terms of managing patients in the community with fast access to acute care or diagnostics when needed.

The CCG was part of the long term national QIPP programme which focused on Risk Profiling, Integrated Teams and Self-Management. The biggest barrier to effective implementation has been

identified that primary health and social care teams were needed and that couldn't be delivered unless the teams were locally based. The CCG is planning in 2014/15 to bring forward the neighbourhood team implementation from LSSR - an essential requirement to advance the care for people with long term conditions either multiple or singular.

Other schemes that the CCG has commissioned support a rapid response (Mobile Outreach Team) to patients so that they can be managed in the community. This has been very successful and will be a key part of the neighbourhood team model.

A new palliative care unit will be opening in July 2014 which will improve the end of life care for patients many of which may have a long term condition such as heart failure that is palliative. These beds will ensure that patients receive the very best end of life care in a hospice style environment with support.

The CCG has been participating in the national LTC programme since October 2011. The goals of the programme are to achieve a 20% reduction in emergency admissions, 25% reduction in length of stay for people with LTC, and an improved patient experience. The programme consists of 3 key drivers – risk profiling, integrated neighbourhood care teams, and self-care/shared decision making. The programme requires all 3 drivers to be implemented. As part of this programme a risk profiling tool, successfully developed by NHS Devon was implemented and currently sits on the Datawatch Dashboard. This dashboard can be accessed by all Lincolnshire practices. In April 2013, a model of integrated neighbourhood care teams was implemented. This is also aligned to the implementation of the new risk profiling DES, where the integrated neighbourhood care teams meet regularly to discuss the results from the risk profiling screening and identifies those patients who would most benefit from direct care management. The work to fully implement the final driver on self-care / shared decision making has been delayed due to the data sharing issues.

4.4.5 Access to the Highest Quality Urgent and Emergency Care

Our vision for urgent and emergency care aligns with the principles outlined in Transforming urgent and emergency care services in England. We have a vision of a responsive urgent care system where patients are helped to select from a range of care options that are tailored to the degree of need.

Patients currently struggle to navigate the urgent care system and too often default to accident and emergency as the service offer they understand and know how to access. Simple navigation to a range of options is a crucial component of a new urgent care service.

NHS 111 is the key navigator to the urgent care response, and we will increase the directory of services for urgent care and move toward directly bookable access via the NHS 111 service. Hospitals will be the reserve for the most urgent of cases, with a range of accessible alternatives available and embedded in communities.
Where people have serious and life threatening needs they will be met through a network of local, intermediate and tertiary centres.

The Future Service Model

A wider range of urgent care options:

Urgent care was one of the four design streams of the Lincolnshire Sustainable Services Review (LSSR). A group of clinicians from all key providers were joined by patient representatives and service leads to explore the options and produce the blueprint for urgent care in Lincolnshire. Although this work pre-dated its publication, the blueprint aligned very well with the principles in the Transforming urgent and emergency care services in England report, envisioning a system of main and subsidiary urgent care centres, which the design group labelled 'NHS Local'.

The blueprint calls for one integrated urgent care service which will replace the current often confusing array of primary care, out of hours, walk in centres, accident and emergency, and community resources.

We will increase the role of non-hospital services and clinicians, and continue our drive to get patients to the most appropriate clinician as early as possible in the pathway. This will increase the role of general practitioners and emergency care practitioners in the urgent care system. More patients will

see a primary care clinician and only those of greatest or specialist need will progress to hospital services or access them directly.

Pro-active care to reduce the demand on hospitals

An important part of the urgent care reform is to reduce the number of people reaching crisis and accessing urgent care systems. A second group of the LSSR looked at Pro-active care - services focussed on patients with known needs who require pro-active management and intervention to escalate care where necessary and reduce the risk of crisis, and to reach out promptly when patients have a greater need. A key component of the pro-active care model is the introduction of neighbourhood teams to provide integrated primary and community based management of patients. We will increase the amount of pre-emptive care planning, and introduce named clinicians for patients with long term conditions. The aim of the pro-active system is to prevent patients reaching crisis wherever possible, and thus reduce the number of patients needing to access the urgent care system.

We will continue to develop alternatives to conveyance to hospital and provide our ambulance service with a range of options where hospital services are not required but an urgent response is necessary.

Emergency response services

It is very challenging to provide emergency first response services in a large rural County such as Lincolnshire, with our very dispersed population and poor road infrastructure. We will continue our investment and development of community first and co-responders, working closely with our ambulance provider on new service models. We believe that rural areas need novel answers to the first response challenge. We are working with our ambulance provider, fire and rescue service and County Council to push the boundaries of co-responding, aiming for a first response that is more tailored and embedded in our communities.

Progress During 2014-15

The Lincolnshire Sustainable Services Review Phase Two:

LSSR phase one has already reviewed the urgent care system in Lincolnshire and involved a wide range of clinicians and stakeholders in developing the blueprint for future services. Current services and patient flows were analysed and initial analysis of the implications of revised urgent care systems were explored. These were presented at a clinical summit at which 200+ clinicians and stakeholders reviewed the blueprint and confirmed their support for moving forward. The ground work has thus been completed for further progress on specific design work during 2014-15.

In January 2014 we will appoint the consultants to support phase two of the LSSR. Phase two will complete the detailed design work on all four work streams (urgent care, pro-active care, planned care and women and children's care) which is important because urgent care systems must be aligned with the design decisions across the whole system. Phase two will determine:

- The location and design of urgent care facilities
- The implications for patient flow and access
- The services provided at each level of the urgent care system

Major Trauma Management

During 2014-15 Lincolnshire will implement the requirements of the major trauma network including the conveyance and transfer of patients to the tertiary centre and role of Pilgrim Hospital Boston and Lincoln County Hospital inpatient stabilisation and management.

Urgent Care Development

Lincolnshire will continue the progress already made in reforming urgent care management and in particular increasing the role of primary care clinicians. This is already well established in Grantham, established and developing in Boston, and under consideration in Lincoln. We will focus on our successful NHS 111 service and significantly increase its role in patient navigation, investing in further

DOS (Directory of Services) management capability and participating in the national work programme to extend the NHS 111 service contribution.

Governance and Leadership

Lincolnshire has an active Urgent Care Working Group (UCWG). The Chairman is the Accountable Officer of the lead CCG supported by a Director of Urgent Care and a programme management office. The UCWG has representatives from all key stakeholders including hospital, community, mental health, ambulance, social services, emergency patient transport services, all four Clinical Commissioning Groups and the County Council. The UCWG has delegated authority to manage the investments and programmes of work in urgent care. Investment of MRET funds will be through the UCWG and focussed on schemes that reduce and manage demand for urgent care.

Local Operational Detail

The CCG can evidence its commitment to this methodology by its proactive role as a member of the Lincolnshire Urgent Care Board programme of work in Lincolnshire, which involves all stakeholders in the planning and delivery of urgent care services, and recognises whole system interdependencies. The result is that we will commission pathways of care, rather than ad hoc services which are peculiar to individual organisations.

Locally, the CCG as part of the Shaping Health programme has two key models that directly impact Urgent and Emergency care. These models have been through full public consultation and therefore already determine the footprint locally for urgent and emergency care. The requirement going forward is to be clear clarity on the network that the Grantham unit sits within particularly as part of phase 2 of LSSR.

- Integrated A&E Care Centre Grantham
- Acute Medicine model including community care

The CCG urgent care leads have played an active role in the Urgent and Emergency Care Review, feeding in how this could work in small district general hospitals like Grantham. The model of care is designed to ensure that patients have the majority of their urgent care need met locally. It is recognised that some patients need to go to specialist units (Super A&Es) where appropriate for events such as stroke and trauma.

Previous audits have shown we know that the majority of patients flowing into Grantham Hospital are medical and therefore need a medical consultant physician rather than an A&E consultant that specialise in trauma. By having a skill mix of A&E and medical staffing, patients would get the right care by the most appropriate health care professional first time. This then directly supports the acute medicine behind the front door.

4.4.6 A Step-Change in the Productivity of Elective Care

Delivering the 20% productivity challenge

The CCG has reviewed the Right Care information and identified areas that require further analysis to determine what service re design could be undertaken. There is already work underway to increase the range and access of services provided under a community surgery scheme which is currently in procurement.

During the Shaping Health Programme of work we have identified the need to improve access, availability and productivity of outpatient and elective care services at Grantham Hospital, where possible offering one stop clinics and day case surgery. This will reduce the numbers of patients required to travel outside of the area and will also reduce the financial burden of paying increased market forces factor for care outside of the county.

The CCG has reviewed the Right Care information and identified areas that require further analysis to determine what service re design could be undertaken during the next two years which will all have detailed business cases approved by the Executive Committee. These are in back pain, dermatology,

diabetes and movement disorders. There is already work underway to increase the range and access of services provided under a community surgery scheme which is currently in procurement.

The CCG has procured Map of Medicine for 2014/15 which is designed support the optimisation of care by providing access to comprehensive, evidence-based guidance, and clinical decision support at the point of care. Map of Medicine care pathways offer the opportunity to improve the way commissioning of health care is planned and delivered locally.

As part of the LSSR our key recommendation of the blue print is to consider an alternative framework for commissioning including lead providers and capitation based budgets. The international evidence suggests this will improve quality and costs effectiveness. Implementation will be agreed as part of phase 3 but will require close working with NHS providers and regulators.

4.4.7 Specialised Services Concentrated in Centres in Excellence

The CCG undertook a service review and redesign project called Shaping Health for Mid Kesteven which was subject to a National Clinical Advisory Team assessment prior to a full public consultation. The models of care reflect best practice and secure local access where possible but recognising that for some conditions care is best delivered in centres of excellence. Examples of this are Stroke Care and Trauma.

The Integrated Urgent Care Model specifically meets the national direction from the Emergency Care review and ensures local urgent care is delivered close to home in a wider network of Super A&Es. Children's Urgent Care will move into this model and admissions for children where they need overnight support will be in centres that have full Paediatric cover.

Further development of this will become evident as part of phase 2 of the LSSR.

4.4.8 Convenient Access to Everyone

The CCG is dedicated to providing services that are local and accessible whilst mindful that it may be in the patient's interest to travel to a centre of excellence for some of their care.

During the Shaping Health consultation in 2013, the public gave their blessing to one of several proposals for the CCG to reconfigure disparate children's services into one children's hub based at Grantham hospital. This will ensure that patients have access to a range of services under one roof and have merged acute care with community care.

The GP practices participate in the design and redesign of treatment pathways as part of the QOF QP programmes of work which bring services once provided in the hospital to a primary care setting. The CCG, in collaboration with the other Lincolnshire CCGs is currently involved in a county wide review of a number of enhanced services that are either currently provided in the main by primary care but had the opportunity to extend provision. The intention is to coordinate these services into one contract with a number of services included that GP practices will commit to delivering. This collaborative approach will ensure that there is parity of delivery across the county but also that the services are accessed locally.

In order to improve patient access to Mental Health services, SWL CCG in collaboration with the other Lincolnshire CCGs and in partnership with Lincolnshire County Council has established integrated commissioning arrangements for Mental Health and Learning Disability Services in Lincolnshire. A joint Assistant Director for the Joint Commissioning of Mental Health and Learning Disability Services has been appointed and this is understood to be the first such new appointment in the Country since the introduction of Clinical Commissioning Groups. The joint Mental Health and Learning Disabilities post will lead on the development of an integrated team focused on delivering agreed priority outcomes and through the development of joint commissioning strategies.

During 2013/14 a number of service changes were implemented, most notably:

- Integration of community mental health teams
- A single point of access to mental health services.

Lincolnshire has also recently agreed a new Dementia Strategy which will help to improve outcomes

and progress integrated and where possible local pathways further in 2013/14 and 2014/15.

During 2014/15 the CCGs and Lincolnshire County Council will develop a joint Mental Health Commissioning Strategy.

We will commission services that are as accessible as possible and engage with as many people as we can in the process of designing and commissioning those services, focussing our engagement on those groups of people who are seldom heard.

A great deal of work has been completed over the last 12 months to improve value for money in relation to Learning Disability Services. Good progress has been made against National and Local Outcomes and other KPI's. Unit costs are well performing and Integrated Assessment and Review performance has also increased significantly. A recent peer review has fed back that the local winterbourne plan is robust and there are no outstanding items form the recent stock take to action.

However the joint commissioning team will be developing a Joint Commissioning Strategy for Adults with Learning Disability in 2014-15 with the ambition to make further progress against priority outcomes including parity of esteem. The strategy will also be informed by priorities identified as part of the Big Health Events help in August 2013 as well as the LD and Autism self-assessments. Key areas to be incorporated into the strategy will include:

- Increased Quality of Life
- People feel and are safe
- Promoting Independence, Choice and Control and a reduced dependence on Residential Care
- Enhanced co-production and local engagement
- Greater range of learning disability services and skill mix within teams to support clinical interventions within the community
- Greater focus on the interface with primary care and Acute care which will support increased access to Health Checks for people with learning disability
- Improved transitions linked to Support and Aspiration

In addition

- Ensuring robust quality assurance and monitoring of placements so that individuals are cared for in the most appropriate and least restrictive environment
- The review and implementation of the joint Autism Strategy for Children, Young People and Adults

BENEFITS

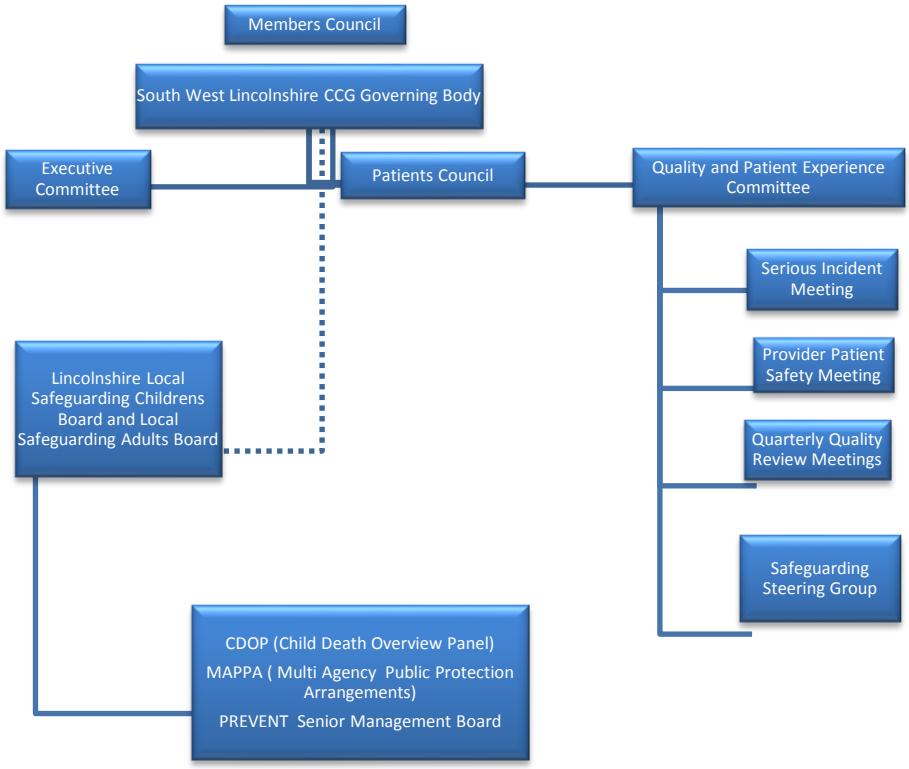
- Securing additional years of life in adults with mental health conditions and or Learning Disability with treatable mental and physical health conditions
- Improve health related quality of life for adults with mental health conditions who have a long term condition;
- Accessible, equitable, high quality mental health services for the people of Lincolnshire ;
- Adults with mental health conditions have Improved health outcomes and timely access to greater range of pathways;
- Adults with learning disabilities have Improved health and care outcomes;
- Adults with learning disabilities have greater support to access annual health checks and number of health checks completed increase
- Learning disability out of area inpatient placements reduced;
- Increased % of adults with learning disabilities supported to live independently;
- Increased number of adults with learning disabilities receiving direct payments;
- Introduction of integrated commissioning unit to improve integration of learning disability, mental health and Autism services.

4.5 IMPROVEMENT INTERVENTIONS – QUALITY

4.5.1 Response to Francis, Berwick and Winterbourne View

In response to Francis, Berwick and Winterbourne the Governing Body has focused on how we assure the quality of care we commission on behalf of our patients and population. Our revised quality assurance framework detailed below will ensure that the organisation is clinically led and publically

accountable and reflects our commitment to focus on cultures and behaviours as much as the transactions we need to make to ensure quality assurance and quality improvement.



The process of quality assurance of commissioned services has a number of component parts which are inter-dependent. These include Contractual Quality elements (Quality Schedule, Nationally Specified Events and the Information Schedule) and CQUINs. Our local clinical focus provides us with the opportunity of extending the depth of 'soft' intelligence with other sources such as complaints, comments, media reports and patient stories that added together form a comprehensive picture of the safety of patients accessing care. The Federated Patient Safety Team triangulates all available data to inform the quality review process for each provider. This helps us to ensure that we are consistent and robust in our scrutiny of service quality with our providers. The Clinical Quality Review Meetings with providers, along with clinical quality visits, ensure a focused approach to quality and uses this information to both celebrate quality improvements and provide challenge and leadership where organisational culture, behaviour and practice does not promote safe and effective care. We will use information to take demonstrable action with providers where the quality and safeguarding of patients is compromised, including channelling through the contract review mechanism and, where necessary, de-commissioning care.

Need a local take on this but also need to refer to the strategic plan (Planning Unit wide) to ensure consistency.

The duty of candour is discharged through the organisations quality assurance framework. Patient focus including safety, experience and clinical outcomes is a core part of Governing Body Meetings held in public. The Governing Body use patient stories to inform decisions at Board level. Health watch are active members of the Governing Body, Quality and Patient Experience Committee and Patients Council. The CCG as a member of the Quality Surveillance Group routinely and methodically shares information and intelligence on the quality of services commissioned. Through Quality Schedules the CCG ensures that Providers adhere to:

- nationally mandated components of the NHS Constitution
- embedding cultural barometer measures and improvement plans
- appropriate processes are in place to ensure improvement in staff satisfaction against the NHS Staff Experience survey
- and that a suite of workforce indicators are monitored on a quarterly basis

Progress in response to Winterbourne is monitored through the organisations Quality and Patient Experience Committee .Partnership arrangements are in place for the delivery of a joint Health & Social Care Learning Disability Self - Assessment Framework. Patients and key stakeholder were engaged in self assessing progress against current plans and the following priorities have been identified for 2014/15:

- A Learning Disability excellence award run by self-advocate groups similar to the Keep Safe scheme for towns
- Increasing in the number of GP's offering annual health checks;
- Expanding coverage of annual health checks through alternative provider models
- Expanding the Learning disability primary care liaison service to be able to offer more service and health action plans as well as complex work
- Explore the commissioning of learning disability community based assertive treatment service (CAST) to take on transitions i.e. 14+
- Commission community based rehabilitation provision expanding current model to reduce hospital lengths of stay
- Establish an Autism liaison service based on the model of 'green light' for mental health
- Developing Autism registers within primary care through QOF or LES
- Introducing Autism screening process in primary care support a diagnostic Pathway
- Transition review process not just for Children but for older adults as well
- Expanding Acute liaison service to 7 days a week
- Increased Mental capacity act training for doctors
- Reviewing transport options that are available in each area and make it more consistent
- Better support for those not able to get a service to get support and employment
- Broadening provider contracts to include people with LD and carers in staff recruitment

The delivery of the Health & Social Care Learning Disability Self - Assessment Framework is monitored by the Local Safeguarding Adults Board.

4.5.2 Patient Safety

The CCG'S Quality Assurance Structure and processes ensure that when people access services their safety is prioritised. The commissioning and contract processes include sections relating to requiring providers to adhere to all legal and regulatory standards to ensure patient safety. The organisation has detailed quality schedules with all provider organisations with a number of key performance indicators (KPIs) relating to patient safety, including, but not exclusively:

- serious incident reporting (including never events)
- medicines management
- Safety Thermometer
- compliance with the hygiene code
- compliance with essential standards for CQC
- safeguarding (including whistle-blowing)
- and the reporting of all risks above an agreed threshold.

These KPIs are monitored on a quarterly basis through the respective provider's quality contract review group. A monthly CCG Patient Safety Meeting takes place with providers to gain further assurance on actions to mitigate risk to patient safety, experience and outcomes where they arise.

The Governing Body receives monthly quality performance reports and quarterly patient safety and patient experience reports (including complaints). The Quality and Patient Experience Committee scrutinises thematic reviews of complaints, serious incidents, PALs, NHS Safety Thermometer– pressure ulcers; falls in care; urinary infection and treatment for new Venous Thromboembolism (VTE) and friends and family test and a programme of external audits is also undertaken by the CCG.

The CCGs Federated Patient Safety Team receives all serious incident reports and the Executive Nurse oversees and signs off RCAs and associated action plans which input from Clinical Members of the Quality and Patient Experience Committee where the issues relate to medical management. GP Practices in South West Lincolnshire are playing an increasingly important role as both commissioners and providers of health care. Whilst these services are commissioned by NHS England, South West

Lincolnshire CCG supports and encourages the development of primary care and the quality of service provision. The CCG is establishing a Member Clinical Governance Group to encourage and engage Member Practices in promoting patient safety. A programme of annual Quality Review Visits will seek to further engage General Practice in the quality agenda and patient safety incidents and preventing and reporting harm will form part of this dialogue with practices.

4.5.3 Patient Experience

South West Lincolnshire CCG values the views and experiences of patients and carers and reported care outcomes that have been provided by patients accessing the services commissioned. Patient Experience is embedded into the quality schedule with all providers through a number of key performance indicators including, but not exclusively:

- improvements in patient survey results;
- progress in respect of the providers patient experience work plan;
- improvement in patient and service user reported measure of respect and dignity in their treatment;
- improvement in overall satisfaction with care;
- Friends and Family Test;
- Complaints;
- And involvement in decisions about treatment.

The quality schedules are monitored via quarterly quality contract review meetings with the provider. Any areas where compliance falls below agreed thresholds is escalated through the contract performance process and action plans are put in place with the provider to achieve compliance within agreed timeframes.

The Quality and Patient Experience Committee retains oversight of achievement of positive patient experience and the Governing Body receives a monthly Quality Indicators Dashboard within includes patient experience indicators i.e. Friends and Family Test, Primary Care patient experience, Hospital Care Patient Experience, PROMS, Mixed Sex Accommodation Breaches. The patient experience information we gather is used to help us understand how patients feel about the services we commission, what may need to change and any improvements proposed by patients and service users. This information is used as an evidence base to support and inform future commissioning decisions and service redesign.

To focus on improving patient experience of the quality of primary care an Annual Quality Review Programme will commence in 2014which will be subject to constant review and development. In the first annual cycle it is proposed to focus on practice visits targeting specific quality areas highlighted from existing quality data sources. Practice Activity Reports utilising data originated from the Secondary Uses Service (SUS), where available, will be utilised to support a dialogue with the Practice. Practices will be chosen at random and each visit will be specific to the practice and flexible enough to cover any quality areas identified for discussion. The visits will seek to:

- Explore the practice and the CCG's aspirations for quality improvement as distinct from contract compliance
- Agree quality improvement priorities by practice
- Support the development of high quality and equitable primary care services that improve patient outcomes, experience and safety and support the direction of travel for the future provision of services in primary care

A Quality Dashboard will be introduced to:

- highlight areas where support may be required
- provide a systematic framework for measuring quality in General Practice, bringing together existing data streams into one comprehensive tool and sharing best practice
- identify any significant deviation from average outturn, to act as a mechanism for initiating dialogue with the practice , in order to offer support and solutions

The outputs from the 2014/14 Annual Quality Review Programme will be used to recognise good

practice and identify where further support can be given to Member Practices as outlined in Figure 1 below.

The CCG will seek to develop Practice Peer Review and a buddying system through Members council to support continued improvements in the quality of primary care.

4.5.4 Compassion in Practice

Delivery of Compassion in Practice Plans is led by Executive Nurses across the Lincolnshire Health economy and embedded into the quality review processes with providers. There is an agreed plan on a page for the delivery of agreed priorities across the Action Areas identified in Compassion in Practice including:

- Integrated working across the whole health economy (health, social care and voluntary sector) to deliver improved outcomes for the frail elderly and in dementia care
- A shared understanding across the whole health economy about the patient and public experience of care
- Patient and public experience of care influences changes to care and services
- Celebrate and share positive experience of care in relation to the 6Cs
- Transparency around quality of care through using metrics which enable benchmarking across all sectors
- Skills, competence and experience of Band 7 nurses in relation to sustaining quality of care
- Focusing on positively managing local nursing talent and succession planning
- A vision for Nurse leadership in Primary Care locally
- Consistency in the recruitment, induction and training of Bands 1-4
- Ensuring that workforce plans reflect local service requirements
- Ensuring staff roles and skills and competencies reflect service needs
- Developing opportunities to support sisters, charge nurses and team leaders in their leadership roles
- Ensuring regular listening to staff and open feedback is a core part of improving care for patients
- Focusing on building staff resilience

The implementation of Compassion in Practice Plans are overseen by the Quality and Patients Experience Committee.

The 6Cs are: Care, Compassion, Competence, Communication, Courage and Commitment

The 6 areas of action are:

- Help people to stay independent, maximising well-being and improving health outcomes
- Work with people to provide a positive experience of care
- Delivery high quality care and measure impact
- Build and strengthen leadership
- Ensure the right staff, with the right skills in the right place
- Support a positive staff experience

4.5.5 Staff Satisfaction

Positive staff experience has a significant impact on patient experience, safety and outcomes. Through our quality contract monitoring arrangements with providers we ensure that the expectations outlined in 'How to ensure the right people, with the right skills, are in the right place at the right time' are embedded in practice. This comprises of a suite of workforce indicators monitored on a quarterly basis including; rate of sickness, staff turnover, vacancy, agency/bank usage rate, baseline establishment for the organisation including, breakdown by staff group and breakdown by directorate/function/locality, as relevant per provider. Providers must be able to demonstrate that they are using appropriate and safe workforce models to ensure that you have the right workforce configuration and that the organisational culture encourages them to perform their job to the best of their abilities. Through quality contact monitoring and professional oversight including walkabouts the CCG ensures that Providers adhere to nationally mandated components of the NHS Constitution, embed cultural barometer measures and improvement plans; and have appropriate processes are in place to ensure improvement in staff satisfaction against the NHS Staff Experience survey.

4.5.6 Seven Day Services

Secondary Care

In order to take the move to seven day working in unscheduled care forward across all sites operated by United Lincolnshire Hospitals NHS Trust a number of key pieces of work have been identified:

In November 2013 a broad cross section of clinical leaders (supported by senior managers) met to outline which medical, diagnostic, therapeutic and support services need to be available to support seven day unscheduled care. This built on work done in 2011 to define a set of standards for unscheduled care that has already resulted in the redesign of a number of services and mortality reduction.

Building upon this dialogue and taking account of draft standards for 7 day working published by NHS England; guidance from learned bodies (e.g. Royal colleges and Professional organisations), and experience elsewhere across the NHS a framework is being developed setting out the services required to deliver unscheduled care services across ULHT. In turn each hospital site within the Trust providing unscheduled care will be required to develop proposals for the delivery of those elements of service on their site. This will ensure consistent standards of service across the Trust whilst allowing for site-specific approaches to delivery

Once proposals for delivery have been developed they will then be the subject of scrutiny by a multi-disciplinary group leading this initiative for the Trust. The purpose of the scrutiny will be to:

- Ensure that the model of delivery is capable of delivering the benefits in terms of mortality reduction, improved patient experience and reduction to length of stay Ensuring that any proposed increase to the cost of delivery is justifiable.
- It should be recognised that the principal objective of this initiative is to deliver the benefits. That said it must also be noted that the move to seven day working for unscheduled care will not, of itself, increase income to the Trust. Therefore, in addition to ensuring that any increased cost of delivery is justifiable the Trust will also:
- Explore with commissioners the scope for either recurrent or non-recurrent financial support to assist with the any increased costs that cannot be accommodated within a national tariff structure that is not based on a model of 7 day working across the NHS
- Explore the financial benefits of reducing length of stay, contractual penalty avoidance, etc… that may be made possible by these changed ways of working.

Ultimately the business case for a move to seven day working setting out both costs and benefits will need to be approved by the Trust Board. It is recognised that any move to seven day working within Lincolnshire hospitals will bring greatest benefit if it as part of a move to seven day working across all organisations and agencies that provide care to the people of Lincolnshire either in hospital, their own homes or other settings.

Discussions will therefore take place with neighbouring NHS organisations (Ambulance, Community & Mental Health service providers) as well as Social Care providers to explore what change may be necessary within their service delivery to maximise the benefits delivered through this initiative. A move to seven day working for unscheduled care across the hospitals operated by ULHT is a significant and important development for both the public and staff affected. It is therefore important that communication is timely and effective. The key audiences identified are:

- The media and general public
- Public leaders, e.g. MP's, Health and Wellbeing Board and Health Overview & Scrutiny Committee
- Neighbouring organisations across the Health Community (see section 3.3)
- Staff-side organisations
- Employees of ULHT

Communication will take place with each of the audiences identified.
The Trust is committed to at least one site within the Trust commencing the delivery of seven day unscheduled care services in April 2014, with all other sites operational by the end of June 2014".

At this point in time South West CCG is looking to support the acute hospital 7 day working via the ½% national tariff uplift.

Community Services

Lincolnshire Community Health Services NHS Trust is committed to delivering high quality, safe services throughout the 7 day working week.

To achieve this in the longer term, the organisation intends to undertake significant transformational change in the way services are delivered. This has been detailed in our 5 year QIPP programme, which was approved by the Trust Board in December 2013. 2 of the 5 themes within the programme are associated with improving productivity and releasing additional clinical by utilising existing resource more effectively. A wider consultation process across LCHS will be commenced April 2014 in line with the QIPP Programme, to address the workforce changes necessary to continue the delivery of high quality patient services throughout the 7 day week.

In the shorter term, immediate actions have been taken to restructure elements of the community nursing resource to work across both the 7 day and 24 hour periods in support of the programme of admission reduction schemes being trialled in the county. Initial funding is in the process of being secured to support particular elements of the trial, which is being viewed as a 'proof of concept' model. The recruitment drive supporting these schemes has been based on a seven day working week, signalling a shift in the organisation's commitment towards a goal of standardising all future clinical appointments throughout the trust.

In addition the organisation has introduced an attendance management tool which supports front-line staff to maximise their capacity and performance manage attendance across a 7 day period, 365 days of the year. This has been supported by the implementation of a roster policy which embeds the principles of improving working lives, whilst ensuring that safe levels of staffing are available to maximise and sustain the delivery of services in the community. Performance management of attendance across community teams is now being formally monitored via internal processes, with significant challenge being applied to areas where there is evidence of in- efficient utilisation of available resource. This is particularly pertinent in times of predicted peak activity.

A review of our existing community work force is being undertaken, which will be shared with the Trust Board and Commissioners in early 2014 and is underpinned by detailed service line reporting evidence.

The aim of this review is to ensure a baseline safe staffing levels are established in the community. Pending the outcome of the review, there may be the potential for some movement of key clinical personnel around the county or indeed evidence of additional investment being required to support a robust community service provision.

In parallel work is being under taken to through our current and future workforce planning, to recruit and retain a much more flexible workforce which can be fully utilised according to need such as; maximising bed occupancy, reducing length of stay and the management of increasingly complex patients being cared for in the community. The organisation also intends to implement new ways of working which require employees to work across a number of geographical areas as well as over seven days per week. This will ensure the future workforce is able to deliver the ambitions of the organisation's clinical strategy and be underpinned by the introduction of annualised hours contracts as well as the availability of a more robust bank system to supplement the existing workforce in times of increased need.

Primary care

In 2013 the NHSE Area Team (AT) communicated with CCGs regarding 7 day working in Medical practices to support winter pressures. However CCGs had already formulated their plans, including the use of any additional funding to support winter pressures elsewhere in the system.

Apart from dental services, the AT only commission 'core' services from primary care contractors. CCGs and Local Authorities commission any additional services. That being said, and with the national imperative for 7 day working, NHS England has just launched the 'Prime Minister's Challenge Fund: Extending Access to General Practice'. I have attached a communication regarding this initiative that provides more detail. We already have a number of Community Pharmacies throughout Leicestershire and Lincolnshire that provide services 7 days a week. The Pharmacy Needs Assessment (PNA) that is led by the Local Authority will no doubt include the need for availability of services over 7 days in future iterations. We also have a number of dental practices that provide 7 day a week services. Currently the Primary Care Strategy is under development and will include 7 day working.

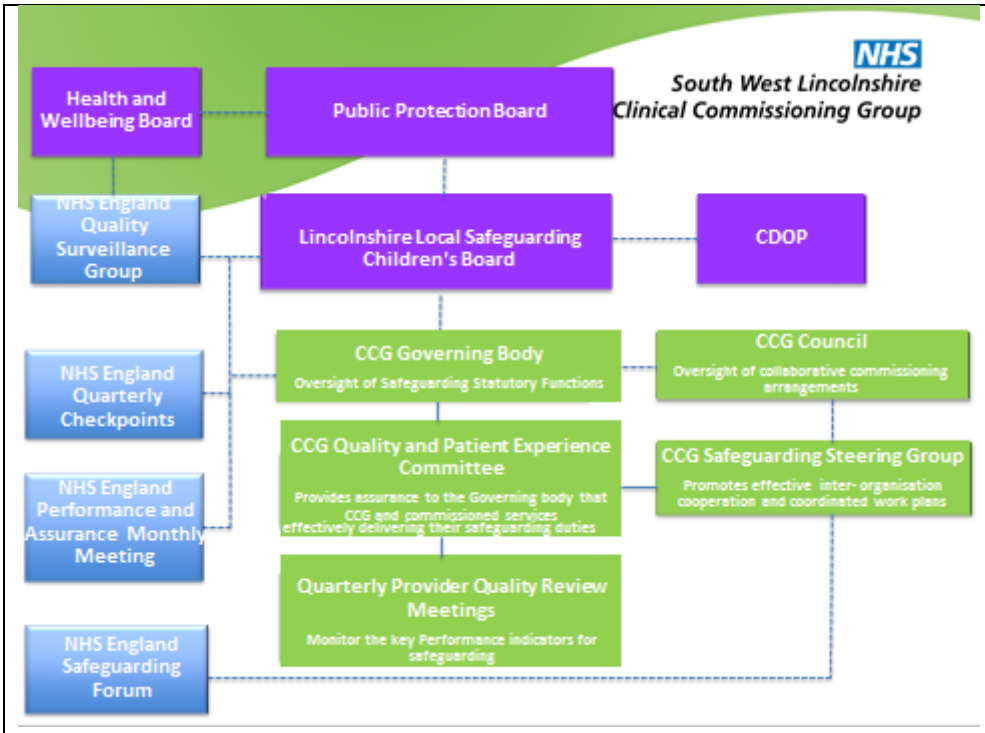
The GMS Contract Changes for 2014/15 include some that may impact in this area, particularly the named co-ordinating GP. There will also be a new DES to cover admission avoidance/pro-active case management etc. We are awaiting further details and plans for this service will need to dovetail with CCG plans.

Mental Health and Learning Disabilities

Lincolnshire Partnership Foundation Trust (LPFT) has an on-going commitment to the ensuring high quality, easily accessible and timely health and social care service provision across Lincolnshire. This is currently being achieved by a combining a number of established and newly developed services with continued innovation and partnership working always high priorities. The Single Point of Access for LPFT now provides one dedicated contact number for all Trust services and is available 24 hours a day, 7 days a week. 7 day services are provided by the Crisis and Home Teams, Rapid Response Teams and the Lincoln HIPs team to both provide care in the community, early discharge and admission avoidance. These services closely link to on-call medical staff, the wider Trust services such as the Integrated Community Mental Teams (7 days a week when required) and the wider health and social care community including the Emergency Duty Team (EDT).

4.5.7 Safeguarding

The CCG are active members of the Local Safeguarding Children's Board, Local Safeguarding Adults Board, Multi Agency Public Protection Arrangements, PREVENT Steering Group and Public Protection Board. Figure below identifies the assurance processes for safeguarding adults, children and young people.



A Safeguarding Steering Group is in place which facilitates and coordinate a culture that embraces safeguarding as everybody's business and ensures that the organisations from which services are commissioned provide a safe system that safeguards children and adults. The Group promotes and assists effective inter-organisation co-operation in order that statutory health bodies operating Lincolnshire co-operate and discharge their statutory responsibilities effectively relating to Safeguarding children, young people and adults at risk.

The safeguarding Adults Assurance Framework, Markers of Good Practice For Safeguarding Children and PREVENT are embedded into all provider contract monitoring processes.

The Federated Safeguarding service ensures that the CCG meets its statutory requirements for safeguarding children, young people and adults. A number of key priorities have been identified aligned to our partnership arrangements which will ensure the CCG establishes clear lines of responsibility and accountability for safeguarding children, young people and adults at risk and has a comprehensive performance framework with particular emphasis on identifying and embedding best practice. They are:

- Ensure arrangements for safeguarding adults, children and young people are robust and fully integrated into existing clinical governance processes.
- Ensure safeguarding training and development programmes are in place, monitored and evaluated for all commissioned services and CCG Member Practices.
- Monitor dissemination and evaluate outcomes of all SCR action plans and SILPs of both single and inter-agency action to receive assurance that plans have been implemented.
- Strengthen processes and systems to ensure effective contribution to partnership arrangements

To ensure that commissioners meet their statutory requirements across Lincolnshire an external review of the designated functions has been commissioned to ensure that the current designated arrangements are fit for purpose and will going forward enable robust safeguarding arrangements to be delivered. This is supported by the LLR and Lincolnshire NHS England Area Team, and associated CCGs. The objective of this review is to assess the current arrangements for discharging the designated functions (Safeguarding Children and Looked After Children) against statutory requirements and existing best practice to inform the future design and delivery model of the designated functions.

5.0 SUSTAINABILITY AND DEVELOPMENT

5.1 Research and Innovation

We will promote research and the use of research by:

- Delivering the statutory duties with respect to research, as an individual organisation or as part of a collaborative with neighbouring CCG's.
- Ensuring that when appropriate, providers have processes in place to facilitate recruitment of patients into research studies.
- Considering the need for commissioners to have in place a process to meet the treatment costs of research for patients who are taking part in research funded by Government and research charity partner organisations.
- Ensuring the best available research evidence is used when commissioning services.
- Ensuring that the responsibility for research and the use of research evidence is clear at a level equivalent to Governing Body level with operational responsibility delegated as appropriate.
- Proactively engaging with local partners who promote and support research, including the local NIHR Clinical Research Networks and the emerging Academic Health Science Networks.

We will promote innovation by having plans in place or under development to:

- Specify local priority areas in line with the current NHS Operating Framework for the NHS in England;
- Consider how local flexibilities in the use of tariff might be used to incentivise innovation;
- Take steps to ensure strong leadership and accountability for innovation within the CCG;
- Facilitate partnerships with public and private sector organisations and patient networks and organisations to enable local innovation and its diffusion;
- Be an active partner in the local Academic Health Science Network

The Governing Body Secondary Care specialist is the CCG lead for research, education and training.

5.2 Financial Position and Delivering Value

As a statutory body, the CCG receives an annual allocation from NHS England to fund the healthcare services it commissions. The allocations have been announced for the next two years and are as follows:

South West Lincolnshire CCG
Notified Allocations

	13/14	14/15	15/16
Allocation (£'000)	144,767	147,865	150,450
Total Growth		2.14%	1.75%

The national funding formula calculates that South West Lincolnshire CCG (SWLCCG) is over target, and has therefore allocated the minimum growth to cover population increases and inflationary pressures.

The CCG has been informed that allocations for 2016-17 to 2018-19 should be assumed as follows:

South West Lincolnshire CCG
Allocation Assumptions

	16/17	17/18	18/19
Growth Assumption	1.80%	1.70%	1.70%
Allocation (£'000)	153,080	155,756	158,479

The planning guidance "Everyone Counts: Planning for Patients 2014/15 to 2018/19" sets out some requirements of CCGs in its financial plans. These commitments are outlined below along with the financial impact for the CCG.

	2014/15	2015/16	2016/17	2017/18	2018/19
CCG Allocation (£'000)	147,865	150,450	153,080	155,756	158,479
BCF allocation (£'000)		2,499	2,499	2,499	2,499
Contingency (minimum)	0.50%	0.50%	0.50%	0.50%	0.50%
Impact on SWLCCG (£000)	763	787	800	814	827
Cumulative Surplus	1.00%	1.00%	1.00%	1.00%	1.00%
Impact on SWLCCG (£000)	1,525	1,574	1,600	1,627	1,655
Non-Recurrent Spend	2.50%	1.00%	1.00%	1.00%	1.00%
Impact on SWLCCG (£000)	3,697	1,505	1,532	1,558	1,584
Allocation remaining (£000)	141,880	149,083	151,725	154,262	156,843

The allocations detailed above note the additional £2.5m BCF (Better Care Fund) allocation which shall come directly to the CCG in 15/16 against which expenditure has been committed in conjunction with the BCF plans agreed by the Health and Well Being Board. The CCGs actual contribution to the BCF pool of resources is £18.3m.

The allocation remaining in each year will be used to purchase healthcare services for the population of South West Lincolnshire (in 2014/15 this is £142m).

In 2014/15, the requirement to spend 2.5% of resources on a non-recurrent basis includes a 1% (£1.5m) fund to be used for transformation.

The CCG is also required to drive efficiency in the use of its resources and to make Quality Innovation Prevention and Productivity (QIPP) savings. In 2014/15 the value of savings is £2.856m and £2.833m in 2015/16. The schemes that have been developed for implementation in 2014/15 have been built up by GPs on the Executive Committee and have been assessed for their likely QIPP impact, covering quality improvements as well as activity and financial changes. The schemes focus on moving activity from the acute hospitals into the community setting. The implementation of Neighbourhood teams will commence during 14/15 to support closure of acute hospital beds, which is an early implementation of the LSSR strategy.

The details of the 2 year Sip schemes are detailed below:

QIPP	14/15	15/16
Prescribing	-£500.0	
Spinal Injury	-£250.0	
MSK Follow up	-£130.0	-£50.0
Dermatology	-£160.0	
Cardiology - reduced new referrals (Ambulatory ECG monitoring)	-£58.0	-£20.0
DVT Ddimer	-£89.0	-£20.0
Paediatrics reduced admissions (expansion A&E bays)	-£170.0	
Development of local tariff - Independent Sector	-£200.0	
Full Year Effect 2013-14	-£527.0	
Care Home Education	-£150.0	
LSSR Neighbourhood teams - reduced admissions via intermediate care expansion	-£200.0	-£250.0
LSSR Neighbourhood teams - reduced admissions via supported community care	-£200.0	-£2,000.0
LSSR Neighbourhood Teams - Reduction to XBD for Long term conditions	-£120.0	-£300.0
LSSR Neighbourhood teams - XBD reduction via intermediate care expansion	-£100.0	-£192.0
	-£2,854.0	**-£2,832.0**

The Lincolnshire Sustainable Services Review (LSSR) (as detailed in section 1) is the main vehicle for driving system change and efficiency in the period covered by this plan. Beyond the development of the Neighbourhood teams, there is unlikely to be a major financial impact in 2014/15 as the first changes start to happen. The wider health economy savings will start to come through in 2015/16. Detailed workings of these savings have not been completed yet, and are part of the stage 2 work being undertaken during 2014.

The Better Care Fund was announced in June as part of the 2013 Spending Round. It requires CCGs to work more closely with the Local Authority to transform services to ensure more integration of care and support. South West Lincolnshire CCG is working with Lincolnshire County Council and the other Lincolnshire CCGs to develop plans for the Lincolnshire Better Care Fund. SWLCCG will be contributing £18.3m to the pooled fund from 2015/16. This contribution will support:

- the development of Neighbourhood teams,
- greater integration of intermediate care services,
- seven day working,
- extending current pooled fund arrangements for Mental Health and LD services
- funding enablers for LSSR

SWLCCG has budgeted for all emergency admissions at 100%. 30% of this will be paid to the acute trusts for admissions over the 2008/09 baseline. The remaining 70%, supporting admission avoidance has been put into a reserve at a value of £1.7m. This will be invested in demand management schemes to reduce emergency admissions, which will be agreed with the Urgent Care Working Group and published on the CCG website.

The CCG planned programme expenditure can be broken down as follows :

Programme Expenditure	13/14 (forecast)	14/15	15/16
Acute	82,299	82,736	81,045
Mental Health	14,915	14,656	15,264
Community	10,728	12,849	15,696
Continuing Care	7,138	7,439	8,073
Primary Care	23,141	25,221	25,933
Other Programme	6,148	4,140	6,106
Total Programme Costs	144,370	147,041	152,117

The expenditure in the table above includes the BCF 15/16 allocation of £2.5m and excludes the required contingency.

The running cost allocations and are estimating 14/15 £24.73 and 15/16 £22.11 per head of population. The CCG will run its administration function within confirmed running cost allocations.

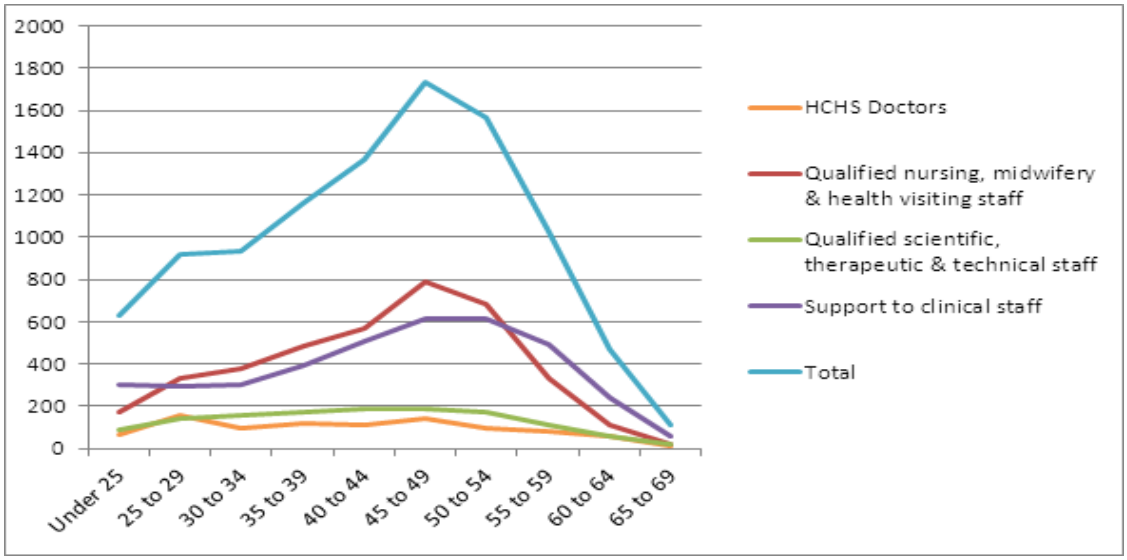
Risks to delivery

The key risks to delivery of this plan are:

- the effective delivery of the CCG's QIPP programme and associated transformation projects
- the early implementation of the first stages of the Lincolnshire Sustainable Services Review
- the risk of growth in acute hospital admissions
- poor quality data received from providers to understand the real position
- legal constraints on the use of patient data to validate payments to providers
- the effective delivery and continuous improvement of commissioning support services - to be provided by Greater East Midlands Commissioning Support Unit (GEM)
- the effective agreement and operation of the Lincolnshire CCG's Collaboration Agreement and the performance of providers in delivering the outcomes targeted by national and local plans.

5.3 Workforce

The profile below shows the numbers of the existing medical/clinical workforce by age group and indicates that there are significant numbers of staff (almost 50%), who are aged 45+. The clinical support workforce has an older age profile and relatively few numbers of staff aged below 35, which may impact on the ability to 'grow our own' in the future.



Key Challenges

- Recruitment and retention of qualified staff, particularly medical staff and GPs, this is reflected in high temporary and locum expenditure
- Lincolnshire has an ageing workforce in key professional groups
- Lincolnshire generally has an ageing population and therefore demand for older people's services will increase
- Lincolnshire is a 'net exporter' of young people who leave the county and don't return
- Amongst the 18 – 49 age group qualification levels are generally lower than the national average; this is more acute in the east of the county
- Amongst the professional/technical workforce the majority of people are employed in the public administration, education and health sector

Key Opportunities

- Ageing workforce is an opportunity to transform the workforce provided there are effective succession plans in place
- There is some inward migration of young families to the county and there may be opportunities to bring some of these people into the healthcare workforce
- Increased healthcare provision at the University of Lincoln may attract young people to stay in the county
- Opportunities to link health and wellbeing work in deprived areas with return to work schemes
- Marketing of Lincolnshire across the country to attract highly skilled professionals to the county – possibility of linking to areas of over-supply
- Optimising the deployment and utilisation of workforce capacity
- Implementing new ways of working – traditional roles currently dominate

Implications of the LSSR

- Analysis by PWC suggests that there is a significant workforce productivity gain possible through system redesign. This has been quantified at approx. 18m per annum.
- As part of the workforce analysis of the LSSR it has been identified that the Lincolnshire community spends 10 million more that its peer group on agency staffing
- The emerging model of neighbourhood teams will require new skill sets, mind-sets and cross professional structures to make sure that integrated local teams provide safe, effective coordinated care.
- The culture within the workforce is both a challenge and an opportunity. The LSSR suggests that to deliver our aspirations will require a workforce which is flexible, resilient and is not confined by organisational boundaries or traditional views of the care system.
- One of the major changes which will become clear in phase 2 will be the need to develop a community based generic care workforce delivering health and social care interventions.

5.4 Points of Service Delivery (Estates)

The LSSR identifies the requirement to ensure the provision and availability of 'fit for purpose' Estates as one of the key enablers for change.

- It is acknowledged that a significant amount of Lincolnshire's estate is in poor condition or unfit for its current purpose with significant cost implications assigned to maintenance backlog (further work to quantify this is yet to be done as part of the LSSR work)
- Models of care remain largely designed around buildings
- Consideration must be given in Phase 2 of the LSSR to how innovative estates management within Lincolnshire's health and social care economy can facilitate fundamental change, help to improve efficiency, move more care out of hospitals and exploit new technologies.

SECTION 6: ACTIVITY

6. ACTIVITY

The activity trajectories are profiled in the table below

Activity	2014-15	2015-16	2016-17	2017-18	2018-19
Elective Admissions - Ordinary Admissions	3,505	3,542	3,580	3,618	3,655
Total Elective Admissions - Day Cases (FFCEs)	14,262	14,416	14,570	14,722	14,875
Total Referrals	39,927	40,357	40,788	41,214	41,641
Non-elective FFCEs	11,644	11,534	11,308	10,969	10,528
All First Outpatient Attendances	37,779	38,187	38,594	38,997	39,401
All Subsequent Outpatient Attendances	78,223	79,067	79,911	80,746	81,581
Total	**185,339**	**187,104**	**188,750**	**190,265**	**191,681**
Activity Growth compared to previous year		100.95%	100.88%	100.80%	100.74%
Population	130,957	131,845	132,745	133,652	134,564
Population Growth compared to previous year	100.65%	100.68%	100.68%	100.68%	100.68%

It is important to note that the location of the activity will change in line with the LSSR strategy to move activity away from the acute hospitals into the community setting. The specific provider impact will be further determined in the next phase development of the LSSR blue print turning vision into reality.

SECTION 7: BETTER CARE FUND

7. BETTER CARE FUND

The Lincolnshire CCGs and Lincolnshire County Council have formally agreed to proceed with revised joint commissioning arrangements across proactive care, children and maternity, mental health and learning disabilities services. It is a Strategic objective that by joint commissioning at scale in line LSSR we will achieve a significant improvement in quality and outcomes (more individuals cared for closer to home and maintaining their independence for longer); additionally generating sufficient efficiencies to bridge the anticipated gap between resources available to health and care economy and likely demand beyond 2016. This ambition is reflected in the scale of the pooled budget across health and social care.

Section 4 outlines the wider benefits to patients resulting from the BCF implementation and the wider LSSR strategy. The governance for overseeing the implementation and monitoring of the BCF is defined below. With reference to the national performance measures, the BCF is also expected to deliver against the metrics noted in the table below:

Metrics	Metrics measurement	Delivery Board Responsible	Metrics outcome / benefit
Admissions of older people to residential care	Based on admissions to council funded permanent long term care and will be monitored through both the proactive care board	Proactive Care Delivery Board	There will be a reduction in admissions to permanent long term care over and above estimated growth in population through integrated intermediate care, neighbourhood teams, 7 day working and prevention schemes

Proportion of older people still at home over 91 days	Measures the benefit to individuals from reablement, intermediate care and rehabilitation following a hospital episode. Data is available on an annual basis and will be monitored through the proactive care board	Proactive Care Delivery Board	An increasing number of people will be maintained to live at home through integrated intermediate care, neighbourhood teams and 7 day working schemes
DTOC from ULHT acute hospital (including health and social)	This is based on ONS Population stats for 18 years over and is measuring health and social care reasons for DTOC from main acute hospital (ULHT). The monitoring will be undertaken on a monthly basis via the unscheduled care board	Unscheduled Care Delivery Board	There will be a reduction in the DTOC over and above estimated growth in population. This will support an easing of pressures on acute hospital beds.
Avoidable Emergency Admissions	Awaiting national baseline information	Unscheduled Care Delivery Board	Although the baseline figure is not yet available intermediate care, neighbourhood teams and 7 days working should support a reduction in emergency avoidable admissions
Patient Experience Metrics	Awaiting National Metrics publication	Proactive Care Delivery Board	All the schemes should support an improvement in patient experience of health and social care
Local metric - Proportion of people feeling supported to manage their (long term) condition	This measure is based on the GP patient survey question 'In the last 6 months, have you received enough support from local services/ organisations to help manage your long term condition	Proactive Care Delivery Board	All the schemes should support an increase in the proportion of people who feel that they are supported to manage their long term conditions

The metrics across Lincolnshire Health and Social care system are being monitored against the performance improvements noted in the table below. The weighted capitation of South West Lincolnshire population approximates 16.5% and we expect to see an equitable improvement within our CCG as part of the Lincolnshire wide improvements defined as follows:

Metrics		Current Baseline (as at….)	Performance underpinning	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	816	N/A	785
	Numerator	1217		1301
	Denominator	149150		165597
		(April 2012 - March 2013)		(April 2014 - March 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*	72.40%	N/A	80%
	Numerator	653		800
	Denominator	902		1000
		(April 2012 - March 2013)		(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	**131**	**128.3**	**127.2**
	Numerator	5279	6787	4487
	Denominator	575467	587782	587782
		April 2013 - October 2013	(April -	(January - June 2015)
Avoidable emergency admissions (composite measure)	*Metric Value*			
	Numerator			
	Denominator			
		BASELINE DATA TO BE PUBLISHED JAN 2014	(April - September	(October 2014 - March 2015)
Patient / service user experience		Pending national	N/A	Pending national publication
Proportion of people feeling supported to manage their (long term) condition - ***Query on baseline data o/s with CCG's***	*Metric Value*	63%		64%
	Numerator	9418		9600
	Denominator	14933		15000
		July 2012 - March 2013	*N/A*	*July 2014 - March 2015*

SECTION 8: FINANCIAL PLAN

8.1 FINANCIAL PLAN SUMMARY

South West Lincolnshire has a balanced detailed financial plan for 2014/15 and 2015/16. Strategic financial plans for 2016/17, 2017/18 and 2018/19 are also in balance. The plans provide for a planned year-end surplus of 1%. The CCG's plan assumes the return of the 1% achieved in 2013/14 of £1.467m.

The plan is compliant with all aspects of the NHS England planning guidance, providing for a 0.5% contingency reserve. The CCG's QIPP programme for 2014/15 and 2015/16 totals £2.8m in each year, equating to 2% of CCG programme resources net of contingency. In 2014/15, the requirement to spend 2.5% of resources on a non-recurrent basis includes a 1% (£1.5m) fund to be used for transformation. The non-recurrent investments are aimed at improving the quality of services, and bringing care closer to home via the development of Neighbourhood teams.

70% non-elective marginal rate resources have been assumed to be available for reshaping the delivery of the non-elective care pathways across the county in preparation for winter and in support of the LSSR. These plans require approval by the Urgent Care Working Group.

The key risks to delivery of this plan in 2014/15 are:

- The effective delivery of the CCG's QIPP programme and associated transformation projects
- The risk of growth in acute hospital admissions in particular over the winter period.
- Uncertainty regarding the transfer of resources with regard to Continuing Healthcare retrospective claims
- Dementia trajectories being higher than those anticipated to date.

8.2 REVENUE RESOURCE LIMIT

The RRL (excluding BCF allocation in 15/16 is noted in the table below

South West Lincolnshire CCG
Notified Allocations

	13/14	14/15	15/16
Allocation (£'000)	144,767	147,865	150,450
Total Growth		2.14%	1.75%

8.3 KEY PLANNING ASSUMPTIONS AND ALIGNMENT OF PLANS

The following key assumptions underpin the financial plan

- The commissioning intentions to embed plans outlined in the BCF and LSSR will come to fruition within the required timeline to develop capacity within the community setting and release resources from the acute sector.
- The national tariff impact/changes and national statistical population growth assumptions will apply.
- Planned surplus will be available in the following year
- 70% MRET funds will support re-shaping of non-elective care pathways as agreed by the Urgent Care Working Group, in preparation for winter and in support of the LSSR
- QIPP schemes will deliver in a timely way.
- The contingencies are sufficient to manage risk within reasonable parameters.
- The re-procurement of CSU services ensures provision of a responsive support service which delivers the service required.

8.4 HIGH LEVEL FINANCIAL PLAN

The high level financial plan is detailed in the table below:

	2014/15	2015/16	2016/17	2017/18	2018/19
CCG Allocation (£'000)	147,865	150,450	153,080	155,756	158,479
BCF allocation (£'000)		2,499	2,499	2,499	2,499
Contingency (minimum)	0.50%	0.50%	0.50%	0.50%	0.50%
Impact on SWLCCG (£000)	763	787	800	814	827
Cumulative Surplus	1.00%	1.00%	1.00%	1.00%	1.00%
Impact on SWLCCG (£000)	1,525	1,574	1,600	1,627	1,655
Non-Recurrent Spend	2.50%	1.00%	1.00%	1.00%	1.00%
Impact on SWLCCG (£000)	3,697	1,505	1,532	1,558	1,584
Allocation remaining (£000)	141,880	149,083	151,725	154,262	156,843

8.5 OVERVIEW OF QIPP AND RISK TO DELIVERY

South West Lincolnshire CCG has identified a £2.8m QIPP programme for 14/15 and 15/16, which is 2% of programme allocation adjusted for contingency. For 2014/15, the CCG QIPP programme is focussed on reducing avoidable hospital admissions and appropriate prescribing, particularly in relation to the CCG's frail elderly population, in respect of ambulatory care conditions and in relation to long term conditions.

For 15/16 the QiPP savings are centred on implementation of the 5 LSSR early implementers in particular Neighbourhood Teams to reduce acute hospital pressures (in particular non elective).

8.6 RISK

For 14/15 the magnitude of risks is identified it the table below and equates to £1,275k. In 15/16 the level of risk is estimated at £1,473k. In both years the risk is being mitigated by the 0.5% contingency reserve and the activity management reserve.

Risks	Full Risk Value 15 £'000	Probability of risk being realised	Potential Risk Value £'000	Proportion of Total %	Commentary 15
Acute	2,000	50.00%	1,000	78.43%	Overperformance of non-electives, particularly over winter in Acute Trusts. There have been data issues with ULHT during 2013-14 which may continue into the new year, and have an impact upon accurate modelling.
CHC	500	25.00%	125	9.80%	Uncertainty regarding the transfer of resources with regard to retrospective settlements on 01/04/2014.
Other Prog.	300	50.00%	150	11.76%	Increased impact of Dementia over and above that which can be reasonably anticipated to date.

8.7 PLANS FOR USE OF NON-RECURRENT INVESTMENT

A summary of the 14/15 schemes for utilising non-recurrent monies is detailed below. In 15/16 the non-recurrent funds are planned to be used in their entirety to support implementation of the LSSR including rolling out Neighbourhood Teams at scale across the CCG.

14/15 schemes	headroom £'000	MRET £'000
Primary Care schemes & Business Case for Diabetes	£520	
Primary Care Clinical Involvement in LSSR	£250	
Establishment Neighbourhood teams	£950	
Over 75's Primary Care	£627	
Dementia	£200	
CSU procurement	£150	
Expansion Intermediate Care (care home beds)	£350	
SEND project	£200	
Implementation of LSSR/preparation for winter		£1,749
Sleaford Primary Care project	£450	
	£3,697	£1,749

8.8 STATEMENT OF FINANCIAL POSITION

The financial plan details monthly profiles of the SOFP and presents a balanced position in both years.

8.9 CASH

The CCG is awaiting the cash resource limit to be confirmed and is estimating £128.2m for 14/15 and 15/16. The details of the cash monthly profiling is detailed within the financial plan and includes a balanced cash flow with an average monthly carry forward surplus of £518k for the first year.

8.10 CAPITAL

There are no defined or resourced capital schemes at this point in time.

					Outputs 2014/15 and 2015/16				
Project	**Description**	**Start date**	**Milestones**	**Performance indicators**	**Quality**	**Activity**		**Cost savings £000's**	
						14/15	**15/16**	**14/15**	**15/16**
Service contact point (Single Point of Access) (Lincolnshire Community Health Services / Lincolnshire Partnership Foundation Trust)	This scheme is now fully operational and delivers two Service Contact Centre's operational by 18/11/2013 merging to one at some stage during 2014.	18th Nov 2013		• A&E conversion rate	Hospital avoidance	5% less A&E attends		TBD	
Ambulatory Care Centres (United Lincolnshire Hospitals)	Now fully operational and delivers a discrete Ambulatory Care Unit on the Pilgrim, Lincoln and Grantham sites with high quality patient care, good clinical outcomes, and an excellent patient experience	From November 2013		• Readmission rates	Hospital avoidance	12 fewer admissions/day Lincolns and Boston and 5 at Grantham (3%)		TBD	
Rapid Response (Lincolnshire Community Health Services / Lincolnshire Partnership Foundation Trust)	Now fully operational and delivers a reduced number of people conveyed to hospital unnecessarily - accepting patients from EMAS/GPs at the patient's 'front door' - offering choice of avoiding A&E.	18th November 2013		• Nos. on caseload not admitted by day 91 following referral	Reduced delayed discharge.	5.2 referrals /day		TBD	

Increased Adult Social Care Workforce capacity in acute sites (Lincolnshire County Council)	Teams now in place and functioning well. Are enabling smoother discharge process, increased capacity, collaborative working, and support for 7 day working and working as part of MDT discharge team.	November 2013		• DTOC • Attribution to ASC within upper quartile • % of home support packages within 48 hours of referral	Care closer to home in reablement or rehab services	5% increase I home support packages		TBD	
Increased domiciliary care (Lincolnshire County Council)	Additional agency staff now recruited providing 900 hours / week x county of care worker support. To increase DCW in community to expedite discharge, reduce avoidable admissions, prevent readmissions, and promote independence.	November 2013		• % at home after 91 days of discharge • Reduced admissions to residential/ nursing homes per 1000	Reduced DTOCs	TBD		TBD	
Hospital Psychiatric Liaison Service (HIPS) Lincolnshire Partnership Foundation Trust)	Teams already in place and contributing to reduction in breaches in A&E waiting crisis referral. Facilitating improved discharge, keeping patients at home and serves pts of all ages.	November 2013		• Achievement of national CQUIN standard for assessment rates	'Feel Safe' safeguarding referrals	Reduced LOS to <8 days average		TBD	
Increase acute physician cover for Grantham emergency admission unit (United Lincolnshire Hospitals)	Now fully implemented and provides senior daily review and increase discharge on AEU. Provide medical senior decision making in A&E Consultant carrying a phone during working hours to be available for GPs for admission avoidance advice.	November 2013		• Rate of non-elective admissions for people defined within a defined set of conditions.	Hospital avoidance	Part of 5% reduction in emergency admissions OPD and managed with advice		TBD	

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Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of South Lincolnshire Clinical Commissioning Group

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**25 March 2014**
Subject:	**NHS South Lincolnshire's Strategic Operational Plan**

Summary:
Our Strategic aims for the five years will mirror that of the Lincolnshire Sustainability Services Review (LSSR) of which SLCCG and our Stakeholders will play a key role. Plans have been jointly submitted to use the BCF to benefit patient services locally with strategies, where appropriate to enhance and sustain proven effective service delivery.

Our Vision, Mission and Values statement is the outcome of the Stakeholder event held during July 2013 and reflects what these statements mean to our stakeholders.

Our commissioning intentions are the outcome of patient and public, provider and local authority engagement, JSNA and Health and Wellbeing board priorities for the population of South Lincolnshire.

Improving Health –
Working with HWB boards to deliver the five outcomes identified ensuring commissioning decisions align with outcomes where appropriate, this has and will continue to involve reviewing Primary Care data at our clinical commissioning attended by all 15 practice representatives. Each practice identifies areas to work on to improve primary care for patients. The delivery and development team with clinical teams have already started work on areas such as CVD, Heart failure, Cancer prevention and LTC's. Commissioning plans against the five outcome areas can be seen in Appendix A.

Reducing Inequalities –
New Arrival Communities
We had already engaged the services of GEM Equality and Diversity Manager to develop and implement a comprehensive action plan to improve awareness of and access to health care services specifically:
Improving access to *health* screening information – including mapping new arrival health needs and reviewing screening information in terms of language and cultural requirements.
Improving access to health care - by using existing support groups to engage with / support new arrivals as to the differential service offerings between their originating country

compare to the local system; through work with GP's to address any barriers to access; the promotion of GP registration and use of the 111 service and; developing Health Champions within new arrival communities.

Long term, we are in the process of ensuring that we cater for the needs of this population within the all of our commissioning activities, including our many work programmes. Although we of course must acknowledge and recognise the cultural and language differences of these communities, these differences should not be the factors that define this group of people – put simply we need to provide services for individuals and not see these in terms of cohorts defined by their illness, their disability or their background.

As well as stating that this is an underlying strategy in all our work programmes we are currently arranging some specific training for D & D staff so that we can develop some appropriate tools to ensure that this is not a tick box exercise.

The CCG have recently completed an EDS2 Evaluation report which has actions proposed to address areas outcomes as required.

Parity of Esteem
SLCCG will be working with the other Lincolnshire CCGs to apply the principles addressed in the national Parity of Esteem document, including a requirement that providers have a mental health champion on their boards to raise awareness and the profile of mental health services, particularly within the acute setting.

During 13/14 SLCCG have funded a dementia liaison nurse at PSHFT to identify patients that have undiagnosed dementia, once identified, the GP is notified and patients are referred to the care and support they need. There are also already psychiatric liaison services on all three ULHT sites. These include a Hospital Intensive Psychiatric Service in Lincoln and Older Adult Liaison through nursing staff in Boston and Grantham. Part of the liaison role is to raise awareness and educate acute staff on mental health and mental illness. The intermediate care liaison function of the Community Mental Health teams for Older People also provides awareness and training for community health care staff

Regarding awareness of physical health care needs in the mental health environment, the Lincolnshire Partnership NHS Foundation Trust has trained staff in basic physical health care with two link nurses who are physical health care trained to support areas of LPFT. The MECC CQUIN has rolled out across the Trust with routine conversations around smoking cessation and obesity, with mental health nurses employed by the smoking cessation service.

Actions Required:
To formally support South Lincolnshire CCG Strategic Operational Plans for 2014/15 – 2015/16.

1. Background

Everyone Counts, planning for patients 2014/15 to 2018/19 final guidance published in December 2013 sets out how NHS England propose the NHS budget is invested to drive

continuous improvement and to make high quality care for all, now and for future generations into a reality.

It asks that commissioner's work with providers and partners in local government to develop strong, robust and ambitious five year plans to secure the continuity of sustainable high quality care.

Jointly Lincolnshire CCGs, provider's, local authorities, patients and public are developing and will implement a five year plan for Lincolnshire. SLCCG have produced, with partners, a two year operational plan that will work towards the five year strategy and where appropriate, accelerate the implementation of integrated working.

The Strategic plan aligns with all national frameworks and strategies including the NHS Outcomes Framework, The Mandate and Everyone Counts, planning for patients 2014/5 to 2018/19 and takes into account identified financial constraints.

SLCCGs main areas of concern during 13/14 have been:

- A&E of which we work collaboratively with our main three providers inputting into recovery plans funding schemes to keep patients in the community rather than hospital.
- Cancer services, SLCCG are lead for cancer services we have and will continue to work with ULHT to get full implementation of the cancer reform strategy and the strategy for cancer, trying to encourage adoption of recognised good practices learnt from.
- Health Care acquired infections – A detailed work programme to ensure infections both in community and hospital are prevented and where acquired dealt with effectively and with appropriate learning shared has been implemented, recruitment of infection prevention control nurse in December 2013. SLCCG have been successful during year reducing quinolone prescribing through raising awareness and joining localities prescribing groups.

The CCG will continue to focus on these areas throughout 14/15/16 with a view to going beyond acceptable by developing new pathways, working together with our partners to localise and integrate services were possible.

2. Conclusion

Patient safety, patient experience and value for money for the taxpayer will be the basis on which all services are commissioned. Where these are not achieved SLCCG will review and investigate to ensure that lessons are learnt and that appropriate, timely action is taken to address the issues.

SLCCG will be proactive in the move towards the LSSR five year strategy constantly seeking to improve services, processes and where appropriate using the BCF to begin services that are delivered by the community, integrating with providers and local authorities to enable patients to have a seamless journey localised where possible.

The LSSR builds on our current initiatives that the CCG is undertaking, such as Assertive In reach Teams and Community Response and Recuperation. It will ensure that both patients and the wider population recognise one health and care system, with local issues

within it, and that no one falls through any gaps that might appear due to boundary difficulties.

The BCF is supporting 14/15 and 15/15 transition years and is aligned with the LSSR. Jointly across the wider health and social community, we have carefully selected five 'Early Implementers' that are seen as central to securing early progress against the LSSR. They will also help ensure we are well placed to meet the requirements for performance improvement against the BCF national targets and our locally selected target. In addition these Early Implementers are intended to build on some of the pre-existing infrastructure that exists and which require further development if they are to secure profound improvement to outcomes, quality and sustainability – as such they provide early momentum and opportunity for learning. Finally, they have been chosen as pre-requisites to creating the opportunity for substantial reductions in acute beds which in turn frees-up resources for further primary/community based capacity – with the expectation that this will produce a virtuous cycle.

The Early Implementers are:

- The development of 'neighbourhood teams' at a number of locations reflecting GP clusters.
- The Development of a pooled budget and jointly commissioned Intermediate Care Layer.
- Seven-Day Working which will begin in the Acute Sector but be developed into community where appropriate.

Prevention, this will incorporate a number of short term projects funded by the BCF and the developing 'Wellbeing' service led by Public Health colleagues. It will also need to include young people – notably regarding the implications of 'Support and Aspiration'

3. Consultation

Development of the two year operational plan has included collaborative working with patients, carers, citizens, stakeholder's providers and outputs from locality group development meetings.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	H&WB commissioning plans
Appendix B	SLCCG Strategy on a page
Website address for full SOP	http://www.southlincolnshireccg.nhs.uk/

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 Cumba Balding who can be contacted on (insert tel.) or Cumba.Balding@SouthLincolnhsireCCG.nhs.uk

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Lincolnshire Health and Wellbeing Board outcomes and services planned and commissioned.

Promoting Healthy Lifestyles

The evidence in the JSNA indicates that smoking is currently the most significant behaviour contributing to poor health and well-being. Most smokers wish to stop and there are interventions which are proven to be effective. The JSNA evidence also indicates that obesity, and its two major components – food and physical activity, is also a major problem. Unlike smoking this is increasing as a risk factor and requires urgent attention. This applies to both children and young people and to adults.

Outcome – People are supported to lead healthier lifestyles

Aims	Commissioning plans / Implemented Services
Decrease smoking	Phoenix Smoking Cessation Service
Decrease obesity	Dietician referrals/Weightwatchers Phoenix/Exercise on referral
Increase physical activity	Exercise on referral
Sensible alcohol use	DARTS/Addaction
Improve sense mental wellbeing	Self referral IAPT

Improving Health and Well Being for Older People

The data illustrates once again the high proportion of older people aged 50 and over living in Lincolnshire and the projections for this proportion to increase over the next decades. This affects not just the obvious issues of health and social care, benefits and pensions, housing and transport, but also prevention of ill-health, promotion of well-being and quality of life, and work and volunteering opportunities.

Outcome – Older People are able to live life to the full and feel part of their community.

Aims	Commissioning plans / Implemented Services
Deliver "wellbeing" support and community health services for older people in Lincolnshire	Making every contact count
Develop a network of "wellbeing" services aimed at supporting older people to live healthier, happier and independent lives	Parkinson Nurse
Ensure services for older people are locally based, cost-effective and sustainable	Parkinson nurse
Use public, private, voluntary and community organisations/groups to provide co-ordinated low level preventative services	Wellbeing Support Network

Delivering high quality systematic care for major cause of ill health and disability.

All the reviews of major illnesses illustrate the benefits of prevention, early diagnosis and good management of risk factors and the condition itself. There is clear

evidence that systematic care with defined care pathways and protocols which utilise effective interventions will produce better outcomes. The JSNA gives us evidence that this systematic prevention and care is not universally available in Lincolnshire. We must ensure we have in place systematic programmes of risk identification and management, long-term condition management and management of major diseases such as heart disease, stroke, cancer and diabetes.

Outcome – People are prevented from developing long term health conditions, have them identified early if they do develop them and are supported effectively to manage them

Aims	**Commissioning plans / Implemented Services**
Improve the diagnosis and care for people with diabetes	Diabetic Nurse/Hypoglycaemic pathway Weight watchers/Exercise on referral.
Reduce unplanned hospital admissions and mortality for people with COPD	Respiratory nurses Unplanned care. South Holland looked at frequent attenders with COPD and set up individual management plans for them.
Reduce mortality rates from CHD and improve treatment for patients following an MI	CVD Lifestyle checks/Heart failure Nurse Cardiac rehabilitation nurses
Improve the speed and effectiveness of care provided to people who suffer a stroke	Setting up of specialist centres for stroke treatment.
Reduce mortality rates from cancer and improve take up of screening	SLCCG is the lead commissioner for Cancer
Minimise the impact of long term health conditions on mental health	IAPT – (**Improving Access to Psychological Therapies)**

Improving health and social outcomes and reducing inequalities for children.

The evidence in the JSNA points to deprivation and poverty being major drivers of health inequalities in children and to obesity, smoking, and teenage pregnancy as the main health issues to be addressed.

Outcome – Ensure all children get the best possible start in life and achieve their potential

Aims	**Commissioning plans / Implemented Services**
Ensure all children have the best start in life by Improving educational attainment for all children	Work with partner organisations to promote
Improving parenting confidence and ability to support their child's healthy development.	The CCG is committed to the Operating Framework requirement to increase Health Visitors
Reduce childhood obesity	Work with partner organisations to promote healthy lifestyles, to support reduction in obesity
Ensure children and young people feel happy, and stay safe from harm and make good choices about their lives - particularly the vulnerable and disadvantaged.	The CCG is committed to the increase in health visitors

Tackling the social determinants of health

The JSNA points to worklessness being a highly significant determinant of people's health. Work improves mental health, reduces the likelihood of poverty and increases self esteem. There are links between health and the quality of work too. The evidence in the JSNA, taken originally from the Economic Assessment, indicates that in certain parts of Lincolnshire this is a major issue for health and well-being.

Outcome – Peoples health and well-being is improved through addressing wider determining factors of health that affect the whole community

Aims	**Commissioning plans / Implemented Services**
Support more vulnerable into good quality work	Work with partner organisations to develop and support the vulnerable.
Ensure public sector policies on getting best value for money include clear reference and judgement criteria about local social impact, with particular reference to protection and promotion of work opportunities and investment in workforce health and well-being	Improved pathways of care,
Ensure that people have access to good quality, energy efficient housing that is both affordable and meets their needs	Warm Homes scheme(R2W– Responders to Warmth) Council run

These aims and commissioning decisions have been endorsed by Lincolnshire County Council, Lincolnshire's CCGs, District Councils, Healthwatch Lincolnshire, and Lincolnshire and Leicester Local Office of the NHS Commissioning Board.

All will hold each other to account for ensuring that their commissioning and decommissioning decisions are in line with the JHWS and deliver the outcomes which are included in the five themes.

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SLCCG Planning Strategy 2014/15 – 2018/19

NHS
South Lincolnshire
Clinical Commissioning Group

Developed in Partnership

Planning Cycle for 2014/15 to 2015/16

- Stakeholder Engagement
- Clinical Committee
- Provider consultation
- Public consultation
- Listening Event
- LSSR

MOST IMPORTANT TO PATIENTS AND PUBLIC

- Preventative services are important
- Care delivered locally
- Patients seen quickly
- People encouraged to take responsibility for their own health
- Make communication between organisations better
- Treat patients with compassion and support them and staff to get involved

Getting There - Outcome focussed

Improving Quality, Francis and Winterbourne actions are and will continue to be implemented

Patient Safety, Internal and external processes are in place for monitoring and ensuring patients are kept safe

Improving patient experience by, localising and integrating services where appropriate, ensuring implementation of the Friends and Family Test, working with providers to guarantee patients constitutional rights and pledges are delivered

Robust contract monitoring and commissioning processes for quality and value for money

Start implementation of the agreed outcomes of the Lincolnshire Sustainable Services Review

Begin to locally integrate teams i.e. Multiple Discipline Teams in primary care

Continue to develop improvements and implement and service redesign to local hospitals

Work to national and local agreed outcomes

Repeat planning cycle throughout years

Delivery through working Together

Our Vision

Primary Care
GPs
Community Nursing
Specialist Nurses
Pharmacy
Therapy Services

Local Neighbourhood Teams
Maintaining at home
Occupational Therapy services
Social care support services
Complex Case Managers
Care Coordinators

Sub-Acute Units e.g. Van Geest / Johnson
Minor Injuries Unit @ front door
Nurse led
Nurse specialists
Sub-acute in-patients (step up/ down)
As wide a catchment as possible
Therapy led
Medical support bought in

Acute Hospital admission – Appropriate referrals only
Seven Day Services Improvement Programme
Patient transport
Pathway Redesign
Discharge planning

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Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of Peter Huskisson, Commissioning Director

Leics, Lincs & East Midlands Specialised Commissioning, Leicestershire and Lincolnshire Area Team NHS England

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**25 March 2014**
Subject:	**Draft Operational Plan 2014-16 & Emerging Strategy Update**

Summary:

The draft operational plans are being shared with commissioning partners in the 4 health and wellbeing boards and with clinical commissioning groups. Plans have been developed taking account of health needs of the population from resources made available and by canvassing directors of public health in November to identify key strategic issues. It is requested that feedback on the plans is provided during March via Directors of Public Health, to ensure final documents adopted in April can respond to comments.

Actions Required:

The Board to note and comment on the Draft Operational Plan 2014-16 & Emerging Strategy Update NHS England Commissioning Plan.

1. Background

A wide range of guidance has been published up to the end of January 2014 to inform operational plans for the next 2 financial years. The core requirements for operational plans are to set out financial and performance goals, and affirm the commissioner's intentions to adopt the priorities set out in planning guidance. Concurrently with the operational planning cycle, a degree of assurance has been sought about development of 5 year strategy including a 'unit of planning' health system plan to which NHS England services contribute.

Full 5 year strategies are not required until June 2014, and are expected to encompass outcome ambitions set with local authority partners for health and care services, with the

national strategies for specialised services and primary care yet to be produced to inform local strategies.

No standard format has been required in this planning round, and given the benefit of outlining strategic direction for informing 2 year plans, the Leicestershire and Lincolnshire Area Team have produced this combined document that provides an update on the strategic development of commissioned services, and the health needs to which plans relate, alongside the core operational plan requirements.

A 'plan on a page' summary is provided for the commissioning of primary care and NHS public health services. For specialised services operational plans and summaries are being nationally developed to a single consistent document expected to be made available later this month.

2. Conclusion

The Health and Wellbeing Board note the contents of the report.

3. Consultation

This report is part of the ongoing consultation process before the production of the plans in June 2014.

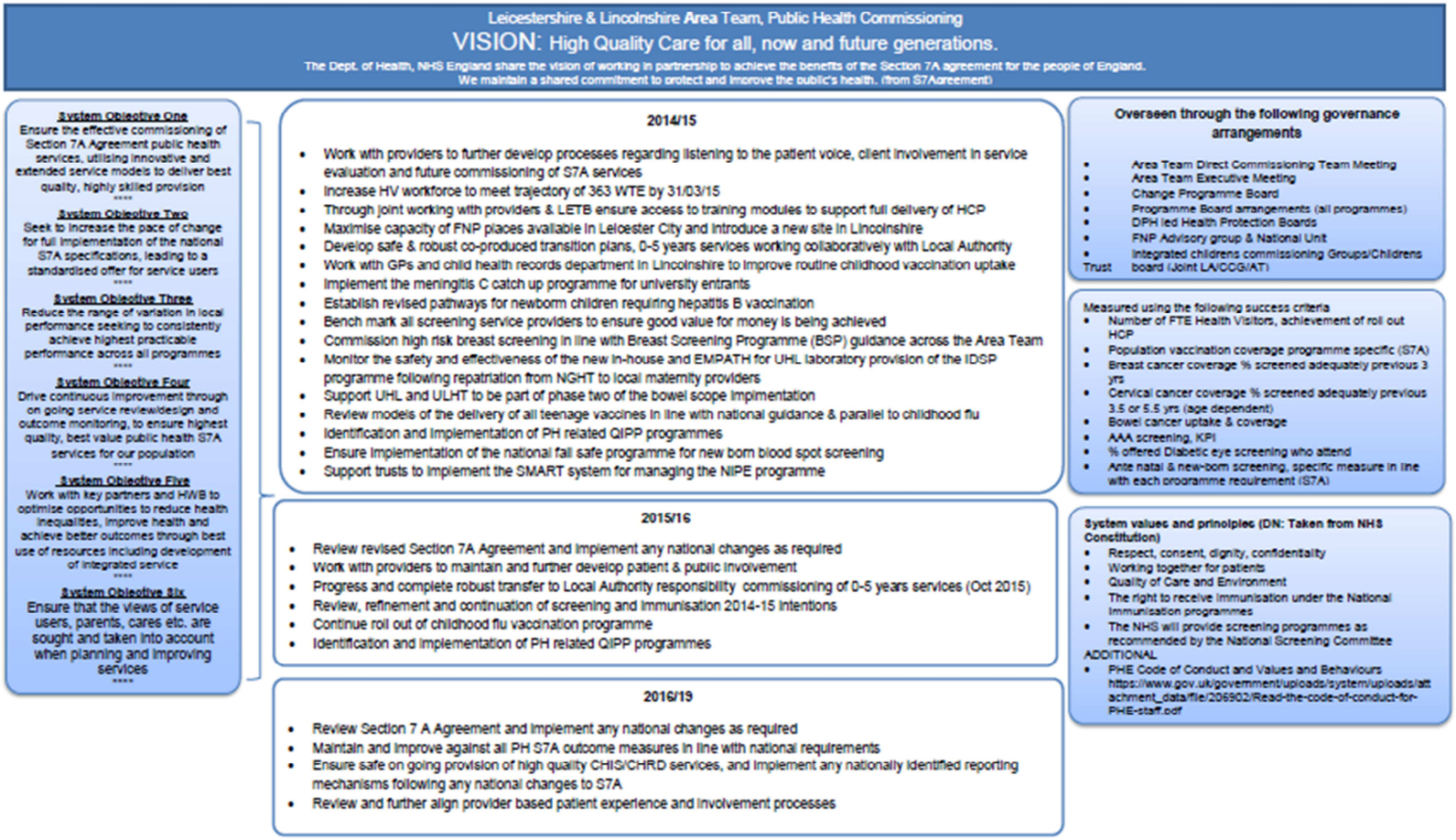
4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Plan on a page

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 Peter Huskisson, who can be contacted on 0116 259 3439 or peter.huskinson@nhs.net


Leicestershire & Lincolnshire Area Team, Public Health Commissioning
VISION: High Quality Care for all, now and future generations.
The Dept. of Health, NHS England share the vision of working in partnership to achieve the benefits of the Section 7A agreement for the people of England.
We maintain a shared commitment to protect and improve the public's health. (from S7Agreement)
System Objective One
Ensure the effective commissioning of Section 7A Agreement public health services, utilising innovative and extended service models to deliver best quality, highly skilled provision
System Objective Two
Seek to increase the pace of change for full implementation of the national S7A specifications, leading to a standardised offer for service users
System Objective Three
Reduce the range of variation in local performance seeking to consistently achieve highest practicable performance across all programmes
System Objective Four
Drive continuous improvement through on going service review/design and outcome monitoring, to ensure highest quality, best value public health S7A services for our population
System Objective Five
Work with key partners and HWB to optimise opportunities to reduce health inequalities, improve health and achieve better outcomes through best use of resources including development of integrated service
System Objective Six
Ensure that the views of service users, parents, cares etc. are sought and taken into account when planning and improving services
2014/15
Work with providers to further develop processes regarding listening to the patient voice, client involvement in service evaluation and future commissioning of S7A services
Increase HV workforce to meet trajectory of 363 WTE by 31/03/15
Through joint working with providers & LETB ensure access to training modules to support full delivery of HCP
Maximise capacity of FNP places available in Leicester City and introduce a new site in Lincolnshire
Develop safe & robust co-produced transition plans, 0-5 years services working collaboratively with Local Authority
Work with GPs and child health records department in Lincolnshire to improve routine childhood vaccination uptake
Implement the meningitis C catch up programme for university entrants
Establish revised pathways for newborn children requiring hepatitis B vaccination
Bench mark all screening service providers to ensure good value for money is being achieved
Commission high risk breast screening in line with Breast Screening Programme (BSP) guidance across the Area Team
Monitor the safety and effectiveness of the new in-house and EMPATH for UHL laboratory provision of the IDSP programme following repatriation from NGHT to local maternity providers
Support UHL and ULHT to be part of phase two of the bowel scope implmentation
Review models of the delivery of all teenage vaccines in line with national guidance & parallel to childhood flu
Identification and implementation of PH related QIPP programmes
Ensure implementation of the national fail safe programme for new born blood spot screening
Support trusts to implement the SMART system for managing the NIPE programme
2015/16
Review revised Section 7A Agreement and implement any national changes as required
Work with providers to maintain and further develop patient & public involvement
Progress and complete robust transfer to Local Authority responsibility commissioning of 0-5 years services (Oct 2015)
Review, refinement and continuation of screening and immunisation 2014-15 intentions
Continue roll out of childhood flu vaccination programme
Identification and implementation of PH related QIPP programmes
2016/19
Review Section 7 A Agreement and implement any national changes as required
Maintain and improve against all PH S7A outcome measures in line with national requirements
Ensure safe on going provision of high quality CHIS/CHRD services, and implement any nationally identified reporting mechanisms following any national changes to S7A
Review and further align provider based patient experience and involvement processes
Overseen through the following governance arrangements
Area Team Direct Commissioning Team Meeting
Area Team Executive Meeting
Change Programme Board
Programme Board arrangements (all programmes)
DPH led Health Protection Boards
FNP Advisory group & National Unit
Integrated childrens commissioning Groups/Childrens Trust board (Joint LA/CCG/AT)
Measured using the following success criteria
Number of FTE Health Visitors, achievement of roll out HCP
Population vaccination coverage programme specific (S7A)
Breast cancer coverage % screened adequately previous 3 yrs
Cervical cancer coverage % screened adequately previous 3.5 or 5.5 yrs (age dependent)
Bowel cancer uptake & coverage
AAA screening, KPI
% offered Diabetic eye screening who attend
Ante natal & new-born screening, specific measure in line with each programme requirement (S7A)
System values and principles (DN: Taken from NHS Constitution)
Respect, consent, dignity, confidentiality
Working together for patients
Quality of Care and Environment
The right to receive immunisation under the National Immunisation programmes
The NHS will provide screening programmes as recommended by the National Screening Committee
ADDITIONAL
PHE Code of Conduct and Values and Behaviours https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/206902/Read-the-code-of-conduct-for-PHE-staff.pdf

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Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

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

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**25 March 2014**
Subject:	**Annual Report of the Director of Public Health on the Health of the People of Lincolnshire 2013**

Summary:

The annual report on the health of the people of Lincolnshire from the Director of Public Health, attached at Appendix A, is an independent statutory report to Lincolnshire County Council. The report raises issues of importance to the health of the population of Lincolnshire.

Actions Required:

The Lincolnshire Health and Wellbeing Board is asked to receive a presentation and to consider the recommendations included in each chapter of the Report.

1. Background

It is a statutory duty of the Director of Public Health to make an annual report on the health of the people of the area he/she serves. The report attached at Appendix A is the fourth report of the Director of Public Health for Lincolnshire, and the first in his new role based in Lincolnshire County Council. The report is not an annual account of the work of the Public Health team, but an independent professional view of the state of the health of the people of Lincolnshire, with recommendations on the action needed by a range of organisations and partnerships.

Inevitably, there has to be a range of topics covered in any one year and the Director of Public Health has tried to address issues that, in his view, are likely to be priorities, or where there is scope and need for action to be taken.

2. Conclusion

The fourth statutory annual report of the Director of Public Health on the health of the people of Lincolnshire has now been prepared, attached at Appendix A, and the Health Scrutiny Committee for Lincolnshire is asked to receive a presentation and consider the recommendations included in each chapter.

3. Consultation

None.

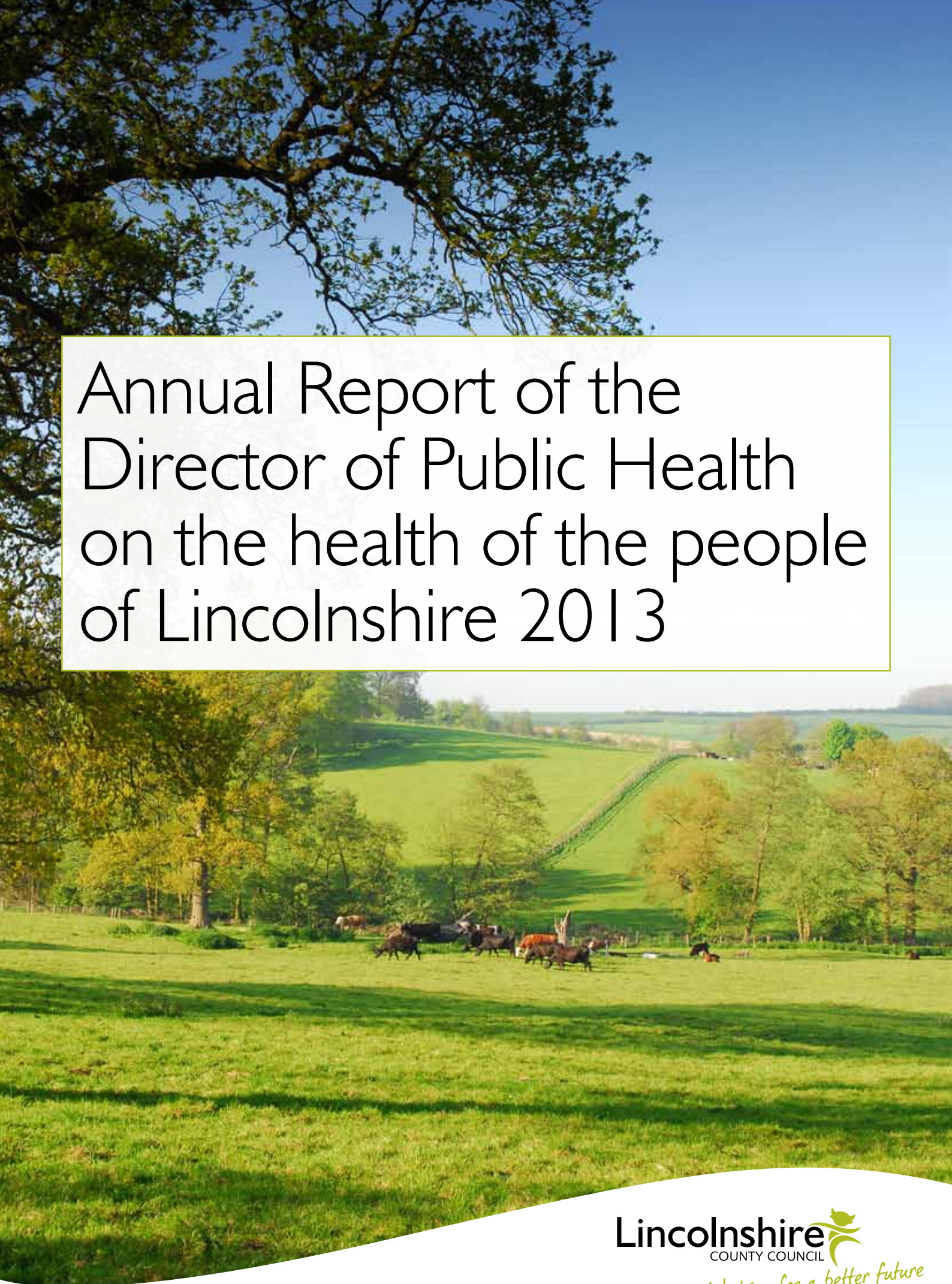
4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Annual Report of the Director of Public Health on the Health of the People of Lincolnshire 2013.

5. Background Papers

Document title	Where the document can be viewed
NHS Commissioning Board Emergency Preparedness Framework 2013	www.lincolnshireprepared.co.uk
WHO, 2010 Developing Sexual Health Programmes, A Framework for Action	whqlibdoc.who.int/hq/2010/WHO_RHR_HRP_10.22_eng.pdf
Improving Outcomes and Supporting Transparency – The Public Health Outcomes Framework for 2013 – 2016.	www.gov.uk/government/publications/healthy-lives-healthy-people-improving-outcomes-and-supporting-transparency
A Framework for Sexual Health Improvement in England, 2013	www.gov.uk/government/publications/a-framework-for-sexual-health-improvement-in-england
	www.nat.org.uk/HIV-Facts/Statistics/Latest-UK-Statistics.aspx
	www.phoutcomes.info/public-health-outcomes-framework#grid/1000043/par/E12000004
	www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1204619474055
	www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/HV/HIVData/

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



Annual Report of the Director of Public Health on the health of the people of Lincolnshire 2013

Lincolnshire COUNTY COUNCIL

Working for a better future

Introduction

This is my fourth annual report on the health of the people of Lincolnshire, and the first in my new role based in Lincolnshire County Council. I have a statutory duty to make this report, which is not an annual account of the work of the Public Health Team, but an independent professional view of the state of the health of our area, with recommendations on the action needed by a range of organisations and partnerships.

Inevitably, there has to be a range of topics covered in any one year and I have tried to address issues that, in my view, are likely to be priorities or where there is scope and need for action to be taken.

The first chapter considers the health needs of international migrants and outcomes we should be striving for. This is an issue of considerable importance in Lincolnshire.

Tobacco is responsible for a very large proportion of deaths in our population, and this is rightly an important priority in our Joint Health and Wellbeing Strategy. This is not just a responsibility of the County Council or of the NHS. Many others have a part to play and chapter two details some of this.

Part of the rationale for moving local Public Health responsibilities from Primary Care Trusts to Local Authorities was to support those who influence the wider determinants of health. Spatial planning has influence over many factors which strongly influence health and wellbeing. Chapter three describes spearhead work in Lincolnshire and recommends how this could be developed. This links to the development of Public Health skills in the wider work force which is considered in chapter four.

The Director of Public Health not only has some roles and responsibilities in protecting the health of the population, but also has a role "to be assured" that other organisations and professional groups are working well together to protect health. How we do this and the current picture is described in chapter five.

I would like to thank my staff who have been involved in producing this report. As ever, I and they would welcome comments and dialogue with you.

Tony Hill
Director of Public Health,
Lincolnshire County Council

Contents

Progress on Previous Recommendations

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.	Work has been undertaken to convert the health needs assessment into a more detailed understanding of service needs for now and the future, including social needs. This is informing the commissioning plans of the Joint Commissioning Board.
2. Primary care should be encouraged to identify and record all people with learning disabilities.	I am not aware of any action that has been taken on this recommendation.
3. Preventive healthcare and public health activities should be reviewed to ensure provision across Lincolnshire.	All public health services will be reviewed by the end of March 2014, and implementation plans are already in place for some services. The county's prevention and early intervention strategy is under review, and will be relaunched early in 2014.
4. All services should provide the opportunity for adults with learning disabilities to access healthy lifestyle initiatives and services.	This has been established as part of the specification for the Wellbeing Service which is currently being procured.
5. All GP practices should be encouraged to provide annual healthchecks for people with a learning disability.	More focus on achieving annual health checks is currently being promoted across community learning disability services and primary care.
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.	I am not aware of any action that has been taken on this recommendation.
7. 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.	NHS Health check performance has been raised at CCG meetings. Distribution of practice performance data has increased from quarterly to monthly – sent to practices and CCGs. We are looking at restructuring the service specification for 2014/15 to increase and stretch target payments to encourage an increase in uptake.

	A pilot is being set up with the Co-op providing health checks for some of the highest risk patients at the four non-participating practices (1st January 2014 to 31st March 2014). This will be evaluated to see if it is a viable alternative service model.
8. 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.	Practices are being encouraged to make and record referrals to lifestyle services through the NHS Health Check. LWCCG have included a target for referrals onto weight management services for patients accessing their NHS Health Check who have a recorded BMI of 30 or above. In total, 45 people received Make Every Contact Count (MECC) Train the Trainer sessions in 2012/13. These trainers ranged from across NHS organisations and associated professionals such as pharmacists, to Lincolnshire County Council and District Council Housing teams. Over 791 frontline NHS staff were trained to enable them to effectively discuss lifestyle issues with patients, and provide signposting, referral or support for the patient in choosing to make a lifestyle change.
9. All involved with children should raise the profile and implications of childhood obesity with local communities.	Childhood obesity continues to be a problem within our county. However, all key partners are working together to address this issue. Nationally, we received praise for our joint working in the School Food Plan which was a review commissioned by central government.
10. Maternity primary care and children's services should support mothers to effectively breastfeed.	Initiating breastfeeding at birth and prolonging the duration an infant is breastfed continue to be priorities in Lincolnshire. An ongoing training programme for frontline staff has been established in order that women receive consistent messages about the benefits of breastfeeding, and the support to do so, both in hospital and community settings.
11. We should all promote healthy food choices and appropriate portion sizes in the home, nursery and school.	We have worked continually with schools and early years settings to promote the use of appropriate portion sizes. Our Healthy Schools Team has employed 2 specialist consultants to work specifically with early years settings on their food provision.
12. Schools need to increase the numbers of children eating healthy school meals and reduce those eating packed lunches.	The new School Food Plan is at the heart of our way forward for working with schools and caterers on the uptake of healthy school meals. Key partners are working to accommodate the new universal free school meal offer which will provide free school meals to all children under the age of eight as of September 2014.
13. We all need to promote active lifestyles in the home, nursery and school.	Our healthy schools team continues to promote the Healthy Early Years Award, which has seen good uptake in the past 12 months, 39 schools are now enrolled and 26 schools have achieved the award. We are also currently developing a new healthy lifestyles pathway for families with young children, in conjunction with children's centres and early years settings around the county.

14. 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.	The level and quality of provision of public health advice and support was one of the tests in the authorisation process for CCGs. All four Lincolnshire CCGs are fully authorised by NHS England without conditions. A Memorandum of Understanding is in place between Lincolnshire's Public Health Directorate and each CCG which sets out mutual expectations. Each CCG has a public health consultant as a member of their Governing Body, to provide advice to them across the three domains.
15. 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.	Each CCG is represented on the Health and Wellbeing Board. Each of the five themes of the Joint Health and Wellbeing Strategy has a lead GP, as well as a lead elected member and a lead public health consultant.
16. Around half of the staff time of Lincolnshire's public health directorate be devoted to work on behalf of NHS commissioners.	This is a commitment within the Memorandum of Understanding between Lincolnshire's Public Health Directorate and the four Lincolnshire CCGs. This commitment has been met, and has been reaffirmed for 2014/2015.
17. 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.	Terms of Reference have been agreed for the LHRP in Lincolnshire, with appropriate representation from all NHS organisations. A 3 year strategic plan is currently being developed, with agreement on the key priorities during this time period. Actions identified during incidents and lessons are agreed and managed through the group. The LHRP links into other Local Resilience Forum standing groups to ensure a clear governance structure is in place for emergency preparedness, resilience and response within Lincolnshire.
18. A Health Protection Group is established involving commissioners and providers to assist the Director of Public Health to give advice, challenge and advocacy.	The clarity of the role of this group has now been established, and it will meet for the first time in Spring 2014.
19. The Local Area Team of the NHS Commissioning Board continues with the current coordination arrangements for each of the screening programmes.	The Local Area Team have now assumed responsibility for commissioning national screening programmes. Lincolnshire County Council retains a responsibility to seek assurance of the performance and quality of the local screening programmes, and to challenge and scrutinise as appropriate. Lincolnshire County Council has developed a local health promotion plan which introduces initiatives to increase uptake, reduce missed appointments and address inequalities in screening programmes in Lincolnshire.

Chapter 1
Addressing Health Equity and Health Outcomes for International Migrants

It is essential that commissioners of healthcare and health improvement services understand the changing health needs of their populations and can tailor services to meet specific health needs. Internal and international migration within the UK and within Lincolnshire is an inherent part of modern life. In May 2004, the Treaty of Accession to the European Union (EU) between the existing 15 member states and 10 new states came into force. The new states included eight countries of central and eastern Europe (Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia), termed the A8 countries, along with Cyprus and Malta. The expansion of the EU has seen areas with little previous experience of immigration facing unprecedented changes, particularly rural areas, and it is acknowledged that parts of Lincolnshire have seen significant numbers of international migrants coming to live and work. More recently, it has become possible for people to migrate from Bulgaria and Romania but the impact of this group is not considered in this needs assessment. This will be monitored in the future.

Migrant workers actively contribute to economic prosperity, are often highly educated, and as they tend to have a younger profile than the resident population, they can help to balance demographics and dependency ratios. In addition to economic migration, around 17% of students in higher education institutions in the UK are from overseas.[1]

The Health and Social Care Act 2012 has resulted in significant change to the health and social care agenda. Understanding the health and other needs of migrants is essential in addressing health inequalities and delivering the policy objectives of the Marmot Review, 'Fair Society, Healthy Lives'.[2]

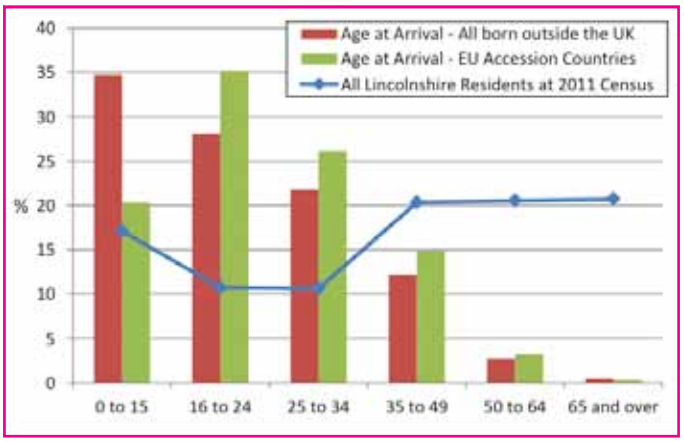
Health (along with employment, education and housing) has been identified as a key indicator of migrants' integration. If migrant workers intend to stay in the UK, even if their stay is temporary but long-term, it is essential that their health needs are routinely considered, along with projected levels of demand for and access to service provision.

International Migrants in Lincolnshire

Of the 713,653 people resident in Lincolnshire at the 2011 census, just over 7% were born outside of the UK compared to just over 13% across England and Wales. Of these non-UK born residents in Lincolnshire, around 60% were from EU member states and accession countries and 40% were from elsewhere in the world. Increased rates of migration were particularly seen between 2004 and 2009 following the accession of new states to the EU, after which rates again reduced.

International migrants tend to be relatively young, with health needs similar to those of indigenous individuals of equivalent age and sex. Figure 1 shows the age profile of all Lincolnshire residents at the 2011 census compared to the age of arrival for international in-migrants.

Figure 1.1: Age profile of all Lincolnshire residents at the 2011 census versus age at arrival of international in-migrants[3]

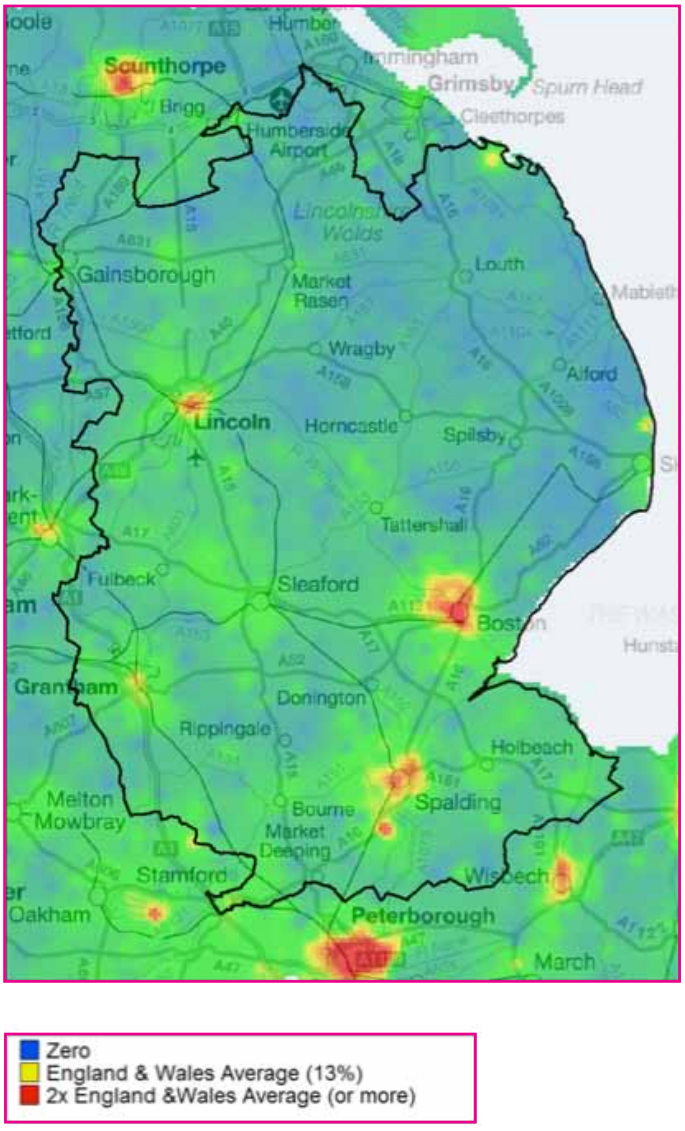


Source: 2011 Census of Population, Office for National Statistics, 2011

Figures from the Department for Work and Pensions[4] show that just over 5,300 international migrants in Lincolnshire registered for a national insurance number in 2012/13, with Boston and South Holland seeing the highest numbers of registrants. Since 2004, 34% of national insurance numbers allocated to overseas nationals in the UK have concerned people from A8 countries. In Lincolnshire, the figure is 83%, suggesting the county is more attractive to migrant workers from the A8 countries than to those from other parts of the world. In July 2012, over 15,000 people from the A8 community were recorded as being registered with a Lincolnshire GP, with most recorded as living in the areas of Boston, Spalding, Grantham, Skegness and Lincoln. A large proportion of A8 migrants in Lincolnshire live in areas with high levels of multiple deprivation, they earn the lowest wages compared to other migrant groups, and their employment does not correspond to their educational background and skills.[5]

Information from the 2011 census shows that there are very low proportions of people living across wide areas of the county whose country of birth is outside of the UK in comparison to the England and Wales average. Residence tends to be concentrated on the areas of Boston, Spalding, Lincoln, and to a smaller extent, Grantham, consistent with GP registration data. In addition, there are concentrations of residents born outside of the UK in areas close to the Lincolnshire border, such as in Scunthorpe, Newark and Peterborough, and these residents may also access employment and services within the county.

Figure 1.2: Proportion of residents whose country of birth is non-UK[3]



Source: 2011 Census of Population, Office for National Statistics, 2011

In England and Wales, in the 10 years between the 2001 and 2011 censuses, the largest increase in people born outside the UK was of those born in Poland. The census also identifies that Polish-born residents are concentrated in West London, Slough in Berkshire and Boston in Lincolnshire. In Boston specifically, around 3,000 people (just over 4% of residents) were born in Poland. In the most recent year of national insurance number registrants (2012/13), A8 migrants to Lincolnshire were predominantly from Lithuania (40%), Poland (34%) and Latvia (19%).

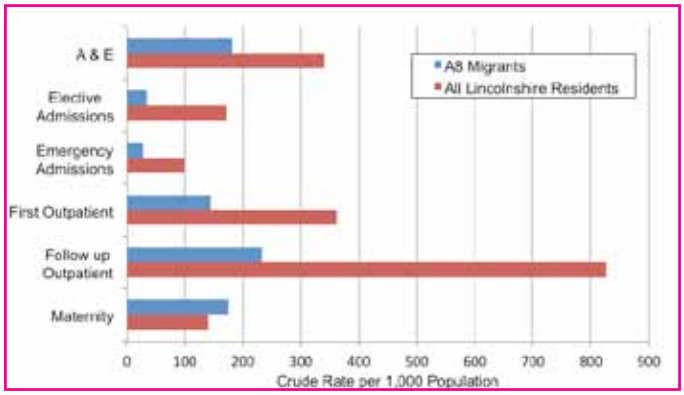
Health Needs and Service Use of Migrants

Migrants have a range of health needs, partly determined by their individual characteristics (such as age, sex, and ethnicity), their country of origin, the circumstances of their migration and the socio-economic conditions in the host country. The Health Protection Agency (HPA), now part of Public Health England (PHE), identifies several groups of vulnerable migrants living in the UK, including low-paid migrant workers[6]. Work commissioned by the Department of Health also describes the wide determinants of health and well-being for migrants[7].

There is evidence that international migrants are relatively healthy on arrival, and are unlikely to impose a disproportionate burden on health services. This is, to a large extent, due to their young age profile but is also due to the fact that the life changing decision to migrate (usually to work) will tend to be made by those who are already in relatively good health. However, health may deteriorate the longer they stay in the host country. This can be due to a number of reasons, including taking on some of the poorer lifestyle behaviours of the indigenous population where these exist (lower exercise and outdoor activity, alcohol use, smoking, poor eating habits for example), and a combination of changes brought about by their migration. For example, migrant workers from A8 countries frequently live in privately-rented flats or houses, many of which are multiple occupancy and of poor quality[8]. This can tend towards overcrowding, lack of cooking and heating facilities, and property that is badly maintained and/or damp. There are also issues associated with 'cross-border' driving, with road-police officers stressing the need to educate some migrant workers about aspects of road safety. In particular, they are concerned about problems caused by not using seat belts or child seats, and poor driving (driving when tired, speeding and drink-driving)[9].

As migrants begin to settle in the host country their need for health services changes. The rate of hospital service use in all cases is lower for A8 migrants in Lincolnshire than for Lincolnshire residents as a whole, apart from a slightly higher rate for use maternity services. In 2011, 15.7% of all births in Lincolnshire were to non-UK-born mothers and 10% were to mothers from countries that had recently become part of the EU. This is consistent with the health and demographic status of the migrant group.

Figure 1.3: Use of hospital services by all residents and by A8 migrants, 2011/12[10]



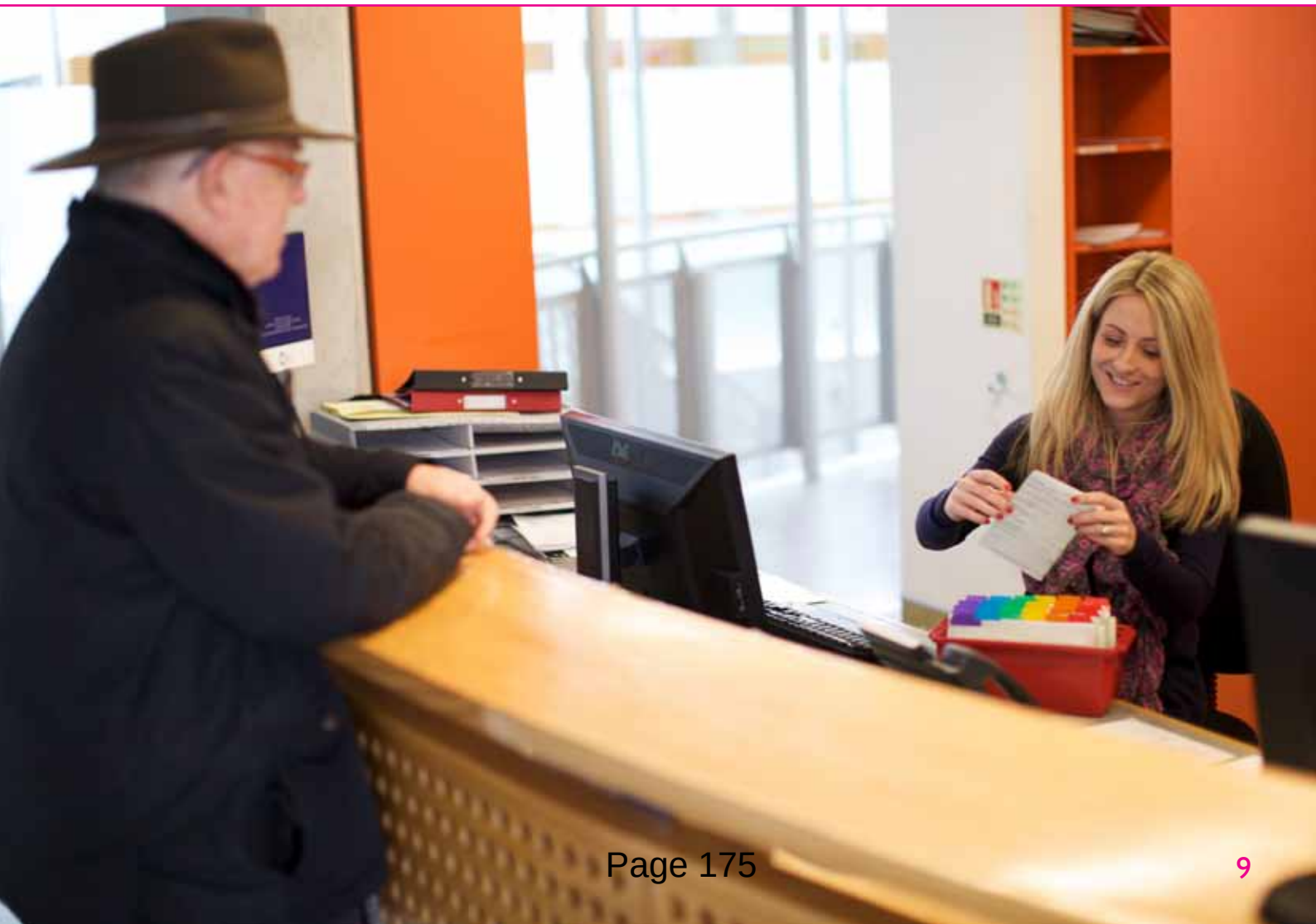
Source: NHS Secondary Uses Service (SUS) Data, Health and Social Care Information Centre (HSCIC), 2011/12

Migrants' health may also be affected by their ability to access healthcare services. It is reported that, for various reasons, many migrants do not register quickly (if at all) with a GP. Language difficulties and a lack of knowledge of how the healthcare system in the UK operates are both cited as obstacles to migrants' ability to access health services and health information in the UK. Some migrants return to their home country for healthcare. In an NHS Lincolnshire survey of A8 migrants with 131 respondents, 58% said that they returned to their home country for medical treatment (including predominantly dental treatment), and 51% of those returning home for healthcare said that this was because they found it easier to communicate.

Addressing Inequalities in Health and Health Outcomes

Inequalities in health and health outcomes amongst migrant workers are often linked to language barriers and a lack of understanding about access to healthcare and other public services.

A range of guidance is available to support in managing the health needs of the migrant population. NICE (National Institute for Health and Clinical Excellence) guidance sets the standards for high quality healthcare and encourages healthy living. A number of NICE guidelines are specifically relevant to providing healthcare and health improvement for the migrant population. The Migrant Health Guide from the HPA (now part of PHE) also provides a wide range of information in relation to the healthcare of the migrant population. Both of these sources can be used by the NHS, Local Authorities, employers, voluntary groups and anyone else involved in delivering care or promoting wellbeing.



Recommendations

There are a number of recommendations which could improve the inclusivity and equality of healthcare provision to the migrant populations in Lincolnshire.

- In the provision of any strategy, programme or service, the specific needs of migrants should be considered to understand whether these are any different to those of the general population. Where specific differences are identified in the needs of the migrant populations, these should then be taken into account.

- Commissioners and healthcare providers must be fully aware of, and use, the guidance for providing healthcare to international migrants, including Public Health England and NICE guidance.

- Service providers and intermediaries engaging with international migrants in any capacity should encourage them to register with a GP to enable them to access the full range of primary care services, including screening and other preventative services.

- Staff providing health services should be made aware of the translation services available for people who require them, and ensure that the benefits of English language courses are promoted to all migrants.

- Links should be strengthened between health service providers, other service providers, intermediary and support organisations and employers to ensure that services are better understood by migrants and are more appropriately accessed.

Further information on these recommendations, and the evidence which underpins them, can be found in the report 'Ensuring Inclusive Healthcare' produced by the Public Health directorate of Lincolnshire County Council.[11]

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Chapter 2
Tobacco Control

The Joint Health and Wellbeing Strategy for Lincolnshire 2013 – 2018 identified the need for the development and delivery of a five year Tobacco Control Plan incorporating a broad partnership approach to tackle tobacco control issues. The following information outlines the work done so far and the developments for the future.

Introduction

Tobacco has been used by people for centuries, but it was the introduction of ready-made cigarettes in around 1884 that led to a global explosion in tobacco use. An estimated 100 million deaths in the twentieth century are attributed to tobacco smoking.[1]

Globally, smoking is the biggest preventable cause of death. Tobacco is unique in that it is the only product that kills when it is used entirely as intended (smoked and inhaled). In doing this, it kills half of its consumers. Smoking causes 50 different conditions and costs the NHS £2.7 billion to treat every year.[2] Tobacco is a leading cause of health inequalities and is responsible for half of the difference in life expectancy between the rich and the poor. Approximately 900[3] adults aged 35 and over die each year in Lincolnshire from a smoking related condition.

Tobacco use and second-hand exposure to tobacco smoke increase the risk of death from lung and other cancers, heart disease, stroke, chronic respiratory disease and other conditions.[4] A burning cigarette spends over 90% of the time smouldering. The smoke contains toxic chemicals (approximately 4,000) which are released into the air for others to breathe. There are approximately 70 cancer causing chemicals contained within each cigarette.[5] In England, deaths from smoking are more numerous than the next six most common causes of preventable death combined (i.e. drug use, road accidents, other accidents and falls, preventable diabetes, suicide and alcohol abuse).[6]

Figure 2.1 What is in a cigarette?[7]

In an effort to address this issue, the government introduced legislation that prohibited smoking in virtually all enclosed public places and workplaces throughout the United Kingdom. The smokefree law in England forms part of the Health Act 2006 and followed similar laws that were implemented in Scotland (March 2006), and Wales and Northern Ireland (April 2007). Smoking is no longer permitted in enclosed and "substantially enclosed" workplaces, as well as in work vehicles if they are used by more than one person at any time. The legislation has enforcement offences specified and compliance enacted through local authorities.

The health of the public has been significantly improved since the introduction of this piece of legislation, which suggests it is one of the most significant Public Health measures since the introduction of seat belts in the 1980s.

The Chief Medical Officer, Sir Liam Donaldson, commissioned the report 'Smokefree England – One Year On' to determine the success of the implementation of the legislation. 81% of businesses agreed that smokefree legislation is 'a good idea' and 40% of businesses reported a positive impact on the company. In addition, compliance was high with 98.2% of premises and vehicles smokefree and 89.3% displaying the correct no smoking signage.[8] This public support is not surprising as in in 2004 the East Midlands undertook a region wide survey titled 'Big Smoke Debate', which asked the public to respond on whether smoking should be allowed to continue in enclosed public places. There was huge interest from the public to the debate with over 24,000 responses collated, 87 per cent indicating that they would prefer public places to be completely smokefree and 82 per cent stating that they would support a law that would make all workplaces smokefree. The Big Smoke Debate was rolled out across the country where public interest continued to grow. Later that year the Government published Choosing Health 'Making Healthier Choices Easier' which outlined a range of initiatives that included a move for smokefree public places.

In 2010 the coalition government launched their Plan, 'Healthy Lives, Healthy People: A Tobacco Control Plan for England', which identified three key ambitions for the next five years. They are to:

- reduce smoking prevalence among adults in England. To reduce adult (aged 18 and over) smoking prevalence in England to 18.5% or less by the end of 2015, equating to around 210,000 fewer smokers a year.
- reduce smoking prevalence among young people in England. To reduce rates of regular smoking among

15 year olds in England to 12 % or less by the end of 2015.

- reduce smoking during pregnancy in England. To reduce rates of smoking throughout pregnancy to 11 % or less by the end of 2015 (measured at time of giving birth).

Lincolnshire's Smoking Prevalence

The majority of smokers start smoking as children or adolescents, before they fully understand the risks of tobacco use, quickly becoming addicted to the nicotine which is as addictive as heroin or cocaine; smoking is a way of feeding that powerful chemical dependence[9] rather than it being a matter of choice.

Nationally, two-thirds of current smokers say that they want to quit smoking, with three-quarters reporting that they have attempted to quit smoking at some point in the past.[10] Market research conducted in July 2012 by the local stop smoking service asked 47 people how they felt about quitting smoking, each of them having different motivations for quitting e.g. cost or health reasons. The responses were varied, with many of these smokers acknowledging that it would be a difficult process. However, equally as many were confident that they could kick the habit.

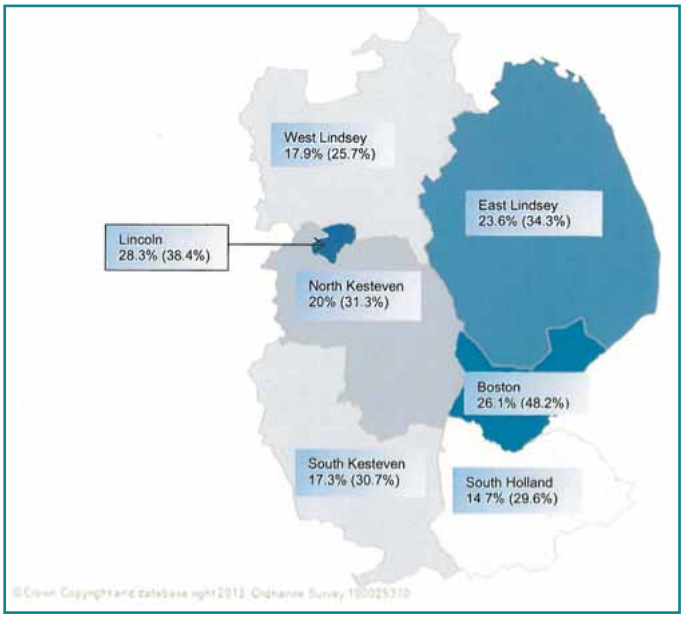
Smoking prevalence continues to fall decade by decade, but Lincolnshire's smoking prevalence of 21% is still higher than England and the East Midlands' average of 20%. Within Lincolnshire's routine and manual (R & M) occupational groups, smoking prevalence is higher still at 33.5% compared to 30.3% and 29.5% respectively. The figure 2.2 shows the difference across the districts, (the bracketed figures relate to R & M groups).[11]

Smoking prevalence is higher in areas such as Lincoln City, Boston and East Lindsey, areas with higher deprivation and greater health inequalities than other parts of the county. These are further exacerbated by smoking and associated ill-health. Targeted activity to focus on these areas of highest need is pursued and monitored closely, but more work is needed to identify health champions who can support their communities by signposting to services and aiding access to specialist support.

Smoking in pregnancy was identified as an area of concern which prompted the development of a working group. Consisting of commissioners, Phoenix NHS stop smoking service, midwives and others, they meet to tackle the disproportionally high smoking prevalence in this target group. Reported at 18.1% in 2011/12 the prevalence has recently been reported to have fallen to 13.7% in 2012/13 in line with the England average. It is difficult to align this fall in reported smoking at time of delivery (SToD) directly with the work of the group. However, the consistent approach used by our midwives in engaging constructively in

conversation about the effects of carbon monoxide (CO) and smoking on their unborn baby may be having an effect. Routine CO testing throughout the women's pregnancy; changing the access into the service by having a stronger physical presence in the hospital; and an earlier antenatal pathway to smoking cessation may be playing a part. As part of their initial work, the group have been able to use provisional data supplied by United Lincolnshire Hospital Trust (ULHT) to identify the smoking prevalence for each of the three hospital sites in Lincolnshire, which showed that Boston's Pilgrim Hospital had the biggest issue with pregnant women smoking, with figures in 2011/12 showing prevalence at 29%. However this too appears to be improving with latest figures for Boston in 2012/13 reported as 23.6%.

Figure 2.2 Lincolnshire's Smoking Prevalence



Source: LRO. Crown Copyright and database right 2013 Ordinance Survey 100025370

Areas of Activity – Six Strands for Tobacco Control

Lincolnshire's "Smokefree Lincs Alliance" sets out to achieve the government's ambitions through the development of a five-year strategy, using the six internationally recognised strands for tobacco control and mirroring global aims:

- Reducing exposure to secondhand smoke.
- Helping tobacco users to quit.
- Effective communication for tobacco control.
- Stopping the promotion of tobacco.
- Making tobacco less affordable.
- Effective regulation of tobacco products.

Reducing Exposure to Secondhand Smoke The majority of smokers start smoking as children or adolescents and it is recognised that children who grow up in a smoking environment are three times more likely to take up smoking themselves. It is also known that children who grow up in an environment free from smoke are more likely to remain smokefree. Evidence suggests that people who live in the most deprived areas on limited income are more likely to smoke and be heavier smokers. Lincolnshire Smokefree Homes programme, established in 2004, targets the most deprived areas of the county. Working through children's centres it targets young families who are at most risk of living in a smoking household. With over 23,500 homes across Lincolnshire registered, protecting just over 24,000 children, this is the biggest and one of the most effective programmes across the country, and has been cited in a number of national reports, including the government's 'Healthy Lives, Healthy People' paper.

Helping Tobacco Users to Quit The Phoenix NHS stop smoking service has undergone a number of changes over recent years. Although numbers accessing the service have recently declined, the success rate of smokers once into the service continues to remain high with over 54% still not smoking when measured at four weeks. 12,076 smokers have successfully quit smoking using Phoenix in the past two years, with 22,108 attempting to quit and setting a quit date. Based on current population figures, Lincolnshire has in excess of 130,000 adult smokers and yet the service only reaches a small proportion of these. Smokers are four times more likely to quit smoking if they access help from a stop smoking service rather than trying to quit on their own, and the Phoenix quit rate of 54% is in excess of national expectations. Services need to understand why most smokers choose not to use them and instead opt for a less effective form of quitting smoking. Armed with this information services can begin to target smokers more effectively.

Effective Communication for Tobacco Control Significant investment by the Department of Health (DH) over the last decade has raised awareness of the dangers associated with smoking and secondhand smoke. Information on how young people are targeted through marketing and their ease of access to tobacco, has resulted in a range of legislative changes to the advertising of tobacco products, age of sale for tobacco, smokefree workplaces and enclosed public places, and the sale of tobacco from vending machines. Because of the complex nature of some of the legislation, this has created a need for additional support for workplaces - specifically small to medium enterprises (SMEs) - that do not have the capacity to interpret the finer legislative details required to ensure their compliance. This has resulted in the development of a workplace toolkit that is circulated upon request which has been circulated to over 1,000 local businesses.

Stopping the Promotion of Tobacco The growing issue of children smoking, particularly young girls, has led to the development of a young persons' programme, 'Teens in Charge of Tobacco (Tic Toc)'. The programme is led by a young persons' specialist who works predominantly with

groups that support more disaffected children. However, this support has also been sought by schools experiencing issues with smoking. Many schools exclude children who are caught smoking on their premises, which impacts on the child's education and social well-being. In response to this increasing demand for support, a policy guidance document (Clean Air Award) has been produced. It conforms to all legislative requirements and helps organisations produce policies and initiatives that support healthier choices by young people. This has led to the production of a range of educational tools that can be used in primary, secondary and higher education, including lesson plans and modules that lead to a qualification in tobacco control (equivalent to an NVQ level 1 or Grade D GCSE). The specialist has also looked at ways to reduce the number of exclusions for tobacco offences. Working with partners these tools have expanded to an online professional development module aimed at people working with children who smoke.

Making Tobacco Less Affordable Illicit and counterfeit tobacco has been an increasing problem across areas of Lincolnshire. Local awareness campaigns have resulted in a growth of local intelligence reports which have helped Lincolnshire Trading Standards target their work more effectively and has culminated in recent joint operations with Lincolnshire Police and the UK Border Agency, making significant inroads in disrupting the supply chain.

Effective Regulation of Tobacco Products Lincolnshire's partnership approach has been the major factor for the breadth of successful outcomes, including criminal action being brought against traders in illegal products. Most recently a trader in Boston was fined £5,000 and given 270 hours of community service under product safety regulations. 'Jin Ling' a tobacco product with no legal trade in the UK and which is not regulated against any standards, had previously been found at a major house fire in the county that resulted in the death of its occupant. Legislation that came into force in November 2011 stated that all cigarettes sold in the European Union should be compliant with 'Reduced Ignition Propensity' regulations. 'Jin Ling' does not comply with this legislation.

Challenges

In 1974, the adult smoking prevalence was 40%[12] falling steeply to 25% by the early 2000s due to public awareness campaigns, publication of evidence and the introduction of a variety of legislation to restrict the advertising, sale of tobacco and where smoking may occur. This has resulted in a further reduction in national smoking prevalence to the current rate of 20%. The majority of smokers have got the message and have quit or attempted to quit. Of the smokers that remain, 70% of them want to quit. However, these smokers tend to be the more entrenched and highly addicted smokers. Our challenge is to find the balance between reaching and engaging with these smokers, without making them feel vilified and further victimised for their addiction.

Despite best efforts, young people are still taking up smoking. 207,000[13] children aged 11 – 15 start smoking every year in the UK. The challenge is how to deter today's young people from smoking.

Some success over the past two years has been seen following illicit and counterfeit public awareness campaigns in the county. Intelligence reports to Lincolnshire Trading Standards increased by 80% as a result of the campaign when compared with the previous year. However we need to continue to raise the profile of illicit and counterfeit products to encourage a better understanding of the problems they cause, both in terms of the link with criminal activity and also a change in social attitudes. The use of illicit and counterfeit tobacco has significant detrimental social and economic impact on society, and for the smoker can seriously damage their long-term health.

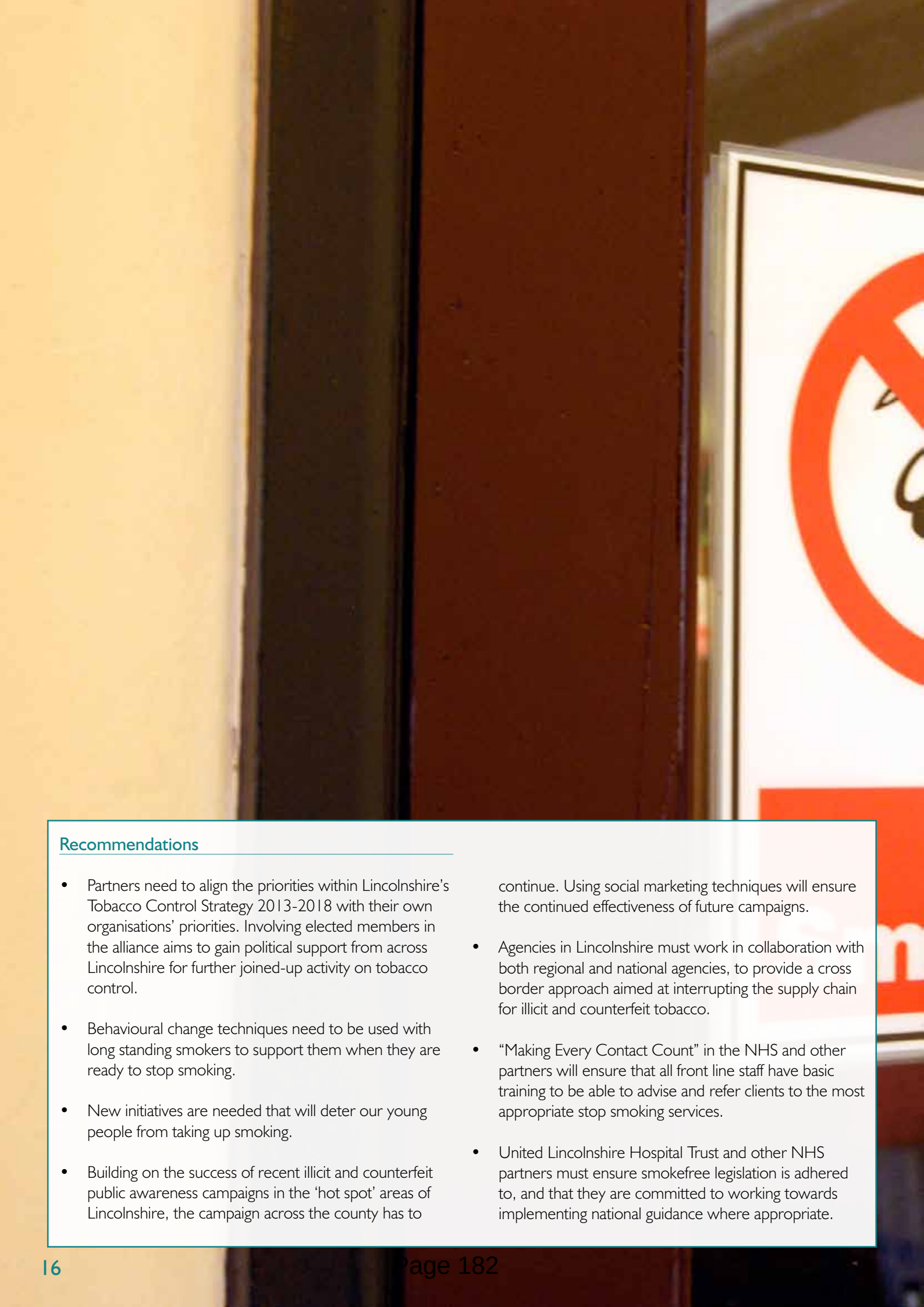
Despite success in disrupting the illicit market through joint operations between Lincolnshire Trading Standards, Lincolnshire Police and UK Border Agency, the ease of supply of illicit and counterfeit tobacco to smokers continues to be a problem. We need to build better links with regional and national colleagues working across borders to disrupt and, if possible, take out the supply chain to our communities.

All front-line staff, particularly in the NHS, need to have the confidence and skills to discuss smoking and be able to provide brief advice and refer effectively.

The implementation of the Health Act 2006, which prohibited smoking in enclosed public places and workplaces, has been viewed as a success in Lincolnshire with few instances of non-compliance. It is important that partners in enforcement roles are proactive in supporting this piece of legislation. NHS colleagues must address the particular challenges of smoking on hospital sites.

Conclusion

Lincolnshire has had many successes over the years in the field of tobacco control. In 2013, the partnership's work contributed to a million smokers quitting and winning an award for the fourth year running in the British Heart Foundation's No Smoking Organiser of the Year competition. Additionally, their work has been cited in major reports and documents. The past decade has seen significant positive change in the public attitudes and behaviour around smoking and this has led to the implementation of a much broader range of legislative restrictions than would have been thought possible just 15 years ago. Public support has been essential in ensuring the success of tobacco control activities. The value of supporting people with resources and information to make an informed choice, is evidenced by the reduction in Lincolnshire's smoking prevalence from 25.8%[14] in 2001-03 to 20.98% in 2011-12, in line with national figures.



Recommendations

- Partners need to align the priorities within Lincolnshire's Tobacco Control Strategy 2013-2018 with their own organisations' priorities. Involving elected members in the alliance aims to gain political support from across Lincolnshire for further joined-up activity on tobacco control.
- Behavioural change techniques need to be used with long standing smokers to support them when they are ready to stop smoking.
- New initiatives are needed that will deter our young people from taking up smoking.
- Building on the success of recent illicit and counterfeit public awareness campaigns in the 'hot spot' areas of Lincolnshire, the campaign across the county has to continue. Using social marketing techniques will ensure the continued effectiveness of future campaigns.
- Agencies in Lincolnshire must work in collaboration with both regional and national agencies, to provide a cross border approach aimed at interrupting the supply chain for illicit and counterfeit tobacco.
- "Making Every Contact Count" in the NHS and other partners will ensure that all front line staff have basic training to be able to advise and refer clients to the most appropriate stop smoking services.
- United Lincolnshire Hospital Trust and other NHS partners must ensure smokefree legislation is adhered to, and that they are committed to working towards implementing national guidance where appropriate.

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Chapter 3
Public Health and Spatial Planning

'Too often we intervene too late in the pathway to ill health and forget that health starts where we live, learn, work and play. Research has shown that the key to foster good health is to build preventative services which address these wider determinants of health and take care of our families, our schools, our workplaces and our playgrounds and parks.'

'Intervening in the Social Determinants of Health to Improve Priority Public Health Conditions and Reduce Health Inequalities.' Institute of Health Equity, p3, 2012.[1]

Keeping people healthier for longer should be a core priority for all public services. One of the opportunities afforded by the current NHS reorganisation is with their new resources and skilled staff, for local authorities to focus on public health and work to achieve beneficial outcomes, across different service areas and responsibilities. Nowhere is this more apparent than in the links between spatial planning and public health.

A new beginning? Health & Planning through the ages...

Although the connection is not commonly realised today, the two professions of public health and spatial planning share common foundations, statutes and goals. They were inextricably linked from the 19th century onwards where the practice of public health and modern urban planning arose from the same stimulus, that of the appalling conditions and devastating death rates in the Victorian city.[2]

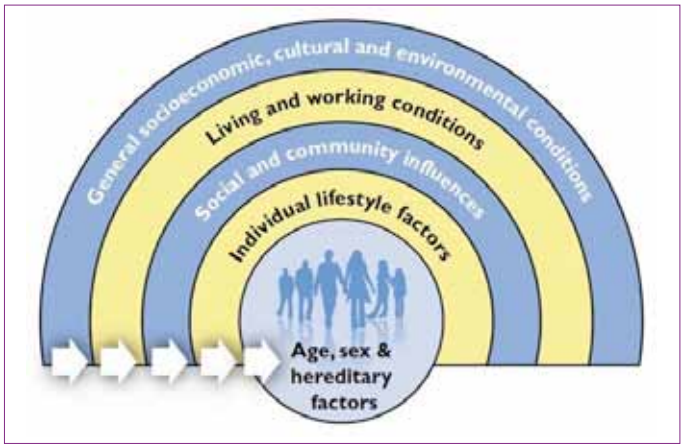
This alliance was to make a far greater contribution than medicine to improving health and increasing life expectancy over the following century. Indeed, most of the fundamental public health challenges of the time were solved by a combined approach of the two, exemplified by the 1875 Public Health Act. This enforced laws about slum clearances, provision of sewage systems and clean water and as a result started to make significant inroads in dreadful childhood and adult mortality levels and suffering from disease. The symbiosis continues today. Many of the issues for which spatial planners are responsible interact with human health, and can, if we get them right, contribute to improving our physical and mental health, and diminish inequalities in health, in Lincolnshire. The infections, respiratory disease and malnutrition of the 19th century have been replaced by heart disease, cancer and obesity today.

Unfortunately, the two professions became distanced from each other and drifted apart throughout the 20th century. Whilst both planners and Public Health professionals today still share a common goal, often this remains unwritten and unrecognised, despite planning policy having shifted from land use designation to one where the full interaction of people and places is brought into account. Spatial planning has at its heart the attempt to manage those very same determinants of health - employment, housing, transport, education and environment. You might expect it to be at the forefront of the challenge to improve health and wellbeing, but this is often not the case. There is strong evidence of a poor level of mutual understanding and weak integration between planning and health professionals and their respective interventions.

A new approach

The core relationship between health and the environment has continued to be explored and shown by research. This is most famously realised by the Social Determinants of Health Model developed in the 1990s by the academics Dahlgren and Whitehead as shown in Figure 3.1.

Figure 3.1: Health Determinants Model



Source: Dahlgren and Whitehead, 1991

In its simplest sense this states that health depends on a person's socio-economic and environmental circumstances, as well as hereditary and personal influences. Individuals are at the centre, with a set of fixed genes. Surrounding them are influences on health that can be modified, such as their housing, education, lifestyle and diet. Recently, the Government has provided more of a legislative and policy base to underpin efforts to reunite the two disciplines:

The National Planning Policy Framework (NPPF) The NPPF was adopted in March 2012 and is the national government guidance for local planners in making plans and assessing development proposals. It requires planners to promote healthy communities, use evidence to assess health and wellbeing needs and work with public health leads and organisations.

The NPPF states that the purpose of planning is to 'contribute to the achievement of sustainable development'. This includes:

- Making it easier for jobs to be created in cities, towns and villages,
- Replacing poor design with better design,
- Improving the conditions in which people live, work, travel and take leisure,
- Widening the choice of high-quality homes.

The NPPF requires planners to consider health in a range of different ways. The framework's presumption in favour of sustainable development highlights the importance of achieving social, economic and environmental objectives. Health cuts across all three. It has a whole section on promoting healthy communities, which states that the planning system can play an important role in facilitating social interaction and creating healthy, inclusive communities. This will include measures aimed at reducing health inequalities, improving access to healthy food and reducing obesity, encouraging physical activity, improving mental health and wellbeing, and improving air quality to reduce the incidence of respiratory diseases.

There are other useful hooks to health in the framework, including promoting sustainable transport, delivering a wide choice of high-quality housing and requiring good design. A core planning principle in the NPPF is for plan making and planning decisions to take account of and support local strategies to improve health, social and cultural wellbeing, and to deliver sufficient community and cultural facilities and services to meet local needs.

The NPPF also requires local planning authorities (LPAs) to work with public health leads, local communities and health organisations to develop a robust evidence base that takes into account future changes and barriers to improving health and wellbeing. In Lincolnshire, the Public Health lead will be located at county level, while most of the planning responsibilities will be delivered by district councils.

The Health & Social Care Act 2012 The Act transferred responsibility for Public Health to Lincolnshire County Council from April 2013. It also required the creation of health and wellbeing boards to bring together key commissioners from the local NHS and local government to plan local health and social care services strategically.

As well as, creating the boards, the Act requires an assessment of the relevant health and social care needs of the area through a Joint Strategic Needs Assessment (JSNA) and formulating these needs along with views gained from the local Lincolnshire community into the Joint Health and Wellbeing Strategy (JHWS – see right).

Health and wellbeing boards are responsible for:

- Assessing the current and future health and social care needs of the local community in the JSNA and develop strategies to meet those needs and reduce inequalities in the JHWS.
- Promoting integration and partnership working between the local NHS, local government and other local services.
- Improving democratic accountability for the planning of local health services.
- Bringing oversight and strategic planning to major service redesign.

The Localism Act 2011 This Act gives more power to neighbourhoods, including provisions for neighbourhood planning. The Act also introduced a raft of other changes that have implications for improving health.

The aforementioned NPPF links with this localism agenda through specifying the importance of responding to local views and for consultation/ engagement to occur with local communities.

The role of local planners to establish local housing needs is more critical now that there is a decentralised system of housing needs assessment and allocations through the local plan (previously these were allocated through regional strategies).

Taken together these reforms strengthen the argument for recognising and valuing the influence that planning, housing and other environmental functions have on improving health and wellbeing and reducing health inequalities.

Lincolnshire Joint Health & Wellbeing Strategy 2013-2018 (JHWS)

The first Lincolnshire JHWS has a specific theme on tackling the social determinants of health (Theme 5). This has as an outcome improving people's health and well-being through addressing wider determining factors of health that affect the whole community. This includes proposed action on local housing to ensure that people have access to good quality, energy efficient, 'decent' housing that is both affordable and meets their needs.

A home is defined as 'decent' if it meets certain standards, including a reasonable degree of thermal comfort, a reasonable state of repair and reasonably modern facilities. The percentage of private rented and owner occupied homes in Lincolnshire estimated to be considered as "non-decent" has increased between 2007 and 2009 by 15%. The increase ranges from 19% in Boston to 8% in West Lindsey. The highest percentage of homes estimated as non-decent in 2009 was in East Lindsey (52%).

The Public Health Outcomes Framework

The Public Health Outcomes Framework sets out a vision for public health, desired outcomes and the indicators that will help us understand how well Public Health is being improved and protected.

The Public Health Outcomes Framework sets the context for our county to decide what public health interventions they will make. It sets out two overarching outcomes:

- Increased healthy life expectancy.
- Reduced differences in life expectancy and healthy life expectancy between communities.

The framework has four domains with supporting indicators, as shown in Table 3.1; the influence of planning cuts across all four domains.

Table 3.1: Public Health Outcomes Framework domains

Domain	Indicators relevant to planning
Improving the wider determinants of health	• Killed or seriously injured casualties on England's roads • Utilisation of green space for exercise/ health reasons • Fuel poverty • Older people's perception of community safety (this is a 'placeholder' indicator, which means that major work is still required to develop the rationale and technical information)
Health Improvement	• Excess weight in 4-5 and 10-11 year olds • Excess weight in adults • Proportion of physically active and inactive adults • Self–reported wellbeing
Health Protection	• Air pollution • Public sector organisations with board-approved sustainable development management plan
Healthcare public health and Preventing premature mortality	• Mortality from respiratory diseases

Source: Public Health England, 2013

Practical steps to progress - What planners and Public Health specialists can do

To recap, public health and planning were closely associated a century or so ago. It remains true that much of the role of planning is to promote health and wellbeing, even if that has not been made so explicit in recent decades. So, although not new territory for either profession, there is still much that can be gained by working together and working within the new systems and structures.

Table 3.2 lists some of the key actions that both planners and Public Health specialists can undertake to progress this area of work. This is taken from a document from the Town and Country Planning Association.

Table 3.2: Practical steps to reunite health and planning

What planners can do:

- Review the local plan for compliance with NPPF health policies
- Engage Public Health on major planning applications
- Involve health in infrastructure planning
- Conduct health impact assessments (HIAs)
- Measure planning's influence on health and wellbeing outcomes

What Public Health specialists can do:

- Focus on topics that matter locally
- Understand the role of elected members
- Engage with a variety of stakeholders

What planners and Public Health specialists working together can do:

- Encourage your directors
- Help elected members to understand the links between planning and public health
- Develop a collaborative evidence base
- Engage clinical commissioning groups (CCGs)
- Improve how you communicate

Source: Reuniting Health with Planning – Healthier Homes, Healthier Communities, TCPA, July 20123

Local action in Lincolnshire

The Public Health directorate in Lincolnshire has been and is very active in continuing to promote and drive the health and planning agenda in the county. Although we remain very keen to work with our planning colleagues across all 7 of the district councils in Lincolnshire we have, by necessity of resources, been attempting to trail blaze and create a robust and practical operational model with the Central Lincolnshire Joint Planning Unit (JPU) which develops joint planning policy for West Lindsey and North Kesteven District Councils and City of Lincoln Council with Lincolnshire County Council.

Initially, both Public Health locally and the JPU worked on developing an integrated impact assessment methodology. The integrated impact assessment (IIA) expands the scope of a (statutory) sustainability appraisal to include local health and equality impacts. Officers from the JPU have undertaken the IIA on draft policies. These assessments have then been reviewed by an independent IIA panel established by the JPU, which as well as including a representative from the neighbouring area of South East Lincolnshire (South Holland District and Boston Borough Councils), has also included, for the first time, a Consultant in Public Health from Lincolnshire County Council and a member from the equalities teams at West Lindsey District, North Kesteven District and City of Lincoln Councils.

The IIA approach has been welcomed by all partner agencies in the county as a first step for improving health considerations in the planning process. The Central Lincolnshire Joint Strategic Planning Committee – which includes councillors from the county council and the three district councils – feels it is more user friendly compared with receiving multiple impact reports, and is a more efficient use of officer time.

In the longer term, the aim is to introduce a scheme, currently running in other areas across the UK that requires developers of schemes/projects over a certain threshold to more formally assess the impact (positive or negative) on the population's health and wellbeing through an enhanced Environmental Impact Assessment (EIA) or a separate Health Impact Assessment (HIA).[3]

Lincolnshire Public Health has also continued a fruitful relationship with the Town and Country Planning Association (TCPA). Local contribution was keenly welcomed for their initial national publication on this issue ('Healthier Homes, Healthier Communities' TCPA, July 2012) this is now being followed up throughout this year with more detailed work with key organisations and councils across the county. In September, a joint event was held with the TCPA at North Kesteven District Council which achieved good support, buy-in and dialogue from partners with an aim to build on this in the future.

Public Health England (PHE) have also been taking an interest in health and spatial planning nationally, and have recently set up a professional working group with planning colleagues and PH professionals to develop this agenda. Lincolnshire Public Health colleagues and their ideas are at the forefront of driving this group with lead discussions at PHE Chief Executive level, workshops, seminars and a role in shaping what local support from this body might look like.

Additionally, links with colleagues in Public Health in the West Midlands and their healthy urban development centre. This has resulted in the creation of, again in collaboration with PHE, a wider 'Midlands' learning and sharing network which is open to all professionals in Lincolnshire as another way of developing links and learning.

Finally, Public Health has a role in advocating the formal links between Development Management planners and our[4] four Clinical Commissioning Groups (CCGs) now they are firmly established. Under Local Planning Regulations (2012), both CCGs and NHS England are statutory consultees in local development proposals, and it is therefore vital these links are robustly developed and maintained in Lincolnshire.

These developments, although welcome, are only the first step in the process of reuniting the two professions more fully and achieving the outcomes for health and wellbeing this will bring. We still have a long way to go to meet or exceed the national exemplars in this area such as South Cambridgeshire, Essex or Bristol City, where planning and public health departments overlap, albeit in a unitary authority system, to achieve a seamless transition and added value of the two.

With the two-tier council structure in Lincolnshire, Public Health is both physically and operationally separated from local planning departments in the district councils and therefore good communication and partnership working will be vital in this area. There is still much to be done in promoting and working with our local district councils and, so far, it has been difficult to engage district council planning colleagues in the south-west and coastal areas of the county.

Recommendations

- CCGs and district councils need to develop good communications so that they can work in a timely, thorough and linked way over local planned developments.
- Organisations in Lincolnshire, with responsibility for health and planning need to continue to work regionally and nationally to remove barriers to improving health through spatial planning.

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Chapter 4
Public Health Skills Training

The Health and Social Care Act 2012 set out significant changes to the Public Health system, with the goal of transforming Public Health in this country and achieving a stepchange in outcomes for the population. It is recognised that the transformation cannot be achieved without the right workforce, in the right place, with the right skills. Delivering the government's Public Health aspirations requires a well skilled and competent workforce, which includes not just Public Health specialists and practitioners but also the wider Public Health workforce across health and local government. There is a consensus that success depends on everybody recognising that Public Health is their business, and that a good place to start is by developing the workforce to value their own health and to be developed to support the public in achieving the same goals.[1]

'Healthy Lives, Healthy People: a public health workforce strategy' defines the vision for the public health workforce (Figure 4.1).

Figure 4.1 The vision for the Public Health workforce

The public health workforce will be known for its:

- **Expertise.** Public Health staff, whatever their discipline and wherever they work, will be well-trained and expert in their field, committed to developing and maintaining that expertise and using an evidence based approach to practice.
- **Professionalism.** They will demonstrate the highest standards of professional conduct in their work.
- **Commitment to the population's health and wellbeing.** In everything they do, they will focus on improving and protecting the health and wellbeing of their populations.
- **Flexibility.** They will work effectively and in partnership across organisational boundaries.

There is no better time to join in the effort to promote and protect population health. From growing rates of obesity to bio-terrorism and the advent of new diseases Public Health issues appear regularly on the front pages of our newspapers.

What is Public Health?

Public Health is defined as:

"The science and art of preventing disease, prolonging life, and promoting health through the organised efforts of society."[2]

Unifying principles of public health are its essentially "public" nature and the fact that it is mainly focused on the health of the whole population.

Public Health looks at the causes of ill health and disease in populations and it is at the forefront of tackling the social determinant factors that influence health and lead to health inequalities, such as differences in life span or infant deaths. Public Health practice depends on good evidence. Evidence-based practice builds on epidemiological analysis to help us understand what makes an effective policy, programme or intervention, in terms of its impact on people's health and wellbeing.

In the nineteenth century, the emphasis was on introducing legislative measures to improve sanitation and poor housing. In the twentieth century, this changed to tackling infectious diseases and introducing widespread immunisation and vaccination programmes. The focus in the early twenty-first century is on tackling inequalities in health and promoting healthier lifestyles.

What do we mean by Public Health workforce?

The Public Health workforce in England is best described in terms of:

The Public Health Specialist workforce

This group includes consultants in Public Health medicine and specialists in Public Health who work at a strategic or senior management level or at a senior level of scientific expertise to influence the health of a whole population.

Public Health consultants must look at 'the bigger picture' and then take action to promote healthy lifestyles, prevent disease, protect and improve general health, and improve healthcare services. At this level, an ability to manage change, lead Public Health programmes and work across organisational boundaries is crucial as are technical skills in epidemiology, health promotion and healthcare evaluation.

The Faculty of Public Health oversees the quality of training and professional development of Public Health consultants in the UK, and maintains the professional standards in the discipline.

The Public Health Practitioner workforce

Members of these professional groups spend all or a major part of their time in Public Health practice. They work in multi-professional teams and, in addition to those working within defined Public Health directorates supporting the senior staff, they also include those that work with groups and communities and with individuals, such as health visitors, environmental officers and community development officers.

Particular capabilities for this workforce include effective partnership working and education competencies to develop the skills of the wider workforce so that they can support people in making healthy lifestyle choices and information analysis.

The wider workforce

This group includes those who have a role in health improvement, protecting health and reducing inequalities but who would not necessarily regard themselves as part of the Public Health workforce. Many people make a contribution to the health and wellbeing of others in their daily lives without realising it. This may be, for instance, as a carer, a volunteer, or as part of a workforce not traditionally directly associated with health and wellbeing such as teaching or spatial planning. For example, town planners can have a significant impact on the whole population, since urban design has been shown to influence the type and extent of exercise that people take. Voluntary organisations too are often involved with groups in society who have the worst deprivation and health inequalities.

Barton and Grant and the UKPHA strategic interest group (2006) developed the health map[3] based on Dahlgren and Whitehead's earlier model (Dahlgren and Whitehead 1991) which shows how individual determinants, including a persons age, sex and hereditary factors, are nested within the wider determinants of health which include lifestyle factors, social and community influences, living and working conditions and general socio-economic cultural and environmental conditions.

Figure 4.2 shows an adaptation of Barton and Grant highlighting samples of workforces that have a potential to influence determinants of health and which are considered part of the wider Public Health workforce.

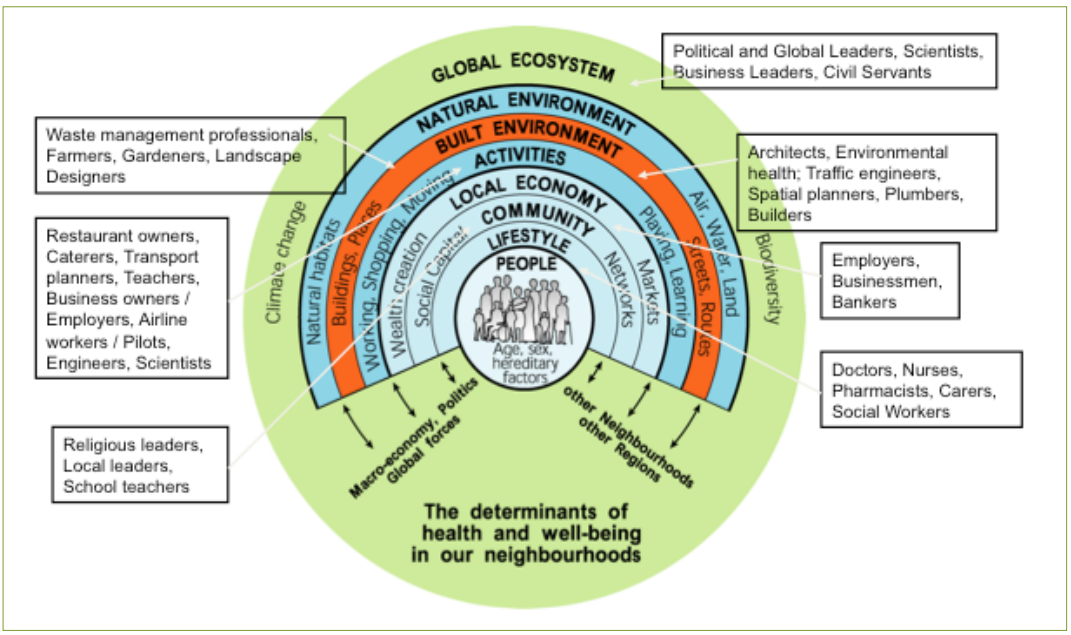
It is now accepted that improving Public Health requires strengthening both the capacity and the capability at the levels of the wider workforce, Public Health practitioners and Public Health specialists.

Public Health Skills and Knowledge Framework

Much of the current work in Public Health workforce development nationally has been based on the original Public Health Skills and Career Framework (PHSCF)[4] which was launched in 2008. As there have been considerable changes in Public Health and the Public Health workforce, the Department of Health recently commissioned a refresher of this framework, the result of which is the new Public Health Skills and Knowledge Framework (PHSKF).[5]

The new framework applies to the whole of the Public Health workforce, in whatever sphere they may be working or however they may be making a contribution to the public's health. It outlines in simple language the skills and knowledge that the workforce need in order to make a difference and it provides a unifying context for a workforce that is dispersed across many organisations such as health and social care organisations, local authorities and the third sector.

Figure 4.2 A sample of Workforce with the potential to influence the determinants of health



Source: The Health Map, Barton & Grant 2006 based on a Public Health concept by Whitehead and Dahlgren. The Lancet 1991.

Skills and knowledge are split across the four core areas of Public Health practice, which anyone working in the field of Public Health will need to have, as well as the five specific areas of practice within which individual practitioners will develop and work.

Core Area	Non-core (defined) areas
1. Surveillance and assessment of the population's health and wellbeing	5. Health improvement
2. Assessing the evidence of effectiveness of interventions, programmes and services to improve population health and wellbeing	6. Health protection
3. Policy and strategy development and implementation for population health and wellbeing	7. Public Health intelligence
4. Leadership and collaborative working for population health and wellbeing	8. Academic Public Health
	9. Health and social care quality

Figure 4.3 Public Health Skills and Knowledge Framework (2013)

The framework consists of nine levels from level 1 where people have little previous knowledge, skills or experience in Public Health to level 9 where people will be setting strategic priorities and direction and providing leadership to improve population health and wellbeing. The diagram in Figure 4.3 captures this.

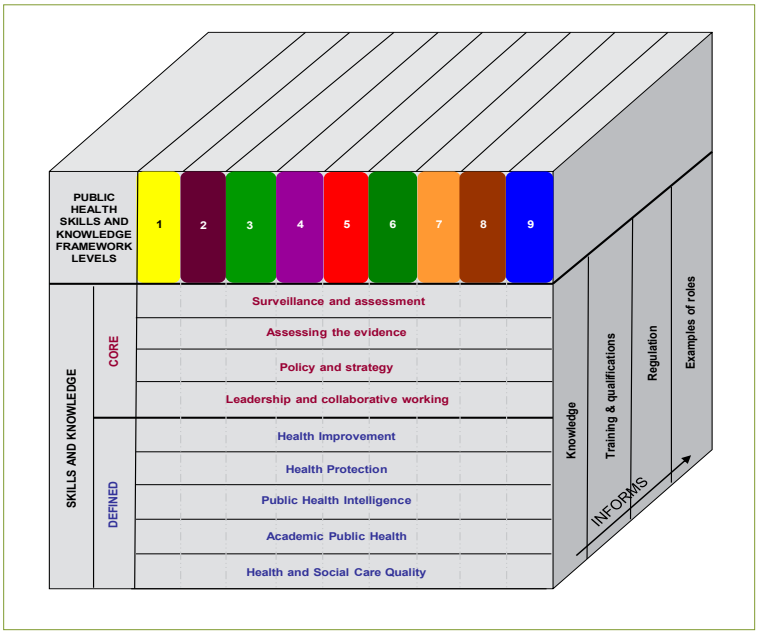
The framework is there to support Public Health development and should be used in conjunction with other frameworks specific to different organisations and employers to help inform where Public Health skills and knowledge can enhance delivery of Public Health outcomes and where additional training of staff may be of benefit.

The most comprehensive information about Public Health skills and careers for all levels (including examples of career stories) is currently found at www.phorcast.org.uk.

Developing the wider Public Health workforce

Effectively addressing social determinants of health requires multisectoral action across government and society. This includes strengthening the wider Public Health workforce and engaging citizens, politicians, service providers, policy-makers, the media, planners and commissioners of health and social care. Also, the importance of community resilience, the quality of social networks and strengthened participation in decision-making for health and wellbeing is increasingly recognised.

Current Public Health challenges require a paradigm shift in the way we live. We need to create an environment which positively influences health and wellbeing, supporting behaviour change in the wider workforce (see pictures overleaf).



Source: PHORCaST.org.uk (2013) and adapted from original PHSCF (2008)

We need to create an enviorment which positively influences health and well-being

Supporting behaviour change in the wider workforce

We need to change our norms...

from this → *to that*

The health map of Barton & Grant in Figure 4.1 illustrates why the social determinants are of such relevance to local government. The majority of local government services impact upon or can influence the conditions in which people live and work and, to a certain extent, the life chances of individuals.[6]

Examples of how local government, the NHS and the third sector can contribute to the wider Public Health workforce:

Local government:

- as the commissioner of children's services, makes a huge contribution to the social, mental and physical wellbeing of young people. It provides them with vital skills and social capital which lead to better life chances as they grow up.

- as a planning authority, can do a great deal to plan for healthy environments; not just those which promote physical activity but also those that promote mental wellbeing by including green space and opportunities to interact with others.

- as a provider and commissioner of leisure and cultural services, can influence health not simply through offering activity and promoting healthy lifestyle but also in the way culture shapes an area and the communities within it.

The health sector also has a big role to play. For instance, nurses have a long history of contributing to the Public Health agenda, but it is generally recognised that the Public Health role of nurses need strengthening. Until now, it has been predominantly those working within community settings who have been acknowledged as key contributors to Public Health. However, all nurses can participate in improving health.

Third sector organisations are often involved with groups in society who have the worst deprivation and health inequalities and very often their activities can lead to great health benefits. Their role in raising awareness of healthy lifestyles, helping navigate through services and championing wellbeing is crucial. Supporting them in their wider Public Health role and equipping them with the right skills is essential.

Developing the wider Public Health workforce in Lincolnshire

In addition to our internal directorate programme that helps and supports our specialists and practitioners to develop and maintain the behaviours, competencies and technical skills, much of our work in the directorate has an impact on the development of the wider workforce. An example is illustrated in chapter three of this report (Public Health and Spatial Planning).

The blue print from the Lincolnshire Sustainable Services Review (LSSR) puts prevention at the heart of the review:

"A health and care system that works in a joined up way, focuses on the prevention of ill health, coordination of care and improves clinical and personal outcomes and goals, with quality driving efficiency."[7]

The Lincolnshire Health and Wellbeing Board is in an unique position to influence the wider determinants of health and help build the wider Public Health capacity needed to improve outcomes and services for the local community.

Public Health is everybody's business and not just the role of our Lincolnshire Public Health team. Both as workers and as citizens we all have a part to play in health improvement (Figure 4.4).

Figure 4.4 Key transferable skills relevant to our entire workforce:

- Assessing your own health behaviour.
- Communicating health information fairly and effectively.
- Respecting people's right to make their own decisions.
- Recognising and using opportunities to promote your own and other people's health and wellbeing.
- Recognising and using opportunities to assist your organisation in becoming healthier.
- Recognising and preventing adverse effects on people's health and wellbeing.

Recommendations

- "Prevention is better than cure" must remain one of the core principles that will drive the implementation of the Lincolnshire Sustainable Services Review blueprint going forward. The understanding of the entire Lincolnshire health and social care workforce of their contribution to 'make every contact count' is crucial if we are to be successful at improving integrated health and social care outcomes across Lincolnshire.

- Develop an approach that recognises that the whole of the public sector workforce are potential contributors to Public Health and increases awareness across all workforces and making sure they have the skills to inform decisions and choices.

- Every local authority chief executive and every director of a council department should regard themselves as having as much responsibility for the health of the population they serve as they do for their own named service area, be it transport, environmental services, children's services, urban or rural planning or sports and cultural services.

- Develop the role of the Public Health practitioner as educator of the wider workforce so capacity for promoting healthy lifestyles is optimised.

- Introduce health improvement courses for partners in health (including local authority colleagues, NHS and voluntary sector) that will provide the participants with the knowledge, skills and language to promote health within their organisation roles and ideally to be delivered as part of the council's corporate training function.

- Shift culture across health and local authority workforce so improved support is offered to citizens to take greater responsibility for their own healthcare and wellbeing.

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Chapter 5
Protecting the Health of the People of Lincolnshire

The Health and Social Care Act 2012 has fundamentally changed the way the NHS in England is organised and run. The driving force behind these changes focuses on quality and improving the quality of care for service users. The NHS is organising itself around a single definition of quality: care that is effective, safe and provides as positive an experience as possible.

This relentless focus on quality means a persistent emphasis on how we can positively transform the lives of the people who use and rely on Lincolnshire services. In contrast, a failure to focus on quality and to make it a primary concern can result in lasting emotional and physical damage, even death, to service users. The failures at Mid-Staffordshire NHS Foundation Trust and at the independent hospital, Winterbourne View, provide stark reminders that when we fall short on our responsibilities in respect of quality, the consequences can be catastrophic.

Health Care Associated Infection (HCAI)

Healthcare Associated Infections (HCAIs) are infections which develop as a direct result of healthcare interventions. HCAIs can be acquired from any place where healthcare is delivered e.g. hospitals, care homes, dental surgeries, and general practice surgeries, including patients' own homes if healthcare is delivered there. HCAIs can result in prolonged hospital stays, long-term disability, increased resistance of microorganisms to antimicrobials, additional costs for health systems, high costs for patients and their families, and unnecessary deaths.

Two of the most common HCAIs are Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium difficile (commonly known as C diff). MRSA is a common bacteria carried by around one in three healthy people; usually on their skin or in their nose. In most cases, it is not harmful but MRSA can cause local infections such as boils and abscesses and may cause wound infections, particularly at surgical sites and where catheters and drips have been put in place. In some cases, it can cause more serious blood stream infections (bacteraemia) which can be life-threatening. C diff is one of the 'normal' bacteria in the gut in up to 3% of healthy adults and is usually kept at bay by all the other bacteria there. With vulnerable people, such as older people and those with a long term illness, it can cause severe diarrhea and in some people, inflammation of the bowel. Prescribing antibiotics in these vulnerable groups can upset the balance of the gut bacteria and when this happens, the C diff bacteria can rapidly multiply, causing complications. Both infections can be spread by hands, equipment and the environment.

Tackling preventable HCAIs is one of the Government's key priorities. From the current financial year there is a zero tolerance of MRSA blood stream infections.

Progress with reducing HCAIs in Lincolnshire

Within Lincolnshire, the number of C diff infections reported each year has reduced from 296 cases in 2008/9 to 131 cases in 2012/13; a decrease of 56%. This is a greater reduction of cases than that achieved by the East Midlands as a whole (52%), but a slightly lower reduction than that achieved by England as a whole (59%).

Locally, the number of MRSA bacteraemias reported each year has reduced from 32 cases in 2008/9 to 8 cases in 2012/13; a decrease of 75%. This decrease is slightly less than that seen across the East Midlands as a whole (80%), but a greater decrease than that achieved by England as a whole (69%).

Progress in this area is good but the consequences of HCAIs are still being felt by our patients and residents.

Responsibility

The Director of Public Health (DPH) has a statutory responsibility 'to be assured' that infection prevention and control systems and processes across the health and social care economy are safe and effective. The patient/service user journey can move across primary, secondary, tertiary care and social care, and could include contact with multiple professionals. It is a collective endeavour, requiring collective effort and collaboration at every level to share information, address concerns and raise standards across Lincolnshire.

Through the Public Health core offer, the Health Protection Team provides specialist advice to Clinical Commissioning Groups (CCGs). It is also responsible for the community infection prevention and control (IPC) service. Under the Health and Social Care Act 2012 this is a statutory responsibility of the Secretary of State, which has been delegated to local authorities and Directors of Public Health.

Assurance

The assurance of IPC across Lincolnshire is obtained from commissioners and providers of health and social care through a number of routes which provides greater reliability and a process to 'confirm and challenge'. When assessing the actual standard and level of compliance, all evidence is taken into consideration and a report is

produced that best summarises the findings from that evidence.

The key methods of assurance gathering are:

- Quarterly reports from commissioners of health and social care services with evidence of systems and processes for IPC including areas of non-compliance and concern.
- Monthly reporting by key health providers on compliance with the Care Quality Commission (CQC) IPC standards and surveillance of reported HCAIs.
- Looking for common issues from Post Infection Reviews (PIR) and Root Cause Analysis (RCA) reports for HCAIs so that we can learn and improve IPC processes.
- Findings from CQC visits, IPC team visits and audits.
- Issues raised by a commissioner of health and social care services and complaints or concerns raised by members of the public.

The way forward

An assurance framework and IPC delivery plan is in place. However, IPC remains a significant area of concern, particularly within the social care and residential/nursing home setting. IPC expertise across the health economy needs boosting, even in hospital sites. Across the social and residential/nursing care setting, expertise in this area is extremely limited and I remain unconvinced that providers give it the priority required. Whilst some care home settings have very robust plans and processes in place, there are many that are falling short of the minimum standards required. This puts both patients, clients and staff at unnecessary risk. Consequently, my priorities over the next year are to:

- work collaboratively with IPC colleagues across healthcare settings to increase IPC capacity;
- implement the assurance framework to identify areas for priority action;
- continue to work proactively with colleagues within adult social care and children's services to ensure that IPC is embedded into contractual frameworks and the delivery of social care.

Emergency Preparedness, Resilience and Response

Health Protection sits as one of the three pillars of Public Health with a key aim to prevent or reduce harm caused by communicable diseases and minimise the health impact from environmental hazards such as chemicals and radiation. Within the health community part of this work is referred to as emergency preparedness, resilience and response (EPRR) and ensures that a wide range of incidents with the potential to impact on health or patient care are planned for and responded to.

Prior to 1st April 2013, primary care trusts had the responsibility to co-ordinate a local NHS response to a major incident, taking the lead for the health community including representation at the Local Resilience Forum (LRF) in Lincolnshire. The LRF is a multi-agency partnership involving all organisations required to both prepare for, and respond to emergencies within the county.

These EPRR responsibilities for the NHS now fall to NHS England and the CCGs. As a non-departmental public body of the Department of Health (DH), NHS England was established to design and deliver the commissioning of primary care services using a single operational model, and to lead on some national based functions previously undertaken by the DH.

The local authority still has a responsibility to contribute to health EPRR and this is discharged through the DPH, who as well as taking steps to ensure adequate plans are in place to protect the health of the population, also involves appropriate escalation of any concerns.[1] Recognising the importance of this role for the populations' health protection, the DPH, together with the Director of Operations and Delivery from NHS England, co-chairs the Local Health Resilience Partnership (LHRP). The group provides a strategic forum for local organisations to facilitate the health sector in its preparedness and planning for emergencies. It then links into wider multi-agency emergency planning work, ensuring that the health needs of the population are fully considered at the Local Resilience Forum level.

The DPH has a personal statutory responsibility "to be assured" that health EPRR is effective. This is carried out through a variety of mechanisms. The LHRP produces a three year strategic plan in line with national EPRR priorities for the health sector. Delivery of this plan will be carried out through the operational sub-group who report as a standing agenda item at each meeting.

A set of NHS Core Standards for EPRR have been developed, with guidelines for measurement against standards. All NHS providers are required to demonstrate compliance with these standards, and a national assurance programme is being introduced. For the fiscal year of 2013-14, this programme is limited to acute, community and ambulance trusts. Full inclusion of NHS providers will take place after April 2014.

Opportunities to test the ability of the health sector to respond to emergencies, and to identify any gaps in planning or training are achieved through regular exercising of these arrangements, and 2013 has seen Lincolnshire host two multi agency exercises focusing on different aspects of EPRR.

Exercise Georgiana gave partners the chance to test the county's ability to respond to a major transport accident, one of the enduring risks identified in the community risk register.[2] The exercise simulated a train crash on the east coast main line, and provided the opportunity for all organisations to work together at a local, regional and national level.

With Exercise Georgiana being carried out in May 2013, it offered the ideal platform for the new emergency response arrangements within the health community to be fully tested. Communication procedures, capability and capacity of both new and existing organisations were challenged and new commanders in the health community given the opportunity to test new roles, policies and procedures.

Local authority Public Health staff and Public Health England worked together during the exercise to provide comprehensive Public Health advice and guidance to the community in Lincolnshire.

The exercise gave the DPH assurance that in the event of a major incident, such as a train crash, the health community in Lincolnshire is able to respond in a timely and co-ordinated manner.

Many learning points relating to EPRR arrangements were identified throughout the two days, and a comprehensive action plan has been compiled with realistic time frames and identified lead organisations. This is then reported through the LHRP ensuring appropriate progress is being made. Equally as important as response work is the ability for the county to recover from an incident, often a long and complex process.

Exercise Lazarus, carried out in November of 2013, focused on county's ability to recover from an east coast flooding incident. The DPH co-ordinated the health, social care and education response, identifying key issues and developing action plans to address them.

Again the learning from this exercise has proved invaluable in further developing the health, social care and education recovery plan, and fully understanding how this fits in with multi-agency recovery work. This exercise was unfortunately put into live operation shortly afterwards following coastal flooding in the county on 5 December 2013. The health cell was invoked and demonstrated both a pro-active and dynamically reactive approach to the 'health' response.

Every incident and exercise offers many learning opportunities, whilst providing local assurance on the ability of the health care community to respond when required. Further recommendations include:

- Clarity on the command and control structure for the health response.
- Clear communications strategy for the health community promoting the single clear message before, during and after the emergency.

Sexual Health

Good sexual health is important not only for individuals but also for wider communities. People are entitled to a safe, healthy relationship free of coercion with access to good quality services for contraception and sexual health issues. Communities want to ensure controls are in place to prevent transmission of infection and that the issue of positive relationships and pleasure are as central as the negative aspects of infection, dysfunction, sexual violence and unintended pregnancy. According to the World Health Organisation,[3]

"The ability of men and women to achieve sexual health and well-being depends on their access to:

- *comprehensive good-quality information about sex and sexuality;*
- *knowledge about the risks they face and their vulnerability to the adverse consequences of sexual activity;*
- *their access to sexual health care;*
- *an environment that affirms and promotes sexual health."*

It is therefore important to have access to the right services in the right places supported by a programme of prevention to ensure population needs are met.

In April 2013 the way in which sexual health services were commissioned in England changed. The Health and Social Care Act 2012 mandated Local Authorities, rather than the NHS, to commission comprehensive open access sexual health services. Responsibility for a few services has remained with CCGs and NHS England, such as the sexual assault referral centre and HIV treatment, alongside general contraception within primary care.

There are three indicators within the Public Health Outcomes Framework 2013-1016 which recognise the importance of good sexual health, these are:

- under 18 conceptions;
- chlamydia diagnoses in the 15-24 year age group;
- late diagnosis of HIV.

Lincolnshire has a comprehensive programme which supports continued progress against these areas as well as other features felt locally to be key including reducing rates of undiagnosed STIs, sexual health promotion and access to a wide range of contraception.

Teenage Pregnancy

Teenage pregnancy rates both locally and nationally are at the lowest level since 1969. However, reducing the under-18 conception rate remains a high priority as highlighted in the Public Health Outcomes Framework (2013-16)[4], the Sexual Health Improvement Framework, 2013[5] and the Child Poverty Strategy.

National: 2011 data for England shows the under-18 conception rate is 30.7 per 1000 females aged 15-17, a fall of 10.2% from 2010. The reduction from the baseline year in 1998 of the Teenage Pregnancy Strategy is now 34%.

Regional: The East Midlands rate is now 31.3 per 1000 showing a 36% decrease from the baseline year.

Local: The rate for Lincolnshire is now 32.3 per 1000 indicating a decrease of 35.53% since the baseline year and a 6.1% decline in the last year. The percentage of teenage conceptions leading to abortion in Lincolnshire is 42.1%. Huge improvement has therefore been made locally but there is still work to be done and maintained.

The work needs to continue because *"a teenage pregnancy prevention strategy that seeks to reduce conception rates by a substantial margin cannot concentrate on high risk groups alone. Although certain girls are at much greater risk of conceiving and giving birth as teenagers than others, the majority of girls that conceive do not share these risk factors."* (Teenage Pregnancy in England DfE research report 2013).

We are still only two thirds of the way towards levels experienced by young people in similar Western European countries. The majority of under-18 conceptions are unplanned, with a high percentage leading to abortion and the outcomes for young parents and their children remain disproportionately poor.

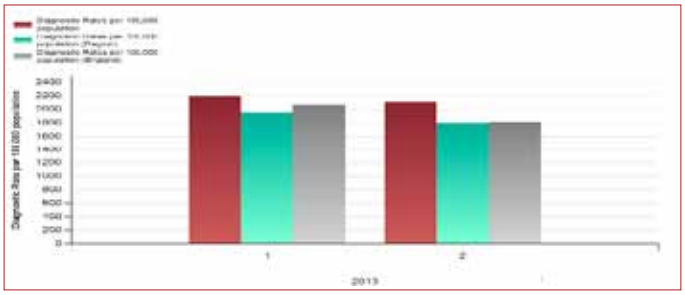
Evidence[6] shows that the most effective ways to reduce the rates is to provide young people with a comprehensive sex and relationships education programme and access to young people-friendly contraception and sexual health services. There is also added value in giving positive messages to young people and open and honest conversations about relationships and sexual health help young people make well informed choices.

Chlamydia Screening

Chlamydia is the most common sexually transmitted infection (STI) in the UK, with sexually active young people at highest risk. As chlamydia often has no symptoms and can have serious health consequences (e.g. pelvic inflammatory disease, ectopic pregnancy and infertility), screening remains an essential element of good quality sexual health services for young adults.

In order to reduce the amount of chlamydia infection in the community it is important to diagnose and treat as many people as possible. The public health outcome indicator for 2013/2016 is to achieve 2,300 diagnoses per 100,000 15-24 year olds.

Figure 5.1 Quarterly Chlamydia Diagnostic Rates for Lincolnshire vs.Midlands and East of England (Jan-Dec 2013)



Data source: CTAD surveillance, Public Health England

During the first half of 2013 Lincolnshire has achieved a diagnosis rate that exceeds the regional and national figures.

General practice has a key role in offering chlamydia screening alongside contraceptive and sexually transmitted infections advice. The 3Cs & HIV Programme is a Public Health England initiative to support general practices to make a basic sexual health offer during routine consultations:

- '3Cs' – offering a chlamydia screen, signposting or provision of contraceptive advice and free condoms to young adults (15 – 24 years old).
- HIV – offering testing to adults (≥ 16 years) in line with current clinical guidelines.

An initial pilot has been shown to increase general practice screening test rates by 76% and chlamydia diagnoses by 40% according to new research on sexually transmitted infections. 20 practices across Lincolnshire have signed up to the programme so far in order to improve services to young people.

HIV

There are thought to be 77,610 people in the UK diagnosed with HIV but a further 21,900 remain undiagnosed by the end of 2012.[7] 47% of HIV diagnoses nationally were diagnosed late and this is associated with an increased risk of death and AIDS. In the over 50s, more than 1 in 10 of individuals diagnosed late die within 12 months. Late diagnosis was highest among heterosexuals, with two-thirds of men and over half of women diagnosed late. The latest data for Lincolnshire (2009 – 2011) indicates that 34.1% of HIV diagnoses are late.[8] This is lower than the England rate of 50% and the lowest in the East Midlands, but is not a reason to be complacent. Early diagnosis prevents onward transmission of infection by reducing the levels of the HIV virus in patients, providing earlier partner notification (so that they can also be tested) and earlier behaviour change counselling. These are essential components in the reduction of HIV transmission.

Sexual Health

According to PHE data for England[9], young people under 25 have the highest rates of acute STIs, with females recording higher than males. In the older age groups however males have a higher diagnosis rate. The rates of many STIs have steadily risen between 2009 and 2012, with chlamydia being the most common. Syphilis diagnoses are significantly lower than other STIs although the rates in men for 2012 are ten times that seen in women.

Figure 5.2 PHE Statistics (2012 data) NB 95% confidence intervals apply to all statistics:

Rate of Acute STIs – per 100,000 population	England	Midlands and East	Lincolnshire
All STIs	863.7	683.4	512.3
Chlamydia (all ages)	371.6	324.8	298.1
Gonorrhoea	45.9	31.4	15.1
Herpes	58.4	50.4	29.9
Syphillis	5.4	2.6	2.5
Warts	134.6	120.8	97.8

Data Source, HPA, Public Health England, 2012[10]

Usually patients can be offered an appointment within 48 hours for STI testing and treatment by contacting either Lincolnshire Community Health Services clinics via a countywide central booking line or one of two primary care led services in Louth or Spalding.

Services across Lincolnshire currently include a range of community and primary care led genito-urinary medicine clinics, contraception services (long-acting contraception as well as other types including emergency hormonal contraception), a dedicated sexual assault referral centre and psycho-sexual counselling services. Pharmacies are able to provide signposting and many services for young people including a condom scheme. Working with the community sector has enabled outreach and health promotion services to be commissioned alongside services to support those infected with and affected by HIV. More is being done to ensure all services address gaps and needs; making sure people know what is available and where and ensuring strong links are made with those who are most at risk and vulnerable.

Recommendations

- Maintain access to all services across the county to reach a geographically spread community.
- Services should work collaboratively to avoid fragmentation of service delivery.
- Services should work across the wider health and social care system to ensure integrated delivery and planning with a range of other key areas, such as drugs and alcohol, children's services, adult social care and sexual exploitation and violence.
- Service providers must maintain a trained workforce to ensure services are comprehensive.

References

[1] NHS Commissioning Board Emergency Preparedness Framework 2013

[2] www.lincolnshireprepared.co.uk

[3] WHO, 2010 Developing Sexual Health Programmes, A Framework for Action. Accessed at: whqlibdoc.who.int/hq/2010/WHO_RHR_HRP_10.22_eng.pdf

[4] Improving Outcomes and Supporting Transparency - The Public Health Outcomes Framework for 2013-2016. Accessed at www.gov.uk/government/publications/healthy-lives-healthy-people-improving-outcomes-and-supporting-transparency

[5] A Framework for sexual Health Improvement in England, 2013 accessed at: www.gov.uk/government/publications/a-framework-for-sexual-health-improvement-in-england

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[7] www.nat.org.uk/HIV-Facts/Statistics/Latest-UK-Statistics.aspx

[8] www.phoutcomes.info/public-health-outcomes-framework#gid/1000043/par/E12000004

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LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of The Lincolnshire Safeguarding Children's Board

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**25 March 2014**
Subject:	**The Lincolnshire Safeguarding Children's Board**

Summary:

This report is intended to provide the Health and Wellbeing board with an update on the work currently being undertaken by the Lincolnshire Safeguarding Children Board (LSCB) and its Sub-Groups.

Actions Required:

The Health and Wellbeing Board to note the contents of the report and direct any queries to the officer in attendance or the author of the report.

1. Background

Section 13 of the Children Act 2004 required each local authority to establish a Local Safeguarding Children Board (LSCB) for their area. The Act specifies the organisations and individuals that should be involved and Section 14 describes the key statutory objectives of the LSCB. These are:

a) To co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area: and

b) To ensure the effectiveness of what is done by each such person or body for those purposes.

Regulation 5 of the Local Safeguarding Child Boards Regulations 2006 sets out the functions of the LSCB in relation to the objectives under Section 14 of the Children Act

2004. These include developing safeguarding Policy and Procedure; agreeing with partners the actions to be taken where there are concerns about a child's safety; training those who work with children; recruitment and supervision of staff; investigation of allegations against people working with children; ensuring the safety and welfare of privately fostered children; monitoring the effectiveness of what is done by the authority and their Board partners; undertaking reviews of serious cases ensuring that the lessons learned are widely understood and reviewing the deaths of all children in the local authority area.

Lincolnshire's LSCB comprises a Strategic Management Group that meets quarterly and an Operational Delivery group that meets every eight weeks. In addition the LSCB has a number of Sub-Groups that drive the work of the Board. This report is intended to provide an overview of current issues and the work being undertaken by the respective groups to help enable the Safeguarding and health and Wellbeing board link to each other's roles, responsibilities and work.

Since December 2013 a number of LSCB documents have been completed and refreshed (attached), and the LSCB is satisfied that its Business plan and Performance Framework are in a strong position moving into 2014.

As part of the reviewing process, a decision was made to reduce the number of Sub Groups under the LSCB in order to refocus the efforts of the LSCB and its partners. The sub groups will be reduced to the following 4:

Child Sexual Exploitation
Child Death Overview
Serious Incident review
Policy, Procedure, Training and Development

The Board is seeking to ensure that there is adequate time and focus given to each of these groups to ensure that business is conducted both efficiently and effectively. It is envisaged that this distillation of the groups will provide the opportunity to ensure business is being completed and agencies or better engaged and held to account for these crucial functions.

The issue of adequate Audit oversight of Serious Incidents, and Audit of practice in general, is a focus for the LSCB and all agencies involved. In response to the need to better manage audit and oversight of actions from Serious Incident reviews, the LSCB has advertised to employ a policy and Audit officer by mid-2014. In addition to the appointment of an Audit officer, the Quality Assurance department has revised is basic scoping template to ensure that in all audits that included any element of multi-agency working, where there is a requirement to contacts, liaise and work together, this will be included a standalone inspection aspect of any QA process.

The LSCB has also 2 lay members who actively challenge agencies and seek to hold them to account through the lay perspective.

The LSCB is about to start a full S11 audit of all partners, and by August 2014 will be able to produce a moderated assurance that all agencies engaged in safeguarding work are robust and accountable. The LSCB has made the decision to increase the how regularly the audits are conducted, this is likely to be increased to every 18 months.

The Child Death Overview Panel continues to review the deaths of all children in Lincolnshire. The Panel Chair has commissioned work on co-sleeping; a well-recognised risk factor for Sudden Infant Death Syndrome and the LSCB has committed money to ensure this is delivered. In addition to this, CDOP has commissioned a review of all the recent child suicide in Lincolnshire. This piece of work is being dovetailed with work being undertaken by public health s they work towards a suicide prevention strategy.

Multi-agency training through the LSCB has increased significantly over the last couple of years. The two day courses are run most weeks and are very well attended. E-Safety training in schools is also very popular and is directly engaging with young people. The Training Sub-Group has now developed clearer training pathways to identify the training delivered within each agency to ensure that the LSCB multi-agency training is building on that 'in-house' training and adding to the learning of participants. Serious Case Review findings are incorporated into the training delivered by the LSCB. Any Identified deficits in the take up of training are being address through Communication from the Independent Chair to the senior management of the relevant agencies in order to hold them to account for their training commitments.

As always the Significant Incident Review Group is reviewing those incidents that agencies refer to the LSCB when there are safeguarding concerns about the way in which a child has been dealt with or responded to. In particular it considers incidents where inter-agency working has fallen short of required standards. In the future the group will also be focussing on cases where there are examples of good inter-agency working. The learning from 'good' case work is a valuable tool for practitioners. Once again the distillation of the sub groups should support the more appropriate focus and delivery of critical areas of LSCB business.

2. Conclusion

The LSCB continues to carry out its statutory functions set out in the LSCB Regulations 2006 and statutory guidance Working Together 2013. There are a number of challenges facing the LSCB, including Ofsted's impeding inspection. The daily mechanics of the LSCB and its responsibility is outlined in this report, and all the activity will all go towards providing evidence as to the effectiveness of the LSCB.

The LSCB hopes that the work of both these boards can be closely aligned to benefit all the people of Lincolnshire.

It is hoped that closer ties between the boards can be forged as all bodies have responsibilities to ensure the vulnerable are properly safeguarded, and as such safeguarding is not the sole responsibility of any single agency or partnership. All key strategic plans whether they be formulated by individual agencies or by partnership forums should include safeguarding as a cross-cutting theme to ensure that existing strategies and service delivery as well as emerging plans for change and improvement include effective safeguarding arrangements that ensure that all people in Lincolnshire are safe and their well-being is protected.

3. Consultation

N/A

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Annual Business Plan

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 Andrew Morris, who can be contacted on 01522 553916, or email Andrew.morris@lincolnshire.gov.uk.

Annual Report

2012/13

Contents

FOREWORD

I am once again pleased to present the Lincolnshire Safeguarding Children Board's Annual Report 2012-2013 which will be formally submitted to the Chief Executive and Leader of the County Council, the Police and Crime Commissioner and the Chair of the Health and Well-being Board. The report provides local partners and the public with an assessment of the performance and effectiveness of child safeguarding across Lincolnshire.

The last twelve months have certainly been challenging and a number of our partners have had to manage a changing landscape particularly in Health, Education and the Police. The terrain has certainly altered throughout the last year which has seen the development of the Clinical Commissioning Groups, the election of the Police Crime Commissioner and an increase in the number of Academies.

Whilst our agencies in Lincolnshire have experienced some significant financial constraints during the last year they have continued to treat safeguarding as a priority and I commend them for maintaining their focus on the safety of children. At a time when budgets have been subject to pressure, further investment has been made to strengthen our capability and extra resources have been identified to support the frontline particularly in tackling child sexual exploitation.

The Board has continued to develop its role as a co-ordinating body and has been involved in piloting a Public Protection Forum which incorporates the other key elements of Adult Safeguarding, Multi-agency Public Protection arrangements (MAPPA), Domestic Abuse and Community Safety. This body has been examining cross-cutting issues such as information sharing protocols; trafficking; Child Sexual Exploitation and the design of a MASH (Multi-Agency Safeguarding Hub) to meet the operational needs of our agencies and increase their effectiveness.

Despite the changing environment, the partnership continues to thrive on openness, transparency and professional challenge. As the Board reviews the way in which it gathers and monitors performance information from across the partnership, and begins to develop a framework that supports audit, evaluation and quality assurance, we believe that we will have a far greater evidence base on which to measure the effectiveness of partnership working. This, in turn, will provide the Board with a clearer understanding of where improvements are necessary. The LSCB is not complacent and it is important to remember:

'Coming together is the beginning. Keeping together is progress. Working together is success'. (Henry Ford)

Chris Cook
Independent Chair

LSCB Objectives and Functions

The objectives of the LSCB are set out in Section 14 of the Children Act 2004 and are:

a) To co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and

b) To ensure the effectiveness of what is done by each such person or body for those purposes.

Safeguarding and promoting the welfare of children is defined as:

- Protecting children from maltreatment
- Preventing impairment of children's health or development
- Ensuring that children are growing up in circumstances consistent with the provision of such effective care.

Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the functions of the LSCB as follows:

1a) Developing policies and procedures for safeguarding and promoting the welfare of children in the area of the authority, including policies in relation to:

i) The action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention;
ii) Training of persons who work with children or in services affecting the safety and welfare of children;
iii) Recruitment and supervision of persons who work with children;
iv) Investigation of allegations concerning persons who work with children
v) Safety and welfare of children who are privately fostered;
vi) Co-operation with neighbouring children's services authorities and their Board partners;

1b) Communicating to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encouraging them to do so;

1c) Monitoring and evaluating the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children in the area of the authority and advising them on ways to improve;

1d) Participating in the planning of services for children in the area of the authority; and

1e) Undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

Regulation 5 (2) relates to the LSCB Serious Case Review function and Regulation 6 which relates to the LSCB Child Death function.

LSCB Membership

Strategic Management Group

Chris Cook – Chair	*Independent Chair*
Debbie Barnes	*Lincolnshire County Council Children's Services*
Janice Spencer	*Lincolnshire County Council Children's Services*
Roger Bannister	*Lincolnshire Police*
Peter Adey-Johnson	*Lincolnshire Probation*
Julie Hall	*Lincolnshire Partnership Foundation Trust*
Rachel North	*West Lindsey District Council (representing all District Councils)*
Jane Appleby	*Strategic Health Authority*
Phil Vickers	*Safer Communities*
Kay Darby	*Lincolnshire Community Health Services*
Allan Kitt	*Clinical Commissioning Group*
Lynne Moody	*Clinical Commissioning Group*
Bridget McPherson	*Schools*
James Greenwood	*Schools*
Michelle Bunn	*Schools*
Cllr Patricia Bradwell	*Lead Member Children's Services*

Operational Delivery Group

Chris Cook	*Independent Chair*
Roz Cordy	*Lincolnshire County Council Children's Services*
Rick Hatton	*Lincolnshire Police*
Guy Leach	*Lincolnshire Police*
Dr Robert Wilson	*NHS Lincolnshire*
Debra Burley	*Representing Lincolnshire GPs*
Karen Shooter	*Domestic Abuse Strategic Management Group*
Janice Ward	*CAFCASS*
Andy Cook	*Lincolnshire Youth Offending Service*
Keith Laughton	*Lincolnshire Probation*
Jade Warren	*North Kesteven District Council (representing all District Councils)*
Sue Proudlove	*NSPCC*
Andy Payne	*Lincolnshire Fire ad Rescue*
Ginny Blackoe	*Lincolnshire Community Health Services*
Michelle Johnstone	*Lincolnshire Community Health Services*
Elaine Todd	*United Lincolnshire Hospitals Trust*
Liz Bainbridge	*Lincolnshire Partnership Foundation Trust*
Joy Gilbert	*Lincolnshire Community Health Services*
Nicole Hilton	*Multi-Agency Public Protection Panel*
Leila Barron	*Action for Children (representing the voluntary sector)*

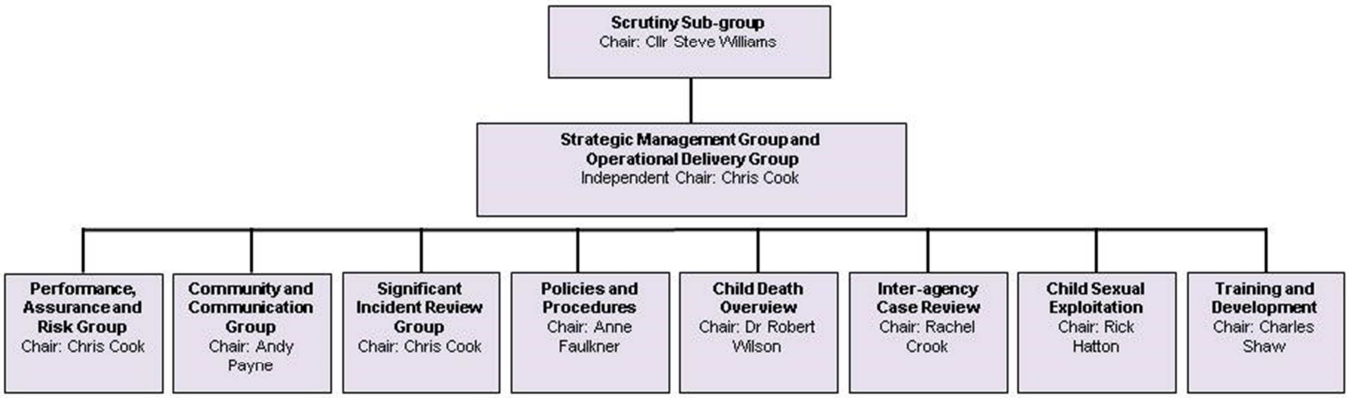
Blanche Lentz	*East Midlands Ambulance Service*
Mandy Cook	*Adult Safeguarding and Dignity Board*
Richard Greener	*Lincolnshire Road Safety Partnership*
Jacque Mullins	*SSAFA*
Dave Clarke	*Lincolnshire Secure Unit*
Dr Margaret Crawford	*Designated Doctor*
Jan Gunter	*Designated Nurse*
Robin Bellamy	*Safer Communities*
Michael Mulvaney	*Lincolnshire County Council Private Fostering*
Phil Taylor	*Representing Housing*
Sue Roy	*Schools*
Rachel Shaw	*Schools*
Sue Barnicoat	*Schools*

LSCB Staffing

Paula Whitehead	*Business Manager*
Sue Hill	*Administrator*
Ben Rush	*Administrator*
Mary-Ann Round	*Training Officer*
Max Prangnell	*Training Officer*
Dan Hawbrook	*e-Safety Officer*
Anne Faulkner	*Local Authority Designated Officer*
Nicola Brangam	*Local Authority Designated Officer*
Viv Thomas	*Child Death Administrator*

Toni Geraghty, Legal Services Manager, is Legal Adviser to the LSCB.

LSCB Structure



In 2012/13 we said we would:

Continue to expand and develop new training opportunities to increase effectiveness of multi-agency support to children, young people and their families.

We have continued to develop and deliver a multi-agency training programme including a new one day course on Team around the Child (TAC). Numbers accessing LSCB training have increased by almost 400% in the last three years.

Increase co-ordination and effectiveness of resources targeted at reducing Child Sexual Exploitation, and improve early support for those vulnerable to all forms of exploitation.

We have developed a Strategy and Action Plan and identified additional multi-agency resources to employ a Co-ordinator for this area of work.

Respond positively to local and national safeguarding priorities including the new statutory arrangements incorporated in the revised *Working Together* documents.

We have responded to the government's consultation and new guidance published in March 2013. We have asked all agencies to undertake an impact assessment on the implications of the revised guidance within their services. We have also revised our threshold document, *Meeting the Needs,* to ensure that it reflects important changes.

Increase the participation of children, young people, families and the voluntary sector in all area's of the Board's work.

We have increased participation by the Voluntary Sector and are encouraging full engagement in Board business.

Scrutiny and Accountability

The LSCB Scrutiny Sub-group merged with the Lincolnshire Safeguarding Adults Scrutiny Sub-group in 2011 to become the **Lincolnshire Safeguarding Boards Scrutiny Sub-group**. The sub-group is chaired by Councillor Steve Williams. The Sub-Committee forms part of the governance arrangements of LSCB and its role is essential due to the unique independent role of LSCB. The Sub-group's role is to oversee and scrutinise the effectiveness of the partnership arrangements of LSCB.

The Scrutiny Sub-group has an on-going work plan and during the course of 2012/13 has, in relation to the LSCB:

- Considered the work around e-Safety and Cyber Bullying in schools
- Reviewed and monitored the Action Plan in response to the Munro Review of Child Protection

- Examined the changes to the Vetting and Barring Scheme
- Scrutinised the work being undertaken in relation to child sexual exploitation

LSCB Sub-groups

Child Death Overview Panel

The Child Death Overview Panel has continued to review all deaths of children under 18 years. There are approximately 150,000 children in Lincolnshire. In 2012/13 there were 63 child deaths. The Panel reviewed 41 deaths. All deaths are reviewed within 6 months of being eligible for review; delay being caused by criminal enquiries or Coroner's Inquests.

The Panel is required to consider whether each death had any modifiable factors, defined as "The panel have identified one or more factors, in any domain, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths." In 2012 the panel considered that 2 child deaths in Lincolnshire had modifiable factors that met this definition.

Inter-agency Case Review Group

This year the sub-group has reviewed it's Terms of Reference in order to ensure that the reviews undertaken are done so efficiently; are effective and make the best use of the professional expertise available.

Cases reviewed met the following criteria:

- The case highlighted concerns regarding the quality of inter-agency working and the Escalation process had not resolved the issues
- The child had become subject to a Child Protection Plan for a second or subsequent time
- The child had been the subject of a Child Protection Plan for more than 18 months and the Independent Chair or Head of Service considered inter-agency review appropriate
- The Independent Chair had overturned a decision regarding Child Protection Plan at Child Protection Conference
- The case highlighted effective and/or innovative inter-agency working
- The case has been referred for review by the Significant Incident Review Group

Training and Development Sub-group

In January 2013 the LSCB launched a new Learning Management System hosted by the Virtual College with whom the LSCB has worked closely to deliver e-Learning for the last four years. The new system allows Learners to book face to face training on-line using their 'log on' information in the same way they do when accessing e-Learning Modules. Each Learner has a 'Learner Dashboard' that records all LSCB training enabling access to the training details and the materials they will require.

This system is already enabling the LSCB to provide up to date and accurate information to partners on attendance and from April 2013 the analysis of the impact of training will be clearer. Learners can access their LSCB training record and can identify their training needs which will enable professional learning logs to be kept up to date.

Multi-agency face to faced training from April 2012 to March 2013 includes:

- Inter-agency Working Together (2 day): 31 courses; 533 participants
- Child Sexual Exploitation (1 day): 5 courses; 79 participants
- Working with Uncooperative and Hostile Parents (1/2 day): 2 courses; 30 participants
- Achieving Best Evidence (3 day): 2 courses; 34 participants
- Team Around the Child (1 day): 7 course; 190 participants
- GP Training event (1/2 day): 80 participants

The total number of participants undertaking LSCB face to face training during 2012/13 was 946.

The evaluations from face to face training demonstrate that 96% of participants rate the training as excellent or good.

The e-learning continues to build on its previous success with 7102 learners completing a course during the last year compared with 5981 in 2011/12. The courses are continually reviewed in partnership with Virtual College, other local authorities and partner agencies.

At the end of the learning course Learners complete an evaluation which enables both quantitive and qualitative data to be collected.

99% of Learners were either very satisfied or satisfied that the course gave them all the information they needed to know.

97% of Learners would recommend the courses to other people.

Future Priorities:

All courses are and will continue to be reviewed and developed to reflect the revised statutory guidance *Working Together* 2013; findings from Serious Case Reviews both local and national, and to provide a pathway for personal development.

The training group will continue to develop a quality assurance and standardisation system with all partners to ensure continuity and quality of both single and multi-agency training.

Policies and Procedures Sub-group

The Sub-group met five times during 2012/13 and expanded the membership to include a representative form the Children with Disabilities Service.

Further to the learning from a Serious Case Review the group has developed and published a multi-agency Pre-Birth Protocol and a Pathway for identification and treatment of Mongolian Blue Spot. Both can be found on the LSCB website.

In conjunction with the activities of the Child Sexual Exploitation group work has been undertaken to revise the policy and procedure in respect of sexual exploitation of children. This now reflects the current language and terminology in relation to this form of child abuse. The policy links closely to the Missing Children policy.

The sub-group work plan for the future includes:

- Revision of the Safer Recruitment Toolkit to reflect changes in relation to the Disclosure and Barring Service and the review of the Safer Recruitment statutory guidance
- Review of the policy and procedure in respect of safeguarding children with disabilities
- The development of a policy and guidance on the use of physical intervention and restraint

Significant Incident Review Group

This group (formerly known as the Serious Case Review Sub-group) has revised the process for notification to the LSCB of significant and serious incidents.

It is a statutory duty for the LSCB to undertake Serious Case Reviews (SCR) when abuse or neglect of a child is known or suspected and either the child has died or there is cause for concern as to the way in which the authority, the Board partners or other relevant persons have worked together to safeguard the child. In addition the Sub-group also considers cases which do not meet the criteria for a SCR but which can provide valuable lessons about how organisations are working together to safeguard and promote the welfare of children.

<u>The Learning</u>

One SCR has reached completion during 2012/13 and is due for publication following completion of the criminal process. A key recommendation from this review has been the introduction of a multi-agency Pre-Birth Protocol. A second SCR has been commissioned during this period; the findings of which will be published in the coming year.

The Sub-group has commissioned reviews of four cases which did not meet the criteria for SCR; two of these were single agency reviews. In all instances the findings are reported back to the Sub-group and the implementation of Recommendations is monitored through the group. One of the recommendations arising from these reviews was for a more robust monitoring of the effectiveness of the plans for children who are the subjects of Supervision Orders at home. In two of

the reviews considered there were issues relating to young people with a diagnosis of Autism. As a result of these cases, and information from the partner organisations, a recommendation was made to commission a thematic review of Autism in Lincolnshire. Finally, and as a further result of one of the reviews, the Serious Incident Review Group has decided to commission the Performance, Assurance and Risk Group to undertake an audit of Team around the Child cases to consider the effectiveness of the process.

In November 2012 BASPCAN research was published entitled *A study of family involvement in case reviews: Messages for Policy and Practice.* Two families from Lincolnshire, as well as Board partners, took part in this research. The conclusion includes the following: 'The findings from this study suggest that family involvement has the potential to make an important contribution to the learning from reviews of the most serious cases of child death or serious injury arising from abuse or neglect' (Morris, Brandon and Tudor 2012). This is something that Lincolnshire LSCB has long been committed to and the Board is pleased that the research supports the value of family participation in reviews.

Performance, Assurance and Risk Sub-group

This Sub-group (formerly known as Quality Assurance and Risk Management group) has been commissioned by the Serious Incident Review Group to undertake an audit of Team around the Child (TAC) cases and a final report is due to be reported to the Board in the near future.

In the coming year the Sub-group will finalise the development of an on-line system for Section 11 self-assessment which will give agencies the opportunity to undertake the self-assessment as a continuous process rather than a single event. This should provide a more efficient and effective way of monitoring progress within the agency prior to moderation by the Board every three years.

Communities and Communications Sub-group

The Sub-group has now successfully designed and distributed a poster promoting the telephone number of the Children's Services' Customer Service Centre to ensure that Lincolnshire residents are aware of what to do if they have concerns about a child's welfare. Over 4000 posters have been distributed countywide by partner agencies.

The LSCB website has been improved. More than 3000 unique visitors have viewed over 18,000 pages in the last 12 months. 60% of visitors are viewing the site for the first time. The LSCB continues to explore other means of engagement with professionals and the public, including children and young people.

The award winning Stay Safe Days have continued this year in a new interactive format. The first of the new look days was held at Lincolnshire Fire and Rescue's training facility in Waddington before moving on the Butlins in Skegness for a further 3 days of interaction with young people. Agencies delivering short, educational sessions included Lincolnshire Police, Fire and Rescue, the Red Cross, Western Power, Stagecoach and the LSCB e-Safety Officer.

The Stay Safe partnership has delivered safety lessons to more than 400 children in 16 schools in the county.

E-Safety

The LSCB e-Safety Officer has delivered sessions to:

- 5387 children and young people
- 211 parents and carers
- 166 professionals

In addition since April 2012 775 students have received an e-Safety awareness session as part of the *It's That Easy* programme.

In June 2012 the LSCB once again had a stand at the Lincolnshire Show where around 180 young people engaged in a Facebook Quiz on the safe use of social websites.

The e-Safety Officer has provided a number of sessions on *Keeping Safe* to young people with a learning disability acknowledging the added vulnerability of this group of children.

Child Sexual Exploitation Sub-group

The sexual exploitation of children and young people involves exploitative situations, contexts and relationships where young people receive 'something' in return for performing, or having others perform on them, sexual activities. This can occur through the use of technology without the child having any immediate awareness of what is being done.

The LSCB is responding to the increasing prevalence of this form of child abuse brought to its attention by the growing body of information and several high profile investigations elsewhere in the country.

During 2012/13 the Sub-group has:

1. Developed a Child Sexual Exploitation Strategy to identify children and young people who are subjects of, or at risk of sexual exploitation and to disrupt and prosecute offenders. The four elements of the Strategy are:

    - Identification
    - Engagement
    - Disruption
    - Prosecution

2. Devised an Action Plan to which all agencies are working to ensure that children are heard and safeguarded
3. Developed a Risk Assessment Tool to assist professionals in understanding and recognising where exploitation occurs and how to identify those young people at risk
4. Secured commitment of the Board to appoint a Child Sexual Exploitation Safeguarding Co-ordinator to lead the multi-agency response to this issue
5. Revised the Missing Children policy to include those at risk of sexual exploitation
6. Secured a dedicated Police resource to safeguard those children at risk

7. Undertaken awareness raising of this issue with over 8,000 pupils in Lincolnshire schools through the drama production 'Chelsea's Choice', commissioned by the LSCB

In 2013/14 the priorities for this Sub-group are:

- To consolidate and complete the Sub-group Action Plan
- To forge closer working relationships between the statutory agencies and the Voluntary and Community Sector to enable appropriate information sharing
- Continue to raise awareness of on-line risks with both young people and their parents/carers
- To continue to raise awareness of the issues with young people through the drama production, Chelsea's Choice
- To target those young people and families who are 'harder to reach'

Looking ahead

The LSCB is anticipating the publication of the revised *Working Together* statutory guidance. This will be fundamental to a thorough review of the LSCB's work; performance and overall function. The LSCB will need to assure itself that it has appropriate arrangements in place to ensure the effectiveness of safeguarding children in Lincolnshire. The Board will critically evaluate its own performance and ensure that any identified areas of weakness are addressed.

Performance

Children with Child Protection Plans

The number of children with Child Protection Plans is measured as a rate per 10,000 population aged 0 to 17. Over 2012/13 the rate in Lincolnshire has risen with the figure at the end of March 2013 at 21.3 per 10,000. At the end of March 2012 the rate was 17.4 per 10,000. Lincolnshire compares favourably to national statistics and the increase in the numbers of children subject to child protection plans is indicative of the rise in numbers across the country following the publication of a number of high profile cases of child abuse and neglect. Through robust multi-agency working risk to children is being managed at home, where appropriate, rather than in care.

Review of Child Protection Plans

For protection plans to be effective, it is essential that they are reviewed at regular intervals (NI067). This ensures that protection arrangements reflect the family's circumstances and the level of risk the child is exposed to. This standard requires multi-agency commitment with a target of 100% of plans reviewed at the required

interval set. At the end of March 2013 96.8% of Child Protection Plans had been reviewed within timescale.

Children subject to a Child Protection Plan for a Second or Subsequent Time

The Safeguarding Board is keen to ensure that children are not failing to access the appropriate services they need when they are subject to a Child Protection Plan which leads them to become subject to a Plan for a second or subsequent time (NI065). LSCB therefore monitors the number of children placed on Protection Plans for a second or subsequent time. At the end of March 2013 53 children who had become subject to a Child Protection Plan during the year had previously been the subject of a Child Protection Plan. This is 12.4% of all children who became subjects of Child Protection Plans throughout 2012/13. It is important to remember that if there is a change in circumstances which leads to a change in the level of risk, then it is wholly appropriate for a child to be made subject to a Child Protection Plan for a second or subsequent time.

Child protection plans lasting 2 years or more

NI064 measures the number of children ceasing to be subject to a Child Protection Plan for whom plans lasted two years or more, as a percentage of all children ceasing to be subject to a Child Protection Plan during the year. At the end of March 2013 this figure was 4.0%. Over the course of the year performance has been consistently good and is excellent when viewed with national comparisons.

Agencies work well together to ensure that there is robust and timely management of Child Protection Plans. For those children who remain subject to Plans for more than two years this is usually a reflection of complex and changing circumstances within their homes.

Looked After Children per 10,000 population aged under 18

The measure is the number of Looked After Children per 10,000 population under 18. Over the course of the year 2012/13 there has been a consistent increase in the numbers of Looked After Children. At the end of March 2013 the figure was 42.4 per 10,000 population under 18. This is 591 children currently in the care of Lincolnshire Children's Services. This increase is consistent with the increase in the numbers of Looked After Children nationally.

TAC and Number of Referrals

There were 2225 TAC cases initiated throughout 2012/13 which represents 75 children per 10,000 under 18 population in Lincolnshire. This demonstrates the on-going commitment to children receiving early intervention. Our intention is to offer early support to families to prevent needs escalating and requiring more specialist intervention.

Private Fostering

Lincolnshire County Council has developed a comprehensive service for Privately Fostered children, and all those involved in Private Fostering, to ensure that the

authority complies with relevant legislation and meets the National Minimum Standards.

There is a good partnership approach to the safeguarding of children and young people who are privately fostered. There is an on-going process to raise awareness of Private Fostering. At the end of March 2013 there had been 69 notifications of potential Private Fostering cases. Of these 89.9% of visits and assessments were completed within timescale which is a further improvement on last year's performance which was 88%.

LSCB Finance

Income 2012/13

Partner Agency Contributions 2012/13

Agency	Contribution
Children's Services	£93,132
Health	£42,370
Police	£42,370
Probation	£8,390
West Lindsey DC	£2,936
East Lindsey DC	2,936
Boston Borough Council	£2,936
South Kesteven DC	£2,936
North Kesteven DC	£2,936
Lincoln City Council	£2,936
South Holland DC	£2,936
Lincolnshire Fire and Rescue	£2,936
Safer Communities	£30,00
Training Income	£86,268

Budget Totals	£326,018

The LSCB had, at the end of 2012/13 **£249,937.58** in Reserves.

Expenditure 2012/13

Narrative	Expenditure
Staffing	£230,490
Travel	£14,040
Consultancy and Legal Costs	£54,390
Telephone and IT Services	£9,770
Room Hire	£3,015
Training Expenditure	£19,715
Stationery and Printing	£820
Equipment, Materials and Stationery	£24,650
Total	**£339,620**
Overspend to be drawn down from Reserves	**£13,602**

Specific Expenditure relating to Child Death Review and Serious Case Reviews

In 2012/13 the LSCB spent £39,201 on commissioned independent consultants so undertake reviews, including Serious Case Reviews.

In relation to Child Deaths the only expenditure in 2012/13 was in costs associated with staffing which amounted to £10,000.

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Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of
South West Lincolnshire Clinical Commissioning Group
West Lincolnshire Clinical Commissioning Group
Lincolnshire East Clinical Commissioning Group
South Lincolnshire Clinical Commissioning Group

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**25 March 2014**
Subject:	**Review of Health Services for Children Looked After and Safeguarding in Lincolnshire**

Summary:
The Care Quality Commission (CQC) undertook a review of the health services for looked after children and safeguarding across the health economy in November 2013.

The report of findings was published on the CQC website 24 February 2014 and is embedded / attached to this document as an appendix or may be downloaded via http://www.cqc.org.uk/search/site/Safeguarding%20Looked%20After%20Children%20Lincolnshire

There is a health intra-agency action plan currently being populated to address the recommendations which will be submitted to the CQC by the 24 March 2014.

The report and action plan will be presented to the next CYPSP meeting in May 2014 by Jan Gunter who is the Designated Nurse for Safeguarding and for Looked After Children.

The governance arrangements regarding the implementation of the action plan require reporting of performance to the NHS Safeguarding Steering Group and the CCG Collaborative. The LSCB will be overseeing the arrangements and will hold the CCGs, and NHS Providers to account.

Actions Required:
For the Health and Wellbeing Board to receive the report for information and acknowledge any future implications for the commissioning of children's services.

For the Health and Wellbeing Board to advise of any future reporting required associated with the CQC report.

1. Background

The CQC has developed a model of review that mirrors the OFSTED framework for children's services external to health. Accordingly the methodology explores the child's journey through services. Lincolnshire was only the third area to be reviewed under the new arrangements, and accordingly the process identified learning for Lincolnshire, and the inspectors undertaking the review. The inspectors were on site in Lincolnshire for one week.

Notification of the review identified the requirement to prepare the case files of 10 specifically profiled complex cases of CQC choice. The cases incorporated multiple vulnerabilities including mental health of parents, substance misuse, domestic abuse, child protection, sexual abuse, teenage pregnancy, CAMHS et al.

The case profiles submitted included the records / summaries of each health agency involvement with each case which were reviewed to illustrate the journey experience, timely referrals and access and outcomes.

In addition 53 case files were 'dip sampled' by the inspectors, and then tracked through each health agency involved.

25 Recommendations have been made across 9 themes.

2. Conclusion

The CQC review did not identify any areas requiring strengthening that were unknown to health.

The key issues for address are:

- Capacity of the safeguarding and looked after children's designated and named roles and functions.
- Timely access to specialist services
- Variable quality of statutory health assessments provided through the local arrangements within primary care.
- Embedding of LSCB and multi-agency protocols, e.g. pre-birth protocol
- Self-harm Pathway
- Access to perinatal mental health services
- Commissioning strategies regarding the sufficiency of CAMHS provision

3. Consultation

The report has been published on a public access site.

All health agencies and senior management from Children's services have contributed and participated in the inspection process and in preparing the action plan.

Leads for specific actions have been identified and the plan will be signed off by executive leads within each agency.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	The CQC Report: Review of health Service for Children Looked After and Safeguarding in Lincolnshire

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 Jan Gunter, who can be contacted on 01479 406599 / 07818405359 or jan.gunter@southwestlincolnshireccg.nhs.uk

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Review of Health Services for Children Looked After and Safeguarding in Lincolnshire

Children Looked After and Safeguarding
The role of health services in Lincolnshire

Date of Review:	**4th November 2013 – 8th November 2013**
Date of Publication:	**21st February 2014**
CQC Inspector names:	**Lynette Ranson, Jan Clark, Lea Pickerill**
Provider Services Included:	**Lincolnshire Community Healthcare Services, Lincolnshire Partnership NHS Foundation Trust United Lincolnshire Hospitals NHS Trust**
CCGs included:	**Lincolnshire West CCG; South Lincolnshire CCG; South West Lincolnshire CCG; Lincolnshire East CCG**
NHS England Area:	**Leicestershire and Lincolnshire Area Team**
CQC Region:	**Central East**
CQC Regional Director:	**Dr Andrea Gordon**

Contents

Summary of the review

This report records the findings of the review of health services in safeguarding and looked after children services in Lincolnshire. It focuses on the experiences and outcomes for children within the geographical boundaries of the local authority area and reports on the performance of health providers serving the area including NHS trusts, clinical commissioning groups (CCGs) and the local area team (AT) of NHS England.

Where the findings relate to children and families in local authority areas other than Lincolnshire, cross boundary arrangements have been considered and commented on. Arrangements for the health related needs and risks for children placed out of the area are also included.

About the review

- The review was conducted under Section 48 of the Health and Social Care Act 2008 which permits CQC to review the provision of NHS healthcare and the exercise of functions of NHS England and Clinical Commissioning Groups

- The review explored the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements within health for all children.

- The focus was on the experiences of looked after children and of children and their families who receive safeguarding services.

- We looked at
  - the role of healthcare providers and commissioners.
  - the role of healthcare organisations in understanding risk factors, identifying needs, communicating effectively with children and families, liaising with other agencies, assessing needs and responding to those needs and contributing to multi-agency assessments and reviews.
  - the contribution of health services in promoting and improving the health and wellbeing of looked after children including carrying out health assessments and providing appropriate services.

- We also checked whether healthcare organisations were working in accordance with their responsibilities under Section 11 of the Children Act 2004. This includes the statutory guidance, Working Together to Safeguard Children 2013.

How we carried out the review

We used a range of methods to gather information both during and before the visit. This included document reviews, interviews, focus groups and visits. Where possible we met and spoke with children and young people and families. This approach provided us with evidence that could be checked and confirmed in several ways.

We tracked a number of individual cases where there had been safeguarding concerns about children. This included some cases where children were referred to social care and also some cases where children and families were not referred, but where they were assessed as needing early help and received it from health services. We also sampled a spread of other such cases.

Our tracking and sampling also followed the experiences of looked after children to explore the effectiveness of health services in promoting their well-being.

In total we took into account the experiences of 53 children and young people.

Context of the review

Lincolnshire is the fourth largest county in England with an estimated population of 718, 000, of whom 22% are aged under 19 years. Approximately seven per cent of school age children speak English as a second language but in the Boston district, about one third of the population using local health services are from an eastern European country. The county has a spread of both urban areas and very rural, isolated areas. The percentage of children living in poverty ranges from 10% in a southern district to 24% in Lincoln. Approximately 580 children are looked after by Lincolnshire and another 400 have been placed in Lincolnshire by other local authorities. Approximately 400 Lincolnshire children are currently subject to a child protection plan.

Commissioning and planning of health services is led through the Children and Young People's Strategic Partnership, with the four CCGs and Lincolnshire county council as the lead commissioners. Acute hospital services are also commissioned jointly by the CCGs and are provided by the United Lincolnshire Hospitals NHS trust (ULHT). Lincolnshire community healthcare services (LCHS) provide health visiting, school nursing and children's therapy services, the looked after children's health service, sexual health services, two minor injuries units, two 24 hour access urgent care centres and a walk in centre. Health services for children with disabilities are provided through integrated arrangements between the council and CCGs, and joint funding arrangements are in place. Child and adolescent mental health services (CAMHS) and a targeted adolescent mental health service which works in partnership with schools are provided through integrated arrangements between the council and Lincolnshire Partnership NHS Foundation trust. A specialist mental health nurse works with the Barnados leaving care service in providing a care leavers' CAMHS transition service.

The last inspection of health services for Lincolnshire's children took place in June 2010 as a joint inspection, with Ofsted, of safeguarding and looked after children's services.

The report

This report follows the "child's journey" reflecting the experiences of children and young people or parents/carers to whom we spoke, or whose experiences we tracked or checked. A number of recommendations for improvement are made at the end of the report.

What people told us

We heard from several foster carers about their experiences of looked-after children's health assessments and reviews.

One parent told us how his child is deteriorating because of lack of physiotherapy input. The foster carers told us that they tell the GP as part of the health review and then nothing happens.

Another foster carer had better experiences; *"I have a 30 mile round trip to see the GP who does the health review. She is interested and doesn't just tick the boxes."*

We heard a lot of praise from carers for a particular consultant paediatrician: *"She really listens and treats you with respect*".

Sadly, we also heard some young people and carers' very poor experiences of health practitioners. One young person told us: *"health staff don't talk to you."*

"Some health professionals don't want to speak to foster carers. They say 'I need to speak to a professional".

"We had to use A&E over the Christmas period, we were told to go home with an inhaler. This is for a child who was deteriorating with his shunt. They wouldn't listen to his foster carers".

Others commented on a range of communication and health planning issues impacting on children's health:

"We wait too long for essential equipment. His current wheel chair means he can't wear winter clothes because he won't fit in the chair"

"There is no numbing cream for his eyes in the local hospital so we have to travel to Boston Hospital".

"We have been waiting for important emergency surgery that couldn't proceed because of getting consent. This is for a child who has complex health needs"

Another foster carer told us: *"Getting the right equipment is difficult and we are told it's because of the budget. Why should our children suffer?"*

Foster carers we met were in universal agreement that the health professionals they meet do not understand the added needs of a looked-after child.

"I haven't been able to get support or training for family members to be able to tube feed my foster child. This means I have to be there to do every feed myself, even though other family members would like to give me a break". (Foster carer of a child with complex health needs"

One foster carer said how their 14 year old foster child was well supported by a nurse who made weekly visits and arranged for CAMHS and the smoking cessation service. However, the foster carer did not get any support or training.

We heard that the blue book, the local hand held record of looked after children's health history, hadn't been rolled out in a way that made it effective: *"The only reason he (the child) has his health history is because I save everything. GPs and other health professionals won't fill in the blue book, it's a complete waste of time*."(foster carer of a child)

The Child's Journey

This section records children's experiences of health services in relation to safeguarding, child protection and being looked after.

1. Early help

1.1 General practitioners (GPs) have an important role in early help in pregnancy as they are often the first point of contact for pregnant women in Lincolnshire; the information GPs send to midwifery is variable and doesn't always ensure midwives have all the relevant information where early help might be needed. A new booking format has recently been introduced which carries more information and also gives more information to the mother and this should improve mothers' access to early help.

1.2 Systems such as antenatal chronologies are in place to help early identification and monitoring of safeguarding risks in pregnancy. We saw a range of cases where midwives appropriately identified risks to protect unborn babies. However, some risks may be missed when these systems are not consistently used as in a case we saw:

Some concerns had already been identified as the mother to be hadn't disclosed at booking that an older child was placed with another family member; this part of the system worked well. However, the key antenatal chronology was not completed. It was unclear whether the community midwife was notified when the mother failed to attend her first scan, which is important to ensure prompt follow-up.

1.3 Many children, young people and their families are helped by preventative and targeted support from health staff in seven local multi-agency teams in co-located bases such as community hospitals, health centres, children's centres' and GP's surgeries. Co-location helps handover arrangements between midwives and health visitors which are generally effective and consistent in protecting vulnerable babies.

1.4 Community midwifery services try to maintain the same midwife throughout pregnancy as this gives mother and baby continuity but capacity problems mean this isn't always the case. Never the less, we saw examples where pre-birth maternity care is very effective in identifying the need for support at an early stage.

We saw an exemplar case of obstetric care of a pregnant teenager. Risks were discussed with her with great sensitivity and the young person was given time to reflect and consider her options. The maternity record is clearly written and of excellent quality.

1.5 Vulnerable women or those for whom an increased level of risk has been identified are visited by community midwives for up to 10 days post natal, which is also good practice in protecting mothers and babies. Joint ante natal visits are common and the community midwife's final visit is usually a joint visit with the health visitor. We heard about some effective partnership work between health practitioners, social care, children's centres and schools to support families.

1.6 The well regarded peri-natal mental health service works with health visitors and school nurses to support improved outcomes for women in Gainsborough and Lincoln. Lack of service for new mothers in other areas of Lincolnshire is an acknowledged gap as the value of perinatal services is recognised; in the last two serious case reviews, workers had contacted peri-natal health for advice about the new mothers' mental health (recommendation 5.2). Many parents in the county access and benefit from IAPT[1] services to help manage anxiety and depression. The service works closely with the mother and baby unit (in Nottingham) and helps support gaps in local peri-natal services.

1.7 Although some health visitors and GPs work well together to identify families who might need help, this isn't consistent across the county. There is no agreed system in place, for instance for regular formal joint meetings between GPs and health visitors or school nurses (recommendation 4.2).

1.8 The needs of children in families where their parents have mental ill health are properly recognised through highly effective `*think family*` systems across adult mental health services. Safeguarding screening tools are embedded in mental health services working with adults and parents, ensuring that all adults accessing services are routinely questioned about children in their families so that the children's needs can be taken into account at an early stage.

The IAPT early help mental health service helps many parents and ensures that risks to all children in the household are picked up, rather than just those for whom the adult has parental responsibility. The screening tool it uses is good practice. With the introduction of the IAPTus management information system, an already very sound system is being further strengthened.

[1] Improving Access to Psychological Therapies (IAPT) provides access to brief counselling interventions

1.9 School nurses are engaged with all schools and provide school drop in sessions. They are kept up to date about current issues and risks, in order to offer early help, information and advice about issues that trouble young people. However, there is no countywide use of a substance use screening tool to assess young people's drug and alcohol use as part of any other needs assessments. Using a recognised screening tool to identify young people who might need more targeted help could improve their early access to services.

1.10 We found a general lack of clarity about any referral pathway from health services to Young AddAction which offers specialist help to young people who misuse drugs or alcohol (recommendation) A&E departments are also in a very good position to identify young people who are putting themselves at risk through drug or alcohol use. We heard that this is being addressed with a multi-agency protocol which is awaiting ratification by the LSCB. (recommendation 3.2).

1.11 Accident and emergency (A&E) staff make an otherwise fairly comprehensive assessment of the child or young person on admission, including details of parents. There are though, inconsistencies in clarifying who has parental responsibility. At Grantham A&E, children are prioritised and almost always seen within 15 minutes. The clinical triage notes indicate if the presenting injury or condition is consistent with the explanation offered. A note is also made of who is accompanying the child to the department. In A&Es and the minor injuries unit (MIU) we visited, we saw good safeguarding risk assessment by most clinicians.

Spalding MIU identified and responded appropriately to safeguarding risks, notifying the health visitor, social care and MARAC about domestic violence witnessed by children and informing the parent about the referral being made.

1.12 In case sampling at three acute care locations we saw that onward referral systems to ensure young people have access to early help are not robust. At the Pilgrim Hospital at Boston, A&E actions are not routinely recorded in the paediatric liaison nurse (PLN) folder and CAS cards are often left in a pile to await the PLN's twice weekly visit. Although the PLN and acute trust named nurse are working together to try to address this, compliance with the agreed safeguarding discharge protocol remains low. At Grantham we also saw a lack of clarity about cases referred to the PLN and their outcomes (recommendation 3.1).

At the Pilgrim hospital's A&E we saw good work from staff in assessment of risks, effective questioning of the incident and treatment of an 18 month old little girl who had swallowed a small amount of oven cleaner. This case wasn't entered into the PLN liaison book however, to ensure there would be community follow up.

1.13 Young AddAction provides a good quality, easily accessible drug and alcohol specialist service for young people that thoroughly assesses risks and engages young people very flexibly. On one file we were impressed how the Young AddAction service responded to the parent's concerns whilst respecting the views of the young person.

1.14 We saw examples of the work of the `vulnerable children's team' (VCT) which provides a specialist health service to meet the health needs of vulnerable children and young people, including children in public care (0-19 years of age) within Lincolnshire and those at risk of social or educational exclusion.

1.15 Where community health services are using the same IT system, information sharing about children at risk is supported across a range of services. This helps health staff to respond to the needs of individual children. As a result of the shared information system, regular liaison between MIUs and school nurses is now routine practice and enables improved understanding of concerns about young people in the county.

1.16 Where risks to the health, safety, development and wellbeing of children are identified we found timely and appropriate follow up to ensure the child's health needs are met, particularly among health visitors and school nurses. We heard that progress is on track to meet national health visitor targets, although case loads and capacity are variable currently and there is widespread use of nursery nurses in order to deliver the core offer. Unless there are child protection or child in need plans to mitigate risks to the child and mother, new born babies are handed over to nursery nurses for the universal service after 6 weeks; this potentially impacts on the ability to identify early needs for help.

1.17 Integrated GUM, sexual health services and family planning are provided in one stop clinics across Lincolnshire. Dedicated clinics for young people are not provided, but reception staff make sure that young people are seen by experienced staff. Clinical guidelines reflect national policy in that any young person aged 13 or under as well as any young person or adult with additional vulnerability is referred to children's social care.

1.18 Agencies are working together to try to increase understanding and develop provision to meet the health needs of eastern European migrants and their children. We saw how mothers are supported by obstetric consultants who are sensitive to patient's ethnicity and ensure interpreting services are provided as required. Midwives and community services have taken steps to better meet the needs of the Polish community in the Boston district including information leaflets and recruiting a Polish speaking midwife in each area of the county; some midwives have developed a glossary of Polish terms to help them in working with this community. The community services named nurse lead for diversity is very involved in developing greater understanding of cultural norms and ensuring that potential risks to the wellbeing of children in migrant communities are recognised and addressed.

1.19 We heard from several sources including Healthwatch about the impact of the shortage of paediatricians in Lincolnshire. All paediatricians in Lincolnshire are currently employed by the acute hospital trust. We heard that around the county it is hard for a child to get a paediatric referral and children have to wait for appointments which often impacts on their well-being. The limitations of available paediatric resources impact on children entering into care who may have complex or hidden needs (recommendation 1.3). Only the 10% who are being considered for adoption are seen by a paediatrician for their initial health assessment, all others are seen by GPs and then have to join waiting lists if more specialist assessment is needed. Some children and foster carers told us that they are not always listened to when they see a paediatrician.

1.20 We saw consistently determined efforts across health services to engage young people and families who are challenging or hard to engage. Non-attendance at clinical appointments is well followed up by most partners. GPs told us that they hear about missed hospital appointments but could be better engaged about risks in families if they were also informed about missed community health appointments.

1.21 The school health service has good engagement with schools countywide. Practitioners identify needs effectively and target additional drop in work at schools where young people are most at risk. We saw some effective individual work too, for example, a teenager in a very chaotic family for whom engagement and support from the school nurse is instrumental in ensuring his fundamental needs are met.

1.22 Staffing turnover and reducing capacity in the school health service presents a threat to continuing the current level of engagement which is helping to safeguard all school age children, for example capacity in the north east sector, where there are high levels of need, has been significantly challenged during 2013.

1.23 Vulnerable children and families in Lincolnshire benefit from the range of children's centres and also have access to some health-led early help services which are effective in delivering positive outcomes; in particular the young expectant parents group (YEP) run by community midwives is accessible to all young parents. The 10 week course starts and finishes at different times ensuring there is no delay in young parents starting with the group. Young people can attain a qualification equivalent to a GCSE. Recently a YEP cycle has run for a small group of five 14 year old young people who all joined at the same time. Young people feedback that they found this highly supportive and helpful.

1.24 The number of teenage pregnancies has reduced year on year, as in most parts of England though latest data shows that the rate of 1.7 is worse than the rate for the East Midlands region and the England average rate of 1.3. Teenage pregnancies are highest in the Lincoln area although we did not see targeted activity to address this or the impact on the life chances of these young parents and their children.

2. Children in Need

2.1 Midwives carry out thorough assessments of risk and where concerns are identified, these are shared early. Vulnerable mothers are supported by targeted ante natal care from health visitors from 26 weeks currently though this is changing and will be available as soon as a pregnancy is confirmed.

2.2 Children in need and their families are helped by multi agency team around the child (TAC) groups based on the common assessment framework (CAF). This is an embedded model of supporting children in need and may be led by a range of professionals including health staff and schools. This is delivering good outcomes where parents are in agreement with the setting up of a TAC. We saw a good example where a child protection plan was replaced by a child in need plan when the child moved into the county and the child is supported by a TAC in which her school nurse is an active partner.

2.3 Young people who may be reluctant to engage with CAMHS services are supported to access the service by a sensitive policy on non-attendances. We saw examples where workers sought to engage the young person for as long as possible and used different routes to try to do so rather than closing the case. Effective and separate work can be done with parents or foster parents to support them when a child is working through difficult issues supported by CAMHS.

We saw an exemplar case of effective, sensitive support by health services in Lincolnshire for a young person who had suffered serious sexual exploitation before being placed in Lincolnshire by another council

2.4 The contraception and sexual health service (CASH) appropriately explores risks to identify safeguarding concerns and potential sexual exploitation of young people. This includes asking the young person for the age and name of their partner and whether sex had been consensual. Services ensure that children aged 13 and under are identified as being potentially at risk by an automatic flag on the CASH database. All cases of concern had been referred to children and families social care. However, we did see a number of cases where children aged 13 and under had a contraceptive implant in situ and the CASH could not identify the source of these implants. This indicates that some GPs or other family planning practitioners are unaware of guidance and policy to safeguard these vulnerable young people (recommendation 4.2).

2.5 CAMHs employ some very good self-assessment tools and aids in working with young people to enable them to explore their emotional journey and to assess their progress and personal growth. Many young people have timely access to services, especially at tier 3 where the average wait is just over three weeks. However, increased demand and holiday arrangements led to some delays during several months in 2013, for example for tier 2 primary CAMHS, 61% were seen within the six week target (recommendation 5.1).

2.6 Significant numbers of young people in Lincolnshire have complex needs including self-harming behaviours. The most recent national data set on hospital admissions as a result of self-harm reported a rate of 127 (or 177 admissions), significantly higher than the England average rate of 115 and with increased numbers being seen since this data.

2.7 Many of the young people presenting at A&Es in Lincolnshire have been placed by other councils without first ensuring their health needs can be met in Lincolnshire. We saw several cases where health professionals in Lincolnshire had worked hard to engage with and try to ensure that young people received appropriate help.

2.8 Problems in access pathways from A&E services to CAMHS were flagged as an issue in the SLAC inspection in 2010. The LSCB has since co-ordinated work to simplify pathways. A case example suggested further exploration by commissioners would be warranted to ensure effective planning for Lincolnshire children returning from out of county placements ensures there are smooth and robust pathways to support them. The self-harm pathway of overnight admission to a paediatric ward and assessment by CAMHS is providing good support to many children and young people. However, there continue to be cases where this pathway does not work well and children's access to appropriate support is delayed as professionals try to balance these needs with the needs of other children on the paediatric wards (recommendation 9.1)

2.9 These cases are usually resolved through the intervention of the CAMHS consultant liaising directly with the paediatric consultant. We heard that work is in hand across partnership agencies to resolve this long standing issue including a trial at Lincoln hospital which is providing two additional members of staff to provide additional support where young people are admitted to the paediatric ward for CAMHS assessment. Use of the self-harm pathway at Pilgrim Hospital is also being closely monitored by the named nurse as it has not always worked effectively (recommendation 3.1).

3. Child Protection

3.1 Most health professionals recognise safeguarding thresholds and their professional accountabilities for keeping children and young people safe. School nurses, for example, understand their role in safeguarding and make appropriate referrals when they identify concerns. In one case we saw that a school nurse took appropriate actions in making a safeguarding referral when a 12 year old child disclosed sexual activity and concerns about a possible sexually transmitted disease (STD).

3.2 Health professionals are making prompt referrals to social care when they have concerns about risks to children. However, we saw a common theme across a number of services with examples as in the following paragraphs where risks to children are not being clearly articulated and health managers are not quality assuring referrals to support practice development in this key area (recommendation 7.2).

3.3 Most referrals from midwives to social care about pre-birth concerns are made electronically but not routinely printed off and placed on the mother's record. This approach means the named midwife or supervisory staff are unable to review and audit the quality of referral to ensure that the risks to the unborn are clearly articulated. Some midwives do print and file their referrals and this practice is to be encouraged (recommendation 7.2).

3.4 Midwives are skilled at identifying unborn babies who might be at risk, they are making early referrals to social care and alerting the named midwife. The recent introduction of a pre-birth protocol is a positive development but its effectiveness had not yet been reviewed by partners (recommendation 7.4). This review identified areas for development in the protocol to ensure health staff including GPs and midwives will in future be involved in core assessments through early establishment of a TAC[2] where concerns are raised about risks to unborn babies as this strengthens the involvement of health staff (recommendation 8.1).

The mother to be, a looked after child with complex needs herself, was well known to a range of health professionals who were concerned that her chaotic and risky lifestyle represented risks to the wellbeing of the unborn baby. These risks were inadequately identified in the notification to the named midwife. Though the poor history of the young woman was set out, concerns in relation to her ability to parent the child effectively and the likely early delivery were not mentioned (recommendation 7.2).

The core assessment inaccurately attributed the midwife as having "no concerns" despite high levels of concern among professionals familiar with the expectant mother. This case highlighted areas for development within the pre-birth protocol to ensure early multi agency involvement in decision making. We referred the case *back for review and appropriate action was taken (recommendation 7.4)*.

[2] Team around the child

3.5 We reviewed a case where concerns about parenting capacity have been present since before the first child's birth three years ago. This case demonstrates a cluster of known risk factors including missed appointments, avoidance, deteriorating mental health, increasing misuse of alcohol, problematic living conditions, and risks from a large dog. Whilst there have been diligent attempts at engagement with the mother, health records we saw lacked clear assessments about the impact on the wellbeing and development of the small child or the then unborn baby and a lack of clear planning. We saw no evidence of multi-agency meetings prior to the second baby's birth or of decision making about parenting capacity or risks to the baby or young child. Although a TAC was suggested recently, as concerns multiplied, the protocol requires the agreement of the family. In this case when the parent declined a TAC, there was a further period of slippage during which concerns increased. The case had recently been escalated to child protection.

3.6 Identifying risks to children through the use of a vulnerability and resilience matrix is a good model is now being used in health visiting and, we heard, more widely in other agencies undertaking assessments of risk. This can support practitioners to evaluate a case more effectively and to make good quality referrals to children's social care. The very newly implemented electronic version should further help community health practitioners to make referrals which set out risks more clearly. Some staff are currently unclear on the expected usage of the electronic matrix however (recommendation 8.1).

3.7 Another of the cases we saw involved long standing neglect which has continued for many years despite CP and CIN plans but the mother's behaviours and needs impact on her ability to parent her children. Since recent re-escalation to child protection brought an experienced school nurse's involvement to the family, she has used considerable skills to win acceptance of the mother and has started to address the son's unmet health needs.

3.8 We also saw an example case where the GP took prompt and appropriate safeguarding action in response to a disclosure that a child had witnessed a domestic violence incident. The GP did not however, clearly articulate the risks to the child in his report to conference (recommendations 4.1, 7.2).

3.9 Overall, GPs are keen to improve their safeguarding practice and positive progress has been achieved under the leadership of a very committed named GP. GPs recognise how important it is for the GP to attend child protection meetings if possible. Short notice periods and scheduling during surgery times are obstacles to improving GP attendance. Alternative means of securing GP participation such as teleconferencing have not been explored.

3.10 Where child protection plans are in place and adult mental health, including peri-natal mental health, are engaged with the parent, practitioners are very clear on their role in protecting the child. We saw an example where adult mental health practitioners were actively ensuring that the mother was compliant with the child protection plan and reported this back to conference.

3.11 We saw a `*think family*` approach in the work undertaken by LPFT's Drug & Alcohol Recovery Team (DART) with adults who misuse drugs and alcohol and who have children. Risk assessments, screening tools and a parenting check list ensure there is a joint focus on the needs of any children present in the family. We also saw good examples of contingency planning within recovery plans should a client fail to engage which is good practice.

3.12 However, outside of formal safeguarding meetings and conferences there was some evidence that the Drug and Alcohol Recovery Team (DART) workers did not always share information and concerns with other agencies in a timely manner. Other agencies who are monitoring risks to children are often reliant upon the client passing on and disclosing information that may be unreliable. We saw a lack of consultation between the adult drug and alcohol service and midwives for their clients. In one case we saw, the woman had disclosed on going substance misuse to the drugs worker but this information had not been shared with the midwife. This means that the midwife was not aware of information that could impact on the safety and wellbeing of the mother and the unborn baby (recommendation 7.3).

3.13 The drugs and alcohol team advised us that they are not asked to provide information to children in need meetings involving parents who receive support from their service. They also advised us that they are not consistently invited to relevant child protection meetings and often experience late receipt of minutes of CP meetings (recommendation 7.3). We heard that work is underway between LPFT and children's service managers in respect of drug and alcohol issues for parents based on the Ofsted/CQC 2013 report, "*What about the children*?"

3.14 Health professionals routinely participate in strategy meetings when they are invited; the expert knowledge about the child from school nursing, health visiting and midwifery can be instrumental in decision making about the level of intervention likely to deliver the best outcome for the child. Pressures on the school health service and the skill mix of a very limited number of more senior nurses, risks capacity for this valuable part of the role.

3.15 Health professionals prioritise attendance at child protection conferences and core groups and prepare reports as needed. Some reports lack the detail that would make the best contribution to multi-agency decision making. GPs are unclear what information to include when they submit reports. There is no agreed report template which they would find helpful and which would optimise their professional contribution to case conferences (recommendation 4.3).

3.16 Resources available to young people in the county aged 16 or under who have significant mental health needs include T4 CAMHS in-patient service provision. Young people are sometimes placed out of county in accordance with NHS England's commissioning protocol either to suit their circumstances or when the local places are already full. It is rarely necessary to admit a young person aged 16-17 to an adult ward. Though we noted from Trust papers that this had occurred on two occasions in 2013, reports provide assurance that both of these young people were supported by appropriate safeguards.

CAMHS are providing good support to a young person who had experienced significant abuse resulting in criminal proceedings. The tier 3 CAMH service liaises carefully with other agencies including the Crown Prosecution Service (CPS) to ascertain whether outside issues are likely to impact on the child's mental health and to take the work at the child's pace. This is more likely to result in positive outcomes for the young person.

3.17 Where child protection plans are in place and adult mental health, including peri-natal mental health, are engaged with the parent, practitioners are very clear on their role in protecting the child. We saw an example where adult mental health practitioners were actively ensuring that mother was compliant with the child protection plan and reported this back to conference.

3.18 Our case sampling in A&E identified that processes and arrangements do not currently ensure that A&E attendances by children for whom risks are identified will be robustly followed up. This is especially important where children move between areas or live out of county. We saw an example of a young person for who effective follow up was required but the notification was a brief, routine, system-generated letter to a GP although staff have the option to provide individualised information. In cases of risk and self-harm, these arrangements are insufficient to alert receiving primary care team (recommendation 3.1):

A 13 year old girl from a neighbouring county was brought to Grantham A&E after taking a deliberate and significant overdose of medication to harm herself. Staff also identified previous self-harm and did a good job of triage, assessment, gleaning important information and alerting receiving hospitals. Some inconsistencies in the circumstances needed more exploration but suggested additional concerns. The case number was added to the PLN's list for her next weekly visit. A routine PAS system generated letter to her GP contained insufficient details to prompt any special follow up.

3.19 Young people from 14 years old are well supported by the sexual assault referral centre (SARC) at Spring Lodge, Lincoln when they need to access this service. Effective work by the ISVA[3] ensures the young person receives appropriate aftercare.

3.20 We saw some good, persistent work by skilled community health practitioners to promote the health of children in vulnerable families and children subject to child protection plans. In one case, since the school nurse's involvement as part of the core group, she has successfully gained the trust of the mother and has started to address the child's unmet health needs by getting him registered with a GP and dentist. We also saw an example of good multi-agency working to explore strategies to manage a child at high risk of serious self-harm. An appropriate out of area placement has been secured and the child is doing well.

[3] LPFTs Independent Sexual Violence Advisors (ISVA) service

3.21 Barnados are commissioned to provide an effective care leaver service. All young people have a pathway plan which includes a health component but a positive new development, also provided by Barnados, is the CAMHS transition service. This has been particularly effective in helping young people who have left care to overcome often long standing and unresolved emotional and mental health concerns. The Barnados services working closely with the vulnerable children's nurses and also act as advocates for young people. We saw a number of examples of the impact of this work, including:

Case example: *Barnados worked closely with the community mental health team to successfully maintain a female care leaver in education. A positive outcome from multi-agency working.*

Case example: *A young male care leaver with autism. Helped into supported living and employment. Targeted CAMHS was able to clarify which of his needs were down to the autism and which were functional mental health issues. As a result, he was able to access the right level of support.*

3.22 Care leavers have not until now had the support of a dedicated pathway to ensure that their needs and those of their unborn or new babies are addressed. However, having identified an increasing number of pregnancies amongst care leavers, the looked-after child health team and Barnados are putting together a work plan for this (recommendation 2.4).

4. Looked after Children

4.1 The number of children in the care of Lincolnshire county council has steadily risen since 2010, to approximately 580. Additionally, children in the care of other local authorities are increasingly being placed in new private sector care homes within Lincolnshire, currently about 400 children. Assuring the health and wellbeing of such a large number of children, many of whom have complex needs is a significant challenge. Health agencies are fully involved in the safeguarding partnership's work to identify themes and seek resolutions. This is most notable in last year's project in which analysis of intelligence about a cohort of children most frequently reported as missing identified and intervened in respect of child protection and sexual exploitation concerns for all. The continued influx of children placed by other areas into private residential services in Lincolnshire without first ensuring their complex health needs can be met is presenting a particular challenge to a range of local services.

4.2 Whilst there is a protocol for moderate to high scores in strengths and difficulties questionnaires to be reviewed, there are no arrangements to monitor this or to collate outcomes to ensure that children in care are receiving the right services to meet their needs. The arrangements needed to be strengthened by developing monitoring and audit to ensure that individual SDQ scores of 14 or above are reviewed by specialist professionals; that changes to the health care plans are considered and implemented where necessary and that there is more visible tracking of subsequent scores to indicate outcomes of interventions (recommendation 2.1). Since this review, children's services re-launched the SDQ review group and procedure to monitor children with scores over 14 at a children's services team managers' meeting. Attendance at the group includes educational psychologist, CAMHs, LACES (education services) and LAC managers. This is in its early stages and should be monitored for process and outcomes, including the involvement of practitioners who undertake assessments and reviews.

4.3 We found that more needs to be done to ensure the link of general health and mental health evaluations in order to provide timely specialist help. The SDQ[4] scores of a high proportion of young people who have been in care for longer than a year indicate concerns deserving closer analysis and attention given that they are significantly higher than national averages. The designated doctor has flagged up the need to ensure that health reviews take into account all available information about the holistic health needs of looked after children including their emotional wellbeing but progress is slow (recommendation 2.1).

4.4 The specialist vulnerable children's team has oversight of the health needs of children and young people as they move through care. We identified positive relationships with children and young people and the VCNs effectively engage with children and co-ordinate their support. Outreach work by VCNs and CASH staff in some children's homes is valued by care staff.

[4] SDQ – strengths and difficulties questionnaire, an annual national survey to assess the emotional well-being of young people who have been in care for one year or more

4.5 Management of the extensive volume of health assessments is supported by a co-ordinator and administrative staff. Even so, children's initial health assessments (IHAs) are too often affected by delays, often as a result of late notification of placements by social care staff. GPs are being encouraged to direct requests for health assessments for children placed by other areas through the co-ordinator but at present there is no reliable system to ensure oversight and quality assurance of these assessments (recommendation 2.5).

4.6 Looked after children can access support from a dedicated primary CAMHS service which engages well with a range of other health practitioners who support the child. We saw examples where children are benefitting from imaginative child focused interventions which move at the child's pace, providing every opportunity for the child to evaluate their own progress.

4.7 Unfortunately with the increased number of children in care locally, demand for the looked-after children primary CAMH service can outstrip supply. At times children wait longer than the four week target for initial appointments; as many were waiting as were being seen in some periods. In August 72.5% of looked after children were seen within four weeks, compared to the 95% target. This worsened in September when only 49% of looked-after children who were referred were seen within 4 weeks. LPT monitors performance closely and ensures that commissioners of CAMHS services are aware of difficulties. Positively, we understand that some additional resources were found to increase service capacity during 2013 (recommendation 5.1).

4.8 Care leavers who have accessed CAMHS and meet adult service thresholds have a seamless transition pathway from CAMHS, as CAMHS and adult mental health have the same provider. A looked-after child can usually access CAMHS up to the age of 18 with a transition starting at 17.5 although this can be extended for example, to support a young person moving onto university. This is good practice.

4.9 Work has been done to improve compliance with statutory expectations that all children and young people coming into care benefit from a timely assessment of their health (an initial health assessment) and a comprehensive plan to meet their health needs. More children are having their health needs assessed within the statutory timeframe but this is from a low base and less than half (40 – 45%) of children entering care have an assessment within the timeframe with some considerably delayed. Recently introduced reporting now clearly sets out points of delay and this has assisted the improvement. Even so, the reasons for delays are not always clearly set out or understood.

4.10 The quality of GP initial and review health assessments is highly variable and is a priority area for development. From examples of very good practice, reflecting a comprehensive assessment of the child's health and wellbeing and highly reflective of the child as an individual; we have seen assessments of unacceptably poor quality: hand written and mainly illegible containing the most basic information, with no sense of the child as an individual and no attempt to reflect the voice of the child. Despite the efforts of a highly committed designated doctor, the quality assurance process for health assessments and reviews lacks rigor and is not sufficiently robust (recommendation 2.5).

4.11 The quality of health plans is also very variable. Some are comprehensive and child centred with good efforts made to engage children, others are not. Some good assessments are weakened by poor quality health plans which lack measurable objectives, timescales and accountabilities (recommendation 2.5).

4.12 It has been recognised for a number of years that looked after children have not had the quality of health support service which they need :

Several foster carers we met felt that their role in supporting and advocating for children with disabilities was not recognised by health professionals. They are not routinely sent copies of the child's assessments or health plans and are often excluded from assessments, reviews and important discussions about health needs. One foster carer told us how health professionals had held an end of life discussion about the child she has fostered since infancy and had not included her.

4.13 A looked after child's health plan should identify the health support each child needs and be reviewed and revised after each assessment. However, foster carers told us about their experiences of the ineffectiveness of arrangements in meeting the children's needs.

4.14 They explained how assessments and reviews are stand alone, not linking into other medical assessments and appointments. Case files also showed that reviews and health plans could have greater impact if all available information, such as annual and specialist SDQ's, or updates from specialists was drawn together in advance, so that all needs including emotional well-being are considered at the time of the health review.

4.15 Looked after children have good access to primary care, they are promptly registered with GPs and dental checks and immunisations are arranged for almost all looked after children. Community health staff use IT to record heights, weights and immunisations which helps to track progress and identifies gaps.

4.16 The records we saw showed that most health reviews are episodic and are not informed by the previous review although these are routinely sent to the GP to inform the current assessment. The child's own GP is not asked to contribute their often extensive knowledge of the child before the review. As we saw and heard from foster carers, where other services such as paediatricians or other specialists, CAMHS or therapies such speech and language SALT are involved with the child, their knowledge of the child is not contributing progress information to the health review (recommendation 2.5). We heard from a foster carer about their concerns that health reviews give insufficient attention to the health needs of young people with disabilities who will be leaving care: *"There is no preparation for young people turning 18. I told my young person about the birds and the bees.*"

"Now he does get fast tracked to the paediatric ward but it has taken ages and lots of admissions for that to happen."

4.17 The high numbers of children placed into Lincolnshire from other areas challenge all facets of the service. School nurses demonstrate dogged determination in obtaining information from professionals in other placing authorities about children for who there are safeguarding concerns. Diminution of the capacity of school nursing risks losing the most effective part of the safeguarding system in its reach to school age children.

4.18 Looked-after children are well supported by knowledgeable and committed vulnerable children's specialist nurses. They work closely with residential staff, foster carers and a wide range of other professionals and are well regarded.

4.19 There are significant difficulties in ensuring that appropriate equipment to meet the assessed needs of looked-after children with complex disabilities is provided in a timely way. This is a long standing frustration for foster carers. One told us that as her foster child has outgrown his wheelchair, he cannot wear his winter coat when he goes out as he cannot fit in the chair. These difficulties are indicators that health services and health care plans are not effectively supporting looked after children's health needs (recommendation 2.2 &2.5).

"We got him a new chair and it took four and a half months for someone to come out and fit the parts so he could use it." (foster carer of a child with disabilities)

"Depends on the social worker in terms of what support you get. Therapy support helps you maintain the placement".

4.20 We saw case examples where help for young people was delayed because the access pathway for the looked-after child CAMHS service does not accept referrals from the vulnerable children and young people specialist team. They often know the child best and in some cases this would have expedited a child's access into a service likely to result in good outcomes. We understand this was addressed following our review.

4.21 Insufficient attention is paid to ensuring that care leavers have access to their full health history and this is an issue which is of great importance to many young people who leave care. While the provision of the blue book has the potential to provide a comprehensive health history for when the young person leaves care, foster carers told us that most health professionals, GPs, dentists and specialists are reluctant to make entries, diminishing its value to the young person (recommendation 2.3).

5. Management

This section records our findings about how well led the health services are in relation to safeguarding and looked after children.

5.1 Leadership and Management

5.1.1 CCGs and NHS England's area team (AT) provide good leadership to continuously improve health safeguarding and children looked after arrangements.

5.1.2 Lincolnshire's CCGs have put in place a reporting and accountability framework for safeguarding children, including those who are looked after. This has the potential to deliver improvements and ensure effective governance. There is a shared acknowledgement of the challenges and priorities for improvement. Strengthened governance arrangements are in place for the early identification of learning points from serious case reviews (SCRs) for monitoring and evaluation and to ensure timely action is taken to improve services.

5.1.3 At the time of the SLAC in 2010 completion of health assessments was poor. Revised arrangements were developed to recruit GPs on local extended contracts for this work. This has involved a great deal of work and has improved access to health assessments though such a disparate service has struggled to achieve the expected quality and more sustainable arrangements are needed. Senior managers recognise that more needs to be done to secure quality across their responsibilities for both safeguarding and health care for children who are looked after (recommendation 1.2).

5.1.4 Challenges to the leadership resource for the significant task of driving both safeguarding and looked after children's health agendas across a large county is recognised by the CCGs. An external review has been commissioned. The designated professionals all have limited capacity to develop and drive comprehensive plans for changes across the health economy (recommendation 1.1). We found that they are all respected and committed professionals working hard to address challenges many of which are long standing and require more strategic solutions.

5.1.5 Prompt investigative action has been taken in response to our concerns about a case we sampled at A&E where an inadequately managed discharge from an out of county in-patient mental health unit resulted in the child self-harming and requiring emergency treatment.

5.1.6 Information technology is increasingly supporting timely and effective exchange of information especially in the community. Increased use of NHS secure internet and more electronic records has speeded up notification processes. As in many areas, lack of connectivity between the main health providers remains a barrier to effectiveness. Wide use is made of electronic records in many services but LPFT, ULHT and CASH all use different systems which cannot connect. A bid to link these health service data bases is with NHS England.

5.1.7 There are some strengths here, for instance the data base used in community services, therapies, by community paediatricians based in ULHT, and all but one of the looked-after children GPs. Not all GPs use the system, but where they do they can enable other LCHS staff to view specific records. The community health data base has also been provided for read-only use by A&E staff in the acute hospitals. However, A&E and other key health professionals do not have direct access to terminals with the social care data base which is possible in many other areas of the country. This means staff need to make phone calls to check whether children and families are known to social care and it is acknowledged that there can be difficulties in making timely contact in this way. Positively, health partners have been consulted in relation to social care's planned system upgrade.

5.1.8 The use of audits has contributed to improvements in the quality of some looked-after children's health assessments but overall quality remains inconsistent.

5.1.9 There remain unmet pressures on capacity and skill mix for carrying out health assessments compared to the volume of work and complexity of needs of children coming into care. The 2011/12 Annual Report on the health of looked after children highlighted the variability in the quality of health assessments and health care plans and recommended that community paediatricians should undertake IHAs (recommendation 1.2). Children and young people have not benefitted from any progress towards this recommendation though audit evidence was used recently to request a review of arrangements for IHAs at safeguarding steering group.

5.1.10 Strategic partnership working is good. Health strategic leads describe positive relationships across the partnership and particularly with the director of children's services who also has a health background. Strategic leads meet regularly and partners are able to have a mature dialogue about a range of issues and common themes. Strategic managers identify an improved connectivity between strategic management and frontline operational staff. Operational managers are increasingly seeking multi agency solutions when issues are identified though some intransigent problems have yet to be resolved fully. CASH services in Lincolnshire are not formally represented in the partnership that is addressing sexual exploitation and this is a gap since the service will be able to contribute strategically and in respect of operational issues and individual cases (recommendation 4.2).

5.1.11 We heard about an example where the named GP was able to liaise with social care when an issue was identified by GPs. As a result, social care's processes were amended to ensure that GP calls are now logged to contribute to risk assessment about children and their families.

5.1.12 Partnerships with and in CAMH services are improving but case examples showed a range of issues where better coordination between services could improve outcomes for young people and their families. This is evident where support for young people who attend A&E's with emotional, behavioural and mental health needs continues to be inconsistent as professionals struggle to reconcile the needs of different groups of children. We also saw the significant impact of poor discharge arrangements and communication from an external T4 CAMHS which failed to ensure that local services are in place (recommendation 5.3).

5.1.13 Families with foster children told us how better co-ordination between health professionals would benefit the young people by ensuring their health needs are fully taken into account.

5.1.14 We saw little evidence that the views of children, their families and carers are regularly heard and taken into account. Much more focus is needed to ensure that children and young people are encouraged to regularly share their views and experiences in evaluating the quality and impact of local health services (recommendation 7.1).

The community health trust's recently strengthened arrangements for safeguarding leadership were bringing the important health perspective to child protection strategy discussions. Through a rota system, the county-wide team of deputy named nurses is available at any time and this is an imaginative response in a large county area.

5.1.15 We found that health professionals recognise the value of team around the child work but in some areas of work, capacity issues prevent their involvement, with this being a particular issue for staff employed by ULHT. Capacity within the ULHT safeguarding team generally has been flagged up in CQCs compliance inspection of this trust. The children's safeguarding team of two health professionals liaises with the named midwife team and the adult team. Operating across several disparate sites and ensuring an effective safeguarding partnership with other providers adds to the challenges of the role.

5.2 Governance

5.2.1 Each trust has governance arrangements in place which include regular reporting on local safeguarding arrangements.

5.2.2 NHS England and the four CCG's have given high priority to the work needed to continuously improve safeguarding and children in care health services. The priorities for safeguarding are currently clearer than for children in care. Through a memorandum of understanding between the four CCGs, this work is led by Southwest Lincolnshire CCG, its chief nurse, and the designated professionals.

5.2.3 Progress has been made in some areas and the designated nurse for safeguarding and looked-after children is providing strong leadership. However, she and other designated professionals have insufficient capacity for strategic planning, comprehensive quality assurance of operational delivery and ensuring continuous improvement (recommendation 1.1).

5.2.4 The capacity of the looked-after children health team has not kept pace with the growth in numbers of looked-after children in the county, including high numbers of children placed by other councils and the complexity of needs. Well over 1000 health assessments and reviews are required each year, with significant preparatory and follow up work including quality assurance of the assessments and health plans. Although efficiently supported by the co-ordinator and administrative support, the designated doctor's allocated one session per week is inadequate to deliver the strategic role and quality assurance work. The designated nurse role is also challenged in seeking to deliver the full statutory role with approximately one third of a post for LAC work and one third for children's safeguarding leadership. These pressures impact on capacity to drive and embed quality standards across the large county (recommendation 1.1 and 1.2).

5.2.5 We found that performance reporting arrangements around the holistic health needs of all looked-after children, the services to meet their needs and the outcomes that are achieved is insufficient to ensure that looked-after children receive the help they need (recommendation 2.2). The format of the annual report on the health of looked-after children is quite narrow in scope. This misses the opportunity to set out the full picture of their needs and outcomes and to identify key issues that are of concern to looked-after children generally or to local children in particular. Limited performance reporting about needs, outcomes and gaps in services for looked-after children impacts on the ability to make robust plans to deliver improvements. Information about the health needs of looked-after children with long term conditions is not currently collated from their individual health assessments. This results in a lack of oversight of the capacity of services to meet their current needs and that their health needs are recognised in transition planning for their future. This remains an outstanding action although identified by the looked-after children service to be addressed during 2012/2013 (recommendation 1.2).

5.2.6 The community trust provides paediatric liaison nurses (PLNs) in A&E departments run by ULHT and at the minor injuries units (MIUs). In some locations we found un-explained gaps in referrals to the PLN and a lack of managerial oversight or quality assurance. As a result, it is not clear that staff across acute services properly regard this as a whole system approach and there are inherent risks that children are not effectively protected. The addition of the new MIU at Peterborough to the portfolio of the paediatric liaison service has added significant pressure on the capacity of the service, which is already stretched (recommendation 3.3).

5.2.7 Within ULHT strengthening of safeguarding has started to progress with the appointment of an interim named midwife, a new post currently at Band 7 created in response to a serious case review as the role did not exist before March 2013. The named midwife post is an integrated role within ULHT, supported the safeguarding leads for adults and children. Managers recognise that the role requires the greater seniority and experience of a Band 8 midwife and a business case is being developed to seek appropriate recruitment of suitably qualified midwife. The current post holder is doing a good job from a zero base but has insufficient experience in safeguarding to put in place a fully robust framework and monitoring for effectiveness and quality.

5.2.8 Midwifery services are being reconfigured to best meet local need with the Louth community midwife team being transferred to Grimsby hospital. This makes good sense as most deliveries in that area happen at Grimsby hospital. The Grantham stand-alone unit is to close in February. This has been subject to consultation and services will move to Lincoln site to focus resources where most required.

5.2.9 The LPT safeguarding consultant named nurse oversees safeguarding activity in CAMHS, SARC, DART and adult mental health. She provides strong and effective leadership and has put a good system in place. The LCHS's safeguarding team also operates very effectively in most areas of work and makes good use of its management information.

5.2.10 The oversight and clinical governance of safeguarding in A&E and MIU locations we visited is not fully effective. Paediatric liaison arrangements lack a systematic, county wide approach. The paediatric liaison nurse records any actions she takes on her visits to review CAS Cards and holds this data. Recognised safeguarding issues within ULHT and LCHS are cascaded upwards through the Trust's Safeguarding Committee's and downwards via the Trust's Safeguarding Champions Network / deputy named nurses. However, the details of PLN activity are held by the PLN. It is not collated to provide useful performance information which ULHT and LCHS could use to monitor departmental and clinicians' safeguarding practice, identify trends and drive continuous improvement and is not subject to reporting through clinical governance arrangements (recommendation 3.3).

5.2.11 A&E staff routinely seek advice and guidance from the ULHT safeguarding team when they have concerns about individual children. We saw examples of recent improvements by the named nurses which are helping to strengthen safeguarding systems. Where staff do identify safeguarding concerns, the advice sheets then generated by the ULHT safeguarding team provide a useful audit trail of the issue and the advice or instructions given to address the safeguarding concern.

5.2.12 Arrangements are not in place to collate the health needs of looked-after children or to track their access to treatment and subsequent outcomes (recommendation 2.2). We heard about children waiting unacceptably long times for a range of services and equipment. Collation of this data would help to inform commissioning and ensure that there are appropriate, effective services in place.

5.3 Training and Supervision

5.3.1 Safeguarding champions provide a structure for sharing learning within their localities and teams. A&E at Grantham has particularly strong leadership from its A&E sister who is very well respected. As a safeguarding champion she has brought in bespoke training which has helped to skill up all the staff. Her leadership helps to mitigate for against any systems difficulties and she personally takes a role in ensuring issues are followed up.

5.3.2 Ensuring that health practitioners are trained to levels of safeguarding competence commensurate with their roles remains a priority challenge for some services. Since the previous inspection, additional investment by the LCSB has increased the availability of multi-agency safeguarding training. We saw how health staff are taking advantage of the programme, using on line booking arrangements to access targeted training to fit their roles.

5.3.3 Health visitors and school nurses are well trained in safeguarding and looked after children work and their competencies are checked to support compliance with *Working Together* and intercollegiate guidance.

5.3.4 There is now a clear grip on safeguarding training requirements for all staff of the acute trust following a period when compliance and oversight of safeguarding training was poor. This remains a priority area for improvement at ULHT and is being well monitored. As additional staff are recruited, more are able to be released for training. A good trust wide initiative by ULHT's safeguarding practitioner, in conjunction with the PLNs, is open surgeries / workshops allowing all A/E staff to access advice and guidance. These are aimed at developing safeguarding practice and confidence in addition to offering reiteration of the Safeguarding / PLN Teams' roles, unfortunately, take up is low.

5.3.5 It is not clear whether safeguarding training at level 1 is fully equipping reception staff at A&Es and MIUs to undertake risk assessment involving a high proportion of children, as they are doing on a day to day basis. Examples were given however, of cases where reception staff had identified safeguarding risks and had acted promptly in notifying clinical staff of their concerns.

5.3.6 We visited three emergency care centres which treat both children and adults and asked about arrangements to ensure staff had appropriate training to equip them to nurse children. Grantham hospital A&E is usually able to offer nursing care by at least one paediatric –trained nurse at all times. However, arrangements to ensure staff working with children across the acute trust (ULHT) and in the MIUs can access and maintain EPLS training are not sufficiently rigorous and practitioners are overdue essential refresher training (recommendation 3.4).

5.3.7 The NHS England area team (AT) and CCG leadership are working together to secure a sustainable approach to safeguarding training arrangements for GPs and this is recognised as a current area of risk. The county initially undertook a series of level 3 training sessions to cover all GPs between 2010 and 2011 but for about one third of all of those who attended then, that training is now over three years old. Training sessions for GPs are available from ULHT or the LCSB and attended by some GPs.

5.3.8 A new system is being put into place to track individual GP's training needs and attendance and ensure that arrangements are also in place for practice staff. Work is also starting, with the NHS England area team, to develop a university accredited training programme for primary care practitioners alongside an in-house programme and this is very positive.

5.3.9 Safeguarding supervision is at an early stage of implementation in some health services. However, LCHS performs well overall, with very good visible performance management information across a range of safeguarding themes including safeguarding supervision which is reported quarterly. Compliance with planned supervision in the summer quarter was 91.08%. Health visitors are routinely receiving quarterly 1:1 and also group supervision. All LPFT staff discuss safeguarding at every managerial supervision session which is a minimum of 6 weekly.

5.3.10 In some other service areas such as the MIUs (LCHS) and in midwifery (ULHT), supervision is a recent introduction which is not embedded. It is early days for group supervision and no individual supervision is in place. Although there are safeguarding champions in midwifery services, there are no safeguarding supervisory staff other than the named midwife. There are no formal safeguarding supervision arrangements for A&E staff at ULHT (recommendation 6.1). Without regular formal supervision as set out in statutory guidance, practitioner's annual appraisal cannot be fully informed as part of a robust workforce development model.

Recommendations

1. Lincolnshire West CCG; South Lincolnshire CCG; South West Lincolnshire CCG; Lincolnshire East CCG should:

1.1 Review the leadership capacity for safeguarding children and children in care to fully meet statutory requirements and secure the timely delivery of quality services for safeguarding children and children who are looked after.

1.2 Ensure commissioning governance and assurance provide effective scrutiny of the experiences and impact of local health services in delivering improved outcomes for children and young people who are looked after.

1.3 Use the opportunity of the local strategic review to consider the commissioning of specialist paediatric care and ensure its effectiveness in enabling children who have specialist needs to have access to timely, child centred assessment and treatment.

2. Lincolnshire West CCG; South Lincolnshire CCG; South West Lincolnshire CCG; Lincolnshire East CCG and LCHS should :

2.1 Ensure the emotional wellbeing and mental health of children in care is fully addressed in health care assessments, reviews and health plans.

2.2 Regularly report on child health outcomes for children in care, proactively identifying local trends, and robustly addressing risks to their health and wellbeing.

2.3 Fully implement holistic health summaries for young people leaving care and ensure they are responsive to their individual wishes and needs.

2.4 Ensure that arrangements are put into place to provide consistent support for looked after young people and care leavers who become pregnant or become parents.

2.5 Ensure that all children in care have prompt and high quality, holistic assessments of their needs and regular reviews followed by SMART health plans that ensure their needs are met.

3. Lincolnshire West CCG; South Lincolnshire CCG; South West Lincolnshire CCG; Lincolnshire East CCG, LCHS and ULHT should:

3.1 Ensure that discharge pathways from MIUs, A&Es and other settings are effective in ensuring the sharing of information about risks and involving appropriate professionals to secure best outcomes for the young people.

3.2 Ensure that opportunities are maximised to offer young people help through drug and alcohol support services by embedding the LSCB led multi-agency protocol which provides clear referral pathways from health services including urgent care settings to Young Addaction .

3.3 Review paediatric liaison capacity, seniority and clinical governance arrangements to ensure that robust, effective arrangements are in place across all services so that risks to children are effectively identified and followed up.

3.4 Ensure all children and young people requiring urgent care in the MIUs and Accident and Emergency Departments are cared for by appropriately trained nursing staff with updated specialist paediatric skills.[5]

4. NHS England, Lincolnshire West CCG; South Lincolnshire CCG; South West Lincolnshire CCG; Lincolnshire East CCG and LCHS should:

4.1 Ensure that GPs are properly equipped and competent for their roles in safeguarding, child protection and meeting the needs of children in care through robust development opportunities.

4.2 Ensure that GPs and others who may provide contraceptive services to young people are aware of the law in relation to the age of consent, particularly in relation to their responsibilities where a girl is under 13 years of age.

4.3 Ensure there are robust local systems for GPs to regularly share information about children and families where risks are identified.

[5] *"In district general hospital mixed emergency departments, a minimum of one registered children's nurse with trauma experience and valid EPLS/APLS training must be available at all times"* (RCN and RCPCH 2010; RCPCH, 2012).

5. NHS England, Lincolnshire West CCG; South Lincolnshire CCG; South West Lincolnshire CCG; Lincolnshire East CCG and LPFT should:

5.1 Continue to work in partnership to ensure that commissioning and operational arrangements enable children needing CAMH services to have timely access to early help, specialist assessment and treatment.

5.2 Ensure that mothers and their babies in all areas of Lincolnshire have access to perinatal mental health services to secure effective early intervention and support.

5.3 Review arrangements for young people placed out of county so that discharge protocols from or between CAMH tier 4 services and to other services ensure that these young people receive the support they need. .

6. Lincolnshire West CCG; South Lincolnshire CCG; South West Lincolnshire CCG; Lincolnshire East CCG, and ULHT should:

6.1 Ensure an appropriate system of supervision is in place for all staff who are involved in safeguarding and child protection work, including urgent care and midwifery, in line with inter-collegiate professional requirements.

7. Lincolnshire West CCG; South Lincolnshire CCG; South West Lincolnshire CCG; Lincolnshire East CCG, LCHS, ULHT and LPFT should:

7.1 Expand opportunities for listening to and learning from the experiences of young people and their families/carers, actively engaging them in service improvements.

7.2 Ensure that robust arrangements are put in place to assure the quality of referrals by health professionals and ensure that children for whom risks are identified receive prompt support.

7.3 Ensure, through working with partners, that staff across all health disciplines including adult drug and alcohol services are fully engaged in robust, consistent information sharing about children and their families for whom risks or concerns are known.

7.4 Ensure that the pre-birth protocol is audited for effectiveness in all cases including those where there is a known high degree of risk around the expectant mother

8. LCHS:

8.1 Ensure that all relevant staff are properly equipped prior to any roll out of new policies or systems including the electronic version of the vulnerability assessment matrix, to ensure use is consistent and effective.

9. NHS England and Lincolnshire West CCG; South Lincolnshire CCG; South West Lincolnshire CCG; Lincolnshire East CCG should:

9.1 Review commissioning strategies, local needs analyses and pathways to ensure children benefit from sufficiency of CAMHs provision, including tier 4, tier 3+ and community based alternatives to in-patient care, to facilitate care close to home and to ensure that other young children on paediatric wards are not put at risk of harm or distress

Next steps

An action plan addressing the above recommendations is required from South West Lincolnshire CCG on behalf of the federation within 20 working days of receipt of this report. Please submit your action plan to CQC through childrens-services-inspection@cqc.org.uk. The plan will be considered by the inspection team and progress will be followed up through CQC's regional team.

Lincolnshire 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:	**25 March 2014**
Subject:	**Autism Self-Evaluation 2013**

Summary

The Department of Health is currently leading a formal review of progress against the National Autism Strategy (DH, 2010). This is an opportunity for the National Government to assess whether the objectives of the Strategy remain fundamentally the right ones, to be assured of the progress that is being achieved by Local Authorities and the NHS, and consider what should happen to continue to make progress.

As part of the review process, a self-evaluation questionnaire was issued to all local authorities in summer 2013.

The completed self-evaluation for Lincolnshire was submitted to Public Health England as required by 30 September 2013.

The response for each local authority area was required to be agreed by the Autism Partnership Board or equivalent group, and the ratings validated by people who have autism. The questionnaire was completed in co-production with members of the local Autism Partnership Group, who also agreed the contents of the questionnaire prior to submission.

There is also a requirement for the content of the questionnaire to be signed off by the local Health and Wellbeing Board as evidence for local planning, health needs assessment strategy development and support for local implementation work.

Actions Required:

The Health and Wellbeing board is requested to note, discuss as necessary and agree the contents of the self-evaluation as evidence of local planning and support for local implementation work.

1. Background

Statutory guidance which accompanies 'Fulfilling and Rewarding Lives' (DH, 2010), the Government's strategy for adults with autism, issued under section 2 of the Autism Act (2009), sets out key objectives for local authorities and NHS bodies in England, principally to ensure that:

All adults with autism are able to live fulfilling and rewarding lives within a society that accepts and understands them. They can get a diagnosis and access support if they need it, and they can depend on mainstream public services to treat them fairly as individuals, helping them make the most of their talents.

The Department of Health is carrying out a review of the the National Autism Strategy (DH, 2010). The investigative stage of the review lasted until the end of October 2013 and the Strategy will be revised as necessary with an anticipated completion of March 2014. Part of this review is to understand how the strategy is being implemented, and what progression is being made by Local Authorities and the NHS. Part of that review was asking local authorities and their NHS partners to complete a self-assessment questionnaire.

Local authorities and the NHS play a key role in implementing the recommendations of the National Autism Strategy and the statutory guidance that supports it. The purpose of the self-evaluation was to:

- assist local authorities and their partners in assessing progress in implementing the 2010 Adult Autism Strategy;

- evaluate how much progress has been made since the baseline survey, as at February 2012;

- provide evidence of examples of good progress that can be shared and to note remaining challenges.

The self-assessment builds on the first self-assessment exercise which looked at what progress had been made since February 2012. This was based around the self-assessment framework which the Department of Health launched in April 2011 to support localities with the delivery of the Adult Autism Strategy and the statutory guidance for health and social care which was issued in December 2010.

The complete self-assessment questionnaire is attached as Appendix A, but the key themes from the local return were:

- Joint commissioning is in place
- There are issues around data collection
- Good co-production in place
- Lack of service improvement
- Lack of consideration of Older People with Autism
- Some progression on training, but more to do
- Diagnostic pathway is in place
- Problems separating Learning Disability and Autism

- Good local information sources
- Lack of a holistic approach
    - No links to housing
    - Lack of employment support
    - Lack of engagement with the Criminal Justice System

2. Conclusion

The Lincolnshire self-evaluation was submitted by the deadline date of 30 September 2013. All 152 local authorities in England Wales completed the self-assessment exercise by November 2013.

A report summarising the initial findings has been published by Public Health England, and is attached to this report as Appendix B.

The Public Health England website remains opens so local authorities can confirm the date on which the self-evaluation was considered by Health and Wellbeing Boards, and we will update the website after the Lincolnshire Health and Wellbeing Board have considered this report and the questionnaire itself.

A fuller report giving regional and local details along with thematic analysis of key themes is scheduled to be published shortly. At that stage, Public Health England will also be making available the returns from local areas in full, both as document files and as a spread sheet to facilitate comparative analysis. This will be used locally to support the development of an All-age Autism Strategy for Lincolnshire.

3. Consultation

As part of the completion process the text and ratings submitted in the self-evaluation were discussed and agreed before submission by the Autism Partnership Group. All members were invited to make contributions including members with autism. Lead commissioners for both health and social care sectors were also involved.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Autism Self Evaluation
Appendix B	Autism self-assessment exercise 2013 Initial Findings

5. Background Papers

Fulfilling and rewarding lives: the strategy for adults with autism in England - http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113369

This report was written by Paul Herniman who can be contacted on (01522 554219) or (paul.herniman@lincolnshire.gov.uk)

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Autism Self Evaluation

Local authority area

1. How many Clinical Commissioning Groups do you need to work with to implement the Adult Autism Strategy in your local authority area?

4

Comment

South West Lincolnshire Clinical Commissioning Group has the lead function under a federative arrangement with the three other CCGs.

2. Are you working with other local authorities to implement part or all of the priorities of the strategy?

- ⊗ *Yes*
- ○ *No*

If yes, how are you doing this?

Working with the Autism Leads Network for the East Midlands which provides peer support for local authority commissioning managers and lead officers with responsibility for autism.

The regional clinical leads network is in the process of being refreshed.

Planning

3. Do you have a named joint commissioner/senior manager of responsible for services for adults with autism?

- ⊗ *Yes*
- ○ *No*

If yes, what are their responsibilities and who do they report to? Please provide their name and contact details.

Justin Hackney, Joint Assistant Director MH & LD Commissioner & Category Manager

Senior Commissioner for MH & LD Services, including autism. Reports to Director of Adult Social Services. The existing Joint Commissioning Board for Learning Disabilities will be recreated to include autism and mental health.

Tel: 01522 554259
Mobile: 07774 661042
Email: justin.hackney@lincolnshire.gov.uk
Address: Room 114a, County Offices, Newland, Lincoln, LN1 1YQ

4. Is Autism included in the local JSNA?

- ◯ Red
- ⊗ Amber
- ◯ Green

Comment

Autism will be included in next JSNA due for publication in 2014. An autism commentary will be included in Mental Health narrative. An application for a separate autism chapter in the JSNA has been lodged.

5. Have you started to collect data on people with a diagnosis of autism?

- ◯ Red
- ⊗ Amber
- ◯ Green

Comment

Lincolnshire Partnership Foundation NHS Trust collect some data relating to referrals specifically for ASD assessments.

These figures will establish some baseline information on service users understood to have autism and development plans will address the need to ensure comprehensive data capture in the future.

Primary care also collects some data on the incidence of autism but this is not currently available. Further discussions with CCGs will aim to agree guidance on read codes, and a data sharing protocol.

The national prevalence database PANSI (Projecting Adult Needs and Service Information System) projects the number of adults 18-64 with autism spectrum disorders. The figures for Lincolnshire show : 4,237 (2014), 4,288 (2016), 4,343 (2018), 4,381 (2020).

6. Do you collect data on the number of people with a diagnosis of autism meeting eligibility criteria for social care (irrespective of whether they receive any)?

- ◯ Yes
- ⊗ No

If yes, what is

the total number of people?

the number who are also identified as having a learning disability?

the number who are identified as also having mental health problems?

Comment

Data on autism is not currently collected by Lincolnshire County Council using the social care database AIS. However, an internal audit of 1,978 sample cases currently open to Learning Disability Services has shown the following results :

** How many cases in total are currently open to your team? 1,978*

** Of this total, how many service users have a confirmed diagnosis of Autism? 459*

** Of the total, how many additionally do you regard as having Autism? 299*

7. Does your commissioning plan reflect local data and needs of people with autism?

- [x] *Yes*
- [ ] *No*

If yes, how is this demonstrated?

If yes, how is this demonstrated?

Local data is acknowledged in the Adult Care current commissioning intentions plan for 2013/14 although this document is not yet published.

8. What data collection sources do you use?

- [ ] *Red*
- [ ] *Red/Amber*
- [x] *Amber*
- [ ] *Amber/Green*
- [ ] *Green*

Comment

PANSI and social care data referred to in Q5 and Q6 above.

9. Is your local Clinical Commissioning Group or Clinical Commissioning Groups (including the Support Service) engaged in the planning and implementation of the strategy in your local area?

- [ ] *Red*
- [x] *Amber*
- [ ] *Green*

Comment

A CCG representative is a permanent member of the Autism Partnership Group and is in regular liaison with Lincolnshire County Council.

10. How have you and your partners engaged people with autism and their carers in planning?

- [ ] *Red*
- [ ] *Amber*
- [x] *Green*

Please give an example to demonstrate your score.

People with autism, and carers of people with autism are involved in the Autism Partnership Group, and included in co-production of the Adults with Autism Strategy and other documents.
A consultation process leading to the drafting of a Joint Commissioning Strategy for Lincolnshire was held earlier in 2013. A consultation questionnaire was developed and made available on-line, in hard copy and in an easy read format. In addition to the questionnaire, a facilitated consultation workshop was conducted to discuss key themes in respect of autism with a wider audience consisting of service users, carers and providers.

The finale of the consultation period also coincided with the 10th Lincolnshire Autism Conference, organised by the Lincolnshire Autistic Society and STAPS (Specialist Teaching and Applied Psychology Service. Each delegate (approximately 225) was provided with a hard copy of the consultation questionnaire in their delegate pack, which they were able to complete and return to staff on the day for submission.

A total of 214 questionnaires were received during the consultation period, with 160 of these submitted online. A further 54 hard copy paper versions of the questionnaire were returned, five of which were completed in the Easy Read format.

21 people stated that they were a person with autism, which amounts to 9.8% of the total responses. Almost 50% of respondents (106) confirmed that they were a carer of someone with autism.
A significantly larger proportion of females (73.8%) completed the questionnaire, with the number of male respondents being 44, which amounts to 20.6% of the total participants. 12 people (5.6%) preferred not to provide details of their gender.

All future planning work incorporates the need for involving people with autism and carers. This will include work to review current autism pathways and to develop autism training plans.

11. Have reasonable adjustments been made to everyday services to improve access and support for people with autism?

- ⊗ *Red*
- ○ *Amber*
- ○ *Green*

Please give an example.

No clear policy has been published yet. Some anecdotal examples suggest improvements are being made as a result of autism awareness and professional training.
Future work will ensure that the needs of people with autism are specified in the procurement of everyday services.

12. Do you have a Transition process in place from Children's social services to Adult social services?

- ⊗ *Yes*
- ○ *No*

If yes, please give brief details of whether this is automatic or requires a parental request, the mechanism and any restrictions on who it applies to.

The transition process is intended to be comprehensive and to account for all young people from age 14 (Year 9) who are identified as having autism. Children with autism identified in the Special Educational Needs system have statements of Special Educational Needs (SEN) and are entitled to transition planning from Year 9 . This process is intended to include anticipated social care need which can initiate a request for a social care assessment by the local authority. Parents and carers can also request a social care assessment independently by contacting the Customer Services team. Access to services following a social care assessment is subject to meeting access criteria. Children and carers not meeitng access criteria for social care may be signposted to alternative sources of support.

13. Does your planning consider the particular needs of older people with Autism?

- ⊗ *Red*
- ○ *Amber*
- ○ *Green*

Comment

Members of the autism partnership are aware of this issue and the need for further work in this area. Older people with autism are mostly supported in generic older peoples services; Learning Difficulty services can cater for older people with autism if they also have a learning difficulty. Older People's Mental Health services can offer a similar specialist function. Future planning will incorporate reccomendations from the National Autistic Society report "Getting On ?" (2013) which summarises the work of the Autism and Ageing Commission.

Training

14. Have you got a multi-agency autism training plan?

- ⊗ *Yes*
- ○ *No*

15. Is autism awareness training being/been made available to all staff working in health and social care?

- ○ *Red*
- ⊗ *Amber*
- ○ *Green*

Comment: Specify whether Self-Advocates with autism are included in the design of training and/or whether they have a role as trainers. If the latter specify whether face-to-face or on video/other recorded media.

Lincolnshire Partnership Foundation NHS Trust provides autism awareness training to all its staff as part of the mandatory training programme.

A similar training programme is being extended to social care staff; to date 48 have attended, including 24 assessment and care management staff, the majority in learning disability services.

Training plans are being developed to ensure that all adult care staff receive an appropriate level of autism awareness or training. Members of the autism partnership have had input into training design and will be represented on the autism training working group.

There is limited self-advocate involvement in training delivery. Training plans will ensure self-advocate involvement in future delivery.

16. Is specific training being/been provided to staff that carry out statutory assessments on how to make adjustments in their approach and communication?

- ⊗ *Red*
- ○ *Amber*
- ○ *Green*

Comments

Some specialist training has been provided for assessment staff but this has been on a voluntary basis and does not cover 50% of those eligible. A revised training plan will address this requirement to ensure all assessment staff are able to make necessary adjustments.
Lincolnshire Partnership Foundation NHS Trust provides training to staff under an existing programme.

17. Have Clinical Commissioning Group(s) been involved in the development of workforce planning and are general practitioners and primary care practitioners engaged included in the training agenda?

- ⊗ *Yes*
- ○ *No*

Please comment further on any developments and challenges.

Some training has been promoted to GPs but no comprehensive plan has been developed yet. CCGs will be included in developing training plans.

18. Have local Criminal Justice services engaged in the training agenda?

- [x] Yes
- [ ] No

Please comment further on any developments and challenges.

Lincolnshire Police provide some autism awareness training to their staff delivered by a self-advocate.
Lincolnshire County Council has appointed a dedicated social worker (Associate Lead Professional) to develop advice and in-reach support to local prison inmates. The opportunity will also be taken to raise awareness of autism and address the needs of inmates with autism.

Diagnosis led by the local NHS Commissioner

19. Have you got an established local diagnostic pathway?

- [ ] Red
- [ ] Amber
- [x] Green

Please provide further comment.

The pathway enables individuals with presenting needs to receive a spot purchased DISCO (Diagnostic Interview for Social and Communication Disorders) assessment, Those requesting a diagnosis who have no presenting needs do not have access to a diagnostic assessment. Waiting times are within 6 months and NICE guidelines are considered within the model.

20. If you have got an established local diagnostic pathway, when was the pathway put in place?

Month (Numerical, e.g. January 01)

10

Year (Four figures, e.g. 2013)

2012

Comment

Pathway to be reviewed October 2013

21. How long is the average wait for referral to diagnostic services?

Please report the total number of weeks

4

Comment

Average wait 4 weeks, longest wait 11 weeks.

22. How many people have completed the pathway in the last year?

25

Comment

25 individuals excluding learning disabilities (data for secondary diagnosis ASD for people with a primary LD diagnosis is not collected)
Around 50% of referrals have had funding for an assessment agreed

23. Has the local Clinical Commissioning Group(s)/support services taken the lead in developing the pathway?

- [x] *Yes*
- [ ] *No*

Comment

Through a federated function agreement with South West Lincolnshire CCG

24. How would you describe the local diagnostic pathway, ie Integrated with mainstream statutory services with a specialist awareness of autism for diagnosis or a specialist autism specific service?

- [x] *a. Integrated with mainstream statutory services with a specialist awareness of autism for diagnosis*
- [ ] *b. Specialist autism specific service*

Please comment further

Specialist diagnostic pathway via main stream mental health practitioners who have undergone DISCO training. The diagnostic pathway is compatible with pathways for community health services and for social care although it is acknowledged that improvements need to be made. The diagnostic pathway review due to be launched in October 2013 will give opportunities to develop a more integrated autism pathway.

25. In your local diagnostic path does a diagnosis of autism automatically trigger an offer of a Community Care Assessment?

- [ ] *Yes*
- [x] *No*

Please comment, i.e. if not who receives notification from diagnosticians when someone has received a diagnosis?

A referral may be made but diagnosis is not in itself accepted as a prima facie need for assessment. Where a carer has been identified an automatic referral for a Carer's Assessment is made. Referrals can also be made to universal support services such as First Contact. The First Contact scheme, is a partnership operating across Lincolnshire which encourages older people to fill in the First Contact checklist. The checklist helps people to access free information and advice from a range of relevant organisations offering help to stay safe and independent.

26. What post-diagnostic support (in a wider personalisation perspective, not just assuming statutory services), is available to people diagnosed?

Local information and advice website www.mychoicemycare.org.uk
National and local voluntary organisations such as the National Autistic Society
Continuing healthcare NHS funding (subject to eligibility)
Signposting to housing support, advocacy, short breaks
Telephone advice lines : National Autistic Society
Statutory social care services (subject to eligibility)

Care and support

27. Of those adults who were assessed as being eligible for adult social care services and are in receipt of a personal care budget, how many people have a diagnosis of Autism both with a co-occurring learning disability and without?

a. Number of adults assessed as being eligible for adult social care services and in receipt of a personal budget

532

b. Number of those reported in 27a. who have a diagnosis of Autism but not learning disability

c. Number of those reported in 27a. who have both a diagnosis of Autism AND Learning Disability

Comment

Of the total of 5,232 for all adults, 1,080 are people with a Learning Disability receiving a Personal Budget. Of this number 283 have a Direct Payment. It is not currently possible to confirm numbers of people with autism within these figures. A new IT system is currently being designed and will incorporate the necessary functionality to capture autism data.

28. Do you have a single identifiable contact point where people with autism whether or not in receipt of statutory services can get information signposting autism-friendly entry points for a wide range of local services?

- [x] *Yes*
- [ ] *No*

If yes, please give details

The local website www.mychoicemycare.org.uk which lists sources of health and social care support.

29. Do you have a recognised pathway for people with autism but without a learning disability to access a community care assessment and other support?

- [x] *Yes*
- [ ] *No*

If yes, please give details

The general community care assessment pathway is available but is not autism specific and is subject to eligibility criteria. Access is through the Customer Service team who carry out an initial screening process and refer for full assessment or sign post to alternative cources of advice or support. The local website MyChoiceMyCare is widely advertised as a source of information for those either wishing or needing to access services independently.

30. Do you have a programme in place to ensure that all advocates working with people with autism have training in their specific requirements?

- [ ] *Red*
- [x] *Amber*
- [ ] *Green*

Comment

Staff with the contracted advocacy service provided by Voiceability receive some autism awareness training. Not all advocates have received autism training but those that have are matched with clients with autism.

31. Do adults with autism who could not otherwise meaningfully participate in needs assessments, care and support planning, appeals, reviews, or safeguarding processes have access to an advocate?

- ◯ *Red*
- ◯ *Amber*
- ⊗ *Green*

Comment

Lincolnshire County Council commissions a generic advocacy service from Voiceablity.

32. Can people with autism access support if they are non Fair Access Criteria eligible or not eligible for statutory services?

- ⊗ *Yes*
- ◯ *No*

Provide an example of the type of support that is available in your area.

Support is available from a number of Third Sector groups. Support is likely to be information, guidance and emotional support such as that provided by First Contact : www.firstcontact.org.uk

33. How would you assess the level of information about local support in your area being accessible to people with autism?

- ◯ *Red*
- ⊗ *Amber*
- ◯ *Green*

Comment

Comment: some lower level, preventative services provide befriending, advocacy and social activity. A database of services relevant to autism has been compiled and is available on-line. It is being revised to ensure it is as comprehensive as possible. In a large county such as Lincolnshire not all services are available in all districts.

Housing & Accommodation

34. Does your local housing strategy specifically identify Autism?

- ⊗ *Red*
- ◯ *Amber*
- ◯ *Green*

Comment

The seven district local authorities with housing responsibility have separate housing strategies. Lincolnshire County Council is proposing to develop a countywide Housing and Support Strategy which will include Extra Care Housing. The tasks involved would include:
Reviewing existing Extra Care Housing, and general housing, strategies
Develop new strategy (complete review and analysis)
Link into Capital and Infrastructure Plan
Map existing provision
Develop with assessment and care management and performance clients groups and postcodes
Develop the relationship with health commissioners
Agree whether we go out to tender for a care/support contract
This project is included in the current work programme but timescales or resources have yet to be confirmed.

Employment

35. How have you promoted in your area the employment of people on the Autistic Spectrum?

◯ *Red*
⊗ *Amber*
◯ *Green*

Comment

A number of Third Sector agencies such as Linkage and The Shaw Trust provide employment related support for people with special needs including autism. Usually this forms part of the transition process for young people but services can be extended to age 25 in some instances. The Welfare to Work programme fulfils a similar role for the statutory sector.

36. Do transition processes to adult services have an employment focus?

◯ *Red*
⊗ *Amber*
◯ *Green*

Comment

Linkage, an independent trust provides employment related support as part of the transitions pathway. Other groups such as the Shaw Trust, Pelican Trust and Lincoln College play a role in employment related support.
The Welfare to Work programme fulfils a similar role for the statutory sector : for the financial year 2012 - 2013 the number of people aged 17 - 26 receiving employment placement support through this programme was 44. During the same period the number of children and young people with special needs receiving Welfare to Work related training was 169. Data for the Welfare to Work programme does not currently identify how many people accounted for in this data are on the Autistic Spectrum.

Criminal Justice System (CJS)

37. Are the CJS engaging with you as a key partner in your planning for adults with autism?

◯ *Red*
⊗ *Amber*
◯ *Green*

Comment

The police are members of the Autism Partnership Group. A regional conference on autism and CJC will take place in October 2013. It is intended that this event will initiate further work among the elements of the CJC in Lincolnshire.

A dedicated social worker (Associate Lead Professional) has been appointed to develop advice and in-reach support to local prison inmates. The opportunity will also be taken to raise awareness of autism and address the needs of inmates with autism.

Optional Self-advocate stories

Self-advocate stories.

Up to 5 stories may be added. These need to be less than 2000 characters. In the first box, indicate the Question Number(s) of the points they illustrate (may be more than one. In the comment box provide the story.

Self-advocate story one

Question number

35

Comment

In the few months Peter has been a student at Linkage College, he has amassed a collection of first-time experiences. He has attended his own review, ridden a horse , performed in public for the first time and, most significantly, had a blood test for the first time.
Peter is severely autistic and his new experiences, all challenging in their own way, are all reasons to celebrate.
'He has made remarkable progress in such a short space of time,' says the manager of Linkage's specialist autism provision.
The manager explained that Peter was also accessing more courses in a shorter space of time than had ever been envisaged. The process has been speeded up dramatically, with Peter now accessing College provision on three days each week in addition to work experience at an animal rescue centre.
The scale of Peter's achievements is all the more significant because of the challenging journey he has travelled, which included a 'disastrous' experience in specialist further education previously. His parents are over the moon.
Peter's father explains that his son's most significant progress has been through his confidence and trust in the staff who work with him. This has enabled him to feel safe and supported in becoming more independent and also in controlling his emotions and handling situations differently.
Being able to deal with challenging situations more positively, has also enabled Peter to take on lots of new situations with much greater confidence. He is studying stable management and enjoying riding for the first time. He also enjoys a course in performing arts, part of which involved him singing in a recent College show. He attends a leisure, health and fitness course, works in the College bistro and has started work experience at a local animal rescue centre.
He proudly carries his folder of certificates with him whenever he goes home, one of which - the Helpful Horse Award - refers to his skills ensuring a horse does not escape from his paddock.

Self-advocate story two

Question number

Comment

Self-advocate story three

Question number

Comment

Self-advocate story four

Question number

Comment

Self-advocate story five

Question number

Comment

This marks the end of principal data collection.

Can you confirm that the two requirements for the process to be complete have been met?

a. Have you inspected the pdf output to ensure that the answers recorded on the system match what you intended to enter?

☒ *Yes*

b. Has the response for your Local Authority area been agreed by the Autism Partnership Board or equivalent group, and the ratings validated by people who have autism, as requested in the ministerial letter of 5th August 2013?

☒ *Yes*

The data set used for report-writing purposes will be taken from the system on 30th September 2013.

The data fill will remain open after that for two reasons:

1. to allow entry of the dates on which Health and Well Being Boards discuss the submission and
2. to allow modifications arising from this discussion to be made to RAG rated or yes/no questions.

Please note modifications to comment text or additional stories entered after this point will not be used in the final report.

What was the date of the meeting of the Health and Well Being Board that this was discussed?

Please enter in the following format: 01/01/2014 for the 1st January 2014.

Day

Month

Year

Public Health England

Autism self-assessment exercise 2013

Initial findings

About Public Health England

Public Health England's mission is to protect and improve the nation's health and to address inequalities through working with national and local government, the NHS, industry and the voluntary and community sector. PHE is an operationally autonomous executive agency of the Department of Health.

Public Health England
133-155 Waterloo Road
Wellington House
London SE1 8UG
Tel: 020 7654 8000
http://www.gov.uk/phe
Twitter: @PHE_uk

Prepared by: Anna Christie and Gyles Glover, Improving Health and Lives Learning Disabilities Observatory
For queries relating to this document, please contact: AutismSAF.help@ihal.org.uk

You can download this publication from www.gov.uk/phe

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Contents

What is autism?

Autism is a lifelong developmental disability that affects how a person communicates with, and relates to, other people. It also affects how they make sense of the world around them.

It is a spectrum condition, which means that, while all people with autism share certain difficulties, their condition will affect them in different ways. Some people with autism are able to live relatively independent lives but others may have accompanying learning disabilities and need a lifetime of specialist support. People with autism may also experience over- or under-sensitivity to sounds, touch, tastes, smells, light or colours.

Asperger syndrome is a form of autism. People with Asperger syndrome are often of average or above average intelligence. They have fewer problems with speech but may still have difficulties with understanding and processing language.

Source: The National Autistic Society (www.autism.org.uk). For further information about Autism see www.autism.org.uk/about-autism.aspx.

Executive summary

Background

This report presents initial findings from the second self-assessment exercise of the Adult Autism Strategy [1]. The purpose of the exercise was to provide wider context for local authorities and their NHS and other partners in assessing their progress in implementing the Strategy. It also aims to provide evidence of examples of good progress made that can be shared and of remaining challenges. Along with other information gathering commissioned by the Department of Health, these findings are intended to inform the current review of the Strategy. A more detailed report will follow.

Initial findings

Response

All 152 upper tier local authorities responded. This was an improvement on the baseline exercise where responses were received from only 137 (90%).

Local authority area

Local authorities work with a number of partners. In the majority of areas the local authority (71%) works with only a single NHS clinical commissioning group (CCG), but in 29% the situation is more complex. 8% of local authorities work with four or more CCGs. 59% of local authorities reported that they also work with other local authorities in implementing parts of the strategy.

Planning

Almost all authorities (99%) now have a joint commissioner or senior manager responsible for services for adults with autism.

A majority of authorities reported using data about people with autism in their Joint Strategic Needs Assessment (JSNA) (56%) and commissioning plans (87%). 63% reported that they collect data on the number of people with autism eligible for social care.

The involvement of CCGs and people with autism and their carers in planning the implementation of the strategy was mostly rated positively (60%). However, there was minimal widespread implementation of reasonable adjustments to everyday services (12%).

Training

The majority of authorities reported having a multi-agency autism training plan (59%). The majority of authorities also reported that CCGs and primary care practitioners (60%) and local criminal justices services were involved in the training agenda (61%).

Most authorities reported that there was a good range of local autism training that meets NICE guidelines (53%). Half of authorities reported that at least 50% of staff that carry out statutory assessments have attended specialist autism training (50%).

Diagnosis led by the local NHS Commissioner

Just under half the respondents stated that they had asatisfactory local diagnostic pathway (49%). Most reported that the local CCG had taken the lead in developing a pathway (72%), and just over half reported it as a specialist autism specific service (51%). In 58% of cases the pathway was integrated with local authority adult social care services, with diagnosis triggering an automatic offer of a Community Care Assessment.

Care and support

There were positive results in the ways people with autism can access care and support. However, the proportion of amber ratings indicated that training for advocates (47%) and the level of information about local support are areas that could be improved (74%).

Housing and accommodation

The question asked referred to the local housing strategy, but the top (green) response option required both consideration in the local housing strategy and the availability of a range of accommodation options. 18% of local authorities indicated that they reached this level. A further 63% reported that the needs of disabled people were addressed in the local housing strategy, although not necessarily specifically those of people with autism.

Employment

The majority of authorities reported that autism awareness is delivered to employers on an individual basis, local employment support services include autism and there some contact with local jobs centres in most areas (65%). Most areas had detailed reference to employment in their transition processes to adult services (49%).

Criminal justice system

In most areas, discussions were underway to improve criminal justice system involvement in planning for adults with autism (60%).

Further publications

This report provides only an initial outline view of the responses to coded questions. More detailed reports covering commentary as well as rated questions will follow. A separate collection of 258 personal stories included by 91 local authority areas will be published at the same time as this report.

Introduction

The Adult Autism Strategy

Autism is a lifelong developmental disability that affects how a person communicates with, and relates to, other people. It also affects how they make sense of the world around them (see description on page four). In 2009, the Autism Act was passed by the UK Parliament [2]. This commits the Department of Health in England to producing, and periodically revising, an Autism Strategy for England and Guidance for local health and social care services about its implementation. "Fulfilling and rewarding lives: the strategy for adults with autism in England" [1] was published in 2010. It focusses on five areas:

1. Increasing awareness and understanding of autism
2. Developing clear, consistent pathways for diagnosis of autism
3. Improving access for adults with autism to services and support
4. Helping adults with autism into work
5. Enabling local partners to develop relevant services

The Strategy is not just about providing special services for people with autism, but also about enabling equal access to mainstream services, support and opportunities through reasonable adjustments, training and awareness raising.

Review of the strategy

The Autism Act requires the government to review the Strategy and the associated Statutory Guidance [3] from time to time. In doing this the government is required to work with a wide range of other government departments and agencies, local health and social service providers, self-advocates and family carers. In revising the associated Guidance it is also required to take into progress made towards implementing the strategy.

The Department of Health is now undertaking a formal review of the Strategy. This review has two main phases. The first investigative phase comprised a range of information gathering exercises including a survey of people with autism, a small number of in-depth local area reviews and the self-assessment exercise for all local authorities described in this document. Other government departments are also reviewing their progress in this area at the same time. The second phase, anticipated to run through December 2013 and January 2014, will comprise a focussed engagement with stakeholders to develop a refreshed Strategy. The full outcome is expected to be published in March 2014.

About self-assessment exercise 2013

Local authorities play a key role in implementing the recommendations of the Strategy and the statutory Guidance that supports it. An initial self-assessment exercise was conducted to establish the extent of the task in achieving the Strategy aims. This reflected the position as at March 2011, soon after the publication of the initial Guidance [4-5]. This second self-assessment followed the basic format of the first exercise. Its purpose was to:

- help local authorities and their partners asses their progress implementing the Strategy
- establish how much progress has been made since the baseline survey, reflecting the position as at March 2011
- provide examples of good progress and identify remaining challenges

To help address all these aspects, the structure of the survey was developed in a number of ways. Most questions were reworded for clarification. More detailed guidance was given about how each of the questions inviting ratings of "Green" (good), "Amber" (working on it) or "Red" (little or no progress) should be rated. In some cases additional, more specific questions were added. In addition to documenting progress, the exercise also aimed to understand the nature of the challenges impeding progress and the local solutions people have found for them. To achieve this, respondents were invited to contribute commentary in relation to most questions. A section for illustrative personal stories was also added. All the findings of the exercise will feed into the review of the Strategy. Full details of the self-assessment exercise can be found at:

http://www.improvinghealthandlives.org.uk/projects/autism2013

Structure and arrangements

The 2013 exercise ran between August and October 2013. Local authorities reported responses directly onto the Improving Health and Lives (IHaL) Learning Disabilities Observatory website. Local authorities were asked to co-ordinate their local responses, but instructions emphasised the importance of obtaining a multi-agency perspective, reflecting the task of implementing the strategy. They were specifically asked to include liaison with the new NHS Clinical Commissioning Groups.

Questions covered broadly the same areas as in the previous exercise:

1. Local authority area
2. Planning
3. Training
4. Diagnosis led by the NHS Commissioner
5. Care and support
6. Housing and accommodation
7. Employment
8. Criminal Justice System
9. Optional Self-advocate stories

Initial findings structure

For some questions numbers were required, for some it was yes or no answers. For some questions local authorites were asked to rate their area Red, Amber or Green (RAG) using a set of defined criteria for each related question. Finally, accompanying most of these questions, respondents were asked for further comments or explanations of the answers. In the final section, respondents had the opportunity to provide up to five self-advocate stories to illustrate the answers they had given to some of the questions.

The returns were analysed by Public Health England and Improving Health and Lives (IHaL) Learning Disabilities Observatory.

Presentation in this report

This report provides the initial findings from the Autism Self-Assessment Exercise 2013. Firstly, the response rate by local authorities is reported. Then for each section, background information to the questions is provided. This includes a summary of the results from the previous exercise where appropriate. Next, a narrative summary of findings from the questions in that section is given followed by the results.

For questions seeking yes/no answers or RAG ratings, responses are shown as a single horizontal bar colloured to represent the numbers of each type of answer. Numbers and percentages are shown below the bars. For RAG rated questions, the rating criteria is reproduced below each question. Number questions were analysed in several different ways; these are described in the sections.

Further publications

This report provides only an initial outline view of the responses to coded questions. A fuller report providing regional breakdowns, maps and thematic analysis of comments will follow in March. Alongside the full report we will publish all local authority responses, including comment text, both as reports for individual local authority areas and as a spreadsheet to facilitate comparative analysis.

Many areas provided illustrative personal accounts and/or stories of people with autism, providing a perspective of using local services often in their own words. These stories, anonymised, will be published in a separate volume alongside this report. They are intended not as critique of specific local services, but to provide an insight into the experience of living with autism in England today.

Findings

Response rate

All 152 local authorities in England completed the self-assessment exercise on the IHaL website. This was a substantial improvement on the baseline exercise when only 137 responded. Respondents were asked to confirm that they had completed two requirements before finishing the data collection process:

1. Inspected the PDF output available online to ensure that the answers recorded on the system match what they intended to enter
2. Agreed the response for their local authority area with their local Autism Partnership Board or equivalent group, and had the ratings validated by people who have autism, as requested in the ministerial letter [6] of 5th August 2013

Table 1 shows the numbers and proportion of authorities confirming completion of these requirements. 148 (97.4%) authorities reported they had checked the output for accuracy, 123 (80.9%) authorities confirmed they had completed both.

Table 1. The proportion and number of local authorities confirming they had met the two requirements and finished the data collection process

	Yes N (%)	
Submitted data	152	(100.0%)
Data checked	148	(97.4%)
Data validated	123	(80.9%)
Checked and validate	123	(80.9%)

Local authority area

Background

The majority of the responsibility of implementing the Strategy lies with local authorities, NHS bodies and other partnership organisations working together to plan and deliver services in their local authority area. The findings of the first self-assessment exercise [4] indicated that some local authorities had been working together. This was because a number of answers were repeated from different authorities.

Since the first self-assessment exercise there have also been a number of changes in the way health and social services are delivered and commissioned. These were introduced via the Health and Social Care Act 2012 [7] which came into being on 1st April 2013. One of the aims of the Act was to have more joint commissioning of services between local government and health services. This could impact on how the Strategy was implemented in each area.

This year, the exercise ask how many Clinical Commissioning Groups each area had to work with and if they were working with other local authorities to implement the Adult Autism Strategy in their area.

Initial findings

The results showed that 108 (71%) authorities worked with one Clinical Commissioning Group (CCGs) to implement the Strategy. One local authority reported they had 8 CCGs to work with. Over half of all local authorities in England reported that they work with other local authorities to implement part or all of the priorities of the Strategy.

1. How many Clinical Commissioning Groups do you need to work with to implement the Adult Autism Strategy in your local authority area?

Number ofCCGs	N (%)
1	108 (71%)
2	15 (10%)
3	15 (10%)
4	2 (1%)
5 or more	11 (7%)
No answer	1 (1%)

2. Are you working with other local authorities to implement part or all of the priorities of the strategy?

Yes: 89 (59%) No: 62 (41%) No answer: 1 (1%)

Planning

Background

The Adult Autism Strategy and the statutory Guidance features a number of recommendations and expectations about the planning of the services for adults with autism locally. These include:

- the appointment of a joint commissioner or senior manager who have a clear commissioning responsibility for adults with autism
- the development of a local commissioning plan for adults with autism based on the Joint Strategic Needs Assessment (JSNA) and other relevant data
- the improvement of transition planning for young people with autism
- the improvement of transition planning and reasonable adjustments to services and support for adults with autism to enable them to live independently

The results from the first self-assessment exercise showed that 75% of authorities indicated they were considering allocating responsibility to a named joint commissioner or senior manager of community care services for adults with autism in their area by rating themselves as green. However, 66% of authorities rated their area as amber when asked if their JSNA mentioned adults with autism and if they had plans to collect and collate relevant data about adults with autism. This indicated that they were working on it. There was an even split between areas who answered the question whether or not they were in a position to answer a series of numerical questions about people with autism and services.

Findings

The results showed that 151 (99%) authorities said they had a named joint commissioner or senior manager responsible for services for adults with autism. 85 (56%) authorities who submitted data rated their area as green indicating that autism is included in the local JSNA.116 (76%) authorities rated themselves as amber when asked about the collection of data on people with diagnosis of autism. This means that most authorities agree with the statement: "A variety of mechanisms are being used so a cross section of people on the autistic spectrum are meaningfully engaged in the planning and implementation of the Adult Autism Strategy. People with autism are thoroughly involved in the Autism Partnership Group."

3. Do you have a named joint commissioner/senior manager of responsible for services for adults with autism?

Yes: 151 (99%) No: 1 (1%) No answer: 0 (0%)

4. Is Autism included in the local JSNA?

Red: 6 (4%) Amber: 60 (39%) Green: 85 (56%) No Answer: 1 (1%)

No.

Steps are in place to include in the next JSNA.

Yes.

5. Have you started to collect data on people with a diagnosis of autism?

Red: 18 (12%) Amber: 116 (76%) Green: 18 (12%) No Answer: 0 (0%)

Data recorded on adults with autism is sparse and collected in an ad hoc way.

Current data recorded annually but there are gaps identified in statutory health and/or social care services data. Some data sharing exists between services.

Have you an established data collection sharing policy inclusive of primary care, health provision and adult social care.

The results showed that 96 (63%) of authorities said they collected data on the number of people with a diagnosis of autism meeting the eligibility criteria for social care (irrespective of whether they received any).

6. Do you collect data on the number of people with a diagnosis of autism meeting eligibility criteria for social care (irrespective of whether they receive any)?

Yes: 96 (63%) No: 55 (36%) No answer: 1 (1%)

Table two shows the total rate and the number of local authorities who provided numbers per client type. 88 authorities were able to provide a figure for the number of people who had a diagnosis of autism and met eligibility criteria for social care. Using the combined figure for these authorities and 2012 mid-year estimates [8] the overall rate was 47.2 people per 100,000 of their population. 78 of these authorities were able to report the numbers of people known to them with autism who also had learning disabilities. The proportion of people with autism and a learning disability for these authorities combined was 69.2%. 67 of these authorities were able to report the numbers of people known to them with autism who also had mental health problems. The proportion of people with autism and a mental health problem for these authorities combined was 16.4%. Table two also shows the profile of how these values varied between local authorities.

Table 2. Rates of people known with autism and meeting eligibility criteria for social care, and proportions of these also identified as having learning disabilities and mental health problems. The bottom row shows the number of local authorities from which data were available in each case.

Rate of diagnosis		Proportion with learning disability		Proportion with mental health problem	
Rate per 100,000	Number of LAs	% with LD	Number of LAs	% with MH problems	Number of LAs
<20	18	<20%	0	<2%	9
20 to 39.9	18	20%-39.9%	8	2%-3.9%	9
40 to 59.9	14	40%-59.9%	18	4%-5.9%	13
60 to 79.9	11	60%-79.9%	14	6%-7.9%	19
80 to 99.9	12	80% or more	38	8% or more	17
100 or more	15				
Number of LAs	88	Number of LAs	78	Number of LAs	67

This year, most authorities indicated they had met two of the expectations outlined in the Strategy. Firstly, 132 (87%) authorities reported that they had a commissioning plan that reflected local data and needs of people with autism. Secondly, 151 (99%) authorities reported that they had a transition process in place.

For three out of five of the RAG rated questions in this section amber was the most frequently reported rating by authorities. 82 (54%) authorities agreed that for the data collection sources they use they "Have made a start in collecting data and plan to progress." 96 (63%) authorities agreed that they had "clear council policy covering statutory and other wider public services" regarding reasonable adjustments (Q19). Only 18 (12%) authorities agreed that there was "evidence of widespread implementation". 86 (57%) authorities agreed that "training in some but not all services designed for use by older people, and data collection on people over-65 with autism;" when asked about the planning for the needs of older people.

For the other two RAG rated question, green was the most frequent rating. 91 (60%) authorities reported that "CCG are fully engaged and work collaboratively to implement the NHS responsibilities of the strategy and are equal partners in the implementation of the strategy at a local level." 83 (55%) authorities reported that "a variety of mechanisms are being used so a cross section of people on the autistic spectrum are meaningfully engaged in the planning and implementation of the Adult Autism Strategy. People with autism are thoroughly involved in the Autism Partnership Group."

7. Does your commissioning plan reflect local data and needs of people with autism?

Yes: 132 (87%) No: 20 (13%) No answer: 0 (0%)

8. What data collection sources do you use?

Red: 0 (0%) Red/Amber: 18 (12%) Amber: 82 (54%) Amber/Green: 44 (29%) Green: 7 (5%) No Answer: 1 (1%)

No work underway.

Collection of limited data sources.

Have made a start in collecting data and plan to progress.

Have started to collect data and while not comprehensive, feel that it is an accurate reflection.

Information from GPs, Schools or Local Education Authority, voluntary sector, providers, assessments and diagnosis are all collected and compared against the local population prevalence rate.

9. Is your local CCG or CCGs (including the Support Service) engaged in the planning and implementation of the strategy in your local area?

Red: 8 (5%) Amber: 52 (34%) Green: 91 (60%) No Answer: 1 (1%)

None or Minimal engagement with the LA in planning and implementation.

Representative from CCG and/or the Support Service sits on autism partnership board or alternative and are in regular liaison with the LA about planning and implementation.

CCG are fully engaged and work collaboratively to implement the NHS responsibilities of the strategy and are equal partners in the implementation of the strategy at a local level.

10. How have you and your partners engaged people with autism and their carers in planning?

Red: 7 (5%) Amber: 61 (40%) Green: 83 (55%) No Answer: 1 (1%)

Minimal autism engagement work has taken place.

Some autism specific consultation work has taken place. Autism Partnership Group is regularly attended by one person with autism and one parent or carer who are meaningfully involved.

A variety of mechanisms are being used so a cross section of people on the autistic spectrum are meaningfully engaged in the planning and implementation of the Adult Autism Strategy. People with autism are thoroughly involved in the Autism Partnership Group.

11. Have reasonable adjustments been made to everyday services to improve access and support for people with autism?

Red: 38 (25%) Amber: 96 (63%) Green: 18 (12%) No Answer: 0 (0%)

Only anecdotal examples.

Clear council policy covering statutory and other wider public services.

Clear council policy and evidence of widespread implementation.

12. Do you have a Transition process in place from Children's social services to Adult social services?

Yes: 151 (99%) No: 1 (1%) No answer: 0 (0%)

13. Does your planning consider the particular needs of older people with Autism?

Red: 48 (32%) Amber: 86 (57%) Green: 17 (11%) No Answer: 1 (1%)

No consideration of the needs of older people with autism: no data collection; no analysis of need; no training in older people's services.

Training in some but not all services designed for use by older people, and data collection on people over-65 with autism.

Training inclusive of older people's services. Analysis of the needs of population of older people inclusive of autism and specialist commissioning where necessary and the appropriate reasonable adjustments made.

Training

Background

The training of staff who provide relevant services to adults with autism is one of the six areas of the Autism Act that required guidance to cover. The Strategy states that it is important for autism training to be available for everyone working in health or social care. This training should aim to change staff behaviour and attitudes as well as improve knowledge and understanding of autism. The Guidance for implementing the strategy is aimed at both general autism awareness training and specialised training for staff in key roles.

In the first self-assessment exercise, most authorities rated themselves as amber when asked about issues in relation to training. 57% of authorities rated themselves as amber when asked are staff who carry out assessments receiving training on how to make adjustment in their behaviour and communication. This indicates that they were working on it. 66% rated their area as amber when asked if they have considered what autism awareness training is made available to all staff working in health and social and how training can be prioritised. In addition, when asked about adults autism no longer managed inappropriately in the criminal justice system, thirty authorities had highlighted autism awareness training as a positive area. Twenty authorities identified this as a gap.

Initial findings

The results outlined on the following page show that just over half of the authorities answered positively to the three yes or no questions about training. Firstly, 89 (59%) authorities reported that they have got a multi-agency autism training plan. Secondly, 91 (60%) said that CCGs have involved in the development of workforce planning and are GPs and primary care practitioners engaged included in the training agenda. Finally, 93 (61%) said their local Criminal Justice services have engaged in the training agenda.

Authorities most frequently rated their areas as amber for the RAG questions relating to training. 80 (53%) authorities agreed that there was a "good range of local autism training that meets NICE guidelines - and some data on take up. Workforce training data available from statutory organisations on request. Autism training plan or strategy near completion." 76 (50%) authorities agreed that for staff that carry out statutory assessments "at least 50% of assessors have attended specialist autism training."

14. Have you got a multi-agency autism training plan?

Yes: 89 (59%) No: 63 (41%) No answer: 0 (0%)

15. Is autism awareness training being/been made available to all staff working in health and social care?

Red: 14 (9%) Amber: 80 (53%) Green: 58 (38%) No Answer: 0 (0%)

Historical workforce training data available from statutory organisations on request. Not yet devised an autism training plan or strategy.

Good range of local autism training that meets NICE guidelines - and some data on take up. Workforce training data available from statutory organisations on request. Autism training plan or strategy near completion.

Comprehensive range of local autism training that meets NICE guidelines and data on take up. Workforce training data collected from all statutory organisations and collated annually, gaps identified and plans developed to address. Autism training plan/strategy published.

16. Is specific training being/been provided to staff that carry out statutory assessments on how to make adjustments in their approach and communication?

Red: 30 (20%) Amber: 76 (50%) Green: 46 (30%) No Answer: 0 (0%)

No specific training is being offered

At least 50% of assessors have attended specialist autism training.

More than 75% of assessors have attended specialist autism training specifically aimed at applying the knowledge in their undertaking of a statutory assessment, ie applying FACs, NHS Community Care Act.

17. Have CCGs been involved in the development of workforce planning and are GPs and primary care practitioners engaged included in the training agenda?

Yes: 91 (60%) No: 60 (39%) No answer: 1 (1%)

18. Have local Criminal Justice services engaged in the training agenda?

Yes: 93 (61%) No: 57 (38%) No answer: 2 (1%)

Diagnosis led by the local NHS Commissioner

Background

For people with autism and their families and carers, having a clear clinical diagnosis of autism is an important step in leading fulfilling and rewarding lives. A diagnosis can help people understand their behaviour and responses and access services and support [1].

However, the Strategy emphasised that a diagnosis is not the end goal and should be part of an integrated process. The Strategy and required Guidance made several recommendations about what this process should entail. These include:

- appointing a lead professional to develop diagnostic and assessment services for adults with autism working closely with the specialised commissioning group
- a clear pathway to diagnosis by 2013
- recognition of an autism diagnosis as a reason for assessment under the NHS and Community Care Act 1990 and for a carer's assessment
- local authorities and health services commissioners develop relevant, clear and accessible information for adults with autism and their families and carers

A clear and trusted diagnostic pathway available locally was one of the identified service ambitions in the first self-assessment exercise. The previous results showed that when asked "Have you a clear pathway developed locally?", the most common rating was amber (62%) by authorities who responded. Amber again was the most common answer (46%) when asked "Following diagnosis does the pathway include the healthcare professional informing the adult diagnosed the under the NHS Community Care Act 1990 LAs have a duty to carry out an assessment?". These amber ratings indicated that areas were working on it. Of the 48 local authorities who answered this question, there was a overall rate of 0.4 people per 1,000 population who had been assessed in the past 12 months using the diagnostic pathway. An issue which was identified in the thematic analyses was that diagnostic pathways were only available for adults with learning disabilities and/or a mental health problem.

Initial findings

The results showed that 74 (49%) authorities rated their area as green, agreeing with the statement "A local diagnostic pathway is in place and accessible, GPs are aware and involved in the process. Wait for referral to diagnostic service is within 6 months. NICE guidelines are considered within the model". 102 authorities reported the date when the pathway was put in place and 116 authorities reported the average wait for referral to diagnostic services. Below the tables for questions 20 and 21 show the profile of how these reported figures varied between local authorities.

110 (72%) authorities reported that the local CCG or support services had taken the lead in developing the pathway. 78 (51%) authorities described the local pathway as a specialist autism specific services compared to the 64 (42%) authorities who described it as integrated with mainstream statutory services. However, 10 authorities did not answer the question. 88 (58%) authorities reported that in their local diagnostic path a diagnosis of autism automatically triggers an offer of a community care assessment.

19. Have you got an established local diagnostic pathway?

Red: 13 (9%) Amber: 64 (42%) Green: 74 (49%) No Answer: 1 (1%)

No local diagnosis service planned or established. No clear transparent pathway to obtaining a diagnosis for adults identified and only ad-hoc spot purchasing of out of area services. NICE guidelines are not being followed.

Local diagnosis pathway established or in process of implementation / sign off but unclear referral route. A transparent but out of locality diagnostic pathway is in place. Some NICE guidelines are being applied.

A local diagnostic pathway is in place and accessible, GPs are aware and involved in the process. Wait for referral to diagnostic service is within 6 months. NICE guidelines are considered within the model

20. When was the pathway put in place?

	Number of LAs
Date specified	102
<6 months	21
6 to <12 months	19
12 to <18 months	16
18 to <24 months	10
24 to <30 months	11
30 to <36 months	4
3 or more years	16
Future start date	5

21. How long is the average wait for referral to diagnostic services?

	Number of LAs
Wait specified	116
1 to 5 weeks	19
6 to 10 weeks	31
11 to 15 weeks	25
16 to 20 weeks	12
20 or more weeks	29

22. How many people have completed the pathway in the last year?

	Number of LAs
Total specified	110
1 to 9	24
10 to 19	29
20 to 29	6
30 to 39	21
40 to 49	6
50 or more	24

23. Has the local CCG or support services taken the lead in developing the pathway?

Yes: 110 (72%) No: 40 (26%) No answer: 2 (1%)

24. How would you describe the local diagnostic pathway, ie Integrated with mainstream statutory services with a specialist awareness of autism for diagnosis or a specialist autism specific service?

Integrated with mainstream statutory services with a specialist awareness of autism for diagnosis: 64 (42%)
Specialist autism specific service: 78 (51%)
No answer: 10 (7%)

The final question in this section explored the wider aspects of how the whole diagnostic pathway brought together health and social care components.

25. In your local diagnostic path does a diagnosis of autism automatically trigger an offer of a Community Care Assessment?

Yes: 88 (58%) No: 59 (39%) No answer: 5 (3%)

Care and support

Background

Personalisation of social care is an integral part of the Strategy. Both the Strategy and the Guidance have a number of recommendations about the care and support an adult with autism should receive to live independently and access mainstream services. This includes achieving the same improvement to public services for people with autism that has occurred for people with learning disabilities and mental health problems through existing programmes. There has been feedback to suggest that people with autism are missing out due not fitting into either of these categories.

In the first self-assessment exercise, most authorities rated themselves as amber when "Do you know how many adults are in receipt of a personal budget?" (48%) and "Are you able to provide advocates to work with adults with autism?" (52%). These answers indicated where areas were working on it.

Initial findings

89 authorities were able to provide a figures for the number of adults with autism who were assessed as being eligible for adult social care services and were in receipt of a personal budget. Altogether these authorities were providing this type of help for 6845 people, a rate of 29 per 100,000 adult population. In giving these numbers, authorities were asked to distinguish between those with autism but not learning disability, and those with both. The overall proportion with autism but not learning disability was 29.47% although this varied widely between authoritis. In 13 authorities, amongst people with autism receiving personal budgets, those without learning disabilities outnumbered those with. Table three shows the profile of how these two figures varied between local authorities.

Table 3. Profile of rates of people assessed as eligible for adult social care services and in receipt of a personal budgets per 100,000 adult population (left hand table). Profile of proportions of those diagnosed with autism and receiving a personal budget who do not have learning disabilities. The bottom row shows the number of local authorities from which data were available in each case.

Numbers with autism, eligible for social care, and receiving personal budgets		Proportion of those receiving personal budgets with autism who do not have learning disabilities	
Rate per 100,000 receiving personal budgets for autism	Number of LAs	% with autism but not learning disabilities	Number of LAs
Less than 10	20	Less than 1%	20
10 but less than 20	16	1% but less than 5%	13
20 but less than 30	18	5% but less than 10%	14
30 but less than 50	22	10% but less than 50%	26
50 or more	13	50% or more	16
Total	89	Total	89

Authorities were asked about entry points for services. 104 (68%) said they had a single identifiable contact point where people with autism can get information signposting a wide range of local services. 119 (78%) reported they had a recognised pathway for people with autism but without a learning disability to access a community care assessment and other support. 140 (92%) reported that people with autism can access support if they are non-Fair Access Criteria eligible or not eligible for statutory services.

28. Do you have a single identifiable contact point where people with autism whether or not in receipt of statutory services can get information signposting autism-friendly entry points for a wide range of local services?

Yes: 104 (68%) No: 46 (30%) No answer: 2 (1%)

29. Do you have a recognised pathway for people with autism but without a learning disability to access a community care assessment and other support?

Yes: 119 (78%) No: 32 (21%) No answer: 1 (1%)

For two out the three RAG rated questions in this section the most common rating was amber. 72 (47%) authorities when asked about training programmes for advocates reported that "Programme in place, not all advocates are covered." 95 (63%) authorities gave this rating agreeing with the statement "Some existence of low level, preventative services such as befriending or mentoring, advocacy, social groups, outreach, activity groups, and access to therapies and counselling (ie IAPT primary care mental health services). Database of universal and autism specific services has known gaps." This was the amber rating asked how would you assess the level of information about local support in your area being accessible to people with autism. Most authorities 85 (56%) rated themselves green when asked do adults with autism have access to an advocate where appropriate. The rating was defined as "Yes. There are mechanisms in place to ensure that all advocates working with adults with autism have received specialist autism training."

30. Do you have a programme in place to ensure that all advocates working with people with autism have training in their specific requirements?

Red: 22 (14%) Amber: 72 (47%) Green: 56 (37%) No Answer: 2 (1%)

No programme in place.

Programme in place, not all advocates are covered.

Programme in place, all advocates are covered.

31. Do adults with autism who could not otherwise meaningfully participate in needs assessments, care and support planning, appeals, reviews, or safeguarding processes have access to an advocate?

Red: 2 (1%) Amber: 64 (42%) Green: 85 (56%) No Answer: 1 (1%)

No.

Yes. Local advocacy services are also developing training in autism.

Yes. There are mechanisms in place to ensure that all advocates working with adults with autism have received specialist autism training.

32. Can people with autism access support if they are non Fair Access Criteria eligible or not eligible for statutory services?

Yes: 140 (92%) No: 9 (6%) No answer: 3 (2%)

33. How would you assess the level of information about local support in your area being accessible to people with autism?

Red: 17 (11%) Amber: 112 (74%) Green: 22 (14%) No Answer: 1 (1%)

Minimal choice of appropriate local provision and where required local care and support services. Database of universal and autism specific services is out of date.

Some existence of low level, preventative services such as befriending or mentoring, advocacy, social groups, outreach, activity groups, and access to therapies and counselling (ie IAPT primary care mental health services). Database of universal and autism specific services has known gaps.

Accessible information available on the range of autism accessible support services such as befriending or mentoring, advocacy, social groups, outreach, activity groups, and carer support. There is a progressive level of support dependant of the needs of the individual who happens to have autism. More specialist services accessible to meet their needs with autism for those who needs it from advocacy to high level services.

Housing and accommodation

Background

The government aims to enable adults with autism and their families to have greater choice and control over where and how they live. This means that planning of local housing should take into account the needs of adults with autism.

In the previous self-assessment exercise, authorities most commonly (66%) rated their local housing strategy as amber when asked if it is addressing the short and long-term requirement of adults with autism. This indicated that authorities were working on it.

This year, 95 (63%) authorities reported that their local housing strategy specifically included details of the needs of people with disabilities though not necessarily of people with autism. The top (green) rating which 28 (18%) authorities said described their position required not only full consideration in their housing strategy, but also the availability of an appropriate range and amount of accommodation provision to meet the needs of people with autism.

34. Does your local housing strategy specifically identify Autism?

Red: 28 (18%) Amber: 95 (63%) Green: 28 (18%) No Answer: 1 (1%)

No mention of Autism within the local housing strategy. No range of options available to meet the broad needs of someone with a diagnosis of Autism. No data available on individual housing needs and usage of different housing services.

Universal housing strategy details needs of people with disabilities, autism not specifically referenced. Minimal current and historic data availability on individual housing needs and usage of different housing services.

Autism accessible housing detailed in universal housing strategy. A range of housing and accommodation options available to meet the broad needs of people with autism including universal housing supported living, residential care, etc. Using data to inform future planning, of accommodation and housing needs.

Employment

Background

Helping adults with autism into work is one of the key areas in the Strategy. The Guidance emphasises plans for employment as an aspect of effective transition planning.

In the previous self-assessment exercise, most authorities rated themselves as amber in relation two questions about employment. 69% when asked about engaging with local employers to examine and increase employment levels for adults with autism and 66% when asked do transition processes to adult services have an employment focus. This indicated authorities were working on it.

Initial findings

This year, 99 (65%) authorities rated themselves as amber, agreeing with the statement "Autism awareness is delivered to employers on an individual basis. Local employment support services include Autism. Some contact made with local Job Centres." Green was the most common rating 75 (49%) authorities reporting this answer when asked do transition processes have an employment focus. This was defined as "Transition plans include detailed reference to employment, accesses to further development in relation to individual's future aspirations, choice and opportunities available."

35. How have you promoted in your area the employment of people on the Autistic Spectrum?

Red: 15 (10%) Amber: 99 (65%) Green: 36 (24%) No Answer: 2 (1%)

- No work in this area has been provided or minimal information not applied to the local area specific to Autism. Local employment support services are not trained in autism or consider the support needs of the individual taking into account their autism. Local Job Centres are not engaged.
- Autism awareness is delivered to employers on an individual basis. Local employment support services include Autism. Some contact made with local Job Centres.
- Autism is included within the Employment or worklessness Strategy for the Council or included In a disability employment strategy. Focused Autism trained Employment support. Proactive engagement with local employers specifically about employment people with autism including retaining work. Engagement of the local Job Centre in supporting reasonable adjustments in the workplace via Access to work.

36. Do transition processes to adult services have an employment focus?

Red: 6 (4%) Amber: 70 (46%) Green: 75 (49%) No Answer: 1 (1%)

- Transition plans do not include specific reference to employment or continued learning.
- Transition plans include reference to employment or activity opportunities.
- Transition plans include detailed reference to employment, accesses to further development in relation to individual's future aspirations, choice and opportunities available.

Criminal justice system

Background

The Strategy recommends that all staff within the criminal justice sector should have training and access to expertise to enable them to support people with autism. In addition, pathways through the system should be developed to identify others who they may need to work with.

In the previous self-assessment exercise, sixteen authorities identified improving links with organisations in the criminal justice system as a priority.

Initial findings

This question was asked in the same way as the previous self-assessment exercise. Amber was the most common response from both exercises, with 91 (60%) authorities rate CJS engagment as this. However, these are not directly comparable due to the way the percentages have been calculated. This year, the rating was defined as "Discussions with the CJS are underway, including training of the police and wider CJS and inclusive of the use of alert cards. Representative from CJS sits on autism partnership board or alternative."

37. Are the CJS engaging with you as a key partner in your planning for adults with autism?

Red: 34 (22%) Amber: 91 (60%) Green: 23 (15%) No Answer: 4 (3%)

Minimal or no engagement with the CJS.

Discussions with the CJS are underway, including training of the police and wider CJS and inclusive of the use of alert cards. Representative from CJS sits on autism partnership board or alternative.

People with Autism are included in the local work of local diversion team's from CJS. Representative from CJS regularly attends meetings of autism partnership board or alternative. Alert card or similar scheme in operation. Police training in place.

Optional self-advocate stories

Respondents had the opportunity to leave up to five self-advocate stories. These were to illustrate one or more of the questions in the self-assessment exercise.

92 (61%) authorities provide at least one story. A total of 258 stories about personal experiences of individuals with autism were sent in. Some were told by supporters, advocates or carers, but many were in the voice of the person themselves. These are published in an accompanying report.

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Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

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

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**25 March 2014**
Subject:	**Support and Aspiration**

Summary:

This report provides an update for the Health and Wellbeing Board on the progress of the SEN Implementation Project designed to implement the reforms to Special Educational Needs (SEN) support set out in Part 3 of the Children and Families Bill, draft SEN Code of Practice and draft regulations.

Actions Required:

This report is for information.

1. Background

The Reforms

1.1 Part 3 of the current Children and Families Bill (due for Royal Assent in Spring 2014) seeks to align and 'streamline' the system of SEN assessment, support and provision for children and young people 0 - 25, bringing together the provisions of a variety of Acts covering education, health and care and introducing new provisions. Statutory implementation of associated duties, regulations and a new SEN Code of Practice are planned from 1st September 2104.

1.2 The SEN reforms set out in the Bill are:

i. Extending the SEN system from birth to 25, giving children, young people and their parents/carers greater control and choice in decisions about provision
ii. Replacing statements and learning difficulty assessments with a new birth- to-25 Education, Health and Care (EHC) Plan

iii. Offering families the option of personal budgets when an EHC plan is implemented
iv. Improving cooperation between all the services and requiring particularly local authorities and health authorities to work together
v. Requiring LAs to involve children, young people and parents in reviewing and developing provision for those with special educational needs and to publish a 'local offer' of support
vi. Publication of a new SEN Code of Practice and regulations covering the work of early years providers, schools and post-16 education providers, Local Authorities (LAs) and Health Authorities.

1.3 There is a sharper focus on the measurable outcomes for Children and Young People. It is expected that the majority of children with SEN will have their needs met and outcomes achieved through mainstream education provision and will not need EHC plans. These are explicit themes across the new draft SEN Code of Practice.

1.4 Parents and young people must be involved directly in discussions and decisions about the support available to them individually and more strategically, particularly through the 'co-production' and delivery of the new SEN assessment and EHC planning process and the Local Offer.

1.5 Central government's expectation is that by 1st September 2014 the SEN local offer and arrangements for statutory assessment and EHC planning will be in place for all new applicants. Existing SEN Statements and post 16 Learning Difficulties Assessments will be transferred to the new system over period that is currently subject to consultation (3 years for Statements and 1 year for Learning Difficulties Assessments).

The Lincolnshire SEN Implementation Project

1.6 Implementation of the SEN reforms in Lincolnshire is being managed through a corporate project with a robust model of project governance comprising:

i. A Project Board consisting of senior representatives from the LA's managed functions in education and children's services, the Parent Carer Forum, and education support across Health and Voluntary sector stakeholders. The Board meets fortnightly.
ii. Three 'Task and Finish' groups comprising similar representation from LA managed services, Health and other stakeholder organisations, working on the key aspects and products required by the reforms
iii. A Stakeholder Group made up of representatives of Children, Young People, parents/carers, education, health and care agencies (including relevant statutory and voluntary organisations) across the 0-25 age range.

1.7 The project acts as the focus for the developments that various agencies and services need to undertake in order to be statutorily compliant from 1st September 2014 - e.g.;

a) the Council's Additional Needs, Children With Disabilities, Specialist Teaching and Psychology services, Performance Team; b) Clinical Commissioning Groups and; c) therapy and support services delivered by Health Trusts.

1.8 There are 9 major work-streams led by the Task and Finish groups, focused on establishing an effective Lincolnshire Local Offer and new assessment, planning and delivery processes by 1st September 2014, i.e.:

i. Engagement of Children, Young People and Families
ii. Cohesive Assessment
iii. Cohesive Planning
iv. Personal Budgets
v. Support for vulnerable Children and Families
vi. The Local Offer
vii. Transition planning, support and implementation
viii. Commissioning
ix. Training and development

1.9 The project (supported to a large extent by the expectations of the draft Code of Practice) is working on the premise that existing resources will be re-aligned to the new system and full advantage will be taken of opportunities to drive efficiencies into the delivery of SEN support. For example, by introducing a 'tell it once' culture that cuts down on the amount of time families have to engage with a variety of professionals, and by introducing a focused 'key working' and co-production approach to assessment and planning the project aims to drive more cost effectiveness into existing resource deployment.

1.10 An un-ring-fenced government grant of £75k was allocated to all non-pathfinder LAs for 2013/14 (paid in October) to support the delivery of the reforms. This year's grant funding is currently being allocated across the planned co-production activities and events within the project plan, including costs for venues, re-imbursement of expenses incurred by parents attending co-production activities and costs for specialist input from stakeholders groups and others identified by the Project Board as necessary.

1.11 Government funding in 2014/15 to support LAs to deliver the reforms will be significantly higher. Lincolnshire will receive £900,833 in 4 instalments from May 2014 through to February 2015; how this money will be spent is being determined currently.

Current progress and emerging issues

1.12 All work-streams are developing their new SEN systems, processes and products in readiness for trialling and refining from 1st April to 31st August 2014, with volunteer cohorts of children, young people, families and other stakeholders, in readiness for statutory implementation from 1st September.

1.13 **The SEN Local Offer;** this work-stream is aligning the development of the SEN local offer with the on-going development of the Council's website, the Family Service Directory (FSD) and embedding the new SEN local offer within the Early Help offer. A stipulation of the draft Code of Practice is that the SEN local offer should not be simply a directory of services but a more interactive vehicle to enable children, young people and families to be involved in the co-production of their own support and also to be involved in the overall review and development of the wider local offer.

The Council has engaged the company *Open Objects* to develop the web-based carrier for the Lincolnshire SEN local offer (the company already delivers the FSD carrier for

Lincolnshire and many other Local Authorities across England have adopted their approach to the SN local offer). The project is working with *Open Objects* to design and populate the SEN local offer, particularly with family users, developing the first version in readiness for the April 2014 trial launch.

1.14 **Involvement of Children and Young People (CYP) and other stakeholders;** the project is working to ensure that there is proper functional representation of CYP throughout the project's structure and activities, avoiding tokenistic inclusion. To this end a programme of events and activities has been arranged and is being delivered currently across the County, focused on engaging CYP and families in co-producing and influencing the development of all the important aspects of the SEN reforms. These events are proving to be highly popular (with attendances of 50 or more at several) and are providing the project with invaluable opportunities to test out and trial the SEN developments and to recruit families for the trials being arranged for 1st April to 31st August.

1.15 **Cohesive and streamlined assessment processes and EHC Planning;** a draft EHC Plan and the associated assessment processes have been produced by the working group focused on the co-production of these. Over the coming weeks these will be refined further, involving CYP and families, practitioners and key stakeholders, in readiness for trialling and refinement from 1st April to 31st September. There is a focus on the role of practitioners across the various agencies in contributing to the development of 'key working' where families can expect to be supported through the process by a trusted key worker.

1.16 **Strategic collaboration, joint commissioning and alignment with the Lincolnshire Sustainable Services Review (LSSR).** An important focus of the project is to support the new LA duty to promote integration between special educational, health and social care provision, and particularly:

- the requirement for Health authorities and other bodies to co-operate with the LA to identify and support CYP with SEN and
- the requirement for the LA and CCGs to commission services jointly for children and young people with SEN.

1.17 The project is working with Health commissioners and providers to develop effective methods of commissioning and providing SEN support, and this work is being aligned with the Health and Wellbeing Strategy and the outcomes of the LSSR. The emerging themes and outcomes from the LSSR including the joint Council/Health appointment of a single commissioner for children's services, a single pot of money for commissioning and the potential creation of children's services under one operational management structure are all congruent with the Bill's vision for a cohesive multi-agency commitment and approach to SEN support.

This LSSR approach also represents a real platform for delivering more cost-effective approaches to SEN assessment, planning and support across all agencies and services. When the Joint Commissioning Board is established later in the spring the project will engage directly with the Board in the development of the systems and processes necessary to ensure that joint resource is aligned effectively with the key strategic priorities of the Health and Wellbeing Board in relation to improving outcomes for CYP with SEN. Work is being carried out at present to identify the Council and CCG budgets that could be pooled/aligned within section 75 agreements to deliver coordinated services

for supporting CYP with SEN.

The results of this work will be presented to the new Joint Commissioning Board for further consideration and action. The project is also working with CCG colleagues on defining the expectations of the draft SEN Code of Practice that a Designated Health Officer should be appointed to ensure that the CCGs' statutory duties are fulfilled appropriately.

1.18 **4.6 Personal Budgets (PBs);** this new development in terms of SEN provision but has of course been an important aspect of personalised support in adult and children's social care for some time now. PBs will be part of the offer to CYP and families who are in receipt of EHC Plans. These Plans are intended for children and young people with the most complex needs and therefore, on current estimates could be requested on behalf of 3 - 4% (approximately 3 - 4000+) CYP aged 0 - 25 in Lincolnshire.

1.19 The policy for the provision and administration of the new PB process is being carefully addressed by the project, both in terms of developing the most cost-effective ways of processing the demand and also in terms of the potential impact of PBs on existing commissioning and arrangements for SEN support and continuing health care and social care. The experience of SEN pathfinder LAs and neighbouring LAs is being closely followed to ensure that we can capitalise on their experience of successful development and delivery. CYP and families are involved in the co-production of the approach to PBs, managing expectations and shaping provision with a sharp focus on the planned outcomes for CYP.

The project is also focusing on the alignment of Education and Health joint commissioning and resource allocation with the developing approach to PBs in order to assure that resources are used to best effect in improving outcomes for children and young people with SEN.

There is a focus on managing the impact of the new developments; for example, if PBs comprise a significant element of direct payment or personally managed budget for the purchase of support and provision then this will have an impact on the market; new providers may emerge to meet demand whilst existing provision (including that made through Council and Health services and providers) may face pressures caused by reducing levels of demand and fixed cost inflation, particularly in relation to staffing, equipment and buildings costs.

The project is working to ensure that there are proper mechanisms in place to manage PBs and joint commissioning at strategic and operational levels.

2. Conclusion

The project is on track to deliver the reforms envisaged by the Children and Families Bill within the timetable expected by central government. The new SEN assessment process, Local Offer, the EHC Plan, joint commissioning arrangements and PBs are all subject to co-production with CYP and families and will be trialled and refined from April 1st to 31st August 2014 in readiness for statutory implementation 1st September 2014.

3. Consultation

The success of the project relies on effective consultation and co-production of the new approaches to SEN provision and is involving a broad range of stakeholders across families, the Local Authority, Health Authorities, voluntary organisations, early years providers, schools, colleges, universities and other education providers. All stakeholders are involved in consultation through the project architecture and communication strategy.

4. Appendices

There are no appendices.

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 Dave Dickinson who can be contacted on daviddickinson@cfbt.com

Meeting Date	Minute No	Agenda Item & Decision made
11 June 2013	1	**Election of Chairman** That Councillor Mrs S Woolley be elected as Chairman of the Lincolnshire Health & Wellbeing Board for 2013/2014.
	2	**Election of Vice-Chairman** That Dr Sunil Hindocha be elected as Vice-Chairman of the Lincolnshire Health & Wellbeing Board for 2013/2014.
	7	**Chairman's Announcements** For the Chairman to send a response on behalf of the Lincolnshire Health & Wellbeing Board with regard to the Letter from Norman Lamb MP Minister of State for Care and Support – Delivery of the Winterbourne View Concordat and review commitments.
	8	**Health & Wellbeing Boards Terms of Reference and Operating Procedures** 1. That the terms of reference detailed at Appendix A be amended to incorporate the amendments listed and any other typographical errors. 2. That the Health & Wellbeing Board Advisor be requested to present membership information of other Health & Wellbeing Boards to the next meeting of the Board.
	9	**Disabled Children's Charter** That the Health & Wellbeing Board agreed to sign up to the Disabled Children's Charter for Health & Wellbeing Boards, subject to the wording of the Charter being Amended to read 'engaged with'.
	10	**Health & Wellbeing Board – Development Tool** 1. That the Boards current position within the assessment tool be noted and that the Boards progress be review in March 2014 to inform the 2013/2014 Annual Report. 2. That the Health & Wellbeing Board Advisor was to have a discussion with Andrew Leary concerning functions discharged at a local level and that this information should be presented to the next meeting of the Board.
	11	**The Lincolnshire Public Health Annual Report 2012** That the Lincolnshire Public Health Annual Report 2012 be received.

	12	**Dementia Strategy Update** 1. That the launch of the consultation for the Lincolnshire Joint Strategy for Dementia be noted. 2. That the Board members be encouraged to comment on the discussion document through the website. 3. That the approach for partnership working be agreed.
	13	**Letter inviting expressions of interest for Health and Social Care Integration 'Pioneers'** That the Lincolnshire Health & Wellbeing Board offered their support to the making of an expression of interest for Health and Social Care Integration Pioneers on behalf of Lincolnshire
	14	**Lincolnshire Health & Safety Wellbeing Board – forward plan items** That the items raised at the minute numbers 8 and 10, and those detailed above be included on the work programme for the Lincolnshire Health and Wellbeing Board.
	16	**Future scheduled meeting dates** That the following scheduled meeting dates be noted – Tuesday 10 September 2013 Tuesday 10 December 2013 Tuesday 25 March 2014 Tuesday 10 June 2014 Tuesday 30 September 2014 Tuesday 9 December 2014
10 September 2013	19	**Minutes of the Meeting held on 11 June 2013** That the Minutes of the meeting held on 11 June 2013 be confirmed and signed by the Chairman as a correct record.
	22	**Pharmaceutical Needs Assessment** 1. That agreement be given to the continuation of the Pharmaceutical Needs Assessment (PNA) Core Group to develop the needs assessment on its behalf in line with statutory regulations. 2. That the necessary representation be provided at the PNA Core Group in order to provide the expertise required to fulfil the legal requirements placed on the Board in relation to the PNA.

	23	**Terms of Reference and Procedure Rules** 1. That the Terms of Reference and Procedural Rules presented be approved subject to the Roles and Responsibilities of NHS England being amended by the health and Wellbeing Board Advisor after the meeting. 2. That the Terms of Reference be reviewed at the June 2014 meeting of the Board.
	24	**Joint Health and Wellbeing Board Statement of Intent** 1.That the Statement of Intent for the Board detailed below be agreed. *'Lincolnshire Health and Wellbeing Board is taking the lead for better health and wellbeing for the people of our county'* 2. That the Statement of Intent agreed at 1 above be reviewed at the AGM.
	25	**Joint Health and Wellbeing Strategy Sponsors** That the Board agrees to the Sponsors as detailed in the minutes to take forward the outcomes within the five themes of the Joint Health and Wellbeing Strategy and the details agreed in relation to the operating/delivery groups identified to support the work of the Strategy.
	26	**Lincolnshire Sustainable Review** That the presentation entitled 'Lincolnshire Sustainable Services review Health and Wellbeing Board Update' be received.
	27	**Social Care and Health Funding** 1. That the 2013/14 projected outturn be noted. 2. That the guidance on the ITF from the Local Government Association and NHS England detailed at Appendix B to the report be noted. 3 That the plans for bringing a updated paper to the December meeting indicating proposed investment in 2014/15 and 2015/16 be noted
	28	**An Action Log of Previous Decisions** That the Action Log of previous decisions of the Board be noted.
	29	**Lincolnshire Health and Wellbeing Board – Forward Plan** That the Forward Plan presented be accepted subject to the addition of:- Social Care and Health Funding be added to the agenda for December 2013 and March 2014 meeting.

		Sustainable Services Review and Commissioning Plans being added to the March 2014 meeting; and Terms of Reference and procedure Rules and Statement of Intent being added to the June 2014 meeting.
10 December 2013	32	**Minutes of the Meeting held of 10 September 2013** That the minutes of the meeting held on 10 September2013 be confirmed and signed by the Chairman as a correct record.
	33	**Action Updates from the previous meeting** That the completed actions as detailed be noted.
	35	**Lincolnshire Sustainable Services Review** That approval be given to the blueprint document presented and that further reports during phase two of the programme be received by the Board.
	36	**Integrated Transformation Fund proposals to Develop a Structure to Support Joint Commissioning** 1 That the content of the report and Appendices be noted. 2. That the agreement previously reached in March 2013, on the use of allocated funds in 2013/14 be noted, in order that money can be transferred from the Area Team to Lincolnshire (Appendices A, B and C). 3. That the 'special. Meeting of the Health and Wellbeing Board meeting on 5 February 2014 to formally agree the two year plan to spend the Integration Transformation Fund in 2104/15 and 2105/16 be noted. 4. That the five 'early implementers' priorities be agreed. 5. That the outline structure for joint commissioning arrangements as detailed at Appendix D be agreed.
	37	**The Lincolnshire Children and Young People's Plan** That the Children and Young People's Plan 2013 – 2016 be noted.
	38	**Lincolnshire Joint Commissioning Strategy for Dementia Care 2014 2017: The Way Forward** 1. That the Consultation Evaluation Report detailed at Appendix A be endorsed and that

		agreement be given to its publication. 2. That the draft Joint Commissioning Strategy 2014 – 2017 be endorsed; and that the planned timetable for further County Council sign-off through the Adult Scrutiny Committee on 29 January 2014; and the Executive on 4 February 2014 (Appendix B); and Health sign-off via Mental health Lead Officer, Allan Kitt through the four CCG Governing Bodies in December and January, following endorsement by the Board be agreed. 3. That the draft Initial Action Plan (Appendix C) be noted. 4. That the proposed approach to manage strategy delivery via the Joint Dementia Core Group be endorsed.
	39	**Healthwatch Lincolnshire** That the report be noted.
	40	**An Action Log of Previous Decisions** That the Action Log of previous decisions of the Board be noted.
	41	**Lincolnshire Health and Wellbeing Board – Forward Plan** That the forward plan for formal meetings and informal workshop sessions as presented be accepted.
28 January 2014	44	**Better Care Fund Submission Document: 'First –Cut'** 1. That the content of the Better Care Fund submission document as presented be noted. 2. That the Better Care Fund 'first-cut' submission document to NHS England be agreed, and that a copy of any subsequent amendments be emailed out to Board members for comments/information prior to the documents submission to NHS England by 15 February 2014 to meet the national conditions. 3. That a further report concerning the Better Care Fund final submission be received at the next meeting of the Lincolnshire Health and wellbeing Board on 25 March 2014, prior to submission to NHS England. 4 That the Better Care Fund be added as an item for discussion for the informal meeting scheduled to be held on the 25 February 2014.

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Formal meeting dates	Decision/Authorisation item	Discussion item	Information item
10th September 2013	• **Pharmaceutical Needs Assessment –** Discharge of HWB statutory functions – **David Stacey, Programme Manager** • **Terms of Reference and Procedural Rules** Formal agreement and adoption **Martin Wilson, Health and Wellbeing Board Advisor** • **Health and Wellbeing Board 'Statement of Intent'** Formal agreement and adoption **Martin Wilson, Health and Wellbeing Board Advisor** • **Joint Health and Wellbeing Strategy theme sponsors** To agree new theme sponsors and operational groups **Martin Wilson, Health and Wellbeing Board Advisor**	• **Sustainable Services Review –** Discussion of proposals for Lincolnshire **Rose Taylor, Price Waterhouse Cooper**	**Social care and health funding –** update report from June meeting **Glen Garrod, Director of Adult Social Services**-
10th December 2013	**Sustainable Services Review** Formal agreement and adoption of plans **Tony Hill, Director of Public health** **Rose Taylor, Price Waterhouse Cooper** **Social care and health funding –** Update/final report from Septembers meeting **Glen Garrod, Director of Adult Social Services**	**Childrens and Young Person Plan** Debbie Barnes, Executive Director of Children's Services **Dementia Strategy** Information for the Board **Richard Collins**	**Healthwatch** Information for the Board **Malcolm Swinburn**

Formal meeting dates	Decision/Authorisation item	Discussion item	Information item
28th January 2014 (additional meeting)	**Better Care Fund** First cut funding proposals assurance before submission to NHS England **Glen Garrod, Director of Adult Social Services**		
25th March 2014	**Better Care Fund** Final funding proposals assurance before submission to NHS England **Glen Garrod, Director of Adult Social Services** **Commissioning plans** • 4 Clinical Commissioning Groups • NHS England Local Area Team	**Lincolnshire Annual Public Health Report** The Annual Report from the Director of Public Health **Tony Hill, Director of Public Health** **Sustainable Services Review** Verbal update on current position **Tony Hill, Director of Public Health**	**Lincolnshire Safeguarding Children's Board** – Annual Report and Business Plan to inform the Board of the current position. (Theme 4 JHWS activity update) **Andrew Morris LSCB Business Manager** **Review of Health Services for Children Looked After and Safeguarding in Lincolnshire** Care Quality Commission report - information for the Board (Theme 4 JHWS activity update) **Jan Gunter – Consultant Nurse Safeguarding, SWL CCG** **Autism – Lincolnshire self assessment statement** Information for the Board (Theme 3 JHWS activity update) **Richard Collins, Head of Service**

Formal meeting dates	Decision/Authorisation item	Discussion item	Information item
25th March 2014 (continued)			**"Support and aspiration"** – changes for supporting children with special educational need / disability as information for the Board (Theme 4 activity update) **Jill Hodges – CFBT Education Services**
9th May 2014 (additional meeting)	**Sustainable Services Review** Update of plans in next phase and agreement of actions required **Tony Hill, Director of Public Health**		
10th June 2014	• **Annual General Meeting** Election of Chair and Vice Chair Review and agreement of TOR and Procedural Rules • **Review of performance of HWB**	• **Lincolnshire Health and Wellbeing Board development assessment tool** Review current position against baseline in June 2013 **Martin Wilson, Health and Wellbeing Board Advisor**	
30th September 2014	• **Sustainable Services Review** Update of plans in next phase and agreement of actions required **Tony Hill, Director of Public Health**	• **Pharmaceutical Needs Assessment** – Discharge of HWB statutory functions – **David Stacey, Programme Manager, Public Health**	

Formal meeting dates	Decision/Authorisation item	Discussion item	Information item
9th December 2014	• **Pharmaceutical Needs Assessment –** Discharge of HWB statutory functions and decision – **David Stacey, Programme Manager**	**Commissioning plans** • CCG • ASC • Childrens • LAT • Public Health	
27th January 2015 (proposed date)			
24th March 2015 (proposed date)			

Informal workshop sessions for Health and Wellbeing Board

Meeting date	Discussion item	Information item
29th October 2013	**Sustainable Services Review** Informal discussion of proposed blueprint. **Tony Hill, Director of Public Health**	
28th January 2014	**Commissioning plans** • **Better Care Fund**	
25th February 2014	**Commissioning plans** • 4 Clinical Commissioning Groups • Adult Social Care • Children's services • NHS England Local Area Team • Public Health	
9th May 2014	**Lincolnshire Sustainable Services Review** Informal discussion on consultation proposals **Health and Wellbeing Strategy** Discussion with Board sponsors on current position on delivery of outcomes to inform Annual Report for the Board	
9th/11th September 2014 (proposed additional meeting moved from 8th July)	**Lincolnshire Sustainable Services Review** Informal Board session to review results of consultation and draft proposals for implementation	
28th October 2014		

26th November 2014
24th February 2015 (proposed date)