APPENDIX B

Joint Health and Wellbeing Strategy – Draft Chapters
28 March 2012

THEME ONE – Promoting Healthy Lifestyles

Our ambition is to:

- Strengthen self-esteem, confidence and personal responsibility
- Positively promote 'healthier' behaviours and lifestyles
- Adapt the environment to make healthier choices easier

These three key elements of *'Healthy Lives, Healthy People' a Strategy for Public Health in England*, are coterminous with local ambitions and action planning.

Healthy Lives, Healthy People' is quite clear that the government recognises it is not possible to promote healthier lifestyles simply by forcing policy change. Instead an approach is required that empowers people to make healthy choices and gives communities the tools to make healthy choices easier. This approach resonates with local ambitions around increasing the prevalence of community health champions and using local assets to tackle issues in innovative ways. The priorities identified for this theme are:

- Tackling adult obesity and addressing physical inactivity
- Tobacco Control
- Alcohol misuse

During the initial consultation process mental and emotional wellbeing was also identified as a vital part of promoting healthier lifestyles. It is important that we work with communities and individuals to promote emotional wellbeing, enabling resilient communities that can cope with day to day pressures in a positive way. Resilience is a key factor in protecting and promoting good mental health. It is the quality of being able to deal with the 'ups and downs of life' and has its basis in good self-esteem. In order to support and promote mental health and wellbeing alongside our three priority areas of tackling adult obesity and addressing physical inactivity, tobacco control and alcohol misuse we suggest the following approaches:

Mental Health Promotion Strategy
In order to develop a clear multi -agency approach across the County the strategy will build on what has been working well in Lincolnshire as well as identifying any gaps.

Mental Health First Aid
This is a 12 hour evidence based training programme that provides an overview of common mental health problems, causes and symptoms and treatments. It aims to give everyone the knowledge and confidence to recognise signs of mental health problems, encourage someone to seek the right help, and to reduce the stigma around mental illness. Mental Health First Aid been running across Lincolnshire for 4 years and approximately 225 people have accessed this training run through the Healthy Hub, the programme covers:

- Spot the early signs of a mental health problem
- Help stop a mental illness from getting worse
- Help someone recover faster

- Guide someone towards the right support
- Reduce the stigma of mental health problems

Making Every Contact Count
In recognition of the fact that some people need more support than others when it comes to making positive life style choices. The 2013 – 2016 Public Health Outcomes framework is clear that:

*"The NHS will remain critical to **protecting and improving the population's health**. It will be charged with delivering some public health services, and with **promoting health** through all its clinical activity, striving to use the millions of patient contacts that take place each day as opportunities to promote healthier living – **"making every contact count[1]"**.*

With this ethos in mind, 'making every contact count' will be translated into systematic brief advice and brief intervention approaches promoting healthy lifestyles across all three priority areas.

Community Health Champions
Community health champions are local people working voluntarily within their communities to improve health and wellbeing and to empower people to make healthier choices. Health champions are provided with training and support so they can raise awareness and motivate others. They can provide support and advice which is locally relevant and may have a greater understanding of any barriers and concerns and be able to provide support needed from this perspective. Again it is hoped that a health champion could influence outcomes across all three priorities, whilst taking into account the different levels and types of support that local people may need to adopt healthier lifestyles. Evidence also suggests the health champion volunteers themselves benefit from enhanced knowledge and awareness, and increased self-esteem and confidence[2].

This theme links to Marmot principles:

a) Give every child the best start in life

b) Enable all children, young people and adults to maximise their capabilities and have control over their lives

d) Ensure healthy standard of living for all

e) Create and develop healthy and sustainable places and communities

f) Strengthen the role and impact of ill health prevention

[1] The NHS Future Forum will report in January 2012 on the best way for the NHS to contribute to improving the public's health
[2] White et al 2010; Altogether Better Community Health Champions and Empowerment

Priority 1.1 - Tackling Adult Obesity and Addressing Physical Inactivity

Where are we now?

The Department of Health Obesity Strategy, 'Healthy Lives, Healthy People': "A Call to Action on Obesity in England" (October 2011), gives local commissioners and communities the ability to set local robust actions and outcomes to tackle adult obesity. To date there has been broad recognition that the spread of adult obesity cannot be dealt with by individual action alone. The Lincolnshire response to guidance released previously by the Department of Health 'Healthy Weight, Healthy Lives' sets out our commitment to tackling obesity in adults through:

- Building physical activity into our lives
- Improved access to healthier food and healthy eating
- Weight management support for people who are obese

Whilst services currently commissioned to tackle this issue are performance managed, measuring the contribution to the above commitments is difficult. For this reason, current data relating to obesity in the county is based on one of two sources; GP reported patient obesity which only reflects people measured by GPs, which typically are those people engaged with primary care and tend to be older with long-term health conditions (or at-risk conditions) or modelled estimates based on 2006-08 data.

GP data indicates that patient obesity in Lincolnshire is 32.5% whilst modelled estimates for the whole Lincolnshire population suggest that obesity rates are around 24.09%.

Physical activity level estimates are based on the Active People Survey results, the latest data indicates that just over 54% of adults in Lincolnshire are inactive however the 4% stretch target to increase the number of adults aged 16 and over taking part in 3 x 30 minutes of moderate intensity physical activity, active recreation and sport has been reached. This equates to approximately 20,000 people reporting they are taking part in 3 x 30 minutes of physical activity on a weekly basis since 2006/2007.

Department of Health report "Start Active, Stay Active" (July 2011) is the new guidance of physical activity and health by the chief medical officers from the four home counties in the UK. This report emphasises for the first time the importance of physical activity for all ages. Regular physical activity can reduce the risk of many chronic conditions both physical and mental. Even relatively small increases in physical activity are associated with some protection against chronic diseases and an improved quality of life.

Adult obesity and physical inactivity are usually shown to correlate with areas of increased deprivation, aging populations, and diseases such as diabetes and hypertension. The spread of obesity in Lincolnshire matches all trends closely across all local authority districts with the exception of Lincoln City itself which is lowest in terms of GP reported patient obesity and modelled estimates of adult obesity.

Why does this matter?

The impact that excess weight can have at an individual level in terms of emotional resilience has not been subject to scrutiny locally however it seems to be a fair

assumption that confidence, motivation and overall wellbeing are likely to be affected to some extent by obesity and a lack of physical activity, particularly in more extreme cases. Any emotional impact that obesity may have on an individual stands to be exacerbated further by the increased likelihood of life limiting illnesses associated with the condition. Notably amongst these is type 2 diabetes, people diagnosed with type 2 diabetes are about 20 times more likely to be very obese i.e. BMI of 35kg/$m^{2.}$ Cardiovascular disease, hypertensions and respiratory diseases all show evidenced links to obesity[3]. There is a growing evidence base in terms of obesity and cancer, with 10% of all cancer deaths amongst non smokers being linked to obesity, increasing to 30% for endometrial cancers. Obesity also increases the risk of colon cancer is increased three times for both men and women.

National predictions indicate that by 2050 almost 60% of the population could be obese based on current trends. The population of Lincolnshire is typically a sedentary and ageing population, with higher rates of diabetes, Coronary Heart Disease and hypertension. All factors associated directly with physical inactivity and obesity. Excess weight has a substantial human cost contributing to onset of disease and premature death this has serious financial consequences for the NHS and the wider economy. In 2007 it was estimated that the total cost to the NHS was £4.2 billion and to the wider economy £15.8 billion.

What will our objectives will be?

- Continue to commission effective life style services for the people of Lincolnshire
- Commission an additional 4,000 adult weight management places
- Support initiatives which support people to be more active more often

Priority 1.2 - Tobacco Control

Where are we now?

Smoking remains the largest single cause of premature death and is a fundamental component to health inequalities. Approximately 1,270 people die each year in Lincolnshire from smoking related diseases[4].

The success of tackling tobacco control is heavily reliant on partnership working with joined up solutions, which doesn't only focus on stopping smoking. Prevention is vital and incorporates activities such as: legislation, regulation, campaigns, media work, reducing supply and demand, smoking initiation, harm minimisation e.g. smoke free homes, as well as personalised interventions. The local tobacco control team and smoking cessation services engage the local population in surveys and obtain user feedback on a regular basis.

There has been a historical and steady decline in smoking prevalence in England and this is mirrored across Lincolnshire, (Current prevalence is 21.7% in Lincolnshire). However this decline has now plateaued and we need to look at new and creative ways of continuing to reduce smoking prevalence across the county.

[3] Healthy Weight, Health Lives: A toolkit for developing local strategies, page 23 and 24
[4] Office of National Statistics, Mortality File Jan 2011 to Dec 2011

2010/11 data indicates that 52% of people attending the stop smoking service in Lincolnshire were not smoking at 4 weeks later, this equated to 6426 people in real terms this impacts on 9% of the adult smoking population of Lincolnshire.

Why does this matter?

Smoking rates are much higher in low income groups. The gap in smoking prevalence between men and women is reducing, with more young women taking up smoking. Smoking is also the single biggest cause of inequalities in death and disease rates between the richest and poorest in our communities.

The independent review into health inequalities in England undertaken by Professor Sir Michael Marmot culminated in the publication in 2010 of Fair Society, Healthy Lives. The review identified the most effective evidence-based strategies for reducing health inequalities in England and made the following recommendation:

"Tobacco control is central to any strategy to tackle health inequalities as smoking accounts for approximately half of the difference in life expectancy between the lowest and highest income groups. Smoking-related death rates are two to three times higher in low-income groups than in wealthier social groups."

There are several papers linking tobacco use and smoking to issues around mental wellbeing the high smoking prevalence among people facing social and economic deprivation suggests that smoking may be seen as a stress coping mechanism. However, instead of helping people relax, smoking increases anxiety and tension. The feeling of relaxation is temporary and soon gives way to withdrawal symptoms and increased cravings. In the UK, smoking rates among adults with depression are about twice as high as among adults without depression. Most people start to smoke before they show signs of depression so it is unclear whether smoking leads to depression or depression encourages people to start smoking.

What will our objectives will be?

Building on the previous Tobacco Control Strategy for Lincolnshire we will develop a comprehensive Tobacco Control Plan for Lincolnshire based on the internationally recognised strands for Tobacco Control:

We will concentrate activity to:

- Prevent the uptake of tobacco use
- Support smokers from target groups to quit
- Tackle illicit tobacco sales
- Normalise smoke free environments

Priority 1.3 - Alcohol

Where are we now?

Levels of alcohol misuse can range from those at a low risk of harm through to those people who are considered to be alcohol dependant. Most of the population are considered to be at low risk of harm, the groups with higher levels of risk can be broken down into three main types:

- Dependant drinkers – it is estimated that 17,160 people in Lincolnshire fall into this group
- Higher risk drinkers – estimates indicate that 24,949 people in the County are in this category
- Increasing risk drinkers – over 106,000 people in Lincolnshire are thought to be drinking at a level indicating an increased risk to their health

In total these synthetic estimates show that Lincolnshire may have up to 148,109 people within the resident population who fall into the three highest risk groups in terms of their alcohol misuse. At the end of 2010/11 roughly 5% of the estimated 17,160 dependant drinkers in the county had accessed specialist treatment services.

This priority area is not taking the dependant drinking population as its main area of focus however. The recognised gap locally is more around the level of preventative work currently being done so that the increasing and higher risk drinkers of today do not become the dependant drinkers of tomorrow.

Why does this matter?

At a personal level alcohol misuse can impact negatively on family life, emotional wellbeing and employability. At the more sever end of the scale, four of Lincolnshire's seven districts are exceeding the regional and national averages in terms of months of life lost in males under 75 due to alcohol. Boston, East Lindsey, West Lindsey and Lincoln all exceed the wider average of 9.14 months of life lost for males under the age of 75 due to alcohol based on 2007 to 2009 data. This trend shows no sign of abating and latest data shows a 12% increase in alcohol related hospital admissions in Lincolnshire, here again Boston, East Lindsey and Lincoln all sit well above regional and national averages.

Put simply, excessive alcohol use is endangering increasing numbers of lives in Lincolnshire, these negative trends run largely in parallel to areas of deprivation across the county. Furthermore this trend shows no signs of changing direction in the near future; alcohol is having an increasing impact on healthy life expectancy and on the consumption of secondary care services in the county.

The links between mental health and alcohol consumption are also significant; mental health problems not only result from drinking too much alcohol. They can also cause people to drink too much. Put very simply, a major reason for drinking alcohol is to elicit a change in mood or mental state. Alcohol can temporarily alleviate feelings of anxiety and depression; it can also help to temporarily relieve the symptoms of more serious mental health problems.

Alcohol problems are more common among people with more severe mental health problems. This does not necessarily mean that alcohol causes severe mental illness. Drinking to deal with difficult feelings or symptoms of mental illness is sometimes called 'self-medication'; this is often why people with mental health problems drink. But it can make existing mental health problems worse.

Evidence shows that people who consume high amounts of alcohol are vulnerable to higher levels of mental ill health and it can be a contributory factor in some mental illnesses, such as depression. The Department of Health is likely to be publishing its updated Alcohol Plan later this year; therefore stakeholders from across the partnership will use this document in order to develop service principles further.

What will our objectives will be?

Looking at the evidence around trends in alcohol use and impacts both locally and nationally, the prevention strand of work is impossible to ignore. This is an area of activity which has been a gap for several years now with resources understandably being directed at acute treatment services. Our objective will therefore be to try and create a strategic lead for alcohol that can bring relevant stakeholders together to try and generate innovative ideas in order to share the responsibility of the prevention agenda.

Early identification is also a strand of work that this priority will work to progress, NHS health checks now include alcohol brief intervention/ brief advice questions (AUDIT C). It is hoped to embed this more systematically across primary care over the next 12 months. Both of these elements of work could benefit from increased attention and promotion, this will ensure that frontline staff across the partnership are 'Making Every Contact Count' and that people are able to access reliable information and signposting from a range of agencies across the county:

- Identify a strategic lead for alcohol who will coordinate a multi-agency partnership response to the Alcohol Plan and ensure a joined up approach to alcohol which incorporates prevention , early identification and treatment
- Work with partners to ensure systematic early identification and referral
- Continue to commission evidence based effective alcohol services.

Action Plan – Year One

1. Develop a comprehensive Multi-agency Mental Health Promotion Strategy for Lincolnshire which will inform the way forward over the next 5 years.
2. Work with the three main NHS Providers (LCHS, LPfT, ULHT) to develop a systematic 'Making Every Contact Count' programme based on SHA guidance and use CQUIN to support activity.
3. Map existing community health champion (or similar) activity across the county as part of the volunteering review, in order to inform a Lincolnshire Community Health Champion model which can inform a business case to allow it to be rolled out across the County.
4. Review existing healthy life style activity that supports people to eat more healthily, be more active and loose and maintain a healthy weight in order to address any gaps in provision.
5. Develop a comprehensive multi-agency Tobacco Control Plan which will maximise partnership approach to tackling tobacco control across the County over the next 5 years.
6. Identify a senior Alcohol lead that will ensure a multi-agency approach to addressing Alcohol issues across the county with a strong focus on prevention and early detection.

Action Plan Review (year's two to five)

1. The Mental Health Promotion Plan will act as an over arching plan to which we can be held accountable. This plan will ensure we have a wide range of partners committed to addressing mental wellbeing across the County.
2. Expand ‘Making Every Contact Count’ across all front line staff within the three main NHS providers by end of year two and continue to monitor activity and outcomes to ensure effective and equitable delivery.
3. Dependent on the review outcomes it is expected that we will have agreed a comprehensive and effective model for community health champions which will be evaluated to ensure it is reaching the ‘harder to reach’ people within our communities.
4. Implement and review partner contributions to the five year Tobacco Plan for Lincolnshire Maintain Lincolnshire’s high national profile in Tobacco Control.
5. Implementation of the five year Alcohol Plan for Lincolnshire.

THEME TWO – Improve the Health and Wellbeing of Older People in Lincolnshire

Our ambition is to:

Achieve a:

- shift in the Strategic Spend Profile; and
- support the further development of a Wellbeing Support Network to improve the health and wellbeing of Older People in Lincolnshire.

Strategic Spend Profile

Following extensive consultation with commissioners, providers, and service users; all involved in the Excellent Ageing programme have concluded and subsequently agreed, that *'shifting the Strategic Spend Profile'* is the most significant issue that would help change towards improving the health and wellbeing of older people in Lincolnshire, alongside earlier intervention and wellbeing services.

Shifting the Strategic Spend Profile would be the enabler to improvements in services; and if money in hospitals, and residential and nursing care, was reallocated over a period of time into front end service; upstream investment would lead to downstream savings.

There is recognition that this is a highly aspirational priority area, and a focus on this priority requires a real commitment from all commissioners and providers, alongside local communities.

Wellbeing Support Network

A key discussion point that has been repeatedly raised is the interdependency of issues for older people in the county, and how dealing with one would often have an impact on a number of others.

Support for the Wellbeing Support Network was put forward, and subsequently agreed, rather than prioritising a series of potential issues such as 'falls', 'food and nutrition' or 'loneliness', as there is significant evidence in both health and social care bases that universal, low threshold services, that intervene both reactively and proactively with people at risk of losing independence, are cost effective. To quote the recent paper on '*Commissioning of a Wellbeing Support Network'*; to be most effective, these services need to develop and maintain relationships with people and be able to escalate support for short periods of time, offsetting the need for referral into health and social care services.

It is anticipated that the Wellbeing Support Network, through access to universal, low threshold/community based services, will enhance wellbeing, and reduce or delay escalation to formal services.

This theme links to Marmot principles:

b) Enable all children, young people and adults to maximise their capabilities and have control over their lives

c) Create fair employment and good work for all

d) Ensure healthy standard of living for all

e) Create and develop healthy and sustainable places and communities

f) Strengthen the role and impact of ill health prevention

Priority 2.1 - Shifting the Strategic Spend Profile

Where are we now?

The Excellent Ageing programme was set up in July 2010 to improve the health and wellbeing of older people in Lincolnshire, in line with the 10 priority outcomes identified. Over 40% of the population of Lincolnshire are aged over 50 years, compared to 34% nationally. This is predicted to rise to nearly 50% by 2033, with an additional 100,000 plus people aged 65 in the County over the next decade.

Over 50% of the £875 million spent on over 50s in 2009/10 was on acute care (hospitals, and residential and nursing care), and a customer journey, based on a real life older couple; showed 29 interventions over 23 years, costing £500,000 and delivering very little real improvement. (See Appendix A, Deloitte Funding Flow Report, and Appendix B, Customer Journey)

How the Excellent Ageing programme can influence the total spend on older people, in order to start to deliver a shift from acute services to a wellbeing programme, has been a key focus of the Steering Group. Currently, funding is not coordinated effectively to deliver the best outcomes for older people, and there is no recognised strategic approach which policy makers, budget setters and senior managers are signed up to, which addresses this area.

There is already a commitment to this through the reablement monies from Health. The £9.1m, is additional funding focused on transformation, based on early work from Excellent Ageing to support the reablement programme and is a prequel to the Action Plan below.

Why does this matter?

As described above, the data in the JSNA illustrates the high proportion of older people aged 50 and over living in Lincolnshire, and the projections are for this proportion to increase over the next decade. This affects not just the obvious issues of health and social care, benefits and pensions, housing and transport, but also prevention of ill-health, promotion of well-being and quality of life, and work and volunteering opportunities. This inevitable change has been recognised, and through the Excellent Ageing programme we are embracing this change rather than just responding to it.

At the joint Excellent Ageing and Shadow Health and Wellbeing Board consultation event in October, made up of stakeholders (147 individuals from 53 organisations); there was agreement on the need for budgets to be focused on prevention and a widely held consensus that spend on acute provision is too high. The comment that this priority would be the solution to everything else is indicative of the overall view of those involved in the consultation exercise, and that it is viewed as an extremely significant priority.

What will our objectives will be?

Ultimately, this theme is seeking to improve the health and wellbeing of older people in Lincolnshire. In 5 years time there should begin to be a shift in the way resources are allocated to reduce both social and financial costs. We want to delay or avoid people in Lincolnshire accessing acute care, and ensure access to low threshold, universal provision, to help to improve their quality of life.

The Excellent Ageing programme has a long term vision that by 2020:

- Older people have more choice and control, can receive the help they need and are valued and respected within their communities;
- Public, private and voluntary sectors work together with communities in a seamless way to ensure service, facilities and resources meet demand and are accessible;
- Services and support are locally based, cost-effective and sustainable.

We will know we have made a difference, when older people feel that a positive impact and difference has been made to their lives when measured against the ten priority outcomes initially identified by the Excellent Ageing programme. In addition, when we see a reduced demand for secondary care provided in the traditional institutional style model.

Priority 2.2 - Support development of the Wellbeing Support Network

Where are we now?

The Wellbeing Support Network is a concept that already exists and Lincolnshire County Council's (LCC) Executive has already approved to the principle of commissioning such a service, building on that which already exists; such as First Contact, the FALLS service, and other NHS Lincolnshire and LCC commissioned interventions. (See Appendix D, examples of interventions).

In addition, Excellent Ageing already has a programme of projects under four Working Groups that underpin this objective around transforming services, and could support the Wellbeing Support Network concept in whole or part. (See Appendix E, list of Excellent Ageing projects).

As part of this, if the Excellent Ageing programme is going to succeed, we need to have a step change in what services or support mechanisms are already in the community, and this requires a mechanism to spread good and effective schemes into other communities and with some urgency.

As a programme, we have the opportunity to promote a system that enables skilled individuals to work alongside people in communities, to help build relationships with key people and organisations, and to identify common concerns. They can create opportunities for the community to learn new skills and, by enabling people to act together, help to foster social inclusion, equality, and to maximise the effective use of community resources.

Why does this matter?

There is significant evidence in both health and social care evidence bases that universal, low threshold services, that intervene both reactively and proactively with people at risk of losing independence are cost effective. To be most effective, these services need to develop and maintain relationships with people and be able to escalate support for short periods of time, offsetting the need for referral into health and social care services.

The scope of escalation would need to offer additional services, such as assistive technology, night visits, next day liaison and social inclusion activities. However, the scope falls short of personal care interventions. All of these interventions would require a co-ordination function, most usually a call centre/ assistive technology.

There are a significant number of providers who wish to pursue this course as a diversification from their role in either one or the other sector. Providers to some service user groups are already offering such integrated services whilst managing a complex set of performance and contract systems.

The JSNA analysis around major diseases and the older people population in Lincolnshire shows the need for increased early, wellbeing support services:

- Premature death from **heart disease** can in many cases be preventable in terms of lifestyle issues such as smoking and poor diet and healthcare support to control high blood pressure and cholesterol.
- The risk of **stroke** increases with age, and lifestyle can play significant part in reducing the risk of stroke including issues such as smoking, excessive alcohol consumption, poor diet and low levels of physical activity.
- Age is a key factor in **diabetes** prevalence and is also closely associated with deprivation. People with diabetes are also at an increased risk of having a stroke and dying from heart disease.
- **Obesity** is directly associated with deprivation, older age, low income, urbanisation, ethnicity, marital status, diabetes and hypertension. The distribution of obesity across Lincolnshire correlates with age, deprivation and disease trends.
- Physical inactivity as well as age related health conditions all increase peoples risk of **falling**.
- For every degree Celsius in temperature below the winter average there are an extra 8,000 **deaths** across the UK. Diseases related to circulation and/or respiration increases the risk for people during winter.

14 topic areas and options were considered by the theme group for prioritisation in the JHWS, (see Appendix F, October event feedback summary), but due to the interdependency of the issues raised for discussion, such as ‘falls’, ‘food and nutrition’ or ‘loneliness’, and the fact that dealing with one would often have an impact on a number of others, these two priorities were agreed.

Our stakeholders and older people have told us what their priority outcomes are, and we believe we can only see real step change in these outcomes for older people through addressing these two priorities, as a county (see Appendix C, 10 priority outcomes).

What will our objectives will be?

It is anticipated that the service model will reduce the likelihood of clients entering into the community support model, therefore reducing the burden on Adult Social Care Fairer Access to Care services (FACs). The service model will also offer an exit route for clients in receipt of Adult Social Care services whose needs have reduced, again reducing the burden on our Social Care partners.

The critical measures of success will be:

- increased numbers of people accessing lower level services; and the reduced demand for secondary care;
- diverting people away from secondary care by additional investment into community based wellbeing support services;
- in 5 years time; resources re-allocated away from secondary care based on a formula of a 1% reduction per year over 5 years producing savings for re-investment;
- more community based preventive services and less secondary based interventions or delayed secondary interventions into later life;
- older people having active and healthier lifestyles with community support and reduced demand for secondary care services; and
- accessible community support networks across the County and reduced demand for all forms of secondary care interventions.

Action Plan – Year One

1. Agree 1% from each of the Lincolnshire commissioners per year for a number of years to be agreed in year 1 (CCGs, Adult's Social Care) to be transferred to supporting the development of Wellbeing in the county. (NB: percentage and amount to be confirmed and reviewed annually).
2. Agree to a single pot of money with robust governance arrangements.
3. Agree a robust plan for distribution of the monies to ensure older people's needs are met.
4. Work with organisations across the public, private and voluntary, to map the current provision of services, groups and organisations set up to support Older People across the county by locality and what needs are being met. This should be worked through across the themes of the strategy.
5. Using the information established through the mapping described above; scope a long term programme to ensure a community is able to build its own capacity.
6. Support the development of the Wellbeing Support Network and its implementation from April 2013.

Action Plan Review (year's two to five)

1. Continued payment by commissioners of the agreed 1% (or amount as agreed on review), into the single pot agreed in year 1 to support the development of Wellbeing in the county.
2. Continued support for the development of the Wellbeing Support Network to ensure it is meeting the needs of the older population through the provision of low threshold, universal and accessible services.

THEME THREE – Delivering High Quality Systematic Care for Major Causes of Ill Health and Disability

Our ambition is to:

Ensure that everyone who needs it can access evidence based programmes of:

- Primary prevention
- Risk identification and management
- Long-term condition management

This theme links to Marmot principles:

g) Ensure healthy standard of living for all

f) Strengthen the role and impact of ill health prevention

Priority 3.1(a) - Long Term Conditions (Diabetes)

Where are we now?

The National Service Framework (NSF) for Diabetes was established in 2001 to improve services by setting standards to improve quality and tackle variations in care. The 12 standards address issues in relation to the prevention of diabetes through to the detection and management of diabetic complications. In 2011, The National Institute of Health and Clinical Excellence (NICE) produced some quality standards to compliment the NSF standards.

There is evidence to show that:

- The onset of Type 2 diabetes can be delayed, or even prevented
- Effective management of the condition increases life expectancy and reduces the risk of complications
- Self-management is the cornerstone of effective diabetes care.

A lot of work has taken place in Lincolnshire to address the standards set out in the NSF, for example, development of preventative programmes, management in primary care through the delivery of the Quality Outcome Framework (QOF) and development of educational programmes to help people manage their condition.

Diabetes is a core topic in Lincolnshire's Joint Strategic Needs Assessment. This provides information on the prevalence of diabetes amongst the Lincolnshire population and differences that exist across the County. Diabetes does not affect everyone equally. The risk of developing diabetes, particularly type 2, increases with higher levels of deprivation. Prevalence also increases with age. It is not only the risk of developing diabetes that is associated with deprivation. Diabetics who experience higher levels of deprivation also have increased levels of mortality and morbidity resulting from diabetes complications.

Information from the JSNA shows that the mean prevalence of recorded cases of diabetes in 2009/10 was 4.92%, the highest prevalence being 6.50% in East Lindsey and lowest at 4.03% in Lincoln. This very much reflects the levels of deprivation and age structures of people living in these areas.

This gives a modelled estimate mean prevalence for all cases over the same period again being highest in East Lindsey estimated at 6.00% and lowest in Lincoln estimated at 4.29%.

Extrapolating to 2025 the county average is likely to be in the region of 7.25%. Again East Lindsey is likely to see highest rates at 8.97% whilst Lincoln is predicted to see the lowest prevalence at 5.76%. This Lincolnshire wide projection is higher than the national projected average at 2025, which is 6.48%.

In Lincolnshire, 54% of all people with diabetes aged 17 years and older who are not excepted from the QOF, have an HbA1c of 7% or less (an important dimension of diabetes care).

Why does this matter?

Diabetes is a chronic and progressive disease that impacts upon almost every aspect of life. It affects people of all ages, and is becoming more common. Type II diabetes is largely caused by obesity, and thus many cases are preventable. People with diabetes:

- Are twice as likely as people without the condition to die between the ages of 20 and 79
- On average have a reduced life expectancy of 15 years
- Are five times more likely to die from coronary heart disease
- Are three times more likely to have a stroke
- Women who are pregnant have an increased risk of complications

Cost of diabetes in terms of health and social care services are:

- Around 5% of the total spend on NHS services
- Up to 10% of the spend on hospital in-patient services
- Diabetic patients are twice as likely to be admitted to hospital as the general population
- Diabetic patients are likely to have twice the average length of stay in hospital
- NHS Cost from diabetic complications increased more than five fold
- Social Service Cost from diabetic complications increased four fold

What will our objectives will be?

- To halt the year on year rise in the proportion of the population who are obese (**DN** there is presumably a target elsewhere in the strategy, and this objective will need to match)
- To increase the proportion of patients with diabetes who are diagnosed, and included on the Register of patients with diabetes maintained by their general practice.
- increase the proportion of patients with diabetes who have an HbA1c of 7.5% or lower

Priority 3.1(b) - Long Term Conditions (Chronic Obstructive Pulmonary Disease, COPD)

Where are we now?

In Lincolnshire COPD has been a priority for a number of years. Having established a clear strategy and referral pathway a large amount of work has been undertaken to respond to the discrepancies of resources and service provision that existed across the county. To ensure excellent and consistent standards in care, reduce inappropriate secondary care activity and improve access across the community, the following provision has been made:

- Additional services to extend Lincolnshire Community Health Service's Respiratory Services. This has increased access across the county to Early Supported Discharge, Acute Respiratory Assessment, and COPD complex case management services in the community
- Countywide Adult Oxygen Assessment Service provided for patients with COPD, is a joint service provide by Primary and Secondary Care
- Community Pulmonary Rehabilitation provision has been extended across the whole county and has increased access for COPD population from 1.7/2.4% to 5% of patients (640 patient places per year)
- Improved skills, knowledge and care provision in Primary Care

Service improvement in COPD care needs to be a continual cycle and will be continued to be reviewed and enhanced by GP Commissioning Consortia.

Why does this matter?

Chronic Obstructive Pulmonary Disease (COPD) is a chronic, disabling disease causing a gradual decline in lung function with increasing episodes of chest infections and exacerbations as the condition progresses. In the UK COPD is the fifth biggest killer, the second most common cause of emergency admission to hospital and one of the most costly inpatient conditions treated by the NHS.

In 2009/10 the recorded COPD prevalence in Lincolnshire was 1.9% of the population. In some areas of the county (e.g. East Lindsey) this reaches as high as 2.52%.

For all of the wards within Lincolnshire the estimated prevalence is higher than the recorded prevalence.

Smoking is much the biggest single risk factor for COPD. Prevalence also rises with age, and is higher in areas of deprivation. Thus in Lincolnshire the prevalence of COPD is higher in those areas that experience higher levels of deprivation such as Lincoln, Boston and East Lindsey. These areas also have the highest percentage of adults reported smoking.

An additional factor along the east coast is that a large number of older people with pre-existing disease have migrated into the county, often from former mining areas.

The number of COPD Emergency Admissions in 2009/10 (per 1,000 population – all ages) was reported as 1.09% for Lincolnshire; the highest rates of hospital admissions are found in Lincoln, Boston and South Holland.

What will our objectives will be?

- To reduce the proportion of adults who smoke (**DN** there is presumably a target elsewhere in the strategy, and this objective will need to match)
- To reduce the number of unplanned hospital admissions due to COPD

Priority 3.1(c) - Long Term Conditions (Coronary Heart Disease, CHD)

Where are we now?

The number of deaths from Coronary Heart Disease (CHD) in people aged under 75 has dropped dramatically in Lincolnshire, with greater than a 40% reduction over the past 12 years.

Despite this reduction, CHD continues to be a key cause of premature death across the county, and there is significant evidence of how this could be addressed. Further reductions could be expected from improvements in lifestyle (especially a reduction in smoking rates, and a reduction in the proportion of the population who are obese), and better treatment (especially better control of blood pressure and improvements in care following myocardial infarction).

Lincoln has the highest number of premature deaths from CHD at 52.01 per 100,000 people, but the lowest recorded prevalence of CHD at 3.63% which could indicate that we are missing people off the CHD Quality Outcomes Framework (QoF) register.

Each GP practice has a CHD register and the recorded prevalence in Lincolnshire is lower than the modelled prevalence. This could indicate that there are a number of patients still missed off the disease register and not being treated appropriately.

Why does this matter?

CHD is a key health inequality and a primary cause of premature death across the county. Early detection of people at risk of CHD enables them to take advantage of evidenced based primary care services, such as controlling high blood pressure and cholesterol. Risk factors linked to CHD, such as lifestyle choices (including smoking, lack of physical activity ,a poor diet and being overweight), poor housing and low education attainment as well as low uptake rates of treatment within primary care (in particular to cholesterol and blood pressure lowering treatment or smoking cessation services) are often more prevalent in areas of higher deprivation.

Collectively, vascular disease (heart disease, stroke, diabetes and kidney disease) affects the lives of more than four million people and kills 170,000 in the UK every

year. These conditions also account for more than half the mortality gap between rich and poor.

What will our objectives will be?

- To reduce mortality rates from coronary heart disease (**DN** need to insert here the targets that have been agreed with East Midlands SHA)
- To reduce the variation in performance between general practices in the QOF indicator relating to the proportion of patients who following a myocardial infarction receive treatment with aspirin, a statin, an ACE inhibitor and a beta blocker.

Priority 3.1(d) - Long Term Conditions (Stroke)

Where are we now?

Using the recorded prevalence for the disease, around 2.04% of the population (14,280 people based on a 700,000 population) are recorded as having had and are living with the disease in 2010. This prevalence figure has risen steadily year on year from around 1.9% (13,300) in 2005.

This recorded prevalence from people who have had a stroke is still less than the estimated level. Modelled estimates suggest a slightly higher number of people have had a stroke in the county (2.24%, 15,680) by 2010.
Geographically, the highest prevalence of the disease is in East Lindsay (2.44% - 2.58%) with the lowest prevalence in the district area of South Kesteven, 1.88% actual prevalence. This geographic split has remained constant over both time (since 2005) and in estimated modelled figures.

By the year 2020, it is estimated that 3.10% or the population will have had a stroke, which with an estimated growing population in the County might equate to roughly 20,000 people living with the consequences of this disease.

Using age standardised, data the admissions rates for Stroke in the County in 2009-2010 was just 1.03 per 1,000, meaning approximately 1030 people were admitted for a stroke in the last year in the county's hospitals. The highest admissions rates were in the Boston and South Holland areas.

When looking at mortality (i.e. deaths) from stroke. Using a yearly moving average in 2009 the directly age standardised death rate from stroke was 12.1 per 100,000 population. This would equate to roughly 88 people dying from stroke from the county during these 12 months. The highest death rates (which will none the less be numerically small) are recorded in East Lindsey and Boston. Such data must be treated with caution however as this death rate seems abnormally low.

Why does this matter?

Stroke is the third biggest cause of death in the UK and the largest single cause of severe disability. Each year over 110,000 people in England will have a stroke (with direct costs to the NHS of over £2.8 billion). Stroke causes disability in 250,000

people in the UK and contributes to wider costs of £7 billion (e.g. lost income, long term benefits and informal care costs). Key issues regarding stroke include:

- The risk of stroke increases with age – most strokes occur in people aged 65 years and over
- Men have a greater risk of premature mortality as a result of a stroke than women
- Hypertension (high blood pressure) is the single most important risk factor for stroke
- People with diabetes are 2 to 4 times more likely to die from a stroke
- Smokers are 50% more likely to have a stroke than non-smokers; smokers are more likely to have a second stroke than non-smokers

Other risk factors include: obesity; excessive alcohol or binge drinking; poor diet with low consumption of fruit and vegetables; low levels of physical activity.

What will our objectives will be?

- To increase the proportion of patients who have a stroke who are admitted to hospital within three hours of the onset of symptoms
- To increase the proportion of patients who have a stroke who are treated in a specialist stroke unit

Priority 3.2 - Cancer

Where are we now?

The Directly Age Standardised Rate (DASR) for the incidence (number of new cases) of cancer per 100,000 females aged under 75 years between 2005 and 2007 shows an average of 307.33 with:

- Highest rate in Lincoln at 352.48 per 100,000
- Lowest rate in South Holland at 275.06 per 100,000

The Directly Age Standardised Rate (DASR) for the incidence of cancer per 100,000 males aged under 75 years between 2005 and 2007 shows an average of 314.12 per 100,000 with:

- Highest rate in South Holland at 338.69 per 100,000
- Lowest rate in East Lindsey at 290.79 per 100,000

Between 2007 and 2009 the DASR for deaths from cancer in females aged under 75 years shows an average of 102.89 per 100,000 with:

- The highest rate is in Lincoln at 121.31 per 100,000
- Lowest rate is in East Lindsey at 90.91 per 100,000

Between 2007 and 2009 the DASR for deaths from cancer in males aged under 75 years shows an average of 124.22 per 100,000 with:

- The highest rate is in Lincoln at 138.07 per 100,000
- Lowest rate is in East Lindsey at 118.24 per 100,000

This data shows the following:

- There are more new cases of cancer, and more deaths from cancer, in men than in women. This is primarily due to men having higher smoking rates and a poorer diet than women
- Incidence rates and death rates from cancer vary within the county. As the City of Lincoln is the most deprived area in Lincolnshire it is not surprising that it has high numbers of new cases and deaths compared to the average for Lincolnshire.

Why does this matter?

One in three of us will be diagnosed with cancer at some point in our lives, and around one quarter of us will die from cancer. Most cases of cancer are preventable: smoking (on its own responsible for one third of all cases), obesity/poor diet, high alcohol consumption, sunburn and occupational exposure are the main risk factors.

There are national screening programmes for breast cancer, cervical cancer and colorectal cancer.

There are challenging targets relating to the time taken to diagnose cancer, and then to start treatment.

Survival rates have improved substantially in recent years. For example, over 80% of women diagnosed with breast cancer are still alive five years following diagnosis. "Survivorship" is therefore an important issue in cancer care.

What will our objectives will be?

- To reduce mortality rates from cancer (**DN** need to insert here the targets agreed with the East Midlands SHA)
- To meet national waiting times targets
- To increase uptake rates for the national cancer screening programmes

Action Plan – Year One

1. Finalise membership of the Lincolnshire Cancer Strategy Group, to include representation from each Clinical Commissioning Group.
2. Produce the Cancer Strategy for Lincolnshire.
3. Ensure that there is a county-wide lead commissioner for cancer.
4. Work with United Lincolnshire Hospitals NHS Trust to ensure that national cancer waiting times targets are met consistently.
5. Ensure engagement within each Clinical Commissioning Group with the Early Presentation of Cancer (EPOC) initiative.
6. Assess Lincolnshire's performance against the NICE Diabetes in Adults Quality Standards.

7. Review the performance of each general practice in the county against relevant indicators within the Quality and Outcomes Framework.
8. Work with United Lincolnshire Hospitals NHS Trust to increase the proportion of patients with a myocardial infarction who are treated by means of primary angioplasty.

Action Plan Review (year's two to five)

1. Implement the Lincolnshire Cancer Strategy.
2. Continue to implement the EPOC programme in Lincolnshire.
3. Ensure implementation and use of the Macmillan referral guidance.
4. Monitor, and thereby improve, uptake within Lincolnshire of the NHS cancer screening programmes.
5. Use the Health Inequalities National Support Team (HINST) tool to develop and implement a plan for delivering the contribution of primary care to the management of diabetes, cardiovascular disease and chronic obstructive pulmonary disease.

THEME FOUR – Improving health and social outcomes and reducing inequalities for children

Our ambition is to:

Ensure all children, young people and their families in Lincolnshire are supported to allow optimum health development, including emotional and mental health. Strong foundations here will increase self-confidence, self-esteem and ultimately help them achieve improved social outcomes.

This theme links to Marmot principles:

c) Give every child the best start in life

d) Enable all children, young people and adults to maximise their capabilities and have control over their lives

e) Create fair employment and good work for all

g) Ensure healthy standard of living for all

h) Create and develop healthy and sustainable places and communities

i) Strengthen the role and impact of ill health prevention

Priority 4.1 - Early years impacts on health and social outcomes

Where are we now?

Children's health and social outcomes are initially determined during their time in the womb and their early developmental years. Therefore, early access to maternity care is an important opportunity for healthcare professionals to interact and build relationships with women and families who, although in most need would not otherwise access services. Early access allows midwives to monitor the pregnancy, the baby's growth and development and focus on the mother's health & wellbeing, including lifestyle factors such as diet, physical activity, smoking, drugs and alcohol. Information on benefits, housing, free vitamins available through the Healthy Start programme along with support to breastfeed are also vitally important at this stage to address the health inequalities experienced by children within our most vulnerable groups. Initiative such as Families Working Together support families through targeted, coordinated support from all essential agencies.

Evidence suggests five critical factors during the foundation years:

- **Children's health in early life:** this includes factors such as low birth weight and affects wellbeing, development and behaviour. A child's health is strongly influenced by their parents' health and behaviour, particularly that of their mothers. Smoking and nutrition in pregnancy, breastfeeding and immunisations are key predictors of children's health in later life;
- **good maternal mental health:** mothers' mental health is significantly associated with child development outcomes, particularly social, behavioural and emotional development;
- **quality of parenting and parent-child relationships:** children do better when they have a close and positive relationship with their parents, and mothers and fathers work together to provide warm, authoritative, responsive, and sensitive parenting;
- **learning activities:** the things that parents help children to do at home, like reading and playing, are key predictors of future development and readiness for school;
- **high-quality early education:** making a difference to children's achievement in the early years is crucial. Pupils who start off in the bottom 20 per cent of attainment at age five are six times more likely to be in the bottom 20 per cent at key stage one.

Early Access to Maternity Care: Across England approximately 16% of women delay booking into maternity care until after 5 months, this delay often results in worse outcomes for both mother and baby. Across Lincolnshire around 90% of pregnant women book for their antenatal care before their 12th week of pregnancy.
In Lincolnshire optimal children's health outcomes are achieved by offering support and information to mothers and their families before and during pregnancy along with the child's early years. Generic maternity services provide Midwifery and Obstetric care through United Lincolnshire Hospitals Trust (ULHT) to all women living in Lincolnshire. This includes all antenatal, intranatal and postnatal care. Normally, postnatal care transfers to the Lincolnshire Community Health Service (LCHS) when the infant is 10 days old. The Healthy Child Programme offers support and interventions where appropriate from birth to 19 years of age. LCHS's Health Visiting and School Nursing teams deliver the Healthy Child Programme in Lincolnshire. Lincolnshire County Council's (LCC) Children's Centres also support antenatal care and deliver elements of the Healthy Child Programme in partnership with LCHS generic teams. The third sector organisation Home Start is commissioned by NHSL and LCC to offer support to families and in particular those who are most vulnerable. HELP project to support birth to 5 years is commissioned by LCC.

Breastfeeding. There is a wealth of evidence which acknowledges breastfeeding has both short and long-term health benefits for mothers and babies. The World Health Organisation recommends that wherever possible infants should be fed exclusively on breast milk from birth until six months of age. The overall breastfeeding rates in Lincolnshire are around 39% to 40% of mothers continuing to breastfeed until their baby is 6 to 8 weeks of age. Nevertheless, in more deprived areas the rates are between 25% and 30%. In Lincolnshire, staff from a range of backgrounds along with service users are working together to improve breastfeeding rates through increased education for staff, support (including peer support) and information for women.
This work also includes raising the profile of breastfeeding in other areas for example through the media, breastfeeding friendly restaurants or cafes and working with Local Authority planners. The UNICEF Baby Friendly initiative is currently underway across Lincolnshire. The purpose of this is to offer training to all staff who are involved with

pregnant and postnatal women to be able to offer support for breastfeeding.

Smoking during Pregnancy is the single most modifiable risk factor influencing adverse health outcomes in children. Although, only a small proportion of women continue to smoke during pregnancy; around about 17% in Lincolnshire, these tend to be the heaviest and most addicted smokers who find it more difficult to stop. NHS Lincolnshire has committed significant resources to specialist stop smoking services for pregnant women since 2005. An important aspect of stop smoking services for pregnant women is that if the quit attempt during pregnancy is not successful then women should continue to be advised to stop after their child is born. **Lincolnshire Smoke Free Homes** is a countywide initiative with **20,312** homes in Lincolnshire are currently signed up to a promise to reduce the amount of cigarette smoke within rooms. The focus of this work is on the most vulnerable and deprived populations. This helps protect around **21,209** children from the effects of second hand smoke in their own homes within some of the most deprived areas in Lincolnshire.

Antenatal Obesity poses significant risk to mothers during pregnancy and delivery. Babies born to obese women also face several health risks including a higher risk of stillbirth, congenital abnormality and subsequent obesity. The NHS Lincolnshire Antenatal Weight Management Project is a pilot initiative, which targets women with a 12 week booking BMI >30 by providing an assessment and personalised advice on healthy eating and how to be physically active during their pregnancy.

Antenatal and Newborn Screening: Undetected infection, inherited conditions and physical problems which have appeared without previous warning can cause extreme distress for the parents. Early Public Health detection protects, prepares and allows for early diagnosis and treatment which improves the overall developmental, health and social outcomes for the child. There are 6 Programmes available in Lincolnshire:

1. Infectious Disease in Pregnancy
2. Sickle Cell and Thalassaemia Screening
3. Foetal Anomaly Screening
4. Newborn Blood Spot Screening
5. Newborn Infant Physical Examination
6. Newborn Hearing Screening Programme

Childhood Immunisation

One of the most important things that a parent can do for their child is to make sure that they have all of their routine childhood vaccinations. It's the most effective way of keeping them protected against a range of serious and potentially fatal infectious diseases. If more parents have their children vaccinated, this increases the numbers of children in the community protected against catching the disease. This helps reduce the overall numbers of children who are able to pass the disease on to others therefore, the chance of an outbreak of the disease is lower: this is called ‘Herd Immunity’.

Teenage pregnancy is a complex and serious social problem. Having children at a young age can influence young women’s health and wellbeing, severely limit education and career prospects and result in negative health outcomes for their children, who are significantly more likely to become teenage parents themselves. In Lincolnshire the conception rates for girls living in areas of very high deprivation are over 4 times greater than those of girls from the most affluent areas. The Lincolnshire

Teenage Pregnancy Strategy focuses both on high rate areas and high-risk groups, maximising the impact these services have on health inequalities in children.

The Child Poverty Act (2010) and Lincolnshire Child Poverty Strategy: this legislation compels Governments at local and national levels to take positive action to achieve this. The Strategy has been written in partnership with all agencies involved with both the causes and outcomes of poverty, these include: local authority education, housing, children's & adult social services, job centre plus, police, probation and youth offending teams, health services, voluntary and third sector organisations, local people along with children and young people. The priority outcomes are: maximising family income and narrowing the gap in health and education outcomes between the most disadvantaged and affluent in Lincolnshire.

Why does this matter?

Health inequalities can be defined as: ***General differences in health outcomes between different populations which cannot be explained in biological terms, and are mainly due to social or economic factors.*** Children are amongst the most vulnerable sections of society. As such, they are greatly affected by the outcomes of any social and economic deterioration surrounding them. These inequalities mean poorer health, reduced quality of life and an overall shorter life expectancy for many. Children are susceptible throughout their life course; from before birth and all the way through their crucial developmental, preschool and school years.

Their early physical and emotional development will eventually help determine educational and social progress, employment prospects and health outcomes. The need to ensure all children within Lincolnshire get the support they need to obtain the best start in life is obvious. Social inequalities in breastfeeding exist, where more affluent mothers are more likely to successfully breastfeed than mothers from deprived areas. Nevertheless, we must be aware that breastfeeding has a greater impact on the health outcomes of more vulnerable infants. Breastfeeding is a crucial line of attack to decrease inequalities in children's health, including: lowering infant mortality rates, reducing preventable infections and unnecessary hospital admissions in infancy, halting the rise in obesity in under 11s and improving the general health and well-being of children and young people. Smoking during pregnancy can increase the risk of infant death by up to 40%. It also increases the risk of premature labour and is likely to cause growth restriction of the baby in the womb where the baby is starved of vital nutrients and loses weight. Low birth weight is closely associated with poor health outcomes in childhood and later in adult life. The numbers of people smoking within more disadvantaged communities is higher than affluent populations. Children are also more vulnerable to the health effects of cigarette smoke because they have higher oxygen demands, smaller airways and faster breathing rates. Small children receive a higher nicotine dose from smoke compared to adults and this can: increase their risk of cot death and respiratory disorders.
Poorer access to screening and vaccination services along with greater numbers of obese pregnant women, etc. are all closely associated with more vulnerable families.

A universal Public Health measurable end point is: **Infant Mortality**. This is the number of babies who die before their first birthday. It is an important indicator of inequalities in health outcomes for children and society as a whole. Although the overall infant mortality rate in England has fallen to just under 5 deaths per 1000 births, there continues to be a gap in outcomes between the poorer and more affluent groups in society. Infant mortality is closely associated with all aspects of health

inequalities and deprivation; housing quality and living environment, maternal lifestyle factors, infant feeding choice, smoking, early access to maternity services and so on. These in turn are directly affected by the education level of the mother, her age, her income, etc. Crucially, there is no single method of tackling these wide-ranging causes. Babies born in the most deprived areas of England can be up to 6 times more likely to die than those from more affluent areas. This trend is reflected in Lincolnshire where infant mortality rates are greater within our more deprived populations. In particular, over 86% of the Skegness and Coast population demonstrate significant levels of deprivation; Boston, South Holland and Lincolnshire West also exhibit higher concentrations. Demonstrating the 'layering effect' deprivation has on society.

What will our objectives will be?

Conclusion: Impacting on children's health and social outcomes in the early years is not easy to address, the evidence clearly shows that any one agency on its own will not have sufficient impact to guarantee a reduction in the gap currently observed between populations. The examples of current services and strategies within this chapter specifically focusing on improving outcomes illustrate that actions need to be executed in partnership with all agencies involved in the wider causes and outcomes of child health inequalities. Early interventions are central to improving health and social outcomes in children (Marmot Fair Society, Healthy Lives 2010, Maternity Matters 2007, Child Health Programme 2009, Maternity and Early Years: making a good start to family life 2010).

Objectives:

1. More women and families will have access to support and information from all agencies involved in their care; before, during and after pregnancy to ensure they are fully informed of lifestyle influences on their health and that of their children along with information to tackle the broader social determinants of health such as benefits maximisation, educational opportunities, housing issues, etc.
2. Agencies and the public will work together to action the Child Poverty Strategy: therefore, reducing the impact of child poverty on children's lives by tackling the underlying causes and mitigating the effects
3. More women and families will have access to support and information from all agencies involved in their care; before, during and after pregnancy to ensure they are fully informed of the benefits of immunisation and antenatal and newborn screening.
4. More young people will access appropriate sex and relationship information and will have easy access to contraception and genitourinary medicine services.
5. More children will have access to good quality education throughout their life course.

Priority 4.2 - Social and emotional development and mental well being

Where are we now?

A child's social & emotional development and subsequent mental health outcomes has significant implications for current and later social functioning, educational and employment success. If emotional development is fostered at a young age, children are more likely to settle well into school, work cooperatively, confidently and independently, and behave appropriately. A child with poor social and emotional development is at risk of fostering worse relationships with peers, academic problems, later involvement in crime and developing physical health and adult mental-health problems. Some of the most challenging issues we face arise from young people's perception of not feeling engaged, respected, listened to or valued.

The emotional and mental health of children and young people in Lincolnshire is currently addressed through many agencies and covers an extremely broad age range, settings, methods and many varying levels of severity and consequent need. **Building Emotional Resilience**: During the child's early years, the emotional and physical development is primarily assessed and supported through the implementation of the Healthy Child Programme where Health Visiting teams and colleagues in Children's Centres recognise the importance of emotional and mental health development in reducing health inequalities in children. As the child progresses to school the School Nursing Service supports school aged children (whether they are attending state school or not). These programmes work alongside the many other agencies that support this statutory work.

Obviously a child's emotional development cannot be considered in isolation and a major influence on any child's development is the mental health of their parents. Postnatal depression and puerperal psychosis can severely affect the mother during the early months or even years of their child's life. Identification and early treatment is essential to improve outcomes.

In Lincolnshire the Healthy Schools Team supports the social and emotional development of the child's early relationship with parents or caregivers. This helps provide a secure base from which children grow into well-rounded, capable adults with robust mental health. Programmes include: Pyramid, Peer Mediation and School Council. The Targeted Mental Health in Schools Programme (TaMHS) was a three-year pathfinder programme aimed at supporting the development of innovative models of therapeutic and holistic support in schools for children and young people aged 5 to 13 years and their families. NHS Lincolnshire (NHSL), Lincolnshire County Council (LCC) and Lincolnshire Partnership Foundation Trust (LPFT) have used this model to provide the current Tier 2 service: Triple P, utilising integrated social care teams working across the schools pathway. LPFT's primary care service offer support and training to schools on 5 main topics: Depression, Eating disorder, Attachment, Self-Harm and Anxiety. Other initiatives in Lincolnshire include Kooth on line counselling provided by Lincolnshire County Council.

Bullying and Self Harm: The Lincolnshire County Council Multi Agency Anti Bullying Working Group meets regularly and is attended by a wide range of partners with positive progress being made and reported back to the Anti-Bullying Partnership Steering Group. Our latest data shows that in Lincolnshire Primary schools 21.5% of pupils say they have been bullied compared to 22.1% nationally and in Secondary schools 12.3% of pupils say they have been bullied compared to 11.3% nationally. The Healthy Schools team provide awareness raising for pupils and staff on issues surrounding bullying including homophobic bullying in schools. **Self-Harm** is a way of

expressing very deep distress. This is a broad term used to describe how people may injure themselves intentionally through physical injury or poison. In Lincolnshire in 2009 / 10 there were 157 young people aged 12 to 17 years admitted to hospital as a result of self-harm. The majority of these were admitted following the ingestion of a poison / drug. These figures are only for admissions to hospital, there are many more minor attendances linked with self-harm and understanding these is central to developing a successful strategy. One group in particular who are at greater risk of self- harm and therefore in need of additional support and interventions in Lincolnshire are Looked after Children (LAC). **Children with disability**: families, children and young people require additional support to ensure they maximise all opportunities to improve their health and social outcomes.

Children and Adolescent Mental Health Services (CAMHS)

The Children and Adolescent Mental Health Service in Lincolnshire comprise of 4 Tiers in total and there is an approximate budget of £7 million across the community.

Tier 1: preventative services "everybody's business"

As discussed earlier this is a very broad base of many services being delivered by many agencies. As a result this preventive tier is patchy at times and will benefit from being part of the overarching Health and Wellbeing Strategy for Lincolnshire.

Tier 2: rapid access, short term interventions

Tier 3: structured multi-disciplinary intervention and treatment in the community

Tiers 2 and 3 are delivered by Lincolnshire Partnership Foundation Trust (LPFT)

Primary Mental Health Service (Tier 2 supporting Tier 1) is a team of 12 Primary Mental Health Workers covering the county, providing early intervention and preventative services. Consultation is available to any agency including GPs where there are concerns about developing mental health difficulties or a deterioration in emotional well-being.

Specialist (Tier 3) teams, now organised into North Area and South Area teams, see children with moderate or severe depression, bipolar disorder, anxiety, OCD, anorexia nervosa, bulimia nervosa, somatoform disorders, self- harming behaviours/suicidal ideation, severe ADHD, complex trauma and psychosis. For each condition LPFT are able to offer. Specialist Child & Family Services staff also work in Youth Offending Services, with foster carers of Looked After Children, with ULHT children's diabetes service, and with staff from Addaction in accordance with a jointly agreed pathway

Tier 4: Specialist (Tier 4) adolescent mental health inpatient unit Ash Villa is a 12 bed facility for 11-17 year olds providing intensive assessment and intervention for young people with complex disorders.
LPFT also provide very specialist (Tier 4) expertise for children with mental health disorders and severe learning disabilities, and children requiring a clinical forensic psychology assessment.

Clearly building resilience within the Lincolnshire population to support healthy emotional development and proactively address issues of delayed development, poor self-esteem, bullying, self-harm and more serious mental health issues is

fundamental. There are clear interdependencies between current groups and strategies across many different agencies, for example: Parenting Strategy, Safeguarding, Suicide Reduction Strategy, Children and Young People Strategic Partnership, Bullying Strategy, Self-Harm Pathway and the Overarching Mental Health Strategy. Other areas where emotional and mental health also crosses over: sexual health services, teenage pregnancy, drug and alcohol services, stop smoking, employment and worklessness, obesity strategy, Youth Offending, Looked after Children and Children with Disability Strategy. This list is not exhaustive and it is important to highlight that this serious issue affects many children and young people throughout their life course.

Examples of emerging issues:

- Increased cyber / social network bullying
- Increased sexual grooming / assault
- Body image / anorexia
- Self-harm
- Domestic violence including child on parent abuse
- General conduct and behavioural problems
- Increased diagnosis of Autistic Spectrum disorders

Why does this matter?

Mental health is an intrinsic part of wellbeing and not just the absence of mental illness.

There is growing evidence that improving wellbeing, including mental wellbeing, increases the resilience of individuals and groups and has a wide range of benefits across society including reduced mental illness and suicide, improved physical health and life expectancy, better educational achievement, reduced health risk behaviour such as smoking, alcohol and drug use, improved employment rates and productivity, reduced antisocial behaviour and criminality, and higher levels of social interaction and participation (No Health without Mental Health 2011).

Mental ill-health is common with a significant impact on individuals, their families and the whole population: 22.8% of burden of disease in UK is due to mental disorder and self-reported injury compared to 15.9% for cancer and 16.2% for cardiovascular disease (WHO, 2008). Mental ill-health affects people early, (50% of cases occur by age 14) and without intervention it can damage educational attainment, employment and a range of future outcomes. Because of the broad range of impacts over a long period some, but not all, of the economic consequences can be calculated.
One in ten children between 5 and 16 years have mental health problems, many continue to have mental health illness in their adult years. We estimate in the UK that 1 in 10 of new mothers develop post natal depression. As discussed earlier this can have a significant impact on the emotional development of young children. The 4-Tier comprehensive CAMHS model (Together We Stand, 1995, National Service Framework for Children Young People & Maternity Services 2004) remains the optimum means of providing for the spectrum of mental health disorders and psychological problems of childhood although it is currently under threat from financial restraint (Young Minds 2011).

What will our objectives will be?

The objectives for this area of the strategy should mirror those of the National Mental Health and Wellbeing Strategy 2011: No Health without Mental Health'.

1. More children and young people will have good mental health
2. More children and young people with mental health problems will recover
3. More children and young people with mental health problems will have good mental health
4. More children and young people will have a positive experience of care and support
5. Fewer children and young people will suffer avoidable harm
6. Fewer children and young people will experience stigma and discrimination
7. Build self esteem and improve resilience so that young people are able to make informed and healthy/ safe choices as they move towards independence

Priority 4.2 – Childhood Obesity

Where are we now?

Both internationally and within the UK there is widespread concern about the increasing prevalence of obesity and overweight among adults and children. The health, social and personal cost associated with a consistent increase in the prevalence of overweight and obesity will undoubtedly overwhelm both services and personal lives in the future if this rising trend is not reversed. In 2008 the Government launched the *Healthy Weight, Healthy Lives: A Cross-Government Strategy for England* which outlined the ambition to be the first major nation to reverse the rising tide of obesity and overweight in the population. The initial focus of this strategy was on children with the goal of reducing the proportion of overweight and obese children to the 2000 levels by 2020. Subsequently the Government's White Paper, *Healthy Lives, Healthy People: Our strategy for public health in England* has established commitment to improving public health and tackling causes of premature death and illness, including obesity. Tackling childhood obesity is an important issue for Lincolnshire to prevent long term illness and tackle health inequalities.

Tackling childhood obesity in Lincolnshire: Tackling childhood obesity requires a broad multifaceted partnership approach to influence the factors that can lead to obesity. The causes of obesity are complex and relate to a number of genetic, behavioural, psychological, social, cultural and environmental factors.
It is recognised that we now live within an 'obesogenic' society where our modern lives are more sedentary involving less walking, less play, reliance upon cars, changing food and eating habits and changing work patterns. These factors lead to 'passive obesity' which results in approximately a 0.5% year on year increase in obesity.
While a number of national and local initiatives aimed at preventing childhood obesity currently exist, there is yet to be a systematic approach within the county. To this end, NHS Lincolnshire, Lincolnshire County Council and other partners aim to work collaboratively to -

1) Develop systematic, comprehensive and evidence-based early interventions to reduce childhood obesity as part of the 'life course approach', across
   - Antenatal and Postnatal periods,
   - The Early Years,

- Primary Schools, and
- Secondary Schools.

2) Establish interventions provided by both NHS and non NHS providers to cover an obesity care pathway with four tiers:

   - Tier 0 Universal / The Environment.
   - Tier 1 Primary Prevention Activities.
   - Tier 2 Targeted Interventions.
   - Tier 3 Intensive Interventions.

Central to this strategy is a partnership approach engaging a range of stakeholders (for example, Children's Services, Home Start, NHS Lincolnshire, Lincolnshire Sports Partnership, Healthy Schools etc). In 2010 a Lincolnshire Childhood Obesity Partnership Steering Group was established in order to provide strategic oversight to the development of work to address childhood obesity.

Current Services across the 'life course': The life course approach views the context of individuals' lives through various key life stages and transitioning points that occur from birth to death. It is recognised that these key life stages can be important points that affect health outcomes. The antenatal, postnatal, early years and school years are all important life stages. These stages present key opportunities to deliver important health messages and interventions. Evidence suggests that children who are overweight or obese often continue to be overweight or obese into adulthood. Intervening early could prevent this trend.

Why does this matter?

Health, Social and Economic Consequences of Obesity

Obesity is a major public health issue that has considerable health, social and economic costs. Currently within the UK, about 3 in 10 boys and girls between the ages of 2 and 15 are classed as either overweight or obese. Projections suggest that if trends continue, obesity rates among boys could double by 2025 and increase by nearly 50% among girls. The link between obesity and poor health is well established with impacts on physical, mental and social wellbeing.

Obesity is an important risk factor for cardiovascular disease, type 2 diabetes, non-alcoholic fatty liver disease and some types of cancer. Longstanding obesity increases the risk of these conditions as children progress into adulthood. The association between poor emotional health and obesity can lead to obese individuals experiencing higher rates of depression, mood or anxiety disorders.

It is also not uncommon for obese children to exhibit evidence of psychological distress. Finally, research shows that obese individuals can experience stigma, discrimination and social isolation. Obesity within childhood is also likely to be associated with poor self-esteem or being perceived as being unattractive. Nationally, childhood obesity has a relationship with deprivation and is an important cause of health inequalities. The economic costs of obesity are significant. Direct healthcare costs to the NHS have been estimated to be as much as £4.2 billion. In 1998 it was estimated that 18 million sick days from work, and 40,000 years of working life were lost as a consequence of obesity. Modelled predictions suggest costs to the wider economy could be as much as £27 billion by 2015.

Overweight and Obesity among Children in Lincolnshire: The National Child Measurement Programme (NCMP) is an annual programme, which measures the height and weight of children in Reception (aged 4-5 years) and Year 6 (aged 10-11 years) within state maintained schools in England[11]. Compared to both the England average for the East Midlands, Lincolnshire has a high prevalence of overweight and obese in both age groups. 23.8% of Reception children and 35.3% of Year 6 children were overweight or obese in 2010/11 in Lincolnshire. The percentage of obese Reception children rose from 9.9% in 2008/9 to 10.8% in 2009/10. Since 2009/10 there has been a small decline to 9.4% in 2010/11. Comparatively, there has been a sustained increase in the percentage of obese children measured in Year 6 from 18.5% in 2008/9 to 20.2% in 2010/11.

What will our objectives be?

Tackling obesity requires long-term action. The significant numbers of children and young people who are overweight or obese mean that reversing the trend will take a concerted, sustained effort by all partners.

1. **Halt the trend until 2015: stop levels increasing and start to see a small reduction in current obesity and overweight levels until 2015: Reception**: maintain obesity rates and start to see a small reduction to below 9% and obesity and overweight combined rates below 23%. **Year 6**: maintain obesity rates and start to see a small reduction to below 20% and obesity and overweight combined rates below 35%.

2. **Reverse the trend: Reduce rates by 2022 to: Reception**: reduce rates to 6% and obesity and overweight combined rates below 15%. **Year 6**: reduce rates to 15% and obesity and overweight combined rates to 30%.

3. **Reduce rates in the long term (2030 and beyond) to at least: Reception**: obesity to 3% and obesity and overweight combined to 10%**. Year 6**: obesity to 12% and combined rates to 26%.

Action Plan – Year One

1. Continue to build the membership of the current multiagency Lincolnshire Childhood Obesity Partnership Group and ensure reporting mechanisms are in place to inform the Health and Wellbeing Board and CYPSP.
2. Launch the Childhood Obesity 5 year strategy, associated Care Pathway, Asset Mapping Report and 2011/12 Annual Report.
3. Continue to support the development of the National Child Measurement Programme (NCMP).
4. Develop and analyse a robust dataset (quantitative and qualitative data) utilising data from a range of different areas and agencies to impact on Childhood Obesity levels in Lincolnshire.
5. Develop a multiagency Maternity and Early Years Strategic Forum which will build on the current membership of the Maternity and Infant Feeding Group.

Robust reporting mechanisms will be put in place to inform the Health and Wellbeing Board and CYPSP.

6. Develop and analyse a robust dataset (quantitative and qualitative data) utilising data from a range of different areas and agencies to impact on the 'Early Years' for children in Lincolnshire.
7. Form a multiagency Emotional and Mental Health Wellbeing Strategic Forum to support the recommendations for the National Mental Health Strategy 'No Health without Mental Health'. Robust reporting mechanisms will be put in place to inform the Health and Wellbeing Board and CYPSP.
8. Develop and analyse a robust dataset (quantitative and qualitative data) utilising data from a range of different areas and agencies to impact on the Emotional and Mental Health Wellbeing of children and young people in Lincolnshire.
9. Develop evaluated social marketing and community engagement strategies for all areas of Theme 4.

Action Plan Review (year's two to five)

1. Implement the Childhood Obesity Strategy

2. Analyse the qualitative and quantitative datasets for each of the 3 areas of the theme 4 chapter.

3. Set appropriate targets for 5 years, these should incorporate where possible existing targets set for all partner organisations for example: Public Health trajectories are currently agreed for the next 5 years for - Childhood Obesity, Breastfeeding, Smoking at Time of Delivery, 12 Week Access to Maternity care and Teenage Pregnancy.

4. Develop Annual Reports and combined Strategies where possible for the Early Years and Emotional and Mental Health Wellbeing sections of Theme 4.

5. Assess changes in the external environment affecting the themes and priorities (e.g. new national targets, refreshed JSNA evidence, and organisational change).

6. Review how the strategy fits with and responds to the overall strategic direction provided by the Health and Wellbeing Board
7. Report on and react appropriately to outcomes of Social Marketing and Community Development work on all 3 areas of the Theme 4 Chapter.

THEME FIVE – Reducing Worklessness

Our ambition is to:

1. Give vulnerable people the best chance of securing and maintaining employment that supports their health and wellbeing.
2. Work with employers to maximise opportunities for inward investment and job creation in Lincolnshire.

It is not our intention to cut across the work of agencies that are already active in this area, but to ensure the multiple routes and schemes for people who need support into work are cohesive.

The aim would be to embed the knowledge that physical, social and mental health all contribute to the prosperity of a community, and that includes having a population that is fit for work.

We will know we have been successful when we have done what we can to increase the availability of work through public spending, reached agreement with support agencies about how they can best target their work and commissioned a closing of any gaps in support for our most vulnerable people.

This theme links to Marmot principles:

h) Create fair employment and good work for all

i) Ensure healthy standard of living for all

j) Create and develop healthy and sustainable places and communities

k) Strengthen the role and impact of ill health prevention

Priority 5.1 - A joined up approach to improving support into work for vulnerable people

Where are we now?

The relationship between work and health is multifaceted, and impacts on areas of social justice, generational poverty and health inequalities.

Several of the Marmot Review's policy objectives link directly to the 'world of work'. These include:

- enabling people to maximise their capabilities and maintain control of their lives;
- ensuring healthy standards of living for everyone;
- creating healthy and sustainable places and communities; and
- strengthening the role and impact of ill health prevention

In the wake of Dame Carol Black's 2008 review of the health of Britain's working age population, 'Working for a Healthier Tomorrow', efforts have begun to be made to promote work as a health outcome.

In the Outcomes Framework of its 2010 public health white paper, 'Healthy Lives, Healthy People', the government included the employment of people with long-term conditions and those with mental illnesses as key outcomes. The paper emphasised that 'enabling more people to work, safeguarding and improving their health at work, and supporting disabled people or people who have health conditions to enter, stay in or return to work are critical components of our public health challenge.'

The employment of people with mental health problems is also a crucial priority area in the new Mental Health Strategy. The 2011/12 NHS Outcomes Framework highlights the employment of people with mental illness and long-term conditions as areas for improvement in the second of its five 'domains', which is concerned with enhancing quality of life for such people.

There are currently a wide range of services that support people into work. DWP provide various contracts to providers which target certain groups of participants, for example "Work choice" and "Access to Work" and "The Work Programme". Additional to this we have local provision which come from various funding streams such as European Social Fund (ESF), Young People Learning Agency, along with Statutory funding for Welfare To Work Services.

Employment is also the focus for many learning providers, schools and colleges all completing an element of supporting individuals to have work as an outcome.

Why does this matter?

Work is good for people in giving a sense of purpose and achievement, improving self esteem and increasing their household income, with all the benefits that accrue from that.

Lincolnshire's unemployed and claiming benefit increased by 1,188 to a total of 16,032 in January 2012. The county's unemployment rate of 3.7 per cent remains below regional and national rates. The overall worklessness rate in Lincolnshire is 11% (measured by people on out of work benefits). Despite this also being lower than the regional and national rates these two figures mask underlying inequalities in employment within the county with Lincoln having a worklessness rate of 14.9%. There is also a marked difference between rural and urban rates of unemployment in the county.

However unemployment is on the rise and is predicted to increase with the economic climate and the review of all participants on incapacity benefit.

Unemployment has reached 2.62 million, the highest figure for seventeen years. With the Coalition Government's welfare reforms looking to move thousands of claimants off benefits and into sustainable employment, innovative and joined-up methods of stimulating the job market and training and up-skilling individuals are essential.

Lincolnshire currently has a resident population estimated at over 434,000 persons of working age 16-64, both males and females, mid year 2010. The number of working age people claiming out of work benefits, i.e. Jobseekers' Allowance, Incapacity Benefit, Lone Parent Income Support and others on income related benefits is 48,170.

(Source: DWP) The number of 16-18 year olds 'Not in Employment Education or Training' (NEET) is 1,220. This is usually an average of 3 months data (Nov-Dec-Jan).

Although levels of long term unemployment have declined overall during 2010, levels of youth unemployment (i.e. aged 19 and under) have started to rise, with two in every three wards having rates higher than the national average.

With the raising of the participation age from 2013, young people will be required to continue in education or training until the end of the academic year in which they turn 17 years. From 2015, they will be required to continue until their 18th birthday. This will affect the employment arena, as there is an expectation that every young person will have to complete at least 20 hours per week in an educational environment. This will have an impact on employers although it is difficult to ascertain in what way.

The numbers of people in poverty and health benefit claimants in vulnerable groups – lone parents, children in poverty, people with disabilities/ill-health is 22,155.

The percentage of people with a learning disability in Lincolnshire who are in employment is 4.6%. This is lower than other comparable local authorities which stand at 5.3%, and the percentage for England is 7.1%.

The table below (taken from the Local Economic Assessment 2011) shows the top industry providers of employment in Lincolnshire Business Register Employment Survey 2009, Defra Agricultural Survey 2008

Industry	**% of Total Employment**	**Index (England = 100)**
Government Services	27	100
Retail & Wholesale	18	114
Financial & Business Services	14	67
Agri-Food	10	228
Non-Food Manufacturing	8	105
Tourism	7	103

Over four-fifths of the county's workforce (over 230,000 people) is employed in the six broad industry groups shown.

This table also shows that "Government Services" have the biggest percentage of jobs, this gives us the opportunity to be leading the way forward with not just a job, but as Marmot refers to "Good Jobs, for people".

Whilst most people would assume that Lincolnshire would be mainly agricultural, this tests assumption, and a major important factor to take into account is the importance of including employers in the very planning of what is needed for Lincolnshire.

Projections show that the county's economy will continue to grow. Twenty-eight thousand new jobs could be created by 2030 and the level of skills in the county's workforce is also expected to improve. Unfortunately, these positive projections will not be enough to push Lincolnshire any closer to the national or regional rates of economic activity without intervention.

Local Enterprise Partnerships (LEPs) are led by local authorities and businesses across natural economic areas. They provide the vision, knowledge and strategic leadership needed to drive sustainable private sector growth and job creation in their area.

Despite all the current programmes there is no one forum which brings together all the experts in the field of worklessness. A key development for Lincolnshire would see the creation of such a forum which could be the catalyst for ensuring that during a time of significant climate difficulties, that everyone is working to the same agenda, good practice is shared, gaps in service delivery are addressed and future long term economic issues are addressed and planned for.

This theme addresses the main challenges and opportunities. As the Government targets a community based approach to unemployment, and with new developments in the 'Get Britain Working Campaign', this timely event brings together the key departments, organisations and individuals setting and implementing worklessness policy and programmes.

What will our objectives will be?

Our focus for this priority will be on vulnerable adults, vulnerable young people in transition and those with enduring mental illness. Specific enquiry and development will be centred on people whose vulnerability is an additional barrier to work but not great enough to gain them the attention of support services.

We will know we have made a difference with this part of the strategy when:

1. There is an effective coordination mechanism in place that meets the needs of the multiple agencies engaged in supporting people into employment in Lincolnshire.
2. The delivery plans of these agencies, where their funding or central mandates allow, provide for a targeted approach that maximises the range of people offering support.
3. The needs of people who have additional barriers to work but who do not have access to support are identified and support commissioned to meet their needs.
4. More people with enduring mental illness who are transitioning out of school, or have lower levels of barrier, are in meaningful and sustainable employment.

Priority 5.2 - Maximising work for local people from public expenditure

Where are we now?

Drawing on findings from expert interviews and local workshops we are able to use recommendations from the 'Working together, promoting work as a health outcome' about the concrete actions various parties can take in promoting work as a health outcome. It aims to help actors at the local level translate national-level policy objectives to encourage those with health conditions back to work, and enable others to remain employed when health problems arise.

Recommended actions for:

Employers

- Making work more meaningful. Employers who set up health programmes without providing workers with a meaningful role are likely to find that their efforts are less successful than those of companies with high rates of job satisfaction.
- Providing evidence of effective interventions to those working with employers to address staff health issues. Evidence can also help obtain buy-in from large employer organisations, such as Chambers of Commerce, the Federation of Small Businesses or the Confederation of British Industry.
- Strengthening lines of communication between employers and GPs, to map out what the worker can do now and what he or she will be able to do in the future.

Health Services

- Informing GPs about the operational practices of industries in their locality by helping them understand the tasks that individuals perform. This is likely to increase the utility and accuracy of Fit Notes.
- Adding a question on work as a health outcome to the Fit Note to increase GPs' engagement. The forthcoming electronic version of the Fit Note should ask whether GPs have considered referring the patient to back-to-work services.

Health and Wellbeing Board

- Involving GPs in developing Joint Strategic Needs Assessments (JSNA), which should take more account of work as a health outcome.
- Considering having a larger stakeholder forum feeding into the Board, including employers, providers of back-to-work services and other interested parties. The latter could meet less frequently than the main board and make recommendations to it based on pilot programmes or evidence from other localities on how to reduce health-related worklessness.

Local Authorities

- Building health provision into the commissioning process so that supplier firms that invest in workforce health are favoured when contracts are awarded.
- Making stronger efforts to increase health services' awareness of back-to-work programmes, thereby becoming a repository for information on health and work. These efforts might include council representatives visiting Clinical Commissioning Groups to inform them about services and providing GP surgeries with marketing materials that publicise the services.

On a more local level we can look at the suggestions below to support the development of the strategy.

1. Understand the role local Enterprise Partnerships and Social Enterprises can play in creating jobs locally. This fits in with the vision of Big Society.
2. Learn the most effective methods of partnership working between housing providers, charities and the private sector in the delivery of skills and work-related training.
3. Examine how we can work with Housing Associations to provide innovative approach to providing tailored training and support for unemployed tenants.

4. Gain insight from success when scheme engaging with ex-offenders and prospective employers in overcoming barriers to accessing work.
5. The JHWS gives us the opportunity to develop and highlight ways in which employers, health services, Health and Wellbeing Boards, Public Health Directors and Local Authorities could translate national-level policy objectives intended to promote work as a health outcome into local action and achievement.
6. Using the council's purchasing power to influence and build into contract conditions in procurement.

Why does this matter?

- 175 million working days in Britain are lost due to ill health annually.
- The cost of sickness absence and worklessness in Britain is estimated at £100 billion annually.
- The World Health Organisation estimates that by 2020, depression will have become the second leading cause of disability in the world.
- One quarter of GP consultations are work related.
- 5.4 million people declare a work-limiting disability, of whom 50% are in employment.

What will our objectives will be?

We will know we have made a difference with this part of the strategy when:-

1. Public sector policies on getting best value for money include clear reference and judgement criteria about local social impact, with particular reference to protection and promotion of work opportunities, and ensuring suppliers and providers can demonstrate investment to its workforce's health provision.
2. More spending from Lincolnshire's public sector organisations is spent in the county, driving prosperity and creating employment.

Action Plan – Year One

1. Develop a Lincolnshire Alliance for Employment Support made up of all the commissioners and deliverers of support into employment.
2. Develop a Memorandum of Understanding between the agencies to improve targeting of resources within the constraints of each organisations programmes.
3. Work with Procurement Lincolnshire on extension of policies on local procurement and 'social gain' criteria in public sector procurement.

Action Plan Review (year's two to five)

1. Develop work with the voluntary and community sector to provide more work experience and skills development for vulnerable people.

2. Introduce more joined up support for young people in transition to adulthood with particular barriers to getting and maintaining employment.
3. Introduce more joined up support for people mental health problems with particular barriers to getting and maintaining employment.