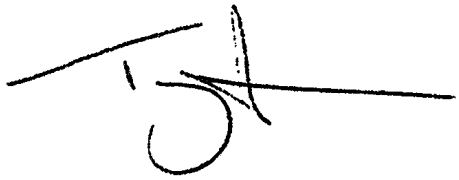
County Offices
Newland
Lincoln
LN1 1YL

1 March 2017

Community and Public Safety Scrutiny Committee

A meeting of the Community and Public Safety Scrutiny Committee will be held on **Thursday, 9 March 2017 at 10.00 am in Waddington Training Facility, Sleaford Road, Bracebridge Heath, Lincoln, LN5 9FG** for the transaction of the business set out on the attached Agenda.

Yours sincerely



Tony McArdle
Chief Executive

Membership of the Community and Public Safety Scrutiny Committee
(11 Members of the Council)

Councillors C J T H Brewis (Chairman), L Wootten (Vice-Chairman), K J Clarke, D C Morgan, A G Hagues, C R Oxby, S L W Palmer, Mrs N J Smith, R Wootten, Mrs E J Sneath and 1 Vacancy

COMMUNITY AND PUBLIC SAFETY SCRUTINY COMMITTEE AGENDA
THURSDAY, 9 MARCH 2017

Item	Title	Pages
1	**Apologies for Absence/Replacement Councillors**	
2	**Declaration of Members' Interests**	
3	**Minutes of Meetings of the Community and Public Safety Scrutiny Committee held on:**	
	3a 25 January 2017	5 - 14
	3b 1 March 2017	15 - 18
4	**Update from Executive Councillors and Chief Operating Officers**	Verbal Report
5	**Annual Report of the Director of Public Health on the Health of the People of Lincolnshire 2016** *(To receive a report from Tony McGinty, Interim Director of Public Health which provides the Committee with an opportunity to consider the Annual Report of the Director of Public Health on the Health of the People of Lincolnshire. The report raises issues of importance to the health of the population of Lincolnshire)*	19 - 56
6	**Quarter 3 Performance - 1 October to 31 December 2016** *(To receive a report which provides Members with an opportunity to consider key performance information relevant to the work of the Community and Public Safety Committee. Daryl Pearce, County Officer Public Protection; Nicole Hilton, Community Assets and Resilience Commissioning Manager; Robin Bellamy, Assistant Director Public Health Commissioning and Nick Borrill, Chief Fire Officer will all be in attendance for this item)*	57 - 90
7	**Community and Public Safety Scrutiny Committee Work Programme** *(To receive a report by Daniel Steel, Scrutiny Officer, which provides the Committee with an opportunity to consider and comment on the content of its work programme for the coming year)*	91 - 94

Democratic Services Officer Contact Details

Name: **Catherine Wilman**

Direct Dial **01522 553788**

E Mail Address catherine.wilman@lincolnshire.gov.uk

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

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

Contact details set out above.

All papers for council meetings are available on:
www.lincolnshire.gov.uk/committeerecords

COMMUNITY AND PUBLIC SAFETY SCRUTINY COMMITTEE
25 JANUARY 2017

PRESENT: COUNCILLOR C J T H BREWIS (CHAIRMAN)

Councillors L Wootten (Vice-Chairman), K J Clarke, D C Morgan, A G Hagues, C R Oxby, S L W Palmer, Mrs N J Smith, R Wootten and R G Fairman

Councillors: N H Pepper, C N Worth and B Young attended the meeting as observers

Officers in attendance:-

Sara Barry (Safer Communities Manager), Nick Borrill (Chief Fire Officer), Michelle Grady (Head of Finance (Communities)), Daniel Steel (Scrutiny Officer), Chris Weston (Consultant in Public Health, Public Health Intelligence) and Rachel Wilson (Democratic Services Officer)

35 APOLOGIES FOR ABSENCE/REPLACEMENT COUNCILLORS

Apologies for absence were received from Councillor R J Phillips.

36 DECLARATION OF MEMBERS' INTERESTS

There were no declarations of interest at this point in the meeting.

37 MINUTES OF THE PREVIOUS MEETING OF THE COMMUNITY AND PUBLIC SAFETY SCRUTINY COMMITTEE HELD ON 14 DECEMBER 2016

During consideration of the minutes, it was clarified that in relation to minute number 29, bullet point 6 there was a minimum age of 18 to become a retained fire fighter, however, there was no upper age limit, subject to the expected criteria being met. Also, members were advised that the information requested in relation to the last bullet point regarding the number of female retained fire fighters would be circulated shortly.

RESOLVED

That the minutes of the meeting held on 14 December 2016 be signed by the Chairman as a correct record.

38 UPDATE FROM EXECUTIVE COUNCILLORS AND CHIEF OPERATING OFFICERS

The Executive Councillor Community Safety and People Management reported that the launch of the Assisting Rehabilitation through Collaboration (ARC) had taken place the previous Friday. It was commented that this was a very important subject and a report should come before the committee in the future. It was noted that 2% of offenders in Lincolnshire committed 13% of all offences, and the top 2% in Lincoln were responsible for 27% of offences.

39 REVENUE & CAPITAL BUDGET PROPOSALS 2017/18

Consideration was given to a report which described the budget proposals arising from the Provisional Local Government Settlement, announced on 15 December 2016 and the implications for the following commissioning strategies – Community Resilience and Assets; Wellbeing; protecting the Public; Sustaining & Developing Prosperity through Infrastructure (heritage Services only).

The Executive would be consulting on a one year budget, and there were still difficult circumstances in terms of understanding the total amount of cost pressures as well as the funding that would be available. The Council was proposing to increase council tax by 1.95% and also by an additional 2% increase for the adult social care precept, making a total proposed increase of 3.95%.

Members were provided with an opportunity to ask questions to the officers present in relation to the information contained within the report and some of the points raised during discussion included the following:

Community Resilience & Assets

- In relation to the pension scheme, and the intention to reduce the amount paid by service areas and make a lump sum corporate contribution to the fund, it was commented that the effect of reducing numbers of staff on the scheme had not registered. It was noted that reviews of the pension scheme were done on a cyclical basis, and the contribution method had been changed to ensure that the council's responsibilities were being met.
- It was queried why the Council was not setting a 4/5 year budget, but the districts had been able to. Members were advised that it was the Executive's decision to set a one year budget. There were also some cost pressures which were specific to the County Council such as adult social care and waste disposal costs. There were also still questions around the Better Care Fund (BCF). It was commented that South Holland District Council had also only set a one year4 budget.
- With the announcement that approval would be sought for a poll on unitary authorities, it was queried whether the additional money would come to the county council if the districts were dissolved. It was noted that the savings would come from reducing the administration of eight authorities. The government was moving towards a localisation of funding.
- It was commented that with more services being cut the voluntary sector would become more and more important. Members were advised that there

were a high number of disparate service level agreements with organisations, and they would be brought together under one agreement.

- It was queried how the budget for the CAB could be reduced by £0.684m but it was still going to be funded. It was reported that the £684,000 was in the base budget, which was a commitment to pay this amount every year. However, this amount was going to be removed from the base budget, and would instead be funded on a one off basis from the reserves. It was commented that CAB was a vital service.
- In terms of the savings from the community and voluntary sector, it was clarified that the same support would be provided, but in more economical way.

Wellbeing

- Concerns were raised regarding the proposals to reduce the funding for walking programmes. However, it was understood why the reductions were being made, but it was requested whether they could be reinstated if more funding became available.
- In terms of the health improvement activities, it was commented that they would have been implemented as a need for them was identified at some point. It was queried whether there was a need to track the effects of the reduction of these services and the impact it would have on other services such as the NHS. It was noted that this information was tracked by Public Health, and there may be changes seen in a few years.

Protecting the Public

- It was noted that the service was currently receiving funding from the Better Care Fund (BCF) towards the costs of co-responding. However, no long term decisions around this funding had been made by central government.
- It was queried how the Registration, Celebratory and Coroners Service would generate additional income. Members were advised that a lot of work had been done and this service was almost self-funding. It was noted that the additional income came from the issuing of certificates, additional wedding venues and celebratory services. There were now a lot of services which the authority could charge for.
- A formal consultation on the Coroners service was due to be issued by the MoJ.
- Clarification was sought regarding the proposed reduction Road Safety budget and how it would become self-funding. Members were advised that this referred to the Lincolnshire Road Safety Partnership generating income through speed awareness courses. It was noted that there were no further changes planned.

(Councillor S L W Palmer declared an interest at this point in the meeting as a member of L.I.V.E.S)

- It was commented that co-responding was a very important part of the fire service. It was queried what the risk was in terms of the future funding for this service. It was stated that the intention was to secure continued funding support for this service from the BCF, there were ear-marked reserves to match this.
- Changing response times to stations to help recruitment was considered on a case by case basis.

RESOLVED

That the comments made in relation to the budget proposals be passed to the Executive for consideration at its meeting on 7 February 2017.

40 COMMUNITY SUBSTANCE MISUSE TREATMENT SERVICES RE-COMMISSIONING UPDATE

Consideration was given to a report which provided an update on the re-commissioning work that had been undertaken and detailed the what new services had been contracted and what they would deliver over the next five years.

It was reported that in March 2015, the Executive approved the re-commissioning of substance mis-use treatment services, and agreed that the contracts be reviewed at the end of the current contract period.

Significant engagement and consultation took place between January and November 2015, and Lincolnshire County Council used this partner input to develop two new specifications that included:

- Lot 1 – A comprehensive treatment system that included alcohol and drug treatment for young people and adults, delivering both psychosocial and clinical interventions across Lincolnshire. This specification also included a comprehensive needle syringe programme that had both specialist and pharmacy based services.
- Lot 2 – A new recovery service that would help bridge the gap between treatment and full recover and integration into local communities by improving social inclusion and employability of those in recovery. To help achieve this there would be a heavy reliance upon mutual aid and peer support, as well as training and education.

Members were advised that the specifications used an outcome focused approach which enabled the Council to detail what the service should achieve rather than saying how it should be structured. This allowed bidder more room for innovation and potentially more efficient ways of working. It was reported that on 30 March 2016, Addaction were awarded both contracts for the Treatment and Recovery Services.

Fern Hensley and Natasha Swift from Addaction were in attendance to answer any questions from the Committee in relation to the operation of the service.

The Committee was provided with the opportunity to ask questions to the officers present in relation to the information contained within the report and some of the points raised during discussion included the following:

- Volunteers would be welcomed from anywhere in the county. Officers confirmed that they would provide members with leaflets to distribute in their areas regarding volunteering opportunities.
- It was queried what was meant by 'full recovery' and whether there would be follow up of clients. Members were advised that recovery was a very personal

thing, and there wasn't a 'checklist', but was instead dependent on what the individuals' aspirations for recovery were. The service would not cherry pick who it worked with based on how long their recovery would take, but would work with everyone who approached them for treatment services. It was noted that it would be a massive task to track everyone after recovery, and was not viable in the budgets that the service had. However, if an individual came back into treatment that would be tracked.

- In terms of the recovery service, it was noted that students from outside of Lincoln would be offered transportation costs, but this had been budgeted for. As the service developed there would be increased infrastructure costs, but the costs of transport would reduce.
- It was noted that the service already carried out work in schools across the county, either with individuals or through group support.
- It was commented that work so far was encouraging and it was a very comprehensive service.
- It was queried what involvement there had been with LHAC and it was reported that working in partnership was not a viable option at the moment. However, Addaction worked in partnership with a lot of GP's across the county as well as other health organisations.
- Members were advised that it was unlikely that there would be an overlap between the work of this service and Public Health. The funding that was received was for treatment and recovery services, whilst public health would have more of a focus on prevention which was a different area completely. It was noted that there would be scope within the STP to look at the prevention agenda.
- It relation to the recruitment of volunteers, it was noted that a central contact point would be helpful, and this would be added to the leaflets. When someone called they would be put in touch with a manager to explain what would be required.
- In terms of people relapsing after treatment, members were advised that if someone wanted to engage in treatment they could be tracked through a national database during their treatment journey. If someone was frequently in and out of treatment there would be a need for parameters on their treatment journey. The service would never refuse to treat someone. There would be a need to learn from why someone had relapsed and then try to help them deal with that, e.g. if it was due to a relationship breakdown.
- In respect of the 20% service credits and the target relating to reducing the number of clients re-presenting to treatment, it was queried how this would work in practice. It was reported that parameters would be set for what was considered a successful completion, and there would be gradual re-integration.
- A report from Public Health England measured those that left treatment in the first six months of a year and re-presented in the last six months of the year on a rolling 12 months. If someone stayed away from treatment services for at least six months, there was less chance of them going back into treatment.
- In relation to the leaflet attached at Appendix C to the report, it was queried how people would know that there was a site available in their area. It was

noted that the main admin centres were listed on the leaflet, but officers would look whether this could be amended.

- Concerns were raised regarding the use of language in relation to stop smoking services, as it was felt that alternative phrases to 'giving up' should be used. Members were advised that it was personal preference in relation to language used, but it was vital that people understood the services being offered.
- It was queried whether there was a benefit to someone going 'cold turkey' and members were advised that this depended on what substance was being talked about, as it could be medically dangerous to stop drinking altogether if someone was drinking at dangerous levels.
- The service needed to be accessible for as many people as possible. Addaction was also working in partnership with smoking cessation services.
- The representatives from Addaction were congratulated for the work they were doing as it was acknowledged that it was a difficult job.
- People who were arrested for drugs offences could be referred to the service if they had a history of substance misuse, but it was not mandatory.
- It was highlighted that not everyone who misused substances was a criminal, and volunteers were aware of any risks.
- In terms of mental health, a piece of work with LPFT was underway to look at dual diagnoses, and meetings were being held at practitioner level to make the process smoother and more robust.
- If there was a need to escalate an issue, Addaction sat on the substance misuse delivery board which also involved a lot of key partners. There was also access to the health and wellbeing board. Members were advised that there was a governance structure in place if any issues with partners arose.
- It was requested that the Committee receive periodic updates on this service.

RESOLVED

1. That the comments made in relation to the report be noted.
2. That the Committee receive periodic updates on the work of this service.

41 BESPOKE BUSINESS ADVICE PROVIDED BY TRADING STANDARDS UPDATE

Consideration was given to a report which provided an update and overview following the introduction of chargeable advice to Lincolnshire businesses on 1 April 2016 by the County Council's Trading Standards Service. It was reported that Trading Standards was now able to offer many services to Lincolnshire businesses on a cost recovery basis including providing up to the minute advice on complex consumer legislation. Members were advised that since April 2016 the following levels of advice were available:

- General basic advice without charge up to one hour of a Trading Standards Officer's time to provide a general explanation of the law to help the business comply with the law

- Where a business requires more in-depth information and guidance or required detailed research an hourly charge of £58 (plus VAT) would be incurred.
- A Primary Authority Partnership was available for those eligible authorities and traded outside of the County. This was a national statutory scheme signed off by the secretary of state which allowed businesses to form a partnership with a single local authority. Qualifying businesses would receive an annually agreed package of advice and support charged at £58.00 per hour. Primary Authority also simplified how businesses could comply with the necessary regulations and helped Lincolnshire Trading Standards to engage better with businesses in Lincolnshire.

Members were advised that there was no price rise in 2015/16 and it was proposed to increase the charges to £60.00 per hour from 1 April 2017.

The Committee was provided with an opportunity to ask questions to the officers present in relation to the information contained within the report and some of the points raised during discussion included the following:

- It was confirmed that the advice provided to businesses was legally binding and it would also be put in writing to the business as well.
- There had been a need to restructure business advice service to ensure that there was a balance with the enforcement role.
- It was confirmed that Trading Standards was only able to charge an amount which enabled them to recover their costs. It was noted that this referred to all costs including accommodation, IT services and officer time.
- It was noted that the charge had not been increased for 18 months.
- It was requested the Committee could receive updates on this service in the future.

RESOLVED

1. That the Committee support the continuation of the business advice strategy service which commenced in April 2016.
2. That the Committee support the proposed price increase from 1 April 2017.
3. That further reports be received in the future.

42 FUNDING FOR SUPPORTED HOUSING CONSULTATION

The Committee received a report which provided the opportunity to consider and comment on government proposals for the future funding of supported housing.

It was reported that supported and sheltered housing supports tens of thousands of people across the country, including the elderly, homeless and those living with disabilities, to live independently and get their lives back on track. In September 2016, the Departments for Work and Pensions and Communities and Local Government outlined proposals to change the way that supported housing would be funded. The Government announced that a new system would be introduced in April 2019 and a formal consultation process was underway.

Members were advised that the consultation would run for 12 weeks until 13 February 2017 and a Green Paper on detailed arrangements for the local top-up model and approach to short-term accommodation would follow in the spring.

The Committee received a presentation which outlined the key elements of the proposals, and provided further information in relation to the following areas:

- Supported housing
- Groups of people in supported housing
- The government funding reform
- The key elements of the new proposals
- What next
- The consultation covers these key areas
- The impact for Lincolnshire

Members were provided with the opportunity to ask questions to the officers present in relation to the information contained within the report and presentation and some of the points raised during discussion included the following:

- It was clarified that 'older people with support needs' referred to those people in extra care, longer term care, residential homes and those with re-ablement needs.
- LCC invested £4m per year in supported housing related issues.
- It was requested whether the draft formal response could be sent to the Committee.
- It was commented that there was a short time frame for the consultation and it was queried how service users would be engaged with. Members were advised that this document had already been sent to a lot of providers to ask if they wanted to provide a response.
- It was suggested that there was a need for much closer working with districts, and it was noted that a co-ordinated response was expected from the districts on this consultation.
- Concerns were raised that a lot of service users were very vulnerable and so may not speak out if they did not agree with the housing association. Members were advised that there were engagement groups which service users would be able to feed into.
- Devolved responsibilities would come with devolved funding, and whether this would include funding for administration would be included within the response.

RESOLVED

That the Committee welcome the consultation and the authority's approach to a response.

43 COMMUNITY AND PUBLIC SAFETY SCRUTINY COMMITTEE WORK PROGRAMME

The Committee received a report which provided the opportunity for members to consider and comment on the content of the work programme for the coming year to ensure that scrutiny activity was focused where it could be of greatest benefit.

During consideration of the work programme, the following was noted:

- The Director of Public Health's Annual Report would be added to the agenda for the meeting on 9 March 2017.
- Re-commissioning of the Wellbeing service and Blue Light Collaboration Process were still in the planning stages
- There may be a requirement for an additional meeting in order to consider pre-decision scrutiny items prior to the Executive in March.
- An item on ARC would also be programmed in.

RESOLVED

1. That the work programme, as presented, be agreed.
2. That the above items be noted for inclusion on future agenda's.

44 SEXUAL VIOLENCE AND ABUSE

Consideration was given to a report which outlined the partnership approach to reducing sexual violence and abuse in Lincolnshire. It also provided information on what role Lincolnshire County Council would take in supporting and protecting the victims and tackling the perpetrators of this crime.

It was reported that sexual violence was a new priority, and there was now more high profile reporting. Some analysis had been carried out using police data and it was found that there had been a 55% increase in sexual violence and abuse offences in Lincolnshire between 2012 and 2014.

Members were provided with the opportunity to ask questions to the officers present in relation to the information contained within the report and some of the points raised during discussion included the following:

- It was acknowledged that the actual number of rapes which took place nationally was over 200,000 per year, based on only 11% being reported.
- Child sexual abuse would be dealt with by the safeguarding teams as they were very different issues and had different profiles in terms of perpetrators.
- It was queried what the actual figures were for the number of offences in Lincolnshire between 2012 and 2014, rather than a percentage. Officers agreed to circulate this information to the Committee.
- It was reported that a new team had been set up within the Police to engage with migrant groups. This was commissioned by the Police and Crime Commissioner.

- It was queried what legal duties there were on organisations/groups to require them to report to the authority if sexual violence or abuse was suspected. It was noted that this depended on the age of the person, as there were increased in relation to safeguarding if a child was involved. Safeguarding requirements were also within LCC's standard contracting terms.
- There was a time lag on the reported figures as the most up to date data was from at least two years ago.
- It was queried were the number of incidents would continue to rise as Lincolnshire's population grew.
- It was reported that one of the areas with an increasing number of incidents was the student population, but they would not be included as part of the census. It was noted that this issue was not unique to the University of Lincoln, but they were becoming a very important partner in this work.
- It was thought that these incidents were growing within the student population due to a combination of freedom, no parental supervision and access to alcohol.
- It was confirmed that the team also worked with colleges, and it was suggested that the team also contacted the Youth Council as well.

RESOLVED

That the comments made in relation to the report be noted.

The meeting closed at 12.50 pm

COMMUNITY AND PUBLIC SAFETY SCRUTINY COMMITTEE
1 MARCH 2017

PRESENT: COUNCILLOR C J T H BREWIS (CHAIRMAN)

Councillors L Wootten (Vice-Chairman), K J Clarke, R G Fairman, A G Hagues, C R Oxby, S L W Palmer, Mrs N J Smith and R Wootten

Councillors: N H Pepper, C N Worth and B Young attended the meeting as observers

Officers in attendance:-

Robin Bellamy (Wellbeing Commissioning Manager), Nick Borrill (Chief Fire Officer), Alina Hackney (Senior Strategic Commercial and Procurement Manager), Kevin Kendall (County Property Officer), Pete Moore (Executive Director, Finance and Public Protection), Daniel Steel (Scrutiny Officer), Dave Pennington (Development Programme Manager), Seiglinde Erwee (Principal Laywer) and Carl Miller (Commercial and Procurement Manager)

45 APOLOGIES FOR ABSENCE/REPLACEMENT COUNCILLORS

Apologies for absence from Councillor Mrs E J Sneath.

46 DECLARATIONS OF COUNCILLORS' INTERESTS

Councillor S L W Palmer advised the Committee that he was a LIVES First Responder and, when activated, was under the employment of the East Midlands Ambulance Service NHS Trust (EMAS);

Councillor C J T H Brewis declared that he was a member of the Sutton Emergency Team.

47 WELLBEING SERVICE RE-PROCUREMENT

The Committee considered a report which was due to be considered by the Executive Councillor for Adult Care, Health and Children's Services between 17 and 24 March 2017.

The Committee agreed to pass on the following comments to the Executive Councillor for Adult Care, Health and Children's Services as part of her consideration of this item.

- The Committee supported the involvement of the voluntary sector as part of the proposed arrangements and welcomed the proposals for fortnightly reviews to keep service users informed and reduce the volume of avoidable contacts querying how cases are progressing;
- The Committee highlighted concerns about the capacity of the proposed arrangements and highlighted the need to ensure planning was in place to allow for increased demand and growth on the service. Officers confirmed that a 2.5% increase in service capacity had been planned as part of the contract specification;
- The Committee queried the proposal not to recommission the home from hospital transport element of the current service and instead rely on NHS provision. In addition, the Committee queried how this change would impact residents who are required to access services outside of Lincolnshire. Officers confirmed that the service needs to be flexible in relation to the Lincolnshire patients it supports and additional that additional work would be undertaken with the NHS;
- A member of the Committee highlighted the need to ensure the proposed reduction in delayed discharge and better coordination of services was achieved as part of the re-procurement process. Officers highlighted the benefits of the preventative side of the Wellbeing Service in helping to reduce the need for hospital admissions, the work being undertaken in aiding hospital discharge and support provided to patients returning home;
- The Committee highlighted that one of the key challenges for this service had been identified in the report as limited accountability. A member of the committee queried the proposal to allow the new provider to sub-contract to other providers, highlighting that these arrangements had the possibility to further impact the level of accountability on service delivery. Officers confirmed that the new contract would provide a robust framework to hold the contracted provider to account, and that similar arrangements would be made between the contractor and any sub-contractors;
- A member of the Committee highlighted the need for any new provider to meet their obligations under TUPE arrangements. Officers confirmed that work was underway as part of the assessment process to ensure that TUPE obligations were met;
- A member of the Committee highlighted the twelve week generic support service support as part of the 'Description of Services' and queried whether this would work in conjunction with the newly formed new Neighbourhood Teams;
- The Committee highlighted concern in relation to the sub-contracting arrangements and the possibility that these arrangements could add an additional tier of management and bureaucracy to the service, and not result in a real-term saving to the County Council. Officers confirmed that as part of any bid, providers would need to demonstrate affordability as well as the ability to meet the agreed level of service;
- The Committee highlighted the need to maintain the level of involvement and contact with District Councils, CAB and other additional services as part of the new arrangements, in order to support and promote continued joined up working.

RESOLVED

1. That the Committee support the recommendations to the Executive Councillor as set out in the report;

2. That the comments made, in relation to this item, be agreed and passed to the Executive Councillor for Adult Care, Health and Children's Services.

48 BLUE LIGHT CAMPUS AND COLLABORATION AGREEMENT

Consideration was given to a report which was due to be considered by the Executive at its meeting on 7 March 2017. The views of the Committee would be reported to the Executive as part of its consideration of the item.

The Committee agreed to pass on the following comments to the Executive:

- The Committee supported the combination of three Blue Light Services at one location at South Park and the proposed co-location of Lincolnshire Police and Lincolnshire Fire & Rescue Command and Control Centre at Nettleham;
- The Committee highlighted the proposed Collaboration Agreement and queried how a potential withdrawal by one of the key service partners from the project would be handled. Officers confirmed that the agreement would put in place an appropriate Governance arrangement and that suitable provision will be included to cover the potential for early withdrawal;
- A member of the Committee queried how the proposed £4.8m investment could be justified at times of reducing budgets. Officers confirmed that the proposed investment would be capital expenditure, not from the day to day revenue budget and would allow longer term revenue savings to be achieved;
- The Committee recommended that sustainable construction methods be given consideration as part of the project, considering the energy efficient, water use and construction materials, etc;
- A member of the Committee queried the approval in June 2016 of a maximum financial contribution of £2m and noted the current £4.8m updated estimate. Officers confirmed that an additional £2.8m from the Capital Reserve had been approved by the Executive Director of Finance and Public Protection under delegated authority;

RESOLVED

1. That the Committee support the recommendations to the Executive as set out in the report;

2. That the comments made, in relation to this item, be agreed and passed to the Executive as part of its consideration of the item.

The meeting closed at 3.35 pm

This page is intentionally left blank

Lincolnshire COUNTY COUNCIL Working for a better future

Policy and Scrutiny

Open Report on behalf of Tony McGinty, Interim Director of Public Health

Report to:	**Community and Public Safety Scrutiny Committee**
Date:	**09 March 2017**
Subject:	**Annual Report of the Director of Public Health on the Health of the People of Lincolnshire 2016**

Summary:

The Annual Report of the Director of Public Health on the Health of the People of Lincolnshire is an independent statutory report to Lincolnshire County Council. The report raises issues of importance to the health of the population of Lincolnshire.

Actions Required:

The Community and Public Safety Scrutiny Committee is requested to receive the Annual Report on the Health of the People of Lincolnshire from the Interim Director of Public Health and consider 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.

As Interim Director of Public Health this is my first annual description of the state of the health of the people of Lincolnshire, and one I have enjoyed working with my colleagues to design and compile.

I decided this year to focus on the mental health and mental illness profile of local people. My decision was based on the principle best described as 'no health without mental health', which leads us to a definition of mental health as a resource, rather than simply a state involving the absence of illness or distress.

Good mental health is a valid goal in, and of, itself for individuals and communities to pursue. However, it is also a pre-requisite for people to achieve their goals and potential in life; to support their ability to make good choices and protect themselves from harm. Many different factors can support or challenge the mental health of individuals and communities, and these have more or less effect at different points in people's lives. For this reason my report is presented as a series of points along the average life-course, highlighting the risks and opportunities to mental health at each of these stages of life.

2. Conclusion

The statutory annual report of the Interim Director of Public Health on the health of the people of Lincolnshire has now been prepared and the Health Scrutiny Committee for Lincolnshire is asked to receive and note the recommendations included in each chapter.

3. Consultation

This is not a consultation item.

a) Have Risks and Impact Analysis been carried out??

No

b) Risks and Impact Analysis

n/a

4. Appendices

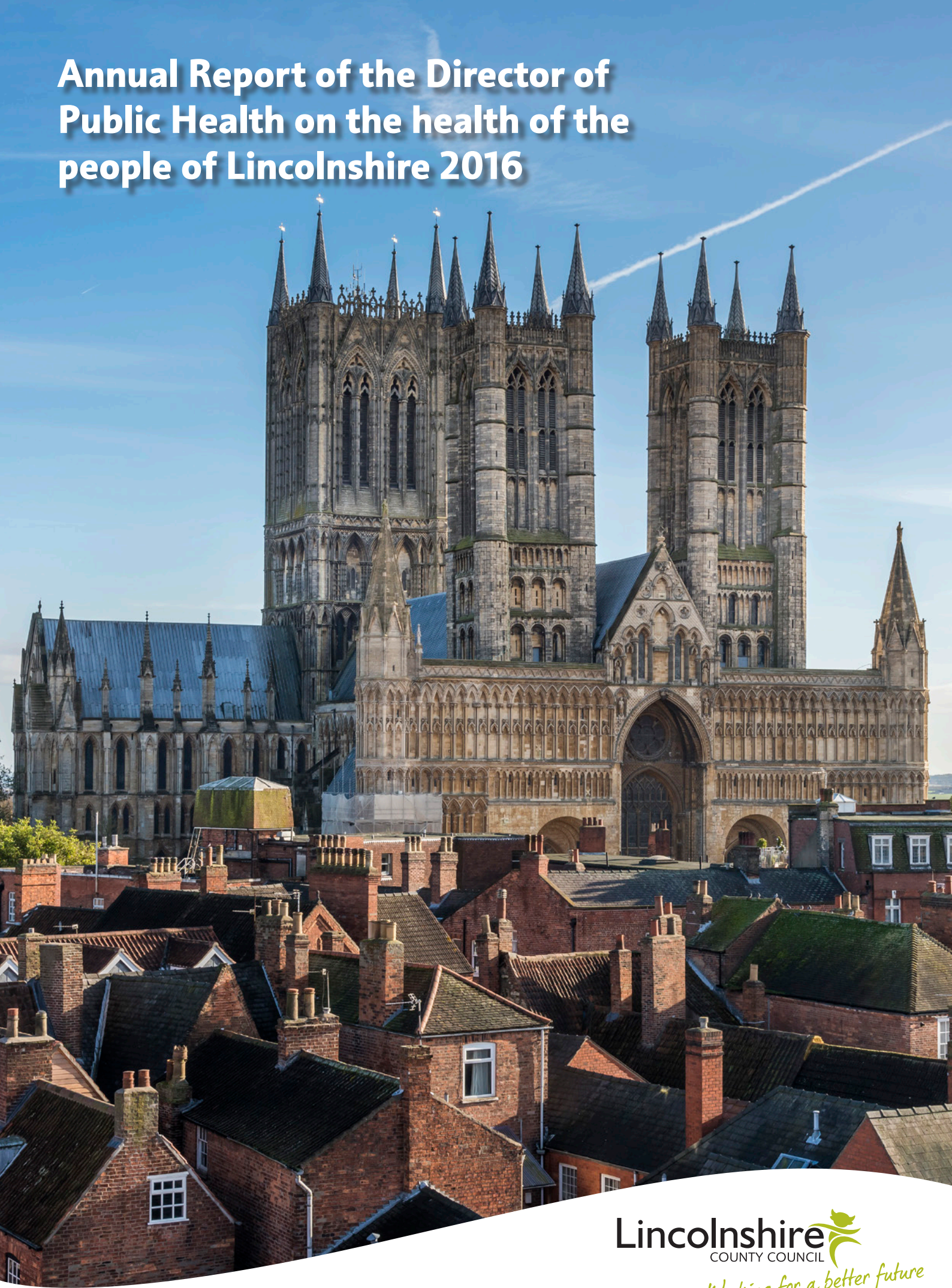
These are listed below and attached at the back of the report	
Appendix A	Annual Report of the Director of Public Health on the Health of the People of Lincolnshire 2016

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 Tony McGinty, who can be contacted on 01522 554229 or tony.mcginty@lincolnshire.gov.uk

Annual Report of the Director of Public Health on the health of the people of Lincolnshire 2016



Lincolnshire COUNTY COUNCIL

Working for a better future

Introduction

Welcome to this Annual Report of the Director of Public Health for Lincolnshire. As Interim Director of Public Health this is my first ever annual description of the state of the health of the people of Lincolnshire, and one I have enjoyed working with my colleagues to design and compile.

I decided this year to focus on the mental health and mental illness profile of local people. My decision was based on the principle best described as 'no health without mental health', which leads us to a definition of mental health as a resource, rather than simply a state involving the absence of illness or distress.

Good mental health is a valid goal in and of itself for individuals and communities to pursue. However, it is also a prerequisite for people to achieve their goals and potential in life; to support their ability to make good choices and protect themselves from harm. Many different factors can support or challenge the mental health of individuals and communities, and these have more or less effect at different points in people's lives. For this reason my report is presented as a series of points along the average life-course, highlighting the risks and opportunities to mental health at each of these stages of life.

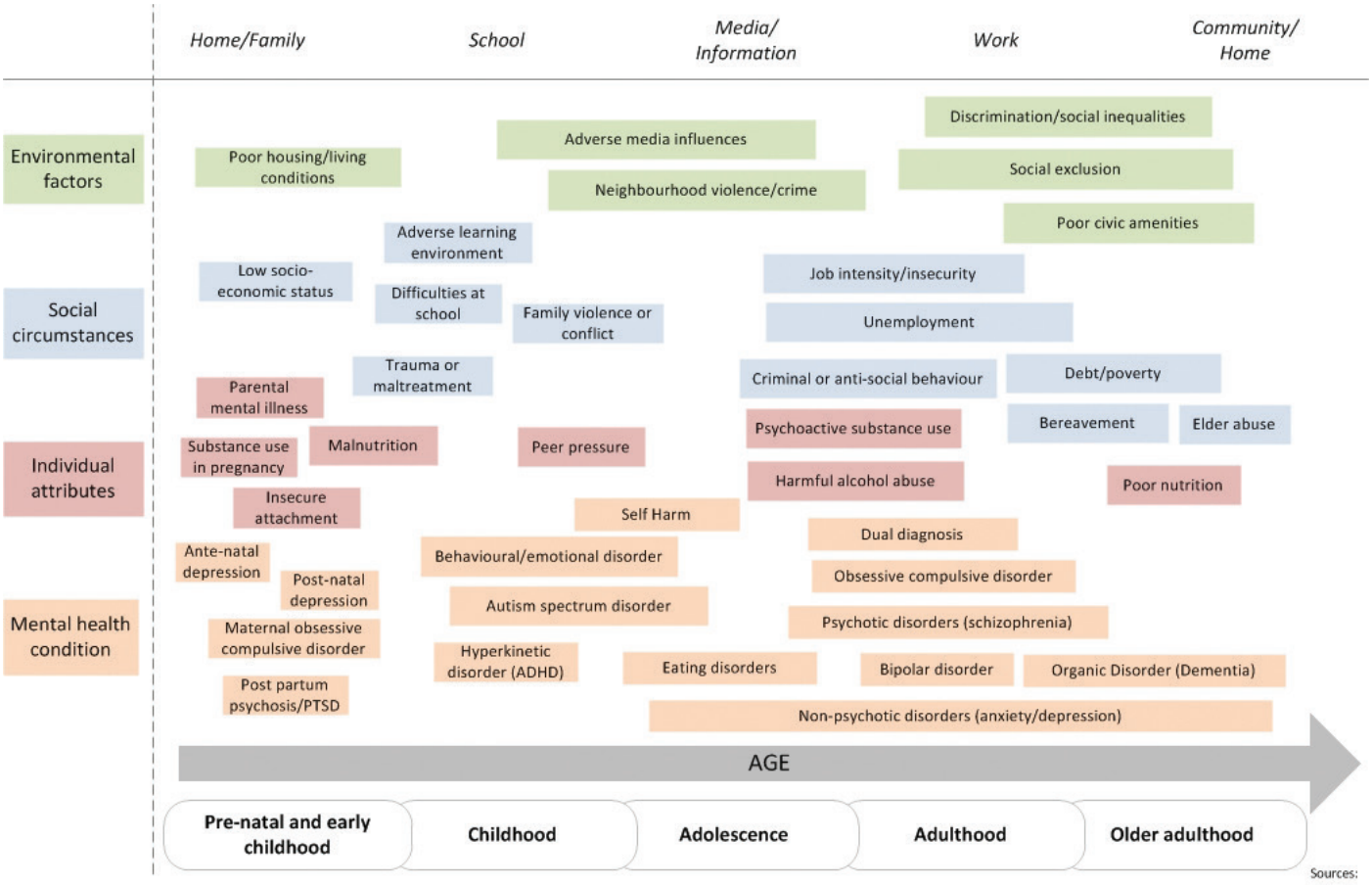
These are summarised in the table below and described more fully in each of the chapters presented.

I commend the report and its recommendations to the reader, and hope the reading will encourage you to think about your own mental health and that of those around you. For those of you who have a wider sphere of influence I trust that you will work with me to:

- applaud the things in Lincolnshire that already support mental health;
- reflect on the things that we could do more of, or be better at;
- ensure that we adjust what we do to make it as easy as possible for those of us whose mental health is challenged to get the best out of life.

Tony McGinty
Interim Director of Public Health

Figure 1: Mental health across the life-course – a framework for the ADPHR 2016/17



Sources:
World Health Organisation. Risks to mental health: An overview of vulnerabilities and risk factors, 2012
Djuretic, T. Mental Health in London, http://www.birmingham.ac.uk/schools/social-policy/departments/health-services-management-centre/news/2016/06/making-change-happen-for-mental-health.aspx
Maternal Mental Health Alliance - http://everyonesbusiness.org.uk/?page_id=6

Contents

Progress against last year's recommendations 4

Executive Summary 7

Chapter 1: Risk factors: What influences our mental health? 8

Chapter 2: Perinatal and maternal mental health conditions 16

Chapter 3: Childhood and adolescent mental health conditions 20

Chapter 4: Adult and older adult mental health conditions 25

Chapter 5: Recommendations 30

Glossary 31

References 32

Progress against last year's recommendations

In the 2015 Annual Report, the then Director of Public Health 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.

<table>
<tr><th>Recommendations</th><th>Update</th></tr>
<tr><td colspan="2">Data and Intelligence</td></tr>
<tr><td>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.</td><td>The Lincolnshire liver disease strategy group will look into the feasibility of liver disease being recorded in primary care data.</td></tr>
<tr><td>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.</td><td>A multi-agency, high level Lincolnshire liver disease strategy group has been set up to develop a county-wide liver disease strategy, which is working very closely with Public Health England.</td></tr>
<tr><td colspan="2">Awareness</td></tr>
<tr><td>3. National campaigns aimed at increasing the awareness of liver disease should be supported locally.</td><td rowspan="2">The launch of the Public Health England One You campaign, which is promoted locally, has encouraged over 4,700 people in Lincolnshire to engage with the campaign, either by completing the 'How Are You' self-assessment tool and/or downloading an associated support app (Oct 16). From this cohort, 21.9% of these people were not achieving the recommended levels of physical activity, 12.1% were smokers, 5.6% were drinking over the alcohol recommendations and 3.2% were not meeting the healthy eating recommendations for optimal health.
Lincolnshire County Council has begun engaging with partners across the county via the locality health and wellbeing networks, JSNA expert panels, events, various media channels and via the newly formed Health Improvement Partnership. As a result of the partnership we are able to form a collaborative response to national campaigns and are able to effectively utilise partners' communication channels. Commissioned services, and other willing organisations, are being encouraged to co-brand with One You to increase consistency and awareness of the initiative.</td></tr>
<tr><td>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.</td></tr>
<tr><td>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.</td><td>Liver disease is taught in medical curriculum.</td></tr>
<tr><td colspan="2">Early Detection and Treatment</td></tr>
<tr><td>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.</td><td rowspan="2">NHS Health Checks, which is primarily a vascular disease screening programme, has successfully recruited eligible people to engage with the Health Checks programme:
(Source – NHS Health Checks Annual Report 2015-16)
<table><tr><td>NHS Health Check</td><td>England</td><td>East Midlands</td><td>Lincolnshire</td></tr><tr><td>Offered (Invited)</td><td>56.4%</td><td>54.4%</td><td>60.8%</td></tr><tr><td>Received (Uptake)</td><td>48.4%</td><td>53.8%</td><td>57.3%</td></tr></table></td></tr>
<tr><td>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).</td></tr>
</table>

Recommendations	Update
	In terms of identifying overweight and obese adults within the Health Checks, the programme has identified more than 16,000 people as overweight (BMI 25+) and 6,500 as obese (BMI 30+) in Lincolnshire. Only 445 adults were referred to some form of weight management intervention (6.8% of the obese population referred on to services). This referral to weight management indicator is a low number and is being investigated further. Despite this low activity, GP based support and brief intervention is being documented (currently on an ad-hoc basis).
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.	The Public Health Immunisation Programme Officer will be tasked to investigate methods of promotion and targeting of HepB immunisations. Lincolnshire Integrated Sexual Health Services (LISH) already conducts thorough screening. This service sees many of the relevant target population and will monitor uptake of HepB immunisations within their services. This work will be supported through education and outreach work provided by Positive Health and The Terrence Higgins Trust, both significant partners within LISH. A new JSNA around HIV prevention for publication in 2016 will reference the need to utilise MECC and signpost to liver disease reduction measures. Newly commissioned substance misuse treatment services offer Hepatitis B vaccination and Hepatitis C screening, including pre and post-test counselling, to all those accessing services. Onward referrals are made for further testing and treatment as necessary and anyone who declines screening has the offer repeated at intervals throughout their recovery journey.
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.	Specialist substance misuse services provide individually structured support to everyone who accesses services; this includes harm minimisation advice and a personal recovery plan. The provider also offers Identification and Brief Advice training as well as a specialist hospital liaison service which is currently under development and will be available from February 2017.
12. The alcohol treatment services within local authority commissioning of substance misuse services should be of high quality and outcome based.	During 2016 re-commissioning of all specialist treatment services was undertaken by the local authority and a new contract commenced with Addaction in October 2016. This new service realises efficiency savings and provides Lincolnshire with a flexible, outcome based service to meet the current need and future changes in substance misuse trends. The new contract has a total of thirty outcomes spread over seven separate domains which are: • Freedom from dependence on drugs or alcohol • Improvement in mental and physical wellbeing • Prevention of substance misuse related deaths and blood borne viruses • A reduction in crime and re-offending • Sustained employment • Improved relationships with family members, partners and friends • Improved capacity to be an effective caring parent

Recommendations	Update
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.	The Health and Wellbeing Board has included outcomes relating to prevention, early identification and treatment of liver disease within its Joint Health and Wellbeing Strategy for Lincolnshire and they receive annual assurance reports relating to the progress of the strategy.
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.	The Public Health Division is actively involved with Public Health England policy reviews and regional forums. It is anticipated that a new substance misuse strategy including initiatives for alcohol will be released in February 2017 alongside new clinical guidelines for treatment services.
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.	This has become a national policy agenda with plans to implement a "sugar tax" on fizzy drinks. Little local advocacy or regulation has been undertaken.
16. A multi-agency obesity and overweight reductions strategy should be developed.	Obesity reduction forms a key part of the prevention programme that has been developed as part of the Lincolnshire Sustainability and Transformation Plan (STP). This is an all age strategy, although there is recognition that forming healthy life long habits are best begun during childhood. Therefore a multi-agency strategic action plan to reduce obesity in children through actions across health and social care, business and education is currently in development. A new model of children's health services due to be implemented in Lincolnshire in 2017 has elements known to promote healthy weight in childhood such as breastfeeding, a healthy start to eating and physical activity at its heart.
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.	A public health consultant has been allocated to work closely with each of the Council's Executive Director areas of service. They are tasked with supporting the delivery of the service areas' objectives, seek integration and influence these service areas to achieve maximum health gain.
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.	Lincolnshire Chamber of Commerce has been commissioned to establish Pubwatch schemes in all towns within the county in order to reduce anti-social behaviour (ASB) by driving those who cause problems in alcohol out of the night time economy. Pubwatch was also set up raise the standards of the bars within the scheme. In Boston a Community Alcohol Partnership has been set up in order to tackle underage drinking including point of sale through test purchasing activity and training for off-licenses, prevention education and investing in diversionary activities for young people in the local community. In Spalding and Lincoln a Public Space Protection Order has been set up in the town centre to prevent street drinking in parks and the town centres in order to reduce ASB related to alcohol.

Executive Summary

Good mental health is the cornerstone of the achievement of other life goals, and ultimately has an effect on the choices and opportunities people make about every aspect of their lives. In the pressure of day to day life, and the sometimes more urgent demands on local people and services the focus on good mental health as a resource is easily overlooked. It is for this reason that this Director of Public Health (DPH) Annual Report focuses entirely on mental health and illness in Lincolnshire.

In focusing on mental health and illness, this report is even more topical at publication than it was at inception, with the Prime Minister identifying the need for new energy in public services around mental health and illness. For some time now there has been focus in national and local policy on the comparatively low investment in mental illness services, through a focus on parity of esteem with physical conditions for example.

The need to have mental health crisis managed in a seamless fashion has also been a focus of development, with the development of local 'Crisis Concordats' and the service developments arising from them.

This report uses national and local data alongside research to set out what we know about mental ill-health in Lincolnshire, describing the scale of the problem, the risk-factors associated with mental ill-health, and the services in Lincolnshire that seek to prevent and treat ill-health. A 'life-course' approach has been used, focussing on specific populations grouped by age in order to understand how the influences on our mental wellbeing can change as time passes.

Mental Ill-Health in Lincolnshire

Mental ill-health is more common than many people think. Recent national research tells us that "1 in 4 adults will be diagnosed with a common mental disorder (such as depression or anxiety) during their lifetime"[1]. Many more may struggle with these issues without seeking help or meeting the threshold for a clinical diagnosis. We estimate that at any one time over 100,000 people aged 16+ in Lincolnshire are living with a diagnosed common mental disorder[2].

Of course, mental illnesses can be of varying severity, but for some the outcomes are tragic; we know that between 2011 and 2013 there were over 2,400 emergency hospital admissions for self-harm in Lincolnshire, and that every year since 1999 there have been at least 60 deaths in Lincolnshire from suicide.

For more than half of the estimated 100,000 adults in Lincolnshire with a common disorder, it is expected that their condition would have begun before the age of 14 years.

Nationally, 1 in 10 children and young people aged 5 to 16 have a clinical diagnosis relating to mental ill-health[3]. Improving and protecting the mental health of children and young people is thus crucial for ensuring a healthy, happy population across all ages.

Summary Statistics – Mental Ill-Health in Lincolnshire

- It has been estimated that over 3,000 Lincolnshire women per year have mental health problems during pregnancy and after childbirth[2];
- Over 9% of Lincolnshire's children aged 5 to 16 are estimated to have a diagnosed condition, similar to national rates. The national Child and Adolescent Mental Health Intelligence Network estimate over 9,000 children in Lincolnshire have a mental health disorder[2];
- Over 100,000 adults in Lincolnshire are estimated to have a diagnosed common mental disorder, such as depression or anxiety[2];
- Every year since 1999 there have been at least 60 deaths from suicide in Lincolnshire[2]

The Economic Cost of Mental Ill-Health

Nationally, mental ill-health has been estimated to cost the economy over £70bn per year[4]. "In Lincolnshire, the estimated cost to the economy of mental ill-health equates to at least £230m per year"[5]. In addition to the burden of population ill-health, there is a clear economic mandate to ensure people in Lincolnshire are helped to be as mentally healthy as possible.

Risk Factors

Although at an individual level anyone can suffer from poor mental health, across a population we are able to identify some factors which increase the risk of mental ill-health for some population groups. The start that babies in Lincolnshire get in life is crucial; we know that babies born into loving, supportive families tend to have better mental health as they grow up[6]. For children, the family environment is fundamental, and as they grow up the influence of peers and the school environment grow; and the potential for issues that damage mental health, such as bullying, grows.

As we all know, any child or adult can have good days and bad days when it comes to their mental wellbeing, but research tells us that negative life experiences; unemployment, grief and struggling to get by can vastly increase stress and affect our mental health[7]. These risk factors can 'accumulate,' especially in the lives of those at the margins of society, meaning that there is a known link between socio-economic deprivation and mental ill-health. These inequalities can be addressed through a combination of targeted and universal services that meet the population's health needs.

Chapter 1 Risk factors: What influences our mental health?

What Influences our Mental Health?
Our mental health, like our physical health, is something that can change throughout our lives; it is not a static state and can be influenced for improvement or deterioration at any time. Sometimes we have excellent mental health, and sometimes our mental health isn't so good. Research tells us that 1 in 4 people will experience a mental health problem at some point in their life and, at any one time, 1 in 6 adults have a common mental disorder. Our mental health is fundamental to our health in general, both influencing our physical health and being influenced by it[8].

Many different factors and circumstances affect how we think, how we feel, and our general level of wellbeing. Some of these factors relate to our environment, some to our social circumstances and some are individual characteristics. This chapter will take a closer look at these factors, emphasising both the risk factors that can undermine our mental health as well as the protective factors that can improve our wellbeing. In order to do this we will use a 'life-course' approach, where we will examine the factors that influence the mental health and development of young children, through school-age years and then into adolescence, working age and then eventually finishing with the factors that can influence the mental health of adults.

Birth and Early Years
The emotional and relational environment into which a baby is born has a fundamental effect on their neurological development. Put simply, a baby who receives positive, loving care and affection from the adults caring for them will develop with significant neurological differences from a child who experiences prolonged exposure to severe stress[9 10].The development of a baby's brain and nervous system has been said to depend 'as much on human relationship as it does on nutrition'[8]. Positive and secure attachment between baby and caregiver also results in healthy and positive emotional and social development, and can predict mental wellbeing and ill-health in adulthood[8 11 12 13]. Thus early childhood experiences can have a significant impact on mental health and wellbeing in later life.

Parental mental health can also be an important factor in the lives of young children. We know that parenting behaviour can have a real effect on the emotional and behavioural development of children[14] and that maternal distress can influence cognitive, social and emotional development[15]. Importantly, scientific studies have shown that children of mothers who experience depression show greater vulnerability to anxiety, depressive and conduct disorders[16]. So the environment we are raised in influences the degree to which we are vulnerable to mental ill-health from the beginning of our lives; conversely, it follows that children, who are raised in loving and supportive environments, may have less of these risk factors and perhaps a lower degree of vulnerability to mental ill-health as they grow.

Two Babies; Very Different Worlds
Imagine two babies born in Lincolnshire this year. The first baby is born into an environment where she gets loving care from her mum. Like any baby, she gets distressed and cries when she's hungry, needs changing, or is bored and wanting to play. But whenever she cries, someone is there to make it better. As she grows and develops she starts to trust that whenever she needs help, she will get it; a loving adult will help and the problem will go away.

And then we have another child, born into a situation where those around her aren't willing or able to help in the same way. If the lack of love and care is extreme, research tells us that clear developmental differences will be seen in the baby's brain. Importantly, we can't say that this means that the child will grow to have a mental illness, but it means that the risk of this is higher. Insecure attachment has been shown to predict depression, anxiety, and other mental health problems. This underlines the importance of providing the best start we can for babies and young children in Lincolnshire. When, as parents and carers, we are looking after our children in a positive and loving manner we are helping to improve their wellbeing and reduce their risk of mental ill-health in the future.

Children and Young People
Mental Health Surveys of children and young people in Great Britain have found that 1 in 10 children and young people under the age of 16 have a diagnosable mental disorder[17]. At this age, the family and parenting environment is still of primary importance, and the primary predictor of these diagnosable mental disorders remains parenting and the quality of the parent-child relationship[8]. Nonetheless, during the school years the child or young person's experience at school becomes a huge influence on their mental wellbeing.

Bullying
Children who have been victims of bullying have been consistently found to be at greater risk of being diagnosed

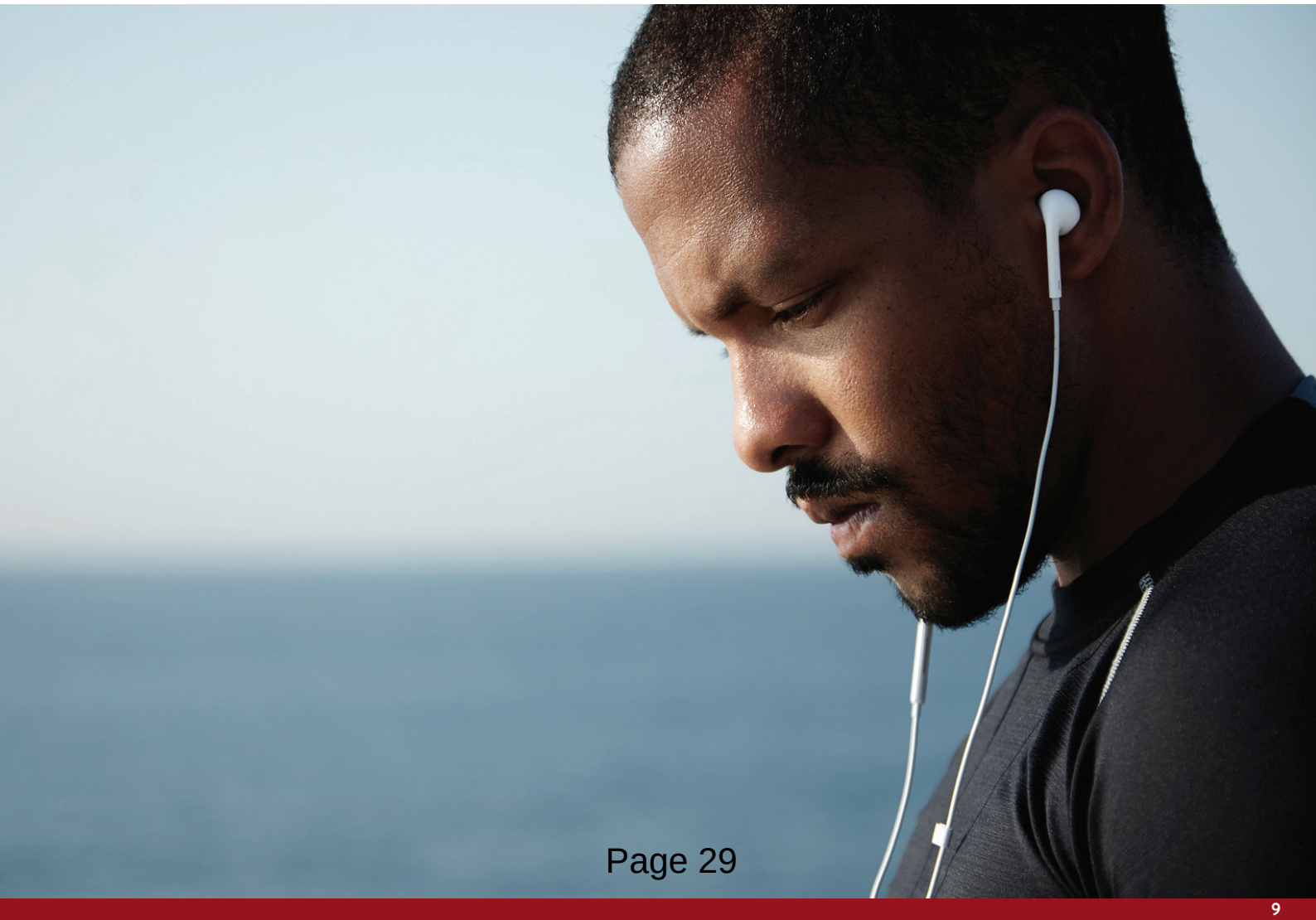
with depression or anxiety disorder at some stage before the age of 50[18] and being bullied has been linked to suicidality[19].Having excellent schools that prevent bullying and help children to develop to their full potential is fundamental to protecting and improving the mental health of children and young people.

Children and Young People with Learning Disabilities
We also know that children and young people with learning disabilities are more likely to experience mental health problems[20]. In Lincolnshire, a rough estimate would be that there are approximately 2,400 children and young people with a learning disability, of whom approximately 1,000 might be expected to suffer from a mental health problem, based on the size of the population in Lincolnshire[2].

Looked-after Children
Children who are looked-after by the local authority are another group who have a greater risk of mental ill-health than the wider population. In fact, evidence tells us that looked-after children are approximately 5 times more likely than their peers to have a diagnosis of a psychiatric condition[21].The most common reasons for children being taken into care are abuse or neglect, and it is known that children in these situations can experience significant trauma, and that this trauma can be linked to mental illness during childhood and in later years[22].

Adverse Childhood Experiences
Negative experiences in childhood can have an impact on all of us in later life. If those negative experiences are traumatic, it is understandable that this can be related to mental illness. Research tells us that adverse childhood experiences such as neglect or 'maternal antipathy' are linked to self-harm[23].We also know that those children with extremely negative experiences, such as homelessness and drug use, are likely to be depressed and also vulnerable to physical diseases such as AIDS and viral hepatitis[24]; 67% of rough sleepers aged 16 to 25 were found to have mental health issues in one study[25].

Adolescence
Moving from childhood into adulthood is a challenging time for all young people, where physical, social and emotional changes combine with the pressures of teenage life and the need to establish an identity as an independent adult. During this time, the influence of a young person's parents on their life diminishes (but remains important) and the influence of peers increases. In recent surveys of young people in the UK, mental & emotional health and wellbeing are consistently identified as priorities[26] [27].Adolescence is a time where all young people can experiment with different interests and behaviours, and where a degree of anxiety and confusion can be expected. However, it is known that a majority of adults with a diagnosable mental health condition identify that these conditions had



their genesis in childhood and adolescence[3]. Furthermore, in some cases, this can include experiments with alcohol, drugs and sex which come with their own distinct risks to mental and physical health.

A Tale of Two Teens

Risk factors for mental health often correlate strongly with socio-economic deprivation, but this is only true across a population; when we look at people, we find unique individuals, not populations. It isn't possible to make assumptions about who will suffer from poor mental health and who won't. Imagine a young person who has been through the care system; all of the available data tells us that this young person has a much greater risk of poor educational outcomes, of interacting with the criminal justice system, and of being out of work. But this young person, let's call her Aisha, despite the trauma related to the abuse that she's suffered, finds support from her social worker, her foster carers, and from a teacher at school who takes a special interest in her. This teacher starts lending her books, and she develops an interest in writing. She passes her English exams, and decides to stay in education after she's 16. Despite the challenges of her upbringing, she gets excellent results and wins a scholarship to a top university.

And then we have another teen, let's call him Ben. Ben is raised in an affluent household in Lincoln, and attends a top school. He is sporty, confident, and has a wide circle of friends. Both of his parents work and are high-flyers in their own careers. Ben is expected to do well in his exams; he has few of the risk-factors associated with developing a mental illness. But depression and anxiety are there beneath the exterior, as they are for many of us, and he feels increasingly isolated. Confused and unsure of where to turn, he experiments with substance abuse and starts to feel like his life is spinning out of control. It's not hard to see how, if he doesn't get the support he needs, this fairly normal 'low point' for Ben could deepen, and eventually, if he sought help, he could be diagnosed with a common mental disorder, such as depression. For some young people in Lincolnshire, we know that this path ends in self-harm or even suicide. The importance of schools, parents, social workers, the health service and all of us working together to prevent such an outcome is clear. For some young people in Lincolnshire, the stakes couldn't be higher.

Environmental Risk Factors – Mental Health and the Built Environment

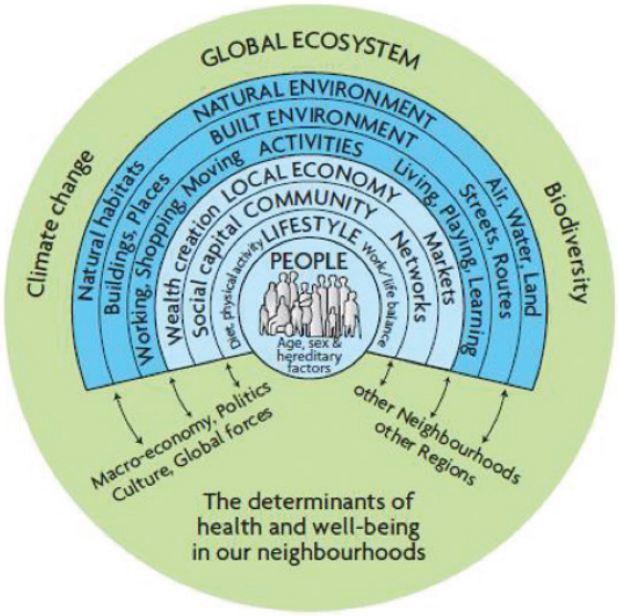
For all of us, the environment we live in can have a profound effect on our mental health. Evidence suggests that a range of features of the built environment have an impact.

The impact of the built environment on our mental health and wellbeing

Place and space have an impact on health and wellbeing. What's more, individual actions to improve lifestyle or health and wellbeing status are likely to be influenced by the context in which they take place; to put it simply, someone who has access to safe outside space may find it a lot easier to go out for a walk than someone who does not. When we think of the health impact of the built environment, we need to consider not only the physical structures in and around which we live our lives, but also the open space, networks and connectivity (such as roads, footpaths and cycle paths) between these places. We need to consider the places where people work, live, play and socialise. All of these shape the social, economic and environmental conditions in which we live our lives. These determinants of health are depicted in Figure 2 below.

Figure 2: The determinants of health and wellbeing in our neighbourhoods.

Diagram by Barton, H & Grant, M, 2006, derived from Whitehead, M & Dahlgren, G, The determinants of health and wellbeing, 1991.



What features of the built environment affect health and wellbeing?

In order to understand how the world around us can influence our mental health and wellbeing, it helps to unpick how this effect can operate. In a June 2011 report ('Steps to Healthy Planning: Proposals for Action'), the Spatial Planning and Health Group (SPAHG) suggested that several specific features of the built environment have an impact on both physical and mental health:

- the location, density and mix of land uses
- street layout and connectivity
- access to public services, employment, local fresh food and other services
- safety and security

- open and green space
- affordable and energy efficient housing
- air quality and noise
- extreme weather events and a changing climate
- community interaction
- transport and car dependency

It's important to note that these features of the built environment can have both a positive and negative impact on our mental health, and could thus be either a protective factor or a risk factor for mental illness. The places in which we live can make a real difference to how we feel, think and live our lives.

How does the built environment influence our health?
To help identify how the built environment influences our health (both physical and mental); we will consider some specific ways in which this happens.

Social networks, communities and isolation
The influence of social networks, our friends, colleagues and those we have a positive health connection with is an area of growing interest. Fewer social networks may be associated with a number of health outcomes including mental health problems[28]. Some neighbourhood designs enable or encourage community connections, whereas others do not. Neighbourhood designs most likely to promote social networks are those that are mixed use and pedestrian-oriented, enabling residents to perform daily activities without the use of a car[29]. Studies have shown that as traffic volumes increase, people's sense of neighbourliness decrease. In residential streets, people on 'light traffic use' streets considered the whole street to be their territory and reported more social networks than those living on 'heavy traffic use' streets[30]. The availability of parks and civic spaces also increases the potential for social interaction and community activities[31].

The evidence shows that cohesive communities foster better mental health through the creation of neighbourhoods and communities that are in control, and that pull together to shape the world around them. Evidence also shows that fostering and supporting social action, social inclusion and volunteering can improve wellbeing.

Local community groups, such as local voluntary groups, peer support services, user led self-help groups, mentoring and befriending etc., enable participants to be both providers and recipients of support. This allows members of a community to play an active role in their own wellbeing and that of their community[32].

Loneliness is a growing problem amongst older people. It is associated with poor health outcomes, specifically higher blood pressure, depression and higher rates of mortality comparable to those associated with smoking and alcohol[33]. Neighbourhoods that make it difficult for cohesive communities to form could increase isolation and loneliness; this can be a problem for those in rural areas, where distance can make it harder to visit friends and colleagues.

Long commuting times can also impact on mental health, family life and social networks, with people having less time for engagement in the lives of their communities[34].

Housing design and space
Adequate provision of space has also been linked to health outcomes. An association has been found between poor mental health and lack of space within the home as well as lack of social space for interaction inside and outside the home.28 Multi-occupation dwellings and flats, particularly high rise flats, are the types of housing most strongly associated with poor mental health[35].

Housing quality
Good housing is known to have a beneficial impact on maintaining mental health in general. Having secured and settled accommodation, together with the right type of support, can have a positive impact on people's lives. However, people with mental health problems are particularly likely to have poor and/or insecure housing and compared with the general population are four times more likely to say that their health has been worsened by their housing. Mental ill-health is common among people who experience homelessness and rough sleepers.

Based on an extensive literature review, and with input from expert environmental health practitioners, the Chartered Institute of Environmental Health (CIEH) produced a 'Health and Housing Resource' to provide evidence, case studies and guidance to enhance local understanding of the relationship between the home environment and health. The evidence for the mental health and wellbeing impacts of housing, especially poor housing conditions, is less developed than that supporting physical health impacts. However, there is some evidence of pathways that might link poor housing conditions to mental health outcomes. For example, living in poor housing conditions has been shown to increase stress, and reduce empowerment and control. Homelessness, lack of security of tenure and the fear of retaliatory eviction by landlords if tenants complain contribute to an individual's mental health and wellbeing. See table 1 for a breakdown of how the link between poor housing and poor mental health can operate.

Interventions that improve housing conditions have been shown to result in improvements on mental health measures, including reduced anxiety or depression, psychological distress, and improved patient reported health score[36]. Providing a warm home has been clearly shown to benefit both the young and old in relation to their feeling of wellbeing as well as reducing the physical risks that can arise from cold homes[37].

Table 1: Hazards and their mental health and wellbeing effects

Hazard	Mental health and wellbeing effect	Vulnerable groups
General Substandard Housing	Mental health – anxiety, depression ; Socio-emotional development; Disruption to education and impact on academic achievement.	25 years or less
Damp and Mould Growth	Depression and anxiety; Feeling of Shame.	14 years or less
Excess Cold	Depression and anxiety; Slower physical growth and cognitive development in children	65 years plus
Lead	Continual exposure at low levels has been shown to cause impaired cognitive development and behavioural problems in children.	Under 3 years
Crowding and Space	Psychological distress and mental disorders; Reduction of tolerance; A reduction of the ability to concentrate; Disruption to education and impact on academic achievement; Stress tension and sometimes family break-up; Lack of privacy.	
Entry by Intruders	Fear of crime; Stress and anguish.	
Lighting	Depression and psychological effects caused by a lack of natural light or the lack of a window with a view.	
Noise	Stress responses; Sleep disorders; Lack of concentration; Anxiety and irritability.	
Domestic Hygiene, Pests and Refuse	Emotional distress.	
Personal Hygiene, Sanitation and Drainage	Feeling of shame.	

Light
Levels of illumination, particularly the amount of daylight exposure, can impact on psychological wellbeing. An association has been found between depression and lack of adequate daylight[38].

Green space
Green space can help us have better mental wellbeing. There is evidence of preventive, physical, mental and social benefits of engagement with the natural environment for people suffering from mental illness and dementia. Less greenspace in a living environment is associated with greater risk of anxiety, depression, and feelings of loneliness and perceived shortage of social support. Contact with nature is linked with improved mood, and reduced stress and anxiety[39].

Natural England has developed an Accessible Natural Greenspace Standard (ANGSt) which provides local authorities with a detailed guide as to what constitutes accessible green space. The Accessible Natural Greenspace Standard not only recommends the distance people should live from certain types of green spaces but also recommends the size of the green spaces in conjunction with distance to homes. All people should have accessible natural green space:

- Of at least two hectares in size, no more than 300m (five minutes' walk) from home.
- At least one accessible 20 hectare site within 2km of home.
- One accessible 100 hectare site within 5km of home.
- One accessible 500 hectare site within 10km of home.

A study from MIND comparing groups taking part in two walks in contrasting environments, a country park compared to a shopping centre found that the group in the country park reported significant improvement in self-esteem, depression, anger, tension, confusion, fatigue compared to the group walking in the shopping centre[40].

Lincolnshire – ambitious for growth
Lincolnshire is a great place to live, and we know that the population is likely to grow in the future. In terms of the environment, Lincolnshire is a large, mainly rural county with many sparsely populated areas. The districts are characterised by market towns, villages and hamlets. The city of Lincoln is the largest urban centre but it is still small in comparison to other regional centres in the East Midlands, such as Leicester and Nottingham.

We know how important it is that there is enough housing in Lincolnshire for the growing population. New Local Plans with ambitious but realistic housing growth targets are being prepared across Lincolnshire to set out local planning policies in light of the National Planning Policy Framework (NPPF). It is expected that large parts of this growth will be accommodated in new communities built on to existing urban conurbations, known as Sustainable Urban Extension (SUEs).

This new national planning framework, the NPPF, refers to a healthy community as a good place to grow up and grow old in – something that we want to ensure is the case across Lincolnshire. To help ensure Lincolnshire's new communities are healthy, we can use research from elsewhere in the country to guide us as to how best to plan for this growth – see 'Learning from Cambourne's Story'.

Learning from Cambourne's Story
South Cambridgeshire has a number of existing and planned new communities. Research on one of these, Cambourne, found that early residents in these new communities had higher than average mental health problems. This was attributed to a lack of facilities in the new community (so-called 'new town blues'). The Clinical Commissioning Group and County Council produced a Joint Strategic Needs Assessment on new housing developments and the built environment. The local planning authority's Health Impact Assessment Supplementary Planning Document was a response to these findings. It is recommended that similar guidance is produced and adopted across Lincolnshire with plans progressing for central Lincolnshire in the first instance.

Rural Isolation
We know that lots of issues, which have the potential to result in poor mental health, are experienced by people living in rural areas, where distances can increase the chances of social isolation and compound the effects of poor-quality housing. There are recurring themes in the literature, which are applicable to rural settings as well as urban, suburban and market towns in terms of housing quality, social networks, car dependency, overcrowding, etc.[28]

Social Circumstances
We've seen how risk and protective factors for mental illness work across infancy, childhood and adolescence. We've considered how the environment, especially the built environment in which we live our lives, can influence our mental wellbeing. It's also important to consider the ways in which our circumstances throughout adulthood can affect our mental health, especially when seeking to understand how to best help those most at risk of self-harm and suicide.

We know that certain population subgroups are more likely to experience mental ill-health or attempt suicide. It's also clear that specific risk factors, or vulnerabilities, may operate in isolation or interact within individuals to further increase risk. For example, for an individual and amongst a population, unemployment can lead to lack of self-esteem, poor quality housing, and an increase in socio-economic deprivation. We will look at some risk factors in turn, starting with this – socio-economic deprivation.

i) Deprivation
We know that adults living in the most deprived areas are at a higher risk of poor mental health, as are their children[41]. Overall, Lincolnshire is less deprived than many areas in England, ranking 90th out of 152 local authorities in England, where 1st is the most deprivedxxxv. However, like any county in England, there are areas that are relatively much more deprived than others. We know that there are approximately 50,000 people living in areas in Lincolnshire that rank amongst the most deprived 10% in the country[42].

ii) Homelessness
People who are homeless are more than twice as likely to have a common mental health problem than people in the general population, and between 4 and 15 times more likely to have a psychosis. Serious mental illness is often accompanied by alcohol or substance misuse problems, and research suggests that between 10 and 20% of homeless people may suffer from such a dependency[43].
We know that in 2014-15 across Lincolnshire 646 people were accepted for housing support who identified as homeless. Over a third of these were in Lincoln and almost a further third in South Kesteven. The numbers of those living with insecure or unstable housing is far higher; in 2014-15, Lincolnshire managed 3,320 cases where a household was in danger of becoming homeless but this was avoided[44].

iii) Debts & Financial Problems
We can all worry about money at times, but people, who are really struggling, such as those with multiple debts, perhaps at high levels of interest, can experience mental and physical health problems as a result. For example, people with five or more separate debts are six times more likely to have a mental illness, and we know that difficulty repaying debt is a significant risk factor for suicide[45].

iv) Unemployment
We know that those in employment are at a lower risk of both mental and physical ill-health than those who are unemployed. However, in order to be protective of health, employment needs to be 'good' employment. This has been defined as work that offers a living wage, is sustainable, has opportunities for development and advancement, protection from adverse working conditions and allows a balance between work and family life[46]. Although unemployment in Lincolnshire is lower than the national average, across the county there are pockets of long-term unemployment and there are places, especially on the east coast, that have a high degree of seasonal employment – which in many cases cannot offer the security, sustainability, wages and work-life balance to protect health. Furthermore, unemployment among younger adults (aged 18-24 years) is higher than the national average in Lincolnshire. Lincolnshire also has a higher proportion of people not in work who are on long-term sick leave

compared with the East Midlands and England (26% compared to 23% and 22% respectively).[47]

v) Substance Misuse
Substance use (alcohol and drugs) and mental health problems often coexist, with a complex relationship existing between substance misuse and mental health. It is clear that substance use is a risk factor for the onset of mental health problems[48], and dependency on these substances can cause a wide range of mental and behavioural disorders. It is also true to say that people with mental health problems may use substances to manage their symptoms, for example to self-medicate the symptoms of depression or anxiety. However, substance use can also exacerbate these symptoms and may interact with medications used to treat conditions such as mood stabilisers and anti-depressants.

vi) Loneliness and Social Isolation
It is estimated that between 5% and 16% of over 65 year olds nationally have reported loneliness, while 12% reported social isolation.1 Both loneliness and social isolation can negatively impact on health and wellbeing, with high blood pressure and depression being closely associated amongst those who are lonely or who feel isolated.

Whilst there is no current data to identify loneliness or social isolation in Lincolnshire, we can provide a rough estimate using given national rates. Of the 159,953 over 65 year old residents living in Lincolnshire, we can estimate that between 8,000 (5%) and 25,500 (16%) are lonely, with a further 19,200 who feel isolated[2].

Groups at a Specific Risk of Suicide
In Lincolnshire, between 2011 and 2013 there were 184 deaths due to suicide. Although it is not always possible to identify specific people at a higher risk of suicide, we do know that there are certain population sub-groups who have a higher risk of completing suicide. We will examine some of these groups in turn[2].

1. People in Institutional Care or Custody
We know that certain groups have a higher risk of completing suicide than others, and this is certainly true for people in institutional care or custody, the rate of suicide and self-harm is much greater in the prison population that the general population. We also know that there are high levels of self-harm and suicide among detained asylum seekers, even when compared with the UK prison population[49].

2. People with Post-natal Depression
Suicide is the leading cause of death amongst new mothers in England. Key risk factors for maternal suicide in-

cluded severe onset of mental illness soon after childbirth, being an older mother and being relatively privileged in terms of social circumstances; which is important as it means that in this instance, it isn't necessarily people from more socio-economically deprived backgrounds who are most at risk[50].

3. People of Sexual Minorities

Lesbian, gay, bisexual and trans-gender (LGBT) people are at higher risk of suicidal behaviour, mental disorder and substance misuse and dependence than heterosexual people. This may be linked to experiences of homophobic discrimination and bullying, especially during the vulnerable adolescent years[51]. This is a large population across all ages, ethnicities and social groups, numbering (if estimates of 5-7% of the population are accurate) between 36,575 and 51,205 people who self-identify as LGBT in Lincolnshire.

4. Veterans

Young men who leave the armed forces can be 2-3 times more likely to complete suicide than members of the general population, which is especially important in Lincolnshire as there are a large number of armed forces and ex-armed forces personnel in the county. Although it is also important to note that men aged 30-49 years who leave the armed forces have a lower risk of suicide than in the general population[52].

5. Students at University and College

Students make up approximately 3% of the Lincolnshire population (about 23,000 people). In the past 12-months there have been three suicides in the student population in Lincolnshire, ii which represents a higher rate than in the general population. In recent years the University of Lincoln has reported an increasing number of students seeking support for mental health and complex mental health needs through the University's Student Wellbeing and Mental Health Service.

6. People Bereaved by Suicide

Research suggests that there is an increased risk of suicide in mothers bereaved by the suicide of an adult child, and in partner's who have been bereaved by suicide. There is also a higher risk of a range of other mental health issues for people bereaved by suicide[53]. It is important to ensure mental health services are able to support those people who are bereaved by suicide, in order to help to reduce the future burden of mental ill-health and suicide mortality.

7. People who Have Self-harmed

Self-harm is something that has a high degree of stigma attached to it. It is considered to be shameful, something that people don't like to talk about. We know that there is an increased risk of suicide following self-harm episodes, and this could be as high as a 30-fold increased risk of suicide compared with the general population[54]. Suicide rates have been found to be especially high in the six months after a self-harm episode, suggesting that early intervention after an episode of self-harm may be important to reduce the risk of suicide[54].

Summary: Interaction of Risk Factors

"Sorrows come not in single spies, but in battalions" - William Shakespeare

This overview of the risk factors for poor mental health in childhood and adolescence highlights the complexity of the influences on our mental health. Put simply, there is clear evidence linking negative experiences throughout childhood and adolescence with a higher risk of mental ill-health. In adulthood, the built environment and the circumstances of our lives can influence our mental and our physical health. Unfortunately, these risk factors are not always evenly distributed throughout the population, specific people and groups of people can experience many of these risk factors at the same time. Specifically, we know that many of these risk factors can affect those in the most deprived groups; the unemployed, for example, who perhaps live in the areas of Lincolnshire with the lowest-cost housing and consequently have the highest degree of exposure to environmental risk factors.

Summary: Risk Factor or Protective Factor?

When considering how to improve the health of the population, it can seem daunting when we consider the wide range of risk factors that can influence our mental health, but intuitively this makes sense. We know that fundamentally, life can affect us negatively. For some, this may simply affect their sense of wellbeing. For others, it may coincide with the onset of a mental illness. But it is also critical to see these factors as potential protective factors. If we can improve the level of good employment in Lincolnshire, or increase the degree to which our communities are cohesive, or positively influence any of these risk factors, we will be potentially helping to protect the mental health of the population of Lincolnshire. With the wide range of factors that can influence our mental health, there are correspondingly a wide range of actions we can take to improve our health. The challenge for us is to ensure we take the actions that help the most.

Recommendations

Policy statements and actions to inform place based health proprieties that give:

- clear reference and commitment to access to green space in development and regeneration policies for Lincolnshire neighbourhoods.
- clear reference and commitment to community space availability, both safe informal spaces like pubs and seating areas and buildings where communities can come together in more organised groups.

Chapter 2 Perinatal and maternal mental health conditions

Definition of the Problem
Mental health problems that affect women during pregnancy and the postnatal period (defined as up to one year after childbirth) are known as perinatal mental health conditions. Mental health problems occurring during the perinatal period can range from symptoms which do not meet the threshold for clinical diagnosis (subthreshold) to severe mental illness.

Women going through pregnancy and childbirth can experience the same mental health problems as the general population but it is particularly important to address them during this period. The mental health of the mother has a far reaching effect on the foetus, baby, the wider family and mother's long term health. Problems are not always disclosed, recognised or treated during this period, making general awareness, normalisation of the problem and assessment by professionals at each contact extremely important.

Depression and anxiety are the most common mental health problems experienced during the perinatal period[55].Additionally, women with existing mental health problems can be at increased risk; for example, women with a history of bipolar disorder are at increased risk of relapse in the postnatal period.

The health of a baby is crucially affected by the mental health and wellbeing of its mother and wider family. Maternal mental health problems can affect the quality of the mother-baby relationship, which is necessary for secure attachment and good development of the child. In babies and toddlers, healthy social and emotional development is essential to prevent behavioural problems and mental illness later in life and support educational attainment. It is recognised that some fathers have mental health problems during this period that may have similar effects upon the whole family, but in measuring the scale of the problem, most studies refer to women only.

NICE defines attachment as:
"A secure relationship with a main caregiver, usually a parent, allowing a baby or child to grow and develop physically, emotionally and intellectually. Babies and children need to feel safe, protected and nurtured by caregivers who identify and respond appropriately to their needs. Unmet attachment needs may lead to social, behavioural or emotional difficulties, which can affect the child's physical and emotional development and learning."
NICE. Looked-after children and young people. NICE guidelines (PH28). London: National Institute for Health and Clinical Excellence, 2010. Available from: www.nice.org.uk/guidance/ph28

The individual and societal cost of mental health problems in young families are reflected in economic analysis. The average cost to society of one case of perinatal depression is £74,000, of which £23,000 relates to the mother and £51,000 relates to the impact on the child. This is likely to roughly double for each episode of perinatal psychosis[56].

What is the Size of the Problem for Lincolnshire?
"It is estimated that between 10% and 20% of women are affected by mental health problems at some point during pregnancy or the first year after childbirth[57]."

Based on the number of women giving birth each year in Lincolnshire, we would estimate the following numbers of women to suffer a diagnosed mental health problem in the perinatal period. Please see glossary for definitions of each mental health condition mentioned in the table. These estimates are based on national estimates of the conditions and have been rounded up to the nearest five. They do not take into account differences in population groups or anything else which is likely to cause local variation. Without local data, we cannot detect differences between smaller geographical areas or groups within Lincolnshire. Therefore it is useful to consider this information alongside the chapter on risk factors to understand which groups may be more vulnerable to perinatal mental health problems.

Table 2: Estimated number of Lincolnshire women with mental health problems during pregnancy and after childbirth (2015)[58 59]

Diagnosed mental health condition	Estimated number of women affected
Postpartum psychosis	16
Chronic serious mental illness (SMI)	16
Severe depressive illness	234
Mild-moderate depressive illness and anxiety	Between 781 – 1,171
Post traumatic stress disorder (PTSD)	234
Adjustment disorders and distress	Between 1,171 – 2,342

N.B. Adding all these estimates together will not give an overall estimate of the number of women with each mental health condition, as some women may suffer with more than one condition.

Suicide risk

Whilst there is no local data available for Lincolnshire, the latest report from Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) Saving Lives, Improving Mothers' Care (2015)[60] reported that between 2011-13, almost a quarter of women who died between six weeks and one year after pregnancy in the UK died from mental-health related causes, and that 1 in 7 of these died by suicide.

The care of more than 100 women, who died by suicide during pregnancy, or in the year after giving birth, between 2009 and 2013, was reviewed in detail. The report warns that although severe maternal mental illness is uncommon, it can develop very quickly in women after birth; the woman, her family and mainstream mental health services may not recognise this or move fast enough to take action.

The care for women with substance misuse problems and those living socially complex lives was also reviewed. The messages for future care echoed those for women with mental health problems, including the need for joined up multi-agency care to ensure that these women do not fall through the cracks between services.

Figure 3: Post-Traumatic Stress Disorder in Lincolnshire

Who is most at risk of perinatal mental health conditions in Lincolnshire?

Attachment disorder

Secure attachment forms the building block of good mental health and wellbeing for both mother and baby and is essential for children's healthy development. The presence of mental health problems, even low level anxiety and depression (which may go undetected) can interfere with good parent-child bonding.

There is no reliable data available on parent-baby attachment, but it is important to consider the risk factors that can lead to attachment problems. These are discussed below and throughout the other chapters in this report.

Domestic violence and abuse

There appears to be a link between domestic violence and antenatal depression, postnatal depression, anxiety and post-traumatic stress disorder (PTSD), although it is not clear whether domestic violence actually causes mental health problems or simply that the two often go hand in hand because people are more vulnerable[61]. Although we cannot say that it causes maternal mental health problems, domestic violence in groups within our population are likely to predict higher levels of perinatal mental health problems. Pregnancy is known to be a potential trigger. Almost one in three women, who suffered domestic abuse during their lifetime, report that the first incidence of violence happened while they were pregnant[62]. Living in a household with domestic violence is also a risk factor for poor mental health in babies and toddlers[63].

Lincolnshire does have slightly lower levels of reported domestic violence; 14.1 incidents per 1,000 population compared to 16.1 for the East Midlands and 15.6 nationally. Offering adequate support for parents suffering domestic abuse is a good opportunity to prevent further mental health problems within the family.

Poor social support

Women who lack social support have been found to be at increased risk of antenatal and postnatal depression[64]. Having a poor relationship with a partner is also a risk factor for postnatal depression[7]. The number of births which were registered by the mother alone may give an indication of the number of mother and babies who lack the support of the father during transition to parenthood. In Lincolnshire in 2014, there were 425 sole registrations (5.5% of all births, which is similar to the England average of 5.4%).

Parents with a drug and alcohol problem

Those with mental health problems are more likely to misuse drugs and alcohol and vice versa. Within Lincolnshire, the number of pregnant women entering treatment services for drug and/or alcohol misuse is low, with year-end figures reducing from 20 in 2014/15 to 9 in 2015/16. When shown as a proportion of all women in treatment, the latest figures throughout 2015/16 show 1.8% of women in treatment were pregnant at the start of treatment,

which is lower than the 2.4% seen nationally. This shows a decrease on the 3.9% of women who were pregnant at the start of treatment during 2014/15, when the Lincolnshire rate rose higher than the national average of 2.3%[65].

Table 3: Percentage of women in Lincolnshire who were recorded as pregnant at the start of treatment [65]

	2013/14	2014/15	2015/16
Total females in treatment	498	514	500
Females pregnant	10	20	9
% pregnant	2.0%	3.9%	1.8%
England average	2.3%	2.3%	2.4%

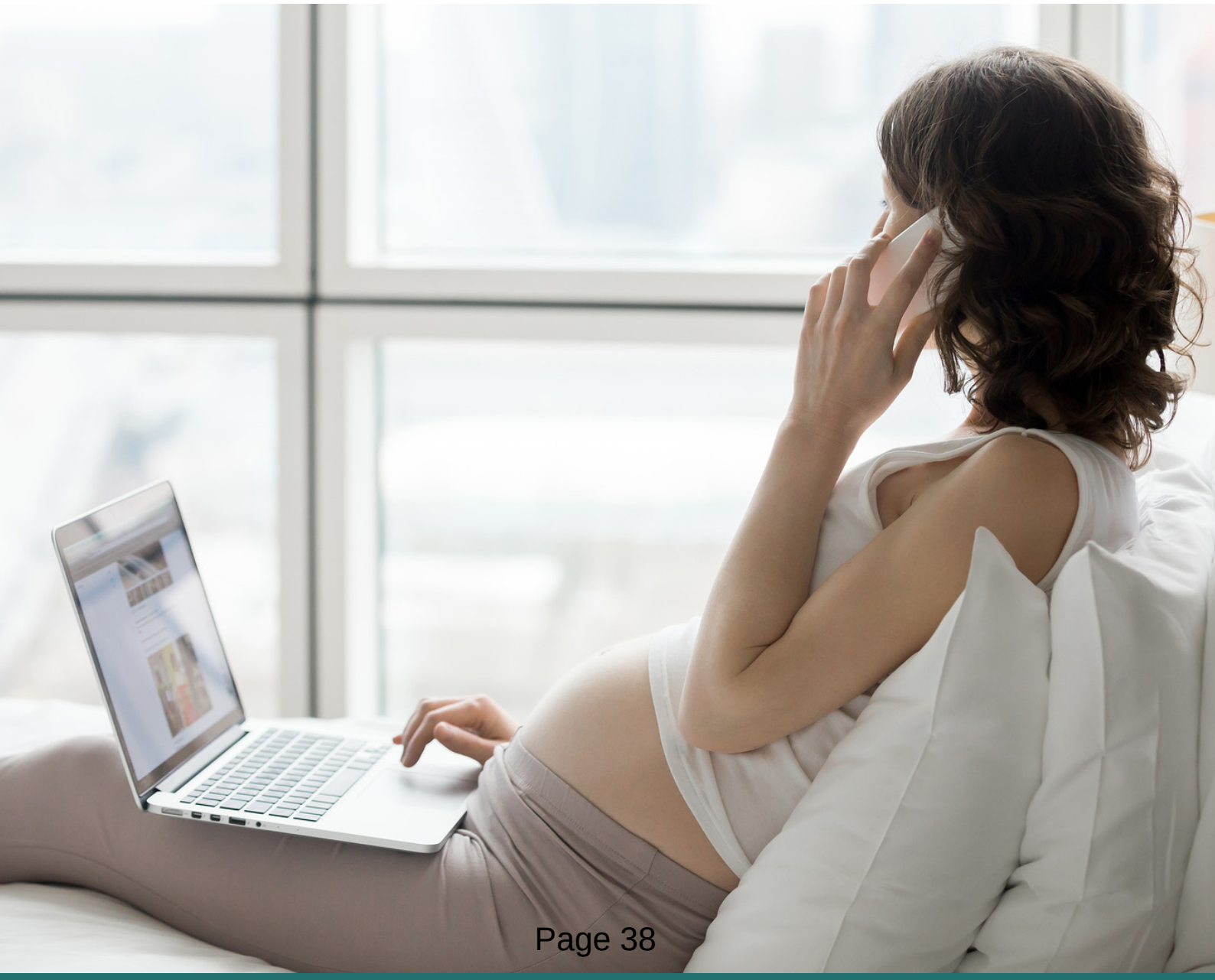
It should be noted that these figures only include those women who started a new treatment journey between the 1st April and 31st March of the respective year and will not include any that still remain in their existing course of treatment for over a year.

Teenage parents

Pregnancy in under-18 year olds is linked to poorer health and social outcomes for both the mother and child; for example, lower educational attainment, emotional and behavioural problems, maltreatment or harm, and illness, accidents and injuries[66].The vulnerability of young parents can make them more susceptible to many of the risk factors for mental health problems that have already been described. Teenage mothers are more at risk of developing postnatal depression than average[67]. Lincolnshire teenage pregnancy rates have fallen rapidly in recent years, from 50.1 to 22.4 per 1,000 births in 2014 and remain similar to the England average[68].

Family homelessness

454 families in Lincolnshire containing children or a pregnant woman were homeless in 2014/15[69]. Babies and toddlers that live in families that are homeless are vulnerable to poor social and emotional wellbeing and even developmental function[70].As described in the National Society for the Prevention of Cruelty to Children (NSPCC) report 'An unstable start', providing high quality care can be extremely difficult for parents who are homeless,



notwithstanding the additional stress that impacts on the mother-child relationship. The Lincolnshire rate (1.4 per 1,000 households) is slightly higher than the East Midlands average (1.3 per 1,000), but lower than the England average (1.8 per 1,000)[44].

What do we have that works well for Lincolnshire people?

Assets & protective factors

Informal support networks such as family, friends and groups such as mother and baby or toddler groups, are invaluable in supporting people through the transition to parenthood and managing with the demands of family life. Accessing these is likely to have a positive effect on mental wellbeing and resilience, although it is acknowledged that some groups within the population, such as young parents, those in isolated rural areas, with low incomes, parents with disabilities and long term conditions, may need additional support to access these. The new 0-19 children's health services (public health nursing) include an antenatal education programme, open to all women, which are hoped to help develop peer networks for support.

Lincolnshire benefits from a large network of children centres that support children and families. Early Help Workers deliver a range of evidenced based programmes addressing home conditions, budgeting or parenting to help the family prepare practically and emotionally for the birth, one to one at home or in a group. For pregnant teenagers there is a Young Expectant Parent (YEP) programme, supported by the use of virtual babies. Learning from the Family Nurse Partnership programme is being embedded in the new services to support families with children aged 0-19 years, with enhanced support planned for young and vulnerable parents.

Services

All contacts with pregnant women include assessment of mental health in accordance with NICE guidance.55 Women have access to the same psychological therapies as the general population through self-referral, or via their GP or other health professional, in addition to specialist perinatal mental health services. The Perinatal Mental Health Services (PERIMNS) provides assessment, support and treatment for childbearing women with, or at risk of, serious mental illness who cannot be managed effectively by primary care or other mental health services, as well as advice and assistance to other professionals on the treatment and management of serious perinatal mental illness.

Additional targeted services such as 'Birth after thoughts' (Lincoln based) support women who have had a service difficult or traumatic delivery, and a United Lincolnshire Hospitals Trust (ULHT) service which works with families in the event of a miscarriage/stillbirth or neo-natal death.

Where are the gaps?

We know the number of women, who are treated for severe post-natal depression, but we lack information on the number of women who suffer from 'lower' level post-natal depression and the ability to separate out those who seek and go on to get help and those who may not get the support they need.

Recommendations

- Women should continue to be assessed for mental health problems at every contact with a health professional and throughout a child's early years.
- Low level support should be maximised through upskilling of Health Visitors and developing peer support networks, meaning that a lower number of women will need onward referral to specialist services.
- All professionals who come into contact with women during the ante and postnatal periods should ask about substance misuse, especially in women with known mental health problems, and refer on for additional support where needed.
- Evidence based support for low level or undiagnosed mental health problems should be made available through early years' pathways to improve maternal and child mental health.
- Data to find out the level of need should be collected through local surveys and/or by professionals who come into contact with pregnant women and young families.
- Women and families should be signposted to informal support where appropriate and awareness of the common nature of mental health problems should be raised in all groups who work with families and young children.

Chapter 3 Childhood and adolescent mental health conditions

Definition of the Problem
Common mental health problems affecting children and young people include conduct disorders, anxiety, depression and hyperkinetic disorder (severe attention deficit hyperactivity disorder often known as ADHD). A national survey published in 2004[17] reported that "one in ten children and young people (10%) aged 5–16 have a clinically diagnosed mental disorder: 4% an emotional disorder (anxiety or depression); 6% a conduct disorder; 2% a hyperkinetic disorder, and 1% a less common disorder (including autism, tics, eating disorders and selective mutism). Some children (2%) had more than one type of disorder." The rates rise sharply in mid to late teens, with the type of disorder becoming more similar to those seen in adults.

Children and young people with mental health problems represent some of our most vulnerable people. Emotional and behavioural problems in early life are predictors of poor outcomes in later years, and can lead to mental health problems. Over half of all mental ill-health starts before the age of 14 years, and 75% have developed by the age of 18 years[71].

The costs to society of treating mental health problems are high. A recent report conducted by the London School of Economics found that for young people aged 12–15 at baseline assessment, mental health-related costs over the following three years averaged £1,778 per individual per year; 90% of this cost fell to the education sector, with the remaining cost divided between health and social care. Fewer young people with mental health problems were in employment and training; more were in receipt of benefits and/or in contact with the criminal justice system than their counterparts without mental health problems[72].

The costs to individuals are high in terms of reduced life chances. Young people with mental health problems have worse physical health, their educational and work prospects and their chances of committing a crime and even the length of their life are reduced[73]. Among young people aged 11–16, those with an emotional disorder are more likely to smoke, drink and use drugs than other children.1

Of great concern is the rise in the number of children and young people identified with a mental health problem in recent years. Reported rates of "depression and anxiety among teenagers have increased by 70% in the past 25 years[74], the proportion of 15/16 year olds reporting that they frequently feel anxious or depressed has doubled in the last 30 years (from 1 in 30 to 2 in 30 for boys and 1 in 10 to 2 in 10 for girls)[75], emergency department presentations due to self-harm by those aged 17 and under have risen by 30% since 2003-04"[76]. Young Minds, a UK charity committed to improving the emotional wellbeing and mental health of children and young people identifies the following threats to children and young people's mental health[77]:

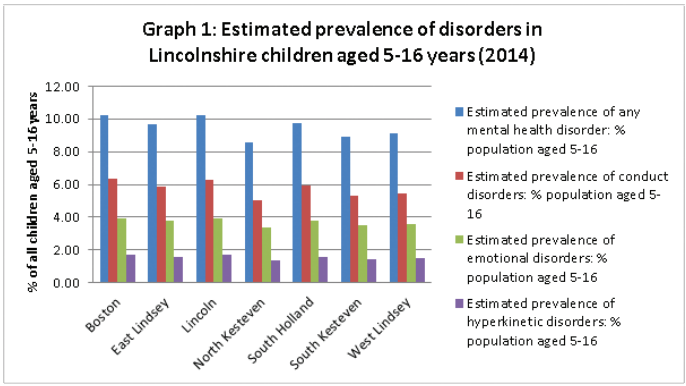
- Family breakdown is widespread
- There is so much pressure to have access to money, the perfect body and lifestyle
- Materialist culture heavily influences young people
- 24 hour social networking and what young people can access from a young age can have a negative impact on their mental health and wellbeing
- Body image is a source of much distress for many young people
- Bullying on and offline is rife
- Increasing sexual pressures and early sexualisation throw young people into an adult world they don't understand
- Violence is rife in many communities and fear of crime a constant source of distress for thousands of young people
- Schools are getting more and more like exam factories; university entry has become more competitive and expensive
- 13% of 16-24 year olds are not in employment, education or training (NEET)

What is the size of the problem for Lincolnshire?
Estimates of mental health problems in children and young people in Lincolnshire is taken from national surveys undertaken in 1999 and 2004[17], since there is no local data available.

Public Health England Children's and Young People's Mental Health and Wellbeing profiling tool calculates local estimates of prevalence for 2014. Some key findings for Lincolnshire are:

- The estimated prevalence of any mental health disorder: % GP registered population aged 5-16 is 9.3% for England, with East Midlands and Lincoln marginally higher at 9.4%. The range across the county shows Boston and Lincoln highest at 10.2% and North Kesteven lowest at 8.6%.

Graph 1: Estimated prevalence of disorders in Lincolnshire children aged 5-16 years (2014)



- Child admissions for mental health: rate per 100,000 aged 0-17 years for England is 87.4, East Midlands is lower at 83.3. Lincolnshire is moderately higher at 94.8.

- The emotional wellbeing of looked after children: average score for England is 13.9, East Midlands and Lincolnshire slightly higher with 15.5 and 15.3 respectively.

The National Child and Maternal Health Intelligence Network's CAMHS Needs Assessment estimates that in Lincolnshire in 2014-15:

- 3,410 children aged 5-10 years and 5,325 children aged 11-16 years have mental health disorders
- 2,210 children aged 5-10 years and 3,075 children aged 11-16 years have a conduct disorder, (e.g. awkward, troublesome, aggressive and antisocial behaviours)
- 1,050 children aged 5-10 years and 2,360 children aged 11-16 years have an emotional disorder. (e.g. anxiety and depression)
- 750 children aged 5-10 years and 670 children aged 11-16 years have a hyperkinetic disorder, (involving inattention and over activity)
- 565 children aged 5-10 years and 575 children aged 11-16 years have a less common disorder, (e.g. Autistic Spectrum Disorder and multiple disorders)

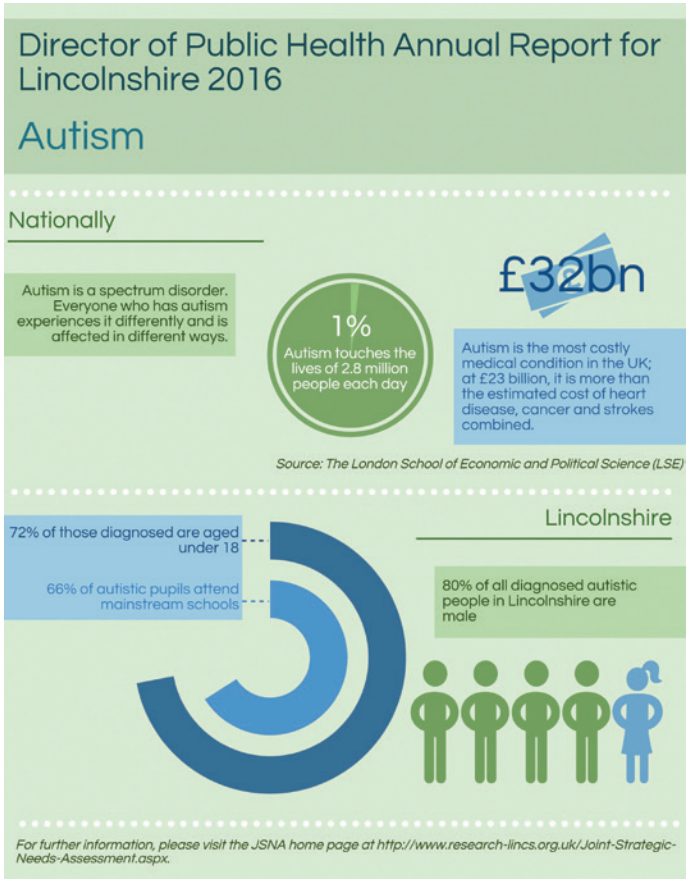
The total number of referrals to Lincolnshire Child and Adolescent Mental Health Services (CAMHS) between April 2015 and March 2016 was 4,427. This number does not represent single individual cases but includes some individuals with more than one condition requiring CAMHS intervention, or repeat referrals during the year. It is important to remember that a large proportion of children and young people with mental health needs will have been seen in universal services provided by practitioners who are not mental health specialists (e.g. GPs, health visitors, or school nurses); only those requiring more specialist support may have been referred to CAHMS.

Suicide is the leading cause of death in young people nationally. In Lincolnshire there were 4 confirmed cases of suicide and 2 suspected cases of suicide between September 2011 and January 2014 amongst under-eighteens. Risk factors include being male (up to three times more males than females complete suicide), previous self-harm and mental health problems[78]. Young people who complete suicide are less likely to be in contact with mental health services compared with adults (14% vs 26%). We also know that young men, who are more likely to complete suicide, are less likely to be in contact with mental health services than young women[78].

In Lincolnshire, the number of hospital admissions as a result of self-harm in people ages 10-24 years in 2014/15 was 500, giving a rate that is similar to the national average[79]. A Healthwatch survey of 1,251 young people in Lincolnshire identified that 20.5% (n=257) have never self-harmed[80]. Reasons for self-harm included being bullied (40.2%), anxiety/hopelessness (46.7%), difficulties at school/college (52.1%), family problems (58.7%), depression (61.8%) and loneliness/isolation (38.2%). Almost two-fifths of young carers stated that they self-harm.

Figure 4: Autism in Lincolnshire

Which children and young people are most likely to suffer with mental health problems?



Individual reasons for mental health problems in childhood are likely to be complex. However, we are able to identify those groups at highest risk[81 82 83 84].

- Children and young people with learning disabilities
- Looked after children
- Homeless children and those sleeping rough
- Children who are being or have been bullied

In addition to these groups, children living with parents who misuse drugs and alcohol are adversely affected both physically and mentally[85]. There were 149 parents living with their children and receiving drug treatment in Lincolnshire during 2012/13 and 207 in alcohol treatment[86];there are also likely to be parents in Lincolnshire who misuse drugs and alcohol but are not in treatment.

Service use

Local provider data on the reasons for presenting to Lincolnshire CAMHS at tier 2 and tier 3 in 2013-14 show that the three most common presenting conditions were anxiety, depression and low mood (33%), behavioural problems (22%) and self-harm (17%). This does not consider those young people who may have been supported in tier 1 services or whose mental health problems have not been referred to services.

What do we have that works well for Lincolnshire people?

Assets & protective factors

The Department of Health report, Future in Mind states that "if we are to have the greatest chance of influencing the determinants of health and wellbeing, we should focus efforts on actions to improve the quality of care for children and families. We should start by making efforts to ensure a safe and healthy pregnancy, a nurturing childhood and support for families in providing such circumstances in which to bring up children." The new Lincolnshire 0-19 service model wholly supports this by emphasising support from the antenatal period onwards, through transition to school and the teen years where needed. New locally based interventions and support delivered by Health Visiting teams are based on evidence for a strong link between parental (particularly maternal) mental health and children's mental health. These interventions are known to offer better outcomes not only for the mother, but also across their children's lifetime[87].

Early help teams provide a team approach to supporting children and young people alongside their family, adopting an early intervention approach with a single route into other services where needed.

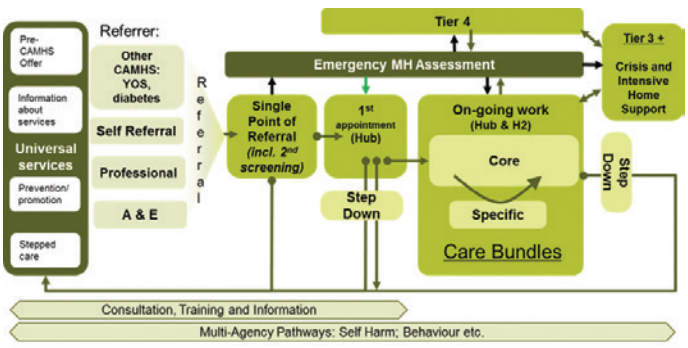
Many schools in Lincolnshire have already developed a whole school approach to promoting resilience and improving emotional wellbeing, preventing mental health problems from arising and offering early support where they do. Evidence shows[88] that interventions taking a whole school approach to wellbeing have a positive impact in relation to physical health and mental wellbeing outcomes, for example, body mass index (BMI), tobacco use and being bullied.

Services
Lincolnshire Child and Adolescent Mental Health Services (CAMHS) underwent a complete review and remodelling in 2016. A new delivery model has been developed and an additional £1.4 million for delivery was secured through transformation funds from April 2016.

Key improvements to the service include:

- Improved access to services, reducing waiting times from 12 to 6 weeks, with even shorter waiting times for certain vulnerable groups (4 weeks for looked after children and 3 weeks for young people under the care of Youth Offending Services).
- Removal of tiers and discrete teams which can lead to silo working.
- A Single Point of Access (SPA).
- Support to other children's 'universal' services, including:
  - a professional advice line,
  - consultation clinics,
  - a full programme of training for staff working in universal services,
  - the development of self-help psychosocial education materials,
  - development of a directory of the local CAMH Services and other potential services that may be beneficial to the young person.
- An integrated CAMHS provision delivering evidenced based pathways with a wider range of interventions offered and focused on outcomes; known as Core CAMHS.
- Extended opening hours into the evening.
- Access to crisis intervention and home treatment 24 hours a day, 7 days a week, aiming to avoid admission to hospital where possible. This includes rapid assessment where there is thought to be a possibility of life threatening harm to self or harm to others and follow-up after assessment for self-harm at A&E.
- A community based eating disorder service known as CAMHS EDS.
- Support to vulnerable groups including young people with a learning disability.
- Care and support through transition to adult services.

Figure 5: Illustration of the CAMHS pathway in Lincolnshire



In addition to these local services jointly commissioned by the Local Authority and Clinical Commissioning Groups, NHS England is responsible for commissioning specialised mental health services, including specialised eating disorder services, secure mental health services, specialised mental health services for the deaf, gender identity services, perinatal mental health services and other specialised mental health services (such as severe obsessive compulsive disorder and body dysmorphic disorder service).

Where are the gaps?
Often the presence of other problems, such as sensory impairment or behavioural problems, can make it more difficult to detect mental health problems in children and young people. Behaviour that challenges often presents a problem for parents and the professionals trying to support them. The new Behaviour Outreach Support Services (BOSS) aims to bridge this gap, taking a joined up approach to supporting the needs of children with challenging behaviour, working alongside universal health programmes, early help services and specialist health services.

The Lincolnshire Joint Strategic Needs Assessment (JSNA) recently identified the following gaps:

Skills of universal children's services workforce: children and young people's mental health 'system' is much broader than specialist CAMHS services, encompassing support offered by GPs, schools, community health centres and local hospitals. The role of universal staff such as teachers, youth workers, GPs, social workers and NHS staff needs to be acknowledged and supported through joint training, helping to foster shared culture and values. Future in Mind called for joint training to be provided for teachers and CAMHS staff, and further training of universal staff e.g. teachers in techniques such as mental health first aid. In partnership with LSCB, LPFT is delivering multi-agency mental health training, specifically in regards to children and young people to universal services, including education.

Transition to Adult Mental Health: given that mental health problems often emerge in late adolescence, for those young people who are accessing mental health support, it is imperative that they receive continuity of care. If young people lose touch with services or have their care disrupted at a crucial point, there is a risk that this could have a significant impact on their future health and well-being. Lincolnshire services are working together to develop effective transition protocols, ensure that transition takes place at a time that is right for the young person.

Reducing Stigma associated with mental health problems: this can prevent young people accessing services quickly. There is an average delay of ten years between experiencing first symptoms of a mental health problem and

receiving help for young people, mostly due to delay in their seeking help. The national mental health awareness campaign, Time to Change, has made strides to tackle stigma; since 2007 there has been an 8.3% improvement in public attitudes towards mental health. This needs to continue to reduce the stigma associated with accessing mental health services and seeking early help in children and young people.

Social Media and Young People's Mental Health: the past two decades has seen a sharp increase in children's use of digital media. Availability of digital devices has fundamentally reshaped young people's relationships with the online world. We know that children are now spending more time on screens - messaging on apps, creating their own blogs and consuming YouTube content. The evidence from a recent report[89] demonstrates the very real impact that the digital world can have on young people's mental health and wellbeing, both positive and negative.

It is essential to keep abreast of how social media is impacting on children and young people's mental health, strategies for this include schools working e-safety into the curriculum, developing engaging and age-appropriate information about mental health on the CAMHS website and apps and ensuring that teachers, social workers and professionals working in Child and Adolescent Mental Health Services are skilled in understanding young people's experience of the online world and how to help them to build their digital resilience

Summary

- Societal influences and risks to mental health resilience and wellbeing are changing for children and young people.
- The number of children and young people being identified with mental health problems has increased over recent years. Whilst we want to see and overall reduction in the number of children and young people having mental health problems, encouraging them to come forward for help is an important first step.

Recommendations

- Services should offer a continuous pathway to children and young people, enabling them to access appropriate support at any point.
- Commissioners and providers should undertake engagement activity to understand more about children and young people's mental health including what they find helps them, what worries them most and what would help them feel able to ask for help.
- Support parents and schools to deliver interventions to children and young people which focus on programmes that improve resilience.
- Ensure access to a range of interventions of different intensity, through channels that work for young people.

Chapter 4 Adult and older adult mental health conditions

Definition of the Problem
Mental illness is a problem which, for most of us, will either affect us directly at some point during our life or will impact on the lives of those around us. Nationally, I in 4 adults will be diagnosed with a mental health condition during their lifetime, and at the time of the recent Adult Psychiatric Morbidity Survey (APMS) 1 in 6 adults had a Common Mental Disorder (CMD) – about 1 in five women and 1 in eight men.

It is important to understand that mental health can have a real influence on our physical health. In order to grasp the scale of the influence, researchers have studied the difference in life expectancy between those who have a serious mental illness (such as schizophrenia) and those who don't. People with such an illness have been found to live between 15 and 25 years less than people who don't.i For people living with such a condition, this can have a real impact on their risk of dying of specific conditions: for example, for people with a serious mental illness, the risk of dying of heart disease has been found to be between one and a half and three times as high as other people. Worldwide, mental health problems are estimated to account for 23% of all of the years of life lost to death or disability amongst the population (Disability Adjusted Life Years – or 'DALYs')[91] and that, in England, just like the rest of the world, depression is the single biggest cause of disability[92].

What is the size of the problem for Lincolnshire?
In Lincolnshire, mental health conditions are reducing both the quality and length of lives amongst the population, and for the population of those with serious mental illnesses, the difference in lifespan, on average, would be expected to be around 20 years. This is a very important issue for the health and well-being of our population.

The most recent national survey data, applied to the population of Lincolnshire, would suggest that at any one time about 104,000 adults in Lincolnshire are living with a common mental disorder, which is roughly 17% of the population aged over 16. Common mental disorders include types of depression, anxiety, phobias, panic disorders and obsessive-compulsive disorders.

We know that the prevalence of CMD is higher in younger age groups but is at its highest in people aged between 45 and 54, at 19.9%.

Almost twice as many women as men report having one of these conditions nationally, which in Lincolnshire would equate to approximately 39,000 men and 65,000 women, with the most prevalent single common mental disorder being Generalised Anxiety Disorder. Please see Figure 3 for a further breakdown of the numbers of people estimated to be suffering from a CMD in Lincolnshire.

Figure 6: Common Mental Disorders in Lincolnshire

Depression
Locally produced calculations, based on national data, suggest that over 20,000 people in Lincolnshire

are expected to suffer from depression at any one time. General Practices in the UK keep a record of all patients diagnosed with depression. At present, over 9% of adults in Lincolnshire were on the depression register, over 57,000 people. This has been increasing, but of course we would expect these lists to include the majority of people who have ever reported depression to their GP, rather than just those experiencing symptoms now. Depression is the leading cause of disability worldwide according to the World Health Organisation. There is vast health, social and economic costs associated with it. Depressive disorders that have been clinically diagnosed account for nearly 3% of all of the years lost to ill-health, disability or death in the UK[92].

Self-harm

For some people, overwhelming emotional distress can lead to self- harming, usually as a coping mechanism[93]. This may be associated with depression, and can be associated with suicide; over half of people, who die by suicide, have a history of self-harm[93]. Between 2011 and 2013 there were 2,448 emergency admissions for intentional self-harm in Lincolnshire. We know that 1 in 10 young people can be expected to harm themselves, and that it is something that people of all ages do.

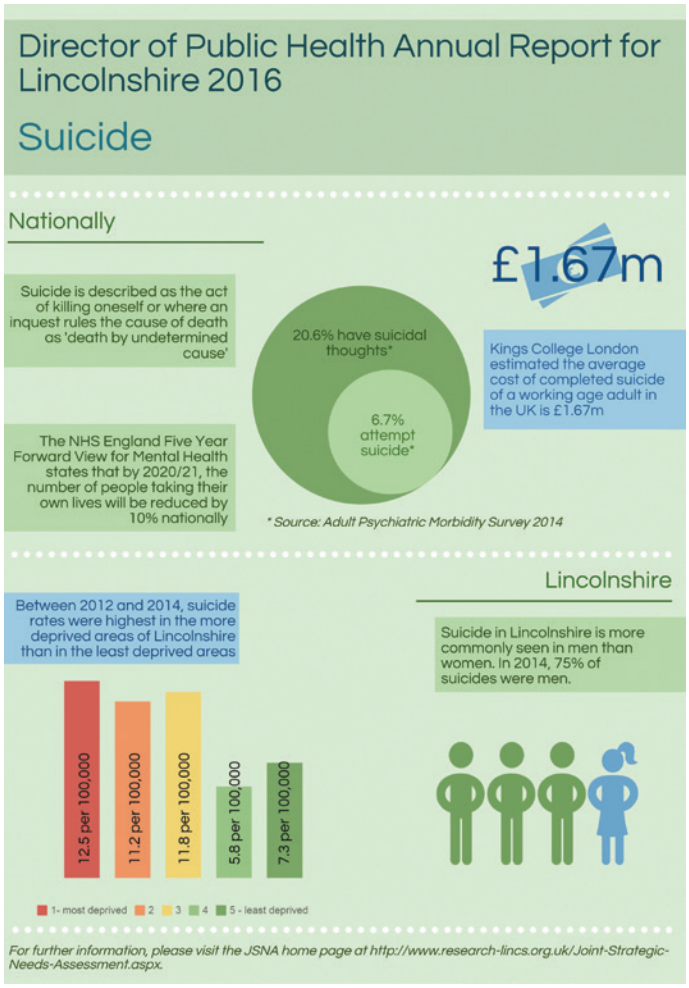
Importantly, people living in the most deprived areas are five times more likely to have an emergency admission to hospital for self-harm than people in the least deprived areas[94].

Suicide

Between 2011 and 2013, 184 people aged 15 years and older died from suicide and suspected suicide in Lincolnshire. Every year since 1999 there have been at least 60 deaths in Lincolnshire from suicide.[2] Suicide is a tragic event and can have a huge impact on the family and friends of people who take their own lives. Suicide prevention is a priority for Lincolnshire, and county NHS and local government organisations are working together to implement a suicide prevention action plan which can be viewed online at www.lpft.nhs.uk

Some groups of people tend to have a higher rate of suicide than the average across the population. The groups include people in institutional care or custody, such as prisoners, people of sexual minorities, veterans, those bereaved by suicide, as well as minority ethnic groups. Understanding the warning signs and risk factors for suicide is an important part of suicide prevention. Anyone concerned about someone, or are struggling with suicidal thoughts themselves, can seek help via their GP or through organisations such as the Samaritans (www.samaritans.org).

Figure 7: Suicide in Lincolnshire



Drug & Alcohol abuse

Drug and alcohol abuse often go hand in hand with mental health problems. People can use these and other psychoactive substances as a means of 'self-medicating,' dulling the pain or distracting from it when they are feeling overwhelmed. But this is problematic, as these things can be addictive and often end up with the user becoming dependant on them. This can add serious social problems to mental health issues, thus adding to and exacerbating underlying conditions. It is not unusual for people in Lincolnshire who have serious mental health problems to also have substance abuse or dependency problems, and this can make recovery more challenging.

If we apply the national rates of harmful drinking to the population of Lincolnshire, we see that there are an estimated 23,064 people aged 16 years and older who are drinking at harmful levels,[2] based on the

2014 Lincolnshire population. There are inequalities in the rate of hospital admissions for mental and behavioural disorders due to use of alcohol, with more people being admitted to hospital for these reasons from the most deprived areas, and relatively less from the least deprived areas. In Lincolnshire, Lincolnshire West CCG has the highest rate of hospital admissions for mental and behavioural disorders due to the use of alcohol (76.8/100,000) and South Lincolnshire has the lowest rate (47.7/100,000)[2].

We know that men in Lincolnshire are far more likely to be admitted to hospital for mental health problems related to substance abuse than women, the rate of these hospital admissions is nearly three times higher for men than for women, which is suggestive of a greater tendency amongst men to 'self-medicate' rather than seek help[95].The number of people estimated to be dependent on drugs in Lincolnshire has previously been estimated to be over 20,000 people[95].

More information on alcohol consumption in Lincolnshire can be found in the Lincolnshire substance misuse health needs assessment 2015, which can be accessed from the following website: www.research-lincs.org.uk/Home.aspx [17]. For more information on drugs, you can have a look at the Lincolnshire substance misuse health needs assessment 2015, which can be accessed from the following website: http://www.research-lincs.org.uk/JSNA-Topics.aspx

Older Adults

Depression in older people has been described as a 'growing concern,' with depression affecting one in five older people living in the community and two in five, nearly half, of those living in care homes[4]. Nationally, it has been estimated that 1.2 million people aged over 50 were severely socially excluded, having little or no engagement with their communities or with society in general[94]. In Lincolnshire, we would expect this number to be over 15,000 people, possibly far higher. Loneliness has been linked to both depression and dementia[96 97], and reports have even suggested that loneliness can be as bad for your health as smoking[98].

Dementia

Dementia is a term that is used to describe a set of symptoms; these can include loss of memory, mood changes, and problems with communication and reasoning. There are many types of dementia of which the most common are Alzheimer's Disease and vascular dementia[99], and although people of all ages can be affected it usually affects people over the age of 65. The risk of developing dementia increases as people age[100]. Importantly, dementia differs from other

mental health conditions discussed in this chapter in terms of the physical causes. Alzheimer's disease, one of the most common forms of dementia, is thought to be caused by a build-up of proteins in the brain, and vascular dementia is associated with damage caused by a loss or restriction of blood supply inside areas of the brain[101]. These processes can lead to a decline in both a person's mental health, including in terms of memory and cognitive function, and possibly a reduction in physical abilities.

Lincolnshire's Joint Dementia Strategy[99] outlines how the number of people living with dementia in Lincolnshire is expected to grow to over 13,500 by 2020, from under 10,500 in 2012. Lincolnshire has a population which is relatively more elderly than the national average, with around 21% of the population aged over 65, compared to only 16% for the whole of England[102]. Dementia has thus been described as one of the most pressing challenges for health services locally[100].

Services

People in Lincolnshire with mental ill-health can access a wide range of primary, community and secondary care services to address their health needs. A recent Health Needs Assessment has been conducted to fully analyse mental health needs in Lincolnshire as well as the degree to which current services meet those needs. The following discussion of these services is adapted from this work, which can be viewed in full here www.research-lincs.org.uk/Health-Needs-Assessments.aspx#HNA_Current

Mental health services in Lincolnshire begin with primary care - e.g. GPs, dentists, opticians and pharmacies. These services are central to addressing the health needs of people with mental ill- health, and they also provide for the needs of families and other carers.

One way this is done is through the use of psychological therapies, such as the Improving Access to Psychological Therapies programme (IAPT). In Lincolnshire, the IAPT service is for anyone over the age of 16 who is feeling stressed, anxious, low in mood or depressed.

The Adult Psychology service works alongside the primary mental health teams throughout Lincolnshire. Service users may be referred because of the complex and enduring nature of their mental health difficulties, or because of a lack of response to other accessible therapeutic interventions, such as counselling and cognitive behavioural therapy. Other services exist to help people overcome specific problems that can be linked to mental ill-health, such as eating disorders or a lack of secure employment.

In Lincolnshire, specialist health and care services for people with mental health problems and learning disabilities are provided by Lincolnshire Partnership NHS Foundation Trust (LPFT). LPFT Adult Mental Health Services care for people who are experiencing severe episodes of mental ill-health, or who need longer-term recovery plans put in place in order to return to independent living. LPFT also provides a dementia and specialist older adult mental health service for people of any age dealing with suspected or diagnosed dementia, and for older adults presenting with complex mental health problems.

LPFT's services include community mental health provision, where care is provided in the community for people who are recovering from a mental health problem. In addition to this, crisis resolution and home treatment support is provided to people at risk of being admitted to hospital, and for those who do need to be admitted acute inpatient care is provided. This is for people who are experiencing a severe, short-term episode of mental ill-health that cannot be managed by the community service. Treatment, usually for a short time, is provided on an inpatient ward at Lincoln, Grantham or Boston.

During 2016 re-commissioning of all specialist drug and alcohol treatment services was undertaken in Lincolnshire. A new contract commenced with Addaction in October 2016. This new service provides Lincolnshire with a flexible, outcome based service to meet the current need and future changes in substance misuse trends whilst delivering financial efficiencies. A clear focus for these services is on developing a social recovery model of support with less emphasis being placed on medical interventions and a greater focus on prevention, abstinence, social inclusion and aftercare to enable service users to ultimately lead meaningful and productive lives. As such the new contract has a total of thirty outcomes spread over seven separate domains which are:

- Freedom from dependence on drugs or alcohol
- Improvement in mental and physical wellbeing
- Prevention of substance misuse related deaths and blood borne viruses
- A reduction in crime and re-offending

- Sustained employment
- Improved relationships with family members, partners and friends
- Improved capacity to be an effective caring parent

Forensic mental health services are provided for the care and treatment of individuals experiencing mental health problems who also pose a risk to the public. This service also provides care co-ordination for people suffering from mental ill-health, who are placed out of the county in low, medium or high-security hospitals.

Where are the gaps?

Lincolnshire has a wide range of services to support those with mental health issues. In addition to the services discussed here, community and voluntary sector organisations operate to support people with mental health needs. Information about these services is not always easy to access, both for the general public and for medical professionals such as general practitioners. As such, bringing together information on mental health services into one place so that both users and provider organisations are clear what services and support networks are available and how to access them could be a valuable innovation.

This need for better organisation of information about services and pathways is symptomatic of the degree of complexity in the Lincolnshire landscape of mental health service. This can make it difficult for both patients and professionals to determine the best route for service access and treatment for patients. Furthermore, some services have specific thresholds for access which ensure that only those who are in clear clinical need of the service receive it. Whilst these thresholds are necessary to target provision at those most in need, this may prevent people who are in need but do not meet the clinical threshold for treatment from receiving preventative help. Secondary prevention, where people in the early stages of a mental health need which, left untreated, may get worse, should thus be a priority for Lincolnshire, along with primary prevention (preventing these issues in the first place) and treatment.

Summary

- Mental ill-health is a common problem, with 1 in 4 adults in the UK diagnosed with a common mental disorder in their lifetime. It is estimated that over 100,000 adults in Lincolnshire will be living with such a condition at any time.
- Common mental disorders include depression, anxiety, phobias and a panic disorder.
- Lincolnshire has a wide range of mental health services including primary care, therapeutic and preventative interventions, and acute and specialist care for those with more severe conditions.

Recommendations

Five recommendations for Lincolnshire have been identified as part of the recent Mental Health Needs Assessment for Lincolnshire. For further details, this needs assessment can be viewed here: www.research-lincs.org.uk/UI/Documents/MiHNA%20final%20report.pd

- Identification and recording of mental ill-health: Work should be undertaken to ensure that health professionals can correctly and consistently identify and record the signs and symptoms of all forms of mental ill-health.
- Timely access to mental health services based on needs: Whilst most adult outpatients are initially seen within the 18 week target, timely access to specific services such as IAPT and dynamic psychotherapy could be improved.
- Data sharing between different organisations: The sharing of data between organisations needs to be improved. This includes between local providers but also between national data controllers and local intelligence teams of data such as the Mental Health Minimum Dataset, Hospital Episodes Data, and GP patient demographic data.
- Awareness of services and support: More should be done to comprehensively bring together information on mental health services and support networks in one place, so that both the public and professionals are clear on what is available and how it can be accessed.
- Service user consultation: Service user feedback is important for understanding and improving the experience of service users. Providers should seek feedback from those who contact or use all mental health services and support networks.

Chapter 5 Recommendations

Risk factors:
What influences our mental health?

- Clear reference and commitment to access to green space in development and regeneration policies for Lincolnshire neighbourhoods.
- Clear reference and commitment to community space availability, both safe informal spaces like pubs and seating areas and buildings where communities can come together in more organised groups.

Perinatal and maternal mental health conditions

- Women should continue to be assessed for mental health problems at every contact with a health professional and throughout a child's early years. Low level support should be maximised through upskilling of Health Visitors and developing peer support networks, meaning that a lower number of women will need onward referral to specialist services.
- All professionals who come into contact with women during the ante and postnatal periods should ask about substance misuse, especially in women with known mental health problems, and refer on for additional support where needed.
- Evidence based support for low level or undiagnosed mental health problems should be made available through early years' pathways to improve maternal and child mental health. Data to find out the level of need should be collected through local surveys and/or by professionals who come into contact with pregnant women and young families.
- Women and families should be signposted to informal support where appropriate and awareness of the common nature of mental health problems should be raised in all groups who work with families and young children.

Childhood and adolescent mental health conditions

- Services should offer a continuous pathway to children and young people, enabling them to access appropriate support at any point.
- Commissioners and providers should undertake engagement activity to understand more about children and young people's mental health including what they find helps them, what worries them most and what would help them feel able to ask for help.
- Support parents and schools to deliver interventions to children and young people which focus on programmes that improve resilience.
- Ensure access to a range of interventions of different intensity, through channels that work for young people.

Adult and Older Adult Mental Health Conditions

- Identification and recording of mental ill-health: Work should be undertaken to ensure that health professionals can correctly and consistently identify and record the signs and symptoms of all forms of mental ill-health.
- Timely access to mental health services based on needs: Whilst most adult outpatients are initially seen within the 18 week target, timely access to specific services such as IAPT and dynamic psychotherapy could be improved.
- Data sharing between different organisations: The sharing of data between organisations needs to be improved. This includes between local providers but also between national data controllers and local intelligence teams of data such as the Mental Health Minimum Dataset, Hospital Episodes Data, and GP patient demographic data.
- Awareness of services and support: More should be done to comprehensively bring together information on mental health services and support networks in one place, so that both the public and professionals are clear on what is available and how it can be accessed.
- Service user consultation: Service user feedback is important for understanding and improving the experience of service users. Providers should seek feedback from those who contact or use all mental health services and support networks.

Glossary

Glossary: mental health conditions

Adjustment disorders
Adjustment Disorder is a state of mixed emotions such as depression and anxiety which occurs as a reaction to major life events or when having to face major life changes such as illness or relationship breakdown.

Source: Royal College of Psychiatrists

Mild-moderate depression and anxiety
The main symptoms of depression are losing pleasure in things that were once enjoyable and losing interest in other people and usual activities. A person with depression may also commonly experience some of the following: feeling tearful, irritable or tired most of the time, changes in appetite, problems with sleep, concentration and memory. People with depression typically have lots of negative thoughts and feelings of guilt and worthlessness. Sometimes people with depression harm themselves, have thoughts about suicide, or may even attempt suicide.

Mild depression is when a person has a small number of symptoms that have a limited effect on their daily life. Moderate depression is when a person has more symptoms that can make their daily life much more difficult than usual.

Mild anxiety is experienced as feelings of being overwhelmed by responsibilities and unable to cope. People with depression may have feelings of anxiety as well.

Source: NICE27, Best Beginnings

Postpartum psychosis
Postpartum psychosis (or puerperal psychosis) is a severe episode of mental illness which begins suddenly in the days or weeks after having a baby. Symptoms vary and can change rapidly. They can include high mood (mania), depression, confusion, hallucinations and delusions.

Source: Royal College of Psychiatrists

Post-traumatic stress disorder
Postnatal Post Traumatic Stress Disorder (PTSD) is experienced as nightmares, flashbacks, anger, and difficulty concentrating and sleeping. It may be a pre-existing condition or be triggered by a traumatic labour.

Source: Best Beginnings

Serious mental illness (severe mental illness)
Serious mental illness includes diagnoses which involve psychosis. The most common disorders which are associated with psychotic symptoms are schizophrenia, bipolar disorder and psychotic depression. Psychosis is used to describe symptoms or experiences that happen together. Each person will have different symptoms, but the common feature is that they do not experience reality like most people. A person with psychosis may have: hallucinations, delusions, muddled thinking, lack of insight.

Source: Mental Health Wales, Royal College of Psychiatrists

Severe depressive illness
Severe depression is when a person has many symptoms that can make their daily life extremely difficult. Sometimes a person with severe depression may have hallucinations and delusions (psychotic symptoms).

Source: NICE

References

1. McManus S, Bebbington P, Jenkins R, Brugha T. (eds.) (2016) Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014. Leeds: NHS Digital.
2. Gavens, L (2016) A Mental Illness Health Needs Assessment for Lincolnshire, Lincoln, 2016
3. Regan M, Elliot I, Goldie I (2016) Better Mental Health for All: A public health approach to mental health improvement, London, 2016, p19
4. Better Mental Health For All, Faculty of Public Health, London, 2016, available at http://www.fph.org.uk/better_mental_health_for_all
5. Based on estimated Lincolnshire economy of approx. £10bn per year, see http://www.research-lincs.org.uk/Local-Economic-Assessment.aspx
6. Gerhardt, S. (2014). Why love matters: How affection shapes a baby's brain (2nd Edition). Routledge.
7. Bell, M.A., Ashton, K., Hughe.s, K., Ford, K., Bishop, J. and Paranjothy. (2015). Adverse Childhood Experiences and their impact on health-harming behaviours in the Welsh adult population. Wales: Public Health Wales.
8. Faculty of Public Health. (2016). Better Mental Health For All. london. Retrieved from http://www.fph.org.uk/better_mental_health_for_all
9. Blank L, Baxter S, Messina J, Fairbrother H, Goyder L, Chilcott J. Summary review of the factors relating to risk of children experiencing social and emotional difficulties and cognitive difficulties. Available at www.nice.org.uk/nicemedia/live/13634/58884/58884.pdf.
10. Gerhardt, S. (2014). Why love matters: How affection shapes a baby's brain (2nd Edition). Routledge.
11. Bosmans, G., Braet, C. & Van Vlierberghe, L. (2010). Attachment and symptoms of psychopathology: early maladaptive schemas as a cognitive link? Clinical Psychology & Psychotherapy, 17, 374-85.
12. Gormley, B. & McNiel, D.E. (2010). Adult attachment orientations, depressive symptoms, anger, and self-directed aggression by psychiatric patients. Cognitive Therapy and Research, 34, 272-281.
13. Ein-Dor, T., Doron, G., Solomon, Z., Mikulincer, M. & Shaver, P.R. (2010). Together in pain: attachment-related dyadic processes and post traumatic stress disorder. Journal of Counselling Psychology, 57, 317-327.
14. Giallo, R., Cooklin, A., Wade, C., D'Esposito, F., & Nicholson, J. M. (2014). Maternal postnatal mental health and later emotional-behavioural development of children: The mediating role of parenting behaviour. Child: Care, Health and Development, 40(3), 327–336. https://doi.org/10.1111/cch.12028
15. Kingston, D., Tough, S., & Whitfield, H. (2012). Prenatal and Postpartum Maternal Psychological Distress and Infant Development : A Systematic Review, 683–714. https://doi.org/10.1007/s10578-012-0291-4
16. Apter-Levy, Feldman, Vakart, Ebstein, & Feldman (2013), Impact of Maternal Depression Across the First 6 Years of Life on the Child's Mental Health, Social Engagement, and Empathy: The Moderating Role of Oxytocin, Am J Psychiatry 2013; 170:1161–1168, 2013
17. Green, H., McGinnity, A., Meltzer, H., Ford, T., & Goodman, R. (2005). Mental Health of Children and Young People in Great Britain, 2004. London. https://doi.org/10.1037/e557702010-001
18. Wolke, D., & Lereya, S. T. (2015). Long-term effects of bullying. Archives of Disease in Childhood, 100(9), 879–85. https://doi.org/10.1136/archdischild-2014-306667
19. Klomek, A., Sourander, A., & Gould, M. (2010). The association of suicide and bullying in childhood to young adulthood: A review of cross-sectional and longitudinal research findings. Canadian Journal of Psychiatry, 55(5), 282-288
20. E. Emerson and C. Hatton, "Estimating Future Needs for Adult Social Care for People with Learning Disabilities in England," Centre for Disability research, Lancaster University, Lancaster, 2008.
21. Ford, T., Vostanis, P., Meltzer, H., & Goodman, R. (2007). Psychiatric disorder among British children looked Psychiatric disorder among British children looked after by local authorities: comparison with children living in private households. British Journal of Psychiatry, 190(319), 319–325. Retrieved from http://bjp.rcpsych.org.eresources.shef.ac.uk/content/bjprcpsych/190/4/319.full.pdf
22. McAuley, C., & Davis, T. (2009). Emotional well-being and mental health of looked after children in England. Child & Family Social Work, 14(2), 147–155. https://doi.org/10.1111/j.1365-2206.2009.00619.x
23. Kaess, M., Parzer, P., Mattern, M., Plener, PL., Bifulco, A., Resch, F., & Brunner, R. (2013) Adverse childhood experiences and their impact on frequency, severity, and the individual function of nonsuicidal self-injury in youth, Psychiatry Research, Volume 206, Issues 2–3, 30 April 2013, Pages 265-272.
24. Vostanis (2002). Mental health of homeless children and their families, Advances in Psychiatric Treatment, vol. 8, pp. 463-469.
25. C. Vasiliou (2006), "Making the link between mental health and youth homelessness. a pan-London study," Mental Health Foundation, London, 2006
26. Nottinghamshire County Council (2015), Young People's Health Strategy for Nottinghamshire, Nottingham, 2015, available at: http://www.notting-

hamshire.gov.uk/
27. Susan Matthews & Susie Sykes (2012) Exploring Health Priorities for Young People Leaving Care, Child Care in Practice, 18:4, 393-407, DOI: 10.1080/13575279.2012.717913
28. Berkman LK, Kawachi I, eds. Social Epidemiology. New York: Oxford University Press; 2000
29. Leyden KM. Social Capital and the Built Environment: The Importance of Walkable Neighborhoods. Am J Public Health 2003;93(9):1546-1551
30. Cave B, Coutts A. Health Evidence base for the Mayor's draft Cultural Strategy. London: South East London Strategic Health Authority and East London & the City Health Action Zone; 2002
31. Michie C, De Rozarieux D. Rapid Review to Support the Mayor of London's Biodiversity Strategy. The Health Impacts of Green Spaces in London. London: Ealing Hospital NHS Trust; 2001..
32. Delivering mixed, balanced communities. 2009, p. Chapter 26.
33. Government, Department for Communities and Local. Transferable Lessons from the New Towns. 2006
34. Dannenberg AL, Jackson RJ, Frumlin H, Schieber RA, Pratt M, Kochtizky C, et al. The Impact of Community Design and Land-Use Choices on Public Health: A scientific research agenda. Am J Public Health 2003;93(9
35. Taske N, Taylor L, Mulvihill C, Doyle N, Goodrich J, Killoran A. Housing and Public Health: A Review of Reviews of Interventions for Improving Health. Evidence briefing: National Institute for Health and Clinical Excellence; 2005.
36. Evans GW, Wells NM, Moch A. Housing and mental health: a review of the evidence and a methodological and conceptual critique. J Soc Issues. 2003;59:475–500. doi: 10.1111/1540-4560.00074
37. Marcia Gibson a,n, MarkPetticrew b, ClareBambra c, AmandaJ.Sowden d, KathE.Wright d, Margaret Whitehead (2011), Housing and health inequalities: A synthesis of systematic reviews of interventions aimed at different pathways linking housing and health, Health & Place Volume 17, Issue 1, January 2011, Pages 175–184, http://dx.doi.org/10.1016/j.healthplace.2010.09.011
38. World Health Organisation Europe. Fourth Ministerial Conference on Environment and Health. Budapest 2004.
39. CABE, 2010a; Croucher et al., 2007; Pretty et al., 2007; Clark at al., 2013; Maas et al., 2009; CABE, 2010b.
40. MIND. Ecotherapy – the green agenda for mental health Key findings Green exercise at local Mind groups . 2007.
41. M. Stafford and M. Marmot, Neighbourhood deprivation and health: does it affect us all equally?, International Journal of Epidemiology, vol. 32, pp. 357-66, 2003.
42. Department for Communities and Local Government (2015) , The Indices of Multiple Deprivation, available at https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015, 2015
43. Department for Communities and Local Government (2015) , The Indices of Multiple Deprivation, available at https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015, 2015
44. Office for National Statistics, "Statutory homelessness in England," Department for Communities and Local Government, London, 2015
45. H. Meltzer, P. Bebbington, T. Brugha, R. Jenkins, S. McManus and M. Dennis, "Personal debt and suicidal ideation.," Psychological Medicine, vol. 41, pp. 771-778, 2011.
46. Marmot (2010), Fair Society, healthy Lives: The Marmot Review, London, 2010, p26
47. NOMIS, "Labour Market Profile - Lincolnshire," Office for National Statistics, Newport, 2015.
48. Faculty of Public Health (2016), Better Mental Health For All, London, 2016, available at http://www.fph.org.uk/better_mental_health_for_all
49. J. Cohen, "Safe in our hands? A study of suicide and self harm in asylum seekers," Journal of Forensic and Legal Medicine, vol. 15, pp. 235-244, 2008
50. M. Oates, "Suicide: the leading cause of maternal death," The British Journal of Psychiatry, vol. 183, pp. 279-81, 2003.
51. Public Health England/Royal College of Nursing, "Preventing suicide among lesbian, gay and bisexual young people," Public Health England, London, 2015.
52. N. Kapur, D. While, N. Blatchley, I. Bray and K. Harrison, "Suicide after leaving the UK Armed Forces," PLOS Medicine, 2009.
53. A. Pitman, D. Osborn, M. King and A. Erlangsen, "Effects of suicide bereavement on mental health and suicide risk," The Lancet Psychiatry, vol. 1, pp. 86-94, 2014.
54. J. Cooper, N. Kapur, R. Webb, M. Lawlor, E. Guthrie, K. Mackway-Jones and L. Appleby, "Suicide after deliberatre self-harm: a 4-year cohort study," American Journal of Psychiatry, vol. 162, pp. 297-303, 2005.
55. NICE. Antenatal and postnatal mental health: clinical management and service guidance. NICE Clinical Guideline (CG192). London: National Institute for Health and Care Excellence, 2014. Available from: https://www.nice.org.uk/guidance/cg192
56. NICE. Antenatal and postnatal mental health: clinical management and service guidance. NICE Clinical Guideline (CG192). London: National Institute for Health and Care Excellence, 2014. Available from: https://www.nice.org.uk/guidance/cg192
57. Hogg S. Prevention in mind. All babies count: spotlight on perinatal mental health. London: NSPCC, 2012 (cited 2015 Sep 03). Available from:

www.nspcc.org.uk/services-and-resources/research-and-resources/2013/all-babies-count-spotlight-perinatal-mental-health/
58. Number of maternities (live and still births): ONS Birth Summary Tables - England and Wales 2015 Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/datasets/birthsummarytables (Accessed 29.12.16)
59. Rates of disorders: Joint Commissioning Panel for Mental Health. Guidance for commissioners of perinatal mental health services. Volume two: practical mental health commissioning. London: Joint Commissioning Panel for Mental Health; 2012. Available from: www.jcpmh.info/resource/guidance-perinatal-mental-health-services/
60. Marian Knight, Derek Tuffnell, Sara Kenyon, Judy Shakespeare, Ron Gray, Jennifer J Kurinczuk (Eds.) Saving Lives, Improving Mothers' Care Surveillance of maternal deaths in the UK 2011-13 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-13 December 2015. Available at: https://www.npeu.ox.ac.uk/mbrrace-uk/reports
61. Howard LM, Oram S, Galley H, Trevillion K, Feder G. Domestic violence and perinatal mental disorders: a systematic review and meta-analysis. PLOS Medicine. 2013;10(5):e1001452. doi: 10.1371/journal.pmed.1001452.
62. Lewis, G, Drife, J, et al. (2001) Why mothers die: Report from the confidential enquiries into maternal deaths in the UK 1997-9; commissioned by Department of Health from RCOG and NICE (London: RCOG Press)
63. NICE. Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively. NICE guidelines (PH50). London: National Institute for Health and Care Excellence, 2014. Available from: www.nice.org.uk/guidance/ph50
64. NICE clinical knowledge summary. Depression - antenatal and postnatal. London: National Institute for Health and Clinical Excellence; 2013. Available from: cks.nice.org.uk/depression-antenatal-and-postnatal
65. NDTMS, Adult Partnership Activity Report, Lincolnshire
66. NICE. Contraceptive services with a focus on young people up to the age of 25. NICE guidelines (PH51). London: National Institute for Health and Care Excellence, 2014. Available from: www.nice.org.uk/guidance/ph51
67. Mental Health Foundation. Young mums together: promoting young mothers' wellbeing. London: Mental Health Foundation, 2013. Available from: www.mentalhealth.org.uk/content/assets/PDF/publications/young-mums-together-report.pdf
68. Public Health Outcomes Framework tool (accessed 29.11.16): available at: http://www.phoutcomes.info/public-health-outcomes-framework#page/4/gid/1000042/pat/6/par/E12000004/ati/102/are/E10000019/iid/20401/age/173/sex/2
69. Source: Department for Communities and Local Government
70. Hogg S, Haynes A, Baradon T, Cuthbert C. An unstable start: All babies count: spotlight on homelessness. London: NSPCC and Anna Freud Centre, 2015. Available from: www.nspcc.org.uk/services-and-resources/research-and-resources/2015/all-babies-count-spotlight-homelessness-an-unstable-start/
71. Murphy M and Fonagy P (2012). Mental health problems in children and young people. In: Annual Report of the Chief Medical Officer 2012. London: Department of Health.
72. Personal Social Services Research Unit, London School of Economics and Political Science and Young Minds, 2016. Youth Mental Health: New Economic Evidence. Available at: www.pssru.ac.uk/publication-details.php?id=5160
73. NHS England. Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing. October 2015. Department of Health.
74. Childhood and Adolescent Mental Health: understanding the lifetime impacts, Mental Health Foundation, 2004
75. Nuffield Foundation (2012) Social trends and mental health: introducing the main findings London: Nuffield Foundation
76. Hospital Episode Statistics (HES), Health and Social Care Information Centre
77. Young Minds: webpages available at: http://www.youngminds.org.uk/about/whats_the_problem (Accessed 5.12.16).
78. K. Windfuhr, "Suicide in juveniles and adolescents in the United Kingdom," Journal of Child Psychology and Psychiatry, vol. 49, pp. 1157-67, 2008.
79. Public Health England, "Child Health Profiles - local authorities," [Online]. Available: www.altas.chimat.ork.uk/dataviews/report/fullpage?viewId=493&reportId=535&geold=4&geoReportIs=4618 [Accessed 17 September 2015].
80. Healthwatch Lincolnshire, ""Hear our voice": children and young people of Lincolnshire," Healthwatch Lincolnshire, Boston, 2014
81. E. Emerson and C. Hatton, "Estimating Future Needs for Adult Social Care for People with Learning Disabilities in England," Centre for Disability research, Lancaster University, Lancaster, 2008.
82. T. Ford, P. Vostanis, H. Meltzer and R. Goodman, "Psychiatric disorder among British children looked after by local authorities: comparison with children living in private households," British Journal of Psychiatry, vol. 190, pp. 319-325, 2007.

83. H. Meltzer, R. Gatward, T. Corbin, R. Goodman and T. Ford, "The mental health of young people looked after by local authorities in England," Office for National Statistics, London, 2003
84. P. Vostanis, "Mental health of homeless children and their families," Advances in Psychiatric Treatment, vol. 8, pp. 463-469, 2002
85. Advisory Council on the Misuse of Drugs. Hidden harm- responding to the needs of children of problem drug users. London: Advisory Council on the Misuse of Drugs, 2011. Available from: www.gov.uk/government/publications/amcd-inquiry-hidden-harm-report-on-children-of-drug-users
86. Health & Wellbeing – Alcohol & Drugs, Public Health England.
87. Bauer A, Parsonage M, Knapp M, Iemmi V, and Adelaja B (2014). The costs of perinatal mental health problems. London: Centre for Mental Health.
88. Brooks F (2012). Life stage: School Years. In: Annual Report of the Chief Medical Officer 2012. Our Children Deserve Better: Prevention Pays. London: Department of Health.
89. Resilience for the Digital World. Ecorys and YoungMinds. 2016. Available at: http://www.uk.ecorys.com/news/building-digital-resilience-key-keeping-young-people-safe-online-%E2%80%93-new-report
90. Wahlbeck, K. et al., 2011. Outcomes of Nordic mental health systems: life expectancy of patients with mental disorders, pp.453–458.
91. Murray CJL, Lopez Ad, eds. (1996). The global burden of disease and injury series, volume 1: a comprehensive assessment of mortality and disability from diseases, injuries, and risk factors in 1990 and project to 2020. Cambridge MA, USA: Harvard University Press
92. World Health Organisation (2013) Mental Health Action Plan: 2012-2020, http://www.who.int/mental_health/action_plan_2013/en/
93. NHS Choices, Self Harm, http://www.nhs.uk/conditions/self-injury/Pages/Introduction.aspx, accessed 24.01.17
94. Cacioppo J. T. and Patrick, W. (2008). Loneliness: Human Nature and the Need for Social Connection. New York: W. W. Norton.
95. NHS Secondary Uses Service Data, used with permission of the Health and Social Care Information Centre
96. Morgan, E. and Swann, C. (2004). Social capital for health: Issues of definitions, measurement and links to health. London: Health Development agency.
97. Mental Health Foundation. (2010). The Lonely Society. London: Mental Health Foundation.
98. Cacioppo, J.T., Fowler, J.H. and Christakis, N.A. (2009). Alone in the crowd: The structure and spread of loneliness in a large social network. Journal of Personality and Social Psychology 97 (6), 977-991.
99. Lincolnshire County Council (2014), Lincolnshire Joint Strategy for Dementia,p5 available at https://www.lincolnshire.gov.uk/residents/adult-social-care/strategies/joint-dementia-strategy-2014-%E2%80%93-2017/121668.article
100. NHS Choices, About Dementia, http://www.nhs.uk/Conditions/dementia-guide/Pages/about-dementia.aspx, accessed 18/01/17
101. NHS Choices, Causes of Dementia, http://www.nhs.uk/Conditions/dementia-guide/Pages/causes-of-dementia.aspx, accessed 18/01/17

Lincolnshire
COUNTY COUNCIL
Working for a better future

Lincolnshire COUNTY COUNCIL
Working for a better future

Policy and Scrutiny

Open Report on behalf of Pete Moore, Executive Director of Finance and Public Protection	
Report to:	**Community and Public Safety Scrutiny Committee**
Date:	**09 March 2017**
Subject:	**Quarter 3 Performance – 1 October to 31 December 2016**

Summary:

The accompanying appendices to this report provide key performance information that is relevant to the work of the Community and Public Safety Scrutiny Committee.

Actions Required:

Members of the Community and Public Safety Scrutiny Committee are invited to consider and comment on the performance information contained in the appendices to this report and highlight any recommendations or further actions for consideration.

1. Background

The appendices to this report provide the Committee with performance information relating to Community Safety, Libraries and Heritage and Public Health, which is aligned to the relevant priorities and performance indicators set out in the Council's Business Plan.

Council Business Plan 2016/2017

The Council Business Plan 2016/17 was approved by Council in February 2016 and has been organised around the 17 commissioning strategies. Appendix A lists the measures in the Council Business Plan that are within the remit of this Scrutiny Committee and have been highlighted for further discussion.

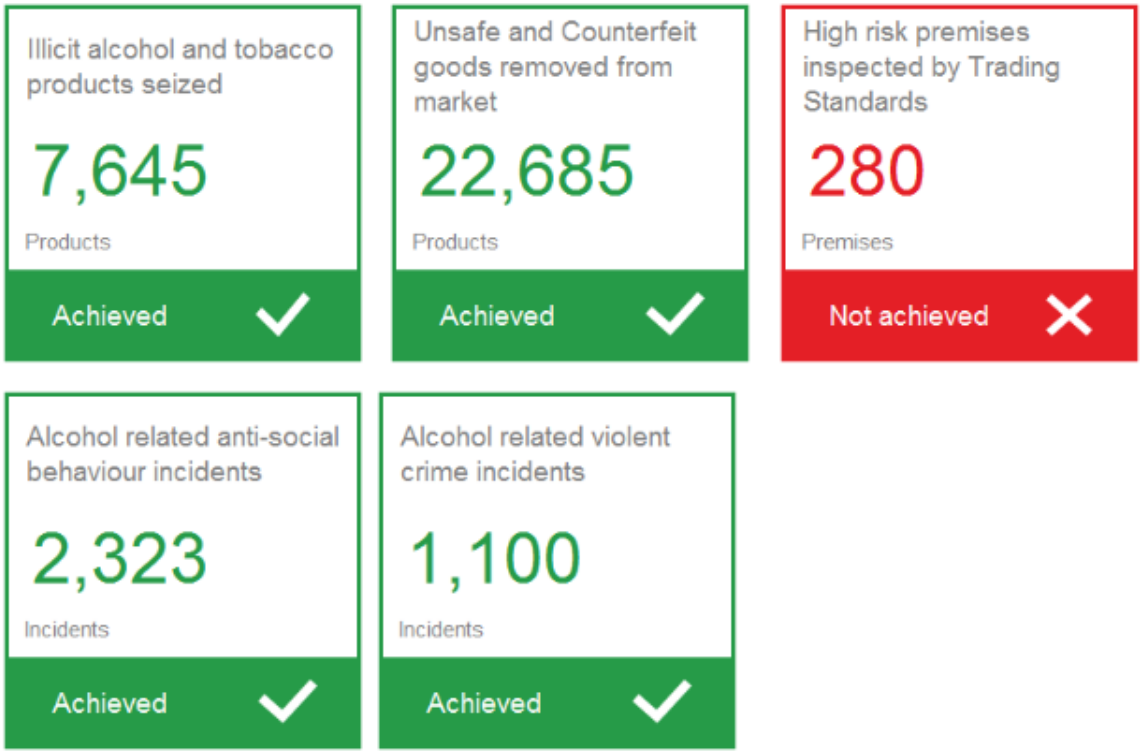
The full detail of all performance measures can be found online via the Performance Dashboard.

Web link - http://www.research-lincs.org.uk/CBP-Landing-page.aspx

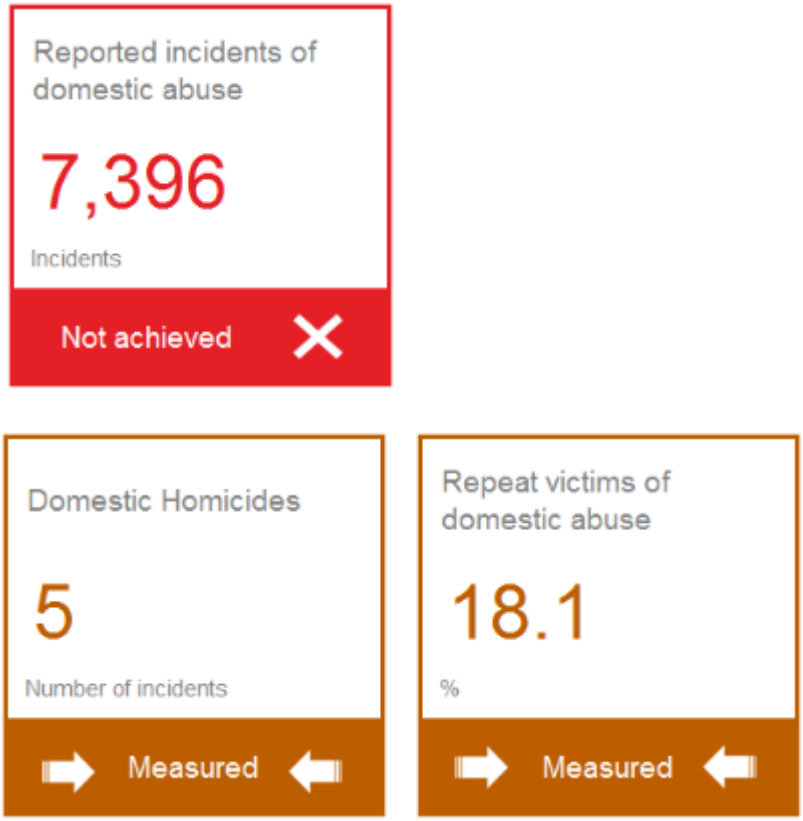
Appendix B shows a breakdown of customer satisfaction information.

Public Protection

The public are protected from unsafe and dangerous goods

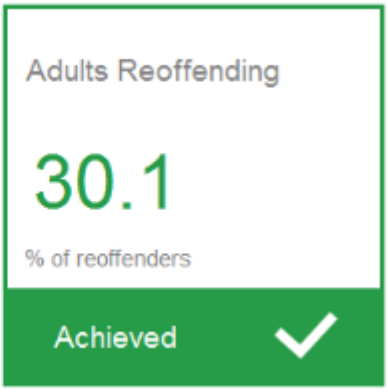


Increase public confidence in how we tackle domestic abuse

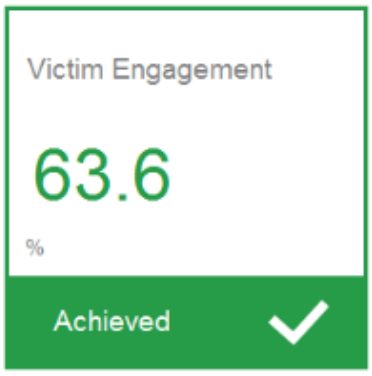


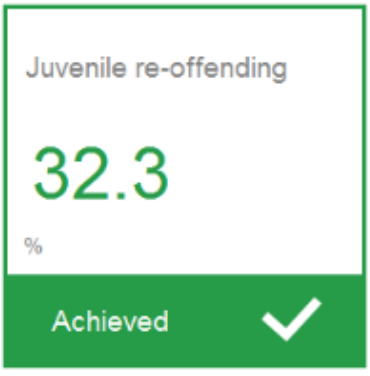
Reduce the number of people killed and seriously injured on Lincolnshire's roads

Reduce adult reoffending

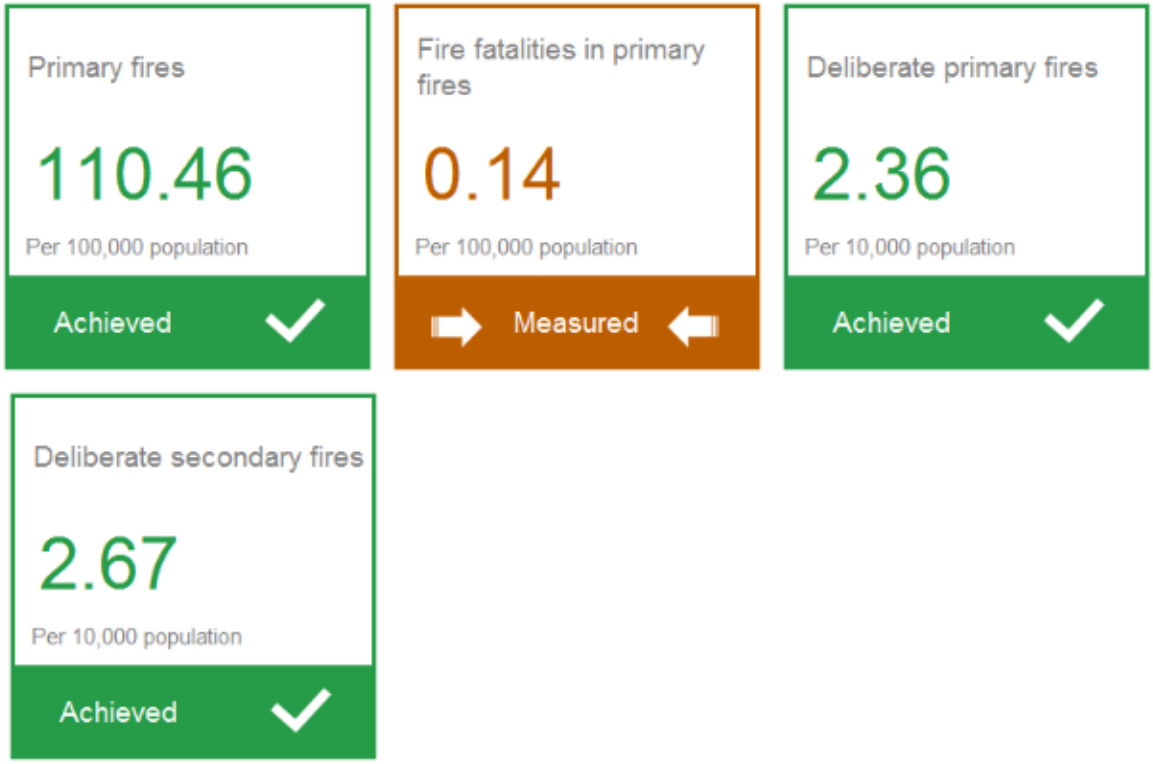


Reduce the number of young people committing a crime

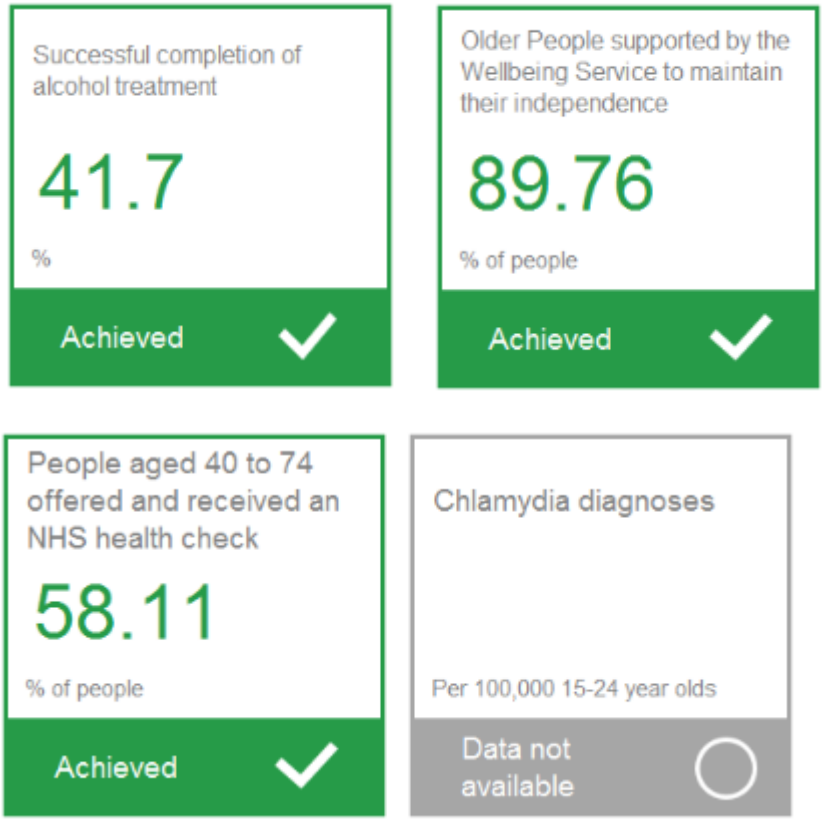




Lincolnshire Fire and Rescue

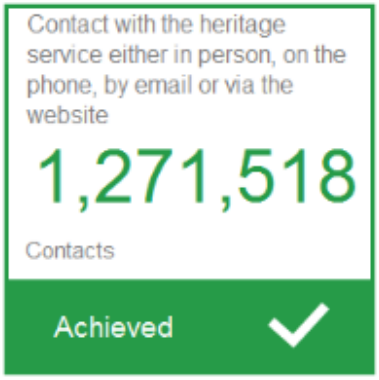


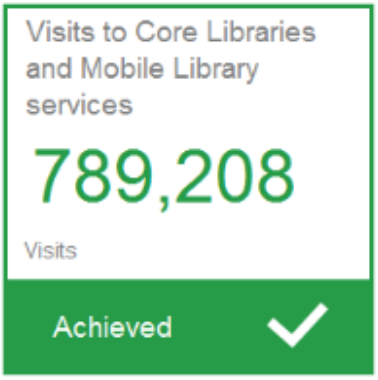
Wellbeing

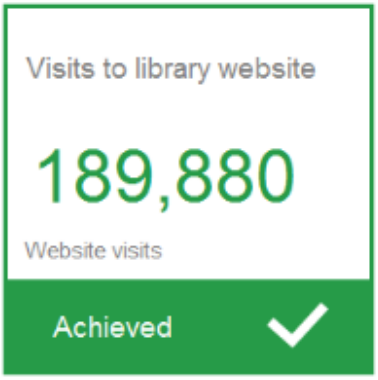


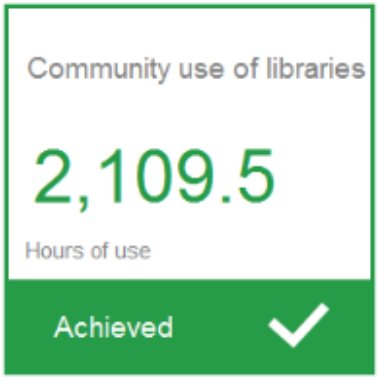
Community Assets and Resilience Commissioning

Enable and encourage people to participate in Lincolnshire's culture









Communities and residents are supported to be involved in local decision making and have their views taken into account

2. Conclusion

Members of the Community and Public Safety Scrutiny Committee are invited to consider and comment on the performance information contained in the appendices to this report and highlight any recommendations or further actions for consideration.

3. Consultation

a) Have Risks and Impact Analysis been carried out?

N/A

b) Risks and Impact Analysis

N/A

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Quarter 3 Performance – 1 October to 31 December 2016
Appendix B	Q3 Customer Satisfaction Information

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 collated by Daniel Steel, Scrutiny Officer, who can be contacted on 01522 552102 or daniel.steel@lincolnshire.gov.uk.

Lincolnshire COUNTY COUNCIL
Working for a better future

Communities are safe and protected

The public are protected from unsafe and dangerous goods

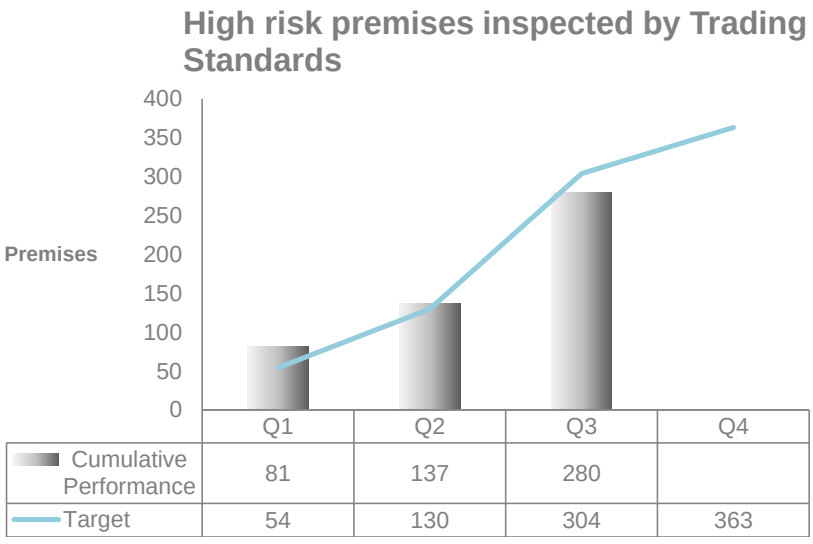
High risk premises inspected by Trading Standards

This is a count of the number of premises that are categorised as 'High risk' that have been inspected by Trading Standards. A 'High risk' premises is one that has been categorised as such by the Food Standards Agency, DEFRA, and the Better Regulation Delivery Office as requiring an annual compliance visit based upon an assessment of the risk posed to the public. Trading Standards then use a combination of this information combined with officer knowledge, the history of the premises over the last 12 months, and intelligence to create an inspection list for the year. Trading Standards will sometimes select premises that are not deemed 'high risk'. This could be due to local or national issues, e.g. we looked at a number of restaurants last year in light of the changes to allergen legislation. Trading Standards follow the principals set out in the DEFRA Framework Agreement, which was a working arrangement set up between APHA/DEFRA and Trading Standards several years ago. As well as identifying traditional 'high risk' premises it also identifies premises which are critical control points for disease and we try to focus resources on these.

Not achieved

280
Premises
Quarter 3 December 2016

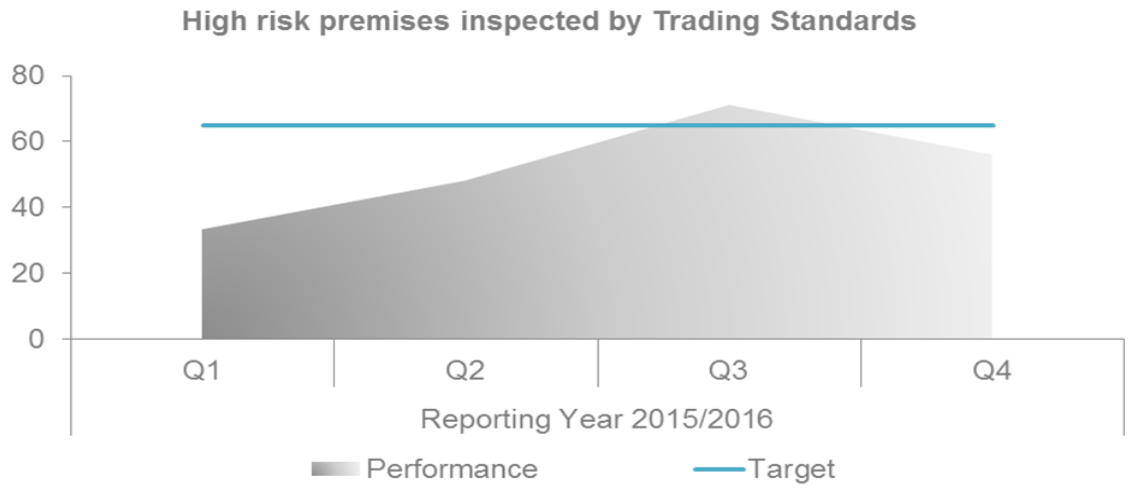
304
Premises
Target for December 2016



About the latest performance

Although visits are slightly behind schedule we are confident these will be completed by the end of Quarter 4. The current Avian Influenza incidents in the county have impacted on resources and our inspection programme. To date 280 high risk premises have been inspected. This includes 183 feed premises, 15 weights and measures premises, 11 markets and carboots, 10 animal health/farm premises, 20 food premises, 7 Top Trader (most complained about premises), 34 fireworks/explosives premise.

Further details



	Reporting Year 2015/2016					
	Q1	Q2	Q3	Q4	Total	Target 2016/17
Performance	33	48	71	56	208	
Target	65	65	65	65	260	260

About the target

The target is the number of premises that are categorised as 'High risk' by the respective bodies. This can change annually depending on the number of businesses that are operating, some could cease trading and new businesses could emerge. The assessment by the respective bodies could also change.

About the target range

The target range for this measure allows for no fluctuation against the target

About benchmarking

This measure is local to Lincolnshire and therefore is not benchmarked against any other area.

Lincolnshire COUNTY COUNCIL
Working for a better future

Communities are safe and protected

Increase public confidence in how we tackle domestic abuse

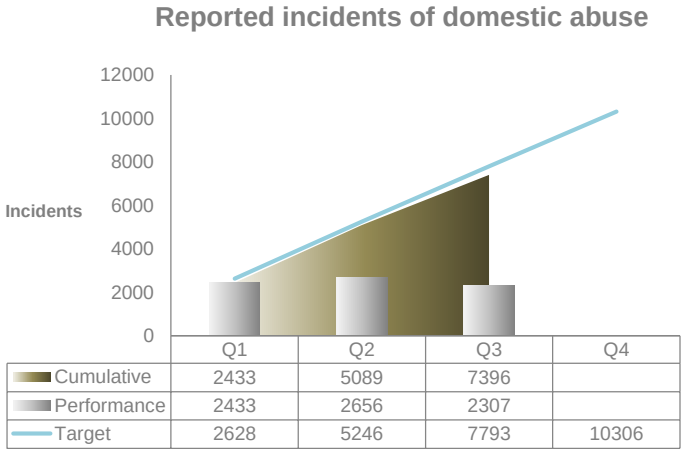
Reported incidents of domestic abuse

This measure is a count of all incidents reported to the Police where a Domestic Abuse Stalking and Harassment (DASH) risk assessment was completed. These risk assessments are performed in all incidents that meet the government's definition of domestic abuse:
"Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to:
Psychological
Physical
Sexual
Financial
Emotional"

Not achieved

7,396
Incidents
Quarter 3 December 2016

7,793
Incidents
Target for December 2016

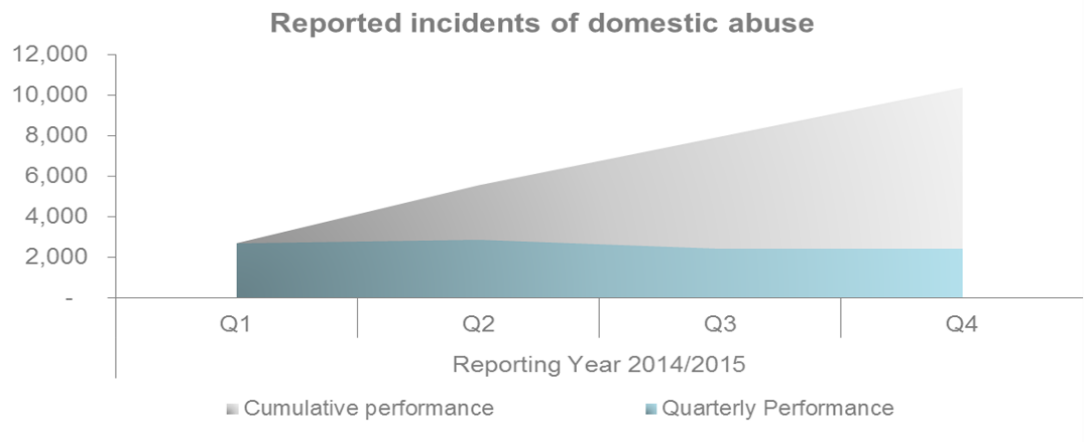


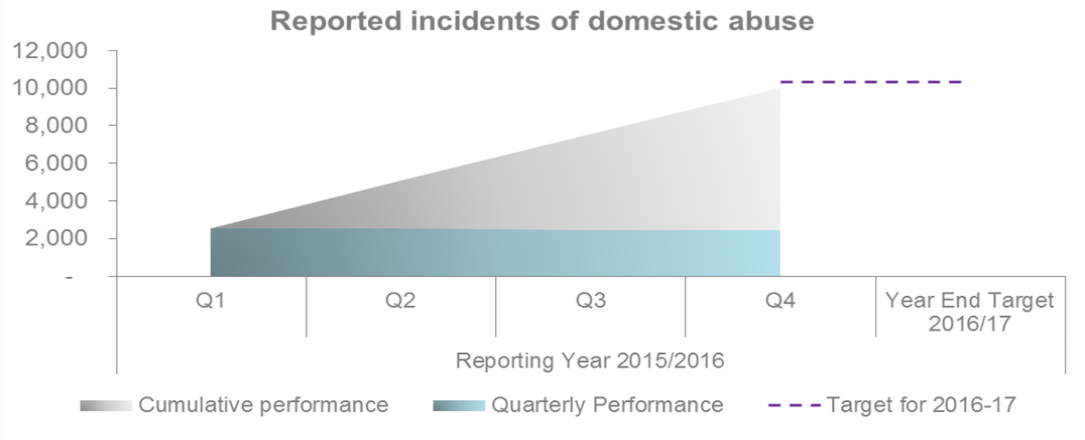
	Q1	Q2	Q3	Q4
Cumulative	2433	5089	7396	
Performance	2433	2656	2307	
Target	2628	5246	7793	10306

About the latest performance

Domestic abuse incidents reported to the police are 9% lower in Quarter 3 2016/17 than in Quarter 3 of 2015/16. Year to date, the number of domestic abuse incidents reported to the police are 2% lower in 2016/17 than they were in 2015/16. Last year was the first year that we saw a plateauing of incidents reported to the police and it was therefore not possible to determine whether this was going to be replicated this year. We can see from the data that there hasn't been as many incidents reported to the police as expected. It is not clear why reporting of incidents is not increasing and is something that will require a considerable amount of analysis and longer term trend data.

Further details





	Reporting Year 2014/2015				Reporting Year 2015/2016				
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Year End Target 2016/17
Cumulative performance	2,663	5,512	7,936	10,327	2,551	5,093	7,566	10,006	
Quarterly Performance	2,666	2,849	2,424	2,391	2,551	2,542	2,473	2,440	10,306

About the target

Increase reports of domestic abuse to the Police by 3%. Domestic Abuse is under reported for many reasons. We take reports of Domestic Abuse seriously and encourage reporting to the Police. Therefore, we want to see an increase in reporting so that we can reach more people who need support.

About the target range

The target range for this measure allows for minimal fluctuation against the target increase of 3%.

About benchmarking

This measure is local to Lincolnshire and therefore is not benchmarked against any other area.

Lincolnshire COUNTY COUNCIL
Working for a better future

Communities are safe and protected

Increase public confidence in how we tackle domestic abuse

Domestic Homicides

A Domestic Homicide is identified by the Police and refers to when someone has been killed as a result of domestic violence. The Police will identify and then notify the Chair of the Community Safety Partnership (CSP) of a domestic homicide and the decision is then made whether or not a Domestic Homicide Review should be undertaken.
A Domestic Homicide Review (DHR) is a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:
(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or
(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.
This measure is a count of the Police notified Domestic Homicides, regardless of whether the decision is made to conduct a DHR or not.

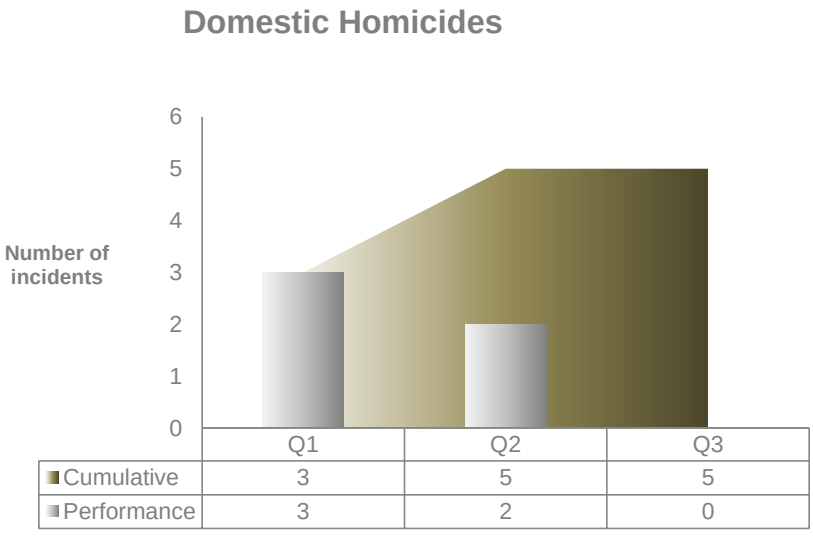
Measured

5

Number of incidents
Quarter 3 December 2016

5

Number of incidents
Quarter 2 2016



	Q1	Q2	Q3
Cumulative	3	5	5
Performance	3	2	0

About the latest performance

So far there are no specific trends or connections between any of the deaths that could account for the sudden increase in domestic homicides in 2016. Each death will be fully reviewed and lessons shared.

Further details

In 2013/14 there was 1 domestic homicide which occurred in Q2.
In 2014/15 there was 1 domestic homicide which occurred in Q1.
In 2015/16 there was 1 domestic homicide which occcured in Q1.

About the target

It is not appropriate to set a target for this measure however early intervention and a multi-agency approach to Domestic Abuse across Lincolnshire means our objective is to have no Domestic Homicides.

About the target range

A target range is not applicable as this is a contextual measure.

About benchmarking

This measure is local to Lincolnshire and therefore is not benchmarked against any other area.

Lincolnshire COUNTY COUNCIL
Working for a better future

Communities are safe and protected

Increase public confidence in how we tackle domestic abuse

Repeat victims of domestic abuse

The Multi-Agency Risk Assessment Conference (MARAC) is a meeting where key agencies formulate action plans to help protect victims of domestic abuse who are at a high risk of murder or serious harm. Local agencies refer high risk victims to MARAC following completion of a Domestic Abuse Stalking and Harrassment (DASH) risk assessment. Following being heard at MARAC, if within 12 months there is a further serious incident reported to the police or a disclosure received by any of the agencies the victim is to be referred back to the MARAC as a 'repeat'. This measure is a count of repeat referrals to MARAC expressed as a percentage of the total MARAC referrals on a rolling 12 month basis. Although this measure is used as a proxy for repeat victims of domestic abuse, it does not provide a full or accurate picture of repeat victimisation. MARAC covers high risk domestic abuse victims who account for less than 8% of all reported incidents of domestic abuse. This disproportion means that there are likely to be higher numbers of repeat victims than can be detected in the MARAC data.

Measured

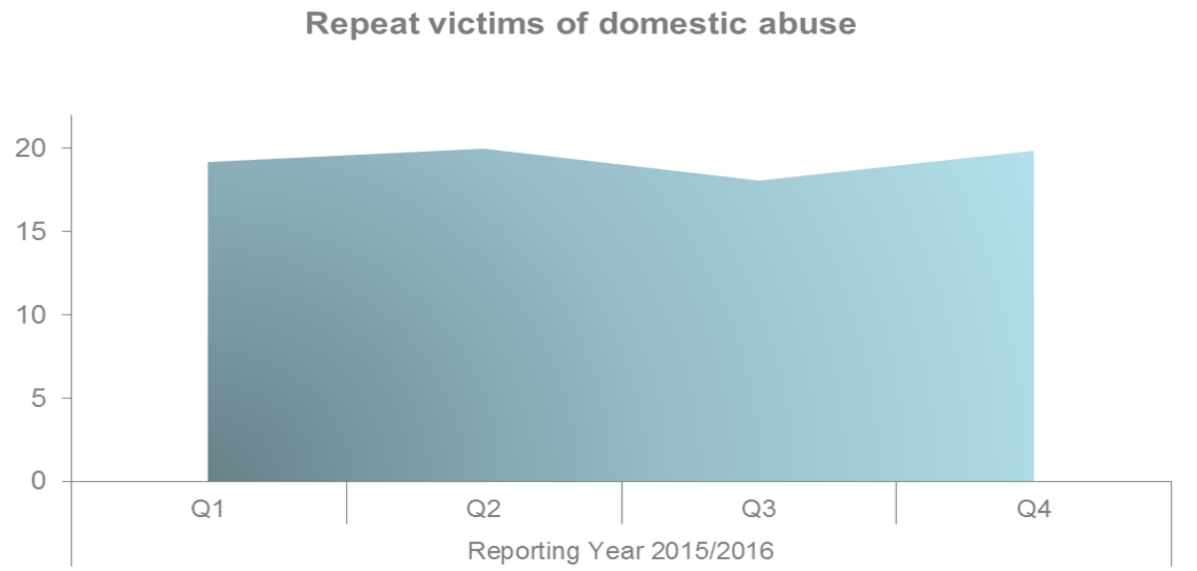
18.1
%
Quarter 3 December 2016

17.8
%
March to June 2016

About the latest performance

Repeat referrals to the Multi-Agency Risk Assessment Conference (MARAC) remain in range of what is expected. Quality assurance work on the MARAC continues and there is a good degree of reassurance that repeat incidents that meet the MARAC repeat referral criteria are being submitted. There are very few inappropriate referrals.

Further details



	Reporting Year 2015/2016			
	Q1	Q2	Q3	Q4
Performance	19.2	20.0	18.1	19.9

About the target

There is currently no active target set and therefore this indicator is reported as measured.

About the target range

A target range is not applicable as this is a contextual measure.

About benchmarking

It is not appropriate to benchmark this measure.

Communities are safe and protected

Reduce the number of people killed and seriously injured on Lincolnshire's roads

People killed and seriously injured in road traffic collisions

Data is reported by calendar year, with 3 month (1 quarter) lag. Revisions in previously reported data can sometimes occur when the reported severity of an injury can increase or decrease (For example an injury may worsen over time or an unreported injury is later found). Subsequent quarter cumulative totals may include revised figures from previous quarters.

Measured

144

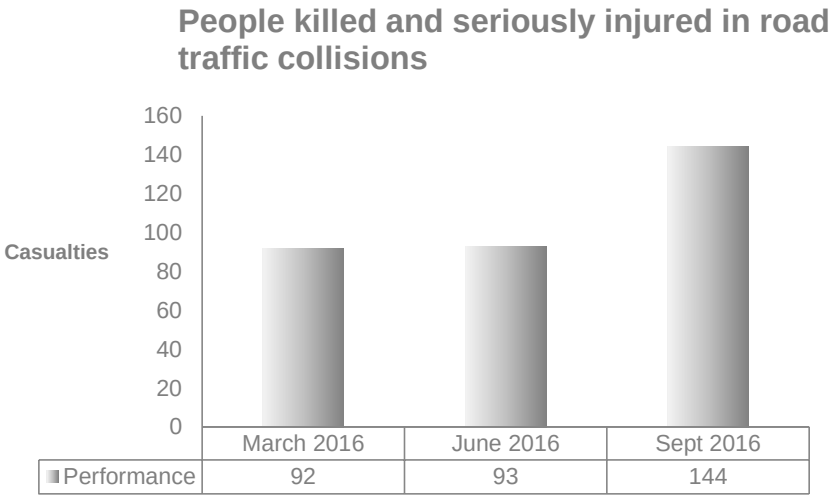
Casualties

June to September 2016

93

Casualties

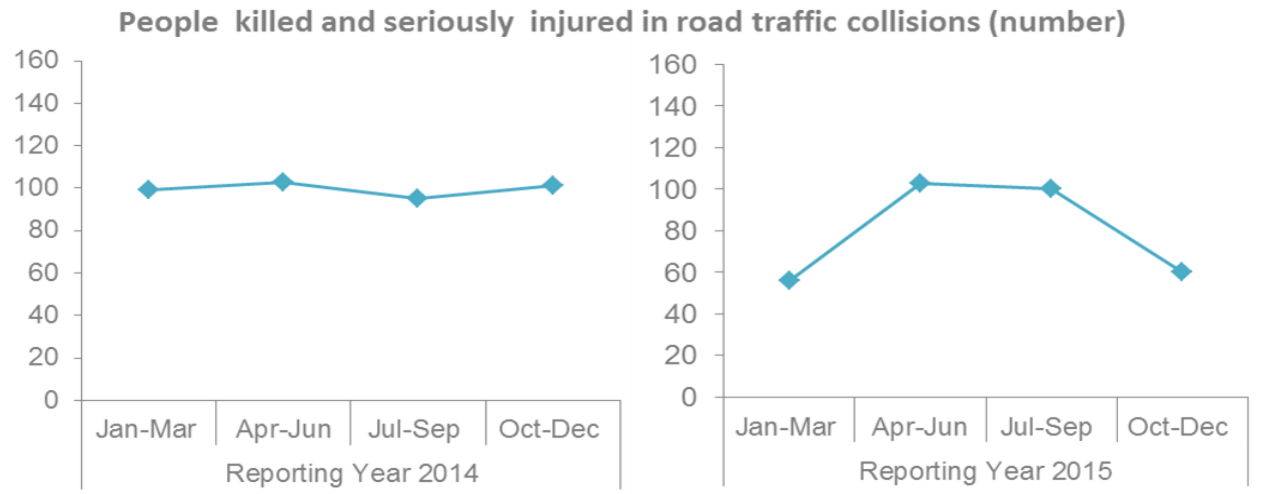
March to June 2016



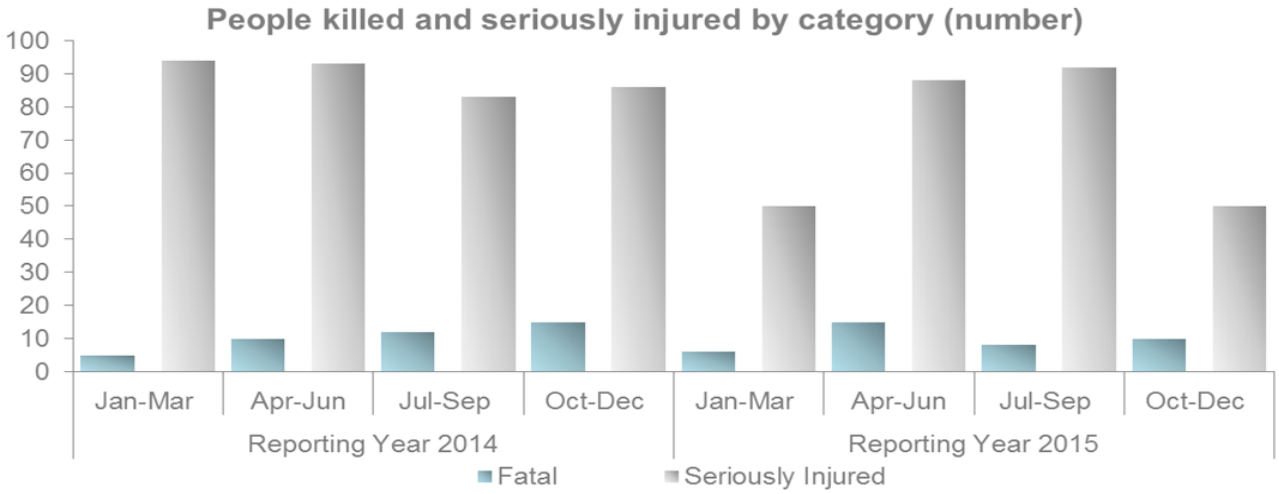
About the latest performance

There is no single area responsible for this increase which has been made up of road users of all types. However, Pedestrian and Child casualties have shown more of an increase. Please note due to revised figures being submitted, Q1's performance figure has been changed accordingly.

Further details



	Reporting Year 2014				Reporting Year 2015			
	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec
People Killed and Seriously Injured	99	103	95	101	56	103	100	60



	Reporting Year 2014				Reporting Year 2015			
	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec
Fatal	5	10	12	15	6	15	8	10
Seriously Injured	94	93	83	86	50	88	92	50

About the target

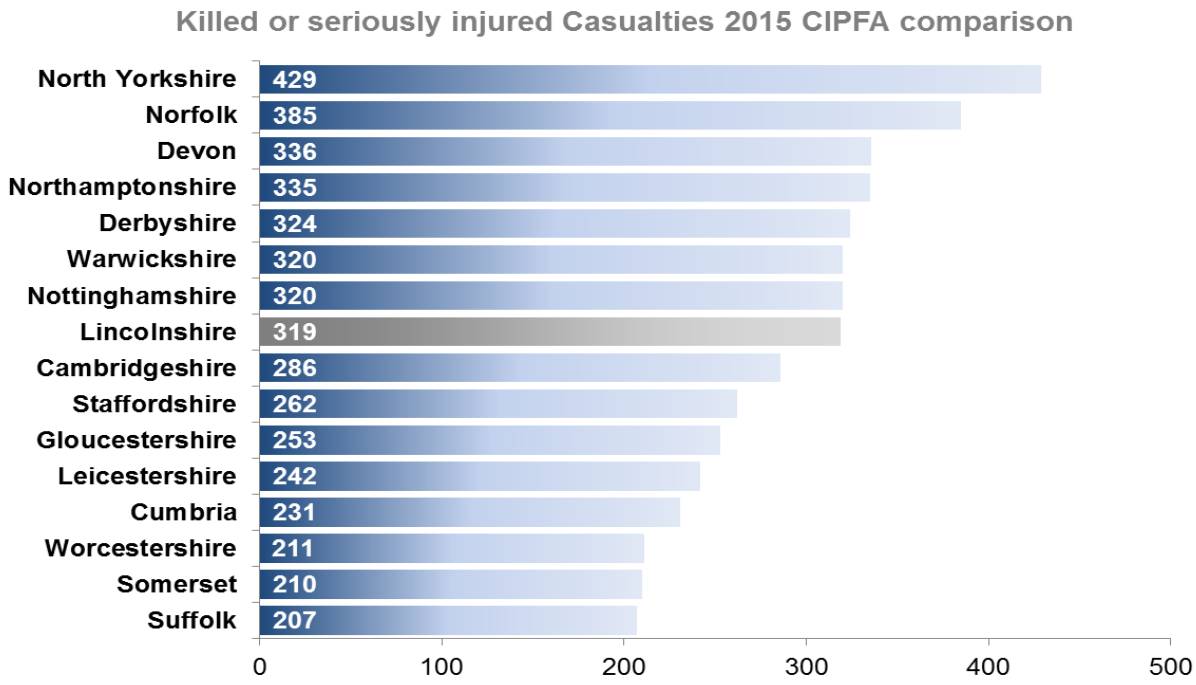
It is not appropriate to set a target for this measure however the Lincolnshire Road Safety Partnership want to see a 20% reduction over 10 years from the 2010/2012 annual average.

About the target range

A target range is not applicable as this is a contextual measure.

About benchmarking

The Department for Transport publish data which allow comparisons to be made with other Councils. Comparison has been made against the CIPFA group of local authorities. The Chartered Institute of Public Finance and Accountancy (CIPFA) facilitates a benchmarking services to enable Local Authority performance to be monitored against other similar local authorities. We benchmark against other Local Authorities within our CIPFA Group of 16 authorities.



Communities are safe and protected

Reduce the number of people killed and seriously injured on Lincolnshire's roads

Children killed or seriously injured in road traffic collisions

Data is reported by calendar year, with 3 month (1 quarter) lag. Revisions in previously reported data can sometimes occur when the reported severity of an injury can increase or decrease (For example an injury may worsen over time or an unreported injury is later found). Subsequent quarter cumulative totals may include revised figures from previous quarters.

Measured

11

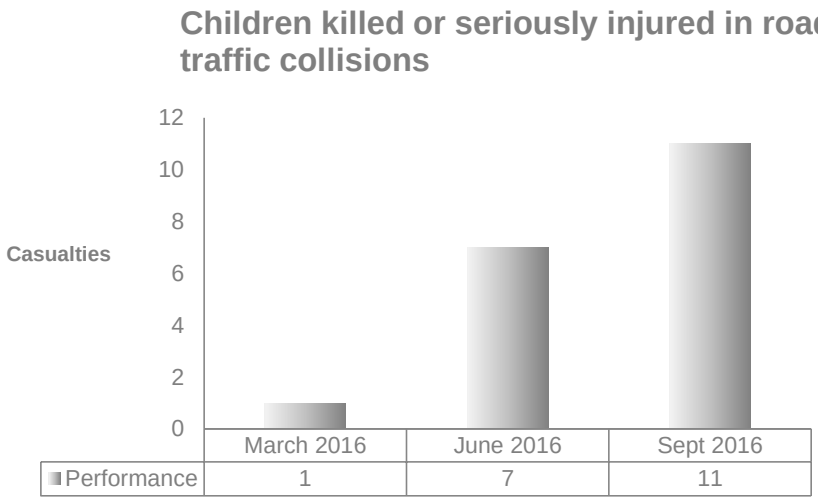
Casualties

June to September 2016

7

Casualties

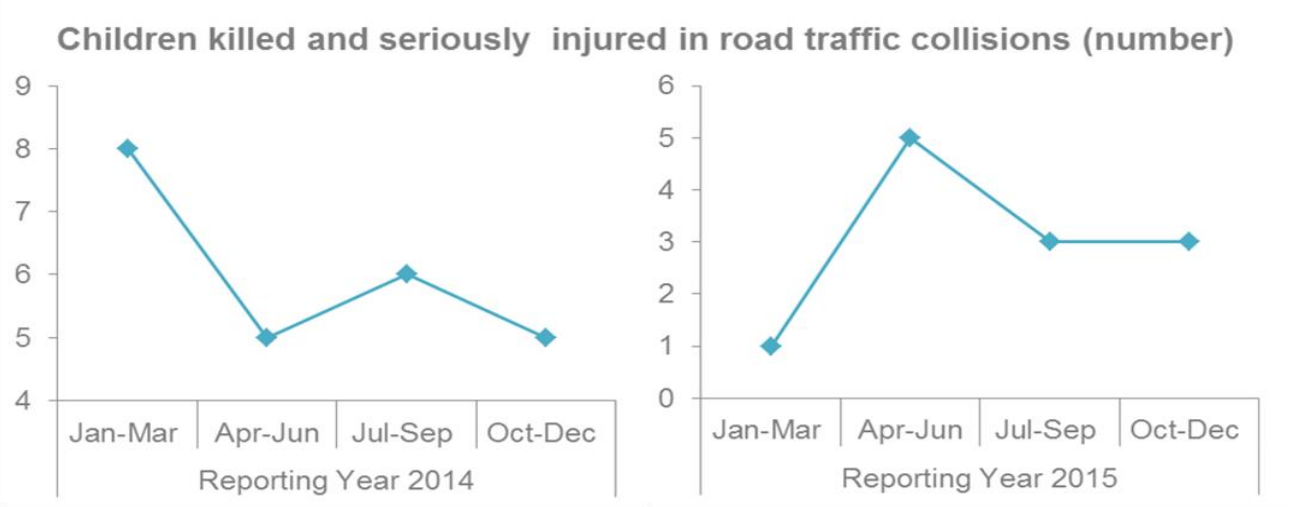
March to June 2016



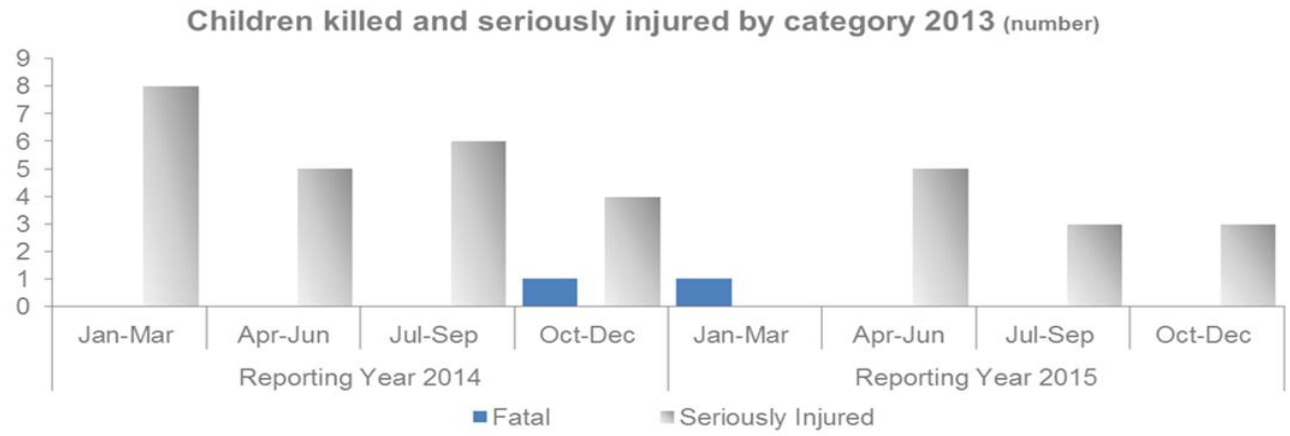
About the latest performance

Highest recorded quarter this decade. This follows 9 (amended from the previous figure of 7) in Quarter 2. Year-end projection will be higher than the most recent 3 years, but still lower than those in 2012 & 2013.

Further details



	Reporting Year 2014				Reporting Year 2015			
	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec
Children Killed and seriously Injured	8	5	6	5	1	5	3	3



	Reporting Year 2014				Reporting Year 2015			
	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec
Fatal	0	0	0	1	1	0	0	0
Seriously Injured	8	5	6	4	0	5	3	3

About the target

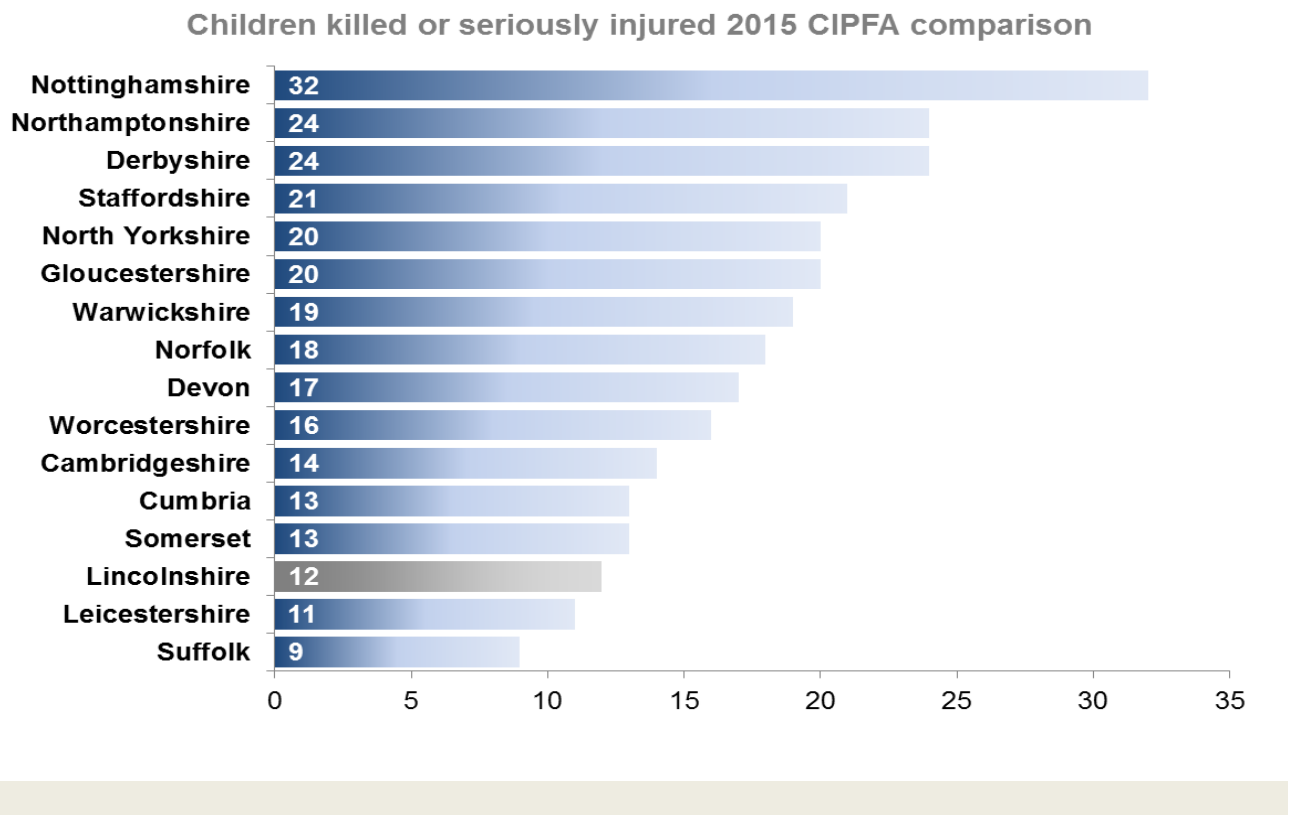
It is not appropriate to set a target for this measure however the Lincolnshire Road Safety Partnership want to see a 20% reduction over 10 years from the 2010/2012 annual average.

About the target range

A target range is not applicable as this is a contextual measure.

About benchmarking

The Department for Transport publish data which allow comparisons to be made with other Councils. Comparison has been made against the CIPFA group of local authorities. The Chartered Institute of Public Finance and Accountancy (CIPFA) facilitates a benchmarking services to enable Local Authority performance to be monitored against other similar local authorities. We benchmark against other Local Authorities within our CIPFA Group of 16 authorities.



Lincolnshire COUNTY COUNCIL
Working for a better future

Communities are safe and protected

Reduce adult reoffending

Satisfaction with response to crime and anti-social behaviour

This measure helps demonstrate our achievement against Section 17 of the Crime and Disorder Act 1998 "Duty to consider crime and disorder implications" which sets out the requirement for Local Authorities to work in partnership with relevant agencies " …to do all that it reasonably can to prevent crime and disorder in its area". Satisfaction that the Police and Local Council are dealing with anti-social behaviour and crime issues is a measure of successful multi-agency response in Lincolnshire.

The measure is a national statistic by the United Kingdom Statistics Authority and is sourced directly from Crime Survey for England and Wales (CSEW) reports.
Data is reported with a 3 month (1 quarter) lag so 2015/16 data will be reported in Q1 2016/17.
Numerator: The number of respondents strongly agreeing or tending to agree that Police and Local Council are dealing with issues.
Denominator: The number of respondents who answered the question.
The Crime Survey for England and Wales does not provide data for the numerator or denominator.

Not achieved

55.6

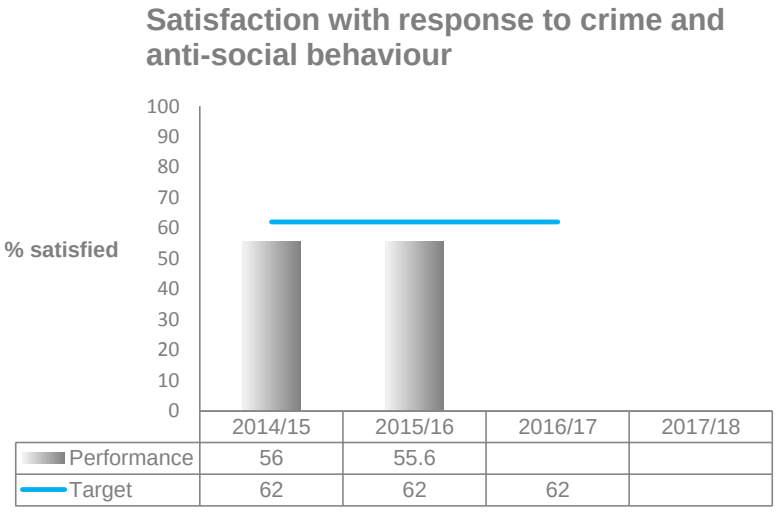
% satisfied

March 2016

62

% satisfied

Target for 2015/16



About the latest performance

Previously under performance has been linked to the failure of officers to keep victims updated in respect of local actions. Further work is required to better understand the drop in performance this year.

Further details

Performance in 2014/15 was 56.2%. A target of 62% is set for 2015/16, and is benchmarked against the national average for England and Wales

About the target

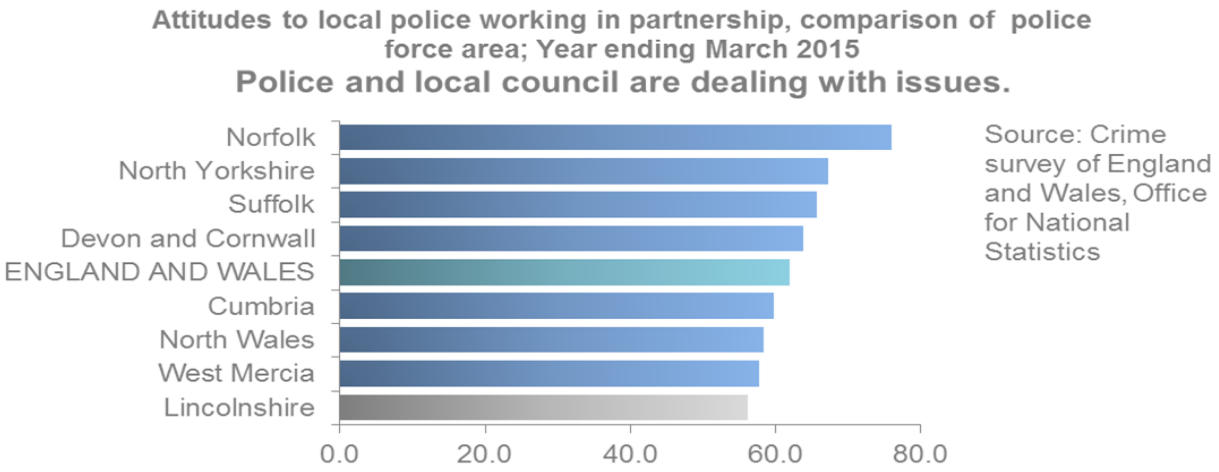
We want to ensure that we fulfil our duty to the public and that our customers are satisfied. Therefore the target for this measure is to exceed the national average for England and Wales (62% in 2014-15).

About the target range

The target range for this measure allows for no fluctuation against the target.

About benchmarking

This measure has been benchmarked against the national average for England and Wales (62% in 2014-15). We aim to exceed the national figure.



% saying strongly agree/tend to agree	
Year ending March 2015	
Lincolnshire	56.2
West Mercia	57.8
North Wales	58.5
Cumbria	59.8
ENGLAND AND WALES	62.0
Devon and Cornwall	63.8
Suffolk	65.8
North Yorkshire	67.3
Norfolk	76.1

c

Communities are safe and protected

Reduce the number of young people committing a crime

Juvenile first time offenders

The First Time Entrant (FTE) measure is a rate per 100,000 of 10-17 population in Lincolnshire. However, for this purpose we are reporting the actual number of young people, rather than the rate. A lower number is a sign of good performance.

Not achieved

293

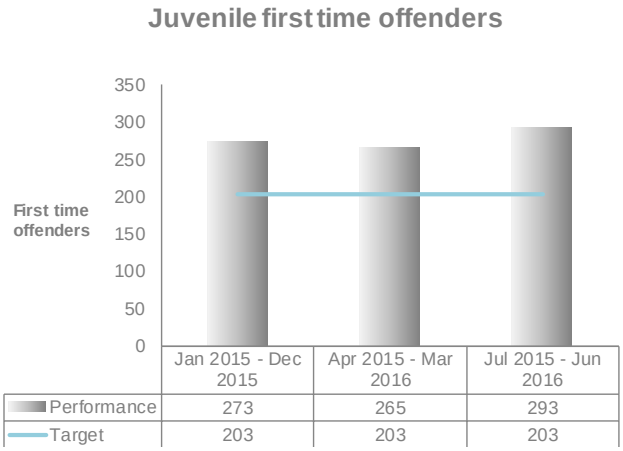
First time offenders

July 2015 to June 2016

203

First time offenders

Target for June 2016

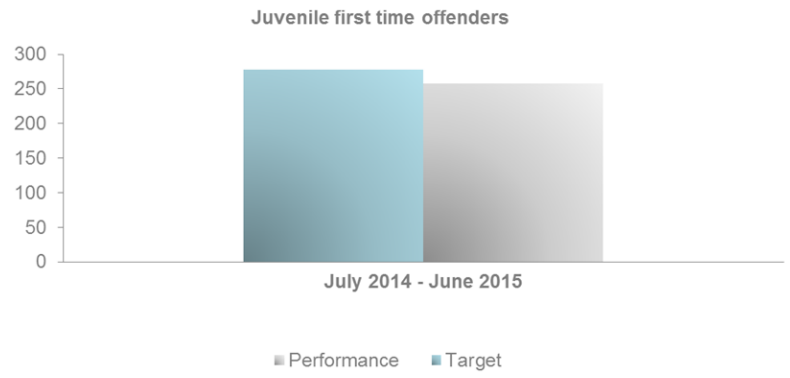


About the latest performance

The most recent published FTE (first time entrants) figure for Lincolnshire is 293 actual young people. This is higher than the target figure of 203, and a slight increase on previous numbers. The number of young people entering the criminal justice system for the first time is mostly controlled by external influences, e.g. Police policies, and therefore it is difficult to predict future performance. However, there are no expectations that this figure is likely to rise sharply in the near future. The figure of 293, when expressed as a rate per 100,000, 10 to 17 year old population is 471, is little higher than the local Midlands region of 377, however the National average is 348.

We are actively examining alternative models of diverting young people away from entering the criminal justice system in the first place. Local Youth Offending Teams in Derbyshire and Leicestershire have run successful schemes over the last 12 months, and we will see how their policies can be applied locally.

Further details



	July 2014 - June 2015
Performance	258.0
Target	278.0

About the target

Our target is based on the average performance of Youth Offending Services within the Midlands Youth Justice Board region. The target is set by Lincolnshire County Council, the Youth Justice Board monitor and challenge progress.

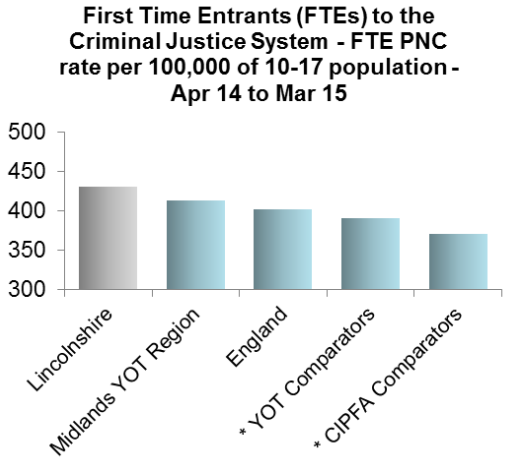
About the target range

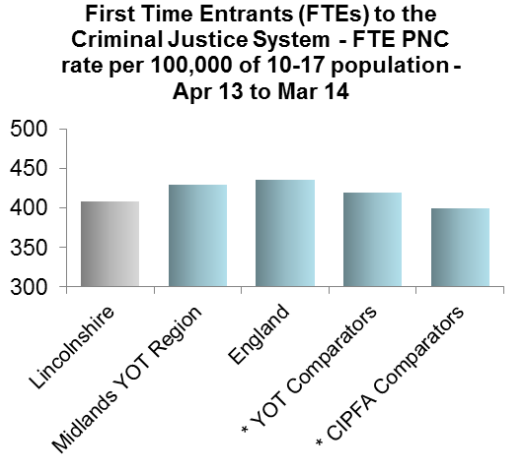
Target ranges are difficult to define as external factors can have a major influence on the numbers of young people entering the criminal justice system for the first time, for example arrests made by the Police and decisions whether to prosecute or not.

About benchmarking

Data from the Ministry of Justice is used to benchmark First Time Entrant per 100,000 population. The Youth Offending Team (YOT) comparators in this instance are Cambridgeshire, Cornwall, Devon, Gloucestershire, Leicestershire, Norfolk, North Yorkshire, Somerset, and West Mercia.
NOTE: The original analysis used in calculating the YOT families (based on socio-economic factors) is now around 10 years old. In that time, the demographics and socio-economic factors of the local areas will have changed. Therefore, it is advised caution be used when using these YOTs families.

Lincolnshire County Council provides performance reports to the Chartered Institute of Public Finance and Accountancy (CIPFA) which facilitates benchmarking services to enable performance to be monitored against other local authorities. We benchmark against other Local Authorities within our CIPFA Group of 16 authorities. The CIPFA comparators in this instance are Cumbria, Derbyshire, Gloucestershire, Norfolk, Nottinghamshire, Somerset, Staffordshire, Suffolk, and Warwickshire.
NOTE: The comparators are taken from the CIPFA website and use the default options for selecting Councils similar to Lincolnshire.





Juvenile first time offenders	Apr 13 - Mar 14		Apr 14 - Mar 15	
	Number	Rate	Number	Rate
Lincolnshire	262	408	271	430
Midlands YOT Region	4122	429	3946	413
England	21372	436	19660	402
* YOT Comparators	2013	420	1801	390
* CIPFA Comparators	2204	400	2004	370

Lincolnshire COUNTY COUNCIL
Working for a better future

Communities are safe and protected

Reduce fires and their consequences

Fire fatalities in primary fires

Number of fatalities from primary fires where the Fire Service attended (per 100,000 population).
Numerator is the number of fire fatalities in primary fires.
Denominator is the population of Lincolnshire.
The rate per 100,000 population is calculated as follows:
Numerator divided by the denominator multiplied by 100,000.

Measured

0.14

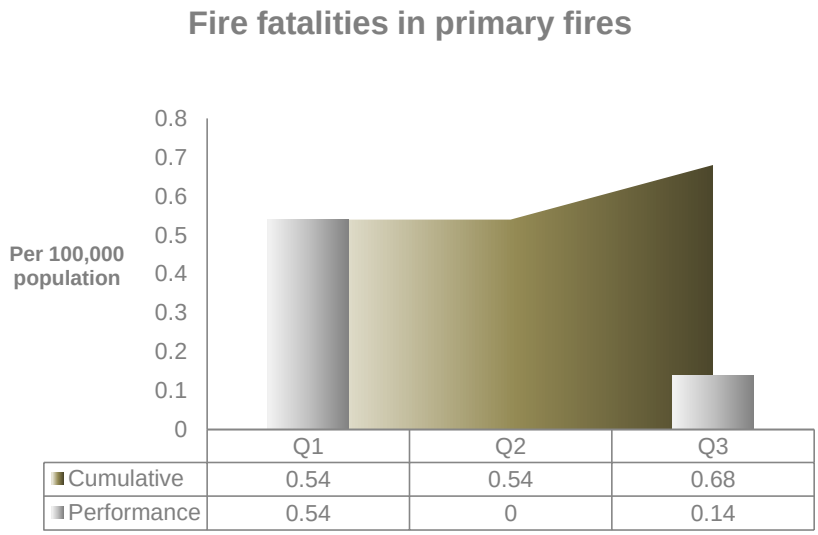
Per 100,000 population

Quarter 3 December 2016

0.00

Per 100,000 population

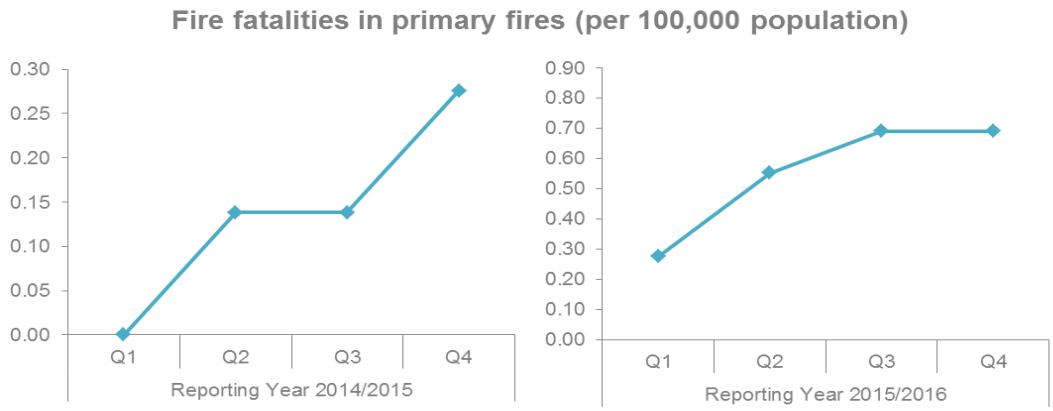
March to June 2016



About the latest performance

Sadly we have had 5 fire fatalities in quarter 3, 3 of which occurred at the same incident, with all 5 fatalities occurring in accidental dwelling fires. The multiple fatality incident was caused by smoking materials, with one of the further fatality incidents being attributed to an unknown cause. The latest fire fatality was unconnected and caused by inappropriate use of heating equipment. We have undertaken targeted campaigns within the community to highlight the dangers associated with these incidents.

Further details



	Reporting Year 2014/2015				Reporting Year 2015/2016			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Value	0.00	0.14	0.14	0.28	0.28	0.55	0.69	0.69
Numerator	0	1	1	2	2	4	5	5
Denominator	724,500	724,500	724,500	724,500	724,500	724,500	724,500	724,500

The graphs have been updated to reflect final coroner verdicts on fire fatalities.

About the target

No target set as this is measured

About the target range

A target range is not applicable as this is a contextual measure.

About benchmarking

Benchmarking data for this measure is not available

Health and Wellbeing is improved

Peoples' health and wellbeing is improved

Chlamydia diagnoses

Crude rate of chlamydia diagnoses per 100,000 young adults aged 15-24 based on their area of residence.

Chlamydia is the most commonly diagnosed sexually transmitted infection. It causes avoidable sexual and reproductive ill-health, including symptomatic acute infections and complications such as pelvic inflammatory disease (PID), ectopic pregnancy and tubal-factor infertility. The chlamydia diagnosis rate amongst under 25 year olds is a measure of chlamydia control activities. It represents infections identified (reducing risk of sequelae in those patients and interrupting transmission onto others). Increasing diagnostic rates indicates increased control activity: it is not a measure of morbidity. Inclusion of this indicator in the Public Health Outcomes Framework allows monitoring of progress to control chlamydia.

Numerator:
The number of people aged 15-24 diagnosed with chlamydia
(http://www.chlamydiascreening.nhs.uk/ps/data.asp)

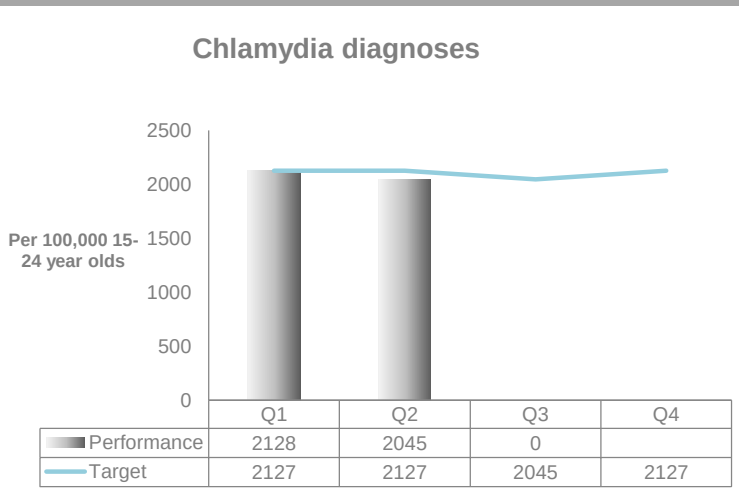
Denominator:
Resident population aged 15-24
(Office of National Statistics)

Data not available

Per 100,000 15-24 year olds
Quarter 1 June 2016

2,045

Per 100,000 15-24 year olds
Target for June 2016

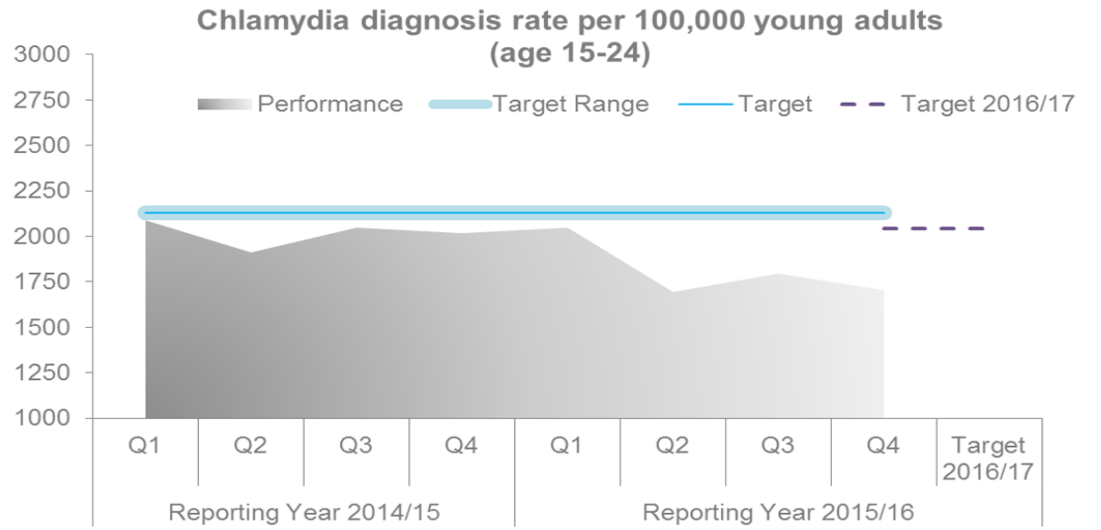


	Q1	Q2	Q3	Q4
Performance	2128	2045	0	
Target	2127	2127	2045	2127

About the latest performance

We are unable to report chlamydia performance for this quarter due to data quality issues between nationally published information and performance data submitted by our provider. This is being investigated through contract management discussions with the provider to clarify. Data is expected to be reported again in Q4.

Further details



	Reporting Year 2014/15				Reporting Year 2015/16				
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Target 2016/17
Performance	2087	1910	2045	2015	2045	1692	1795	1702	
Numerator	1786	1635	1635	1725	2127	2127	2127	2127	
Denominator	85587	85587	85587	85587	85587	85587	85587	85587	
Target	2127	2127	2127	2127	2127	2127	2127	2127	2045
Upper Range +2%	2170	2170	2170	2170	2170	2170	2170	2170	
Lower Range -2%	2084	2084	2084	2084	2084	2084	2084	2084	

About the target

After taking advice from National Chlamydia Screening Programme and the Director of Public Health for Lincolnshire, we have agreed a target lower than the national figure of 2,300 in order for it to be realistic for Lincolnshire. Historical data shows it is unlikely that the national target will be reached locally. The lower target of 2,127 per 100,000 young adults age 15- 24 equates to a 10% increase on the previous year's performance.

About the target range

The target range for this measure is between 2021 and 2233, this is based on an expectation of fluctuation in performance across the year

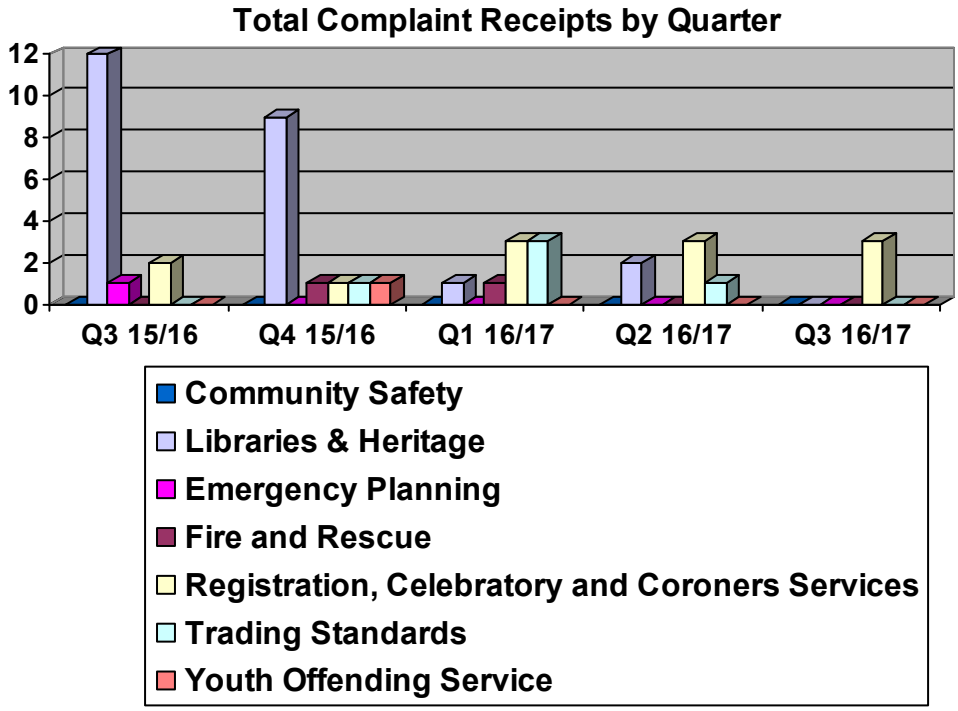
About benchmarking

There is no benchmarking currently available for this measure but will be included from 2016/17

Customer Satisfaction Information – Scrutiny Committees

Community and Public Safety Scrutiny Committee		
Date Range for Report	1st of October – 31st of December (1st of July – 30th of September)	
Total number of complaints received across all LCC service area.	143 (117)* individual school complaints not included.	
Total number of complaints relating to <u>Communities Scrutiny Committee</u>	3 (6)	
Total number of compliments relating to <u>Communities Scrutiny Committee</u>	47 (26)	
Total Service Area Complaints	Community Safety	0 (0)
	Community Cohesion	0 (0)
	Emergency Planning	0 (0)
	Fire and Rescue	0 (0)
	Registration, Celebratory and Coroners Services	3 (3)
	Trading Standards	0 (1)
	Youth Offending Service	0 (0)
	Public Health	0 (0)
	Libraries & Heritage	0 (2)
Libraries and Heritage Complaint Reasons	Age	0 (0)
	Breach of Confidence	0 (0)
	Conduct/Attitude/Rudeness of staff	0 (0)
	Delayed Assessment of Service Request	0 (0)
	Disability	0 (0)
	Disagree with Policy	0 (1)
	Disagree with Procedure	0 (0)
	Geographic Location	0 (0)
	Insufficient Information Provided	0 (0)
	Lack of Choice	0 (0)
	Policy of LCC not to provide service	0 (0)
	Policy - Other	0 (0)
	Racism	0 (0)
	Religion/Belief	0 (0)
	Other	0 (0)
	Professional – other	0 (1)
	Procedural – other	0 (0)
	Procedure not followed	0 (0)
	Service Delay	0 (0)
Fire & Rescue Complaint Reasons	Breach of Confidence	0 (0)
	Conduct/Attitude/Rudeness of staff	0 (0)
	Delayed Assessment of Service Request	0 (0)

	Disagree with Procedure	0 (0)
	Disagree with Policy	0 (0)
	Insufficient Information Provided	0 (0)
	Other	0 (0)
	Procedure Not Followed	0 (0)
	Procedural - Other	0 (0)
	Professional - Other	0 (0)
	Service Delay	0 (0)
Registration, Celebratory and Coroners Complaint Reasons	Breach of Confidence	0 (0)
	Conduct/Attitude/Rudeness of staff	1 (2)
	Disagree with policy	0 (0)
	Disagree with Procedure	0 (0)
	Insufficient Information Provided	2 (0)
	Service delay	0 (1)
	Policy - Other	0 (0)
	Procedure not followed	0 (0)
	Professional – Other	0 (0)
Trading Standards Complaint Reasons	Conduct/Attitude/Rudeness of staff	0 (0)
	Delayed Assessment of Service Request	0 (0)
	Disagree with Policy	0 (1)
	Disagree with Procedure	0 (0)
	Procedure not followed	0 (0)
Youth Offending Complaint Reasons	Conduct/Attitude/Rudeness of staff	0 (0)
	Other	0 (0)
	Procedural – Other	0 (0)
	Professional – Other	0 (0)
	Lack of Information/Communication	0 (0)
Public Health Complaint Reasons	Breach of Confidence	0 (0)
Service Area Compliments	Community Safety	8 (0)
	Libraries and Heritage	18 (6)
	Emergency planning	0 (0)
	Fire and Rescue	11 (8)
	Registration, Celebratory and Coroners Services	10 (12)
	Trading Standards	0 (0)
	Youth Offending Service	0 (0)
	Public Health	0 (0)
How many LCC Corporate complaints have not been resolved within service standard	6 (8)	
Number of complaints referred to Ombudsman	8 (8)	



Summary

LCC Overview of Complaints

The total number of LCC complaints received this Quarter (Q3) shows a 18% increase on the previous quarter (Q2). When comparing this Quarter with Q3 of 2015/16, there is a 6% decrease when 152 complaints were received.

Overall Communities Complaints
This Quarter Communities has received 3 complaints which is a 50% decrease on the previous Quarter (Q1).

Libraries and Heritage Complaints
This Quarter Libraries and Heritage received 0 complaints.

Registration, Celebratory and Coroners Complaints
This Quarter, Registration, Celebratory and Coroners received 3 complaints which is the same as last quarter. 1 of these complaints received was regarding a member of the complainants estranged family conducted the wedding ceremony to his new wife. This was recorded as partly substantiated. 1 complaint was regarding the appearance and manner of a registrar. There has been no outcome registered against this complaint. The 3rd complaint was regarding delays with the coroners' service. There has been no outcome registered against this complaint.

Fire and Rescue Complaints
Fire and Rescue received no complaints this Quarter.

Youth Offending Complaints
Youth Offending received no complaints this Quarter.

Public Health Complaints
Public Health received no complaints this Quarter.

Trading Standards Complaints
Trading Standards received no complaints this Quarter.

Overall Communities Compliments
This Quarter, Communities received 46 compliments which is an increase of 21 compliments to the number of compliments received last Quarter when 26 were received.

Libraries and Heritage Compliments
Libraries and Heritage received 17 compliments this Quarter. The Libraries and Heritage compliments are:

- 9 compliments were for the archives services.
- 6 compliments were received for visits to Lincoln Castle, including thanks for the Castle improvements, the Somme event and praise for the Lincoln Castle Staff.
- 2 compliments were received in relation to Grantham library staff.

Registration, Celebratory and Coroners Compliments
Registration, Celebratory and Coroners has received 10 compliments this Quarter. This is an decrease of 2 compliments from the previous Quarter when 12 were received.
The compliments are:

- 8 notes of thanks for wedding/civil partnership ceremonies.
- 2 notes of thanks for support during death registrations and services.

Community Safety Compliments
This Quarter, Community Safety has received 8 compliments. These were all in relation to the "Ask Angela" campaign

Fire & Rescue Compliments
This Quarter, Fire & Rescue received 11 compliments; this is an increase of 3 compliments from last Quarter when 8 were received.
The compliments are:

- 5 compliments received for a fire Responder who attended medical emergencies
- 1 compliment from a member of the public on installation of their fire alarm.
- 1 compliment from Shropshire fire service on the training facility
- 2 compliments were received for attendance at minor house fires
- 1 compliment was received from a class who visited a fire station
- 1 compliment was received from Skegness library in relation to a pre Christmas fire safety event.

Ombudsman Complaints
In Quarter 3 of 2016/17, 8 LCC complaints were registered with the Ombudsman. Communities and Public safety received no complaints that were considered by the Ombudsman.

Lincolnshire COUNTY COUNCIL
Working for a better future

Policy and Scrutiny

Open Report on behalf of Richard Wills, Director responsible for Democratic Services	
Report to:	**Community and Public Safety Scrutiny Committee**
Date:	**09 March 2017**
Subject:	**Community and Public Safety Scrutiny Committee Work Programme**

Summary:

This item enables the Committee to consider and comment on the content of its work programme for the coming year to ensure that scrutiny activity is focused where it can be of greatest benefit. Members are encouraged to highlight items that could be included for consideration in the work programme.

The work programme will be reviewed at each meeting of the Committee to ensure that its contents are still relevant and will add value to the work of the Council and partners.

Actions Required:

Members of the Committee are invited to consider and comment on the work programme as set out in Appendix A to this report and highlight any additional scrutiny activity that could be included for consideration in the work programme.

1. Background

The Committee's work programme for the coming year is attached at Appendix A to this report. The Committee is invited to consider and comment on the content of the work programme.

Work Programme Definitions

Set out below are the definitions used to describe the types of scrutiny, relating to the items on the Work Programme:

Budget Scrutiny - The Committee is scrutinising the previous year's budget, or the current year's budget or proposals for the future year's budget.

Pre-Decision Scrutiny - The Committee is scrutinising a proposal, prior to a decision on the proposal by the Executive, the Executive Councillor or a senior officer.

Performance Scrutiny - The Committee is scrutinising periodic performance, issue specific performance or external inspection reports.

Policy Development - The Committee is involved in the development of policy, usually at an early stage, where a range of options are being considered.

Consultation - The Committee is responding to (or making arrangements to) respond to a consultation, either formally or informally. This includes pre-consultation engagement.

Status Report - The Committee is considering a topic for the first time where a specific issue has been raised or members wish to gain a greater understanding.

Update Report - The Committee is scrutinising an item following earlier consideration.

Scrutiny Review Activity - This includes discussion on possible scrutiny review items; finalising the scoping for the review; monitoring or interim reports; approval of the final report; and the response to the report.

2. Conclusion

To consider and comment on the work programme and highlight any additional scrutiny activity that could be included for consideration.

3. Consultation

a) Have Risks and Impact Analysis been carried out?
Not Applicable

b) Risks and Impact Analysis
Not Applicable

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Community and Public Safety Scrutiny Committee Work Programme
Appendix B	Forward Plan of Decisions relating to Community and Public Safety Scrutiny Committee

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 Daniel Steel, Scrutiny Officer, who can be contacted on 01522 552102 or by e-mail at daniel.steel@lincolnshire.gov.uk

COMMUNITY AND PUBLIC SAFETY SCRUTINY COMMITTEE

Chairman: Councillor Chris Brewis
Vice Chairman: Councillor Linda Wootten

Thursday 09 March 2017 Fire & Rescue Training Facility, Waddington		
Item	**Contributor**	**Purpose**
Annual Report of the Director of Public Health on the Health of the People of Lincolnshire 2016	Tony McGinty, Interim Director of Public Health	Annual Report
Performance Report, Quarter 3 (1 October to 31 December 2016)	Daryl Pearce, County Officer Public Protection; Nicole Hilton, Community Assets and Resilience Commissioning Manager; Robin Bellamy, Assistant Director Public Health Commissioning, Nick Borrill, Acting Chief Fire Officer	Performance Scrutiny

19 April 2017		
Item	**Contributor**	**Purpose**

For more information about the work of the Community and Public Safety Scrutiny Committee please contact Daniel Steel, Scrutiny Officer on 01522 552102 or by e-mail at daniel.steel@lincolnshire.gov.uk

APPENDIX B

Forward Plan of Decisions relating to Community and Public Safety Scrutiny Committee

DEC REF	MATTERS FOR DECISION	DATE OF DECISION	DECISION MAKER	PEOPLE/GROUPS CONSULTED PRIOR TO DECISION	DOCUMENTS TO BE SUBMITTED FOR DECISION	HOW AND WHEN TO COMMENT PRIOR TO THE DECISION BEING TAKEN	RESPONSIBLE PORTFOLIO HOLDER AND CHIEF OFFICER	KEY DECISION YES/NO	DIVISIONS AFFECTED
I012990	Re-procurement of Wellbeing Service	Between 17 March 2017 and 24 March 2017	Executive Councillor: Adult Care, Health and Children's Services	Community and Public Safety Scrutiny Committee	Report	Senior Strategic Commissioning Support Manager - People Services Tel: 01522 553919 Email: alina.hackney@lincolnshire.gov.uk	Executive Councillor: Adult Care, Health and Children's Services and Executive Director of Children's Services	Yes	All Divisions