County Offices
Newland
Lincoln
LN1 1YL

16 March 2020

Lincolnshire Health and Wellbeing Board

A meeting of the **Lincolnshire Health and Wellbeing Board** will be held on **Tuesday, 24 March 2020 at 2.00 pm in Committee Room One, County Offices, Newland, Lincoln Lincs LN1 1YL** for the transaction of the business set out on the attached Agenda.

Yours sincerely

Debbie Barnes OBE
Chief Executive

MEMBERS OF THE BOARD

Lincolnshire County Council: Councillors: Mrs S Woolley (Executive Councillor NHS Liaison and Community Engagement) (Chairman), Mrs P A Bradwell OBE (Executive Councillor Adult Care, Health and Children's Services), C N Worth (Executive Councillor Culture and Emergency Services), Mrs W Bowkett, R J Kendrick, C E H Marfleet, C R Oxby and N H Pepper

Lincolnshire County Council Officers: Debbie Barnes OBE (Chief Executive), Glen Garrod (Executive Director of Adult Care and Community Wellbeing) and Professor Derek Ward (Director of Public Health)

District Council: Councillor Donald Nannestad

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

Healthwatch Lincolnshire: Sarah Fletcher

NHS E/I: Peter Burnett

Police and Crime Commissioner: Marc Jones

Lincolnshire Co-Ordinating Board: Elaine Baylis

Associate Member (Non-Voting): Jason Harwin (Lincolnshire Police)

LINCOLNSHIRE HEALTH AND WELLBEING BOARD AGENDA
TUESDAY, 24 MARCH 2020

7c **Social Prescribing Update** 129 - 146

(To receive a report on behalf of the Lincolnshire Sustainability and Transformation Partnership on the social prescribing 'proof of concept' service that has been running across Lincolnshire since June 2018. The report also outlines the new service model from April 2020 along with recommendations to be able to scale up the approach over the next four years. Kirsteen Redmile, Lead Change Manager – Personalisation STP System Deliver Unit will be in attendance for this item)

7d **Suicide Prevention Strategy** 147 - 160

(To receive a report on behalf of Derek Ward, Director of Public Health, which advises the Board of the draft Suicide Prevention Strategy which has been co-produced with partners across the system through the Suicide Prevention Steering Group)

8 Information items

8a **The Lincolnshire Better Care Fund (BCF)** 161 - 184

(To receive a report from Glen Garrod, Executive Director Adult Care and Community Wellbeing, which provides the Lincolnshire Health and Wellbeing Board with an update on Lincolnshire's BCF plan)

8b **An Action Log of Previous Decisions** 185 - 188

(For the Health and Wellbeing Board to note decisions taken since June 2019)

8c **Lincolnshire Health and Wellbeing Board Forward Plan** 189 - 190

(This item provides the Board with an opportunity to discuss matters for future meetings, which will subsequently be included in the forward plan)

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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.

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www.lincolnshire.gov.uk/committeerecords

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LINCOLNSHIRE HEALTH AND WELLBEING BOARD
4 FEBRUARY 2020

PRESENT: COUNCILLOR MRS S WOOLLEY (CHAIRMAN)

Lincolnshire County Council: Councillors Mrs W Bowkett, C R Oxby and N H Pepper.

Lincolnshire County Council Officers: Professor Derek Ward (Director of Public Health) and Heather Sandy (Interim Director of Education).

District Council: Councillor Donald Nannestad (District Council).

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

Healthwatch Lincolnshire: Sarah Fletcher.

NHS E/I: Peter Burnett.

Police and Crime Commissioner: Stuart Tweedale (Deputy Police and Crime Commissioner).

Lincolnshire Co-Ordinating Board: No representative present.

Associate Member (non-voting): Jason Harwin (Lincolnshire Police).

Officers In Attendance: Alison Christie (Programme Manager, Health and Wellbeing Board), Katrina Cope (Senior Democratic Services Officer), Emma Krasinska (Commissioning Manager, Adult Care & Community Wellbeing), Semantha Neal (Chief Commissioning Officer), Amy Thomas (Head of Communities at Community Lincs (part of YMCA Lincolnshire)), Michelle Howard (Assistant Director People, East Lindsey District Council) and Andy Fox (Consultant in Public Health).

Councillor Dr Michael Ernest Thompson, (Executive Councillor NHS Liaison and Community Engagement) attended the meeting as an observer.

19 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

Apologies for absence were received from Councillors Mrs P A Bradwell OBE, Executive Councillor Adult Care, Health Services and Children's Services, C N Worth, Executive Councillor Culture and Emergency Services, Debbie Barnes OBE, Chief Executive/Executive Director of Children's Services and Marc Jones, Police and Crime Commissioner.

It was noted that Heather Sandy, Interim Director of Education and Stuart Tweedale, Deputy Police and Crime Commissioner were in attendance for Debbie Barnes OBE, Chief Executive/Executive Director of Children's Services and Marc Jones, Police and Crime Commissioner respectively, for this meeting only.

It was noted further that Peter Burnett would now be the representative for NHS England/Improvement going forward in place of Hayley Jackson.

The Chairman invited the Board to consider the appointment of Jason Harwin, Deputy Chief Constable Lincolnshire Police as an Associate Member of the Board (in accordance with Paragraph 6.2 of the Lincolnshire Health and Wellbeing Board – Terms of Reference and Procedure Rules).

RESOLVED

That Jason Harwin, Deputy Chief Constable Lincolnshire Police be invited to be an Associate Member of the Lincolnshire Health and Wellbeing Board.

20 DECLARATIONS OF MEMBERS' INTEREST

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

21 MINUTES OF THE LINCOLNSHIRE HEALTH AND WELLBEING BOARD MEETING HELD ON 24 SEPTEMBER 2019

RESOLVED

That the minutes of the Lincolnshire Health and Wellbeing Board meeting held on 24 September 2019 be agreed and signed by the Chairman as a correct record.

22 ACTION UPDATES

RESOLVED

That a copy of the Action Updates be circulated to members of Board following the meeting.

23 CHAIRMAN'S ANNOUNCEMENTS

RESOLVED

That a copy of the Chairman's Announcements be circulated to members' of the Board, following the meeting; and that the supplementary announcements circulated at the meeting be received.

24 DISCUSSION ITEMS

24a Presentation on the Director of Public Health Annual Report

The Board gave consideration to a report from Derek Ward, Director of Public Health, which provided the independent statutory report of the health of the people of Lincolnshire.

A copy of the 2019 report was attached at Appendix A for the Board to consider. It was highlighted that the Annual Report was focused on the burden of disease in Lincolnshire.

The Director of Public Health provided the Board with a short video and presentation, which advised how the report had for the first time used the Global Burden of Disease (GBD) methodology. It was highlighted that GBD was a study into how disease affected the population in terms of morbidity and mortality, which could be used to drive change in order to improve the population's health.

The Board received an explanation of what made up the GBD; an explanation of Lincolnshire's burden of disease, which provided information of the top ten health issues relating to Years Lived with a Disability (YLD), Years of Life Lost (YLL), and Disability Adjusted Life Years (DALYs).

It was reported that whilst life expectancy had increased, the period of time that people lived with a disability had also increased. It was reported further that the biggest killers were ischaemic heart disease, lung cancer, stroke, and chronic constructive pulmonary disease (COPD). It was highlighted that Alzheimer's accounted for nearly 6% of all Years Lost in Lincolnshire.

The Board was advised when it came to Years Lived with Disability the top five disorders identified were low back pain, headache disorders, depressive disorders, neck pain and age related hearing loss. The Board was advised further that Diabetes and CPD had also been identified as had falls, anxiety disorders and oral disorders.

It was highlighted that when premature mortality and disability data were combined to compare the overall burden of disease, the greatest single burden in Lincolnshire was ischaemic heart disease and the second was lower back pain. It was noted that when lower back pain and neck pain were combined they became the greatest cause of DALY in Lincolnshire.

The Board was advised that a fundamental shift was required to refocus on prevention and early detection. It was noted that the greatest risk factor was smoking, along with high blood pressure, high body mass index and high cholesterol, and that these were all risk factors that could be improved.

The Director of Public Health responded to questions raised which included:

- The level to which the GBD data was available. Confirmation was given that at the moment county level was the lowest level data was available;
- Behavioural change – The Board noted that this would be gradual process, but the ultimate aim was to keep as healthy as possible. It was noted further that everyone had a role in primary prevention; and
- Cholesterol levels and associated medications. It was noted that as a result of medications, levels were down to individuals.

RESOLVED

That the Director of Public Health Report 2019 – The Burden of Disease in Lincolnshire and associated presentation be received.

24b Whole Systems Approach to Healthy Weight

Consideration was given to a report which provided an update from the Lincolnshire Whole Systems Healthy Weight Partnership (WSHWP) on the development of the whole system approach to tackling obesity in Lincolnshire.

Attached to the report were the following Appendices for the Board to consider:-

- Appendix A – The Process for implementing the whole systems approach;
- Appendix B – A copy of the System Map for Lincolnshire;
- Appendix C – A copy of an Action Map (which identified the current actions mapped against the perceived caused of obesity); and
- Appendix D – A Systems Map for Lincolnshire with current actions identified overlaid.

Andy Fox, Public Health Consultant provided a short presentation, which identified that the Lincolnshire WSHWP had been set up in February 2019 and comprised of county and district councillors, senior managers within clinical Commissioning Groups, Children's Services, School Head Teachers and representation from the University of Lincoln.

The Board noted that the partnership had agreed that the focus would be on healthy weight rather than obesity. Details of the progress made to date were shown on pages 40 and 41 of the report.

It was highlighted that a prerequisite to developing a local whole system approach was having an overview of actions currently being undertaken. It was highlighted further that a mapping tool had been created by Leeds Beckett University and the whole system approach to obesity pilot teams. Information relating to the 'Action Mapping' was shown on page 41 of the report and in Appendix C to the report.

The Board was advised of the next steps, which included the arranging of further themed meetings; working with district councils to progress the countywide action map; prioritise areas to intervene with the themes; develop actions across sub-

groups; and conduct wider network meetings to update and agree the next steps required collectively.

A short discussion ensued, which raised the need to promote physical activity more, Officers confirmed that work was on going and that more needed to be done across the whole of the county. It was also highlighted that district councils also had a role to play at local planning stage, with planned built environments and the provision of leisure facilities. Confirmation was given that district councils were in agreement with the system based approach.

RESOLVED

That the progress made by Lincolnshire's Whole Systems Healthy Weight Partnership and how this was contributing to delivering the healthy weight priority of the Joint Health and Wellbeing Strategy be noted.

24c Joint Health and Wellbeing Strategy Carers Priority Update

The Board received a joint report from Sem Neal, Chief Commissioning Officer Prevention & Early Intervention and Emma Krasinska, Programme Manager, which provided a update from the Carers Delivery Group on the delivery of key areas of work within the Carers Priority Delivery Plan.

Attached to the report were the following Appendices:

- Appendix A – A copy of Lincolnshire's Long Term Commitment to Carers: A Health and Wellbeing Memorandum of Understanding;
- Appendix B – Survey of Adult Carers in Lincolnshire; and
- Appendix C – A copy of the Draft Refreshed Carer Priority Delivery Plan.

The report clearly identified that a lot of progress had been made against the Supporting Carers Priority identified in the Joint Health and Wellbeing Strategy (JHWS). The Board noted that the Carers Delivery Group oversaw the work supporting this priority through the Carer Delivery Plan.

In guiding the Board through the report, particular reference was made to: the Lincolnshire JHWS Carers Priority Objectives and Next Steps which were detailed within the report presented.

It was highlighted that Lincolnshire was estimated to have 88,000 carers by 2021; and that the most rapidly rising cohort of carers were carers aged 85 and over.

The Board noted that evidence from the 2018/19 DHSC Survey of Adult Carers in England (Appendix B) reinforced the need for primary care to further develop its role in supporting carers. It was noted further that many of the Lincolnshire respondents stated that their GP did not know that they were a carer, and that they saw their GP as an important professional to whom they would confide any concerns about their own safety.

The Board was advised that Lincolnshire Carers Service workers were embedded within Hospital Social work teams and were working collaboratively with partner organisations across acute hospitals and multiple wards to support over 1,000 unique carers each year.

It was noted that with plans for an Integrated Care System (ICS), local implementation of the NHS Long Term Plan, national recognition of good integrated carers practice, the placing of carers as a priority within the JHWS and a refreshed Carers Delivery Plan for 2020, it was felt that it was the right moment for Lincolnshire to take the next step of a system-led 'Long Term Commitment to Carers'. A copy of the Memorandum of Understanding was attached at Appendix A to the report.

Reference was also made to the Carer Quality Award which had helped many local health practitioners improve their identification and support of carers. It was highlighted that 42% of Lincolnshire's GP practices now had an up to date Carers Register. Details pertaining to the Carer Quality Award were shown on page 55 of the report.

During discussion, issues raised included the need for more awareness across all organisations; including Pharmacists and the Police.

RESOLVED

1. That the progress made to date and next steps detailed in the Joint Health and Wellbeing Strategy Carers Priority Update Report presented be noted.

2. That support be given to the achievement of the refreshed Carers Priority Plan as detailed in Appendix B.

3. That support be given to championing a System Led approach to supporting carers and to support the implementation of the NHS Long Term Plan by:

    - Asking their own organisations to:

        - sign the 'Commitment to Carers' Memorandum of Understanding (Appendix A);
        - sign up to achieving the Carer Quality Award, if not already underway;
        - identify and support young carers and their families' needs;
        - support the establishment of Carers Champions in their own organisations;
        - support their own staff in a caring role by signing up to 'Employers for Carers', conducting a benchmarking survey of staff in a caring role and developing a staff carers' network;
    - Asking service providers and partner agencies to adopt these initiatives;
    - Asking all NHS partners including Primary Care Networks (PCNs) and General practice (GPs) to sign up to GP Quality Markers.

24d Better Ageing in Rural Areas - Learning from East Lindsey

The Board gave consideration to a report from East Lindsey District Council and Community Lincs, which provided an overview of the Talk, Eat and Drink (TED) and Age Friendly projects in East Lindsey as well as providing an update on the Centre for Ageing Better (CFAB).

The Chairman welcomed to the meeting Michelle Howard, Assistant Director People, East Lindsey District Council and Amy Thomas, Head of Communities at Community Lincs part of YMCA Lincolnshire.

It was reported that with an increasing ageing population, that by 2037, a quarter of the total UK population would be over 65. It was noted that in particular East Lindsey would continue to have a higher than national average number of older residents and that projected numbers state that by 2041, East Lindsey would have 40% of its residents over 65.

The report presented to the Board provided an update on two established programmes of work in East Lindsey, where there was a particular focus and emphasis on supporting and enabling Better Ageing across rural and coastal communities.

The Board noted that TED was delivered as part of a £78 million National Lottery funded 'Ageing Better Programme' (2015-2021). TED had been successful in achieving its objectives (primarily in reducing isolation and loneliness within an ageing population, developing and delivering innovative programmes of work and contributing effectively to the national programme). Details of the programmes outcomes were shown on pages 89 to 91 of the report.

It was reported that locally, TED participants had reported that they were much more actively involved in their communities. It was noted that 76% of individuals now had more social contact following participation in TED activities and 75% had increased their participation in social events as a result of TED. Further details relating to delivery statistics and learning reports were detailed on pages 92 to 94 of the report.

The Board was advised that East Lindsey had been working closely with Community Lincs (Lincolnshire YMCA). The Board was advised further that the Council had been the first in the country to join the UK network of Age Friendly communities. It was noted that East Lindsey had demonstrated commitment to supporting people to live healthier, have more active lives as part of its commitment to Better Ageing. The Council in 2019 had also introduced a portfolio structure to supporting Better Ageing.

The Board was advised that in 2019, the Centre for Ageing Better (CfAB) had invited the opportunity for a rural area to become its Rural Strategic Partner. With the support and engagement of a wide range of partners and with the agreement of Lincolnshire Housing, Health & Care Delivery Group; an expression of interest for Lincolnshire was submitted in August 2019. The supplementary announcements earlier in the agenda had confirmed that Lincolnshire had been chosen as a strategic

rural localities partner. A copy of the CfAB priorities was attached to the report at Appendix A.

During discussion, reference was made to: the synergies between TED and CfAB; future proofing for old age – homes for life; safety scams; the need to extend the good practice in East Lindsey to other districts – confirmation was given that TED was a national programme and officers from East Lindsey were more than happy to share with others what initiatives had been successful. The Board was also advised that learning reports relating to TED were available on the website.

Congratulations were extended to Michelle and Amy for all their hard work.

RESOLVED

1. That the outcomes to date from the work underway in East Lindsey to support and enable Better Ageing be noted.

2. That the opportunities to extend learning across Lincolnshire be considered.

3. That continued dialogue be supported with the Centre for Ageing Better (CfAB) to develop a positive working relationship and benefit from their expertise.

25 INFORMATION ITEMS

25a The Lincolnshire Better Care Fund (BCF)

The Board received a report from the Executive Director of Adult Care and Community Wellbeing, which provided an update of the Lincolnshire Better Care Fund performance for Quarter 2.

RESOLVED

That the Lincolnshire Better Care Fund performance report for Quarter 2 presented be noted.

25b Half Yearly Update on Health Protection Arrangements

The Board received a half yearly update report from the Director of Public Health concerning Health Protection Arrangements.

The Director responded to a question raised concerning Immunisation. Confirmation was given that it was a system approach taken to immunisation.

RESOLVED

1. That the overall good position of health protection arrangements within Lincolnshire be noted.

2. That the areas of the health protection service facing challenges be noted.

25c An Action Log of Previous Decisions

RESOLVED

That the log of decisions taken by the Lincolnshire Health and Wellbeing Board since 11 June 2019 be received.

25d Lincolnshire Health and Wellbeing Board Forward Plan

RESOLVED

That the Lincolnshire Health and Wellbeing Board Forward Plan – February 2020 to June 2020 be received.

The meeting closed at 3.50 pm.

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Meeting Date	Minute No	Agenda Item & Action Required	Update and Action Taken
11.06.19		**No update to report**	
24.09.19	**17c**	**Advancing our health: Prevention in the 2020's Green paper** 1. That a response be sent on behalf of the Health and Wellbeing Board, and any comments for inclusion should be sent to Alison Christie by 1 October 2019 2. That the Chairman of the Board sign off the response prior to submission on 14 October 2019	A formal response on behalf of the Lincolnshire Health and Wellbeing Board to the Advancing our health: Prevention in the 2020's Green Paper was submitted on 4 October 2019.
04.02.20	**22**	**Action Updates** That a copy of the Action Updates be circulated to members' of the Board following the meeting.	A copy of the Action Updates were sent to all members' of the Board on 7 February 2020
	23	**Chairman's Announcements** That a copy of the Chairman's Announcement be circulated to members' of the Board following the meeting.	A copy of the Chairman's Announcements was sent to all members' of the Board on 7 February 2020.

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Lincolnshire Health and Wellbeing Board – 24 March 2020

Chairman's Announcements

Coronavirus (COVID-19)

The position with regard to coronavirus (COVID 19) changes daily. I have requested that the County Council's Director of Public Health provide an update for the Board, which in order to reflect the most recent information, will be circulated at the meeting on 24 March 2020.

East Midland Clinical Senate

On 26th February, I attended the regional Senate Council's Annual Development Day supported by Katy Thomas, from the council's Public Health team. We provided a development session for senior clinicians from across the region on how Population Health Management practices can help us to move from a health and care system designed to treat and care for those with ill health, which is under unprecedented and unsustainable demand, to one which enhances health and addresses health inequalities.

We described how, alongside improvements in the effectiveness & efficiency of health and care pathways, there needs to be a focus on prevention across populations, life-spans and generations, as well as early interventions for those individuals at rising risk, to prevent their health from deteriorating and avoid adverse incident. This is how, through joint working, we will achieve improvements in health outcomes, quality and effectiveness and make best use of our collective resources. We shared how local authority public health teams are well positioned to make a substantial contribution to this, and to foster the joint working required outside of health and care systems, with district councils, parishes, communities and the voluntary sector, as well as the role that Health and Wellbeing Boards can play as democratic, accountable bodies, with joint priorities. I'm pleased to say that the session was extremely well received and there was huge interest in Lincolnshire's experiences and progress, despite being at the early stages of our own journey.

Substance Misuse Strategy for Lincolnshire

On the 4th March the first steps were taken to develop a new substance misuse strategy for Lincolnshire. An event hosted by Lincolnshire Police was attended by key partners including Probation, NHS trusts, PCC, county council and current service providers. Lincolnshire Police plan to use the information from the event to develop a partnership strategy that guides positive change across the sector including reducing the demand, restricting the supply and promoting recovery. It is anticipated the new strategy will be published before the end of 2020.

Centre for Ageing Better Rural Strategic Partnership

As briefly mentioned at our last meeting in February, I am pleased to confirm the Centre for Ageing Better has selected Lincolnshire as its strategic rural partner. The joint submission with East Lindsey District Council is evidence of a united vision and commitment to ensuring that Lincolnshire's residents are enabled to live well as they approach later life. Work is currently underway with Ageing Better colleagues to ensure appropriate governance arrangements are in place and to agree the priority areas of focus for the next two years.

Primary Care Network Clinical Director Session

On 13 February 2020 I attended a PCN development session with Carolyn Nice, Assistant Director Adult Care – Adult Frailty and Long Term Conditions. The session gave an overview of the work undertaken to date and gave us an opportunity to contribute to future developments. I am grateful to the PCN leads for inviting us to the session and recognising the opportunity to strengthen partnership working.

Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of Derek Ward, Director of Public Health

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**24 March 2020**
Subject:	**Lincolnshire Pharmaceutical Needs Assessment**

Summary:
The purpose of this report is to remind the Health and Wellbeing Board of its responsibility to produce and publish a Pharmaceutical Needs Assessment (PNA) every three years and to set out the process for developing the next PNA, due for publication by 31 March 2021.

Actions Required:

The Health and Wellbeing Board is asked to:

- note the content of this report
- approve the process for developing the next PNA due for publication by 31 March 2021.

1. Background

1.1 Statutory Responsibilities

The Health and Social Care Act 2012 places a statutory responsibility on the Health and Wellbeing Board (HWB) to prepare a Pharmaceutical Needs Assessment (PNA) for Lincolnshire. The NHS Pharmaceutical Services and Local Pharmaceutical Services Regulations 2013 sets out the legislative basis for developing and updating PNAs.

The PNA is a report of the present and future needs for pharmaceutical services. It is used to identify any gaps in current services or improvements that could be made in future pharmaceutical service provision. To prepare the report, data is gathered from pharmacy contractors, dispensing GP practices, pharmacy users and from a range of data sources. The report will include a range of maps that are produced from data collected as part of the PNA process.

The current PNA for Lincolnshire was approved by the HWB in March 2018 and can be accessed on the Lincolnshire Research Observatory. The HWB is required to publish an updated PNA every three years; therefore the next assessment is due for approval and publication in March 2021.

1.2 Governance

The PNA Steering Group will oversee the development of the PNA on behalf of the HWB. It includes representation from Public Health, NHSE, Clinical Commission Groups, Healthwatch, Local Pharmaceutical Committee and the Local Medical Committee. The PNA Steering Group terms of reference have been reviewed and are provided in Appendix A.

The first meeting of the PNA Steering Group is on 24 April 2020. At this meeting the terms of reference, project plan and equality impact assessment (EIA) will be signed off. In addition, the group will finalise arrangements to gather views from community pharmacists and dispensing GP practices. Healthwatch will be supporting the process to gather initial views from patients and service users.

1.3 Process

As detailed in Appendix B, the draft PNA will be prepared between April to August 2020 and will be considered by the Steering Group at a meeting at the end of August 2020. The draft assessment and recommendations from the Steering Group will be presented to HWB members at the meeting in September 2020 to sign off the document for the 60 day mandatory consultation. The intention is to run the statutory consultation between October to December 2020.

The consultation reports will be considered by the Steering Group in January 2021 so the final PNA document can be considered and approved by the HWB at the meeting in March 2021.

1.4 Statutory Consultation

Regulation 8 of the Pharmaceutical Services Regulations specifies that the HWB must consult with the following:

- the Local Pharmaceutical Committee;
- the Local Medical Committee;
- any persons on the pharmaceutical lists and any dispensing doctors listed for its area;
- any local pharmaceutical services (LPS) chemists in its area with who NHSE has made arrangements for the provision of any local pharmaceutical services;
- Healthwatch, and any other patient, consumer or community group in its area which in the view of the HWB has an interest in the provision of pharmaceutical services in its area;
- any NHS trust or NHS foundation trust in its area;
- NHSE
- Any neighbouring HWB.

The HWB must consult with the above list at least once during the process. Those being consulted can be directed to a website address containing the draft PNA document, but if required, can request an electronic or hard copy version. The intention is to also make the draft PNA available on the council's website to enable views to be gathered from wider partners over and above the statutory consultees.

2. Conclusion

The HWB has a statutory responsibility to publish a PNA for Lincolnshire. This report provides details on the review process and timescales to enable the new PNA to be in place by 31 March 2021.

3. Joint Strategic Needs Assessment and Joint Health & Wellbeing Strategy

The Council and Clinical Commissioning Groups must have regard to the Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS).

Evidence from the JSNA will be used to inform the development of the PNA.

4. Consultation

The views of key stakeholders will be gathered as part of an initial engagement process as well as part of the mandatory 60 day consultation period. The findings from these exercises will be used to inform the development of the PNA.

5. Appendices

These are listed below and attached at the back of the report	
Appendix A	PNA Steering Group Terms of Reference
Appendix B	PNA Project Plan

6. Background Papers

Document	Where can it be accessed
NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013	http://www.dh.gov.uk/health/2013/02/pharmaceutical-services-regulations/
Pharmaceutical Needs Assessment – information pack for local authority Health and Wellbeing Boards 2013	https://www.gov.uk/government/publications/pharmaceutical-needs-assessments-information-pack
Lincolnshire Pharmaceutical Needs Assessment 2018	http://www.research-lincs.org.uk/JSNA-PNA.aspx

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

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PNA Steering Group Terms of Reference

1. Background

In order to provide pharmaceutical services, providers (most commonly community pharmacists but also dispensing appliance contractors and GPs in rural areas) are required to apply to be included on a pharmaceutical list. For their inclusion to be approved they are required to demonstrate that the services they wish to provide meet an identified need in the Pharmaceutical Needs Assessment (PNA) for the area.

From April 2013, the Health and Social Care Act 2012 transferred responsibility for developing and updating PNAs from the Primary Care Trusts (PCTs) to Health and Wellbeing Boards (HWB). At the same time the responsibility for using PNAs as the basis for determining market entry to the pharmaceutical list transferred from PCTs to NHS England.

2. Purpose

The Lincolnshire HWB has the legal responsibility for producing a PNA for every three years. A revised PNA for Lincolnshire needs to be published by 1 April 2021.

The purpose of the PNA Steering Group (PNA SG) is to develop the revised PNA on behalf of the HWB.

The PNA SG will set the timetable for the development of the PNA, agree the format and content, oversee the statutory consultation exercise and ensure the PNA complies with statutory requirements.

3. Role

The PNA SG has been established to:

- Oversee and drive the formal process to review the PNA for Lincolnshire, including the 60 day statutory consultation exercise.
- Ensure the published PNA complies with all the statutory requirements set out in the appropriate Regulations.
- Promote integration and linkages with other key strategies and plans including the Lincolnshire Strategic Needs Assessment (JSNA), the Joint Health and Wellbeing Strategy (JHWS) for Lincolnshire and Lincolnshire's Long Term Plan.
- Establish arrangements to regularly review the PNA following publication, including issuing subsequent supplementary statements in response to any significant changes.

4. Key Functions

- To oversee the PNA process.
- To approve the framework for the PNA.
- To approve the project plan and timeline, and drive delivery to ensure key milestones are met.
- To ensure the development of the PNA meets all statutory requirements.
- To determine the localities which will be used for the basis of the assessment.
- To undertake an assessment of the pharmaceutical needs of the population including;

    - mapping current pharmaceutical service provision in Lincolnshire;
    - reviewing opening hours and location of services;
    - using the JSNA and other profile data to review the health needs of the population;
    - analysing current and projected population changes in conjunction with existing patterns of service provision;
    - identifying any gaps in service provision and proposed solutions on how gaps can be addressed; and
    - considering future needs, including housing growth, and its impact on the development of services – in terms of essential, advanced and enhanced service provision.
- To produce a draft PNA for consultation.
- To ensure active engagement arrangements are in place.
- To oversee the consultation exercise ensuring that it meets the requirements set out in the Pharmaceutical Regulations 2013.
- To consider and act upon formal responses received during the formal consultation process, amending the PNA document as appropriate.
- To ensure the Lincolnshire HWB is updated on progress and that the final PNA is signed off by the Board by the end of March 2021.

5. Membership

Core membership will consist of:

- Member of the Public Health Senior Leadership Team (LCC) (Chair)
- Programme Manager Strategy and Development (LCC) (Project Manager)
- Programme Manager Public Health Intelligence (LCC)
- Primary Care Support Contract Manager (NHS England – Central & Midland area)
- Representative, Healthwatch Lincolnshire
- Representative, Local Pharmaceutical Committee
- Representative, Local Medical Committee
- Representative, Lincolnshire Clinical Commissioning Group
- Specialist Pharmacist Lead

In addition to the PNA SG core membership, specific expertise will be requested as required in order to meet specific elements of the Regulations, for example LCC'S Communications and Community Engagement Team will be asked to support and advice on the publication and consultation exercise.

Each core member has one vote. Core members may provide a deputy to meetings in their absence. The SG shall be quorate with five core members in attendance.

Non-attending members are unable to cast a vote – that vote may otherwise sway the casting decision.

The following are core members which are required for quoracy:
- Member of the Public Health Senior Leadership Team (LCC) (Chair)
- Primary Care Support Contract Manager (NHS England – Central & Midland area)
- Representative, Local Pharmaceutical Committee
- Representative, Local Medical Committee

6. Reporting Arrangements

- The PNA SG will report to the HWB and Health Scrutiny Committee for Lincolnshire as required.
- The Chair of the PNA SG will provide regular updates on progress to the Chairman of the HWB and the Director of Public Health.

7. Frequency of Meetings

The PNA SG will meet, either on a face to face basis or virtually (conference call or email discussion), bi monthly or in accordance with the project plan.

Following publication of the agreed PNA, the SG will be convened on a quarterly basis to fulfil its role in timely maintenance of the PNA.

The meetings will be administered by Public Health, Lincolnshire County Council.

8. Declarations of Interest

Declarations of interest will be a standing item on each PNA SG agenda and the details will be recorded in the minutes. Where a member has a conflict of interest for any given item, they will be entitled to participate in the discussion but will not be permitted to be involved in final decision making.

If any issues arise concerning conflicts of interest, these will be reported to the HWB.

9. Steering Group Member Responsibilities

Members of the PNA SG will:

- Commit time to attend meetings.
- Nominate a deputy, wherever possible, to attend meetings on their behalf in their absence.
- Actively contribute to the compilation of the revised PNA and any subsequent supplementary statements.
- Come to meetings prepared with all documents and contribute to the debate.
- Understand that the discussions at the PNA SG are confidential, unless stated otherwise, and are not to be disclose to any unauthorised person.
- Declare any conflicts of interest which might have a bearing on their actions, views and involvement with the PNA SG.

10. Review

These Terms of Reference will be reviewed on an annual basis.

Last updated: January 2020

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Project Plan - Lincolnshire PNA 2021	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Governance Meetings														
PNA Steering Group meeting			23											
Health Scrutiny Committee for Lincolnshire			16					16					TBC	
HWB meetings		24						29			1			23
Set up														
Schedule PNA Steering Group meetings														
Produce draft Communication & engagement plan														
Draft initial PNA EIA														
Update PNA SG Terms of Reference														
Draft project plan														
Write reports for HWB & HSC		5												
Development														
Agree data & intelligence requirements														
Request data and strategic documents from CCG & NHSE														
Draft Dispensing GP & Community Pharmacy questionnaires														
Draft questions for public engagement														
Liaise with Healthwatch re public engagement approach														
Identify list of key stakeholders														
Agree GP & Community Pharmacy questionnaire (by email)			9											
Agree public engagement approach with Healthwatch (by email)			9											
Produce update for HWB (Chairman's announcements)				22										
Data collection and stakeholder engagement														
Data collection sheets sent to key stakeholders			1											
Distribute dispensing GP & community pharmacy questionnaires			14											
Healthwatch engagement starts			14											
Deadline for questionnaires to be completed				8										
Heathwatch engagement ends				12										
Engagement results analysed				29										
Collate & analysis of all information collected														
Develop Public Health Chapter														
Pharmacy lists, categorised by type produced														
Maps produced														
Planning - new developments assessed for impact														
Pharmacies who provide advanced services														

Pharmacies who provide enhanced/locally commissioned services														
Compare information against PNA 2018														
Review and identify any gaps in service - current & future														
Deadline for drafting PNA document								1						
Write HWB & HSC reports for September meetings								4						
Statutory Consultation														
Prepare consultation questions														
Prepare communications to key stakeholders														
Prepare online consultation														
Draft PNA Document finalised and signed off by HWB for consultation								29						
Consultation goes lives									5					
Consultation link and details sent to key stakeholders									5					
Prepare updates for HWB & HSC														
Consultation ends											4			
Produce Consultation report														
Circulate consultation report to PNA SG														
Sign off & Publication														
Deadline for making final changes to the PNA document												17		
Proof read and quality check PNA document												28		
Produce report for HSC												tbc		
Make any changes														
Produce HWB report														
Set up web page and prep for publication														
Sign off at HWB meeting													23	
PNA published													31	

Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of Derek Ward, Director of Public Health

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**24 March 2020**
Subject:	**Lincolnshire Health and Wellbeing Board Review**

Summary:

From 1 April 2020, the four CCGs in Lincolnshire will merge to form the NHS Lincolnshire CCG. This change, along with other emerging system developments such as Integrated Care Systems (ICSs) and population health management need to be reflected in the membership and terms of reference of the Health and Wellbeing Boards (HWB). The HWB is asked to consider arrangements for completing a review of the Board.

A further paper setting out the proposed changes arising from the review will be presented at the meeting in June for the Board to approve the recommendations. Any revisions to membership requiring a change to the County Council's Constitution will need to be approved by Full Council. The earliest expected date for this would be 18 September 2020.

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

- to review the Board's membership and terms of reference;
- to receive a further paper on the outcome of the review at the June meeting;
- to make recommendations to Full Council on proposed changes to the council's Constitution.

1. Background

Under the Health and Social Care Act 2012, all upper tier and unitary local authorities are required to establish a Health and Wellbeing Board (HWB) for its area. In 2013, the HWB was formally established as a committee of Lincolnshire County Council. The functions of the HWB are set out in Section 195 and 196 of the Act as follows:

- to encourage persons who arrange for the provision of any health and social care services in the area to work in an integrated manner;
- to provide advice, assistance or other support, as it thinks appropriate, for the purpose of encouraging joint commissioning;
- to prepare and publish a Joint Strategic Needs Assessment (JSNA) on the local population;
- to prepare and publish a Joint Health and Wellbeing Strategy (JHWS);
- to receive the commissioning plans for the Clinical Commissioning Groups – this includes involvement in preparing the plans and ensuring that they take account of the JSNA and JHWS.

In addition to the statutory functions listed above, the Act also makes provision for the local authority to delegate any powers or functions exercisable by the authority to the HWB.

The Act states the statutory core membership of the HWB should consist of:

- at least one Councillor of the local authority;
- the Director of Adult Social Services for the local authority;
- the Director of Children's Services for the local authority;
- the Director of Public Health for the local authority;
- a representative of the local Healthwatch organisation;
- a representative of each relevant Clinical Commissioning Group (CCG);

Non statutory members of the HWB will be directly appointed to the HWB by the statutory elected member (i.e. Leader of the Council). Additional members may be appointed to the HWB as it thinks appropriate at any point, however, before any new member is appointed to the HWB the Board must be consulted.

The membership was last reviewed in 2017 resulting in the Police and Crime Commissioner and the Chair of the Coordination Board becoming members of the HWB. The current membership and functions of the HWB, as detailed in the Council's Constitution, is presented in Appendix A.

A full timetable for the review process will be presented at the meeting but in broad terms the process will include:

April -	consultation with HWB members and wider partners
May -	consultation with HWB members and wider partners
June -	options/recommendations presented to HWB
Sept -	changes to the Council's Constitution presented to Full Council

2. Conclusion

In line with statutory requirements, the review will seek the views of current HWB members and wider partners. Any subsequent changes endorsed by the Board will be submitted to Full Council for formal approval.

3. Joint Strategic Needs Assessment and Joint Health & Wellbeing Strategy

The Council and Clinical Commissioning Groups must have regard to the Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS).

The HWB is responsible for producing and maintaining the JSNA and using it as an evidence base to inform the JHWS.

4. Consultation

As in line with the requirements of the Health and Care Act 2012, members of the HWB will be consulted as part of the review process.

5. Appendices

These are listed below and attached at the back of the report	
Appendix A	Extract from Lincolnshire County Council's Constitution – Lincolnshire Health and Wellbeing.

6. Background Papers

Document	How it can be accessed
Lincolnshire County Council Constitution	https://www.lincolnshire.gov.uk/directory-record/61673/constitution
Health and Social Care Act 2012	http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted

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

Appendix A

Extract from Lincolnshire's County Council's Constitution - Lincolnshire Health and Wellbeing Board

The HWB is a Committee of the County Council. The Council's Constitution (Part 2, Section 7.07) sets out the governance arrangements for the Board as follows:

There will be a Health and Wellbeing Board. The Board will comprise:

The Executive Councillor for NHS Liaison, Community Engagement
The Executive Councillor for Adult Care, Health and Children's Services
The Executive Councillor for Culture and Emergency Services
Five Further County Councillors
The Director of Public Health
The Executive Director - Children's Services
The Executive Director - Adult Care and Community Wellbeing

A designated representative from each clinical commissioning group in Lincolnshire
A designated representative from the NHS Commissioning Board
One designated District Council representative
A designated representative of Healthwatch
The Police and Crime Commissioner for Lincolnshire
The Chairman of the Lincolnshire Coordination Board

Functions

- To encourage persons who arrange the provision of any health and social care services in the area to work in an integrated manner
- To provide such advice, assistance or other services as it thinks appropriate for the purpose of encouraging joint commissioning
- To prepare and publish a Joint Strategic Needs Assessment
- To prepare and publish a Joint Health and Wellbeing Strategy

Quorum

One third of the membership of the Board to include a representative from the clinical commissioning groups, a Lincolnshire County Council Executive Councillor and either the Chairman or the Vice Chairman.

Frequency of Meetings

The Board shall meet no less than four times each year including an AGM.

Chairman and Vice

The Board shall elect its Chairman and Vice Chairman at its AGM.

Voting

Each member of the Board shall have one vote and decisions will be made by a simple majority. The Chairman will have a casting vote.

Substitutes

Each member of the Board can nominate a named substitute. Two working days advance notice that a substitute member can attend a meeting of the Board will be given to the Democratic Services Manager. Substitute members will have the same powers as Board members.

Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of John Turner, Chief Officer, Lincolnshire CCGs and Chief Officer, Lincolnshire STP

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**24 March 2020**
Subject:	**Healthy Conversation 2019 – Final Engagement Report**

Summary:

We are pleased to present our first 'Lincolnshire NHS' engagement report. The engagement campaign 'Healthy Conversation 2019' took place during March to October 2019 and was delivered by the all the Lincolnshire NHS organisations together.

This report provides a summary of the feedback from the Healthy Conversation 2019 (HC2019) campaign to the public, staff, NHS organisations, partners and stakeholders. It details the campaign activity and explains how the feedback and results have informed the development of Lincolnshire's Long Term Plan and NHS work programmes as well as being used to shape emerging options for the Acute Services Review consultation.

The appendices provide further details of the campaign's communication and engagement activities and the feedback received.

Actions Required:

The board is asked to note this, and other more locality and service specific feedback in the accompanying appendices, in order that it be considered effectively and as appropriate in future discussions and decision making.

1. Background

Healthy Conversation 2019 was an NHS engagement exercise with the people of Lincolnshire to understand what matters to them in order to inform NHS service development in the future.

It incorporated information and feedback requests across the spectrum of prevention and self-care through to sharing detail regarding the current thinking within the acute services review transformation work.

Details of the engagement are attached in Appendices A to F.

2. Conclusion

There have been some key pieces of public feedback that have been captured through the campaign.

We have heard that the people of Lincolnshire:

- Have respect and admiration for staff in the NHS
- Believe that prevention is better than cure
- Would like more education on healthier lifestyles and prevention
- Want support to manage their own health conditions proactively
- Want help to look after themselves better
- Recognise that NHS staff and skills are precious and we should use them sensibly
- Acknowledge that seeing a doctor is not always the best option
- Are enthusiastic about engaging with us through digital means as much as possible
- Want joined up care
- Are genuinely concerned about how the NHS can help people living in deprived areas

This information has been shared with Lincolnshire NHS' lead clinicians and service review experts to ensure their inclusion and consideration in current and future transformation programmes including the Acute Services Review. The report has been shared through Lincolnshire's SET and LCB, as well as all NHS organisation boards and governing bodies.

3. Joint Strategic Needs Assessment and Joint Health & Wellbeing Strategy

The Council and Clinical Commissioning Groups must have regard to the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy.

This report captures the views and opinions of the public, and numerous stakeholders upon matters within the JSNA and JHWS. It is intended that these views and opinions influence future development of the themes and priority areas in the JSNA and JHWS as they have done with the Lincolnshire Long Term Plan.

4. Consultation

n/a

5. Appendices

These are listed below and attached at the back of the report	
Appendix A	Final Report for Healthy Conversation 2019
Appendix B	Healthy Conversation 2019 Purpose and Activities
Appendix C	Engagement Feedback
Appendix D	Workshop Frequently Asked Questions
Appendix E	Acute Services Review Survey Report
Appendix F	The People's Partnership Acute Services Review engagement with hidden and hard to reach communities ***Due to the size of this report, it is not being circulated with the papers but can be accessed at https://www.lincolnshire.nhs.uk/healthy-conversation/healthy-conversations-2019-report***

6. 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 Charley Blyth, director of communications and engagement, Lincolnshire NHS, who can be contacted on 07811 762 435 or charley.blyth@nhs.net

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www.lincolnshire.nhs.uk

Final Report for Healthy Conversation 2019

An NHS engagement exercise with the people of Lincolnshire to understand what matters to them in order to inform NHS service development in the future

People are at the heart of everything we do and it's important that they are involved not just in decisions about their care, but also in decisions that shape the current and future health services in Lincolnshire.

Introduction

We are pleased to present our first 'Lincolnshire NHS' engagement report. The engagement campaign 'Healthy Conversation 2019' took place during March to October 2019 and was delivered by the all the Lincolnshire NHS organisations together.

This report provides a summary of the feedback from the Healthy Conversation 2019 (HC2019) campaign to the public, staff, NHS organisations, partners and stakeholders. It details the campaign activity and explains how the feedback and results have informed the development of Lincolnshire's Long Term Plan and NHS work programmes as well as being used to shape emerging options for the Acute Services Review consultation.

The appendices provide further details of the campaign's communication and engagement activities and the feedback received.

Healthy Conversation 2019 Executive Summary

Through the HC2019 engagement campaign and associated communications, there have been a vast number of contacts using a variety of methods such as Facebook, Twitter and other social media platforms. Other methods have included face to face contacts such as events, surveys, forms, market days and supermarkets. Healthy Conversation 2019 has been communicated widely via different channels and with the support of our stakeholders and partner organisations, sharing information on our behalf. Below is a summary of these contacts, and the breadth of opportunity available for people to engage with.

HEALTHY CONVERSATION 2019

Summary of activities

Engagement

Launch day
- Successful event held in a central, accessible location within Lincolnshire
- Press and key stakeholders in attendance
- Clinicians and senior executives available to answer questions and provide interviews
- Also launched through communication channels such as local media, social media and radio
- Key stakeholder briefings took place and information provide via press packs

Open Events
- 9 events across the county
- 'Interactive' face to face approach involving clinicians, senior executives and managers.
- Displays showcasing information and opportunities for involvement in prevention and self-care, integrated community care, mental health, hospital services, enablers (digital, workforce, estates), NHS Long Term Plan, travel and transport
- Promotion of opportunities to get involved e.g. Survey, feedback forms, Keep in Touch forms

Workshops
- 4 workshops held in 2 locations
- 'Deep dive' sessions held in the localities for the public to ask detailed questions
- Clinicians and senior executives present to talk through rationale, opportunities and risks
- Feedback and FAQs from the workshops published

Roadshows
- Spokespeople visited 12 different communities by attending various market days and supermarkets across the county
- Provided opportunities to share information, answer questions and gather feedback
- Helped to reach people that may not attend other events or feel able or confident enough to speak up in unfamiliar settings
- Increased campaign awareness

Existing community meetings
- Captured people's views at community meetings with various groups such as Lincs Sensory Service, Parent and Toddler groups and village friendship groups
- Attended existing external events e.g. New College Stamford Fresher's Fair, Safeguarding Conference 2019, Race Equality Conference and Annual Public Meetings etc.

Stakeholder Management

- Partner working with EMAS, neighbouring Trusts and HealthWatch
- Updates presented to our Stakeholder Board and Voluntary Engagement Team
- Formal attendance at Health Overview and Scrutiny Committee and Health and Wellbeing Board
- Updates sent to local MPs, District Councils, Parish Councils, Health partners, campaign groups, local influencers, staff reps and regulators.

Media

- Press/public hub established March 2019 on the day of the launch
- Encouraged media to attend and report on all events
- 160 enquiries handled from the press and the public
- 19 press releases issued
- Featured on radio, TV and print press
- Healthy Conversation hotline number and email address used for all enquiries
- Regular media monitoring- featured in 40 positive stories, 28 negative and 15 neutral.
- Several case studies created and published on Lincolnshire NHS' website

Marketing

- Pull up banners, leaflets, survey, stakeholder mailing lists, display boards and posters, 'You Said, We Did' leaflets , displays on TV screens in GP practices, information in County News, hand delivered leaflets and posters to local outlets, posted leaflets and posters to all GP practices and NHS organisations
- Freepost address established

Information films
- 20 information films available to all
- Covering various topics such as Breast and Stroke service and Urgent and Emergency Care services etc.
- Promoted and available to watch via YouTube, Facebook, Twitter and the Lincolnshire NHS website
- 1659 video views

Digital

Website
- Website established March 2019
- One central hub available to all for communications and engagement activity and background information
- Creation of FAQs section and 'You Said, We Did'
- Update report published September 2019
- Monthly infographic summarising communications and engagement activity
- 54,695 page views

Social Media
- Creation of Facebook, Twitter and Instagram accounts
- Post reach of over 175,000 Facebook
- A total of 286,531 tweet impressions
- Regular key messages and information shared widely
- Promotion of events and workshops
- Used as a platform for communicating good news stories and connecting with the public

Equality and Diversity

- Worked with People's Partnership to further engage with protected characteristics groups
- Worked with the Equality and Diversity team to distribute translated leaflets via Health Promotion Events which took place on several occasions at Bakkavor, Moy Park
- Survey translated into the 5 most spoken foreign languages in Lincolnshire
- Easy read, braille and audio versions of the survey available on request
- Downloadable and printable version of the survey online

NHS Staff

- Initial detailed team briefings across all 7 organisations in Lincolnshire coincided with the launch day.
- Screen savers displayed on staff computers across 7 organisations
- Built on existing methods of communication in organisations such as websites, staff briefings, bulletins and local intranets
- Regular updates on staff wide bulletins, intranets executive blogs and emails and team briefings
- Captured staff views by attending events such as the STP Digital Connected Care Event where 300+ people attended

Key messages from Healthy Conversation 2019

We have heard that the people of Lincolnshire:

- Have respect and admiration for staff in the NHS
- Believe that prevention is better than cure
- Would like more education on healthier lifestyles and prevention
- Want support to manage their own health conditions proactively
- Want help to look after themselves better
- Recognise that NHS staff and skills are precious and we should use them sensibly
- Acknowledge that seeing a doctor is not always the best option
- Are enthusiastic about engaging with us through digital means as much as possible
- Want joined up care
- Are genuinely concerned about how the NHS can help people living in deprived areas

We heard that people in the Grantham area:

- Want 24/7 ‘walk in’ access to urgent care services at Grantham Hospital
- Support a centre of excellence for elective care at Grantham Hospital

We heard that people in the Boston area:

- Want to keep maternity, neonatal and paediatric services at Pilgrim Hospital (with only one option going into the ASR public consultation)
- Are concerned about travel time for people with symptoms of a suspected stroke if the service is no longer at Pilgrim Hospital

We heard that people across Lincolnshire as a whole:

- Are concerned that Lincoln Hospital is not big enough to have more services moved there
- Are concerned that some patients, families and those from deprived backgrounds will have difficulty travelling to Lincoln Hospital, exacerbated by general issues with road networks and public transport in the county
- Are worried about current difficulties getting a GP appointment, and believe GPs and other services could be better linked
- Are concerned about the recruitment challenges faced by the NHS locally and nationally

Next Steps

All feedback received throughout Healthy Conversation 2019 has been reviewed and analysed by our lead clinicians and is already being, or will be, used as follows:

- Lincolnshire's Long Term Plan (LTP) has been developed and will be published shortly in line with the national timeframe. The LTP details many actions being taken forward which are consistent with the feedback received from the public
- You said that you wanted improved joined up care – we have expanded how we work together through our integrated neighbourhood working teams and Primary Care Networks. These are groups of 'multi-disciplinary' staff, working across their skills in your local area to link up care
- To inform the next stage of the Acute Services Review (ASR) programme, most notably developing the emerging options being considered for full public consultation
- As the NHS enters its national annual planning cycle, all of the HC2019 feedback continues to be delivered to our clinicians and strategists as part of the briefing process which will influence this planning
- You said that you wanted more help on healthy lifestyles. In January 2020, we celebrated a reduction in smoking rates in the county in the past 12 months and we are committed to continuing to work with our Public Health England colleagues in the county to create continued successes across both prevention and self care
- You are concerned about travel in the county, both road networks and public transport. We are actively working with Lincolnshire County Council, who are responsible for these areas, and other relevant partners in order to develop solutions and improvements. A significant example of this co-development is the joint transport strategy we are all signed up to
- You are interested in how digital technology can improve access to the NHS in the county
- We are in the process of establishing a showcase and information event for the public in 2020 to hear your views on what solutions would work best for patients and their carers
- We heard that HC2019 was welcomed and the opportunity for the public to continuously influence decisions in this way is something we all want to commit to continuing. We are actively in the process of establishing Lincolnshire's Citizens Panel, which will help broaden

and deepen our interaction and feedback processes across the county, one of many examples of improved processes we are implementing.

Conclusion

Healthy Conversation 2019 has evidenced the public's willingness to engage in difficult conversations, and offer suggestions regarding how we can improve. They want the NHS to have increasing focus on prevention and self-care, use a common language and link all its different elements better. They welcome that we are listening. Healthy Conversation 2019 has not just been about what people want, but understanding what matters to them, what they think would work best and why.

These conversations have been framed within realistic parameters about what the NHS can and cannot deliver. Lincolnshire NHS pledges to build on Healthy Conversation 2019 and develop this conversation in 2020.

The feedback received has been used to inform the development of Lincolnshire's Long Term Plan, NHS work programmes and further shaped the emerging options for the Acute Services Review consultation. As the NHS enters its national annual planning cycle, all of the HC2019 feedback forms will also be used in the briefing process to influence this planning.

Appendices:

Appendix	Content
1	Healthy Conversation 2019 purpose and activities
2	Feedback from: • Open engagement events • Paper and online forms and queries • Workshops 1 & 2 • Market days • Community group meetings • Stamford Freshers' Fayre • Overview of Acute Services Review survey and The People's Partnership report
3	Workshop Frequently Asked Questions
4	Acute Services Review survey report
5	The People's Partnership Acute Services Review engagement with hidden and hard to reach communities

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Appendix 1: Healthy Conversation 2019 purpose and activities

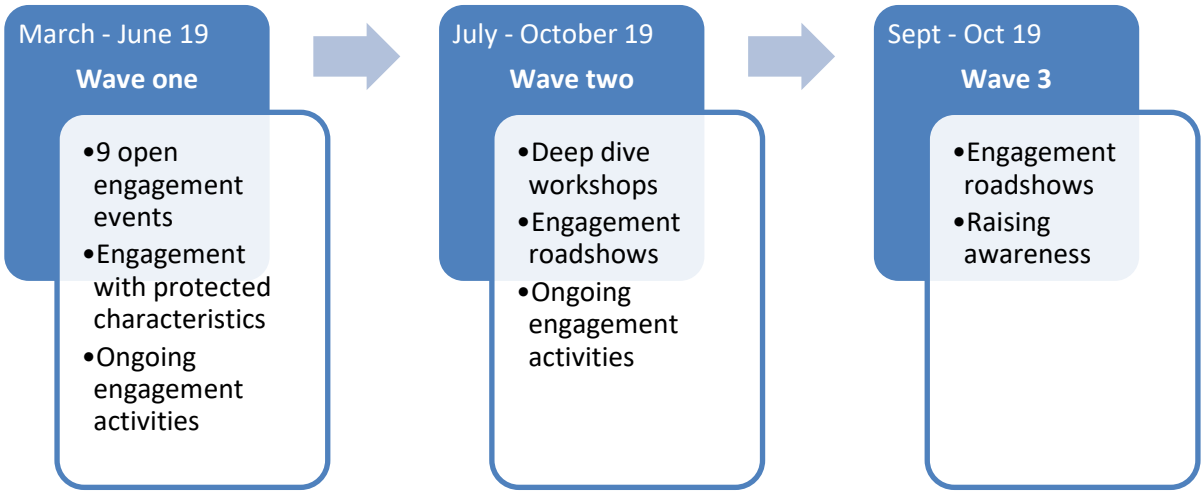
On 5 March 2019, the NHS across Lincolnshire launched its Healthy Conversation 2019. This was an open engagement exercise to shape how the NHS in Lincolnshire takes health care forward in the years ahead. It was a chance for everyone to learn more about the NHS's current thinking on the future of NHS services and a way to get meaningful feedback from our patients, their representatives, the public, NHS partners and staff about what future services may look like. Healthy Conversation 2019 continued throughout the year, with a wide range of engagement events and discussions across the county. Almost seven months of engagement came to a close on 31st October 2019 and has enabled all feedback received to be considered in a timely manner and informed the Lincolnshire's Long Term Plan, alongside the Healthwatch engagement results. Feedback has also been reported into system programmes as well as shaping emerging options for the Acute Services Review consultation.

The key overarching Healthy Conversation 2019 campaign messages have been:

- Lincolnshire's NHS needs to continue to transform to improve quality, attract staff and be fit for the future
- The way we all use the NHS needs to change too
- We need to make this change together – get involved

Engagement activity undertaken:

The various waves of communications and engagement have incorporated a number of activities to give as many people as possible the opportunity to get involved and share their views in a way that suits them:



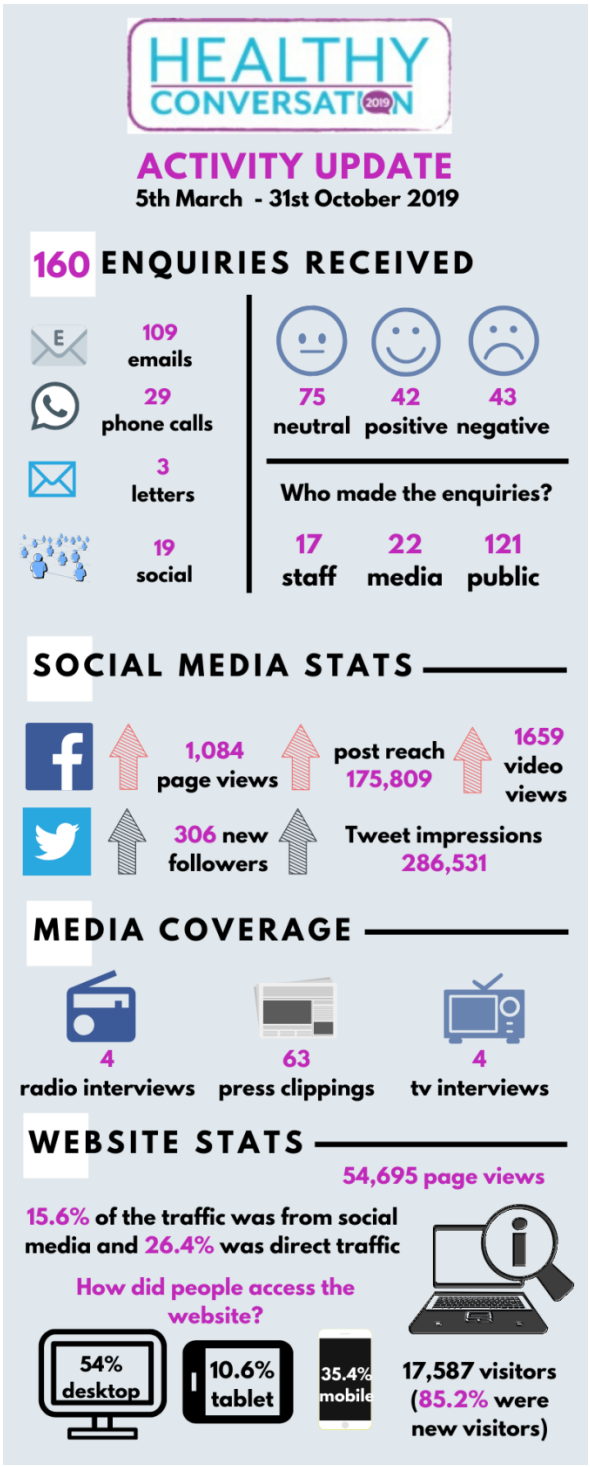
Overview of engagement to date:

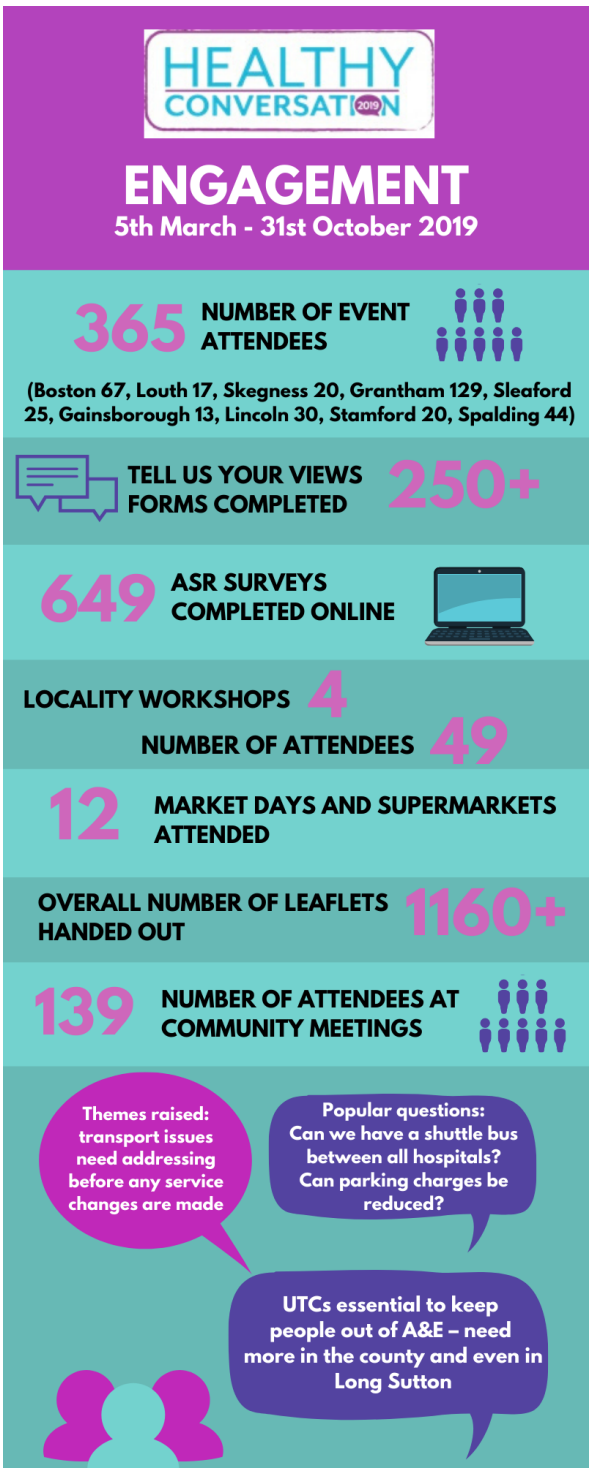
Engagement activity	Reach
Acute Service Review (ASR) survey *(closed 31st August 2019)* (also translated into Romanian, Polish, Russian, Latvian, Lithuanian, and Portuguese)	649 responses
General feedback forms	200+ responses
9 Healthy Conversation open events in Boston, Louth, Skegness, Grantham, Sleaford, Gainsborough, Lincoln, Stamford and Spalding	365 attendees
People's Partnership engagement with protected characteristics	130 responses
Roadshows (market days, supermarkets, shopping centres)	55 feedback forms received and 416 leaflets handed out
Distribution of leaflets and posters (see appendix A)	All NHS organisations and staff, GP practices, libraries, pharmacies, colleges etc
Locality workshops Grantham: 19 June 2019 Boston: 27 June 2019 Grantham: 9 October 2019 Boston: 10 October 2019	49 attendees across the workshops
Community meetings (e.g. Health Improvement Partnership, Toddler Group, Blind Society meetings etc)	139 attendees at meetings with a reach of over 7000 members.
Health Scrutiny Committee meetings • 20 March 2019: Introduction to HC2019 • 15 May 2019: Urgent & Emergency Care proposal • 12 June 2019: Womens & Childrens / Breast Services / Stroke Services case for change and emerging options • 10 July 2019: Mental Health Learning Disabilities & Autism Services • 18 September 2019: HC2019 update / medical services at Grantham Hospital case for change and emerging options • 16 October 2019: Haemotology & Oncology	District Councilors and Public in attendance Subsequent Media reporting Minutes and papers published on LCC website

Stakeholder meetings	Non-Executive Directors/Lay members workshops, District Council meetings, Health Scrutiny Committee updates etc
All staff briefed	All 7 organisations, primary care and the Charity and Voluntary sector.
Media engagement took place on the day of the	
Ongoing direct contact with the HC2019 team via telephone, email and letter	
Social media updates throughout	

This has been supported by widespread media and social media activity as well as direct calls and emails to the team. Although the volume of media coverage has dropped over time, the amount of social media activity continues to grow with to date an audience reach for posts of over 175,000 and over 54,000 website views since the launch of the campaign in March.

The following infographics summarise communications and engagement activity throughout the campaign.


HEALTHY CONVERSATION 2019
ACTIVITY UPDATE
5th March - 31st October 2019
160 ENQUIRIES RECEIVED
109 emails
29 phone calls
3 letters
19 social
75 neutral
42 positive
43 negative
Who made the enquiries?
17 staff
22 media
121 public
SOCIAL MEDIA STATS
1,084 page views
post reach 175,809
1659 video views
306 new followers
Tweet impressions 286,531
MEDIA COVERAGE
4 radio interviews
63 press clippings
4 tv interviews
WEBSITE STATS
54,695 page views
15.6% of the traffic was from social media and 26.4% was direct traffic
How did people access the website?
54% desktop
10.6% tablet
35.4% mobile
17,587 visitors (85.2% were new visitors)


HEALTHY CONVERSATION 2019
ENGAGEMENT
5th March - 31st October 2019
365 NUMBER OF EVENT ATTENDEES
(Boston 67, Louth 17, Skegness 20, Grantham 129, Sleaford 25, Gainsborough 13, Lincoln 30, Stamford 20, Spalding 44)
TELL US YOUR VIEWS FORMS COMPLETED 250+
649 ASR SURVEYS COMPLETED ONLINE
LOCALITY WORKSHOPS 4
NUMBER OF ATTENDEES 49
12 MARKET DAYS AND SUPERMARKETS ATTENDED
OVERALL NUMBER OF LEAFLETS HANDED OUT 1160+
139 NUMBER OF ATTENDEES AT COMMUNITY MEETINGS
Themes raised: transport issues need addressing before any service changes are made
Popular questions: Can we have a shuttle bus between all hospitals? Can parking charges be reduced?
UTCs essential to keep people out of A&E – need more in the county and even in Long Sutton

Appendix 2: Engagement feedback

This appendix summarises HC2019 feedback received from:

- 9 open engagement events
- Paper and online forms and queries
- Workshops 1 & 2
- Market days
- Community group meetings
- Stamford Freshers Fayre

All of the detailed feedback received has been circulated to the Senior Responsible Officers for the system programmes to inform the development of Lincolnshire's Long Term Plan and also to shape their programmes and projects.

Feedback from open engagement events:

Since the campaign launch, we have held 9 Healthy Conversation 2019 events, advertised locally, for the public to attend drop in sessions between 2-7pm in the locations in the table below. These were hosted by a range of senior managers and clinicians, available to talk to the public and walk them around displays showcasing information and opportunities for involvement in prevention and self-care, integrated community care, mental health, hospital services, enablers (digital, workforce, estates), NHS Long Term Plan, travel and transport.

These events have been attended by 365 people and the core themes raised through direct verbal discussions and feedback forms were:

Date	Location	Key Locality Themes	No. of attendees
13/03	Boston	• Accessibility of stroke services in the future • Loss of services to Boston as a whole	67
14/03	Louth	• Threat of hospital closure (this was an initial concern that alleviated once responded to)	17
19/03	Skegness	• Accessibility of stroke services in the future • Loss of services to Boston as a whole	20
20/03	Grantham	• Concern that A&E is being 'downgraded' • Urgent Treatment Centres and what they are	129
20/05	Sleaford	• Lack of GP access • Lack of coordination following discharge from	25

		hospital	
21/05	Gainsborough	• Lack of GP access • Financial difficulties when having to travel to visit family	13
22/05	Lincoln	• Financial difficulties for family members having to travel to hospital • Professionals should be able see each other's notes to make it more streamlined for patient	30
12/06	Stamford	• Ensure links with North West Anglian NHS Trust for services in Stamford • Grantham A&E closure overnight	20
13/06	Spalding	• UTCs essential to keep people out of A&E – need more in the county and even in Long Sutton	44

Throughout all events, we consistently heard that the public are concerned about:

- Transport to services for patients and family
- NHS111 and its effectiveness
- EMAS and response times
- Issues of overburden on Lincoln County Hospital

Feedback from paper and online forms and queries:

We have received over 200 completed HC2019 feedback forms on various elements of the campaign via social media, telephone, email and forms at events and on our website. The detailed feedback has been circulated to programme Senior Responsible Officers and a summary of the key themes and suggestions for each of the services is provided below:

Acute Medical Services

Key themes:

- Capacity issues at Lincoln hospital – delays in being seen
- Length of time to get to hospital

Suggestions include:

- Airlift to specialist hospitals outside of Lincolnshire if case is too complex

Breast services

Key themes:

- Poor infrastructure and road networks causing access difficulties for patients and families who need to get to Lincoln
- Lack of confidence in Lincoln Hospital having sufficient capacity
- Preference of keeping services at Pilgrim

Diabetes, Self-Care and Prevention Services

Key themes:

- Variation in standard of diabetes care between GP Practices
- No infrastructure to support the communities, especially in Mablethorpe

Suggestions included:

- Focus on education and generational change
- Clinic appointments needed outside of working hours to reduce time needed off work
- Regular blood tests for everyone to alert people to problems before they arise

General Surgery Services

Key themes:

- Lack of confidence that current staff will be able to deal with more complex issues
- Team is mainly built up of agency staff meaning current service is not sustainable
- Journey will be too long for people in severe pain to travel
- Lack of signage around Grantham hospital currently

Suggestions include:

- To hold follow up clinics and monitoring in local hospitals

Haematology and Oncology Services

Key themes:

- Capacity/ issues of over burden on Lincoln hospital – overcrowded and poorly staffed, not enough beds
- Costly travel and parking that could cause hardship for both patients and their families when having to visit on such a regular basis
- Frequent cancellations and delays to appointments at present

Suggestions include:

- To have follow up appointments locally

Mental Health Services

Key themes:

- Really good care and support especially with autism
- Impossible to get appointment with CAMHS
- Lack of awareness on how to care for people with dementia and the care plans put in place by social services
- Additional community based services, enabling patients to stay at home with family

Suggestions included:

- More information required for parents about what services are available, especially online
- Improve links (transition) from children to adult services
- Improve flexibility of CBT appointments for those who work
- More information is required about what support is available in times of a mental health crisis – A+E seems too often to be the only option
- Share updates on mental health patients with the police so they have an understanding on how to deal with the individual

Primary Care Services

Key themes:

- Interface between GPs and other services – so patients do not have to tell their story multiple times
- Lack of availability for appointments

Suggestions included:

- Charge patients if they (do not attend) DNAs booked GP appointments
- Communicate all options for appointments as patients don't always need to see a GP
- Suggestion that one 'carer' cares for all of the people in one area; this would give more caring time and cut down on travel

Stroke Services

Key themes:

- 'Golden Hour' not achievable from some parts of the county
- Consideration of population need by locality before determining locations of service
- No mention of step down / rehabilitation
- Ambulance response times are poor – assurance needed
- Capacity issues – overburden on Lincoln hospital
- Loss of service at Pilgrim Hospital

Suggestions included:

- Scope how to link mental health support and stroke community rehabilitation
- Transport issues need addressing before any services are relocated

Technology and Innovation

Key themes:

- Welcome e-consultations to avoid concerns regarding transport/reducing the NHS' carbon footprint
- Refreshing to hear; innovative thinking, digital is the future
- Due to cyber-attacks, how safe is the 'digital system'?
- Many people do not have access to the internet and will need alternative options
- Areas of poor broadband and poor mobile phone signal
- Shouldn't need to keep re-telling your story/medical history

Suggestions included:

- Patients holding their own records and notes like in France
- Other communications needed such as face to face and local newspapers

Travel and Transport

Key themes:

- Issue isn't the hospitals but travelling to them – poor road networks and lack of public transport
- Early appointments not achievable when using public transport
- Costly travelling across the county to hospitals further away
- Hardship to patients and families by having to take additional time off work to travel further
- Can't always rely on family and friends
- Community transport sometimes unreliable
- Unable to get back from hospitals if taken by ambulance

Suggestions included:

- Inter-site transport - provision of shuttle between hospitals or accommodation for family to stay
- Development of a driver volunteer scheme
- Direct trains between Boston, Skegness and Lincoln
- Routes and times clearly displayed at all bus stops
- Introduction of a travel helpline

Urgent and Emergency Care Services
Key themes:

Grantham

- Grantham is on major road and rail links and needs an A&E open 24/7
- New housing developments with increasing local population
- Travelling time is not within the 'golden hour' from parts of the county, especially for those without their own transport
- Poor road networks and lack of public transport, especially in rural villages
- Ambulance availability and response time concerns
- Capacity issues – overburden on Lincoln Hospital
- Inability to get back from hospitals if taken by ambulance
- Lack of transport to attend another A&E during the night
- NHS 111 and its effectiveness

Suggestions included:

- If people call NHS 111, Grantham Hospital needs to be the first option
- Educate the public on how not to abuse the NHS
- Patients need to be clearly informed about the UTC's capabilities and limitations
- Free shuttle bus or volunteer transport to hospitals from main train and bus stations and between hospitals

Stamford (proposal)

- Great service in Stamford Hospital, would like an extended service
- Support for UTC in Stamford to reduce need to travel elsewhere for emergency care
- UTC will reduce the pressure on surrounding hospital

Suggestions included:

- Increase in population anticipated therefore need extended access to urgent care 7 days a week
- Hospital could provide additional outpatient and emergency clinics

Women's and Children's Services
Key themes:

- Lack of transport if service is moved Lincoln
- Length of time taken to get to Lincoln in an emergency is too long
- Loss of services at Boston and the desire to retains women's and children's at Pilgrim

Suggestions included:

- The need for an easier way to access community Paediatrics before children's education is affected
- To send out clearer communication about the situations concerning women's and children's services at Pilgrim hospital

Feedback from Grantham and Boston workshops 1 and 2:

Lincolnshire's NHS held workshops, open to all, in Grantham on 19th June and Boston on 27th June. Two further workshops were held on 9th and 10th October in Grantham and Boston.

In the June workshops clinicians and staff were involved in discussions with attendees about the key themes relating to the ongoing Acute Services Review in the county which had emerged from previous engagement. This focused on the proposed changes to services for women's and children's and stroke services in Boston and Urgent and Emergency Care in Grantham and also travel and transport for each of the services.

This feedback summarises the main points and issues raised during conversations. Our subsequent response to those Frequently Asked Questions (FAQs) and scenarios which emerged during the workshops is attached as appendix 4.

At the follow-up workshops in October, attendees were provided with the feedback from the June workshops and along with staff and clinicians were asked to:

1. Review and sense check the feedback and suggest amendments
2. Make suggestions about how these messages and scenarios could be communicated more widely with the public
3. Raise any outstanding concerns

Main themes raised at Grantham workshops:

- Service and staffing provision within the proposed Urgent Treatment Centre (UTC) and how this may impact other hospitals
- How any proposed changes might affect other wards and services at Grantham Hospital
- Healthy Conversation 2019 engagement process prior to consultation and involvement of those with protected characteristics
- NHS 111 service provision and performance
- NHS support offered to disadvantaged patients, especially for travel and transport
- Access to services and inadequate public transport provision in areas
- East Midlands Ambulance Service (EMAS) service provision, performance and the 'golden hour'

Main themes raised at Boston workshops:

- Travel times and ambulance transfers to Lincoln Hospital
- Treatment times for patients suffering a stroke
- East Midlands Ambulance Service (EMAS) performance and targets
- Advertising of engagement events and provision for those not able to attend
- Additional travel needs of friends and families if paediatric patients moved to other hospitals
- Options being consulted on for women's and children's services
- Recruitment, retention and availability of staff to deliver services in Boston Hospital
- Rural funding for Lincolnshire
- Stroke care in the community

Feedback from market days:

During the months of September and October we visited 12 localities across Lincolnshire where we spent time at local markets and supermarkets, speaking to members of the public. Leaflets were handed out to 416 people and the core themes that were raised (through direct verbal feedback and formal forms) were:

Date	Location	Key Locality Themes	No. of leaflets	No. feedback forms
04/09	ASDA, Lincoln	• Generational change - need to educate the young on self-care and prevention • Bring back nursing apprenticeships	105	6
05/09	Waterside, Lincoln	• Lack of public transport from rural areas • Delayed waiting times at Lincoln Hospital	96	4
23/09	Skegness	• Lack of patient note reading • Cancellation of appointments without the patients being made aware	18	4
01/10	Gainsborough	• Teaching children how to lead a healthy lifestyle • Nursing careers need to be made more attractive	4	3
02/10	Sleaford	• Importance of integrated	12	0

		community care and neighbourhood working		
04/10	Long Sutton	• Staff shortages at Johnson Hospital • Same day available appointments at your GP practice	53	3
10/10	Horncastle	• Encouraging to see NHS staff out in the heart of local communities • Happy with the local GP practice	21	7
11/10	Stamford	• Good to see the NHS out and about, make the NHS seem more accessible and friendly to approach and talk to • Would like to see more mental health support	26	3
17/10	Mablethorpe	• Coming to our local market is better than holding events that many may not be able to get to • Access to GP appointments • Lack of mental health services	32	14
18/10	Alford	• Young people should be educated on healthier lifestyles and prevention to save money • Difficulty in booking GP appointments	18	5
23/10	Louth	• Lack of personalisation when visiting the GP • The NHS should charge for missed appointments	21	5
24/10	Bourne	• People are abusing A&E, we need to re-educate people on what it is for • The NHS should embrace technology	9	1

Across the county, we consistently heard that the public are concerned about:

- Access to GP appointments
- Waiting times in hospitals
- Educating the younger generation on self-care and prevention
- Making sure the NHS is not abused, re-education on what services are for

Feedback from community group meetings:

Throughout HC2019, we have also attended a range of community groups and meetings to raise awareness of HC2019, promote opportunities for involvement and gather feedback about their experiences and any issues or concerns.

The feedback is summarised below:

GPs and primary care:

- Preference for email or text reminders for appointments rather than letters (which can be delayed) and then the appointment is missed, which then looks like the patient Did Not Attend.
- Still experiencing difficulties getting appointments and would like to be told when booking an appointment if it is with a nurse rather than a doctor to manage expectations.
- Some concerns that health visitors are not contacting all new parents and some may be missed.

Workforce:

- It would be good to upskill and increase staff recruitment by being 'attached' to a training hospital
- Staff not well looked after as employees, for example having to supply their own refreshments including tea bags; "how do we expect to fill our vacancies when we are not looking after the ones we've got!"

Technology:

- Welcomed the use of technology such as the care portal, as not having the correct notes in front of the doctor or consultant was very frustrating for some of this group.
- Not sure about using the phone for 'facetime' but liked the idea of having a hub to go to (for example at a GP practice) where people can be supported to log onto e-consultations etc. It was also felt the elderly would embrace this as it means less travel and less costs.

Supporting engagement with hard to reach groups:

- Suggestions provided on how to support deaf / blind people to attend health events such as providing transport and translation into braille etc.

- People with sight or hearing loss struggle with access to services, access to GP appointments, optometrist appointments and dentist appointments and travel to appointments. Often no interpretation service is offered and patients have to sit with a doctor and write notes between them.
- Making a doctor's appointment is usually via phoning the practice- not everyone has access to the online services so it would be useful to introduce text for deaf patients.
- An example was provided of an elderly couple who have sight difficulties and needed to travel by train for a hospital appointment which lasted 10 minutes but they were out of the house for 9 hours.
- One query was raised about how someone will book appointments etc. once they go deaf as they already have an amplifier and still struggle to hear.

Travel and transport

- Travel was a concern for the majority of the group in south Lincolnshire for both GP and hospital visits. Their nearest hospital is Grantham, but a lot of the time they are sent to either Boston or Lincoln for appointments/treatment. This can be extremely difficult for those who do not drive as there is only one bus into Lincoln or they have to pay for a taxi.
- Alternative suggestions include volunteer driver schemes and patients only have to pay for the mileage.
- Frustration with Thames Ambulance Service Limited (TASL) which is now no longer accepting a patient who has been using it previously for six years.
- Some people are often not given a choice of which hospital they would like to go to for treatment and the majority agreed they would travel out of county if it meant receiving treatment quicker.
- In Peterborough they run a service where paramedics, occupational therapists and nurses visit the frail and elderly if ill or had a fall – this team prevents that patient going into hospital and keeps them in their own home.

Feedback from Stamford Freshers Fayre:

On 10th September we attended Stamford Freshers Fayre and received 31 completed surveys, from which we heard the following:

The most important things respondents would like to see improve with the NHS are:

Mental health services – prevention is better than cure, over-stretched and hard to access, not advertised enough locally
GP appointments – improved access, ability to book in advance and more telephone appointments
Being taken seriously – important to be respected like adults are

If they wanted to find out more about NHS services they would use the following methods:

Online	20
Ask your GP	17
Friends and family	14
Hospital website	11
Support group	6
Social Media	6
Email	4
Welfare officer	2
Local press	1

Feedback from the Acute Services Review survey and The People's Partnership Acute Services Review engagement with hidden and hard to reach communities

The Acute Services Review survey was closed on 31st August 2019 following six months of engagement. These results have been analysed and reported into the Lincolnshire NHS system to ensure it informs the next stage of the acute services review programme and informed the emerging options being considered for full public consultation.

The Lincolnshire NHS organisations also commissioned a local specialist, The People's Partnership, to undertake a specific piece of engagement work, in order to ensure our Healthy Conversation 2019 exercise captured the views and concerns of hidden and hard to reach communities across the county. This was an important addition to our established engagement work for a number of reasons:

We were aware that the range of engagement events and activities we publicised to the general public and patients were not always appropriate for people with protected characteristics. This might be because the level of noise could prohibit full involvement, or anxiety about participation in such a group may inhibit and prevent attendance for example.

We know that people with protected characteristics have an important voice, and can often be particularly impacted by any potential service changes. It is important that we seek these voices out in order to ensure they are represented.

The People's Partnership undertook a detailed, and bespoke engagement in order to understand these views. This meant utilising their established networks, and developing new, in order to reach the people often missed. Our survey was adapted to become meaningful and understandable to the audiences we approached, and time was spent to ensure that the purpose was understood.

The following document details the outputs from this exercise, information which is being incorporated into our next stages of development and service review alongside all other outputs of our engagement events and surveys. The full analysis and reports are available at appendices 4 and 5.

Appendix 3: workshops summary feedback report and FAQs

Healthy Conversation 2019 workshops summary feedback report

Grantham 19th June 2019 / 9th October 2019
Boston 27th June 2019 / 10th October 2019

1. Purpose

Lincolnshire's NHS held workshops, open to all, in Grantham on 19th June and Boston on 27th June. Two further workshops were held on 9th and 10th October in Grantham and Boston.

In the June workshops clinicians and staff were involved in discussions with attendees about the key themes relating to the ongoing Acute Services Review in the county which had emerged from previous engagement. This focused on the proposed changes to services for women's and children's, stroke services and Grantham A&E and also travel and transport for each of the services.

This document provides a summary of the main points and issues raised during conversations and our subsequent response to those Frequently Asked Questions (FAQs) and scenarios which emerged during the workshops.

At the follow-up workshops in October, attendees were provided with the feedback from the June workshops and along with staff and clinicians were asked to:

1. Check the feedback makes sense and make any amendments required following their review
2. Gather their suggestions for how we can communicate these messages and scenarios more widely with the public
3. Ask if they have any more outstanding concerns

This document now includes any supplementary questions which resulted from the workshops held on 9th and 10th October and any amendments to the previous FAQs or additional responses are highlighted in bold/blue.

2. Summary of feedback from June and October workshops Discussions were held around the following main themes and specific questions and answers are presented in the subsequent section of the report.

<u>Main themes raised at Grantham workshops:</u>

- Service and staffing provision within the proposed Urgent Treatment Centre (UTC) and how this may impact other hospitals
- How any proposed changes might affect other wards and services at Grantham Hospital
- Healthy Conversation 2019 engagement process prior to consultation and involvement of those with protected characteristics

- NHS 111 service provision and performance
- NHS support offered to disadvantaged patients, especially for travel and transport
- Access to services and inadequate public transport provision in areas
- East Midlands Ambulance Service (EMAS) service provision, performance and the 'golden hour'

Main themes raised at Boston workshops:

- Travel times and ambulance transfers to Lincoln Hospital
- Treatment times for patients suffering a stroke
- East Midlands Ambulance Service (EMAS) performance and targets
- Advertising of engagement events and provision for those not able to attend
- Additional travel needs of friends and families if paediatric patients moved to other hospitals
- Options being consulted on for women's and children's services
- Recruitment, retention and availability of staff to deliver services in Boston Hospital
- Rural funding for Lincolnshire

2. FAQs

2.1 Grantham service change FAQs

What is the current service at Grantham A&E?
Grantham Hospital has not had a full A&E department for a number of years. It provides a restricted range of services.

Grantham A&E is open from 8am – 6.30pm, seven days a week.

After 6.30pm, there are services in place such as the NHS111 Services, the Lincolnshire Clinical Assessment Service (CAS), East Midlands Ambulance Service (EMAS) and the out of hours service to maximise the number of patients who can still be treated at Grantham Hospital. This means that some patients may still be brought by ambulance to Grantham overnight.

Our emerging option envisages the vast majority of patients who are treated at Grantham Hospital today, will be able to receive the same care in the Grantham Urgent Treatment Centre (UTC). In fact, there is very little difference in the service which has been available in the Grantham A&E department in recent years to that of a UTC.

A fully functioning A&E department requires a comprehensive range of back up services and facilities, such as specialist critical care and specialist medicine, emergency surgery, paediatric assessment and maternity services. Grantham Hospital does not currently have these services.

If someone is critically ill or injured, it is crucial that they get to the right hospital with the right facilities, first time, in order to ensure the best chance of a positive outcome.

ADDITIONAL QUESTIONS FROM 9th OCTOBER WORKSHOP

Are we aware of the impact on other hospitals following the closure of A&E?
Do we have statistics showing how many people are being sent elsewhere?
Do we have statistics to show the number of patients pre and post closure?
Since the overnight closure of Grantham A&E, we have seen a small increase in the number of patients from Grantham being seen at our A&Es in Lincoln and Pilgrim – an average of just over two people each day. The growth in patients to Peterborough, which has been widely reported in the media, equates to three patients a week. This reflects the overall increase in A& E attendances both locally and nationally over the last few years. We consider these figures with the commissioners and remain aware of the activity at the other hospitals for both planned and emergency care.

Why are staff being moved from Grantham to cover Lincoln?
There is no evidence that ULHT is instructing staff to do this or that it is happening locally either. On occasion, however, all staff working in any of our three acute hospitals (Lincoln, Boston and Grantham) may be asked to volunteer to cover additional shifts in other hospitals.

If Grantham A&E becomes an Urgent Treatment Centre, what services will be provided?

UTCs, which are slowly being introduced into Lincolnshire, having just launched in Louth and Skegness, provide urgent care for people whose conditions are not life threatening. Services provided by UTCs means Emergency Departments (A&E) services are protected for those who need specialist emergency care. UTCs are GP-led, staffed by multi-disciplinary teams of doctors, nurses, therapists and other professionals, who are trained in life support for adults and children. At Grantham specifically, there will be a higher level of staffing than the national specification – including staff with skills equivalent to middle grade A&E doctors; GPs and nurse practitioners - to ensure the vast majority of patients who are treated at Grantham Hospital today, will be able to receive care in the UTC.

Examples of conditions which may be treated at a UTC include:

- Sprains and strains
- Suspected broken limbs
- Minor head injuries
- Cuts and grazes
- Bites and stings
- Minor scalds and burns
- Ear and throat infections
- Skin infections and rashes
- Eye problems
- Coughs and colds
- Feverish illness in adults
- Feverish illness in children
- Abdominal pain
- Vomiting and diarrhoea
- Emergency contraception

There will be minimal changes to services currently provided at Grantham A&E. Patients who are likely to require critical care services will be cared for at Lincoln, Boston, Nottingham or Peterborough hospitals, where they will receive the specialist care they require to enable the best outcome possible. These patients are likely to have been assessed by a GP or paramedic and taken directly to the most appropriate place for treatment. Those patients with critical care / specialist needs who do arrive at Grantham in the first instance will be stabilised and then transferred. This works out at approximately 200 patients a year who currently attend Grantham Hospital but are very ill and require specialist treatment at a more specialist hospital.

ADDITIONAL QUESTIONS FROM 9th OCTOBER WORKSHOP

Will patients with long term conditions still be seen and treated at Grantham?

Yes. The appropriate place for treatment depends on the level of severity of the patient's symptoms.

What will happen to the cardio ward at Grantham?

Grantham does not now have a cardiology ward.

Would Grantham Urgent Treatment Centre be open 24/7?
The national specification is that UTCs are required to be open for at least 12 hours a day, seven days a week, including bank holidays. People can walk into UTCs during the opening hours, while others may be referred by NHS111 or by a GP.
Our emerging preferred option is to have 24/7 access to urgent care through the introduction of a UTC at Grantham Hospital.

The emerging option suggests that in the 'out of hours' period, access would be through NHS 111 for the reasons of patient safety. We will be listening to a wide range of feedback in order to inform our thinking, including people's views on how the service could best be accessed.

The NHS 111 service is able to book the patient into the right urgent care service first time so they have an appointment which is convenient for the patient and reduces their waiting time. The NHS 111 and Clinical Assessment Service (CAS) has a Directory of Services informing, for example, where and when an x-ray service is available. They are able to advise the patient where to go to receive such a service meaning the patient goes to the right place first time. It will improve the speed of treatment and stop patients having to move between services. Crucially it will advise when an A&E attendance is necessary, preventing the patient wasting potentially vital time going to the UTC first.

Patients with booked appointments will take precedence over walk in patients – unless there is a clinical priority and will therefore not have to wait as long.

A final decision on UTCs will not be made until after the formal consultation.

What if national funding is reduced? Would this mean Grantham UTC would be reduced to the national minimum specification of 12 hours per day?
While we cannot predict what might happen in the future, our current commitment is to offer Grantham residents a quality service which is sustainable and deliverable, e.g. we can attract the right staff, and one which instils confidence throughout the community. There will be a formal consultation on the proposed option of an UTC and the outcome will inform future decisions on the UTC such as opening times etc.

Who will staff work for in a UTC? Will they be able to stabilise patients?
All staff working in the UTC will be able to provide emergency care. It is anticipated that the majority of staff in the UTC will be employed by Lincolnshire Community Health Services NHS Trust (LCHS). It is also proposed that staff on the Grantham Hospital site will work in an integrated way so clinicians on the site (employed by other organisations) will be available to provide advice. Today, consultants on other hospital sites already provide advice when needed for example, consultants are available via telemedicine or to review scans sent to them.

If this proposed UTC is implemented following the formal consultation, transfer of staff from the current A&E to the UTC (with additional staff to deliver the model if needed) will be looked into in more detail. We will consult with staff and follow HR guidance. This does not mean a downgrade in services or skills and we will support our staff to have the right skills if there are changes to any roles. Our staff are our greatest asset.

What will happen to ambulance admissions into Grantham Hospital overnight if there is a UTC?
If an ambulance is dispatched, the paramedic will decide if the patient's needs can be met in the UTC or whether the patient has more specialist needs that require a specialist hospital. The paramedic is able to take advice by phone, talking with clinicians either in the CAS or a consultant in an A&E, to assist making this decision. This happens now.

The paramedic will take the patient to the right service that will be able to meet the patient's needs and ensure the best possible outcome.

One of the options for care will be taking low acuity patients to Grantham Hospital at night and directly admitting the patient (with prior agreement with night teams). Treating patients locally and within the Grantham community is important, as is keeping people out of hospital whenever that is possible.

What do we mean when we refer to the "right place, right time"?
We know that the best outcome for critically ill patients comes from being in the right place, where the right service can be provided as quickly as possible.

While this may mean they are not treated at the hospital closest to them, it means they will be taken directly to a hospital which can give them the immediate treatment they require, therefore giving them the best possible chance of a positive outcome.
Arriving at a hospital which is not equipped to treat them (and their specific condition) can waste critical time. The extra travel time getting to the right place far outweighs the risk of delayed treatment.

Patients who do arrive at a hospital that cannot treat their specific condition will still be cared for and the model being discussed does include a contingency for this scenario. Appropriate processes will be in place and staff will be able to stabilise those patients until they are transported safely to the most appropriate place.

ADDITIONAL QUESTION FROM 9th OCTOBER WORKSHOP

Who decides where a patient goes if an ambulance is called?
Ambulances go to Grantham hospital where this is appropriate. If an ambulance is dispatched, the ambulance crew will decide if the patient's clinical needs can be met or whether the patient has more specialist needs that require a specialist hospital. The paramedic is able to take advice by phone, talking with clinicians either in the CAS or a consultant in A&E, to assist making this decision. Our senior clinicians recommend that our patients go to the right hospital first time, rather than going to the closest NHS location, as this will not necessarily be able to provide the right care. Patients, carers or families should always phone 999 for an emergency ambulance if they believe that there is a life threatening health situation. Our senior clinicians are reviewing the current exclusion protocol (restriction criteria) to ensure that critically injured and ill patients will be cared for at the right service; treated safely and quickly by staff who have the right training and experience to give the best outcome.

If a patient is given a diagnosis at Grantham's A&E or proposed Urgent Treatment Centre but then transferred to another hospital, would they need to be triaged twice?
Triage is a process carried out on all patients attending A&E. Triage ensures people with the most serious conditions are seen first. Triage should not be required twice; however it is right that when the patient with a serious condition arrives on a new hospital site that they are assessed again so the specialist clinicians can make a clinical decision on further treatment.

Who will run medical beds in Grantham Hospital? What exactly are they?
Our preferred option is to maintain medical services at Grantham Hospital by joining up the hospital services with local primary and community services and be managed as part of the local enhanced neighbourhood team. This new model would be led by Lincolnshire Community Health Services NHS Trust (LCHS) which means that medical staff would in future be able to provide care in people's homes and local community settings, as part of a local integrated service, as well as to patients in the hospital. However, they will be working closely with the hospital trust and other health care providers so staff can support patients who, for example, deteriorate and need additional care. This model aims to keep patients out of hospital where appropriate but also to get them back home as soon as possible if they are admitted. This model of care in Grantham will be the first in the county.

The medical beds will be for patients with, for example, pneumonia, diabetes, chest infections, asthma, other respiratory diseases, i.e illnesses not requiring surgery – those who have a range of chronic ailments who can manage perfectly well most of the time but sometimes have a crises and need to go to the right place to be stabilised.

How have the views of the people who signed the petition to keep the A&E been taken in to account? How are the rallies we had in the town with 4000 or 5000 people to save A&E going to be taken in to account? How have all the views so far been taken into account?
We have listened carefully to the voices of the public and councilors and will continue to do so. We have also received a copy of the petition. Sometimes it is not possible to make the changes that are suggested to us because of factors such as patient safety or staffing. Through Healthy Conversation 2019, we have been open with the public about what is and is not possible for us to deliver, and the clinical and service reasons for that. It is right that any NHS service must be safe and sustainable. We have to be realistic as we do not have the staff to run three full A&E departments and it is highly unlikely that will change with a national shortage of A&E Consultants. We have 19 A&E consultant posts in Lincolnshire but only four of these have substantive consultants in posts.

Our emerging preferred option of a 24/7 UTC would enable more patients to receive services in Grantham than is currently the case.

Whilst the Healthy Conversation 2019 has taken place, how have you reached hard to reach and protected characteristic groups?
The workshops are publicised extensively through the following media channels: local newspapers/magazines, local radio, social media, websites, e-shots to stakeholder groups and through relevant third parties. As this event was open to all and was not invite only, we could not guarantee that people with protected characteristics would attend but ensured a wide reach with our communications so the opportunity was there.

In addition, these workshops are only one part of the much bigger programme of engagement we are undertaking and understand that events like this are not the best way

for some people to engage with us. Therefore, we offer a variety of ways for people to tell us their views if they don't want to or are unable to come along to a workshop, for example our paper and online surveys which are also available in different languages, paper and online feedback forms, meeting us when we're out and about in town centres and supermarkets, and people can phone, email or write to us. Consultation opportunities will continue as we move into the formal public consultation.

The purpose of these specific workshops was a 'deep dive' into the particular themes which emerged from the wave 1 engagement events and therefore smaller, more detailed group discussions was an appropriate way to achieve this. We are also mindful that our clinical staff's time is extremely valuable and we are grateful that they were able to sit around tables and have a conversation with our patients and the public, something which would not have been possible with larger scale events.

Further details of our proactive engagement with groups with protected characteristics will be made publically available on completion and we will share this with you. As reported in the Health Scrutiny Committee, we are working with The People's Partnership, an independent partner to ensure proactive engagement with people with protected characteristics.

The People's Partnership is made up of a Leadership Team who represent major areas of disability and some areas of the protected characteristics. In addition to the Leadership Team, they have individual members, members of groups and communities, and members who support the hidden and hard to reach communities.

The current members of the Leadership Team are:

- Age UK Lincoln & South Lincolnshire
- CarersFIRST
- Children's Links
- Every-One (contributes and facilitates the organisation of the People's Partnership)
- Linkage Community Trust
- Links Lighthouse
- South Lincolnshire Blind Society

As part of the engagement, The People's Partnership has engaged with a number of hidden and hard to reach communities which included 56 respondents who identified as having sight loss.

Will a formal consultation exercise be undertaken on the Grantham UTC?
Yes. The Healthy Conversation 2019 engagement exercise is providing invaluable feedback and will help to shape any emerging options on our proposed service changes. We will go out to formal consultation to gather further views and no final decision will be made until after this has concluded.

ADDITIONAL QUESTION FROM 9th OCTOBER WORKSHOP

When will the public consultation around Grantham take place? Why is taking so long?
Before we can start public consultation, capital funding must be secured so that we can be confident we can implement any proposals. As soon as there is any progress, the consultation will be widely publicised and we will inform the public of our next steps.

NHS 111

Is Grantham Hospital given as an option when you call NHS111 for minor conditions?
If you call NHS111 for a minor condition, Grantham Hospital is currently offered to patients as an option if it is the most appropriate place for their treatment.
The Directory of Services profile for the Grantham Minor Injury Unit is a nurse-led profile in operation 7 days a week 18:30 – 23:30. Patients ringing NHS111 within these timeframes with clinically appropriate symptoms for this unit will be directed there.

ADDITIONAL QUESTIONS FROM 9th OCTOBER WORKSHOP

Is Grantham Hospital available as NHS111 option?

Yes. The Out of Hours service at Grantham Hospital operates between 18.30 to 08:00 Monday to Thursday and from 18:30 on Friday through to 08:00 on Monday. Access is via NHS111 and the Clinical Assessment Service. The service offers telephone advice, face to face consultations (15 minute appointments) or home visits if required. Appointments can be made during the night if necessary although most activity is before 23:00.

Are we going to see any improvements with NHS111?
NHS111 is receiving an increasing number of calls, particularly just for advice or guidance, with CAS fielding 10.5k calls per month across Lincolnshire.

How is NHS111 currently monitored?
We receive monthly reports on the activity, performance and quality in the 111 service and attend formal monthly meetings with our NHS111 provider that are led by the lead commissioner. In addition, ad hoc issues are raised to the lead commissioner and provider as they arise.

How do foreign nationals access NHS111?
In the same way.

How does our CAS performance compare to other regions?
We cannot make direct comparisons between our CAS and other CASs in the country because they operate differently. It is also pertinent to note that all cases reaching CAS have been assessed as being safe to wait for at least 30 minutes, although 22% were still called back within ten minutes.

Around 70% of calls from NHS111 got to CAS and, of those, approximately 70% of those calls have their needs met and treatment provided by CAS.

What is NHS111 and who will answer my call?
The NHS111 service is available 24 hours a day, every day of the year and is intended for urgent but not life-threatening health issues. Depending on the situation the caller will be advised what local service can help; be connected to a nurse, emergency dentist, pharmacist or GP; get a face-to-face appointment booked if required; be told how to get any medicine that may be needed; and get self-care advice. NHS111 can also send an ambulance if needed.

A Health Advisor takes the calls and asks the caller a series of questions to determine what the best service is for their needs. Health Advisors undergo 12 weeks of intensive training to enable them to answer NHS111 calls. Health Advisors are not clinicians and do not make clinical decisions. They follow a nationally agreed and signed off algorithms (NHS Pathways) that determine the clinical need of the patient. In addition to this, the Health Advisors are supported by a range of clinical staff to provide any advice required.

If a patient needs to speak to a local clinician the health advisor will arrange this, or arrange for a clinician to call the patient back in a time frame suitable to the clinical urgency. The Lincolnshire Clinical Assessment Service (CAS) picks up these clinical calls. The Clinical Assessment Service is staffed by Lincolnshire clinicians; GPs, nurses, paramedics, pharmacists. This clinician is able to discuss the patient's health needs, recommend and arrange treatment and/or refer the patient onwards to the most appropriate service within the county. Around 70 per cent of calls from NHS111 go to CAS and, of those, approximately 70 per cent of callers have their needs met and treatment provided by CAS.

ADDITIONAL QUESTION FROM 9th OCTOBER WORKSHOP

Do NHS111 call handlers know the local area?
The NHS111 call handler is able to see information relating to the caller's location and while they may not be *familiar* with the local area, services pertinent to the caller's condition/query will be visible to the call handler on the Directory of Services (DoS), such as service opening times, appropriateness for the caller's needs and distance from the caller's location. Call handlers are supported by local clinicians via CAS.

What are the waiting times since Clinical Assessment Service (CAS) has been introduced?
The introduction of CAS means that if NHS111 decides the patient needs to talk to a clinician, a Lincolnshire clinician will take that call. The clinician is able to discuss the patient's health needs, recommend and arrange treatment and/or refer the patient onwards to the most appropriate service within the county. CAS exists to get to the right solution quickly – this means no unnecessary travel and waiting time for the patient and no unnecessary use of acute services.

The introduction of CAS has, so far, saved 35,000 visits for patients, therefore saving time and reducing the need to travel. We are still awaiting final statistics but its initial six months has resulted in a saving of over £600,000 for Lincolnshire NHS.

What is being done to encourage the public to call NHS111 to book appointments at an Urgent Treatment Centre day or night, rather than just turning up?
The national winter NHS England / Improvement communications campaign is designed to do exactly that and it is where the majority of the investment for winter is being made this year.

UTCs in Louth and Skegness are being introduced into Lincolnshire in October so not currently 'live' to NHS111 and promoting these services has already started. The main message is to access an UTC, patients should ideally contact NHS111 although there may be the ability to walk in. Patients who are booked in using the NHS111 service will be seen before patients who have walked in, as will patients who may present with more serious conditions. Only clinically appropriate patients will be booked into UTCs. If a patient's situation is very serious, then that patient will be referred or transported to the most appropriate place for treatment.

Calling 111 will ensure patients are directed to the right place for treatment in the first instance, rather than walking in to an UTC and then being transferred elsewhere for the right treatment.

If you are concerned about your health but it is not an emergency, call NHS111 or walk in to the Urgent Treatment Centre. If you are concerned because you are clearly very ill, call 999 and an ambulance will be sent and your condition will be assessed, so that you are taken to the most appropriate place for treatment.

WHAT WOULD HAPPEN IN THE FOLLOWING SCENARIOS IF GRANTHAM BECAME AN URGENT TREATMENT CENTRE?

Suspected heart attack or stroke
If the patient rang NHS 111 and described the symptoms of a potential heart attack or stroke, then an ambulance would be dispatched. The paramedic would assess the symptoms and start treatment in the ambulance, depending on the condition. If the paramedic's assessment indicated a heart attack or a stroke, he / she would liaise with The Lincolnshire Heart Centre/ stroke unit and transport the patient direct to the Heart Centre / stroke unit at Lincoln Hospital to ensure the patient receives the specialist treatment needed. If the paramedic's assessment was that the patient did not require these specialist services e.g. chest pain NOT suggestive of a heart attack- they could be taken to Grantham hospital – see scenario below.

If the 111 call handler was unsure about the patient's symptoms, they can call CAS to talk to a clinician, who will advise about whether the patient needs an ambulance, or should attend the UTC.

If a patient arrived at an Urgent Treatment Centre with a suspected heart attack they would not be turned away. They would immediately be assessed and triaged as a priority while initial stages of treatment – such as blood tests and ECG – took place. If it's evident they were having a heart attack, then the most appropriate care would be to transport them in a blue light ambulance to Lincoln Hospital's Heart Centre where the patient would have the best and most appropriate care, and therefore the best possible outcome. There would be liaison between the UTC, ambulance service and The Heart Centre pre and during transfer of the patient.

Patients arriving with other suspected serious conditions, such as suspected stroke, will be treated in the same way. Staff will be on hand to start treatment until the patient is transported, via blue light ambulance, to the most appropriate place for care e.g the stroke unit at Lincoln County hospital.

Someone collapses and needs resuscitating
If the patient collapses in an UTC, resuscitation and treatment would take place.

If someone in a surrounding village / in the community collapses, the ambulance paramedics would resuscitate and treat them, then take them to the hospital which can provide the best specialist care.

Compound Fractures with compartment syndrome (needing immediate treatment or risk limb amputations)
A compound fracture – where a broken bone has pierced the skin – is a medical emergency and a 999 call would result in patients being transported to Boston or Lincoln hospitals. If someone presented to an UTC with a compound fracture they would be assessed, stabilised then transported to the right place for treatment.

Non-specified chest pain
The appropriate place for treatment depends on the level of severity of the chest pain. A patient who is in low level / moderate pain who presents at the UTC would be assessed / treated accordingly. So, for example, the chest pain is muscular or indigestion, it would be treated in the UTC.

If a patient is in severe pain and has called 999, paramedics would assess if it was felt to be a heart problem and would stabilise and transport the patient if needed to the The Lincolnshire Heart Centre. Similarly, if someone presented to an UTC with severe chest pain they would be assessed, stabilised and where this was felt to require specialist treatment they would then be transported to the right place for treatment.

Breathlessness
The appropriate place for treatment depends on the level of severity of the breathlessness. If the patient is in acute respiratory distress with oxygen saturation <91% on room air 'unless' the patient has significant frailty or known significant chronic lung disease they would be taken to another hospital with more specialist services. We would not expect a patient or their family to make these assessments.

If a patient attends an UTC, staff will be able to treat their symptoms (for example with an inhaler or nebulizer, oxygen).

If a patient's breathing is highly compromised at home, they should dial 999; the paramedics will stabilise and transport to the most suitable place for treatment. Similarly, if someone presented to an UTC with severe breathing problems they would be stabilised then where necessary transported to the right place for treatment.

Acute exacerbation of inflammatory bowel diseases
The appropriate place for treatment depends on the level of severity of the patient's symptoms and whether the patient knows that they have inflammatory bowel disease and is confident to manage their illness.

A patient who has low level / moderate symptoms could ring their GP and / or 111 and talk with a clinician for advice. If advised, they could be booked into an appointment at the UTC for further assessment / treatment. Those who present at the UTC would be assessed / treated accordingly.

If a patient is experiencing severe symptoms and has called 999, paramedics would assess the symptoms and treat the patient accordingly which could be to take further clinical advice over the telephone. If further treatment is indicated, the patient will be transported to the right place for treatment.

Anaphylaxis

An anaphylactic reaction is a severe and potentially life-threatening reaction to a trigger such as an allergy or bee sting.

If the patient has a reduced conscious level, an ambulance should be called and the paramedic can make a decision about treatment / next steps. If someone already knows that they have an allergy and carries an epipen (medication used in emergencies to treat very serious allergic reactions to insect stings/bites, foods, drugs, or other substances) whose reaction is not improving despite self-medicating, should seek urgent clinical advice via GP, 111, at an UTC or A&E depending on the severity of their condition. In this circumstance, if the patient experiences any reduced conscious level, an ambulance should be called and the paramedic can make a decision about treatment / next steps.

Sepsis

Sepsis is a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs. A diagnosis can be made in the UTC and a first treatment may be administered. The most appropriate next steps for treatment will be decided by the UTC clinical staff depending on the severity of the illness.

If the patient has a reduced conscious level (not alert) at home, an ambulance should be called and the paramedic can make a decision about treatment / next steps. The paramedic will assess the patient and if the paramedic decides that the symptoms could be severe sepsis they will usually not be taken to an UTC.

Diabetic emergencies

If someone's condition is life threatening then it is crucial that the person gets to the right place at the right time. As with any life threatening situation, a call should be made to 999. If someone presents at an UTC with a diabetic emergency then the clinical team will assess that person and start treatment.

Complications of cancer

The appropriate place for treatment depends on the level of severity of the patient's symptoms and the type of cancer diagnosis that the patient has received.

Some potential complications of cancer and cancer treatment, e.g. chemotherapy, can be anticipated and the patient will already know the plan of care should such symptoms occur, such as directly ringing the cancer ward at Lincoln Hospital and getting clinical advice. Other complications / symptoms will not be anticipated and should be treated as an unexpected illness and depends on the severity of the symptom.

Kidney failure

Acute kidney injury (AKI) is when your kidneys suddenly stop working properly. It can range from minor loss of kidney function to complete kidney failure. AKI normally happens as a complication of another serious illness. This type of kidney damage is usually seen in older people who are unwell with other conditions and the kidneys are also affected.

The appropriate place for treatment depends on the level of severity of the patient's symptoms.

A patient who has low level / moderate symptoms could ring their GP and / or 111 and talk with a clinician for advice. If advised, they could be booked into an appointment at the UTC for further assessment / treatment. Those who present at the UTC would be assessed / treated accordingly.

If a patient is experiencing severe symptoms and has called 999, paramedics would assess the symptoms and treat the patient accordingly which could be to take further clinical advice over the telephone. If further treatment is indicated, the patient will be transported to the right place for treatment.

Seizures

If someone's condition is life threatening then it is crucial that the person gets to the right place at the right time. As with any life threatening situation, a call should be made to 999. If someone presents at an UTC with a seizure then the clinical team will assess that person, start treatment and decide whether the person needs to be transported to a more specialist site.

Mental health emergencies

If a patient arrives at an UTC with a mental health emergency, the appropriate place for treatment depends on the level of severity of the patient's symptoms. The UTC staff will liaise with the mental health crisis team and agree a plan of care.

Overdose

The appropriate place for treatment depends on the level of severity of the patient's symptoms.

A patient who has low level / moderate symptoms could go to the UTC for further assessment / treatment. The UTC staff will liaise with A&E consultants on another site for advice if required. They will refer the patient to Mental Health services.

If a patient is experiencing severe symptoms and has called 999, paramedics would assess the symptoms and treat the patient accordingly which could be to take further clinical advice over the telephone. If further treatment is indicated, the patient will be transported to the right place for treatment.

If the patient has a reduced conscious level (not alert) at home, an ambulance should be called and the paramedic can make a decision about treatment / next steps.

Suicide attempt

An example was given of a young male who cut a vein in his arm and lost a lot of blood. An ambulance was called, his arm was dressed and then transported to Grantham A&E where he received four units of blood. He was then transferred to Boston Hospital for an operation to repair the vein. We were asked in this scenario, what would happen with an UTC?

If Grantham A&E becomes an UTC, the young male would still be attended by paramedics following the 999 call. They would start treatment, e.g. by giving him intravenous fluids and dressing his wound and care for him while they transport him directly to Boston or Lincoln Hospital where he would receive blood and surgical care.

3.2 Grantham travel and transport FAQs

Some people may not be able to afford to travel to other A&Es outside of Grantham – what support can you offer them?
Our preference is to reduce the need for patients to be transported to another hospital by providing care locally when appropriate. We will only ask patients to travel further if they have complex, specialised needs and/or their outcome(s) will be improved by additional travel. We have heard from Lincolnshire's public that they agree with this approach and receiving the right care, first time is their priority, even if that means further travel.

It could be that some need for transport becomes reduced, for example by increasing numbers of virtual consultations such as telephone calls, Skype or online services. We understand that some members of the public want virtual consultations and others prefer face to face, this will be accommodated. For other people, the need for transport can be reduced if we help them to manage their long term conditions better through local community-based care.

If someone's condition is life threatening then it is crucial that the person gets to the right place as fast as possible. As with any life threatening situation, a call should be made to 999. We have worked with EMAS throughout the process to date and continue to do so.

If someone's condition means that they need assistance to travel for health reasons, this is provided through non-emergency patient transport services and will be provided to and between services.

If someone's condition means that they need to travel for health care but they do not have any health reasons for transport, they will not receive non-emergency patient transport. It is then that affordability, convenience and other forms of (non health) transport need to be considered.

Lincolnshire County Council (LCC) has responsibility for statuary Home to School, Adult and Children's Social Care transport and for Public Transport services. The NHS has responsibility for transport if there is a health reason; this does not include affordability and convenience.

Both the NHS and LCC understand how crucial transport is so that patients can access NHS services, therefore we are working closely together on a joint transport strategy to improve public transport and look at other viable options to supplement non-emergency patient travel.

At the Grantham Healthy Conversation workshop on 19 June, the public suggested some ideas to resolve the affordability and convenience issues. This proved a very useful starting point and the following list is a summary of the ideas on which we are now actively working with the LCC;

- Co-ordination of transport budgets, infrastructure and existing transport provision to maximise the value of what's already there
- Digital mechanisms to reward providers of lift-shares (UBER style) - digital payment infrastructure that tracks per mile travelled in a registered car share. Automated payments on a cost-share basis. Rates set by the scheme to avoid profiteering. Scheme provides safeguarding and vetting of participants.
- Vehicle loan schemes e.g. wheels to work. Broaden the scope, capitalise on the added value of these schemes.

- Tackling “The last mile”: Create transport hubs/interchanges; make waiting more social, comfortable or usable time. Integrate transport information and potentially other rural information hubs.
- Goods delivery: identify opportunities for village retailers to provide distinctive offers: align rural services with delivery hubs, e.g. delivery of medicines.
- There are already a variety of local and voluntary transport services which could be utilised, such as Call Connect and Grantham Community Transport, for example. Maximise the opportunities these services offer.
- A bus service that travels between hospital sites for staff, patients and carers.

These are ideas and final ideas will be finalised in the joint transport strategy.

ADDITIONAL QUESTIONS FROM 9th OCTOBER WORKSHOP

What is being done / what support is being provided for patients with transport difficulties?

The NHS is responsible for delivering medical and health care services and only has responsibility for transport if there is a health reason; this does not include affordability and convenience. Lincolnshire County Council is responsible for public transport, statutory Home to School, Adult and Children’s Social Care transport. However, while we must spend our funds on health provision, we fully appreciate how crucial transport is so that patients can access NHS services, therefore we are working closely with Lincolnshire County Council on a joint transport strategy to improve public transport and look at other viable options to supplement patient travel. If someone’s condition is life threatening then it is crucial that the person gets to the right place as fast as possible. As with any life threatening situation a call should be made to 999. We have worked with EMAS throughout the process to date and continue to do so.

If someone needs assistance to travel for health reasons, this is provided through non-emergency patient transport services and will be provided to and between services. If someone needs to travel for health care but they do not have any health reasons for transport, they will not receive non-emergency patient transport. It is then that affordability, convenience and other forms of (non-health) transport need to be considered.

Call Connect is a public bus service that operates in response to pre-booked requests. Registration is free but you must be a member to book a journey. You can then use the service for any reason and as frequently as required. The fully accessible minibuses operate from 7am – 7pm, Monday to Friday, and from 7.30am – 6.30pm on Saturdays, with some local variations. In most cases. Call Connect will pick up and set down at designated locations in each village or town. Passengers with a disability or those living in more isolated locations can be picked up and returned to their home address, if it is safe and practical to do so.

You can use Call Connect to travel anywhere within each service’s operating area. You can also use it to connect with the main Interconnect bus service or other bus and train services. Concessionary bus passes are valid on all services.

We are working to a principle of the most regular care requirements remaining close to home, such as routine screens in cancer care for example. It is when care needs become more complex and specialised that further travel is required; we have heard from Lincolnshire’s public that the right care, first time is the priority, even if that means further to travel.

We are also working to a principle of trying to reduce the need for transport, for example by increasing the numbers of virtual consultations such as telephone calls, Skype or online services. We understand that some members of the public want virtual consultations and others prefer face to face, this will be accommodated. For other people, the need for transport can be reduced if we help them to manage their long term conditions better through local community-based care.

Can we share the data collated by HealthWatch Lincolnshire around non-emergency transport? These are worrying figures as the number of people denied access has increased.

Healthwatch received 15 items of patient feedback in relation to all non-emergency transport over the last six months. These are included in Healthwatch monthly reports which are in the public domain and can be accessed via the Healthwatch website: **https://www.healthwatchlincolnshire.co.uk/**

The population is increasing and the public consider that public transport is inadequate. What is being done to improve the access to Lincoln if everything is going there?
We have taken into account the expected growth in population in Grantham town and feel that our emerging option of an UTC would meet this demand.

We are part of the 'One Public Estate' initiative with many partners involved in the development planning around Grantham, and are therefore fully aware of the future potential growth in housing, which has been incorporated into our planning work.

The NHS and Lincolnshire County Council are working together on the single travel and transport strategy, so that we start to address the issues that the public are describing. See above FAQ.

What happens if a patient is taken to an alternative hospital by ambulance and ambulances are queueing outside?
There is a lot of work being undertaken to improve this. Critically ill patients are handed over immediately to the hospital and do not have to sit and wait, as the ambulance is able to contact the hospital so hospital staff are waiting for the patient on arrival.

Patients whose needs are less urgent who are not able to be handed over to the hospital straightaway are constantly monitored and looked after by the ambulance crew while they wait. The most clinically unwell patients are seen first.

Patients taken to hospital by ambulance will not necessarily get priority treatment over someone who has transported themselves to hospital. If a patient is clinically well enough they will be transferred from the ambulance to the waiting room with everyone else.

What is the 'golden hour' and is it achievable?
The golden hour is the period of time following a traumatic injury during which there is the highest likelihood that prompt medical and surgical treatment will prevent death. While initially defined as an hour the exact time period depends on the nature of the injury, and can be more than or less than this duration. It is well established that the person's chances of

survival are greatest if they receive care within a short period of time after a severe injury; however, there is no evidence to suggest that survival rates drop off after 60 minutes. Some have come to use the term to refer to the core principle of rapid intervention in trauma cases, rather than the narrow meaning of a critical one-hour time period.

The golden hour for stroke services
The golden hour refers to the door to needle time, i.e. from the patient arriving in hospital to administering the thrombolysis treatment. It is a target and has no clinical significance to outcome. The sooner the treatment is given, the better the chance of a better outcome for those who are going to benefit from the treatment; not everybody can have this treatment as it depends on the type of stroke. 15% of all stroke patients can receive this treatment. Out of this 15% of stroke patients that receive thrombolysis, one third will benefit from the treatment (5%). Our clinicians believe their recommendations for stroke services will improve care and outcomes for the overwhelming majority of patients (95%).

There is a 4.5 hour time limit in the national clinical stroke guidance which refers to the time within which we can administer the thrombolysis treatment within the current licence. It is more relevant to clinical practice, but it starts from the time of onset of stroke symptoms, or from when the last time the patient was seen well.

People are concerned about Lincoln Hospital A&E not being able to cope with demand and, as a result, do not want to want to go there instead of Grantham Hospital.
There is no evidence to suggest that Lincoln hospital is unable to cope with the increased number of patients from the Grantham area. Lincoln hospital A&E sees an average of two additional patients per day from Grantham since the overnight closure of Grantham's A&E, against an average of 200 attendances per day - an increase of only one per cent.

Why are we not using the Kingfisher Ward?
We are using the Kingfisher Ward – it is our children's clinic at Grantham hospital, which is used for general paediatric and community paediatric clinics throughout the week. Currently, between 750 and 900 children are seen there per month.

Will Grantham be a Centre of Excellence?
As outlined in the Healthy Conversation 2019, our NHS preferred emerging option is to consolidate most elective care and make Grantham Hospital a 'centre of excellence' for elective short stay and day case orthopaedic and general surgery. The benefits of this emerging option could include:

The benefits of this emerging option could include:

- Far fewer cancelled operations for all in the county
- Better clinical results for patients, lower rates of re-admission, reduced length of hospital stay and reduced risk of infections and injuries
- Improved job satisfaction, morale and productivity for our staff

3.3 Boston stroke services FAQs

Attendees of the workshops in June (and this was raised again at the October workshop)felt that travel times to Lincoln Hospital, especially for those living on the coast, are a concern.

Our clinicians tell us that the best outcome for critically ill patients comes from being in the right place first time, where the right service can be provided as quickly as possible.

While this may mean patients are not treated at the hospital closest to them, it means they will be taken directly to a hospital which can give them the immediate treatment they require; therefore giving them the best possible chance of a positive outcome. Arriving at a hospital which is not equipped to treat them can waste critical time. The extra travel time getting to the right place far outweighs the risk of delayed treatment.

Historically, patients would be taken to the nearest hospital but we now know that getting to specialist care results in better outcomes. An example of this is major trauma - we don't have specialist major trauma centres in Lincolnshire and patients have had better outcomes by traveling to Nottingham, where their care is delivered by a specialist trauma team who look after larger numbers of patients and have the expertise and skills to deliver this care. This is the same for hyper acute stroke care.

The preferred option for stroke services - a fully staffed single multi-disciplinary team on the Lincoln site - will improve the outcomes of all patients who are cared for in the stroke unit. Even if patients have to travel further, outcomes and recovery will be greatly improved.

It's about getting to the right place as quickly as possible - even if that means going past a more local hospital to get to specialist care.

When will the joint conveyances start to happen?

In terms of JACP (Joint Ambulance Conveyance Project), EMAS has a partnership with Lincolnshire Fire Service and LIVES, and Lincolnshire Fire provide a co-responder response to emergency calls in a fire ambulance, staffed by LIVES trained fire responders. If the EMAS response to that incident is a car and not an ambulance, it gives the option of transport without waiting for an EMAS ambulance with the paramedic travelling in the fire ambulance. They do not transport patients without EMAS presence.

ADDITIONAL QUESTIONS FROM 10th OCTOBER WORKSHOP

Why not centralise stroke services in Boston? If the heart centre is also moved to Boston, the heart, stroke and vascular services would all be together

The over-riding, influential factor is staffing – it is easier to recruit to Lincoln, than it is to Boston, therefore the current and the future stability of the service will be protected if we specialize in Lincoln. We also know it is very difficult to recruit doctors to Boston for stroke services.

Co-location of services is very important, but we already have an established and highly successful heart centre in Lincoln. The cost of transferring estates is high and potentially unachievable and very risky, as is the cost and likelihood of successfully transferring all staff of this service.

More patients would be displaced if the centre was moved from Lincoln. There has been lots of analysis undertaken – there would be greater displacement across the county if located in Boston than in Lincoln. Lincoln is a better solution for more of Lincolnshire's population.

Can clarification be given as to when treatment starts, as the time taken for patients to begin receiving treatment after a stroke is critical?
There is a 4.5 hour time limit in the national stroke clinical guidance which refers to the time within which we can administer the thrombolysis treatment within the current drug licence. It is more relevant to clinical practice, but it starts from the time of onset of stroke symptoms, or from when the last time the patient was seen well.

Sometimes the 'golden hour' is talked about in relationship to stroke services. This refers to the door to needle time, i.e. from the patient arriving in hospital to administering the thrombolysis treatment. It is a target and has no clinical significance to outcome. The sooner the treatment is given, the better the chance of a better outcome for those who are going to benefit from the treatment; not everybody can have this treatment as it depends on the type of stroke. 15% of all stroke patients can receive this treatment. Out of this 15% of stroke patients that receive thrombolysis, one third will benefit from the treatment (5%). Our clinicians believe their recommendations (preferred option) for stroke services will improve care and outcomes for the overwhelming majority of patients (95%).

Obesity, hypertension or cardiovascular disease, for example, all need to be addressed as part of the STPs approach to stroke and stroke care, what is being done about prevention services?

Lincolnshire County Council has protected and invested in primary preventative services when other areas have been reducing them. The Lincolnshire system is taking a life-course approach, supporting children to have the best start in life and providing parenting support to families in the early years, and focusing on diet, physical activity and mental health support for school age children.
In addition, we have recently commissioned a new integrated lifestyle service, 'One You Lincolnshire', which comprises smoking, alcohol and a tier 2 weight management service. This is targeted at the population with chronic disease, such as hypertension and/or type 2 diabetes.

Attendees of the workshops had concerns about staffing.
There are currently only two substantive consultants in post across Lincoln and Pilgrim Hospitals compared to national guidelines which recommend eight full time posts.

Staffing issues are not about money; in fact more is being spent at the moment through the need to have locums and agency staff. It is recognised that nationally more consultants are needed, as there are more vacancies than staff. Our preferred option is to treat more patients in a single site which means concentrating our skilled workforce in one place to provide improved care, treating a greater number of patients and more opportunity to develop specialist skills.

Another challenge is that some consultants have retired and a number of staff are getting near retirement age too.

We now have the new medical school at Lincoln University and are hoping that trainee doctors stay in Lincolnshire when they qualify. This is not a quick solution and will have an impact in the coming years. We're working with Visit Lincolnshire and looking at what other organisations, such as Siemens, have done to attract staff; all of the NHS partner organisations are working together to resolve our recruitment issues.

Will EMAS be able to cope with the transfer of stroke patients to Lincoln Hospital?
We recognise that Lincolnshire is a large geographic county and travel times vary across the county, particularly coming to and from the coast. We also know that the best outcome for critically ill patients comes from being in the right place where the right services can be provided and, at times, this means driving past a more local hospital to get to specialist care.

EMAS take on average 60 calls a day in Lincolnshire for category one patients with life threatening conditions and the ambulance aims to get to the patient within seven minutes. EMAS constantly reviews where their ambulances are needed and moves them around the county if needed. EMAS has a range of quick response cars and four wheel drive cars for inclement weather.

We have been working jointly with EMAS on the stroke service options and EMAS can transport the patients.

ADDITIONAL QUESTIONS FROM 10 OCTOBER WORKSHOP

When will EMAS achieve its targets?
EMAS has plans to meet key performance targets in April 2020. Current performance is not meeting the trajectory and it is unlikely that EMAS will be able to meet the April 2020 position. There are a number of reasons for the lower than planned performance including increased demand for ambulance services, hand over delays at hospitals and resources within EMAS. We are continuing to work with EMAS to achieve targets as soon as possible.

EMAS should be held to task for not meeting targets for cat 1 and 2
The trajectory is to hit targets by April 2020 due to an increase in staff completing the correct training. By April next year, EMAS will have enough people with the right skills to help achieve its targets. EMAS has additional cars and responders who can help stroke patients. Additionally, representatives regularly attend the Health Scrutiny Committee.

EMAS funding is inadequate and Simon Stevens should be challenged. There has been millions spent on the TV campaign FAST yet patients are not reached in time as there are not enough ambulances. The £1.25 million received 4 years ago for ambulances is not adequate. Fundamental aspects for stroke need to be in place before looking at changes and conveyances is one of them.
Patients calling EMAS with stroke symptoms are prioritised.

In Lincolnshire we do not have any 4x4 ambulance, this is not acceptable on Lincolnshire roads especially in the winter; there could be a three hour ride due to the weather conditions.
EMAS has a range of quick response cars and four wheel drive cars for inclement weather. We recognise that Lincolnshire is a large geographic county and travel times vary across the county, particularly coming to and from the coast. We also know that the best outcome for critically ill patients comes from being in the right place where the right services can be provided and, at times, this means driving past a more local hospital to get to specialist care. EMAS take on average 60 calls a day in Lincolnshire for category one patients with life threatening conditions and the ambulance aims to get to the patient within seven minutes. EMAS constantly reviews where their ambulances are needed and moves them around the county if needed. We have been working jointly with EMAS on the stroke service options and EMAS can transport the patients.

What about the air ambulance for moving patients?
Although there are some conditions for which this isn't appropriate, the air ambulance can and is regularly used to transfer patients. There is one aircraft available in Lincolnshire but we also get support from neighbouring counties and coast guard search and rescue if necessary under exceptional circumstances. The air ambulance is a 24 hour service but there are limitations to this service due to night time flying regulations.

How are events advertised for people with visual impairment and how are all organisations implementing the Accessible Information Standard?
Since the workshop in June, meetings have been held with several community groups to ensure messages reach all communities in Lincolnshire. These included South Lincolnshire Blind Society and Lincolnshire Sensory Services, to improve our communications with deaf, blind and deaf / blind members of the public. We are now able to utilise existing newsletters and bulletins sent out by both organisations plus Lincolnshire Blind Society has offered to hold focused workshops with blind and visually impaired people to hear their views and opinions. We have also met with Carers First to improve our communications and opportunities for engagement with carers in Lincolnshire. Over the next few months, it is our intention to meet with further organisations to strengthen communications with members of their communities such as groups who support people with disabilities, Black Minority Ethnic groups, travellers, eastern European groups, faith groups and LGBT+ communities etc.

The Clinical Commissioning Groups (CCGs) across Lincolnshire are working with their GP practices to reiterate their responsibilities around the Accessible Information Standard. Information can be found on the CCGs websites. Additionally, all systems at Lincolnshire Partnership Foundation Trust (LPFT) are now AIS compliant. United Lincolnshire Hospitals Trust (ULHT) has, since the AIS was published, been working on a structured approach to implement the standard and continues to undertake further promotion with service users. ULHT will also be undertaking a gap analysis of its own systems to ensure best delivery of the AIS.

Lincolnshire Community Health Service NHS Trust (LCHS) has raised awareness of how to record patients' access needs, and sign-ups in clinics encourage patients to declare any access needs.

3.4 Boston women's and children's services FAQs

There are concerns that paediatric patients are being moved to Lincoln, Peterborough, Kings Lynn and Grimsby Hospitals rather than Boston, resulting in additional travel for families.
The NHS is responsible for delivering medical and health care services and local councils are responsible for public transport. However, we fully appreciate how crucial transport is so that patients can access NHS services and family can visit their loved one. Therefore we are working closely with Lincolnshire County Council on a joint transport strategy to improve public transport and look at other viable options to supplement patient travel. We have worked to a principle of the most regular care requirements remaining close to home, such as routine outpatient appointments for example. It is when care needs become more complex and specialised that we introduce further travel; we have heard from Lincolnshire's public that the right care, first time is the priority, even if that means further travel.

For carers– if there's a transfer from Boston to Lincoln - travel may be an issue. There is support for carers - personal budget that pays for that transport.

At the Grantham Healthy Conversation 2019 workshop on 19 June, the public suggested some ideas to resolve the affordability and convenience issues for travel across Lincolnshire. This proved a very useful starting point and the following list is a summary of the ideas on which we are now actively working with LCC;

- Co-ordination of transport budgets, infrastructure and existing transport provision to maximise the value of what's already there
- Digital mechanisms to reward providers of lift-shares (UBER style) - digital payment infrastructure that tracks per mile travelled in a registered car share. Automated payments on a cost-share basis. Rates set by the scheme to avoid profiteering. Scheme provides safeguarding and vetting of participants.
- Tackling "The last mile": Create transport hubs/interchanges; make waiting more social, comfortable or usable time. Integrate transport information and potentially other rural information hubs.
- There are already a variety of local and voluntary transport services which could be utilised, such as Call Connect and Grantham Community Transport, for example. Maximise the opportunities these services offer.
- A bus service that travels between hospital sites for staff, patients and carers.

These are ideas at this stage and their feasibility is being explored; final options will be incorporated into the joint travel strategy.

ADDITIONAL QUESTIONS FROM 10 OCTOBER WORKSHOP

Why do we have two options if one option is not viable and the NHS preference is for one only?
National guidance suggests that it is preferable to consult on more than one option for a service change, but this is not always necessary or possible. On those occasions, if only one option for change is viable this one option can be consulted on. The Healthy Conversation 2019 is about engaging and hearing people's views about both options for women's and children's services. All of the work that has been done since August 2018 is striving to avoid a single site option and the NHS' preferred option is to continue with these services at Pilgrim Hospital.

There is a lack of trust in survey questions – we will only get the answers to the questions we ask – if you ask if people are prepared to travel a bit further for the specialist services, then most people will say yes but if you asked would they prefer having the specialist services in their local hospital then most people would prefer this.
We will not give an option if this isn't viable, for example, if there are not enough specialist staff to provide a local service. We want to be open and honest with the public even when messages are difficult. We always allow a section for people to share their own concerns or comment in order to ensure people do not feel there are any restrictions upon what they want to say.

Back in 2015 – Alan Kitt and Dr Tony Hill stated in the LHAC document that "nothing is going to change until there has been a full consultation" however things are changing under the banner of safety concerns. Changes are being made by stealth.
This statement remains true. We will engage and consult with the public on any significant changes to services. However, it is also our duty to ensure our services are safe and on

occasion urgent changes are needed to maintain the safety of patients / services. Any changes made on this basis are temporary and a full consultation will follow.

How have you taken into account population increases when determining the preferred emerging option?
Yes, we use predicted population growth identified by the County Council.

The STP is supposed to not disadvantage people. In the East coast residents are extremely disadvantaged. There is a lot of deprivation. Everyone seems to be pushed towards Lincoln. Lincolnshire is so big it should have two hospitals which are equally as big. Should be equal on all levels – it must be something to do with finances?
The east coast population does have a high rate of deprivation. The options presented for service reconfigurations were assessed using four criteria, one of which was financial sustainability. However, all four criteria were equally weighted. Our ability to recruit staff to the east coast is the most significant challenge.

Are there enough staff to deliver these services?
Recruitment challenges are a national issue as well as a local one for Lincolnshire and a lot of work is being undertaken to recruit staff at all levels. We are working with many partners in the county in order to ensure Lincolnshire is presented as a thriving and appealing place to live and work.

Our Talent Academy brings together health and care organisations from across the county to help recruitment and skills development for our current and future workforce. The academy's initiatives include visiting schools, organising careers fairs, and developing our apprenticeship programme to inform and encourage careers in health care.

Alongside our colleagues across the health and care sector in the county, we have also established Lincolnshire's Attraction Strategy programme. This group focuses upon promoting the appeal of Lincolnshire as a place to live and work, as well as raising awareness of the career opportunities in the county.

Lincolnshire has developed a model for GP international recruitment that has now been adopted across England, thanks to the success we saw in the county. Central to Lincolnshire's 'grow our own' recruitment initiative, the University of Lincoln's Medical School's first students have started training in September 2019 alongside two other much needed staff groups, paediatric nurses and midwives who have also started in September 2019.

Our recruitment strategy includes increasing the number of Advanced Neonatal Nurse Practitioners in the service and their use across the Trust (there is a role for ANNPs in the SCBU at Boston). We are unlikely to attract trained ANNPs as they are in short supply across the country. The nursing team are therefore looking at getting local nurses onto training courses – final plans are currently in development.

ADDITIONAL QUESTION FROM 10 OCTOBER WORKSHOP

Is recruitment and retention improving? Are staffing vacancies still an issue?
Workforce shortages and a decrease in the number of training places have led to an increase in vacancy figures across the system especially within our acute services. We have a high number of vacancies and shortage of supply locally (and nationally) for registered nursing and midwifery staff, learning disability and other professions such as radiologists, Children's Nurses, Consultants and Middle Grade (SAS/Speciality Doctors). The geographical component is also often overlooked. Sparser and smaller populations, higher employment rates, an older population and relatively fewer younger people pose challenges for recruitment, retention and workforce development in rural areas and down the East Coast of our County especially.

Lincolnshire finds itself competing with employers on our boarders as well as those nationally from a reduced supply and labour pool and therefore success of attraction and retention very much depends upon the "total reward" package offered and the experience felt by candidates which is being addressed through our People Plan objectives particular "to become the employer of choice". Our primary focus is to reduce agency costs through substantive recruitment, attracting the best talent to Lincolnshire with a positive candidate experience and career opportunities. Our acute provider has recently contracted with a Strategic Partner in regard to International Recruitment, whilst the System as a whole implements new ways of working including different employment models, portfolio working, detailed job plans and changes to rotas, introduction of new roles and return to practice to aid the attraction and retention of our workforce. Using the positive relationship with our local University and Medical School as well as those colleges and higher education institutions further afield, we are increasing clinical placements, developing further opportunities with various apprenticeship roles and ensuring that investment supports our current workforce's future skills and competency need.

The NHS should be engaging with schoolchildren at an early age to educate them about careers in the health service. Schools are an untapped opportunity. Aspirations for young people in Lincolnshire are very low and we need to let them know everyone is needed – we need home grown talent. ParentMail is an easy system which reaches a lot of people quickly.
We are working with schools and colleges throughout the county, as well as undertaking work with the Talent Academy, and note the helpful comments around reaching children at an earlier age to 'plant the seed' of a career in the health service.

General questions

Why isn't more being done to increase funding that Lincolnshire receives?
Our executives and non-executives are in regular contact with politicians and central government about funding opportunities and promoting Lincolnshire. We have had some recent successes:

- The Prime Minister recently announced £21m fir ULHT (around one fifth of the money we have requested from NHSE)
- Mental health early implementation funding was also announced in September 2019.
- Funding has been sought, and received to support a range of initiatives from NHSE.
- A number of training initiatives have been funded by Health Education England

- Some of the Trusts have received extra funding from the Provider Sustainability Fund for their performance from NHSE
- The NHS applies for capital monies at every opportunity and has received funding to support with the development of business cases from NHSE digital

The Long Term Plan also refers to extra funding for initiatives such as digitally enabling primary care and outpatient care. We also appreciate efforts by members of the public who encourage their local MPs to lobby for more funding for Lincolnshire.

Why is the Government removing funding from rural pharmacies?
A new funding settlement has been agreed for all pharmacies contractors for the next 5 years. This should enable pharmacies to be able to plan and make any necessary changes. As part of this there is a recognition of rural pharmacies who receive Pharmacy Access Scheme payment. This gives rural pharmacies an additional level of funding.

Further information can be found here:

https://www.england.nhs.uk/primary-care/pharmacy/community-pharmacy-contractual-framework/

https://psnc.org.uk/our-news/contractor-announcement-funding-negotiations-result-in-five-year-cpcf-deal/

Is getting patients back out into the community the best approach? Is the money there to care for patients at home? Is it the best use of resources – especially with shortages of staff? Aren't patients better off in hospitals rather than sending them home?
At first glance it might seem obvious that hospital would be the best place to look after someone, but in fact there is evidence to show that this may not be the case.

Studies suggest that admitting frail older people to hospital can lead to a decline in their physical ability. For all ages, there is also a risk of getting a hospital-acquired infection, which can cause serious complications or even death. And if someone is already receiving regular care at home, sending someone into hospital can interrupt the relationship with their carer and their family. The carer bond can be hard to re-establish.

There are also financial as well as personal costs associated with hospital care. Keeping people in hospital is costly, and people over 85 account for a quarter of all bed days in the NHS. Avoiding this would be better for older people, reduce admission to residential care and keep people living at home longer, and also save money.

How successful is being stabilized by a paramedic?
Paramedics have a highly responsible role, often being the most senior ambulance service health care professional in a range of emergency and non-emergency situations. They are trained to deliver their care in the pre hospital setting and so by doing this are considered experts in their field.

They are highly skilled professionals who assess a patient's condition and make potentially lifesaving decisions. In an emergency they are trained to managed complex situations and use high tech equipment such as defibrillators and intravenous drugs. In essence they provide a mobile emergency clinic and are capable of delivering advanced life support techniques to resuscitate/stabilise

patients using sophisticated procedures, techniques, equipment and drugs. They do all of this autonomously, but do have facilities to speak with other clinicians to support their clinical decision making, for example, speaking with a doctor from a trauma centre.

Paramedics follow guidelines to support them in their role and have the facilities to consult this guidance via an electronic system which they carry with them.

Have we considered the coast in the summer and tourism? How do we factor in the extra number of visitors?
We are very adept at managing and forecasting trajectories for activity increases, for example seasonal swells such as summer or winter tourism. We are kept informed of most events taking place within the county, such as large shows, and have business continuity plans in place to ensure everything is managed well.

Alison Marriott would like to see published the options appraisal information complete with scoring from January 2017.
Options appraisal scoring from February 2018 will be published with the Pre-Consultation Business Case prior to public consultation.

END

THE FOLLOWING QUESTIONS AND ANSWERS HAVE BEEN INCLUDED UPON REQUEST BY ALISON MARRIOTT.

Why is option 2, centralising consultant-led maternity etc. to Lincoln, still in the engagement options? We have been told that it is to ensure that "there is a conversation" and so that "there isn't a done deal". Who decided that this was the case? Who decided that this unacceptable option would be included (high-risk, high-impact on patients and families) and why not a lower-risk option?

Through 2018, Clinicians considered a long list of options and reduced these to a short list of options. It is this short list that we are currently engaging on through Healthy Conversation. National guidance suggests that it is preferable to consult on more than one option for a service change, but this is not always necessary or possible. On those occasions, if only one option for change is viable this one option can be consulted on. The Healthy Conversation is about engaging and hearing people's views about both options. All of the work that has been done since August 2018 is striving to avoid a single site option and the NHS's preferred option is to continue with these services at Pilgrim Hospital.

If it is to be a genuine conversation/consultation at the next stage, why are you not putting forward an option to have the inpatient paediatric beds and level 2 neonatal unit (LNU) at Pilgrim instead of Lincoln? As the RCPCH review report said that in some ways Pilgrim should be the site for the LNU as the population needs it. Also as

ULHT have admitted that the larger population of children with the highest needs are in this side of the county? Surely this would be a more genuine conversation if you had more than 2 options (including an option which keeps inpatient children's services at Pilgrim). Especially given that one of the current options is completely unacceptable from a risk point of view (centralisation - option 2) when considered objectively based on all the available research evidence and experience of staff. Sources of evidence can be provided on request.

Through 2018, Clinicians considered a long list of options and reduced these to a short list of options. It is this short list that we are currently engaging on through Healthy Conversation. Their experience continues to be that recruiting staff to Pilgrim Hospital remains difficult. However recent recruitment campaigns have proved more successful when recruiting to paediatric posts on a rotational basis working at both Lincoln and Pilgrim Hospitals.

What sources are you basing your travel times on between Boston and Lincoln, Skegness and Lincoln? Please quote the travel times you are using along with the sources.

The travel time is dependent on the patient's condition and road conditions. We have used the following travel time thresholds for modelling purposes. These are locally agreed thresholds, there are no national travel times guidance.

The three thresholds are 45 minutes (A&E, maternity and non-elective paediatrics), 60 minutes (all other non-electives and outpatients) and 75 minutes (elective paediatrics, day case surgery and elective surgery).

What impact will the national neonatal transformation programme have on Lincolnshire, and in particular Pilgrim neonatal unit? Has any member of staff in Lincolnshire (any of the NHS organisations) actually seen the draft report yet? If so how will it impact on your plans and the proposed options?

The national neonatal report has been drafted and a number of people have had sight of the draft report. Our ULHT Divisional Head of Midwifery and Nursing) is a member of the national working party, and we have ensured that the plans for Lincolnshire are aligned to this as much as possible. The neonatal work programme is an essential part of the Lincolnshire Local Maternity and Neonatal System. The latest information suggests that the national review will not be published, but there will be a focus on delivery. We are actively engaged with the East Midlands Neonatal Network to ensure that we are able to meet the national standards to sustain a full SCBU at PHB.

At the moment we have dedicated ambulances for transferring children from Pilgrim to Lincoln... if the changes are to be made permanent as in option 1, what will you be putting in place regarding transfers? Will there be a dedicated ambulance? Will EMAS be providing extra services ? Especially as moving stroke patients too are in the options...

The additional ambulance service on the Pilgrim site (started in August 2018 to support the interim model) will continue to transfer any patient that does not meet the category 1 classification (an immediate response to life threatening condition). Category 1 patients will be transferred by EMAS via 999 emergency vehicle. For neonatal babies and children being transferred to tertiary units there are specialised retrieval teams, with their own ambulance, who will attend the hospital to move patients.

6. On the SSNAP audits, Pilgrim stroke unit is mainly scored higher than Lincoln, and the figures of patients are often very similar.... so why not centralise the service Pilgrim? What is the specific and detailed rationale for choosing the Lincoln site, including specific details of any co-located dependent services, whether those services previously existed at Pilgrim, if so why were they moved, reduced or closed, what consultation process was followed, and was the potential future impact on other services made clear to the public at the time?

The stroke unit at Pilgrim does get good outcomes, but the medical staffing is fragile with temporary staffing plus one retired consultant who is returning on an annual contract. The intention is to change the stroke model so care after 7 days takes place in the community and this rehabilitation will better meet patients' needs and will reduce the overall number of beds required. The combination of a single unit will make it more attractive to staff, facilitate access to advanced treatments as they evolve, allow patients to recover in the community and make it more cost effective. The treatment that is expected to evolve over the coming years is the Mechanical Thrombectomy Service. This is currently not provided in Lincolnshire. It is anticipated that this service will be co-located with the Cardiac service in future years. The centralisation of the Cardiac Service at Lincoln Hospital has improved mortality over the last 5 years.

Where has this event been publicised? In which other languages and formats? What facilities are you providing at the venue to allow disabled people to participate equally and information in a range of formats so that everyone can understand? Please list specifically what you are doing/providing so that residents with protected characteristics can participate fully and on an informed basis.

The workshops are publicised extensively through the following media channels: local newspapers/magazines, local radio, social media, websites, e-shots to stakeholder groups and through relevant third parties. As this event was open to all and was not invite only, we could not guarantee that people with protected characteristics would attend but ensured a wide reach with our communications so the opportunity was there.

In addition, these workshops are only one part of the much bigger programme of engagement we are undertaking and understand that events like this are not the best way for some people to engage with us. Therefore, we offer a variety of ways for people to tell us their views if they don't want to or are unable to come along to a workshop, for example our paper and online surveys which are also available in different languages, paper and online feedback forms, meeting us when we're out and about in town centres and supermarkets, and people can phone, email or write to us. This is just the first part of our engagement and we will continue with many more extensive engagement and consultation opportunities as we move into the formal public consultation.

The purpose of these workshops was a 'deep dive' into the particular themes which emerged from the wave 1 engagement events and therefore smaller, more detailed group discussions was an appropriate way to achieve this. We are also mindful that our clinical staffs' time is extremely valuable and we are grateful that they were able to sit around tables and have a conversation with our patients and the public which would not have been possible with larger scale events .

Further details of our proactive engagement with groups with protected characteristics will be made publically availability on completion and we will share this with you. As reported in the Health Scrutiny Committee, we are working with People's Partnership, an independent partner to ensure proactive engagement with people with protected characteristics.

The People's Partnership is made up of a Leadership Team who represent major areas of disability and some areas of the protected characteristics. In addition to the Leadership Team, they have individual members, members of groups and communities, and members who support the hidden and hard to reach communities.

The current members of the Leadership Team are:

- *Age UK Lincoln & South Lincolnshire*
- *CarersFIRST*
- *Children's Links*
- *Every-One (contributes and facilitates the organisation of the People's Partnership)*
- *Linkage Community Trust*
- *Links Lighthouse*
- *South Lincolnshire Blind Society*

As part of the engagement, The People's Partnership have engaged with a number of hidden and hard to reach communities which included 56 respondents who identified as having sight loss.

Funding - what are you doing to ensure that Lincolnshire gets its fair share of funding and are you getting the support you need politically? For example, this report from the Nuffield foundation and NCRHC (based in Lincoln) suggests that we are underfunded. So this is not just driven by safety, is it? https://www.nuffieldtrust.org.uk/research/rural-health-care

We are aware of this report having contributed to its development and we understand that the NCRHC are taking this forward nationally. With the current national methodology on funding allocation, we are receiving our 'fair share' so any national review is welcomed.

A set of four criteria were developed for the purpose of assessing any future options and proposals, namely: 'quality of care', 'access to care, 'affordability' and 'deliverability'. Safety

is part of quality and funding is part of affordability. These four criteria are considered as equal and not weighted.

What are the exclusion protocol for ambulances and GP's, i.e not taking or sending babies, children and pregnant women to the Pilgrim at the moment? What were they before the August 2018 changes? What will they be under the proposals? (by each option). For example, will all pregnant women under 37 weeks experiencing any problem be told to go to Lincoln (or taken by ambulance) under option 2?

Today, babies born pre 29-weeks and children under five who require surgery are all treated out of county. Some of these patients will require planned care, other patients will receive initial treatment in county and be transported to tertiary services as their care needs require specialist support. This will continue in the future.

There are no exclusion protocols for ambulances and GPs taking babies, children or pregnant women to Pilgrim Hospital now nor before August 2018. There will no exclusion criteria for option 1 in the proposals.

For option 2, there would be no neonatal service or consultant obstetric service at Pilgrim Hospital. This means that if the lady is planned to have a consultant led birth, they will attend Lincoln Hospital or a hospital outside of the county for treatment / the birth. Pregnant women can still attend Pilgrim Hospital, would be treated and transferred with their baby if necessary.

We were informed by ULHT on 18th June that the reason for including Women & Children's option 2 in the Healthy Conversation engagement documents was due to advice from NHS England that these two options were necessary for valid public consultation.

We believe the event you refer to was the Paediatric Engagement Event held at Pilgrim Hospital, United Lincolnshire Hospitals Trust (ULHT) on 18th.

NHS England (NHSE) does not give instructions on the number of options to consult on. NHSE's approach is to issue guidance and promote the use of 'best practice'.

It is preferable to consult on more than one option for a service change, but this is not always necessary or possible. On those occasions if only one option for change was viable this one option can be consulted on.

Please note there are other Acute Services Review services too where we have included a second option, which is theoretically deliverable, even though we have been clear that it is not our NHS preferred option.

Please would you provide a copy of the advice from NHS England, or from any other source if it wasn't NHS England.

We are currently engaging on our options and are using the NHSE guidance available at

https://www.england.nhs.uk/publication/planning-assuring-and-delivering-service-change-for-patients/

Appendix 4: Acute Services Review survey report

Contents:

Background and introduction

During 2018 we engaged with our communities on hospital services to start developing options for how services need to change. We undertook a survey and number of public events to explore this.

All of the feedback we received was shared with clinicians and senior leaders to consider these views and experiences when thinking about the options for how we might deliver these services in the future. Any options that suggest significant change to hospital services will go through NHS England assurance processes and public consultation before service changes are made.

This previous engagement helped us to identify some emerging options upon which we invited further views using a variety of engagement activities as part of the Healthy Conversation 2019 campaign, such as open events and a survey. This report summarises the results of this survey as well as respondents' thoughts on travel and transport and technology to support these possible changes in services.

All of the detailed feedback received has been circulated to the Senior Responsible Officers for the system programmes to inform the development of Lincolnshire's Long Term Plan and also to shape their programmes and projects and emerging options prior to any public consultation.

Survey feedback:

During the course of the engagement we received 649 completed surveys with a varying number of respondents answering each question.

Respondent profile:

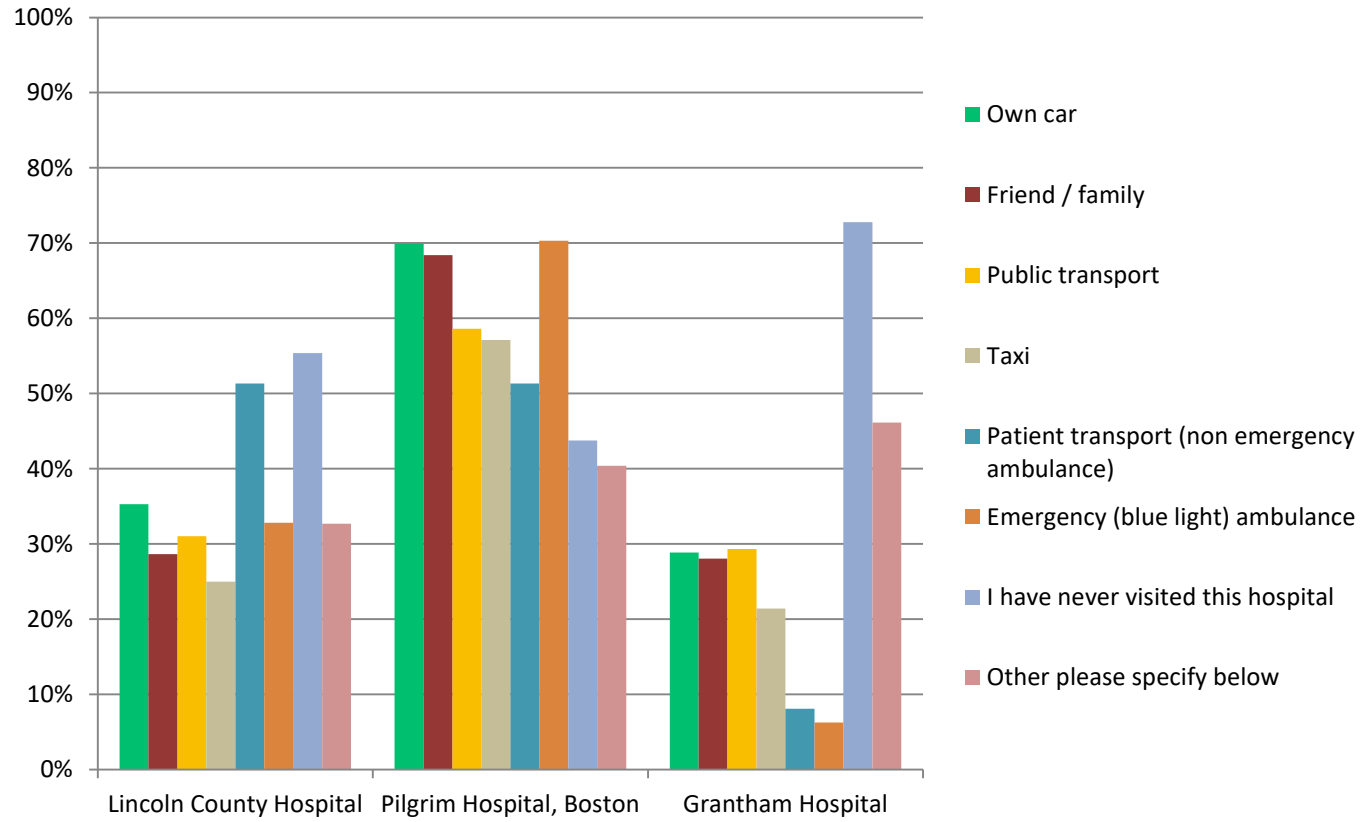
- 83% (537) members of the public
- 11% (73) member of NHS staff
- 5% (34) Organisation or other
- 5 did not answer this question

Travel to and use of Lincoln, Pilgrim Boston and Grantham Hospitals

Initial questions in the survey asked respondents how they travelled to hospitals, how often they attended and if they experienced any difficulties attending any of the sites.

These results demonstrate that a higher proportion of respondents to the survey visit Pilgrim Hospital, Boston than Lincoln and Grantham Hospitals and so subsequent answers received will also show a larger number of views relating to Pilgrim Hospital.

Q3: If you have used any/all of the 3 main hospitals in Lincolnshire within the last 12 months what was the main way you travelled to each of these hospitals?



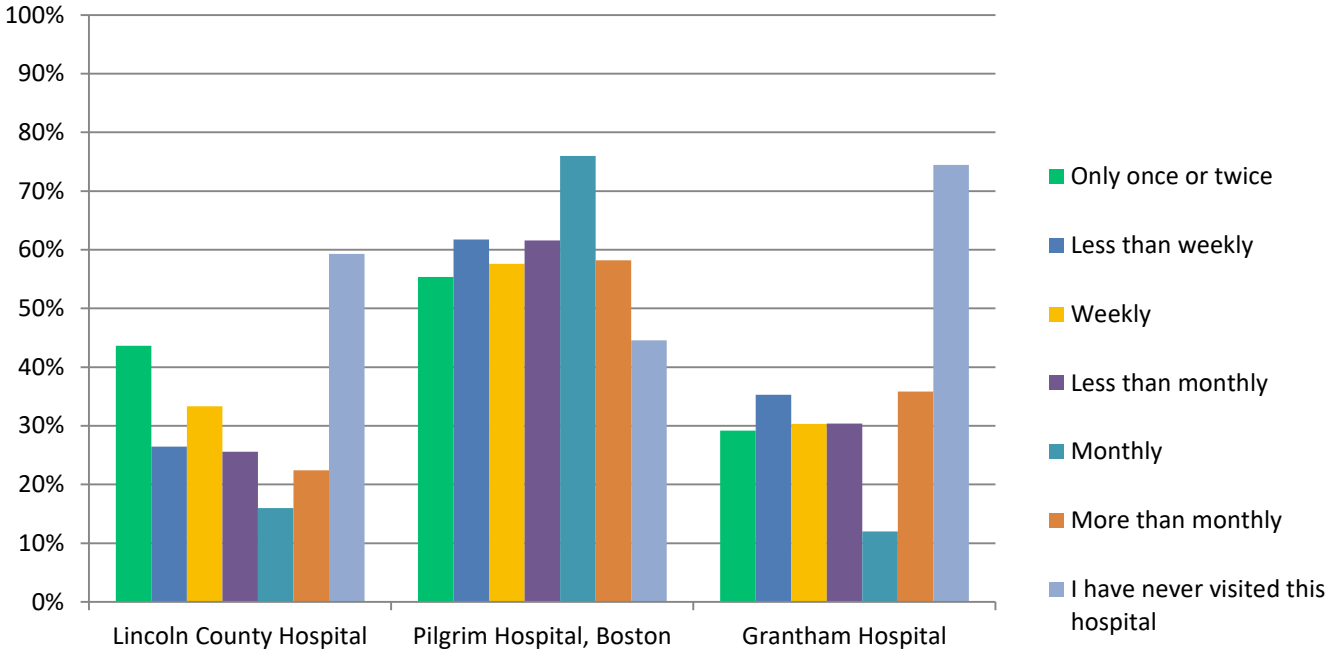
A large proportion of respondents visited each hospital using their own cars.

Lincoln Hospital: the highest number of those who have visited the hospital attended by patient transport. Those who suggested other methods of travel indicated that they either walked or attended a different hospital.

Pilgrim Hospital Boston: most respondents attended by emergency (blue light) ambulance. Those who suggested other methods of travel indicated that they walked, used voluntary transport or attended a different hospital.

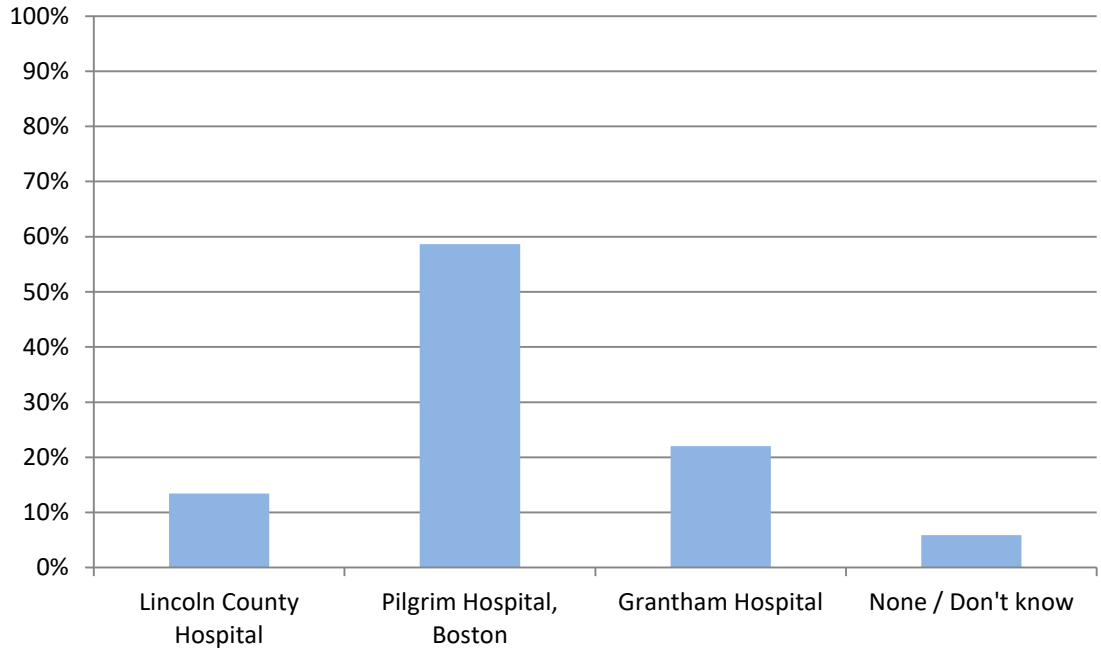
Grantham Hospital: the majority of respondents who didn't use one of these travel methods indicated that they walked to the hospital.

Q4: Over the last 12 months, approximately how often have you visited each of the 3 hospitals?



Most respondents indicated that they hadn't visited Lincoln and Grantham Hospitals.

Q5: Which is the main hospital site you have travelled to?



Q6: Why is this the main hospital you travel to?

	Lincoln Hospital	Pilgrim Hospital	Grantham Hospital	None / Don't Know
Responses	84 (13%)	367 (59%)	138 (22%)	37 (6%)
I am given appointments for this hospital	**50%**	25%	22%	8%
It is closest to where I live	27%	**64%**	**66%**	8%
It is easy to get to using public transport	1%	1%	1%	3%
My family / carer can take me	2%	2%	1%	0%
There is enough parking at the hospital	0%	0%	1%	0%
It is in an area where I work or shop	2%	2%	3%	0%
Other reason (please specify)	17%	5%	7%	**41%**
Answer left blank				41%

23 respondents did not answer this question. The main reasons for visiting each hospital are highlighted in green.

Other reasons:

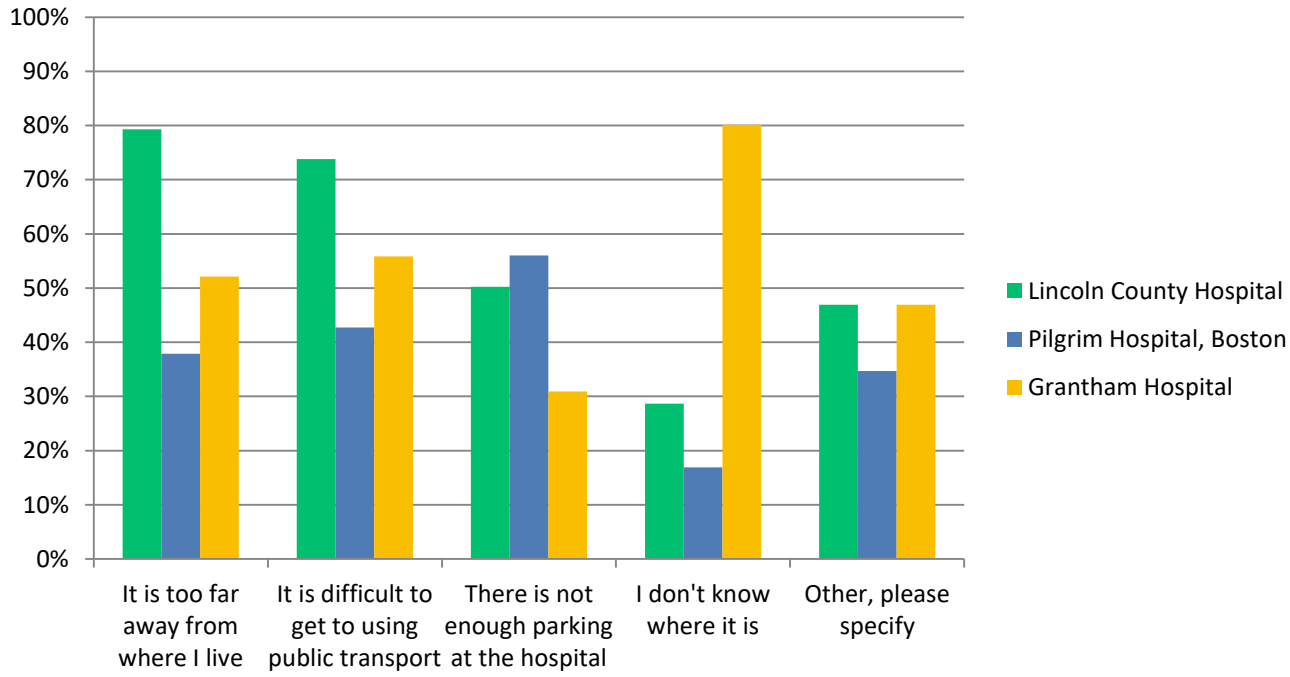
Lincoln Hospital: Closest A&E open 24/7; only location for treatment required; advised to attend this hospital

Pilgrim Hospital, Boston: Only location for clinic/treatment; closest for family to visit; better roads and familiar with hospital

Grantham Hospital: Requested to go here; easy to get to; quicker treatment in A&E

None/Don't know: Use other hospitals especially Stamford or Peterborough

Q7: For each hospital please tell us if there is ONE main thing that makes it difficult to access services at each hospital



The main reason it is difficult to access services:

Lincoln Hospital: It is too far away from where patients live.
Other reasons: too expensive to get there; long delays to get appointments; traffic congestion; would access another hospital.

Pilgrim Hospital, Boston: There is not enough parking at the hospital.
Other reasons: cost of parking; reputation; too far to travel in an emergency

Grantham Hospital: Patients don't know where it is.
Other reasons: other hospitals are easier to access; reduced services; cost of parking

Digital:

Q8: Virtual consultations could be phone or video call with a clinician rather than needing to travel for a face to face appointment. Please tell us to what extent you would like to be offered a virtual consultation instead of having to travel to an appointment?

I would definitely like to be offered a virtual consultation	14%	46% positive
I might like to be offered a virtual consultation	32%	
I don't think I would like to be offered a virtual consultation	23%	50% negative
I definitely would not like to be offered a virtual consultation	27%	
Don't know	4%	

Q9: Please tell us the reasons for your answer to question 8

Positive	• Great for patients too poorly to drive • Often difficult to arrange transport so this would be great • Saves time and more environmentally friendly • Much easier than having to travel and pay for fuel and parking • More time efficient when hospital conversations sometimes only last minutes but travelling could take hours • Reduces need for patient/family to take time off work • Much better for patients with children or dependents • Better use of clinician time and resulting in more appointments available
Negative	• Lack of confidence in dealing with people via technology, far more comfortable with face-to-face meetings • Not everybody has access to the internet or technology • Physical examinations are far better • Those with disabilities may have difficulties with technology • Some important information could be missed by not seeing the patient • It would feel strange and impersonal • Concerns about discussing personal information on the internet/via computer

Q10: Some digital solutions can be used at home to monitor your own health (for example, self-monitoring or remote monitoring technology such as blood sugar monitor, blood pressure monitor, activity tracker).

To what extent would you use these if that meant you could avoid an unnecessary appointment or stay in your home for longer rather than having to go into hospital?

I would definitely use technology to monitor my health at home	49%	86% positive
I might use technology to monitor my health at home	37%	
I don't think I would use technology to monitor my health at home	6%	10% negative
I definitely would not use technology to monitor my health at home	4%	
Don't know	4%	

Q11: Please tell us the reasons for your answer to question 10

Positive	• Frees up time for other patients • Saves the NHS time and money • Reduction in time away from work, less pressure on NHS resource, reduction in carbon footprint re travel • Many patients already monitor their health at home such as blood pressure – just need plenty of support and information about when to seek help and when to continue alone at home • The technology exists and produces the same results with less inconvenience to myself and frees up resources for other people who may have no other option but to physically attend • With advancing age travel is becoming a problem • We all need to take more responsibility for our own health. It is our responsibility to monitor day to day health
Negative	• Would not feel reassured as much as seeing a doctor • Not suitable for certain conditions • I do not understand the technology and don't trust it. I dislike doing things on line

Q12: If you were offered support and training to use digital technology to what extent would this encourage you to use it?

I would definitely consider using it after support and training	50%	85% positive
I might consider using it after support and training	35%	
I don't think I would use it even after support and training	7%	11% negative
I definitely wouldn't use it even after support and training	4%	
Don't know	4%	

Q13: Family members or carers could have access to parts of your medical records with your permission. This would mean that they could check your upcoming appointments, see your prescribed medications or contact a medical provider on your behalf.

Please tell us if you would like to give permission for family members or carers to access your medical records

I would definitely like to give family or carers permission to access my medical records	36%	71% positive
I might like to give family or carers permission to access my medical records	35%	
I don't think I would like to give family or carers permission to access my medical records	12%	26% negative
I definitely would not like to give family or carers permission to access my medical records	14%	
Don't know	4%	

Q14: Please tell us the reasons for your answer to question 13

Positive	• The more people involved in my care the better for me • Useful for older people or those with additional needs who need support with these things • Patients happy for family to know their medical details • If it speeded up diagnosis and meant better treatment
Negative	• Privacy concerns • Totally inappropriate unless incapable of making own decisions • Maybe as I get older but not at the moment

Q15: If you have any concerns about using digital technology such as having video/skype consultations, using self-monitoring technology or apps please tell us below

- This is fine as long as patients are given a choice
- Privacy and cyber security are a concern
- Patients might not understand how to do it
- Patients might not have concerns but would like to be given suitable training how to use these technology
- Do not have internet access or technology to use it
- Sometimes only face to face appointments are suitable

Q16: If there is anything that would help you to use these technologies to take advantage of the benefits they bring, please tell us below

- Suitable training and support would be needed
- Each step at a time- patients can't even access medical records online yet. GP front line staff need to be fully trained in assisting/encouraging would-be NHS digital users
- Full subtitles and not having to use a phone
- Guarantee security of information
- Possibly, a dedicated room in public buildings such as surgeries, libraries, council offices etc, where the public can drop in to use technology for telehealth consultations. This could be beneficial in areas where connectivity is poor
- Provide the technology for patients to use
- Better broadband, easy access to support 24hrs a day if there are problems using the technology
- Once they are proved to be secure patients might consider it

The following questions were based on the eight services included in the Acute Services Review. Due to the nature of the questions asking respondents to identify concerns and problems they have about the emerging options, the responses are mainly negative. This will enable us to consider what we can do to mitigate any of the problems people might face if services are changed.

Breast services

Q17: Please tell us if you would have any problems accessing these breast services at Lincoln County Hospital and if you have any suggestions of how we could overcome this

52% of 644 respondents to this question provided negative examples of how they could have problems accessing services and of those, the reasons given included:

- Distance and accessibility - hospital is far away from home; too far to travel
- Transport – unable to drive or rely on family/friends
- Cost – hardship to patients or family

9% of respondents provided neutral answers to this question, 7% were positive and respondents felt they wouldn't have any problem with this option and 33% were unanswered.

Suggestions included:

- Mobile units at GP Practices
- Provide free, reliable transport for sick patients, for example scale up the charity car projects
- Send out details of travel and transport with appointments
- Keep outpatients appointments local

(Respondents unaware that this is already part of the emerging option)

Q18: Please tell us if you would have any problems accessing these breast services at Grantham Hospital and if you have any suggestions of how we could overcome this

41% of 647 respondents to this question provided negative examples of how they could have problems accessing services and of those, the reasons given included:

- Distance and accessibility - hospital is far away from home; too far to travel
- Transport – unable to drive and lack of public transport
- Cost – hardship to patients or family

6% of respondents provided neutral answers to this question, 15% were positive and respondents felt they wouldn't have any problem with this option and would be prepared to travel if it meant a quicker appointment and 38% were unanswered.

Suggestions included:

- Offer hospital transport
- Better parking and free for disabled patients
- Skype would help for routine follow up appointments

Q19: Please tell us if you have any other comments or suggestions about our emerging options for breast services

Other comments included:

- Concern about services being centred around Lincoln
- Services should be more widely available in all hospitals across Lincolnshire
- Could utilize other hospitals such as Grantham, Pilgrim Boston, Peterborough and Stamford
- Would need travel support to and from Lincoln Hospital
- Centralising is sensible
- Received great care at Lincoln previously

Stroke services

Q20: Please tell us if you would have any problems accessing these stroke services at <u>Lincoln County Hospital</u> and if you have any suggestions of how we could overcome this

62% of 644 respondents to this question provided negative examples of how they could have problems accessing services and of those, the reasons given included:

- Distance and accessibility – concern about the 'Golden Hour', long distance away for people at the coast, road infrastructure inadequate
- Transport – no public transport from some areas, would have to rely on family/friends
- Cost – hardship to patients or family

3% of respondents provided neutral answers to this question, 7% were positive and respondents felt they wouldn't have any problem getting to Lincoln and would appreciate swift treatment at a centre of excellence and 28% were unanswered.

Suggestions included:

- Retaining stroke services as Pilgrim Boston
- Consider the impact on friends and family
- Provide a fully funded transport system

Q21: Please tell us if you would have any problems accessing these stroke services at <u>Pilgrim Hospital,</u> Boston and if you have any suggestions of how we could overcome this

28% of 643 respondents to this question provided negative examples of how they could have problems accessing services and of those, the reasons given included:

- Distance and accessibility – too far to travel , excessive traffic congestion and long delays
- Transport – no transport links from some areas, unable to drive and would have to rely on family/friends

3% of respondents provided neutral answers to this question, 28% were positive and respondents felt they wouldn't have any problem getting to Boston as this was closer to home and 40% were unanswered.

Suggestions included:

- Improved parking required and at reduced costs
- Use Skype if possible

- Provide stroke services in Grantham and other local hospitals

Q22: Please tell us if you have any other comments or suggestions about our emerging options for stroke services

Other comments included:

- Treatment in a timely manner is important but where this is located varies depending on where patients live in the county
- Provision of stroke services in other local hospitals
- Local rehabilitation

Women's and children's services

Q23: Please tell us if you would have any problems accessing Lincoln County Hospital for consultant led services for both consultant led and maternity services and if you have any suggestions of how we could overcome this

54% of 643 respondents to this question provided negative examples of how they could have problems accessing services and of those, the reasons given included:

- Distance and accessibility – too far away from where some patients live, difficult to get to especially with young children or in emergencies
- Transport – difficult in times of heavy traffic, inadequate public transport and can't get there for early appointments,
- Cost – hardship to patients or family, can take a whole day for appointments with the additional travel and need to take unpaid leave, difficult to travel with other work and family commitments

7% of respondents provided neutral answers to this question, 4% were positive from respondents who lived closer to Lincoln and felt it would be easier to travel to and 35% were unanswered.

Suggestions included:

- Provide additional parking – extra land needed
- Keep maternity services at Pilgrim Boston and use both Lincoln and Pilgrim Hospitals
- Improved transport links for patients

Q24: Please tell us if you would have any problems accessing Pilgrim Hospital, Boston for maternity-led services or both consultant-led and maternity services and if you have any suggestions of how we could overcome this

19% of 643 respondents to this question provided negative examples of how they could have problems accessing services and of those, the reasons given included:

- Distance and accessibility – too far away from where some patients live, still a long way to get to using public transport from the coast
- Transport – traffic congestion at certain times of the day; terrible public transport options, other hospitals are closer and easier to get to

9% of respondents provided neutral answers to this question, 20% were positive from respondents who lived closer to Boston and felt it would be easier to travel to and 52% were unanswered.

Suggestions included:

- More staff needed to deliver the fabulous care they are capable of
- Keep services as they are
- Deliver services in other local community hospitals

Q25: Please tell us if you have any other comments or suggestions about our emerging options for women's and children's services

Other comments included:

- Concern about services becoming Lincoln centric
- Localise services to make them accessible for all
- Increase staffing levels
- Consider the impact of the wider family and dependents if women and children have to travel to a hospital further away from their homes.

Medical services at Grantham Hospital

Q26: Please tell us if you would have any problems accessing acute medical beds at Grantham Hospital and if you have any suggestions of how we could overcome this

30% of 644 respondents to this question provided negative examples of how they could have problems accessing services and of those, the reasons given included:

- Distance and accessibility – too far away from where some patients live,
- Transport – poor public transport links and difficult to access if unable to drive
- Cost – hardship to patients or family who cannot afford the travel costs

6% of respondents provided neutral answers to this question, 18% were positive from respondents who felt they would have no problems accessing Grantham Hospital and were keen for services to remain there and 46% were unanswered.

Suggestions included:

- Need to keep all medical treatment local and easy to access
- Train staff in-house and build on the apprenticeship scheme to share knowledge of experienced staff
- More beds and staff needed at Grantham Hospital.

Q27: Please tell us if you have any other comments or suggestions about our emerging options for acute medical beds at Grantham Hospital

Other comments included:

- The acute care beds might take some pressure from Pilgrim and Lincoln hospitals
- Use of other local community hospitals
- Keeping as many services as possible at Grantham is very important. If we only have 3 main hospitals in this county we need to keep as many local services available as possible.

- The community healthcare support model is being used at Hospice in the Hospital at Grantham and has thrown up a variety of challenges which should be considered before any changes are made to the hospital itself.

Trauma and Orthopaedics

Q28: Please tell us if you would have any problems accessing trauma and orthopaedic services at Grantham Hospital and if you have any suggestions of how we could overcome this

36% of 648 respondents to this question provided negative examples of how they could have problems accessing services and of those, the reasons given included:

- Distance and accessibility – Grantham Hospital is too far away from people living in South Lincolnshire and they would go to Peterborough, too far to travel in pain after an operation
- Transport – poor public transport links and the railway is too far away from the hospital, no public transport available to get to the hospital early in preparation for operations, some journeys would take over 3 hours

5% of respondents provided neutral answers to this question, 17% were positive from respondents who felt it was convenient for those living locally and some had good experiences of orthopaedic care at Grantham and 42% were unanswered.

Suggestions included:

- Offer these services at multiple hospital sites
- Provision of transport for hospital services

Q29: Please tell us if you have any other comments or suggestions about our emerging option for trauma and orthopaedic services at Grantham Hospital

Other comments included:

- I would be happy to travel to Grantham knowing there was a reduced chance of the appointment being cancelled and a day off being wasted
- Centralisation cannot work without a complete change in transport and road infrastructure
- Too far to travel from certain areas of the county

General Surgery

Q30: Please tell us if you would have any problems accessing general surgery services at Grantham Hospital and if you have any suggestions of how we could overcome this

35% of 642 respondents to this question provided negative examples of how they could have problems accessing services and of those, the reasons given included:

- Distance and accessibility – too far to travel especially when on top of already feeling ill or after surgery
- Transport – accessing for early start surgery would be impossible using public transport, difficult to use public transport straight after day surgery and if you don't have a car it would be impossible to get home

3% of respondents provided neutral answers to this question, 18% were positive from respondents who would have no problems accessing Grantham Hospital if they were local and others were happy to travel for planned care and 44% were unanswered.

Suggestions included:

- Put more resources at a local level – need 3 centres of excellence
- Transport needed to the hospital from the train station
- Appointment times should reflect train / bus arrival times

Q31: Please tell us if you have any other comments or suggestions about our emerging option for general surgery services at Grantham Hospital

Other comments included:

- Other community hospitals should also deliver these services
- A vast rural area like Lincolnshire need services in local hospitals rather than centres of excellence
- Retain breast surgery with general surgery
- Support for general surgery to be delivered at Grantham Hospital

Urgent and Emergency Care services

Q32: Please tell us if you would have any problems accessing urgent and emergency care services at Grantham Hospital and if you have any suggestions of how we could overcome this

35% of 644 respondents to this question provided negative examples of how they could have problems accessing services and of those, the reasons given included:

- Distance and accessibility – too far away for some especially in an emergency and treatment may be outside of the 'Golden Hour', many would go to their nearest hospital
- Transport – without a car access is very difficult from other areas in the county and the poor and inadequate roads are dangerous to drive on in an emergency.

8% of respondents provided neutral answers to this question, 13% were positive from respondents who would have no problems accessing Grantham Hospital if they were local and recognise the need to relieve emergency services at the other hospitals and 45% were unanswered.

Suggestions included:

- Upgrade other local community hospitals to provide urgent and emergency care
- Urgent and emergency care services required 24 hours a day 7 days a week
- Offer walk in services 24/7 with full resuscitation and imaging

Q33: Please tell us if you have any other comments or suggestions about our emerging option for urgent and emergency care services at Grantham Hospital

Other comments included:

- Development of other community hospitals to provide urgent and emergency care and urgent treatment centres, especially for Stamford and Spalding
- 24/7 access to urgent and emergency care in Grantham
- Improve the NHS 111 service

- More education required on self-care

Haematology and Oncology services

Q34: Please tell us if you would have any problems accessing inpatient haematology and oncology services at Lincoln Hospital and if you have any suggestions of how we could overcome this

47% of 643 respondents to this question provided negative examples of how they could have problems accessing services and of those, the reasons given included:

- Distance and accessibility – too far away for many people, 3-4 hour round trips are unacceptable when having treatment for cancer and poorly, parking is inadequate
- Transport – little public transport and not suitable for such poorly patients and friends and family unable to visit
- Cost – too expensive to travel so far even if you have a car, if you don't and can't use public transport due to being so poorly then taxis are even more expensive, friends and family will be unable to visit due to cost

3% of respondents provided neutral answers to this question, 9% were positive who felt able to access Lincoln Hospital as long as outpatients are offered at Grantham and mobile units still available and 41% were unanswered.

Suggestions included:

- Set up telephone conversations for follow ups and reviews
- Supply transport for patients
- Increase the use of voluntary car schemes

Q35: Please tell us if you have any other comments or suggestions about our emerging option for haematology and oncology services at Lincoln Hospital

Other comments included:

- Consider accessibility options for service users in the south, north and east of the county, especially those who are unable to drive
- Use more local hospitals
- There should be equally good services at all sites
- Centralisation cannot work without a complete change in transport and road infrastructure

Equalities monitoring

Under the provisions of the Equality Act 2010, all NHS organisations are required to demonstrate that their processes are fair, and that they are not discriminating or disadvantaging anyone because of their age, disability, gender reassignment status, marriage or civil partnership status, pregnancy or maternity, race, religion or belief, sex or sexual orientation.

Age group	Responses	
Under 18	0%	1
18- 25	3%	18
25-30	6%	38
31 - 35	10%	60
36 - 40	9%	56
41-45	7%	42
46-50	10%	64
51-55	8%	52
56-60	9%	55
61-65	11%	69
66-70	14%	87
71 +	12%	78
Rather not say	1%	8
	Answered	**628**
	Skipped	**21**

Do you consider yourself to have a disability?		
	Responses	
Yes	24%	151
No	71%	445
Rather not say	5%	29
	Answered	**625**
	Skipped	**24**

If yes do you have a:		
	Responses	
Physical Impairment	42%	66
Sensory Impairment	7%	11
Learning Disability	1%	1
Mental Health Condition (Long Term)	10%	16
Other Health Condition (Long Term)	41%	65
	Answered	**159**
	Skipped	**490**

Gender	Responses	
Male	20%	127
Female	76%	476
Rather not say	3%	20
	Answered	**623**
	Skipped	**26**

Do you now, or have you ever considered yourself to be transgender?		
	Responses	
Yes	0%	1
No	96%	557
Rather not say	4%	21
	Answered	**579**
	Skipped	**70**

Religion or beliefs	Responses	
Atheism	11%	67
Agnosticism	3%	18
Buddhism	1%	3
Christianity	54%	323
Hinduism	0%	1
Humanism	1%	4
Islam	0%	1
Jainism	0%	0
Judaism	0%	2
Sikhism	0%	1
Any Other Religion/Belief	2%	13
No Religion or Belief	18%	110
Rather not say	9%	53
	Answered	**596**
	Skipped	**53**

Ethnicity	Responses	
Bangladeshi	0%	0
Indian	0%	3
Pakistani	0%	0
Any Other Asian Background	0%	0
African	0%	1
Caribbean	0%	0
Any Other Black Background	0%	0
White and Asian	1%	4
White and Black African	0%	0
White and Black Caribbean	0%	0
Any Other Mixed Background	1%	5
White British	89%	546
White Irish	0%	3
Any Other White Background	2%	11
Chinese	0%	0
Gypsies & Travellers	0%	1
Any Other Ethnic Group	0%	1
Rather not say	6%	39
	Answered	**614**
	Skipped	**35**

Sexual orientation	Responses	
Bisexual	2%	14
Gay Man	0%	0
Gay Woman	0%	1
Heterosexual	87%	501
Lesbian	0%	2
Other	1%	4
Rather not say	9%	53
	Answered	**575**
	Skipped	**74**

Pregnancy and maternity - are you an expectant mother?		
	Responses	
Yes	3%	18
No	94%	549
Rather not say	3%	15
	Answered	**582**
	Skipped	**67**

Pregnancy and maternity - have you utilised local maternity services in the last 18 months		
	Responses	
Yes	11%	64
No	86%	488
Rather not say	3%	17
	Answered	**569**
	Skipped	**80**

Carer- are you currently providing support and care to a partner, child, relative, friend or neighbour who cannot manage without your help or/ and support?		
	Responses	
Yes	34%	199
No	61%	357
Rather not say	5%	29
	Answered	**585**
	Skipped	**64**

You said, we did

All of the detailed feedback received has been circulated to the Senior Responsible Officers for the system programmes to inform the development of Lincolnshire's Long Term Plan and also to shape their programmes and projects.

This feedback has also informed the continued development of the emerging options for changes to hospital services which will go through NHS England assurance processes and public consultation before service changes are made.

Appendix 1: survey

Lincolnshire Acute Services Review Engagement 2019

During 2018 we engaged with our communities on hospital services to start developing options for how services need to change. We undertook a survey and number of public events to explore this.

All of the useful feedback we received has been shared with clinicians and senior leaders to consider these views and experiences when thinking about the options for how we might deliver these services in the future. Any options that suggest significant change to hospital services will go through NHS England assurance processes and public consultation before service changes are made.

This previous engagement has helped us to identify some **emerging options** which we would now like your views on before they are finalised for the formal public consultation. We would welcome feedback on these and in particular your thoughts on travel and transport and technology to support these possible changes in services.

Please visit our website for more information about these services, explanations of why we need to change and the benefits of these emerging options: https://www.lincolnshire.nhs.uk and get involved in a #HealthyConversation.

We would like your views on all of the questions, but if you don't want to answer some or feel they are not relevant, please just skip them and move onto the next question.

Please return this survey to:
Central STP Office
Room 2
Wyvern House
Kesteven Street
Lincoln
LN5 7LH

1. Please tell us the first 5 digits of your postcode

2. Are you:

☐ Member of the public
☐ Member of NHS staff
☐ GP
☐ Organisation or other, please tell us below:

3. If you have used any/all of the 3 main hospitals in Lincolnshire within the last 12 months what was the <u>main</u> way you travelled to each of these hospitals? (one tick per column)

	Lincoln County Hospital	Pilgrim Hospital, Boston	Grantham Hospital
Own car	☐	☐	☐
Friend / family	☐	☐	☐
Public transport	☐	☐	☐
Taxi	☐	☐	☐
Patient transport (non-emergency ambulance)	☐	☐	☐
Emergency (blue light) ambulance	☐	☐	☐
I have never visited this hospital	☐	☐	☐
Other, please specify below	☐	☐	☐

4. Over the last 12 months, approximately how often have you visited each of the 3 hospitals? (one tick per column)

	Lincoln County Hospital	Pilgrim Hospital, Boston	Grantham Hospital
Only once or twice	☐	☐	☐
Less than weekly	☐	☐	☐
Weekly	☐	☐	☐
Less than monthly	☐	☐	☐
Monthly	☐	☐	☐
More than monthly	☐	☐	☐
I have never visited this hospital	☐	☐	☐

We recognise that in an emergency you will go to your nearest, most appropriate hospital. Please consider the following questions for outpatient or planned appointments.

5. Which is the main hospital site you have travelled to? (please tick one box):

☐ Lincoln County Hospital ☐ None / don't know

☐ Pilgrim Hospital, Boston ☐ Grantham Hospital

6. Why is this the main hospital you travel to?

☐ I am given appointments for this hospital
☐ It is closest to where I live
☐ It is easy to get to using public transport
☐ My family / carer can take me
☐ There is enough parking at the hospital
☐ It is in an area where I work or shop
☐ Other reason (please specify)

7. For each hospital please tell us if there is ONE main thing that makes it difficult to access services at each hospital (one tick per column)

	Lincoln County Hospital	Pilgrim Hospital, Boston	Grantham Hospital
It is too far away from where I live	☐	☐	☐
It is difficult to get to using public transport	☐	☐	☐
There is not enough parking at the hospital	☐	☐	☐
I don't know where it is	☐	☐	☐
Other, please specify below	☐	☐	☐

Improvements in information technology is important for all of the service transformation in Lincolnshire for both staff and patients. In a rural county like Lincolnshire, some patients have to travel long distances for appointments - we need to look at how technology can help, such as self-monitoring technology and video/skype consultations so patients do not have to travel unnecessarily.

8. Virtual consultations could be phone or video call with a clinician rather than needing to travel for a face to face appointment.

Please tell us to what extent you would like to be offered a virtual consultation instead of having to travel to an appointment?

☐ I would definitely like to be offered a virtual consultation
☐ I might like to be offered a virtual consultation
☐ I don't think I would like to be offered a virtual consultation
☐ I definitely would not like to be offered a virtual consultation
☐ Don’t know

9. Please tell us the reasons for your answer to question 8

10. Some digital solutions can be used at home to monitor your own health (for example, self-monitoring or remote monitoring technology such as blood sugar monitor, blood pressure monitor, activity tracker).

To what extent would you use these if that meant you could avoid an unnecessary appointment or stay in your home for longer rather than having to go into hospital?

☐ I would definitely use technology to monitor my health at home
☐ I might use technology to monitor my health at home
☐ I don't think I would use technology to monitor my health at home
☐ I definitely would not use technology to monitor my health at home
☐ Don't know

11. Please tell us the reasons for your answer to question 10

12. If you were offered support and training to use digital technology to what extent would this encourage you to use it?

☐ I would definitely consider using it after support and training
☐ I might consider using it after support and training
☐ I don't think I would use it even after support and training
☐ I definitely wouldn't use it even after support and training
☐ Don't know

13. Family members or carers could have access to parts of your medical records with your permission. This would mean that they could check your upcoming appointments, see your prescribed medications or contact a medical provider on your behalf.

Please tell us if you would like to give permission for family members or carers to access your medical records

☐ I would definitely like to give family or carers permission to access my medical records
☐ I might like to give family or carers permission to access my medical records
☐ I don't think I would like to give family or carers permission to access my medical records
☐ I definitely would not like to give family or carers permission to access my medical records
☐ Don't know

14. Please tell us the reasons for your answer to question 13

15. If you have any concerns about using digital technology such as having video/skype consultations, using self-monitoring technology or apps please tell us below

16. If there is anything that would help you to use these technologies to take advantage of the benefits they bring, please tell us below

Breast services

Breast services refer to a range of screening, diagnosis and treatment of breast problems, including cancer. These services are currently delivered across Lincoln County, Pilgrim and Grantham hospitals with a small number of patients seen in Louth Hospital. There is also a mobile breast screening mammography service that travels across the county.

We think that a centre of excellence approach would work well in Lincolnshire as has already proven so in rural Cornwall – visit our website to see a case study. We think this will help us address the quality of care issues and shortage of specialist staff.

In practice, this emerging option would mean that all follow-up outpatient appointments and routine breast mammography screening services would continue to be available across the county as they are now. These appointments are where most patients receive their care. First outpatient appointments and all surgery would be provided at the centre of excellence. This would enable specialist staff to fully cover rotas, see more patients and retain and develop their skills. Together, this means patients will be seen more quickly and receive a better standard of care.

Our emerging options indicate that this centre of excellence could be at Lincoln Hospital or Grantham Hospital. **The NHS's current preferred emerging option is Lincoln Hospital for this centre of excellence** as it requires the least amount of capital funding. If located at Grantham, any complex breast surgery would be done at Lincoln.

17. Please tell us if you would have any problems accessing these breast services at Lincoln County Hospital and if you have any suggestions of how we could overcome this

18. Please tell us if you would have any problems accessing these breast services at Grantham Hospital and if you have any suggestions of how we could overcome this

19. Please tell us if you have any other comments or suggestions about our emerging options for breast services

Stroke services

Stroke services refer to a range of services for the diagnosis of stroke, acute treatment, rehabilitation and follow-up after discharge from hospital. Currently these services are delivered at Lincoln and Pilgrim Hospitals. Diagnostic services start in our emergency departments and then patients have treatment on the acute stroke units in these two hospitals. There is also a stroke rehabilitation service in the community that cares for people after they have been discharged from hospital.

Our first emerging option, similar to that for breast services, is to take a centre of excellence approach, providing acute stroke care from the Lincoln Hospital site. This is the NHS's current preferred emerging option because it will provide the best model to meet national care standards for patients, and to recruit and retain staff.

The second emerging option is to retain the current service at Lincoln and Pilgrim Hospitals but with an out of hours combined on-call rota being based at Lincoln.

In both emerging options, our intention would be to enhance rehabilitation in the community across Lincolnshire to reduce the length of stay in hospital from 14 days to 7 days in line with national best practice.

20. Please tell us if you would have any problems accessing these stroke services at Lincoln County Hospital and if you have any suggestions of how we could overcome this

21. Please tell us if you would have any problems accessing these stroke services at Pilgrim Hospital, Boston and if you have any suggestions of how we could overcome this

22. Please tell us if you have any other comments or suggestions about our emerging options for stroke services

Women's and children's services

Women's and children's services refer to a wide range of services across acute and community settings including obstetrics (maternity care), neonatal (care of premature or sick babies), paediatric (care of children) and gynaecology (care for women and girls, especially related to the reproductive system).

Currently all these hospital services are delivered in both Lincoln and Pilgrim Hospitals. We have a neonatology intensive care unit at Lincoln Hospital and a special care baby unit at Pilgrim Hospital. Babies born pre 29-weeks and children under five who require surgery are all treated out of county. Women in Lincolnshire have a choice of giving birth at home or in a consultant-led obstetrics unit at these two hospitals. Midwife services are available in the community and at home.

There are two emerging options.

The first emerging option is to have the following services at the two hospital sites;

<u>At Pilgrim Hospital</u>

- to continue with a consultant led obstetric service with the addition of a co-located midwife-led unit
- to continue with a specialist care baby unit caring for babies born from 32 weeks (the interim position is that it currently cares for babies born from 34 weeks. Prior to August 2018 it cared for babies from 30 weeks)
- to have a short stay paediatric assessment ward for children needing up to 23 hours of care
- to have low acuity paediatric in-patient beds overnight
- to have paediatric day case surgery.

<u>At Lincoln Hospital</u>

- to continue with a consultant led obstetric service with the addition of a co-located midwife-led unit
- to have a neonatal unit caring for babies born from 27 weeks
- to have a short stay paediatric assessment ward
- to have paediatric in-patient beds
- to have paediatric day case and planned surgery.

We would wish to keep the gynaecology services the same as now on both Lincoln and Pilgrim Hospital sites with our clinicians working as one team across these two sites. **<u>This is currently the NHS's preferred emerging option.</u>**

The second emerging option is to have consultant obstetric, neonatal and paediatric services at Lincoln Hospital and a midwife-led unit and short stay paediatric assessment ward at Pilgrim Hospital. Both hospitals will have midwifery-led units.

23. Please tell us if you would have any problems accessing Lincoln County Hospital for consultant led services or both consultant led and maternity services and if you have any suggestions of how we could overcome this

24. Please tell us if you would have any problems accessing Pilgrim Hospital, Boston for maternity-led services or both consultant-led and maternity services and if you have any suggestions of how we could overcome this

25. Please tell us if you have any other comments or suggestions about our emerging options for women's and children's services

Medical services at Grantham Hospital

The medical services at Grantham Hospital support urgent and acute patients in the A&E Department, on the in-patient wards and in the out-patients department. There is currently a range of medical conditions which Grantham Hospital does not provide
services for, meaning that the most acutely ill patients with life threatening illness and injuries go to a more specialist site, first time to receive treatment. Specialist doctors from Lincoln Hospital also remotely support Grantham Hospital staff and patients (using online technology) when required.

There are two emerging options.

The first emerging option is to maintain inpatient medical services at Grantham Hospital and adopt a new model whereby they are joined up with local primary and community services and managed as part of the local enhanced neighbourhood team. This new model would be led by Community Health Services (not ULHT) with hospital doctors and the hospital services
being part of an integrated service with GP services, community health and other local services. **This is the NHS's preferred emerging option.**

The second emerging option is to have no medical inpatient services at Grantham Hospital. Diagnostics and outpatients would continue.

26. Please tell us if you would have any problems accessing acute medical beds at Grantham Hospital and if you have any suggestions of how we could overcome this

27. Please tell us if you have any other comments or suggestions about our emerging options for acute medical beds at Grantham Hospital

Trauma and Orthopaedics

These services diagnose and treat a wide range of conditions of the musculoskeletal system. This includes bones and joints and their associated structures that enable movement - ligaments, tendons, muscles and nerves. Currently, both urgent and planned care is delivered in Lincoln, Pilgrim and Grantham Hospitals, with additional activity in our local community hospitals. These services are out-patients, minor procedures and operations.

National clinical best practice evidence is that separating urgent work from planned work prevents operations being cancelled. Planned care sites have better outcomes for patients, lower rates of readmission, reduced lengths of stay and reduced risk of infections and injuries.

We have been testing this way of working since August 2018 at Grantham Hospital and this pilot is due to conclude in April 2019. This pilot has virtually eliminated cancelled operations. The evaluation will help decide whether the best practice model of care works in Lincolnshire, including the extent to which non-complex trauma could continue at the Grantham Hospital site. Outpatient services will remain at all sites.

Our emerging option is to make Grantham Hospital a 'centre of excellence' for planned and day case orthopaedic surgery.

Lincoln and Pilgrim Hospitals would provide some day case surgery and planned care for those patients with complex needs. Outpatient services would remain at Lincoln, Pilgrim and Grantham Hospital as now.

28. Please tell us if you would have any problems accessing trauma and orthopaedic services at Grantham Hospital and if you have any suggestions of how we could overcome this

29. Please tell us if you have any other comments or suggestions about our emerging option for trauma and orthopaedic services at Grantham Hospital

General Surgery

These services focus mainly on the abdominal organs; stomach, gall bladder, small bowel, colon, rectum and anus. Benign skin conditions and hernias are also included within general surgery. This surgery is currently carried out at Lincoln, Pilgrim and Grantham Hospitals, with more complex cases seen at Lincoln and Pilgrim Hospitals only.

Our emerging option is to consolidate most elective care and make Grantham Hospital a 'centre of excellence' for elective short stay and day case General Surgery. Lincoln and Pilgrim Hospitals will provide some day case/elective care for patients needing complex surgery, those with complex needs. Outpatients will remain at all three hospitals.

30. Please tell us if you would have any problems accessing general surgery services at Grantham Hospital and if you have any suggestions of how we could overcome this

31. Please tell us if you have any other comments or suggestions about our emerging option for general surgery services at Grantham Hospital

Urgent and Emergency Care services

Emergency care is when you have a serious or life threatening accident or illness and you would usually have to be treated in a major hospital. Urgent care relates to less serious health problems requiring attention which can be treated by services such as NHS111, pharmacies, GP practices, GP Extended Access Hubs, and Urgent Treatment Centres. The vast majority of urgent care needs are met by our GPs and community health services.

Emergency care is provided in A&E departments and we currently have three A&E departments at Lincoln, Pilgrim and Grantham Hospitals. For the last five years, Grantham's A&E has had restrictions upon the conditions that can be treated at this site, for example, the ambulance service does not take patients with suspected stroke or certain types of heart attacks to Grantham. Since August 2016, Grantham's A&E has had restricted opening hours.

Our emerging option is to maintain A&E services at both Lincoln and Pilgrim Hospitals and to add an Urgent Treatment Centre at both sites. We would introduce a new Urgent Treatment Centre at Grantham Hospital to provide 24 hour, 7 day a week access to urgent care services locally. This means that the vast majority of local patients who need care quickly

will be supported in Grantham as they are now. To ensure the local population receive the right urgent and emergency care, overnight, access to this Urgent Treatment Centre will be supported by NHS111, to ensure patients are sent to the right place, first time.
NHS111 will serve as the entry point to the Urgent Treatment Centre during the overnight period.

Grantham's UTC would still be able to receive patients by ambulance. Refinements to the current access criteria will ensure that critically injured and ill patients will be cared for at their nearest A&E; treated safely and quickly by staff who have the right training and experience to give the best outcome.

This emerging option would also see the 24/7 Grantham Hospital Urgent Treatment Centre provided by Community Health Services rather than ULHT, with hospital clinicians providing specialist advice where this is required for patients. We would also like to develop Urgent Treatment Centre services at Louth, Skegness and Stamford Hospitals and explore options for Spalding and Gainsborough.

32. Please tell us if you would have any problems accessing urgent and emergency care services at Grantham Hospital and if you have any suggestions of how we could overcome this

33. Please tell us if you have any other comments or suggestions about our emerging option for urgent and emergency care services at Grantham Hospital

Haematology and Oncology services

Haematology services diagnose and treat blood disorders for conditions such as haemophilia and leukaemia and provide treatments including blood transfusion services. Oncology deals with the treatment of cancer. These services are delivered in outpatient clinics and in-patient beds. We currently provide these services across Lincoln, Pilgrim and Grantham Hospitals (haematology out-patients only at Grantham), with the majority of care delivered at Lincoln Hospital.

Our emerging option is to have all haematology and oncology inpatient services at Lincoln Hospital.

All other services stay the same. This means that haematology and oncology outpatients and day cases will continue to be provided from all three hospital sites, creating no additional travel for these most frequent appointments. Chemotherapy and radiotherapy will be provided at Lincoln Hospital as now. Chemotherapy day cases will continue to be provided locally at Pilgrim and Grantham Hospitals.

34. Please tell us if you would have any problems accessing inpatient haematology and oncology services at Lincoln Hospital and if you have any suggestions of how we could overcome this

35. Please tell us if you have any other comments or suggestions about our emerging option for haematology and oncology services at Lincoln Hospital

Equalities Monitoring

Under the provisions of the Equality Act 2010, all NHS organisations are required to demonstrate that their processes are fair, and that they are not discriminating or disadvantaging anyone because of their age, disability, gender reassignment status, marriage or civil partnership status, pregnancy or maternity, race, religion or belief, sex or sexual orientation. Please help us to monitor how well we engage with the population we serve, by completing the monitoring section below.

Your answers will be kept strictly confidential in line with the Data Protection Act 1998 and you will not be personally identifiable through your answers.

Age

○ Under 18 ○ 18 - 25 ○ 26 – 30 ○ 31 – 35 ○ 36 - 40 ○ 41 – 45 ○ 46 – 50
○ 51 – 55 ○ 56 – 60 ○ 61 – 65 ○ 66 - 70 ○ 71 and above
○ Prefer not to say

Do you consider yourself to have a disability or long term health condition?

○ Yes ○ No

If yes, please tell us below:

○ Physical impairment ○ Sensory impairment
○ Mental health condition ○ Learning disability / difficulty
○ Long standing illness ○ Prefer not to say
○ Other (please specify)

How do you describe your ethnic origin?

○ White British ○ White Irish ○ White European
○ White other ○ Black British ○ Black Caribbean
○ Black African ○ Black other ○ Asian British
○ Asian Indian ○ Asian Pakistani ○ Asian Bangladeshi
○ Asian Chinese ○ Asian other ○ Mixed background
○ Prefer not to say
○ Other (please specify)

Gender

○ Male ○ Female ○ Prefer not to say

Do you now, or have you ever considered yourself to be transgender?

○ Yes ○ No ○ Prefer not to say

What is your religion or belief?

○ Atheism ○ Agnosticism ○ Buddhism ○ Christianity ○ Hinduism ○ Humanism ○ Islam ○ Jainism
○ Judaism ○ Sikhism ○ No Religion or Belief
○ Rather not say ○ Other (please specify

Please indicate the option which best describes your sexual orientation

○ Lesbian ○ Gay ○ Bisexual ○ Heterosexual ○ Prefer not to say

Pregnancy and maternity - are you an expectant mother?

○ Yes ○ No ○ Prefer not to say

Pregnancy and maternity - have you utilised local maternity services in the last 18 months?

○ Yes ○ No ○ Prefer not to say

Carer- are you currently providing support and care to a partner, child, relative, friend or neighbour who cannot manage without your help or/ and support?

○ Yes ○ No ○ Prefer not to say

Thank you for completing this survey, your views are important to us.

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Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of the Lincolnshire Sustainability and Transformation Partnership

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**24 March 2020**
Subject:	**Social Prescribing Update**

Summary:
This paper updates the Health and Wellbeing Board (HWB) on the Social Prescribing "proof of concept" service that has been running across Lincolnshire since June 2018 and will outline the new service model from the 1st April 2020 along with the recommendations to be able to scale up the approach over the next 4 years, which includes a strategic decision from the Health and Care system to investigate and agree how the model should be funded and commissioned to ensure that the Voluntary, Charity and Social Enterprise (VCSE) sector is able to develop sustainable ways to support the service.

Actions Required:
The Health and Wellbeing Board is asked to note the impact and outcomes of the Social Prescribing service during the proof of concept period and comment and advise on the recommendations outlined in the report to scale up the service offer across the Neighbourhoods and Primary Care networks (PCN's)

1. Background

National and Local Context

Social prescribing is about enabling people to become more involved in community life, to improve their health and well-being. It is not a new concept, it may be known by a different name such as care navigation, community connectors, and local area coordination. In Lincolnshire the focus has been to commission services which are able to offer healthy life style support, prevention and low level community and social interventions, such as the Wellbeing Lincs, One You and Carers First services all of which have aspects of social prescribing as part of their offer.

However in 2016/17 social prescribing and community support was becoming seen as a key driver for the NHS to help shift the focus from a medicalised, reactive and urgent response model

to a more proactive, personalised and community based asset rich approach which is embedded in primary care and neighbourhoods.

The evidence base for social prescribing has been and continues to develop and demonstrate impact such as;

- In a recent 2019 Royal College GP survey, 59% of family doctors think that social prescribing can help reduce workload.

- An evidence review, from the University of Westminster, found that studies report an average drop of 28% in demand on GP services following a referral to a social prescribing service.

Social prescribing has now become a key priority for the health and care systems over the last 12 months following the publication of the NHS Universal Personalised Care, where it is identified as one of the six components of the comprehensive model and one of the key drivers in the NHS Long Term Plan (LTP).

NHS England and Improvement (NHSEI) are hoping to see over 1000 social prescribing link workers recruited to in England, during 2020/2021 and have included the posts in the PCN additional roles reimbursable scheme which has included fully funded social prescribing link workers as one of the 10 roles that should be embedded in PCN's over the next 4 years.

Social prescribing has been included in the PCN Direct Enhanced Service (DES) for 2020/2021 with all PCN's being required to offer a service from 1st April 2020.

2. PART A

a) Local Response - 2018 – 2020

In 2017, the HWB awarded non-recurrent funding of £369,016 to the neighbourhood working programme to support the development of a social prescribing / community connector's concept in Lincolnshire which was aligned to health and primary care services.

The proof of concept commenced in the summer of 2018 in Gainsborough and was co designed and delivered by Voluntary Centre Services (VCS). The impact at a neighbourhood level was almost immediate, and was extended across the county with additional short term funding from GP Federations, CCG's and Better Care Funding (BCF).

VCS and Lincolnshire Community Voluntary Services (LCVS) have been the two providers who have been working in partnership with each other and key stakeholders to develop, design and deliver the model.

The total funding supported the employment of 18 whole time equivalent (WTE) Social Prescribing Link Workers (including senior roles), equating to 23 posts – see below

Post	**Number of posts (WTE)**
Link Workers (Supporting individuals across the Care Navigation / social prescribing spectrum)	13.3
Coordinators (responsible for referral management, administration, coordination of the activity for link workers)	2.5
Management, supervision & strategic lead (A mixture of a dedicated post in LCVS and a realigning and expansion of current roles in VCS)	2

The posts were not evenly distributed across the county due to funding arrangements at the time, e.g.: Boston Neighbourhood have had 2 Link workers whereas East Lindsey has only had access to 0.6 wte..

In October 2019 Lincolnshire successfully put in a bid to NHSE/I for funding to transform community mental health services. A key component of the bid was being able to offer a social prescribing service to people with severe and enduring mental health conditions. A pragmatic approach was taken and the CCG subcontracted LCVS and VCS to develop and enhance the establish model further to include a mental health offer. The funding available will support additional Social Prescribing link workers, supervisory support, co-production of a digital platform and funding for VCSE development.

b) The Model (see appendix a)

The model is built around a localised team, embedded within neighbourhood working, PCN's and the Mental Health Community Transformation Project. The team consists of a Link Worker supported by an element of coordination and admin support, and a Social Prescribing Lead offering management, supervision and a strategic steer for the local area; offering all the benefits of a managed and coordinated service.

The model is based on procedures and guidelines that ensure consistent good practice across the county but with the added flexibility and track record of coproduction and co-design that makes sure local issues are fully recognised.

The coordinated team operates as part of the core neighbourhood team delivering a local social prescribing service in line with national good practice, embedding the following components:

- Easy referral from all local agencies including primary care.
- Workforce development
- Common outcomes framework
- What matters to me (creating a personalised plan)
- Support for community groups
- Collaborative commissioning and partnership working

The offer might be in GP surgeries in the form of clinics, local community venues or at individuals' homes depending on the agreed local need.

This provision adopts the Lincolnshire model for care navigation and social prescribing embedding the three levels of support, using the principles and competencies of care navigation within the Health Education England (HEE) competency framework.

Level 1
I know what I need help with
I would like some advice on where to access activities in my local area

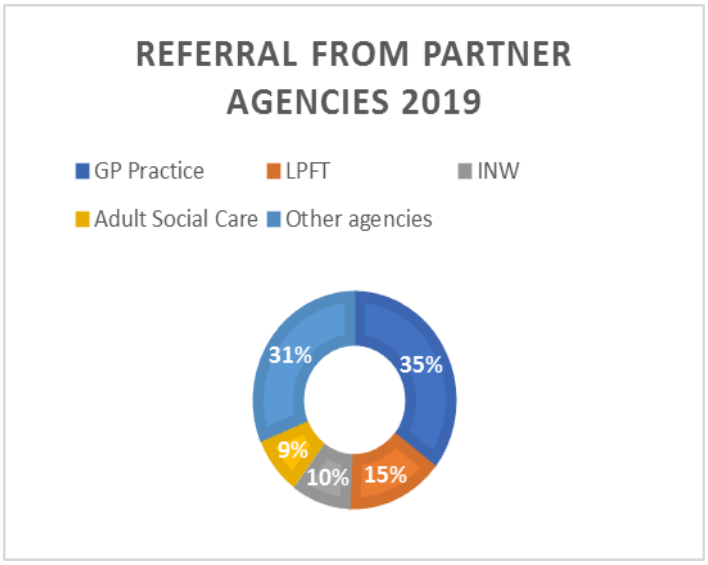
Level 2
I need some guidance to know what might help and where I can find it
I would like some help to think about what my goals are and some advice on how to access activities in my local area.

Level 3
I need practical support to get me started
I would like some help to think about my goals and someone to support me whilst I begin to move towards them.

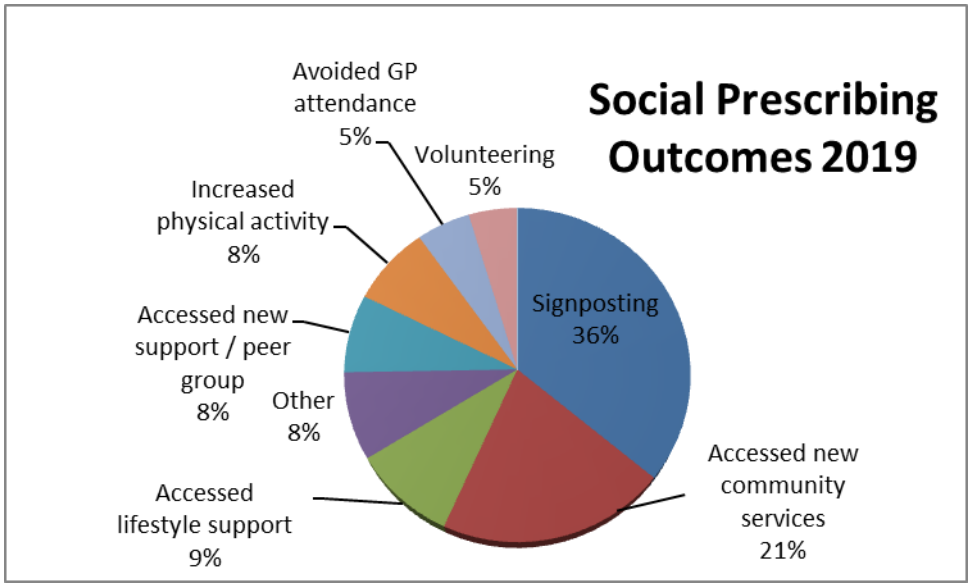
The link workers during the proof of concept were not given individual targets. Each area moved at a different pace depending on the development of the neighbourhood teams, recruitment and retention of link workers, the awareness of the service, whilst generating as many appropriate referrals as possible plus integrating staff within neighbourhood teams and supporting and growing the community groups and activities within the service referral networks.

C1) Outcomes and Impact

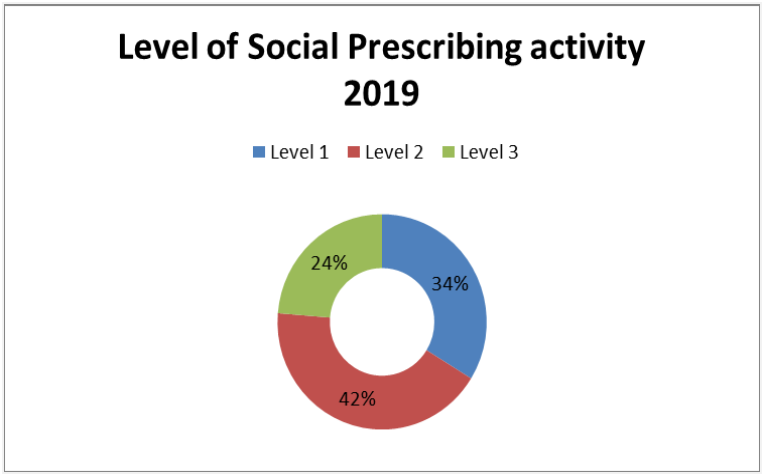
*To note: NHSE trajectories for Lincolnshire 19/20 were set between 762 and 1524 referrals, to present date (01.04.19 – 03.03.20); the social prescribing service has received **1613** referrals, exceeding the higher band.*



Referrals have been received from a wide range of 28 partner agencies. The majority have been from Primary Care.



Since the beginning of the county-wide roll out of the model in October 2018 the service has received 2058 referrals and supported over **1,700 people** and has evidenced demonstrable impacts on people's health, wellbeing and increased social inclusion through cultural, recreational and sports activities, befriending, resolving financial issues, volunteering and greater community participation.



The providers have recorded in excess of 2314 activities against participant records with a mean average duration for each activity of 26 minutes. That's over 1000 hours of direct and indirect support provided by the social prescribing team.

This support has sat alongside the time that link workers have spent developing relationships with colleagues, referrers and community organizations.

C2) Impact on People

616 cases were successfully closed during 2019 with over 94% participants reporting positive outcomes.

Feedback from Sleaford participant reflected on social prescribing; ***"I've been supported by lots of professionals over the years, but no-one has taken time to help me set goals for myself that I believe I can achieve in the way you have".***

Appendix B describes the case of an individual who really valued their social prescribing experience.

Appendix C illustrates participant feedback & impact on health and wellbeing of 35 participants, a sample caseload (sample, from when, how many, what level), participants have indicated that as a result of the support they have received through the social prescribing service, their physical health, safety, emotional health and empowerment have improved.

C3) Impact on the community

The social prescribing referral network continues to grow with participants supported to access over 500 different local groups and services.

C4) Measuring Social Value

Social Return on Investment (SROI) is a way of developing a value for less tangible outcomes delivered through the social prescribing service. SROI provides a more rounded view of what is being achieved (including the broader outcomes in addition to meeting the targets, outputs and outcomes). Through external support and the nationally accredited Social Value Engine, we can evidence that the social prescribing service generates **£8.07 of social value for every £1 invested**.

C5) Impact on the Health and Care System

During the 'proof of concept' it has been challenging to demonstrate impact at system level due to the relatively small numbers of people the service has been supporting, however as the model

expands over the next 4 years, there is an expectation that Social Prescribing will be able to demonstrate an impact on the Health and care system.

D1) The Lessons learnt

Throughout the proof of concept a number of key lessons have been learnt and will be considered during the next phase of the social prescribing service.

D2) Workforce

Recruitment across the county has always been a challenge and recruiting link workers is no exception. Getting the right candidates with the skills and competencies is a struggle especially for in Boston, Skegness and Coast neighbourhoods so working with the PCN's and neighbourhoods has been particularly important to understand methods and approaches that could be used.

With the number of Link workers projected to increase, recruitment to posts could be challenging in parts of the county.

One solution would be to develop a "Social Prescriber Apprenticeship pathway" This idea is currently been developed into a business case by LCVS and VCS.

Exploring a range of employers as host organisations is also being considered as a way of localising the offer and widening the opportunities for people to apply.

D3) IM&T Infrastructure

The current recording system (V- BASE) was developed to meet the demands of one neighbourhood team (Gainsborough) with a few social prescribers; the system ask is increasing. As the project has grown the proof of concept has identified weaknesses within the database that need to be addressed

- The current system offers no read across to other systems such as Mosaic or the Care Portal.
- The application is not user friendly and the current data confidence is lower than required.
- Information Governance and data sharing remains a challenge for the VCSE to be able to access and see relevant information about the people they are working with. Precedents have been set in Lincolnshire and options are currently being explored to find a solution.

Investment in a countywide system is needed, meeting the demands of an increasing workforce including community development teams and a wider stakeholder group. Any new system needs to be sustainable and have capacity for growth as well as being able to deal with the increased complexities and requirements of system reporting.

D4) Commissioned Services

Although when the Social Prescribing service first commenced there was a concern that this would impact on commissioned services or vice versa. There is further work to do to understand the synergy between the offers, and how the processes could be aligned, on the ground the staff work really well together making sure people get to the right service at the right time.

D5) Primary Care Engagement

It has been crucial over the last 12 months to engage where possible with Primary Care. This has been challenging with different levels of support, interest and understanding of social prescribing. Where there has been engagement GP's and Practice managers have encouraged the service

through social media (**See appendix D**), leafleting, offering space for clinics in surgeries and or being an advocate for social prescribing.

This will continue to be key area of engagement of the next 12 months.

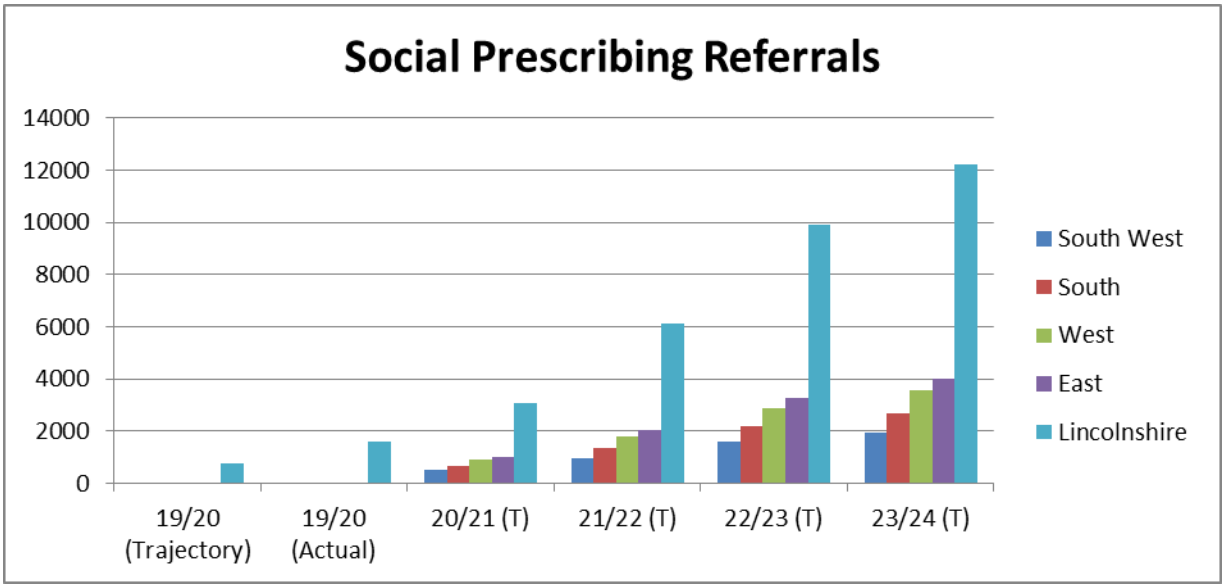
D6) VCSE Funding

The PCN funding will only fund link worker posts, plus a small amount for the coordination and management of the service and should not be used for community asset building or VCSE funding. NHS England are aware of the sectors concerns and are discussing the challenge nationally, however for Lincolnshire this leaves a significant risk that as the service expands over the next 3 years, an agreed approach to commissioning / funding a vibrant and flourishing VCSE will be required.

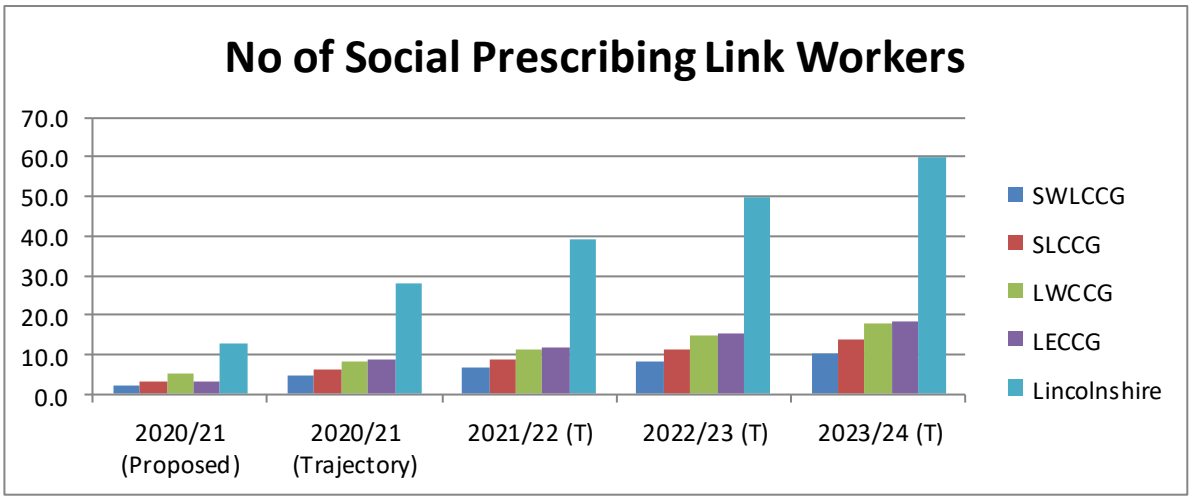
This should be seen as a system risk, which includes health, social care and the VCSE as jointly responsible for developing a sustainable financial model that will be flexible enough to meet the ever changing world of social prescribing.

Part B: Lincolnshire's Ambition 2020 onwards

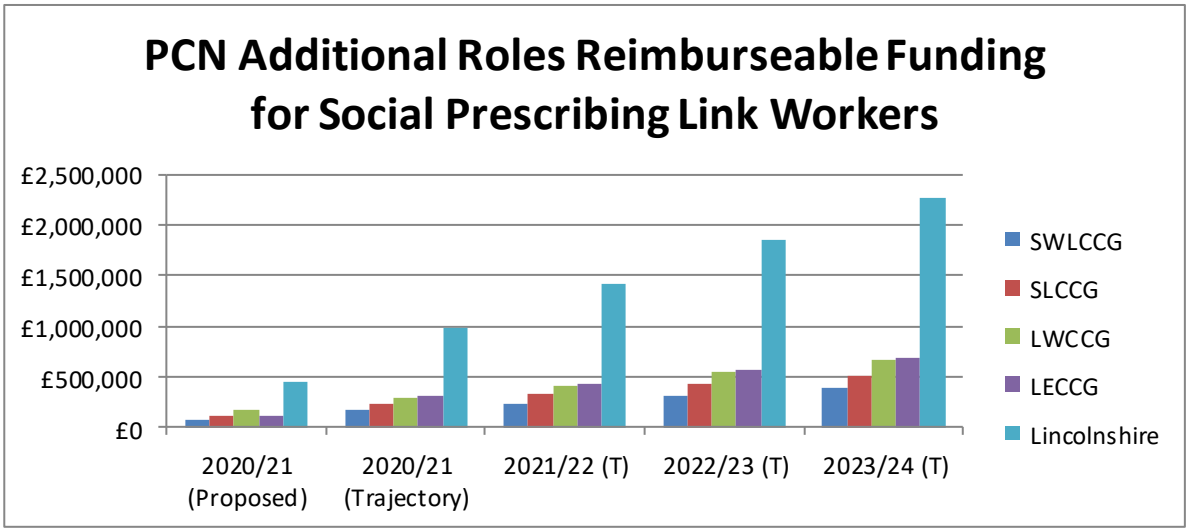
A) What are the expectations of Social Prescribing in Lincolnshire's Long Term plan?



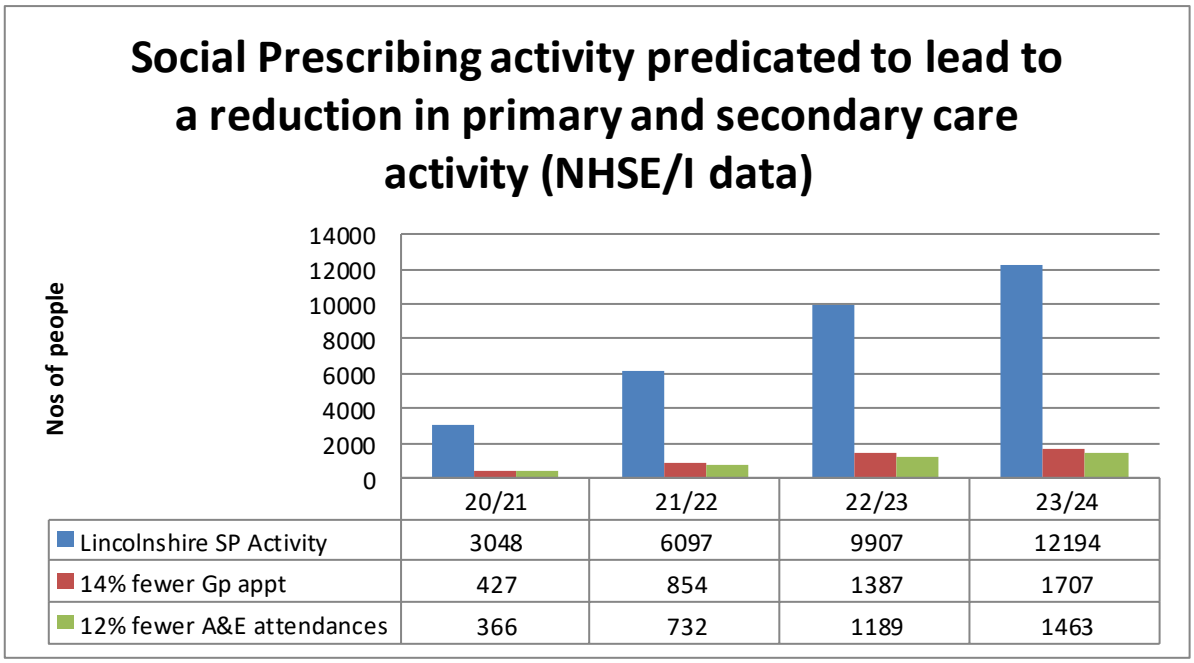
By 23/24 at least 12,194 people will have been referred to Social Prescribing.



13 PCN's will have access to 60 Social Prescribing link workers



The additional roles reimbursable scheme potentially brings in a significant amount of funding into social prescribing over the next 4 years - £2,260,000



	20/21	21/22	22/23	23/24
Lincolnshire SP Activity	3048	6097	9907	12194
14% fewer Gp appt	427	854	1387	1707
12% fewer A&E attendances	366	732	1189	1463

NHSE/I evidence indicates that social prescribing should reduce GP contacts and A&E attendances for those who access the service by 14% and 12% respect – this is what it could look like for Lincolnshire

B) Lincolnshire's ambition

Building on the success and taking the learning of the ever evolving social prescribing model that has been developed over the last 18 months the Lincolnshire Social Prescribing working group which is made up of colleagues from across the health and care sector are extending their ambition and vision for what the offer could be for the people of Lincolnshire.

This has been further endorsed by the 13 PCN's who have all agreed to subcontract LCVS and VCS to recruit at least 1 Social Prescribing link worker / PCN with an expectation that this will increase over the year. Plus the additional 2 Mental Health Link workers for Boston, Grantham, Gainsborough and Lincoln City south who will come into post from the 1st April 2020.

Lincolnshire's aim is to continue to develop the current model to include a co-produced, digitally enabled social prescribing offer at the heart of communities that will support local populations. It will have a virtual offer and will join the various commissioned and non-regulatory services together, within a funding envelope that will enable local community services (VCSE) to thrive and flourish – meeting the requirements of local populations 2020 onwards.

There are 6 strands to this ambition; **(see appendix E)**

1. **Information and Advice (level 1)**
2. **Embedding social prescribing into Primary Care and Mental Health (Level 2 & 3)**
3. **The Digital Platform – already in development**
4. **A simple way to access – to included commissioned services**
5. **Support for community groups**
6. **Integrated Volunteering Approach**

C) 20/21 Costs for PCN Social Prescribing link workers

CCG	PCN 2020/21 (Proposed)	100%(£35,389) Contribution 2020/21 (Proposed)	Total with 14 link worker in PCN	Contribution towards admin and management (shortfalls) on proposed
SWLCCG	2.0	£70,778	£74,422	£3,644
SLCCG	3.0	£106,167	£111,633	£5,466
LWCCG	5.0	£176,945	£192,170	£15,225
LECCG	4.0	£141,556	£148,844	£7,288
Lincolnshire	14.0	£495,446	£527,069	**£31,623**

All the PCN's will be drawing down the full contribution available for social prescribing link workers, which covers salary, on costs and some management and coordination costs. However there is currently a £31,623 cost pressure on the providers which is being negotiated with CCG's at time of this report. However NHSE regional trajectories for Lincolnshire expect PCN's to have recruited to 28 Social Prescribing link workers by the end of 20/21. If this is achieved, the economies of scale that can be applied will remove the risk to the Providers altogether and potentially build in some community capacity building particularly when we move into years 3 & 4.

CCG	PCN 2020/21 (20/21 Lincs actual target)	100%(£35,389) Contribution 2020/21 (Target)		Contribution towards admin and management (shortfalls) on proposed
SWLCCG	5	£176,945	Across the 3	-2295
SLCCG	6	£212,334		-2754
LWCCG	8	£283,112		12438
LECCG	9	£318,501		-4131
Lincolnshire	28	£990,892		

Community Mental Health costs are being managed through the Community Mental Health Transformation fund, however where there are opportunities to reduce on costs and management costs across the providers this is being done.

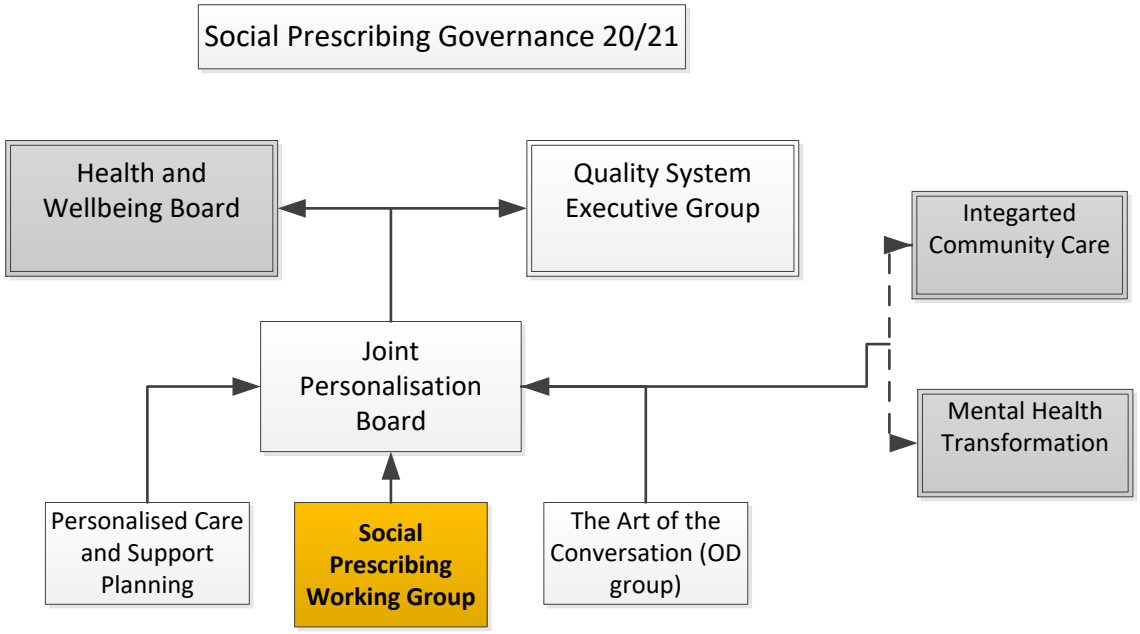
D) Measuring the impact of social prescribing from April 2020

The outcome of social prescribing covers the following three key areas;

- **Impact on the person** - How a person's wellbeing has improved, whether they are less lonely, whether they feel more in control and have a better quality of life.
    - This will be measured through the use of the Outcome Star which is currently being trialled with both providers and the introduction of the Patient Activation Measure (PAM's) which is being recommended by NHSE/I however there are some reservations about the effectiveness of the tool with a number of cohorts.
- **Impact on the community groups** – The Voluntary Engagement Team (VET) will be the central point of contact with the VCSE, and using the web portal, https://lincsvoluntarysectorportal.org.uk/ forums, and the annual conference to understand the state of the VCSE sector. NHS England and partners will support local areas to introduce a regular 'confidence' survey of local community groups, to identify development needs, test whether groups are fully involved and supported to receive appropriate social prescribing referrals.

- **Impact on the health and care system** –
  The national evidence is being aligned to a 14% reduction in GP visits and a 12% reduction at A&E for those individuals who have actively participated in Social Prescribing and or connected back into their community.

E) Governance arrangements



The first joint personalisation board will take place on the 25th March 2020. The Social Prescribing working group has been operating since April 2019 with the following membership;

- LCC - Public Health
- LCC – Adult Care
- Clinical Commissioning Group
- Primary Care Networks
- Lincolnshire STP
- Lincoln University
- Strategic Co production Group
- LPFT
- Neighbourhood Leads
- LCVS
- VCS
- Voluntary Engagement Team
-

The Social Prescribing project currently does not have an identified Senior Responsible Officer or a dedicated programme / project manager.

Part 3 Conclusion

Through the national agenda, the building evidence case and high profile of Social Prescribing it is clear to say that building resilient communities, supporting people to connect for the first time or reconnect with hobbies, interests and understanding what's important to them is a key priority for the health and care system.

In Lincolnshire we have made a really good start with an established model and offer that has already exceeded the higher level NHSE/I expectations for 19/20, and has been able to demonstrate significant positive impact on peoples health and wellbeing over the last 18 months.

The service will be available to all Primary Care Networks from the 1st April with an added mental health enhancement in 4 areas.

It is worth noting there is an added challenge and opportunity with two new roles being included in the PCN 'additional roles reimbursable funding'; health coaches and care coordinators, both aligned to social prescribing and fully funded. This will need to be considered in the discussion and decisions that are made at PCN level as the model develops over time.

As the report describes there is a real ambition to build on the established model through co production and design with PCN's and people, starting with the digital platform to be able to reach more people virtually so they feel connected and supported but on their own terms.

However for the Lincolnshire ambition to be realised the following recommendations are being made to the Health and Care system.

1. An SRO for Social Prescribing needs to be identified
2. Dedicated capacity and resource is required to bring the six strands of the ambition together over the next 12 months.
3. A Clinical Director for Social Prescribing needs to be agreed
4. A facilitated strategic discussion is required across the Health and Care system to address the main lesson learnt; ***the need for a sustainable financial model for the VCSE that will be flexible enough to meet their ever changing world and that of social prescribing.***
5. To explore the IM&T requirements of an expanding social prescribing model as the current system is not fit for purpose and has impacted on the level of data and information that can be easily retrieved and analysed.

3. Joint Strategic Needs Assessment and Joint Health & Wellbeing Strategy

The Council and Clinical Commissioning Groups must have regard to the Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS).

4. Consultation

Not applicable

5. Appendices

These are listed below and attached at the back of the report	
Appendix A	Detailed delivery model based on NHSE model
Appendix B	Case Study
Appendix C	Participation outcomes
Appendix D	Social Media Coverage
Appendix E	The ambition for 2020 onwards

6. Background Papers

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

This report was written by Kirsteen Redmile, who can be contacted on (01522 307315) or (kirsteen.redmile1@nhs.net)

Detailed Delivery Model **Appendix A**

Easy referral from all local agencies

- Simple and effective telephone and secure email referral process, facilitating multi agency and self-referral.
- Easy referrals directly into practice based social prescribing clinics, facilitated by the Link Workers.
- Multi agency referrals directly through the Integrated Neighbourhood Working (INW) multi-disciplinary

Collaborative commission and partnership working

- Facilitating cross sector partnership, networking and engagement events.
- Pro-active partnership working through INW with local services and partnerships including the Wellbeing Service and Integrated Lifestyle Support Service.
- Supporting all partners to come together to create stronger and more resilient local communities building on community assets.

Workforce development

- Raising awareness and enhancing the knowledge of staff teams to ensure relevant referrals through embedding the principles of care navigation.
- Providing robust line management, peer supervision and clinical support.
- Providing access to a range of training and professional development opportunities and resources through the National Association of Link Workers network.

Support for community groups

- Support and expand the existing network of over 500 community and voluntary groups to grow, develop and sustain their services and impact.
- Identify gaps in provision and stimulate the development of new ideas and services.
- Developing robust quality assurance using the five core principles of Welcoming & Accessible, Safe, Well Governed, Supporting People to Grow and Making a Difference to Wellbeing.

What matters to me (Create a personalised plan)

- Personalised support to individuals, their families and carers to take control of their wellbeing, through a holistic approach, based on the persons priorities.
- Co-producing a simple personalised care and support plan.
- Supporting and connecting people to community groups and services.

Common outcomes framework

- Single, centralised management information system capturing all patient data and activity for Lincolnshire feeding into the INW outcomes framework.
- Embedding tools to measure the distance travelled and qualitative impact on individuals, including PAM.
- Utilising the Social Value Engine to evidence the impact and return on investment.

Social Prescribing Case Study **Appendix B**

MB was referred into social prescribing by his OT at Grantham Hospital. He described himself as "very lost and bored after my brain injury and not sure how I was going to build my life again".

MB wanted to be more involved in his local community and more structured to enable him to move forward. He wanted help to set some goals and, with the support of his Social Prescribing Link Worker, decided to:

- Get into volunteering to help others to learn and supporting charities.
- Increase his computer skills and qualifications.
- Get involved in a local social group to meet new people and make new friends.
- Become involved with new community opportunities as are established.

With his Link Worker's encouragement, he started looking at options to reach his goals. Over time he has developed the confidence to do this independently.

This has helped him get into learning and increased interaction within his local community. He is now attending a social group, completed a computer skills training course, completed a cookery course and started volunteering every week at a local British Heart Foundation Charity Shop.

The changes in MB's health, wellbeing and long-term outlook are significant;

- VB reports increased confidence and self-esteem.
- His mood and wellbeing have improved.
- He has increased social activities and has structure to his week.
- He is learning how to look after himself better and is ready to move on in life.

The Social Prescribing Link Worker helped MB to find, contact, arrange meetings and try new groups and services. She supported him to attend initial meetings with his chosen groups so that he could build confidence to become involved independently.

MB says, *"I am developing my resilience in my life alongside living with my impairment. I realise I may be able to achieve paid employment in the future."*

Appendix C

Participant feedback & impact on health and wellbeing 35 participants

Through a sample caseload (sample, from when, how many, what level) , participants have indicated that as a result of the support they have received through the social prescribing service, their physical health, safety, emotional health and empowerment have improved as follows:

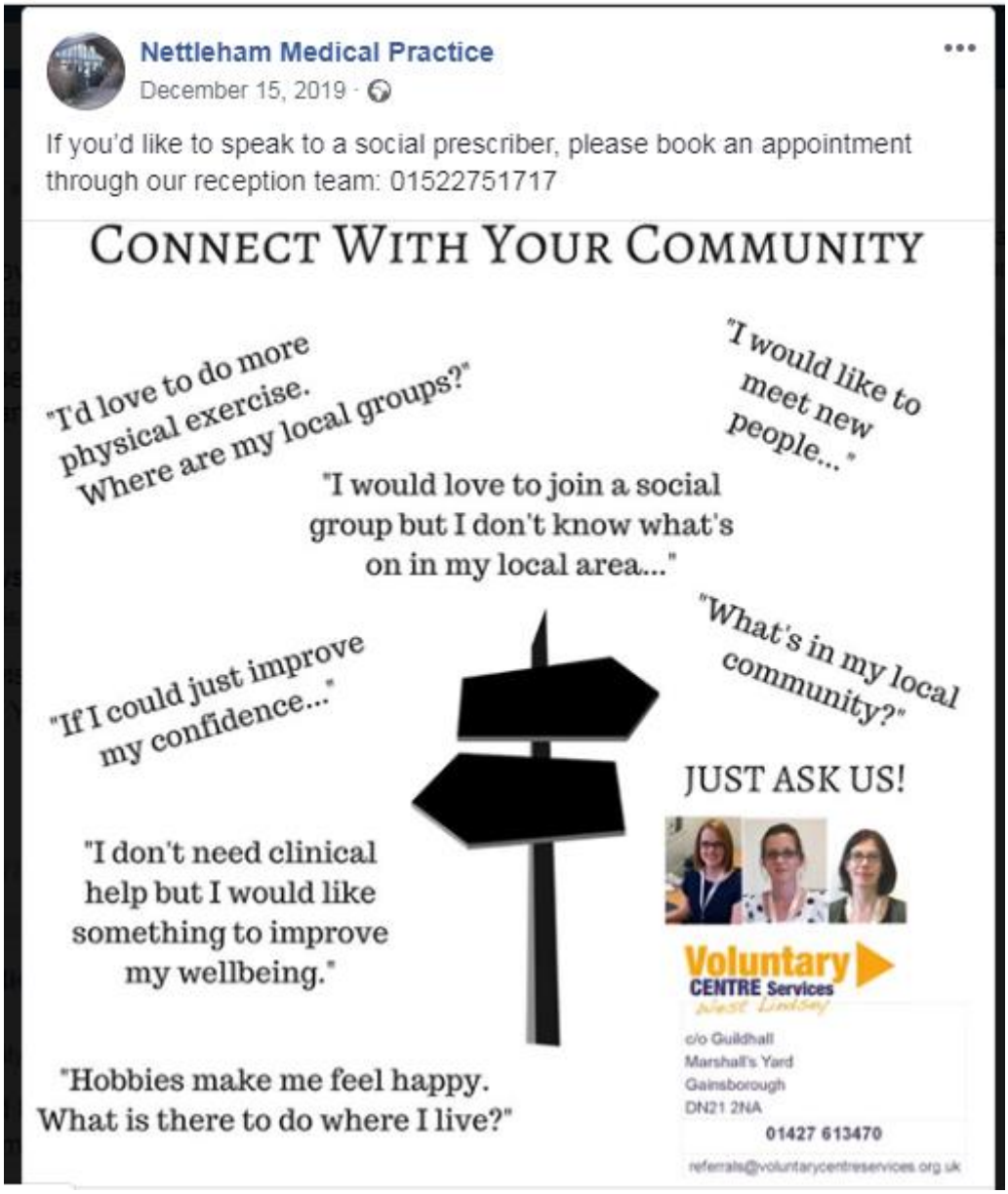
- 78% spend more time in their community
- 89% have more people that they can talk to
- 85% are visiting more groups and activities

- 62% find it easier to manage their physical health
- 74% take better care of themselves
- 62% participating in more physical activities
- 66% feel more confident moving around
- 73% are less worried about falling

- 78% feel more hopeful
- 64% feel their sense of self-esteem has improved
- 70% overall emotional wellbeing has improved

- 71% have a better understanding of the situation
- 78% find it easier to set goals
- 75% achieve the goals they set themselves
- 74% are more confident to try new things
- 68% feel more in control of their lives

Social Media Activity – Facebook

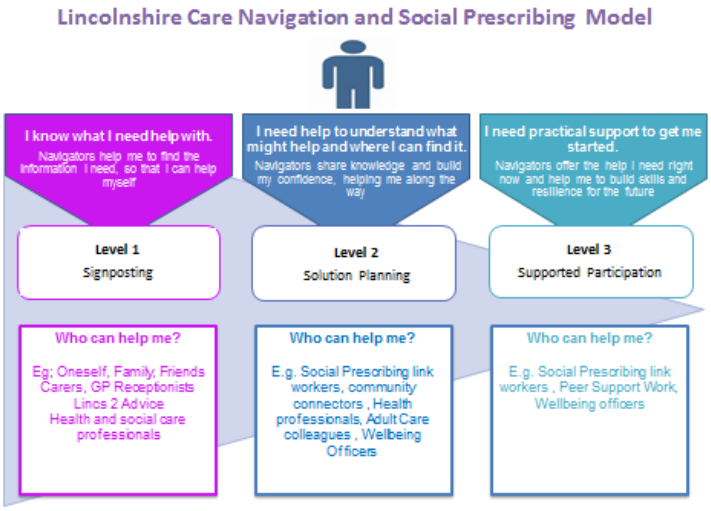


Appendix E

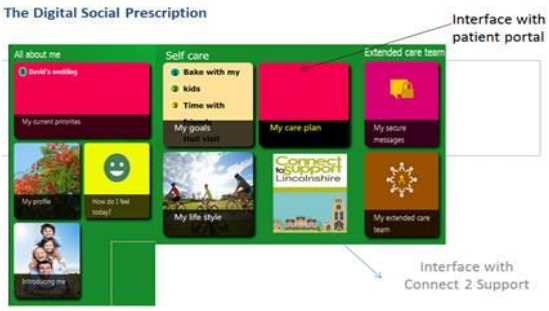
What is Lincolnshire's ambition for Social Prescribing 2020 onwards?

Lincolnshire's ambition is to have a co-produced, digitally enabled social prescribing offer at the heart of Primary Care Networks and communities that will support local populations. It will have a virtual offer and will join the various commissioned and non-regulatory services together, within a funding envelope that will enable local community services (VCSE) to thrive and flourish – meeting the requirements of local populations 2020 onwards.

There are 6 strands to this ambition;



1. **Information and advice (Level 1).** Positioning Connect 2 Support and Lincs 2 Advice as the **first place** people and staff go for information and advice about the local services, what's going on in communities, opportunities to volunteer, purchasing services etc . Individuals will be able to self-service and select through the website or may require Lincs 2 Advice to help people to find the information they need, so they can help themselves.
2. **Embedding Social Prescribing (Level 2 & 3**) in PCN's and Neighbourhoods, which will include the Mental Health aspect of supporting those who have severe or enduring mental health.
3. **The Digital Platform, t**o extend the reach of social prescribing and connecting people to their local communities, we are co-producing with people a digital platform which will support the three levels of care navigation.



Using the digital platforms already available in Lincolnshire; Vitrucare and Connect 2 Support Lincs (library of information and advice), the co-production group will design and test the set/s of tiles that individuals will use to encourage and support self-care and self-management, with social prescribing link workers being available virtually as and when needed.

4. **A simple way to access** local Social Prescribing Services embedded within the PCN. The countywide system will have agreed common set of outcomes, linked into a robust countywide managed IT network (Or IT networks that talk). This model will be closely linked to the commissioned services; clients can be referred into and out of the Commissioned services and the localised social prescribing provision. Link workers will play a pivotal role in ensuring clients are supported into the right service at the right time.
5. **Support for community groups** – Part of the NHSE model for Social Prescribing; Support and expand the existing network of over 500 community and voluntary groups to grow, develop and sustain their services and impact, Identify gaps in provision and stimulate the development of new ideas and services, developing robust quality assurance using the five core principles of Welcoming & Accessible, Safe, Well Governed, Supporting People to Grow and Making a Difference to Wellbeing.
6. **Integrated Volunteering Approach** - Voluntary Engagement Team and NHS are currently developing a bid for year 2 funding from NH5E II to embed volunteering in our social prescribing model-to 'Extend the offer of volunteering to individuals who access the service and seek volunteers to be part of the service particularly digital champions to support the digital platform.

Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of Derek Ward, Director of Public Health

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**24 March 2020**
Subject:	**Suicide Prevention Strategy**

Summary:
The purpose of this report is to inform the Lincolnshire Health and Wellbeing Board (LHWB) of the draft Suicide Prevention Strategy. This has been co-produced with partners across the system through the Suicide Prevention Steering Group (SPSG) and recommendations have been made for Lincolnshire's approach to suicide prevention. The draft Suicide Prevention Strategy and the SPSG membership list are attached as Appendices A and B respectively.

Actions Required:
The Lincolnshire Health and Wellbeing Board are asked to consider:

- Approving the draft Suicide Prevention Strategy to progress for further discussions, before signing off the final strategy in April;
- Agreeing for the SPSG to continue developing the Suicide Prevention Action Plan.

1. Background

HM Government's 'Preventing Suicide in England Strategy 2012' cites that *'much of the planning and work to prevent suicides will be carried out locally'* and from April 2013, local responsibility for coordinating and implementing a local suicide prevention action plan became an integral part of Public Health's responsibility within Local Authorities. A local action plan for Lincolnshire was developed in 2016, however this has become outdated and a refresh is required.

2. Conclusion

The LHWB are asked to consider the recommendations set out above. Public Health colleagues will then attend the Lincolnshire County Council Corporate Leadership Team on Wednesday 1 April for final sign off of the strategy. It should be noted that Public Health colleagues have already attended the following meetings to gage comments and sign off from partners:

- Tuesday 25 February 2020 – Mental Health, Learning Disabilities and Autism Board
- Monday 9 March 2020 – Lincolnshire Safeguarding Adults Board
- Thursday 12 March 2020 – Lincolnshire Safeguarding Children Partnership

Public Health colleagues have worked with the Communications Lead for Adult Care and Community Wellbeing and the design and print of the Strategy has been scheduled for April 2020.

The Strategy is planned to be launched during Mental Health Awareness Week 16–20 May 2020 using a soft launch approach. Electronic versions of the Strategy will be shared through partners.

Further publicity will take place on 10 September 2020 for World Suicide Prevention Day and 10 October 2020 for World Mental Health Day around the Strategy and the Action Plan.

3. Joint Strategic Needs Assessment and Joint Health & Wellbeing Strategy

The Council and Clinical Commissioning Groups must have regard to the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy. The Suicide Prevention work sits under the Mental Health (Adults) priority area of the Joint Health and Wellbeing Strategy. Within the action plan for the Mental Health (Adults), one of the key deliverable is to "Implement a Suicide Prevention Programme," this strategy sets out the programme of work around Suicide Prevention. There is also a Joint Strategic Needs Assessment for Suicide, which is due to be updated in May/June 2020 and the new Strategy and Action Plan will be featured within the update.

4. Consultation

The draft Suicide Prevention Strategy has not undergone formal consultation; however it has been co-produced with partners across the system through the Suicide Prevention Steering Group (SPSG) and the list of the SPSG membership can be found within Appendix B.

5. Appendices

These are listed below and attached at the back of the report	
Appendix A	Draft Suicide Prevention Strategy
Appendix B	SPSG membership list

6. 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 Shabana Edinboro, who can be contacted on 01522 552299 or shabana.edinboro@lincolnshire.gov.uk

Appendix A

LINCOLNSHIRE'S SUICIDE PREVENTION STRATEGY 2020-2023

REACHING OUT AND SAVING LIVES

Forward from Cllr Bradwell – To Follow

Purpose

1. Suicide is a major issue for society and a leading cause of years of life lost. It is the biggest killer of people under the age of 35 and the biggest killer of men under the age of 50. It is the leading cause of death in the UK for 10-19 year olds. These deaths are often the result of the ultimate loss of hope and meaning of purpose in life. Suicide can devastate families and leave a lasting impact on their own wellbeing. However, suicide is not always inevitable and is preventable.
2. The Lincolnshire Suicide Prevention Strategy 2020 – 2023, which has been developed on a multi-agency basis strives to reduce suicide and suicide behaviours in Lincolnshire to a minimum.

This document sets out Lincolnshire's shared vision, mission and priorities. Some organisations in Lincolnshire are required to have, or have chosen to develop their own suicide prevention strategies (for example Lincolnshire Partnership NHS Foundation Trust). All other organisations and partners will have agreed to reference this document in their own strategies as well as provide details on how they will contribute to achieving the shared priorities identified.

Executive Summary

1. Since a historical low in 2007 the suicide rate in England and Lincolnshire has steadily increased.
2. During 2017-18 on average more than 1 person per week took their own life in Lincolnshire.
3. It is estimated that one in five people consider suicide at some point in their lives.
4. The human cost of death by suicide is high and tends to have an especially heightened and widespread effect for those in the family and beyond. Research suggests that around 135 people may be affected by each person dying by suicide. This can impact on people's ability to work, to continue with caring responsibilities and to have satisfying relationships.
5. National guidance recommends that every Local Authority carries out a suicide audit, develops a suicide prevention action plan, and establishes a multi-agency group to co-ordinate effective action within the local area.
6. In line with this guidance, this strategy has been developed by actively engaging local partnerships through the Suicide Prevention Steering Group and the Lincolnshire Mental Health Crisis Concordat, using local data and intelligence and with reference to regional and national strategies. A multi-agency governance structure has been developed to manage delivery of the strategy and monitor how well it is achieving its objectives.
7. The success of this strategy is dependent upon the vision and resources of partner agencies and within our local communities. It is underpinned by the

assumption that more can be delivered by improved coordination of existing services and activities, alongside key stakeholders working to a common vision and plan. Lincolnshire has currently not received any of the National funding available for suicide prevention.

8. The suicide agenda is closely aligned to the Mental Health agenda and the additional national investment in mental health provision, and in particular Mental Health Crisis provision, will play a key role in delivering our local suicide prevention offer.
9. Our vision in Lincolnshire is consistent with the national suicide prevention strategy for England, the outcome of the Lincolnshire Suicide Prevention Summit and the Suicide Prevention strategies of partner agencies, including those of NHS partners, who operate a zero based approach to suicide.

Our Vision and Mission

Our Vision and Mission statements as agreed at the Lincolnshire summit meeting are set out below.

Our Vision

Lincolnshire is a place where people continue to have hope and suicide is rarely an option considered.

Mission

Reaching out and savings lives

Values

We believe the loss of any life to suicide is a tragedy and therefore we want people to seek help before they consider that suicide is their only option. We want people to have *hope* that things can get better. We also want people to understand that they can receive help and support through a range of different ways.

We recognise that people sometimes find it difficult to talk about their feelings and therefore it is important to regularly ask people if they are ok and whether they want to talk anything through. A single discussion may be enough to give someone *hope* and help them to seek further support.

Many organisations and professionals have a key role in recognising and supporting people with thoughts of suicide and should be supported in this through adequate training and procedures. We also expect that family, friends and carers can regularly

ask people how they are and to start a conversation. However it is not necessary to know someone to recognise that they may be worried about something or may be unwell. We would therefore encourage everyone to reach out a hand of kindness, as this simple action could potentially be enough to save a life.

We want everyone to know how best to support someone if they need to talk about how they are feeling, through providing information, advice and signposting. This way everyone can play their part in preventing suicide and is the foundation stone of this strategy.

Governance

The Director of Public Health (DPH) is formally responsible for the development of a local Suicide Prevention Strategy and Action Plan through co-production with partners across Lincolnshire. The governance arrangements for the development and implementation of this strategy and action plan, including monitoring performance, lays with the Mental Health, Learning Disabilities and A Board (MH, LD, A Board). The MH, LD, A Board will provide assurance to the Lincolnshire Health and Wellbeing Board through the reporting mechanism for the Mental Health (Adults) priority of the Joint Health and Wellbeing Strategy. The Suicide Prevention Steering Group (SPSG) will sit under the MH, LD, A Board and will carrying out the tasks within the action plan. Further task and finish groups may form under the SPSG.

Drivers

Whilst acknowledging that there are a number of factors that influence suicide prevention, the essential ones are identified below:

1. Our Lincolnshire aspiration to protect people from harm and our vision to prevent every single death by suicide;
2. The strategy has also been informed by the outcome of the Lincolnshire Suicide Summit which took place in January 2019;
3. The Cross-Government Suicide Prevention Workplan 2019 from the Suicide Prevention Minister, which sets out key priorities to include in local action plans is as follows:
    a. Reducing suicide in high risk groups
    b. Tailoring approaches to improve mental health in specific groups
    c. Tailoring approaches to support Children and Young People
    d. Reducing access to means of suicide
    e. Providing better information and support to those bereaved or affected by suicide
    f. Supporting the media to deliver a sensitive approach to suicide and suicidal behaviour
    g. Supporting research, data collection and information.

All drivers can be found in the Joint Strategic Needs Assessment Suicide Topic on the Lincolnshire Research Observatory website.

Local Analysis

There is a requirement for Public Health teams to complete an annual suicide audit. As part of these audits, information from the coroner's office is incorporated into the

analysis. These audits produce intelligence that helps us to identify cohorts of people who are at high risk of suicide. This intelligence also helps us to consider local priority actions for preventing suicide. The Lincolnshire Annual Audit 2018 identified a number of key statistics and issues as follows:

- An increase in the number of suicides to 63 compared to 58 in 2017
- 2 in 3 are male deaths
- Hanging is the most frequent cause of death
- The most prevalent age groups for males is 40-44 and females 45-49
- Suicide rates in the most deprived areas of the County are twice the national average and three times the rate in the least deprived areas of Lincolnshire
- Target occupation groups include male skilled construction and building trades; male skilled agricultural workers and related trades; males elementary trade and related occupations; and female caring personal services occupations.

All Lincolnshire Annual Suicide Audits can be found on the Lincolnshire Research Observatory website.

Key Objectives – Priorities for Action

The following priorities for action have been identified from the Lincolnshire Suicide Prevention Summit in 2019, national guidance and feedback from key stakeholders.

The key objectives will be underpinned by the concepts of Prevention, Intervention and Postvention.

- Suicide prevention refers to diminishing the risk of self-inflicted harm with the intent to end life. It may not be possible to remove the risk of suicide completely, but it is possible to reduce this risk. Intentional efforts to reduce the risk (i.e. education), in addition to the presence of natural protective factors (i.e. social support and connectedness), can aid in suicide prevention.
- Suicide intervention refers to a direct effort to prevent someone from intentionally attempting to end their own life.
- Suicide postvention refers to measures occurring after a suicide and attempted suicide has taken place that address the needs of those affected. Postvention can take many forms, but its purpose is to support those affected to cope with the loss, reduce the risk of suicidal behaviour and support healthy recovery in the aftermath of a suicide. Postvention also serves as prevention when it promotes healing of those affected which then can reduce their risk of suicide.

In order to deliver our vision, we have developed the following shared objectives:

1. We will develop a Local Suicide Prevention Core Offer. This will confirm what help and support is available to people if they have self-harmed, have experienced suicidal thoughts and those that are bereaved by suicide. It will also set out a pathway of how help and support can be accessed, using a no wrong door approach.
2. We will target high risk groups. We will develop our understanding of how best to prevent suicide in high risk groups through research, analysis and engagement with key stakeholders. The Suicide Prevention Steering Group

responsible for developing and implementing this strategy will develop specific prevention initiatives to be targeted at these high risk groups.

3. We will support Children, Young People (CYP) and their families. We will develop our understanding of how best to reduce suicide and suicidal behaviour in children and young people through research, analysis and engagement with key stakeholders. The key focus will be to promote and improve children and young people's emotional wellbeing and mental health through effective awareness and support to CYP and families from birth right through school to adulthood, as well as improving access to support, creating mentally health schools and communities for CYP, targeting promotion and support for the most vulnerable and providing effective crisis support when required.
4. We will develop our knowledge and intelligence. A key source of intelligence that has informed this strategy are the annual suicide audits completed by colleagues in Public Health. This will continue to be strengthened with further intelligence to determine the focus of the Suicide Prevention Strategy and Action Plan.
5. We will raise awareness and improve training. We will agree a common approach to raising awareness of suicide and of identifying training needs. The Lincolnshire Core Suicide Prevention Offer will include guidance that professionals and the public can access to increase awareness of suicide, associate risks and what they can do to help prevent suicide. Targeted suicide awareness training for community groups as well as professional front line staff will be established and will form an important element of this strategy.

Lincolnshire's Suicide Prevention Action Plan

A summary of the priority actions relevant to this strategy can be found in the document entitled Lincolnshire's Suicide Prevention Action Plan.

It is our intention to review these priority actions annually following consideration of the annual suicide audit intelligence, and after reviewing progress against the action plan and also performance against local indicators that we will monitor as part of this strategy.

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Suicide Prevention Steering Group Membership				
Council				
Name	Job Role	Organisation	Contact Details	Deputy
Derek Ward	Director of Public Health	Lincolnshire County Council - Public Health	derek.ward@lincolnshire.gov.uk MSO: Claire Launders x 54236	Kakoli Choudhury kakoli.choudhury@lincolnshire.gov.uk
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Sally Savage	Chief Commissioning	Lincolnshire County Council – Children	x53204	MSO: Helen Warburton x 550628

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TBC	TBC	District Council Rep	TBC	TBC
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Cookson				
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Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

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

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**24 March 2020**
Subject:	**The Lincolnshire Better Care Fund (BCF)**

Summary:

This paper provides the Lincolnshire Health and Wellbeing Board (HWB) with an update on the Lincolnshire Better Care Fund performance for Q3 and notes the confirmation of DFG allocations for 2020/21.

Actions Required:

The Lincolnshire Health and wellbeing Board are asked to note the content of the report.

1. Background

The Lincolnshire BCF plan was endorsed by the HWB 24 September 2020 and submitted to NHS England for approval 27 September 2020. The plan submitted was a total of £254m, which included iBCF and winter pressures grant funding.

The key performance elements of the BCF plan relate to:

- Non-elective admissions. This is the total number of specific acute non-elective spells per 100,000 population.
- Delayed transfers of care. This is the total daily delays from hospital for people aged 18 and over.
- Residential admissions. Long term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population.

- Reablement. Proportion of older people (age 65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services.

Appendix A contains the Lincolnshire Better Care Fund performance report for Q3

The target for permanent admissions to care homes has been achieved with an actual total of 601 admissions in the quarter and a year-end forecast of 801 against the target of 863 admissions. Delayed transfers of care has achieved the measure with 4,974 delayed days, this is less than the target of a maximum of 5,399. Unfortunately non-elective admissions continue to underperform with 23,323 admissions, a figure which is over the target of 18,774.

Appendix B contains the letter from the Ministry of Housing, Communities and Local Government, confirming the DFG (Disabled Facilities Grant) allocations for 2020/21. £505m has been made available to all systems, with £6,148,560 allocated to the Lincolnshire District Councils. Although paid to Lincolnshire County Council, the resource must be transferred to the District Councils in full, so they can fulfil the statutory duty regarding housing adaptations. There is an exception to this and subject to agreement between the District and LCC; the fund may be used for wider social care capital projects. This should be agreed by the HWB and included within the BCF.

Although the 2020/21 BCF planning guidance has not been published, Lincolnshire County Council and CCG Finance Officers have started a programme to review BCF schemes in preparation for submitting the plan in 2020/21. There remains an opportunity for Lincolnshire to agree alternative DFG schemes as part of planning for 2020/21 BCF plan submission.

2. Conclusion

The Lincolnshire Health and Wellbeing Board are asked to note the information provided within this report.

3. Joint Strategic Needs Assessment and Joint Health & Wellbeing Strategy

The Council and Clinical Commissioning Groups must have regard to the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy.

4. Consultation

None required

5. Appendices

These are listed below and attached at the back of the report	
Appendix A	Lincolnshire BCF Q3 Performance Report
Appendix B	DFG allocations letter

6. Background Papers

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

This report was written by Gareth Everton who can be contacted on (01522 554055) or (gareth.everton@lincolnshire.gov.uk)

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Better Care Fund - 2019/20

Performance Report

Quarter 3

Produced February 2020

Highlights

- Non elective admissions have remained above target throughout the year.
- The target for admissions into care homes for clients aged 65+ continue to be achieved with the Q3 figure being 601 which is 30% below the target of 863, 97 of these new admissions have passed away. This also is a 4.9% decrease from this time last year which was 632.
- At the end of Q3 reablement offered by Libertas for clients aged 65+ had 92% (616) of clients still at home after 91 days after discharged from hospital which is above the target of 80%. This is part of the ASCOF 2B part 1 measure however the full measure is only completed once a year as part of SALT.
- In Q1 Non Acute delays only came to 431 (65 being social care) however in Q3 this has increased to 1371 (146 being social care). Lincolnshire has achieved the total target of 58.7 delayed days per month every month this year.
- Q1 Acute delays came to 3612 (362 being social care) this decreased slightly to 3603 in Q3 (368 being social care).
- New clients who have been referred to reablement year to date has been 2,045 with 90% of these receiving no long term services afterwards
- Admissions into care homes for clients 65+ continues to achieve with 601 admissions year to date which is 30.36% below target of 863.
- Making Every Contact Count data is no longer captured due to BCF funding ending in Q2.
- Trusted Assessors have this quarter saved 1,468 bed days within hospitals which is up 5.4% from last quarter (1398) and have completed 614 assessments.

Performance Alerts for main Health & wellbeing Board measures only

Performance is on or ahead of target	Achieved: 4
Performance is behind target, with no improvement	Not achieved: 1
Performance is behind target, with some improvement	Improving but not achieved: 0
Performance is not reported in this period	Not reported in period: 1
Total Health & Wellbeing Board measures	6

Produced by Lincolnshire County Council, Adult Care Performance & Intelligence Team
ASC_Performance@lincolnshire.gov.uk

A detailed analysis of the BCF measures is provided later in this report, showing baselines, trends, measure calculations 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		Current Year				
					2019/20 Quarter 3				
			2017/18	2018/19	Actual	Y/E forecast	Target	Trend~	Alert
Health and Wellbeing Better Care Fund Measures									
Smaller is Better	1. Total non-elective admissions into hospital : General and Acute IN QUARTER	Ruth Cumbers (NHS)	20,750 (Q4)	21,789 (Q4)	23,323	n/a	18,774	↑	Not Achieved
Smaller is Better	2. Permanent admissions to residential and nursing care homes in the year - aged 65+ **ASCOF 2A part 2**	Carolyn Nice (LCC)	1,020	1,005	601	801	863	↓	Achieved
Bigger is Better	3. % people (65+) at home 91 days after discharge from hospital into Reablement/rehabilitation **ASCOF 2B part 1** REPORTED YEARLY	NHS / Tracy Perrett (LCC)	81%	88%	Annual Measure reported in Q4 only				Not reported in period
	3a social care only	Tracy Perrett (LCC)	83%	89%	92%	n/a	80%	↔	Achieved
Smaller is Better	4 (i) . Delayed transfers of care: **Total** delayed days from hospital, aged 18+ IN QUARTER	NHS / LCC	6,198 (Q4)	4,848 (Q4)	4,974	n/a	5,399	↔	Achieved
Smaller is Better	4 (ii). NEW Oct-18* Delayed transfers of care: Average delayed days per day from hospital, aged 18+ IN MONTH	NHS / LCC	74.5 (annualised)	48.5 (Mar-19)	56.7	n/a	58.7	↑	Achieved
iBCF Measures									
	5. Number of home care packages provided in the year	LCC	4,581	4,611	4,288	tbc	n/a	↓	n/a
	6. Total number of paid hours of homecare provided in the year	LCC	1,456,768	1,397,019	1,175,833	1,567,777	n/a	↑	n/a
	7. Number of funded care home placements at the end of the period	LCC	3,271	3,296	3,225	n/a	n/a	↔	n/a
	8. Number of new funded clients with LD	LCC	-	-	31	n/a	n/a	n/a	n/a
	9. Number of new managed care networks projects: Estimated number of direct beneficiaries	LCC	2,784	2,669	2,683	n/a	n/a	↔	n/a
Local Measures									
Bigger is Better	10. Social Care Reablement hours delivered in the year	LCC	128,272	123,699	82,886	110,515	n/a	↓	n/a
Bigger is Better	11. Reablement - % episodes completed in the year where the person was reabled to no service **(LCC Council Business Plan)**	LCC	87%	88%	90%	n/a	95%	↔	Achieved
Bigger is Better	12. 7 Day Services - % patients discharged to Social Care at the weekend IN QUARTER	LCC	12.4%	12.5%	12.5%	n/a	n/a	↔	n/a
Bigger is Better	13. Carers Supported by Lincolnshire Carers Service in the last 12 months, per 100k population **(LCC Council Business Plan)**	LCC	1,631	1,692	1,944	n/a	1,730	↑	Achieved
Bigger is Better	14. Trusted Assessors: Hospital bed days saved in the year		-	3,560	4,030	5,373	-	↑	n/a
Bigger is Better	15. Make Every Contact Count: Staff trained in the year **(LCC Council Business Plan)**	LCC	1,258	1,126	-	-	-		BCF Funding ceased at end of Q2

Notes:

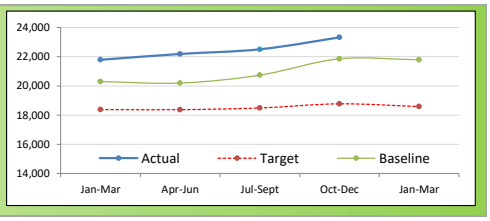
* the DTOC measure and targets were amended with effect from 01 October 2018 to move away from quarterly monitoring of total delays to monthly monitoring of average days per day.

~ Y/E forecast is used where appropriate else the 18/19 Q4, the trend is within a +/-5% tolerance.

Health and Wellbeing Board Measures

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)

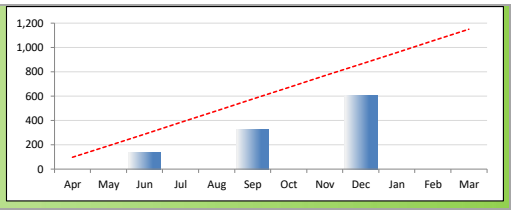


Prior Year	2018/19											
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
In Month	6,640	6,976	6,581	6,937	7,015	6,786	7,275	7,305	7,275	7,696	6,764	7,329
In Quarter (cumulative)	6,640	13,616	20,197	6,937	13,952	20,738	7,275	14,580	21,855	7,696	14,460	21,789

Current Year		2019/20											
		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
In Month		7,316	7,718	7,154	7,939	7,380	7,186	8,127	7,500	7,696			
In Quarter		7,316	15,034	22,188	7,939	15,319	22,505	8,127	15,627	23,323			
HWB NEA Plan - Target		6,125	12,250	18,375	6,164	12,327	18,491	6,258	12,516	18,774	6,196	12,392	18,588
Actual reduction (negative indicates an increase)	number	-1,191	-2,784	-3,813	-1,775	-2,992	-4,014	-1,869	-3,111	-4,549	6,196	12,392	18,588
	%	-16.28%	-18.52%	-17.18%	-22.36%	-19.53%	-17.84%	-23.00%	-19.91%	-19.50%			
Performance		Not Achieved	Not Achieved	Not Achieved	Not Achieved	Not Achieved	Not Achieved	Not Achieved	Not Achieved	Not Achieved			

2: Admissions to residential / nursing care homes - aged 65+ (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: Mosaic data: Local Adult Care Monitoring (LTC admissions report & SALT return).
Note: Figure reported cumulatively



Prior Year	2018/19											
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
In Quarter			296			164			172			373
Cumulative YTD			296			460			632			1,005

Current Year	18/19	2019/20											
		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
In Quarter	**1,005**			137			191			273			
Cumulative YTD	**1,005**			137			328			601			
Target (admissions)				**288**			**575**			**863**			
Performance				Achieved			Achieved			Achieved			

3: % people (65+) at home 91 days after discharge from hospital into Reablement/rehabilitation (ASCOF 2B part 1) UPDATED YEARLY - Includes NHS and Social Care service

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: Yearly - ASCOF 2B part 1
Source: Mosaic Reablement data and LCH data for Q3

	18/19	2019/20											
		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Numerator	451			-			-			-			
Denominator	513			-			-			-			
Value	87.91%			-			-			-			
Target	**80.0%**			**-**			**-**			**-**			**80.0%**
Performance	Achieved												

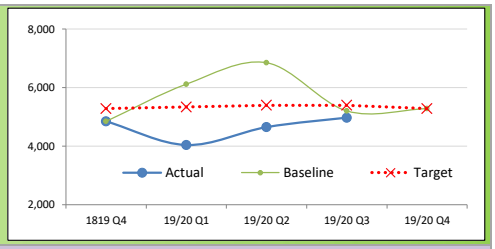
3a: % people (65+) at home 91 days after discharge from hospital into Reablement/rehabilitation - SOCIAL CARE REABLEMENT SERVICE ONLY
Definition: The percentage of older people (within a 3 month sample period) discharged from an acute or non-acute hospital to their own home/residential or nursing care home/ extra care housing for rehabilitation, where the person is at home 91 days after their date of discharge from hospital. Q1 data will be clients discharged between January-March, Q2 will be clients discharged between April-June etc.
Frequency / Reporting Basis: Quarterly
Source: Mosaic data: Reablement

	18/19 Social Care Only	2019/20											
		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Numerator	377			569			635			616			
Denominator	422			608			683			670			
Value	89%			94%			93%			92%			
Target	**80.0%**			**80.0%**			**80.0%**			**80.0%**			**80.0%**
Performance	Achieved			Achieved			Achieved			Achieved			

4: Delayed transfers of care (delayed days) from hospital for adults aged 18+

Definition: The number of delayed transfers of care (days) for adults who were ready for discharge from acute and non-acute beds. This changed to average delayed days per day from October 2018. Both have been reported below.
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. This measure has evolved over time from rate per 100,000 to total days and now performance is judged based on average bed days per month.



Prior Year

	2018/19											
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Days Delayed in Quarter	2,039	4,175	6,117	2,174	4,508	6,848	1,784	3,549	5,203	1,587	3,344	4,848
Target (days)	**2,096**	**4,125**	**6,087**	**1,895**	**3,723**	**5,483**	**1,819**	**3,580**	**5,400**	**1,819**	**3,463**	**5,282**

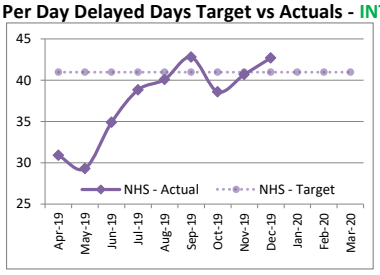
Current Year

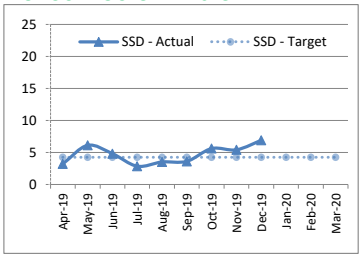
	Qtr 4 1819	2019/20											
		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Average Per Day	48.5	40.8	46	46.4	46.9	51.6	53.3	49.8	55.7	56.7			
In month	1,504	1,224	1,426	1,391	1,453	1,601	1,598	1,545	1,671	1,758			
In Quarter (cumulative)	4,848	1,224	2,650	4,041	1,453	3,054	4,652	1,545	3,216	4,974	-	-	-
Target (days)	**5,282**	**1,761**	**3,580**	**5,340**	**1,819**	**3,638**	**5,399**	**1,819**	**3,580**	**5,399**	**1,819**	**3,462**	**5,282**
Performance	Achieved	Achieved	Achieved	Achieved	Achieved	Achieved	Achieved	Achieved	Achieved	Achieved			

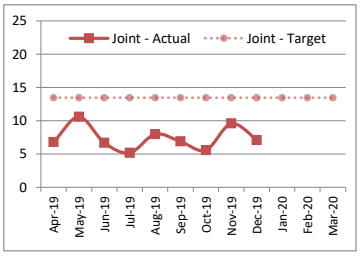
by Type of Care

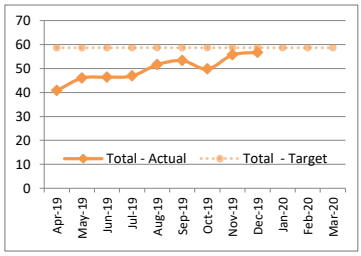
	18/19 Q4	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Acute	4,258	1,095	1,239	1,276	1,224	1,338	1,121	1,133	1,240	1,230			
Non Acute	590	129	187	115	229	263	477	412	431	528			
Total	**4,848**	**1,224**	**1,426**	**1,391**	**1,453**	**1,601**	**1,598**	**1,545**	**1,671**	**1,758**	-	-	-

Per Day Delayed Days Target vs Actuals - INTRODUCED OCTOBER 2018







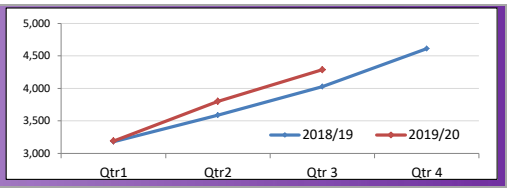


Average days	1819	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
NHS - Actual	32.7	30.9	29.3	34.9	38.8	40.1	42.8	38.6	40.7	42.7			
NHS - Target	41	41.0	41.0	41.0	41.0	41.0	41.0	41.0	41.0	41.0	41.0	41.0	41.0
Performance	Achieved	Achieved	Achieved	Achieved	Achieved	Achieved	Not Achieved	Achieved	Achieved	Not Achieved			
SSD - Actual	4.6	3.2	6.1	4.8	2.8	3.5	3.6	5.6	5.4	6.9			
SSD - Target	4.2	4.2	4.2	4.2	4.2	4.2	4.2	4.2	4.2	4.2	4.2	4.2	4.2
Performance	Not Achieved	Achieved	Not Achieved	Not Achieved	Achieved	Achieved	Achieved	Not Achieved	Not Achieved	Not Achieved			
Joint - Actual	11.2	6.8	10.6	6.7	5.2	8.0	6.9	5.6	9.6	7.1			
Joint - Target	13.5	13.5	13.5	13.5	13.5	13.5	13.5	13.5	13.5	13.5	13.5	13.5	13.5
Performance	Achieved	Achieved	Achieved	Achieved	Achieved	Achieved	Achieved	Achieved	Achieved	Achieved			
Total - Actual	**48.5**	**40.8**	**46.0**	**46.4**	**46.9**	**51.6**	**53.3**	**49.8**	**55.7**	**56.7**			
Total - Target	**58.7**	**58.7**	**58.7**	**58.7**	**58.7**	**58.7**	**58.7**	**58.7**	**58.7**	**58.7**	**58.7**	**58.7**	**58.7**
Performance	Achieved	Achieved	Achieved	Achieved	Achieved	Achieved	Achieved	Achieved	Achieved	Achieved			

iBCF Measures

5: Number of Home Care packages provided in the reporting year

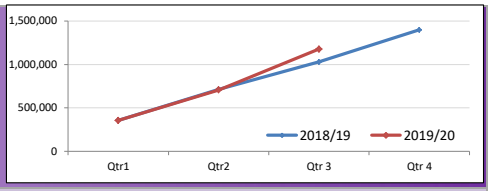
Definition: Cumulative YTD number of all clients who have received a permanent home care package during the year
Frequency / Reporting Basis: Monthly / Cumulative within quarter only
Source: Brokerage weekly service returns



Prior Year		2018/19											
		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Clients in receipt of homecare (YTD)				3,179			3,589			4,028			4,611

Current Year		2019/20											
		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Clients in receipt of homecare (YTD)				3,191			3,802			4,288			

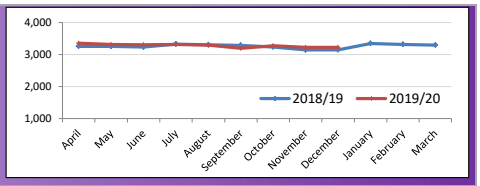
6: Total number of paid hours of Home Care provided in the quarter
Definition: Cumulative YTD number of all paid hours of homecare delivered
Frequency / Reporting Basis: Monthly / Cumulative within quarter only
Source: Brokerage weekly service returns



Prior Year		2018/19											
		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Hours Delivered				357,266			714,479			1,028,275			1,397,019

Current Year		2019/20											
		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Hours Delivered				355,248			707,809			1,175,833			

7: Number of funded care home placement at the end of the period
Definition: Number of clients that are in a social care wholly or part funded care home placement at the end of the period.
Frequency / Reporting Basis: Monthly / Snapshot
Source: BO Report - Long Term Care (Summary)



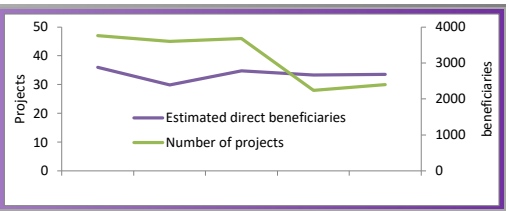
Prior Year		2018/19											
		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Care Home Placements (YTD)		3,258	3,261	3,238	3,333	3,310	3,292	3,240	3,147	3,151	3,349	3,321	3,296

Current Year		2019/20											
		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Care Home Placements (YTD)		3,356	3,317	3,311	3,322	3,295	3,194	3,275	3,225	3,225			

8: Number of newly funded clients with LD
Definition: Number of LD starters that have started a new service within each quarter.
Frequency / Reporting Basis: Quarterly
Source: Finance Team - Adult Care & Community Wellbeing

		2019/20											
by Age Group		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
18-25		3	7	5	12	8	6	6	10	1			
26-40		6	2	2	3	1	1	5	1	0			
41-64		1	3	3	3	4	3	1	4	2			
65+		2	0	0	1	0	0	1	0	0			
In month		**12**	**12**	**10**	**19**	**13**	**10**	**13**	**15**	**3**			
In Quarter (cumulative)		**12**	**24**	**34**	**19**	**32**	**42**	**13**	**28**	**31**			

9: Number of new managed care networks projects
Definition: Number of projects supported by the managed care network and estimated direct beneficiaries.
Frequency / Reporting Basis:
Source: LPFT, Managed Care Network Administrator



Contract End	Sep-15	Sep-16	Sep-17	Sep-18	Sep-19	Sep-20
Number of projects	47	45	46	28	30	
New Projects	**14**	**9**	**19**	**8**	22	
Estimated direct beneficiaries	**2,875**	**2,393**	**2,784**	**2,669**	2,683	

Local Measures

10. Number of Reablement Hours Delivered in the period
Definition: Total number of face to face contact hours delivered
Frequency / Reporting Basis: Quarterly (Cumulative)
Source: Reablement Provider Contract KPI's

Current Year	18/19	2019/20											
		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Hours delivered (in month)	-	10,655	9,970	9,187	8,888	9,051	8,400	8,760	8,877	9,098			
Hours delivered (in quarter)	-	10,655	20,625	29,812	8,888	17,939	26,339	8,760	17,637	26,735			
Hours delivered (YTD)	-	10,655	20,625	29,812	38,700	47,751	56,151	64,911	73,788	82,886			

11. Reablement: % of people reabled to no service, or a lower service (ASCOF 2D)
Definition: % of concluded episodes of reablement for NEW clients where the sequel to reablement is no support or support of a lower level
Frequency / Reporting Basis: Quarterly / Cumulative YTD
Source: Short & Long Term Return (SALT STS002a)/ (CBP 124)

Current Year	18/19	2019/20											
		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Numerator	2,350			620			1,210			1,848			
Denominator	2,661			632			1,324			2,045			
Actual	88.3%			98.1%			91.4%			90.4%			
Target	95%			95%			95%			95%			
Performance	Not Achieved			Achieved			Achieved			Achieved			

12. 7 Day Services: % of hospital discharges to Social Care which occur at the weekend
Definition: Of the total number of patients discharged from hospital to a Social Care hospital team, the % that were discharged at the weekend
Frequency / Reporting Basis: Quarterly / Cumulative (in quarter)
Source: BO Report - Hospital Discharges

Current Year	18/19	2019/20											
		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
	Q4			Q1 1920			Q2 1920			Q3 1920			Q4 1920
Numerator	404			389			450			407			
Denominator	3,222			3,154			3,360			3,250			
Actual	12.5%			12.3%			13.4%			12.5%			

13. Carers Supported by Carers Service and Adult Care
Definition: The total number of Carers Supported by Lincolnshire County Council in the last 12 months
Frequency / Reporting Basis: Quarterly / Rolling 12 month period
Source: Council Business Plan (Carers Strategy) (SALT LTS003 total)

Current Year	2018/19	2019/20											
		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Numerator	10,324			10,481			**10,578**			11,859			
Denominator	6.10			6.1			6.1			6.1			
Actual	**1,692**			**1,718**			**1,734**			**1,944**			
Target	1,730			1,730			1,730			1,730			
Performance	Achieved			Achieved			Achieved			Achieved			

14. Trusted Assessors: Hospital Bed Days Saved
Definition: The number of assessments completed by workers, actual discharges that have taken place and total bed days saved by workers
Frequency / Reporting Basis: Quarterly
Source: Lincolnshire Care Association

Current Year	2018/19	2019/20											
		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Completed Assessments	1,468			485			598			614			
Actual Discharges	980			298			337			359			
Bed Days Saved (in quarter)	-			**1,169**			**1,393**			**1,468**			
Bed Days Saved (YTD)	**3,560**			**1,169**			**2,562**			**4,030**			

15. Making Every Contact Count
Definition: The total number of front line staff and volunteers who have been trained on Making Every Contact Count (MECC) during the year.
Frequency / Reporting Basis: Quarterly / Cumulative
Source: Council Business Plan (Wellbeing Strategy)

Current Year	2018/19	2019/20											
		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Staff trained (YTD)	1,126			78			133			-			-
Target	1,000			100			200			300			400
Performance	Achieved			Not Achieved			Not Achieved						

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Ministry of Housing,
Communities &
Local Government

Cathy Page

Deputy Director,
Housing Support Division

Fry Building
2 Marsham Street
London
SW1P 4DF

28 February 2020

To Local authority Chief Executives in:

1. Unitary Authorities
2. Metropolitan Borough Councils
3. County Councils
4. London Boroughs (including the City of London)

CC: District Councils
CC: Foundations, National Body for Home Improvement Agencies

£505 million for the Disabled Facilities Grant (DFG) in 2020-21

Dear Local Authority Chief Executives,

I am pleased to inform you that £505 million will be made available for the DFG in 2020-21, which has been confirmed to us by the Department of Health and Social Care. This is in recognition of Government's continued support to local authorities to help older and disabled people to live independently and safely in their own homes for longer. As in previous years, we intend to make these payments to local authorities in England in May, and details of each local authority's allocation can be found in **Annex B** below. This also includes indicative allocations for each district council in the two-tier areas.

As you know, the DFG is capital funding for the provision of home adaptations to help older and disabled people to live as independently and safely as possible in their homes. Where agreed locally (and in two-tier areas with the express agreement of district councils), a portion of the grant may also be used for wider social care capital projects. A grant determination letter outlining the conditions of grant usage will be issued to local authorities to coincide with the payments being made.

In two-tier areas the main DFG funding will be paid to the Upper-Tier authorities (county councils), while the statutory duty to provide adaptations to the homes of those eligible people who qualify, continues to sit with local housing authorities (district councils). I can confirm that, building on the approach taken in previous years, each area should allocate DFG funding primarily for the provision of home adaptations, and in two-tier areas, unless specific agreement is given by any district council, Upper Tiers must pass down the DFG funding to their district councils in full,

and in a timely manner, to enable the districts to continue to meet their statutory duty. Further details will be set out in the BCF Policy Framework for 2020-21, which will be published shortly.

The Ministry of Housing, Communities and Local Government would also like to draw your attention to Foundations, who are funded by this Department. Foundations is the National Body for Home Improvement Agencies and can offer advice and support to both local authorities and home improvement agencies on the efficient delivery of DFGs, and to local authority commissioners on commissioning local home improvement services. More information can be found at: https://www.foundations.uk.com/

Finally, I would like to signpost the Regulatory Reform Order (2002) to local authorities to encourage uptake of locally published RROs. At present we are aware that around 85% of authorities have a locally published RRO policy, but we would like to see this rise to closer to 100% uptake. The RRO gives authorities a general power to introduce local policies for assisting individuals with renewals, repairs and adaptations in their homes through grants or loans. For example, it can provide authorities a vehicle for funding essential repairs to reduce injury and accidents in the home, to ensure homes are adequately heated, and to expand the scope of adaptations available under the DFG legislation. Local authorities can also use the RRO to create assistance schemes which help people meet their needs without going through the full DFG process. Schemes such as these can, for example, provide 'fast track' mechanisms for low level adaptations, which do not require a full social care assessment or means test. If your authority is interested in publishing a local RRO policy, please contact Foundations for help and assistance.

If you have any general questions about your authority's DFG funding in 2020-21 please send them to Disabled.facilitiesgrants@communities.gov.uk.

Regards,

Cathy Page
Deputy Director
Housing Support Division

Annex B

DISABLED FACILITIES GRANT ALLOCATIONS 2020-21

Tier 1 Authorities	2020-21 Allocations
Cambridgeshire	**£4,467,928**
Cambridge	£746,881
East Cambridgeshire	£608,184
Fenland	£1,070,614
Huntingdonshire	£1,315,029
South Cambridgeshire	£727,221
Cumbria	**£6,284,315**
Allerdale	£1,214,265
Barrow-in-Furness	£1,242,491
Carlisle	£1,899,764
Copeland	£714,771
Eden	£477,740
South Lakeland	£735,284
Derbyshire	**£6,960,719**
Amber Valley	£1,281,883
Bolsover	£999,472
Chesterfield	£1,208,957
Derbyshire Dales	£530,326
Erewash	£936,182
High Peak	£489,109
North East Derbyshire	£722,417
South Derbyshire	£792,375
Devon	**£7,266,863**
East Devon	£1,349,522
Exeter	£858,523
Mid Devon	£720,795
North Devon	£979,268
South Hams	£775,187
Teignbridge	£1,328,793
Torridge	£746,953
West Devon	£507,822
Dorset	**£4,235,709**
Christchurch	£576,044

East Dorset	£826,145
North Dorset	£471,750
Purbeck	£433,965
West Dorset	£992,920
Weymouth and Portland	£934,884
East Sussex	**£7,159,553**
Eastbourne	£1,546,926
Hastings	£1,812,584
Lewes	£1,080,405
Rother	£1,625,876
Wealden	£1,093,762
Essex	**£10,474,954**
Basildon	£1,267,929
Braintree	£931,069
Brentwood	£370,282
Castle Point	£732,741
Chelmsford	£970,881
Colchester	£1,279,778
Epping Forest	£855,956
Harlow	£798,153
Maldon	£539,488
Rochford	£475,968
Tendring	£2,045,092
Uttlesford	£207,619
Gloucestershire	**£6,030,346**
Cheltenham	£902,940
Cotswold	£1,170,291
Forest of Dean	£879,755
Gloucester	£1,125,384
Stroud	£727,679
Tewkesbury	£1,224,297
Hampshire	**£12,561,045**
Basingstoke and Deane	£1,377,158
East Hampshire	£1,489,813
Eastleigh	£1,163,139
Fareham	£757,036
Gosport	£795,489
Hart	£738,645
Havant	£1,756,631

New Forest	£1,125,419
Rushmoor	£1,060,510
Test Valley	£1,212,262
Winchester	£1,084,944
Hertfordshire	**£7,283,182**
Broxbourne	£743,767
Dacorum	£870,316
East Hertfordshire	£680,871
Hertsmere	£691,310
North Hertfordshire	£840,076
St Albans	£683,034
Stevenage	£746,540
Three Rivers	£586,315
Watford	£675,859
Welwyn Hatfield	£765,094
Kent	**£16,882,585**
Ashford	£909,625
Canterbury	£1,188,396
Dartford	£602,440
Dover	£1,298,504
Gravesham	£1,037,911
Maidstone	£1,328,182
Sevenoaks	£1,148,482
Shepway	£1,326,767
Swale	£2,570,919
Thanet	£3,015,899
Tonbridge and Malling	£1,184,711
Tunbridge Wells	£1,270,749
Lancashire	**£14,731,268**
Burnley	£2,399,450
Chorley	£774,675
Fylde	£1,090,401
Hyndburn	£965,897
Lancaster	£1,889,809
Pendle	£973,703
Preston	£1,481,033
Ribble Valley	£346,368
Rossendale	£1,022,385
South Ribble	£682,271
West Lancashire	£1,272,147

Wyre	£1,833,127
Leicestershire	**£3,919,459**
Blaby	£585,028
Charnwood	£992,908
Harborough	£451,561
Hinckley and Bosworth	£510,231
Melton	£303,802
North West Leicestershire	£670,314
Oadby and Wigston	£405,615
Lincolnshire	**£6,148,560**
Boston	£557,628
East Lindsey	£1,797,485
Lincoln	£750,881
North Kesteven	£802,480
South Holland	£680,721
South Kesteven	£859,556
West Lindsey	£699,809
Norfolk	**£8,070,995**
Breckland	£1,171,850
Broadland	£893,405
Great Yarmouth	£1,188,068
King's Lynn and West Norfolk	£1,571,235
North Norfolk	£1,193,858
Norwich	£1,140,032
South Norfolk	£912,547
Northamptonshire	**£4,513,005**
Corby	£518,331
Daventry	£428,429
East Northamptonshire	£508,259
Kettering	£647,698
Northampton	£1,407,050
South Northamptonshire	£419,781
Wellingborough	£583,457
North Yorkshire	**£4,507,917**
Craven	£556,818
Hambleton	£477,134
Harrogate	£727,721
Richmondshire	£272,249

Ryedale	£583,807
Scarborough	£1,446,593
Selby	£443,595
Nottinghamshire	**£6,950,696**
Ashfield	£922,788
Bassetlaw	£1,167,487
Broxtowe	£867,198
Gedling	£1,048,082
Mansfield	£1,256,409
Newark and Sherwood	£1,021,695
Rushcliffe	£667,037
Oxfordshire	**£5,868,351**
Cherwell	£1,092,792
Oxford	£1,252,746
South Oxfordshire	£1,366,451
Vale of White Horse	£1,444,470
West Oxfordshire	£711,891
Somerset	**£4,365,069**
Mendip	£889,785
Sedgemoor	£962,833
South Somerset	£1,238,632
Taunton Deane	£833,162
West Somerset	£440,657
Staffordshire	**£8,817,994**
Cannock Chase	£926,471
East Staffordshire	£1,022,684
Lichfield	£977,562
Newcastle-under-Lyme	£1,511,575
South Staffordshire	£992,957
Stafford	£1,341,408
Staffordshire Moorlands	£1,563,346
Tamworth	£481,989
Suffolk	**£6,170,607**
Babergh	£670,029
Forest Heath	£467,378
Ipswich	£1,205,089
Mid Suffolk	£615,135
St Edmundsbury	£814,544

Suffolk Coastal	£990,442
Waveney	£1,407,990
Surrey	**£8,950,616**
Elmbridge	£861,053
Epsom and Ewell	£692,090
Guildford	£710,262
Mole Valley	£781,577
Reigate and Banstead	£1,133,996
Runnymede	£770,460
Spelthorne	£831,303
Surrey Heath	£779,111
Tandridge	£460,387
Waverley	£751,424
Woking	£1,178,953
Warwickshire	**£4,516,609**
North Warwickshire	£700,267
Nuneaton and Bedworth	£1,456,056
Rugby	£632,119
Stratford-on-Avon	£847,346
Warwick	£880,821
West Sussex	**£8,297,661**
Adur	£652,378
Arun	£1,673,053
Chichester	£1,516,963
Crawley	£927,566
Horsham	£1,237,206
Mid Sussex	£1,025,094
Worthing	£1,265,402
Worcestershire	**£5,432,123**
Bromsgrove	£913,295
Malvern Hills	£601,836
Redditch	£839,355
Worcester	£687,629
Wychavon	£1,103,362
Wyre Forest	£1,286,646
Tier 1 Authorities Total:	**£190,868,130**

Unitary Authorities and London Boroughs	2020-21 Allocations
Barking And Dagenham	£1,636,536
Barnet	£2,542,210
Barnsley	£2,976,280
Bath And North East Somerset	£1,270,789
Bedford	£1,243,320
Bexley	£2,613,112
Birmingham	£11,407,088
Blackburn With Darwen	£1,876,999
Blackpool	£2,304,619
Bolton	£3,153,289
Bournemouth	£1,475,312
Bracknell Forest	£853,469
Bradford	£4,527,491
Brent	£4,685,921
Brighton And Hove	£2,038,449
Bristol, City Of	£3,109,627
Bromley	£2,152,696
Buckinghamshire Council	£3,583,439
Bury	£1,830,172
Calderdale	£2,673,074
Camden	£922,516
Central Bedfordshire	£1,698,077
Cheshire East	£2,064,279
Cheshire West And Chester	£3,250,597
City Of London	£32,689
Cornwall	£6,652,704
County Durham	£6,158,831
Coventry	£3,685,430
Croydon	£2,637,527
Darlington	£937,154
Derby	£2,047,589
Doncaster	£2,451,971
Dudley	£5,679,451
Ealing	£3,282,472
East Riding Of Yorkshire	£2,719,960
Enfield	£3,292,570
Gateshead	£1,860,611
Greenwich	£2,517,810
Hackney	£1,525,299
Halton	£1,757,984

Hammersmith And Fulham	£1,318,109
Haringey	£2,360,942
Harrow	£1,517,250
Hartlepool	£1,076,870
Havering	£1,812,714
Herefordshire, County Of	£1,999,424
Hillingdon	£4,504,510
Hounslow	£2,643,609
Isle Of Wight	£2,002,408
Isles Of Scilly	£25,862
Islington	£1,709,575
Kensington And Chelsea	£845,918
Kingston Upon Hull, City Of	£2,533,171
Kingston Upon Thames	£1,339,715
Kirklees	£3,193,921
Knowsley	£2,420,693
Lambeth	£1,479,227
Leeds	£7,302,720
Leicester	£2,391,923
Lewisham	£1,338,708
Liverpool	£7,503,889
Luton	£1,417,554
Manchester	£7,476,077
Medway	£2,177,470
Merton	£1,279,883
Middlesbrough	£1,998,957
Milton Keynes	£1,117,331
Newcastle Upon Tyne	£2,399,392
Newham	£2,510,077
North East Lincolnshire	£2,838,604
North Lincolnshire	£2,280,050
North Somerset	£2,081,237
North Tyneside	£1,647,220
Northumberland	£2,933,884
Nottingham	£2,439,908
Oldham	£2,065,201
Peterborough	£1,970,984
Plymouth	£2,479,859
Poole	£1,049,425
Portsmouth	£1,815,258
Reading	£1,055,248
Redbridge	£2,140,914
Redcar And Cleveland	£1,577,780

Richmond Upon Thames	£1,697,204
Rochdale	£2,632,865
Rotherham	£2,700,150
Rutland	£238,183
Salford	£3,084,633
Sandwell	£4,167,539
Sefton	£4,250,963
Sheffield	£4,502,097
Shropshire	£3,209,291
Slough	£1,005,311
Solihull	£2,189,967
South Gloucestershire	£2,061,494
South Tyneside	£1,690,787
Southampton	£2,215,050
Southend-On-Sea	£1,516,820
Southwark	£1,486,043
St. Helens	£2,774,199
Stockport	£2,543,381
Stockton-On-Tees	£1,590,490
Stoke-On-Trent	£3,034,932
Sunderland	£3,574,130
Sutton	£1,593,249
Swindon	£1,151,362
Tameside	£2,511,180
Telford And Wrekin	£2,033,004
Thurrock	£1,162,050
Torbay	£1,876,070
Tower Hamlets	£2,045,288
Trafford	£2,176,858
Wakefield	£3,825,582
Walsall	£3,704,013
Waltham Forest	£2,081,964
Wandsworth	£1,551,147
Warrington	£1,958,612
West Berkshire	£1,820,120
Westminster	£1,523,990
Wigan	£4,013,889
Wiltshire	£3,273,126
Windsor And Maidenhead	£909,645
Wirral	£4,163,057
Wokingham	£948,004
Wolverhampton	£3,147,482
York	£1,293,767

Unitary Authorities & London Boroughs Total:	**£314,131,871**
Overall Total for DFG in 2020-21:	**£505,000,000**

Health and Wellbeing Board – Decisions from 11 June 2019

Meeting Date	Minute No	Agenda Item & Decision made
11 June 2019	**1**	**Election of Chairman** That Councillor Mrs S Woolley be elected as the Chairman of the Lincolnshire Health and Wellbeing Board for 2018/19
	2	**Election of Vice-Chairman** That Dr Kevin Hill be elected as the Vice-Chairman of the Lincolnshire Health and Wellbeing Board for 2019/20
	5	**Minutes** That the minutes of the Lincolnshire Health and Wellbeing Board meeting held on 26 March 2019, 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, Roles and responsibilities of Core Board Members** That the Terms of Reference, Procedure Rules and Board Members Roles and Responsibilities be agreed.
	9a	**Health and Wellbeing Board Annual Report** That the Board: • Note the information provided in the annual report; • Note comments made on the way the JHWS was reported; • Note that the JHWS remained focused on the key health and wellbeing issues facing Lincolnshire.
	9b	**Clinical Commissioning Groups – Developing Management Arrangements** That the following be noted by the Health and Wellbeing Board: • The initial and developing executive and staffing arrangements • The emerging joint governing body arrangements • The emerging joint governance committee arrangements • The early consideration of the national NHS Long term Plan commitments to the development of integrated care systems, strategic commissioning and the future roles of CCGs; and • The developing arrangements with the new NHS England/Improvement Midlands Regional Team
	9c	**Lincolnshire NHS Healthy Conversation 2019 – General Update** That the progress on the delivery of the Healthy Conversation 2019 campaign be noted.
	9d	**Health Protection Board Assurance for 2018/19** That the governance and assurance arrangements in place for the protection of the health of the people of Lincolnshire be noted; That the challenges within the health protection programmes in Lincolnshire, and the plans to address them be noted; That the plan to report to the Board twice yearly on this area of service be approved.

	9e	**Lincolnshire Physical Activity Taskforce Launch of "A Blueprint for Creating a More Active Lincolnshire"** That the Health and Wellbeing Board notes the progress made by the Lincolnshire Physical Activity Taskforce, the production of 'A Blueprint for Creating a More Active Lincolnshire' and the development of a collaborative approach to increasing physical activity levels across Lincolnshire.
	10a	**Better Care Fund 18/19 Quarter 4 Update** That the BCF report update be noted.
	10b	**An Action Log of Previous Decisions** That the report for information be noted.
	10c	**Lincolnshire Health and Wellbeing Board Forward Plan** That the report for information be received.
24 September 2020	**16a**	**The Lincolnshire Better Care Fund (BCF)** That the Lincolnshire Health and Wellbeing Board approves the BCF Narrative Plan for 2019/20 and notes the update to performance activity.
	17a	**Lincolnshire NHS Healthy Conversation 2019 – General Update** That the progress on the delivery of the Health Conversation 2019 campaign be noted.
	17b	**Joint Health and Wellbeing Strategy Housing and Health priority** 1. That the report and progress made to date be noted. 2. That the direction of travel to further develop the Housing and Health priority delivery plan be supported.
	17c	**Advancing our health: prevention in the 2020s Green Paper** 1. That the draft response to the Prevention Green paper be noted; 2. That a response be sent on behalf of the Health and Wellbeing Board, and any comments for inclusion should be sent to Alison Christie by 1 October 2019. 3. That the Chairman of the Board sign off the response prior to submission on 14 October 2019.
	18a	**Children's Emotional Wellbeing and Mental Health** That the report be noted.
	18b	**An Action Log of Previous Decisions** That the report for information be noted.
4 February 2020	**24a**	**Presentation on the Director of Public Health's Annual Report** That the Director of Public Health Report 2019 – The Burden of Disease in Lincolnshire and associated presentation be received.
	24b	**Whole Systems Approach to Healthy Weight** That the progress made by Lincolnshire's Whole Systems Healthy Weight Partnership and how this was contributing to delivering the healthy weight priority of the Joint Health and Wellbeing Strategy be noted.
	24c	**Joint Health and Wellbeing Strategy Carers Priority Update** 1. That the progress made to date and next steps detailed in the Joint Health and Wellbeing Strategy Carers Priority Update Report presented be noted. 2. That support be given to the achievement of the refreshed Carers Priority Plan as detailed in Appendix B.

		3. That support be given to championing a System Led approach to supporting carers and to support the implementation of the NHS Long Term Plan by: • Asking their own organisations to: o sign the 'Commitment to Carers' Memorandum of Understanding (Appendix A); o sign up to achieving the Carer Quality Award, if not already underway; o identify and support young carers and their families' needs; o support the establishment of Carers Champions in their own organisations; o support their own staff in a caring role by signing up to 'Employers for Carers', conducting a benchmarking survey of staff in a caring role and developing a staff carers' network; • Asking service providers and partner agencies to adopt these initiatives; • Asking all NHS partners including Primary Care Networks (PCNs) and General practice (GPs) to sign up to GP Quality Markers.
	24d	**Better Ageing in Rural Areas – Learning from East Lindsey** 1. That the outcomes to date from the work underway in East Lindsey to support and enable Better Ageing be noted. 2. That the opportunities to extend learning across Lincolnshire be considered. 3. That continued dialogue be supported with the Centre for Ageing Better (CfAB) to develop a positive working relationship and benefit from their expertise.
	25a	**The Lincolnshire Better Care Fund (BCF)** That the Lincolnshire Better Care Fund performance report for Quarter 2 presented be noted.
	25b	**Half Yearly Update on Health Protection Arrangements** 1. That the overall good position of health protection arrangements within Lincolnshire be noted. 2. That the areas of the health protection service facing challenges be noted.
	25c	**An Action Log of Previous Decisions** That the log of decisions taken by the Lincolnshire Health and Wellbeing Board since 11 June 2019 be received.

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Lincolnshire Health and Wellbeing Board Forward Plan March 2020 to September 2020

Items for the Lincolnshire Health and Wellbeing Board are shown below:

24 March 2020, 2pm, Committee Room 1, County Offices, Lincoln		
Item & Rationale	**Presenter/Contributor**	**Purpose**
Lincolnshire Pharmaceutical Needs Assessment To receive a report from the PNA Steering Group asking the Lincolnshire Health and Wellbeing Board to agree the process and timescales for reviewing the PNA 2021	Alison Christie, Programme Manager, Public Health on behalf of the PNA Steering Group	Decision
Health and Wellbeing Board Review To receive a report on behalf of Derek Ward, Director of Public Health asking the Board to consider arrangements for completing a review of the Board in light of the four Clinical Commissioning Groups merging to form a single Clinical Commissioning Group for Lincolnshire.	Alison Christie Programme Manager Public Health	Decision
Clinical Commissioning Groups - Update To receive a verbal update from John Turner, Chief Accountable Officer on behalf of the Clinical Commissioning Groups on current developments and future plans.	John Turner, Chief Accountable Officer on behalf of Lincolnshire CCGs	Discussion
NHS Healthy Conversation 2019 – Final Report To receive a report on behalf of the Lincolnshire Health System on the Healthy Conversation 2019, an engagement exercise with partners, stakeholders, patients and the public on future options for change.	John Turner, Chief Accountable Office and Charley Blyth, Director of Communications and Engagement	Discussion
Social Prescribing update To receive a report on behalf of the Lincolnshire Sustainability and Transformation Partnership on the social prescribing 'proof of concept' service that has been running across Lincolnshire since June 2018. The report also outlines the new service model from April 2020 along with recommendations to be able to scale up the approach over the next four years.	Kirsteen Redmile Lead Change Manager – Personalisation STP System Delivery Unit	Discussion
Suicide Prevention Strategy To receive a report on behalf of Derek Ward, Director of Public Health informing the Board of the draft Suicide Prevention Strategy which has been co-produced with partners across the system through the Suicide Prevention Steering Group.	Derek Ward Director of Public Health	Discussion
Better Care Fund – Quarterly Update To receive a report on behalf of the Executive Director Adult Care and Community Wellbeing which provides the Lincolnshire Health and Wellbeing Board with an update on Lincolnshire's BCF plan.	Glen Garrod Executive Director Adult Care and Community Wellbeing	Information

Lincolnshire Health and Wellbeing Board Forward Plan March 2020 to September 2020

Planned items for future Lincolnshire Health and Wellbeing Board are shown below:

9 June 2020, 2pm, Committee Room 1, County Offices, Lincoln		
Item & Rationale	**Presenter/Contributor**	**Purpose**
AGM - Election of Chairman and Vice Chairman		Decision
Terms of Reference and Procedural Rules, roles and responsibilities of core Board members To receive a report which asks the Board to review the Terms of Reference and Procedural Rules	Alison Christie, Programme Manager Public Health	Decision
Health and Wellbeing Board Annual Report To receive the Board's Annual Report	Alison Christie, Programme Manager Public Health	Discussion
JHWS Mental Health (Adults) – update Item deferred from March meeting	TBC	Discussion
JHWS Dementia Priority – update	TBC	Discussion

29 September 2020, 2pm, Committee Room 1, County Offices, Lincoln		
Item & Rationale	**Presenter/Contributor**	**Purpose**
Lincolnshire Pharmaceutical Needs Assessment To receive a report from the PNA Steering Group asking the Lincolnshire Health and Wellbeing Board to sign off the draft PNA document as ready for the 60 day statutory consultation exercise.	Alison Christie, Programme Manager Health and Wellbeing	Decision

Items to be programmed:

- **Green Paper on Social Care for Older People**
- **Medical School Overview and Update**
- **Joint Strategic Asset Assessment**
- **Digital Maturity in Care Providers**