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2 June 2014

## Lincolnshire Health and Wellbeing Board

**A Meeting of the Lincolnshire Health and Wellbeing Board will be held on Tuesday, 10 June 2014 at 2.00 pm in Committee Room One, County Offices, Newland, Lincoln LN1 1YL**

Yours sincerely

Tony McArdle
Chief Executive

**MEMBERS OF THE BOARD** (*)

**Lincolnshire County Council:** Councillors: Mrs S Woolley (Executive Councillor for NHS Liaison, Community Engagement) (Chairman), Mrs P A Bradwell (Executive Councillor for Adult Care and Health Services, Children's Services), C N Worth (Executive Councillor for Libraries, Heritage, Culture), D Brailsford, J P Churchill, B W Keimach, C R Oxby and S M Tweedale

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

**District Council:** Councillor Marion Brighton OBE

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

**Healthwatch Lincolnshire:** Mr Malcolm Swinburn

**NHS England:** Mr Andy Leary

(*) Permanent Membership

**LINCOLNSHIRE HEALTH AND WELLBEING BOARD AGENDA**
**TUESDAY, 10 JUNE 2014**


| Item | | Title | Pages | Estimated Time |
|---|---|---|---|---|
| 1 | | **Election of Chairman** | | |
| 2 | | **Election of Vice-Chairman** | | |
| 3 | | **Apologies for Absence/replacement Members** | | |
| 4 | | **Declarations of Members' Interests** | | |
| 5 | | **Minutes of meetings of the Lincolnshire Health and Wellbeing Board** | | |
| | 5a | **Minutes of the meeting held on 25 March 2014** | 1 - 14 | |
| | 5b | **Minutes of the Extraordinary meeting held on 9 May 2014** | 15 - 20 | |
| 6 | | **Actions Updates from the previous meeting** *(For the Health and Wellbeing Board to consider the actions arising from the previous meeting)* | 21 - 22 | |
| 7 | | **Chairman's Announcements** | | |
| 8 | | **Decision/Authorisation Items** | | |
| | 8a | **Terms of Reference and Procedural Rules, Board Members Roles and Responsibilities** *(To receive a report from Martin Wilson, Health and Wellbeing Board Advisor, which asks the Board to consider, review and formally agree its Terms of Reference and Procedures Rules, and Members Roles and Responsibilities)* | 23 - 40 | |
| | 8b | **Draft Direct Commissioning Operational Plan 2014 - 16 & Emerging Strategy Update** *(To receive a report from Leicestershire and Lincolnshire Area Team, which sets out plans for services commissioned by NHS England's Leicestershire and Lincolnshire Team)* | 41 - 146 | |

| Item | Title | Pages | Estimated Time |
| --- | --- | --- | --- |
| **9** | **Discussion/Debate items** | | |
| **9a** | **Lincolnshire Health and Wellbeing Board Development Toolkit - Current Position**<br>*(To receive a report from Martin Wilson, Health and Wellbeing Advisor, which provides the Board with a stocktake position as to where the Board is with its maturity in delivering the outcomes for the Health and Wellbeing Strategy)* | 147 - 190 | |
| **9b** | **Update on Lincolnshire Health and Care**<br>*(To receive a verbal update from the Chairman of the Lincolnshire Health and Care Programme Board on the progress with the Lincolnshire Health and Care proposals since the Care Summit on 8 May 2014)* | Verbal Report | |
| **9c** | **The CQC Review of Health Services for Children Looked After and Safeguarding in Lincolnshire**<br>*(To receive a report and presentation from Sharon Robson, Executive Nurse, South West Lincolnshire CCG, which advises the Board of the CQC Review of Health Services for Children Looked After and Safeguarding in Lincolnshire and the associated Action Plan submitted to the CQC in response to the recommendations from the report)* | 191 - 240 | |
| **10** | **Information Items** | | |
| **10a** | **An Action Log of Previous Decisions**<br>*(For the Health and Wellbeing Board to note decisions taken since 11 June 2013)* | 241 - 248 | |
| **10b** | **Lincolnshire Health and Wellbeing Board - Forward Plan**<br>*(This item provides the Board with an opportunity to discuss potential agenda items for future meetings which will subsequently be included on the Forward Plan for the Board. Martin Wilson, Health and Wellbeing Board Advisor to lead on this item)* | 249 - 252 | |

| Item | Title | Pages | Estimated Time |
|---|---|---|---|
| 10c | **Future Scheduled Meeting Dates**<br>*(For the Board to note the following scheduled meeting dates for the remainder of 2014 and for 2015:*<br><br>*10 June 2014; 30 September 2014; 9 December 2014, 24 March 2015, 9 June 2015, 29 September 2015 and 8 December 2015. Please note that all the above meetings start at 2.00pm)* | Verbal Report | |


Democratic Services Officer Contact Details

Name: **Katrina Cope**

Direct Dial **01522 552104**

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


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

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

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

**LINCOLNSHIRE HEALTH AND WELLBEING BOARD**
**25 MARCH 2014**

**PRESENT: COUNCILLOR MRS S WOOLLEY (CHAIRMAN)**

**Lincolnshire County Council:** Councillors C N Worth (Executive Councillor for Libraries, Heritage, Culture), D Brailsford, J P Churchill, B W Keimach, C R Oxby and S M Tweedale

**Lincolnshire County Council Officers:** Glen Garrod (Director of Adult Social Services) and Dr Tony Hill (Executive Director of Public Health).

**District Councillor:** Councillors Marion Brighton OBE.

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

**Healthwatch Lincolnshire:** Mr Malcolm Swinburn.

**NHS England:** Mr Andy Leary.

**Officers In Attendance:** Katrina Cope (Team Leader Democratic and Civic Services), Richard Collins (Head of Service Policy and Development), Chris Cook (Independent Chairman of Lincolnshire Safeguarding Children's Board), John O'Connor (Head of Service School Administration), Martin Wilson (Health and Wellbeing Board Advisor), Annette Lumb (Head of Planning, West Lincolnshire CCG), Sally Savage (Assistant Director of Children's Services) and Gary Thompson (Accountable Officer South Lincolnshire CCG).

## 45 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

Apologies for absence were received from Councillor Mrs P A Bradwell (Executive Councillor Adult Care and Health Services, Children's Services), and Debbie Barnes (Executive Director of Children's Services).

It was noted that Sally Savage (Assistant Director of Children's Services) had replaced Debbie Barnes (Executive Director of Children's Services) for this meeting only.

## 46 DECLARATIONS OF MEMBERS' INTERESTS

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

47 MINUTES OF MEETINGS OF THE LINCOLNSHIRE HEALTH AND WELLBEING BOARD

(a) Minutes of the meeting held on 10 December 2013

RESOLVED

That the minutes of the meeting of the Lincolnshire Health and Wellbeing Board held on 10 December 2013, be confirmed and signed by the Chairman as a correct record, subject to the sixth sub-heading on the list of attendees present being amended to read 'NHS England'.

(b) Minutes of the Extraordinary meeting held on 28 January 2014

RESOLVED

That the minutes of the meeting of the Lincolnshire Health and Wellbeing Board held on 28 January 2014, be confirmed and signed by the Chairman as a correct record, subject to the sixth sub-heading on the list of attendees present being amended to read 'NHS England'.

48 ACTION UPDATES FROM THE PREVIOUS MEETING

RESOLVED

That the completed actions as detailed be noted.

49 CHAIRMAN'S ANNOUNCEMENTS

The Chairman advised the Board that having recently attended events in the Local Government Association and NHS arena, it was noticeable that the Lincolnshire Health and Wellbeing Board was well in advance of other Boards in its overall achievements.

**DECISION/AUTHORISATION ITEMS**

50 BETTER CARE FUND FINAL SUBMISSION

Pursuant to Minute No. 44 (3) consideration was given to a report from the Director of Adult Social Services, which provided the Board with details of the Better Care Fund (BCF) final submission to NHS England.

On 11 February 2014, a letter had been sent to NHS England (a copy if which was detailed at Appendix A to the report) along with a copy of the national template which was divided into two parts. Part one described the overall plan details, and agreed vision and schemes, and Part two, described the performance measures to be used and the agreement on the use of the BCF in 2014/15 and 2015/16.

On 11 March 2014, a letter was received from NHS England – BCF Assurance Update (a copy of which was shown on page 47 of the report), which provided details on three issues. Page 51 to 53 (Appendix C) provided the Board with supplementary information to the assurance process guide.

A copy of the BCF – Part 1 (Final Submission document) was detailed on pages 55 to 79 (Appendix D) which contained the additional information required by NHS England. Particular reference was made to the governance arrangements for monitoring progress and outcomes (page 69); the implications for the acute sector (page 68); protecting social care services (page 71); and the implications of the Care Bill and funding (page 77).

It was noted that transformation would be implemented in an incremental way through the Sustainable Services Review, to ensure that there was a risk management approach to change management and a protection for social care services.

During discussion, the following issues were raised:-

- Concern was expressed to the reduction in the number of acute beds and whether these beds were going to disappear. The Board were advised that as part of the vision for reconfiguring services, it was hoped to significantly reduce acute bed capacity by 2016/17 and strengthen community based services. It was highlighted that escalation beds would be available should an emergency arise in, and out of County;
- Clarification as to the demographic trends with regard to the ageing population, the document seemed to suggest that the West and South were ageing more. Officers agreed to look into this;
- Seven day working – Concern was expressed as to how this would impact on GP contracts, nurses and other staff, the budget and the proposed services. It was highlighted that there was an expectation for seven day working, particularly around facilitating discharge from hospital, and from the proposed neighbourhood teams. It was noted that there was still a lot to do around the issue. The Board were advised that some seven day pilot schemes would be underway in April and that there was a good example of how working methods could be changed and done differently in Salford. It was highlighted that the underlying issue was to meet the needs of the patient in all that was proposed;
- The remit of the Autism Strategy - Concern was expressed as to whether the Autism Strategy took into consideration the needs of children and adults. The Board were advised that the Government requirement was for a strategy for adults, not children. However, the County Council had decided that Lincolnshire would have an all ages strategy in relation to Autism, and that the Board would be receiving a report later in the year; and
- Disabled Facility Grants - Concern was expressed as to the implications for Disabled Facility Grants, administered currently by the districts. The Board were advised that work was underway with districts with regard to this issue, to ensure that DFG's continued into 2015, and beyond as part of the Wellbeing Service. It was highlighted further, that most of the district council areas were

split into more than one CCG area. Reassurance was given that the concerns raised would be looked into and addressed.

RESOLVED

1. That the Better Care Fund (BCF) Planning Template – Part 1 (Final Submission document), as detailed at Appendix D to the report be agreed by the Board.

2. That the Board note that further updates concerning the BCF submission and the tracking of its progress be managed through the LSSR Governance Board in the first instance and ultimately the Health and Wellbeing Board.

51 COMMISSIONING PLANS

The Board gave consideration to the Commissioning Plans from the four Clinical Commissioning Groups and NHS England Local Area Team.

West Lincolnshire Clinical Commissioning Group – Operational Plan

The Board received a joint presentation from Dr Sunil Hindocha and Annette Lumb concerning the West Lincolnshire's Operational Plan.

Copies of the Lincolnshire West CCG Plan to a Page for 2014/15 – 2015/16, and data relating to Quality Premium Measures was circulated to members of the Board at the meeting.

The Plan to a Page outlined the vision for patients in Lincolnshire West, detailed the improvements the CCG had for Proactive Care; Urgent Care; Elective Care and for women and children for the next two years. The Plan also highlighted the cross cutting themes relating to improving quality, working with partners to develop the Primary Care Strategy, Carers Strategy and the enablers required to enable the vision to happen.

Particular reference was also made to page 83 of the report presented, which provided the Board with information relating to the quality premium for 2104/15, which was supplemented by the additional data circulated at the meeting. It was noted that Lincolnshire West intended to improve medical errors by 1% for 2014/15; improve physiological therapies by 1%; and as a local priority to increase by at least 5% the number of Atrial Fibrillation patients who were prescribed optimum preventive therapy, to help reduce the number of stroke admissions to hospital.

Agreement was given by the Board to the West Lincolnshire Operational Plan.

Lincolnshire East Clinical Commissioning Group – Operational Plan

Dr Simon Lowe presented the Lincolnshire East Operational Plan.

A copy of the Lincolnshire East CCG Operational Plan 2014/2016; Plan to a Page was circulated to members of the Board at the meeting.

The Plan to a Page outlined the vision for Lincolnshire East CCG; it detailed where the CCG needed to be in relation to national and local drivers, the NHS Outcomes framework and targets, the LSSR, BCF and the Lincolnshire Joint Health and Wellbeing Strategy. The plan detailed what needed to be done against the East's four key programmes of work and ambition for delivery over the next two years. The four areas shown were wider primary care provision; the creation of a modern model of integrated care, access to the highest quality urgent and emergency care and productive elective care. The plan also highlighted the impacts of the selected projects for 2014 to 2016. It was noted that there were crossing cutting issues within all of the boxes detailed.

During consideration, it was highlighted that reference to elderly people, one of the Joint Health and Wellbeing Strategy themes was missing from the plan. Dr Lowe agreed that this would be included. Some explanation was sought regarding one of the impacts to reduce the number of people reporting poor experience in inpatient care to 146 per 10000 by March 2016, unfortunately, data relating to this figure was not available at the meeting for an answer to be given.

Reference was also made generally, that the plans overall did not have a lot of outcomes for children; some discussion was had relating to obesity in children. It was highlighted that this document was only a plan to a page and that within the detail behind the plan, children were included.

Agreement was given to the Lincolnshire East Operational Plan.

South West Lincolnshire Clinical Commissioning Group – Operational Plan

Dr Vindi Bhandal presented to the Board the South West Lincolnshire Clinical Commissioning Operational Plan.

The Board were referred to the report detailed in the agenda pack at page 97 and the accompanying detailed Operational and Strategic Plan for 2014/2019 attached to the report as Appendix A. The document contained comprehensive information relating to the CCG's mission and values; its improvement intentions against its five domains of preventing people from dying prematurely, ensuring that patients with mental health and long term conditions got the best quality of life; ensuring that patients recovered quicker and that patients had a positive experience of care, and were kept safe from all avoidable harm. Particular reference was also made to the provision of a proposed hub, which would integrate health and social care in the community.

Agreement was given to the South West Lincolnshire Operational Plan.

South Lincolnshire Clinical Commissioning Group – Operational Plan

Gary Thompson presented to the Board the South Lincolnshire Clinical Commissioning Groups Operational Plan.

The report presented at page 149 to 153 provided the Board with an explanation to the rationale behind the plan. Appendix A to the report provided information as to how the South Lincolnshire's Plan linked into the five themes of the Joint Health and Wellbeing Strategy. Appendix B to the report provided the South Lincolnshire CCG Planning Strategy for 2014 to 2019.

Particular reference was made to the South Lincolnshire's main areas of concern for 2014/16 which were working collaboratively with A & E to keep patients in the community rather than in hospital; working to get full implementation of the cancer reform strategy; and health care acquired infections. Reference was also made to the fact that 16% of the population received care outside of the County and that a large number of the population were European and that work needed to be done get them registered with a GP.

Some discussion ensued, relating to the future of Peterborough Hospital. The Board were advised that meetings were going on and would continue to go on with Peterborough hospital regarding this issue. It was highlighted that the hospital, despite its financial problems did provide a good quality service.

Agreement was given to the South Lincolnshire Operational Plan.

A question was asked as to whether Plans were flexible enough to take into consideration changes reported during the year. It was highlighted that plans were evolving and that commissioning was looked at early in the year and as a result some emerging issues might get missed. With regard to the obesity issue, it was suggested that those who that had not included this in their current plans were encouraged to think about it for their future plans.

NHS England Draft Operational Plan 2014/16 and Emerging Strategy Update

Andy Leary presented to the Board the NHS Local Area Team Draft Operational Plan 2014/16 and the Emerging Strategy update.

A report on page 161 of the agenda provided the background behind the plan and detailed at Appendix A to the report was a copy of Leicestershire & Lincolnshire Area Team, Public Health Commissioning Plan to a Page summary, which provided information for the commissioning of primary care and NHS public health services.

It was highlighted that Specialised Services Operational Plans and summaries were being developed nationally to a single consistent document which would be available shortly, and that the Five Year Strategy Plan would be available by the June submission date.

The Board requested a larger print version of the plan to a page document, and concerns were raised with regard to the counting of immunisations, and the lack of provision for Children & Adolescent Mental Health Service (CAMHS) Tier four beds.

RESOLVED

1. That the contents of the Operational Plans for the

   West Lincolnshire Clinical Commissioning Group;
   Lincolnshire East Clinical Commissioning Group;
   South West Lincolnshire Clinical Commissioning Group; and
   South Lincolnshire Clinical Commissioning Group

   be accepted by the Lincolnshire Health and Wellbeing Board as meeting the outcomes of the Lincolnshire Joint Health and Wellbeing Strategy.

2. That the NHS England Draft Operational Plan 2014/16 and Emerging Strategy Update as presented be noted and that a copy of the National Specialised Plan be presented to the June meeting of the Lincolnshire Health and Wellbeing Board.

**DISCUSSION/DEBATE ITEMS**

52 ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH ON THE HEALTH OF THE PEOPLE OF LINCOLNSHIRE 2013

Consideration was given to the annual report on the health of the people of Lincolnshire from the Director of Public Health. Detailed at Appendix A to the report was a copy of the said annual report.

It was reported that this was the fourth report of the Director of Public Health for Lincolnshire, and the first in his new role based at Lincolnshire County Council. It was highlighted that the report was not an annual account of the work undertaken in the Public Health Team, but an independent professional view of the state of the health of the people of Lincolnshire.

In guiding the Board through the annual report, the Director made reference to the following:

Chapter One – Addressing Health Equity and Health Outcomes for International Migrants

Figures had identified that just over 7% of the people resident in Lincolnshire were born outside the UK. In July 2012, over 15,000 people from A8 countries were recorded as being registered with a Lincolnshire GP, with most being recorded as living of Boston, Spalding, Grantham Skegness and Lincoln. It was highlighted that evidence suggested that international migrants were relatively healthy on arrival, and were unlikely to impose a disproportionate burden on health services, with some preferring to access health services back home. It was highlighted further that the inequality of health services provision to migrants was often linked to language barriers and a lack of understanding of how the system worked. The recommendations at the end of the chapter concentrated on improving the inclusivity and equality of health care provision to the migrant population in Lincolnshire.

Chapter Two – Tobacco Control

It was highlighted that smoking prevalence continued to fall, but Lincolnshire's smoking prevalence of 21% was still higher than England and the East Midlands' average of 20%. Smoking prevalence was higher in areas such as Lincoln City, Boston and East Lindsey, who had areas with higher deprivation and greater health inequalities than other parts of the country.

It was reported that due to the hard work of public health team, and maternity services, it was reported that in 2011/12 18.1% of pregnant women smoked and that this figure had now been reported as being reduced to 13.7% in 2012/13.

The Board were advised that people who were referred to the stop smoking service were four times more likely stop.

Chapter Three – Public Health and Spatial Planning

The Board were advised that the Public Health Directorate had been active in promoting and driving the health agenda in the County, by working to create a robust and practical model with the Central Lincolnshire Joint Planning unit who developed policy for the western half of Lincolnshire.

It was highlighted that there was still lots of work to do to improve health through spatial planning.

Chapter Four – Health Skills Training

The Board were advised that development of the wider Public Health workforce was necessary to promote health care and wellbeing.

Chapter Five – Protecting the Health of the People of Lincolnshire

The Director advised that as the Director of Public Health he needed to be assured that infection prevention and control systems and processes were in place across the health and social care economy were safe and effective.

During discussion, the Board made reference to the smoking cessation figures; the inclusion of what can be done for existing housing stock and the impact on public health. Members were advised that districts had information available relating to rented accommodation.

RESOLVED

> That the Annual Report of the Director of Public Health on the Health of the People of Lincolnshire 2013 be noted.

53 LINCOLNSHIRE SUSTAINABLE SERVICES REVIEW

The Director of Public Health, as Senior Responsible Officer for the Programme and Chairman of the Programme Board, provided the Board with an update on the Lincolnshire Sustainability Review.

At the 10 December 2013 meeting, the Lincolnshire Health and Wellbeing Board had given its approval to the blueprint document. As a result of the approval more detailed planning was being done with the help of PricewaterhouseCoopers, and that the Phase one blueprint would be looked at in more detail by the four clinical design groups to identify which of the four would be looked at, as early implementers.

On 9 May 2014, the Board would be asked to agree the next course of action. It was noted that the consultation period would then commence for a three month period.

A final version of the blue print and the implementation plan would then be brought back to the Board in September for approval, following which, Phase three would commence, to implement the LSSR over the next two to three years.

During discussion, some concerns were raised in relation to the consultation process, and whether the proposed consultation was meaningful, or whether it was just going to be a tick box exercise, in view of the fact that ULHT had already produced their plans based on the outcomes of the LSSR.

The Board were reassured that the action was to go out for formal consultation from mid-May for three months and that a lot of work was going into the consultation process. It was highlighted that even before the consultation, there had been lots of engagements with different groups around the county, and staff, GP's, elected members and Healthwatch had all been involved in this engagement before the development of the blueprint.

Further to this, the Board were advised that a website was due to come on line 'Lincolnshire Health and Care', which would advise people in Lincolnshire what was going on.

The Board were advised that the ULHT Strategy did follow the blueprint set out in December 2103, and if they were anticipating what the LSSR was going to come up with at the end of the process then they did so at their risk. If there was an issue, and the ULHT strategy did not fit into the LSSR, then they would have to change their strategy.

RESOLVED

That the verbal update on the progress of the Lincolnshire Sustainable Services Review be noted.

**INFORMATION ITEMS**

54 THE LINCOLNSHIRE SAFEGUARDING CHILDREN'S BOARD

Consideration was given to a report from The Lincolnshire Safeguarding Children's Board, which provided an update on the work currently being undertaken by the Lincolnshire Safeguarding Children Board (LSCB) and its Sub-Groups.

Dr Simon Lowe left the meeting at 4.00pm.

The Independent Chairman of the Lincolnshire Safeguarding Board guided the Board through the report, making reference to the South West CCG's lead on safeguarding issues.

It was reported that the LSCB comprised of a Strategic Management Group that met quarterly and an Operational Delivery Group that met every eight weeks. In addition the LSCB had a number of Sub-Groups who were driving forward the work of the Board.

The purpose of the report was to provide an overview of the current issues and the work being undertaken by the respective groups to enable the Safeguarding and the Health and Wellbeing Board to link better into each other's roles and responsibilities to ensure that all people in Lincolnshire were safe, and that their well-being was protected.

The Board were advised that there were a number of challenges facing the LSCB, including Ofsted's impending inspection.

The Sub-Groups had recently been reduced to four to help focus the efforts of the LSCB and its partners in the following areas:

- Child Sexual Exploitation
- Child Death Overview
- Serious Incident Review and
- Policy, Procedure, Training and Development

To assist with the issue of Child Sexual Exploitation a Sexual Co-ordinator had been employed, as there were pockets of exploitation in Lincolnshire. It was noted that work had been done with regard to e-safety.

In response to the need for better audit and oversight of actions from Serious Incident reviews, the Board were advised that the LSCB had advertised to employ a Policy and Audit Officer by mid-2014 to help in a very busy high profile area.

Detailed at Appendix A to the report was a copy the LSCB annual report for 2012/13, which provided more detailed information into the work of the LSCB.

During discussion, the Board asked what work had been done into preventative measures. It was reported lots of work had been done relating to e-safety for young children, educating them on social media, and across the internet with regard to sexual exploitation, implementation of the Stay Safe Programme and the implementation of the Team Around the Child.

The Chairman of the Health and Wellbeing Board agreed to have a meeting with the Independent Chairman of the LSCB outside of the meeting.

RESOLVED

> That the report on the role of the Lincolnshire Safeguarding Children Board and its Sub-Groups be noted.

55 REVIEW OF HEALTH SERVICES FOR CHILDREN LOOKED AFTER AND SAFEGUARDING IN LINCOLNSHIRE

RESOLVED

> That the Review of Health Services for Children Looked After and Safeguarding Lincolnshire item be deferred to a future meeting of the Board.

56 AUTISM SELF- EVALUATION 2013

The Board gave consideration to a report from the Director of Adult Social Services, which provided information as to the process undertaken as part of the Lincolnshire Autism Self-Evaluation 2013.

A report summary of the initial findings published by Public Health England was attached at Appendix B to the report.

It was reported that the Public Health England website remained open to enable local authorities to confirm the date on which the self-evaluation was considered by the respective Health and Wellbeing Boards.

Appendix A provided the Board with a copy of the Autism Self Evaluation questionnaire, which had been issued to all local authorities in the summer of 2013. The questionnaire was completed in co-production with members of the local Autism Partnership Group, who had also agreed the contents of the questionnaire prior to submission.

The Health and Wellbeing Board were asked to sign off the content of the questionnaire as evidence for local planning, health needs assessment, strategy development and support for local implementation work.

The Head of Service Policy and Development explained that it had been hoped to get this item on to an earlier agenda, and therefore the decision to be taken was a retrospective one.

The Head of Service and Policy Development guided the Board through the report, from which the following issues were raised with regard to district council involvement in extra care. The Board were advised that a CCG representative sat on the Partnership Board and that the representative should cascade information back to others sitting under the joint commissioning team. It was highlighted that affordable housing was an on-going discussion, irrespective of the type of housing.

RESOLVED

> That the Autism Self-Evaluation 2013 be noted as evidence of local planning and support for local implementation work.

57 SUPPORT AND ASPIRATION

Consideration was given to a report from the Executive Director of Children's Services, which provided the Health and Wellbeing Board with an update on the progress of the Special Educational Needs (SEN) Implementation Project designed to implement the reforms to Special Educational Needs support set out in Part 3 of the Children and Families Bill, draft SEN Code of Practice and draft regulations.

Members were advised that the Bill had now been granted to streamline the system of SEN assessment by:

- Extending the SEN support and provision for children and young people 0 – 25 giving children, young people and their parent/carers greater control and choice in decisions about provision;
- Replacing statements and learning difficulty assessments with a new birth to 25 Education, Health and Care (EHC) Plan;
- Offering families the option of personal budgets when a EHC plan is implemented;
- Improving co-operation between all agencies and services; and
- Requiring local authorities to involve children and young people and parents in the development and review of provision for those with SEN and to publish a local offer of support.

Members were advised that despite the delay with the Bill, the project was on track to deliver the reforms, and that the new assessment process would be trialled and refined from 1 April to 31 August 2014, in readiness for the statutory implementation of 1 September 2014.

Councillor D Brailsford left the meeting at 4.35pm.

Discussion ensued, from which the following issues were raised:

- Information as to where the money was spent. The Board were advised that details were monitored by the Value for Money Scrutiny Committee;

- Whether this scheme would help trouble families. The Board were advised that this scheme was to help individual children and young people who had a special health or educational needs; and
- Personal budgets, the need to ensure that there was a co-ordinated approach in relation to Adults, Children and Health personal budgets. Members were reassured that there were lots of overlaps and that these would be managed.

RESOLVED

That the Support and Aspiration report presented be noted.

58 AN ACTION LOG OF PREVIOUS DECISIONS

RESOLVED

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

59 LINCOLNSHIRE HEALTH AND WELLBEING BOARD - FORWARD PLAN

The Health and Wellbeing Board Advisor presented the Boards current Forward Plan.

It was highlighted that there would be an additional formal meeting of the Lincolnshire Health and Wellbeing Board on 9 May 2014, and that this meeting would take place at the end of the informal meeting already scheduled for that day at The New Life Centre, Sleaford. The purpose of the additional meeting was to receive an update on the plans for the LSSR.

The Board were advised that further details of the informal meeting on 9 May 2014, would be forwarded to them in due course.

That the informal meeting date scheduled for 8 July would now be moved to 11 September 2014, to enable the Board to have an informal discussion on the results of the consultation and draft proposals for implementation. It was highlighted that this would be held in the afternoon of the 11 September 2014 at a venue to be agreed.

That Officers should look into identifying future dates for formal meetings for the Board for January and March 2015, and for an informal meeting date for the Board for February 2015.

RESOLVED

1. That the forward plan for informal meetings and informal workshops sessions as presented be agreed.

2. That the deferred item Review of Health Services for Children Looked After and Safeguarding in Lincolnshire be added to a future agenda.

3. That the National Specialised Plan from NHS England be added to the agenda for the 10 June 2014 meeting.

The meeting closed at 4.50 pm

**LINCOLNSHIRE HEALTH AND WELLBEING BOARD
9 MAY 2014**

**PRESENT: COUNCILLOR MRS S WOOLLEY (CHAIRMAN)**

**Lincolnshire County Council:** Councillors Mrs P A Bradwell (Executive Councillor for Adult Care and Health Services, Children's Services), J P Churchill, B W Keimach, C R Oxby and S M Tweedale.

**Lincolnshire County Council Officers:** Glen Garrod (Director of Adult Social Services), Dr Tony Hill (Executive Director of Public Health) and Stuart Carlton (Assistant Director - Lead Early Help).

**District Council:** Councillor Marion Brighton OBE (District Councils).

**GP Commissioning Group:** Dr Kevin Hill (South Lincolnshire CCG), Allan Kitt (South West Lincolnshire CCG) and Sarah Newton (Lincolnshire West CCG).

**Healthwatch Lincolnshire:** Mr Malcolm Swinburn.

**NHS England:** Mr Andy Leary.

**Officers In Attendance:** Katrina Cope (Team Leader Democratic and Civic Services), Martin Wilson (Health and Wellbeing Board Advisor) and David O'Connor (Programme Director Lincolnshire Health and Care).

David O'Connor (Programme Director for Lincolnshire Health and Care) was also in attendance.

60 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

Apologies for absence were received from Debbie Barnes (Executive Director Children's Services), Dr Vindi Bhandal (South West Lincolnshire CCG), Dr Sunil Hindocha (Lincolnshire West CCG), Dr Simon Lowe (Lincolnshire East CCG) and Councillor C N Worth (Executive Councillor for Libraries, Heritage, Culture).

It was noted that Stuart Carlton (Assistant Director – Lead Early Help), Allan Kitt (South West Lincolnshire CCG), Sarah Newton (Lincolnshire West CCG) had replaced Debbie Barnes (Executive Director Children's Services), Dr Vindi Bhandal (South West Lincolnshire CCG), Dr Sunil Hindocha (Lincolnshire West CCG) respectively, for this meeting only.

## 61 DECLARATIONS OF MEMBERS' INTERESTS

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

## 62 LINCOLNSHIRE HEALTH AND CARE (FORMERLY KNOWN AS THE LINCOLNSHIRE SUSTAINABLE SERVICES REVIEW)

Consideration was given to a report from the Chairman of the Lincolnshire Health and Care Programme Board, which provided the Board with an update, which sought to address:

- The process for developing the proposal for change and business case assurance;
- Formal decision making on the proposal and the business case;
- Formal consultation; and
- Responding to the formal consultation and agreeing the final proposal for change and the business case.

Appendix A to the report provided a revised summary timeline, which had been considered by the LHAC Programme Board earlier in the day.

The Chairman of the Lincolnshire Health and Care Programme Board reported that over the last couple of months the detail of the blue print had been developed, this had been achieved through three meetings of the four Care Design Groups set up for Phase 1, which had resulted in a Care Summit on 8 May 2014. The Board were advised that 260 people had attended the aforementioned Care Summit.

The Care Design work had been informed by external facilitation and technical input from Pricewaterhouse Coopers LLP and input from informal engagement with a wide range of stakeholders across the county and including Healthwatch.

It was highlighted that work was underway to develop the scope and deployment of Neighbourhood Teams. Also, in addition, work had been done to establish the current state of several enablers which were Workforce, Transport, Information Management & Technology, Estates and Contracting.

The Programme Director for Lincolnshire Health and Care advised that over the next six weeks a modelling process would take place, which would include impact assessments and options appraisals. Following this process, a proposal for change and a business case would be produced. This would then be revisited following the formal consultation process.

Reassurance was given that assurance of the proposal would involve both internal and external mechanisms. The internal assurance for the clinical options was being obtained through the engagement of senior clinicians in Care Design. The internal assurance for the financial issues would be going through LCC and the NHS Finance Officers Group.

It was highlighted that as LHAC was identifying significant changes to services, it would therefore be subject to mandatory external assurance from the NHS Area Team. It was highlighted further that there was no mandatory external assurance for social care changes.

The Board were advised that LHAC was the first programme to go through the new NHS assurance process in the East Midlands. The assurance requirements focussed on the four tests set out in the 2014/15 Mandate from the Government to NHS England, which were:

- Strong public and patient engagement;
- Consistency with current and prospective need for patient choice;
- Clear clinical evidence base; and
- Support for proposals from clinical commissioners.

It was noted that in addition to this, the proposals for change had to be supported by a business case which would take into account not only the four tests, but also clinical sustainability within available resources, which would be underpinned by robust economic and financial evidence.

It was brought to the Board's attention that failure to satisfy NHS assurance would stop the proposal progressing to the formal consultation stage. The assurance mechanisms were:

- NHS England external assurance – It was noted that this operated in two stages, a strategic sense check followed by if necessary by an assurance checkpoint. At the Strategic Sense Check on 30 April, the overall feedback was that they had been 'very impressed' with the programme, and the Board were advised that formal written feedback to that effect would be received shortly;
- Health Gateway Reviews – LHAC had hosted a Health Gateway, some concerns had been expressed about the pace of activity. Partners and the Gateway Team had also recommended that public consultation would be more effective, if it was delayed until September; and
- Clinical Senate – Members noted that dialogue was ongoing with colleagues from the Clinical Senate.

The Board were advised that the LHAC proposal was likely to be a 'Key Decision' for the County Council. It was therefore proposed for the proposal and business case to go to the following bodies/committees for consideration/decision:

- Health Scrutiny Committee for Lincolnshire
- Four CCG Governing Bodies
- LCC Adults and Children's Scrutiny Committees
- LCC Executive
- Lincolnshire Health and Wellbeing Board

It was reported that formal consultation mechanisms would be developed alongside the proposal and the business case. The Board were advised that a third party would be procured to operate the consultation and analyse the feedback. It was proposed to get the format for the formal consultation approved by the LHAC Programme Board on 6 August 2014, with the formal consultation being programmed to run for twelve weeks from 3 September 2014. The findings from the consultation would then be reported to the LHAC Programme Board on 3 December 2014.

It was anticipated that the formal decision making process would then be completed by the end of January 2015. At this time, the programme would be at the implementation stage, the nature of the implementation and governance would depend on the final proposal for change and business case, and it was highlighted that a report would be brought back to the Board for consideration at that time.

During discussion, some concern was expressed as to the assurance process and it was suggested that further assurance should be done through the LGA in relation to Social Care. Officers agreed to look into this matter outside of the meeting.

A further concern raised was the timing of the formal decision making process in July 2104, as the South Lincolnshire CCG meeting was not planned to take place until 30 July 2014. Again, Officers agreed to look in to this matter outside of the meeting.

Members were reassured by the NHS England representative that the Council would have been advised if there had been any concerns during the process.

RESOLVED

1. That the processes set out in the report which focused on the areas detailed below be noted.

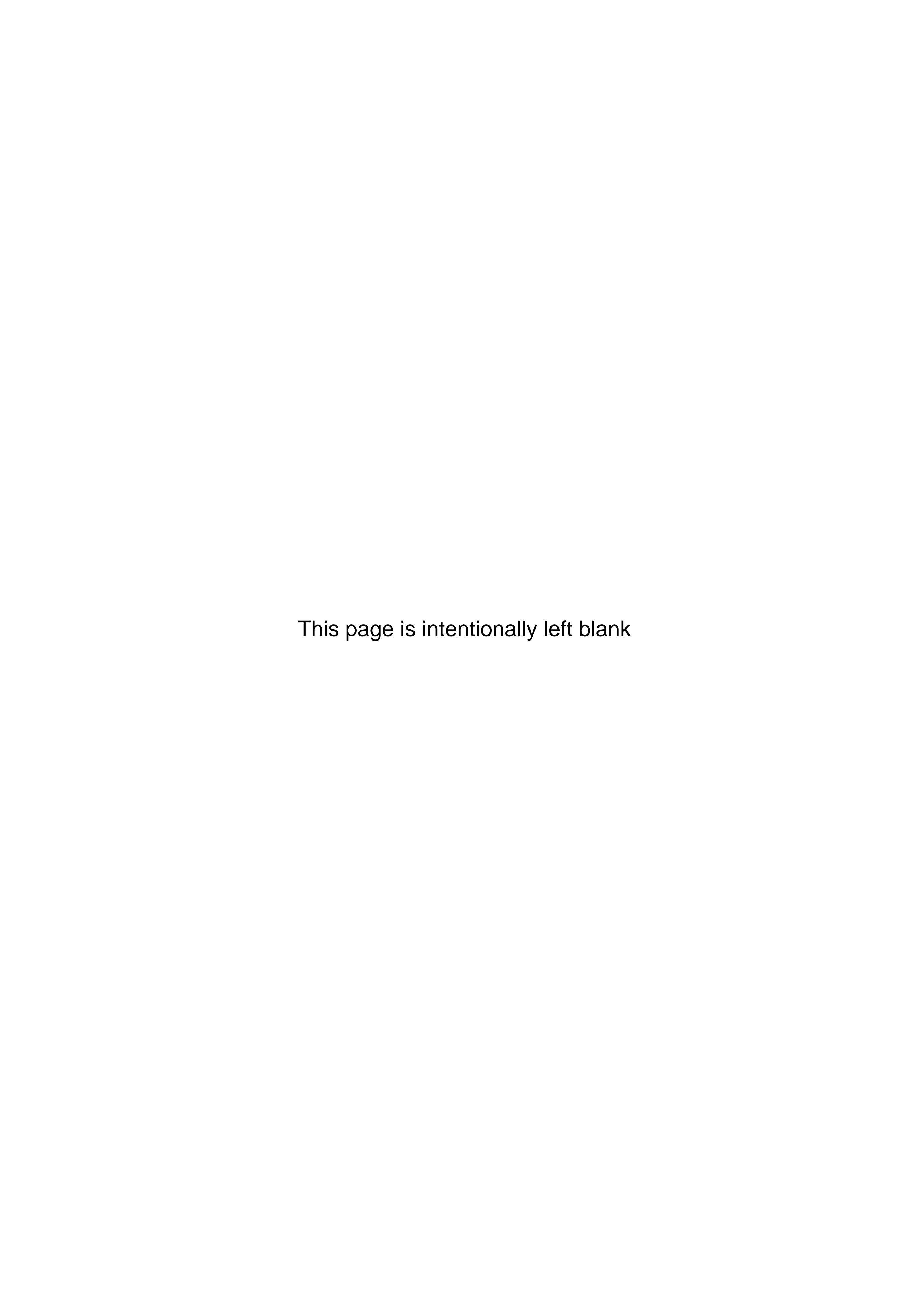
    - Developing robust proposals for a sustainable and safe health and social care economy for the future;
    - Achieving external assurance on the proposal;
    - Consulting widely on the proposal;
    - Responding to feedback in the final proposal; and
    - Robust decision making throughout.

2. That the revised programme detailed at Appendix B to the report be noted.

3. That agreement be given for an additional meeting of the Lincolnshire Health and Wellbeing Board at a date to be agreed as part of the decision making on the proposal and business case for consultation.

4. That agreement be given to a further meeting of the Lincolnshire Health and Wellbeing Board at the end of January 2015, as part of decision making on the final proposal and business case.

The meeting closed at 4.17 pm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Lincolnshire Health and Wellbeing Board – Actions from the previous meeting

| Meeting Date | Minute No | Agenda Item & Action Required | Action by |
|---|---|---|---|
| **11.06.2013** | 1 and 2 | **Election of Chairman** – Records to be updated Councillor Mrs S Woolley elected as Chairman and Dr Sunil Hindocha elected as Vice-Chairman. | Katrina Cope |
| | 7 | **Chairman's Announcements** – The Chairman to send a response on behalf of Board with regard to the Letter from Norman Lamb MP Minister of State for Care and Support – Delivery of the Winterbourne View Concordat and review commitments. | Dr Tony Hill |
| | 8 | **Health & Wellbeing Boards Terms of reference and operating procedures -** The Health & Wellbeing Board Advisor to present membership information of other Health & Wellbeing Boards to the September meeting of the Board. | Martin Wilson |
| | 9 | **Disabled Children's Charter** The Disabled Children's Charter for Health was agreed subject to the wording of the Charter being Amended to read 'engaged with'. | Martin Wilson/ Sheridan Dodsworth |
| | 10 | **Health & Wellbeing Board – Development Tool** The Health & Wellbeing Board Advisor to have a discussion with Andrew Leary concerning functions discharged at a local level and that this information should be presented to the next meeting of the Board. | Martin Wilson |
| | 13 | **Letter inviting expressions of interest for Health and Social Care Integration 'Pioneers'** – Expression of interest to be made by the Executive Director of Public Health. | Dr Tony Hill |
| | 14 | **Lincolnshire Health & Safety Wellbeing Board – forward plan Items** – That the items raised at the minute numbers 8 and 10, and those detailed above be included on the work programme for the Lincolnshire Health and Wellbeing Board | Martin Wilson/Katrina Cope |
| **10.09.2013** | 21 | **Chairman's Announcements**<br>Communications – All members to forward a photograph to the generic email address HWB@lincolnshire.gov.uk for the attention of the Health and Wellbeing Board Advisor, Martin Wilson<br>Substitute Members - Members who had not provided the name of a designated substitute were asked to forward the name of their substitute to the generic email address (As above).<br><br>Membership of other Boards – The Health and Wellbeing Board Advisor to send a copy of the regional board information to members following the meeting. | All Members<br><br><br><br>All Members<br><br><br><br>Martin Wilson |
| | 23 | **Terms of Reference** The Health and Wellbeing Board Advisor to amend the Roles and Responsibilities of NHS England following the meeting. | Martin Wilson |

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| | | That this item should be included on the forward plan for review at the June 2014 meeting. | Martin Wilson |
| | 24 | **Joint Health and Wellbeing Board Statement of Intent**<br>That this item should be included on the Forward Plan for review at the June 2014 meeting. | |
| | 26 | **Lincolnshire Sustainability Review**<br>That this Item needed including on the Forward Plan for future meetings. | Martin Wilson |
| | 27 | **Social Care and Health Funding**<br>That this item needed including on the forward plan for the 10 December 2013 meeting. | Martin Wilson |
| **10.12.2013** | | **No Actions** | |
| **28.01.2014** | 44 | **Better Care Fund Submission Document 'First-Cut'**<br>That a copy of any subsequent amendments should be emailed to all members prior to the documents submission to NHS England. | Katrina Cope |
| **25.03.2014** | 47(a)(b) | **Minutes of the meetings held on 10 December 2013 and 28 January 2014**<br>That the minute template would be amended to read 'NHS England'. | Katrina Cope |
| | 54 | **The Lincolnshire Safeguarding Children's Board**<br>The Chairman to have a meeting with the Independent Chairman of the LSCB outside of the meeting. | Cllr Mrs S Woolley |
| | 59 | **Lincolnshire Health and Wellbeing Board – Forward Plan**<br>For officers to identify future dates for formal meeting for the Board for January and March 2015.<br><br>That the National specialised Plan from the NHS be added to the agenda for the 10 June 2014 meeting. | Martin Wilson |
| **09.05.2014** | 62 | **Lincolnshire health and Care (Formerly known as the Lincolnshire Sustainable Services Review)**<br>Officers agreed to look into the assurance process.<br><br>Officers agreed to revisit the dates for the formal decision making process for July 2014. | David O'Connor<br><br>David O'Connor |

# LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of Martin Wilson, Health and Wellbeing Board Advisor

| | |
|---|---|
| Report to | **Lincolnshire Health and Wellbeing Board** |
| Date: | **10 June 2014** |
| Subject: | **Terms of Reference and Procedural Rules, Board Members Roles and Responsibilities** |

**Summary:**

The Board agreed in September that it would review its Terms of Reference and Procedural Rules at the June 2014 meeting.

**Actions Required:**

That the Health and Wellbeing Board consider, review and formally agree the Terms of Reference and Procedural Rules, and Members Roles and Responsibilities.

## 1. Background

The functions of the Health and Wellbeing Board are set out in Sections 195 and 196 of the Health and Social Care Act 2012 as follows:-

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

It was agreed at Lincolnshire's full Council meeting on the 22 February 2013 that it would establish a Lincolnshire Health and Wellbeing Board, which formally started on the 1 April 2013. The Terms of Reference and Procedural Rules were agreed within September's formal meeting with a review date of June 2014.

## 2. Conclusion

The Board members are asked to consider, review and agree the revised documents as attached at Appendix A and B.

## 3. Consultation

N/A

## 4. Appendices

| These are listed below and attached at the back of the report | |
|---|---|
| Appendix A | Lincolnshire Health and Wellbeing Board Terms of Reference and Procedural Rules |
| Appendix B | Roles and Responsibilities of Lincolnshire Health and Wellbeing Board (HWB) Core Members |

## 5. Background Papers

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

This report was written by Martin Wilson, Health and Wellbeing Board Advisor, who can be contacted on 01522 554292 or martin.wilson@lincolnshire.gov.uk

# LINCOLNSHIRE HEALTH AND WELLBEING BOARD

# TERMS OF REFERENCE and PROCEDURAL RULES

June 2014

Review date June 2015

# Lincolnshire Health and Wellbeing Board
# Terms of Reference
# and Procedural Rules

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## 1. Context

1.1 The full name shall be the Lincolnshire Health and Wellbeing Board. ("The Board").

1.2 The Board is established as a consequence of Section 194 of the Health and Social Care Act as a committee of Lincolnshire County Council.

## 2. Aim

2.1 The Board must, for the purpose of advancing the health and wellbeing of the people in its area, encourage persons who arrange for the provision of any Health or Social Care services in Lincolnshire to work in an integrated manner.

2.2 The Board must provide advice, assistance and support for the purpose of encouraging the making of arrangements under section 75 of the National Health Service Act 2006 in connection with the provision of such services.

2.3 The Board must encourage those involved in arranging the provision of Health-Related Services to work closely with the Board.

## 3. Objectives

3.1 To provide strong local leadership for improvement of health and wellbeing.

3.2 Monitor the implementation and performance of health and wellbeing outcome targets defined within the Joint Health and Wellbeing Strategy (JHWS).

3.3 Lead on the production and delivery of a Joint Strategic Needs Assessment (JSNA) and ensure that partner agencies use the evidence base as part of their commissioning plans.

3.4 Lead on the implementation of the Joint Health and Wellbeing Strategy (JHWS).

3.5 Confirm and challenge the joint commissioning plans for Health and Social care to ensure they meet the needs identified by the JSNA and in line with the JHWS.

3.6 Review any reconfiguration of Health or Social care services in Lincolnshire to ensure they support the outcomes of the Joint Health and Wellbeing strategy.

3.7 Maximise opportunities and circumstances for joint working and integration of services and make the best use of existing opportunities and processes and prevent duplication or omission within Lincolnshire.

## 4. Roles and Responsibilities of members of the Board

4.1 To work together effectively to ensure the delivery of the JSNA and JHWS for the benefit of Lincolnshire's communities.

4.2 To work within the Board to build a partnership approach to key issues and provide collective and collaborative leadership for the communities of Lincolnshire.

4.3 To participate in discussion to reflect the views of their partner organisations, being sufficiently briefed and able to make recommendations about future policy developments and service delivery.

4.4 To champion the work of the Board in their wider networks and in the community.

4.5 To ensure that there are communication mechanisms in place within the partner organisations to enable information about the priorities and recommendations of the Board to be disseminated and actioned to ensure the health and wellbeing of the community of Lincolnshire is improved.

4.6 To promote any consequent changes to strategy, policy, budget and service delivery within their own partner organisations to align with the recommendations of the Board.

In particular, it is the Boards expectations that members will act in accordance with Board members/champions responsibilities listed at Appendix A.

## 5. Accountability

5.1 The Board carries formal delegated authority to carry out its functions under the Health and Social Care Act 2012 from full Council.

5.2 Core Members bring the responsibility, accountability and duties of their individual roles to the Board and provide information, data and consultation material, as appropriate, to inform the discussions and decisions.

5.3 The Board will discharge its responsibilities by means of recommendations to the relevant partner organisations, who will act in accordance with their respective powers and duties to improve the health and wellbeing of the population of Lincolnshire.



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5.4 The District Council Core Member will ensure that they keep all Districts advised of the work of the Board.

5.5 The Board will report to the Full Council and the NHS England via the Area Team (AT) by sending meeting minutes and presenting papers as and when requested.

5.6 The Board will provide information to the public through publications, local media, and wider public activities and by publishing the minutes on the Lincolnshire County Council website.

5.7 The members of the Board will also take part in round table discussions with the public, voluntary, community, private, independent and NHS sectors to ensure there is a 'conversation' with Lincolnshire communities about health and wellbeing.

## 6. Membership

6.1 The core membership of the Board will comprise the following:

- Executive Councillor Adult Care, Children's and Health Services,
- Executive Councillor NHS Liaison and Community Engagement,
- Executive Councillor Libraries, Heritage and Culture,
- Five designated Lincolnshire County Councillor's,
- The Executive Director of Public Health,
- The Executive Director of Adult Care,
- The Executive Director of Children's Services,
- Designated representative from each Clinical Commissioning Group in Lincolnshire,
- Designated NHS England (Area Team LAT) representative ,
- One designated District Council representative (representing all seven districts),
- A designated representative from Healthwatch

6.2 The Core Members, through a majority vote, have the authority to approve individuals as Associate Members of the Board. The length of their membership will be for up to one year and will be subject to re-selection at the next Annual General Meeting (AGM).

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

## 7. Frequency of Meetings

7.1 The Board will meet no less than four times per year including an AGM.

7.2 Additional meetings of the Board may be convened with agreement of the Chairman.

## 8. Agenda and Notice of Meetings

8.1 The agenda for each ordinary meeting of The Board will be against the following headings:

1. Apologies
2. Declaration of members interests
3. Minutes from the previous meetings
4. Action updates from previous meetings
5. Chairman's announcements
6. Decision/Authorisation items
7. Discussion/debate items
8. Information items
9. The work programme of planned future work
10. An action log of previous decisions
11. Date of next meeting

All papers for The Board to be provided to the Democratic Services Manager of Lincolnshire County Council ("the Secretariat") 15 working days before the date of the scheduled meeting, with appropriate template short report for the appropriate agenda item, for the agenda setting meeting with the Chairman. (See process map at Appendix B)

8.2 All finalised agenda items or reports to be tabled at the meeting should be submitted to the Secretariat no later than seven working days in advance of the next meeting. No business will be conducted that is not on the agenda.

8.3 The Secretariat will circulate and publish the agenda and reports at least five working days prior to the next meeting. Exempt or Confidential Information shall only be circulated to Core Members.

## 9. Annual General Meeting

9.1 The Board shall elect the Chairman and Vice Chairman at each AGM, The appointment will be by majority vote of all Core Members/substitutes present at the meeting and will be for a term of one year.

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9.2 The Board will approve the representative nominations by the partner organisations as Core Members.

## 10. Quorum

10.1 Any full meeting of the Board shall be quorate if not less than a third of the Core Members are present. This third should include a representative from the Clinical Commissioning Groups and a Lincolnshire County Council Executive Councillor and either the Chairman or Vice Chairman.

10.2 Failure to achieve a quorum within thirty minutes of the scheduled start of the meeting, or should the meeting become inquorate after it has started, shall render the meeting adjourned until the next scheduled meeting of the Board.

## 11. Procedure at Meetings

11.1 Members of the Public may attend all ordinary meetings of the Board subject to the exceptions set out in the Access to Information Procedure Rules set out in Part 4 of the Lincolnshire County Council's constitution.

11.2 Only the Core and Substitute Members are entitled to speak through the Chairman. Associate Members and the Public are entitled to speak if pre-arranged with the Chairman before the meeting.

11.3 With the agreement of the Board, the Board can set up operational/working sub-groups to consider distinct areas of work to support the activities of the Board.

11.4 The operational/working sub-group will be responsible for arranging the frequency and venue of their meetings.

11.5 Any recommendations of the operational/working sub-group will be made to the Board who will consider them in accordance with these terms of reference.

11.6 The aim of the Board is to make its business accessible to all members of the community and partners with special needs. Accessibility will be achieved in the following ways:

- Ensuring adequate physical access to Board meetings,
- Providing signers, interpreters or other specialist support within existing resources on request to the secretariat,
- To include a work programme of planned future work on the agenda,
- Reports and presentations are in a style that is accessible to the wider community, and of a suitable length, so that their content can be understood,
- Enabling the recording of meetings to assist the secretariat in accurately recording actions and decisions of the Board.

## 12. Voting

12.1 Each Core Member and Substitute Member shall have one vote.

12.2 Wherever possible decisions will be reached by consensus. In exceptional circumstances and where decisions cannot be reached by consensus of opinion, voting will take place and decisions agreed by a simple majority. The Chairman will have a casting vote.

12.3 Decisions of the Board will be as recommendations to the partner organisations to deliver improvements in the Health and Wellbeing of the population of Lincolnshire.

## 13. Minutes

13.1 The Secretariat shall minute the meetings and produce and circulate an executive summary and action log to all Core Members.

13.2 The Secretariat will send the draft minutes and action log to the Chairman within five working days of the meeting for comment.

13.3 The draft minutes, as agreed by the Chairman, will be circulated to Core Members.

13.4 The draft minutes will be approved at the next quorate minuted meeting of the Board.

13.5 The Secretariat will publish the minutes, excluding Exempt and Confidential Information, on the Lincolnshire County Council website.

## 14. Expenses

14.1 The partnership organisation's are responsible for meeting the expenses of their own representatives.

## 15. Declarations of Interest

15.1 At the commencement of all meetings all Core Members who are members of Lincolnshire County Council shall declare any interests in accordance with the Member's Code of Conduct which is set out in Part 5 of the Lincolnshire County Council's constitution.

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## 16. Conduct of Core Members at Meetings

16.1 It is important to ensure that there is no impression created that individuals are using their position to promote their own interest, whether financial or otherwise, rather than for the general public interest.

16.2 When at Board meetings or when representing the Board, in whatever capacity a Core Member must uphold the principles of:

- Selflessness
- Honesty and Integrity
- Objectivity
- Accountability and Openness
- Respect for Others
- Cooperation

## 17. Review

17.1 The above terms of reference will be reviewed at the AGM or earlier if necessary.

17.2 Any amendments shall only be included by unanimous vote.

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***Definition***

***Exempt Information***
*Which is information falling within any of the descriptions set out in Part I of Schedule 12A to the Local Government Act 1972 subject to the qualifications set out in Part II and the interpretation provisions set out in Part III of the said Schedule in each case read as if references therein to "the authority" were references to "Board" or any of the partner organisations.*

***Confidential Information***
*Information furnished to, partner organisations or the Board by a government department upon terms (however expressed) which forbid the disclosure of the information to the public; and information the disclosure of which to the public is prohibited by or under any enactment or by the order of a court are to be discussed.*

***Associate Members***

*Associate Member status is appropriate for individuals wanting to be involved with the work of the Board, but who not designated core members are. The Board has the authority to invite Associate Members to join and approve their membership before they take their place. Associate Members will not, unless specifically requested, be consulted on dates and venues of meetings, but are invited to submit agenda items, and have a standing invitation to attend meetings if an issue they are keen to discuss is on the agenda. Associate members will not have voting rights at HWBB meetings.*

***Health Services***
*Means services that are provided as part of the health service.*

***Health-Related Services** means services that may have an effect on the health of individuals but are not health services or social care services.*

***Social Care Services***
*Means services that are provided in pursuance of the social services functions of local authorities (within the meaning of the Local Authority Social Services Act 1970).*

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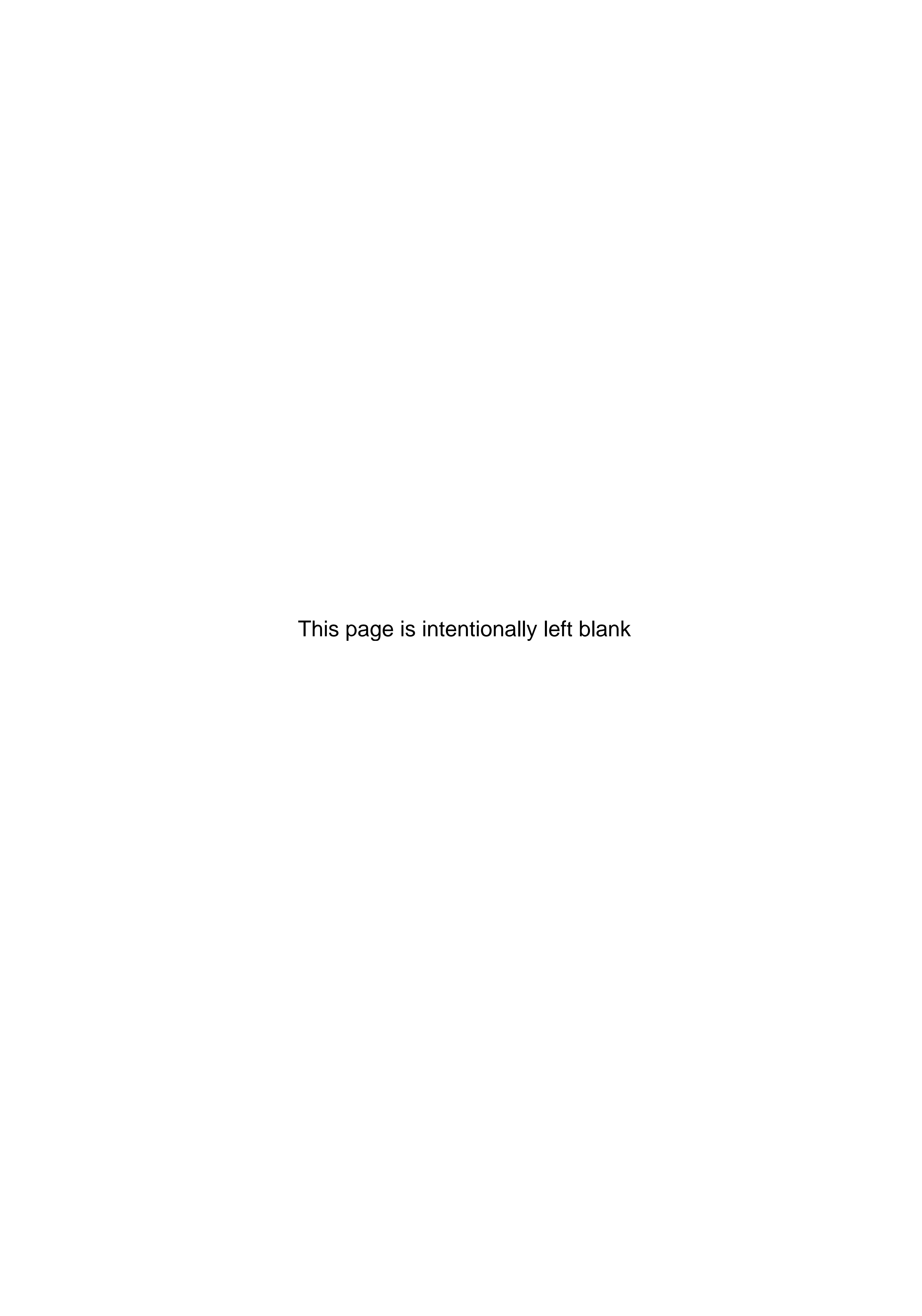

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## Lincolnshire Health and Wellbeing Board Responsibilities

Key responsibilities of **ALL** board members:

- Agreement of CCG Commissioning plans
- Oversight of Annual Public Health Report/Public Health Issues
- Agreement of Children's commissioning plans
- Oversight of Healthwatch Plans/Annual Report
- Agreement of Adult's commissioning plans
- Creation of Joint Strategic Needs Assessment (JSNA), and the Joint Health and Wellbeing Strategy (JHWS)
- Adhere to the Equalities Duty Act 2010, including the Public Sector Duty
- Performance and Quality Monitoring
- Promote integration and partnership across areas
- Undertake a compliance role in relation to major service redesign
- Support joint commissioning plans and pooled budget arrangements to meet the needs identified by the JSNA and to support the implementation of the Health and Well-being Strategy
- Ensure all commissioning plans have been co-produced
- Joint health and wellbeing strategy sponsor members of the Board should also ensure the strategy is developed according to the direction of the Board and to provide assurance to the Board that it is working within agreed timescales

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**All members of the HWB will be expected to**

- **Represent** and **speak** on behalf of their organisation or sector
- Be **accountable** to their organisation or sector when participating in the HWB ensure organisations/sector are kept informed of HWB business and that information from their organisation/sector is reported to the HWB
- **Support** the agreed majority view when speaking on behalf of the HWB to other parties
- **Attend** HWB meetings or ensure that a named deputy is briefed when attending on their behalf
- **Declare** any conflicts of interest should they arise
- **Read** agenda papers prior to meetings so that they are ready to contribute and discuss HWB business
- **Work collaboratively** with other board members in pursuit of HWB business;
- **Ensure** that the HWB adheres to its agreed terms of reference and responsibilities;
- **Listen** and respect the views of fellow Board members;
- **Be willing** to take on special tasks or attend additional meetings or functions to represent the HWB

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## Key roles and responsibilities of individual core board members:

### Lincolnshire County Council Executive members

- Report any issues raised by the public to the Board
- Report any issues raised by other councillors to the Board
- Report any issues raised by other members of the Board
- Provide strategic direction in relation to Lincolnshire's Joint Health and Wellbeing Strategy
- Report publicly on the work and progress of the Board
- Report to Executive on the work and progress of the Board
- Promote and ensure co-production of all commissioning plans and proposals

### Lincolnshire County Councillors

- Report publicly on the work and progress of the Board
- Report any issues raised by the public to the Board
- Report any issues raised by other councillors to the Board

### Executive Director for Public Health

- Update the Board on public health related activity taking place in Lincolnshire
- Report to the Board any relevant information provided from Public Health England (PHE) and report any relevant board matters to PHE
- Ensure Lincolnshire is addressing health inequalities and promoting the health and wellbeing of all Lincolnshire residents
- Lead the revision and publication of the JSNA
- Lead the revision and publication of the Joint Health and Well-being Strategy

### Adults and Children's Executive Directors

- Report on commissioning activity to the Board
- Provide relevant information requested by the Board
- Contribute to the creation of the JSNA



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- Have regard to the JSNA and the JHWBS when developing commissioning and budget proposals
- Report Board activity to assistant directors and heads of service

**Clinical Commissioning Group representative**

- Ensure that the Clinical Commissioning Group members/partners directly feed into the JSNA
- Have regard to the JSNA and the JHWBS when developing commissioning and budget proposals
- Report commissioning activity to the Board
- Report Board activity to other Clinical Commissioning Group members

**Lincolnshire Healthwatch representative**

- Reflect the public's views acting as the patient's voice to report any issues raised by the public to the Board
- Feedback board response to issues raised and activity undertaken
- Promote community participation and co-production in support of activity
- Ensure evidence from Healthwatch is fed into JSNA evidence base
- Report on and from Healthwatch England
- Ensure the Joint health and Wellbeing Strategy reflects the need of Lincolnshire's population
- Provide reports to the Board on issues raised by providers or the public of Lincolnshire

**District Council representative**

- Promote the Boards intentions to District Council partners
- Ensure evidence from the District Council is fed into JSNA evidence base
- Feedback any issues raised by partner districts or the public to the Board

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**NHS England representative**

- Update the board on any national Commissioning issues which will affect Lincolnshire's Joint Health and Wellbeing Strategy
- Ensure evidence from Healthwatch is fed into JSNA evidence base for Lincolnshire
- Feedback on any issues raised by the Board affecting Lincolnshire to the NHS Commissioning Board
- report on direct commissioning activity
- have regard to JSNA and JHWBs when developing commissioning and budget proposals
- provide strategic direction in relation to Lincolnshire JHWB strategy
- provide an opportunity for issues that fall within the Area Team role of NHS to be reported in a meeting held in public.

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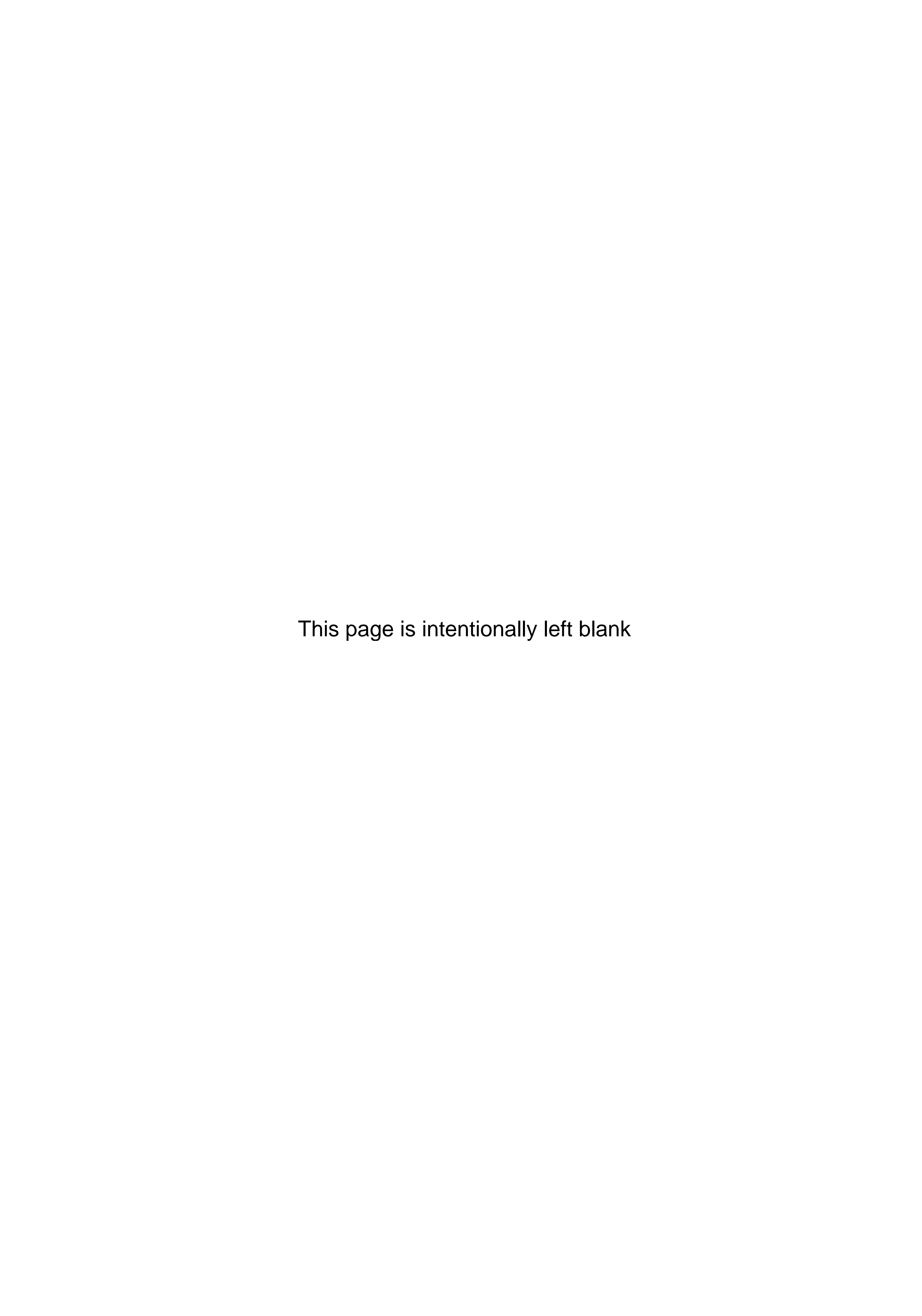
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# LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of Leicestershire and Lincolnshire Area Team

| | |
|---|---|
| Report to | **Lincolnshire Health and Wellbeing Board** |
| Date: | **10 June 2014** |
| Subject: | **Draft Direct Commissioning Operational Plan 2014-16<br>& Emerging Strategy Update** |

**Summary:**

This document sets out proposed plans for services commissioned by NHS England's Leicestershire and Lincolnshire team. It sets out which services we commission, which communities we serve and how these plans compliment the plans and work of other bodies that are responsible for related health and social care services. It provides an overview of relevant aspects of our communities' health needs, & the current state of our healthcare services.

**Actions Required:**

Members are asked to note the scope of the operational plans for Direct Commissioning:

Primary Care – Leicestershire and Lincolnshire

Public Health – Leicestershire and Lincolnshire

Specialised Commissioning – East Midlands

## 1. Background

See Appendix A

## 2. Conclusion

See Appendix A

## 3. Consultation

N/A

## 4. Appendices

| These are listed below and attached at the back of the report | |
|---|---|
| Appendix A | Draft Direct Commissioning Operational Plan 2014-16<br>& Emerging Strategy Update |

## 5. Background Papers

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

This report was written by Peter Huskinson; please refer any queries regarding the report to Andy Leary Director of Finance and Commissioning:
andyleary@nhs.net

# Draft Operational Plan 2014-16 & Emerging Strategy Update

## NHS England (Leicestershire & Lincolnshire)

# NHS England (Leicestershire & Lincolnshire) Operational Plan 2014-16, Emerging Strategic Plans 2014-2019 & Strategy Update

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# Foreword

This document sets out proposed plans for services commissioned by NHS England's Leicestershire and Lincolnshire team. It sets out which services we commission, which communities we serve and how these plans compliment the plans and work of other bodies that are responsible for related health and social care services. It provides an overview of relevant aspects of our communities' health needs, & the current state of our healthcare services.

National priorities for healthcare are set by a mandate from the government to NHS England. NHS England has set out its response to achieving those priorities in 'Everyone counts' guidance, & in National commissioning intentions for some services, reflected in these plans.

National regulators govern aspects of how services are commissioned: Monitor sets national prices for many services, and determines rules governing to whom and how contracts to deliver healthcare services may be awarded. Core Quality standards are set out by the Care Quality Commission directly to health and social care providers. The National Institute for Clinical Excellence assesses treatments for clinical and cost effectiveness to recommend which treatments should be made available, & provide guidelines for their use. The contracts with independent contractors who provide primary care (General Practitioners, Optometrists, Pharmacists and Dentists) are nationally negotiated.

Our plans apply locally those national priorities and standards for which we have local responsibility, prioritised within the financial and human resources made available to us, focused on those things that we believe will achieve the greatest impact on health outcomes, given the particular challenges and opportunities we face.

This is the first draft of these plans. The draft reflects early and on-going consultation with other local partners with commissioning responsibilities, and will be further refined as we receive feedback from partners and from regional and national stakeholders. They reflect and will inform related work scheduled for completion after operational plans are concluded, by June 2014: The national primary care strategy and national strategy for specialised services, the Leicestershire & Lincolnshire primary care strategy, and further work on the health system plans for Leicestershire Leicester & Rutland, and Lincolnshire Sustainable Services Review, including outcome ambitions and 'commissioning for prevention' goals.

The NHS at its best is a shared endeavour in pursuit of our vision: "*High quality care for all, now and for future generations*". This purpose is even more important at a time when resources are constrained. It is our intention through these plans to make this vision a reality for the people in our communities who fund, use & work within or in partnership with the NHS.

**Peter Huskinson**
**Director of Commissioning**

## Executive Summary

NHS England commissioning plans cover primary care, public health services (immunisation, screening and health visiting) and specialised acute and mental health.

For Lincolnshire, Leicester, Leicestershire and Rutland authority areas the key health needs the plans respond to are **life expectancy** below peers in the 2 large county authorities and low in absolute terms in Leicester city, **years of life lost from causes amenable to healthcare** below peers in Leicester city, Lincolnshire and Rutland, and surveyed GP experience below peers in Leicestershire and Lincolnshire, and low in absolute terms in Leicester city, along with poor oral health.

Specialised services has a provider profile of large tertiary trusts (2 acute and 2 mental health providers account for over 70% of spend) as well as some services at 7 other acute and 7 other mental health providers. NHS England are the largest single commissioner of University Hospitals of Leicester NHS Trust, Nottingham University Hospitals NHS Trust, and Nottinghamshire Healthcare NHS Trust.

The key issues for east midlands providers are relatively high Care Quality Commission risk ratings and financial sustainability. Service prices reflect generally good levels of efficiency and more established clinically based access policies now migrated to national consistent policies, making the achievement of further financial savings require more innovative solutions than other regions without this track record.

Commissioning plans implement national commissioning intentions, including plans to converge prices for specialised care where this is outside national tariff, and to make better use of the NHS' national purchasing power for drugs and devices. Of particular importance is the adoption of national clinical service specifications in 2013/14. Providers have areas with time limited permission to become compliant in order to continue to provide services so monitoring action plans in 2014/15 are a key to ensure all patients enjoy consistent standards of care. The national strategy for specialised services is likely to recommend consolidating services to a much smaller number of providers than today, providing improved clinical outcomes through centres of excellence, and a means to achieve 7 day working in a financially sustainable way.

Quality improvement is integral to commissioning plans, and embedded in accountability processes for contracts and via multidisciplinary medical, nursing and primary care contracting review as well as through local and regional Quality Surveillance Groups and close partnership with the Care Quality Commission (CQC). In addition to adopting national Clinical Quality and Innovation (CQUIN) incentive schemes, the area team are working with partners to adopt the chief nursing officer strategy Compassion in Practice (care, compassion, competence, communication, courage and commitment), to further develop learning from complaints, through listening events, and the new data on patient experience available to us from the new year, with priority work plans on healthcare acquired infection, incident reporting, harm free care, and staff satisfaction as levers for change.

Plans also reflect a range of issues specific to the east midlands and to partner commissioners:

1. Addressing the national capacity issues in Child and Adolescent Mental Health (CAMHS) Services through appropriate capacity at each tier. East Midlands has few Tier 3+ services, although some areas now have plans in place to commission them.
2. Aligning capacity across pathways for obesity, weight management and bariatric surgery to ensure patients gain appropriate access to specialist services after first line treatments commissioned by Clinical Commissioning Groups (CCGs) and local authorities have been tried.
3. Provision of appropriate radiotherapy capacity and configuration of related cancer pathways in the South Midlands, reflecting new clinical partnerships between Northampton and Leicester, and Milton Keynes and Oxford.
4. Ensuring the sustainability of HIV services in east midlands providers is not adversely affected by local authority commissioning intentions for sexual health services given the service and workforce dependencies.
5. Appropriate service access to community and inpatient perinatal services following notice given by LPT for a service unable to meet core service standards.
6. Responding to the national review of children's and adult cardiac services
7. The completion of rollout of the East Midlands major trauma network with patients taken to the Major Trauma centre at Nottingham, which will significantly improve survival rates for patients

Specialised service commissioning is adopting a number of innovative interventions including 'NHS Improving Quality' support to providers for establishing 7 day working, internationally proven evidence based clinical decision support systems to improve hospital workflow, beginning in critical care at the 2 largest centres, and a national pilot for hand hygiene technology with promising evidence of reductions in rates of infection.

For public health services, plans build on the excellent progress in becoming the largest national pilot site for the Fluenz vaccination programme for children, making plans for transferring commissioning responsibility for the under 5 health visitor services to local authorities and continuing to expand health visitor and family nurse partnership services to support more families, and the introduction of bowel scoping to the bowel cancer screening programme.

Primary healthcare providers face distinct challenges. For GPs significant variations in patient surveyed satisfaction, major differences in opening hours and ease of access, and services geared around Monday to Friday despite progress in evening and Saturday appointments by some. The national service direction is for wider primary care services provided at scale, recognising the challenge that smaller standalone providers face in dealing with rising population need within constrained financial resources.

Plans for primary care are set out based on a number of ambitions developed through working with professionals and partners, including health watch which will inform the strategy for primary care:

<u>To reduce unjustified variation in quality of services</u> – including working with CCGs to ensure patients with more complex needs benefit from national changes to the GP contract requiring new models of care delivery, and a systematic approach to monitoring quality and addressing outlier practices, and working to tackle capacity issues.

To reduce unjustifiable inequalities in health outcomes and access to services for vulnerable groups, including implementing reviews of enhanced services for dementia, health checks for people with learning disabilities, and alcohol abuse to incorporate assessments for depression and anxiety, working to improve oral health in Leicester city and producing an eye health needs assessment to inform future plans.

To increase citizen participation and empowerment in primary care services, including the friends and family test for GP practices, relaxation of boundaries to extent patient choice of where to register, and full rollout of online booking prescriptions and medical record access, and others.

To improve the quality of life for older people and those with long term conditions though implementing GP contract changes focusing on the 2% of patients at highest risk of unplanned admission

To improve access to primary care services and secondary care dental services including supporting pilot practice groups in the prime minister's challenge fund to deliver new models of access and 7 day working.

To reduce unjustified variation in funding received by providers, and secure the highest quality care and best outcomes for every pound invested. This will involve implementing national contract changes, such as phasing out minimum practice incomes, to ensure resources follow patients, and undertaking a review of all PMS contracts to ensure the higher funding is reflected in higher service standards than GMS practices, and where this is not the case releasing resources to support the strategic development of primary care.

Based on international evidence reviews undertaken for NHS England by Nuffield, a number of care delivery models will be supported, with further work to take place:

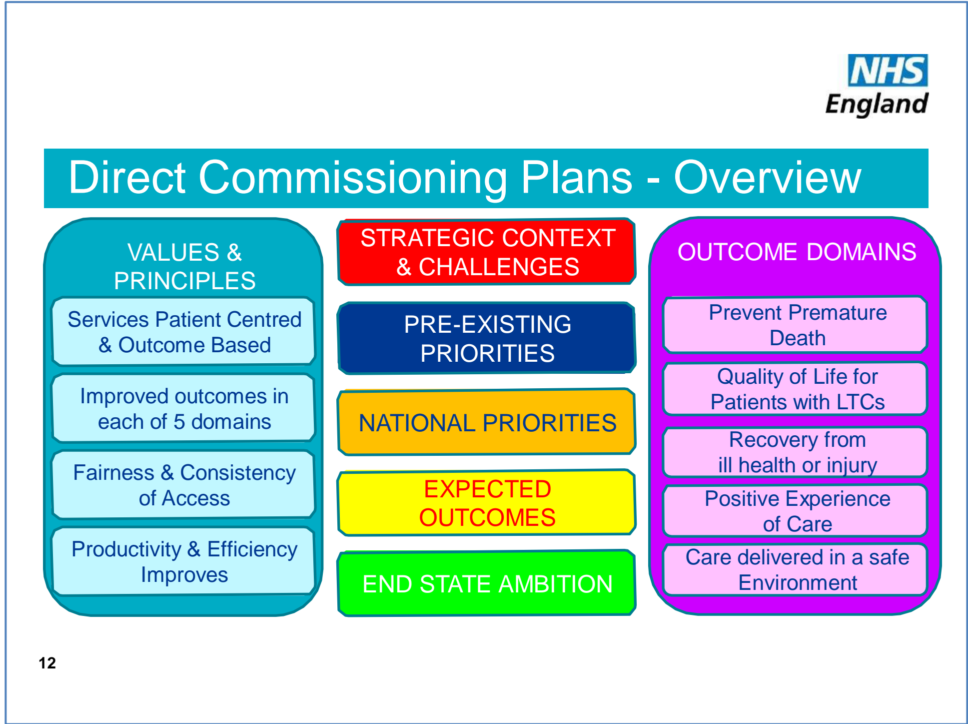
- Integration around specific medical conditions
- Integration across a wide range of conditions in a geography (neighbourhood)
- Colocation and mergers of practices to gain synergies
- Creative use of rural primary care with other public sector and community services
- Federation to manage core services and functions on a shared basis
- Specialist GP services for targeted populations and conditions.

The commissioning plans deliver financially balanced plans in a challenging financial climate whilst responding to a wide range of new ambitions and initiatives set out in 'everyone counts' planning guidance.

Further work with local authority and CCG partners is anticipated using the 'commissioning for prevention' methodology provided nationally to set improvement ambitions jointly with all partners. The area team has prioritised demand management and prevention in its use of monies from emergency care tariffs, and will engage local authority partners in the next months to contribute to refreshing the programme of work in this area.

## Overview

Our plans for services sit within a common national framework:




For all services, NHS England's values and principles are that:

- Services should be patient centred and outcome based
- Plans should drive improved outcomes in the five domains set out by government
- Fairness and consistency of access to address health inequalities
- Improvements in productivity and efficiency allow improved quality within available resources

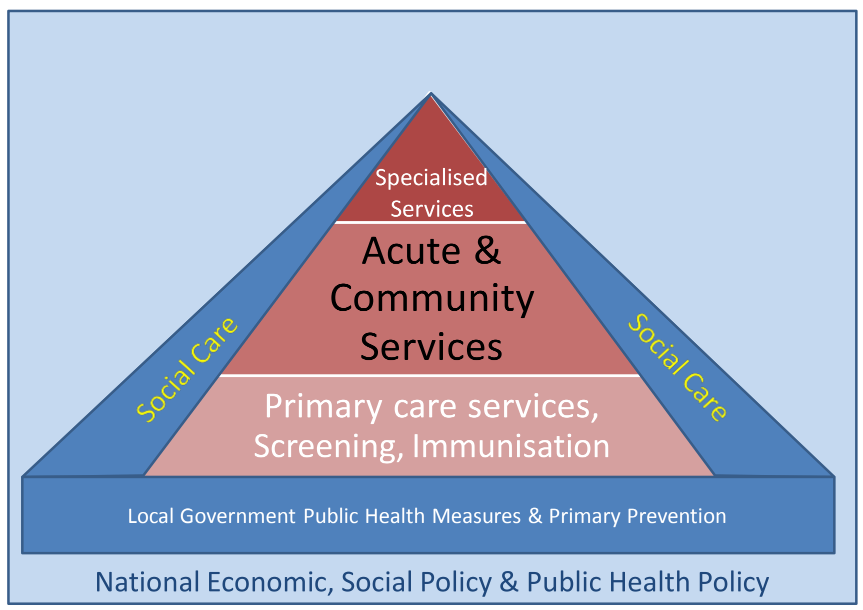
Section one and two set out the strategic context and challenges faced by our population and by providers and commissioners of healthcare. Section three outlines our priorities, the emerging direction for services and the expected outcomes of our plans. Section four focuses on delivery with financial framework for the next two years, and the impact of our change programme for Quality, Innovation, Productivity and Prevention.

Our direct commissioning plans, and those of our CCGs, operate in tandem with a full and active programme of quality improvement led through the NHS England area team and its partners. The outline of the programme is set out in the appendices to these commissioning plans.

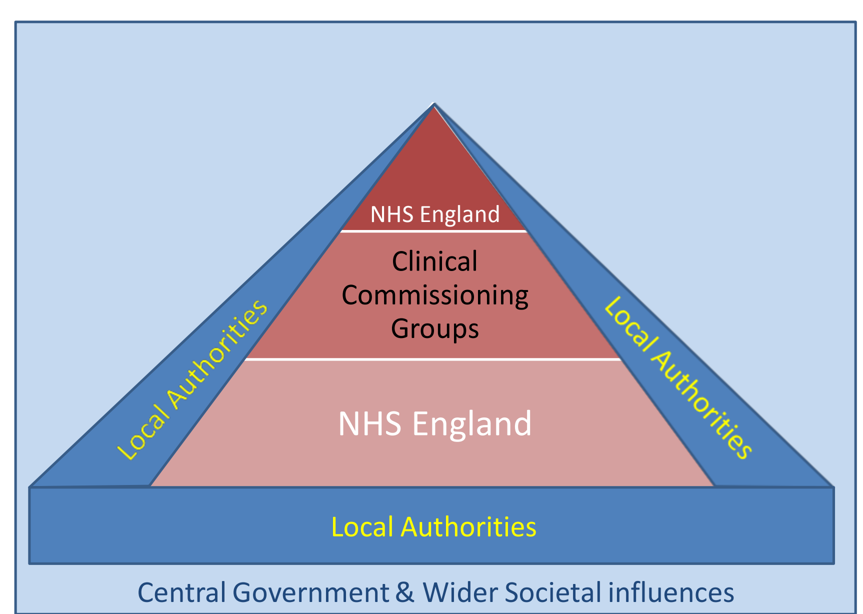
## SECTION ONE: NATIONAL AND LOCAL CONTEXT

### NHS England's Directly Commissioned Services – An Overview

The NHS in England provides comprehensive healthcare treatment for the whole population for, on average, £34 per person per week, or £1,770 per year. These services, alongside a wide range of other factors, contribute to our life expectancy and the quality of life we live:




A range of public bodies are responsible for these different aspects of care:



At a national level, spend on NHS healthcare in the year ahead is broken down as follows[1]:

| NHS Commissioner | Total Spend | Spend Per Person in Population |
|---|---|---|
| Specialised Commissioning – NHS England | £13.5bn | £247 |
| Acute and Community Care – CCGs | £64.3bn | £1,179 |
| Primary Care – NHS England | £12.3bn | £225 |
| Immunisation, screening & health Visiting – NHS England | £1.8bn | £33 |
| Other (Better care fund, Health & Justice, National Programmes) | £4.7bn | £86 |
| **TOTAL (54.55m People)** | **£96.6 bn** | **£1,770** |

In Context:

- Two thirds of this money is planned and spent by clinical commissioning groups
- Just under £1 in every £6 is spent on complex and specialised care,
- Around £1 in £8 is spent on Primary Care, and
- Just below £1 in every £50 is spent on NHS Public Health Services (Immunisation, screening & health visiting)

Together the services commissioned by NHS England comprise around £1 in every £4 of spending on the NHS.

Our plans describe NHS England's intentions for Primary Care and NHS Public health Services for the 1.8 million people of Leicester, Leicestershire, Lincoln and Rutland and for all Providers of complex & specialised acute and mental healthcare who are based in the East Midlands, who primarily serve the 4.9 million people in this region, but also some services on a national basis.

Primary care and public health services plans inform the wider population based plans for Leicester Leicestershire & Rutland that all commissioning bodies in the NHS and local authority are developing. The plans for specialised services reflect a national approach to commissioning to ensure nationally consistent access and quality, and complement the local health system population based plans, with all services contributing to the overall outcomes goals the government has set for health and social care.

[1] Source: ONS Population projections, NHS England Allocations working paper 2014

# Our Three Commissioning Responsibilities

## Direct Commissioning of Specialised Services: Context

In April 2013, NHS England became the sole direct commissioner of all specialised services, with a related budget of some £13.5 Billion (14/15). Specialised services are services which are provided for less common disorders and need to be concentrated in centres of excellence where the highest quality care can be provided – care that is clinically effective, safe and offers a positive experience for patients. It is important that these services are connected to research and teaching.

NHS England is now the sole commissioner of specialised services with a clear responsibility to show leadership in delivering the best outcomes and experience of care for patients. In doing so, NHS England is keen to demonstrate its commitment to working in partnership with patients, the public, clinicians, patient organisations, providers, industry, academia and others, to develop its priorities in the coming years. To support the delivery of this commitment, NHS England is working with the Specialised Healthcare Alliance and Rare Disease UK to develop a national 5 year strategy.

Ten of NHS England's 27 area teams have direct commissioning responsibility for specialised services. They account for over 10 per cent of the overall NHS budget. Area teams are required to implement these national policies at a local level, managing contracts with their providers on behalf of all patients in England.

The Leicestershire, Lincolnshire area team is one of these area teams with commissioning responsibility for commissioning specialised services for the population of England for all providers in the East midlands. This operational plan provides an account of the first two years of the five year strategy from the perspective of the Leicestershire Lincolnshire Area team.

The Strategic direction of NHS England is to deliver quality specialised services for all. This includes ensuring there is access to services for all, the services must be clinically and financially sustainable. To achieve this we are undertaking a systematic and coordinated review of all of the specialised services that we commission. This will involve exploring capacity, capability and access associated with all of the services in the East Midlands. The co-dependency of services and the relationship between those that provide services and commission them is a fundamental to the success of this process. This will inevitable involve adopting new approaches to the delivery of care and the integration of services from both a provider and commissioning perspective. As an Area Team we are working with one of our constituent CCGs (Southern Derbyshire) to pilot one of five national pathfinder projects looking at pathways of care that transcend commissioning boundaries. A project board has been established and project initiation document has been developed in line with the project brief. The focus of the project on commissioning and development of commissioning tools that can be adopted nationally for the management of Acute Kidney Injury.

The systematic and transparent approach to commissioning is underpinned by adhering to a systematic rules based approach. We have adopted a coordinated and constant approach to assessing services against the service specification by ensuring that we have external validation of the process by using members of the regional team, strategic clinical networks and senate as part of this process. Being proactive in ensuring we have a team approach to all aspects of commissioning ensures that maximum use is made of everyone's skills and experience to deliver services which are both clinically and financially sustainable.

All of our commissioning intentions and ambitions are considered within the context of the local healthcare environment. This includes any sustainability reviews being undertaken that are exploring the long-term provision of healthcare over a wide geographical area (Lincolnshire). Well established and programmed peer reviews of cohorts of specialist services (cancer) or service inspections (Keogh or CQC). The impact of changes in the demographics and the dispersal of populations are factors that will need to be considered in implementing nationally set policies and guidance. Local intelligence will come from engagement with the strategic clinical networks and senates, health related charities and user groups. Close cooperation with public health colleagues and the integration of the commissioning function of Public Health England into the organisation will ensure the wider aspects of health care are considered when planning changes to how we commission healthcare. We support Strategic Clinical Networks and Academic Health Science Networks to develop work plans which focus on strategic care models and pathway development for key health needs. This enables integration of care and a shift toward earlier intervention and treatment. The benefit from this work will manifest where there is a direct link to access to specialised care pathways such as in obesity, kidney care and cancer services. Although we will not lose sight of the importance of access, egress, quality and availability of specialised services the team must also be mindful of the financial sustainability of any specialised service that we commission.

A key area for the Area Team is managing its financial risks and for developing the value for money and quality it delivers through its service providers. In order to do this we have an established team of supplier managers and service leads who work together in a matrix to underpin a formal approach to the way that we manage our suppliers. This includes:

- Contract management, negotiation, & where required dispute resolution.
- Co-ordinating the delivery of outcomes and quality including the management of Significant Incidents & commissioning Quality Innovation (CQUIN) schemes.
- Forecasting Demand and Planning Capacity of services
- Production of monthly reporting of performance indicators for service providers
- Financial performance – including carrying out monthly financial review and forecasts, assuring co-ordination with service providers cost base and being accountable to the Head of Finance for accurate financial reporting.
- Maintaining detailed Trust specific business knowledge, including maintaining awareness of providers' service risks.
- Raising and resolving performance issues (e.g. readmission levels, mortality ).
- Identifying and managing efficiency programs and targets.
- Supporting the adoption of "best practice" to ensure value for money care processes
- Maintaining high visibility with senior management and clinicians in providers.
- Business Case Review for service developments.
- Benchmarking costs/performance with service specialists

## Direct Commissioning of Primary Care: Context

From 1st April 2013, NHS England became the sole commissioner of primary medical, ophthalmic and pharmaceutical services, and all dental services with an associated budget

of £12.6bn. This also included contractor payments, patient registration and primary care support services (Family Health Services).

All 27 Area Teams have direct commissioning responsibility for these services and this is summarised in the table below along with the responsibilities of other commissioners where there is a joint commissioning role.

| NHS England Area Team | Related Commissioning |
|---|---|
| **Primary Medical Services**<br>Essential and additional primary medical services through GP contracts and nationally commissioned enhanced services.<br><br>Out of hours primary medical services (where practices have retained the responsibility for providing out-of-hours services.<br><br>Improving the quality of primary care, access and patient experience. | **CCGs** - Community-based services that go beyond the scope of the GP contract (akin to the current Local Enhanced Services).<br><br>**CCGs** - Out-of-hours primary medical services (where practices have opted out of providing out-of-hours services under the GP contract).<br><br>**CCGs** - A duty to support the Area Team to improve the quality of primary medical care. |
| **Pharmaceutical Services**<br>Pharmaceutical services provided by community pharmacy contractors (not though a contract but the contractors' terms of service are included in Regulation), dispensing doctors and appliance contractors. | **CCGs** – meeting the costs of prescriptions written by member practices (but not the associated dispensing costs).<br><br>**Local Authority** – production of the Pharmaceutical Needs Assessment. |
| **General Ophthalmic Services**<br>Primary ophthalmic services, NHS sight tests and optical vouchers. | **CCGs** – any other community-based eye care services and secondary care services. |
| **Dental Services**<br>All dental services, including primary, community, and secondary care services, plus urgent and emergency dental care. | **Local Authority** – Dental Public Health. |

The strategic direction of NHS England is to enable primary care to play a greater role in the move to more integrated out-of-hospital services that deliver better health outcomes and deliver more personalised and proactive care, an excellent patient experience, high standards of quality, and the best possible value for money.

The main challenges for primary care are:

- How can primary care support prevention, care navigation, and case management through an increasingly multidisciplinary approach to service delivery?
- How can primary care reduce expensive unplanned admissions to secondary care and build capacity in the community to deliver integrated out-of-hospital services?
- How can primary care resolve its capacity issues to raise standards and improve consistency?

The Leicestershire and Lincolnshire Area Team's five year strategy aims to address these 'big issues' and deliver our vision for primary care. This includes:

- supporting innovative sustainable models of service delivery, workforce capacity solutions, improved access,
- working through contractual limitations,
- valuing the role of the primary care generalist in providing continuity, coordination and a personal approach, and
- involving patients in our commissioning of services.

The operational plan outlines the first two years of that journey.

## Direct Commissioning of Public Health Services: Context

The public health function is responsible for commissioning the 30 services defined in section 7a of the agreement between the Department of Health and NHS England. Twenty six of these relate to national screening programmes and to immunisation programmes. The Public Health England embedded team lead on the commissioning of these services. The remaining four services include health visiting services for those under 5 years, child health records departments, public health services for detained offenders and sexual health referral centres.

Commissioning of all these services requires close working links with other commissioners including:

- CCGs and specialised services commissioners as they commissioning many of the treatment pathways that follow on from screening programmes
- primary care commissioners as much of immunisation is commissioned from primary care as part of the GMS/PMS contract
- local authority commissioners due to the links with school nursing and immunisation services and the transfer of responsibility for commissioning health visiting services that will take place in October 2015.

Whilst the financial value of these services is relatively modest the reach is great with several hundred thousand contacts per year from these services within the population of Leicestershire, Lincolnshire & Rutland

# SECTION TWO: OUR CURRENT STATE

## Demand for Healthcare - The Health Needs of our Population

**Leicester, Leicestershire & Rutland and Lincolnshire**

Leicestershire, Lincolnshire and Rutland are the areas whose population is served by our Primary care and Public Health services, geographically amongst the largest footprint served by NHS England's area teams at over 9,500 square km, almost 60% of the east midlands.

The population is diverse with a 40 fold difference in rurality between the 4 local authority areas. The main centres of population are the cities of Leicester and Lincoln with smaller market towns serving the county areas of Leicestershire, Lincolnshire and Rutland in otherwise predominantly rural areas, as well as coastal East Lincolnshire, with a seasonal migrant population. The BME community is under 3% in Lincolnshire and Rutland, 15% in Leicestershire and 49% in Leicester city, with a large South Asian population.

Geographically, Lincolnshire is the third largest county in England and covers an area of 2350 square miles. Leicestershire covers an area of 800 square miles and Rutland is the smallest county in England and covers an area of 152 square miles.

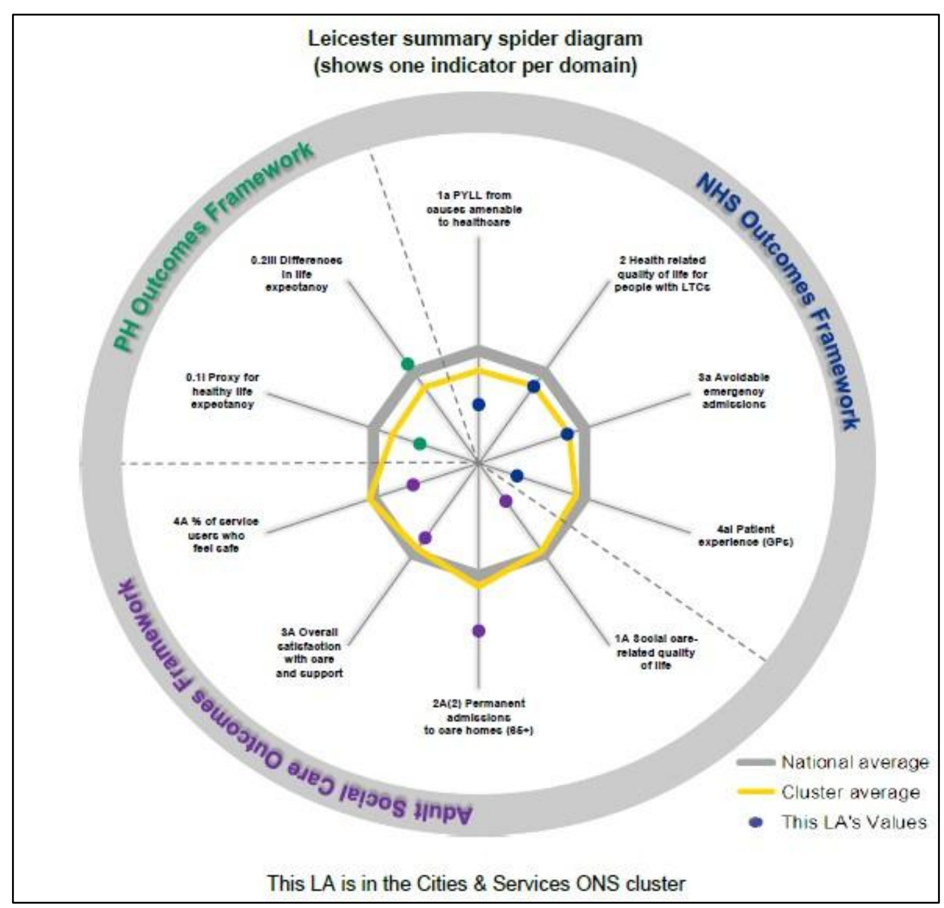
By road, it is approximately 125 miles to travel from the north to south of the area and 140 miles west to east.

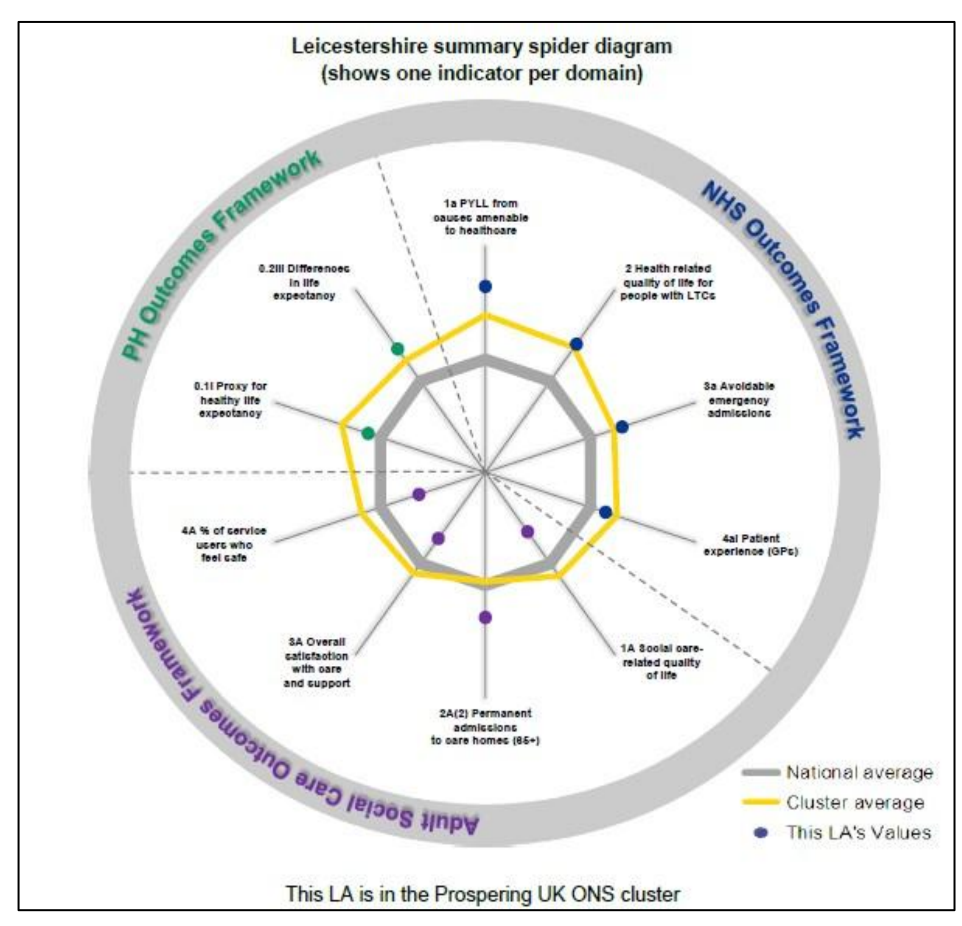
The Leicestershire and Lincolnshire area has a registered population of 1,792,400 with a higher proportion of 0-9 year olds in its population than the England average, a lower proportion of 25-39 year olds in its population than the England average, and a higher proportion of residents aged 60+.

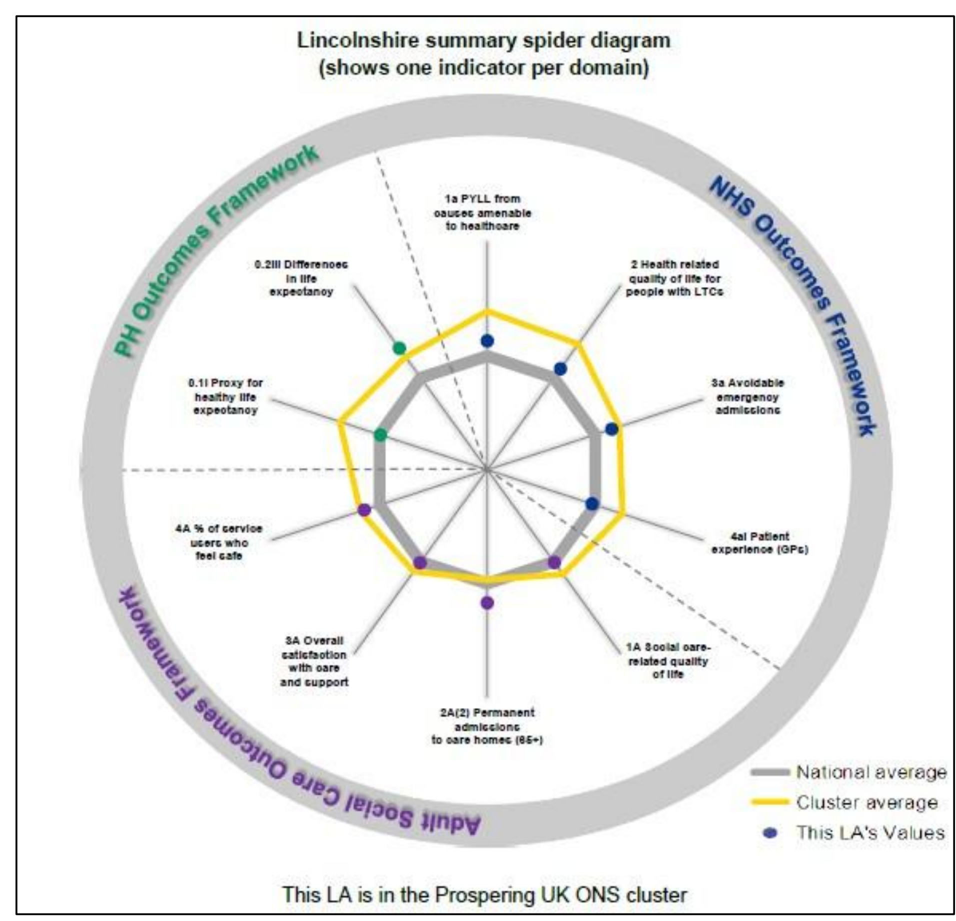
## Summary of Health in Leicestershire, Lincolnshire & Rutland

Outcomes benchmarking support packs published by NHS England, Public Health England, The Information Centre and Local Government association identify the existing health and care system performance in Leicestershire, Lincolnshire and Rutland compared to England averages and to similar comparable populations for the outcomes indicators defined by government for health, public health, and social care. The overview of these comparators is shown overleaf. The key health issues identified are:

| Leic City | Lincs | Leics | Rutland |
|---|---|---|---|
| Poor Patient surveyed GP Experience | More years of life lost from causes amenable to healthcare than peers | Average Life expectancy below peers | More years of life lost from causes amenable to healthcare than peers |
| High Years of life lost from causes amendable to healthcare | Health related Quality of life for people with LTC below peers | Patient surveyed GP experience below peers | |
| Low Average Health Life Expectancy | Patient surveyed GP experience below peers | | |
| | Average Life expectancy below peers | | |




Leicestershire summary spider diagram
(shows one indicator per domain)
PH Outcomes Framework
NHS Outcomes Framework
Adult Social Care Outcomes Framework
1a PYLL from causes amenable to healthcare
2 Health related quality of life for people with LTCs
3a Avoidable emergency admissions
4aI Patient experience (GPs)
1A Social care-related quality of life
2A(2) Permanent admissions to care homes (65+)
3A Overall satisfaction with care and support
4A % of service users who feel safe
0.1I Proxy for healthy life expectancy
0.2III Differences in life expectancy
National average
Cluster average
This LA's Values
This LA is in the Prospering UK ONS cluster


Lincolnshire summary spider diagram
(shows one indicator per domain)
PH Outcomes Framework
NHS Outcomes Framework
Adult Social Care Outcomes Framework
1a PYLL from causes amenable to healthcare
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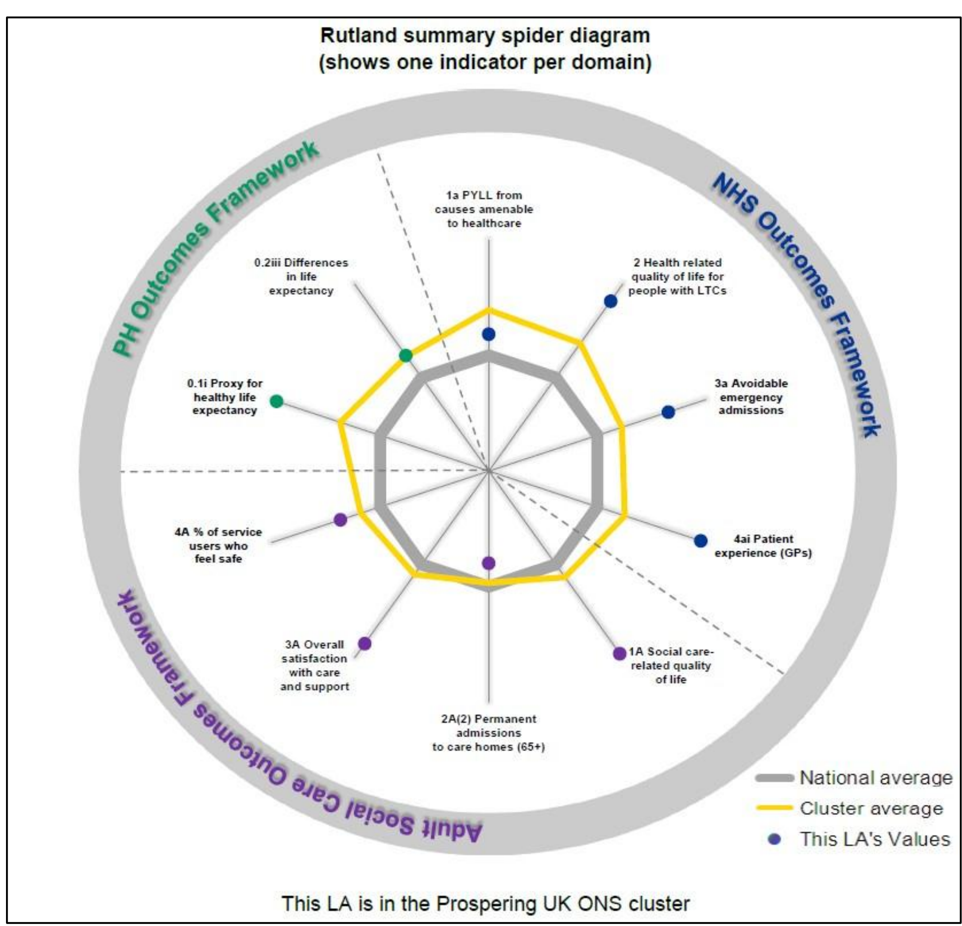
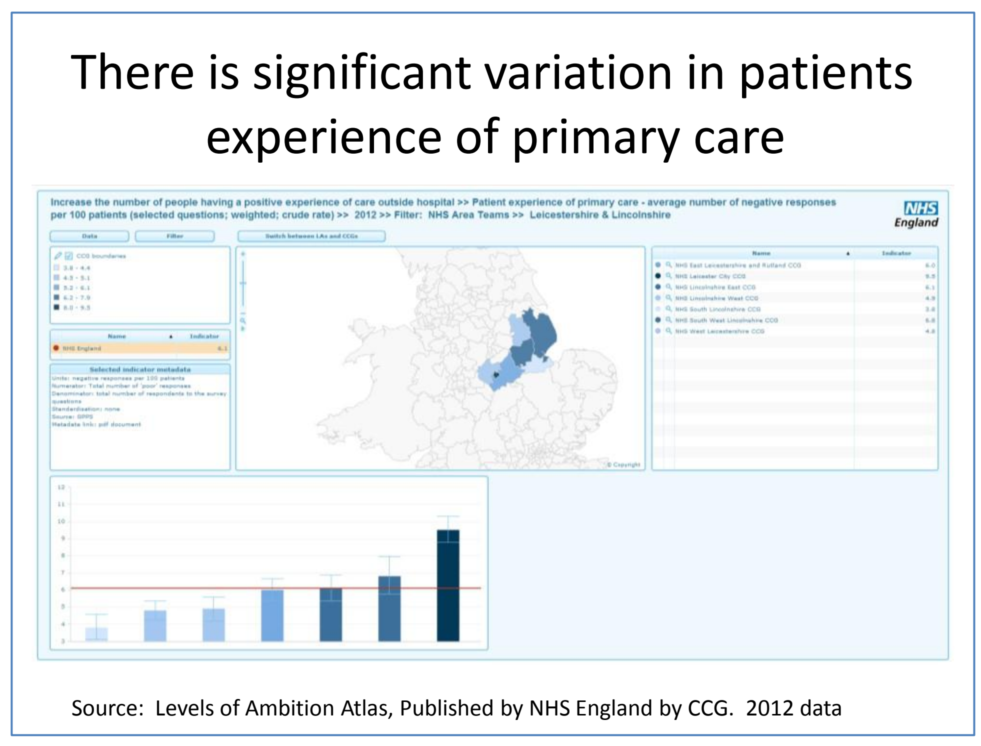
3A Overall satisfaction with care and support
4A % of service users who feel safe
0.1I Proxy for healthy life expectancy
0.2III Differences in life expectancy
National average
Cluster average
This LA's Values
This LA is in the Prospering UK ONS cluster




**Insights from the Atlas of Variation**

The range of issues to be addressed in partnership with the seven CCGs serving Leicestershire and Lincolnshire includes significant variation in the outcomes and experience affected by primary care and public health:




As well as the significant difference in primary care in Leicester city, Lincolnshire South West and Lincolnshire East Appendix 1 highlights greater potential years of life lost in Leicester city and East Lincolnshire, poorer reported quality of life for people with long term conditions in Leicester city, East and west Lincolnshire, and higher levels of avoidable emergency admission in East Lincolnshire. These variances in outcomes help to define the joint agenda between NHS England and CCGs for improving the quality and contribution of primary care services to the wider health and care system.

## The East Midlands

Other than national chains of healthcare providers, our commissioned specialised services providers are based in the East Midlands. Our responsibilities are for all patients nationally who use these services; including patients from other regions who choose to use services in the East Midlands. Our providers provide a range of specialised services which address the health needs of the populations they serve. The majority of which will come from the East Midlands catchment. Some specialised services used by the population in the region are not delivered by East Midlands providers; patients from the East Midlands will travel to other providers elsewhere in the UK for those services.

The East Midlands is geographically the fourth largest region in England in terms of area (15,607 sq km) and has a resident population of approximately 4.9 million. The provider landscape includes; two large teaching hospitals for acute care are situated in the region, Nottingham University Hospitals and University Hospitals of Leicester, both of which provide specialised tertiary care. There are seven district general hospitals and five NHS mental health providers which also provide elements of specialised care. Rampton Hospital, which is part of Nottinghamshire Healthcare NHS Trust, the largest Mental Health Trust in the country, is one of three providers of High Secure Psychiatric Services.

The East Midlands has a diverse population with the main centres of population in the cities of Derby, Leicester, Lincoln & Nottingham, & the large town of Northampton. The county areas of Derbyshire, Leicestershire, Lincolnshire, Northamptonshire, Nottinghamshire & Rutland are predominantly rural. Overall, the East Midlands region has the second lowest population density in England. In the cities a substantial proportion of the population is drawn from black & minority ethnic groups & there are high levels of deprivation, as there are in particular areas such as the old mining villages & steel towns. There are particularly low levels of deprivation in some county areas & the average deprivation for the East Midlands is similar to that of England. Increases in births, decreases in deaths, changes in migration & the pattern of UK immigration have all contributed to population growth since 2001.

## Summary of Health in the East Midlands

The East Midlands Health Profile 2010, produced by the Association of Public Health Observatories and Department of Health, provides a snapshot of health in the region. It compares East Midlands with other regions and the England average for a range of indicators.

The health of people in the East Midlands is generally close to the England average. However, levels of physical activity in adults, children in Reception year classified as obese and hospital stays for alcohol related harm are all better than the average for England, whilst levels of smoking in pregnancy, breast feeding initiation and infant deaths are all worse.

There are inequalities in health within the East Midlands which are closely associated with deprivation. For example, the health of people in Harborough, Rushcliffe and South Northamptonshire is generally better than both the England average and the East Midlands average, while the health of people in Nottingham, Mansfield and Derby is generally worse.

Death rates from all causes for both males and females have reduced over recent years; however life expectancy for both men and women living in the East Midlands is lower than the England average.

In the East Midlands, levels of people diagnosed with diabetes have increased over the last five years, and are higher than the average for England.

The priorities for the East Midlands are to address health inequalities, tobacco and alcohol use, obesity, physical activity, avoidable injury and death, affordable warmth and the health of children and young people.

The Outcomes benchmarking support packs published by NHS England, Public Health England, The Information Centre and Local Government association identify the existing health and care system performance in the other 6 local authority areas across the east midlands in addition to Leicestershire, Lincolnshire and Rutland. The packs compare to England averages and to similar comparable populations for the outcomes indicators defined by government for health, public health, and social care. The overview of these comparators is shown overleaf. The key health issues identified are:

| Notts | Derbyshire | Nottm City | Derby City | Leic City | Lincs | Leics | Rutland | Northants | MK |
|---|---|---|---|---|---|---|---|---|---|
| Differences in life expectancy better than peers but larger than average | Average life expectancy better than peers but below average | Low Average Life expectancy | Low Average Life expectancy | Poor Patient surveyed GP Experience | More years of life lost from causes amenable to healthcare than peers | Average Life expectancy below peers | More years of life lost from causes amenable to healthcare than peers | Differences in life expectancy average, but larger than peers | More years of life lost from causes amenable to healthcare than |
| Quality of Life for LTC patients better than peers but below average | Quality of Life for LTC patients better than peers but below average | Large differences in life expectancy | Large differences in life expectancy | High Years of life lost from causes amendable to healthcare | Health related Quality of life for people with LTC below peers | Patient surveyed GP experience below peers | | More years of life lost from causes amenable to healthcare than peers | Health related Quality of life for people with LTC below peers |
| | | High years of life lost from causes amenable to healthcare | | Low Average Health Life Expectancy | Patient surveyed GP experience below peers | | | More avoidable emergency admissions than peers | Poor Patient surveyed GP Experience |
| | | Poor health related quality of life for people with LTC | | | Average Life expectancy below peers | | | | |

Health Profile Summaries for other East Midlands Authorities are shown in the appendix.

Demographic factors which particularly influence need for services are the age structure, gender, levels of deprivation and ethnicity. Changes in regional demographics will impact on the health care needs and in turn directly influence the type and volume of health services required by a population.

## Population Trends

| Area Team CCG Breakdown Year on Year ONS Estimates Growth All Ages | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 9 Year Total |
|---|---|---|---|---|---|---|---|---|---|---|
| NHS Lincolnshire East CCG | 1.4% | 1.3% | 1.3% | 1.3% | 1.2% | 1.2% | 1.2% | 1.1% | 1.1% | 11.7% |
| NHS Lincolnshire West CCG | 0.9% | 0.9% | 0.8% | 0.8% | 0.8% | 0.8% | 0.7% | 0.7% | 0.7% | 7.4% |
| NHS South West Lincolnshire CCG | 1.1% | 1.1% | 1.1% | 1.1% | 1.1% | 1.0% | 1.0% | 1.0% | 1.0% | 10.0% |
| NHS South Lincolnshire CCG | 1.3% | 1.3% | 1.3% | 1.3% | 1.3% | 1.2% | 1.2% | 1.2% | 1.2% | 12.0% |
| | | | | | | | | | | |
| NHS Leicester City CCG | 0.5% | 0.5% | 0.5% | 0.5% | 0.5% | 0.4% | 0.4% | 0.4% | 0.4% | 4.2% |
| NHS East Leicestershire And Rutland CCG | 1.0% | 0.9% | 0.9% | 0.9% | 0.9% | 0.8% | 0.8% | 0.8% | 0.8% | 8.1% |
| NHS West Leicestershire CCG | 1.1% | 1.0% | 1.0% | 0.9% | 0.8% | 0.8% | 0.8% | 0.7% | 0.7% | 8.2% |
| | | | | | | | | | | |
| Leics Year on year | 0.9% | 0.8% | 0.8% | 0.8% | 0.7% | 0.7% | 0.7% | 0.7% | 0.6% | 6.9% |
| Lincs Year on year | 1.2% | 1.2% | 1.1% | 1.1% | 1.1% | 1.0% | 1.0% | 1.0% | 1.0% | 10.1% |
| | | | | | | | | | | |
| **L&L Year on Year** | 1.0% | 1.0% | 0.9% | 0.9% | 0.9% | 0.8% | 0.8% | 0.8% | 0.8% | 8.2% |
| **Derbyshire And Nottinghamshire Area Team Year on Year** | 0.7% | 0.7% | 0.7% | 0.7% | 0.7% | 0.7% | 0.6% | 0.6% | 0.6% | 6.3% |
| **Hertfordshire And The South Midlands (E Mids) Year on Year** | 1.3% | 1.3% | 1.3% | 1.2% | 1.2% | 1.2% | 1.1% | 1.1% | 1.1% | 11.4% |
| **EAST MIDLANDS TOTAL YEAR ON YEAR** | 1.0% | 0.9% | 0.9% | 0.9% | 0.9% | 0.8% | 0.8% | 0.8% | 0.8% | 8.0% |
| | | | | | | | | | | |
| **England Total Year on Year** | 0.9% | 0.9% | 0.9% | 0.8% | 0.8% | 0.8% | 0.8% | 0.8% | 0.8% | 7.7% |

For primary care and public health services, the area team's population served will grow at slightly above the national and east midlands rate. This masks an underlying significant difference between Leicester city which will grow at a significantly lower rate, just over half the regional and national rates of growth, but Lincolnshire as a whole, particularly the east and south of Lincolnshire is forecast to grow at rates significantly above regional and national levels.

For specialised services, the East Midlands population will grow 0.3 percentage points above the national rate over the next 7 years with the South Midlands population growing 50% faster than England as a whole offset by lower growth in Derbyshire & Nottinghamshire with implications for the balance of provider capacity over time, to be factored into the future strategy for specialised services.

## Supply of Healthcare – Our Healthcare Providers

### Provider Profile – Specialised Services

The Area team hold Acute contracts to the value of circa - £600m (nine providers) and Mental Health contracts to the value of - circa £285m (nine providers):

| ACUTE SPECIALISED SERVICES | TYPE | CQC Risk Rating | 2013/14 Annual Budget | % of Acute Specialised Budget | Provider Annual Turnover | Specialised Budget as % of Provider Turnover 2012/13 |
|---|---|---|---|---|---|---|
| Provider | | | £m | % | £m | % |
| Nottingham University Hospitals | NHS Trust | 2 | 228 | 38% | 631 | 36% |
| University Hospitals of Leicester | NHS Trust | 1 | 198 | 33% | 649 | 31% |
| Derby Hospitals NHS | Foundation Trust | 3 | 55 | 9% | 411 | 13% |
| United Lincolnshire Hospitals | NHS Trust | 1 | 42 | 7% | 383 | 11% |
| Northampton General Hospital | NHS Trust | 1 | 32 | 5% | 236 | 13% |
| Kettering General Hospital T | Foundation Trust | 2 | 19 | 3% | 165 | 11% |
| Milton Keynes Hospital | Foundation Trust | 3 | 15 | 2% | 163 | 9% |
| Sherwood Forest Hospitals | Foundation Trust | 1 | 10 | 2% | 258 | 4% |
| Chesterfield Royal Hospital | Foundation Trust | 5 | 8 | 1% | 178 | 5% |
| **TOTAL** | | | **607** | **100%** | | |
| **SPECIALISED MENTAL HEALTH** | **TYPE** | | **2013/14 Annual Budget** | **% of Mental Health Specialised budget** | **Provider Annual Turnover** | **Specialised budget as % of Provider Turnover 2012/13** |
| | | | £m | % | £m | % |
| Nottinghamshire Healthcare | Partnership Trust | | 139 | 49% | 385 | 36% |
| St Andrew's Healthcare | Charity | | 100 | 35% | 169 | 59% |
| Northamptonshire Healthcare | Foundation Trust | | 10 | 4% | 171 | 6% |
| Leicestershire Partnership | Partnership Trust | | 8 | 3% | 235 | 3% |
| Raphael Healthcare | Independent | | 8 | 3% | | |
| Derbyshire Healthcare | Foundation Trust | | 5 | 2% | 125 | 4% |
| Lincolnshire Partnership | Foundation Trust | | 4 | 1% | 94 | 4% |
| Severe Personality Disorder | | | 6 | 2% | | |
| The Ansel Group | Independent | | 4 | 1% | | |
| Meadow View Hospital (Curate) | Independent | | 3 | 1% | | |
| **TOTAL** | | | **285** | **100%** | | |

Within the acute services sector:

- Over 70% of Commissioned spend is with the 2 main tertiary teaching trusts in the region, where NHS England is the largest single commissioner of services at between 30-40% of Total Trust Income

- For the other providers NHS England is only 5-13% of Trust income reflecting a much narrower range of services
- Over 83% of spend is with providers yet to achieve foundation trust status
- Over 85% of spend is at providers in the two highest CQC quality risk ratings
- Financially the 2 NHS Trusts in Leicestershire and Lincolnshire are operating with a large financial deficit (over £70m combined) and three of the five foundation trusts are rated in the highest financial risk rating by Monitor.

This wider context reflects the major priority, working in partnership with CCGs, to achieve financial sustainability and improvements in quality at the whole system level across the majority of acute providers in the East Midlands. The strategy for specialised services will take account of this context

Within the Mental Health Sector, although the spend shows similarly high levels of concentration at the top 2 providers, the drivers are very different:

- More than a third of total spend in this sector, is on one of three national High secure services, which represents 60% of the spend with Nottinghamshire healthcare
- The second largest spend reflects the East Midlands lead for an independent provider with services across 3 regions for which this area team takes a lead role
- The remaining contracts are below £10m in value, with individual case management, rather than high volume treatment, the predominant characteristic of mental health services commissioned.

A key dimension of the profile of providers of specialised healthcare is their current service levels compliance to nationally developed clinical service specifications and policies.

There are currently 359 services identified in the acute services that are currently under consideration for compliance against the service specification. The table below is a summary of the current status with services described in three main categories; **compliant** with the service specification, services not compliant but they have applied for **derogation**[2] and services where only part of the pathway is provided and the service is **provided in partnership**.

Table: Summary of current position of the acute services in the East Midlands current delivery specialist services in accordance with the service specifications

| Hospital | Compliant | Derogation | In partnership | TOTAL |
|---|---|---|---|---|
| **Chesterfield Royal Hospital** | 4 | | 10 | **14** |
| **Derby Hospitals** | 27 | 3 | 4 | **34** |
| **Kettering General Hospital Milton** | 6 | 4 | 52 | **62** |
| **Keynes Foundation Trust** | 4 | 4 | 9 | **17** |
| **Northampton General Hospital** | 23 | 6 | 7 | **36** |
| **Sherwood Forest Hospitals** | 4 | | 2 | **6** |
| **University Hospitals of Leicester** | 75 | 10 | 2 | **87** |
| **United Lincolnshire Hospitals** | 2 | 7 | 5 | **14** |
| **Nottingham University Hospitals** | 68 | 21 | 0 | **89** |
| **Total** | **213** | **55** | **91** | **359** |

[2] Derogation is a time-limited conditional agreement to operate at variance to the national specification

Our operational plans set out later in this document outline the intentions for addressing areas of non-compliance with service specifications in line with the emerging strategy for specialised services.

NHS England commissions according to agreed policies and service specifications, which identify where treatments, devices and services are routinely commissioned. Commissioning policies that specify treatment thresholds and criteria act within the NHS contract as 'group prior-approvals' for treatment. In some cases, additional audit may be required with to give prior approval for individual patients by commissioners. Where policies and specifications make clear that treatments, devices and services are not routinely commissioned, or where treatment thresholds and criteria have not been adhered to providers will not receive funding if they initiate these treatments. This ensures, so the money provided to us by the government is available for treatments our population need that do have clear evidence of benefit, in line with NHS England's ethical framework for prioritisation.

Providers are also required to comply with national audit requirements as part of the service specifications. Resulting audit data will be reviewed and used to inform service and quality improvement initiatives as part of on-going contractual monitoring arrangements.

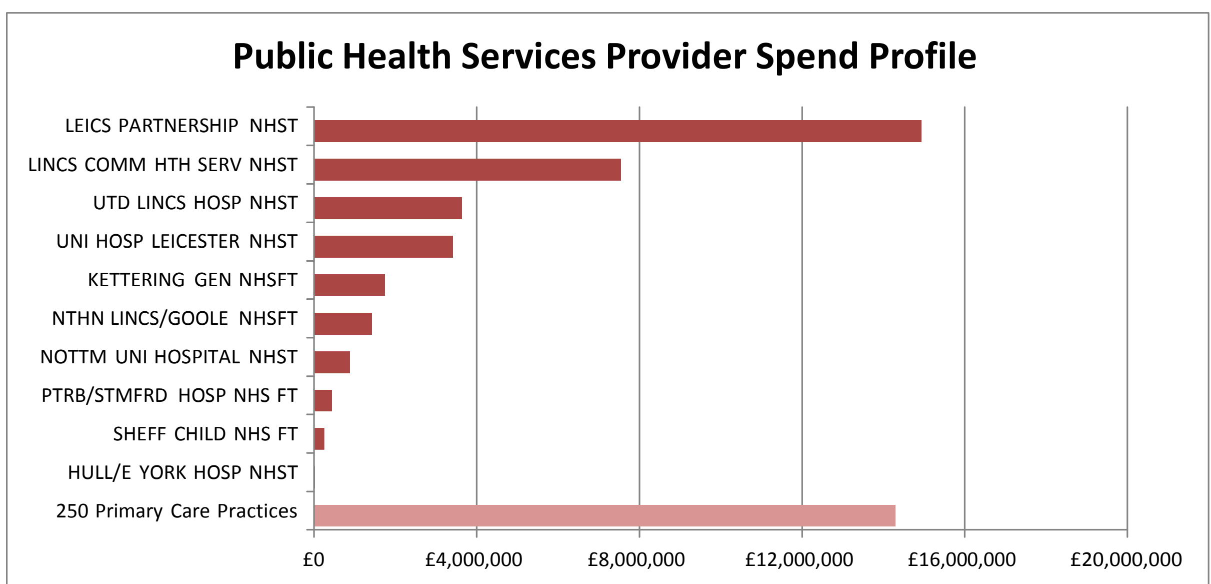
## Provider Profile – Public Health Services

| PUBLIC HEALTH SERVICES | TYPE | 2013/14 Annual Spend | % of Public Health Services Budget | Provider Annual Turnover | L&L Public Health Spend as % of Provider Turnover 2012/13 |
|---|---|---|---|---|---|
| **Provider** | | £m | % | £m | % |
| Leicester Partnership Trust | Partnership Trust | 14.9 | 31% | 235 | 6% |
| Lincolnshire Community Health Services | NHS Trust | 7.5 | 16% | 109 | 7% |
| United Lincolnshire Hospitals | NHS Trust | 3.6 | 7% | 383 | 1% |
| University Hospitals of Leicester | NHS Trust | 3.4 | 7% | 649 | 0.5% |
| Kettering General Hospital | Foundation Trust | 1.7 | 4% | 165 | 1% |
| North Lincs and Goole Hospitals | Foundation Trust | 1.4 | 3% | 285 | 0.5% |
| Nottingham University Hospitals | NHS Trust | 0.9 | 2% | 631 | 0.1% |
| Peterborough & Stamford | Foundation | 0.4 | 1% | 219 | 0.2% |
| Other Acute | | 0.3 | 1% | N/A | N/A |
| Primary Care Practices | Independent Contractors | 14.3 | 29% | Varies | Varies |

Public health services across Leicestershire and Lincolnshire are shown below. The provider base falls into three categories:

- One large provider of community services in each county with spend on child health services though health visitors and family nurse partnerships. These services also provide some immunisation services where not delivered in general practice, and account for just under half (45%) public health services commissioning spend. These services form a relatively small but significant share of provider income.

- Acute services contracts in the area team's geography and neighbouring geographies predominantly screening services. These services comprise a quarter of public health spend but typically represent below 1% of provider turnover.
- Primary care providers, predominantly for immunisation, where the proportion of turnover is higher but overall spend is much less concentrated and geographically decentralised into local communities, spread across over 250 contractors.




The focus for provider development for public health services is at the service level ensuring development in line with national standards and responding to audit visits of national clinical teams.

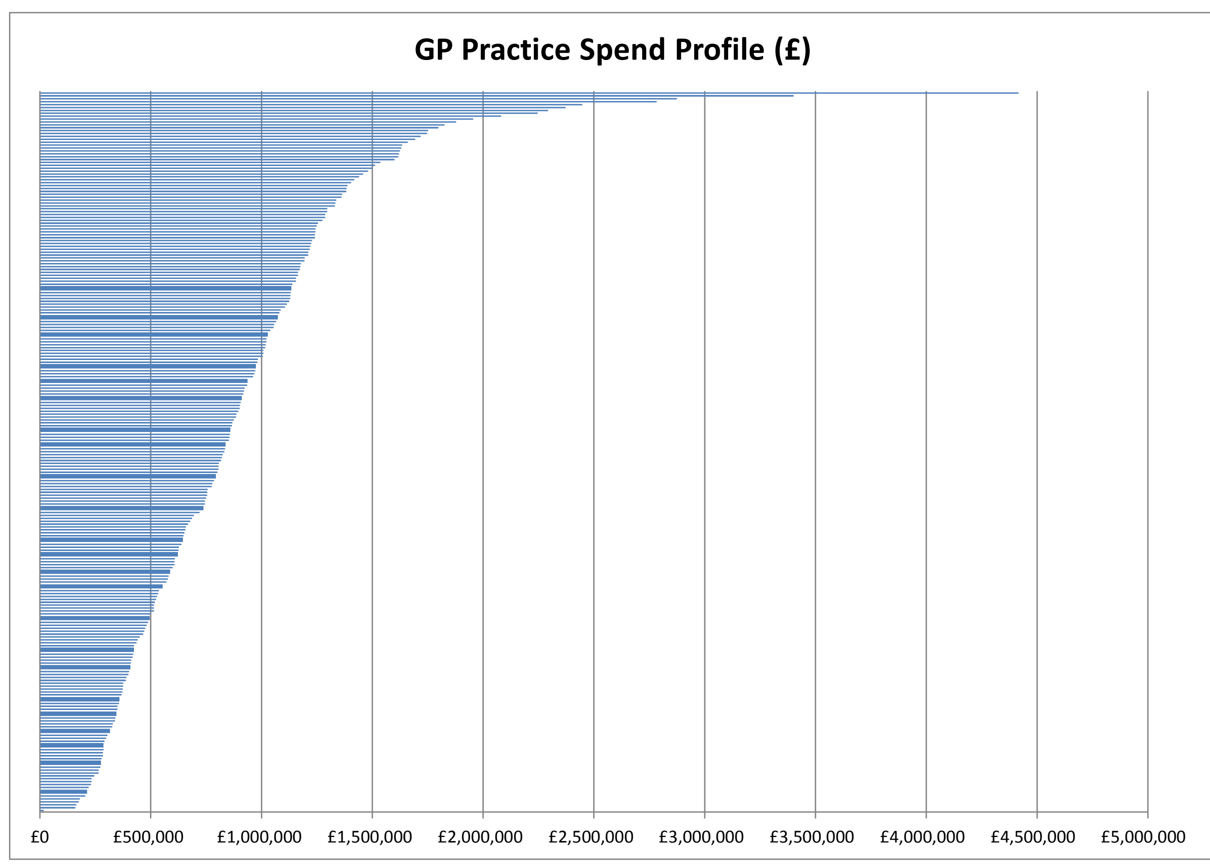
## Provider Profile – General Practice

Across Leicestershire and Lincolnshire Primary care services are provided through over 1,100 independent contractors, of which 250 are general practitioner medical services contracts, the balance being primary care dentistry, optometry and pharmacy.

More than nine in ten encounters with the NHS are with Primary healthcare providers. For GP services NHS England represents a single national contracting body, and although practices may be funded by clinical commissioning groups and local authorities for other services, typically well over 95% of practice income will come from NHS England's commissioning of primary care [3]

Commissioning spend with general practice has low levels of concentration with the largest primary care contract accounting for only 2% of NHS England's spend. Within this however, there is considerable variation in the scale of primary care:

[3] Enhanced services vs core services spend set out in the HSCIC report 'Investment in General Practice' 2013




The spread of spend is illustrated below:

| Practice Contract | Annual Spend |
|---|---|
| **Upper Decile** | £1.60m |
| **Upper Quartile** | £1.16m |
| **Median Spend** | £0.83m |
| **Lower Quartile** | £0.47m |
| **Lower Decile** | £0.30m |

Strategic plans for primary care acknowledge and respond to the diversity in the scale and size of existing primary care providers, with contracts up to £4.4m per annum from significantly sized organisations, down to small business holders.

## Patient Experience of General Practice

*GP Patient Survey Results – General Practice*

| | NHS EAST LEICESTERSHIRE AND RUTLAND CCG | | NHS LEICESTER CITY CCG | | NHS LINCOLNSHIRE EAST CCG | | NHS LINCOLNSHIRE WEST CCG | | NHS SOUTH LINCOLNSHIRE CCG | | NHS SOUTH WEST LINCOLNSHIRE CCG | | NHS WEST LEICESTERSHIRE CCG | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Satisfaction with Accessing Primary Care** | %age | No. red outliers | %age | No. red outliers | %age | No. red outliers | %age | No. red outliers | %age | No. red outliers | %age | No. red outliers | %age | No. red outliers |
| Accessing GP Services | 75 | 45 | 72 | 70 | 74 | 38 | 76 | 39 | 78 | 8 | 77 | 16 | 76 | 61 |
| Making an Appointment | 85 | 26 | 84 | 41 | 85 | 19 | 87 | 17 | 89 | 3 | 90 | 8 | 88 | 14 |
| Opening Hours | 80 | 18 | 82 | 15 | 82 | 11 | 83 | 6 | 85 | 1 | 82 | 5 | 82 | 15 |
| **Average of All Three/sum of outliers** | 80 | 89 | 79 | 126 | 80 | 68 | 82 | 62 | 84 | 12 | 83 | 29 | 82 | 90 |
| **Satisfaction with the Quality of Consultation at the GP Practice** | %age | No. red outliers | %age | No. red outliers | %age | No. red outliers | %age | No. red outliers | %age | No. red outliers | %age | No. red outliers | %age | No. red outliers |
| Seeing a Doctor | 89 | 27 | 83 | 118 | 86 | 44 | 89 | 25 | 90 | 7 | 90 | 15 | 88 | 49 |
| Seeing a Nurse | 90 | 9 | 87 | 29 | 91 | 4 | 92 | 3 | 92 | 2 | 92 | 0 | 89 | 40 |
| **Average of both/sum of outliers** | 90 | 36 | 85 | 147 | 89 | 48 | 91 | 28 | 91 | 9 | 91 | 15 | 89 | 89 |
| **Satisfaction with the overall care received at the surgery** | %age | No. red outliers | %age | No. red outliers | %age | No. red outliers | %age | No. red outliers | %age | No. red outliers | %age | No. red outliers | %age | No. red outliers |
| Overall Experience | 84 | 19 | 77 | 42 | 81 | 16 | 84 | 10 | 88 | 3 | 86 | 7 | 85 | 18 |

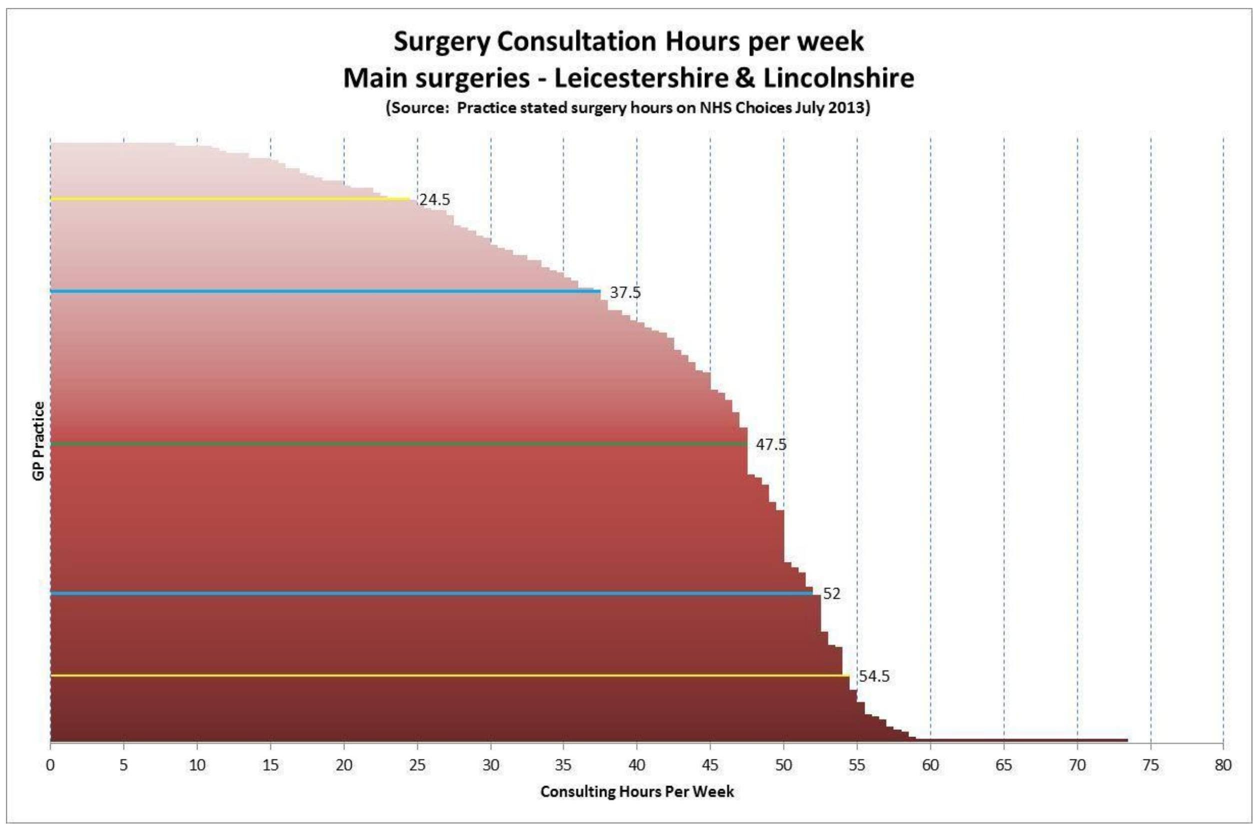
Work to improve quality is a joint responsibility of NHS England and Clinical commissioning groups. The table above illustrates that even where overall satisfaction rates are good across an area there are practices who are adverse outliers. This informs our priorities set out later in this plan taken forward with the relevant CCG.

| Analysis of number of outliers | | | | | | |
|---|---|---|---|---|---|---|
| **CCG** | **Practices with no outliers** | **1<5** | **6<10** | **11<15** | **16<21** | **Total no of practices** |
| NHS EAST LEICESTERSHIRE & RUTLAND CCG | 11 | 10 | 6 | 4 | 3 | 34 |
| NHS LEICESTER CITY CCG | 13 | 27 | 7 | 10 | 7 | 64 |
| NHS LINCOLNSHIRE EAST CCG | 6 | 11 | 10 | 2 | 1 | 30 |
| NHS LINCOLNSHIRE WEST CCG | 11 | 18 | 8 | 1 | 0 | 38 |
| NHS SOUTH LINCOLNSHIRE CCG | 6 | 7 | 2 | 0 | 0 | 15 |
| NHS SOUTH WEST LINCOLNSHIRE CCG | 8 | 8 | 0 | 2 | 1 | 19 |
| NHS WEST LEICESTERSHIRE CCG | 13 | 19 | 16 | 2 | 0 | 50 |

**Red Outliers** - indicate where the practice score for a particular question is significantly worse compared to the national average (i.e. where confidence intervals for the practice and the national average do not overlap).

*Ease of Access to GP practices*

In addition to patient surveyed perception of the opening hours and ease of making an appointment, local analysis has been undertaken highlighting the significant differences in the degree to which a GP consultation is available at times that are convenient to all:




Whilst a quarter of practices provide more than 52 hours per week in which to book appointments, a quarter of our practices offer fewer than 37.5 hours, and one in ten less than 25 hours per week.

The distribution of opening hours illustrates times when our population are less likely to be able to secure a routine GP appointment, depending on the practice they are registered with.

Specific opening hours are not a condition of national GMS contracts held by GPs although meeting the reasonable needs of patients is required. As general practice is supported to make a greater contribution to the health and care system, the availability of services at times convenient to all, together with the cost effective use of premises and workforce in primary care, is a key consideration.

We will continue to work with our CCG colleagues to drive improvement in patient experience of general practice. This will be informed further by the results from the Friends & Family Test, which states in general practice in December 2014.

## Leicestershire and Lincolnshire Area

**% Area Open for GP-Routine Appointments (Main & Branches)**

| Commencing | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|---|---|---|---|---|---|---|---|
| 06:00 | 0% | 0% | 0% | 0% | 0% | 0% | 0% |
| 06:30 | 0% | 0% | 0% | 0% | 0% | 0% | 0% |
| 07:00 | 2% | 1% | 1% | 2% | 0% | 1% | 0% |
| 07:30 | 5% | 6% | 4% | 6% | 3% | 1% | 0% |
| 08:00 | 31% | 31% | 33% | 30% | 30% | 4% | 0% |
| 08:30 | 78% | 76% | 77% | 77% | 77% | 7% | 1% |
| 09:00 | 98% | 97% | 97% | 98% | 97% | 9% | 1% |
| 09:30 | 100% | 99% | 99% | 100% | 99% | 8% | 1% |
| 10:00 | 100% | 99% | 99% | 100% | 99% | 9% | 1% |
| 10:30 | 97% | 96% | 96% | 96% | 96% | 7% | 1% |
| 11:00 | 89% | 89% | 89% | 89% | 89% | 5% | 0% |
| 11:30 | 77% | 78% | 76% | 75% | 75% | 3% | 0% |
| 12:00 | 63% | 65% | 61% | 61% | 62% | 2% | 0% |
| 12:30 | 49% | 50% | 47% | 47% | 49% | 2% | 0% |
| 13:00 | 43% | 42% | 40% | 39% | 41% | 1% | 0% |
| 13:30 | 43% | 42% | 39% | 38% | 41% | 1% | 0% |
| 14:00 | 58% | 55% | 53% | 49% | 57% | 1% | 0% |
| 14:30 | 65% | 61% | 59% | 54% | 63% | 1% | 0% |
| 15:00 | 73% | 69% | 65% | 59% | 71% | 1% | 0% |
| 15:30 | 85% | 78% | 73% | 65% | 80% | 0% | 0% |
| 16:00 | 96% | 92% | 84% | 75% | 93% | 0% | 0% |
| 16:30 | 97% | 93% | 85% | 76% | 95% | 0% | 0% |
| 17:00 | 94% | 93% | 84% | 73% | 93% | 0% | 0% |
| 17:30 | 86% | 84% | 78% | 68% | 84% | 0% | 0% |
| 18:00 | 64% | 62% | 59% | 52% | 62% | 0% | 0% |
| 18:30 | 36% | 32% | 33% | 27% | 28% | 0% | 0% |
| 19:00 | 18% | 12% | 10% | 5% | 5% | 0% | 0% |
| 19:30 | 15% | 9% | 9% | 3% | 2% | 0% | 0% |
| 20:00 | 11% | 5% | 7% | 2% | 1% | 0% | 0% |
| 20:30 | 3% | 2% | 2% | 1% | 1% | 0% | 0% |
| 21:00 | 2% | 0% | 1% | 1% | 0% | 0% | 0% |
| 21:30 | 0% | 0% | 0% | 0% | 0% | 0% | 0% |
| 22:00 | 0% | 0% | 0% | 0% | 0% | 0% | 0% |

**% of Practice sites offering routine GP appointments**

Key:

- Darker Green = High number of practices
- Yellow = Medium number of practices
- Orange = Low number of practices
- Darker Red = Minimum number of practices

(Source: Practice Declared Surgery Hours. NHS Choices July 2013)

i. Effectiveness

*General Practice - Primary Care Web Tool*

The Assurance Management Framework for Primary Medical Services introduces high level indicators supported by outcome standards which are a set of measurable indicators for general practice. The aim is to inform practices and commissioners on a range of measures that are evidence based, outcome focused and are appropriate measures to use for any practice.

Clinical effectiveness and patient experience is assured through a nationally consistent approach using 2 tools: The General Practice Outcome Standards (GPOS) and the General Practice High Level Indicators (GPHLI).

The General Practice High Level Indicators (GPHLI) form part of the assurance management framework for primary medical services and the indicators present a minimum level of service and outcomes that patients can expect from general practice. Indicators have been grouped across the NHS Outcomes Framework domains and will change and evolve over time. The purpose of the tool is to generate the start of a discussion between Area Teams and practices so that they can understand the reasons behind variation, be that warranted or unwarranted, and where necessary to support practices to make improvements

or changes. Examples of the indicators are emergency asthma admissions per 100 patients on the disease register and emergency diabetes admissions per 100 patients on the disease register both of which sit under Domain 2 of the NHS Outcomes Framework.
Across the Leicestershire and Lincolnshire area we have 26 outliers against the GPHLI.

The General Practice Outcome Standards (GPOS) have been provided to support quality improvement; they can be used for peer review and benchmarking and also to provide a consistent platform for Area Teams and CCGs to identify areas for quality improvement. The outcome standards are not process based indicators and therefore represent a good measure of practice achievement; they represent the basics patients should expect to receive from general practice. The outcome standards also represent a benchmark for how a practice is doing over time compared to other practices in a similar context. The benchmarked data will help us to understand whether variation is fair or unwarranted. However, individual outcome standards should not be viewed in isolation, these need to be triangulated with other information, such as GPHLIs, hospital activity data, and patient complaints, in order to identify areas of unwarranted variation and monitor improvement. Examples of the outcome standards are satisfaction with the quality of consultation at the
GP practice and satisfaction with accessing primary care both of which sit under Domain 4 of the NHS Outcomes Framework.
Across the Leicestershire and Lincolnshire area we have 41 outliers against the GPOS.

## Provider Profile – Dentistry

**Provider Profile – Dentistry**

| Dental Service Provider | Type | Total Number | Total Contract Value | Average (£Thousand) |
|---|---|---|---|---|
| General Dental Services (GDS) Providers | Independent Contractor (Sole/Partnership) | 140 | £33.2m | £237 |
| General Dental Services (GDS) Providers | Body Corporate | 60 | £22.7m | £378 |
| Personal Dental Services (PDS) Providers | Independent Contractor (Sole/Partnership) | 36 | £7.4 m | £205 |
| Personal Dental Services (PDS) Providers | Body Corporate | 15 | £4.0 m | £267 |
| Personal Dental Services Plus (PDS Plus) Providers | Independent Contractor (Sole/Partnership) | 4 | £0.6 m | £141 |
| Personal Dental Services Plus (PDS Plus) Providers | Body Corporate | 10 | £4.9 m | £490 |
| General Dental Services Provider GDS (Pilot contract) | Body Corporate | 1 | £0.8 m | £774 |
| General Dental Services Provider GDS (Pilot contract) | Independent Contractor (Sole/Partnership) | 1 | £0.5 m | £529 |
| **Total** | | **267** | **£74.2 m** | **£278** |

**Primary Dental Services Commissioning**
Since April 2006, the following contracting routes have been available to enable the commissioning of primary dental services:
• General Dental Services contracts (GDS)
• Personal Dental Service contracts (PDS) which includes non -mandatory services such as orthodontic services and sedation services.
PDS Plus Contracts area variation of the PDS contract and include KP's (quality metrics) that reward the delivery of good oral health and care pathway and improved access.

**GDS contracts and PDS agreements**
GDS contracts are nationally negotiated contracts and PDS agreements are negotiated locally but are underpinned by national regulations. The main differences between GDS and PDS are that GDS contracts are not time limited (PDS agreements are) and that PDS can apply to non-mandatory services (eg orthodontic only practices).
Community or Salaried Dental Services are directly commissioned using the PDS contract framework and generally provide services for vulnerable and hard to reach groups.

Primary dental services comprise:
**Essential services**
Every GDS practice is required to provide a full range of general dental services (mandatory services) plus any agreed non -mandatory services. PDS may also include mandatory services and a mix of additional locally negotiated services, but can also be agreed for solely non-mandatory services (i.e. with no general dental services).
Community or Salaried Dental Services are as defined locally.
All GDS providers and PDS contractors with a mandatory service agreement are expected to provide a full range of primary care dental services to all their NHS patients based on clinical need (limited only by their ability to clinically provide the intervention).

**Additional services**
All GDS and PDS practices can contract or agree to provide additional services with the commissioner.

**General Dental Services Provider GDS (Pilot contract)**
Dental Pilots have been established to test new ways of working in order to inform a new national contract.

Locally our primary care dental contracts are split as follows:
GDS contracts = 76%
PDS agreements = 18%
PDS Plus agreements = 5%
Dental Pilots = 1%

NHS England will be the sole NHS commissioner with dental practices, but the key characteristic of this contractor group is that under 60% of primary care dentistry is commissioned and funded through the NHS with private healthcare (self-funded, and insurance and corporate benefit based) comprising over 40%.

*GP Patient Survey Results – General Dental Practice*

March 2013 data from the GPPS results show 83% Positive Experience for Leicestershire & Lincolnshire, which when benchmarked to other Area Teams in the region, puts us at the lowest level of positive experience but we are not statistically significantly different to the national position.
From the most recent data available from e-reporting (Sept 2013), the % of patients satisfied with the treatment received was 92.3% (national % = 92.5%, regional % = 92.7%).
When looking at the number of unique patients seen in the last 24 months, there is a slight improvement compared to the previous year (ranked 4th in the region). However there has been a drop in the activity commissioned when compared to last year.

*Quality and Access - General Dental Practice*

The drivers for NHS dental services for us are high quality dental services, improved access, patient centred services, appropriate referrals into secondary care and prevention focus through 'Delivery Better Oral Health' and our operational plan.

**Community and Acute Dental Services**

Whilst Local Authorities have a central role to play in oral health promotion, NHS England area team commissions all steps in dental pathways, with contracts with community and acute services for more complex care. The provider profile for spend on these services is:

| COMMUNITY AND ACUTE ORAL HEALTHCARE SERVICES | TYPE | 2013/14 Annual Spend | % of Secondary Dental Services Budget | Provider Annual Turnover | L&L Public Health Spend as % of Provider Turnover 2012/13 |
|---|---|---|---|---|---|
| **Provider** | | £m | % | £m | % |
| University Hospitals of Leicester | NHS Trust | 5.6 | 32% | 649 | 0.9% |
| United Lincolnshire Hospitals | NHS Trust | 5.4 | 31% | 383 | 1.4% |
| Derbyshire Community Health Services (in Leicestershire) | NHS Trust | 3.3 | 19% | 198 | 2% |
| Lincolnshire Community Health Services | NHS Trust | 1.7 | 10% | 109 | 2% |
| Peterborough & Stamford | Foundation | 0.9 | 5% | 219 | 0.2% |
| Kettering General Hospital T | Foundation Trust | 0.2 | 1% | 165 | 0.1% |
| Derby Hospitals | Foundation Trust | 0.2 | 1% | 285 | <0.1% |
| Nottingham University Hospitals | NHS Trust | 0.2 | 1% | 631 | <0.1% |

For all providers, these services constitute a very small share of turnover. The supply base segments into three groups:

- Two Acute Dentistry in-area contracts, 63% of spend
- Two Community Dental services (DCHS serves Leicestershire), 29% of spend
- Small contracts for out of county acute dentistry flows 8% of spend

Acute contracts are predominantly funded through nationally set prices (Payment by Results) with demand and capacity management to maintain NHS constitution rights to treatment within 18 weeks a key focus. Community provider dentistry contracts are more varied reflecting models to improve access for populations with specific needs.

## Provider Profile - General Ophthalmic Services

**Provider Profile – General Ophthalmic Services**

| Ophthalmic Service Provider | Type | Number | 13/14 Contract Value |
|---|---|---|---|
| | | | |
| Mandatory Services Contracts | Independent Contractor (Sole/Partnership) | 67 | |
| Mandatory Services Contracts | Body Corporate | 129 | |
| Total Mandatory Contracts | | 196 | |
| Additional Services Contracts | Independent Contractor (Sole/Partnership) | 38 | |
| Additional Services Contracts | Body Corporate | 67 | |
| Total Additional Services Contracts | | 105 | |
| **Total Optometry Contracts** | | **301** | **£18m** |

The primary characteristic of provider profiles for Ophthalmic services is a mature retail market with an even split between larger chain and independent outlets. NHS commissioned spend is based on nationally negotiated services and prices, and represents less than £1 in every £5 of provider income, the vast majority being private spending on eye care.

## Provider Profile - Community Pharmacy

**Provider Profile – Pharmaceutical Services**

| Pharmaceutical Service Provider | Type | Number | 13/14 Spend (Forecast) |
|---|---|---|---|
| Community Pharmacy | Independent Contractor (Sole/Partnership) | 151 | £52.6m |
| Community Pharmacy | Multiple/Chain | 195 | |
| Dispensing Practices | Independent Contractor (Sole/Partnership) | 84 | £13.2m [4] |
| **Total Providers** | | **430** | **£65.8m** |

The Community Pharmacy Contractual Framework was introduced in April 2005.

[4] Professional fees associated with dispensing costs

The contractual framework for community pharmacies has three different elements:

1. **Essential Services** – the following list of services must be provided by all contractors:

    - The dispensing of medicines
    - The dispensing of appliances
    - Repeat dispensing
    - Clinical governance
    - Public health (promotion of healthy lifestyles)
    - Signposting and
    - Support for self –care

2. **Advanced Services** – these services can be provided by all contractors if they have met the accreditation requirements and are providing ALL essential services. There are two advanced services:

    - Medicine Use Reviews
    - New Medicines Service

Both essential and advanced services are commissioned by NHS England.

3. **Locally commissioned services** (previously known as enhanced services) – these are commissioned to meet local health care needs and are commissioned by CCGs or Local Authorities. They can include services such as smoking cessation, provision of emergency hormonal contraception, and minor ailment services.

Dispensing doctors provide the following services to patients:

- The dispensing of medicines
- The dispensing of appliances.

These services are funded by NHS England.

Community Pharmacy can make an important contribution to the provision and delivery of integrated services for patients. For example, the hospitals discharge process. There is a risk that commissioners do not see the potential of community pharmacy and this valuable resource may be overlooked. Our plans are designed to ensure that the risk of community pharmacy is optimised. Generally hours of availability of community pharmacies extend into the evenings and weekends. In addition, across the area, there are 36 pharmacies that open for 100 hours per week.

Like ophthalmic services NHS commissioned spend on community pharmacy is a relatively small part (£1 in every £6) of the large £14.5bn industry, the main dynamics being the competition between the supermarket, national chain and independent providers, with over the counter medicines and diversified retail playing a large role. The services commissioned by NHS England fund prescription medicine dispensing, medicines use reviews with potential for a wider range of primary healthcare services to be delivered by pharmacists as an alternative primary care local facility with wide opening hours.

Summary

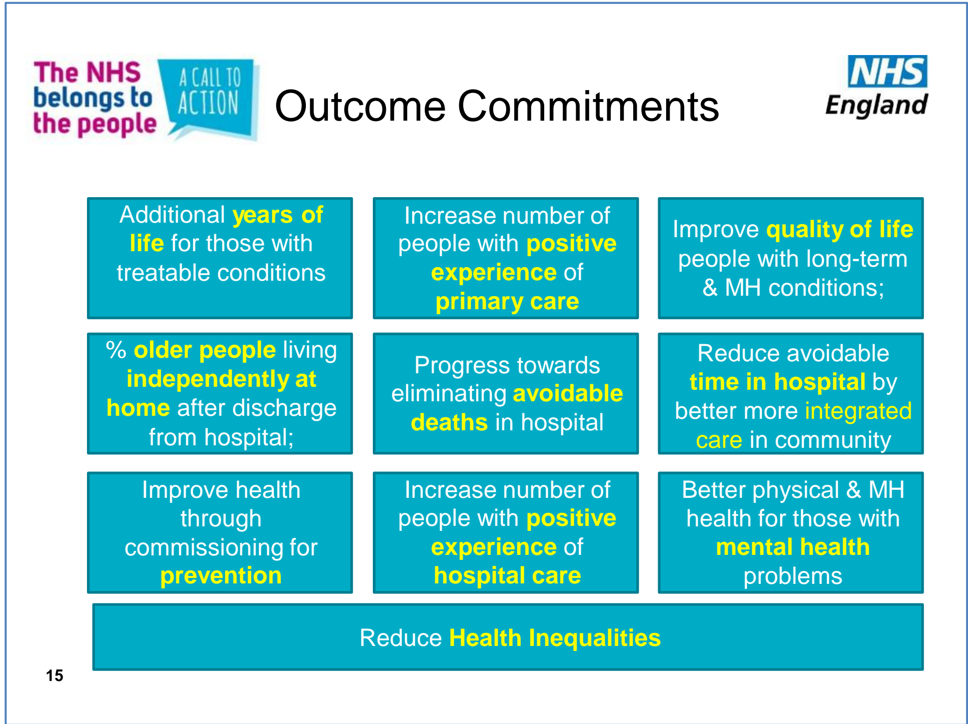
Our plans and future strategy for the three commissioning responsibilities reflect the health needs and priorities of the communities we serve, but the key issues, and the nature of healthcare provider services varies greatly between primary care, public health service and specialised commissioning. A 'one size fits all' approach would not be effective. The next section sets out our Ambitions and plans in light of these different challenges.

## SECTION THREE: OUR AMBITIONS AND PLANS

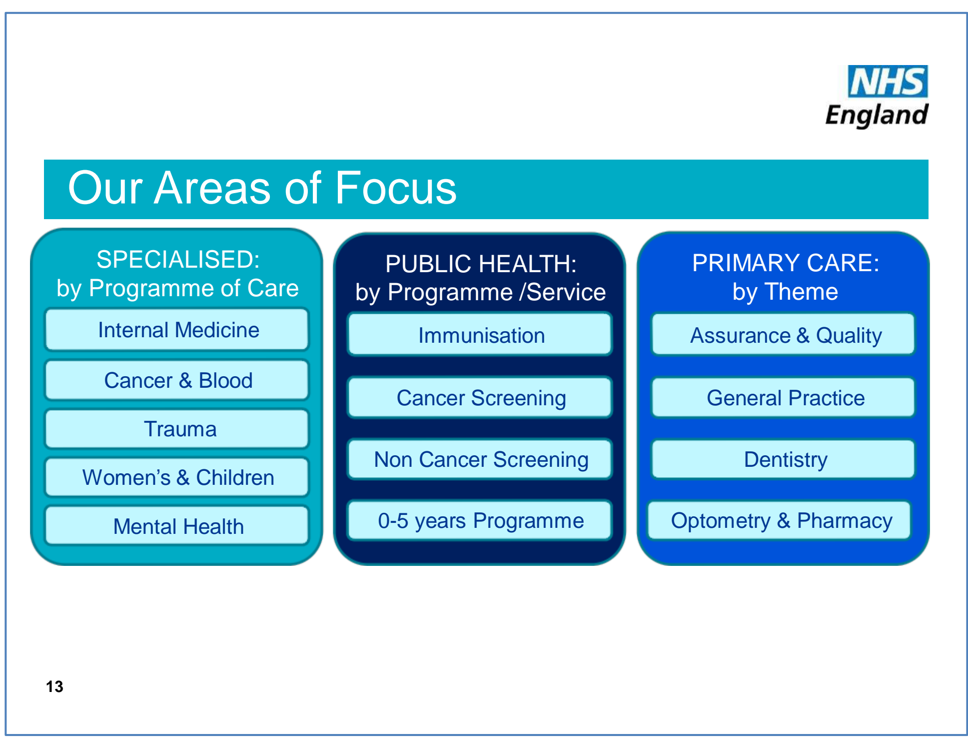
Values and Principles:

- Services Patient Centred and Outcome Based
- Improved outcomes in each of the 5 domains
- Fairness and Consistency of Access
- Productivity and Efficiency Improves

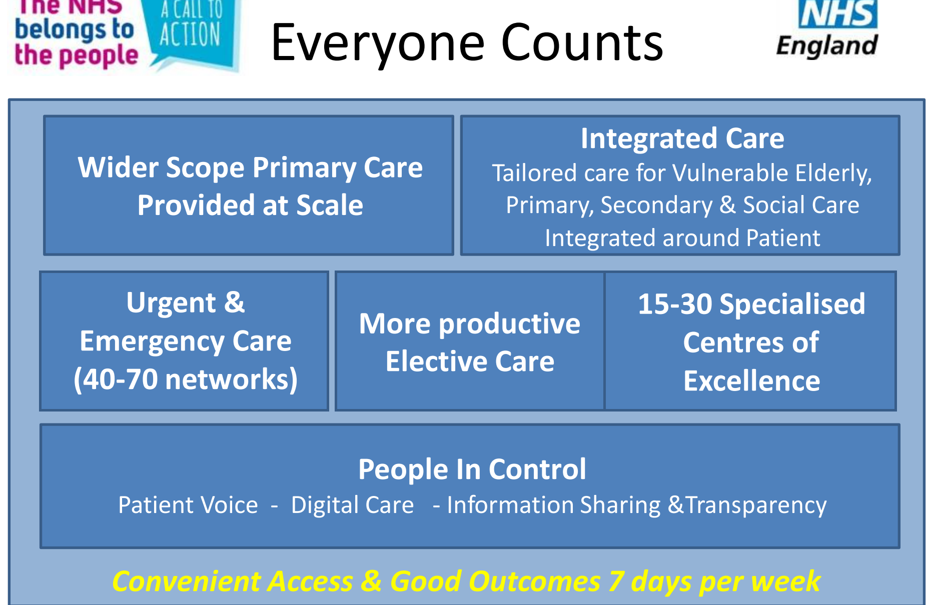
These will be underpinned by the delivery of the goals set out within Everyone Counts. Published in December 2013, Everyone counts: Planning for patients 2014/15 to 2018/19 sets out proposals to make the NHS England vision and purpose "High quality care for all, now and for future generations" a reality. The ten goals set out in the guidance include:




Our ambition and actions to address these ten goals and ensure delivery across the five domains and seven outcome measures of the NHS Outcomes Framework are set out in summary below, for each of our three commissioning responsibilities.




Within this section below, for each of our commissioning responsibilities we also set out the direction for service development, in particular how our strategy responds to the emerging national direction for services set out in 'everyone counts' and the national review of Emergency and Urgent Care:




In some cases initiatives are managed as projects with the aim of a measurable improvement in Quality, in Innovation, in Productivity, or in Prevention. These projects are referred to as QIPP and help free up financial resources to commit to strategic priorities and to remain within allocated budgets.

## Specialised Services – Our Ambitions and Plans

Our ambition and actions to address these ten goals and ensure delivery across the five domains and seven outcome measures of the NHS Outcomes Framework are set out in summary within the following tables split between the mental health programme of care, and the 4 programmes of care delivered through acute services:

**Table: Delivering Everyone Counts - Specialised Mental Health Services Objectives**

| Goals | Key actions/features |
|---|---|
| Secure **additional years of life** for people with treatable mental & physical health conditions | "**Plans to reduce 20yr gap in life expectancy for people with severe mental illness**"<br>For our services this is most applicable to people with psychotic illness and the long term effects of psychotropic medication and poor access to physical healthcare.<br>• Specialised commissioners introduced a CQUIN in 2011 in high secure and 2013 for all other specialised mental health services targeted at improving physical healthcare. This will be built on in 2014/15 and in future years.<br>• We have been working closely with the nursing and quality team to examine any Serious Incidents/deaths in specialised services which may relate to poor access to physical healthcare and will build on this and any lessons learnt going forward.<br>• Contracted requirements are to ensure continued improvement of healthy lifestyles for staff and patients. |
| Improve **health-related quality of life** for 15 million people with MH & Long Term conditions | • Ensuring services are effective and of high quality through service user feedback and service visits provides assurance that health related quality of life is maximised for service users.<br>• Ensuring that the CQUIN for 13/14 physical health care is rolled into the quality schedule of the contract and will built upon in future years.<br>• Patients have access to education and training opportunities whilst an inpatient to improve the options available to them on discharge. |
| Reduce **avoidable time in hospital** through better, more integrated care in community | "**Identification and support for young people with mental health problems**"<br>• NHS England took on responsibility for commissioning Tier 4 CAMHS in April 2013. There is currently a national review of CAMHS tier 4 taking place which will report March/April. We will need to build in to the plan implementing the findings of the review.<br>• Locally we need to commit to continued funding of the 2 CAMHS case managers who are ensuring appropriate, efficient and effective care pathways into and out of Tier 4 services and are starting to work with East Midlands providers to improve the quality of services and patient experience.<br>• Case managers actively engage with patients and clinical teams to ensure patients are in the right place at the right time for treatment and that delayed discharges are avoided.<br>• CAMHS patients are reviewed regularly and case managers actively work with partner agencies to ensure that care pathways and discharge plans are effective to reduce length of stays and avoidable delays. |

| Goals | Key actions/features |
|---|---|
| | • Introduction of shared pathway into specialised services, providers asked to implement a recovery approach which includes identifying the most appropriate recovery tools for their populations, drawing upon a range of recovery resources and which supports service users to engage directly in identifying outcomes, care planning and the CPA process, E.g. Recovery Star, My Shared Pathway Resource Books, Care Index, and Wrap. |
| Increasing number of people having a **positive experience** of **Hospital** care | • We have been working closely with the nursing and quality team to examine any Serious Incidents/deaths in specialised services which may relate to poor access to physical healthcare and will build on this and any lessons learnt going forward.<br>• Service visits and interviews with service users to gain direct service user feedback and take actions with the provider to improve positive experiences in hospital.<br>• CQUIN for innovation introduced into specialised services to enhance patient choice and experience for example CPA for CAMHS and Adults, which in future years will be established as common practice.<br>• Case managers actively engage with patients and clinical teams to ensure patients are in the right place at the right time for treatment and that delayed discharges are avoided. |

| Goals | Key actions/features |
|---|---|
| Increasing number of people having a **positive experience** of **GP & community** care | • All patients in secure hospitals will have an annual health check, this is a contractual requirement and was measured as part of the 'My Shared pathway' CQUIN<br>• In addition all patients with a learning disability will be offered an annual health check that meets the criteria of the Cardiff health check tool<br>• That patients in secure hospitals will have access to healthcare equal to that which they would receive via a GP and commissioned by CCGs<br>• The area team will continue to implement a comprehensive response to the winterbourne view findings:<br>✓ Quarterly data collection process will provide detail to the Leicestershire and Lincolnshire Area on the number of adults and young people with Learning Disabilities and/or Autism in secure hospitals hosted in the Leicestershire and Lincolnshire Area.<br>✓ Our case managers will continue to work with providers to ensure all patients who are detained and in secure services in the East Midlands have robust care plans in place and that discharge planning commences as possible; ensuring patients with a learning disabilities and/or autism do not remain in secure hospital care any longer than is clinically appropriate.<br>✓ Our case managers monitor the CPA process to ensure each patient identified as being fit for discharge are proceeding though their treatment and discharge pathway in a timely and appropriate way.<br>✓ Our case managers regularly meet and liaise with our area CCG colleagues and the patient care co-ordinators to monitor the patient's discharge pathway.<br>✓ As a net importer of patients from other areas into our large services providers, such as St Andrews Healthcare, we work closely with the other Area Teams. A number of these patients will be identified as needing to transition to lower security or to community settings by the local Area Teams and CCGs and we will continue to work with our partners to move patients on to appropriate services.<br>✓ Area Team will link in with CCG and Local Authority strategic planning and reporting on Winterbourne View Review, Autism Strategy, Learning Disability Self-Assessment Framework (LD SAF) and Joint Strategic Assessment Needs( JSNA) |
| Make progress in eliminating **avoidable deaths in hospital** caused by problems in care | • Serious incident investigation and quality management via Area Team Quality and Nursing Directorate.<br>• Suicide prevention is a contract requirement and hospitals are required to not using non-collapsible rails in patient areas.<br>• Annual ligature audit is required in all services.<br>• Specialised commissioners introduced a CQUIN in 2011 in high secure and 2013 for all other specialised mental health services targeted at improving physical healthcare. This will be built on in 2014/15 and in future years. |

| Goals | Key actions/features |
|---|---|
| Reducing health **inequalities** | • All commissioned services are required to have Equity of Access, Equality and Non-Discrimination policies.<br>• Access to services it through a nationally agreed access assessment process to ensure patients access the right services at the right time for the right treatment.<br>• Guidance for the transfer of prisoners to hospital for treatment.<br>• Case managers and quality reviews in hospitals will check that 'reasonable measures' are taken by providers to ensure a patient's needs are met across the all elements covered by the Equality Act.<br>• The CAMHS Tier 4 review will look at location and access of provision, which will then inform commissioners future location planning.<br>• Commissioners will also work with Clinical Reference Groups to look at specialised service provision such a perinatal inpatient services to ensure that location of future commissioned services takes into account location and access. |
| **Parity of Esteem**: Equal focus on **improvements in Mental Health** & on physical outcomes for people with MH problems | The approach to achieving parity of esteem for mental health includes:<br>• Review the % of the specialised budget this year that is mental health and commit to at least maintaining it, if not increasing which is probably warranted across some of the new services we have taken on recently.<br>• Patient length of stay is being monitored to compare parity in services and outcomes.<br>• Working with providers to ensure that not only are mental health services are compliant with minimum services specification requirements but that they meet high quality standards. This may require additional investment as East Midlands prices are at the lower end of national provision.<br>• We have among the most price efficient MH services in the country which has been confirmed during the 10 Area Team benchmarking exercises.<br>• The Area Team will contribute and support to national procurement exercises being planned for mental health services to ensure that the services commissioned represent high quality and value for money.<br><br>Our parity of esteem is reflected by:<br>• A small number of services that are lower than the national average and where this has a negative impact on the ability for the provider to deliver the national service specifications, the Area Team will work with the provider to address this, providing parity of esteem for patients closer to home and supporting the stabilisation of high quality service delivery.<br>• Size of provider, capacity, quality of service and outcomes are considered when negotiating contracts to ensure there is local and national parity.<br>• Provider stabilisation, capacity and demand at local and national levels are also incorporated into contract negotiations.<br>• The 10 Area Teams managing mental health services work closely to ensure that providers across the country are treated and managed consistently. |

**Table 2 Delivering Everyone Counts - Specialised Acute Services Objectives**

| Goals | Key actions/features |
|---|---|
| Secure **additional years of life** for people with treatable mental & physical health conditions<br><br>Preventing people from dying prematurely | A comprehensive review of all specialised services against the service specification will ensure that care is centred around centres of excellence and this should increase the efficacy of health care in the EM. Given that 2 major providers deliver 70% of the specialist services in the region it is likely that there will be a concentration of expertise in these areas.<br>Effective use of a Major Trauma system with a coordinated approach between MTC, trauma units and the ambulance service should prevent unnecessary deaths, increase both life years in real terms and in quality terms.<br>The use of a coordinated approach to rehabilitation across the EM will also assist with the above. The development of a rehabilitation network is in its infancy but work associated with increasing wellbeing, early return to work and achieving better measurable rehabilitation outcomes will see improvements in this area. A coordinated approach which includes assessing all formally designated services delivering specialised rehabilitation, a review of the activity using the UKROC data and support for the development of a clinical network charged with developing rehabilitation across the East Midlands will add quality years to the lives of patients.<br>Implementation of Specialised Services Policies, CQUINS and QIPP schemes aim to achieve increased services quality and improved patient experience and better outcomes. |
| Improve **health-related quality of life** for 15 million people with MH & Long Term conditions | Use of the medical intelligence from the review of all services providing specialist services using the service specification coupled with a complete assessment against the activity in these centres and the population distribution in the EM we will be able to develop a long term strategy to ensure access to specialist care is available for all. This is particular important for patients with long-term conditions when access to care spans the spectrum from intensive inpatient care and also specialist care in the home or close to their home. Cooperation with clinical networks, CCGs, relevant charities and local authorities will ensure there is a comprehensive "network" of care for patients with long-term conditions. Support for the principle of providing specialist care throughout the whole pathway (in patient and the community) by making effective use of support workers and specialist nurses / therapists will provide a supportive platform for this cohort of patients and their families. Examples of this are the current support for support workers / nurses / therapists to span both the inpatient aspect of specialist care an care in the community can be found in a number of specialist areas including: HIV, burns and plastics, cancer, Teenager and Young Adults services, Long Term Ventilation and neurological conditions. There are plans to work with acute providers to expand this mode of care across more specialist areas. This initiative will be supported on the basis that it can reduce hospital admissions, promote early discharge and improve patient care.<br>Ensuring that appropriate the CQUINs for 14/15 accurately reflect improvements in this area also acts as a stimulus to promoting quality. The intention is to ensure the quality schedule of the contract is managed robustly. |

| Goals | Key actions/features |
|---|---|
| Reduce **avoidable time in hospital** through better, more integrated care in community | "**Identification and support for initiatives that ensure that the whole pathway for specialised services is provided for by adopting an integrated approach to the delivery of specialised services that spans both the acute care and primary care environment"**<br>Identifying specialist services that are commissioned to provide or it is beneficial to provide services using a model that reaches out into the community will both reduce hospital admissions and provide a more integrated service. The intention is where appropriate to support providers to provide specialist posts that bridge the gap between the acute and community environment.<br>Examples of this are the current support for support workers / nurses / therapists to span both the inpatient aspect of specialist care and care in the community can be found in a number of specialist areas including: HIV, burns and plastics, cancer, Teenager and Young Adults services, Long Term Ventilation and neurological conditions. There are plans to work with acute providers to expand this mode of care across more specialist areas. This initiative will be supported on the basis that it can reduce hospital admissions, promote early discharge and improve patient care. |
| Increase % **older people living independently** following hospital **discharge** | Better rehabilitation services, specialist community support and case management will address this issue (as above). This is all covered by the philosophy of providing an integrated model of working for specialised services. |
| Increasing number of people having a **positive experience** of **Hospital** care | We have been working closely with the nursing and quality team to examine any Serious Incidents/deaths in specialised services which may relate to the timely access to specialised services.<br>Some qualitative data is available regarding the enhanced patient experience of operating a specialist outreach service (burns service outreach team). The intention is to continue to evaluate this form of initiative. There is work underway to do a joint evaluation of specialist nursing teams delivering burns care in the community. This will be undertaken jointly by members of the service specialist team and the burns outreach team.<br>Providers of specialised services will be compliant with the requirement to seek patient feedback using the Friends and Family test and provide feedback to commissioners on progress. |
| Make progress in eliminating **avoidable deaths in hospital** caused by problems in care | Serious incident investigation and quality management via Area Team Quality and Nursing Directorate.<br>Audit of major trauma data, increased numbers of unexpected survivors as a result of implementation of major trauma system.<br>Region wide peer review / mortality and morbidity meetings to peer review clinical outcomes (Burns Audit, Major Trauma, Cancer |

| Goals | Key actions/features |
|---|---|
| Improve health through **commissioning for prevention** and every contact counts | • Support for the implementation of a rehabilitation network and endorsing initiatives that promote wellbeing may have a positive effect on prevention.<br>• Support for enhanced Long Term Ventilation team and Long Term Conditions (such as neurological conditions) will help to prevent avoidable events that require hospital admission or episodes of sub optimal health. E.g. Neuromuscular Dystrophy |
| Reducing health **inequalities** | • The use of the service specifications and a comprehensive review of all services will provide the medical intelligence to undertake a review of all specialised services against the population served. This will ensure there is a matrix of specialised services that is accessible to all. This work will take 2 to 5 years to complete but is part of a long term strategy to ensure that the right specialists services are in the right place to ensure there is equality of access for all patients in the EM. This will help address any issues associated with health inequality. |
| Parity of Esteem | For acute services parity of esteem relates both to the delivery of improvements in mental health services, and focusing with providers of physical health care, on differences in relative outcomes for those in receipt of mental health services.<br>• As the availability of data improves through national developments such as care.data we will explore with CCG and CSU partners the opportunities to provide improved insights for our providers of acute care to target services where outcome differentials are significant and not attributable to presenting differences in health status. |

## Specialised Services - Service Development

### Commissioning for prevention

The partnership challenge to achieve financial sustainability of services is well illustrated in specialised healthcare. Research indicates that year on year growth in spend for specialised services has been on average 4% higher than for other sectors of care over the last ten years, partly due to the availability of new technologies and drugs but also due to growth in underlying health needs. The key levers to address this rise relate to wider prevention and early intervention commissioned through local authorities and clinical commissioning groups – for example interventions to address alcohol use, exercise, smoking, and diet through local authority led public sector partnerships, and the effective management of chronic kidney disease in primary care will both have an impact on rates of growth for renal dialysis and transplant. By the time patients present with a need for high cost specialist interventions the opportunity to intervene at lower cost has been lost.

We will work with our partners within the ten Health and Wellbeing Boards, utilising the 5 steps recommended in the 'Commissioning for prevention' report to address key service risks and improve health outcomes in our region:

1. Analyse key health problems
2. Prioritise & set common goals
3. Identify high-impact programmes

4. Plan resources
5. Measure & experiment

**National Issues being addressed by all Specialised Commissioners:**

- Continued variation in access
- Sustainability of some services
- Achieving compliance with full service specifications and supporting reconfiguration where this is not a realistic prospect
- Financial affordability
- Supporting new models for commissioning to promote integrated care
- National reviews of capacity and service models including radiotherapy, cardiac surgery, Tier 4 CAMHS and liver transplant services
- Development of remaining service specifications and clinical policies
- Development of national procurement arrangements and key priority areas
- Financial benchmarking and development of standardised prices

## Key issues for East Midlands services by programme of care

**Programme of Care: Internal Medicine**

***Obesity/ Bariatric surgery***

Implementation of the Clinical Commissioning Policy for Complex and Specialised Obesity Surgery

The Area Team is working with CCGs and Local Authorities to develop a co-ordinated plan to achieve a safe managed transition to the new national commissioning policy. This aims to keep the capacity of services at each stage of the pathway in balance. Including benchmarking and a flow model that will help identify required inputs at each level of service. Pathways will be agreed across commissioners and patients will receive a seamless service so that patients who may benefit from potentially lifesaving surgery are be identified after they have completed Tier-3 weight management and referred in a timely manner for specialised surgery. The pathway should include long term Public Health initiatives which impact on behaviour and reduce demand for specialised surgery.

**Programme of Care: Blood and Cancer**

***Radiotherapy Review***

From 1 April 2013 NHS England became the commissioners of radiotherapy services for England as a prescribed service, enabling strategic decisions about service needs and clinical pathways across geographical boundaries to be made. Locally, decisions in relation to radiotherapy delivery partner at Milton Keynes and relationships with NGH and OUH on cancer pathways require the involvement of the Area Team and network in advising on

appropriate options for consideration in the light of the sustainability of services. An option appraisal has been completed and recommendations are being developed pending further activity and outcomes modelling and national guidance.

### *HIV Services*

There are risks to the sustainability of HIV/GUM services in some East Midlands Providers due to the re procurement of Sexual Health Services by Local Authorities- Risk of segregation of services and introduction of private sector providers. In addition emerging cost pressure of the introduction of new service tariffs for HIV services (year of care).

## Programme of Care: Mental Health

### *Perinatal Mental Health*

A provider - Leicestershire Partnership Trust (LPT) has given notice to NHS England that it cannot comply with the service specification, necessary quality standards or invest the finances required to bring the current service up to standard. NHS England has been liaising with LPT and the CCG's regarding the way forward and the need to ensure that the pathway to Inpatient Perinatal beds is clear and widely known by all stakeholders to ensure that women receiving effective treatment and admission when identified as appropriate by the Community Perinatal Service.

Since NHS England has developed a national service specification to ensure that all Perinatal Inpatient Units across the country are of the same standard and deliver the same quality and standard of care, the East Midlands CCG's and Perinatal Quality Network are working together to write a regional service specification for Community Perinatal Services. This will also ensure that all areas of the East Midlands are working towards a Gold Standard service for pregnant women and mothers with mental health problems. And no matter where a woman may become ill the quality and standard of support she receives will not depend upon the area, county or postcode where she resides or receives her treatment.

## Programme of Care: Women and Children's Services

### *Paediatric congenital cardiac Services*

A new national review has been established to consider the whole lifetime pathway of care for people with congenital heart disease (CHD). This aims to:

- Secure best outcomes for patients
- Tackle variation
- Deliver great patient experience

University Hospitals Leicester is one of the providers currently providing paediatric congenital cardiac surgery. They are currently providing monthly returns on the transition dashboard which is being implemented nationally. CRGs are developing national commissioning products including service specifications incorporating new standards of care. Upon the outcome of the review the Area Team will be required to support

implementation of an action plan to deliver the recommendations. This may involve the decommissioning /reconfiguration of current service models in the region.

## Strategic Ambition to build a sustainable coordinated approach to the provision of specialised services in the East Midlands

### Addressing Services not yet at national service specification standards

The assessment of all specialised services against the service specifications developed by the Clinical Reference Groups will inform this strategic direction of travel and ensure that there is a robust platform on which we can develop a plan to deliver commission specialised services in a manner that improves quality, access and efficiency. Throughout the process of reviewing all specialised services in the East Midlands there has been good engagement with the providers and both the strategic and operational delivery networks. This has ensured that historic knowledge and current medical intelligence from a variety of sources has been taken into consideration when measuring compliance of the services against the specification.

There are currently 359 services identified in the acute services that are currently under consideration for compliance against the service specification. The table in section two provides a summary of the current status with services described in three main categories; **compliant** with the service specification, services not compliant but they have applied for **derogation** and services where only part of the pathway is provided and the service is **provided in partnership**.

The two major hospitals providing specialised services in the region Leicester and Nottingham have 87 and 89 specialised services respectively. This supports the intention, set out below, to concentrate specialised services in centres of excellence with some 15 to 30 such centres being viable in England (NHS England, 2013a). This process will become part of the current contract round and form the basis of planning of service provision in the future. NUH have the most services undergoing the derogation process (21). The principle deficits identified are associated with gaps in resources (staffing or infrastructure) to meet all of the service specification. The level of clinical risk associated with the derogation plans have been reviewed with regards to the providers continuing to provide these services.

### Specialised services concentrated in centres of excellence

NHS England now develops specialised service policies and service specifications nationally. These specify the services patients can expect to receive and where they will be provided, they also set out what high cost treatments NHS England will or won't routinely fund.

Strategic Direction of travel outlined in 'Everyone counts' is for Specialised services to be consolidated in fewer providers, linked to Academic Health Science Networks, utilising service specifications, policy and national procurement where required.

For the purpose of planning it is understood that consolidation of specialised services is expected and that this will be to the most capable provider where issues of quality or affordability are unresolvable. Approximately 60% of specialised services are already provided in fewer than 30 centres. We would therefore expect that most specialised services, which are by their nature often rare and complex, should be provided in relatively

few centres, although there are of course, exceptions. As part of NHS England's work on the 5-year strategy they will be looking at the evidence base for greater consolidation of services at both service and provider level.

Our Aspirations for partnering East Midlands commissioners & providers to deliver this change:

- The provider landscape is redesigned in partnership with providers and CCGs in line with local whole system change programmes. The new provider landscape is:
    - Best for patients overall health and outcomes (CCG population and commissioned provider population) - Reducing the no of years of life lost for treatable conditions
    - Local citizens will be included in all aspects of service change resulting from the consolidation of services
    - Best for the economic climate – model ensures Value for money and better use of resources
    - There is oversight and assurance of CCG plans to ensure overlap and integration is managed – we have agreed future mechanisms for engagement and partnership working.
    - Prime contracting models are in place for networked care delivering in partnership with tight clinical governance across providers (80% of services within programmes of care).

In order to ensure that NHS funded care is appropriately placed, we will agree plans and work together with providers and CCG commissioners, to ensure that all elements of the care pathway are aligned and reflect local strategic reviews (e.g. Better Care Together programme for Leicestershire & Rutland, and Lincolnshire Sustainable Services Review).

The on-going work across the East Midlands will secure consistent levels of quality and efficiency, as the team works with regional providers to ensure compliance to national service specifications. This, together with a programme of redesign to ensure our providers can deliver services in line with the most efficient peers has the potential to identify further services that are not clinically sustainable to national standards at efficient levels of spend

These services, together with services which cannot meet national standards for structural reasons (e.g. undertaking insufficient cases per year, or serving a population catchment insufficient to maintain standalone services) or services unable to make the transition to seven day consistent outcomes on a standalone basis will be the focus of strategic change.

Subject to the approval of regulators we will look favourably on clinical joint ventures between the 2 main tertiary providers to create the opportunity for clinicians to drive the consolidation and collaboration agenda, respecting patient's opportunities to exercise choice in neighbouring services at the point of tertiary referral and publishing outcomes relative to others to ensure such choices are well informed and lead to greater volumes of treatment at services achieving better outcomes.

Where there are benefits significant economies of scale which achieve better clinical outcomes or financial sustainability we will encourage providers to consider consolidation of

sites and more centralised access to services, whilst preserving access locally where these gains are not significant.

**Principal Deliverables that underpin the strategy for improving the provision of specialised care**

| Deliverable | Description |
|---|---|
| **Seven day services** | We will engage with NHS IQ to model and plan the potential for 7 day working across our provider footprint ensuring that this reflects clinical quality requirements within national service specifications and the available affordability envelope. This will link with ambitions to consolidate specialised services within a reduced provider footprint which will require the redesign and modernisation of services and associated patient pathways. |
| **Highest Quality Urgent and Emergency Care** | In the East Midlands the major trauma network will be completed by April 14 which will cover the whole of the region and be centred on the Major Trauma Centre (MTC) located within Nottingham University Hospital NHS Trust. Development of a comprehensive major trauma network and system has involved the MTC working with other providers of emergency care in local Accident and Emergency Departments, the East Midlands Ambulance Service and the Major Trauma Network. Because trauma and urgent care spans the commissioning responsibilities of both CCGs and specialised commissioners a number of the services will have to be commissioned in a manner that involves working in partnership. Major trauma is commissioned by NHS England and falls under the remit of those responsible for specialised services with other Emergency Medicine services being the responsibility of CCGs.<br>One of the challenges is the traditional boundaries of the clinical networks which are not aligned with all of the services commissioned in the East Midlands. To develop a truly integrated system for urgent and emergency care commissioners (specialised and non- specialised), clinicians (primary and secondary care), clinical networks and the ambulance services will have to work in partnership. |
| **Research and Innovation** | As part of the redesign of the specialised provider landscape we will actively encourage providers to seek research opportunities. This will be supported through local commissioning decisions where possible and linked to Academic Health Science networks. |
| **Access and utilisation of reliable and robust medical intelligence** | Joint working between commissioners and providers to implement system wide processes to monitor bed utilisation will help all those involved in health care to develop a strategic plan which is robust, defensible and delivers quality care. The use of Utilisation Reviews has been incorporated into the CQUIN process to incentivise healthcare providers to embrace this technology. In addition to influencing lasting organisational change associated with bed utilisation there are also plans to influence clinical practice by encouraging the use of new technologies to reduce hospital acquired infection. This is seen as a priority across all clinical areas. |

## Supporting Delivery of Specialised Commissioning

The number of staff involved in specialised commissioning has significantly reduced since 2012/13, whilst the range of services included within the specialised commissioning portfolio has increased by almost two-fold. The task of moving from between 10 and 152 different ways of commissioning services, to a single consistent national model, has been immense. It is recognised that there needs to be some immediate improvements to the way in which specialised services are commissioned in order to put specialised commissioning on a stronger footing for the future.

NHS England's Executive Team is committed to supporting specialised commissioning at this challenging time and is putting additional resources in place to support the existing teams, drawing on the wealth of skills and expertise from across the organisation. This will involve around 50 additional individuals, identified for the unique contribution they will be able to make, temporarily taking up posts within the team.

There will be seven distinct workstreams with a particular focus on financial control in 2014-15 and planning for the 2015-16 commissioning round. This workstream will be headed up by Dr Paul Watson, Regional Director (Midlands and East), and Chair of the Specialsied Commissioning Oversight Group (SCOG).

The team is working to a three-month timetable. The seven workstreams are:

Workstream 1 – **Strategic Projects**, headed up by Ann Sutton, Director of Commissioning (Corporate). This team will ensure continuation of the most complex and highly specialised programmes such as Proton Beam Therapy, and ensure delivery of a prioritisation framework for 2015/16.

Workstream 2 – **Strategy**, headed up by Michael Macdonnell, Head of Strategy. This team will develop a financial sustainability strategy for specialised commissioning, and make recommendations about how the range of specialised services and commissioning models should change.

Workstream 3 - **Clinically Driven Change**, headed up by James Palmer, Clinical Director, Specialised Services. This team will ensure that our programmes continue to be clinically led, driving forward programmes that deliver clinical benefit alongside efficiency improvements. They will also be responsible for ensuring a sustainable approach to the commissioning of cancer drugs.

Workstream 4 - **Operational Leadership**, headed up by Cathy Edwards, Director of Commissioning in South Yorkshire & Bassetlaw Area Team. This team will be the engine room of specialised commissioning, ensuring all programmes are properly led, working collaboratively with our area teams and stakeholders. They will have overall responsibility for our QIPP programme, and will develop recommendations on the future shape of the specialised commissioning infrastructure. This team will also include a communications and engagement function, dedicated to ensuring that all stakeholders, including NHS England staff, are well informed; and will also support the work of the Specialised Commissioning Oversight Group (SCOG) and the Patient and Public Voice Assurance Group (PPV AG).

Workstream 5 - **Commercial and Technical Delivery**, headed up by Peter Huskinson, Director of Commissioning in Leicestershire & Lincolnshire Area Team. This team will ensure specialised commissioning manages its provider market in a highly effective, mature way, through well planned and rigorous procurement and contracting programmes, supported by building capacity and embedding best practice across area teams.

Workstream 6 - **Strong Financial Control**, headed up by Rachel Hardy, Regional Director of Finance in Midlands & East. This team will ensure specialised commissioning has strong financial leadership and focus across all of its programmes. It will also carry out specific technical pieces of work on area teams' financial baselines, and will provide support to the Clinical Priorities Advisory Group (CPAG).

Workstream 7 – **Analytics**, headed up by Ming Tang, Director, Data and Information Management Systems. This team will ensure specialised commissioning is supported by good data and intelligence, building capacity and capability across area teams and commissioning support units (CSUs), as well as moving towards much greater standardisation of informatics processes.

A communications and engagement plan to is being developed to support this important programme and stakeholders will be fully informed of the progress of this work.

## Public Health Services – Our Ambitions and Plans

The function of the public health team within the Area Team is to implement the content of the section 7a agreement. Currently this contains 30 specifications; 14 immunisation programmes, 12 screening programmes and four other programmes the largest of which is the public health services for under 5s, predominantly health visiting and family nurse partnerships.

### Aligning priorities to anticipated changes to section 7a agreement

The content of the section 7a will change over time. The three major changes that are already known are:

1. Roll out of the Fluenz programme (intranasal flu vaccine) to all 2-16 year olds
2. The transfer of the commissioning responsibility for public health services for the under 5s to local authorities. This is likely to take place in October 2015.
3. The introduction of bowel scoping as part of the bowel cancer screening programme. This will see sigmoidoscopy offered to everyone at the age of 55 years.

Other potential changes to the section 7a agreement the possible introduction of a meningococcal B vaccine in to the childhood immunisation schedule, additions to the new born screening programme with tests for other rare conditions using the blood spot sample at 3 days, and possibly a move to using HPV testing as the primary test in cervical screening. The introduction of other new immunisation or screening programmes within a 5 year timescale is quite conceivable.

### Changes to provider landscape for public health services

There are two main drivers that might affect the provider landscape over a five year period:

1. Decisions at national level as to the ideal size of a provider of screening services. For example there is a desire to see larger grading units for diabetic eye screening services. This may see work being brought together at an East Midlands or even larger level. Conversely, the current arrangement that sees Kettering as the lead bowel cancer screening provider for Leicestershire and Northamptonshire is currently being split up as the national team has decreed that the unit is too large for efficient operation.

2. Any requirement to go out to tender may significantly change the provider landscape for screening services. If independent providers become involved in the screening services the processes for referring in to the programmes and for the onward referral to treatment services are likely to become more complicated, as will the necessary fail safe systems.

The Fluenz programme is sufficiently large that it may change the way that immunisation services are provided. Currently in Leicestershire and Lincolnshire only HPV vaccine is given through schools. The move to providing Fluenz through schools may dictate the need to establish a robust immunisation service for schools in both areas. It may then make sense to move the teenage booster for Td/IPV and the new teenage booster for meningitis C from general practice in to schools. This would require investment.

**Demography / prevalence**

Both screening and immunisation services are population based services and are therefore sensitive to demographic changes. The Knowledge and Information Team (KIT) in the PHE Centre have been asked to take on the work for the East Midlands of modelling the impact of demographic changes for all screening and immunisation services. This will include taking account of the predicted changes in prevalence of diabetes in different geographical areas. There will also be the option to look at sensitivity analyses around uptake of services as this is the other principal driver of resource use.

**Core business over the next five years**

The core business for the next five years will be to ensure efficient, effective and equitable service provision informed by patient experience. This will be include targeted actions in support of the following themes:

| | |
|---|---|
| Quality | • To ensure that screening programmes meet the minimum acceptable targets at the earliest opportunity and to strive to meet the achievable targets over this time.<br>• To comply with the recommendations following regional QA visits<br>• To meet new recommendations from national programmes including amendments to section 7a service specifications<br>• To ensure childhood immunisation programmes move towards 95% uptake for all programmes. |
| Productive Efficiency | • To ensure that services are provided at costs that are at least not higher than the median price for the service nationally |
| Allocative efficiency | • To ensure that resources within the public health ring fence are allocated to services in the most appropriate way resulting in all services being fairly resourced and able to generate maximal health benefit. |
| Equity | • To undertake equity audits and act on the outcomes to ensure that services are accessed by, and provide benefit to, all parts of society according to need. |
| Patient experience | • To find innovative and effective ways to gather patient views about service provision and to involve patients in the design and evaluation of services. |
| Governance | • To ensure a managed process for the transfer of commissioning responsibility for public health services for children under 5 years from the Area Team to upper tier local authorities<br>• To ensure that all programmes are subject to good governance procedures and processes. |

## Public Health Services - Two Year Plan Priorities

The Development programme over the next 2 years is outlined below:

The services that are commissioned by the AT under the section 7a agreement are specific and clearly defined. This plan therefore focusses on each service rather than looking at overarching themes such as the ten goals or six themes.

**Immunisation services**

***Routine childhood immunisation***

In Leicestershire we will strive to maintain existing good performance with a focus on the practices that are performing least well.

In Lincolnshire performance compares unfavourably with peer "PCT" areas (the only unit of comparison available). A work stream is in place to improve all aspects of the patient pathway, including the child health information service involvement, to ensure that accurate and timely information is available that will be used to drive up performance.

***Meningitis C teenage booster***

For 2014 this will be given in general practice. During 2014/15 work will be undertaken to establish a new commissioning arrangement from April 2015 in line with national guidance. This links to work around the Fluenz programme as there may be benefit in concentrating all teenage immunisations through a school based service.

***New Meningitis C catch up for university entrants***

The detail of this catch-up has yet to be announced. It is assumed that this will be a GP provided service but the contractual mechanism for this is not yet clear. It is assumed that new money will be available for this catch-up programme.

***HPV vaccination***

In Leicestershire and in Leicester City the target of 90% has been achieved in 2012/13. For the City this was the first time the target has been achieved so the aim is to maintain this excellent performance.

In Lincolnshire the performance was slightly below the target at 88%. Work is in hand to improve this rate with an expectation that 90% will be achieved for dose three in 2014 and beyond.

***Seasonal flu***

Performance across the Area Team for those over 65 is likely to be slightly under the 75% target for 2013/14. It is difficult to know what else to put in place to try to improve uptake further. For those at risk under 65 the aim is to immunise more individuals each year. The target of 75% for this group is unattainable due to the methodology of data collection, hence the focus on numbers of individuals immunised.

In addition to the normal cohorts general practices have immunised >40% of all 2 and 3 year olds with Fluenz in 2013/14. The aim will be to increase this percentage on an annual basis and to add in the 4 year old cohort from 2014.

***Pneumococcal vaccine***

There is reference to a change to the adult pneumococcal programme. The details of this are not known but we are confident that we can implement any change.

***Fluenz programme in schools***

Leicestershire ran the largest pilot of Fluenz in primary schools in 2013. In 2014 the aspiration is to extend the primary school pilot to cover the whole of the LLR primary school population as well as offering the vaccine to years 7 and 8 in secondary schools. This is dependent on national funding being available. In 2015 we will at least match whatever the national plan is for this programme which has yet to be announced.

Lincolnshire in 2014 will offer the vaccine to all years 7 and 8 in secondary schools. In 2015 we will follow whatever the national plan is for this programme which has yet to be announced.

***Neonatal hepatitis B***

We will establish revised pathways of care to ensure that all at risk babies receive hep B vaccination in line with national policy and that an appropriate failsafe process is in place involving CHIS to ensure that no children fall through the net. We will also initiate the blood spot test at one year.

**Screening Services**

***Bench marking***

For screening services that are not based on a national funding formula we will continue with our benchmarking work to ensure that we are achieving value for money from the services that we commission.

***Breast cancer screening***

**Leicestershire:**

We will implement the pathway for high risk women in line with NICE guidance. We will maintain the good level of uptake that this service has traditionally secured.

**Lincolnshire**

We will implement the pathway for high risk women in line with NICE guidance. We will ensure that the service becomes fully digital at the earliest opportunity. We will work with the trust to ensure that they can deliver a robust and effective service based on effective team working.

***Cervical cancer screening***

We will commission HPV testing as part of the cervical screening programme. We will look to stop the decline in uptake of cervical screening particularly in younger women.

***Bowel cancer screening***

We will establish University Hospitals of Leicester NHS Trust as an independent bowel cancer screening unit. We will support the trust to participate in wave two of implementation of the bowel scope extension of the bowel screening programme.

We will ensure that United Lincolnshire Hospitals NHS Trust can provide this service in fully accredited facilities. We will support their aspiration to be in phase two of implementing the bowel scope programme.

***Diabetic eye screening programme***

We will implement the new pathway for surveillance. We will work with both providers to look at better ways of contracting for this service, potentially building on the local tariff developed in Nottingham and Derbyshire Area Team.

***Abdominal aortic aneurysm screening***

We will take on the commissioning and contracting responsibility from the national team for the site in Lincolnshire and will continue to support the site in Leicestershire.

***Antenatal and Newborn screening***

We will implement the fail safe programme for the new born blood spot programme.

We will support trusts to implement the SMART system for managing the NIPE programme.

***Child health information system***

We will ensure that the local Child Health Information Systems are in accordance with the national service specification by the end of March 2015 and will work with our providers to address any issue they may have in attaining the required standards.

**Child & Family Health Services**

***Health visiting for under 5s***

We will commission such that in each area they will reach the nationally required trajectory for health visiting numbers. We will also ensure that the rest of the skill mix of the teams is appropriNGHate given the rapid expansion in qualified health visitor numbers.

We will work jointly with colleagues from local authorities to manage the transfer of commissioning from NHS England to local authorities to take effect whenever that transfer is confirmed.

***Family nurse partnership***

We will commission the required expansion of the nationally agreed increase in the number of FNP places which include the introduction of a new site in Lincolnshire and the continued support of the existing site in Leicester City.

We will work jointly with colleagues from local authorities to manage the transfer of commissioning from NHS England to local authorities to take effect whenever that transfer is confirmed.

## Primary Care Services – Our Ambitions and Plans

### Local Ambition One (Quality)

To **reduce unjustified variation in the quality** of the services received by patients.
Key outcomes:

- a high quality workforce, optimising the skill mix across all primary care service providers to ensure the right people, with the right skills, are in the right place at the right time ;
- modern models of integrated working designed around the patient, recognising the expanded role of general practice in co-ordinating and delivering personalised care and the potential role of others such as community pharmacy.;
- Optimising the new GMS contract changes, in partnership with CCGs, to deliver more proactive care for people with more complex needs and promoting consistently high standards of quality;
- Improved patient experience.

**Improvement interventions**

We will establish more robust mechanisms for triangulating data and information to improve our understanding of the quality of the service provided by primary care. We will develop robust quality and performance assurance frameworks for primary care to ensure that there is a consistent approach to managing unwarranted variation in quality.

Implementing the GMS Contract changes for 14/15 – the range of changes to the GMS contract seek to enable integration, new ways of working, and proactive care that is 'wrapped around' patients, particularly those with complex needs; this supports local CCG plans for managing multi morbidity through integrated neighbourhood teams.

The new enhanced service for reducing unplanned hospital admissions will again support CCG plans and by working together and giving consistent messages we can ensure that there is no duplication of effort or confusion for general practice and we can improve patient experience and outcomes.

Working with CCGs to address capacity issues in Primary Care and secure a high quality workforce. As a starting point we need to understand our GP workforce and identify the gaps. During the next 12 months we are planning to undertake a GP recruitment initiative in partnership with CCG's.

For dental service providers we are looking to better use of resources, IMOS pathway (awaited) and Orthodontic Framework.

**Local Ambition Two (Outcomes)**

To reduce **unjustifiable inequalities** in health outcomes and access to services
Key outcomes:

- commissioning across pathways (e.g. LD, homeless etc)
- federated models of delivery across independent contractors
- modern models of integrated working designed around the patient

**Improvement interventions**
*GMS contract changes 14/15*
Implementing other nationally negotiated changes which include:

- A review of the enhanced service for Diagnosis and Care for People with Dementia;
- A review of the enhanced service for Annual Health Checks for People with Learning Disabilities
- A review of the enhanced service for Alcohol Abuse, to incorporate additional assessment for depression and anxiety.

*Improving oral health*
Partnership working with Leicester City Council to deliver the Oral Health Promotion Strategy (2014-2017) for pre-school children. Five year old children in Leicester have the highest experience of dental decay observed in England. The aim of the strategy is to support co-ordinated activity across Leicester City to improve oral health, reduce oral health inequalities and lay solid foundations for good oral health throughout life. The ambition is for a 10% increase in the proportion of 5 year olds in Leicester with no signs of dental disease by 2019. We will jointly explore different models of service provision, direct access to dental therapists etc, and ensure access is equitable.

The Leicestershire, Leicester City and Lincolnshire Oral Health Needs Assessment is being produced and this is expected to be completed by June 2014.

*Eye health*
The Eye Health Needs Assessment (gap analysis) is being produced for our area and will be overseen by the Eye Health LPN.

Improve access to and uptake of GOS sight testing for vulnerable groups and at risks groups, for example the homeless. This proposal will be implemented through the Eye Health LPN task and finish group in 2014/15.

**Local Ambition Three (Patient Services): To increase citizen participation and empowerment and ensure that they are at the centre of our planning.**

Key outcomes:

- Improved access to the right services in a timely manner through better information
- Greater access to NHS Choices
- Choice of GP practice
- Greater involvement of patients in service design and commissioning.
- Friends and family test implemented

**Improvement Intervention**

*GMS contract changes 14/15*
The Friends and family test will be a contractual requirement for GP practices from December 2014. Practices will be able to develop a second question and we are encouraging practice to discuss this with their CCG and the Area Team. The Friends and family test has already been piloted in Lincolnshire. This is expected to be introduced for other primary care providers by March 2015.

From October 2014, all GP practices will be able to register patients from outside their boundary area without a duty to provide home visits.

From April 2014 it will be a contractual requirement for GP practices to promote and offer patients the opportunity to book appointments, order repeat prescriptions and gain access to medical records on line.

The patient participation enhanced service will be reviewed so that this is greater innovation in how practices seek and act on patient feedback, including the views of patients with mental health needs.

*Patient Engagement and Empowerment*
Introduction of patient stories which engage patients, relatives, and carers in ways that use their knowledge and experience to directly influence future service provision. This has commenced in January 2014 within the Lincolnshire Salaried Dental Service. It is the intention to develop this approach and roll it out.

Establish a 'People Bank' where citizens and organisations can register an interest in participation opportunities. Commissioners can also use it to identify interested people for engagement activities.

Hold a local 'listening event' to understand how patients want to participate in the management of their care and how they wish to participate in the commissioning process itself.

Good links with Healthwatch have already been established and we want to strengthen this further in 2014/15 through the primary care meeting structure and the development and implementation of the primary care strategy.

Patient involvement in the planned procurements for 2014/15.
Review Area Team structures and processes to ensure that the local need, local voice and shared decision making with patient representatives are incorporated at every stage of the commissioning cycle from design to delivery to contract monitoring.

**Local Ambition Four (Patient Services): To improve the quality of life for older patients and those patients with one or more Long Term Condition.**

Key outcomes:

- Commissioning for outcomes
- Wider primary care, provided at scale
- Modern models of integrated working designed around the patient

**Improvement Intervention**

*GMS contract changes 14/15*
Implementing nationally negotiated changes for general practice that support more personalised care for older people and those with complex needs.

There will be a new enhanced service to improve services for patients with complex health and care needs and reduce avoidable emergency admissions. The resources released from the QOF quality and productivity domain (100 points) and the risk stratification DES (which will cease with effect from 31st March 2104) will fund the new enhanced service. Given the level of funding associated with the new enhanced service, the expectation is that the majority of practices will sign up to provide this service.
The key elements of the scheme are intended to reduce unplanned admissions, for example proactive care management of at least 2% of patients with complex needs and at the high risk of emergency admissions.

As part of a commitment to more personalised care for patients with long-term conditions, all patients aged 75 and over will have a named, accountable GP with overall responsibility for their care. This will be a contractual duty from 01 April 2014 and any new patients will be notified within 21 days and existing patients notified by June 2014.

These changes will be reflected in PMS contracts once underpinning legislative changes and guidance are in place. These changes will also be reflected in all our local newly procured APMS contracts as a minimum.

We are working with CCGs to ensure that the funding available to support practice plans that improve the quality of care for older people, complement the above core contract changes.

The Eye Health LPN will establish a task and finish group in 2014/15 to take forward Falls Prevention with the aim to reduce avoidable emergency admissions.

Now that the Pharmacy LPN and Eye Health LPN have been established we will be strengthening links with CCGs to improve patient pathways.

Implementing the GMS Contract changes for 14/15 – the range of changes to the GMS contract seek to enable integration, new ways of working, and proactive care that is ‘wrapped around’ patients, particularly those with complex needs; this supports local CCG plans for managing multi morbidity through integrated neighbourhood teams.

The new enhanced service for reducing unplanned hospital admissions will again support CCG plans and by working together and giving consistent messages we can ensure that there is no duplication of effort or confusion for general practice and we can improve patient experience and outcomes.

**Local Ambition Five (Access):To improve access to primary care services & secondary care dental services.**

Key outcomes:

- Annual improvement in patient experience of access to services
- Pilot(s) in place for testing new ways of working for general practice

**Improvement Intervention**

*PM Challenge Fund: Improving Access to General Practice*

This national scheme is seeking bids for a 2 year pilot to test out innovative models of service delivery, such as federated models, new ways of working that improve access, and make better use of email and phone consultations.

*Local Service Reviews*

Align the local primary care strategy with the Lincolnshire Sustainable Services Review and the LLR Better Care Together Programme to ensure that there is a ‘fit’ with local approaches to new models of service delivery and integrated patient care packages.

*Access to dental services*
The Leicestershire, Leicester City and Lincolnshire Oral Health Needs Assessment is being produced and this is expected to be completed by June 2014. This will provide
Access to dental services – dental look at the % of patients seen

Secondary care pathway development across primary, community, and secondary care dental services. Currently prioritising minor oral surgery and orthodontics (awaiting national pathways) and restorative dentistry, which requires a local review due to differences in the referral criteria applied across the area.

Service reconfiguration project for the Leicestershire Salaried Dental Service, including a review of dental out of hours services and Dental Access Centres. The project was established late in 13/14 and will be taken forward in 2014/15

*Access to sight testing*
Improve access to and uptake of GOS sight testing for vulnerable groups and at risks groups, for example the homeless. This proposal will be implemented through the Eye Health LPN task and finish group in 2014/15.

**Local Ambition 6 (Delivering Value): To reduce unjustified variation in funding levels received by providers and secure the highest quality of care and the best outcomes for every pound invested.**

Key outcomes:

- better use of estate from which primary care services are delivered (quality of premises and value for money)
- Delivery of financial plan and associated QIPP schemes
- Redirection of resources to primary care services aligned to strategic direction for scale, scope and integrated care.

**Improvement Interventions**

*Encouraging the adoption of new models of primary and integrated care*
A key priority for NHS England is to implement the new arrangements for GP practices to deliver tailored and co-ordinated care for older people and those with complex needs, in partnership with CCGs.

We will support wider primary care delivered in conjunction with social care, community services and formerly acute services where CCG plans support this. This may mean embedding NHS England GP practice contracts in wider arrangements, and jointly commissioning providers of a wider range of integrated care, as a practical way to support tangible delivery aligned to the purpose of the Better Care Fund.

We will support, enabled by a regional and national programme of Primary Care Development, 6 potential care delivery models relevant to local needs and aspirations:

1. Integration around related services for a specific medical condition or group of conditions, in line with the intentions of Leicestershire CCGs.

2. Integration across a wide range of conditions around a specific geography, as reflected in Lincolnshire sustainable services review priority for neighbourhood teams

3. Colocation & merger of practices where it allows improvements in premises in a more cost effective way than standalone development, whilst preserving a level of choice.

4. Creative use of primary care with other public sector and community services in more rural locations

5. Support for practices to bring core services and functions together and manage them jointly on a shared basis such as through federation agreements, whilst preserving individual contractual arrangements for patients.

6. Exploration of the use and expansion of specialist GP services for targeted populations, where evidence suggests clustering patients with specific conditions or needs with others achieves better outcomes than dispersed in small numbers within general contracts.

Except where there are no other alternatives, it is expected these arrangements will take priority in any resource allocation decisions over standalone developments. Further dialogue with commissioning partners and local representative committees will take place to more fully articulate the range of models we will provide support to, as part of the implementation plans for the primary care strategy currently under development

*GMS Contract changes 14/15*

All area teams in NHS England are implementing the nationally agreed phase out of Minimum practice income guarantee (MPIG) funding for GP practices from 01 April 2014 with a pace of change of 7 years. Funding will be recycled into global sum payments so that funding is more fairly matched to number of patients and key determinants of practice workload.

Local impact for practices – we have 6 ‘outlier’ practices (nationally there are 98) which will lose the largest amount of funding per patient. We will need to discuss possible options with those practices: this could include federation or networking, merging with another practice, other cost-efficiency improvements within the practice, or other commissioning/contracting solutions.

*PMS reviews*

Impact for practices (assessed on the same basis as GMS) – we have 8 ‘outlier’ practices . We will review all practices, starting with the 8 ‘outlier’ practices, and the resources released will support QIPP delivery. Where possible these resources will be targeted towards our strategic aims for primary care, such as wider primary care provided at scale, supporting new models of care (federation, networks, and neighbourhood teams) and better more convenient access. This will involve joint working with our CCGs, particularly in supporting local urgent and emergency care networks and reducing avoidable emergency admissions. Implement equitable funding mechanisms with an agreed pace of change; with a part year effect in Year 1 to accommodate a reasonable notice period of change.

*Local 'premium' for Leicestershire practices* (from PCT fairer funding exercise).
We will Implement equitable funding mechanisms with an agreed pace of change in consultation with Local Medical Committees (LMCs), practices and CCGs recognising a managed process is needed. Again released resources will be targeted to strategic aims.

*Premises utilisation/Rent abatement policy*
We will implement the rent abatement policy for GP practices (which means where practices host wider services they attract a share of the premises rent). This will ensure that the true costs of wider primary and community services are reflected. We will implement this in a staged way for existing services, ensuring finances are aligned between commissioners, and there are no unintended consequences. All new services delivered in practice will be costed taking account of rent costs due.

*Time limited contracts*
We will review the time limited contracts and where appropriate re-procure services, which is already underway. Design and commission services in partnership with local communities, so that we secure value for money, improve health outcomes and offer new models of care.

**Sustainability**
Delivery of financial plan and associated QIPP schemes to address the local financial gap for primary care and secondary care dental services. Detailed QIPP plans will be made available as they are further developed.

We need to address workforce capacity and resilience in order to sustain the large-scale shift to community-based patient care and new models of integrated working. In partnership with CCGs and Local Education and Training Boards we aim to have a workforce that can deliver personalised and cost effective care; two key elements are

- An expanded, skilled, resilient and flexible workforce working within integrated teams.
- Academic and quality-improvement activity plus a positive learning climate embedded in primary care.

**Governance Overview**
Within NHS England, the AT Change Programme Board and Primary Care Strategy Group will oversee the delivery of the improvement interventions reporting to the Area Team executive, and with national line of sight through Primary Care Oversight Group as required.

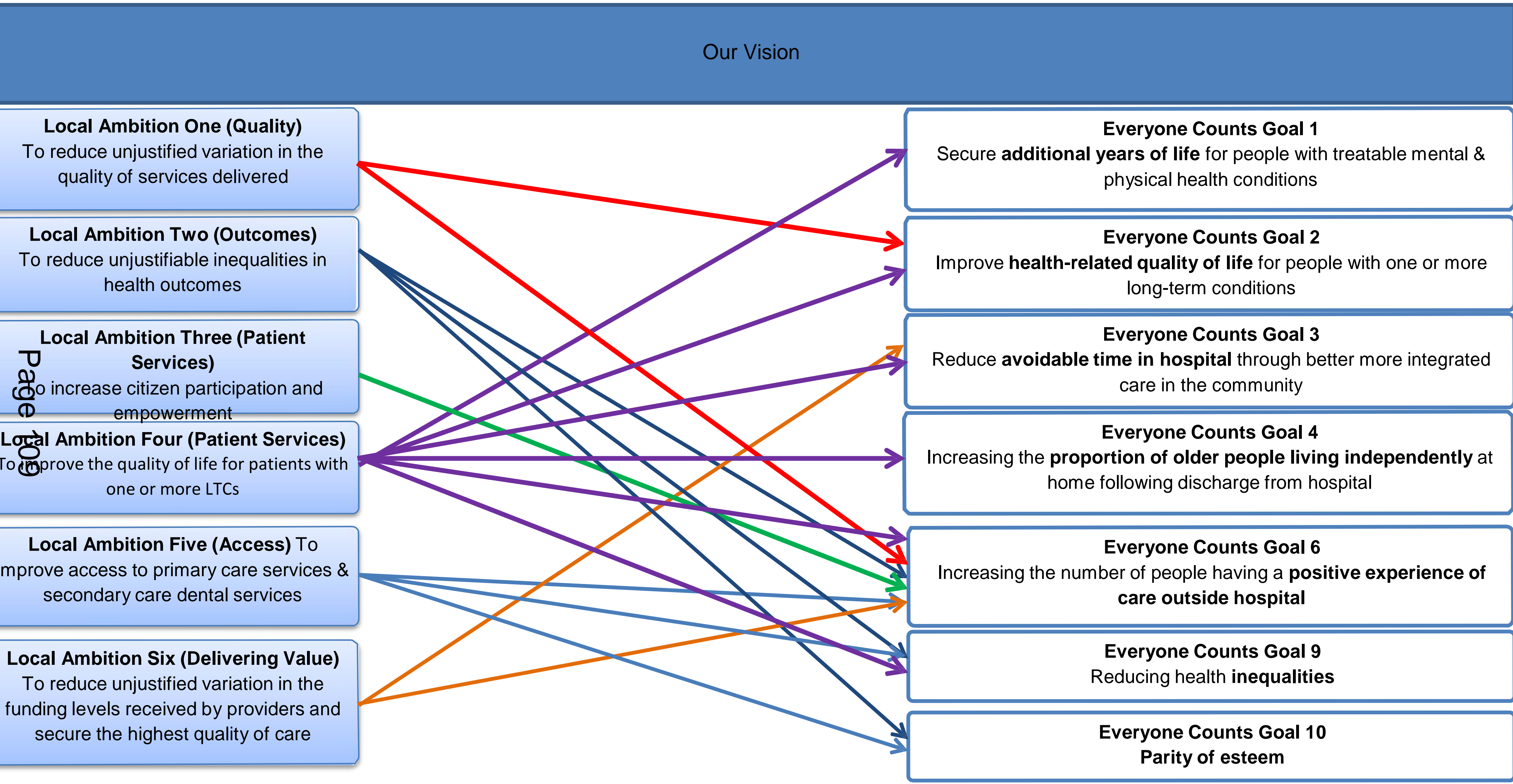
- On-going dialogue with CCGs on progress, recognising our shared agenda
- Membership of the Lincolnshire Sustainable Services Review Steering Board and LLR Better Care Together Programme Board and relevant delivery groups to ensure alignment
- Quarterly updates to the 4 health and wellbeing boards

**Key values and principles**

- Common core offer of high quality patient centred primary care
- Continuous improvement in health outcomes across the domains
- Patient experience and clinical leadership driving the commissioning agenda
- Maximise value by securing the highest quality of care and the best outcomes for every pound invested

The diagram (overleaf) maps primary care operational plans to ‘everyone counts’ guidance:

## Primary Care Services – Everyone Counts

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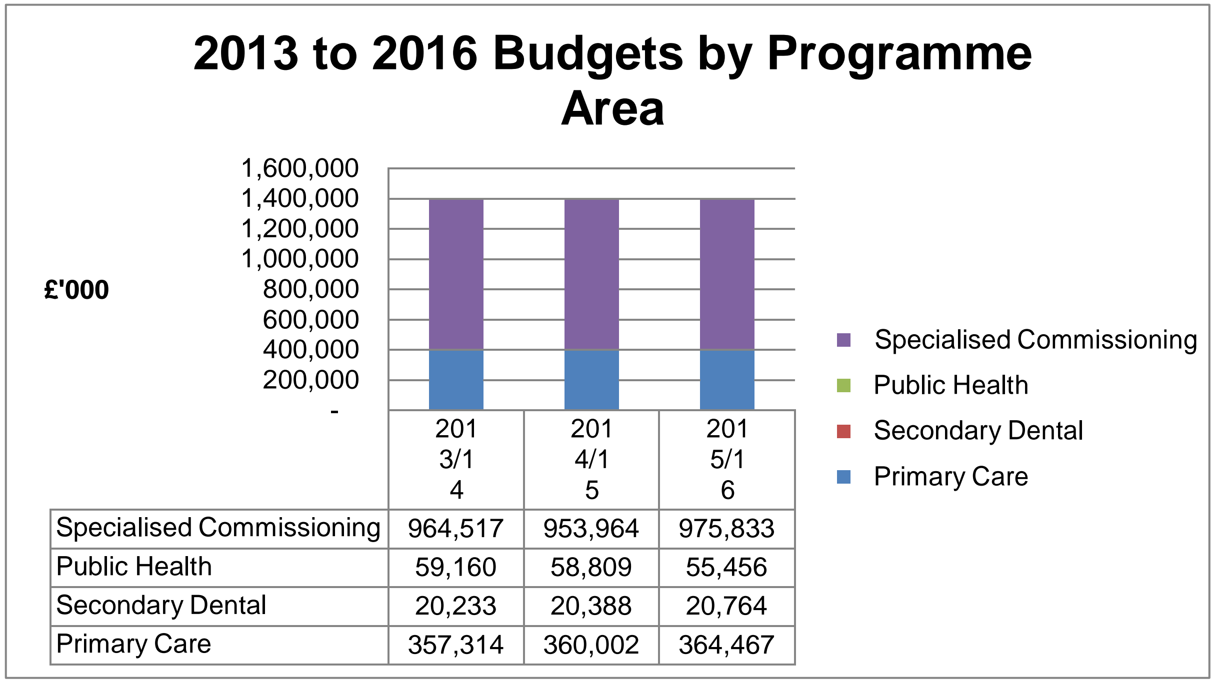
# SECTION FOUR: FINANCE, PERFORMANCE, AND DELIVERY

## Draft Financial Plans – Financial Commentary

### Introduction

Leicestershire & Lincolnshire Area Team has a budget of £1.4bn, as shown in the graph below. This financial commentary is intended to highlight the changes assumed with the budgets below from 2013/14 to 2015/16, and the outcomes as a result of those changes.




| | 2013/14 | 2014/15 | 2015/16 |
|---|---|---|---|
| Specialised Commissioning | 964,517 | 953,964 | 975,833 |
| Public Health | 59,160 | 58,809 | 55,456 |
| Secondary Dental | 20,233 | 20,388 | 20,764 |
| Primary Care | 357,314 | 360,002 | 364,467 |

Plans have been developed in detail for 2014/15 and 2015/16. Financial plans have been populated for 2016/17 to 2018/19 however these reflect continuation of basic assumptions for allocations and costs in line with 2014 to 2016. Strategic plans are to be developed for the plan submission required in March.

The plans have been developed in line with commissioning plans, and reflect the current development of operational planning, and currently available information.

### Requirements

Table 1 shows a list of the key business rules for Direct Commissioning. In summary these are in line with 2013/14 apart from the requirement of specialised commissioning to deliver a 1% surplus, and ensure a headroom reserve is placed aside, where in 13/14 this was used in lieu of growth.

The other major change is the increase of the headroom from 2% to 2.5% in 2014/15. This then returns to 2% in 2015/16 onwards. A minimum of 1% of the headroom should be used for transformation.

All areas are expected to maintain a 0.5% contingency for in year pressures.

Although the requirement is for a 1% surplus, the requirement for 2014/15 is that the current agreed forecast surplus in 2013/14 is the required surplus for 2014/15. Reductions to surplus can be made in 2015/16 to meet the

‘financial cliff edge’.

The 1% surplus from 2013/14 has been confirmed will be carried forward from 2013/14 in Primary Care, and secondary Dental. The forms currently allow all surplus/deficits to impact on 2014/15, which has an impact for Specialised Commissioning as it is currently forecasting to be £4.6m overspent. In line with national discussions on specialist commissioning it has been assumed that this pressure will be met centrally.

Table 1. Business rules for 2014/15 and 2015/16

| | 2014/15 | | | 2015/16 | | |
|---|---|---|---|---|---|---|
| Commissioned Area | Surplus | Contingency | Headroom | Surplus | Contingency | Headroom |
| Specialised Commissioning | 1.0% | 0.5% | 2.5% | 1.0% | 0.5% | 2.0% |
| Primary care | 1.0% | 0.5% | 2.5% | 1.0% | 0.5% | 2.0% |
| Public Health | 0.0% | 0.5% | 0.0% | 0.0% | 0.5% | 0.0% |
| Secondary Dental | 1.0% | 0.5% | 2.5% | 1.0% | 0.5% | 2.0% |

**Allocations**

Allocation changes are summarised in table 2. Specialised commissioning received an uplift of 4.3%. This was designed to allow specialised commissioners to meet in year pressures from 2013/14 and reflecting the evidence about relative pace of growth in healthcare need for complex services such as new high cost drugs being made available.

Primary care increases for the Leicestershire and Lincolnshire Area are 2.2% in 2014/15. This is weighted taking into account forecast population changes, and unmet need. This increase is also applied to Secondary Dental, which nationally is considered as part of the primary care allocation.

The public health growth in allocation is being retained nationally. The intention is to allocate the growth based upon the outcome of the plans. As a result it’s expected with the investment requirements in public health that the financial plans will be overspent pending agreed transfers.

For technical reasons financial plans templates in 2014/15 and onwards allow for no anticipated allocations. This means where recurrent allocations haven’t been included with the national allocation notified for the plans the position this causes a pressure in the position. These have been notified to the central team and amount to £1.831m within Primary care. £1.41m of this relates to agreed infrastructure allocation corrections with

Leicestershire CCGs.

Table 2. 2014/15 to 2015/16 Recurrent Allocations

| | Specialised Commissioning | | Public Health | | Secondary Dental | | Primary Care | |
|---|---|---|---|---|---|---|---|---|
| | 2014/15 £000 | 2015/16 £000 | 2014/15 £000 | 2015/16 £000 | 2014/15 £000 | 2015/16 £000 | 2014/15 £000 | 2015/16 £000 |
| **Total Recurrent Notified Allocation** | 953,964 | 1,011,679 | 58,809 | 58,693 | 20,190 | 20,560 | 356,130 | 362,680 |

### Key Assumptions

Below is a list of the key assumptions made within the financial plans.

***Specialised***

4% Tariff efficiency will be applied in full to health care providers, apart from primary care providers.

2.8% Tariff Increase – Different from national at 2.7%, which reflects local view that the impact will not reflect in the same proportions as anticipated nationally.

Demographic growth at 0.82% - determined by projections on local ONS data.

Non-demographic growth of 4.6% - This relates to drugs and device increases and other service growth.

Coding and Counting issues expected to cost around £6m (where providers can increase charges for care delivered according to national rules where improved coding results in extra activity being billed).

Convergence costs over 13/14 of £12.4m reflecting additional eligibility for treatment under new national clinical policies

A separate ring fenced fund for demand management and prevention for specialised services as a result of the national tariff for emergency care, with £4m planned in line with
2013/14.

Cancer Drugs Fund allocations and costs are removed for 14/15 onwards as funding held centrally by NHS England.

***Public Health***

Contracts change in line with national assumptions i.e. 4% tariff efficiency 2.7% price increase

Demographic Growth at 0.82%

***Secondary Dental***

Contracts change in line with national assumptions i.e. 4% tariff efficiency 2.7% price increase

Demographic Growth at 0.82%

***Primary care***

Inflation applied in line with previous year's impact at 1.25% on GPs.

Demographic Growth at 0.82% or GP demographics are in line with national assumptions, 1.3% and 1.2% for 14/15 and 15/16 respectively.

GP IT allocation and costs are excluded from the position.

Where not population based, no increase has been assumed, in line with previous experience on Primary care.

**Investments**

Increases to costs over the assumptions already highlighted are listed within recurrent investments sheets (those which are required from the baseline), and non-recurrent investments (those that utilise the 'headroom'). A summary of those investments are contained within table 3.

Table 3. 2014/15 Recurrent and Non-Recurrent Investments

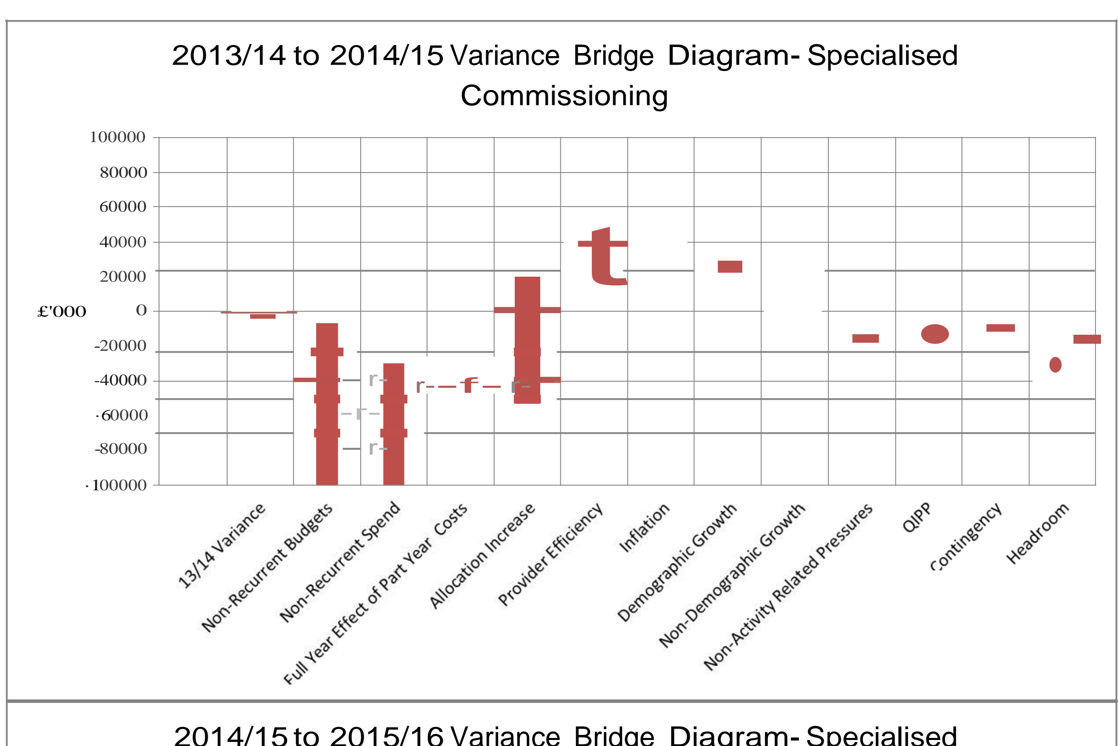
| **Programme Area** | **Recurrent £'000** | **Non-Recurrent £'000** |
|---|---|---|
| Specialised Commissioning | 0 | 23849 |
| Public Health | 5992 | 0 |
| Secondary Dental | 0 | 506 |
| Primary Care | 11887 | 4591 |
| **Total** | **17879** | **28946** |

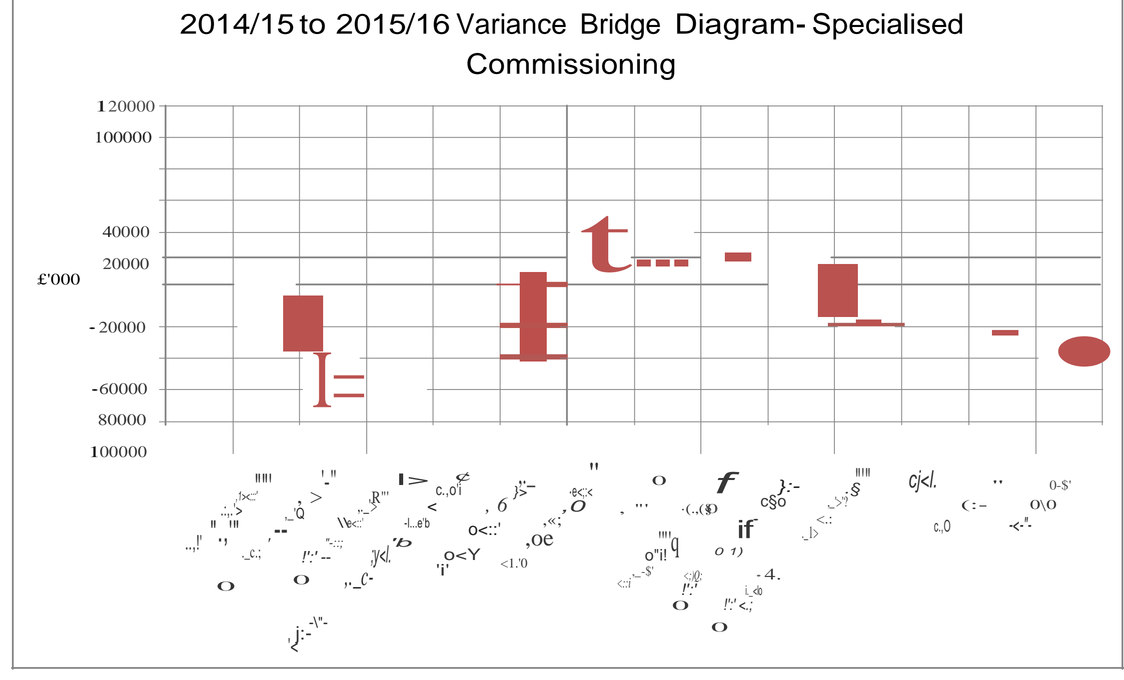
GP IT is excluded from resource and expenditure from 2014/15 onwards as it is being transferred to CCGs.

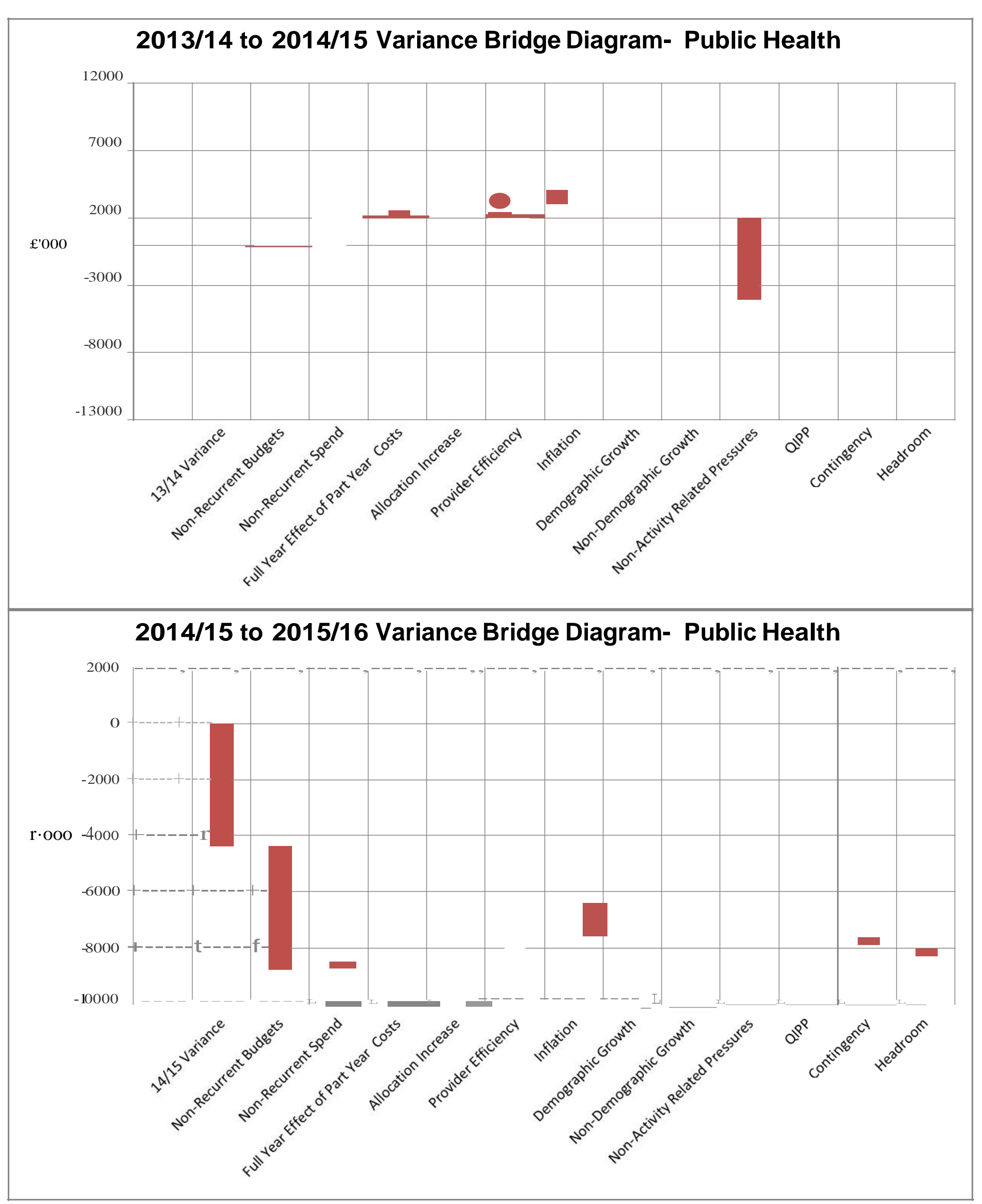
Detailed financial plans are assured through the NHS England regional office, a summary of which will be made available following finalisation.

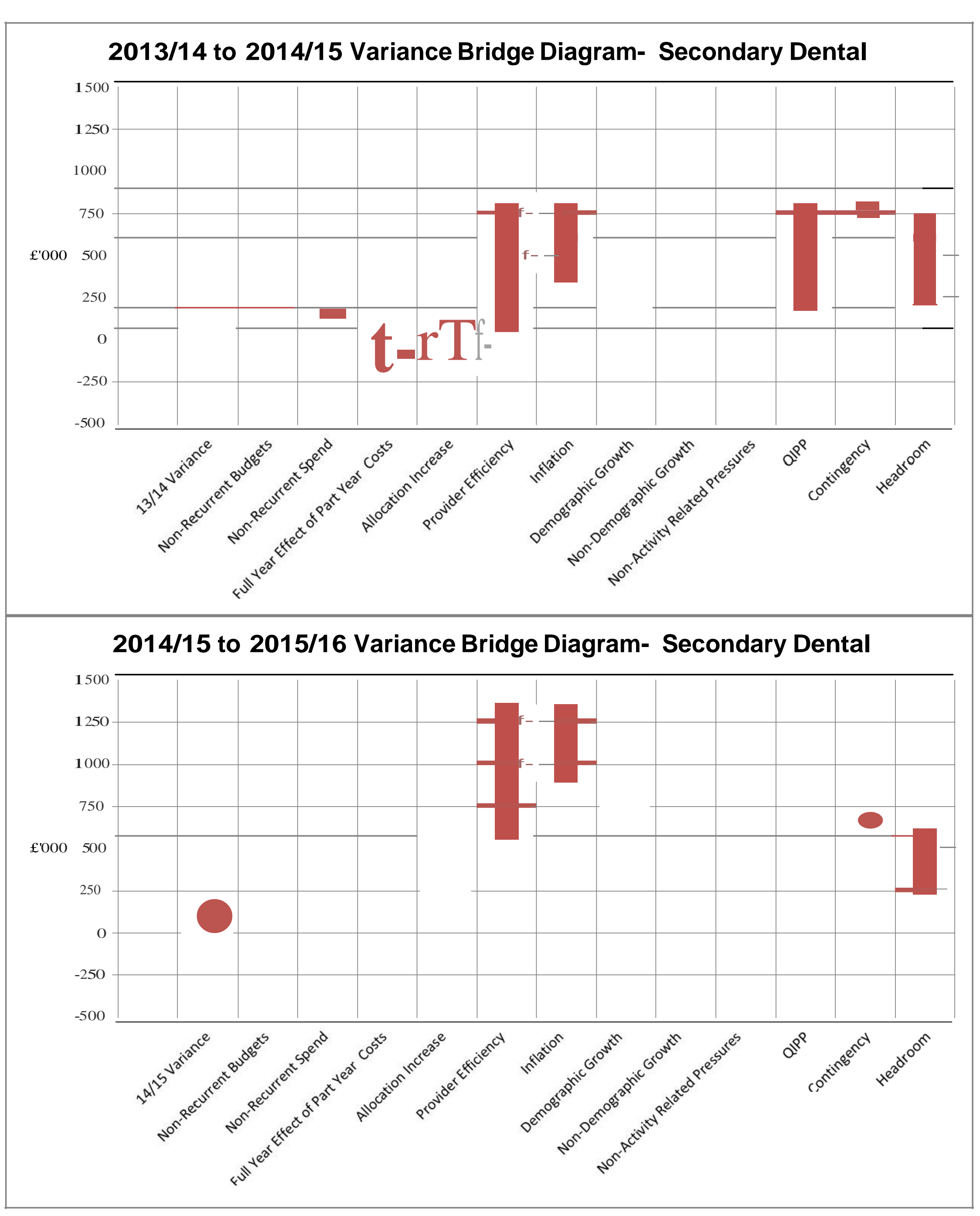
## Bridge Diagrams

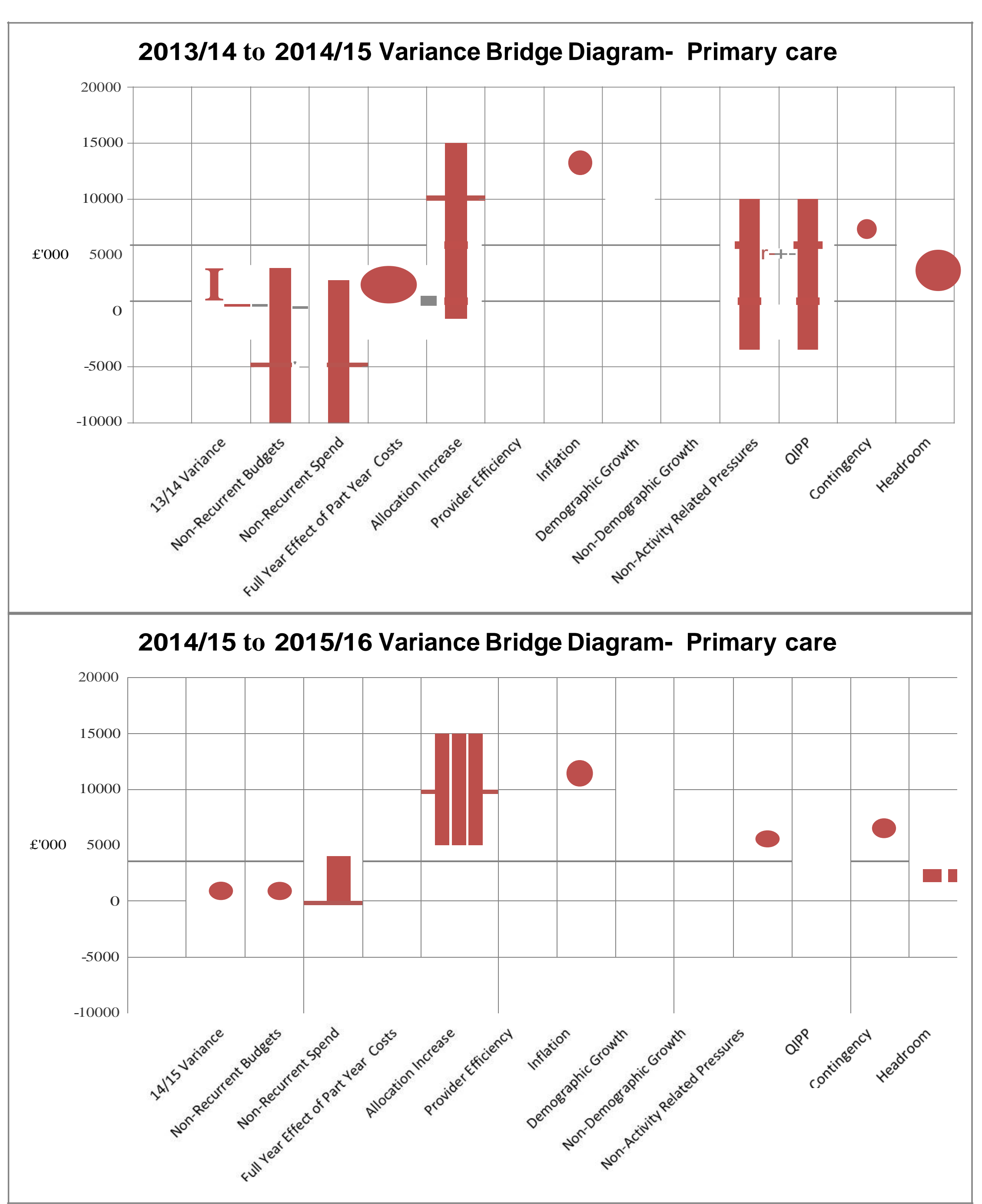
Below are bridge diagrams highlighting key movements within the financial plans from 2013/14 forecast outturn to 2015/16.




2013/14 to 2014/15 Variance Bridge Diagram- Public Health
12000
7000
2000
£'000
-3000
-8000
-13000
13/14 Variance
Non-Recurrent Budgets
Non-Recurrent Spend
Full Year Effect of Part Year Costs
Allocation Increase
Provider Efficiency
Inflation
Demographic Growth
Non-Demographic Growth
Non-Activity Related Pressures
QIPP
Contingency
Headroom
2014/15 to 2015/16 Variance Bridge Diagram- Public Health
2000
0
-2000
-4000
-6000
-8000
-10000
14/15 Variance
Non-Recurrent Budgets
Non-Recurrent Spend
Full Year Effect of Part Year Costs
Allocation Increase
Provider Efficiency
Inflation
Demographic Growth
Non-Demographic Growth
Non-Activity Related Pressures
QIPP
Contingency
Headroom

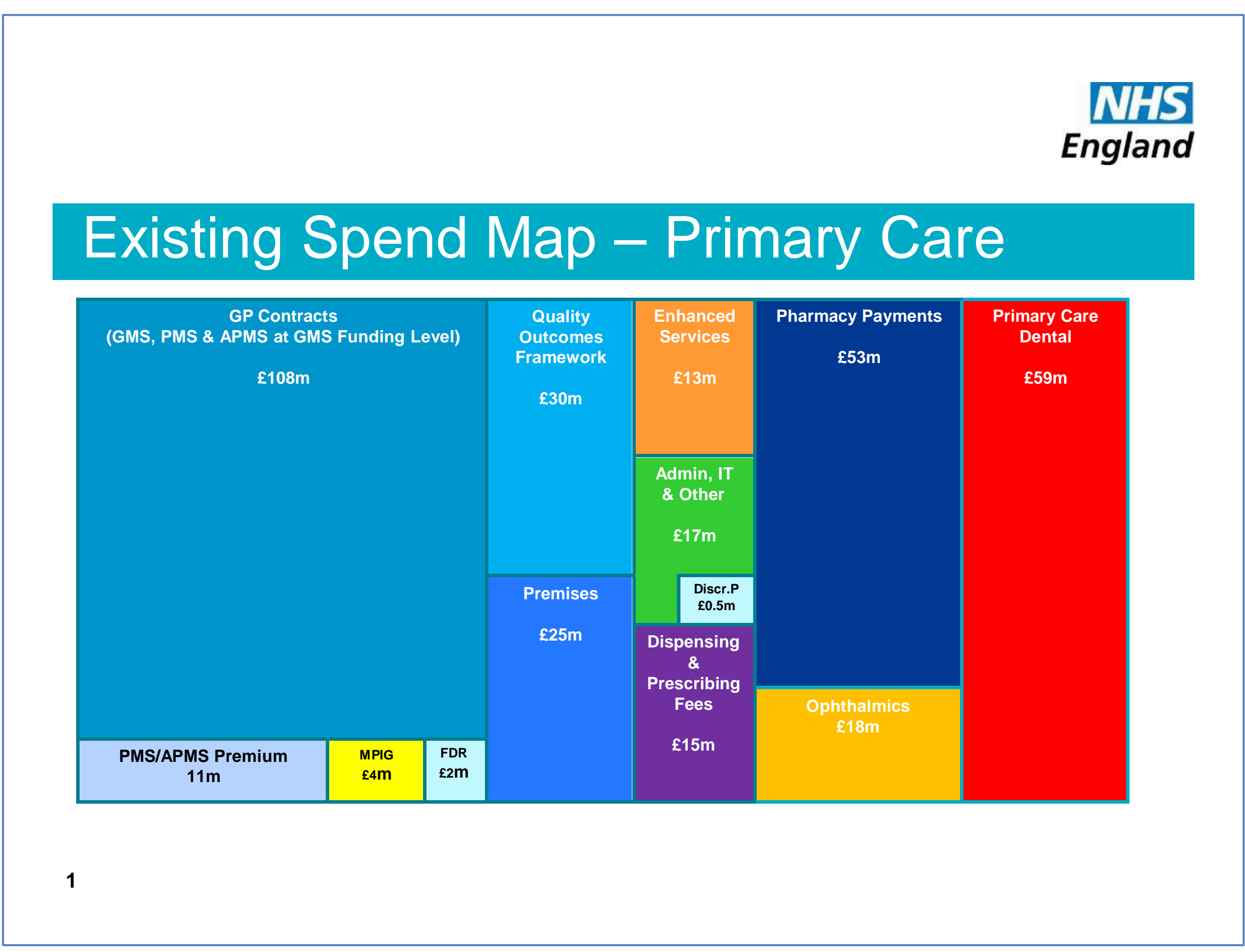

2013/14 to 2014/15 Variance Bridge Diagram- Secondary Dental
£'000
1 500
1 250
1000
750
500
250
0
-250
-500
13/14 Variance
Non-Recurrent Budgets
Non-Recurrent Spend
Full Year Effect of Part Year Costs
Allocation Increase
Provider Efficiency
Inflation
Demographic Growth
Non-Demographic Growth
Non-Activity Related Pressures
QIPP
Contingency
Headroom
2014/15 to 2015/16 Variance Bridge Diagram- Secondary Dental
£'000
1 500
1 250
1 000
750
500
250
0
-250
-500
14/15 Variance
Non-Recurrent Budgets
Non-Recurrent Spend
Full Year Effect of Part Year Costs
Allocation Increase
Provider Efficiency
Inflation
Demographic Growth
Non-Demographic Growth
Non-Activity Related Pressures
QIPP
Contingency
Headroom


2013/14 to 2014/15 Variance Bridge Diagram- Primary care
£'000
20000
15000
10000
5000
0
-5000
-10000
13/14 Variance
Non-Recurrent Budgets
Non-Recurrent Spend
Full Year Effect of Part Year Costs
Allocation Increase
Provider Efficiency
Inflation
Demographic Growth
Non-Demographic Growth
Non-Activity Related Pressures
QIPP
Contingency
Headroom
2014/15 to 2015/16 Variance Bridge Diagram- Primary care
£'000
20000
15000
10000
5000
0
-5000
-10000
14/15 Variance
Non-Recurrent Budgets
Non-Recurrent Spend
Full Year Effect of Part Year Costs
Allocation Increase
Provider Efficiency
Inflation
Demographic Growth
Non-Demographic Growth
Non-Activity Related Pressures
QIPP
Contingency
Headroom

## Financial Mapping for Direct Commissioning to inform QIPP Goals

The Charts below show the relative sizes of areas of spend within each direct commissioning budget, grouping together areas of spend in relation to the potential levers for change. In some cases there is scope for local action, and other areas are set by national policy.

### Primary Care Financial Mapping




For each area of spend it is potentially possible, at national for some services or at local level for others to address the quantity of service commissioned, or the price/ level of payment for that service. Each spend area has specific contstraints:

**GP contracts** are funded to the level within GMS on a per registered patient basis at £108m. It is possible to reduce the number of registered patients through cleansing the GP registered list to ensure those who have left the area have been removed, but once this is being done annually and is reflected in the baseline spend levels, the spend in this area is not subject to local determination as the GMS spend per patient is nationally negotiated, and local population demographics will drive the level of patients registered.

**PMS/APMS contract premiums** are an example of funding per patient above GMS funded levels either to provide enhanced service levels to target groups with specific health needs (e.g. homeless people) or for more stretching quality KPIs. This is an area in which local action e.g. through a contract review may impact the number of practices receiving such payments, the conditions for payment, or the level of payment.

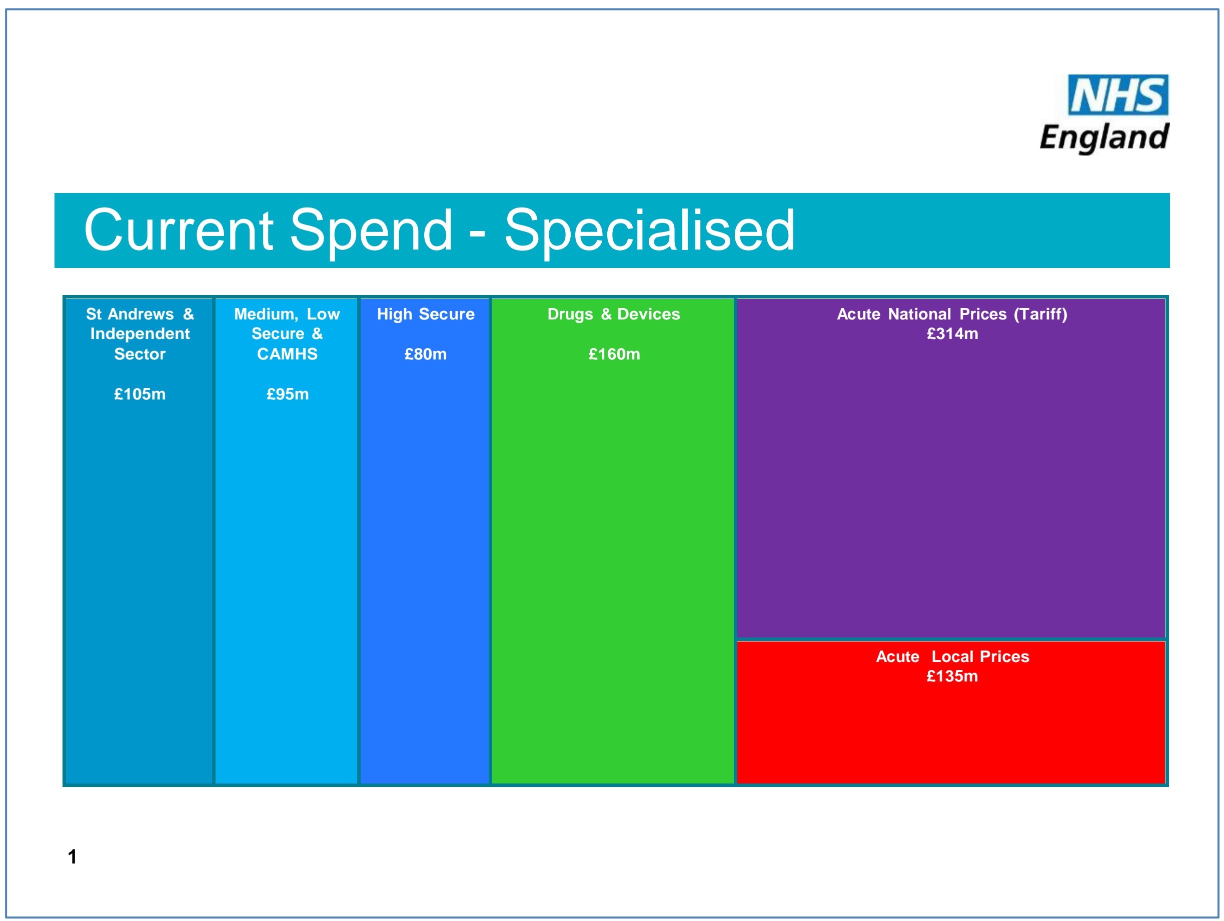
**National and Directed Enhanced Services** are areas where, once on-going payment verification is in place, uptake of services is determined by the choices of practices, with payment at nationally negotiated levels.

The benefit of financial mapping is to ensure informed dialogue in the setting of financial improvement plans. For primary care services this is particularly challenging, as the areas with local levers and discretion.

Setting a top down 3% Improvement target across the full £357m primary care budget requires year on year recurrent savings of £10.7m.

Our QIPP plans will be reviewed to address the gap against nationally set requirements based on setting bottom up % change for each area of spend and holding dialogue with regional and national teams to be assured goals are stretching but realistic and achievable without destabilising provider viability, or undermining strategic aims for the future role of primary care.

**Specialised Commissioning Financial Mapping**



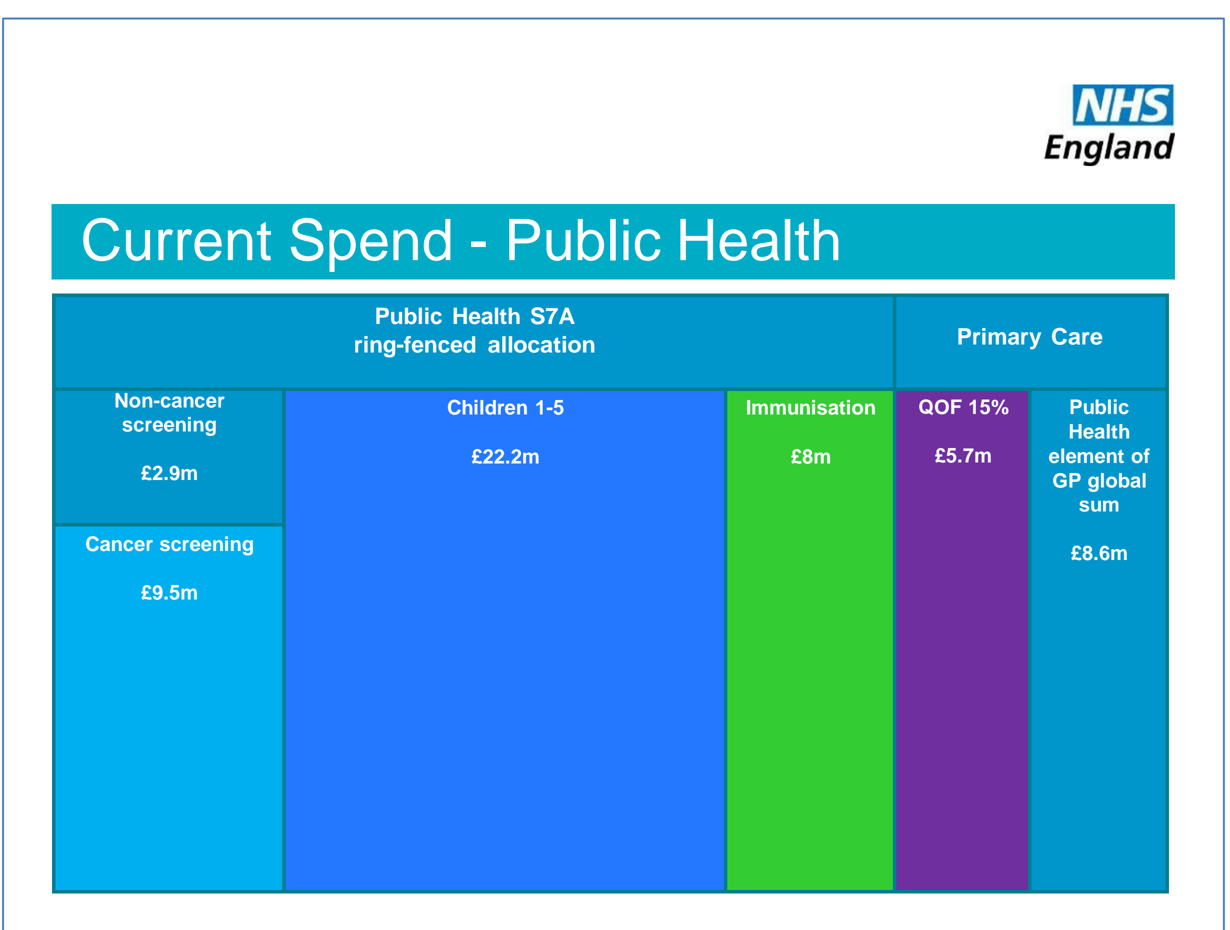
For specialised services the mental health spend profile is heavily influenced by High secure and national independent sector mental health responsibilities where placement levels are not in the control of the area team. The QIPP initiatives planned for medium, low secure, and CAMHS amount to around 2% of baseline spend in those areas.

For the 4 acute programmes of care, there are three distinct areas with different levers. A stretching cost improvement for high cost drugs and devices, on top of cost growth avoidance initiatives, of almost 7% of baseline spend, has robust local plans in place.

For the acute services paid at national tariff it is not possible to negotiate prices so areas of focus relate to reducing treatment volumes through clinical threshold auditing. Previous national benchmarks suggest levels of use by the east midlands population are low so the impact of clinical policies in aligning historic practice to current evidence will be less significant. Areas of bed day based spend through clinical utilisation review is an additional area where improvements are expected over a 1-3 year period of sustained change.

For acute services at local prices some price negotiation is possible. Many east midlands services are already at or below best quartile cost based prices, which reduces the scope to negotiate further reductions without impact on quality but there are exceptions to this, which inform contracting goals.

**Public Health Financial Mapping**

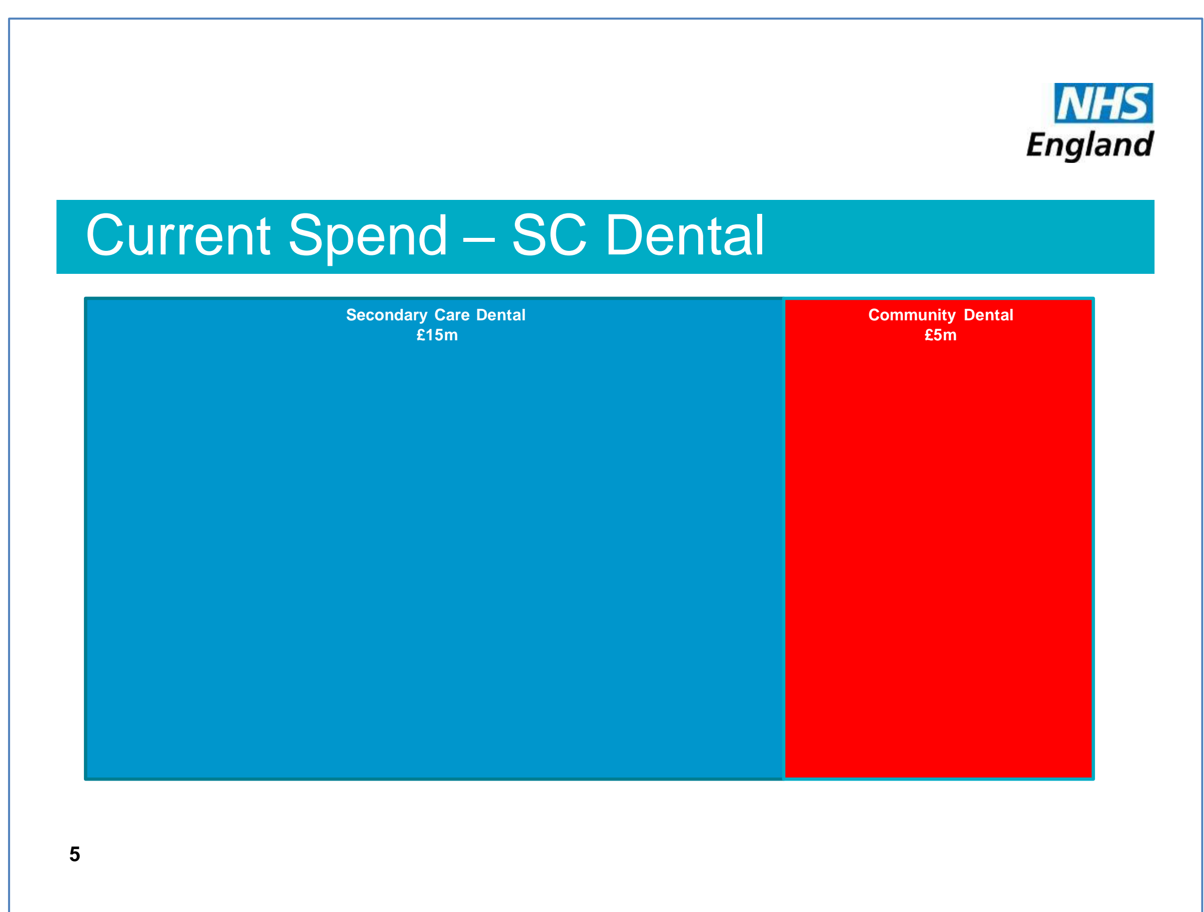


The three distinct areas (screening, child health, and immunisation) are subject to different dynamics. For QOF and global sum prices are nationally set, and constraining the level of achievement would be counter to the health outcome aims of commissioners. Immunisations are similarly paid at a 'going' rate to GP practices with links to patient registered list to maintain records a significant benefit of retaining a GP model where possible.

The major area of spend is on child health. This is subject to mandated targets for resource inputs (national targeted number of health visitors and family nurse partners employed) and agenda for change national pay scales. Efficiency can, in this area of spend, only come from reductions in the corporate overhead on services or in limited cases by changes to skill mix, although the nature of national targets allow limited flexibility.

The QIPP programme for public health is necessarily most focussed on screening services. Again whilst it is neither possible nor desirable to reduce quantity of screening activity (greater reach to populations is a positive health gain) there is opportunity to work with providers whose unit costs are not yet at the levels of the most efficient services, and to ensure service economies of scale are realised to support the commissioning of the national developments planned.

**Secondary Dental Financial Mapping**




Acute dental spend uses nationally set prices, with opportunities for productivity (reduced follow ups) and reductions in referrals through better primary care management, but beyond

this treatment volumes need to keep pace with referrals in order to meet NHS constitution rights of patients to be treated within 18 weeks of referral. The more significant area is community dental services where locally negotiated prices and service models are informing the work of the commissioning team to improve value.

**Performance and Delivery - Specialised Services**

All specialised services treatment must meet the standards in the NHS constitution, but the key performance measures are at trust wide levels, rather than split between specialised and non-specialised services, so no performance trajectories have been requested for operational plans.

Key areas of delivery, alongside the service development agenda are the management and effective governance of contracts, and the managed uptake of drugs and devices in line with best evidence and value.

**Individual Funding Request and Cancer Drugs Fund (IFR/CDF)**

The Area Team is also responsible for the establishment of a region-wide Individual Funding Request and Cancer Drugs Fund process hosted in the Leicestershire & Lincolnshire Area Team. Effective systems and processes have been established to administer the CDF and the IFR process and the team is working well. Cancer Drugs Fund budget is £50,248

**PbR Excluded Drugs**

During 14/15 we plan to achieve the following:

- Work with Provider Trusts and CCGs to repatriate post-transplant prescribing of renal immunosuppressant medication
- Work with Providers and CCGs to repatriate prescribing of inhaled antibacterials prescribed for Cystic Fibrosis
- Ensure there is a consistent understanding and application across East Midlands Provider Trusts of chemotherapy associated costs (procurement costs and supplementary medicines)
- Agree schemes with Providers so that the benefits associated with more efficient use of medicines not reimbursed through national prices are shared. We aim to agree 5 new schemes in 14/15 and 5 new schemes in 15/16

**Effective procurement of high cost drugs**
The Area Team is an active member of the national procurement framework for excluded drugs and devices and will continue to be an active contributor to the work plans of the Regional Pharmacy collaborative. Both of these mechanisms will ensure consistent pricing of high cost drugs and best value to the NHS.

**NICE appraisal**
Drugs as detailed in the current NHS England excluded drug list will be commissioned in line with NHS England commissioning policies and NICE Technology Appraisals (TA). NICE approved drugs recommended within a NICE Technology Appraisal that are excluded from tariff will be automatically funded from day 90 of its publication. Some approved drugs and devices may be funded before this time at the discretion of NHS England.

**Sharing the benefits associated with more efficient use of medicines not reimbursed through national prices**

Because acquisition costs of medicines not reimbursed through national prices are reimbursed by commissioners, there may be little incentive for a provider to maximise the cost-effectiveness of these treatments, particularly where providers have to make decisions on prioritisation of their resources or if improvements in cost-effectiveness require the commitment of additional resources. The AT will incentivise provider trusts to ensure maximum value for money from medicines excluded from the national tariff. This will be done through clear, up-front agreements on the share of financial savings with both commissioners and providers and according to the principles described in national NHS England guidance.

**Budget setting and reporting**
Budgets for excluded drugs will be set on an annual basis. This will be based on the provider's assessment of need through horizon scanning, and agreed through a 'confirm and challenge' meeting with the provider. Analysis of monthly reports of Trust activity against budget will be undertaken, and questions on performance will be raised when necessary.

**Post- transplant immunosuppressants and inhaled antibiotics for cystic fibrosis**
All post-transplant immunosuppressants and inhaled antibiotics for cystic fibrosis will be commissioned directly from Trusts by April 2016. The AT will work with Trusts and CCGs to ensure that prescribing of these drugs are safely repatriated from primary care to secondary care.

**Homecare**
The AT will work with Trusts to ensure that the recommendations identified in the Hackett Report are implemented effectively. The AT will work with Providers to ensure that Homecare services are safe and effective and make best use of NHS resources.

**Chemotherapy**
NHS England commissioning intentions states that only those drugs which are defined as a priority within a recognised chemotherapy regimen will be funded as part of the pass through arrangements. It does not include drugs which are provided for symptoms that arise post chemotherapy (e.g. antiemetics, unless given to all patients as part of the standard regimen) and it does not include longer-term use of non-chemotherapeutic agents such as bisphosphonates. In addition, hormone therapies, unless specifically identified as excluded by the national Payment by Results team or by agreement with NHS England, are considered in tariff.

The AT will work with Trusts to ensure that supportive medicines for chemotherapy are dealt with in a consistent manner across the East Midlands and will work towards a consistent national mechanism of payment.

Procurement costs related to chemotherapy will be agreed in line with national principles and the AT will work with colleagues nationally to develop a consistent mechanism of payment.

**Performance and Delivery – Public Health Services**

Public health measures performance trajectories based on the outlined plans are stated overleaf. These are subject to further refinement.

| | | | UNIFY Target | Current Achievement | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | Q1 | Q2 | | | |
| | | | | Unless alt. period specified | | 14-15 | 15-16 | 2018/19 |
| E.F.1 | Population Vaccination Coverage – Dtap / IPV / Hib ( 1 year old) | | >=94.7% | 97.1 | 96.9 | 97.5 | 97.5 | 97.5 |
| E.F.2 | Population Vaccination Coverage – MenC ( 1 year old) | | 93.9% | 96.7% | 95.6 | 97.5 | 97.5 | 97.5 |
| E.F.3 | Population Vaccination Coverage – PCV ( 1 year old) | | 94.2% | 97.0% | 96.9 | 97.5 | 97.5 | 97.5 |
| E.F.4 | Population Vaccination Coverage – Dtap / IPV / Hib ( 2 years old) | | 96.1% | 98.1% | 98 | 98 | 98 | 98 |
| E.F.5 | Population Vaccination Coverage – PCV Booster (2 years old) | | 91.5% | 95.6% | 95.8 | 96 | 96 | 96 |
| E.F.6 | Population Vaccination Coverage – Hib / MenC Booster ( 2 years old) | | 92.3% | 95.8% | 95.9 | 96 | 96 | 96 |
| E.F.7 | Population Vaccination Coverage – MMR for One Dose (2 years old) | | 91.2% | 95.2% | 95.4 | 96 | 96 | 96 |
| E.F.8 | Population Vaccination Coverage – MMR for One Dose ( 5 years old) | | 92.9% | 96.2% | 96.3 | 97 | 97 | 97 |
| E.F.9 | Population Vaccination Coverage – MMR for Two Doses (5 years old) | | 86.0% | 92.0% | 91.3 | 93 | 94 | 95 |
| E.F.10 | Population vaccination coverage - Hib / MenC booster (5 years old) | | 88.6% | 94.6% | 94 | 95 | 95 | 96 |
| E.F.11 | Population Vaccination Coverage - Hepatitis B (1 year old) | | tbc | | | | | |
| E.F.12 | Population Vaccination Coverage - Hepatitis B ( 2 years old) | | tbc | | | | | |
| E.F.13 | Population Vaccination Coverage - HPV | | 86.8% | | | 90 | 90 | 90 |
| E.F.14 | Population Vaccination Coverage - PPV | | 68.3% | 69% | | 69 | 70 | 71 |
| E.F.15 | Population Vaccination Coverage - Flu (aged 65+) | | 73.4% | 72.0% | | 74 | 75 | 75 |
| E.F.16 | Population Vaccination Coverage - Flu (at risk individuals) | | 51.3% | 47.4% | | 51 | 55 | 60 |
| E.F.17 | Percentage of Pregnant Women eligible for Infectious Disease Screening who are tested for HIV, leading to a Conclusive Result | | 98.1% | 99.0% | 99.23% | 99 | 99 | 99 |
| E.F.18 | Percentage of Women Booked for Antenatal Care, as reported by Maternity Services, who have a Screening Test for Syphilis, Hepatitis B and Susceptibility to Rubella leading to a Conclusive Result | | tbc | not available | not available | | | |
| E.F.19 | Percentage of Pregnant Women eligible for Antenatal Sickle Cell and Thalassaemia Screening for whom a Conclusive Screening Result is available at the Day of Report | | 98.0% | 99.3% | 99.1% | 99 | 99 | 99 |
| E.F.20 | Percentage of Babies Registered within the Local Authority area both at Birth and at the Time of Report who are Eligible for Newborn Blood Spot Screening and have a Conclusive Result Recorded on the Child Health Information System within an Effective Timeframe | | 92.3% | 87.1% | 71.2% | | | |
| E.F.21 | Percentage of Babies Eligible for Newborn Hearing Screening for whom the Screening Process is Complete within 4 Weeks Corrected Age (hospital programmes – well babies, all programmes – NICU babies) or 5 Weeks Corrected Age (community programmes – well babies) | | 97.5% | 99.3% | 99.1% | 99 | 99 | 99 |
| E.F.22 | Percentage of Babies Eligible for the Newborn Physical Examination who were Tested within 72 hours of Birth | | tbc | | 98.27% | 98 | 99 | 99 |
| E.F.23 | Percentage of those offered Screening for Diabetic Eye Screening who attend a Digital Screening Event | | 80.2% | | To Dec across AT =62% | 82 | 83 | 84 |
| E.F.24 | Abdominal Aortic Aneurysm (AAA) KPI | | - | | | | | |
| E.F.25 | Breast Cancer Screening Coverage - Percentage of Eligible Women Screened Adequately within the Previous 3 Years on 31st March | | 76.9% | | 82% | 82 | 82 | 83 |
| E.F.26 | Cervical Cancer Screening Coverage - Percentage of Eligible Women Screened Adequately within the Previous 3.5 or 5.5 Years (according to age) on 31st March | | 75.3% | | 80% 2012-13 | 80 | 80 | 80 |
| E.F.27 | Bowel Cancer Screening - Uptake and Coverage over 2.5 Years | | 55.8% | | | 57 | 58 | 60 |
| E.F.28 | Number of FTE Health Visitors | | tbc-improvement | | | | | |

## Performance and Delivery – Primary Care Services

Primary Care performance trajectories based on the outlined plans are stated overleaf. These are subject to further refinement and subject to a degree of inherent uncertainty due to the nature of the measures.

| ANNEX D: PRIMARY CARE MEASURE | Reference number | Area team to complete | Target / trajectory guidance | 2013/14 | 2014/15 | 2015/16 | Comment ( 1 line Rationale for how change will be achieved) |
|---|---|---|---|---|---|---|---|
| **Medical** | | | | | | | |
| **Patient satisfaction** | | | | | | | |
| Satisfaction with the quality of consultation at the GP practice | ED1 | YES | Annual improvement | 611 | 615 | 619 | Year on year reduction in the number of practices with red outliers (25% reduction).Review the practices that have more than 10 red outliers, triangulate with other measures in GPOS and GPHLI and in partnership with CCGs and their local balanced scorecard,as part of the assurance framework process. Agree action plan and timeframes for improvement. |
| Satisfaction with the overall care received at the surgery | ED2 | YES | Annual improvement | 166 | 168 | 170 | Year on year reduction in the number of practices with red outliers (25% reduction).Review the practices that have more than 10 red outliers, triangulate with other measures in GPOS and GPHLI and in partnership with CCGs and their local balanced scorecard,as part of the assurance framework process.Agree action plan and timeframes for improvement. |
| Satisfaction with accessing primary care | ED3 | YES | Annual improvement | 252 | 254 | 256 | Year on year reduction in the number of practices with red outliers (25% reduction).When looking at the availability of routine appointments, we intend to address the lack of availability during core hours and aim to ensure that access to extended hours is offered and available to patients. Improvement in the number of consultation hours available per week. This should improve patient satisfaction with GP opening hours and the convenience of opening times. |
| **Referrals** | | | | | | | |
| Proportion of new cancer cases referred using 2 week wait pathway | ED4 | NO | None as area team not to complete | | | | |
| **Vaccinations** | | | | | | | |
| Flu vaccinations – at risk coverage | ED5 | YES | At or above 51.3% | | | | |
| **Mental health** | | | | | | | |
| Identifying the prevalence of depression compared to estimated model | ED6 | YES | The guidance quoted on GPOS gives an aim to reduce the outliers from level 1 and level 2 outliers - so I'd suggest reducing the number of outliers in the area and plans to tackle the level 2 outlieing practices | Trigger level 2 = 5 practices Trigger level 1 = 10 | Reduce trigger level 2 practices from 5 to 3 | Reduce trigger level 1 practices from 10 to 5 | Target those that are at trigger level 2 in 14/15 (triangulating with other measures) and agree action plans with timescales for improvement. Review those practices that are at trigger level 1 in 15/16 and target those practices that have are 'approaching review ' under GPOS. Again agree action plans with timescale for improvement. |
| **Dental** | | | | | | | |
| **Access** | | | | | | | |
| % Patients seen – 24 month measure | ED7 | YES | Exceeding the % of patients seen in 2012/13 | 55% | 54% | 54% | We have remained at the 55% level throughout 13/14. In 13/14 we clawedback under performance, we did not commission any additional activity (either recurrently or non recurrently), and we renegotiated contracts to reduce the level of recurrent under performance, hence in 14/15 we are likely to see the % level drop. There may be some positive impact from the monitoring of recall intervals but this is difficult to quantify. We are not planning to commission additional UDAs in 14/15 hence the % is likely to remain at 54%. |
| **Activity** | | | | | | | |
| Number of course of treatments per 100,000 population | ED8 | YES | None in guidance - assume planning numbers rather than an improvement | 2,779,098 UDAs contracted | 2,779,098 UDAs contracted | 2,779,098 UDAs contracted | This is based on the number of UDAs commissioned (Dec 2013 positio) rather than courses of treatment. This will remain the same for 14/15 & 15/16 because we are not planning to commission additional activity at this time. |
| Patient experience | | | | | | | |
| GPPS % Positive experience | ED9 | YES | None given but based on Medical patient satisfaction assume an annual improvement | 83% | 83% | 83% | If positive experience is based on questions relating to access improvement above 83% is unlikely; on the basis that patients may not wish to travel to where dental access is available and we are not planning to commissioned additional activity. Initiatives to impeove access relate more to the shift from secondary care to community based services. |
| **General Ophthalmic Services** | | | | | | | |
| **Activity** | | | | | | | |
| Total number of sight tests/per 100,000 population | ED10 | YES | None - assume planning numbers rather than an increase | 28096 | 28808 | 29520 | waiting for guidance |
| **Quality and Innovation** | | | | | | | |
| %of tints per voucher | ED11 | YES | None - assume planning numbers rather than an increase | not available | not available | not available | waiting for guidance |
| % of repairs per voucher and % of replacements per voucher | ED12 | YES | None - assume planning numbers rather than an increase | not available | not available | not available | waiting for guidance |
| % of prisms per voucher | ED13 | YES | None - assume planning numbers rather than an increase | not available | not available | not available | waiting for guidance |

# APPENDICES

## Appendix 1: Primary Care Summary – Regional Plan on a Page Format

## Appendix 2: Public Health Summary – Regional Plan on a Page Format

See following pages

## Note: Specialised Operating Plan – National format

The Specialised Operating Plan contains key elements of this document and is available as a separate standalone publication. The Operating plan contains further detail of the financial element of QIPP plans assessed against national opportunities.

Leicestershire & Lincolnshire

## Primary Care 5 year Strategic Plan on a Page

**Our Vision**

To have in place a **strong and effective primary care** that delivers high **quality and responsive services** to patients, that fulfils its pivotal role in improving the **health outcomes** of our population whilst **containing costs**, and hence makes a vital contribution to a **high-performing** and **sustainable well integrated** healthcare system.



**Local Ambition One (Quality)**
To reduce unjustified variation in the quality of services delivered

**Local Ambition Two (Outcomes)**
To reduce unjustifiable inequalities in health outcomes

**Delivered through intervention**

- Working with CCGs to address capacity issues in Primary Care and secure a high quality workforce
- Developing robust quality and performance assurance frameworks for primary care to ensure that there is a consistent approach to managing unwarranted variation in quality
- Supporting wider primary care in conjunction with social care, community services and acute services where this is supported by CCG plans

**Local Ambition Three (Patient Services)**
To increase citizen participation and empowerment

**Local Ambition Four (Patient Services)** To improve the quality of life for patients with one or more LTCs

**Delivered through intervention**

- Review Area Team structures and processes to ensure that the local need, local voice and shared decision making with patient representatives are incorporated at every stage of the commissioning cycle from design to delivery to contract monitoring
- Implementing nationally negotiated changes for general practice that support more personalised care for older people and those with complex needs in partnership with CCGs.

**Local Ambition Five (Access)**
To improve access to primary care services & secondary care dental services

**Local Ambition Six (Delivering Value)**
To replace unjustified variation in the funding levels received by providers with strategic investment in new models of primary care

**Delivered through intervention**

- Provide support to PM's Challenge Fund pilot bids to improve access
- Align the local primary care strategy with the Lincolnshire Sustainable Services Review and the LLR Better Care Together Programme to ensure that there is a 'fit' with local approaches to new models of service delivery and integrated patient care packages
- Implement equitable funding mechanisms with an appropriate pace of change
- Implement QIPP schemes

**Overseen through the following governance arrangements**

- The AT Change Programme Board and Primary Care Strategy Group will oversee delivery
- On-going dialogue with CCGs & Health and Wellbeing boards on progress, recognising our shared agenda
- Better care Together & LSSR Partnership boards

**Sustainability Goals**

- Delivery of financial plan & QIPP schemes
- Delivery of the local ambitions
- Academic and quality-improvement activity and a positive learning climate embedded in primary care
- An expanded, skilled, resilient and flexible workforce working within integrated teams

**Key Values and Principles**

- Common core offer of high quality patient centred primary care
- Continuous improvement in health outcomes across the domains
- Patient experience and clinical leadership driving the commissioning agenda
- Maximise value by securing the highest quality of care and the best outcomes for every pound invested

Leicestershire & Lincolnshire **Area** Team, Public Health Commissioning

# VISION: High Quality Care for all, now and future generations.

The Dept. of Health, NHS England share the vision of working in partnership to achieve the benefits of the Section 7A agreement for the people of England. We maintain a shared commitment to protect and improve the public's health. (from S7Agreement)

**System Objective One**
Ensure the effective commissioning of Section 7A Agreement public health services, utilising innovative and extended service models to deliver best quality, highly skilled provision
****

**System Objective Two**
Seek to increase the pace of change for full implementation of the national S7A specifications, leading to a standardised offer for service users
****

**System Objective Three**
Reduce the range of variation in local performance seeking to consistently achieve highest practicable performance across all programmes
****

**System Objective Four**
Drive continuous improvement through on going service review/design and outcome monitoring, to ensure highest quality, best value public health S7A services for our population
****

**System Objective Five**
Work with key partners and HWB to optimise opportunities to reduce health inequalities, improve health and achieve better outcomes through best use of resources including development of integrated service
****

**System Objective Six**
Ensure that the views of service users, parents, cares etc. are sought and taken into account when planning and improving services
****

**2014/15**

- Work with providers to further develop processes regarding listening to the patient voice, client involvement in service evaluation and future commissioning of S7A services
- Increase HV workforce to meet trajectory of 363 WTE by 31/03/15
- Through joint working with providers & LETB ensure access to training modules to support full delivery of HCP
- Maximise capacity of FNP places available in Leicester City and introduce a new site in Lincolnshire
- Develop safe & robust co-produced transition plans, 0-5 years services working collaboratively with Local Authority
- Work with GPs and child health records department in Lincolnshire to improve routine childhood vaccination uptake
- Implement the meningitis C catch up programme for university entrants
- Establish revised pathways for newborn children requiring hepatitis B vaccination
- Bench mark all screening service providers to ensure good value for money is being achieved
- Commission high risk breast screening in line with Breast Screening Programme (BSP) guidance across the Area Team
- Monitor the safety and effectiveness of the new in-house and EMPATH for UHL laboratory provision of the IDSP programme following repatriation from NGHT to local maternity providers
- Support UHL and ULHT to be part of phase two of the bowel scope implmentation
- Review models of the delivery of all teenage vaccines in line with national guidance & parallel to childhood flu
- Identification and Implementation of PH related QIPP programmes
- Ensure implementation of the national fail safe programme for new born blood spot screening
- Support trusts to implement the SMART system for managing the NIPE programme

**2015/16**

- Review revised Section 7A Agreement and implement any national changes as required
- Work with providers to maintain and further develop patient & public involvement
- Progress and complete robust transfer to Local Authority responsibility commissioning of 0-5 years services (Oct 2015)
- Review, refinement and continuation of screening and immunisation 2014-15 intentions
- Continue roll out of childhood flu vaccination programme
- Identification and implementation of PH related QIPP programmes

**2016/19**

- Review Section 7 A Agreement and implement any national changes as required
- Maintain and improve against all PH S7A outcome measures in line with national requirements
- Ensure safe on going provision of high quality CHIS/CHRD services, and implement any nationally identified reporting mechanisms following any national changes to S7A
- Review and further align provider based patient experience and involvement processes

**Overseen through the following governance arrangements**

- Area Team Direct Commissioning Team Meeting
- Area Team Executive Meeting
- Change Programme Board
- Programme Board arrangements (all programmes)
- DPH led Health Protection Boards
- FNP Advisory group & National Unit
- Integrated childrens commissioning Groups/Childrens Trust board (Joint LA/CCG/AT)

Measured using the following success criteria

- Number of FTE Health Visitors, achievement of roll out HCP
- Population vaccination coverage programme specific (S7A)
- Breast cancer coverage % screened adequately previous 3 yrs
- Cervical cancer coverage % screened adequately previous 3.5 or 5.5 yrs (age dependent)
- Bowel cancer uptake & coverage
- AAA screening, KPI
- % offered Diabetic eye screening who attend
- Ante natal & new-born screening, specific measure in line with each programme requirement (S7A)

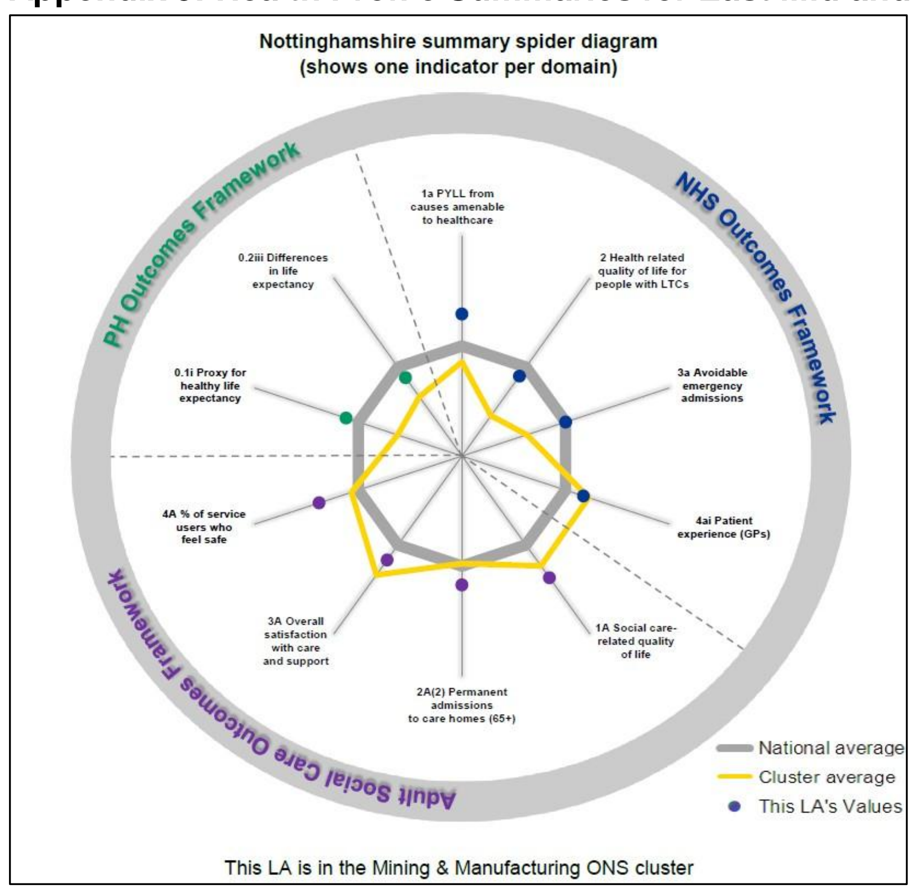
**System values and principles (DN: Taken from NHS Constitution)**

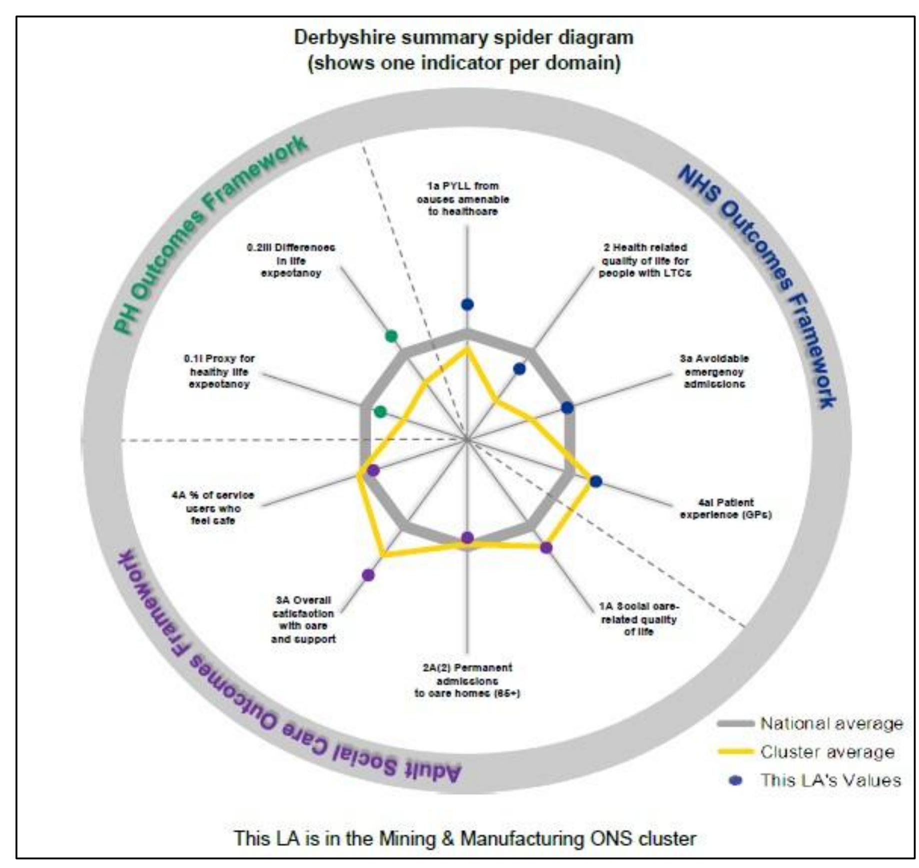
- Respect, consent, dignity, confidentiality
- Working together for patients
- Quality of Care and Environment
- The right to receive immunisation under the National Immunisation programmes
- The NHS will provide screening programmes as recommended by the National Screening Committee

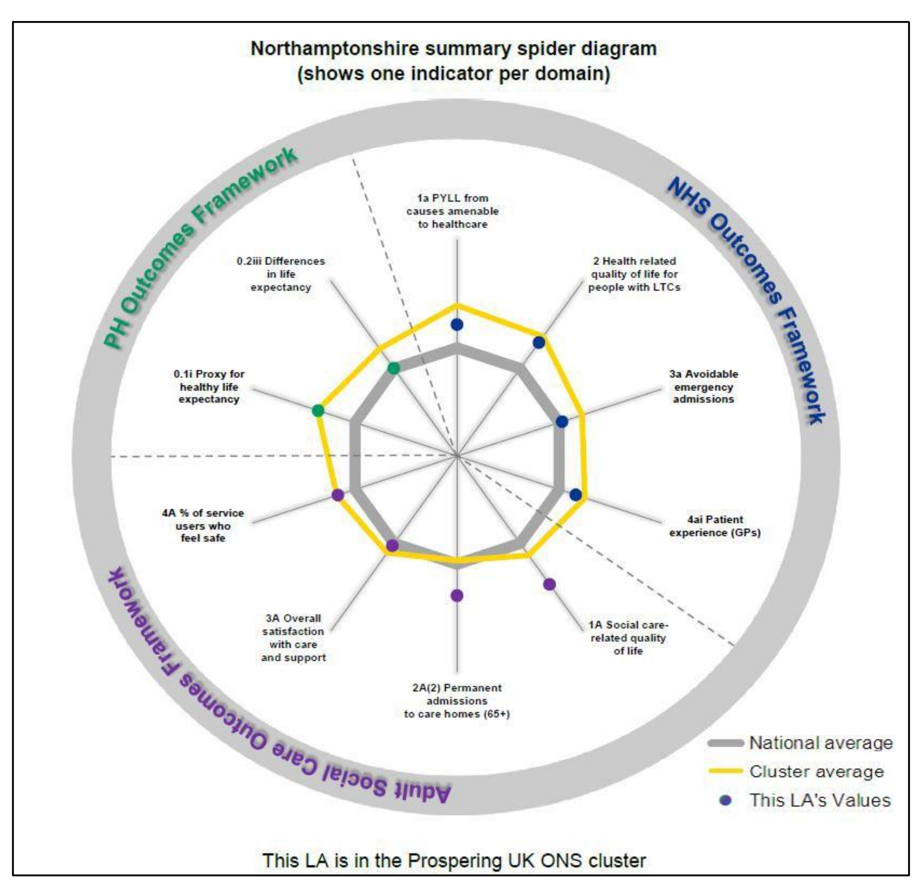
ADDITIONAL

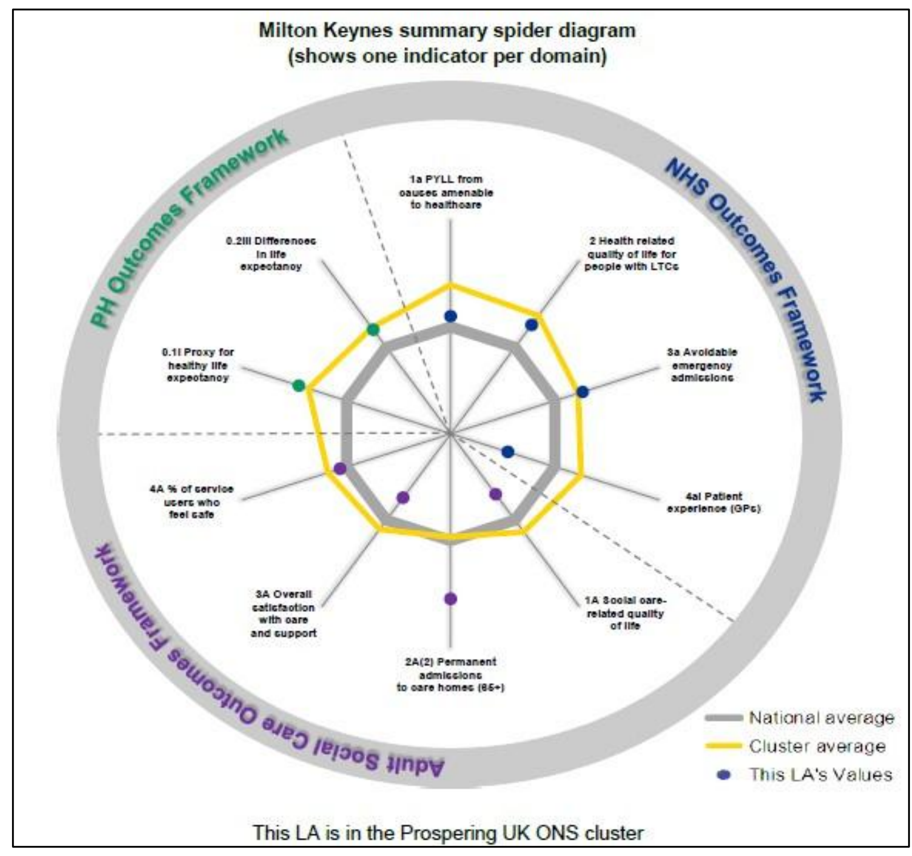
- PHE Code of Conduct and Values and Behaviours https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/206902/Read-the-code-of-conduct-for-PHE-staff.pdf

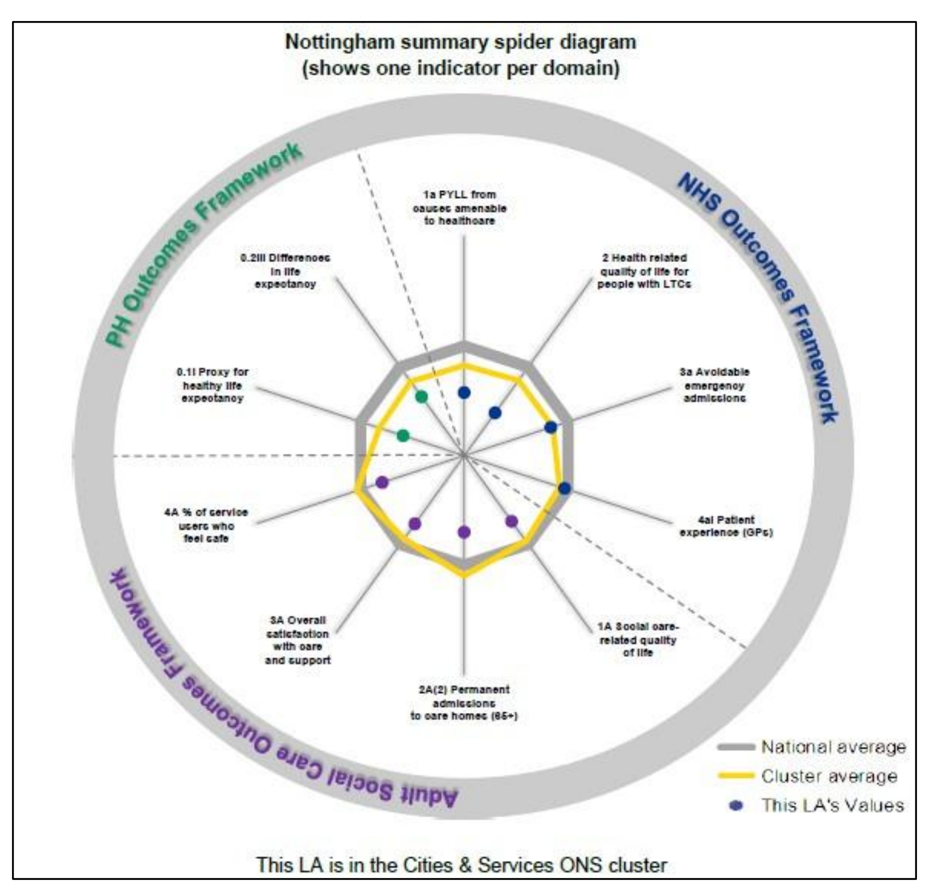
## Appendix 3: Health Profile Summaries for East Midlands Authorities

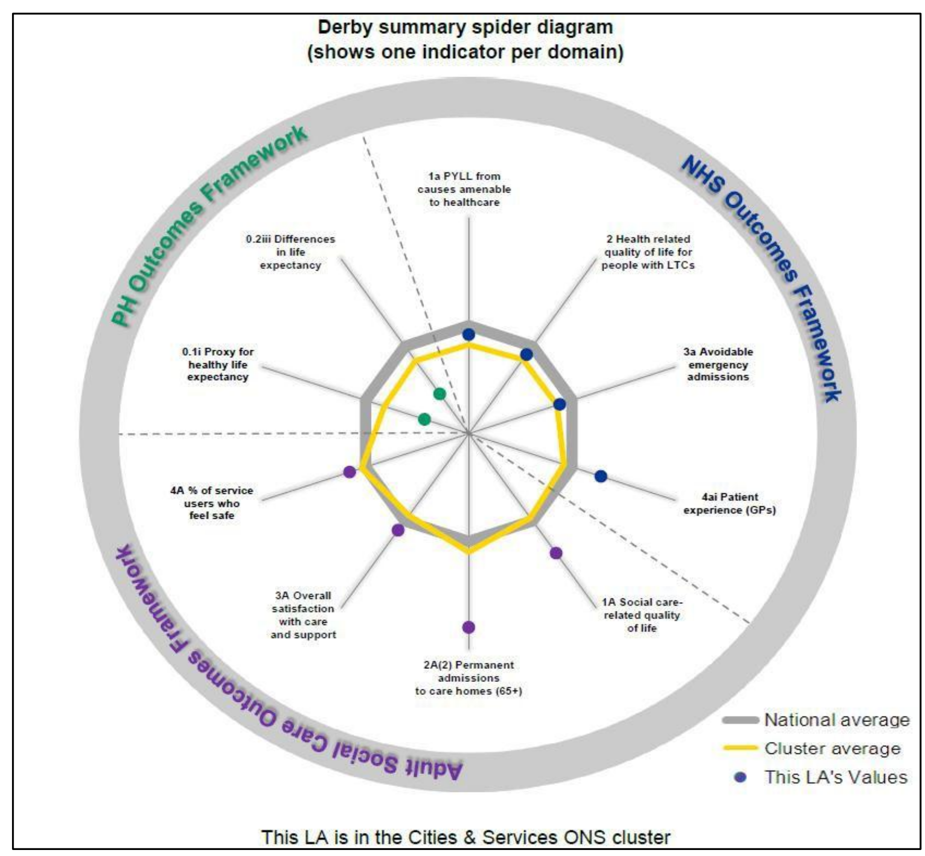



Northamptonshire summary spider diagram
(shows one indicator per domain)
PH Outcomes Framework
NHS Outcomes Framework
Adult Social Care Outcomes Framework
1a PYLL from causes amenable to healthcare
2 Health related quality of life for people with LTCs
3a Avoidable emergency admissions
4ai Patient experience (GPs)
1A Social care-related quality of life
2A(2) Permanent admissions to care homes (65+)
3A Overall satisfaction with care and support
4A % of service users who feel safe
0.1i Proxy for healthy life expectancy
0.2iii Differences in life expectancy
National average
Cluster average
This LA's Values
This LA is in the Prospering UK ONS cluster


Milton Keynes summary spider diagram
(shows one indicator per domain)
PH Outcomes Framework
NHS Outcomes Framework
Adult Social Care Outcomes Framework
1a PYLL from causes amenable to healthcare
2 Health related quality of life for people with LTCs
3a Avoidable emergency admissions
4ai Patient experience (GPs)
1A Social care-related quality of life
2A(2) Permanent admissions to care homes (65+)
3A Overall satisfaction with care and support
4A % of service users who feel safe
0.1i Proxy for healthy life expectancy
0.2iii Differences in life expectancy
National average
Cluster average
This LA's Values
This LA is in the Prospering UK ONS cluster


Nottingham summary spider diagram
(shows one indicator per domain)
PH Outcomes Framework
NHS Outcomes Framework
Adult Social Care Outcomes Framework
1a PYLL from causes amenable to healthcare
2 Health related quality of life for people with LTCs
3a Avoidable emergency admissions
4ai Patient experience (GPs)
1A Social care-related quality of life
2A(2) Permanent admissions to care homes (65+)
3A Overall satisfaction with care and support
4A % of service users who feel safe
0.1i Proxy for healthy life expectancy
0.2iii Differences in life expectancy
National average
Cluster average
This LA's Values
This LA is in the Cities & Services ONS cluster


Derby summary spider diagram
(shows one indicator per domain)
PH Outcomes Framework
NHS Outcomes Framework
Adult Social Care Outcomes Framework
1a PYLL from causes amenable to healthcare
2 Health related quality of life for people with LTCs
3a Avoidable emergency admissions
4ai Patient experience (GPs)
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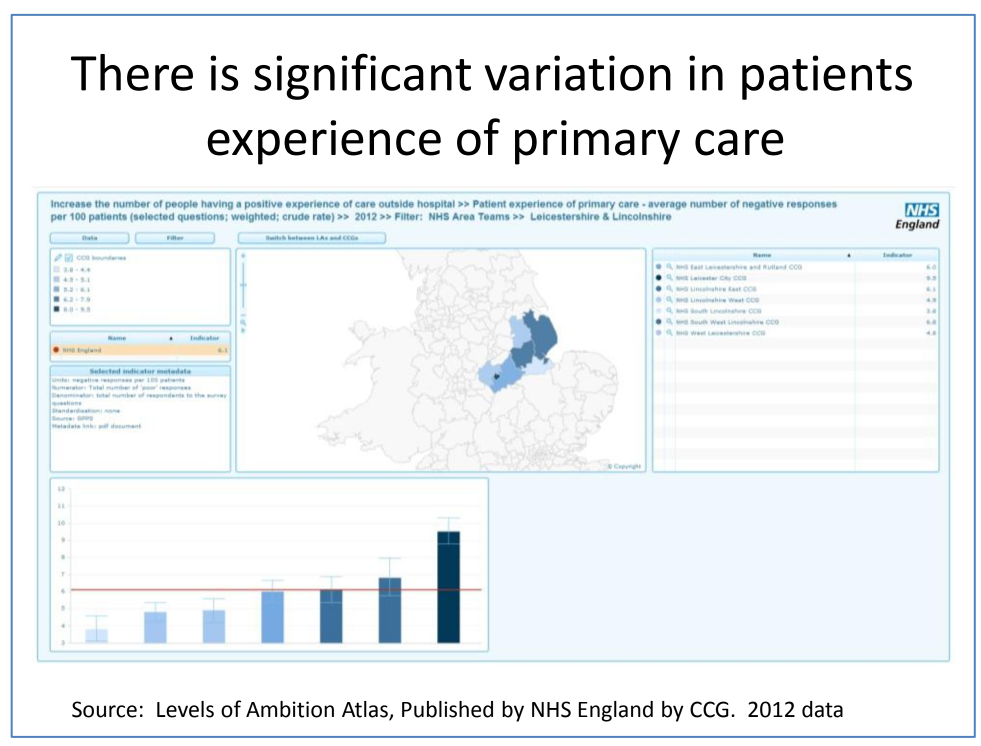
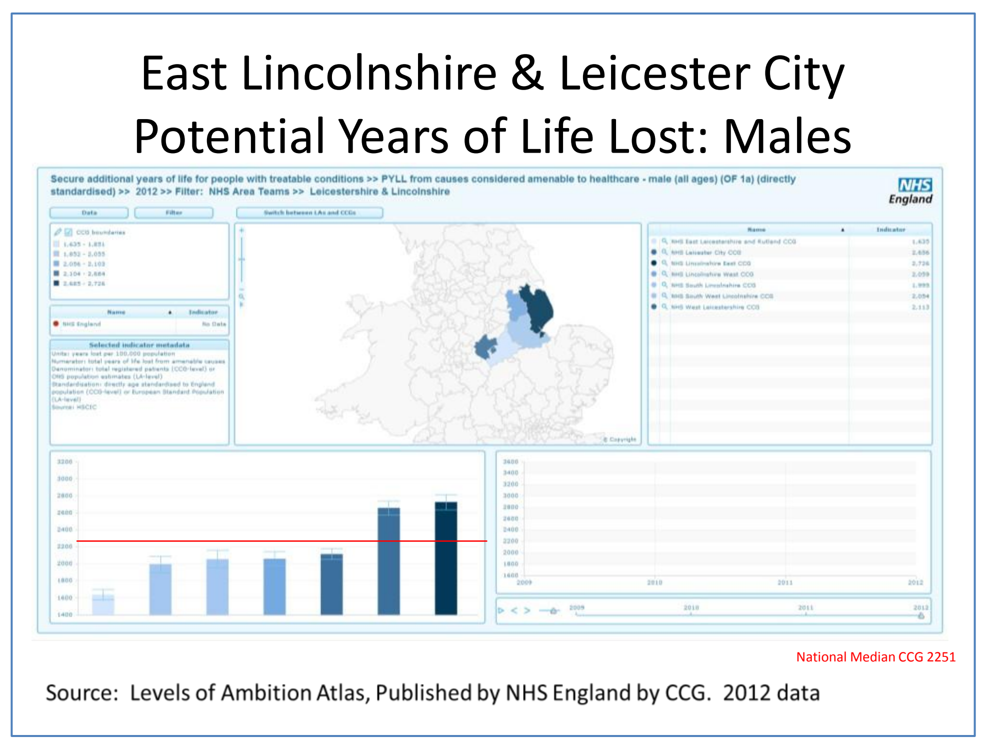
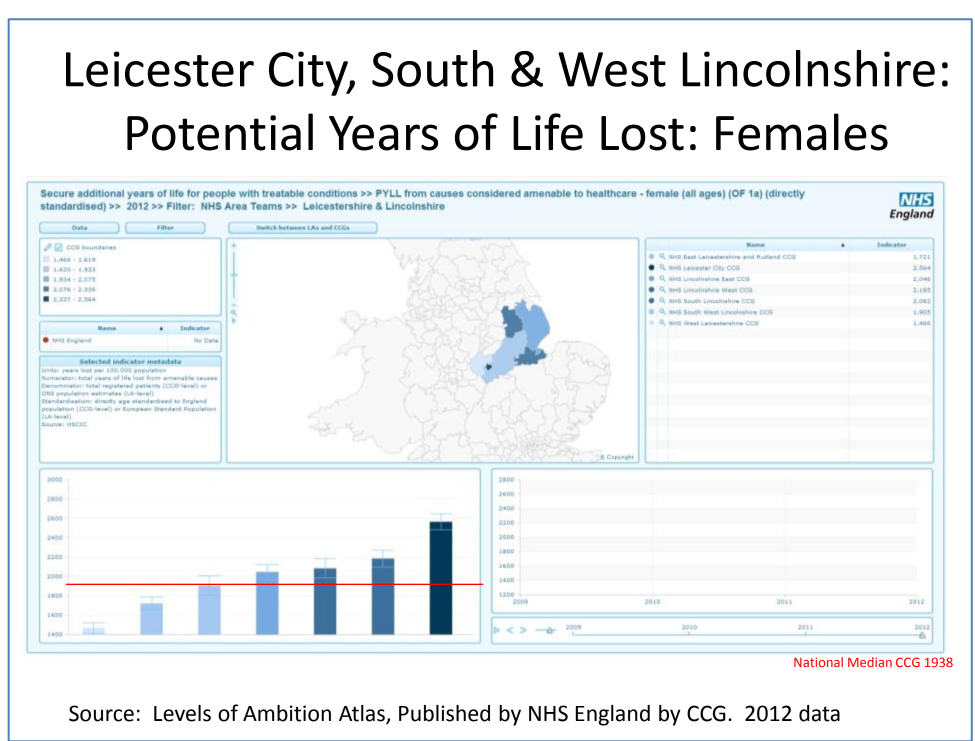
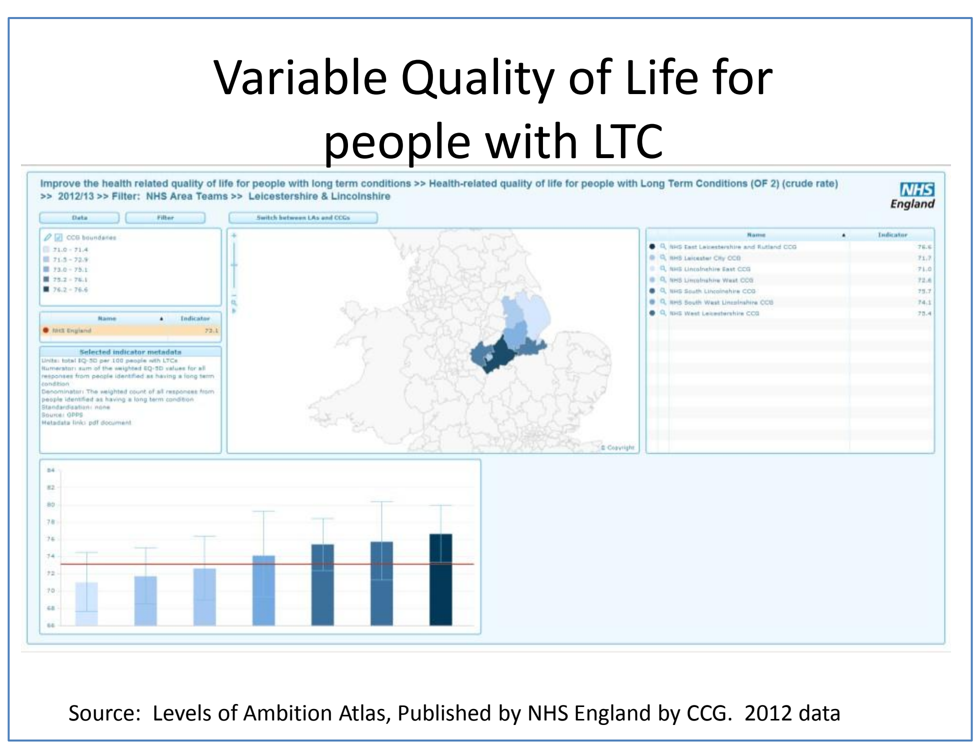
0.1i Proxy for healthy life expectancy
0.2iii Differences in life expectancy
National average
Cluster average
This LA's Values
This LA is in the Cities & Services ONS cluster

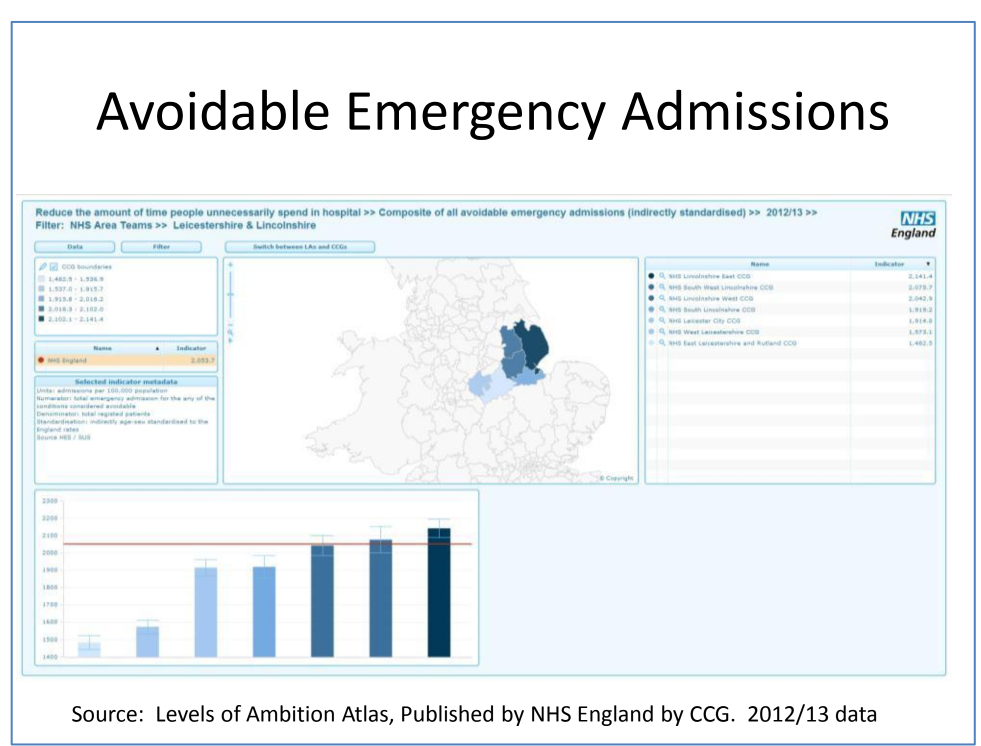
## Appendix 4: Levels of Ambition Atlas Extracts




Leicester City, South & West Lincolnshire:
Potential Years of Life Lost: Females
Secure additional years of life for people with treatable conditions >> PYLL from causes considered amenable to healthcare - female (all ages) (OF 1a) (directly standardised) >> 2012 >> Filter: NHS Area Teams >> Leicestershire & Lincolnshire
NHS England
National Median CCG 1938
Source: Levels of Ambition Atlas, Published by NHS England by CCG. 2012 data


Variable Quality of Life for
people with LTC
Improve the health related quality of life for people with long term conditions >> Health-related quality of life for people with Long Term Conditions (OF 2) (crude rate) >> 2012/13 >> Filter: NHS Area Teams >> Leicestershire & Lincolnshire
NHS England
Source: Levels of Ambition Atlas, Published by NHS England by CCG. 2012 data


Avoidable Emergency Admissions
Reduce the amount of time people unnecessarily spend in hospital >> Composite of all avoidable emergency admissions (indirectly standardised) >> 2012/13 >>
Filter: NHS Area Teams >> Leicestershire & Lincolnshire
NHS England
Data
Filter
Switch between LAs and CCGs
CCG boundaries
Name
Indicator
NHS England
Selected indicator metadata
Units: admissions per 100,000 population
Source HES / SUS
NHS Lincolnshire East CCG
NHS South West Lincolnshire CCG
NHS Lincolnshire West CCG
NHS South Lincolnshire CCG
NHS Leicester City CCG
NHS West Leicestershire CCG
NHS East Leicestershire and Rutland CCG
2300
2200
2100
2000
1900
1800
1700
1600
1500
1400
Source: Levels of Ambition Atlas, Published by NHS England by CCG. 2012/13 data

## Appendix 5: Quality and Safety Plans

### Introduction

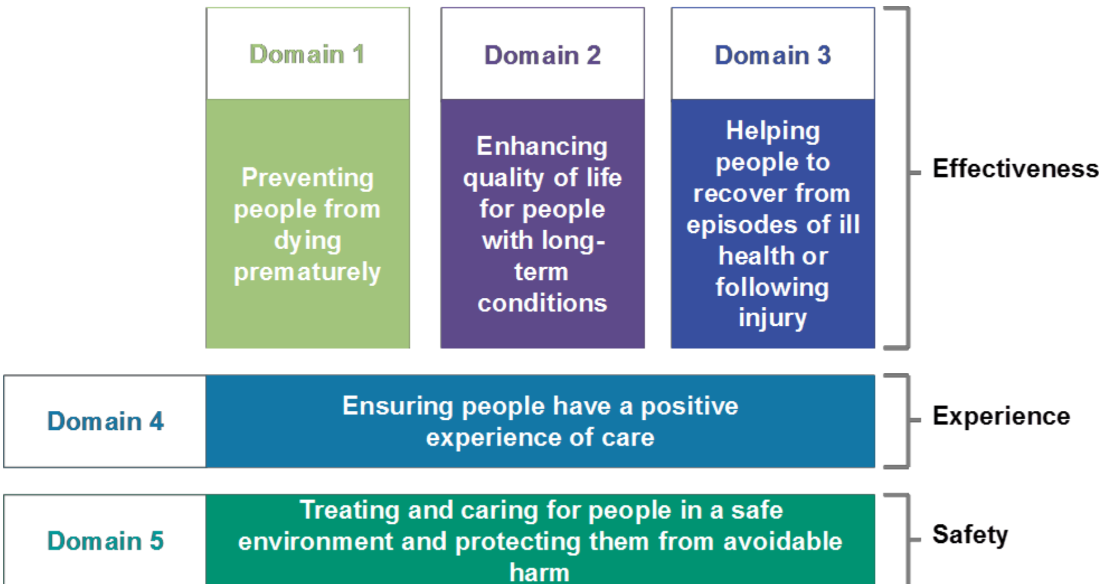
NHS England's mission is to secure **high quality care for all – now and for future generations.**

The NHS should support everyone to have greater control of their health and wellbeing, and to live longer, healthier lives by offering high quality health and care services that are compassionate, inclusive and constantly improving

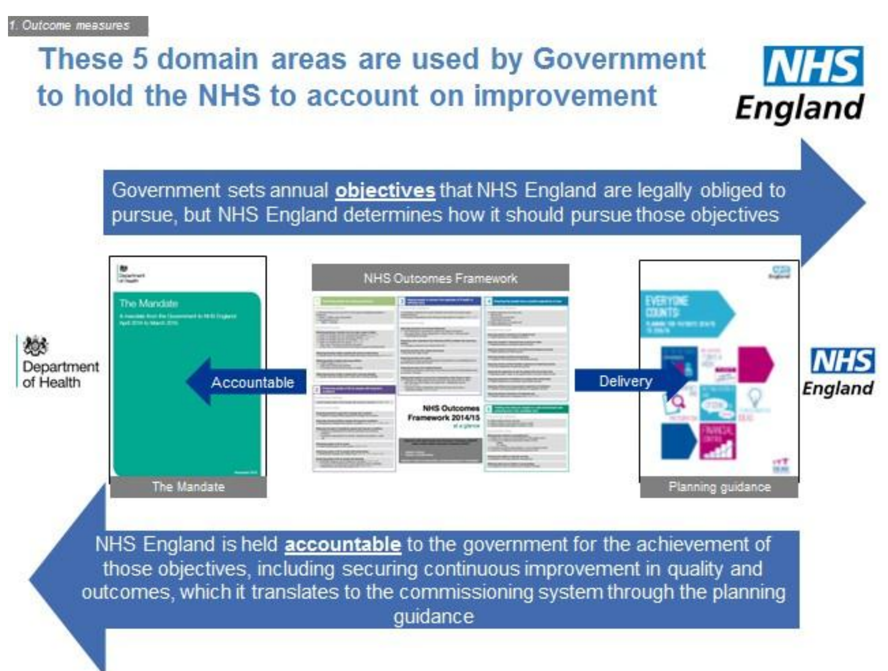
The single common definition of quality encompasses three equally important parts:

- Care that is **clinically effective**- not just in the eyes of clinicians but in the eyes of patients themselves;
- Care that is **safe**; and,
- Care that provides as positive an **experience** for patients as possible

At a national level, the **NHS Outcomes Framework** has been developed. This framework provides us with a way of measuring the actual outcomes we are achieving for the population of England.




Further information on High Quality Care for all and the NHS Outcomes Framework: http://www.england.nhs.uk/about/imp-our-mission




NHS England's planning guidance 'Everyone Counts: Planning for patients 2014/15 to 2018/19' sets out NHS England's clear commitment to an outcomes based approach and CCG's together with NHS England Area Teams are expected to jointly set levels of ambition against seven overarching outcomes.

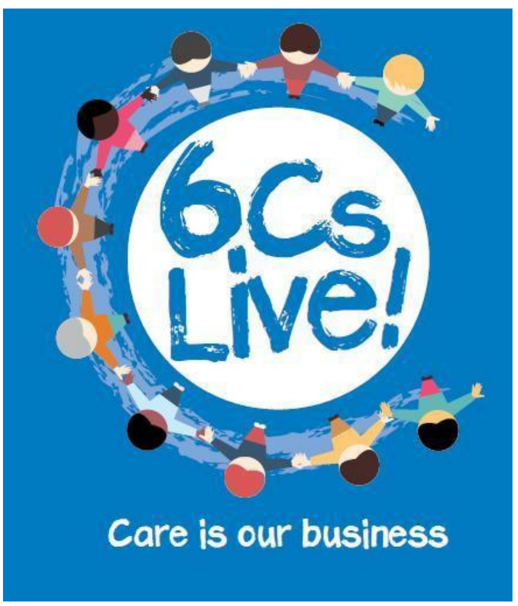
A full version of our planning guide can be found at: http://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf

## 2. Compassion in practice

The CNO strategy describes the **6 C's**

- ***C**are*;
- ***C**ompassion*;
- ***C**ompetence*;
- ***C**ommunication*;
- ***C**ourage*; and,
- ***C**ommitment*,

The 6C's have been developed to support a culture where patients and service users will have the best possible care.




These 6C's are not just for nurses and midwives but should underpin values and behaviours of all our staff. As such the CNO strategy underpins a significant proportion of the elements of our quality work with CCGs, and directly commissioned services.

- During the next two years we will establish a baseline to better understand how the ethos of the Nursing and midwifery strategy can be embedded into Primary Care and Specialised Services.

- We will ensure local provider plans are delivering against the six action areas associated with the 6 C's:

  - **Action area one:** Helping people to stay independent, maximise well-being and improving health outcomes
  - **Action area two:** Working with people to provide a positive experience of care
  - **Action area three:** Delivering high quality care and measuring the impact
  - **Action area four:** Building and strengthening leadership
  - **Action area five:** Ensuring we have the right staff, with the right skills, in the right place
  - **Action area six:** Supporting positive staff experience

We will work closely with our CCG colleagues to monitor the impact of compassion in practice across our local health service providers.

For more information about Compassion in Practice please visit: http://www.england.nhs.uk/nursingvision/

## 2. Learning from national reports

A number of recent high profile reports (Report of the Mid Staffordshire NHS Public Enquiry, by Robert Francis QC [2013]; Winterbourne View [DH, 2012]; Review into the quality of care and treatment provided by 14 hospital trust in England, by Professor Sir Bruce Keogh KBE [2013]; and Improving the Safety of Patients in England, National Advisory Group on the Safety of Patients in England [2013]), have identified that vulnerable people were not provided with basic standards of care and that their fundamental rights to dignity were not respected.

- We will utilise the messages from these, and subsequent national reports and investigations, to identify and set key deliverable targets for quality and patient safety. In particular we will ensure we commission services to deliver the requirements of the Winterbourne Concordat.

- A key target will be to develop 'listening events' with vulnerable group's e.g. patients with a Learning Difficulty and Carers.

- Further to this we will engage with local healthwatch organisations and NHS partners to promote a culture of learning from complaints and PALs services, and encourage our local population to use the complaints route without fear of retribution, to help identify areas for improvement.

- We will endeavour to better understand the public satisfaction levels with our complaints service. The benefits of this will provide us with the opportunity to include thematic analysis into our quality reviews of directly commissioned services.

## 3. Patient Experience

Patient Experience is a key priority area for NHS England and has been outlined in:

- Domain 4 of the NHS Outcomes Framework: Ensuring that patients have a positive experience of care;
- Action area two of the Compassion in Practice strategy: Working with people to provide a positive experience of care; and,
- NHS England's 5 year planning guidance[5] under ambitions 5 & 6

**Patient Experience**

[5] Everyone Counts: Planning for patients 2014/15 to 2018/19, available at: http://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf

- We will continue to work with our CCG commissioning colleagues to drive improvement in patient experience of hospital care.

- We will support the roll-out of the Friends & Family Test across Primary Care starting in General Practice.

- We will collaboratively develop local systems to drive improved patient empowerment, linking to the national drivers 'Patients in control' and 'Personal health budgets'.

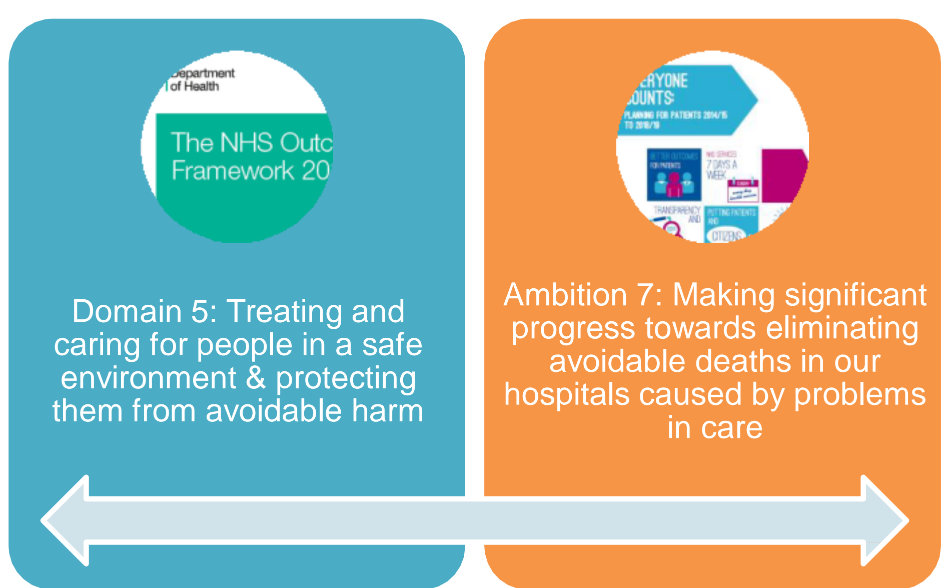
- We will improve partnership working with our local healthwatch establishments to enable lessons to be shared and provide scrutiny to our complaints process

- We will establish more robust mechanisms of triangulating data and information in order to improve our understanding of the available information. This improved data set and understanding will then be used to support our local delivery plans.

## 4. Patient Safety

Domain 5 of the NHS Outcomes Framework has been developed to measure a reduction in avoidable harm. Ambition 7 of NHS England's 5 year planning guide also focusses on patient safety.

**Patient Safety**




**Healthcare Acquired Infections:**

- We will take a whole health community approach to reducing healthcare acquired infections (HCAI) and continue to support our CCG colleagues to deliver improvements.

- We will ensure that CCGs and provider organisations are supported to analyse the underlying causes of HCAI and utilise this information to develop robust action plans to meet stringent targets for reducing Clostridium Difficile infections and MRSA bacteraemias.

**Incident Reporting:** Nationally and locally we recognise incident reporting from primary care is low. Across the Leicestershire & Lincolnshire area the rate of incidents reported from Primary Care per 100,000 population is 3.05 compared to 646 across all NHS sectors nationally.

- We will actively promote incident reporting across primary care through a structured education and training programme to increase incident reporting from Primary Care.

**Harm Free Care:** The NHS Safety Thermometer is a local improvement tool for measuring, monitoring, and analysing patient harms and 'harm free' care.

- Through systematic monitoring and analysis of the NHS safety thermometer data, and continuous work with our CCG colleagues, we aim to reduce avoidable harm from pressure ulcers; falls; urinary tract infections (UTI) and venous thromboembolism.

Local analysis suggests the priority for our community health service providers should be in relation to a reduction in pressure ulcers. For our acute providers focus should be on a reduction in pressure ulcers and, patients with a catheter and a UTI.

- Through collaboration with our CCG partners we will ensure the relevant priority areas are included within the local Commissioning for Quality and Innovation (CQUIN) schemes for 2014/15, as described in the NHS England CQUIN guidance 2014/15 document, published in December 2013.

The full CQUIN guidance can be found at: http://www.england.nhs.uk/wp-content/uploads/2013/12/cquin-guid-1415.pdf

**Serious Incident Management:** We will work with our CCG and provider colleagues to ensure the NHS Commissioning Board Serious Incident Framework (2013) is adhered to.

- We will undertake systematic analysis of themes and trends of all serious incidents reported to NHS England Leicestershire & Lincolnshire Area Team to ensure to ensure robust investigations have been undertaken and that appropriate lessons have been learnt.

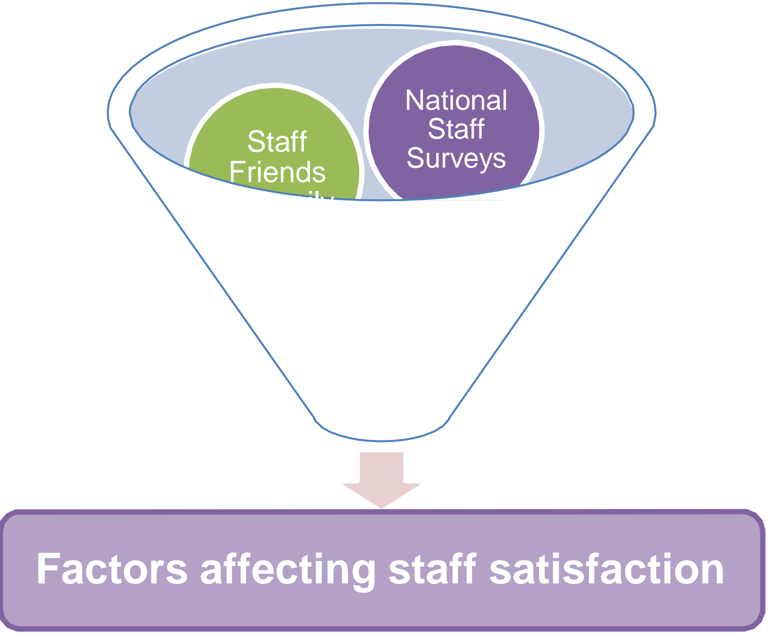
  This analysis will also be used to identify areas of patient safety for further scrutiny or improvement and will be used to support our local delivery plans.

- We will introduce a regular mechanism for disseminating lessons learnt across the health community, as appropriate, to ensure that others can learn the lessons and prevent a recurrence of the same event happening elsewhere.

## 5. Staff satisfaction

Action area six from the 6C's relates to supporting positive staff experience. Staff opinions, about their place of work, will continue to be collected via the annual staff surveys.

- We will undertake to analyse the outputs from these surveys to understand the factors affecting staff satisfaction in the local health economy and how staff satisfaction benchmarks against others.




- We will work with our CCG colleagues to ensure the new Staff Friends & Family Test is rolled out as per the NHS England CQUIN guidance 2014/15 document, published in December 2013.

- We will continue to promote the uptake of the NHS England staff barometer and co-ordinate the information to improve our local staff satisfaction.

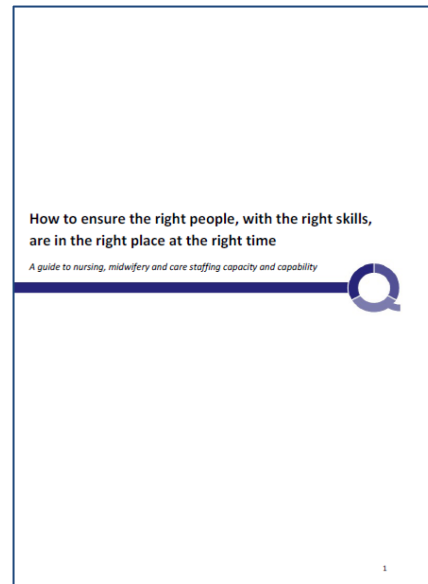
## 6. Safeguarding

- We will continue to support the strategic vision and direction of safeguarding across Leicestershire & Lincolnshire through pro-active engagement and attendance at all of the local safeguarding boards.
- We will ensure that all our staff undertakes safeguarding training, which is commensurate with their roles and responsibilities.

- We will develop the role of the 'Named GP' locally to support primary care professionals in the operational delivery of safeguarding the local population.

- We will work with the CCG's to utilise messages from Serious Case Reviews and Domestic Homicide reviews, as well as the wider learning sourced from the safeguarding boards learning and development frameworks, to improve practice standards.

## 7. Staffing Capacity & Capability


How to ensure the right people, with the right skills, are in the right place at the right time

*A guide to nursing, midwifery and care staffing capacity and capability*

1

The National Quality Board report: How to ensure the right people, with the right skills, are in the right place at the right time, *A guide to nursing, midwifery and care staffing capacity and capability* [2013] identified 10 expectations. The expectation is that all organisations are meeting these requirements currently, or taking active steps to ensure they do in the very near future.

- We will work with our internal, CCG and provider colleagues to ensure that the 10 expectations identified in the report have been implemented appropriately.

- We will link this work to Action areas 4 and 5 of the 6C's to ensure strong leadership and ensuring we have the right staff, with the right skills, in the right place.

**Staffing Capacity & Capability**

Implementation of the 10 Expectations

Action area 4: Building and strengthening leadership

Action area 5:Ensuring we have the right staff, with the right skills, in the right place

- We will proactively support the development and implementation of a robust revalidation and appraisal system that is congruent with the NMC guidance for nurse revalidation.

- Individual practitioner concerns will be managed in a fair and open system that promotes learning and improvement and NHS England Clinical Teams will continue to actively contribute to the local governance arrangements relating to individual practitioners.

## 8. Quality Assurance Framework

- We will develop robust Quality Assurance Frameworks for all services directly commissioned by the Area Team, ensuring they offer the best possible outcomes for patients.

- We will set clear specifications for monitoring and assuring quality in the service contract and ensure patient and other stakeholder views are considered.

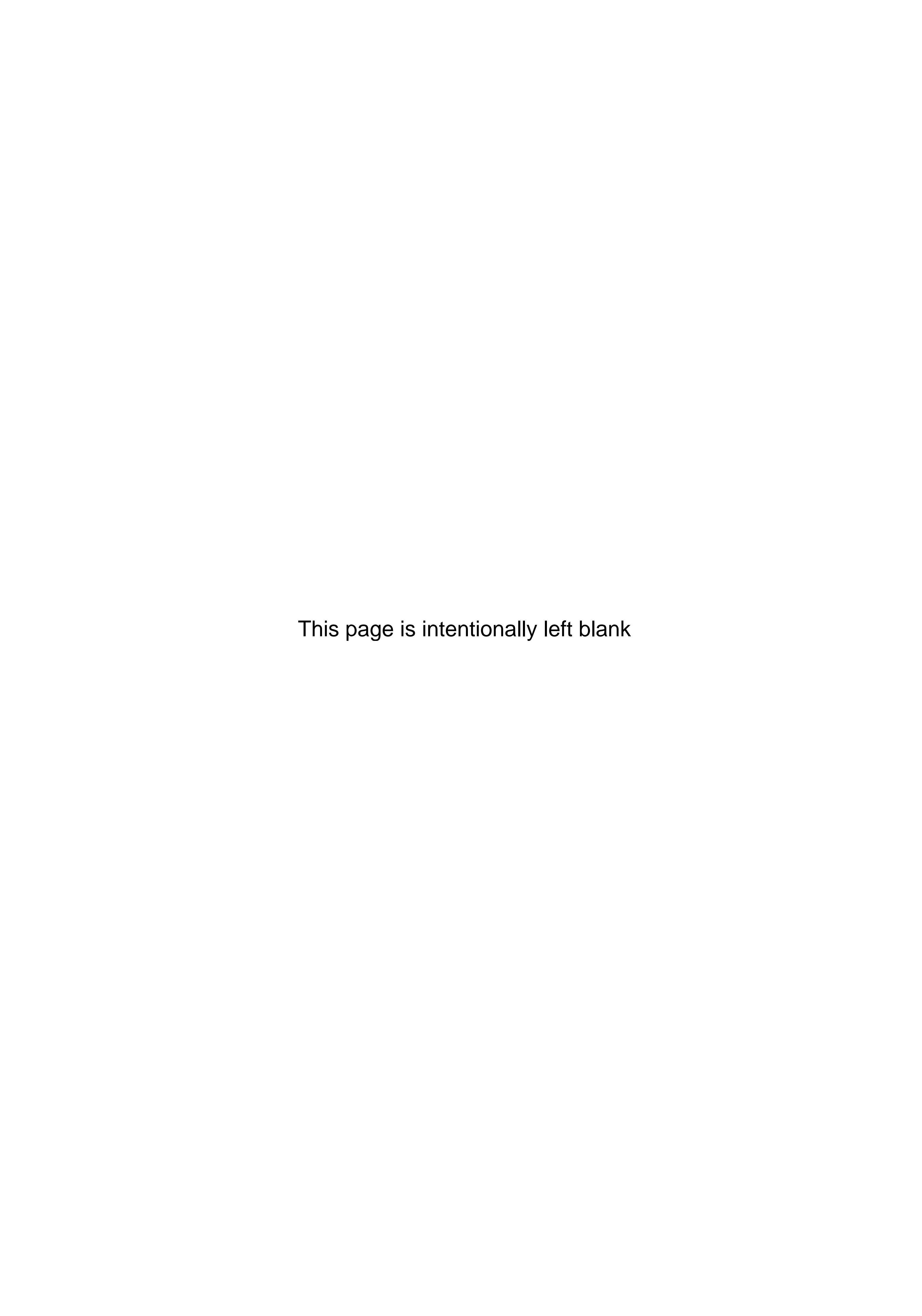
- We will maintain and improve the existing partnership relationships with local and regional Quality Surveillance Group members.

- We will ensure the local Quality Surveillance Group continues to provide constructive challenge and scrutiny of our local providers by systematically bringing together different parts of the health and care economy to routinely and methodically share information and intelligence about quality. The QSG will continue to:

  - Present information, including soft intelligence gathered through a variety of methods
  - Provide a forum, supported and facilitated by NHS England, for local health and care economies to work openly and honestly together to ensure quality across the system
  - Ensure a shared view of risks to quality through sharing intelligence
  - Acting as an early warning mechanism of risk about poor quality, and
  - Provide opportunities to coordinate actions to drive improvement whilst respecting statutory responsibilities of and on-going operational liaison between organisations

Document Version History

| File | Notes |
|---|---|
| 140210 Strategic & Operational plans LL Draft v1 | Initial draft |
| 140210 Strategic & Operational plans LL Draft v2i | Incorporating changes from initial regional NHS England review |
| 140303 Strategic & Operational plans LL Draft v2j | Section completion primary care provider profiles. Explanatory notes for some technical terms. Truncation of technical financial commentary. Separation of draft QIPP projects to supplementary document for further development. Addition of Executive Summary and Document version history. |
| 140305 Strategic & Operational plans LL Draft v2k | Amended to remove abbreviations for specific healthcare provider |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# LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of Martin Wilson, Health and Wellbeing Board Advisor

| | |
|---|---|
| Report to | **Lincolnshire Health and Wellbeing Board** |
| Date: | **10 June 2014** |
| Subject: | **Lincolnshire Health and Wellbeing Board Development Toolkit – Current Position** |

**Summary:**

Lincolnshire Health and Wellbeing Board has been in operation for 12 months, the use of this toolkit is an attempt to determine, against certain statements, how mature the Board is in delivering improved outcomes for the population of Lincolnshire and any agreed celebration of activities and action plan for improvements.

**Actions Required:**

The Board to discuss attached papers.

The Board to agree to the formation of a small Task and Finish Group to help develop an Action Plan and for expressions of interest to be sent to the Health and Wellbeing Advisor.

The Board to agree to the Action Plan being presented as a 'decision' item at September's formal board session.

## 1. Background

Lincolnshire Health and Wellbeing Board became a formal committee of Lincolnshire County Council on 1st April 2013; it was created as a result of the Health and Social Care Act 2012 and was designed to become the interface for health and social care to improve the health and wellbeing of the population of Lincolnshire. The main two outputs statutorily required from the Board are an evidence base, the Joint Strategic Needs Assessment (JSNA) and a Joint Health and Wellbeing Strategy (JHWS). The Board also

has responsibility to assure itself that the commissioning plans for health and social care providers are designed to help deliver the outcomes of the JHWS and also integration of health and social care services align to the strategy.

As part of the Health and Wellbeing System Improvement Programme, the Department of Communities and Local Government has, in conjunction with a number of partners, created a toolkit for Health and Wellbeing Boards. The tool provides an opportunity for the Board to evaluate their position using a maturity model. By using the statements the can consider current practice, benchmark against others and recognise what is working well.

The toolkit is split into six different dimensions

- **Vision (14)**
- **Strategy (14)**
- **Leadership (19)**
- **Needs assessment and management of priorities (18)**
- **Governance , risk sharing and assurance of outcomes (22)**
- **Information and intelligence (16)**

Each of the dimensions has a number of characteristics/statements attributed (figures in brackets above) split across four levels of 'maturity' of development of the Board. They are

- **Young**
- **Established**
- **Mature**
- **Exemplar**

(see Appendix A for full matrix)

It is in essence a self-assessment toolkit for the Board to judge how it has developed since its inception and areas it should look at to move towards a mature/exemplar Board and develop an action plan.

**October 2013 Stocktake**

In October 2013 I completed a six month draft stocktake, gathering evidence against the characteristics/statements within the toolkit. Statements which could be fully evidenced were marked as complete. The review found that the Board could fully evidence 17 of the statements and was 46% compliant against being designated as 'young' (see Appendix B).

At this point we had only held two formal meetings and still with limited guidance from central government about what they expected the Board to achieve. The 18 months spent as an informal board before the 1st April did give Lincolnshire a head start in developing the maturity required to improve the health and wellbeing of Lincolnshire residents.

**June 2014 draft Stocktake**

I have now repeated the stocktake exercise after the Board has been in operation for over 12 months. The Board can now fully evidence 22 of the statements and is 60%

compliant against being designated as 'young' and overall 26% towards becoming 'mature' (see Appendix C). There are also a significant number of statements where the Board can evidence significant progress but not all elements of the statements are yet in place to enable it to be considered as fully met/evidenced. Appendix D provides details of the evidence and shows the current status and direction of travel for those statements yet to be met.

The Board has shown considerable improvement across all areas as organisations become aware of the statutory roles of the Board around compliance with the Health and Wellbeing Strategy outcomes. The members of the Board now have more awareness of their roles and responsibilities in this new committee structure. The Board has looked at and discussed a wide range of topics, and agreed some major funding decisions (Better Care Fund).

**Next Steps**

The Board is asked to consider the setting up of a small Task and Finish Group to work with the Health and Wellbeing Advisor to develop an Action Plan to be presented as a decision item at the next formal session in September.

## 2. Conclusion

Lincolnshire Health and Wellbeing Board has made major strides in developing its 'maturity' in developing and improving the Health and Wellbeing for the people of Lincolnshire. The next stage is to develop an action plan for the Board to enable it to progress to 'mature' by June 2015.

## 3. Consultation

N/A

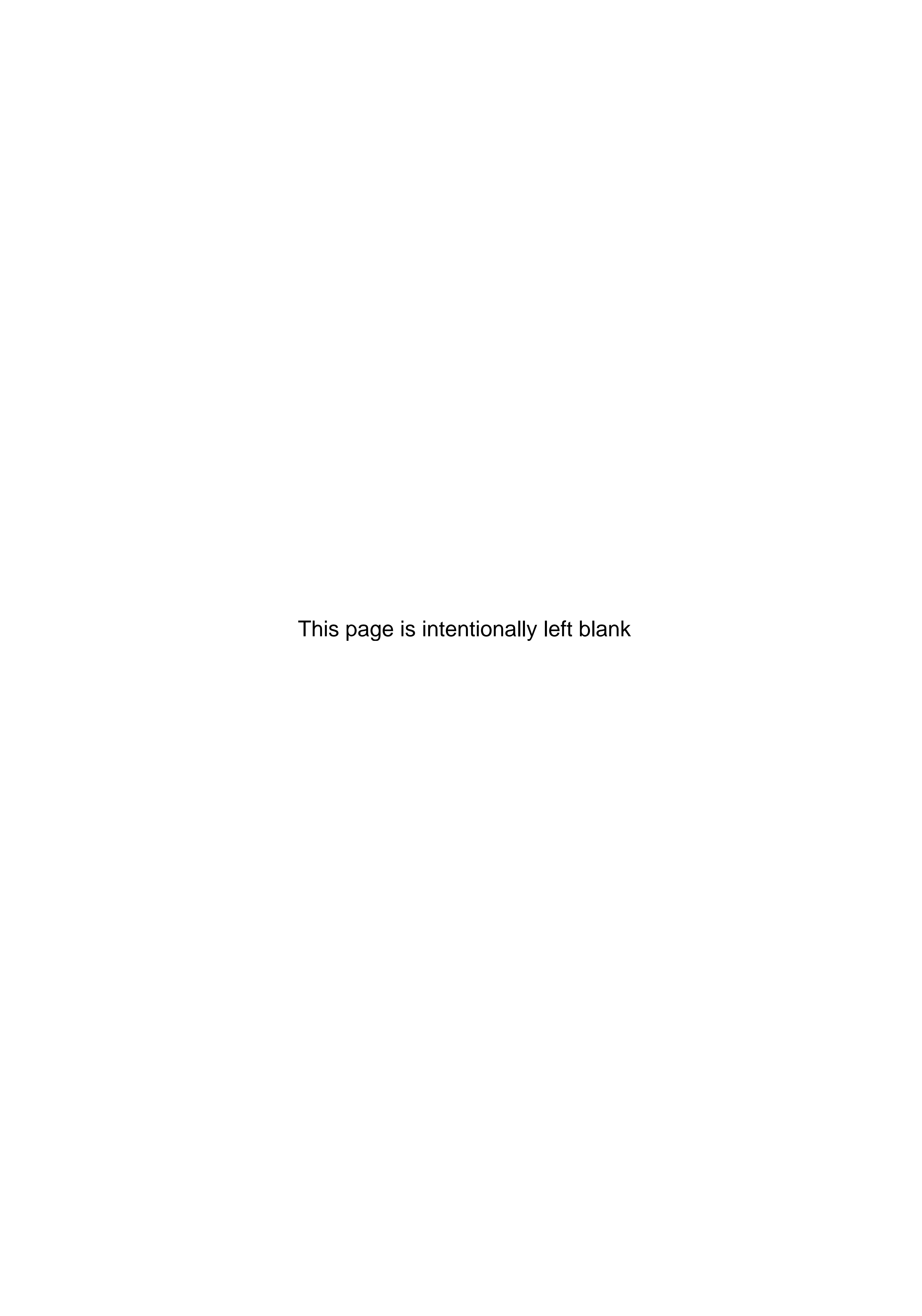
## 4. Appendices

| These are listed below and attached at the back of the report | |
|---|---|
| Appendix A | Health and Wellbeing Development Toolkit Matrix |
| Appendix B | October 2013 Stocktake position |
| Appendix C | June 2014 Stocktake position |
| Appendix D | Development toolkit evidence base |

## 5. Background Papers

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

This report was written by Martin Wilson, Health and Wellbeing Board Advisor, who can be contacted on 01522 554292 or martin.wilson@lincolnshire.gov.uk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APPENDIX A

# Health and Wellbeing System Improvement Programme

# Development Tool

## September 2013

# Development tool for Health and Wellbeing Boards

**Introduction**

Working with Health and Wellbeing (HWB) partners, we have co- produced this tool as an alternative to peer challenge. Whilst aligning with the peer challenge methodology, it offers HWBs an opportunity to evaluate their position using a maturity model. The tool describes characteristics of a 'young HWB'; an 'established HWB'; a 'mature HWB'; and an 'exemplar HWB' against six dimensions for an effective partnership.

The tool is one part of the wider offer on health and wellbeing system improvement. HWBs are encouraged to use the statements in the tool as a prompt to consider and challenge their own practice, to benchmark with others and as a stepping stone towards developing an improvement plan. We see it as a tool intended to help shape a local conversation rather than a scoring exercise. How individual HWBs use the tool is up to them and we recognise that some may wish to use it flexibly.

The content of the tool will be kept under review to ensure it meets the future needs of HWBs. Comments and feedback about how the tool might be further improved and how HWBs have used this development tool would be welcomed. Please send your feedback, reflections and stories to caroline.bosdet@local.gov.uk.

HWBs are challenged to develop complex and innovative approaches that require new ways of working. Help is available from several national and regional organisations. A good starting place for assistance is the health and wellbeing system improvement programme web resource (http://goo.gl/9FWfSk).

**Guiding principles**

The following guiding principles, developed with HWB partners, underpin the development tool:

- **Promoting a local narrative**: The tool aims to promote an honest narrative within individual HWBs, to assist them in exploring their strengths, challenges and opportunities to improve.
- **Promoting partnership, shared leadership and shared decision making**: The tool intends to build on the foundations that have already been established, to support continual development and challenge in becoming an effective operating HWB across local health and social care economies.
- **Engaging stakeholders**: The tool reflects the need to put stakeholder engagement at the heart of the HWB, underpinned by transparency and mechanisms that allow stakeholders to contribute.
- **Understanding and striving for effectiveness**: The tool promotes an evidence-based approach through the cycle of: needs assessment; prioritisation; decision making; implementation; and evaluation of outcomes.
- **Assurance, learning and self-development**: HWBs should be learning forums, self-driven and undertake continual reflection on progress and address emerging issues. Benchmarking and aspiring to the highest level of performance should be the norm.
- **Celebrating success, sharing innovation and recognising barriers**: This tool also aims to encourage HWBs sharing their own practice and identifying and addressing barriers to progress.

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**Lincolnshire Health and Wellbeing Board Development Toolkit Matrix**

| | Young HWB | Established HWB | Mature HWB | Exemplar HWB |
|---|---|---|---|---|
| **Vision** | 1. The HWB has a clear vision, shared by all partners in the system, which outlines its core purpose and values and its role in the local health and care system.<br><br>2. The HWB has sought, heard and listened to the views of local communities and citizens and this is reflected in the HWB vision.<br><br>3. The HWB has a planned approach to define its membership as well as stakeholder engagement and management. | 4. Stakeholders and partners understand the vision, values and core purpose of the HWB. There is an understanding of the opportunities and constraints of partnership and joint leadership within the HWB.<br><br>5. The HWB understands and can articulate the shape of the local health and care system that is required in order to deliver its own vision, and how it will work with partners to achieve this.<br><br>6. Partners, providers, users and wider stakeholders agree there has been meaningful engagement in the development and delivery of the vision.<br><br>7. The vision is rooted in local evidence data and voice – and politicians support the vision and purpose of the HWB.<br><br>8. All strategies and actions from the strategic plan directly align with the vision of the HWB. | 9. Local communities, citizens, service providers and service users 'get' the vision and purpose and feel they have shared ownership of it.<br><br>10. Service providers and partners refer to the vision in their own strategies and commissioning plans. They acknowledge it as a vision for the 'local place'.<br><br>11. The vision is revisited regularly as part of an on-going strategic plan review with members challenging the vision in light of changing circumstances. | 12 The decisions and actions of the HWB are entirely driven by the shared vision. The HWB is strategically aware, a social innovator, a partnership that makes a difference in all it does.<br><br>13 The HWB is an organisation that is supported by all the partners who have a stake in it and the communities that it serves.<br><br>14 The leadership of the HWB has a relentless focus on its vision to improve health and wellbeing services and outcomes for local people. There is a shared clinical and political resolve to deliver the vision. |

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| | **Young HWB** | **Established HWB** | **Mature HWB** | **Exemplar HWB** |
|---|---|---|---|---|
| **Strategy** | 1. The HWB has a compelling narrative describing its purpose and ambitions for its local community. The narrative sets out '*where we are now*' and is underpinned by intended outcomes. The strategy can demonstrate how it has taken account of the public voice.<br><br>2. All members of the HWB can articulate the strategy.<br><br>3. The strategy is reflected in partner strategies and commissioning plans. Service providers are engaged and have contributed to the strategy.<br><br>4. A shared communications strategy is in place that includes visible engagement and articulation of the strategy to the public and stakeholders. It is easily accessible on a dedicated HWB website, and is embedded in the web-presence of partners and related partnerships or networks. | 5. The strategy has been refined and refreshed in light of feedback and new intelligence.<br><br>6. Stakeholders and partners, including providers, can articulate the strategy.<br><br>7. The strategy is having a demonstrable impact on commissioning plans with clear measurable outcomes upon which the HWB can hold itself to account.<br><br>8. Regular reports articulate progress of the strategy, celebrating success and identifying blockages. | 9. The HWB regularly assesses its delivery against the strategy, refining and regaining momentum, where needed.<br><br>10. The HWB can describe what it has achieved, the changes made for local people and future improvement plans ('*where we are going*').<br><br>11. There are clear links and interdependencies with other relevant plans and strategies. Reconfiguration and de-commissioning has been handled professionally and transparently from strategy to implementation with strong shared clinical and political support.<br><br>12. The community can describe how the HWB has made a difference. | 13 The HWB has a demonstrable and recognised track record for leading improvements in outcomes and service change. It systematically identifies and addresses systemic issues and drives integration of health and social care.<br><br>14 There are examples and evidence of system transformation and whole system benefits. |

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| | **Young HWB** | **Established HWB** | **Mature HWB** | **Exemplar HWB** |
|---|---|---|---|---|
| **LEADERSHIP** | 1. HWB members understand and work towards achieving shared system leadership, involving all statutory core members plus other members of the HWB.<br><br>2. The HWB has a code of conduct which is explicit about expectations of behavior and the values it aspires to and has an agreement about minimum attendance at meetings.<br><br>3. Trust has been established, constructive challenge is the norm, and a conflict resolution process is in place.<br><br>4. The HWB understands its own development needs and has plans in place to address these.<br><br>5. The HWB has brought together Councillor's, local Healthwatch representatives and CCG members in an informal setting and spent time on HWB team building and development. | 6. The HWB is viewed as an entity in its own right and stakeholders understand and appreciate its system leadership role.<br><br>7. Leadership influence is distributed among many members and individual team members may lead at different times depending on their skills and knowledge.<br><br>8. There is a 'can do' culture HWB members look for win-win solutions focused on beneficial outcomes for the community.<br><br>9. The HWB is able to demonstrate mature dispute resolution. Major risks and issues are discussed openly and honestly, without members leaving the table.<br><br>10. HWB members understand the culture of individual member organisations and support each other to pursue shared priorities. Relationships enable members to influence beyond their own organisations. Regular development sessions are the norm. | 11. The HWB and its vision and strategy has withstood political challenge and political change. Leadership succession planning is in place. Local organisations seek to contribute to the work of the HWB.<br><br>12. The HWB has led on contentious issues (e.g. service de-commissioning) without activities that would undermine shared leadership.<br><br>13. All members take responsibility for unforeseen risks / problems and credit for success. Board members view each other as leaders and peers.<br><br>14. The HWB is a beacon of excellence in relation to equality and diversity and can show positive outcomes for the health and wellbeing of minority groups.<br><br>15. The HWB shares good practice with others. | 16 Leadership is strong across the HWB and resolution to challenges is achieved quickly and without negative impact on the work of the HWB. All core members feel that they are allowed to contribute to the success of the HWB.<br><br>17 Transformation has taken place at scale and pace.<br><br>18 Leadership is distributed across all members of the HWB.<br><br>19 The leadership of the HWB proactively seeks out excellence in all it does and the way it operates and is relentlessly focused on delivering improvements with, and for, local people. |

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| | Young HWB | Established HWB | Mature HWB | Exemplar HWB |
|---|---|---|---|---|
| **Needs assessment and management of priorities** | 1. The JSNA and JHWS are jointly developed in line with legislative requirements and formally agreed with all partners. Individual CCG and LA commissioning plans are being aligned.<br><br>2. The JSNA and JHWS explicitly recognise the needs of vulnerable people and hard to reach groups; priorities are designed to tackle health inequalities.<br><br>3. The JSNA and JHWS consider the needs of all age groups across the population, and recognise key transitions.<br><br>4. The HWB has agreed a realistic set of specific priorities through robust debate and challenge and the process included community engagement. A process exists for managing priorities. Prioritisation considers where the greatest impact can be made within available resources.<br><br>5. Priorities balance the short, medium and long term and balance issues across physical and mental health and wellbeing. They are linked to clear measurable outcomes. | 6. The JSNA and JHWS are embedded in plans of service providers.<br><br>7. The JSNA and JHWS are kept under constant review and revised regularly. They are realigned with commissioning plans to reflect changes.<br><br>8. A wide range of evidence, including data and voice (e.g. service user and patient stories) are systematically assessed to determine priorities.<br><br>9. All priorities directly align with the vision of the HWB and there is constructive challenge of plans to make this happen.<br><br>10. The HWB has put in place lines of accountability and decision making to enable it to have a grip on the things only it can do.<br><br>11. The HWB has achieved some of its shared priorities and can demonstrate improvements it has made to outcomes and services for local people. | 12. The JSNA process improves iteratively, learning from previous experience and best practice elsewhere.<br><br>13. The HWB has a track record of delivering its priorities and is able to communicate to communities about how it has made a difference to improving services and outcomes for local people.<br><br>14. Priorities have been robustly challenged and reviewed and this can be demonstrated with new priorities coming forward as previous priorities have been achieved or revised.<br><br>15. JHWS and commissioning plans are aligned with those of neighbouring HWBs where relevant (e.g. meeting specialised needs where HWBs may need to plan across a larger population or tackling service re-configuration across a larger geography). | 16 Local communities and citizens recognise the priorities of the HWB as their own.<br><br>17 The HWB can demonstrate long term buy in to, and achievement against, its priorities.<br><br>18 The HWB has a track record of enabling efficient, effective and integrated commissioning of services, working across administrative boundaries where appropriate. |

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| | **Young HWB** | **Established HWB** | **Mature HWB** | **Exemplar HWB** |
|---|---|---|---|---|
| **Governance, risk sharing and assurance of outcomes** | 1. HWB membership, governance, operational structures, scheme of delegation and mechanisms for engaging partners are clear, transparent and accessible to the public. Partners are clear about their individual and collective roles, responsibilities and accountabilities.<br><br>2. The HWB understands its accountabilities in relation to other partnerships. HWB accountabilities are incorporated into partner governance arrangements<br><br>3. The HWB has dedicated and skilful officer support, available to all members of the HWB<br>.<br>4. The HWB has an agreed set of outcome measures, matched to its priorities.<br><br>5. Local Healthwatch is empowered to act as an independent and effective voice for users, communities and the public.<br><br>6. The relationship between scrutiny and external regulators is agreed and an initial effectiveness review has been completed. | 7. A clear framework exists for deciding on contentious issues. Decisions of the HWB are accepted and acted on by all member organisations.<br><br>8. HWB partners are able to have honest discussions about budgets and financial positions.<br><br>9. The HWB invites peer scrutiny and works constructively with regulators and scrutiny bodies. The HWB reviews itself regularly against benchmarks and adapts plans as necessary.<br><br>10. The HWB receives regular and timely updates on progress against indicators and takes corrective action if necessary.<br><br>11. The HWB can demonstrate it has considered and acted upon the views of local people, feedback obtained from the community and evaluation of citizen experience.<br><br>12. The HWB seeks assurance on progress towards integrated care. | 13. The wider system understands how the HWB and related structures operate.<br><br>14. Reporting and governance is evaluated across partners and streamlined where appropriate.<br><br>15. Systems are in place to ensure decisions result in direct action across the partnership.<br><br>16. Resources are pooled where appropriate, whether in back office functions or integrated commissioning, with good governance.<br><br>17. Barriers to achieving priorities are identified and reviewed, and plans are in place to overcome/minimise these.<br><br>18. The HWB regularly demonstrates and communicates its achievements of outcomes.<br><br>19. Whole system safeguarding mechanisms are in place, including accountabilities. | 20 Integrated decision making, commissioning and governance are the 'norm' for the HWB.<br><br>21 The HWB has an integrated 'whole system' (rather than individual organisation measures) outcomes framework of high level indicators, supported by a 'dashboard' across the health and wellbeing system.<br><br>22 Budget planning is open and resources are directed to support agreed priorities and improvements for local communities. Risk sharing agreement exists between the LA, CCGs and other relevant partners. |

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| | Young HWB | Established HWB | Mature HWB | Exemplar HWB |
|---|---|---|---|---|
| **Information and intelligence** | 1. The JSNA provides a clear population profile and identification of health and wellbeing needs of all local communities and identifies inequalities.<br><br>2. Services and provision are mapped against local need and assets.<br><br>3. Engagement structures are mapped and include and build on partners' own processes, e.g. Healthwatch.<br><br>4. The HWB shares information and intelligence across members. | 5. The JSNA is in the public domain and a 'real time' document and the engagement of local people is clearly evident in its development.<br><br>6. The HWB understands the power of, and utilises, quantitative and qualitative 'voice' data, for examples, from service users, patients, carers and communities, alongside data from other sources to give a full picture of local needs and resources.<br><br>7. Shared population data is used in individual partner organisations' business planning and feeds commissioning strategies.<br><br>8. HWB partner organisations have aligned their engagement structures and plans around key priorities so that there is a coordinated approach to involving and engaging communities and citizens.<br><br>9. The HWB recognises where there are gaps in the intelligence base in the local population and has a strategic approach to ensuring that the information is understood. | 10. HWB informed by real-time intelligence, demonstrating improved outcomes, quality and efficiency across the health and wellbeing system.<br><br>11. Integrated information available to GPs, politicians and services users.<br><br>12. Effective data and intelligence sharing across partners drives the development of shared strategies and commissioning plans.<br><br>13. HWB monitors evidence of the outcomes from and impact of its strategy, and uses this to update JSNA and JHWS. | 14 The HWB has the ability to disaggregate data to CCG and district level andbelow (e.g. locality).<br><br>15 The HWB has shared data resources accessible to all partners, which brings together all needs assessments and the wider determinants of health and wellbeing (e.g. Housing, justice, child poverty, citizens' views).<br><br>16 The HWB understands its communities and their needs, has a single clear population profile across all partners and all services. It knows the total spend invested in an area and the extent to which that investment is being directed to meet the identified needs. |

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# Lincolnshire Health and Welbeing Board

**Board Development tool**

**Board development position as at Oct 2013**

Characteristic with no colour are evidenced

**Board Maturity**

- Exemplar
- Mature
- Established
- Young

| Vision | Strategy | Leadership | Needs | Governance | Information |
|---|---|---|---|---|---|
| | | | | 22 | |
| | | | | 21 | |
| | | | | 20 | |
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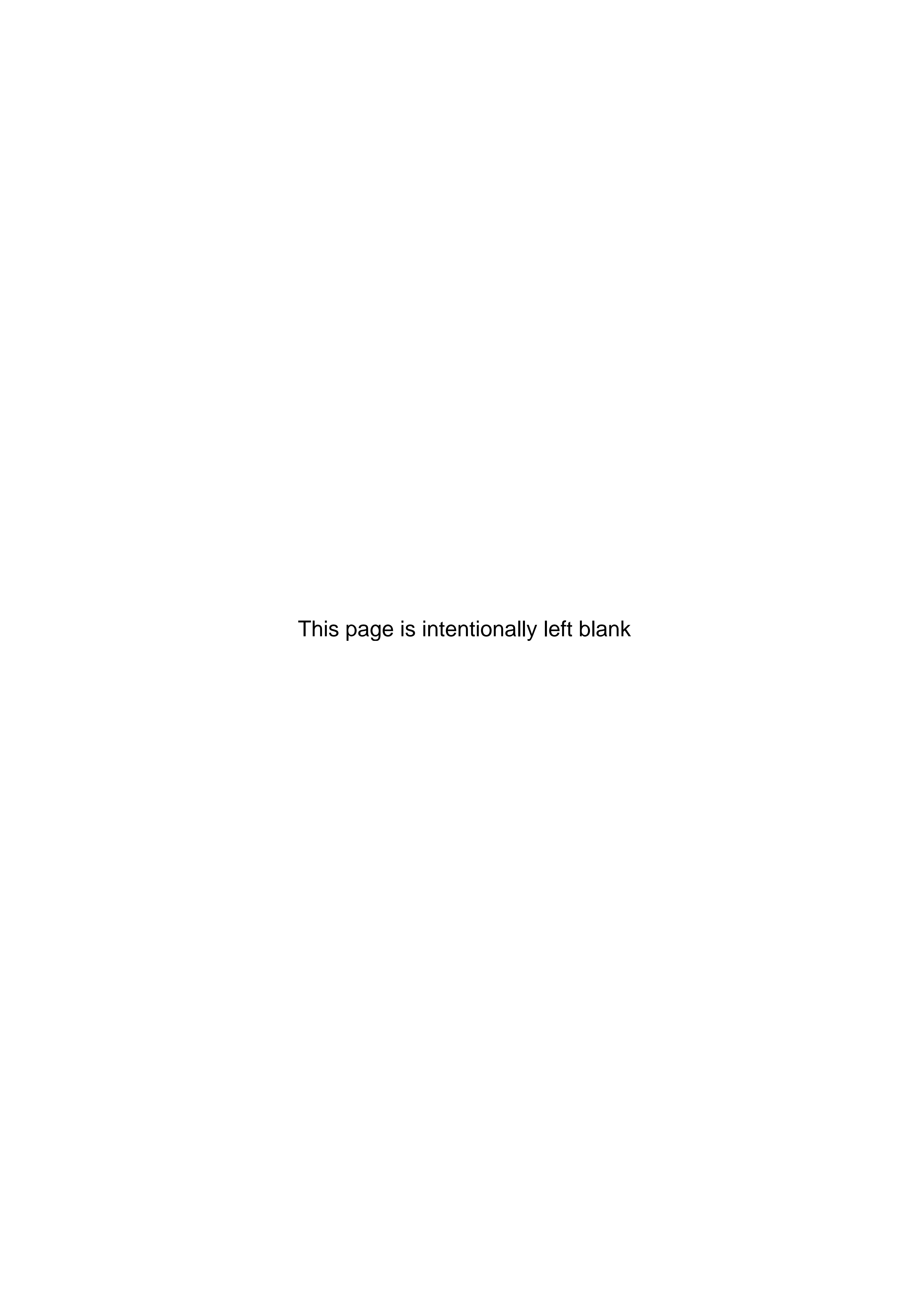
| 4 | 4 | 4 | 4 | 4 | 4 |
| 3 | 3 | 3 | 3 | 3 | 3 |
| 2 | 2 | 2 | 2 | 2 | 2 |
| 1 | 1 | 1 | 1 | 1 | 1 |

**Numbered characteristic statements for each dimension of the Board**



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## Lincolnshire Health and Wellbeing Board

**Board Development tool**

**Board development position as at June 2014**

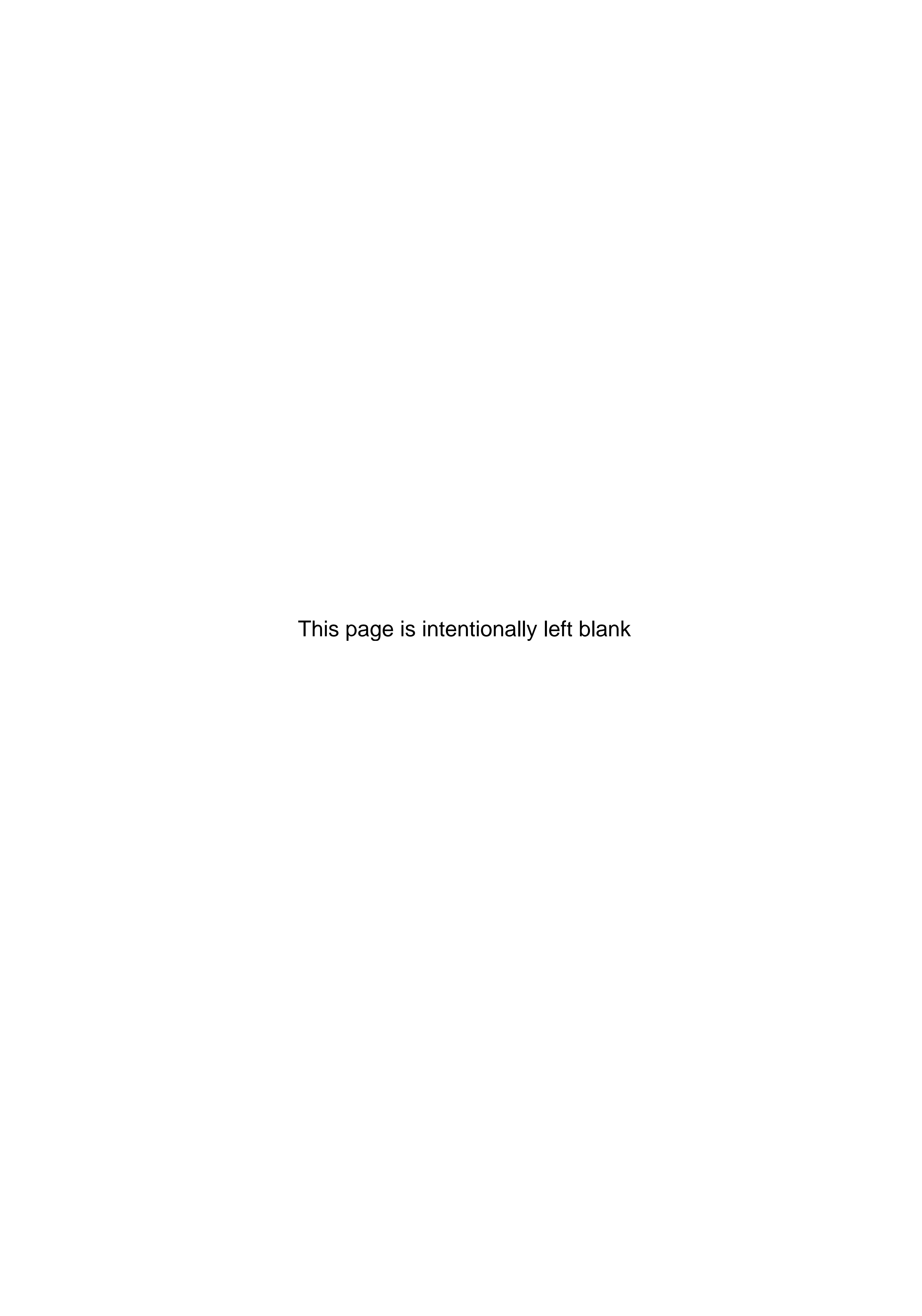
Characteristic with no colour are evidenced

**Board Maturity**

- Exemplar
- Mature
- Established
- Young

| Vision | Strategy | Leadership | Needs | Governance | Information |
|---|---|---|---|---|---|
| | | | | 22 | |
| | | | | 21 | |
| | | | | 20 | |
| | | 19 | | 19 | |
| | | 18 | 18 | 18 | |
| | | 17 | 17 | 17 | |
| | | 16 | 16 | 16 | 16 |
| | | 15 | 15 | 15 | 15 |
| 14 | 14 | 14 | 14 | 14 | 14 |
| 13 | 13 | 13 | 13 | 13 | 13 |
| 12 | 12 | 12 | 12 | 12 | 12 |
| 11 | 11 | 11 | 11 | 11 | 11 |
| 10 | 10 | 10 | 10 | 10 | 10 |
| 9 | 9 | 9 | 9 | 9 | 9 |
| 8 | 8 | 8 | 8 | 8 | 8 |
| 7 | 7 | 7 | 7 | 7 | 7 |
| 6 | 6 | 6 | 6 | 6 | 6 |
| 5 | 5 | 5 | 5 | 5 | 5 |
| 4 | 4 | 4 | 4 | 4 | 4 |
| 3 | 3 | 3 | 3 | 3 | 3 |
| 2 | 2 | 2 | 2 | 2 | 2 |
| 1 | 1 | 1 | 1 | 1 | 1 |

**Numbered characteristic statements for each dimension of the Board**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LINCOLNSHIRE HEALTH AND WELLBEING BOARD

*'Lincolnshire Health and Wellbeing board is taking the lead for better health in our county'*

**Lincolnshire Health and Wellbeing Board**

**Development tool evidence and action plan**

**Dimension – VISION**

Progress towards being a mature Health and Wellbeing Board for the **Vision dimension** is currently at **9 %**

| KEY | Fully Evidenced | Partially Evidenced | Too early to evidence | Improving | Static |
|---|---|---|---|---|---|

| | Characteristics | Evidence | Owner | Status | Direction of Travel | Development need |
|---|---|---|---|---|---|---|
| Young | 1. The HWB has a clear vision, shared by all partners in the system, which outlines its core purpose and values and its role in the local health and care system. | Vision statement agreed by the Board in September 2013 | | Fully Evidenced | | To be reviewed & reaffirmed in September 2014 |
| Young | 2. The HWB has sought, heard and listened to the views of local communities and citizens and this is reflected in the HWB vision. | Consultation for JHWS has informed an element of the Board's choice of vision.<br><br>An extensive consultation and engagement plan is being developed as part of Lincolnshire Health & Care (LHAC) and feedback from this will need to be reflected in future reviews of the HWB vision. | | Partially Evidenced | Improving | |

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| | | | | | | |
|---|---|---|---|---|---|---|
| | 3. The HWB has a planned approach to define its membership as well as stakeholder engagement and management. | Board membership is agreed as required by statutory regulations. LCC membership is agreed by Full Council as part of the Constitution.<br><br>However there are no defined approaches to stakeholder engagement and management. | | ● | ⇔ | To be reviewed June 2014 |
| **Established** | 4. Stakeholders and partners understand the vision, values and core purpose of the HWB. There is an understanding of the opportunities and constraints of partnership and joint leadership within the HWB. | Too early to clearly evidence, however blueprint for LSSR (now LHAC) agreed at December 2013 Board meeting and ongoing work in clinical design groups has begun the process of understanding | | ? | | |
| | 5. The HWB understands and can articulate the shape of the local health and care system that is required in order to deliver its own vision, and how it will work with partners to achieve this. | See above | | ? | | |
| | 6 Partners, providers, users and wider stakeholders agree there has been meaningful engagement in the development and delivery of the vision. | Not clearly evidenced | | ? | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | 7 The vision is rooted in local evidence data and voice – and politicians support the vision and purpose of the HWB. | Not clearly evidenced | | ? | | |
| | 8 All strategies and actions from the strategic plan directly align with the vision of the HWB. | Too early to clearly evidence | | ? | | |
| **Mature** | 9 Local communities, citizens, service providers and service users 'get' the vision and purpose and feel they have shared ownership of it. | Not clearly evidenced | | ? | | |
| | 10 Service providers and partners refer to the vision in their own strategies and commissioning plans. They acknowledge it as a vision for the 'local place' | Not fully evidenced, however more partners are now linking their commissioning plans to the strategy, but not everybody. Further work required to ensure it is a vision for the 'local place' | | ● | ⇔ | |
| | 11 The vision is revisited regularly as part of an on-going strategic plan review with members challenging the vision in light of changing circumstances. | Review still to happen in September 2014 in light of LHAC | | ● | ⇧ | |

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| | | | | | | |
|---|---|---|---|---|---|---|
| **Exemplar** | 12 The decisions and actions of the HWB are entirely driven by the shared vision. The HWB is strategically aware, a social innovator, a partnership that makes a difference in all it does. | | | | | |
| | 13 The HWB is supported by all the partners who have a stake in it and the communities that it serves. | | | | | |
| | 14 The leadership of the HWB has a relentless focus on its vision to improve health and wellbeing services and outcomes for local people. There is a shared clinical and political resolve to deliver the vision. | | | | | |

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**Development tool evidence and action plan**

**Dimension – STRATEGY**

| KEY | Fully Evidenced | Partially Evidenced | Too early to evidence | Improving | Static |
|---|---|---|---|---|---|

Progress towards being a mature Health and Wellbeing Board for the **Strategy dimension** is currently at **16 %**

| | Characteristics | Evidence | Owner | Status | Direction of Travel | Development need |
|---|---|---|---|---|---|---|
| | 1. The HWB has a compelling narrative describing its purpose and ambitions for its local community. The narrative sets out '*where we are now*' and is underpinned by intended outcomes. The strategy can demonstrate how it has taken account of the public voice. | A JSNA and JHWS are completed for Lincolnshire.<br>The JSNA is available for all stakeholders and the general public to view through the Lincolnshire Research Observatory website.<br><br>An annual stakeholder survey is conducted for the JSNA.<br>JHWS theme specific workshops have been organised and held. | | Fully Evidenced (+) | | |

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| | Characteristics | Evidence | Owner | Status | Direction of Travel | Development need |
|---|---|---|---|---|---|---|
| Young | 2. All members of the HWB can articulate the strategy. | Board Sponsors have a good understanding of their own themes but there is limited evidence of wider understanding of other themes outcomes.<br><br>The Assurance Report, to be presented at June 2014 meeting, will help inform with understanding of the strategy outcomes. | | ● | ⇧ | |
| | 3. The strategy is reflected in partner strategies and commissioning plans. Service providers are engaged and have contributed to the strategy. | There are some partners who have reflected the strategy in commissioning plans but the Board needs to ensure/challenge that this continues across all theme outcomes. | | ● | ⇧ | |
| | 4. A shared communications strategy is in place that includes visible engagement and articulation of the strategy to the public and stakeholders. It is easily accessible on a dedicated HWB website, and is embedded in the web-presence of partners and related partnerships or networks. | There is a partially developed communication strategy and plan but this has yet to be approved by the Board. However, this will need to be revisited in light of LHAC developments.<br><br>HWB has a web presence hosted on LCConnects, however this is not a dedicated HWB website.<br><br>Limited evidence of it being embedded in partners/partnership networks. | | ? | | |

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| | Characteristics | Evidence | Owner | Status | Direction of Travel | Development need |
|---|---|---|---|---|---|---|
| Established | 5. The strategy has been refined and refreshed in light of feedback and new intelligence. | It is a 5 year strategy but it is reviewed annually with the refresh of the JSNA evidence and commentaries | | ✚ | | |
| | 6. Stakeholders and partners, including providers, can articulate the strategy. | Not clearly evidenced. | | | | |
| | 7. The strategy is having a demonstrable impact on commissioning plans with clear measurable outcomes upon which the HWB can hold itself to account. | Evidence is limited; some work has been undertaken, particularly around a HWB 'dashboard' of indicators which forms part of the Assurance Report. However, further work is required. | | ● | ⇧ | |
| | 8. Regular reports articulate progress of the strategy, celebrating success and identifying blockages. | Process still in development. The first Assurance Report is being presented to the Board in June 2014. | | ● | ⇧ | |
| | 9. The HWB regularly assesses its delivery against the strategy, refining and regaining a momentum, where needed. | Will be reviewed in June 2014 following presentation of Assurance Report. | | ? | | |

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| | Characteristics | Evidence | Owner | Status | Direction of Travel | Development need |
|---|---|---|---|---|---|---|
| Mature | 10. The HWB can describe what it has achieved, the changes made for local people and future improvement plans (‘*where we are going*’). | Will not be able to describe activity until it has been in operation for 18 months to see demonstrable changes | | ? | | |
| | 11. There are clear links and interdependencies with other relevant plans and strategies. Reconfiguration and de-commissioning has been handled professionally and transparently from strategy to implementation with strong shared clinical and political support. | There is strong evidence of political and clinical support and many of the proposed change will result LHAC which is still the early engagement phase. | | ● | ⇧ | |
| | 12. The community can describe how the HWB has made a difference . | Process still to be developed | | ? | | |
| Exemplar | 13 The HWB has a demonstrable and recognised track record for leading improvements in outcomes and service change. It systematically identifies and addresses systemic issues and drives integration of health and social care. | | | | | |

| | Characteristics | Evidence | Owner | Status | Direction of Travel | Development need |
|---|---|---|---|---|---|---|
| | 14 There are examples and evidence of system transformation and whole system benefits. | | | | | |

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

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Progress towards being a mature Health and Wellbeing Board for the **Leadership dimension** is currently at **20 %**

**Lincolnshire Health and Wellbeing Board**

**Development tool evidence and action plan**

**Dimension – LEADERSHIP**

| KEY | + Fully Evidenced | ● Partially Evidenced | ? Too early to evidence | ⇧ Improving | ⇔ Static |
|---|---|---|---|---|---|



| | Characteristics | Evidence | Owner | Status | Direction of Travel | Development need |
|---|---|---|---|---|---|---|
| Young | 1. HWB members understand and work towards achieving shared system leadership, involving all statutory core members plus other members of the HWB. | There is some evidence that the Board is moving towards shared system leadership and that all statutory core members are involved in developing that understanding. | | ● | ⇧ | |
| | 2. The HWB has a code of conduct which is explicit about expectations of behaviour and the values it aspires to and has an agreement about minimum attendance at meetings. | TOR, terms of conduct, members roles and responsibilities agreed in September 2013 | | + | | To be reviewed in June 2014 |
| | 3. Trust has been established, constructive challenge is the norm, and a conflict resolution process is in place. | The Board has agreed Terms of Reference which sets out that all decisions are agreed by consensus. | | + | | |

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

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| | Characteristics | Evidence | Owner | Status | Direction of Travel | Development need |
|---|---|---|---|---|---|---|
| | 4. The HWB understands its own development needs and has plans in place to address these. | Still in development | | ? | | |
| | 5. The HWB has brought together Councillors, local Healthwatch representatives and CCG members in an informal setting and spent time on HWB team building and development . | Using informal meetings to work through practical resolutions of problems as a tool to develop working relationships of the board. | | + | | |
| Established | 6. The HWB is viewed as an entity in its own right and stakeholders understand and appreciate its system leadership role. | Growing understanding between the core partners about the Board's role but further engagement with stakeholders is needed to ensure it is fully embedded. | | ● | ⇔ | |
| | 7. Leadership influence is distributed among many members and individual team members may lead at different times depending on their skills and knowledge. | Board Sponsors have started the journey providing Theme updates at the Informal Meeting in May 2014. They will also be reporting individually to Lincolnshire Health Overview and Scrutiny Committee. | | ● | ⇧ | |
| | 8. There is a 'can do' culture HWB members look for win-win solutions focused on beneficial outcomes for the community. | Too early in Board development to clearly evidence a 'can do' culture. | | | | |
| | 9. The HWB is able to | Too early to clearly evidence | | ? | | |

| | Characteristics | Evidence | Owner | Status | Direction of Travel | Development need |
|---|---|---|---|---|---|---|
| | demonstrate mature dispute resolution. Major risks and issues are discussed openly and honestly, without members leaving the table. | | | | | |
| | 10. HWB members understand the culture of individual member organisations and support each other to pursue shared priorities. Relationships enable members to influence beyond their own organisations. Regular development sessions are the norm. | Will take time to develop | | ? | | |
| Mature | 11. The HWB and its vision and strategy has withstood political challenge and political change. Leadership succession planning is in place. Local organisations seek to contribute to the work of the HWB. | Too early to clearly evidence | | ? | | |
| | 12. The HWB has led on contentious issues (e.g. service de-commissioning) without activities that would undermine shared leadership | As above | | ? | | |

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

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| | Characteristics | Evidence | Owner | Status | Direction of Travel | Development need |
|---|---|---|---|---|---|---|
| | 13. All members take responsibility for unforeseen risks / problems and credit for success. Board members view each other as leaders and peers. | As above | | ? | | |
| | 14. The HWB is a beacon of excellence in relation to equality and diversity and can show positive outcomes for the health and wellbeing of minority groups. | As above | | ? | | |
| | 15. The HWB shares good practice with others. | The Board Chair regularly attends regional events but these networks are also in early stages of development. | | ● | ⇧ | |
| **Exemplar** | 16 Leadership is strong across the HWB and resolution to challemges is achieved quickly and without negative impact on the work of the HWB. All core members feel that they are allowed to contribute to the success of the HWB | | | | | |
| | 17 Transformation has taken place at scale and pace | | | | | |

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

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| | Characteristics | Evidence | Owner | Status | Direction of Travel | Development need |
|---|---|---|---|---|---|---|
| | 18 Leadership is distributed across all members of the HWB | | | | | |
| | 19 The leadership of the HWB proactively seeks out excellence in all it does and the way it operates and is relentlessly focused on delivering improvements, with and for, local people. | | | | | |

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

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Progress towards being a mature Health and Wellbeing Board for the **Needs assessment and management of priorities dimension** is currently at **46 %**

**Lincolnshire Health and Wellbeing Board**

**Development tool evidence and action plan**

**Dimension – NEEDS ASSESSMENT AND MANAGEMENT OF PRIORITIES**

| KEY | ✚ Fully Evidenced | ● Partially Evidenced | ? Too early to evidence | ⇧ Improving | ⇔ Static |
|---|---|---|---|---|---|

| | Characteristics | Evidence | Owner | Status | Direction of Travel | Development need |
|---|---|---|---|---|---|---|
| Young | 1. The JSNA and JHWS are jointly developed in line with legislative requirements and formally agreed with all partners. Individual CCG and LA commissioning plans are being aligned. | JSNA and JHWS published.<br>JSNA Topic commentaries in the process of being updated by topic owners.<br>Overview report to be published late 2013.<br>Annual JSNA stakeholder survey undertaken.<br>Support consultants in advice to CCG around the 3 local priorities for inclusion in their plans. | | ✚ | | |
| Young | 2. The JSNA and JHWS explicitly recognise the needs of vulnerable people and hard to reach groups; priorities are designed to tackle health inequalities. | JHWS themes:<br>1) Promoting Healthier Lifestyles<br>2) Improve the health and wellbeing of older people<br>3) Delivering high quality systematic care for major causes of ill health and disability.<br>4) Improve health and social outcomes for children and reduce inequalities.<br>5) Tackling the social determinants of health.<br><br>The priorities within these themes are aimed at tackling health inequalities across the County. | | ✚ | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | 3. The JSNA and JHWS consider the needs of all age groups across the population, and recognise key transitions. | The JHWS has themes and priorities that consider the needs of groups of people across the County.<br>The JSNA has a range of indicators that considers a range of age groups and populations. | | ✚ | | |
| | 4. The HWB has agreed a realistic set of specific priorities through robust debate and challenge and the process included community engagement. A process exists for managing priorities. Prioritisation considers where the greatest impact can be made within available resources. | The JHWS has themes and priorities that consider the needs of groups of people across the County.<br>The JSNA has a range of indicators that considers a range of age groups and populations.<br>Prioritisation tools were developed to include impact in relation to certainty as well as within resources available | | ✚ | | |
| | 5. Priorities balance the short, medium and long term and balance issues across physical and mental health and wellbeing. They are linked to clear measurable outcomes. | The JHWS has themes and priorities that consider the needs of groups of people across the County.<br>The JSNA has a range of indicators that considers a range of age groups and populations.<br>Each priority has agreed and shared measures of success across Public Health, Adult Care and NHS | | ✚ | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Established** | 6. The JSNA and JHWS are embedded in plans of service providers. | Some evidence that they have been referenced in CCG commissioning plans and Public Health Service Reviews | | ● | ⇧ | |
| | 7. The JSNA and JHWS are kept under constant review and revised regularly. They are realigned with commissioning plans to reflect changes. | JSNA topic reviews are annual conducted by the topic owners. | | ✚ | | |
| | 8. A wide range of evidence, including data and voice (e.g. service user and patient stories) are systematically assessed to determine priorities. | A draft Health and Wellbeing Board Dashboard has been created to monitor the indicators in the JHWS.<br><br>Work is underway with VCS to embed their community level evidence into the JSNA evidence base.<br><br>But currently there are no service user or patient stories. | | ● | ⇧ | |
| | 9. All priorities directly align with the vision of the HWB and there is constructive challenge of plans to make this happen. | Too early to clearly evidence | | ? | | |

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| | | | | | | |
|---|---|---|---|---|---|---|
| | 10. The HWB has put in place lines of accountability and decision making to enable it to have a grip on the things only it can do. | The Board is a formal committee of LCC and has agreed Terms of reference on how decisions will be made by the Board. However, the lack of national guidance/steer on the things that only the Board can do has given the Board a lack of focus. | | ● | ⇧ | |
| | 11. The HWB has achieved some of its shared priorities and can demonstrate improvements it has made to outcomes and services for local people. | Too early to clearly evidence | | ? | | |
| **Mature** | 12. The JSNA process improves iteratively, learning from previous experience and best practice elsewhere. | Topics are currently refreshed annually, latest 2014 | | + | | |
| | 13. The HWB has a track record of delivering its priorities and is able to communicate to communities about how it has made a difference to improving services and outcomes for local people | Too early to clearly evidenced | | ? | | |
| | 14. Priorities have been robustly challenged and reviewed and this can be demonstrated with new priorities coming forward as previous priorities have been achieved or revised. | Too early to be clearly evidenced | | ? | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | 15. JHWS and commissioning plans are aligned with those of neighboring HWBs where relevant (e.g. meeting specialised needs where HWBs may need to plan across a larger population or tackling service re- configuration across a larger geography). | Still in development | | ? | | |
| **Exemplar** | 16 Local communities and citizens recognise the priorities of the HWB as their own | | | | | |
| | 17 The HWB can demonstrate long term buy in to, and achievement against its priorities. | | | | | |
| | 18 The HWB has a track record of enabling efficient, effective and integrated commissioning of services, working across administrative boundaries where appropriate. | | | | | |

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

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**Lincolnshire Health and Wellbeing Board**

**Development tool evidence and action plan**

**Dimension – GOVERNANCE, RISK SHARING AND ASSURNACE OF OUTCOMES**

| KEY | Fully Evidenced | Partially Evidenced | Too early to evidence | Improving | Static |
|---|---|---|---|---|---|

Progress towards being a mature Health and Wellbeing Board for the **Governance, risk sharing and assurance of outcomes dimension** is currently at **36%**

| | Characteristics | Evidence | Owner | Status | Direction of Travel | Development need |
|---|---|---|---|---|---|---|
| Young | 1. HWB membership, governance, operational structures, scheme of delegation and mechanisms for engaging partners are clear, transparent and accessible to the public. Partners are clear about their individual and collective roles, responsibilities and accountabilities. | TOR and procedural rules, members roles and responsibilities agreed at Sept 13 meeting | | Fully Evidenced | | Review TOR at AGM in June 2014 |
| | 2. The HWB understands its accountabilities in relation to other partnerships. HWB accountabilities are incorporated into partner governance arrangements | Still in development | | Too early to evidence | | |

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

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| Characteristics | Evidence | Owner | Status | Direction of Travel | Development need |
|---|---|---|---|---|---|
| 3. The HWB has dedicated and skillful officer support, available to all members of the HWB | Senior Manager has role as Health and Wellbeing Board Advisor to work with all members of the board and partners. Support is also provide by Democratic Services. | | + | | |
| 4. The HWB has an agreed set of outcome measures, matched to its priorities. | Not clearly evidenced. Health and wellbeing board dashboard being developed, which tracks the indicators included in the JHWS. | | + | | |
| 5. Local Healthwatch is empowered to act as an independent and effective voice for users, communities and the public. | Healthwatch representative sits on board as a core member and is part of all development activity of the Board | | + | | |
| 6. The relationship between scrutiny and external regulators is agreed and an initial effectiveness review has been completed. | Scrutiny review process is still in development | | ? | | |
| 7. A clear framework exists for deciding on contentious issues. Decisions of the HWB are accepted and acted on by all member organisations. | TOR details meeting protocols and decision making | | + | | |

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

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| | Characteristics | Evidence | Owner | Status | Direction of Travel | Development need |
|---|---|---|---|---|---|---|
| Established | 8. HWB partners are able to have honest discussions about budgets and financial positions. | Informal meetings are programmed throughout the year to enable 'honest' discussions about budgets and financial positions | | ✚ | | |
| | 9. The HWB invites peer scrutiny and works constructively with regulators and scrutiny bodies. The HWB reviews itself regularly against benchmarks and adapts plans as necessary | Process still in development, some of which will be informed by national developments. However, the completion of this matrix demonstrates the Board understands the importance of self-review. | | ● | ⇧ | |
| | 10. The HWB receives regular and timely updates on progress against indicators and takes corrective action if necessary. | Process still in development, first Assurance report being presented to the Board in June 2014. | | ● | ⇧ | |
| | 11. The HWB can demonstrate it has considered and acted upon the views of local people, feedback obtained from the community and evaluation of citizen experience. | The only evidence currently is in process for the development of the JSNA and JHWS | | ? | | |
| | 12. The HWB seeks assurance on progress towards integrated care. | The current LHAC project will develop HWB assurance of integrated care | | ✚ | | |

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

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| | Characteristics | Evidence | Owner | Status | Direction of Travel | Development need |
|---|---|---|---|---|---|---|
| Mature | 13. The wider system understands how the HWB and related structures operate. | Still in development | | ? | | |
| | 14. Reporting and governance is evaluated across partners and streamlined where appropriate. | Still in development | | ? | | |
| | 15. Systems are in place to ensure decisions result in direct action across the partnership. | Still in development | | ? | | |
| | 16. Resources are pooled where appropriate, whether in back office functions or integrated commissioning, with good governance. | Evidence is not clear | | ? | | |
| | 17. Barriers to achieving priorities are identified and reviewed, and plans are in place to overcome/minimise these. | Evidence is not clear | | ? | | |

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| | Characteristics | Evidence | Owner | Status | Direction of Travel | Development need |
|---|---|---|---|---|---|---|
| | 18. The HWB regularly demonstrates and communicates its achievements of outcomes. | Still early in development of HWB and its activities | | ? | | |
| | 19. Whole system safeguarding mechanisms are in place, including accountabilities. | Still in development | | ? | | |
| Exemplar | 20 Integrated decision making, commissioning and governance are the 'norm' for the HWB. | | | | | |
| | 21 The HWB has an integrated 'whole system' (rather than individual organisation measures) outcomes framework of high level indicators supported by a 'dashboard' across the Health and Wellbeing system. | | | | | |
| | 22 Budget planning is open and resources are directed to support agreed priorities and improvements for local communities. Risk sharing agreement exists between the LA, CCG's and other relevant parties. | | | | | |

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

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**Lincolnshire Health and Wellbeing Board**

**Development tool evidence and action plan**

**Dimension – INFORMATION AND INTELLIGENCE**

Progress towards being a mature Health and Wellbeing Board for the **Information and intelligence dimension** is currently at **15%**

| KEY | ✚ Fully Evidenced | ● Partially Evidenced | ? Too early to evidence | ⇧ Improving | ⇔ Static |
|---|---|---|---|---|---|



| | Characteristics | Evidence | Owner | Status | Direction of Travel | Development need |
|---|---|---|---|---|---|---|
| Young | 1. The JSNA provides a clear population profile and identification of health and wellbeing needs of all local communities and identifies inequalities. | The JSNA has a range of indicators that considers different age groups and populations. Some of these indicators inform the JHWS. | | ✚ | | |
| | 2. Services and provision are mapped against local need and assets. | Not clearly evidenced.Initial Asset Assessment work undertaken but further work being done with VCS currently<br>JSNA to develop to support all aspects of the commissioning cycle including service provision, access and utilisation data sets | | ● | ⇧ | |
| | 3. Engagement structures are mapped and include and build on partners' own processes, e.g. Healthwatch. | Still in development | | ? | | |

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| | Characteristics | Evidence | Owner | Status | Direction of Travel | Development need |
|---|---|---|---|---|---|---|
| | 4. The HWB shares information and intelligence across members. | Not clearly evidenced. Partially for some areas | | ? | | |
| Established | 5. The JSNA is in the public domain and a 'real time' document and the engagement of local people is clearly evident in its development. | The JSNA is uploaded to the Lincolnshire Research Observatory website. An annual JSNA stakeholder survey is conducted, with topic reviews currently being conducted. | | + | | |
| Established | 6. The HWB understands the power of, and utilises, quantitative and qualitative 'voice' data, for examples, from service users, patients, carers and communities, alongside data from other sources to give a full picture of local needs and resources. | Limited evidence | | ? | | |
| Established | 7. Shared population data is used in individual partner organisations' business planning and feeds commissioning strategies. | Some references are made to the use of data Work undertaken in some localities to map the county level priorities within JHWS to the local population to support for local level prioritisation. Board need assurance that partners are using the JSNA as the shared evidence base. | | ● | ⇧ | |

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

*'Lincolnshire Health and Wellbeing board is taking the lead for better health in our county'*



| | Characteristics | Evidence | Owner | Status | Direction of Travel | Development need |
|---|---|---|---|---|---|---|
| | 8. HWB partner organisations have aligned their engagement structures and plans around key priorities so that there is a coordinated approach to involving and engaging communities and citizens. | Not clearly evidenced. | | ? | | |
| | 9. The HWB recognises where there are gaps in the intelligence base in the local population and has a strategic approach to ensuring that the information is understood . | The HWB has some awareness of the gaps in intelligence but are still developing the commissioning plans so the evidence gaps are not clear yet. | | ● | ⇔ | |
| **Mature** | 10. HWB informed by real-time intelligence, demonstrating improved outcomes, quality and efficiency across the health and wellbeing system. | Currently in development | | ? | | |
| | 11. Integrated information available to GPs, politicians and services users. | Currently in Development | | ? | | |

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

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| | Characteristics | Evidence | Owner | Status | Direction of Travel | Development need |
|---|---|---|---|---|---|---|
| | 12. Effective data and intelligence sharing across partners drives the development of shared strategies and commissioning plans. | Still in development | | ? | | |
| | 13. HWB monitors evidence of the outcomes from and impact of its strategy, and uses this to update JSNA and JHWS . | Still in development | | ? | | |
| Exemplar | 14 The HWB has the ability to aggregate data to CCG, district level and below (e.g. locality) | | | | | |
| | 15 The HWB has shared data resources accessible to all partners, which brings together all needs assessments and the wider determinant of health and wellbeing (e.g. housing, justice, child poverty, citizens views) | | | | | |
| | 16 The HWB understands the communities and their needs, has a single clear population profile across all partners and all services. It knows the total spend invested in an area and the extent to which that investment is being directed to meet the identified needs. | | | | | |

# LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open report on behalf of Jan Gunter, Designated Safeguarding Nurse, South West Lincolnshire CCG

| | |
|---|---|
| Report to | **Lincolnshire Health and Wellbeing Board** |
| Date: | **10 June 2014** |
| Subject: | The CQC Review of Health Services for Children Looked After and Safeguarding in Lincolnshire |

**Summary:** To inform the Lincolnshire Health and Wellbeing Board of the CQC Review of Health Services for Children Looked After and Safeguarding in Lincolnshire and the associated action plan submitted to the CQC in response to the recommendations of the report.

**Actions Required:**

Receive the report.

## 1. Background

This report records the findings of the review of health services in safeguarding and looked after children services in Lincolnshire. It focuses on the experiences and outcomes for children within the geographical boundaries of the local authority area and reports on the performance of health providers serving the area including NHS trusts, clinical commissioning groups (CCGs) and the local area team (AT) of NHS England.

Where the findings relate to children and families in local authority areas other than Lincolnshire, cross boundary arrangements have been considered and commented on. Arrangements for the health related needs and risks for children placed out of the area are also included.

The review was conducted under Section 48 of the Health and Social Care Act 2008 which permits CQC to review the provision of NHS healthcare and the exercise of functions of NHS England and Clinical Commissioning Groups

- The review explored the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements within health for all children.

- The focus was on the experiences of looked after children and of children and their families who receive safeguarding services.

- It looked at the role of healthcare providers and commissioners; the role of healthcare organisations in understanding risk factors, identifying needs, communicating effectively with children and families, liaising with other agencies, assessing needs and responding to those needs and contributing to multi-agency assessments and reviews.

The contribution of health services in promoting and improving the health and wellbeing looked after children including carrying out health assessments and providing appropriate services.

Further, it checked whether healthcare organisations were working in accordance with their responsibilities under Section 11 of the Children Act 2004. This includes the statutory guidance, Working Together to Safeguard Children 2013.

## 2. Conclusion

The CQC review was undertaken in November 2013 which included a site visit for I week by two inspectors. The review included case file tracking of the child's journey of a 10 highly complex cases involving a number of health agencies plus 53 cases that were dip sampled from case records and then tracked though each service they encountered across health including primary care.

The review identified areas of good practice, specifically around the interface between CAMHS and adult mental health services and the screening tools and vulnerability risk assessments utilised in the community services. The review also identified good partnership working and professional challenge. The review did not identify any issues that were unknown to commissioning and provider services:

  - Capacity of the designate professionals for safeguarding and looked after children for strategic leadership and commissioning planning.
  - Paediatric expertise within unscheduled care / A&E settings
  - The self- harm pathway is not embedded in practice
  - Variance in quality of the statutory health assessment for looked after children
  - The impact of externally placed children in independent care settings on local resources.

***Recommendations***:

- There were 25 recommendations made across 9 themes for both commissioning and provider organisations across Lincolnshire and NHS England Area Team.
- All themes include all four CCGs and are therefore being managed collaboratively and in association with NHS provider organisations.
- There are 45 strategic actions planned and included in the appendix of this report to address the recommendations which have been accepted.
- The action plan is being co-ordinated through the Federated Safeguarding Service Team.
- The action plan is RAG rated locally to monitor progress. There were no areas rated as Red on submission of the action plan to the CQC.

Whilst being a health review, it was acknowledged by the CQC that some recommendations require effective partnership working with the LA.

## 3. Consultation

Patients and staff were consulted during this review in line with CQC methodology.

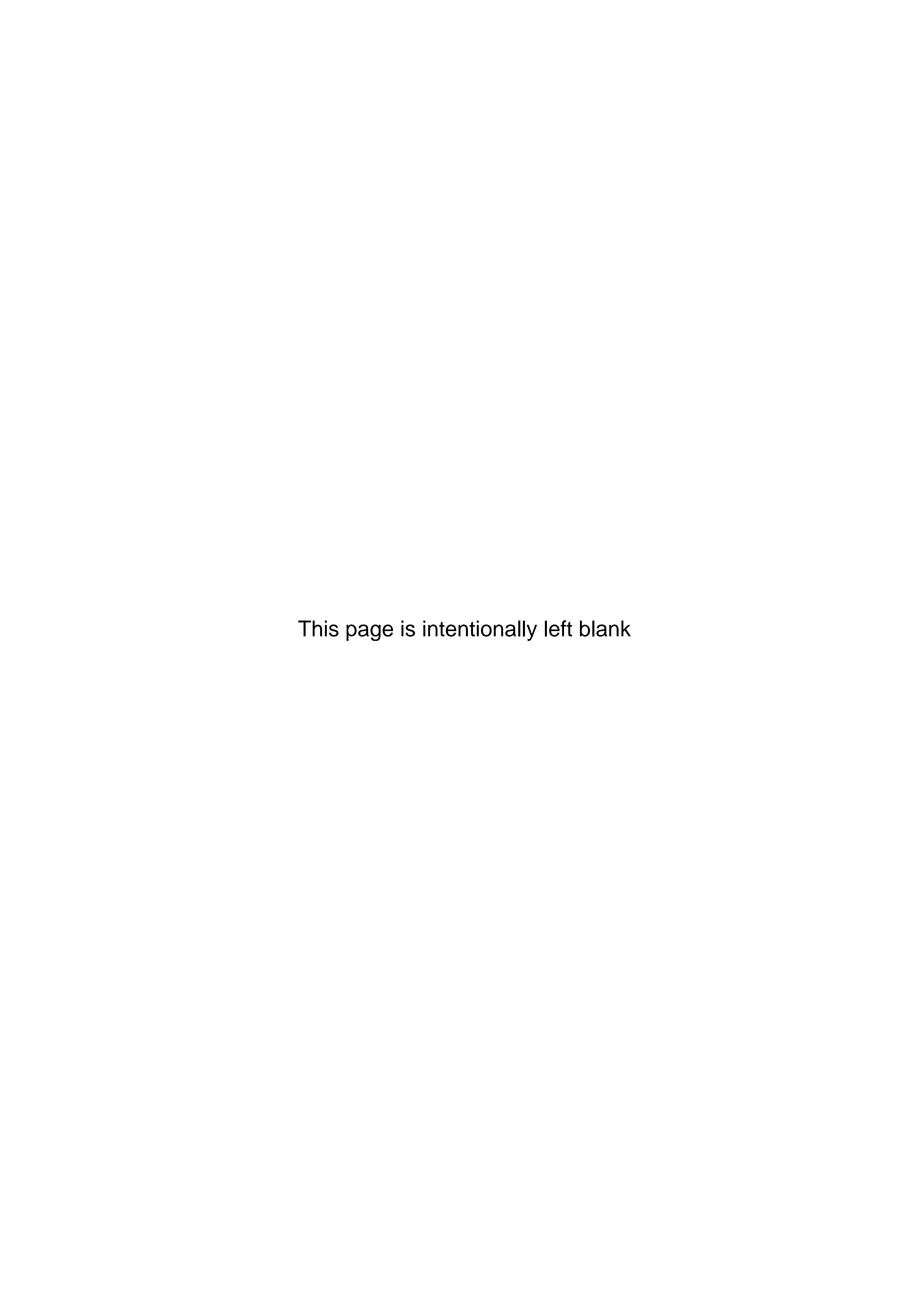
## 4. Appendices

| These are listed below and attached at the back of the report | |
|---|---|
| Appendix A | CQC Report |
| Appendix B | Action Plan in response to CQC Report |

## 5. Background Papers

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

This report was written by Jan Gunter Designated Safeguarding Nurse South West Lincolnshire CCG, who can be contacted on jan.gunter@southwestlincolnshireccg.nhs.uk



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# Review of Health Services for Children Looked After and Safeguarding in Lincolnshire

| Children Looked After and Safeguarding<br>The role of health services in Lincolnshire | |
|---|---|
| **Date of Review:** | **4th November 2013 – 8th November 2013** |
| **Date of Publication:** | **21st February 2014** |
| **CQC Inspector names:** | **Lynette Ranson, Jan Clark, Lea Pickerill** |
| **Provider Services Included:** | **Lincolnshire Community Healthcare Services, Lincolnshire Partnership NHS Foundation Trust United Lincolnshire Hospitals NHS Trust** |
| **CCGs included:** | **Lincolnshire West CCG; South Lincolnshire CCG; South West Lincolnshire CCG; Lincolnshire East CCG** |
| **NHS England Area:** | **Leicestershire and Lincolnshire Area Team** |
| **CQC Region:** | **Central East** |
| **CQC Regional Director:** | **Dr Andrea Gordon** |

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## Summary of the review

This report records the findings of the review of health services in safeguarding and looked after children services in Lincolnshire. It focuses on the experiences and outcomes for children within the geographical boundaries of the local authority area and reports on the performance of health providers serving the area including NHS trusts, clinical commissioning groups (CCGs) and the local area team (AT) of NHS England.

Where the findings relate to children and families in local authority areas other than Lincolnshire, cross boundary arrangements have been considered and commented on. Arrangements for the health related needs and risks for children placed out of the area are also included.

## About the review

- The review was conducted under Section 48 of the Health and Social Care Act 2008 which permits CQC to review the provision of NHS healthcare and the exercise of functions of NHS England and Clinical Commissioning Groups

- The review explored the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements within health for all children.

- The focus was on the experiences of looked after children and of children and their families who receive safeguarding services.

- We looked at
  - the role of healthcare providers and commissioners.
  - the role of healthcare organisations in understanding risk factors, identifying needs, communicating effectively with children and families, liaising with other agencies, assessing needs and responding to those needs and contributing to multi-agency assessments and reviews.
  - the contribution of health services in promoting and improving the health and wellbeing of looked after children including carrying out health assessments and providing appropriate services.

- We also checked whether healthcare organisations were working in accordance with their responsibilities under Section 11 of the Children Act 2004. This includes the statutory guidance, Working Together to Safeguard Children 2013.

## How we carried out the review

We used a range of methods to gather information both during and before the visit. This included document reviews, interviews, focus groups and visits. Where possible we met and spoke with children and young people and families. This approach provided us with evidence that could be checked and confirmed in several ways.

We tracked a number of individual cases where there had been safeguarding concerns about children. This included some cases where children were referred to social care and also some cases where children and families were not referred, but where they were assessed as needing early help and received it from health services. We also sampled a spread of other such cases.

Our tracking and sampling also followed the experiences of looked after children to explore the effectiveness of health services in promoting their well-being.

In total we took into account the experiences of 53 children and young people.

## Context of the review

Lincolnshire is the fourth largest county in England with an estimated population of 718, 000, of whom 22% are aged under 19 years. Approximately seven per cent of school age children speak English as a second language but in the Boston district, about one third of the population using local health services are from an eastern European country. The county has a spread of both urban areas and very rural, isolated areas. The percentage of children living in poverty ranges from 10% in a southern district to 24% in Lincoln. Approximately 580 children are looked after by Lincolnshire and another 400 have been placed in Lincolnshire by other local authorities. Approximately 400 Lincolnshire children are currently subject to a child protection plan.

Commissioning and planning of health services is led through the Children and Young People's Strategic Partnership, with the four CCGs and Lincolnshire county council as the lead commissioners. Acute hospital services are also commissioned jointly by the CCGs and are provided by the United Lincolnshire Hospitals NHS trust (ULHT). Lincolnshire community healthcare services (LCHS) provide health visiting, school nursing and children's therapy services, the looked after children's health service, sexual health services, two minor injuries units, two 24 hour access urgent care centres and a walk in centre. Health services for children with disabilities are provided through integrated arrangements between the council and CCGs, and joint funding arrangements are in place. Child and adolescent mental health services (CAMHS) and a targeted adolescent mental health service which works in partnership with schools are provided through integrated arrangements between the council and Lincolnshire Partnership NHS Foundation trust. A specialist mental health nurse works with the Barnados leaving care service in providing a care leavers' CAMHS transition service.

*The last inspection of health services for Lincolnshire's children took place in June 2010 as a joint inspection, with Ofsted, of safeguarding and looked after children's services.*

## The report

This report follows the "child's journey" reflecting the experiences of children and young people or parents/carers to whom we spoke, or whose experiences we tracked or checked. A number of recommendations for improvement are made at the end of the report.

# What people told us

We heard from several foster carers about their experiences of looked-after children's health assessments and reviews.

One parent told us how his child is deteriorating because of lack of physiotherapy input. The foster carers told us that they tell the GP as part of the health review and then nothing happens.

Another foster carer had better experiences; *"I have a 30 mile round trip to see the GP who does the health review. She is interested and doesn't just tick the boxes."*

We heard a lot of praise from carers for a particular consultant paediatrician: *"She really listens and treats you with respect*'.

Sadly, we also heard some young people and carers' very poor experiences of health practitioners. One young person told us: *"health staff don't talk to you."*

*"Some health professionals don't want to speak to foster carers. They say 'I need to speak to a professional".*

*"We had to use A&E over the Christmas period, we were told to go home with an inhaler. This is for a child who was deteriorating with his shunt. They wouldn't listen to his foster carers".*

Others commented on a range of communication and health planning issues impacting on children's health:

*"We wait too long for essential equipment. His current wheel chair means he can't wear winter clothes because he won't fit in the chair"*

*"There is no numbing cream for his eyes in the local hospital so we have to travel to Boston Hospital".*

*"We have been waiting for important emergency surgery that couldn't proceed because of getting consent. This is for a child who has complex health needs"*

Another foster carer told us: *"Getting the right equipment is difficult and we are told it's because of the budget. Why should our children suffer?"*

Foster carers we met were in universal agreement that the health professionals they meet do not understand the added needs of a looked-after child.

*"I haven't been able to get support or training for family members to be able to tube feed my foster child. This means I have to be there to do every feed myself, even though other family members would like to give me a break".* (Foster carer of a child with complex health needs"

One foster carer said how their 14 year old foster child was well supported by a nurse who made weekly visits and arranged for CAMHS and the smoking cessation service. However, the foster carer did not get any support or training.

We heard that the blue book, the local hand held record of looked after children's health history, hadn't been rolled out in a way that made it effective: *"The only reason he (the child) has his health history is because I save everything. GPs and other health professionals won't fill in the blue book, it's a complete waste of time.*"(foster carer of a child)

# The Child’s Journey

This section records children’s experiences of health services in relation to safeguarding, child protection and being looked after.

## 1. Early help

1.1 General practitioners (GPs) have an important role in early help in pregnancy as they are often the first point of contact for pregnant women in Lincolnshire; the information GPs send to midwifery is variable and doesn’t always ensure midwives have all the relevant information where early help might be needed. A new booking format has recently been introduced which carries more information and also gives more information to the mother and this should improve mothers’ access to early help.

1.2 Systems such as antenatal chronologies are in place to help early identification and monitoring of safeguarding risks in pregnancy. We saw a range of cases where midwives appropriately identified risks to protect unborn babies. However, some risks may be missed when these systems are not consistently used as in a case we saw:

*Some concerns had already been identified as the mother to be hadn’t disclosed at booking that an older child was placed with another family member; this part of the system worked well. However, the key antenatal chronology was not completed. It was unclear whether the community midwife was notified when the mother failed to attend her first scan, which is important to ensure prompt follow-up.*

1.3 Many children, young people and their families are helped by preventative and targeted support from health staff in seven local multi-agency teams in co-located bases such as community hospitals, health centres, children’s centres’ and GP’s surgeries. Co-location helps handover arrangements between midwives and health visitors which are generally effective and consistent in protecting vulnerable babies.

1.4 Community midwifery services try to maintain the same midwife throughout pregnancy as this gives mother and baby continuity but capacity problems mean this isn’t always the case. Never the less, we saw examples where pre-birth maternity care is very effective in identifying the need for support at an early stage.

*We saw an exemplar case of obstetric care of a pregnant teenager. Risks were discussed with her with great sensitivity and the young person was given time to reflect and consider her options. The maternity record is clearly written and of excellent quality.*

1.5 Vulnerable women or those for whom an increased level of risk has been identified are visited by community midwives for up to 10 days post natal, which is also good practice in protecting mothers and babies. Joint ante natal visits are common and the community midwife's final visit is usually a joint visit with the health visitor. We heard about some effective partnership work between health practitioners, social care, children's centres and schools to support families.

1.6 The well regarded peri-natal mental health service works with health visitors and school nurses to support improved outcomes for women in Gainsborough and Lincoln. Lack of service for new mothers in other areas of Lincolnshire is an acknowledged gap as the value of perinatal services is recognised; in the last two serious case reviews, workers had contacted peri-natal health for advice about the new mothers' mental health (recommendation 5.2). Many parents in the county access and benefit from IAPT[1] services to help manage anxiety and depression. The service works closely with the mother and baby unit (in Nottingham) and helps support gaps in local peri-natal services.

1.7 Although some health visitors and GPs work well together to identify families who might need help, this isn't consistent across the county. There is no agreed system in place, for instance for regular formal joint meetings between GPs and health visitors or school nurses (recommendation 4.2).

1.8 The needs of children in families where their parents have mental ill health are properly recognised through highly effective `*think family*` systems across adult mental health services. Safeguarding screening tools are embedded in mental health services working with adults and parents, ensuring that all adults accessing services are routinely questioned about children in their families so that the children's needs can be taken into account at an early stage.

*The IAPT early help mental health service helps many parents and ensures that risks to all children in the household are picked up, rather than just those for whom the adult has parental responsibility. The screening tool it uses is good practice. With the introduction of the IAPTus management information system, an already very sound system is being further strengthened.*

[1] Improving Access to Psychological Therapies (IAPT) provides access to brief counselling interventions

1.9 School nurses are engaged with all schools and provide school drop in sessions. They are kept up to date about current issues and risks, in order to offer early help, information and advice about issues that trouble young people. However, there is no countywide use of a substance use screening tool to assess young people's drug and alcohol use as part of any other needs assessments. Using a recognised screening tool to identify young people who might need more targeted help could improve their early access to services.

1.10 We found a general lack of clarity about any referral pathway from health services to Young AddAction which offers specialist help to young people who misuse drugs or alcohol (recommendation) A&E departments are also in a very good position to identify young people who are putting themselves at risk through drug or alcohol use. We heard that this is being addressed with a multi-agency protocol which is awaiting ratification by the LSCB. (recommendation 3.2).

1.11 Accident and emergency (A&E) staff make an otherwise fairly comprehensive assessment of the child or young person on admission, including details of parents. There are though, inconsistencies in clarifying who has parental responsibility. At Grantham A&E, children are prioritised and almost always seen within 15 minutes. The clinical triage notes indicate if the presenting injury or condition is consistent with the explanation offered. A note is also made of who is accompanying the child to the department. In A&Es and the minor injuries unit (MIU) we visited, we saw good safeguarding risk assessment by most clinicians.

*Spalding MIU identified and responded appropriately to safeguarding risks, notifying the health visitor, social care and MARAC about domestic violence witnessed by children and informing the parent about the referral being made.*

1.12 In case sampling at three acute care locations we saw that onward referral systems to ensure young people have access to early help are not robust. At the Pilgrim Hospital at Boston, A&E actions are not routinely recorded in the paediatric liaison nurse (PLN) folder and CAS cards are often left in a pile to await the PLN's twice weekly visit. Although the PLN and acute trust named nurse are working together to try to address this, compliance with the agreed safeguarding discharge protocol remains low. At Grantham we also saw a lack of clarity about cases referred to the PLN and their outcomes (recommendation 3.1).

*At the Pilgrim hospital's A&E we saw good work from staff in assessment of risks, effective questioning of the incident and treatment of an 18 month old little girl who had swallowed a small amount of oven cleaner. This case wasn't entered into the PLN liaison book however, to ensure there would be community follow up.*

1.13 Young AddAction provides a good quality, easily accessible drug and alcohol specialist service for young people that thoroughly assesses risks and engages young people very flexibly. On one file we were impressed how the Young AddAction service responded to the parent's concerns whilst respecting the views of the young person.

1.14 We saw examples of the work of the `vulnerable children's team' (VCT) which provides a specialist health service to meet the health needs of vulnerable children and young people, including children in public care (0-19 years of age) within Lincolnshire and those at risk of social or educational exclusion.

1.15 Where community health services are using the same IT system, information sharing about children at risk is supported across a range of services. This helps health staff to respond to the needs of individual children. As a result of the shared information system, regular liaison between MIUs and school nurses is now routine practice and enables improved understanding of concerns about young people in the county.

1.16 Where risks to the health, safety, development and wellbeing of children are identified we found timely and appropriate follow up to ensure the child's health needs are met, particularly among health visitors and school nurses. We heard that progress is on track to meet national health visitor targets, although case loads and capacity are variable currently and there is widespread use of nursery nurses in order to deliver the core offer. Unless there are child protection or child in need plans to mitigate risks to the child and mother, new born babies are handed over to nursery nurses for the universal service after 6 weeks; this potentially impacts on the ability to identify early needs for help.

1.17 Integrated GUM, sexual health services and family planning are provided in one stop clinics across Lincolnshire. Dedicated clinics for young people are not provided, but reception staff make sure that young people are seen by experienced staff. Clinical guidelines reflect national policy in that any young person aged 13 or under as well as any young person or adult with additional vulnerability is referred to children's social care.

1.18 Agencies are working together to try to increase understanding and develop provision to meet the health needs of eastern European migrants and their children. We saw how mothers are supported by obstetric consultants who are sensitive to patient's ethnicity and ensure interpreting services are provided as required. Midwives and community services have taken steps to better meet the needs of the Polish community in the Boston district including information leaflets and recruiting a Polish speaking midwife in each area of the county; some midwives have developed a glossary of Polish terms to help them in working with this community. The community services named nurse lead for diversity is very involved in developing greater understanding of cultural norms and ensuring that potential risks to the wellbeing of children in migrant communities are recognised and addressed.

1.19 We heard from several sources including Healthwatch about the impact of the shortage of paediatricians in Lincolnshire. All paediatricians in Lincolnshire are currently employed by the acute hospital trust. We heard that around the county it is hard for a child to get a paediatric referral and children have to wait for appointments which often impacts on their well-being. The limitations of available paediatric resources impact on children entering into care who may have complex or hidden needs (recommendation 1.3). Only the 10% who are being considered for adoption are seen by a paediatrician for their initial health assessment, all others are seen by GPs and then have to join waiting lists if more specialist assessment is needed. Some children and foster carers told us that they are not always listened to when they see a paediatrician.

1.20 We saw consistently determined efforts across health services to engage young people and families who are challenging or hard to engage. Non-attendance at clinical appointments is well followed up by most partners. GPs told us that they hear about missed hospital appointments but could be better engaged about risks in families if they were also informed about missed community health appointments.

1.21 The school health service has good engagement with schools countywide. Practitioners identify needs effectively and target additional drop in work at schools where young people are most at risk. We saw some effective individual work too, for example, a teenager in a very chaotic family for whom engagement and support from the school nurse is instrumental in ensuring his fundamental needs are met.

1.22 Staffing turnover and reducing capacity in the school health service presents a threat to continuing the current level of engagement which is helping to safeguard all school age children, for example capacity in the north east sector, where there are high levels of need, has been significantly challenged during 2013.

1.23 Vulnerable children and families in Lincolnshire benefit from the range of children’s centres and also have access to some health-led early help services which are effective in delivering positive outcomes; in particular the young expectant parents group (YEP) run by community midwives is accessible to all young parents. The 10 week course starts and finishes at different times ensuring there is no delay in young parents starting with the group. Young people can attain a qualification equivalent to a GCSE. Recently a YEP cycle has run for a small group of five 14 year old young people who all joined at the same time. Young people feedback that they found this highly supportive and helpful.

1.24 The number of teenage pregnancies has reduced year on year, as in most parts of England though latest data shows that the rate of 1.7 is worse than the rate for the East Midlands region and the England average rate of 1.3. Teenage pregnancies are highest in the Lincoln area although we did not see targeted activity to address this or the impact on the life chances of these young parents and their children.

## 2. Children in Need

2.1 Midwives carry out thorough assessments of risk and where concerns are identified, these are shared early. Vulnerable mothers are supported by targeted ante natal care from health visitors from 26 weeks currently though this is changing and will be available as soon as a pregnancy is confirmed.

2.2 Children in need and their families are helped by multi agency team around the child (TAC) groups based on the common assessment framework (CAF). This is an embedded model of supporting children in need and may be led by a range of professionals including health staff and schools. This is delivering good outcomes where parents are in agreement with the setting up of a TAC. We saw a good example where a child protection plan was replaced by a child in need plan when the child moved into the county and the child is supported by a TAC in which her school nurse is an active partner.

2.3 Young people who may be reluctant to engage with CAMHS services are supported to access the service by a sensitive policy on non-attendances. We saw examples where workers sought to engage the young person for as long as possible and used different routes to try to do so rather than closing the case. Effective and separate work can be done with parents or foster parents to support them when a child is working through difficult issues supported by CAMHS.

*We saw an exemplar case of effective, sensitive support by health services in Lincolnshire for a young person who had suffered serious sexual exploitation before being placed in Lincolnshire by another council*

2.4 The contraception and sexual health service (CASH) appropriately explores risks to identify safeguarding concerns and potential sexual exploitation of young people. This includes asking the young person for the age and name of their partner and whether sex had been consensual. Services ensure that children aged 13 and under are identified as being potentially at risk by an automatic flag on the CASH database. All cases of concern had been referred to children and families social care. However, we did see a number of cases where children aged 13 and under had a contraceptive implant in situ and the CASH could not identify the source of these implants. This indicates that some GPs or other family planning practitioners are unaware of guidance and policy to safeguard these vulnerable young people (recommendation 4.2).

2.5 CAMHs employ some very good self-assessment tools and aids in working with young people to enable them to explore their emotional journey and to assess their progress and personal growth. Many young people have timely access to services, especially at tier 3 where the average wait is just over three weeks. However, increased demand and holiday arrangements led to some delays during several months in 2013, for example for tier 2 primary CAMHS, 61% were seen within the six week target (recommendation 5.1).

2.6 Significant numbers of young people in Lincolnshire have complex needs including self-harming behaviours. The most recent national data set on hospital admissions as a result of self-harm reported a rate of 127 (or 177 admissions), significantly higher than the England average rate of 115 and with increased numbers being seen since this data.

2.7 Many of the young people presenting at A&Es in Lincolnshire have been placed by other councils without first ensuring their health needs can be met in Lincolnshire. We saw several cases where health professionals in Lincolnshire had worked hard to engage with and try to ensure that young people received appropriate help.

2.8 Problems in access pathways from A&E services to CAMHS were flagged as an issue in the SLAC inspection in 2010. The LSCB has since co-ordinated work to simplify pathways. A case example suggested further exploration by commissioners would be warranted to ensure effective planning for Lincolnshire children returning from out of county placements ensures there are smooth and robust pathways to support them. The self-harm pathway of overnight admission to a paediatric ward and assessment by CAMHS is providing good support to many children and young people. However, there continue to be cases where this pathway does not work well and children's access to appropriate support is delayed as professionals try to balance these needs with the needs of other children on the paediatric wards (recommendation 9.1)

2.9 These cases are usually resolved through the intervention of the CAMHS consultant liaising directly with the paediatric consultant. We heard that work is in hand across partnership agencies to resolve this long standing issue including a trial at Lincoln hospital which is providing two additional members of staff to provide additional support where young people are admitted to the paediatric ward for CAMHS assessment. Use of the self-harm pathway at Pilgrim Hospital is also being closely monitored by the named nurse as it has not always worked effectively (recommendation 3.1).

## 3. Child Protection

3.1 Most health professionals recognise safeguarding thresholds and their professional accountabilities for keeping children and young people safe. School nurses, for example, understand their role in safeguarding and make appropriate referrals when they identify concerns. In one case we saw that a school nurse took appropriate actions in making a safeguarding referral when a 12 year old child disclosed sexual activity and concerns about a possible sexually transmitted disease (STD).

3.2 Health professionals are making prompt referrals to social care when they have concerns about risks to children. However, we saw a common theme across a number of services with examples as in the following paragraphs where risks to children are not being clearly articulated and health managers are not quality assuring referrals to support practice development in this key area (recommendation 7.2).

3.3 Most referrals from midwives to social care about pre-birth concerns are made electronically but not routinely printed off and placed on the mother's record. This approach means the named midwife or supervisory staff are unable to review and audit the quality of referral to ensure that the risks to the unborn are clearly articulated. Some midwives do print and file their referrals and this practice is to be encouraged (recommendation 7.2).

3.4 Midwives are skilled at identifying unborn babies who might be at risk, they are making early referrals to social care and alerting the named midwife. The recent introduction of a pre-birth protocol is a positive development but its effectiveness had not yet been reviewed by partners (recommendation 7.4). This review identified areas for development in the protocol to ensure health staff including GPs and midwives will in future be involved in core assessments through early establishment of a TAC[2] where concerns are raised about risks to unborn babies as this strengthens the involvement of health staff (recommendation 8.1).

*The mother to be, a looked after child with complex needs herself, was well known to a range of health professionals who were concerned that her chaotic and risky lifestyle represented risks to the wellbeing of the unborn baby. These risks were inadequately identified in the notification to the named midwife. Though the poor history of the young woman was set out, concerns in relation to her ability to parent the child effectively and the likely early delivery were not mentioned (recommendation 7.2).*

*The core assessment inaccurately attributed the midwife as having "no concerns" despite high levels of concern among professionals familiar with the expectant mother. This case highlighted areas for development within the pre-birth protocol to ensure early multi agency involvement in decision making. We referred the case back for review and appropriate action was taken (recommendation 7.4).*

[2] Team around the child

3.5 We reviewed a case where concerns about parenting capacity have been present since before the first child's birth three years ago. This case demonstrates a cluster of known risk factors including missed appointments, avoidance, deteriorating mental health, increasing misuse of alcohol, problematic living conditions, and risks from a large dog. Whilst there have been diligent attempts at engagement with the mother, health records we saw lacked clear assessments about the impact on the wellbeing and development of the small child or the then unborn baby and a lack of clear planning. We saw no evidence of multi-agency meetings prior to the second baby's birth or of decision making about parenting capacity or risks to the baby or young child. Although a TAC was suggested recently, as concerns multiplied, the protocol requires the agreement of the family. In this case when the parent declined a TAC, there was a further period of slippage during which concerns increased. The case had recently been escalated to child protection.

3.6 Identifying risks to children through the use of a vulnerability and resilience matrix is a good model is now being used in health visiting and, we heard, more widely in other agencies undertaking assessments of risk. This can support practitioners to evaluate a case more effectively and to make good quality referrals to children's social care. The very newly implemented electronic version should further help community health practitioners to make referrals which set out risks more clearly. Some staff are currently unclear on the expected usage of the electronic matrix however (recommendation 8.1).

3.7 Another of the cases we saw involved long standing neglect which has continued for many years despite CP and CIN plans but the mother's behaviours and needs impact on her ability to parent her children. Since recent re-escalation to child protection brought an experienced school nurse's involvement to the family, she has used considerable skills to win acceptance of the mother and has started to address the son's unmet health needs.

3.8 We also saw an example case where the GP took prompt and appropriate safeguarding action in response to a disclosure that a child had witnessed a domestic violence incident. The GP did not however, clearly articulate the risks to the child in his report to conference (recommendations 4.1, 7.2).

3.9 Overall, GPs are keen to improve their safeguarding practice and positive progress has been achieved under the leadership of a very committed named GP. GPs recognise how important it is for the GP to attend child protection meetings if possible. Short notice periods and scheduling during surgery times are obstacles to improving GP attendance. Alternative means of securing GP participation such as teleconferencing have not been explored.

3.10 Where child protection plans are in place and adult mental health, including peri-natal mental health, are engaged with the parent, practitioners are very clear on their role in protecting the child. We saw an example where adult mental health practitioners were actively ensuring that the mother was compliant with the child protection plan and reported this back to conference.

3.11 We saw a `*think family*` approach in the work undertaken by LPFT's Drug & Alcohol Recovery Team (DART) with adults who misuse drugs and alcohol and who have children. Risk assessments, screening tools and a parenting check list ensure there is a joint focus on the needs of any children present in the family. We also saw good examples of contingency planning within recovery plans should a client fail to engage which is good practice.

3.12 However, outside of formal safeguarding meetings and conferences there was some evidence that the Drug and Alcohol Recovery Team (DART) workers did not always share information and concerns with other agencies in a timely manner. Other agencies who are monitoring risks to children are often reliant upon the client passing on and disclosing information that may be unreliable. We saw a lack of consultation between the adult drug and alcohol service and midwives for their clients. In one case we saw, the woman had disclosed on going substance misuse to the drugs worker but this information had not been shared with the midwife. This means that the midwife was not aware of information that could impact on the safety and wellbeing of the mother and the unborn baby (recommendation 7.3).

3.13 The drugs and alcohol team advised us that they are not asked to provide information to children in need meetings involving parents who receive support from their service. They also advised us that they are not consistently invited to relevant child protection meetings and often experience late receipt of minutes of CP meetings (recommendation 7.3). We heard that work is underway between LPFT and children's service managers in respect of drug and alcohol issues for parents based on the Ofsted/CQC 2013 report, "*What about the children*?"

3.14 Health professionals routinely participate in strategy meetings when they are invited; the expert knowledge about the child from school nursing, health visiting and midwifery can be instrumental in decision making about the level of intervention likely to deliver the best outcome for the child. Pressures on the school health service and the skill mix of a very limited number of more senior nurses, risks capacity for this valuable part of the role.

3.15 Health professionals prioritise attendance at child protection conferences and core groups and prepare reports as needed. Some reports lack the detail that would make the best contribution to multi-agency decision making. GPs are unclear what information to include when they submit reports. There is no agreed report template which they would find helpful and which would optimise their professional contribution to case conferences (recommendation 4.3).

3.16 Resources available to young people in the county aged 16 or under who have significant mental health needs include T4 CAMHS in-patient service provision. Young people are sometimes placed out of county in accordance with NHS England's commissioning protocol either to suit their circumstances or when the local places are already full. It is rarely necessary to admit a young person aged 16-17 to an adult ward. Though we noted from Trust papers that this had occurred on two occasions in 2013, reports provide assurance that both of these young people were supported by appropriate safeguards.

*CAMHS are providing good support to a young person who had experienced significant abuse resulting in criminal proceedings. The tier 3 CAMH service liaises carefully with other agencies including the Crown Prosecution Service (CPS) to ascertain whether outside issues are likely to impact on the child's mental health and to take the work at the child's pace. This is more likely to result in positive outcomes for the young person.*

3.17 Where child protection plans are in place and adult mental health, including peri-natal mental health, are engaged with the parent, practitioners are very clear on their role in protecting the child. We saw an example where adult mental health practitioners were actively ensuring that mother was compliant with the child protection plan and reported this back to conference.

3.18 Our case sampling in A&E identified that processes and arrangements do not currently ensure that A&E attendances by children for whom risks are identified will be robustly followed up. This is especially important where children move between areas or live out of county. We saw an example of a young person for who effective follow up was required but the notification was a brief, routine, system-generated letter to a GP although staff have the option to provide individualised information. In cases of risk and self-harm, these arrangements are insufficient to alert receiving primary care team (recommendation 3.1):

*A 13 year old girl from a neighbouring county was brought to Grantham A&E after taking a deliberate and significant overdose of medication to harm herself. Staff also identified previous self-harm and did a good job of triage, assessment, gleaning important information and alerting receiving hospitals. Some inconsistencies in the circumstances needed more exploration but suggested additional concerns. The case number was added to the PLN's list for her next weekly visit. A routine PAS system generated letter to her GP contained insufficient details to prompt any special follow up.*

3.19 Young people from 14 years old are well supported by the sexual assault referral centre (SARC) at Spring Lodge, Lincoln when they need to access this service. Effective work by the ISVA[3] ensures the young person receives appropriate aftercare.

3.20 We saw some good, persistent work by skilled community health practitioners to promote the health of children in vulnerable families and children subject to child protection plans. In one case, since the school nurse's involvement as part of the core group, she has successfully gained the trust of the mother and has started to address the child's unmet health needs by getting him registered with a GP and dentist. We also saw an example of good multi-agency working to explore strategies to manage a child at high risk of serious self-harm. An appropriate out of area placement has been secured and the child is doing well.

[3] LPFTs Independent Sexual Violence Advisors (ISVA) service

3.21 Barnados are commissioned to provide an effective care leaver service. All young people have a pathway plan which includes a health component but a positive new development, also provided by Barnados, is the CAMHS transition service. This has been particularly effective in helping young people who have left care to overcome often long standing and unresolved emotional and mental health concerns. The Barnados services working closely with the vulnerable children's nurses and also act as advocates for young people. We saw a number of examples of the impact of this work, including:

***Case example:*** *Barnados worked closely with the community mental health team to successfully maintain a female care leaver in education. A positive outcome from multi-agency working.*

***Case example:*** *A young male care leaver with autism. Helped into supported living and employment. Targeted CAMHS was able to clarify which of his needs were down to the autism and which were functional mental health issues. As a result, he was able to access the right level of support.*

3.22 Care leavers have not until now had the support of a dedicated pathway to ensure that their needs and those of their unborn or new babies are addressed. However, having identified an increasing number of pregnancies amongst care leavers, the looked-after child health team and Barnados are putting together a work plan for this (recommendation 2.4).

## 4. Looked after Children

4.1 The number of children in the care of Lincolnshire county council has steadily risen since 2010, to approximately 580. Additionally, children in the care of other local authorities are increasingly being placed in new private sector care homes within Lincolnshire, currently about 400 children. Assuring the health and wellbeing of such a large number of children, many of whom have complex needs is a significant challenge. Health agencies are fully involved in the safeguarding partnership's work to identify themes and seek resolutions. This is most notable in last year's project in which analysis of intelligence about a cohort of children most frequently reported as missing identified and intervened in respect of child protection and sexual exploitation concerns for all. The continued influx of children placed by other areas into private residential services in Lincolnshire without first ensuring their complex health needs can be met is presenting a particular challenge to a range of local services.

4.2 Whilst there is a protocol for moderate to high scores in strengths and difficulties questionnaires to be reviewed, there are no arrangements to monitor this or to collate outcomes to ensure that children in care are receiving the right services to meet their needs. The arrangements needed to be strengthened by developing monitoring and audit to ensure that individual SDQ scores of 14 or above are reviewed by specialist professionals; that changes to the health care plans are considered and implemented where necessary and that there is more visible tracking of subsequent scores to indicate outcomes of interventions (recommendation 2.1). Since this review, children's services re-launched the SDQ review group and procedure to monitor children with scores over 14 at a children's services team managers' meeting. Attendance at the group includes educational psychologist, CAMHs, LACES (education services) and LAC managers. This is in its early stages and should be monitored for process and outcomes, including the involvement of practitioners who undertake assessments and reviews.

4.3 We found that more needs to be done to ensure the link of general health and mental health evaluations in order to provide timely specialist help. The SDQ[4] scores of a high proportion of young people who have been in care for longer than a year indicate concerns deserving closer analysis and attention given that they are significantly higher than national averages. The designated doctor has flagged up the need to ensure that health reviews take into account all available information about the holistic health needs of looked after children including their emotional wellbeing but progress is slow (recommendation 2.1).

4.4 The specialist vulnerable children's team has oversight of the health needs of children and young people as they move through care. We identified positive relationships with children and young people and the VCNs effectively engage with children and co-ordinate their support. Outreach work by VCNs and CASH staff in some children's homes is valued by care staff.

[4] SDQ – strengths and difficulties questionnaire, an annual national survey to assess the emotional well-being of young people who have been in care for one year or more

4.5 Management of the extensive volume of health assessments is supported by a co-ordinator and administrative staff. Even so, children's initial health assessments (IHAs) are too often affected by delays, often as a result of late notification of placements by social care staff. GPs are being encouraged to direct requests for health assessments for children placed by other areas through the co-ordinator but at present there is no reliable system to ensure oversight and quality assurance of these assessments (recommendation 2.5).

4.6 Looked after children can access support from a dedicated primary CAMHS service which engages well with a range of other health practitioners who support the child. We saw examples where children are benefitting from imaginative child focused interventions which move at the child's pace, providing every opportunity for the child to evaluate their own progress.

4.7 Unfortunately with the increased number of children in care locally, demand for the looked-after children primary CAMH service can outstrip supply. At times children wait longer than the four week target for initial appointments; as many were waiting as were being seen in some periods. In August 72.5% of looked after children were seen within four weeks, compared to the 95% target. This worsened in September when only 49% of looked-after children who were referred were seen within 4 weeks. LPT monitors performance closely and ensures that commissioners of CAMHS services are aware of difficulties. Positively, we understand that some additional resources were found to increase service capacity during 2013 (recommendation 5.1).

4.8 Care leavers who have accessed CAMHS and meet adult service thresholds have a seamless transition pathway from CAMHS, as CAMHS and adult mental health have the same provider. A looked-after child can usually access CAMHS up to the age of 18 with a transition starting at 17.5 although this can be extended for example, to support a young person moving onto university. This is good practice.

4.9 Work has been done to improve compliance with statutory expectations that all children and young people coming into care benefit from a timely assessment of their health (an initial health assessment) and a comprehensive plan to meet their health needs. More children are having their health needs assessed within the statutory timeframe but this is from a low base and less than half (40 – 45%) of children entering care have an assessment within the timeframe with some considerably delayed. Recently introduced reporting now clearly sets out points of delay and this has assisted the improvement. Even so, the reasons for delays are not always clearly set out or understood.

4.10 The quality of GP initial and review health assessments is highly variable and is a priority area for development. From examples of very good practice, reflecting a comprehensive assessment of the child's health and wellbeing and highly reflective of the child as an individual; we have seen assessments of unacceptably poor quality: hand written and mainly illegible containing the most basic information, with no sense of the child as an individual and no attempt to reflect the voice of the child. Despite the efforts of a highly committed designated doctor, the quality assurance process for health assessments and reviews lacks rigor and is not sufficiently robust (recommendation 2.5).

4.11 The quality of health plans is also very variable. Some are comprehensive and child centred with good efforts made to engage children, others are not. Some good assessments are weakened by poor quality health plans which lack measurable objectives, timescales and accountabilities (recommendation 2.5).

4.12 It has been recognised for a number of years that looked after children have not had the quality of health support service which they need :

*Several foster carers we met felt that their role in supporting and advocating for children with disabilities was not recognised by health professionals. They are not routinely sent copies of the child's assessments or health plans and are often excluded from assessments, reviews and important discussions about health needs. One foster carer told us how health professionals had held an end of life discussion about the child she has fostered since infancy and had not included her.*

4.13 A looked after child's health plan should identify the health support each child needs and be reviewed and revised after each assessment. However, foster carers told us about their experiences of the ineffectiveness of arrangements in meeting the children's needs.

4.14 They explained how assessments and reviews are stand alone, not linking into other medical assessments and appointments. Case files also showed that reviews and health plans could have greater impact if all available information, such as annual and specialist SDQ's, or updates from specialists was drawn together in advance, so that all needs including emotional well-being are considered at the time of the health review.

4.15 Looked after children have good access to primary care, they are promptly registered with GPs and dental checks and immunisations are arranged for almost all looked after children. Community health staff use IT to record heights, weights and immunisations which helps to track progress and identifies gaps.

4.16 The records we saw showed that most health reviews are episodic and are not informed by the previous review although these are routinely sent to the GP to inform the current assessment. The child's own GP is not asked to contribute their often extensive knowledge of the child before the review. As we saw and heard from foster carers, where other services such as paediatricians or other specialists, CAMHS or therapies such speech and language SALT are involved with the child, their knowledge of the child is not contributing progress information to the health review (recommendation 2.5). We heard from a foster carer about their concerns that health reviews give insufficient attention to the health needs of young people with disabilities who will be leaving care: *"There is no preparation for young people turning 18. I told my young person about the birds and the bees.*"

*"Now he does get fast tracked to the paediatric ward but it has taken ages and lots of admissions for that to happen."*

4.17 The high numbers of children placed into Lincolnshire from other areas challenge all facets of the service. School nurses demonstrate dogged determination in obtaining information from professionals in other placing authorities about children for who there are safeguarding concerns. Diminution of the capacity of school nursing risks losing the most effective part of the safeguarding system in its reach to school age children.

4.18 Looked-after children are well supported by knowledgeable and committed vulnerable children's specialist nurses. They work closely with residential staff, foster carers and a wide range of other professionals and are well regarded.

4.19 There are significant difficulties in ensuring that appropriate equipment to meet the assessed needs of looked-after children with complex disabilities is provided in a timely way. This is a long standing frustration for foster carers. One told us that as her foster child has outgrown his wheelchair, he cannot wear his winter coat when he goes out as he cannot fit in the chair. These difficulties are indicators that health services and health care plans are not effectively supporting looked after children's health needs (recommendation 2.2 &2.5).

*"We got him a new chair and it took four and a half months for someone to come out and fit the parts so he could use it."* (foster carer of a child with disabilities)

*"Depends on the social worker in terms of what support you get. Therapy support helps you maintain the placement".*

4.20 We saw case examples where help for young people was delayed because the access pathway for the looked-after child CAMHS service does not accept referrals from the vulnerable children and young people specialist team. They often know the child best and in some cases this would have expedited a child's access into a service likely to result in good outcomes. We understand this was addressed following our review.

4.21 Insufficient attention is paid to ensuring that care leavers have access to their full health history and this is an issue which is of great importance to many young people who leave care. While the provision of the blue book has the potential to provide a comprehensive health history for when the young person leaves care, foster carers told us that most health professionals, GPs, dentists and specialists are reluctant to make entries, diminishing its value to the young person (recommendation 2.3).

# 5. Management

*This section records our findings about how well led the health services are in relation to safeguarding and looked after children.*

## 5.1 Leadership and Management

5.1.1 CCGs and NHS England's area team (AT) provide good leadership to continuously improve health safeguarding and children looked after arrangements.

5.1.2 Lincolnshire's CCGs have put in place a reporting and accountability framework for safeguarding children, including those who are looked after. This has the potential to deliver improvements and ensure effective governance. There is a shared acknowledgement of the challenges and priorities for improvement. Strengthened governance arrangements are in place for the early identification of learning points from serious case reviews (SCRs) for monitoring and evaluation and to ensure timely action is taken to improve services.

5.1.3 At the time of the SLAC in 2010 completion of health assessments was poor. Revised arrangements were developed to recruit GPs on local extended contracts for this work. This has involved a great deal of work and has improved access to health assessments though such a disparate service has struggled to achieve the expected quality and more sustainable arrangements are needed. Senior managers recognise that more needs to be done to secure quality across their responsibilities for both safeguarding and health care for children who are looked after (recommendation 1.2).

5.1.4 Challenges to the leadership resource for the significant task of driving both safeguarding and looked after children's health agendas across a large county is recognised by the CCGs. An external review has been commissioned. The designated professionals all have limited capacity to develop and drive comprehensive plans for changes across the health economy (recommendation 1.1). We found that they are all respected and committed professionals working hard to address challenges many of which are long standing and require more strategic solutions.

5.1.5 Prompt investigative action has been taken in response to our concerns about a case we sampled at A&E where an inadequately managed discharge from an out of county in-patient mental health unit resulted in the child self-harming and requiring emergency treatment.

5.1.6 Information technology is increasingly supporting timely and effective exchange of information especially in the community. Increased use of NHS secure internet and more electronic records has speeded up notification processes. As in many areas, lack of connectivity between the main health providers remains a barrier to effectiveness. Wide use is made of electronic records in many services but LPFT, ULHT and CASH all use different systems which cannot connect. A bid to link these health service data bases is with NHS England.

5.1.7 There are some strengths here, for instance the data base used in community services, therapies, by community paediatricians based in ULHT, and all but one of the looked-after children GPs. Not all GPs use the system, but where they do they can enable other LCHS staff to view specific records. The community health data base has also been provided for read-only use by A&E staff in the acute hospitals. However, A&E and other key health professionals do not have direct access to terminals with the social care data base which is possible in many other areas of the country. This means staff need to make phone calls to check whether children and families are known to social care and it is acknowledged that there can be difficulties in making timely contact in this way. Positively, health partners have been consulted in relation to social care's planned system upgrade.

5.1.8 The use of audits has contributed to improvements in the quality of some looked-after children's health assessments but overall quality remains inconsistent.

5.1.9 There remain unmet pressures on capacity and skill mix for carrying out health assessments compared to the volume of work and complexity of needs of children coming into care. The 2011/12 Annual Report on the health of looked after children highlighted the variability in the quality of health assessments and health care plans and recommended that community paediatricians should undertake IHAs (recommendation 1.2). Children and young people have not benefitted from any progress towards this recommendation though audit evidence was used recently to request a review of arrangements for IHAs at safeguarding steering group.

5.1.10 Strategic partnership working is good. Health strategic leads describe positive relationships across the partnership and particularly with the director of children's services who also has a health background. Strategic leads meet regularly and partners are able to have a mature dialogue about a range of issues and common themes. Strategic managers identify an improved connectivity between strategic management and frontline operational staff. Operational managers are increasingly seeking multi agency solutions when issues are identified though some intransigent problems have yet to be resolved fully. CASH services in Lincolnshire are not formally represented in the partnership that is addressing sexual exploitation and this is a gap since the service will be able to contribute strategically and in respect of operational issues and individual cases (recommendation 4.2).

5.1.11 We heard about an example where the named GP was able to liaise with social care when an issue was identified by GPs. As a result, social care's processes were amended to ensure that GP calls are now logged to contribute to risk assessment about children and their families.

5.1.12 Partnerships with and in CAMH services are improving but case examples showed a range of issues where better coordination between services could improve outcomes for young people and their families. This is evident where support for young people who attend A&E's with emotional, behavioural and mental health needs continues to be inconsistent as professionals struggle to reconcile the needs of different groups of children. We also saw the significant impact of poor discharge arrangements and communication from an external T4 CAMHS which failed to ensure that local services are in place (recommendation 5.3).

5.1.13 Families with foster children told us how better co-ordination between health professionals would benefit the young people by ensuring their health needs are fully taken into account.

5.1.14 We saw little evidence that the views of children, their families and carers are regularly heard and taken into account. Much more focus is needed to ensure that children and young people are encouraged to regularly share their views and experiences in evaluating the quality and impact of local health services (recommendation 7.1).

*The community health trust's recently strengthened arrangements for safeguarding leadership were bringing the important health perspective to child protection strategy discussions. Through a rota system, the county-wide team of deputy named nurses is available at any time and this is an imaginative response in a large county area.*

5.1.15 We found that health professionals recognise the value of team around the child work but in some areas of work, capacity issues prevent their involvement, with this being a particular issue for staff employed by ULHT. Capacity within the ULHT safeguarding team generally has been flagged up in CQCs compliance inspection of this trust. The children's safeguarding team of two health professionals liaises with the named midwife team and the adult team. Operating across several disparate sites and ensuring an effective safeguarding partnership with other providers adds to the challenges of the role.

## 5.2 Governance

5.2.1 Each trust has governance arrangements in place which include regular reporting on local safeguarding arrangements.

5.2.2 NHS England and the four CCG's have given high priority to the work needed to continuously improve safeguarding and children in care health services. The priorities for safeguarding are currently clearer than for children in care. Through a memorandum of understanding between the four CCGs, this work is led by Southwest Lincolnshire CCG, its chief nurse, and the designated professionals.

5.2.3 Progress has been made in some areas and the designated nurse for safeguarding and looked-after children is providing strong leadership. However, she and other designated professionals have insufficient capacity for strategic planning, comprehensive quality assurance of operational delivery and ensuring continuous improvement (recommendation 1.1).

5.2.4 The capacity of the looked-after children health team has not kept pace with the growth in numbers of looked-after children in the county, including high numbers of children placed by other councils and the complexity of needs. Well over 1000 health assessments and reviews are required each year, with significant preparatory and follow up work including quality assurance of the assessments and health plans. Although efficiently supported by the co-ordinator and administrative support, the designated doctor's allocated one session per week is inadequate to deliver the strategic role and quality assurance work. The designated nurse role is also challenged in seeking to deliver the full statutory role with approximately one third of a post for LAC work and one third for children's safeguarding leadership. These pressures impact on capacity to drive and embed quality standards across the large county (recommendation 1.1 and 1.2).

5.2.5 We found that performance reporting arrangements around the holistic health needs of all looked-after children, the services to meet their needs and the outcomes that are achieved is insufficient to ensure that looked-after children receive the help they need (recommendation 2.2). The format of the annual report on the health of looked-after children is quite narrow in scope. This misses the opportunity to set out the full picture of their needs and outcomes and to identify key issues that are of concern to looked-after children generally or to local children in particular. Limited performance reporting about needs, outcomes and gaps in services for looked-after children impacts on the ability to make robust plans to deliver improvements. Information about the health needs of looked-after children with long term conditions is not currently collated from their individual health assessments. This results in a lack of oversight of the capacity of services to meet their current needs and that their health needs are recognised in transition planning for their future. This remains an outstanding action although identified by the looked-after children service to be addressed during 2012/2013 (recommendation 1.2).

5.2.6 The community trust provides paediatric liaison nurses (PLNs) in A&E departments run by ULHT and at the minor injuries units (MIUs). In some locations we found un-explained gaps in referrals to the PLN and a lack of managerial oversight or quality assurance. As a result, it is not clear that staff across acute services properly regard this as a whole system approach and there are inherent risks that children are not effectively protected. The addition of the new MIU at Peterborough to the portfolio of the paediatric liaison service has added significant pressure on the capacity of the service, which is already stretched (recommendation 3.3).

5.2.7 Within ULHT strengthening of safeguarding has started to progress with the appointment of an interim named midwife, a new post currently at Band 7 created in response to a serious case review as the role did not exist before March 2013. The named midwife post is an integrated role within ULHT, supported the safeguarding leads for adults and children. Managers recognise that the role requires the greater seniority and experience of a Band 8 midwife and a business case is being developed to seek appropriate recruitment of suitably qualified midwife. The current post holder is doing a good job from a zero base but has insufficient experience in safeguarding to put in place a fully robust framework and monitoring for effectiveness and quality.

5.2.8 Midwifery services are being reconfigured to best meet local need with the Louth community midwife team being transferred to Grimsby hospital. This makes good sense as most deliveries in that area happen at Grimsby hospital. The Grantham stand-alone unit is to close in February. This has been subject to consultation and services will move to Lincoln site to focus resources where most required.

5.2.9 The LPT safeguarding consultant named nurse oversees safeguarding activity in CAMHS, SARC, DART and adult mental health. She provides strong and effective leadership and has put a good system in place. The LCHS's safeguarding team also operates very effectively in most areas of work and makes good use of its management information.

5.2.10 The oversight and clinical governance of safeguarding in A&E and MIU locations we visited is not fully effective. Paediatric liaison arrangements lack a systematic, county wide approach. The paediatric liaison nurse records any actions she takes on her visits to review CAS Cards and holds this data. Recognised safeguarding issues within ULHT and LCHS are cascaded upwards through the Trust's Safeguarding Committee's and downwards via the Trust's Safeguarding Champions Network / deputy named nurses. However, the details of PLN activity are held by the PLN. It is not collated to provide useful performance information which ULHT and LCHS could use to monitor departmental and clinicians' safeguarding practice, identify trends and drive continuous improvement and is not subject to reporting through clinical governance arrangements (recommendation 3.3).

5.2.11 A&E staff routinely seek advice and guidance from the ULHT safeguarding team when they have concerns about individual children. We saw examples of recent improvements by the named nurses which are helping to strengthen safeguarding systems. Where staff do identify safeguarding concerns, the advice sheets then generated by the ULHT safeguarding team provide a useful audit trail of the issue and the advice or instructions given to address the safeguarding concern.

5.2.12 Arrangements are not in place to collate the health needs of looked-after children or to track their access to treatment and subsequent outcomes (recommendation 2.2). We heard about children waiting unacceptably long times for a range of services and equipment. Collation of this data would help to inform commissioning and ensure that there are appropriate, effective services in place.

## 5.3 Training and Supervision

5.3.1 Safeguarding champions provide a structure for sharing learning within their localities and teams. A&E at Grantham has particularly strong leadership from its A&E sister who is very well respected. As a safeguarding champion she has brought in bespoke training which has helped to skill up all the staff. Her leadership helps to mitigate for against any systems difficulties and she personally takes a role in ensuring issues are followed up.

5.3.2 Ensuring that health practitioners are trained to levels of safeguarding competence commensurate with their roles remains a priority challenge for some services. Since the previous inspection, additional investment by the LCSB has increased the availability of multi-agency safeguarding training. We saw how health staff are taking advantage of the programme, using on line booking arrangements to access targeted training to fit their roles.

5.3.3 Health visitors and school nurses are well trained in safeguarding and looked after children work and their competencies are checked to support compliance with *Working Together* and intercollegiate guidance.

5.3.4 There is now a clear grip on safeguarding training requirements for all staff of the acute trust following a period when compliance and oversight of safeguarding training was poor. This remains a priority area for improvement at ULHT and is being well monitored. As additional staff are recruited, more are able to be released for training. A good trust wide initiative by ULHT's safeguarding practitioner, in conjunction with the PLNs, is open surgeries / workshops allowing all A/E staff to access advice and guidance. These are aimed at developing safeguarding practice and confidence in addition to offering reiteration of the Safeguarding / PLN Teams' roles, unfortunately, take up is low.

5.3.5 It is not clear whether safeguarding training at level 1 is fully equipping reception staff at A&Es and MIUs to undertake risk assessment involving a high proportion of children, as they are doing on a day to day basis. Examples were given however, of cases where reception staff had identified safeguarding risks and had acted promptly in notifying clinical staff of their concerns.

5.3.6 We visited three emergency care centres which treat both children and adults and asked about arrangements to ensure staff had appropriate training to equip them to nurse children. Grantham hospital A&E is usually able to offer nursing care by at least one paediatric –trained nurse at all times. However, arrangements to ensure staff working with children across the acute trust (ULHT) and in the MIUs can access and maintain EPLS training are not sufficiently rigorous and practitioners are overdue essential refresher training (recommendation 3.4).

5.3.7 The NHS England area team (AT) and CCG leadership are working together to secure a sustainable approach to safeguarding training arrangements for GPs and this is recognised as a current area of risk. The county initially undertook a series of level 3 training sessions to cover all GPs between 2010 and 2011 but for about one third of all of those who attended then, that training is now over three years old. Training sessions for GPs are available from ULHT or the LCSB and attended by some GPs.

5.3.8 A new system is being put into place to track individual GP's training needs and attendance and ensure that arrangements are also in place for practice staff. Work is also starting, with the NHS England area team, to develop a university accredited training programme for primary care practitioners alongside an in-house programme and this is very positive.

5.3.9 Safeguarding supervision is at an early stage of implementation in some health services. However, LCHS performs well overall, with very good visible performance management information across a range of safeguarding themes including safeguarding supervision which is reported quarterly. Compliance with planned supervision in the summer quarter was 91.08%. Health visitors are routinely receiving quarterly 1:1 and also group supervision. All LPFT staff discuss safeguarding at every managerial supervision session which is a minimum of 6 weekly.

5.3.10 In some other service areas such as the MIUs (LCHS) and in midwifery (ULHT), supervision is a recent introduction which is not embedded. It is early days for group supervision and no individual supervision is in place. Although there are safeguarding champions in midwifery services, there are no safeguarding supervisory staff other than the named midwife. There are no formal safeguarding supervision arrangements for A&E staff at ULHT (recommendation 6.1). Without regular formal supervision as set out in statutory guidance, practitioner's annual appraisal cannot be fully informed as part of a robust workforce development model.

# Recommendations

**1. Lincolnshire West CCG; South Lincolnshire CCG; South West Lincolnshire CCG; Lincolnshire East CCG should:**

1.1 Review the leadership capacity for safeguarding children and children in care to fully meet statutory requirements and secure the timely delivery of quality services for safeguarding children and children who are looked after.

1.2 Ensure commissioning governance and assurance provide effective scrutiny of the experiences and impact of local health services in delivering improved outcomes for children and young people who are looked after.

1.3 Use the opportunity of the local strategic review to consider the commissioning of specialist paediatric care and ensure its effectiveness in enabling children who have specialist needs to have access to timely, child centred assessment and treatment.

**2. Lincolnshire West CCG; South Lincolnshire CCG; South West Lincolnshire CCG; Lincolnshire East CCG and LCHS should :**

2.1 Ensure the emotional wellbeing and mental health of children in care is fully addressed in health care assessments, reviews and health plans.

2.2 Regularly report on child health outcomes for children in care, proactively identifying local trends, and robustly addressing risks to their health and wellbeing.

2.3 Fully implement holistic health summaries for young people leaving care and ensure they are responsive to their individual wishes and needs.

2.4 Ensure that arrangements are put into place to provide consistent support for looked after young people and care leavers who become pregnant or become parents.

2.5 Ensure that all children in care have prompt and high quality, holistic assessments of their needs and regular reviews followed by SMART health plans that ensure their needs are met.

**3. Lincolnshire West CCG; South Lincolnshire CCG; South West Lincolnshire CCG; Lincolnshire East CCG, LCHS and ULHT should:**

3.1 Ensure that discharge pathways from MIUs, A&Es and other settings are effective in ensuring the sharing of information about risks and involving appropriate professionals to secure best outcomes for the young people.

3.2 Ensure that opportunities are maximised to offer young people help through drug and alcohol support services by embedding the LSCB led multi-agency protocol which provides clear referral pathways from health services including urgent care settings to Young Addaction .

3.3 Review paediatric liaison capacity, seniority and clinical governance arrangements to ensure that robust, effective arrangements are in place across all services so that risks to children are effectively identified and followed up.

3.4 Ensure all children and young people requiring urgent care in the MIUs and Accident and Emergency Departments are cared for by appropriately trained nursing staff with updated specialist paediatric skills.[5]

**4. NHS England, Lincolnshire West CCG; South Lincolnshire CCG; South West Lincolnshire CCG; Lincolnshire East CCG and LCHS should:**

4.1 Ensure that GPs are properly equipped and competent for their roles in safeguarding, child protection and meeting the needs of children in care through robust development opportunities.

4.2 Ensure that GPs and others who may provide contraceptive services to young people are aware of the law in relation to the age of consent, particularly in relation to their responsibilities where a girl is under 13 years of age.

4.3 Ensure there are robust local systems for GPs to regularly share information about children and families where risks are identified.

[5] *"In district general hospital mixed emergency departments, a minimum of one registered children's nurse with trauma experience and valid EPLS/APLS training must be available at all times"* (RCN and RCPCH 2010; RCPCH, 2012).

5. **NHS England, Lincolnshire West CCG; South Lincolnshire CCG; South West Lincolnshire CCG; Lincolnshire East CCG and LPFT should:**

5.1 Continue to work in partnership to ensure that commissioning and operational arrangements enable children needing CAMH services to have timely access to early help, specialist assessment and treatment.

5.2 Ensure that mothers and their babies in all areas of Lincolnshire have access to perinatal mental health services to secure effective early intervention and support.

5.3 Review arrangements for young people placed out of county so that discharge protocols from or between CAMH tier 4 services and to other services ensure that these young people receive the support they need. .

6. **Lincolnshire West CCG; South Lincolnshire CCG; South West Lincolnshire CCG; Lincolnshire East CCG, and ULHT should:**

6.1 Ensure an appropriate system of supervision is in place for all staff who are involved in safeguarding and child protection work, including urgent care and midwifery, in line with inter-collegiate professional requirements.

7. **Lincolnshire West CCG; South Lincolnshire CCG; South West Lincolnshire CCG; Lincolnshire East CCG, LCHS, ULHT and LPFT should:**

7.1 Expand opportunities for listening to and learning from the experiences of young people and their families/carers, actively engaging them in service improvements.

7.2 Ensure that robust arrangements are put in place to assure the quality of referrals by health professionals and ensure that children for whom risks are identified receive prompt support.

7.3 Ensure, through working with partners, that staff across all health disciplines including adult drug and alcohol services are fully engaged in robust, consistent information sharing about children and their families for whom risks or concerns are known.

7.4 Ensure that the pre-birth protocol is audited for effectiveness in all cases including those where there is a known high degree of risk around the expectant mother

**8. LCHS:**

8.1 Ensure that all relevant staff are properly equipped prior to any roll out of new policies or systems including the electronic version of the vulnerability assessment matrix, to ensure use is consistent and effective.

**9. NHS England and Lincolnshire West CCG; South Lincolnshire CCG; South West Lincolnshire CCG; Lincolnshire East CCG should:**

9.1 Review commissioning strategies, local needs analyses and pathways to ensure children benefit from sufficiency of CAMHs provision, including tier 4, tier 3+ and community based alternatives to in-patient care, to facilitate care close to home and to ensure that other young children on paediatric wards are not put at risk of harm or distress

## Next steps

An action plan addressing the above recommendations is required from South West Lincolnshire CCG on behalf of the federation within 20 working days of receipt of this report. Please submit your action plan to CQC through childrens-services-inspection@cqc.org.uk. The plan will be considered by the inspection team and progress will be followed up through CQC's regional team.

# CQC Review of Health Services for Looked After Children and Safeguarding in Lincolnshire

| Recommendations | Current Position in Lincolnshire | Actions Proposed | Agency | Named Person | Time Scale |
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| **Lincolnshire** | | | | | |
| **1. Lincolnshire West CCG; South Lincolnshire CCG; South West Lincolnshire CCG; Lincolnshire East CCG should:** | | | | | |
| | **The recommendation specifically relates to 5.1.4 5,2,3 and 5,2.4 of the CQC report regarding capacity of the safeguarding leadership p including leadership for looked after children:** Lincolnshire currently operates a federated safeguarding service, hosted by South West Lincolnshire CCG on behalf of all four CCG's in the county, the other CCGs being West Lincolnshire CCG, Lincolnshire East CCG, and South Lincolnshire CCG. Leicestershire and Lincolnshire Area Team are overseeing an external review of the role function and capacity of the Designated Professionals and Named Doctors across both Counties. The CCG's have collaboratively funded the external review of the designated professionals and named doctor statutory role and function in the context of the new NHS recognising that there is insufficient capacity in the hosted service. All relevant professionals have been interviewed and a draft report has been submitted. The Area Team is currently awaiting the final report from the externally commissioned author. | The draft review report identifies additional capacity requirements for Lincolnshire. The external review report will be presented to the CCG collaborative in May 2014 for endorsement, with an associated business case to increase resource and capacity in accordance with the report recommendations and to proceed with recruitment. | SWCCG (Host) in collaboration with LECCG, SLCCG and WLCCG | Executive Nurses for each CCG: Sharon Robson, Wendy Martin, Tracey Pilcher, Lynne Moody | May-14 |
| **1.1** Review the leadership capacity for safeguarding children and children in care to fully meet statutory requirements and secure the timely delivery of quality services for safeguarding children and children who are looked after. | It has been acknowledged that there is insufficient capacity for the designated professionals to proactively drive the safeguarding and looked after children services in the new NHS. Commissioning for needs led services is dependent upon understanding the health profile of the child population and the needs of the looked after children residing in Lincolnshire. Public health data, the Looked After Children's database and the Local authority system of reporting are separate systems. Data from each is brought together in the form of annual reports. The Annual reporting of the Health and Wellbeing of Looked-after Children is developing, and integrating with the LA from 2014/15 to demonstrate the health profile of looked-after children more robustly in support of evidence based commissioning. There is a Looked After Steering Children's Steering Group established who are overseeing the annual report development and reporting of progress is required at each bi-monthly meeting. Quarterly reporting is required the LA Senior Management Team, the Children's and Young people's Strategic partnership (for corporately parented looked after children), to the LSCB for those looked after children externally placed and within health to the Strategic Safeguarding Steering Group. | The Looked-after Children Steering Group is overseeing the development of the revised Annual Report and reports into the Strategic Safeguarding Steering Group where progress will be monitored quarterly. The integrated annual report will be delivered to the Lincolnshire County Council / Directorate Management Team for LAC corporately parented. The management team receive quarterly reports of the achievement and quality of the statutory health assessments. The LSCB will receive quarterly reports of all LAC externally placed to ensure strategic oversight. The recruitment process for staff within the community health services has started. | SWCCG (Host) in collaboration with LECCG, SLCCG and WLCCG and LCHS (for backroom function - reporting etc.) and staff | Designated Doctor Dr F Johnson<br>Designated Nurse Jan Gunter | 7 Months (October 2014) |
| | The service specification for looked after children's statutory health assessments has been reviewed and updated by the designated professionals. LCHS has commenced recruitment to increase capacity within the vulnerable children and young people's team in support of the increased activity currently required. The Designated Professional's review has in the draft report recommended increased capacity for the designates for looked after children. The external review report on completion is, as detailed above, awaited. A service specification has being written by the Designated Doctor and the Designated Nurse including the current statutory health assessment level of need. | The designated professional roles and capacity is included in the external review and will be presented to the CCG collaborative as above. With regard to capacity for statutory health plans. An options appraisal is almost complete and will be presented to the Strategic Safeguarding Group in May 2014. LCHS have commenced recruitment in response to the additional requirement within the vulnerable children and young people's team. | SWCCG (Host) in collaboration with LECCG, SLCCG and WLCCG and LCHS (for backroom function - reporting etc.) | Designated Doctor Dr F Johnson<br>Designated Nurse Jan Gunter | May-14 |

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| **1.2** Ensure commissioning governance and assurance provide effective scrutiny of the experiences and impact of local health services in delivering improved outcomes for children and young people who are looked after. | **The recommendation specifically relates to 5.1.3, 5.1.9 and 5.2.4 or the CQC report relating to the capacity and quality of statutory health assessments for Looked-after Children (LAC):**<br>Currently a Locally Enhanced Service (LES) for the statutory health assessments has been provided by GPs and Nurses who have undertaken additional training. The Designated and named professionals have been involved in the additional training which has been led by the Designated Doctor, a Community Consultant Paediatrician and delivered through the Named Nurse and her team. The training has been well attended and evaluated. The GPs involved in the LES have stated that the additional training they have received has impacted positively on their practice when dealing with children in the general population. The LES however, had been acknowledged as producing variable quality and capacity issues and a review of the service had been proposed prior to the CQC review. Accordingly the service specification has been revised by the designated professionals and an options appraisal is being developed to meet current and projected increase in demand for presentation to the CCG collaborative. | The service specification proposes that Initial Health Assessments ( IHA) for children under 5 years to be completed by Paediatric Consultants, IHAs for children over 5 years for suitably skilled medical practitioners, which could incorporate those GPs who have a special interest or paediatricians and Review Health Assessments (RHAs) to become a nurse led service. There is an options appraisal being prepared to address capacity and access issues and improve quality and consistency which will be presented to the Strategic Steering Group in May 2014 | SWCCG (Host) in collaboration with LECCG, SLCCG & WLCCG | Designated Doctor Dr F Johnson<br>Designated Nurse Jan Gunter | May-14 |
| | The service is currently being provided by GPs and Nurses who have undertaken additional training. As detailed above the specification is being revised to reflect current need and an options appraisal being drawn up for presentation to the SSG . Using community paediatrician's for the under 5 years of age IHA is incorporated within the option appraisal. The capacity to undertake safeguarding and quality audits has also been incorporated in the service specification. | The service specification and the option appraisal will be presented to the CCG collaborative in May 2014 | SWCCG (Host) in collaboration with LECCG, SLCCG & WLCCG | Executive Nurses for each CCG: Sharon Robson, Wendy Martin, Tracey Pilcher, Lynne Moody | 6 months (September 2014) |
| | The lack of capacity within the vulnerable children and young people team has been acknowledged and a business case approved within LCHS to recruit further nursing capacity into the team. The capacity of the designated professionals role and function has been reviewed externally as detailed above and within the draft report identifies additional resource is required, and the final report is awaited. It is widely acknowledged that capacity within safeguarding and looked-after children requires strengthening and has the commitment of the CCGs. | The active phase of recruiting additional nurses to the VCYPT has commenced within LCHS. The looked after children's health assessments specification is forming the basis of the contracts to undertake the work and for review health assessments to become a nurse led service. | LCHS | Michelle Johnstone | 01/05/15 |

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| **1.3** Use the opportunity of the local strategic review to consider the commissioning of specialist paediatric care and ensure its effectiveness in enabling children who have specialist needs to have access to timely, child centred assessment and treatment. | **The recommendation specifically relates to 1.19 of the CQC report relating to the access of paediatricians (LAC):** ULHT has 5 Consultant Paediatricians located at Pilgrim Hospital, Boston; 7 located at Lincoln County Hospital and 7 Community Consultant Paediatricians (one of whom has specific responsibility as the Designated Doctor for LAC). Lincolnshire was identified as having sufficient acute Consultant paediatricians in the 2009 paediatric review whilst slightly under established for community paediatricians. These have since been recruited to and incorporate specialist function within each role. Alongside all services in Lincolnshire the paediatric service is being reviewed within the Sustainability Framework. Where children with a plan for adoption are undergoing an adoption medical as required by the regulation, the large majority of cases, more than 80%, have adoption medicals undertaken by paediatricians. The two medical advisors contracted to undertake this work demonstrably respond at short notice to comply with completion timescales for care proceedings. Where Paediatric input is, at an early stage, flagging up issues which require further scrutiny, e.g. parental substance misuse or potential chromosomal abnormalities which are followed up promptly. Social care regularly pay for additional investigation / testing around these issues, with agreed timescales for completion. This information is critical to matching. The management team are made aware of any delays in access to specialist services and subsequent delay in the child's journey that compromise legal proceedings. There is no waiting list to see the Adoption Medical Advisors. | The Designated professionals for LAC have reviewed and updated the service specification and are developing the options appraisal for service delivery. Lincolnshire is reviewing all services within the Sustainable Services Review which included the whole paediatric service. With regard to statutory health assessments for looked after children, the preferred option is to develop clinics for children to undertake their IHA's and it is planned to then bring together the adoption medical service together with the initial health assessments within a clinic setting to improve quality, timeliness and consistency. for children's access to paediatrician's. | SWCCG (Host) in collaboration with LECCG, SLCCG & WLCCG | Accountable Officers | May 2015 1 year |
| **2. Lincolnshire West CCG; South Lincolnshire CCG; South West Lincolnshire CCG; Lincolnshire East CCG and LCHS should :** | | | | | |
| **2.1** Ensure the emotional wellbeing and mental health of children in care is fully addressed in health care assessments, reviews and health plans. | **The recommendation specifically relates to 4.3 of the CQC report relating to the follow up of the Strengths and Difficulties Questionnaire (SDQ):** Recently a mechanism to ensure follow up of pathways within CAMHS has been introduced. This is with regard to children scoring 14 or over with in SDQ and is identified as requiring a review within the S75 agreement. There is currently an absence of audit evidence regarding this aspect of CAMHS services which has been recognised and an SDQ group has been specifically formulated to address the issues identified. The group has already met and the Designated Doctor for Looked After Children is proactively working with. The group is represented at the Looked After Steering Group and reports will be received there. | The S75 arrangement will be reviewed to ensure there is the ability for the SDQ group to review scores over 14 and follow into the GP health assessment. The success is dependent on collaboration and receipt of data from CAMHS current section 75 arrangements. A Process is being developed for practitioners feedback regarding SDQ scores and access into CAMHS<br>The initiatives will monitored through audit. | The LA & LPFT working collaboratively with providers | Janice Spencer & Liz Bainbridge | 3 months (June2014) Quarterly reporting from audits thereafter. |
| **2.2** Regularly report on child health outcomes for children in care, Proactively identifying local trends, and robustly addressing risks to their health and wellbeing. | **The recommendation specifically relates to 4.19 and 5.2.5 of the CQC report relating to the timely access to equipment, specifically wheelchairs**: The provision of equipment services are currently contracted through Millbrook. The contract explicitly incorporates and covers children's equipment including wheelchairs. The parent contact the provider directly who will initiate a new assessment and provide a wheelchair based upon the assessment. There is no evidence of a waiting list and the contract is performance managed. | Review of database and performance measures currently being carried out increase of data fields to incorporate long-term conditions and social environment. There is a review of the wheel Chair service being planned. This will include performance management of contract and quality assurance. | SWLCCG - Lead | Colin Warren | 3 months |
| | **The recommendation specifically relates to 4.19, 4.5, 5.2.5 and 5.2.12 of the CQC report regarding performance reporting of the holistic health needs of looked after children and tracking of outcomes:**<br>It is acknowledged that the Looked After Children Annual Health Report has been limited in scope. The data sources required to demonstrate a full health profile is limited and not integrated. Recent developments have enabled improved and more robust data regarding initial health assessments. Data fields on SystmOne are being continually improved to incorporate health information and are currently prioritising long term conditions identification and reporting. The annual health report template has been changed to incorporate health conditions and their prevalence and will be integrated with the LA annual report, based upon evidence from the LAC and their carers. The process is being driven by the LAC Steering Group and being reported against bi-monthly. | Reporting systems in both health and the e LA are under further development with regards to reporting the health issues and inequalities experienced by LAC. the plan is to incorporate wider health determinants and outcomes of interventions for LAC. WLCCG are the lead CCG for the county in this area. The specification for LAC services has been reviewed and updated by the Designated professionals from which the contracts will be agreed and performance managed against. | SWCCG (Host) in collaboration with LECCG, SLCCG & WLCCG | Designated Doctor Dr F Johnson & Designated Nurse Jan Gunter | 6 months (September 2014) |

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|  | The extrapolation of data from SystmOne is under further development. Reporting of long term conditions will be possible for 14/15. The follow-up of the health care plan, attendance at referrals and outcomes rec ording for children is being developed in association with the local authority by strengthening the use of the Red and Blue Books (Red book is the Child Health Record and Blue Book is the Looked After Children record). Therein the recording of health assessments within the books is now a component of the revised specification, and monitoring of progress to been overseen by the independent reviewing officers (within social care) who quality assure the care management of children regularly in-between statutory health assessments | There is a re launch of the use of the Blue Book and Red Book in the context of Looked-after Children health assessments across health and social care. Within the new contracts being drawn up there is a requirement for all health practitioners to record each contact in the books and complete the IHA / RHA components within the Blue Book. There is a need to develop a Service Level Agreement with the LA for the IRO to quality assure the progress. SLN review was mentioned. Closer working with Health watch is planned to explore emerging themes and healthwatch will contribute to collating evidence. LCC are reviewing the purchasing arrangements with regard to these issues. | SWCCG (Host) in collaboration with LECCG, SLCCG & WLCCG working with the LA | Designated professionals, Dr F Johnson & Designated Nurse Jan Gunter | 6 months (September 2014) |
| **2.3** Fully implement holistic health summaries for young people leaving care and ensure they are responsive to their individual wishes and needs. | **The recommendation specifically relates to 4.21 of the CQC report regarding health summaries for children leaving care:** Currently all children in care receive a Blue Book which is the comprehensive health record for the child's length of time spent in care. It is acknowledged that this and the Red Book - Child Health record requires further embedding to improve the health history of each child. | As detailed above there is a plan to relaunch the Red and Blue Books as the comprehensive / contemporaneous record of the LAC health. In addition a template for a health summary is under development. The responsibility of the leaving care summary will sit with the nurse led service managing the RHAs and has been made explicit within the LAC service specification and will be performance managed through the contracts | SWLCCG (host) in collaboration with LECCG, SLCCG, WLCCG | Designated Professionals, Dr F Johnson & Designated Nurse Jan Gunter | 6 Months (September 2014) |

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| **2.4** Ensure that arrangements are put into place to provide consistent support for looked after young people and care leavers who become pregnant or become parents. | **The recommendation specifically relates to 3.22 of the CQC report regarding dedicated pathways regarding pregnancies in children leaving care**: Currently Barnardos are commissioned to deliver this in Lincolnshire. Once the young person informs their Barbardos leaving care worker that they are pregnant or becoming a father, it is recorded on the system electronically. The outcome is then recorded under categories that include: deceased, adopted, fostered, living with care leavers or other. The leaving care worker works in accordance with the Multi-agency Pre Birth protocol in partnership with children's services and health to meet the needs of the young person and child | A care leavers pathway is under development that will require all young people leaving care who are expectant or actual parents will have the support of a TAC to ensure that agencies are working effectively together to support the family. Reporting against the pathway outcomes will inform future commissioning | LA CCG'S & LCHS | Janice Spencer & Jean Burbidge | NA LCHS barnados lead through LA commissioning – LCHS has no control. |
| **2.5** Ensure that all children in care have prompt and high quality, holistic assessments of their needs and regular reviews followed by SMART health plans that ensure their needs are met. | **The recommendation specifically relates to 4.1, 4.5 4.11, 4.16 and 4.19 of the CQC report regarding the resource capacity and quality of health plans for looked after children:** The current provision within LCHS for managing the backroom function and provision of review health assessments for children has not keep pace with the significant recent increase in the total number of LAC internal (from within Lincolnshire) and externally through placing authorities) The revised specification for LAC health assessments incorporates the increased activity and projected increase in demand and includes the requirement of quality assurance provision of health assessments which will be performance managed against the contract. Audit has consistently demonstrated health assessments carried out by VCYP team are prompt and of a high quality. LCHS provide database countywide backroom functions. | LCHS are currently in the process of recruiting additional staff to the VCYPT in response to the required need. Included in the recruitment is a post for a nurse to quality assure the health assessments. There is an options appraisal being submitted to the CCG collaborative regarding the pathway of IHAs Reference to quality of GP assessments Reporting of capacity issues is to be incorporated into the quarterly reporting to inform commissioning and quality assurance process. Oversight within health will be managed through the Safeguarding Steering Group and within the LA through LCC and the Corporate Parenting Group. | CCG commissioning LCHS provider | Michelle Johnstone | Apr-14 |
| | A review of the service had already been proposed for the statutory health assessments due to acknowledged variability of quality. As detailed above in 4.0 the service specification for LAC has been reviewed by the designated professionals and quality assurance capacity is explicitly included to ensure consistency and quality of the assessment and subsequent health plan. the issues of electronic reporting, quality assurance and reduced variability. The ensuing contracts raised to undertake this work will be performance managed against the specification. An option appraisal is being prepared by the designated professionals for presentation to the CCG collaborative regarding a new pathway for LAC health assessments. The preferred option being proposed to the CCG collaborative includes the use of Community Paediatricians for Initial health assessments, especially for the younger children. The evidence from the reviews of the needs of the looked-after children population will inform the commissioning in the future. | The LAC specification has been reviewed by the designated professionals. WLCCG is overseeing the contracts development which will be used to performance manage the delivery of the service. Reporting will be via the Quality Surveillance Group and Quality and Patient Experience Committees for each CCG. Reporting quarterly within health, to the CPYSP/LCC for those LAC corporately parented and to the LSCB for those placed by external authorities | CCG commissioning + provider organisations | Designated Doctor Dr F Johnson<br>Designated Nurse Jan Gunter | 3 months |
| | A review of the service had already been proposed for the statutory health assessments due to acknowledged variability of quality. As detailed above in 4.10 and 4.11 the service specification for LAC has been reviewed by the designated professionals and quality assurance capacity is explicitly included to ensure consistency and quality of the assessment and subsequent health plan. the issues of electronic reporting, quality assurance and reduced variability. The ensuing contracts raised to undertake this work will be performance managed against the specification. An option appraisal is being prepared by the designated professionals for presentation to the CCG collaborative regarding a new pathway for LAC health assessments. The preferred option being proposed to the CCG collaborative includes the use of Community Paediatricians for Initial health assessments, especially for the younger children. The evidence from the reviews of the needs of the looked-after children population will inform the commissioning in the future. | The LAC service specification has been reviewed and delivered to WLCCG. Contracts being raised and taken up to deliver the service will be performance managed through the contracting teams and Quality and Patient experience committees for each CCG. Reporting quarterly within health, to the CPYSP/LCC for those LAC corporately parented and to the LSCB for those placed by external authorities | WLCCG | Designated Doctor Dr F Johnson<br>Designated Nurse Jan Gunter | 3 months |
| | A review of the service had already been proposed for the statutory health assessments due to acknowledged variability of quality. As detailed above in 4.10 and 4.11 the service specification for LAC has been reviewed by the designated professionals and quality assurance capacity is explicitly included to ensure consistency and quality of the assessment and subsequent health plan. the issues of electronic reporting, quality assurance and reduced variability. The ensuing contracts raised to undertake this work will be performance managed against the specification. An option appraisal is being prepared by the designated professionals for presentation to the CCG collaborative regarding a new pathway for LAC health assessments. The preferred option being proposed to the CCG collaborative includes the use of Community Paediatricians for Initial health assessments, especially for the younger children. All health practitioners have been reminded of the need to look back in children's records to the previous entries to ensure continuum of care. The evidence from the reviews of the needs of the looked-after children population will inform the commissioning in the future. | The LAC service specification has been reviewed and delivered to WLCCG. The LAC health care co-ordinator will request reports from allied health professionals involved with the child in preparation for the RHA and the quality assurance post within LCHS will monitor through audit. Contracts being raised and taken up to deliver the service will be performance managed through the contracting teams. Reporting quarterly within health, to the Quality and Patient experience committees for each CCG, the Safeguarding Steering Group and LAC Steering Group, externally to the CPYSP/LCC for those LAC corporately parented and to the LSCB for those placed by external authorities | WLCCG | Designated Doctor Dr F Johnson<br>Designated Nurse Jan Gunter | 3 Months |

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| | The provision of equipment services are currently provided through Millbrook. The contract makes explicit that children 's equipment is incoproated and covered by the contract. A parent makes contact with the provider directly who then arranges an assessment of need. Equipmane is then provided in accordance with the assessment findings. The contract is performance managed. | Review of database and performance measures currently being carried out increase of data fields to incorporate long-term conditions and social environment. There is a review of the wheel Chair service being planned. This will include performance management of contract and quality assurance. | SWLCCG - Lead | Colin Warren | 3 months |

| **3. Lincolnshire West CCG; South Lincolnshire CCG; South West Lincolnshire CCG; Lincolnshire East CCG, LCHS and ULHT should:** | | | | | |
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| | **The recommendation specifically relates to 1.12, 2.9 and 3.18 of the CQC report regarding onward referrals from unscheduled care settings including the self harm pathway:** WLCCG are the lead CCG for the acute Trust and LECCG act as lead CCG for LCHS through which the 2 Paediatric Liaison Nurses (PLN) are employed and have been judged as Good practice. They provide an 'in hours' service. Within LCHS a discharge pathway for children within and across unscheduled care settings that LCHS manage has been reviewed and this now incorporates a management review of all child attendees on daily basis to ensure appropriate action and onward referral has been taken irrespective of site. ULHT support full integration of the PLN role within each A&E site. It is acknowledged that there needs to be collaborative working model between LCHS ULHT and commissioning to ensure appropriate provision of this role. | Quarterly performance reporting to ensure continued quality is now required. A discharge pathway review is planned within ULHT on each site ED to review and clarify discharge pathway for children. Full ULHT Action is below. Quarterly performance reporting to ensure continued quality. LCHS are prioritising their unscheduled care provision. | LCHS | Michelle Johnstone Head of Safeguarding LCHS | Completed LCHS |
| | The PLN process is in place within A/E and Paediatric areas. Staff members have access to PLN Discharge Criteria. ULHT ED are committed and working to develop a consistent approach for sharing information with the PLNs | Each ULHT ED site will agree a Pathway for referral to PLN which prevents delays and inappropriate referrals. | ULHT | PLN<br>SG Practitioner<br>Named Nurse SG ED Matrons<br>Medical Director | Jun-14 |
| **3.1** Ensure that discharge pathways from MIUs, A&Es and other settings are effective in ensuring the sharing of information about risks and involving appropriate professionals to secure best outcomes for the young people. | SWLCCG is the lead CCG for MH services working closely with the Local Authority who commission CAMHS through a S75 agreement. A revised Self-Harm Pathway (SHP) has been signed off between the Executive nurses for LPFT and LCHS and the LSCB. It is acknowledged that currently the self harm pathway was not been fully embedded and therefore could working more effectively. Auditing and monitoring reports are awaited. A proposal of tracking cases for the SHP has been given for quality audit purposes and the SHP will be performance managed. ULHT support the SHP and are actively developing the internal mechanism for implementing the pathway recommendations. Acknowledged that these Patients are ULHT patients with a need for LPFT input. | ULHT will embed the SHP and identify where the child is to be paediatrically assessed and mental health assessment is required / completed in accordance with NICE guidance ULHT will manage performance internally (via Datix). WLCCG will performance manage as lead CCG through the contracting quality meetings. For children presenting through A&E that require admission (without a physical health need) there will be quality assurance that both paediatric and mental health assessment occurs prior to decision on best place of safety / admission. There has been additional investment from the CCGs into LPFT (with CAMHS and HIPS) to support this pathway. | ULHT LA / LPFT | Safeguarding Lead ULHT & Karen Berry Interim Director for Operations LPFT | Jun-14 |
| | Discharge letters are system-generated but there is a facility for staff to add additional relevant information in a 'free text' section. . | A/E staff to include any safeguarding concerns or safeguarding actions taken within 'free text' box on discharge letter. ULHT will ensure that A/E staff are aware of the need to include any safeguarding concerns or actions taken within 'free text' box on discharge letter. Staff will be informed by letter to Clinical Leads and Matrons; with inclusion in training going forward. | ULHT | Safeguarding Lead A&E<br>Consultant Nurses and<br>Clinical Directors | Mar-14 |
| **3.2** Ensure that opportunities are maximised to offer young people help through drug and alcohol support services by embedding the LSCB led multi-agency protocol which provides clear referral pathways from health services including urgent care settings to Young Addaction . | **The recommendation specifically relates to 1.1 of the CQC report regarding referrals from A&E departments to drugs and alcohol services:** A pathway of referral into Adaction has been developed by the LSCB which was awaiting ratification at the time of the inspection. This pathway has now been ratified. Referral pathways for accessing young addaction and relevant literature has been disseminated to all A&E staff through organisational team briefs (delivered monthly by line manager) and team meetings. | There is a plan in place to monitor by number of appropriate referrals into the service and audit outcomes. There is also a programme of back to floor visits by appropriately skilled staff. Feedback will be through the clinical governance processes. The designated nurse will receive a report. | ULHT | Chair of Safguarding Committee via Named Nurse Safeguarding | Apr-14 |
| **3.3** Review paediatric liaison capacity, seniority and clinical governance arrangements to ensure that robust, effective arrangements are in place across all services so that risks to children are effectively identified and followed up. | **The recommendation specifically relates to 5.2.6, and 5.2.10 of the CQC report regarding the paediatric liaison service:** WLCCG are the lead CCG for the acute Trust and LECCG act as lead CCG for LCHS through which the PLNs are employed. There are 2 Paediatric Liaison Nurses (PLN) employed by LCHS and have been judged as Good practice. They provide an 'in hours' service. Within LCHS a discharge pathway for children within and across unscheduled care settings that LCHS manage has been reviewed and this now incorporates a management review of all child attendees on daily basis to ensure appropriate action and onward referral has been taken irrespective of site. ULHT support full integration of the PLN role within each A&E site. | Current establishment remains the same at Band 6 provision is currently under review with the growth of unscheduled care provision within LCHS and the demands on the capacity and the efficient working of the role will be prioritised according to LCHS establishments. | LCHS | Michelle Johnstone | Apr-14 |

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| **3.4** Ensure all children and young people requiring urgent care in the MIUs and Accident and Emergency Departments are cared for by appropriately trained nursing staff with updated specialist paediatric skills.5 | **The recommendation specifically relates to 5.3.6 of the CQC report regarding capacity of appropriately trained staff to provide paediatric care in A&E and MIU departments:** LCHS have in place training for the MIU which can be demonstrated through compliance via mandatory training matrix | Regular audit and quarterly reporting through the clinical governance process | LCHS | Michelle Johnstone | Completed |
| | Within ULHT EPLS training is available to staff working in A&E. There are Attendance Criteria Pathways in existence to ensure patients attend an emergency department on a site relevant to their level of dependence. | Staff to be released to access EPLS training. Managerial oversight required to monitor compliance. | ULHT | A/E Matrons, Nurse Consultant and Clinical Directors for Child division and Emergency Care. | Jun-14 |

| **4. NHS England, Lincolnshire West CCG; South Lincolnshire CCG; South West Lincolnshire CCG; Lincolnshire East CCG and LCHS should:** | | | | | |
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| **4.1** Ensure that GPs are properly equipped and competent for their roles in safeguarding, child protection and meeting the needs of children in care through robust development opportunities. | **The recommendation specifically relates to 3.8 and 1.7 of the CQC report regarding GPs being equipped and competent in safeguarding roles:** Since April 2013 NHS England commissions primary care / GP services. All GPs are required to have the requisite competence and skill to provide for their patients including safeguarding issues incorporating domestic violence. MARAC training has been incorporated into safeguarding training for a number of years. They are performance managed through evidence of appraisal and evaluation. Support and advice systems for GPs are currently being reviewed- NHS England and the Local CCGs are exploring the current provision, and will negotiate appropriate training and development opportunities within this review.GP A Database is being is being created, and currently survey monkey has gone out to all GP's regarding their safeguarding training, including domestic abuse training and is awaiting response. | LCHS employed GPs are subject to the same training matrix as other employees of LCHS . Mapping of the safeguarding training requirements for all GPs across Lincolnshire is being undertaken. The outcome of which will inform commissioning of prioritised training needs | LCHS, NHS England, | Pam Palmer NHS England Tracy Pilcher Executive Nurse LECCG & Michelle Johnstone Head of Safeguarding LCHS | LCHS Completed NHS England 6 months |
| | It is acknowledged that there is an absence of an agreed system of communication between health professionals including HVs and GPs. HVs are no longer based in GP surgeries and operate corporate caseloads. PP to send in narrative. It is acknowledged that there are gaps wider than LCHS HVs including ULHT and LA. This is a large piece of work. The LSSR neighbourhood teams include key workers who are essential to improving communication. | Neighbourhood Key workers will be proactive in engaging with GPs as part of the implementation of the LSSR framework. | NHS England & LCHS | Pam Palmer & Michelle Johnstone | May-15 |
| **4.2** Ensure that GPs and others who may provide contraceptive services to young people are aware of the law in relation to the age of consent, particularly in relation to their responsibilities where a girl is under 13 years of age. | **The recommendation specifically relates to 2.4 and 5.1.10 of the CQC report regarding the competence and profile / exposure of contraception and sexual health services across the partnership arrangements:** Fraser competencies and age of consent are included within level 3 safeguarding training. This also includes the practitioners responsibility in relation to sexual abuse/child sexual exploitation. Focusing on responsibilities and legal implications all GPs and sexual health service practitioners attend level 3 safeguarding children training. Following this review an enquiry was undertaken within LCHS who manage the service and no evidence could be found to identify the children aged under 13 or under. Thus tracking of the child and services accessed has proved impossible. | The Fraser competencies , practitioner responsibilities and legal implications of very young people requiring sexual health services will remain on the safeguarding children level 3 programme to remind professionals on a regular basis | NHS England CCGs LCHS | Pam Palmer NHS England Tracy Pilcher Executive Nurse LECCG & Michelle Johnstone Head of Safeguarding LCHS | Completed |
| | There is an acknowledged need to expose CASH services positively and ensure that the service is represented appropriately at partnership meetings | CASH has identified staff to attend Sexual Exploitation meetings/training. Requirements to work in partnership arenas and develop effective partnerships will be included in Job Descriptions and contracts | LCHS | CASH lead | With immediate effect |
| **4.3** Ensure there are robust local systems for GPs to regularly share information about children and families where risks are identified. | **The recommendation specifically relates to 3.15 of the CQC report regarding GP contribution in sharing information for safeguarding:** There is a template currently under review in line with E signs of safety common template referral process which is being developed by the LCC. A Pilot project is being undertaken regarding the Signs of Safety Approach which is bring lead by LA and is under development, this will include GP's as all health professionals working with social workers adopting the approach. | There is currently a template for professionals to complete for CP conferences this is utilised by LCHS,, ULHT, LPFT which will be rolled out for all GPs and provide consistency | LA CCG'S LAT | Designated Nurse Jan Gunter | Complete |

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| **5. NHS England, Lincolnshire West CCG; South Lincolnshire CCG; South West Lincolnshire CCG; Lincolnshire East CCG and LPFT should:** | | | | | |
| **5.1** Continue to work in partnership to ensure that commissioning and operational arrangements enable children needing CAMH services to have timely access to early help, specialist assessment and treatment. | **The recommendation specifically relates to 2.5 and 4.7 of the CQC report regarding capacity &E and MIU departments**: There is an acknowledged shortfall nationally within CAMHS . CAMHS within Lincolnshire are commissioned by the LA incorporating a S75 agreement. | The Local Authority NHS England and CCG Commissioners meet throughout the year as a joint body to discuss mental health commissioning and operational arrangements. | NHS England, CCG | Pam Palmer, Sally savage LA Lead CCG representative | May 2015 1 year |
| | Tier 3 CAMHS being reviewed through procurement process procuring by 2015. Well performance managed contract | | | Pam Palmer NHS England, Sally Savage Children's Commissioner in the LA, Colin Warren Lead CCG representative | |
| **5.2** Ensure that mothers and their babies in all areas of Lincolnshire have access to perinatal mental health services to secure effective early intervention and support. | **The recommendation specifically relates to 1.6 of the CQC report regarding capacity of perinatal mental health service:** Adopting specification procurement 2014/15 in discussions with LPFT have commenced. It is acknowledged that there is insufficient capacity within the Perinatal Nursing Service. The issue has been prioritised in the associated submitted business plan. All women are seen by mental health staff, receive care but not by Perinatal specialist nurses. | NHS England has recommended that all CCG's within the region adopt the Perinatal Clinical Network devised service specification. NHS England and CCG's Commissioners meet throughout the year as a regional body to discuss mental health commissioning and operational arrangements and this includes Perinatal Services. | NHS England | Pam Palmer | May 2015 1 year |
| **5.3** Review arrangements for young people placed out of county so that discharge protocols from or between CAMH tier 4 services and to other services ensure that these young people receive the support they need. | **The recommendation specifically relates to 5.1.12 of the CQC report regarding capacity of A&Es to manage care for children from or in-between T4 CAMHS provision:** Currently within NHS England Local Area Team there are 2 co-coordinators in post to manage and co-ordinate Tier 4 placements | NHS England has two CAMHS Case Managers who assist local care co-ordinators to fulfil this function. | NHS England | Pam Palmer NHS England | Completed |
| **6. Lincolnshire West CCG; South Lincolnshire CCG; South West Lincolnshire CCG; Lincolnshire East CCG, and ULHT should:** | | | | | |
| **6.1** Ensure an appropriate system of supervision is in place for all staff who are involved in safeguarding and child protection work, including urgent care and midwifery, in line with inter-collegiate professional requirements. | **The recommendation specifically relates to 5.3.10 of the CQC report regarding supervision of staff working in safeguarding:** LCHS have an up to date safeguarding supervision policy in place and staff are performance managed against compliance. Within ULHT Safeguarding Supervision is available to all staff on an individual and group basis; with the Named Midwife, Named Nurse for Safeguarding and other Senior staff members trained to deliver. The uptake of staff is recorded. Currently there is not a formal Policy for Safeguarding Supervision in place. However the Safeguarding Supervision Policy has been written and is out for consultation. The Governance/Monitoring arrangements are documented within the policy . | LCHS Completed Draft Safeguarding Supervision Policy is to be presented to ULHT Safeguarding Committee for comments/approval in April 2014. | ULHT | Elaine Todd Named Nurse for Safeguarding | Apr-14 |

| **7. Lincolnshire West CCG; South Lincolnshire CCG; South West Lincolnshire CCG; Lincolnshire East CCG, LCHS, ULHT and LPFT should:** | | | | | |
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| **7.1** Expand opportunities for listening to and learning from the experiences of young people and their families/carers, actively engaging them in service improvements. | **The recommendation specifically relates to 5.1.14 of the CQC report regarding hearing the child's voice**: All NHS and social care agencies are CA Section 11 compliant. A mystery shopper exercise was undertaken, overseen by the LA and involving young people. The feedback resulted in accepted actions being put into place. Lincolnshire Young Inspectors joined with the teenage pregnancy team to carry out a C-Card mystery shopping exercise. May 2013 with revisits to establish if actions had been put in place October 2013. Sixteen venues were then selected from across the county and a mix of registration and pick up points were visited. The young inspectors said "Overall we found the venues were welcoming and accessible and staff members are friendly.<br>At the end of the mystery shops, the young people came together to share their experiences and make an active contribution to a report including recommendations for change. These included staff being re-trained, new and updated guidance for C-Card Venues and improvements to C- Card Mobile. The recommendations have had a significant impact on improving the overall service.<br>CAMHS information submitted at time of inspection. CCG Executive Nurses supported this submission as evidence in response to CQC. LPFT have outstanding data from every session regarding the outcomes and experience of children and this is transferred in to service need and development with commissioners. | Currently in place:<br>Interview panels<br>Local authority tell us survey which incorporates health<br>Voice of the child survey/questionnaire included on assessment template | LCC LCHS LPFT ULHT | Janice Spencer AD LCC, Sue Cousland Chief Nurse LCHS, Eiri Jones ULHT, Julie Hall DON LPFT | Complete |
| | Healthwatch Lincolnshire is currently working with schools, colleges and other young people's activities to support 7.1. We have designed a questionnaire for the young people to complete to provide some baseline data on current young people's perception of access and support to health and social care. | Healthwatch will be facilitating sessions to ensure young people (11 - 18 years) understand their voice is important. | Healthwatch Lincolnshire | Tim Barzycki | February - April 2014 and ongoing |
| | Exits cards available for patients to complete, but often completed by parents rather than the children and young people. | ULHT's Children and Young People Strategic Board to consider potential options available for capturing patient feedback. Trust's Children and Young People Strategic Board to consider potential options available for capturing patient feedback. Patient Experience team to work with the relevant Services and provide assurance via the Patient Experience Committee. | ULHT | C&YPSB Members and Paediatric Matrons | Jun-14 |
| **7.2** Ensure that robust arrangements are put in place to assure the quality of referrals by health professionals and ensure that children for whom risks are identified receive prompt support. | **The recommendation specifically relates to 3.2, 3.3 and 3.8 of the CQC report regarding timeliness and appropriateness of referrals:** The CAMHS LAC referral pathway has been amended to include LCHS Vulnerable Children's Nurses as accepted referrers. within the CQC report LCHS is recognised as providing good appropriate referrals | To carry out audit of referrals into children's services on a quarterly basis as a quality assurance process. | LPFT LCHS | Michelle Johnstone | Apr-14 |
| | 3.3 was specific to midwives. Midwives file a copy of the referral (SAF) form into the patient's records to allow quality assurance of referrals made. | Ongoing quality audit | ULHT | Named MW | Complete |
| | The notification of referral process in other areas does offer the ability to QA referrals made to CSC | The Safeguarding Children Policy/referral Pathway is to be reviewed and amended to adopt similar process to that used in Midwifery | ULHT | Elaine Todd Named Nurse Safeguarding | Jun-14 |
| | All GPs are required to have the requisite competence and skill to provide for their patients including domestic violence. MARAC training has been incorporated into safeguarding training for a number of years. A database of GP safeguarding training has been created and is currently being populated to aid prioritising of commissioning need. NHS England hold the GP's to account contractually. Safeguarding Children Training evidence is a requirement of appraisal and evaluation. | Completion of the database, and performance management of GPs through the Area Team | NHS England | Pam Palmer NHS England | May 2015 1 year |

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| **7.3** Ensure, through working with partners, that staff across all health disciplines including adult drug and alcohol services are fully engaged in robust, consistent information sharing about children and their families for whom risks or concerns are known. | **The recommendation specifically relates to 3.12 of the CQC report regarding timely sharing of information from the Drug and Alcohol Recovery Team (DART):** The DART management team have embedded a set of additional safeguarding children actions. There are Safeguarding Champions established within DART. The CQC inspector's example has been added to DART and all other safeguarding children training in line with CQC report. LPFT and Children's Services have completed an audit on DART and AMH cases with a multi-agency action plan. LPFT have developed an action plan in response to "What about the children 2013" managed via Safeguarding and Mental Capacity Committee. In relation to midwives LCHS were recognised within the report as performing well | LPFT Safeguarding Team to send out information to all LPFT services regarding sharing information with other agencies and Lead Professionals directly and not via the service user. | LCHS LPFT | Liz Bainbridge &Michelle Johnstone | LPFT 3 months |
| | 'Think Family' approach is incorporated into all levels of Safeguarding Training. It is discussed in both Safeguarding Supervision and in advice offered by the Safeguarding Team. The Trust's Safeguarding Champions Network has been revised in order to address issues relevant to children and adults. The Safeguarding site on the Intranet has a link to the relevant SCIE 2012 'Think Child, Think Parent, Think Family' report. | Think family approach to be more robustly embedded within the SG Children and Young people Policy. | ULHT | Named Nurse Safeguarding | Jun-14 |
| **7.4** Ensure that the pre-birth protocol is audited for effectiveness in all cases including those where there is a known high degree of risk around the expectant mother | **The recommendation specifically relates to 3.4 of the CQC report regarding the understanding and embedding of the Multi Agency Pre Birth Protocol:** The LSCB have developed a multi-agency audit framework and the multi-agency audit agenda commences in April 2014 which will includes audit of the impact of the pre-birth protocol. | Health agencies including LPFT, LCHS, ULHT and the CCGs are working alongside partner agencies to support the multi-agency audit program. An audit has been carried out by children's services and monitored via the LSCB | LSCB | Andy Morris | 6 months |
| **LCHS:** | | | | | |
| 8.1 Ensure that all relevant staff are properly equipped prior to any roll out of new policies or systems including the electronic version of the vulnerability assessment matrix, to ensure use is consistent and effective. | **The recommendation specifically relates to 3.6 of the CQC report regarding identification and recognition of vulnerability, specifically utilising the electronic vulnerability matrix within LCHS:** LSCB and the CCGs seek assurance from NHS providers that all relevant staff are properly equipped prior to any roll out of new policies or systems in general and all agencies are compliant and tested through the CA S11 audit and Markers of Good Practice. This recommendation is specific to LCHS regarding the electronic version of the vulnerability assessment matrix, to ensure use is consistent and effective. | LCHS: All new policies and processes/systems have an identified implementation plan. This includes training and audit. This will also be assessed through back to floor visits and record keeping audit. | LCHS | Michelle Johnstone Head of Safeguarding LCHS | Completed |
| **9. NHS England and Lincolnshire West CCG; South Lincolnshire CCG; South West Lincolnshire CCG; Lincolnshire East CCG should:** | | | | | |
| **9.1** Review commissioning strategies, local needs analyses and pathways to ensure children benefit from sufficiency of CAMHs provision, including tier 4, tier 3+ and community based alternatives to in-patient care, to facilitate care close to home and to ensure that other young children on paediatric wards are not put at risk of harm or distress | **The recommendation specifically relates to 2.8 of the CQC report regarding the pathway from A&E services to CAMHS:** CAMHS services are commissioned by the Local Authority via a S75 agreement. A revised Self-Harm Pathway (SHP) has been signed off between the mental health services provider (LPFT) and the acute trust (ULHT). The SHP has been signed off with the LSCB and Executive Nurses for both Trusts who are overseeing the implementation. Currently it is acknowledged that the self harm pathway was not been fully embedded and could work more effectively. Auditing and monitoring reports are awaited. A proposal of tracking cases for the SHP has been given for quality audit purposes and the SHP will be performance managed. ULHT support the SHP and are actively developing the internal mechanism for implementing the pathway recommendations. Acknowledged that these Patients are ULHT patients with a need for LPFT input. NHS England commission T4 services and performance manage the contracts with providers. | The actions specific to th eSHP have been described earlier at 3.1. The commissioning pathways for all services now sit within the Lincolnshire Sustainable Services Review Framework to ensure that needs led commissioning provides quality services for the Lincolnshire populace. The framework is being managed at the highest level acorss health and social care | The LA NHS England | Justin Hackney AD LA + accountable officers for the CCGs. | 1 year |

| Meeting Date | Minute No | Agenda Item & Decision made |
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| **11 June 2013** | 1 | **Election of Chairman**<br>That Councillor Mrs S Woolley be elected as Chairman of the Lincolnshire Health & Wellbeing Board for 2013/2014. |
| | 2 | **Election of Vice-Chairman**<br>That Dr Sunil Hindocha be elected as Vice-Chairman of the Lincolnshire Health & Wellbeing Board for 2013/2014. |
| | 7 | **Chairman's Announcements**<br>For the Chairman to send a response on behalf of the Lincolnshire Health & Wellbeing Board with regard to the Letter from Norman Lamb MP Minister of State for Care and Support – Delivery of the Winterbourne View Concordat and review commitments. |
| | 8 | **Health & Wellbeing Boards Terms of Reference and Operating Procedures**<br>1. That the terms of reference detailed at Appendix A be amended to incorporate the amendments listed and any other typographical errors.<br>2. That the Health & Wellbeing Board Advisor be requested to present membership information of other Health & Wellbeing Boards to the next meeting of the Board. |
| | 9 | **Disabled Children's Charter**<br>That the Health & Wellbeing Board agreed to sign up to the Disabled Children's Charter for Health & Wellbeing Boards, subject to the wording of the Charter being Amended to read 'engaged with'. |
| | 10 | **Health & Wellbeing Board – Development Tool**<br>1. That the Boards current position within the assessment tool be noted and that the Boards progress be review in March 2014 to inform the 2013/2014 Annual Report.<br>2. That the Health & Wellbeing Board Advisor was to have a discussion with Andrew Leary concerning functions discharged at a local level and that this information should be presented to the next meeting of the Board. |
| | 11 | **The Lincolnshire Public Health Annual Report 2012**<br>That the Lincolnshire Public Health Annual Report 2012 be received. |

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| | 12 | **Dementia Strategy Update**<br>1. That the launch of the consultation for the Lincolnshire Joint Strategy for Dementia be noted.<br>2. That the Board members be encouraged to comment on the discussion document through the website.<br>3. That the approach for partnership working be agreed. |
| | 13 | **Letter inviting expressions of interest for Health and Social Care Integration 'Pioneers'**<br>That the Lincolnshire Health & Wellbeing Board offered their support to the making of an expression of interest for Health and Social Care Integration Pioneers on behalf of Lincolnshire |
| | 14 | **Lincolnshire Health & Safety Wellbeing Board – forward plan items**<br>That the items raised at the minute numbers 8 and 10, and those detailed above be included on the work programme for the Lincolnshire Health and Wellbeing Board. |
| | 16 | **Future scheduled meeting dates**<br>That the following scheduled meeting dates be noted –<br>Tuesday 10 September 2013<br>Tuesday 10 December 2013<br>Tuesday 25 March 2014<br>Tuesday 10 June 2014<br>Tuesday 30 September 2014<br>Tuesday 9 December 2014 |
| **10 September 2013** | 19 | **Minutes of the Meeting held on 11 June 2013**<br>That the Minutes of the meeting held on 11 June 2013 be confirmed and signed by the Chairman as a correct record. |
| | 22 | **Pharmaceutical Needs Assessment**<br>1. That agreement be given to the continuation of the Pharmaceutical Needs Assessment (PNA) Core Group to develop the needs assessment on its behalf in line with statutory regulations.<br>2. That the necessary representation be provided at the PNA Core Group in order to provide the expertise required to fulfil the legal requirements placed on the Board in relation to the PNA. |

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| | 23 | **Terms of Reference and Procedure Rules**<br>1. That the Terms of Reference and Procedural Rules presented be approved subject to the Roles and Responsibilities of NHS England being amended by the health and Wellbeing Board Advisor after the meeting.<br>2. That the Terms of Reference be reviewed at the June 2014 meeting of the Board. |
| | 24 | **Joint Health and Wellbeing Board Statement of Intent**<br>1.That the Statement of Intent for the Board detailed below be agreed.<br>*'Lincolnshire Health and Wellbeing Board is taking the lead for better health and wellbeing for the people of our county'*<br>2. That the Statement of Intent agreed at 1 above be reviewed at the AGM. |
| | 25 | **Joint Health and Wellbeing Strategy Sponsors**<br>That the Board agrees to the Sponsors as detailed in the minutes to take forward the outcomes within the five themes of the Joint Health and Wellbeing Strategy and the details agreed in relation to the operating/delivery groups identified to support the work of the Strategy. |
| | 26 | **Lincolnshire Sustainable Review**<br>That the presentation entitled 'Lincolnshire Sustainable Services review Health and Wellbeing Board Update' be received. |
| | 27 | **Social Care and Health Funding**<br>1. That the 2013/14 projected outturn be noted.<br>2. That the guidance on the ITF from the Local Government Association and NHS England detailed at Appendix B to the report be noted.<br>3 That the plans for bringing a updated paper to the December meeting indicating proposed investment in 2014/15 and 2015/16 be noted |
| | 28 | **An Action Log of Previous Decisions**<br>That the Action Log of previous decisions of the Board be noted. |
| | 29 | **Lincolnshire Health and Wellbeing Board – Forward Plan**<br>That the Forward Plan presented be accepted subject to the addition of:-<br>Social Care and Health Funding be added to the agenda for December 2013 and March 2014 meeting. |

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| | | Sustainable Services Review and Commissioning Plans being added to the March 2014 meeting; and<br>Terms of Reference and procedure Rules and Statement of Intent being added to the June 2014 meeting. |
| **10 December 2013** | 32 | **Minutes of the Meeting held of 10 September 2013**<br>That the minutes of the meeting held on 10 September2013 be confirmed and signed by the Chairman as a correct record. |
| | 33 | **Action Updates from the previous meeting**<br>That the completed actions as detailed be noted. |
| | 35 | **Lincolnshire Sustainable Services Review**<br>That approval be given to the blueprint document presented and that further reports during phase two of the programme be received by the Board. |
| | 36 | **Integrated Transformation Fund proposals to Develop a Structure to Support Joint Commissioning**<br>1 That the content of the report and Appendices be noted.<br>2. That the agreement previously reached in March 2013, on the use of allocated funds in 2013/14 be noted, in order that money can be transferred from the Area Team to Lincolnshire (Appendices A, B and C).<br>3. That the 'special. Meeting of the Health and Wellbeing Board meeting on 5 February 2014 to formally agree the two year plan to spend the Integration Transformation Fund in 2104/15 and 2105/16 be noted.<br>4. That the five 'early implementers' priorities be agreed.<br>5. That the outline structure for joint commissioning arrangements as detailed at Appendix D be agreed. |
| | 37 | **The Lincolnshire Children and Young People's Plan**<br>That the Children and Young People's Plan 2013 – 2016 be noted. |
| | 38 | **Lincolnshire Joint Commissioning Strategy for Dementia Care 2014 2017: The Way Forward**<br>1. That the Consultation Evaluation Report detailed at Appendix A be endorsed and that |

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| | | agreement be given to its publication.<br>2. That the draft Joint Commissioning Strategy 2014 – 2017 be endorsed; and that the planned timetable for further County Council sign-off through the Adult Scrutiny Committee on 29 January 2014; and the Executive on 4 February 2014 (Appendix B); and Health sign-off via Mental health Lead Officer, Allan Kitt through the four CCG Governing Bodies in December and January, following endorsement by the Board be agreed.<br>3. That the draft Initial Action Plan (Appendix C) be noted.<br>4. That the proposed approach to manage strategy delivery via the Joint Dementia Core Group be endorsed. |
| | 39 | **Healthwatch Lincolnshire**<br>That the report be noted. |
| | 40 | **An Action Log of Previous Decisions**<br>That the Action Log of previous decisions of the Board be noted. |
| | 41 | **Lincolnshire Health and Wellbeing Board – Forward Plan**<br>That the forward plan for formal meetings and informal workshop sessions as presented be accepted. |
| **28 January 2014** | 44 | **Better Care Fund Submission Document: 'First –Cut'**<br>1. That the content of the Better Care Fund submission document as presented be noted.<br>2. That the Better Care Fund 'first-cut' submission document to NHS England be agreed, and that a copy of any subsequent amendments be emailed out to Board members for comments/information prior to the documents submission to NHS England by 15 February 2014 to meet the national conditions.<br>3. That a further report concerning the Better Care Fund final submission be received at the next meeting of the Lincolnshire Health and wellbeing Board on 25 March 2014, prior to submission to NHS England.<br>4 That the Better Care Fund be added as an item for discussion for the informal meeting scheduled to be held on the 25 February 2014. |
| **25 March 2014** | 47a | **Minutes of Meetings of the Lincolnshire Health and Wellbeing Board – 10 December 2013**<br>That the minutes of the meeting of the Lincolnshire Health and Wellbeing Board held |

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| | | on 10 December 2013, be confirmed and signed by the Chairman as a correct record, subject to the sixth sub-heading on the list of attendees present being amended to read 'NHS England' |
| | 47b | **Minutes of Meetings of the Lincolnshire Health and Wellbeing Board – 28 January 2014**<br>That the minutes of the meeting of the Lincolnshire Health and Wellbeing Board held on 28 January 2014, be confirmed and signed by the Chairman as a correct record, subject to the sixth sub-heading on the list of attendees present being amended to read 'NHS England' |
| | 48 | **Action Updates from the Previous Meeting**<br>That the completed actions as detailed be noted. |
| | 50 | **Better Care Fund Final Submission**<br>1. That the Better Care Fund (BCF) Planning Template – part 1 (Final Submission document), as detailed at Appendix D to the report be agreed by the Board.<br>2. That the Board note that further updates concerning the BCF submission and the tracking of its progress be managed through the LSSR Governance Board in first instance and ultimately by the Health and Wellbeing Board. |
| | 51 | **Commissioning Plans**<br>1. That the contents of the Operational Plans for the<br>West Lincolnshire CCG;<br>Lincolnshire East CCG;<br>South West Lincolnshire CCG; and<br>South Lincolnshire CCG<br>be accepted by the Lincolnshire Health and Wellbeing Board as meeting the outcomes of the Lincolnshire Joint Health and Wellbeing Strategy.<br>2. That the NHS England Draft Operational Plan 2014/16 and Emerging Strategy Update as presented be noted and that a copy of the National Specialised Plan be presented to the June meeting of the Lincolnshire Health and Wellbeing Board. |
| | 52 | **Annual Report of the Director of Public Health on the Health of the People of Lincolnshire 2013**<br>That the Annual report of the Director of Public Health on the Health of the People of Lincolnshire 2013 be noted. |

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| | 53 | **Lincolnshire Sustainable Services Review**<br>That the verbal update on the progress of the Lincolnshire Sustainable Services Review be noted. |
| | 54 | **The Lincolnshire Safeguarding Children's Board**<br>That the report on the role of the Lincolnshire safeguarding Children Board and its Sub-Group be noted. |
| | 55 | **Revire of Health Services for Children Looked After and Safeguarding in Lincolnshire**<br>That the review of Health Services for Children Looked After and Safeguarding Lincolnshire item be deferred to a future meeting of the Board. |
| | 56 | **Autism Self-Evaluation 2013**<br>That the Autism Self-Evaluation 2013 be noted as evidence of local planning and support for local implementation work. |
| | 57 | **Support and Aspiration**<br>That the Support and Aspiration report presented be noted. |
| | 58 | **That the Action Log of Previous**<br>That the Action Log of previous decisions of the Lincolnshire Health and Wellbeing Board be noted. |
| | 59 | **Lincolnshire Health and Wellbeing Board – Forward Plan**<br>1. That the forward plan for informal meetings and informal workshops sessions as presented be agreed.<br>2. That the deferred item Review of Health Services for Children Looked After and Safeguarding in Lincolnshire be added to a future agenda.<br>3. That the National Specialised Plan from NHS England be added to the agenda for the 10 June 2014 meeting. |
| **9 May 2014** | 62 | **Lincolnshire Health and Care (Formerly known as the Lincolnshire Sustainable Services Review**<br>1. That the processes set out in the report which focused on the areas detailed below be noted.<br><br>Developing robust proposals for a sustainable and safe health and social care economy for the future;<br>Achieving external assurance on the proposal;<br>Consulting widely on the proposal;<br>Responding to feedback in the final proposal; and<br>Robust decision making throughout. |

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| | | 2. That the revised programme detailed at Appendix B to the report be noted.<br><br>3. That agreement be given for an additional meeting of the Lincolnshire Health and Wellbeing Board at a date to be agreed as part of the decision making on the proposal and business case for consultation.<br><br>4. That agreement be given to a further meeting of the Lincolnshire Health and Wellbeing Board at the end of January 2015, as part of decision making on the final proposal and business case. |

| Formal meeting dates | Decision/Authorisation item | Discussion item | Information item |
|---|---|---|---|
| **9th May 2014**<br><br>**(additional meeting) 3.30 @New Life Centre, Sleaford** | **Lincolnshire Health and Care (formerly known as Lincolnshire Sustainable Services Review**<br>Update of plans in next phase, approach and decision making process<br>**Dr Tony Hill, Director of Public Health** | | |
| **10th June 2014**<br><br>**2.00pm in Committee room 1 @Lincolnshire County Council** | **Annual General Meeting**<br>Election of Chair and Vice Chair<br><br>**Terms of Reference and Procedural Rules, roles and responsibilities of core Board members**<br>Review and formal agreement<br>**Martin Wilson, Health and Wellbeing Board Advisor**<br><br>**Draft Direct Commissioning Operational Plan 2014-16 & Emerging Strategy Update**<br>NHS England Local Area Team<br>**Andy Leary, NHS England** | **Lincolnshire Health and Wellbeing Board development assessment tool**<br>Review current position against baseline in June 2013<br>**Martin Wilson, Health and Wellbeing Board Advisor**<br><br>**Lincolnshire Health and Care**<br>Update on current position<br>**Dr Tony Hill, Director of Public Health**<br><br>**Review of Health Services for Children Looked After and Safeguarding in Lincolnshire(B/F from previous meeting)**<br>Care Quality Commission report - information for the Board (Theme 4 JHWS activity update)<br>**Sharon Robson , Executive Nurse, SWL CCG and Jan Gunter,** | |

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| Formal meeting dates | Decision/Authorisation item | Discussion item | Information item |
|---|---|---|---|
| | | **Designated Nurse Safeguarding, SWL CCG** | |
| **30th September 2014**<br><br>**2.00pm in Committee room 1 @Lincolnshire County Council** | **Joint Health and Wellbeing Strategy Assurance Report 2014-15**<br>Report on assurance framework to identify areas of progress in the delivery of the JHWS and other areas of development.<br>**David Stacey, Programme Manager for Strategy and Performance**<br><br>**Lincolnshire Health and Care**<br>Update of plans in next phase and agreement of actions required<br>**Dr Tony Hill, Director of Public Health** | **Pharmaceutical Needs Assessment** – Discharge of HWB statutory functions –<br>**David Stacey, Programme Manager, Public Health**<br><br>**Lincolnshire Joint Commissioning Board**<br>Discussion paper on linkages to Health and Wellbeing Board<br>**Gary Thompson, Chair** | |
| **9th December 2014**<br><br>**2.00pm in Committee room 1 @Lincolnshire County Council** | **Pharmaceutical Needs Assessment** – Discharge of HWB statutory functions and decision –<br>**David Stacey, Programme Manager** | **Commissioning plans**<br>• CCG<br>• ASC<br>• Childrens<br>• NHS England<br>• Public Health | |
| **27th January 2015**<br><br>**2.00pm in Committee room 1 @Lincolnshire County Council** | | | |

| Formal meeting dates | Decision/Authorisation item | Discussion item | Information item |
|---|---|---|---|
| **24th March 2015**<br><br>**2.00pm in Committee room 1 @Lincolnshire County Council** | | | |

## Informal workshop sessions for Health and Wellbeing Board

| Meeting date | Discussion item | Information item |
|---|---|---|
| **9th May 2014**<br><br>**12.00 @New Life Centre, Sleaford** | **Lincolnshire Health and Care**<br>Informal discussion on consultation proposals<br><br>**Health and Wellbeing Strategy**<br>Discussion with Board sponsors on current position on delivery of outcomes | |
| **11th September 2014**<br><br>**(proposed additional meeting moved from 8th July)** | **Join Health and Wellbeing Strategy Assurance**<br>Informal discussion on the Assurance Process<br><br>**Lincolnshire Health and Care**<br>Informal Board session to review current position | |
| **28th October 2014**<br><br>**Venue tbc** | | |
| **26th November 2014**<br><br>**Venue tbc** | Voluntary sector update on support for the health and wellbeing strategy | |
| **24th February 2015**<br><br>**Venue tbc** | | |

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