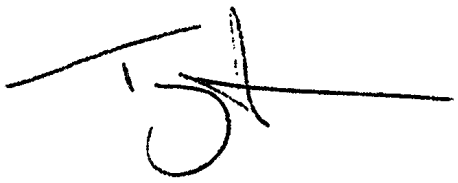
County Offices
Newland
Lincoln
LN1 1YL

14 March 2016

Lincolnshire Health and Wellbeing Board

A Meeting of the Lincolnshire Health and Wellbeing Board will be held on Tuesday, 22 March 2016 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: Sarah Fletcher

NHS England: Mr Jim Heys

(*) Permanent Membership

LINCOLNSHIRE HEALTH AND WELLBEING BOARD AGENDA
TUESDAY, 22 MARCH 2016

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 8 December 2015**	5 - 16	
4	**Action Updates from the previous meeting** *(For the Lincolnshire Health and Wellbeing Board to consider the actions arising from the previous meeting)*	17 - 18	
5	**Chairman's Announcements** *(For the Lincolnshire Health and Wellbeing Board to note the Chairman's announcements)*	Verbal Report	
6	**Decision/Authorisation Items**		
6a	**Proposals on the future provision of Lincolnshire's Joint Strategic Needs Assessment** *(To receive a report from Chris Weston, Chairman of the Joint Strategic Needs Assessment Steering Group, which asks the Board to agree the recommendations arising from the review of the Joint Strategic Needs Assessment)*	19 - 28	
6b	**Clinical Commissioning Group Commissioning/Operational Plans** *(To receive a report from each of the four CCG's, which ask the Board to review commissioning intentions/operational plans for 2016/17 against the priorities in the Joint Health and Wellbeing Strategy)*	29 - 72	
6c	**The Lincolnshire Better Care Fund (BCF) Submission 2016/17** *(To receive a report and presentation from Glen Garrod, Director of Adult Care, which asks the Board to approve the 2016/17 Better Care Fund submission). (Please note: Appendix C is to follow)*	73 - 112	

Item	Title	Pages	Estimated Time
7	**Discussion Items**		
7a	**Joint Commissioning Board - Update Report** *(To receive an update from Dr Sunil Hindocha, Chairman of the Joint Commissioning Board, which provides the Board with an update on joint commissioning arrangements in Lincolnshire)*	113 - 114	
7b	**Lincolnshire Health and Care - Update Report** *(To receive a verbal update from Allan Kitt, Leading Chief Officer, Lincolnshire Health and Care, which provides a status report with regard to Lincolnshire Health and Care)*	Verbal Report	
7c	**Annual Report of the Director of Public Health on the health of the people of Lincolnshire 2015** *(To receive a report from Dr Tony Hill, Executive Director of Community Wellbeing and Public Health, which provides the Board with the Annual report on the health of the people of Lincolnshire 2015. Chris Weston, Consultant Public Health to present the report to the Board)*	115 - 152	
7d	**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)*		
7e	**Joint Health and Wellbeing Strategy Theme Updates** *(To receive a verbal update from Dr Kevin Hill and Councillor Ron Oxby, Board Sponsors for Theme 2 of the Joint Health and Wellbeing Strategy concerning current funding issues relating to volunteering and the third sector, in order to ensure support for older people in Lincolnshire)*	Verbal Report	
8	**Information Items**		
8a	**Lincolnshire Joint Ambulance Conveyance Project** *(To receive a presentation from Nick Borrill, Acting Chief Fire Officer, which provides the Board with information relating to the Joint Ambulance Conveying Project, a joint project between Lincolnshire Fire & Rescue, East Midlands Ambulance Service and Lincolnshire Integrated Voluntary Services (LIVES))*	Verbal Report	

Item	Title	Pages	Estimated Time
8b	**An Action Log of Previous Decisions** *(For the Health and Wellbeing Board to note decisions taken since 9 June 2015)*	153 - 156	
8c	**Lincolnshire Health and Wellbeing Board - Forward Plan** *(This item provides the Board with an opportunity to discuss items for future meetings which will subsequently be included on the Forward Plan)*	157 - 160	

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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
8 DECEMBER 2015

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 N H Pepper.

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 C Leyland (District Council Representative).

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: Sarah Fletcher (Healthwatch Lincolnshire).

NHS England:

Officers In Attendance: Alison Christie (Programme Manager Health and Wellbeing) Katrina Cope (Democratic Services), Mark Housley, Alison Christie (Programme Manager Health and Wellbeing), Gary James (Accountable Officer, Lincolnshire East CCG), Allan Kitt (Chief Officer South West Lincolnshire CCG).

Councillor P A Robinson Executive Councillor Fire & Rescue, Emergency Planning, Trading Standards, Equality and Diversity) and John Bains (Chairman of Healthwatch Lincolnshire) attended the meeting as observers.

19 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

Apologies for absence were received from Councillor S M Tweedale, Councillor Mrs M Brighton OBE (District Council representative) and Jim Heys (NHS England).

It was reported that Councillor C Leyland (District Council representative) had replaced Councillor Mrs M Brighton OBE (District Council representative) for this meeting only.

20 DECLARATIONS OF MEMBERS' INTEREST

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

21 MINUTES OF THE LINCOLNSHIRE HEALTH AND WELLBEING BOARD MEETING HELD ON 29 SEPTEMBER 2015

RESOLVED

That the minutes of the Lincolnshire Health and Wellbeing Board meeting held on 29 September 2015, be confirmed and signed by the Chairman as a correct record.

22 DISCUSSION ITEM

22a Lincolnshire System Resilience Group System Wide Winter Plan 2015/16

Consideration was given to a report from the Chairman of the Lincolnshire System Resilience Group, which outlined to the Board the key drivers, requirements and highlights of the Lincolnshire System Resilience Group System Wide Winter Plan for 2015/16. The plan outlined how collectively Lincolnshire Commissioners, providers and voluntary and community sectors would collectively prepare, respond and recover from Winter 2015/16.

It was reported that the winter plan was underpinned and organised according to the principles of integrated emergency management: Anticipate; Access, Prevent; Prepare; Respond and Recover. The plan also identified the shared risks across the health and care system and the joint mitigations in place to reduce risk levels. It was highlighted that the plan was a live working document, and as such would be updated up to the week before Christmas. It was noted that the Plan was guided by national frameworks and expectations such as the Public Health England Cold Weather Plan.

The Board were asked to note the highlights of the Plan, which were detailed on page six of the report presented.

A copy of the Lincolnshire System Resilience Group System Wide Winter Plan 2015/16 was attached at Appendix A to the report. In guiding the Board through the Plan, particular reference was made to:-

- Page 27 – That for the first time, the youngest primary school children would be eligible to receive the free nasal spray vaccine;
- Page 28 – That Lincolnshire County Council had funded flu vouchers for contracted domiciliary care workers in the County, and that any surplus from the flu vouchers procured would be offered to contracted residential care homes for their staff;
- Page 29 – Paragraph 4.3 - Business Continuity Plans were seen locally as a key vehicle for ensuring quality and access to services was maintained through periods of system pressure;

- Page 29 - Paragraph 4.4 – The role of Neighbourhood Teams with the voluntary and community sector. It was highlighted that the TED initiative in East Lindsey to combat loneliness and isolation played a vital element in maintaining winter community resilience;
- Page 31 – It was highlighted that the Clinical Assessment Service was to be phased in from November 2015. The integrated services was provided by LCHS, Care UK, EMAS, LFPT and ULHT and provided enhanced clinical assessment with a view to decreasing the number of attendees at A & E departments;
- Page 31 – Additional Primary Care Capacity. It was noted that each practice was striving to improve access; that patients were educated about the importance of self – care, and were aware of the appropriate way for accessing care in different situations; extended hours of provision; assurance to NHS England on the quality of business continuity plans; reducing staff sickness through winter by maximising flu vaccinations;
- Page 33 – Acute Care Plans – It was highlighted that plans were in place to minimise hospital admissions; improve the flow of patients out of A & E into hospital, and through the hospital; and reducing delayed transfers of care to release hospital beds;
- Page 34 - Transitional Care (Intermediate Care), Reablement and Home Care Capacity/Facilitated Discharge Teams;
- Page 35 – Local Authority Plans – It was noted that the Local Authority had a critical role in ensuring that the system was able to cope through the winter, details of which were shown on page 35;
- Care UK – 111 – The Board noted that the Service Resilience Group Dashboard included performance data for 111; and through the contractual process commissioners would ensure that 111 escalation plans were clear in terms of their communication in to the system;
- Page 38 – Mental Health Support – Psychiatric Liaison Services for the County – The Board were advised that the new multi-disciplinary Mental Health Liaison Service would be based at Lincoln, Grantham, Boston and Peterborough acute hospitals and would take referrals from acute trust staff, and also case-finding to deliver rapid assessment of mental health needs;
- Page 39 – Excess winter deaths and wellbeing – It was noted that Public Health with Partners and Providers aimed to reduce excess winter deaths and improve well-being. Partner agencies would be working to support the implementation of the proposed NICE guidelines 'Excess winter deaths and morbidity and the health risks associated with a cold home', targeting vulnerable people; and
- Page 40 – This page provided a list of interventions being undertaken to increase an individual's resilience against the cold.

In conclusion, the Board were advised that the plan demonstrated a detailed and connected approach across health and care organisations to prepare, respond and recover to the presenting risks and challenges of the winter. The Board welcomed the report.

During discussion, the Board raised the following issues:-

- The inclusion of District Councils on the distribution list. It was also reported that Districts had a wealth of knowledge and data about their area and their vulnerable people;
- That the plan seemed like an NHS Plan, and as such did not tackle the big issue of the availability of Pharmacists across the County. The rurality of Lincolnshire and the reduced openings over the Christmas period made it difficult for people to access the service if required. It was noted that there was a problem with Pharmacists; however, anyone requiring the service was able to ring 111 and obtain information as to the nearest available Pharmacists to their location;
- The need to encourage staff to have a flu vaccines going forward. It was noted that organisations funded their own vaccines. Some discussion was had as to the effectiveness of a flu vaccine. It was highlighted that no vaccine was 100% effective, as the flu virus continually mutated, and it also took six months to produce a flu vaccine. On the whole, the flu vaccine was effective at preventing flu, but not a cold. It was highlighted that there was a need for a combined effort by all involved organisations to encourage staff to have a flu vaccine;
- The positive impact that Neighbourhood Teams would have in the winter planning process going forward;
- The need to include more reference to children and young people, children's paediatrics and the need to look into increased use of Children's Centres by Health Visitors; and
- To help alleviate discharge blockages, it was highlighted that there needed to be more work done on the flow process, as the biggest delays were caused by NHS delays, such as assessments, prescriptions. Eighteen out of twenty cases were simple, it was the cases that were more complex that were taking the time. The plan was to have the most acute patients in and out within seven days.

RESOLVED

That the report on the joint health and care system approach to winter planning be noted.

23 ACTION UPDATES FROM THE PREVIOUS MEETING

RESOLVED

That the completed actions as detailed be noted.

24 CHAIRMAN'S ANNOUNCEMENTS

The Chairman advised the Board that since the despatch of the agenda, one item had been brought to her attention and that was that the Joint Ambulance Project had won a National Award within the Fire and Rescue Arena. The Chairman extended congratulations on behalf of the Board to everyone involved in the Project.

The Board were advised further that since the publication of the papers for the agenda a further Pharmaceutical Needs Assessment had been received (Sixth application received). The Board noted that the application would be put on hold as NHS England had not taken on responsibility for this matter, and as a result, the Chairman would be writing to NHS England.

RESOLVED

That the announcements as detailed; and the verbal update provided be noted.

25 DECISION/AUTHORISATION ITEMS

25a Clinical Commissioning Group Commissioning/Operational Plans

The Board received a presentation from each of the four Clinical Commissioning Groups on their high level commissioning intentions for 2016/17.

Dr Peter Holmes presented the Commissioning Intentions & Plans 2016/17 for the Lincolnshire East Clinical Commissioning Group (CCG).

The Board were advised that the CCG would be focussing on:-

- The outcomes from the Lincolnshire Health and Care consultation;
- Stability across the whole system to deliver NHS Constitution Standards;
- Parity of Esteem;
- Primary Care – Out of Hospital Strategy;
- Estates Strategy link to the Primary Care Transformation Fund;
- Primary Care Co-Commissioning, particularly for quality, integration and future sustainability;
- Five-Year Forward Plan;
- Dementia Pathway review linked to Dementia Friendly Communities;
- Systematic approach to Frailty; and
- Clinical effective and cost efficient prescribing across the system.

The Board received a short verbal update from Dr Kevin Hill regarding the Commissioning Intentions Development for 2016/17 for the South Lincolnshire Clinical Commissioning Group.

The Board were advised that the CCG would be focussing on:-

- Mental Health;
- End of Life Care;
- Proactive Care;
- Neighbourhood Working;
- More Services at Local GP Practices;
- Care Closer to Home;

- Cancer Services; and
- Dementia Care.

Allan Kitt, Chief Officer, presented the High Level Plan for 2016/17 for the South West Lincolnshire Clinical Commissioning Group.

In guiding the Board through the presentation, reference was made to the programmed areas of work for 2016/17, which included:-

- Urgent Care;
- Primary Care;
- Cancer Services;
- Planned Care;
- Mental Health, Learning Disabilities;
- End of Life Care; and
- Proactive Care.

The Board received a short presentation from Dr Sunil Hindocha concerning the emerging Commissioning Intentions/Priorities for 2016/17 for the Lincolnshire West Clinical Commissioning Group.

The Priorities for the CCG were as follows:-

- NHS Constitution – The priority was to improve the customer experience for patients suffering with cancer;
- Mental Health;
- Diabetes;
- Cardio Vascular Disease;
- Childhood obesity; and
- The implementation of the Primary Care Strategy.

During discussion, the Board made reference to:-

- The need to rationalise estates across the NHS;
- That Deprivation issues were included within Lincolnshire East CCG's Plans. Reference was made to the Director of Public Health's Annual report, which referred to preventable diseases, and early mortality for the under 75's within the East Lindsey area;
- Issues for concern going forward liver disease, hepatitis, alcohol abuse diabetes and obesity. It was noted that the Public Health report had identified Boston and East Lindsey as having issues in a number of areas;
- Educating parents to take responsibility for their children; and adults to take responsibility for themselves;
- The need for more diabetic support groups throughout the County. Some members felt that it was important to tackle the issue early, through education, exercise and partnership working; and

- The need to tackle childhood obesity. The Board were advised that Healthwatch had conducted a survey in schools, the results of which would be available at the end of January 2016.

The Chairman extended thanks to the four CCG's for their plans and advised that the Board looked forward to receiving the final versions at its 22 March 2016 meeting.

RESOLVED

That the Clinical Commissioning Groups Commissioning/Operational Plans presented be noted.

26 DISCUSSION ITEMS - CONTINUED

26a New Psychoactive Drugs - Briefing

The Board gave consideration to a report from Mark Housley, County Officer - Public Protection, which provided information on the new Psychoactive Substances (NPS) and details of the current situation in Lincolnshire.

It was reported that Lincolnshire had over the last few years seen a considerable increase in the use of (NPS). However, in the last three years the Lincolnshire Community Safety Partnership had responded to the challenge by delivering a focussed approach with regard to education, engagement, intelligence sharing and increased enforcement. Appendix A to the report provided the Board with a more detailed briefing on the situation in Lincolnshire.

In conclusion, the Board were advised that there had been considerable success in closing down retailers, also over 5,000 young people had now engaged in programmes; and over 1,000 practitioners had participated in training. It was noted that intelligence was continuing to be developed to help resources to be maximised. Also, it was highlighted that enforcement continued with the use of Police and Trading Standards Legislation, and that at present all effort was being focussed on organised crime groups operating in Lincolnshire.

Particular reference was made to the FOI Results from Forces reporting incident relating to NPS, which was detailed on page 66 on the report presented. It was highlighted that critical to the success of the Lincolnshire approach was to encourage reporting and recording, which had enabled the County to be better informed to tackle the problem.

A suggestion was also made that officers should make representation to governors of schools to help get the message out to young people.

RESOLVED

That the report be noted.

26b Update on Activity - Lincolnshire Joint Commissioning Board (JCB)

The Board gave consideration to a report from the Chairman of the Joint Commissioning Board, which provided an update on the activities of the Lincolnshire Health and Care Programme, the Better Care Fund, and the Joint Commissioning Boards.

A short verbal presentation was received from Allan Kitt, Chief Officer, South West Lincolnshire CCG, which provided the Board with an update on progress made with the Lincolnshire Health and Care (LHAC) Programme.

It was reported that since the sign-off of the first phase of the LHAC by all stakeholder organisations over the winter of 2013, the programme had been working towards finalising the more detailed recommendations for change. The overarching vision for Lincolnshire Health and Care was the development of a system that prevented ill health, supported people as early on in their journey as possible, maintained their independence, and gave them choice and control at every stage of their journey.

The Board noted that in order for the case for change to be fully made and improved, a strategic outline case was required to be developed. It was noted further that the outline case needed to be assured by NHS England who had legal responsibility to ensure that any proposed reconfiguration met the key standards required. The strategic case also needed to be reviewed by the Clinical Senate who has regional wide responsibility for ensuing that proposed changes to services are both clinically evidenced, and reflect safe, high quality services.

The Board was advised that following feedback from the Clinical Senate and initial review by NHS England it had been identified that despite the strategic outline case being very strong, there was still a number of areas where further work needed to be undertaken. These were mainly around the detail surrounding the options for reconfiguration. To complete this, work was being done, which would then be reviewed by the LHAC Stakeholder Board and others, prior to going out to public consultation.

The Board was reassured that they would be kept updated as the strategic case was finalised and the assurance process with NHS England and the Clinical Senate was completed. It was also highlighted that the public consultation would be at the end of the winter, and that the programme remained in a very strong place and that work on the Neighbourhood Teams continued to be developed.

Glen Garrod, the Director of Adult Social Services, provided the Board with an update on the Better Care Fund (BCF).

It was reported that progress had been reviewed on the progress of the £197.3m BCF pooled fund and that the BCF Task Group had recently agreed to move to fortnightly meetings to enable it to:-

- Review 2015/16 BCF schemes being invested in across Lincolnshire;

- To consider the challenges facing health and care over the next year, particularly £20m to protect Adult Care;
- Look at funding for 2016/17. It was highlighted that it was anticipated that the national requirement would be for an agreed position to have been reached by February 2016;
- The work being undertaken to complete Quarter 2 return was due to be submitted by 27 November 2015. It was noted that the target of achieving a 3.5% reduction in non-elective admissions was achieved in the first quarter of 2015 would not be achieved in the quarter ending June, and September, and that it was currently being viewed as being very doubtful for the quarter ending 31 December 2015;
- The establishment of a £1m Local Integration Support Fund with individual bids for a maximum of £50K being requested; and
- An update on the recently announced Comprehensive Spending Review on the effects upon health and social care and the BCF. It was noted the extra money from the Districts would add £500m by the end of the decade for Disabled Facility Grants on top of existing allocations.

During discussion, one member raised the issue that prior to the LHAC consultation exercise, consideration should be given to employing a Communications expert to ensure that the right message was being delivered. The Board were advised that a person had been engaged to ensure that key messages were delivered, and key personnel were briefed to ensure consistency of the message being delivered.

RESOLVED

That the report be noted.

26c Health and Wellbeing Board Grant Fund Projects - Update Report

Consideration was given to a report from Alison Christie, Programme Manager Health and Wellbeing Board, which provided the Board with an update on the ten projects that had been allocated £1,316,234.00 of the Health and Wellbeing Grant Fund at the meeting of the Health and Wellbeing Board held on 24 March 2015.

It was reported that since the March meeting one of the projects 'Getting Lincolnshire Active' had been withdrawn as a result of Lincolnshire's Sport's application to Sport England for match funding being unsuccessful. Full details relating to the withdrawal were contained within the report presented.

The Board were advised that taking account of the money that would have been allocated to Lincolnshire Sport, the amount of unallocated HWB Grant Fund was now £162,427.00.

The Board were advised further that Grant Funding Agreements were now in place for eight of the remaining projects with the final agreement due for signing shortly.

The Board were advised that a number of projects had experienced some delays in setting up due to problems in recruiting staff and/or volunteers or prolonged

procurement processes. Also the 'My Rural Life' project due to have been completed by the end of quarter two, was delayed due to issues with Agresso and the late payment of invoices. The Board was advised that the project was now due to be completed in December 2015.

Appendix A to the report provided the Board with an overview of Live Projects.

A short discussion ensued, from which the Board enquired whether the 'Get Started' project on page 77 was compliant from an educational prospective. Further comments were made with regard to the lack of progress made. The Board were advised that since September some money had been drawn down.

RESOLVED

1. That the project updates as detailed in Appendix A be noted.

2. That a half yearly update report on the Health and Wellbeing Grant Fund Projects be received at the 7 June 2016 meeting.

26d District/Locality Updates

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

26e Joint Health and Wellbeing Strategy Theme Updates

The Programme Manager Health and Wellbeing advised the Board 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.

27 INFORMATION ITEMS

27a Greater Lincolnshire proposals for devolved powers from Government

Consideration was given to a report from Dr Tony Hill, Executive Director of Community Wellbeing and Public Health, which provided the Board with an update on the Greater Lincolnshire proposals for devolved powers from Government.

The Board was advised that Greater Lincolnshire had submitted an expression of interest on 4 September 2015, a copy of which was appended as Appendix A to the report.

The Board were advised further that the document had been signed by the Leaders of ten local authorities, along with other public sector organisations including six Clinical Commissioning Groups and the Chairman of the Greater Lincolnshire Enterprise Partnership. The submission set out the ambition for the area and focussed on the benefits of the approach which included:-

- Accelerating economic growth;
- Improving transport links regionally, nationally and internationally;
- Tailoring skills to the needs of local employers to boost employment opportunities in the County;
- Managing flood risk;
- Meeting the housing needs of all residents; and
- Joining up health and care services to improve people's health and wellbeing.

The Board noted that the Greater Lincolnshire expression provided genuine opportunity for the area to take on some responsibility from central government to make more decisions locally to improve the quality of life and prospects for greater prosperity in Greater Lincolnshire.

RESOLVED

That the report be noted.

27b An Action Log of Previous Decisions

RESOLVED

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

27c Lincolnshire Health and Wellbeing Board - Forward Plan

The Programme Manager Health and Wellbeing presented to the Board the current Forward Plan for consideration.

One member suggested having an informal session of all relevant organisations to look at strategic issues, and enable partners to review the 'whole' commissioning picture for Lincolnshire.

The Board welcomed Councillor Leyland's attendance as an observer at meetings going forward.

RESOLVED

That the Forward Plan presented for formal and informal meetings be received.

The meeting closed at 3.50 pm

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Meeting Date	Minute No.	Agenda Item & Action Required	Update on Action taken
09.06.15	**7**	**CHAIRMAN'S ANNOUNCEMENTS** 2015 Health Profiles - Members were invited to email the Programme Manager Health and Wellbeing regarding any issues they wanted to raise.	2015 Health Profiles for Lincolnshire were circulated to Board Members. No issues have been raised with the Programme Manager.
29.09.15	**15**	**CHAIRMAN'S ANNOUNCEMENTS** The Chairman to send a letter of thanks to Malcolm Swinburn on behalf of the LHWBB	The Chairman, on behalf of the Board, sent a letter of thanks to Malcolm Swinburn on 9 October 2015.
	16a	**ANNUAL ASSURANCE REPORT** That Gary Janes (Chairman of the Resilience Group) form Lincolnshire East CCG should be invited to attend the 9 December meeting. **Theme 4 – Improve health and social outcomes for children and reduce inequalities** – It was agreed that unintentional injury hospital admissions data from A & E should be made available to members of the Board **Theme 5 – Tackling the Social Determinants of Health –** It was agreed that the Public Health Consultant – Wider Determinants & Children would circulate to members of the Board, membership details for the Greater Lincolnshire Local Enterprise Health and Social Care Board.	An item on Winter Pressures was included on the HWB agenda for 9 December 2015. A briefing paper on Childhood Injuries in Lincolnshire provided to Board Members as part of Chairman's Announcements on 8 December 2015. Further clarification regarding the Greater Lincolnshire Local Enterprise Board, including details on membership, provided to the Board as part of Chairman's Announcements on 8 December 2015.
08.12.15	**24**	**CHAIRMAN'S ANNOUNCEMENTS** Pharmaceutical Needs Assessment application– That the Chairman would write to NHS England regarding this application.	A letter, from the Chairman, was sent to NHS England on 15 December 2015.
	25a	**CLINICAL COMMISSIONING GROUP COMMISSIONING/OPERATIONAL PLANS** Childhood Obesity – Healthwatch to provide the Board with the results of a survey conducted in schools (available at the end of January 2016).	Healthwatch Lincolnshire's report on Food and Fitness was circulated to HWB Board Members as part of February's HWB Monthly Briefing. A copy of the report has also been sent the Lead for the JHWS Theme *'Improve health and social outcomes for children and reduce inequalities.'*

	27a	**<u>Lincolnshire Health and Wellbeing Board – Forward Plan</u>** Informal session of all relevant organisations to look at strategic issues, and enable partners to review the whole commissioning picture for Lincolnshire.	The Informal Health and Wellbeing Board held on 9 February 2016 reviewed the emerging 2016/17 Commissioning intentions for Adult Care, Children's Services, Public Health and all four CCGs.

Lincolnshire COUNTY COUNCIL
Working for a better future

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:	**22 March 2016**
Subject:	**Proposals on the future provision of Lincolnshire's Joint Strategic Needs Assessment**

Summary:

In March 2015, the Board agreed the process of review for the Joint Strategic Needs Assessment (JSNA). This report presents the key findings from the stakeholder engagement exercise, completed in December 2015, and suggests proposals to further improve Lincolnshire's JSNA.

Actions Required:

The Board is asked to:

1. Discuss and comment on the findings from the stakeholder engagement exercise;
2. Agree the recommendations for the future provision of Lincolnshire's JSNA shown in Section 4 of Appendix A
3. Give a clear steer on the inclusion of new JSNA Topics, including the topics suggested by stakeholders shown in List 3 of Appendix B.

1. Background

The requirement to produce a JSNA was first introduced by Local Government and Public Involvement in Health Act (2007) which placed a joint responsibility on the Directors of Public Health, Adult Care and Children's Services to produce a JSNA for the local area. The Health and Care Act (2012) amended the 2007 Act by introducing statutory duties and responsibilities on the Health and Wellbeing Board in relation to the JSNA and the Joint Health and Wellbeing Strategy (JHWS).

The JSNA is an assessment of the current and future health and social care needs of the local population. The JSNA is the overarching evidence base and is used by the Board and partners to:

- Inform the priorities in the JHWS by identifying the important health and wellbeing issues which require joint action; and
- Inform decisions about how services are designed, commissioned and delivered.

The current format of the JSNA has been in place since 2011 and is constructed around 35 individual topics that consider very specific areas. In March 2015, the Board agreed a process of review for the JSNA to inform the development of the new JHWS, to be in place by April 2018.

A multi-agency JSNA Steering Group has been established to oversee the review process and support the refresh process which will take place during 2016. The Group is made up of representatives from each of the CCGs, Adult Care, Children's Services, Public Health, Healthwatch Lincolnshire, District Councils and the voluntary & community sector.

The first stage of the review, to December 2015, examined the content, structure and processes underpinning the JSNA. The report, in Appendix A, summarises the key findings from the stakeholder engagement exercise and sets out a number of proposals and recommendations to further improve Lincolnshire's JSNA. It should be noted that, whilst the report focusses on where improvements can be made, processes for continuous improvement have been in place throughout the provision of the JSNA, and it should be recognised that Lincolnshire's current JSNA already meets a wide variety of need.

The starting point for the review during 2016/17 will be 33 of the current JSNA topics, see List 1, Appendix B. Feedback from the stakeholder exercise has suggested that two of the current topics are no longer relevant (List 2, Appendix B) and stakeholders have also suggested a number of possible new topics for inclusion in the future JSNA (List 3, Appendix B).

Alongside the JSNA review, work will also begin to develop a prioritisation framework for the new JHWS. The intention is to bring a paper to the Board in September 2016 for the Board to agree the framework and the approach to be taken to identify a long list of priorities for consultation during 2017. Appendix C provides a high level timeline showing the key elements of the JSNA and JHWS reviews from now until March 2018.

2. Conclusion

Lincolnshire Health and Wellbeing Board has a statutory duty to produce a JSNA and to use this to inform the priorities in the JHWS. This report sets out a number of proposals to further improve Lincolnshire's JSNA.

3. Consultation

A stakeholder engagement exercise was conducted between September and December 2015; this included all the statutory organisations on the Board, District Councils, NHS Providers, and Voluntary and Community Sector organisations. Views were also sought from the Health Scrutiny Committee for Lincolnshire.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Findings and Proposals of the 2015 Review of Lincolnshire's Joint Strategic Needs Assessment
Appendix B	JSNA Topic Lists
Appendix C	Review timeline

5. Background Papers

Document Title	Where the document can be viewed
Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies (2011, Department of Health)	https://www.gov.uk/government/publications/jsnas-and-jhws-statutory-guidance

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

Findings and Proposals of the 2015 Review of Lincolnshire's Joint Strategic Needs Assessment

1. Introduction

The Joint Strategic Needs Assessment (JSNA) reports on the health and wellbeing needs of the people of Lincolnshire. It brings together detailed information on local health and wellbeing needs and looks ahead at emerging challenges and projected future needs.

The JSNA is not an end in itself, but a continuous process of strategic assessment and planning led by Public Health and involving Children's and Adult Services, Clinical Commissioning Groups (CCGs), District Councils, Healthwatch Lincolnshire, the Voluntary and Community Sector and other partners. Overall responsibility for producing the JSNA rests with the Health and Wellbeing Board (HWB). The JSNA is used by the HWB to inform the priorities in the Joint Health and Wellbeing Strategy (JHWS), and as the basis for planning and commissioning services.

The current format of the JSNA has been in place since 2011 and is constructed around 35 individual topics that consider very specific areas, details provided in Appendix B. The JSNA is a shared resource which is available to stakeholders through the Lincolnshire Research Observatory (LRO). The objectives of the review are to identify ways of enhancing the current JSNA and to ensure future systems and processes support ongoing awareness, engagement and use.

2. Approach

The first stage of the review, to December 2015, examined the content, structure and processes underpinning the JSNA. Evidence was gathered through a variety of means including attendance at 64 stakeholder board meetings and events; 121 responses, including 10 corporate responses, to an on-line stakeholder feedback survey; research of the findings of previous engagement activities and past experience; and investigation of national guidance and experience of others.

The statutory guidance on JSNAs does not prescribe either format or content, advising only that 'local areas are free to undertake JSNAs in a way best suited to their local circumstances' – there is no template or format that must be used and no mandatory data set to be included.[1] Therefore the discussion and proposals in this report are aligned to the five principles suggested by the (then) Care Services Improvement Partnership on behalf of the Department of Health, and adopted in the provision of Lincolnshire's current JSNA. These principles are:

- Clear Purpose
- Effective Engagement
- Clear Content
- Commissioning & Outcomes
- Continuous Improvement

The remainder of the report will therefore be structured to the five principles.

[1] Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies (2011), Department of Health

3. General Findings

3.1 Clear Purpose

There is wide variation in the awareness and use of the JSNA. For stakeholders familiar with the JSNA the purpose and benefit was clear, and it is seen as the 'go-to evidence base'. Feedback on the data within the JSNA was also very positive suggesting that the current content supports its purpose. Partners have used the JSNA to inform business planning, funding applications, evidence of resource need, service prioritisation, identification and filling of service gaps (particularly noted in relation to diabetes and obesity) and strategy development.

However, a significant number of respondents were completely unaware of the JSNA or, where they were aware, have never used it. These stakeholders were under the impression that the JSNA is solely for commissioners and cited examples of other data resources as their main sources of evidence, for example Public Health England Health Profiles and Office for National Statistics. There is also a wide perception that the JSNA is a single, stand-alone document rather than a body of evidence.

A number of suggestions for improvement were made, including on-going awareness raising of all aspects of the JSNA, as well as better information on the purpose and benefits of using the JSNA. These were seen as key to improve levels of understanding and buy-in. Furthermore, it was felt that there was a need to demonstrate the differences and links between the JSNA evidence base and the priorities in the Joint Health and Wellbeing Strategy. Increased data sharing and provision of partner intelligence to the JSNA was seen as a way of making it a more useful and purposeful evidence base.

3.2 Effective Engagement

Engaging partners effectively in the JSNA is as much about relationship building, as information flows, and it is apparent that buy-in across stakeholders is inconsistent. Many partners, wrongly perceived, that Public Health alone was responsible for producing the JSNA, with little awareness of the statutory nature of the evidence base nor the requirements placed on Health and Wellbeing Board members/organisations to be involved in its development.

Feedback suggests that the JSNA review needs to be a 'genuine offer' to engage more effectively with partners and stakeholders. It is positive that, following the presentations, several boards and networks have offered to make the JSNA a standing item at their meetings, if the key contacts and processes for involvement can be outlined. This reflects a growing awareness and recognition of its importance to partner organisations, including those in the third sector. In general, organisations welcome the opportunity to be more engaged in the JSNA, seeing it as an opportunity to increase 'networking' and 'collaborative working'. Therefore there is an opportunity to build on this willingness during the forthcoming refresh.

Stakeholders felt that on-going promotion and awareness should include information on the processes for developing, updating and interpreting intelligence and information on how all partners could feed information and data into the JSNA. Some felt that the benefit of using the Voluntary and Community Sector (VCS) organisations and local partners to access intelligence on more 'hard to reach' communities should be recognised, as these often have established and trusted 'routes in'. There is also a role for VCS infrastructure

organisations in involving and disseminating information to smaller, grass roots community-organisations and groups.

3.3 Clear Content

Feedback in relation to this principle most frequently centred on making the JSNA 'easier to use' and 'easier to understand'. Respondents highlighted the importance of appropriate language, suggesting solutions such as reducing jargon, the use of easy to understand terminology and continuation of the easy read version of the JSNA. It was also suggested that topic commentaries could be made more simple, concise and accessible, and that the intelligence within them could benefit from a more flexible approach to provision across the JSNA.

There were also suggestions on how the evidence base could be broadened. These include addition of Asset Based information (in reference to 'building healthy, sustainable communities'), widening of data on issues such as mental health, sensory impairment, disability, neurology, health inequalities, dementia, autism, end of life care, offenders, domestic violence, financial inclusion and wider determinants of health (for example, housing, deprivation and isolation), and by focusing on particular groups such as marginalised and minority groups. There was also a view that wherever possible data should be provided at the lowest level to aid local commissioners.

Feedback was also received asking for the topics on Residential & Nursing Care and Personalisation to be removed from the future JSNA as these were services rather than needs.

Away from specific gaps, the value of other types of evidence was noted. It was felt that rich, qualitative data that 'tells a story' should be included, and that in order to achieve this, the purpose, use and value of this type of data needed to be defined. Information on assets and strengths were seen as an important part of the picture, not just need. Examples of useful qualitative evidence include case studies, service-user views and those of specific client groups, best practice examples and experiences of others.

3.4 Commissioning & Outcomes

The current JSNA is not fully embedded and is not consistently or routinely used by stakeholders in the development, review and commissioning of services. There is a need to ensure all statutory partners take account of the JSNA in decision making and the commissioning of services. To help facilitate this, the links between the JSNA and the priorities in the JHWS need to be made clearer and more explicit.

As in other principles, local level intelligence, additional data sources and practical examples were all raised in relation to the ability of the JSNA to influence commissioning decisions. The issue of practical examples was noted a number of times and this suggests that commissioners lack confidence to interpret and utilise the evidence provided in the JSNA.

3.5 Continuous Improvement

It should be noted that, whilst this report focuses on where improvements can be made, there were a large number of positive comments about the existing format and usability of the JSNA. This should be acknowledged to ensure that existing good practice is not lost and that the current provision is built upon to further support commissioners, services and communities of Lincolnshire in protecting and improving health and wellbeing. In addition,

processes for continuous improvement have been in place throughout the provision of a JSNA in Lincolnshire, and it should be recognised that the current JSNA already meets a wide variety of needs.

4. Proposals and Recommendations for the Future Provision of Lincolnshire's JSNA

1. Feedback suggests that all but two of the current 35 topics are still relevant therefore the **recommendation is to continue with a base of 33 topics shown in List 1 of Appendix B**. These 33 topics will form the basis of the fundamental review of the JSNA content during 2016/17.

2. Feedback suggests that two topics, shown in List 2 of Appendix B, are no longer relevant as they are services not needs, therefore the **recommendation is to remove these topics from the refreshed JSNA**.

3. Feedback suggests there are gaps in the current list of JSNA topics and a number of possible new topic areas have been suggested by stakeholders, shown in List 3 of Appendix A. Whilst there is a need to ensure the JSNA accurately reflects the health and care needs in Lincolnshire, this should to be balanced against keeping the number of topics manageable. Therefore the **Board is asked to give a clear steer on the inclusion of new JSNA topics**. Based on the Boards recommendation the JSNA Steering Group will work with, and task key stakeholders to explore potential gaps.

4. Feedback suggests the current processes for updating the JSNA topics are not adequate and it is **recommended that a more formalised process supported by specialist and analytical capacity is required to support the refresh**. To ensure this, it is proposed to:
    - Prioritise the topics for review into rolling cohorts – 5 or 6 topics per cohort;
    - Stagger the review start date for each cohort so not all the topics are being reviewed simultaneously;
    - Establish expert panels, made up of representatives from the County Council, CCGs and other appropriate partners, for each topic. The expert panel will be responsible for overseeing the refresh of the topic;
    - Allocate a Public Health Analyst to each topic to support the work of the expert panels.
    - Members of the JSNA Delivery Group lead aspects of the review.
    - The expert panels will be time limited in duration to ensure all topics are assessed appropriately in year.

5. Feedback suggests that ownership and buy-in needs to be strengthened. It is therefore **recommended that the governance arrangements for the JSNA are reviewed and the JSNA Steering Group is refocused into a Delivery Group**. This new group will have a clear role in championing the JSNA in their organisation and supporting/tasking colleagues to input into the review.

6. Feedback suggests that awareness and information about the purpose and role of the JSNA needs to be improved. It is therefore **recommended that a programme of engagement and communication is developed to support the programme of review** outlined in recommendation 4. Communication and engagement activities will be delivered, and supported by HWB partners, in line with the Engagement Framework that was agreed by the Board in September 2015.

Appendix B

JSNA Topic Lists

List 1 – Current JSNA Topics

Alcohol (Adults) Breastfeeding Cancer Childhood Immunisation Childhood Obesity and Weight Problems Chlamydia Screening Chronic Obstructive Pulmonary Disease Chronic Heart Disease Diabetes Drug Misuse Educational Attainment (Foundation) Educational Attainment (KS4) Excess Seasonal Deaths Falls Food & Nutrition Housing Learning Disabilities	Life Expectancy Looked After Children Mental Health Obesity (Adults) Physical Activity Physical Disabilities Pregnancy and Maternal Health Road Traffic Collisions Smoking (Adults) Special Educational Needs Stroke Suicide Teenage Pregnancy Unpaid Carers Young People within the Criminal Justice System Youth Work

List 2 – Current JSNA Topics – proposal is to remove from the future JSNA

Topics	Rationale and Comment
Residential and Nursing Care Personalisation	These topics are not areas of need but services that are delivered to meet the needs.

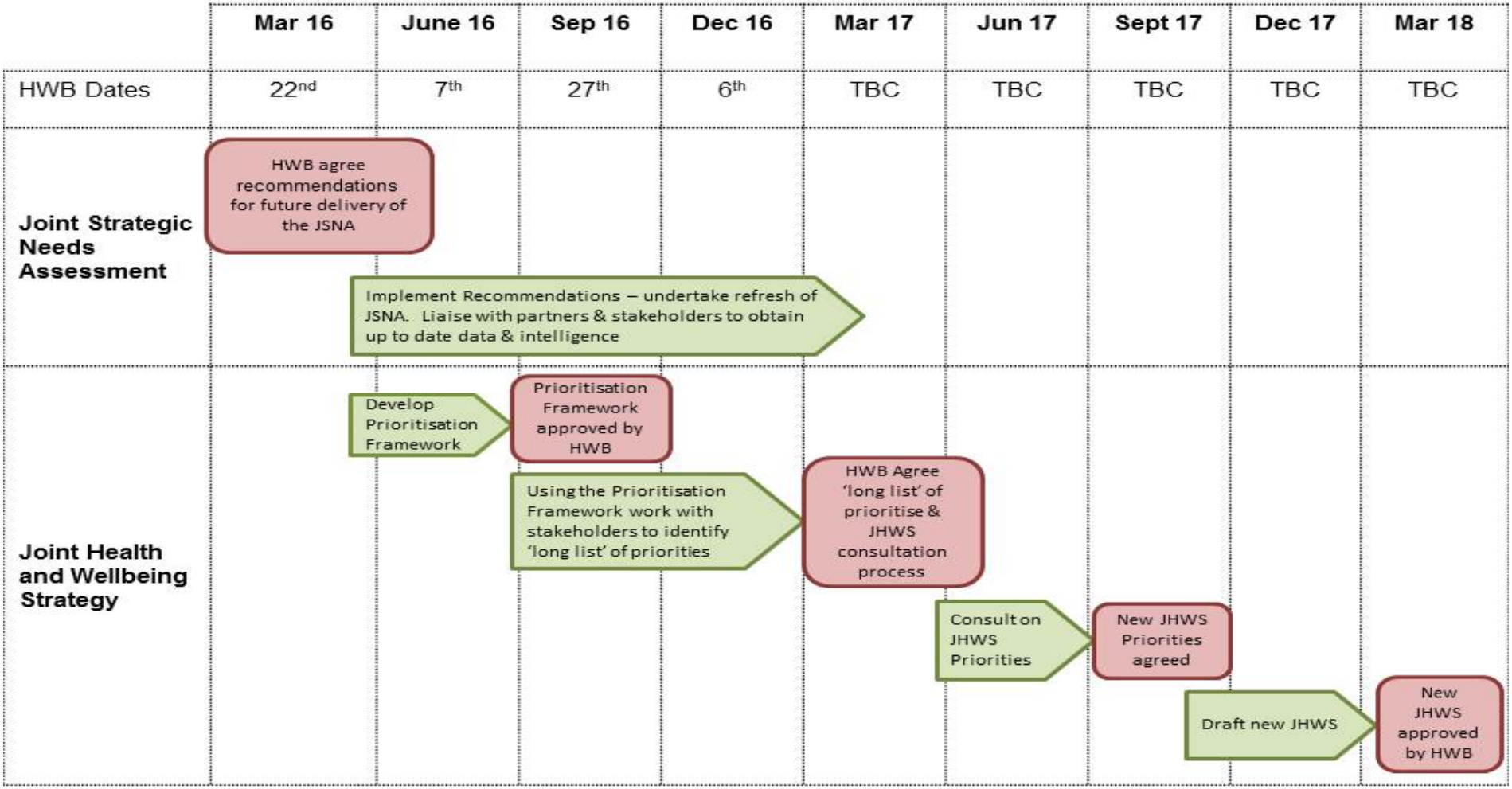
List 3 – Suggested New JSNA Topics – identified through the stakeholder engagement exercise

Suggested new topic	Rationale and Comment
Autism	Autism is briefly mentioned in the Special Educational Needs and Learning Disability topic. However neither topic gives a full assessment of the needs of people with Autism.
Dementia	Dementia is currently included in the Mental Health topic but given Lincolnshire's ageing population stakeholders have suggested it would be advantageous to have a separate topic on dementia.
Domestic Abuse	Not currently covered in the JSNA. The rates of domestic abuse are increasing and there are some issues about under reporting in certain demographics.
End of Life Care	Not specifically referenced in the current JSNA. The preference would be to not have this as a separate topic but to incorporate aspects of End of Life Care into existing topics covering long term conditions for example Cancer, Stroke, COPD, CHD.
Environmental Resilience	Not currently covered in the JSNA

Financial Inclusion	Aspects of financial inclusion are covered in a number of existing JSNA topics. However, stakeholder feedback suggests, as this issue has a significant impact on people's life chances and wellbeing, it warrants being a topic in its own right.
Health inequalities/deprivation	The current JSNA does not include sufficient information and data on health inequalities and deprivation, and this has been identified as an area for improvement. The preference would be not to create a separate topic on health inequalities but to ensure, where possible, relevant information is incorporated into existing topic commentaries.
Isolation/transport/access	Not currently covered in the JSNA. Isolation, loneliness and access to transport have been highlighted as significant issues in many parts of Lincolnshire, especially given the rural nature of the county and the ageing population.
Neurology	Not currently a topic in the JSNA. This is a long term condition and the prevalence of neurological conditions is likely to rise due to Lincolnshire's ageing population.
Offenders	Offenders have been suggested as a specific group that needs to be included in the JSNA. Many of the current topics already make reference to the needs of various disadvantaged groups and the preference would be not to have a separate topic on Offenders but to ensure their needs are fully included in existing topic commentaries, for example Mental Health, Housing, Drug Misuse
Sensory Impairment	Sensory Impairment is already included in the Physical Disabilities topic; therefore the preference would be not to have this as a separate topic but to ensure the Physical Disability topic fully reflects the needs of people with sensory impairment.

Appendix C

JSNA & JHWS Development Timeline



Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on Behalf of NHS South Lincolnshire Clinical Commissioning Group (CCG)

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**22 March 2016**
Subject:	**NHS South Lincolnshire CCG 2016/17 Operational Plan**

Summary:

In addition to aligning our 2016/17 work programmes with the Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS) we have also used the information provided by our patients, public and stakeholders along with national and local outcomes data such as the Atlas of Variation to create our focus areas for 2016/17. Our commissioning intentions and one year operational plan aim to deliver changes working in partnership and collaboratively ensuring capacity and capability is in place.

Commissioning plans and a joint action plan with Public Health details the work the CCG will carry out during 2016/17, Appendix A

The information presented and attached is still in draft format until final sign off by all parties once completed the full 2016/17 Operational Plan will be available for viewing at http://southlincolnshireccg.nhs.uk

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

1. Background

South Lincolnshire's 2016/17 Operational Plan begins with a current position and a plan to secure patients safety and quality outcomes throughout, forwards to the process SLCCG has taken to produce the plan working collaboratively, engaging, and being transparent and inclusive of all. Using national and local information such as the Five Year Forward View, The Mandate, the JSNA and Commissioning for Value pack the

CCG has, jointly with the Health and Wellbeing Boards, focussed on the needs and service requirements that are most relevant and important to its population.

2. Conclusion

We will achieve the overall system wide transformation described by the LHAC and the five year strategy whilst at the same time deliver the local aims developed in partnership with our population and stakeholders. We will work with our stakeholders and public empowering patients and their carers to commission the best possible outcomes within financial resources available as set out in the summary plan on a page, appendix B.

3. Consultation

SLCCG is committed to empowering patients giving them more choice and control over their condition and health service. The CCG continues to actively engage with all stakeholders, patients and the public using a robust and embedded communications and engagement approach to continuous listening. We proactively ensure the views of all population groups are listened to and fed back into the decision making process in the CCG.

Events held during 2015 asked a range of people to tell us what is important to them when we develop future service priorities. Attendees were from a number of organisations and community groups, such as healthcare providers, local authorities, voluntary organisations and patient representative community groups and they told us that the following were important to them:

- Mental Health: continuing to support with education and learning for both patients and professionals to improve patient experience.
- End of Life Care: Continuing to improve end of life planning with patients; carers; families and friends.
- Proactive Care: Following on from our Chronic Heart Failure; diabetes and stroke prevention work. More education and learning for patients to better self-manage and better prescribing to reduce long term risks.
- Neighbourhood Working: Professionals working better together and locally for a better patient journey.
- More Services at Local GP Practices: Increasing the amount of services that are available at a GP practice
- Cancer Services: continuing to improve local access to services.
- Dementia Care: focussing on earlier diagnosis of dementia and pathways of services after diagnosis.

The CCG has used this feedback to identify and develop our transformation programmes for 2016/17 that will enhance service provision and quality where clinically appropriate, SLCCG 2016/17 work programmes is attached as Appendix C.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	SLCCG Commissioning plans and PH Joint Action Plan
Appendix B	Plan on a Page
Appendix C	SLCCG Work Programmes

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

Appendix A

Commissioned & Planned Services aligned to JSNA and Joint PH Action Plan

The full Public Health profile (an appendix to the full operational plan) provides an overview of the health of the population living in the geographical area covered by South Lincolnshire CCG (SLCCG). It describes key demographics of people living in the area, outlines key health concerns, and highlights areas of health inequalities in SLCCG.

When reading the information it is important to consider the following caveats:

- The data included in the profile is a snap shot of demographic and health data for the time period indicated; and,
- Most of the information used relates to the GP registered population. However, some data sources use ONS population estimates.

Full referencing is provided throughout to enable to reader to access source information.

Key Points

- South Lincolnshire CCG has a lower prevalence of income deprivation, child poverty and unemployment compared with other areas in Lincolnshire and the England average.

- The population has an older profile than other Lincolnshire CCGs and England. There is a higher proportion of people aged 50 years and older.

- Life expectancy at birth in the CCG is slightly higher than the England average for males (80.0 compared with 78.9 years), and almost the same for females (83.1 versus 82.8 years).

- The prevalence of cancer, diabetes, coronary heart disease, stroke and respiratory disease are all slightly higher in SLCCG than the England average. This may partly reflect the older age profile of the SLCCG population.

- Emergency admissions to hospital are below the national average and elective admissions are significantly higher.

The profile should be read alongside the Joint Strategic Needs Assessment (JSNA) in order for the reader to consider how the five priority themes of the JSNA link to key health and health inequality concerns in SLCCG. The five priority themes are:

1. Promoting healthier lifestyles
2. Improving the health and wellbeing of older people
3. Delivering high quality systematic care for major causes of ill health
4. Improving health and social outcomes for children and reduce inequalities
5. Tackling the social determinants of health

Services have been and will be commissioned to meet these aims and all commissioning decisions have been endorsed by Lincolnshire County Council, Lincolnshire's CCGs, and District Councils, Health watch 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 Joint Health and Wellbeing Strategy (JHSW) and deliver the outcomes which are included in the five themes.

3.1 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	Quit 51 Smoking Cessation Service
Decrease obesity	Dietician referrals/Diabetes Prevention Programme
Increase physical activity	PH Exploring alternative options to deliver physical activity interventions, Health trainers Lincolnshire Sport
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 Vitality - Evergreen Care
Develop a network of "wellbeing" services aimed at supporting older people to live healthier, happier and independent lives	Parkinson Nurse Dementia Support Network Bourne Dementia Support Network Spalding Age concern square hole club Dementia café Butterfield Centre Alzheimer's UK – various clubs across SL Start Afresh Rethink Mind
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 will support the lead commissioner WLCCG for cancer to implement the cancer strategy for Lincolnshire whilst focussing on local improvement areas identified. St Barnabas services Red Cross
Minimise the impact of long term health conditions on mental health	IAPT – Maintaining performance, EIP - Implementing new NICE guidance, access to extended age group.

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 wellbeing
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 Home Start services for under 5 years old
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

SLCCG, working jointly with Public Health is reviewing the action plan below and will continue the actions set out during 2015 to reduce inequalities and improve patient outcomes.

3.2 South Lincolnshire CCG Public Health Action Plan 2015/16/17

Action	Objectives	Lead	Timescale	Comments
Commissioning for Prevention – Cardiovascular Disease.	CCG working towards the mature scenario identified in the Framework for Commissioning Prevention.	CCG/Public Health	Ongoing	In some areas the CCG is already working at the 'mature scenario' outlined in the Commissioning for Prevention guidance but currently we would assess ourselves as largely 'Emerging'.
To continue with the local priority measure to reduce the CVD under 75 mortality rate to the England level or below.	QIPP schemes implemented around specific tools for example GRASP AF Tool, IMPAKT Tool and the COPD Tool with specific performance indicators as quick wins to address issues around variation in practice performance for the management of these conditions. This will contribute to reductions in PYLL and U75 mortality rates.	CCG	2016/17	U75 CVD mortality rate of 66.35 (based on 2012 date); target to reduce to 65.47 in 2014 (based on 2013 data); mortality rate achieved was 66.8. Rate achieved in 2014 was 60.8.
Implement GRASP AF tools across all GP practices within the South Lincolnshire locality.	Incorporate prevention measures for example smoking cessation and brief advice as a standard element of commissioning services	CCG	2016/17	The CCG to work with GEM contracting to achieve this.
Implement IMPAKT Chronic Kidney Disease tool across all practices	To ensure that MECC is incorporated into contracts issued to ensure that the prevention and lifestyle agenda is taken forward and a mechanism for recording interventions.	CCG	2016/17	The CCG to work with GEM contracting to achieve this.

Action	Objectives	Lead	Timescale	Comments
Personalised Care	Implement the My Right Care Tool to be used across all practices using the 'Personal Care and Support Planning Handbook: The Journey to Person-Centred Care'. Engage with patients with regards to the My Right Care App.	CCG/Practices	July 15	The My Right Care web based care planning solution will enable integrated working between all providers and allow for a patients care plan to be shared it the patient consents for this to happen. The My Right Care work will be linked to the 2% risk stratification work.
Engagement with A8 communities	Further engagement events are to be arranged throughout the years to ensure that the CCG engage with A8 communities	SL engagement officer	April 15	Various events have already been held throughout the year to engage with A8 communities and encourage communities to register with a GP and advise on the correct pathways to access health care and inappropriate use of A&E.
Diabetes	The CCG have commissioned a series of diabetes workshops in order to help patients with the condition manage this more effectively. Implement National Diabetes Prevention Programme as part of first wave	SL engagement officer /Health Trainers CCG/PH	Throughout 15/16 and ongoing 16/17	The sessions will be as follows: • Session 1 – An introduction to the course and information on pre-diabetes and diabetes. • Session 2 – healthy eating information, eat well plates, food labelling and portion control. • Session 3 – benefits of physical activity. • Session 4 – grow your own fruit and veg. • Session 5 – Healthy cooking session. • Session 6 – Signposting and referrals

Action	Objectives	Lead	Timescale	Comments
Implement the 5 high impact interventions identified by the NAO report	To implement the 5 most cost effective high impact interventions identified by NAO report on Health Inequalities: □ Increased prescribing of drugs to control blood pressure □ Increased prescribing of drugs to control cholesterol □ Increased access to smoking cessation services In order to implement the above we need to identify patients and optimise the management of these patients. The CCG will do this by carrying out NHS Health Checks. Public Health and the CCG will continue to the NHSE/PHE intelligence packs to highlight differences in practice performance across a range of disease management areas. This will continue to facilitate a peer review process through the CCG Clinical Committee to address differences in practice performance and explore and share best practice.	Public Health/CCG	Ongoing	All South Lincolnshire practices' have signed up to providing NHS Health Checks.
NHS Health Checks Compliance Audits	This will be a re-audit from 15/16 to: • Ensure Read coding is correct; • Ensure there is a high risk register and that appropriate patients are added to it; • That patients on the high risk register are reviewed appropriately • That patients identified with hypertension etc. are added to the appropriate register and managed accordingly • That staff are competent at providing lifestyle advice • Patients are provided with appropriate literature • Patients are referred to lifestyle interventions as appropriate; • Non-compliant areas are identified and an action plan put in place,	GP Practices/PH	March 17	PH will provide training on giving lifestyle advice for those who have not received it or need a refresher

Action	Objectives	Lead	Timescale	Comments
Increasing anti-coagulant therapy for AF	Increase the anticoagulant therapy for AF through the implementation of the AF GRASP tool. This will be completed by rolling out training for the use of the tool to all South Lincolnshire practices. We will review if this project has been a success by the following: □ An increase in the proportion of AF patients receiving this intervention □ A reduction in exception reporting for the relevant QOF indicator □ A reduction in acute admissions for strokes associated with diagnosed and undiagnosed AF	CCG	March 16	9 practices have received AF training. 10 practices have received HF training. All practices should have received training.
Clear trajectories for reducing health inequalities	Trajectory for reducing PYLL and Under 75 Mortality Rates	CCG	Ongoing	To achieve a year on year reduction in PYLL and Under 75 Mortality Rates. Actions to achieve this are the same as the commissioning for prevention actions
Premature Mortality Audit	A premature mortality audit to be conducted to identify deaths which were potentially avoidable and identify areas of practice or themes which can be targeted to prevent premature deaths in the future. Brighton and Hove model to be used. □ Audit to be completed within the next 18 months.	Public Health/CCG	16/17	This audit will look at individual patient records to explore common themes which are amenable to quality issues.
MECC (Making Every Contact Count)	□ To encourage all practices to participate in MECC utilise the MECC scheme	Public Health/CCG	Ongoing	
Social Prescribing Model	□ Present evidence based review of community navigator (and similar) models. □ Pilot a social prescribing initiative.	LCC Public Health CCG/LCC PH	Apr 16 Jan – Apr 16	Awaiting date for development session Project being undertaken in Spalding to refer/signpost people with mild mental illness into creative arts projects

CCG: NHS South Lincolnshire 2016/17 operational plan on a page **Appendix B**

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, care planning, Transitional care and CAS implementation, admission avoidance in A&E and discharge planning current performance 94.8%

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

RTT Capacity commissioned to sustain reduction in backlogs and achievement of RTT standards, CCG current performance 93.8%

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 62 day upgrade 90.7%

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.

Early Intervention in Psychosis New guidance to be implemented, target achievement Q2 and sustained.

Dementia Continue to achieve national standard, practices have use of CANTAB tool for early identification, Dementia support co-ordinator working with neighbourhood teams and support services commissioned with voluntary sector

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

Primary Care- use new models to commissioning localised, integrated care, address variation, inequalities, and increase access over weekends.

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 service.

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 CfV pack focuses on diabetes, MSK and respiratory, actions will be put in place where required. Preventative diabetes education continues and increased provision has been secured. Clinical quality reports will be produced and shared with all practices to track progress against performance. Learning from the Health checks projects in

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, increased service provision of Psychiatric Liaison within PSHFT and Pilgrim hospitals.

Focus on increasing personal health budgets

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 is on target at present

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 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.

Equality and Diversity

The CCG is working with seldom heard groups such as the A8 community, the homeless, travellers, ex-offenders and young people recently leaving care to understand the challenges and barriers to accessing primary care, with the aim of seeking solutions to improve uptake of primary care.

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 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 the clinical standards. Care bundles and pathways being developed to secure 7 day services.

Response to Transforming Care

Service requires re-engineering to prevent admission and maintain patients safely within the community. Service required for transforming care requirements for children and young people. There are coordinated CTRs based on clinical need of the patients. It is proposed that the transforming care partnership should be developed through the Autism/ LD transformation board which is already in place as many of the same issues and priorities will be developed through this board already. Engagement events are scheduled.

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

Delivering value

- Financial resilience and value for money rigorously pursued through transformation.
- Financial plan delivers 1% surplus, £2.04m in 2015/16.
- The CCG's underlying surplus in 2015/16 is planned to be 1.3%
- 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.

2015/16 PCF Schemes have been through a clinical review for effectiveness by

Transformation programmes, reconfiguration plans and reprocurement

- Development of neighbourhood teams
- Movement of Maternity Services for certain practices to stop fragmentation of service
- Care closer to home includes procurement of community ENT Audiology and Ophthalmology.
- 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
- Management of CVD in primary care
- Management of respiratory in primary care
- Review of all MSK services

Programme	Scheme	CCG or County Wide	Case for change – clinical evidence Patient feedback	Ambition to improve outcomes/ quality and measure	Scheme start date
CVD	GRASP AF	CCG	Opportunity identified through East Midlands Strategic Clinical Network. Evidence base NICE Clinical Guidelines for identification and treatment of AF.	To reduce the number of hospital admissions for Stroke caused by Atrial Fibrillation and avoid preventable deaths by identifying patients diagnosed with AF who are not currently on anticoagulation and assisting in identifying patients not currently diagnosed. Scheme measurement is reduction stroke non elective admissions and practice data reported through the GRASP AF Tool monthly. The HRG used for this scheme measurement has been removed from those used to measure the cardio vascular disease scheme to avoid double counting.	3 year programme commenced April 2015
	GRASP HF	CCG	Opportunity identified through SLCCG Commissioning for Value Pack using Right Care methodology. Assessment has been supported through Public Health CVD Deep Dive, Best Practice and Evidence Based interventions with clinically identified improvement opportunities through SLCCG Clinical Committee	Best Practice management of Heart Failure Patients to prevent admission to hospital using the GRASP HF tool supported by upskilling. Wider CVD scheme of work currently in development including Self Management Support, Pre Diabetic Education Programme and pathway design. Scheme measurement is reduction in Coronary Heart Disease, Problems of circulation & Problems of Rhythm Inpatient Activity (The HRGs used for this scheme are those aligned to CfV Circulation) and practice data reported through the GRASP HF Tool monthly	3 year programme commenced April 2015
	Clincal Upskilling	CCG			Programme throughout 16/17 aimed at Nurses and GPs to support transformation schemes
	NHS England Diabetes Prevention Programme	County wide			April 16
	Patient Self-Management and Support Working with HOPE (hearts of positive energy)	CCG			CCG is working with HOPE to understand the scope for 16/17
Respiratory	GRASP COPD	CCG	Opportunity identified through SLCCG Commissioning for Value Pack using Right Care methodology. Quality Improvement opportunities identified through East Midlands Health Science Network - Respiratory	Best practice management of COPD in general practice using the GRASP COPD tool supported by upskilling. Scheme measurement is reduction in Problems of the Respiratory System Inpatient Activity (The HRGs used for this	3 year programme commenced April 2015
	Clinical Upskilling	CCG			Programme throughout 16/17

Programme	Scheme	CCG or County Wide	Case for change – clinical evidence Patient feedback	Ambition to improve outcomes/ quality and measure	Scheme start date
			Network and SLCCG Respiratory Clinical Lead.	scheme are those aligned to CfV Respiratory) and practice data reported through the GRASP HF Tool monthly.	aimed at Nurses and GPs to support transformation schemes
	Review Pulmonary Rehabilitation	CCG			CCG currently scoping provision for population
	Health Foundation Expression of Interest to take part in regional spread of Community asset based respiratory clinics	CCG		As above, however in addition, Univeristy evaluation is bult into the project itself. key impact areas of the project; □ Transformational change in patient reported quality of life. □ Increased mental well-being □ Improved ability to self-manage. □ Reduced unplanned admissions. □ New model of service delivered in co-production.	SLCCG submitting and EOI to take part in this programme 26th February
Genitourinary	IMPAKT CKD	CCG	Opportunity identified through SLCCG Commissioning for Value Pack using Right Care methodology. Assessment has been supported by East Midlands Clinical Network Best Practice and Evidence Based interventions with clinically identified improvement opportunities through SLCCG Clinical Committee	Best practice management of CKD in general practice using the IMPAKT tool supported by upskilling. Scheme measurement is reduction in Genito Urinary Inpatient Activity (The HRGs used for this scheme are those aligned to CfV Genitourinary) and practice data reported through the IMPAKT Tool monthly.	3 year programme commenced April 2015
	Care Home Educator	CCG			Commenced Q2 15/16
	Clinical Upskilling	CCG			Programme throughout 16/17 aimed at Nurses and GPs to support transformation schemes
	Practice variation UTI emergency admissions	CCG			April 2016

Programme	Scheme	CCG or County Wide	Case for change – clinical evidence Patient feedback	Ambition to improve outcomes/ quality and measure	Scheme start date
Neurology	Neurological Services	Countywide	Opportunity confirmed through SLCCG Commissioning for Value Pack using Right Care methodology	Still being scoped as deep dive due for review in March 16.	Deep Dive Commissioned from GEM CSU to be discussed at planned care meeting in March 16
MSK	Transformation of MSK	Countywide	Opportunity identified through SLCCG Commissioning for Value Pack using Right Care methodology. CCG working with National MSK Network and fellow CCGs to identify potential solutions.	SLCCG currently has high spend and poor outcomes for MSK with a large opportunity to improve in both. Scheme measurement is reduction in CFV Chronic Pain, Problems due to Trauma & Injuries & Problems of the Muskuloskeletal system Inpatient Activity (The HRGs used for this scheme are those aligned to CfV MSK)	Deep Dive reviewed by CCM in January 16. Scheme currently being worked up.
Dementia	Dementia Identification and Community Support	Countywide	National Priority	Maintain achievement of dementia target	Ongoing
Care Closer to Home	Community Surgery Scheme (increased usage)	CCG	SLCCG are low users of the CSS service, opportunity identified through review of activity.	Maximise use of existing CSS providers/procedures across all SLCCG GP Practices. Usage of CSS by practice will be monitored and report by CI monthly	Ongoing
	Community Surgery Scheme (additional)	Countywide	Opportunity to increase services provided through CSS identified through appropriate review.	Increase opportunity for patients to access services closer to home. Measurement through useage of schemes once live.	Additional schemes currently being progressed anticipated start date July16
	Concordia ENT service Increase access	County Wide	SLCCG usage of the scheme has been identified as	Increased usage of ENT service. Measurement through CI data reports on service.	April 16
	Adult Hearing Services	County Wide	Scheme piloted in SWLCCG. Lincolnshire CCGs to take forward during 16/17	Improved access to audiology services for Hearing Aid Devices in closer to home. Measurements as per pilot in SWLCCG, linked to patient experience and reduction in acute services spend.	Countywide planned care group currently scoping opportunities for each CCG.

Programme	Scheme	CCG or County Wide	Case for change – clinical evidence Patient feedback	Ambition to improve outcomes/ quality and measure	Scheme start date
Prescribing	PMOS supported efficiencies	CCG	The Prescribing and Medicines Optimisation Service (PMOS) have completed an initial review of national and local priorities and have produced a recommended list of Prescribing QIPP initiatives for action in 2016/17. The review considered information around patent expiries, product pricing, product availability and new guidance.	The Prescribing and Medicines Optimisation Service (PMOS) have completed an initial review of national and local priorities and have produced a recommended list of Prescribing QIPP initiatives for action in 2016/17. The review considered information around patent expiries, product pricing, product availability and new guidance. Measured through PMOS standardised monthly reporting.	Ongoing
	PINCER Trial To test intervention aimed to reduce prescribing errors in Primary Care	CCG	Prescrining errors in General Practice are an important and expensive preventable cause of illness, hospitalisation and deaths.	PINCER trial developed to study whether a pharamcist led IT-based intervention could reduce medication error rates within the primary care setting. As a research trial all measures will be as per protocol.	Discussion at Prescribing Committe
	Optimise Rx	CCG	Fellow Lincs CCG successfully implemented during 14/15. Opportunity for SLCCG efficiencies assessed using results of this. Optimise RX suggestions are based on best practice, safety and cost.	Roll out of Optimise RX tool. Optimise RX is a piece of medicines optimisation software which is a delivery mechanism for providing national best practice and local formulary advice to clinicians at the point of prescribing. Prescribing efficiencies realised are reported through the software for each practice monthly. Software is constructed to ensure no double counting.	Ongoi ng

Programme	Scheme	CCG or County Wide	Case for change – clinical evidence Patient feedback	Ambition to improve outcomes/ quality and measure	Scheme start date
	Medicines Wastage Scheme	CCG	The Steering Group on Improving the Use of Medicines noted that "Repeat prescribing accounts for 60-70% by cost and 80% by volume of prescription items dispensed in primary care. Around half of all registered patients receive repeat prescriptions and the rate is rising In the paper 'Evaluation of the Scale, Causes and Costs of Waste Medicines' (2010), York Health Economics Consortium and School of Pharmacy University of London estimates that wasted medication amounts to a cost of £300 million per year and:"…includes an estimated £90 million worth of unused prescription medicines that are retained in individuals' homes at any one time, £110 million returned to community pharmacies over the course of a year, and £50 million worth of NHS supplied medicines that are disposed of unused by care homes."	Reduction in Wasted medication, measures built into the scheme.	Currently being scoped inernally
Mental Health / Parity of Esteem	ADHD Adult (PoE)	County			Phase one BC accepted Unlikely to progress phases 2&3
	CAMHS (PoE)	County	Transformation plan	Access to Eating disorders and IAPT for C&YP	
	ImROC alignment with nhts	County	Refocussed to ICMHT and ImRoc links to NHTs		
	ADHD child	County	Part of transformation plan for Child and family service not phase one		Needs whole pathway review
	Step 4 Pyschology	County	Access is low and waits very long. Demand exceeds capacity		Redesign proceeding but challenged
	Mental Health Triage Car (PoE)	County		Improved access and quality	Ongoing

Programme	Scheme	CCG or County Wide	Case for change – clinical evidence Patient feedback	Ambition to improve outcomes/ quality and measure	Scheme start date
	Section 136 (PoE)	County		Better quality care increased beds 1-2. C&YP protocol in place	New suite due to open February – increased staffing recruited
	Chronic Fatigue Service (PoE)	County			Non –recurrent support?
	Anorexia Day Programme	County			Ongoing
	Mental Health Liaison Services for Acute hospitals (PoE)	County			Service agreed in mobilisation phase
	Open Dialogue	Project in CCG			Further development required.
Neighbourhood Teams	Development of two Neighbourhood teams in SLCCG	Countywide	LHAC Blueprint	Outcome measures currently being devised through countywide implementation group	Localised Implementation plan – aligned to the countywide plan - being progressed
Clinical Assessment Service	Implementation of Clinical Assessment Service	County wide	The original planning assumptions were based on the LHAC blueprint documents. During the first weeks of the Proof of Concept, a revision of the impact of the Clinical Assessment Service has been undertaken owing to: - A better understanding of the information and data used to make the original assumptions - The technical and workforce changes required to deliver an integrated model	The Clinical Assessment Service is a component part of the Lincolnshire Recovery Plan to fully achieve NHS Constitution Standards. It is an enabling service and forms part of the Lincolnshire Health and Care (LHAC) programme. It comprises all the clinical elements of the Hear and Treat services currently in place within the system.ie EMAS, NHS111, Out Of Hours. Success measures include standard activity such as A&E attendances and non-elective admissions.	Commenced Nov 15

Report Reference: **0.0**

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of Lincolnshire West Clinical Commissioning Group

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**22nd March 2016**
Subject:	Lincolnshire West Clinical Commissioning Group Draft Operational Plan 2016-2017

Summary: Lincolnshire West Clinical Commissioning Group Draft Operational 2016-2017 Plan on a Page is listed below.

Lincolnshire West CCG 2016/17 Plan on a Page

Transformational Programmes

Delivering Integrated Diabetes Care

- Identification of people at high risk of developing diabetes & provide support to reduce incidence; Reduce outpatients by 30%, emergency admissions by 5%
- Improved access for people diagnosed with diabetes to 'Self Care' support & advice;
- Increased number of people with Diabetes receive care in line with NICE Guidance - 8 key care processes. Minimum 80%

SCHEME Integrated Diabetes pathway

Supporting People with Heart Failure

- Identify undiagnosed heart failure and record diagnosis on primary care registers at least equal to like CCGs
- Ensure people are on the most appropriate heart failure treatments
- Fewer people with underlying hear failure admitted to hospital

SCHEME: Best practice care for Heart Failure project.

Enhancing Mental Health

Deliver early intervention in psychosis Access Standard
SCHEMES: Local specialist mental health early intervention, ICMHT review, delivery July 2016.

Improve Crisis Care SCHEMES review Crisis Home Treatment Team, feasibility repatriate out of county placements, action plan Crisis Concordat,

Transforming Care for people with Learning Disabilities SCHEMES: Redesign community services, Personal Health Budgets, implement autism strategy

Access Standard IAPT SCHEMES: 2016/17 contract delivery.

Dementia diagnosis SCHEMES: CCG Improvement Plan diagnosis rates & post support

Improving Prescribing Efficiency

High quality, cost effective prescribing.

SCHEMES:

- Appropriate antibiotic prescribing
- Best Practice prescribing for people with LTC
- Care Home prescribing
- Cancer prescribing

Supporting Sustainable Primary Care

- Primary Care Strategy induding workforce, estates & use of communications technology
- Working with HEE, HEEM & LMC to implement plans to address workforce issues.
- Enable greater integrated working with other healthcare professionals,
- Encourage practices to federate & form alliances to provide greater resilience & capacity

Improving Cancer Outcomes

- Deliver Cancer standards,
- Improve one year survival rates
- Improve palliative care access
- Maintain screening uptake rates for cervical, breast and bowel

SCHEMES: Deliver improvement Plan, including use of alternative providers. CCG priorities: Lung/Lower GI/Upper GI/Urology, LHAC configuration review, Rightcare prescribing review

Urgent Care

Deliver Access A&E Standard SCHEMES: Improvement plan - crisis care for all ages. Transitional care, Clinical Assessment Service, Crisis Concordat, scope Urgent Care Centre at Lincoln County. Urgent Care Front Door paediatric training

Deliver AMBULANCE WAITS CAT A SCHEMES: Co responders, Lives, CAS

LHAC consultation

Planned Care

Deliver RTT Access Standard
SCHEMES: RTT Improvement plan, use of alternative providers, Rightcare: MSK, Neurology pathway reviews

Women & Children

CAMHS SCHEMES: CAMHS transformation plan, Transforming Care

Paediatric Admissions review, community paediatric review

LHAC consultation - maternity,

Proactive Care

Reduce A&E attendances, emergency admissions, facilitate hospital discharge

Reduce DTOC 2.5% SCHEMES: Phase 2 Neighbourhood Teams, Care Home project, implementation of Transitional Care , Promoting Wellbeing and self-care & enhanced carer support project, SAFER bundle & review - community hospitals,

Quality

Reduction in avoidable mortality in hospital
SCHEMES: CQUIN Sepsis screening & treatment, Mortality Summit, quality review/ assurance cycle and support mechanisms-, Quality and CQUIN (End of Life Care) built into Contacts

Seven Day Services: roll out 4 clinical priority standards
SCHEMES: contract management

Patient Experience Improve patient choice maternity & end of life - patient experience score GP, OOH – FFT, inpatient, & maternity
SCHEMES: Improving Patient Voice for Maternity Services, Review trends in F&F for GP practices. Develop cancer engagement pathway. Outpatient Communication charter

Finance

QIPP 2% – year 1 of 5 year programme, implementation of Proactive care schemes, Rightcare, prescribing

Aggregate financial balance jointly managed risk & demand, capacity plans aligned,

Meet business rules on financial plans surplus, contingency and non-recurrent expenditure

Workforce

Recruitment & Retention
SCHEMES; Leadership Academy, Marketing Strategy, LMC/HEEM project. Learning hub, LETC.

Training,
SCHEMES Lincoln Uni & College projects, apprenticeships, expansion of AP role

Estates Projects

Primary Care Estate: Options appraisal 3 localities
Estate utilisation review completed April 16,
Primary Care Urgent care centre feasibility study

IT Digital Road Map

Better Care Fund

Integrated services- reduce **delayed transfers of care**, & non-elective admissions, people still at home 91 days after discharge, people feeling support to manage long term conditions, care and support gives better quality of life

LHAC Programmes

Supporting programmes

Actions Required: Formal consideration of the Lincolnshire West Clinical Commissioning Group 2016/17 Operational Plan to ensure the Plan takes account of the JSNA/local priorities in the JHWS.

1. Background

NHS England is requiring the NHS locally to produce two separate but connected plans:

- A five year Sustainability and Transformation Plan (STP), place-based and driving the Five Year Forward View; and
- A one year Operational Plan for 2016/17, organisation-based but consistent with the emerging STP.

5 Five Year Sustainability and Transformation Plan (2016/17 – 2020/21)

CCGs in Lincolnshire have agreed a Lincolnshire wide initial footprint for the 5 Five Year Sustainability and Transformation Plan to support collaborative working across CCGs and the Lincolnshire County Council and to facilitate transformation and strategic planning with our 3 main healthcare provider trusts. The Lincolnshire Health and Care (LHAC) is a key element strategic plan. North Lincolnshire is also conducting a review of its strategic footprint which may result in the need to conduct further review of the Lincolnshire Strategic Footprint.

Nationally it included an £8.4 billion real terms increase by 2020/21, front-loaded. With these resources, we now need to close the health and wellbeing gap, the care and quality gap, and the finance and efficiency gap.

For the first time, the local NHS planning process will have significant central money attached. The STPs will become the single application and approval process for being accepted onto programmes with transformational funding for 2017/18 onwards. This step is intended to reduce bureaucracy and help with the local join-up of multiple national initiatives

CCG Operational Plan

The NHS Lincolnshire West Local Operational Plan specifically relates to the financial year 2016/17, and is the first year of the 5 year Sustainability and Transformation Plan. The Plan describes how commissioning intentions will be delivered with a focus on meeting

- NHS Constitution Standards, and Governments mandate to the NHS for 2016/17
- Delivering the Forward View: NHS Planning Guidance 2016/17 – 2020/21 Annex 2 to the Technical Guidance: Guidance on Commissioner Operational Plans (including '9 MUST Dos')
- Implementing Primary Care Strategy and developing place based integration across the CCG.
- Ours Plan is informed by;
    - **The Lincolnshire Joint Strategic Needs Assessment (JSNA)** (the JSNA is currently being updated and our draft plan may be further updated during March to reflect this),
    - Our understanding of the populations health needs emanating from discussion and consultation with local people,
    - Benchmarking using tools such as 'RightCare' ,
    - CCG Localities, local providers and other stakeholders and through working in close partnership with local authorities, and public health.

The table to the left describes headline opportunities to improve and is taken from historical data and comparative benchmarking with like CCGs developed by Right Care.

With the exception of GU, each of the areas shown in the Table is addressed in this plan either as a CCG Transformational Programme, or LHAC Programme.

Our plans are aligned to

- Lincolnshire Health and Care (LHAC), 5 year Blueprint, which has been agreed by all Four Lincolnshire CCGs,
- Clinical Strategies from three main NHS providers in Lincolnshire.
- **Lincolnshire Health and Well Being Strategy** (five main themes, with mental health running throughout)

HWBS Theme	CCG Operational Plan Priority
Promoting healthier lifestyles	LHAC Proactive Care Programme Transformation Programme Diabetes Transformation Programme Heart Failure Transformation Programme Mental Health Sustainable Primary Care Programme
Improve health and wellbeing of older people	LHAC Proactive Care Programme Transformation Programme Diabetes Transformation Programme Heart Failure Transformation Programme Mental Health Sustainable Primary Care Programme
Delivering high quality systematic care for major causes of ill health and disability	Support Programme Quality Our 6 major Transformation Programmes
Improve health and social outcomes for children and reduce inequalities	LHAC Women and Children Programme Support Programme Quality Sustainable Primary Care Programme
Tackling the social determinants of health	LHAC Proactive Care Programme Sustainable Primary Care Programme

Why is our plan important?

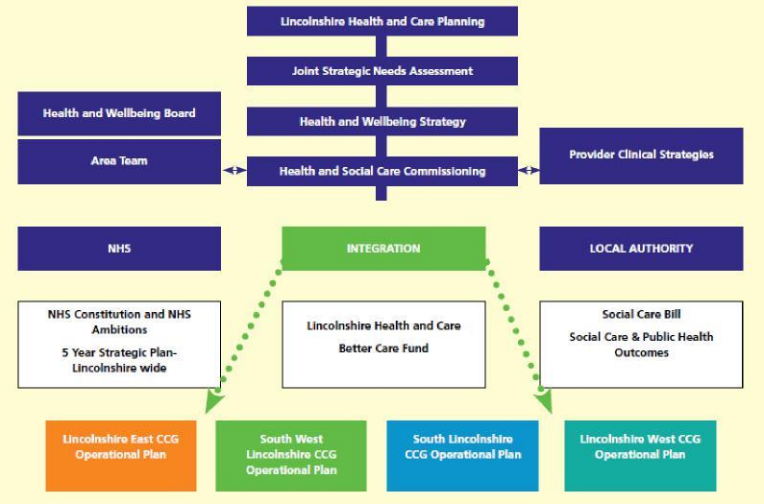
- To ensure our citizens can access services that at least meet national standards for quality and access and which do not vary in quality depending on where our citizens live or what services they access.
- To support our citizens to live longer healthier lives and prevent our citizens dying avoidably and prematurely form the major causes of illness in our population such as cancer, diabetes, heart failure, or as a result of mental health conditions
- To ensure we achieve maximum value for every pound we spend on behalf of our citizens.

This year our local plans will focus on working with our providers to achieve ‘9 MUST Dos’ and associated priorities outlined in the 2016/17 planning guidance, national standards such as the NHS Constitution Standards and 6 major transformation programmes

Delivering the 5 Year Forward view – Overview CCG work streams and transformation programmes - meeting 2016/17 planning priorities 9 'MUST Dos'

Lincolnshire West CCG Local Priorities	National 'Must Do'	Develop a high quality and agreed **STP**	Return the system to **aggregate financial balance**.	Develop and implement a local plan to address the **sustainability and quality of general practice**, including workforce and workload issues.	**Access standards for A&E and ambulance waits**	Improvement against and maintenance of the NHS Constitution standards RTT	Deliver the NHS Constitution Cancer	Achieve and maintain the **two new mental health access standards: IAPT & EI, dementia**	Deliver actions set out in local plans to transform care for people with **learning disabilities**	Develop and implement an affordable plan to make **improvements in quality**
Lincolnshire Health and Care including county wide work streams (STP): Proactive Care		✓	✓	✓						✓
Urgent Care (including SRG)		✓	✓	✓	✓					✓
Women and Children		✓			✓					✓
Planned Care		✓	✓	✓		✓	✓			✓
Mental Health, Learning Disabilities & Autism		✓			✓			✓	✓	✓
Finance, Estates, IT and Workforce Strategies		✓	✓	✓	✓	✓	✓	✓	✓	✓
Quality & Safety:		✓]	✓	✓	✓	✓	✓	✓	✓	✓
CCG Transformation Programme- Sustainability/quality/access to Primary Care		✓	✓	✓	✓			✓		✓
CCG Transformation Programme – Mental Health			✓	✓	✓		✓	✓		✓
CCG Transformation Programme - Cancer			✓	✓			✓			✓
CCG Transformation Programme - Diabetes			✓	✓	✓					✓
CCG Transformation Programme – Heart Failure			✓	✓	✓					✓
CCG Transformation Programme - Prescribing			✓	✓						✓
Financial Plan		✓	✓	✓	✓	✓	✓	✓	✓	✓
Better Care Fund			✓	✓	✓				✓	✓

Lincolnshire Health and Care and CCG integrated approach to developing the Plan



The table left summarises the framework for developing the 5 Year Plan and local CCG Operational Plans

Strategic Priorities

- Delivering sustainable quality services that are
- financially viable in the medium and long term
- Delivering NHS Constitution Access Standards in the short and longer term
- Develop sustainability & quality of general practice
- Developing high quality integrated place based integrated care.

Currently, health and social care services are commissioned and provided by a number of separate organisations. Service models have developed and evolved based on these partial views of the system, with services being fragmented by organisation boundaries, traditional professional distinctions, and separate funding, regulation, physical locations, and IT systems.
The leaders of health and social care across Lincolnshire have come together to focus on defining the right services for Lincolnshire to improve quality and outcomes, and deliver services that the population will value, and care professionals can be proud of.

Since August 2013, the Lincolnshire Health and Care (LHAC) Programme has brought together the health and social care community in Lincolnshire to establish a system vision for health and social care provision, and to focus on how the people of Lincolnshire can achieve the best health and social care outcomes for the resources available, and what care should look like in the future. The overall objective is to

Collaboratively design and implement a sustainable health and care system that works in a joined up way, focuses on the prevention of ill health, co-ordination of care and improves clinical and patient outcomes and goals, with quality driving efficiency.

LHAC will form the basis of the Sustainability and Transformation Plan (STP) covering 6 specific work streams:

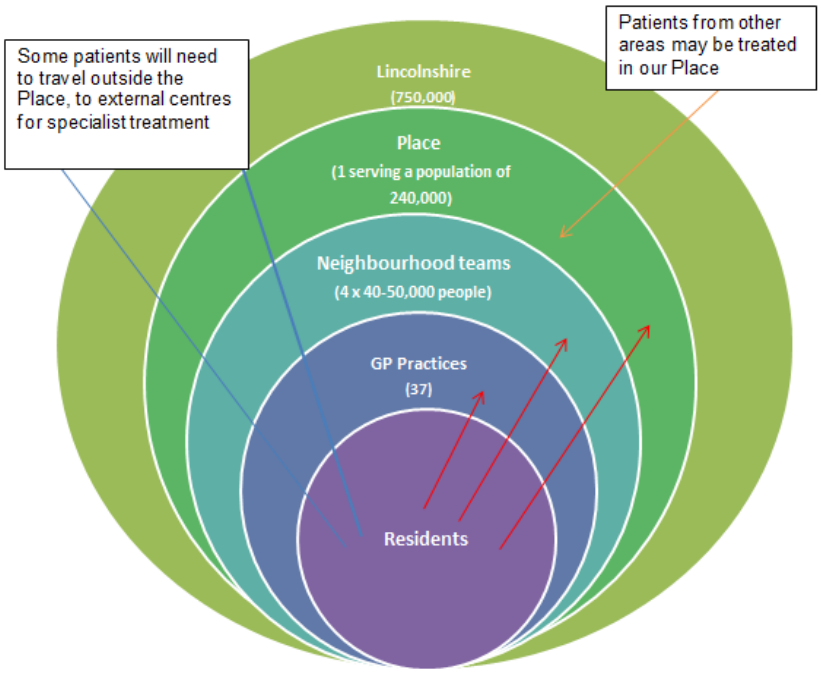
- Proactive Care
- Urgent care
- Women's and Children's
- Planned Care
- Mental Health , Learning Disabilities and Autism
- Enablers; Workforce, IT, Estates and Transport

The Lincolnshire System STP will be subject to a full public consultation which will seek the views of the Lincolnshire public on the options for change.

The spring and summer the LHAC programme will continue to engage with the public and opinion shapers inside and outside of Health and Social Care in preparation for the public consultation.
The Contracting work stream of LHAC has identified that new contractual and organisational forms will be required to deliver the ambitions of the programme. Work is currently underway across the system on reaching a definitive view on which FYFV model is the best fit. However there is broad consensus amongst local commissioners that "Accountable Care" type organisations are most likely to succeed.

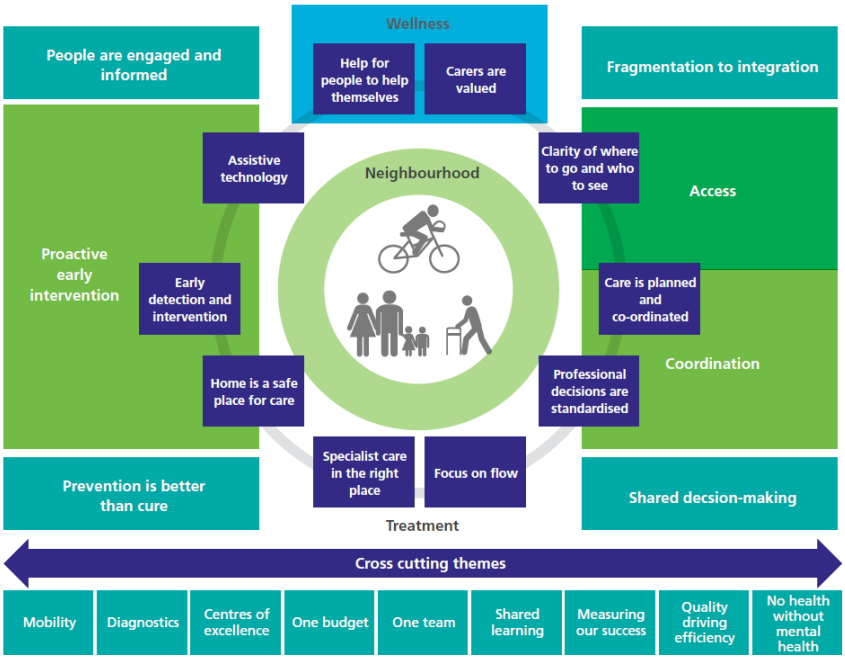
One of the emerging models is a place based approach, based on multi-speciality/care of commissioning and delivering services to health and care needs of a population of approximately 250,000. It is envisaged there would be three such organisations in Lincolnshire, each based around a local hospital site (Lincoln, Boston and Grantham). These three place based systems would work together as part of the Lincolnshire wide network. The vast majority of services would be accessed locally, but with a recognition that for highly specialised services, there would be a need to buy in care from specialist providers outside Lincolnshire. The 'place' based approach would be built up from GP practices who in turn work in Neighbourhoods of approximately 50,000 – 60,000 population.

How a Place based approach might works is illustrated on the next page



GP Practice - Routine primary care
Neighbourhood teams • Community Midwifery • Community Nursing • Community Mental Health • Community Therapies • Community Intermediate care beds • Community Children's Services • Simple Elective Procedures • Social Care
Place • Urgent care centre • Elective & non elective beds • Day Case Unit • Outpatients & diagnostics (including follow- ups) • Psychiatric Unit, including acute beds • Theatres • Inpatient related therapies
Lincolnshire – Services which need, for quality, workforce or efficiency reasons to be delivered to a larger population than Place e.g. • 24/7 A&E department • Consultant led midwifery • Inpatient paediatric & neonatal beds • Complex elective surgery
Beyond Lincolnshire – Specialist services that need a population larger than 750,000 to be viable, e.g. • Spinal surgery

The Plan on a Page, below, has been developed by the Lincolnshire Health and Care Programme (LHAC) and has therefore been signed up to, and agreed, across all Health and Social Care partners in Lincolnshire.



Our 6 major transformation Programmes are:

- **Cancer (linked to LHAC work stream**) - the primary focus will be to improve one year survival rates, meeting the NHS Constitution Standards and deliver Outcomes outlined in the National Cancer Strategy for England Achieving World Class Cancer Outcomes.
- **Diabetes** – to ensure people with Type 1 and Type 2 diabetes received NICE-recommended care processes
- **Mental Health** – To ensure effective care for people living with severe mental health conditions such as psychosis, bipolar disorder or server anxiety or depression. This will focus on recommendations in the newly published Mental Health Taskforce Report, delivery on new waiting time standards for Early Intervention in Psychosis, and include proactive integrated physical and mental health care through to crisis home treatment support and repatriation of out of area placements.
- **Heart Failure** - During 2016 scope and establish project to ensure sure best practice care for Heart Failure is delivered across the CCG area through e.g. Improved detection, targeted screening, primary care audit and medication review, more rapid access to echocardiograms and specialist advice, more specialised in-patient care, improved discharge coordination and monitoring and better access to cardiac rehabilitation.
- **Prescribing** – reduction in inappropriate prescribing across primary and secondary care
- **Primary Care Sustainability** – Implementation of Primary Care Strategy and associated improvement schemes

NHS Constitutional Standards

The NHS Constitution Standards set out the rights 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 waiting time standards.** Significant improvement work took place countywide in 2015/16, which Has begun to impact on performance and this work will continue at pace during 2016/17 with a focus on delivering the strategic objectives outlined in the National Cancer Strategy for England Achieving World Class Cancer Outcomes
- **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. Two initiatives implemented in 2015/16 Clinical Assessment Service and Transitional Care are expected to impact on improved performance in 2016/17
- **Ambulance CAT A 8min:** There are a number of initiatives currently taking place in Lincolnshire which either directly or indirectly affect reactive urgent and emergency care including the Joint Ambulance Conveyance Project, Co-responders, LIVES and Clinical Assessment Service implementation.
- **18 week referral to treatment waiting**: Significant improvement work took place countywide in 2015/16, which has started to impact on performance and this work will continue at pace during 2016/17. A critical success factor for this work stream will be management of the interdependency with the urgent care work stream. The planned care work programme for 2016/17 will support delivery of NHS Constitution Standards, the long term strategic objectives as outlined in LHAC blueprint and the 5 year forward view. As year one of the wider sustainable and transformation plan the focus will be on building the foundations of a planned care system that will enable service delivery to be transformed.

The CCG will also focus on achievement of the mental health NHS Constitution Standards in 2015/16

- **Dementia Diagnosis**: During 2014/15 the CCG commissioned a new Memory Assessment and Management Service (MAMS) that was fully operational in 2015/16. The CCG has seen an increase in referral rates to form 54. 9 - 62.8% Jan 2016. The CCG has now appointed a mental health commissioning manager to support improvement and further improvement work is planned for 2016/17 to ensure the CCG achieves 67% target.
- **New mental health waiting time standards**: The CCG expects to achieve Improving Access to Psychological Therapy (IAPT) waiting time standards (6 and 18 weeks) from April 2016. The CCG will not achieve 2 week standards for Early Intervention in psychosis (EI) form April. Improvement plans

are currently being developed with an expectation that EI standards will be achieved from July 2016 onwards.

The CCG will also support delivery of the following county wide Lincolnshire Health and Care Programmes during 2016/17

- **Urgent Care** – Lincolnshire commissioners wish to continue to develop a more locally responsive urgent and emergency care service that meets the needs of our population. In addition, commissioners will ensure there is resilience in the urgent and emergency care services / system during periods of surge. Develop a locally determined model for Ambulance Service (East Midland Ambulance Service)
- **Proactive Care** - Further development of Neighbourhood Teams , implementation of Transitional Care, wellbeing, self-care, carer support and care homes
- **Planned Care -** The planned care work programme for 2016/17 will support the long term strategic objectives as outlined in LHAC blueprint and the 5 year forward view. As year one of the wider sustainable and transformation plan the focus will be on building the foundations of a planned care system that will enable service delivery to be transformed.
- **Women and Children** – This programme will lead on the implementation of Transforming Care for Child and Adolescent Mental Health Services (Inc. eating disorders)
- **Mental Health, Learning Disabilities and Autism** – This programme will include Transforming Care for people with learning disability through redesign of community services to ensure more robust comprehensive service provision in the community and ensure hospital admission is avoided where ever possible.

Quality Priorities 2016/17

- **Improved Mortality Rates**: Continued action by ULHT against Mortality Reduction Action Plan and Keogh, plus CQC recommendations. Latest SHMI indicates higher than expected mortality rates in quarter 4 2014/15. The focus to address mortality outlier areas will therefore be maintained, including assurance on actions being taken to improve sepsis management i.e. robust implementation of the Sepsis Care Bundle, which includes antibiotics within the hour where indicated.
- **2016/17 Priority Seven Day Services**. The CCG is committed to safe good quality services seven days per week twenty four hours per day. It will achieve this by ensuring we have robust emergency and urgent care systems (see work stream urgent care, primary care) where possible we will increase diagnostic capacity across both primary and secondary care, we are also committed to enabling our provider to provide timely senior clinical review and senior clinician lead care. Another vital element of seven day services will be to ensure we have the workforce to deliver this (see workforce section).
- 2**016/17 Priority further National quality improvement priorities**
    - Existing national quality improvement work programmes e.g. Friends and Family; Safety Thermometer (including Pressure Ulcer Reduction and zero tolerance of avoidable pressure ulcers); Dementia; VTE; Healthcare Associated Infection Reduction (notably MRSA and CDiff) will continue to be driven forward by the CCGs.
    - CQUINs for 2016/17
    - Each larger commissioned service has a Commissioning for Quality and Innovation Scheme (CQUIN) Scheme funded by the CCGs which comprises of both nationally developed schemes and locally developed schemes. An overview of the National scheme and proposed local schemes is provided below

Commissioning of Primary Care

The CCG was granted delegated responsibility for commissioning primary care services in March 2015 taking effect from April 2015. The Primary Care Strategy developed during 2015/16 (workforce, estates and service design) will drive improvements in 2016/17.

Specialist Services
Work is ongoing to confirm arrangements for specialist commissioning in 2016/17

Financial Plan (Draft)

The summary shown below sets out the CCGs financial plan for 2016/17 (please note this is work in progress and does not represent a final version at this stage).

Revenue Resource Limit		
£ 000	**2015/16**	**2016/17**
Recurrent	304,354	313,611
Non-Recurrent	5,460	2,798
Total	309,814	316,409
Income and Expenditure		
Acute	147,668	149,460
Mental Health	28,792	29,561
Community	25,229	26,287
Continuing Care	18,383	18,085
Primary Care	47,057	47,163
Other Programme	4,845	6,568
Primary Care Co-Commissioning	28,650	29,795
Total Programme Costs	**300,624**	**306,919**
Running Costs	4,992	4,970
Contingency	1,400	1,650
Total Costs	**307,016**	**313,539**

£ 000	**2015/16**	**2016/17**
Surplus/(Deficit) In-Year Movement	(500)	72
Surplus/(Deficit) Cumulative	2,798	2,870
Surplus/(Deficit) %	1.0%	1.0%
Surplus (RAG)	**AMBER**	**GREEN**
Net Risk/Headroom		11
Risk Adjusted Surplus/(Deficit) Cumulative		2,881
Risk Adjusted Surplus/(Deficit) %		1.0%
Risk Adjusted Surplus/(Deficit) (RAG)		**GREEN**
Underlying position - Surplus/ (Deficit) Cumulative	6,359	7,607
Underlying position - Surplus/ (Deficit) %	2.1%	2.7%
Underlying position (RAG)	**GREEN**	**GREEN**
Contingency	1,400	1,650
Contingency %	0.5%	0.5%
Contingency (RAG)	**GREEN**	**GREEN**

Overview of financial position:

- Acute tariff uplifts are in line with the planning guidance proposal of a net 1.8% inflator. This may change once the tariff consultation concludes.
- Demographic growth of 0.6% has been applied in line with the year on year projected population increase. Further non-demographic growth has been applied in individual service areas depending on the trend analysis of expenditure.
- Prescribing is a key focus for the CCG and efforts will be concentrated on addressing unwarranted variation within localities.
- QIPP plans are still being developed and will focus on the key priorities of the CCG as identified through Right Care, (these are listed elsewhere within this plan).
- CCG intentions are to invest further in the 3rd sector especially in community based health services.
- Mental Health investment will increase in line with the CCG allocation to meet Parity of Esteem requirements.
- CCG contributions to the Continuing Healthcare Risk Pool nationally will reduce from £250m to £100m. The Lincolnshire West CCG contribution has reduced by 40% for 2016/17 from £1.742m to £0.697m, in line with national planning guidance

QIPP

Lincolnshire West CCG has targeted delivery of 2% in QIPP productivity, equating to £6.2m. Plans have been developed for countywide schemes for Secondary Care prescribing, Clinical Assessment Service and Transitional Care. The CCG is in the process of developing schemes in respect of Primary Care prescribing and continuing healthcare and using the atlas of variation to identify the opportunity for productivity savings that support the five key priorities for the CCG.

Consideration has been given to an increase in the targeted level of QIPP from 2% to 3% (in line with the regional baseline) but the CCG has elected to retain a target of 2%. In part, the rationale for this is that the local health economy has discussed the development of a single economy wide QIPP plan for 2016/17 and 2% is the CIP target for providers.

The table below shows the QIPP schemes in detail including description of the scheme, the stage of progress and when the cost savings are planned to be delivered.

QIPP scheme	Description of scheme	Stage	2016/17	2017/18
Prescribing	1. The introduction of Optimise RX will deliver significant shifts in prescribing towards more clinically and cost effective choices.	Outline	330	360
	2. Care homes support provided around medicines management for patients residing in care homes	Well progressed	120	0
	3. Utilisation of CfV and SPOT tools to identify areas of outlying expenditure (30% savings of full opportunity deliverable in year 1 and 2)	Outline	869	869
MSK pathway redesign	Right Care approach for MSK (utilising the C4V packs and SPOT tool analysis) 25% achievement in yr1 and 45% in yr 2.	Outline	697	1253
CVD pathway redesign	Right Care approach for CVD (utilising the C4V packs and SPOT tool analysis) 25% achievement in yr1 and 45% in yr 2.	Outline	236	425
Cancer pathway redesign	Right Care approach for Cancer (utilising the C4V packs and SPOT tool analysis) 25% achievement in yr1 and 45% in yr 2.	Outline	195	351
Continuing Healthcare transactional QIPP	Reduce the inefficiencies in the management of fast track patients in CHC. Assessments to be made in a shorter timeframe.	Outline	750	900
Mental Health transactional QIPP	Mental Health contract efficiencies	Outline	200	0
Running cost transactional QIPP	CSU contract efficiencies	Outline	22	200
CAS	The Clinical Assessment Service is an enabling service and forms part of the Lincolnshire Health and Care (LHAC) programme. It comprises all the clinical elements of the Hear and Treat services currently in place within the system.ie EMAS, NHS111, Out Of Hours.	Well progressed	528	0
Transitional Care	The transitional care scheme plans to reduce the expenditure on reablement (30 day beds). LCHS have agreed to work with the CCG's to improve productivity over a number of performance indicators.	Well progressed	430	0
Secondary Care Prescribing	A secondary care prescribing cost reduction scheme focussed on the" High Cost Drugs" (i.e. excluded drugs under PbR). The scheme is based on combined work of the Trust Pharmacists and the CCG, with both parties incentivised to seek savings via a gain share agreement.	Well progressed	45	0
Dermatology	Redesigned pathway and telederm being offered to reduce activity.	Outline	50	0
ENT	Contract efficiencies	Well progressed	128	0
Integrated personal health budgets	Continuation of 15/16 scheme with more emphasis and greater promotion.	Well progressed	150	150
Unidentified			1450	2000
	Total		6200	6508

Better Care Fund *(further development of plans is taking place in parallel to operational planning during March 2016)*

The Better Care Fund was announced in June 2013 as part of the 2013 Spending Round. It provides an opportunity to transform local services so that people are provided with better integrated care and support. The Fund will be an important enabler to take the integration agenda forward at scale and pace, acting as a significant catalyst for change. Lincolnshire West Clinical Commissioning Group is clear that the LHAC must move at real pace to bring about necessary change in each year of this planning cycle. Lincolnshire West Clinical Commissioning Group has worked very closely with the Local Authority and partner CCG's to develop pace for the creation of the Better Care Fund for the county. The BCF will be embedded with the LHAC programme, and is seen by the CCG as an opportunity to lever system efficiency through closer, more integrated working across the health and social care sector. The Fund will support the aim of providing people with the right care, in the right place, at the right time, including through a significant expansion of care in community settings. This will build on the work Clinical Commissioning Groups (CCGs) and councils are already doing. Summary funding arrangements in Lincolnshire are listed in the table below. In 2016-17 NHS England has mandated a minimum of £3.9 billion of the overall Clinical Commissioning Groups allocation to be deployed via the Better Care Fund, in order to support greater integration between health and social care. The minimum BCF contribution based on the allocations for Lincolnshire West CCG in 2016-17 is £14,453m, (2015/16 - £14.497m)

Better Care Fund		
Clinical Commissioning Group	**Minimum contribution 2015/16 £m**	**Minimum contribution 2016/17 £m**
Lincolnshire West	14.5	14.4
Lincolnshire East	16.2	16.3
South Lincolnshire	9.8	9.9
South West Lincolnshire	7.9	8.0
Total	**48.4**	**48.6**

The CCG still awaits planning guidance for the Better Care Fund in 2016/17 and it is unclear at this stage whether there will be a pay for performance element in respect of delayed transfers of care.

Better Care Fund Metrics
National:

- Non-elective admissions (General and Acute);
- Admissions to residential and care homes; older people (65 and over)
- Effectiveness of reablement; older people (65 and over) who were still at home 91 days after discharge
- Delayed transfers of care.

Local:

- People feeling supported to manage their (long term) condition
- Do care and support services help you to have a better quality of life

2. Conclusion

The Lincolnshire West Clinical Commissioning Group Operational Plan 2016-2017 sets out our commissioning intentions and priorities for the forthcoming year. The 5 Year Sustainability and Transformation Plan will be published in summer 2016 following review the NHS England therefore assumptions that have informed this plan are based on best available evidence at the time of writing and the plan may need to change in year to reflect the published 5 year Plan.

Communication and Engagement is still ongoing and will not be concluded until late march 2016.

Financial analysis and activity projections (***please note that projections are not a final version and represents work in progress at the time of producing this report)***

Planning Timetable 2016/17
29 January: Submit proposals for STP footprints

8 February: Initial submission of operational plans to NHSE to include BCF and transformation plan with narrative and copy of Unify templates to locality teams (copy narrative plan to HWBB)
9 February: Review by HWBB
9-12 February: Review of plans by NHSE locality team.
15 February: Feedback on operational plan to CCGs

2 March: Second draft of operational plan submission
7th March: Submit draft narrative plan to HWBB
3-11 March: Review of plans by NHSE locality team
15 March: Feedback on operational plan to CCGs
22nd March: HWBB review plans

11 April: Submission final 2016/17 operational plans aligned with contracts

End of June: Submit full STPs
October: Begin implementation of approved STPs

3. Consultation The Operational Plan outlines how stakeholders have been engaged in developing the plan and the process for stakeholder engagement in future strategic planning.

- August – September 2015 consultation with CCG Locality Groups
- October 2015 stakeholder engagement events in Lincoln and Gainsborough using 'Open Space' methodology and Listening Event Lincoln resulted in a number of emerging themes
- November 2015 CCG Executive Committee planning event to review emerging themes, evidence form Joint Strategic Needs Assessment and Right Care and develop first cut priorities
- December 2015 Health and Wellbeing Board review emerging priorities
- January – February 2016 stakeholder event and stakeholder survey to review priorities and identify local quality premium priorities
- February 2016 Health and Wellbeing Board review first cut plan
- Easy read and plain English version of the plan on a page will be produced and used to conduct an equality impact of the plan during March / April 2015.
- March 2016 Health and Wellbeing Board review final draft plan

The table left summarises key themes identified by stakeholders and how the CCG has responded in the operational plan

All projects within the Operational Plan are required to have an equality impact assessment and an equality impact assessment is being completed on the plan as a whole during March 2016.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	

5. Background Papers

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

This report was written by Annette Lumb head of Planning and Corporate Governance Lincolnshire West Clinical Commissioning Group who can be contacted on (01522 513355.) or (annette.lumb@lincolnshirewestccg.nhs.uk)

Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on Behalf of
(Lincolnshire East CCG)

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**22 March 2016**
Subject:	**NHS Lincolnshire East CCG 2016/17 Operational Plan**

Summary:

Our 2016/17 work programmes have been developed with the clinical leads within the Lincolnshire East Clinical Commissioning Group, (CCG), and from intelligence taken from our patient and public listening events; national and local outcome data, such as the Atlas of Variation; Commissioning for Value packs using the RightCare principles, (a tool that Lincolnshire East CCG are adopting for 16/17), and in alignment with the Joint Strategic Needs Assessment (JSNA), and the Joint Health and Wellbeing Strategy (JHWS).

During 16/17, there is a requirement for the NHS to produce two separate, but connected plans:

- a five year Sustainability and Transformation Plan (STP), place-based and driving the Five Year Forward View; and
- a one year Operational Plan for 2016/17, organisation-based but consistent with the emerging STP

Our commissioning intentions and the first year of what will be the five year plan, aims to develop and deliver changes in models of care, working in partnership with organisations within our health and social care system

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

Our 16/17 Operational Plan will be available for viewing on Lincolnshire East CCG website http://lincolnshireeastccg.nhs.uk once the required levels of approval have been given. It is currently in second draft format and the final version will be submitted by 11 April 16

Actions Required:

Confirmation that Lincolnshire East CCG plans meet the needs and outcomes of the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy

1. Background

Lincolnshire East CCG's 2016/17 Operational Plan outlines our current position across a number of key areas and our plans to continue to develop and deliver plans to provide services that are safe and will deliver the quality outcomes for our patients.

Using information and national priorities such as the new '9 Must be Done's' in 'Delivering the Forward View: Planning Guidance 2016/17 – 2020/21; the NHS Constitution; Everyone Counts: Planning for Patients 2014/15 to 2018/19; , and local data from the Joint Strategic Needs Assessment, the Health and Wellbeing Strategy and from internal sources, Lincolnshire East CCG has focussed on the requirements and needs most important to its population

Lincolnshire East CCG has also recently been selected as one of 60 CCGs to receive additional support to implement the local Commissioning for Value approach, using information provided by Public Health England (PHE), NHS England (NHSE), and RightCare. This approach provides a *"methodology for quality improvement, led by clinicians. It not only improves quality but also makes best use of the taxpayers' pound".*

https://www.england.nhs.uk/resources/resources-for-ccgs/comm-for-value/mids-eoe-2015/

2. Conclusion

Key priorities for the Lincolnshire East CCG in 2016/17 are to achieve the overall system wide transformation described within the Lincolnshire Health and Care (LHAC) programme and the 5 year Sustainability and Transformational Plan (STP) but very much focussing on delivering to meet the local needs of our population. We will work with our patients, public and stakeholders to continue to commission the quality services required to provide the best outcomes within the financial resource available to us. Summary of Lincolnshire East CCG 2016/17 work programmes is attached as **Appendix A**.

3. Consultation

Consultation is undertaken by LECCG in concert with appropriate stakeholders utilising different approaches with a clear link to LHAC. The CCG has a Communications and Engagement plan which outlines our communications and engagement aims and objectives and is aligned to its commissioning intentions and general direction of travel. The CCG actively engages with all stakeholders, patients and the public and continues to improve upon its continuous listening approach. 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 Programme of Work

5 Background Papers

Document	Where to Access
Delivering the Forward View: NHS Planning Guidance 2016/17 – 2020/21 New Mandate to NHS England – Annexe 2	https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf
NHS Constitution	https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england
Commissioning for Value: Refreshed NHS RightCare Value Packs	https://www.england.nhs.uk/wp-content/uploads/2016/01/lincs-est-ccg-16.pdf
NHS RightCare - Atlas of Variation	http://www.rightcare.nhs.uk/atlas/downloads/2909/RC_nhsAtlasFULL_LOW_290915.pdf
JSNA (update Report 2013)	http://www.research-lincs.org.uk/UI/Documents/jsna-overview-update-report-2013.pdf
Joint Health and Wellbeing Strategy for Lincolnshire 2013-18	http://www.lincolnshire.gov.uk/residents/public-health/behind-the-scenes/health-and-wellbeing-board/115339.article

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

This report was written by Audrey Brown, who can be contacted on 01522 5153355 ext. 5347 or Audrey.Brown@lincolnshireeastccg.nhs.uuk

Programme	Scheme	CCG Countywide	Description	Ambition	Timescale
Urgent Care	Clinical Assessment Service	Countywide CCG support	Part of the Lincolnshire Recovery Programme to achieve constitution standards – Made up of the component parts of the urgent care system.ie EMAS, NHS111, Out Of Hours. Aim to improve the current process by introducing a robust assessment service	Reduce emergency admissions Reduce waiting times Improve patient experience	Part of SRG programme 16/17
	Transitional Care	Countywide CCG Support	Programme of work to commission levels of care/services which are required to support people to stay in their home. This includes: development of 'Assisted Discharge' teams and Intermediate care bed procurement for Boston locality	Reduction of admission to hospital when alternative care can be provided Reduced costs from non admittance Improved use of acute hospital beds	Part of SRG Programme 16/17
	Vulnerable Patient Pathway (previously £5 per head)	CCG	Review the current over 75 £5 per head scheme to identify the best practice for all 25 schemes and deliver across participating practices in 16/17 with a view to full procurement in 17/18	To reduce emergency admissions To support vulnerable people within the community	On-going 15/16/17
Prescribing	PMOS QIPP Review	CCG	The Prescribing and Medicines Optimisation Service (PMOS) have completed an initial review of national and local priorities and have produced a recommended list of Prescribing QIPP initiatives for action in 2016/17. The review considered information around patent expiries, product pricing, product availability and new guidance. Measured through PMOS standardised monthly reporting.	Reduce prescribing costs Improve effective, efficient prescribing	On-going

Planned Care	Community Access to Audiology	Countywide CCG	Improved access to audiology services for Hearing Aid Devices in closer to home. Measurements as per pilot in SWLCCG, linked to patient experience and reduction in acute services spend.	Currently proof of concept delivered in LSWCCG. Reviewing for remaining CCGs	Scoping already started. Scheme start in 16/17
	Community ENT service	3 CCGs	Increased usage of ENT service. Measurement through CI data reports on service. LECCG reviewing current contract with community provider	To reduce numbers referred to secondary care To improve local access for patients	Scoping already started. Scheme start in 16/17
	Community Surgery Scheme	Countywide	Increase opportunity for patients to access services closer to home. Measurement through useage of schemes once live. Increase additional services available through the CSS	Reduce numbers referred to secondary care Reduce cost Improve local access by provision of services	Scoping already started. Scheme start in 16/17
	Secondary Care Follow Ups		Around 130,000 outpatient follow-up appointments will take place 2015/16. Identify if all are required as traditional face to face appointments. Some may not be required at all. This project will establish a benchmarked current position in terms of ULHT first to follow-up ratio's at speciality level and secondly seek to increase the utilisation of non-face to face follow up methods.	Reduce no. of follow up appointments in secondary care Improve patient waiting times	Scoping already started. Scheme start in 16/17
	Advice and Guidance	Countywide CCG support	Work with secondary and primary care clinicans to develop a robust and usable Advice and Guidance service for GPs to access for expert support. Commencing with Cardiology	Reduce referrals to secondary care Improved waiting times Better patient experience	Scoping already started. Scheme start in 16/17
	Community Dermatology Service	CCG	To procure a Community Dermatology Proof of Concept to inform full procurement commissioning intentions, in order	Improve patient waiting times Reduce referrals to secondary care	Scheme started. Stringent monitor and

			that we can develop a bespoke LECCG service Phase 2: Full procurement of community dermatology service for 3-5 year period		review during 16/17
	Review of MSK CATs service	CCG	Review usage by CCG by locality. Challenge referral pathways and impact on secondary care. Challenge MSK CATs outcomes Identify how the service can be measured as cost effective. Does LECCG wish to continue to commission an MSK Service.	Improve use of service if identified as more efficient and cost effective service. Reduction in the perceived 'duplication' of treatments/procedures Improve waiting times in secondary care	Scoping already started. Scheme start in 16/1716/17
	Neurology – Planned Care Board priority	Countywide	Review Neurology services across Lincolnshire. Undertake deep dive on all services connected eg prescribing LECCG committed to commissioning a PD Nurse through PD Society	Improve neurological services across Lincolnshire	Still being scoped as deep dive due for review in March 16.
CVD – Cardiovascular Pathway	Cardiology Up-skilling Training	CCG	Opportunity identified through CfV using Right Care methodology. Series of Cardiology Upskilling Training to GPs/PNs delivered in LECCG. Assessment has been supported by East Midlands Clinical Network Best Practice and Evidence Based interventions	The aim is to anti- coagulate at least half (as a minimum of) the patient group currently not receiving any anticoagulant drug therapy at each practice. Ambition to: Reduce number of strokes Avoid preventable deaths Improve management of AF Patients	Commenced 15/16 as part of 2-3 year programme of work
	Atrial Fibrillation	CCG	Review practice and processes regarding management of AF. Increase identification of patients with AF and optimise clinical management with anticoagulation where necessary.		
	NHS Diabetes Prevention Programme	Countywide CCG supporting	Part of the Lincolnshire cohort to receive support in diabetes prevention awareness	Improve early detection of preventable diabetes	Start April 16
	Integrated Diabetes Pathway	CCG	Diabetes pathway to be an integrated model across both primary and secondary care with	Reduce variation of care Manage discharge of non Super 6 patients from secondary care	

			the expectation that the majority of activity will take place in a primary care/community setting.		
Mental Health	Dementia Services	CCG	Continue with supporting practices to identify and diagnose Dementia. Continue with progression of Dementia Support Network	Diagnose and optimally treat dementia	On-going
	Review of Community MH Team	Countywide	Undertake review to identify where gaps in service provision are, improve current provision		

Research and Development - Technology	Prescribing – PINCER Trial To test intervention aimed to reduce prescribing errors in Primary Care		PINCER trial developed to study whether a pharamcist led IT-based intervention could reduce medication error rates within the primary care setting. As a research trial all measures will be as per protocol.		
	'MyHealthLincolnshire' Web App	CCG	The development of a web-based multi-media information portal to promote patient self-care. The portal will have 3 links on the home page - I am ill - My child is ill - I have a long term condition (development to be added)	Strengthen greater patient control and responsibility for the management of their long term condition. This will include both long term life style change and self-management of minor acute exacerbations/deteriorations	
Quality /Efficiency	Review of Butterfly Hospice	CCG	Currently underutilised as bed occupancy averaged 64%. Communication to the Hospice on increasing in-take on a daily basis (currently only 1 admission accepted) and communication out to all practices to ensure awareness	Increase bed occupancy to 80% Encourage as many LECCG GPs to use the service, as is practicable. Contribute to reduction in hospital admission as EOL patients could use this facility	

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Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of South West Lincolnshire CCG

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**22 March 2016**
Subject:	**Draft 1 year Operational Plan South West Lincolnshire CCG**

Summary: The Operational plan outlines the key priorities for 2016/17 for SWL CCG

Actions Required:

For review and comment on alignment to H&WB strategy and JSNA priorities.

1. Background

CCGs are required to produce a 1 year operational plan outlining short term commissioning priorities. This will be supplemented by a 5 year Sustainability and Transformation Plan which must be produced by June 2016 outlining how a balanced system which delivers the key outcomes will be achieved.

The plan outlines the key priorities for the CCG:

2. Conclusion

The operational plan remains in draft format and will be subject to review as the national pricing framework for the NHS has not yet been released, this may impact significantly on future final version.

3. Appendices

These are listed below and attached at the back of the report	
Appendix A	Operational Plan – Plan on a Page SWLCCG (The Nine Must Do's)

4. 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 Shona Brewster, who can be contacted on (01476 406598) or (sbrewster@nhs.net)

South West Lincolnshire Clinical Commissioning Group - 2016/17 Operational Plan on a Page

The CCGs Operational Plan outlines how we will balance our resources, both recurrent and non-recurrent, and how this will be used to improve quality and outcomes for patients within the CCG locality. A key element of this plan will be to use a Right Care approach with a focus on elective care and prescribing whilst continuing the transformation of care in the community for those that do not require an acute setting. We will aim for a joined up system with patients and families at the centre with proactive care providing early intervention and supported self-care being the prime drivers for change.
This plan on a page reflects the CCGs intentions aligned to the nine National priorities for 2016/17.

Sustainability and Transformational Plan

Currently, health and social care services are commissioned and provided by a number of separate organisations with service models based on partial views of the system. This system is fragmented by organisation boundaries, traditional professional distinctions, and separate funding, regulation, physical locations, and IT systems. The leaders of health and social care across Lincolnshire have come together to focus on defining the right services for Lincolnshire to improve quality and outcomes, and deliver services that the population will value, and care professionals can be proud of. Lincolnshire Health and Care will form the basis of the Sustainability and Transformation Plan (STP) covering 6 specific work streams – proactive; urgent; women's and children's; planned; mental health, learning disabilities and autism; the enablers (workforce, IT, estates & transport).

Financial Balance

The CCG has received the lower threshold of growth allocation which presents a number of challenges for the CCG that will also be influenced by the financially stretched local health and social care economy. A robust and sustainable QiPP programme which is clinically led is essential to ensure financial balance.
The focus for the CCG in 2016/17 is a comprehensive review of outpatients, elective care and diagnostic direct referrals with scrutiny on consultant to consultant referrals. A review of specific elective care pathways which could be commissioned in a community setting, rather than within an acute hospital, will be undertaken. The Right Care information packs are being reviewed to ensure we target our focus to maximum gain both in terms of best use of resources and quality outcome for patients.

General Practice

The CCG has a draft vision to support our member practices to deliver consistent, accessible and high quality primary care, using networks of healthcare and other professionals and innovative solutions to deliver services. We will support members to widen the primary care offering to our patients, to allow them to receive care in the community where appropriate.
Key themes to tackle in 2016/17 are: 1)Delivering sustainable primary care that is able to meet local needs and which are fit for the future; 2) Develop local based services with closer integration to enable robust out of hospital care; 3)Workforce planning, including innovative recruitment; 4) Working in new ways and using technology to improve care and reduce unwarranted variation; 5) Making it easier for GPs to refer patients correctly to other services where required

Access

The A&E performance in Lincolnshire has deteriorated since September 2014 and has not had a sustained recovery. This is not unique to Lincolnshire with many Trusts in neighbouring areas also not achieving the 95% standard. A remedial action plan has been implemented by ULHT in January 2016. Other initiatives are being considered or implemented to support recovery.
The East Midlands Ambulance Service continues to fail against all of the standards. A number of actions have been put into place to manage this poor performance – 1) revised remedial action plan including an improvement plan and core system actions; 2) A Recovery Action Plan (RAP) is being drafted and will cover - handover, activity & Staffing; 3) A review of the service improvement plan including improved retention of resources; 4) A trajectory plan for 2016/17; 5) Review of the national pilot to test out the re-categorisation of Red 1 and 2 calls and changes to response times.

Referral to Treatment

It is a priority to maintain the NHS Constitution standard that 92% of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment, including offering patient choice. As at November 2015 92% of our patients on an incomplete pathway were within the 18 weeks standard. Our main provider United Lincolnshire Hospitals NHS Trust (ULHT) is just below the standard at 91.2%. At this Trust a number of specialties are not achieving the incomplete standard and remedial action plans are in place for recovery.
The Planned Care improvement plan for 2016/17 will promote - improved outcomes; reduce unplanned contact; improved patient access the right person at the right time; reduced demand for secondary care services; supported recovery from acute treatment; profiling elective care to increase non-electives during winter

Cancer

Cancer performance has been recovering throughout 2015/16. As at November 2015, 6 out of the 8 cancer standards were being achieved, however year to date only 2 of the 8 standards have been achieved.

The Lincolnshire Cancer Improvement Plan will be designed to deliver the strategic objectives outlined in the National Cancer Strategy for England *Achieving World Class Cancer Outcomes.* The overarching objective of the local plan for 2016 / 17 will be to – 1) To establish clinical pathways that enable referral to diagnosis within four weeks; 2) To ensure that service models and configuration enable sustainable delivery of cancer services through proactive management of identified constraints.

Mental Health

Physical health care has been embedded into contracts to help reduce the health inequalities between people with serious mental illness and the general population. Investments in mental health include dementia, Children and Adolescent Mental Health Service (CAMHS) and a self-harm pathway. Improvements include - early intervention sub teams have been re-established; training in Family intervention skills planned February 2016; Cognitive Behaviour Practitioners identified and training arranged to increase capacity; Performance monitoring has been agreed and capacity will be reviewed in line with performance; Trajectory for achieving compliance with Early Intervention waiting time standard has been agreed.
IAPT - Current performance exceeds the required target. This will be monitored via the contract management group.
A refurbished S136 suite is due to open in February 2016, allowing police officers to detain people who may be a risk to themselves or others and arrange admission for assessment in the suite.

Learning Disabilities

The Transforming Care Partnership in Lincolnshire has been established between the 4 CCGs and Lincolnshire County Council (LCC) and SROs from both organisations are in place. A Transforming Care Board has been convened to enable organisations to work together and create a plan to transform services for people with a learning disability and/or autism who also have, or are at risk of developing, a mental health condition or behaviours described as challenging, in Lincolnshire. This includes people of all ages and those with ASD who do not also have a learning disability.
Key areas of the transformation plan include – 1) Redesign of community learning disability services to ensure community focus and less reliance on inpatient beds; 2) 24/7 access to crisis intervention and home assessment and treatment for people with a learning disability; 3) Increased liaison functions to increase access to mainstream services. Including widening this function to include autism liaison as well as physical health and mental health liaison; 4) Safe spaces and alternative to hospital crisis options

Quality

The CCG will have a number of areas of focus and these will include:

- Mortality rates and avoidable deaths
- Healthcare Associated Infections (HCAI)
- Maternity Review
- Safeguarding
- Equality and Diversity
- Palliative Care and End of Life
- Patient Experience
- Improving Patient Choice
- Friends and Family Test
- Personal Health Budgets

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Lincolnshire COUNTY COUNCIL
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LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of Glen Garrod, Executive Director of Adult Social Services on behalf of the BCF Task Group and the Joint Commissioning Board

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**22 March 2016**
Subject:	**The Lincolnshire Better Care Fund (BCF) Submission 2016/17**

Summary:

Members will note that the BCF for 2015/16 reached a total pooled fund of £197.3m (national allocation £53.4m), which made Lincolnshire one of only 6 local health and social care systems in the country in achieving such a high level of 'integration'. Additionally, the BCF level of protection in 2015/16 for adult social care provided £20m, significantly above the £15.4m required.

The Chancellors Comprehensive Spending Review announcements in November 2015 described the future of the BCF and extended the BCF from a one year programme to one that would last for the duration of the parliament – up to 2020. The BCF was also linked to 'Integration Plans' for the first time. Integration Plans are required for all local systems by March 2017. If an integration plan is agreed then a BCF plan will not be needed and, the substantial growth in the BCF from 2017 to 2020 by a further £1.5bn will be allocated through upper tier-authorities. So, failure to produce an integration plan runs the risk of a significant financial penalty.

Non-elective admissions (NEA) were a priority for 2015/16 against which a pay for performance element was required. For 2016/17 both NEAs and delayed transfers of care (DTOC) are now a priority. This is primarily because both nationally and locally NEA and DTOC have increased and is now an additional financial pressure on NHS partners. Whilst no pay for performance element exists in the new BCF guidance it is nonetheless considered necessary to hold some contingency should anticipated performance improvement not be achieved.

Actions Required:

1. Note the changes to the BCF national guidance and content for BCF submissions 2016/17;
2. Support the creation of a contingency sum of £3m as part of the pooled fund arrangements to help manage NEA and DTOC;
3. Support a 'level of protection' for Adult Social Services for 2016/17 of £16.825m;
4. Note the priority attached to delivering improved NEA and DTOC in 2016/17; Health and Wellbeing Board identifies a suitable forum for regular oversight of the performance against these two activities;
5. Support the proposal that allocation for DFGs for 2016/17 should reflect the allocation in 2015/16 ie. no growth;
6. support the use of part of the DFG element of the BCF to support the development of a Preventative Housing Strategy;
7. support a one-off investment from part of the DFG element of the BCF in the MOSAIC ICT platform to ensure the Council's contribution towards meeting the National Conditions for both the BCF and integration are met;
8. Support the provision from part of the DFG element of the BCF of a `one-off' contribution to the contingency sum indicated in paragraph 2 above.
9. Agree to update 3 Section 75s agreements (that will otherwise end) to support the continuation of the BCF into 2016/17: namely the 'Partnership Framework Agreement', 'Proactive Care' and 'Corporate'.
10. Agree to delegate to the Chair of the Health and Wellbeing Board any final decisions related to the BCF submission for 2016/17 that may be required in advance of a formal meeting of the Board subject to any such request having been previously agreed by the 5 formal partners (4 CCGs, Lincolnshire County Council) to the submission.

1. Background

By way of a recap the 2015/16 BCF included the following elements:

- £54.3m national allocation
- £20m 'protection for adult social services' (national minimum £15.4m)
- £2.97m Disabled Facilities Grant – pass-ported to District/City Councils
- £197.3m total pooled amount
- A Partnership Framework Agreement covering 5 Section 75 agreements and 2 'aligned budgets' (See Appendix A)
- A pay for performance requirement against an NEA target of a 3.5% reduction during the calendar year 2015 spread over 4 quarters
- A £1m risk against 10 areas of performance in adult care – as part of the £20m above.

- A contingency to help manage risk, of which £3.75m underwrites failure to deliver the NEA targets

The BCF Guidance 2016/17

With the Chancellors announcement in November 2015 the BCF became a longer term national programme leading to anticipated integration between health and social care by 2020 (Nb. integration plans by March 2017). Guidance and planning templates to support BCF submissions for 2016/17 were due to be published prior to Christmas 2015. However, they were not produced until February 23. The guidance is attached as Appendix B.

In summary the guidance identifies a number of requirements but does not include a pay for performance element – this has been removed. A number of requirements relate to continuing to protect adult social care, securing services for carers and those needing advocacy (notably mental health advocacy), re-ablement services and ongoing support for the Care Act are also referred to. There is also guidance (and subsequent clarifications published by the LGA) related to DFG allocations which grew substantially between 2015/16 and 2016/17.

Additionally, and perhaps most significantly the guidance provides a high profile to Non-Elective Admissions and Delayed Transfer of Care (DTOC). This is primarily due to the fact that nationally, and locally non-elective admissions have not reduced to meet the target set in 2015 and, delayed transfers of care have been growing both locally and nationally. Twice in the guidance the phrase 'can't count the money twice' is used and reinforces the need for NHS colleagues to ensure that if NEA and DTOC performance does not improve then there is sufficient funding to cover the increased costs that arise in consequence. As such the guidance in effect creates a need for a risk share/ contingency which, in Lincolnshire is considered to need to be £3.0m. Agreement has been reached between officers of the County Council and CCGs as to how this can be constructed and Appendix C (to follow) contains a draft revised Schedule 3 to the Partnership 'Framework Agreement' detailing the agreement reached.

CCGs have already identified a target in their Operating Plans for NEAs in 2016/17 of a 2% reduction. The System Resilience Group under the Chairmanship of Gary James, Chief Officer Lincolnshire East CCG is working on a recommended performance requirement for DTOCs. These two areas of performance will become a very high priority for the Joint Commissioning Board in the coming 12 months.

Whilst this paper concentrates upon the performance and financial elements related to the BCF the outcomes for individual patients is an important component to bear in mind. Inappropriate or unnecessary A&E attendances, delayed transfers from hospital are all typically bad for those people affected in terms of clinical outcomes and potential for regaining independence.

Protecting Adult Social Services

In 2015/16 the minimum national requirement for protecting adult social services in Lincolnshire equated to £15.4m. At the time NHS colleagues were able to offer a higher level of protection and agreed to do so and in 2015/16 the level of protection equalled £20m which, nationally was considered 'a very good settlement'.

However, during 2015/16 NHS financial pressures have grown and in Lincolnshire have created a particularly fragile NHS community. At the same time NEA and DTOC figures have deteriorated which represents a further financial risk to the NHS locally.

Additionally, during Autumn/Winter 2015 all schemes funded by the BCF were reviewed against a national template. This review enabled a number of schemes to be tested for effect and, those that represented 'programme costs' to be reviewed and scaled back. The consequence of these reviews overseen by the Joint Commissioning Board was to reduce the ongoing financial cost within the BCF. As such the level of 'protection' required also diminished, at the same time the County Council agreed to support adult care with additional funding.

The net effect of all the above has meant that the level of protection afforded by the BCF reduces to a figure of £16.825m.

Disabled Facilities Grant Funding

In addition and as part of the BCF planning process for 2016/17 more attention has been given to DFGs than was the case in 2015/16. It had been assumed that capital allocations would be very similar to 2015/16 when there was £2.97m available for DFGs and £1.9m for Adult Care as a capital sum to support Care Act implementation. The details for 2016/17 that were issued week commencing 8 February provided a surprise, with the entire capital allocation seemingly being made available for DFGs. The figures, publically available on the DCLG website for Lincolnshire show DFGs of £4.884m (not £2.97m) as follows:-

District Council	**2016/17**
	£000
Boston	446
East Lindsey	1,459
Lincoln	586
North Kesteven	627
South Holland	540
South Kesteven	671
West Lindsey	555
Total	4,884

The apparent growth in DFG funding comes at the expense of Care Act monies and Adult Care capital funding. The LGA feedback to DoH is that communication on the DFG/Capital changes has been poor. The National BCF Programme Team response has been that it will be down to local areas to agree how to commit this resource and it does not have to be exclusively on DFGs, it could be other capital that supports health and wellbeing in the local place. Subsequent 'clarifications' posted by the LGA have confirmed this extra flexibility.

Earlier conversations about the recommended approach with the seven District/City Councils took place prior to this additional information concerning DFG 'growth'. The subsequent national guidance makes it clear that *"…the DFG will be allocated through the BCF …..to take a joined-up approach to improving outcomes across health, social care and housing".*

Meetings with District/City senior officers and Chief Executives (see Appendix D) have indicated a level of support for an approach as follows:

i) the allocation for DFGs for 2016/17 should reflect the allocation in 2015/16 ie. no growth and,
ii) To facilitate the development of a Preventative Housing Strategy
iii) To support a one-off investment in the MOSAIC ICT platform to ensure the Council's contribution towards meeting the National Conditions for both the BCF and integration are met.
iv) Provide a `one-off' contribution to the contingency sum indicated above.

The Chancellor announced year on year growth to DFGs until the end of the decade. It is estimated that by 2020 the value of DFGs in Lincolnshire funded via the BCF could approximate £7m per annum. As such a more strategic approach to meeting future need for suitable housing recommends itself. All of the above proposals commit DFG allocations for 2016/17 only and as such presents a level of motivation for all partners in working towards a preventative housing strategy that can be in place for 2017/18.

The Assurance Process

This is one further area in which the BCF for 2016/17 differs to that in 2015/16. Where previously the assurance process was managed nationally, for 2016/17 Regional Panels will provide the necessary assurance that BCF submissions meet national requirements and are fit for purpose.

The Regional Panels are constituted of 3 people for each of the nine regions. They are the relevant NHS England Director of Commissioning Operations, the Regional LGA Chief Executive lead for health and care and the Regional ADASS Chair.

Regional panels will 'assure' local plan submissions twice. The first level of assurance concerns the metrics and financial details in a standardised 'Planning Template'. This occurred on 3 March for the East Midlands. The next level is scheduled for 23 March when a further iteration of the Planning Template is provided with a 'Narrative Plan' (to follow) which should be a much shorter and updated edition of that which was provided for the BCF submissions in 2015/16.

Should plans be considered 'high risk' national resources will be called upon to work with local systems that are struggling to meet the requirements.

The Timeline

This has changed repeatedly as delays to the guidance were repeated. As Members will note, they are very, very short timescales. (See Appendix E for details).

Contractual Arrangements

Of the 5 Section 75s detailed in Appendix A the following were one year arrangements and expire on 31 March 2016:-

- Partnership Framework Agreement
- Proactive Care Section 75 Agreement

- Corporate Section 75 Agreement

Although the Partnership Framework Agreement can be extended by notice given prior to 31 March 2016, the delay in receipt of the BCF Guidance and the fact that the final submission is yet to be made means that a new Partnership Framework Agreement will be needed.

Something therefore needs to be done with these Agreements as part of the 2016/17 BCF submission. The rest continue in force in accordance with their terms and do not require action as part of the BCF although they are subject to their own ongoing change control processes.

It is not considered that these Agreements need to be in place prior to the BCF submission being finalised and there is good reason why they would follow on from the BCF submission. As this is not yet finalised it is not possible to report on the final form of these Agreements. This will become clearer as the submission is worked on and it is intended to seek approval for these documents in a near final form at CCG Boards in late March and the Council's Executive on 5 April 2016. None of the Agreements is considered to require extensive revision and the most important changes are referred to below.

The Partnership Framework Agreement contains the general terms governing the relationship between the parties in terms of identifying opportunities for and managing the risks of entering into partnership arrangements. The main provision in the Agreement is Schedule 3 containing the risk sharing arrangements and a draft of a revised version of that Schedule is attached at Appendix C (to follow) as referred to earlier in this Report.

The Corporate section 75 created a pooled contingency fund drawn from monies set aside and underspends on a number of the section 75 Agreements. This pooled fund will be needed again in 2016/17 but it will reflect the revised risk sharing arrangements. In particular in 2016/17 underspends will not be put in a corporate contingency fund but managed within the relevant section 75 Agreement. In 2015/16 the Corporate Section 75 also contained monies for LHAC programmes.

The Proactive Care Section 75 Agreement will be amended to reflect the outcome of the review of programmes and to amend the financial provisions.

2. Conclusion

The Better Care Fund is now an established national programme for the country intended to run at least until 2020. The BCF is increasingly being used to further integration ambitions with a requirement to have an agreed integration plan by March 2017 and delivery by 2020. Success on this journey will secure improved outcomes and remove the requirement to produce a BCF for 2017/18 and facilitate the allocation of additional sums between 2017 and 2020.

In developing the BCF submission for 2016/17 the timeline has become condensed to a matter of weeks due to the delay in producing the national guidance. Negotiations are still underway framed by an increasingly difficult financial environment for both the Council and NHS colleagues.

3. Consultation

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Pooled Funding Arrangements
Appendix B	BCF National Guidance 2016/17
Appendix C	Draft Schedule 3 to the Partnership Framework Agreement (to follow)
Appendix D	Letter to District/City CEOs
Appendix E	BCF Regional Assurance Process

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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Appendix A

Formal pooled fund arrangements

Existing Arrangements

(1) Children and Adolescent Mental Health Section 75 Agreement

(2) Learning Disabilities Section 31 Agreement

(3) Integrated Community Equipment Service (ICES) Section 75 Agreement

New Pooled Fund Section 75 Agreements

(4) Proactive Care Section 75 Agreement

(5) Corporate Section 75 Agreement

Aligned existing arrangements

(6) Adult Mental Health Section 75 Agreement between the Council and Lincolnshire Partnership Foundation Trust

(7) National Health Service contract between the CCGs and LPFT for adult mental health services.

Of the arrangements referred to above, the following were one year arrangements and expire on 31 March 2016:-

- Partnership Framework Agreement
- Proactive Care Section 75 Agreement
- Corporate Section 75 Agreement

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Technical Guidance Annex 4:

Better Care Fund Planning Requirements for 2016-17

February 2016

NHS England Publications Gateway Reference 04437

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INTRODUCTION

1. The Department of Health (DH) and the Department for Communities and Local Government (DCLG) have published a detailed policy framework[1] for the implementation of the Better Care Fund in 2016-17, developed in partnership with the Local Government Association, Association of Directors of Adult Social Services and NHS England. This forms part of the NHS Mandate for 2016-17 to 2017-18. It requires NHS England to issue further detailed guidance to local areas on developing Better Care Fund (BCF) plans for 2016-17.

2. For 2016-17 it has been agreed that the BCF planning and assurance process should be integrated as fully as possible with the core NHS operational planning and assurance process. This guidance, which has been developed in conjunction with the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS), is therefore included here as an annex to the core NHS planning guidance for 2016-17. This does not diminish the requirement for plans to be jointly developed with local government partners, and approved by Health and Wellbeing Boards. This guidance is also being disseminated directly to local authorities via the Local Government Association.

3. The policy framework signals the need for stability in 2016-17, and a reduction in the overall planning and assurance requirements on local areas. This includes a shorter narrative plan requirement, reduced detailed requirements on the scheme level data, and for plan assurance to be owned by NHS England and local government regional teams, rather than through the national assurance and resubmission process that existed for 2015-16.

4. Whilst the policy framework remains broadly stable in 2016-17, local areas should be mindful in developing their plans about the linkages with NHS sustainability and transformation plans which NHS partners will be required to produce in 2016, and the Government's Spending Review requirement to produce a whole system integration plan for 2017. Both planning requirements will require a whole system approach from 2017-20.

POLICY REQUIREMENTS

5. The legal framework for the Fund derives from the amended NHS Act 2006, which requires that in each area the Fund is transferred into one or more pooled budgets, established under Section 75, and that plans are approved by NHS England in consultation with DH and DCLG. The Act also gives NHS England powers to attach additional conditions to the payment of the Better Care Fund to ensure that the policy framework is delivered through local plans. In 2016-17, NHS England will set eight conditions, which local areas will need to meet through the planning process in order to access the funding. The conditions require:

    i. That a BCF Plan, covering a minimum of the pooled Fund specified in the Spending Review, should be signed off by the HWB itself, and by the constituent Councils and CCGs;

[1] https://www.gov.uk/government/publications/better-care-fund-how-it-will-work-in-2016-to-2017

ii. A demonstration of how the area will meet the national condition to maintain provision of social care services in 2016-17.

iii. Confirmation of agreement on how plans will support progress on meeting the 2020 standards for seven-day services, to prevent unnecessary non-elective admissions and support timely discharge;

iv. Better data sharing between health and social care, based on the NHS number;

v. A joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional;

vi. Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans;

vii. That a proportion of the area's allocation is invested in NHS commissioned out-of-hospital services, or retained pending release as part of a local risk sharing agreement; and

viii. Agreement on a local action plan to reduce delayed transfers of care.

6. Conditions i - vi, above are based on policy set out in the 2013 Spending Review and were included in the 2015-16 BCF framework. They have been updated to reflect further policy developments and the 2015 Spending Review.

7. New condition vii replaces the national payment-for-performance element of the Fund, linked to delivering a reduction in non-elective activity that was a condition in 2015-16. We expect a similar local performance element will be deployed other than in those local areas that delivered their emergency admission reductions in 2015-16 and are confident that this can be repeated in 2016-17.Condition viii is also a new national condition for 2016-17. The details of each of the conditions are set out in the new policy framework.

PLANNING REQUIREMENTS

8. Local partners will need to develop a joint spending plan that is approved by NHS England as a condition of the NHS contribution to the Fund being released into pooled budgets. The process for developing plans will be simplified from the approach used for 2015-16 plans and will be aligned to the timetable for developing CCG operational plans. All national partners have agreed to minimise the amount of information that is collected and assured nationally as part of this process. In developing BCF plans for 2016-17 local partners will be required to develop, and agree, through the relevant Health and Wellbeing Board (HWB):

i. A short, jointly agreed narrative plan including details of how they are addressing the national conditions;

ii. Confirmed funding contributions from each partner organisation including arrangements in relation to funding within the BCF for specific purposes;

iii. A scheme level spending plan demonstrating how the fund will be spent;

iv. Quarterly plan figures for the national metrics.

9. The below table sets out where the information to fulfil the above planning requirements will be collected and how it will be assured:

Requirement	Collection method	Assurance approach
Narrative plans	Submitted to NHS England regional / local Directors of Commissioning Operations (DCO) teams in an agreed format	Assured by DCO teams, with regional moderation involving the LGA and ADASS
Confirmation of funding contributions	Submitted through CCG Finance Template and through a nationally developed high level BCF planning return (spreadsheet)	Collated and analysed nationally, with feedback provided to DCO teams for regional moderation and assurance process
National Conditions	Detail submitted to NHS England regional / DCO teams through narrative plans (as above), with further confirmations submitted through a nationally developed high level BCF planning return (spreadsheet)	Assured by DCO teams, with regional moderation involving the LGA and ADASS
Scheme level spending plan	Submitted to NHS England regional / DCO teams through a nationally developed high level BCF planning return (spreadsheet)	Collated and analysed nationally, with feedback provided to DCO teams for regional moderation and assurance process
National Metrics	Submitted through UNIFY and through a nationally developed high level BCF template return (spreadsheet)	Collated and analysed nationally, with feedback provided to DCO teams for regional moderation and assurance process

These will be the only planning requirements for the Better Care Fund in 2016-17.

NARRATIVE PLANS

10. There will not be a 'Nationally Consistent Assurance Review' of BCF plans for 2016-17 and therefore no national assessment of narrative plans. Local partners are still required to have in place a shared HWB level plan for integrating health and social care services through the BCF. This should build on approved plans for 2015-16 and demonstrate that local partners have reviewed progress in the first year of the BCF as the basis for developing plans for 2016-17. High level narrative plans produced for 2016-17 will therefore be expected to demonstrate incremental changes to 2015-16 plans reflecting this review of progress. As part of its assurance of CCG plans, NHS England will review BCF plans to ensure the appropriate use of risk management arrangements in the context of the BCF Condition 7.

11. In building on current BCF plans, the high level narrative plans that will need to be produced will also need to demonstrate that local partners have collectively agreed the following:

i. The local vision for health and social care services – showing how services will be transformed to implement the vision of the Five Year Forward View and moving towards integrated health and social care services by 2020, and the role the BCF plan in 2016-17 plays in that context;

ii. An evidence base supporting the case for change;

iii. A coordinated and integrated plan of action for delivering that change;

iv. A clear articulation of how they plan to meet each national condition; and

v. An agreed approach to financial risk sharing and contingency.

12. In all cases these elements can be demonstrated and referenced from existing plans or initiatives, including refreshed 2015-16 BCF plans. There will not be a need to restate information that is already satisfactorily provided in existing plans. This does not diminish the need for local areas to develop plans together and publish them in line with the requirements of their respective organisations.

13. In addition to the national condition relating to improving data sharing (see below), narrative plans are expected to demonstrate how digital or information technology is being established as an instrumental enabler to the delivery of integration, with reference to the Five Year Forward View and Personalised Health and Care 2020[2]. 90 communities have so far come together to create local digital roadmaps, with CCGs and local authorities included in each one. Where these are in place they should be referenced within BCF plans; where they are not it is expected that BCF plans will include a reference to their development. This recognises that integrated planning and delivery of the enabling information technology (including access to integrated digital records) is a vital part of the infrastructure to support improved operational performance on a number of areas that are a core focus of the BCF. These include reducing unnecessary non-elective admissions, seven day-a-week out-of-hospital services, and timely discharge.

CONFIRMATION OF FUNDING CONTRIBUTION

14. NHS England has published individual HWB level allocations of the BCF for 2016-17, and the detailed formulae used, on its website.[3] This builds upon confirmation of each CCG's contributions to the BCF in 2016-17 which is included in the core CCG allocations, also published on the NHS England website.[4]

15. All local partners will need to confirm mandatory and additional funding contributions to all plans to which they are a partner. This will include confirming that individual elements of the funding have been used in accordance with their purpose as set out in the policy framework and below. This will be collected nationally through a high level BCF Planning Return. Detailed instructions on completing this are included in the guidance section of the return template. Local

[2] https://www.england.nhs.uk/ourwork/futurenhs/nhs-five-year-forward-view-web-version/ and https://www.gov.uk/government/publications/personalised-health-and-care-2020
[3] https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/
[4] https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/

areas must include an explanation of how local adult social care services will continue to be supported within their plans in a manner consistent with 2015-16.

Disabled Facilities Grant

16. Following the approach taken in 2015-16, the Disabled Facilities Grant (DFG) will again be allocated through the BCF. This is to encourage areas to think strategically about the use of home adaptations, use of technologies to support people in their own homes, and to take a joined-up approach to improving outcomes across health, social care and housing. In 2016-17, the housing element has been strengthened through the National Conditions, which require local housing authority representatives to be involved in developing and agreeing BCF plans. Again, following the approach taken in 2015-16, the DFG will be paid to upper-tier authorities in 2016-17. However, the statutory duty on local housing authorities to provide DFG to those who qualify for it will remain. Therefore each area will have to allocate this funding to its respective housing authorities (district councils in two-tier areas) from the pooled budget to enable them to continue to meet their statutory duty to provide adaptations to the homes of disabled people, including in relation to young people aged 17 and under.

Care Act 2014 Monies

17. As described in the Policy Framework, the BCF allocation to CCGs includes £138m to support the implementation of the Care Act 2014 and other policies. BCF plans should set out how informal family carers will be supported by local authorities and the NHS. This funding is not new but has been uplifted from the £135m made available through the BCF in 2015-16 for a broader set of duties around the Care Act – this has been simplified to focus mainly on carer support. Further guidance and details of the exact breakdown will be set out in the Local Authority Social Services Letter, which will be sent by the Department of Health to the Directors of Adult Social Services in due course.

Former Carers' Break Funding

18. The BCF also includes, as in 2015-16, £130m of funds previously earmarked for NHS replacement care so that carers can have a break. Local plans should set out the level of resource that will be dedicated to carer-specific support, including carers' breaks, and identify how the chosen methods for supporting carers will help to meet key outcomes (e.g. reducing delayed transfers of care).

Reablement Funding

19. The Better Care Fund also includes, as in 2015-16, £300m of NHS funding to maintain current reablement capacity in councils, community health services, the independent and voluntary sectors to help people regain their independence and reduce the need for ongoing care.

NATIONAL CONDITIONS

20. Local partners will be required to articulate a plan for meeting each national condition, as set out in the BCF policy framework and operationalised by the guidance contained in this document, through their BCF narrative plan. This

should include clear links to other relevant programmes or streams of work in place locally to deliver on these priorities. It is expected that local areas will want to provide more detailed plans for the new conditions in 2016-17. There will also be a requirement to confirm whether plans are in place to meet the conditions as part of the BCF planning return.

21. The two new national conditions and the conditions on 'Better data sharing between health and social care, based on the NHS number' and 'Maintain provision of social care services' should be read in conjunction with the additional guidance as set out in paragraphs 23 –34 below.

22. Confirmation that BCF plans meet the eight national conditions will be collected nationally through a high level BCF Planning Return and detailed instructions on completing this are included in the guidance section of the template.

FURTHER GUIDANCE ON NATIONAL CONDITIONS

Maintain provision of social care services

23. Local areas must include an explanation within their plans of how the use of BCF resources will meet the national condition to maintain provision of social care services.

24. In setting the level of protection for social care localities should ensure that any change does not destabilise the local social and health care system as a whole. This will be assessed compared to 2015-16 figures through NHS England's regional assurance process.

25. It should also be consistent with 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013-14:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf"

Better data sharing between health and social care, based on the NHS number

26. At the present time the HSCIC is not extending the NHS Number batch service to additional local authorities. We understand that for some local authorities this will be causing difficulties in meeting the condition set out in the BCF to use the NHS Number as an identifier across the health and care system. We are working closely together to resolve the issue at a national level. If a locality is currently unable to obtain the NHS Number from the HSCIC then this should be noted in the BCF plan and it will be taken into account when assessing the plan.

Agreement to invest in NHS commissioned out-of-hospital services

27. The BCF Policy Framework establishes that £1 billion of the CCG contribution to the Fund required to deliver investment to the NHS and previously linked to the performance framework will continue to be ring-fenced to deliver investment or equivalent savings to the NHS, whilst supporting local integration aims. Each

CCG's share of this funding will be set out in allocations and will need to be spent as set out in the new national condition.

28. Local areas should agree how they will use their share of the £1 billion that had previously been used to create the national payment for performance element of the fund. This should be achieved in one of the following ways:

    - To fund NHS commissioned out-of-hospital services, that demonstrably lead to off-setting reductions in other NHS costs against the 2014-15 baseline; or

    - Local areas that did not meet their 2015-16 emergency admission reduction goals are expected to consider putting an appropriate proportion of their share of the ring-fenced £1bn into a local risk-sharing agreement as part of contingency planning in the event of excess emergency hospital activity, with the balance spent on NHS commissioned out-of-hospital services, which may include a wide range of services (local areas should seek, as a minimum, to maintain provision of NHS commissioned out of hospital services in a manner consistent with 2015-16).

29. Specifically, where local areas successfully delivered their agreed 2015-16 emergency admission reductions and all partners are confident that the 2016-17 BCF plan can meet its objectives then they can choose to invest the full element of the £1bn linked to NHS-commissioned out-of-hospital services upfront. This could include a wide range of services, to be determined locally. CCGs and Councils should include a breakdown of planned expenditure, including the amount they identify as NHS-commissioned spend, within the scheme level spending plan.

30. However, where the local partners recognise a significant degree of risk associated with the delivery of their 2016-17 BCF plan, for example where emergency admission reductions targets were consistently not met in 2015-16, we expect them to consider using a local risk sharing agreement, given that 'the same pound cannot be spent twice' – on emergency admissions *and* on NHS-commissioned out-of-hospital activity at the same time.

31. Where local partners agree to use a risk share agreement the default approach should be to base this on the 2015-16 approach, as set out at **Appendix 2**. However, we are open to other local approaches that demonstrably achieve the same objective. The key point is that BCF investment does not cause a CCG to over extend itself in financial terms and hence put the financial balance of the health economy at risk.

32. As part of BCF planning returns, local areas will need to demonstrate that they are using their share of the NHS-ring-fenced £1 billion fund in the way described above. The template includes confirmation of the local share, and calculates the amount invested in NHS Commissioned out-of-hospital services from the spending plan. There is also an opportunity to confirm the value of additional funds that are part of appropriate risk sharing arrangements. Further details on this are set out in the guidance section of the return template.

Agreement on a local action plan to reduce delayed transfers of care (DTOC) and improve patient flow

33. In planning to meet this condition all areas should consider their performance in relation to DTOC (and patient flow) and work together to develop a proportionate plan to improve their position. The key elements that local areas should include in their action plan are set out below. These are drawn from existing best practice approaches and available mechanisms for managing effective transfers and delays, rather than introducing new ones.

- **Situation Analysis**
  In order to ensure that the plan developed is proportionate to address the local situation partners should review their current performance and assess the level of opportunity within the system for reducing delays and improving transfers. This should include:
    - Detailed analysis of current performance levels (including trend analysis) and the causes of delays;
    - An assessment of current schemes in place to reduce delays and improve transfers of care and how effective these are;
    - A gap analysis comparing local measures to the best practice interventions (see below);
    - A consideration of whether additional measures are required where rates of delay are very high, including whether a risk sharing arrangement may be appropriate.

- **Target and Action Plan**
  In developing their plan, local partners are expected to agree a target for reducing DTOC that is realistic but ambitious. There should be a clear articulation of how the target has been set, with reference to the situation analysis. The DTOC target and CCG planning assumption should be in alignment and include a trajectory for reducing the number of delays. The target should be underpinned by a set of clear actions to deliver improvement that builds both on successful local initiatives and on the nationally agreed best practice interventions. In addition, areas may also want to consider other metrics which monitor patient flow (such as average length of stay) at a local level. There are a number of metrics being used locally by the Emergency Care Improvement Programme (ECIP) which can be shared.

  Information about the best practice interventions can be found on the Local Government Association's website at http://www.local.gov.uk/adult-social-care/-/journal_content/56/10180/5516287/ARTICLE#impact-change or on the Better Care Exchange at https://bettercare.tibbr.com/tibbr/

- **Accountability Arrangements**
  All actions need to be clearly owned, so the plan should set out lines of responsibility and accountability for delivering each element of the plan, as well as an agreed process for local assurance and escalation where any issue cannot readily be resolved.

- **Using Local Capacity**
  Local partners are encouraged to include an analysis of their local capacity and requirements in their plans and to set out how that capacity can best be used across health and social care to minimise delays and meet evolving

need. A joint commissioning approach between health and care is encouraged. In capacity mapping and planning, local areas will need to consider the long-term sustainability of the market for both health and social care.

Many areas already recognise the role that the voluntary and community sector can play in supporting patients to remain in their own home or return there more quickly following a period in hospital. Local plans can consider explicitly how this sector can contribute to reductions in DTOC. Areas should consider whether other local stakeholders, such as housing providers, have a role to play in efforts to reduce delays.

- **Additional measures**
  As set out above, areas should consider as part of the situation analysis and the development of an action plan, what measures are proportionate to address local levels of performance. Where DTOC are high and rising, or there are significant issues with patient flow across the health and care system, local areas should demonstrate how they have considered all options for addressing this, including the potential use of risk sharing arrangements and broader incentives within the system.

  A local CQUIN has also been included in the NHS contract for 2016-17 which provides a mechanism for local areas to reward improvement in the proportion of patients discharged to their usual place of residence within 7 days of admission.

  If there is local agreement that a risk sharing arrangement for DTOC is appropriate then local areas should consider the use of existing mechanisms. At a national level, the Care Act 2014 sets out a discretionary system whereby the NHS can seek reimbursement from a local authority (LA) if the LA does not meet its statutory duties to assess and, where appropriate, put in place care and support arrangements to allow a patient to be discharged from acute care. These arrangements are explained in the Care and Support Statutory Guidance and reiterated in NHS England's Monthly Delayed Transfers of Care Situation Reports: Definitions and Guidance[5].

  Local areas may decide that they want to use wider mechanisms as part of a risk sharing mechanism and have the flexibility to do so. In doing so, local areas should ensure that their approach takes into account the legal framework on payments set out in the Care Act and that they are content that they are not acting in any way which goes against current legislation.[6]

  In considering the use of reimbursement under the Care Act and wider risk sharing mechanisms, local areas should agree collectively on the approach and assure themselves that it will lead to resources being spent in the best interest of the local population and with a positive impact on the performance of the local health and care system.

[5] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/315993/Care-Act-Guidance.pdf and https://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/

[6] http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted/data.htm and http://www.legislation.gov.uk/allTheCareandSupportDischargeofHospitalPatientsRegulations2014

SCHEME LEVEL SPENDING PLAN

34. A scheme level spending plan will be required to account for the use of the full value of the budgets pooled through the BCF. These plans will need to include:
    - Area of spend
    - Scheme type
    - Commissioner type
    - Provider type
    - Funding source
    - Total 15-16 investment (if existing scheme)
    - Total 16-17 investment.

35. Detail on scheme-level spending plans will be collected nationally through a high level BCF Planning Return and detailed instructions on completing this are included in the guidance section of the template.

NATIONAL METRICS

36. The BCF Policy Framework establishes that the national metrics for measuring progress of integration through the BCF will continue as they were set out for 2015-16, with only minor amendments to reflect changes to the definition of individual metrics. In summary these are:

    a. Non-elective admissions (General and Acute);
    b. Admissions to residential and care homes[7];
    c. Effectiveness of reablement;
    d. Delayed transfers of care.

37. The detailed definition of the non-elective admissions (NEA) metric is set out in the Planning Round Technical Definitions[8]. BCF plans will need to establish a HWB-level NEA activity plan. This will initially be established by mapping agreed CCG level activity plans to the HWB footprint using the mapping formula provided in the planning return template. Figures submitted in first draft CCG operating plan returns have been pre-populated into the template centrally and mapped accordingly. HWBs will be expected to agree CCG level activity plans for NEAs as part of the operational planning process and through the BCF to ensure broader system ownership of the non-elective admission plan as part of a whole system integrated care approach.

38. The level of non-elective activity which BCF plans seek to avoid, in addition to reductions already included within the calculation of CCG operating plan figures, should be clearly identified in the BCF planning return. This reduction should be set at a level which the CCG and local system feel can be achieved, and, in any case, the emergency admissions baseline for 2016-17 must not be set any higher than the BCF stretch ambitions used in 2015-16. This is because 'the same pound cannot be spent twice', so if emergency admissions were not prevented in 2015-16 then the funding will have had to be used to reimburse

[7] The ASCOF definition of this metric has changed. The revised definition is now used in the full specification of metric at the end of this annex.
[8] https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/

hospitals for their emergency admissions.

39. The detailed definitions of the other three metrics are set out at the end of this document. HWBs will be required to set ambitious plans in relation to each metric. The national condition on DToC sets out further requirements in relation to setting targets for that metric.

40. Information on all four metrics will continue to be collected nationally. The below table sets out a summary of the information required and where this will be collected:

Metric	Collection method	Data required
Non-elective admissions (General and Acute)	• Collected nationally through UNIFY at CCG level • HWB level figures confirmed through BCF Planning Return	Quarterly HWB level activity plan figures for 2016-17, mapped directly from CCG operating plan figures, using mapping provided, against the original 2014-15 baseline and 2015-16 targets.
Admissions to residential and care homes;	• Collected through nationally developed high level BCF Planning Return	Annual target for 2016-17
Effectiveness of reablement;	• Collected through nationally developed high level BCF Planning Return	Annual target for 2016-17
Delayed transfers of care;	• Collected through nationally developed high level BCF Planning Return	Quarterly target for 2016-17

Further information on the data to be provided for each metric can be found in the guidance section of the BCF planning return template.

41. In addition the requirement for BCF plans to include a locally determined metric and a locally determined patient experience metric is again included within the requirements of the BCF planning return. It is expected that local areas will continue to use measures that allow them to effectively track the implementation of integrated care locally.

42. Work to establish a set of new integration metrics continues to be led by the Department of Health. Information collected on a number of potential new measures through the BCF quarter 2 reporting return will help inform that process. The new measures will not be used as part of the BCF framework for 2016-17. Work will continue through 2016-17 to develop them further.

LOCAL PLAN DEVELOPMENT, SIGN OFF AND ASSURANCE

43. Local partners are expected to continue working together to develop a joint, HWB level plan for integrating health and social care services. These should continue to build on plans delivered in 2015-16, and also look forward to longer

term strategic plans. There may be flexibility for devolution sites to submit plans over a larger footprint if appropriate.

44. The Better Care Support Team will provide a range of resources to help local areas develop their plans, including signposting to existing support and advice available on integrated care, technical support on the BCF planning requirements, and continuing to share examples of good practice. Information on planning support requirements collected through the BCF Q2 quarterly returns will also be used to develop further planning specific support. A self-assessment process is also being conducted as part of the main NHS planning approach to identify areas which feel they need more targeted support.

45. The first stage of the overall assurance of plans will be local sign-off by the relevant local authority and CCG(s). In line with the NHS operational planning assurance process, plans will then be subject to regional assurance and moderation. Assurance and judgements on potential support needs through the planning process will be 'risk-based' (based on a planning readiness self-assessment pooled with other system level intelligence) with the level of assurance of an areas plan being proportionate to the perceived level of risk in a system.

46. BCF plans will be submitted and assured through the following steps:-

- The first submission will be of the high level BCF Planning Return only, detailing the technical elements of the planning requirements, including funding contributions, a scheme level spending plan, national metric plans, and any local risk sharing agreement.
- Then brief narrative plans will be submitted to regional teams from HWBs, setting out how the plan will meet the national conditions and the other planning requirements.
- At the same point HWB partners will be required to submit a second version of the completed BCF Planning Return.
- CCGs will also be submitting further versions of their operational planning returns during this period, using central UNIFY and Finance return templates. This will include some of the same data – including funding contributions and NEA figures. There will be a national reconciliation process to ensure the data provided matches in all cases.
- The assurance process, including reconciling any data issues, will happen within NHS England's Directors of Commissioning Operations' (DCO) teams, in alignment with the process for reviewing CCG operating plans. Better Care Managers will work with these teams to ensure they have the knowledge and capacity required to review and assure BCF plans. A set of consistent 'Key Lines Of Enquiry (KLOE) will be produced to support the assurance process and will be available to local areas as a guide in developing plans.
- The assurance process will check specifically that the requirements of Condition 7 have been satisfied, i.e. that planned investment in the Better Care Fund is affordable to CCGs, and contains adequate performance/risk management schemes in respect of emergency hospital admissions.

- To support this, local government regional leads for the BCF (LGA lead CEOs and ADASS chairs) will be part of the moderation process at a regional level (supported with additional resource to contribute to both assurance and moderation) and will be consulted by DCO teams when making recommendations about plan approval;
- As part of that regional moderation process an assessment will then be made of the risk to delivery of the plan due to local context and challenges, using information from NHS England, the Trust Development Authority, Monitor and local government;
- These judgements on 'plan development' and 'risks to delivery' will help inform the placing of plans by NHS England into three categories – 'Approved', 'Approved with support', 'Not approved'. The next steps for a HWB whose plan is placed within each category are set out below:
    - Approved – proceed with implementation in line with plans;
    - Approved with support – proceed with implementation with some ongoing support from regional teams to address specific issues relating to 'plan development' and / or 'risks to delivery';
    - Not Approved – do not proceed with implementation. Work with the NHS England DCO team, Better Care Manager and LGA / ADASS representatives to put in place steps for achieving plan approval (and / or meet relevant conditions) ahead of April 2016.

47. The overall assurance process is illustrated in the schematic at **Appendix 3**.

NATIONAL ASSURANCE AND PLAN APPROVAL

48. There will be no national assurance process for BCF Plans for 2016-17. Instead regional teams will work with the Better Care Support Team to provide assurance to the national Integration Partnership Board (jointly chaired by DH and DCLG whose membership includes NHS England, LGA and ADASS) that the above process has been implemented to ensure that high quality plans are in place which meet national policy requirements and have robust risk-sharing agreements where appropriate. This will include offering assurance that appropriate support and assurance arrangements are in place for high risk areas.

49. In accordance with the legal framework set out in section 223GA of the NHS Act 2006, final decisions on approval will be made by NHS England in consultation with DH and DCLG. These decisions will be based on the advice of the moderation and assurance process set out above. Where plans are not initially approved NHS England will implement a programme of support to help areas to achieve approval (and / or meet relevant conditions) ahead of April 2016.

50. NHS England has the ability to direct use of the CCG contribution to a local fund where an area fails to meet one of the BCF conditions. This includes the requirement to develop a plan that can be approved by NHS England. If a local plan cannot be agreed, any proposal to direct use of the fund and / or impose a spending plan on a local area, and the content of any imposed plan, will be

subject to consultation with DH and DCLG (as required under the 2016-17 NHS Mandate), with the decision then taken by NHS England.

HIGH LEVEL TIMETABLE

51. The submission and assurance process will follow the following timetable:

NHS Planning Guidance for 2016-17 issued	22 December 2015
Technical Annexes to the planning guidance issued,	19 January 2016
BCF Planning Requirements; Planning Return template, BCF Allocations published	February 2016
First BCF submission (following CCG Operating Plan submission on 8 Feb), agreed by CCGs and local authorities, to consist of: • BCF planning return only All submissions will need to be sent to DCO teams and copied to england.bettercaresupport@nhs.net .	2 March 2016
Assurance of CCG Operating Plans and BCF plans	March 2016
Second submission following assurance and feedback, to consist of: • Revised BCF planning return • High level narrative plan All submissions will need to be sent to DCO teams and copied to england.bettercaresupport@nhs.net	21 March 2016
Assurance status of draft plans confirmed	By 8 April
Final BCF plans submitted, having been signed off by Health and Wellbeing Boards	25 April 2016
All Section 75 agreements to be signed and in place	30 June 2016

52. This timetable should be read alongside the timetable of page 16 of the NHS shared planning guidance.[9]

STATUTORY FRAMEWORK AND ALLOCATIONS[10]

53. The Care Act 2014 amended the NHS Act 2006 to provide the legislative basis for the Better Care Fund. It allows for the NHS Mandate to include specific requirements relating to the establishment and use of an integration fund.

54. Under the NHS Mandate for 2016-17, NHS England is required to ring-fence £3.519 billion within its overall allocation to CCGs to establish the BCF. The remainder of the £3.9 billion fund will be made up of the £394 million Disabled Facilities Grant, which is paid directly from the Government to local authorities.

[9] https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/
[10] As set out in the policy framework for the BCF in 2016-17: https://www.gov.uk/government/publications/better-care-fund-how-it-will-work-in-2016-to-2017

55. Of the £3.519 billion BCF allocation to CCGs, £2.519 billion will be available upfront to HWBs to be spent in accordance with the local BCF plan. The remaining £1 billion of Clinical Commissioning Group Better Care Fund allocation will be subject to the requirement of the new national condition vii set out in paras 27 to 32 above.

56. Within the BCF allocation to CCGs is £138m to support the implementation of the Care Act 2014 and other policies (£135m in 2015-16). Funding previously earmarked for reablement (over £300m) and for the provision of carers' breaks (over £130m) also remains in the allocation. Further information on this can be found in paragraphs 14-19 above.

57. For 2016-17, the allocations have been based on a mixture of the CCG allocations formula, the social care formula, and a specific distribution formula for the Disabled Facilities Grant element of the Better Care Fund. Full HWB level allocations have been published on the NHS England website.[11]

[11] https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/

APPENDIX 1- SPECIFICATION OF BETTER CARE FUND METRICS

Metric 1: Non-Elective Admissions (General and Acute)

The baseline for measurement continues to be 2014-15, as incorporated into the local 2015-16 targets.

The definition of this metric is published as part of the technical definitions for NHS planning in 2016-17, which can be found here:

https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/

Metric 2: Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population

Outcome sought	Reducing inappropriate admissions of older people (65+) in to residential care
Rationale	Avoiding permanent placements in residential and nursing care homes is a good measure of delaying dependency, and the inclusion of this measure in the framework supports local health and social care services to work together to reduce avoidable admissions. Research suggests that, where possible, people prefer to stay in their own home rather than move into residential care. However, it is acknowledged that for some client groups that admission to residential or nursing care homes can represent an improvement in their situation.
Definition	**Description**: Annual rate of older people whose long-term support needs are best met by admission to residential and nursing care homes. **Numerator**: The sum of the number of council-supported older people (aged 65 and over) whose long-term support needs were met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care). This data is taken from Short- and Long-Term Support (SALT) collected by HSCIC **Denominator**: Size of the older people population in area (aged 65 and over). This should be the appropriate ONS mid-year population estimate or projection.
Source	Adult Social Care Outcomes Framework: (HSCIC - SALT: http://www.hscic.gov.uk/socialcarecollections2016) Population statistics (Office for National Statistics, http://www.ons.gov.uk/ons/rel/pop-estimate/population-estimates-for-england-and-wales/index.html)
Reporting schedule for data source	Frequency: Annual (collected Apr-March) Timing: Final data for 2014-15 was published in October 2015 Baseline: This will be 2014-15 data as published by the HSCIC (note that for the published data the 2014, not the 2015 ONS population estimate has been used for the population denominator)

Historic	Data first collected 2014-15 following a change to the data source. The transition from ASC-CAR to SALT resulted in a change to which admissions were captured by this measure, and a change to the measure definition. Previously, the measure was defined as "Permanent admissions of older adults to residential and nursing care homes, per 100,000 population". With the introduction of SALT, the measure was re-defined as "Long-term support needs of older adults met by admission to residential and nursing care homes, per 100,000 population."

Metric 3: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

Outcome sought	Increase in effectiveness of these services whilst ensuring that those offered service does not decrease
Rationale	Improving the effectiveness of these services is a good measure of delaying dependency, and the inclusion of this measure in the scheme supports local health and social care services to work together to reduce avoidable admissions. Ensuring that the rate at which these services are offered is also maintained or increased also supports this goal.
Definition	The proportion of older people aged 65 and over discharged from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital. **Numerator:** Number of older people discharged from acute or community hospitals to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital. This should only include the outcome for those cases referred to in the denominator. The numerator will be collected from 1 January to 31 March during the 91-day follow-up period for each case included in the denominator. This data is taken from Short- and Long-Term Support (SALT) collected by HSCIC **Denominator:** Number of older people discharged from acute or community hospitals from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting). The collection of the denominator will be between 1 October and 31 December. This data is taken from Short- and Long-Term Support (SALT) collected by HSCIC Alongside this measure is the requirement that there is **no decrease** in the proportion of people (aged 65 and over) offered rehabilitation services following discharge from acute or community hospital.
Source	Adult Social Care Outcomes Framework: (HSCIC - SALT: http://www.hscic.gov.uk/socialcarecollections2016)

Reporting schedule for data source	Frequency: Annual (although based on 2x3 months data – see definition above) Timing: Final data for 2014-15 was published in October 2015 Baseline: This should be 2014-15 data as published by the HSCIC.
Historic	Data first collected 2011-12 (currently four years data final available (2011-12, 2012-13, 2013-14 and 2014-15)

Metric 4: Delayed transfers of care from hospital per 100,000 population

Outcome sought	Effective joint working of hospital services (acute, mental health and non-acute) and community-based care in facilitating timely and appropriate transfer from all hospitals for all adults.
Rationale	This is an important marker of the effective joint working of local partners, and is a measure of the effectiveness of the interface between health and social care services. Minimising delayed transfers of care and enabling people to live independently at home is one of the desired outcomes of social care.
Definition	Total number of delayed transfers of care (delayed days) per 100,000 population (attributable to either NHS, social care or both)* A delayed transfer of care occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed. A patient is ready for transfer when: (a) a clinical decision has been made that the patient is ready for transfer AND (b) a multi-disciplinary team decision has been made that the patient is ready for transfer AND (c) the patient is safe to discharge/transfer. **Numerator:** The total number of delayed days (for patients aged 18 and over) for all months of baseline/payment period* **Denominator:** ONS mid-year population estimate (mid-year projection for 18+ population) *Note: this is different to ASCOF Delayed Transfer of Care publication which uses 'patient snapshot' collected for one day each month.
Source	Delayed Transfers of Care (NHS England http://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/) Population statistics (Office for National Statistics, http://www.ons.gov.uk/ons/rel/pop-estimate/population-estimates-for-england-and-wales/index.html)
Reporting schedule for data source	Frequency: Numerator collected monthly (aggregated to quarters for monitoring). (Denominator annual) Timing: 2 month lag. Baseline: 2014/15 quarterly rates
Historic	Data first collected Aug 2010

APPENDIX 2 – REQUIREMENTS FOR RISK SHARE AGREEMENTS

1. Paragraph 30 sets out circumstances in which local areas are expected to consider including a risk sharing arrangement which is specifically linked to the delivery of their plan for Non-Elective Admissions in 2016-17. Where this is the case the arrangements should be described within narrative plans in line with the requirements set out in paragraph 31 to include an agreed approach to financial risk sharing and contingency.

2. In addition, the finance and activity data underpinning the arrangements should be detailed within the BCF planning return template on the metrics tab. Further guidance on how to complete this is included within the guidance tab of the template itself.

3. As a minimum, a risk sharing arrangement that is put in place in this way should:

    a) Create a maximum risk share fund which is equal to the value of non-elective admissions that original BCF plans aimed to avoid.

    The reference point below which reductions can be credited to the BCF is the LOWER of the 14/15 outturn used as the baseline for 15-16 BCF plans, or the activity levels included in CCG Operating Plans for 16-17 after accounting for efficiency measures to reduce non-elective admissions (but before adjusting for the impact of actions taken in the context of 16-17 BCF plans). This is how the BCF risk fund meets the principle that "the money follows the patient" and "the same pound can't be spent twice" – on the emergency admission not avoided, and on other services.

    b) Ensure the value of this fund is withheld by CCGs from their BCF allocation which is paid into the pooled budget at the beginning of the year (recognising that CCG allocations have been set to take account of a number of efficiency measures to reduce non elective admissions which will need to be taken account of when setting the baseline against which the impact of BCF initiatives will be measured);

    c) Make payments into the pooled fund on a quarterly basis equivalent to the value of admissions avoided, up to the maximum risk share fund;

    d) Ensure that unreleased funds are retained by the CCG to cover the cost of additional non-elective activity.

4. If the planned levels of activity are achieved and, as such, value is delivered to the NHS in that way, then this funding may be released to be spent as agreed by the HWB. Otherwise it is retained as a contingency fund to cover the cost of any additional activity which results from BCF schemes not having the expected impact in reducing demand. Arrangements will need to demonstrate how and when it will be agreed to release this funding from the contingency into the pooled budget if it is not required.

5. In addition to this specific guidance, the assurance of overall risk sharing arrangements and contingency plans will look at the management of risk in each plan, with reference to key metrics. This will be consistent with the approach set out in guidance for 2015-16, focusing on whether each plan includes:

a) A quantified pooled funding amount that is ‘at risk’;

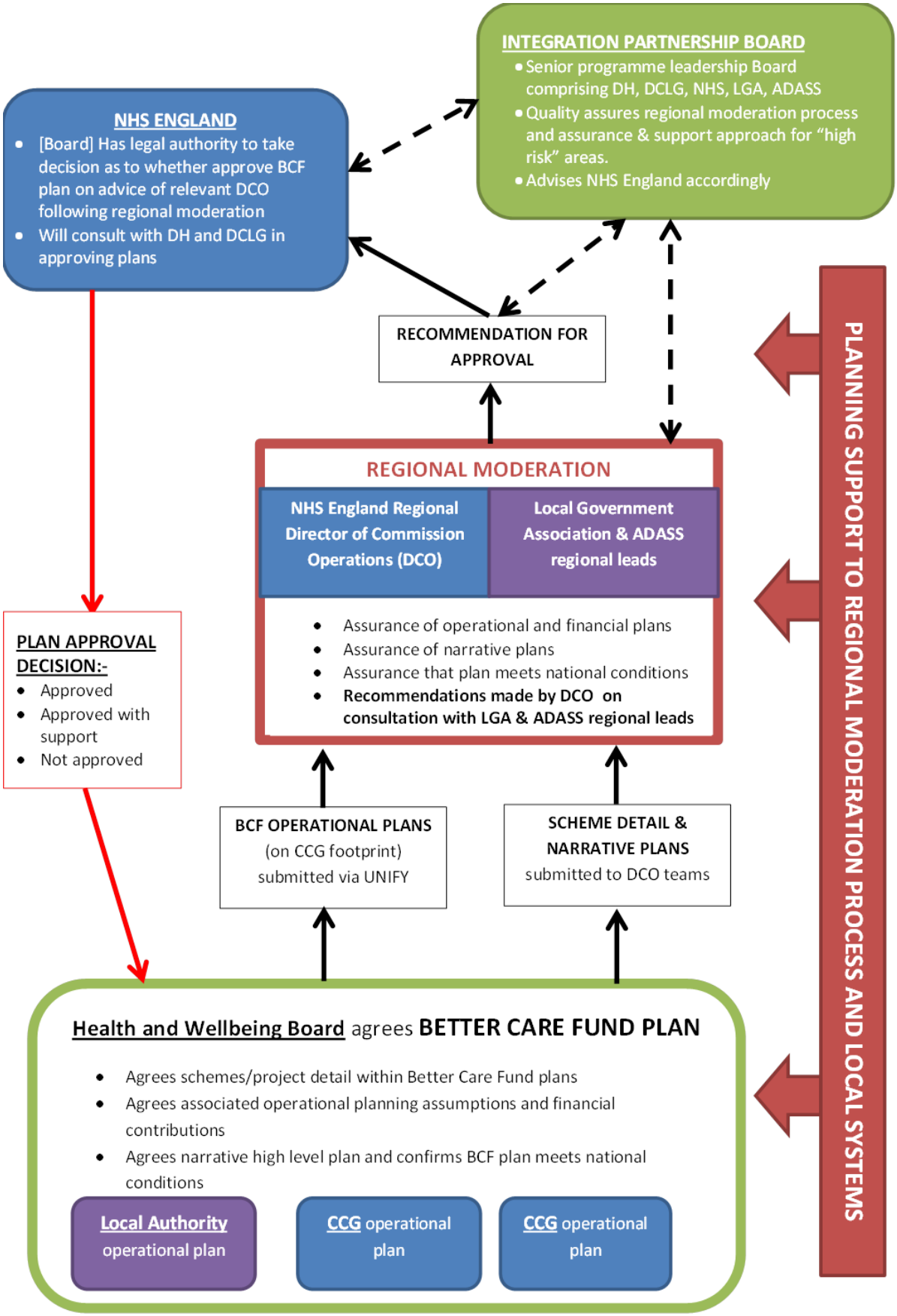
b) Demonstration that this has been calculated using clear analytics and modelling;

c) An articulation of any other risks associated with not meeting BCF targets Non-Elective Admissions and Delayed Transfers Of Care in 2016-17;

d) An articulation of the risk sharing arrangements in place across the health and care system, and how these are reflected in contracting and payment arrangements;

e) An articulation of the proportion of the financial risk will be borne by each party, and how these are reflected in contracting and payment arrangements.

APPENDIX 3 - ASSURANCE DIAGRAM



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Lincolnshire COUNTY COUNCIL
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To: Please see Distribution List

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16th February 2016

My ref: GG/KH

Dear Colleague

DISABLED FACILITIES GRANT

For 2015/16 the funding vehicle for Disabled Facilities Grant (DFG) was changed and incorporated into the Better Care Fund (BCF). The national guidance supporting this change effectively encouraged Clinical Commissioning Groups (CCGs) alongside councils with responsibility for adult social care to passport this capital funding to respective district/city councils in two tier areas.

The value in 2015/16 of the national allocations for DFG in Lincolnshire was £2.97m. The allocation was passported through to each district/city council in full. The allocations are identified in the table below

Disabled facilities grant (DFG) budgets and completions

	Boston	Lincoln	E.Lindsey	N.Kesteven	S.Holland	S.Kesteven	W.Lindsey	TOTAL
	2015/16	2015/16	2015/16	2015/16	2015/16	2015/16	2015/16	
Total subsidy received	280	328	972	352	325	376	337	2970
LA top up provided	29	0	275	88	110	0	70	572
Budget	309	328	1247	440	435	376	407	3542

It is recognised that the figures above are typically added to by respective councils as a 'discretionary top up'. This allows more activity in adapting properties than would otherwise be possible if it were dependent solely on the national allocation.

The future for the BCF at the beginning of 2015/16 was uncertain and the Lincolnshire BCF submission – as with all others – only looked ahead one year. However, in November 2015 the Chancellor's Comprehensive Spending Review announcement described the future for the Better Care Fund and within it Disabled Facilities Grant funding. At the time of writing this letter the guidance for 2016/17 is outstanding but a number of key elements are clear and these bear upon the purpose of this letter. In his announcement the Chancellor indicated that the BCF would continue for the duration of the Parliament and that DFG allocations would rise substantially during the course of the period between 2017 and 2020. The net effect in Lincolnshire would see the DFG allocation rise from £2.97m to £7m.

Alongside this announcement was the expectation that the funding would secure reduced reliance on residential placements by Adult Care for Older People. The national figure provided was that there would be 8,600 fewer placements as a result of the increased DFG allocation. The announcement therefore provided greater clarity on not just the longevity and funding for DFGs but also represents a substantial shift in focus.

A brief synopsis of 'contributions' towards improved housing to meet identified needs would include a number of disparate elements. Adult Care, Public Health, the four CCGs and Lincolnshire health providers (N = 3) have an Integrated Community Equipment Service that provides equipment to 28,000 people each year with a total contract value of £6.1m provided by NRS Healthcare.

Furthermore, Adult Care has allocated a budget of £500,000 pa from capital to address DFG requests that districts would not meet, for example in facilitating a discharge from Hospital, or, other social care need. Some evidence exists from pilot work funded by the Wellbeing Fund that there is some measurable benefit to be achieved from an 'acute' system for housing adaptation to support maintenance of independence and return from care. In addition, Public Health in association with Adult Care, commissions a Wellbeing Service that, as one element of it, delivers minor aids and tele care equipment as authorities with responsibility for social care are responsible for delivering minor adaptations costing under £1,000.

In total the value of equipment and adaptations to property has a significant annual value in Lincolnshire which, by 2019/20 will have a combined value of £13.6m (revenue and capital).

In parallel the national policy 'Transforming Care' (the sequel to 'Winterbourne View') indicates more profoundly disabled people, notably with learning disability and mental health needs will require a 'normalised' approach to housing – as hospital in-patient capacity is reduced - which is currently not available. At the same time there are an increasing number of disabled people – young and old, in Lincolnshire that require access to appropriately engineered property that meets their needs not currently available.

It should also be noted that the number of young people with profound disabilities moving into adulthood is increasing.

In consequence of the above analysis the four Clinical Commissioning Groups and the County Council wish to work with you in developing an approach to housing focused on promoting the independence of vulnerable people. This would require the agencies currently involved (which includes your own) to think and behave differently to secure a greater collective outcome. Some of the components will be:

1. 'Designing-in' accessible and adaptable housing into new build and refurbishment programmes.
2. Improving the management and allocation of already adapted stock through smarter allocations systems that operate across housing authority areas.

3. Approaching the subject of accessible housing at both strategic and operational levels as a collective endeavour.
4. Developing a collective understanding of need and performance.
5. A shared approach to future utilisation of the national DFG funding allocation into Lincolnshire.

Summary

The above constructs a picture that does not suggest a coherent and cohesive approach to providing housing for people with social or health care needs, let alone housing need. Each organisation involved operates to different target audiences. The net effect does not suggest a Lincolnshire-wide/strategic approach creating a 'housing legacy' to meet both current and future needs for all the population, and specifically not for those with a social or health care need.

As the DFG element increases substantially it is argued here that the time has come to take a broader view to housing that provides a coherent and cogent approach to meeting current and future needs for all those requiring them.

Our Lead Managers for this agenda, Justin Hackney and Tony McGinty, recently joined the Housing Forum to talk about some of the issues I have identified above, and to seek agreement to explore joint working. From this, a working party has been agreed, with County and District officer membership, which will seek to add flesh to the thinking and develop a draft scoping document for us to consider.

I trust you will work with me and others to develop this thinking further in due course.

Yours sincerely

Glen Garrod

Glen Garrod
Director of Adult Social Services
(on behalf of the four Clinical Commissioning Groups and the County Council)

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Andrew Morgan – Chief Executive, Lincolnshire Community Health Services Trust

BCF Assurance timetable

Proposed timeline	Dates (all 2016)
Planning guidance and planning template issued	22 February
Submission 1 BCF Planning Return submitted by HWB areas to DCO teams, copied to the national team. This will detail the technical elements of the planning requirements, including funding contributions, a scheme level spending plan, national metric plans, and any local risk sharing agreement.	**2nd March**
National team provide analysis of BCF planning returns in a single spreadsheet and send to DCOs and BCMs, highlighting any potential issues in the information provided	7th March
Feedback from regions, DCOs and BCMs to the national team on any outstanding issues or support needs arising from the first submission. To be coordinated regionally.	16 March
Submission 2 Full BCF plan submitted by HWBs to DCO teams, including BCF Planning Return version 2, which is to be copied to the national team for analysis	**21st March**
National team provide analysis of BCF planning returns in a single spreadsheet and send to DCOs and BCMs, highlighting any potential issues in the information provided	24th March
Deadline for regional confirmation of draft assurance ratings for all BCF plans to the **national team**	6th April
National calibration exercise carried out across regions to ensure consistency	7th – 8th April
Deadlines for feedback from DCO teams and BCMs **to local areas** to confirm draft assurance status and actions required	11th April
Submission 3 Final plans submitted, having been formally signed off by HWBs	**25th April**
Deadline for regional confirmation of final assurance rating to BCST and local area	13th May
Deadline for signed Section 75 agreements to be in place in every area	30th June

Key: Action for regions, DCO teams and BCMs | Action for local systems | Action for the Better Care Support Team

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Lincolnshire COUNTY COUNCIL
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LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of The Joint Commissioning Board

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**22 March 2016**
Subject:	**Joint Commissioning Board**

Summary:

Terms of Reference have been updated to reflect LHAC reporting structure – this is now being dealt with by the newly formed Programme Board.

Actions Required:

To receive the update and direction of travel for the Joint Commissioning Board

1. Background

The main commissioners of health and social care in Lincolnshire are the four Clinical Commissioning Groups (Lincolnshire East CCG, Lincolnshire West CCG, South Lincolnshire CCG & South West Lincolnshire CCG) and Lincolnshire County Council. They are committed to working together as commissioners, with providers and patient / carer representatives to create and maintain a joint Vision for a sustainable to safe health and social care economy for Lincolnshire where Lincolnshire residents will have access to safe and good quality services which focus on keeping them as well as possible to reduce the need for unnecessary hospital and long term social care.

To drive this, the commissioners' governing bodies have set up the Joint Commissioning Board for Lincolnshire Health and Care (JCB).The JCB is the place where senior commissioners come together to further the vision for sustainable health and care in Lincolnshire that has been agreed by their governing bodies.
In order to do so, JCB activities will include, but not be limited to:

- Oversight of the Better Care Fund (BCF) Pooled Budget s75 agreement, other relevant pooled budget, and joint working arrangements (those legal agreements may include specific legal requirements that will form part of JCB Governance)
- Developing an effective 'whole system' for health and care
- Contributing to creating regular value-adding Joint Strategic Needs Assessments for Lincolnshire through the Health & Wellbeing Board
- Contributing to creating and implementing a high quality Health & Wellbeing Strategy for Lincolnshire through the Health & Wellbeing Board
- Alignment of strategic plans between commissioners with particular focus on a sustainable health and care system
- Providing reports to governing bodies, the Lincolnshire Health & Wellbeing Board, Health Scrutiny Committee for Lincolnshire and others as appropriate

Attendance at the JCB will be open to:

- Accountable Officers and Chief Operating Officers of CCGs
- Executive Directors and Directors of the County Council
- Chief Financial Officers of CCGs
- Relevant financial managers from LCC
- JCB Programme Directors by invitation
- Director of Specialized Commissioning from Central Midlands NHS E Area Team by invitation

2. Conclusion

The JCB plays a crucial role in the operational delivery and monitoring of integrated plans. The BCF is the main focus of discussion. Review of section 75 agreements will be the other main area of work.

3. Consultation

Not applicable

4. Appendices

Not applicable

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 Sunil Hindocha who can be contacted on sunil.hindocha@lincolnshirewestccg.nhs.uk.

Lincolnshire COUNTY COUNCIL
Working for a better future

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:	**22nd March, 2016**
Subject:	**Annual Report of the Director of Public Health on the Health of the People of Lincolnshire 2015.**

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:

That the Lincolnshire Health & Wellbeing Board receive the Report and a presentation and note the recommendations included in each chapter.

1. Background

It is a statutory duty of the Director of Public Health to produce an annual report on the health of the people of the area he/she serves. It is a statutory duty on the local authority for that area (in this case the Council) to publish that Report. The report attached at Appendix A is the latest 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. Last year the annual report on the health of the people of Lincolnshire focused on the

major causes of premature mortality that is people who die under the age of 75 years. The report highlighted three major findings, one of which is getting worse, this is liver disease.

Concern about the increase in preventable liver disease is so great that this year's report concentrates solely on this issue. We describe liver disease, its stages and causes, its patterns and associations, its facts and figures. Following that, the three main causes; obesity, alcohol and hepatitis, are covered in a chapter each. We finish with some recommendations, but chief among them must be that we see some sustained investment in liver disease prevention and treatment and the development of effective pathways of care for people with liver disease and its causes. This reflects the joint contributions of prevention and treatment to conditions where progress has been made and maximises our chances of success. It is to be hoped that next year's commissioning plans will address these needs.

2. Conclusion

The 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 note 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 2015. (Please note this document has been circulated electronically and can be viewed at: http://lincolnshire.moderngov.co.uk/mgCommitteeDetails.aspx?ID=488

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 2015

Lincolnshire COUNTY COUNCIL
Working for a better future

Introduction

Last year the annual report on the health of the people of Lincolnshire focussed on the major causes of premature mortality; that is people who die under the age of 75 years. The report highlighted three major findings. Firstly, that for six of the seven major causes of premature mortality, the numbers of deaths were decreasing, even though they are still too high. It is also worth pointing out that around half of this reduction is the result of preventive measures and about half results from improvements to the effectiveness and quality of care. Secondly, it demonstrated the presence of geographical disparity. So, for nearly all the main causes and in nearly all population groups, premature mortality is highest in the Lincolnshire East Clinical Commissioning Group area, which are broadly speaking, East Lindsey and Boston Borough. Finally, the one cause of premature mortality which is getting worse is liver disease. There has been some progress on the recommendations made in last year's report and this progress is reported on Page 5. This is being written in late December 2015 and so the full extent of the commissioning intentions of Clinical Commissioning Groups and the County Council are not yet clear. It is likely that more progress will happen over the next year.

I am so concerned about the increase in preventable liver disease that this year's report concentrates solely on this issue. We describe liver disease, its stages and causes, its patterns and associations, its facts and figures. Following that, the three main causes; obesity, alcohol and hepatitis, are covered in a chapter each. We finish with some recommendations but chief among them must be that we see some sustained investment in liver disease prevention and treatment, and the development of effective pathways of care for people with liver disease and its causes. This reflects the joint contributions of prevention and treatment to conditions where progress has been made and maximises our chances of success. I hope that next year's commissioning plans will address these needs.

I want to thank those public health staff who have contributed to this report, in some cases hugely, and hope that you will find much of it of interest and use again this year.

Dr Tony Hill
Director of Public Health,
Lincolnshire County Council

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Progress against last year's recommendations

In my 2014 Director of Public Health's Annual Report, I made a series of recommendations. I would like to use this opportunity to provide an update on progress against these. I am aware that a wide range of organisations are involved in leading and supporting the implementation of the recommendations and this report is intended to provide information on some of this work rather than a comprehensive overview.

Recommendations	Update
Multi-agency work in Lincolnshire should continue to address lifestyle and behavioural factors, such as smoking, obesity, physical inactivity and alcohol and substance misuse.	A range of organisations (for example, local authorities, NHS and voluntary organisations) commission and provide healthy lifestyles services, for example tobacco control/ smoking cessation service, physical activity, cooking and growing classes, weight management, substance misuse service and wellbeing and independence.
The number of brief interventions given across organisations in Lincolnshire should be increased, whilst ensuring that Making Every Contact Count (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.	MECC has developed in many organisations in Lincolnshire during the past year. A number of organisations have signed the Memorandum of Understanding and are therefore committed to providing annual feedback on how MECC has been implemented within their organisations. A comprehensive training programme has taken place, which has resulted in several hundred frontline staff receiving MECC training.
Where appropriate, lifestyle interventions should be tailored to individuals with specific conditions and early indications of disease.	Health improvement interventions engage the general population for primary prevention and support adults with existing physical and mental health conditions for secondary and tertiary prevention benefits, for example, smoking cessation service for adults with long term medical conditions (LTCs) like cardiovascular disease, stroke and chronic obstructive pulmonary disease (COPD), and exercise referral programmes for people with diabetes. Wellbeing Service is provided to help older people to be independent in their own home and avoid social isolation. The stop smoking service specification has been changed to focus on particular groups, for example, pregnant women and people with a mental health problem.
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 primary care and county level to offer health checks to the eligible population, and to encourage uptake of appointments.	During 2014/15, the overall uptake of the NHS Health Check programme in Lincolnshire was 55%, slightly reduced from the previous year (57.7%) although still higher than the uptake for England as a whole at 48%. A countywide audit is underway which will assist general practices with the correct recording of NHS Health Check data, ensure the assessments are being carried out correctly and offer advice on improving uptake rates. Good practice from general practices with a high uptake will be shared with all the practices and Clinical Commissioning Groups (CCGs). Quarterly NHS Health Check performance reports are shared with general practices and CCGs.

Recommendations	Update
It must be ensured that individuals identified by the health check as having, or being at risk of developing medical conditions, like cardiovascular disease and stroke, which are related to premature deaths (i.e. death before the age of 75 years) are appropriately followed up in general practice, and that they receive appropriate lifestyle and pharmacological interventions or onward referral.	The NHS Health Check service specification includes the requirement to carry out a risk assessment, communicate the risk and manage the risk by sign posting/referring to services and pharmacological interventions. Phase One of the NHS Health Check audit is to ensure that patient data is recorded correctly, high risk patients are placed on the high risk register, followed up appropriately and referred to lifestyle services. Phase Two of the audit is planned to be rolled out in 2016/17 and will concentrate on follow up for patients identified with cardiovascular disease.
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 long term conditions (LTCs) and those recorded on disease 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.	As part of the delivery of CCG plans, there have been a number of Quality, Innovation, Productivity and Prevention (QIPP) initiatives to ensure that people, who need to be, are on disease registers and receive the appropriate management, for example, in relation to atrial fibrillation. Proactive care is part of the Lincolnshire Health and Care (LHAC) programme and self-care for people with long term conditions is an integral part of this.
Work should be done to improve the management of LTCs. Many people with diseases, 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.	As part of the delivery of CCG plans, a range of interventions are commissioned and provided to support people with LTCs, for example, respiratory and diabetic services. With improved survival rates, cancer is becoming recognised as a long term condition and services are being developed to support people to reduce their risk of reoccurrence. Medicines Use Reviews take place as part of the Community Pharmacy Contractual Framework. Lincolnshire County Council commissions a range of services which can help people with a long term conditions to manage their condition, for example, the smoking cessation service.
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.	The management of LTCs is a key part of the mid-term review of the Joint Health and Wellbeing Strategy for Lincolnshire. Across Lincolnshire, some pathways of care have been reviewed and developed, for example, in relation to diabetes. There has been some use of 'Map of Medicine' across the Lincolnshire CCGs.
Lincolnshire Public Health should work closely with Clinical Commissioning Groups to deliver the Lincolnshire Tobacco Control Strategy, assisting tobacco users to quit.	Lincolnshire Tobacco Control Strategy has a number of strands, which includes helping tobacco users to quit. A range of partners deliver the strategy, which includes providing a stop smoking service. CCGs have been engaged in the mobilisation process for the new stop smoking service provision.

Recommendations	Update
Lincolnshire Public Health should continue to promote the benefits and opportunities available for physical activity across all age ranges of the population.	There are a range of physical activity programmes across Lincolnshire, which provides opportunities to adults across all ages to become and remain physically active. Lincolnshire Public Health also supports other organisations, like district councils and CCGs, to jointly bid for funding from various sources to develop physical activity programmes in their local areas.
Work should continue through specific initiatives, and with partners such as NHS England, to further improve the uptake of cancer screening programmes.	Lincolnshire has a jointly chaired (with NHS England) Screening Health Improvement Board which is well attended by a number of stakeholders. The Board focuses on improving uptake in cancer screening programmes and involves numerous initiatives in a focused action plan, particularly targeted to specific geographical areas.
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.	Actions to promote the need to be vigilant for the potential signs of cancer are having a positive impact and the number of two week wait referrals is continuing to rise. This is challenging providers throughout Lincolnshire to deliver the required level of capacity to meet the growing demand for two week wait appointments and subsequent treatments. New and improved ways of working are being developed to ensure that patients are treated in accordance with the constitutional standards. This includes one stop diagnostic appointments, direct access by GPs and streamlined pathways. These measures have shown improvement in performance. For example, United Lincolnshire Hospitals NHS Trust (ULHT) is currently on track to deliver the 62-day cancer standard (Source: Lincolnshire Health Scrutiny Committee report on Lincolnshire recovery programme, January 2016)
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.	A project has been developed to improve the surveillance of suicides that take place in the county. This has involved working with Coroners to provide information on potential suicide risk factors, such as, history of mental health and bereavement. The information from the surveillance system will help inform future work on preventing suicides. The Lincolnshire Choosing Life Group has been replaced with a high level multi agency Suicide Prevention Steering Group, which is developing a county-wide suicide prevention action plan.
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.	The SafeTALK and ASIST programmes have continued but had limited access from communities in Lincolnshire. In order to promote suicide awareness, work is ongoing to identify further resources and good practice.
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 newly formed Suicide Prevention Steering Group has a range of organisations involved, for example, the Police and the voluntary sector. The group is developing a local action plan, in line with the recommendations in the National Preventing Suicide in England Strategy. The action plan will be informed, in some part, by the Lincolnshire Mental Illness Health Needs Assessment.

Recommendations	Update
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 the 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.	A working group is to be established to improve the uptake of all the vaccination/immunisation programmes. This will involve Lincolnshire County Council, CCGs, NHS England and service users.
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 under-report the number of road collisions, however, an accurate understanding is crucial in identifying and directing effective road safety interventions.	Lincolnshire Road Safety Partnership (LRSP), which is a multi-agency partnership, maintains a countywide road collision database. LRSP has developed a 10-year (2015-2025) Road Safety Strategy with the objective of continuing to reduce the number of people killed or seriously injured on Lincolnshire's roads. Its priorities are reviewed annually following analysis of collision trends and causation factors.
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.	There is an agreement between Public Health, Children's Services and Fire and Rescue to ensure that the most vulnerable children and families in the county have access to a Safer Homes Service, which may include the fitting of home safety equipment. The scheme will be promoted to staff and partners working with vulnerable under 5's and their families. Children's Centres will promote home safety through activities in the community. Public Health will offer home safety training workshops to staff and partner agencies.
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, maintaining a healthy weight, being physically active and not drinking excessively, they can potentially add 14 years of chronological age at death.	The decision to have liver disease as the focus of this year's DPH Annual Report will help to raise the awareness of liver disease.
The multi-agency Alcohol and Drug Strategy should be implemented, including primary prevention and systematic use of brief interventions, such as NHS Health Checks.	A multi-agency strategy is being implemented as part of the Community Safety work of Lincolnshire County Council. Alcohol awareness and advice is embedded in the MECC programme. The preparation of a tender for a newly commissioned alcohol and drugs treatment service includes the requirement to provide education and training for professionals in the county.
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.	The production of this Annual Report has resulted in further analysis being carried out in relation to liver disease to enable a better understanding on how this condition affects the Lincolnshire population.

Executive Summary

1. Liver Disease
Liver disease is a general term that describes a reduced functioning of the liver. Some types of liver disease are inherited, but most are caused by preventable factors like alcohol, obesity and infection.

Rates of liver disease in the United Kingdom (UK) are rising, but in the rest of Europe they are falling. Liver disease is one of the top five contributors to premature mortality in Lincolnshire.

Liver disease does not usually cause obvious signs or symptoms until damage to the liver is quite advanced (often too advanced to be cured). For most patients, this means that the disease is only detected by tests.

The liver has a tremendous capacity to regenerate during the early stages of liver disease. However, once liver scarring has occurred this cannot be reversed. It is therefore important that we take action to address the causes of liver disease to prevent ill health and early death.

2. Epidemiology of Liver Disease in Lincolnshire
In Lincolnshire, between 2011 and 2014, there were a total of 1010 hospital admissions for liver disease. There are age, gender and ethnic variations in the rate of hospital admissions for liver disease. Ninety three percent of hospital admissions for liver disease in Lincolnshire between 2011 and 2014 were among people aged less than 75 years.

Further, around 100 people die due to liver disease in Lincolnshire annually. More than 75 of these deaths are among people under the age of 75.

Alcoholic liver disease is the major cause of deaths and hospital admissions due to liver disease. For women, in Lincolnshire, alcohol-related hospital admission rates have increased since 2010. For men, the rate increased up to 2012 and has since decreased to 2010 levels.

3. Causes of Liver Disease
The three main causes of preventable liver disease are alcohol consumption, obesity and viral hepatitis.

a. Alcohol
Current UK Government guidelines state that:

Women should not regularly drink more than 2-3 units a day
Men should not regularly drink more than 3-4 units a day

'Regularly' means drinking most days or every day [1].

In January 2016 a new proposed drinking guideline of no more than 14 units a week for men and women was announced [2]. This new guideline is currently out for consultation.

Excessive alcohol consumption, over time, above the current UK government guidelines limit, is the leading cause of liver disease in the UK.

Reducing levels of excessive alcohol consumption will lead to a reduction in alcohol-related liver disease. A range of policies are in place at a national and local level to help people to reduce their alcohol consumption and the harms associated with it.

The Lincolnshire Alcohol and Drug Strategy 2014-2019 identifies a number of ways in which action is being taken in Lincolnshire to reduce alcohol consumption and related health harms. This includes a range of services, including specialist treatment, like psychosocial and pharmacological interventions, which are provided by Addaction and the Drug and Alcohol Recovery Team (DART).

b. Obesity
The number of people who are overweight or obese has increased dramatically in almost all countries over the past 10 years. Obesity causes excess fat deposits within the liver which, over a period of time, can cause permanent liver damage. However, damage can be prevented and, in its early stages, can be reversed by weight-loss.

Tackling obesity has been a government priority for a number of years with a primary goal being a downward trend in the level of excess weight in adults and a sustained downward trend in the level of excess weight in children by 2020.

The number of people who are obese in Lincolnshire is above the average for England and the East Midlands. In Lincolnshire, a number of programmes provide help for people to lose weight or maintain a healthy weight. These programmes provide a comprehensive collection of services supporting people at various levels of overweight/obesity.

c. Viral Hepatitis
Hepatitis B virus and Hepatitis C virus are blood-borne viruses transmitted through contaminated blood and other bodily fluids. The body's response to the presence of a hepatitis virus over a long period of time may lead to permanent liver damage.

Short-term (acute) Hepatitis B and C infection may or may not cause visible symptoms. Some individuals recover without ever realising they have been infected.

A vaccine is available to prevent Hepatitis B transmission in high risk groups e.g. injecting drug users. No vaccine is available for Hepatitis C. In Lincolnshire, Hepatitis B vaccination and Hepatitis C testing are encouraged in high risk groups. Lincolnshire's two prisons also offer Hepatitis B vaccination and Hepatitis C testing.

4. Conclusion
Prevention and early treatment are keys to preventing end-stage liver disease. This includes prevention and early treatment of risk factors, for example, excessive alcohol consumption, obesity and viral hepatitis.

Chapter 1: Liver Disease

Key Points

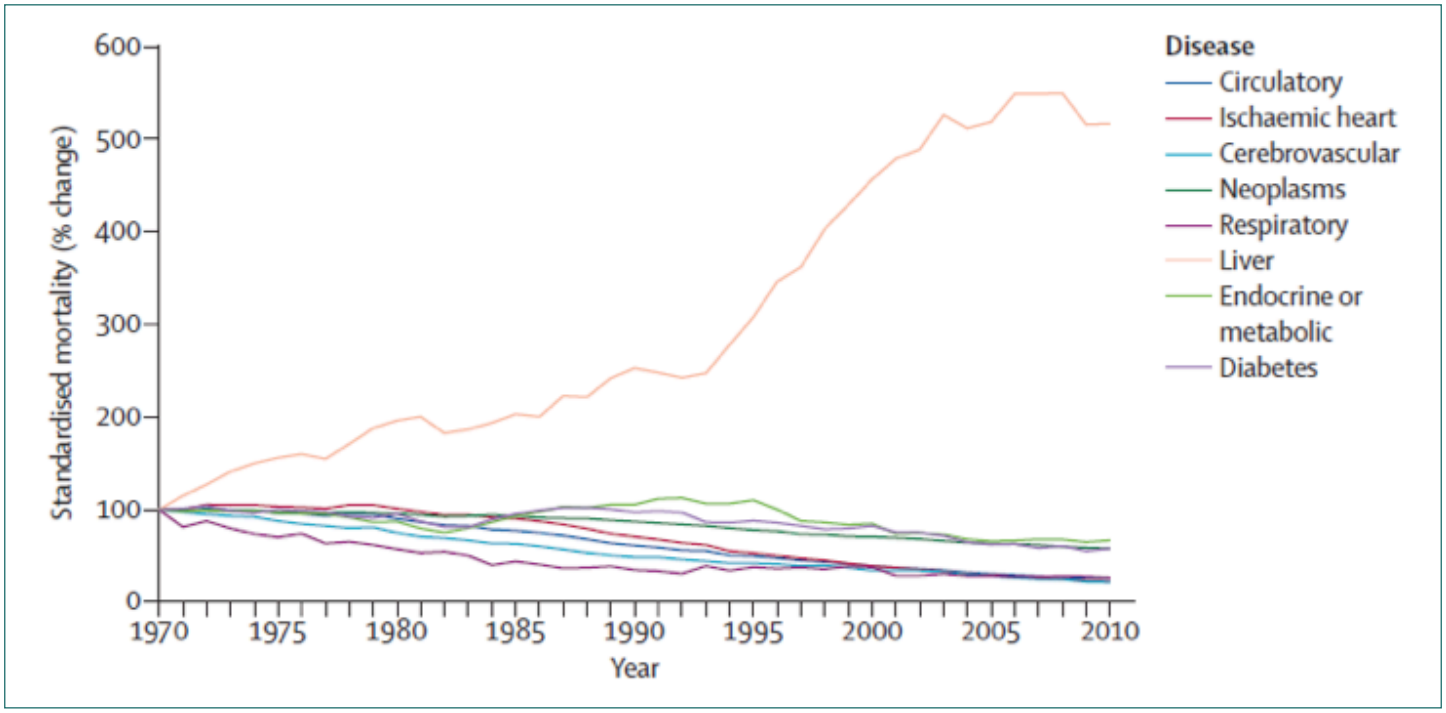
- Rates of liver disease in the UK are rising. In the rest of Europe they are falling.
- Liver disease is one of the top five contributors to premature mortality in Lincolnshire.
- There are three main causes of preventable liver disease:
- Alcohol
- Obesity
- Viral hepatitis
- The liver has a tremendous capacity to regenerate during the early stages of liver disease. However, once liver scarring has occurred this cannot be reversed.
- Liver disease does not usually cause obvious signs or symptoms until damage to the liver is quite advanced (often too advanced to be cured).
- Therefore, action to address the causes of liver disease is important for preventing ill health and early deaths from liver disease.

1.1 Introduction

The 2014 Director of Public Health Report for Lincolnshire identified liver disease as one of the five leading causes of deaths in people aged less than 75 years (premature deaths) in the county [1].

Unlike all other major causes of premature deaths in the United Kingdom (UK) which have fallen over the past half century, death rates from liver disease have shown a continuous rising trend (see Figure 1.1). The death rate from liver disease, across all age groups, has risen more than 400% since 1970. However, among those aged under the age of 65 years, this increase has been 500%. Comparative data from across Europe shows that this rise has not been seen in other European countries, highlighting the need to take action in the UK.

Figure 1.1: Trends in UK death rate, normalised to 100% in 1970



Source: Chart taken from The Lancet [2]; Data taken from the WHO-HFA database [3].

1.2 What is liver disease?

The liver performs many complex functions, such as fighting infections, removing toxins and other harmful chemicals from the body, synthesising proteins and producing chemicals required for digestion. Liver disease is a general term that describes a reduced functioning of the liver. Some types of liver disease are inherited, but most are caused by preventable factors like alcohol, obesity and infection.

1.3 What are the causes of liver disease?

There are three main causes of preventable liver disease:

- Alcohol
- Obesity
- Viral hepatitis (e.g. Hepatitis B and Hepatitis C)

Alcohol is the commonest cause of liver disease. Regular and heavy drinking over a period of time can put a strain on the liver, leading to liver damage. This is called alcohol-related liver disease (ARLD). In the UK, three-quarters of deaths from liver disease are related to excess alcohol consumption [4].

Obesity is the second commonest cause of preventable liver disease, which causes a build-up of fat in the liver. This is called non-alcoholic fatty liver disease (NAFLD) [5].

Viral hepatitis is the third commonest cause of preventable liver disease. Hepatitis B and C viruses can produce chronic inflammation of the liver and lead to severe liver complications. Viral hepatitis is a notifiable condition in England, which means that any new case must be reported to the local health protection team or the (district level) local authority.

An individual may have more than one cause of liver disease. For example, a person who is obese may also drink harmful amounts of alcohol over a long period of time or have viral hepatitis. So, it is likely that certain groups within the population are at an even greater risk of developing liver disease than those people exposed to just one cause of liver disease. However, we do not currently know how much having multiple risk factors increases the chance that someone will develop liver disease.

1.4 The stages of liver disease

There are three key stages in the development of liver disease.

Stage 1

When a person with a healthy liver is exposed to infection or toxins over a long period of time, fats can build up in the liver resulting in fatty liver disease. If preventive action is taken at this stage, the liver can return to normal. There are rarely any symptoms at this stage.

Stage 2

After lengthy exposure to an infection or toxin the liver can become inflamed. This is the second stage in the development of liver disease. Severe cases of inflammation can cause serious health problems and may even be fatal. Many people only discover their liver damage when the condition is at this critical stage. At this stage, liver disease may still be reversed by removing the toxin or curing the infection.

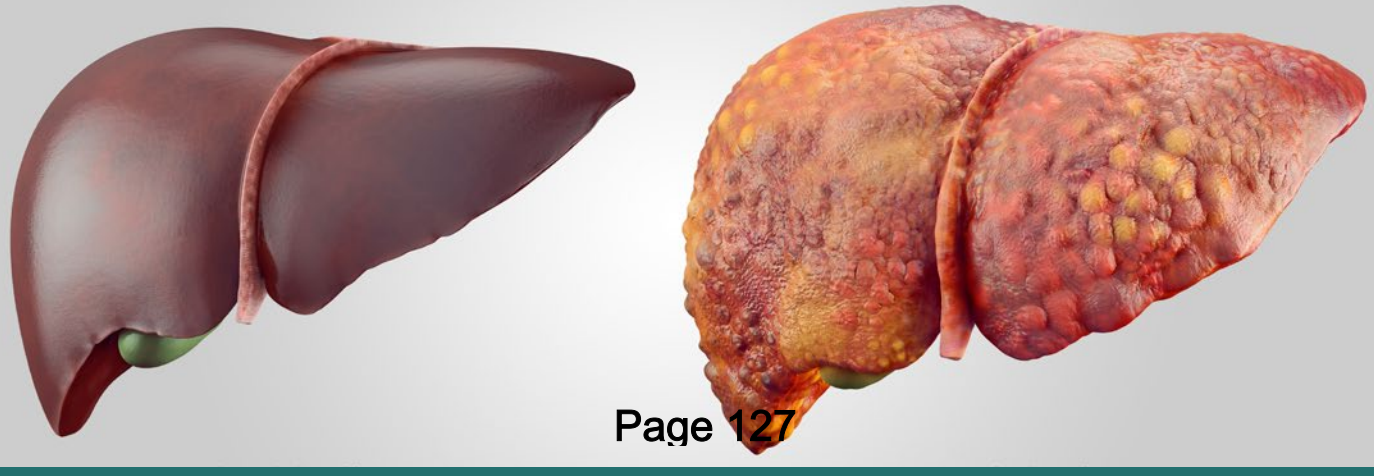
Stage 3

The final stage of liver disease is cirrhosis, which occurs when there is a significant scarring in the liver tissues. Generally, cirrhosis is not reversible but it is possible to prevent further damage by removal of the toxin. Over time, cirrhosis leads to liver failure and death. At this stage, liver transplantation is the final option for patients.

Liver disease does not usually cause obvious signs or symptoms until damage to the liver is quite advanced. For most patients, this means that the disease is only detected by tests. Once detected, the disease is often too advanced to be cured, which has a huge impact on outcomes for the patient (e.g. quality of life and death) and places a heavy burden on health services.

1.5 Prevention and treatment of liver disease

Comprehensive strategies are needed to reduce the causes of liver disease because early action can prevent permanent damage. A range of organisations have a role in preventing and treating liver disease, including national government, local authorities, the NHS, and the business sector (e.g. the alcohol and food industries). All these organisations need to work together constructively. National policies and Lincolnshire strategies to reduce alcohol consumption and obesity, and to prevent the transmission of viral hepatitis, are presented in Chapters 3 - 5 of this report.



Chapter 2: Epidemiology of Liver Disease in Lincolnshire

Key Points

- The age-standardised rate of hospital admissions for liver disease in Lincolnshire is 94.8/100,000. This is lower than the rate across England. Age standardised rates take into account how many young and old people are in the population.
- In Lincolnshire, 93% of hospital admissions for liver disease between 2010/11 and 2013/14 were among people aged less than 75 years.
- There are age, gender and ethnic variations in the rate of hospital admissions for liver disease.
- On average, around 100 people die due to liver disease in Lincolnshire annually. More than three quarters of those deaths are among people under the age of 75 years.
- Alcoholic liver disease is the major cause of deaths and hospital admissions due to liver disease.
- For women in Lincolnshire, alcohol-related hospital admission rates have increased since 2010. For men the rate increased up to 2012 and since then has fallen back to 2010 levels.

2.1 Introduction

Since the 1970s, deaths from liver disease across all age groups have increased by 400%, and among those younger than 65 years of age this rise has been 500% in the UK. The average age of death from liver disease is 59 years, compared with 82-84 years for those with heart disease, lung disease or stroke [6]. There is also a deprivation gradient with those in the most deprived fifth of the population being more than twice as likely to die from liver disease compared to those in the least deprived group in the UK [7].

In 2012, there were 600,000 people with liver disease in the UK and 57,682 admissions to hospital related to liver disease. Since 1970, the UK has seen a year-on-year increase in the number of admissions to hospital with end-stage liver disease, cirrhosis, or liver failure. This is in contrast to many other European countries, for example France, Italy and Spain, where there has been a decline in deaths from liver disease.

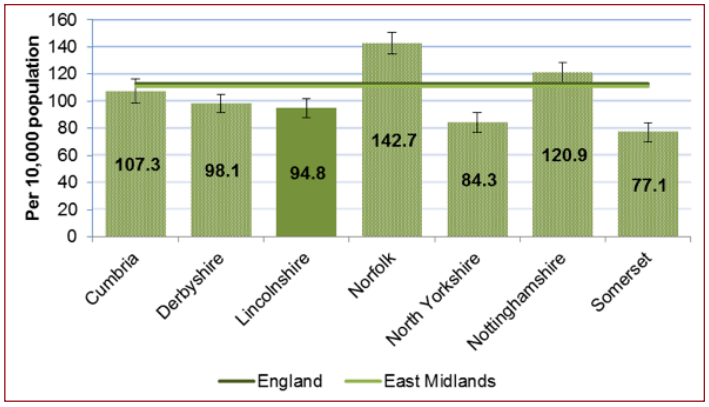
Three quarters of deaths from liver disease are alcohol related. However, liver disease due to obesity is increasing. Whilst relatively smaller, the burden of Hepatitis B and C is also growing, with annual deaths due to Hepatitis B and C having increased almost four-fold since 1996. Around 75% of people with Hepatitis B and C infections may not have any symptoms, making control of transmission difficult [8].

The exact regional prevalence of liver disease in the UK is unknown as there is no register for liver disease patients; instead, hospital admissions for liver disease are used as indicator of the burden of disease. It is important to remember that only cases requiring hospitalisation are captured by these statistics, which may vary due to differences in patient presentation and medical approaches. Further, the data reflects the number of hospital episodes and not individuals with the disease. This may over- or under-represent the true disease prevalence.

2.2 Prevalence of liver disease in Lincolnshire

Lincolnshire has a lower rate of hospital admissions for all liver disease (preventable and non-preventable) than England, as well as some of our statistical neighbours such as Norfolk and Nottinghamshire (see Figure 2.1) (see Appendix 1 for a description of the disease codes used to perform this comparison). Statistical neighbour is a term used to describe local authorities with similar characteristics, such as age profile, rurality or deprivation.

Figure 2.1: Directly age-standardised rate of hospital admissions due to liver disease/100,000 population, 2012/13



Source: Public Health England Liver Disease Profiles September 2015; http://fingertips.phe.org.uk/liver-disease.

In Lincolnshire, between 2011 and 2014 there were a total of 1010 hospital admissions due to liver disease (see Table 2.1). This includes patients of all ages for whom liver disease was recorded as a primary diagnosis for hospital admission. Some patients may have had multiple admissions during the year.

Table 2.1: Numbers of hospital admissions for liver disease by financial year, Lincolnshire GP-registered population, all ages

Type of liver disease	2011/12	2012/13	2013/14	3 years total
Alcoholic liver disease	130	140	170	430
Fibrosis and cirrhosis of liver	90	70	90	250
Liver cancer	40	60	40	140
Fatty liver disease	40	30	40	110
Hepatitis C infection	20	20	20	50
Chronic hepatitis	0	0	10	10
Hepatitis infection	10	0	0	10
Grand Total	310	330	360	1010

2.3 Demographic variations in admissions for liver disease in Lincolnshire

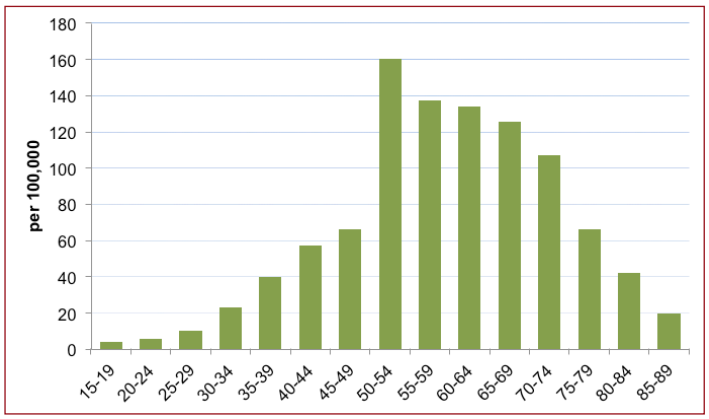
Rates of admission for different types of liver disease varied by age as follows (Figure 2.2):

- Hospital admission for alcohol related liver disease was highest in the 50-54 age group
- Admission rates for fatty liver disease were highest in those aged over 60 years
- Admissions for fibrosis and cirrhosis of the liver were high amongst patients aged between 55 and 74 years, which may reflect that this is a more advanced stage of disease progression
- Admission rates for liver cancer were highest in patients aged 65-69 years

Other demographic variations in hospital admissions for liver disease include the following:

- Males were twice as likely as females to be admitted to hospital for alcoholic liver disease.
- Males were more likely to be admitted for liver cancer, fibrosis and cirrhosis of the liver.
- 90% of patients admitted to hospital for liver disease were white British, 7% any other white background and the remaining 3% were from a range of other ethnic groups. This reflects the ethnic breakdown of the wider Lincolnshire population.

Figure 2.2: Age specific rate of hospital admission for liver disease, 2011/2-2013/14, Lincolnshire GP-registered patients

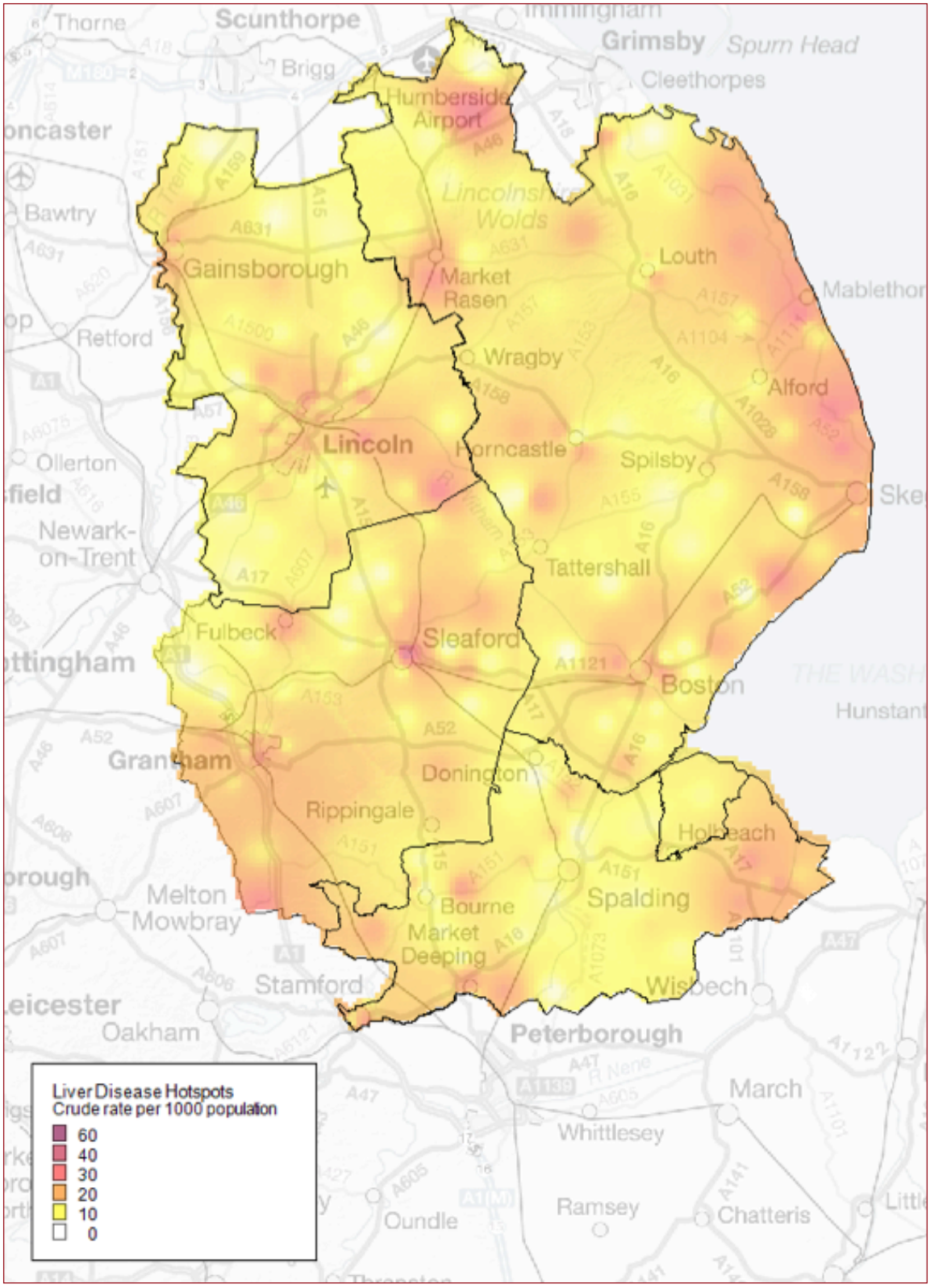


2.4 Geographical variations in hospital admissions for liver disease

Office of National Statistics uses Lower Super Output Areas (LSOA) to collect and publish small area statistics. Each LSOA has on an average about 1500 residents and 650 households.

In order to identify geographical areas that have higher rates of ill-health resulting from liver disease, hospital admissions rates for the period 2011/12 to 2013/14 were mapped to LSOAs. Ranks were assigned to LSOA based on these calculated rates. The results were divided into five categories based on the rank. The results are shown in Figure 2.3, where the darkest colour on the map represents the top 20% of areas in Lincolnshire with highest rates of hospital admissions for liver disease. Rates are highest along the East Coast of the county, and in small pockets around Lincoln, Sleaford and Grantham.

Figure 2.3: Liver disease 'hot spots' in Lincolnshire based on analysis of hospital admissions data (2011/12 – 2013/14) by place of patient residence



Source: HSCIC, Hospital Episodes Statistics (HES) Copyright © 2014, re-used with the permission of The Health & Social Care Information Centre. All rights reserved.
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2.5 Deaths from liver disease in Lincolnshire

On average, around 100 people die due to liver disease in Lincolnshire each year. More than three quarters of these deaths are among people aged less than 75 years old.

The number of deaths from liver disease in the Lincolnshire GP-registered population from 2011-2014 are presented in Table 2.2. Alcoholic liver disease was the most commonly recorded cause of death amongst those with liver disease, followed by fibrosis and cirrhosis of the liver, and liver cancer.

Men were twice as likely as females to die from alcoholic liver disease. There were few deaths from hepatitis recorded in Lincolnshire. The numbers were too small to be included in the table.

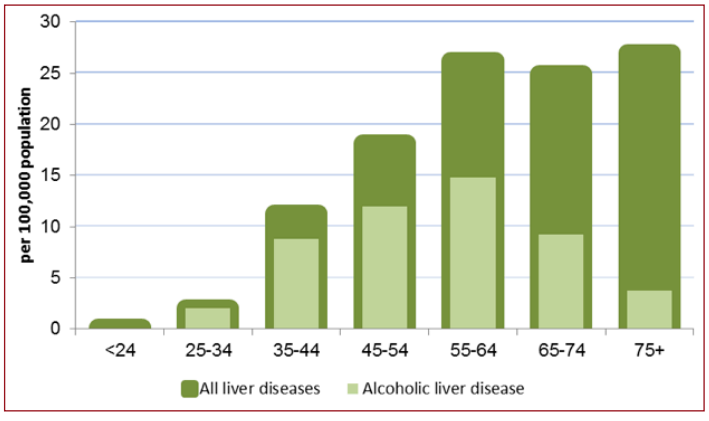
Table 2.2: Number of deaths from liver disease by disease type and year of death registration, all ages, Lincolnshire GP-registered population. (All numbers are rounded to the nearest 10; due to rounding, numbers may not add up to total)

Underlying cause of death	2011	2012	2013	2014
Alcoholic liver disease	40	60	40	30
Fibrosis and cirrhosis of liver	20	40	20	20
Liver cancer	20	10	20	10
Fatty liver disease	10	0	10	0
Total	**100**	**110**	**90**	**70**

Source: HSCIC, Primary Care Mortality Database.

In Lincolnshire, death rates from liver disease generally increase with age. However, deaths from alcoholic liver disease follow a slightly different pattern; the death rate for this cause is highest in people aged 55-64 years old. Figure 2.4 illustrates this, showing deaths rates for all liver disease and alcoholic liver disease at different ages. Death rates from liver disease are highest in the most deprived areas in England.

Figure 2.4: Age specific death rates from liver disease, 2011-13, Lincolnshire GP-registered population



Source: HSCIC, Primary Care Mortality Database

2.6 Alcohol-related liver disease

Alcoholic liver disease accounts for the largest number of liver disease deaths and hospital admissions.

Geographical Variations in Hospital Admissions from liver disease

To compare geographical variations in hospital admissions for liver disease across the four Lincolnshire Clinical Commissioning Groups (CCGs), admission rates for alcoholic liver disease were calculated using 2013 European Standard Population to account for differences in age profiles between the areas. This data does not represent all liver disease admissions, but alcoholic liver disease accounts for almost half of admissions over the 3-year period 2011-2013.

South West Lincolnshire CCG had the highest rate of hospital admissions due to alcoholic liver disease (see Figure 2.5). However the rate of alcohol-specific hospital admissions South West Lincolnshire CCG is significantly lower than admissions from other Lincolnshire CCGs (see Figure 2.6). This result is unexpected because we might have expected rates of hospital admissions due to alcoholic liver disease to be higher in Lincolnshire East and Lincolnshire West CCGs areas where hospital admissions for alcohol specific causes are highest.

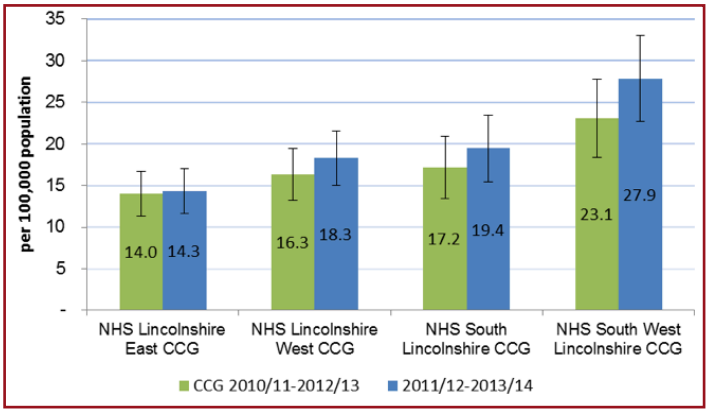
There are a number of possible explanations for this. Firstly, alcohol-specific conditions include those conditions where alcohol is causally implicated in all cases of the condition; for example, alcohol-related liver cirrhosis, alcohol-induced behavioural disorders, etc. Therefore the different definitions may produce different findings because alcoholic liver disease is only one of many conditions included in data on alcohol-specific conditions, and many of these other conditions occur much more frequently than alcoholic liver disease.

Secondly, hospital admission rates are based on the number of admissions rather than individual patients. So the high rates in South West Lincolnshire CCG may have been caused by multiple admissions of a small number of patients. In contrast, alcohol-specific hospital admissions are the result of person-based analysis; therefore each patient is only counted once within a financial year period.

Finally, whilst adjusting for age and sex helps us to get nearer to comparable populations between areas, migration between areas can confuse matters. In Lincolnshire there is a high level of migration. Older people move to the east coast to retire and so the area in which people now live is not necessarily the area that influenced their health across the life course. This may mean that even after adjusting for age and gender, rates of hospital admissions for alcoholic liver disease in Lincolnshire East CCG are better than we might have expected given the deprivation levels in the area. Similarly, Lincoln is an urban area with more deprivation. However, as the young people who migrate to Lincoln have better levels of health than is normal for the city, this may skew the figures.

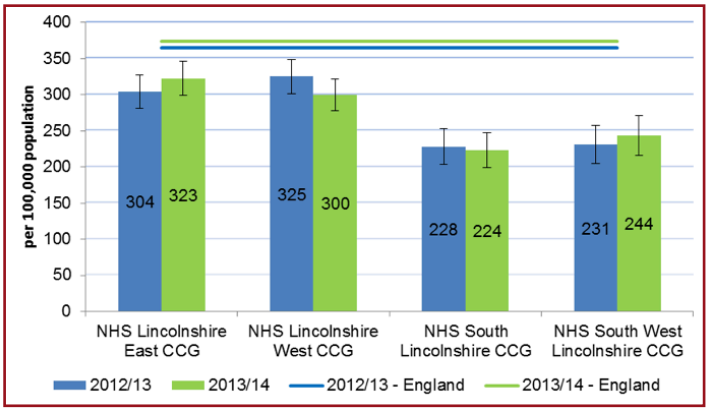
In summary, although South West Lincolnshire CCG has the highest rate of alcoholic liver disease in Lincolnshire, it is not possible to unpick exactly why rates are highest in this area without access to individual level data.

Figure 2.5: Alcoholic-liver disease, age standardised hospital admissions rates/100,000 population by CCG (GP-registered population), all ages, 3-years' pooled data



Source: Hospital Episodes Statistics (HES) Copyright © 2014, re-used with the permission of The Health & Social Care Information Centre. All rights reserved.

Figure 2.6: Directly age standardised hospital admission rates for alcohol-specific conditions by CCG and financial year, all ages



Source: Public Health England, Local Alcohol Profiles for England, September 2015; http://fingertips.phe.org.uk/profile/local-alcohol-profiles

Trends in Hospital Admissions over Time

The 5-year trend in hospital admissions for alcohol-related liver disease in Lincolnshire and England is shown in Table 2.3. This rate includes hospital episodes where the primary or any secondary diagnoses are an International Classification of Diseases (ICD) alcohol-attributable alcoholic liver disease code.

Table 2.3: Admission episodes for alcohol-related alcoholic liver disease conditions, directly age-standardised rate per 100,000 population by financial year and gender

	England		Lincolnshire	
Financial year	Female	Male	Female	Male
2009/10	53.9	124.7	32.4	80.7
2010/11	57.5	137.3	37.9	82.2
2011/12	60.8	140.5	36.6	85.5
2012/13	61.4	142.2	32.7	83.9
2013/14	65.8	147.1	37.0	81.7

Source: Public Health England, Local Alcohol Profiles for England, September 2015; http://fingertips.phe.org.uk/local-alcohol-profiles

Across the 5-year period, the rate of hospital admissions in Lincolnshire has been lower than the national level for both males and females. For women in Lincolnshire, rates have fluctuated but show a general trend towards increasing over time, from 32.4 to 37.0 per 100,000 between 2009-10 and 2013-14. For men in Lincolnshire, the rate increased from 80.7 to 85.5 between 2009-10 and 2011-12, before decreasing to a level similar to that in 2009-10 by 2013-14.

These fluctuations in alcohol-related liver disease are likely to reflect a national trend of rising alcohol consumption in the 1990s and 2000s, which has since fallen slightly [9].

Whilst rates of alcohol-related liver disease in Lincolnshire are lower than the England average, liver disease remains an important contributor to premature mortality in Lincolnshire.

Chapter 3: Causes of Liver Disease – Alcohol

Key Points

- Excessive alcohol consumption over time is the leading cause of liver disease in the UK.
- People may be more vulnerable to harmful alcohol consumption due to a range of factors such as their gender, socio-economic status, relationship status and environment (e.g. alcohol pricing and availability policies).
- The Government published its latest Alcohol Strategy in March 2012. It focuses on preventing alcohol-related harm by reducing the number of people drinking excessively and making "less risky" drinking the norm, through local and national action.
- The Lincolnshire Alcohol and Drug Strategy 2014-2019 identifies a number of ways in which action is being taken in Lincolnshire to reduce alcohol consumption and related health harms.
- A range of psychosocial and pharmacological interventions are provided by Addaction and the Drug and Alcohol Recovery Team in Lincolnshire for adults who require specialist alcohol treatment services.

3.1 Introduction

Excessive alcohol consumption is the leading cause of liver disease in the UK. This chapter gives an overview of excessive alcohol consumption, how it causes liver disease, who are most at risk of liver damage due to excessive alcohol consumption and how common excessive alcohol consumption is in Lincolnshire. It also gives a brief description of the national policy and local strategy to reduce excessive alcohol consumption, and the local alcohol prevention and treatment services available within Lincolnshire.

3.2 What is excessive drinking?

The current UK Government drinking guidelines state that:

- Women should not regularly drink more than 2-3 units a day.
- Men should not regularly drink more than 3-4 units a day.

'Regularly' means drinking most days or every day [1].

In 2012 the Government announced a review of the drinking guidelines to be led by the Chief Medical Officer [12]). This review was completed in 2015 and new proposed guidelines were announced in January 2016. The proposed new guideline is a weekly guideline for men and women who drink regularly or frequently (people who drink most weeks) [2]:

- You are safest not to drink regularly more than 14 units per week, to keep health risks from drinking alcohol to a low level.
- If you do drink as much as 14 units per week, it is best to spread this evenly over 3 days or more. If you have one or two heavy drinking sessions, you increase your risks of death from long term illnesses and from accidents and injuries.

The proposed new guideline is currently out for consultation until 1st April 2016.

Figure 3.1 provides a guide of how many units are in different drinks.

Many people drink within the current drinking guidelines. However, in 2012, 55% of men and 53% of women in England reported exceeding this guideline, including 31% of men and 24% of women who drank more than twice the recommended amount [13]. Excessive alcohol consumption is defined as regular and heavy drinking above the UK government guidelines.

Figure 3.1: Unit guide per drink type [13]

Source: Help4Addiction
http://help4addiction.co.uk/resources/about-alcohol/alcohol-facts/alcohol-unit-guide

3.3 How does excessive alcohol consumption cause liver disease

The liver carries out many important functions in the body, one of which is to break down ethanol (a toxin) to allow it to be removed. Excessive alcohol consumption over time can

put a strain on the liver, leading to damage called alcohol-related liver disease (ARLD). Initially the damage is reversible, but with continued drinking the damage can become permanent. This damage is called liver cirrhosis. If a person stops drinking at this stage, they can prevent further damage. However, if they continue to drink, it can lead to liver failure. For individuals who continue to drink excessively after they have developed cirrhosis, there is only a 50% chance of living another five years [14].

3.4 Who is most at risk of excessive alcohol consumption?
There is a wide range of individual and societal risk factors for excessive alcohol consumption [15]. The greater number of vulnerabilities a person has, the more likely they are to develop liver disease [16].

People may be more vulnerable to excessive alcohol consumption depending on:

- **Gender:** The prevalence of harmful and dependent drinking is higher among men than women (9% of men and 4% of women show signs of alcohol dependence) [17].
- **Age at first drink:** The age at which a young person starts drinking and their pattern of drinking during adolescence can increase the risk of developing alcohol dependence in later life [18] [19]. Looked after children are at particularly high risk of alcohol misuse [20]
- **Socio-economic status:** People of higher socio-economic status are more likely to drink alcohol, and more likely to drink above the government guidelines [21]. But, people of higher socio-economic status are less likely to experience alcohol-related harm [22].
- **Marginalisation:** Alcohol consumption and related harm is high among homeless people [23]. Excessive drinking is also high among men and women prisoners – those who report daily drinking drink an average of 20 units per day [17].
- **Pricing and availability policies:** Societies that have more stringent pricing and taxation strategies for alcohol, that place greater restrictions on marketing of alcohol products, and that seek to limit in some way the availability of alcohol (e.g. through restrictions on purchasing age, density of outlets and opening hours), in general have lower levels of alcohol consumption and alcohol-related harm [24]
- **Genetic markers:** There are a number of genetic factors that influence how the body responds to alcohol [25]. Genetics can also influence other characteristics (e.g. personality traits) that are linked to certain drinking patterns [26].

Understanding the main vulnerabilities for excessive alcohol consumption can help us to target preventive strategies and treatment towards those groups in society who have the greatest need.

3.5 Excessive alcohol consumption in Lincolnshire
Alcohol consumption at a national level is measured through a combination of sales data and national surveys (e.g. the Health Survey for England). Regional patterns of alcohol consumption are not measured directly and therefore a range of negative outcomes attributed to alcohol (e.g. alcohol-specific deaths and hospital admissions) are used to estimate the prevalence of excessive alcohol consumption at lower geographical levels. Local alcohol profiles are produced by Public Health England, which enable comparisons of negative alcohol-related outcomes between areas.

In 2011-2013, across a range of health measures (e.g. alcohol-specific deaths and alcohol-specific hospital admissions), Lincolnshire had better outcomes than both the East Midlands and England (see Table 3.1) [27].

Table 3.1: Alcohol-specific deaths and hospital admissions in England, East Midlands and Lincolnshire, 2011-13 [27]

	Alcohol-specific deaths (rate/100,000)	Alcohol-specific hospital admissions (rate/100,000)
England	11.9	374
East Midlands	11.7	318
Lincolnshire	8.3	282

Source: Public Health England, Local Alcohol Profiles for England, September 2015; http://fingertips.phe.org.uk/local-alcohol-profiles

Table 3.2: Alcohol-specific deaths and hospital admissions in Lincolnshire districts, 2011-13 [28]

	Alcohol-specific deaths (rate/100,000)	Alcohol-specific hospital admissions (rate/100,000)
East Lindsey	7.7	322
West Lindsey	7.7	238
North Kesteven	4.0	194
South Kesteven	9.8	255
Lincoln	15.0	432
South Holland	5.6	212
Boston	8.7	344

Source: Public Health England, Local Alcohol Profiles for England, September 2015; http://fingertips.phe.org.uk/local-alcohol-profiles

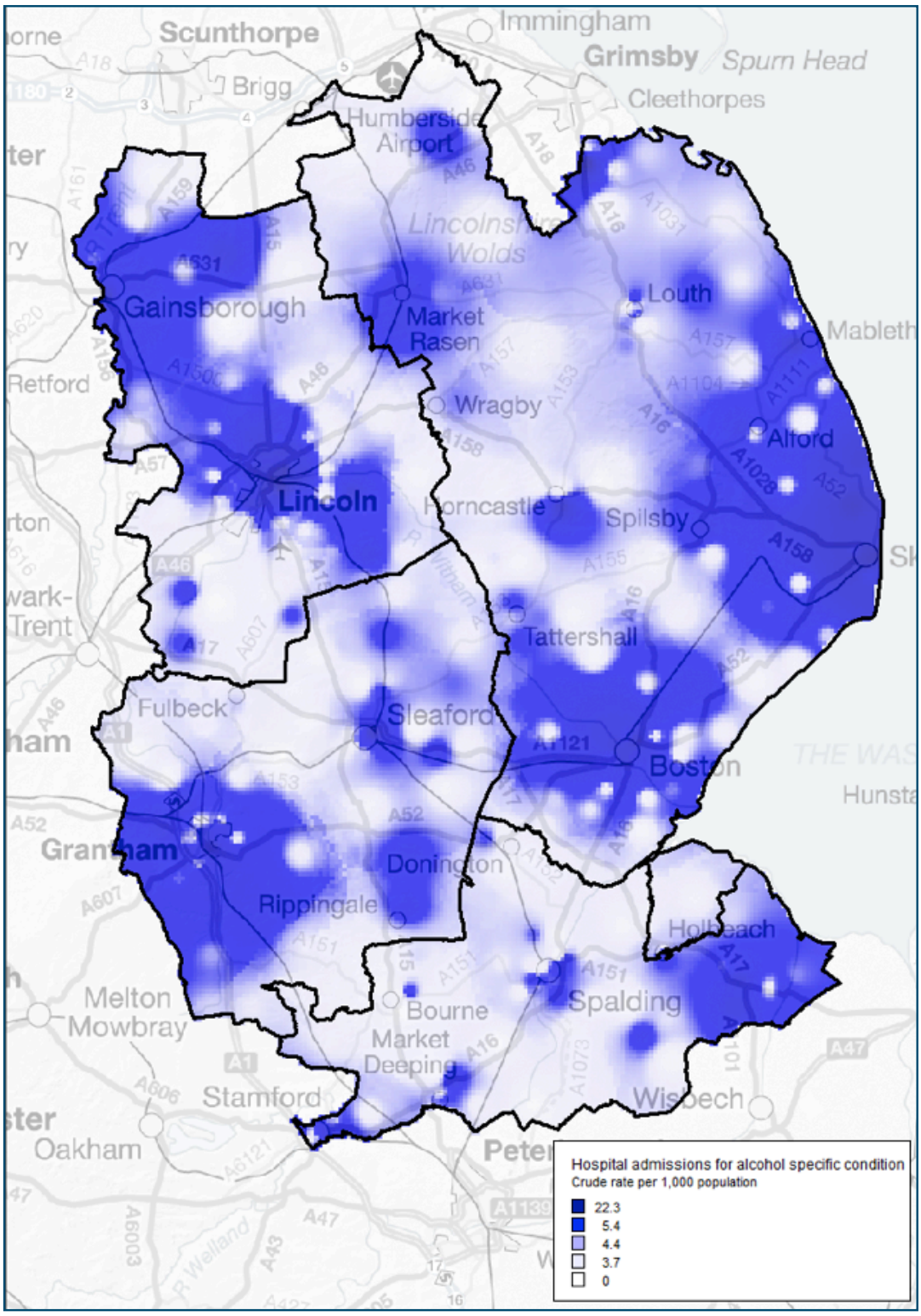
Comparing across districts, the alcohol-specific death rate is lower than the Lincolnshire average in East Lindsey, North Kesteven, South Holland and West Lindsey (see Table 3.2). Death rates are much higher than average in Lincoln. District level alcohol-specific hospital admission rates are below average for Lincolnshire in West Lindsey, North Kesteven, South Kesteven and South Holland. Again, alcohol-specific hospital admission rates are above the county average in Lincoln.

Rates of alcohol-specific hospital admissions in Lincolnshire are mapped across the county in Figure 3.2. The data includes hospital admissions where an alcohol-specific condition is recorded as a primary or secondary diagnosis. This map highlights areas in which rates of alcohol-specific hospital admissions are high (darker blue equals higher rates). In particular, the more deprived areas along the East coast of Lincolnshire and the larger built up areas (e.g. Lincoln and Boston) have higher levels of alcohol-specific hospital admissions.

3.6 National policy to reduce excessive alcohol consumption

Alcohol-related liver disease (ARLD) develops over time as a result of excessive alcohol consumption. We need to reduce excessive alcohol consumption in the population to prevent ARLD.

Figure 3.2: Hot spot map of alcohol-specific hospital admissions in Lincolnshire



Source: HSCIC, Hospital Episodes Statistics (HES) Copyright © 2014, re-used with the permission of The Health & Social Care Information Centre. All rights reserved.

ONS Population Estimates © Crown Copyright and database right 2015. Ordnance Survey 100025370

The most recent Government Alcohol Strategy was published in March 2012 [29]. The strategy focuses on preventing alcohol-related harm by reducing the number of people drinking excessively and making "less risky" drinking the norm, both through local and national action. Following consultation on the Alcohol Strategy, the key policies focus on strengthening mandatory licensing conditions, challenging the alcohol industry to encourage responsible drinking and supporting local authorities to take action locally [30].

The National Institute for Health and Care Excellence (NICE), which provides national guidance to improve health and social care, has published a briefing for local authorities recommending actions they can take to implement the national strategy locally. This includes influencing where alcohol is sold through planning regulations, ensuring licensed premises operate responsibly, enforcing laws on underage sales, commissioning alcohol treatment services and being responsible for the assessment of alcohol as part of the NHS Health Check programme [31]. In Lincolnshire, responsibility for some of these functions is at district council level (e.g. planning regulations and enforcing laws on underage sales) and others at county council level (e.g. treatment services and the Health Check programme).

3.7 Helping people to reduce their alcohol consumption

In England a range of population and individual level actions are being taken to help people to reduce their alcohol consumption [31]. Population wide approaches can:

- reduce the number of people who start to drink excessively;
- help those who are not in contact with services to drink less; and
- help those who have been advised to drink less by building an environment that encourages and supports less risky drinking.

Individual approaches are also important to help people to become aware of the risks of their drinking and to minimise or prevent further harm.

A mechanism for engaging with individual drinkers is Making Every Contact Count (MECC). MECC is a national strategy based on the premise that all organisations with a responsibility for health, wellbeing, care and safety have an opportunity to impact on people's mental and physical wellbeing. It is about using every opportunity to talk to individuals about improving their health and wellbeing, influencing lifestyle and health behaviours.

The Department of Health [32] has issued guidance recommending a range of treatment services for adults who drink excessively. These include [33]:

- Alcohol information, screening and brief advice for hazardous and harmful drinkers, delivered by non-specialists within a range of settings (e.g. GPs, A&E, social care)
- Open access and outreach services that provide alcohol advice, assessment and extended brief interventions in a range of settings
- Community-based, specialised alcohol assessment and treatment including prescribing, psychosocial therapy and support within a care plan, specialised drug and alcohol practitioners and input from medical staff
- Residential, specialised alcohol assessment and treatment including prescribing, psychosocial therapies, support and aftercare, delivered by medical staff who specialise in substance misuse

Psychosocial interventions are those that focus on the social and psychological factors that influence behaviour. NICE recommends that psychological interventions should be used in the treatment of harmful drinkers and people with mild alcohol dependence, with the intervention focused specifically on alcohol-related cognitions, behaviour, problems and social networks [34]. Evidence-based psychological treatments supported by NICE are:

- Cognitive behavioural therapy;
- Behavioural therapies focused on alcohol-related problems;
- Social network and environment-based therapies;
- Behavioural couple's therapy on alcohol-related problems and their impact on relationships.

Pharmacological or drug-based interventions can be used to support people with moderate or severe alcohol dependence to stay alcohol-free following successful withdrawal from alcohol. Drugs are currently available which have the following effects:

- Reduce the reward associated with alcohol consumption;
- Stabilise the chemical imbalance caused by alcohol withdrawal;
- Create an acute sensitivity to ethanol and result in unpleasant side-effects from drinking.

Pharmacological interventions should only be used if supported by psychosocial interventions.

NICE has also developed a treatment pathway for alcohol use disorders that incorporates prevention and diagnosis and management within a single overarching framework [35].

3.7 Local strategy and services

Broad, evidenced-based approaches to reducing alcohol consumption and hence improving liver health are identified in Improving Liver Health in the East Midlands by Public Health England [36]. These include primary prevention (such as DPHs responding to licensing decisions in their local areas and managing the availability of alcohol), identification and brief advice to people who are at risk of or who are experiencing harm as a result of their drinking, hospital-based alcohol services, and a comprehensive treatment system to support those who are dependent on alcohol to recover from their alcohol misuse.

The Lincolnshire Alcohol and Drug Strategy 2014-2019 [37] identifies a number of ways in which action is being taken in Lincolnshire to reduce alcohol consumption and alcohol related health harms. Promoting responsible drinking is a core theme of the strategy and is enacted through programmes such as:

- School-based alcohol-harm and drug misuse education programmes;
- The Blue Light Project; and
- Increasing support for raising the topic of alcohol consumption within the Making Every Contact Count (MECC) programme.

Addaction and the Drug and Alcohol Recovery Team currently provide a range of psychosocial and pharmacological interventions for adult drinkers who require specialist alcohol treatment services in Lincolnshire. Young Addaction provides holistic services for children and young people who are under 19 years of age. Young people's services are outreach driven to enable engagement with young drinkers in an appropriate environment.

The diversity of stakeholders involved in the interventions described above, including schools, the police, the local authority, substance misuse services and all healthcare professionals (within MECC), highlight the important role that organisations have, to work together to address alcohol related liver disease.

Chapter 4: Causes of Liver Disease – Obesity

Key Points

- The number of people who are overweight or obese has increased dramatically in almost all countries over the past 10 years.
- Obesity causes excess fat deposits within the liver which, over a period of time, can cause permanent liver damage. However, damage can be prevented and, in its early stages, reversed by weight-loss.
- A number of individual, societal and environmental factors act across individuals' lives to increase their risk of becoming overweight or obese.
- The number of people who are obese in Lincolnshire is above the average for England and the East Midlands.
- Tackling obesity has been a government priority for a number of years with a primary goal being a downward trend in the level of excess weight in adults and a sustained downward trend in the level of excess weight in children by 2020.
- In Lincolnshire, public health and local authority, health-care services, education and several commercial organisations recognise and promote the need to encourage healthier diet and increased levels of physical activity in adults and children.

4.1 Introduction

The number of people who are overweight or obese has increased dramatically in almost all countries over the past decade. Obesity is now widely recognised as an important public health issue. In England, almost seven in ten men and six in every ten women are overweight or obese [38]. This chapter outlines what obesity is and how it may add to the growing burden of liver disease.

4.2 How are overweight and obesity defined?

The World Health Organisation (WHO) defines being overweight or obese as an accumulation of excess fat that could cause serious physical and psychological health problems [39]. In adults, obesity is most frequently defined through a person's body mass index (BMI). BMI is the ratio of a person's weight in kilograms (kg) to their height in meters squared (m^2) [40]. For example, an adult who weighs 70kg and whose height is 1.75m will have a BMI of 22.9.

$$\textbf{BMI} = 70\ \text{kg} / (1.75\ \text{m}^2) = 70 / 3.06 = 22.9$$

For adults having a BMI of greater than 25 and less than 30kg/m^2 means you are overweight and having a BMI of greater than or equal to 30 kg/m^2 means you are obese.

Children's BMI may be measured differently using reference growth charts.

4.3 What makes us put on excess weight?

At its simplest, overweight and obesity are caused by a long-term energy imbalance where the energy (calories) we consume exceeds the calories we expend. In reality, this balance is influenced by a complex web of factors [41] (Figure 4.1).

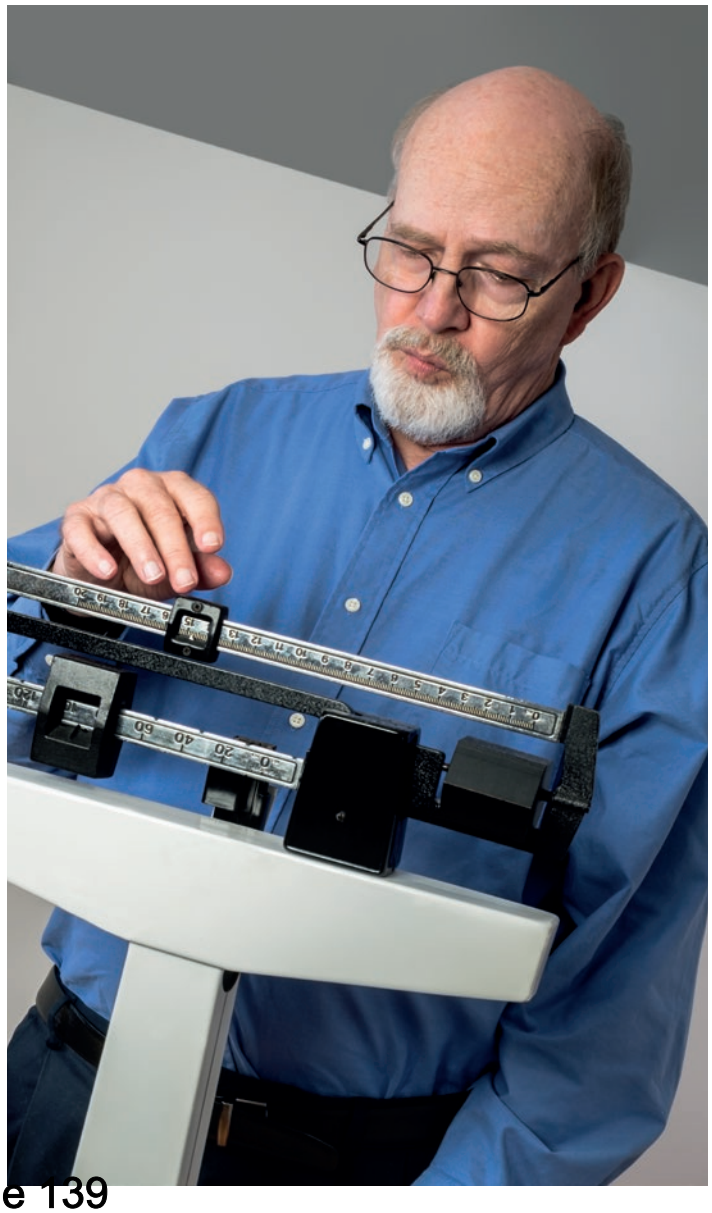
The key contributing factors for being overweight or obese are:

- **Individual food consumption:** The quality, quantity and frequency of food consumption all influence our heath. Increasing portion size and over-consumption of high-fat, high-sugar foods that contain lots of energy but few nutrients, as well as high energy drinks (e.g. fizzy drinks, sports drinks and fruit juice) has led to the consumption of excess calories.
- **Individual psychology:** How we perceive our own and others body size; our food habits; and how we respond to stress and other emotions all impact food consumption.
- **Physical activity:** Levels of occupational, domestic and recreational activity are all key contributing factors that can influence our ability to maintain weight.
- **Food environment:** The food environment covers a broad spectrum of factors that may influence individual food intake. These factors range from food marketing and promotional offers to the links between obesity and exposure to fast food outlets [42].
- **Societal:** Social norms and the socio-cultural value of food, media consumption, education and peer pressure are all social factors that may influence both individual and population decisions relating to food intake.
- **Physical environment:** The infrastructure and environment around us may also encourage or discourage activity and thus influence our behaviour. For example, a decision to cycle to work may be influenced by road safety, air pollution and the provision of workplace facilities for bike storage and showering.

Figure 4.1: An overview of the complex web of factors contributing to increasing levels of obesity in the UK

Government Office for Science: Tackling obesity: Future Choices Project Report 2nd editio

Interacting with these factors is a small number of genetic markers that make individuals more prone to obesity [43]. However, in all but a small number of cases, it is the influence of our environment and how we respond to it that determines our risk of becoming obese [44].



4.4 Obesity in Lincolnshire

The number of people, in Lincolnshire, who are obese, is above the average for England and the East Midlands.

In 2014/15 in Lincolnshire, according to the National Child Measurement Programme (NCMP), 8.5% of children in Reception and 19.4% of children in Year 6 were obese. While trends in the UK have shown signs of decline over the last seven years, Lincolnshire rates of obesity have, until recently, increased (see Figure 4.2).

In adults, the prevalence of overweight and obesity is again higher than in either the East Midlands or England (see Figure 4.3). At CCG level, Lincolnshire CCG's are ranked amongst those with the highest prevalence of obesity (see Table 4.1). Comparison between CCGs is not possible as confidence in the data is limited by differences in reporting practices. There are no significant differences between the levels of obesity in adults in different districts.

At a national level, higher levels of obesity in adults are linked with greater deprivation. This could not be assessed on a local level in adults; however, in Lincolnshire, a similar relationship was found between obesity levels in children and deprivation at a population level.

Figure 4.2: National child measurement programme: obesity levels in Lincolnshire compared with national levels

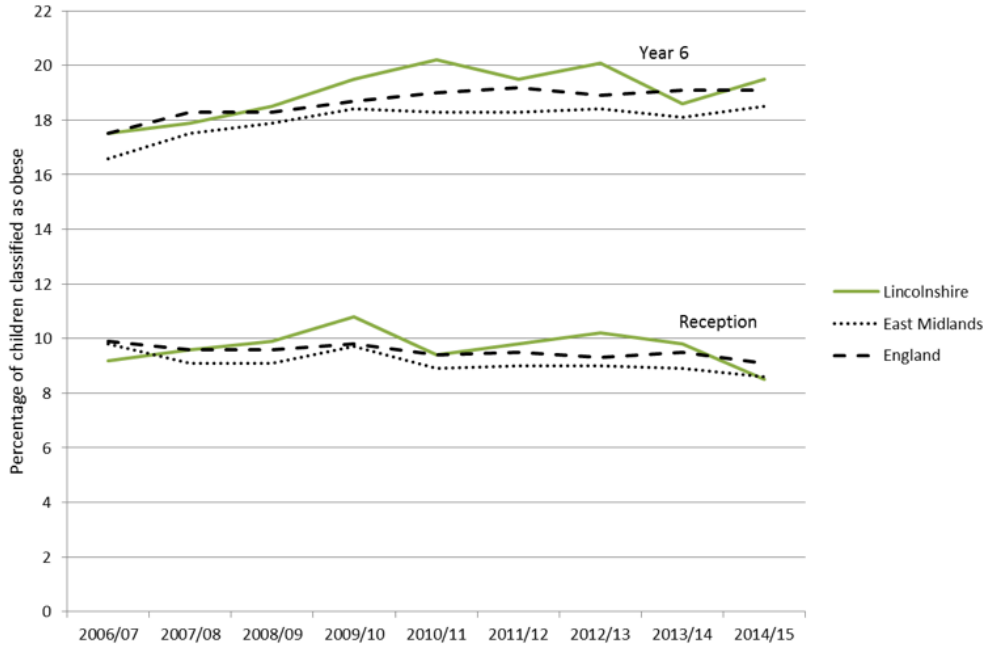


Figure 4.3: Percentage of population who are overweight or obese from the Public Health Outcomes Framework

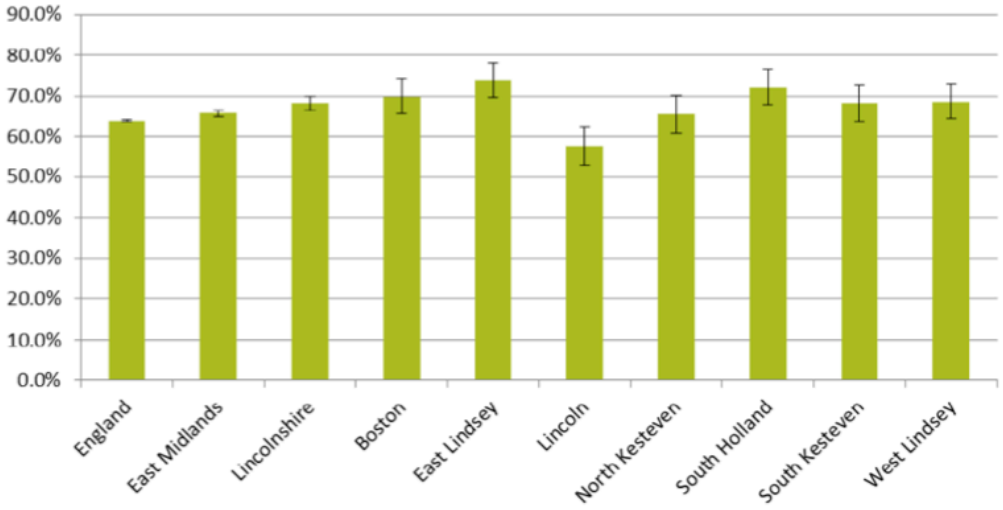


Table 4.1: Obesity prevalence and ranking of Lincolnshire CCGs from QOF Obesity Register Data

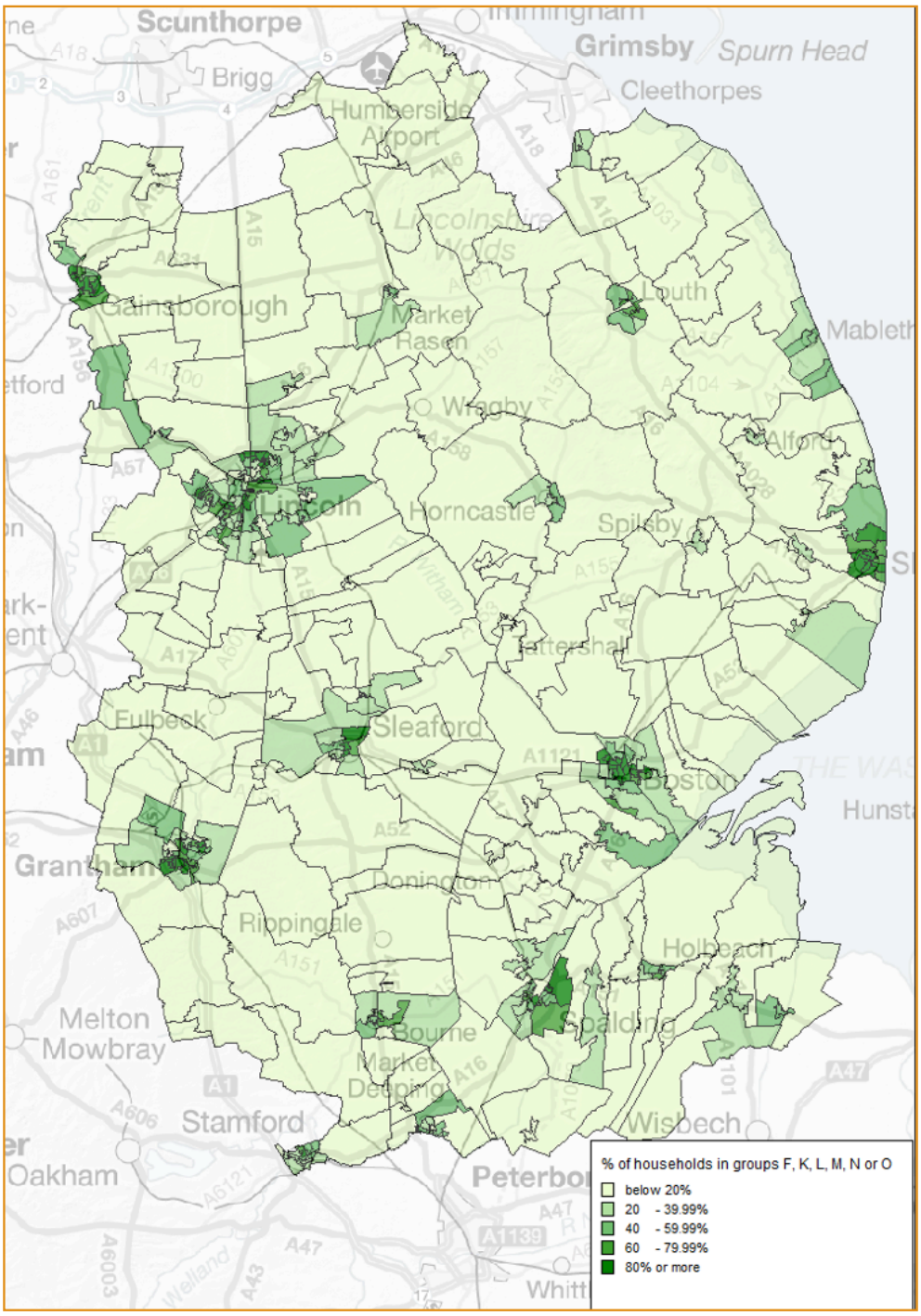
CCG	Prevalence from QOF	Rank (of 211 CCGs)	Percentage Rank & Position Comment
Lincolnshire East CCG	13.5%	26	Highest 12% - within the top sixth of CCGs for obesity prevalence (from QOF data)
Lincolnshire West CCG	13.0%	42	Highest 20% - within the top fifth of CCGs for obesity prevalence (from QOF data)
South Lincolnshire CCG	12.3%	56	Highest 26% - Just outside the top quarter of CCGs for obesity prevalence (from QOF data)
South-West Lincolnshire CCG	12.2%	58	Highest 27% - Just outside the top quarter of CCGs for obesity prevalence (from QOF data)

Source: Quality Outcomes Framework

4.5 Risk factors for obesity in Lincolnshire

In a 2013/14 survey conducted by Sport for England, 55.8% of Lincolnshire's adult (16+yr) population questioned were considered to be undertaking sufficient physical activity with 29% considered inactive. These are similar to the England averages (56.0% and 28.3% respectively). The same survey estimated 49.8% of people in Lincolnshire consume five or more portions of fruit and/or vegetables a day. This is slightly lower than the England average (51.4%). Modelled data suggests that 36% of Lincolnshire households fall within the 'at risk' group for obesity (Figure 4.4).

Figure 4.4: Concentration of 'high risk' group for obesity as a percentage of households by Lower Super Output Area (LSOA)



Source: Experian - Mosaic Public Sector 2015

4.6 How can obesity damage the liver?

Obesity causes excess fat deposits within the liver, which, if remain unchecked, can cause permanent liver damage.

Fatty liver or non-alcoholic fatty liver disease (NAFLD) is relatively common in the obese population. In the early stages of NAFLD, a small amount of fat in the liver does not usually cause any symptoms. However, the presence of fat in the liver has been associated with an increased risk of stroke or heart attack [45]. A build-up of fat also makes the liver vulnerable to further injury, resulting in inflammation and scarring of the liver (Non-alcohol steatohepatitis

(NASH)). The accumulation of fat in liver cells, accompanied by inflammation and scarring (fibrosis), may lead to the cirrhosis of the liver and liver cancer.

4.7 What can we do to reduce non-alcoholic fatty liver disease (NAFLD)?

The early stages of non-alcoholic liver disease are reversible. Programmes that address unhealthy food habits, reduce weight and increase physical activity are all able to reduce the amount of fat in your liver. As most cases of NAFLD are linked to being obese or overweight, treatment and/or prevention of obesity is the key to reducing the prevalence of NAFLD.

Once NAFLD has progressed to scarring and cirrhosis, there is no cure. However, removing the cause of the liver disease (e.g. obesity) can help to prevent disease progression.

4.8 National policy to reduce obesity

The 2010-2015 Obesity and Healthy Eating Strategy targeted a downward trend in the level of excess weight in adults and a sustained downward trend in the level of excess weight in children by 2020. National programmes such as Change4Life and the Public Health Responsibility Deal have sought to help people make healthier choices and encourage responsible business via health education activities, food labelling and voluntary pledges from the food industry to reduce portion size and harmful ingredients.

Nationally, work continues to update guidelines including, most recently, recommendations to restrict intake of added sugar to less than 5% of total energy intake. Many of the suggested responses to this new challenge act at a national level [46], although a local authority pilot in Brighton and Hove has instigated a voluntary sugar sweetened beverage tax of 10p per item as part of a Sugar Smart City Campaign [47].

4.9 What are we doing in Lincolnshire to help you?

Collective work across public health and local authorities, health-care services, education and several commercial organisations in Lincolnshire recognises and promotes the need for a healthy diet and increased levels of physical activity, with the ultimate goal of reducing the prevalence of obesity in adults and children.

Childhood obesity and dietary habits are known to track into adolescence and adulthood making early prevention an important feature of obesity strategy. The National Childhood Measurement Programme identifies those whose weight may put them at risk of future weight-related issues in adulthood. Furthermore, health screening in adults via the NHS Health Check programme identifies those who may benefit from weight management advice. Collaborative work by CCGs is ongoing to provide specialist support to those with a BMI between 35kg/m2 and 45kg/m2. For individuals with a BMI of 45kg/m2 and above, who have other related illnesses (e.g. diabetes) and have not had success with behavioural interventions, surgery is considered as an effective intervention [48].

The latest (May 2014) obesity update of the Lincolnshire Joint Strategic Needs Assessment (JSNA) highlighted a number of actions including supporting the development of and improving accessibility to, weight management services. The JSNA update also suggested Lincolnshire County Council would look to maximise the contribution of the planning system and engage new partners across the commercial, corporate, and voluntary and public sectors to contribute to tackling obesity.

Chapter 5: Causes of Liver Disease – Viral Hepatitis

Key Points

- Hepatitis B virus (HBV) and Hepatitis C virus (HCV) are blood borne viruses (BBVs) transmitted through contaminated blood and body fluids.
- The body's response to the presence of the virus over a long period of time may lead to permanent liver damage.
- Short-term (acute) Hepatitis B and C infection may or may not cause visible symptoms. Some individuals recover without ever realising they have been infected.
- A vaccine is available to prevent Hepatitis B transmission in high risk groups e.g. intravenous drug users.
- No vaccine is available for Hepatitis C.
- In Lincolnshire, Hepatitis B vaccination and Hepatitis C testing is encouraged alongside adult substance misuse services. Lincolnshire's two prisons also offer Hepatitis B vaccination and Hepatitis C testing.

5.1 What are Hepatitis B and C?

Hepatitis B virus (HBV) and Hepatitis C virus (HCV) are blood borne viruses (BBVs) transmitted through contaminated blood and other body fluids. When infected, the virus is carried in the blood to the liver cells and creates copies of itself. In doing this, it interferes with the functions of the liver. The body's immune system reacts to combat and eliminate the infectious agent leading to inflammation.

The prevalence of chronic (long-term) Hepatitis B infection in the UK is estimated to be 0.3% (approximately 180,000 people). The rate of Hepatitis B infections appears highest in large city areas, likely due to the concentration of high-risk populations in these areas [49] (Figure 5.1).

Within the UK the most recent national estimates suggest that around 215,000 individuals are chronically infected with Hepatitis C (HCV) in the UK. Apart from 2010, the overall trend is of a year-on-year increase in the number of new Hepatitis C reports. This may be due, in part, to more complete reporting and/or more targeted testing of individuals. In 2014 there were 11,997 new Hepatitis reports in England and Wales [50].

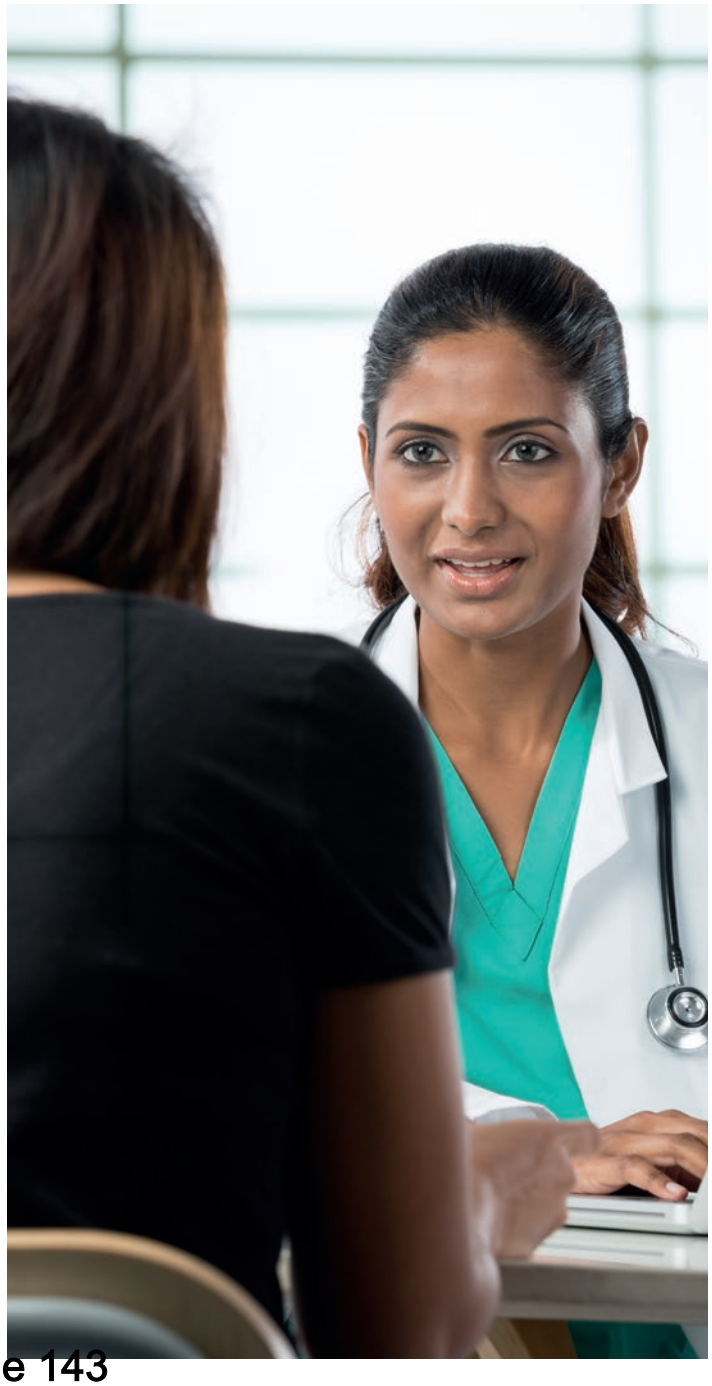
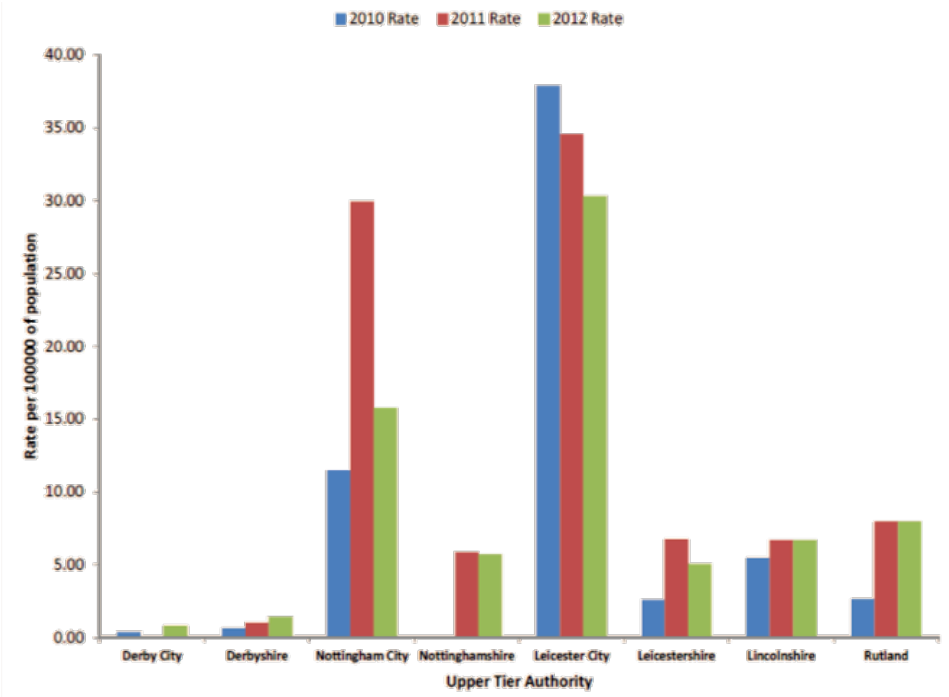


Figure 5.1: Rate per 100,000 of Hepatitis B by Upper Tier Authority, PHE East Midlands Centre area 2010-2012 [49]



Data source: LabBase Interrogated for East Midlands data locally. Population data obtained from ONS mid-year estimates.

5.2 What are the consequences of Hepatitis B and C?
Long-term (chronic) infection with either Hepatitis B virus or Hepatitis C virus over a number of years can cause significant liver damage leading to scarring of the liver (cirrhosis) and, in some cases, liver cancer.

Acute (short-term) Hepatitis B and C infections may or may not cause visible symptoms. Some individuals recover without ever realising they have been infected. Where symptoms do appear, they can present as mild to severe fatigue, loss of appetite, depression or anxiety, poor memory or concentration and pain or discomfort in the liver.

The majority of Hepatitis B infections are acute with only 10% of adults going on to develop chronic infection [51]. The risk of developing chronic Hepatitis B infection depends on the age at which infection is acquired with chronic infection most likely in children [51]. Of those adults with chronic Hepatitis B infection, 20% go on to experience scarring of the liver (cirrhosis) with one in ten of these going on to develop cancer [52].

Approximately 15-20% of infected people clear a Hepatitis C infection within six months. Of those who develop chronic Hepatitis C infection, approximately 20-30% will go on to develop cirrhosis within 20 years (Table 5.1) [53].

Table 5.1: Estimated proportion of HCV disease states in 2013 in Lincolnshire and predicted disease burden in these individuals in 2023 (based on 3% of chronic cases being treated)

Disease state (HCV)	2013	2023
Mild	763	506
Moderate	415	348
Cirrhotic	56	55
End stage disease	20	21
Died (all causes)		207
Sustained virologic response		118

Source: PHE Hepatitis C Commissioning Toolkit

5.3 Who is at greatest risk of infection of Hepatitis B and C?
Box 5.1 lists the risk factors for acquiring Hepatitis B and C. The rate of Hepatitis C infection within the East Midlands is highest in those aged 25-44 and is higher in males than females.

5.4 Can Hepatitis B and C be prevented and treated?
Through the prevention of infection and the treatment of chronic infections, the vast majority of long-term liver damage caused by viral hepatitis is preventable. Testing and early identification of Hepatitis B and C infection are keys to preventing further liver damage for the patient and also stopping further transmission of the disease.

An effective vaccine is available against Hepatitis B but not

Hepatitis C. Hepatitis B vaccination is offered to those at greatest risk, such as children born to Hepatitis B positive mothers, those who change sexual partners frequently and people who inject drugs [36]. The Hepatitis B vaccine consists of a series of three injections over several months. This can make it difficult for those with chaotic lifestyles such as injecting drug users, or individuals who are homeless, and therefore an accelerated schedule can be adopted.

Curative treatments for chronic Hepatitis B infection are not yet available, but treatments do exist to control the infection and in doing so can lead to a reversal in liver disease and a reduced risk of infecting others. Effective treatments exist for Hepatitis C and now offer a 90% and above cure rate with few side effects and shorter treatment duration. The active identification of Hepatitis C positive individuals is important for both harm reduction and treatment programmes to be effective.

Box 5.1: Risk groups for Hepatitis B and Hepatitis C. Adapted from [54].

Groups at increased risk of Hepatitis B compared with the general UK population include:

- People born or brought up in a country with an intermediate or high prevalence (2% or greater) of chronic Hepatitis B. This includes all countries in Africa, Asia, the Caribbean, Central and South America, Eastern and Southern Europe, the Middle East and the Pacific islands.
- Babies born to mothers infected with Hepatitis B.
- People who have ever injected drugs.
- Men who have sex with men.
- Anyone who has had unprotected sex, particularly people who have had multiple sexual partners, people reporting unprotected sexual contact in areas of intermediate and high prevalence, people presenting at sexual health and genitourinary medicine clinics, people diagnosed with a sexually transmitted disease, commercial sex workers.

Groups at increased risk of Hepatitis C compared with the general UK population include:

- People who have ever injected drugs.
- People who received a blood transfusion before 1991 or blood products before 1986, when screening of blood donors for Hepatitis C infection, or heat treatment for inactivation of viruses were introduced.
- People born or brought up in a country with an intermediate or high prevalence (2% or greater) of chronic Hepatitis C. For practical purposes this includes all countries in Africa, Asia, the Caribbean, Central and South America, Eastern and Southern Europe, the Middle East and the Pacific islands.
- Babies born to mothers infected with Hepatitis C.
- Prisoners, including young offenders.
- Looked-after children and young people, including those living in care homes.
- People living in hostels for the homeless or sleeping on the streets.
- HIV-positive men who have sex with men.
- Close contacts of someone known to be chronically infected with Hepatitis C.

5.5 What's happening in Lincolnshire?

In Lincolnshire, Addaction and Drug and Alcohol Recovery Team are commissioned to deliver adult substance misuse services. Addaction is also commissioned to deliver a young person's service. All three services currently have resource sites based in Lincoln, Grantham and Boston but also work from satellite sites across the county.

A key preventative intervention for both Hepatitis B and C transmission is needle exchange. In Lincolnshire, this programme is provided at the Addaction centres in Lincoln, Grantham and Boston but also in 16 pharmacies to provide additional cover across our rural county. Additionally, the following services are provided for Hepatitis B and C separately.

Hepatitis B

Lincolnshire's Hepatitis B vaccination programme sits alongside substance misuse services and prisons in the region. Across the East Midlands, testing also occurs in a number of primary care services (e.g. GP practices, Prison services, Accident and Emergency, and drug dependency services) and secondary care services (e.g. fertility services, paediatric services and specialist liver services).

Data collection methods make interpretation of trends and geographical variation in the vaccination coverage in prisons, difficult and this is being addressed nationally. The latest reports suggest that over 50% of prisoners are vaccinated within a month of arrival at HMP North Sea Camp and just under 15% at HMP Lincoln. However, detail of the number of prisoners arriving at each prison, who have already had the vaccination, is unknown.

Of those starting new episodes of specialist drug treatment in Lincolnshire, who are, or have previously been injecting drug users, 3.9% were offered and accepted Hepatitis B testing in contrast to 21.3% nationally. Just over half (56.9%) of these individuals went on to start vaccination treatment for Hepatitis B and 38.5% went on to finish the course [55].

The number of women receiving antenatal screening steadily increased in the East Midlands between 2005 and 2011. In Lincolnshire, in 2012, 6380 women were screened. This continues to be an important proactive step in the prevention of new infection in new born babies.

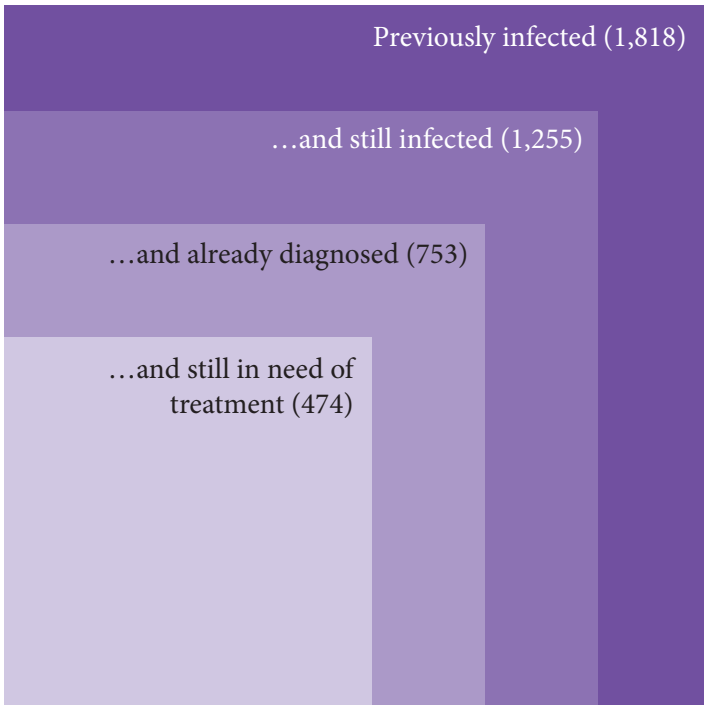
Hepatitis C

There is no vaccine for Hepatitis C. Therefore early detection of infection and treatment are important to prevent permanent liver disease and further transmission. In England, during 2011, it is estimated that 3% of those with Hepatitis C infection were in treatment.

Of those starting new episodes of specialist drug treatment in Lincolnshire, who are, or have previously been injecting drug users, 21.1% accepted Hepatitis C testing in comparison to 44.1% nationally. However, in Lincolnshire, 100% of these were converted into actual Hepatitis C tests unlike nationally where the conversion rate is 72.8%.

Within county data on prevalence of Hepatitis C and treatment need is not available; however, a PHE commissioning tool has provided estimates by stage of diagnosis and treatment (see Figure 5.2). Currently, Hepatitis C testing occurs within a number of primary and secondary care services across the county (Table 5.3).

Figure 5.2: Number of people infected with Hepatitis C in Lincolnshire by stage of diagnosis in 2013 [53]



Source: PHE Hepatitis C Commissioning Toolkit

Table 5.2: Hepatitis C commissioning/provider map

Service		Provider
Testing Services	Substance Misuse Services	Drug and Alcohol Recovery Team
	Substance Misuse Services	Addaction
	Prison Services	HMP Lincoln - healthcare arm = Nottinghamshire Healthcare
	Prison Services	HMP North Sea Camp - healthcare arm = Nottinghamshire Healthcare
	Immigration Removal centre	IRC Morton Hall - healthcare provided by G4S
	Genito-Urinary Medicine clinics and Sexual Health clinics	Lincolnshire Community Health Services (NHS) Trust
	Specialist primary care based sexual health services	Newmarket Practice, Louth and Beechfield Surgery, Spalding
	GP Practices	Over 100 sites across Lincolnshire
	Occupational Health	Various public and private sector
	Secondary Care depts. E.g. maternity; haematology	United Lincolnshire Hospitals NHS Trust (ULHT)
	Lab Testing	Pathlinks
Treatment Services	Boston Pilgrim Hospital	ULHT
	Lincoln County Hospital	ULHT
	HMP Lincoln (Healthcare Dept.)	Nottinghamshire Healthcare NHS Trust
Hep C Drugs	Hep C drugs funding	ULHT

Chapter 6: Recommendations

A range of recommendations have been identified to tackle liver disease in Lincolnshire. A number of organisations across the county can play an important role in delivering these recommendations. This includes the local authority, district councils, CCGs, health and social care providers, the community and voluntary sector and the general population.

Data and Intelligence

1. Mechanisms for collecting more comprehensive data on liver disease should be explored. For example, investigating whether liver disease can be recorded in primary care data.
2. Lincolnshire organisations should play an active role in the East Midlands Liver Programme Group, which is led by Public Health England's East Midlands Centre. This will help in learning from our regional partners about best practice in addressing liver disease.

Awareness

3. National campaigns aimed at increasing the awareness of liver disease should be supported locally.
4. There is a need for stakeholders to work jointly to raise awareness of links between obesity, excessive alcohol consumption and liver disease amongst the local population, particularly in areas with high rates of liver disease-related hospital admissions.
5. There is a need to work with Health Education England to improve the awareness of health professionals on the causes of, and treatments for, liver disease, as well as the importance of early detection.

Early Detection and Treatment

6. Stakeholders should work together to facilitate early identification of risk factors for Liver disease through continued action to improve the participation of individuals in NHS Health Checks, at a GP and county level.
7. Health checks are a potential intervention point for those at risk of liver disease. It must be ensured that individuals, who are identified as having relevant risk factors, are followed up in general practice, provided appropriate onward referral or, where referral is no longer available, provided a brief intervention by their GP practice (e.g. advice on dietary improvement and/or weight-loss).
8. Hepatitis B screening for migrant populations should be improved through local measures, for example primary care registrations and new-registrant screening for new migrants from medium and high prevalence countries.
9. The uptake of Hepatitis B vaccination by individuals at high risk of exposure to the disease should be increased.
10. Rates of diagnostic testing for Hepatitis C should be increased among individuals at high risk of the disease, in order to detect disease early and to commence treatment.
11. The specialist alcohol and substance misuse services should support people to reduce problematic alcohol consumption. This should include links with hospitals to identify and support people who might benefit from such specialist support.
12. The alcohol treatment services within local authority commissioning of substance misuse services should be of high quality and outcome based.

Strategy and Policy

13. The Health and Wellbeing Board should take leadership in prevention, early identification and treatment of liver disease, as recommended by the Chief Medical Officer.
14. Lincolnshire organisations should advocate for evidence based national policies to reduce excessive alcohol consumption, for example health and wellbeing to become a 5th licensing objective.
15. Lincolnshire organisations should advocate for governmental regulations to reduce sugar and saturated fat content in food and drink that are informed by evidence, for example Public Health England recommended policy actions to reduce sugar intake.
16. A multi-agency obesity and overweight reductions strategy should be developed.
17. There is a need to continue to integrate public health across local authority departments to ensure public health is considered in areas such as planning and licensing, for example, using local planning powers to support play and active travel.
18. There is a need to explore innovative legislative, planning and environmental actions to improve the health of the local population, for example learning from 'Reducing the Strength' in Ipswich and Brighton's 'Sugar Smart City' policy.

Appendix 1: Calculating Rates of Liver Disease

Comparing liver disease rates between countries and regions

To compare rates of liver disease between Lincolnshire and other counties and regions, age standardised rates were calculated using International Classification of Disease Version 10 (ICD-10) codes for all liver-related conditions (e.g. preventable and non-preventable disease). Age standardisation is a process through which differences in age profiles between different areas can be accounted for. The ICD10 codes included were B15-B19, C22, I81, I85, K70-K77, T86.4. Only the primary diagnosis code was used to identify admissions.

Local prevalence of preventable liver disease

To better understand the prevalence of preventable liver disease locally, detailed analyses for Lincolnshire were limited to the following preventable liver diseases (International Classification of Diseases 10 or ICD10 codes):

- Fibrosis and cirrhosis of liver (K74)
- Selected liver cancers (e.g. liver cell carcinoma) (C220)
- Chronic heptatis (K73)
- Alcoholic liver disease (K70)
- Non-alcohol fatty liver disease (NAFLD) (K760)
- Hepatitis B (B16, B180-181)
- Hepatitis C (B171, B182)

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Health and Wellbeing Board – Decisions from 9 June 2015

Meeting Date	Minute No	Agenda Item & Decision made
9 June 2015	1	**Election of Vice-Chairman** That Dr Sunil Hindocha be elected as the Vice-Chairman of the Lincolnshire Health and Wellbeing Board 2015/16.
	2	**Election of Chairman** That Councillor Mrs S Woolley be elected as the Chairman of the Lincolnshire Health and Wellbeing Board for 2015/16.
	5a	**Minutes of meeting held on 25 March 2015** That the minutes of the meeting of the Lincolnshire Health and Wellbeing Board held on 24 March 2015, 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.
	7	**Chairman's Announcements** That the announcements as detailed be noted.
	8a	**Terms of Reference and Procedural Rules, Board Members Roles and Responsibilities**. 1. That the Terms of Reference, Procedure Rules, and Members Roles and Responsibilities as detailed at Appendices A, B and C be re-affirmed. 2. That the Assurance Framework as detailed at Appendix D be formally adopted.
	8b	**Joint Health and wellbeing Strategy Board Sponsors** 1. That the revised list of Board Sponsors as shown at Paragraph 1 of the report be agreed. 2. That the Theme Sponsor and Theme Lead – Role Descriptions detailed at Appendix A be agreed.
	8c	**Mid Term Review of the Joint Health and Wellbeing Strategy** That the Mid-term review of the Joint health and wellbeing Strategy as detailed in Appendices A to E presented be agreed.
	9a	**Meeting the Prevention Challenge in Lincolnshire** That then report be noted.

	9b	**Public Health on a Page** That the Public Health Plan to a Page be noted.
	9c	**Lincolnshire Health and Care** That the presentation be received.
	9d	**Better Care Fund** 1. That the report presented be noted. 2. That a further update on the Better Care Fund be received at the next meeting of the Lincolnshire Health and Wellbeing Board.
	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** That the forward plan for formal and informal meetings presented be received.
	10c	**Future Scheduled Meeting Dates** That the following scheduled meeting dates for the remainder of 2015 and for 2016 be noted. 29 September 2015 8 December 2015 22 March 2016 7 June 2016 27 September 2016 6 December 2016 (All the above meetings commence at 2.00pm)
29 September 2015	16a	**Annual Assurance Report** 1. That the outcome of the Board's Self-Assessment be noted and that the improvement plan detailed at Appendix B be agreed. 2. That the JHWS Scorecard and Theme Dashboards as shown in Appendices C – H be noted. 3. That the issues raised as detailed above be noted
	16b	**Lincolnshire Health and Wellbeing Board Engagement Framework** 1. That commitment be given to the principles underpinning the Health and Wellbeing Board Engagement Framework.

		2. That approval be given to the Health and Wellbeing Board Engagement Framework and the proposed approach to stakeholder engagement.
	16c	**Transforming Child and Adolescent Mental Health Services** That final approval of the Lincolnshire Plan on behalf of partners across the areas covered by South Lincolnshire CCG, Lincolnshire West CCG, South West Lincolnshire CCG and Lincolnshire East CCG be delegated to the Chairman of the Lincolnshire Health and Wellbeing Board, Councillor Mrs S Woolley to sign off, prior to its submission for assurance by NHS England on 14 October 2015.
	17a	**Joint Strategic Needs Assessment (JSNA) Review Update and Engagement Plan** That the report and attached Engagement Plan be noted.
	17b	**Lincolnshire Health and Care** That the verbal update be noted.
	17c	**Better Care Fund** That the report be noted.
	18a	**District/Locality Updates – Boston Health and Wellbeing Strategy and Action Plan** That the report and presentation be noted,
	18b	**An Action Log of Previous Decisions** That the Action Log of previous decisions of the Lincolnshire health and Wellbeing Board be noted.
	18c	**Lincolnshire Health and Wellbeing Board – Forward Plan** That the Forward Plan presented for formal and informal meetings be received subject to the inclusion of the two items listed above.
8 December 2015	22a	**Lincolnshire System Resilience Group System Wide Winter Plan 2015/16** That the report on the joint health and care system approach to winter planning be noted.
	23	**Action Updates from the Previous Meeting** That the completed actions as detailed be noted.
	24	**Chairman's Announcements** That the announcement as detailed; and the verbal update provided be noted.
	25a	**Clinical Commissioning Group Commissioning/Operational Plans** That the Clinical Commissioning Groups Commissioning/Operational Plans presented be noted.
	26a	**New Psychoactive Drugs – Briefing** That the report be noted.

	26b	**Update on Activity – Lincolnshire Joint Commissioning Board (JCB)** That the report be noted.
	26c	**Health and Wellbeing Grant Fund Projects – Update Report** 1. That the project updates as detailed in Appendix A be noted. 2. That a half yearly update report on the Health and Wellbeing Grant Fund Projects be received at the 7 June 2016 meeting.
	27a	**Greater Lincolnshire Proposals for Devolved Powers from Government** That the report be noted.
	27b	**An Action Log of Previous Decisions** That the Action Log of previous decisions of the Lincolnshire Health and Wellbeing Board be noted.
	27c	**Lincolnshire Health and Wellbeing Board – Forward Plan** That the Forward Plan presented for formal and informal meetings be received.

Lincolnshire Health and Wellbeing Board Forward Plan: March 2016 – December 2016

Meeting Dates	Decision/Authorisation Item	Discussion Item	Information Item
22 March 2016 **2pm in Committee Room 1, County Offices, Newland, Lincoln LN1 1YL**	**Joint Strategic Needs Assessment – Outcome of Review** To receive a report from the JSNA Steering Group asking the Board to agree the recommendations arising from the review of the JSNA. **Chris Weston, Consultant Public Health** **CCG Commissioning/Operational Plans** To receive a report from each CCG which asks the Board to review the commissioning intentions/operational plans for 2016/17 against the priorities in the Joint Health and Wellbeing Strategy **Better Care Fund 2016/17** To receive a report from the Director of Adult Care asking the Board to approve the 2016/17 BCF Submission **Glen Garrod, Director of Adult Care**	**Joint Commissioning Board – Update Report** To receive an update report from the JCB on joint commissioning arrangements in Lincolnshire. **Sunil Hindocha, Chairman of the JCB** **Lincolnshire Health and Care – verbal update** To receive an update on the LHAC programme **Allan Kitt, Leading Chief Officer, LHAC Programme**. **Annual Report of the Director of Public Health on the health of the people of Lincolnshire 2015** To receive the Annual Report on the Health of the people of Lincolnshire **Chris Weston, Consultant 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: • Current funding issues relating to volunteering and the third sector, in order to ensure support for older people in Lincolnshire. **Dr Kevin Hill and Cllr Ron Oxby, Board Sponsors for Theme 2 of the Joint Health and Wellbeing Strategy**	**Lincolnshire Joint Ambulance Conveyance Project** To receive a presentation on the Joint Ambulance Conveyancing Project – a joint project between Lincolnshire Fire & Rescue, East Midlands Ambulance Service and Lincolnshire Integrated Voluntary Emergency Service (LIVES). **Nick Borrill, Acting Chief Fire Officer, Lincolnshire Fire and Rescue**

Meeting Dates	Decision/Authorisation Item	Discussion Item	Information Item
7 June 2016 **2pm in Committee Room 1, County Offices, Newland, Lincoln LN1 1YL**	**Annual General Meeting** Election of Chair and Vice Chair **Terms of Reference and Procedural Rules, roles and responsibilities of core Board members** Review and formal agreement **Alison Christie, Programme Manager Health and Wellbeing** **Sustainability and Transformation Plan for Lincolnshire -TBC**	**Joint Commissioning Board – Update Report** To receive an update report from the JCB on joint commissioning arrangements in Lincolnshire. **Sunil Hindocha, Chairman of the JCB** **Lincolnshire Health and Care – verbal update** To receive an update on the LHAC programme **Allan Kitt, Leading Chief Officer, LHAC Programme** **Health and Wellbeing Grant Fund – Update** To receive a half yearly report on the Health and Wellbeing Grant Fund projects. **Alison Christie, Programme Manager Health and Wellbeing** **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	
27 September 2016 **2pm in Committee Room 1, County Offices, Newland, Lincoln LN1 1YL**	**Annual Assurance Report** To receive a report from the Programme Manager asking the Board to agree the Board's Assurance Report and Theme Dashboards. **Alison Christie, Programme Manager Health and Wellbeing** **Prioritisation Framework for the Joint Health and Wellbeing Strategy** To receive a report asking the Board to agree the prioritisation framework for the new JHWS and to agree the process for developing the JHWS. **David Stacey, Programme Manager, Strategy and Performance**	**Joint Commissioning Board – Update Report** To receive an update report from the JCB on joint commissioning arrangements in Lincolnshire. **Sunil Hindocha, Chairman of the JCB** **Lincolnshire Health and Care – verbal update** To receive an update on the LHAC programme **Allan Kitt, Leading Chief Officer, LHAC Programme** **District/Locality Updates** Standing agenda item for the Board to receive updates, by exception, from District/locality partnerships	

Meeting Dates	Decision/Authorisation Item	Discussion Item	Information Item
6 December 2016 **2pm in Committee Room 1, County Offices, Newland, Lincoln LN1 1YL**		**Joint Commissioning Board – Update Report** To receive an update report from the JCB on joint commissioning arrangements in Lincolnshire. **Sunil Hindocha, Chairman of the JCB** **Lincolnshire Health and Care – verbal update** To receive an update on the LHAC programme **Allan Kitt, Leading Chief Officer, LHAC Programme** **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	

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