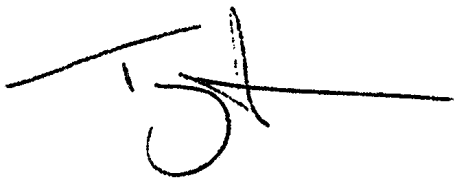
County Offices
Newland
Lincoln
LN1 1YL

19 September 2016

Lincolnshire Health and Wellbeing Board

A Meeting of the Lincolnshire Health and Wellbeing Board will be held on Tuesday, 27 September 2016 at 2.00 pm in Committee Room One, County Offices, Newland, Lincoln LN1 1YL

Yours sincerely



Tony McArdle
Chief Executive

MEMBERS OF THE BOARD (*)

Lincolnshire County Council: Councillors: Mrs S Woolley (Executive Councillor for NHS Liaison and Community Engagement) (Chairman), Mrs P A Bradwell (Executive Councillor for Adult Care, Health and Children's Services), C N Worth (Executive Councillor for Culture and Emergency Services), D Brailsford, B W Keimach, C R Oxby and N H Pepper and 1 vacancy

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

District Council: Councillor Marion Brighton OBE

GP Commissioning Group: 1 Vacancy, Dr Vindi Bhandal (South West Lincolnshire CCG), Dr Kevin Hill (South Lincolnshire CCG), Dr Sunil Hindocha (Lincolnshire West CCG) and Dr Peter Holmes (Lincolnshire East CCG)

Healthwatch Lincolnshire: Sarah Fletcher

NHS England: Mr Jim Heys

(*) Permanent Membership

LINCOLNSHIRE HEALTH AND WELLBEING BOARD AGENDA
TUESDAY, 27 SEPTEMBER 2016

Item	Title	Pages	Estimated Time
1	**Apologies for absence/Replacement Members**		
2	**Declarations of Members' Interest**		
3	**Minutes of the Lincolnshire Health and Wellbeing Board meeting held on 7 June 2016**	5 - 14	
4	**Action Updates from the previous meeting** *(For the Lincolnshire Health and Wellbeing Board to consider the actions arising from the previous meeting)*	15 - 16	
5	**Chairman's Announcement** *(For the Lincolnshire Health and Wellbeing Board to note the Chairman's announcements)*	17 - 22	
6	**Decision/Authorisation Items**		
6a	**Annual Assurance Report** *(To receive a report from Alison Christie, Programme Manager Health and Wellbeing, which asks the Board to agree the Board's Assurance Report and Theme Dashboards)*	23 - 38	
6b	**Prioritisation Framework for the Development of the Joint Health and Wellbeing Strategy** *(To receive a report from David Stacey, Programme Manager, Strategy and Performance, which asks the Board to agree the prioritisation framework for the new Joint Health and Wellbeing Strategy; (JHWS) and to agree the process for developing the JHWS)*	39 - 48	
7	**Discussion Items**		
7a	**Joint Commissioning Board - Update Report** *(For the Board to receive an update report from Glen Garrod, Executive Director Adult Social Services with regard to the Better Care Fund; and Dr Sunil Hindocha, Chairman of the Joint Commissioning Board concerning the joint commissioning arrangements in Lincolnshire)*	49 - 64	

Item	Title	Pages	Estimated Time
7b	**Lincolnshire Sustainability and Transformation Plan - (including Lincolnshire Health and Care)** *(To receive an update report from Sarah Furley, Programme Director for the Lincolnshire Health and Care Sustainability and Transformation Plan, concerning the LSP/LHAC)*	65 - 72	
7c	**District/Locality Updates** *(To receive by exception, updates from District/Locality partnerships on issues which may impact on the delivery of the Joint Health and Wellbeing Strategy. No items tabled for this meeting)*	Verbal Report	
8	**Information Items**		
8a	**An Action Log of previous Decisions** *(For the Health and Wellbeing Board to note decisions taken since June 2016)*	73 - 74	
8b	**Lincolnshire Health and Wellbeing Board - Forward Plan** *(This item provides the Board with an opportunity to discuss items for future meetings which will subsequently be included on the Forward Plan)*	75 - 76	

Democratic Services Officer Contact Details

Name: **Katrina Cope**

Direct Dial **01522 552104**

E Mail Address katrina.cope@lincolnshire.gov.uk

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

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

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

This page is intentionally left blank

LINCOLNSHIRE HEALTH AND WELLBEING BOARD
7 JUNE 2016

PRESENT: COUNCILLOR MRS S WOOLLEY (CHAIRMAN)

Lincolnshire County Council: Councillors D Brailsford, B W Keimach and N H Pepper.

Lincolnshire County Council Officers: Glen Garrod (Executive Director of Adult Social Services), Mary Meredith (Head of Children's Service Manager, Inclusion) and Liz Morgan (Consultant in Public Health, Health Protection).

District Council: Councillor Jeff Summers.

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

Healthwatch Lincolnshire: Sarah Fletcher.

NHS England: Hayley Jackson.

Officers In Attendance: Katrina Cope (Senior Democratic Services Officer), Alison Christie (Programme Manager, Health and Wellbeing Board), Allan Kitt (Chief Officer South West Lincolnshire CCG) and David Stacey (Programme Manager, Public Health).

1 ELECTION OF CHAIRMAN

RESOLVED

That Councillor Mrs S Woolley be elected as the Chairman of the Lincolnshire Health and Wellbeing Board for 2016/17.

COUNCILLOR MRS SUE WOOLLEY IN THE CHAIR

2 ELECTION OF VICE-CHAIRMAN

RESOLVED

That Dr Sunil Hindocha be elected as the Vice-Chairman of the Lincolnshire Health and Wellbeing Board for 2016/17.

3 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

Apologies for absence were received from Councillors Mrs P A Bradwell (Executive Councillor Adult Care, Health and Children's Services), C N Worth (Executive Councillor Culture and Emergency Services), C R Oxby, and Debbie Barnes (Executive Director Children's Services), Dr Tony Hill (Executive Director of Public Health), Councillor Mrs M Brighton OBE, (District Council Representative), Dr Peter Holmes, Lincolnshire East CCG) and Mr Jim Heys (NHS England).

It was reported that Mary Meredith (Head of Children's Service Manager, Inclusion), Liz Morgan (Public Health Consultant, Health Protection), Councillor J Summers (District Council representative), Andy Rix (Lincolnshire East CCG) and Hayley Jackson (NHS England) had replaced Debbie Barnes (Executive Director Children's Services), Dr Tony Hill (Executive Director of Public Health), Councillor Mrs M Brighton OBE (District representative), Dr Peter Holmes (Lincolnshire East CCG), and Mr Jim Heys (NHS England) respectively, for this meeting only.

4 DECLARATIONS OF MEMBERS' INTEREST

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

5 MINUTES OF THE LINCOLNSHIRE HEALTH AND WELLBEING BOARD MEETING HELD ON 22 MARCH 2016

RESOLVED

That the minutes of the Lincolnshire Health and Wellbeing Board meeting, held on 22 March 2016, be confirmed and signed by the Chairman as a correct record.

6 ACTION UPDATES FROM THE PREVIOUS MEETING

RESOLVED

That the completed actions as detailed be noted.

7 CHAIRMAN'S ANNOUNCEMENT

The Board was advised that Cllr Stuart Tweedale had stepped down from the Committee due to other commitments. The Chairman extended thanks on behalf of Board to Councillor Tweedale for all his support.

The Chairman thanked members for attending the informal session, and invited the Board them to come forward with any suggestions to encourage others to attend informal meetings.

8 DECISION/AUTHORISATION ITEMS

8a Terms of Reference, Procedural Rules, Board Members Roles and Responsibilities

The Board gave consideration to a report from Alison Christie, Programme Manager Health and Wellbeing, which asked the Board to review and re-affirm the Terms of Reference, Procedural Rules and Board Members Roles and Responsibilities, as there were no significant changes.

A copy of the Lincolnshire Health and Wellbeing Board Terms of Reference and Procedure Rules was detailed as Appendix A to the report presented for the Board's consideration.

Concerns were expressed from Councillor G Summers (District Council representative) concerning whether the amount of Disabled Facility Grant received by the Districts for 2016/17 was correct, and that the Districts felt that they should decide where to spend it. The District representative also expressed concerns as to whether the Lincolnshire Health and Wellbeing Board in signing off the BCF was in breach of national grant conditions. Officers advised that an explanation would be given under item 9a on the agenda.

A further concern was expressed by the District representative to the membership of the Board; as it was felt that there were too many top tier members, and it was felt that the Districts needed more members to fully express their needs with regard to housing, devolution and DFG's.

The Chairman reiterated that she had been disappointed with District Council attendance at the informal meeting, when all had been invited. The evidence to date had clearly shown that when invitations were religiously sent to all, hardly any District representatives attended.

Clarification was sought by the District representative as to how Councillor M Brighton OBE had been appointed to the Board in the first instance. The Board was advised that the appointment had been made through the Chief Executive's and Leaders meeting. The Chairman agreed to look into the Board make-up, and advised that the formal meeting of the Board was open to the public; and as such all Districts' could send either an officer or elected member to observe.

A further comment made was that with the Lincolnshire Aspiration for Devolution, there would need to be a more balanced approach on the Board with the NHS and other members this would then encourage positive dialogue, and a more balance approach, which would be fit for purpose as developments moved forward.

The District representative requested clarification with regard to the decision making process relating to the BCF. The Executive Director of Adult Social Services agreed to respond to the District's with regard to the BCF process.

RESOLVED

That the Terms of Reference, Procedural Rules and Board Members Roles and Responsibilities be re-affirmed.

8b Proposal for the development of the Joint Health and Wellbeing Strategy

Consideration was given to a report from David Stacey, Programme Manager, Strategy and Performance, which asked the Board to consider the approach to be taken for the development of the next Joint Health and Wellbeing Strategy. It was noted that it would have a specific focus on the framework and principles on how evidence from the Joint Strategic Needs Assessment would be synthesised and prioritised into the themes and priorities for the next Joint Health and Wellbeing Strategy through adopting a systematic methodology.

It was highlighted that a statutory duty under the Health and Social Care Act 2012 required the Local Authority and its partner clinical commissioning groups to produce a Joint Health and Wellbeing Strategy (JHWS) for meeting the needs identified in the Joint Strategic Needs Assessment (JSNA). The Board noted that the current JHWS was due to end in 2018, and that the review of the JSNA which was being undertaken would be expected to form the basis upon which a new JHWS would be developed.

The Board were advised that evidence had suggested that a prioritisation framework should be developed and should ideally contain five principle elements, which were:-

- Stakeholder engagement;
- A clear and transparent process;
- Decisions based on clear value choices (underpinned by a sound evidence base); and
- Selection of an agreed prioritisation methodology that takes into account the ranking/scoring of a range of factors, or criteria.

It was reported that there was a range of prioritisation tools available across the health and care sector. It was noted that for the purpose of this exercise it was proposed that a variation on the multi-criteria decision analysis (MCDA) would be used. The Board was advised that an initial nine proposed criteria had been drafted to potentially be taken into account in developing a prioritisation framework for Lincolnshire. The nine criteria were as follows:-

- Strategic fit with national and/or local policy and outcome framework;
- Potential to reduce or improve health inequalities/equity;
- Strength of evidence demonstrating better outcomes or being receptive to change;
- Consideration of any economic evaluations undertaken to ensure value for money;
- Likely magnitude of benefit relating to improved clinical and social outcomes;
- Scale of impact in terms of the number of people benefiting;

- Public acceptability based on wider recognition of the priority by the population;
- Unintended consequences based on risk of not investing/prioritising; and
- Impact and likelihood to delay and prevent need through supporting prevention.

It was reported that statutory guidance published by the Department of Health set out who 'must' be involved and who 'should' be involved in the development of the JSNA and JHWS. The report proposed that the following stakeholder should be involved in the initial prioritisation work which would inform the proposed priorities for the JHWS, which were:-

- Member organisations of the HWB; and
- Stakeholders who are invited to informal sessions of the HWB; and
- Any other stakeholders identified in the engagement plan as having a high degree of interest and/or influence over the JSNA.

Some discussion was had with regard to how prioritisation would happen. The Board was advised that this would be discussed further at the Informal Health and Wellbeing Board schedule for 12 July 2016, and it would then be formally agreed by the Board at its September meeting.

RESOLVED

That the following proposals be agreed:-

- That the prioritisation framework the HWBB adopted to develop the JHWS is rooted in the topics included within its JSNA;
- The HWBB adopts the five core principles as detailed above, and set out in the report within which the development of the JHWS will be undertaken;
- The HWBB adopts the nine criteria as detailed above are worked up into a formal prioritisation framework that can be used for the purposes of developing the JHWS for Lincolnshire;
- The proposed stakeholders identified as being involved in the initial engagement on the prioritisation framework; and
- The HWBB agrees the final prioritisation framework in September 2016 with a view to completing the prioritisation work by March 2017.

9 DISCUSSION ITEM(S)

9a Joint Commissioning Board - Update

Better Care Fund – Update

The Board received a verbal update from Glen Garrod, Executive Director, Adult Social Services on the progress of the Better Care Fund (BCF).

It was reported that from the Comprehensive Spending review announcements in November 2015, the BCF had become a longer term national programme leading to anticipated integration between health and social care by 2020. It was noted integration plans would come into place from April 2017.

Guidance to support BCF submissions for 2016/17 had not made available until February 2016. It was noted that the guidance had identified a number of requirements but did not now include a pay for performance element. It was noted further that a number of requirements related to continuing to protect adult social care, securing services for carers and those needing advocacy, re-ablement services and ongoing support. Guidance also made reference to Disabled Facilities Grants (DFG); and a higher profile to Non-Elective Admissions and Delayed Transfer of Care (DTOC).

The figures from the Department for Communities and Local Government for Lincolnshire had shown the DFG allocation as £4.884m. The National BCF Programme Team response had been that it was down to local areas to agree how to commit the resource, and that the money did not have to be used exclusively on DFGs, the resource could be used for other capital improvements to meeting the needs for housing, health and social care in localities. Subsequent clarifications posted by the Local Government Association had then confirmed the extra flexibility; and subsequent national guidance made it clear that DFG would be allocated through the BCF.

On 16 February a letter was sent to all seven districts Chief Executive explaining the situation pertaining to DFG's; and asking for support for a unified approach to the arrangements for the DFG. Subsequent meetings with District/City senior officers and Chief Executives had indicated support to working towards a preventative housing strategy to be in place for 2017/18.

The final BCF submission for Lincolnshire was required to get agreement from the five statutory partners: the four CCG's and LCC. The five key elements of the proposals for 2016/17 were:-

- Agree the continuation of Section 75 Agreements;
- Agree the level of protection for Adult Care in 2016/17;
- The consolidation of a number of schemes supported by the BCF programme;
- A renewed focus on Delayed Transfers of Care led by the System Resilience Group; and
- A joint approach between the four CCgs and the County Council to the seven districts in pursuit of a Lincolnshire preventative housing strategy.

The Health and Wellbeing Board had considered and approved the Lincolnshire Better Care Fund Submission for 2016/17 at its meeting on 22 March 2016, prior to its submission on 20 April 2016.

Sustainability and Transformation Plan for Lincolnshire

Allan Kitt, Leading Chief Officer for the Sustainability and Transformation Plan updated the Board on the progress of Sustainability and Transformation Plan for Lincolnshire.

The Board was advised that NHS organisations in Lincolnshire had produced individual operational plans for 2016/17, which would form year one of the emerging Sustainability and Transformation Plan and align to Lincolnshire Health and Care. It was noted that NHSE England and NHS Improvements had asked that every health and care system should work together to produce a five year Sustainability and Transformation Plan for 2016/17 - 2020/21, showing how local services would evolve and become clinically and financially sustainable over the next five years; and have a clear understanding of the health and wellbeing, care and finance and efficiency gaps.

It was reported that the proposals that had been developed through Lincolnshire Health and Care (LHAC) would form an important part of Lincolnshire's STP, and make a substantial contribution to both the quality improvements demanded by Government and the plans needed to bring things back in to line.

It was highlighted that the STP was critical and needed to be owned and delivered by the whole system, all commissioners and all providers. The STP submission would only be a draft document and would not need to be signed off by the Boards of all CCGs and three providers, formally, but it was expected that all partners were signed up to the plan. It was noted that completion was planned for the end of June, and then the document would be submitted to NHS England for validation and approval.

RESOLVED

That the verbal updates relating to the BCF and the STP be noted.

9b Lincolnshire Health and Care - Verbal Update

The Board received a verbal update from Allan Kitt, Leading Chief Officer, Lincolnshire Health and Care on the Lincolnshire Health and Care Programme.

The Board noted that the current model of care was based on treating episodes of illness, being reactive in dealing with the crisis rather than preventing one.

It was reported that LHAC new model was built on local and national evidence and best practise; and was based on the experience of professionals, patients, service-users and carers. The new model will be more proactive and preventative and care would be provided more in the local community with the help of a remodelled hospital system.

The first phase of the LHAC had been signed off by all stakeholders in late 2013; and since then, the programme had been working toward finalising more detailed

recommendations for change. The key areas where public consultation for Lincolnshire would be around service reconfiguration, in particular where there would be a reduced or different requirement for hospital based care. The Board noted that during the autumn of 2016, once the STP had been approved there would be a full public consultation.

It was highlighted that there would be lots of concern regarding change, but what had to be remembered was the existing model was not sustainable. And following the consultation, NHS England would still have to sign off the final model.

Some concern was raised regarding the current financial deficit in the NHS and the problems encountered in trying to recruit health professionals to Lincolnshire.

The Healthwatch representative also reassured that steps would be taken to ensure that any transformation plans were in plain English and fully explained what was required, or what was going to be delivered.

RESOLVED

That the verbal update be noted.

9c Health and Wellbeing Grant Fund - Update Report

Consideration was given to a report from the Programme Manager, Health and Wellbeing, which provided the Board with a half yearly update on the Health and Wellbeing Grant Fund Projects. Appendix A to the report provided details of each of the projects. It was noted that the Health and Wellbeing Board Grant Fund Sub-Group at its April meeting had made a decision to cease the Prince's Trust project 'Get Started and Get into Healthy Lives', following concerns being raised by Children's Services concerning project compliance with new requirements relating to Raising the Participation Age. Also, the project had failed to engage the anticipated number of young people and did not offer sufficient value for money.

RESOLVED

That the update report on the Health and Wellbeing Grant Fund Projects be noted.

9d District/Locality Updates

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

9e Joint Health and Wellbeing Strategy Theme Updates

Dr Kevin Hill, one of the Board Sponsors for Theme 2 advised that an update for Theme 2 had been circulated to member of the Board via email following the last meeting held on 22 March 2016.

The Board noted that that as Lincolnshire had an ageing population with increasingly complex health and social needs; and that it was very important area to be considered, as the strategy moved forward.

RESOLVED

That the update be received.

10 INFORMATION ITEMS

10a An Action Log of Previous Decisions

RESOLVED

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

10b Lincolnshire Health and Wellbeing Board - Forward Plan

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

The Board was advised that an Update on the Sustainability and Transformation Plan would be added to the agenda for the meeting on 27 September 2016.

The Board were invited to put forward items for consideration. No items were received at the meeting.

RESOLVED

That the Forward Plan for formal and informal meetings of the Lincolnshire Health and Wellbeing Board presented be received, subject to an Update on the Sustainability and Transformation Plan being added to the agenda for the meeting on 27 September 2016.

10c Future Scheduled Meeting Dates

RESOLVED

That the following scheduled meeting dates for the remainder of 2016 and for 2017 be noted.

27 September 2016
6 December 2016
28 March 2017
26 September 2017
5 December 2017

(All the above meetings to commence at 2.00 p.m.)

The meeting closed at 3.30 p.m.

Meeting Date	Minute No	Agenda Item & Action Required	Update and Action Taken
07.06.16	**8a**	**TERMS OF REFERENCE, PROCEDURAL RULES, MEMBERS ROLES AND RESPONSIBILITIES** The Chairman agreed to look into the Boards make-up with regard to District Council Membership and Devolution implications. The Executive Director of Adult Care agreed to respond to the District's with regard to the BCF process.	This action is pending until after the County Council election in May 2017. The Executive Director of Adult Care has responded to the District's with regard to the BCF process. Some discussions are still ongoing.
	10b	**LINCOLNSHIRE HEALTH AND WELLBEING BOARD – FORWARD PLAN** That an Update on the Sustainability and Transformation Plan be added as an item to the Forward Plan for the 27 September 2016 meeting of the Lincolnshire health and wellbeing Board.	A report on the Sustainability and Transformation Plan presented to the Board on 27 September 2016

This page is intentionally left blank

Lincolnshire Health and Wellbeing Board – 27 September 2016

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

Temporary Changes to the opening hours of Grantham A&E

On behalf of the Lincolnshire Health and Wellbeing Board I have written to the Jan Sobieraj, Chief Executive of the United Lincolnshire Hospital Trust (ULHT) raising concerns about the level of emergency provision in the south of the county, in particular the capacity of the Ambulance Service to be able to respond to any increase in demand.

In the letter I have asked ULHT to provide the Board with assurance that a full assessment of ambulance service provision was considered ahead of the decision being made, and that robust plans are in place to cope with the predicted demand. A copy of my letter and the response I have received from Jan Sobieraj are attached for information.

Health and Wellbeing Board Meeting – 21 March 2017

I would like to advise the Board of a change to the date of the Health and Wellbeing Board meeting in March 2017. Due to local government elections in May 2017 the meeting scheduled for 21 March 2017 falls within the purdah period. Therefore I would like to advise Board Members that the meeting will now take place on 7 March 2017 at 2pm.

A formal appointment will be issued by Democratic Services, but can I also ask Board Members to note the change in their diary.

This page is intentionally left blank

My Ref:

17 August 2016

Mr Jan Sobieraj
Chief Executive
United Lincolnshire Hospital Trust
Trust Headquarters
Lincoln County Hospital
Greetwell Road
Lincoln
LN2 5QY

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

Dear Jan

Re: Temporary changes to the opening hours of Grantham A&E

I am writing to you in my capacity as Chairman of the Lincolnshire Health and Wellbeing Board in connection with the Trust's decision to temporarily change the opening hours of Grantham A&E due to a reduction in the availability of emergency doctors in Lincolnshire.

Whilst the Board is fully aware of the pressures the Trust is facing and accepts the decision has been taken to ensure patient safety is maintained across Lincolnshire, I am concerned about the level of emergency provision in the south of the county, particularly the capacity of EMAS to respond to an increase in demand.

The Trust's statement, dated 11 August 2016, makes reference to the support being given by other health trusts in Lincolnshire, including EMAS. It states that '*We have put plans in place with East Midlands Ambulance Service (EMAS), the out of hours service and our emergency assessment unit, to maximise the number of patients who can still be treated at Grantham hospital after 6.30pm despite the change.'* In addition the frequently asked questions published on the your website state that you have consulted EMAS and that they can cope with the potential extra demands that may be placed on their services as you *'predict only three patients will need to be transferred by ambulance to alternative A&Es*'.

However, I am not yet convinced about the level of ambulance cover in the south of the county and whether there is adequate provision to meet any potential increase in demand. I am therefore seeking your assurance that a full assessment of ambulance service provision in the area was considered ahead of the decision being taken and that

robust plans are in place to cope with the predicted demand, ensuring that other patients who would ordinarily be using an emergency ambulance are not disadvantaged.

Yours sincerely

Cllr Sue Woolley
Chairman
Lincolnshire Health and Wellbeing Board

CARING FOR YOU

United Lincolnshire Hospitals NHS
NHS Trust

Trust Headquarters
Lincoln County Hospital
Greetwell Road
Lincoln
LN2 5QY

Tel: 01522 573977
Fax: 01522 573991

e.mail: jan.sobieraj@ulh.nhs.uk

Cllr Sue Woolley
Chairman
Lincolnshire Health and Wellbeing Board
County Offices
Newland
Lincoln
LN1 1YL

6 September 2016

Dear Ms Woolley

Temporary Changes to the Opening Hours of Grantham A & E

Thank you for your letter of 17 August 2016, whereby you are seeking assurance that a full assessment of ambulance service provision, for the area, was considered ahead of the temporary reduction in the opening hours at Grantham A & E.

I can confirm the level of impact on EMAS was reviewed throughout the planning process (prior to the temporary closure) and showed a requirement for up to 6 patients requiring transfer to alternative providers.

Since the temporary closure has come into place the available information shows 2 patients per evening have been affected. We are closely monitoring the situation, along with EMAS.

I can also confirm that during the process of reviewing the service model, conversations occurred with EMAS to inform the plans and also discuss the potential impact.

These discussions, with EMAS and Local Commissioners, are continuing to ensure that the impact on patients is minimized..

Yours sincerely

Jan Sobieraj
Chief Executive

This page is intentionally left blank

Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of Dr Tony Hill, Executive Director of Community Wellbeing and Public Health

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**27 September 2016**
Subject:	**Annual Assurance Report**

Summary:

In June 2015 the Board agreed the Assurance Framework which sets out how the Board will assess the progress being made to deliver the outcomes in the Joint Health and Wellbeing Strategy (JHWS).

This report provides details of the Board's achievements over the past year and presents the JHWS Theme dashboard for 2015/16. The information contained in the dashboards reports will enable the Board to assess the impact of the JHWS and the improvements being made to improve the health and wellbeing of the people of Lincolnshire.

Actions Required:
The Board is asked to:

- Consider and comment on the JHWS Scorecard and Theme Dashboards shown in Appendices A - F.
- Identify any specific areas of concern on which the Board would like to receive further information and assurance.
- Confirm that the information provided in this report assures the Board that progress is being made to deliver the outcomes in the JHWS.

1. Background

Under the Health and Social Care Act 2012, Health and Wellbeing Boards (the Board) are required to produce a Joint Health and Wellbeing Strategy (JHWS). The purpose of the JHWS is to set out the strategic commissioning direction for all organisations that commission services, in order to improve the health and wellbeing of the people in Lincolnshire and to reduce inequalities.

The current JHWS for Lincolnshire 2013 – 2018 was agreed in September 2012 and is based on the priorities identified in the 2011 Joint Strategic Needs Assessment. As part of the agreeing the JHWS, the Board agreed that board members would '*hold each other to account for ensuring that their commissioning and decommissioning decisions are in line with the JHWS, and deliver the outcomes which are included in the each of the thematic chapters.'* Therefore one of the Board's ongoing roles is to assure itself, the Council, and wider partners that the Board is fulfilling its statutory duty, and progress is being made to deliver the outcomes in the JHWS.

The Board's Assurance Framework, agreed in June 2015, set the approach to be taken which includes an annual assurance report providing an update on the work of the Board over the past year, and dashboard reports on each of the JHWS Themes.

Key Achievements

Since the last Assurance Report in September 2015, the Board has undertaken a number of activities to maximise opportunities for joint working and the integration of services. This includes:

- Undertaking a stakeholder engagement exercise in autumn 2015 to gather views and feedback on the structure, policy and procedures for the Joint Strategic Needs Assessment (JSNA). The findings were reported to the Board in March 2016.
- Beginning the fundamental review of the JSNA. To date, 460 stakeholders have been invited to 14 Expert Panels events, and reviews have begun in 22 of the 35 topics. The new JSNA will be published in Spring 2017.
- In conjunction with partners, identifying four new JSNA topics – Dementia, Autism, Domestic Abuse and Financial Inclusion.
- Agreeing the 2016/17 Better Care Fund submission.
- Completing an annual review of Lincolnshire's Pharmaceutical Needs Assessment (PNA). The review found no significant changes to the PNA published in March 2015 therefore there was no requirement to issue a Supplementary Statement.
- Reviewing the commissioning intentions for 2016/17 for all four Clinical Commissioning Groups, Children's Services, Adult Care and Public Health.
- Continuing to progress the HWB Grant Fund projects, half yearly update reports were presented to the Board in December 2015 and June 2016.

JHWS Scorecard and Theme Dashboards

As part of the Mid-Term Review of the JHWS in June 2015, the Board agreed to monitor and report against 34 primary indicators as a way of monitoring the progress being made to meet the outcomes and priorities in the JHWS. The JHWS primary indicator scorecard, presented in Appendix A, shows 2015/16 year end data for the 34 primary measures compared against the 2012/13 baseline and 2014/15. Wherever possible, 2015/16 performance is also benchmarked against regional and national averages. The analysis

in the table below shows the progress being made to improve health and wellbeing in Lincolnshire since the JHWS started in April 2013:

	2014/2015	2015/2016
Improving local trend	13	17
Neither an improving nor declining local trend	8	9
Declining local trend	12	8
Missing data	1	0

The individual JHWS Theme dashboards are contained in Appendices B to F. Each dashboard includes a summary position statement which provides narrative linked to the primary and secondary indicators, as well as information on key achievements during 2015/16, and future challenges or opportunities that may impact on the Theme.

2. Conclusion

The Board has a statutory duty to produce a JHWS and part of the Board's ongoing role is to assure itself and partners that progress is being made to deliver improved health and wellbeing outcomes, including reducing inequalities.

The Board is therefore asked to consider the information provided in the JHWS scorecard and Theme dashboards, and identify any specific areas of concern that the Board would like addressed. Finally, the Board is asked to confirm that the information provided in this report provides sufficient assurance on the progress being made to deliver the outcomes in the JHWS.

3. Consultation

Theme delivery groups and relevant partners were consulted during the preparation of the Theme dashboards

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	JHWS Primary Indicator Scorecard 2016
Appendix B	Theme 1 Dashboard – Promoting healthier lifestyles
Appendix C	Theme 2 Dashboard – Improve the health and wellbeing of older people
Appendix D	Theme 3 Dashboard – Delivering high quality systematic care for major causes of ill health and disability
Appendix E	Theme 4 Dashboard – Improve health and social outcomes for children and reduce inequalities
Appendix F	Theme 5 Dashboard – Tackling the social determinants of health

5. Background Papers

This report was written by Alison Christie, Programme Manager Health and Wellbeing, who can be contacted on 01522 552322 or alison.christie@lincolnshire.gov.uk

This page is intentionally left blank

Lincolnshire Joint Health and Wellbeing Strategy | Primary Indicator Scorecard

Appendix A

Key:

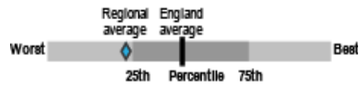
- Significantly better than England average
- Not significantly different from England average
- Significantly w orse than England average
- No significance can be calculated

= Improving local trend

= Local trend is neither improving nor declining

= Declining local trend

England Key:



Indicator	Baseline - 2012/2013		Year End - 2014/2015		Year End - 2015/2016		Local Trend	Eng Avg	Eng Worst	National Position	Eng Best	Source Indicator
	Local Number	Local Value	Local Number	Local Value	Local Number	Local Value						
Theme 1												
Smoking Prevalence (U18s)	N/A	N/A	*	7.89	*	7.89	⇨	8.20	14.95		3.39	PH 2.09
Smoking status at time of delivery	1056	13.80	1091	14.88	1091	14.88	⇩	11.99	27.48		1.90	PH 2.03
Smoking prevalence	N/A	20.88	N/A	19.07	N/A	17.49	⇧	18.24	26.93		9.80	PH 2.14
Excess weight in adults	N/A	N/A	N/A	70.07	N/A	70.07	⇨	64.27	74.76		46.01	PH 2.12
Proportion of physically active adults	N/A	55.73	1838	56.89	1838	56.89	⇧	57.04	45.12		71.19	PH 2.13i
Proportion of physically inactive adults	N/A	29.00	1205	28.18	1205	28.18	⇨	27.73	39.30		14.74	PH 2.13ii
Theme 2												
Permanent admissions to residential and nursing care (18-64)	76	14.20	61	15.30	62	14.60	⇨	14.20	68.50		0.00	ASC 2A(I)
Permanent admissions to residential and nursing care (65+)	1217	784.60	1046	653.90	960	585.10	⇧	668.80	2341.80		79.90	ASC 2A(II)
Older people still at home 91 days after discharge from hospital	655	72.40	869	74.60	652	78.80	⇧	82.10	48.10		100.00	ASC 2B / NHS 3.6i
Health related quality of life for people with long term conditions	4922	0.74	4609	0.74	4405	0.74	⇨	0.74	0.63		0.82	NHS 2
Social Isolation: % of adult social care users who have as much social contact as they would like	N/A	37.40	N/A	44.90	N/A	44.80	⇧	44.59	34.60		54.80	PH 1.18i
Social Isolation: % of adult carers who have as much social contact as they would like	N/A	37.10	N/A	37.10	N/A	36.50	⇨	37.78	18.20		52.60	PH 1.18ii
Theme 3												
Recorded diabetes (against expected prevalence)	42032	6.92	44168	7.19	45298	7.47	⇩	6.36	2.77		8.86	PH 2.17
Under 75 mortality from respiratory disease	645	31.70	693	32.81	685	31.55	⇧	32.62	72.33		18.03	PH 4.07i
Under 75 mortality rate from respiratory disease considered preventable	310	15.02	358	16.60	361	16.37	⇨	17.83	47.17		7.28	PH 4.07ii
Under 75 mortality from cardiovascular disease	1746	85.52	1719	81.62	1691.54	78.74	⇧	75.72	120.47		53.23	PH 4.04i
Under 75 mortality rate from cardiovascular diseases considered preventable	1148	56.13	1184	56.03	1171	54.32	⇧	49.19	78.88		32.73	PH 4.04ii
Under 75 mortality from cancer	3035	147.01	3021	141.69	2997	137.93	⇧	141.51	187.41		110.27	PH 4.05i
Under 75 mortality rate from cancer considered preventable	1700	82.23	1684	78.91	1682.72	77.57	⇧	82.95	123.07		54.35	PH 4.05ii
Health related quality of life for people with a long term mental health condition	N/A	N/A	*	*	60	0.59	⇨	0.53	0.34		0.75	CCG 2.16
Excess under 75 mortality rate in adults with serious mental illness	N/A	256.60	N/A	264.10	N/A	246.10	⇧	351.80	587.70		135.40	NHS 1.5
Theme 4												
Foundation Stage Achievement gap between pupils eligible for free school meals and their peers	N/A	22.00	N/A	18.00	N/A	14.00	⇧	*	*		*	CS
KS2 Achievement gap between pupils eligible for free school meals and their peers	N/A	23.00	N/A	21.00	N/A	22.00	⇨	*	*		*	CS
Hospital admissions caused by unintentional and deliberate injuries (0-4)	572	147.36	561	142.48	542	135.88	⇧	140.42	292.42		44.97	PH 2.07i
Hospital admissions caused by unintentional and deliberate injuries (0-14)	1280	112.55	1399	121.74	1327	114.65	⇩	111.93	199.72		61.32	PH 2.07ii
Percentage of children aged 4-5 classified as overweight or obese	1893	25.64	1819	24.02	1743	22.22	⇧	22.06	27.38		14.94	PH 2.06i
The proportion of young people Lincolnshire looked after by the local authority per 100,000	N/A	41.91	N/A	45.10	N/A	44.70	⇩	*	*		*	CS
Theme 5												
Fuel poverty and fuel poverty gap	40061	12.92	29958	9.57	29958	9.57	⇧	10.39	22.43		3.88	PH 1.17
Employment for those with a long term health condition	N/A	17.80	N/A	13.20	N/A	9.40	⇩	13.80	32.00		0.50	NHS 2.2
i - Gap in the employment rate between those with a long-term health condition and the overall employment rate	N/A	N/A	N/A	10.00	N/A	6.80	⇧	8.81	21.20		-8.40	PH 1.08i
ii - Gap in the employment rate between those with a learning disability and the overall employment rate	N/A	64.30	N/A	69.70	N/A	70.90	⇩	65.84	79.80		44.00	PH 1.08ii
iii - Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate	N/A	67.80	N/A	71.70	N/A	71.60	⇧	65.60	77.50		54.20	PH 1.08iii
Sickness absence - The percentage of employees who had at least one day off in the previous week	N/A	2.21	N/A	2.54	N/A	2.48	⇩	2.43	4.26		0.59	PH 1.09i
Sickness absence - The percent of working days lost due to sickness absence	N/A	1.70	N/A	1.59	N/A	1.73	⇩	1.51	2.81		0.31	PH 1.09ii

This page is intentionally left blank

Theme Position Statement

Smoking at the Time of Delivery (SATOD) – for the second year the SATOD data has not been published for Lincolnshire. Data is routinely collected and submitted by the United Lincolnshire Hospitals NHS Trust; however the scale of the `unknown` results from quarterly submissions is outside the required quality standards (greater than 5% unknowns). To this effect the data for all the four CCGs is exempt from publication (unknowns range from 7.9%-20.6%; Quarter 4, 2015/16).

2013/14 was the last year county data was published when SATOD was at 14.9% of pregnant women smoking at delivery, a decline from 18% previously.

Smoking Prevalence (u18s) – 7.9% of the u18 population is estimated to be an occasional smoker. This is compared to a national estimate of 8.2%. Such figures are extrapolated from a national survey. In 2015, a local piece of research published figures of 6.8% of u16s as regular smokers, 4.4% smoking every day.

Smoking Prevalence (Adults) – 17.5% of the adult population are estimated to be regular smokers. This is a continued decline over recent years and is a value below the England prevalence of 18.25%.

As a local comparator to this national estimate the NHS Health Checks programme has screened 24,800 adults for health risks in 2015/16. Across the CCG areas the prevalence of adult smoking was:

Table: Adult Smoking Prevalence (NHS Health Checks)

CCG	Smoking Prevalence
LSCCG	17.9%
LECCG	17.7%
LSWCCG	14.8%
L W CCG	17.0%

Source: NHS Health Checks Annual Report, 2015/16

Excess Weight in Adults – A new indicator from the Active people Survey estimates that 70.7% of the adult population has excess weight (27% being obese). This figure is higher than the England value of 64.3% and is higher than all of the county's comparator local authorities.

Table: Excess Weight (Percentage)

Area	Count	Value
Cambridgeshire	-	63.6
Cumbria	-	67.3
Derbyshire	-	68.8
Gloucestershire	-	65.0
Leicestershire	-	64.7
Lincolnshire	-	70.1
Norfolk	-	66.3
North Yorkshire	-	66.7
Northamptonshire	-	67.7
Nottinghamshire	-	67.3
Somerset	-	66.1
Staffordshire	-	68.6
Suffolk	-	65.9

There is variation across the county. The district local authority areas estimates from the Active People Survey display a range of excess weight from 64.4% - 73.2%.

Table: Excess Weight (Percentage)

Area	Count	Value
Boston	-	73.2
East Lindsey	-	72.3
Lincoln	-	64.4
North Kesteven	-	69.2
South Holland	-	72.2
South Kesteven	-	70.3
West Lindsey	-	68.9

The NHS Health Checks programme screening recorded a range of excess weight and obesity:

Table: Adult Excess Weight (NHS Health Checks)

CCG	Percentage assessed with Excess Weight	Percentage assessed Obese
LSCCG	66.0%	27.2%
LECCG	66.2%	26.2%
LSWCCG	62.9%	24.6%
LWCCG	62.9%	25.6%

Source: NHS Health Checks Annual Report, 2015/16

Proportion of Physically Active and Inactive Adults – the two indicators from the Active People Survey report that of the adult population (16+) 57% report being moderately active for 150 minutes per week. Conversely, 28.1% inactive (report doing less than 30 minutes of moderate activity). The England values are 57% active and 27.7% inactive respectively.. The active results have improved over time, a 1% improvement in three years.

The NHS Health Checks programme has recorded the percentage of clients as moderately active to active by CCG:

Table: Activity Levels: NHS Health Checks

CCG	Activity Levels
LSCCG	79%
LECCG	69%
LSWCCG	63%
LWCCG	69%

What's Working Well – examples of key achievements 2015/16

Tobacco Control and Smoking

Lincolnshire County Council re-commissioned a new smoking cessation service, included within that the transfer of the Tobacco Control Team. A new provider Quit51 was mobilised in January 2016. As of July 2016 the new service has recruited over 80 GP practices and pharmacies into their community network of sub-contracted providers.

The NHS Health Checks programme screens adults aged between 40-74 years. Each year approximately

25,000 adults are screened for at-risk conditions and undiagnosed disease. The locally recorded measures are used as local comparators to the national estimates.

Lincolnshire Partnerships Foundation NHS Trust has committed for all of its mental health in-patient sites to be smoke-free in 2016.

The enforcement actions on illicit and illegal tobacco by Trading Standards and Lincolnshire Police have generated substantial prosecutions and custodial sentences for smuggling, illegal and underage sales.

Excess Weight

Commissioned weight management services have engaged with 3,215 adults with a BMI range from 28 through to greater than 40. Between 80-88% of clients across the BMI range lost weight respectively and overall 48% of client lost greater than 5% of their original weight.

Ninety adults have accessed bariatric surgery and clinical support (pre and post intervention).

Physical Activity

The top sports / participation rates in Lincolnshire are in: swimming, cycling, athletics (and running) and football.

Commissioned exercise by referral schemes have engaged 3,988 inactive and obese adults. 64% of clients completed the programme with positive outcomes – improved fitness, mobility, strength. Approx. 11% of clients achieved greater than 5% weight loss.

The commissioned Walking for Health schemes seek the views of clients in addition to monitoring service provision, for example, the Boston Walking for Health scheme regularly survey clients. In a recent sample 24% of walkers had lost weight as result of their regular walking, 81% were walking more and using their car less and 29% had lowered their blood pressure. Such findings and feedback reinforce the value of physical activity to service users.

Future Challenges

Lincolnshire County Council's continue to have to make difficult budget decisions and the full impact of these on lifestyle services will not be realised until April 2017. Mitigating efforts, such as, the commercialisation of lifestyle support services and devolution of the walking programmes to volunteers will be assessed over the coming years.

Tobacco Control and Smoking

SATOD - ULHT plan to resolve this data quality problem through a review of process and with an upgrade in IT systems. It is anticipated that the first reliable data publication for SATOD will be in 2017/18.

The changing staffing levels with GP settings are impacting upon the commitment of practices to contribute to continuation of smoking cessation activity.

Excess Weight

Tier 4 Bariatric Services are provided from numerous sites outside of the county. No local support exists. Tier 3 specialist weight management services do not exist locally. There are dietetic services and a specialist midwife role for diabetes/obesity within ULHT.

Tier 2 weight management services have been de-commissioned. Commercial weight management programmes are available locally.

The Health Trainer programme has been de-commissioned with the subsequent loss of staff and expertise in the county.

Large proportions of the population do not see obesity as their public health problem.

Physical Activity

Physical inactivity is significantly higher amongst the most deprived population groups.

Tier 2 exercise referral schemes have been decommissioned with some loss of staffing and expertise in the county.

The national guidance of 150 minutes of moderate activity and strength building is sufficient for a healthy adult, but not an overweight adult. Overweight or obese adults need to be x2-x3 more active to secure any health benefits. This enhanced message is not being applied extensively.

The Active Peoples Survey is to change in the coming year. This will change the questions being surveyed and as a consequence cease the trend profile used to measure changes over time.

Future Opportunities

A component of the National Diabetes Prevention Programme is being applied to the greater Lincolnshire area.

A review of Smoking in Pregnancy in Lincolnshire will take place in the autumn, 2016.

A community alcohol partnership (CAP) is to be formed for the Boston area.

Further tobacco control legislation will come into force during 2016.

A Department of Health childhood obesity plan has been produced (August 2016).

The Five Year Plan for the NHS and the subsequent Sustainability and Transformation Plan (STP) for CCGs calls for a county-wide prevention plan that seeks to define the prevention, disease management and care plans to reduce premature mortality across and within the county's populations.

The national Sport and Physical Activity Strategy calls for a focus to help inactive people to be active; "more people, more active; more often".

The legacy of the decommissioning of services has led to a commercial model of provision for active lifestyles support being promoted across the county. The potential to develop a sustainable model of volunteer-led Walking for Health schemes is being actively explored.

Lincolnshire Sport has secured funding for the MacMillan Cancer project for a further year.

Lincolnshire Sport, in partnership with the England Federation for Disability Sport, have secured funding for a three year project in East Lindsey for greater participation of vulnerable adults into physical activity and sport.

Public Health England's One You campaign has been launched. Lincolnshire County Council endorses the campaign for health improvement. This will entail the development with a One You partnership to support this theme of the Health & Wellbeing strategy.

Theme: Improve the Health and Wellbeing of Older People

Appendix C

Outcome: Older People are able to live life to the full and feel part of their community

Theme Position Statement

Lincolnshire faces the double challenge of an ageing population with increasingly complex needs and increasing budget pressures for the whole health and social care community, particularly in areas relating to non-statutory services. The case for greater integration and service transformation is well evidenced through the Lincolnshire Health and Care (LHAC) programme and the Better Care Fund Agreement (BCF), and both of these initiatives are key enablers to improving the health and wellbeing of older people, particularly in relation to the self-care agenda. A number of the indicators being used to monitor this Theme are also key metrics for the BCF. Alongside this, the Excellent Ageing Partnership brings together a range of organisations from the public, private, and voluntary and community sector working to improve the health and wellbeing of older people. Excellent Ageing focuses on ten outcomes aligned to the Theme priorities

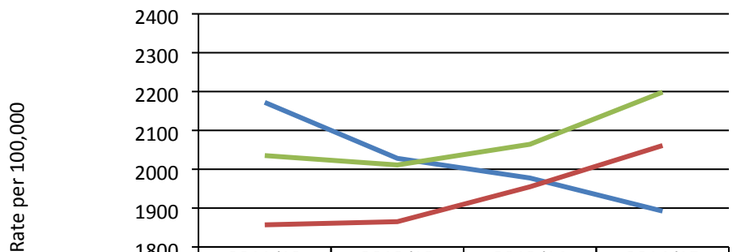
Spend a greater proportion of our money on helping Older People to stay safe and well at home

The number of people experiencing a fall each year in England and across the East Midlands is rising, as you would expect to see with a rapidly ageing population. However, injuries due to falls in Lincolnshire have continued to reduce and for the first time in 2014/15 this was significantly lower than rates of injuries across the East Midlands.

The Local Account was introduced by the government to let local residents know about the successes, challenges and priorities within their local Adult Care services. Lincolnshire's Local Account for 2014/15 reported that:

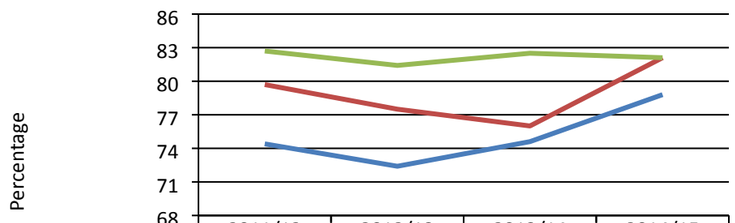
- Adult Care spent £138.68m in 2014-15 of which 44% is spent on older people services. In delivering £7.9m of efficiency savings local Adult Care services contributed to helping people to stay safe and well at home through a number of projects including projects to divert people away for long term residential care.
- Updated data from last year's position statement shows that the continued reduction in rates of people being admitted to residential and nursing care in Lincolnshire exceeds what has been achieved across the East Midlands and the rest of England.
- Whilst the percentage of people still at home 91 days after discharge from hospital remains lower than the East Midlands and England, the levels have continued to increase across Lincolnshire and are at their highest level in 2014/15 against a context of worsening performance across England.
- The Better Care Fund was announced by the Government in June 2013 to ensure delivery of integrated health and social care between the NHS and local government. In Lincolnshire, the value of the total value of pooled funding between the NHS and Lincolnshire County Council was £197.3m to ensure people's wellbeing is the focus of health and care services.

Injuries due to falls in people aged 65 and over (small is better)



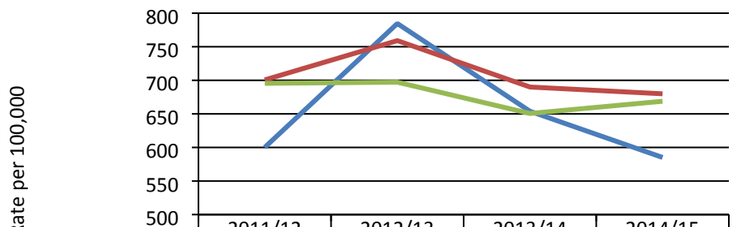
	2011/12	2012/13	2013/14	2014/15
Lincs	2172.1	2028.1	1977.4	1892.2
East Mids	1856.9	1865.0	1954.8	2061.1
England	2035.2	2011.0	2064.3	2198.5

Older people still at home 91 days after discharge from hospital (big is better)



	2011/12	2012/13	2013/14	2014/15
Lincs	74.4	72.4	74.6	78.8
East Mids	79.7	77.5	76.0	82.1
England	82.7	81.4	82.5	82.1

Permanent admissions to residential and nursing care (65+) (small is better)



	2011/12	2012/13	2013/14	2014/15
Lincs	600.1	784.6	653.9	585.1
East Mids	700.6	759.1	690.0	679.9
England	695.5	697.2	650.6	668.8

Develop a network of services to helping older people lead a more healthy and active life and cope with frailty

The Wellbeing Service, continues to support people to live independently with support and/or technology in their own home, by providing more proactive, integrated, high quality support delivered through multi-disciplinary working. This includes the joining up information and advice services and making equipment, minor adaptions and assistive technology available quickly on a low level preventive basis.

Alongside the Wellbeing Service being linked into the roll out Neighbourhood Teams as part of LHAC, it has also sought to increase its links with the wider self-care agenda. During the last 12 months the service has worked with the LHAC programme in the development of the Self-care Strategic Plan, the vision of which is to ensure that "people and communities have the confidence and motivation to improve and maintain their health and wellbeing".

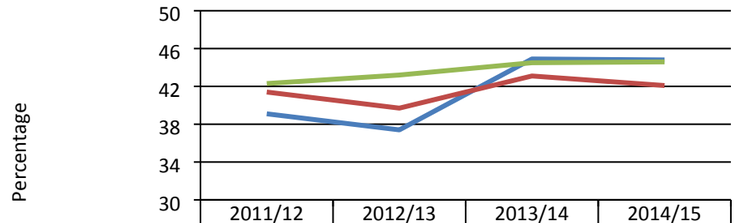
Prevention measures which continue to support people to remain self and well at home in 2014/15 included 18,970 new referrals for adult care leading to information and advice/Universal Services being provided, over 3500 referrals to the Wellbeing Service (see later for more details) and 3000 people receiving support from the countywide Reablement service

Increase respect and support for older people within their community.

Adult social care users who told us through the Adult Social Care Survey that they have as much social contact as they would like maintained the improvement seen in 2013/14 (44.8% in 2014/15). This level continues to outperform both England and East Midlands levels however the difference is not significant.

Alongside this adult care services continue to support people to feel safe and secure with the level in Lincolnshire increasing in 2014-15 to 93.6% from 84.1% in 2013/14. This continues to exceed levels across the East Midlands and England.

Social Isolation: adult social care users who have as much social contact as they would like (big is better)



	2011/12	2012/13	2013/14	2014/15
Lincs	39.1	37.4	44.9	44.8
East Mids	41.4	39.7	43.1	42.1
England	42.3	43.2	44.5	44.6

What's Working Well – examples of key achievements 2015/16

I want to be active:

- Over 50's participation in physical activity programmes, such as healthy walks, outdoor gyms, 50+ classes and Vitality, continued to increase in 2015/16. Lincolnshire Sport has developed an online activity finder to allow people to search for activities to get involved with.
- Walking for Health services are being supported to become independently constituted bodies to ensure they can continue to provide support for active living on a self-sustainable basis.

I want to be healthy:

- A review of the Falls JSNA topic page was completed April 2015. There has been a continued trend of reductions in falls over the last 12 months.
- A multi-agency dementia officers group has been established which meets monthly to coordinate the Dementia Strategy Action Plan.
- Dementia Action Alliances (DDA) have been established across all Clinical Commissioning Group areas in Lincolnshire. The DAA continues to provide an effective forum for Lincolnshire County Council and strategic partners to promote co-ordinated improvements in dementia care and support.
- Dementia Friends Awareness sessions are increasingly held across a number of organisations and community groups
- A Dementia Family Support Service was launched in 2015 to ensure families have access to a support worker who will give information, guidance and practical assistance on a consistent basis to help avoid unnecessary crises. The DFSS will work closely with GPs and clinics to make sure good support is offered to people as soon as they need it following a diagnosis. Since October 2015 the service has supported over 1,000 carers and people living with dementia.

I want to put something back into the community:

- Senior Forum leads now attend Excellent Ageing Advisory meetings to act as independent older people representatives.
- Working with Community Advisors to promote the services being offered in community hubs and incorporating information in the asset mapping process.
- Members from the Lincolnshire Senior Forums attend quarterly meetings of the East Midlands Later Life Forum to share experiences and good practice

I want to be able to afford my life and understand my options:

- Links have been made between the Financial Inclusion Steering Group and Excellent Ageing to ensure both partnerships coordinate activities which affect older people.
- Development of programme of work with Trading Standards and Lincolnshire Police to raise awareness of scams, in order to protect vulnerable adults
- Over 80% of people reported that they feel they have choice and control over their daily life with 80%

I want to feel safe:

- Make Every Contact Count training has been delivered to fire safety advocates to enable them to delivery lifestyle messages to the public, including older people.
- People who receive services continue to feel safe and secure as a result of these services (see above)
- Adult Care continues to work to support people subject to the Deprivation of Liberty Safeguards (DoLS) and their families, providing advice and guidance. This has also included working with hospitals and care homes as numbers of applications have increased to ensure priority cases are identified.
- The Lincolnshire Safeguarding Adults Board (LSAB) continues to fulfil multi-agency responsibilities in relation to the protection of adults at risk from abuse and neglect in line with the requirements made in the Care Act 2014.

I want to have relationships and not be lonely:

- Research has demonstrated that the influence of social relationships on the risk of death are comparable with other well-established risk factors for mortality such as smoking and alcohol consumption and exceed the influence of other risk factors such as physical inactivity and obesity. Excellent Ageing and it's partners continue to tackle this through the following actions:
- The Wellbeing Service supports people who wish to improve their social relationships. In 2015/16, 87% of people identifying a need to do so were supported to access local services and groups.
- Talk, Eat, Drink (TED) in East Lindsey, funded by the Big Lottery, went live in April 2015. The project is being managed by Community Lincs and aims to reduce rural isolation and loneliness amongst older people.
- Good Neighbour Schemes are being developed in the county.
- The Excellent Ageing Advisory Group has reviewed NICE Guidelines NG32, "Older People: independence and mental wellbeing ", to ensure that the work of excellent ageing is aligned to principles identified in the guidance.

I want to be able to get around easily:

- Dementia Friendly Lincoln City Conference held in April 2015.
- Community Transport schemes continue to support older people across the county.

I want the right help when I need it from people I trust:

- Dementia Reading Well material launched in Lincolnshire Libraries as part of the Reading Well campaign and books on prescription scheme.
- Community Pharmacies have run advice and information campaigns targeted at older people, including dementia awareness, obesity and cancer.
- Development of Neighbourhood Teams has supported the more vulnerable elderly across all CCGs

I want to live at home for longer:

- Lincolnshire Health & Care promotes this, and case studies suggest that appropriate and timely intervention reduces admissions to hospital and residential care.
- The Lincolnshire Health and Care programme continues to strive to provide joined up care provided at the right time closer to peoples' homes.
- Following the publication of the Joint Carers Strategy 2014-18 and the Care Act 2014, carers are now supported by the Care & Wellbeing Hub located in the LCC Customer Service Centre, or by one of the Trusted Assessors for Carers based around the County, the majority of which are offered support to meet their particular needs as a carer.

I want to end my life with dignity:

- Planning My Future Care booklet and e-form have been refreshed and reprinted. Copies have been distributed to the LCYCP for inclusion in Carers Information Packs. Connection also made to 'All About Me' document.
- From 1st July 2015, a new partnership of Age UK Lincoln, Barnardos and the Lincolnshire Advice Network, led by Voiceability, is to further develop specialist advocacy for adults, children and young people into one service. This will support people to make their views about the care and support they receive heard and understood. It is a vital safeguard for people who may feel powerless in the face of professional opinion.

Future Challenges

- A growing ageing population with increasingly complex needs.
- Increasing financial pressures and budget reductions from central government affecting both the health and social care sectors, resulting in reductions of delivered services
- Increased reliance on the Third Sector and Faith communities. Reduced funding and increased difficulty in accessing wider grant funding has implications for future delivery from these sectors.
- Increased reliance on volunteers with the need to continue to support communities and individuals in volunteering roles.
- Behavioural and cultural change is needed to support the development of community based self-care

Future Opportunities

- Proactive care in the community and an increased focus on prevention will reduce demand on higher cost services.
- Further opportunities for health and social care integration including the pooling of resources.
- Promoting the role of the Voluntary and Community sector, and making better use of community assets.
- Increased partnership working across all sectors, in order to use reduced resources more effectively
- Lincolnshire County Council intends to use the following principles when commissioning Adult Care services in future:
  - Enhance quality of life for people with care and support needs
  - Delay and reduce the need for care and support
  - Ensure that people have a positive experience of care and support

Theme: Delivering high quality systematic care for major causes of ill health and disability **Appendix D**

Outcome: People are prevented from developing long term health conditions, have them identified early if they do develop them, and are supported to manage them effectively

Theme Position Statement

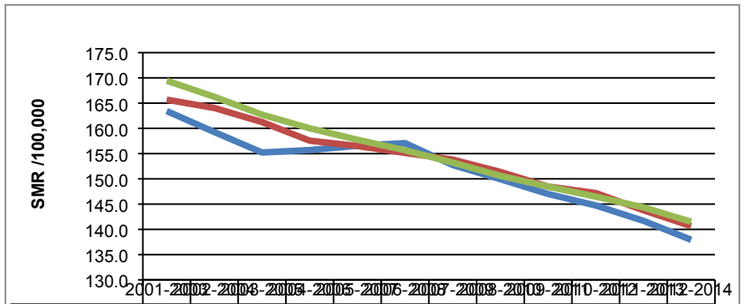
The management of long term conditions (LTCs) is a significant challenge for health and social care. With advances in the care and treatment of many LTCs, a greater proportion of the population is able to lead a longer and more active life. Overall 70% of the total expenditure on health and care in England is associated with the treatment of the 30% of the population with LTCs. The prevalence of LTCs is projected to increase and there is an increasing number of people with more than one LTC. [1]

It is essential that people who have a LTC are provided with health and social care services and support to help them manage their care. Effective prevention, management and treatment interventions are essential. Theme 1 of the JHWS provides information on some of the public health interventions, for example, smoking cessation, that contribute to the prevention of the priority areas in Theme 3. Many of the key areas in the CCG 2016/17 Operational Plans support the delivery of the Theme 3 priorities and the Lincolnshire Sustainability and Transformation Plan (STP) will significantly contribute to this Theme.

Cancer

- In Lincolnshire during 2012-2014, 2997 people died prematurely (<75years) from cancer of which 1683 were considered preventable through public health interventions.
- Cancer mortality rates (under 75 years) have decreased over the last decade, however, it remains one of the main causes of mortality. In Lincolnshire the standardised mortality rate (SMR) from cancer (<75years) in 2001-2003 was 163/100,000, compared to 137/100,000 in 2012-2014.

Figure 1: Under 75 Mortality from Cancer. SMR/100,000

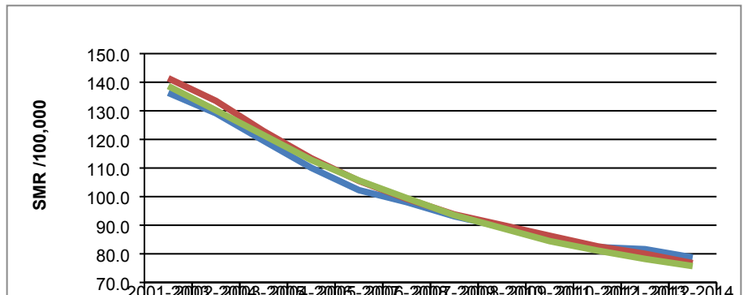


	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014
Lincs	163.4	159.3	155.2	155.7	156.6	157.1	152.7	149.9	147.0	144.7	141.7	137.9
East Midlands	165.7	164.0	161.3	157.6	156.5	155.1	153.8	151.4	148.5	147.2	143.8	140.6
England	169.4	166.3	162.7	160.0	157.8	155.7	153.2	150.6	148.5	146.5	144.4	141.5

Cardiovascular Disease (CVD)

- In Lincolnshire during 2012-2014, 1692 people died prematurely (<75years) from CVD of which 1171 were considered preventable.
- In Lincolnshire the standardised mortality rate from CVD (<75years) in 2001-2003 was 136/100,000, compared to 78/100,000 in 2012-2014.

Figure 2: Under 75 Mortality from CVD. SMR/100,000

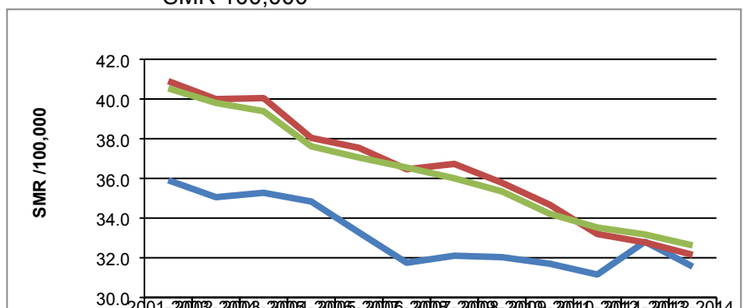


	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014
Lincs	136.3	129.1	119.5	110.1	102.3	98.1	93.1	89.4	85.5	82.3	81.6	78.7
East Midlands	141.4	133.5	122.9	113.4	105.5	99.2	93.8	90.1	86.3	82.6	80.0	76.7
England	138.7	130.2	121.5	112.8	105.6	99.5	93.5	89.0	84.4	81.1	78.2	75.7

Respiratory Disease

- In Lincolnshire during 2012-2014, 685 people died prematurely from respiratory disease of which 361 were considered preventable.
- In Lincolnshire the standardised mortality rate from respiratory disease (<75years) in 2001- 2003 was 36/100,000, compared to 31 in 2012-14.

Figure 3: Under 75 Mortality from Respiratory Disease. SMR 100,000



	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014
Lincs	35.9	35.1	35.3	34.8	33.3	31.7	32.1	32.0	31.7	31.2	32.8	31.6
East Midlands	40.9	40.0	40.0	38.0	37.5	36.5	36.7	35.8	34.7	33.2	32.8	32.1
England	40.5	39.8	39.4	37.6	37.1	36.5	36.0	35.3	34.2	33.5	33.2	32.6

Lincolnshire East and West Clinical Commissioning Groups have the highest levels of mortality from cancer and CVD.

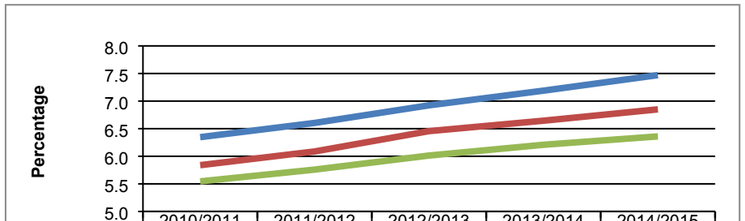
Higher rates of premature mortality among people with a serious mental illness (SMI) are mainly due to a higher burden of CVD, cancer and liver disease. Therefore prevention, early intervention and early diagnosis of co-morbidities are essential to reduce mortality rates for people with a SMI. Addressing excess mortality amongst people with a SMI is an indicator in the Public Health Outcome Framework.

Identification and Management of Long Term Conditions (LTCs)

A range of interventions are commissioned and provided to identify people with LTCs, for example, the NHS Health Check Programme. In Lincolnshire during 2015/16, 59.8% of people who were invited for a NHS Health Check were assessed.

The Quality and Outcomes Framework (QOF) requires general practices to maintain a register of people with certain LTCs. For example, during 2014/15, the recorded prevalence of diabetes amongst the adult population was 7.3% (45955 people), with Lincolnshire East CCG having the highest prevalence (8.5%) amongst the four Lincolnshire CCGs. Figure 4 shows the increase in diabetes prevalence from 2010/11 – 2014/15.

Figure 4: Recorded Diabetes (17years and over).



	2010/2011	2011/2012	2012/2013	2013/2014	2014/2015
Lincs	6.3	6.6	6.9	7.2	7.5
East Midlands	5.8	6.1	6.5	6.6	6.9
England	5.5	5.8	6.0	6.2	6.4

General Practices, using the ongoing management QOF indicators provide interventions for people on the disease registers, for example, effective control and monitoring (e.g. blood pressure, cholesterol and HbA1c) of diabetics.

The Right Care Commissioning for Value programme[2] provides data on a range of pathways that address Theme 3 priorities, for example, diabetes, heart disease and stroke. This programme identifies where CCGs are performing better or worse than similar CCGs on a range

[1] Managing the care of people with long-term conditions. www.publications.parliament.uk/

[2] http://www.rightcare.nhs.uk/index.php/commissioning-for-value/

of indicators across a number of pathways, for example, patients receiving the National Diabetes Audit (NDA) eight key processes. The programme identifies many care and treatment opportunities.

CCGs commission a range of service to support the delivery of Theme 3 and a range of standards are used to measure the performance of these services, for example, that 80% of stroke patients spend at least 90% of their time in hospital on a stroke unit and cancer wait (2week) and treatment times (31 and 62days).

Cancer Screening

NHS England has an objective to ensure effective commissioning of cancer screening programmes, for example, cervical and breast. Local Authority Public Health has a role in encouraging participation in screening programmes. In Lincolnshire in 2015 both the breast and cervical screening programmes had coverage just below 80% (78.30% and 76.49% respectively).

What's Working Well – examples of key achievements 2015/16

- CCGs commission a range of programmes that are part of their operational plans that contribute to the achievement of Theme 3's outcomes.
- The Lincolnshire Strategic Cancer Board has carried out work looking at system wide plans for cancer pathways. Organisations are involved in a work programme that aims to raise awareness, facilitate early referral, improve outcomes and provide holistic care for those living with and beyond cancer.
- CCGs are continuing to develop Neighbourhood Teams as part of the Lincolnshire Health and Care (LHAC) proactive care work stream. Across Lincolnshire there are 13 Neighbourhood Teams and work is ongoing to embed them with key health and social care organisations.
- As part of the LHAC proactive care work stream, a Self-Care Strategic Plan has been developed.
- Lincolnshire CCGs are reviewing their diabetes pathways and services and are making service improvements to existing services. GP practice staff have received training to enable them to support diabetes patients more effectively in the community. Lincolnshire (as a Greater Lincolnshire programme) is part of the first wave of the National Diabetes Prevention Programme and a diabetes education programme is being developed from Lincolnshire Health and Wellbeing Board Funds.
- The current CCG QIPP (Quality, Innovation, Productivity and Prevention) programme largely focuses on the Rightcare Programme with the aim of improving outcomes and quality across a number of areas, for example, cancer and CVD. Two of the Lincolnshire CCGs are part of NHS England's wave 1 roll out of the Right Care Programme.
- A range of public health programmes are commissioned and provided that address the Theme's outcome, for example, NHS Health Check, smoking cessation and Making Every Contact Count (MECC). (See Theme 1 for further information). During 2015/16 Lincolnshire performed better than England and East Midlands on both eligible people invited and assessed for the NHS Health Check Programme.
- Physical health care has been embedded into contracts to help reduce the health inequalities between people with serious mental illness and the general population. The quality schedule has been updated to include monitoring and management of physical health needs. 'Experts by Experience' have been introduced to support access to health checks and to improve pathways into and through services.

Future Challenges

- Despite the decline in mortality from some priority areas in this Theme (e.g. cancer and CVD), these conditions continue to causes significant premature mortality in Lincolnshire, with specific communities being particularly affected.
- The continued increase in the prevalence of long term conditions, for example diabetes, is likely to continue given the age profile of the population and the lifestyles that contribute to this.
- With the current financial challenges there is a concern regarding how funding decisions may impact on the prevalence and management of long term conditions and the longer term mortality.

Future Opportunities

- Reducing premature mortality is an aim that is shared between the NHS Outcomes Framework and the Public Health Outcomes Framework. Both CCGs and local authorities have a significant impact on reducing premature mortality by determining which contributory factors have the greatest effect on their local population, and commissioning and providing interventions accordingly. The Lincolnshire Sustainability and Transformation Plan will significantly contribute to Theme 3.
- By organisations working together, a range of effective interventions can be commissioned and provided. This includes general prevention (e.g. promoting lifestyle change), population screening, risk identification/management and effective treatment.
- The LHAC programme offers opportunities to address the priorities in this Theme of the Strategy .
- Primary care co-commissioning offers opportunities to take forward some of the actions that have been identified in the refresh of this theme, for example, optimising the management of long term conditions through the delivery of the General Practice QOF.

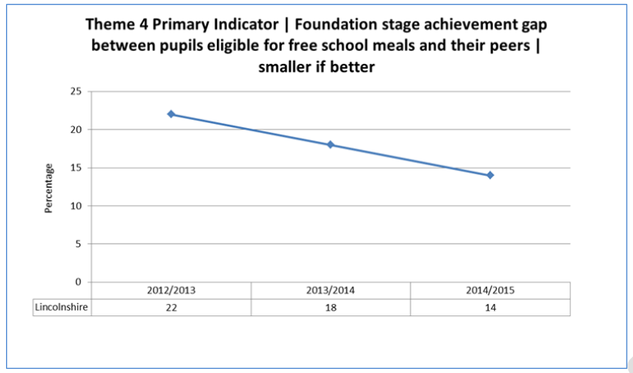
Theme Position Statement

Ensure all Children have the best start in life by

- Improving educational attainment
- Improving parenting confidence and ability to support their child's healthy development through access to a defined early help offer
- Reduce childhood obesity
- Ensure children and young people feel happy, stay safe from harm and make good choices about their lives particularly children who are vulnerable or disadvantaged

Best start in life

The links between health and wellbeing and educational attainment are well documented; pupils with better health and wellbeing are likely to achieve better academically. High take up of early education and the quality of provision within the county mean our children have a good start in their journey through education.



Compared with 2010, the gap is closing between the outcomes for Year 6 pupils eligible for Free School Meals (FSM) who achieved level 4 or above in reading, writing and maths and all other pupils. However, only 59% of pupils' eligible for FSM attained L4+ compared with 64% of similar pupils nationally. Nationally, 84% of non-disadvantaged pupils attained L4+ (disadvantaged pupils are defined as those who are eligible for FSM or who have been in Looked After Care in the last 6 months). In order to address this, there will continue to be a focus on the performance of all groups of pupils, and particularly those disadvantaged pupils eligible for the Pupil Premium Grant.
Data Source: Figures from DfE Local Authority Interactive Tool (LAIT)

In 2015 Lincolnshire's 5+ A*-C including English and maths figure is below our Statistical Neighbours average (56.9%). Lincolnshire's figure of 56.1% continues to remain below the National figure of 57.3%.
Lincolnshire's average capped points score per pupil in 2015 (calculated using the best 8 GCSE and equivalent results for each pupil) of 311.5 falls below the National figure of 313.5. The percentage of Lincolnshire pupils making expected progress in English is 70% and continues to fall significantly below the national figure of 71.3% and the Statistical Neighbour average of 70.4%.

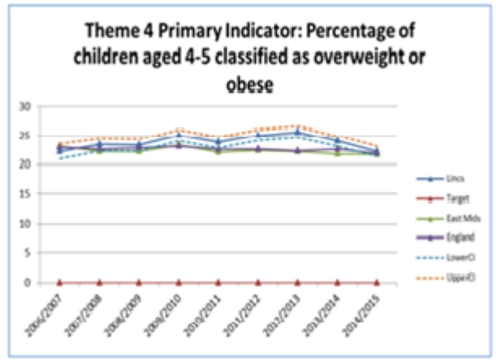
The percentage of Lincolnshire pupils making expected progress in Maths was 64.9% in 2015 and remains below the national rate in 2015 which is 67%.Lincolnshire's gap in attainment for 5+ A*-C including English and maths between disadvantaged pupils and others is increasing. The attainment gap has widened further in Lincolnshire than the gap nationally over time. In 2015 the GAP has widened by 3.7% to 32.6%, from 28.9% in 2014; this is significantly greater than the national gap in 2015 of 28.0%. At secondary level the percentage of students with a statement of Special Educational Needs (SEN) is in line with the national figure and a higher percentage than the national figure has SEN Support.

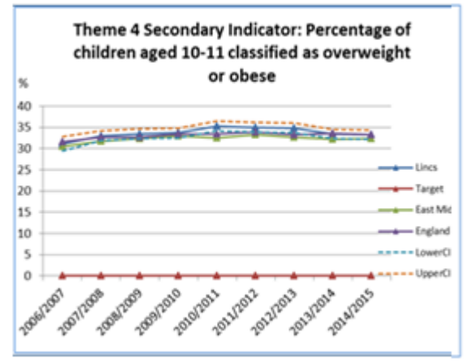
The gap measured at Key Stage 4 between the performance of disadvantaged and non-disadvantaged pupils in Lincolnshire is closing over time, at a rate that is more rapid than seen nationally. However, the measure as it stands at 28.9%, is still wider than seen nationally and is wider than the gap between FSM eligible and non-FSM pupils seen in Lincolnshire for both Foundation Stage (18%) and Key Stage 2 (21%). The LA 'Closing the Gap' offer to educational settings will contribute to Lincolnshire's Child Poverty Strategy by focusing on closing the educational gaps for vulnerable groups, particularly those children and young people eligible for Pupil Premium Grant.
Data Source: Figures from DfE Local Authority Interactive Tool (LAIT).

Childhood Obesity

The Governments National Child Measurement Programme (NCMP) measures the weight and height of children in reception class (aged 4 to 5 years) and year 6 (aged 10 to 11 years) to assess overweight children and obesity levels within primary school.

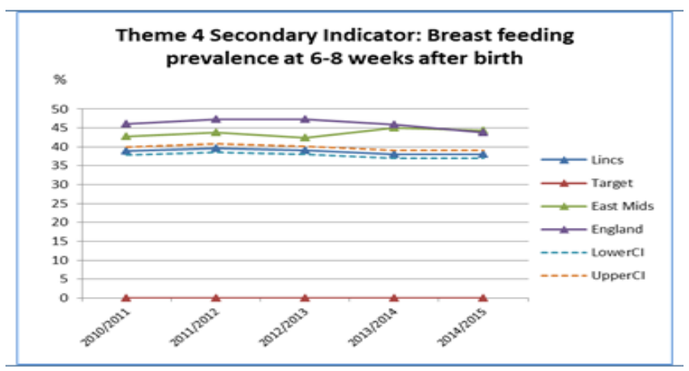
Children in Lincolnshire have similar levels of obesity to the England average at both 4-5 and 10-11 years. However, when rates are compared across Districts within the County, marked variation is seen. Rates in some Districts such as Boston and East Lindsey are currently significantly higher than the England average, and some (North Kesteven), significantly lower. Trend data for the whole of Lincolnshire shows that rates at County level appear to be aligning with national averages. However, due to year on year variation within many Districts, local trends should be viewed with caution.





Breastfeeding

From April 2012 to March 2014 breastfeeding initiation levels in Lincolnshire were higher than National and the East Midlands averages. However there are variations across the districts initiation rates for Lincoln and West Lindsey being slightly lower than the national average and Boston slightly higher.



Unintentional Injuries

Unintentional injury is the single major avoidable cause of death in childhood in England and the social class gradient in child injury is steeper than for any other cause of childhood death or long-term disability. Rates of A&E attendances are higher in the most deprived quintile of households in Lincolnshire with rates reducing as households become less deprived (see table A). In 2014/15, unintentional injuries for 0-4 year olds accounted for 41% of 0-19 hospital admissions due to unintentional injury. Lincolnshire rates of hospital admissions for 0-14s caused by unintentional and deliberate injury (Public Health indicator 2.07i) are higher than the England average and the highest in the East Midlands region (see table B). Areas of Boston have admission rates 78% above the England and 62% above the Lincolnshire averages (based on 212/13 data).

Table A:

A&E attendances in children aged 5 and under due to accidents, by quintile of deprivation, Lincolnshire, crude rate per 1,000: 2014/15

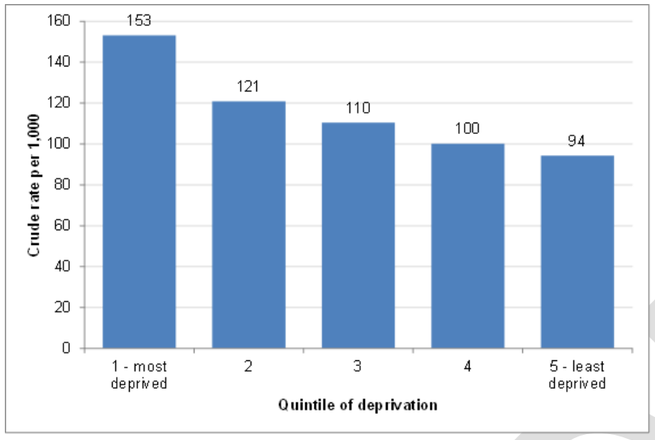


Table B:

2.07i - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years) 2014/15

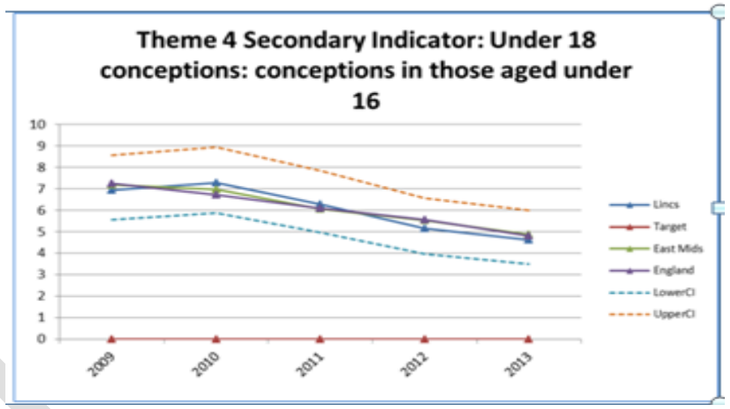
Crude rate - per 10,000

Area	Count	Value	95% Lower CI	95% Upper CI
England	106,043	109.6	108.9	110.3
East Midlands region	7,430	92.8	90.7	95.0
Lincolnshire	1,327	114.6	108.6	121.0
Northamptonshire	1,513	112.3	106.7	118.1
Derbyshire	1,207	96.0	90.6	101.5
Nottinghamshire	1,208	89.7	84.7	94.9
Nottingham	485	88.2	80.5	96.4
Leicestershire	835	75.3	70.3	80.6
Leicester	479	70.0	63.9	76.5
Derby	336	68.2	61.1	75.9
Rutland	40	68.0	48.6	92.6

Source: Hospital Episode Statistics (HES)

Teenage conceptions

Teenage pregnancy is an issue of inequality affecting the health, well-being, and life chances of young women, young men, and their children. The under 18 conception rate for 2014 is the lowest since 1969 at 22.9 conceptions per thousand women aged 15 to 17. The regional rate for the East Midlands is below the national rate at 21.6% but slightly higher for Lincolnshire at 22.4%. Most areas in Lincolnshire have shown a reduction but Boston and Lincoln City are still higher than national, regional or county rates at 33.7% and 36% respectively (ONS 2016)



What's Working Well – examples of key achievements 2015/16

Lincolnshire was the only local authority area in the country to receive a grade of “Outstanding” both for overall effectiveness and capacity for improvement for safeguarding services. Looked after children services have been rated “Good” for overall effectiveness, with “Outstanding” capacity for improvement

Behaviour Outreach Support Services (BOSS). The service will be available for all maintained mainstream Schools and academies in Lincolnshire to support their ability to positively manage pupils who are displaying behaviour that challenges. The service will form part of the "Lincolnshire ladder of intervention" and support Children's Services in promoting the ethos of the "Inclusive Lincolnshire Strategy", in particular to support reducing the number of schools exclusions.

Future Challenges

The recent publication of the Governments Childhood obesity: A Plan for Action (August 2016) addresses the complex issues around Childhood obesity that require action at every level, from the individual to society, and across all sectors. They cannot be effectively tackled by one discipline alone and local authorities, led by public health colleagues, are ideally placed to develop coordinated action to tackle obesity across its various departments, services and partner organisations.

Future Opportunities

Closer working across CCGs and other partners utilizing the Public Health Children's Team to support priorities and actions led through the Lincolnshire Women and Children's Joint Commissioning Board (WCJCB) working across the Children's Health 0-19 agenda.

Expansion of the existing Children and Young People's Plan by providing evidence behind the four Children's Service Commissioning Plans, Ready for Adult life, Ready for School, Learn and Achieve and Healthy and Safe.

A local strategic action plan to promote healthy weight in childhood is in development, based upon the life course approach to tackling obesity

Theme Position Statement

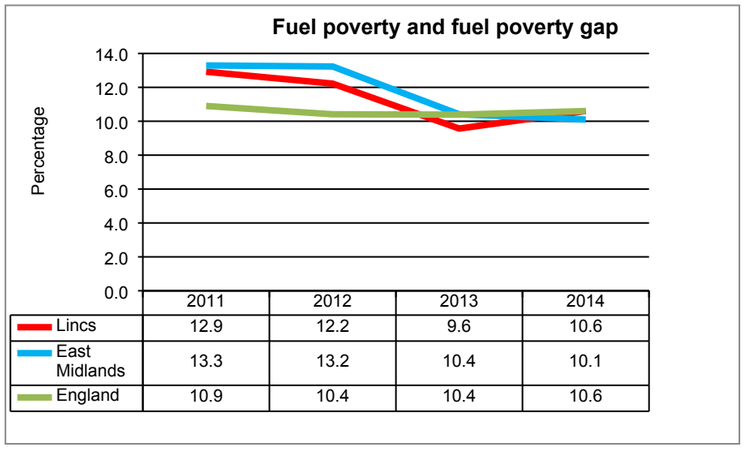
Housing – ensure that people have access to good quality, energy efficient housing that is both affordable and meets their need.

Housing is a main priority, largely measured by secondary indicators. There were 13,563 households on the housing waiting lists across Lincolnshire on 1 April 2014.

Overall, provision of new, affordable housing remains low in comparison to estimated demand but more are on site or in the planning process. Local housing authorities that hold housing stock continue to build some new council houses with several councils pursuing opportunities for new housing companies similar to Welland Homes Ltd in South Holland, including Lincoln and North Kesteven, (which is now incorporated and work is due to start on site in 2015/16). Others have affordable housing development programme partnerships with registered providers.

The Lincolnshire Homelessness Strategy deals with homelessness prevention, with a particular focus on addressing the needs of people with complex and mental health needs and a refresh is in progress.

The number of households accepted as being homeless and in priority need saw a significant fall (528 in 2016/17 down 18% from 646 in 2015/16) after rising steadily. The largest numbers remained in South Kesteven (171) and Lincoln (142) but are considerably reduced between years from 202 (down 15%) and 251 (down 43%). This is against the national experience of rising levels of homelessness. Main reasons for homelessness were: ending of assured shorthold private rented tenancies; violence and domestic abuse; and families no longer being willing to accommodate relatives.

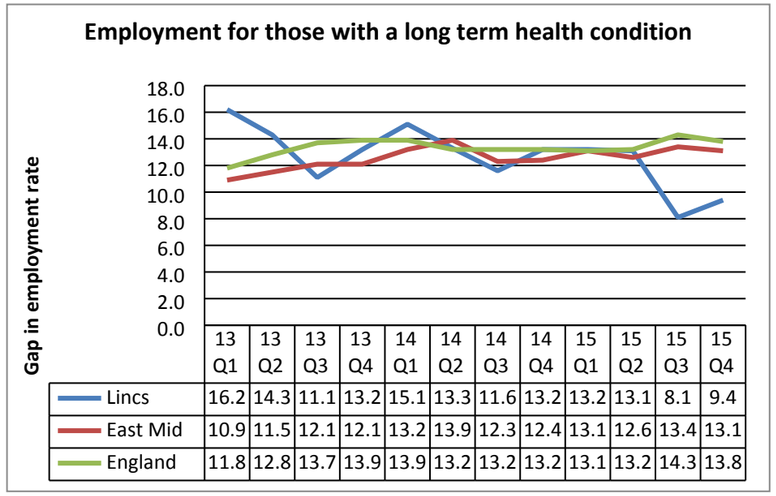


	2011	2012	2013	2014
Lincs	12.9	12.2	9.6	10.6
East Midlands	13.3	13.2	10.4	10.1
England	10.9	10.4	10.4	10.6

Following an apparent significant fall between 2012 and 2013, fuel poverty rates in Lincolnshire rose by 1.0% in 2014 to the same as the England average and a little higher than the East midlands average.

Work - support more vulnerable people into good quality work (such as young people, carers and people with learning disabilities, mental health and long term health conditions).

Overall employment rates have risen from 70.9% in 2013 to 74.2% in 2015, and the gap for those in employment with a health condition has fallen. Caution should be exercised over measures that involve 'gaps' as, if the denominator on unemployment increases, this could have the effect of narrowing the gap. Claimants on health related benefits represent over 60% of the entire claimant base and are strongly in focus with DWP at present. Of those figures over 40% cite mental health conditions as the primary reason for their claim; with that figure rising to 70% when secondary conditions are included.



	13 Q1	13 Q2	13 Q3	13 Q4	14 Q1	14 Q2	14 Q3	14 Q4	15 Q1	15 Q2	15 Q3	15 Q4
Lincs	16.2	14.3	11.1	13.2	15.1	13.3	11.6	13.2	13.2	13.1	8.1	9.4
East Mid	10.9	11.5	12.1	12.1	13.2	13.9	12.3	12.4	13.1	12.6	13.4	13.1
England	11.8	12.8	13.7	13.9	13.9	13.2	13.2	13.2	13.1	13.2	14.3	13.8

Lincolnshire has not benefitted from widespread programmes aimed at supporting or keeping people in work with health problems in the past, but some good work is currently being done to support people. DWP has partnership links into Lincolnshire Partnership Foundation Trust (LPFT), particularly a service called Individual Placement and Support. The scheme revolves around employment teams LPFT has had to establish providing intensive employment advocacy to secondary care service users.

Other projects targeting disadvantaged adults and young people have been supported through the health and wellbeing fund, enabling skills and experience to be gained to enhance employment opportunities. These are in progress and delivering against this priority over the next couple of years but it is too soon to claim these have had an impact on the numbers:

- Assisting low income households in to work, led by City of Lincoln Council in conjunction with Lincoln College; and
- Step Forward, led by Adult Specialist Services through contracted providers.

Sickness absence rates suggest the need to improve the quality of employee wellbeing within Lincolnshire. Large public sector employers are well placed to lead the way and share best practice. Opportunities to link into Greater Lincolnshire Local Enterprise Partnership (GLEPP) workforce health and wellbeing work and national programmes such as One You need to be exploited.

General work around improving the social determinants of health and reducing poverty also relates strongly to supporting individuals and families into work, but there is a need to ensure that this includes adequate hours, with decent conditions and pay. The national living wage should help to achieve this.

Social impact - Ensure public sector policies on getting best value for money include clear reference and judgment criteria about local social impact with particular reference to protection and promotion of work opportunities and investment in workforce health and wellbeing.

The social impact priority is about a way of working, and an opportunity for public sector bodies to lead in good practice, maximising social value for the local population wherever possible. Secondary indicators are still being developed to monitor the number of social impact clauses in public sector contracts.

No actions were identified in the Strategy refresh for 2015/16; however, the opportunity of commissioning organisations to set a good example within the public sector and maximise benefits to local populations, balancing this with good management of public monies; needs to be exploited. For example, HACT (Housing Associations' Charitable Trust) have recently released a new toolkit for the housing sector to help housing providers and contractors better manage, increase and evaluate social value in procurement.

What's Working Well – examples of key achievements 2015/16

Use Planning and Housing policies to address current and future housing and support needs of residents, maximise positive health outcomes and protect against environmental hazards.

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. Providing a coordinated response, two joint strategic planning committees are preparing joint Local Plans for Central Lincolnshire (Lincoln, North Kesteven and West Lindsey) and South East Lincolnshire (Boston and South Holland). The Central Lincolnshire Plan has been submitted to the Planning Inspectorate containing a health policy requiring health impact assessments on larger developments.

Boston Borough Council and City of Lincoln Council were successful in receiving Government funding to tackle rogue landlords in 2015/16. 580 inspections were carried out in Lincoln (11% of which had Category 1 hazards) and 97 in Boston – leading to Police led raids, emergency prohibitions, improvement notices and prosecutions.

Deliver the Lincolnshire Homelessness Strategy (focus on addressing the needs of people with complex and mental health needs).

The County Homelessness Strategy Working Group continues to be well attended by a wide range of partners and works well to coordinate joined up action. Relationships with housing related support and supported housing providers are working well to prevent homelessness. New arrangements with Children's Services to tackle youth homelessness have been put in place. Of particular note is the mainstreaming of a previously Government funded rough sleeping (street outreach) service into Public Health commissioned services. Despite figures starting to increase again rough sleeping reduced by 47%; this and the mainstreaming being recognised as best practice as the only example in the country.

Refresh and deliver the Lincolnshire Affordable Warmth Strategy to address fuel poverty and reduce the fuel poverty gap.

The refresh of the Lincolnshire Affordable Warmth Strategy is in hand, overseen by the Home Energy Lincs Partnership (HELP). Much of the focus of the strategy will be to capitalise on the new obligation on energy suppliers to fund affordable warmth measures from April 2017. Strategy actions will focus on the NICE guidelines for preventing excess winter deaths and illness from living in cold homes. Following a successful bid for the Government Central Heating Fund, a scheme providing first-time installation of central heating for fuel poor homes is being established. The Lincolnshire Energy Switch scheme continues under a new contract, to support people to switch to lower gas and electricity tariffs.

Develop an alliance between commissioners and deliverers of employment support and financial inclusion services to provide strategic direction.

The Financial Inclusion Partnership (FIP) is well established to fulfil the role of an alliance. Financial Inclusion is to become a new topic in the JSNA. Partnership working in the third sector takes advantage of the Big Lottery, Building Better Opportunities funded projects:

- Money and debt advice strand led by the Lincolnshire Community Foundation;
- Considering Employment Options project led by Voluntary Centre Services (Urban Challenge Ltd);
- Engagement into Learning Project led by Grantham College
- Support for the Economically Inactive.

Programmes that support mentoring and increased self efficacy for health related benefit claimants are in short supply, especially those focusing on stepped progression, like Steps 2 Health and Work. The parameters of this contract would need widening to anyone affected by mental health to address the issue in the scale required.

Early feedback from Step Forward project providers (and Jobcentre Plus) suggests that its strength is that it is not solely based on job outcomes and is flexible enough to allow individuals to take their time through the programme and go at their own pace. This might include deviating from the programme temporarily to access other services that might complement Step Forward and help them on their way to employment, e.g. weight management, pre-entry learning. There is also good work done by a project called Wellbeing through Work.

Link employment support with the Greater Lincolnshire Local Enterprise Partnership (GLLEP) and its economic growth agenda.

The GLLEP has had to focus its efforts on the broader Devolution for Lincolnshire bid around economic and housing growth and so the link with employment support has not been established.

Future Challenges

As always, the major issue partners identify is the availability of funding to be able to provide adequate housing and work related support projects. Cuts in public sector funding reduce service provision and increase demand on existing services. District councils are concerned as to whether the County will continue to fund housing related support services including floating support, accommodation based services and domestic abuse services.

Homelessness and worklessness support programmes and projects such as tackling rogue landlords and specialist advocacy support would benefit from any opportunity to jointly fund. The increasing complexity of homelessness cases with mental ill health and financial exclusion is of increasing concern. People with complex needs are finding it difficult to secure any form of accommodation, including County commissioned services.

There are a plethora of potential Government policy changes on the horizon making future planning difficult. There is a continued focus on home ownership with the extension of the Right to Buy scheme to registered social housing providers and withdrawal of government grant for new affordable housing will impact on the overall number of affordable homes available and new provision. In addition, local authorities are to be made to sell high value council homes that become void to fund the Right to Buy. Pay to Stay proposals intend to charge higher rents to social tenant households on high incomes.

Local authorities' ability to secure affordable housing (with the exception of starter homes) on many sites has been removed, alongside general viability issues around securing units through developer (section 106) contributions. The possible change in the affordable housing definition to starter homes may also reduce the amount of new affordable homes able to be provided. Funding new infrastructure needed to sustain housing growth will also give rise to a potential reduction in the proportion of new affordable housing able to be provided through the planning system.

The impact of welfare reform – including continued rollout of Universal Credit (UC) means support to the most vulnerable clients will remain essential. Those on UC are more likely to be in rent areas and face eviction. Welfare reforms are making it more difficult for certain groups to find and sustain affordable accommodation (e.g. housing benefit restrictions for under 35s who risk being excluded from housing altogether). The overall benefit cap and caps on Local Housing Allowance present a challenge, especially around supported housing. Social Housing providers are becoming stricter on who they will accommodate due to their own financial pressures, exacerbated through rent reductions.

Future Opportunities

Strategic Housing Market Assessments carried out across Lincolnshire identify the need for more homes. Greater Lincolnshire local authorities have an aspiration to deliver 100,000 new homes.

Devolution is impacting on this agenda. There are a number of initiatives taking place to encourage acceleration in housing delivery towards targets agreed with Government. This partly focuses on the housing market itself but there are other more specific activities designed to make the case for additional affordable housing and other forms of specialist properties to meet certain needs, e.g. extra care. This work is also supported by the One Public Estate programme which will include a 'challenge' theme designed to establish whether the existing public sector estate can provide increased opportunities to realise priorities, including housing.

It has been recognised that there is a lack of a strategic approach to delivering housing that supports a person living independently in their own home or in extra care housing. County and district councils are working together to see how a holistic approach, including disabled facilities grants, could improve outcomes by redesigning services.

The refresh of the Lincolnshire Homelessness Strategy, Lincolnshire Affordable Warmth Strategy and district Housing Strategies present opportunities to address the plethora of emerging Government policies. New policy development including allocations policies will strengthen homelessness prevention. Increased joint working with other statutory and voluntary organisations and development of new initiatives and interventions will focus delivery where most needed.

Strengthening links with the GLLEP has resulted in a multi agency bid for a project that would offer a strong opportunity to address a range of issues related to health related worklessness due to impacting on the employability status of the Employment and Support Allowance claimants through a health and wellbeing focused approach, to contribute to a reduction in demand on public services.

There will also be some projects launched in the near future utilising the European Social Fund. These projects will have a specific focus on those out of work and people who are most at risk of social exclusion (e.g. people with health problems (including mental health) and people who are homeless or at risk of homelessness).

Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

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

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**27 September 2016**
Subject:	**Prioritisation Framework for the Development of the Joint Health and Wellbeing Strategy**

Summary:
A report was presented to the HWBB in June 2016 setting out some proposed principles for developing the next JHWS as well as a draft prioritisation framework which the HWBB agreed should be further reviewed and tested as part of its informal session on 12th July 2016.

On the 12th July a workshop was held with members of the HWBB alongside wider partners and stakeholders. The objectives of the session were to:

1. Agree the key criteria for use within the prioritisation framework for the next JHWS
2. Weight the criteria to reflect the varying importance each one has in prioritising JSNA evidence
3. Test the prioritisation framework with a JSNA topic commentary (the draft Breastfeeding topic commentary was used for this purpose due it already having been completed)

The workshop successfully reviewed the criteria and made recommendations for amendments, agreed a weighting for and assigned a score to each criterion within the framework. Following the workshop the framework has been amended along with a proposed weighting of criteria based on feedback and weighting from individual tables at the workshop.

The HWBB is therefore asked to agree the prioritisation framework at Appendix A and that final refining is undertaken following further testing

Actions Required:
The Health and Wellbeing Board is asked to:

- Consider the feedback from the workshop on the prioritisation framework for the

next Joint Health and Wellbeing Strategy for Lincolnshire; and
- Agree the Prioritisation Framework for developing the next Joint Health and Wellbeing Strategy for Lincolnshire.

1. Background

Currently the JHWS produced by the Health and Wellbeing Board for Lincolnshire (HWBB) is due to end 2018 and the review of the JSNA which is being undertaken will be expected to form the basis upon which a new JHWS will be developed.

A report was presented to the HWBB in June 2016 setting out some proposed principles for developing the next JHWS as well as a draft prioritisation framework which the HWBB agreed should be further reviewed and tested as part of its informal session on 12th July 2016.

The HWBB agreed in June were that adopting a prioritisation framework will assist with the prioritisation process in a systematic way, ensuring a clear, rational approach and a defensible, transparent process for local decision making, whilst ensuring the active engagement of key stakeholders in the development of the JHWS. In order to achieve this the following core principles for developing the next JHWS were agreed as follows:

1. Stakeholder engagement (that builds public and patient confidence in the process)
2. A clear and transparent process
3. Careful information management
4. Decisions based on clear value choices (underpinned by a sound evidence base)
5. Selection of an agreed prioritisation methodology that takes into account the ranking/scoring of a range of factors, or 'criteria'.

The initial criteria the HWBB agreed to review in a workshop session were as follows:

- **Strategic fit** with national and/or local policy and outcome frameworks
- Potential to reduce or improve **health inequalities/equity**
- **Strength of evidence** demonstrating better outcome or being receptive to change
- Consideration of any economic evaluations undertaken to ensure **value for money**
- Likely **magnitude of benefit** relating to improved clinical and social outcomes
- Scale of impact in terms of the **number of people benefiting**
- **Public acceptability** based on wider recognition of the priority by the population
- Unintended consequences based on **risk of not investing/prioritising**
- Impact and likelihood to delay and prevent need through **supporting prevention**

Workshop Session

On the 12th July a workshop was held with members of the HWBB alongside wider partners and stakeholders. The objectives of the session were to:

4. Agree the key criteria for use within the prioritisation framework for the next JHWS
5. Weight the criteria to reflect the varying importance each one has in prioritising JSNA evidence
6. Test the prioritisation framework with a JSNA topic commentary (the draft Breastfeeding topic commentary was used due it already having been completed)

These objectives formed the basis of three separate exercises in the workshop.

Feedback

In total 31 people attended the workshop and were placed across five tables. Each table worked through each objective in turn. A full summary of feedback for each of the individual objectives/exercises above is provided at Appendix A.

Some key messages from the session included the following points:

- Framework needs to incorporate a time component to reflect the length of time over which outcomes or impacts might be realised.

- The JSNA commentaries need to be effectively peer reviewed before being used as the basis for prioritisation to ensure they contain all the necessary information upon which scoring judgements can be made

- Whilst the criteria are not in any order of importance as set out, it was felt that prevention criteria should appear at the top of the framework rather than the bottom.

- Magnitude of benefit (regarding outcomes) and scale of benefit (regarding numbers of people benefitting) should be merged into one criterion.

The resultant draft prioritisation framework to support the HWBB in developing the next JHWS for Lincolnshire is attached at Appendix B to this report.

Next Steps

The JSNA continues to be reviewed and the assurance and peer review process has been made more robust to ensure the JSNA commentaries provide the evidence required to enable to HWBB to undertake the JHWS prioritisation.

It is planned that the prioritisation work will be undertaken between January and March 2017 and workshops will be arranged to enable both the HWBB and stakeholders to take part in this work.

Further engagement will then be undertaken with the wider public prior to the JHWS being drafted in line with the current strategy coming to an end in March 2018.

2. Conclusion

All tables at the workshop successfully reviewed the criteria and made recommendations for amendments, agreed a weighting for and assigned a score to each criterion within the framework. Following the workshop the framework has been amended along with a proposed weighting of criteria based on feedback and weighting from individual tables at the workshop. There are some limitations to the framework however with some further testing and refinement it is expected that these can be addressed.

The framework itself performed in a fairly consistent way following sensitivity analysis and so is judged to be fit for purpose from this perspective.

The HWBB is therefore asked to agree the prioritisation framework at Appendix A and that final refining is undertaken following further testing.

3. Consultation

A full consultation and engagement plan is being developed to ensure that statutory requirements are met in the development of the JHWS for Lincolnshire.

4. Appendices

Appendix A – Feedback from workshop held 12 July 2016

Appendix B – Draft Prioritisation Framework for the development of the Joint Health and Wellbeing Strategy for Lincolnshire

5. Background Papers

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

This report was written by David Stacey, Programme Manager for Strategy and Performance who can be contacted on 01522 554017 or david.stacey@lincolnshire.gov.uk

Appendix A – Feedback from workshop held 12 July 2016

Exercise 1: Agree the key criteria for use within the prioritisation framework for the next JHWS

Criteria	Summary Feedback	Recommended Action
1. Strategic Fit	Local policy context was felt to be of greater importance so statements can be amended to reflect this.	Wording has been amended to that scoring favourably weights the alignment and 'fit' of the JSNA topic area with local policy priorities/ measures, as opposed to solely being a national priority/indicator.
2. Health inequalities/equity	Difference between health inequality and equity requires explaining and reflecting in scoring statements	Wording of criterion and scoring statements has been amended
3. Strength of evidence	Scoring statements need to reflect a less strict academic framework to allow for impact of wider knowledge and softer evidence	This amendment has been made to provide a balance of qualitative and quantitative evidence within the scoring
4. Value for money	Scoring statements need to reflect a time component and also incorporate the potential value for money benefit as well as any evidence of actual VFM calculations already undertaken	Potential for value for money and timeframes have been incorporated.
5. Magnitude of benefit (clinical and social)	Need to clarify difference between clinical and social outcomes. Scoring statements need to reflect qualitative and quantitative scales. Potential for double counting across number of people benefitting so perhaps these criteria could be combined.	Statements and criterion amended to remove any differentiation between clinical and social outcomes. Criterion merged with number of people benefitting and incorporating qualitative and quantitative component.
6. Number of people benefitting	Need to incorporate qualitative element to scoring statements	See above
7. Public acceptability	Change heading to reflect the criterion is about "Public understanding and engagement". Current wording is vague and changing would enable evidence to be drawn from the Local Views section of the JSNA commentary	Heading changed with further definition provided and JSNA process strengthened to ensure that where views have been sought as part of topic that these are captured in the JSNA commentary.
8. Risk of not prioritising	Remove reference to "unintended consequences" from criterion and include inter-dependencies to other services within statements	Removed "unintended consequences" and amended statements to reflect interdependencies
9. Supporting prevention	Remove reference to "call for action" and define what is meant by prevention as well as review statements to ensure they are quantifiable. Move prevention criterion to the top of the list. An element of time is required for this criterion.	Reference to "call for action" removed and statement reviewed. Criterion moved to top of list. Time has not been included in the amended framework. Given the scope of the JSNA it would be difficult to define this explicitly. However, clearer definition has been built in which focuses criteria more clearly around primary, secondary and tertiary prevention.

Exercise 2: Weight the criteria to reflect the varying importance each one has in prioritising JSNA evidence

Criteria	Weighting by workshop table					Proposed Weighting
	Table 1	Table 2	Table 3	Table 4	Table 5	
Strategic fit	High	Low	High	Medium	Low	**Medium**
Health inequalities/equity	High	Medium	High	High	High	**High**
Strength of evidence	High	Medium	High	High	High	**High**
Value for money	High	High	High	Medium	Medium	**High**
Magnitude of benefit (clinical and social)	Low	High	High	High	High	**High**
Number of people benefitting	Medium	High	High	Low	Low	
Public acceptability	High	Low	Medium	Medium	Low	**High**
Risk of not prioritising	Medium	Medium	Medium	Low	Low	**Medium**
Supporting prevention	High	Medium	High	High	High	**High**

Tables were consistent in 6 of the 9 criteria resulting in a clear majority in favour for one weighting. The most consistent criteria were "Health inequalities/equity", "Strength of evidence", "Magnitude of benefit" and "Supporting prevention" all of which received a weighting of high from 4 of the 5 tables.

For 3 of the 9 criteria there was not a majority opinion:

- For "Strategic fit" the median weighting was used as 2 tables selected it as high, 2 as low and 1 as medium.

- Applying the proposal from Exercise 1 to merge the "Magnitude of benefit" and "Number of people benefitting" criteria this provided a majority across the two for high priority. Had these two criteria not been merged "Magnitude of benefit" would have been weighted as high and "Number of people benefitting" would have been weighted as medium using the same rationale as for "Strategic fit".

- "Public Acceptability" did not demonstrate a clear majority decision or an obvious median position to take as 2 voted for a medium weighting of this criteria and 2 for low (with 1 voting it a high weighting). Given there were concerns raised about the vagueness of the criteria in earlier discussions and that this may have affected the weighting some tables gave it has been proposed that in the final criterion this is given a medium weighting.

The proposed weightings in the table above have also been included in the draft prioritisation framework at Appendix B.

Exercise 3: Test the prioritisation framework with a JSNA topic commentary

Each table was given the Breastfeeding JSNA topic commentary and was asked to systematically work through the framework scoring each of the criteria within the prioritisation framework. Where a criteria was judged to be low, the score was multiplied by a factor of 1; where the criteria was judged as medium, the score was multiplied by 2 and where they were judged as high they were multiplied by a factor of 3.

Due to tables having weighted the criteria independently of each other during Exercise 2, there were wide variations in the resultant scores which could be misinterpreted as meaning that the prioritisation framework was not robust enough.

To test this, sensitivity analysis of the results was performed by applying each tables scores for each criteria to both the proposed weighting and the weighting each table applied to see what effect this had on the final ranking of each tables results.[1]

Substituting individual table weightings with that of the proposed weighting to the scores resulted in a slight shift in the ranked order between tables 2, 3 and 5. However the difference between weighted scores for these three was not greater than 10% under the proposed weighted criteria. Table 1 and table 4 were ranked highest and lowest respectively regardless of whether their own table weighting or the proposed weighting was applied.

Criteria	Table 1	Table 2	Table 3	Table 4	Table 5
Strategic fit	4	4	3	2	4
Health inequalities/equity	3	4	4	2	4
Strength of evidence	5	5	4	3	4
Value for money	4	1	3	1	1
Magnitude of benefit (clinical and social)	5	4	4	1	5
Number of people benefitting	5	5	4	5	5
Public acceptability	4	3	3	1	3
Risk of not prioritising	3	2	2	2	3
Supporting prevention	5	3	4	3	5
TOTAL	**38**	**31**	**31**	**20**	**34**

Scores by criteria and table when assessing Breastfeeding JSNA topic commentary

Workshop Table	Unweighted		Table weighting		Proposed weighting	
	Score	Rank	Score	Rank	Score	Rank
No. 1	38	1	96	1	98	1
No. 2	31	3	65	4	79	4
No. 3	31	3	88	2	81	3
No. 4	20	5	42	5	50	5
No. 5	34	2	71	3	87	2

Score and rank of workshop tables when assessing Breastfeeding JSNA topic commentary

Summary

All tables at the workshop were able to review the criteria, agree a weighting and assign a score to each criterion despite the feedback provided on the criteria themselves at Exercise 1. However, due to the need to refine and clarify the criteria and the statements attached to them it is possible that attendees/tables applied different interpretations to the same criterion which would explain the variance in the scores given. The proposed weighting has resulted in 6 criteria being weighted as high and 2 as medium. Due to this lack in range within the weighting there is a risk of "clustering" of scores which may lead to difficultly in differentiating between JSNA topics when prioritising them. Evidence from another area, whose prioritisation framework this tool was based on, was that it not result in this "clustering" happening. However, further refinement of the tool might be required once the first cohort of JSNA topics have been tested within the tool.

[1] Wilson, E. C., Rees, J., & Fordham, R. J. (2006). Developing a prioritisation framework in an English Primary Care Trust. Cost Effectiveness and Resource Allocation, 4(1), 1

Appendix B – Draft Prioritisation Framework for the development of the Joint Health and Wellbeing Strategy for Lincolnshire

JHWS Prioritisation Framework Criteria	Weighting of criteria	Very Low (Score = 1)	Low (Score = 2)	Mid-scale (Score = 3)	High (Score = 4)	Very High (Score = 5)
Supporting prevention Does addressing the topic area (i) improve the overall health and wellbeing of the population; (ii) reduce the escalation of health and care needs in future, e.g. through identifying individuals at risk of health conditions or events; (iii) maximise peoples independence through effective treatment and recovery of health conditions?	Medium	No evidence of improvement to health, delay or prevention in the use of healthcare services and/or improvement treatment and recovery	Slight evidence of improvement to health, delay or prevention in the use of healthcare services and/or improvement treatment and recovery	Moderate evidence of improvement to health, delay or prevention in the use of healthcare services and/or improvement treatment and recovery	Significant evidence of improvement to health, delay or prevention in the use of healthcare services and/or improvement treatment and recovery	Strong evidence of improvement to health, delay or prevention in the use of healthcare services and/or improvement treatment and recovery
Strategic fit: National requirement or Outcome Framework indicator (PH, NHS, ASC) or local policy priority.	High	Not a national requirement or indicator and no clear local policy priority	Addresses one or more national requirements or indicators but is not a local policy priority	Addresses one/two national requirements or indicators and is a local policy priority	Addresses three national requirements and/or indicators and is a local policy priority across two or more partners	Addresses four or more national requirements and/or indicators and is a policy priority across multiple partners (three plus)
Health inequalities/equity: The criteria incorporates both health inequity (an unfair or unjustifiable difference in health) and health inequality (differences in health arising from social inequalities in the conditions in which people are born, grow, live, work & age). The criteria assesses the scale of inequalities (defined as inequalities in access and outcomes) as relevant to the JSNA topic area.	High	No evidence of inequalities/inequity amongst different groups of individuals, as relates to the topic area.	Limited amount of evidence of inequalities/inequity affecting a small number/group of individuals, as relates to the topic area.	Evidence of geographic or population-based inequalities, affecting a moderate number/group of individuals	Significant evidence of geographic or population-based inequalities, affecting multiple groups of individuals	Strong documented evidence exists demonstrating the impact of persistent & wide-scale geographic or population-based health inequalities/inequity affecting a large section of the community.
Strength of evidence: How strong is the evidence of need contained within the topic commentary? Does it include a mixture of both qualitative & quantitative data sources to provide a broader context around the topic area?	High	Evidence of need is poor	Evidence of need is limited to one type of data source	Evidence of need includes a combination of qualitative & quantitative data sources but there	Evidence of need includes a combination of qualitative & quantitative data sources with a	Evidence of need is robust containing strong and consistent evidence of need derived from

JHWS Prioritisation Framework Criteria	Weighting of criteria	Very Low (Score = 1)	Low (Score = 2)	Mid-scale (Score = 3)	High (Score = 4)	Very High (Score = 5)
				is no consistent 'message' regarding needs	coherent & consistent 'message' regarding needs	multiple & diverse data sources.
Value for money: The criteria assesses the extent to which value for money considerations regarding service/activity interventions are evidenced in the JSNA topic area. Have any calculations been undertaken, e.g. Spend and Outcome (Return on Investment) Tools (SPOT)?	High	No VFM calculations available	VFM calculations available and demonstrate poor value for money	VFM calculations available showing cost effective service interventions (or the potential for them to be delivered) across a short timeframe only (1-2 years)	VFM calculations showing cost effective service interventions that deliver (or the potential to deliver) sustained value for money across a short and medium term period (3-5 years)	VFM calculations and/or good programme budgeting intelligence to support investments that deliver (or have the potential to deliver) VFM across short, medium and longer term
Magnitude & scale of benefit : What is the scale of the benefit in terms of quality of life improvements and size of population (potentially) affected? The criteria incorporates (i) scale of improvements in health or life expectancy and (ii) number of people benefitting/affected.	High	Negligible improvement in health or life expectancy with <1% of the population (approximately 700-800 people) affected/benefiting	A small improvement in health or life expectancy with 1%-3% of the population (approximately 800 to 20,000 people) affected/benefiting	Moderate improvements in health or life expectancy with 3%-5% of the population (approximately 20,000 to 35,000 people) affected/benefiting	Significant improvements in health or life expectancy with between 5%-7% of the population (approximately 35,000- 50,000) people affected/benefiting	Large and proven improvements in health or life expectancy with >7% of the population (approximately >50,000 people) affected/benefiting
Public Understanding & Engagement: This criteria considers the extent to which there is consistent and robust evidence regarding the local views and priorities from stakeholders incl. residents and/or service users.	Medium	No evidence of views from stakeholders, patients, residents and/or service users	Weak evidence of views from stakeholders, patients, residents and/or service users	Evidence of views from stakeholders, patients, residents and/or service users is provided but no consistent 'messages' are evident	Some evidence of strong views from stakeholders, patients, residents and/or service users	Comprehensive engagement leading to evidence of strong & informed views from stakeholders, patients, residents and/or service users.

JHWS Prioritisation Framework Criteria	Weighting of criteria	Very Low (Score = 1)	Low (Score = 2)	Mid-scale (Score = 3)	High (Score = 4)	Very High (Score = 5)
Risk of not prioritising: This criteria considers the risk of not prioritising the topic area having considered the level of need (incorporating trend, severity of need, comparator data, etc.) evidenced in the topic commentary.	High	No risk	Risk is low. Available evidence suggests low risk (i.e. because data demonstrates needs are stable & in-line with regional, national or comparator area data)	Risk is fairly high. Available evidence suggests fairly high risk (i.e. because data demonstrates above-average prevalence/need relative to regional, national or comparator areas and/or a gradual worsening trend)	Risk is high. Available evidence suggests high risk (i.e. because data demonstrates need is worse when compared to regional, national and/or comparator areas and/or a worsening trend that is predicted to continue).	Risk is very high. Available evidence suggests very high risk (i.e. because data demonstrates need is significantly worse than regional, national and/or comparator areas, with a rapid worsening of need over time if the topic need is not addressed.)

Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

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

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**27 September 2016**
Subject:	**The Lincolnshire Better Care Fund (BCF) 2016/17**

Summary:
This report provides the Health and Wellbeing Board with an update on Lincolnshire's Better Care Fund (BCF) 2016/17.

Actions:
The Board is asked to consider and comment on the information contained in this report.

Background
The Lincolnshire Better Care Fund totals £193.8m in 2016/17 of which £53.8m is the national allocation. The remaining sums are pooled budgets into the fund from Lincolnshire County Council and the four Lincolnshire CCG's, plus 'aligned' Mental Health funds from the same organisations. For 2016/17 both Non Elective Admissions (NEA) and delayed transfers of care (DTOC) are a priority primarily because both nationally and locally NEA and DTOC have increased and are causing additional financial pressures particularly to NHS partners.

Nationally, approval to BCF Plans has been a time consuming task, although it is pleasing to report that the Lincolnshire Plan was approved by the prescribed deadline on 5 July 2016 (Appendix A). The key difficulty many areas have experienced is providing assurance around the Protection of Adult Services. This was not an issue for the Lincolnshire bid. The Lincolnshire Plan was discussed at the 22 March 2016 meeting of the Board and subsequently approved by the Chair of the Board under delegated powers.

Performance
A performance report is attached as Appendix B. On the key national performance targets there is still a need for improvement, with the key targets showing:-

- Non-elective admissions – officially recorded as 'showing improvement but not achieved'.
- Permanent admissions to residential and nursing care – not achieved

- Delayed Transfers of Care – not achieved

A more detailed analysis identifies that in 2016/17 Quarter 1 there have been some promising signs of improvement, although more time is needed to determine if the funded BCF's schemes and other investments are proving fruitful.

Nationally there has been an upward trend in the number of patients unnecessarily delayed in hospital and the same with the associated days. In Lincolnshire patient flow appeared to be recovering slightly in April, but by the end of the first quarter delayed days were 1% higher than the target. In the first quarter, the NHS are responsible for 67% of total delayed days, Social Care for 24%, and the remaining 9% of delayed days are down to both the NHS and Social Care. The most common delay reasons are waiting for care packages in a care home, in the community and waiting for further non-acute care. Previously, awaiting an assessment was a common reason but this has reduced by half since the last quarter of 2015/16. Historically, acute care constituted two thirds of delays, but more recently non-acute delays have been on the increase, to the point where they are approaching half of total delays. A £3.6m Risk Contingency has been established to address the financial impact of not achieving the NEA target and at the September meeting of the JCB, initial consideration will be given to any application of the contingency.

There have been 260 Residential and nursing home placements in the first quarter against a target of 246 placements. There clearly are pressures in this area but it is still hoped that the annual target of 982 placements can be achieved.

Performance is reported on a monthly basis to the Joint Commissioning Board and on a regular basis to the appropriate Delivery Board, with the A&E Delivery Board (previously the System Resilience Group) and ProActive Care Board in particular, receiving regular updates on the key performance indicators.

The quarterly 2016 BCF data collection national template was submitted to NHS England earlier this month. In addition to the weaknesses in performance detailed above other areas where full compliance is unclear includes:-

- Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate
- Are support services, both in the hospital and in primary, community and mental health settings available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken (Standard 9)?
- Is there a Digital Integrated Care Record pilot currently underway in your Health and Wellbeing Board area?
- Are integrated care teams (any team comprising both health and social care staff) in place and operating in the **non-acute** setting?
- Are integrated care teams (any team comprising both health and social care staff) in place and operating in the **acute** setting?

Finance

One of the main recommendations from a recent CCG internal audit of the BCF was for improved reporting of BCF finances and performance to the CCG Governing Boards. Accordingly the finance officers from the 5 co-signatories to the BCF now meet regularly to discuss and review BCF and related S75 financial and performance issues. The group

met in August and will continue on a monthly basis. It will assist with the review of BCF expenditure and also the reporting of such expenditure to the respective Governing Bodies.

A new finance template has been agreed as the reporting tool on BCF investment. This template will be used to report expenditure to the JCB, to the respective Delivery Boards and onwards to individual CCG Boards.

Section 75s
Three of the S75 agreements agreed in 2015/16 were one year arrangements and so expired on 31 March 2016. These were:-

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

All have been refreshed for 2016/17 and signed-off by JCB at its meeting in time for the due date of 30 June 2016. None of the agreements were considered to require extensive revision and the most important changes are referred to below.

The **Proactive Care Section 75 Agreement** was considered at the Proactive Care Board on 14 May 2016. A small group of Board members had volunteered to work with David Coleman from Legal Services to review and refresh the Section 75 in advance of the meeting. The key issues for review within this agreement were:-

- Confirmation of the main BCF national targets around NEA and DTOC The DFG funding arrangements to be in place for 2016/17
- Impact of non-achievement of the NEA and the need to establish a Risk Contingency

The **Partnership Framework Agreement** contains the general terms governing the relationship between the parties, in terms of identifying opportunities for and managing the risks of entering into partnership arrangements. The terms of the Partnership Framework Agreement for 2015/16 were reproduced in the new Agreement for 2016/17. The main substantive provision is the risk sharing arrangements and this was amended to reflect the different risks in 2016/17.

The **Corporate Section 75** creates a pooled contingency fund drawn from monies set aside and underspends on a number of the Section 75 Agreements. In 2015/16 the Corporate Section 75 also contained monies for LHAC programmes and this continues to be the case, although the amount of that funding will be reduced and comprises the underspend on the 2015/16 allocation.

The remaining S75s e.g. ICES, Specialist Services and CAMHS S75s, continue in force in accordance with their terms although they are subject to their own ongoing change control processes. In addition the JCB as part of its overall BCF governance arrangements has asked for an update report on each of these S75s this calendar year. The ICES S75 was reviewed at the JCB in August and Specialist Services and CAMHS are due to be reviewed at the November and December meetings respectively.

Risk Registers
There are a variety of Risk Registers covering the BCF arrangements. The format of these was reviewed at the July 2016 JCB with a recommendation that each register should:-

- focus on high level and key risks
- Better describe the mitigations in place and proposed, against each risk identified
- Show a 'post-mitigation score for each risk

The registers are to be reviewed at the respective Delivery Board on at least a quarterly basis and also presented quarterly to the JCB

Disabled Facilities Grants and Housing for Independence
Lincolnshire received £4.884m BCF capital funding in 2016/17. £2.97m of this has been distributed to the District Council's in accordance with the approved BCF Plan. The remaining sum has been allocated to Mosaic development (£1m), the Risk Contingency (£0.6m),with the remaining £314k to the Housing for Independence project.

The various DCLG regulations on the use of DFG funding for 2016/17 is open to interpretation, and we are currently in discussion with one District Council about the funding provided in 2016/17. Essentially the district is unhappy with its allocation and is challenging the interpretation of the guidance. The outcome to those discussions may result in a need to come back to the funding partners for a further decision.

There are ongoing discussions between commissioners and the District Councils about the Housing for Independence Project. Initial scoping of the work includes:

- Understanding the unmet and forthcoming need for housing for independence

- Develop a new model for providing housing adaptations across the health, social care and housing system that links into potential changes to therapy services.

- Potential to incorporate housing need into assessment of health and social care need, developing new pathways for defined groups and areas that are not based on adaptation alone.

- Explore partnership with the private sector as well as with the social sector.

- Agree the estate that is required and work collaboratively to deliver it, probably gathering evidence of need for this as other work streams progress.

- Improve knowledge of different parts of the system in all practitioners and improve collaboration.

The project can deliver a range of positive housing and non-housing related outcomes, with key benefits for service users and the commissioners of both health and social care services.

As was announced in the Comprehensive Spending Review in November 2015 it is expected that additional capital funding will be made available by the Government in future years, with a year on year expansion to around £7m per annum by 2019/20.

Protection for Adult Care Services (PACS)
Nationally significant debate and discussion has taken place over the summer about the money allocated to for the 'Protection for Adult Care Services (PACS)'. Narrative Plans have **not** been given national approval unless they included a minimum 1.5% uplift to the

minimum figure for PACS nationally identified for 2015/16. In Lincolnshire the submitted BCF Narrative Plan showed a sum of £16.825m available in 2016/17, some £1.15m above the nationally prescribed minimum. This helped Lincolnshire's Narrative Plan to be one of the earlier plans approved. In addition to the £16.825m, an extra £300k has been made available for PACS from underspends in 2015/16.

The schemes within PACS are subject to the same scrutiny and review as all other BCF schemes.

Risk Contingency

The Risk Contingency has been established at £3.6m for 2016/17. This sum is built from:-

- The remaining contingency at 31 March 2016
- Underspending of the BCF in 2015/16, particularly the Learning Disability S75
- An element of the DFG funding

The contingency is due to be reviewed at the JCB (earlier in the day than this meeting) on 27 September 2016. The key discussions will focus on:-

- Due to any under-performance against the NEA target is there a requirement to release funding into the health community to compensate for the resulting additional costs incurred
- Is there any overspending (or under-spending) on BCF schemes and how should any such overspending (or under-spending) be addressed
- Should any of the remaining Risk Contingency be utilised against any new requirements identified since April 2016

Programme of Reviews for the remainder of 2016/17

Key areas for review in the latter half of 2016/17 include:-

- Quarterly review at the JCB of the Risk Contingency, key performance targets and financial monitoring
- Performance and financial monitoring at the Delivery Boards
- Submission to National BCF Team of quarterly BCF returns
- Review of DFG investments and the delivery of outcomes by the District Councils
- Progress on the development of the Housing for Independence project

Planning for 2017/18

There are early indications that the BCF will continue into 2017/18 and possibly beyond. Earlier assumptions that Integration Plans may replace the BCF by March 2017appear to be not sufficiently advanced to fully replace the BCF at a national level for the coming financial year.

It appears that the Department of Health (DH) would prefer to link BCF planning with their own overall health planning cycle for 2017/18 and that they wish this to be undertaken earlier in the annual round than in recent years.. There could be an announcement on this by the DoH during September, and if so the Board will be advised verbally at the meeting.

Current thinking is that we may be required to submit draft BCF plans for 2017/18 and possibly 2018/19 (a 2 year cycle)) by December with final plans to be approved by February 2017. To produce the planning documents within this timeframe will mean bringing forward a number of activities e.g. review of 2016/17 investments and which schemes to fund in 2017/18, discussions on the BCF and Housing for Independence, the sum for the Protection of Adult Care Services, Risk Contingency considerations and any

P4P requirements, etc.

Overview and going forward Gaining early national approval to Lincolnshire's BCF Plan has been helpful both locally and nationally. It demonstrates the success of collaborative working between health and social care commissioners, and that the plans are recognised as 'fit for purpose'.

Performance delivery against key national targets has in the first quarter not been as strong as would have been hoped. This applies to each of the three key targets around NEA, DTOC and residential admissions. In each of these areas there is some ground for optimism, but until improved performance is consistently delivered there will be ongoing concerns and additional expenditure being incurred.

Assuming the BCF continues into 2017/18, there will be additional work required in the coming months and this will need to commence very soon. Key tasks are likely to include:-

- Ensuring adequate and effective conversations take place between commissioners, providers, District Councils and other interested parties
- Developing a refreshed BCF Narrative Plan
- Establishing targets for key national and local objectives in 2017/18
- Reviewing 2016/17 investment plans to determine which revenue schemes to continue with into the 2017/18 financial year
- Agreeing the funding for 'the Protection of Adult Care Services'
- Determining whether a Risk Contingency is required in 2017/18 and where the funding to build the reserve is to come from
- Resolving funding issues specifically on DFG investments and the Housing for Independence project

Appendices

These are listed below and attached at the back of the report
Appendix A - NHS England approval letter 5th July 2016
Appendix B – BCF first quarterly performance report

This report was written by David Laws, BCF and Financial Special Projects Manager, who can be contacted on 01522 554091 or david.laws@lincolnshire.gov.uk

Appendix A

NHS England
Skipton House
80 London Road
London,
SE1 6LH
E-mail: Andrew.ridley1@nhs.net

To: *(by email)*

Councillor Sue Woolley, Chair of Lincolnshire Health & Wellbeing Board
Tony McArdle, Chief Executive, Lincolnshire County Council
Glen Garrod, Director of Adult Social Services, Lincolnshire Council
Gary James, Accountable Officer, East Lincolnshire Clinical Commissioning Group
Sunil Hindocha, Accountable Officer, West Lincolnshire Clinical Commissioning Group
Allan Kitt, Accountable Officer, South West Lincolnshire Clinical Commissioning Group

5 July 2016

Dear colleagues

BETTER CARE FUND 2016-17

Thank you for submitting your Better Care Fund (BCF) plan for regional assurance. We know that the BCF has again presented challenges in preparing plans at pace and we are grateful for your commitment in providing your agreed plan. As you will be aware the Spending Review in November 2015, reaffirmed the Government's commitment to the integration of health and social care and the continuation of the BCF itself.

I am delighted to let you know that, following the regional assurance process, your plan has been classified as '**Approved**'. Essentially, your plan meets all requirements and the focus should now be on delivery.

Your BCF funding can therefore now be released subject to the funding being used in accordance with your final approved plan, which has demonstrated compliance with the conditions set out in the BCF policy framework for 2016-17 and the BCF planning guidance for 2016-17, and which include the funding being transferred into pooled funds under a section 75 agreement.

These conditions have been imposed through NHS England's powers under sections 223G and 223GA of the NHS Act 2006 (as amended by the Care Act 2014). These sections allow NHS England to make payment of the BCF funding subject to conditions. If the conditions are not complied with, NHS England is able to withhold or recover funding, or direct the CCGs in your Health and Wellbeing Board area as to the use of the funding.

You should now progress with your plans for implementation. Ongoing support and oversight with your BCF plan will be led by your local Better Care Manager.

Once again, thank you for your work and best wishes with implementation and delivery.

Yours sincerely,

Andrew Ridley
Regional Director, South of England, and SRO for the Better Care Fund

NHS England

Copy (by email) to:

Trish Thompson, Director Operations and Delivery,
NHS England – Midlands & East
Anthony Kealy, Programme Director, Better Care Support Team

Better Care Fund - 2016/17

Performance Report

Quarter 1

June 2016

Performance Alerts

Performance is on or ahead of target

Performance is behind target, with no improvement

Performance is behind target, with some improvement

Performance is not reported in this period

Total measures

Summary

	BCF metrics
Achieved	0
Not achieved	2
Improving but not achieved	1
Not reported in period	3
	6

Symbols Key:

CCG NEA Target reduction met ✓

CCG NEA Target reduction not met ✗

Chart legend:

Actual

Target

Baseline

Produced by Lincolnshire County Council, Adult Care Performance & Intelligence Team

ASC_Performance@lincolnshire.gov.uk

A detailed analysis of the national BCF measures is provided later in this report, showing baselines, trends, measure calculations, CCG breakdown and targets, with charts where appropriate. Guidance is also provided for each measure below the measure descriptor for ease of reference.

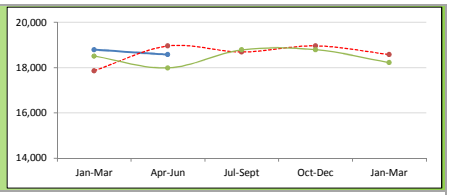
Polarity	Indicator Description	Responsibility	Previous Years		2016/17					Annual Target
					Current - June 2016			Forecast - Quarter 1		
			2014/15	2015/16	Actual	Plan	Alert	Actual	HWB Plan	
Health and Wellbeing Better Care Fund Metrics										
Smaller is Better	1. Total non-elective admissions into hospital : General and Acute	NHS	6,034 (average per month)	6,101 (average per month)	18,572	18,447	Improving but not achieved	-	-	-
Smaller is Better	2. Permanent admissions to residential and nursing care homes - aged 65+ **ASCOF 2A part 2**	LCC	938	1,019	260	246	Not achieved	-	-	982
Bigger is Better	3. % people (65+) at home 91 days after discharge from hospital into Reablement/rehabilitation **ASCOF 2B part 1**	LCC	78.8%	76.0%	Not reported in period			-	-	80%
Smaller is Better	1. Delayed transfers of care: Delayed days from hospital, aged 18+	NHS / LCC	1,765 (average per month)	2,787 (average per month)	9,218	9,127	Not achieved	-	-	-
Local Performance Metric										
Bigger is Better	Percentage of older people leaving hospital who received reablement/rehabilitation services **ASCOF 2B part 2**	NHS	3.6%	4.2%	Not reported in period			-	-	4.4%
Local Patient Experience Metric										
Bigger is Better	3. Proportion of people feeling supported to manage their long term condition (local indicator) (%)	NHS	63.8%	63.0%	Not reported in period			-	-	66.0%

Health and Wellbeing Better Care Fund Metrics

1: Total non-elective admissions in to hospital (general and acute)

Definition: The total number of emergency admissions for people of all ages where an acute condition was the primary diagnosis, that would not usually require hospital admission.

Frequency / Reporting Basis: Monthly / Cumulative within quarter only
Source: MAR data provided by GEMS Arden NHS Commissioning Support Unit



Observations from the data:
The BCF plan committed CCGs to a 2.7% reduction in the HWB Plan figures in the first quarter of the year (April to June 2016). At the end of the quarter, the actual reduction in non-elective admissions in the quarter was 2.0%, so this measure has been marked as improving but not achieved. A total of 382 non-elective admissions have been saved, but 126 less than target. The East, West and South CCG's showed a reduction in admissions compared to the HWB plan, but nly the West and South CCGs achieved the 2.7% reduction. The South CCG showed the greatest reduction with 6.2% fewer admissions than planned in April and May; 219 saved admissions. In the South West CCG, admissions were 1.6% higher than planned.

Prior Year	2015/16 BCF (Calendar Year)											
	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
In Month	5,947	6,179	5,858	6,538	6,031	6,212	6,354	6,107	6,330	5,975	5,926	6,316
In Quarter	5,947	12,126	17,984	6,538	12,569	18,781	6,354	12,461	18,791	5,975	11,901	18,217

Current Year		2016/17 BCF (Calendar Year)											
		Quarter 1			Quarter 2			Quarter 3			Quarter 4		
		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
In Month		6,122	6,236	6,214									
In Quarter		6,122	12,358	18,572									
HWB Plan Total		6,318	12,636	18,955	6,229	12,459	18,688	6,320	12,639	18,959	6,192	12,384	18,577
HWB NEA Plan (after reduction) - TARGET		6,149	12,298	18,447	6,062	12,124	18,185	6,152	12,304	18,456	6,027	12,053	18,080
Planned reduction	number	169	339	508	168	335	503	224	335	503	221	331	497
	%	2.68%	2.68%	2.68%	2.69%	2.69%	2.69%	2.65%	2.65%	2.65%	2.68%	2.68%	2.68%
Actual reduction	number	196	278	382									
	%	3.11%	2.20%	2.02%									
Performance		Achieved	Improving but not achieved	Improving but not achieved									

by CCG

Actual In Quarter	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
East CCG	2,125	4,293	6,481									
West CCG	1,908	3,775	5,683									
South CCG	1,040	2,250	3,321									
South West CCG	927	1,791	2,711									
Other contributing CCGs	122	250	376									
Total	**6,122**	**12,358**	**18,572**									

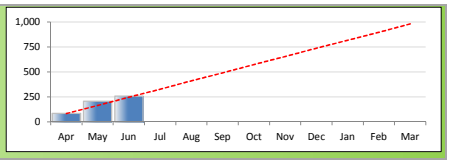
HWB Plan	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
East CCG	2,169	4,337	6,506									
West CCG	1,961	3,923	5,884									
South CCG	1,180	2,360	3,540									
South West CCG	890	1,780	2,670									
Other contributing CCGs	118	236	355									
Total	**6,318**	**12,636**	**18,955**									

Change from plan (cumulative in Qtr)	monthly increase/decrease	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
East CCG	■■■	-44	-45	-25									
West CCG	■■■	-54	-148	-201									
South CCG	■■■	-140	-110	-219									
South West CCG	■■■	37	11	41									
Other contributing CCGs	■■■	4	14	22									
Total	■■■	**-196**	**-278**	**-382**									

East CCG	✗ -2.01%	✗ -1.03%	✗ -0.38%									
West CCG	✓ -2.74%	✓ -3.77%	✓ -3.41%									
South CCG	✓ -11.83%	✓ -4.65%	✓ -6.20%									
South West CCG	✗ 4.17%	✗ 0.61%	✗ 1.55%									
Other contributing CCGs	✗ 3.20%	✗ 5.72%	✗ 6.12%									
Total	✓ -3.11%	✗ -2.20%	✗ -2.02%									

2: Admissions to residential / nursing care homes - aged 65+ per 100,000 population (ASCOF 2A part ii)

Definition: The total number of admissions to permanent residential or nursing care during the year (excluding transfers between homes unless the type of care has changed from temporary to permanent)
Frequency / Reporting Basis: Monthly / Cumulative YTD
Source: AIS data: Local Adult Care Monitoring (LTC admissions report & SALT)



Observations from the data:
In the first quarter of the monitoring period, there have been 260 permanent admissions to care homes for older people, which is 9% higher than the same time last year, but only 6% higher than the target number of 246 for the quarter. There was an unusually high number of admissions to care homes in May. These cases are being checked to determine the reasons for admission. The highest admission rate is in the East CCG.

Prior Year	2015/16 BCF (Financial Year)											
	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
In month	81	72	85	87	79	118	80	95	75	86	75	86
In Quarter	81	153	238	325	404	522	602	697	772	858	933	1,019

Current Year	2016/17 BCF (Financial Year)											
	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
In month	87	121	52									
Cumulative YTD	87	208	260									
Denominator	172,133	172,133	172,133									
Per 100,000	50.5	120.8	151.0									
Target (adm)	82	164	246	327	409	491	573	655	737	818	900	982
Target (per 100k)	47.5	95.1	142.6	190.2	237.7	285.2	332.8	380.3	427.9	475.4	522.9	570.5
Performance	Not achieved	Not achieved	Not achieved									

by CCG

Care home admissions (Cumulative)	2015/16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
East	385	41	90	110									
West	339	22	51	61									
South	167	13	38	46									
South West	106	11	28	42									
Not Recorded	22	-	1	1									
Total	**1,019**	**87**	**208**	**260**									
Est. CCG population (aged 65+)	**2015/16**	**Apr-16**	**May-16**	**Jun-16**	**Jul-16**	**Aug-16**	**Sep-16**	**Oct-16**	**Nov-16**	**Dec-16**	**Jan-17**	**Feb-17**	**Mar-17**
East	58,286	62,724	62,724	62,724									
West	44,185	47,550	47,550	47,550									
South	31,865	34,291	34,291	34,291									
South West	25,617	27,568	27,568	27,568									
Not Recorded	-	-	-	-									
Total	**159,953**	**172,133**	**172,133**	**172,133**									
Rate per 100,000	**2015/16**	**Apr-16**	**May-16**	**Jun-16**	**Jul-16**	**Aug-16**	**Sep-16**	**Oct-16**	**Nov-16**	**Dec-16**	**Jan-17**	**Feb-17**	**Mar-17**
East	660.5	65.4	143.5	175.4									
West	767.2	46.3	107.3	128.3									
South	524.1	37.9	110.8	134.1									
South West	413.8	39.9	101.6	152.4									
Not Recorded	-	-	-	-									
Total	**637.1**	**50.5**	**120.8**	**151.0**									

3: % people (65+) at home 91 days after discharge from hospital into Reablement/rehabilitation (ASCOF 2B part 1)

Definition: The percentage of older people (within a 3 month sample period) discharged from an acute or non-acute hospital to their own home/residential or nursing care home/ extra care housing for rehabilitation, where the person is at home 91 days after their date of discharge from hospital.
Frequency / Reporting Basis: 6-monthly / Cumulative for sample period
Source: Reablement/ILT - external service provider, rehabilitation - LCHS

Observations from the data:
This is an annual measure taken from the Adult Care Short And Long Term (SALT) return. However, the intention is the calculate a mid-year position looking at April to June discharges into Reablement services, which will be reported at the end of September. Part 2 of this ASCOF measure has been chosen as the local performance measure, so both the effectiveness (part 1) and the offer rate (part 2) will be monitored in the BCF in 2016/17.

	2015/16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Numerator	728												
Denominator	958												
Actual	**76.0%**												
Target	80.0%						80.0%						80.0%
Performance													

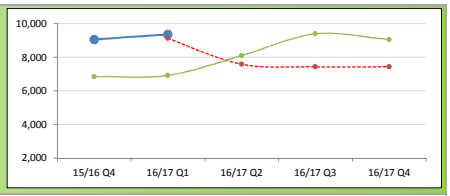
by CCG

Numerator	2015/16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
East	318												
West	157												
South	122												
South West	114												
Not known	17												
Total	**728**						-						
Denominator	**2015/16**	**Apr-16**	**May-16**	**Jun-16**	**Jul-16**	**Aug-16**	**Sep-16**	**Oct-16**	**Nov-16**	**Dec-16**	**Jan-17**	**Feb-17**	**Mar-17**
East	403												
West	214												
South	165												
South West	158												
Not known	18												
Total	**958**						-						
Actual	**2015/16**	**Apr-16**	**May-16**	**Jun-16**	**Jul-16**	**Aug-16**	**Sep-16**	**Oct-16**	**Nov-16**	**Dec-16**	**Jan-17**	**Feb-17**	**Mar-17**
East	78.9%												
West	73.4%												
South	73.9%												
South West	72.2%												
Not Recorded	-												
Total	**76.0%**												

4: Delayed transfers of care (delayed days) from hospital for adults aged aged 18+, per 100,000 population

Definition: The number of delayed transfers of care (days) for adults who were ready for discharge from acute and non-acute beds, expressed as the rate per 100,000 of the adult population of Lincolnshire.
Frequency / Reporting Basis: Monthly / Cumulatively within the quarter
Source: NHSE Published Delayed Days Report (Sitrep)

Table note: In the analysis by delay reason below, the organisation that the delay reason is attributable to in included in parentheses i.e. NHS, SSD, NHS or SSD, BOTH.



Observations from the data:
There were a total of 2,985 delayed days in June for patients with unnecessary delays in acute and non-acute beds, the lowest monthly total so far. In total, there were 9,218 delayed days in the quarter, which is 1% higher than the target for the quarter, and 33% higher than the same quarter in 2015/16. Non-acute delays continue to creep up as a proportion of all delayed days and make up 43% of delayed days, up from 32% in the previous quarter. NHS delays have stabilised at 67% of all delayed days, as have Social Care delays currently at 24%. The most common delay reasons, accounting for two-thirds of delays are awaiting a a package in the community, awaiting a care home placement, and awaiting further NHS non-acute care. It should also be noted that assessment delays as a reason have reduced to 13%, which is almost half the position in Quarter 4 of 2015/16. Half of delayed days are in the United Lincolnshire's Hospital Trust, which is a reduction from 63% in the previous quarter. There is a marked increase in delayed days in the Lincolnshire Partnership Foundation Trust, which has experienced almost three times the number of delayed days compared to the previous quarter.

Prior Year	**2015/16 BCF (Financial Year)**											
	Apr-15	**May-15**	**Jun-15**	**Jul-15**	**Aug-15**	**Sep-15**	**Oct-15**	**Nov-15**	**Dec-15**	**Jan-16**	**Feb-16**	**Mar-16**
Numerator	2,283	4,490	6,910	2,548	5,360	8,094	3,514	6,333	9,386	3,543	6,301	9,052
Denominator	591,829	591,829	591,829	591,829	591,829	591,829	591,829	591,829	591,829	596,120	596,120	596,120
Actual	**385.8**	**758.7**	**1,167.6**	**430.5**	**905.7**	**1,367.6**	**593.8**	**1,070.1**	***1,585.9***	**598.7**	**1,057**	**1,518**

Current Year	**2016/17 BCF (Financial Year)**											
	Apr-16	**May-16**	**Jun-16**	**Jul-16**	**Aug-16**	**Sep-16**	**Oct-16**	**Nov-16**	**Dec-16**	**Jan-17**	**Feb-17**	**Mar-17**
In month	3,006	3,227	2,985									
Cumulative	3,006	6,233	9,218									
Denominator	598,595	598,595	598,595									
Value (per 100k)	**502.2**	**1,041.3**	**1,539.9**									
Target (days)	3,042	6,085	9,127	2,525	5,050	7,575	2,475	4,950	7,425	2,475	4,950	7,425
Target (per 100k)	508.2	1,016.5	1,524.7	421.8	843.6	1,265.5	413.5	826.9	1,240.4	410.5	821.1	1,231.6
Performance	Achieved	Not achieved	Not achieved									

by Type of Care

	2015/16 Q4	**Apr-16**	**May-16**	**Jun-16**	**Jul-16**	**Aug-16**	**Sep-16**	**Oct-16**	**Nov-16**	**Dec-16**	**Jan-17**	**Feb-17**	**Mar-17**
Acute	6,171	1,806	3,682	5,217									
Non Acute	2,881	1,200	2,551	4,001									
Total	**9,052**	**3,006**	**6,233**	**9,218**									
	2015/16 Q4	**Apr-16**	**May-16**	**Jun-16**	**Jul-16**	**Aug-16**	**Sep-16**	**Oct-16**	**Nov-16**	**Dec-16**	**Jan-17**	**Feb-17**	**Mar-17**
Acute	68%	60%	59%	57%									
Non Acute	32%	40%	41%	43%									

by Responsible Organisation

	2015/16 Q4	**Apr-16**	**May-16**	**Jun-16**	**Jul-16**	**Aug-16**	**Sep-16**	**Oct-16**	**Nov-16**	**Dec-16**	**Jan-17**	**Feb-17**	**Mar-17**
NHS	6,184	2,000	4,307	6,157									
Social Care (SSD)	2,415	830	1,489	2,226									
Both	453	176	437	835									
Total	**9,052**	**3,006**	**6,233**	**9,218**	-	-	-	-	-	-	-	-	
	2015/16 Q4	**Apr-16**	**May-16**	**Jun-16**	**Jul-16**	**Aug-16**	**Sep-16**	**Oct-16**	**Nov-16**	**Dec-16**	**Jan-17**	**Feb-17**	**Mar-17**
NHS	68%	67%	69%	67%									
Social Care (SSD)	27%	28%	24%	24%									
Both	5%	6%	7%	9%									

by Delay Reason

	2015/16 Q4	**Apr-16**	**May-16**	**Jun-16**	**Jul-16**	**Aug-16**	**Sep-16**	**Oct-16**	**Nov-16**	**Dec-16**	**Jan-17**	**Feb-17**	**Mar-17**
A. Completion of Assessment **(BOTH)**	2,252	473	792	1,180									
B. Public Funding **(BOTH)**	114	13	106	159									
C. Awaiting NHS Non-acute care **(NHS)**	1,366	511	1,157	1,654									
D. Residential or Nursing Care **(BOTH)**	1,211	612	1,293	2,035									
E. Care Package at home **(BOTH)**	2,693	833	1,602	2,275									
F. Awaiting Equipment **(BOTH)**	434	133	264	465									
G. Patient or Family Choice **(NHS or SSD)**	779	283	638	839									
H. Disputes **(NHS or SSD)**	132	73	200	304									
I. Housing - **(SSD)**	71	75	181	307									
Total	**9,052**	**3,006**	**6,233**	**9,218**	-	-	-	-	-	-	-	-	
	2015/16 Q4	**Apr-16**	**May-16**	**Jun-16**	**Jul-16**	**Aug-16**	**Sep-16**	**Oct-16**	**Nov-16**	**Dec-16**	**Jan-17**	**Feb-17**	**Mar-17**
A. Completion of Assessment **(BOTH)**	25%	16%	13%	13%									
B. Public Funding **(BOTH)**	1%	0%	2%	2%									
C. Awaiting NHS Non-acute care **(NHS)**	15%	17%	19%	18%									
D. Residential or Nursing Care **(BOTH)**	13%	20%	21%	22%									
E. Care Package at home **(BOTH)**	30%	28%	26%	25%									
F. Awaiting Equipment **(BOTH)**	5%	4%	4%	5%									
G. Patient or Family Choice **(NHS or SSD)**	9%	9%	10%	9%									
H. Disputes **(NHS or SSD)**	1%	2%	3%	3%									
I. Housing - **(SSD)**	1%	2%	3%	3%									

by NHS Trust

	2015/16	**Apr-16**	**May-16**	**Jun-16**	**Jul-16**	**Aug-16**	**Sep-16**	**Oct-16**	**Nov-16**	**Dec-16**	**Jan-17**	**Feb-17**	**Mar-17**
ULHT	4,829	1,303	2,762	3,923									
LCHS	2,055	670	1,235	1,694									
LPFT	811	530	1,316	2,307									
Total*	**7,695**	**2,503**	**5,313**	**7,924**	-	-	-	-	-	-	-	-	
	2015/16	**Apr-16**	**May-16**	**Jun-16**	**Jul-16**	**Aug-16**	**Sep-16**	**Oct-16**	**Nov-16**	**Dec-16**	**Jan-17**	**Feb-17**	**Mar-17**
ULHT	63%	52%	52%	50%									
LCHS	27%	27%	23%	21%									
LPFT	11%	21%	25%	29%									

Note: *Total of NHS Trust delayed days will never equal Total LCC delayed days, because NHS delays can relate to treatment of residents from other authorities.

Local Performance / Patient Experience Metrics

	5. The proportion of people aged 65+ offered Reablement services following discharge from hospital (ASCOF 2B part 2)	6. Proportion of people feeling supported to manage their long term condition
	Definition: The number of people aged 65+ offered Reablement services following discharge from hospital during October to December, as a proportion of the total number of people aged 65+, discharged alive from hospitals in England between 1 October 2015 and 31 December 2015 **Frequency / Reporting Basis:** Annual **Source**: SALT STS004 / Hospital Episode Statistics	**Definition:** Of the number of people identifying a long-term condition in their responses, the % who responded 'Yes, definitely' or 'Yes, to some extent' to the question 'In the last 6 months, have you had enough support from local services or organisations to help you manage your long-term health condition(s)?'. **Frequency / Reporting Basis:** 6-monthly / results from 2 GP patient surveys in the year are aggregated and reported as an annual figure **Source:** GP Patient Survey
	Observations from the data: This is a new measure for the 2016/17 BCF. The calculation relies on hospital episode statistics published by NHS Digital, so will officially be reported annually in line with the ASCOF timetable. However, as with the other reablement measure, a mid year position will be calculated to show progress.	**Observations from the data:** Figures for 2015/16 have just been provided for 2015/16. The target of 64% was only just missed. The South West CCG was the only CCG to hit the 64% target, and had the highest proportion of patients who felt supported, with 65.1%.

	2015/16	2016/17	2015/16	2016/17
Numerator	958		3,719	
Denominator	22,830		5,900	
Actual	4.2%		63.0%	
Target	Not monitored in BCF in 2015/16	4.4%	64.0%	66.0%
Performance	-			

By CCG				
Numerator	**2015/16**	**2016/17**	**2015/16**	**2016/17**
East CCG	403		1252	
West CCG	214		1018	
South CCG	165		767	
South West CCG	158		682	
Not known	18		0	
Total	958	0	3719	0
Denominator	**2015/16**	**2016/17**	**2015/16**	**2016/17**
East CCG	Data not disaggregated by CCG	Data not disaggregated by CCG	2032	
West CCG			1621	
South CCG			1200	
South West CCG			1047	
Not known			0	
Total	22,830	0	5,900	0
Actual	**2015/16**	**2016/17**	**2015/16**	**2016/17**
East CCG	Data not disaggregated by CCG	Data not disaggregated by CCG	61.6%	
West CCG			62.8%	
South CCG			63.9%	
South West CCG			65.1%	
Not known			0.0%	
Total	4.2%	0	63.0%	0

This page is intentionally left blank

Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of Lincolnshire's System Executive Team and the STP Board

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**27 September 2016**
Subject:	**Lincolnshire's Sustainability and Transformation Plan (including Lincolnshire Health and Care)**

Summary:

This Report provides an update to the Health and Wellbeing Board on Lincolnshire's Sustainability and Transformation Plan. It is an information item only, focusing largely on the process, governance, approach and high level progress of the STP in Lincolnshire. An initial draft of the Plan was submitted to NHSE on 30th June 2016. Feedback, both verbal and written, was received from NHSE and the Plan is now in the process of being refreshed to take into account this feedback. The detail of the Plan is still therefore in draft form and subject to local agreement before submission to NHSE on 21st October this year. It is important to note that the elements of the plan which relate to significant service redesign as developed over the last 3 years through Lincolnshire Health and Care (LHAC), will be subject to public consultation, once the STP has been agreed and approved by NHS England and NHS Improvement.

Actions Required:

That the Board note the progress of the Sustainability and Transformation Plan.

1. Background

The Department of Health has asked that every health and care system (based on an agreed local footprint) work together to produce a 5 year Sustainability and Transformation Plan 2016/17 – 2020/21, showing how local services will evolve and become clinically and financially sustainable over the next five years – ultimately delivering the NHS Five Year Forward View vision through implementing new models of

care that restore and maintain financial balance and deliver core access and quality standards for patients. The STP must demonstrate a clear understanding of:

- the health and wellbeing gap
- the care and quality gap
- the finance and efficiency gap

and present a credible plan for how the system will work collaboratively to close those gaps over the period of the plan. The following are essential elements of the plan.

1. Prevention of ill health and moderation of demand
2. Engagement of patients, communities and NHS staff
3. Support for, investment in and improvement of general practice
4. Implementing new care models outlined in the 5 year Forward View that address local challenges
5. Achievement and maintenance of performance against core standards such as the NHS Constitution
6. Achievement of 2020 national ambitions for key clinical priorities i.e. cancer, mental health, learning disabilities and autism, maternity and neonatal care, and dementia
7. Plans to improve and maintain quality and safety
8. Deployment of technology, such as the digital road map, to accelerate change
9. Workforce development plans
10. Achievement and maintenance of system aggregate financial balance (a balanced financial picture for the healthcare system in Lincolnshire as a whole rather than looking at each organisation individually and asking for each to balance their books)

The four CCGs and the three providers have been working together to develop Lincolnshire's STP, with ongoing dialogue with wider partners such as the County Council, primary care colleagues and others. Development of Lincolnshire's STP is a priority for partners in the county and a detailed governance structure has been established to oversee the development and the delivery of the STP. A diagram of this structure is attached at Appendix A.

This governance structure was refreshed in July, following feedback from NHSE and the experience as a county of working together to deliver the first draft submission. The new structure introduces more accountability and transparency of key workstreams, and establishes a new System Executive Team (SET) made up of the Chief Executives or Chief Officers of the 3 Provider Trusts and 4 CCGs with representation from LCC and the LMC. This new SET meets weekly and can quickly make decisions and deal with risks and issues as they arise. In addition we have introduced a Joint Board session, Lincolnshire Coordinating Board, which brings together the Boards and Governing Bodies of the 7 key NHS partners, plus the County Council Management Board for discussion, dialogue and engagement on the emerging Plan. This has been well received and provides a valuable opportunity for Boards to come together as a Lincolnshire System to discuss the challenges, opportunities and solutions for the county.

Another core part of the governance structure is the STP finance group established to develop a single aggregate financial plan for Lincolnshire with membership from the Chief Financial Officers of all the NHS partners. This group has agreed on the gross high level deficit figure of £260m by 2021 if no savings or efficiencies are made.

In 2016/17 NHS transformation funding is focused on supporting providers in deficit, but going forward access to transformation funding will be dependent on Lincolnshire

producing a credible and ambitious STP. Therefore, the STP is a critical plan that must be owned and delivered by the whole system, all commissioners and all providers.

2. Lincolnshire's Plan

Lincolnshire's STP has built on three years of engagement, dialogue and discussion about the future of health and care services in Lincolnshire, undertaken through the Lincolnshire Health and Care Programme (LHAC). This has included the largest engagement exercise ever conducted in the county, reaching over 18,000 people and involving discussions with the public, with stakeholder and patient groups and with staff. In the last 12 months over 150 engagement sessions have been held with stakeholder groups, patients, staff and public. A Case for Change document was published on 29th June 2016, setting out very clearly the challenges that Lincolnshire faces, and providing an update on the progress of the LHAC programme and initiatives already in train, such as the Care Portal. This was very well received and generated extensive media coverage. On the back of this, we have undertaken additional engagement over the summer to reach several thousand further people, asking for views and comments on some of the areas covered in the Case for Change report. The detailed proposals for the new system of care in Lincolnshire have had strong clinical input through a number of expert reference groups, as well as building on best practice elsewhere in the country and, more recently, looking at the emerging Vanguard new models of care.

Initially, five work streams were established, each led by a Lincolnshire Provider Chief Executive or CCG Chief Operating Officer to look at quality and financial improvement to deliver the Plan. These are:

- Clinical service redesign – this incorporates the finalisation of the LHAC review, and any proposals for significant change which will be subject to consultation. However, it also includes the self-care work, the ongoing development of Neighbourhood Teams and the introduction of new services like the Clinical Assessment Service and the Care Portal which do not require consultation and are already being implemented. A critical part of this workstream is the plan for out of hospital care, prevention and primary care development which will be the bedrock of the new model of health and care, reducing demand on acute services. This includes how Lincolnshire will develop the new models of care as set out in the Five Year Forward View and adopt emerging best practice from the Vanguards such as the blueprint for Multi-specialty Community Providers.
- Workforce redesign – this will consider plans to address current workforce gaps, new role design and developing more flexible workforce models.
- Capacity optimisation – this will set out plans to improve the efficiency of the health system including plans for elective patients to be repatriated back to Lincolnshire. This workstream also covers proposals to reduce delays in the current systems and reduce diagnostic testing activity levels, in particular removing duplication
- Provider efficiency – this will set out longer term plans for improved efficiency across all providers, including primary care provision. This work stream will also draw from Lord Carter's review of efficiency opportunities including reducing spend on agency staff, savings on pay costs, reduced costs of prescribing and pharmacy, estates and facilities rationalisation, reduced back office costs, more effective procurement and contracting.
- Review of commissioning priorities in line with the national Right Care Programme – reviewing some areas where we spend money but the clinical benefits for patients are

limited and further developing a consistent application of referral thresholds. Benchmarking suggests that we spend significantly more than our peers in a number of areas including planned surgery and prescribing of some drugs.

Following submission in June, feedback received both from NHSE and from local Governing Bodies and Boards, suggested that there was a need to articulate more clearly an overarching vision for health and care by 2021 to show how the various elements that would be likely to change could, in total, deliver a coherent health and care system which would deliver better care to patients within available resources. This was agreed by the SET on 24th August and is set out below.

Vision for the Lincolnshire Sustainability and Transformation Plan
The aim is to achieve really good health for the people of Lincolnshire with support from an excellent and accessible health and care service delivered within our financial allocation by 2021.

The challenge
- The challenge for the Lincolnshire Health and Care system is well set out in the 'Lincolnshire Health and Care Case for Change' dated 24th June 2016. The key components of the challenge are described below:
- Our current model doesn't always deliver high quality, safe services – despite best efforts we often struggle to deliver the quality of care that we would be proud of
- Demand for our services is increasing because of our population profile (an ageing population, many with long term conditions and multiple needs)
- We can't get the skilled workforce to sustain the services - that's not just about money, it's about national shortages of key staff and about Lincolnshire not always being seen as an attractive place to work – the result is that we rely on expensive temporary staff or have unfilled vacancies which puts a huge strain on existing staff
- We can't afford to sustain what is an outdated system of care – there is too much demand on our hospital system which is over £60m in deficit. We need to rebalance the system and treat people before they reach crisis point
- Too often too many people are travelling too far for care at a hospital site which could be provided closer to home at facilities such as a GP surgery or a community hospital
- We are not smart at joining up services – users of multiple services, who are often our most vulnerable residents, end up with a fragmented, and often poor, service. This is a poor use of staff time and leads to a duplication of work.

Our service vision
To overcome the gaps in Health and Wellbeing, Care and Quality, and Finance and Efficiency, our vision is for

- More focus and resources targeted at keeping people well and healthy for longer; we will give them the tools, information and support within their community to make healthy lifestyle choices and take more control over their own care. This will improve quality of life for people who live with health conditions and reduce the numbers of people dying early from diseases that can be prevented.
- A change in the relationship between individuals and the care system, with a move to greater personal responsibility for health; more people will use personal budgets for health and care.
- A radically different model of care, moving care from acute hospital settings to neighbourhood teams in the community, closer to home for patients; Services will be

joined up for physical and mental health and for health and social care, with barriers removed so that people can access support from their communities and from a range of professionals to live well.

- Support to neighbourhood teams by a network of small community hospital facilities which will include an urgent care centre, diagnostic support such as x-rays and tests, outpatient facilities and a limited number of beds
- A small number of specialised mental health inpatient facilities to give expert support to neighbourhood teams and community hospitals
- A smaller but more resilient acute hospital sector providing emergency and planned care incorporating a specialist emergency centre; specialist services for heart, stroke, trauma, maternity and children; Hospital doctors who are specialists will support neighbourhood teams and community facilities, to provide expert advice.
- A major reduction in referrals to acute hospitals, with a simplified journey for patients with specific diseases, based on what works well; there will be clear referral thresholds and access criteria; improved community based services; fewer people travelling out of county for care; and some services which do not deliver good results for patients will be stopped.
- High quality services where NHS constitutional standards are met; all services are rated as good or outstanding; environments meet patient expectations; and permanent staff are the norm.

Our governance vision

To support our service vision a radically different governance and organisational structure will be required. We anticipate that in time this will extend across the whole of Greater Lincolnshire. The components will be:

- Neighbourhood Teams as the initial building block providing services to a geographically based population of between 30,000 and 50,000 people and linking a GP Federation with other primary care professionals, prevention services, community health services, community mental health services, pharmacy, therapies and social care. Community involvement will be essential. They will have lead clinicians and managers.
- A small number of Multispecialty Community Providers each coordinating four to seven Neighbourhood Teams and commissioning care within a strategic context
- A more efficient way of working which reduces transaction costs and overheads
- An acute hospital sector with links to a number of larger specialist hospitals out of county
- A more integrated strategic commissioning arrangement for health and social care with appropriate clinical support and advisory arrangements

How will it be different for patients?

In the future residents of Lincolnshire will take more responsibility for their own health, both in managing long term conditions and in making healthy lifestyle choices to keep fit and well. They will be able to access their records via the Care Portal to assist them with caring for themselves if they have self-limiting or long-term conditions. They will know who their GP is but are likely to have initial consultations with a range of primary care and community based health and care staff, often via phone or using telemedicine. They will find they don't need to explain their health and care issues in detail more than once. For ongoing health and care issues, their main contact may well be their GP. They can expect that most diagnostic tests and specialist consultations will be undertaken locally. If they need specialist emergency or planned care, they may need to travel to an acute hospital

but will be able to return to their own community very quickly. They will find that all those caring for them are well trained and motivated, working effectively with their colleagues, and that their care is delivered in comfortable surroundings. They will be able to access the right service first time and will consistently receive good quality, safe care wherever they live in the county.

The staff perspective
Lincolnshire will be a great place to work, a place where staff feel valued and empowered to carry out their roles. Staff will have a clear understanding of their own role and skills and where these fit in with others across the health and social care setting, enabling them to work seamlessly with their colleagues. They will work in pleasant environments, mostly in community settings, free of the frustrations from IT systems and unreasonable work load expectations. They will have a good work life balance and their job roles will be varied and exciting with greater opportunities for development.

Feedback from NHSE following 30th June submission:
Following the submission of the draft STP on 30th June, Lincolnshire representatives attended a meeting with Simon Stephens, Jim Mackay and others on 22nd July. This was an hour long session to provide an opportunity for the national leadership to ask questions, challenge and feedback on the Lincolnshire Plan. Overall the meeting went well – the key points raised are highlighted below:

- Lincolnshire has worked hard as a System on their STP, supported by the LHAC transformation programme and the extensive work undertaken through this to develop a new model for health and care in Lincolnshire
- The submission did not do justice to all the work that has gone on behind the scenes; the presentation could have been clearer, with more focus on the big changes that are required to deliver on quality, health and wellbeing and finance.
- The Governance could be simpler with more of a focus on accountability for delivery
- The evidence for hospital service changes needs to be more clearly articulated – this should inform any business case which would need to be completed before the public consultation.
- Lincolnshire must submit a balanced plan (the first submission had approximately £50m shortfall)

This has been helpful in focusing attention on the key areas where the plan needs more work, ahead of the next submission.

3. Conclusion

September is a crucial month for the STP, with much activity focused on a number of key elements. Below are some of the critical milestones:

- **16th September:** A refreshed finance submission to NHSE including more detail on capital, efficiency sources and investments for all STPs
- **Mid September:** Review of progress with the Clinical Senate
- **Mid September:** A workshop to kick start discussion of 2 year cross-organisational operational plans which need to be finalised by December 2016; draft commissioning intentions also agreed by end of September.

- **September:** Ongoing dialogue with key stakeholders, staff and public on the high level vision for 2021; planning for more extensive engagement and the consultation on the LHAC proposals after the 21st October submission date.
- **Early October:** discussion of refreshed STP submission by local Boards and Governing Bodies
- **21st October:** Submission of refreshed STP draft to NHSE
- **Post 21st October:** Approval of STP and confirmation of timetable for consultation; STP made available to the public.

There is a strong commitment from all STP partners to meet these challenging timeframes and to make progress on transforming our health and care system. We will continue to engage with our residents and our clinical community as we move forward from planning, into implementation. The introduction of the Care Portal and the CAS this autumn have shown that we can be at the forefront of best practice nationally, with both of these initiatives sited as "exemplars" in developing solutions to clinical need with buy-in and ownership from our whole community.

Similarly, we have been able to make good progress on a number of solutions to tackle our recruitment challenges, such as the introduction of the first Integrated Health and Social Care Apprenticeship, the MSc in Frailty (the first of its kind nationally) and initiatives to support flexible working for those nearing retirement and provide county-based courses for those who wish to requalify to return to practice. We are also looking at international recruitment initiatives and mentoring and training schemes for our GP workforce.

4. Appendices

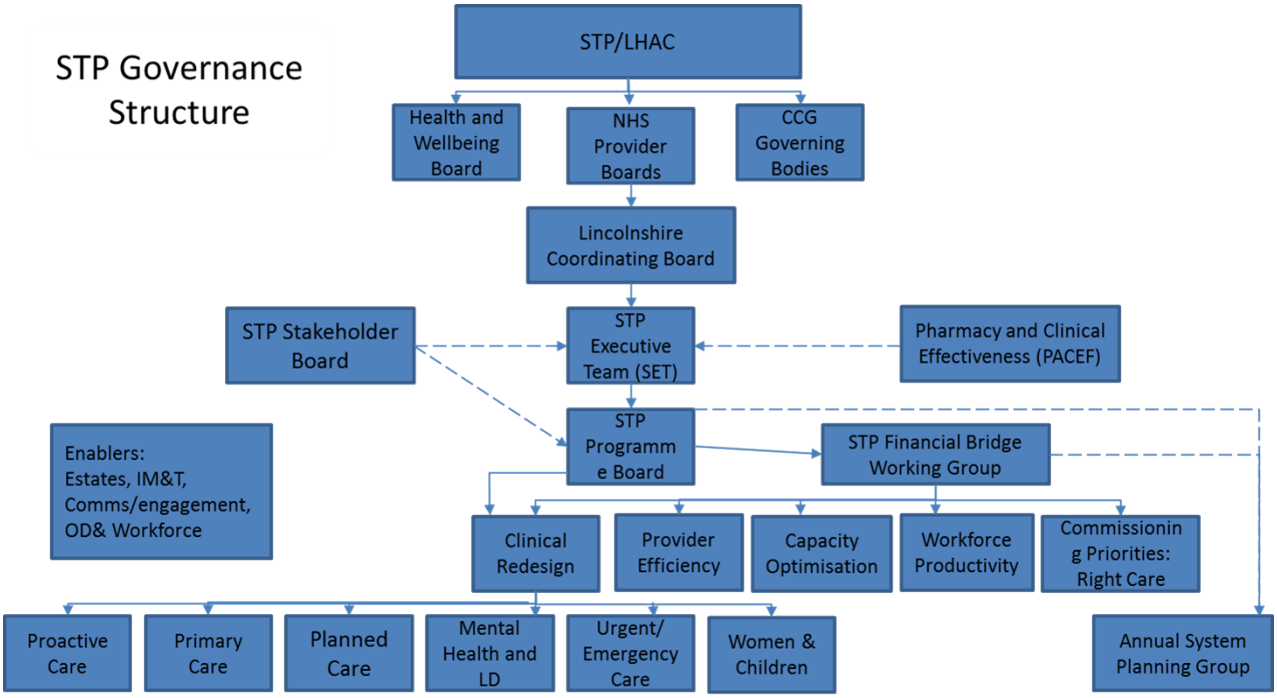
These are listed below and attached at the back of the report	
Appendix A	Governance Structure for Lincolnshire's STP

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 Sarah Furley who can be contacted on sarah.furley@lincolnshireeastccg.nhs.uk

Appendix A: Governance structure for Lincolnshire's STP



Health and Wellbeing Board – Decisions from 7 June 2016

Meeting Date	Minute No	Agenda Item & Decision made
7 June 2016	**1**	**Election of Chairman** That Councillor Mrs S Woolley be elected as the Chairman of the Lincolnshire Health and Wellbeing Board for 2016/17
	2	**Election of Vice-Chairman** That Dr Sunil Hindocha be elected as the Vice-Chairman of the Lincolnshire Health and Wellbeing Board for 2016/17
	5	**Minutes** That the minutes of the Lincolnshire Health and Wellbeing Board meeting held on 22 March 2016, be confirmed by the Chairman as a correct record.
	6	**Action Updates from the previous meeting** That the completed actions as detailed be noted.
	8a	**Terms of Reference, Procedural Rules, Board members Roles and responsibilities** That the Terms of Reference. Procedure Rules and Board Members Roles and Responsibilities be re-affirmed.
	8b	**Proposal for the development of the Joint Health and Wellbeing Strategy** That the following proposal be agreed:- That the prioritisation framework the HWBB adopted to develop the JHWS is rooted in the topics included within the JSNA; That the HWBB adopts the five core principles as detailed in the minutes and set out in the report within which the development of the JHWS will be undertaken; The HWBB adopts the nine criteria as detailed in the minutes are worked up into a formal prioritisation framework that can be used for the purposes of developing the JHWS for Lincolnshire; The proposed stakeholders identified as being involved in the initial engagement on the prioritisation framework; and The HWBB agrees the final prioritisation framework in September 2016, with a view to completing prioritisation work by March 2017.
	9a	**Joint Commissioning Board – Update** That the verbal updates relating to the BCF and the STP be noted.
	9b	**Lincolnshire health and Care – Verbal Update** That the verbal update be noted.
	9c	**Health and Wellbeing Grant Fund – Update Report** That the update report on the Health and Wellbeing Grant Fund Project be noted.

7 June (continued)	**9e**	**Joint Health and Wellbeing Strategy Theme Updates** That the update be noted.
	10a	**Action Log of Previous Decisions** That the Action Log of previous decisions of the Lincolnshire health and Wellbeing Board be noted.
	10b	**Lincolnshire health and Wellbeing Board – Forward Plan** That the Forward Plan for formal and informal meetings presented be received, subject to a 'Update on the Sustainability and Transformation Plan being added to the agenda for the meeting on 27 September 2016
	10c	**Future Scheduled Meeting Dates** That the following scheduled meeting dates for the remainder of 2016 and for 2017 be noted. 27 September 2016 6 December 2016 28 March 2017 26 September 2017 5 December 2017 (All the above meetings to commence at 2.00pm)

Lincolnshire Health and Wellbeing Board Forward Plan: September 2016 – March 2017

Meeting Dates	Decision/Authorisation Item	Discussion Item	Information Item
27 September 2016 **2pm in Committee Room 1, County Offices, Newland, Lincoln LN1 1YL**	**Annual Assurance Report** To receive a report from the Programme Manager asking the Board to agree the Board's Assurance Report and Theme Dashboards. **Alison Christie, Programme Manager Health and Wellbeing** **Prioritisation Framework for the development of the Joint Health and Wellbeing Strategy** To receive a report asking the Board to agree the prioritisation framework for the new JHWS and to agree the process for developing the JHWS. **David Stacey, Programme Manager, Strategy and Performance**	**Joint Commissioning Board – BCF Update Report** To receive an update report from the JCB on the Better Care Fund and joint commissioning arrangements in Lincolnshire. **Glen Garrod, Director of Adult Care / Sunil Hindocha, Chairman of the JCB** **Lincolnshire Sustainability and Transformation Plan (including Lincolnshire Health and Care)** To receive a report on Lincolnshire's Sustainability and Transformation Plan and LHAC programme **Sarah Furley, Lincolnshire East Clinical Commissioning Group** **District/Locality Updates** Standing agenda item for the Board to receive updates, by exception, from District/locality partnerships	
6 December 2016 **2pm in Committee Room 1, County Offices, Newland, Lincoln LN1 1YL**	**Joint Strategic Needs Assessment Review** To receive an update on the fundamental review of the JSNA and to seek approval from the Board to the next steps. **Chris Weston, Public Health Consultant – Public Health Intelligence and Health Improvement** **Engagement Strategy for the implementation of the Joint Strategic Needs Assessment and the development of the Joint Health and Wellbeing Strategy** To receive a report asking the Board to agree the engagement approach and strategy for the JSNA and the development of the JHWS.	**Joint Commissioning Board – Update Report** To receive an update report from the JCB on the Better Care Fund and joint commissioning arrangements in Lincolnshire. **Glen Garrod, Director of Adult Care / Sunil Hindocha, Chairman of the JCB** **Lincolnshire Sustainability & Transformation Plan (including Lincolnshire Health and Care Programme) – update report** To receive an update on the LHAC programme **Allan Kitt, Leading Chief Officer, LHAC Programme** **Health and Wellbeing Grant Fund – Update** To receive a half yearly report on the Health and Wellbeing Grant Fund projects. **Alison Christie, Programme Manager Health and Wellbeing**	

Meeting Dates	Decision/Authorisation Item	Discussion Item	Information Item
	Alison Christie, Programme Manager Health and Wellbeing and David Stacey, Programme Manager, Strategy and Performance	**District/Locality Updates** Standing agenda item for the Board to receive updates, by exception, from District/locality partnerships **Joint Health and Wellbeing Strategy Theme Updates** Standing agenda item for the Board to receive updates, by exception, from JHWS Themes	
7th March 2017 **2pm in Committee Room 1, County Offices, Newland, Lincoln LN1 1YL**	**Development of the Joint Health and Wellbeing Strategy** To receive a report on the priorities to be consulted on and to ask the Board to agree the consultation arrangements. **David Stacey, Programme Manager, Strategy and Performance**	**Joint Commissioning Board – Update Report** To receive an update report from the JCB on the Better Care Fund and joint commissioning arrangements in Lincolnshire. **Glen Garrod, Director of Adult Care / Sunil Hindocha, Chairman of the JCB** **Children and Young Peoples Commissioning Plan 2017-2020** To receive a report from Children's Services on the Children and Young People's Commissioning Plan and provide the Board with an opportunity to discuss and comment on the plan. **Andrew McLean, Children's Service Manager - Commissioning** **Lincolnshire Sustainability & Transformation Plan (including Lincolnshire Health and Care Programme) – update report** To receive an update on the LHAC programme **Allan Kitt, Leading Chief Officer, LHAC Programme** **District/Locality Updates** Standing agenda item for the Board to receive updates, by exception, from District/locality partnerships **Joint Health and Wellbeing Strategy Theme Updates** Standing agenda item for the Board to receive updates, by exception, from JHWS Themes	