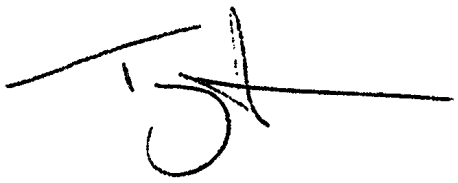
County Offices
Newland
Lincoln
LN1 1YL

27 February 2017

Lincolnshire Health and Wellbeing Board

A Meeting of the Lincolnshire Health and Wellbeing Board will be held on Tuesday, 7 March 2017 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 Care and Community Wellbeing) and Tony McGinty (Interim Director of Public Health Lincolnshire)

District Council: Councillor Marion Brighton OBE

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

Healthwatch Lincolnshire: Sarah Fletcher

NHS England: Jim Heys

(*) Permanent Membership

LINCOLNSHIRE HEALTH AND WELLBEING BOARD AGENDA
TUESDAY, 7 MARCH 2017

Item	Title	Pages	Estimated Time
1	**Apologies for absence/Replacement Members**		
2	**Declarations of Members' Interest**		
3	**Minutes from the Lincolnshire Health and Wellbeing Board meeting held on 6 December 2016**	5 - 12	
4	**Action Updates from the previous meeting** *(For the Lincolnshire Health and Wellbeing Board to consider the actions arising from the previous meeting)*	13 - 14	
5	**Chairman's Announcements** *(For the Lincolnshire Health and Wellbeing Board to note the Chairman's announcements)*	15 - 18	
6	**Decision/Authorisation Items**		
6a	**Annual Report of the Director of Public Health on the health of the people of Lincolnshire 2016** *(To receive a report from Tony McGinty, Interim Director of Public Health, which provides the Board with the Annual report on the health of the people of Lincolnshire 2016)*	19 - 56	
6b	**Joint Health and Wellbeing Strategy - Engagement Plan** (*To receive a report from David Stacey, Programme Manager, Health and Wellbeing, which asks the Board to approve the engagement approach for developing the next Joint Health and Wellbeing Strategy)*	57 - 60	
6c	**Better Care Fund (BCF) 2016/17 and Future Planning** *(To receive a report from Glen Garrod, Executive Director Adult Care and Community Wellbeing concerning the 2017/18 – 2018/19 Better Care Fund submission)*	61 - 100	

Item	Title	Pages	Estimated Time
6d	**Integration Self-Assessment - Next Steps** *(To receive a report from Alison Christie, Programme Manager, Health and Wellbeing, which asks the Board to agree the Integration Improvement Plan, developed following the Integration Self-Assessment)*	101 - 106	
7	**Discussion Items**		
7a	**Service Users with Learning Disabilities** *(To receive a report from Justin Hackney, Assistant Director, Specialist Adult Services Adult Care and Community Wellbeing, which provides the Board with an update on a Regional Improvement Programme in relation to support for people with Learning Disabilities)*	107 - 120	
7b	**NHS Immunisation and Screening for patients in Lincolnshire** *(To receive a report from Sarah Fletcher, Chief Executive Officer, Healthwatch Lincolnshire on the findings of their work around Immunisation and Screening services)*	121 - 152	
7c	**District/Locality Update: North Kesteven's Health and Wellbeing Strategy** *(To receive a joint report from Phil Roberts and Luisa McIntosh which asks the Board to receive North Kesteven's new Health and Wellbeing Strategy)*	153 - 172	
8	**Information Items**		
8a	**'ACTion Lincs' - Tackling Entrenched Rough Sleeping in Lincolnshire (Social Impact Bond Funding)** *(To receive a joint report from Lisa Loy, Housing for Independence Manager, Public Health and Michelle Howard, West Lindsey District Council which asks the Board to receive the recent bid to DCLG for an Entrenched Rough Sleepers Social Impact Bond)*	173 - 180	
8b	**Government Proposals for the Future Funding of Supported Housing** *(To receive an information report from Lisa Loy, Housing for Independence Manager, concerning the government proposals on the future funding of social housing)*	181 - 226	

Item	Title	Pages	Estimated Time
8c	**An Action Log of previous Decisions** *(For the Health and Wellbeing Board to note decisions taken since June 2016)*	227 - 230	
8d	**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)*	231 - 234	

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

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

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

LINCOLNSHIRE HEALTH AND WELLBEING BOARD
6 DECEMBER 2016

PRESENT: COUNCILLOR MRS S WOOLLEY (CHAIRMAN)

Lincolnshire County Council: Councillors 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.

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

District Council: Councillor Donald Nannestad.

GP Commissioning Group: Dr Kevin Hill (South Lincolnshire CCG) and Dr Sunil Hindocha (Lincolnshire West CCG).

Healthwatch Lincolnshire: Sarah Fletcher.

NHS England: No representative in attendance.

Officers in Attendance: Alison Christie (Programme Manager, Health and Wellbeing Board), Katrina Cope (Senior Democratic Services Officer) and Councillor Mrs Judith Mary Renshaw attended the meeting as an observer.

22 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

Apologies for absence were received from Councillor Mrs M Brighton OBE (District Council representative) and Dr Peter Holmes (Lincolnshire East Clinical Commissioning Group).

The Committee was advised that Councillor D Nannestad (District Council representative) had replaced Councillor Mrs M Brighton OBE (District Council representative) for this meeting only.

23 DECLARATIONS OF MEMBERS' INTEREST

There were no declarations of members' interest made at this stage of the proceedings.

24 MINUTES FROM THE LINCOLNSHIRE HEALTH AND WELLBEING BOARD MEETING HELD ON 27 SEPTEMBER 2016

RESOLVED

That the minutes of the previous meeting of the Lincolnshire Health and Wellbeing Board meeting held on 27 September 2016, be confirmed and signed by the Chairman as a correct record.

25 ACTION UPDATES FROM THE PREVIOUS MEETING

RESOLVED

That the Action updates from the previous meeting be noted.

26 CHAIRMAN'S ANNOUNCEMENTS

Further to the Chairman's announcements circulated with the agenda, members of the Board received an additional announcement sheet, which provided an update relating to Entrenched Rough Sleepers Social Impact Bond; and the 2016 Autism Self-Assessment Framework.

The Chairman also highlighted that as a result of the Clinical Commissioning Groups poor performance with regard to cancer ratings, (details of which had been published by NHS England on 4 October 2016), compared with other areas of England, a letter had been sent to Chief Officer's expressing the Board's concerns. A copy of the said letter was attached as Appendix A. Also, attached at Appendix B was a copy of a response letter from the four CCGs.

27 DECISION/AUTHORISATION ITEM

27a Integration Self-Assessment

Consideration was given to a report from Alison Christie, Programme Manager Health and Wellbeing, which provided the Board with the outcome of the self-assessment exercise. It was highlighted that integration between health and social care was a key driver to providing high quality and sustainable services to meet the needs of the local population; and also address local priorities. The Integration Self-Assessment tool developed by the Local Government Association was aimed to focus on the key elements and characteristics needed for successful integration.

It was highlighted that the Health and Wellbeing Board was required to promote joint working and integration to improve health and wellbeing in Lincolnshire. In doing this, partners and key stakeholders had been asked to take part in the self-assessment exercise; the findings from this exercise were then discussed at the Informal Health and Wellbeing Board meeting held in November. The findings of the self-assessment exercise were detailed in Appendix A to the report; and feedback

from the Informal Health and Wellbeing Board meeting held on 8 November was provided in Appendix B for the Board to consider.

Overall, the general view was that progress had been made initially; but there was still progress to be made in Lincolnshire to ensure that all partners and stakeholders were engaged in the integration journey. To enable this to happen, the Board was requesting commitment from partners to share the outcome of the self-assessment exercise; and to identify priority areas for improvement. A further report would then be presented to the meeting in March 2017, which would ask the Board to agree a small number of improvement actions to progress which would be based on the ranked list of priorities.

During a short discussion, the following points were raised:-

- Some concern was expressed to the number of responses received (11 corporate responses). The Board was encouraged to disseminate the information provided, to ensure that a better representation was received;
- Some concern was expressed as to what happened next in the process. An explanation of the next steps to be taken was provided to the Board. (This information was detailed on page 25 of the report presented). Confirmation was given that the Board was working towards the themes as agreed in the Joint Health and Wellbeing Strategy;
- Some members highlighted that during the last 12/18 months some areas of integration had not been taken forward as far they possibly could have been. It was highlighted that in some cases this had been as a result of lack of financing; and
- Scrutiny of the local Sustainability and Transformation Plan (STP). The Board was advised that STP would be included as an item on the March agenda; and that STP would remain as an item on the agenda thereafter going forward. The Board was advised further that scrutiny of the STP would be conducted by the Health Scrutiny Committee for Lincolnshire.

Following discussion, the Board agreed to:-

RESOLVED

1. That the details of the Integration Self-Assessment as detailed in Appendices A and B be noted.

2. That the next steps as detailed below be approved:-

    - Each partner organisation, including all district councils, NHS providers and Involving Lincs, share the details of this exercise with their governing body to raise awareness of the feedback and to gain commitment from stakeholders to develop a shared improvement plan to address the issues highlighted through this exercise;
    - Each partner is asked to identify their top three priority areas for improvement (ranked 1 to 3, with 1 being the top priority) and to

feed this information back to the Programme Manager Health and Wellbeing by the end of January 2017;

- The organisational priorities are collated and developed into a ranked long list;
- A further report is presented to the Health and Wellbeing Board in March 2017.

27b Better Care Fund (BCF) 2016/17 & 2017/18

The Board gave consideration to a report from Glen Garrod, Executive Director of Adult Care and Community Wellbeing, which provided an update on Lincolnshire's plans for the Better Care Fund Narrative Plan and Planning Template for 2017/18 and 2018/19.

The Board was advised that there had been a number of changes by the Government, one was that CCGs and Upper Tier Councils needed to agree a joint plan to deliver the requirements of the BCF for 2017/18 and 2018/19 via the Health and Wellbeing Board.

It was reported that nationally an additional £105m was anticipated to be made available to Upper-Tier Councils through the BCF in 2017/18, and £825m in 2018/19.

That would mean that the sums for Lincolnshire would be:-

- 2017/18 – a further £2.1m;
- 2018/19 – a further £12.1m; and
- 2019/20 – a further £10.9m, making the BCF £25.1m greater than in 2016/17.

It was noted that the sums were expected to come to the County Council via a Section 31, direct from Government.

The Committee noted that officers were busy working on the BCF submission for 7 January 2017, but this process was being hampered as guidance information had still not been received from the Government. It was noted further that there was an informal consensus that Lincolnshire should make an application to be a pilot 'graduation site.' It was noted further that this was the Government's latest phase for moving local areas from the BCF to the full integration of health and social care. However, the benefits of being a 'graduation pilot' were still being determined nationally.

In conclusion, the Board was advised that there was a considerable amount of work to be undertaken to ensure that Lincolnshire was able to submit an agreed BCF Plan within the timescales.

It was further reported that the eight Lincolnshire local authorities had developed and agreed an approach to managing and reforming the Disabled Facilities Grant (DFG) system in Lincolnshire over the two years of the 'new' BCF. The outline agreement

had been presented to the Joint Commissioning Board on 22 November, details of which were contained within Appendix B to the report presented.

Appendix A to the report provided the Board with details of the Better Care Fund Performance Report – Overview for Quarter 2.

A discussion ensued, from which the Board raised the following points:-

- The Board were advised that DFG also applied to private housing; and that District Councils had the statutory responsibility for DFGs;
- Some concern was expressed from the District representative to the target of eight weeks for a DFG to be completed from self-referral to job completion. It was felt that this might not be achievable particularly in instances when planning permission was required. A suggestion was made as to whether it would be more appropriate for this to be amended to being 85% complete within the timescale. The Board noted that at the moment the document only had overarching officer agreement and had not been politically signed off by the Districts. Therefore a formal agreement would still have to be considered through the decision making process as key decisions on implementation still had to be made;
- Reference was made to a level of disappointment that the Chancellor's Speech had not made reference to health and social care. However, it was noted that some dialogue was ongoing with the Government, and that there was some optimism that there might be added resource to social care;
- A suggestion was made that Districts should look into using smaller contractors; as in some cases there was more flexibility locally and costs were lower; and
- A suggestion was made for ensuring that a Memorandum of Understanding was established between the County Council, the four CCGs and the Districts. Officers reassured the Board that a Memorandum of Understanding was already being drafted.

Councillor C R Oxby wished it to be noted that he had worked on DFG works for a local Carity Housing Association.

The Board was reminded that any delegation from the Lincolnshire Health and Wellbeing Board was dependent on the statutory signatories.

RESOLVED

1. That delegation be given to the Executive Director of Adult Care and Community Wellbeing, in consultation with the Chairman of the Lincolnshire Health and Wellbeing Board, the responsibility to submit the BCF Plans for 2017/18 – 2018/19.

2. That the Lincolnshire Health and Wellbeing Board notes that the Joint Commissioning Board is likely to recommend that the Protection of Adult Care Services should be at the minimum amount identified in Planning Guidance due to be issued after 12 December 2016, and that the Council

are likely to accept this minimum amount (all subject to any material requirements in the national guidance).

3. That the Lincolnshire Health and Wellbeing Board defers to the A & E Board target setting; and notes that 'stretch targets' will be set for both 2017/18 and 2018/19, notably with respect to Non-elective Admissions (NEA) and Delayed Transfers of Care (DTOC).

4. That agreement be given to the Disabled Facilities Grant paper (detailed at Appendix B), prepared by the Interim Director of Public Health should provide a steer on the way forward to address DFGs for 2017/18 – 2018/19; but should take into account the comments raised with regard to amending the proposed target for completing DFGs from self-referral to job completion.

5. That agreement be given to Lincolnshire making an application to be a pilot 'graduation site'.

6. That agreement be given to not progressing any work in developing a contingency sum in the next BCF submission. (Subject to any material requirements in the national guidance).

27c Lincolnshire Clinical Commissioning Groups Draft Operational Plan

Consideration was given to a report on behalf of the four Clinical Commissioning Groups (CCGs), which provided the Board with a copy of a Joint Draft Operational Plan for 2017/19. It was highlighted that NHS England had brought the NHS Planning Cycle forward by three months, (normally the Health and Wellbeing Board would have considered four individual CCG Plans at its March meeting) and had required CCGs to align operational planning to years 2 and 3 of the local Sustainability and Transformation Plan (STP).

It was reported that the two year operational plans had been developed by cross organisational working, and that all seven NHS organisations had come together to agree the operational plans. The CCGs were required to submit final Operational Plans to NHS England on 23 December 2016, alongside finalising contract negotiations with providers.

The Board noted that in addition to being held to account for delivery of the STP the CCG Improvement and Assessment Framework would provide the framework by which CCGs performance would be monitored during the life cycle of the operational plan. An overview of current performance against the CCG Improvement and Assessment Framework was detailed on pages 64/65 of the report presented. Appendix A provided the Board with a copy of the Lincolnshire CCGs Draft Joint Operational Plan on a Page for 2017/19.

During discussion, the Board raised the following issues:-

- One member felt that the document should make reference to the Lincolnshire Health and Wellbeing Strategy;
- Some reference was made to the poor cancer diagnosis; and dementia rates. The Board was advised that there was concern regarding early diagnosis and that work was being done around the two weekly pathway up to diagnosis. However, for cancer survival rates Lincolnshire was performing well. It was noted that good practice was shared locally and within East Midlands. The Board was advised that the message had not reached the most deprived areas with regard to screening for cancer. It was highlighted that two week appointments were made for patients who might have cancer, but unfortunately a lot of these patients did not attend the appointments. The Board was advised further that a cancer campaign was to be released 'Find out Faster' encouraging those at risk to get the necessary tests done; and
- The variance surrounding childhood obesity between Lincolnshire East and South West Lincolnshire CCG. It was highlighted that deprivation was one factor that could be associated with obesity; however some concern was expressed as to the data; which provided information at a population level – it was currently based on a weight at reception and year 6, but did not track individual children. Some members felt that more needed to be done at school to promote health and wellbeing as part of the curriculum. Some felt that more exercise should be encouraged. Overall, the Board realised that this was a complex area of work.

RESOLVED

That the Lincolnshire Clinical Commissioning Groups Draft Joint Operational Plan on a Page 2017/19 be noted.

28 DISCUSSION ITEMS

28a 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.

29 INFORMATION ITEMS

29a Health and Wellbeing Grant Fund - Update

Consideration was given to a report from Tony McGinty, Interim Director of Public Health, which provided the Board with an update on the Health and Wellbeing Grant Funded projects.

The Board noted that this was the third half yearly report on the projects since the funding was agreed by the Board in March 2015. The Board was asked to note the information provided in Appendix A.

RESOLVED

That the Quarter 2 information concerning the Health and Wellbeing Grant Fund Projects 2016 – 2017 provided in Appendix A be noted.

29b An Action Log of previous Decisions

RESOLVED

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

29c 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 invited to put forward items for consideration. The following items were put forward:-

- Sustainability and Transformation Plan to be included as a standing item;
- Alternative Lead Officers;
- North Kesteven Health and Wellbeing Strategy – March meeting;
- East Lindsey Health and Wellbeing Strategy – June meeting;
- Entrenched Rough Sleepers Social Impact Bond;
- Discussion item from Healthwatch relating to immunisation and screening.

RESOLVED

That the Forward Plan for formal and informal meetings of the Lincolnshire Health and Wellbeing Board presented be received, subject to the inclusion of the items as detailed above.

The meeting closed at 3.20 pm.

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
27.09.16		**NO ACTIONS RECORDED**	
06.12.16	**27a**	**INTEGRATION SELF-ASSESSMENT** Each partner organisation, including all district councils, NHS providers and Involving Lincs, share the details of this exercise with their governing body to raise awareness of the feedback and to gain commitment from stakeholders to develop a shared improvement plan to address the issues highlighted through this exercise Each partner is asked to identify their top three priority areas for improvement (ranked 1 to 3, with 1 being the top priority) and to feed this information back to the Programme Manager	A formal letter from Cllr Woolley and details of the Integration Self-Assessment were sent to partners on 12 December 2016. The letter asked partners to share the feedback with their governing bodies and to take the opportunity to identify up to 3 possible improvement areas which the Board could promote to improve integration in Lincolnshire. Partners were invited to send details of their priority areas to Alison Christie by Monday 30 January 2017. A reminder email was sent to partners on 16 January 2016

		Health and Wellbeing by the end of January 2017 A further report will then be presented to the March meeting	Report presented at March 2017 meeting
	27b	**BETTER CARE FUND 2016/17 & 2017/18** Delegation was given to the Executive Director of Adult Care and Community Wellbeing, in consultation with the Chairman of the Lincolnshire Health and Wellbeing Board, the responsibility to submit the BCF Plans 2017/18 – 2018/19	BCF Plans for 2017/18 – 2018/19 progressed by the Executive Director of Adult Care and Community Wellbeing in consultation with the Chairman of the Lincolnshire Health and Wellbeing Board.
	29c	**LINCOLNSHIRE HEALTH AND WELLBEING BOARD – FORWARD PLAN** That the following items be added to the Forward Plan:- • Sustainability & Transformation Plan to be included as a standing item; • Alternative Lead Officers; • North Kesteven Health and Wellbeing Strategy – March meeting • East Lindsey Health and Wellbeing – June meeting • Entrenched Rough Sleepers Social Impact Bond • Discussion item from Healthwatch relating to immunisation and screening	• At the 7 March 2017 Board meeting an update on the Sustainability and Transformation Plan is provided as part of Chairman's Announcements. • Changes noted and updated accordingly • North Kesteven's Health and Wellbeing Strategy included on the agenda for March 2017 • East Lindsey Health and Wellbeing Strategy added to the Forward Plan for June 2017 • An information report on the Entrenched Rough Sleepers Social Impact Bond included on the agenda for March 2017 • A discussion item on the report by Healthwatch into Immunisation and Screening Services included on the agenda for March 2017

Lincolnshire Health and Wellbeing Board – 7 March 2017

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

Sustainability and Transformation Plan

An update on the Sustainability and Transformation Plan (STP), provided by Sarah Furley, STP Programme Director, is presented in Appendix A for information.

Pharmaceutical Needs Assessment (PNA)

In January 2017, the Health Scrutiny Committee for Lincolnshire considered a report on the how the implementation of '*Community Pharmacy in 2016/17 and Beyond: The Final Package'* was impacting on local pharmacies. Steve Mosley (Chief Officer of the Lincolnshire Local Pharmaceutical Committee) was in attendance. The Committee heard that the full impact of the new funding arrangements will not be fully known until the summer months. It is, therefore, too soon to know how many community pharmacies may be lost in Lincolnshire.

The Board is required to publish a new PNA by March 2018 and a paper will be presented to the Board in June providing details of the review process, including the timescales for the 60 day statutory consultation period. However, due to the level of uncertainty, detailed work on the PNA will not begin until the summer.

Sarah Newton and Allan Kitt

It is with great sadness that we bid farewell to Sarah Newton and Allan Kitt. On behalf of the Board I would like to thank them for their service and contribution to the health and care community in Lincolnshire and we wish them both a happy retirement.

Dr Peter Holmes

Dr Peter Holmes has stepped down as the Chairman of the Lincolnshire East Clinical Commissioning Group Governing Body in order to focus on the management of the Stuart House Surgery in Boston. Dr Stephen Baird is acting as Interim Chairman of the Governing Body.

I would like to express my thanks to Dr Holmes for the support he has given to the Lincolnshire Health and Wellbeing Board.

New Year's Honours List

I would like to congratulate Dr Tony Hill, former Executive Director of Public Health and Community Wellbeing, and Chris Cook, Chairman of the Lincolnshire Safeguarding Children's Board, who received awards in the Queen's New Year's Honours List.

Dr Hill has been awarded a MBE for services to Public Health and Chris Cook has received an OBE for services to children.

Appendix A

STP Update for Health and Wellbeing Board

Lincolnshire's new five year health and care plan, the Sustainability and Transformation Plan (STP), was published on 6th December 2016. Its vision for more joined up care, delivering closer to home and more preventative support to keep people out of hospital has been broadly welcomed across the county though concerns have been raised by some about accessing care if certain services end up being centralised onto one site.

It is a live document that will continue to evolve through the implementation of the two year operational plans. The contracts signed on 23rd December 2016 between commissioners and providers cover the ongoing delivery of core healthcare services. The contracts and the operational plans do not contain any changes which require full public consultation. Any major change will only be made after full public consultation and, once undertaken, if this leads to a change in the way that hospital services will be provided, then commissioners would go through the normal process of contract variation to update the contract to reflect the new service provision.

Whilst formal public consultation on the options for service changes will not start until after the LCC elections in May 2017, communication and engagement activities with all stakeholders have started in earnest. Over 100 engagement sessions are underway talking to groups, communities and key stakeholders across the county to get their thoughts, views and input into the STP. There have been nine briefing sessions with strategic stakeholders, such as elected members and the STP stakeholder board, plus over 20 engagement events to brief staff about the plan and what it means for them.

Further progress has also been made on the proposals for changes to major services, including stroke, maternity and paediatrics, learning disability, urgent and emergency care and some elements of planned care. An event on 25th January with 135 senior clinicians, leaders and stakeholders looked at a range of options for these services and assessed each option against a set of agreed criteria: quality, access, affordability and deliverability. This is part of the process which will enable a final agreed set of options to be put to the public for consultation in the summer after it has been reviewed by the clinical senate and approved by NHS England. No decisions will be made until after public consultation.

Many elements of Lincolnshire's STP are already in progress: the clinical assessment service is already operational and providing a vital service to ensure those with urgent and emergency care needs get to the right service first time. The Care Portal, too, is about to go live, enabling professionals to access appropriate patient information with consent and to make more informed decisions about their care. A key focus for the next year will also be the full implementation of integrated neighbourhood care teams which will deliver better quality of life and enhanced health and wellbeing for patients, reducing crisis and unplanned admissions and enhancing patients' experience of care through more co-ordinated and personalised support.

Our Arms Length Bodies' assessment of the STP is that it is a realistic plan which both addresses the long standing quality challenges around our services, in

particular our need to re-balance our system, as well as tackling the long standing challenges of sub-scale delivery in a number of specialties, plus provides a framework, within the assumptions outlined in the plan, to enable financial balance by 2021. However, it is also recognised that it is a high risk plan and there are a number of key areas to be addressed:

- Deliverability - the change management capacity needs mobilising. Change is at an unprecedented scale for Lincolnshire and with the right kind of support probability of success will be significantly improved.

- Capital – a significant number of feasibility studies have been undertaken and securing capital is a very real enabler to improving the chances of the Lincolnshire system in delivering its new care model and resolving the long standing quality issues faced.

- Multi-Specialty Community Providers – these new models of care, underpinned by the ongoing development of the neighbourhood teams and work taking place to deliver the GP Forward View, are fundamental to being able to deliver our vision. This work will include how strategic commissioning will evolve.

- Governance – The STP approach is not addressed in law. The mixed executive and non-executive groups that have assumed a leading role in the STP are not in themselves legal entities. Work has commenced to set out in writing how organisations within the STP are going to work together and this will probably take the form of a memorandum of understanding (MoU).

- Risk and benefits sharing mechanism – there has been much debate about agreeing a single system control total in Lincolnshire for the NHS budget. Risk sharing will need to be explicit in our agreed governance process to make sure money flows to where it can deliver the best results.

We now have a single system wide plan for the county with a vision for a new model of care that will deliver improved health and wellbeing and consistent quality by 2021, as well as bringing us back into balance. There is strong commitment from all NHS partners to work together in partnership to deliver this plan. We have the opportunity to transform patient care and deliver a safe, sustainable and good quality health and care service which is fit for the future. We are only at the start of a five year process and will continue to listen to, engage with and involve both staff and public as we work together to deliver this plan.

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Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

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

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**07 March 2017**
Subject:	**Annual Report of the Director of Public Health on the Health of the People of Lincolnshire 2016**

Summary:

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

Actions Required:

The Lincolnshire Health and Wellbeing Board is requested to receive the Annual Report on the Health of the People of Lincolnshire from the Interim Director of Public Health and consider the recommendations included in each chapter.

1. Background

It is a statutory duty of the Director of Public Health to produce an annual report on the health of the people of the area he/she serves. It is a statutory duty on the local authority for that area (in this case the Council) to publish that Report. The report attached at Appendix A is the latest report of the Director of Public Health for Lincolnshire. The report is not an annual account of the work of the Public Health Team, but an independent professional view of the state of the health of the people of Lincolnshire, with recommendations on the action needed by a range of organisations and partnerships.

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

I decided this year to focus on the mental health and mental illness profile of local people. My decision was based on the principle best described as 'no health without mental health',

which leads us to a definition of mental health as a resource, rather than simply a state involving the absence of illness or distress.

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

2. Conclusion

The statutory Annual Report of the Interim Director of Public Health on the health of the people of Lincolnshire has now been prepared and the Lincolnshire Health and Wellbeing Board is asked to receive and note the recommendations included in each chapter.

3. Consultation

This is not a consultation item.

4. Appendices

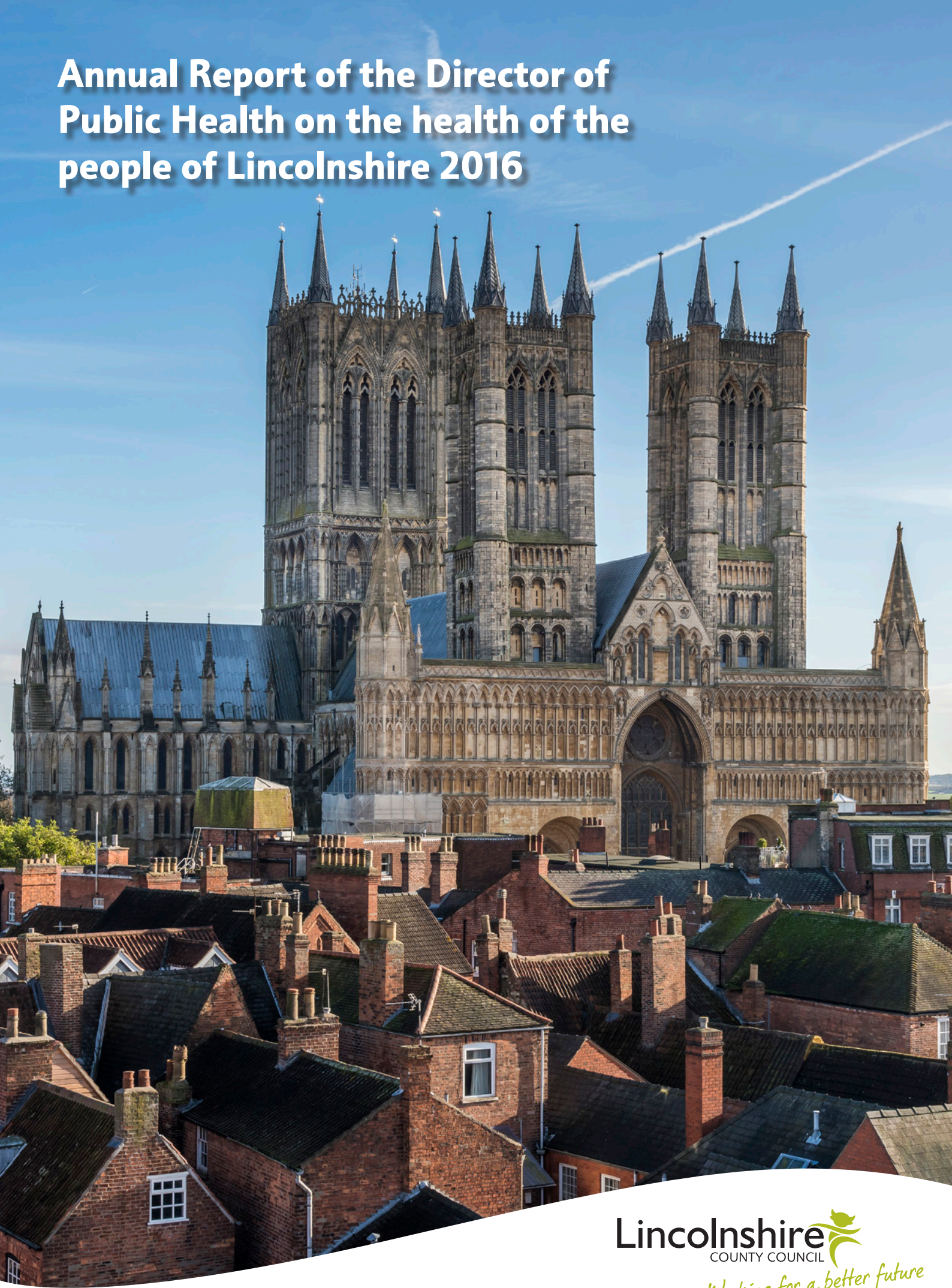
These are listed below and attached at the back of the report	
Appendix A	Annual Report of the Director of Public Health on the Health of the People of Lincolnshire 2016

5. Background Papers

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

This report was written by Tony McGinty, who can be contacted on 01522 554229 or tony.mcginty@lincolnshire.gov.uk

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



Lincolnshire COUNTY COUNCIL

Working for a better future

Introduction

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

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

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

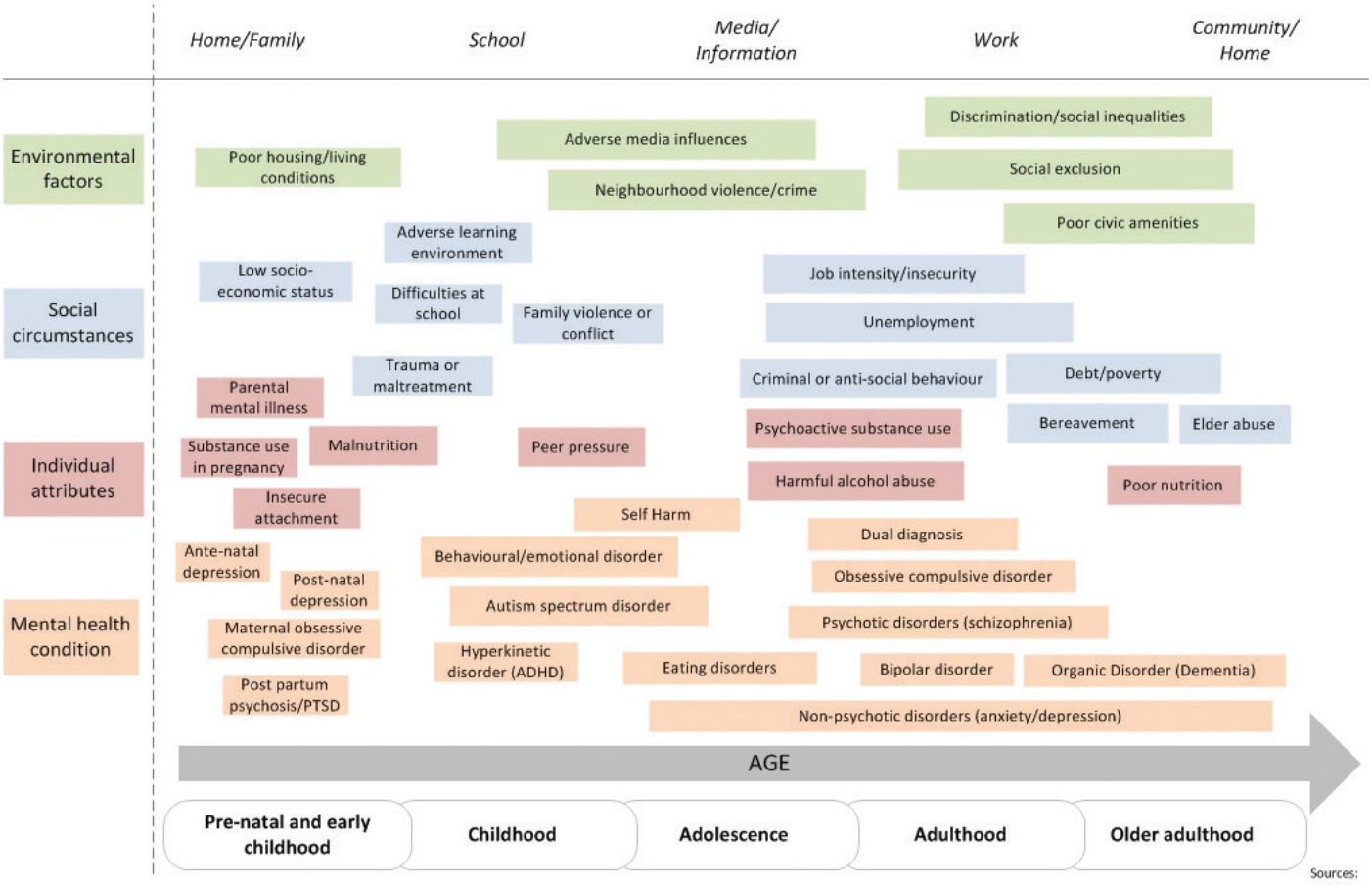
These are summarised in the table below and described more fully in each of the chapters presented.

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

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

Tony McGinty
Interim Director of Public Health

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



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

Contents

Progress against last year's recommendations

In the 2015 Annual Report, the then Director of Public Health made a series of recommendations. I would like to use this opportunity to provide an update on progress against these. I am aware that a wide range of organisations are involved in leading and supporting the implementation of the recommendations and this report is intended to provide information on some of this work rather than a comprehensive overview.

<table>
<tr><th>Recommendations</th><th>Update</th></tr>
<tr><td colspan="2">Data and Intelligence</td></tr>
<tr><td>1. Mechanisms for collecting more comprehensive data on liver disease should be explored. For example, investigating whether liver disease can be recorded in primary care data.</td><td>The Lincolnshire liver disease strategy group will look into the feasibility of liver disease being recorded in primary care data.</td></tr>
<tr><td>2. Lincolnshire organisations should play an active role in the East Midlands Liver Programme Group, which is led by Public Health England's East Midlands Centre. This will help in learning from our regional partners about best practice in addressing liver disease.</td><td>A multi-agency, high level Lincolnshire liver disease strategy group has been set up to develop a county-wide liver disease strategy, which is working very closely with Public Health England.</td></tr>
<tr><td colspan="2">Awareness</td></tr>
<tr><td>3. National campaigns aimed at increasing the awareness of liver disease should be supported locally.</td><td rowspan="2">The launch of the Public Health England One You campaign, which is promoted locally, has encouraged over 4,700 people in Lincolnshire to engage with the campaign, either by completing the 'How Are You' self-assessment tool and/or downloading an associated support app (Oct 16). From this cohort, 21.9% of these people were not achieving the recommended levels of physical activity, 12.1% were smokers, 5.6% were drinking over the alcohol recommendations and 3.2% were not meeting the healthy eating recommendations for optimal health.
Lincolnshire County Council has begun engaging with partners across the county via the locality health and wellbeing networks, JSNA expert panels, events, various media channels and via the newly formed Health Improvement Partnership. As a result of the partnership we are able to form a collaborative response to national campaigns and are able to effectively utilise partners' communication channels. Commissioned services, and other willing organisations, are being encouraged to co-brand with One You to increase consistency and awareness of the initiative.</td></tr>
<tr><td>4. There is a need for stakeholders to work jointly to raise awareness of links between obesity, excessive alcohol consumption and liver disease amongst the local population, particularly in areas with high rates of liver disease-related hospital admissions.</td></tr>
<tr><td>5. There is a need to work with Health Education England to improve the awareness of health professionals on the causes of, and treatments for, liver disease, as well as the importance of early detection.</td><td>Liver disease is taught in medical curriculum.</td></tr>
<tr><td colspan="2">Early Detection and Treatment</td></tr>
<tr><td>6. Stakeholders should work together to facilitate early identification of risk factors for Liver disease through continued action to improve the participation of individuals in NHS Health Checks, at a GP and county level.</td><td rowspan="2">NHS Health Checks, which is primarily a vascular disease screening programme, has successfully recruited eligible people to engage with the Health Checks programme:
(Source – NHS Health Checks Annual Report 2015-16)
<table><tr><td>NHS Health Check</td><td>England</td><td>East Midlands</td><td>Lincolnshire</td></tr><tr><td>Offered (Invited)</td><td>56.4%</td><td>54.4%</td><td>60.8%</td></tr><tr><td>Received (Uptake)</td><td>48.4%</td><td>53.8%</td><td>57.3%</td></tr></table></td></tr>
<tr><td>7. Health checks are a potential intervention point for those at risk of liver disease. It must be ensured that individuals, who are identified as having relevant risk factors are followed up in general practice, provided appropriate onward referral or, where referral is no longer available, provided a brief intervention by their GP practice (e.g. advice on dietary improvement and/or weight-loss).</td></tr>
</table>

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

Recommendations	Update
Strategy and Policy	
13. The Health and Wellbeing Board should take leadership in prevention, early identification and treatment of liver disease, as recommended by the Chief Medical Officer.	The Health and Wellbeing Board has included outcomes relating to prevention, early identification and treatment of liver disease within its Joint Health and Wellbeing Strategy for Lincolnshire and they receive annual assurance reports relating to the progress of the strategy.
14. Lincolnshire organisations should advocate for evidence based national policies to reduce excessive alcohol consumption, for example health and wellbeing to become a 5th licensing objective.	The Public Health Division is actively involved with Public Health England policy reviews and regional forums. It is anticipated that a new substance misuse strategy including initiatives for alcohol will be released in February 2017 alongside new clinical guidelines for treatment services.
15. Lincolnshire organisations should advocate for governmental regulations to reduce sugar and saturated fat content in food and drink that are informed by evidence, for example Public Health England recommended policy actions to reduce sugar intake.	This has become a national policy agenda with plans to implement a "sugar tax" on fizzy drinks. Little local advocacy or regulation has been undertaken.
16. A multi-agency obesity and overweight reductions strategy should be developed.	Obesity reduction forms a key part of the prevention programme that has been developed as part of the Lincolnshire Sustainability and Transformation Plan (STP). This is an all age strategy, although there is recognition that forming healthy life long habits are best begun during childhood. Therefore a multi-agency strategic action plan to reduce obesity in children through actions across health and social care, business and education is currently in development. A new model of children's health services due to be implemented in Lincolnshire in 2017 has elements known to promote healthy weight in childhood such as breastfeeding, a healthy start to eating and physical activity at its heart.
17. There is a need to continue to integrate public health across local authority departments to ensure public health is considered in areas such as planning and licensing, for example, using local planning powers to support play and active travel.	A public health consultant has been allocated to work closely with each of the Council's Executive Director areas of service. They are tasked with supporting the delivery of the service areas' objectives, seek integration and influence these service areas to achieve maximum health gain.
18. There is a need to explore innovative legislative, planning and environmental actions to improve the health of the local population, for example learning from 'Reducing the Strength' in Ipswich and Brighton's 'Sugar Smart City' policy.	Lincolnshire Chamber of Commerce has been commissioned to establish Pubwatch schemes in all towns within the county in order to reduce anti-social behaviour (ASB) by driving those who cause problems in alcohol out of the night time economy. Pubwatch was also set up raise the standards of the bars within the scheme. In Boston a Community Alcohol Partnership has been set up in order to tackle underage drinking including point of sale through test purchasing activity and training for off-licenses, prevention education and investing in diversionary activities for young people in the local community. In Spalding and Lincoln a Public Space Protection Order has been set up in the town centre to prevent street drinking in parks and the town centres in order to reduce ASB related to alcohol.

Executive Summary

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

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

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

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

Mental Ill-Health in Lincolnshire

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

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

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

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

Summary Statistics – Mental Ill-Health in Lincolnshire

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

The Economic Cost of Mental Ill-Health

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

Risk Factors

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

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

Chapter 1 Risk factors: What influences our mental health?

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

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

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

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

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

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

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

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

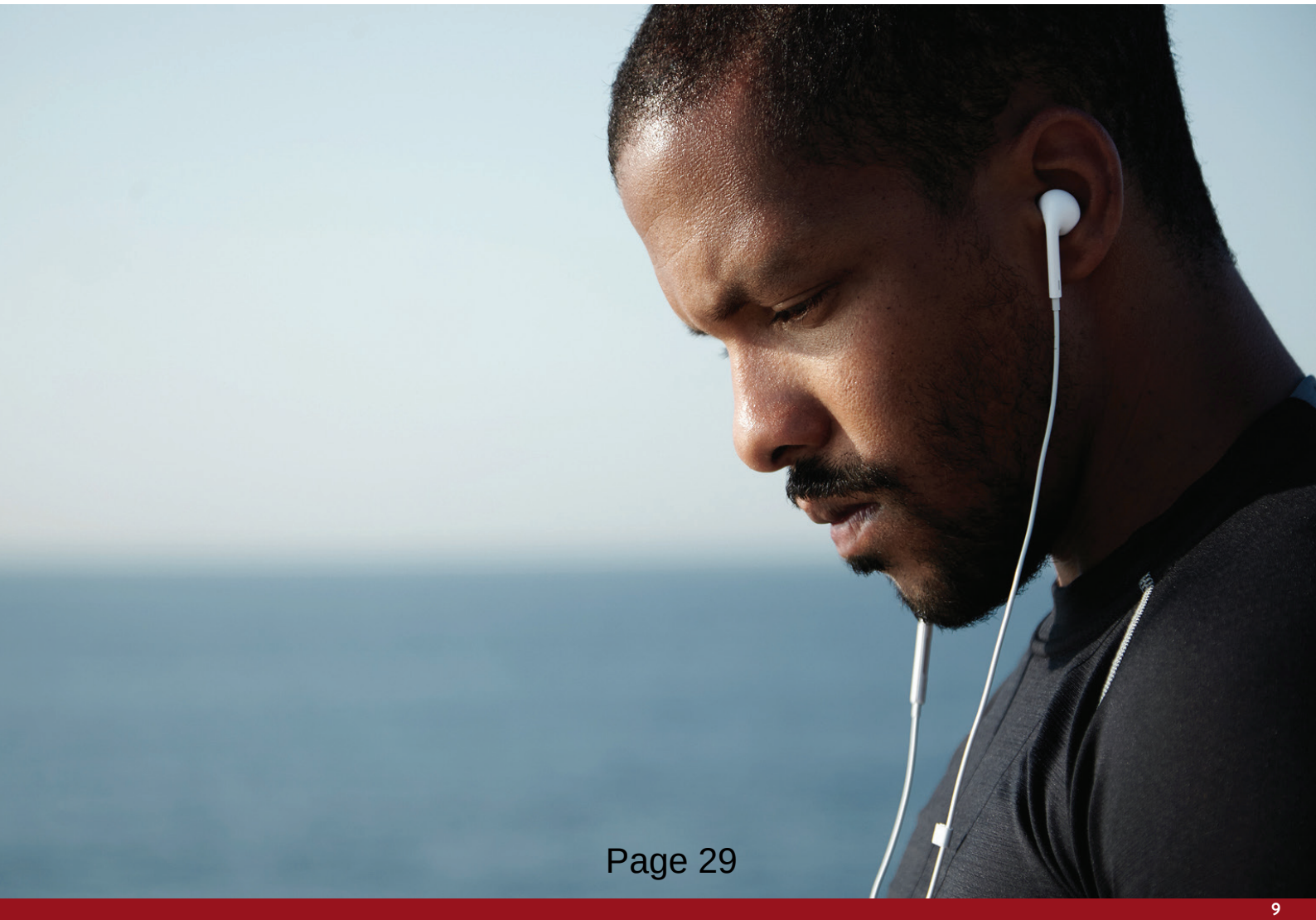
with depression or anxiety disorder at some stage before the age of 50[18] and being bullied has been linked to suicidality[19].Having excellent schools that prevent bullying and help children to develop to their full potential is fundamental to protecting and improving the mental health of children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

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

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

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

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



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

A Tale of Two Teens

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

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

Environmental Risk Factors – Mental Health and the Built Environment

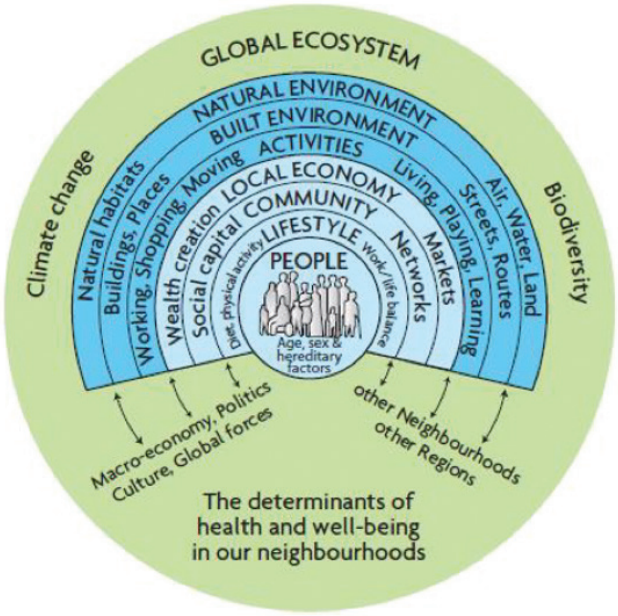
For all of us, the environment we live in can have a profound effect on our mental health. Evidence suggests that a range of features of the built environment have an impact.

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

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

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

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



What features of the built environment affect health and wellbeing?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Table 1: Hazards and their mental health and wellbeing effects

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. People of Sexual Minorities

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

4. Veterans

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

5. Students at University and College

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

6. People Bereaved by Suicide

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

7. People who Have Self-harmed

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

Summary: Interaction of Risk Factors

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

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

Summary: Risk Factor or Protective Factor?

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

Recommendations

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

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

Chapter 2 Perinatal and maternal mental health conditions

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

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

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

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

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

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

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

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

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

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

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

Suicide risk

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

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

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

Figure 3: Post-Traumatic Stress Disorder in Lincolnshire

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

Attachment disorder

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

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

Domestic violence and abuse

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

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

Poor social support

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

Parents with a drug and alcohol problem

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

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

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

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

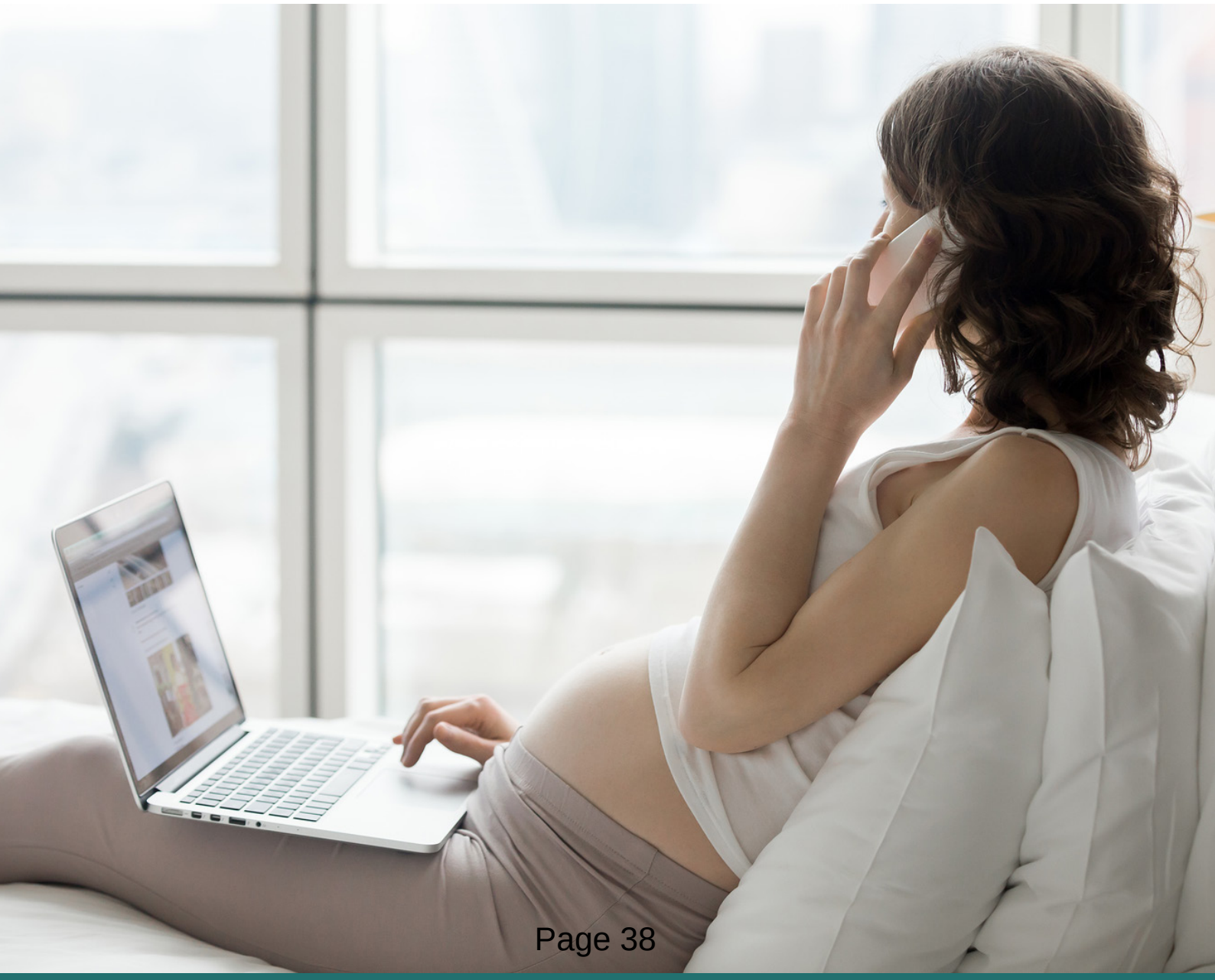
It should be noted that these figures only include those women who started a new treatment journey between the 1st April and 31st March of the respective year and will not include any that still remain in their existing course of treatment for over a year.

Teenage parents

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

Family homelessness

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



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

What do we have that works well for Lincolnshire people?

Assets & protective factors

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

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

Services

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

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

Where are the gaps?

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

Recommendations

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

Chapter 3 Childhood and adolescent mental health conditions

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

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

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

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

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

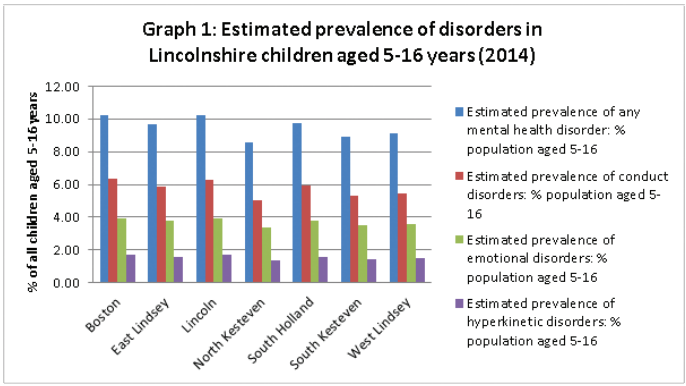
- Family breakdown is widespread
- There is so much pressure to have access to money, the perfect body and lifestyle
- Materialist culture heavily influences young people
- 24 hour social networking and what young people can access from a young age can have a negative impact on their mental health and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

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

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

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

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



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

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

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

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

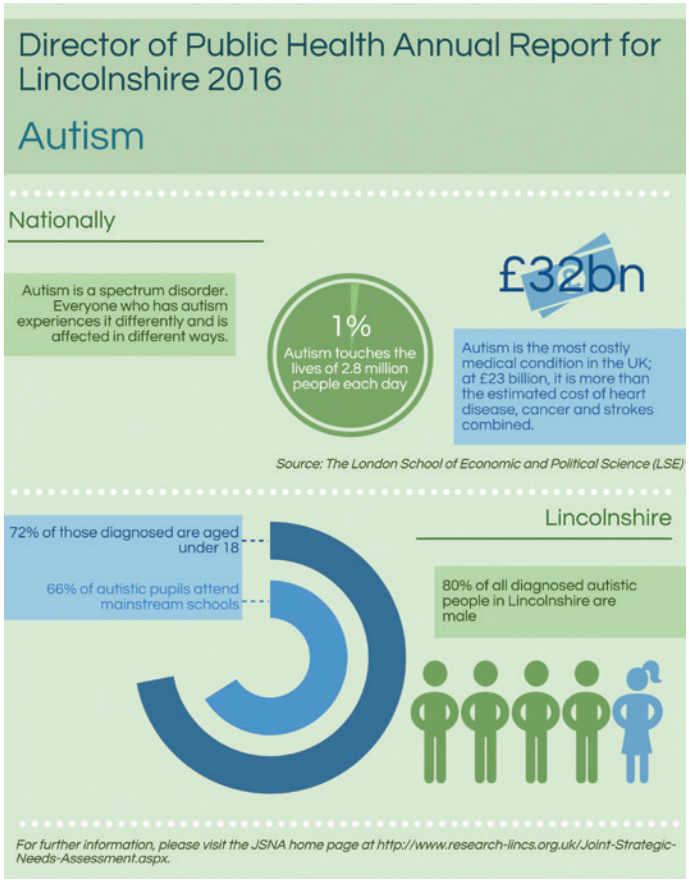
The total number of referrals to Lincolnshire Child and Adolescent Mental Health Services (CAMHS) between April 2015 and March 2016 was 4,427. This number does not represent single individual cases but includes some individuals with more than one condition requiring CAMHS intervention, or repeat referrals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

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

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

Figure 4: Autism in Lincolnshire

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



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

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

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

Service use

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

What do we have that works well for Lincolnshire people?

Assets & protective factors

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

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

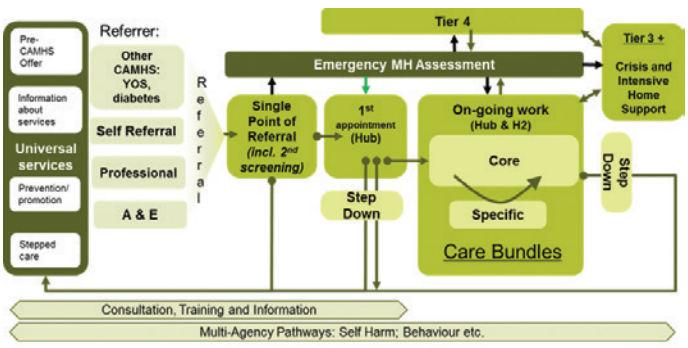
Many schools in Lincolnshire have already developed a whole school approach to promoting resilience and improving emotional wellbeing, preventing mental health problems from arising and offering early support where they do. Evidence shows[88] that interventions taking a whole school approach to wellbeing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

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

Key improvements to the service include:

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

Figure 5: Illustration of the CAMHS pathway in Lincolnshire



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

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

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

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

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

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

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

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

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

Summary

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

Recommendations

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

Chapter 4 Adult and older adult mental health conditions

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

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

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

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

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

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

Figure 6: Common Mental Disorders in Lincolnshire

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

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

Self-harm

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

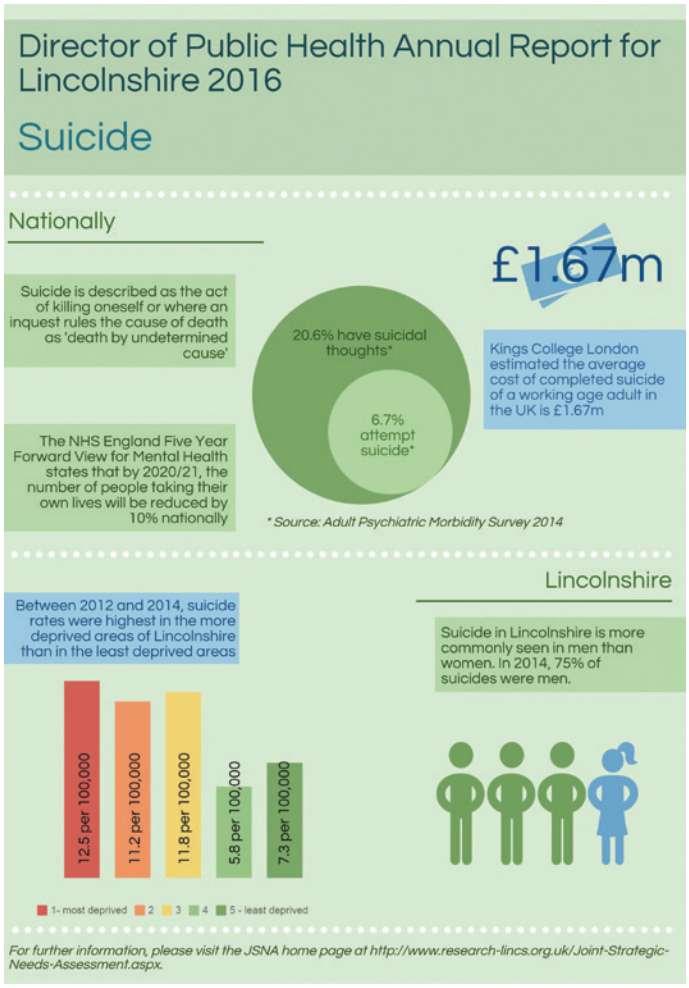
Importantly, people living in the most deprived areas are five times more likely to have an emergency admission to hospital for self-harm than people in the least deprived areas[94].

Suicide

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

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

Figure 7: Suicide in Lincolnshire



Drug & Alcohol abuse

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

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

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

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

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

Older Adults

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

Dementia

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

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

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

Services

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

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

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

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

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

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

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

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

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

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

Where are the gaps?

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

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

Summary

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

Recommendations

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

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

Chapter 5 Recommendations

Risk factors:
What influences our mental health?

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

Perinatal and maternal mental health conditions

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

Childhood and adolescent mental health conditions

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

Adult and Older Adult Mental Health Conditions

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- Service user consultation: Service user feedback is important for understanding and improving the experience of service users. Providers should seek feedback from those who contact or use all mental health services and support networks.

Glossary

Glossary: mental health conditions

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

Source: Royal College of Psychiatrists

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

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

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

Source: NICE27, Best Beginnings

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

Source: Royal College of Psychiatrists

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

Source: Best Beginnings

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

Source: Mental Health Wales, Royal College of Psychiatrists

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

Source: NICE

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LINCOLNSHIRE HEALTH AND WELLBEING BOARD

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

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**07 March 2017**
Subject:	**Joint Health and Wellbeing Strategy – Engagement Plan**

Summary:

The purpose of this report is to ensure that the Lincolnshire Health and Wellbeing Board (LHWB), as part of delivering its statutory requirements to produce a Joint Health and Wellbeing Strategy (JHWS), has a clear and unambiguous plan which sets out how it will engage with people that live and work in Lincolnshire.

Actions Required:

The Lincolnshire Health and Wellbeing Board is requested to:

- Receive and consider this report and agree the approach to engagement and development of the JHWS for Lincolnshire.
- Nominate a lead officer from each of the representative organisations on the LHWB to undertake the prioritisation of Joint Strategic Needs Assessment (JSNA) evidence.
- Agree to report back to respective Boards and Management Teams, where appropriate, on the progress and approach being taken to the development of the JHWS.

1. Background

The purpose of this report is to ensure that the LHWB, as part of delivering its statutory requirements to produce a JHWS, has a clear and unambiguous plan which sets out how it will engage with people that live and work in Lincolnshire.

A review of the JSNA for Lincolnshire has been undertaken and is due to be published in the Spring 2017. Alongside this work, the LHWB has also agreed an approach to developing the next JHWS for Lincolnshire (due to be published in 2018), which will take evidence from the JSNA and prioritise the health needs it wishes the health and care community to tackle over the course of the five years from 2018 onwards.

Stakeholder consultation

Local Authorities and Clinical Commissioning Groups (CCGs) have equal and joint duties to prepare a JSNA and JHWS through the Health and Wellbeing Board. In March 2013, the Department of Health published 'Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies', which identifies the partners who 'must' be involved in producing the JSNA and JHWS as well as the partners who 'should' be involved in this process.

Based on this statutory guidance, the LHWB needs to develop an approach to engagement which enables people who live and work in Lincolnshire an opportunity to have an input into the JSNA and JHWS for Lincolnshire.

Community engagement

In preparing the next JHWS, the proposed approach is to hold a series of engagement events that will enable the LHWB to identify health and wellbeing priorities, based on the evidence in the JSNA, that will form the basis for the next JHWS for Lincolnshire.

It is proposed that this engagement is staged, with the work undertaken to develop the new JHWS grouped into three key stages:

1. Initial work undertaken by nominated lead officers from organisational members of the LHWB across 4 - 6 workshops to review all the JSNA evidence and draft the priorities for inclusion in the next JHWS. As part of this phase, the LHWB is requested to **nominate a lead officer from each of the representative organisations on the LHWB to undertake the prioritisation of JSNA evidence.**

2. In order to ensure the inclusion and engagement of wider stakeholders in the prioritisation process, a number of public engagement events will then take place across the county. Evidence from the JSNA will be thematically presented, with those attending undertaking a similar prioritisation exercise to identify the key JSNA priorities. At this stage there will also be a progress report presented to Health Scrutiny Committee to allow them to review the initial prioritisation work and feedback their response to the LHWB.

3. Following this, discussion and moderation of the prioritisation will take place by LHWB members & wider invited stakeholders at an informal LHWB Board session.

Recognising that engagement mechanisms need to be inclusive to ensure that the 'voice' of more marginalised individuals is captured, it is proposed that a reference group/s of under-represented individuals/groups are held as a means of 'checking back' and verifying the outcome of the prioritisation exercise.

The above approach will be led and supported by the Public Health Division of the Adult Care and Community Wellbeing Executive Director area within the Council.

Communications

There are multiple partnerships and Boards that need to be identified and included as stakeholders in this review. It is requested that as part of the communication by the LHWB that **members of the LHWB agree to report back to respective Boards and Management Teams, where appropriate, on the progress and approach being taken to the development of the Strategy**. A mapping of existing networks and Boards, and ways to communicate with them, will also be undertaken as part of developing a detailed delivery plan for the engagement.

The following bullet points form the proposed principles of all LHWB communications with stakeholders. In producing a JHWS for Lincolnshire, the LHWB want to:

- understand local need to ensure that services delivered are appropriate and effective;
- work with other organisations and the public to identify the key issues and needs of the community on an ongoing basis so we can all tackle them together;
- involve people in Lincolnshire so that they may inform our local priorities in order that we can work to improve the health and wellbeing of the local community and reduce health inequalities.

Next Steps and Timescales

Action	Timescale
Initial nomination of lead officers from each member organisation of the LHWB to undertake the prioritisation scoring (across 4-6 workshops)	April - June 2017
Wider stakeholder engagement in the prioritisation process, including feedback from a working group with Health Scrutiny Committee Members	June – July 2017
Discussion/moderation of prioritisation by the LHWB at an informal session	July 2017
Reference group/s of under-represented individuals/groups as a means of checking back and verifying	July – Aug 2017
Report the final proposed outcome and draft structure of the JHWS to the LHWB	September 2017
Allocated theme lead organisations to draft the JHWS	Oct - Dec 2017
Finalise and sign off of JHWS for Lincolnshire 2018 – 2023	Jan - Mar 2018

2. Conclusion

In undertaking engagement on the development of the JHWS, the LHWB will be able to demonstrate it has taken account of the views of people who live and work in Lincolnshire and that the process has been undertaken in an open and transparent way.

3. Consultation

This is not a consultation item.

4. Appendices

None

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, who can be contacted on 01522 554017 or david.stacey@lincolnshire.gov.uk

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LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of Glen Garrod, Executive Director of Adult Care & Community Wellbeing on behalf of the Joint Commissioning Board

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**7 March 2017**
Subject:	**Better Care Fund (BCF) 2016/17 and Future Planning**

Summary:

This report provides the Lincolnshire Health and Wellbeing Board with an update on Lincolnshire's plans for updating the BCF Narrative Plan and Planning Template for 2017/18 and 2018/19. Also included are:

- Appendix A is a performance update which provides the Board with information on performance against the key BCF metrics for the first nine months of 2016/17.
- Appendix B is an LCC Internal Audit paper reviewing BCF Performance Reporting
- Appendix C is the latest version of a draft Graduation Plan

Actions Required:

The Health and Wellbeing Board is asked to consider and agree the following proposals:-

- that the HWB discuss the paper on BCF performance (Appendix A) for the first nine months of 2016/17
- that the HWB note that given the performance achieved on Non-Elective Admissions in the first nine months of 2016/17 it is recommended by the Joint Commissioning Board that the £3m Risk Contingency established for this financial year will be fully utilised by the CCGs in meeting the extra cost to ULHT.
- that the HWB note the Internal audit report (Appendix B) on performance reporting.
- that the HWB note the updated draft Graduation Plan (Appendix C).

1. Background

The Lincolnshire Better Care Fund totals £196.5m in 2016/17 of which £53.8m is the national allocation. Lincolnshire's fund is the fourth largest in the country and this does help us to have some influence at national level. In addition to the £53.8m, there are pooled budgets for Learning Disabilities, CAMHS and Community Equipment 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's and DTOC have increased and are causing additional financial pressures particularly to NHS partners.

The overall BCF now comprises:-

S75 agreement	**£m**
Proactive Care	46.3
Community Equipment	5.8
CAMHS	5.4
Specialist Services	63.7
Mental Health	5.6
Corporate (see note 1 below)	4.0
	130.8
Mental Health (LCC aligned budget)	63.0
16/17 BCF Plan	**193.8**
LCHC Community Beds	2.7
Total	**196.5**

(note 1 – the £4m comprises £3m for the Risk Contingency and £1m for LHAC)

BCF 2017/18 and 2018/19

At the time of writing this report we have not received the BCF Planning Guidance for 2017/18 and 2018/19. The Guidance was originally expected in November/December 2016 and is still being discussed within central government.

Indicative timetables for the production of plans have previously been shared with the Board. Those dates will now be superseded by a new timetable to be issued by central government at the same time as the national guidance.

BCF Performance 2016/17

Appendix A is a performance update which provides the Board with information on performance against the key BCF metrics for the first nine months of 2016/17. On the key national performance targets there is still a need for improvement, with the key targets showing:-

- Non-Elective Admissions (NEA's) – the local target is for a 2.7% reduction in NEA's. In the first six months a reduction of 1.6% was achieved. However performance has worsened in each month of the third quarter with an average increase in NEA's of 8.4%. Over the whole nine months, performance shows a 1.7% increase, 4.4% over the planned target. The South CCG has over-achieved against the target, though all other CCG's have experienced significant increases

- Permanent admissions to residential and nursing care – From April to December, there have been 842 permanent admissions to care homes for older people, which is 105 admissions more than planned at this point in the year. From December the data for this measure has been taken from our finance system, due to the introduction of Mosaic which replaces AIS as the adult care case management system within LCC. Overall the number of admissions remains higher than target. This appears to have been caused by discharge pressures in hospitals and an increase in the level of support people are requiring in the community. Work is being undertaken to quality assure the placements we are making, however the early indication is that we are dealing with a higher level of acuity and therefore the placements are fully justified. We are experiencing a higher level of demand for services generally and a similar proportion of people are being admitted to care homes as in previous years. All the while though, over the 2 years, the ratio of people in residential care to community has stayed pretty static (1:2) suggesting we are consistently placing people as appropriate

- Delayed Transfers of Care (DTOC) – There were a total of 9,503 delayed days for patients in Q3, 2,078 higher than the target of 7,425 days. This number of delayed days is 1% higher than for the same quarter (Q3) last year. The trend throughout the year is quite linear and consistent compared to 2015/16, where delayed days showed a more pronounced increase throughout the year. The number of delayed days for November and December shows an improvement compared to October's figures. The proportion of non-acute delays has remained at 41% of total delayed days and Social Care delays remain at 16% .NHS delays account for 74% of delayed days and have been at a similar level during Q3, following a steady increase from the start of the year. In terms of delay reasons, two-thirds (67%) of delayed days relate to waiting for further non-acute care, residential or packages in the persons home. The proportion of delays attributed to these reasons has increased from 62% in Q2. As mentioned in previous reports this year, housing delays are higher than usual and the proportion of delays attributed to housing has increased steadily throughout the year, levelling out within Q3 and now accounts for 8% of delay reasons.

- Nationally performance is worsening in key targeted areas, notably NEA and DTOC. See tables below:-

NEA Performance

Period	Total Emergency Admissions via A&E	Other Emergency Admissions (i.e. not via A&E)	Total Emergency Admissions
Dec-11	321,017	120,638	441,655
Dec-12	330,541	120,640	451,181
Dec-13	337,470	124,948	462,418
Dec-14	359,010	125,350	484,361
Dec-15	358,131	129,667	487,798
Dec-16	370,548	127,367	497,915

DTOC Performance

Date	NHS	Social Care	Both	Total		% DTOC attributable to social care
Dec-16	109,699	70,217	15,370	195,286		**36.0%**
Dec-15	93,861	49,656	10,491	154,008		**32.2%**
Dec-14	92,319	36,613	10,093	139,025		**26.3%**
Dec-13	76,459	29,264	6,906	112,629		**26.6%**
Dec-12	71,999	28,626	7,027	107,652		**24.7%**
Dec-11	69,865	33,248	8,983	112,096		**29.7%**

- The performance locally suggests we are improving against a national deterioration on NEAs, though our local target is not being met. For DTOC there are 33 local systems that have been identified for Ministerial intervention where DTOCs are above 8%. Lincolnshire is not on that list and again – at least for Adult Care local performance suggests we are improving, not deteriorating.

Finance
A £3.6m Risk Contingency has been established to address the financial impact of not achieving the NEA target. Due to the worsening NEA performance in the third quarter it is now assumed that the entire Risk Contingency will need to be utilised. The Joint Commissioning Board recommended this at its February 2017 meeting, to enable the CCGs to meet some of the additional costs being incurred by ULHT due to the higher non-elective admission numbers.

As reported and approved at the last meeting of this Board we are currently assuming there will be no Pay-for-Performance requirements in 2017/18.

Audit Report on BCF Performance Reporting
Appendix B contains an Internal Audit report prepared by the LCC Audit Team into the various aspects of BCF Performance Reporting.

The key points within the report include:-

- The report provides 'substantial assurance' around systems and processes in this area
- It is 'confirmed that BCF performance reporting information produced on a monthly and quarterly basis is accurate and agrees to source data
- 'Improvements have been made to the layout of the quarterly performance reports to make them more reader friendly and easier to understand'

The main area identified for further action is, 'there is a lack of visible or clear relationship between poor metric performance and the BCF remedial action and investment decisions made'. Essentially this is the 'so what' question, challenging all parties to reflect on plans, priorities and resources/investments, to ensure available funds are allocated to the areas of greatest need and/or which meet key target areas. Discussions on this are a constant feature of the JCB and an exercise is currently underway to review the effectiveness of

2016/17 investments and prioritise areas for investment in the financial years 2017/18 and 2018/19.

Disabled Facilities Grant
As stated earlier in the paper, we have not yet received the BCF Planning Guidance which should hopefully provide clarity on the arrangement for DFGs'.
Until the guidance is received we are unable to finalise discussions with key stakeholders (particularly 7 district councils).

Graduation Plan
At the last meeting of the Board it was agreed that a Graduation Plan be prepared by Lincolnshire. A copy of the latest iteration of the plan is attached as Appendix C and the plan has been shared with and supported by the regional BCF manager. The timetable for submission of Graduation Plans is one element of the slippage in the entire BCF programme, and we have not yet received firm guidance of what is required within our submission. The aim is to tailor the final submission to reflect national requirements and the timetable for submission of the plan.

2. Conclusion

N/A

3. Consultation

N/A

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	BCF Performance Report to 31 December 2016
Appendix B	Internal Audit Report on BCF Performance Reporting
Appendix C	Draft Graduation Plan

5. Background Papers

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

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

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Better Care Fund - 2016/17

Performance Report

Quarter 3 Report

December 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	3
Improving but not achieved	0
Not reported in period	3
	6

Symbols Key:

CCG NEA Target reduction met ✓

CCG NEA Target reduction not met ✗

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.

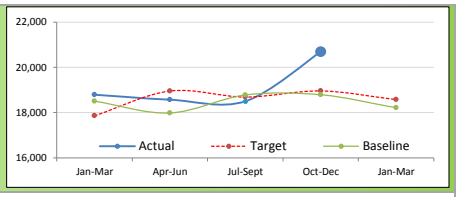
Polarity	Indicator Description	Responsibility	Previous Years		2016/17					
					Current - December 2016			Forecasting		
			2014/15	2015/16	Actual	Plan	Alert	Forecast	Target/Plan	Target/Plan (Period)
Health and Wellbeing Better Care Fund Metrics										
Smaller is Better	1. Total non-elective admissions into hospital : General and Acute	NHS	6,034 (average per month)	6,101 (average per month)	20,695	18,456	Not achieved	-	18,456	Quarterly
Smaller is Better	2. Permanent admissions to residential and nursing care homes - aged 65+ **ASCOF 2A part 2**	LCC	938	1,019	842	737	Not achieved	1,123	982	Annual
Bigger is Better	3. % people (65+) at home 91 days after discharge from hospital into Reablement/rehabilitation **ASCOF 2B part 1**	NHS / LCC	78.8%	76.0%	Not reported in period			-	80%	Annual
Smaller is Better	4. Delayed transfers of care: Delayed days from hospital, aged 18+	NHS / LCC	1,765 (average per month)	2,787 (average per month)	9,503	7,425	Not achieved	-	7,425	Quarterly
Local Performance Metric										
Bigger is Better	5. Percentage of older people leaving hospital who received reablement/rehabilitation services **ASCOF 2B part 2**	NHS / LCC	3.6%	4.2%	Not reported in period			-	4.4%	Annual
Local Patient Experience Metric										
Bigger is Better	6. Proportion of people feeling supported to manage their long term condition (local indicator) (%)	NHS	63.8%	63.0%	Not reported in period			-	66.0%	Annual

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 (Monthly NHS England published hospital episode statistics)



Observations from the data:
The BCF plan committed CCGs to a 2.7% reduction in the HWB Plan figures in each quarter of the year. A total of 20,969 admissions were made during Q3, which is 1,737 more than the original CCG plans. The level of activity is 10% higher compared to the same period last year. The measure has been marked as not achieved for this month. Only the South CCG have consistently experienced monthly admission rates lower than the HWB Planned reduction, saving 149 admissions in the area this quarter; an 4.1% reduction. All CCGs except the South saw an increase in admissions against plan within Q3.

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 (cumulative)	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	6,183	6,206	6,112	6,818	6,868	7,009			
In Quarter		6,122	12,358	18,572	6,183	12,389	18,501	6,818	13,686	20,695			
HWB Plan Total		6,318	12,636	18,955	6,229	12,459	18,688	6,320	12,639	18,959			
HWB NEA Plan (after reduction) - TARGET		**6,149**	**12,298**	**18,447**	**6,062**	**12,124**	**18,185**	**6,152**	**12,304**	**18,456**			
Planned reduction	number	169	339	508	168	335	503	168	335	503			
	%	2.68%	2.68%	2.68%	2.69%	2.69%	2.69%	2.65%	2.65%	2.65%			
Actual reduction (negative indicates an increase)	number	196	278	382	46	70	188	-498	-1,047	-1,736			
	%	3.11%	2.20%	2.02%	0.75%	0.56%	1.00%	-7.89%	-8.28%	-9.16%			
Performance		Achieved	Improving but not achieved	Improving but not achieved	Improving but not achieved	Improving but not achieved	Improving but not achieved	Not achieved	Not achieved	Not achieved			

by CCG

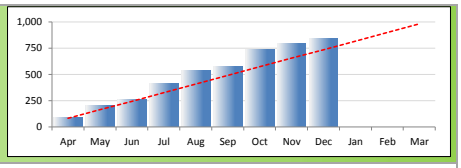
Actual In Quarter	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
East CCG	2,125	4,293	6,481	2,224	4,303	6,417	2,416	4,764	7,236			
West CCG	1,908	3,775	5,683	1,814	3,761	5,559	2,129	4,233	6,433			
South CCG	1,040	2,250	3,321	1,088	2,209	3,344	1,115	2,308	3,485			
South West CCG	927	1,791	2,711	929	1,869	2,815	1,034	2,134	3,170			
Other contributing CCGs	122	250	376	127	247	366	124	248	372			
Total	**6,122**	**12,358**	**18,572**	**6,183**	**12,388**	**18,501**	**6,818**	**13,686**	**20,695**			

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	2,192	4,385	6,577	2,192	4,385	6,577			
West CCG	1,961	3,923	5,884	1,855	3,711	5,566	1,850	3,700	5,550			
South CCG	1,180	2,360	3,540	1,160	2,319	3,479	1,211	2,423	3,634			
South West CCG	890	1,780	2,670	903	1,806	2,709	945	1,891	2,836			
Other contributing CCGs	118	236	355	119	238	357	121	241	362			
Total	**6,318**	**12,636**	**18,955**	**6,229**	**12,459**	**18,688**	**6,320**	**12,639**	**18,959**			

Variance from plan (cumulative in Qtr)	monthly increase/reduction	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	32	-82	-160	223	379	659			
West CCG		-54	-148	-201	-41	50	-7	279	533	883			
South CCG		-140	-110	-219	-71	-111	-135	-97	-114	-149			
South West CCG		37	11	41	26	63	106	89	243	334			
Other contributing CCGs		4	14	22	8	9	9	4	6	10			
Total		**-196**	**-278**	**-382**	**-47**	**-70**	**-188**	**498**	**1,047**	**1,736**			

% Variance from plan (cumulative in Qtr)	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	✗ -2.01%	✗ -1.03%	✗ -0.38%	✗ 1.45%	✗ -1.87%	✗ -2.44%	✗ 10.19%	✗ 8.65%	✗ 10.02%			
West CCG	✓ -2.74%	✓ -3.77%	✓ -3.41%	✗ -2.23%	✗ 1.35%	✗ -0.13%	✗ 15.09%	✗ 14.40%	✗ 15.91%			
South CCG	✓ -11.83%	✓ -4.65%	✓ -6.20%	✓ -6.14%	✓ -4.77%	✓ -3.88%	✓ -7.98%	✓ -4.72%	✓ -4.09%			
South West CCG	✗ 4.17%	✗ 0.61%	✗ 1.55%	✗ 2.88%	✗ 3.50%	✗ 3.91%	✗ 9.41%	✗ 12.86%	✗ 11.77%			
Other contributing CCGs	✗ 3.20%	✗ 5.72%	✗ 6.12%	✗ 6.81%	✗ 3.82%	✗ 2.48%	✗ 2.90%	✗ 2.61%	✗ 2.66%			
Total	✓ -3.11%	✗ -2.20%	✗ -2.02%	✗ -0.75%	✗ -0.57%	✗ -1.00%	✗ 7.89%	✗ 8.28%	✗ 9.16%			

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 return) upto Nov 2016. Local finance system from Dec 2016.
Note: Figure reported cumulatively, so monthly figures show increases in placements recorded & not necessarily within that month

Observations from the data:
From April to December, there have been 842 permanent admissions to care homes for older people, which is 105 admissions more than planned at this point in the year. From December the data for this measure has been taken from our finance system, due to the introduction of Mosaic which replaces AIS as the adult care case management system within LCC. As such the December figure for this measure shows an artificial improvment as the number of reported admissions at this stage is 42, although this is expected to increase when recording is complete. Overall the number of admissions remains higher than target. This appears to have been caused by discharge pressures in hospitals and an increase in the level of support people are requiring in the community. Work is being undertaken to quality assure the placements we are making, however the early indication is that we are dealing with a higher level of acuity and therefore the placements are fully justified. We are experiencing a higher level of demand for services generally and a similar proportion of people are being admitted to care homes as in previous years. All the while though, over the 2 years, the ratio of people in res care to community has stayed pretty static (1:2) suggesting we are consistently placing people as appropriate.

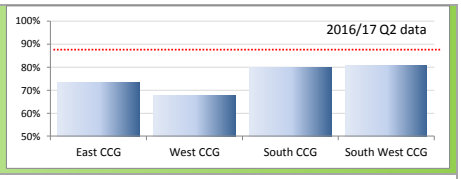
Prior Year	2015/16 BCF (Financial Year)											
	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
In month	81	72	85	87	79	118	80	95	75	86	75	86
Cumulative YTD	81	153	238	325	404	522	602	697	772	858	933	1,019

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
Additions per month	87	120	52	154	123	43	158	63	42			
Cumulative YTD	87	207	259	413	536	579	737	800	842			
Denominator	172,133	172,133	172,133	172,133	172,133	172,133	172,133	172,133	172,133			
Rate per 100,000	50.5	120.3	150.5	239.9	311.4	336.4	428.2	464.8	489.2			
Target (admissions)	**82**	**164**	**246**	**327**	**409**	**491**	**573**	**655**	**737**			
Target (per 100k)	48	95	143	190	238	285	333	380	428			
Performance	Not achieved	Not achieved	Not achieved	Not achieved	Not achieved	Not achieved	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	177	223	239	298	322	339			
West	339	22	51	61	101	131	144	193	208	219			
South	167	13	38	46	61	94	100	127	147	154			
South West	106	11	28	42	69	77	85	105	109	112			
Not Recorded	22	-	-	-	5	11	11	14	14	18			
Total	**1,019**	**87**	**207**	**259**	**413**	**536**	**579**	**737**	**800**	**842**			
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 CCG	58,286	62,724	62,724	62,724	62,724	62,724	62,724	62,724	62,724	62,724			
West CCG	44,185	47,550	47,550	47,550	47,550	47,550	47,550	47,550	47,550	47,550			
South CCG	31,865	34,291	34,291	34,291	34,291	34,291	34,291	34,291	34,291	34,291			
South West CCG	25,617	27,568	27,568	27,568	27,568	27,568	27,568	27,568	27,568	27,568			
Lincolnshire	**159,953**	**172,133**	**172,133**	**172,133**	**172,133**	**172,133**	**172,133**	**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 CCG	661	65	143	175	282	356	381	475	513	540			
West CCG	767	46	107	128	212	276	303	406	437	461			
South CCG	524	38	111	134	178	274	292	370	429	449			
South West CCG	414	40	102	152	250	279	308	381	395	406			
Lincolnshire	**637**	**51**	**120**	**150**	**240**	**311**	**336**	**428**	**465**	**489**			

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 - external service provider - Allied Healthcare, rehabilitation - LCHS

Observations from the data:
This measure is not reported in Quarter 3.

	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						658						
Denominator	958						896						
Value	76.0%						73.4%						
Target	**80.0%**						**80.0%**						**80.0%**
Performance	Not achieved						Not achieved						

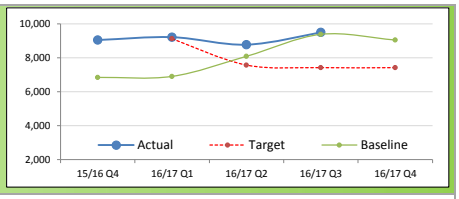
by CCG

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 CCG	318						241						
West CCG	157						196						
South CCG	122						119						
South West CCG	114						96						
Not known	17						6						
Total	**728**						**658**						
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 CCG	403						329						
West CCG	214						290						
South CCG	165						149						
South West CCG	158						119						
Not known	18						9						
Total	**958**						**896**						
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 CCG	78.9%						73.3%						
West CCG	73.4%						67.6%						
South CCG	73.9%						79.9%						
South West CCG	72.2%						80.7%						
Total	**76.0%**						**73.4%**						

4: Delayed transfers of care (delayed days) from hospital for adults 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 9,503 delayed days for patients in Q3, 2,078 higher than the target of 7,425 days. This number of delayed days is 1% higher than for the same quarter (Q3) last year. The trend throughout the year is quite linear and consistent compared to 2015/16 where delayed days showed a more pronounced increase throughout the year. The number of delayed days for November and December shows an improvement compared to October's figures.

The proportion of non-acute delays has remained at 41% of total delayed days and Social Care delays remain at 16% .NHS delays account for 74% of delayed days and have been at a similar level during Q3, following a steady increase from the start of the year.

In terms of delay reasons, two-thirds (67%) of delayed days relate to waiting for further non-acute care, residential or packages in the persons home. The proportion of delays attributed to these reasons has increased from 62% in Q2. As mentioned in previous reports this year, housing delays are higher than usual and the proportion of delays attributed housing has increased steadily throughout the year, leveling out within Q3 and now accounts for 8% of delay reasons.

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	3,048	2,856	2,873	3,347	3,212	2,944			
In Quarter (cumulative)	3,006	6,233	9,218	3,048	5,904	8,777	3,347	6,559	9,503			
Denominator	598,595	598,595	598,595	598,595	598,595	598,595	598,595	598,595	598,595			
Rate per 100,000 population	502.2	1,041.3	1,539.9	509.2	986.3	1,466.3	559.1	1,095.7	1,587.6			
Target (days)	**3,042**	**6,085**	**9,127**	**2,525**	**5,050**	**7,575**	**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			
Performance	Achieved	Not achieved	Not achieved	Not achieved	Not achieved	Not achieved	Not 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	1,530	3,093	4,645	1,926	3,874	5,618			
Non Acute	2,881	1,200	2,551	4,001	1,518	2,811	4,132	1,421	2,685	3,885			
Total	**9,052**	**3,006**	**6,233**	**9,218**	**3,048**	**5,904**	**8,777**	**3,347**	**6,559**	**9,503**			
	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%	50%	52%	53%	58%	59%	59%			
Non Acute	32%	40%	41%	43%	50%	48%	47%	42%	41%	41%			

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	1,931	4,020	6,163	2,476	4,925	7,016			
Social Care (SSD)	2,415	830	1,489	2,226	848	1,370	1,897	596	1,063	1,554			
Both	453	176	437	835	269	514	717	275	571	933			
Total	**9,052**	**3,006**	**6,233**	**9,218**	**3,048**	**5,904**	**8,777**	**3,347**	**6,559**	**9,503**	-	-	
	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%	63%	68%	70%	74%	75%	74%			
Social Care (SSD)	27%	28%	24%	24%	28%	23%	22%	18%	16%	16%			
Both	5%	6%	7%	9%	9%	9%	8%	8%	9%	10%			

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	542	1,020	1,434	281	655	956			
B. Public Funding **(BOTH)**	114	13	106	159	46	88	177	33	189	260			
C. Awaiting NHS Non-acute care **(NHS)**	1,366	511	1,157	1,654	543	1,099	1,714	825	1,562	2,199			
D. Residential or Nursing Care **(BOTH)**	1,211	612	1,293	2,035	570	1,264	1,794	596	1,187	1,769			
E. Care Package at home **(BOTH)**	2,693	833	1,602	2,275	701	1,294	1,976	871	1,599	2,432			
F. Awaiting Equipment **(BOTH)**	434	133	264	465	79	138	218	80	140	234			
G. Patient or Family Choice **(NHS or SSD)**	779	283	638	839	299	511	804	357	598	792			
H. Disputes **(NHS or SSD)**	132	73	200	304	76	188	248	31	31	70			
I. Housing - **(SSD)**	71	75	181	307	192	302	412	273	598	791			
Total	**9,052**	**3,006**	**6,233**	**9,218**	**3,048**	**5,904**	**8,777**	**3,347**	**6,559**	**9,503**	-	-	
	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%	18%	17%	16%	8%	10%	10%			
B. Public Funding **(BOTH)**	1%	0%	2%	2%	2%	1%	2%	1%	3%	3%			
C. Awaiting NHS Non-acute care **(NHS)**	15%	17%	19%	18%	18%	19%	20%	25%	24%	23%			
D. Residential or Nursing Care **(BOTH)**	13%	20%	21%	22%	19%	21%	20%	18%	18%	19%			
E. Care Package at home **(BOTH)**	30%	28%	26%	25%	23%	22%	23%	26%	24%	26%			
F. Awaiting Equipment **(BOTH)**	5%	4%	4%	5%	3%	2%	2%	2%	2%	2%			
G. Patient or Family Choice **(NHS or SSD)**	9%	9%	10%	9%	10%	9%	9%	11%	9%	8%			
H. Disputes **(NHS or SSD)**	1%	2%	3%	3%	2%	3%	3%	1%	0%	1%			
I. Housing - **(SSD)**	1%	2%	3%	3%	6%	5%	5%	8%	9%	8%			

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	1,149	2,335	3,480	1,476	2,964	4,321			
LCHS	2,055	670	1,235	1,694	540	983	1,665	607	990	1,237			
LPFT	811	530	1,316	2,307	978	1,828	2,467	814	1,644	2,592			
Total*	**7,695**	**2,503**	**5,313**	**7,924**	**2,667**	**5,146**	**7,612**	**2,897**	**5,598**	**8,150**	-	-	
	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%	43%	45%	46%	51%	53%	53%			
LCHS	27%	27%	23%	21%	20%	19%	22%	21%	18%	15%			
LPFT	11%	21%	25%	29%	37%	36%	32%	28%	29%	32%			

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 measure is not reported in Quarter 3.	**Observations from the data:** This measure is not reported in Quarter 3.

	2015/16	Q2 2016/17	2015/16	2016/17
Numerator	958	896	3,719	
Denominator	22,830	22,830	5,900	
Value	4.2%	3.9%	63.0%	
Target	**Not monitored in BCF in 2015/16**	**4.4%**	**64.0%**	**66.0%**
Performance	-	Not achieved		

By CCG

Numerator	**2015/16**	**Q2 2016/17**	**2015/16**	**2016/17**
East CCG	403	329	1252	
West CCG	214	290	1018	
South CCG	165	149	767	
South West CCG	158	119	682	
Not known	18	9	0	
Total	958	896	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	22,830	5,900	0
Value	**2015/16**	**Q2 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%	3.9%	63.0%	0

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Lincolnshire COUNTY COUNCIL

Working for a better future

Internal Audit Report

BETTER CARE FUND PERFORMANCE REPORTING

Date: October 2016

What we do best...

Innovative assurance services

Specialists at internal audit

Comprehensive risk management

Experts in countering fraud

...and what sets us apart

Unrivalled best value to our customers

Existing strong regional public sector partnership

Auditors with the knowledge and expertise to get the job done

Already working extensively with the not-for-profit and third sector

Contents

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Auditor

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Background and Scope

Background and Context

The Better Care Fund was introduced by Government in June 2013 to ensure a transformation in integrated health and social care. The Better Care Fund (BCF) creates a local single pooled budget to incentivise the NHS and local government to work more closely together around people, placing their well-being as the focus of health and care services.

Lincolnshire's BCF is one of the largest in the Country, setting a 2016/17 budget of £193.7m. This pooled budget is supported by a delivery plan, which specifies where expenditure will be targeted to maximise the chance of outcomes and performance indicators being met.

Lincolnshire County Council (LCC), as host authority for the fund, are responsible for accounting and audit as well as completion and submission of quarterly and annual performance returns. The performance returns are sent on a monthly basis to the Proactive Board and the Joint commissioning Board for review.

The Better Care Fund is regulated by S75 agreements. The format of the performance reporting information included in the Quarterly reports however is prescribed by the NHS England Better Care Fund Technical guidance.This guidance also details how the performance figures should be calculated and the source data reports to be used.

Although the Better Care Fund has a combined assurance rating of Green (which supports a high management confidence in the ability to manage risk in this area),the BCF and its performance reporting is a high value, high profile and politically sensitive area.

Scope

The focus of our audit aims to provide assurance over the effectiveness of LCC in discharging its role as host. Specifically that it has the right resources and skills and receives appropriate support and information from partners to fulfil this role well and to produce satisfactory performance reporting.

We identified the following as the key risks for this audit area:

- Performance information is not accurate, meaningful or complete.
- Management and staffing arrangements for the BCF in relation to Performance reporting are inadequate.
- Relevant partners do not have visibility of performance metrics

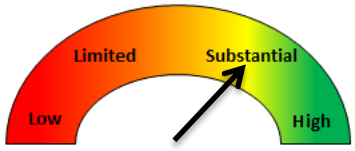
Background and Scope

- Remedial action is not taken to address poor performance in key indicators.

In order to gain assurance over these risks we performed the following audit work:

- Review Management and staffing arrangements for the BCF in relation to Performance reporting
- Review Quarterly performance reporting information for compliance with technical guidance, accuracy, format and sources of information.
- Review flow of information from Clinical Commissioning Group to Lincolnshire County Council
- Review process of reporting information and Governance structure.

Executive Summary



Substantial Assurance

Risk	Rating (R-A-G)	Recommendations	
		High	Medium
Risk 1 - Performance reporting information is not accurate, meaningful and complete	**Green**	**0**	**1**
Risk 2 - Relevant partners do not have visibility of performance metrics	**Green**	**0**	**1**
Risk 3 - Remedial action is not taken to address poor performance in key indicators.	**Amber**	**1**	**0**

Key Messages

We confirmed that Better Care Fund performance reporting information produced on a monthly and quarterly basis is accurate and agrees to source data. Throughout 2015/16 improvements have been made to the layout of the Quarterly performance reports to make them more reader friendly and easier to understand. Joint working between the CCG's and the Council has also taken place during 2015/16 in order to identify the most appropriate and efficient ways of sharing data and developing appropriate flows of information.

The audit was therefore given substantial assurance. However we did identify the following areas of weakness where improvements could be made:
Performance Reporting presentational issues: Although the performance reporting information was found to be accurate we did identify some presentational areas for improvement which could increase the clarity and the interpretational value of this information for Better Care Fund decision making.

Target setting: There is no formalised target setting process for the metrics in the Quarterly

Executive Summary

Key Messages

performance reports and supporting rationale documentation for the targets set is limited.

Remedial action: There is lack of a visible or clear relationship between poor metric performance and Better Care Fund remedial action and investment decisions made.

We would like to thank all the Better Care Fund Performance team for all their help in carrying out this audit. They always made themselves available to provide any supporting information in a timely manner.

Management Response

Management Response

It is reassuring to receive substantial assurance on the BCF Performance Reporting approach and that LCC is effectively discharging it responsibilities as host organisation. Improvements to the Performance Report have been made throughout 2016/17 and the comments in this audit report are acknowledged and will inform future report development. The Performance report is widely used within both the health and social care communities with each of the CCG's using it to form part of their own reports on performance to CCG Boards and governing bodies.

The next BCF submission is for 2 years covering 2017/18 and 2018/19 and we are currently awaiting final guidance, however, there is no requirement to include locally determined performance indicators and therefore the recommendation on GP survey data is no longer applicable.

In preparation for the next BCF submission work has begun on target setting and investment decisions for 2017/18 and 2018/19. The targets for both of the health care indicators, DTOC and NEA's will be set as part of the NHS Sustainability and Transformation Plans and the 2 social care indicators will be agreed as art of Exec DMT.

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Action Plan

1	Risk Description	Current Rating	Target Rating
	Performance reporting information is not accurate, meaningful and complete	GREEN	GREEN

Findings

We reviewed the quarterly performance reports and found the information to be correctly calculated in accordance with the NHS guidance and agreed to source documentation.
We did identify, however, some areas of potential presentational improvements and where improved evidential documentation is recommended.
In some cases within the performance reports there was a:

- Lack of detailed supporting explanation for non- achievement of targets
- Lack of audit trail for some of the monthly reporting figures.
- Lack of future years target data.
- Lack of documentation showing the rationale for the target set.
- Missing data in some metrics

Implications

These presentational and supporting evidence issues reduce the interpretational value of the quarterly reporting information and may impact on decision making.

Recommendation	Priority level
LCC should consider in future: - Retaining a screen print or a download from the external data source as evidence to support the figures included monthly in the performance reports.	**Medium**

Action Plan

- Providing on the Overview schedule a "Highlights section" to explain the performance results and why they are considered good or not so good. - Establishing a "rationale" process to support the targets set and ensuring that the targets are set in a timely manner. - Requesting from CCG's greater operational explanations and insights for the performance data provided. This would enable LCC to expand the comments paragraph to give more detailed supporting explanations for achievement or non- achievement of the target. - Removing monthly columns where the data is only provided annually. - Removing future years target figures which are not available.	

Agreed Action	Responsibility	Implementation date
An additional position has been created as part of the service area restructure in August 2016 in part to provide additional capacity to support the production of the BCF performance report. The report will be reviewed following the submission of the 2017/18 BCF the recommendations on presentation will be included as part of this review For 2017/18 the BCF performance requirements are reduced to 4 key measures – DTOC, NEA's, residential care admissions and reablement performance. Targets for DTOC and NEA's will be agreed as part of the NHS Sustainability and Transformation Plans with residential care admissions and reablement performance agreed by adult care Exec DMT	Emma Scarth	April 2017

Action Plan

2	Risk Description	Current Rating	Target Rating
	Relevant partners do not have visibility of performance metrics	GREEN	GREEN

Findings
The BCF performance metrics include information which is provided in some cases via CCG's. At the start of the performance reporting process this caused some difficulties in obtaining this information. The CCG's and Lincolnshire County Council jointly identified the most appropriate way of sharing data and developed appropriate flows of information to address this. However this sharing of data did not apply to the GP survey data. As a result there was no data to include for this metric at the year end.

Implications
There was no data to include for the GP survey data metric Which could impact on decision making.

Recommendation	Priority level
LCC need to discuss with the CCG's the reasons for the lack of timely information in relation to the GP survey data and jointly identify the most appropriate way of sharing data for this metric in future.	**Medium**

Agreed Action	Responsibility	Implementation date
GP Survey data has now been submitted from the CCG's, however, the BCF for 2017/18 onwards there is no requirement for this measure to be reported	N/A	N/A

Action Plan

	Risk Description	Current Rating	Target Rating
3	Remedial action is not taken to address poor performance in key indicators.	AMBER	GREEN

Findings
In every BCF Quarterly performance report there are BCF key indicators (metrics) where the target has not been achieved. However there is no clear or visible relationship between non achievement of target and Better Care Fund remedial action and investment decisions made.

Implications
Remedial action is not taken or ineffective remedial action is taken to address poor performance in key indicators.

Recommendation	Priority level
In future we suggest that the Joint Commissioning Board : - Improve the clarity of their decision making process - Provide greater rationale for investment decisions made - Evidence the links between the non-achievement of BCF indicators and BCF actions and investments made.	High

Agreed Action	Responsibility	Implementation date

Action Plan

The JCB received the Performance report on a quarterly basis and discussion are held regarding performance, it is however, acknowledged that these have not always been minuted. Future JCB minutes will ensure that discussion on performance are reflected in the minutes As part of the planning process for the 2017/18 submission the County Council have already reviewd all its BCF schemes and future investments taking into account current performance. A paper is due to go to JCB on 20.12.16 recommending that the CCG's review their BCF schemes and future investment taking into account current performance	Glen Garrod/ David Laws	April 2017

Advisory Points - Adding Value through Efficiencies

The following items are advisory recommendations / comments arising from the audit, which management may wish to consider implementing to improve efficiency of the system or performance.

Ref	Finding	Advice
AP1	Inconsistent or incorrect graph usage was applied within the performance reports	Include a graph with up to date data for all the performance metrics and provide legends where possible.
AP2	Misleading headings ("Total" and "Actual") were used in some of the performance reporting tables	Review the headings used in the reports to ensure that they are not misleading and amend where appropriate.

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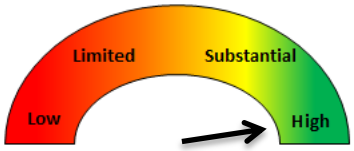
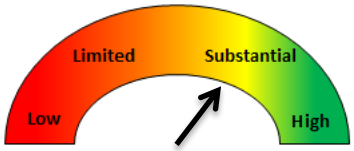
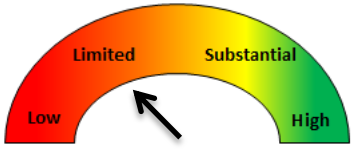
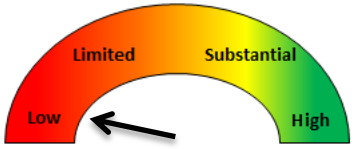
Appendix 1 - Assurance Definitions

High	Substantial
Our critical review or assessment on the activity gives us a high level of confidence on service delivery arrangements, management of risks, and the operation of controls and / or performance. 	Our critical review or assessment on the activity gives us a substantial level of confidence (assurance) on service delivery arrangements, management of risks, and operation of controls and / or performance. 
The risk of the activity not achieving its objectives or outcomes is low. Controls have been evaluated as adequate, appropriate and are operating effectively.	There are some improvements needed in the application of controls to manage risks. However, the controls have been evaluated as adequate, appropriate and operating sufficiently so that the risk of the activity not achieving its objectives is medium to low.
Limited	**Low**
Our critical review or assessment on the activity gives us a limited level of confidence on service delivery arrangements, management of risks, and operation of controls and / or performance. 	Our critical review or assessment on the activity identified significant concerns on service delivery arrangements, management of risks, and operation of controls and / or performance. 
The controls to manage the key risks were found not always to be operating or are inadequate. Therefore, the controls evaluated are unlikely to give a reasonable level of confidence (assurance) that the risks are being managed effectively. It is unlikely that the activity will achieve its objectives.	There are either gaps in the control framework managing the key risks or the controls have been evaluated as not adequate, appropriate or are not being effectively operated. Therefore the risk of the activity not achieving its objectives is high.

Appendix 1 - Assurance Definitions

Action Priority	
High	Immediate management attention is required - an internal control or risk issue where there is a high certainty of: substantial loss / non-compliance with corporate strategies, policies or values / serious reputational damage / adverse regulatory impact and / or material fines (action taken usually within 3 months).
Medium	Timely management action is warranted - an internal control or risk issue that could lead to financial loss / reputational damage / adverse regulatory impact, public sanction and / or immaterial fines (action taken usually within 6 to 12 months).

Appendix 2 – Distribution List

Distribution List

Glen Garrod – Director of Adult Care and Community Wellbeing Services

Emma Scarth – Commissioning manager- Performance, Quality, Workforce Development

David Laws – Adult Care Strategic Financial Advisor

Disclaimer

The matters raised in this report are only those which came to our attention during our internal audit work. Our quality assurance processes ensure that our work is conducted in conformance with the UK Public Sector Internal Audit Standards and that the information contained in this report is as accurate as possible – we do not provide absolute assurance that material errors, fraud or loss do not exist.

This report has been prepared solely for the use of Members and Management of Lincolnshire County Council. Details may be made available to specified external organisations, including external auditors, but otherwise the report should not be used or referred to in whole or in part without prior consent. No responsibility to any third party is accepted as the report has not been prepared, and is not intended for any other purpose.

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Application form for graduation from the Better Care Fund (BCF) v1.1 14 December 2016

Q1. Who is making the application and is the application approved by all signatories to the BCF Plan? (Eligibility criterion reference b)

Which Better Care Fund partnership is applying? Please include the names and contact details of a single person able to field queries about the application. Also confirm approval to the application from BCF plan signatories.

The bid is on behalf of the health and social care 'system leaders' in Lincolnshire, and the BCF co-signatories. Much of the detail contained in this application is also reflected in the STP for Lincolnshire. The contact officer is:
Glen Garrod, Executive Director of Adult Care and Community Wellbeing, Lincolnshire County Council
glen.garrod@lincolnshire.gov.uk
01522 550808 or 07799 478985

The bid for graduation status has been extensively discussed across the Lincolnshire health and social care community. All parties are supportive of the application, and fully engaged in the opportunities that may present themselves as part of a national programme of 'Graduation Pilots'.

The proposals:-

- Have been discussed and approved by the Lincolnshire Health and Wellbeing Board and has the personal support of Cllr Sue Woolley who chairs the Board.

- Have been discussed and approved at the Lincolnshire Joint Commissioning Board, and by the four Lincolnshire CCGs.
  Lincolnshire East CCG – Chief Officer Gary James
  South West Lincolnshire CCG – Chief Officer Allan Kitt
  South Lincolnshire CCG – Chief Officer John Turner
  West Lincolnshire CCG – Chief Officer Dr Sunil Hindocha

- Been discussed and agreed with the BCF Regional Manager Wendy Hoult.

- Also discussed and agreed at the Lincolnshire Strategic Executive Team – a forum which brings together the Chief Officers of the 4 Lincolnshire CCG's, the Chief Executives of the three main health providers United Lincolnshire (United Lincolnshire Hospitals NHS Trust (ULHT), Lincolnshire Partnership NHS Foundation Trust (LPFT) and Lincolnshire Community Health Services NHS Trust (LCHS), the chair of the local Medical Committee and the County Council in the form of both the Chief Executive and the Executive Director as above.

- Internally at officer and member level within Lincolnshire County Council, including the Executive, Adult Scrutiny Committee and the Council's Corporate Management Board

In addition, we are eager to expand the interpretation of what integration might mean by ensuring that Children's Services, Public Health and Housing (despite being a two-tier area) are part of the nucleus for building an effective and outcomes focused integration platform against which the needs of our local communities can be better met. We recognise the vital contributions a 'housing for independence' programme can make and to this end have engaged with all 7 District Councils within Lincolnshire during 2016. We also see considerable opportunities to expand the preventative 'offer' from public health led services and so it is encouraging to note the long term and active engagement of the Director for Public Health on our integration journey.

We would also like to refer to the support of the Lincolnshire Care Association (LINCA) which is a strategic partner in the application representing the interests of care providers within the independent and voluntary sector in Lincolnshire.

Q2. What are you trying to achieve through graduation from the BCF and what plans/systems do you have in place to support delivery? (Eligibility criterion reference a)

Please set out your mature system of health and social care with evidence of:

i. A strong shared local political, clinical, commissioner and community leadership.
ii. An agreed system-wide strategy for improving health and wellbeing through health and social care integration to 2020. The government supports a range of models of health and social care integration, as set out in the Integration Models section. You should reference your integration strategy or action plans and their links to wider health and local government strategies.
iii. A robust approach to managing risk, including adequate financial risk management arrangements proportionate to the level of risk in the system, for example, if any CCG is subject to financial directions, a clear plan of mitigation.

Lincolnshire has for a number of years recognised the value of closer working to secure better outcomes which includes integration. As such our approach has been pragmatic: we develop our journey together building integration where there is a clear business case. We believe this is likely to deliver more sustained improvements through integration that better wins the hearts and minds of those who will operationalise our collective ambition. In 2013 local stakeholders across the public, private and not-for-profit sectors devised the Lincolnshire Health and Care Programme (or LHAC). This commenced with an analysis (involving PWC) of the future funding, pressures and quality considerations with respect to health and social care. This local initiative helped inform the Better Care Fund submission for 2015/16 and 2016/17. Indeed, the level of public engagement and analysis undertaken in LHAC was also extensively utilised by NHS colleagues in their production of the STP for Lincolnshire in December 2016.

Building on earlier successes our BCF submission has for the previous two submissions represented one of the top 5 pooled BCF budget amounts nationally – in excess of £196m covering such areas as learning disability, mental health, community equipment, residential placements; and we continue to build. We recognise that pooled funds are not, in themselves sufficient and in both learning disability and mental health there are also integrated teams and management. We are eager to build out from these areas of success, notably in evolving our integrated Neighbourhood Team model.

Three very different examples are identified below:

1. Integration of Children's Services

<u>0-19 Children's Health Services</u>

As an example, through a single management structure across four locality teams, it is believed that practitioners can better support families through the resources that are available, match need to available skills and expertise and put the needs of children first. One of the recent Ofsted inspections found that "the co-location of 0–19 teams has improved communication and promoted integrated practice. Inspectors saw many examples of highly effective early help practice which prevented escalation to statutory services".

Lincolnshire's Children's Service's aspiration is defined as: "PUTTING CHILDREN FIRST: Working together with families to enhance children's present and future lives". This statement sets out clearly the Council's ambition to work in a collaborative way with families, where children are placed at the heart of everything that we do to enhance their present and future lives.

The Council is also further investing a number of services that will have a strong interface with integrated locality teams - online counselling for young people and a new emotional wellbeing service will offer fast access to counselling support where young people do not meet thresholds for services

such as CAMHS (see later Qu.6) but still need support with emotional wellbeing concerns. The Council is also integrating sexual health services for young people aged 13+ with services for those under age 13. The total investment in all of these services is c£11.5m p/a.

2. Housing for Independence Programme

We recognise that appropriate housing is a key factor in determining whether an individual can maximise their independence in the community and avoid the need for, or reduce the length of stays in residential and/or hospital settings.

Our proposals are currently intended to be a crucial component helping to make improved use of the much expanded Disabled Facilities Grant (DFG) funding available in future years. The proposal is though much more than DFG focused and aims to integrate such funding into a wider programme.

Building on what we have already achieved during the course of the next three years we expect further integration around Occupational therapy, Integrated Equipment and Disabled Facilities Grants; a substantial expansion of the IPC programme in line with NHSE ambitions, the integration of commissioning budgets that will grow the overall pooling to in-excess of £300m and, the evolution of our Neighbourhood Team model.

3. Integrated Personal Commissioning (IPC)

Lincolnshire was selected as one of the lead demonstrator sites for the delivery of Integrated Personal Commissioning (IPC) a joint transformation programme across Health and Social Care. We have made excellent progress in agreeing the local core offer for Personal Health Budgets (PHB'S), continue to achieve programme targets and have ambitious growth targets for 2017-18 and following years. The local IPC Board and (PHB) Boards have now been amalgamated, therefore integrated programme governance and delivery arrangements which includes a plan for the further development of related care and assessment infrastructure.

4. Risk

Both financial and performance metrics are regularly reported to the Joint Commissioning Board. A risk contingency fund was established for each of the 2015/16 and 2016/17 financial years, specifically around the potential non-achievement of Non-Elective Admissions targets. The current year's (2016/17) contingency is £3.6m, and reports are regularly provided to the JCB and are discussed in advance at the S75 Finance Group. In 2016/17 the contingency will be released in full to CCGs to compensate for lack of delivery against NEA targets.

Q3. Is your performance against the Better Care Fund metrics on a positive trajectory? If not, are you taking measures to address this? (Please describe your current performance levels, approach to improving performance and your expectations for accelerated improvement post-graduation). (Eligibility criterion reference c).

BCF targets are listed below:

1. Total non-elective admissions in to hospital (general and acute) CCG baseline performance in Lincolnshire is considered in the upper-quartile and so starts from a good position. The BCF plan committed CCGs to a 2.7% reduction in each quarter of the year for 2016/17. In the month of April 2016 the target reduction was achieved, for the rest of quarters 1 and 2 performance is improving but has not reached the target reduction levels, ranging from a reduction of 0.56% to 2.2% per month. The number of non-elective admissions has been fairly consistent throughout the first six months (6122 in April and 6112 for September). Performance has improved against previous years outturns with 18,781 admissions in Q2 2015 compared to 18,501 in Q2 2016, against an increasingly growing older population.

2. Admissions to residential / nursing care homes - aged 65+ per 100,000 population (ASCOF 2A part ii).From April to September, there have been 579 permanent admissions to care homes for older people, which is 88 more than target at this point in the year. When compared to other authorities within the CIPFA group, Lincolnshire is ranked ninth out of 16 for this indicator in 2015/16. A shift of policy within Adult Care to reducing extended 'short-stays' has had a considerable impact on this figure and during 2017/18 further work will be underway to seek to reduce un-necessary residential placements.

3. % people (65+) at home 91 days after discharge from hospital into reablement (ASCOF 2B part 1).During the sample period April to June the proportion of patients at home, with or without support, on the 91st day was 73.4% against a target of 80%. This is lower than the 2015/16 year end figure of 76% reported as an ASCOF measure. Whist the target has not been reached part 2 of this indicator measures the % of people who are offered reablement services following discharge from hospital (ASCOF 2B part 2) The outturn for 2015/16 for Lincolnshire was 4.2%, ranking Lincolnshire's performance second out of sixteen and within the top quartile. This demonstrates that Lincolnshire has a broad offer of reablement and supports greater numbers of people with reablement service

In November 2015 the local authority recommissioned its reablement service to increase capacity and improve service delivery. The service went through a period of transition and is now beginning to deliver consistent levels of service. It is anticipated that the final year end position will show an improvement on this indicator for 2016/17. The service has a number of KPI's that are showing significant improvement e.g. The number of visits completed by the service provider increased from 14,206 in April 2016 to 17,117 in Sept 2016, with an increase in face to face contact hours from 7,360 in April 2016 to 10,737 in October 2016. In Q2 100% of people reported that they were extremely or very satisfied with the care and support provided.

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

There were a total of 3,347 delayed days for patients in October, 872 higher than the target of 2,475 days, therefore not achieving target. For the third consecutive month, the proportion of non-acute delays has fallen, and now makes up 42% of total delayed days. Social care delays have dropped to 18%.

Whilst not achieving the target performance has improved on the same period last month with the rate per 100,000 of 559.1 for October 2016, compared to 593.8 for the same month in 2015. Compared to the national position Lincolnshire is showing an improved position on DTOC. Nationally delayed days in October 2016 compared to October 2015 shows that there has been a 25% increase in total delayed days, whereas in Lincolnshire, delayed days in the month of October are 5% lower than the same time last year. Nationally delayed days in the month of October 2016, social care delays at a national level accounted for 34.9% of total delayed days. In Lincolnshire, social care delays have been coming down since 2015/16 and in the month of October, accounted for 18% of delays.

Q4. Do you agree to pool or align the commissioning of an amount greater than the minimum levels of BCF including NHS contributions to adult social care and investment in out-of-hospital services on an agreed footprint of HWB, STP or combined authority arrangements? (Eligibility criterion reference d). Please provide details:

In summary – yes. Our approach to the BCF in the preceding 2 years indicates not only our overall commitment to going beyond the minimum but provides a significantly higher baseline than the national minimum requirements. In the 2016/17 financial year Lincolnshire's approved BCF Plan provided for investment of £193.8m. This has now been extended to a pooled fund in

the current year of £196.5m and comprises services described within 6 Sect 75 agreements and two aligned Mental Health budgets.
The 2017/18 plan will be based on the same principles as that applying in 2016/17, which should enable a Pooled Fund of circa £200m to be available. A review of scheme investments is currently taking place and this should help ensure that this significant sum is invested in services that the Health and Wellbeing Board and the five commissioning organisations believe is most appropriate to the needs of Lincolnshire and helps support improvement in the key areas targeted by national and local BCF funding.

Funding and service issues are discussed in a number of fora including:

- HWB, CCG and LCC Board/Committee meetings
- SET and the JCB
- At the STP Financial Bridge Working Group and at the S75 Finance Group
- The JCB has reviewed each S75 during the course of 2016/17 as part of overall governance. An example (covering the S75 for CAMHS) is shown in the attached link

The longer term plan envisages the range of services within the BCF Plan to be extended to include:

- A broader range of Children's Services
- Continuing Health Care
- Broadening the Pro-active S75 and linking this more closely to Wellbeing Service commissioning, to bring certain functions together under the Wellbeing umbrella e.g. HART, Care Navigation

and hence ensure wider integration of service provision across both Children's and Adults Services**.**

Q5. Do health partners in your area agree to continue to maintain social care contributions and NHS commissioned out of hospital services in line with inflation? (Eligibility criterion reference e). Please provide details:

In summary – yes. In both 2015/16 and 2016/17 the 4 CCGs have invested a significantly higher BCF sum in Adult Social Care than was prescribed nationally as the minimum requirement. These investments have led to additional Adult Care funding of approximately £6m over the two BCF years 2015/16 and 2016/17 and has been used to support a range of services including Intermediate Care, Reablement, 7-day services, home care, etc. Whilst it is difficult to determine the full benefit of any one investment, all schemes have been reviewed on an annual basis and only receive ongoing funding if the benefits are clear. For the 2016/17 BCF submission, the review was completed using the national review tools made available.

In the last 12 months the financial state of the NHS both nationally and locally has become clear and represents a significant deficit. Additionally, future BCF funding is being split and additional sums for the protection of adult care is being routed from central government direct to Councils (though still part of the BCF pool locally). NHSE Regional Directors now instruct CCGs to apportion only the minimum sums required and as such CCGs have less discretion – should they choose to use it – to allocate sums over and above the mandated minimum.

Taking account of all the above, it is currently proposed that the CCGs will fund Adult Care in 2017/18, in line with the minimum requirement, including any inflationary increase required. This proposal currently has the support of the four CCGs and the Executive of the County Council.

It is important to note that the County Council will be subject to local elections in May 2017 though there is broad support amongst the political groups for the work to integrate health and

social care building on the approach taken in previous years that provides a degree of reassurance that better outcomes and more effective services are the result.

The focus of both the minimum BCF investment and the entire 2016/17 BCF pooled funding of £196.5m is around social care and community health provision. There are no investments that are solely into the acute sector. This focus will continue into 2017/18 as part of a broader strategy of building up primary and community resources. On this basis Lincolnshire expects to continue to invest extensively in NHS commissioned out of hospital services, and will be boosting investment in line with inflation. This is in line with the STP's focus around community provision and the planned reductions in acute sector spend.

Q6. We expect that first wave graduates will work with national partners to develop and share practice. Are you committed to 'a sector led improvement' approach and to participate in peer-led activity to support other areas looking to graduate? (Eligibility criterion reference f). Please confirm your commitment to this activity and set out your views on how you could support other areas wishing to graduate from the BCF.

Lincolnshire is fully committed to a 'sector-led improvement' approach and to participating in peer-led activity. Peer-led activity within the County Council in recent months has included a peer review of Adult Social Care Services focusing on key lines of enquiry within (a) Adult Frailty and Long Term Conditions (b) Adult Safeguarding. Indeed the independent Chair of the Safeguarding Board has agreed to pilot in February a Peer Review of Boards with the LGA as an initiative that may develop into a national programme.

The Health and Wellbeing Board used the LGA Integration and Self-Assessment Toolkit at a meeting in November 2016 and will return with recommendations for agreement in March 2017.

- In addition a number of colleagues have been involved in peer reviews covering: Glen Garrod – Lead DASS and Peer Reviewer for Warwickshire and Derbyshire, Pete Sidgwick – Derby City (July 2016),Emma Scarth – Leicestershire County Council (April 2016),Carolyn Nice – Leicester City (March 2016),and David Laws visited Northamptonshire County Council to assist with their BCF preparations

On a broader regional basis:

- Glen Garrod, Rob Croot (Chief Financial Officer at Lincolnshire West CCG) and David Laws (BCF Manager) presented a half day seminar at a Regional event in August 2016 in Leicester entitled 'The Lincolnshire Experience'

- Glen Garrod and Allan Kitt (Chief Operation Officer at South West Lincolnshire CCG) have already co-presented at an East Midlands integration event in January 2017

- The graduation bid has been discussed with regional/national BCF representatives: Wendy Hoult (Better Care Implementation Manager for the East Midlands), Matthew West (National Better Care Fund Support Team).

We are also keen to share our learning and learn from others in such areas as:

1. CAMHS

The Children's and Adolescent Mental Health Service (CAMHS) is funded by Lincolnshire County Council (LCC) and the four Clinical Commissioning Groups (CCGs). LCC Children's Services has the

delegated lead commissioning responsibility from the CCG's which is agreed in the form of a Section 75 Agreement. All parties have shown commitment to this service by putting in place a revised S75 agreement which covers funding until 31st March 2019. The current funding for CAMHS in Lincolnshire is £7,009,164. This is made up of £6,284,575 (CCG's), and £724,589 (LCC).

To ensure a coordinated, holistic and integrative approach to supporting children and young people's mental health, the service works closely with and provides support to universal services. This includes GPs, Community Paediatricians, A&E, Health Visitors, Schools, School Nurses, Colleges, further education and third sector agencies.

A joint bid was successful in securing transformation funding which resulted in a new service model commencing 1st April 2016 and which included a number of core changes that are based on national drivers, local need and service user feedback e.g. transitioned to a tier-less service to reduce perceived stigma for the service user of moving between tiers; streamlined the referral process by implementing a single point of access; Implemented an out of hours, crisis and home treatment service which is reducing A&E admissions and Tier 4 in-patients and to improve outcomes for young people in crisis; reduction in waits from 12 to 6 weeks.

2. Co-responders

This scheme uses the Councils Fire Brigade to work alongside the Regional Ambulance service in responding to tier 1 and 2 emergency calls. The scheme builds on the availability of fire services in our rural county and enhances the ambulance service responsiveness. The scheme is funded from BCF resources and in 2015/16 took over 4,500 calls.

3. IPC/Occupational Therapy and Community Equipment

We are particularly keen to support further learning given our strong position with respect to the Integrated Personal Commissioning programme as a first tranche national 'demonstrator site' and to work in two-tier areas in pursuing better outcomes from a more collective endeavour entailing Occupational therapy, Community Equipment and DFG resources – most notably how these can be better combined into a whole-systems approach to reducing acute pressures (e.g. fast-track discharge) and preventative/demand management.

4. Intelligence and Analytics

Our approach to demand management and 'flow', we believe, presents opportunities for wider learning building on our current work to develop our understanding of flow through acute and community systems. We believe this provides an opportunity to consider what strategic investments can be made to better reduce or ameliorate demand. The approach being taken to map such activity in Lincolnshire has already been agreed as a priority for the East Midlands region in 2017/18 and we would wish to see this expand further within the national support programme.

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Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

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

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**7 March 2017**
Subject:	**Integration Self-Assessment – Next Steps**

Summary:

A report detailing the feedback from a self-assessment exercise with Board members and wider partner organisations was presented to the Board in December 2016. As a result of this, meeting partners were asked to share the details of the self-assessment exercise with their Clinical Commissioning Group Governing Bodies and to identify up to three priority areas for improvement.

This report presents the priority areas for improvement identified by stakeholders and proposes a series of next steps for the Board to take to promote further integration.

Actions Required:

The Board is asked to:

- Consider and note the feedback from partners detailed in Appendix A.
- Agree with the proposal to focus activities on:
    - promoting closing integration between health, care and housing; and
    - progressing the Proactive Care agenda.
- Delegate to the Executive Director of Adult Care and Community Wellbeing and the Interim Director of Public Health, responsibility for progressing the Next Steps under section 1a and 1b on the third page of this report.

1. Background

Closer integration between health and social care is a key national driver through programmes such as the Better Care Fund. At a local level, the Lincolnshire Health and Wellbeing Board has a duty to bring together local health and care leaders to promote integration and oversee the commissioning of services in line with the Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS).

To support this process, in October 2016 the Board invited partners to take part in an Integration Self-Assessment exercise. The toolkit developed by the Local Government Association enables local health and care leaders to critically assess local ambition, capabilities and capacity to integrate services. Feedback from this exercise was presented to the Board in December 2016. Overall, the general view was that progress has been made in Lincolnshire; but there is still scope for further progress to be made to ensure all partners and stakeholders were engaged in the integration journey. To enable this to progress, the Board asked for commitment from partners to share the outcome of the self-assessment exercise within their organisation and as a next step, to identify priority areas for improvement.

A letter from the Chairman of the Board was sent to wider partners on 9 December 2016 asking for comments by 30 January 2017. Five responses were received and a summary of the feedback is contained in Appendix A. Although only a limited number of responses were received from partners, the clear message that can be drawn from the overall self-assessment exercise is that Lincolnshire has an ambition to work closer together to integrate health and social care. To address the areas for improvement shown in Appendix A, two transformational agendas have been identified where it is recommended the Board promotes greater integration.

a) Integration Commissioning Approach to Health, Care & Housing

Suitable accommodation that is safe and warm is one of the foundations of personal wellbeing. It enables people to access basic services, build good relationships and maintain their independence – all resulting in a better quality of life. Helping people to stay well and maintain independence as they grow older is critical for health, and helps to reduce pressure on health and care services. Therefore, good housing and preventive services can make a fundamental difference to health and wellbeing.

Ensuring people in Lincolnshire have access to good quality, energy efficient housing that is both affordable and meets their needs is a key priority for the Board in the Joint Health & Wellbeing Strategy (JHWS). Although progress has been made since 2013 to address the issues of fuel poverty and tackle homelessness, there is a growing recognition that health, care and housing need to work closer together to improve the outcomes for individuals, alleviate pressures on health and care services and help maintain people's independence.

There have been some recent successes:

- As part of the current Joint Strategic Needs Assessment (JSNA) review, the District Housing Network have taken on the role of Expert Panel for the '*Housing*' JSNA topic. The review has highlighted the close connection between housing and health, and the new topic commentary reflects this relationship.

- The successful bid to the Entrenched Rough Sleepers Social Impact Bond Funding Programme. The bid was put together by a multi-agency partnership made up of the County Council, District Councils, health providers, Clinical Commissioning Groups, voluntary & community sector organisations and community safety organisations.

Next steps

- The Board is to encourage health, care and housing partners to work together to agree a shared understanding and commitment to closer integration.

- Under the guidance of the Board, governance arrangements to be agreed which clearly sets out roles and responsibilities, working relationships and accountability to the Health and Wellbeing Board.

- The establishment of the Strategic Delivery Group to develop the integrated commissioning approach to health, care and housing with regular updates and reports on progress to the Health and Wellbeing Board.

b) Proactive Care Agenda

The Proactive Care agenda aligns to the JHWS theme focused on *'Supporting people to lead healthier lives*' and is a key component of the Sustainability and Transformation Plan (STP). The vision of the Proactive Care Plan focuses on targeting resources on keeping people well and healthier for longer by giving them the tools, information and support within their community to help people make healthier choices and take control over their own care. To achieve this, there will need to be a change in the relationship between individuals and the health and care system, with a move to greater personal responsibility. Activities are focused around three workstreams:

- Prevention – the delivery of population based prevention programmes such as smoking cessation, adult and childhood obesity and Making Every Contact Count.

- Self-Care – providing access to a range of low level support and care to help people maintain their independence such as a directory of services, social prescribing and integrated personal care commissioning.

- Proactive Care – the provision of support that is responsive and, wherever safe to do so, is delivered in, or close to, people's own home through integrated cross organisational neighbourhood teams.

Next Steps:

- The Board is to encourage partners to work together on progressing the Proactive Care Agenda by:

    - Ensuring appropriate governance and programme management arrangements are in place which sets out clear roles and responsibilities, accountability and relationship to the Board.

    - Receiving recommendations about future involvement.

    - Receiving regular updates on the progress being made to deliver the Proactive Care Plan.

2. Conclusion

The Health and Wellbeing Board has a duty to promote joint working and encourage integration to improve health and wellbeing in Lincolnshire. The Integration Self-Assessment exercise has enabled the Board to assess the key elements and characteristics needed for successful integration. Following further engagement with partners, this report proposes two priority areas for improvement.

3. Consultation

Partners from statutory and non-statutory agencies were invited to give feedback to the Board as part of the self-assessment exercise.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Priority Areas for Improvement

5. Background Papers

Document Title	Where can the document be viewed
Stepping up to the place: Integration Self-Assessment Tool	http://www.local.gov.uk/adult-social-care/-/journal_content/56/10180/7859151/ARTICLE

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AREAS FOR IMPROVEMENT **Appendix A**

Rank	Areas for Improvement	Essential requirements	Feedback
1	Getting it done in Lincolnshire	• Appropriate arrangements and transactional skills in place to deliver across the whole health and care system • Appropriate governance arrangements in place to make binding decisions at the required pace • Appropriate agreed processes in place to support local changes • Agreed change model for the whole of the health and care system	Integration needs to go beyond health and care organisations it engages wider partners who can contribute to health and wellbeing, for example housing, and include wider partners and stakeholders, for example the housing and the third sector.
1	Shared Vision	• Clear understanding of where there are gaps in capacity and resources • Local case for change reflects the national challenges • Clear evidence base informing the future demand for services • Clear picture of future resources	Shared commitment to prevention and wellbeing which sets out the role all partner agencies can play in improving the health and wellbeing of communities and tackling health inequalities.
1	Shared Systems (Models)	• Partners have agreed which modern care delivery models best improve health and wellbeing outcomes in Lincolnshire • Partners have agreed how financial resources will be deployed to best effect	Develop a community catalyst model for social prescribing, self-care and self-management as part of multi-specialty community practice. Embedding voluntary sector infrastructure into the integrated Neighbourhood Teams and social prescribing pilots.
2	Shared Commitment	• Shared understanding on the objectives of integration and prevention • Shared understanding on the benefits and challenges of integration • Shared and demonstrable commitment to a preventive approach • Commitment from all stakeholders to the changes required for transformation • Services and local system is designed around individuals and the outcomes important to them	Develop an integrated commissioning approach to health, care and housing to improve the outcomes for individuals to alleviate pressures on health and care services and to promote closer integration and working relationships with District Councils and Housing providers. Development of a Joint Commissioning Strategy for Health, Care & Housing through a Joint Commissioning Board with accountability to the HWB.

Rank	Areas for Improvement	Essential requirements	Feedback
2	Shared Decision Making	• Right stakeholders involved to make binding decisions • All relevant partners are engaged and committed to playing their part • Agreed governance for local system-wide working	There is still a need to agree governance arrangements which enable service integration to be achieved. Closer working with other statutory boards, e.g. Safeguarding Boards, with the aim of promoting the right to live safely, free from abuse and neglect.
3	Shared Leadership and Accountability	• Right relationships, shared values and behaviours to work together for the public good • Able to reach shared solutions • Willingness to put the needs of the public before the needs of individual organisations • Trust between system leaders and organisations • Arrangements in place to hold organisations to account for delivery • Clear governance in place to inform partners on progress • Roles and responsibilities clearly set out in terms of reference • Open communication	Building understanding between agencies is vital to securing integration. Partners need to be honest about their strengths and weaknesses, and seek to understand the drivers for the actions of others, especially where they may disagree with these. It is easy to resource actions, but giving time to develop and assess the healthy relationships is harder to justify. Building trust involves shared ownership for failures and criticism, as well as successes and praise, and underpins the ability to achieve shared or delegated decision making.

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LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of Glen Garrod
Executive Director of Adult Care and Community Wellbeing

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**7 March 2017**
Subject:	**Service Users with Learning Disabilities**

Summary:

The purpose of the Report is an information paper to update Health and Wellbeing Board on a Regional Improvement Programme in relation to support for people with Learning Disabilities and to provide a position statement for Lincolnshire against the agreed regional baseline standards. The Report also confirms additional work that is being taken forward to deliver further local, regional and National improvement.

Actions Required:

The Health and Wellbeing Board is requested to consider and note the contents of the Report.

1. Background

Introduction

People with Learning Disabilities can experience a number of challenges in maintaining good health and leading fulfilling lives. It is common for people with Learning Disabilities to have co-existing conditions such as Mental Illness and Physical Disabilities and the average life expectancy for people with a Learning Disability is lower than the general population.

However, care and support arrangements, medical advances and improved diagnostics, have resulted in an overall improvement in outcomes in recent years. In particular the number of people with Learning Disabilities (nationally and locally) is projected to increase in the medium to long term, particularly in the 65+ age group.

Many people with a Learning Disability may live long and fulfilling lives without the need for Care and Support from the Local Authority. For example, the latest Learning Disability JSNA [Joint Strategic Needs Assessment] Commentary estimates that there are over 15,000 people with a Learning Disability living in Lincolnshire, but that only 1,700 of these people will be eligible for Adult Social Care and receive care and support via the local Section 75 Agreement and pooled fund hosted by Lincolnshire County Council during 2016-17.

The updated JSNA chapter for Learning Disability, when formally published, estimates that there will be an overall increase of 3.2% of Adults with a Learning Disability in County by 2020, but with a predicted increase of 11.1% in Older People (Source: PANSI and POPPI National prevalence rates). Therefore the overall number of people with a Learning Disability projected to be eligible for Adult Care is also expected to increase as is the complexity of needs of these people. So, more profoundly disabled people being supported.

As well as additional demand pressures on the Council and the NHS, it is also likely to be more challenging to achieve consistent levels of performance outcome. In particular, there are ongoing difficulties with the recruitment and retention of Nurses and care staff within the care markets impacting on market supply. Complexity of needs of service users is impacting on market prices and presents additional challenges for commissioners in supporting people with Learning Disabilities to live a 'close-to' normal life. For example support into employment or alternative vocational opportunities.

National Policy

There has been no National Learning Disability specific policy publication since Valuing People (*Department of Health, 2001*) and Valuing People Now (*Department of Health*, *2009*). Whilst the National Transforming Care Programme, especially the national service model published in October 2015 (NHS England, 2015, ADASS [*Association of Directors of Adult Social Services*], Local Government Association) has placed emphasis on reducing the number of people placed within NHS Inpatient provision, this policy has had a relatively narrow focus and on a relatively small number of people.

In the absence of updated National Policy, in consideration of Local Account information and in reference to the wider responsibilities of Local Authorities, a view emerged within the East Midlands Branch of the Association of Directors of Adult Social Services (ADASS), that there would be some benefit in having a regional improvement programme with a wider focus on the needs of people with a Learning Disability who may be eligible for Adult Social Care.

During 2016 - Nine Local Authorities across the East Midlands including Lincolnshire participated in a number of interviews undertaken by an independent consultant to establish a baseline position against which good practice could be noted and opportunities for improvement and sustained performance could be considered further.

Whilst the final report on the regional baseline position called "What is Happening for Adults with Learning Disabilities in the East Midlands?" is still being finalised, participating Authorities have had initial feedback from the consultant and a meeting of all East Midlands Authorities in November 2016 has agreed to a common set of standards that we

will work on together to benchmark good practice and focus further improvement work against. This report provides the Health and Wellbeing Board with a position statement for Lincolnshire against the 9 Standards agreed.

Overview of the initial Feedback to Lincolnshire

Whilst the overarching regional baseline report has still to be finalised, Lincolnshire has received some initial feedback from the regional consultant in relation to our current arrangements. This feedback is summarised below:

"The strategic context is characterised by excellent joint governance arrangements with the NHS at both commissioning and operational levels. There is a Joint Commissioning Board with Executive representatives from Health and Social Care. Four Delivery Groups report to the Board, including a Joint Delivery Board for Specialist Adult Services (Learning Disability, Autism and Mental Health Commissioning).

There is a Section 75 Agreement between the four Lincolnshire CCGs and Lincolnshire County Council (LCC) that facilitates a pooled budget that funds Adult Social Care and Continuing Health Care for people with a Learning Disability. The pooled fund is hosted by LCC. An integrated Assessment and Care Management Team is managed by a County Manager for Learning Disability Services. The joint teams deal with Continuing Health Care checklists and are working through issues of how to account for Continuing Health Care eligibility and associated issues of charging. This joint service is justifiably proud of delivering timely assessments and reviews and a track record of best value (evidenced by relatively low costs of services in a CIPFA analysis). This is a rare example of Local Authority systems leadership across the full range of Health and Social Care services in the County.

An emerging strategic issue in Lincolnshire is reducing Market Capacity (the market responded quickly to the need to urgently close the ATU in the County in 2015, but it is felt that this response would no longer be viable in today's conditions), relatively high staffing turnover rates in the Residential and Community Supported Living Market and difficulties in recruitment and retention of Nurses and Care Staff in these markets. It is understood that these may also be emerging regional and national issues."

The regional baseline work has identified that Lincolnshire has particular strengths across a number of the nine common regional standards. Other Authorities in the region are being asked to consider Lincolnshire as a site for good practice to inform their own local improvement plans. The feedback has also suggested areas of good practice in other Local Authorities that may be helpful for Lincolnshire to consider as areas for further development. The table below provides a summary of areas of strengths opportunity for further progress:

Regional Standard	Existing Area of Strength in Lincolnshire	Opportunity for further Development
Transforming Care	X	
Strategy and Partnership	X	
Choice and Control	X	
Preparing for Adulthood	X	X
Support for Family Carers	X	
Housing Options		X
Connecting into Communities		X
Supporting people to get a job	X	X
Co-Production	X	X

Lincolnshire Position Statement in relation to the 9 Regional Standards

This section of the Report provides a summary position statement for each of the regional standards from a Lincolnshire perspective.

Transforming Care

The National Transforming Care programme is led by NHS England and supported by the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS).

Lincolnshire has established its local Transforming Care Partnership (TCP) Board and has agreed a local Transforming Care Partnership Plan with NHS England, which includes targets for reduced numbers of people being supported within Inpatient Care. Pamela Palmer, Executive Nurse, South West CCG is the Senior Responsible Officer (SRO) for the Lincolnshire TCP with Justin Hackney, Assistant Director Adult Care as the Deputy SRO.

The following extract from the Lincolnshire Transforming Care Plan summarises the local vision:

"Early help, wellbeing and quality personalised care and support will be the foundation stones of our Lincolnshire Transforming Care Partnership offer. We will all passionately champion holistic and integrated community based support that minimises crisis and eliminates the need for inpatient care."

NHS England and Lincolnshire CCGs commission Inpatient Care for people with Learning Disabilities. The table below shows that the numbers of people in Inpatient Care commissioned locally by Lincolnshire CCGs at the time the TCP Plan was agreed and the latest position as at December 2016.

CCG Commissioned Inpatient Beds as at 31 March 2016	As at 31 March 2016	As at 19 Dec 2016
Specialist Learning Disability Hospitals	10	7
Mainstream Mental Health Hospitals	12	12
Total	22	19

It should be noted that the overall number of Lincolnshire people with a Learning Disability in Inpatient Care was already very low which, in relation to the Transforming Care agenda, is a marker of success. This low starting baseline is informed by prior integrated working linked to the original Winterbourne view national action plan.

Another mark of success for Lincolnshire is that reasonable adjustments have been made to facilitate the assessment and treatment of people with a Learning Disability in mainstream Mental Health Units rather than within Specialist Learning Disability Units where Inpatient Care is necessary.

The Lincolnshire CCGs have invested funding in developing community based specialist support for people with Learning Disabilities and are commissioning these new models of care directly from Lincolnshire Partnership NHS Foundation Trust (LPFT). It is understood that CCGs also plan to consult on the permanent closure of Long Leys Court in 2017. The CCG commissioned services complement the Integrated Assessment and Care Management Team provided via the Local Authority.

Lincolnshire has a strong leadership profile in relation to the Transforming Care agenda and Lincolnshire colleagues have presented at Regional and National Transforming Care events. NHS England have also utilised Lincolnshire in a number of video's demonstrating good practice.

Overall, there have only been 16 new admissions to Inpatient Care by Lincolnshire CCGs since 1 April 2016 and all of these requiring a Care Treatment Review prior of admission. Of the 16 Admissions only 3 have been to Specialist Learning Disability Units and the remainder within mainstream Mental Health Units.

Of the original cohort of 22 people in CCG commissioned Inpatient Care, there are only 11 that remain in hospital and 7 of these people are subject to Ministry of Justice Sections. The TCP Plan target is to have a maximum of 11 people in Inpatient Care by the 31 March 2019. Whilst this may be very challenging to achieve, given the complex needs of the individuals concerned, it is an ambition that locally the TCP is committed to.

Strategy and Partnership

Whilst the Lincolnshire Transforming Care Plan does have a clear focus on minimising Inpatient placements for people with a Learning Disability, it also sets out the wider strategy and integrated working arrangements in Lincolnshire for People with a Learning Disability.

A key strength of existing integrated arrangements is the Section 75 Agreement between the four Lincolnshire CCGs and the County Council. This agreement facilitates a pooled

budget which is hosted and operated by the Council. It provides for an Integrated Assessment and Care Management Team that facilitates personal budgets and care and support plans for Adults with a Learning Disability with eligibility for Social care and or Continuing Health Care.

The Section 75 Agreement has reduced disagreements between responsible commissioners about who should pay for care and support and instead has a keen focus on what outcomes are needed and how best they may be achieved.

The Section 75 Agreement is supported via strong governance arrangements, including the Lincolnshire Joint Commissioning Board and the Specialist Adult Services Delivery Board. A number of other Authorities continue to contact Lincolnshire with an interest in learning from our local arrangements, with a view to developing stronger local working for the benefit of their own local populations.

Choice and Control

Adult Care has facilitated a significant increase in choice and control for Adults with eligible need through the implementation of personal budgets and related care and support plans.

The latest Lincolnshire performance information for Learning Disability suggests that 100% of people now have a personal budget. Approximately 39% of people choose to take their personal budget via a direct payment, which allows people to commission provision directly to meet agreed needs. The remaining 61% of people have chosen for the Local Authority to commission services on their behalf. The 2015-16 - National Data All England Average confirms that 40% of people choose to have a direct payment, which is roughly in line with the position in Lincolnshire.

Lincolnshire is also one of 9 National Demonstrator sites for the implementation of Integrated Personal Commissioning (IPC). We were selected from a large number of areas that applied and were identified as a demonstrator site via a selection process facilitated by the Department of Health. IPC offers the opportunity for people to combine their personal budget via Adult Care with a Personal Health Budget funded by CCGs. CCGs have national targets to develop the expansion of Personal Health Budgets at pace. Lincolnshire's pooled budget arrangements have been of assistance in delivering integrated personal budgets for people with a Learning Disability.

Lincolnshire is demonstrating a high level of leadership in relation to choice and control at a Local, Regional and National level. Our teams continue to promote the take up of direct payments to improve choice and control, particularly for young people in transition where these can assist with the continuity of care.

Preparing for Adulthood

In Lincolnshire, we have good working relationships between the Adult Care Intake Team and Children's Services in relation to the transition of young people to Adult Care. However, preparing for Adulthood has a significantly wider scope than purely transition to Adult Care. In recognition of this, Lincolnshire have a Preparing for Adulthood Commissioning Strategy led by Children's Services.

We have also invested Better Care Funding (BCF) with Children's Services to provide initiatives that promote independence as part of the preparing for Adulthood. This has included the development of information and advice materials for young people and parents, independent travel training, day opportunities, providing learning to cook and other independent living skills training. Some young people have also been helped to secure their own mortgage to support independent living.

Preparing for Adulthood is a standard that the Regional Group recognises as a common area for additional focus in all Authorities. Whilst we do have some clear strengths in Lincolnshire, Preparing for Adulthood is also recognised as an area for further improvement.

In particular, there is a dependency on the implementation of Mosaic to improve the provision of planning information to inform preparing for Adulthood activities. We are currently initiating a project to review and update the transitions protocol for young people likely to be eligible for Adult Services.

The young people that are in transition to Adult Care are presenting with an increased complexity of needs. Earlier engagement by Adult Care with young people and their families prior to transition to help them to plan for the future, has the potential to improve outcomes and value for money, but may need some further investment. There is a need to better explain the differences in support that is available to young people (and their Carers), once they become Adults in comparison to what is available when a Child.

There is also an opportunity to consider further the support offer to Carers of young people with a Learning Disability, at the time when educational provision ends and there are additional pressures on Carers capacity.

Support for Family Carers

Lincolnshire has recently reviewed and has completed a re-provision of the local Carers Support Services. Consideration of the Care Act 2014 (and a Carer's right to an assessment of their own needs), was included in the re-provision. Adult Care has also developed a specific commissioning strategy for Carers. An outline of the current support offer for Carers, including Carers for people with a Learning Disability is provided below.

Enquiries for Carer support are initially handled by the Council's Customer Service Centre (CSC) provided by SERCO. SERCO will offer information and advice to Carers who contact them. If a Carer's assessment is requested, SERCO will also support the Carer via a telephone assessment, or if a face to face assessment is preferred, SERCO will refer the Carer to Carers FIRST. If the Carer is eligible for support, they will be provided with a personal budget to meet assessment needs.

Carers of people with Learning Disabilities are also identified and referred to the Carers Service by the Adult Care Learning Disability Service. In addition, the Carers Service works with Children's Services to provide support for parent carers of Children with Learning Disabilities. Other Children in the family who are also providing care, called Young Carers, are initially supported by Children's Services. However, once they reach the age of 16 years, Carers FIRST works alongside Children's Services, the family and the Young Carer. This is to support the Young Carer during transition to becoming a Young Adult Carer. The Young Adult Carer will receive support from thereon to assist them in continuing their education or taking up employment.

Whist the service is a generic Carers Support Service, activity is monitored for different Carer types. AIS Data suggests that over 240 Carers of Adults with Learning Disabilities (43 who are not receiving any direct support), have been provided with support so far this year, via the new arrangements.

Carers FIRST provides a range of additional Carers support activities. Support can be accessed by all Carers irrespective of whether they request an assessment of need, or are eligible for Local Authority support or not. Examples of some of this additional support activity provided by Carers FIRST includes:

- Supports to a group for Parent Carers in Lincoln on Birchwood, for Carers of Children with Special Educational Needs.

- Promotes a Learning Disability Carers Group that meets on the 3rd Wednesday of the month, 10am – 12pm, at The Pilgrim Lounge, Boston Football Club.

- As part of the initial marketing campaign, visited; the ADHD coffee morning on the Ermine in Lincoln, the Rainbow Stars Autism Carers Group in Sleaford and SNAP in Lincoln (we receive referrals from these groups). A Support Worker attended the Boston Disability Forum. Attended a workshop at the Parents and Autistic Children Together Conference on 15 November and have involvement with them also.

- Attended County Carers 'Count me in' event that was held at Butlin's, Skegness in September and are regularly at the same marketplace events together.

- Members of the Autism Partnership and Learning Disability Partnership Boards.

In addition to the core Carers Service, Adult Care have also utilised some BCF Funding in 2015-16 to do some targeted work with ageing Carers of people with a Learning Disability. The project was focused on helping ageing Carers to plan for emergencies and also to consider plans for the time when it may be difficult to continue their Carer's role. A support tool is also being finalised, which can be used by Carers to aid them in thinking about planning for the future.

An Adult Care Carers Emergency Response Service is available to all Carers and delivered by SERCO as part of the Customer Service Centre. Carers are able to register their emergency plan and this will be activated if the Carer is suddenly unavailable. For example, if a Carer is admitted to Hospital for emergency treatment, the arrangements set out in the emergency plan can be activated for the Adult that the Carer supports.

A new National Carers Strategy expected in Spring 2017, is anticipated to raise the profile of support for Carers to remain in employment. This is an area Specialist Adult Services will be exploring with the County Manager responsible for the Adult Care Carers Strategy, with a focus on Carer's for young people in transition. The point where formal education ends can be a critical time for family based care.

Housing Options

A high percentage of the people with Learning Disabilities we support in Lincolnshire live in community based settings, with a smaller proportion of people living in Residential or Nursing Care.

Some Authorities consider that a high percentage of people living in community based placements rather than Residential or Nursing Care is a positive outcome, as it may be a proxy measure of success in promoting independence. In Lincolnshire, we take a pragmatic approach to agreeing care and support plans that will best meet assessed needs, whilst also taking into consideration the availability of resources.

The Adult Social Care Outcomes Framework (ASCOF) has a proxy measure that can be used to see how we compare against others. The measure is: *The Proportion of working age (18-64) service users who received long-term support during the year with a primary support reason of Learning Disability support, who are living on their own or with their family (%).* Detail of comparable performance from the 2015-16 latest data is provided below:

Comparator Group 2015-16	% Living on their own or with Family
Lincolnshire	74.7
Statistical Comparator Group (Average)	74.1
Shire Counties (Average)	73.9
East Midlands Region (Average)	76.1
England (Average)	75.4

Whilst Lincolnshire has a higher percentage of people living on their own or with family in comparison to our statistical comparator group and Shire Counties, we are slightly below the England Average and the East Midlands Average.

There are, however, a number of other factors to take into account when considering this measure. These factors include, but are not limited to complexity of need, personal choice, available resources and whether the comparator groups include two tier Authorities where housing responsibilities may sit outside of the Authority's direct control.

In Lincolnshire we do want to increase the overall proportion of people living in community based placements. Here, there are a range of options which include (but are not limited to), living with family, shared lives solutions, shared tenancy, extra care, Registered Social Landlord (RSL), Private accommodation, or privately owned solutions.

Until recently Public Health colleagues have held the direct relationships with District Housing Authorities and Housing providers on behalf of LCC. However, with the recent integration of Public Health functions with Adult Care, there are now also much stronger direct links being made between Adult Care and the Housing Sector.

In particular work is currently underway to develop a "Housing for Independence" Strategy with District Councils. This work is being led by Public Health colleagues, but with input from Adult Care to inform priorities. Specialist Adult Services are also working with a number of Districts and Housing providers to explore opportunities to increase housing capacity for use by the people we support. This may include adapting existing properties through the use of Disabled Facilities Grant (DFG), capital and or assistive technology or the development of additional housing opportunities via RSL's and or the Private Sector.

A key consideration for existing community supported living arrangements and future ones is dependency on the cap on Local Housing Allowance, which has to date excluded vulnerable people, but is suggested to be expanded to include them with effect from 2019. A Consultation on this extension of the capping arrangement is currently in progress and scheduled to close in February 2017. Adult Care and Community Wellbeing is co-ordinating a response to the Consultation.

Connecting Into Communities

Whilst the Section 75 Agreement for Learning Disability provides care and support for people who are eligible for Adult Social Care and/or Continuing Health Care (CHC), there are also a number of people living in Lincolnshire with Learning Disabilities who do not currently meet the eligibility criteria. The JSNA estimated that there may be more than 15,000 people with a Learning Disability living in Lincolnshire, whilst it is estimated that there are approximately 1,700 people who will meet eligibility criteria in 2016-17.

The Regional improvement work has identified opportunities for wider engagement with Local Communities to support improved outcomes for some people who are eligible for care and support, but also for those who may be at risk of needing care and support in the future.

Whilst in Lincolnshire we do have the Community Wellbeing Network and evolving Neighbourhood Teams, there is very limited capacity within Adult Care Assessment and Care Management Teams to do such outreach work with our Local Communities.

With the integration of Public Health with Adult Care and the development of Personal Health Budgets across the CCGs, this is a key area to revisit to explore additional opportunities for community capacity building and early intervention.

Supporting People to get a Job

Having employment not only provides an income, but offers the opportunity to develop new skills and knowledge. It also offers the opportunity for greater social inclusion, friendships, personal pride and a number of other benefits to support improved health and wellbeing.

The Adult Social Care Outcomes Framework (ASCOF) has a performance measure that considers what proportion of Adult Care service users are in more than 16 hours of employment per week. The table below shows how Lincolnshire compares or others (higher is better).

Comparator Group 2015-16	% of SU working 16 hours or more per week
Lincolnshire	4.5
Statistical Comparator Group (Average)	4.7
Shire Counties (Average)	5.3
East Midlands Region (Average)	3.3
England (Average)	5.8

This benchmarking information indicates Lincolnshire has a similar proportion of service users in 16 hours or more work per week as our statistical comparator group, a higher percentage than the East Midland average, but lower proportion in comparison to the Shire Counties average and the All England Average.

Adult Care has already identified that providing people with Learning Disability, Autism and or Mental Health the opportunity to secure a job, experience work and or participate in volunteering is a priority area for us locally.

We think the above measure is helpful to some extent to allow benchmarking, but the measure also has some limitations. In particular, the measure does not take account of the range of complexity of needs of service users in each comparator group. Given the Care Act now provides a single national eligibility criterion for Adult Care, there is limited understanding of the range of complexity of need across Local Authorities. Lincolnshire is, however, working on a tool that may help us to better understand the range of complexity across our respective client groups that may assist further with service and financial planning.

Interestingly the proportion of service users in employment in Unitary Authorities (7%) and Outer London (8%) and Inner London (5.7%), are higher than all of the Lincolnshire Comparison Groups which may indicate rurality and structure of employment market are key factors to consider. We know that Lincolnshire is very rural and that transport links can be a key dependency for securing and sustaining employment. We also know that many employers in Lincolnshire are small to medium sized companies.

An area of good practice that was identified as part of the Regional work was Lincolnshire's Step Forward project. Via funding from the Health and Wellbeing Board, funding was secured to support the provision of employment support services for Adults with Autism, a Learning Disability and/ or a Mental Health need.

Lincolnshire residents who are 18 or over and are unemployed can access a range of support including:

- careers advice and a personal activity plan;
- support with exploring suitable job options;
- CV and covering letter;
- identification and statement of personal support requirements;
- advice on disclosing requirements to employers;
- work experience placement to enable beneficiary to identify factors in a working environment that might impact on his/her ability to function effectively;
- support with accessing Better Off calculations for benefit claimants;
- some in work support for those that secure employment;
- Learners complete the Workstar22 (part of the Outcomes Star suite) at the start, middle and end of the programme to measure soft outcomes and 'distance travelled'.

In addition, commissioners are currently completing follow up work with some of the Local Authorities with a high proportion of service users in employment to identify how they are achieving those results and via what mechanisms. This will inform recommendations for further consideration in Lincolnshire.

Co-production

Our Learning Disability Partnership Group has been recognised as strength and co-production is a discipline we are committed to in Lincolnshire, for which there is a good track record. For example, the All Age Autism Partnership Group was identified as good practice example in the updated National Strategy.

We are currently working with the Autism Partnership Board and the Learning Disability Partnership to share good practice evident in both, and to explore the Learning Disability Partnership Board also taking on an all age approach. This may have specific benefits to the co-production in transition planning.

Working in partnership with the Lincolnshire CCGs, opportunities have been created for Experts with Experience to be employed to inform local integrated working. In particular, the CCG employed an expert by experience with Autism who

helps with the programme management of the Transforming Care Programme. The CCG and LCC also with to explore with the Learning Disability Partnership Board, opportunities for the input of experts with experience to our wider commissioning activities. This is hoped to provide increased opportunity for work experience and volunteering by linking this work also to community capacity building and public health support.

2. Conclusion

Lincolnshire continues to demonstrate a range of strengths in supporting people with Learning Disabilities to achieve improved outcomes.

Projected increases in demand, complexity of need and changes in market conditions are likely to increase pressures on existing resources and increase difficulty in sustaining exiting performance.

Working with other Authorities to identify common standards to drive forward opportunities for further development and improvement will help to mitigate these identified pressures.

3. Consultation

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

No

b) Risks and Impact Analysis

The risk and impact analysis will be completed following receipt of the final report on phase 1 of the regional improvement programme, establishing a Baseline.

4. Appendices

These are listed below and attached at the back of the report	
	There are no Appendices

5. Background Papers

Document title	Where the document can be viewed
Valuing People (Department of Health, 2001)	https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/250877/5086.pdf
Valuing People Now (Department of Health 2009)	http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_093375.pdf
National Transforming Care Programme Service Model – Building the Right Support	https://www.england.nhs.uk/wp-content/uploads/2015/10/ld-nat-imp-plan-oct15.pdf
Lincolnshire's Transforming Care Partnership Plan – Building the Right Support	http://southwestlincolnshireccg.nhs.uk/about-us/transforming-care-in-lincolnshire
Learning Disabilities JSNA Commentary (Adult Care and Community Wellbeing, LCC)	Awaiting formal publication

This report was written by Justin Hackney, who can be contacted on 01522 554259 or justin.hackney@lincolnshire.gov.uk

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Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of Healthwatch Lincolnshire (HWL)

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**7 March 2017**
Subject:	**NHS Immunisation and screening for patients in Lincolnshire**

Summary:

From September to December 2016 Healthwatch Lincolnshire conducted a countywide survey asking patients to complete a pre-designed survey which would provide information as to their experiences of NHS Immunisation and Screening.

The results of the survey have highlighted a number of concerns including

- 1 in 4 families who are choosing not to immunise their child/ren are doing this due to concerns about safety
- 42% of responding individuals told us they had not been invited to attend pneumococcal immunisation
- Potentially in Lincolnshire 14,000 woman are choosing not to attend cervical screening
- Where a woman misses her cervical appointment our data told us they were 3 times more likely not to reschedule the appointment
- 23% of adults told us they have not been offered bowel screening
- 13.7% of women told us they are not being offered breast screening
- A staggering 59% of male respondents told us they have not been offered AAA screening
- 43% of respondents (potentially 146,000 eligible adults) told us they are not being offered NHS Health Checks

Actions Required:
To consider the findings of the report and provide any further next step recommendations.

1. Background

For the past 3 years, HWL has been hearing from health providers and commissioners of their concerns that a number of patients are not attending when invited important NHS

screenings. These screenings help to detect whether there might be a health problem that needs further investigation and include areas such as breast, cervical and bowel screening. Also, at some of the meetings HWL attend eg Lincolnshire Health Protection Board, there is an indication that more patients need to keep their immunisations up to date. Doing this helps to avoid both them personally getting very ill, and them potentially spreading infectious diseases to other people eg measles and flu.

In addition to this, we are hearing more and more the phrase 'self-care', which in its simplest terms means what steps patients (the public) are taking to help look after themselves. Whether this self-care is maintaining a healthy weight, eating better or attending important health appointments, it's all about how we are looking after our own health.

To help our health colleagues in Lincolnshire better understand why people are not attending some of these important services, HWL agreed to carry out a project that focused on gathering relevant patient experiences. The project was broken down into three main areas:

1 & 2 Childhood and adult immunisations and 3 Adult Screening

2. Conclusion

HWL was able to identify 10 areas of observation/suggestion and recommendations. From these 10 areas we would conclude they can be summaries into

- Information – it appears there needs to be an increase in the amount of public (patient) information and messages that are clear and consistent. This will help to provide better understanding of the importance and risks to patients (both in non-attendance and with regards to safety)
- Attitudes – this includes the public who needs to treat medical appointments as very important (reducing DNA) and to help alleviate personal barriers that are at times preventing people from attending eg fear. Also, where positive attitudes from medical staff have been experienced this was raised as very important to how patients will commit to their future attitude towards attending.
- System – we were concerned with the number of people who indicated they had not been offered an appointment to attend screening, breast, AAA and bowel in particular. From our data we have calculated this potentially could be 240,000 Lincolnshire residents who have not been invited to take part in screening. As a matter of urgency we believe this needs investigating and have already been in contact with NHS England to support some test cases.

3. Consultation

785 people were consulted with as part of this project. The consultation was completed via electronic and paper surveys which were distributed across Lincolnshire. Final responses indicated our engagement work enabled us to receive responses from all areas of our county.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Healthwatch Lincolnshire NHS Immunisation and screening report

5. Background Papers

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

This report was written by Sarah Fletcher, Chief Executive Officer, Healthwatch Lincolnshire who can be contacted on 01205 820892 or sarah.fletcher@healthwatchlincolnshire.co.uk

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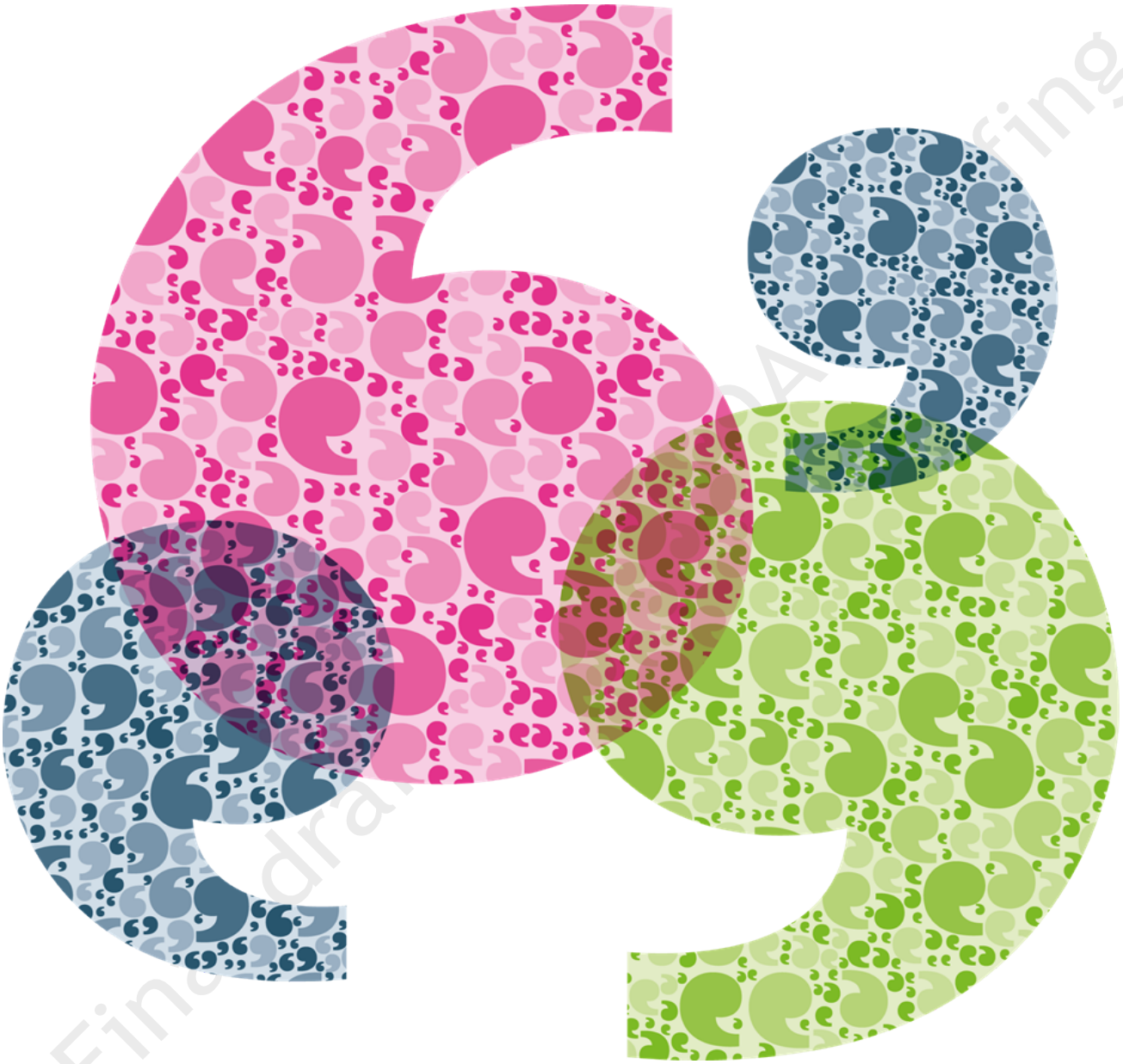
healthwatch Lincolnshire

NHS Immunisation and Screening for patients in Lincolnshire



Report produced by Healthwatch Lincolnshire

Date: February 2017

Index, acronyms and flag ratings

Acronyms

- Commissioner – organisation that has the money to pay for health or care services
- CCG (Clinical Commissioning Group) – there are 4 of these in Lincolnshire one in East, South, South West and West, they include GP's who know a lot about the needs of patients in their area
- DNA – Did not attend refers to a patient not attending a health appointment
- HWL – Healthwatch Lincolnshire
- LCC – Lincolnshire County Council

Red flag – the recommendation or text in the report requires action or noting

Amber flag – the recommendation or text in the report is important or provides some key facts

Green flag – the recommendation or text in the report is best practice or provides some interesting content

Acknowledgements

In order for a project of this size (countywide), we recognise that HWL needed to engage with specialist organisations (for advice) and enlist the help of our fantastic team of volunteers to enable us to reach our across the county to promote the survey linked to this project. We would like to thank the following for their support:

Lincolnshire Public Health
NHS England – Dr Tim Davies and the NHS Regional Immunisation and Screening Team
HWL Volunteer and Employee teams
People and organisations that helped to electronically circulate the survey

And most importantly, we would like to thank the 785 Lincolnshire people who completed either our electronic survey monkey or paper questionnaire, their responses formed the basis of our findings which have been included in this report.

Executive Summary

This report provides important evidence as to the experiences of Lincolnshire people when receiving NHS immunisations and screenings.

The work involved included gathering information from 785 people across Lincolnshire during the period of September to December 2016. Their experiences have enabled us to highlight that:

- 1 in 4 families are who choose not to immunise their child/ren are doing this due to concerns about safety
- 42% of responding individuals told us they had not been invited to attend pneumococcal immunisation
- Potentially in Lincolnshire 14,000 woman are choosing not to attend cervical screening
- Where a woman misses her cervical appointment our data told us they were 3 times more likely not to reschedule the appointment
- 23% of adults told us they have not been offered bowel screening
- 13.7% of women told us they are not being offered breast screening
- A staggering 59% of male respondents told us they have not been offered AAA screening
- 43% of respondents (potentially 146,000 eligible adults) told us they are not being offered NHS Health Checks

With more emphasis on self-care', which in its simplest terms means what steps patients (the public) are taking to help look after themselves, whether this is maintaining a healthy weight, eating better or attending important health appointments. Being offered timely appointments for screening and immunisation is vital if we are to become more involved in our own health.

This report highlights many of the concerns and barriers people face when accessing NHS immunisations and screenings. Some of these barriers are self-generated such as fear or simply forgetting to attend appointments whilst others are organisational barriers such as administration errors or inflexible clinics.

Observations/Suggestions and Recommendations

The following 10 points have been summarised as a result of the analysis we have drawn from this project. HWL recognises that a majority of the

Child

1. Safety information - It is clear there is an issue relating to some parents feeling that information available to them, especially concerning immunisation risks to children, does not provide them with sufficient evidence to make an informed decision whether or not to have their child immunised. This is evidenced by 33% of respondents in our survey specifically indicating this fact. It also appears there may be some inconsistencies across the county in the approach by GP Surgery's etc. when contacting parents with children.
2. Interaction with medical staff - We noted that where experiences were positive in pre-preparing the parent and child in advance of receiving immunisations, where questions and discussion were able to occur, this approach worked really well for all concerned. We would recommend all medical staff adopt such an approach where practical.
3. Increasing number of children immunised - Healthwatch feels that more work should be done to better understand the reasons for lack of 'take up' in the households that choose not to have their child/ren immunised. For instance, lack of balanced information, scare mongering, knowledge about alternatives, confusion about gaining and accessing an appointment, were all reasons given for not giving immunisations to children.
4. Accessing appointments for working parents – Whilst we recognise that the majority of parents are able to arrange time off to take their child to health appointments, it was noted that for some getting time off work was an issue. HWL feel there should be greater emphasis within employer sector to reinforce parents' rights in relation to unpaid leave in these circumstances.
5. Ongoing resources for parents – parents indicated they would like more help with reminders as to when their child/ren should be immunised. Implementing personal immunisation record cards or linking all families to the electronic tool (see page 14) would give families the necessary information at any time, this would also transfer some of the responsibility to ensure immunisations are completed when required with the family.
6. **HWL summary of points 1 - 5** is for Lincolnshire Children Services, 4 Lincolnshire CCGs, Lincolnshire Public Health and Lincolnshire Health Protection to work together to establish what the current differing approaches are across the county in relation to child immunisation, particularly at point of access. Following this consider the adoption of one approach, along with clear methods and messages being produced, including the focus on ensuring parents assume some responsibility for ensuring immunisations are carried out over the required timeline. (eg given a childhood immunisation planner at birth). An approach such as this would look to providing more equal and better understanding across the county.

Adults

7. Invitation to attend – due to the high number of respondents that indicated they had not been invited to receive adult immunisation, particularly for pneumococcal immunisation, **we would recommend NHS England and the 4 Lincolnshire CCGs investigate whether there are any problems at point of invitation.** HWL is supporting this recommendation by contacting survey respondents who indicated they had not been invited to ask if they would give permission to be part of a pilot study to check their individual health record.

8. Self-care - if the NHS **is** serious about the need for more self-care, then patients will need to have the right information to encourage this to happen. **HWL considers a collaborative approach between NHS organisations and local community and patient groups would provide opportunities to develop the right messages, in formats that the public will be able to understand.**

   Once the self-care messages have been finalised successful campaigns to encourage more self-care will require:
   - A more proactive approach to patient engagement, avoidance to working in isolation of other public messages
   - A more consistent approach to patients from all services, for instance mixed messages are confusing and lead to personal interpretations.
   - Avoidance of information shared being done in a way that is too formal, full of jargon, and with an approach that meets the NHS Accessible Information Standards
   - Employer cooperation and taking a view that health and care is as relevant to its business as it is to the individuals it employs

9. Failure to attend – where patients are not attending appointments HWL believes much more should be done to understand what the barriers are. Attending vital health screenings should be something that everyone is able to easily do. Where patients are choosing not to attend, there needs to be a much better understanding of what concerns are driving this, whether it is transport issues, fear of what is going to happen during the screening or what results of tests mean, learning what the main barriers are will enable those delivering the service to introduce ways in which to alleviate the problems.

10. Failure to receive an appointment – most worryingly from our data, we are able to calculate that potentially 240,000 adults are not being invited to attend health screenings (this figure is focusing on breast, AAA and NHS Health Checks). As we know early detection is vital for the patient however, if patients are not even being given an opportunity to access screening in the first place then this suggests there may be serious health inequalities occurring in our county. Even if we factor into the equation those people who choose to ignore invitation letters (maybe even throwing them away as junk mail); have moved house and failed to inform their health providers of this fact; or it may be administration errors, this still indicates there may be a significant number of people involved.

About Healthwatch Lincolnshire

HWL came into effect on 1st April 2013 as the independent consumer champion for statutory health and care services, HWL is a registered charity and Company Limited by Guarantee.

Healthwatch as a network is included in the Health and Social Care Act 2012. It was prior to this Act that it was nationally recognised there was a need for a public independent consumer champion for health and social care services to cover each of the 152 England county councils or boroughs, with one overarching body, Healthwatch England. The Health and Social Care Act 2012 provided each Healthwatch with the following statutory powers:

1. Promoting and supporting the involvement of local people in the commissioning, the provision and scrutiny of local care services.

2. Enabling local people to monitor the standard of provision of local care services and whether and how local care services could and ought to be improved.

3. Obtaining the views of local people regarding their needs for, and experiences of, local care services and importantly to make these views known.

4. Making reports and recommendations about how local care services could or ought to be improved. These should be directed to commissioners and providers of care services and people responsible for managing or scrutinising local care services and shared with Healthwatch England.

5. Providing advice and information about access to local care services so choices can be made about local care services.

6. Formulating views on the standard of provision and whether and how the local care services could and ought to be improved; and sharing these views with Healthwatch England.

7. Making recommendations to Healthwatch England to advise the Care Quality Commission (CQC) to conduct special reviews or investigations (or, where the circumstances justify doing so, making such recommendations direct to the CQC); and to make recommendations to Healthwatch England to publish reports about particular issues.

8. Providing Healthwatch England with the intelligence and insight it needs to enable it to perform effectively.

Healthwatch Lincolnshire activities can be broken down into 3 core functions:

Influencing - We are here to listen to people's views and personal experiences of their health and social care services and share the key messages we hear in order to help influence improvements in services.

Signposting - signposting people to help them access advice, choice and information about their local health and social care services.

Watchdog - to ensure change is happening.

You can find out more about the work of Healthwatch Lincolnshire by visiting our website at www.healthwatchlincolnshire.co.uk or contact us where a member of our team will be happy to discuss further.

Background information

For the past 3 years, HWL has been hearing from health providers and commissioners of their concerns that a number of patients are not attending when invited important NHS screenings. These screenings help to detect whether there might be a health problem that needs further investigation and include areas such as breast, cervical and bowel screening. Also, at some of the meetings HWL attend eg Lincolnshire Health Protection Board, there is an indication that more patients need to keep their immunisations up to date. Doing this helps to avoid both them personally getting very ill, and them potentially spreading infectious diseases to other people eg measles and flu.

In addition to this, we are hearing more and more the phrase 'self-care', which in its simplest terms means what steps patients (the public) are taking to help look after themselves. Whether this self-care is maintaining a healthy weight, eating better or attending important health appointments, it's all about how we are looking after our own health.

To help our health colleagues in Lincolnshire better understand why people are not attending some of these important services, HWL agreed to carry out a project that focused on gathering relevant patient experiences. The project was broken down into three main areas:

1 & 2 Childhood and adult immunisations and 3 Adult Screening

Child and adult immunisations

What is immunisation?

Immunisation is a way of protecting against serious diseases. Once we have been immunised, our bodies are better able to fight those diseases if we come into contact with them.

How do vaccines work?

Vaccines contain a small part of the bacterium or virus that causes a disease, or tiny amounts of the chemicals that the bacterium produces. Vaccines work by causing the body's immune system to make antibodies (substances that fight off infection and disease).

Childhood immunisations

Immunisation is a way of protecting ourselves from serious diseases. There are some diseases that can kill children or cause lasting damage to their health. Immunisations are given to prepare your child's immune system (its natural defence system) to fight off those diseases when your child comes into contact with them. If your child comes into contact with the infection, the antibodies will recognise it and be ready to protect him or her. Because vaccines have been used so successfully in the UK, diseases such as diphtheria have almost disappeared from this country.

The above information was taken from www.immunisationscotland.org.uk and Gov.uk websites

NHS Screening

What is Adult NHS Screening Services?

Screening is a way of identifying apparently healthy people who may have an increased risk of a particular condition. The NHS offers a range of screening tests to different sections of the population. (NHS Choices, 2015)

Screening is different from diagnostic tests as it is used to identify potential increased risk of future illness within given populations. Sometimes following screening, people can then be offered information, further tests and treatment to reduce their risk and/or any complications arising from the disease or condition.

"Screening is designed to reduce the risk or impact of disease in a defined population. Screening programmes aim to identify the individuals most at risk of a disease so that they can be offered early treatment. Screening programmes are based on careful calculation, including who will benefit, the scope for treatment, and the level of accuracy of the tests". (Sense about Science-Making Sense of Screening, 2015)

The NHS screening programmes currently offered in England are listed below (information taken from NHS Choices).

Screening in pregnancy

Expectant mothers will be offered some screening tests during pregnancy to try to find any health problems that could affect you or your baby, such as infectious diseases, Down's syndrome, or physical abnormalities. Healthwatch did not include this type of screening.

Screening for new-born babies

Every baby is offered a thorough physical examination soon after birth to check their eyes, heart, hips and, in boys, the testicles (testes). In addition tests for hearing and a blood test to check for serious illnesses is carried out. Healthwatch did not include this type of screening.

Diabetic eye screening

From the age of 12, all people with diabetes are offered an annual diabetic eye test to check for early signs of diabetic retinopathy. Healthwatch did include this type of screening.

Cervical screening

Cervical screening is offered to women aged 25 to 64 to check the health of cells in the cervix. It is offered every three years for those aged 26 to 49, and every five years from the ages of 50 to 64. Healthwatch did include this type of screening.

Breast screening

Breast screening is offered to women aged 50 to 70 to detect early signs of breast cancer. Women over 70 can self-refer. Healthwatch did include this type of screening.

Bowel cancer screening

There are two types of screening for bowel cancer. A home testing kit is offered to men and women aged 60 to 74. Bowel scope screening uses a thin, flexible tube with a tiny camera on the end to look at the large bowel. It is offered to men and women at the age of 55 in some parts of England. Healthwatch did include this type of screening.

Abdominal aortic aneurysm (AAA) screening

AAA screening is offered to men in their 65th year to detect abdominal aortic aneurysms (a dangerous swelling in the aorta). Men over 65 can self-refer. Healthwatch did include this type of screening.

Different types of screening have different benefits and risks. Some of these are listed below.

The benefits of having a screening test include:

- Screening can detect a problem early, before you have any symptoms.
- Finding out about a problem early can mean that treatment is more effective.
- Finding out you have a health problem or an increased risk of a health problem can help people make better informed decisions about their health.
- Screening can reduce the risk of developing a condition or its complications.
- Screening can save lives.

The risks and limitations of screening include:

- Screening tests are not 100% accurate. You could be told you have a problem when you don't – this is called a "false positive" and may lead to some people having unnecessary further tests or treatment as a result of screening. A screening test could also miss a problem – this is called a "false negative" and could lead to people ignoring symptoms in the future.
- Some screening tests can lead to difficult decisions. For example, if a pregnancy screening test tells you your baby has a higher risk of a particular condition, you may then be faced with a decision about having further diagnostic tests that involve a risk to your pregnancy. If the diagnostic test is positive, you may then need to decide whether to continue with your pregnancy.
- Finding out you may have a health problem can cause considerable anxiety.
- Even if you're screening test result is normal or negative (i.e. you are not at high risk), you could still go on to develop the condition.

Methodology

Our background investigation work focused on gathering the views of local people's experiences of accessing and receiving NHS Immunisation and Screening services.

HWL conducted an independent study over the period September 2016 to December 2016. Project planning work commenced in July 2016 with publication of this final report in February 2017.

Participation involved Lincolnshire residents completing a survey which was accessed via Survey Monkey (461 were completed online) and provided as a paper based version (324 were hand written). By offering different methods of survey completion ensured people who are not comfortable or don't have easy access to computers to be involved. The questionnaire was distributed via our Website, Facebook, and Twitter our own engagement and volunteer teams, as well as other relevant stakeholders and organisations including the 4 Lincolnshire CCG's, Lincs County Council and voluntary and community sector organisations.

The survey design work included liaison with Lincolnshire Public Health and NHS England, their expertise was extremely important in helping us include the right questions. The survey was split into the following 3 sections:

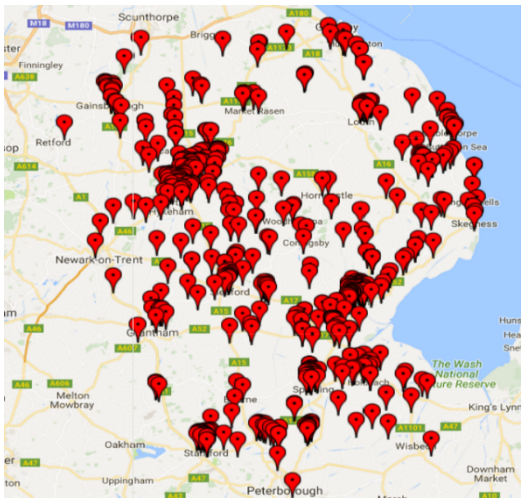
1. Section One – Child NHS Immunisations – for families where they have a child/children that is under 6 years of age
2. Section Two – Adult NHS Screening Services
3. Section Three – Adult NHS Immunisations

We had a target of 1,000 completed surveys, although our final total of completed surveys was 785. Factors that attributed to us not quite making target was perhaps the length and detail of the questions and an individual's perception of relevance to this work.

If you would like to receive a copy of the survey questions please contact Healthwatch Lincolnshire office on 01205 820892.

It should be noted that any personal comments included in this report are from members of the public who contributed and therefore will not always be the opinions of HWL. HWL acknowledge that some of the recommendations and requests from the public may not adhere to medical opinions and research. However, it is important to note that shared experiences provide essential learning opportunities for providers and commissioners of health and care services.

This map shows where in Lincolnshire the people who responded to our survey live. Reassuringly it



confirms that our project covered countywide experiences.

Results

Section one - Childhood immunisation.

From the 785 respondents who completed the survey, 23% (179) of these related to the child immunisation section of the survey. The following information provides a breakdown of results of the significant questions:

Question 2 and 3 - How up to date is your child/children's immunisations?

- 85% of respondents knew their child's immunisations were completely up to date, with a further 11% responding that they were 'somewhat up to date' and only 1.7% indicated they were not up to date; 1.7% were not sure (1.6% did not respond).
- Of those parents who's child had not received their immunisations:
  - **1 in 4 (25%) had concerns about safety;**
  - 21% admitted to forgetting;
  - 12.5% had difficulty in getting an appointment
  - 12.5% didn't feel their child/ren's current health would cope

Question 4 - is there enough information provided about child immunisations?

33% of respondents did not think (or were not sure if) there is enough information provided about child immunisations. Many comments we received relate to lack of information available which provides 'rounded view of vaccines', there was also comments made about the scaremongering online which some parents felt influenced their decisions.

Carer (respondent) comments

Is it safe for my child to be immunised? - 25% of those responding felt it was not safe to allow their child/ren to be immunised. When we extrapolate these figures we are then looking at a possible 5,300 children in Lincolnshire who have not been immunised. Below provides a few of the comments made, further respondent comments are included in appendix 2.

"Information not completely balanced - only reflects the benefits and short term side effects, rather than any longer term potential effects."

"I think that it would be useful for reminders to book in for, then should be sent inclusive of the information relating to the diseases which are to be immunised against. How many injections to expect etc"

"When I take my child for immunisation I don't know what it is for and they don't tell us what the immunisation or vaccinations for. Not enough information about the reasons or the risk effects"

"There's a lot of scaremongering online, in popular chat forums"

Q6 - How easy was it to get an appointment

- 81% of respondents found getting an appointment for their child to be immunised was easy. Where comments were made in the negative, they did relate to inflexible clinics (particularly difficult for working parents), and lack of help for patients with disabled child (this does differ from surgery to surgery).
- 57% of families were able to get an appointment within a week (or less).

Carer (respondent) comments

Below provides a few of the comments made. Further respondent feedback is included in appendix 2.

"Appointments not at convenient times, inflexible clinics. Often have to ring back because only one clinic is available and if you can't do that day then there are no others available to book till that one is fully booked. It often feels it is very difficult to get your child immunised"

"I would like my appointments in more advance notification please as it was beyond the milestone that the services wrote to me with the clinic appointment"

"We have an excellent GP practice and they send letters reminding you. They had even sent a letter with registration documents to our house before I got out of hospital with new baby. Comment regarding patients at Beechfield Medical Centre Spalding"

"Work and childcare arrangements make it difficult for a clinic one day per week".

Q8 - Where do children go to receive immunisation?

We note from the responses that the vast majority of immunisation is completed within the GP setting.

Service Type	% of responses*
GP	95.86
Health clinic	2.37
School	2.96
Other	2.96

*please note, the total number of responses calculates 101.19%, this was due to the fact that recipients ticked more than one option.

Useful information for parents - The following link provides a very useful resource for families as it enables an electronic record of child immunisations to be stored by the family which includes due dates.

Child Immunisations http://www.nhs.uk/Tools/Pages/NHSvaccinationplanner.aspx

Observations/Suggestion/Recommendations – Child Immunisation

1. Safety information - It is clear there is an issue relating to some parents feeling that information available to them, especially concerning immunisation risks to children, does not provide them with sufficient evidence to make an informed decision whether or not to have their child immunised. This is evidenced by 33% of respondents in our survey specifically indicating this fact. It also appears there may be some inconsistencies across the county in the approach by GP Surgery's etc. when contacting parents with children.
2. Interaction with medical staff - We noted that where experiences were positive in pre-preparing the parent and child in advance of receiving immunisations, where questions and discussion were able to occur, this approach worked really well for all concerned. We would recommend all medical staff adopt such an approach where practical.
3. Increasing number of children immunised - Healthwatch feels that more work should be done to better understand the reasons for lack of 'take up' in the households that choose not to have their child/ren immunised. For instance, lack of balanced information, scare mongering, knowledge about alternatives, confusion about gaining and accessing an appointment, were all reasons given for not giving immunisations to children.
4. Accessing appointments for working parents – Whilst we recognise that the majority of parents are able to arrange time off to take their child to health appointments, it was noted that for some getting time off work was an issue. HWL feel there should be greater emphasis within employer sector to reinforce parents' rights in relation to unpaid leave in these circumstances.
5. Ongoing resources for parents – parents indicated they would like more help with reminders as to when their child/ren should be immunised. Implementing personal immunisation record cards or linking all families to the electronic tool (see page 14) would give families the necessary information at any time, this would also transfer some of the responsibility to ensure immunisations are completed when required with the family.
6. **HWL summary of points 1 - 5** is for Lincolnshire Children Services, 4 Lincolnshire CCGs, Lincolnshire Public Health and Lincolnshire Health Protection to work together to establish what the current differing approaches are across the county in relation to child immunisation, particularly at point of access. Following this consider the adoption of one approach, along with clear methods and messages being produced, including the focus on ensuring parents assume some responsibility for ensuring immunisations are carried out over the required timeline. (eg given a childhood immunisation planner at birth). An approach such as this would look to providing more equal and better understanding across the county.

Section two - Adult Immunisation

Q16 - Have you been invited to receive any of the listed immunisations?

From the Respondents that had been invited to attend immunisations:

- Flu – 10% fell within criteria but hadn't been invited, with 11% having been invited but then 'did not attend'.

- Pneumococcal – 42% fell within criteria but indicated they hadn't been invited.

  There are 167,671 adults in Lincolnshire over the age 65 years (*Office of National statistics, 2015)*. Therefore we can assume that if 42% (based on the number of respondents in our survey) of adults fall within the criteria are not being invited to pneumococcal immunisation this potentially equals 70,400 patients.

  The high rate of this statistic is concerning and we feel does require further investigation to ascertain why so many people are not being invited to receive a pneumococcal injection.

- Shingles – 34% of respondents fell within the criteria but indicated they hadn't been invited (there is no requirement to be invited for shingles vaccine). There is also some confusion around understanding of the criteria, which is that a patient must be 70 at a specific date rather than on the birthday

Flu - A number of comments were provided which relate to fear of the side effects of flu injections. Comments also suggest there is a certain amount of apathy or misunderstanding by patients, all resulting in the patient refusing to have the flu injection.

Q18 - How easy was it to make an appointment to receive your immunisation?

Reassuringly, the response rate to this question was over 90% positive that it was easy to arrange an appointment to receive immunisation. This contradicts the daily feedback HWL receives with regards to access to GP appointments but may reflect that such injections are most likely administered by the practice nurse and within a pre-arranged flu clinic setting.

Observations/Suggestion/Recommendations - Adult Immunisation

Invitation to attend - due to the high number of respondents that indicated they had not been invited to receive adult immunisation particularly for pneumococcal immunisation, we would recommend NHS England and the 4 Lincolnshire CCGs investigate whether there are any problems within the system at point of invitation.

Section three - Adult Screening

Q11 – Have you been invited to attend cervical, breast, bowel, Abdominal Aortic Aneurism (AAA) or NHS Health Check?

- **Cervical screening is offered to women aged 25 – 64 every 3 to 5 years.** 7.7% (33) out of 431 women who responded to our survey have been invited to cervical screening but chose not to go 'DNA'. Lincolnshire has low rates of cervical screening take up which is in line with national data for cervical screening.

According to the *Office of National Statistics (2015 data)* there are 188,000 eligible women for cervical screening between the ages of 25 – 64 years of age in Lincolnshire, our data suggests there could be as many as 14,476 women in Lincolnshire not attending cervical screening when invited.

We received a significant number of comments from respondent telling us that embarrassment and pain from previous cervical screenings resulting in them not attending again.

Respondent comments

"In common with many women I had a very painful experience with cervical screening and consequently have not attended again since. Obviously this has put my health at risk, and that of many other women too. Unfortunately, publicity about the changes to the service and attitudes/patience of practitioners and changes to the equipment used have not been publicised. I had a screening done by a consultant recently and I just could not believe the difference in the experience"!

"Accessing cervical screening is very difficult at my surgery. You are informed in a timely manner that you are due to call to make an appointment. In my experience I call and they are full as they only book 6 weeks in advance, they give me a date to call back and when I do they are again full and tell me to call back in the future. This happened to me before making my screen 1 year late last time, currently going through the same situation".

Lincolnshire Health Screening and Immunisation services report Lincolnshire is not achieving its required targets for cervical screening. However, it is worth noting that the published data we used is relatively old being 2014/15. The most recent data is indicating that the age group between **25-49 years of age is the cohort of population who are less likely to undertake cervical screening**, with 50-64 years of age patients achieving its targets.

Our data told us that where a respondent misses an appointment for cervical screening they were 3 times more likely than any other screening not to re-schedule the appointment.

Other reasons for not attending cervical screening appointments were, not being able to organise childcare, and not being able not get time off work.

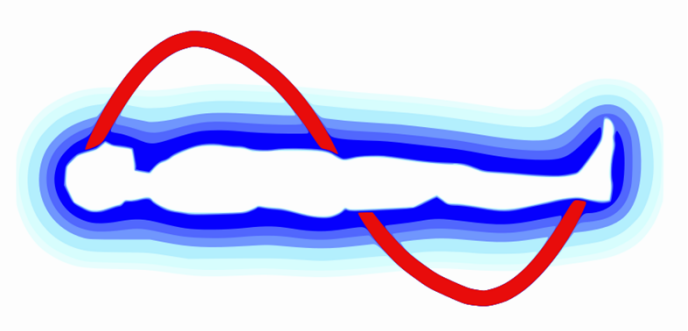
Patients need to better understand the importance of all screening, cervical cancer in particular is a cancer that is known as a silent killer due to the fact that symptoms do not always become obvious until the cancer has taken hold. *Every year in the UK, over 3,000 women will be diagnosed with cervical cancer. Cervical cancer is the most common cancer in women aged 35 and under. https://www.jostrust.org.uk/about-us*

Bowel screening is offered to adults aged 60 to 71 years of age every 2 years

- 10.1% of those invited to complete bowel screening chose not to complete the testing kit.
- 23% of respondents indicated they were within the criteria range but had not been offered the screening.

According to the *Office of National Statistics (2015 data)* there are 140,000 eligible people for bowel screening between the ages of 60 to 71 years of age in Lincolnshire, our data suggests there could be as many as 32,200 adults in Lincolnshire not being offered bowel screening.

Other issues as to why people chose not to complete bowel screening include comments such as “I was worried about what the results might mean”, “I didn’t understand what the procedure was for”.



Breast screening is offered to women aged 47 to 73 years of age every 3 years

- 13.7% of respondents told us that they had not been invited to this screening but indicated they fell within the criteria.

According to the *Office of National Statistics (2015 data)* there are 137,696 eligible females for breast screening between the ages of 47 – 73 years of age in Lincolnshire. Our data suggests there could be as many as 18,864 women in Lincolnshire not being offered breast screening.

Respondent comment

"I live in Billinghay. Ladies in the village, and surrounding villages, have to travel to Sleaford for breast screening. For ladies requiring public transport, this nine mile journey involves catching 2 buses there and 2 home!! Very limited public transport makes this journey almost impossible, especially for those who are less mobile. Secondly, the mobile mammography unit is based at Hockmeyer Motors: no woman should have to attend a garage for screening of any kind. For both these reasons, I am aware that Billinghay ladies do not attend for breast screening. I am currently investigating the possibility of the mobile mammography unit coming to Billinghay (possibly the village hall). Any info on the necessary requirements would be gratefully received. Many thanks"

Lincolnshire Health Screening and Immunisation services report that Lincolnshire is generally achieving their required targets for breast screening with the exception of Lincolnshire East and to a lesser degree, Lincolnshire West.

Abdominal Aortic Aneurysm (AAA) is offered to men in their 65th year

- 59% of respondents told us they had not been offered this screening despite being within the criteria range.

According to the *Office of National Statistics (2015 data)* there are 4,900 eligible males 65 years of age in Lincolnshire. Our data suggests there could be as many as 2,891 men in Lincolnshire not being offered AAA screening each year. It is also worth noting that again, according to the *Office of National Statistics* there are 78,525 men in Lincolnshire over 65 years of age (any man 65 or over can self-refer for AAA screening) meaning a possible 46,340 men have not accessed AAA screening.

AAA screening detects any dangerous swelling (aneurysm) of the aorta – the main blood vessel that runs from the heart, down through the abdomen to the rest of the body. Early detection is important because once identified AAAs can be monitored or treated, greatly reducing the chances of the aneurysm causing serious problems in the future. (Public Health matters gov.uk).

Lincolnshire Health Screening and Immunisation services report Lincolnshire is not achieving its required targets for this screening. HWL believes much more should be done to address this problem due to the high levels of stroke and cardio-vascular incidents in Lincolnshire being higher than regional or national averages http://www.research-lincs.org.uk/UI/Documents/cardiovascular-disease-in-lincolnshire.PDF

NHS Health Checks are offered to all adults between 40 and 74 every 5 years

- 43% of respondents indicated that they had not been offered a check but felt they were entitled within the criteria.

According to the *Office of National Statistics (2015 data)* there are 340,000 eligible adults between the ages of 40 – 74 years of age in Lincolnshire. Our data suggests there could be as many as 146,200 people in Lincolnshire not being offered an NHS Health Check.

Respondents raised additional comments with regards to NHS Health checks including:

- being worried about the results and what they might mean
- not feeling the check was relevant
- not understanding what the screening was for
- forgetting to make the appointment or rescheduling and
- not being able to have the time off work

The NHS Health Check is offered to everyone aged 40-74 to prevent premature death from heart disease, stroke, kidney disease and diabetes. It does this by picking up warning signs that your risk of these health conditions is higher than average. You can then be given lifestyle advice and possibly medical treatment to bring your risk down. Some warning signs of cardiovascular disease, such as high blood pressure and high cholesterol, are "silent", which means they have no symptoms. So you can feel well even though your risk is raised. With more emphasis being placed on the patient to keep as healthy and well as possible NHS Health Checks will become a very important part of your self-care regime.

Q12 – How easy was it to get a screening appointment?

Responses for this question indicated there was generally no difficulties for patients organising an appointment for screening once they had been invited.

Q15 –Additional information shared?

We received a significant number of text comments with regards to all NHS screenings some key messages include:

- not being sent screening appointments
- patients having to take the initiative
- didn't know about health checks

Respondent comment

"I failed to make an appointment for NHS screening when invited, my reason was I knew my employer would not be happy with me asking for two appointments one week apart".

A full list of respondent comments to NHS screening and immunisations can be read in appendix 2.

Observations/Suggestion/Recommendations – NHS Adult Screenings

7. Invitation to attend – due to the high number of respondents that indicated they had not been invited to receive adult immunisation, particularly for pneumococcal immunisation, **we would recommend NHS England and the 4 Lincolnshire CCGs investigate whether there are any problems at point of invitation.** HWL is supporting this recommendation by contacting survey respondents who indicated they had not been invited to ask if they would give permission to be part of a pilot study to check their individual health record.

8. Self-care - if the NHS **is** serious about the need for more self-care, then patients will need to have the right information to encourage this to happen. **HWL considers a collaborative approach between NHS organisations and local community and patient groups would provide opportunities to develop the right messages, in formats that the public will be able to understand.**

   Once the self-care messages have been finalised successful campaigns to encourage more self-care will require:

   A more proactive approach to patient engagement, avoidance to working in isolation of other public messages

   A more consistent approach to patients from all services, for instance mixed messages are confusing and lead to personal interpretations.

   Avoidance of information shared being done in a way that is too formal, full of jargon, and with an approach that meets the NHS Accessible Information Standards

   Employer cooperation and taking a view that health and care is as relevant to its business as it is to the individuals it employs

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10. Failure to receive an appointment – most worryingly from our data, we are able to calculate that potentially 240,000 adults are not being invited to attend health screenings (this figure is focusing on breast, AAA and NHS Health Checks). As we know early detection is vital for the patient however, if patients are not even being given an opportunity to access screening in the first place then this suggests there may be serious health inequalities occurring in our county. Even if we factor into the equation those people who choose to ignore invitation letters (maybe even throwing them away as junk mail); have moved house and failed to inform their health providers of this fact; or it may be administration errors, this still indicates there may be a significant number of people involved.

Conclusion and next steps

At this end of this project HWL was able to identify 10 areas of observation/suggestion and recommendations. From these 10 areas we would conclude they can be summarised into the following 3 areas:

- Information – it appears there needs to be an increase in the amount of public (patient) information and messages that are clear and consistent. This will help to provide better understanding of the importance and risks to patients (both in non-attendance and with regards to safety)
- Attitudes – this includes the public treating medical appointments as very important (reducing DNA) and to help alleviate any personal barriers that are at times preventing people from attending eg fear. Also, where positive attitudes from medical staff have been experienced this was raised as very important to how patients will commit to their future attitude towards attending, we believe such approaches should be replicated across the county
- System – we were concerned with the number of people who indicated they had not been offered an appointment to attend screening, breast, AAA and bowel in particular. From our data we have calculated this potentially could be 240,000 Lincolnshire residents who have not been invited to take part in screening. As a matter of urgency we believe this needs investigating and have already been in contact with NHS England to support some test cases into this

This report will be shared with Lincolnshire Public Health, Lincolnshire County Council, 4 Lincolnshire Clinical Commissioning Groups; Lincolnshire Health Protection Board, NHS England and Healthwatch England for information and consideration.

Once the above organisations have had an opportunity to consider the contents of this report, we will be asking them to provide responses to our observations, suggestions and recommendations. In addition we will be asking that they provide an update of any actions being implemented updated to HWL at their earliest opportunity.

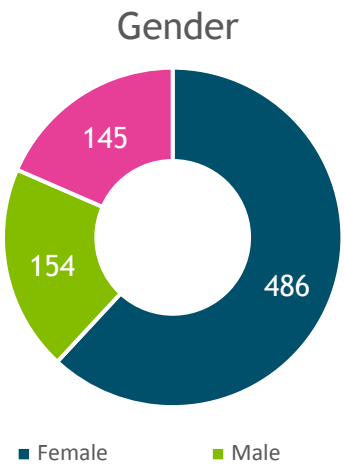
Lincolnshire Joint Strategic Needs Assessment and immunisation

Lincolnshire Joint Strategic Needs Assessment (JSNA) is currently updating their datasets, this includes child and adult immunisation. We are pleased to have supported this work and have noted the contents of the refresh documents as part of our background research. More information about the JSNA can be found using this link http://www.research-lincs.org.uk/Joint-Strategic-Needs-Assessment.aspx

Pease note, if you would like a copy of our project survey for Immunisation and Screening please contact our Swineshead office (details in back cover).

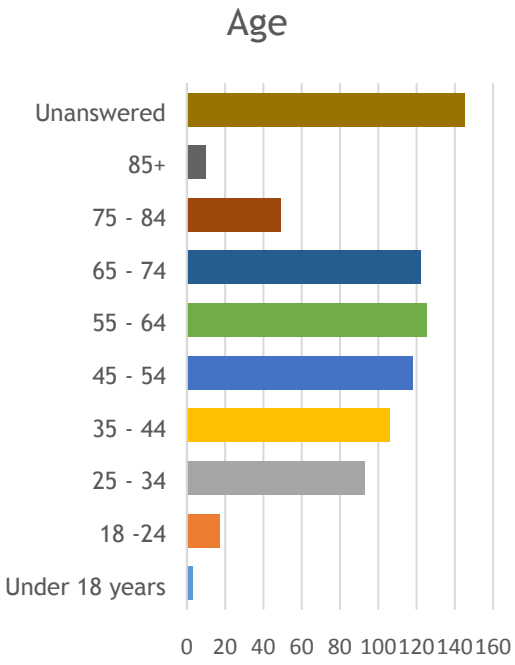
Appendices

Appendix 1 - Demographics



Gender	Percentage	Number
Female	61.9%	486
Male	19.6%	154
Unanswered	18.5%	145
	Total	785

Age	Percentage	Number
Under 18 years	0.4%	3
18 - 24	2.2%	17
25 - 34	11.8%	93
35 - 44	13.5%	106
45 - 54	15.0%	118
55 - 64	15.9%	125
65 - 74	15.5%	122
75 - 84	6.2%	49
85+	1.3%	10
Unanswered	18.5%	145
	Total	785



The above tables provide information as to the demographics of the people who completed our immunisation and screening survey. We are pleased to record that we have received responses from all age ranges but note that the largest number of responses was from people aged 25 - 74. The number of men and women responding reflects normal trends in that more women than men tend to complete surveys.

Appendix 2 – Text comments

HWL received a significant number of comments with regards to child and adult immunisations and adult screening, below gives examples of the comments from each category. If anyone is interested in receiving a full copy of all comments we received please contact our Swineshead office.

Child immunisation

It is worth noting that we received many comments in the positive with regards to how wonderful nurses are with children - not all are listed below.

All Good. But I would like my son to have his TB and there is not much information about this. Also as he is now entering Secondary School, we have not been offered any other information or vaccinations for age group 11-18yrs.
Appointments very good for children
At the 3rd lot we got told she had not had 2nd lot (which she had) due to error on system as both 1st and 2 and had been in same month (was a long month) and it listed by month, so if we had not been on top of it she would have had extra 2nd lot. Thankfully the red book proved us correct. Also at GP surgery the automatic booking does not work for triple appointments, as baby did not get signed in for last one (even though screen confirmed it) so nearly missed his first lot of vaccinations - computer system needs to be sorted to fix this error as ended up waiting 1 hour and 30 mins with a 2 y old and new born, which was needless stressful for us all
Good service. Dr's surgery automatically send a letter when an immunisation is due.
I believe strongly in immunisation but feel that access is difficult. As a working parent the services are not readily accessible even though I make every effort to ensure that my child doesn't miss any.
I dislike the NHS culture of giving parents the impression that immunisations are compulsory. The language used is loaded and emotive. HCP are also dismissive of any parents who question the NHS literature and present with other evidence based studies.
I had to wait for flu vaccine and all available appointments I could not go to due to work (I only work 3 days) for a couple of weeks. Luckily my mother took her although I would have much rather preferred to take her myself.
I have always been kept well informed and been given my appointments when necessary, I am happy with the service my GP provides.
I hope all these immunisations do not produce any long term effects in my children
I think the immunisations is useful and also if at the beginning I was not sure about it, my previous GP in Kent told me very clear the reason of this important step in the life of a new little person, when I moved with my family in Stamford (Lincolnshire) my little girl has had the other immunisation last Year but after that I didn't have other information about other kind of vaccinations useful to know. My little girl is very delicate and often with cold and cough and she already had few Paediatrician appointment, she has some medication with Salamol inhaler and I think I need to know more about the possible vaccination for flu because every time she has a normal cold for her never end...because she is more delicate the other kids.
My son is severely autistic and refuses to attend Dr's appointments. He is not up to date on his jabs. He also refused the flu vaccine at school so that wasn't done either. There are no alternative methods offered to help parents in my situation which ultimately leaves him vulnerable to these illnesses.
Not enough information about what is on the immunisations and the possible side effects
Nurses have always been brilliant with my daughter, the surgery staff generally are really helpful, positive and friendly about all appointments for my child and immunisations have been no

exception.
Please supply full ingredients and side effects I need to know what they are putting into my child regardless of how they will help the child Parents should be fully informed.
reminders that immunisation are due would be a good thing
Since moving to Lincolnshire I have had no contact even though I have registered at GP surgery
The nurse was awesome. I saw her in advance of the appointment and we chatted about the preparation of my son who was 3.5 at the time so unlike his previous immunisations, he would now be more aware of what was going on. Maybe a social story could be distributed to all parents prior to the 3 years immunisations as without me talking to her how to prepare him I was totally in the dark as to let him know what to expect or not.
The system should be more flexible according to patients as people who move into the country with kids find it difficult to understand the different vaccination schedule of the new country

Doctors and hospitals may need to send out more information about appointments to avoid missing opportunities to be immunised.
I am concerned because so many immunisations are required over such a short period
I didn't receive any information about the immunisations the kids have had to have, and nothing to address the concerns that people scaremonger about.
I don't feel we are given a balanced opinion therefore it's very difficult to make an informed choice.
I had to constantly remind the GP for my appointment for vaccination
I have no idea when the next ones are due, I rely on my doctors surgery telling me
I think that it would be useful for reminders to book in for them should be sent inclusive of the information relating to the diseases which are to be immunised against. How many injections to expect etc
I think the information is heavily biased towards pushing parents to have them. I would like to see more balanced information readily available.
I would like a full list of ingredients and side effects before I take my child for them. With normal medication you get the leaflet with all information, you get nothing with injections, why? it's wrong
Just didn't feel that well informed and was all a bit of a 'new baby blur'!
Leaflets could be sent out prior to Immunisations so you could get the facts prior to the event.
We get letters for immunisation but don't know what is due at what age, I am assuming our GP could answer this when attending a routine appointment.

Adult Immunisation and screening

I am responsible for my own health and so I eat well and walk plenty. If I want advice I will not be going to a fat nurse who smokes just to contribute to the surgery's cash box. I do not wish to take statins or worry about my cholesterol. No wonder all this costs so much. We should all be encouraged to be far more responsible and get on with our lives rather than using the NHS as a nannying service.
As I have a family history of bowel cancer - I believe screening is relevant to me even though I'm not 60 years old - I haven't been given this option.
Because of heart problems and related medication I attend a review every year
Bowel screening was by post from Nottingham University. I declined a health check for several reasons. I look after my own health. I am active and only slightly overweight. I eat a good diet. The person who would do the check was not medically qualified and would refer you to a medical

person. Nettleham Surgery. That's what the letter said. They have a very overweight pharmacist, at least one overweight doctor, at least one overweight nurse, an overweight assistant manager. Why are they giving other people advice? When you go to visit in hospital some of the staff are obese. The phrase 'Physician heal thyself' comes to mind. I do not have chest problems so have never had a flu vaccination. I have also refused a shingles vaccination. The doctors' usual remedy is to hand out pills instead of referring you to a dietician. The scales and blood pressure machine are in a shabby corner behind a screen in the reception area. That is a good reflection of their perspective.
Breast screening is a concern for me but I am ineligible due to age
Concerns I have not been called for an NHS screening and note I will soon be too old to go anyway.
Didn't know about NHS Health check! Simple as that! Needs to be advertised a lot more!
Difficult to arrange appointment as had moved from a different area. Made more tricky as needed check prior to three year interval
Disappointing to have to apply for breast screening after 73 and bowel cancer screening after 69.
Early stage breast cancer detected and treated accordingly bowel Cancer Screening was one of the kits sent in the post I had an AAA screening as my mother has been diagnosed with this condition and it was suggested that this would be prudent
Had abnormal cervical cells from the age of 20yrs was treated and monitored regularly until having hysterectomy. I had a lump in breast and was given a mammogram at Pilgrim within 8 weeks.
Had bowel cancer at 45 so too early for screening
Have always been on bowel cancer screening done the test 3 times now. But have never been invited to others. I do see my GP twice a year for a review of my heart medication and maybe this covers the other items.
I am a cardiac pacing patient and on changing GP practice my annual blood test for cardiac patients has been stopped. I received annual cardiac blood testing and monitoring for 7 years at my previous practice. I was also not offered a flu jab last year despite being offered one annually at my last practice for 7 years. Have the criteria for these two checks changed or have I simply been missed out? I have a pacemaker for sinus node disease.
I attended the NHS Health Check and it was noted I have high blood pressure. Blood tests were taken and medication prescribed in 2015. I have never been asked to attend a hyper tension clinic nor have I had a medication review although my prescription states I should have had one in January 2015.
I failed to make an appointment for NHS screening when invited, my reason was I knew my employer would not be happy with me asking for two appointments one week apart.
I had to make my own appointment for NHS Health check. Never received an invitation from GP.
I have attended some invitations to screening but not others. As a survivor of rape I find intimate examinations extremely difficult and there is absolutely no understanding or provision for this scenario. More needs to be done!
I have been invited for NHS Health check but have been too busy to respond - I will do though. It would be easier if the tests could be done on a Saturday
I have had breast cancer so am being screened through that route. A scan at 47 might have found the cancer earlier and saved me a lot of treatment.
I have never been asked to attend an NHS health check. I am 51 years of age and female
I have not attended for the most recent NHS Health Check as the delay in appointments discouraged me. My last Cervical screening was some years ago.
I like this proactive approach to health, much better than waiting until people are ill and then treating them too late.
I moved house and changed GPs around the time of my 40th birthday, so it is possible that an

invitation to health check screening was missed, but it is now over five years so I should be due for another invitation - not received anything as yet.
My last Cervical Screening appointment, over 2 years ago, was a complete failure. I have always found the smear a painful experience (far more than 'uncomfortable' as is claimed) and I'm now over-weight which I understand makes it harder but the nurse who saw me was clumsy and insensitive while she caused me a lot of pain. She rushed off to catch the transport while I got dressed and when she came back she cheerfully said she couldn't see my cervix so she may not have scraped the right cells and the test might have to be one again. The next day I had a message from the surgery to say I needed to book another test, not because there was anything abnormal or too few cells, my sample had not even been tested, the lab sent it straight back because it wasn't identified properly and she'd not completed the paperwork correctly! I was reluctant to go through the experience again but when I saw a female GP for something else I asked her about it and she was sympathetic and suggested I book a double appointment with herself and a particularly experienced nurse for a smear. I tried to get such an appointment but the receptionist was unhelpful wanting an explanation for why I wanted to see both and I had to discuss the matter quite loudly because of the glass screen between us, in the middle of the surgery which I found very embarrassing. I did not get an appointment because of staff holidays and pre-bookings meaning she couldn't find a slot in the next 6 weeks which is as far ahead as they book. I've tried twice since without luck and am now waiting for the female doctor to come back from maternity leave, when I shall try again but surely this should be an easier process?
Neither myself or my husband have been sent and NHS Health Check
Over 40's check identified renal failure - and I am a health professional! Did not notice any changes in my health
Pleased to attend 40-74 health check every year
PSA test discovered Prostate cancer early on
Screening very good the older you get

Distribution of this Report:

This report will be available to download from the Healthwatch Lincolnshire website, copies can also be available in other formats by request.

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Report to be shared with:

Lincolnshire Public Health, 4 Lincolnshire CCGs, Lincolnshire County Council, Lincolnshire Health and Wellbeing Board, NHS England and Healthwatch England

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Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of Cllr Mrs Marion Brighton OBE, Leader of North Kesteven District Council

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**7 March 2017**
Subject:	**North Kesteven's Health and Wellbeing Strategy**

Summary:

This report provides the Health and Wellbeing Board with a brief overview of North Kesteven District Council's health and wellbeing strategy, which is attached in full as Appendix A.

Actions Required:

The Health and Wellbeing Board is asked to consider the strategy, and if appropriate propose its ratification.

1. Background

North Kesteven District Council is clear about the role a District Council plays in supporting residents to achieve optimal health and wellbeing. In December 2016, the Council published its strategy, *Inspiring Health and Wellbeing in North Kesteven*.

A number of data sources were used to inform the strategy, but particularly the Joint Strategic Needs Assessment and the Association of Public Health Observatories District Health Profiles. Each of these provided a valuable insight into the health of the District's residents and helped to define the purpose and aims of the strategy. A further list of documents and online resources referred to can be seen on page 17 of the strategy.

The purpose of the strategy is to:

- Identify the key priorities for improving health and wellbeing,

- Identify existing arrangements that support residents to improve their health and wellbeing,
- Set out on a very practical level what the Council is able to achieve to support good health and wellbeing, and
- To support the creation of a District wide action plan to support good health and wellbeing.

The strategy sets out three principal aims which are:

- To improve coordination of health and wellbeing activities across the District,
- To drive and influence the delivery of health care in the District, and
- To reduce health inequalities and improve health and wellbeing for everyone.

In order to achieve the aims of this strategy, an action plan has been prepared in collaboration with Partnership NK – the District's Local Strategic Partnership - and other service deliverers from across North Kesteven. This action plan sets out a series of realistic tasks that can be delivered over the coming years, identifies who the key deliverers are, and what success will look like. The progress against these tasks will be monitored on a quarterly basis by Partnership NK, and reported through the District Council's overview and scrutiny process.

2. Conclusion

North Kesteven is clear about the role it plays in health and wellbeing. Its latest strategy, *Inspiring Health and Wellbeing in North Kesteven* sets out a commitment to work with others to continue to improve the health and wellbeing of residents. The Health and Wellbeing Board is asked to consider the strategy which is attached as Appendix A, and if deemed appropriate, propose its ratification.

3. Consultation

Consultation has taken place with key stakeholders and elected members.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Inspiring Health and Wellbeing in North Kesteven

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 Luisa McIntosh who can be contacted on 01529 414155 or luisa_mcintosh@n-kesteven.gov.uk

North Kesteven District Council

Health and Wellbeing Strategy

districtnk
North Kesteven District Council

Inspiring Health and Wellbeing in North Kesteven





Contents

North Kesteven District Council is committed to health and wellbeing

We believe that improving health and wellbeing will help the council to achieve its vision and priorities for North Kesteven; a vision for flourishing communities, and priorities linked to health improvement, community and economic development.

1 Introduction

In 2013, when the first Health and Wellbeing Strategy was published for North Kesteven, the key message from Public Health England was making health everybody's business. This marked the introduction of a new public health system with an integrated, whole system approach that included public health functions being integrated into local authorities, in Lincolnshire's case, the County Council.

The principle aim was to help people to live longer and healthier lives by reducing preventable deaths and the burden of ill health associated with smoking, high blood pressure, obesity, poor diet, poor mental health, insufficient exercise and alcohol. Since then there has been an increasing realisation that to achieve that aim, there needs to be a far greater emphasis on coordinating efforts.

In September 2016, Professor Sir Bruce Keogh, Medical Director of the NHS said: "For the NHS to be sustainable, people need to become more active in managing their own health, wellbeing and care. They need to be supported to make good choices and more equal conversations, based on a strong partnership between clinician and patient, are vital for achieving this".

Preventing ill health is the new buzz phrase and relies on people to step up to the challenge of managing their own health, as Sir Keogh states. To encourage this, there are new, straight forward initiatives that are giving clinicians and residents the means to make realistic lifestyle changes. Initiatives like Health Coaching that encourages a better conversation with GPs and their patients, and Make Every Contact Count, a behaviour change mechanism using existing day to day interactions to support people to make positive changes to their physical and mental health and wellbeing. Both of these are designed to nurture a culture of change.

Today there is a much stronger lean towards physical and mental health and wellbeing and less of a focus on simply diet and exercise, in recognition of the need to nurture good mental health alongside the physical elements of health. This strategy aims to set out the ways in which North Kesteven District Council, with key partners from across the piece can play a lead role in providing practical and sustainable support to residents to enable them to live longer, healthier lives.

Ian Fytche
Chief Executive

Cllr Marion Brighton OBE
Council Leader

2 The purpose of this strategy is to:

- **Identify the key priorities for improving health and wellbeing**
- **Identify existing arrangements that support residents to improve their health and wellbeing**
- **Set out on a very practical level what we are able to achieve to support good health and wellbeing, and**
- **To support the creation of a District wide action plan to support good health and wellbeing.**

There are three principal aims which are:

To improve coordination of health and wellbeing activities across the District	To drive and influence the delivery of health care in our District	To reduce health inequalities and improve health and wellbeing for everyone

3 Health and Wellbeing in North Kesteven (a snapshot)

North Kesteven is one of the 20% least deprived districts/unitary authorities in England. Life expectancy for both men and women is higher than the England average, at 81.5 years and 83.9 years respectively, and the District has retained the position of the safest place to live in the country for the last three years. Educational attainment is high, unemployment is low, and the area is recognised as being a good place to live.

In September 2016 the Office for National Statistics (ONS) annual Wellbeing Survey rated North Kesteven as the top District in the country in terms of life satisfaction, and second in the country for people feeling like life is worthwhile. The District was also in the top 10% for happiness and the top 20% for least anxiety.

Public Health England, District Health Profile

The 2016 Health Profile for the District published by Public Health England includes an assessment of whether a local authority's performance is significantly better than the English average, not significantly different from the average, or significantly worse than the average. The 2016 profile indicates that the health of people in North Kesteven is on the whole significantly better than the England average. The profile provides a comparison of 31 indicators in five different categories (or domains), and these categories are:

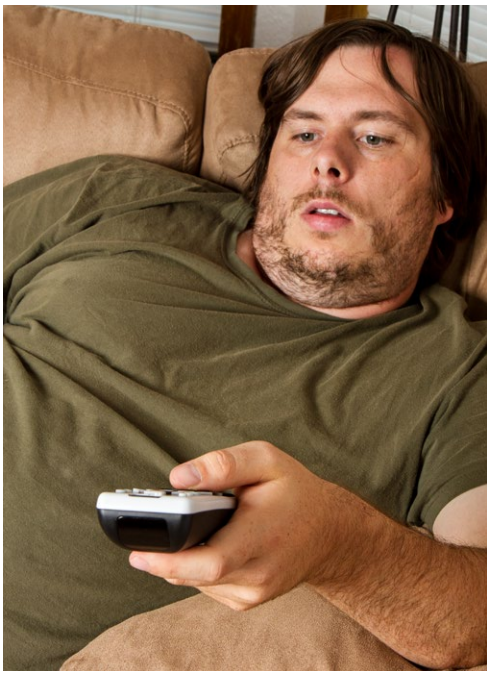
1. **Our communities**
2. **Children's and young people's health**
3. **Adults' health and lifestyle**
4. **Disease and poor health, and**
5. **Life expectancy and causes of death.**

North Kesteven rated significantly better in 18 indicators, there was no significant difference in three indicators, and no comparable data for six indicators. However, the District was rated as being significantly worse than the England average for the following four indicators:

Indicator	District Health Profile 2016	
	England Value	NK Value
Excess weight in adults	64.6%	69.2%
Recorded diabetes	6.4%	7.0%
Hip fractures in over 65s (Rate per 100,000 population)	571	698
Killed and seriously injured on roads (Rate per 100,000 population)	39.3	50.4

4 Specific impacts on health and wellbeing

Excess weight and obesity in adults



Data extracted from the Active People Survey 2012 and 2013, and recorded in the District Health Profile, indicates that excess weight in adults is continuing to increase, from 65.5% to 69.2%. It is not possible to provide more than a two year data comparison for adult excess weight as the data collection methods are not consistent.

Sedentary lifestyles, lack of time and subsequently an increasing reliance on quick-fix, convenience foods means that sadly, the percentage of adults who are obese or carry excess weight will continue to rise. Added to this, obese adults are seven times more likely to become a type 2 diabetic than adults of a healthy weight, and excess weight can lead to the onset of other physical health conditions including heart disease, reduced mobility, isolation and depression.

The economic costs are great, too. The nation spends more each year on the treatment of obesity and diabetes than we do on the police, fire service and judicial system combined. It was estimated that in 2014/15 the NHS in England spent £5.1 billion on overweight and obesity-related ill-health.

Excess weight and obesity in young people

Today nearly a third of children aged 2 to 15 are overweight or obese, and younger generations are becoming obese at earlier ages and staying obese for longer. In North Kesteven, the level of obesity in children is less than the England average but is still considered to be an area of concern.

In January 2016 North Kesteven made headline news as the results of the Government's National Child Measurement Programme (NCMP) identified that nearly a quarter of year six (11 year olds) were leaving primary school overweight or obese. The NCMP analyses the prevalence of underweight, healthy weight, overweight and obese children in state school reception and year six classes across the country. The data from the NCMP for the last three years is as follows:

4 Specific impacts on health and wellbeing

Indicator – Reception		2012/13	2013/14	2014/15
Prevalence of	Underweight	0.2%	0.5%	*
	Healthy weight	76.8%	78.2%	*
	Overweight (Inc. obese)	23.6%	21.2%	19.0%
	Overweight	15.6%	13.5%	12.8%
	Obesity	8.0%	7.7%	6.2%
Indicator – Year Six				
Prevalence of	Under weight	1.0%	0.8%	1.02%
	Healthy weight	68.7%	68.7%	74.3%
	Overweight (Inc. obese)	30.3%	30.3%	24.7%
	Overweight	14.5%	15.3%	11.6%
	Obesity	15.8%	15.5%	13.0%

* Insufficient value for chart

In comparing year on year data collected, it is encouraging to see that the prevalence of children who are overweight is slowly declining. This can be demonstrated further by reviewing data from the Public Health England, District Health Profiles over a six year period that shows the percentage of obese children in year six, at the point they leave primary school:

Indicator	Health Profile	Data Year	Value
% of obese children in year 6	2011	2009/10	13%
	2012	2010/11	16.5%
	2013	2011/12	17.3%
	2014	2012/13	15.8%
	2015	2013/14	15.3%
	2016	2014/15	13%

Whilst this downward trend is promising, and the 2015 figure puts us in the best 10% in England, national statistics generally indicate that children are eating more saturated fat and sugar than is recommended, and not enough fruit and vegetables. Carrying weight into adulthood increases the risk of developing heart disease in later life. Therefore reducing excess weight and obesity in all ages must be a priority for North Kesteven.

4 Specific impacts on health and wellbeing

A growing and ageing population

North Kesteven has a growing population. By 2038 the population is estimated to be around 127,000. North Kesteven is a prime location for retirement, and people moving into the District is the key driver for the population increase.

North Kesteven has an ageing population. The number of people over the age of 80 is predicated to increase by 100% over the next 15 years, and the number of people over 90 by 200%. The Projecting Older People Population Information System (POPPI) developed by the Institute of Public Care (IPC) provides a useful insight into projected data for the over 65s in North Kesteven, as does the data from the Office for National Statistics (ONS):

Data Description	2014	2030	% Change
Projected no. of people living alone (ONS)	8,968	13,387	+49.3
Predicted prevalence of depression age 65 and over (POPPI)	2,148	3,046	+41.8
Predicted prevalence of older people suffering from severe depression age 65 and over (POPPI)	681	997	+46
Projected prevalence of Dementia, age 65 and over (POPPI)	1,650	2,919	+76.9
Projected number of people providing unpaid care age 65 and over (ONS)	2,857	3,663	+29.2

A growing, ageing population will put increasing pressure on an already stretched national health service.

4 Specific impacts on health and wellbeing

Mental health and wellbeing

Poor mental health and well-being can have an impact on every area of a person's life; physical health, education, employment, family, relationships, criminality, and productivity. At least one in four people will experience a mental health problem at some point in their life and one in six adults has a mental health problem at any one time.

The prevalence of mental health and illness collected at a local level by the two Clinical Commissioning Groups in North Kesteven in 2016 is as follows:

Public Health England		
Community Mental Health Profile Indicator	Lincolnshire West CCG	South West Lincolnshire CCG
Recorded prevalence of depression	9%	7.5%
Depression incidence (new)	1.4%	1.2%
Depression and anxiety prevalence	12.4%	11%
Mental health problems	0.9%	0.62%
Reporting of a long term mental health problem	5%	4.5%

These figures indicate that the prevalence of both depression and anxiety is relatively low, which is positive. However these figures would not reflect the number of people with depression who are not being treated by a clinician. The prevalence could be much higher.

Wellbeing is about people feeling good and getting the most out of life. In North Kesteven the term flourishing is often used as a descriptor for wellbeing as the District Council's vision is to create flourishing communities.

In its simplest sense, an individual who is flourishing is often described as experiencing higher levels of wellbeing. As well as feeling satisfied and happy, wellbeing also means developing as a person, being fulfilled and importantly, making a contribution to the community. The District Council is in the process of defining a flourishing scale which will also be a useful tool in future for contributing to an assessment of health and wellbeing.

4 Specific impacts on health and wellbeing

Social isolation and loneliness

Social isolation is characterised by an absence of social interactions, social support structures and engagement with wider community activities or structures. Loneliness describes an individual's personal, subjective sense of lacking connection and contact with social interactions to the extent that they are wanted or needed.

The rural nature of North Kesteven coupled with the ageing demographic and infrequency of public transport means that the propensity for residents to experience social isolation and loneliness is much greater.

Whilst in the past, loneliness was sometimes viewed as a trivial matter, it is increasingly understood to be a serious condition which can affect a person's mental and physical health detrimentally. There is very strong evidence that loneliness can increase the pressure on a wide range of council and health services. It can be the tipping point for referral to adult social care and can be the cause of a significant number of attendances at GP surgeries. Loneliness can increase the risk of premature death by 30%. Local authorities are being urged to consider "addressing loneliness" as an outcome measure in local strategies, and work with partners to define the local issue of loneliness, and to create practical solutions to overcome it.

4 Specific impacts on health and wellbeing

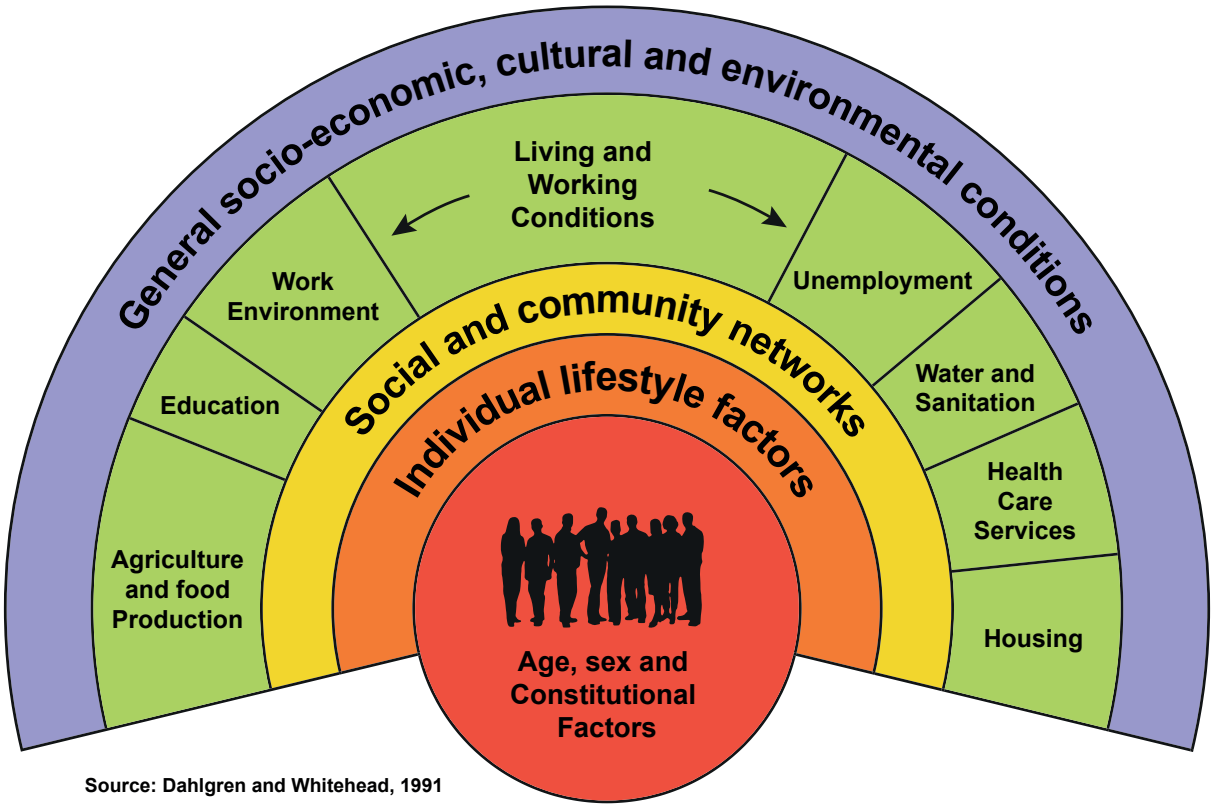
Social determinants of heath

There are many different factors that combine together to affect health and wellbeing. Whether people are healthy or not is to a greater extent determined by their circumstances and environment. Factors such as where we live, the state of our environment, genetics, our income and education level, and our relationships with friends and family all have considerable impacts on health, whereas the more commonly considered factors such as access and use of health care services often have less of an impact.

The social health factors have been explored by researchers using several models, but the most widely used is the Dahlgren-Whitehead 'rainbow model'.

The model maps the relationship between the individual, their environment and health. Individuals are placed at the centre, and surrounding them are the various layers of influences on health – such as individual lifestyle factors, community influences, living and working conditions, and more general social conditions.

The Dahlgren-Whitehead Rainbow



Source: Dahlgren and Whitehead, 1991

The role the District Council plays in influencing the social determinants of health ranges greatly, from providing decent homes, to supporting the local economy, providing access to leisure, sport and cultural activities, determining planning applications and collecting waste.

5 Key priorities

When the first health and wellbeing strategy was published in 2013, the principal areas of concern for North Kesteven were: smoking in pregnancy, childhood obesity, adult obesity, diabetes and road injuries and deaths.

In 2016, the principal areas of concern are still adult obesity, diabetes and road injuries and deaths, but as we take more of a lean towards wellbeing, should also include the impact on mental health and wellbeing of isolation and the risks associated with loneliness. Smoking during pregnancy is no longer a great concern as significant progress has been made thanks to an effective smoking cessation programme.

It is not possible to track the direction of travel on the indicators that are used in the District Health Profile more than three or so years at a time as the way in which data is collected changes frequently. However, the one indicator that can be compared is the one for recorded diabetes as this has been collected consistently from GP registers.

Taking into account the variability of data to support every likely priority and subsequently the need to rely on anecdotal evidence, the following priorities have been identified:

1 **Promoting healthier lifestyles**

2 **Improving the health and wellbeing of older people**

3 **The social determinants of health**

The first and third priorities are purposefully not age specific as each is relevant - in different measures - to every age group.

6 Existing arrangements and architecture that supports health and wellbeing

There are plans, strategies, boards, groups and partnerships on a local, county and national level that play a part in guiding the commissioning of services that have an impact on health and wellbeing.

The plans and strategies include:

The NHS Five year Forward View, 2014 - 2019
The Sport England Strategy 2016 - 2021: Towards an Active Nation
Lincolnshire's Joint Health and Wellbeing Strategy, 2013 - 2018
Lincolnshire's Sustainability and Transformation Plan, 2016
Clinical Commissioning Group Operating Plans, 2016
North Kesteven's Corporate Plan, 2016
North Kesteven's Community Plan, 2016 - 2021
North Kesteven's Sport and Physical Activity Strategy, 2016 - 2021
Lincolnshire Financial Inclusion Strategy, 2013 - 2016
Central Lincolnshire Local Plan, 2016 - 2036
Central Lincolnshire Housing Growth Strategy, 2016
Greater Lincolnshire Local Enterprise Partnership, Strategic Economic Plan, 2016

The boards, groups, partnerships and other initiatives include:

The Lincolnshire Health and Wellbeing Board (HWBB) is a forum which brings together key leaders from the health, public health and care systems to work together to improve the health and wellbeing of the people of Lincolnshire and reduce health inequalities. The HWBB is responsible for producing the Joint Strategic Needs Assessment, the Pharmaceutical Needs Assessment and the Joint Health and Wellbeing Strategy.

The Lincolnshire Health and Care Programme (LHAC) promises a fundamental restructure of health and social care in Lincolnshire. Focused on reducing costs and improving services, LHAC includes establishing neighbourhood teams, with a focus on self-care and the prevention of ill health. The work undertaken through LHAC has provided the foundations for Lincolnshire's NHS Sustainability and Transformation Plan (STP) which will be key to taking health care services forward over the next few years. The aim of the STP is: to achieve really good health for the people of Lincolnshire with support from an excellent and accessible health and care service delivered within the financial allocation.

Whole Systems Obesity Pilot: North Kesteven District Council is a Pilot Local Authority in the Public Health England Whole Systems Obesity three year programme. The key aim of the programme is to co-produce and pilot a framework of practical innovative tools to support and sustain whole system approaches to tackle obesity at a local level looking forward to a five, 10 and 15 year horizon; drawing on national and international evidence, learning and practise.

The District Council Health and Wellbeing Network: was established in 2013 to enable the flow of information from all seven district councils to the Health and Wellbeing Board through the sole district council representative. The group is also a conduit for information that supports theme five of the county, Joint Health and Wellbeing Strategy and Tackling The Social Determinants of Health.

Partnership NK: North Kesteven has a well-established partnership framework that encourages collaboration on projects across the District. This partnership plays a principal role in guiding, delivering and overseeing projects that meet health and wellbeing objectives through its Our Communities action group.

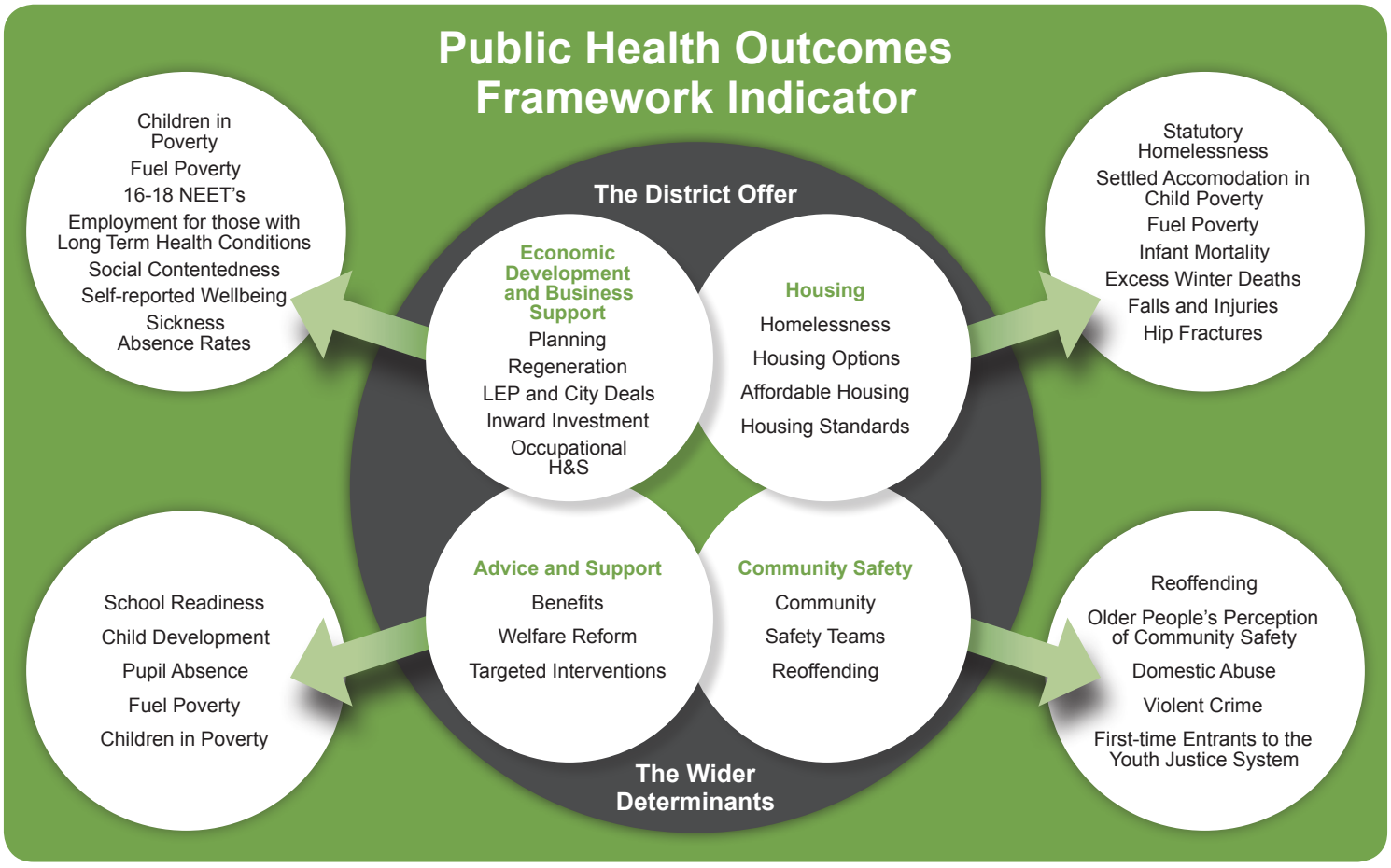
Lincolnshire Health Improvement Partnership: a new partnership headed up by the public health team that aims to join up activity, share best practise and influence the future commissioning of services.

7 District Council's influence on health and wellbeing

There are many different ways that North Kesteven District Council can contribute to its residents' health and wellbeing, including to:

- Promote and support sustainable economic growth and employment,
- Facilitate collaborative partnership work to support communities,
- Increase the supply of decent affordable homes,
- Prevent homelessness wherever possible,
- Encourage safer communities and reduce the fear of crime, and
- Provide access to excellent cultural and leisure services.

The Public Health Outcomes Framework Indicator diagram – taken from the District Council Network's publication 'District Action on Public Health' - sets out how these concepts interlink and impact on health and wellbeing in general. The inner circles set out the priority services provided by District Councils and how they may impact on public health outcomes.



In two-tier areas, like Lincolnshire, districts are the key stakeholders in improving the wider determinants. From economic development to housing and occupational health and safety, districts have a fundamental impact on shaping communities and enabling residents to lead fulfilling, healthy lives.

8 Action Plan

In order to achieve the aims of this strategy, a series of objectives have been identified for each of the priorities. Each of these objectives can only be achieved by working in collaboration with other service deliverers from across the District.

Priority: Promoting healthier lifestyles

Objectives:

- To improve coordination of health and wellbeing activities across the District and link to national campaigns to encourage healthier lifestyles
- To reduce the number of adults and young people who are overweight or obese
- To reduce the number of adults developing Type 2 Diabetes
- To support people to eat well and be more active, more often
- To increase the use of green space for exercise and leisure
- To embed Make Every Contact Count and One You, the lifestyle support programme.

Priority: Improving the health and wellbeing of older people

Objectives:

- To improve coordination of functions and services that support older people
- To enable older people to remain independent for as long as possible
- To tackle social isolation for older people in rural communities
- To tackle loneliness experienced by disengaged older people
- To work together better to meet the needs of our ageing population
- To encourage age friendly and Dementia friendly towns and villages

Priority: The social determinants of health

Objectives:

- To drive and influence the delivery of improved health care services in the District
- To reduce the number of people in fuel poverty
- To support the development of homes to meet need
- To work in partnership to create opportunities for young people to gain employment
- To provide support to communities to enable them to flourish

The objectives listed in this action plan give an indication of the activities that will be carried out for each of the three priorities. Further details will be included in the Our Communities Partnership Action Plan which is updated annually.

9 Monitoring and Evaluation

North Kesteven has an existing performance management system that will be used to monitor the performance of actions defined in this strategy.

Partnership NK's Our Communities Action Group will take responsibility for the monitoring and evaluation of objectives outlined in this strategy. This group includes representatives from several different organisations that have a direct involvement in delivering health and wellbeing activities in North Kesteven, and will provide a direct link to wider partnership arrangements. The group meets quarterly and will continually review progress and report back accordingly. If required, separate interventions will be put in place to ensure objectives are achieved.

10 References and sources

The following documents and online resources have been used to write this strategy:

- Association of Public Health Observatories, North Kesteven Health Profile (2008 - 2016)
- Department of Health, Healthy Lives, Healthy People: A call to action on obesity in England, (2011)
- Department of Health, No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages, (2011)
- District Councils' Network, District Action on Public Health, (2012)
- Lincolnshire NHS, Lincolnshire County Council, Joint Health and Wellbeing Strategy for Lincolnshire 2013-2018, (2012)
- Lincolnshire Research Observatory, Lincolnshire Joint Strategic Needs Assessment
- Public Health England: https://fingertips.phe.org.uk
- Local Government Association, National Child Measurement Programme, (2013, 2015)
- Office for National Statistics, 2011 Census: Data for North Kesteven, (2012)
- Professor Sir Michael Marmot, the Strategic Review of Health Inequalities in England post-
- 2010,'Fair Society Healthy Lives' (The Marmot Review), (2010)
- The Kings Fund, Transforming the delivery of health and social care, (2012)
- Making health everybody's business, Professor Kevin Fenton, National Director Public Health England, (2013)
- Better conversation, better health, health coaching, The Health Coaching Coalition, (2016)
- Bid to improve health care through 'better conversation', Yorkshire and Humber Academic Health Science Network, (2016)
- NHS Five Year Forward View, 2014 – 2019 (2014)
- Lincolnshire Health and Care, Case for Change (2016)

partnershipnk
working together in North Kesteven

districtnk
North Kesteven District Council

Telephone: (01529) 414155 **www.n-kesteven.gov.uk**

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Lincolnshire COUNTY COUNCIL
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LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of ACTion Lincs Partnership

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**7 March 2017**
Subject:	**'ACTion Lincs' - Tackling Entrenched Rough Sleeping in Lincolnshire (Social Impact Bond Funding)**

Summary:

In 2016, the Department for Communities and Local Government (DCLG) made £10m outcomes funding available to enable local commissioning of Social Impact Bonds (SIB) in order to support the most entrenched rough sleepers by helping them into accommodation and to address their other needs through intensive and tailored support, as well as enabling an integrated strategic approach to tackling rough sleeping. A collaboration of Lincolnshire organisations recently submitted a successful bid for £1.3m. Lincolnshire is one of eight successful SIB areas across the country.

This report is for information and provides the HWB will an overview of the project in Lincolnshire.

Actions Required:

The Health & Wellbeing Board is asked to note the content of this report.

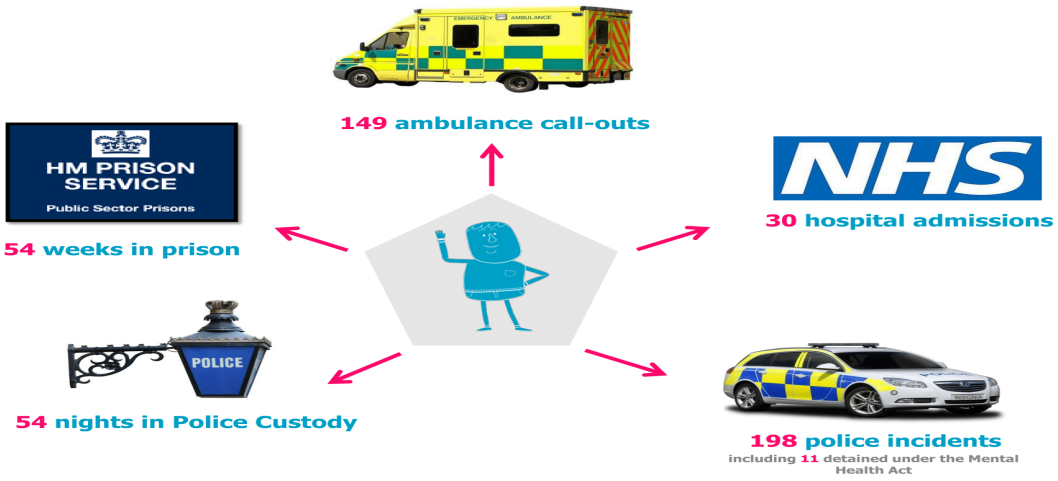
1. Background

Context

Rough sleeping continues to increase nationally, regionally and locally. Rough sleeping in Lincolnshire continues to rise despite the success of the street outreach service which has supported over 250 people to exit the streets. Across Lincolnshire there has been an increase in rough sleeping as a result of evictions, difficulties in accessing affordable housing and through barriers to accessing mainstream housing, health and support services.

It is increasingly difficult to meet the needs of the most vulnerable, complex individuals within existing services and systems and through traditional methods of engagement. There are no specific services for those with the most complex needs.

Improving outcomes for entrenched rough sleepers will have a positive impact across housing, health & criminal justice services. The cost to the public purse (health & criminal justice) of just one entrenched rough sleeper in Lincolnshire over a four year period has been calculated as £215,000.

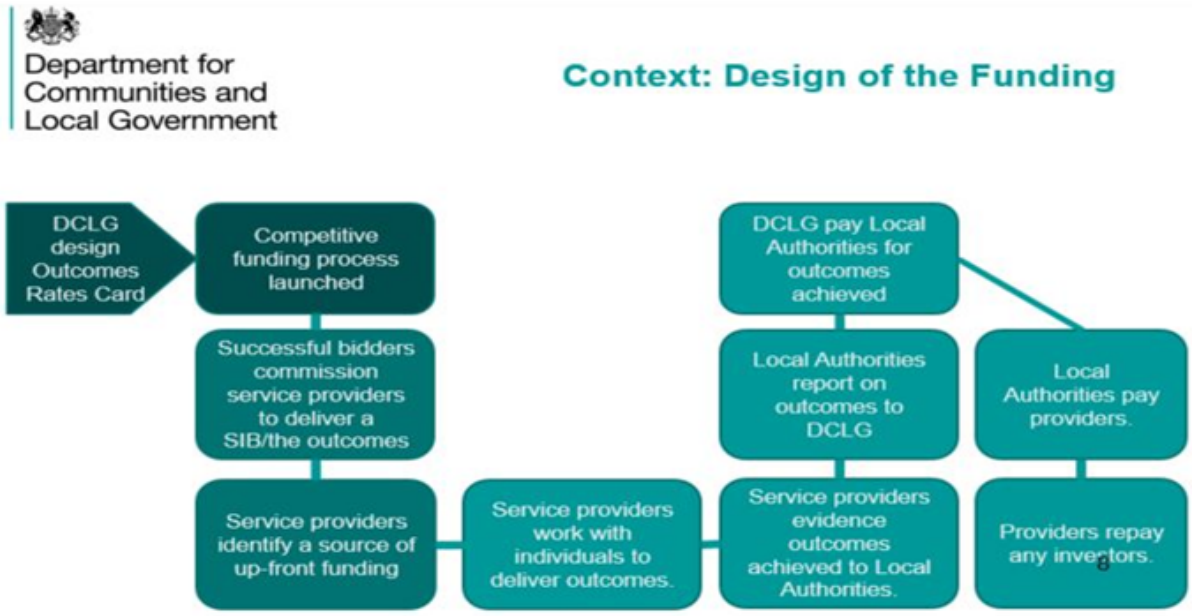


Collaborative work on homelessness is well established across Lincolnshire. It is based on the strength of this collaborative approach and opportunity to build on existing provision and evidence base that Lincolnshire was able to present a strong and successful application for Social Impact Bond funding.

Overview of Social Impact Bond Funding Model

Through its 2016 homelessness prevention programme in 2016, DCLG made £10m outcomes funding available to enable local commissioning of Social Impact Bonds to support the most entrenched rough sleepers by helping them into accommodation and to address their other needs through intensive and tailored support, as well as enabling an integrated strategic approach to tackling rough sleeping. Preference was given to multi-agency partnerships from across the wider public sector and, where appropriate, across geographical boundaries to develop a genuinely integrated approach to tackling rough sleeping that takes account of the multiple, complex and diverse needs of this vulnerable client group.

The Social Impact Bond outcomes funding model is set out below. Lincolnshire County Council (LCC) will act as commissioner for the ACTion Lincs project. A provider has already been secured through approval for the existing LCC contract with P3 to be varied to incorporate this project. It will be the responsibility of the provider to secure social investment.



Evidencing the need for a different approach to tackle entrenched rough sleeping in Lincolnshire

An analysis of Lincolnshire's street outreach service data (July 2015 – October 2016) showed that:

- 540 individuals seen rough sleeping at least once
- 156 different individuals seen rough sleeping six or more times and/or seen rough sleeping less than six times but known to homelessness services for more than three years. Of these 156:-

    - 55% (86) accommodated at least once but returned to the streets
    - 91% (142) have support needs around substance misuse
    - 83% (129) have an offending history
    - 30% (47) have support needs around mental health *
    - 8% (12) have a schizophrenia diagnosis (4 detained in hospital directly from the streets)
    - 17% (26) have long term physical health conditions *
    - 6 confirmed as deceased (a further 3 are believed to have died but weren't known to services at the time of their death)

    ** Likely to be higher, however; difficulties accessing services*

Current barriers to tackling entrenched rough sleeping in Lincolnshire

- *Housing related support model* – Current supported accommodation services rely on individuals being able to fit into a structured model of support. The model is transitional in nature, providing 'generic', time limited support, for up to nine months. Traditionally, this client group have been unable to progress through this into their own accommodation. Clients are considered too 'high risk' and being declined/evicted from services due to them not being able to manage risk because of communal facilities and high support needs.

- *Street Outreach Team* – Contracted to deliver brief interventions supporting people off the streets into accommodation. Restrictions include lack of specialist roles and limited capacity to deliver intensive, longer term support.

- *Mental health services exist, but are inflexible to the needs of entrenched rough sleepers:* Entry into services, unless detained under the Mental Health Act, is via GP referral or A&E presentation. Currently, there is no service that assertively engages in a community setting unless there is a statutory duty for aftercare. Individuals are reaching crisis point before interventions are offered. Sporadic client engagement leads to discharge when support is needed the most.

- *Substance misuse services* exist, but current support offered by single provider at limited locations/times.

- *Inflexibility from GPs* **-** Appointments not offered in advance. Patients have to call at 8 a.m. on the day. Appointments offered on a first come first serve basis.

- *No formal Hospital/Prison discharge pathways* – Individuals are revolving between homelessness, Prison and Hospital.

- *Adult social care* – A need to move to a consistent assessment timescale for both physical and mental health needs *(note: this has now been addressed)*

Overview: the ACTion Lincs Project:

Referral & Cohort Identification: Eligibility criteria for the project is defined by the DCLG parameters for the bid:

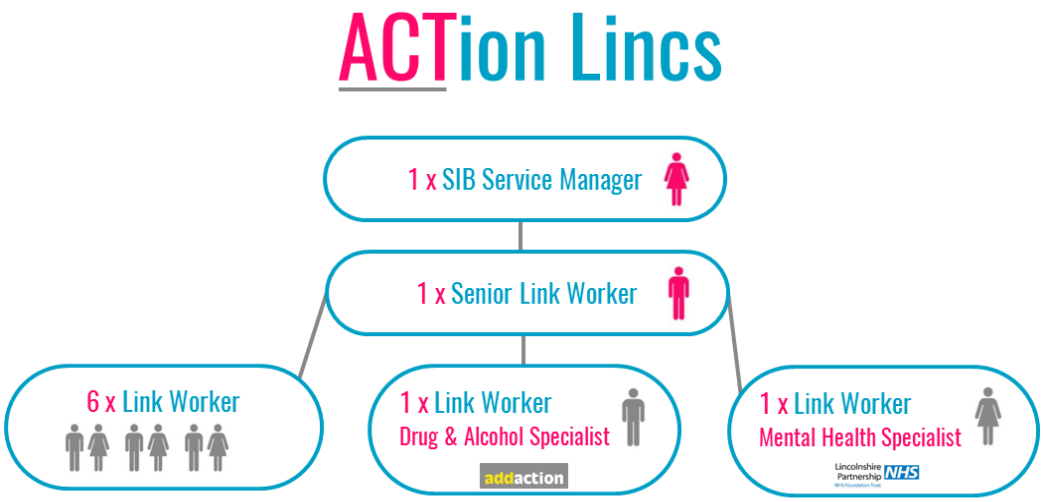
- Aged over 18, and;
- Single or not living with their family and;
- Not pregnant and without dependent children, and;
- Homeless as defined in the homelessness legislation,
- A history of rough sleeping (seen rough sleeping at least six times over the last two years), and
- Has at least two other complex needs, including but not necessarily limited to:

    - Substance misuse or
    - A history of offending (five+ offences in the last five years or one offence in the last year)
    - A history of anti-social behaviour
    - Mental health problems (including self-reported)
    - A history of rough sleeping (seen rough sleeping at least six times over the last two years), and;

- Are currently not being adequately or effectively supported through existing service provision.

Initially, to identify the cohort, data from 'The Avenue' will be matched against eligibility criteria to determine access to the service. Referrals from other partners will be accepted.

Operational Delivery: ACTion Lincs will support approximately 120 individuals for a four year period. Delivered by a co-located **A**ssertive **C**ommunity **T**eam' (ACT), the service will comprise of eight 'Link Workers', two of whom will be specialists seconded from Lincolnshire Partnership NHS Foundation Trust (LPFT) and Addaction bringing specialist knowledge, streamlined treatment pathways and a critical link back into those services.



Support will be provided in any setting and at any time, focussing on understanding and meeting the needs and aspirations of individuals within the cohort, and linking them with local services through innovative, personalised solutions for clients working outside of traditional methods of engagement

Accommodation is a key factor in the success of the model. Accommodation will be sourced through a number of means based on individual need, stock availability and suitability.

Collaboration, Governance and Oversight: A multi-agency steering group will be developed to:

- Provide strategic direction and engage stakeholders and local commissioners.
- Ensure that the project integrates and complements existing services.
- Ensure effective, efficient communication with partners and relevant strategic forums.
- Ensure fair, equitable and co-ordinated access to the service.
- Play an active role in overcoming barriers to enabling change for the cohort.
- Ensure alternative services are offered for those that do not meet the thresholds for this service.
- Use evidence from the project to inform prevention activity (housing, health, criminal justice) and future commissioning opportunities.

Integration and Strategic Fit

Countywide Approach to Tackling Homelessness

- Well established countywide strategic partnerships (Lincolnshire Homelessness Strategy Group and, at a senior level, the District Housing Network (DHN)) consisting of statutory and voluntary sector partners with a shared approach to preventing homelessness.
- Countywide homelessness strategy (Since 2002) with rough sleeping as a main priority since 2012.
- LCC have maintained investment in housing related support provision.

Health

- The partnership will build upon national statutory requirements such as The Care Act (2014) which now makes a requirement for closer co-operation between health, care and services that address the wider determinants of health, including housing, to deliver whole systems, outcomes based support to meet individual needs.

- Housing identified as a key priority for Lincolnshire in the Joint Health and Wellbeing Strategy 2013 - 2018. The Lincolnshire Health and Wellbeing Board (HWBB) is one of only 12 (out of 150) across the country to have identified it as such.

- Engagement with Joint Strategic Needs Assessment as the evidence base to understand the issues regarding Housing and Health and future commissioning options.

- Opportunity to demonstrate impact on local ambitions related to hospital admissions/discharges, subsumed within the local Better Care Fund (BCF). Potential for future financial support via the BCF.

Criminal Justice

Complements the Police & Crime Commissioners 'Safer Together' objectives:

- Create a coherent approach to managing offenders released from prison to maximise the chance of rehabilitation and reduce re-offending, joining up probation, health, housing, skills and employment interventions

Community Safety Partnership focuses on reducing offending through:

- Improving housing options & outcomes for offenders.
- Reducing rough sleeping.
- Integrated approach to supporting prolific offenders who are homeless.

Safeguarding

Complements Lincolnshire Safeguarding Adults Board (LSAB) ambition to 'make safeguarding personal':

- Many entrenched rough sleepers have health and care needs which are not being met, exposing them to significant risk of abuse/harm and self-neglect.

- The LSAB, underpinned by the Care Act, presents an opportunity to overcome barriers to safeguarding rough sleepers, ensuring strong links with safeguarding adults systems.

Genuine Partnership Collaboration

The strength of this bid was the genuine partnership collaboration behind it. It was readily acknowledged that improving outcomes for entrenched rough sleepers will have a positive impact across housing, health & criminal justice services. All partners demonstrated a common approach and shared vision to support those most vulnerable from rough sleeping, not only to develop a 'project' but to use it as an opportunity for longer term systems change and service transformation.

Lincolnshire County Council will act as commissioner for the SIB. P3 are a current provider of LCC's 'Countywide Floating Support and Rough Sleeper Outreach Service'. Legal agreement has been obtained for LCC to secure P3 as the SIB provider through a variation of the existing street outreach service contract.

2. Conclusion

Key partners involved in the development of the bid are currently working together to develop a mobilisation and communications plan. We also continue to liaise closely with DCLG colleagues and other successful Social Impact Bond areas[1].

3. Consultation:

Not applicable to this report.

4. Appendices

None

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 Michelle Howard, West Lindsey District Council who can be contacted on 01427 676609 or michelle.howard@west-lindsey.gov.uk

[1] Other successful SIB areas: Bristol, Kent, East Sussex, Gloucestershire, Newcastle, Greater Manchester, Greater London

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Lincolnshire COUNTY COUNCIL
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LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of Glen Garrod, Executive Director of Adult Care & Community Wellbeing

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**7 March 2017**
Subject:	**Government Proposals for the Future Funding of Supported Housing**

Summary:
Supported and sheltered housing enables tens of thousands of people across the country, including the elderly, homeless and those living with disabilities, to live independently and help get their lives back on track. Stable funding for these vital support services reduces pressure on more costly public services, such as the NHS and social care, saving the taxpayer an estimated £3.5bn per year.

In September 2016, the Department for Work and Pensions (DWP) and the Department for Communities and Local Government (DCLG) outlined proposals to change the way supported housing is funded. A consultation by the Government ended on 13 February 2017. The aim is to have a new system in place by April 2019.

Actions Required:
The Committee is asked to note this report as an information item.

1. Background

Lincolnshire County Council currently commissions a range of supported housing services across Adult Care and Community Wellbeing including:

- Extra care schemes;
- Refuges for people at risk of domestic abuse;
- Emergency accommodation for homeless singles;
- Crisis housing for people with mental health problems.

All of the services above will be impacted by the proposed funding changes.

LCC approached the response of a formal submission by:

- Officers working collectively to co-ordinate a LCC wide response;
- Early identification of risks and the possible impact of the proposals;
- Informing providers of the consultation to ensure they had the opportunity to contribute;
- Achieving an appetite for Lincolnshire to be a shadow pilot site.

.

A consultation ran for 12 weeks and ended on 13 February 2017. A Green Paper on the detailed arrangements for the local top-up model and approach to short-term accommodation will follow in the spring.

2. Conclusion

It is expected there will be a large, strong response from across the country by a range of organisations on this complex service area.

The Communities and Public Safety Scrutiny Committee received this presentation on 25 January 2017 and fully supported officers' approach to the consultation response.

This item is presented to the Health and Wellbeing Board for information purposes. It is a high profile topic and will have a big impact on residents of Lincolnshire.

3. Consultation

Not applicable

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Funding For Supported Housing - DCLG/DWP Consultation
Appendix B	Learning Disability England: Changes to Supported Housing – What do you Think?
Appendix C	Funding for Supported Housing Consultation - Lincolnshire County Council Response

5. Background Papers

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

This report was written by Lisa Loy, Housing for Independence Manager who can be contacted on 01522 554697 or lisa.loy@lincolnshire.gov.uk

Department for Communities and Local Government

Department for Work & Pensions

Funding for Supported Housing

Consultation

November 2016
Department for Communities and Local Government
Department for Work and Pensions

This document/publication is also available on our website at www.gov.uk/dclg

If you have any enquiries regarding this document/publication, complete the form at http://forms.communities.gov.uk/ or write to us at:

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November 2016

ISBN: 978-1-4098-4942-1

Contents

Scope of the consultation

Topic of this consultation:	This consultation seeks views on the design of the Government's new housing costs funding model for supported housing, as well as views on how funding for emergency and short term placements should work. It covers the following areas: 1. Devolved top-up funding to local authorities in England; and 2. Funding for emergency and short term supported housing placements across Great Britain.
Scope of this consultation:	Housing costs funding for supported housing.
Geographical scope:	This consultation seeks views on arrangements for funding the additional housing costs associated with providing supported housing in England, and on funding for emergency and short term placements across Great Britain.
Impact Assessment:	Not needed at this stage.

Basic Information

To:	This consultation is aimed at supported housing commissioners and providers, developers and investors, residents and those who represent their views.
Body/bodies responsible for the consultation:	The Secretary of State for Communities and Local Government and Secretary of State for Work and Pensions.
Duration:	This consultation will last for 12 weeks from 21 November (closing on Monday 13 February 2017).
Enquiries:	For any enquiries about the consultation please contact: supportedhousing@communities.gsi.gov.uk
How to respond:	You may respond by emailing your response to the questions in this consultation to: supportedhousing@communities.gsi.gov.uk Please title the email: "Supported housing consultation response". If you are responding in writing, please make it clear which questions you are responding to.

	Written responses should be sent to: Department for Communities and Local Government Supported Housing Programme Fry Building 3rd Floor 2 Marsham Street London SW1P 4DF When you reply it would be very useful if you confirm whether you are replying as an individual or submitting an official response on behalf of an organisation and include: - your name, - your position (if applicable), - the name of organisation (if applicable), - an address (including post-code), - an email address, - a contact telephone number, and - if you are responding about arrangements for short term accommodation whether you are responding with regards to England, Scotland or Wales.

Introduction

1. One of the Government's key commitments is to protect the most vulnerable. Supported housing helps to underpin this obligation and supports hundreds of thousands of the most vulnerable people across the country. From helping those with learning disabilities to providing older people with support needs with somewhere to live that can meet their changing needs as they age, crisis accommodation for people fleeing domestic abuse or emergency places for rough sleepers, help for those recovering from drug or alcohol dependency, or support to vulnerable young people such as care leavers to get the help they need to move on and get a job and to live independently.

2. The Government is committed to protecting and boosting the supply of supported housing and ensuring it provides value for money and works for those who use it as well as those who pay for it. Over the past months, we have talked extensively to supported housing commissioners, providers, and developers as well as representatives of supported housing residents about what a workable and sustainable funding model for the sector should look like.

3. Two things are absolutely clear. Firstly, doing nothing is not an option. Universal Credit is being rolled out to working age claimants across Great Britain and is an important reform to improve work incentives and enhance simplicity for claimants. In this context, we need to consider how best to fund the supported housing sector to cater for its specific needs and circumstances. Secondly, it is absolutely critical that we get the detail right to ensure we deliver a funding model that is flexible enough to reflect the diversity of the sector and meets the needs of individual tenants, providers and commissioners. In particular, we recognise the vital importance of ensuring that providers are able to develop new, much needed, supported housing and we want the long-term funding model to support this. As part of this reform we also want to increase the role that quality, individual outcomes and value for money play in the funding model.

4. That is why we have confirmed to Parliament in a Written Ministerial Statement that we will defer the application of the Local Housing Allowance (LHA) rates to supported housing until 2019/20.[1] From 1 April 2019, we will bring in a new funding model which will ensure that supported housing continues to be funded at the same level it would have otherwise been in 2019/20, taking account of our plans on social rents.

[1] Written Ministerial Statement (15 September 2016): http://www.parliament.uk/business/publications/written-questions-answers-statements/written-statement/Commons/2016-09-15/HCWS154/

5. The new model will mean that core rent and service charges will be funded through Universal Credit (or Housing Benefit for pensioners and where Universal Credit has yet to be fully rolled out) up to the level of the applicable LHA rate. Local authorities are best placed to make decisions about how to support vulnerable people in their areas and to commission the supported housing services that are needed locally. The new model will devolve funding to local authorities in England to provide a 'top-up' where necessary to providers, reflecting the often higher costs of offering supported housing. We recognise a different approach may be needed for short term accommodation, including hostels and refuges, but this type of accommodation will benefit from the same protection as supported housing in general.

6. In England, this will give local authorities an enhanced role in commissioning supported housing in their area. This will also allow local authorities to take a more coherent approach to commissioning for needs across housing, health and social care. Better local knowledge will help drive transparency, quality and value for money from providers in their area.

7. We want to continue the conversation we have begun with the supported housing sector and work with them to develop the detail for the new model. This document begins the consultation process alongside a programme of task and finish groups working with the sector on key design components of the model and designing a new approach for short term accommodation. We will also work with local authorities and other partners to determine how funding should be distributed among individual local authorities.

8. While the framework for the new funding model has been set, this consultation seeks views on key system design elements to ensure the model will work for tenants, commissioners, providers and developers.

9. Across the United Kingdom, core rent and service charges will continue to be funded through Universal Credit (or Housing Benefit for pensioners or where Universal Credit has yet to be fully rolled out) up to the level of the applicable LHA rate. The Scottish Government and Welsh Government have devolved responsibility for housing policy and already determine their own priorities in relation to supported housing. Alongside the transition to a new funding model in England, the UK Government will therefore also ensure that the devolved administrations receive a level of funding in 2019/20 equivalent to that which would otherwise have been available through the welfare system in order to meet the additional costs of supported housing.

10. This consultation will run for 12 weeks until 13 February 2017. There will then be a Green Paper on the detailed arrangements for the local top-up model and approach to short term accommodation in the spring. A final package will be announced in autumn 2017 to allow time for transitional arrangements and any necessary legislation to be made ahead of the new model commencing on 1 April 2019. We propose to put shadow arrangements on the detail and allocation of funding in place from April 2018 to allow full transition to a new model.

11. While designing the mechanics of a new funding model is important to provide certainty for service users, commissioners, providers and developers, the

Government views this as the start of a longer term process in England. During this consultation process we want to work with the sector to consider wider strategic goals such as responding to growing future demand for support to maintain people's independence as well as looking for opportunities for service transformation, for example, to strengthen links across public service commissioning, including health, housing, social care and criminal justice. We are also keen to explore with the private, social and public sector the potential for alternative finance and delivery models for increasing supported housing supply through the use of social investments. We will set out any conclusions on these broader considerations in the Green Paper next spring.

1. Supporting people to live independently

Who needs support?

12. Supported housing plays a crucial role in supporting hundreds of thousands of the most vulnerable people. The Supported Accommodation Evidence Review, published alongside this consultation, suggests up to 716,000 people were using supported housing across Great Britain at any given point in time at the end of 2015.[2]

13. Providing a safe, stable and supportive place to live can be the key to unlocking better outcomes for vulnerable people, from tackling poverty and disadvantage to managing crises, rehabilitation or maintaining people's independence. For many, it is a stepping stone to independent living in the longer term. For some, it is vital life-long support that helps them to live independently in the community.

14. The types of people in supported housing include:

- Older people with support needs;
- People at risk of or recovering from homelessness;
- People with learning disabilities;
- People with mental health problems;
- People with physical or sensory disabilities;
- People with drug or alcohol problems;
- People experiencing or at risk of domestic abuse;
- Vulnerable young people (such as care leavers or teenage parents);
- Ex-offenders;
- Vulnerable armed forces veterans; and
- Others (such as refugees with support needs).

What is supported housing?

15. Supported housing is any housing scheme where housing is provided alongside care, support or supervision to help people live as independently as possible in the community. It covers a range of different housing types, including hostels, refuges, supported living complexes, extra care schemes and sheltered housing. Supported housing can provide long term support for years for some vulnerable groups such as

[2] Supported Accommodation Review: the scale, scope and cost of the supported housing sector (2016), see: https://www.gov.uk/government/publications/supported-accommodation-review

older people and disabled people or very short term immediate emergency help for when people are in times of crisis, such as use of hostels and refuges.

16. Accommodation is predominantly provided by social landlords, including housing associations and local authorities, as well as charitable and voluntary organisations. Housing associations provide over 70 percent of supported housing units in Great Britain. Some private sector "for profit" organisations also provide supported housing, both as landlords and/or support providers.

17. The Supported Accommodation Evidence Review provides a national level snapshot estimate of the size and composition of the sector at the end of 2015. It suggests there were approximately 651,500 supported housing units in Great Britain. The majority in England (85%), with nine percent in Scotland and six percent in Wales.

18. We use a broad umbrella term 'supported housing' to cover both supported housing in general and sheltered housing for older people. This consultation considers both types of provision and both working and pension age residents. Also covered are the two complementary definitions used in the benefits system, Supported Exempt Accommodation[3] and Specified Accommodation.[4]

Why supported housing is important

19. Supported housing provides vital support to some of our country's most vulnerable people. It helps many people to lead independent lives or turn their lives around and is a vital service for a country that works for all. It is also an investment which brings savings to other parts of the public sector, such as health and social care and underpins a range of policy objectives across Government including:

- **Supporting vulnerable people:** such as frail, older people and disabled people, people with mental health problems, and vulnerable ex-service veterans;
- **Tackling homelessness:** preventing homelessness in the first place and helping people recover and move on from homelessness;

[3] Supported Exempt Accommodation is defined as being either: a resettlement place; or accommodation which is provided by a county council, housing association, registered charity or voluntary organisation where that body, or person acting on their behalf, provides the claimant with care, support or supervision.

[4] Specified Accommodation includes supported exempt accommodation, and adds three more categories: (i) Managed properties, which includes supported housing which would meet the definition of supported exempt accommodation but for the care support or supervision being provided by someone other than the landlord; (ii) Refuges provided for someone who has left their home as a result of domestic violence; and (iii) Hostels, including hostels provided by local authorities where care, support of supervision is provided. People living in specified accommodation are eligible to continue to receive Housing Benefit in respect of their housing costs, even where they claim Universal Credit, and the housing support paid through Housing Benefit does not count towards the Benefit Cap.

- **Providing refuge:** through crisis and follow-on accommodation and support services for those fleeing domestic abuse;
- **Tackling poverty and disadvantage:** such as helping people with learning disabilities or vulnerable young people, including care leavers', transition to independent living;
- **Recovery:** such as support and treatment for those with drug and or alcohol problems or helping ex-offenders to integrate back into the community; and
- **Improving public health and supporting the health and care system:** by helping older people or people with disabilities to lead healthy and independent lives keeping them out of acute health settings and residential care or smoothing their discharge from hospital.

20. DCLG analysis, based on the Frontier Economics report for the Homes and Communities Agency on Specialist Housing in 2010, estimates that the net fiscal benefit of providing supported housing is £3.53 billion per year.[5]

The Government's commitment to supported housing

21. The Government has a strong track record in protecting individuals living in the supported housing sector. For example, the Housing Benefit paid in respect of most types of supported housing is not taken into account for Benefit Cap purposes. While work has been ongoing to align the funding approach to supported housing and Universal Credit, temporary provision has been made to allow claimants living in supported housing to continue to receive Housing Benefit for their housing costs alongside Universal Credit for their other living costs.

22. The Government also has a strong track record of boosting supply of supported housing. Between 2011 and 2015 the Government delivered over 18,000 new supported homes across England.

23. At the Spending Review we committed £400 million to deliver a further 8,000 supported housing units through the Department for Communities and Local Government's Shared Ownership and Affordable Homes Programme. In addition, the Department of Health's Care and Support Specialised Housing (CASSH) fund was launched in 2012 with over £200 million being invested to build over 6,000 supported homes over the next few years.

24. The Department of Health has also recently launched a £25 million Capital Fund for Housing and Technology for People with Learning Disabilities. A further £40 million was invested in the Homelessness Change/Platform for Life programme to upgrade

[5] Frontier Economics (2010) Financial benefits of investment in specialist housing for vulnerable and older people, see: https://www.frontier-economics.com/documents/2014/06/financial-benefits-of-investment-frontier-report.pdf

homeless hostels and improve health facilities. We are also fully committed to ensuring that no victim of domestic abuse is turned away from the support they need, as reaffirmed in the strategy to end Violence Against Women and Girls (VAWG) published in March. As part of this we have committed £80 million of extra funding up to 2020 to tackle violence against women and girls, including funding for securing the future of refuges and other accommodation based services. As part of this, a £20 million fund was launched on 3 November for local authorities to bid to increase refuge spaces and other accommodation for women fleeing domestic violence.[6]

Current delivery and costs

25. Supported housing is enormously diverse, with provider type, scheme characteristics and delivery models and commissioning structures varying across Great Britain.

26. The Government recognises that supported housing costs can often be higher than mainstream housing for a variety of reasons. This includes higher maintenance, repairs and rates of turnover and the specific needs and characteristics of residents, which may require the provision of communal areas and facilities as well as enhanced security. We also recognise that retirement housing, including sheltered housing and extra care, can also often have higher housing costs. We wish to ensure the new funding model works for the whole sector.

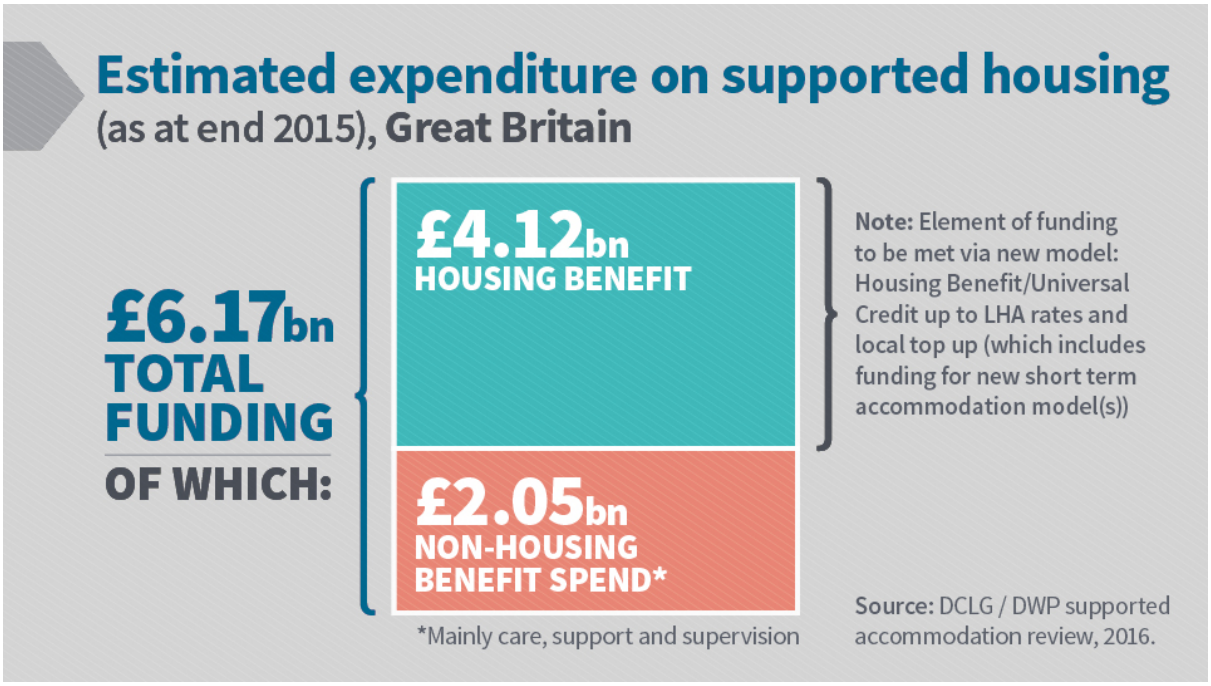
27. Funding for supported housing is complex and comes from a variety of sources. Housing Benefit plays a significant role. It meets eligible housing-related costs, including core rent and eligible service changes (which can include for example, the cost of repairs, renewing communal furnishing and fittings and some intensive housing management costs). The Supported Accommodation Evidence Review estimates that the annualised Housing Benefit expenditure for supported housing across Great Britain as at December 2015 is £4.12 billion. This represents around 17 percent of the total expenditure on Housing Benefit. The majority of supported housing expenditure from Housing Benefit is for older people, at an estimated £2.4 billion, with an estimated £1.7 billion spent on working-age provision.

28. The Supported Accommodation Evidence Review conservatively estimates at the end of 2015 that around £2.05 billion is spent in addition to Housing Benefit, on mainly support and care services for tenants in supported housing (see Figure 1 below). The principal sources of separate care and support funding are local authority adult social care services, housing and homelessness funding. Further funding comes from sources such as children's services, substance misuse

[6] DCLG, 2016-2018 Domestic Abuse Fund: prospectus, see: https://www.gov.uk/government/publications/domestic-abuse-fund-prospectus

services, charitable grants and Big Lottery funding, as well as from health sources and a small amount from fundraising and donations.

Figure 1



29. Work towards the Supported Accommodation Evidence Review found many examples of excellent practice in terms of local areas strategically assessing and identifying need for supported housing, strong commissioning and regular review of provision for individuals to support those who are able to move on into independent living and to make best use of provision.

30. The review also found some circumstances of patchy commissioning practice, alongside some frustration among commissioners about providers only being required to comply with welfare rules. This has resulted in some providers setting up provision outside local commissioning structures or scrutiny with poor assurance of outcomes, quality or value for money. Both issues further support the case for change.

2. The case for change

Rationale and objectives

31. There are two clear reasons for seeking to reform the funding of supported housing. The roll out of Universal Credit for working age people, as described above, is one but there is also a need to more fundamentally consider how supported housing across the whole sector should be planned for, commissioned and delivered and how to manage growing demand within a tighter public spending climate:

- **Universal Credit** – a new funding mechanism is required to work in conjunction with Universal Credit. Universal Credit will meet core housing costs, up to the level of the relevant LHA rate, and therefore the question arises about the most effective way to deal with additional costs in excess of this.
- **A local focus on outcomes, oversight and cost control** – we want the quality of services and a focus on outcomes for the people who use them to be at the forefront of supported housing provision. The current system for funding the housing costs of supported housing is not well designed to ensure effective oversight of quality or control of spending to ensure value for money. We must consider new approaches to transparency and oversight in order to achieve consistent quality and to demonstrate to the taxpayer the value of the considerable public investment in these services.

32. In addition, supported housing plays a critical role in meeting our objectives for supporting vulnerable people across Government. Our overall objectives for reform are:

    - To ensure that vulnerable people receive the support they need;
    - To establish a funding system that protects genuine supported housing and provides certainty to maintain and encourage the development of new supply;
    - To deliver provision that focusses on service users – getting access at the right time as well as, where possible, help to move on at the right time – and focusses on their individual outcomes as well as the quality of provision;
    - To better align responsibility for commissioning services with greater control of the budgets to ensure improvements in quality, value for money, appropriate oversight, transparency and accountability; and
    - To seek opportunities for greater collaboration and innovation through local commissioning across public sector commissioning, including strengthening the links between health, housing and social care.

Universal Credit and the impact on Supported Housing

33. Universal Credit, which is currently being rolled out nationwide, is a benefit for working age people who are both in and out of work. It replaces six existing benefits, and includes support for rental costs where applicable. Universal Credit is paid monthly directly to claimants. Universal Credit is currently available in every Jobcentre in Great Britain for single jobseekers. Full rollout of Universal Credit for all

claimant types is currently underway and will be complete in 2022. Housing costs for those of pension age will also continue to be met through the welfare system. For those in supported housing, welfare payments up to the level of the LHA rate will be supplemented where necessary by the local top-up fund from April 2019.

34. Universal Credit offers significant benefits, in terms of simplicity, ease of access and improved work incentives for all claimants, including those individuals living in supported housing.

35. Local knowledge is central to the current system for funding supported housing through Housing Benefit. In addition, much supported housing provision is developed in consultation with and is commissioned by local authorities to meet the needs of local people and this requires close co-operation at the local level. Determining individual entitlement where the claimant lives in supported housing requires very detailed consideration of which costs are eligible and whether the costs cited are reasonable. Such a system usually requires local knowledge, expertise and involvement.

36. For providers of certain types of short term accommodation, Universal Credit, which is typically paid monthly, presents challenges. Shorter term accommodation may include provision such as:

- hostels for homeless people or domestic violence refuges;
- short term emergency accommodation provided by a local authority whilst their duty to house a homeless person is assessed; and
- other supported housing settings where stays may be short term.

37. The Government also recognises that different funding models for the short term accommodation types set out above may also be applicable to Temporary Accommodation provided by local authorities in discharging their homelessness duties.

38. We are seeking views on how best to provide support for short term stays alongside the monthly assessment and payment in Universal Credit. Challenges include ensuring we remain responsive to housing needs at the start of someone's Universal Credit claim while entitlement is determined and first payments are made.

A local focus on outcomes

39. As we have set out above, local knowledge is of crucial importance in ensuring supported housing is commissioned in the right way. In addition to preparing for a new local role as part of the implementation of Universal Credit, many local authorities have also told us that they would welcome an enhanced local commissioning role. Some councils have raised concerns about the existing Housing Benefit regime, in particular regarding insufficient local control over the establishment and location of supported housing services and quality of some services being provided outside of their commissioning arrangements. Supported housing providers and developers have been clear that they are seeking as much

clarity as possible about what funding is available as well as a strong desire for consistency around the availability of funding and its administration.

40. Concerns have also been raised that the current Housing Benefit regulations restrict who can provide supported housing, and receive the enhanced funding through the supported exempt provisions, to non-metropolitan county councils, housing associations, registered charities and voluntary organisations. This leaves no room for other providers and can restrict the claimants' choice of who delivers support services, since to qualify for the enhanced funding through Housing Benefit the care, support or supervision must be provided by, or on behalf of, the landlord.

41. Longer term, we also need to build a system which is better able to manage future demand as the population is ageing and medical advances also mean that more people with severe physical and learning disabilities are enjoying longer lives. This makes it even more important that spending provides value for money and is targeted effectively and providers are able to develop new supported housing supply.

3. A new framework for future supported housing costs

42. On 15 September, the Government announced a new funding model for supported housing. Government has deferred the application of the Local Housing Allowance (LHA) policy for supported housing until 2019/20. At this point we will bring in a new funding model which will ensure that supported housing continues to be funded at the same level it would have otherwise been in 2019/20, taking into account the effect of Government policy on social sector rents.

43. We also announced that, as planned, the Government would apply the social rent reduction to supported housing, with rents in these properties decreasing by 1% a year for 3 years, up to and including 2019/20. The existing exemption for specialised supported housing will remain in place and will be extended over the remaining 3 years of the policy for fully mutuals/co-operatives, almshouses and Community Land Trusts and refuges.

44. It is our intention that from 2019/20 core rent and service charges will be funded through Housing Benefit or Universal Credit up to the level of the applicable LHA rate. This will apply to all those living in supported accommodation from this date. The Shared Accommodation Rate will not apply to people living in the supported housing sector, in recognition of the particular challenges this would have placed upon them.

45. In England, we will devolve funding to local authorities to provide additional ‘top-up’ funding to providers where necessary, reflecting the higher average costs of offering supported accommodation, compared to general needs. This will give local authorities an enhanced role in commissioning supported housing in their area. This will also allow local authorities to ensure a more coherent approach to commissioning for needs across housing, health and social care, using local knowledge to drive transparency, quality and value for money from providers in their area.

46. Separate existing funding streams for care, support and supervision (such as legacy Supporting People funding) would remain part of the funding mix for supported housing but will not be changed by these reforms. The intention would be for the top-up fund to be used in conjunction with the wide range of funding dedicated to local commissioning.

47. We will ring-fence the top-up fund to ensure it continues to support vulnerable people. The amount of top-up funding will be set on the basis of current projections of future need. This will also help to provide certainty for providers that reductions in funding from Housing Benefit or Universal Credit due to LHA rates, can be met elsewhere as well as to give greater assurance to developers of new supported housing supply.

48. While we are confident that this model will meet the needs of the majority of the sector, we recognise some particular challenges may remain for very short term accommodation, including hostels and refuges. We will work with the sector to develop further options to ensure that providers of shorter term accommodation continue to receive appropriate funding for their important work. Whilst the mechanism may be different, funding for this type of accommodation will benefit from the same protection as supported housing in general.

4. Consultation: key issues and questions

49. This is a consultation on how the new local funding model should work in England.

50. There are five key issues that we would like to explore through this consultation to develop the detail that will underpin the new approach to funding for supported housing set out on 15 September. These are:

    I. Fair access to funding, the detailed design of the ring-fence and whether other protections are needed for particular client groups to ensure appropriate access to funding, including for those without existing statutory duties;
    II. Clarifying expectations for local roles and responsibilities, including what planning, commissioning and partnership arrangements might be necessary locally;
    III. Confirming what further arrangements there should be to provide oversight and assurance for Government and taxpayers around ensuring value for money and quality outcomes focussed services;
    IV. Exploring the appropriate balance between local flexibility and provider certainty, including what other assurance can be provided beyond the ring-fence, for developers and investors to ensure a pipeline of new supply; and
    V. Developing options for workable funding model(s) for short term accommodation, including hostels and refuges.

    Issues I – IV relate to the detailed arrangements for the local top up model in England. Issue V relates to short term accommodation provision across Great Britain, as it is currently funded through the welfare system.

I. Fair access to funding, the detailed design of the ring-fence and whether other protections are needed for particular client groups to ensure appropriate access to funding, including for those without existing statutory duties.

51. Local authorities will administer the local top-up, and in two tier areas, there is a case for the upper-tier local authority to hold the funding as they tend to be responsible for commissioning the bulk of supported housing services.

52. Different types of supported housing provision and services are commissioned by different bodies locally, such as Clinical Commissioning Groups and district housing authorities. It will be important to ensure that funding streams are better aligned so they can deliver their respective commissioning objectives.

    Q1. The local top-up will be devolved to local authorities. Who should hold the funding; and, in two tier areas, ***should the upper tier authority hold the funding?***

Q2. How should the funding model be designed to maximise the opportunities for local agencies to collaborate, encourage planning and commissioning across service boundaries, and ensure that different ***local commissioning bodies can have fair access to funding?***

53. We will ring-fence the top-up fund to ensure it continues to support vulnerable people. We propose that the ring-fence should be set to cover expenditure on a general definition of supported housing provision, rather than there being separate ring-fenced pots for different client groups.

54. Many people who rely upon supported housing have multiple and complex needs and supported housing services often address a combination of these needs (e.g. homelessness, mental health issues and substance misuse problems) and therefore, breaking down funding between different client groups becomes complicated and could limit flexibility for local areas to manage changing circumstances. Local authorities will, of course, need to comply with the public sector equality duty under section 149 of the Equality Act 2010 when deciding how to allocate funding.

55. However, some stakeholders have raised concerns that certain vulnerable groups could be overlooked, or particular groups could be prioritised for funding at the expense of others. We are keen to understand what, if any, statutory provision could be made to provide reassurance, including what potential role additional statutory duties for local authorities in England could play, particularly in terms of protecting provision for specific vulnerable groups within the context of the overall ring-fence.

Q3. How can we ensure that ***local allocation*** *of funding by local authorities matches local need for supported housing across all client groups?*

Q4. Do you think ***other funding protections for vulnerable groups****, beyond the ring-fence, are needed to provide fair access to funding for all client groups, including those without existing statutory duties (including for example the case for any new statutory duties or any other sort of statutory provision)?*

II. Clarifying expectations for local roles and responsibilities, including what planning, commissioning and partnership arrangements might be necessary locally.

56. The new model will give local authorities in England an enhanced role in commissioning supported housing in their areas. In addition, local partnerships could combine this funding with existing care, support and supervision funding to commission services. This could be helpful in encouraging local authorities to consider all supported housing funding in the round. It should incentivise efficiencies and join up existing care and support funding, helping with health and social care integration across the life course.

57. We will consider what level of new burdens funding would be appropriate to enable local authorities to fulfill their new role.

*Q5. What expectations should there be for **local roles and responsibilities?** What planning, commissioning and partnership and monitoring arrangements might be necessary, both nationally and locally?*

*Q6. For local authority respondents, what **administrative impact and specific tasks** might this new role involve for your local authority?*

III. Confirming what further arrangements there should be to provide oversight and assurance for Government and taxpayers around ensuring value for money and quality outcomes focussed services.

58. Supported housing is of vital importance to vulnerable people and we want to continue to work with providers to ensure that services are as good as they can be. We want to build on the work of excellent providers to drive all quality and value for money up to the level of the best. These reforms, giving local areas greater control and strategic oversight, represent the first step towards that goal, whilst giving the sector the necessary certainty over the total amount of funding available nationally. We also want quality and a focus on individual outcomes to play a greater role in how we fund the sector.

*Q7. We welcome your views on what features the new model should include to provide **greater oversight and assurance** to tax payers that supported housing services are providing value for money, are of good quality and are delivering outcomes for individual tenants?*

IV. Exploring the appropriate balance between local flexibility and provider certainty, including what other assurance can be provided beyond the ring-fence, for developers and investors to ensure a pipeline of new supply.

59. Providers have told us that within a localised funding model they would prefer a degree of standardisation with regards to the administration of a local top-up as well as the underpinning framework for reaching a funding decision – for example, via a national statement of expectations or a national commissioning framework. This is particularly important for larger providers who operate across many different local areas and would welcome a degree of standardisation and consistency. However, it is important to balance this against the need to preserve flexibility for local areas to design the delivery of the top-up in their area in a way which best meets the needs and circumstances of supporting vulnerable people in their areas.

*Q8. We are interested in your views on how to strike a balance between local flexibility and provider/developer certainty and simplicity. What features should the funding model have to provide **greater certainty to providers** and in particular, developers of new supply?*

*Q9. Should there be a **national statement of expectations or national commissioning framework** within which local areas tailor their funding? How should this work with existing commissioning arrangements, for example across health and social care, and how would we ensure it was followed?*

*Q10. The Government wants a **smooth transition** to the new funding arrangement on 1 April 2019. What transitional arrangements might be helpful in supporting the transition to the new regime?*

*Q11. Do you have **any other views** about how the local top-up model can be designed to ensure it works for tenants, commissioners, providers and developers?*

V. Developing options for workable funding model(s) for short term accommodation, including hostels and refuges.

60. While we are confident that the local top up model will meet the needs of the majority of the sector, we recognise some particular challenges, such as the monthly payment of Universal Credit, may remain for very short term accommodation, including hostels and refuges. We will work with the sector to develop further options to ensure that providers of shorter term accommodation continue to receive appropriate funding for their important work. Whilst the mechanism or mechanisms (if more than one model is necessary) may be different, funding for this type of accommodation will benefit from the same protection as supported housing in general.

*Q12. We welcome your views on how **emergency and short term accommodation** should be defined and how funding should be provided outside Universal Credit. How should funding be provided for tenants in these situations?*

Task and finish groups

61. There will be four task and finish groups working across these key issues outlined through this consultation, which will include membership from key stakeholders and partners from across the sector and from across Government departments and the devolved administrations where appropriate. This work will run in tandem with this consultation exercise and report back to Government. The task and finish groups will cover the following:

A. **Fair access to funding** (issue I above);
B. **Local roles & responsibilities including ensuring value for money, quality and appropriate oversight** (combining issues II and III above): exploring how the new model should work in practice and how to assure quality;
C. **Ensuring new supply of supported housing** (issue IV above): looking at how to provide assurance and certainty for developers as well as maintaining local flexibility for commissioners; and
D. **Short term accommodation** (issue V above): developing options for a workable and sustainable funding model or models for short term accommodation.

Timetable

62. This document begins the consultation process alongside a programme of task and finish groups working with the sector on key design components of the model and designing a new approach for short term accommodation.

63. While the framework for the new funding model has been set, this consultation seeks views on key system design elements to ensure the model(s) will work for tenants, commissioners, providers and developers. The specific issues we wish to resolve through this consultation include fair access to funding; clarifying expectations for local roles and responsibilities; confirming what further arrangements there should be to provide oversight and assurance; exploring the appropriate balance between local flexibility and provider certainty; and gathering views on developing a workable funding model(s) for short term accommodation, including hostels and refuges.

64. This consultation will run for 12 weeks until 13 February 2017. There will then be a Green Paper on the detailed arrangements for the local top-up model and approach to short term accommodation in the spring. A final package will be announced in autumn 2017 to allow time for transitional arrangements to be made ahead of the new model commencing on 1 April 2019.

Timetable	**Delivery phase**
Nov 2016 To Feb 2017	Consultation: consultation document
Nov/Dec/Jan/Feb	Stakeholder engagement and task and finish groups
Spring 2017	Green Paper on detailed model(s) and funding distribution consideration
Autumn 2017	Announce detailed funding model(s) and local authority funding allocations
April 2018	Shadow year arrangements in place on detail and allocation of funding to allow full transition to new model
April 2019	Commencement of new funding model(s)

About this consultation

This consultation document and consultation process have been planned to adhere to the Consultation Principles issued by the Cabinet Office.

Representative groups are asked to give a summary of the people and organisations they represent, and where relevant who else they have consulted in reaching their conclusions when they respond.

Information provided in response to this consultation, including personal information, may be published or disclosed in accordance with the access to information regimes (these are primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004.

If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

The Department for Communities and Local Government will process your personal data in accordance with DPA and in the majority of circumstances this will mean that your personal data will not be disclosed to third parties.

Individual responses will not be acknowledged unless specifically requested.

Your opinions are valuable to us. Thank you for taking the time to read this document and respond.

Learning Disability England

Changes to supported housing- what do you think?

This is a plain English summary of the *Funding for Supported Housing* consultation from the government. You can find the full version here: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/571013/161121_-_Supported_housing_consultation.pdf

What is supported housing?

Supported housing is where people live as a tenant but also get some support to live there.

Supported housing can be living in a flat by yourself, living in a shared house or living in a network or block of flats where everyone gets support.

If you have been asked to say what you think about these changes, it is probably because you live in supported housing. Though you might not call where you live supported housing and just call it 'home'.

What the government wants to do

The government wants to change how the money works for supported housing.

They want to do this because they think that planning for supported housing should happen locally.

They also want to do this so that it fits with Welfare Reform.

This means that the money you get to pay your rent will be part of what is called Universal Credit.

Universal Credit is bringing all of your benefits together in one payment.

The most money you will get for your rent will be the Local Housing Allowance.

The Local Housing Allowance is a fixed amount of money that is set at what the lowest local rents are in your area.

The government knows that this is not enough money for some supported housing.

They want the extra money that pays for supported housing to go to local councils. They think that local councils can plan and decide how the extra money for supported housing is spent better.

How will it affect tenants with learning disabilities?

At the moment, supported housing providers develop housing for people with learning disabilities and they say how much the rent will be.

Sometimes they do this in partnership with the local council and sometimes they don't.

Supported housing providers usually charge more rent than most other landlords because they have extra costs to support tenants and make the housing right for them.

Now supported housing landlords will get the same rent as other landlords.

The extra money for supported housing will go from the government to the local council.

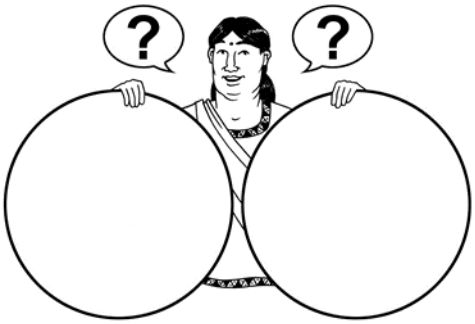
The local council will make the decision about whether they give the landlord extra money or not.

The local council will also decide how much extra money they will give the landlord.

This means that the landlord and council have to work together and agree.

It is important that tenants with learning disabilities and their families are involved and say what they want.

Some good opportunities?



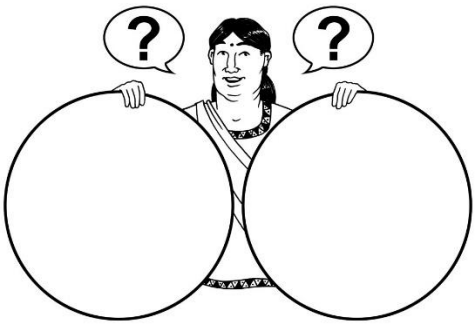
There will be better co-ordination and local planning for supported housing if landlords and councils work together well.

It will be especially good if councils involve people with learning disabilities and families in planning what supported housing there should be locally.

This will stop any landlords that charge too much rent when they don't need to.

The old rules meant that people who organised their own housing and support had difficulty getting extra money for their rent because it wasn't considered to be supported housing. This can change under the new rules.

Some worries?



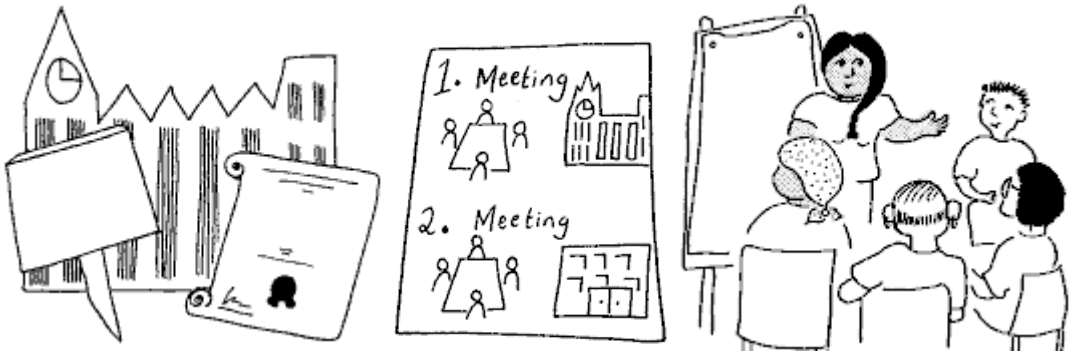
If councils and supported housing providers don't work together well there may be no other way to make supported housing work.

It will be more complicated to make supported housing happen as the money has to come from 2 different places and there has to be more planning.

Because it is more complicated, it may put off some supported housing providers from developing supported housing.

Current tenants may be worried about the future of their tenancies.

What the government is asking?



From now until the 13th February 2017, the government is asking landlords, tenants and councils to say what they think about these plans. This is called a consultation.

They are asking questions about these 5 areas:

1. How can they make sure the funding councils give for housing is fair for everybody that needs support?
2. What is needed locally to plan and pay for housing?

3. How can we make sure that that supported housing gives tenants what they want and is good value for money?
4. How can we make sure that housing providers and funders will keep building supported housing if the money is not guaranteed from central government?

5. The plans suit people in longer tenancies but what about people who need temporary housing?

What will happen next?

The government is asking all of these questions in a consultation.

The consultation will last until the 13th February 2017

When the consultation is finished, they will think about what people have said and write a proposal for how they will make the changes to supported housing. This is called a Green Paper.

We will get a chance to say what we think about the Green Paper.

In Autumn 2017, the government will say how they are going to make the changes.

In April 2018, there will be a 1 year transition period

In April 2019, the new way of funding supported housing will be in place.

Say what you think!

Learning Disability England will tell the government what our members say.

We want to know what members who are tenants, families, supported housing providers and commissioners think.

Some of the questions the government is asking are very technical and mean little to most tenants and their families.

We want to make sure that the government understands what supported housing means to tenants with learning disabilities and their families.

We want to make sure that people's homes are protected.

We want to make sure that good supported housing is available in the future for people with learning disabilities.

We also want to make sure the government understands how supported housing for people with learning disabilities is different to supported housing for other groups of people.

We will gather together this information and need it by **Monday 6th February 2017**.

Send it to mariana.ortiz@LDEngland.org.uk

The more people and organisations that respond, the stronger it will be and that means we can make a bigger difference with what we say.

You can also send in your response to the government directly by 13th February 2017.

Supported Housing and Commissioner members

We would like you to tell us what you think. You can do this by answering the 5 questions in plain English below. We have provided extra discussion questions to support the process of consultation. You can also use the 5 questions with technical words in the government consultation document.

We have provided some additional questions in plain English for tenants and families. We suggest that you both survey tenants and families individually and also have focus groups to discuss the questions.

Organisation:

Name and job title:

Contact details:

1. **How can they make sure the funding councils give for housing is fair for everybody that needs support?**
   Questions:
   Who should hold the money in the council, the housing department or social services?
   How should the money work to make sure all the local commissioners and housing organisations work together locally and fairly?
   How do we make sure that the money councils get from the government is enough for all people that need supported housing?

2. **What is needed locally to plan and pay for housing?**
   Questions:
   What local roles do we need to make this work and what should they be responsible for?
   What partnerships do we need to make this work?
   How do we check it is working locally and nationally?
   For councils, what do you need in your local authority to make this work?

3. **How can we make sure that that supported housing gives tenants what they want and is good value for money?**
   Questions:
   What are your ideas for making the new way of getting supported housing work for you?

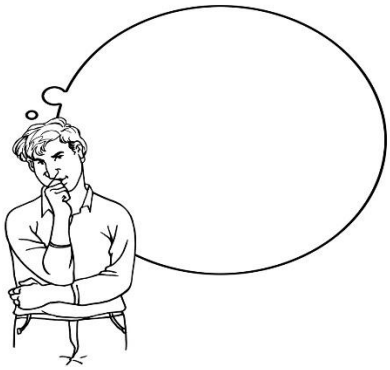
4. **How can we make sure that housing providers and funders will keep building supported housing if the money is not guaranteed from central government?**
   Questions:
   How do we make sure that people's tenancies are safe?
   How do we make sure that the changes don't stop more housing for people with learning disabilities?
   How do we make sure that the changes are smooth and tenants don't suffer?

5. **The plans suit people in longer tenancies but what about people who need temporary housing?**
   Questions:
   How do you think short term accommodation like hostels and refuges could be funded?

Additional discussion questions for tenants (and future tenants) and their families and advocates

Number of tenants, families and advocates involved in the consultation:

What does supported housing mean to you?



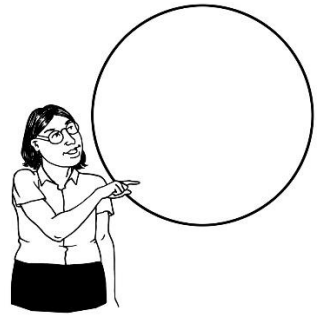
What does supported housing help you achieve in your life?

What do you think about the changes to supported housing that the government is proposing?

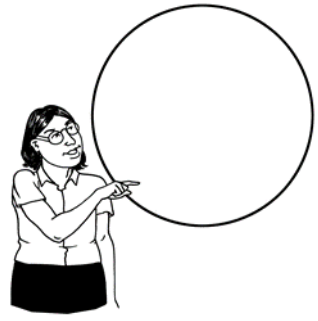
What do you think is good about the changes?

What worries you about the changes?

Have you got ideas for making sure people with learning disabilities get the supported housing they want and need?



Have you got ideas for checking that local supported housing is good quality?



Lincolnshire County Council response to the

Funding for Supported Housing – Consultation

Fair access to funding, the detailed design of the ring fence and whether other protections are needed for particular client groups to ensure appropriate access to funding, including for those without existing statutory duties
Q1: The local top up will be devolved to local authorities. Who should hold the funding; and in two tier area, should the upper tier authority hold the funding? Lincolnshire has a local authority two-tier system. Lincolnshire County Council (LCC) is the lead commissioner for social care for vulnerable adults and children. LCC also act as lead commissioner for some health provision. A number of vulnerable people will be affected by a housing benefit cap. Devolving the top up funding to LCC will allow best value co-ordination of the top-up grant to minimise impact on vulnerable service users. It would also likely be best value in relation to administration costs reducing the need to negotiate top-ups with multiple district councils. This may also assist diversion of funds to other spend areas and limit overheads charged to the top up fund by second tier authorities. Disabled Facilities Grant (DFG) funding is already directed to upper tier authorities via the Better Care Fund (BCF), and aids the co-ordination of housing related investment across the 8 Authorities. Top-up funding being co-ordinated by the upper tier authority will further strengthen this leadership and co-ordinating role. Housing Related Support (HRS) services in Lincolnshire continue to benefit from £4m per year of investment from LCC since the Supporting People ring-fence was removed, with an additional £900,000 invested in supported accommodation services for 16-17 year olds and Care Leavers. The investment demonstrates the continued importance attributed by LCC to this work. This would be an excellent opportunity to be responsible for the effective, localised commissioning of outcomes focussed, value for money support housing services.
Q2: How should the funding model be designed to maximise the opportunities for local agencies to collaborate, encourage planning and commissioning across services boundaries, and ensure that different local commissioning bodies have fair access to funding? The introduction of a local housing 'commissioning hub' (or hubs) / 'information gateway' would ensure multi-agency collaboration and strategic overview of all planned and existing commissioned provision across Lincolnshire, maximising resources and reducing duplication. Possibly sited / hosted by the 'top-up funding' agency. This 'hub' would provide a consistent, data collation point providing robust analysis required in order to ensure funding resources are adequately matched to meet current and future supported housing need evidenced across a range of eligible/identified groups. Intelligence gathered will be closely linked to existing housing strategies and towards ensuring clear housing pathways exist in order for all housing options to be maximised for the individual.

The use of the funding should be linked to local strategic aims for health, social care and community safety through, for example, Health and Wellbeing Boards; Corporate Parenting Panel; Transforming Care Partnership; Community Safety Partnership. This would help drive integration of housing support for more vulnerable people with the existing health and care integration systems. It is important the approach to these reforms promotes change in planning and commissioning arrangements, as well as in delivery.

In relation to the ring-fence/mechanism model, any annual settlement will be required to take account of increases in need, inflationary uplifts and avoid the administering of top ups at a time of dwindling resource, but when needs are likely to increase.

Note: The above will need further discussion, both between internal departments and through collaboration with DCs, CCGs, Criminal Justice services, in order to determine the model, who would host, resources etc.

Q3: How can we ensure that local allocation of funding by local authorities matches local need for supported housing across all groups?

To ensure appropriate funding, multi-agency commissioning intelligence, data and financial forecasting is collated and analysed across all client groups.

It is important any overarching funding 'ring fence' requires and supports the need to budget protect or retain a baseline figure for particular groups. Collation of information and data analysis through a local commissioning hub/information gateway model would include:

- How many people are currently in supported housing and what is this likely to be in the future;
- Is current supported housing meeting need now and into the future;
- Who accesses supported housing;
    - Is this model of accommodation best suited to their needs;
    - How long do they stay/what are the throughput/move-on rates;
    - What are the outcomes, i.e. what difference has supported housing made;
    - How is supported housing contributing to other local and national outcomes, for example take up of employment, reduction in access to emergency services.
- Localised and current rent charges and assimilation to LHA, financial forecasting i.e. any shortfall of which would in part equate to the amount of 'top-up' funding required.

The provision of supported housing for vulnerable people should also be viewed in the context of the whole market for available care and support services. For older people, supported extra care housing is an option amongst other services such as residential care. The calculation of the amount needed locally could be linked to the formula for calculating social care allocations through the BCF, whilst ensuring the needs of Young People and Care Leavers are taken into account.

Q4: Do you think other funding protections for vulnerable groups, beyond the ring-fence, are needed to provide fair access to funding for all client groups, including those without existing statutory duties (including for example the case for any new statutory provision)?

Yes.

It is important any overarching funding 'ring fence' requires and supports the need to budget protect or retain a baseline figure for particular groups. As local authority and other

statutory health and care funding pressures continue, there is a need to ensure the 'ring-fence' protection does not allow for the dilution or removal of funding for any 'non-statutory' groups, for example the prioritising of statutory/social care needs over non-priority single homeless people and/or those with drug/alcohol issues requiring supported housing. This service provision is often the intervention that prevents some individuals from going on to access more expensive statutory or emergency services.

Any decision making processes in relation to the 'top-up' allocation should include the completion of an equality impact assessment to ensure all identified groups have fair and equal access to supported housing. Having a welfare system where rates are set nationally but a Local Housing Allowance (LHA) applied to supported housing may see some of the most vulnerable at a disadvantage and unable to access good quality supported housing in areas where the LHA is lower and therefore a greater 'top-up' is required.

Supported housing for people with learning disabilities and/or autism is a key towards ensuring individuals have choice and control in their lives. It supports the Transforming Care agenda as it provides an alternative to traditional models of housing such as residential care. It can do this through longer term tailored housing solutions and reassurance of housing stability. Alternatively, it can be a stepping stone to other forms of independent housing by enabling individuals to have increased confidence, social and living skills, but continues to be an option and safety net at times when greater support is needed towards achieving longer term sustainability.

Similarly, supported accommodation for 16-17 year olds and Care Leavers is an essential part of the County's Corporate Parenting role for (Looked After) Children and Young People. It supports them to avoid homelessness at times of family breakdown or when leaving care and helps them to maintain education and training opportunities, leading to a readiness for adult life and move-on to employment and independent living.

There should be funding protection in relation to fair access and local connection. Those who have experienced transient accommodation history outside of local boundaries due to, for example, experiencing domestic abuse, or being looked after children or care leavers, should not have access restricted linked to uncertainties around funding responsibilities or could be left street homeless whilst reconnection is sorted. Equally, local housing policies, including local connection, must be able to support move-on, where appropriate, to ensure continued individual progression towards independence through other housing options.

Clarifying expectations for local roles and responsibilities, including what planning, commissioning and partnership arrangements might be necessary locally

Q5: What expectations should there be for local roles and responsibilities? What planning, commissioning and partnership and monitoring arrangements might be necessary, both locally and nationally?

In the case of two tier authorities such as Lincolnshire, the existence of a housing strategy or strategies as a key document for and agreed by all interested stakeholders, including District Councils, CCG's, Social Care, the Justice System and service user delivery boards. The strategy will include working protocols between agencies and make clear all housing pathways and access arrangements for both professionals and service users and carers.

The introduction of a local housing 'commissioning hub'/'information gateway' to underpin a multi-agency collaborative approach and strategic overview of all planned and existing commissioned provision across Lincolnshire, maximising resources and reducing duplication.

This 'hub' would provide a consistent, data collation point providing robust analysis required in order to ensure funding resources are adequately matched to meet current and future supported housing need, evidenced across a range of eligible/identified groups.

Multi-agency monitoring information and commissioning intelligence, data and financial forecasting is collated and analysed across all client groups. Collation of information and data analysis through a local commissioning hub/information gateway model would include:

- How many people are currently in supported housing and what is this likely to be in the future;
- Is current supported housing meeting need now and into the future;
- Who accesses supported housing;
    - Is this model of accommodation best suited to their needs;
    - How long do they stay/what are the throughput/move-on rates;
    - What are the outcomes, i.e. what difference has supported housing made;
    - How is supported housing contributing to other local and national outcomes, for example take up of employment, reduction in access to emergency services.
- Localised and current rent charges and assimilation to LHA, financial forecasting i.e. any shortfall of which would in part equate to the amount of 'top-up' funding required.

This local information and monitoring intelligence should feed into a national data set in order to evidence performance nationally, ensuring fair and equal access to supported housing, localised trends and early indications of progress or shortfall of funding issues.

An existing mechanism for planning and commissioning co-ordination should be specified as having a lead role. A number of solutions are available, including Health and Wellbeing Boards, the Better Care Fund partnerships that already have the lead for Disabled Facility Grant funds and the Youth Housing Strategy Delivery Board. This will further ensure a joined up approach and that housing need is integral to all local plans.

There will need to be close monitoring of expenditure to ensure the top up fund is not exhausted part way through a year and providers no longer receive payments. At present, the district councils can continue to spend and reclaim the money back from Government.

Q6: For local authority respondents, what administrative impact and specific tasks might this new role involve for your local authority?

As the potential 'host' for any 'top-up' funding arrangements, collation of intelligence data and evidence of need, the successful delivery model required to introduce and administer these changes will create additional resource implications and therefore additional funding pressures. Individual agency and District Council processes would require the establishment of a multi-agency mechanism underpinned by appropriate IT function, particularly where integration of existing IT systems is not possible due to incompatible technology.

There would need to be a project plan and timetable in line with the Government's implementation date, with sufficient time to allow any procurement exercises, for example IT systems.

It is difficult to be more precise at this time until we know the full details of the funding allocation mechanism and the information/evidence required by Government in order to access appropriate funds. Clarity on national frameworks and the actual financial effect of these in each administrative area is essential as early as possible in the programme of implementation. However, some of the following will be required to be undertaken:

- Replication and/or improvement of existing mechanisms for planning supported housing development;
- Establish which organisations already receive funding, what this is for, how much and potential impact going forward; monitoring of exit strategies;
- Consider support required to service users;
- Manage applications for funding and decisions about funding awards;
- Make payments to providers;
- Monitoring arrangements to ensure required outcomes are being achieved;
- Ensuring acceptable services are being provided;
- Maximising value for money.

Confirming what further arrangements there should be to provide oversight and assurance for Government and taxpayers around ensuring value for money and quality outcomes focussed services

Q7: We welcome your views on what features the new model should include to provide greater oversight and assurance to tax payers that supported housing services are providing value for money, are of good quality and are delivering outcomes for individual tenants?

As described in previous answers, the introduction of a local housing 'commissioning hub' or hubs/'information gateway' that co-ordinates and collates all supported housing activity, looking to maximise resources and reduce duplication will provide assurance of appropriate and quality provision. Multi-agency commissioning functions carried out in terms of evaluation of current provision, consultation and involvement of those who use services will ensure provision remains of good quality and continues to meet local need. Lincolnshire County Council is an outcomes focused authority that requires services to make a real difference to people's lives.

In its simplest form, this multi-agency fund requires a multi-agency planning and commissioning mechanism to provide it with the right level of oversight. Current and available mechanisms exist such as the Health and Wellbeing Board, local Better Care Fund partnership or Youth Housing Strategy Delivery Board, with both having local democratic accountability through the upper tier local authorities' scrutiny processes.

Exploring the appropriate balance between local flexibility and provider certainty, including what other assurance can be provided beyond the ring-fence, for developers and investors to ensure a pipeline of supply

Q8: We are interested in your views on how to strike a balance between local flexibility and provider/developer certainty and simplicity. What features should the funding model have to provider greater certainty to providers and in particular, developers of new supply?

We recognise supported housing is an important provision that provides a tailored package of support towards maintaining and sustaining health and wellbeing for those 'at risk' and/or vulnerable individuals. Supported housing can be more expensive to provide. Individuals with complex or multiple needs require skilled and knowledgeable staff often with intensive periods of support and sometimes on a one to one basis. Housing management costs are, therefore, higher than general needs housing. Any funding model needs to take into account the costs involved in the delivery of good quality supported housing.

To support personalised and outcomes focussed services, the establishment of a clear and transparent local pricing framework and funding tool would help provide certainty to providers. This would help with business planning and future forecasting. Equally a local and strategic housing strategy will help providers to know and understand current and future demand.

A pricing framework/funding tool could be, for example and in simple terms, services are commissioned depending on the individual's assessed 'band of need'. This 'band of need' is aligned with the level of intervention an individual requires, which in turn relates to a price range. There would need to be incentives for progress and move-on where appropriate to ensure individuals do not necessarily remain in supported housing beyond its usefulness.

Service providers would need to have in place 'open book accounting' systems that can clearly evidence where funding is being spent, and be able to evidence the difference a service is making to individuals' lives.

The setting of a commissioning framework or market position statement, based on a set of firm financial allocations over time will ensure the appropriate strategic and financial clarity for providers to have confidence. It will also assure appropriate context is set with other key programmes of work.

There will need to be close monitoring of expenditure to ensure the top up fund is not exhausted part way through a year and providers no longer receive payments. At present, the district councils can continue to spend and reclaim the money back from Government.

If the entire budget is allocated up-front there will be no money for new services, unlike now where new services can apply for the intensive housing management support through Housing Benefit (HB) and will always be paid. There also needs to be some consideration in relation to aspects not covered by HB i.e. ineligibles such as communal service charges.

Some developers only build the accommodation, with a different organisation leasing the accommodation and providing the service. The developer needs confidence they will get a service provider, with the service provider needing the assurance that "supported accommodation" funding will be provided. They will probably need the assurance at planning stage and not when the building is complete.

Most providers won't want the risk of not having guaranteed funding. Funding, therefore, needs to be in advanced block payments and over an agreed term or providers could

move away from providing supported accommodation.

Q9: Should there be a national statement of expectations or national commissioning framework within which local areas tailor their funding? How should this work with existing commissioning arrangements, for example across health and social care and how would we ensure it was followed?

Yes.

Having national expectations would ensure the 'ring fence' protection does not allow for the dilution, removal or diversion of funding elsewhere. A national statement of expectations should help to prevent a 'postcode lottery' of different arrangements in different areas and should be evidence-based on what works and existing good practice e.g. St. Basil's Positive Pathway.

Local information and monitoring intelligence should feed into a national data set in order to evidence performance nationally, ensuring fair and equal access to support housing, localised trends and early indications of progress or shortfall/funding issues.

How this would work and the assurance that it would be followed can be found in answers 2, 3, 5 and 7.

Q10: The Government wants a smooth transition to the new funding arrangement on 1st April 2019. What transitional arrangements might be helpful in supporting the transition to the new regime?

It would be helpful to have ‘pilot areas’ to undertake early adoption in order to identify and resolve any implementation issues, unintended consequences and lessons learnt to share with government and other areas. Transition funding would be required to ensure success and progress.

A local delivery model needs to be established and agreed as soon as possible with partners and stakeholder groups, following further guidance from Government as to the exact funding mechanism. Mapping of existing administrative and commissioning arrangements across Lincolnshire, project design and implementation plans should be initiated as soon as possible to enable key decisions to be made in relation to lead roles and fund ‘hosting’ arrangements.

Clarity on national frameworks and the actual financial effect of these in each administrative area is essential as early as possible in the programme of implementation. This will enable commissioners to try and align the new funding arrangements to existing commissioning plans.

Current services that didn't meet the new specification once set by Lincolnshire would need to be informed as early as possible to enable exit strategies to be drawn up and TUPE negotiations to begin. If the service was able to adapt to meet the new specification, transitional protection might be needed for a period of time.

If a scheme were to no longer receive funding, they would be at risk of closure which at worst could result in homelessness. Tenants might need to be assisted to move to alternative accommodation if they still required support, or the rents were no longer affordable. Some tenants might need to start contributing towards the rent and require support to do so. Rent arrears would likely increase.

If providers are concerned they won't receive funding from 2019 they could soon start considering closing services.

Q11: Do you have any other views about how the local top-up model can be designed to ensure it works for tenants, commissioners, providers and developers?

Involvement and co-production with current service users and their families and carers is essential to success. The suggested funding model toolkit/framework described in the answer to Q8 should ensure service users are clear about the type of support they can expect, how this will meet outcomes and the cost in order to be able to make informed housing choices.

It is important that the provision of 'floating support' is recognised within the funding model. Someone, for example, through choice and control wishes to live in 'general needs' accommodation but requires floating 'housing support' in order to sustain their accommodation and maximise independence (and avoiding potentially more expensive options) should still have a funding 'top-up' applied.

Any funding model needs to be simple and transparent for all those with an interest in supported housing. Commissioners want to be sure through open book accounting they are getting value for money alongside quality provision, that makes a difference to people's lives and helps them to progress towards independence. Providers and developers want to be assured the costs of providing supported housing are fully understood by commissioners and that any funding is fair and sufficient to develop and sustain supported housing into the future. Equally, projects commissioned and provided by local authorities directly should be supported through the funding model to acknowledge the additional costs of supported accommodation services.

The local top-up model should enable housing providers to provide accommodation for people who get housing benefit as well as those not receiving housing benefit. This is particularly important for Extra Care Housing providers whose schemes are often made up of a mix of housing benefit claimants and those who fund their own care and accommodation – both groups would be charged the same level of rent. There may be a danger of providers needing to set up a two-tier cost structure to pay for the cost of the accommodation.

Local Housing Allowance amounts vary across each of the 7 districts in Lincolnshire, for example there is a £13 per week difference for one bedroom in one District compared to another. Top ups across districts may need to vary to avoid providers only providing accommodation in the higher paying areas. In areas where the LHA is low, the gap between the rent/service charges and the LHA may be too much for tenants to make up, resulting in evictions or clients on low incomes being declined accommodation.

Living in supported accommodation can be a barrier to obtaining employment because the rents are too high for working people. This needs to be overcome to enable service users to obtain employment and not have to leave the accommodation because it's no longer affordable. Some funds might need to be ring fenced to enable this to happen.

Developing options for workable funding model(s) for short term accommodation, including hostels and refuges

Q12: We welcome your views on how emergency and short term accommodation should be defined and how funding should be provided outside Universal Credit. How should funding be provided for tenants in these situations?

It is important people do not go into supported housing 'emergency' or 'short term' as a matter of course, when they could receive appropriate support within longer term housing solutions.

Emergency and Short Term could be defined as supported accommodation intended to provide shelter for a minimal term with minimal security of tenure i.e. licensee.

Emergency

Immediate access to accommodation and support - without the intervention of supported housing their safety, health and wellbeing is likely to deteriorate or they will be 'at risk' of serious harm or will require access to other emergency 'blue light' service provision. This provision is an intense 48 hour/7 day service to enable settlement/adjustment and assessment of need/multi agency collaboration solutions. Move-on options include 'short-term' supported accommodation, longer term support or general needs accommodation. This should not necessarily see the individual having to physically move, but a change to the 'band of need'.

Short Term

A definition of short term can vary widely according to the group/s identified within this consultation. It is distinctive from Extra Care and Community Supported Living Schemes which provide longer term housing solutions for as long as someone chooses to live there.

Robust support planning alongside person-centred outcomes would determine the length of stay. Arguably, once 'short term' outcomes identified have been met then there should be move-on planning away from provision. Incentives may need to be included to ensure progression and throughput, supporting transition into other forms of alternative/ appropriate accommodation. This could be incentivised using payment by results methods.

General

Services must receive the housing element direct in order to remain financially viable. Providers can't operate and employ staff if they aren't guaranteed the funding to pay the wages etc. Where someone moves into supported accommodation there should not be any delays in benefit claims being re-assessed.

Providers cannot wait 6 weeks for a claim to be assessed, or payments made direct to the client, because this would result in rent arrears in many cases and providers not having the finances to continue the service. Short term accommodation providers need to be protected in order to be financially viable.

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)
27 September 2016	**13**	**Minutes** That the minutes of the previous meeting of the Lincolnshire Health and Wellbeing Board held on 27 September 2016, be confirmed as a correct record and signed by the Chairman.
	14	**Action Updates from the previous meeting** That the report be noted.
	15	**Chairman's Announcements** That the report be noted.
	16a	**Annual Assurance Report** That the report, comments made by the Board and the responses of officers, be noted.
	16b	**Prioritisation Framework for the Development of the Joint Health and Wellbeing Strategy** That the feedback from the workshop on the Prioritisation Framework be noted and welcomed. That, subject to the amendments identified by the Board in Exercise 2 of Appendix B, for developing the next Joint Health and Wellbeing Strategy for Lincolnshire, the Prioritisation Framework be agreed.
	17a	**Joint Commissioning Board – Update Report** That the report be noted. That the recommendation of the Joint Commissioning Board not to accede to the request from the concerned District Council in connection with their Disabled Fund Grant for 2016/17, be agreed.

	17b	**Lincolnshire Sustainability and Transformation Plan – (including Lincolnshire Health and Care)** That the report be noted.
	19	**An Action log of Previous Decisions** That the report be noted.
6 December 2016	**24**	**Minutes** That the minutes of the previous meeting of the Lincolnshire Health and Wellbeing Board meeting held on 27 September 2016, be conformed and signed by the Chairman as a correct record.
	27a	**Integration Self-Assessment** 1. That the details of the Integration Self-Assessment as detailed in Appendices A and B be noted. 2. That the next steps as detailed below be approved:- Each partner organisation, including all dostric councils, NHS providers and Involving Lincs, share the details of this exercise with their governing body to raise awareness of the feedback and to gain commitment from stakeholders to develop a shared improvement plan to address the issues highlighted through this exercise; Each partner is asked to identify their top three priority areas for improvement (ranked 1 to 3, with 1 being the top priority) and to feed this information back to the Programme Manager , Health and wellbeing by the end of January 2017; The organisational priorities are collated and developed into a ranked long list; A further report is presented to the health and Wellbeing Board in March 2017
	27b	**Better Care Fund** 1. That delegation be given to the Executive Director of Adult Care and Community Wellbeing, in consultation with the Chairman of the Lincolnshire Health and Wellbeing Board, the responsibility to submit the BCF Plans for 2017/18 – 2018/19 2. That the Lincolnshire Health and Wellbeing Board notes that the Joint Commissioning Board is likely to recommend that the Protection of Adult Care Services should be at the minimum amount identified in Planning Guidance to be issued after 12 December 2016, and that the Council are likely to accept this minimum amount (all subject to any material requirements in the national guidance). 3. That the Lincolnshire Health and wellbeing Board defers to the A & E Board target setting; and notes that 'stretch targets' will be set for

		both 2017/18 and 2018/19, notably with respect to Non-elective Admissions (NEA) and Delayed Transfers of Care (DTOC). 4. That agreement be given to the Disabled Facilities Grant paper (detailed at Appendix B), prepared by the Interim Director of Public health should provide a steer on the way forward to address DFGs for 2017/18 – 2018/19; but should take into account the comments raised with regard to amending the proposed target for completing DFGs from self-referral to job completion. 5. That agreement be given to Lincolnshire making an application to be a pilot 'graduation site'. 6. That agreement be given to not progressing any work in developing a contingency sum in the next BCF submission, (Subject to any material requirements in the national guidance).
	27c	**Lincolnshire Clinical Commissioning Groups Draft Operational Plan** That the Lincolnshire Clinical Commissioning Groups Draft Joint Operational Plan on a Page 2017/19 be noted.
	29a	**Health and Wellbeing Grant Fund – Update** That the Quarter 2 information concerning the Health and Wellbeing Grant Fund projects 2016 – 2017 provided in Appendix A be noted.
	29b	**An Action Log of previous Decisions** That the Action Log of previous decisions of the Lincolnshire Health and Wellbeing Board be noted.
	29c	**Lincolnshire health and Wellbeing Board – Forward Plan** That the Forward Plan for informal and informal meetings of the Lincolnshire Health and Wellbeing Board presented be received, subject to the inclusion of the items as detailed above.

Lincolnshire Health and Wellbeing Board Forward Plan: March 2017 – December 2017

Meeting Dates	Decision/Authorisation Item	Discussion Item	Information Item
7th March 2017 **2pm in Committee Room 1, County Offices, Newland, Lincoln LN1 1YL**	**Annual Report of the Director of Public Health on the health of the people of Lincolnshire 2016** To receive the Annual Report on the Health of the people of Lincolnshire. **Tony McGinty, Interim Director of Public Health** **Joint Health and Wellbeing Strategy – Engagement Plan** To receive a report asking the Board to approve the engagement approach for developing the next JHWS. **David Stacey, Programme Manager, Strategy and Performance** **Better Care Fund Submission/ Graduation** To receive a report on the 2017/18 – 201/19 BCF Submission **Glen Garrod, Director of Adult Care & Community Wellbeing** **Integration Self-Assessment – Next Steps** To receive a report asking the Board to agree the next steps following the Integration Self-Assessment **Alison Christie, Programme Manager Health and Wellbeing**	**Service Users with Learning Disabilities** To receive a report on the Regional Improvement Programme to support people with Learning Disabilities and to present the position statement for Lincolnshire against the agreed regional baseline standards. **Justine Hackney, Assistant Director, Specialist Adult Services** **NHS Immunisation & Screening for Patients in Lincolnshire** To receive a report from Healthwatch Lincolnshire on the findings of their work around Immunisation and Screening services **Sarah Fletcher, Chief Executive Officer, Healthwatch Lincolnshire** **<u>District/Locality Item</u>** **North Kesteven's Health and Wellbeing Strategy** To receive a report on North Kesteven's new Health and Wellbeing Strategy **Phil Roberts & Luisa McIntosh, North Kesteven District Council**	**ACTion Lincs' – Tackling Entrenched Rough Sleeping in Lincolnshire (Social Impact Bond Funding)** To receive an information report on the recent bid to DCLG for an Entrenched Rough Sleepers Social Impact Bond **Michelle Howard, West Lindsey District Council** **Government Proposals for the Future Funding of Supported Housing** To receive an information report on government proposals on the future funding of social housing **Lisa Loy, Housing for Independence Manager**
6 June 2017 **2pm, Committee Room 1, County Offices**	**Annual General Meeting** Election of Chair and Vice Chair **Terms of Reference and Procedural Rules, roles and responsibilities of core Board members** Review and formal agreement **Alison Christie, Programme Manager Health and Wellbeing**	**Sustainability and Transformation Plan** To receive an update on the delivery of the STP **Chief Officer, Clinical Commissioning Group** **Better Care Fund** To receive an update on the BCF **Glen Garrod, Director of Adult Care & Community Wellbeing**	

Meeting Dates	Decision/Authorisation Item	Discussion Item	Information Item
	Joint Strategic Needs Assessment – Overview Report To receive a report providing an overview of the topics in the new JSNA published Spring 2017. **Chris Weston, Public Health Consultant – Wider Determinants of Health** **Lincolnshire Pharmaceutical Needs Assessment (PNA) & impact of changes to Community Pharmacy funding** To receive a report by the PNA Steering Group outline the arrangements for the review of Lincolnshire's PNA (due to be republished March 2018) and to update the Board on any impact on pharmacy provision as a result of changes to how community pharmacies are funded **Chris Weston, Public Health Consultant – Wider Determinants of Health**	**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** **Carer's Memorandum of Understanding** To receive a report asking the Board to comment on the Carer's MOU **Jane Mason, Commissioning Manager & Emma Krasinska, Carer's Lead, Adult Care** **<u>District/Locality Item</u>** **East Lindsey Health and Wellbeing Strategy** To receive a report on East Lindsey's new Health and Wellbeing Strategy **Sem Neale, East Lindsey District Council**	
26 September 2017 **2pm, Committee Room 1, County Offices**	**Development of the new Joint Health and Wellbeing Strategy** To receive the findings of the prioritisation process and stakeholder engagement for the next JHWS. **David Stacey, Programme Manager, Strategy and Performance** **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**	**Sustainability and Transformation Plan** To receive an update on the delivery of the STP **Chief Officer, Clinical Commissioning Group** **Better Care Fund** To receive an update on the BCF **Glen Garrod, Director of Adult Care & Community Wellbeing** **District/Locality Items** Standing agenda item for the Board to receive updates, by exception, from District/locality partnerships	

Meeting Dates	Decision/Authorisation Item	Discussion Item	Information Item
5 December 2017 **2pm, Committee Room 1, County Offices**	**Joint Health and Wellbeing Strategy** A presentation on the early first draft of the new JHWS. **David Stacey, Programme Manager, Strategy and Performance along with relevant Chapter Sponsors/Authors**		

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