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16 March 2015

Lincolnshire Health and Wellbeing Board

A Meeting of the Lincolnshire Health and Wellbeing Board will be held on Tuesday, 24 March 2015 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, B W Keimach, C R Oxby, N H Pepper and S M Tweedale

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

District Council: Councillor Marion Brighton OBE

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

Healthwatch Lincolnshire: Mr Malcolm Swinburn

NHS England: Mr Jim Heys

(*) Permanent Membership

LINCOLNSHIRE HEALTH AND WELLBEING BOARD AGENDA
TUESDAY, 24 MARCH 2015

Item		Title	Pages	Estimated Time
1		**Apologies for absence/Replacement Members**		
2		**Declarations of Members' Interest**		
3		**Minutes of the Lincolnshire Health and Wellbeing Board meeting held on 9 December 2014**	5 - 14	
4		**Action Updates from the previous meeting** *(For the Lincolnshire Health and Wellbeing Board to consider the actions arising from the previous meeting)*	15 - 20	
5		**Chairman's Announcements** *(For the Lincolnshire Health and Wellbeing Board to note the Chairman's announcements)*	21 - 22	
6		**Decision/Authorisation Items**		
	6a	**Lincolnshire Pharmaceutical Needs Assessment (PNA)** *(To receive a report from Chris Weston, Consultant in Public Health, which asks the Board to approve the PNA for Lincolnshire)*	23 - 106	
	6b	**CCG Operational Plans** *(To receive a report from each of the four Clinical Commissioning Groups, which asks the Board to review the Operational Plans for 2015/16 against the priorities in the Joint Health and Wellbeing Strategy)*	107 - 198	
	6c	**Better Care Fund Section 75 Agreement(s)** *(To receive a report from Glen Garrod, Director of Adult Social Services, which asks the Board to endorse the Section 75 Agreement(s))*	199 - 268	
	6d	**Health and Wellbeing Grant Fund** *(To receive a report Alison Christie, Programme Manager – Health and Wellbeing Board, which asks the Board to approve the recommendations from the Sub Group regarding applications to the Health and Wellbeing Grant Fund)*	269 - 274	

Item		Title	Pages	Estimated Time
7		**Discussion/Debate Items**		
	7a	**Lincolnshire Health and Care** *(To receive a verbal update from Dr Tony Hill, Executive Director of Community Wellbeing and Public Health on the current position with regard to the Lincolnshire Health Care proposals)*		
	7b	**Annual Report of the Director of Public Health on the Health of the People of Lincolnshire 2014** *(To receive a report from Dr Tony Hill the Director of Public Health, which provides the Board with the Annual Report on the health of the people of Lincolnshire)*	275 - 332	
	7c	**District/Locality Updates** *(To receive, by exception, updates from District/Locality partnerships on issues which may impact on the delivery of the Joint Health and Wellbeing Strategy. No items have been tabled for this meeting)*		
	7d	**Joint Health and Wellbeing Strategy Theme Update** *(To receive, by exception, updates from Theme Sponsors and Leads on issues which may impact on the delivery of the Joint Health and Wellbeing Strategy. No items have been tabled for this meeting)*		
8		**Information Items**		
	8a	**Joint Commissioning Arrangements in Lincolnshire** *(To receive a joint report from Gary Thompson, Chief Operating Officer South CCG and Glen Garrod, Director of Adult Social Services, which provides information on the organisational structure and reporting lines that support joint commissioning arrangements in Lincolnshire between health and social care)*	333 - 338	
	8b	**Review of Processes for Lincolnshire's Joint Strategic Needs Assessment (JSNA)** *(To receive a report from Chris Weston, Consultant Public Health regarding the proposals and timescales for reviewing the Joint Strategic Needs Assessment)*	339 - 346	

Item	Title	Pages	Estimated Time
8c	**Mental Health Crisis Care Concordat** *(To receive a report from Colin Warrant, Head of Mental Health Commissioning, Specialist Adult Services, which asks the Board to endorse the Mental Health Crisis Care Concordat and Action Plan)*	347 - 366	
8d	**An Action Log of Previous Decisions** *(For the Lincolnshire Health and Wellbeing Board to note decisions taken since May 2014)*	367 - 374	
8e	**Lincolnshire Health and Wellbeing Board - Forward Plan** *(This item provides the Board with an opportunity to discuss potential items for future meetings which will subsequently be included on the Forward Plan. Alison Christie, Programme Manager – Health and Wellbeing Board)*	375 - 378	

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 HEALTH AND WELLBEING BOARD
9 DECEMBER 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), D Brailsford, 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 Care) and Dr Tony Hill (Executive Director of Community Wellbeing and Public Health).

District Council: Councillor Marion Brighton OBE (District Council).

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 Jim Heys (NHS England).

Officers in Attendance: Alison Christie (Health and Wellbeing Board Business Manager), Katrina Cope (Team Leader, Democratic and Civic Services), Justin Hackney (Chief Commissioning Officer, Joint Commissioning and Specialist Services), Annette Lumb (Head of Planning and Governance, Lincolnshire West CCG), Elaine Baylis, QPM (Independent Chairman, Lincolnshire Safeguarding Adults Board), Dave Culy (Lincolnshire Safeguarding Adults Board Business Manager), Sharon Jeffreys (Head of Commissioning for Autism and Learning Disabilities) and David Stacey (Programme Manager, Public Health).

22 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

An apology for absence was received from Councillor Mrs J P Churchill.

23 DECLARATIONS OF MEMBERS' INTEREST

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

24 MINUTES OF THE LINCOLNSHIRE HEALTH AND WELLBEING BOARD MEETING HELD ON 30 SEPTEMBER 2014

RESOLVED

That the minutes of the Lincolnshire Health and Wellbeing Board held on 30 September 2014, be confirmed and signed by the Chairman as a correct record.

25 ACTION UPDATES FROM THE PREVIOUS MEETING

RESOLVED

That the completed actions as detailed be noted.

26 CHAIRMAN'S ANNOUNCEMENTS

The Chairman welcomed to the meeting Jim Heys, as the NHS England representative.

Further to the announcements circulated with the agenda, the Chairman advised the Board that a letter had been received from the Department of Health and NHS England concerning Clinical Commissioning Group progress on dementia diagnosis rates in Lincolnshire. The Board were advised that a copy of the letter would be forwarded onto them after the meeting.

The Chairman advised further that a copy of The Dalton Review – Examining new options and opportunities for providers of NHS care published on 5 December 2014, had been received. It was agreed that a copy of the full and summary reports from the Dalton Review document would be forwarded on to members of the Board after the meeting.

27 DECISION/AUTHORISATION ITEMS

(a) Protocol between Lincolnshire Health and Wellbeing Board and Lincolnshire Safeguarding Adults Board

Pursuant to Minute number 19(d) from the meeting held on 30 September 2014, consideration was given to a report from the Health and Wellbeing Board Business Manager, which asked the Board to approve the draft Protocol between the Lincolnshire Health and Wellbeing Board and Lincolnshire Safeguard Adults Board which was appended as Appendix A to the report presented.

It was highlighted that from April 2015, new statutory requirements were due to come in to force as a result of the Care Act 2014. The Act formally set out the local authority's responsibility for adult safeguarding for the first time in primary legislation. Whilst the guidance did not formalise a relationship between the two Boards, there

was an expectation that the Boards would work together to ensure effective adult safeguarding arrangements were in place.

The Protocol proposed a framework to ensure effective joint working between the two Boards. It also set out their distinct roles and responsibilities and provided a mechanism to ensure effective safeguarding arrangements were in place.

It was reported that the Protocol had been prepared by officers supporting the Lincolnshire Health and Wellbeing Board and Lincolnshire Safeguarding Adult's Board and had been shared with the Chairman of the Lincolnshire Safeguarding Adult's Board.

It was noted that the Protocol would be reviewed in a year's time, and then bi-annually thereafter, or in response to any new national guidance issued in relation to Health and Wellbeing Boards or Local Safeguarding Boards.

It was highlighted to the Board that there was an error on page 29, seventh bullet point, should read *'Provide a formal response to the LSAB's Annual Report'* rather than LSCB's Annual Report.

RESOLVED

1. That the draft Protocol shown at Appendix A be approved.

2. That authority be delegated to the Health and Wellbeing Business Manager, in consultation with the Chairman, to make any necessary alterations following consideration by Lincolnshire Safeguarding Adults Board that do not fundamentally affect the intentions of the Protocol.

(b) Health and Wellbeing Grant Fund

The Board gave consideration to a report from the Executive Director of Community Wellbeing and Public Health, which advised that a decision had been taken in June 2014, to disband the Health and Wellbeing Fund Board and transfer the responsibility for the remaining money (£1.3m) to the Lincolnshire Health and Wellbeing Board. Following this decision, a revised Section 245 Agreement had been signed between Lincolnshire County Council and the four Clinical Commissioning Groups. The new agreement detailed at Appendix A now reflected the change in governance and updated the funding criteria to take into account the Joint Health and Wellbeing Strategy (JHWS).

The report provided a summary guide detailing the criteria and process for making an application for funding, and also asked the Board to establish a Sub Group to review and endorse formal project proposals ahead of final sign off by the Board. Detailed at Appendix A was a copy of the Section 256 Agreement, and Appendix B provided a copy of the Health and Wellbeing Grant Project Summary Guidance and Application Process document for the Boards consideration.

Page 32 of the report provided key points on how to apply for funding, and provided a summary of the application process.

RESOLVED

1. That the new Section 256 Agreement be noted.

2. That agreement be given to the application process shown in Section 7 and the roles and responsibilities shown in Section 8 of Appendix B.

3. That agreement be given to the establishment of a Sub Group to review and endorse the formal project proposal ahead of final sign off by the Board.

28 DISCUSSION/DEBATE ITEMS

(a) Lincolnshire Health and Care

The Executive Director of Community Wellbeing and Public Health provided a verbal update to the Board with regard to the Lincolnshire Health and Care (LHAC) proposals.

The Board were advised that LHAC were currently looking at governance arrangements going forward to implementation.

It was noted that the Programme Board had been retained as a Stakeholder Board to help make arrangements work.

Work was also being finished with regard to the Clinical Model; pieces of work were being finalised and actions agreed in readiness for the consultation document for consultation in June 2015.

The Board were advised that there were now eight early implementer Neighbourhood Teams. Four further Neighbourhood Teams had been set up around the county since the last meeting these were at Long Sutton, Grantham, Lincoln North and Louth and Mablethorpe.

One Board member enquired as to how long it would be before Neighbourhood Teams were established across the county. It was reported that originally it was thought that the Neighbourhood Teams would be established across the county by April 2015. It was thought that at the moment, establishment of the teams would be April 2015 or just after.

(b) Better Care Fund

Consideration was given to a report from the Director of Adult Social Services, which provided an update to the Board concerning the three strand of work relating to the Lincolnshire Better Care Fund (BCF), these were:-

- Detailed work to produce a re-submission document required to be returned to NHS England on 9 January 2015;
- Development of the Section 75 Legal Agreement; this would incorporate all the pooled budgets ambition across Health Care in 2015/16, which equates to £197m; and
- Details of the work to agree funding for schemes and the protection of Adult Care supported by the BCF in 2015/16.

Full details of the background to the BCF were shown within the report presented.

Appended to the report were the following documents for consideration by the Board:-

- Appendix A – BCF Resubmission – Section Updated and Action Tracker;
- Appendix B – BCF Task Group Terms of Reference;
- Appendix C – Report to JCB – Pooled Fund Update; and
- Appendix D – List of Schemes funded by the BCF in 2015/16.

The Director guided the Board through the report and responded to questions raised, which included:-

- Whether any revisions in the document affected Disabled Facility Grants. The Board were advised that there were no amendments pertaining to DFG's, however the BCF for 2016/17 was uncertain and dependent upon the government post 7 May 2015. It was also highlighted that the allocation for 2015/16 was not guaranteed until the governments final settlement allowance was announced later in December;
- Contingency plans if the BCF application was not approved. It was reported that there was no guidance should the final submission be rejected, but it was felt that rejection would be dealt in the same manner as had been done in the earlier round where five areas BCF submission had been rejected. Reassurance was given that in cases where the BCF had not been accepted the local authority and the CCG's had not agreed, this was not the case in Lincolnshire. It was highlighted that in some other areas there was closer working with the Acute Trust, this was something that needed to improve in Lincolnshire.

RESOLVED

1. That the work to date and the timeline for re-submission of the BCF and the production of the Section 75 be noted.

2. That agreement be given for the BCF re-submission as detailed in the accompanying papers, be delegated to the Chairman of the Lincolnshire Health and Wellbeing Board to sign off, subject to there being no material change to the BCF affecting performance of finances and subject to

agreement by the four CCG's and the Director of Adult Social Services (Appendix A).

3. That the BCF task Group Terms of Reference detailed at Appendix B be noted.

4. That agreement be given to the schemes detailed in Appendix D.

5. That agreement be given to receiving a subsequent report to each of the next four Lincolnshire Health and Wellbeing Board formal meetings throughout 2015.

(c) Lincolnshire's All-Age Autism Strategy 2015 - 2018

A report from the Director of Adult Social Services was received, which presented to the Board the draft All-Age Autism Strategy for Lincolnshire. The purpose of the Strategy was to set out the strategic direction to ensure that people with autism in Lincolnshire were able to live fulfilling and rewarding lives within autism-friendly communities that understand their needs and make reasonable adjustments, so that there was access to and support from mainstream public services. The Board were asked to review and comment on the document as part of the consultation being conducted with key stakeholders.

It was reported that an action plan had been developed, which incorporated four key strategic programmes to deliver the Autism Strategy, and that this was underpinned by measurable objectives which were:-

- Awareness raising and training;
- Involvement and collaboration with people with lived experience and carers at every stage;
- Data systems and information gathering; and
- Service provision.

A copy of the Lincolnshire's All-Age Autism Strategy – Initial Action Plan was detailed on pages 69/70.

Work was also being undertaken to develop and strengthen the Autism Partnership Board, including a review of the membership, to ensure that it was fit for purpose.

It was reported that consultation on the draft Lincolnshire All-Age Autism Strategy had commenced with key stakeholders and would be open for the public to respond on the proposed eight strategic principles and building blocks for action.

A copy of the draft Lincolnshire All-Age Autism Strategy 2015/18 was detailed at Appendix A to the report presented.

During discussion, the following issues were raised:-

- That the Action Plan needed to be very robust and tie in to meet the needs of young people through in to adulthood;
- The need for commitment to a multi-agency approach. It was also highlighted that there needed to be the same approach with regard to diagnosis between schools and GP's; and
- Concern was raised that District Councils had not been involved in the Strategy. Officers advised that there was to be a re-launch of the Strategy at the end of January 2015, to which each District Council would be able to send a representative. It was agreed that the details would be emailed out to the district after the meeting.

RESOLVED

That the draft All-Age Autism Strategy for Lincolnshire be received and that Panel members be invited to provide feedback on the content of the document.

(d) Lincolnshire Safeguarding Adults Board Business Plan

The Board gave consideration to a report from Elaine Baylis, QPM, Independent Chairman for the Lincolnshire Safeguarding Adults Board, which asked the Board to consider the Lincolnshire Safeguarding Adults Board (LSAB) Business Plan.

It was reported that Schedule 2 of the Care Act 2014 which comes in to effect on 1 April 2015 states that a Safeguarding Adults Board must publish a Strategic Plan and Annual report (full details of the requirements were shown on pages 86/87 of the report presented). It was noted that it was the intention of the LSAB to publish its first strategy by April 2015 ensuring, wherever possible, alignment with the Joint Health and Wellbeing Strategy for Lincolnshire. The Board were advised that the first Annual Report was expected to be published in the summer of 2016, and that this would be shared with the Lincolnshire Health and Wellbeing Board.

A copy of the LSAB Business Plan was appended to the report presented.

Reassurance was given to the Board, that the LSAB would be producing the required documents as defined in the Care Act 2014.

RESOLVED

1. That the current Lincolnshire Adults Board (LSAB) Business Plan presented be noted.

2. That a copy of the LSAB 2015/16 Strategic Plan would be available to be presented to the Board after April 2015.

3. That a copy of the LSAB 2015/16 Annual Report would be available to be presented to the Board during the summer of 2016.

(e) Draft Lincolnshire Unit of Planning 5 Year Strategic Plan

Consideration was given to a report from the four Lincolnshire Clinical Commissioning Groups, which provided the Board with a copy of the Draft Lincolnshire Unit of Planning 5 Year Strategic Plan 2014/15 to 2018/19.

It was reported that the Lincolnshire Health and Social Care (LHAC) was in essence the five year strategic plan, with the addition of two further major work streams i.e. Primary Care and Mental Health Learning Disabilities and Autism.

The plan included interventions that could be developed and implemented locally through routine consultation as part of the annual commissioning cycle and a number of high level options, some of which would have a significant impact on the service delivery landscape across Lincolnshire that would require further development and formal consultation before the preferred options were identified in 2015.

The purpose of the Strategic Plan was to improve the quality of services through six major work streams (proactive care, urgent care, elective care, services for women and children, primary care and mental health learning disability and autism). The plan outlined the LHAC (high level options where further work and consultation was planned for 2015) the revised financial plan which was only provisional, the strategic approach to developing primary care, mental health, learning disability and autism. It was noted that the plan was the key document which aligned LHAC, CCG Operational Plans and the Lincolnshire Unit of Planning 5 year Strategy.

A discussion ensued from which the following issues were raised:-

- The absence of information relating to resource in the future and how that would be overcome. The Board were advised that allocation of monies to CCG's was based on population figures and that work was ongoing with planners with regard to housing development at a local level and with Lincolnshire County Council. District Councils felt that there needed to be closer working with them. The Board were advised that spatial planning and housing growth was a national issue and that there was a gap in resource, and that work was ongoing locally to try and close the gap;
- Timeframe for the consultation process. The Board were advised that as the proposed consultation was a major consultation, residents of Lincolnshire would have the opportunity to air their views in June 2015;
- Financial deficit – The Board were advised that there was a gap in funding, but that this would be partly resolved by the reconfiguration of services and some by efficiencies within the services provided;
- Concerns were raised with regard to the huge training deficit, and how it was anticipated getting professionals to deliver the newly configured services. The Board were advised that one of the drivers for reviewing service provision was problems with recruitment. Some discussion was had with regard to Lincolnshire having the right workforce, but just in the wrong place. It was stressed that retention of staff was a problem in Lincolnshire and that this must be a priority for LHAC. It was noted that Health Education East Midlands

actually funded people to go to university, and that there were people that wanted to train; and

- Involvement of Lincolnshire Primary Foundation Trust (LPFT) on the Board. The Board were advised that representatives from LPFT had been involved through LHAC. It was felt that at present there was not a need to include LPFT on the Board. It was highlighted that LPFT was being involved as part of integrated team working.

RESOLVED

That the Lincolnshire Health and Wellbeing Board notes:

- The current status of the strategic plan and that there would be a final draft of the strategic plan for December 2014;
- That the financial modelling was only provisional at this stage;
- That the LHAC Programme Board was considering the integration of the NHS England '5 Year Forward View' and detailed LHAC implementation timelines and resource requirements at its meeting on 25 November 2014 (this would inform the final draft of the strategic plan).

29 DISTRICT/LOCALITY UPDATE

The Health and Wellbeing Board Business Manager advised that no issues from District/Locality partnerships on issues which might impact of the delivery of the Joint Health and Wellbeing Strategy had been received.

30 JOINT HEALTH AND WELLBEING STRATEGY THEME UPDATE

The Health and Wellbeing Board Business Manager advised that no updates had been received from Theme Sponsors or Leads on issues that might impact on the delivery of the Joint Health and Wellbeing Strategy.

31 INFORMATION ITEMS

(a) Updated Joint Strategic Needs Assessment (JSNA) Overview Report 2013/14

The Board gave consideration to a report from the Strategy and Performance Team, which advised on the key changes within the Joint Strategic Needs Assessment (JSNA) evidence base over the last 12 months.

It was reported by the Programme Manager, Public Health that this year the overview report had been produced slightly different to previous years, the executive summaries from all the JSNA topic commentaries that had been updated through 2013/14 had been extracted and used to make up the body of the document. It was also noted that a full review of the JSNA processes and working arrangements was currently underway and that this would be the subject of a future board report.

The purpose of the report was to establish what had changed within the JSNA over the course of the year and what impact this would have on the future direction of the JSNA in terms of new topics to be added or amendments to existing topics.

It was highlighted that as in previous years an 'easy read' version of the JSNA overview report had also been produced and was available on the JSNA area of the Lincolnshire Research Observatory.

Detailed at Appendix A was a copy of the 2013/14 JSNA Annual Report.

A short discussion ensued from which the following issues were raised:

- The inclusion of dementia and autism into the JSNA. It was reported that dementia was already included and that the future full review would pick up issues around any new topics required; and
- That if the JSNA was amended then the Joint Health and Wellbeing Strategy needed to be refreshed. It was noted that following the review of the JSNA the priorities emerging from this would form the basis of a review of the Joint Health and Wellbeing Strategy (JHWS).

RESOLVED

That the updated JSNA Overview Report 2013/14 be noted.

(b) An Action Log of Previous Decisions

RESOLVED

That the Action Log of previous decisions of the Lincolnshire Health and Wellbeing Board be noted.

(c) Lincolnshire Health and Wellbeing Board - Forward Plan

The Health and Wellbeing Board Business Manager presented the Boards current Forward Plan for consideration.

The Business Manager invited members to put forward items for inclusion on the forward plan. No items were received at the meeting.

RESOLVED

That the forward plan for formal and informal meetings as presented, be received.

The meeting closed at 3.45 am

Meeting Date	Minute No.	Agenda Item & Action Required	Update on Action taken
09.05.14	62	**Lincolnshire Health and Care (Formerly known as the Lincolnshire Sustainable Services Review)** Officers agreed to look into the assurance process. Officers agreed to revisit the dates for the formal decision making process for July 2014. (David O'Connor)	Lincolnshire Health and Care has been subject to an assurance process involving NHS England, Health, Gateway Reviews and the Clinical Senate. Lincolnshire Health and Care was the first one to go through the process. Following a re-profiling of the programme there was no longer a requirement for additional Board meetings in July 2014 or January 2015.
10.06.14	9(1)	**Lincolnshire Health and Wellbeing Board Development Toolkit – Current Position** That a small Task and Finish Group should be formed to help develop an Action Plan; and that expression of interests should be sent to Alison Christie, the Health and Wellbeing Board's Advisor. (Alison Christie/All Board Members)	Expressions of interest were received from Cllrs Mrs Woolley and Worth. The Task and Finish Group was established and met on 25th July 2014. The Development Assessment Action Plan was presented to the Board on 30th September 2014 and the improvement actions agreed.
11.09.14	13	**Better Care Fund Final Re-Submission** 1. That the BCF Task Group be delegated to make any final iteration to the final submission between this meeting and 19 September 2014. (Glen Garrod) 4. That an expression of interest on behalf of the Council should be made to participate in the national pilot scheme for personal health budgets (Glen Garrod)	The BCF Task Group completed the final iteration to the BCF re-submission. The documentation was submitted to the Department of Health by the 19th September 2014 deadline. An expression of interest to take part in the national pilot scheme for the Integrated Personal Commissioning (IPC) Programme was submitted to the Department of Health by the deadline.
30.09.14	18	**Chairman's Announcements** Better Care Fund That a standing update item would be included on future agendas of the Board (Katrina Cope) Integrated Personal Commissioning (IPC) Programme That a detailed submission should be submitted by 7 November and that this would need to be agreed by the Board (Glen Garrod) Letter from Lincolnshire Partnership Foundation Trust The Chairman to provide an update on outcome of a meeting with LPFT. (Chairman)	 Standing item on the Board's agenda from the 9th December 2014. Detailed submission sent to the Department of Health by the 7th November 2014 deadline. The Chairman of the Board provided a supporting statement. The Chairman and Board Business Manager met with Eileen Ziemer-Cottingham on 3rd October. The meeting covered how LPFT could support the refresh of the Joint Strategic Needs Assessment and the

			development of the Mental Health Crisis Care Concordat. Wider engagement through the People's Partnership was also discussed
		Mental Health Crisis Care Concordat: making change happen in your area That a Declaration for Lincolnshire would be present to the Board for endorsement (Colin Warren)	A cross agency working group has been established and work is currently underway to develop a Declaration for Lincolnshire, which needs to be in place for April 2015. The Forward Plan has been updated to receive a report on the Declaration on the 24th March 2015.
		Safeguarding of Children Copy of the ministerial statement to be circulated to all the Board members (Alison Christie)	A copy of the ministerial statement was circulated to Board Members on 29th September 2014.
		Neighbouring Health and Wellbeing Board Pharmaceutical Needs Assessments (PNA) Draft response from the PNA Steering Group to be circulated to members of the Board (Alison Christie)	The PNA Steering Group has met to consider neighbouring HWB PNAs (received from Leicestershire, Nottinghamshire, Rutland and North East Lincolnshire). The proposed responses were circulated to Board Members for any further comments on 12th November. Formal responses to the consultations on behalf of the Board were submitted on 21st November 2014.
	19a	**Lincolnshire Health and Wellbeing Board Development Assessment Action Plan** That progress against the Development Assessment Action Plan should be reported to the Bard as part of future annual assurances updates (Alison Christie)	An update on progress against the Assessment Action Plan will be included in the Annual Assurance Report 2014-15 to be presented to the Board on 9th June 2015.
	19b	**Joint Health and Wellbeing Strategy Assurance Report 2014** • Each theme should review their suite of indicators, and to identify any additional actions that can be taken by the theme • Each current Board sponsor roles and support mechanisms should be reviewed • A full review of the Joint Strategic Needs Assessment should be undertaken during 2015/16, and that proposals for undertaking the work should be presented to a future meeting of the Board	Work is ongoing to review each of the themes; this includes looking at the suite of indicators and any additional actions that can be taken. The outcome of this review will be presented to the Board on 24th March 2015. Proposals are being drawn up and will be presented to the Board on 9th June 2015 as part of the annual review of the Terms of Reference. A paper setting out the process and timescales for reviewing the JSNA and JHWS will be presented to the Board on 24 March 2015.

	19c	**Protocol Between the Lincolnshire Health and Wellbeing Board, Healthwatch Lincolnshire and the Health Scrutiny Committee for Lincolnshire** • The draft protocol should be referred to the Health Scrutiny Committee for Lincolnshire and Healthwatch Lincolnshire for consideration and approval. (Alison Christie) • That delegated authority was given to the Health and Wellbeing Board Business Manager, in consultation with the Chairman to make any necessary amendments following consideration by the Health Scrutiny Committee for Lincolnshire and Healthwatch (Alison Christie/Chairman)	The draft Protocol was considered by the Health Scrutiny Committee for Lincolnshire on 22nd October 2014. The protocol was agreed subject to the addition of information detailing the makeup of the Health and Wellbeing Board and Health Scrutiny Committee for Lincolnshire. The Protocol has been amended to reflect the comments from Health Scrutiny Committee for Lincolnshire. The protocol was formally signed by all parties in November 2014..
	19d	**Protocol Between the Lincolnshire Health and Wellbeing Board and the Lincolnshire Safeguarding Children Board** • That delegated authority was given to the Health and Wellbeing Business Manager in consultation with the Chairman to make any necessary amendments following consideration by the Lincolnshire Safeguarding Children Board (Alison Christie)	As requested by the Board, a number of amendments were made to the protocol and agreed by the Chairman. The protocol was formally signed by the Chairmen of both Boards on 16th October 2014.
	21a(2)	**Action Log of Previous Decisions** That in future only decision relating to the previous 12 months should be presented to the Board	Effective from 9th December 2014.
	21c	**Lincolnshire Health and Wellbeing Board – Forward Plan** Items for inclusion on the agenda for 24 March 2015 • Proposal for reviewing the JSNA for 2015/16 • CCG's Operational Plans • Rochdale Action Plan regarding Child Exploitation (9 December 2014)	All items added to the Forward Plan apart from the Child Exploitation Action Plan which was circulated to the Members of the Board by email for information.
09.12.14	26	**Chairman's Announcements** • That a copy of the letter from the Department of Health and NHS England concerning Clinical Commissioning Group progress on dementia diagnosis rates in Lincolnshire would be forwarded	Letter circulated to Board Members on 11 December 2014.

		on to members of the Board after the meeting. • That a copy of the full and summary reports from the Dalton Review – Examining new options and opportunities for providers of NHS care published on 5 December 2014 would be forwarded onto members of the Board after the meeting.	Briefing note, along with a copy of the full and summary reports on the Dalton Review, circulated to Board Members on 10 December 2014.
	27a	**Protocol between Lincolnshire Health and Wellbeing Board and Lincolnshire Safeguarding Adults Board** • That authority be delegated to the Health and Wellbeing Business Manager, in consultation with the Chairman, to make any necessary alterations following consideration by Lincolnshire Safeguarding Adults Board do not fundamentally affect the intentions of the Protocol.	As requested by the Board, a number of amendments were made to the protocol and agreed by the Chairman. The protocol was formally signed by the Chairmen of both Boards on 17th December 2014.
	27b	**Health and Wellbeing Grant Fund** • That a Sub-Group should be established to review and endorse the formal project proposal ahead of final sign off by the Board	HWB Fund Sub Group established. Membership included Cllr Woolley (LCC representative) and Gary James (CCG representative). The Sub Group met on 25th February to review 20 Project Proposals. 10 Project Proposals have been recommended to the HWB for agreement at the Board meeting on 24 March 2015.
	28b	**Better Care Fund** • That agreement be given for the BCF re-submission as detailed in the accompanying papers, be delegated to the Chairman of the Lincolnshire Health and wellbeing Board to sign off, subject to there being no material change to the BCF affecting performance of finances and subject to agreement by the four CCG's and the Director of Adult Social Services (Appendix A) • That subsequent reports be received to each of the next four Lincolnshire Health and Wellbeing Board formal meetings throughout 2015.	The BCF Task Group completed the final iteration to the BCF re-submission. The documentation was submitted to the Department of Health by the deadline. BCF is now a standing item on the HWB agenda.
	28c	**Lincolnshire's All-Age Autism strategy 2015 – 2018** • That Board members were invited to provide feedback on the content of the document.	Details of an engagement event were circulated to HWB Members.

	28d	**Lincolnshire Safeguarding Adults Board Business Plan** • That a copy of the LSAB 2014/16 Strategic Plan to be presented to the after April 2015 • That a copy of the LSAB 2015/16 Annual Report to be presented to the Board during the summer of 2016	Item added to HWB Forward Plan. To be tabled as an item for information at the June 2015 meeting. Item added to HWB Forward Plan as an item to be programmed once date confirmed.
	28e	**Draft Lincolnshire Unit of Planning 5 Year Strategic Plan** That a final draft of the strategic plan to be presented to a future meeting of the Board.	The CCG Operational Plans 2015/16 were discussed at the Informal Health and Wellbeing workshop on 24th February 2015 and presented to the Health and Wellbeing Board on 24th March 2015.

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Lincolnshire Health and Wellbeing Board – 24 March 2015

Announcements from: **Cllr Sue Woolley, Chairman of the Lincolnshire Health and Wellbeing Board**

Future Role of Health and Wellbeing Boards

In the run up to the Election in May there are a number of national and regional meetings exploring the future role of Health and Wellbeing Boards. In particular, in my capacity as Chairman of the East Midlands HWB Chair's Network, I was invited to attend the LGA Community Wellbeing Committee on 11 March 2015 followed by a consultative workshop. The discussions focused on:

- How effective are HWBs – what is working well?
- What needs to be improved?
- What is the future vision of HWBs – is there an appetite for HWBs to have greater influence over integrated commissioning?
- What do we mean by integrated commissioning? Is there clarity and consensus on this?
- Do you see support for a greater role for HWBs in integrated commissioning – How do HWBs need to change and develop in order to be a partnership of equals that drives forward a place-based approach to commissioning service to make a real difference to health and wellbeing?
- What are the national and local barriers to achieving this?
- What can LGA and NHS CC do to support HWBs and to promote their interests with the new Government?

A further discussion on the future role of Health and Wellbeing Boards is also on the agenda for the HWB Chairs Network meeting on 25 March 2015.

Healthier Future for the East Midlands

I was invited to attend the East Midlands Improvement and Transformation Board on 2 March 2015 to take part in a broad discussion about health in the East Midlands. This follows the publication of a report by the East Midlands Councils entitled '*Healthier Future for the East Midland'*. This report examines a number of issues facing the region and identifies four priority areas:

- Inequalities in health outcomes;
- Inequalities in funding for healthcare;
- Recruitment and retention of the health workforce;
- The need for collective leadership.

A copy of the report was circulated to Board members on 4 March 2015 and is also available on the East Midlands Councils' website.

Evidence from this report, especially relating to retention and recruitment will be fed into a meeting of the County All Party Parliamentary Group.

New Co-Commissioning Arrangements

Applications by the four Clinical Commissioning Groups in Lincolnshire to take on greater responsibility for the commissioning of general practice services from 1 April 2015 have been approved by NHS England. The announcement on 18 February 2015 means that from April 2015 the following co-commissioning arrangements will apply:

- Combined co-commissioning arrangement covering Lincolnshire South West, South and East CCGs
- Co-Commissioning arrangement covering Lincolnshire West CCG.

As Chairman of the Lincolnshire Health and Wellbeing Board, I have been invited to sit as a non-voting member on the Boards overseeing the two co-commissioning arrangements. Healthwatch have also been offered non-voting membership.

Caring for Greater Manchester Together: Devolution of Health and Care Funding

Greater Manchester and NHS England have recently announced plans to bring together devolved health and social care budgets – a combined sum of £6bn. This trailblazing move sees NHS England, 12 NHS Clinical Commissioning Groups, 15 NHS Providers and 10 local authorities agree a framework for joint decision making. The scope of the Memorandum of Understanding countersigned by the Chancellor and the Secretary for Health includes the entire health and social care system in Greater Manchester, including adult, primary and social care, mental health and community services and public health. The second part of the agreement provides a framework for strategies around governance and regulation, resources and finances, the property estate, health education, workforce, information sharing and systems being brought together. A new strategic health and social care partnership board will be established to oversee the new arrangements which will impact on around three million people.

This announcement represents an opportunity for the local leadership in Greater Manchester to make important decisions about the future of health and care - potentially driving integration, innovation and improvement. If successful this model and approach could be rolled out to other regions in England.

Cllr Jo Churchill

Cllr Churchill has resigned from the Health and Wellbeing Board due to other commitments. I would like to thank Cllr Churchill for her contributions to the Board and welcome Cllr Nigel Pepper, who has been appointed as Cllr Churchill replacement on the Board. In the short term, I have asked Cllr Pepper if he would take over Cllr Churchill's role of Board Sponsor for Theme 3 (Delivering High Quality Systematic Care for Major Care of Ill Health and Disability).

Lincolnshire East CCG Representation

I have received notification that Dr Simon Lowe, representative for Lincolnshire East Clinical Commissioning Group has stood down from the Health and Wellbeing Board. Dr Peter Holmes joins the Board as the representative for Lincolnshire East Clinical Commissioning Group. I would like to thank Simon for his contribution to the Board and welcome Dr Peter Holmes to the Board.

David Sharp

David Sharp (Director of NHS England Central Midlands Area Team) is leaving NHS England to take up a senior management position with Optum, a large globally focussed division of United Healthcare. I would like to take this opportunity to thank David for the support he has given to Lincolnshire and to wish him well in the future.

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of Chris Weston MPH,FFPH
Consultant in Public Health

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**24 March 2015**
Subject:	**Lincolnshire Pharmaceutical Needs Assessment (PNA)**

Summary:
The Health and Wellbeing Board (HWB) has a legal requirement to produce a Pharmaceutical Needs Assessment (PNA) by 1st April 2015.

The consultation took place for a period of 60 days, from 6 October 2014 to 4 December 2014.

We have now completed a PNA assessment that:

- looks at the need for pharmaceutical services for the residents of Lincolnshire;
- describes the current services available within the county; and
- makes recommendations for the future provision of pharmaceutical services.

The PNA steering group is mindful of its continuing duties to the residents of Lincolnshire to monitor and review change in the pharmacy sector locally and will update the document accordingly going forwards. As an aid to this process, Healthwatch will be asked to formally join the PNA Steering Group, so any further work can continue to be firmly grounded in local residents' views.

Actions Required:
The Health and Wellbeing Board is asked to:
1) Note the content of this report
2) Agree with and endorse the conclusions/ recommendations set out in the final PNA
3) Formally agree to publish the PNA

1. Background

From the 1 April 2013 the Health and Social Care Act 2012 transferred responsibility to develop and update Pharmaceutical Needs Assessments from Primary Care Trusts (PCTs) to Health and Wellbeing Boards (HWB).

National Context

In order to provide pharmaceutical services, providers (most commonly community pharmacists but also dispensing appliance contractors and GPs in rural areas) are required to apply to be included on a pharmaceutical list.

The first PNAs were published by NHS Primary Care Trusts (PCTs) and were required to be published by 1 February 2011.

Local Context

Historically, the PCT in Lincolnshire established a PNA Core Group to manage the process of developing, consulting upon and publishing the PNA. The PCT held the responsibility to sign off the PNA and Lincolnshire's was first published in 2011.

The Core Group has previously had a critical membership of key staff to provide expert advice in relation to:

- Need (Public Health Intelligence/Health Informatics);
- Supply (Contract Management);
- Demand (Prescribing).

Previously, these roles all sat within the PCT, however, since the 1 April 2013 they now sit in different parts of the health care system as follows:

- Public Health Intelligence (Lincolnshire County Council Public Health);
- Health Informatics (Greater East Midlands Commissioning Support Unit);
- Contract Management (NHS England, Leicestershire and Lincolnshire Area Team);
- Prescribing (Greater East Midlands Commissioning Support Unit, Prescribing and Medicines Optimisation Service).

The PNA Core Group continued to meet and operate in order to undertake the work necessary for the Board to publish its first PNA by 1 April 2015.

The PNA for Lincolnshire will continue to be managed on behalf of the HWB by the PNA Steering Group. This will include the ongoing legal requirement for the HWB to review the PNA, and issue supplementary statements, as and when required.

Publication

The HWB is required to publish a revised assessment within three years of the first assessment.

If the HWB identifies a significant change to the availability of pharmaceutical services since the publication of its PNA, then it will be required to publish a revised assessment as soon as is reasonably practical.

However, if the HWB is satisfied that making a revised assessment would be a disproportionate response to those changes then it can, instead, issue a Supplementary Statement to its PNA detailing the changes which have occurred and specifying their decision that this change did not warrant a full revision of the PNA.

2. Conclusion

Following this consultation, the final draft of the PNA is now presented to the HWB at Appendix A.

In line with the regulations, the PNA includes the full report detailing the consultation that was undertaken.

3. Consultation

The consultation opened on the 6th October 2014 for a period of 60 days. A SNAP (online) survey was created and published on the HWB web page. Over 250 formal letters were sent out to those identified in the regulations. A further email reminder was sent out near to the closing date to encourage more responses..

We extended this invitation to additional people, who were deemed appropriate for consultation. To ensure that the draft PNA was accessible to all, it was also published on the HWB webpage in an Easy Read format.

The volume of responses was low, however the content of those received were very detailed as expected.

All survey responses and written comments were read and considered by the PNA steering group. Any common themes were noted, and the responses were sorted into thematic groups accordingly.

The themes were then thoroughly discussed by the PNA steering group.

Consultation responses:

Type of response	Number of responses
Electronic	13
Hard Copy	5
Other	1

A more detailed list of responses can be found in the full report Appendix B

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Lincolnshire Pharmaceutical Needs Assessment
Appendix B	Lincolnshire PNA Consultation Report

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 Lisa Loy who can be contacted on (07787151128) or lisa.loy@lincolnshire.gov.uk

Lincolnshire Pharmaceutical Needs Assessment

Lincolnshire Health and Wellbeing Board

March 2015

Final version 31 March 2015

Foreword

Our pharmacies provide people in Lincolnshire with vital supportive health services in ways which are accessible and timely. With over 19.4 million prescribed items being dispensed in Lincolnshire's pharmacies every year, the public is provided with easy access to the supply of medicines and appliances that they need as a vital part of the local healthcare system

Communicating health messages to people who are sick, as well as reassurance, advice and guidance to people who are well, is another key strength of the work that pharmacies deliver, and one which we need to make the most of, and build on.

We also need to ensure that pharmacies are able to play a stronger role in out-of-hospital care, the management of long-term conditions and signposting residents to useful health and wellbeing, social care and voluntary sector services, in partnership with other health professionals.

I therefore welcome this Pharmaceutical Needs Assessment, which considers the need for pharmaceutical services, describes the current services available to the county, and makes recommendations for the future provision of pharmaceutical services.

I trust that NHS England and others will find this assessment informative and useful in their commissioning of pharmaceutical services.

Sue Woolley

Cllr Sue Woolley
Chairman of the Lincolnshire Health and Wellbeing Board

Acknowledgements

With grateful thanks to the many people who have contributed to the production of this Pharmaceutical Needs Assessment, and special thanks to the people of Lincolnshire for their contributions to the consultation.

Particular thanks to the members of the Pharmaceutical Needs Assessment Steering Group, for their significant contribution to the development and writing of the assessment.

The Pharmaceutical Needs Assessment Steering Group

Position	Job title	Organisation
Chris Weston (Chair)	Consultant in Public Health	Public Health Directorate Lincolnshire County Council
Avril McDermott	Local Professional Network Chair	NHS England
David Stacey	Programme Manager (Strategy and Performance)	Public Health Directorate Lincolnshire County Council
Stephen Gibson	Head of Prescribing and Medicines Optimisation	Greater East Midlands Commissioning Support Unit
Mark Hall	Primary Care Support Contract Manager	NHS England (Leics & Lincs Area)
Marta Kowalczyk	Public Health Analyst	Public Health Directorate Lincolnshire County Council

Additional contributions

For part of the assessment process, the Steering Group was assisted by Adrian Audis, Assistant Contract Manager from NHS England.

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Glossary

C-Card	Scheme providing free condoms and lubricants to teenagers, along with safe-sex information and signposting to other services
CCG	Clinical Commissioning Group
CHD	Coronary Heart Disease
COPD	Chronic Obstructive Pulmonary Disease
DH	Department of Health
DRUM	Dispensing Review of Use of Medicines
DSQS	Dispensing Services Quality Scheme
EHC	Emergency Hormonal Contraception
GP	General Practitioner
GUM	Genito-Urinary Medicine
HIV	Human Immunodeficiency Virus
HWB	Health and Wellbeing Board
IMD	Index of Multiple Deprivation
JSNA	Joint Strategic Needs Assessment
JHWS	Joint Health and Wellbeing Strategy
LA	Local Authority
LMC	Local Medical Committee
LPC	Local Pharmaceutical Committee
LSOA	Lower Super Output Area
MUR	Medicines Use Review
NHS	National Health Service
NMS	New Medicine Service
NSP	Needle and Syringe Programme
ONS	Office for National Statistics
OOH	Out of Hours
PBEvP	EHC via patient group direction provided from a community pharmacy
PBNEX	Pharmacy Based Needle Exchange
PBSAP	Pharmacy Based Supervised Administration Programme
PGD	Patient Group Direction
PNA	Pharmaceutical Needs Assessment
QOF	Quality Outcomes Framework

Executive Summary

The purpose of the Lincolnshire Pharmaceutical Needs Assessment (PNA) is to review existing pharmaceutical service provision in Lincolnshire and to identify any gaps or deficiencies that need to be addressed. Proposed changes may include increasing service provision, improving access to services or broadening the range of services available for Lincolnshire patients, with the ultimate goal of improving their health and wellbeing.

Methods

The data included in this review was compiled by members of the Public Health informatics (PHI) team at Lincolnshire County Council. Interpretation and presentation of the data has been the responsibility of the PNA Steering Group, comprised of staff from NHS England, GEM Commissioning Support Unit and Public Health.

The document reviews the prescribed process that must be followed to produce a PNA. It also considers both the health needs and the pharmaceutical needs of the Lincolnshire population. Health needs have been reviewed down to the level of each district council area and/or CCG boundary, dependent on the data. Within each of these localities, existing pharmaceutical service provision was reviewed, in order to identify geographical gaps in services (i.e. localities in which pharmaceutical service provision may be inadequate.

Lincolnshire

Lincolnshire is one of the largest counties in England. However, the population density in the county is less than a third of the average. Despite lower than average deprivation compared to the UK as a whole, there is considerable variation in deprivation across the county. Similarly, reported health also varies greatly across the county, with smoking, excess weight, diabetes, cardiovascular disease and COPD all more prevalent in Lincolnshire than in the rest of the UK.

Changes in the population structure resulting from an ageing population, in conjunction with a projected increase in obesity rates, are likely to have a negative effect on general health, and lead to an increase in the prevalence of associated diseases in the county.

Current pharmaceutical provision

Maps included in the document illustrate the distribution of pharmacies and dispensing practices across the county, as well as the provision of advanced community pharmacy services, such as Medicines Use Reviews (MURs) and the New Medicine Service (NMS). In addition, tables show the availability of pharmaceutical services commissioned by NHS England, including Saturday opening, 100-hour pharmacies, and the presence of dispensing and non-dispensing GP surgeries. These tables and maps show that most places in Lincolnshire have at least one accessible provider of dispensing services, whether a dispensing practice or a community pharmacy, and that some places have access to both types. The map of community pharmacy provision illustrates that some essential and advanced pharmaceutical services (e.g. help

with self-care, over-the-counter medicines, MURs and the NMS), which are only available through community pharmacies, are not consistently available across the whole of the county.

The PNA Steering Group committee has identified several gaps in service provision, and made recommendations on future actions to address this.

Conclusions and Recommendations

- Residents of Lincolnshire are adequately served by providers of dispensing services in both urban and rural areas. However, ongoing change linked to population growth in many localities will necessitate frequent review of this position. The Steering Group will use the population figures released annually by the ONS to inform such reviews.
- Patient access to self-care through the provision of healthcare advice and over-the-counter medicines is only available from community pharmacies. There are many rural areas of the county where dispensing services are available, but patients have no access to self-care, over-the-counter medicines or community pharmacy advanced services, such as Medicines Use Reviews (MURs) and the New Medicine Service (NMS).
- Having reviewed the evidence for the provision of a wide range of locally commissioned services through community pharmacy, the PNA Steering Group concluded that further expansion, and wider availability, of the range of services currently provided through community pharmacies would benefit the Lincolnshire population, subject to local need, patient demand, and clear evidence of benefit, value for money and improved health outcomes. This expansion should be done with existing community pharmacies, because establishing new pharmacies could lead to over-provision of essential services, and may destabilise current provision.
- The PNA Steering Group is supportive of patients exercising their right to choose where they access their pharmaceutical services. Patient choice is likely to be further enabled by the wider implementation of electronic prescribing across the county.
- As required by The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013, the PNA Steering Group intends to continue reviewing pharmaceutical needs and local service provision, and publishing regular updates and supplementary statements where circumstances change.
- During July 2014, Healthwatch published a questionnaire, targeting people who use pharmacy services in Lincolnshire. In order to build on the findings from their Pharmacy Questionnaire, and subsequent recommendations, and bearing in mind their independent role, the PNA Steering Group would like to work with Healthwatch. Therefore, they would like to invite Healthwatch to send a representative to be a member of the PNA steering group.

1. Introduction

1.1 Legal framework

The provision of pharmaceutical services falls under The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013. The regulations cover:

- the production of this Pharmaceutical Needs Assessment (PNA),
- the application and decision-making process for opening pharmacies, and
- the terms of service for pharmacies, dispensing appliance contractors and dispensing doctors.

New to the regulations is the inclusion of performance sanctions, which NHS England can use where contractors are not meeting their terms of service.

The regulations also cover the dispensing of medication to patients by doctors; Lincolnshire has 65 dispensing GP practices.

There are strict criteria regarding who may, or may not, receive dispensed medication. *'Dispensing status'* must be granted by NHS England, and is usually reserved for patients who:

- live more than 1.6 km from a pharmacy, and
- live in a controlled locality.

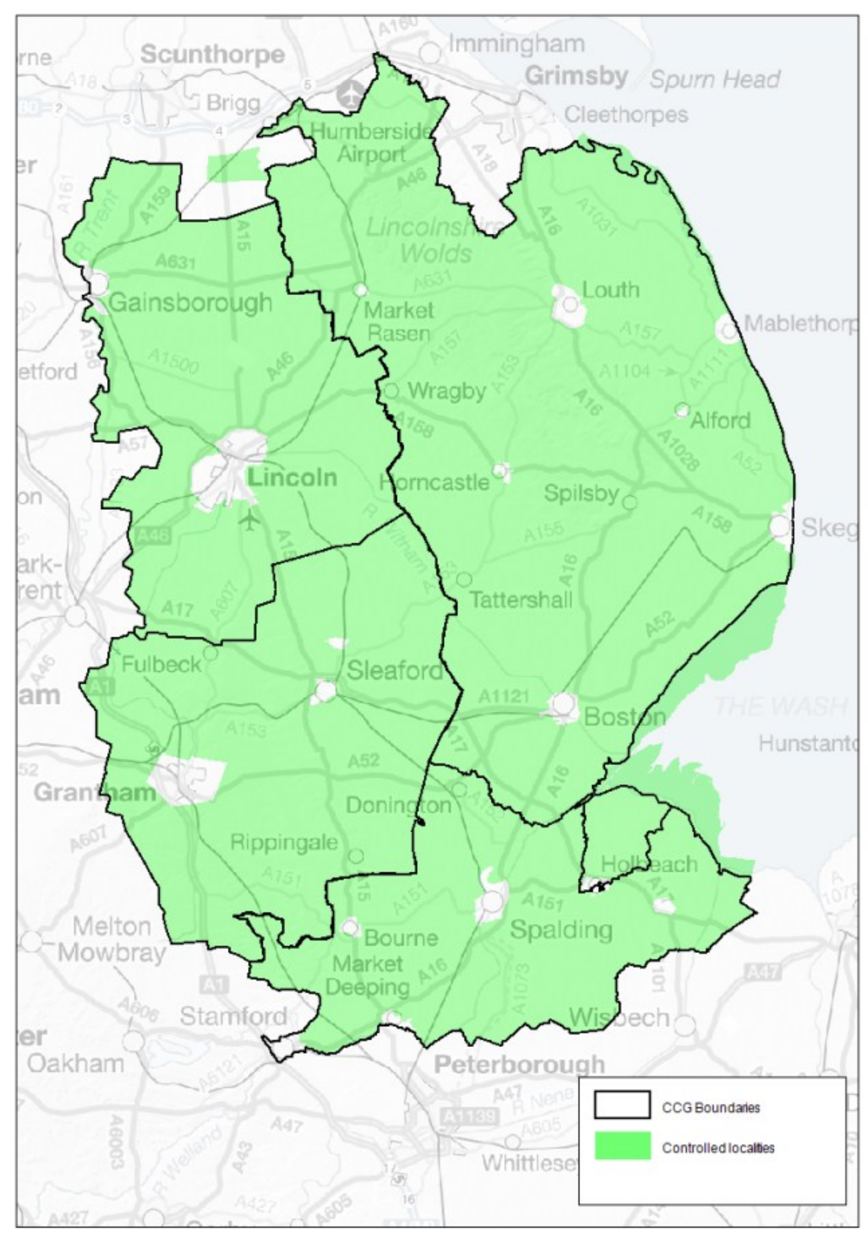
A controlled locality is an area which has been defined as such under the Regulations. An area that is defined as 'controlled' is usually rural in character.

Map 1 shows the controlled localities in Lincolnshire.

Responsibility for producing the PNA lies with the local Health and Wellbeing Board (HWB), with NHS England having responsibility for the application process and for ensuring that pharmacies comply with their terms of service.

This PNA informs the application and decision-making process, although NHS England ultimately has responsibility for approving or rejecting an application.

Map 1: Controlled localities in Lincolnshire



Source: NHS England

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1.1.1 Pharmaceutical needs assessment (PNA)

The NHS Regulations 2013 cover what constitutes a pharmaceutical service for the purposes of conducting a PNA, how and when the PNA is to be produced, and what information is to be contained within it, as well as matters for consideration when making an assessment.

Matters for consideration

Part 2 of the Regulations details matters for consideration in making an assessment. These cover:

- 'the demographic profile of the HWB's area,

- choice in obtaining pharmaceutical services,
- any differences in need within that HWB area, and
- services provided in neighbouring HWB areas which may affect the needs within that HWB area.

Finally, the PNA must consider any likely future needs, in order to make a proper assessment of the matters noted above.

Information to be contained in the PNA

Schedule 1 of the Regulations sets out the information to be contained within the PNA. This includes:

- provision and gaps in pharmaceutical services,
- improvement in access regarding gaps in provision,
- how the assessment was carried out, and
- maps detailing the provision of services.

1.1.2 Commissioning of pharmaceutical provision

The Regulations set out the types of application that can be made. These fall into two categories: 'Routine' and 'Excepted' applications.

'Routine' applications

'Routine' applications must meet the 'market entry test', which is that an application may be granted if NHS England is satisfied that:

- it is necessary to grant the application in order for the HWB to meet a need in its area for all, or some, of the services specified in the application, or
- granting the application would secure improvements in, or better access to, pharmaceutical services in its area.

Different types of 'Routine' application are:

- Current needs (identified in PNA)
- Future needs (identified in PNA)
- Improvements or better access to services (identified in PNA)
- Future improvements or better access to services (identified in PNA)
- Unforeseen benefits (something which has not been identified in the PNA: this could be examples of new and innovative types of service delivery)

'Excepted' applications

'Excepted' applications do not have to meet the market entry test,

and are not dependent on needs or improvements identified in the PNA.

Different types of 'Excepted' applications are:

- Relocations that do not result in significant change
- Distance-selling premises
- Changes of ownership
- Combined changes of ownership and relocations that do not result in significant change
- Applications for temporary listings arising out of suspensions
- Applications from persons exercising a right of return to a pharmaceutical list
- Applications relating to emergencies requiring the flexible provision of pharmaceutical services
- Applications offering to provide additional directed services

The changes to the NHS from the 1st April 2013 have led to changes in the commissioning of 'enhanced services'[a] from community pharmacies. Previously, Primary Care Trusts would commission all services, but now NHS England is the only organisation entitled to commission enhanced services.

CCGs and Local Authorities can commission services from pharmacies, such services now being referred to as 'locally commissioned services'[b]. These do not fall under the definition of 'pharmaceutical service' for the PNA, and will not be taken into consideration for applications. Nonetheless, in this PNA, these services have occasionally been referenced in order to demonstrate the wider impact they have on meeting health needs. Any such inclusions have been clearly identified as not being in the formal definition of pharmaceutical services for the purpose of producing the PNA.

1.2 Production of the PNA

The NHS Regulations specify that the PNA must include information about how it was carried out. This includes the requirement to explain how the localities referred to were chosen, how the PNA has taken account of differences in needs between the various localities, and how the consultation on the PNA was carried out.

The production of this PNA for Lincolnshire has been led by a PNA Steering Group made up of representatives from NHS England, Greater East Midlands

[a] These are explained in section 4.1
[b] These are discussed in section 5.4.1

Commissioning Support Unit and Public Health within Lincolnshire County Council.

1.2.1 Determination of localities

Localities included in this PNA were selected by the Steering Group because they conform to the Clinical Commissioning Group (CCG) boundaries in Lincolnshire. It is not always possible to report data on health needs at these levels, so where CCG-level data was not available, the administrative boundaries of local authorities (districts) were used instead. In reviewing the evidence, the PNA Steering Group has also referenced smaller areas within CCGs that appear, from the maps, to show gaps in pharmaceutical provision.

1.2.2 Assessment of differences in need in Lincolnshire

In assessing Lincolnshire's needs for this PNA, comparisons have been drawn with other areas (such as the East Midlands and England), and the variation in need within the county has been analysed. Where possible, the data from both local authority and CCG level has been used for comparison.

Data analysis for health needs was carried out as far as 31 March 2014, and analysis relating to population continued up to June 2014 to ensure a consistent approach throughout the PNA.

The regulations governing the production of the PNA require an explanation of how the needs of people who share one of the 'protected characteristics' (identified in the Equality Act 2010[1]) were considered as part of the overall assessment of needs. Therefore, where data is available, sections relating to need have also considered 'protected characteristics'.

1.2.3 Consultation

The NHS Regulations stipulate who the HWB must consult whilst carrying out the PNA. It is also specified that those being consulted may be directed to a website address containing the draft PNA, but that they are entitled to request an electronic or hard copy version, as an alternative.

Furthermore, a minimum period of 60 days for consultation responses is set down in the Regulations, and at the end of this time, a full report on the consultation must be published as part of the PNA.

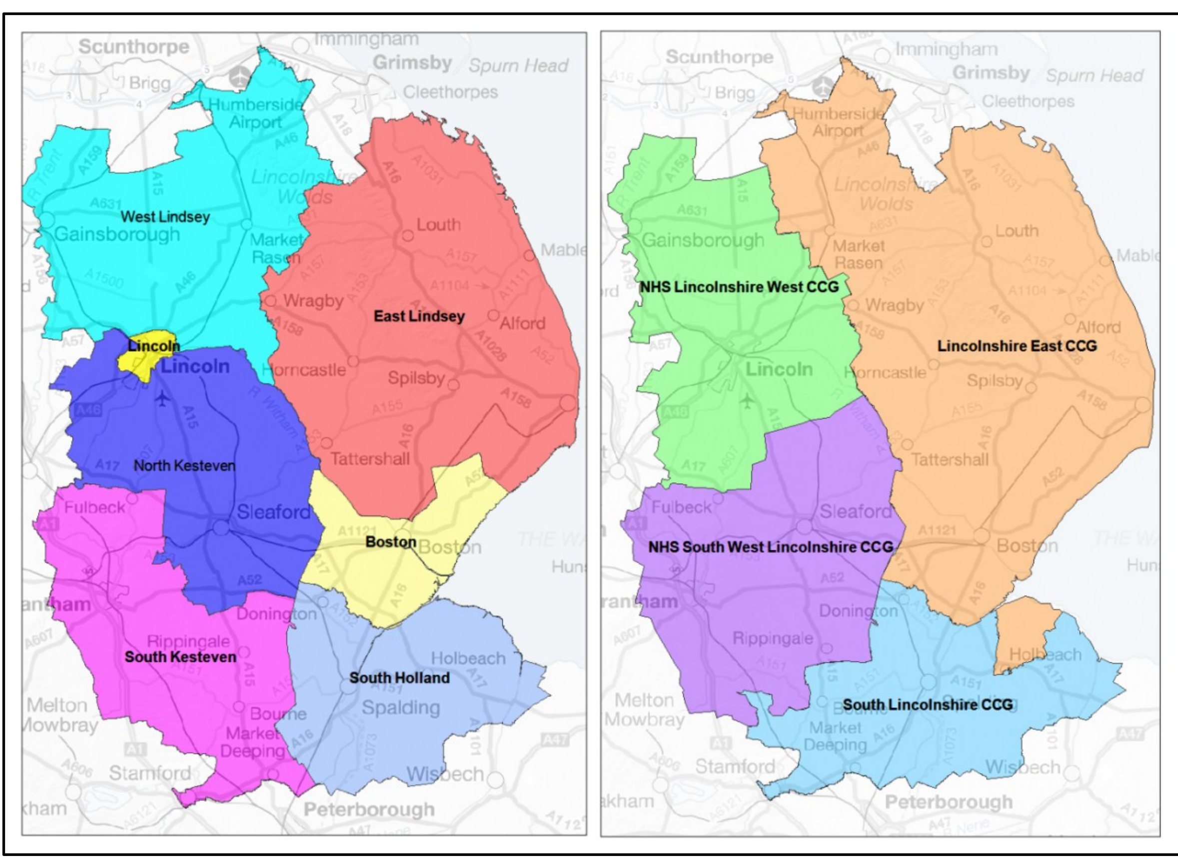
2. Lincolnshire Population and Socio-economic Context

2.1 Geography of Lincolnshire

Lincolnshire is one of the largest counties in England, with a land area of 5,937 square kilometres[2]. The county has a diverse geography, comprising large rural and agricultural areas, urban areas and market towns, and a long eastern coastline.

In 2013, there was an estimated population of 724,500. The population density in the county is just 121 persons per square kilometre (less than a third of the average for England and Wales)[c].

Map 2: Location of Lincolnshire's district council and clinical commissioning group areas



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[c] Based on 2011 mid-year population estimates and UK Standard Area Measurements from the ONS

2.2 Population

In June 2013, the population mid-year estimate for the area covered by Lincolnshire County Council was 724,500[3].

The rate of increase in Lincolnshire's population has slowed in recent years; figures indicate the rate was below the national rate of growth. However, the annual percentage change between 2012 and 2013 shows the increase in the population of Lincolnshire (0.9 per cent) was higher than the national figure (0.7 per cent) for the first time in many years.

Lincolnshire's population is projected to increase by approximately 49,700 people by 2023 (Table 1). This is a growth rate of 6.9%, which is very similar to the projected growth of the population of England and Wales[4].

Table 1: Summary of Lincolnshire's demographic and socio-economic characteristics

Area name	Population (i)	Proportion of 65+ (ii)	Projected increase by 2023 (iii)	People in 20% most deprived areas (iv)	Unemployment (v)	Youth unemployment (vi)
Boston	65,900	20.6%	8.7%	19.5%	2.4%	4.5%
East Lindsey	136,700	27.8%	5.9%	22.3%	3.3%	6.5%
Lincoln	95,600	14.7%	2.0%	28.4%	4.1%	4.3%
North Kesteven	109,900	22.3%	8.7%	0.0%	1.6%	3.8%
South Holland	89,200	23.8%	9.6%	0.0%	2.2%	4.0%
South Kesteven	136,400	20.7%	7.4%	3.3%	2.0%	3.6%
West Lindsey	90,700	22.5%	6.3%	10.6%	3.3%	6.8%
Lincolnshire	**724,500**	**22.1%**	**6.9%**	**11.7%**	**2.7%**	**4.7%**

Key to Table 1:

(i) ONS, 2013 mid-year population estimate

(ii) Proportion of the 2013 population aged 65 or over; ONS 2013 mid-year population estimate

(iii) Total population increase based on the difference between 2013 mid-year estimates and the 2023 projected population estimates, 2012 based; ONS

(iv) Percentage of population living in what is classed as 20% most deprived areas in England, based on 2010 IMD scores

(v) Claimant count as proportion of working-age population, November 2013

(vi) Claimant count for ages 18-24, November 2013

Map 3: Population density in Lincolnshire

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Source: Office for National Statistics (ONS)

It is known that, at certain times of the year, tourism greatly increases the population of Lincolnshire. This is particularly noticeable around the City of Lincoln and along the Lincolnshire coast, although the population also increases in other areas, such as around the rural market towns and near to the many cultural assets of the county.

According to Lincolnshire County Council estimates, based on the STEAM model[d] in 2013, the county attracted nearly 18.5 million visitors, including day visitors and overnight domestic and international visitors.

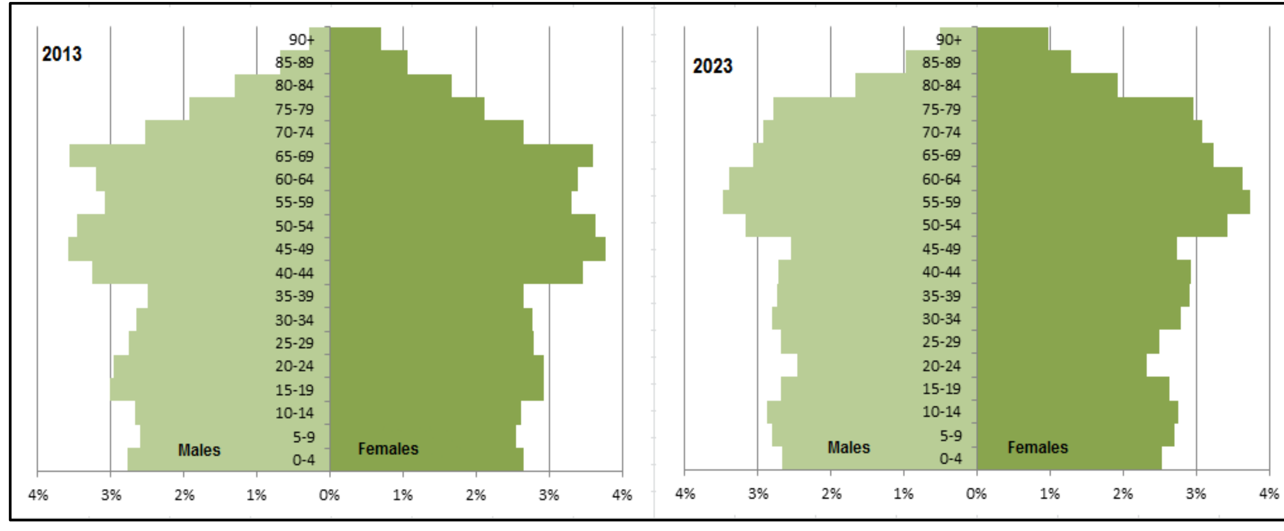
2.2.1 Age structure

The proportion of children and young people in Lincolnshire (aged under 18 years) fell from approximately 21% of the total population in 2003 to 19% in 2013. By contrast, during the same period, the population of those in the county aged 65 years and over increased by 3% to approximately 22%.

By 2023, all local authority district areas of Lincolnshire are projected to experience a decrease in the proportion of the population which is of working age.

Although the projected decrease is relatively small, when considered alongside the increasingly ageing population, it will present a challenge in respect of a declining tax-paying and care-giving population at a time when the need for services for an ageing population will be rising.

Figure 1: Age structure of the Lincolnshire population, 2013 estimate and 2023 projection



Source: ONS, 2013 Mid-year population estimate, June 2014; ONS Population Projections, 2012 based

[d] Scarborough Tourism Economic Activity Monitor model, which looks at tourism based on total revenue by district, total revenue by sector, number and type of visitor and the number of employment opportunities created.

Map 4: Proportion of the population aged 65 years and over

Population aged 65 and over
% of entire population by LSOA
- 28 or more
- 24 to 28
- 21 to 24
- 16 to 21
- 2 to 16

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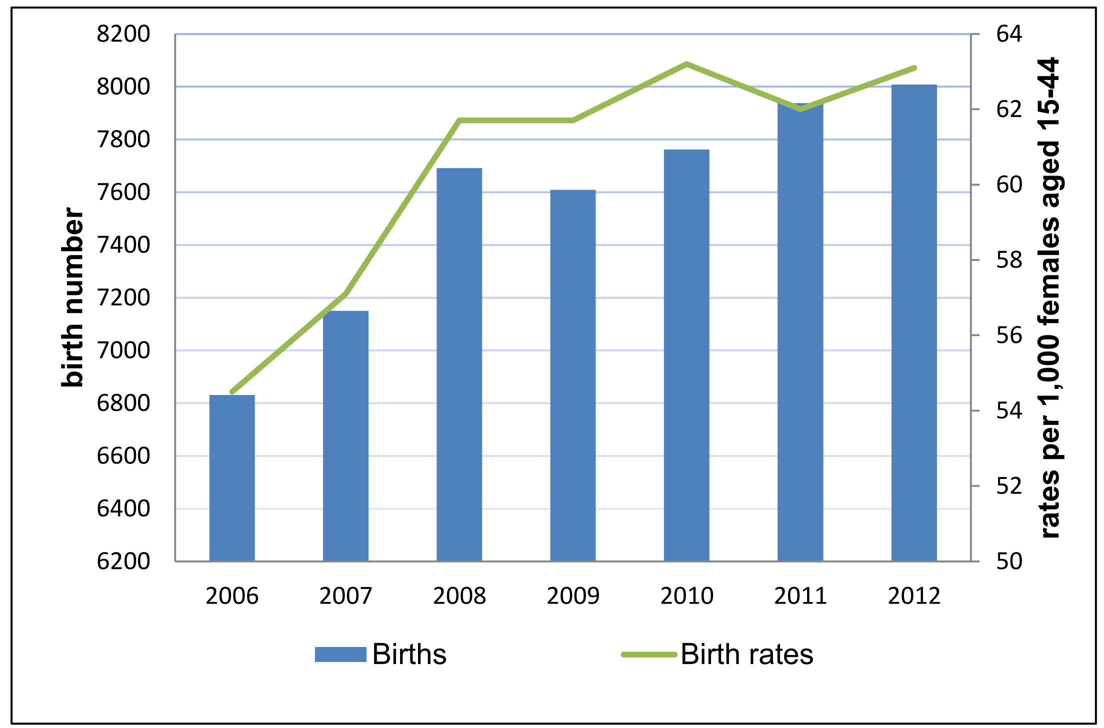
Source: Office for National Statistics (ONS)

2.2.2 Births, mortality and life expectancy

Lincolnshire has experienced an increase in the annual number of births in recent years. Despite this increase, birth rates in 2012 were still below national rates: 63.1 per 1,000 females aged 15-44 years in Lincolnshire compared to 64.8 in England and Wales[5].

Figure 2: Number of live births and birth rates in Lincolnshire, 2006-2012



Source: Office for National Statistics (ONS)

Infant mortality in Lincolnshire was 4.1 per 1,000 live births in 2010-2012, which is at the average national level[e].

For the same period, life expectancy at birth was 82.9 years for females and 79.1 years for males in Lincolnshire, which is just at the average level for England. Healthy life expectancy (years a person would expect to live in good health, based on mortality rates and self-reported good health) is 64.6 years for both genders, and is not significantly different from national or regional figures[f].

In Lincolnshire, mortality rates from leading causes like cancers, cardiovascular diseases and respiratory conditions are generally lower than, or similar to, national figures[g].

[e] Public Health Outcomes Framework, Indicator 4.01, Available from: http://www.phoutcomes.info/public-health-outcomes-framework

[f] Public Health Outcomes Framework, Indicators 0.1i-ii, Available from: http://www.phoutcomes.info/public-health-outcomes-framework

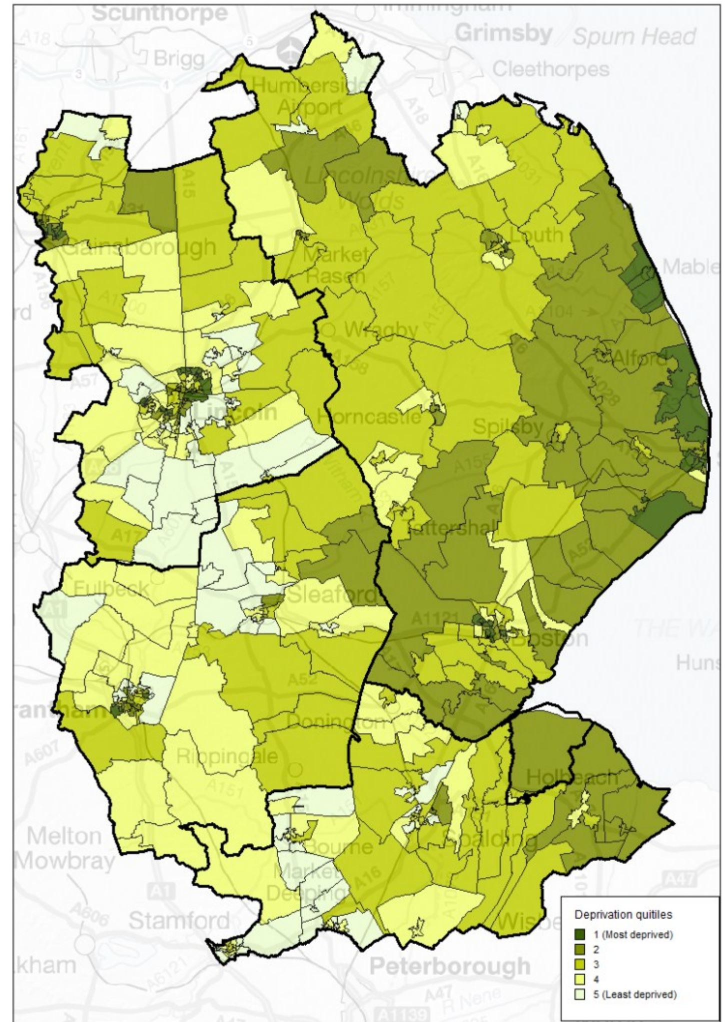
[g] Public Health Outcomes Framework, Indicators 4.04,4.05,4.07, Available from: http://www.phoutcomes.info/public-health-outcomes-framework

2.3 Deprivation

Across Lincolnshire, 12% of the residents live within areas classified as being amongst the 20% most deprived in England. Although this 'average' deprivation is lower than the national rate, there are differences across the county. In Lincoln City, 28.4% of people live within this national quintile of deprivation, followed by 22.3% in East Lindsey and 19.5% in Boston Borough[h].

Nationally, deprivation tends to be associated with pockets of urban areas, which, in Lincolnshire, can be found in such areas as Lincoln, Gainsborough and Boston. However, with relatively poor transport and broadband infrastructure, the county also suffers from wide areas of rural deprivation.

Map 5: Deprivation: National quintile of deprivation by LSOA



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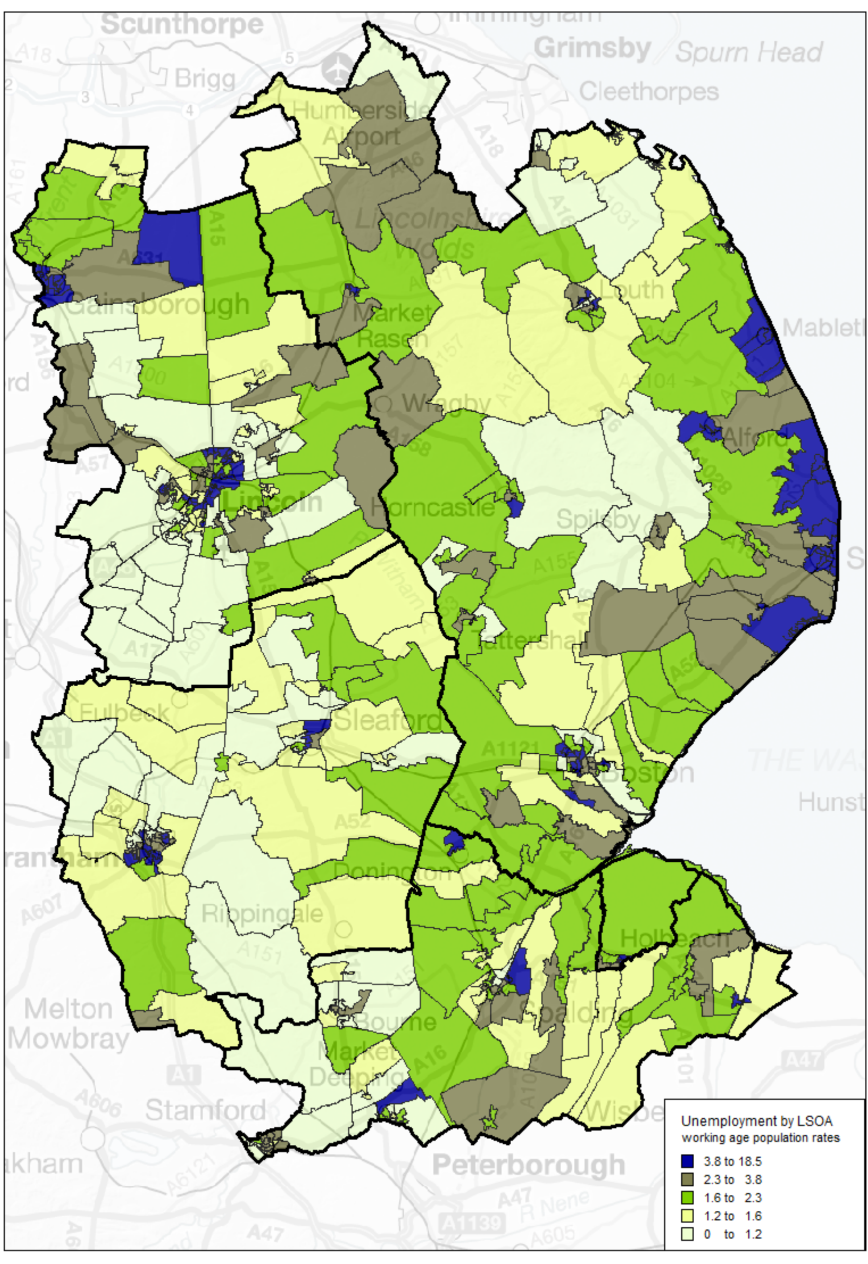
Source: Department for Communities and Local Government (DCLG)

[h] Based on Indices of Multiple Deprivation, 2010. Department for Communities and Local Government and ONS Mid-year Population Estimates, 2013

2.4 Employment and skills

Average unemployment in Lincolnshire is lower than the national rate, but there are pockets of long-term unemployment, as well as seasonal employment and unemployment in the major industries of agriculture and tourism. Unemployment among the younger population (aged 24 years and below) is higher than the national average[i].

Map 6: Unemployment: Claimant rate as a proportion of working-age population, December 2013



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Source: Office for National Statistics (ONS)

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[i] Office of National Statistics claimant count, November 2013. [cited Feb 2014] Available from: http://www.nomisweb.co.uk

The predominantly low-wage and low-skilled economy encourages the outflow of more highly educated residents, and the general level of education among adults is below both the national and regional levels, according to the Office for National Statistics (ONS)[j].

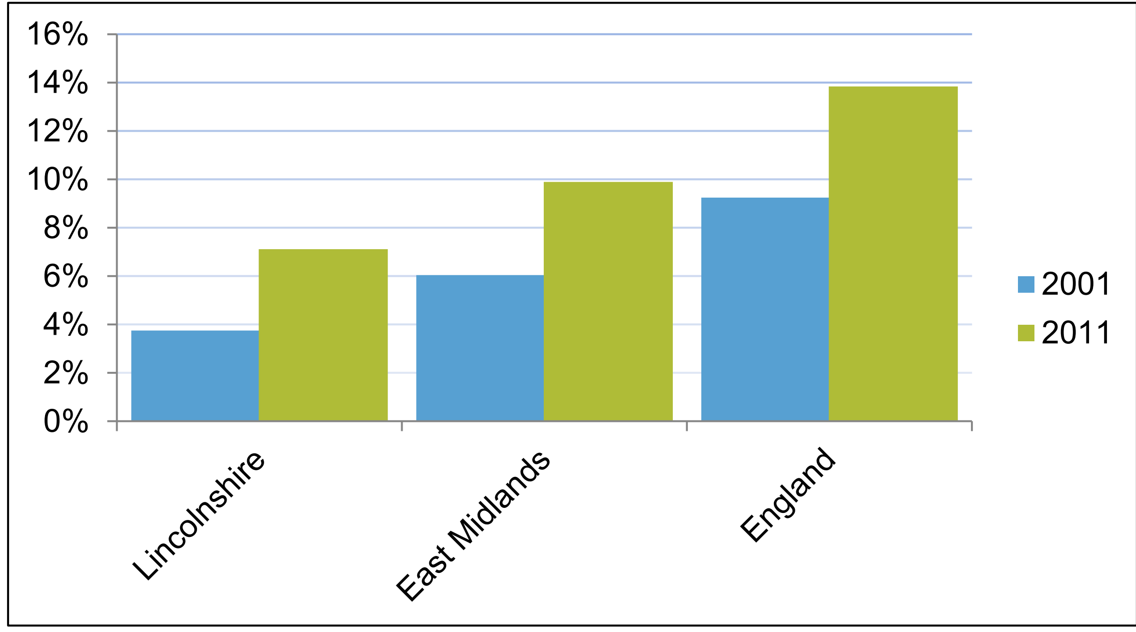
2.5 Ethnicity and country of birth

At the 2011 census, the non-white population made up 2.4% of Lincolnshire residents, compared to 1.4% in 2001. Despite the increase, the percentage was still lower than that for the national non-white population, which was 14%.

Between 2001 and 2011, the number of Lincolnshire residents who were born outside the UK more than doubled. According to the ONS 2011 population census, the proportion of foreign-born residents in Lincolnshire then stood at 7.1% (compared to 13.8% nationally).

The majority of recently-arrived international migrants came from Eastern and Central Europe, and tended to be younger and more economically active than the UK-born residents of Lincolnshire[6].

Figure 3: Proportion of residents born outside the UK



Source: ONS, 2001 and 2011 Population Census

[j] Office for National Statistics (ONS), 2012, Annual Population Survey (APS). Available from: http://www.research-lincs.org.uk

3. Health Needs in Lincolnshire

3.1 General health

Based on the 2011 census, the proportion of people who reported having bad, or very bad, health was slightly higher in Lincolnshire than in England (5.9% compared to 5.5%).

The data from the census shows a link between poor health and an ageing population, and also suggests a link between poor health and deprivation (although IMD scores themselves do include aspects of health). East Lindsey district had the highest proportion of self-reported poor health among the Lincolnshire districts across the entire adult population.

The proportion of people of all ages whose day-to-day activities were limited because of their health was also greater in Lincolnshire than in England (20.4% compared to 17.6%)[7].

3.2 Health and lifestyle

3.2.1 Smoking

The Lincolnshire Tobacco Control Profile (2012) indicated that the number of diseases and deaths in the county that were attributable to smoking were comparable with the England averages, and were representative of health inequalities, both historically and currently, within Lincolnshire (e.g. Lincoln has the highest disease and death rates that are attributable to smoking)[8].

Smoking prevalence for Lincolnshire in 2012 was quoted as 20.9% in the Public Health Outcomes Framework. This is above the percentage for both the East Midlands (19.9%) and England (19.5%)[k].

For routine and manual workers in Lincolnshire, the smoking prevalence percentage was 35.6%, which was higher than that for either the East Midlands (29.4%) or England (29.7%)[l].

In 2011/12, 18.4% of women in Lincolnshire who gave birth were current smokers at the time of delivery (figure quoted for all maternities where smoking in pregnancy status was recorded). This compares unfavourably with average percentages for both the East Midlands region (15.84%) and England as a whole (13.31%)[m].

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[k] Public Health Outcomes Framework, Indicator 2.14, Available from: http://www.phoutcomes.info/public-health-outcomes-framework

[l] Public Health Outcomes Framework, Indicator 2.14, Available from: http://www.phoutcomes.info/public-health-outcomes-framework

[m] Public Health Outcomes Framework, Indicator 2.03, Available from: http://www.phoutcomes.info/public-health-outcomes-framework

3.2.2 Alcohol (adults)

Alcohol treatment data is reliable. However, the minimum data set is small, and so insight into population trends is limited. In 2010/11, the numbers of people entering specialist alcohol treatment services dropped by 19%, after having increased by 71% between 2008/09 and 2009/10[9]. (A total of 892 people were in treatment at the end of March 2011.)

Within Lincolnshire, there is a clear divide between male and female mortality attributable to alcohol. Across all districts, male mortality rates are higher than female mortality rates. The highest rates for males are in Lincoln, which are higher than the East Midlands and England rates (although the differences are not statistically significant). However, mortality rates for males in North Kesteven and South Holland are significantly lower than the national and regional rates. For females, the highest rates are in East Lindsey[n]. Numbers for South Kesteven are very low, and so have been suppressed from publication. Regional differences in female mortality attributable to alcohol cannot be considered statistically significant, due to the small numbers of observed cases.

Table 2: Alcohol-specific mortality by Lincolnshire district (males and females, 2010-2012)

Area name	Males	*Lower 95% CI*	*Upper 95% CI*	Females	*Lower 95% CI*	*Upper 95% CI*
Boston	14.57	*7.69*	*24.86*	5.31	*1.68*	*12.16*
East Lindsey	10.62	*6.66*	*15.84*	8.66	*5.15*	*13.34*
Lincoln	22.37	*14.49*	*32.73*	4.75	*1.71*	*10.33*
North Kesteven	6.20	*2.93*	*11.38*	3.04	*0.94*	*7.05*
South Holland	6.76	*3.06*	*12.81*	*	*	*
South Kesteven	12.98	*8.42*	*18.97*	3.76	*1.60*	*7.36*
West Lindsey	9.50	*4.76*	*16.66*	6.91	*3.25*	*12.76*
East Midlands	14.40	*13.49*	*15.36*	6.42	*5.83*	*7.06*
England	14.57	*14.29*	*14.85*	6.78	*6.59*	*6.96*

Source: LAPE: Local Authority Alcohol Indicators

3.2.3 Drug misuse

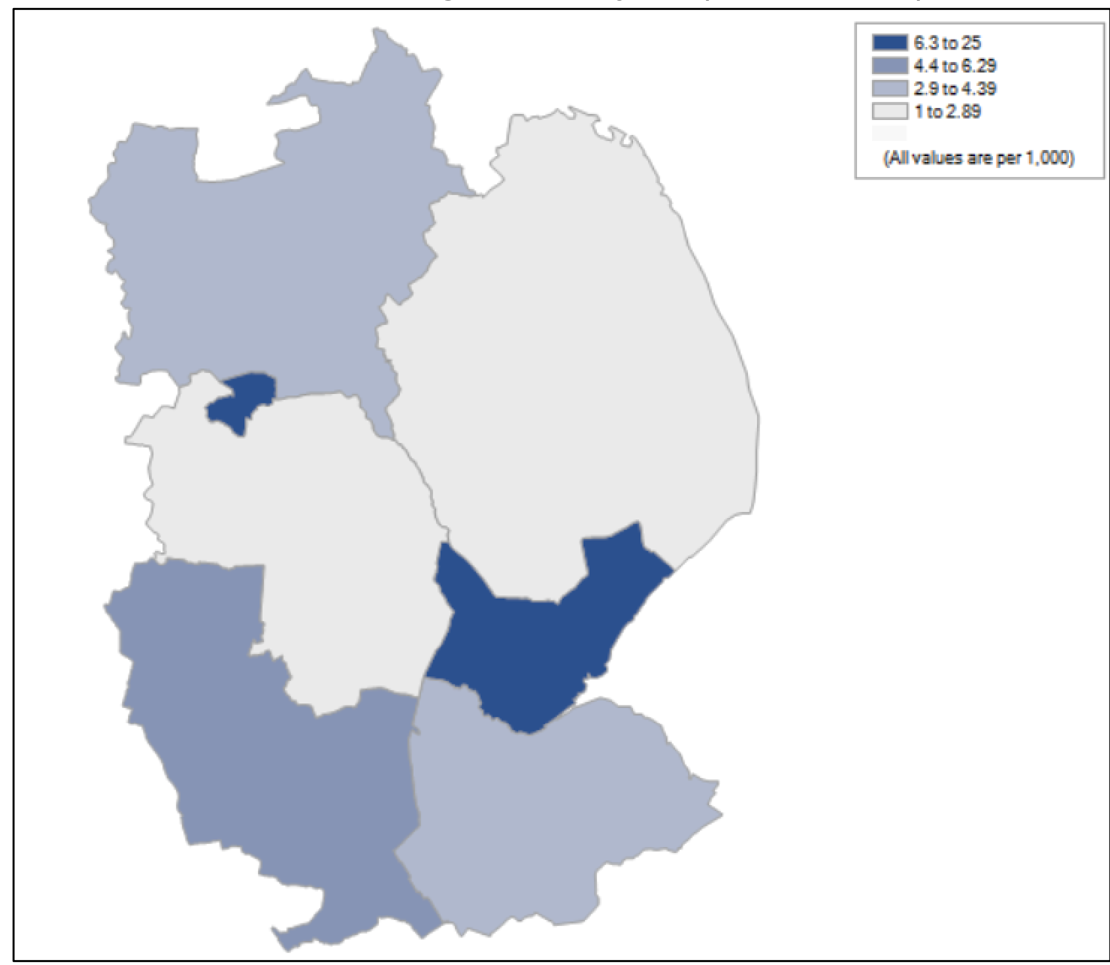
Between 2006/07 and 2010/11, the estimated number of problem drug users of crack and/or opiates in Lincolnshire (crude rate per 1,000 for

[n] Public Health England, Local Alcohol Profiles for England. Available from: http://www.lape.org.uk/

those aged 15-64 years) was consistently lower than the estimates for either the East Midlands or England.

However, as demonstrated in Map 7, there were differences between the districts, with the more urban areas, such as Lincoln and Boston, typically having higher crude rates than the more rural districts of the county[o].

Map 7: Drug misuse, estimated problem drug users (crack and/or opiates), crude rate per 1,000: ages 15 to 64 years (Health Profiles), 2010/11



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Source: Public Health England / LRO

In the financial year 2012/13, of 2,050 adults who were engaged in effective drug treatment in Lincolnshire, 1,774 were problem drug users[p].

The estimated number of problematic drug users for 2012/13 has not yet been published, but the estimate for 2011/12 was 3,039 users[q].

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[o] Drug Misuse, Estimated problem drug users (crack and/or opiates). Available from: http://fingertips.phe.org.uk/profile/health-profiles

[p] PHE, National Drug Treatment Monitoring System (NDTMS), 'Adult Alcohol Performance Report (HTLA) for Lincolnshire – Quarter 4, 2013/14'

[q] Drug Misuse, Estimated problem drug users (crack and/or opiates), crude rate per 1000: Ages 15 to 64 (Health Profiles), 2010-2011 – Public Health England/LRO

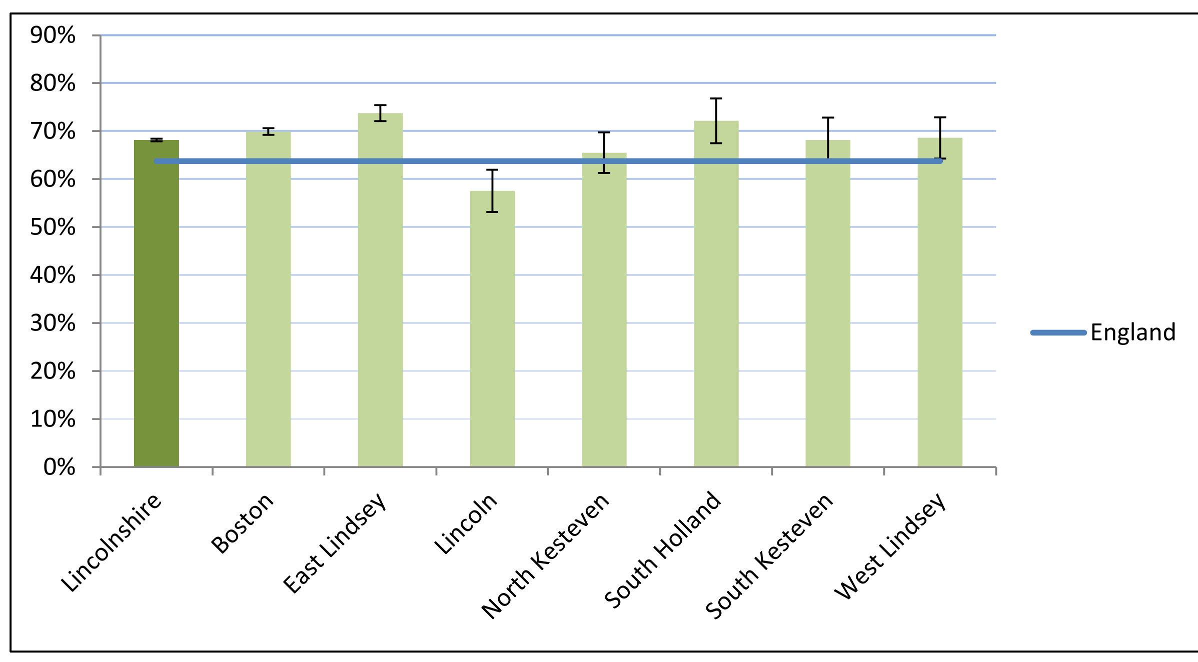
3.2.4 Excess weight (adults and children)

Data on excess weight in adults is part of the Public Health Outcomes Framework (PHOF). The data is comprised of estimates, based on responses to the 'Active People' survey, and, in 2012, suggested that more than half (54.7%) of the Lincolnshire population were carrying excess weight. This included 36.1% who were overweight and 18.6% who were obese.

For both obesity and excess weight, there is a higher prevalence in Lincolnshire than in either the East Midlands or England.

Although there are differences in obesity prevalence between the Lincolnshire districts, these are not statistically significant. The prevalence of excess weight (including obesity) in Lincoln is significantly lower than that for all other Lincolnshire districts, but the difference between Lincoln and North Kesteven is not significant, as shown in Figure 4[r].

Figure 4: Estimated prevalence of excess weight in the population (percentage either overweight or obese), 2012



Source: Public Health England (Public Health Outcomes Framework)

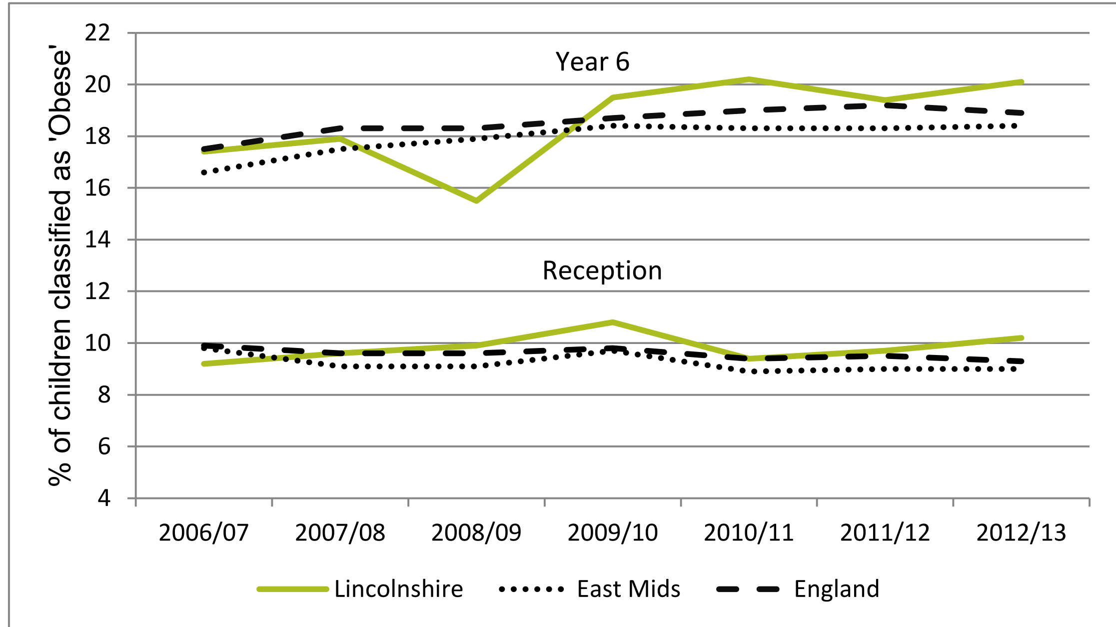
The National Child Measurement Programme (NCMP) provides an excellent insight into the height and weight of children in Reception and Year 6, and has been running since the academic year 2006/07. Data gathered under the programme indicates that the prevalence of obesity amongst children in Lincolnshire is higher than the prevalence in either

[r] Public Health Outcomes Framework, Indicator 2.12. Available from: http://www.phoutcomes.info/public-health-outcomes-framework

the East Midlands or England, for children in Reception classes and for those in Year 6.

The trend revealed through all seven years of NCMP data is that obesity rates are increasing, and although the increase is only marginal in the case of children in Reception classes, it is more rapid amongst children in Year 6.

Figure 5: Prevalence of childhood obesity (trend over time)



Source: National Child Measurement Programme

At district level, the prevalence of obesity in North Kesteven was significantly lower than that in East Lindsey, South Holland or West Lindsey amongst children in Reception, and significantly lower than that in Boston, East Lindsey or South Holland amongst Year 6 children[s].

3.3 Long-term conditions

3.3.1 Diabetes

Between 2009/10 and 2012/13, the prevalence rate of diabetes in Lincolnshire (for those aged 17 years and over) increased from 6.1% to 6.96%, and thus has remained higher than the prevalence in England, which increased from 5.4% to 6.0% during the same period.

Within Lincolnshire, there are variations between the districts, as demonstrated in Map 8[t].

[s] Public Health Outcomes Framework, Indicator 2.06. Available from: http://www.phoutcomes.info/public-health-outcomes-framework

[t] HSCIC, Quality and Outcomes Framework. Available from: http://www.hscic.gov.uk/qof

Map 8: Disease prevalence, diabetes, percentage: actual (recorded), persons aged 17 years and over, 2012-2013

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Source: Public Health England and NHS Health and Social Care Information Centre / LRO

By 2020, Lincolnshire is projected to have a disease prevalence estimate of 8.7% for diabetes (compared to an estimate of 8.2% for England), and by 2030, the figure is expected to be 9.6% (compared to 8.8% for England).

Estimated and projected rates include all people, aged 16 years and over, who are living with diabetes (both diagnosed and undiagnosed). The projected increase is due to the changing age and ethnic structure of the population, as well as a projected increase in obesity rates[10].

3.3.2 Coronary heart disease (CHD)

Each GP practice has a coronary heart disease (CHD) register. The actual prevalence of CHD in Lincolnshire is lower than the modelled prevalence. This could indicate that a number of patients are missed off the disease register, and are not being treated appropriately[11].

The disease prevalence for CHD across Lincolnshire is 4.49%, compared with 3.3% for England. East Lindsey is the district with the highest percentage (5.88%), and the City of Lincoln has the lowest percentage (3.36%).

Map 9: Disease prevalence, coronary heart disease (CHD), percentage: actual (recorded), all ages, 2012-2013

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Source: Public Health England and NHS Health and Social Care Information Centre / LRO

In Lincolnshire, in the past 12 years, there has been a dramatic reduction of more than 40% in the number of deaths from CHD for people aged under 75 years[11]. However, there are variations between the districts, with the highest rates being found in Boston and South Holland, and the lowest in North and South Kesteven.

CHD continues to be a key cause of premature death across the county. However, there is significant evidence to suggest that continued investment in lifestyle services, such as smoking cessation and weight management, would be of benefit in addressing this issue[11].

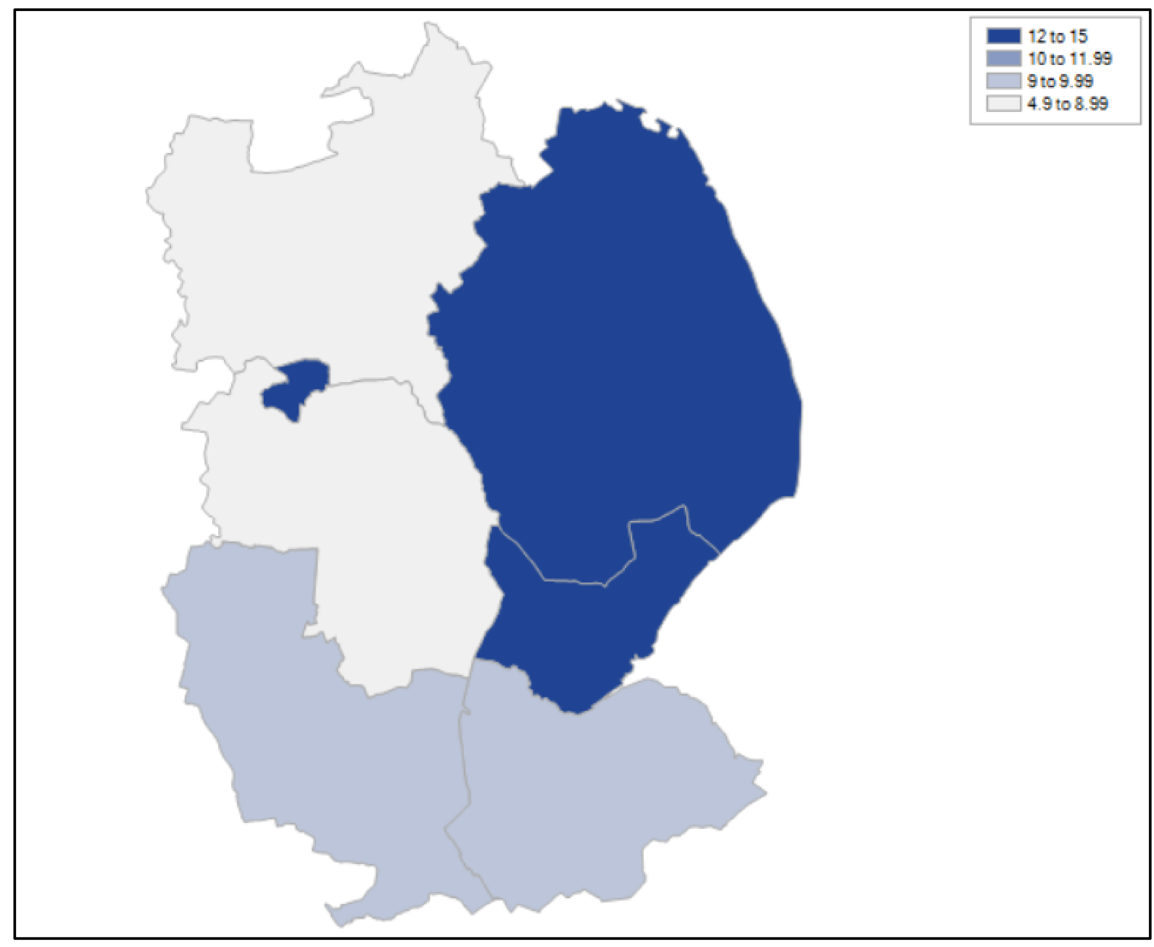
Although Lincoln has the highest number of premature deaths from CHD, at 52.01 per 100,000 people, it also has the lowest actual prevalence of CHD, at 3.63%. This could indicate that some people are being missed off the CHD Quality and Outcomes Framework (QOF) register[11].

3.3.3 Chronic obstructive pulmonary disease (COPD)

According to data from the 2012/13 QOF, the actual recorded prevalence of chronic obstructive pulmonary disease (COPD) in Lincolnshire was 2.05%, which was higher than the national rate of 1.7%.

Of the Lincolnshire districts, East Lindsey had the highest prevalence rate, which is unsurprising, since the average age of its population is also higher than the county's average, and the prevalence rates are not adjusted for age.

Map 10: Disease prevalence, chronic obstructive pulmonary disease (COPD), percentage: actual (recorded), all ages, 2012-2013



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Source: Public Health England and NHS Health and Social Care Information Centre / LRO

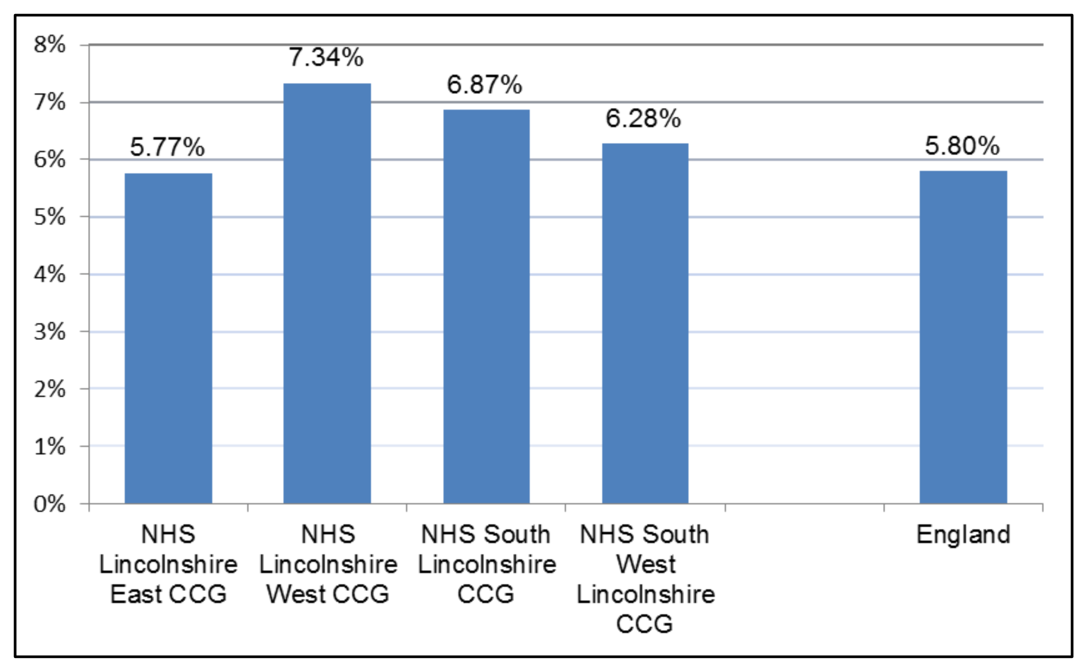
Between 2010 and 2012, over 300 people in Lincolnshire died prematurely from COPD, although the county's directly standardised mortality rates for those aged under 75 years (10.2 per 100,000) are lower than those for England and Wales (11.7 per 100,000)[12].

3.3.4 Depression

General Practices in the UK keep a record of all patients diagnosed with depression.

Figure 6 shows the proportion of patients, aged 18 years and over, who are on the depression register. From the chart, Lincolnshire West CCG appears to have a higher rate of such patients (7.34%) than the other Lincolnshire CCGs, and one which is higher than the England rate of 5.80%. However, it is difficult to know whether or not this rate may be influenced by diagnostic or recording behaviour within the CCG[u].

Figure 6: Percentage of patients, aged 18 years and over, with depression, as recorded on GP practice depression registers (all patients diagnosed since April 2006)



Source: Quality and Outcomes Framework 2012/13

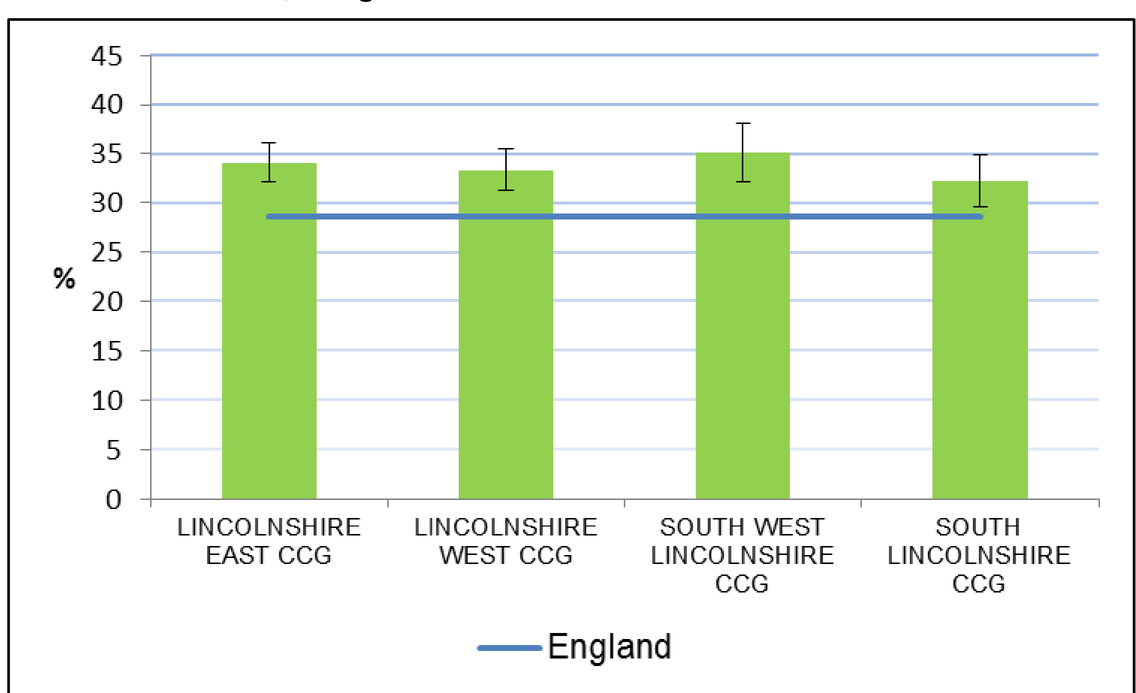
[u] HSCIC, Quality and Outcomes Framework. Available from: http://www.hscic.gov.uk/qof

3.4 End-of-life care

Between 2010 and 2012, on average, 7,300 patients in Lincolnshire died each year, with 23% of them dying in their own homes.

During the same period, 2,150 people in the county died from cancer. The percentage of cancer patients who died at home was higher than that for people who died at home as a result of other causes. Indeed, more than a third of Lincolnshire cancer patients (33.7%) died at home compared with the national average of 28.7%[v].

Figure 7: Home deaths as a percentage of all cancer deaths in Lincolnshire, 2010-2012, all ages



Source: Public Health England, End of Life Care CCG Profiles

A high proportion of home deaths may suggest increased demand on palliative care medicines.

Nonetheless, there is no significant difference between the Lincolnshire CCGs in respect of the proportion of home deaths in their respective areas.

[v] Public Health England, End-of-Life CCG Profiles. Available from: http://www.endoflifecare-intelligence.org.uk/profiles/CCGs/Place_and_Cause_of_Death/atlas.html

3.5 Vulnerable groups and enclosed communities

3.5.1 Adults with dementia

According to the QOF data, there were 5,190 people with dementia on GP registers in Lincolnshire, in 2012/13. The prevalence of dementia was highest in the area served by Lincolnshire East CCG, which accords with the older population profile of this CCG[w].

However, based on national estimates from the Alzheimer's Society, the estimated number of people with dementia in the county is more than twice as high as the reported number. This could suggest that dementia is being underdiagnosed[x].

Assuming that the prevalence rates will remain stable, the number of people suffering from dementia in Lincolnshire is projected to increase by a third by 2021, partly because of general growth in the size of the population, and partly because the population profile will include a greater proportion of elderly residents[y].

Approximately 12.5% of dementia patients are estimated to suffer from the severe form of the disease[z].

3.5.2 Adults in residential homes

In Lincolnshire, there has been a steady increase in the number of people, aged 65 years and over, who are in residential or nursing care.

Table 3: Number of people (aged 65 years and over) in residential or nursing care in Lincolnshire

Year	2010-11	2011-12	2012-13
Residential and nursing care home residents, persons: aged 65 years and over, residential care	1,966	1,995	2,458
Residential and nursing care home residents, persons: aged 65 years and over, nursing care	670	705	911
Total	**2,636**	**2,700**	**3,369**

Source: Lincolnshire County Council Adult Social Care

[w] HSCIC, Quality and Outcomes Framework. Available from: http://www.hscic.gov.uk/qof
[x] Alzheimer's Society, Dementia UK, 2007
[y] Projecting Older People Population Information System. Available from: www.poppi.org.uk
[z] Available from: www.poppi.org.uk

A wide range of care options is available for individuals who require long-term care. One of the key objectives is to enable people to maintain their independence in their own home, and this may be possible through the use of such services as:

- reablement,
- intermediate care,
- extra care housing, and
- telecare.

The availability of the services listed above may help to explain why admissions to residential and care homes are falling[13].

3.6 Sexual health and sexually-transmitted diseases

3.6.1 Chlamydia

Chlamydia is the most common sexually-transmitted infection 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.

The exact prevalence of the infection is unclear, both for Lincolnshire and for the UK as a whole. The main focus of the National Chlamydia Screening Programme is to increase diagnostic rates, with a view to identifying and treating as many infected individuals as possible[14].

Table 4: Activity of national chlamydia screening programme in Lincolnshire by financial year

	2008/09	2009/10	2010/11	2011/12	2012/13
Total number of screens	8,175	20,899	25,209	25,489	24,067
Total number of positives	621	1672	*	1,743	1,770
Positivity rate	7.60%	8%	*	6.80%	7.40%
Diagnostic rate (per 100,000) population aged 15-24	744	1,896	*	2,029	2,040

*Data not available

Source: NHS Lincolnshire chlamydia screening monitoring report

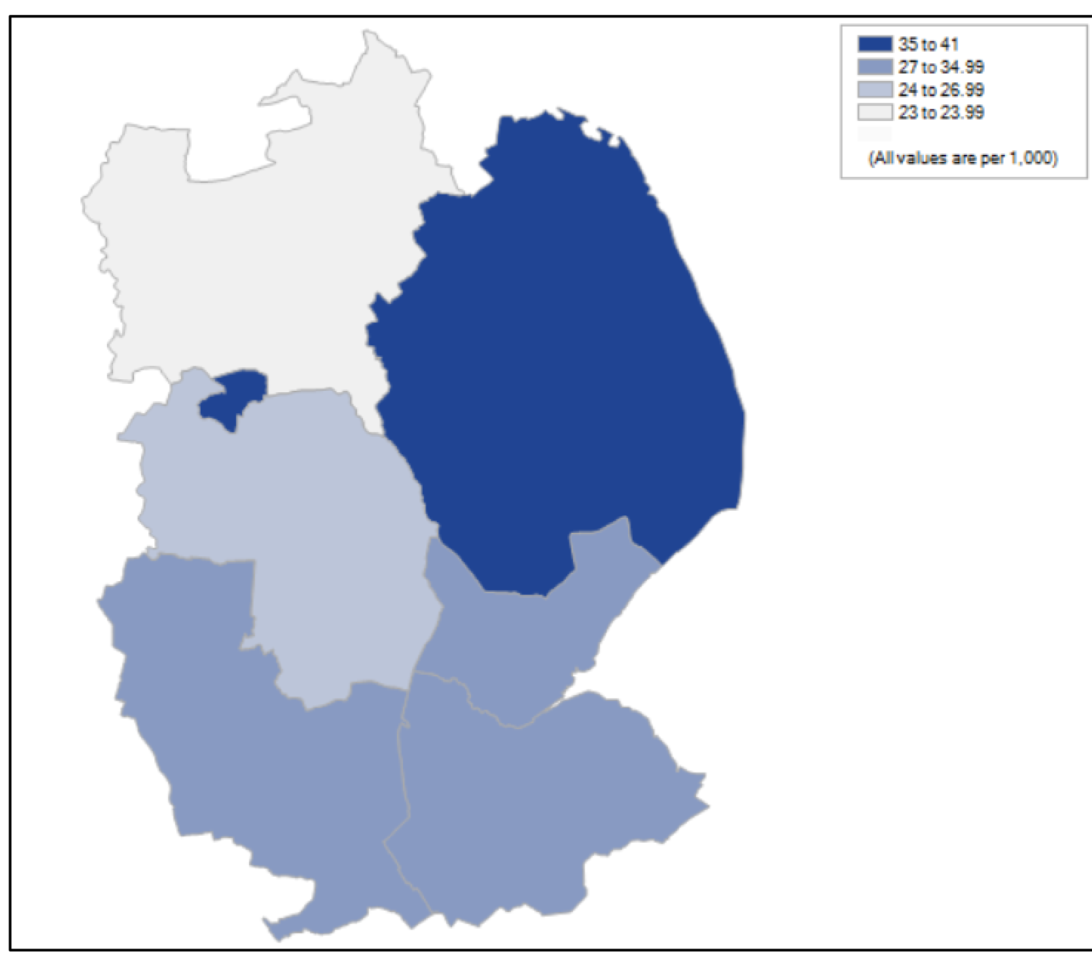
3.6.2 Teenage pregnancy

Teenage pregnancy rates in Lincolnshire have continued to drop in line with national and regional rates.

However, between 2011 and 2012, the decline was slower than that observed either nationally or regionally, and the under-18 conception rate was 30.5 per 1,000 females aged 15-17 years, compared to 27.7 in England.

Lincoln district had the highest teenage conception rate (40 per 1,000) amongst the local authorities in Lincolnshire, which was comparable with the national rate of 2008. Conception rates in East Lindsey and Boston also remained above both the national average and the Lincolnshire average in 2012, as shown in Map 11[15].

Map 11: Under-18 conceptions, rate per 1,000 females aged 15-17 years, 2012



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Source: Office for National Statistics / LRO

3.6.3 HIV / AIDS

According to Public Health England, there were 250 people in Lincolnshire accessing HIV-related care in 2012.

The diagnosed prevalence of HIV in Lincolnshire was 0.6 per 1,000 population aged 15-59 years. This is lower than either the prevalence in the East Midlands (1.2 per 1,000) or the national prevalence (2.1 per 1,000)[aa].

Table 5: Diagnosed prevalence of HIV in Lincolnshire by district

Local Authority	Residents accessing HIV-related care (aged 15-59)	Diagnosed HIV prevalence per 1,000 (aged 15-59)
Boston	28	0.77
East Lindsey	35	0.51
Lincoln	40	0.65
North Kesteven	41	0.68
South Holland	32	0.67
South Kesteven	36	0.47
West Lindsey	38	0.77
Lincolnshire	**250**	**0.6**

Source: Survey of Prevalent HIV Infections Diagnosed (SOPHID), Public Health England, 2012

3.7 Future needs

The trend in recent years has been for the population of Lincolnshire to increase slowly, and growth is projected to continue at the rate of approximately 0.7% annually over the next three years [bb].

However, the projected rate of increase for people aged 65 years and older is much faster, at approximately 2.5% annually, while the number of working-age people in the county is unlikely to change much[cc].

Although some negative lifestyle choices (such as smoking) are showing a declining trend, which is likely to continue, other factors (including a population structure which has an increasing proportion of elderly residents, and a projected increase in obesity rates) are likely to have a negative effect on the general health and disease prevalence in the county.

Future pharmaceutical provision will need to be kept under review, to take into account the dynamics of the population in Lincolnshire.

[aa] Public Health England, Diagnosed HIV prevalence by upper and lower tier local authority. https://www.gov.uk/government/statistics/hiv-data-tables

[bb] Office for National Statistics, Population Estimates for UK, England and Wales, Scotland and Ireland

[cc] Ibid.

4. Pharmaceutical Provision

4.1 Background

The NHS Regulations 2013 specify that the pharmaceutical services to which the PNA must relate are all provided under commissioning arrangements made by NHS England. These are defined as:

- Essential services:- These must be available from every community pharmacy providing NHS pharmaceutical services, and are defined within the terms of service. They include:
    - dispensing of medicines;
    - repeat dispensing;
    - disposal of waste medicines;
    - promotion of healthy lifestyles;
    - participation in Public Health campaigns; and
    - support for self-care.

- Advanced services:- These are services that may be provided by community pharmacy contractors and dispensing appliance contractors, subject to accreditation, and include the following:
    - Medicines Use Reviews (MURs);
    - New Medicines Service (NMS) from community pharmacies;
    - Appliance Use Reviews;
    - Stoma Customisation Service provided by dispensing appliance contractors; and
    - Appliance Use Review Services for Specified Appliances provided by dispensing appliance contractors.

- Enhanced services:- Until 31 March 2013, all services that were commissioned locally were known as enhanced services. Since 1 April 2013, only services that are commissioned by NHS England are classed as enhanced services. This could include the following:
    - Anticoagulation monitoring;
    - Care home service;
    - Disease specific medicines management service;
    - Gluten-free food supply service;
    - Independent prescribing service;
    - Home delivery service;

- Language access service;
- Medication review service;
- Medicines assessment and compliance support;
- Minor ailment service;
- On-demand availability of specialist drugs;
- Out-of-hours service;
- Patient group direction service (not related to public health services);
- Prescriber support service;
- Schools service; and
- Supplementary prescribing service.

- Dispensing services provided by GPs:- In relation to other providers of pharmaceutical services, dispensing practices have been considered as part of the PNA, but solely as providers of dispensing services. In accordance with the NHS Regulations, other services, such as provision of the Dispensing Review of Use of Medicines (DRUM) service through the Dispensing Quality Scheme, have not been included.

4.2 Access to pharmaceutical services

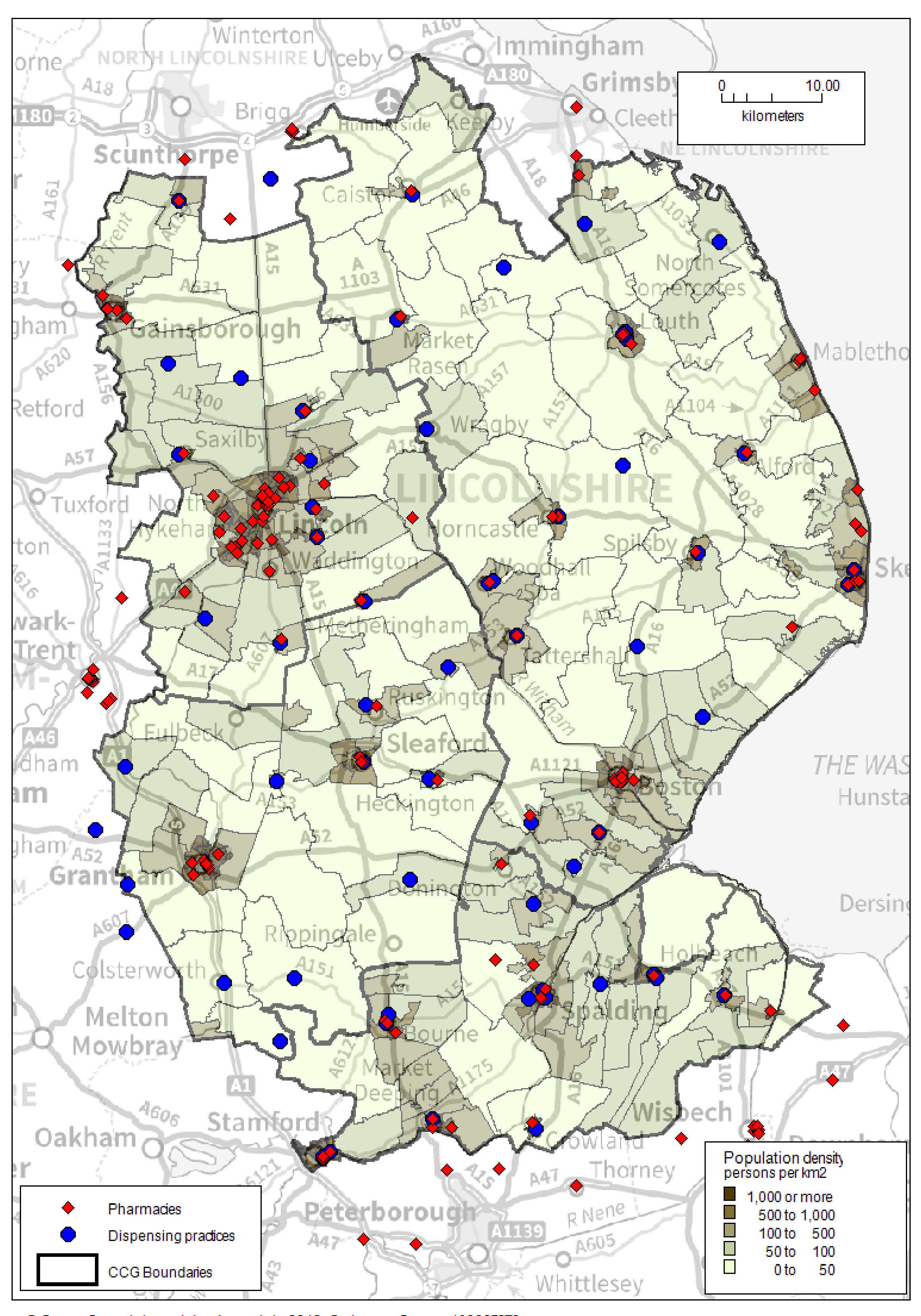
For patients in Lincolnshire, there is a split across the county, with community pharmacies and GP practices both providing services to patients.

Approximately 74% of patients registered with Lincolnshire practices are registered as non-dispensing and are able to use community pharmacies for their pharmaceutical services. The remaining 26% are dispensing patients and have their prescriptions dispensed from their dispensing GP practice.

Many Lincolnshire dispensing practices participate in the Dispensing Services Quality Scheme, and consistently demonstrate high quality services and high levels of patient satisfaction. Nonetheless, there are a number of key pharmaceutical services that are available from community pharmacies, but not from dispensing practices.

The PNA Steering Group felt that it was important for patients to be aware that they have this choice.

Map 12: Pharmacies and dispensing practices, including out-of-county pharmacies



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Source: NHS England

100-hour pharmacies were established under the 2005 regulatory framework, and are required to open for 100 contracted hours each week, as agreed with NHS England.

Map 13: 100-hour pharmacies in Lincolnshire

100 hours pharmacies
All Lincolnshire pharmacies
County boundary

Population density persons per km2
1,000 or more
500 to 1,000
100 to 500
50 to 100
0 to 50

0 10,00 kilometers

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4.3 CCG-level provision

4.3.1 Lincolnshire East CCG

Table 6: Locations with a dispensing practice, but no community pharmacy, Lincolnshire East CCG

Location	Dispensing GP practices*	All GP practices
Binbrook	1	1
North Somercotes	1	1
North Thoresby	1	1
Old Leake	1	1
Stickney	1	1
Tetford	1	1
Wragby	1	1
Lincolnshire East	**7**	**7**

*Most dispensing at GP practices is only available within the core opening hours of the practice

Source: NHS England

Table 7: Pharmaceutical services, Lincolnshire East CCG

Location	Pharmacies	Saturday opening	Sunday opening	100-hour	GP practices	Dispensing GPs practices*
Alford	1	1	0	0	1	1
Boston	7	6	2	1	5	0
Caistor	1	1	0	0	1	1
Chapel St Leonards	1	0	0	0	0	0
Coningsby	1	1	0	0	1	1
Holton-le-Clay	1	1	0	0	0	0
Horncastle	2	2	0	0	1	1
Ingoldmells	2	1	1	1	0	0
Kirton	1	1	0	0	1	1
Louth	4	4	3	0	3	3
Mablethorpe	3	2	1	1	1	0
Market Rasen	1	1	0	0	1	1
Skegness	5	3	2	0	2	2
Spilsby	1	1	0	0	1	1
Sutton on Sea	2	2	0	0	0	0
Swineshead	1	0	0	0	1	1
Wainfleet	1	1	0	0	1	0
Woodhall Spa	1	1	0	0	2	2
Lincolnshire East	**36**	**29**	**9**	**3**	**22**	**15**

*Most dispensing at GP practices is only available within the core opening hours of the practice

Source: NHS England

Table 8: Advanced pharmaceutical services, Lincolnshire East CCG

Location	New Medicine Service (NMS)	Medicines Use Review (MUR)
Alford	1	1
Boston	6	7
Caistor	1	1
Chapel St Leonards	1	1
Coningsby	1	1
Holton-le-Clay	1	1
Horncastle	2	2
Ingoldmells	1	2
Kirton	1	1
Louth	4	4
Mablethorpe	3	3
Market Rasen	1	1
Skegness	5	5
Spilsby	1	1
Sutton on Sea	2	2
Swineshead	1	1
Wainfleet	1	1
Woodhall Spa	1	1
Lincolnshire East	**34**	**36**

Source: NHS England

Extended-hours pharmacies in Louth

NHS England commissions extended opening hours for pharmacies in Louth as an 'enhanced service'. Currently, four pharmacies in Louth are commissioned as part of this service.

Table 9: Extended-hours pharmacies in Louth

Pharmacy Name	Pharmacy Address	Town	Post Code
Your Local Boots Pharmacy	96-98 Eastgate	Louth	LN11 9AA
Louth Pharmacy	155 Newmarket	Louth	LN11 9EH
Boots the Chemists Ltd	26 Mercer Row	Louth	LN11 9JQ
Lincoln Co-op Chemists Ltd	52 Eastgate	Louth	LN11 9PG

Source: NHS England

4.3.2 Lincolnshire West CCG

Table 10: Locations with a dispensing practice, but no community pharmacy, Lincolnshire West CCG

Location	Dispensing GP practices*	All GP practices
Bassingham	1	1
Hibaldstow[+]	1	1
Ingham	1	1
Willingham By Stow	1	1
Lincolnshire West	**4**	**4**

*Most dispensing at GP practices is only available within the core opening hours of the practice
[+]This GP practice is located outside the Lincolnshire Health and Wellbeing Board Area

Source: NHS England

Table 11: Pharmaceutical services, Lincolnshire West CCG

Location	Pharmacies	Saturday opening	Sunday opening	100-hour	GP practices	Dispensing GP practices*
Bardney	1	0	0	0	0	0
Bracebridge Heath	1	1	0	0	0	0
Branston	1	1	0	0	1	1
Cherry Willingham	1	1	0	0	0	0
Gainsborough	5	4	1	0	3	0
Lincoln	22	18	7	3	18	0
Metheringham	1	1	0	0	2	1
Navenby	1	0	0	0	1	1
Nettleham	1	1	0	0	1	1
North Hykeham	4	3	1	1	2	0
Saxilby	1	1	0	0	2	2
Scotter	1	0	0	0	1	1
Skellingthorpe	1	1	0	0	0	0
Waddington	1	1	0	0	0	0
Washingborough	1	1	0	0	1	1
Welton	1	1	0	0	1	1
Witham St Hughs	1	1	0	0	0	0
Lincolnshire West	**45**	**36**	**9**	**4**	**33**	**9**

*Most dispensing at GP practices is only available within the core opening hours of the practice

Source: NHS England

Table 12: Advanced pharmaceutical services, Lincolnshire West CCG

Location	New Medicine Service (NMS)	Medicines Use Review (MUR)
Bardney	1	1
Bracebridge Heath	1	1
Branston	1	1
Cherry Willingham	1	1
Gainsborough	5	5
Lincoln	19	20
Metheringham	1	1
Navenby	1	1
Nettleham	1	1
North Hykeham	3	4
Saxilby	1	1
Scotter	1	1
Skellingthorpe	1	1
Waddington	1	1
Washingborough	1	1
Welton	1	1
Witham St Hughs	1	1
Lincolnshire West	**41**	**43**

Source: NHS England

There is one dispensing appliance contractor in Lincoln. Dispensing appliance contractors provide prescription appliances to patients.

4.3.3 South Lincolnshire CCG

Table 13: Locations with a dispensing practice, but no community pharmacy, South Lincolnshire CCG

Location	Dispensing GP practices*	All GP practices
Gosberton	1	1
Moulton	1	1
Sutterton	1	1
South Lincolnshire	**3**	**3**

*Most dispensing at GP practices is only available within the core opening hours of the practice

Source: NHS England

Table 14: Pharmaceutical services, South Lincolnshire CCG

Location	Pharmacies	Saturday opening	Sunday opening	100-hour	GP practices	Dispensing GP practices*
Bourne	3	3	1	0	2	2
Crowland	1	1	0	0	1	1
Deeping St James	1	1	0	0	0	0
Donington	1	1	0	0	0	0
Holbeach	2	2	0	0	1	1
Long Sutton	1	1	0	0	1	1
Market Deeping	2	1	0	0	1	1
Pinchbeck	1	1	0	0	0	0
Spalding	5	5	2	1	3	3
Stamford	4	4	1	1	3	3
Sutton Bridge	1	1	0	0	0	0
West Pinchbeck	1	0	0	0	0	0
South Lincolnshire	**23**	**21**	**4**	**2**	**12**	**12**

*Most dispensing at GP practices is only available within the core opening hours of the practice

Source: NHS England

Table 15: Advanced pharmaceutical services, South Lincolnshire CCG

Location	New Medicine Service (NMS)	Medicines Use Review (MUR)
Bourne	3	3
Crowland	1	1
Deeping St James	1	1
Donington	1	1
Holbeach	2	2
Long Sutton	1	1
Market Deeping	2	2
Pinchbeck	1	1
Spalding	5	5
Stamford	3	3
Sutton Bridge	0	1
West Pinchbeck	1	1
South Lincolnshire	**21**	**22**

Source: NHS England

In South Lincolnshire area, there is one distance-selling pharmacy, based in West Pinchbeck. Distance-selling pharmacies must provide essential services to patients, without patients entering the premises of the pharmacy. They are able to provide advanced services to patients on site.

4.3.4 South West Lincolnshire CCG

Table 16: Locations with a dispensing practice, but no community pharmacy, South West Lincolnshire CCG

Location	Dispensing GP practices*	All GP practices
Ancaster	1	1
Billingborough	1	1
Billinghay	1	1
Bottesford[+]	2	2
Castle Bytham	1	1
Colsterworth	1	1
Corby Glen	1	1
Croxton Kerrial[+]	1	1
Long Bennington	1	1
Woolsthorpe By Belvoir	1	1
South West Lincolnshire	**11**	**11**

*Most dispensing at GP practices is only available within the core opening hours of the practice

[+]This GP practice is located outside the Lincolnshire Health and Wellbeing Board Area

Source: NHS England

Table 17: Pharmaceutical services, South West Lincolnshire CCG

Location	Pharmacies	Saturday opening	Sunday opening	100-hour	GP practices	Dispensing GP practices*
Grantham	10	10	2	2	5	0
Heckington	1	1	0	0	1	1
Ruskington	1	1	0	0	1	1
Sleaford	4	4	3	2	1	1
South West Lincolnshire	**16**	**16**	**5**	**4**	**8**	**3**

*Most dispensing at GP practices is only available within the core opening hours of the practice

Source: NHS England

Table 18: Advanced pharmaceutical services, South West Lincolnshire CCG

Location	New Medicine Service (NMS)	Medicines Use Review (MUR)
Grantham	9	10
Ruskington	1	1
Sleaford	4	4
South West Lincolnshire	**14**	**15**

Source: NHS England

5. Gaps in Pharmaceutical Provision

5.1 Provision of dispensing services

Map 12 shows all community pharmacies, dispensing practices and out-of-county pharmacies across Lincolnshire and beyond its borders. On the basis of the evidence provided by this map, the PNA Steering Group concluded that the residents of Lincolnshire are adequately served by providers of dispensing services, in both urban and rural areas. Similarly, no case of pharmaceutical need was identified in respect of the provision of dispensing services.

However, community pharmacies provide a wider range of essential services, as well as currently offering 'advanced services' that are not provided by dispensing practices. In particular, the PNA Steering Group recognised that patient access to self-care, through the provision of healthcare advice and over-the-counter medicines, is only available from community pharmacies.

Access to the 'advanced services' provided by community pharmacies (the New Medicine Service (NMS) and the Medicines Use Review (MUR) service) was also identified as a key matter for consideration, as discussed below.

Self-care is about ensuring that people have the necessary advice and support to enable them to look after themselves in a healthy way. This may include advice on healthy eating, exercise, dental hygiene, personal hygiene, smoking cessation and alcohol moderation. It may also include advice on the improved management of a long-term condition, such as diabetes, or supplying a medicine that may be purchased over the counter to treat a minor ailment, such as a cold or hay fever.

Community pharmacy is ideally placed to deliver a wide variety of support to enable people to manage their own health, rather than putting additional strain on front-line medical services, such as general practices or Accident and Emergency departments.

5.2 The New Medicine Service (NMS)

The NMS is designed to provide early support to patients who have been prescribed medicines, for the first time, for a defined range of conditions and therapy areas. These areas are:

- asthma and chronic obstructive pulmonary disease (COPD),
- type 2 diabetes,
- antiplatelet/ anticoagulant therapy, and
- hypertension.

When a patient has been prescribed a 'pre-defined medicine' for the first time, they may be recruited to the NMS, either by prescriber referral, or opportunistically by the community pharmacy. The patient is asked to consent to information arising from the NMS being shared with their GP, as necessary. The pharmacy dispenses the prescription, and provides initial advice as usual,

but agrees with the patient a convenient time for further interventions, and the method by which they may be conducted. The first intervention is an interview conducted by the pharmacist, either face to face, or by telephone, 7 to 14 days after the initial patient engagement. The interview follows a pre-defined schedule, and is designed to:

- assess adherence to therapy,
- identify any early problems (such as poor tolerability or patient concerns), and
- address any need for further information and support.

A further follow-up contact with the patient (again either face to face, or by telephone) takes place 14 to 21 days after the initial intervention, in order to discuss how the patient is getting on with their medicine as it becomes a more established part of their therapy.

At both the intervention and follow-up stages, the pharmacist may identify a problem that needs to be referred back the prescriber for review. In particular, the pharmacist may feed back on:

- potential drug interactions,
- potential or actual adverse drug reactions that are preventing the patient from adhering to therapy,
- concerns that the patient has reported they have stopped taking the medicine or never started taking it,
- difficulties experienced by the patient in using the medicine (due to the delivery device, formulation etc.), or
- concerns that the patient is reporting lack of efficacy, problems with the dosage regime or unresolved concerns about the medicine itself.

The development of the NMS was based on a raft of new research that identified:

- the problems people experience with new medicines;
- the reasons for poor adherence or non-adherence to newly prescribed medicines, and
- the contribution that pharmacy-led intervention can make in supporting adherence.

In a survey of 258 patients with a chronic condition, who were aged over 75 years, and who were just starting on a newly prescribed medicine, almost one-third reported non-adherence, and two-thirds had a medicine-related problem that required further information within 10 days of starting the medicine[16].

A subsequent randomised controlled trial compared the support for patients with a long-term condition, who were receiving a new medicine that was provided by community pharmacy, with the usual care provided for such patients. The results clearly demonstrated significantly lower rates of non-adherence and medicine-related problems or concerns in the intervention group[17].

In summary, problems with newly started medicines emerge rapidly, and require early intervention by an appropriately experienced healthcare professional.

There is strong evidence of the beneficial effect of interventions by community pharmacies to improve adherence, and address medicine-related concerns, in respect of newly prescribed medicines. Such interventions can significantly improve both patient adherence and the patient experience. There is also strong evidence that improved patient adherence can improve disease-related outcomes.

A recent external evaluation of the NMS service by the University of Nottingham, which was commissioned by NHS England, concluded that the NMS service is of value in establishing patient adherence to new medication regimens. As a result of this evaluation, the NMS service has continued to be incorporated within the Community Pharmacy Contractual framework.

5.3 Medicines Use Reviews (MURs)

MURs have been available as part of the Community Pharmacy Contractual Framework for a number of years. They are designed to improve the patient's knowledge, understanding and use of their medicines, and can help to identify and rectify adherence problems. Improved patient understanding should reduce medicines wastage.

Unlike the NMS, which focuses on new medicines, MURs are likely to be focused on patients with an established regimen of therapy. Regulations for MURs require a pharmacy to have a minimum of three months of Patient Medication Records for a patient in order to undertake the review. Patients not accessing a regular pharmacy for dispensing services will not be eligible for a routine annual MUR.

From 1st October 2011, pharmacies have had to ensure that 50% of their MURs are targeted at patients who:

- are taking 'high risk medicines' (defined as non-steroidal anti-inflammatory drugs, anticoagulants, antiplatelet agents and diuretics),
- have recently been discharged from hospital with an amended medicines regimen (ideally, patients discharged from hospital should receive an MUR within four weeks of discharge, although in certain circumstances within eight weeks would be acceptable), or
- have respiratory disease (such as asthma or COPD).

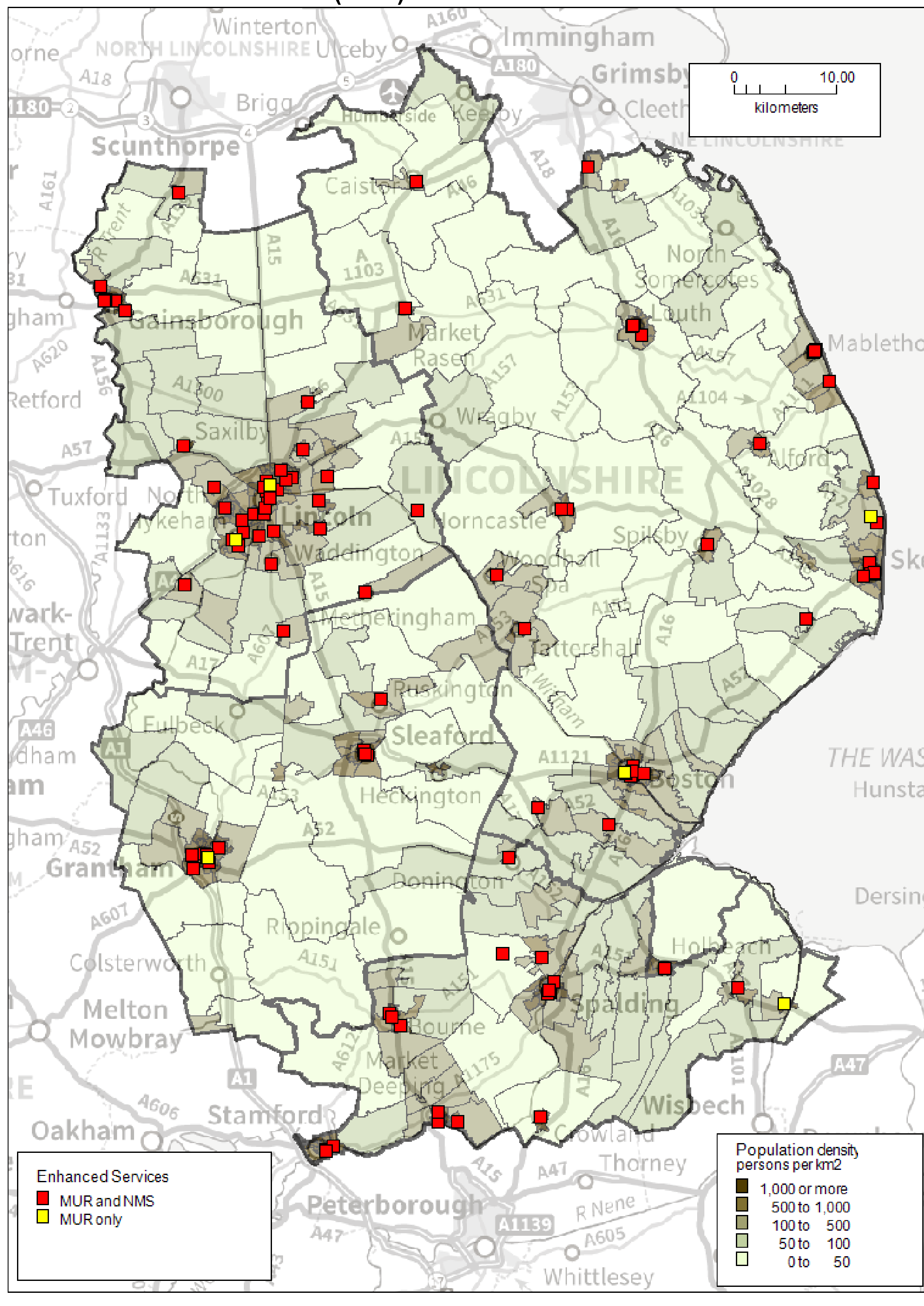
In addition, from 1st January 2015, a fourth target group has been added to this list:

- patients who are at risk of, or who have been diagnosed with, cardiovascular disease, and are regularly being prescribed at least four medicines.

From 1st April 2015, community pharmacies must carry out at least 70% of their MURs within any given financial year on patients in one or more of the agreed target groups. These MURs will focus on all of the medicines currently taken by the patient, not just those defined in the target groups.

The remaining 30% of the MURs provided by the pharmacy may focus on patients who fall outside of the target groups.

Map 14: Pharmacies that provide Medicines Use Reviews (MURs) and the New Medicine Service (NMS)



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Source: NHS England

From Map 14, which shows 'Pharmacies that provide Medicines Use Reviews (MURs) and the New Medicine Service (NMS)', the PNA Steering Group found that there are gaps across the county where Lincolnshire patients are likely to

experience difficulty accessing these, and other services provided by the community pharmacies, including self-care and over-the-counter medicines.

In many rural areas of Lincolnshire, significant gaps in the provision of some essential services (i.e. support with self-care) and some advanced services (i.e. the NMS and MURs) were identified.

5.4 Opportunities

5.4.1 Locally-commissioned services

As long ago as the publication of the '*Pharmacy in England'* White Paper in 2008, community pharmacies were regarded as key contributors to the 'healthy living and better care' agenda, with more recent documents clearly recognising and outlining the contribution that pharmacy-based services can make to improving patient care[18,19].

In both rural and deprived inner city areas, community pharmacies are based in the heart of the community, where people live, work and shop. Consequently, through daily interactions with patients and customers, community pharmacy teams gain a particular understanding of the needs of individuals in their communities. Because they provide convenient access for the public, without the need for an appointment, visitors to pharmacies come from all sectors of the population.

Pharmacies are ideally placed to access ‘hard to reach’ groups and thus reduce health inequalities.

For areas of deprivation, the community pharmacy may provide the only available healthcare professional. Therefore, in the new Public Health service, matters to be addressed by community pharmacies include:

- NHS Health Checks,
- tackling drug and alcohol misuse,
- promoting healthy lifestyles and prevention of long-term illness, and
- increasing the uptake of seasonal flu vaccination[20].

Essential Public Health services provided by all community pharmacies within the contractual framework include:

- acting as centres promoting and supporting healthy living,
- offering both patients and the public advice on healthy lifestyles and support for self-care, and
- providing up to six Public Health campaigns per year, as agreed by the local authority.

In addition to these essential services, a number of local services are already being commissioned from pharmacies in Lincolnshire. These services are primarily being commissioned by Public Health within Lincolnshire County Council, and not by NHS England. Therefore, they

fall outside the definition of 'locally commissioned services', as set out in the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013. Nevertheless, they are recognised as services which benefit patients in Lincolnshire. Such services include:

- support for smoking cessation,
- support for sexual health (e.g. chlamydia screening and treatment, pregnancy testing, provision of condoms and emergency hormonal contraception),
- provision of pharmacy-based needle exchange and supervised administration of methadone,
- pilot for pharmacy-based screening, advice and brief intervention for alcohol use, and
- the Emergency Supply Services and the Minor Ailments Scheme, which are commissioned by the CCGs, and which serve to help reduce patient access to GP practices, A&E and walk-in-centres, because patients attend at the pharmacy in the first instance.

Smoking cessation

- For many years, community pharmacies across Lincolnshire have performed consistently well as part of the Phoenix Smoking Cessation service, with the pharmacy-based clinics routinely achieving quit rates at the higher levels (many achieving in excess of 50% success rates).
- This performance level reflects a national trend. Five review papers on the community pharmacy contribution to smoking cessation indicated that 'stop smoking services' run by trained community pharmacy staff were both effective and cost-effective in helping smokers to quit[21,22,23,24,25].

Pharmacist support for those with long-term conditions

- Further evidence indicated the effectiveness of pharmacy services in reducing lipid levels; the effect was sustained one year after the intervention ended.
- Evidence from a single randomised controlled trial showed the effectiveness of a pharmacy service in significantly increasing the prescribing of antiplatelet medicines, lipid lowering treatment and smoking cessation treatments.
- A workplace-based cardiovascular disease (CVD) risk reduction programme, provided by community pharmacists, significantly reduced blood pressure and improved lipid profiles, but had no effect on weight. A community-pharmacy-based service, where peer educators measured blood pressure and completed CVD risk profiles for people with hypertension, was well received, both by patients and by GPs.

- Medicines management in patients with heart failure, who had recently been discharged from hospital, led to a reduction in hospitalisation, but did not lead to a reduction in mortality[25].

- There was strong evidence that community pharmacists can make an important contribution to the management of diabetes, through screening, helping to improve concordance with medication, and supporting patients to reduce their blood glucose or 'HBA1c'. Community pharmacists were also effective in achieving weight reduction in diabetic patients[25].

- It is clear from the evidence that interventions by pharmacists could promote reduction of cholesterol and high blood pressure to improve cardiovascular health.

- There is also good evidence that community pharmacy interventions can improve the use of medicines by, and the respiratory function of, patients with asthma[25].

Flu vaccination

- Many Lincolnshire pharmacies have already developed the competency and expertise to provide vaccination services, and are providing a high number of private flu vaccinations. These fall outside the data collection for the NHS annual campaigns.

- A recent peer-reviewed research paper concluded that the involvement of community pharmacies in the seasonal influenza vaccination programme is associated with high levels of patient acceptability, and that it could help to increase vaccination rates[18].

- The Parliamentary Health Committee was presented with evidence from a survey of 500,000 people who were vaccinated through a Novartis Vaccines scheme in community pharmacies. Of those who responded, 37% would not have had the vaccination if it had not been offered by the pharmacy[dd].

Sexual health services

- Services that reduce the risks of unwanted pregnancy, such as the provision of emergency hormonal contraception (EHC) and supplying condoms, receive considerable public interest. Pharmacies were highly rated by the women who used them, and there is evidence that pharmacies can provide 'timely access'.

- Through the NHS, the provision of 'on-demand' EHC to 13-to-19 year olds, without the need for an appointment, has been operating in some Lincolnshire pharmacies for a number of years.

[dd] Evidence provided to HC 1048-III Health Committee. Available from: www.parliament.co.uk

- Currently, Lincolnshire pharmacies provide pregnancy testing services, as well as registration for the C-card scheme and distribution of condoms to young people. Chlamydia screening is available from pharmacies, which, more recently, have also provided treatment for those who have tested positive for chlamydia.

- Innovative schemes are being piloted elsewhere to enable pharmacies to supply women who are over 16 years old with regular oral contraception, without the need for a prescription.

Substance use

- The majority of community pharmacies in Lincolnshire work in conjunction with the providers of substance misuse services to deliver supervised administration services, where the patient attends the pharmacy on a daily basis to access the medicines prescribed to treat addiction. This ensures medication is consumed appropriately, in a safe environment, and protects both the client and the public.

- Some evidence on the supervised methadone administrative services provided by community pharmacies shows that high attendance is achieved, and that the service is acceptable to users[23,24,25]. There is evidence from one paper[26] that the introduction of supervised methadone dosing has resulted in a substantial decline in deaths from overdoses of methadone in both Scotland and England. However, the data used was not community pharmacy specific.

- Pharmacy-based needle exchange schemes have been found to be cost effective, and achieve high rates of returned injecting equipment. Evidence for this is based on descriptive studies[25,27].

- Conversation with clients on a daily basis helps to safeguard service users, but could also be used to deliver 'healthy living' messages to the clients at the same time.

Having reviewed the evidence for the provision of a wide range of locally commissioned services through community pharmacy, the PNA Steering Group concluded that further expansion and wider availability of the range of services currently provided through community pharmacies would benefit the Lincolnshire population, subject to:

- local need,
- patient demand, and
- clear evidence of benefit, value for money, and improved health outcomes.

This expansion should be done with existing community pharmacies, because establishing new pharmacies could lead to an over-provision of essential services, and may destabilise current provision.

5.4.2 Local Health and Care (LHAC)

Alongside the aim of expanding the work of the community pharmacies, the PNA Steering Group acknowledged the potential benefit of working with LHAC and the developing neighbourhood teams.

5.4.3 Development of electronic prescribing

Electronic prescribing is being rolled out progressively across Lincolnshire, and has huge implications for patient choice. As part of their registration for electronic prescribing, the patient is required to nominate their preferred pharmacy, or, if appropriate, they may select their dispensing practice.

Historically, 'dispensing patients' in rural areas of the county were expected to collect their dispensed prescription from the dispensing practice that provided their medical services.

Electronic prescribing should enable the patient to decide where they wish to collect their dispensed medicines from. Thus, they should be able to choose a more convenient supplier (perhaps one closer to their workplace), or one that provides a more desirable 'added value' service, such as collection and delivery.

The PNA Steering Group is supportive of patients exercising their right to choose.

6. Conclusions and Recommendations

- Residents of Lincolnshire are adequately served by providers of dispensing services in both urban and rural areas. However, ongoing change linked to population growth in many localities will necessitate frequent review of this position.

- Patient access to self-care through the provision of healthcare advice and supply of over-the-counter medicines is only available from community pharmacies. There are many rural areas of the county where dispensing services are available, but patients have no access to self-care, over-the-counter medicines or community pharmacy advanced services such as Medicines Use Reviews and the New Medicine Service.

  Having reviewed the evidence for the provision of a wide range of locally commissioned services through community pharmacy, the PNA Steering Group concluded that further expansion and wider availability of the range of services currently provided through community pharmacies would benefit the Lincolnshire population subject to local need, patient demand, and clear evidence of benefit, value for money and improved health outcomes. This expansion should be done with existing community pharmacies, because establishing new pharmacies could lead to an over-provision of essential services, and may destabilise current provision.

- The PNA Steering Group is supportive of patients exercising their right to choose where they access their pharmaceutical services. Patient choice should be further enabled by the wider implementation of electronic prescribing across the county.

- As required by The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013, the PNA Steering Group intend to continue reviewing pharmaceutical need and local service provision, and publishing regular updates and supplementary statements where circumstances change.

- During July 2014, Healthwatch published a questionnaire, targeting people who use pharmacy services in Lincolnshire. In order to build on the findings from their Pharmacy Questionnaire, and subsequent recommendations, and bearing in mind their independent role, the PNA Steering Group would like to work with Healthwatch. Therefore, they would like to invite Healthwatch to send a representative to be a member of the PNA steering group.

6.1 Ownership and review

The PNA for Lincolnshire will continue to be managed on behalf of the HWB by the PNA Steering Group. This will include the ongoing legal requirement for the HWB to review the PNA, and issue supplementary statements, as and when required.

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Lincolnshire Pharmaceutical Needs Assessment (PNA)

Consultation Report

Date of Survey: 6th October 2014 – 4th December 2014

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Introduction

The Lincolnshire Health and Wellbeing Board (HWB) has a legal requirement to produce a Pharmaceutical Needs Assessment (PNA) by 1st April 2015.

In line with the legal statutory, requirements, a PNA assessment has been concluded that:

- looks at the need for pharmaceutical services;
- describes the current services available to the county; and
- makes recommendations for the future provision of pharmaceutical services.

The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 set out the legislative basis for developing and updating PNAs.

The Regulations can be found at:

http://www.dh.gov.uk/health/2013/02/pharmaceutical-services-regulations/

Background

From 1 April 2013 the Health and Social Care Act 2012 transferred responsibility to develop and update Pharmaceutical Needs Assessments from Primary Care Trusts (PCTs) to Health and Wellbeing Boards (HWB).

National Context

In order to provide pharmaceutical services, providers (most commonly community pharmacists but also dispensing appliance contractors and GPs in rural areas) are required to apply to be included on a pharmaceutical list.

In order for their inclusion to be approved, they are required to demonstrate that the services they wish to provide meet an identified need as set out in a PNA for the area. There are some exceptions to this, such as if the provider is offering distance selling (internet or mail order) services or to meet needs not foreseen in a PNA.

The first PNAs were published by NHS Primary Care Trusts (PCTs) and were required to be published by 1 February 2011.

From the 1 April 2013 the Health and Social Care Act 2012 transferred responsibility to develop and update PNAs from PCTs to HWBs. At the same time, the responsibility for using PNAs as the basis for determining market entry to a pharmaceutical list transferred from PCTs to NHS England from 1 April 2013.

The Regulations state that HWBs are required to publish their first PNA by 1 April 2015. Subsequent to this, the HWB is required to publish a revised assessment within three years of the first assessment.

Local Context

Historically, the PCT in Lincolnshire established a PNA Core Group to manage the process of developing, consulting upon and publishing the PNA.

The PCT Board was responsible for signing off the PNA and Lincolnshire's PNA was first published in 2011.

Since the first PNA was produced the Core Group has continued to meet in order to ensure that the PNA is up to date and that any supplementary statements to the main PNA are produced and published in a timely manner.

The Core Group has previously had a critical membership of key staff to provide expert advice in relation to:

- Need (Public Health intelligence/Health informatics);
- Supply (Contract management);
- Demand (Prescribing).

Previously these roles all sat within the PCT however since the 1 April 2013 they now sit in different parts of the health care system as follows:

- Public Health Intelligence (Lincolnshire County Council Public Health);
- Health Informatics (Greater East Midlands Commissioning Support Unit);
- Contract Management (NHS England, Leicestershire and Lincolnshire Area Team);
- Prescribing (Greater East Midlands Commissioning Support Unit, Prescribing and Medicines Optimisation Service).

Successful delivery of the PNA in future is, therefore, incumbent on a number of organisations (represented on the HWB) to ensure that the legal requirements as set out in the Regulations are met.

General Methodology

The PNA Core Group continued to meet and operate in order to undertake the work necessary for the Board to publish its first PNA by 1 April 2015.

Particular thanks are given to the significant contribution made by the members of the Pharmaceutical Needs Assessment Steering Group in the development and writing of the assessment.

The PNA steering group is made up of the following people:

Position	Job title	Organisation
Chris Weston (Chair)	Consultant in Public Health	Public Health Directorate Lincolnshire County Council
Avril McDermott	Local Professional Network Chair	NHS England
Adrian Audis (Departed the steering group in December 2014)	Assistant Contract Manager	NHS England
David Stacey	Programme Manager (Strategy and Performance)	Public Health Directorate Lincolnshire County Council
Stephen Gibson	Head of Prescribing & Medicines Optimisation	Greater East Midlands Commissioning Support Unit
Mark Hall	Primary Care Support Contract Manager	NHS England (Leics & Lincs Area)
Marta Kowalczyk	Public Health Analyst	Public Health Directorate Lincolnshire County Council

Requirements

The PNA consultation was determined by the NHS Regulations 2013, which state:

> *When making an assessment for the purposes of publishing a pharmaceutical needs assessment, each HWB must consult the following about the contents of the assessment it is making:*
>
> - *Local Pharmaceutical Committee*
> - *Local Medical Committee*
> - *Any persons on the pharmaceutical lists, or on the dispensing doctors list for its area*
> - *Any Local Pharmaceutical Services (LPS) chemist in its area with whom the NHS Commissioning Board (NHSCB) has made arrangements for the provision of any local pharmaceutical services*
> - *Local Healthwatch organisation*
> - *NHS trust or NHS foundation trust*
> - *The NHSCB*
> - *Neighbouring HWBs*

Note: The NHSCB has subsequently been rebranded as NHS England.

The Regulations also stipulate that these people and organisations must be invited to comment on a draft of the proposed PNA at least once, during the process of preparing the final assessment. The draft copy has to be issued in electronic form, but, if anyone requests a hard copy, this must be provided, free of charge, as soon as possible, and, at the latest, within 14 days.

As well as the information requirements it is also the responsibility of the HWB to produce, publish and maintain maps which detail premises at which pharmaceutical services are provided in their area.

Publication

As mentioned the Regulations state that HWBs

- Are required to publish their first PNA by 1 April 2015.

- And publish a revised assessment within three years of the first assessment.

If the HWB identifies a significant change to the availability of pharmaceutical services since the publication of its PNA, then it will be required to publish a revised assessment as soon as is reasonably practical.

However, if the HWB is satisfied that making a revised assessment would be a disproportionate response to those changes then it can, instead, issue a Supplementary Statement to its PNA detailing the changes which have occurred and specifying their decision that this change did not warrant a full revision of the PNA.

Supplementary statements are a statement of fact which cover information about availability of services (not needs). Once issued a Supplementary Statement becomes a part of the PNA.

Consultation

The consultation took place for a period of 60 days, from 6 October 2014 to 4 December 2014. .

A formal letter from Cllr Sue Woolley (Chair of the Health and Wellbeing Board) was emailed to all relevant parties, as listed in the regulations. The letter directed the reader to the Health and Wellbeing Board (HWB) webpage, where they could access the draft PNA, and invited responses to a web-based on line "SNAP" survey.

We extended this invitation to additional people, who were deemed appropriate for consultation, because they:

- have contact with/ know their communities;
- have experience of pharmaceutical services, and may have ideas about how to improve services for residents; or
- have a job for which the PNA is relevant.

It was hoped that the invitation would elicit a good response to the draft PNA, but, as further encouragement, a few days after the email was sent, a hard copy letter was posted to more than 250 persons, as a reminder to complete the survey. This was felt to be an important back-up to the emailed correspondence, as it is known that some people prefer to receive written letters, rather than digital communications.

Similarly, to ensure that the draft PNA was accessible to all, it was also published on the HWB webpage in an Easy Read format. This format is written in plain English, and is designed to be jargon-free and easy to understand. It is not intended to be solely for the benefit of people with disabilities.

Representation

Due to the legal framework of this survey, personal information (such as gender or age) was not captured from individual respondents.

It was recognised that responses would be submitted from a wide range of professionals, on behalf of various organisations, including the Local Pharmaceutical Committee (LPC) and Local Medical Committee (LMC). However, comments were also welcomed from any individuals who thought they could make a valuable contribution to the consultation.

Whilst the views and comments of Lincolnshire residents are outside the scope of the PNA, this is not to discount their potential value. The HWB feels very strongly that the ethos of the PNA ought to encompass resident's views and the decision taken below, to invite Healthwatch on to the PNA Steering Group, will ensure that in future this is achieved.

During July 2014, Healthwatch published a questionnaire that targeted people using pharmacy services. The final PNA recommends that Healthwatch are invited on to the PNA steering group to build on the findings, and subsequent recommendations, resulting from their Pharmacy Questionnaire.

Reporting Information

Consultation responses:

Type of response	Number of responses
Electronic	13
Hard Copy	5
Other	1

Organisation:

	Organisation Name
1	Lincolnshire Community Health Services NHS Trust
2	NHS England
3	North Lincolnshire Health and Wellbeing Board
4	Healthwatch Lincolnshire
5	The Co-operative Pharmacy
6	Boots UK Ltd
7	Lincolnshire Local Medical Committee

8	Westlee Ltd T/a Medicines Plus Pharmacy
9	Brant Road Surgery
10	Local Medical Committee
11	Lincolnshire Local Pharmaceutical Committee
12	Named individual response
13	Health Scrutiny Committee for Lincolnshire
14	East Lindsey District Council
15	South Lincolnshire CCG
16	The New Springwells Practice
17	Billinghay Medical Practice

Analysis of Themes

The analysis is in two parts. The first is from responses to the SNAP survey, and the second is from the formal written responses. The former were mostly responses from individuals, whilst most of the latter were submitted on behalf of an organisation.

All responses were taken into account in the analysis, and neither type of submission was regarded more favourably than the other by the steering group.

Consultation Questions SNAP Survey

There were 13 responses to the SNAP survey, of which 9 were individual responses.

The tables below show the response percentages for individual questions.

Any comments obtained from the SNAP survey were themed, together with the formal written responses, and brought to the attention of the PNA steering group.

Q6 Are there any other needs which may impact on pharmaceutical services that have not been considered?

Yes	***No***	***Total***
7	6	13
54%	46%	100 %

Q8 In reviewing the maps of pharmaceutical provision in Lincolnshire, do you agree with the conclusion that there is adequate provision?

Yes	No	Total
9	4	13
69%	31%	100 %

Q10 In reviewing the maps of the provision of the New Medicines Service (NMS) and Medicine Use Reviews (MURs) in Lincolnshire, do you agree with the conclusion that there are gaps in provision?

Yes	No	Total
8	5	13
62%	38%	100 %

Q12 Do you agree with the recommendations made in the PNA?

Yes	No	Total
8	4	12
67%	33%	100 %

Qualification

Due to a technical error during the creation of the SNAP survey, Questions 8, 10 and 12 were incorrectly routed, so that ticking the "no" box removed the option to explain why you disagreed with the question.

Professional advice was sought, and after careful consideration of how the effects of the error impacted on the overall responses to the questionnaire, it was decided that a new survey should not be conducted, due to the time constraints imposed by the NHS Regulations.

However, all the survey responses were examined thoroughly, and it transpired that only a few respondents (two) had ticked the "no" box. These respondents were contacted by email with an apology, and given the opportunity to complete a revised questionnaire, which would allow their comments to be included.

Themes

Each written comment in response to the survey and the formal written responses were read and considered by the PNA steering group. Any common themes were noted, and the responses were sorted into groups accordingly.

The themes were then discussed at length by the PNA steering group.

Some of the most frequently mentioned themes have been set out in the table below, together with details of any consequent actions. The table does not include every response submitted, but it does not mean any response was given greater consideration over another by the steering group.

Note: A sample list of responses can be found in Appendix A, however if you wish to see a copy of all the anonymised responses the will be available on the HWB webpage.

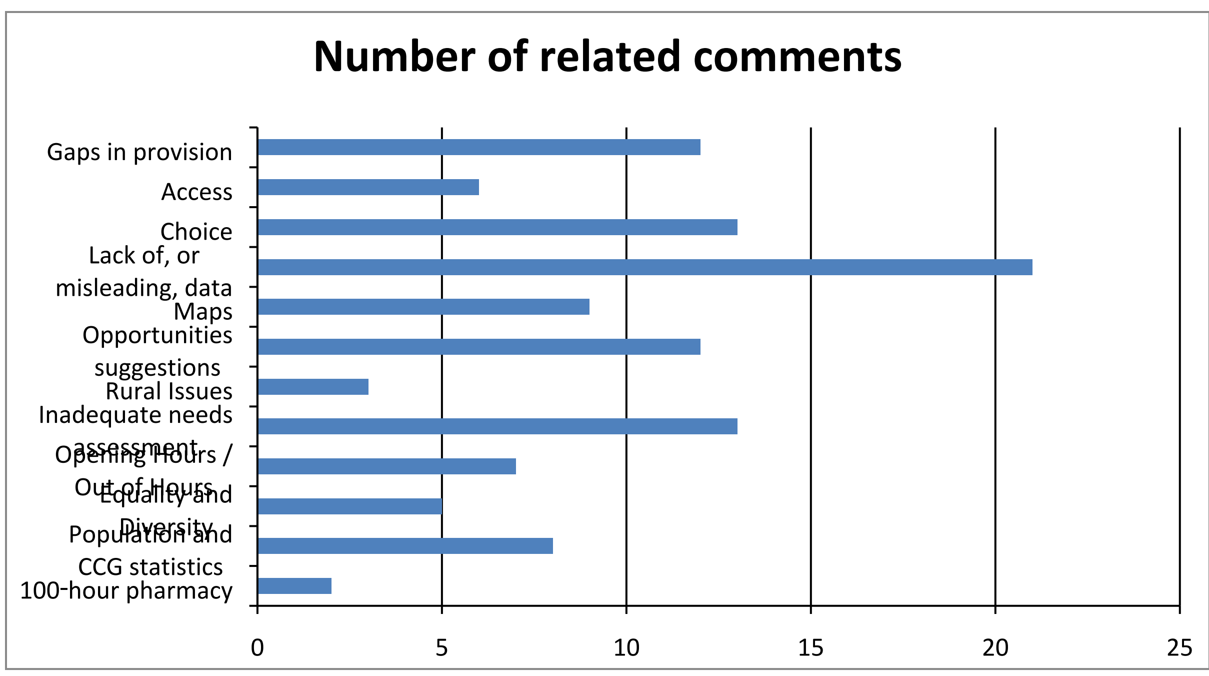

Figure 1: Table to illustrate popularity of themes

Top 5 themes in terms of popularity (numbers of comments associated with the theme):

1. **Misleading information data = 22 comments**

The steering group accepted and welcomed the volume of comments under this theme, with a view that all comments would allow the steering group to clarify and

cross-check the information within the draft document. Not all comments were directly related to incorrect data, some comments referred to unclear statements within the PNA and changes in regulations which had occurred post first the PNA draft publication.

Examples of feedback:

- Accuracy of data (Volume of Prescriptions);
- Lack of referencing;
- "Extended hours" lack of explanation.

Action taken: Every comment has been reviewed by the steering group. Data has since been clarified, unclear chapters have been re-worded and explanations have been added, where needed.

2. Opportunities = 12 comments

This consultation opened the debate for future ways of working with examples such as:

- Better use of community pharmacy to free up the pressure on A&E;
- Developing innovative solutions to enable better access to essential services;
- Aligning pharmacy provision to the LHAC neighbourhood teams.

The steering group noted all of these opportunities.

3. Gaps = 12 comments

The main bulk of the comments in this theme relate to the conclusion and recommendations. The steering group welcomed the comments and after debate have reworded the content.

The steering group have made a commitment to continuously review the PNA. It will ensure that it is up to date and that any supplementary statements are produced and published, whilst ensuring that the legal requirements for the PNAs are met.

4. Choice = 12 comments

In general most of the comments under this theme were positive, for example:

- Respondents welcome and applaud the stance to support patient choice
- Support the principle of patient choice including extending it further to electronic prescribing

However it needs to be noted that some concerns were raised within the responses for example:

- Some *"GP practices often rely heavily on the income generated from the pharmacy service"*
- Actively encouraging patients to move away from dispensing practices will destabilise these practices, particularly in rural areas.

The PNA Steering Group is supportive of patients exercising their right to choose where they access their pharmaceutical services. As stated above, the PNA steering group will continue to meet and proactively assess these comments for future reference.

5. Inadequate Needs Assessment = 12 comments

Within a number of comments it was apparent that there were concerns regarding the standard of the PNA, these concerns related to:

- Detail
- Lack of depth

However, in response to this, the PNA was created to the scope of the National Regulations which do not require PNA’s to cover the entirety of pharmaceutical services provided by dispensing practices or community pharmacies.

Comments

The PNA consultation had effective reach and it is noted with regret that responses were low to this important assessment. However, this does not negate the importance of the very careful and considered responses received from partners. The PNA Steering Group has considered all these responses and made changes to the document appropriately.

The group is mindful of its continuing duties to the residents of Lincolnshire to monitor and review change in the pharmacy sector locally and will update the document accordingly going forwards. As an aid to this process, Healthwatch will be asked to formally join the PNA Steering Group, so any further work can continue to be firmly grounded in local residents' views.

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Appendix A – Detailed Sample of Responses

Theme	Number of related comments	Sample Comments	Action
100-hour pharmacy	2	"Explanation of the term '100-hour pharmacy' to accompany the map showing the location of these pharmacies."	This has been included on the updated version of the PNA.
Population and CCG statistics	8	"A lot of the data is presented at CCG or local authority level, and there will be differences within these areas, such as in disease prevalence."	Please refer to the determinations of localities (1.2.1) in the PNA, for the rationale.
Equality and Diversity	5	"We do not see any reference in the background information to young carers and carers, and wonder if it would be helpful to consider any specific needs faced by these groups in accessing pharmaceutical services."	Young carers and carers are not defined in the Equalities Duty Act 2010, and therefore fall out of the scope of this PNA. This does not mean they are not important.
Opening Hours / Out of Hours	7	"Concerned about the existing lack of service provision in the coastal towns, particularly on Sundays. The lack of Sunday opening in the coastal resorts during the summer season seems to be poor, given the seven-day economy, combined with the higher level of need from the expanded population".	There is no evidence to suggest there is under-provision. The steering group have noted that there is no Sunday opening.

Theme	Number of related comments	Sample Comments	Action
Inadequate needs assessment	13	"Pharmaceutical services are not merely opening hours and a selection of advanced services. They encompass a broad range of services to meet the health needs of an accurately described community, from emergency contraception to smoking cessation and drug misuse. The omission of these aspects of provision calls into question the validity of this document as a PNA."	The steering group have made a commitment to continuously review the PNA in order to ensure that is up to date and that any supplementary statements are produced and published, whilst ensuring that the legal requirements for the PNAs are met.
Rural Issues	3	"Whilst we have stated, 'yes', as there does appear to be a reasonable provision across the county, there are some areas of the county (e.g. East) where coverage is not as robust. This is an area of the county that, due to its rural nature and older population, would benefit from additional provision, should opportunity allow."	The PNA steering group will continue to meet on a regular basis, (bi-monthly) and will review opportunities presented to them that improve the provision for the rural residents of Lincolnshire.
Opportunities suggestions	12	"By reviewing what actually takes place within General Practice and what is intended within the LHAC Neighbourhood Teams which will impact on Pharmacy provision."	The steering group noted all of these opportunities.

Theme	Number of related comments	Sample Comments	Action
Maps	9	"The Committee requests that the document presents the information on population densities."	This was actioned and completed.
Lack of, or misleading, data	21	"Osteoporosis: the statement of this service is unsubstantiated. Treatment and diagnosis of this condition requires medical intervention and diagnostic testing, and is part of the 'core' PMS/GMS services."	This statement was removed.
Choice	13	"Electronic Prescribing: The PNA should support patient choice by emphasising that this will extend the choice of patients to arrange for medications to be collected from a pharmacy away from home (perhaps near a place of work) even if this lies outside the county."	The PNA steering group is supportive of patients exercising their right to choose, but also understands this may affect service stability. Any changes will be monitored and measured by the steering group on a continuous basis.
Access	6	"Little attempt appears to have been made to assess access to pharmaceutical provision. The map on p29 shows the location of pharmacies and dispensing GPs but there are no assessments of distance or time needed to access pharmaceutical services".	The PNA steering group accept that there is no assessment of distance or time; this was not a requirement within the scope of the PNA. There is no national definition for 'travel' time.

Theme	Number of related comments	Sample Comments	Action
Gaps in provision	12	"There appears to be gaps, but many of these geographical areas will be served by dispensing practices rather than community pharmacy."	The steering group have made a commitment to continuously review the PNA. It will ensure that it is up to date and that any supplementary statements are produced and published, whilst ensuring that the legal requirements for the PNAs are met.

Overall, 12 themes were identified from the responses to the survey. In addition, 35 other points were raised, which the PNA steering group is addressing.

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Agenda Item 6b

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of Lincolnshire East Clinical Commissioning Group

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**24 March 2015**
Subject:	**Lincolnshire East Clinical Commissioning Group (LECCG) 2015/16 'Plan on a Page'**

Summary: As part of NHS governance, all NHS Clinical Commissioning Groups (CCGs) must produce an annual rolling programme; the LECCG Operational Plan for 2014/15 and 2015/16 was presented to the Lincolnshire Health and Wellbeing Board on 25 March 2014 and approved. Additionally The draft 5 Year Strategic Plan was presented, and discussed, at the December 2014 meeting.

The *Forward View* Into Action: Planning for 2015/16 (December 2014 NHS England Publications Gateway Number: 02768) sets out the specific planning requirements for CCGs. This document describes the approach for national and local organisations to make a start in 2015/16 towards fulfilling the vision set out in the NHS *Five Year Forward View*, whilst at the same time delivering the high quality, timely care that the people of England expect today.

For this planning round NHS organisations were asked to refresh their operational plans for 2015/16 only utilising the 'Plan on a Page' format with separate supporting narrative.

The purpose of this paper is to assure the Board that the JHWS continues to be supported by the refreshed LECCG plan and to request the Board to formally support the plan.

Actions Required: To formally support the LECCG 2015/16 'Plan on a Page'.

1. Background

The NHS Five Year Forward View was published on 23 October 2014 and sets out a vision for the future of the NHS. It has been developed by the partner organisations that deliver and oversee health and care services including NHS England, Public Health England, Monitor, Health Education England, the Care Quality Commission and the NHS Trust Development Authority. Patient groups, clinicians and independent experts have also provided their advice to create a collective view of how the health service needs to change over the next five years if it is to close the widening gaps in the health of the population, quality of care and the funding of services.

The purpose of the Five Year Forward View is to articulate why change is needed, what that change might look like and how it can be achieved. This will only be possible if NHS funding and efficiency both increase. The view outlines seven models for service provision, which NHS England want local areas to choose from, and actions that need to be taken on four fronts:

- More needs to be done to tackle the root causes of ill health, including action on obesity, alcohol and other major health risks
- A commitment to giving patients more control of their own care, including the option of combining health and social care, and new support for carers and volunteers
- The NHS must change to meet the needs of a population that lives longer. This means removing the boundaries between family doctors and hospitals, between physical and mental health and between health and social care. New models of care are set out, built around the needs of patients
- Actions need to be taken to develop and deliver the new models of care, including greater alignment between the national NHS bodies to provide meaningful local flexibility in the way that payment, rules and regulatory requirements are applied. It proposes more investment in workforce, technology and innovation

Under the proposals, more than half of England should be covered by new models of providing care, such as hospitals running GP practices and GP groups taking over hospitals. There will be no 'one size fits all' approach. New forms of providing and contracting services will be essential for the NHS to be sustainable in future.

The view wants areas to consider adopting one of two leading types of new organisational model.

1. A 'primary and acute care system' (PACS) - this will involve successful foundation trusts delivering GP services with patient lists. It is particularly suited to deprived areas where general practice is under strain
2. A 'multispecialty community provider' (MCP) – this will involve GP practices coming together either as federations or single organisations, and beginning to deliver community, social and potentially acute care services

In order to help move rapidly to new models of care, the next five years could see large scale sell-offs of unused NHS property. For instance, it is estimated that foundation trusts have around £7.5bn worth of unused NHS buildings across England. It also supports a modern workforce, stating that the innovative new care models that NHS England proposes "simply won't become a reality" unless the NHS has a workforce with the right numbers, skills, values and behaviours to deliver it. Emphasis is given to the NHS becoming a better employer, by supporting the health and wellbeing of frontline staff; providing safe, inclusive and non-discriminatory opportunities; supporting employees to raise concerns, and ensuring managers quickly act on them.

The *Forward View* Into Action: Planning for 2015/16 sets out the specific planning requirements for CCGs. This document describes the approach for national and local organisations to make a start in 2015/16 towards fulfilling the vision set out in the NHS *Five Year Forward View*, whilst at the same time delivering the high quality, timely care that the people of England expect today.

For this planning round NHS organisations were asked to refresh their operational plans for 2015/16 only utilising the 'Plan on a Page' format with separate supporting narrative.

2. Conclusion

Key priorities for the refreshed 'Plan on a Page' are detailed in The *Forward View* Into Action: Planning for 2015/16.

3. Consultation

Consultation is undertaken by LECCG in concert with appropriate stakeholders utilising different approaches with a clear link to LHAC. The priorities of LECCG are clearly

aligned to the expectations and requirements as set out by NHS England in the aforementioned documents

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	LECCG Plan on A Page 2015/16 v4 (12 February 2015)

5. Background Papers

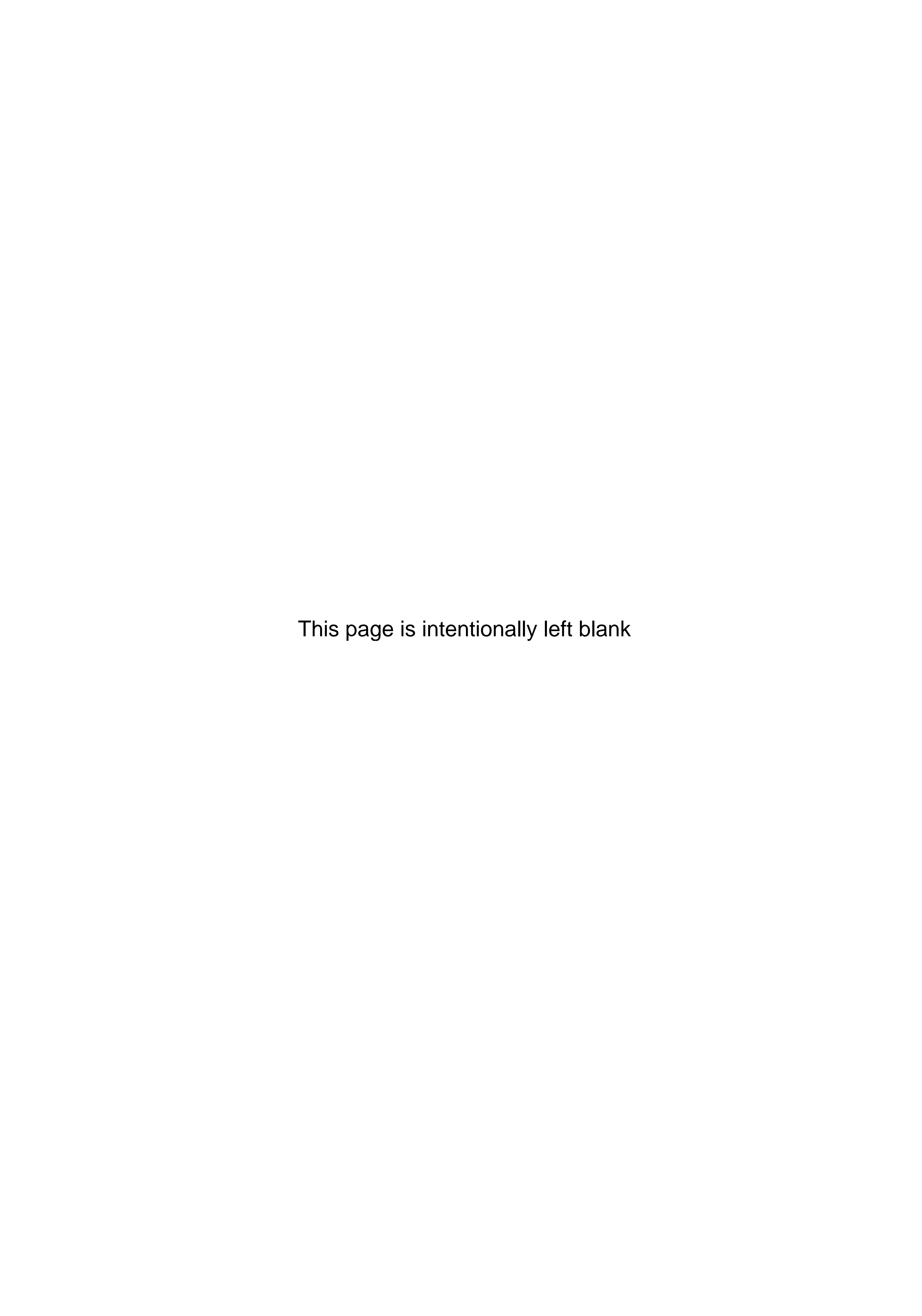
No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

The links to the documents referred to are detailed below:

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

http://www.england.nhs.uk/wp-content/uploads/2014/12/forward-view-plning.pdf

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



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Lincolnshire East CCG version 4 as at 12th February 2015 **2015/16 operational plan on a page Appendix A**

Three key areas of focus for the 2015/16 operational plan

1. Quality and safety first. Working together in partnership and empowering patients and public to take part in planning services
2. Designing and implementing sustainable services for people of East Lincolnshire
3. Developing local services which are integrated and with a clear focus on prevention and self-management

Access

Meeting the NHS Constitution standards and Mandate commitments:

A&E 4 hour waits – Current performance is 96% and we will work on site specific challenges. SRG is coordinating system wide projects that manage demand, activity and flow. CCG schemes focus on a Community MDT In-Reach service based at the front door of Pilgrim A&E, Rapid Response and ILT. Develop and implement Integrated Urgent Care Centres, in Louth and Skegness as part of LHAC.

Winter resilience – improve overall system resilience on proven SRG schemes with ability to flex in periods of high demand (e.g. Rapid Response, Assertive In-Reach, 7 days services –Therapies, Pharmacy). This will be overseen by SRG.

RTT– Additional capacity commissioned with alternative providers to sustain reduction in backlogs and achieve RTT standards. Focus on Choice. Current under performance admitted 85.4% forecast 90%, non-admitted 94% forecast 95%.

Cancer waiting times – Implementation of outcomes from the cancer summit with key priorities for 2015/16 being the redesign of the breast cancer pathway and optimisation of lower GI, dermatology and urology pathways. Current performance is below for 2ww and 62 day wait, additional capacity being commissioned.

Diagnostics– continue to increase provision, promote and utilise AQP contracts.

IAPT – Continue to achieve national standard and new waiting targets and work with local provider to ensure equity of delivery of the standards across LECCG.

Dementia – Continued development of and implementation of dementia pathway. We will increase diagnostic rates utilising best practice guidance and review of disease registers; we will use CANTAB tool and increased identification and care planning in care homes.

Early intervention – MECC is embedded within contacts. Focus on long term conditions e.g. pre diabetes register and development of proactive care (neighbourhood teams).

Primary Care – Maximise the quality of primary care across all domains with particular focus on the management of long term conditions and investment in case management of >75s which links to A&E activity and admission avoidance. Exploring new models for delivering Primary Care.

Outcomes

Delivery across the five domains and seven outcome measures – The CCG will continue focus on PYLL. Public Health will publish report on major disease groups in 2015 and we will develop schemes in response.

Improving health – We will through the two locality level HWB ensure a targeted approach to improving health and recognition of local health issues. The CCG will work with Local Authority Public Health to identify and address short/medium/long term actions for addressing the main causes of mortality in the CCG, focusing on those actions in A Call to Action: Commissioning for Prevention. For 2015/16 joint work will be undertaken to address the issues of social isolation in rural areas eg TED (Talk, Eat, Drink).

Reducing health inequalities – The CCG will work with Public Health to ensure that the five most cost effective high impact interventions on health inequalities are implemented. Continue partnership working with Public Health will aim to reduce inequalities and major diseases (i.e. cancer and CVD) through locality projects such as e.g. Connecting Communities, NHS Health Check Programme, Smoking cessation and weight management services and implementation of the CCGs Long Term conditions work programme. For 2015/16 joint work being undertaken with Public Health to analyse and understand the needs of caravan dwellers/ temporary residents as a key demographic. The new Wellbeing service will be rolled out to ensure vulnerable people are better supported in their own homes.

Parity of esteem - Our commissioning and contracting approaches for Mental Health, Learning Disability and Autism Services will become more outcome focused with Parity of Esteem being a key priority and cross cutting theme. This will include better access to care as well as an increased focus on early intervention and prevention. Delivery of the new national access standards for Mental Health, CAMHS Tier 3+, the Crisis Care Action Plan, further progress in relation to the Transforming Care agenda and an increase in the uptake of Health Checks and Health Action Plans for vulnerable people are priority areas for 2015-16.

Quality

Patient safety - The CCG has a robust system for monitoring and driving improvement in patient safety. The CCG as an organisation has signed up to the 'sign up to safety' campaign. We will ensure that organisations measure and report against a range of patient safety indicators, including harm free care, and serious incident monitoring and reporting. Primary care are encouraged to report through these same mechanisms to ensure system wide learning and development are achieved. The Lincolnshire wide prescribing forum brings together primary and secondary care to drive improvements across the system e.g. antibiotic prescribing and Cdif rate to achieve the target trajectories.

Patient experience – We will monitor against the nationally mandated components of the NHS constitution. Additionally the CCG will drive improvements in patient experience through an active programme. The CCG will use its continuous listening model, to hear the patient voice. We will use our patient council to drive improvements in the quality of patient experience.

Compassion in practice – We will monitor the implementation of compassion in practice, with oversight provided through the Lincolnshire quality forum. This enables integration of the strategy and a common approach in both provider and commissioning organisations. The agreed priorities include leadership, the culture of care and development of core values and behaviours.

Safeguarding – We will implement the strategy the core themes being governance, education and training, monitoring and disseminating learning, and this will strengthen processes to ensure effective partnership working. The key priority is on ensuring the protection of vulnerable people, and setting quality improvement.

Staff satisfaction- We will continue to implement the national CQUIN requirements in relation to the staff friends and family test. This will be monitored through quality monitoring and benchmarking tools. We will increase our focus on provider plans with the implementation of workforce safety metrics and a cultural barometer.

Seven day services - The CCG will continue to work on the delivery of seven day services, working with providers to implement 5 of the clinical standards.

Response to Francis, Berwick and Winterbourne View – We will continue to drive and embed improvements in safe and compassionate care to reflect the learning from these reports. The Duty of candour is embedded within provider quality schedules and monitored as part of the incident reporting and learning process. The Transforming care programme will focus on prioritising care and treatment reviews for patients, and learning from this process will be used to facilitate discharge to the most appropriate setting.

Reconfiguration – We will drive reconfiguration to develop high quality sustainable services where the evidence demonstrates added value.

Delivering value

Financial resilience; delivering VFM for taxpayers and patients and procurement – plan is compliant with all aspects of 5 year forward view.

- Financial plan delivers 1% surplus, £3,298k in 2015/16.
- The CCG's underlying surplus in 2015/16 is planned to be 2.1%, £6,995k.
- Business cases submitted to access drawdown to support transformation of out of hospital care to support integration – £751k
- Planned investment in mental health in accordance with parity of esteem expectations
- 0.5% contingency held to mitigate against unforeseen financial pressures.
- Activity commissioned sufficient to meet population growth c1.27%
- Financial plan sets out the transfer of funds to the Better Care Fund). This will be a key for driving efficiencies and integration.

Transformation programmes, reconfiguration plans and reprocurement

Continued support and implementation of Lincolnshire Health and Care
Development of five Neighbourhood Teams (across health and social care)
Procurement of Integrated Diabetes pathway
Implementation of new community ENT service
Implementation of care home support team
Development of frailty pathway as part of the Long Term Conditions Strategy
Supporting patients Self Care through web app and patient education guides
Procurement of enhanced model of care at Louth Community Hospital
Procurement of countywide Intermediate Care (across health and social care)
Review and develop neurological pathways
Procurement of community support in development of Dementia services

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LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of NHS South Lincolnshire CCG

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**24 March 2015**
Subject:	**SLCCG Operational Plan for 2015/16**

Summary:

SLCCG have a two year operational plan (2014/15 to 2015/16) that was agreed to meet JSNA /JHWS in March 2014.

Recently the CCG have reviewed the plan and where required refreshed actions in line with local needs and national guidance as set out in "Supplementary Information for Commissioner Planning 2015/16." Annex A of this guidance has been completed and submitted to NHSE along with a draft review of the two year plan.

Both these documents are attached.

Actions Required:
Confirmation that SLCCG plans meet the needs / outcomes of JSNA / JHWS

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 asked 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.

SLCCG produced, with partners, a two year operational plan that works towards the LHAC five year strategy and where appropriate, have accelerated the implementation of integrated working. The Strategic plan supports all national frameworks and strategies including the Five Year Forward View, NHS Outcomes Framework, The Mandate and Everyone Counts, planning for patients 2014/5 to 2018/19 and takes into account identified financial constraints.

The CCG has reviewed the two year plans and where appropriate refreshed plans to meet local needs, improve areas of poor performance and ensure alignment to the Five Year Forward View and related documents published in 2014.

Appendix B details progress of plans, delivered services, performance and actions put in place to address areas of poor performance.

Appendix A builds on actions and focuses on plans to deliver the fundamental elements of the operational plan.

Appendix C lists the H&WB plans within the Two Year Operational Plan

Full Strategic Operational Plan and related documents are on the SLCCG website. http://www.southlincolnshireccg.nhs.uk/

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 LHAC, 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.

LHAC builds on current initiatives that the CCG is undertaking, such as Neighbourhood Teams, Assertive In reach Teams, 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. Neighbourhood / Integrated teams will ensure we are well placed to meet the requirements for performance improvement against the BCF national targets and our locally selected target.

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.

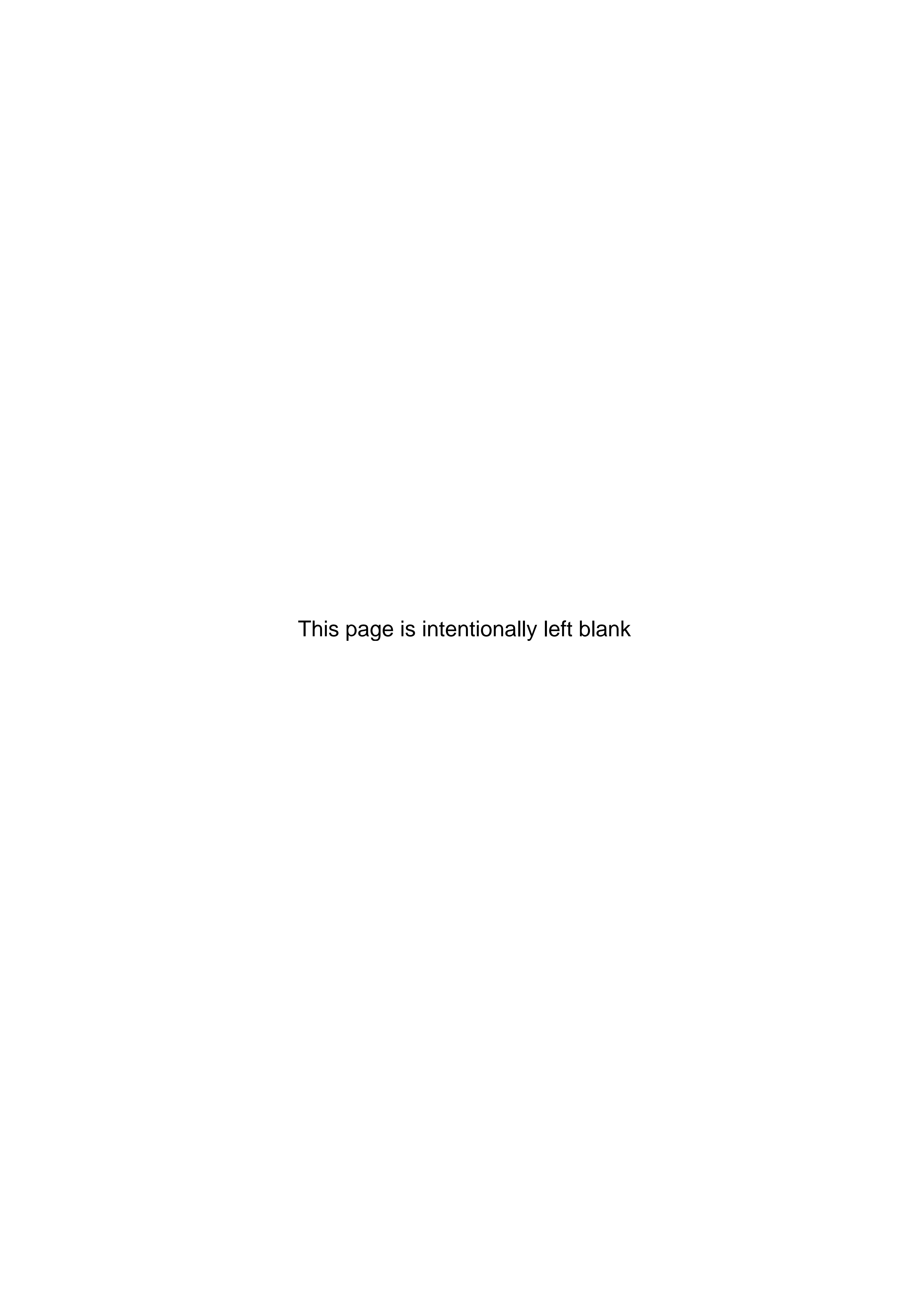
4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Fundamental Elements of Operational Plan
Appendix B	One year review of commissioning plans
Appendix C	H&WB services planned and commissioned
Appendix D	South Lincolnshire CCG 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 Cumba Balding who can be contacted on 01522 573939 or cumba.balding@southlincolnshireccg.nhs.uk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Appendix A – Fundamental Elements of Operational Plan

Fundamental	Key Features to be demonstrated in plans	Page in Operational Plan to evidence and additions
	Outcomes	
Delivery across the five domains and seven outcome measures	• Your understanding of your current position on outcomes as set out in the NHS Outcomes Framework • The actions you need to take to improve outcomes	Page 45-48 of Operational Plan (Appendix 10). In addition: The CCG are fully aware of their position against the domains set out in the NHS Outcomes Framework. Performance is reported to the Governing Body on a monthly basis via a performance report. To review the most up to date performance please follow the below link: http://southlincolnshireccg.nhs.uk/key-documents/cat_view/14-key-documents/16-governing-body-meetings Key actions which the CCG are working on for the Outcomes Framework are highlighted in the One Year Review – page 16 & 17 (Appendix 6).
Improving health	• Working with HWB partners, your planned outcomes from taking the five steps recommended in the commissioning for prevention report	Page 25 (Operational Plan Appendix 10) – Lincolnshire Health and Wellbeing Strategy. In addition to this: The CCG has chosen to focus on Cardio Vascular Disease in terms of commissioning for prevention. This is the disease area which makes the greatest contribution to the CCG's Potential Years of Life Lost and Under 75 mortality rates. In terms of the steps highlighted in the Commissioning for Prevention Call to Action, the CCG is working towards the mature scenario outlined and in some specific areas, is operating at that level. The CCG has continued with the local priority measure to reduce the Under 75 mortality rate to the England level or below. In 2013/14 the standard for South Lincolnshire CCG for CVD mortality rates was 73.2 DSR per 100,000. During that year

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		the CCG reduced to 66.80. In 2013, the South Lincolnshire U75 mortality rate from Cardio Vascular Disease (DSR) standard was 73.2/100,000 registered patients. The CCG achieved 66.8. Analysis of data locally and through the East Midlands Cardio Vascular Disease Strategic Clinical Network has identified a number of areas where specific initiatives such as the GRASP AF tool and the IMPAKT Chronic Kidney Disease tool has been implemented to provide an opportunity to contribute significantly to this priority and these are in the process of being implemented.
Reducing health inequalities	• Identification of the groups if people in your area that have a worse outcomes and experience of care, and your plans to close the gap	Page 24 of Operational Plan (Appendix 10)- JSNA, Demographics and Public Health needs – Improving Health and Reducing Health Inequalities. For full details on trajectories see page 24 onwards of this document. In line with recent guidance released by NHS England and the Collation for collaborative care 'Personalised Care and Support Planning Handbook: The Journey to Person-Centred Care' the CCG's Engagement Manager will be working with the wider Quality team within the CCG to develop a programme of work ensuring that personalised care planning is embedded both within the CCG and each practice sitting within the CCG. In addition to this: The CCG has carried out extensive engagement work, working in partnership with local employers with high proportion of A8 employees – see page 7 of the One Year Review (Appendix 6). We have introduced a CQUIN scheme with Peterborough and Stamford Hospitals to enhance the system of transition for adolescents (12-18 years) who are moving from Children's to Adult Services.

		Working with pre diabetics; those with type 1/2 and their families/carers within the South Lincolnshire area, to support with education and interactive skills to better self-manage and reduce hospital admissions. Educational programme running throughout 15/15 – page 7 of One Year Review (Appendix 6). We are working with people with dementia and their families to develop a programme of awareness raising, to support early diagnosis. Working with local GP Practices SLCCG are working towards the introduction of the CANTAB mobile app – Page 14 & 15 of One Year Review (Appendix 6). In addition various members of the CCG have attended the Dementia Friends course. For Dementia trajectories see appendix 2.
	• Implementation of the five most cost effective high impact interventions recommended by the NAO report on health inequalities	In addition to this: The 5 most cost-effective high impact interventions identified by the NAO report on health inequalities are: -Increased prescribing of drugs to control blood pressure; - Increased prescribing of drugs to reduce cholesterol; - Increase smoking cessation services; - Increased anticoagulant therapy in atrial fibrillation; - Improved blood sugar control in diabetes; There are 2 elements to these high impact interventions – finding patients; and optimising the management of those patients for whom these interventions are appropriate. All practices within the CCG are providers of NHS Health Checks which provides a means of identifying previously undiagnosed patients with or at increased risk of CVD, diabetes and CKD. In Lincolnshire, the NHS Health Checks process has been augmented to also identify

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		patients with AF. NHS Health Checks makes a significant contribution to identifying new patients and therefore to increasing prescribing and disease management in these areas. In common with the majority of other CCGs, there are variations in disease management across practices within the CCG and work is ongoing to identify these and to benchmark practice with peers. The immediate focus for the CCG is cardiovascular disease and chronic kidney disease. This will be completed by April 16. Increasing anticoagulant therapy for AF is going to be a specific focus for the CCG through the implementation of the GRASP AF tool, the training for which has already been rolled out to the majority of practices. The impact of this should be reflected in an increase in the proportion of AF patients receiving this intervention and a reduction in acute admissions for stroke associated with diagnosed and undiagnosed AF. The Local Authority will be working closely with practices to improve data recording in relation to smokers and the proportion of those who are referred or decline referral to stop smoking services. Public Health is currently in the process of identifying someone to undertake the audit.
	• Implementing EDS2	Page 21 of Operational Plan (Appendix 10). In addition to this: In recognition of the benefits that equality can offer, we have adopted the NHS equality standard called the Equality Delivery System (EDS). The EDS is a tool that assists the integration of equality as well as ensuring that commissioning plans meet the legal requirements under the Equality Act 2010. An Equality Delivery System Governance Group has been set up and continues to grow and support the CCG in driving forward the agenda. The Governance Group is a joint initiative between local NHS organisations and provides a coordinated approach to helping the CCG to understand the barriers to healthcare and

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		good health faced by the people of Lincolnshire. It has a critical role in providing systematic scrutiny and monitoring of the CCGs equality agenda. Furthermore, our association with Healthwatch and the Health and Wellbeing Boards helps us to work in partnership to ensure that our priorities encompass the "bigger picture". Next Step: we will be using the refreshed Equality Delivery System (EDS2) as the base for meeting our moral and legal duties. The Governance Group will continue to play the advisor, scrutiny and support role and will grow and develop as new members join the group to help us to commission excellent services.
	• Examination of how the organisation compares against the first NHS Workforce Race Equality Standard	The CCG is committed to ensure that we and the providers that we commission meet the NHS Workforce Equality Standard. We will do this by ensuring that the NHS Workforce Race Equality Standard is included within the 2015/16 NHS Standard contract and that providers commissioned meet the expected standards. We will also ensure that this is embedded both within the internal contracting process/frameworks within the CCG and also the wider contracting team which is provided by GEM. At present the standard is included within the draft NHS Standard contract. This has not yet been signed off but when it is GEM contracting will monitor this requirement on the CCG's behalf.
Parity of esteem	• The resources you are allocating to mental health to achieve parity of esteem	Page 26 of Operational Plan (Appendix 10). In addition to this discussions are taking place across all four Lincolnshire CCG's to allocate appropriate funding to mental health to achieve parity of esteem it is estimated that this will cost 1.3 million across Lincolnshire. The CCG's plan for Mental Health invests 4.5% in excess of the 2.5% required.

		Liaison services currently offer assessment and treatment advice for the older person only. A new service to replace Hospital Intensive Psychiatric Service (HIPs) and across the three ULHT sites is in development and a specification has been written. Discussions are taking place on how to fund this proposed service going forward. In essence this will embed liaison nurses in A&E, on older adult wards and also allow for a peripatetic team to service the remainder of the inpatient areas. The intermediate care liaison function of the Community Mental Health Team (CMHT) for Older People should also provide awareness and training/education for community health care staff (LCHS). These staff remain in place and are working with the emerging neighbourhood teams as well as rapid response and ILT services. Lincolnshire CCG's and Lincolnshire County Council continue to review provider contracts. Service specifications are also being reviewed and amended as necessary through a programme of review and development in order to ensure parity of esteem. An external review has taken place with regards to ensuring suicide prevention policies and effectively implemented. As a consequence LPFT are revising and introducing a new risk assessment and management process which will improve the current position. The whole Trust will be trained and implement the new process to embed a culture of risk management and improve outcomes.

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	• Identification and support for young people with mental health problems • Plans to reduce the 20 year gap in life expectancy for people with severe mental illness	Page 26-28 of Operational Plan (Appendix 10). In addition to this: For children and young people a new self-harm pathway has been initiated for acute hospital sites, Boston and Lincoln offering specialist nursing assessment, treatment and management 8am – 8pm Monday to Fridays with on call arrangements in place out of hours via crisis resolution and treatment and consultant psychiatry. The CAMHS service is currently being redesigned to address perceived gaps in behavioural management and attachment disorders. A new hub and spoke model is being proposed strengthening the current Primary Mental Health Worker role and access to Tier 3 services. Urgent care is being offered via a new Tier 3+ service to offer urgent community intensive care and support to avoid unnecessary admission to inpatient services and to support earlier return to the community. The STEP service which is for early intervention in psychosis (part of the integrated CMHT) is available to people aged 14 to 35 years. This service is part of the ICMHT and is under review to establish fidelity to the model and delivery of best practice going forward. Ensuring the Care Programme Approach supports people with severe mental health conditions. The lead commissioners have identified this as an area on which to focus to ensure that best practice is carried out and that people receive appropriate follow up and support within specified target timescales. Public Health has undertaken some research and has developed a baseline for Mental Health patients. Lincolnshire West CCG are seeking to introduce a specific pilot on improving wellbeing and

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		physical health in partnership with LPFT and this scheme if it evaluates well will be supported across the county and all four CCG's. The Mental Health Promotion Strategy will be published March 15 which will focus on health promotion and the prevention of mental illness. The JSNA for mental Health has been undertaken and is being strengthened to ensure social as well as health factors are addressed. A commissioning strategy will be published to drive developments forward. It is expected that this will be published in March 15.
	• The planned level of real terms increase in spending on mental health services	There will be an increase in spending for perinatal services this will be roughly 1 million (countywide). There will be no reduction in funding above the efficiencies agreed within the contract. Seeking to reduce usage on out of area treatments/placements to invest in services within Lincolnshire particularly with regards to psychiatric intensive care and acute beds.
Access		
Convenient access for everyone	• How you will deliver good access to the full range of services, including general practice and community services, especially mental health services in a way which is timely, convenient and specifically tailored to minority groups	The CCG has planned to review, localise and integrate services including preventative where appropriate. Additional tools such as My Right Care pathway is to be piloted within Primary Care and other key stakeholders. This will complement the risk tool stratification process, patient care planning and management. The five year forward view suggests different models of integrated working between primary, community, mental health

		and secondary care which the CCG are exploring. The CCG has expressed an interest to have fully delegated co-commissioning with a view to use these models along with the new flexibilities in contracting to deliver good access to services. The CCG has also been one of the first implementer sites (Stamford) for the Neighbourhood Teams as part of the LHAC work. The Neighbourhood Teams will allow access to services and ensure that patients receive the appropriate care and remain out of hospital for as long as possible and care is delivered within the community where appropriate. South Lincolnshire CCG has commissioned a Clinical Assessment Team (CAT) car via EMAS. The car will respond to urgent calls received by the call centre for patients who have fallen but after assessment over the phone do not need hospital admission. The Car is staffed with a paramedic and Emergency Care Assistant who will attend the scene and provide a full assessment. They will also ensure that the patient is taken home or to a place of safety. If hospital attendance is needed the crew will call for an ambulance to convey the patient to hospital. The CCG has also in conjunction with other Lincolnshire CCG's successfully completed the tender for ENT to be provided in the community. Next year we will be looking at providing dermatology in the community and we are also considering an AQP for community CSS (Community Surgical Scheme) to put more CSS services into the community proving better access. We have also increased AQP provision in direct access diagnostics. Further AQP for additional CSS service will continue throughout 15/16. Outreach clinics for chemotherapy have also started in Spalding

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		again giving better access to services for patients. Mental Health: A Triage car is currently in the pilot phase, managed by EMAS the car is staffed by a Mental Health Nurse and a paramedic. The car will respond to all urgent calls which do not require an A&E admission. Early results show good rates of both diversion and outcomes which do not result in use of policy custody or admission to hospital. The Crisis Concordat Declaration has been written and signed up to by the main stakeholders. An action plan to support this is in development and will be published in March 2015. This is a whole community approach to Mental Health Care. CCG's support the Mental Health Partnership Group (MHPG) a stakeholder group which provided feedback and communication regarding service performance, gaps and commissioning plans. The Mental Health Trust is a foundation Trust and engages people through their membership with Patient and Carer Governors. This is supported by engagement teams in Public Health and Adult Social Care. Public Health is developing the service user partnership known as the people's partnership. The advocacy and involvement contract has been separated to procure a new range of advocacy services and new involvement mechanism. The MHPG remains in place. The Learning Disability and Autism partnerships remain in place and are developing the Autism Strategy. STEP psychology is being redesigned to deliver better access and outcomes. Emphasis will be on improving psychological support in the CMHT and targeting psychology at the most complex needs. This will be co-produced with commissioners. A SPA within LCHS is in development to rationalise the SPA across

		the county and improve the ease of referral for Mental Health Services. Choice in Mental Health is now implemented in line with legislation and guidance. Access to a range of services will also be improved via the ongoing work of the Neighbourhood Teams. Any gaps identified with regards to the provision of services will be reviewed by the CCG. The contact Centre is also provided for access to Lincolnshire Community Services, this allows easy access for patients and health care professionals including Primary Care by contacting one number and the referral is taking for the service needed. The CCG has also commissioned via LCHS a Rapid Response Service. This additional service will support the development of the Neighbourhood Teams as the service will function as the unplanned urgent response element to support the wider team. A Complex Case Manager will be 'on call' 7 days we week from 8.00am to 8.00pm, supported by a wider MDT team, covering the South Lincolnshire CCG area. Where hospital admission is likely if no interventions occur then a referral can be made to the service. Referrals will be accepted from: • GP's • LCHS Contact Centre • EMAS • A&E • AIR Team • Social Services • Welland Ward, Johnson Hospital • John Van Geest Unit, Stamford

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	• Plans to improve early diagnosis for cancer and to track one-year cancer survival rates	• Any service/person where a hospital admission can be stopped The CCG commission GEM contracting who take lead on acute contracts for the CCG. The contracting team ensure that all contracts with acute providers ensure good access for patients that require secondary care. The CCG also works closely with acute providers and the contracting team to review the pathways between primary and secondary care to improve access, patient experience and flow. Lincolnshire CCGs along with Public Health colleagues will continue to focus on ***Raising Awareness and Early Diagnosis*** working and working with providers /Area Team to increase capacity for screening and detection for: • **Breast Screening –** Age extension implemented offering screening to 47 to 73 year olds • **Cervical Screening -** Human Papilloma Virus triage (HPV) and Test of Cure • **Bowel Cancer –** Age extension has been increased to men and women age 60 to 75. **Collaboration** We will continue to work with the East Midlands Strategic Clinical Network for cancer and Leicestershire and Lincolnshire Area Team with providers to support the delivery of any new or additional projects that deliver local, regional and national goals, missions and values. Through the developing relationships between organisations the CCGs will seek advice from the East Midlands Network and Clinical Senate where it feels appropriate. Where possible (and practical) existing work streams and strategic boards will lead this work for the Lincolnshire population to maximise our use of resource and avoid

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		duplication/double-counting. As part of agreeing the delivery of the proposed plan local leads and 'champions' will be agreed to deliver the outcomes of the work. As this plan is developed further (to include the detail and required outputs of the 'how') local agreement will be needed to underpin its delivery (via task and finish groups, embedded work stream/operational meetings) with clear actions and roles/responsibilities shared across the communities with a collective agreement for shared learning and continuous improvement as part of a methodical approach, allowing best practice to be measured and shared (where needed). The CCG will track one year cancer survival rates using the Cancer Commissioning Toolkit. Early Presentation of Cancer (EPOC) team are aligning to the Lincolnshire CCGs to provide focused support to multiple stakeholders whilst also attending Cancer Research UK training on raising awareness levels in communities/neighbourhood teams, with a view to a phased roll-out of train the trainer teaching. Further information can be found in the Lincolnshire Clinical Commissioning Groups Development and Delivery Plan 2014-16 in Appendix 5.
Meeting the NHS Constitution Standards	• That your plans include commissioning sufficient services to deliver the NHS Constitution rights and pledges for patients on access to treatment as set out in Annex B and how they will be maintained during busy periods	Page 45-48 of Operational Plan (Appendix 10) & page 21 of One Year Review (Appendix 6). The CCG have submitted plans to ensure that we commission sufficient services to deliver NHS constitutional standards. Some changes have included commissioning additional activity from

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		alternative providers where certain specialties have failed to achieve the 18 weeks standard. Also see activity and finance submission with narrative. The CCG have also commissioned alternative capacity for cancer services to be delivered closer to the patients' homes and also to ease the pressure of those providers that have struggled during 14/15. Commissioned activity levels at acute providers are calculated by considering run rates for the previous 12 months and known step changes that have increased or decreased requirements for the service. Provider capacity is also considered and if not sufficient, discussions will be held to try and increase capacity at the provider. Likewise consideration is given to changes in services being considered, e.g. where a community service has been procured, to take activity out of secondary care and put it in the community, both to increase patient choice and geographic availability. Where activity is commissioned in this way, conversations will be had with secondary care providers, to plan reductions in their activity. Within planning assumptions for 15/16 1.72% population growth has been agreed and for non-elective has been taken off 3.5%. Further information on planning assumptions can be found in appendix 8. We also have the following schemes which have been commissioned to ensure achievement of the NHS Constitution and allows access to services for patients: • AIR's Team • DTOC Team • EMAS CAT car

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	• How you will prepare for an implement new mental health access standards	• EMAS Mental Health Car • Operational Resilience schemes following the additional funding provided by NHS England – detailed in the plan previously submitted to NHS England. The CCG have run various AQP's and a full tender process to deliver services out of secondary care and into the community which will ease pressure on secondary care and will improve access for patients. This will continue during 15/16 on other services where appropriate. For the full details of all the commissioning intentions are in the operational plan: http://southlincolnshireccg.nhs.uk/key-documents In addition to this we continue to implement the commissioning priorities of the CCG which includes more care delivered locally, increase access to diagnostics and appropriate services that can be delivered in the community rather than in an acute setting. For full details of commissioning priorities please see Operational Plan (Appendix 10) and the One Year Review (appendix 6). This will be discussed with the current provider and will be implementing this through the contract. Extensive work has been carried out re IAPT and performance is improving across all areas. Additional funding has been used non-recurrently to address service changes. HSCIC data is now embedded as the performance management information. The service is participating in a capacity and demand exercise to establish what is required for each CCG going forward.

Quality		
Response to Francis, Berwick and Winterbourne View	• How your plans will reflect the key findings of the Francis, Berwick and Winterbourne View Reports – including how your plans will make demonstrable progress in reducing the number of inpatients for people with a learning disability and improve the availability of community services for people with a learning disability	Detailed on page 19 of Operational Plan (Appendix 10).

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Patient Safety	• How you will address the need to understand and measure the harm that can occur in healthcare services, to support the development if capacity and capability in patient safety improvement • How you will increase the reporting of harm to patients, particularly in primary care and focused on learning and improvement • Your plans for tackling sepsis and acute kidney injury • How you will improve antibiotic prescribing in primary and secondary care	Detailed on page 19 of Operational Plan (Appendix 10). Detailed on page 19 of Operational Plan (Appendix 10). In addition to this the CCG encourages all practices to report all incidents and serious incidents will be followed up by Significant Event Analysis investigations and lessons learned will be shared. Similarly practices already report any concerns via a health professional feedback system which allows investigation and improvements to be made where needed and this is captured in a summary report which is sent to all practices. Detailed on page 19 of Operational Plan (Appendix 10). In addition to this the CCG will also ensure that all relevant providers implement the acute kidney injury and sepsis CQUIN's. The Lincolnshire wide prescribing and clinical effectiveness forum (PACEF) will continue to be instrumental in ensuring good practice with regard to prescribing of antibiotics across primary and secondary care. This is facilitated by shared formularies and clinical audit against these across all sectors of the health care community. The CCG commission GEM Prescribing Management Team to support and monitor prescribing within Primary Care and the prescribing of Quinolones has been a local priority within the Quality Premium. This has yielded a reduction in the prescribing of Quinolones.

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Patient Experience	• How you will set measurable ambitions to reduce poor experience of inpatient care and poor experience in general practice	Page 20 of Operational Plan (Appendix 10) and see Unify Planning Submission narrative for: • Patient Experience of Primary Care – GP Out of Hours Service (included within the Quality Premium) • The CCG also have a composite indicator which is comprised of (i) GP Services and (ii) GP Out of Hours. The aim is to reduce negative responses to the GP Patient Survey. • The CCG also have a measure from the NHS Outcomes Framework, Domain 4 which is 'patient experience of hospital care' (reduction in average number of negative responses).
	• How you will assess the quality of care experienced by vulnerable groups of patients and how and where experiences will be improved for those patients	Page 20 of Operational Plan (Appendix 10). In addition to this: The quality schedule requires PSHFT to collect patient experience information from those patients with Learning Disabilities and/or Autism Spectrum Conditions. This is then combined with specific complaints and PALS data and thematic analysis undertaken with an action plan produced to support improvements.
	• How you will demonstrate improvement from FFT complaints and other feedback	Page 20 of Operational Plan (Appendix 10).

	• How you will ensure that all the NHS Constitution patient rights and commitments given to patients are met	Detailed on page 20 of Operational Plan (Appendix 10). In addition to this the NHS Constitutional Rights are monitored by the performance team both through GEM and South Lincolnshire CCG and presented to the Governing Body on a monthly basis in the form of a performance report for scrutiny. These standards are also included within the quality schedule which is reported to Clinical Committee.
	• How you will ensure you meet the recommendations of the Caldicott Review that are relevant to the patient experience	The majority of the recommendations within the Caldicott review will have relevance to the patient experience. It is crucial that we get information sharing right - to improve safety, to lessen the need for patients to have to repeat themselves to different health professionals and to make care more efficient. Further, when undertaking research to find new cures and therapies for diseases it is still vital that we respect people's privacy and put them more in control of how their information is used. This is a fine balance to strike, but an achievable one. As commissioners we will undertake the following: • examine existing arrangements, and lead by example with local partners to make it easier to share information • underpin in contracts that relevant personal confidential data is shared among the registered and regulated health and social care professionals who have a legitimate relationship with the individual • seek advice from the ICO and refer to the HSCIC's Confidentiality Code of Practice for further advice on managing and reporting data breaches • mandate that there should be an explanation and an apology for every personal data breach, with appropriate action agreed to prevent recurrence • clearly explain to patients and the public how the personal information they collect could be used in de-

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		identified form for research, audit, public health and other purposes • make clear what rights the individual has open to them on the CCG website including any ability to actively dissent by publication • use the best practice contained in the HSCIC's Confidentiality Code of Practice when reviewing provider information governance practices to ensure that they adhere to the required standards • encourage partners such as social care that social care providers use the Information Governance Toolkit • review with all providers that they have appointed a Caldicott Guardian or Caldicott lead with access to appropriate training and support • encourage via contracting arrangement with local authorities that they consider extending Caldicott Guardian arrangements to children's services • strengthen leadership on information governance by use of a cross organisational group which shares best practice • ensure that the information provided to inform public about how their information is used does not exclude disadvantaged groups • use the revised Caldicott principles in all relevant information governance material and communications • use the NICE Quality Standard 15 in commissioning and monitoring adult NHS services (in relation to information sharing) • investigate, manage, report and publish personal data breaches and ensure that commissioned bodies are investigated, managed, reported and published appropriately

Compassion in Practice	• How your plans will ensure that local provider plans are delivering against the six action areas of the Compassion in Practice implementation plans • How the 6C's are being rolled out across all staff	Page 20 of Operational Plan (Appendix 10). In addition to this: Providers are monitored against implementation of compassion in practice through strengthened quality schedule indicators which are reviewed at the quality review meetings held quarterly. Oversight provided through the Lincolnshire quality forum which enables integration of the strategy and a common approach in both provider and commissioning organisations. Agreed priorities include leadership, the culture of care and development of core values and behaviours.
Staff Satisfaction	• An in depth understanding of the factors affecting staff satisfaction in the local health economy and how staff satisfaction locally benchmarks against others • How you plans will ensure measurable improvements in staff experience in order to improve patient experience	Page 21 of Operational Plan (Appendix 10). In addition to this: The CCG will continue to implement the National CQUINs requirement in relation to the Staff Friends and Family Test. Alongside this we are monitoring proxy measures of staff satisfaction such as turnover on a regular basis. Improvement in staff FFT will be measured through the quality schedule.
Seven Day Services	• How you will make significant further progress in 2015/16 to implement at least 5 of the 10 clinical standards for seven day working	Page 21 &40 of Operational Plan (Appendix 10). The CCG are working with PSHFT as the main provider. We are actively involved in Peterborough's Seven Day Working Board and the provider is aware of the requirements to address 50% of the standards. The further requirement in year 3 to meet all of the required 10 standards. The CCG are working with the provider and will make every effort to ensure that community providers also implement seven day working to support this.
Safeguarding	• How your plans will meet the requirements of the accountability and assurance framework for protecting vulnerable people	Page 20 & Page 38 of Operational Plan (Appendix 10). In addition: The CCG is represented on Local Safeguarding Boards and the Public Protection Board. A CCG Safeguarding Strategy

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outlines the strategic direction the Clinical Commissioning Groups (CCGs) in Lincolnshire will work towards over the next 3 years. The strategy aims to:

- ensure that CCG statutory duties to protect vulnerable people are met;
- commission services to ensure, first and foremost that children young people and adults at risk of abuse are safe;
- encourage, embed and maintain the best safeguarding practice across Lincolnshire;
- ensure continuous improvement and compliance with national and local policies;
- develop and implement systems for quality monitoring that are robust, auditable and effective;
- ensure effectively contribute to multi-agency approaches such as MAPPA, MARAC, PREVENT and the Multi Agency Safeguarding Hub (MASH);
- ensure learn the lessons and good practice from serious case reviews, domestic homicide reviews, significant incident learning processes, local and national enquiries.

A Safeguarding Steering Group is in place which promotes and assists effective inter-organisation co-operation in order that statutory health bodies operating in Lincolnshire co-operate and discharge their statutory safeguarding responsibilities effectively. Safeguarding key performance indicators are embedded in

		provider quality schedules to which includes section 11 audit and markers of good practice, safeguarding adults assurance framework, incidents and response to MARAC,MAPPA and MCA requests, adherence to domestic abuse legislation, response to national cases i.e. Saville/winterbourne, compliance with the prevent strategy, policies and procedures around case management and safeguarding of vulnerable groups including learning disabilities, roll out of signs of safety. The CCG is working with the local authority to develop a Multi-Agency Safeguarding Hub (MASH).
	• The support for quality improvement in application of the Mental Capacity Act	Page 20 & 38 of Operational Plan (Appendix 10). In addition: The CCGs have contractual levers in place to monitor compliance with MCA and DOLS post Cheshire. Targeted, bespoke support for Middle Management/ Supervisors/ Team Leads/Champions is being commissioned to up-skill front-line staff in delivering good quality supervision regarding the MCA requirements on a day-by-day basis and to identify, equip and build capacity of frontline staff to champion MCA understanding and compliance.
	• How you will measure the requirements set out in your plans in order to meet the standards in the prevent agenda	Page 20&38 of Operational Plan (Appendix 10). In addition: A Lincolnshire PREVENT strategy and Action Plan is in place and monitored via the CCG Safeguarding Steering Group. The CCG is represented on the Regional Prevent Forum and the Lincolnshire Prevent Steering Group which has mandated authority to deliver the new national proposals for PREVENT and ChANNEL. Provider compliance with the national prevent strategy is monitored through the quality review meetings with providers.
Innovation		
Research and Innovation	• How your plans fulfil your statutory responsibilities to support research	Page 23 of Operational Plan (Appendix 10).

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	• How you will use Academic Health Science Networks to promote research • How you will adopt innovative approaches using the delivery agenda set out in Innovation Health and Wealth: accelerating adoption and diffusion in the NHS	Page 23 of Operational Plan (Appendix 10). Page 23 of Operational Plan (Appendix 10).
Delivering Value		
Financial resilience; delivering value for money for taxpayers and patients and procurement	• Meeting the business rules on financial plans including surplus, contingency and non-recurrent expenditure • Clear and credible plans that meet the efficiency challenge and are evidence based, including reference to benchmarks • The clear link between service plans, financial and activity plans	Page 52-57 of Operational Plan (Appendix 10) – In addition: Page 24 - 26 of One Year Review (Appendix 6) Page 52-57 of Operational Plan (Appendix 10) – In addition: Page 24 – 26 of One Year Review (Appendix 6) Page 52-57 of Operational Plan (Appendix 10) – In addition: Page 24 – 26 of One Year Review (Appendix 6).
Other		
Clear trajectories set for reducing health inequalities	• Clear trajectories set for reducing health inequalities (for CCG's with averages below national average this might be a trajectory to reduce the gap between the area and the national average, whereas for those with a better than national average baseline it would be expected for them to be looking at reducing the local gaps between communities	South Lincolnshire CCG have a trajectory for reducing PYLL and Under 75 Mortality Rates and we will be aiming to get back on track with performance. South Lincs CCG have arranged for a meeting to take place week commencing 23rd February 15 with Public Health to review data and set further improvement trajectories. After further data analysis Public Health have identified that CVD

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		makes the largest contribution to PYLL and Under 75 Mortality Rates in terms of diseases which are potentially avoidable. Public Health will analyse data further on Under 75 Mortality and PYLL to identify the most common causes and develop a number of clinical quality reports during 15/16 to explore areas for quality improvement, initially focusing on differences between practice outputs. All GP Practices within the CCG are commissioned to deliver the NHS Health Checks Programme. Data from NHS Health Checks suggests that a majority of patients identified as smokers do not have a record of having been referred to, or having declined referrals to a stop smoking service as part of the Health Check Record. Whilst this may be a data recording issue, for 15/16, South Lincolnshire CCG practices will focus on ensuring that patients who are obese and/or smoke have a record of being referred to, or having declines a referral into an appropriate lifestyle service. The target will be 90%. The CCG are aware of the numbers of premature deaths and these numbers as highlighted by Public Health are very small.
Short Medium and Long Term Plans for Health Inequalities	• The CCG should after setting trajectories have short medium and long term plans of how the trajectory will be delivered.	In the short term the GRASP AF tool will be rolled out to all GP Practices within South Lincolnshire. GRASP-AF is a free, easy-to-use tool that assists GP practices to interrogate their clinical data enabling them to improve the management and care of patients with AF and to reduce their risk of stroke through appropriate intervention with anticoagulation. The tool also assists with case-finding activity, helping practices to establish more accurate prevalence rates within the practice population. The CCG along with Public Health will then monitor the number of admissions to secondary care for AF related stroke to see whether the GRASP AF tool is improving performance against the standard and reducing the number of patients accessing secondary care due to

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		AF related stroke. Public Health in conjunction with the CCG will also produce clinical quality reports which will be shared with practices and QOF data will also be analysed – this data will be available in October 16 so will be a long term plan. The CCG will also conduct a premature mortality audit which will identify deaths which were potentially avoidable and identify areas of practice or themes which can be targeted to prevent premature deaths in the future. The Brighton and Hove Preventing Premature Mortality Audit will be used as a basis for the South Lincolnshire CCG audit. It is anticipated that the audit will be completed within the next 18 months. The CCG will also encourage GP Practices to refer patients on the unplanned admissions resister for a pharmacist led MUR. The constraints of the current MUR pharmacy contract will mean that this can only be undertaken for those patients who have their prescriptions dispensed by a community pharmacy.
	• Reducing variation and exception reporting on key measures to ensure for example more of those patients with HF are receiving appropriate anti-coagulation, statins, falls assessment and prevention, CHD patients are getting Cardiac Rehab and Smoking Cessation	This will all be picked up within the Clinical Quality Reports as described earlier.
The use of Brief Intervention Techniques	• The Use of BI Techniques such as MECC in Primary Care as well as services that they commission	The CCG is committed to having a systematic approach to commissioning and contract negotiation in which Making Every Contact Count is encompassed in every contract. All practices are encouraged to use MECC as part of their daily

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		practice and various audits throughout the year will be conducted and shared with practices to monitor top performers and those will lower performance with regards to referral rates. This will then be raised with individual practices and the CCG along with Public Health will work with the practices to encourage better performance.
	• Diabetes Prevention	The CCG has applied for and been successful in its bid to deliver a series of diabetes education programmes. The programme will include 6 sessions running for 2 hours each and will include the following: Session 1 – Introduction. Weight & BMI checks, smoking status and current levels of physical activity. Readiness for change assessment. Food and activity diaries will also be issued. There will then be an introduction to diabetes and pre diabetes. Session 2 – Information on healthy eating and eat well plates, food labelling, portion control and advice on smoking and alcohol consumption. Session 3 – Benefits of physical activity in relation to diabetes and effects on the body. Session 4 – Interactive session showing participants how to grow own fruit and veg and how to incorporate this into their diet. Session 5 – Healthy cooking session Session 6 – signposting/referrals, follow up meetings will also be arranged. The programme will then be evaluated by the senior health trainer and feedback will be given to the CCG to disseminate.
Social Prescribing Models	• Signposting patients into other services can reduce NHS demands and get appropriate support to	This is something that the CCG will look into in the medium/long term plans. This will require investment to identify volunteers

	improve health outcomes	and community navigators which is why this will be in the medium to long term plans. The CCG will review some of the social prescribing projects that have been implemented across the country in partnership with the GEM Prescribing Team. A plan of action will then be developed. It is aimed that an action plan will be developed by December 15 which will outline actions and timescales.
Reducing Inequalities	• How approaches will reduce inequalities. The CCG need to demonstrate an understanding of proportionate universalism and the need to target additional support for improvement towards specific communities/areas.	Page 24-28 of Operational Plan (Appendix 10). The CCG also undertook various events to engage with A8 communities. Full details of the projects can be found in appendix 7 and One Year Review.
Contracting and Procurement to influence health improvement and lifestyle	• How will the CCG use its contracting and procurement influence to contract for health improvement and lifestyle	In 15/16 the CCG will explore including the Making Every Contact Count concept as part of provider contracts. In order to do this over 2015/16 the CCG will scope other work completed by commissioners in other areas to see how this has been implemented within other CCG's. Additional information can be found in the Operational Plan on page 27 (Appendix 10) and page 24-25 of the supporting narrative document. Lifestyle services already commissioned by Public Health are as follows: • Stop Smoking Services • Weight Watchers • Variety of physical activity programmes based at various age groups • Substance Misuse service A pilot is also being run within Lincolnshire East to work with local pharmacies working with Audit C to provide Brief Interventions for alcohol misuse. If this is a success Public Health will roll this out to other CCG's within Lincolnshire.

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Appendix 1

CVD Prevalence

The prevalence of AF across South Lincolnshire is 3,164 (1.98%) the aim is to get to 3,195 (2.00%). If we can reach the target and treat 85% of those patients with anticoagulation we can prevent 31 strokes.

Appendix 2

Dementia Trajectories

Practice	Dementia ES sign up	Cantab Sign up	"Gap" to ambition - updated Dec 14	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April
Abbeyview	Y	Y	18	41.1	44.4	45.2	44.76				
Beechfield	N	Y	51	38.5	41	43.6	43.04				
Bourne Galletly	Y	Y	3	64.2	63.6	65.3	67.02				
Deepings	N	N	66	38.5	41.5	42	47.14				
Gosberton	Y	Y	18	50.5	49.4	50.4	49.94				
Hereward	Y	N	0	69.4	67.9	70.6	72.85				
Littlebury	N	N	12	60.2	56.4	58.2	59.93				
Long Sutton	Y	Y	47	4308	44.5	50.6	50.67				
Moulton	N	Y	35	26.9	29.2	29.7	29.48				
Munro	Y	Y	0	69.8	71.1	72.3	71.94				
Pennygate	N	N	0	150	168	172.4	186.47				
Sutterton	Y	Y	21	28.3	29.2	29.5	29.36				
St Marys	Y	Y	0	63.3	65.4	68.5	70.77				
The Little Surgery	Y	Y	10	33.3	37.9	45.1	57.32				
The New Sheepmarket Surgery	N	Y	48	39.8	40.7	41.6	41.45				

*Gap to ambition is the number of screens needed to achieve the target.

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Further Appendices

Appendix	Document Title	Where the document can be viewed/accessed
Appendix 3	Latest Dementia Report	Contact cumba.balding@southlincolnshireccg.nhs.uk
Appendix 4	South Lincolnshire CCG Assurance Document	Contact cumba.balding@southlincolnshireccg.nhs.uk
Appendix 5	Lincolnshire Clinical Commissioning Groups Cancer Delivery Plan	Contact cumba.balding@southlincolnshireccg.nhs.uk
Appendix 6	South Lincolnshire CCG One Year Review	See Appendix B
Appendix 7	Engagement Reports – Bakkovor & Morrisons	Contact cumba.balding@southlincolnshireccg.nhs.uk
Appendix 8	Planning Assumptions	Contact cumba.balding@southlincolnshireccg.nhs.uk
Appendix 9	South Lincolnshire CCG's 7 Ambition	Contact cumba.balding@southlincolnshireccg.nhs.uk
Appendix 10	South Lincolnshire CCG Operational Plan	http://southlincolnshireccg.nhs.uk/key-documents/cat_view/14-key-documents/72-strategic-and-operational-plan

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Appendix B

South Lincolnshire Clinical Commissioning Group

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Commissioning Intentions

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Acronyms

Acronym	Meaning
SLCCG	South Lincolnshire CCG
PPG's	Patient Participation Groups
QPEC	Quality and Patient Experience Committee
GEM	Greater East Midlands Commissioning Support Unity
PPIC	Patient and Public Involvement Committee
CSU	Commissioning Support Unit
FFT	Friends and Family Test
PROMs	Patient Reported Outcome Measures
AIRs	Assertive In Reach Team
DTOCs	Delayed Transfers of Care

Introduction

South Lincolnshire CCG (SLCCG) serves a registered population of approximately 161,343. The CCG is made up of fifteen practices across two localities with distinct populations and needs. The Welland locality has seven practices serving a population that is mainly affluent with small pockets of deprivation in larger populated centres. The South Holland locality has eight practices and is more deprived with areas of rural poverty and growing migrant worker and new arrivals communities from EU accession countries.

The CCG will be commissioning services for the populations of Stamford, Bourne, Market Deeping, Spalding, Long Sutton, Holbeach and surrounding areas. The main hospitals serving this population are Peterborough and Stamford Hospitals, Johnson Community Hospital, Queen Elizabeth Hospital Kings Lynn and Pilgrim Hospital, Boston.

SLCCG are committed to engaging with all of the communities that we serve. New arrivals from the EU form a substantial minority of the South Lincolnshire community and contribute enormously to the local economy. In order to better engage with this group of people, who may find health services hard to understand and use, we have been working with local employers to take health information to their workers. In 2014 South Lincolnshire CCG conducted a health awareness event running over 3 weeks (1 day a week) which also encouraged GP registration.

Commissioning Intentions have been rolled out for 15/16. Some of which have been carried over from previous years, others have been refreshed/changed. SL CCG are still in negotiation with providers, where we are lead commissioners to secure 2015/16 contracts. For full details of commission Intentions please see page 27.

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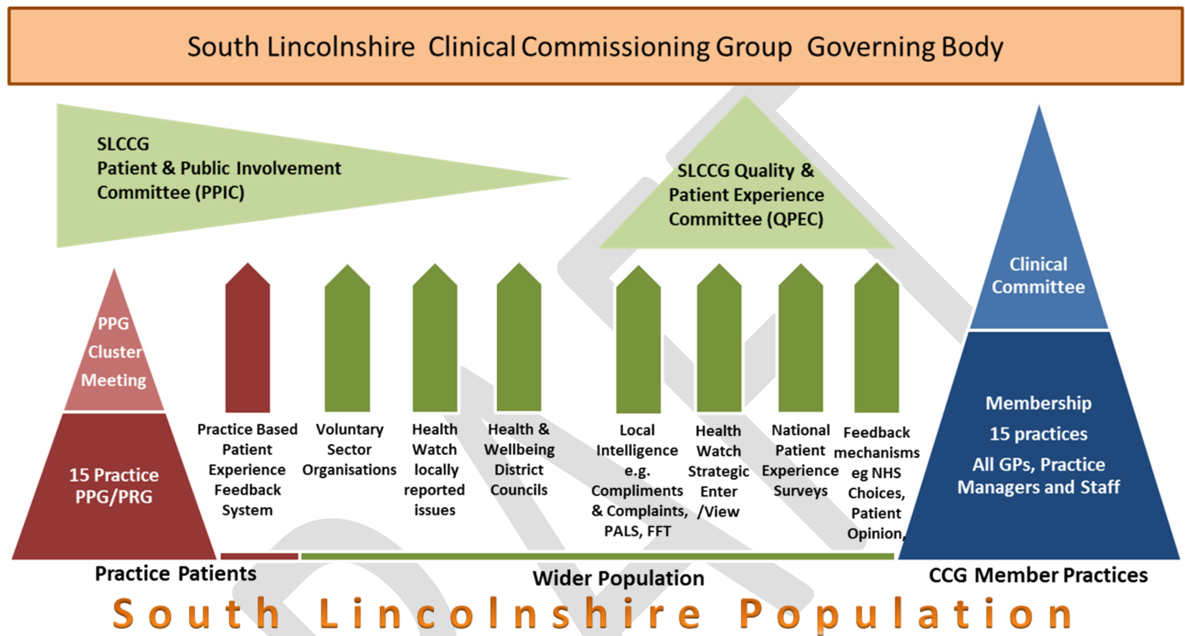
Are patients and the public actively engaged and involved?

Our Systems

The 'Continuous Listening' model depicts how our Governing Body is able to listen to the views, opinions and experiences of the population of South Lincolnshire in terms of our GP practice patients, staff and the wider population enable the CCG.



The two committees that deal with patient and public involvement/engagement as depicted in the model above are:

Quality & Patient Experience Committee

The purpose of the Committee is to regularly review reports on the quality of services commissioned, patients' experiences, specific quality improvement initiatives and any serious failure in quality. It provides assurance to SLCCG Governing Body that commissioned services are being delivered in a high quality and safe manner, ensuring that quality sits at the heart of everything the CGG does. In addition to the standardised reporting reviewed by the committee, provider 'focused reviews' are also conducted to ensure the committee are sufficiently sighted on service quality with enhanced granularity.

The patient voice is heard in a number of ways through the Patient and Public Involvement Committee for example formalised patient generated intelligence including complaints, PALS , Healthwatch enter & view reports, National Patient Experience Surveys and Family and Friends Test.

Membership consists of the following:

- CCG Chief Officer (Chair)
- Director of Quality (Executive Nurse)
- Lay member for Patient and Public Involvement.
- 4 x GPs

Patient & Public Involvement Committee

The Purpose of the PPIC is to provide the SLCCG Governing Body with an assurance and scrutiny function in relation to its duties to communicate and engage with patients and members of the public under the Health and Social Care Act 2012. The Committee provides strategic leadership to ensure that patient and public voice is heard and that engagement informs the planning and commissioning of services that meet local population needs and oversee the delivery of the SLCCG Communication and Engagement Strategy. This committee facilitates the two way communication process necessary to achieve greater engagement between these member organisations and the CCG on a continuous basis. Crucially this committee provides the conduit for 'soft intelligence' regarding patients' experiences of services from its constituent members with intelligence from escalated to both the QPEC and Governing Body as required.

The type of Patient voice heard through this committee is informal 'soft' intelligence from each of its constituent members including Healthwatch (patient reported incidents), voluntary sector, local authority and SLCCG PPGs . CCG Listening event reports also go through this committee. The PPIC has developed a link with the Public Health (Healthy Schools) team to have a representative for school aged children as well.

Membership consists of the following

- SLCCG Lay Member for Patient and Public Involvement (Chair)
- 2 Representatives from the Cluster Patient Participation Group
- Voluntary Sector Representatives
- GP Representative for PPI
- 2 Practice Managers' representatives
- SLCCG Engagement Manager
- GEM Engagement and Consultation Manager
- Health and Wellbeing Representatives from District Councils (SKDC/SHDC)
- Healthwatch Representatives
- Lincolnshire County Council Representatives
- SLCCG Quality Representative
- Representatives from the CCG Delivery and Development Team as required

Patient Experience Log
Patient experience that is gathered from all arenas (including patient opinion & NHS Choices) is collated monthly and logged to identify trends and to support with areas that involve more investigation. This log is used at Senior Management Team meetings and supports the wider intelligence gathering for the PPIC.

What we have done

Recruitment of permanent Engagement Manager who's main focus over 2015/16 will be to ensure patient and public voice and experience is recorded and acted upon and to support the CCG with consultation around statutory requirements and localised projects.

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Commissioning Intentions Engagement
Summer 2014 First phase - 411 patients and members of the public were spoken with about last years' priorities and how they felt about these. This was done through specific forums (i.e. carers groups/mental health forums/healthwatch events); surveys; market stalls in Bourne, Stamford and Spalding and presence in GP practices.

Stakeholder Event held August – 44 stakeholders representing 34 organisations.

Diabetes
2 x consultation events were held (Welland and South Holland) to look diabetes services and self-management. 55 people attended and gave views on what's good/not good; what they would like to see delivered; what would help them self-manage better? Education and peer Support identified as the key thing needed by patients.

SLCCG have since taken the opportunity to work with the Patients in Control programme (funded through NHS England and being led by Kent CSU). To work with patients to understand what peer support and education should look like from their point of view.

SLCCG identified funding opportunities for this work (NHS Challenge Innovation Fund and recent NHS E money, 3 year project) working in collaboration with health trainers to deliver 4 x events per year across our area regarding healthy eating, cooking and growing (of food) and exercise for diabetics and pre diabetic patients.

A8 Community
Extensive engagement work carried out by the CCG working in partnership with local employers with high proportion of A8 employees. 3 x whole day events held within Bakkavor to raise awareness of GP registration and working with partnership agencies to deliver health checks and health promotion (including Phoenix stop smoking team and Early Prevention of Cancer Team).
235 people attended the event
222 people undertook a health check (94.5%)
21 people undertook a TB questionnaire (9%)
23 new A8 registrations with with a SLCCG GP (10%)
Further events planned for March 15.

Listening Events
All 4 Lincs CCG have a programme of 'Keogh style' listening events across the county (4xper year) one in each CCG.

Carers & Young Carers Roadshows
SLCCG have developed links with the Lincolnshire carers and young carers partnerships and have been invited to participate in the yearlong programme of roadshows to facilitate engagement opportunities which will enable this extremely valuable voice to be heard.
A real example of how the continuous listening model has enabled the patient voice to influence our plans is highlighted in the flow diagram below:

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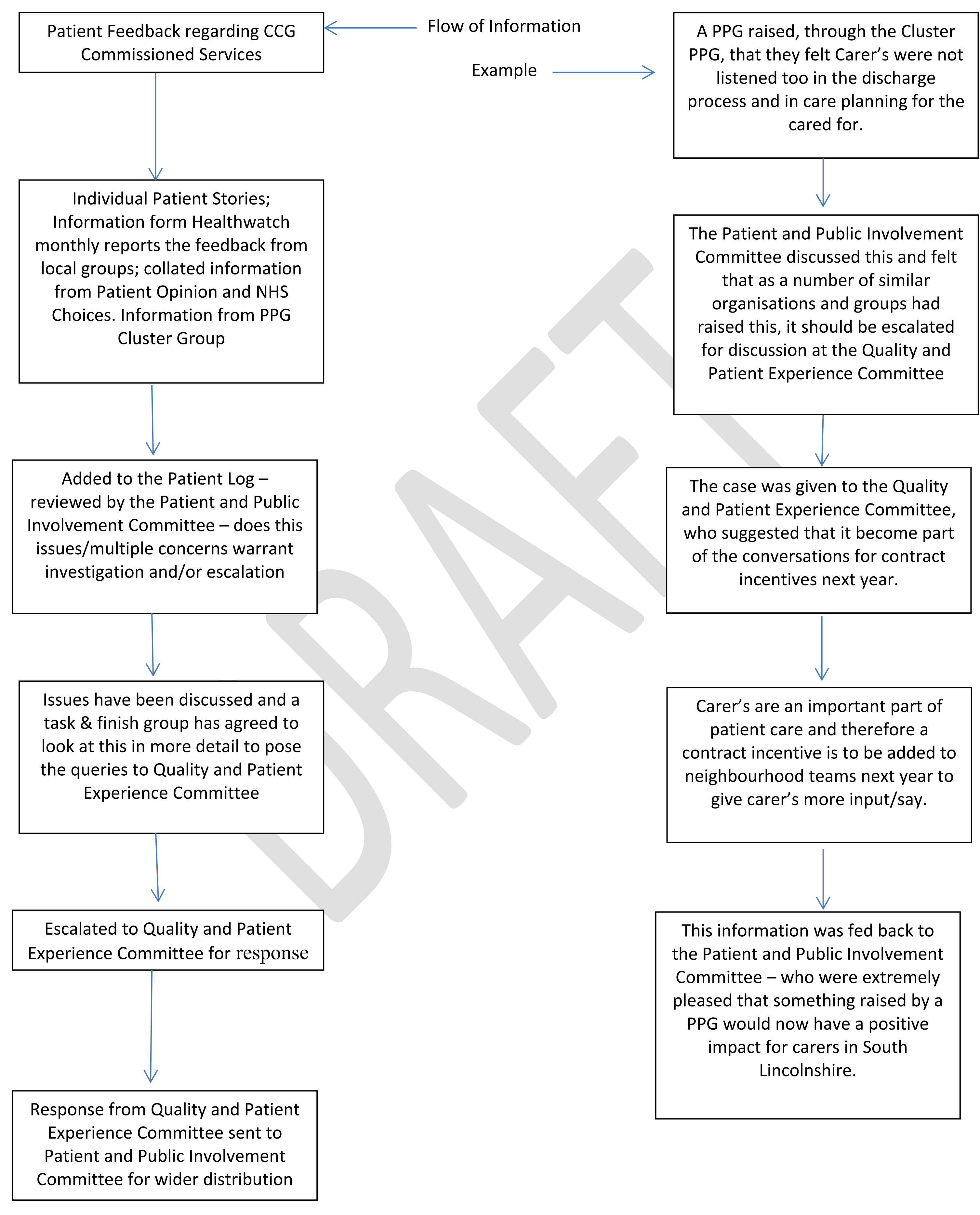

Patient Feedback regarding CCG Commissioned Services
Flow of Information
Example
A PPG raised, through the Cluster PPG, that they felt Carer's were not listened too in the discharge process and in care planning for the cared for.
Individual Patient Stories; Information form Healthwatch monthly reports the feedback from local groups; collated information from Patient Opinion and NHS Choices. Information from PPG Cluster Group
The Patient and Public Involvement Committee discussed this and felt that as a number of similar organisations and groups had raised this, it should be escalated for discussion at the Quality and Patient Experience Committee
Added to the Patient Log – reviewed by the Patient and Public Involvement Committee – does this issues/multiple concerns warrant investigation and/or escalation
The case was given to the Quality and Patient Experience Committee, who suggested that it become part of the conversations for contract incentives next year.
Issues have been discussed and a task & finish group has agreed to look at this in more detail to pose the queries to Quality and Patient Experience Committee
Carer's are an important part of patient care and therefore a contract incentive is to be added to neighbourhood teams next year to give carer's more input/say.
Escalated to Quality and Patient Experience Committee for response
This information was fed back to the Patient and Public Involvement Committee – who were extremely pleased that something raised by a PPG would now have a positive impact for carers in South Lincolnshire.
Response from Quality and Patient Experience Committee sent to Patient and Public Involvement Committee for wider distribution
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Quality Assurance

Quality remains our priority and therefore we have a range of systems and processes to proactively manage the services we commission.

Bi-monthly quality reports are produced for the CCG Quality and Patient Experience Committee with escalation to CCG Governing Body as required. This report consists of a dashboard detailing information including Methicillin-resistant staphylococcus aureus (MRSA) and Clostridium Difficile (CDiff) rates, numbers of new serious incidents and safeguarding concerns. This is supported by a narrative document describing, by exception, the detail behind the numbers in the 'dashboard', together with relevant actions and patient experience information.

Commissioned services are managed via a quality schedule within all contracts. This allows performance management and monitoring of quality and patient safety metrics and indicators (including benchmarking data). There are a variety of sanctions and incentives which can be and are used to secure continuous quality improvement.

In accordance with guidance issued by the National Quality Board, Review of Early Warning Systems in the NHS, SLCCG utilises an early warning system which includes not only the analysis of core data from a wide range of services, but also feedback from patients (derived through complaints), incidents, GPs and the public, to indicate that an issue affecting the safety or quality of care may need to be further investigated.

Further, in accordance with the National Quality Board recent guidance, How to Organise and Run a Rapid Response Review, the CCG is able to organise a rapid Response Review in response to concerns. This may also include mobilising a visiting team to assess the service concerned.

If any part of the local system indicates that there may be a serious quality failure within a Provider organisation which cannot be addressed through established and routine operational systems, a risk summit may be triggered in conjunction with the CQC and/or NHS England Area Team, in line with the National Quality Board guidance on How to Organise and Run a Risk Summit.

Assurance visits to providers up to quarter two are listed in the table below.

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Date	Provider	Level of Review	Reason for review	Reviewers	Summary of findings
23.06.14	St Barnabas Hospice, Lincoln	Level II	general quality assurance	Infection Prevention & Control South Lincolnshire CCG Lincolnshire East CCG	**Positive Factors** • Positive patient experience • Patient centred well organised model of care • The environment was found to be clean and staff were clearly engaged in IP&C processes. The facilities and environment met with HTM/HBN specifications **Further assurance sought:** • minor changes to equipment storage (moving clean items out of 'dirty' rooms) would further enhance the high standards observed
24.06.14	Lincolnshire Partnership Foundation Trust **Site:** Peter Hodgkinson Centre	Level II	Assurance re Infection Prevention & Control	South Lincolnshire CCG	**Areas for further improvement** • There were issues relating to both Criterion 2 and 6 found across the site and some non-infection issues were also noted including: • Cold chain not monitored appropriately (Outcome 9 Medicines management). • Archived patient information found in various cupboards on the wards (Outcome 21 Records management).
30.06.14	United Lincolnshire Hospital Trust **Site:** County Hospital Accident and Emergency, Surgical Emergency Admission Unit and Waddington Ward	Level II	Assurance re Infection Prevention & Control	South Lincolnshire CCG	**Findings on visit against criterion 2 & 8** **Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.** **A&E –** Uniform policy was being adhered to. Commodes inspected were clean and the sluice tidy. Generally there were no issues identified during the visit of any concern. **Surgical Equipment Assesment Unit** – Staff stated the nurses station was cleaned by night staff each shift. Moving the PCs/monitors revealed very large amounts of dust the length of the back of the nurses station which would have taken several days to build up. Drip stand in store room found dirty to under surface of base. In a clinical room there was an orange bag in the bin, this colour is for infectious clinical waste and the contents were various paper products. **Waddington Ward** – Toilet seat raiser had a green is clean sticker from 7 days previously, although clean to the eye, these items should be cleaned at least once daily and after each use. Two IV giving sets had been disconnected from the patient and left hanging on dripstands at the side of the beds. Intermittent infusions should be either left connected or disposed of after each use. Five dripstands were inspected all were found dirty to the under surface of the base. Several Greasby pumps were also found dirty, some had green is clean stickers in situ, the names of the persons who signed these were given to nurse in charge on

					nights to action with Sister. The manual sphygmomanometer cuff holder had high levels of dust inside and the feed pump which was also stored in this holder had obvious feed drips on its sides. There were high levels of dust to the floor edges of the room. On inspection of the stock there were numerous examples of out of date items. Emergency trolley was dirty and dusty to top. In each area of the ward the waste bins had been pushed so far back to the wall that they were actually raised off the floor, rendering the foot pedal inoperable. This was also damaging the fabric of the walls with chips to plaster and paintwork evident. Shower curtain and tray were noted to have brown staining. Two commodes were found dirty, one with substantial blood droplets to the under surface. Neither had green is clean sticker attached. 2 x sharps bins were open i.e semi-closure mechanism not being used. The floor at the back of the fridge was dusty. Underneath the step used to house sharps bins was dusty with a vial of medication and plastic twist caps were also on the floor in this area. Checking the storage drawers revealed two instruments which had both been sterilised several years previously, one of these also had a tear to the packet. **Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection.** **A&E** – There were two episodes of inappropriate use of PPE (Housekeeper emptying bins not wearing apron and porter washing down trolley not wearing apron). Uniform policy was being adhered to. **Surgical Equipment Assessment Unit** – There did not seem to be an understanding of: *"the nurse or other person in charge of any patient or resident area has direct responsibility for ensuring that cleanliness standards are maintained throughout a shift"* Health & Social Care Act (2008) Criterion 2, this was being interpreted as nurse in charge responsible for the physical act of cleaning. There were several occasions witnessed when activities which required apron and gloves e.g. bed washing, waste handling were undertaken by staff only wearing gloves. Hand hygiene was not performed immediately on removal. In one case items were searched for at nurses station prior to hand hygiene with obvious potential for multiple surface contamination. There were high levels of dust and debris behind the fridge. There was dust and debris on worktop behind hypo box. Commodes all clean and labelled appropriately. Sharps bins were located on the floor and there was no use of the temporary closure mechanism **Waddington Ward** – Staff were welcoming and apart from one student who had a long ponytail dangling down her back and a staff nurse with stoned earrings, not adhering to uniform policy.
08.07.14	Peterborough and Stamford Hospitals Foundation Trust	Level II	Assurance re Infection Prevention &	South Lincolnshire CCG	**Positive Factors** • PSHFT is currently above the national average for urinary catheter insertion rates and Some clinicians are recording both electronically and on paper based systems whereas others are using either one or the other.

			Control and assurance re catheter management		• For all of the catheters checked, there were complete daily monitoring charts in place. **Areas for further improvement** • There seemed to be some information missing for some patients mostly in relation to reasons for insertion this is being looked into • In relation to the environment, some key issues were noted and the organisation is aware of the findings.
30.07.14	Lincolnshire Community Health Sservices **Site:** Louth Hospital	Level II	Infection Prevention & Control	South Lincolnshire CCG Lincolnshire East CCG	**Areas for further improvement** • Wide scale inappropriate use of orange 'infectious waste' sacks on Louth Hospital site. • Planned refurbishments are scheduled for 2015 on Carlton and Manby Wards, but not planned in the Urgent Care Centre.
11.08.14	Lincolnshire Community Health Services **Site:** SE Respiratory Service	Level I	15 Steps challenge review	South Lincolnshire CCG Lincolnshire East CCG Lincolnshire Community Health Services Non Executive Director	**Positive Factors** • Good use of patient surveys to try to reduce the number of patients not attending appointments • The team were extremely positive and passionate about their service. They had an excellent understanding of the risks and appeared confident to escalate concerns when appropriate. **Areas for further improvement** • The nurses felt they would like the opportunity to support the TB nurse service. Team to consider 7 day working
26.08.14	Lincolnshire Community Health Services **Site:** Skegness Hospital	Level II	Infection Prevention & Control	South Lincolnshire CCG East Lincolnshire CCG	**Areas for further improvement** • Some general cleanliness issues were noted at this site. It was noted that the Matron has responsibility for Louth and Skegness with a consequence of reduced time on each site. • The Infection Prevention and Control presence is also reduced with only 1 visit every 2 weeks
19.09.14	**Lincolnshire Community Health Services** Johnson Hospital **Site:** Welland ward	Level II	Assurance re safety thermometer pressure area	South Lincolnshire CCG East	**Positive Factors** • The ward sister identified they were making good progress against the on-going action plan • Care of the deteriorating patient had been addressed in the previous action plan and the ward sister is regularly auditing compliance against the NEWS monitoring tool • A newly appointed advanced nurse practitioner now works Monday – Friday to support the

			care and VTE prevention	Lincolnshire CCG	medical staff with prescribing and patient assessments • A medical ward round takes place at 12.30 Monday – Friday by 2 general practitioners • All patient bays are deep cleaned weekly • There is a health care support worker folder in use promoting better continuity of care • Newly appointed band 7 who is enthusiastic and motivated to support improvement and drive change . **Areas for further improvement** • The ward sister identified they were making good progress against the on-going action plan • Care of the deteriorating patient had been addressed in the previous action plan and the ward sister is regularly auditing compliance against the NEWS monitoring tool • A newly appointed advanced nurse practitioner now works Monday – Friday to support the medical staff with prescribing and patient assessments • A medical ward round takes place at 12.30 Monday – Friday by 2 general practitioners • All patient bays are deep cleaned weekly • There is a health care support worker folder in use promoting better continuity of care • Newly appointed band 7 who is enthusiastic and motivated to support improvement and drive change
21.09.14	United Lincolnshire Hospitals Trust **Site:** Pilgrim Wards 5A & 9A	Level ll	Assurance re Infection Prevention & Control	South Lincolnshire CCG West Lincolnshire CCG	**Findings on visit against criterion 2 & 6** **Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.** 5A – There were no major issues identified during the visit. 9A – There was no domestic waste bin, the only bag being tiger stripe; as a result hand towels were being disposed of in the wrong waste stream. There should be no clinical waste, infected or otherwise, being disposed of in a clinical room. The tote boxes on the shelves had high levels of dust on the moulded edges. There were 26 syringe fillers found out of date in the storage bins. Three sharps trays were found on the shelves dirty. Three vials of flucloxicillin were found loose in a plastic box on top of one of the cupboards. The back of the worktop was dusty with obvious debris. The worktop underneath the medicines fridge was extremely dusty (cross to indicate depth of dust found) **Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection.** 9A – Waste management; this was particularly problematic with high use of the blue pharmaceutical plastic bins as sharps bins. Staff were disconnecting needles from syringes and then using the wrong colour bins for disposal of these. Notices on the window for staff to follow had incorrect information typed onto them, this notice had been created at ward level, it was not from facilities.

2014 to 2016 Commissioning Priorities - Progress

During 13/14 patients told us the things important to them:

- Preventative services
- 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

This informed our commissioning priorities for the following two years SLCCG continues to take these forward and improvements have already been seen in areas such as;

- Revising pathways of care to support care close to home –Peterborough Hospitals now provide chemotherapy in Spalding Community Hospital saving patients and their carers travel.
- Movement to best practice in referral and patient management – SLCCG have continued to roll out Pathfinder tool and now look to improve usage across the CCG.
- Expansion of patient choice through Any Qualified Provider (AQP) where market conditions indicate this represents good value for money- AQPs have been successful and increased local provision has already started in ophthalmology, community surgical treatments and physiotherapy.
- Cancer Pathways review – Certain cancer pathway are being reviewed to make sure the reliance upon hospital care is retained at a necessary minimum, whilst at the same time working to support the longer-term 'survivorship' work to support and empower patients and their families to feel more confident once their active cancer treatment has ended.
- Improving End of Life Care – As part of county-wide work, we are focusing on the palliative and end of life care that patients currently have to make sure the patient, their families/carers receive the right level of support to plan ahead more, when this is at all possible. When this is not possible, we are improving the communication and working relationships between our local services in our community to avoid any unnecessary delays to ensure our patient and carer experiences are as positive as possible.
- Improving patient access and experience for Mental Health and Learning Disabilities – SLCCG has secured Cantab mobile an app that is used in primary care to diagnose patients with dementia enabling patients and carers to proactively access support services and plan for future needs, recently commissioned dementia management support for Stamford neighbourhood team and looking to expand. A CAT car has been commissioned via EMAS. The car will respond to urgent calls received by the call centre for patients who have fallen but after assessment over the phone do not need hospital admission. The Car is staffed with a paramedic and Emergency Care Assistant who will attend the scene and provide a full assessment. They will also ensure that the patient is taken home or to a place of safety. If hospital attendance is needed the crew will call for an ambulance to convey the patient to hospital. Also a Triage car is currently in the pilot phase, managed by EMAS the car is staffed by a Mental Health Nurse and a paramedic. The car will respond to all urgent calls which do

not require an A&E admission. Early results show good rates of both diversion and outcomes which do not result in use of policy custody or admission to hospital. The Crisis Concordat Declaration has been written and signed up to by the main stakeholders. An action plan to support this is in development and will be published in March 2015. This is a whole community approach to Mental Health Care.

- Review of Diabetes services to improve community access. Following the patient involvement meetings of March 2014 and the internal review of Diabetes Services patients informed us they wanted local access to services; peer support and more education to self-manage. The implementation of Neighbourhood Teams will support in more localised services. In addition we have secured additional funding to run 4 interactive educational sessions to encourage innovative ways to manage diabetes, the sessions will cover various topic including dietary advise, physical activity and managing the condition.
- Review of pathways into acute care – Work continues on pathways with secondary and primary care clinicians taking the lead.

Other areas the CCG has progressed on during 2014/15 are:

- **ENT** – Procurement during 2014/15 has secured a minor ENT service bringing appropriate services into the community, creating better access for patients and carers.
- **IBS / IBM management** –Faecal Calprotectin testing for the diagnosis of IBS / IBS in order to reduce the requirement to send patients to secondary care for invasive diagnostic testing has been introduced
- **Stroke prevention** – Identification of patients with Atrial Fibrillation using GRASP –AF Tool is currently being rolled out across the CCG practices. Patients identified at risk of a stroke using a CHADS2 scoring system are then prescribed anti-coagulation to reduce the risk of a stroke.
- **Chronic Heart Failure management** – To increase the number of patients on Heart Failure Registers prescribed ACE Inhibitors to reduce hypertension. All South Lincolnshire CCG GP Practices were offered the opportunity of 'up skilling training' on the management of heart failure. 8 out of 15 practices participated in the training. The CCG are now in the process of rolling this training out to the rest of the practices.
- **Dementia Strategy** – Review of services to improve and increase support and levels of intervention for patients and carers. Key achievements in 2014 were the launch of the Cantab Mobile which is a tablet based application that can be used by any health care professional to help in the diagnosis of Dementia. The Delivery and Development Manager has also undertaken the Dementia Friends training and will become a Dementia Champion and will encourage others to participate in the Dementia Friends Scheme. The focus in 2015 will be working with GP Practices who are within the bottom quartile of screening rates to encourage them to utilise the tools that are available to screen patients for Dementia, therefore optimising their Dementia Diagnosis rates.

We aim to continue delivery of NHS national frameworks, constitution, JSNA and H&WB strategies. SLCCG remain focused on the five domains below, the schemes that are delivering effective outcomes, started in 2013 will continue throughout 2015/16 regularly reviewed and where required altered to deliver the local populations needs.

Domain	Title	Further information	Updates / things done
Domain 1	Preventing People from dying prematurely	Early diagnosis Improving early management in community settings Improving acute services and treatment Preventing recurrence after an acute event	Cantab Mobile – identifying dementia early Support for patients and carers commissioned through neighbourhood team
Domain 2:	Enhancing quality of life for people with long-term conditions	Improvements in primary care Putting patients in charge and giving them ownership of care Co-ordination and continuity of care	Neighbourhood teams being rolled out across CCG, high risk patients identified by GPs, assessed by MDTs and patients having care plans discussed with their practices
Domain 3:	Helping people to recover from episodes of ill-health or following injury	Avoidable admissions to hospital need to be addressed Right support at the right time Effective joined up working between secondary and primary care High quality care and efficient care for people in hospital Co-ordinate care and support for people following discharge from hospital	Neighbourhood teams linking with assertive in reach teams, commissioned by CCG, to get patients out of hospital quickly and receive the community support needed to stay at home. Additional funding for independent living team to assist the above. Increased funding for rapid response teams to avoid unnecessary admissions and increased GP support in the community supporting patients in intermediate care. Joint meetings to review and improve pathways are held monthly between PSHFT, SLCCG GPs and C&PCCGs
Domain 4:	Ensuring People have a positive experience of care	Rapid comparable feedback on the experience of patients and carers Building capacity and capability in both providers and commissioners to act on feedback Assess the experience of people who receive care and treatment from a range of providers in a co-	Patient experience is gathered from a number of sources; direct from patients; Healthwatch; online; PPGs and the Cluster PPG and these are reported through PPIC. This enables us to look for trends and seek more information on specific areas and escalate to QPEC for action. Some

		ordinated package	successes this year have included identifying the need for a Carer's CQUIN and identifying delays in outpatient GP letters and resolution has been sought for both.
Domain 5	Treatment and caring for people in a safe environment and protecting them from avoidable harm	Reducing the incidence of avoidable harm Improving the safety of maternity services Delivering safe care to children in acute settings Patient safety incident reporting	Movement of maternity services for Welland patients to be provided by one Trust to stop fragmentation of service is being planned to start April 2015.

For the latest position with regards to performance for the CCG on the 5 domains please follow the below link:

http://southlincolnshireccg.nhs.uk/key-documents/cat_view/14-key-documents/16-governing-body-meetings

Key actions in which the CCG are working on for the Outcomes Framework where performance is below the standard are as follows:

Potential Years of Life Lost – The CCG are working with the local Public Health England Team to analyse the performance of this standard against the 5 year trajectories set and recovery actions/rates will be agreed if and where appropriate.

Mortality Rates including Respiratory Conditions– Public Health England along with CCG Clinical members of the Governing Body have conducted data analysis in order to identify and trends in data which may explain the deterioration in performance. The first round of analysis has shown no trends. Public Health are now looking at the data in more detail particularly looking at deaths from specific diseases, particularly within the CVD umbrella. The local Public Health team have confirmed that numbers are fairly small, particularly from respiratory disease and at practice level. Public Health's initial view is that the deterioration in performance is due to multiple components and there are large variations between practice performance. Public Health are currently gaining commitment to use the principles of Making Every Contact Count to provide meaningful brief lifestyle interventions so we support patients to live healthier lives and contribute to the prevention agenda. This needs to be done in conjunction with commissioning lifestyle services such as stop smoking services and weight management. The aim is to find patients with undiagnosed disease and those who are at increased risk (which we will do using NHS Health Checks); and then optimise the management of those who have been diagnosed with for example heart disease, diabetes and CKD. Interventions that the CCG have put into place to tackle some of the above issues are the GRASP AF tool and the IMPAKT tool for CKD. It is hoped that this will in the short term improve performance.

CVD – The CCG are currently working within GP practices to increase practice use of GRASP AF tools and clinical management training. This will reduce the risk of stroke and/or death from heart failure. For prevalence numbers please see appendix 1. This will result in 31 less strokes as well as a reduction in elective and non-elective procedures. Using the information from Commissioning for Value Packs targeting quality improvement and high cost spend.

The CCG has chosen to focus on Cardio Vascular Disease in terms of commissioning for prevention. This is the disease area which makes the greatest contribution to the CCG's Potential Years of Life Lost and Under 75 mortality rates. In terms of the steps highlighted in the Commissioning for Prevention Call to Action (Appendix 6), the CCG is working towards the mature scenario detailed on page 13 of the A Call to Action: Commissioning for Prevention document and in some specific areas, is operating at that level.

The CCG has continued with the local priority measure to reduce the Under 75 mortality rate to the England level or below. In 2013/14 the standard for South Lincolnshire CCG for CVD mortality rates was 73.2 DSR per 100,000. During that year the CCG reduced to 66.80. In 2013, the South Lincolnshire U75 mortality rate from Cardio Vascular Disease (DSR) standard was 73.2/100,000 registered patients. The CCG achieved 66.8. Analysis of data locally and through the East Midlands Cardio Vascular Disease Strategic Clinical Network has identified a number of areas where specific initiatives such as the GRASP AF tool and the IMPAKT Chronic Kidney Disease tool has been implemented to provide an opportunity to contribute significantly to this priority and these are in the process of being implemented.

Long Term Conditions –The current long term conditions that the practices are working on are Cardiovascular Disease; including heart failure and atrial-fibrillation, Chronic Kidney Disease including acute kidney injury and diabetes. A one to one working programme of action for all South Lincs GP's is currently being developed to support them with early identification of patients at risk, better management of onset long term conditions and adopting best clinical practice. The CCG has adopted the IMPAKT tool which has been implemented across all GP practices and this will improve the identification and management of CKD patients. This will introduce clinical best practice of onset CKD and a slowdown of progression to end stage renal failure.

Cancer –All Lincolnshire CCGs will view cancer as a long term condition and ensure patients are not disadvantaged as a result. The work streams needed to successfully deliver on improving outcomes are outlined in the 2014-16 Cancer Operational Plan (Appendix 3):

- Primary care
- Acute care
- Sub-acute care
- Neighbourhood care

Lincolnshire CCGs will work to reduce the number of ‘premature’ deaths (under 75 years old) in the ‘key’ tumour sites where CCGs appear higher than the national average:

- Malignant melanoma
- Oesophageal
- Prostate

Proportion of people feeling supported to manage their condition – As part of the LHAC work the CCG has established 2 Neighbourhood Teams and identified and will roll out to a total of 6 Neighbourhood Teams across the South Lincolnshire CCG area. The Neighbourhood Teams will bring together the health and social care organisations on a regular basis to identify and put in place whole system care plans for vulnerable patients.

Diagnosis of people with Dementia – SLCCG have implemented the cantab mobile tool to assist with early diagnosis of Dementia and are encouraging practices to utilise the dementia quality site. Progress reports are taken to Governing Body and Clinical Committee meetings each month. Dementia friend training has been completed by some officers and we are looking to have a dementia champion which will then be rolled out across the CCG.

Emergency admissions for acute conditions that should not usually require hospital admission – The CCG are currently working with Public Health and have identified key areas of work. The CCG will continue to work with Public Health England to develop an action plan and this will then be taken to GP Practices. This work will be completed by August 15.

PROMs – PROMs are included within the Quality Schedule and providers are monitored on PROMs performance and are asked for reports where performance is poor.

GP out of Hours – A highlight report of GP Patient Survey Report has been developed and has been taken to Governing Body. Actions are being developed where appropriate.

A target to increase patient satisfaction has been submitted within the first draft of the unify template submission for GP in Hours services. See Appendix 2.

FFT – The CCG incentivise participation and improvements via the national CQUIN and use the Quality Schedule to monitor performance.

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Patient Safety Incident Reporting – This standard is a CQUIN for 15/16. The CCG work closely with the provider in relation to reporting of patient safety incidents and will liaise with the provider to determine any underlying reasons for reported safety incidents appearing the be below the baseline. The CCG has signed up to the 'Sign up to Safety Campaign' and has made organisational pledges as part of this. The organisation is active member of the East Midlands Academic Health Science Network Patient Safety Collaborative.

MRSA/CDIFF – The CCG employ a Head of Infection, Prevention and Control who's role is part of the federated quality function. The Head of Infection Prevention and Control works closely with providers to monitor HCAI incidents to proactively prevent occurrences and ensure that full RCA's are undertaken when incidences occur.

Pressure Ulcers – The CCG uses the National Safety Thermometer CQUIN to incentivise a reduction in pressure ulcers in community and acute settings. Pressure ulcers are also monitored in the quality schedule of providers.

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Constitutional Rights and Pledges

Below is the latest performance dashboard for the NHS Constitutional Standards:

Indicator	Description	Baseline Period	Baseline	Standard/ Target	Lower Threshold	Latest Period	Latest Data	YTD	Trend
EB1	RTT - Admitted Patients	2013/14	91.0%	90%	85%	Jan-15	88.6%	88.3%	⇧
EB2	RTT - Non-Admitted Patients	2013/14	96.5%	95%	90%	Jan-15	94.4%	95.4%	⇩
EB3	RTT - Incomplete Pathways	2013/14	96.3%	92%	87%	Jan-15	94.4%	94.4%	⇧
EB4	Diagnostic Test Waiting Time	2013/14	99.7%	99%	94%	Jan-15	99.1%	99.4%	⇩
EB5	A&E Waiting Time - % of people who spend 4 hours or less in A&E	2013/14	94.9%	95%	90%	Jan-15	85.5%	91.2%	⇩
EB6	Cancer 2 Week Wait - % of patients seen within two weeks of an urgent GP referral for suspected cancer	2013/14	96.3%	93%	88%	Dec-14	94.9%	94.7%	⇔
EB7	Cancer 2 Week Wait - % of patients seen within two weeks of an urgent referral for breast symptoms	2013/14	92.6%	93%	88%	Dec-14	90.9%	91.6%	⇩
EB8	Cancer 31 Day Waits - % of patients receiving first definitive treatment within 31 days of a cancer diagnosis	2013/14	98.2%	96%	91%	Dec-14	100.0%	98.0%	⇧
EB9	Cancer 31 Day Waits - % of patients receiving subsequent treatment for cancer within 31 days where that treatment is surgery	2013/14	96.6%	94%	89%	Dec-14	94.7%	97.0%	⇩
EB10	Cancer 31 Day Waits - % of patients receiving subsequent treatment for cancer within 31 days where that treatment is an anti cancer drug regimen	2013/14	100.0%	98%	93%	Dec-14	100.0%	100.0%	⇔
EB11	Cancer 31 Day Waits - % of patients receiving subsequent treatment for cancer within 31 days where that treatment is radiotherapy treatment course	2013/14	97.5%	94%	89%	Dec-14	93.8%	96.8%	⇩
EB12	Cancer 62 Day Waits - % of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer	2013/14	86.2%	85%	80%	Dec-14	94.3%	82.6%	⇧
EB13	Cancer 62 Day Waits - % of patient receiving first definitive treatment for cancer within 62 days of referral from an NHS Cancer Screening Service	2013/14	88.9%	90%	85%	Dec-14	100.0%	98.4%	⇧
EB14	Cancer 62 Day Waits - % of patients receiving first definitive treatment for cancer within 62 days of a consultant decision to upgrade their priority status	2013/14	100.0%	100%		Dec-14	100.0%	100.0%	⇔
EB15 i	Ambulance Clinical Quality - Category A (Red 1) 8 minute response time (EMAS)	2013/14	71.3%	75%	70%	Jan-15	68.6%	71.8%	⇩
EB15 ii	Ambulance Clinical Quality - Category A (Red 2) 8 minute response time (EMAS)	2013/14	71.5%	75%	70%	Jan-15	65.2%	70.5%	⇩
EB16	Ambulance Clinical Quality - Category A 19 minute transportation time (EMAS)	2013/14	93.8%	95%	90%	Jan-15	90.5%	92.9%	⇧
EB15 i	Ambulance Clinical Quality - Category A (Red 1) 8 minute response time (CCG)	2013/14	61.4%	75%	70%	Jan-15	69.8%	63.8%	⇧
EB15 ii	Ambulance Clinical Quality - Category A (Red 2) 8 minute response time (CCG)	2013/14	63.8%	75%	70%	Jan-15	60.6%	63.8%	⇩
EB16	Ambulance Clinical Quality - Category A 19 minute transportation time (CCG)	2013/14	86.0%	95%	90%	Jan-15	84.9%	85.3%	⇩

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Every One Counts Supporting Measures are below:

Indicator	Description	Baseline Period	Baseline	Standard/ Target	Lower Threshold	Latest Period	Latest Data	YTD	Trend
EBS1	Mixed Sex Accommodation (MSA) Breaches	2013/14	8	Zero Tolerance	NA	Jan-15	0	1	⬄
EBS2	Cancelled Operations - % of patients not re-admitted within 28 days (PSHFT)	2013/14	13.9%	0%	NA	Q3	4.7%	14.0%	⇧
EBS3	Mental Health - Care Programme Approach (CPA) - % of patients under adult mental illness on CPA who were followed up within 7 days of discharge from psychiatric in-patient care	2013/14	99.0%	95%	90%	Q3	100.0%	96.5%	⇧
EBS4	Number of 52 week Referral to Treatment Pathways	2013/14	1	Zero Tolerance	NA	Jan-15	0	2	⬄
EBS5	Trolley waits in A&E - Number of patients who have waited over 12 hours in A&E from decision to admit to admission (PSHFT)	2013/14	0	Zero Tolerance	NA	Jan-15	0	0	⬄
EBS6	Urgent operations cancelled for a second time (PSHFT)	2013/14	0	Zero Tolerance	NA	Jan-15	0	0	⬄
EBS7 i	Ambulance handover time - Number of handover delays of over 30 minutes (Peterborough City Hospital)	2013/14	360	Zero Tolerance	NA	Jan-15	130	894	⇩
EBS7 ii	Ambulance handover time - Number of handover delays of over 1 hour (Peterborough City Hospital)	2013/14	23	Zero Tolerance	NA	Jan-15	20	119	⇧

Trend Key: ⬄= Little or no change, ⇧= Improvement, ⇩= Deterioration

For a full update and narrative for areas below the standard please see the Board Report using the following link: http://southlincolnshireccg.nhs.uk/our-governing-body/governing-body-papers?view=docman

Whilst ensuring delivery of the NHS Constitutional rights identified during 2014/15 some high priority areas of poor performance have required direct attention in partnership with Peterborough and Stamford Hospitals NHS Foundation Trust and United Lincolnshire Hospitals NHS Trust. These are:

- **Cancer services** : Future work with ULHT will continue to concentrate on the various tumour site pathways and their contribution toward the overall sustained improvements to deliver the mandated 14, 31 and 62 day treatment standards (including application of national guidance and best practice (i.e. cancer drugs fund and chemotherapy protocols) and also prevention initiatives through the cancer screening programmes (breast, bowel and cervical) and Early Presentation of Cancer (EPOC) development team. This pathway specific work will deliver and aim to sustain the improvements in current levels of delivery for these standards.
- **EMAS** – SL CCG have a number of schemes in place in order to improve EMAS performance at a South Lincolnshire level; these are EMAS CAT car, EMAS Mental Health Car, Amvail Crew. SL CCG has met with EMAS to discuss further initiatives which could be implemented to improve performance. We are currently awaiting for business cases/proposals from EMAS. There is also a ring fenced ambulance crew operating within the South Lincolnshire area along with the pilot scheme involving the fire and rescue service.
- **Stroke services**: through health checks, rapid access to Transient Ischemic Attack (TIA) clinics, hyper acute stroke assessment and treatment in Boston and Lincoln with dedicated stroke wards and early assisted discharge to ensure services are fully implemented and delivering better outcomes for the people of Lincolnshire. The Executive Nurse and a SLCCG GP visited PSHFT to review the stroke pathway and a quality assurance visit report was

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produced following this detailing any areas for improvement. The SLCCG Performance Manager has also completed Sentinel Stroke National Audit Programme (SNAP) and collated the results of main providers into a report which went to Clinical Committee.

- **Health care acquired infection:** The CCG's federated Infection Prevention and Control Team have developed an action plan detailing the specific assurance elements pertaining to reduction of HCAIs using the 10 criterion detailed within the Health and Social Care Act (2012) Code of Practice on the prevention and control of infections and related guidance. The action plan is split down between providers and this is monitored on a monthly basis with progress reports produced and sent to the CCG monthly.
- A programme of planned visits is scheduled with all providers in relation to the 10 criteria and Infection Prevention and Control. Responsive visits are also implemented whenever needed.
- The CCG Infection Prevention and Control function has provided numerous full day training sessions to Primary Care and commissioned providers. Since March 2014, there have been 6 full day sessions delivered with 5 more planned in quarter 4 2014/15. This effectively enables practices and providers to have dedicated Infection Prevention and Control Link Champions within their own environment to raise standards and support colleagues.
- Ongoing work is being completed to eradicate MRSA and CDIFF wherever possible. All cases of MRSA and CDIFF are subject the RCA and thorough investigation in conjunction with providers and clinical teams.
- **Mixed sex accommodation:** to complete the progress towards the elimination of mixed sex accommodation
- **A and E waiting :** Working with system resilience groups to improve patient flow by increasing integration with primary care services, improving access to primary care and working with the provider of the 111 service to continue to reduce demand and improve the patient experience. Development of Neighbourhood Teams and implementation of further community schemes to support PSHFT to achieve the A&E 4 hour wait standard.
- **Cancelled Operations –** SL CCG are monitoring provider's cancellation rates and this performance is linked to the wider system performance issues which are addressed via the SRG's for both Lincolnshire and Peterborough. SLCCG have also commissioned a dedicated Assertive In Reach Team (AIR's) to ensure the timely discharge of patients and reduce delayed transfers of care (DTOC's) which increases flow within the hospital therefore creating capacity.
- **Ambulance Handover –** Performance is monitored by SL CCG and also via SRG's for both the Lincolnshire and Peterborough System. The CCG actively work with EMAS and the Trust to improve handover performance and have funded the implementation of inbound screens which are currently being implemented. EMAS are invited to attend both SRG's and again would feedback any issues for action.
- **18 week referral to treatment waiting**: building on the steady improvements in reduced waiting lists and improving access the ambition is to not only deliver but surpass national standards. To maintain the momentum of the recent Operational Resilience work which has recently been completed in order to reduce backlogs.

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Attention will be maintained throughout 2015/16 with a view to going beyond what is 'acceptable' to further develop and sustain high quality services. The constant review of the recovery plans and trajectories will ensure delivery of the national quality standards.

Finance

Delivery of the Financial Position in 2014/15

The CCG is forecast to deliver its planned surplus of £1.9m in 2014/15. This has required the management of a number of risks including additional pressures arising from unexpectedly high activity levels.. This pressure has been managed in year through the reprioritisation of expenditure plans and the non-recurrent application of contingencies. The 2015/16 financial plan addresses the financial pressures and makes allowance for the actual growth incurred.

5 year financial plan

Planning Assumptions
The CCG's financial plan complies with, and incorporates all of the suggested key metrics and assumptions within the national guidance; Everyone Counts: Planning for Patients 2014/15 to 2018/19. The key metrics delivered and the planning assumptions used are set out in the table below. In particular, the CCG's financial plan delivers a 1% surplus and at least a 1% risk adjusted surplus in each of the 5 years (based on recurrent, non-recurrent and running costs allocations). The CCG's underlying surplus exceeds 2% in each year.
Within the financial plans the CCG has used local assumptions on population growth. These are based on ONS projections but are informed by the demographic growth evident within GP practice populations. This has resulted in higher population growth than suggested by other sources. The financial plan incorporates tariff changes as highlighted in guidance. The two key areas of expenditure, GP prescribing and continuing health care, that have historically incurred additional growth (above demographic growth) have also been uplifted by 4% and 2% respectively each year.

	2014/15	2015/16	2016/17	2017/18	2018/19
Key Metrics	%	%	%	%	%
Allocation Growth	2.56	1.96	2.09	2.09	2.56
Surplus	1	1	1	1	1
Underlying surplus	3.11	2.25	2.58	3.62	4.96
Non recurrent headroom	2.0	1	1	1	1
Contingency held	0.5	0.5	0.5	0.5	0.5
Planned QIPP	2.1	1.93	1.0	1.0	1.0
Uplift Assumptions					
Health Cost Inflation – acute	2.5	2.9	4.4	3.4	3.3
Health cost Inflation – non acute	2.8	3.1	4.6	3.6	3.5
Provider sector efficiency	-4	-4	-4	-4	-4
Demographic growth	1.82	1.72	1.65	1.59	1.53
Prescribing growth	4	4	4	4	4
Continuing Health Care Growth	2	2	2	2	2

Non Recurrent Funds
The business rules set within planning guidance require CCGs to invest funds from a number of non-recurrent sources. These include the establishment of a fund for headroom and funds recovered from providers for the financial consequences of the Marginal Rate Emergency Tariff (MRET) and unavoidable readmissions. The CCG's financial plan provides for these sums in full and sets out the key areas where it is expected that these sums will be reinvested.

Non recurrent headroom

In 2015/16 the CCG's financial plan provides for 1% non-recurrent expenditure. Of this, £1.2m is required to fund the national continuing healthcare risk pool. The remaining balance is required for transformation and the CCG has committed the total of this sum to supporting the implementation of the Lincolnshire Sustainable Services Review. Specifically, this is expected to be invested to meet the double-running costs likely to be incurred by providers whilst the service changes associated with the review are established.

MRET and Readmissions

The CCG has provided in full within its 5 year plan for the sums withheld from providers in relation to MRET and readmissions. The sums are withheld non-recurrently although since the establishment of MRET funds have been applied to fund schemes designed to reduce emergency admissions and avoid readmissions. Where these schemes have been deemed to be successful the plan assumes that they will be continued and the relevant sums be reinvested

Better Care Fund

In 2015/16 the Better Care Fund will be established. The CCG's financial plan identifies the additional resources received and also sets aside the required expenditure element of its allocation. (£3.087m and £9.810m respectively in 2015/16).
The BCF presents a real opportunity for efficiencies to be delivered through integration and the Lincolnshire CCGs are working closely with the Council to maximise those opportunities. As a result the CCG is contributing an additional £12.5m of services and resource into the fund over and above the minimum level set out. These additional resources represent current expenditure levels associated with mental health services where it is believed that integration and the pooling of resources can derive real benefits for patients together with financial efficiencies.

Risks

The CCG recognises that there are a number of risks inherent within its plans. These largely relate to the risks of activity exceeding the expected and contracted for levels. There are also risks that the QIPP programme fails to deliver the expected financial efficiencies. Risks also exist in areas where growth has historically been seen such as in continuing health care and prescribing. The CCG has endeavoured to ensure that the financial plan includes the financial impact of all likely financial impacts however a level of uncertainty must remain. To mitigate this, the CCG has established a contingency reserve of 0.5% in each of the 5 years. The CCG's programme management approach to QIPP will also identify at an early stage any schemes that are not delivering so that remedial action can be taken.

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Overview of QIPP schemes

In 2014/15 the CCG is forecast to under deliver on its overall QIPP target by £375k. For the remainder of the QIPP programme some schemes did not deliver as planned, others were scaled up and new schemes were implemented to compensate. The impact of the under delivery means that the overall QIPP challenge in 2015/16 has been reassessed to approximately 2% of the CCG's resource limit which equates to circa £4m. Thereafter the CCG plans to deliver 1% QIPP in each financial year, largely through the benefits offered through the LSSR.
There are a large number of schemes that contribute to the overall QIPP programme and these are in differing stages of development however, fully worked up plans deliver 75% of the overall target. The CCG has used the information provided within the Better Value packs to identify the remaining areas on which to focus to ensure overall delivery of the target.
Delivery of QIPP remains an area of risk to the CCG as it exists in a health economy where its two main providers are financially challenged. Nevertheless, the CCG is working closely with those providers to identify areas where efficiencies can be driven out of the whole system rather than cost-shifting between providers and commissioners. From late 2014/15 the Lincolnshire Sustainable Services Review (LSSR) is expected to impact and this is a key strategy that will address the total financial challenge assessed to exist within the County. At this stage the full impact of LSSR has not been factored into plans however, the investment required to secure delivery has been identified as the main call on transformation funds set aside by the CCG in 2015/16.

The CCG has put in place a robust governance process around the development, implementation and monitoring of all service developments and improvement schemes including QIPP. Every potential scheme is developed in accordance with the CCG's business planning process and are initially scoped and prioritised at the CCG's Clinical Committee. Every QIPP scheme must be aligned to and contribute towards the CCG's overall strategic objectives and is signed off by the Governing Body. The overall delivery of the QIPP programme is monitored by the Governing Body.

Summary and Financial Sustainability

The 5 year financial plan supports the delivery of the CCG's strategic and operational intentions. It does this within the constraints of the resources available to it. The financial plan demonstrates how the CCG must direct its resources in the early years to identify and implement strategic change in order to deliver a sustainable financial position within the lifetime of the plan.
Key to the delivery of the plan are the QIPP schemes that will create service changes and deliver a model of care that is more efficient and better for patients. The Lincolnshire Strategic Services review will be a major driving force behind the redesign of services within Lincolnshire and its outcomes are expected to deliver significant reductions in acute care. The importance of the LSSR to the CCG's financial sustainability is reflected in the application of the majority of the transformation funding available within the financial plan to support its delivery and implementation.
In addition to this, South Lincolnshire CCG is mindful that the majority of its acute patient flows are to providers outside the county. Therefore, the CCG has identified further QIPP schemes that impact directly on its other major acute providers. Similarly, the investments funded from MRET and readmissions penalties are applied to schemes that impact on all providers accessed by the CCG's population.
Achievement of the QIPP targets in previous years and in 2015/16 provide the financial capacity to support the establishment of the BCF in 2015/16. The BCF will then be used to facilitate further efficiencies within the health and social care sectors through the closer integration of services.
The BCF and the LSSR provide the two key mechanisms through which to deliver the strategic change necessary to ensure the longer term financial sustainability of the CCG as well as the wider Lincolnshire health economy. The LSSR will identify the necessary service changes while the BCF will

provide the vehicle through which those changes can be transacted.

Provider Commissioning Intentions

2015/16 Commissioning intentions have been sent out to providers and SLCCG are currently in negotiation with providers, where we are lead commissioners, to secure 2015/16 contracts.

Context

The Lincolnshire CCGs are, with local partners, currently implementing our five year strategic plans through the transformational Lincolnshire Health and Care Programme (LHAC). LHAC, and the delivery of sustainable health economy-wide improvements in service quality and efficiency, are the main contractual priorities for 2015/16.

The LHAC process will drive commissioner investment, disinvestment and cross sectional resource shifts on an on-going basis. Any material changes will be subject to the appropriate notice, engagement and consultation as required.

Principles

The overarching principles that CCG's intend to employ are as follows:

- The recurrent activity forecast outturn of the 2014/15 contract (once agreed), as revised for agreed recurrent CV's, shall serve as the baseline for 2015/16. In particular, the FYE of recurrent changes agreed for 2014/15 will be carried forward into 2015/16. Commissioners will expect to see the impact of national, non-recurrently funded activity initiatives undertaken during 2014/15 clearly removed from the baseline.

- The PbR Code of Conduct will apply at all times. Any provider proposed changes or corrections to counting or coding must be agreed in advance with commissioners and comply with national data definitions and information standards.

- For nationally priced services, payments above mandatory tariff will not be made except through local tariff modification applications supported by Monitor.

- Any provider proposed changes to non-mandatory tariff areas must be accompanied by robust minimum data set and subject to audit. In line with guidance we may seek to risk-share the impact of changes that have a significant financial impact.

- Improvements in data quality to support better patient care, demand and capacity planning, and resource utilisation are supported. However, improved coding and counting is not intended to lead to activity and cost inflation.

- Any proposed service changes must be supported by agreed clinical pathways and service specifications. This requires 12 months shadow monitoring and cost analysis. Providers should not initiate service developments unless these are formally requested or agreed by CCGs.

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- The NHS Standard Contract mandatory terms and conditions will apply at all times. Where flexibility is permitted this will be agreed within contract negotiations and adhered to throughout.

- Commissioners will expect that national guidance and policy for the provision of data and information to enable the robust management of patients and services to be adhered to at all times.

- The Commissioners Prior Approval policy shall be adhered to at all times. The commissioners will not pay for treatments within this policy that have not received prior approval or met the clinical thresholds.

- CCGs will seek to implement, where relevant, the findings of any Payment by Results Annual Audit Report by the Audit Commission. Any changes required from this will be reflected in the recurrent starting position from 1 April 2015.

- CCG commissioning intentions are in advance of the publication of the National Outcome Framework (or its equivalent) and final CCG budget allocations for 2015/16. As such, these intentions are subject to change as and when this information is available.

- Final PbR guidance and tariff for 2015/16 are not yet available. Commissioning intentions, as stated, are based on 2014/15 information and are therefore subject to change as and when national guidance becomes available.

Consequent to the final two bullet points above, the CCG's reserve the right to bring forward other issues/proposals for discussion during negotiations.

Priorities

The commissioning intentions for 2015/16 will seek to embed and sustain the service improvements made during 2014/15 and include:

- An increased focus on health, wellbeing and fitness, health improvement and health checks

- Reducing Health inequalities

- Revising pathways of care to support care close to home

- Movement to best practice in referral and patient management

- Expansion of patient choice through Any Qualified Provider (AQP) where market conditions indicate this represents good value for money. In particular, South Lincolnshire CCG plan to continue implementing AQP operational guidance to the NHS extending patient choice of provider in the following areas:
  - Gynaecology diagnostic procedures
  - Cataract procedure
  - Expansion of minor ophthalmology treatments
  - Expansion of minor orthopaedic treatments

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- Expansion of podiatry treatments
- Urology procedures

- Cancer Pathways review
- Improving End of Life care
- Continue to work with Peterborough & Stamford Hospitals Foundation Trust on the clinical strategy for Stamford
- Improving patient access and experience for Mental Health and Learning Disabilities
- Review of Diabetes services to improve community access
- Review of pathways into acute care

In addition to the above priorities the CCG will continue to focus on the following areas during 2015/16 with the aim of implementing service redesign and improvements:

- ENT – Bringing appropriate services into the community, creating better access for patients and carers.
- Dermatology – Develop primary care expertise via formal training in the diagnosis and treatment of dermatological conditions, in order that patients are not unnecessarily referred to hospital, including the assessment of the use of assistive technology to support this.
- Working with A8 Communities- This work stream is to provide better information, support and communication with the A8 communities to encourage appropriate use of the healthcare system improving quality of life for patients and carers.
- Stroke prevention - To identify patients with Atrial Fibrillation using GRASP – AF Tool. Patients identified at risk of a stroke using a CHADS2 scoring system are then prescribed anti-coagulation to reduce the risk of a stroke.
- Chronic Heart Failure management – To increase the number of patients on Heart Failure Registers prescribed ACE Inhibitors to reduce hypertension.
- Dementia Strategy – Review of services to improve and increase support and levels of intervention for patients and carers.

30 Day Emergency Readmissions and Marginal Rate Emergency Threshold (MRET)
CCGs await national guidance on the application of 30 Day Emergency Readmissions and MRET. We are expecting to manage these in line with national guidance and PbR Guidance for 2015/16.

Contract value and unit cost of activity
As stated in our intentions for 2014/15 CCGs will continue to progress plans to increase their investment in community and sub-acute healthcare services and to reduce their relative investment in acute services for 2015/16.

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Appendix 1
CVD Prevalence

The prevalence of AF across South Lincolnshire is 3,164 (1.98%) the aim is to get to 3,195 (2.00%). If we can reach the target and treat 85% of those patients with anticoagulation we can prevent 31 strokes.

Appendix 2
Planning Document

GP – Patient Experience
(a) <u>Satisfaction with the Quality of Consultation at a GP Practice</u> –
The aggregated % of patients who gave positive answers to five selected questions in the GP survey about the quality of appointments at the GP practice

Numerator ***% of patients who answered positively to at how good the doctor or nurse was:***
(1) At giving you enough time
(2) At listening to you
(3) At explaining tests and treatment
(4) At involving you indecisions about your care
(5) At treating you with care & concern

Denominator ***Total no. of patients responding to the questions***

Success ***Plans should show an annual improvement***

<u>Planning assumptions</u>

Targets have been set based on the average scores (%) of the last two GP Surveys and have been set to show an improvement based on the annual position.

Indicator - The Aggregated % of patients who gave positive answers to 5 selected questions in GP Survey about the Quality of appointments at the GP Practice	Jan-Mar 13 and Jul-Sept 13	Jul -Sept 13 and Jan-Mar 14	Jan-Mar 2014 and Jul-Sept 2014 (data released 8/01/15)	Average from Last 2 Surveys	Target for 2015/16
% of patients who answered positively at how good the doctor or nurse was at:					
(1) Giving enough time	0.91	0.88	0.88	0.88	0.89
(2) Listening to you	0.92	0.89	0.88	0.89	0.89
(3) Explaining tests & treatments	0.90	0.88	0.87	0.87	0.88
(4) Involving you in decisions about your care	0.85	0.84	0.82	0.83	0.83
(5) Treating you with care & concern	0.90	0.87	0.86	0.86	0.87
Aggregate (Score out of 500)	448	435	432	433	436

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The calculation for above is as follows: Survey data is at CCG level

Numerator:

Total number of "good" & "Fairly good" responses for each individual question

Denominator:

Total number of responses at CCG Level (GP + Nurse) minus "doesn't apply" for each individual question

(b) <u>Satisfaction with the Overall Care received at the Surgery</u> –

Patient satisfaction: Satisfaction with the overall care received at the surgery

Numerator ***No. of patients who answered "very good" or "fairly good" to the question: Overall, how would you describe your experience of your GP surgery?***

Denominator ***No. of patients responding to the question "Overall, how would you describe your experience of your GP surgery?***

Success ***Annual improvement***

<u>Planning assumptions</u>

Targets have been set based the Jan-Mar 2014 & July – Sept 2014 Surgery and an uplift of 1%.

Satisfaction with the Overall Care received at the Surgery	Jan-Mar 13 and Jul-Sept 13	Jul -Sept 13 and Jan-Mar 14	Jan-Mar 2014 and Jul-Sept 2014 (data released 8/01/15)	Prediction based on 1% uplift	No. of extra responses required
Numerator: No. of patients who answered "very good" or "fairly good" to the question: Overall, how would you describe your experience of your GP surgery?	2403	2289	2221	2265	44
Denominator: No. of patients responding to the question "Overall, how would you describe your experience of your GP surgery?	2664	2609	2545	2545	
% of patients who gave positive answers to the Question	90%	88%	87%	89%	

(c) <u>Satisfaction with the Overall Care received at the Surgery</u> –
Patient satisfaction: Satisfaction with Accessing Primary Care

Numerator ***No. of patients who answered "very good" or "fairly good" to the question: Overall, how would you describe your experience of making an appointment?***

Denominator ***No. of patients responding to the question "Overall, how would you describe your experience of making an appointment?***

Success ***Annual improvement***

<u>Planning assumptions</u>

Targets have been set based the Jan-Mar 2014 & July – Sept 2014 Surgery and an uplift of 1%.

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S Lincs					
Satisfaction with Accessing Primary Care	Jan-Mar 13 and Jul-Sept 13	Jul -Sept 13 and Jan-Mar 14	Jan-Mar 2014 and Jul-Sept 2014 (data released 8/01/15)	Prediction based on 1% uplift	No. of extra responses required
Numerator: No. of patients who answered "very good" or "fairly good" to the question: Overall, how would you describe your experience of making an appointment?	2067	1931	1928	1947	19
Denominator: No. of patients responding to the question "Overall, how would you describe your experience of making an appointment	2625	2524	2478	2478	
% of patients who gave positive answers to the Question	79%	77%	78%	79%	

Appendix 3
Cancer Operational Plan

For a copy of this document contact cumba.balding@southlincolnshireccg.nhs.uk

Appendix 4
Dementia Trajectories

Practice	Dementia ES sign up	Cantab Sign up	"Gap" to ambition - updated Dec 14	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April
Abbeyview	Y	Y	18	41.1	44.4	45.2	44.76				
Beechfield	N	Y	51	38.5	41	43.6	43.04				
Bourne Galletly	Y	Y	3	64.2	63.6	65.3	67.02				
Deepings	N	N	66	38.5	41.5	42	47.14				
Gosberton	Y	Y	18	50.5	49.4	50.4	49.94				
Hereward	Y	N	0	69.4	67.9	70.6	72.85				
Littlebury	N	N	12	60.2	56.4	58.2	59.93				
Long Sutton	Y	Y	47	4308	44.5	50.6	50.67				
Moulton	N	Y	35	26.9	29.2	29.7	29.48				
Munro	Y	Y	0	69.8	71.1	72.3	71.94				
Pennygate	N	N	0	150	168	172.4	186.47				
Sutterton	Y	Y	21	28.3	29.2	29.5	29.36				
St Marys	Y	Y	0	63.3	65.4	68.5	70.77				
The Little Surgery	Y	Y	10	33.3	37.9	45.1	57.32				
The New Sheepmarket Surgery	N	Y	48	39.8	40.7	41.6	41.45				

Appendix 5
Dementia Report to Governing Body

For a copy of this document contact cumba.balding@southlincolnshireccg.nhs.uk

Appendix 6
A Call to Action: Commissioning for Prevention

For a copy of this document contact cumba.balding@southlincolnshireccg.nhs.uk

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Appendix C

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

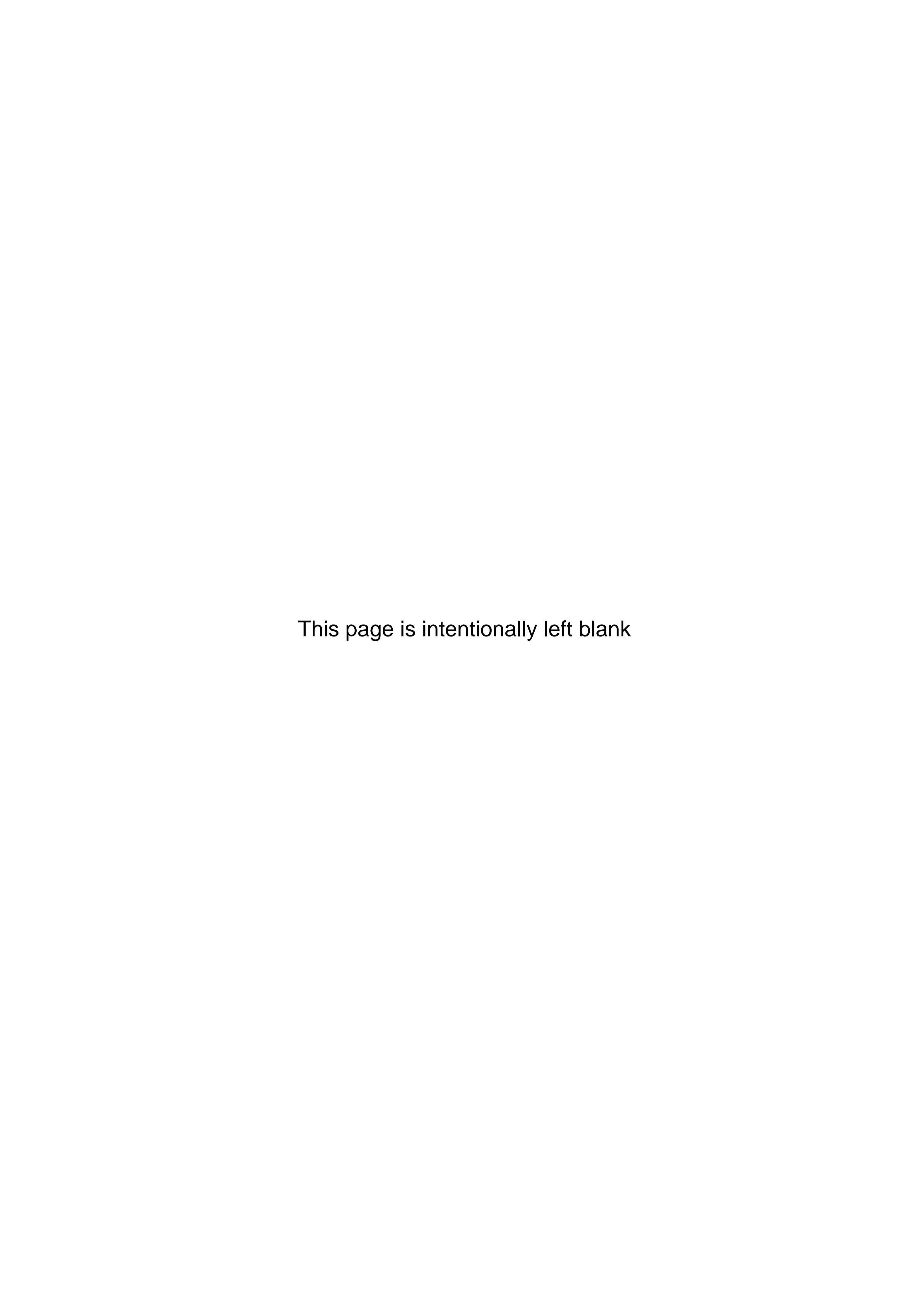
The JSNA points to worklessness being a highly significant determinant of people's health. Work improves mental health, reduces the likelihood of poverty and increases self esteem. There are links between health and the quality of work too. The evidence in the JSNA, taken originally from the Economic 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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CCG: NHS South Lincolnshire

2015/16 operational plan on a page

Three key areas of focus for the 15/16 operational plan

1. **Improving Quality and Outcomes**
2. **Delivering patients constitutional rights and pledges**
3. **Delivering local integrated services including preventative and personal care planning support**

Access

SLCCG with our health and social care partners will work to deliver standards in Lincolnshire and Cambridgeshire; the SRG's are supported by planned, cancer and urgent care boards.

A&E – CCG schemes, neighbourhood teams, web based care planning, rapid response & ILT, IC MDT pilot, admission avoidance in A&E. current performance 91.15% FOT 95%.

Winter resilience continued investments in proven schemes, discharge team in PSHFT, additional IC beds, clinical assessment & treatment car, frailty pathway & unit

RTT – Capacity commissioned to sustain reduction in backlogs and achievement of RTT standards, CCG current underperformance 88.2% for admitted, FOT 90%.

Cancer –additional capacity commissioned with alternative providers to ensure access available to patients, whilst working with challenged Trust to recover performance, CCG currently underperforming in 2ww 91.6% FOT 93%

Diagnostics –Commissioned to continue achievement of standard and increase provision through AQP.

IAPT –Targets set to continue achievement of standard including new waiting time targets.

Dementia – on plan to achieve national standard, practices have CANTAB tool for early identification, Dementia support co-ordinator working with neighbourhood teams

Early intervention –MECC encompassed in contracts, audit analysis used to share good practice, diabetes education programme

Primary Care- EOI, fully delegated co-commissioning use new models to commissioning localised, integrated care, address variation, inequalities, improving access for citizens from A8 communities.

Outcomes

Delivery across the five domains and seven outcome measures

Improving health - The CCG and PH are gaining commitment to use the principles of Making Every Contact Count to provide meaningful brief lifestyle interventions to support patients to live healthier lives and contribute to the prevention agenda. This will be done in conjunction with Local Authorities commissioning lifestyle services for example stop smoking services and weight management.

Reducing health inequalities – In partnership with PH to ensure the five most cost effective high impact interventions on health inequalities are implemented. All practices are providers of NHS Health Checks providing a means of identifying previously undiagnosed patients with or at risk of CVD, diabetes and CKD, deep dive of an CfV pack a focus on PYLL and Under 75 mortality rates, actions will be put in place where required. Clinical quality reports will be produced and shared with all practices to track progress against performance.

Parity of esteem — physical health care has been embedded into contracts to help reduce the health inequalities between people with serious mental illness and the general population. Quality schedule updated to include monitoring and management of physical health needs. Investments in MH include dementia, CAMHS and a self-harm pathway. Introducing 'experts by experience' to support access to health checks and to improve pathways into and through services.

Quality

Patient safety –Quality Schedules are reflective of areas of risk and the CCG ensure organisations report performance against these. Clinical harm or near misses are reported to both commissioners and to patients & relatives as per the NHS Constitution. Investigations & lessons learnt are shared. CQUINs used to incentivise Harm Free Care through Safety Thermometer improvement goals. Whole health community approach to HCAI and CCG current C Diff performance 25 cases against rolling trajectory of 28.

Patient experience –Continuous Listening Model implemented to ensure robust mechanisms in place which enable patient experience to influence our plans and drive improvement. Patient experience log compiled from all soft intelligence available such as PPGs, patient opinion, Healthwatch & listening events. Friends & Family Test CQUIN utilised across all relevant providers and performance monitored at both trust & ward level. Rigorous approach applied to the management of complaints and the triangulation of soft intelligence.

Compassion in practice –.Providers monitored against implementation of compassion in practice, with oversight provided through the Lincolnshire quality forum. This enables integration of the strategy and a common approach in both provider and commissioning organisations. Agreed priorities include leadership, the culture of care and development of core values and behaviours.

Safeguarding – Central federated function for safeguarding which enables a concerted resource and capability to meet the requirements of the accountability and assurance framework for protecting vulnerable people. Strategy developed designed around core themes including governance, education and training, monitoring and disseminating learning, and strengthening processes to ensure effective partnership working. The key priority is on ensuring the protection of vulnerable people, and setting quality improvement

Staff satisfaction –Continuation of national CQUIN requirement in relation to the Staff Friends & Family Test & ongoing monitoring proxy measures of staff satisfaction such as turnover on a regular basis.

Seven day services – The CCG will continue to work on the delivery of seven day services, working with providers to implement 5 of the clinical standards. Co-production of CQUINs to enhance delivery.

Response to Francis, Berwick and Winterbourne View – Francis recommendations translated into quarterly dashboard report highlighting related performance of providers. Extensive engagement work to ensure patients and their carers are involved at all levels within the commissioning cycle including targeted work with the A8 community. Transparency and the duty of candour is reinforced within quality schedules and monitored as part of the incident reporting process. CCG programme of quality assurance visits across all providers which allow the CCG to test out what has been reported. Discharge plans for all 'winterbourne criteria ' patients eligible for discharge are monitored to ensure that they are able to be discharged in a timely way.

Reconfiguration – There is a clear emphasis on reconfiguration to develop high quality sustainable services and SLCCG are fully engaged in the LHAC transformation programme

Delivering value

- Financial resilience and value for money rigorously pursued through transformation.
- Financial plan delivers 1% surplus, £1,968k in 2015/16.
- The CCG's underlying surplus in 2015/16 is planned to be 2.16%, £5,151k.
- No plans to drawdown accumulated surplus.
- Planned investment in mental health in accordance with parity of esteem expectations
- 0.5% contingency held to mitigate against unforeseen financial pressures.
- Activity commissioned sufficient to meet population growth.

Financial plan sets out the transfer of funds to the Better Care Fund (BCF). BCF will be a key

Transformation programmes, reconfiguration plans and reprocurement

- Development of neighbourhood teams
- Develop integrated services where appropriate
- County wide procurement of Intermediate Care
- Movement of Maternity Services for certain practices to stop fragmentation of service
- Care closer to home includes procurement of community ENT and Dermatology Services.
- Dedicated Parkinson's Nurse to care for and enable patients to proactively manage their condition.
- Interactive educational sessions for diabetes patients to encourage innovative ways to manage their condition
- Review of commissioning and delivery of services through co-commissioning

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LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of South West Lincolnshire CCG

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**24 March 2015**
Subject:	**South West Lincolnshire Clinical Commissioning Group 2015/16 'Plan on a Page'**

Summary:

The attached document is the summary plan on a page which is part of the refresh of the Two Year Operational Plan produced by the CCG and reviewed at the Health and Wellbeing Board last year. Planning requirements for this year do not require a full re-submission of the Plan but merely a refresh against progress in delivering the Two Year Operational Plan and the revised planning guidance.

Actions Required:

Health and Wellbeing Board is asked to note and comment on the plan on a page priorities.

1. Background

South West Lincolnshire CCG covers a population of approximately 129,000, 19 practices and approximately 80 GPs. Centred around the market towns of Grantham and Sleaford it is a relatively affluent area but with one practice having a population which is more deprived than the national average. South West Lincolnshire CCG has an above national average incidence of illness with diabetes, cardiovascular disease and respiratory disease being more prevalent than the national average. Overall mortality from cancer is higher than national average, however, areas of focus in past years alone colorectal and breast cancers there has been significant improvement of outcomes are now better than national average.

South West Lincolnshire CCG historically has sent approximately 80% of its acute demand to United Lincolnshire Hospital Trust, with the remaining 20% being spread between Nottingham and Leicestershire providers. This, however, has reduced to 75% in 2013/14 and with only 65% of all planned surgery now going to ULHT with increasing numbers now moving to out of county providers, largely due to difficulties in Lincolnshire based services delivering acceptable waiting times. South West Lincolnshire CCG is currently piloting an urgent care extended hours pilot with local practices around Sleaford and is developing three neighbourhood teams: Sleaford and District, Grantham Town and Grantham Rural.

A Two Year Operational Plan was produced by CCGs in 2013/14 and reviewed at the Health and Wellbeing Board this time last year. CCGs were required to produce a five year strategic plan as part of the planning guidance to refresh their two year operational plans against progress and delivery of the NHS Constitution standards as well as any other strategic objectives. The key priorities for South West Lincolnshire CCG continue to be as follows:

1. Delivering the key quality standards for healthcare for our population including waits in A&E, referral to treatment time for planned surgery and cancer service access times.
2. The delivery of our agenda in support of Lincolnshire Health and Care, the development of neighbourhood teams and the development of community services.
3. Delivery of collective action across Lincolnshire in support of the Joint Health and Wellbeing Strategy and our contribution to the Joint Strategic Needs Assessment. The plan on a page reflects all of the key priorities reflected in this year's planning guidance and the overarching ambition is the delivery of all key NHS Constitutional standards from April 1st. This will involve increasing the use of out of county providers, since access to services at ULHT have deteriorated over the past twelve months for our population and with ongoing capacity issues at United Lincolnshire Hospital Trusts, meaning that they are not able to give us assurance that capacity will be available in the coming year.
4. Delivery of the agenda on parity of esteem for mental health ensuring that resources are targeted at improving outcomes in experience for people with mental health needs and ensuring that mental health needs are considered within physical healthcare services.

2. Conclusion

The plan on a page reflects the current priorities and does reflect the work around Lincolnshire Health and Care which is being implemented around neighbourhood teams. It does place priority on some of the key areas for improvement which remain around NHS Constitutional Standards Delivery for our population.

3. Consultation

There is no formal requirement for public consultation on the plan on a page.

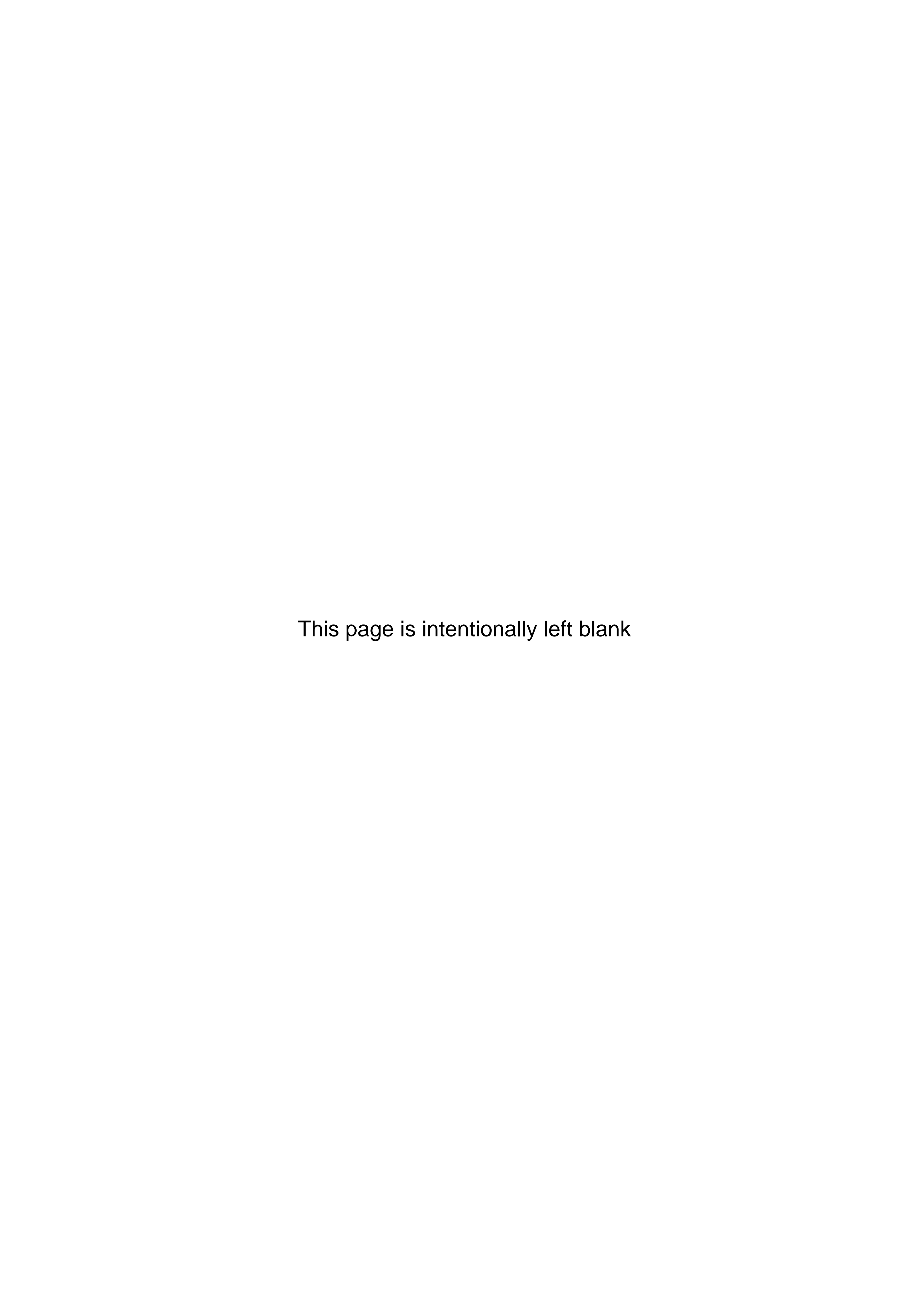
4. Appendices

These are listed below and attached at the back of the report	
Appendix A	South West Lincolnshire CCG 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 Allan Kitt, Chief Officer, who can be contacted on 01476 406578 or Allan.Kitt@southwestlincolnshireccg.nhs.uk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Three key areas of focus for the 15/16 operational plan

1. **A partnership with the local population to improve the Health and Wellbeing for all residents**
2. **Patient safety and quality of provision is paramount delivered within constitutional standards**
3. **Develop local services that are integrated and focus on proactive care.**

Access

Meeting the NHS Constitution standards and Mandate commitments

A&E – Current performance is 92.5%. SRG in place plus CCG projects – GPs in A&E; Sleaford Urgent Care Service; Neighbourhood Teams; additional intermediate care beds; care planning and care home support. Will Improve flow and meet A&E for 2015/16

Winter resilience – Improve overall proactive and urgent care = strengthened system with ability to flex in periods of high demand. This is overseen by the SRG with support from Planned and Urgent Care Boards.

RTT – Current performance is 89% Admitted, 93% Non-admitted, 88% Incomplete. Review of implementation and progress against 10 High Impact Changes. Commission increased activity levels from a wider range of providers to enable achievement of all RTT standards by end Q1 2015/16.

Cancer – Current performance is below for 2ww 88% &69% respectively. Cancer Summit held, actions agreed to improve. CCG already commission with alternative providers (475 slots) to meet demand and subsequent treatment.

Diagnostics – Current performance 99%, continue to promote utilisation of AQP contracts.

IAPT – continue to achieve national standard and new waiting times.

Dementia – roll out of Cantab tool for early identification; care planning for all dementia patients; dementia support network commissioned to meet improved position

Early intervention – continued development of proactive care (Neighbourhood Teams)

Primary Care – Quality assurance in primary care through clinical governance and practice visits, EOI for delegated co-commissioning

Outcomes

Delivery across the five domains and seven outcome measures

Improving health – continue to work with our partners e.g. Public Health, Health and Wellbeing Board to improve the health of our population. MECC and/or signposting to services through proactive care provided through Neighbourhood Teams to support patients and carers. Achieve CDIFF trajectory of 25. Maintain above target position Smoking quit rate and Exercise on referral. NHS Health checks maintain above target invites and FOT uptake of 60%, look at variation.

Reducing health inequalities – review the implementation of the 5 high impact interventions. EG: early identification of AF patients enabling the appropriate use of anti-coagulant therapy, will maintain 1.8% increase to remain in upper quartile. 40% increased drug prescribing for hypertension and cholesterol. Localised Deep dives with public health on improve life expectancy and reduce mortality e.g. CVD related disease – diabetes, heart failure etc. We need an additional 89 people taking anti-platelet or anti-coagulant therapy to achieve the benchmark. We will improve this year on year.

Parity of esteem – physical health care has been embedded into contracts to help reduce the health inequalities between people with serious mental illness and the general population. The quality schedule has been updated to include monitoring and management of physical health needs. Investments in MH include dementia, CAMHS and a self-harm pathway. Introducing 'experts by experience' to support access to health checks and to improve pathways into and through services.

Quality

Patient safety – the Quality Strategy and assurance framework helps to identify; monitor and challenge patient safety and clinical outcomes. QPEC scrutinizes, investigates and takes action on sub-standard performance using contractual and professional levers to effect change. Serious Incident Analysis (including IG and Infection Control incidents) and HCP Feedback Reporting system enables learning across the secondary and primary care interface.

Patient experience - we mmonitor PE through complaints and compliments; Friends and Family Test; Patient Stories regularly shared at Governing Body and other committees; HealthWatch Reports; Walkabouts, talking to patients and their carers; PPGs, Patient Council, social media and NHS Choices and listening events. Patient Experience surveys are completed in line with standardised guidance and benchmarked against regional and national data sets to establish improvement areas.

Compassion in practice - A Quality Forum has been established across Lincolnshire to bring together Executive Leads for quality to enable the critical mass for driving forward the achievement of Compassion in Practice locally. Agreed priority areas for leadership, culture or care and workforce are embedded into the quality schedule and CQUINs.

Safeguarding – The Safeguarding Strategy outlines our governance arrangements and priorities. Delivery is underpinned by a central federated function for safeguarding. Priorities dovetail with business plans for LSCAB, LSAB and the Public Protection Board. We are members of the Multi Agency Prevent Strategic Management Board and engaged in the development of the PREVENT Strategy and CHANNEL.

Staff satisfaction – We continue to implement the National CQUIN requirement in relation to the Staff Friends and Family Test.

Seven day services - Identify priority areas for provider compliance with 7 Day Service Clinical Standards through provider self-assessment (NHS IQ) and monitors implementation in line with the Network approach to service models.

Response to Francis, Berwick and Winterbourne View - The Quality Strategy reflects the learning from the Francis and Berwick Report. Duty of candour is reinforced within quality schedules and monitored as part of the incident reporting process. An action plan in respect of Winterbourne is in place and on track to deliver all actions and embedding Care and Treatment Reviews into 'business as usual'

Reconfiguration – Ensuring links to the LHAC programme and taking into consideration the Five Year Forward View

Delivering value

Financial resilience; delivering VFM for taxpayers and patients and procurement – plan is compliant with all aspects of NHS planning guidance. Working with public health to regularly evaluate services ensuring they are clinically effective and provide value-for-money.
Surplus/Deficit 15/16 – 1%
Underlying surplus/deficit - £3.6m
Drawdown – on target as expected
Investments - £2.8m (1% non-recurrent, MRET and 30 day readmission credit)
Contingency – 0.5%
Activity assumptions –Activity has been commissioned to meet current modelling for growth and changes to pathways
Link to BCF plans - £7.9m into S(75) pooled funds and £10.2m into BCF Partnership Framework.

Transformation programmes, reconfiguration plans and reprocurement

Continued work on the LHAC programme across the system to identify future configuration.
Procurement of wheelchair services, intermediate care and neighbourhood teams.
Service development - Parkinson's service; Programme of HCP Diabetes Education; Dermatology Service; EOL Pathway & Enhanced primary care support for high risk patients.
Continued implementation of the Shaping Health Programme – ambulatory care and hub of children's services

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LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of Lincolnshire West Clinical Commissioning Group

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**24 March 2015**
Subject:	**Lincolnshire West Clinical Commissioning Group (LWCCG) 2015/16 'Plan on a Page'**

Summary: As part of NHS England Assurance Framework for Clinical Commissioning Groups (CCGs), all NHS CCGs must produce an annual rolling programme that outlines the work the CCG will undertake in year to achieve delivery of the NHS Constitution Standards, the Government Mandate to NHS England 2015/16 and NHS Outcomes Framework, in addition to local priorities based on the needs of the population. The *Forward View* Into Action: Planning for 2015/16 (December 2014 NHS England Publications Gateway Number: 02768) sets out the specific planning requirements for CCGs. This document describes the approach for national and local organisations to make a start in 2015/16 towards fulfilling the vision set out in the NHS *Five Year Forward View*, whilst at the same time delivering the high quality, timely care for the local population.

LWCCG Operational Plan for 2014/15 and 2015/16 was presented to the Lincolnshire Health and Wellbeing Board on 25 March 2014 and approved. Additionally The draft 5 Year Strategic Plan was presented, and discussed, at the Health and Wellbeing Board meeting on 9th December 2014.

For this planning round CCGs were asked to refresh their operational plans for 2015/16. The 'Plan on a Page' summarises key priorities, programmes of work and key performance indicators.

The purpose of this paper is to assure the Board that the JHWS continues to be supported by the refreshed LWCCG plan and to request the Board to formally support the plan.

Actions Required: To formally support the LWCCG 2015/16 'Plan on a Page'.

1. Background

The Five Year Forward View

The NHS Five Year Forward View was published on 23 October 2014 and sets out a vision for the future of the NHS. It has been developed by the partner organisations that deliver and oversee health and care services including NHS England, Public Health England, Monitor, Health Education England, the Care Quality Commission and the NHS Trust Development Authority. Patient groups, clinicians and independent experts have also provided their advice to create a collective view of how the health service needs to change over the next five years if it is to close the widening gaps in the health of the population, quality of care and the funding of services.

The purpose of the Five Year Forward View is to articulate why change is needed, what that change might look like and how it can be achieved. This will only be possible if NHS funding and efficiency both increase. The view outlines seven models for service provision, which NHS England want local areas to choose from, and actions that need to be taken on four fronts:

- More needs to be done to tackle the root causes of ill health, including action on obesity, alcohol and other major health risks
- A commitment to giving patients more control of their own care, including the option of combining health and social care, and new support for carers and volunteers
- The NHS must change to meet the needs of a population that lives longer. This means removing the boundaries between family doctors and hospitals, between physical and mental health and between health and social care. New models of care are set out, built around the needs of patients
- Actions need to be taken to develop and deliver the new models of care, including greater alignment between the national NHS bodies to provide meaningful local flexibility in the way that payment, rules and regulatory requirements are applied. It proposes more investment in workforce, technology and innovation

Under the proposals, more than half of England should be covered by new models of providing care, such as hospitals running GP practices and GP groups taking over hospitals. There will be no 'one size fits all' approach. New forms of providing and contracting services will be essential for the NHS to be sustainable in future.

The view wants areas to consider adopting one of two leading types of new organisational model.

1. A 'primary and acute care system' (PACS) - this will involve successful foundation trusts delivering GP services with patient lists. It is particularly suited to deprived areas where general practice is under strain
2. A 'multispecialty community provider' (MCP) – this will involve GP practices coming together either as federations or single organisations, and beginning to deliver community, social and potentially acute care services

In order to help move rapidly to new models of care, the next five years could see large scale sell-offs of unused NHS property. For instance, it is estimated that foundation

trusts have around £7.5bn worth of unused NHS buildings across England. It also supports a modern workforce, stating that the innovative new care models that NHS England proposes "simply won't become a reality" unless the NHS has a workforce with the right numbers, skills, values and behaviours to deliver it. Emphasis is given to the NHS becoming a better employer, by supporting the health and wellbeing of frontline staff; providing safe, inclusive and non-discriminatory opportunities; supporting employees to raise concerns, and ensuring managers quickly act on them.

The Governments Mandate to the NHS

Much of the Governments Mandate to the NHS is focused on the 5 main categories, known as domains in NHS Outcomes Framework which are used to hold CCGs to account via the NHS England. The NHS Outcomes Framework reflects the vision set out in the government's White Paper Liberating the NHS. Its purpose is to provide a national level overview of how well the NHS is performing; to provide an accountability mechanism between the Secretary of State and the NHS England and to act as a catalyst for driving up quality. Indicators in the NHS Outcomes Framework are grouped around the 5 domains, and set out high-level national outcomes that the NHS should be aiming to improve. They focus on improving health and reducing health inequalities:

Within the stable mandate, there are two important updates for 2015/16 to existing objectives.

- To meet NHS England's requirement to ring-fence £3.46bn to establish the Better Care Fund, and lead its effective implementation to join up health and social care services and improve the lives of some of the most vulnerable in society.
- Moving towards parity of esteem making sure that as much focus is placed on mental as physical health and patients with mental health conditions do not suffer health inequalities, because of their mental health conditions or because they don't get the best care for their physical health condition. This includes the introduction of access and waiting time standards for Improving Access to Psychological Therapies (IAPT) from April 2015 and the introduction of waiting times of Early Intervention in Psychosis services by March 2016

NHS Constitutional Standards

The NHS Constitution Standards set out the right s and responsibilities of our population in relation to NHS Services. United Lincolnshire hospitals Trust continues to struggle to deliver performance standards in a number of areas including:

Cancer (2 week and 62 day standards). The CCG has seconded a senior Project Manager to work with ULHT to address the underlying causes of poor performance and improve clinical dialog. A Cancer summit was held on 6 February to develop both short term longer term strategic direction.

A and E waiting times: Performance is variable between sites and throughout the year. As part of the System Resilience Group and its associated Programme of work the CCG will continue to work with ULHT to support redesign of patient flow, reducing inappropriate admissions and attendances.

18 week referral to treatment waiting: The CCG has seconded a senior Project Manager to work with ULHT to address the underlying causes of poor performance and

improve clinical dialog. Monitoring of performance has been hampered by problems arising from the introduction of a new Patient administration system (Medway).

Therefore the CCG will maintain continued focus on achievement of NHS Constitution Standards in 2015/16

Commissioning of Primary Care and Specialist Services

CCGs can choose to have more control over the wider NHS budget taking responsibility:

- For some specialist commissioning services where it makes sense to develop more local integrated commissioning.
- Taking responsibility for co-commissioning primary care services

The CCG was granted delegated responsibility for commissioning primary care services in March 2015 taking effect from April 2015, and is working with NHS England with regard to specialised commissioning. The development of a Primary Care Strategy (workforce, estates and federated working) will be important in maximising the opportunities commissioning of primary care services will bring.

2. Conclusion

Key national priorities for the refreshed 'Plan on a Page' are detailed in The *Forward View* Into Action: Planning for 2015/16.

3. Consultation

Consultation is undertaken by LWCCG in conjunction with appropriate stakeholders utilising different approaches with a clear link to LHAC and NHS England Planning requirements. As part of the refresh of the Operational Plan the CCG has completed the following engagement activities.

1. September 2014 stakeholder event to consult on 2015/16 Draft Commissioning Intentions
2. December 2014 consultation with the LWCCG Patient Engagement Group on Draft Commissioning Intentions for 2015/16
3. February 2015 stakeholder event and stakeholder survey to identify local quality premium priorities

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	LWCCG Draft Plan on A Page 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.

The links to the documents referred to are detailed below:

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

http://www.england.nhs.uk/wp-content/uploads/2014/12/forward-view-plning.pdf

This report was written by Annette Lumb who can be contacted on 01522 513355 or Annette.lumb@lincolnshirewest.nhs.uk

Lincolnshire West CCG 2015/16 Operational Plan on a Page

NHS Lincolnshire West Clinical Commissioning Group

Three key areas of focus for 2015/16

1. **Delivery of NHS Constitution Standards**
2. **Develop localities, the Primary Care Strategy and primary care commissioning**
3. **Develop models of holistic care for people (including people with severe and enduring mental health conditions)**

ACCESS

Meeting the NHS Constitution standards

- **A&E** Reduce emergency admissions by 3.5% and A&E attendances by 0.5%.
  Projects: Neighbourhood Teams. Frailty Pathway. New Mental Health Acute Hospital Liaison Service. DTOC review. Contract management.
- **RTT** 5 % reduction in first outpatient attendances in dermatology, pain, neurology. Improved alignment of demand & capacity plans by supporting patients to choose alternative providers (dermatology, T&O, neurology, ophthalmology).
  Projects: Pathway redesign. LHAC elective projects; vascular, general surgery. Contract Management.
- **Cancer** Secure delivery of standards.
  Projects: LHAC breast, Lung & colorectal redesign. Use of alternative providers.
- **IAPT** Secure delivery of IAPT waiting time targets by Dec 2015, sustainably deliver IAPT access 18% recovery 50%.
  Project: Review of IAPT capacity and re-specify. 2015/16 contract delivery.
- **Dementia** Achieve 67% diagnosed of nationally defined prevalence rate.
  Projects: Roll out phase 2 MAMs. Planning informed by capacity and demand checker. Advanced planning in care homes. Increase post diagnostic support via Managed Care Network.
- **Early Intervention** Deliver mental health 2 week waiting time standard in full by April 2016.
  Projects: Review of capacity and re-specify. 2015/16 contract delivery.
- **Primary Care** Improve access.
  Projects: Re commission Walk-In Centre. Facilitate Primary Care Strategy

OUTCOMES

Delivery across the five domains and seven outcome measures

- Improve PYLL 13/14 performance by 3.2% (securing additional years of life for people with treatable mental health and physical conditions) working closely with public health, with a focus on premature male deaths

Improving health

- **Local quality premium priority Diabetes TBC: Percentage of people identified at risk of developing diabetes referred to healthy lifestyle support**
- Improve 13/14 performance 1.1% for health related quality of life (long term conditions including MH).
- By October 2015 80% of people still at home 91 days after discharge.
- Reduction in smoking at the time of delivery a further 1%.
  Projects: Neighbourhood Teams, smoking cessation, primary care diabetes. Support system for carers developed as part of Neighbourhood Teams. Health Trainers

Reducing health inequalities

- **Local quality premium priority stroke prevention TBC: Appropriate patients with Atrial Fibrillation are prescribed anticoagulation therapy**
- 100% of our practices engaged in EPOC.
- 100% invited for Health checks with 60% take up (currently 50%).
- At least 95% of patients with heart failure who are clinically appropriate are prescribed a beta blocker
- At least 25% of people who have a BMI over 30 are offered referral to weight management.
  Projects: Electronic cancer decision support tool (ECDF) implementation. Chronic heart failure. Primary care weight mgt.

Parity of esteem

- **Local Quality Premium Priority TBC: MH & LD access to healthy lifestyle support – 10 % increase in onward referral to healthy lifestyle support**
- 10% increase in LD Health checks from 2013/14 baseline.
  Projects – Supporting primary care access for people with LD and SMI. Learning Disability Health Checks.

QUALITY

Response to Francis, Berwick and Winterbourne View

- Continued focus on ensuring appropriate care for patients receiving specialist LD support.
  Project: LD Quality Delivery

Patient safety

- Improve quality of commissioned services.
  Projects: Quality review- staffing level compliance with NICE safe staffing. Triangulation quality data sources for all providers incl. general practice & action to address concern and health professional reporting of GP incidents monitoring
- Reduce incidents of acute kidney injury & sepsis.
- Reduce Anti-biotic prescribing
  Projects: CQUINs. Quality Delivery

Patient experience

- 8.3% reduction in poor patient experience score at ULHT
- Hold 4 'Listening Events' across Lincolnshire.
- Improve feedback from carers on end of life care.
- Monitor and identify key trends in Friends and Family Test for GP practices.
  Projects: Quality Delivery, End of Life, Patient engagement

Compassion in practice

- Continue to support education for level 1-4 workforce.
- Short and long term healthcare workforce planning in partnership with HEE
- Values and Behaviour based recruitment evident across all providers.
- Ensure all relevant healthcare training programmes emphasise the 6 Cs.
  Projects: Quality Delivery, Workforce integrated model of care

Staff satisfaction

- Secure at least 5% ↑ in staff opinions via annual Staff Survey (Staff in training Via LETB).
- Secure at least 5% ↑ in The F&F element of the Staff Survey completed by our main providers
  Project: Quality Review

Seven day services

- Local providers deliver the standards 2,3,5,8,9 by March 2016
- Weekend mortality rates as measured by SHMI are no greater than weekdays by Dec 2015.
  Project: Quality & Contract Delivery

Safeguarding

- Increased MCA & DOLS training - all contracts have appropriate clauses.
- Continue to monitor delivery of prevent training & monthly reporting to CCG safeguarding team.
- Work with University of Lincoln to develop an integrated GP training package.
  Projects: Quality delivery, Contract delivery

Delivering Value

Financial resilience; delivering VFM for taxpayers and patients and procurement

- Meet business rules on financial plans including surplus, contingency and non-recurrent expenditure
- Clear and credible plans that meet the efficiency challenge and are evidence based, including
- reference to benchmarks
- The clear link between service plans, financial and activity plans
  Projects: Further development of PMO

Transformation Programmes

- Development & formal consultation on LHAC by autumn 2015.
- Produce draft primary care strategy including estates, workforce and federated working by August 2015.
- Work with Lincoln University & Lincoln College -workforce strategy & evaluation of projects (e.g. Frailty and Neighb'hood Teams).
- Develop new approach to advanced care planning in care homes.
- Continue CCG primary care research in partnership with Nottingham University.
- Parity of Esteem – Develop Neighbourhood Teams to meet the needs of people with mental health conditions.

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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:	**24 March 2015**
Subject:	**Better Care Fund Section 75 Agreement(s)**

Summary: Members of the Board will recall that the BCF submission was approved prior to Christmas 2014 and submitted to the Government on 9th January 2015. In February we were notified that the submission had been approved. The "delivery vehicle" for transfer of the national funding to Lincolnshire is a Section 75 Agreement. This must be signed off by the six signatories on 31st March 2015. The six signatories are the four CCGs, the County Council and the Chair of Health and Wellbeing Board.

The minimum value of the BCF in 2015/16 is £53.2m though Members will note that the level of pooling is actually £197m. This fact alone determines the nature of the agreement, in this case a framework agreement, and the number of separate elements that make up the whole.

Actions Required: Members of Health and Wellbeing Board are asked to:

1. note and comment on the attached documentation;
2. agree the Section 75 arrangements as detailed on the attached;
3. delegate to the Chair of the Health and Wellbeing Board any final iterations to the attached prior to submission on 31st March 2015.

1. Background

The Better Care Fund (BCF) has a long history with the Health and Wellbeing Board and will be presented at all formal Health and Wellbeing Board meetings during 2015.

The Section 75 Agreement documentation attached was presented to the Executive of the County Council on 3rd March 2015. It had previously been to the Adults Scrutiny Committee as a pre-decision item. The report has now been agreed by the County Council and has delegated any final amendments to two Executive Councillors and the Director of Adult Social Services.

It is important to recall that the BCF is for 2015/16 only and does not represent new money. The most pressing area of concern in securing agreement is the level of financial risk that pertains to the BCF and the savings expected in an already stretched health and social care economy.

Notwithstanding the above integration between health and care has a high national profile and it would seem this is set to continue beyond the national elections in May.

2. Conclusion

The BCF represents a significant step on the journey towards closer integration between health and social care in Lincolnshire. This journey will continue and no doubt be given additional impetus with the new Government. The connections with the local LHAC initiative are profound and will continue to be strengthened though the resource requirements to support this present their own challenge in maintaining progress.

3. Consultation

n/a

4. Appendices

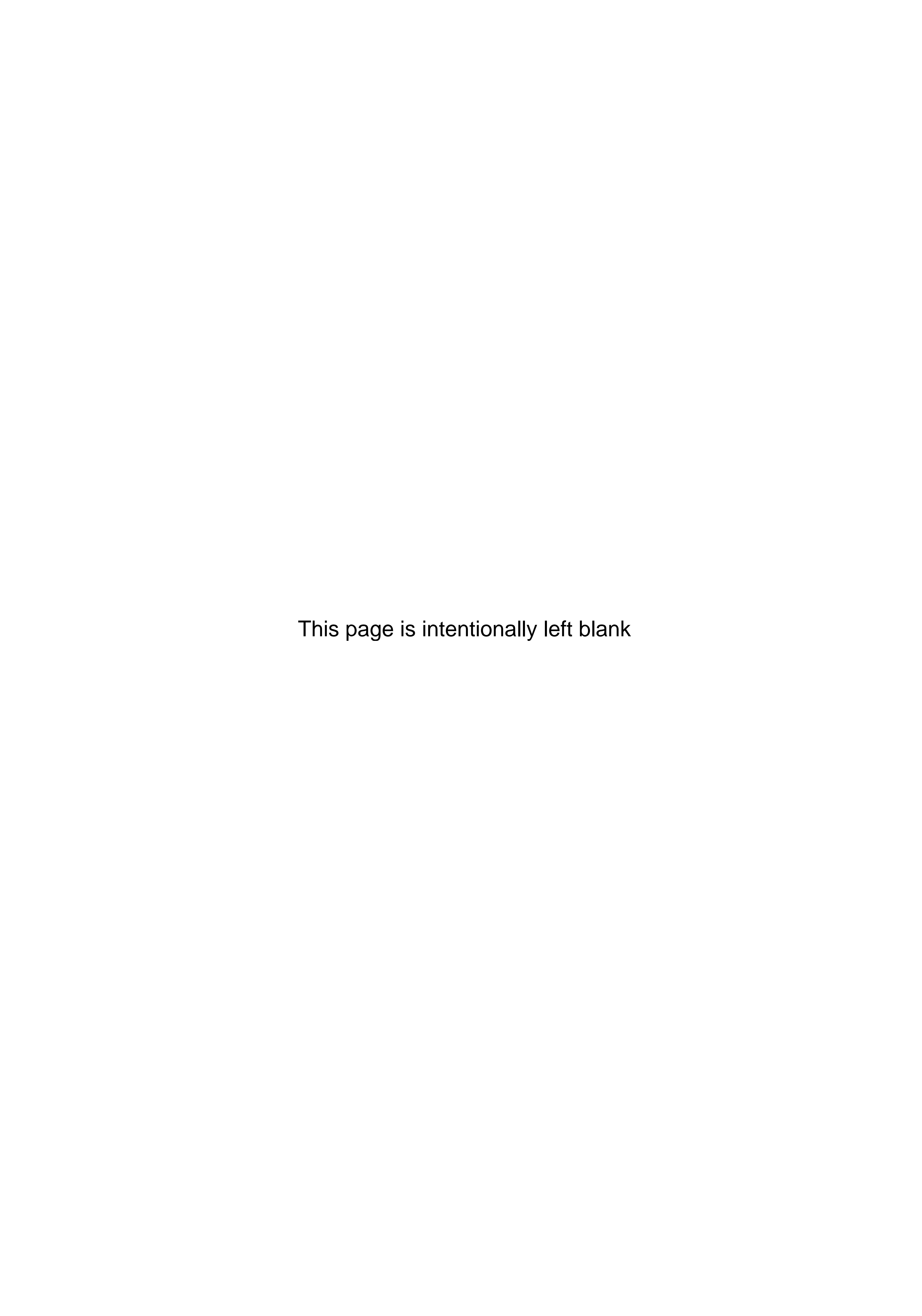
These are listed below and attached at the back of the report	
Appendix A	Report to the Executive on 3rd March 2015 Including appendices A-H: - Partnership Framework Agreement - Description of proposed Section 75 Agreement for proactive care - Description of proposed Section 75 Agreement for corporate matters - Description of proposed Section 75 Agreement for Child and Adolescent Mental Health Services - Description of proposed Section 75 Agreement for Integrated Community Equipment Services - Description of proposed Section 75 Agreement for Learning

	Disabilities - Description of proposed Section 75 Agreement for Adult Mental Health - Spreadsheet Detailing the Allocation of Funding

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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Report Reference:
Executive/Executive Councillor

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

Report to:	**Executive**
Date:	**03 March 2015**
Subject:	**Better Care Fund Section 75 Agreement**
Decision Reference:	**1008553**
Key decision?	**Yes**

Summary:

On 6 February 2015 the Lincolnshire Better Care Fund (BCF) submission was approved by NHS England. One of the key components within the submission is the intent to 'pool' £197m of health and social care expenditure.

The minimum national requirement is for the national allocation of £53.2m to be included in one or more pooled fund arrangements under Section 75 of the National Health Service Act 2006 (the 2006 Act). Subject to the achievement of this minimum level of formal pooling local health and social care bodies may agree a range of other contractual mechanisms to ensure the alignment of other elements of the funding contained in the BCF submission.

This report sets out a pragmatic solution to the issue of pooling and aligning BCF resources in Lincolnshire through the use of a Partnership Framework Agreement underpinned by a mixture of existing or new agreements under Section 75 of the 2006 Act and other existing contractual arrangements.

This Report seeks approval in principle to the entering into of a Partnership Framework Agreement, approval in principle to the entering into of new Section 75 Agreements and the delegation to the Executive Director of Adult Care in consultation with the Executive Councillors for Adult Care and Health, Children's Services and NHS Liaison and Community Engagement of authority to approve the final form of both the Framework Agreement and the individual Section 75 Agreements.

This pragmatic approach will ensure that the Council and the CCGs in Lincolnshire are able to achieve their ambitions as set out in the BCF submission while complying with national requirements and meeting the deadline of 31 March 2015.

Recommendation(s):

That the Executive

1. Approve the entering into by the Council of a Partnership Framework Agreement with the Clinical Commissioning Groups in Lincolnshire generally in the form attached at Appendix A

2. Approve the entering into by the Council of an agreement under Section 75 of the NHS Act 2006 with the Clinical Commissioning Groups in Lincolnshire for proactive care as generally described in Appendix B

3. Approve the entering into by the Council of an agreement under Section 75 of the NHS Act 2006 with the Clinical Commissioning Groups in Lincolnshire for corporate matters as generally described in Appendix C

4. Approve the entering into by the Council of an agreement under Section 75 of the NHS Act 2006 with the Clinical Commissioning Groups in Lincolnshire for Children and Adult Mental Health Services as generally described in Appendix D

5. Approve the entering into by the Council of an agreement under Section 75 of the NHS Act 2006 with the Clinical Commissioning Groups in Lincolnshire for Integrated Community Equipment Services as generally described in Appendix E

6. Approve the entering into by the Council of an agreement under Section 75 of the NHS Act 2006 with the Clinical Commissioning Groups in Lincolnshire for Learning Disabilities as generally described in Appendix F

7. Note the extension of an agreement under Section 75 of the NHS Act 2006 entered into by the Council with Lincolnshire Partnership Foundation Trust for Adult Mental Health as generally described in Appendix G

8. Delegates to the Director of Adult Care in consultation with the Executive Councillor for Adult Care and Health, Children's Services and the Executive Councillor for NHS Liaison and Community Engagement the approval of the final terms and form of and the entering into of all agreements and legal documentation necessary to give effect to the decisions at paragraphs 1 to 7.

Alternatives Considered:

1 Not to pool any of the resources contained in the BCF submission

Formal pooling of the BCF minimum of £53.2m is a requirement for the receipt of £53.2m of funding, £20m of which is to protect Adult Social Services. Failure to pool the minimum requirement will mean this funding

will not be received.

2 To pool only the minimum BCF requirement

The health and social care community has already indicated its ambition to 'pool' £197m of funding. This has allowed two Secretaries of State to highlight this matter in the national media as a point of success in that the national sum for the BCF is £3.8bn but with local "top ups" is £5.3bn. To fail to 'pool' that sum now would give rise to significant reputational risk for the local health and social care community with the Department of Health. Initiatives of long standing within Lincolnshire already account for a large majority of the pooled funding and therefore the level of commitment to new pooling is limited.

3 To pool resources in some contractual way other than as recommended

The contractual options are set out and analysed in the section of the Report headed "Pooling £197m – the options".

Reasons for Recommendation:

Agreement of arrangements meeting the national minimum requirement to formally pool £53.2m of BCF funding must be in place by 31 March 2015. In Lincolnshire this requires the four Clinical Commissioning Groups and the County Council to agree the funding arrangements which will then allow the Health and Wellbeing Board to endorse the application as required by the Government. The recommendations represent a pragmatic solution utilising existing arrangements overlain by a partnership framework agreement.

1. Background

Introduction

The history of and detail surrounding the Better Care Fund or BCF has been well documented in previous reports to the Executive (April 2014 and September 2014), Informal Executive (latest January 2015) and the Health and Wellbeing Board (latest December 2014). This is in addition to multiple presentations to the four Clinical Commissioning Groups during the course of the past 12 months.

The value of the national allocation in 2015/16 is £53.2m, of which £20m has been agreed with the CCGs to 'Protect Adult Social Services'. This sum also includes an allocation to support implementation of the Care Act.

The Lincolnshire BCF submission to Government has been approved. However, to secure the available national funding the minimum BCF allocation must be pooled in one or more formal pooled funds under Section 75 of the National

Health Service Act 2006. Without this level of agreement this funding will not materialise. If any of the five Governing bodies fails to approve the proposed arrangements there will be no transfer of the nationally available sum.

Although the minimum requirement is to pool £53.2m, one of the key components within the Lincolnshire BCF submission is the intent to 'pool' £197m of health and social care expenditure. This represents a step change in the way in which funding for health and care services are organised within the health and care community in Lincolnshire. The approach is in line with national policy and the level of local ambition as detailed in previous BCF reports and a variety of related reports within the Lincolnshire community.

The level of 'pooling' places Lincolnshire as one of only five health and care systems in the country with this level of ambition over and above the national BCF allocation of £53.2m. It also allowed two Secretaries of State to highlight this matter in the national media as a point of success in that the national sum for the BCF is £3.8bn but with local "top ups" is £5.3bn.

The final BCF submission detailing this level of ambition was approved by the Executive on 2 September 2014.

Notwithstanding the national imperative and the local ambition the 'pooling' of such a substantial sum must be framed and that framework understood across the partners. At this point it is important also to note that none of the proposals detailed in this report change the current arrangements for the setting of policy or decision-making: these remain with respective Governing Bodies - the County Council and the four CCGs.

Pooling £197m – the options

The contractual options can be summed up generally as follows

- The creation of a number of separate Section 75 pooled fund and other contractual arrangements without any overarching framework
- The creation of a single pooled fund for the full £197m governed by a single Section 75 Agreement
- The creation of an overarching framework governing a number of separate Section 75 pooled fund agreements with other spend within the £197m sitting outside the framework in separate arrangements
- The creation of an overarching framework governing the whole £197m but consisting of a number of different Section 75 pooled fund arrangements and other contractual arrangements ("the framework partnership agreement")

Single framework or separate agreements

The first consideration in choosing between the general options above is whether a model that involves an overarching framework for some or all of the £197m is preferable to a number of separate agreements. It is proposed that an overarching

framework is essential to give effect to the main purpose of the Better Care Fund which is the allocation of the national minimum sum to Lincolnshire (£53.2m) and greater integration between health and social care.

The need to have a contractual agreement in place for 1 April 2015 requires a high degree of pragmatism at this stage. Governance arrangements already exist for taking forward much of the BCF work involving the themes of Proactive Care, Adult Specialised, System Resilience (including Urgent Care) and Women and Children's with their Joint Delivery Boards reporting to the Joint Commissioning Board and accountable to each of the five Partner Governing Bodies. The conditions exist therefore for creating an overarching contractual governance framework without undue additional work.

In order that the arrangements do not become a strait jacket preventing further change an overarching framework will allow for the implementation of integrated change control processes in which impacts can be assessed within and across Joint Delivery Board workstreams and business cases assessed with a view to impacts across the system.

In this way, regardless of the degree to which formal pooling takes place, all the monies covered by the BCF contract arrangement can be treated as a single resource and managed and monitored under framework arrangements.

Nature of the contract – single Section 75 or framework partnership agreement

Consideration has been given to whether the £197m should be formally pooled in a single Section 75 pooled fund arrangement. However this is not recommended because the creation of a formal pooled fund for the full £197m would need agreement to be reached on who should be the host and who would be the pooled fund manager. It is also likely to require an actual transfer of monies to the host.

On the other hand there are already a number of existing contractual and Section 75 arrangements that could be incorporated into a general framework with a minimum of change or bespoke drafting. This is an attractive way of proceeding given the time constraints.

In the circumstances it is recommended that an overarching framework be created which governs a number of different contractual arrangements some of which may be Section 75 pooled funds but some of which may be agreements to align separate commissioning activity.

Further it is recommended that where there are existing pooled fund and other arrangements in place that have already been approved and tested over time such as the CAMHS service, the Integrated Community Equipment Service, the Learning Disability Services and the Adult Mental Health Services that these arrangements are brought under an overarching framework.

In addition to this two new Section 75 agreements are recommended to ensure the full amount from Government is received and that we reach the £197m agreed ambition.

This approach has been checked with the National Programme Team overseeing the BCF and agreed as acceptable. Indeed, it is the understanding of officers that a number of other areas in the country with similar levels of 'pooled' ambition are taking a similar approach. It should also be noted that this general agreement is for 2015/16 and will be reviewed once the new government has decided the policy direction for integration between health and care and, specifically the future of the BCF.

Before moving on to a more detailed description of the Framework and the individual agreements it is worth saying something first about governance and risk.

Governance

Delegation of Functions

One of the flexibilities available under section 75 of the 2006 Act is the ability of health bodies to authorise the Council to exercise its functions or for the Council to authorise a health body to exercise its functions. That is the case with some of the existing Section 75 Agreements. The CAMHS Section 75, the Learning Disabilities Section 75 and the ICES Section 75 all involve the Council undertaking lead commissioning and exercising authority to commission health services on behalf of the CCGs. Conversely the adult mental health Section 75 authorises LPFT (as opposed to any of the CCGs) to exercise certain of the Council's adult mental health functions.

Where this happens decision-making falls to the body exercising the function and must be carried out in accordance with that organisations' internal governance arrangements.

Where no delegation of function has occurred then each of the bodies entering into the Framework Agreement (the Council and each of the four CCGs) retain all of their functions and their decision-making powers in relation to those functions.

Decision-making

Decision-making within each of the corporate bodies (whether exercising their own functions or a delegated function) will be governed by their internal constitutional arrangements. In the County Council that means that ultimate decision-making will remain vested in the Executive and relevant Executive Councillors and with officers where they have delegated power under the Constitution or are given delegated powers by the Executive.

It is important to note that nothing in the proposals for either the Partnership Framework Agreement or individual arrangements make any changes to this position. Each body will, for instance, continue to make decisions in accordance with their own internal procedures on such issues as:-

- Any extension or variation to the Framework or individual agreements
- Any proposals for new Section 75 arrangements

- Any decisions as to what should be commissioned under individual schemes and how they should be commissioned

At the same time, the Health and Wellbeing Board (HWB) will continue to play a role in providing a forum for the joint consideration of issues affecting the health and social care community in Lincolnshire and in fulfilling its responsibility to encourage integration.

There is still a need, however for a level of governance below that of formal decision-making. This level is concerned with the management of partnership arrangements including monitoring the arrangements and receiving reports and information on the operation of the arrangements

Pooled Funds

Where the partnership arrangements consist of a pooled fund there is a requirement in law to have a host organisation for the pooled fund. The host must be one of the parties to the Section 75 Agreement. The regulations state that the host has the responsibility "for the accounts and audit of the pooled fund arrangements".

Legally the host partner is then required to appoint one of its officers as the pooled fund manager. Under the Regulations the pooled fund manager is responsible for

- Managing the pooled fund on the host partners behalf and
- Submitting to the partners quarterly reports and an annual return about the income of and expenditure from the pooled fund and other information by which the partners can monitor the effectiveness of the pooled fund arrangements.

The governance arrangements for the BCF pooling arrangement will be structured as follows:

- Decision-making will sit with the individual corporate bodies as set out above
- Overall management and monitoring of the framework will be carried out through the existing BCF officer governance arrangements consisting of an overarching Joint Commissioning Board and three Joint Delivery Boards covering thefour BCF Themes – Specialised Services, System Resilience,Proactive Care and Women's and Children's.
- Management and monitoring of individual Section 75 and other agreements will be carried out in accordance with the arrangements (if any) specified in the Agreement and more particularly described in the Appendix relating to that Agreement.

Risk Management

Like governance, risk management needs to be dealt with at more than one level.

At the level of the individual agreement there will be individual risk management arrangements especially with respect to underspends and overspends on the

relevant pooled budget. These risk arrangements are described in the individual Appendix relating to each agreement.

Some risks however are incurred at the level of the BCF framework as a whole and in particular the risk that (up to) £3.7m may be clawed back by the government if targets for reductions in non-elective admissions are not met. This risk is being managed by the creation of a contingency of £3.7m. This is drawn from underspends in the BCF for 2014 and does not affect the £20m agreed to protect adult social care. This will sit in an individual Section 75 Pooled Fund under the Joint Commissioning Board. This contingency will be risk assessed from time to time and judgments made as to whether this contingency can appropriately be reduced.

In addition to this risk there are a number of financial risks to the CCGs which will need to be managed arising partly out of the fact that their contribution of £20m to adult care is not fully funded and will need to be met from savings.

This risk is being partly managed by recognition that if the £3.7 contingency is not required then consideration will be given to that being used to contribute to the NHS deficit created in (amongst other things) transferring £20m to protect adult social care.

The principles for risk management are set out in more detail in Schedule 3 to the Partnership Framework Agreement at Appendix A.

The next section describes in more detail the Partnership Framework Agreement before addressing individual components of the contractual structure.

The Partnership Framework Agreement

A copy of the draft Partnership Framework Agreement is attached at Appendix A. The following aspects of the Agreement are drawn to members' attention.

The Framework Agreement has a duration of one year reflecting the uncertainty of the future of BCF. The Agreement can be extended by the agreement of all the parties as long as they reach such agreement before the expiry of the first year.

The expiry of the Framework Agreement, however, does not affect the continuation of the individual Section 75 Agreements. Where those Section 75 Agreements have a duration in excess of the one year of the Framework they will continue in force until they expire or are terminated in accordance with their own terms. This reflects their longstanding value and in relation to the CAMHS and ICES Agreements the need for the Section 75 Agreement to underpin longer term service contracts.

Although they are incorporated under the Framework, the individual agreements are generally governed wholly by their own terms.

For the Pooled Fund arrangements in particular, however, there are three areas in which the Framework will prevail over the individual Agreements if they are in conflict:-

1 Pooled Fund management and monitoring

The Framework Agreement contains drafting to ensure that the Joint Commissioning Board, Health and Wellbeing Board and five Partner Governing Bodies receive regular reports and information to enable them to be sure that all of the agreements that sit under the framework are meeting financial and performance targets and the whole of the £197m of the BCF funding is being well managed.

2 Governance

The Framework Agreement will give the Joint Delivery Boards and the Joint Commissioning Board a wider role within individual arrangements. In particular it is proposed that variations and change controls will go to the Joint Delivery Boards and Joint Commissioning Board for assessment before being recommended where appropriate to the individual partners to approve through their decision-making arrangements.

This is to ensure that changes are not made to individual arrangements without regard to impacts across the whole health and care system.

3 Risk Management

The Framework Agreement will take precedence to ensure that underspends can be managed in accordance with the risk share arrangements which are described in general in Schedule 3 to the Partnership Framework Agreement at Appendix A to this report.

This is considered to represent a pragmatic and light-touch framework approach to meeting BCF minimum requirements whilst giving the maximum degree of prominence to the individual agreements many of which are long-standing and of proven worth.

The proposed individual arrangements

Seven individual arrangements are proposed to be included within the scope of the Partnership Framework Agreement. Five of those are formal pooled fund arrangements under Section 75 of the 2006 Act. Two of them are separate contractual arrangements that the Council and the CCGs will, if the recommendations are approved, align under the framework. Of the five formal pooled funds, three are already existing arrangements and two are new proposed arrangements.

Each is listed below with detailed descriptions where relevant being contained in Appendices B to G inclusive.

Formal pooled fund arrangements

Existing Arrangements

(1) Children and Adult Mental Health Section 75 Agreement described in Appendix D

(2) Learning Disabilities Section 31 Agreement described in Appendix F

(3) Integrated Community Equipment Service (ICES) Section 75 Agreement described in Appendix E

New Pooled Fund Section 75 Agreements

(4) Proactive Care Section 75 Agreement described in Appendix B

(5) Corporate Section 75 Agreement described in Appendix C

Aligned existing arrangements

(6) Adult Mental Health Section 75 Agreement between the Council and Lincolnshire Partnership Foundation Trust described in Appendix G

(7) National Health Service contract between the CCGs and LPFT for adult mental health services. This contract will continue to be operated separately by the CCGs and is not described or dealt with further in this report

As indicated in each Appendix relating to an individual arrangement, those at paragraphs (2) to (6) are at a stage where they require decisions of the Executive to continue with them or otherwise enter into them. Each one is therefore the subject of a recommendation that the entering into of the agreement is approved. In reaching that decision the Executive must have regard to certain statutory pre-conditions, namely:-

(1) the partnership arrangements must be likely to lead to an improvement in the way in which the functions are exercised; and

(2) the Partners must have consulted jointly such persons as appear to them to be affected by the arrangements.

The way in which these pre-conditions are met in relation to each proposed agreement is set out in the relevant Appendix.

There are no such pre-conditions to the entering into of the Partnership Framework Agreement which is not a Section 75 Agreement.

Overall Financial Picture

The overall financial position including the amounts being contributed by the Council and the CCGs jointly to each of the Agreements is set out in the spreadsheet at Appendix H.

Specific Issues

Included in the Proactive Care Section 75 described at Appendix B is £2.97m funding for Disabled Facilities Grant. This sum will be passported direct and in full to District Councils for them to manage the sums in accordance with their statutory powers and responsibilities.

Legal Considerations

The Council's duty under the Equality Act 2010 needs to be taken into account when coming to a decision.

The Council must, in the exercise of its functions, have due regard to the need to:

(1) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010;

(2) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

(3) foster good relations between persons who share a relevant protected characteristic and persons who do not share it: Equality Act 2010 s 149(1). The relevant protected characteristics are age; disability; gender reassignment; pregnancy and maternity; race; religion or belief; sex; sexual orientation: s 149(7).

Having due regard to the need to advance equality of opportunity involves having due regard, in particular, to the need to:

(1) remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic;

(2) take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it;

(3) encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low.

The steps involved in meeting the needs of disabled persons that are different from the needs of persons who are not disabled include, in particular, steps to take account of disabled persons' disabilities.

Having due regard to the need to foster good relations between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to tackle prejudice, and promote understanding.

Compliance with the duties in this section may involve treating some persons more favourably than others.

This duty cannot be delegated and must be discharged by the decision-maker. To discharge the statutory duty the decision-maker must analyse all the relevant material with the specific statutory obligations in mind. If a risk of adverse impact is identified consideration must be given to measures to avoid that impact as part of the decision making process.

Generally all of the services which are delivered under any of the agreements that are covered by the Partnership Framework Agreement approach directly impact on people with a protected characteristic particularly elderly people and young people and people with a disability. The proposals set out in this report which relate to the organisational and contractual structures that will be put in place between the Council and the CCGs as commissioners of service are not considered to directly impact.

It is at the level of changes to service that the greater potential for impact arises. The potential impact of the changes which form part of the BCF resubmission on people with a protected characteristic will be the subject of detailed analysis prior to their implementation so that the appropriate mitigation strategies can be put into effect.

Further, in reaching a decision, the Council must have regard to the Lincolnshire Child Poverty Strategy, the Joint Strategic Needs Assessment (JSNA) and the Health & Well Being Strategy.

Child Poverty

The BCF is not designed to address child poverty. However, some of the elements within the BCF will support families where there are children and help children in transition into adulthood.

JSNA and Joint Health and Wellbeing Strategy

These underpin the BCF and the ways in which the BCF has been developed in accordance with the Joint Strategic Needs Analysis and the Joint Health and Wellbeing Strategy were detailed in the BCF submission that has now been approved.

2. Conclusion

The intended consequence of the Better Care Fund at both a national and local level was a level of ambition to 'pool' resources and make further progress on integrating health and social care as described by Lincolnshire Health and Care (LHAC). The approach recommended is an evolutionary step towards that ambition and yet, is a pragmatic solution building on what already works and has stood the test of time leaving the existing Governance arrangements untouched.

3. Legal Comments:

The Council has power to enter into the Partnership Framework Agreement and the Individual Agreements under section 1 of the Localism Act 2011 and Section 75 of the National Health Service Act 2006.

Under Section 3 of the Care Act 2014 which will come into force on 1 April 2015, the Council will be under a duty to exercise its functions under that Act with a view to ensuring integration of social care and health provision where it considers this would promote the wellbeing of adults in its area in need of care and support and the wellbeing of carers in its area; contribute to the prevention or delay of the development of need for care and support for adults or support for carers; or improve the quality of care and support for adults and support for carers.

The legal considerations that the Executive must consider in reaching a decision are set out and addressed in detail in the report.

The decision is consistent with the Policy Framework and within the remit of the Executive if it is within the budget.

4. Resource Comments:

The report identifies Lincolnshire's ambition of pooling £197m of health and social care investment in 2015/16, rather than the national minimum requirement of £53.2m.

The County Council has negotiated that a £20m sum from within the £53.2m be made available to protect adult social care and this is to be invested in (a) projects to transform how services are provided, (b) in projects that will help minimise future required investment (c) in additional budget provision to fund demographic pressures and other budgets experiencing funding pressures, (d) required developments to ensure compliance with the Care Act

Key to the protection of the council (and the health community) is the Risk Management paper included as Schedule 3 within the Framework Partnership Arrangement

5. Consultation

a) Has Local Member Been Consulted?

n/a

b) Has Executive Councillor Been Consulted?

Yes

c) Scrutiny Comments

Adults Scrutiny Committee are receiving a copy of the report on 25 February 2015 and their views will be reported at this meeting.

d) Policy Proofing Actions Required

Please refer to the sections within the papers on legal considerations.

6. Appendices

These are listed below and attached at the back of the report	
Appendix A	Partnership Framework Agreement
Appendix B	Description of proposed Section 75 Agreement for proactive care
Appendix C	Description of proposed Section 75 Agreement for corporate matters
Appendix D	Description of proposed Section 75 Agreement for Child and Adolescent Mental Health Services
Appendix E	Description of proposed Section 75 Agreement for Integrated Community Equipment Services
Appendix F	Description of proposed Section 75 Agreement for Learning Disabilities
Appendix G	Description of proposed Section 75 Agreement for Adult Mental Health
Appendix H	Spreadsheet Detailing the Allocation of Funding

7. Background Papers

Document	
Better Care Fund submission to Department of Health dated 9 January 2015	Katrin.Howe@lincolnshire.gov.uk

This report was written by Paula Pilkington, David Coleman, Glen Garrod, who can be contacted on 01522 550808 or by email to glen.garrod@lincolnshire.gov.uk.

Dated 2015

(1) LINCOLNSHIRE COUNTY COUNCIL

and

(2) NHS LINCOLNSHIRE EAST CLINICAL COMMISSIONING GROUP

(3) NHS SOUTH WEST LINCOLNSHIRE CLINICAL COMMISSIONING GROUP

(4) NHS LINCOLNSHIRE WEST CLINICAL COMMISSIONING GROUP

(5) NHS SOUTH LINCOLNSHIRE CLINICAL COMMISSIONING GROUP

FRAMEWORK PARTNERSHIP AGREEMENT RELATING TO THE COMMISSIONING OF HEALTH AND SOCIAL CARE SERVICES AND THE POOLING OF FUNDS FOR THE PURPOSES OF THE BETTER CARE FUND

Contents

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Fleet Place House | 2 Fleet Place | Holborn Viaduct | London EC4M 7RF
T 0870 194 1000 F 0870 194 7800

Kings Orchard | 1 Queen Street | Bristol BS2 0HQ
T 0870 194 1000 F 0870 194 1001

Interchange Place | Edmund Street | Birmingham B3 2TA
T 0870 194 1000 F 0870 194 5001

www.bevanbrittan.com

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SCHEDULE 3 – RISK SHARE AND OVERSPENDS **25**
SCHEDULE 4 – PERFORMANCE ARRANGMENTS **1**
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THIS AGREEMENT is made on day of 2015

PARTIES

(1) **LINCOLNSHIRE COUNTY COUNCIL** of County Offices, Newland, Lincolnshire, LN1 1YL (the **"Council"**) and

(2) **NHS LINCOLNSHIRE EAST CLINICAL COMMISSIONING GROUP** of Cross O'Cliff, Bracebridge Heath, Lincoln, LN4 2HN (the "**LECCG"**)

(3) **NHS SOUTH WEST LINCOLNSHIRE CLINICAL COMMISSIONING GROUP** of South Kesteven District Council Offices, St Peter's Hill, Grantham, NG31 6PZ (the "**SWLCCG"**)

(4) **NHS LINCOLNSHIRE WEST CLINICAL COMMISSIONING GROUP** of Cross O'Cliff, Bracebridge Heath, Lincoln, LN4 2HN (the "**LWCCG"**) and

(5) **NHS SOUTH LINCOLNSHIRE CLINICAL COMMISSIONING GROUP** of Stamford and Rutland Hospital, Ryhall Road, Stamford, Lincolnshire, PE9 1UA (the "**SLCCG"**)

(together the **"CCGs"**) and the Council and each of the CCGs are each a "Partner" and together "the Partners".

BACKGROUND

(A) The Council has responsibility for commissioning and/or providing social care services on behalf of the population of its administrative area.

(B) The CCGs have the responsibility for commissioning health services pursuant to the 2006 Act in their respective areas.

(C) The Better Care Fund has been established by the Government to provide funds to local areas to support the integration of health and social care and to seek to achieve the National Conditions and Local Objectives. It is a requirement of the Better Care Fund that the CCGs and the Council establish a pooled fund or funds for at least the BCF Minimum. The Partners wish to extend the use of pooled funds to include funding streams in excess of the BCF Minimum and to include within this Framework funding streams that are aligned but are not pooled.

(D) Section 75 of the 2006 Act gives powers to local authorities and clinical commissioning groups to establish and maintain pooled funds out of which payment may be made towards expenditure incurred in the exercise of prescribed local authority functions and prescribed NHS functions.

(E) Section 75 of the 2006 Act also gives powers to local authorities and clinical commissioning groups to establish lead commissioning arrangements in the exercise of prescribed local authority functions and prescribed NHS functions.

(F) The purpose of this Agreement is to set out the terms on which the Partners have agreed to collaborate and to establish a framework through which the Partners can secure the future position of health and social care services through the use of Section 75 powers. It is also means through which the Partners will pool funds and align budgets as agreed between the Partners.

(G) The aims and benefits of the Partners in entering in to this Agreement are to:

a) improve the quality and efficiency of the Services;

b) meet the National Conditions;

c) make more effective use of resources through the establishment and maintenance of one or more pooled funds for revenue expenditure on the Services; and

d) achieve the aims and objectives specified in each Individual Scheme Agreement

(H) The Partners are entering into this Agreement in exercise of the powers referred to in Section 75 of the 2006 Act and/or Section 13Z(2) and 14Z(3) of the 2006 Act as applicable, or Section 1 of the Localism Act 2011 to the extent that exercise of these powers is required for this Agreement.

1 DEFINED TERMS AND INTERPRETATION

1.1 In this Agreement, save where the context requires otherwise, the following words, terms and expressions shall have the following meanings:

1998 Act means the Data Protection Act 1998.

2000 Act means the Freedom of Information Act 2000.

2004 Regulations means the Environmental Information Regulations 2004.

2006 Act means the National Health Service Act 2006.

Affected Partner means, in the context of Clause 22, the Partner whose obligations under the Agreement have been affected by the occurrence of a Force Majeure Event

Agreed Individual Schemes means the Individual Schemes specified in Schedule 1

Agreement means this agreement including its Schedules and Appendices.

Aligned Individual Scheme means the Agreed Individual Schemes set out in Part B of Schedule 1 and any other Individual Scheme that does not create a pooled fund

Authorised Officers means an officer of each Partner appointed to be that Partner's representative for the purpose of this Agreement.

BCF Minimum means the legal minimum requirement for pooling of funds as part of the Better Care Fund being for the purposes of the Better Care Fund in Lincolnshire £48.399m

Better Care Fund means the Better Care Fund as described in NHS England Publications Gateway Ref. No.00314 and NHS England Publications Gateway Ref. No.00535 as relevant to the Partners.

Better Care Fund Plan means the BCF submission submitted to the Secretary of State on 9 January 2015 setting out the Partners plan for the use of the Better Care Fund.

CAMHS Section 75 means the partnership agreement dated [ ] and made under section 75 of the 2006 Act between the Council and [] and relating to integrated child and adolescent mental health services

CCG/LPFT Adult Mental Health Section 75 means the [ ] agreement dated [ ] and made between [the CCGs] and [Lincolnshire Partnership Foundation Trust] and relating to the provision of adult mental health services

CCG Statutory Duties means the Duties of the CCG pursuant to Sections 14P to 14Z2 of the 2006 Act

Change in Law means the coming into effect or repeal (without re-enactment or consolidation) in England of any Law, or any amendment or variation to any Law, or any judgment of a relevant court of law which changes binding precedent in England after the date of this Agreement

Commencement Date means 00:01 hrs on 1 April 2015.

Confidential Information means information, data and/or material of any nature which any Partner may receive or obtain in connection with the operation of this Agreement and the Services and:

(a) which comprises Personal Data or Sensitive Personal Data or which relates to any patient or his treatment or medical history;

(b) the release of which is likely to prejudice the commercial interests of a Partner or the interests of a Service User respectively; or

(c) which is a trade secret.

Corporate Section 75 means the partnership agreement dated [ ] and made under Section 75 of the 2006 Act between the Council and [the CCGs] and relating to [ ]

Financial Contributions means the financial contributions made by each Partner to a Pooled Fund in any Financial Year.

Financial Year means each financial year running from 1 April in any year to 31 March in the following calendar year.

Force Majeure Event means one or more of the following:

(a) war, civil war (whether declared or undeclared), riot or armed conflict;

(b) acts of terrorism;

(c) acts of God;

(d) fire or flood;

(e) industrial action;

(f) prevention from or hindrance in obtaining raw materials, energy or other supplies;

(g) any form of contamination or virus outbreak; and

(h) any other event,

in each case where such event is beyond the reasonable control of the Partner claiming relief

Functions means the NHS Functions and the Health Related Functions

Health Related Functions means those of the health related functions of the Council, specified in Regulation 6 of the Regulations as are relevant to the commissioning of the Services and which are further described in the relevant Individual Scheme Agreement.

Host Partner means for each Pooled Fund the Partner that will host the Pooled Fund as set out in the relevant Individual Scheme Agreement

Health and Wellbeing Board means the Health and Wellbeing Board established by the Council pursuant to Section 194 of the Health and Social Care Act 2012.

ICES Section 75 means the partnership agreement dated [ ] and made under section 75 of the 2006 Act between the Council and [LECCG] and relating to integrated community equipment services

Individual Scheme means one of the schemes which is agreed by the Partners to be included within this Agreement using the powers under Section 75 or otherwise, in each case as documented in a relevant Individual Scheme Agreement and at the Commencement Date being the Agreed Individual Schemes.

Individual Scheme Agreement means the contractual arrangement relating to each Individual Scheme being at the Commencement Date

(a) the Learning Disabilities Section 75

(b) the CAMHS Section 75

(c) the ICES Section 75

(d) the Proactive care Section 75

(e) the Corporate Section 75

(f) the LCC/LPFT Adult Mental Health Section 75

(g) the CCG/LPFT Adult Mental Health contract

each of which is incorporated by reference into this Agreement and shall be treated as having been made under this Agreement

Law means:

(a) any statute or proclamation or any delegated or subordinate legislation;

(b) any enforceable community right within the meaning of Section 2(1) European Communities Act 1972;

(c) any guidance, direction or determination with which the Partner(s) or relevant third party (as applicable) are bound to comply to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Partner(s) or relevant third party (as applicable); and

(d) any judgment of a relevant court of law which is a binding precedent in England.

LCC/LPFT Adult Mental Health Section 75 means the partnership agreement dated [ ] and made under Section 75 of the 2006 Act between the Council and [Lincolnshire Partnership Foundation Trust] and relating to the creation of an integrated provider in respect of adult mental health

Lead Commissioning Arrangements means the arrangements by which one Partner commissions Services in relation to an Individual Scheme on behalf of the other Partners in exercise of both the NHS Functions and the Council Functions.

Lead Commissioner means the Partner responsible for commissioning an Individual Service under any Individual Scheme Agreement which involves Lead Commissioning Arrangements

Learning Disabilities Section 75 means the partnership agreement dated [ ] and made under Section 75 of the 2006 Act between the Council and [ ] and relating to learning disabilities services

Month means a calendar month.

National Conditions mean the national conditions as set out in the NHS England Planning Guidance as are amended or replaced from time to time.

NHS Functions means those of the NHS functions listed in Regulation 5 of the Regulations as are exercisable by the CCG as are relevant to the commissioning of any services and which are further described in each Individual Scheme Agreement.

Overspend means any expenditure from a Pooled Fund in a Financial Year which exceeds the Financial Contributions for that Financial Year.

Partner means each of the CCGs and the Council, and references to "**Partners**" shall be construed accordingly.

Partnership Board means the partnership board responsible for review of performance and oversight of this Agreement as set out in Schedule 2.

Personal Data means Personal Data as defined by the 1998 Act.

Pooled Fund means any of pooled funds established and maintained by the Partners as a pooled fund in accordance with the Regulations as set out in an Individual Scheme Agreement

Pooled Fund Individual Scheme means the Agreed Individual Schemes set out in Part A of Schedule 1 and any other Individual Scheme that creates between the Partners a pooled fund

Pooled Fund Manager means such officer of the Host Partner which includes a Section 113 Officer for the relevant Pooled Fund established under an Individual Scheme Agreement as is nominated by the Host Partner from time to time to manage the Pooled Fund.

Proactive Care Section 75 means the partnership agreement dated [ ] and made under Section 75 of the 2006 Act between the Council and [the CCGs] and relating to [ ] services

Provider means a provider of any Services commissioned under the arrangements set out in this Agreement.

Public Health England means the SOSH trading as Public Health England.

Quarter means each of the following periods in a Financial Year:

1 April to 30 June

1 July to 30 September

1 October to 31 December

1 January to 31 March

and "**Quarterly**" shall be interpreted accordingly.

Regulations means the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 No 617 (as amended).

Sensitive Personal Data means Sensitive Personal Data as defined in the 1998 Act.

Services means such health and social care services as are agreed from time to time by the Partners to be commissioned under the arrangements set out in this Agreement as more specifically defined in each Individual Scheme Agreement.

Service Users means those individual for whom the Partners have a responsibility to commission any of the Services as identified in each Individual Scheme Agreement.

SOSH means the Secretary of State for Health.

Working Day means 8.00am to 6.00pm on any day except Saturday, Sunday, Christmas Day, Good Friday or a day which is a bank holiday (in England) under the Banking & Financial Dealings Act 1971.

1.2 In this Agreement, all references to any statute or statutory provision shall be deemed to include references to any statute or statutory provision which amends, extends, consolidates or replaces the same and shall include any orders, regulations, codes of practice, instruments or other subordinate legislation made thereunder and any conditions attaching thereto. Where relevant, references to English statutes and statutory provisions shall be construed as references also to equivalent statutes, statutory provisions and rules of law in other jurisdictions.

1.3 Any headings to Clauses, together with the front cover and the index are for convenience only and shall not affect the meaning of this Agreement. Unless the contrary is stated, references to Clauses and Schedules shall mean the clauses and schedules of this Agreement.

1.4 Any reference to the Partners shall include their respective statutory successors, employees and agents.

1.5 In the event of a conflict, the conditions set out in the Clauses to this Agreement shall take priority over the Schedules.

1.6 Where a term of this Agreement provides for a list of items following the word "including" or "includes", then such list is not to be interpreted as being an exhaustive list.

1.7 In this Agreement, words importing any particular gender include all other genders, and the term "person" includes any individual, partnership, firm, trust, body corporate, government, governmental body, trust, agency, unincorporated body of persons or association and a reference to a person includes a reference to that person's successors and permitted assigns.

1.8 In this Agreement, words importing the singular only shall include the plural and vice versa.

1.9 In this Agreement, "staff" and "employees" shall have the same meaning and shall include reference to any full or part time employee or officer, director, manager and agent.

1.10 Subject to the contrary being stated expressly or implied from the context in these terms and conditions, all communication between the Partners shall be in writing.

1.11 Unless expressly stated otherwise, all monetary amounts are expressed in pounds sterling but in the event that pounds sterling is replaced as legal tender in the United Kingdom by a different currency then all monetary amounts shall be converted into such other currency at the rate prevailing on the date such other currency first became legal tender in the United Kingdom.

1.12 All references to the Agreement include (subject to all relevant approvals) a reference to the Agreement as amended, supplemented, substituted, novated or assigned from time to time.

2 TERM

2.1 This Agreement shall come into force on the Commencement Date.

2.2 This Agreement shall continue in force until midnight on 31 March 2016 at which time it shall terminate automatically unless extended in accordance with Clause 2.4.

2.3 The commencement, duration and termination of the arrangements for each Individual Scheme shall be as set out in the relevant Individual Scheme Agreement. No expiry or termination of this Agreement shall affect the continuation in force of any Individual Scheme Agreement and the expiry or termination of any Individual Scheme Agreement shall not affect the continuation in force of this Agreement.

2.4 This Agreement may be extended to any extent beyond the expiry date of this Agreement set out in clause 2.2 by the written agreement of all the Partners not later than the said date of expiry

3 GENERAL PRINCIPLES

3.1 Nothing in this Agreement shall affect:

3.1.1 the liabilities of the Partners to each other or to any third parties for the exercise of their respective functions and obligations (including the Functions); or

3.1.2 any power or duty to recover charges for the provision of any services (including the Services) in the exercise of any local authority function.

3.2 The Partners agree to:

3.2.1 treat each other with respect and an equality of esteem;

3.2.2 be open with information about the performance and financial status of each; and

3.2.3 provide early information and notice about relevant problems.

3.3 For the avoidance of doubt, the aims and outcomes relating to an Individual Scheme shall be as set out in the relevant Individual Scheme Agreement.

4 PARTNERSHIP FLEXIBILITIES

4.1 This Agreement sets out the mechanism through which the Partners will work together to establish one or more of the following:

4.1.1 Lead Commissioning Arrangements;

4.1.2 the establishment of one or more Pooled Funds;

4.1.3 joint commissioning of services; and

4.1.4 the alignment of their separate commissioning activity towards shared outcomes or objectives

in relation to Individual Schemes (the "Flexibilities")

4.2 The Individual Schemes in place as at the Commencement Date shall be the Agreed Individual Schemes.

4.3 Each Individual Scheme shall be wholly governed by the relevant Individual Scheme Agreement including:-

4.3.1 the extent of any delegation by the Council to the CCGs or any of them of the exercise of Health Related Functions in conjunction with NHS Functions;

4.3.2 the extent of any delegation by the CCGs or any of them to the Council of the exercise of NHS Functions in conjunction with Health-Related Functions;

4.3.3 the extent of any pooling of budgets in Pooled Funds established by a Pooled Fund Individual Scheme and the management of such Funds including treatment of underspends and overspends

save to the extent set out in clause 7.1, clause 10.3 and clause 17.3 and in the event of any inconsistency between such an Individual Scheme Agreement and the provisions of clause 7.1, 10.3 and 17.3 of this Agreement the said clauses 7.1, 10.3 and 17.3 shall prevail.

5 FUNCTIONS

5.1 The purpose of this Agreement is to establish a framework through which the Partners can secure the provision of health and social care services in accordance with the terms of this Agreement.

5.2 This Agreement shall include from the Commencement Date the Individual Schemes listed in the Schedule 1 on the terms of the Individual Scheme Agreements and such other Individual Schemes as the Partners shall agree on such terms as shall be agreed from time to time by the Partners.

5.3 Where the Partners add a new Individual Scheme to this Agreement an Individual Scheme Agreement for each such Individual Scheme shall be completed and agreed between the Partners.

5.4 The Partners shall not enter into an Individual Scheme Agreement in respect of an Individual Scheme (other than the Agreed Individual Schemes) unless they are satisfied that the Individual Scheme in question meets all applicable statutory pre-conditions and requirements relating thereto including (where applicable) those set out in the Regulations.

5.5 The introduction of any Individual Scheme (other than the Agreed Individual Schemes) will be subject to business case development and recommendation by the [Partnership Board] and approval from each of the Partners through their formal decision-making processes

6 ESTABLISHMENT OF POOLED FUNDS

6.1 In exercise of their respective powers under Section 75 of the 2006 Act, the Partners have agreed to establish and maintain such pooled funds for revenue expenditure as are set out in each of the Individual Scheme Agreements.

6.2 Subject to clause 7.1 below, each Pooled Fund shall be managed and maintained in accordance with the terms of the relevant Individual Scheme Agreement.

6.3 Subject to clause 10.3, underspends and Overspends shall be managed in accordance with the terms of each Individual Scheme Agreement

7 POOLED FUND MANAGEMENT

7.1 Each Host Partner in respect of any Individual Scheme where there is a Pooled Fund undertakes to ensure that the Pooled Fund Manager in respect of that Individual Scheme shall, in addition to their duties under the Individual Scheme Agreement relating to that Scheme comply with the following duties and responsibilities under this Agreement:

7.1.1 maintaining an overview of all joint financial issues affecting the Partners in relation to the Pooled Fund;

7.1.2 ensuring that full and proper records for accounting purposes are kept in respect of the Pooled Fund;

7.1.3 reporting to the Partnership Board as required by Schedule 4 and the Partnership Board;

7.1.4 ensuring action is taken to manage any projected under or overspends relating to the Pooled Fund in accordance with the Individual Scheme Agreement;

7.1.5 preparing and submitting to the Partnership Board Quarterly reports (or more frequent reports if required by the Partnership Board) and an annual return about the income and expenditure from the Pooled Fund together with such other information as may be required by the Partners and the Partnership Board to monitor the effectiveness of the Pooled Fund and to enable the Partners to complete their own financial accounts and returns. The Partners agree to provide all necessary information to the Pooled Fund Manager in time for the reporting requirements to be met;

7.1.6 preparing and submitting reports to the Health and Wellbeing Board and each of the Partners as required by them; and

7.1.7 complying with Schedule 3 as regards the management of risk across the Individual Schemes covered by this Agreement

7.2 Each Host Partner in respect of any Individual Scheme shall ensure that in carrying out their responsibilities as provided under the Individual Scheme Agreement and Clause 7.1 the Pooled Fund Manager shall have regard to the recommendations of the Partnership Board.

7.3 The Partnership Board shall consider any proposals for the viring of funds between Pooled Funds before making recommendations to the Partners who shall be responsible for approving any proposed virement.

8 FINANCIAL CONTRIBUTIONS

8.1 The Financial Contribution of the CCG and the Council to any Pooled Fund for any Financial Year of operation of an Individual Scheme shall be as set out in or shall be calculated or determined in accordance with the relevant Individual Scheme Agreement.

8.2 Financial Contributions shall be paid as set out in the each Individual Scheme Agreement.

8.3 With the exception of Clause 11, no provision of this Agreement shall preclude the Partners from making additional contributions of non-recurrent payments to any Pooled Fund from time

to time by mutual agreement. Any such additional contributions of non-recurrent payments shall be explicitly approved by the Partner making the additional contributions and shall recorded in the budget statement for the relevant Pooled Fund as a separate item.

9 NON FINANCIAL CONTRIBUTIONS

9.1 The Individual Scheme Agreement shall set out non-financial contributions of each Partner including staff (including the Pooled Fund Manager), premises, IT support and other non-financial resources necessary to perform its obligations pursuant to the Individual Scheme Agreement (including, but not limited to, management of service contracts and the Pooled Fund).

10 RISK SHARE ARRANGMENTS, OVERSPENDS AND UNDERSPENDS

10.1 Subject to clause 10.3, the risk share arrangements and the arrangements in relation to Overspends and underspends relating to each Individual Scheme shall be as set out in the relevant Individual Scheme Agreement

10.2 The Partners have agreed the risk share arrangements set out in schedule 3, to govern financial risks arising across the Pooled Funds and the financial risk to the Partners arising from the payment for performance element of the Better Care Fund.

10.3 Notwithstanding the provisions of any Individual Scheme Agreement containing a Pooled Fund, in the event of any conflict between the provisions of any Individual Scheme Agreement containing a Pooled Fund and the provisions of Schedule 3, the provisions of Schedule 3 shall prevail.

10.4 The Host Partner for the relevant Pooled Fund shall manage expenditure from a Pooled Fund within the Financial Contributions and shall ensure that the expenditure is limited to permitted expenditure in accordance with the relevant Individual Scheme Agreement.

11 CAPITAL EXPENDITURE

Pooled Funds shall not normally be applied towards any one-off expenditure on goods and/or services, which will provide continuing benefit and would historically have been funded from the capital budgets of one of the Partners. If a need for capital expenditure is identified this must be agreed by the Partners in accordance with the relevant Individual Scheme Agreement.

12 VAT

The treatment of each of the Pooled Funds for VAT purposes shall be as set out in each of the Individual Scheme Agreements.

13 AUDIT AND RIGHT OF ACCESS

13.1 All Partners shall promote a culture of probity and sound financial discipline and control. The Host Partner shall arrange for the audit of the accounts of the relevant Pooled Fund and shall require the Audit Commission to make arrangements to certify an annual return of those accounts under Section 28(1) of the Audit Commission Act 1998.

13.2 All internal and external auditors and all other persons authorised by the Partners will be given the right of access by them to any document, information or explanation they require from any employee, member of the Partner in order to carry out their duties. This right is not limited to financial information or accounting records and applies equally to premises or equipment used in connection with this Agreement. Access may be at any time without notice, provided there is good cause for access without notice.

14 LIABILITIES AND INSURANCE AND INDEMNITY

14.1 Subject to the provisions of Schedule 3, the liabilities of the Partners to each other and the insurance and indemnity provisions relating to any Individual Scheme shall be as set out in the Individual Scheme Agreement.

15 STANDARDS OF CONDUCT AND SERVICE

15.1 The Partners will at all times comply with Law and ensure good corporate governance in respect of each Partner (including the Partners respective Standing Orders and Standing Financial Instructions).

15.2 The Council is subject to the duty of Best Value under the Local Government Act 1999. This Agreement and the operation of the Pooled Funds is therefore subject to the Council's obligations of Best Value and the other Partners will co-operate with all reasonable requests from the Council which the Council considers necessary in order to fulfil its Best Value obligations.

15.3 The CCGs are subject to the CCG Statutory Duties and these incorporate a duty of clinical governance, which is a framework through which they are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. This Agreement and the operation of the Pooled Funds are therefore subject to ensuring compliance with the CCG Statutory Duties and clinical governance obligations.

15.4 The Partners are committed to an approach to equality and equal opportunities as represented in their respective policies. The Partners will maintain and develop these policies as applied to service provision, with the aim of developing a joint strategy for all elements of the service.

16 CONFLICTS OF INTEREST

The Partners shall comply with the agreed policy for identifying and managing conflicts of interest as set out in Schedule 5.

17 GOVERNANCE

17.1 The arrangements for the governance of this Agreement are set out in Schedule 2

17.2 The arrangements for the governance of each Individual Scheme are set out in the relevant Individual Scheme Agreement.

17.3 In the event of any inconsistency between Schedule 2 and the governance arrangements of any Individual Scheme Agreement, Schedule 2 shall prevail.

17.4 Each Partner has secured internal reporting arrangements to ensure the standards of accountability and probity required by each Partner's own statutory duties and organisation are complied with.

17.5 The [Partnership Board] shall be responsible for recommending the addition of new Individual Schemes, or the amendment or variation of existing Individual Schemes ensuring compliance with the Better Care Fund Plan and the strategic direction of the Better Care Fund.

17.6 Approval of the addition of new Individual Schemes is reserved to the Partners all of whom must agree such addition in writing. Approval of the amendment or variation of existing Individual Schemes is reserved to the Partners in accordance with the relevant Individual Scheme Agreement.

18 REVIEW

18.1 Save where the Partnership Board agree alternative arrangements (including alternative frequencies) the Partners shall undertake a review ("**Annual Review**") of the operation of this Agreement not later than 3 Months prior the end of the Financial Year.

18.2 Subject to any variations to this process required by the Partnership Board, the Annual Review shall be conducted in good faith and, where applicable, in accordance with the governance arrangements set out in Schedule 2.

18.3 The Partners shall within [20] Working Days of the annual review prepare a joint report documenting the matters referred to in this Clause 18. A copy of this report shall be provided to the Partnership Board.

18.4 The Report referred to in clause 18.3 shall form the basis of a consideration by the Partnership Board as to whether to recommend to the Partners an extension of this Agreement under clause 2.4.

18.4 In the event that the Partners fail to meet the requirements of the Better Care Fund Plan and NHS England the Partners shall provide full co-operation with NHS England to agree a recovery plan.

19 COMPLAINTS

19.1 Complaints relating to Individual Schemes shall be dealt with in accordance with the relevant Individual Scheme Agreement.

19.2 The Partners' own complaints procedures shall apply to complaints relating to this Agreement. The Partners agree to assist one another in the management of complaints arising from this Agreement or the provision of the Services.

20 TERMINATION & DEFAULT

20.1 This Agreement may be terminated by any Partner giving not less than [3] Months' notice in writing to terminate this Agreement provided that such termination shall not take effect prior to the expiry of the Financial Year in which the notice was given.

20.2 Each Individual Scheme may be terminated in accordance with the terms set out in the relevant Individual Scheme Agreement. In the event of any such termination the parties shall negotiate in good faith such provisions as shall be necessary to ensure compliance with the requirements of the Better Care Fund (if any) in force at that time.

20.3 If any Partner ("Relevant Partner") fails to meet any of its obligations under this Agreement, the other Partners (acting jointly) may by notice require the Relevant Partner to take such reasonable action within a reasonable timescale as the other Partners may specify to rectify such failure. Should the Relevant Partner fail to rectify such failure within such reasonable timescale, the matter shall be referred for resolution in accordance with Clause 21.

20.4 Termination of this Agreement (whether by effluxion of time or otherwise) shall be without prejudice to the Partners' rights in respect of any antecedent breach and the provisions of Clauses [INSERT]

20.5 Upon termination of this Agreement for any reason whatsoever the following shall apply:

20.5.1 the Partners agree that they will work together and co-operate to ensure that the winding down of this Agreement is carried out smoothly and with as little disruption as possible to service users, employees, the Partners and third parties, so as to minimise costs and liabilities of each Partner in doing so; and

20.5.2 Termination of this Agreement shall have no effect on the liability or any rights or remedies of any Partner already accrued, prior to the date upon which such termination takes effect.

20.6 Subject to clauses 7.1, 10.3 and 17.3, in the event of termination of an Individual Scheme the provisions of the Individual Scheme Agreement shall apply.

21 DISPUTE RESOLUTION

21.1 In the event of a dispute between the Partners arising out of this Agreement, any Partner may serve written notice of the dispute on the other Partner, setting out full details of the dispute.

21.2 The Authorised Officer shall meet in good faith as soon as possible and in any event within seven (7) days of notice of the dispute being served pursuant to Clause 21.1, at a meeting convened for the purpose of resolving the dispute.

21.3 If the dispute remains after the meeting detailed in Clause 21.2 has taken place, the Partners' respective [chief executives][*insert position*] or nominees shall meet in good faith as soon as possible after the relevant meeting and in any event with fourteen (14) days of the date of the meeting, for the purpose of resolving the dispute.

21.4 If the dispute remains after the meeting detailed in Clause 21.3 has taken place, then the Partners will attempt to settle such dispute by mediation in accordance with the CEDR Model Mediation Procedure or any other model mediation procedure as agreed by the Partners. To initiate a mediation, any Partner may give notice in writing (a **"Mediation Notice"**) to the others requesting mediation of the dispute and shall send a copy thereof to CEDR or an equivalent mediation organisation as agreed by the Partners asking them to nominate a mediator. The mediation shall commence within twenty (20) Working Days of the Mediation Notice being served. No Partner will terminate such mediation until each of them has made its opening presentation and the mediator has met each of them separately for at least one (1) hour. Thereafter, paragraph 14 of the Model Mediation Procedure will apply (or the equivalent paragraph of any other model mediation procedure agreed by the Partners). The Partners will co-operate with any person appointed as mediator, providing him with such information and other assistance as he shall require and will pay his costs as he shall determine or in the absence of such determination such costs will be shared equally.

21.5 Nothing in the procedure set out in this Clause 21 shall in any way affect any Partner's right to terminate this Agreement in accordance with any of its terms or take immediate legal action.

22 FORCE MAJEURE

22.1 No Partner shall be entitled to bring a claim for a breach of obligations under this Agreement by any other Partner or incur any liability to any other Partner for any losses or damages incurred by that Partner to the extent that a Force Majeure Event occurs and it is prevented from carrying out its obligations by that Force Majeure Event.

22.2 On the occurrence of a Force Majeure Event, the Affected Partner shall notify the other Partners as soon as practicable. Such notification shall include details of the Force Majeure Event, including evidence of its effect on the obligations of the Affected Partner and any action proposed to mitigate its effect.

22.3 As soon as practicable, following notification as detailed in Clause 22.2, the Partners shall consult with each other in good faith and use all reasonable endeavours to agree appropriate terms to mitigate the effects of the Force Majeure Event and, subject to Clause 22.4, facilitate the continued performance of the Agreement.

22.4 If the Force Majeure Event continues for a period of more than [sixty (60) days], any Partner shall have the right to terminate the Agreement by giving [fourteen (14) days] written notice of termination to the other Partners. For the avoidance of doubt, no compensation shall be payable by any Partner as a direct consequence of this Agreement being terminated in accordance with this Clause.

23 CONFIDENTIALITY

23.1 In respect of any Confidential Information a Partner receives from another Partner (the "**Discloser**") and subject always to the remainder of this Clause 23, each Partner (the "**Recipient**") undertakes to keep secret and strictly confidential and shall not disclose any such Confidential Information to any third party, without the Discloser's prior written consent provided that:

23.1.1 the Recipient shall not be prevented from using any general knowledge, experience or skills which were in its possession prior to the Commencement Date; and

23.1.2 the provisions of this Clause 23 shall not apply to any Confidential Information which:

(a) is in or enters the public domain other than by breach of the Agreement or other act or omission of the Recipient; or

(b) is obtained by a third party who is lawfully authorised to disclose such information.

23.2 Nothing in this Clause 23 shall prevent the Recipient from disclosing Confidential Information where it is required to do so in fulfilment of statutory obligations or by judicial, administrative, governmental or regulatory process in connection with any action, suit, proceedings or claim or otherwise by applicable Law.

23.3 Each Partner:

23.3.1 may only disclose Confidential Information to its employees and professional advisors to the extent strictly necessary for such employees to carry out their duties under the Agreement; and

23.3.2 will ensure that, where Confidential Information is disclosed in accordance with Clause 23.3.1, the recipient(s) of that information is made subject to a duty of confidentiality equivalent to that contained in this Clause 23;

23.3.3 shall not use Confidential Information other than strictly for the performance of its obligations under this Agreement.

24 FREEDOM OF INFORMATION AND ENVIRONMENTAL PROTECTION REGULATIONS

24.1 The Partners agree that they will each cooperate with each other to enable any Partner receiving a request for information under the 2000 Act or the 2004 Act to respond to a request promptly and within the statutory timescales. This cooperation shall include but not be limited to finding, retrieving and supplying information held, directing requests to other Partners as appropriate and responding to any requests by the Partner receiving a request for comments or other assistance.

24.2 Any and all agreements between the Partners as to confidentiality shall be subject to their duties under the 2000 Act and 2004 Act. No Partner shall be in breach of Clause 23 if it makes disclosures of information in accordance with the 2000 Act and/or 2004 Act.

25 OMBUDSMEN

The Partners will co-operate with any investigation undertaken by the Health Service Commissioner for England or the Local Government Commissioner for England (or both of them) in connection with this Agreement.

26 INFORMATION SHARING

The Partners will follow the Information Governance Protocol set out in Schedule 6, and in so doing will ensure that the operation this Agreement complies with Law, in particular the 1998 Act**.**

27 NOTICES

27.1 Any notice to be given under this Agreement shall either be delivered personally or sent by facsimile or sent by first class post or electronic mail. The address for service of each Partner shall be as set out in Clause 27.3 or such other address as each Partner may previously have notified to the other Partner in writing. A notice shall be deemed to have been served if:

27.1.1 personally delivered, at the time of delivery;

27.1.2 sent by facsimile, at the time of transmission;

27.1.3 posted, at the expiration of forty eight (48) hours after the envelope containing the same was delivered into the custody of the postal authorities; and

27.1.4 if sent by electronic mail, at the time of transmission and a telephone call must be made to the recipient warning the recipient that an electronic mail message has been sent to him (as evidenced by a contemporaneous note of the Partner sending the notice) and a hard copy of such notice is also sent by first class

recorded delivery post (airmail if overseas) on the same day as that on which the electronic mail is sent.

27.2 In proving such service, it shall be sufficient to prove that personal delivery was made, or that the envelope containing such notice was properly addressed and delivered into the custody of the postal authority as prepaid first class or airmail letter (as appropriate), or that the facsimile was transmitted on a tested line or that the correct transmission report was received from the facsimile machine sending the notice, or that the electronic mail was properly addressed and no message was received informing the sender that it had not been received by the recipient (as the case may be).

27.3 The address for service of notices as referred to in Clause 27.1 shall be as follows unless otherwise notified to the other Partner in writing:

27.3.1 if to the Council, addressed to the [ ];

Tel: [ ]
Fax: [ ]
E.Mail: [ ]

and

27.3.2 If to the

27.3.3 If to the

27.3.4 If to the

27.3.5 if to the CCG, addressed to [ ];

Tel: [ ]
Fax: [ ]
E.Mail: [ ]

28 VARIATION

No variations to this Agreement will be valid unless they are recorded in writing and signed for and on behalf of each of the Partners.

29 CHANGE IN LAW

29.1 The Partners shall ascertain, observe, perform and comply with all relevant Laws, and shall do and execute or cause to be done and executed all acts required to be done under or by virtue of any Laws.

29.2 On the occurrence of any Change in Law, the Partners shall agree in good faith any amendment required to this Agreement as a result of the Change in Law subject to the Partners using all reasonable endeavours to mitigate the adverse effects of such Change in Law and taking all reasonable steps to minimise any increase in costs arising from such Change in Law.

29.3 In the event of failure by the Partners to agree the relevant amendments to the Agreement (as appropriate), Clause 21 (Dispute Resolution) shall apply.

30 WAIVER

No failure or delay by any Partner to exercise any right, power or remedy will operate as a waiver of it nor will any partial exercise preclude any further exercise of the same or of some other right to remedy.

31 SEVERANCE

If any provision of this Agreement, not being of a fundamental nature, shall be held to be illegal or unenforceable, the enforceability of the remainder of this Agreement shall not thereby be affected.

32 ASSIGNMENT AND SUB CONTRACTING

The Partners shall not sub contract, assign or transfer the whole or any part of this Agreement, without the prior written consent of the other Partners, which shall not be unreasonably withheld or delayed. This shall not apply to any assignment to a statutory successor of all or part of a Partner's statutory functions.

33 EXCLUSION OF PARTNERSHIP AND AGENCY

33.1 Nothing in this Agreement shall create or be deemed to create a partnership under the Partnership Act 1890 or the Limited Partnership Act 1907, a joint venture or the relationship of employer and employee between the Partners or render any Partner directly liable to any third party for the debts, liabilities or obligations of the other.

33.2 Except as expressly provided otherwise in this Agreement or where the context or any statutory provision otherwise necessarily requires, no Partner will have authority to, or hold itself out as having authority to:

33.2.1 act as an agent of the others;

33.2.2 make any representations or give any warranties to third parties on behalf of or in respect of the others; or

33.2.3 bind the others in any way.

34 THIRD PARTY RIGHTS

Unless the right of enforcement is expressly provided, no third party shall have the right to pursue any right under this Contract pursuant to the Contracts (Rights of Third Parties) Act 1999 or otherwise.

35 ENTIRE AGREEMENT

35.1 The terms herein contained together with the contents of the Schedules constitute the complete agreement between the Partners with respect to the subject matter hereof and supersede all previous communications representations understandings and agreement and any representation promise or condition not incorporated herein shall not be binding on any Partner.

35.2 No agreement or understanding varying or extending or pursuant to any of the terms or provisions hereof shall be binding upon any Partner unless in writing and signed by a duly authorised officer or representative of the parties.

36 COUNTERPARTS

This Agreement may be executed in one or more counterparts. Any single counterpart or a set of counterparts executed, in either case, by all Partners shall constitute a full original of this Agreement for all purposes.

37 GOVERNING LAW AND JURISDICTION

37.1 This Agreement and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the laws of England and Wales.

37.2 Subject to Clause 21 (Dispute Resolution), the Partners irrevocably agree that the courts of England and Wales shall have exclusive jurisdiction to hear and settle any action, suit,

proceedings, dispute or claim, which may arises out of, or in connection with, this Agreement, its subject matter or formation (including non-contractual disputes or claims).

IN WITNESS WHEREOF this Agreement has been executed by the Partners on the date of this Agreement[1]

THE CORPORATE SEAL of **THE**)
COUNCIL OF [ ])
was hereunto affixed in the presence of:)

Signed for on behalf of **[ ]**
CLINICAL COMMISSIONING GROUP

____

Authorised Signatory

Signed for on behalf of **[ ]**
CLINICAL COMMISSIONING GROUP

____

Authorised Signatory

Signed for on behalf of **[ ]**
CLINICAL COMMISSIONING GROUP

____

Authorised Signatory

Signed for on behalf of **[ ]**
CLINICAL COMMISSIONING GROUP

____

Authorised Signatory

[1] Partners to confirm execution blocks

SCHEDULE 1– AGREED INDIVIDUAL SCHEMES

As at the Commencement Date the following Individual Schemes shall be treated as having been made under and to be incorporated within this Agreement

Part A - Pooled Fund Individual Schemes

(a) **Learning Disabilities Section 75 Individual Scheme** as set out in the partnership agreement dated [ ] and made under Section 75 of the 2006 Act between the Council and [ ] and relating to learning disabilities services

(b) **CAMHS Section 75 Individual Scheme** as set out in the partnership agreement dated [ ] and made under Section 75 of the 2006 Act between the Council and [] and relating to integrated child and adolescent mental health services

(c) **ICES Section 75 Individual Scheme** as set out in the partnership agreement dated [ ] and made under Section 75 of the 2006 Act between the Council and [LECCG] and relating to integrated community equipment services

(d) **Proactive care Section 75 Individual Scheme** as set out in the partnership agreement dated [ ] and made under Section 75 of the 2006 Act between the Council and [the CCGs] and relating to [ ] services

(e) **Corporate Section 75 Individual Scheme** as set out in the partnership agreement dated [ ] and made under Section 75 of the 2006 Act between the Council and [the CCGs] and relating to [ ]

These Individual Schemes involve the creation of Pooled Funds the value of which count towards compliance with the BCF Minimum.

Part B - Aligned Individual Schemes

(f) **LCC/LPFT Adult Mental Health Section 75 Individual Scheme** as set out in the partnership agreement dated [ ] and made under Section 75 of the 2006 Act between the Council and [Lincolnshire Partnership Foundation Trust] and relating to the creation of an integrated provider in respect of adult mental health

This Individual Scheme does not create and does not form part of a Pooled Fund for the purpose of the BCF Minimum or otherwise. This Individual Scheme creates an integrated provider of adult mental health services and is funded wholly by the Council. Whilst the Individual Scheme falls under the provisions of the Agreement it is wholly governed by the terms of its Individual Scheme Agreement including as to risk share and is not covered by the risk share arrangements set out in Schedule 3 of this Agreement.

(g) **CCG/LPFT Adult Mental Health contract Individual Scheme** as set out in means the [ ] agreement dated [ ] and made between [the CCGs] and [Lincolnshire Partnership Foundation Trust] and relating to the provision of adult mental health services

This Individual Scheme does not create and does not form part of a Pooled Fund for the purpose of the BCF Minimum or otherwise. This Individual Scheme is a [ ] contract between [ ] and [ ] for the provision of adult mental health services and is funded wholly by [ ]. Whilst the Individual Scheme falls under the provisions of the Agreement it is wholly governed by the terms of its Individual Scheme Agreement including as to risk share and is not covered by the risk share arrangements set out in Schedule 3 of this Agreement.

BETTER CARE FUND

PARTNERSHIP FRAMEWORK AGREEMENT

SCHEDULE 2

GOVERNANCE

Introduction

1 This Schedule describes the principles that the Partners agree will be applied to the governance of their Better Care Fund arrangements consisting of this Partnership Framework Agreement and the Individual Schemes that are incorporated within it.

2 Governance of the arrangements operates at three levels as follows:-

- Formal decision-making especially concerning change to approved arrangements and the allocation of resources;
- Strategic oversight and overall performance, risk and financial management and monitoring of the BCF arrangements and the formulation of recommendations for strategic decision-makers; and
- Performance, risk and financial management and monitoring of Individual Schemes.

3 This Schedule describes general areas of responsibility within each of these tiers of governance and allocates them to specified bodies. It does not seek to prescribe detailed structures, terms of reference or arrangements within those tiers or detailed rules of engagement as to how the different tiers relate to each other. These are left to be determined flexibly within and between the tiers in a way best calculated to be responsive to changing conditions.

Overview

4 Strategic formal decision-making is reserved to the Partner corporate bodies – Lincolnshire County Council and the four Clinical Commissioning Groups.

5 Strategic oversight and overall performance, risk and financial management and monitoring of the BCF arrangements and the formulation of recommendations for strategic decision-makers will be carried out by:-

- A Joint Commissioning Board having strategic oversight of and responsibility for the whole of the BCF programme; and
- [Five] Joint Delivery Boards providing operational oversight and more detailed management of a theme of the programme including one or more Individual Schemes
- Each Individual Scheme will have its own specified day to day governance arrangement. In some cases this may feed directly into the relevant Joint Delivery Board. In others a specific board or group may be established within the relevant Section 75 Agreement.

6 These general agreed arrangements are described in diagrammatic form at Annex A to this Schedule. In the event of any conflict between the body of this Schedule and Annex A, the body of this Schedule shall prevail.

Formal Decision-making

7 Nothing in this Schedule is intended to or shall change responsibilities for formal decision-making. In particular, but subject to paragraphs 8 and 9 below, none of the Partners delegate

any of their decision-making powers to the Joint Commissioning Board, Joint Delivery Boards or any Individual Scheme Boards.

8 Where an Individual Scheme Agreement transfers the exercise of an NHS Function to the Council or a Council Function to one or more CCGs, that transfer of function shall take effect and the exercise of that function shall be carried out by the body to whom it has been transferred. However, in the exercise of that transferred function the formal decision-making powers of the body exercising that function shall not be affected by the governance arrangements as set out in this Schedule.

9 It shall be for each Partner as a corporate body to take formal decisions in accordance with its own internal constitutional and decision-making arrangements and nothing in this Schedule shall prevent any Partner delegating its decisions within its own organisation in any way it is empowered to do so.

10 Without limiting in any way the scope of each Partner's decision-making role, the types of matters relevant to this Partnership Framework Agreement and the Individual Schemes which are reserved to the Partners as corporate bodies include:-

10.1 The termination or extension of the Partnership Framework Agreement or any Individual Scheme

10.2 Approval of changes to the Partnership Framework Agreement or an Individual Scheme Agreement including in particular:-

10.2.1 changes to the functions to be transferred
10.2.2 changes to the amounts of any contributions by any partner and the overall amount of any Pooled Fund
10.2.3 changes to the terms and conditions of the Partnership Framework Agreement and any Individual Scheme Agreement including the management of any underspends or overspends or risk management arrangements generally

10.3 The use of resources within the BCF arrangement at the end of the Partnership Framework Agreement to manage risks in accordance with Schedule 3 (Risk Management) to this Agreement.

Joint Commissioning Board and Joint Delivery Boards

11 These Boards between them provide strategic oversight and overall performance, risk and financial management and monitoring of the BCF arrangements.

12 The Joint Commissioning Board shall consist of senior officers of all of the Partners and shall fulfil the following general responsibilities:-

12.1 providing assurance to the Partners that the overall BCF arrangements and each Individual Scheme is:-

12.1.1 meeting standards of good governance generally and specifically in relation to the hosting and management of the Pooled Funds;

12.1.2 complying with all applicable performance and financial targets at the level of both the Individual Scheme and the BCF to include savings targets referred to in Appendix B to Schedule 3 (Risk Management) to this Partnership Framework Agreement

12.1.3 meeting the commitments set out in the BCF Plan

12.2 the general risk management of the BCF in accordance with Schedule 3 (Risk Management) to this Partnership Framework Agreement and in particular the formulation of recommendations to Partners as to the treatment of the contingency fund and underspends retained in the Corporate Section 75 Agreement

12.3 fitness for purpose of the overall framework and Individual Schemes for the achievement of the BCF Plan and the wider strategic direction of health and social care in Lincolnshire and the formulation and making of recommendations to the Partners as to changes to the Partnership Framework Agreement or any Individual Scheme to include changes within an Individual Scheme and proposals for new Individual Schemes involving new or different use of the Section 75 flexibilities.

13 The Joint Commissioning Board shall operate on a consensual basis, having no delegated authority as a body to override the wishes of any Partner as expressed by the representative of that Partner.

14 The Joint Delivery Boards shall assist the Joint Commissioning Board by being responsible for the more detailed contract management of Individual Schemes assuring they are meeting the matters set out in paragraph 12.1 above, reporting performance on a regular basis and identifying risks and issues that need resolution at a higher level. The Joint Delivery Boards shall also be responsible for identifying potential change and new developments and the detailed formulation of business cases and recommendations for sign-off or not by the Joint Commissioning Board.

Individual Scheme Governance Arrangements

15 Where an Individual Scheme Agreement makes provision for the Individual Scheme to be governed by any arrangement other than a Joint Delivery Board and the Joint Commissioning Board such Individual Scheme shall be governed in accordance with its Individual Scheme Agreement subject to this Schedule taking precedence in accordance with clause 4.3 of the Partnership Framework Agreement.

16 As a result the governance arrangements in an Individual Scheme shall be subject to the authority of each of the Partner corporate bodies, the Joint Commissioning Board and the Joint Delivery Boards within their areas of responsibility as set out in this Schedule.

Health and Wellbeing Board

17 The Health and Wellbeing Board will receive regular reports on the performance of the BCF arrangements and emerging issues and risks. As the body with statutory responsibilities for encouraging integration the Health and Wellbeing Board will be involved and consulted by the Joint Commissioning Board on all proposals for extension or change to the existing BCF arrangements prior to any recommendations being made to the Partner corporate bodies for formal decision-making.

Scrutiny

18 All governance processes including formal decision-making processes within the Council shall ensure appropriate involvement of relevant Scrutiny Committees.

BETTER CARE FUND

PARTNERSHIP FRAMEWORK AGREEMENT

SCHEDULE 3

RISK MANAGEMENT

Introduction

1 This Schedule sets out the principles against which risk will be managed between the Partners. It operates at two levels

- the level of the Individual Schemes; and
- The level of this Partnership Framework Agreement

Individual Schemes

2 By their very nature Section 75 Agreements and in particular Pooled Fund arrangements provide an appropriate vehicle for managing risk between the associated parties. Each Individual Scheme Agreement will therefore contain risk management arrangements appropriate to the circumstances of that Individual Scheme Agreement.

Partnership Framework Agreement

General

3 This Schedule relates to the BCF schemes included in the S75 Pooled funds as detailed in Schedule 1, totalling £129.707m.

4 Responsibility for the management of the Pooled budgets referred to on paragraph 3 above is split between the CCGs and the Local Authority by mutual agreement. The assigned responsibility for the different elements of the Pooled budgets is shown in the pooled budget responsibility table below (para 7) and set out in detail in each Individual Scheme Agreement. This is in line with the proposed contract structure and governance arrangements proposed.

5 The financial impact of unpredictable incidences on system wide deliverables should be shared proportionately, dependent on the scheme and service, amongst the parties to the agreement. This supports a general principle that all parties are fully engaged and contribute effort to the effectively delivery of the schemes

6 Where the impact is so financially significant that individual bodies could be at financial risk, the parties need to work together to mitigate the impact.

7 All parties recognise that risks associated with the Better Care Fund need to be funded by it and not be a pressure on individual partner's budgets outside the Better Care Fund.

Principal Risks – CCGs

8 The principal risks to the CCGs are those associated with the fact that the CCGs' combined contribution to the BCF funding of £197m is not fully funded either through the BCF itself or the other resources of the CCGs. These funding shortfalls are identified in Appendix A.

Principal Risks – the Council

9 The principal financial risk to the Council is the penalty that the Council will suffer if the BCF programme does not achieve its target for reductions in admissions for non-elective care.

10 The Better Care Fund Plan contains a commitment on the part of the Partners to reduce admissions for non-elective care in the calendar year 2015 by 3.5% compared with the calendar year 2014. If the target is not reached the Council will be required to pay a set figure

for each admission that should not have occurred had the target been reached to the acute trust to compensate them for savings they would have made had the admissions reductions been achieved. The maximum extent of the financial exposure to the Council is £3.75m.

Managing the Principal Risk to the Council

11 In order to fully mitigate the principal risk to the Council a contingency fund will be set up at 1st April 2015. The contingency fund will be in the sum of £3.75m taken from the carried forward surplus from 2014/15 BCF.

12 Depending on the performance against the target some or all of the contingency fund will become available for use by the Partners. The extent of such availability is illustrated in the Table below based on 100%, 75%, 50% and 25% achievement against the target.

Extent of Achievement	Amount of Contingency Fund Available
100% achievement	100% contingency fund available (£3.75m)
75% achievement	75% contingency fund available (£2.81m)
50% achievement	50% contingency fund available (£1.875 m)
25% achievement	25% contingency fund available (£0.9375 m)
0% achievement	No contingency fund available

13 Performance against the target will be monitored and assessed from 1st January 2015 and reported on a quarterly basis to the [Partnership Board] and the Health Wellbeing Board.

14 Performance against the target will be reviewed not later than 1st September 2015 to assess performance to date and any ongoing amounts required to be maintained in the contingency fund for the remainder of the year. The results of this review will be considered by the Partnership Board who will make recommendations to the Partners as to the release of any sums from the contingency fund. The release of such funds shall be subject to agreement of all Partners approved though their internal decision-making processes.

Managing the Principal Risk to the CCGs

15 There are two elements to managing the risk to the CCGs.

16 The first is that, as set out in Appendix A, savings targets have been set which should bridge the funding gap if achieved. [The Partners commit themselves to using all reasonable endeavours to achieve the savings targets.]

17 If these savings are not achieved then there are potentially two sources of funding that could be used to manage this risk:-

- Amounts released from or left in the contingency fund once final performance against the reduction in non-elective admissions target is known; and
- Underspends within any Individual Scheme over and above any savings targets identified in Appendix A.

18 Where such funding as is referred to in paragraph 17 exists it will be treated in accordance with paragraphs 20 to 25 below.

Overspends

19 The management of the financial overspends on each element of the BCF scheme are the responsibility of the organisation who is fixed with that responsibility in accordance with the

Individual Scheme Agreement and will not be funded through the BCF, unless agreed by all the Partners following a recommendation from the [Partnership Board].

Contingency Fund and Underspends

20 The contingency fund shall form part of the Corporate Section 75 Agreement and will be managed in accordance with paragraphs 11 to 14 above.

21 Any net financial underspend on an element of the BCF scheme [at the end of [ ]] will be transferred to the corporate S75 Agreement.

22 Not later than [ ] after the end of [ ], the [Partnership Board shall meet to consider how to use any amount left in the Contingency Fund at the end of [ ] and any underspends transferred to the corporate Section 75 Agreement under paragraph 21 above. The options available to the [Partnership Board] separately or in any combination shall be:-

22.1 allocation to any of the Individual Schemes or investment otherwise in the achievement of the Better Care Fund Plan;

22.2 allocation to the CCGs to cover wholly or partly the funding gap set out in Appendix A to the extent that it has not successfully been managed by the delivery of planned savings; or

22.3 return to the Partners in proportion to their contribution to the BCF.

23 The results of the [Partnership Board's] deliberations shall be a recommendation to the Partners which it shall deliver to the Partners within [ ] of reaching a conclusion in its deliberations.

24 Use of such sums as referred to in paragraph 17, whether in accordance with a recommendation of the Partnership Board or otherwise shall be subject to agreement by all Partners through their internal decision-making processes.

25 If the Partnership Board is not able to reach agreement on a recommendation or having reached agreement on a recommendation such recommendation is not agreed by all the Partners any dispute shall be subject to dispute resolution procedure at clause [21] of the Partnership Framework Agreement.

Delivery Risk

26 The following national conditions must be met in local delivery:

a) Protection for social care services
b) 7 day working in health and social care to prevent unnecessary hospital admissions and facilitate timely discharge
c) Data sharing based upon the NHS number
d) Joint assessments and care planning, including an accountable professional
e) Agreement on the impact on acute care

27 Individual Partners will not undertake any material change in services during 2015 which will have a negative impact on the BCF targets.

Reputational Risk

28 Reputational risk will be managed through an aligned communications and engagement plan.

General Risk Management

29 A comprehensive risk register will be in place to manage or mitigate known and emerging risks associated with the development and implementation of the Better Care Fund Plan

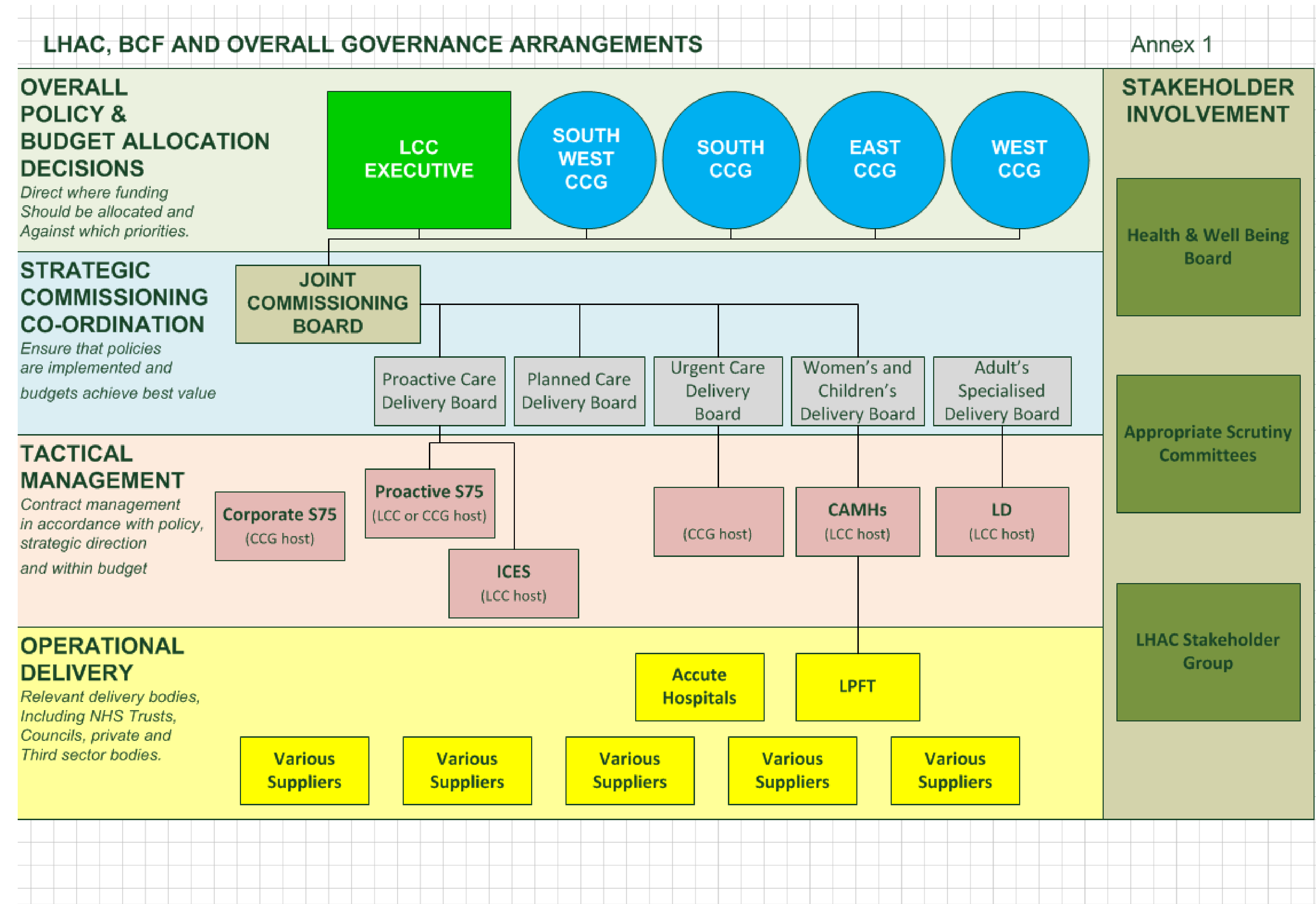
30 Resources to support the development and maintenance of the risk register will be identified by the parties.

31 The Risk Log will be reviewed by groups that are responsible for the individual identified risks – e.g. the finance risks will be reviewed on a monthly basis by the finance group who will

update the Risk log and provide these updates for inclusion into the Master Risk Log. The Risk Log will be updated regularly and reported to the Joint Commissioning Board. Significant risks will be escalated to the Joint Commissioning Board and the Health and Well Being Board as appropriate.

Appendix A - Opening Financial Gap

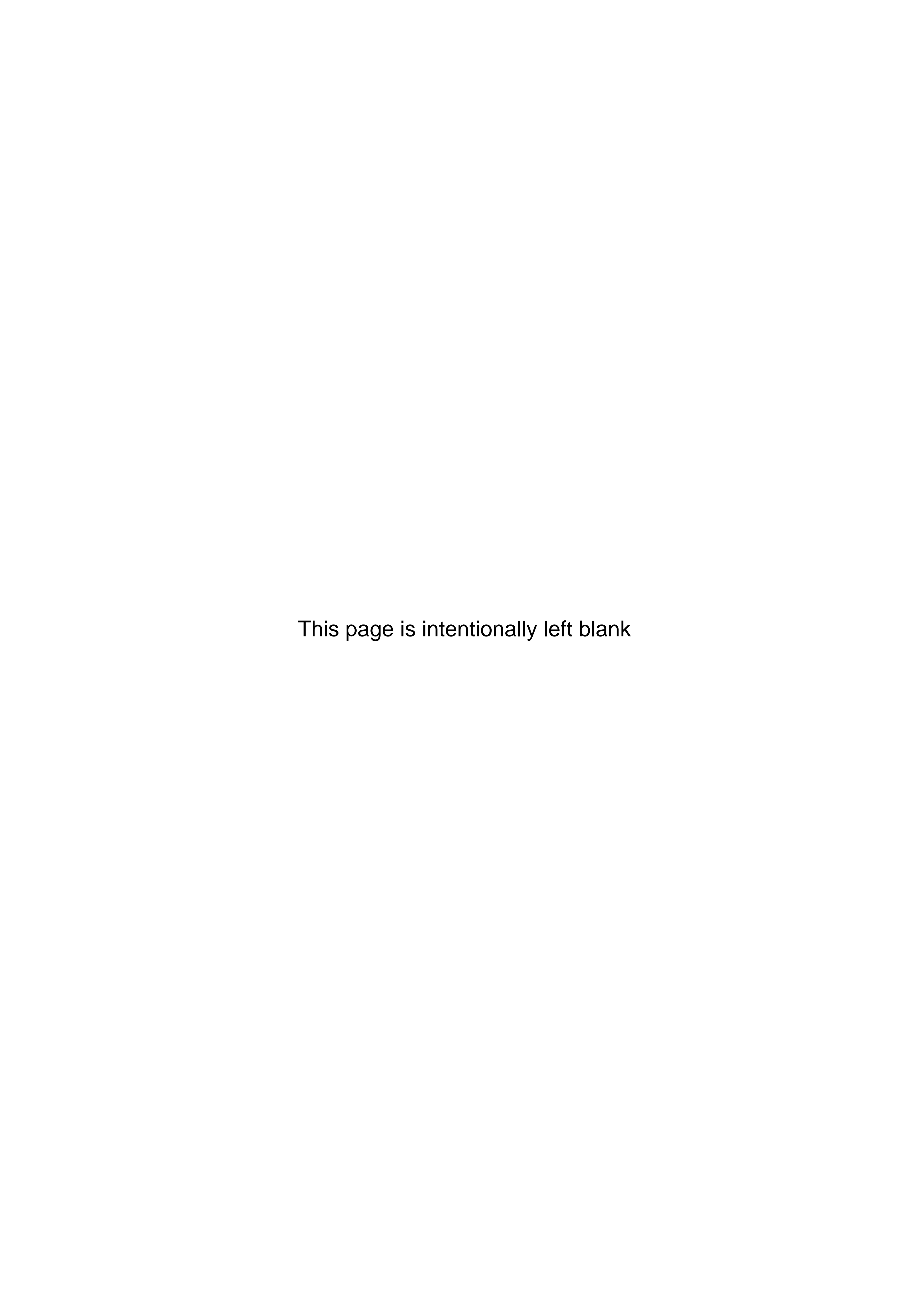
	£m Original Gap	£m Revised Gap	£m Proposed Saving Target
Difference between LCC £20m and £15.45 BCF allocation 2014/15	4.55	4.55	4.55 Allocated on basis of % of gross budget of individual delivery Boards
Post 30 day discharge 2014/15 cost pressure	1.75	1.75	1.75 Proactive Care Board saving target to deliver Intermediate Care Strategy within the recurrent funding envelope
SEND – “health” contribution to new national initiative in 2014	1.00	1.0 (TBC)	1.00 Women and Children Board saving target to deliver SEND within the recurrent funding envelope
CR&R health reablement schemes	2.10	1.2	CCGs to review schemes and if ongoing funding requirement to be picked up by Individual CCG
TOTAL	9.40	8.50	7.30 (Prior to Delivery Boards achieving required savings)


LHAC, BCF AND OVERALL GOVERNANCE ARRANGEMENTS
Annex 1
OVERALL POLICY & BUDGET ALLOCATION DECISIONS
Direct where funding Should be allocated and Against which priorities.
LCC EXECUTIVE
SOUTH WEST CCG
SOUTH CCG
EAST CCG
WEST CCG
STRATEGIC COMMISSIONING CO-ORDINATION
Ensure that policies are implemented and budgets achieve best value
JOINT COMMISSIONING BOARD
Proactive Care Delivery Board
Planned Care Delivery Board
Urgent Care Delivery Board
Women's and Children's Delivery Board
Adult's Specialised Delivery Board
TACTICAL MANAGEMENT
Contract management in accordance with policy, strategic direction and within budget
Corporate S75 (CCG host)
Proactive S75 (LCC or CCG host)
ICES (LCC host)
(CCG host)
CAMHs (LCC host)
LD (LCC host)
OPERATIONAL DELIVERY
Relevant delivery bodies, Including NHS Trusts, Councils, private and Third sector bodies.
Accute Hospitals
LPFT
Various Suppliers
Various Suppliers
Various Suppliers
Various Suppliers
Various Suppliers
STAKEHOLDER INVOLVEMENT
Health & Well Being Board
Appropriate Scrutiny Committees
LHAC Stakeholder Group

SCHEDULE 4– PERFORMANCE AND REPORTING ARRANGMENTS

SCHEDULE 5– POLICY FOR THE MANAGEMENT OF CONFLICTS OF INTEREST

SCHEDULE 6 – INFORMATION GOVERNANCE PROTOCOL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APPENDIX B

Proactive Care Section 75 Agreement

This Agreement is proposed for the purpose of pooling formally through a Section 75 Pooled Fund arrangement various strands of funding that go towards the achievement of the partners' aims and objectives across four themes of the Better Care Fund submission. These are resources that are not currently pooled in an existing arrangement. The themes are as set out below.

BCF Theme 1 - Intermediate Care

Intermediate Care will improve pathways of care and outcomes in the community for people who have an escalating health or social care need, by helping them avoid going into hospital unnecessarily. This will help people to be as independent as possible after a stay in hospital, facilitating a transfer from hospital to avoid any unnecessary delays, and empowering people to choose if and when they would like to move into a residential home.

BCF Theme 2 – Assessment Capacity:

Increasing our assessment capacity will provide additional cover to ensure that the patient / service user has a seamless pathway of care when accessing services no matter what day of the week. Through additional assessment capacity, we will support patients being discharged from hospital and prevent hospital admissions at weekends. By ensuring weekends are treated no different to weekdays, we will reduce weekend mortality rates, increase system efficiency, and ensure service users/patients receive the same standard and quality of care regardless of the day of the week.

BCF Theme 3 - Neighbourhood Teams

Neighbourhood Teams will enable people to be:

- Supported to remain well, independent and safe at home
- Supported as close to home as possible during a crisis
- Supported to return home quickly and safely following a stay in hospital
- Supported to experience a good death when at the end of their lives.

BCF Theme 4 - Wellbeing

Wellbeing is a preventative service, which is designed to:

- Enhance wellbeing, and reduce or delay escalation to statutory support services
- Improve accessibility to support services for individuals to access services more easily when they need them
- Improve mobility throughout service provision, that will enable people to seamlessly get help where required
- Deliver services that are fit for purpose and proactively identify need; adopting a principled approach to commissioning to ensure that services are fit for purpose and provision is balanced across the county

The proposal is that this Section 75 Agreement will be for a period of three years with the option to extend by a further two years. This is to support the intention to jointly procure intermediate care. Some aspects of the agreement however are limited to one year. Examples are the DFG Capital Grant, Carers OP, Care Act and Personal health budgets

Apart from the pooled fund arrangement it is not proposed. that any Council functions would transfer to any of the CCGs or that any NHS functions would transfer to the Council. Each partner will therefore continue to be responsible for the commissioning of services in their own area of responsibility.

This may change to support the joint procurement of intermediate care and, if so, the Section 75 Agreement will be amended at that time.

The respective contributions of the parties to the pooled fund for year one of the Section 75 Agreement is Health (collective contribution for all CCGs) £22.3m and LCC contribution of £26.7m. This is aligned as follows:-

	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Proactive Care 15/16	**East**	**West**	**South**	**South W.**	**CCG**	**LCC**	**TOTAL**
Intermediate Care	£1,856	£1,559	£1,104	£881	£5,400	£1,800	£7,200
Post 30 day discharge	£653	£548	£388	£310	£1,900	£0	£1,900
Neighbourhood Team	£1,823	£1,279	£1,007	£840	£4,950	£20,000	£24,950
DFG/CAP GRANT	£0	£0	£0	£0	£0	£4,900	£4,900
Intermediate Care - Reablement (LARS)	624	652	400	324	£2,000	£0	**£2,000**
Intermediate Care	62	65	40	32	£200	£0	**£200**
NHT- Comm int. reablement agency staff	437	457	280	227	£1,400	£0	**£1,400**
Carers OP	31	33	20	16	£100	£0	**£100**
7 day working - provider of last resort	468	489	300	243	£1,500	£0	**£1,500**
Personal Health budget	31	33	20	16	£100	£0	**£100**
NHT - Co-responders	47	49	30	24	£150	£0	**£150**
NHT- Programme Support Costs	62	65	40	32	£200	£0	**£200**
7 day working - assessments and care	94	98	60	49	£300	£0	**£300**
NHT- Demographic growth	663	693	425	344	£2,125	£0	**£2,125**
Care Act	624	652	400	324	£2,000	£0	**£2,000**
TOTAL PROACTIVE CARE s(75)	**£7,475**	**£6,673**	**£4,515**	**£3,662**	**£22,325**	**£26,700**	**£49,025**

As can be seen the above table sets out the amounts the Council and the CCGs are contributing in relation to each strand of services covered by the arrangement. This sum will be ring-fenced for that organisation to spend against the aims and outcomes of the relevant BCF theme. As each organisation is responsible for its own ring-fenced money, the risk of overspends will lie with those organisations.

Underspends will be dealt with in accordance with the overarching risk management arrangements described in Schedule 3 to the Partnership Framework Agreement.

The question of who will be the host of the pooled fund and will therefore appoint the pooled fund manager has not finally been determined. It is proposed that this falls within the delegation being proposed for the Director of Adult Care.

Because this Section 75 Agreement is so directly related to the achievement of BCF themes it is proposed that it is directly included in the BCF governance

arrangements as set out in Schedule 2 to the Partnership Framework Agreement. Therefore the Proactive Care Joint Delivery Board would manage the Section 75 pooled fund arrangement, subject to the overall governance arrangements set out in Schedule 2 to the Partnership Framework Agreement.

The proactive care Section 75 Agreement aims to :-
.
a. Ensure the delivery of improved Health and Wellbeing (and associated priority Outcomes) for the people of Lincolnshire and who are eligible to access services commissioned locally.
b. Make best economic use of health and social care resources
c. Prioritise and co-ordinate health and social care commissioning for proactive care.
d. facilitate the integration of commissioning activities and provision where ever this adds value

These aims are supported by the following objectives:-

a. securing the necessary shift from acute to community by reducing unnecessary emergency admissions to hospital and securing a profound shift towards integrated health and social care services around primary care - the neighbourhood team concept.

b. Development of robust model(s) for the construction of Neighbourhood Teams with all parties working in partnership with a range of agencies and providers, ensuring resources are prioritised according to need and where they will achieve the most impact

c. Re-commission intermediate care services in Lincolnshire to address the service issues in particular high diversity of services across Lincolnshire; high fragmentation in provision; issues around scope, definition and number of services available; high bed provision compared with home based services; a significant and unplanned increase in 30 day bed usage with scope to improve patient outcomes

d. reviewing existing performance, services, activities and outcomes to identify where existing provision may need to be decommissioned to release resources to enable service re-design

Approval is therefore sought for the entering into of a Section 75 Agreement with the Lincolnshire CCGs for proactive care Services for a three to five year period commencing on 1st April 2015.

The way in which the statutory pre-conditions apply to the Learning Disabilities Section 75 Agreement is as follows:-

(1) The partnership arrangements must be likely to lead to an improvement in the way in which the functions are exercised; and

The aims and objectives of the Section 75 Agreement are set out above. They include ambitious proposals for improved services through the implementation of neighbourhood teams and improved intermediate care services.

(2) The Partners must have consulted jointly such persons as appear to them to be affected by the arrangements.

No specific consultation has taken place concerning the proposals set out in this report. These proposals are essentially about governance and do not change the existing arrangements other than to update them. There are not therefore considered to be any persons who will be affected by these particular arrangements.

The partners will keep under review the potential impacts of the services commissioned and undertake consultation as appropriate.

APPENDIX C

Corporate Section 75 Agreement

This is again a new section 75 Agreement creating a Pooled Fund. This Pooled Fund would contain two elements of funding as follows

- £3.6m of funding split as to £1.75m from the Council (funded as part of the resource transfer from CCGs) and £1.9m from the CCGs to be spent on programme management for the LHAC programme; and

- £3.75m funding from the Council set aside as a contingency to meet the risk of government claw back if targets for 3.5% reduction on non-elective admissions into acute hospital are not met and potentially to fund other risks.

In relation to the first of these it is envisaged that the expenditure of the funds would be approved in principle by the Joint Commissioning Board with formal sign off by each partner organisation against business case submissions as to how the funding might be most efficiently and effectively spent to further the aims of the LHAC programme.

In relation to the second of these elements it is envisaged that a review will take place during the year of the Agreement to identify the degree to which the contingency may be required to meet the risk of the failure to meet targets for reduction of non-elective admissions into acute hospital.

Furthermore the corporate section 75 will be used as a means of pooling any underspends from the other Pooled Fund arrangements forming part of the Framework for allocation in accordance with risk share arrangements defined within the Framework Agreement.

The detail of the way in which these risks will be managed is specified in Schedule 3 to the Partnership Framework Agreement

The question of who will be the host of the pooled fund and will therefore appoint the pooled fund manager has not yet been resolved and it is proposed that this falls within the delegation to the Director of Adult Care

Because this section 75 Agreement is so directly related to management of specifically BCF risks it is proposed that it is directly incorporated into the BCF governance arrangements. Therefore it is proposed that this section 75 Agreement is managed by the Joint Commissioning Board itself seeking input from Joint Delivery Boards as required. This is all subject to the overall provisions of the governance arrangements set out in Schedule 2 to the Partnership Framework Agreement.

Approval is therefore sought for the entering into of a corporate section 75 Agreement with the Lincolnshire CCGs commencing on 1 April 2015 and continuing for a period of 1 year.

The way in which the statutory pre-conditions apply to the Corporate Section 75 Agreement is as follows.

(1) The partnership arrangements must be likely to lead to an improvement in the way in which the functions are exercised

The proposed section 75 Agreement enables funding to be jointly considered when being spent on LHAC programme management activity and when risks relating to the BCF programme are being managed. This will lead to improved integration of decision-making and better informed decisions

(2) The Partners must have consulted jointly such persons as appear to them to be affected by the arrangements.

No specific consultation has taken place concerning the proposals set out in this Report. These proposals are essentially about governance and do not change the way in which individual services are delivered. There are not therefore considered to be any persons who will be affected by these particular arrangements.

The partners will keep under review through other mechanisms including LHAC the potential impacts of the services commissioned and undertake consultation as appropriate.

APPENDIX D

Children and Adult Mental Health Section 75 Agreement

This Agreement was entered into on 27 March 2012 and is due to expire on 31 March 2015.

The existing Agreement establishes a formal Pooled Fund under Section 75 of the 2006 Act and establishes the Council as lead commissioner in the exercise of both Council functions and NHS functions for the commissioning of the following services:-

- Targeted CAMHS Support to Universal Services and Children's Services Local Integrated Teams at Tier 2
- A Specialist CAMHS Looked After Children Service at Tier 2
- A Specialist CAMHS Community Forensic Psychology Service at Tier 3
- Therapeutic Services for Children and Young People Displaying Sexually Harmful Behaviour or that have Sexually Abused
- Therapeutic Services for Sexually Abused Children
- Tier 3 Specialist Community Services
- Learning Disability Service (Tier 3 Specialist Services)
- Youth Offending/CAMHS Nurse Specialist Services (Tier 2/3)
- Self Harm Assessment and Intervention Service (Tier 2/3)
- Input to Diabetes Service

Services commissioned under the Section 75 Agreement are provided by Lincolnshire Partnership NHS Foundation Trust (LPFT) under a contract for services. At its meeting on 3 February 2015, the Executive approved the letting of a contract for the period 1 April 2015 to 31 March 2018.

In order to underpin that contract it is necessary for the Section 75 Agreement itself to be extended for the same period as the contract. Approval is therefore sought for the entering into of a Section 75 Agreement with the Lincolnshire CCGs for Children and Adolescent Mental Health Services for a three year period commencing on 1 April 2015.

The respective contributions of the parties to the pooled fund will be as follows over the period of the Section 75 Agreement (subject to finalisation of the exact CCG CQUIN contribution:-

	2015/16	2016/17	2017/18
Tier 2 Contribution			
LCC	£724,589	£724,589	£724,589
Lincolnshire East CCG	£136,670	£136,670	£136,670
Lincolnshire West CCG	£114,003	£114,003	£114,003
South Lincolnshire CCG	£78,021	£78,021	£78,021
South West Lincolnshire CCG	£64,714	£64,714	£64,714
	£1,117,998	**£1,117,998**	**£1,117,998**
Tier 3 (inc 3+) Contribution			
Lincolnshire East CCG	£1,504,934	£1,504,934	£1,504,934
Lincolnshire West CCG	£1,255,334	£1,255,334	£1,255,334

South Lincolnshire CCG	£859,122	£859,122	£859,122
South West Lincolnshire CCG	£712,599	£712,599	£712,599
	£4,331,989	**£4,331,989**	**£4,331,989**
CQUIN Contribution			
Lincolnshire East CCG	£41,040	£41,040	£41,040
Lincolnshire West CCG	£34,233	£34,233	£34,233
South Lincolnshire CCG	£23,429	£23,429	£23,429
South West Lincolnshire CCG	£19,433	£19,433	£19,433
	£118,135	**£118,135**	**£118,135**
Sub-Total	**£5,568,122**	**£5,568,122**	**£5,568,122**
Contract Variations:			
Self-Harm Nurses	£87,760		
8 x PMHWs	£350,000	£356,400	
	£437,760	**£356,400**	**£0**
Total CAMHS	**£6,005,882**	**£5,924,522**	**£5,568,122**

The Council will be the host of the pooled fund and will appoint the pooled fund manager.

The terms and conditions of the Section 75 Agreement will be the same as the existing arrangement subject to the following changes:-

- To agree with LPFT to restructure service delivery to include a Tier 3+ home crisis and treatment service based on intensive outreach in the community, including out of hours support.

- To develop a single point of referral for all interventions regardless of whether a child's concerns were behaviourally based or resulting from a diagnosable mental illness

- The removal of the following services:

  - Input to Diabetes Service
  - A Specialist CAMHS Service to the Lincoln Secure Unit at Tiers 2 and 3 (1st April 2012 to 31st March 2013)

Governance is undertaken by the Women and Children's Joint Delivery Board who will:

- receive feedback and reports from the commissioners of the Services
- monitor resource allocation and oversee the management any identified cost pressures
- identify potential changes to the commissioning or provision of the Services, within the terms of this Agreement;
- monitor the parties' compliance with the Agreement;
- measure the performance and quality of the service in pursuance of the intended aims, objectives and outcomes

- ensure that services commissioned and any service changes adhere to strategic plans for CAHMS Services; and
- ensure that robust processes are in place to identify any emerging financial or service risks at an early stage and action is taken to minimise or negate such risks

The provisions for the management of underspends and overspends are as follows:-

1. The Host Partner shall make the other Partners aware of any actual or forecast variances of spend against each partners contribution or financial risks as soon as it becomes aware of this possibility. The Host Partner will highlight reasons for the variance both current and projected, and make recommendations to the Women and Children's Joint Delivery Board (WCJDB) for action to bring the overspend into alignment with the budget and each Partner's contribution.

   Where it is agreed by the WCJDB that the overspend cannot be brought back into alignment and where there is no fixed contribution then the other Partner's contribution remains fixed during the year and the value of this contribution may be redefined as part of the following year's budget setting process.

2. If the WCJDB agrees with the recommendations made by the Host Partner in accordance with paragraph 1 above, the appropriate Party will promptly carry out whatever actions are reasonably necessary to implement such recommendations. If the parties cannot agree, then the matter should be referred as soon as possible to the Joint Commissioning Board (JCB) for resolution with recommendation of changes to the Partner organisations. If the JCB is unable to resolve matters within a period of twenty-one (21) days (or such other period as they may agree) then, unless either Partner terminates the Agreement, the amount of overspend will be borne by the Partner to whom such overspend relates).

3. Any actual underspend shall be referred by the Host partner to the WCJDB and the WCJDB shall, subject to the BCF Partnership Framework Agreement, determine how the underspend is to be treated by the Partners.

The way in which the statutory pre-conditions apply to the CAMHS Section 75 Agreement is as follows:-

(1) The partnership arrangements must be likely to lead to an improvement in the way in which the functions are exercised; and

This collaborative commissioning approach enables both parties to maximise the use of resources to improve outcomes for children and young people with mental health issues, targeting support to some of the most vulnerable young people in our society. This has led to past performance of this service exceeding national performance indicators and the revised service being re-designed to provide continuous improvement and to meet anticipated new national delivery guidelines.

(2) The Partners must have consulted jointly such persons as appear to them to be affected by the arrangements.

A full review of the CAMHS service has been undertaken with over 55 groups being consulted, representing a broad range of stakeholders about their experience of the current service and their opinions on future developments. Data on existing need, service delivery and expenditure has also been reviewed to inform recommendations to the WCJDB on the future delivery model.

APPENDIX E

Integrated Community Equipment Service (ICES) Section 75 Agreement

This Agreement was originally entered into on 1 November 2012 and made under Section 75 of the 2006 Act. It is currently due to expire on 31 March 2016. However it has been agreed to start the new Section 75 Agreement one year earlier to coincide with the procurement of a replacement contract for services.

The existing Agreement establishes a formal Pooled Fund and establishes the Council as lead commissioner in the exercise of both Council functions and NHS functions for the commissioning of Integrated Community Equipment Services.

Services commissioned under the Section 31 Agreement are currently provided by Nottingham Rehab Services under a contract for services. The Council is currently preparing to go out to procurement to procure a replacement contract which is due to be in place for 1 April 2016 when the existing contract expires.

The existing Section 75 Agreement comes to an end on 31 March 2016 and it is therefore necessary to put a new Agreement in place to cover the period of the new services contract recognising, as above, the agreement to start the new Section 75 a year early. That period is 1 April 2015 to 31 March 2021. During this period at the annual contributions to the pooled fund will be agreed by February of the preceding financial year i.e. 28 of February 2015 for the 2015/16 financial year.

Although the existing Section 75 Agreement terms are generally considered to be fit for purpose there are two main respects in which they will be changed.

Firstly the existing parties are Lincolnshire County Council, United Lincolnshire Hospitals NHS Trust, Lincolnshire Community Health Services NHS Trust, Lincolnshire Partnership Foundation NHS Trust – i.e the Provider Trusts exercising functions that have been delegated to them by the CCGs. In the new Agreement the Council will contract directly with the CCGs.

Secondly the risk sharing arrangements will be changed. As things stand, the Council hosts the pooled fund and takes the risk of overspends regardless of whether the cost has been incurred in providing equipment that has been identified as NHS funded or equipment that has been identified as Council funded. The prescribing of equipment to meet need is distributed over some 2,000 individual prescribers including health prescribers over which the Council has no control.

In the new Agreement liability for overspends will be tied to the nature of the equipment and whether it has been identified as NHS or Council funded so that the CCGs will take the risk of overspends caused by the prescribing of equipment that is NHS funded and the Council will take the risk of prescribing for equipment that is Council funded.

The respective contributions of the parties to the pooled fund will be determined on an annual basis as set out above.

The Council will be the host of the pooled fund and will appoint the pooled fund manager.

The governance arrangements will stay as they are in the current Section 75 Agreement.

The current arrangements are working well with a high level of performance as evidenced through the reporting of monthly KPI from the operational service provider Nottingham Rehab Ltd. There is a formal work programme as determined by the partnership board for the development of the service which continues to enhance the overall management of the service.

Approval is therefore sought for the entering into of a Section 75 Agreement with the Lincolnshire CCGs for Integrated Community Equipment Services for a six year period commencing on 1 April 2015.

The way in which the statutory pre-conditions apply to the Integrated Community Equipment Services Section 75 Agreement is as follows:-.

(1) The partnership arrangements must be likely to lead to an improvement in the way in which the functions are exercised; and

The arrangements are of longstanding and are subject to the partners seeking continuous improvement through the Section 75 governance arrangements. Positive service developments are noted above and the joint working embodied through the Section 75 Agreement is expected to lead to further improvement.

(2) The Partners must have consulted jointly such persons as appear to them to be affected by the arrangements.

No specific consultation has taken place concerning the proposals set out in this report. These proposals are essentially about governance and do not change the existing arrangements other than to update them. There are not therefore considered to be any persons who will be affected by these particular arrangements.

The partners will keep under review the potential impacts of the services commissioned and undertake consultation as appropriate.

APPENDIX F

Learning Disabilities Section 31 Agreement

This is a longstanding agreement originally entered into and made under Section 31 of the Health Act 1999, the statutory predecessor of Section 75 of the 2006 Act. The Agreement has been renewed on an annual basis since it was originally made but has not been fundamentally reviewed.

The existing Agreement establishes a formal Pooled Fund and establishes the Council as lead commissioner in the exercise of both Council functions and NHS functions for the commissioning of Learning Disability Services for adults including fully funded and joint funded packages of care. This may include Residential, Nursing, reablement and other maintenance services. Some prevention services may also be funded. Other universal and preventative services are also provided via other arrangements outside of the LD Section 75 pooled fund.

Services commissioned under the Section 31 Agreement are currently provided by a wide range of service providers including independent sector care home placements and domiciliary providers of care (excluded are specific NHS providers).

It is appropriate to take the opportunity afforded by the BCF submission to update the existing agreement and bring it into line with other Section 75 Agreements utilising a standard form of Section 75 Agreement agreed within the Lincolnshire health and social care community.

Apart from this it is also intended to include adult specialised service resources which were previously transferred by arrangements under section 256 of the National Health Service Act 2006. The proposed duration of the new Section 75 Agreement is three years with two years possible extension.

The respective contributions of the parties to the pooled fund for the first year of the Section 75 Agreement is as follows in £000's:-

Specialised. LD S(75) : LD schedule 1	**East**	**West**	**South**	**South W.**	**CCG total**	**LCC**	**TOTAL**
Exisitng S(75) LD	£3,576	£3,003	£2,127	£1,696	**£10,401**	£45,970	**£56,371**
Carers	16	16	10	8	£50	£0	**£50**
Specialist Services - Demographic Growth	663	693	425	344	£2,125	£0	**£2,125**
Specialist Services - Programme Support Costs	31	33	20	16	£100	£0	**£100**
Specialist Services - Future Risk Sharing	1373	1435	880	712	£4,400	£0	**£4,400**
s(75) LD POOLED RESOURCES	£5,658	£5,180	£3,462	£2,777	£17,076	£45,970	£63,046

The Council will continue to be the host of the pooled fund which will be managed via the Specialist Adult Services Joint Commissioning Team who will appoint the pooled fund manager.

Specifically excluded from the pooled fund are the costs associated with Specialist Learning Disability Services funded separately from the Lincs Clinical Commissioning Groups and NHS England National Contracts. Also excluded are

other responsible commissioner cases again procured directly by Lincolnshire CCG's.

Governance is undertaken by the Specialist Adult Services Joint Delivery Board which is chaired on rotation by the Accountable Officer for South West Lincolnshire CCG and the Director of Adult Care. It has representatives from all parties.

The provisions for the management of underspends and overspends are a fixed contribution for year one of the agreement for CCGs with any overspends being funded by LCC. The rationale for this is that health have funded non-recurrently via the BCF funds an additional £6.3m to the pooled fund. Year 2 of the contributions and risk share arrangements will be reviewed. Any underspends will be transferred to the Corporate S75 Agreement in accordance with the risk management provisions set out in Schedule 3 of the Partnership Framework Agreement.

The current arrangements are working well and for 2014/15 the S75 is delivering to budget with positive service developments notably for autism pathway during the year.

Approval is therefore sought for the entering into of a Section 75 Agreement with the Lincolnshire CCGs for Learning Disability Services for a three year period commencing on 1 April 2015.

The way in which the statutory pre-conditions apply to the Learning Disabilities Section 75 Agreement is as follows:-.

(1) The partnership arrangements must be likely to lead to an improvement in the way in which the functions are exercised; and

The arrangements are of longstanding and are subject to the partners seeking continuous improvement through the Section 75 governance arrangements. Positive service developments are noted above and the joint working embodied through the Section 75 Agreement is expected to lead to further improvement.

(2) The Partners must have consulted jointly such persons as appear to them to be affected by the arrangements.

No specific consultation has taken place concerning the proposals set out in this report. These proposals are essentially about governance and do not change the existing arrangements other than to update them. There are not therefore considered to be any persons who will be affected by these particular arrangements.

The partners will keep under review the potential impacts of the services commissioned and undertake consultation as appropriate.

APPENDIX G

Adult Mental Health Section 75 Agreement

This Agreement was originally entered into in August 2012 and made under Section 75 of the 2006 Act.

The Agreement is between the Council and Lincolnshire Partnership Foundation NHS Trust (LPFT). The Agreement establishes LPFT as an integrated provider of adult mental health services in exercise of both Council functions and NHS functions. To produce this situation the Council authorises LPFT to exercise specified Council mental health functions alongside NHS mental health functions.

There is no pooled fund. The Council pays LPFT for exercising the Council's functions.

Although the initial term for this Section 75 Agreement comes to an end on 31 March 2015 the existing Section 75 agreement allows for the extension of the agreement up to the 31 March 2017 and this will be actioned through the completion of a deed of variation. This is a delegated decision to the Director of Adult Care.

Although the existing Section 75 Agreement terms are generally considered to be fit for purpose there are several respects in which it is proposed to make amendments tin order to update the service specifications

The main changes are:-

- The Best Interest Assessment service needs to be re-negotiated as well as a full revision of the Service Specification;
- LPFT will be adopting the use of Mosaic System in line with LCC Assessment and Care Management functions;
- The agreement needs to reflect compliancy with the Care Act 2014

The annual contribution of the Council to the cost of exercising the functions as at 2014-15 is £5.6m.

Any overspends are the responsibility of LPFT whilst underspends will either be returned to the Council in full or re-invested in the Section 75 and/or retained by LPFT.

Governance is undertaken through monthly management meetings with a standard agenda to discuss – service levels, contract compliance, finance, performance, safeguarding, quality and improvements.

The current arrangements are working effectively with LPFT. LPFT have delivered annual efficiencies within the first four years of the agreement. A recent annual review gave assurance that delivery of the S75 agreement appears to be well joined up with clear role definitions and accountability within the integrated teams. LPFT have also confirmed that they will have exceeded the levels of efficiency required over the initial period of the agreement by year end.

The existing Section 75 is therefore being extended with Lincolnshire Partnership Foundation NHS Trust for a two year period commencing on 1 April 2015.

As the extension of the Section 75 Agreement is allowed for by the terms of the existing agreement the statutory pre-conditions do not apply.

Appendix H

PARTNERSHIP FRAMEWORK 15/16	East	West	South	South W.	CCG	LCC	TOTAL
Intermediate Care	£1,856	£1,559	£1,104	£881	£5,400	£1,800	£7,200
Post 30 day discharge	£653	£548	£388	£310	£1,900	£0	£1,900
Neighbourhood Team	£1,823	£1,279	£1,007	£840	£4,950	£20,000	£24,950
CAMHs S(75) CCG contribution	£1,665	£1,398	£990	£790	£4,844	£725	£5,569
ICES	£1,112	£934	£662	£528	£3,236	£2,754	£5,990
ICES Income	£0	£0	£0	£0	£0	-£90	-£90
DFG/CAP GRANT	£0	£0	£0	£0	£0	£4,900	£4,900
Existing S(256) Adults	£222	£186	£132	£105	£646	£0	£646
Existing S(256) Childrens	£179	£150	£107	£85	£521	£0	£521
Exisitng S(75) LD	£3,576	£3,003	£2,127	£1,696	£10,401	£45,970	£56,371
Sub-total commitments	£11,087	£9,059	£6,517	£5,235	£31,898	£76,059	£107,957
LHAC	£602	£505	£358	£285	£1,750	£0	£1,750
Payment to LCC	£6,239	£6,524	£4,000	£3,238	£20,000	£0	£20,000
TOTAL S(75) POOLED FUNDS	£17,927	£16,087	£10,874	£8,759	£53,648	£76,059	£129,707
Mental Health (framework -outside pool)	£21,657	£18,186	£12,881	£10,275	£63,000	£5,417	£68,417
Partnership Framework Value 15/16	**£39,584**	**£34,274**	**£23,755**	**£19,034**	**£116,648**	**£81,476**	**£198,124**

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LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of Dr Tony Hill, Executive Director for Community Wellbeing and Public Health

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**24 March 2015**
Subject:	**Health and Wellbeing Grant Fund**

Summary:
At the meeting on 9 December 2014 the Board agreed the application process for allocating the remaining money in the Health and Wellbeing Grant Fund. This process included the establishment of a Sub Group to review Project Proposals and make recommendations to the Board on which projects to fund. This report provides details on the funding recommendations made by the Sub Group at their meeting on 25 February 2015.

Actions Required:
The Health and Wellbeing Board are asked to agree the funding recommendations put forward by the Health and Wellbeing Fund Sub Group.

1. Background

The Health and Wellbeing Fund for Lincolnshire (the fund) was originally established in 2008 under a Section 256 Agreement between Lincolnshire County Council and NHS Lincolnshire. It was set up to support projects and initiatives which improve the health and wellbeing of the people of Lincolnshire. In November 2014 a revised Section 256 Agreement was signed between the County Council and the four Clinical Commissioning Groups and responsibility for allocating the remaining fund, totalling £1,328,661.00 was transferred to the Lincolnshire Health and Wellbeing Board. The process for allocating the remaining fund was agreed by the Board on 9 December 2014.

Significant interest was shown in the fund, far out stripping the amount of money available to allocate. 36 Expressions of Interest were received and reviewed by

the relevant Theme Lead and Board Sponsors to ensure they meet the funding objectives and the priorities in the Joint Health and Wellbeing Strategy. As a result of this 20 applicants were asked to complete a more detailed Project Proposal for consideration by the HWB Fund Sub Group.

The HWB Fund Sub Group, made up of Cllr Woolley (LCC representative) and Gary James (CCG representative) met on 25 February 2015 to review the 20 Project Proposals. The funding recommendations from this meeting are detailed in Appendix A. The Sub Group endorsed ten Projects Proposals totalling £1,306,234.00, leaving £12,427 unallocated to be held in reserve.

Subject to the Board approving the funding recommendations all successful applicants will be issued with a formal funding agreement. The projects will be monitored quarterly by an officer from the County Council's Community Engagement Team and a report on the impact and effectiveness of the projects will be presented to the Board as part of the annual assurance process.

2. Conclusion

The Board is responsible for approving the funding recommendations put forward by the HWB Fund Sub Group. Ten applications have been endorsed by the HWB Fund Sub Group and the Board is asked agree the list of projects shown in Appendix A.

3. Consultation

Relevant Theme Leads and Board Sponsors were consulted as part of Stages 1 and 2 of the Health and Wellbeing Grant Fund application process. Applications were reviewed to ensure they align with the funding objectives and the priorities in the Joint Health and Wellbeing Strategy.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Health and Wellbeing Grant – Funding Recommendations

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 Alison Christie, Programme Manager – Health and Wellbeing, who can be contacted on 01522 552322 or alison.christie@lincolnshire.gov.uk

APPENDIX A

Health and Wellbeing Grant – Funding Recommendations

The amount of the Health and Wellbeing Grant Fund to be allocated is £1,316,234, leaving £12,427 unallocated as a contingency fund.

JHWS Theme One

Getting Lincolnshire Active
Organisation: Lincolnshire Sports Partnership
Total Cost of Project: £450,000
HWB Grant Fund Allocation: £150,000
Project Timescales: June 2015 – May 2018

This project aims to increase participation in sedentary individuals using the '*My Activity Tracker (MAT) system' (*a platform developed for Sport England) to monitor the progress towards improved health and increased participation. MAT gives every participant a swipe card allowing levels of activities to be recorded. Each participant will also be offered a 1:1 consultation/ motivational interview with a Health Trainer who will help them to set goals. Four full time Activity Coaches will be recruited to provide supportive advice and guidance to enable individual's access local sport activities. The project will target people resident in Earlesfield (Grantham), Stamford, Spalding and the Community Sport Activation Fund areas of East Lindsey, Boston and Lincoln. The project aims to engage 5760 sedentary individuals aged over 18 with identified health conditions. It is anticipated, based on previous experience including Exercise Referral that 1728 individuals will continue to be involved in sport after 12 months.

JHWS Theme Two

My Rural Life
Organisation: Sortified CIC
Total Cost of Project: £10,096
HWB Grant Fund Allocation: £10,096
Project Timescales: April 2015 – September 2015

This project aims to develop a questionnaire based toolkit that would prompt individuals to think about their living arrangements based against a set of certain questions and scenarios. The questions will be designed to firstly make people think about living arrangements and how ageing may impact on those arrangements, and secondly would seek to create a score from the questions and scenarios that would link into a risk assessment style system. People will then be able to make life decisions and plan in advance. Information and advice will also be provided to support future planning and help mitigate reliance on health and social care services due to rural living. The toolkit would be created through co-production, and this process would determine the questions, areas to be covered and any areas that are considered out of scope. The project will look to link with existing networks and programmes of work to support the roll out of the toolkit.

JHWS Theme Three

<u>Diabetes Education and Resources</u>
Organisation: 4 Lincolnshire CCGs
Total Cost of Project: £169,800
HWB Grant Fund Allocation: £169,800
Project Timescales: April 2015 – March 2016

This project will enhance the current diabetes services provided within the community by GP Practices and Lincolnshire Community Health Services (LCHS). Patients with Type 2 diabetes referred to the service are invited to attend an education course (Spotlight), which aims to give newly diagnosed patients the knowledge and skills they need to effectively self-manage their diabetes. Many of the Diabetes Specialist Nurses working in the community across Lincolnshire currently utilise a range of books and other resources to show patients what a portion size should be and the nutritional values of different foods. This project will ensure that patients receive a consistent education for their diabetes as well as allowing them to have their own copy of the book or access to an app on their smartphone. Work is currently underway across Lincolnshire to improve the quality of care for people with diabetes and as part of this engagement has been undertaken with diabetes patients in the West and East CCG areas to ensure the new model of care meets their needs and meets national guidance to further integrate diabetes service across GP Practices, community services and hospital settings. The HWB funding supports the delivery of services as it transitions from the current model to the integrated service.

JHWS Theme Four

<u>Care Leavers Mentoring Project</u>
Organisation: Barnardo's
Total Cost of Project: £152,016
HWB Grant Fund Allocation: £150,516
Project Timescales: April 2015 – March 2017

This project will deliver a two year Care Leavers Mentoring project across Lincolnshire offering specialist interventions, broadly out of hours, to sixty care leavers with a clear focus on supporting social inclusion. Barnardo's will recruit a full time Project Worker who will be tasked with recruiting a cohort of twenty Volunteer Mentors. The mentors will be recruited from a wide range of backgrounds including at least 15% previous care leavers who are well placed to help young people in similar situations, as well as offering care leaver mentors valuable up skilling/volunteering experience. The approach is based on the belief that links with local people can support the widening of care leaver's social networks. This will encourage engagement in community activities; and over time a sense of belonging which is key to care leavers becoming more independent.

<u>Let's Get Fizzical</u>
Organisation: Positive Futures Lincolnshire
Total Cost of Project: £41,720
HWB Grant Fund Allocation: £40,720
Project Timescales: April 2015 – March 2016

This project will engage with inactive children aged 8 to 14 in sport, helping to build their confidence and enjoyment as well as improving physical activity levels. Positive Futures seeks to pilot the approach in Lincoln and Boston, working with eight schools in each area. Each school will have an initial taster session, followed by a 6 week programme of activities, 1 session per week, for young people sensitively identified due to concerns over obesity and sedentary behaviour at school. A supportive, child centred approach and the use of incentives and pedometers will be used to encourage attendance. Health promotion advice and motivation will be provided by trained and experienced coaches and volunteers. The project will also offer community based activities in the vicinity of participating schools, open to Let's Get Fizzical participants, other young people, parents and siblings. Specific training will also be provided to help coaches and volunteers better support the mental health and wellbeing of children and young people.

JHWS Theme Five

Get Started and Get into Healthy Lives
Organisation: Lincolnshire Sports Partnership
Total Cost of Project: £403,578
HWB Grant Fund Allocation: £240,000
Project Timescales: April 2015 – March 2018

This project aims to support 234 young people aged 16-25. Specifically aimed at promoting health and wellbeing amongst young people, the project will also provide training and routes into employment within Health and Social Care services. This initiative has been piloted in other parts of the country and works in partnership with local NHS providers and VCS using the 'Get Started' and 'Get into' programmes devised by the Prince's Trust. The 'Get Started' programme uses art, sports and digital themes as 'hooks' to engage young people and use as a gateway to learning, training or job opportunities. The 'Get into Hospital Services' programme will promote health and care and support young people to find employment or training in the health and care sector.

Step Forward
Organisation: LCC to sub contract via a procurement process
Total Cost of Project: £237,323
HWB Grant Fund Allocation: £226,200
Project Timescales: October 2015 – September 2017

The project will support adults aged 18 or over that have learning disability, autism and/or mental health condition and are unemployed. It will focus on those whose health and care needs are mild to moderate and that could enter the world of work with tailored support. Services provided by this project will include development and delivery of customised support packages that will meet the needs of individuals including: one to one sessions with a named support worker, career action/personal development plans; opportunities to experience 'real life' work situations; personal employment pack and tailored support to help individuals identify suitable employment or training opportunities. The Specialist Adults Services Joint Commissioning Team will be responsible for commissioning the service on behalf of Lincolnshire County Council and the four Lincolnshire Clinical Commissioning Groups.

Assisting Low Income Households into Work
Organisation: City of Lincoln Council
Total Cost of Project: £98,000
HWB Grant Fund Allocation: £98,000
Project Timescales: May 2015 – April 2019

This project supports the 'Universal Support Delivered Locally' (USDL) work being carried out by the City of Lincoln and North Kesteven District Council shared Revenues and Benefits Service (known as LINK) linked to the rollout of Universal Credit. LINK will work with social landlords in both districts to identify tenants on low incomes who are not entitled to 'free of charge' college courses but whose incomes are at level that they could not afford to pay for the course themselves. In conjunction with Lincoln College, the project aims to deliver a total of 600 ICT skills courses over the next 4 years to enable low income people gain new skills and improve their employment prospects.

Connecting Communities – Developing Community Assets & Resilience
Organisation: LECCG/LCC in conjunction with Wainfleets2gether & Winthorpe Community Partnerships
Total Cost of Project: £141,302
HWB Grant Fund Allocation: £120,302
Project Timescales: May 2015 – April 2017

The HWB funding will be used to further establish and embed sustainability into two resident led, fully constituted Partnership groups in Wainfleet and Winthorpe by employing two part time coordinators to develop and co-ordinate activities. Many residents living in hard pressed communities and neighbourhoods within the Skegness and Coastal Clinical Commissioning Locality deal with high levels of anti-social behaviour, substance abuse, poor housing and a lack of employment prospects. Through this project each community will develop a Community Action Plan setting out the improvement needs of the community. The coordinators role is pivotal to the development of the partnership's activity within the community, releasing community capacity to establish a long term mechanism for greater co-ordination and dynamic interaction between residents, authorities and local services.

JHWS Carers Cross Cutting Theme

Lincolnshire Carers Charter
Organisation: Lincolnshire Carers and Young Carers Partnership
Total Cost of Project: £110,600
HWB Grant Fund Allocation: £110,600
Project Timescale: April 2015 – March 2017

This project seeks to establish a quality standard 'kite' mark scheme recognisable by all Lincolnshire Carers, providers and partners as a way of addressing some of the difficulties caused by rurality, poor transport infrastructure and sparsity of providers. The quality scheme will give carers the confidence that every intervention in their lives is positive and supportive and supplied/delivered by a trusted provider. The kite mark will also recognise those organisations, groups, businesses and providers who place a high value on the views, needs and ideas of carers and are empathetic towards carers. The funding will be used to develop and promote the Charter and kite mark scheme with a view to sustain the scheme through re-accreditation fees.

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of Dr. Tony Hill, Executive Director for Community Wellbeing and Public Health

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**24 March 2015**
Subject:	**Annual Report of the Director of Public Health on the Health of the People of Lincolnshire 2014.**

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 fifth report of the Director of Public Health for Lincolnshire. 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.

The causes of premature mortality are varied, and this report concentrates on those causes which contribute the largest number of years of life lost in Lincolnshire: cancer; circulatory diseases; suicide; respiratory diseases; accidents and chronic liver disease.

Along with a description of the scale of each of these issues in Lincolnshire, work has been outlined to address and reduce the problems. The end of the report provides thoughts on further actions that could be taken to tackle these causes of premature mortality in the county. It is intended that in conjunction with this annual report, a data compendium will be produced which will provide further data on the issues concerned and on differences at lower geographical areas where possible. This will be produced early in 2015 and shared through the Lincolnshire Research Observatory.

2. Conclusion

The fifth 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 & Wellbeing Board for Lincolnshire is asked to receive a presentation and consider the recommendations included in each chapter.

3. Consultation

None

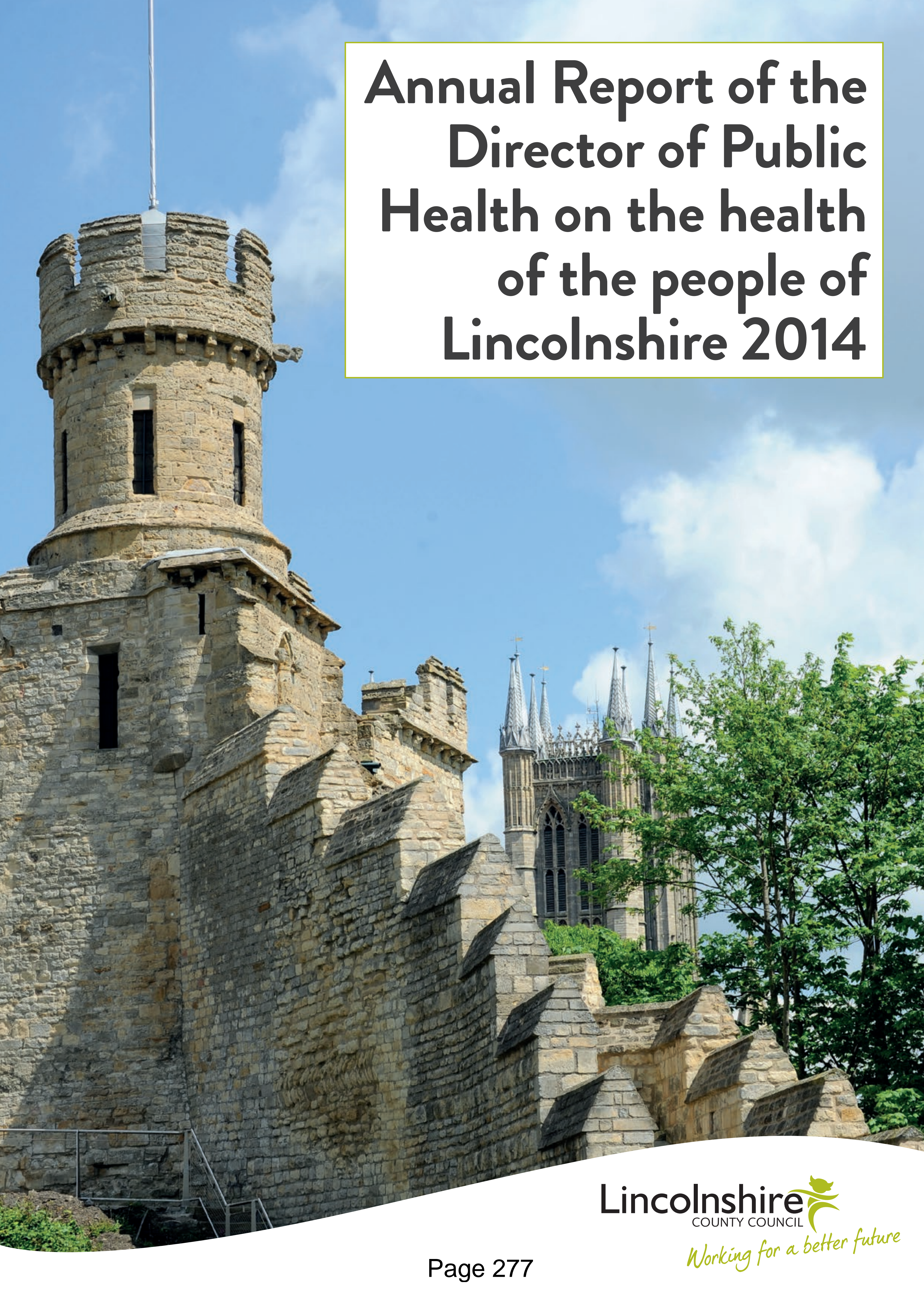
4. Appendices

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 2014.

5. Background Papers

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

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



Annual Report of the Director of Public Health on the health of the people of Lincolnshire 2014

Introduction

This is my fifth annual report as the Director of Public Health for Lincolnshire and my second since Lincolnshire County Council took on its public health responsibilities in April 2013. This year the report focusses on the major causes of premature mortality in Lincolnshire and provides my independent professional view on this element of the state of health in our area. It outlines the actions required by a range of organisations to improve the health of the public in this respect.

The causes of premature mortality are varied, and for this report I have concentrated on those causes which contribute the largest number of years of life lost in Lincolnshire: cancer; circulatory diseases; suicide; respiratory diseases; accidents and chronic liver disease. Along with a description of the scale of each of these issues in Lincolnshire, I have outlined the work that is being done to address and reduce the problems. At the end of the report I provide my thoughts on further actions that could be taken to tackle these causes of premature mortality in the county. It is intended that in conjunction with this annual report, a data compendium will be produced which will provide further data on the issues concerned and on differences at lower geographical areas where possible. This will be produced early in 2015 and shared through the Lincolnshire Research Observatory.

This year I have not included a chapter on protecting health. However, the Ebola outbreak in West Africa has reminded all of us that infectious diseases have not been conquered, and indeed our lifestyles and travel options give ever greater opportunities for infections to spread. My team (and others) put much effort into ensuring systems are in place to protect the people of Lincolnshire should that be necessary

I hope you find this report interesting and of help to you in your work.

Dr Tony Hill
Director of Public Health,
Lincolnshire County Council

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Progress against last year's recommendations

In my 2013 Director of Public Health Annual Report I made a series of recommendations, and I would like to use this opportunity to provide an update on progress against these.

On addressing health equity and outcomes for international migrants:

More organisations are now considering international migrant needs and any differences that these needs present for their commissioning and delivery of services. Progress has also been made in ensuring that commissioners and healthcare providers are fully aware of, and use, the available guidance for providing healthcare to international migrants. Organisations were keen to understand more about the guidance that is available and how this is being applied within their organisations.

Organisations have become more engaged with encouraging migrants to register with a general practice, and we are aware of a number that have carried out programmes and events in support of this recommendation, and have added information to their websites. Organisations have also worked together on programmes and events to increase awareness of the services and support that migrants are able to access.

There seems to have been less progress on improving the promotion of translation services and English language courses, and this is a recommendation which will need continuing focus.

On tobacco control:

A work plan for 2015/16 has been developed and implemented in line with the local and national Tobacco Control Strategies. Alliance members are also reporting each quarter on their contribution and progress.

Behavioural support, with and without pharmacotherapy, is now provided through a broad network of smoking cessation providers. This allows behavioural change techniques to be used to address the needs of long standing smokers when they are ready to stop smoking. A review has recently taken place, and the contract for the stop smoking service in Lincolnshire is to be tendered out based on national standards.

In order to deter young people from taking up smoking, work with young people has been developed to include greater education in smoking awareness and a peer support programme. Young people who are not in employment, education or training are a focus for targeted intervention.

Work on illicit and counterfeit public awareness campaigns has continued, with intelligence reported to Trading Standards and the police, who have increased the number of raids (and prosecutions) on commercial premises.

A regional post is now in place, working with local Trading Standards to coordinate collaborative activity regionally and nationally with the aim of interrupting the supply chain for illicit and counterfeit tobacco.

Over 2,900 front line staff have been trained in Making Every Contact Count (MECC), to ensure that they can advise clients and refer them to appropriate stop smoking services. This has resulted in over 1,900 additional smoking cessation referrals in 2013/14. Smokefree Homes and Cars and Smoking Cessation remain core to this training.

NHS organisations are adhering to smokefree legislation, and their buildings and enclosed public spaces are smoke free. United Lincolnshire Hospitals Trust have also been considering whether their smokefree policy could be extended further within their grounds. Guidance is being strengthened nationally around stop smoking support to mental health service clients.

On Public Health and spatial planning:

Planning consultations are now channelled through the NHS England Local Area Team. This helps to ensure that there are thorough, timely and co-ordinated communications on local

planning developments. A number of meetings have been held, acting as a platform for discussions, and this approach will continue to be reviewed as co-commissioning moves forward.

Partnership work continues in order to improve health through spatial planning. Officers from a range of disciplines have contributed to the development of a National Advisory Guide on planning healthy-weight environments. Both this and continued input into Public Health England's 'Healthy People, Healthy Places' reference group and Spatial Planning and Health Group have informed further national policies and guidance. Discussions are under way on establishing a regional learning forum on the health and planning agenda.

On Public Health skills training:

'Prevention is better than cure' has remained a core principle in the implementation of Lincolnshire Health and Care (LHAC).

Developing the wider Public Health workforce has been one of the key priorities in our training programme this year. Several training modules have been implemented around understanding health improvement across the public sector workforce in Lincolnshire, recognising the whole of the sector as contributors to public health. This has started to shift the culture across health and local authority workforces so that improved support is offered to citizens to take greater responsibility for their own healthcare and wellbeing.

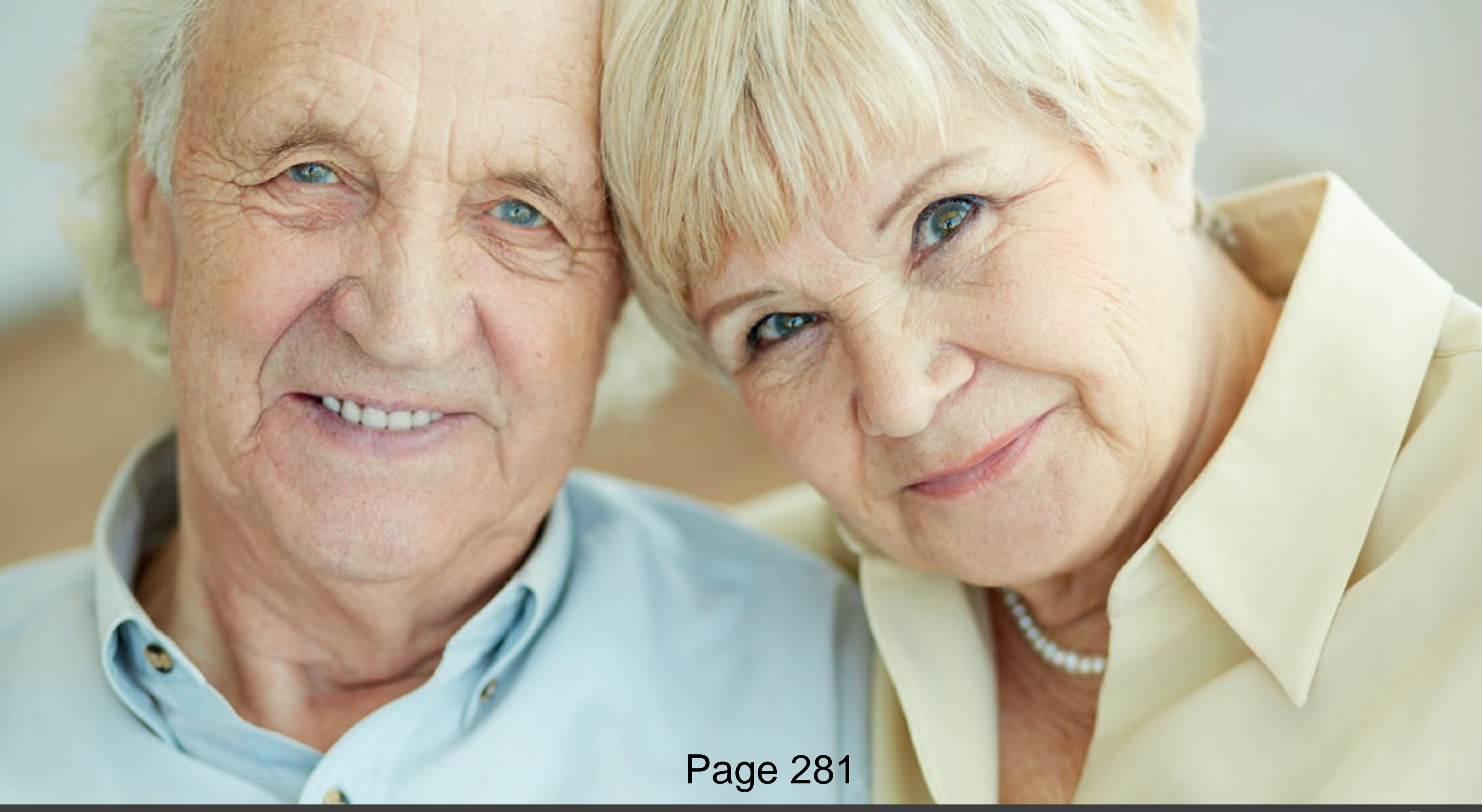
The role of the public health practitioner as educator has been developed through the 'Train the Trainer' programme. This has increased capacity for promoting healthy lifestyles across the workforce, such as, enabling delivery of an accredited Royal Society of Public Health 'Understanding Health Improvement' course.

There has also been progress in rolling out MECC and the 'Train the Trainer' model to practitioners outside of public health, to Adult Social Care and externally to the private sector for example, supporting the integrated health and social care agenda. Links are being established to embed MECC into the LHAC programme as there are clear overlaps in the objectives of the two.

On protecting the health of the people of Lincolnshire:

A comprehensive sexual health needs assessment has been undertaken. This explores issues around access, and will ensure that future service provision is flexible enough to meet the needs of Lincolnshire residents and the concepts encompassed in the Lincolnshire Health and Care Review. The assessment has looked at services beyond those commissioned by Lincolnshire County Council as the different elements of sexual health service provision are largely inter-dependent. The needs assessment will provide evidence and an opportunity to influence other commissioners and improve the quality of commissioned services.

Across all areas of health protection, we have been working in partnership with other organisations, such as NHS England, health and social care providers, and the voluntary sector, to ensure that health protection functions are integrated. An example of this is our close working with NHS England to ensure that HIV services are integrated into the wider sexual health service when those services are re-commissioned. We have also taken a multi-disciplinary approach to infection prevention and control, and have identified opportunities for training within areas of activity which are new to Public Health, such as the Coroner Service.



Premature Mortality in Lincolnshire

Background

Both locally and nationally, life expectancy and overall health continue to improve. However the UK underperforms in comparison to our international peers in terms of premature mortality.[1]

In Lincolnshire, life expectancy at birth is currently 83.0 years for females and 79.2 years for males, compared to very similar figures of 83.1 years and 79.4 years respectively in England. The trend has been generally upward over many years[2] but these are average life expectancy figures for the county's population as a whole. Individual life expectancy is influenced by a whole range of determinants of health, including social and economic factors, the physical environment and an individual's own genetic characteristics and behaviours.

Premature mortality, classed as deaths of those who are under the age of 75, accounted for more than 2,350 deaths per year on average in Lincolnshire from the years 2010 to 2012 inclusive.[3] The majority of these deaths were due to non-communicable diseases, considered to be wholly or partially preventable, including some forms of cancer, circulatory diseases, respiratory diseases, and chronic liver disease. Other potentially preventable causes included accidents and suicides. Over the three years, more than 7,000 people in Lincolnshire died before reaching 75, accounting for around 95,000 years of life lost in total, and an average of over 13 years lost for each person who died prematurely. Despite this, and an estimated return on investment in the order of £12 saving (in primary care costs alone) for every £1 spent on primary prevention, only an estimated 4% of the national healthcare budget is spent on prevention.[1]

Directors of Public Health, supported by their teams, play a major role across health improvement, health protection and healthcare public health (the design and support of effective health services), through direct delivery, leadership and advice to others. Many of the direct interventions in place to tackle premature mortality are detailed in this report. However, public health within the local authority setting also has the opportunity to influence the social, economic and environmental determinants more widely. In this way, we can decrease the scale of premature mortality and waste of life in Lincolnshire, and the total years of life lost to both communicable and non-communicable disease.

Measuring Premature Mortality

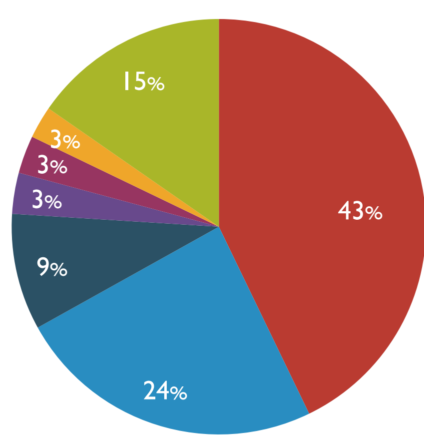
Potential years of life lost (PYLL) is one of the main measures of premature mortality. It is used to compare the relative contribution of different causes of premature death within a population, and can therefore be used by health planners to define priorities for the prevention of such deaths. It can also be used to compare premature mortality across different populations for one specific cause of death.

PYLL is calculated as the length of time a person would have lived had they not died prematurely, using under 75 years of age as a statistical threshold to define 'premature'. By including the age at which death occurred in its calculation, the indicator better quantifies the burden, or impact, on society from the specified cause of mortality than mortality figures alone would allow. The indicator sums the number of deaths at each age up to 74 years, multiplying by the total years remaining up to age 75 years. It is standard practice to use a 3-year rolling total in years of life lost calculations alongside a 3-year rolling population denominator to create an average annual rate for the period. Infant deaths are omitted from the calculation as they are most frequently as a result of causes specific to this age group, and have different aetiologies from deaths later in life.[4]

Causes of Mortality in the under 75s in Lincolnshire

Data from the Health and Social Care Information Centre (HSCIC) show that for the years 2010 to 2012, in Lincolnshire there were 446 PYLL annually per 10,000 residents under the age of 75 (as a directly age standardised rate).[3] This is a very similar rate to the England and Wales figure of 442 years. The causes of these deaths are shown in figure 1.1.

Figure 1.1: Deaths of people aged under 75 years by cause in Lincolnshire, 2010/12



Source: Primary Care Mortality Database, Health and Social Care Information Centre

The most common cause of mortality among people aged under 75 was cancer, accounting for four in every ten premature deaths and 165 PYLL per 10,000 residents. Although mortality from lung cancer is lower in the county than nationally, this form of cancer still accounts for the largest proportion of premature mortality through cancer, being around one fifth of all cancers (and of the 'Cancers' segment in figure 1.1).

Circulatory diseases were the second most common cause of premature death. Mortality rates from stroke and coronary heart disease have improved dramatically over the last two decades, but circulatory diseases as a whole still account for around a quarter of premature deaths in the county. High blood pressure, lipid levels and smoking account for up to three-quarters of coronary heart disease incidents. Despite recent reductions, these risk factors remain at the heart of health inequalities between the socio-economic groups.[5]

Between them, cancer and circulatory diseases account for more premature deaths in Lincolnshire than all other causes combined, being two thirds of the total.

Other major contributing causes of premature mortality in the county include chronic obstructive pulmonary disease (pneumonia is also discussed in the respiratory disease chapter of this report), accidents, chronic liver disease and suicide. The rates of all of these have been reducing in recent years, apart from that for chronic liver disease, which has been increasing in the UK in contrast to the decline in most other European countries. This rise has been linked to obesity and to drinking at harmful levels, both of which have increased nationally and locally.

The Global Burden of Disease Study[6] found that smoking, high blood pressure, high body mass, physical inactivity and alcohol are the five main risk factors for ill health and many of the major causes of premature mortality. In Lincolnshire, a fifth of the adult population are smokers.[7] Approximately 10% of children in reception year in the county are obese (rising to a fifth in year 6),[8] and although only 12% of adults registered with a GP are on a GP obesity register,[9] it is estimated that in reality more than two-thirds are overweight or obese.[10] Over the last five years, there has been a generally increasing trend in alcohol-attributable hospital admissions for the county as a whole and for its districts. It is promising though, that the most recent available figures (for the year 2012/13) for the districts of Lincoln, East Lindsey and West Lindsey indicate a slight fall for the first time in five years.[11]

Core Strategies and Programmes Contributing to Reducing Premature Mortality

The risk factors and determinants for many causes of premature mortality are specifically addressed in various national and local policies, strategies and guidance. Lifestyle and behaviour play a predominant role in premature mortality, and individual risks are frequently associated with more than one disease or condition.

The NHS Mandate for 2014/15 sets out the ambition for England to become one of the most successful countries in Europe at preventing premature deaths. The associated NHS forward plan[12] highlights the issues of obesity, smoking and alcohol-related conditions, and the strain put onto the NHS of treating these. The plan also draws attention to the importance of prevention in tackling health inequalities, as well as the importance of empowering and motivating individuals to improve their own health, rather than being service dependent, and calls on local authorities to increase their spending and activity in these areas.

The Department of Health's programme 'Living Well for Longer: A Call to Action on Avoidable Premature Mortality' outlines the ambition to reduce deaths from the major preventable causes. Public Health England also have a plan, 'From Evidence into Action: Opportunities to Protect and Improve the Nation's Health', which identifies seven priorities addressing the main risk factors for many causes of premature mortality, including tackling obesity, reducing smoking and reducing harmful drinking.

In addition to these broad health strategies, there are a number of plans and reports which concentrate on individual risk factors. These include the Government's:

- 'Healthy Lives, Healthy People: A Tobacco Control Plan for England',
- 'Healthy Lives, Healthy People. A Call to Action on Obesity in England',
- the national alcohol policy, which highlights the need for local support for individuals and organisations in tackling the associated issues of alcohol misuse,
- the national drug strategy 'Reducing Demand, Restricting Supply, Building Recovery: supporting people to live a drug free life',
- guidance on the volume, duration and frequency of physical activity required to maintain fitness and health, under the title 'Start active, stay active', and
- the national initiative 'Change 4 Life', which supports families in making changes in their lives to support a healthier lifestyle.

The NHS Health Checks programme, under the responsibility of local authorities, invites 40-74 year olds, who have not already been diagnosed with heart disease, stroke, diabetes, kidney disease or certain types of dementia, to attend a health check as part of a five-year rolling programme. Following the health check, support and advice are offered, alongside medical intervention, as necessary. The health check provides an opportunity to identify any behavioural and lifestyle-related risk factors associated with causes of premature mortality, and to provide advice to those who attend.

NHS Health Check data shows that just over 45,500 health checks were offered to individuals in Lincolnshire in 2013/14.

From an eligible population of 232,000, this met the target of 20%, and was higher than the England average of 18.5%. Of the people in Lincolnshire who were offered the health check in 2013/14, 57.7% participated in the programme, which again was higher than the England average of 49% for that year. This means that in Lincolnshire, more than 5,000 additional patients received health checks than would have been the case if national rates of invitation and participation were matched.

Throughout these strategies and policies, there is a clear emphasis on a cultural shift. All highlight the importance of prevention and harm reduction in tackling these health issues, along with whole stakeholder engagement across services. This is mirrored in the Joint Health and Wellbeing Strategy (JHWS) for Lincolnshire, which highlights the need for individuals to take more responsibility for their own health, with services providing vital brief advice, and, where needed, additional support to individuals who wish to make healthier lifestyle changes. The JHWS highlights the Health and Wellbeing Board's ambitions to reduce the number of people who are overweight or obese, support people to be more active more often, support people to drink sensibly and reduce or stop illegal drug use. The strategy explains how this will be done locally, using a multi-disciplinary approach, through locally developed networks and partnerships.

Lincolnshire's Joint Strategic Needs Assessment provides the evidence base for the JHWS. It has core themes such as ill health and inequalities, which cut across the determinants and risk factors for premature mortality. It also includes specific topics such as obesity, alcohol, drug misuse, food and nutrition, physical activity and smoking, as well as some of the individual causes of premature mortality including respiratory diseases and circulatory diseases, cancer, suicide and road traffic accidents.

Many local organisations' own plans tackle the causes of premature mortality. The Clinical Commissioning Groups' Strategic and Operational Plans provide detail on how they are to address the requirements set out in the various outcome frameworks, and how they will deliver the Lincolnshire Health and Care (LHAC) programme. The Lincolnshire County Council Business Plan, particularly the Promoting Community Wellbeing and Resilience area, is specifically relevant to these public health issues.

The Lincolnshire Tobacco Control Strategy (2013-2018) includes a range of interventions, such as helping tobacco users to quit, reducing exposure to second-hand smoke and stopping promotion of tobacco products. 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. The Phoenix Stop Smoking Service is currently the commissioned service for Lincolnshire, and seeks to reduce the overall prevalence of tobacco users in the county.

In 2013/14, the Lincolnshire Phoenix Stop Smoking Service achieved 5,291 'four week quits'. Primary care provided a third of these, and although analysis indicates that fewer quits are coming from primary care each year, it is encouraging that the quit rate for those who give up after using the service is 55%, which is higher than the national average. Over 23,500 homes across Lincolnshire are registered with the Lincolnshire Smokefree Homes programme, thus protecting just over 24,000 children from second-hand smoke. This makes it one of the biggest and most effective health improvement programmes to date.

Lincolnshire's Public Health Team, with many key partners, has developed a drug and alcohol strategy. This has been designed to promote responsible drinking and prevent alcohol and drug-related harm, tackle alcohol and drug-related crime and anti-social behaviour and support delivery of high quality alcohol and drug treatment systems. Between March 2012 and March 2014, alcohol treatment services in the county saw an increase of 56%, from 845 to 1,320 people engaging in the service. In October 2014, Public Health England announced a national increase of over 5% in people accessing treatment services since the previous year. Higher levels locally could be due to successful promotion, referral and policy improvements over the period. In 2013/14, there were 400 successful treatment completions across Lincolnshire.

Obesity and physical activity programmes are also run across the county. These include almost 4,000 people attending 12 weeks of funded Weight Watchers sessions each year, and an additional 2,200 people attending local cooking and growing sessions. Physical-activity programmes, such as Vitality, Exercise Referral, and Health Walks, have attracted over 8,000 people throughout the county (all of which are aimed at getting more people more physically active). The Health Trainer Scheme also supports and motivates over 1,800 people each year to make healthier lifestyle choices, and provided brief advice to more than 5,000 people.

Public Health continues to work with local organisations to develop a culture of health and wellbeing in other ways, whether by delivering Making Every Contact Count (MECC) training to organisations or by working with local spatial planners to ensure that future developments promote healthy lifestyles. It is expected that, in this way, an all-encompassing approach will be achieved, which will reduce the number of years of life lost through preventable premature mortality.

The following chapters discuss the main causes of premature mortality in more detail, describing the conditions and their risk factors, and outlining the work that is being done to tackle them.

Cancer

The Condition

Cancer is a series of diseases of the body cells where the cells grow in an uncontrolled way. A group of abnormal cells may form and become a tumour which can be non-cancerous (benign) or cancerous (malignant). There are many different types of cancer which have different characteristics, including the speed by which they grow and spread, and the way they respond to treatment.

Cancer is a key public health priority. It affects around one in three people at some point in their lives, and has not only a devastating human impact, but also a significant financial impact on the NHS and the wider economy.

Although cancer is most common in older people, it is also the leading cause of premature mortality in Lincolnshire for those under 75 years of age.

Causes and Risk Factors

An individual's risk of being diagnosed with cancer depends on many factors, including their age, lifestyle and genetic factors. Approximately half of all cancers are preventable by changes in lifestyle, with regard to smoking, obesity, alcohol consumption and exposure to the sun.

The way in which these lifestyle factors influence an individual's risk varies depending on the type of cancer. For example, there is clear evidence that smoking is a major cause of lung cancer, and is also a significant risk factor in other cancers, such as bladder cancer. Stopping smoking at around the age of 30 can lead to a gain of almost 10 years of life expectancy, and stopping at age 60 can lead to a three-year gain in life expectancy.

Whilst specific dietary factors can influence the development of some cancers, including breast and prostate cancer, the associations are more complex.

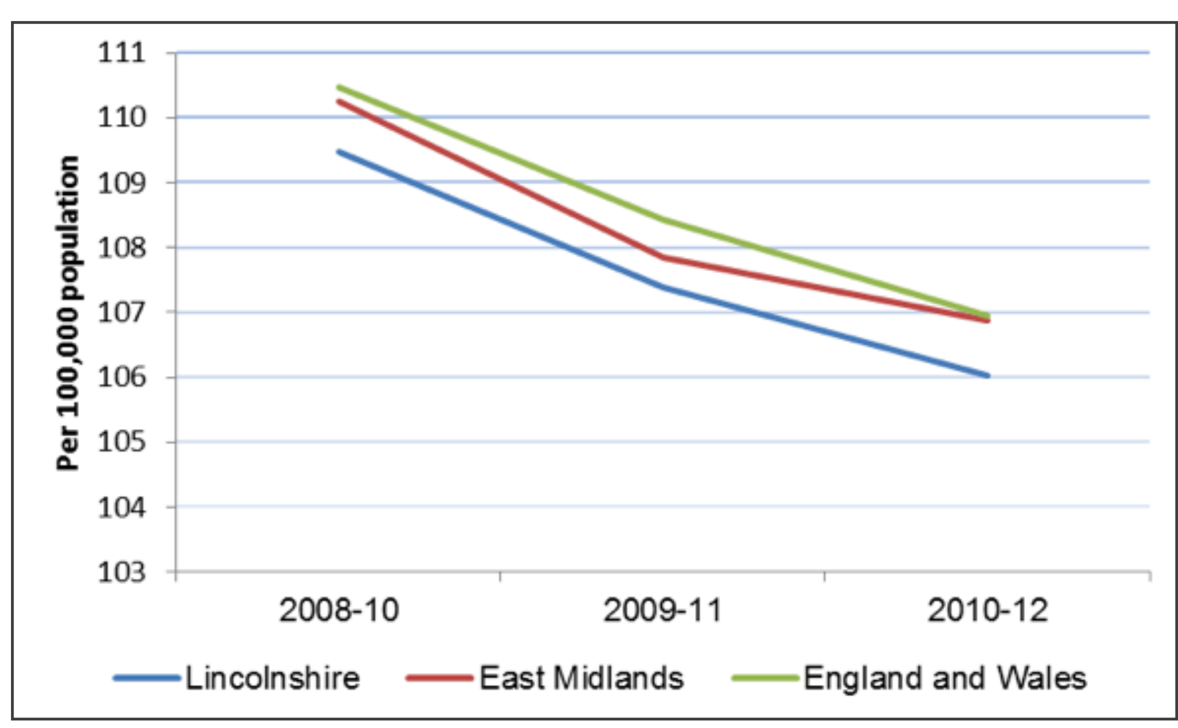
One of the biggest risk factors is increasing age. Cancer can develop at any age, but it is most common in older people. More than three out of five cases are diagnosed in people aged 65 or over, and over a third are diagnosed in those aged 75 or over.[13]

Facts and Figures

In Lincolnshire, between 2009 and 2011, there were 8,619 new cancer registrations amongst people aged under 75 years (a directly age standardised rate of 421 per 100,000 population). The rate amongst males was higher than that for females (445 and 398 per 100,000 respectively), and overall it was higher than the England and Wales figure (408 per 100,000 population).

Premature mortality rates for cancer have decreased over the last decade, as shown in figure 2.1. However, it remains one of the main causes of mortality.

Figure 2.1: Mortality from all cancers, directly aged standardised rates per 100,000 population aged under 75, 3-year pooled data

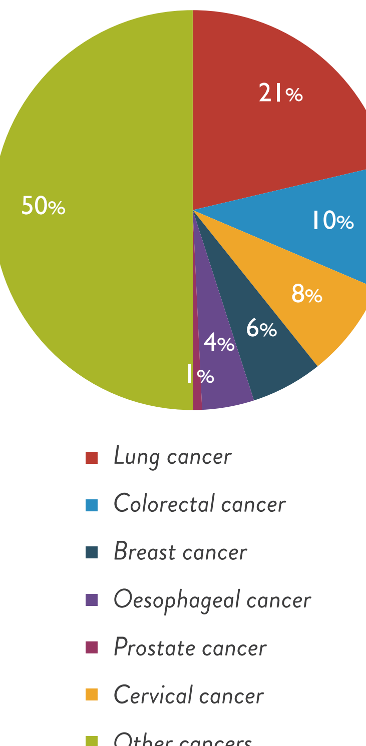


Source: Primary Care Mortality Database, Health and Social Care Information Centre

Overall, premature mortality rates are slightly higher for males than for females. Rates for lung, colorectal and oesophageal cancers are considerably higher amongst the male population, but a number of cancers predominate in females, for obvious reasons. These include breast, cervical, uterine and ovarian cancers.

In Lincolnshire, between 2010 and 2012, there were over 3,000 deaths from cancer (in people under 75 years of age). This represents more than 40% of all deaths amongst this age group. Lung cancer accounted for a fifth (21%) of all cancer deaths, followed by colorectal cancer (10%) and breast cancer (8%), as shown in figure 2.2.

Figure 2.2: Deaths from cancers, by cancer type, in people aged under 75 years in Lincolnshire, 2010/12



Source: Primary Care Mortality Database, Health and Social Care Information Centre

A number of national outcomes frameworks exist which include relevant data. The Public Health Outcomes Framework (PHOF) provides a basis for understanding differences in life expectancy and healthy life expectancy between communities, nationally. Premature mortality from cancers that are considered preventable is one of the indicators in this framework, and shows that, in Lincolnshire between 2011 and 2013, there were 1,684 cancer deaths that were considered preventable (by public health interventions) from a total of 3,021 cancer deaths amongst people under 75 years10. An outcome in the NHS Outcomes Framework (NHSOF) is to reduce the Potential years of life lost (PYLL) that are amendable to healthcare (i.e. premature deaths that should not occur in the presence of timely and effective healthcare). Between 2011 and 2013, there were 17,000 PYLL (721 deaths) from cancers amenable to healthcare across the four Clinical Commissioning Group (CCG) areas which make up Lincolnshire.[14]

Within Lincolnshire, years of life lost to all cancers by CCG are shown in figure 2.3. During the 3-year period from 2010 to 2012, over 1,100 people died prematurely from cancers in Lincolnshire East CCG. The rate of PYLL from cancers amongst the Lincolnshire East patients was 170.5 per 10,000 population; higher than the national rate and significantly higher than any other CCG in Lincolnshire. These differences can be partially explained by lifestyle factors, including higher levels of obesity and smoking prevalence. Although mortality rates for cancers are also higher in Lincolnshire East CCG, the differences in these are not statistically significant, perhaps suggesting that patients were more likely to die from cancer at a younger age. Additional analysis of age-specific mortality rates has reflected this, indicating higher than average mortality rates amongst people in their 40s in this CCG. At lower geographic levels, there is a correlation between deprivation and cancer, and this is reflected in the higher premature mortality rates from cancer seen along the coastal strip of East Lindsey, a more deprived area of the county.

Figure 2.3: PYLL from all cancers, directly standardised rate per 10,000 population in Lincolnshire, 2010/2012

Source: Primary Care Mortality Database, Health and Social Care Information Centre

Policy and Strategy

National frameworks provide the basis upon which government policy and strategy is shaped. Reducing premature mortality from cancer is an aim shared between the NHS Outcomes Framework and the Public Health Outcomes Framework. Both frameworks include indicators that impact on cancer prevalence and mortality. These include indicators of smoking prevalence, excess weight in adults, cancer diagnosed at stage 1 and 2 and cancer screening coverage. There are also indicators which relate to health inequalities, such as excess mortality (<75 years) in people who have serious mental illness (SMI). This is one of the improvement areas in the NHS Outcomes Framework. Higher rates of premature mortality among people with a SMI are due to a number of health issues, including cancer. Therefore, prevention, early intervention and early diagnosis of cancer amongst people with a SMI are all essential to reduce the rate of premature mortality in this group. 'Everyone Counts: Planning for Patients 2014/15 to 2018/19' from NHS England provides information on the many targets that are relevant for cancer. The NHS Constitution includes measures on cancer waits (2 weeks, 31 days and 62 days). The CCG Outcome Indicator Set (2014/15) includes indicators on cancer mortality, survival and stage at diagnosis. Public health measures for NHS England include coverage for the national cancer screening programmes. The Adult Social Care Outcome Framework includes measures relevant to cancer, such as enhancing quality of life for people with care and support needs.

In terms of the general health strategies, tackling premature deaths from cancer is a key part of the NHS Mandate, and a cause of death to be reduced through the Department of Health's 'Living Well for Longer: A Call to Action on Avoidable Premature Mortality' programme.[15] Public Health England's plan 'From Evidence into Action: Opportunities to Protect and Improve the Nation's Health'[16] identifies priorities which include the main risk factors for cancer. 'Healthy Lives, Healthy People: A Tobacco Control Plan for England' and 'Healthy Lives, Healthy People. A Call to Action on Obesity in England' are both also very relevant national strategies focussing on specific cancer risk factors.

Also nationally, the Department of Health's more specific strategy 'Improving Outcomes: A Strategy for Cancer'[17] sets out the approach that health and care services should take to improve outcomes for cancer patients.

Locally, 'Improving Outcomes in Cancer – A Strategy for Lincolnshire 2014-2019', is in development, specifically to address the requirements of the National Strategy. Other local strategies relevant to cancer include the Lincolnshire Tobacco Control Strategy 2013-2018, the Lincolnshire Alcohol and Drug Strategy, and the Lincolnshire County Council Business Plan, particularly the area relating to Promoting Community Wellbeing and Resilience.

A number of the themes of the Lincolnshire Joint Health and Wellbeing Strategy are very relevant to cancer, such as 'Promoting Healthier Lifestyles' and 'Delivering Care for Major Causes of ill Health and Disability'. Cancer is also a topic of the Joint Strategic Needs Assessment, relating to core themes including ill health and inequalities.

It is not easy to assess the specific impact of interventions on reducing premature mortality. In their resource for commissioners,[18] NHS England have made assumptions about

the cumulative effect of a range of measures designed to promote prevention and early diagnosis, rather than identifying benefits of specific interventions. However, there is strong evidence on the impacts of earlier diagnosis (diagnosing a proportion of cancers at stages 1 or 2 instead of at stages 3 or 4).

How is Premature Mortality from Cancer Being Addressed?

Addressing premature mortality from cancer requires organisations to work together to implement a range of interventions, including prevention, early diagnosis and treatment/care. These approaches will address those cancers that are preventable (by public health interventions) and amenable (to early diagnosis and effective treatment).

Various evidence-based approaches and interventions which NHS and Local Authority Commissioners have a role in commissioning have been identified for addressing premature mortality from cancer. These include:

- cancer prevention (including smoking cessation, weight management, and sensible alcohol consumption),
- effective population screening (there is a lower uptake for screening programmes, such as for cervical screening, amongst certain groups of the population),
- promoting symptom awareness to address late presentation of patients with possible cancer symptoms, and thus promote the earlier diagnosis of cancer,
- effective planning of diagnostic capacity to support early diagnosis of cancers, and
- monitoring variation in the patterns of referral, and of diagnosis and outcome rates for cancers amongst local practices, and working with local GPs to understand the reasons for the variation.

NHS England's resource for commissioners provides guidance on reducing premature mortality, and the National Institute for Health and Care Excellence (NICE) also provides a range of guidance in relation to specific issues.

Across the Lincolnshire health and social care sector, interventions are in place to address premature mortality from cancers. The LHAC programme and various clinical workstreams are supporting delivery of some of this work, and the Lincolnshire Strategic Cancer Board has a role in overseeing elements of it. In addition, the East Midlands Cancer Strategic Clinical Network aims to improve services, and to improve both the quality of care and outcomes for patients.

Prevention

Prevention programmes that address the behavioural risk factors which contribute to premature mortality from cancer are commissioned and provided. Many of these are shown in appendix 1. Those with very strong links to cancer prevention include the tobacco control, weight management, alcohol reduction and Making Every Contact Count initiatives.

The Smokefree Lincolnshire Alliance supports and facilitates the adoption and delivery of government and local smokefree policies to reduce harm caused by tobacco consumption. The Lincolnshire Tobacco Control Strategy includes a range of interventions across a number of strands, such as helping tobacco users to quit and reducing exposure to second-hand smoke. Lincolnshire County Council commissions the Phoenix Stop Smoking Service, supporting people to stop smoking. In 2013/14, the service helped 5,291 people to quit successfully.

Through Lincolnshire County Council, Weight Watchers is commissioned to provide a free 12-week programme to adults with a BMI of over 30 across Lincolnshire. During 2013/14, there were 3,854 referrals, of which 64% completed 10 weeks or more of the programme. A 12-week exercise referral programme and a health walks programme are also commissioned. During 2013/14, 4,640 referrals were made to the Lincolnshire Exercise Referral Programme, with approximately 70% completing the programme.

The Lincolnshire Alcohol and Drug Strategy comprises three main themes: promoting responsible drinking and preventing alcohol- and drug-related harm, tackling alcohol- and drug-related crime and anti-social behaviour, and delivering high quality alcohol- and drug-treatment systems.

Making Every Contact Count (MECC) raises awareness of health and wellbeing, and encourages and helps people to make healthier choices to achieve positive long-term behaviour change. The focus on cancer-related risk factors (obesity, physical activity, smoking and alcohol intake) directly addresses the prevention of premature mortality from some forms of cancer. MECC provides training and support for organisations to deliver consistent health messages in multiple ways. Lincolnshire County Council is leading the development of the MECC programme in the county.

Screening and treatment

NHS England's objective to ensure effective commissioning of certain public health services includes cancer screening programmes. Local Authority Public Health is not responsible for commissioning cancer screening programmes, although it does have a significant assurance role in delivering effective programmes, which includes encouraging participation. The Early Presentation of Cancer (EPOC) programme has been commissioned in Lincolnshire to take forward cancer prevention messages in an informative manner, and in a way that is appropriate to individual groups and communities. It encourages people with signs and symptoms of cancer to present to their GP earlier, to improve outcomes. The programme is built upon community development principles. It works with CCGs and primary care to promote screening and early diagnosis, and has supported national campaigns,

such as the 'Be Clear on Cancer' campaign.

The national bowel screening programme was introduced in 2006 for all people aged 60-69 years. From 2008, it has been extended gradually to include people aged 60-74 years. Data from March 2012[19] shows that in Lincolnshire, 60.8% of all people invited for screening in the previous 12 months were screened within 6 months of invitation. This was higher than the national figure of 55.3%. Two-and-a-half-year coverage (the proportion of eligible people screened in the previous 30 months) amongst those aged 60-74 years was 53.8%, also slightly above England's figure. This was despite the fact that, in Lincolnshire, only small numbers of people aged over 70 were invited for screening. Future data will better illustrate what impact the extension of the eligibility criteria has had.

Targeting work has taken place, and continues, to encourage take-up of cervical screening in specific communities where coverage needs to be improved. The proportion of eligible female patients, whose records show that a cervical smear test has been performed in the last five years, was higher in Lincolnshire than in England in 2013.[20] Lincolnshire East CCG had the lowest coverage at 81.8%, being similar to the national level (82.0%), and the other Lincolnshire CCGs had noticeably higher results, with 85.2% in Lincolnshire West CCG being the highest in the county.

The phased extension of the breast screening programme age to 47 to 73 years (from 50 to 70 years in 2012) is also being implemented, and work is taking place to address staffing and capacity issues in the Breast Screening Service. Although there was a small decline in the uptake of breast screening in Lincolnshire between 2011 and 2013, mirroring the national trend, breast screening coverage remained at a significantly higher level in Lincolnshire than in England. In the county, breast screening coverage was 80.7% of eligible woman aged 53-70 years (the age reported by the HSCIC) in 2013, compared to 76.4% nationally.[21]

Lincolnshire Public Health and NHS England are both represented on the Lincolnshire Health Protection Board, which was established to address specific areas for all of the national screening programmes. During 2013/14, 32 new volunteers were recruited through the Early Presentation of Cancer Programme (EPOC), and provided support within their communities. A variety of campaigns were promoted, including the 'Be Clear on Cancer' campaigns, which have raised the profile of screening programmes and of the signs and symptoms of major cancers. There is evidence that targeted work to promote cervical screening amongst people aged 25-49 years has led to an increase in uptake in some areas of the county.

In terms of cancer treatment, Lincolnshire's Clinical Commissioning Groups and NHS England are responsible for commissioning services that meet the cancer waiting time targets and provide the best outcomes for patients.

Next Steps

Cancer is one of the main causes of mortality and premature mortality, and is a key public health issue. As demonstrated, a wide range of interventions is being used to address prevention, early diagnosis and treatment, supporting delivery of both national and local strategies. The local strategy, 'Improving Outcomes in Cancer - A Strategy for Lincolnshire', should be the focus for taking forward the cancer agenda in the county.

There should be particular emphasis on:

- continuing to commission and provide services that tackle lifestyle risk factors for cancer, particularly smoking,
- continuing to develop ways of improving the uptake of the cancer screening programmes,
- continuing to work with health professionals and the public to diagnose cancer in its early stages, and
- NHS commissioners continuing to work with providers of healthcare to enable people to receive the best outcomes in cancer treatment and care.

Circulatory Disease

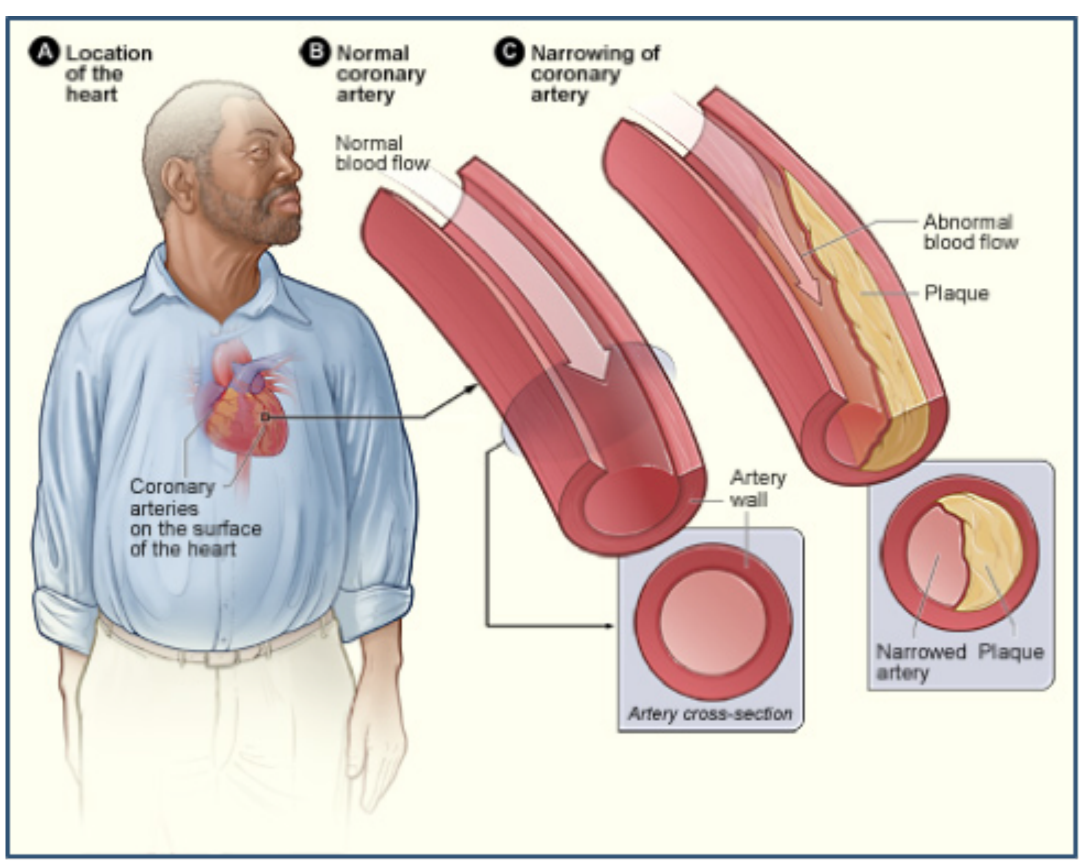
The Condition

The two main circulatory diseases affecting the UK population are coronary heart disease and stroke, both of which are major causes of premature death in the UK. Other circulatory diseases are high blood pressure, kidney disease, peripheral circulation conditions, vasculitis, heart defects and arrhythmias. This chapter focusses primarily on coronary heart disease and stroke as major contributors to premature mortality in the county.

Coronary heart disease

Coronary heart disease (CHD) occurs when the coronary arteries (the blood vessels that supply your heart muscle with oxygen-rich blood) become narrowed, due to a gradual build-up of fatty material. The fatty material is called 'atheroma' or 'plaque' and the condition is called 'atherosclerosis'.

Figure 3.1: Narrowing of the coronary artery



Source: US National Institutes of Health; Heart, Lung and Blood Institute

In time, the arteries may become so narrow that they cannot deliver enough oxygen-rich blood to the heart, resulting in pain and discomfort. This is referred to as 'angina'.

If a piece of atheroma breaks off, it may cause a blood clot to occur somewhere in the body's blood vessels. If the blood clot blocks off the coronary artery supplying the heart, this is known as a 'heart attack', and may result in death or the heart becoming permanently damaged.

Those living with CHD may experience a number of different symptoms, including swollen ankles or feet, problems with sleeping, fatigue (tiredness) and a lack of energy. They may find themselves getting short of breath when undertaking routine activities, such as climbing the stairs or walking up a hill. Others may experience chest pain or discomfort. All these symptoms can cause fear and anxiety, lead to stress and encourage sufferers to limit their activities and stop doing the things that they enjoy.

Stroke

A stroke is a serious, life-threatening medical condition that occurs when the blood supply to part of the brain is cut off, causing permanent damage. If the supply of blood is restricted or stopped, brain cells begin to die, which may lead to injury,

disability or even death. There are two main types of stroke:

- ischaemic: where the blood supply is stopped due to a blood clot (this accounts for 85% of all cases), and
- haemorrhagic: where a weakened blood vessel supplying the brain bursts

There is also a related condition, known as a 'transient ischæmic attack' (TIA), where the supply of blood to the brain is temporarily interrupted, causing a 'mini-stroke'. These frequently last for less than 30 minutes but can last for as long as several hours. TIAs are often a warning sign that there is a risk of having a full stroke in the near future.

The injury to the brain caused by a stroke can lead to widespread and long-lasting problems. These may include cognitive (understanding) and communication problems, depression and emotional problems, fatigue and physical difficulties (including problems with mobility, balance and incontinence), and visual problems.

Although some people may recover quite quickly, many will have to live with the after effects of the stroke. A substantial proportion may be dependent on others to help them with daily living, and require support to regain as much independence as possible.[22]

Although there is a falling trend for premature deaths from circulatory diseases, particularly CHD, they still represent a considerable impact on families, and place a burden on health and social care services within the county. They also contribute heavily to the overall number of deaths that are considered avoidable.

Furthermore, there is a distinct possibility that this falling trend will be reversed as a result of rising levels of obesity, reducing levels of physical activity and an ageing population.

Key to reducing circulatory disease and its effects is the early identification of its risk factors, and providing support, advice and interventions to those identified with elevated risk. The aim is to lower their risk levels and improve circulatory fitness through lifestyle changes, such as increasing physical activity, stopping smoking, reducing excess weight and eating a healthy diet.

CHD is also known to be an important indicator of inequalities. Those who are not well educated, have a low income, and are employed in blue collar occupations have the highest CHD rates. Risk factors linked to CHD, such as poor lifestyle choices, poor housing and limited access to primary healthcare services are often more prevalent in areas of high deprivation.

Causes and Risk Factors

A number of common risk factors are recognised as increasing the risk of individuals developing atherosclerosis and, therefore, CHD.[5] The same risk factors apply to the likelihood of having a stroke. They are:

- high blood pressure,
- high blood cholesterol,
- diabetes,
- lack of physical activity,
- obesity,
- ethnicity, and
- a family history of CHD or stroke.

The risk of CHD increases with age for both men and women, and whilst it generally affects more men, the chances of developing the condition are similar for both men and women from the age of 50 onwards.

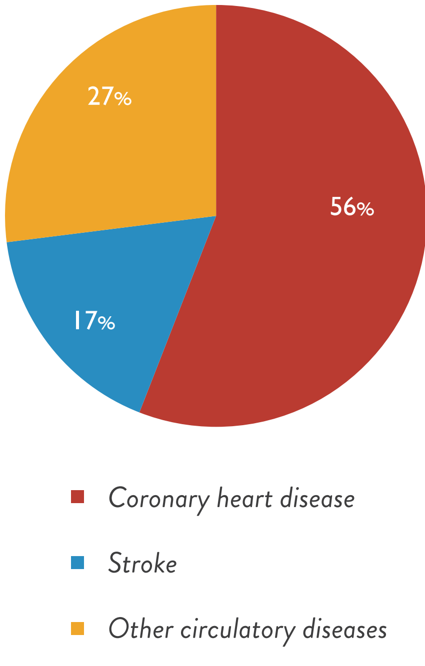
There is a social gradient in the prevalence of CHD, with more deprived areas experiencing higher levels than less deprived areas. In 2011, in the most deprived areas of England and Wales, 11% of men and 5% of women were diagnosed with CHD, compared to 5% of men and 2% of women in the least deprived areas.[23]

Individuals may modify or reduce many of the risk factors for CHD and stroke by making lifestyle/behaviour changes, such as not smoking, taking physical exercise, and eating a healthy diet. Consequently, CHD and stroke are largely preventable diseases. It is known that 80% of strokes are attributable to risk factors that are lifestyle choices.[24] For example, you are twice as likely to experience a stroke if you are a smoker. The good news is that stopping smoking for five years reduces your risk to the same level as that for a non-smoker.[25]

Facts and Figures

In 2011, almost 160,000 people in the UK died from circulatory diseases. Of these deaths, 74,000 were caused by CHD, the UK's leading cause of death.[24] Nationally, about 1 in 6 men and 1 in 10 women die from CHD each year. Many of these deaths are of people under 75 years of age, and may have been prevented, as the causes are considered 'amenable to healthcare interventions'.[24]

Figure 3.2: Mortality from circulatory disease by type in under 75 year olds, in Lincolnshire, 2010/2012



Source: Primary Care Mortality Database, Health and Social Care Information Centre

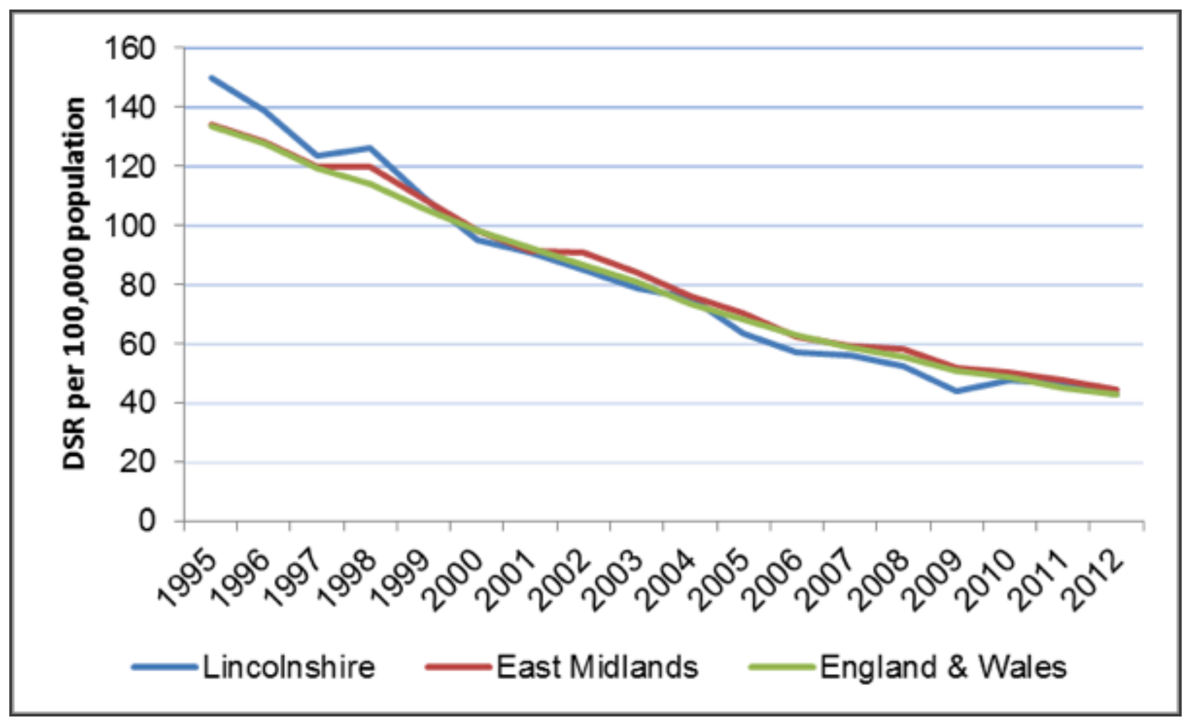
Circulatory conditions are the second largest group of diseases (after cancers) responsible for premature mortality in Lincolnshire. In the three-year period from 2010 to 2012, 1,700 people who were under the age of 75 years died from circulatory disease, this being nearly a quarter (23.1%) of all deaths for this age group in the county.

CHD was the main circulatory disease responsible for these deaths, accounting for 953, which is more than from any other individual cause, including specific cancers (figure 3.2).

Stroke is a major health problem in the UK. In 2012/13, 75,000 people were admitted to hospital in England as a result of a new or recurrent stroke, and a further 27,500 people were admitted with a TIA.[26] In Lincolnshire in 2013/14, 2.2% of the population (16,629 people), had had, or were living with, the condition. This is higher than the national figure of 1.7% of the population.[9] Stroke is also among the leading causes of premature mortality among Lincolnshire residents, resulting in 291 deaths over the three-year period from 2010 to 2012.

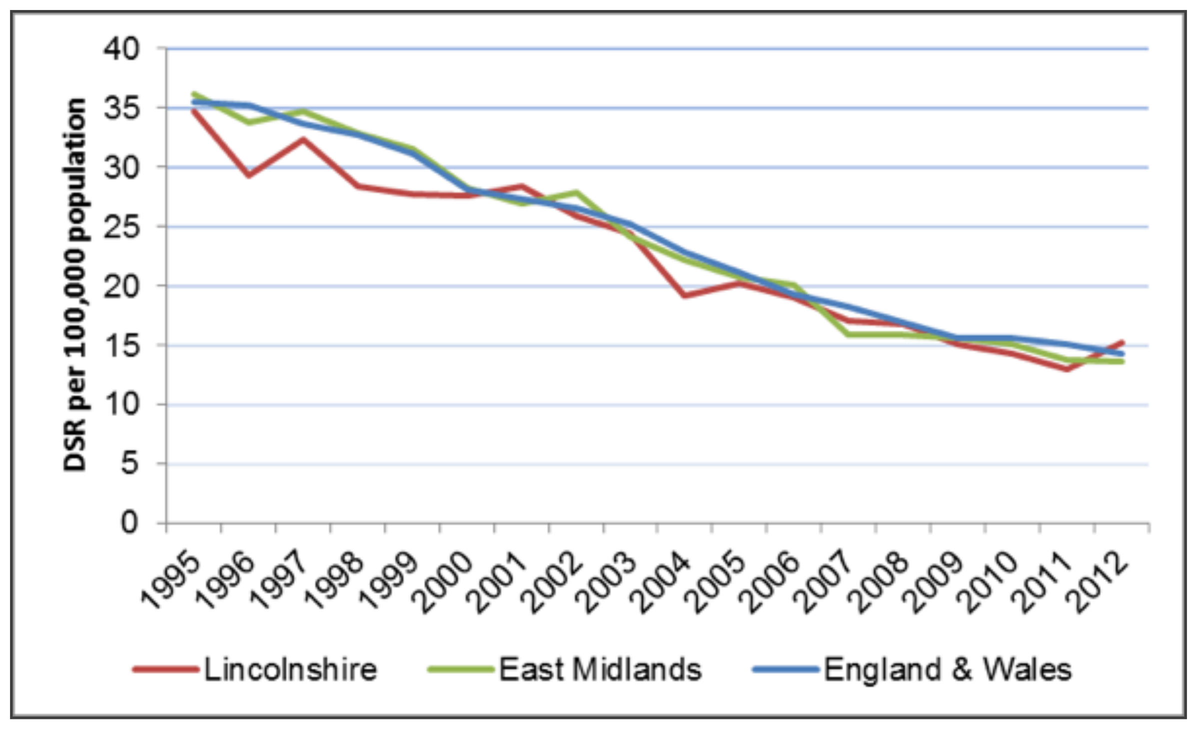
In Lincolnshire, there has been a reduction in premature deaths from CHD and stroke, as measured by directly standardised rates. For CHD there was a 71.4% reduction between 1995 and 2012 (figure 3.3), and for stroke a reduction of 56.2% over the same period (figure 3.4). This suggests that these conditions are being better diagnosed and managed, and that risk factors have been reduced. Addressing risk factors, such as smoking and high blood pressure and cholesterol levels, is thought to have contributed around half of the reduction (between 42% and 58%), the remainder being attributable to improved care during acute cardiac and stroke episodes, and the management of those with known disease.[27,28] Reductions in mortality would have been even greater but for rising levels of obesity and diabetes in the population.

Figure 3.3: Mortality from coronary heart disease, directly age standardised per 100,000 population aged under 75 years, 1995-2012



Source: Primary Care Mortality Database, Health and Social Care Information Centre

Figure 3.4: Mortality from stroke, directly age standardised per 100,000 population aged under 75 years, 1995-2012



Source: Primary Care Mortality Database, Health and Social Care Information Centre

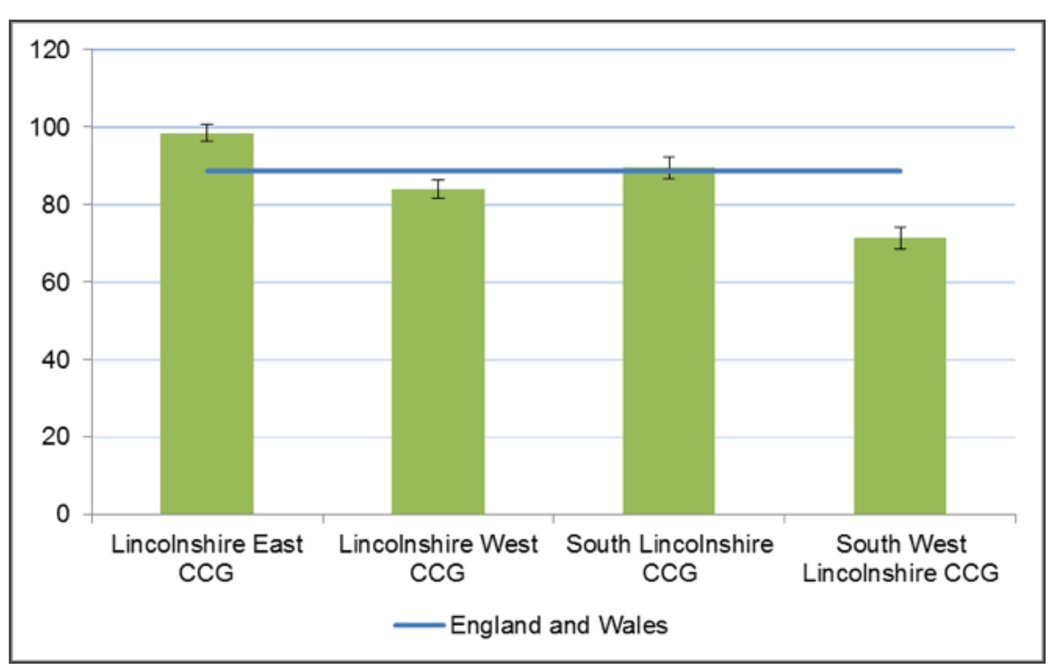
The number of hospital admissions in the county attributable to CHD decreased by 7.6% between 2009/10 and 2010/11, from 22 admissions per 10,000 population to 20.5 admissions per 10,000.[29]

Despite these reductions, circulatory diseases remain responsible for a considerable number of potential years of life lost (PYLL) in Lincolnshire. Based on data from the three-year period from 2010 to 2012, circulatory diseases were responsible for the loss of 91 potential years of life per 10,000 residents in Lincolnshire (around 6,370 total years of life lost prematurely over the three years).

CHD and stroke account for 48 PYLL and 16 PYLL per 10,000 residents respectively (being approximately 3,360 years in total lost to CHD, and 1,120 years lost to stroke in Lincolnshire).

Across Lincolnshire there are differences in the amount of years of life lost due to circulatory diseases. In Lincolnshire East CCG, an average of nearly 100 PYLL were lost per 10,000 population each year due to circulatory diseases in the period 2010 to 2012. This was above the national rate and higher than any other CCG in Lincolnshire. South Lincolnshire CCG had a rate similar to the national level and higher than Lincolnshire West CCG and South West Lincolnshire CCG. High mortality from circulatory disease is consistent with higher rates of excess weight in the east of the county, an important risk factor in the disease. The local authority district area of East Lindsey also has higher than average smoking prevalence, another important risk factor, and makes up a major part of this CCG. Lifestyle-related risk factors, such as smoking and obesity, have a strong correlation with deprivation, and analysis at lower levels shows that premature mortality from circulatory diseases is correlated with deprivation. It is therefore not surprising that less deprived areas of the county, such as South West Lincolnshire, have the lowest rates of PYLL due to circulatory diseases.

Figure 3.5: PYLL from circulatory diseases, directly standardised rate per 10,000 population in Lincolnshire, 2010/12



Source: Primary Care Mortality Database, Health and Social Care Information Centre

Policy and Strategy

The National Stroke Strategy (NSS) was launched in December 2007, providing clear direction for the development of stroke services in England over a 10 year period. The NSS covers the whole stroke pathway, with a strong emphasis on primary prevention of stroke through healthy living. Once a stroke has been diagnosed, the NSS is clear that a rapid and effective transfer, assessment and treatment should be given, including quick access to diagnostic tests and, if required, referral to a specialist 24/7 stroke unit.

An extensive Community Stroke Rehabilitation Service provides a countywide service to support stroke survivors to leave hospital in a timely manner. Clinical Commissioning Groups commission the Family and Care Support Services (FCSS) through the Stroke Association, with a remit to provide high quality information, emotional support and practical advice in the aftermath of a stroke. FCSS currently runs four support groups across Lincolnshire, based in Boston, Spalding, Grantham and Lincoln. Lincolnshire County Council commissions FCSS to undertake a care assessment for carers. This may include identifying their physical and mental health needs, promoting emergency planning and signposting to other services, if appropriate.

The National Service Framework (NSF) for CHD was launched in 2000 as a 10 year strategy, with the aim of

achieving a 40% reduction in CHD and stroke related deaths by March 2010. The target was met five years ahead of schedule, but the work is continuing through the Cardiac Network, which seeks to improve cardiac rehabilitation, spread good practice, and recruit and train Heart Failure Nurses to support those in the community living with the effects of heart failure.

Core government targets, such as those around reducing the prevalence of smoking, guidance on physical activity for fitness and health, initiatives such as 'Change 4 Life' and the NHS Health Checks programme all directly focus on reducing circulatory risk factors.

At the local level, theme 3 of the Joint Health and Wellbeing Strategy ('Delivering high quality systematic care for major causes of ill health and disability') also addresses the challenge of CHD. The JHWS has identified the need to reduce mortality from CHD, and to prioritise improving treatments for patients following a heart attack. Multiple actions are being taken and include:

- monitoring the performance of each general practice in the county against relevant indicators within the Quality and Outcomes Framework, and working with CCGs to make improvements, and
- ensuring, through working with CCGs, that effective, evidence-based preventive measures are commissioned to reduce the prevalence of the major causes of ill health, and minimise the impact of long term conditions on people's mental health (in relation to theme 1 of the JHWS, 'Promoting Healthier Lifestyles').

The Lincolnshire Tobacco Control Strategy also directly addresses smoking-related risks factors for circulatory diseases.

How is Premature Mortality from Circulatory Diseases Being Addressed?

There is a strong focus on health promotion and addressing the lifestyles/behaviours that contribute to increasing the risk of circulatory disease. It is estimated that, if the adult population participated in physical activity to World Health Organisation suggested levels (2.5 hours of moderate activity or 75 minutes of vigorous activity per week), PYLL due to coronary heart disease in Lincolnshire would drop from 48 to 45 years per 10,000 residents (a reduction of 6%).[30] Increasing levels of activity would also have a positive impact on other areas of ill health, resulting in a 9% reduction on all PYLL.

In order to facilitate and encourage the population of Lincolnshire to practice healthier lifestyles, a range of services and programmes are in place, as detailed in appendix 1. Many of these are designed to directly reduce mortality from circulatory diseases, and include:

- Phoenix Stop Smoking Service and the Lincolnshire Smokefree Homes programme,
- exercise referral,
- Health Walks,
- Vitality,
- Fit Kids,
- Health Trainers,
- Community Food Programmes,
- Healthy Schools,
- Community Health Champions, and
- Making Every Contact Count.

Over the last five years, a significant amount of work has also taken place to improve stroke services for the people of Lincolnshire. Two acute stroke units are currently located at Lincoln County Hospital and Boston Pilgrim Hospital, with both units providing acute stroke thrombolysis to reduce the longer term impacts of stroke.

The Lincolnshire Smokefree Homes programme, established in 2004, targets the most deprived areas of the county. In addition to the services that are available to help smokers themselves, this programme works through Children's Centres, focussing on those who are at most risk because they live in a smoking household.

Next Steps

Many of the risk factors for circulatory disease are largely modifiable, being linked to lifestyle choices. Work will continue in order to lessen the burden of circulatory disease, and reduce premature deaths, through health improvement measures and by raising awareness of health issues. This will enable individuals to manage their own health more effectively.

Partnership working with local organisations will also continue to deliver health information lifestyle messages to specific sections of the population.

As circulatory diseases are an indicator of health inequalities, work will also continue to focus on, and support, those occupying the lower socioeconomic brackets, who are more likely to be at risk of, and suffer the consequences of, such diseases.

Work will be undertaken with the Phoenix Stop Smoking Service to better understand why smokers choose not to use the service, and opt for less effective forms of smoking cessation. This intelligence could help to target and support smokers in Lincolnshire more effectively.

Focussing on health improvement messages and delivering services that support individuals to make healthier lifestyle choices should reduce the risk of circulatory diseases for the Lincolnshire population, and further reduce premature deaths from these conditions.

Suicide and Mortality from undetermined Causes

Background

The World Health Organisation (WHO) describes suicide as, "the act of deliberately killing oneself". When the outcome of an inquest into a suspected suicide is ruled as 'death by undetermined cause', this means the evidence is not conclusive enough to rule it as a suicide or otherwise. For the purposes of this chapter, we look at both of these outcomes together, which is standard practice.

The likelihood of a person taking their own life depends on many factors. For many people, it is a combination of problems which are important rather than one single issue or cause. Major risk factors include being male, living alone, being unemployed, alcohol and drug misuse, and difficulties with mental health. In drawing conclusions from local analysis, it is important to be aware that it can be difficult to gather consistent background information across all cases. Therefore analysis provides a helpful indication of the general picture but cannot be assumed to be an absolute portrayal of the situation locally.

It must also be recognised that all individuals are impacted by their different circumstances in different ways and in the vast majority of cases people will find ways of coping with traumatic experiences or difficult circumstances.

This chapter looks at the picture of suicide and death by undetermined means in Lincolnshire. It is important to recognise that the only person who knows the real story about why they decide to take their own life is the individual themselves, so cases are examined individually and conclusions are drawn from the intelligence gained.

Every death by suicide is a tragic loss of life, and the impact of that event is widespread. It is known that, when a person dies in this manner, the emotional cost to the people affected by the death is very high. A study published in 2011 by Kings College London[31] calculated the total economic cost of suicide in various parts of the country. It looked at the various direct costs, such as emergency services, funeral and court costs; at the indirect costs on society, such as time lost from work and unproductive hours; and at the human costs, including lost years of disability-free life, and the pain and grief experienced by family members. The study determined that each suicide cost nearly one and a half million pounds, taking the above factors into consideration. This shows that, not only is suicide a tragic human loss to community and society, but an economic one as well.

Causes and Risk Factors

Key, and emerging, risk factors for suicide may include:

- having financial difficulties,
- being of certain occupational groups,
- having mental health problems,
- having long-term physical health conditions,
- having a history of self-harm,
- alcohol and drug misuse,
- suffering difficulties during childhood (adverse or abusive experiences),
- having special educational needs,
- having had contact with the criminal justice system, and
- suffering bereavement and relationship breakdown.

Some factors, such as being unemployed or having debts, can put pressure on individuals and families that they may find difficult to deal with. Research in Lincolnshire over recent years has shown that around 7% of cases have some indication of financial difficulties within their records.

At a national level, men who work in construction and in plant and machine operation are at the highest risk of suicide, and women who work in health, particularly doctors and nurses, are also at high risk. At the county level, trends are more difficult to identify. However, the highest risk group for men is most described as being 'elementary' occupations, being people who work in low-skilled roles including basic sales and service positions, and basic agricultural and construction labour, amongst many others. For women, there is no clear occupational trend locally to indicate any difference from the national pattern of risk. Lincolnshire is a county with large numbers of armed forces personnel, both serving and veterans, and data from recent years suggests that around 11% of cases had a record of previous military history, amongst other contributing factors.

Mental Health is a state of wellbeing in which the individual realises his/her own abilities, can cope with normal stresses of life, can work meaningfully and fruitfully, and is able to make a contribution to his/her communities.[32] It is reasonable to assume that some people who take their own lives may be having difficulties with their mental health. Nationally, one in four people will have a problem with their mental health each year.[33] In Lincolnshire, investigation has shown that over recent years more than half (58%) of those who died by suicide or undetermined causes had previously had contact with mental

health services. Just over half of all cases had a recorded history of depression.

Nationally, it is known that being diagnosed with some health conditions, such as cancer, heart disease and chronic obstructive pulmonary disease (COPD), can contribute to a higher risk of suicide. From recent research in Lincolnshire, just over 4 in every ten cases included an indication of physical ill health, including back injuries and pain, osteoarthritis, epilepsy, asthma and cancer.

It is estimated that over 17,000 people across Lincolnshire are classified as dependent drinkers, with a further 25,000 people drinking at harmful or higher risk levels. Over 106,000 people are drinking at a level that is an increasing risk to their health.[34] Over the most recent years for which research is available, just under a third of suicide records (29%) indicated a history with alcohol. One in five cases indicated a history of drug misuse.

Experiences in childhood can affect how we live our lives as an adult. The national suicide prevention strategy[35] states that adverse and abusive experiences in childhood are associated with an increased risk in suicidal behaviour. Although specific data for an indication of childhood experience alone is not available, investigation of Lincolnshire data suggests that just under 13% of cases had a record of some history of abuse. Such experiences could include suffering childhood abuse or neglect, but also include those involved in abusive relationships, suffering domestic abuse or being bullied in the workplace.

Risk is also thought to increase in relation to having special educational needs, including problems with literacy, mild learning disability, autism or attention deficit hyperactivity disorder (ADHD). All of these have been identified in recorded suicide cases in the county, although numbers are low.

The national strategy identified that people in contact with the criminal justice system are a high-risk group for suicide. In Lincolnshire over recent years, just over one in seven of those who died by suicide had a recorded history of contact with the criminal justice system, appearing to reflect this risk. It is difficult to estimate the proportion of people in the general population who have had similarly defined historic contact with the criminal justice system, and therefore it is difficult to understand how big a role this plays. However, a Ministry of Justice report[36] has estimated that around 15% of those aged between 10 and 52 years in England and Wales have had at least one conviction for a standard list offence, that is, any offence from which you can be convicted through the courts and which will form part of a criminal record. Therefore the proportion of suicides in Lincolnshire which recorded an indication of contact with the criminal justice system appear to be at a similar level to the rate of contact in the general population. Of those committing suicide in Lincolnshire who had an indication of contact, most also had a history of mental health concerns and half had a history of problems with drugs or alcohol.

Relationship breakdown and bereavement are also known risk factors. Around a third of suicide records in Lincolnshire referred to bereavement, relationship breakdown or relationship difficulties, although other factors may also have been present.

Facts and Figures

In Lincolnshire, between 2010 and 2012 there were 178 deaths from suicide or undetermined causes to those under 75 years (15 years+), 43 in females and 135 in males. The mortality rate, both overall and in males and females, is higher than the England and Wales average, as seen in figure 4.1, although the county rate in females has fallen slightly in the last year.

These deaths accounted for 34.8 potential years of life lost (PYLL) per 10,000 population (directly age standardised rate), 14.1 for females and 56.2 for males. At these levels, death from suicide or undetermined causes is the third biggest cause of years of life lost in Lincolnshire, after cancers and circulatory conditions.

Figure 4.1: Mortality rate from suicide and undetermined causes, directly age standardised per 100,000 population aged 15-74 years in Lincolnshire, 2010/12

	All Persons	Male	Female
England and Wales	10.5	16.3	4.8
Lincolnshire	11.4	17.8	5.2
Boston	9.1	15.1	3.1
East Lindsey	13.1	19.6	6.9
City of Lincoln	16.7	23.8	9.8
North Kesteven	11.8	18.6	5.4
South Holland	8.5	14.2	3.0
South Kesteven	8.9	15.3	2.9
West Lindsey	10.6	16.3	5.5

Source: Primary Care Mortality Database, Health and Social Care Information Centre

Lincolnshire's higher than national average rate can be seen in the table, as can the high rate in the City of Lincoln, which constitutes much, but not all, of the difference. At lower geographic levels, premature mortality from suicide or undetermined causes is correlated with deprivation, when considering rates by quintile of deprivation rank in the county. Due to the low numbers and the nature of the issue, it would not be helpful to attempt to further identify individual locations for targeting.

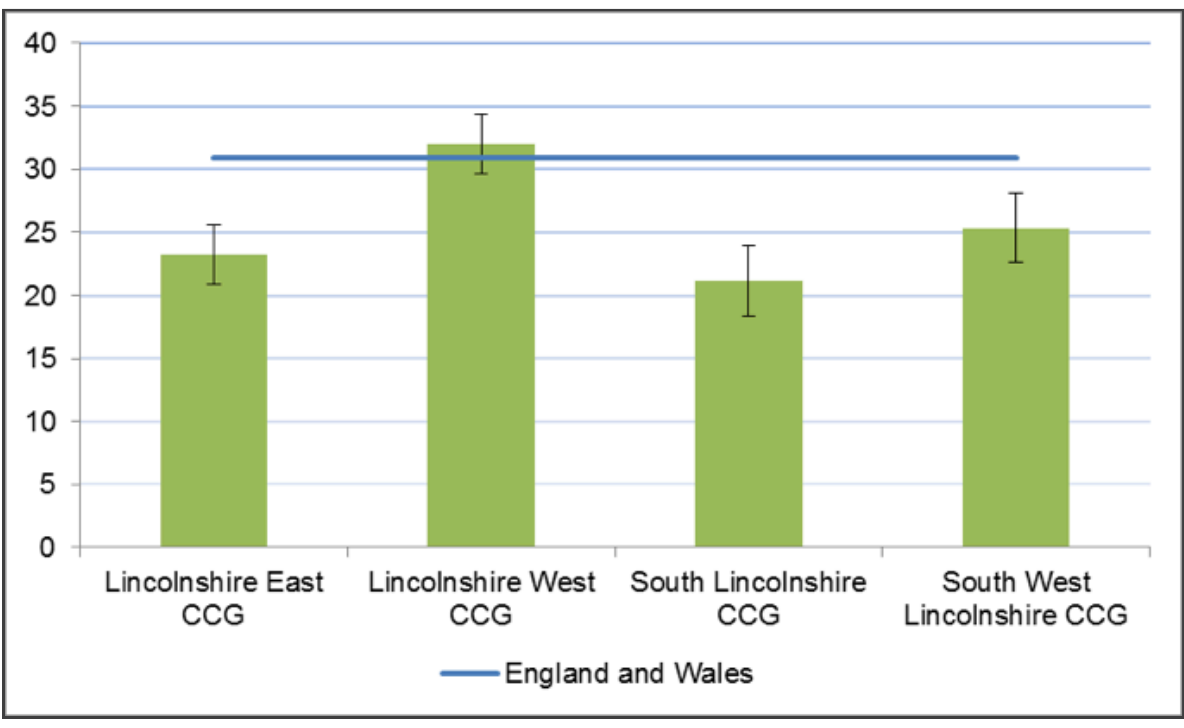
Nationally, the majority of suicides continue to occur in adult males, accounting for approximately three-quarters of all suicides. In Lincolnshire, the ratio is similar, although year on year it tends to fluctuate around this figure, due to the small numbers involved. Over the last two years of data, around 80% of such deaths were in males.

In terms of age, over the last five years the 40 to 45 year age group has seen the highest number, and rate per population, of deaths from suicide or undetermined causes for males. For females, the highest figures and rate were in the 55 to 59 year age group.

The national strategy has identified a need for consideration of ethnic minorities as a higher risk group. From the information available locally, there is no clear picture of this in Lincolnshire.

At the CCG level, PYLL from suicide or undetermined injury is below the national rate in three of Lincolnshire's CCGs, and in Lincolnshire West CCG it is comparable to the national level. Rates of mortality from these causes are known to be higher in the City of Lincoln (figure 4.1), which forms part of Lincolnshire West CCG.

Figure 4.2: PYLL from suicide and undetermined causes, directly standardised rate per 10,000 population in Lincolnshire, 2010/12



Source: Primary Care Mortality Database, Health and Social Care Information Centre

Policy and Strategy

In September 2012, HM Government published 'Preventing suicide in England: A cross-government outcomes strategy to save lives',[35] which aimed to reduce the suicide rates in England, and improve support for those affected by suicide. The strategy sets out key areas for action, states what government departments are going to do to contribute, and brings together knowledge about groups at higher risk, effective interventions and resources to support local action. This document defined the responsibility of local government organisations to do something about suicide, to recognise its devastating effects, and to work with other organisations to prevent suicide and the tragic impact it has, wherever possible.

Public Health England have recently released 'Guidance for developing a local suicide prevention action plan: Information for public health staff in local authorities',[37] which outlines guidance for local authorities on the formation and delivery of action plans for suicide prevention. Adhering to this guidance is key to understanding how we can contribute to the national approach to prevention, and to ensure we can learn from the best practices of others.

The World Health Organisation (WHO) has published guidance for suicide prevention, 'Preventing suicide: A Global Imperative',[38] with the aim of helping all countries to reduce suicide rates by 10%, as a minimum. This report also stresses the importance of raising awareness of suicide prevention as a public health issue, and states that raising the profile of suicide prevention must be given a greater priority in all organisations.

Locally, suicide and death by undetermined causes are reported on each year by Lincolnshire County Council, helping to inform the services provided for suicide prevention about how to more effectively target their audiences.

How is Premature Mortality from Suicide Being Addressed?

The Lincolnshire Coroner Service carries out an inquest into an individual death when triggered through a variety of instances, including death in suspicious circumstances and suspected death by suicide. The inquest investigates the deceased's circumstances and any events which may have influenced their death. Coroners have a responsibility to help reduce death by suicide and undetermined means where they can. They share appropriate intelligence to help target interventions to prevent suicide, and to inform commissioning of prevention and intervention services. They also alert the Local Authority, including Lincolnshire Public Health, should they identify emerging or changing patterns of concern, such as possible clusters of incidents or methods of suicide, so that attention can be focussed on these areas of concern. Where an inquest shows that something specific could be done to prevent further deaths, the coroner reports this to the attention of any organisation (or person) that may have the power to take action, and this organisation must then provide a written response on the action that will be taken.

In Lincolnshire, both multiagency work and commissioned programmes exist to tackle suicide. Two services which tackle stigma around suicide, and raise awareness of suicide prevention, are commissioned through Lincolnshire County Council, these are ASIST and SafeTALK.

Applied Suicide Intervention Skills Training (ASIST) is a two-day intervention skills course, delivered through Lincolnshire Partnership NHS Foundation Trust (LPFT). It helps delegates learn how to spot the signs of someone who is considering suicide, and how to talk to them about it, as well as where to go for help. It is a practical interactive course, which needs no prior experience or qualifications. ASIST is important for front-line staff and volunteers to help them recognise when residents with whom they come into contact every day may be under emotional distress, and know how to help them.

SafeTALK (suicide awareness for everyone) is a three-hour training session, with the objective of raising awareness of suicide and reducing the stigma associated with it. The aim of this course is to get more people talking about suicide and its prevention in an open and non-judgemental way; and to encourage those who have suicidal thoughts to come forward and find help.

In 2014, over 300 people attended ASIST training and more than 130 people received training on SafeTALK across Lincolnshire, with more sessions planned for 2015.

The transfer of Public Health from the NHS to Local Authorities has made access to some data from providers more difficult, but has opened up other opportunities to gain important intelligence. Work has been undertaken to improve appropriate data sharing, in order to enable patterns and trends in suicide across the county to be better understood. In this way, interventions and support can be provided in the best ways to those residents most at risk.

The multi-agency partnership, 'Choosing life', brings together people from organisations all over the county, to develop mechanisms and initiatives to help address the issue.

Whilst these programmes directly address suicide prevention, there is also much activity that is carried out around managing the risk factors associated with suicide. Depression, anxiety and other low-level mental health disorders feature heavily in suicides in Lincolnshire, and these are the focus of many programmes. Many of these are detailed in appendix 1. They include the Health Trainer service, GP exercise referral, Increasing Access to Psychological Therapies (IAPT), Mental Health First Aid and targeted pharmacy campaigns amongst many others. These more population-based approaches to improving support for emotional well-being have enabled a more widespread impact across the county, and addressed some of the known risk factors for suicide.

Next Steps

Evidence suggests that there is still more that can be done to prevent unnecessary deaths through suicide. It is clear that organisations must work together in preventing suicide, and that it is everyone's responsibility. Many organisations, groups and businesses contribute to the emotional well-being of individuals, and can help to prevent suicide and death by undetermined causes. Moreover, some work needs to be further shared, so that all relevant organisations know what is going on across the county and how to direct people to the right places, as well as being aware of any gaps in provision.

As previously noted, suicide and death by undetermined causes are reported on each year by Lincolnshire County Council, and it is important that this work continues to inform suicide prevention plans. The recently released 'Suicide Prevention: Developing a local action plan'[37] from Public Health England will help to provide a framework for delivery, and an indication of how Lincolnshire may contribute to the national approach to prevention, as well as ensuring that we are able to learn from the best practices of others.

Respiratory Disease

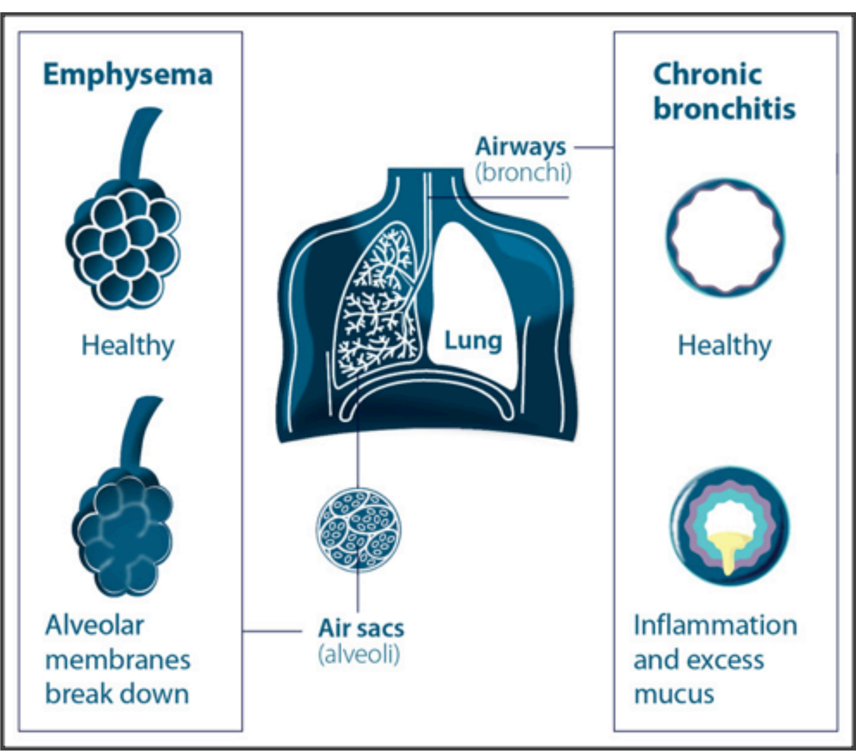
The Condition

The main causes of premature mortality in relation to respiratory diseases are chronic obstructive pulmonary disease (COPD) and pneumonia. Between 2010 and 2012, COPD and pneumonia accounted for 21 potential years of life lost (PYLL) per 10,000 people in Lincolnshire.

Chronic Obstructive Pulmonary Disease

COPD describes a collection of diseases that affect the lungs. These include chronic bronchitis, emphysema and asthma. Emphysema affects the alveoli (air sacs), and chronic bronchitis affects the bronchi (airways). Some people with COPD will have one of these conditions, whilst others will have more than one.

Figure 5.1: Diagram showing how the lungs are affected by COPD



Source: British Lung Foundation[39]

People with COPD have difficulty breathing, and the cvc cobstruction of the airflow, narrowing of airways and loss of lung elasticity give rise to increased breathlessness, a persistent cough and more frequent chest infections.

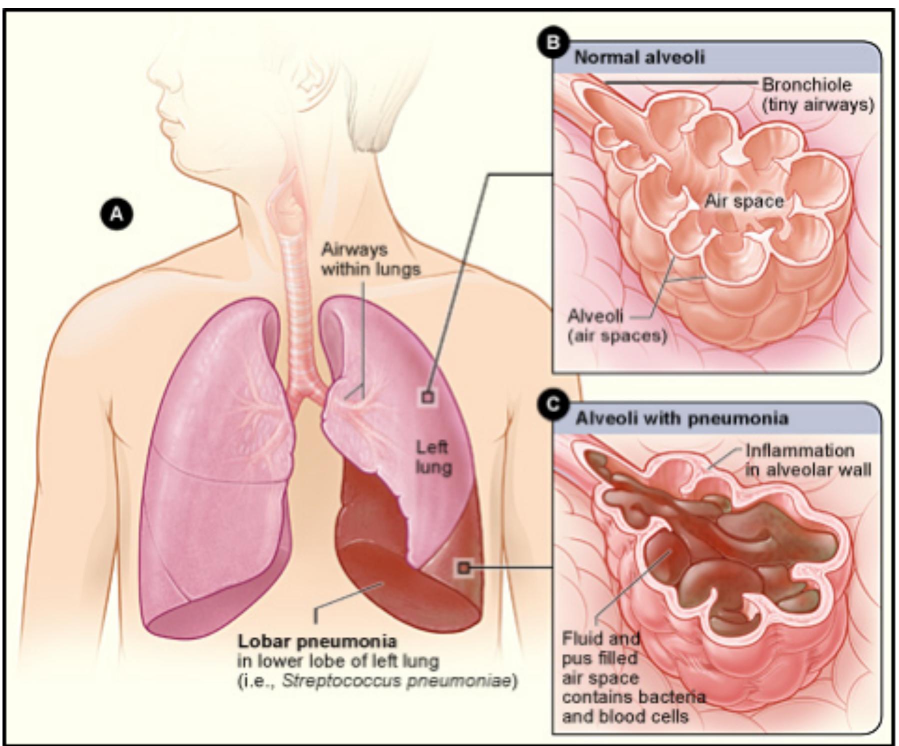
Many people with COPD are on substantial medication. They are more likely to take sick leave from work than those without COPD, and are more likely to be admitted to hospital and to retire prematurely because of ill health.

Individuals with more severe COPD can find everyday activities very difficult. They report being very anxious about becoming breathless, and consequently limiting their activity in order to avoid becoming breathless. As a result, they become less fit, and so become breathless after minimal activity. This is referred to as deconditioning.[40] Many people with COPD report poor quality of life.[41]

Pneumonia

Pneumonia is an inflammation of the tissue in one or both lungs, causing a build-up of fluid in the air sacs clustered at the end of the smallest branches of the breathing tubes in the lungs (figure 5.2).

Figure 5.2: Diagram showing how the lungs and airways are affected by pneumonia



Source: US National Institutes of Health; Heart, Lung and Blood Institute

People with pneumonia have symptoms that can be similar to those of other chest infections. Common symptoms of pneumonia include coughing, difficulty breathing (for example, rapid and shallow breathing, and breathlessness even when resting) and chest pain, which is worse upon breathing or coughing.

Those with mild cases of pneumonia can usually be treated with antibiotics, rest and fluids. While some symptoms may improve quite quickly, a cough is likely to persist for two or three weeks after completing a course of antibiotics, and fatigue may remain for longer. More severe cases may need hospitalisation, where treatment includes antibiotics and fluids given intravenously through a drip, and/or oxygen to help with breathing.

Causes and Risk Factors

COPD usually develops because of long-term damage to the lungs from breathing in harmful substances, such as cigarette smoke or chemical fumes. The most common cause of COPD is smoking tobacco.[42] The likelihood of developing COPD increases with the amount someone smokes and the length of time they have been a smoker. More rarely, COPD is caused by fumes, dust and air pollution, or genetic disorders. Individuals, such as miners, who have experienced occupational exposure to harmful substances, and who are also smokers, are particularly likely to develop COPD.

In addition, COPD is strongly correlated with poverty, and thus is more likely to occur in areas of socio economic deprivation.

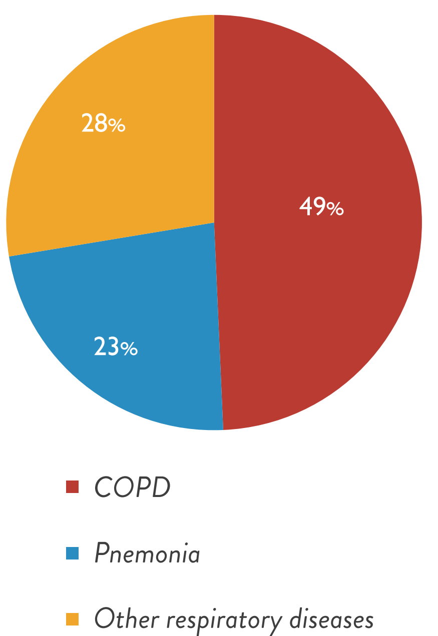
Pneumonia is most commonly caused by the pneumococcus bacteria. Other bacteria and viruses may cause pneumonia, but more rarely. The incubation period for pneumococcal disease is typically one to three days. Pneumococcal infection affects all age groups, but there is greater incidence in those over 64 years old and those under the age of 5 years.[43] Infection is by droplets from coughing or sneezing, or from direct contact with respiratory secretions of someone with the infection. Infection is more common in heavy drinkers, smokers and those who live in overcrowded conditions.[44] Predisposing conditions, such as COPD and influenza (flu) may also increase the risk of developing pneumonia.

Facts and Figures

In the three-year period between 2010 and 2012 in Lincolnshire, there were 641 deaths of people aged under 75 from respiratory conditions (9.1% of all premature deaths). The estimated PYLL due to respiratory conditions was 34 years per 10,000 population in Lincolnshire. Mortality from respiratory conditions in Lincolnshire is above the national average, but the difference is not considered statistically significant. The east of the county has the highest rates of premature mortality from respiratory conditions in Lincolnshire according to NHS Outcomes Framework.

Nearly half of all deaths from respiratory conditions were due to COPD, as shown in figure 5.3.

Figure 5.3: Mortality from respiratory conditions by type in under 75 year olds, in Lincolnshire, 2010/12



Source: Primary Care Mortality Database, Health and Social Care Information Centre

COPD is a long-term condition, which becomes more common with increasing age. Most people with COPD are aged over 40. It is estimated that three million people in the UK,[45] and more than 20,000 people in Lincolnshire, have COPD. COPD is more prevalent in men than women, although the prevalence in women is increasing.[46]

COPD is the fifth biggest killer in the UK, causing about 25,000 deaths each year. It is also a leading cause of premature mortality. In 2008, premature mortality from COPD in the UK was almost twice as high as the European average.[47]

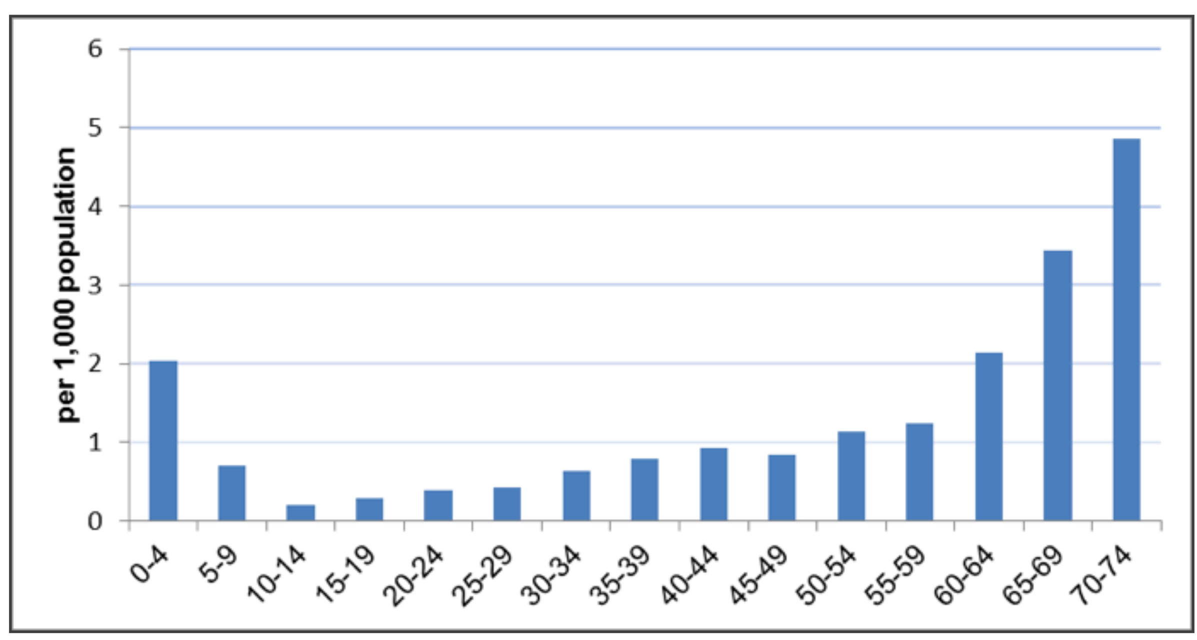
During the period 2010 to 2012, COPD was the underlying cause in 316 deaths in Lincolnshire. There are an estimated 12.1 PYLL to COPD each year per 10,000 residents, making it the eighth greatest cause of PYLL in Lincolnshire, being similar to the England average.

Pneumococcal infection affects all ages. The incidence rate in older children and young adults is 2 per 100,000, but there is a markedly greater incidence of 12 per 100,000 in individuals over 64 years old, and 7 per 100,000 in children aged under 5 years.[48] Pneumococcal infection is the main cause of community-acquired pneumonia. In the UK, the annual incidence of community acquired pneumonia is 5-11 cases per 1,000 for the adult population.[49]

Hospital admission is required for 20-40% of individuals who contract pneumonia, with 5 10% being admitted to a critical care unit.[50] In the UK, this results in approximately 83,000 hospital admissions each year.[48] There is a marked seasonal pattern in cases of pneumonia, with the greatest number of cases, and hospital admissions, occurring between December and January.

Hospital admissions due to pneumonia are far more common amongst infants and children under five years of age than for older children and adults of working age (figure 5.4). In Lincolnshire, between 2010 and 2012, there were 5,872 emergency hospital admissions as a result of pneumonia. Of these, 2,575 were for people aged under 75, being 43.8% of all such emergency admissions. On average, a person aged 75 years or older was 12 times more likely than a younger person to be admitted to hospital because of pneumonia.

Figure 5.4: Emergency hospital admissions due to pneumonia, age specific crude rates per 1,000 population in Lincolnshire, 2010/2012



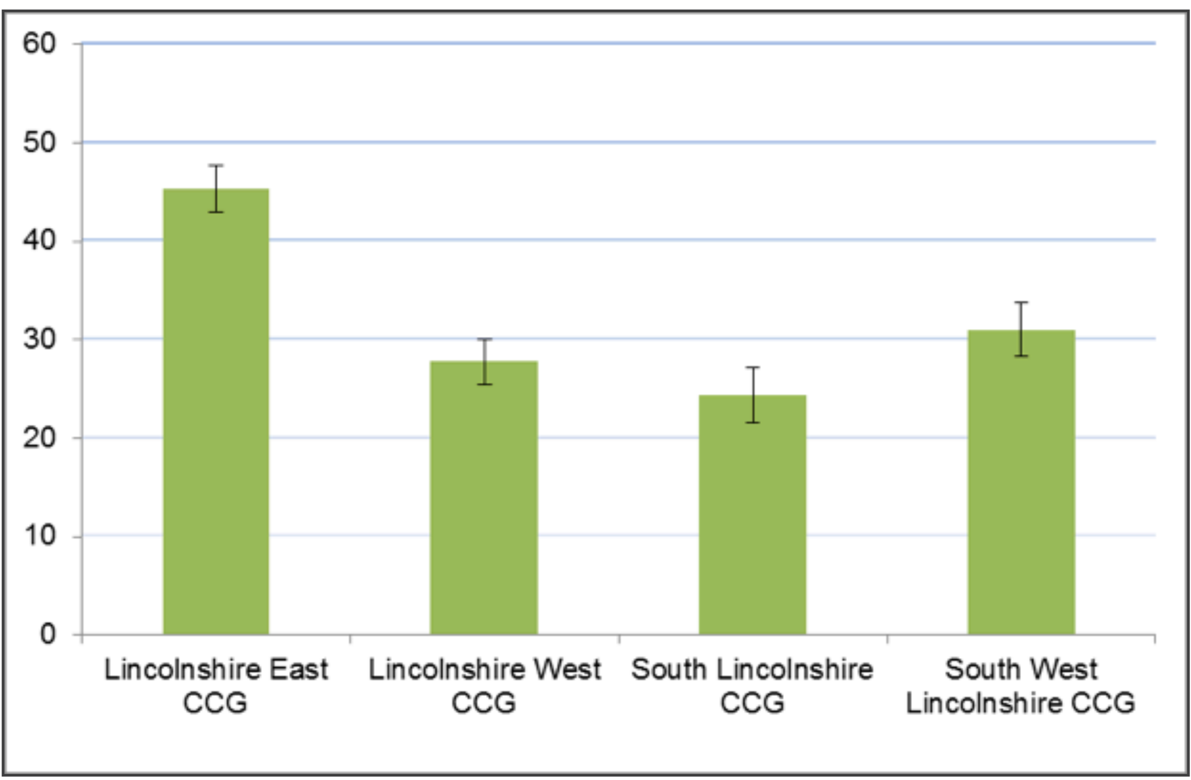
Source: Hospital admissions data, Secondary User Service

In 2010-2012, 150 deaths in Lincolnshire, of people under 75 years of age, were attributed to pneumonia. The directly standardised mortality rate for Lincolnshire (2010-2012) of those under 75 years of age was 7.4 per 100,000 population. This was significantly lower than the directly standardised mortality rate for England and Wales, of 9.2 per 100,000. The rate for those aged 75 years and over was 42.1 per 10,0000 for Lincolnshire, which was statistically lower than the rate for England and Wales (52.4 per 100,000 population).

In the three years from 2010 to 2012, the estimated PYLL due to pneumonia in Lincolnshire was 9.3 per 10,000 population. This was not statistically different from the East Midlands (7.48 per 10,000 population) or England and Wales (7.61 per 10,000 population).

In Lincolnshire East CCG, there were 45 PYLL each year per 10,000 population through respiratory conditions, from 2010 to 2012. As in the case of circulatory disease, this is significantly higher than any other CCG in the county. Again, smoking prevalence is a major risk factor in the disease, and this is higher in this area of the county. However, it is also possible that migration of those with existing problems to the east of the county could be a factor in the statistics. Analysis of age specific mortality rates show that in Lincolnshire East CCG, mortality from respiratory diseases was especially high in the 55-59 years age group, at over 1,000 per 100,000 population, more than twice as high as second highest results in the county (Lincolnshire West CCG). The mortality rate for people aged 60-69 years was also very high (again over 1,000 per 100,000 population), although the differences between CCGs in this age group were smaller. Analysis at lower geographic levels shows strong correlation between premature mortality from respiratory disease and deprivation levels in the county, and the pattern of mortality reflects this, particularly in the East and on the coast, but also in pockets of deprivation across Lincolnshire.

Figure 5.5: PYLL from respiratory diseases, directly standardised rate per 10,000 population in Lincolnshire, 2010/12*



**Please note that a national comparator is not readily available for this indicator.*
Source: Primary Care Mortality Database, Health and Social Care Information Centre

Policy and Strategy

The All-Party Parliamentary Group[51] enquiry into respiratory deaths recommends effective treatment interventions to reduce mortality from COPD, including:

- non-invasive ventilation,
- home oxygen,
- controlled oxygen dosing to minimise oxygen toxicity, and
- pulmonary rehabilitation programmes.

The Quality Outcomes Framework (QOF) requires general practices to maintain a register of people with COPD. In 2012/13, recorded levels of COPD in Lincolnshire practices were between 1.9% and 2.4%. QOF data suggests that there are more than 5,000 people in Lincolnshire with COPD who are not on a COPD register.

'An Outcomes Strategy for Chronic Obstructive Pulmonary Disease (COPD) and Asthma in England'[47] sets out how the NHS, public health and social care services can contribute to achieving a reduction in deaths from respiratory disease. Best practice solutions to achieve this focus on working with people with COPD and asthma as equal partners in their care.[45]

The 'Cold Weather Plan for England 2013'[52] highlights the increased risk of ill health during cold weather for those with COPD, as well as an increased risk of pneumonia. The plan highlights the importance of flu and pneumococcal vaccination programmes for people suffering from these diseases.

Guidance from the National Institute of Health and Clinical Excellence (NICE) for COPD[53] provides advice on the diagnosis, treatment and care of adults with COPD. It again emphasises patient-centred care, and makes similar clinical recommendations to those given in the All-Party Parliamentary Group enquiry into respiratory deaths.

How is Premature Mortality from Respiratory Diseases Being Addressed?

A range of partners work together to reduce mortality from respiratory diseases. These include:

- respiratory networks, which encourage best practice in respiratory health, working across primary and secondary healthcare services,
- NHS England, which commissions the delivery of immunisation programmes, and provides strategic guidance on vaccination to providers (currently GP practices) and monitors uptake,
- GP practices, who currently deliver immunisation programmes,

- the Tobacco Alliance, which supports smoke free spaces, and promotes an understanding of the damage caused by second hand smoke,
- United Lincolnshire Hospitals Trust, and other secondary care providers, which are able to provide opportunistic vaccination for 'at risk' patients during admission,
- The Health and Safety Executive in their role of supporting a safer working environment, with particular reference to reducing hazards that increase the risk of individuals developing COPD,
- local businesses, through the provision of occupational health services that support those with COPD to continue working, and remain healthy at work, and
- third sector partners, such as the British Lung Foundation, which offer support and advice on self management to those with COPD.

Work to reduce smoking, and to reduce the effects of second-hand smoke on others, impacts on many causes of premature mortality, particularly respiratory diseases. Reducing the number of people who smoke is known to have a significant impact on reducing the prevalence of COPD, and thus also reducing the PYLL to this cause.

Influenza (flu) and pneumococcal vaccination are particularly important for people with COPD, as these infections can be more serious in this group. Pneumococcal vaccination is part of the national childhood immunisation programme in the UK. The pneumococcal conjugate vaccine (PCV) is given at two months old, with boosters at four months and 12-13 months. In 2013/14, the uptake for the final PCV booster (by the age of two) was 94.5% in Lincolnshire, compared with 95.2% in the East Midlands and 92.4% in England.[54]

Pneumococcal vaccination for adults was introduced in August 2003 for those aged 80 years and over. Vaccination was extended to those aged 75 years and over in April 2004, and to those aged 65 years and over in April 2005. For those over 65 years old, a single dose of pneumococcal polysaccharide vaccine (PPV) is given. Most healthy adults develop a good antibody response to this by the third week following immunisation, but there is some evidence to suggest that post immunisation antibodies start to wane after five years.[55] Re-vaccination is also recommended for other groups at high risk of infection, such as those with heart disease or chronic renal disease. The uptake of PPV in Lincolnshire in 2012/13 was 69.7% compared with 70.7% in England as a whole.

The current PCV covers 13 different serotypes (variations in a species of bacteria or viruses) that can cause infection, and the current PPV covers 23 variants of invasive pneumococcal disease, accounting for about 96% of those found in the UK. Evidence suggests that PCV is effective in reducing cases of pneumonia in children,[56] and that PPV is effective against pneumococcal disease in adults.[57]

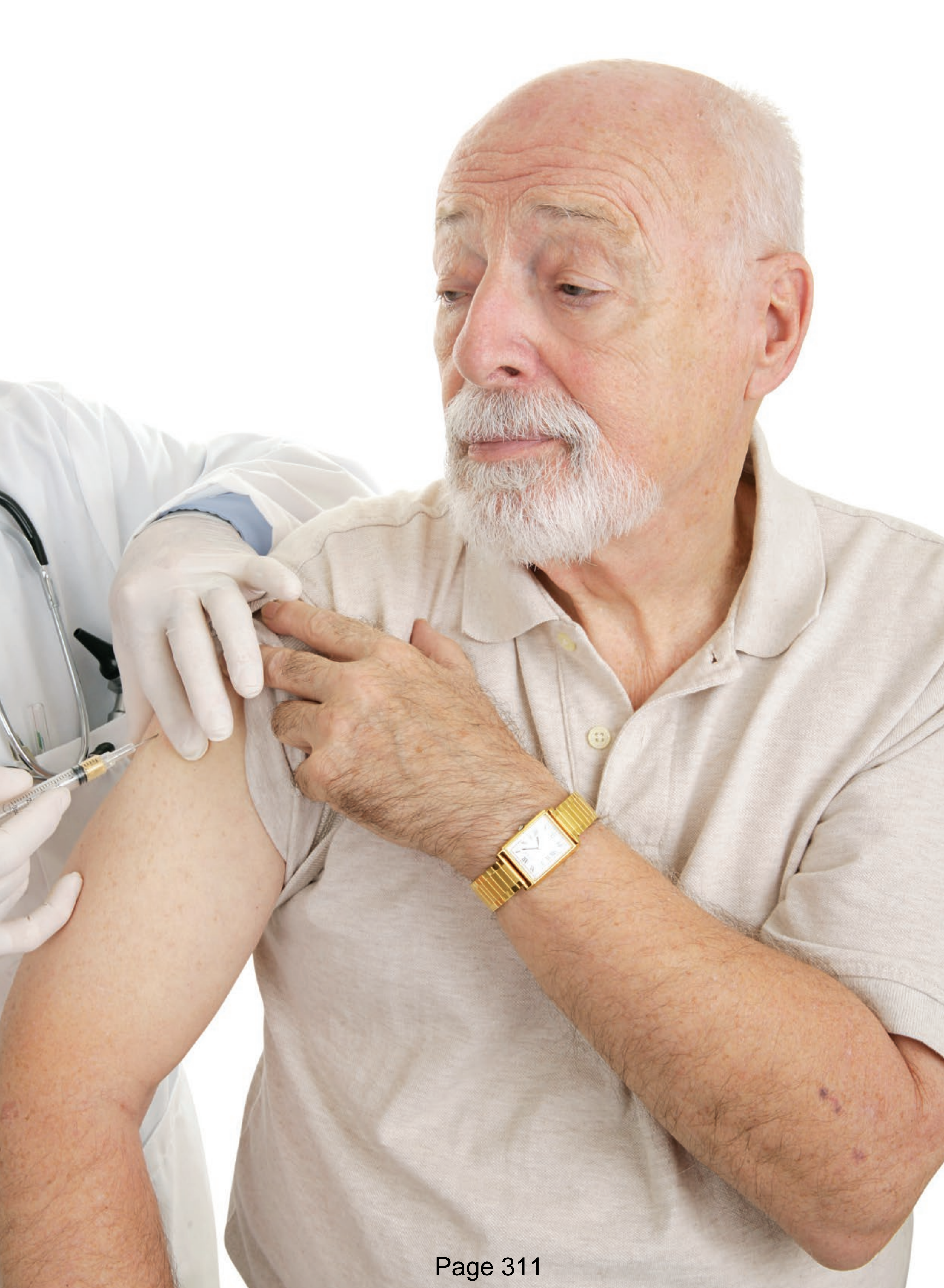
Next Steps

An estimated 80% of those with COPD are current or ex-smokers.[58] Reducing smoking prevalence would, over time, reduce the number of people with COPD in Lincolnshire by 16,000, with corresponding reductions in drug costs and emergency admissions to hospital.

Estimates[59] suggest that many people have undiagnosed and untreated COPD. Increasing the proportion of people whose COPD is identified early should ensure that these people receive timely treatment, thus reducing the debilitating effect of COPD on their lives.

Individuals with COPD can take positive action to improve their own health. Support that enables individuals to 'self-care', including expert patient and local support groups, can be particularly valuable, and is an area which could be further considered.

Increasing the proportion of people receiving pneumococcal vaccination would significantly reduce the number of people admitted to hospital with pneumonia. Using information from the King's Fund, it is estimated that this could result in a saving of £4 million in Lincolnshire each year.



Accidents and unintentional injuries

Background

The term 'accident' implies an unpredictable, and therefore unavoidable, event. As most injuries and their preceding events are both predictable and preventable, the term 'unintentional injury' is more appropriate.

Unintentional injuries are a significant public health issue, being a major cause of avoidable ill health, disability and death, and having a disproportionately large effect on those living in deprived communities.

Office of National Statistics data (2010)[60] suggests that injuries are the leading cause of death in children aged 1-4 years, and the second greatest cause of death in children aged 10-14 years.

"Injuries are a leading cause of hospitalisation and represent a major cause of premature mortality for children and young people. They are also a source of long term health issues, including mental health related to experience(s)."[10]

Accidents and injuries are also extremely costly to the NHS; nationally an estimated £275 million annual cost just for injuries affecting children and young people.[61] The Audit Commission[62] suggests that an unplanned admission to hospital following an accident/avoidable injury in the home may cost £16,900.

Road traffic accidents are costly in both economic and human terms. Casualty figures from the Department for Transport[63] suggest costs of:

- Fatality £1,703,822
- 'Serious' accident £ 191,462
- 'Slight' accident £ 14,760

Each year, thousands of people in Lincolnshire suffer injuries that require hospitalisation, treatment in emergency departments or from general practitioners, or other treatment that does not involve formal medical care.

Serious injuries can have a life-long impact on physical and cognitive abilities, as well as on psychological well-being. Individuals may have to spend a significant amount of time in hospital, and/or require long-term treatment as outpatients. Sustaining a spinal injury, or losing limbs or your sight, may impact on physical abilities, whilst head injuries can result in changes to cognitive abilities and personality.

Individuals may experience vivid, traumatic flashbacks of the accident. Post-traumatic stress, depression and anxiety are all common after a serious accident, and survivors who experience any of these conditions will need ongoing psychological care to achieve good mental health.

Accidents can also be life-changing for the families of those with serious injuries. They may need to provide care and assistance for the person during ongoing hospital treatment, or when attending regular outpatient appointments. Alternatively, they may need to provide practical long-term care at home. All of these may require the carer to be away from work for significant amounts of time.

Moreover, depending on the person's injuries, the family may have to make alterations to their home, car and lifestyle to accommodate their needs.

Losing a family member, especially a child, in an accident is devastating for families; for some, it can lead to family breakdown, job loss and depression. Some individuals never recover from the trauma of the sudden and violent death of a loved one. Bereaved families need ongoing support to cope with their loss, and to guide them through procedures such as inquests and court hearings.

Causes and Risk Factors

NICE (2010)[64] identifies groups that are at greater risk of injury, by age and by other characteristics. Children under the age of five years are more likely to sustain an injury at home, whilst children aged 11 years and over are more likely to be injured on the road.

Children and young people most likely to sustain an injury that requires medical intervention include:

- disabled children (including those with physical and/or learning disabilities),
- children from low-income families, and
- children living in certain types of accommodation (such as multiple occupancy housing, social and privately rented housing, temporary accommodation, and high rise flats).

The Marmot Review[65] identified the social gradient of accidents and avoidable injuries affecting children, both in the home and on the road, suggesting that deprivation in itself increases the risk of sustaining an avoidable injury.

Nationally every year, around 19,000 cyclists are killed or injured in reported road accidents, including around 3,000 who are killed or seriously injured.[66]

Unintentional injuries, including trips and falls, are common in older adults, being associated with poor eyesight, and problems with balance and mobility. Accidents and injuries in adults of all ages are often associated with excess alcohol consumption and the use of illicit drugs.

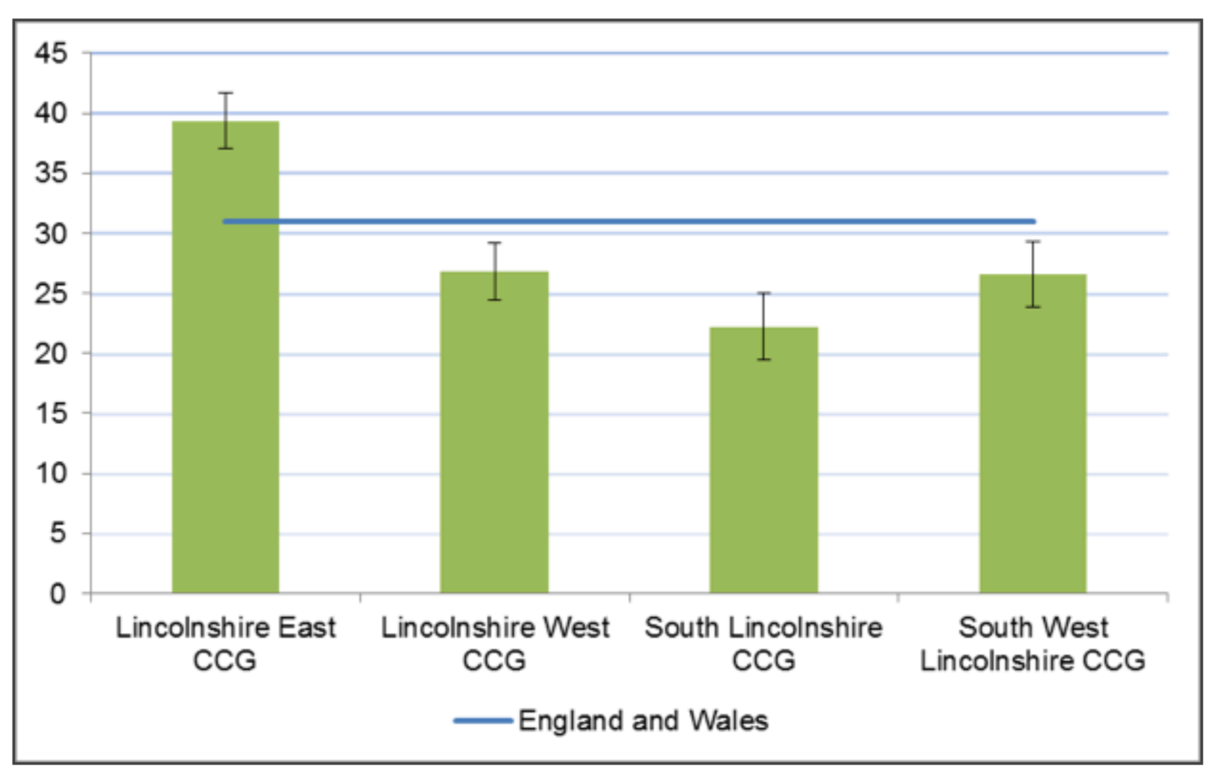
Facts and Figures

During the period from 2010 to 2012, 226 people aged under 75 died in accidents in Lincolnshire. This accounts for just over 3% of all premature deaths in the county. Fewer people died because of an accident than from other significant causes of premature death, such as stroke. However, the amount of potential years of life lost (PYLL) from accidents is twice as high as that from strokes. This is because accidents can affect all age groups, and frequently affect children and younger people, as well as older groups.

During 2011/12, 6,086 children aged 0-4 years attended Emergency Departments in Lincolnshire because of accident or injury.[67] In 2012/13, the rate of hospital admissions in the county for children aged 0-4 years, as a result of either unintentional or deliberate injuries, was 147.4 per 10,000 of the under-5 years population, which, statistically, was significantly higher than the England average.[10] The rate for children aged 0-14 years was also statistically significantly higher than the East Midlands and England averages (112.5 per 10,000 population for Lincolnshire, compared with 86.8 for the East Midlands and 103.8 for England).

Across Lincolnshire's CCG areas, the PYLL due to accidents and unintentional injuries are lower than observed nationally, with the exception of Lincolnshire East CCG. The difference between Lincolnshire East and the other CCGs in the county is statistically significant. This is predominantly due to the higher number of people killed on the roads in this part of the county. The number of people killed or seriously injured in road traffic accidents in East Lindsey is amongst the 10% highest in the country, consistent with the fact that, in England, rural districts have higher levels of death and serious injuries through road accidents than urban areas.

Figure 6.1: PYLL from accidents and unintentional injuries, directly standardised rate per 10,000 population in Lincolnshire, 2010/12



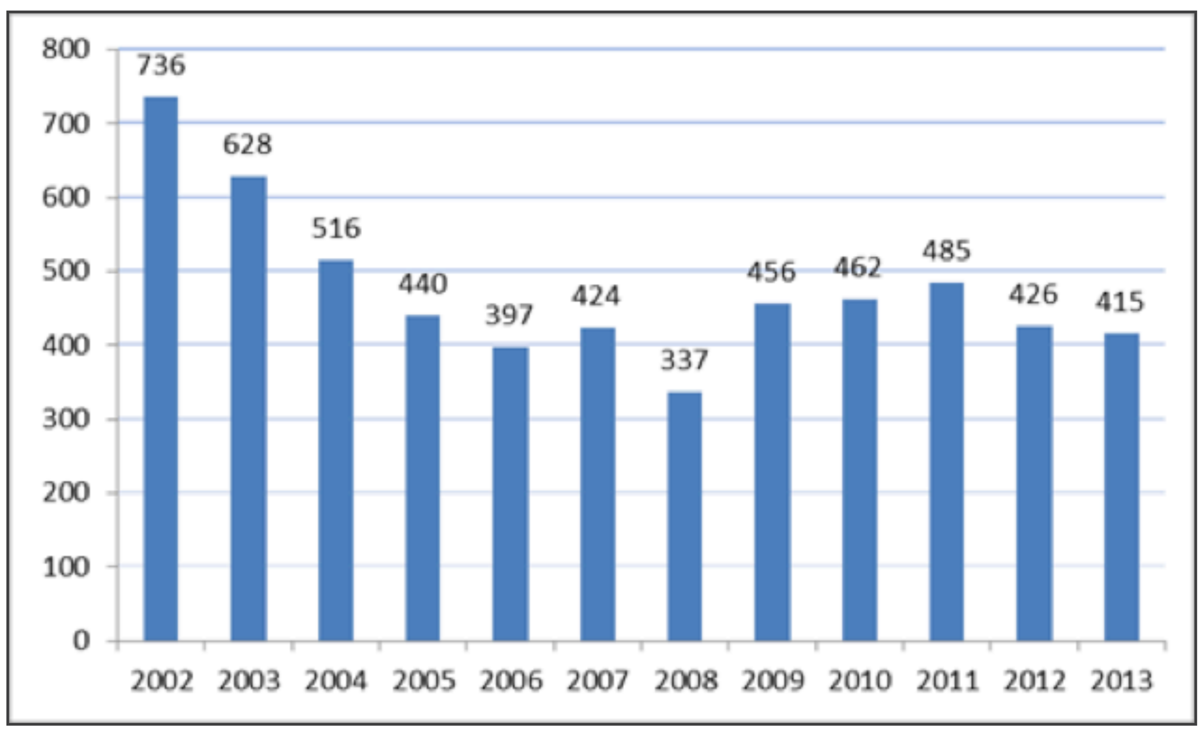
Source: Primary Care Mortality Database, Health and Social Care Information Centre

At lower levels though, the picture is more complicated. Premature mortality is correlated with quintile of deprivation in the county. However, the picture of mortality across the county does not match the recognisable view of deprivation in Lincolnshire. Rather, there is a concentration of mortality from this cause through the centre of the county from north to south, and between Lincoln and Boston. Accidents on the roads are likely to be a cause of this picture, with residents in these areas making the most frequent, potentially hazardous journeys.

Between 2010 and 2012, traffic accidents accounted for around half of the PYLL due to accidents in Lincolnshire: 16 per 10,000 residents, compared to 9 in England and Wales. Thus, PYLL from land traffic accidents in the county was significantly higher than the national average.

However, as shown in figure 6.2, there has been a substantial reduction in the number of people killed or seriously injured (KSI) on Lincolnshire's roads since the 1990s.

Figure 6.2: The number of people killed or seriously injured on Lincolnshire's roads, 1994-2013



Source: Department for Transport

Nonetheless, although there was a year on year reduction in the number of KSIs from 2002 to 2007, this reduction was not sustained. From 2008 to 2011 the number of KSIs increased, but still remained significantly lower than the number of KSIs in the 1994-98 baseline period. More recently, the downward trend has resumed, and early indications suggest this will continue for 2014. Thus, in 2012, there was a 14% reduction in the number of KSIs, with a further 2.6% reduction in 2013. Indeed, 2013 saw only 36 fatalities on Lincolnshire's roads, the lowest figure ever recorded in the county.

There was considerable variation across Lincolnshire in the number of KSIs, as illustrated in figure 6.3.

Figure 6.3: Crude rate of those killed or seriously injured on Lincolnshire's roads in 2012

Area Name	Number killed or seriously injured	Population (thousands)	Number killed or seriously injured per 100,000 population
England	21,626	53,493.7	40.4
Boston	37	64.8	57.1
East Lindsey	106	136.6	77.6
Lincoln	34	94.6	35.9
North Kesteven	64	109.3	58.6
South Holland	69	88.5	78.0
South Kesteven	53	135.0	39.2
West Lindsey	63	90.0	70.0

Source: Department for Transport

Statistically, only South Kesteven and Lincoln had KSI rates significantly lower than the England average. South Holland and East Lindsey had nearly double the England rate of KSIs on the road.

Policy and Strategy

There is a range of specific policies and strategies relating to accident reduction.

In 2014, the World Health Organisation provided guidance for addressing inequities in unintentional injuries.

Nationally, the Department for Transport created a 'Strategic Framework for Road Safety' in May 2011, which suggests a partnership approach to continuing to reduce killed and seriously injured casualties on Britain's roads. There is also a report from the Chief Medical Officer (CMO), 'Our Children Deserve Better: Prevention Pays', which is produced annually, and which focusses on children and young people's health, including death and injury by accidents. Similarly, the Marmot Review, 'Fair society, Healthy Lives', includes specific information relating to accidents. Of the national outcomes frameworks, the Public Health Outcomes Framework includes specific indicators that are relevant.

Locally, the Lincolnshire Road Safety Partnership creates forward strategies and delivery plans to specifically target road accidents. These include ambitious targets, and require partners such as Lincolnshire County Council, the police, Fire & Rescue and the NHS to work together in order to achieve them. 'Road Traffic Collisions' and 'Falls' are both topics of the Lincolnshire Joint Strategic Needs Assessment, the evidence base which informs the Joint Health and Wellbeing Board.

How is Premature Mortality from Accidents Being Addressed?

Evidence shows that many accidents are preventable, but that a strategic and coordinated approach is required at both the national and the local level to reduce avoidable injuries. By preventing accidents, we safeguard people and reduce costs. Ratios for the financial savings brought about by spend on injury prevention include 50:1 for bicycle helmets and 17:1 for smoke alarms.[68]

In 2013, 415 people were killed or seriously injured on Lincolnshire's roads, a lower number than the local improvement target, although clearly every avoidable death and serious injury is a concern. In the same period, 22 children were killed or seriously injured in a road traffic collision in the county, again lower than the reduction target.

Injuries affecting children under five years old, which are most likely to occur at home, can be prevented by the installation of home safety equipment, such as stair gates and window locks, which successfully mitigate the most serious types of injury.[69] There is strong evidence to suggest that an effective, and cost effective,[70] way of reducing avoidable injuries for this age group is through:

- providing targeted home safety assessments,
- installing home safety equipment, and
- offering high quality 'home safety' education.

Many vulnerable families do not purchase home safety equipment for a variety of reasons, including not knowing what equipment to buy or where to buy it, not having the financial resources to purchase equipment, and an assumption that fitting safety equipment is complex.[70]

Lincolnshire Fire and Rescue (LFR) provide home safety assessments, and fit equipment, for households referred to them by Children's Centres. In 2013/14, approximately 350 home safety assessments, and associated provision of home safety equipment, took place across Lincolnshire. Each locality commissions on the basis of available funding, and therefore assessments and fittings are subject to this limitation.

The 'Safe At Home Scheme', led by the Royal Society for the Prevention of Accidents (RoSPA), devolved funding to local areas for the provision of home safety equipment to targeted families. The evaluation of this programme[71] provides a useful source of data on the delivery, costs, effectiveness and acceptability of home safety equipment schemes. Of the families surveyed, 90% were satisfied with the equipment they received, and felt that their home was safer.

Action to reduce premature mortality due to road traffic accidents is led by the multi-agency Lincolnshire Road Safety Partnership (LRSP). LRSP involves the co location of road safety specialists from the police, the County Council and LFR, who work together and share their expertise with the aim of reducing road casualties in Lincolnshire. The safety camera team is also based within the LRSP, which means that all activities relating to road safety education, engineering and enforcement are co ordinated from the LRSP.

LRSP's strategy for road safety is underpinned by the Department for Transport's 'four Es': evaluation, education, engineering and enforcement. The following groups are local priorities:

- young drivers between the ages of 17 and 24 years,
- car drivers, with particular emphasis on business drivers,
- pedestrians,
- riders of two wheeled motor vehicles, and
- pedal cyclists.

The Avoidable Injuries in Children Group is a multi-agency partnership that works to reduce unintentional injuries in children. Key areas of activity include:

- delivering the RoSPA home safety equipment and training sessions;
- communicating safety messages through print and social media; and
- providing advice and information on home safety to professionals.

Next Steps

Evidence from NICE suggests that implementing a range of measures, such as traffic calming and the use of cycle helmets, will reduce the number of people killed or seriously injured on the road. If these measures only halved the number of those killed or seriously injured, Lincolnshire would save £35 million over 10 years, based on Department for Transport casualty costs.

NICE guidance also suggests that the use of home safety equipment, such as stair gates, can significantly reduce the number of accidents in the home affecting children aged 0-4 years. Reducing the number of A&E attendances by 50% would save nearly £350,000 each year in Lincolnshire.

Chronic Liver Disease

The Condition

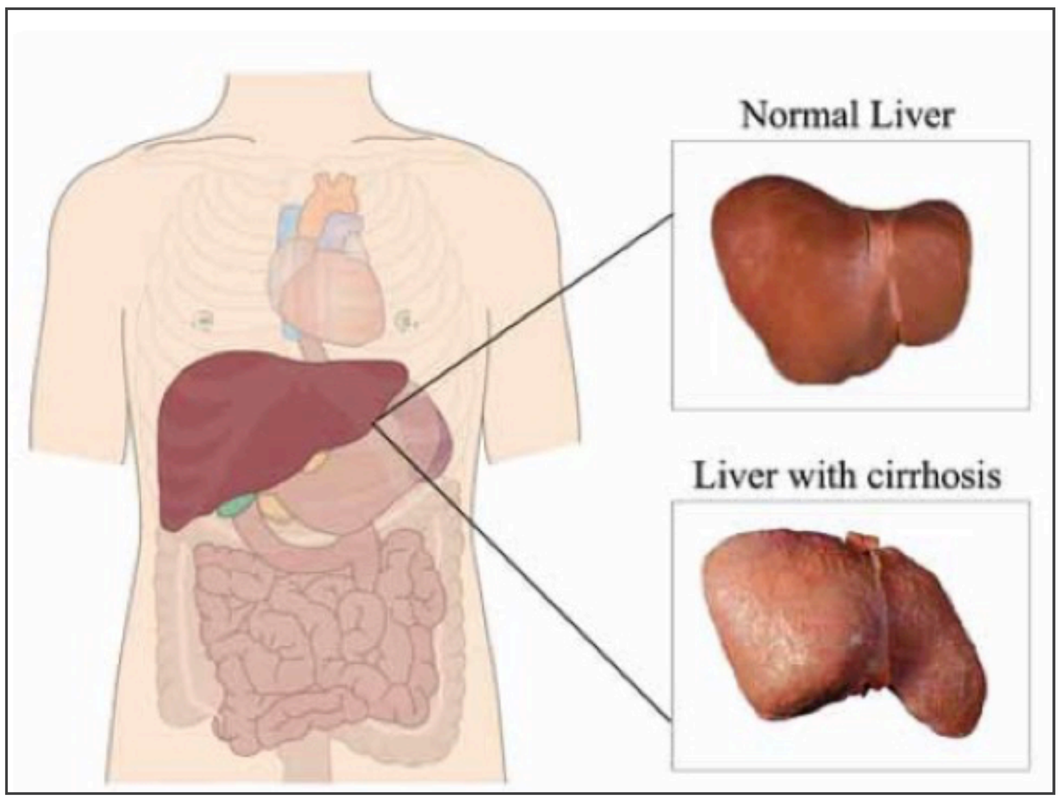
Mortality rates from liver disease in the UK have increased 400% since 1970, and in people younger than 65 years they have risen by almost five-times.[72]

Chronic liver disease is a broad term that covers all the long-term potential problems and diseases that cause the liver to fail in the performance of its designated functions. The liver is responsible for many crucial functions within the body, including filtering toxins from the blood, aiding digestion, regulating blood sugar and cholesterol levels, and helping to fight infection and disease. Loss of liver function can cause significant damage to the body. Liver disease is also referred to as hepatic disease.

The liver is very resilient and is capable of regenerating itself. Each time the liver filters alcohol, some of the liver cells die. The liver can develop new cells, but prolonged alcohol misuse over many years can reduce the liver's ability to regenerate, resulting in serious long term damage.

The liver responds to injury by becoming inflamed, known as hepatitis. Chronic hepatitis describes the condition where the inflammation lasts for a considerable amount of time (over 6 months). Repeated injury prevents new liver cells from being regenerated quickly enough, and scarring, called fibrosis, remains. Simple lifestyle interventions and changes can manage the condition in its early stages, and can reverse some or all of the damage, but, without this, the inflammation and fibrosis can continue to spread, often without symptoms.

Figure 7.1: Diagram showing the location of the liver and its appearance with cirrhosis



Source: British Liver Trust

As chronic liver disease can often progress without symptoms, or with very mild ones, for many people the condition is only discovered during unrelated, or seemingly unrelated, tests. Both the symptoms and the side effects of treatment can have huge impacts though, including discomfort and pain for the patient, and anxiety and depression which can affect the patient and their relatives. Without intervention chronic liver disease can result in significant side effects and can require major treatment and even major surgery. Most patients admitted to hospital with the disease have serious end-stage liver disease, cirrhosis, or liver failure. Patients with end-stage liver disease often require medication to control the amount of protein absorbed in the diet and can suffer lethargy, confusion, or even coma. Diuretic treatments may be required to minimise water retention, and for those with large amounts of fluid in the abdominal cavity, this may need to be removed by syringe using local anaesthetic. Operations may be required to treat portal hypertension and minimize the risk of bleeding.

As chronic liver disease progresses, cirrhosis develops and ultimately there is liver failure. Associated complications may include increased risk of bleeding and infection, malnutrition and weight loss, and decreased cognitive function. Some liver

diseases are associated with an increased risk of developing liver cancer. Liver transplantation is the final option for patients whose livers have failed.

Despite liver disease having many different forms and causes, the three main types are alcohol-related liver disease, non-alcoholic fatty liver disease and viral hepatitis.

Alcohol-related liver disease

Three-quarters of all deaths from liver disease are the result of excess alcohol consumption.[72] In alcohol-related liver disease (ARLD), the liver is damaged after years of alcohol misuse, which can lead to cirrhosis (irreversible damage to the liver). It covers a range of conditions and associated symptoms, although usually few symptoms will be evident until there has been severe damage to the liver. At this point, the sufferer may experience nausea, weight loss, loss of appetite, jaundice, swelling in the ankles and abdomen, confusion, drowsiness and blood in either the vomit or faeces.

Non-alcoholic fatty liver disease

Non-alcoholic fatty liver disease (NAFLD) is a build-up of fat within liver cells, usually seen in people who are overweight or obese, and who do not drink more than the recommended guideline amounts of alcohol. In the early stages, fat accumulates in the liver cells without any inflammation or scarring, but for some people, the disease may progress to cause cirrhosis. Most people categorised as being obese have non-alcoholic fatty liver disease and many, up to 1 in 20 of the UK population, will have ongoing inflammation and scarring which finally leads to cirrhosis. Of those with cirrhosis, 5–10% will get liver cancer.[72]

Viral Hepatitis

Viral hepatitis is inflammation of the liver caused by a viral infection. Some types of hepatitis may pass without causing permanent damage, but other types may persist for many years and cause cirrhosis. In the most serious cases, hepatitis can lead to liver failure or liver cancer, both of which can be fatal. Hepatitis B and C directly cause liver disease.

The hepatitis B virus can be found in blood and in bodily fluids. It is uncommon in this country with most cases being found in certain groups, such as drug users. Most people infected are able to fight off the virus and fully recover within a couple of months. However, small minorities of people develop a long-term infection known as chronic hepatitis B. In some, chronic hepatitis B causes cirrhosis or liver cancer. Chronic hepatitis B is treatable with antiviral medication, and a vaccination is available for preventing hepatitis B.

Hepatitis C is the most common type of viral hepatitis in the UK, affecting around 214,000 people,[73] and caused by the hepatitis C virus. This can be found in the blood and, to a much lesser extent, other bodily fluids of an infected person. Hepatitis C often causes no, or only mild, symptoms, which may be easily mistaken for the flu. Some will fight off the infection and fully recover, but for around three-quarters of those infected, the virus will remain for many years, and may

cause cirrhosis and liver failure. Chronic hepatitis C can be treated with antiviral medication, but there is currently no vaccine for the virus.

Other types of viral hepatitis also exist, including types A, D and E. Around 350 cases of Hepatitis A are reported each year, most of which are contracted abroad, however it is usually a short-term infection, which does not lead to chronic liver disease. Types D and E are both very rare in the UK. Hepatitis D, caused by the hepatitis D virus, is only present in people already infected with hepatitis B. It can increase the risk of developing cirrhosis. Hepatitis E, caused by the hepatitis E virus, is generally a mild and short-term infection, caught through ingestion of contaminated faeces.

Causes and Risk Factors

Alcohol-related liver disease is widespread in the UK, and has been increasing due to rising levels of alcohol misuse. Excessive consumption of alcohol is the major risk factor in ARLD.

Non-alcoholic fatty liver disease is associated with people who are overweight or obese, have a poor diet, and/or are inactive. Therefore, the major risk factors are related to excess weight, poor nutrition and low physical activity levels.

As the hepatitis B virus is found in blood and bodily fluids, it can be spread during unprotected sex, by sharing needles to inject drugs, and by being passed from pregnant women to their babies. The hepatitis C virus is found in the blood and, to a much lesser extent, the saliva and semen or vaginal fluid of an infected person. As it is particularly concentrated in the blood, it is usually transmitted through blood-to-blood contact. In England, it is most commonly spread through sharing needles to inject drugs, which accounts for 9 out of 10 cases.

Facts and Figures

The scale of liver disease in Lincolnshire, as well as across the UK, is increasing due to the increase in the three main causes described. This is in stark contrast to the majority of EU countries, where mortality from liver disease is falling. Between 2001 and 2012, the number of people who died in England with an underlying cause of liver disease rose from 7,841 to 10,948. This represents a 40% increase in all liver disease deaths during this period, and is in contrast to other major causes of disease, which have been declining. Over the last ten years, the rate of mortality in Lincolnshire in those aged under 75 years from all forms of liver disease has increased by around 35%, in line with national trends.

Despite the Lincolnshire average (94.8 hospital admissions due to liver disease per 100,000 people) being lower than the East Midlands (121.8) and England (113) averages, the number of people in the county being diagnosed with liver disease is continuing to rise. According to the latest PHE Liver Disease Profile, the key findings underlying this continuing increase are the correlated rise in people with excess weight (over two-thirds in Lincolnshire) and the number drinking alcohol at increased or higher risk levels (around a quarter in Lincolnshire), leading to 2,013 alcohol-specific hospital admissions in 2012/13.[74] With obesity and alcohol consumption rates continuing to increase, the link to the increase in non-alcoholic fatty liver disease and alcoholic liver disease prevalence is clear.

In Lincolnshire, in the three-year period from 2010 to 2012, more than 200 people under the age of 75 years died specifically from chronic liver disease, accounting for nearly 3% of all premature deaths, with men being twice as likely as women to die prematurely from the disease. It is also estimated that there were nearly 19 PYLL due to chronic liver disease per 10,000 residents, similar to the England average. In both cases, these figures only include recorded mortality from alcoholic liver disease, chronic hepatitis and fibrosis or cirrhosis of the liver.

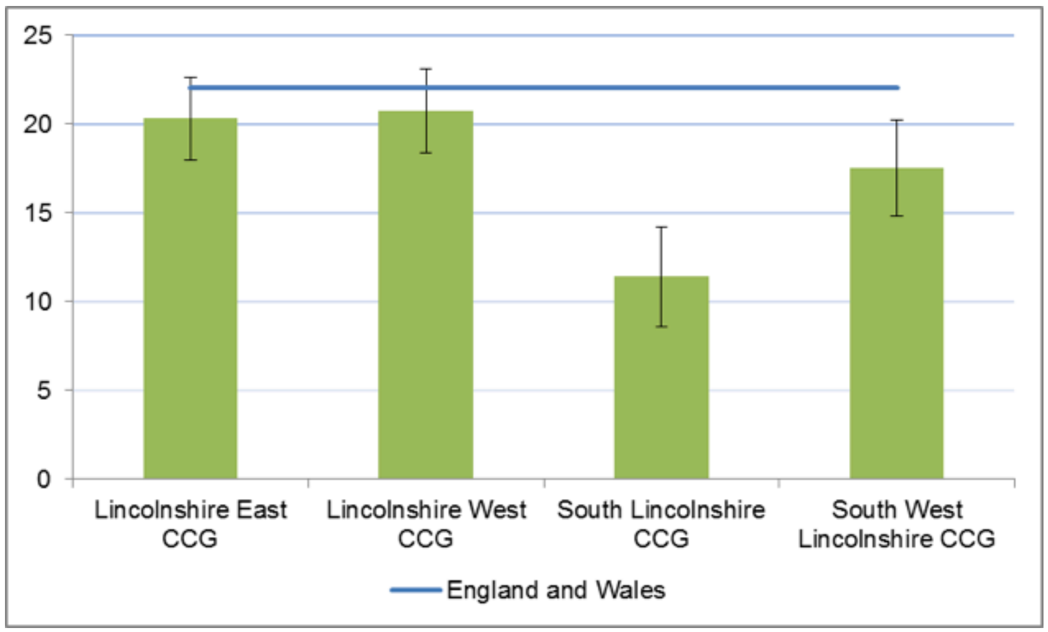
The national implications are serious. It is estimated that liver disease alone costs the NHS £0.5 billion per year, and that this is increasing by 10% year on year. Of liver disease cases, 95% are attributed to poor lifestyle choices, with the other 5% being due to autoimmune conditions.[75]

In Lincolnshire this clearly puts a huge strain on lifestyle services, many of which are working at maximum capacity but only engaging with approximately 5% of the population need. Furthermore, drug and alcohol services in the county are seeing an increase in referrals year on year. This highlights the importance of brief interventions and educating individuals about the risks of unhealthy behaviours and, more importantly, how they may self-manage these issues. Each year, the NHS sees 94.8 hospital admissions per 100,000 population for Liver Disease, which Lincolnshire cannot sustain in the current financial climate and health profile of the county.

Within the county, PYLL due to chronic liver disease in Lincolnshire East and Lincolnshire West CCGs is similar to the national level. However, in South West Lincolnshire CCG and South Lincolnshire CCG levels are lower. South Lincolnshire CCG has rates of PYLL just above half the national level, and significantly lower than any other CCG in Lincolnshire. Alcohol-harm indicators of mortality and hospital admission are lower in the districts in the south of the county (South Holland and South Kesteven) than in other districts in Lincolnshire, impacting upon the figures for these CCGs.

Although Lincolnshire is relatively less deprived than average, there are still large areas of deprivation along the coastal strip, and in areas such as Lincoln, Boston, Grantham and Gainsborough, which are associated with higher levels of increased-risk drinking, drug use and obesity.[34] There are also pockets of rural deprivation in the county. Whilst these issues are clear risk factors in chronic liver disease, premature mortality from this cause is not clearly correlated with deprivation, reflecting the fact that this disease affects those from a wide range of backgrounds and environments.

Figure 7.2: PYLL from Chronic Liver Disease, directly standardised rate per 10,000 population in Lincolnshire, 2010/12



Source: Primary Care Mortality Database, Health and Social Care Information Centre

Policy and Strategy

National policies and strategies in relation to obesity, physical activity, alcohol and drugs all partially address the issue of liver disease although, as yet, there is no national liver disease policy.

The NHS five-year forward plan highlights the major risk factors of obesity and alcohol, and the strain on the NHS of treating related conditions. It draws attention to the importance of prevention in tackling health inequalities, and of empowering and motivating individuals to improve their own health.

Locally, there are no NHS targets relating to adult obesity. However, the government's 'Call to Action on Obesity' does address the major risk factor for non-alcoholic fatty liver disease. The Lincolnshire Joint Strategic Needs Assessment (JSNA) obesity topic highlights the importance of physical activity, weight management support and improved access to healthier food and healthy eating, as determinants of obesity. The Joint Health and Wellbeing Strategy (JHWS) for Lincolnshire also highlights the Council's aims regarding obesity, physical activity, alcohol consumption and illegal drug use. The strategy describes how these aims will be achieved, using a multi-disciplinary approach, through locally-developed networks and partnerships.

The government's alcohol policy highlights the need for local support for individuals and organisations in tackling the associated issues of alcohol misuse, the major risk factor associated with alcohol-related liver disease. The government's strategy, 'Reducing Demand, Restricting Supply, Building Recovery: supporting people to live a drug free life' will help to tackle the viral causes of the spread of hepatitis.

Locally, Lincolnshire's drug and alcohol strategy promotes responsible drinking to prevent alcohol- and drug-related harm, tackles alcohol- and drug-related crime and anti-social behaviour and aims to deliver high quality systems for alcohol- and drug-misuse treatment.

How is Premature Mortality from Chronic Liver Disease Being Addressed?

Public Health commissions services and works closely with local partners and providers to reduce the prevalence of liver disease and its related causes. These activities include a number of those detailed in appendix 1, such as Weight Watchers, local cooking and growing sessions, physical activity programmes (Vitality, Exercise Referral, and Health Walks) and the Health Trainer Scheme.

In addition to the work relating to obesity and physical activity, alcohol-treatment services have seen an increase in numbers, from 845 to 1,320 (56%) in Lincolnshire between March 2012 and March 2014. PHE also announced in October that there had been a national increase of over 5% in people accessing treatment services nationally.

The five-year Lincolnshire Alcohol and Drug Strategy 2014-19, coordinated by Public Health, has a partnership-wide delivery plan, which incorporates the themes of prevention, enforcement and treatment. This is supplemented by other work, such as 'It's that easy' (providing alcohol-prevention work in schools), the 'Pharmacy Project' (a pilot initiative on alcohol screening and intervention based in

pharmacies) and the 'Blue Light Project' (looking to improve the techniques and approaches used with treatment-resistant problem drinkers). The Alcohol Concern initiative 'Dry January' is also supported locally, and ongoing screening for, and vaccination against, hepatitis C and B respectively is carried out by treatment services across the county.

Lincolnshire's NHS Health Check programme provides NHS colleagues with an opportunity to promote the benefits of a healthy lifestyle, and to recommend changes the patient may need to make in relation to liver-disease-related risk factors. Public Health continues to work more generally with partners to develop a culture of health and wellbeing.

Next Steps

The evidence on the risks of liver disease and its three main causes is clear, and it is important that services tackle these issues in order to reduce overall liver disease prevalence, and the PYLL through this cause. As services develop, and the health profile of the county continues to change, it is imperative that Public Health continues to work across organisations to provide the best possible results for local residents. This includes working with Lincolnshire's NHS Trusts, Local Authorities and associated stakeholders, private organisations (such as pharmacies), CCGs, and the voluntary community sector. This approach will improve the impact of key health messages delivered to the public, and reinforce messages. This approach will also ensure that those who need support are able to access local services.

Chronic liver disease is largely preventable; 95% of cases are attributable to poor lifestyle. Therefore, future work must continue to look at developing lifestyle services, as well as continuing to support those that already exist. Further analysis on liver disease in Lincolnshire will be carried out this year to inform public health prevention and early intervention work, building on the evidence base of the Alcohol Health Needs Assessment.

It is clear that, both nationally and within Lincolnshire, issues related to liver disease and its causes need to be tackled. In part, this will be done by continuing to deliver support services which enable individuals to make healthy lifestyle changes. Local organisations must also be clear about what messages need to be delivered to the public, taking into account why individuals and populations continue with unhealthy behaviours. These services and key health messages will be delivered across the county, with particular emphasis on areas with a high prevalence of liver disease. It is also vitally important that we provide the public with consistent health messages across different organisations, including across the voluntary sector. This will ensure that messages and services are aligned with Public Health's aims and objectives, and that more of the "hard to reach" population have access to help and support, enabling individuals to address issues before they progress to requiring admission to hospital.

It is important that Public Health continue to work with the NHS and CCGs to develop and deliver strategies aimed at reducing obesity, drug- and alcohol-misuse, and raising awareness of the risks of hepatitis.

Recommendations

- Multi-agency work in Lincolnshire should continue to address lifestyle and behavioural factors, such as smoking, obesity, physical inactivity and drug- and alcohol-misuse.

- The number of brief interventions given across organisations in Lincolnshire should be increased, whilst ensuring that MECC is systematically embedded. This will enable advice and intervention to be provided opportunistically and where appropriate, and will allow health messages to reach more individuals more often. This will also improve signposting across organisations, and improve the public's experience.

- Where appropriate, lifestyle interventions should be tailored to individuals with specific conditions and early indications of disease.

- Partners should work together to facilitate the early identification of risk factors through increased uptake of periodic NHS health checks. Although health check uptake is above the national level, participation figures remain low. Work is needed at GP level and county level to offer health checks to the eligible population, and to encourage uptake of appointments.

- It must be ensured that individuals identified by the health check as having, or being at risk of developing conditions related to premature mortality are appropriately followed up in general practice, and that they receive appropriate lifestyle and pharmacological interventions or onward referral.

- Work should be undertaken with CCGs to increase the number of people on specific disease registers, such as the COPD register, closing the gaps between the number of people who suffer from conditions and those recorded on registers. This could include raising public awareness of signs and symptoms, encouraging those living with conditions to enquire whether they are on a GP disease register, and workforce development, such as more training for staff in primary care in order to increase the proportion of people receiving early and accurate diagnoses.

- Work should be done to improve the management of long-term conditions (LTCs). Many people with conditions such as COPD report that it limits their daily living, particularly when they have an exacerbation of their disease. GP practices should work with pharmacies to ensure that patients are targeted for Medicines Use Reviews, as this can improve management of LTCs. Commissioners must ensure that they are commissioning high quality services targeted at LTCs, including nurse-led community teams and rehabilitation programmes.

- Systematic care pathways are required for LTCs, in line with the Lincolnshire Joint Health and Wellbeing Strategy. The use of care pathways developed elsewhere, such as 'map of medicine' for COPD, should be increased to support timely diagnosis and effective treatment.

- Lincolnshire Public Health should work closely with Clinical Commissioning Groups to deliver the Lincolnshire Tobacco Control Strategy, assisting tobacco users to quit.

- Lincolnshire Public Health should continue to promote the benefits and opportunities available for physical activity across all age ranges of the population.

- Work should continue through specific initiatives, and with partners such as NHS England, to further improve the uptake of cancer screening programmes.

- There should be further focus on early cancer diagnosis through work with health professionals and the public.

- NHS commissioners should continue to work with providers of healthcare to enable people to receive the best outcomes in cancer treatment and care.

- Monitoring of suicide and death by undetermined causes across the county should continue; the resulting evidence enabling us to work better with partners to address causes, and deliver interventions and pathways that could save lives. This should include the development of a suicide surveillance system, incorporating appropriate information sharing and reporting.

- More people should be trained through the SafeTALK and ASIST programmes, working closely with commissioned providers and raising awareness of how to talk to someone who you think might be at risk of suicide.

- Lincolnshire Public Health should work with a full range of organisations to create an action plan for suicide prevention, working together to better provide people with the help they need, and making sure that frontline staff have the skills and information to help people at risk.

- The proportion of 'at risk' patients receiving pneumococcal vaccination should be increased. It is important that the individuals at greatest risk, including smokers, substance misusers and those with LTCs receive pneumococcal vaccination. Both the development of initiatives to engage vulnerable groups, and working with service providers to raise awareness of the importance of PPV vaccination, could contribute to this.

- Local data sharing on road collisions should be improved, particularly around trend and causation data, to supplement intelligence gained from Stats19, and allow a more accurate picture to be drawn. Stats19, the Department for Transport's collision statistics, are generally believed to underreport the number of road collisions, however, an accurate understanding is crucial in identifying and directing effective road safety interventions.

- A home safety assessment scheme which targets vulnerable families should be commissioned, as it is recognised that many do not purchase home safety equipment. This could include providing targeted home safety assessments in partnership with Lincolnshire Fire and Rescue, home safety equipment installation for those financially unable to purchase equipment themselves, and high quality 'home safety' education.

- Public awareness of liver disease, its causes, and associated risks to life and quality of life should be improved. If people chose to follow a healthy lifestyle of not smoking, being a healthy weight, being physically active and not drinking to excess, they could potentially add 14 years of chronological age at death.[76]

- The multi-agency Alcohol and Drug Strategy should be implemented, including primary prevention and systematic use of brief interventions, such as NHS Health Checks.

- Further analysis on liver disease in Lincolnshire should be carried out to inform public health prevention and early intervention work, building on the evidence base of the Alcohol Health Needs Assessment.

Appendix 1: Intervention Matrix

Interventions		Cause of premature mortality					
		Cancer	Circulatory disease	Suicide and undetermined causes	Respiratory disease	Accidents and unintentional injuries	Chronic liver disease
Weight Management Programme	A weight-management service for people with a Body Mass Index of 30+.	✓	✓				✓
Physical Activity Programmes	A range of programmes that support people to participate in physical activity (for example, Exercise on Referral and Health Walks).	✓	✓				✓
Smoking Cessation and Tobacco Control Programmes	A range of programmes, such as those designed to help tobacco users to quit and reduce people's exposure to second-hand smoke.	✓	✓		✓		
Food and Nutrition Programmes	A range of programmes that support people to eat a 'healthy' diet (for example, community growing and cooking schemes).	✓	✓				✓
Alcohol Reduction Programmes	A range of programmes that aim to promote responsible drinking, prevent alcohol-related harm and deliver alcohol-treatment systems.	✓	✓	✓		✓	✓
Making Every Contact Count	A programme that uses opportunities to talk to individuals about improving their health and well-being.	✓	✓	✓	✓		✓
Health Trainers	A service that works with those in circumstances which put them at risk of poor health.	✓	✓	✓	✓		✓

Interventions		Cause of premature mortality					
		Cancer	Circulatory disease	Suicide and undetermined causes	Respiratory disease	Accidents and unintentional injuries	Chronic liver disease
NHS Health Check Programme	A programme that aims to prevent heart disease, stroke, diabetes, kidney disease and certain types of dementia through the carrying out of a risk assessment and provision of appropriate interventions.	✓	✓		✓		✓
Home Safety Programmes	A range of programmes that promote home safety (for example, safety assessments, installation of equipment, and education).					✓	
Road Safety Programmes	A range of programmes that promote road safety (for example, education and enforcement).					✓	
Immunisation and Vaccination Programmes	The provision of vaccines as part of the NHS vaccination schedule (for example, the HPV vaccine).	✓			✓		✓
Suicide Prevention Programmes	A range of programmes that address the prevention of suicide (for example, training to identify signs and symptoms).			✓			
Promoting Symptom Awareness Programmes	Programmes to help individuals and professionals identify signs and symptoms of disease, thus enabling early diagnosis (for example, the Early Presentation of Cancer (EPOC) programme).	✓					
Cancer Screening Programmes	Three national cancer screening programmes are delivered by the NHS (breast, cervical and bowel).	✓					

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The Annual Report of the Director of Public Health on the Health of the People of Lincolnshire 2014 is available on the Lincolnshire County Council website at
www.lincolnshire.gov.uk/residents/public-health
It can also be found on the Lincolnshire Research Observatory website at **www.research-lincs.org.uk**

I hope you enjoy reading this report and find something in it which will enable you to take action to improve the public's health. We would be more than happy to arrange for a member of Public Health to present further on this report. If you or your organisation would like additional information or discussion, please contact us on 01522 552902 in the first instance.

Lincolnshire County Council Public Health
County Offices
Newland
Lincoln
LN1 1YL

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LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of Gary Thompson Chief Operating Officer South CCG and Glen Garrod Director of Adult Social Services

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**24 March 2015**
Subject:	**Joint Commissioning Arrangements in Lincolnshire**

Summary:

This paper describes the organisational structure and reporting lines that support joint commissioning arrangements in Lincolnshire between health and social care partners.

Actions Required:

1. For Members of the Health and Wellbeing Board to note and comment on the report.
2. To consider how best the Health and Wellbeing Board can support these arrangements in progressing a central requirement on the Board itself: that is to further closer working/integration between health and social care.

1. Background

It is important to remember that joint commissioning arrangements have been in place for many years. Such arrangements as existed prior to 2013 were typically specific to a particular agreement – often a 'Section 75' agreement - in which a formal pooled budget or transfer of functions existed between health and social care and which required a governance structure. Two particular examples are the Section 75 agreement that exists between the County Council and Lincolnshire

Partnership Foundation NHS Trust (LPFT) for the delivery of Adult Mental Health services commissioned by Adult Care. Another is the integrated commissioning of all Learning Disability services for adults across both health and social care undertaken by Adult Care. Both of these arrangements were framed by a legal; agreement approved by relevant executive bodies and overseen by a Governance Board. These formed a patchwork of joint commissioning arrangements. The Integrated Community Equipment Service (ICES) is a further example.

There existed also other and similar arrangements for joint planning, the development of joint strategies and to oversee '256 agreements' – another vehicle for transferring funds for one organisation to another for the delivery of a particular function eg. carer or advocacy services.

By the end of 2013 Lincolnshire Health and Care (LHAC) and the Better Care Fund (BCF), then called the Integration Transformation Fund were two specific influences that required a greater degree of joint organisational structures across health and care organisations. Without a joint commissioning infrastructure the operationalization and oversight of key activities would be disjointed and ultimately dysfunctional.

It should also be noted that similar structures exist across the Country and largely represents similar influences. There are more evolved structures that pre-exist the BCF or indeed LHAC but these tend to be in areas where health and social care were integrated when Primary Care Trusts were created.

As such joint commissioning is not new. At the end of 2013 it became clear that in order to organise around the growth in jointly managed service arrangements, the support required for LHAC and, particularly the BCF that a more comprehensive set of joint commissioning arrangements were necessary. For want of a better phrase this can be interpreted as a senior operational arm of the Health and Wellbeing Board (see attached Appendix A).

What is important to remember is that this infrastructure seeks to make operational sense of a mixed set of influences that derive from either national (BCF) or local initiatives (LHAC). It is also a critical vehicle for managing working relationships across a large number of organisations.

The structure and configuration of Joint Delivery Boards was heavily influenced by LHAC (eg. Proactive Care and Womens and Children's) and was reported to both the Executive/Informal Executive of the County Council and the Health and Wellbeing Board on several occasions during 2014 – most notably as part of previous BCF submissions. The last of these was to Health and Wellbeing Board in December 2014 and the Informal Executive in January 2015. The 4 CCGs have received the same reports throughout the period.

The Joint Commissioning Board and the Joint Delivery Boards have agreed Terms of Reference as do the LHAC Stakeholder Board and the BCF Task Group.

These arrangements will also help monitor progress at an operational level throughout 2015/16 to ensure appropriate levels of oversight of BCF performance

which is a collective endeavour – health and social care. It has already been agreed that the Health and Wellbeing Board will receive a monitoring report at each quarter during 2015.

2. Conclusion

Joint commissioning is not new. However, what is new is the growth of joint commissioning. An infrastructure that manages the consequences of national and local initiatives surrounding increasingly joint working across health and social care agencies has been developed during 2014. It continues to evolve. These arrangements seek to 'make sense' of what would otherwise be a fragmented and dilute set of ad hoc arrangements to manage the work. The resulting Joint Commissioning infrastructure sits within but does not alter the existing Governance structures of the 4 CCGs or, the County Council. Neither do they change the decision-making arrangements that preceded them.

3. Consultation

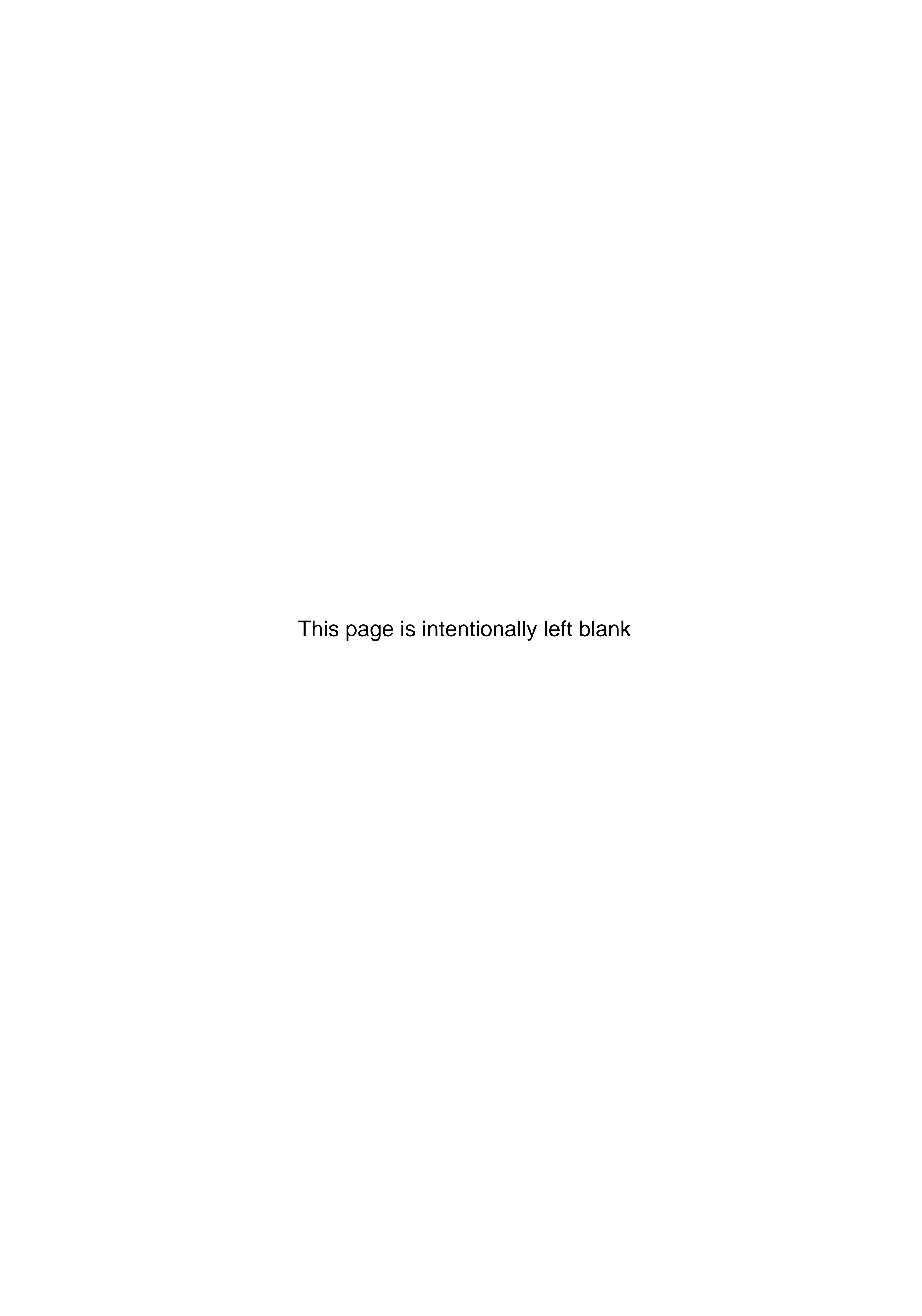
4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Organogram of Joint Commissioning Arrangements 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 Glen Garrod, who can be contacted on (01522 550808) or (Glen.garrod@lincolnshire.gov.uk)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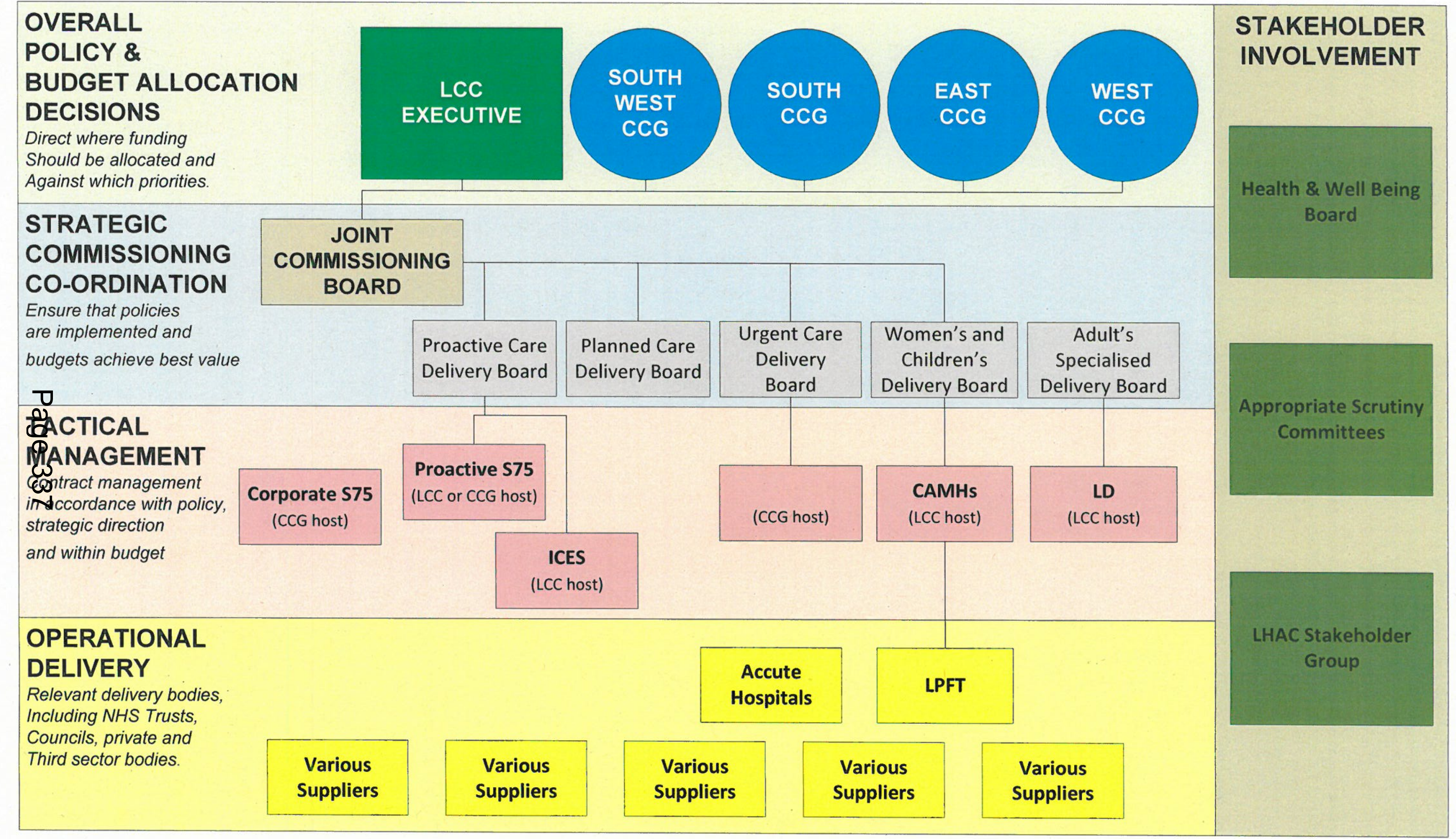
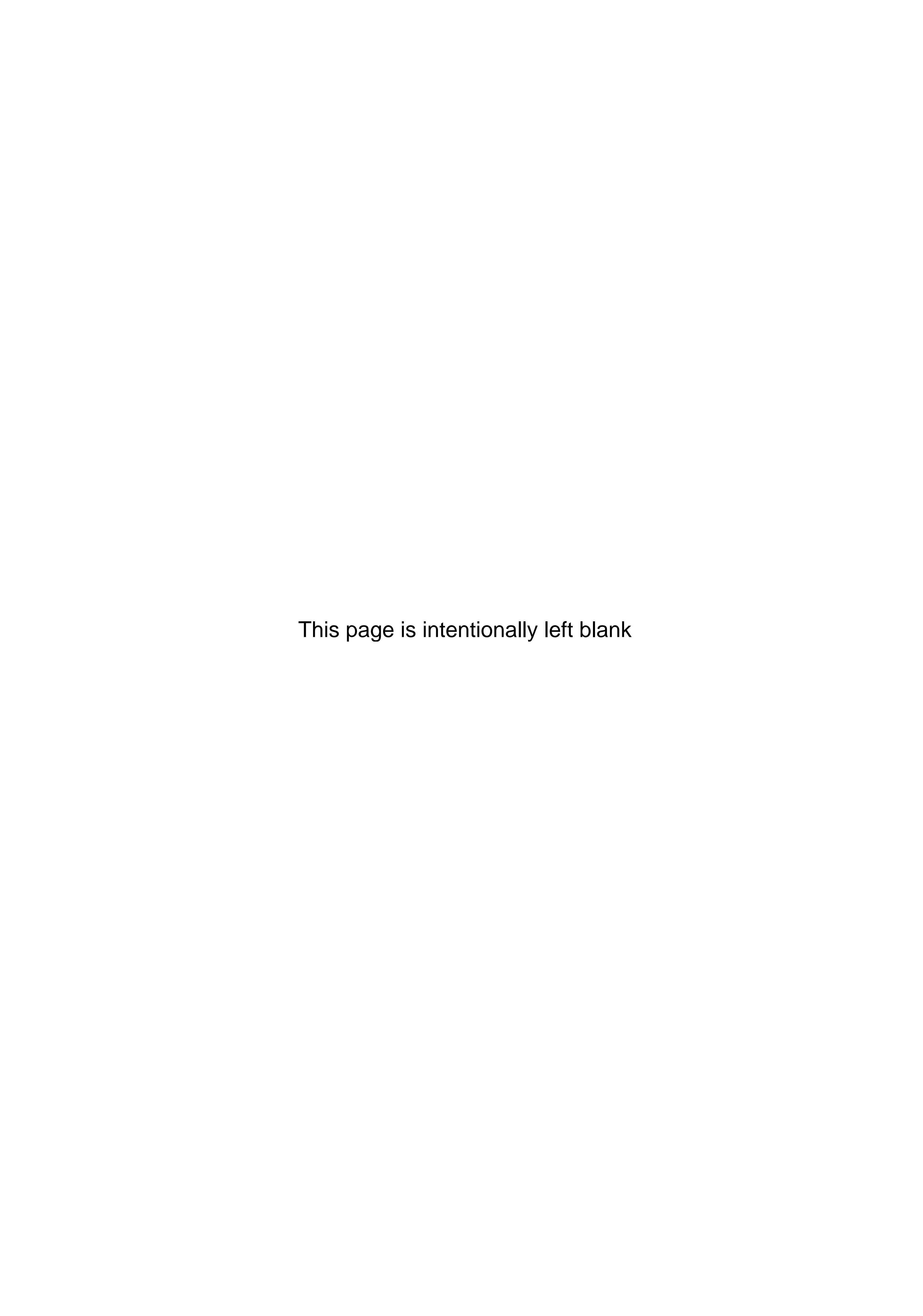

LHAC, BCF AND OVERALL GOVERNANCE ARRANGEMENTS
OVERALL POLICY & BUDGET ALLOCATION DECISIONS
Direct where funding Should be allocated and Against which priorities.
LCC EXECUTIVE
SOUTH WEST CCG
SOUTH CCG
EAST CCG
WEST CCG
STRATEGIC COMMISSIONING CO-ORDINATION
Ensure that policies are implemented and budgets achieve best value
JOINT COMMISSIONING BOARD
Proactive Care Delivery Board
Planned Care Delivery Board
Urgent Care Delivery Board
Women's and Children's Delivery Board
Adult's Specialised Delivery Board
TACTICAL MANAGEMENT
Contract management in accordance with policy, strategic direction and within budget
Corporate S75 (CCG host)
Proactive S75 (LCC or CCG host)
ICES (LCC host)
(CCG host)
CAMHs (LCC host)
LD (LCC host)
OPERATIONAL DELIVERY
Relevant delivery bodies, Including NHS Trusts, Councils, private and Third sector bodies.
Accute Hospitals
LPFT
Various Suppliers
Various Suppliers
Various Suppliers
Various Suppliers
Various Suppliers
STAKEHOLDER INVOLVEMENT
Health & Well Being Board
Appropriate Scrutiny Committees
LHAC Stakeholder Group



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LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of
Dr Tony Hill, Executive Director of Community Wellbeing and Public Health

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**24 March 2015**
Subject:	**Review of Processes for Lincolnshire's Joint Strategic Needs Assessment (JSNA)**

Summary:

To provide the Health and Wellbeing Board with an overview to the upcoming review of content, processes and methodologies underpinning the Joint Strategic Needs Assessment (JSNA).

This briefing paper comprises a description of the scale of review, resources required and some indicative timescales for the review process

Actions Required:
The Health and Wellbeing Board is asked to:

1) Note the content of this report
2) Understand the scale, scope and timescale of the whole JSNA review
3) Provide any comments and feedback

1. Background

The notion of a Joint Strategic Needs Assessment (JSNA) was first introduced by the Department of Health's report Commissioning for Health and Wellbeing. Subsequently the Local Government and Public Involvement in Health Act (2007) has made the JSNA a requirement for which the Directors of Public Health, Adult Social Services and Children and Young People's Services are jointly responsible.

The key features of the JSNA are that it is:

- Joint:

Providing a framework for communities, local government and the NHS to work together in partnership

- Strategic:

Using shared sources of evidence to identify what matters most to local people, solutions that work and gaps that need to be filled

- A Needs Assessment:

Based on people's wants and needs, regardless of what has gone before, including unmet needs.

The results of the JSNA should be published in a concise report which will summarise the needs of the community and act as a reference point for subsequent planning.

Since April 2012 it has been a statutory responsibility of the Lincolnshire Health and Wellbeing Board (H&WB). Currently, topics are added and removed using the process outlined in the JSNA procedures (see Appendix A). The procedures are due for review. Therefore, we are taking this opportunity to initiate a deep dive into the wider procedures, format, content and processes around the JSNA.

In its current format, the JSNA is constructed through 35 individual topics that consider very specific areas. There is a timetable documenting when each topic is due for update, with an expectation that each topic will be updated by the relevant topic owner annually.

The current format of the JSNA has been in place since 2011. It has been recognised that improvements could be made.

Funding secured in 2011 supported further development of JSNA provision through the Lincolnshire Research Observatory (LRO) in 2011/12. This provided an improved interface that enabled users to access information more easily. The look and feel of all JSNA areas on the LRO, including improved navigation, were completed by 30 March 2012. Improvements were then used to benefit the rest of the LRO website throughout the rest of 2012.

2. Conclusion

Timescales:

Date	Action
Jan 2015 – Mar 2015	Agreement to scope of the review of the JSNA
Apr 2015 – Dec 2015	Carry out review (to include review of work associated with objectives set out in the project brief and the wider engagement with stakeholders)
Jan 2016 – March 2016	Consult on findings and agree recommendations for refresh of JSNA with HWB
Apr 2016 – Mar 2017	Implement recommendations through refreshing and updating the JSNA, including its presentation (ie. The web presence and functionality)
April 2017 – June 2017	Consult and agree priorities resulting from refreshed JSNA
Jul 2017 – Dec 2017	Carry out consultation on refreshed Joint Health and Wellbeing Strategy (JHWS) including stakeholder engagement in the process
Jan 2018 – Apr 2018	Finalise and publish JHWS for 2018 – 2023 to coincide with existing JHWS coming to an end on 31/3/18

These timescales are indicative and will be firmed up in the early development stages, with an ultimate aspiration to ensure we use this opportunity to fundamentally improve the processes to demonstrate the impact of the JSNA, and to develop a mechanism to fully engage with stakeholders.

Objectives

- To maintain and enhance the content of the Joint Strategic Needs Assessment for Lincolnshire and to ensure it continues to remain in the vanguard regionally for this
- To enhance the current systems and processes associated with the Lincolnshire JSNA
- To increase the awareness and usage of the JSNA to inform commissioning decisions across the county
- To set up a process to periodically monitor and track how the JSNA is used in other areas of work. For example commissioning and service planning
- To enhance the involvement of the Voluntary and Community Sector (VCS) in the development and compilation of the JSNA
- To utilise the findings of the Joint Strategic Asset Assessment (JSAA) to further enhance the JSNA and empower the Voluntary and Community Sector
- To help secure the best possible outcomes for the people of Lincolnshire

Scope
In the first instance this will look at the criteria an area of health (and related subjects) must meet in order for it to be included as a 'topic' in the JSNA. Time will be spent assessing the relevance of the current topics and considering if they continue to be the right topics. Furthermore it will consider if value could be added by grouping topics under broader headings or integrating further with other areas of the LRO website. Aligned to this, there will also be work undertaken to explore the case for new topics to be added to the JSNA. It will be important to assess where and how data and topics could be strengthened through cross referencing.

In 2011 the commitment was made in the JSNA overview report that future iterations of the JSNA would become more 'asset focused'. It is proposed this review will also evaluate the potential for information linked to community assets to be included within the format.

The proposal to review the JSNA and implement required changes will be dependent on resources, finance, data and technology available. The review may call upon the time of staff from other from other service areas.

3. Consultation

In addition to the review of the JSNA content, it will also be important during 2015/16 to look at stakeholder engagement with the JSNA. From the Voluntary and Community Sector (VCS) to commissioners across the partnership, it is important that the role of each stakeholder group is understood in the context of the JSNA, including trying to ensure the JSNA can meet their needs.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	JSNA Procedures

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 Lisa Loy who can be contacted on (07787151128.) or lisa.loy@lincolnshire.gov.uk

Appendix A: JSNA Procedures

Who is this for?

This document is intended for use by the authors of Joint Strategic Needs Assessment topic commentaries and their nominated Performance and Development team lead. In some cases the author of the commentary will be the topic owner, however in many instances this is not the case; this document may also be of use therefore when the commentary 'writing team' are liaising with topic owners about the update process.

Everything included here is a suggestion to encourage some consistency across all JSNA topics. It is down to the experts themselves to decide the approach that best fits their needs.

What should we consider?

Listed below are some areas that topic authors, leads and nominated support colleagues should consider when they are in the process of reviewing their topic commentary.

It is important to bear in mind that when a topic is being reviewed for update this does not necessarily mean that the whole commentary needs to be re-written, in fact there may be no changes required at all.

If the below suggestions are looked at and the commentary is found to be as up to date as it can be, that in itself is an acceptable conclusion. Only update commentaries if you are improving what already exists.

JSNA Commentary Template

The templates used for JSNA commentaries are split into two overarching sections:

- What do we know? And
- What is this telling us?

The 'What do we know' section has five suggested sub-headings looking at the current provision, current data (and it's limitations) projections for short, medium and long term trends and forecasts. Also any performance targets or outcome measures applied to the topic are defined along with a summary of how performance is doing against these targets. Therefore this section is the presentation of factual evidence.

The 'What is this telling us?' section contains nine sub headings which begin to look at local views and national strategies, and known gaps or inequalities linked to services and the risk associated with doing nothing to change provision. The last two sections cover what developments should be expected in the future and what the priorities should be over the coming year. Overall this section is much more linked to opinions derived from wider engagement and expert opinion.

Appendix A: JSNA Procedures

Other Things to Consider

CCG Priorities

Is this topic reflected within any CCG profiles as a particular area of concern or best practice? If so it may be worth looking into the value of highlighting this within the overall commentary to ensure local inequalities are highlighted any best practice is shared with a wider audience.

Current Data and the Commissioning Cycle

Look at all of the data currently shown on your topic page of the LRO; is this information still relevant? Is it clear? Is it referenced within the current commentary? What else may be of use?

If it is easier; think about the current data set in terms of the commissioning cycle shown below:

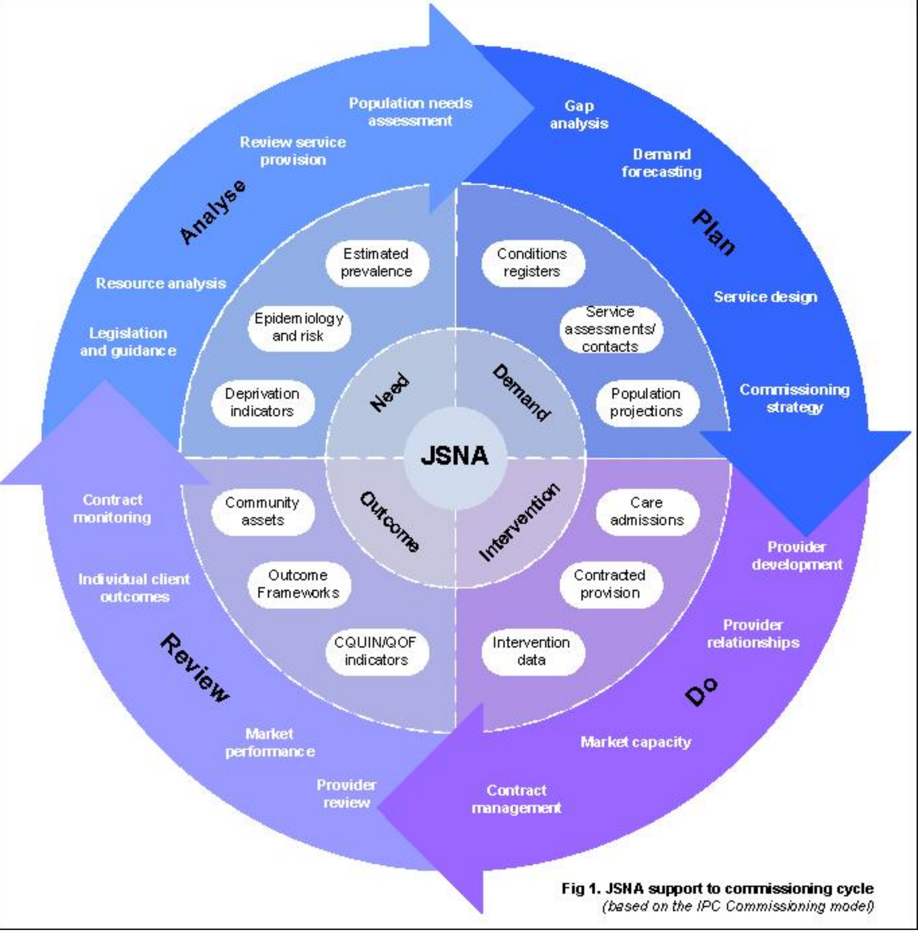


Fig 1. JSNA support to commissioning cycle
(based on the IPC Commissioning model)

Has your topic got data sets which will cover all four quarters of this diagram or is it heavily weighted towards one or two parts?

Work out if data exists that might help you to fill any gaps. If data does not currently exist then speak to any relevant experts linked to the topic to establish if data could be collected to fill these gaps; it is important that the commentary goes on to talk about gaps in data in the same way that it would talk about gaps in provision.

Another way that some people may find it easier to look at data sets is to work out whether what is available covers need, demand and provision. Again, if there is a strong bias towards one of these areas, ensure that your commentary references this and any actions that need to be taken to try and resolve it:

Appendix A: JSNA Procedures

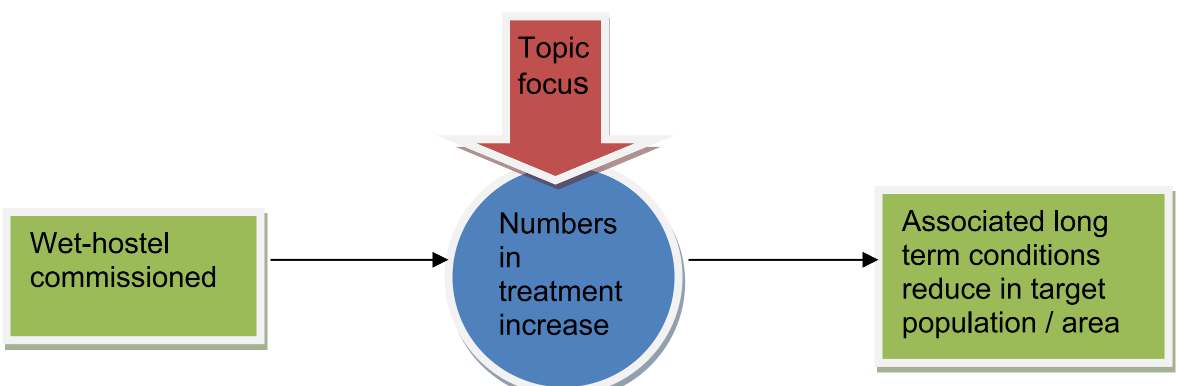
It is not the job of the topic commentary to resolve data gaps; it should bring together what exists already but if data is not there in the first place this should make up part of the subsequent recommendations / action planning.

Cross Cutting Themes

It is very easy to get blinkered by just looking at the topic in question when compiling a commentary but it is important to assess what other issues, topics, themes or priorities may have an impact on your area of focus. In exactly the same way it is also useful to consider what issues, topics, themes or priorities may feel the impact of any work undertaken in your area.

One example of this is:

> *Commissioning a wet-hostel to tackle homelessness particularly for dependant drinkers may have the knock on effect of engaging more people into treatment services, this increased uptake of alcohol treatment may then help to reduce long terms conditions in the population in question (cirrhosis of the liver etc.) which will in turn reduce primary and secondary care burdens.*



Thinking about topics in their broadest sense may help to avoid the duplication of efforts, increase shared evidence bases and in the longer term, facilitate joint commissioning work where gaps are identified across multiple areas.

Linked Strategies

This is fairly self-explanatory and in a lot of ways links to the previous section, however it is important that any and all strategies that may be linked to your topic are referenced accordingly. This will mean that you don’t have to repeat what has already been done and help the JSNA pages of the LRO to become a ‘one stop shop’ for all linked information sources.

Engagement

Hard as it is to believe – it’s not all about the numbers! Talk to key stakeholders about any engagement activity that has been done that may be of relevance to your topic. Any

patient reported outcomes (often referred to by acronyms such as PROMS or TOPs) could also be of use here.

Also any anecdotal feedback or intelligence from frontline staff or key stakeholders can be invaluable.

Depending on how much time you have to complete your work it could be worth looking into the viability of one or two expert panel events, these will help you test the validity of your data with the people who know best, guidance for which can be found here:

Peer Review

The peer review process is designed to ensure topic commentaries meet agreed set quality criteria.

The role of the Peer Reviewer is to provide independent expert critical appraisal of topic commentaries against the criteria set out in section 3.2 of the JSNA procedural guidance. This is to ensure commentaries meet accepted quality standards and prevent the dissemination of irrelevant findings, unwarranted claims, unacceptable interpretations, and personal views.

The peer review process will be co-ordinated by the Performance and Development Team, as part of the topic commentary process, when created, amended and annually reviewed.

The Peer Reviewer is responsible for ensuring their role is undertaken in a supportive manner with suggestions and recommendations made for improvements to topic commentaries wherever possible.

Any Questions?

For further help, information or additional support requests please feel free to contact:

Performance and Development Team
Public Health Directorate
Lincolnshire County Council
Tel: 01522 552795

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of Specialised Adult Services

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**24 March 2015**
Subject:	**Mental Health Crisis Care Concordat**

Summary:

This paper outlines the national context for the development of the Lincolnshire Mental Health Crisis Care Concordat. It outlines what has taken place to date, the partners involved and the next steps in developing the action plan to support delivery of the Crisis Care concordat in Lincolnshire.

Actions Required:

For information

1. **Background**

National Expectation The Mental Health Crisis Care Concordat is a national agreement between services and agencies involved in the care and support of people in crisis. It sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis to improve their outcomes.

In February 2014, 22 national bodies involved in health, policing, social care, housing, local government and the third sector came together and signed the Crisis Care Concordat. It focuses on four main areas:

•**Access to support before crisis point** – making sure people with mental health problems can get help 24 hours a day and that when they ask for help, they are taken seriously.

•**Urgent and emergency access to crisis care** – making sure that a mental health crisis is treated with the same urgency as a physical health emergency**.**
•**Quality of treatment and care when in crisis** – making sure that people are treated with dignity and respect, in a therapeutic environment**.**
•**Recovery and staying well** – preventing future crises by making sure people are referred to appropriate services.

Although the Crisis Care Concordat focuses on the responses to acute mental health crises, it also includes a section on prevention and intervention. The Concordat builds on and does not replace existing guidance. Current service provision will continue while the Action Plan is being devised and implemented.

The national concordat expects that, in every locality in England, local partnerships of health, criminal justice and local authority agencies will agree and commit to local Mental Health Crisis Declarations and Action Plans.

Local Response

The Lincolnshire Mental Health Crisis Care Concordat declaration (Appendix A) was written and developed with the key stakeholders in Lincolnshire including service user groups and carer support groups, through a multi-agency steering group. Our declaration reflects the key areas of the national concordat from a local perspective. The key signatories signed this off for publication in December 2014 and it demonstrates our local commitment to achieving the delivery of the Mental Health Crisis Care Concordat.

Following the principles of the national concordat and our local declaration the Lincolnshire Crisis Care Concordat action plan (Appendix B) has been developed to provide a framework for the co-ordination and development of services to support the aspiration of ensuring people in mental health crisis will be supported and directed to the most appropriate care no matter where they come into contact with the local services.

The Action plan is an overarching framework with high level, strategic actions which require joint delivery. This plan will be underpinned by separate cross organisational and intra organisational plans with each sub group and member organisation being responsible for implementing and monitoring their individual plans to support the delivery of the overarching action plan. This will be a live and iterative process that will need review and updating to ensure existing resources are used effectively. Where gaps are identified then services will be realigned to meet the need if possible or business cases will be developed if new resources are required. It is anticipated that this programme of work will initially run for three years. The Joint Delivery Board for Specialist Services will monitor the progress against this action plan towards achieving the goal of the Mental Health Crisis Care Concordat Declaration.

The action plan which is in final draft format will be signed off by the key signatories and submitted for publication on the Crisis Care Concordat website by 20th March 2015. (http://www.crisiscareconcordat.org.uk/about/)

2. Conclusion – The Mental Health Crisis Care Concordat declaration and action plan brings together the key partners in the Lincolnshire health and care economy to achieve the parity of esteem required for people with mental health needs ensuring that

they are able to access support from which ever service they turn to first both before and during a mental health crisis.

3. Consultation – The Crisis Care Concordat Declaration and Action plan were developed in partnership with the key stakeholders who include

Adult Social Care
Children's Services
Public Health Lincolnshire County Council
South West Lincolnshire Clinical Commissioning Group
South Lincolnshire clinical Commissioning Group
Lincolnshire East Clinical Commissioning Group
Lincolnshire West clinical Commissioning Group
Lincolnshire Police
Lincolnshire Police and Crime Commissioner
Lincolnshire Partnership NHS Foundation Trust
Lincolnshire community Health Services
United Lincolnshire Hospitals Trust
Lincolnshire Carers and Young Carers Partnership
Lincolnshire Shine Network
East Midlands Ambulance Services (EMAS)
Lincolnshire Addaction
British Transport Police

Other organisations are encouraged to sign up and support the Crisis Care Concordat Declaration and Action plan.

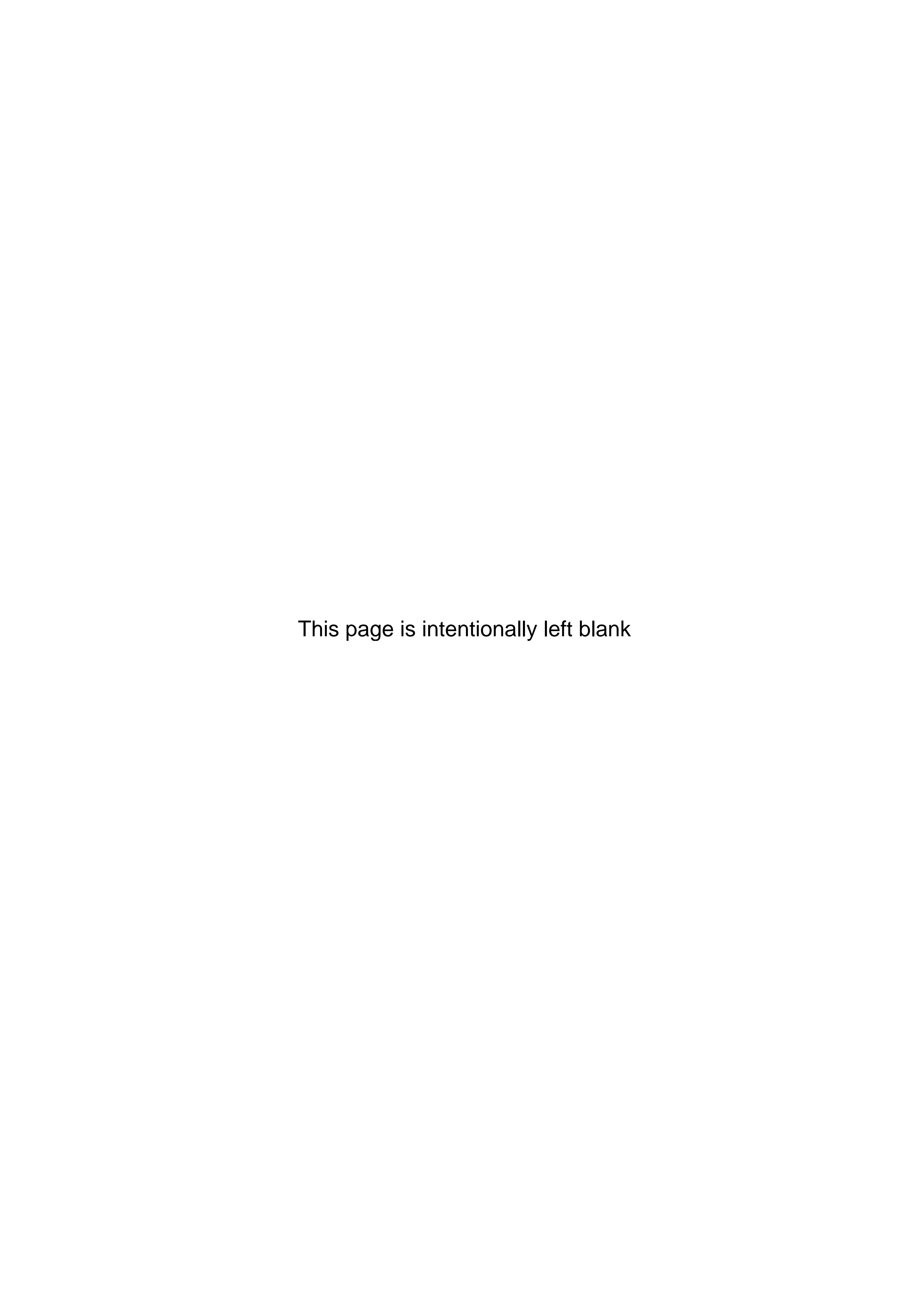
4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Lincolnshire Mental Health Crisis Concordat Declaration. 2014
Appendix B	Lincolnshire Mental health Crisis Concordat Action Plan. 2015-2018

5. Background Papers

Document Title	Where the document can be viewed
Mental Health Crisis Concordat 2014	https://www.gov.uk/government/publications/mental-health-crisis-care-agreement

This report was written by Colin Warren, Head of Mental Health Commissioning, who can be contacted on 01522 839597 or colin.warren@southwestlincolnshireccg.nhs.uk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Crisis Care Concordat
Mental Health

Declaration Statement for Lincolnshire

Our Lincolnshire Declaration on improving outcomes for people experiencing mental health crisis signed December 2014

Our Commitment

We, as partner organisations in Lincolnshire, will work together to put in place the principles of the national **Concordat** to improve the system of care and support so that people in crisis because of a mental health condition are kept safe.

Our Promises To You

- We will treat you with dignity and respect, challenging inappropriate attitudes
- We will help you to find the help you need – whatever the circumstances – from whichever of our services you turn to first.
- We will work together to prevent crises happening whenever possible, offering help and support at an early stage.
- We will meet you and your carers needs in urgent situations, getting the right care at the right time from the right people to make sure of the best outcomes.
- We will improve waiting times and access to services in Lincolnshire
- We will make sure that all relevant agencies or services support people with a mental health problem to help recovery. Everybody who signs this declaration will work towards developing ways of sharing information to help front line staff provide better responses to people in crisis.
- If you are in the care of the Police, we will work together with other agencies to ensure we provide timely advice and appropriate support.
- We will do everything in our power to ensure that anyone under 18 in mental health crisis is not detained in police custody.
- A police station will only be used as a Place of Safety in exceptional circumstances or as a last resort.
- We will consider all pathways as an alternative to admission to a mental health unit or hospital.
- If you cannot get to hospital for voluntarily admission, or are detained under the Mental Health Act we will provide safe, timely and appropriate transport.

Jointly, we hold ourselves accountable for delivering this commitment and our promises across Lincolnshire by putting in place, reviewing and regularly updating our action plan.

Declaration Statement for Lincolnshire

We, the organisations listed below, support this Declaration.

Organisation	Commitment
Lincolnshire County Council	**We are committed to working together to continue to improve crisis care for people with mental health needs in Lincolnshire**
Lincolnshire Clinical Commissioning Groups (CCG's)	**We are committed to working together to continue to improve crisis care for people with mental health needs in Lincolnshire**
NHS England Local Area Team (Primary Care Commissioners)	**We are committed to working together to continue to improve crisis care for people with mental health needs in Lincolnshire**
Lincolnshire Police	**We are committed to working together to continue to improve crisis care for people with mental health needs in Lincolnshire**
British Transport Police	**We are committed to working together to continue to improve crisis care for people with mental health needs in Lincolnshire**
Lincolnshire Ambulance Service	**We are committed to working together to continue to improve crisis care for people with mental health needs in Lincolnshire**
Lincolnshire NHS Partnership Foundation Trust	**We are committed to working together to continue to improve crisis care for people with mental health needs in Lincolnshire**
United Lincolnshire Hospitals Trust	**We are committed to working together to continue to improve crisis care for people with mental health needs in Lincolnshire**
Public Health	**We are committed to working together to continue to improve crisis care for people with mental health needs in Lincolnshire**
Lincolnshire Community Health Services	**We are committed to working together to continue to improve crisis care for people with mental health needs in Lincolnshire**
Lincolnshire Addaction	**We are committed to working together to continue to improve crisis care for people with mental health needs in Lincolnshire**
Lincolnshire Carers Partnership	**We are committed to working together to continue to improve crisis care for people with mental health needs in Lincolnshire**
Lincolnshire Shine Network	**We are committed to working together to continue to improve crisis care for people with mental health needs in Lincolnshire**

Many other local organisations want to support this Declaration because of their commitment to improve mental health care and may make a specific contribution within our action plan for continuous improvements.

This declaration supports equality ('parity of esteem' - see the glossary) between physical and mental health care in the following ways:

- Through everyone agreeing a shared 'care pathway' to safely support, assess and manage anyone who asks any of our services in Lincolnshire for help in a crisis. This will result in the best outcomes for people with suspected serious mental illness, provide advice and support for their carers', and make sure that services work together safely and effectively.
- Through agencies working together to improve individuals' experience (professionals, people who use crisis care services, and carers) and reduce the likelihood of harm to the health and wellbeing of patients, carers and professionals.
- By making sure there is a safe and effective service with clear and agreed policies and procedures in place for people in crisis, and that organisations can access the service and refer people to it in the same way as they would for physical health and social care services.
- By all organisations who sign this declaration working together and accepting our responsibilities to reduce the likelihood of future harm to staff, carers, patients and service users or the wider community and to support people's recovery and wellbeing.

Glossary of terms used in this declaration

Concordat	A document published by the Government. The Concordat is a shared, agreed statement, signed by senior representatives from all the organisations involved. It covers what needs to happen when people in mental-health crisis need help. Title: Mental Health Crisis Care Concordat – Improving outcomes for people experiencing mental health crisis Author: Department of Health and Concordat signatories Document purpose: Guidance Publication date: 18th February 2014 Link: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/36353_Mental_Health_Crisis_accessible.pdf
Mental health crisis	When people – of all ages – with mental health problems urgently need help because of their suicidal behaviour, panic attacks or extreme anxiety, psychotic episodes, or behaviour that seems out of control or irrational and likely to put the person (or other people) in danger.
Parity of esteem	Parity of esteem is when mental health is valued equally with physical health. If people become mentally unwell, the services they use will assess and treat mental health disorders or conditions on a par with physical illnesses. Further information: http://www.england.nhs.uk/ourwork/qual-clin-lead/pe
Recovery	One definition of Recovery within the context of mental health is from Dr. William Anthony: "Recovery is a deeply personal, unique process changing one's attitude, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of psychiatric disability" (Anthony, 1993) Further information http://www.imroc.org/

Lincolnshire

Mental Health

Crisis Care Concordat

Actions to enable delivery of shared goals

Version Control	
DRAFT V2 – 11/02/15	DRAFT V4.3 26/02/15
DRAFT V3 – 17/02/15	FINAL DRAFT 26/02/15
DRAFT V4 – 18/02/15	
DRAFT 4.1 – 19/02/15	
DRAFT 4.2 – 24/02/15	

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INTRODUCTION

Our Lincolnshire **Mental Health Crisis Care Declaration** is a local agreement between services and agencies involved in the care and support of people in crisis. It sets out how we will work together better to make sure that the people of Lincolnshire get the help they need when they are having a mental health crisis.

In December 2014, local bodies involved in health, policing, social care, local government and the third sector came together and signed the **declaration**. This action plan is about how we, as signatories, can work together to deliver a high quality response when people of all ages with mental health problems urgently need help. It sets out what we need to do to enable us to collectively deliver on our commitments made in our declaration.

It focuses on four main areas but what do they mean to you?

Access to support before crisis point

Is about making sure you can get help 24 hours a day and that when you ask for help, you are taken seriously.

Urgent and emergency access to crisis care

Is about making sure that if you have a mental health crisis it is treated with the same urgency as a physical health emergency.

Quality of treatment and care when in crisis

Is about making sure that you are treated with dignity and respect, in a therapeutic environment.

Recovery and staying well

Is about preventing future crises by making sure you are referred to appropriate services.

Although our action plan focuses on acute mental health crises, it also includes a section on prevention and intervention. We will work together, as local organisations, to prevent crises happening whenever possible through prevention and early intervention.

This action plan is a high level overarching plan which focuses on areas of joint delivery or commissioning. Beneath it we have more detailed plans from Lincolnshire Police, EMAS, Lincolnshire County Council, the four Clinical Commissioning Groups (CCG's) and our mental health provider Lincolnshire NHS Partnership Foundation Trust. Other organisational plans are also in development.

Lincolnshire already has a large number of Mental Health services and initiatives in place which form our urgent care pathway such as;

- Single Point of Access for Mental Health Services
- Crisis Resolution Home Treatment Service
- Crisis Houses
- Section 136 Suite
- ISA with Lincolnshire Police regarding Diversion and Liaison
- MOU with Police Negotiators
- Street Triage Car
- Older Adults Liaison Service (Acute Hospital Based)
- CAMHS Self Harm and Liaison Service
- Self- referral to talking therapies (IAPT)
- Emergency Duty Social Work Team
- Fast track re-referral process
- Carers Assessment
- Carers Emergency Response Plan
- Carers Short Break Scheme
- Managed Care Network and SHINE Network

This action plan is about improving those services and addressing the gaps by providing an effective pathway to improve crisis care responses.

The partner agencies within the Lincolnshire Concordat would like to express their thanks to service users from the SHINE Network and Making Space for providing valuable input to the actions identified within this plan.

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Section 1

COMMISSIONING TO ALLOW EARLIER INTERVENTION AND RESPONSIVE CRISIS SERVICES

No	Action	Timescale	Led By	Outcomes
1.1	Clear waiting time limits in line with National Standards will be put into commissioned services	Ongoing	Mental Health Commissioning Leads	Prevention of avoidable crisis and equality of access
1.2	We will complete a gap analysis between current provision and the declaration vision to inform actions and focus priority improvements	March 2015	Concordat Steering Group	Focussed commissioning on areas needing improvement
1.3	We will review existing mental health training across all agencies signed up to the declaration to develop and deliver joint training where the need is identified.	June 2015	Concordat Steering Group	A training needs analysis will inform the development of the programme. Longer term all staff will have the right skills and training to respond to mental health crises appropriately
1.4	Commission a full Mental Health Liaison team on acute hospital sites	Sept 2015	Mental Health Commissioning Leads	People know they will receive the appropriate treatment in hospital sites
1.5	Link with Lincolnshire Suicide Prevention Forum to identify Suicide at risk groups to inform commissioning cycle	April 2015	Public Health with Mental Health Commissioning Leads British Transport Police	Those groups known to be at higher risk of suicide will be identified, such as people in the care of mental health services and criminal justice services.
1.6	Review Cambridgeshire	March 2016	Public Health	Reduced suicides

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	STOP Suicide Campaign. Use learning to implement in Lincolnshire.		with Mental Health Commissioning Leads British Transport Police	in Lincolnshire
1.7	Increase input to JSNA on mental health crisis to show demographic representation specifically with regard to protected equality characteristics	Ongoing	Mental Health Commissioning Leads With Public Health	Commissioners have robust data with which to commission services
1.8	Publish a full Mental Health Needs Assessment for Lincolnshire	June 2015	Public Health	Commissioners have robust data with which to commission services
1.9	Complete a green light review on all crisis services	Oct 2015	LD & Autism Commissioning Lead With LPFT	Mental Health Crisis services will make reasonable adjustments to support people with LD and Autism
1.10	Commission Carers Family Support Network Service	Oct 2015	Adult Social Care	Carers receive the support they need
1.11	Commission an intensive community assessment and treatment service for children and young people (CAMHs Tier 3+)	Dec 2015	LCC Children's Services Commissioning	Children and young people with mental health needs are supported in the community

Measures of success

- People in crisis referred to mental health secondary care services are seen with 4 hours
- Aspire to 0% Suicides in Lincolnshire
- 85% of non- mental health staff to have received training by December 2016

Section 2

ACCESS TO SUPPORT BEFORE CRISIS POINT

No	Action	Timescale	Led By	Outcomes
2.1	Monitor the implementation and effectiveness of the National Criminal Justice and Liaison Service pilot. Use lessons learnt to inform the development of local services.	Bi monthly	Lincolnshire Police	There will be access to liaison and diversion services for people with mental health problems who have been arrested for a criminal offence, and are in police custody or going through court proceedings
2.2	Develop partnerships with voluntary sector providers and service users to understand and respond to inequalities in access to mental health services	Ongoing	ASC With CCG Mental Health Leads	Partnership groups will be established parity of esteem for everyone with a mental health need
2.3	Develop support for carers in line with changes to the Care Act	From March 2015 onwards	ASC with Other providers	People will feel protected when their circumstances make them vulnerable
2.4	Promote early self- referrals to talking therapies (IAPT) to avoid crisis	Ongoing	LPFT	People receive support at an early stage to improve their health and wellbeing
2.5	Establish a baseline of advice and information services available to support good mental health	July 2015	Concordat Steering Group	Directory of services that promote good mental health

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Measures of success

- Increase the number of self-referrals to talking therapies
- Publish a directory of services that promote good mental health and wellbeing by December 2015

Section 3

URGENT AND EMERGENCY ACCESS TO CRISIS CARE

No	Action	Timescale	Led By	Outcomes
3.1	Review & create clear pathways and protocols for referring to mental health services via SPA and NHS 111	Oct 2015	LPFT with CCG Mental Health Leads	People know who to contact to access Mental Health Services
3.2	Scope the provision of a free 24/7 helpline number for people in mental health crisis	Oct 2015	Mental Health Commissioning Leads	People in crisis can receive help at anytime
3.3	Establish baseline of access to psychological therapies for children and young people and set trajectory for improvement.	Oct 2015	LCC Children's Services	Children and young people have better access to talking therapies to prevent crisis occurring.
3.4	Conduct a full review of S136 Health Based Place of Safety to include • Roles of partner agencies • Process • Provision of beds • Minimum Staffing • Diversion before Detention • Pathways • Intoxication • Conveyance • Training • Cultural change • CQC Compliance	Sept 2015	Mental Health Commissioning Leads with Acute Services Lincolnshire Police EMAS AMHPs Louth & District Medical Services British Transport Police	The efficiency, response and running of the suite is appropriate to the needs of the partners and people of Lincolnshire
3.5	Develop agreed local protocols between key partners around S 135 MHA warrants to facilitate partnership working with a 'no surprises' approach	Sept 2015	Lincolnshire Police With AMHPs EMAS Magistrates Court	People subject to this are dealt with in a professional joined up approach

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	including • Criteria for attendance • Conveyance • Use of force			
3.6	Develop crisis services for under 18's, including 136 facility.	Sept 2015	LCC Children's Commissioning With LPFT	Equality of access for all ages
3.7	Develop training and education about existing policies, powers and procedures to all partners.	Sept 2015	Concordat Steering Group	All staff trained to enable a rapid response to people in crisis
3.8	Establish peak demand times and target triage car intelligently to promote liaison and diversion.	May 2015	MH Commissioning Leads with EMAS LPFT	People in crisis are helped at the right time, in the right place, by the right services
3.9	Review crisis house criteria and policies.	Oct 2015	MH Commissioning Lead	An effective, safe alternative to admission
3.10	Complete a review of crisis and home treatment services	July 2015	MH Commissioning Leads with LPFT	People in crisis receive quality & effective services

Measures of success

- All Section 136 requests for transport are responded to within 30 minutes
- A reduction in use of Section 136 police powers
- A reduction in the use of police cells solely as a place of safety
- Crisis resolution and home treatment teams are accessible 24 hours a day, 7 days a week, regardless of diagnosis
- Service users and GP's have access to a local 24 hour helpline staffed by mental health and social care professionals
- Increase in the use of crisis houses as an alternative to admission

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Section 4

QUALITY OF TREATMENT AND CARE WHEN IN CRISIS

No	Action	Timescale	Led By	Outcomes
4.1	Ensure all agencies have a policy or procedure to identify and involve carers at the point of crisis where possible.	Nov 2015	Concordat Steering Group	Improved understanding of an individual's needs. Carers are recognised and valued as experts
4.2	Further develop referral pathways and improved communication strategies to enable all carers to be offered a Carers Assessment	Nov 2015	LCC Adult Social Care with Other Providers	Carers receive the support they need to continue with the caring role. This aligns to the Care Act – April 2015
4.3	Develop Carer & Service User learning, self- management & self- referral programmes	Dec 2015	Carers Partnership Making Space Lincolnshire MH Networks & Other providers	Improved mental well-being in order to enable carers and individuals to self-manage symptoms preventing carer breakdown.
4.4	Enhance & further develop community mentoring support for people with a Mental Illness and their Carers, to support low level need	Dec 2015	Carers Partnership Making Space Lincolnshire MH Networks & Other providers	Emotional support and understanding available when needed to improve wellbeing.
4.5	Develop robust monitoring and evaluation systems across all	Jan 2016	MH Commissioning	Systems are in place for

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	agencies to monitor and improve the quality of care given and response received to people in crisis		**Leads With LPFT**	**review, regulation and reporting within the local mental health provider services**

Measures of success

- **At least a 50% increase in the satisfaction rate of people using mental health services**
- **70% of carers report feeling more involved by services**

Section 5

RECOVERY, STAYING WELL and PREVENTING FUTURE CRISES

No	Action	Timescale	Led By	Outcomes
5.1	Promotion and awareness campaign of Lincolnshire's Mental Health Networks: Shine Managed Care Network Dementia Network	Review Feb 2016	SHINE and LPFT	A range of preventative services and support available to people with a mental health illness
5.2	Promote "12 steps to mental health" in line with the Public Health Campaign	Ongoing	Public Health	Increased awareness of methods for self-care
5.3	Promote the 'time to change' anti-stigma campaign across Lincolnshire.	Rolling Programme Annual review	Concordat Steering Group	Improved community acceptance and support
5.4	Scope the development & roll-out a health passport 'all about me' to all those with a mental health illness.	Sept 2015	All About ME Steering group	People have a better understanding of an individual's needs and wishes
5.5	Scope the current market position for the role of the voluntary and community sector in mental health crisis recovery	Dec 2015	Specialist Adult Services Joint Commissioning Team	All sectors are considered in crisis recovery plans
5.7	Complete an evaluation of the Wellbeing Network	May 2016	Public Health	Clear understanding of the impact of the network and what works for people with Mental Health needs

Measures of success

- Increase in the number of self-help groups supported by the mental health networks
- At least 5000 health passports distributed by March 2016
- 30% reduction in the number of people with a mental illness needing a crisis intervention service by March 2018

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Health and Wellbeing Board – Decisions from June 2013

Meeting Date	Minute No	Agenda Item & Decision made
9 May 2014	62	**Lincolnshire Health and Care (Formerly known as the Lincolnshire Sustainable Services Review** 1. That the processes set out in the report which focused on the areas detailed below be noted. Developing robust proposals for a sustainable and safe health and social care economy for the future; Achieving external assurance on the proposal; Consulting widely on the proposal; Responding to feedback in the final proposal; and Robust decision making throughout. 2. That the revised programme detailed at Appendix B to the report be noted. 3. That agreement be given for an additional meeting of the Lincolnshire Health and Wellbeing Board at a date to be agreed as part of the decision making on the proposal and business case for consultation. 4. That agreement be given to a further meeting of the Lincolnshire Health and Wellbeing Board at the end of January 2015, as part of decision making on the final proposal and business case.
10 June 2014	1	**Election of Chairman** That Councillor Mrs S Woolley be elected as the Chairman of the Lincolnshire Health and Wellbeing Board for 2014/15.
	2	**Election of Vice-Chairman** That Dr Sunil Hindocha be elected as the Vice-Chairman of the Lincolnshire health and Wellbeing Board 2014/15.
	5a	**Minutes of meeting held on 25 March 2015** That the minutes of the meeting of the Lincolnshire Health and Wellbeing Board held on 25 March 2014, be confirmed and signed by the Chairman as a correct record
	5b	**Minutes of the Extraordinary meeting held on 9 May 2014** That the minutes of the meeting of the Lincolnshire health and wellbeing Board held on 9 May 2014, be confirmed and signed by the Chairman as a correct record

	6	**Actions Updates from the previous meeting** That the completed actions as detailed be noted.
	8a	**Terms of Reference and Procedural Rules, Board Members Roles and Responsibilities** That the Terms of Reference and Procedure Rules, and Members Roles and Responsibilities be agreed.
	8b	**Draft Direct Commissioning Operational Plan 2014/2016 & Emerging Strategy Update** That the Lincolnshire Health and Wellbeing Board noted the scope of the operational; plans for Direct Commissioning for:- Primary Care – Leicestershire and Lincolnshire; Public Health – Leicestershire and Lincolnshire; and Specialised Commissioning – East Midlands.
	9a	**Lincolnshire Health and Wellbeing Board Development Toolkit – Current Position** 1 That a small Task and Finish Group be formed to help develop an Action Plan; and that expression of interest should be sent to the Health and Wellbeing Board Advisor. 2. That the Action Plan as mentioned in recommendation (1) be presented as a 'Decision Item' at the September formal Board meeting.
	9b	**Update on Lincolnshire Health and Care** That the verbal update be received.
	9c	**The CQC Review of Health Services for Children Looked After and Safeguarding in Lincolnshire** That the report be noted.
	10a	**An Action Log of Previous Decisions** That the Action Log of previous decisions of the Lincolnshire Health and Wellbeing Board be noted.
	10b	**Lincolnshire Health and Wellbeing Board Forward Plan** 1 That the forward plan for formal and informal meetings a s presented, be agreed subject to the inclusion of the items listed above. 2 That the item 'Care Act and the implications for Lincolnshire' be included as a future agenda item.

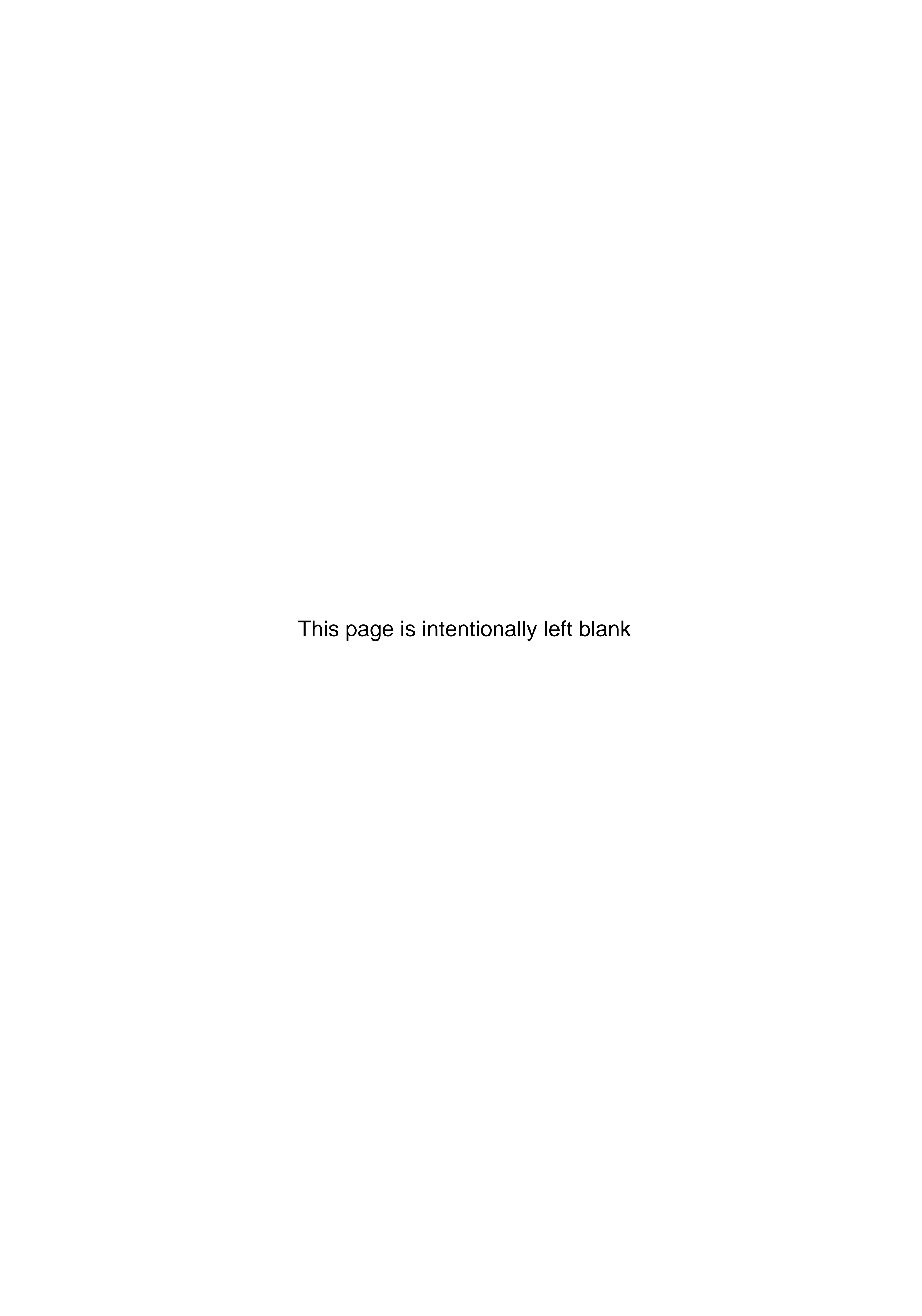
	10c	**Future Scheduled Meeting Dates** That the following scheduled meeting dates for the remainder of 2014 and for 2015 be noted. 30 September 2014 9 December 2014 24 March 2015 9 June 2015 29 September 2015 8 December 2015 (All the above meetings commence at 2.00pm)
11September 2014	13	**Better Care Fund Final Re-Submission** 1. That the report an attached BCF final submission: Part 1 and Part 2 (Appendix B) be noted. 2. That the BCF task Group be delegated to make any final iterations to the aforementioned submission between this meeting and 19 September 2014. 3. That agreement be given to the document as attached for submission to NHS England for 19 September 2014. 4. That agreement in principle be given to an expression of interest being made for the Council to participate in the national pilot scheme for personal health budgets.
30 September 2014	19a	**Lincolnshire Health and Wellbeing Board Development Assessment Action Plan** 1. That the report be noted. 2. That the draft Development Action Plan presented be approved. 3. That progress against the Development Assessment Action Plan be reported to the Board as part of future annual Assurance updates.
	19b	**Joint Health and Wellbeing Strategy Assurance Report 2014** 1. That the Theme Dashboards shown in Appendices A to E of the report be agreed. 2. That each Theme be requested to review the suite of indicators being used to monitor the outcomes and priorities to ensure that they are appropriate, and to identify additional actions that can be taken by the Theme. 3. That the current Board Sponsor roles and support mechanisms be reviewed. 4. That a full review of the Joint Strategic Needs Assessment be agreed to take place during 2015/16 to inform the

		development of a new Joint Health and Wellbeing Strategy which will be in place for 2018, and that proposals for undertaking this work be brought to a future meeting of the Board.
	19c	**Protocol Between the Lincolnshire Health and Wellbeing Board, Healthwatch Lincolnshire and the Health Scrutiny Committee for Lincolnshire** 1. That the draft Protocol between the Lincolnshire Health and Wellbeing Board, Healthwatch Lincolnshire and the Health Scrutiny Committee for Lincolnshire as shown in Appendix A to the report presented, subject to the inclusion of the comments made be approved. 2. That the draft (Amended) Protocol be referred to the Health Scrutiny Committee for Lincolnshire and Healthwatch Lincolnshire for consideration and approval. 3. That authority be delegated to the Health and Wellbeing Board Business Manager, in consultation with the Chairman of the Health and Wellbeing Board, to make any necessary alterations following consideration by the Health Scrutiny Committee for Lincolnshire and Healthwatch Lincolnshire that do not fundamentally affect the intentions of the Protocol.
	19d	**Protocol Between the Lincolnshire health and Wellbeing Board and the Lincolnshire Safeguarding Children Board** 1. That the draft protocol between the Lincolnshire Health and Wellbeing Board and the Lincolnshire Safeguarding Children Board be approved. 2. That authority be delegated to Health and Wellbeing Business Manager, in consultation with the Chairman of the Health and Wellbeing Board, to make any necessary alteration s following consideration by the Lincolnshire Safeguarding Children Board that do not fundamentally affect the intentions of the Protocol.

	19e	**Lincolnshire Pharmaceutical Needs Assessment** 1. That the draft Pharmaceutical Needs Assessment be agreed. 2. That the consultation plan on the draft Pharmaceutical Needs Assessment be agreed.
	21a	**An Action Log of Previous Decisions** 1. That the Action Log of previous decisions of the Lincolnshire Health and Wellbeing Board be noted. 2. That in future only decisions relating to the previous twelve months be presented to the Board.
	21b	**Assuring Transformation: meeting the Winterbourne View Concordat Commitments, Lincolnshire's Current Position on Inpatient Care for Adults with a Learning Disability** That the report presented on the requirements of Local Authorities and Clinical Commissioning Groups in response to the Winterborne View Review and Concordat be noted.
	21c	**Lincolnshire Health and Wellbeing Board – Forward Plan** That the forward plan for formal and informal meetings as presented, be agreed subject to the inclusion of the items listed above.
9 December 2014	24	**Minutes of the Lincolnshire Health and Wellbeing Board meeting held on 30 September 2014** That the minutes of the Lincolnshire Health and Wellbeing Board held on 30 September 2014, be conformed and signed by the Chairman as a correct record.
	25	**Action Updates from the previous meeting** That the completed actions as detailed be noted.
	27a	**Protocol between Lincolnshire Health and Wellbeing Board and Lincolnshire Safeguarding Adults Board** 1. That the draft Protocol shown at Appendix A be approved. 2. That authority be delegated to the Health and Wellbeing Business Manager, in consultation with the Chairman, to make any necessary alterations following consideration by

		Lincolnshire Safeguarding Adults Board that do not fundamentally affect the intentions of the Protocol.
	27b	**Health and Wellbeing Grant Fund** 1. That the new Section 256 Agreement be noted. 2. That agreement be given to the application process shown in Section 7 and the roles and responsibilities shown in Section 8 of Appendix B.
	28b	**Better Care Fund** 1. That the work to date and the timeline for re-submission of the BCF and the production of the Section 75 be noted. 2. That agreement be given for the BCF re-submission as detailed in the accompanying papers, be delegated to the Chairman of the Lincolnshire Health and Wellbeing Board to sign off, subject to there being no material change tom the BCF affecting performance of finances and subject to agreement by the four CCG's and the Director of Adult Social Services (Appendix A) 3. That the BCF task Group Terms of Reference detaiel;d at Appendix B be noted. 4. That agreement be given to the schemes detailed at Appendix D. 5. That agreement be given to receiving a subsequent report to each of the next four Lincolnshire Health and Wellbeing Board formal meetings throughout 2015.
	28c	**Lincolnshire's All-Age Autism Strategy 2015-2018** That the draft All-Age Autism Strategy for Lincolnshire be received and that Panel members be invited to provide feedback on the content of the document.
	28d	**Lincolnshire Safeguarding Adults Board Business Plan** 1. That the current Lincolnshire Adults Board (LSAB) Business Plan presented be noted. 2. That a copy of the LSAB 2015/16 Strategic Plan would be available to be presented to the Board after April 2015. 3. That a copy of the LSAB 2015/16 Annual report would be available to be presented to the Board during the summer of 2016.

	28e	**Draft Lincolnshire Unit of Planning 5 Year Strategic Plan** That the Lincolnshire Health and Wellbeing Board notes: • The current status of the strategic plan and that there would be a final draft of the strategic plan for December 2014. • That the financial modelling is only provisional at this stage. • That the LHAC programme Board is considering the integration of the NHS England '5Year Forward View' and detailed LHAC implementation timelines and resource requirements at its meeting on 25 November 2014 (This will inform the final draft of the strategic plan).
	31a	**Updated Joint Strategic Needs Assessment (JSNA) Overview Report** That the updated JSNA Overview report 2013/14 be noted.
	31b	**Act Action Log of Previous decisions** That the Action Log of previous decisions of the Lincolnshire Health and Wellbeing Board be noted.
	31c	**Lincolnshire health and Wellbeing Board – Forward Plan** That the plan for formal and informal meetings as presented be received.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Lincolnshire Health and Wellbeing Board Forward Plan: March 2015 – December 2015

Formal Health & Wellbeing Board Meeting Dates	Decision/Authorisation Item	Discussion Item	Information Item
24th March 2015 **2.00pm in Committee Room 1, County Offices, Newland, Lincoln LN1 1YL**	**Pharmaceutical Needs Assessment** – Discharge of HWB statutory function – to formally approve the PNA for Lincolnshire **Chris Weston, Consultant Public Health** **CCG Commissioning/Operational Plans** To receive a report from each CCG which asks the Board to review the commissioning plan 2015-17 against the priorities in the Joint Health and Wellbeing Strategy **Better Care Fund** To receive a report on the Better Care Fund asking the Board to sign off the Section 75 Agreement 2015/16 **Glen Garrod, Director of Adult Care** **Health and Wellbeing Fund** To approve the recommendations from the Sub Group on applications to the HWB Fund **Alison Christie, Programme Manager – Health and Wellbeing Board**	**Lincolnshire Health and Care** Verbal update on current position **Dr Tony Hill, Executive Director of Community Wellbeing and Public Health** **Annual Report of the Director of Public Health on the health of the people of Lincolnshire 2014** To receive the Annual Report on the Health of the people of Lincolnshire. **Dr Tony Hill, Executive Director of Community Wellbeing and Public Health** **District/Locality Updates** Standing agenda item for the Board to receive updates, by exception, from District/locality partnerships **Joint Health and Wellbeing Strategy Theme Updates** Standing agenda item for the Board to receive updates, by exception, from JHWS Themes	**Joint Commissioning Arrangements in Lincolnshire** To receive a report from Gary Thompson, Chairman of the Joint Commissioning Board detailing the governance arrangements for joint working between health and care. **Fundamental Review of the JSNA** To receive a report from Chris Weston, Consultant Public Health on the proposals and timescales for reviewing the JSNA **Mental Health Care Crisis Concordat & Action Plan** To receive a report from Colin Warren on Lincolnshire's Mental Health Concordat and Action Plan.
9th June 2015 **2.00pm in Committee Room 1, County Offices, Newland, Lincoln LN1 1YL**	**Review of the Joint Health and Wellbeing Strategy** To receive a report asking the Board to agree the outcome of the mid-term review of the Joint Health and Wellbeing Strategy **Theme Leads & Board Sponsors**	**Lincolnshire Health and Care** Verbal update on current position **Dr Tony Hill, Executive Director of Community Wellbeing and Public Health** **Better Care Fund** Verbal update on current position **Glen Garrod, Director of Adult Care**	**Lincolnshire Safeguarding Adults Board Strategic Plan 2015.16** To receive the LSAB's Strategic Plan inline (Agreed as part of shared Protocol). **Elaine Baylis, Independent Chairman, LSAB**

Formal Health & Wellbeing Board Meeting Dates	Decision/Authorisation Item	Discussion Item	Information Item
29th September 2015 **2.00pm in Committee Room 1, County Offices, Newland, Lincoln LN1 1YL**	**Terms of Reference and Procedural Rules, Roles and Responsibilities of Core Board Members** To agree changes as part of annual review of Terms of Reference **Alison Christie, Programme Manager Health and Wellbeing** **Lincolnshire Carers Commissioning Strategy** To receive a report which asks the Board to review the Carers Commissioning Strategy against the priorities in the Joint Health and Wellbeing Strategy **Glen Garrod, Director of Adult Care**	**District/Locality Updates** Standing agenda item for the Board to receive updates, by exception, from District/locality partnerships **Joint Health and Wellbeing Strategy Theme Updates** Standing agenda item for the Board to receive updates, by exception, from JHWS Themes	**Mental Health Promotion Strategy** To receive a report on the Mental Health Promotion Strategy **Mandy Clarkson, PH Consultant**
		Lincolnshire Health and Care Verbal update on current position Dr Tony Hill, Executive Director of Community Wellbeing and Public Health **Better Care Fund** Verbal update on current position Glen Garrod, Director of Adult Care **District/Locality Updates** Standing agenda item for the Board to receive updates, by exception, from District/locality partnerships **Joint Health and Wellbeing Strategy Theme Updates** Standing agenda item for the Board to receive updates, by exception, from JHWS Themes	

Formal Health & Wellbeing Board Meeting Dates	Decision/Authorisation Item	Discussion Item	Information Item
8th December 2015 **2.00pm in Committee Room 1, County Offices, Newland, Lincoln LN1 1YL**		**Lincolnshire Health and Care** Verbal update on current position Dr Tony Hill, Executive Director of Community Wellbeing and Public Health **Better Care Fund** Verbal update on current position Glen Garrod, Director of Adult Care **District/Locality Updates** Standing agenda item for the Board to receive updates, by exception, from District/locality partnerships **Joint Health and Wellbeing Strategy Theme Updates** Standing agenda item for the Board to receive updates, by exception, from JHWS Themes	

Items to be programmed:

- Lincolnshire Safeguarding Adults Annual Report – Summer/Sept 2016

Informal Health and Wellbeing Workshop Sessions: May 2015 – November 2015

Informal Health and Wellbeing Board Workshop Session Dates	Discussion Item	Information Item
12th May 2015 **2.00pm, Stanhope Hall, Boston Road, Horncastle, LN9 6NF**	**Mid-Term review of the Joint Health and Wellbeing Strategy** Informal discussion on the outcome of the mid-term review of the Joint Health and Wellbeing Strategy undertaken by each Theme	
8th July 2015 **2.00pm, Alive Conference Centre, Newland, Lincolnshire County Council**		
3rd November 2015 **2.00pm, Stanhope Hall, Boston Road, Horncastle, LN9 6NF**		