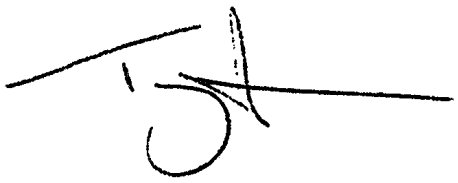
County Offices
Newland
Lincoln
LN1 1YL

12 June 2017

Lincolnshire Health and Wellbeing Board

A Meeting of the Lincolnshire Health and Wellbeing Board will be held on Tuesday, 20 June 2017 at 10.00 am 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 P A Bradwell (Executive Councillor Adult Care, Health and Children's Services), Mrs S Woolley (Executive Councillor NHS Liaison and Community Engagement), C N Worth (Executive Councillor Culture and Emergency Services), Mrs W Bowkett, R L Foulkes, C E H Marfleet, C R Oxby and N H Pepper

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

District Council: 1 Vacancy

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

Healthwatch Lincolnshire: Sarah Fletcher

NHS England: Jim Heys

(*) Permanent Membership

LINCOLNSHIRE HEALTH AND WELLBEING BOARD AGENDA
TUESDAY, 20 JUNE 2017

Item	Title	Pages	Estimated Time
1	**Election of Chairman**		
2	**Election of Vice-Chairman**		
3	**Apologies for Absence/Replacement Members**		
4	**Declarations of Members' Interest**		
5	**Minutes of the Meeting of the Lincolnshire Health and Wellbeing Board meeting held on 7 March 2017**	7 - 18	
6	**Action Updates from the previous meeting** *(For the Lincolnshire Health and Wellbeing Board to consider the actions arising from the previous meeting)*	19 - 20	
7	**Chairman's Announcements** *(For the Lincolnshire Health and Wellbeing Board to note the Chairman's announcements)*	21 - 22	
8	**Decision/Authorisation Items**		
8a	**Terms of Reference and Procedure Rules, Roles and Responsibilities of Core Board Members** *(To receive a report from Alison Christie, Programme Manager Health and Wellbeing, which asks the Board to re-affirm the Terms of Reference, Procedure Rules and Board Members Roles and Responsibilities)*	23 - 38	
8b	**Housing, Health and Care Delivery Group** *(To receive a report from Glen Garrod (Executive Director of Adult Care and Community Wellbeing), which asks the Board to consider and agree the Terms of Reference and governance arrangements and to provide strategic leadership and direction to the Housing, Health and Care Delivery Group. The Board are also asked to identify a suitable Chair for the group)*	39 - 46	

Item	Title	Pages	Estimated Time
8c	**Integration of Services for Children and Young People with a Special Educational Need and/or Disability** *(To receive a report by Debbie Barnes (Executive Director of Children's Services) which identifies the opportunities to improve outcomes for children and young people with special educational needs and disabilities through integration of commissioning and service delivery)*	47 - 58	
8d	**Developing Integrated, Neighbourhood Working - Update** *(To receive a report from Carol Cottingham (Director of Service Redesign – Lincolnshire STP Delivery Unit) which sets out the key elements of the Neighbourhood Working programme and provides an update of the current status of the programme)*	59 - 64	
8e	**Health and Wellbeing in Lincolnshire: Overview of the 2017 Joint Strategic Needs Assessment** *(To receive a report and presentation from Chris Weston (Public Health Consultant – Wider Determinants of Health) which provides the Board with an overview of the topics in the new JSNA published in the Spring 2017)*	65 - 116	
9	**Discussion Items**		
9a	**Lincolnshire Sustainability and Transformation Plan (STP) Priorities and Update** *(To receive a report and presentation from Sarah Furley (STP Programme Director) which provides the Board with an update on the delivery of the Sustainability and Transformation Plan)*	117 - 122	
9b	**Better Care Fund (BCF) 2016/2017 and 2017/2018** *(To receive a report from Glen Garrod (Executive Director of Adult Care and Community Wellbeing) which provides the Board with an update on the Better Care Fund plans and includes an update on the graduation bid, additional funding announced by the Chancellor in March 2017 and performance reporting for 2016/17 and 2017/18)*	123 - 148	

Item	Title	Pages	Estimated Time
10	**Information Items**		
10a	**Lincolnshire Pharmaceutical Needs Assessment** *(To receive a report from Chris Weston (Public Health Consultant – Wider Determinants of Health) which asks the Board to receive a report from the PNA Steering Group which outlines the arrangements for reviewing the PNA (due to be republished in March 2018)*	149 - 156	
10b	**Health and Wellbeing Grant Fund - Half Yearly Update** *(To receive a report from Alison Christie (Programme Manager Health and Wellbeing) which provides the Board with a half yearly report on the Health and Wellbeing Grant Fund projects)*	157 - 168	
10c	**An Action Log of Previous Decisions** *(For the Health and Wellbeing Board to note decisions taken since May 2016)*	169 - 174	
10d	**Lincolnshire Health and Wellbeing Board Forward Plan** *(This item provides the Board with an opportunity to discuss items for future meetings which will subsequently be included on the Forward Plan)*	175 - 176	
10e	**Future Scheduled Meetings Dates** *(For the Board to note the following scheduled meeting dates for the remainder of 2017 and for 2018* *26 September 2017, 5 December 2017, 27 March 2018, 6 June 2018, 25 September 2018 and 4 December 2018. Please note that all the above meetings start at 2.00pm)*		

Democratic Services Officer Contact Details

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

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

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www.lincolnshire.gov.uk/committeerecords

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LINCOLNSHIRE HEALTH AND WELLBEING BOARD
7 MARCH 2017

PRESENT: COUNCILLOR MRS S WOOLLEY (CHAIRMAN)

Lincolnshire County Council: Councillors Mrs P A Bradwell (Executive Councillor for Adult Care, Health and Children's Services), D Brailsford (Executive Support Councillor Children's Services), C R Oxby and N H Pepper.

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

District Council: Councillor Donald Nannestad (District Council).

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

Healthwatch Lincolnshire: Sarah Fletcher.

NHS England: Jim Heys.

Officers In Attendance: Alison Christie (Programme Manager, Health and Wellbeing Board), Katrina Cope (Senior Democratic Services Officer), David Stacey (Programme Manager, Public Health), Councillor Sylvia Hughes (Chairman of Northamptonshire Health and Wellbeing Board) and Luisa McIntosh (North Kesteven District Council).

30 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

Apologies for absence were received from Councillors C N Worth (Executive Councillor Culture and Emergency Services), B W Keimach and Mrs M Brighton OBE (District Council representative).

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

The Chairman welcomed to the meeting Councillor Sylvia Hughes, Chairman of Northamptonshire Health and Wellbeing Board.

31 DECLARATIONS OF MEMBERS' INTEREST

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

32 MINUTES FROM THE LINCOLNSHIRE HEALTH AND WELLBEING BOARD MEETING HELD ON 6 DECEMBER 2016

RESOLVED

That the minutes of the previous meeting of the Lincolnshire Health and Wellbeing Board meeting held on 6 December 2016, be confirmed and signed by the Chairman as a correct record.

33 ACTION UPDATES FROM THE PREVIOUS MEETING

RESOLVED

That the Action Updates from the previous meeting be noted.

34 CHAIRMAN'S ANNOUNCEMENTS

The Chairman advised the Committee that there were no further amendments to those already circulated.

The Board was advised that the Sustainability and Transformation Plan (STP) had not been included as an item on the agenda, as there was nothing further to add at the moment. It was noted that the STP had been sent to NHS England and that it would be approximately 5/6 weeks before a response was received.

35 DECISION/AUTHORISATION ITEMS

35a Annual Report of the Director of Public Health on the health of the people of Lincolnshire 2016

Consideration was given to a report from Tony McGinty, Interim Director of Public Health, which provided the Board with the Director of Public Health's Annual report on the health of the people of Lincolnshire 2016, a copy of which was detailed at Appendix A to the report.

The Board were reminded that it was statutory duty of the Director of Public Health to produce an annual report on the health of the people of the areas he/she serves. The report was an independent professional view of the state of the health of the people of Lincolnshire, with recommendations on the action needed by a range of organisations and partnerships.

The Interim Director of Public Health in his short presentation advised that this was his first annual description of the state of the health of the people of Lincolnshire.

The Board was advised that the focus of this year's report was on mental health and mental illness profile of local people.

The report highlighted that mental health was fundamental to all, in enabling individuals to achieve their goals and potential in life; and to support their ability to make good choices through life. It was highlighted that many different things through life could challenge or support the mental health of individuals and communities. The annual report was therefore presented as a series of points along the average life-span, highlighting the risks and opportunities to mental health at each of the various stages of life, with each chapter describing more fully each of the stages. Then at the end of each chapter were a series of recommendations to ensure improvement.

The presentation highlighted the scale of mental ill-health in Lincolnshire. The Board noted that it was estimated that there was over 3,000 Lincolnshire women per year having mental health problems during pregnancy and after childbirth. That over 9% of Lincolnshire's children aged 5 to 16 were estimated to have a diagnosed condition; and that over 100,000 adults in Lincolnshire were estimated to have a diagnosed common mental health disorder; and that since 1999 there had been at least 60 deaths from suicide in Lincolnshire.

In conclusion, the Board was advised that there were seventeen recommendations within the report which were grouped into four key focus areas. These were:-

- Risk factors;
- Perinatal and maternal mental health conditions;
- Childhood and adolescent mental health conditions; and
- Adult & older adult mental health conditions.

It was highlighted that there were a number of organisations who had a role to play in delivering the recommendations, including the local authority, district councils, Clinical Commissioning Groups, health and social care providers, community and voluntary sector and the general population.

During discussion, the following issues were raised:-

- Some concern was expressed regarding the childhood and adolescent mental health slide, last bullet point which seemed to suggest that Looked After Children had a higher risk of mental ill health. It was highlighted that most LAC had issues prior to coming into the authority. Officers agreed to amend the slide accordingly;
- Some members extended their thanks to the Interim Director of Public Health for an excellent piece of work which would help inform the Joint Strategic Needs Assessment. A request was made for a work plan to be compiled so that an overall picture could be tracked as all organisations had a responsibility for mental health issues;
- That there needed to be more joined up thinking during the transition from children's to adults. The Board was advised that work was ongoing with children's services with regard to early intervention. Reference was also made for the need for better integration with CCGs and Child Adolescent Mental

Health Service (CAMHS) to provide more community based provision. Officers agreed to look at the activity and to be more proactive when pulling streams together;

- The Board was advised that there was not a significant difference between the figures pertaining to Lincolnshire and the East Midlands;
- The professional categorisation of mental health. Some members felt that Mental Health was under diagnosed, it was mainly support that was offered, as diagnosis was too sub-specialised; and
- Reference was made to the fact that mental health issues had not been identified as a separate priority in the current Joint Health and Wellbeing Strategy, as it was like a golden thread, affecting all ages from birth to death at different stages of an individual's life.

RESOLVED

That the Annual Report on the health of the people of Lincolnshire from the Interim Director of Public Health and the recommendations contained within each chapter be received.

35b Integration Self-Assessment - Next Steps

Consideration was given to a report from Tony McGinty, Interim Director of Public Health, which presented to the Board information relating to priority areas for improvement which had been identified by stakeholders; and to propose a series of next steps to promote further integration.

The Programme Manager Health and Wellbeing advised the Board of the progress that had taken place following the Integration Self-Assessment exercise. The Board was advised that five responses had been received; and that a summary of the feedback was contained in Appendix A to the report. The report proposed two priority areas for improvement.

During discussion, the following points were raised:-

- A request was made for the inclusion of children with disabilities and children with special educational needs; and
- That it was felt that as the Districts were responsible for housing; this particular area of work should be driven by the districts.

RESOLVED

1. That the feedback from partners as detailed in Appendix A be noted.

2. That the proposal to focus on:

    - Promoting closer integration between health, care and housing; and
    - Progressing the Proactive Care agenda to include children with disabilities and children with special needs.

3. That delegation be given to the Executive Director of Adult Care and Community Wellbeing and the Interim Director of Public Health the responsibility for progressing the Next Steps under Section 1a and 1b of the report presented.

35c Joint Health and Wellbeing Strategy - Engagement Plan

The Committee gave consideration to a report from David Stacey, Programme Manager, Health and Wellbeing, which reminded the Board of its statutory requirements to produce a Joint Health and Wellbeing Strategy (JHWS), which would set out how it would engage with people that live and work in Lincolnshire.

It was reported that a review of the Joint Strategic Needs Assessment for Lincolnshire had been undertaken and was due to be published in the spring. Also, it was noted that the Board had agreed an approach to developing the next JHWS, which would take evidence from the JSNA to prioritise the health needs and care in the community over the course of the next five years.

The report explained what stakeholder and community engagement would be undertaken; and a request was made that as part of the communication by the Board, that members of the Board agreed to report back to respective Boards and Management Teams, where appropriate, on the progress and approach being taken to develop the Strategy. The proposed principles of all Lincolnshire Health and Wellbeing Board (LHWB) communications with stakeholders were set out on page 59 of the report presented.

Details of the next steps required and timescales were shown at the bottom of page 59. The timescales advised that the JHWS for 2018/2023 would be finalised and signed off during January/March 2018.

In conclusion, it was noted that in undertaking engagement on the development of the JHWS, the LHWB would be able to demonstrate that it had taken account of the views of the people who lived and worked in Lincolnshire; and that the process had been undertaken in an open and transparent way.

During discussion, the following issues were raised:-

- The need for input from each organisation on the Board to help create the Joint Health and Wellbeing Strategy. An invitation was extended to one/two officers from each District to attend the workshops; and
- One member felt that more public consultation needed to be done; rather than just approaching selective groups. It was important to have an equal voice if the Strategy was going to be owned. A suggestion was made as to whether consultation could be undertaken on-line, as not everyone would be available to attend a meeting. Officers agreed that on-line consultation could be built in to the process. It was confirmed that there was currently 35 topics in the strategy, which were reported to the Board each year. It was felt that the prioritization framework would be used as a benchmark, and that each

representative organisation should nominate a lead officer to attend the prioritisation workshops.

RESOLVED

1. That the approach to engagement and development of the JHWS for Lincolnshire be agreed.

2. That a lead officer be nominated from each of the representative organisations on the LHWB to undertake the prioritisation of the Joint Strategic Needs Assessment (JSNA) evidence.

3. That all members agree to report back to respective Boards and Management Teams, where appropriate, on the progress and approach being taken to the development of the JHWS.

35d Better Care Fund (BCF) 2016/17 and Future Planning

Consideration was given to a report from Glen Garrod, Executive Director of Adult Care & Community Wellbeing on behalf of the Joint Commissioning Board, which provided the Board with an update on Lincolnshire's Plan for updating the Better Care Narrative Plan and Planning Template for 2017/18 and 2018/19. Documents appended to the report included:-

- Appendix A which provided the Board with an update on performance against the key BCF metrics for the first nine months of 2016/17;
- Appendix B provided a copy of the Lincolnshire County Council Internal Audit paper, which had reviewed BCF Performance reporting; and
- Appendix C which provided the Board with the latest version of the draft Graduation Plan.

The Executive Director of Adult Care & Community Wellbeing when guiding the Board through the report made particular reference to:-

- That the Better Care Fund guidance had still not been received;
- That in tier two areas there were additional challenges; and that all had a contribution to make;
- That the BCF was for two years, and that there was to be further changes in next 12 months;
- The Board was advised that it was expected that in the budget speech the Chancellor would be announcing there would be extra money for social care;
- That there was still a need for improvement for non-elective admissions (NEA); the local target was for a 2.7% reduction. It was noted that for the first six months a reduction of 1.6% had been achieved;
- That for permanent admissions to residential and nursing care there had been 105 more than planned for at this point in the year;
- That for Delayed Transfers of Care there had been a total of 9,503 delayed days for patients in Q3, this figure was 2,078 higher than the original target of

7,425 days. It was further highlighted that nationally performance was worsening in key targeted areas, notably non-elective admissions and Delayed Transfers of Care. Detailed information in relation to the two areas was detailed at the bottom of page 63 and the top of page 64 of the report presented. It was reported that a £3.6m Risk Contingency had been established to address the financial impact of not achieving the NEA target. The Board was reminded that the Council was currently assuming that there would be no Pay-for-Performance requirements in 2017/18;

- The extra complication with regard to Disabled Facility Grants. It was hoped that the BCF Planning Guidance would hopefully provide some clarity on the arrangements for DFGs; and
- The Board noted that a Graduation Submission had been prepared by Lincolnshire, a copy of which was detailed at Appendix D to the report.

During discussion, the following issues were raised:-

- Page 72 of Appendix A – Better Care Fund 2016/17 Performance Report – Quarter 3 – A suggestion was made that District Councils might be able to help with regard to housing issues. It was noted that the performance reflected the national template set by government;
- It was highlighted that any housing delays were discussed with Districts and the NHS. It was noted that relatively few delays were as a result of DFGs, or for the need of specialist equipment. Some Councils elsewhere in the Country did however apply a fastrack process; and
- It was reported that some patients had encountered some problems when leaving hospital, an example given was concerning a patient that had spent a year in a nursing home, as social care had no suitable care packages available. The Board was advised that the Council had a small number of patients in nursing homes, just so that the hospital system could be freed up. It was highlighted that the pressure on hospitals now was significant, as now all patients leave hospital as soon as possible. It was felt by some members that the 30 day turn around was just shifting the pressure on to another area.

RESOLVED

1. That the BCF performance as detailed at Appendix A for the first nine months of 2016/17 be noted.

2. That the performance achieved on Non-Elective Admissions in the first nine months of 2016/17 it is recommended by the Joint Commissioning Board that £3m Risk Contingency established for this financial year will be fully utilised by the CCGs in meeting the extra cost to ULHT be noted.

3. That the Internal Audit Report at Appendix B on performance reporting be noted.

4. That the updated draft Graduation Plan at Appendix C be noted.

36 DISCUSSION ITEMS

36a Service Users with Learning Disabilities

The Board gave consideration to a report from Glen Garrod, Executive Director of Adult Care and Community Wellbeing, which provide an update on a Regional Improvement programme in relation to support for people with Learning Disabilities and provided a position statement for Lincolnshire against the agreed regional baseline standards. The report also highlighted the additional work that was being taken forward to deliver further local, regional and National improvement.

In conclusion, it was reported that Lincolnshire continued to demonstrate a range of strengths in supporting people with Learning Disabilities to achieve improved outcomes.

Some members agreed that the report highlighted a good piece of work which had been collectively done; and represented a good example of integrated working.

Members of the Board expressed their thanks to officers for a job well done.

RESOLVED

That the report concerning Service Users with Disabilities be noted.

36b NHS Immunisation and Screening for patients in Lincolnshire

Consideration was given to a report from Healthwatch Lincolnshire, which provided the Board with the findings of a Healthwatch Lincolnshire countywide survey as to patient's experiences of NHS Immunisation and Screening.

As summary of the results of the survey were highlighted on page 121 of the report. Some of the concerns raised included:-

- That 1 in 4 families were choosing not to immunise children because of safety concerns;
- 42% of responding individuals had advised that they had not been invited to attend pneumococcal immunisation;
- That 14,000 woman were choosing not to attend cervical screening;
- That where a woman had missed her cervical appointment, data had suggested that they were three times more likely not to re-schedule their appointment;
- That 23% of adults had not been offered bowel screening;
- 13.7% of women had advised they had not been offered breast screening;
- 59% of male respondents had advised that they had not been offered AAA; and
- 43% of respondents had not been offered NHS Health checks.

In summary, it was felt that communication needed to be increased and be more clear and consistent; that attitudes needed to be more positive; to increase patient participation; and that a system needed to be put into place to improve patient screening.

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

- Some members found the information presented surprising; as screening was a national programme which people were invited to attend, but quite a few had chosen to forget. Some concern was expressed to the number of people that had not participated in screening programmes. The Board noted that cervical screening patients received 3 reminders;
- Some concern was expressed that the survey conclusions was from a small number of responders. It was felt that the results needed to be analysed further;
- It was felt that there was a misconception from a patient perceptive as to what a health check comprised of; one member highlighted that part of the health visitor's role used to be to encourage patients to attend screening; and participate in immunisation programmes. It was highlighted that due to changes in provision, the GPs present felt that this no longer happened. It was highlighted that there was some confusion as to what was commissioned and by whom concerning immunisations, a responsibility that rested with Public Health England (PHE) for early years immunisations. It was agreed that a further report from the Health Protection Board concerning the performance of immunisation/screening programme would be reported to a future meeting of the Board; and
- Clarification was given that the Health Protection Board had a statutory responsibility to ensure delivery to local people.

The Board extended their thanks to Healthwatch Lincolnshire for an excellent piece of collective work.

RESOLVED

1. That the report concerning NHS immunisation and screening for patients in Lincolnshire be received.

2. That a report from the Health Protection Board concerning immunisation/screening programme performance be received at a future meeting of the Board.

36c District/Locality Update: North Kesteven's Health and Wellbeing Strategy

The Board gave consideration to a report from Councillor Mrs Marion Brighton OBE, Leader of North Kesteven District Council, which provided a brief overview of North Kesteven District Council's health and wellbeing strategy.

Louisa McIntosh from North Kesteven District Council guided the Board through the strategy; and advised that the purpose of the strategy was to identify the key priorities for improving health and wellbeing; identify existing arrangements that supported residents to improve their health and wellbeing; identify a practical level as to what the Council was able to achieve to support good health and wellbeing; and to support the creation of a District wide action plan to support good health and wellbeing. A copy of the strategy attached as Appendix A to the report.

An action plan was detailed on page 169 of the Appendix which identified a series of objectives that had been identified for each of the priorities, which would be achieved by working in collaboration with other service providers across the District.

The Board was advised that North Kesteven had an existing performance management system which would be used to monitor the performance of actions defined in the strategy and that Partnership NK's Our Communities Action Group would be taking responsibility for the monitoring and evaluation of objectives outlined in the strategy.

It was highlighted that the Strategy was work in progress; and as such was updated on a regular basis.

The Chairman on behalf of the Board extended her thanks for the presentation; and for the compilation of a very readable document.

RESOLVED

That the North Kesteven's Health and Wellbeing Strategy, as presented be received.

37 INFORMATION ITEMS

37a 'ACTion Lincs' - Tackling Entrenched Rough Sleeping in Lincolnshire (Social Impact Bond Funding)

Consideration was given to a report from ACTion Lincs Partnership, which provided the Board with an overview of the project of Tackling Entrenched Rough Sleeping in Lincolnshire.

It was noted that an action plan was to be developed which would be presented to a future meeting of the Board.

RESOLVED

That the report be noted; and that an Action/Deliver Plan relating to ACTion Lincs – Tackling Entrenched Rough Sleeping in Lincolnshire (Social Impact Bond) be received at a future meeting.

37b Government Proposals for the Future Funding of Supported Housing

Report received for information.

37c An Action Log of previous Decisions

Report received for information.

37d Lincolnshire Health and Wellbeing Board - Forward Plan

Report received for information.

The meeting closed at 4.25 p.m.

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Meeting Date	Minute No	Agenda Item & Action Required	Update and Action Taken
07.06.16	**8a**	**TERMS OF REFERENCE, PROCEDURAL RULES, MEMBERS ROLES AND RESPONSIBILITIES** The Chairman agreed to look into the Boards make-up with regard to District Council Membership and Devolution implications. The Executive Director of Adult Care agreed to respond to the District's with regard to the BCF process.	This action is pending until after the County Council election in May 2017. The Executive Director of Adult Care has responded to the District's with regard to the BCF process. Some discussions are still ongoing.
	10b	**LINCOLNSHIRE HEALTH AND WELLBEING BOARD – FORWARD PLAN** That an Update on the Sustainability and Transformation Plan be added as an item to the Forward Plan for the 27 September 2016 meeting of the Lincolnshire Health and Wellbeing Board.	A report on the Sustainability and Transformation Plan presented to the Board on 27 September 2016
27.09.16		**NO ACTIONS RECORDED**	
06.12.16	**27a**	**INTEGRATION SELF-ASSESSMENT** Each partner organisation, including all district councils, NHS providers and Involving Lincs, share the details of this exercise with their governing body to raise awareness of the feedback and to gain commitment from stakeholders to develop a shared improvement plan to address the issues highlighted through this exercise Each partner is asked to identify their top three priority areas for improvement (ranked 1 to 3, with 1 being the top priority) and to feed this information back to the Programme Manager	A formal letter from Cllr Woolley and details of the Integration Self-Assessment were sent to partners on 12 December 2016. The letter asked partners to share the feedback with their governing bodies and to take the opportunity to identify up to 3 possible improvement areas which the Board could promote to improve integration in Lincolnshire. Partners were invited to send details of their priority areas to Alison Christie by Monday 30 January 2017. A reminder email was sent to partners on 16 January 2016

		Health and Wellbeing by the end of January 2017 A further report will then be presented to the March meeting	Report presented at March 2017 meeting
	27b	**BETTER CARE FUND 2016/17 & 2017/18** Delegation was given to the Executive Director of Adult Care and Community Wellbeing, in consultation with the Chairman of the Lincolnshire Health and Wellbeing Board, the responsibility to submit the BCF Plans 2017/18 – 2018/19	BCF Plans for 2017/18 – 2018/19 progressed by the Executive Director of Adult Care and Community Wellbeing in consultation with the Chairman of the Lincolnshire Health and Wellbeing Board.
	29c	**LINCOLNSHIRE HEALTH AND WELLBEING BOARD – FORWARD PLAN** That the following items be added to the Forward Plan:- • Sustainability & Transformation Plan to be included as a standing item; • Alternative Lead Officers; • North Kesteven Health and Wellbeing Strategy – March meeting • East Lindsey Health and Wellbeing – June meeting • Entrenched Rough Sleepers Social Impact Bond • Discussion item from Healthwatch relating to immunisation and screening	• At the 7 March 2017 Board meeting an update on the Sustainability and Transformation Plan is provided as part of Chairman's Announcements. • Changes noted and updated accordingly • North Kesteven's Health and Wellbeing Strategy included on the agenda for March 2017 • East Lindsey Health and Wellbeing Strategy added to the Forward Plan for June 2017 • An information report on the Entrenched Rough Sleepers Social Impact Bond included on the agenda for March 2017 • A discussion item on the report by Healthwatch into Immunisation and Screening Services included on the agenda for March 2017
07.03.17	**35a**	NO ACTIONS RECORDED	

Lincolnshire Health and Wellbeing Board – 20 June 2017

Chairman's Announcements

Cllr Mrs Marion Brighton OBE

In March 2017, Cllr Mrs Brighton announced she would be stepping down as a district councillor and as Leader of North Kesteven District Council. As a result of this decision Cllr Brighton will no longer be the district council representative on the Lincolnshire Health and Wellbeing Board. She has been a member of the Board since April 2013. On behalf of the Board, I would like to thank Cllr Brighton for her contribution in helping to improve the health and wellbeing outcomes in Lincolnshire.

Circulation of information to HWB Members

Following a re-organisation of duties in within Democratic Services, Katrina Cope will no longer be responsible for providing administrative support to the Health and Wellbeing Board. As a result, information sent out on behalf of the Chairman or Board will no longer be circulated by Katrina. All emails to Board Members will now be sent out from the hwb@lincolnshire.gov.uk email account.

Lincolnshire Safeguarding Children Board - Annual Report 2016/17

A copy of the Lincolnshire Safeguarding Children Board (LSCB) Annual Report 2016/17 has been circulated to Board Members for information. The report details the work carried out by the LSCB during the last twelve months and in particular highlight the areas of development.

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Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

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

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**20 June 2017**
Subject:	**Terms of Reference and Procedural Rules, Roles and Responsibilities of Core Board Members**

Summary:
The Lincolnshire Health and Wellbeing Board (HWB) is required to review its governance arrangements at the Annual General Meeting. This paper asks the HWB to re-affirm the Terms of Reference, Procedural Rules and Board Members Roles and Responsibilities.

In addition, the HWB is asked to consider proposals to review the Board's membership to ensure it is fit for purpose and able to provide place based system leadership.

Actions Required:
The Board is asked to:

- Re-affirm the Terms of Reference, Procedural Rules and Board Members Roles and Responsibilities;
- Agree to review membership as detailed in this report.

1. Background

The functions of the HWB 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;
- to provide advice, assistance or other support, as it thinks appropriate, for the purpose of encouraging joint commissioning;
- to prepare and publish a Joint Strategic Needs Assessment (JSNA) on the local population; and
- to prepare and publish a Joint Health and Wellbeing Strategy (JHWS).

In line with the legislation, the HWB became a formal committee of the County Council in April 2013. The HWB's Terms of Reference and Procedural Rules were formally adopted in September 2013 and are subject to annual review. The Terms of Reference and Procedural Rules, along with the Board Member's Roles and Responsibilities and Agenda Management Process, provide the formal governance arrangement for the HWB.

Legislation and statutory guidance pertaining to health and wellbeing boards has not been updated since the Board's formation in 2013. Therefore from a statutory perspective the aim, purpose and function of the HWB remains the same. However, following the local elections in May 2017, the Executive Councillor representation has been updated to reflect changes in portfolio areas confirmed at Full Council on 19 May 2017.

Following discussion with Democratic Services, minor changes have also been made to Section 13 in order to clarify the process for the production and approval of the minutes.

Review of Board Membership

Whilst the statutory requirements concerning core membership of HWBs have not changed since their conception in 2013, the clear drive is for HWBs to provide place based system leadership. The introduction of Sustainable Transformation Plans (STP); the increasing focus on closer partnership working and integration; the need to look beyond just health and care with specific initiatives which address wider determinants of health; and ongoing financial pressures mean the HWB needs to move beyond just developing a shared vision to agreeing action to deliver the shared vision.

National research by the Local Government Association refers to HWB needing to '*develop their place based leadership role to provide a compelling strategic context for STPs and to make progress on the wider determinants of health which are critically important to achieving a more sustainable health and care system in the long term.'*

With this in mind, the HWB is asked to agree to a review of the Board's membership during 2017 to ensure the Board is engaging the right stakeholders and is able to drive the integration agenda. The review will need to take account of:

- the national context and any policy changes as a result of the new government;
- the new Joint Health and Wellbeing Strategy;
- the establishment of a sub group of the HWB for Housing, Health and Care; and
- any arrangements or actions required to progress the priority areas for integration agreed by the HWB in March 2017.

The intention is to undertake the review during 2017 alongside the development of the JWHS. The outcome of the review will be presented to the HWB by December 2017 and the HWB will need to ask Lincolnshire County Council to formally approve any proposals as it will require a change to the Council's Constitution.

2. Conclusion

The Board is asked to re-affirm the governance documents and consider the proposal to review membership.

3. Consultation

Not applicable

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Terms of Reference, Procedural Rules, Board Members Roles and Responsibilities

5. Background Papers

Document	Where it can be accessed
The Power of Place – Health and Wellbeing Boards in 2017	https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/health-and-wellbeing-systems/research

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

Lincolnshire COUNTY COUNCIL

Appendix A

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

TERMS OF REFERENCE and PROCEDUAL RULES

June 2017

Next review date June 2018

Lincolnshire Health and Wellbeing Board
Terms of Reference and
Procedural Rules

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 production of the Pharmaceutical Needs Assessment and liaise with NHS England to ensure recommendations or gaps in service are addressed.

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

3.6 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.

3.7 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 Board's expectations that members will act in accordance with Board members/champions responsibilities listed at Appendix B.

5. Accountability

5.1 The Board carries formal delegated authority to carry out its functions under Sections 195 and 196 of 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.

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 Culture & Emergency Services
- Five designated Lincolnshire County Councillor's,
- The 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 to the Democratic Services Officer. 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 member's interests
3. Minutes from the previous meeting
4. Action updates from previous meeting
5. Chairman's Announcements
6. Decision/Authorisation Items
7. Discussion/Debate Items
8. Information Items
9. An action log of previous decisions
10. The work programme of planned future work
11. Date of next meeting

All papers for The Board to be provided to the Programme Manager Health and Wellbeing 15 working days before the date of the scheduled meeting for approval

with the Chairman. The appropriate committee report template should be used (See Agenda Process at Appendix C)

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 clear working days prior to the 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.

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.

1.5 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.

1.6 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 action log as part of the agenda to all Core Members.

13.2 The Secretariat will send the draft minutes to the Director of Public Health and lead officers within ten working days of the meeting for comment.

13.3 The draft minutes, following comment from relevant officers (point 13.2 above), 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 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.

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.

DEFINITIONS

Exempt Information
Information falling within any of the descriptions set out in Part I of Schedule 12A of 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 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 are not designated as core members. 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 Board meetings.

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

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

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

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
- Ensure progress is being made to address the priorities in the JHWS
- 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 JHWS
- Ensure all commissioning plans have been co-produced
- JHWS Board Sponsor 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

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.

Key roles and responsibilities of individual core board members:

Core Member	Key Roles and Responsibilities
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 Councillor	• 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
Director of 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 • 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	• Ensure that the Clinical Commissioning Group

Group representative	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
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.

Lincolnshire Health and Wellbeing Board Agenda Process

Standard Agenda Item	Item Detail	By When
1. Apologies	Core Members of the Board unable to attend formal HWB meeting	Notification of apologies to be sent to the Secretariat **Two working days** before Board meeting
2. Declaration of members interests	Core Members to declare any interest against agenda item listed	Notification to be given either **two working days** before Board meeting, or to the Chairman on the day of the meeting
3. Minutes from the previous meeting	Core members to formally amend and agree previous minutes which will be placed on the LCC website	At meeting
4. Action updates from previous meetings	Record to activity of the Board	Updated by Programme Manager Health and Wellbeing and presented at Board meeting for noting.
5. Chairman's announcements	Announcements of local, regional or national interest to the delivery of health and wellbeing in Lincolnshire	Written notice of announcements to Secretariat **seven working days** before Board meeting. Additional verbal updates provided at meeting.
6. Decision/Authorisation Items	Forward Plan items e.g. commissioning plans, service re-configuration, Joint Strategic Needs Assessment, Pharmaceutical Needs Assessment, Joint Health and Wellbeing Strategy	Agenda items agreed with the Chairman no later than **five weeks** prior to the meeting. Draft reports **15 working days** before Board meeting to Programme Manager Health and Welling for approval with Chairman. Final reports (including any presentation) to Secretariat **seven working days** before Board meeting.
7. Discussion/Debate Items	For example Health and Wellbeing theme ideas, updates from partners, national policy changes, items for Forward Plan	Agenda items agreed with the Chairman no later than **five weeks** prior to the meeting. Draft reports **15 working days** before Board meeting to Programme Manager Health and Welling for approval with Chairman.

		Final reports (including any presentation) to Secretariat **seven working days** before Board meeting.
8. Information Items	Information items to be shared with partner agencies from Core Members	Agenda items agreed with the Chairman no later than **five weeks** prior to the meeting. Draft reports **15 working days** before Board meeting to Programme Manager Health and Welling for approval with Chairman. Final reports (including any presentation) to Secretariat **seven working days** before Board meeting.
9. Action log of previous decisions	Record of decisions taken by the Board at previous meetings	Updated by Secretariat and presented at Board meeting for noting.
10. Forward Plan/Work Programme	Future planned work	Forward Plan to secretariat seven working days before the Board Meeting. For comment and noting by the Board.
11. Date of next meeting	Dates to be set for full year by Full Council at annual AGM	Dates confirmed with Board at annual AGM meeting in June.

Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

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

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**20th June 2017**
Subject:	**Housing, Health and Care Delivery Group**

Summary:

The previous Government incorporated Disabled Facilities Grant funding (DFGs) into the Better Care Fund (BCF) in 2016/17. Revised guidance around its use was also published. This created an opportunity to make stronger connections between multiple sources of funding to secure improved housing options that address *housing, social care and health* needs in a given population.

Lincolnshire is a two tier area of local government. This presents a significant opportunity to better meet needs through appropriate housing, as well as bringing a collective focus across the different parties involved. Within this context "Housing for Independence" (HfI) was formed.

Housing for Independence is an evolving agenda. As the necessary partnerships and confidence are starting to develop, the Health and Wellbeing Board recognised the need for a Strategic Housing Delivery Group.

In March 2017, the Board agreed to establish the Housing, Health and Care Delivery Group. The board sought support from the District Housing Network to help shape and develop the governance arrangements and its terms of reference (ToR).

This report forms two parts A and B.

A. The Draft ToR

B. Appointment of a Chair

Actions Required: The Board is asked to:

Part A.

- Agree the ToR and governance arrangements set out in this paper.
- Agree to provide strategic leadership and direction to the Housing, Health and Care delivery group

Part B.

- Identify, with a sense of urgency, a suitable Chair who meets the proposed essential criteria.

1. Background

One of the statutory functions of the Health and Wellbeing Board ("the Board") is to promote closer joint working and encourage integrated commissioning. The Board identified the need for an integrated, strategic approach to housing, health and care as a key work area. The Board sought support from the District Housing Network to help shape and develop the Terms of Reference (ToR) and governance arrangements for this new delivery group.

This paper will:

A.
- Provide the aims and objectives of the Housing, Health and Care Delivery Group;
- Key Work responsibilities
- Governance
- Financial Information

B.
- Describe the Role of the Chair with defined responsibilities and required essential criteria;

Part A

Aim and Objectives

The aim of the Housing, Health and Care Delivery Group is to provide strategic direction and governance to the wider Housing for Independence (HfI) agenda for Lincolnshire in an integrated, collaborative manner. The delivery group will seek direction and leadership from the HWB. The benefits of the delivery group will be evidenced once we have an established group that can demonstrate the value of sharing issues and align strategies to form a coherent set of investments and actions that deliver more from what resources are available and are better targeted

.

The ToR is detailed in the remainder of this document and on the attached, setting out in finer detail membership requirements with roles and responsibilities. It is proposed that the delivery group will seek representation and advice from across each District Council, Public Health, Adult Care, Children's Services, NHS partners, and other key stakeholders such as Housing Associations with a close connection with Lincolnshire. Additional members may be sought once the group has established.

Key work responsibilities

- Oversee and update the countywide Memorandum of Understanding (MoU);
- Be responsible for the Housing and Health Joint Strategic Needs Assessment (JSNA) topic;
- Be responsible for best use of the DFG budget and, potentially associated funding from Adult Care and Community Wellbeing;
- Agree to support and direct the modernisation of DFGs in Lincolnshire;
- Take ownership of the performance reporting template to monitor performance and activity related to DFGs across Lincolnshire and report on performance to relevant stakeholders on a regular basis;
- Agree priority work streams to address key housing issues impacting on Lincolnshire, such as delayed transfers of care (DToC);
- Explore future pooled funding arrangements to secure best value for 2018/19 which should include the DFG element.

Governance

The Housing, Health and Care Chair will report directly into the Board and take responsibility for regular reporting to relevant District Committees, health forums and the Adults and Community Wellbeing Scrutiny Committee of the County Council. The Health and Wellbeing Board meets at least four times a year, including an AGM, and will receive updates from the Housing, Health and Care Sub Group in line with the reporting mechanisms/requests agreed by the Board.

A series of short term task and finish groups may be developed by the Delivery Group to address specific areas of work such as the 'Moving Forward' with DFG modernisation. Task and finish project leads will report into the delivery group in readiness for any relevant information to be escalated to the Board**.**

Financial Information

The DCLG allocation to Lincolnshire for DFGs for 2017/18 is £5.291m and an estimated £5.8m in 2018/19. The funding comes to the County Council as the host body for the Better Care Fund and will be passported directly from the BCF to the individual District Councils in line with national guidance. The sums involved are shown in the following table:-

District Council	**2017/18 Allocation (£)**		**District Council**	**2017/18 Allocation (£)**
Boston	481,386		South Holland	585,287
East Lindsey	1,562,286		South Kesteven	733,770
Lincoln	641,018		West Lindsey	602,093
North Kesteven	685,298			

There is therefore a minimum of £10m+ available for DFGs in the current 2 year period, a substantial increase on the available funding ever made available for this service.

Part B

Appointment of a chair

In order for the delivery group to become a proactive forward thinking group an experienced chair is needed, outlined below are the details of the qualities required.

Chairs Role

- To chair the new delivery group.
- To report on performance and raise issues requiring resolution to the Board.
- Provide direction and leadership for the Hfl programme.
- Be the credible voice for the Hfl programme.
- Lead the co-ordination of activity and secure a coherent approach to Hfl across Lincolnshire, and provide arbitration where required.

Chairperson's Responsibilities

- Provide guidance and direction to task and finish groups including the Hfl manager.
- Manage stakeholders and provide sponsorship and be the figurehead for events and key workshops.
- Monitor effectiveness of governance structure.
- Monitoring and control of progress against plan.

Essential Criteria for the role

- Strong leader with credibility in the housing arena.
- Proven ability and experience in the housing field in Lincolnshire.
- Experience, knowledge and ability to take a lead role in governance of strategic partner-wide programmes.
- Ability to resolve disagreements between partners and take positive actions to ensure programme overcomes barriers to successful delivery.
- Familiar with managing stakeholders at a local, regional and national level.

2. Conclusion

The opportunity to achieve a significantly better housing offer for Lincolnshire residents exists and this proposed Delivery Group provides the vehicle but momentum is necessary now! There is a strong willingness and desire to establish this delivery group from partners and stakeholders. The Board agreed in March to take the required steps to instigate the construction of this delivery group and sought support from the district housing network. It is envisaged the new chair would want to help shape the finished product.

3. Consultation

This report has been written with support from the district housing network.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Draft Terms of Reference

5. Background Papers

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

This report was written by Lisa Loy who can be contacted on 07787151128 or lisa.loy@lincolnshire.gov.uk

Appendix A

DRAFT TERMS OF REFERENCE
"HOUSING HEALTH AND CARE DELIVERY GROUP"
JUNE 2017

1. Context

1.1 The Housing Health and Care delivery group was established at the Annual General meeting of the Health and Wellbeing Board held in June 2017.

1.2 The delivery group was created to focus on the need for closer integration between Housing Health and Care to address shared issues and align strategies and merge resources to be complementary to one another.

1.3 Housing is primarily provided by and via the seven District Councils in terms of direct provision, through other social housing providers in their strategic housing role and through their development and planning functions. The Health and Wellbeing Board recognises these important roles and the need to engage with the housing sectors in better integration of health and wellbeing and housing.

2. Housing Health and Care Delivery Group

2.1 Purpose and aim

The aim of the Housing, Health and Care delivery group is to provide strategic direction and oversight to the wider Housing for Independence (HfI) agenda in an integrated, collaborative manner.

2.1 Good housing is inextricably linked to better health and health outcomes both physical and mental. There is also good evidence that targeted housing can reduce long term social care costs and facilitate greater independence.

2.2 Affordable and warm housing can help people to stay physically well and assist in recovery times from ill health.

2.3 The provision of housing that is suitable to an individual's additional needs assists in sustained independence and lower demand for residential and nursing care.

2.4 Good quality housing suitable for an individual's additional needs reduces the likelihood of falls and other forms of physical injury

2.5 A warm, safe, affordable and secure place to sleep is a prerequisite of better mental health, which is a foundation for all other health issues

2.6 Initiatives to tackle Homelessness for those with complex and chaotic lifestyles have to be through a multi-agency approach i.e. it is more than the physical homelessness that needs to be addressed.

2.2 Objectives

The objectives for the delivery group are to:

- To support the HWBB to develop and adopt strategies that integrates housing need into the wider health and wellbeing agenda.
- To lead on the development of the JNSA Housing theme and strategy.

- To be the mechanism of matching housing development opportunities with evidenced need as well as commissioning requirements and strategies.
- Maximise opportunities and circumstances for joint working and integration of housing services and make the best use of opportunities and processes and prevent duplication or omission within Lincolnshire.
- To develop and lead on implementation of a full integrated Housing and health MoU and strategy under the auspices of the HWBB.
- Be responsible for best use of the DFG budget and potentially associated funding from Adult Care and Community Wellbeing;
- Agree to support and direct the modernisation of DFGs in Lincolnshire
- Be responsible for the performance reporting template to monitor performance and activity related to DFGs across Lincolnshire and timely report on performance to relevant stakeholders on a regular basis. This will include prescribed reporting regarding BCF spend and activity.
- Agree priority work streams to address key housing issues impacting on Lincolnshire, such as delayed transfers of care (DToC);
- Explore future pooled funding arrangements to secure best value for 2018/19.

2.3 Membership

It is proposed that the group will identify representation from:

Health and Well-being Core Board member District Council representative
HWB District Board Member – two to support the chair
Senior housing lead officer Boston Borough Council
Senior housing lead officer City of Lincoln Council
Senior housing lead officer East Lindsey District Council
Senior housing lead officer North Kesteven District Council
Senior housing lead officer South Holland District Council
Senior housing lead officer South Kesteven District Council
Senior housing lead officer West Lindsey District Council
Lincolnshire County Council Housing for Independence Manager
Lincolnshire County Council Health and Well-Being Programme Manager
NHS Lincolnshire representatives
Adult Care and Community Wellbeing representatives
Housing Association representative

2.4 <u>Roles and responsibilities</u>

2.5 To build consensus and increased collaboration across the partner agencies. To work together on the evidence bases and needs analysis of the JSNA Housing theme.

2.6 To work together to agree and deliver the Housing Theme of the Joint Health and Wellbeing Strategy for Lincolnshire.

2.7 To bring the principles and priorities agreed in the Housing for Independence Strategy development to full strategic proposals, and recommendations for implementation.

2.8 To work with the main HWBB to build a partnership approach to key issues and provide recommendations to the HWBB for consideration of initiatives designed to improve housing and health outcomes for the people of Lincolnshire

2.9 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.

2.10 To champion the work of the sub-group and HWBB in their wider networks and in the community

2.11 To ensure that there are communication mechanisms in place within the partner organisations to enable information about the priorities and recommendation of the sub-group and HWBB to be disseminated and actioned to ensure that the health and wellbeing of the community of Lincolnshire is improved.

2.12 To promote any consequent changes to strategy, policy, budget and service delivery within their own partner organisation to align with the recommendations of the sub-group as ratified by the Board.

2.13 Governance and Accountability

The Housing, Health and Care Chair will report directly into the Board which will include responsibility for regular reporting to relevant District Committees, health forums and the Adults and Community Wellbeing Scrutiny Committee of the County Council. The Health and Wellbeing Board meets at least four times a year, including an AGM, and will receive updates from the Housing, Health and Care Sub Group in line with the reporting mechanisms/requests agreed by the Board.

A series of short term task and finish groups can be developed by the Delivery Group to address specific areas of work such as the Moving Forward with DFG modernisation. Tasks and finish project leads will report into the delivery group in readiness for any relevant information to be escalated to the Board.

2.14 Frequency of Meetings

To be determined by the Delivery group though given the nature of the role it is expected that there will be a minimum requirement for bi-monthly meetings.

2.15 Review

The final Terms of Reference will be reviewed every two years or at the discretion of the Board.

Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open report on behalf of Debbie Barnes, Executive Director of Children's Services

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**20th June 2017**
Subject:	**Integration of Services for Children and Young People with a Special Educational Need and/or Disability**

Summary:

This paper identifies the opportunities to improve outcomes for children and young people with special educational needs and disabilities through integration of commissioning and service delivery.

Actions Required:

- Members are asked to confirm a strategic intent to develop an integration plan for Health and Local Authority services for children and young people with special educational needs and disabilities.
- CCGs are asked to commit resource to undertake the work required to review and remodel the current commissioning arrangements for health provision. LCC commitment has been confirmed.
- It is proposed that this work is governed via the Women and Children's Joint Delivery Board reporting to the Health and Wellbeing Board.

1. Background

The Joint Health and Wellbeing Strategy has as one of its themes improving health and social outcomes and reducing inequalities with the desired outcome being that children are able to get the best start in life and achieve their potential. Specific actions have been identified to reduce inequalities by targeting vulnerable groups such as children with special education needs and disabilities (SEND) and to improve service delivery through greater integration.

Joint commissioning to meet the needs children and young people with SEND is a requirement under the Children and Families Act 2014 as is the publication of a Local Offer which describes the services available and the routes to access them. Both were flagged as areas requiring development in a peer review undertaken in Lincolnshire earlier this year (which is attached as Appendix A) and will be subject to joint inspection by Ofsted and the CQC.

We have joint commissioning arrangements in place for meeting the mental health needs of children with a learning disability via a Section 75 agreement. The provision of short breaks for children and young people with disabilities is commissioned from a pooled budget as part of the Better Care Fund in Lincolnshire. These current arrangements do not cover the whole range of needs of this group. The current integrated commissioning arrangements which are in place could be further enhanced by increasing our collective ability to improve outcomes and the life chances of children and young people with SEND:

- Whilst there are individual bespoke packages of care in response to need, there needs to be a greater clarity over some specific health services for this group e.g. continence; specialist therapy services, including those for sensory integration; and end of life care.

- The Joint Commissioning Board has identified that the current pathways for the diagnosis of autistic spectrum disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD) and the provision of ongoing support have areas of duplication and this leads to families and professionals being unclear about which services to access. The JSNA identifies the relatively high numbers of children and young people who have special educational needs as a result of ASD and or ADHD. We also have higher numbers of these young people in the Transforming Care cohort who are in high cost placements, a number of which are out of county. There is a collective ambition to better meet the needs of this cohort nearer to their home.

- Children's Services are currently undertaking a review of special schools to ensure that the Council is able to meet the needs of as many children as possible close to home. The provision of health services alongside education provision will be crucial to this being successful. This will provide Health commissioners with the opportunity to refresh the health offer for local schools and to review systems and processes on how CCGs can better meet the health needs of individuals with Education Health and Care Plans where they have needs which are beyond the core offer but do not meet the threshold for Continuing Care funding.

- There is currently a process for identifying the funding split between agencies of expensive and/or complex care packages so costs are apportioned appropriately between education, health and care. Whilst this is effective and is functioning well, it is time consuming and has the potential to hinder timely decision making. Pooled budgets are an option that has been used elsewhere to support more effective decision making.

2. Conclusion

- Children, young people, parents and carers have all told us that the complexity of current commissioning and provision makes it hard for them to access and gain benefit from the services provided.
- Integrated commissioning is consistent with local and national policy.
- Integrated provision is an opportunity to improve outcomes by streamlining assessment, planning and delivery of care.
- Integration has the potential to reduce duplication and achieve greater efficiency.

3. Consultation

No specific consultation has taken place regarding this proposal.

However regular consultation with parents and children takes place via the Lincolnshire Parent and Carer Forum. CCGs have recently established formal links with the Forum in partnership with Healthwatch. There is a consistent message that services need to be more integrated and the offer easier to understand and access.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Report form the Peer Review of SEND in Lincolnshire

5. Background Papers

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

This report was written by Sally Savage, Chief Commissioning Officer, Children's Services who can be contacted on sally.savage@lincolnshire.gov.uk .

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Derby City Council

Lincolnshire Local Area Peer Review

20 – 22 March 2017

1 Methodology

1.1 The peer review team comprised of:

- Iain Peel – Lead (Service Director, Learning & Skills, Derby City Council)
- Paula Nightingale (Head of Inclusion Services, Derby City Council)
- Nicki Hodson (Designated Clinical Officer, Nottinghamshire County / Nottingham City NHS Clinical Commissioning Groups)
- Dave Nutting (Parent Carer Forum, Leicester)

During the course of the peer review, we met with:

- seven headteachers, six Special Educational Needs Co-ordinators (SENCOs) & three staff from the local Further Education (FE) college.
- Six young people and their workers.
- Three Parent Carer Forum (PCF) representatives and one parent phone call.
- 42 Local Authority (LA) officers.
- 17 health professionals.
- Eight strategic leads including the local cabinet member political lead.

In addition, we reviewed a range of data and reports in line with the key lines and enquiry and which were provided by the local area.

2 Key lines of enquiry

2.1 The peer review examined three key lines of enquiry (KLOE).

- KLOE 1: How are services helping to manage the growing demand for statutory assessment?
- KLOE 2: How effective are multi agency services in securing better outcomes for young people with special educational needs and disabilities (SEND)?
- KLOE 3: How are parents carers involved in co-production of strategic priorities?

The peer review was not an inspection.

3 Overall strengths

3.1 This is a local area with a number of strengths. These include:

- this is an area which has moved to address the special educational needs and disability (SEND) reforms.
- Strategic leaders from both the local authority and health who engaged with the peer review all had a clear focus on improvement and performance management.
- Operational links between health professionals and other services are evident.
- Young people described their involvement in the education health and care planning system as being generally positive.
- Headteachers who contributed to the peer review were very positive about inclusion outreach services provided by both the local authority (LA) and also those provided directly by special schools. Importantly, headteachers were able to describe how outreach services worked in conjunction with LA services in order to avoid duplication.
- Pastoral support plans (PSPs) have been developed and in place for approximately one year. These were intended to try to help reduce SEND exclusions and they are clearly having an impact.
- Therapists and early help services ensure that their service offer is focused on young people and managing demand.
- The PCF steering group is predominately new to their PCF roles. The PCF is now re-establishing its links.

4 KLOE 1: How are services helping to manage the growing demand for statutory assessment

4.1 **A Strengths**

- The local area has a wide offer of support for emotional and heath well being (EHWB). This has been recently extended via a new emotional health and well-being team, a behaviour support service, multi-agency teams, educational psychologists, Futures in Mind and Children and Mental Health Services (CAMHS). This provides a clear EHWB pathway and it is important that all stakeholders know of the right pathways for the right young people.
- The headteachers and SENCOs who contributed to the review commented that the education psychology (EP) service was improving. Indeed, one Headteacher commented "... (we have had the) strongest relationships with EPs for a while". This is to be welcomed, although some SENCOs reflected that the quality of the service was

partially dependent upon the quality of the individual EP. Headteachers were positive about the new deployment system for EPs and that the additional administration associated with the request for an EP was worth investing the effort if it secured greater and better access to EPs. Whilst Headteachers did not know why the new deployment strategy came into place, they were positive about the direction of travel with the EP service.

- Headteachers who contributed to the peer review were very positive about inclusion outreach services provided by both the local authority (LA) and directly by special schools. Importantly, headteachers were able to describe how outreach services worked in conjunction with LA services in order to avoid duplication.

- The LA has invested time to ensure that stakeholders know about the graduated response. Hence SENCO briefings have been redefined as graduated response briefings. These take place across the county and are intended to address key issues across the local area.

- Headteachers and SENCOs were very positive about specialist teaching services. They describe how well the service is led. The service has been trading for over ten years and the team has doubled in that time. Schools value the services, refer to them when their interventions have not worked and when there is no clear direction as to what the school might provide next to meet the need.

- Therapists are involved from early years onwards. 0-19 year olds can be referred to therapy service for support and intervention often before the full need around SEND has been identified. The therapy teams within the National Health Service (NHS) are integrated and services refer between teams (e.g. occupational therapist (OT) to physiotherapy).

- Health visitors and early years teams are often unable to do a joint 2-2 ½ year integrated review so have devised a specific handover page to communicate difficulties to the other team. This sits within the parent held (red book) record.

- Headteachers report that speech and language therapy training (SALT) is available for teaching assistants if schools commission this. This is intended to support the development of language and communication and is part of the graduated response. A continual challenge for the LA and SALT is to ensure that schools are aware of the training or of commercial packages in order to help stem referrals to SALT.

- Pastoral support plans (PSPs) have been developed and in place for approximately one year. These were intended to try to help reduce SEND exclusions and they are clearly having an impact. For example, in half term 1 of 2015/16, eleven young people with a statement / education and health care (EHC) plan were permanently excluded from school. This dropped to two young people in the same period in 2016.17. The PSPs provide multi-agency support including early help services. A question remains for the LA to ensure that an unintended consequence is avoided by ensuring that PSPs do not add to the demand for statutory assessments by escalating assessments too quickly.

- The early year's team actively help manage demand by early support screening. The early year's team is mapping the need to distinguish between early child development, English as an additional language and possible SEND, through child focused and multidisciplinary delivery within the locality teams. The team works effectively with the Early Support Care Co-ordination (ESCO) Panel to ensure that support is allocated early to children, parent carer and settings. This joint work allows services to be clear on the needs of the child following the graduated response so that the needs are met at the right level.

- The work of the Headteacher for the Virtual School for looked after children is proactive in helping to manage demand for statutory assessments. He regularly liaises with a range of services and social workers and keeps the needs of young people as his focus.

- Therapists and early help services ensure that their service offers are focused on young people and managing demand. For example, they offer parents a range of courses such as sleep therapy, de-escalation strategies and behaviour management. Whilst no evidence was presented to show the impact of these services, they should help to prevent the escalation of some cases to a stage where a statutory assessment is requested.
- The PCF steering group is predominately new to their PCF roles. The PCF is now re-establishing its links, many of them with new staff at the LA and developing new connections with the Clinical Commissioning Group (CCG) that they have never previously been able to establish.

B Areas for development

- Early help services have much to offer and clearly contribute to PSPs. Therefore, consideration should be given to early help services attending the graduated response briefings to ensure they are conversant with latest developments.

- The LA has provided training and briefings on the pathways for statutory assessments. However the SENCOs who were interviewed reported that they are not fully clear on the pathways for assessment. This is echoed by PCF and Liaise who reported that they were not clear on the pathways for assessment and also the funding of plans.

- SENCOs, headteachers and some LA services were unclear on the graduated response.

- Schools expressed concern of waiting times for some health services such as paediatricians, CAMHS and speech and language therapy.

- A danger exists that some parent carers and providers could become confused by a duplication of advice provided by several services. For example, child or young person may access early help services, the inclusion service, the emotional health and well-being service and also an EP. Therefore, pathways should be clear.

- Further work is required with the education psychology service to ensure that they are clear as to what constitutes their statutory offer.

C Recommendations

- Reiterate the communication of the graduated assessment. This is important to manage demand.

- Ensure pathways are clear for a referral to a paediatrician. If they are unclear it will impact on demand.

- Ensure pathways are clear for a referral to clinical services.

5 KLOE 2: How effective are multi agency services in securing better outcomes for SEND

5.1 **A Strengths**

- Strategic leaders from both the LA and health who engaged with the peer review all had a clear focus on improvement and performance management. This was a clear strength. Similarly, other LA officers, health professionals and school and college staff all presented as committed individuals and with a clear determination to secure the best for children and young people.

- The feedback on the education psychology service was variable. Overall school professionals felt that it was improving, bust still too variable. However, headteachers were very positive about the specialist teaching service with a well-known leader and champion for the child.

- Headteachers report that social care staff regularly visit special schools and know the staff and children and young people, visits to mainstream schools were less regular. However, overall relationships with social care were described by headteachers as being strong. One mainstream headteacher described how their school employs heir own family support worker and whereby the LA provides the professional supervision for this person.

- Links with LA services were generally positively described by schools. For example, headteachers were positive about inclusion outreach services (both provided by the LA and schools) and SENCOs believed that the Special Educational Needs Assessment (SEN) Service was approachable. This is important if EHC plans are to meaningfully co-produced. A recent development of the SEN Assessment Service has been being clear with schools about the reasons for turning down a request for a statutory assessment. Headteachers were positive about the development and in gaining a better understanding of the reason for the decisions.

- Operational links between health professionals and other services are evident. For example, a CCG professional reported that an information sharing protocol is in place between all key partners. This could be used as a foundation upon which to build strategic planning between partners.

- The governance of the SEND reforms ultimately reports through to the Health and Well Being Board. Sitting beneath this is the Women and Children's Board and a CCG professional reported that both governance arrangements and operational working are improving via the Women and Children's Board.

B Areas for development

- When pressed, strategic leaders were unable to point to consistent strong engagement of strategic health leaders in the SEND reforms. Similarly, whilst LA data was readily provided, there was an absence of health data during the peer review.

- Headteachers were positive about the recent developments in statutory assessment refusal to assess or 'turn down' letters. However, parents/carers and Liaise were uncertain about the reasons for turning down an assessment and mediation cases may reduce if parents / carers were clearer about the reasons.

- Health and social care professionals require on going training about SEND reforms and the needs of young people. This is to ensure that they are aware of the latest research in to meeting learning needs of young people with SEND.

- The SEN Assessment Team managers and officers have clearly made a positive impact on improving timeliness of statutory assessments. However, they were unable to outline how EHC plans are monitored and how the outcomes feed through to the commissioning cycle.

- The CCGs have struggled to appoint a Designated Medical Officer or Designated Clinical Officer. Whilst CCGs could have provided another qualified person to the EHC panel, it is important that health is now represented on this panel.

- Transitioning to adults services and FE requires more work.

C Recommendations

- Secure the prioritisation of the SEND reforms by strategic health leaders.

- Strengthen the Joint Strategic Needs Assessment and commissioning cycle by the use of health data.

- Consider how to monitor EHC plans to strengthen their impact on children and young people outcomes.

- Include health on EHC panel.

6 KLOE 3: How are parents carers involved in co-production of strategic priorities?

A Strengths

- Three of the young people described their engagement in their own EHC processes. This was generally positive and they had enjoyed the opportunity to share their life's ambitions and difficulties they face in achieving them. They generally they felt that their education and courses were the right ones for their progression to their desired outcomes.

- The young people reported that amongst the courses and activities they are engaged in they were taking up travel training. Those present all felt it was a positive step in promoting their independence, building their confidence and self-esteem and they had all enjoyed the process of 'getting out of the house' more often. The training was considered very comprehensive and included how to use cash if (as had been the case with one) you lose your bus pass. Therefore, a number of the very real apprehensions SEND young people have around travel and engaging with the wider community were being addressed.
- The PCF acts as a registered charity formed from its original contact group; The Parent Carer Council. It provides direct information on its activities to approximately 2000 people. It also hosts regular coffee mornings in several key geographic points in the area from which it gathers the views of parent carers on local area plans and developments that they share with those present. The PCF steering group (all annually elected at an AGM) then uses this information to highlight issues using a traffic light' system of the noted areas. They report that they use this to inform or engage with policy makers, commissioners and providers to help them to identify areas for improvement. The PCF then feeds back any responses to the coffee mornings and via their website and Facebook page.

- The PCF is currently engaged in a Memorandum of Understanding agreement between themselves, the LA, 'Liaise' and Core Assets in understanding the area's information, advice and support needs and trying to develop everyone's understanding of the support required by parent carers, children and young people with SEND.
- Health providers talk about being data rich, for example, health visitors undertaking engagement events. There are examples of co-productions, such as 'Dad's Day', 'Local Films by Local Children' etc.

- CAMHS / therapists / 0-19 service all undertake a Friends / Family Test to shape services going forward.

B Areas for development

- The group reported that there was no strategic young person's forum. This aligns with your self-assessment.

- The young people explained that they were unaware why the previous young people's group had been stopped.

- One young person reported that there had been ongoing discussions about her health care support to enable her full inclusion in a number of activities for the past two years and that the issues remain unresolved. She reported that the only real conversations she had been having around transitions with adult services seemed to focus on her having the choice of which care home she moved into while her ambition was to live as independently as possible.

- No examples were forthcoming from young people about co-production

- The PCF felt that 'Health' (NHSE/CCG/Public) have been difficult to engage with and they were unaware of any integrated systems of engagement between them and other areas involved in SEND provision for the local area, or integrated system for personal budgets. However it was fed back that there had been an engagement piece of work undertaken with the PCF and the CCGs.

- Questions were raised about whether there was a disconnect between many of the areas of support from education, health and social care, most notably in the additional areas of transitions from children's to adult services across the area that they had expected the Children and Families Act and Care Act to have resolved. However PCF was confident about the future and that engagement between the PCF/LA/CCG/voluntary services was developing well and there was a real sense that working together was now taking shape.

- The current issues within the PCF have been resolved but are compounded by a subsequent LA decision to cease its funding. This needs to be resolved quickly as the PCF cannot provide its historic network of information gathering and sharing or develop the connections required of it by the local area's education, health and care commissioners and providers for an area as large and diverse as Lincolnshire with just the DfE grant to resource them.

C Recommendations

- Develop a forum to strategically capture the voice of CYP and their parent carers.

- Maximise the momentum building up with the new PCF and use this to help co-develop strategies and to engage partners.

To summarise. It is worth remembering that the PCF is with you. Indeed, one parent commented,

> "…I'm very confident about the future; the PCF, voluntary agencies and the LA are all developing a better understanding and there is a real sense amongst parents and carers that working together is taking shape ..."

Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of the Lincolnshire STP

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**20 June 2017**
Subject:	**Developing Integrated, Neighbourhood Working – Update**

Summary:
The creation of integrated Neighbourhood Care Teams and supporting 'self-care' networks is a flagship programme across Lincolnshire, which brings together health and care professionals, the third sector, local authority and independent organisations.

The vision is to empower people and communities to take an active role in their health and wellbeing, with greater choice and control over their care.

Whilst this programme of work was originally developed as part of the Lincolnshire Health and Care Programme, it has been in the last 6 months that a clear strategy and plan has been in place to ensure true, integrated working is established.

Integrated Neighbourhood Working has been identified by the System Executive Team (SET) as its key priority, as the need to ensure people are supported to remain well, independent and at home, is seen as an essential focus if Lincolnshire is to ensure sustainable health and care services into the future.

This paper sets out:

- The key elements of the Neighbourhood Working programme.
- A brief up-date of the current status of the programme.

Actions Required:

The Health and Wellbeing Board is asked to:

- Note the content of this Programme of work.
- Note the current progress and key actions
- Discuss and agree how the link between the Neighbourhood Working Programme and the Health and Wellbeing Board can be developed and strengthened.
- An outline of the Governance Structure that is in place to support this work.

1. Background

The development of Neighbourhoods has been a key priority across Lincolnshire for some time, with currently a number of community based disciplinary teams operating across the County. However, they have not realised the original vision of whole population management via a fully integrated Neighbourhood approach.

Work has now taken place to re-assess the Programme of work and a real emphasis is now being placed on supporting this development to become a reality.

The System Executive Team (SET) has identified Neighbourhood working as its main priority and have spent considerable time in recent weeks agreeing a package of support to facilitate more rapid implementation with at least 4 Neighbourhoods to be fully established by March 2018, with full coverage by March 2019. The sites will be identified by 30 June 2017 and will immediately commence implementation.

The main outcome of the support is to facilitate Primary Care's much greater involvement in the future design and implementation of the teams, with GP leadership central to the teams.

Their aim will be:

To empower people and communities to take an active role in their health and wellbeing, with greater choice and control over their care.

The key outcomes for people will include:

- Better quality of life and enhanced health and wellbeing
- Fewer Crises that lead to unplanned admission to hospital and institutional care
- Enhanced experience of care through better coordination and personalisation of health, social care and other services.

The Integrated Neighbourhood Working programme has a number of key work streams in place to support implementation, these include:

- Prevention – working with the Public Health team to support implementation of the emerging Prevention Strategy.
- Developing Neighbourhood Networks – supported self-care.
- Implementation of 12 Integrated Neighbourhood Care teams – at least 4 fully functioning areas by 1 April 2018.
- Enhanced support to Care Homes.
- Primary Care – GP Forward View
- Transitional Care service development (Intermediate Care)

This Programme of work is included within the Lincolnshire Sustainability and Transformation Plan (STP) and has dedicated resource within the System Delivery Unit (SDU) to drive implementation forward.

Attached at appendix A is the current Governance Structure to support this work, this is emerging and may well change over the coming weeks.

Although improving the local populations Health and Wellbeing is a key outcome for this work, until this point the link with the Health and Wellbeing Board has not been formally defined, there is an obvious synergy between the two work streams and it would be sensible to identify and agree how the relationship can operate differently in the future.

2. Conclusion

The work to develop neighbourhood working is now gathering pace and the need to ensure all elements of the system work together to deliver the key outcomes is essential. Therefore, it is timely to work with the Health and Wellbeing Board to identify opportunities for closer working and support that maybe available via the H&WB Board's work programme.

3. Consultation

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Model For Integrated Neighbourhood Working –
Appendix B	Integrated Neighbourhood Working – Governance Structure DRAFT

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 Carol Cottingham who can be contacted on 07909993097 or e-mail: carol.cottingham@lincolnshirewestccg.nhs.uk

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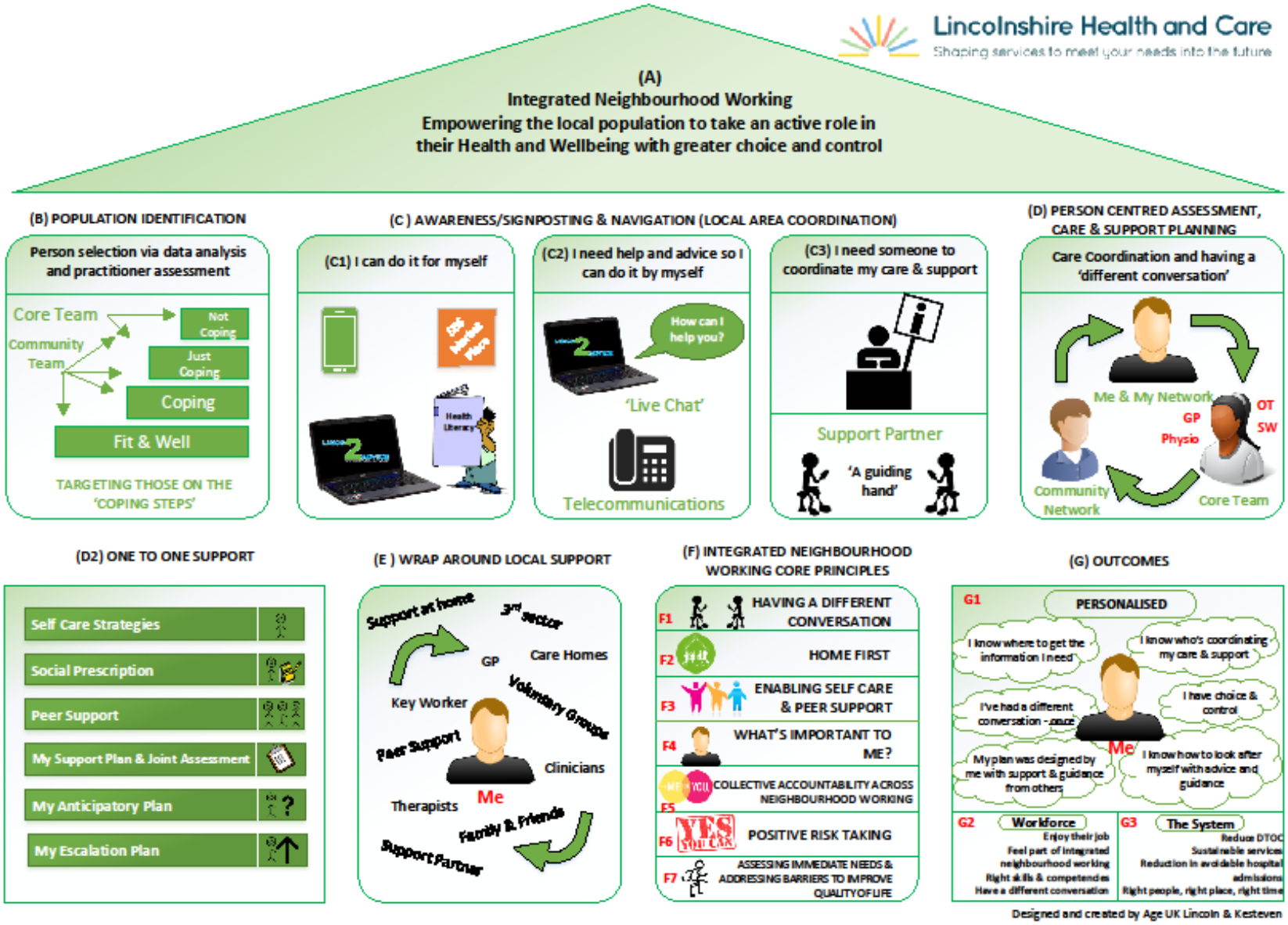
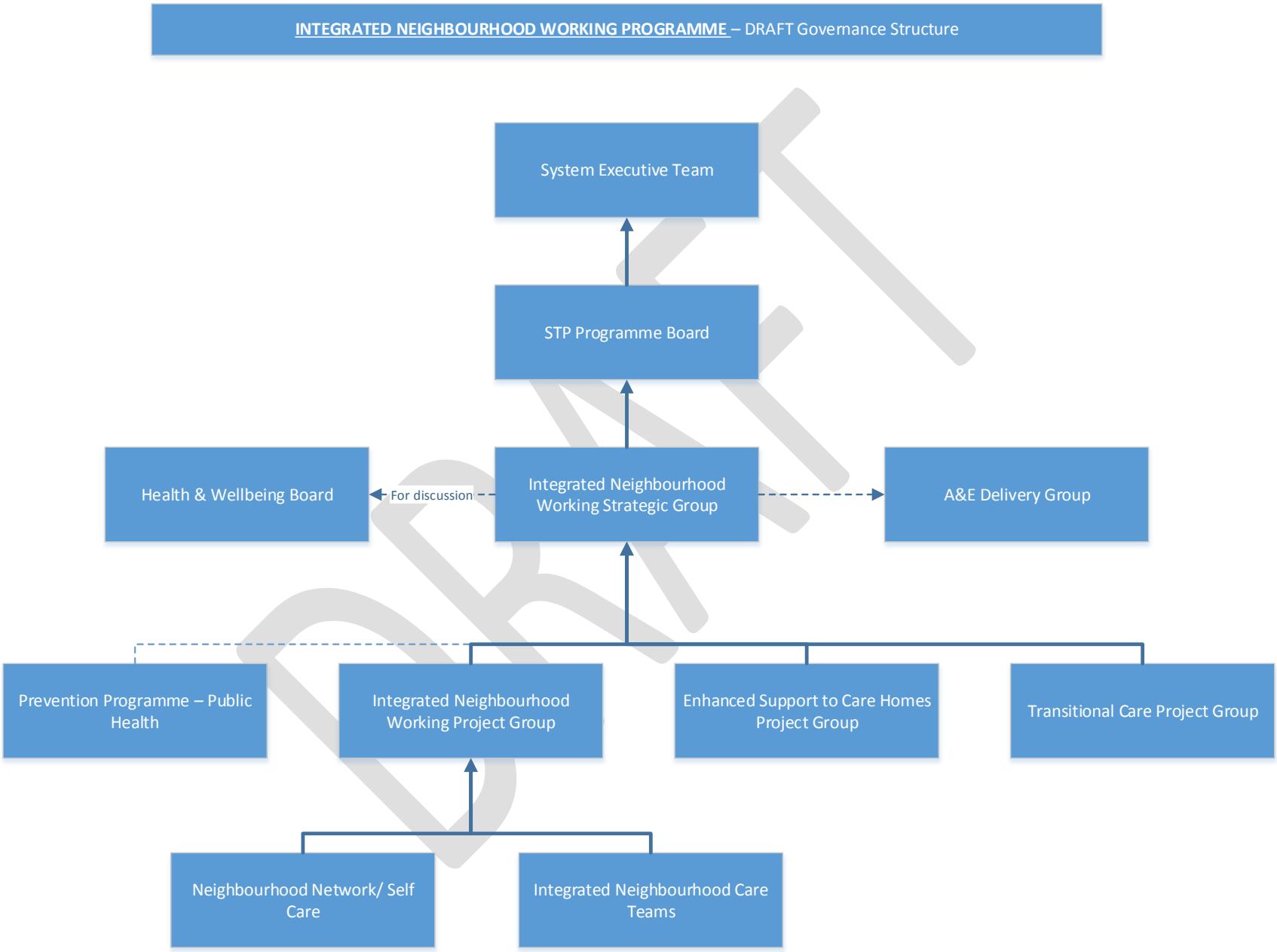
Appendix A


Lincolnshire Health and Care
Shaping services to meet your needs into the future
(A)
Integrated Neighbourhood Working
Empowering the local population to take an active role in their Health and Wellbeing with greater choice and control
(B) POPULATION IDENTIFICATION
Person selection via data analysis and practitioner assessment
Core Team
Community Team
Not Coping
Just Coping
Coping
Fit & Well
TARGETING THOSE ON THE 'COPING STEPS'
(C) AWARENESS/SIGNPOSTING & NAVIGATION (LOCAL AREA COORDINATION)
(C1) I can do it for myself
(C2) I need help and advice so I can do it by myself
How can I help you?
'Live Chat'
Telecommunications
(C3) I need someone to coordinate my care & support
Support Partner
'A guiding hand'
(D) PERSON CENTRED ASSESSMENT, CARE & SUPPORT PLANNING
Care Coordination and having a 'different conversation'
Me & My Network
GP
Physio
OT
SW
Community Network
Core Team
(D2) ONE TO ONE SUPPORT
Self Care Strategies
Social Prescription
Peer Support
My Support Plan & Joint Assessment
My Anticipatory Plan
My Escalation Plan
(E) WRAP AROUND LOCAL SUPPORT
Support at home
3rd sector
GP
Care Homes
Key Worker
Voluntary Groups
Peer Support
Clinicians
Me
Therapists
Family & Friends
Support Partner
(F) INTEGRATED NEIGHBOURHOOD WORKING CORE PRINCIPLES
F1 HAVING A DIFFERENT CONVERSATION
F2 HOME FIRST
F3 ENABLING SELF CARE & PEER SUPPORT
F4 WHAT'S IMPORTANT TO ME?
F5 COLLECTIVE ACCOUNTABILITY ACROSS NEIGHBOURHOOD WORKING
F6 POSITIVE RISK TAKING
F7 ASSESSING IMMEDIATE NEEDS & ADDRESSING BARRIERS TO IMPROVE QUALITY OF LIFE
(G) OUTCOMES
G1 PERSONALISED
I know where to get the information I need
I know who's coordinating my care & support
I've had a different conversation - once
I have choice & control
Me
My plan was designed by me with support & guidance from others
I know how to look after myself with advice and guidance
G2 Workforce
Enjoy their job
Feel part of integrated neighbourhood working
Right skills & competences
Have a different conversation
G3 The System
Reduce DTOC
Sustainable services
Reduction in avoidable hospital admissions
Right people, right place, right time
Designed and created by Age UK Lincoln & Kesteven

Appendix B


INTEGRATED NEIGHBOURHOOD WORKING PROGRAMME – DRAFT Governance Structure
System Executive Team
STP Programme Board
Health & Wellbeing Board
For discussion
Integrated Neighbourhood Working Strategic Group
A&E Delivery Group
Prevention Programme – Public Health
Integrated Neighbourhood Working Project Group
Enhanced Support to Care Homes Project Group
Transitional Care Project Group
Neighbourhood Network/ Self Care
Integrated Neighbourhood Care Teams
DRAFT

Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

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

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**20 June 2017**
Subject:	**Health and Wellbeing in Lincolnshire: Overview of the 2017 Joint Strategic Needs Assessment**

Summary:
The Joint Strategic Needs Assessment (JSNA) is an assessment of the current and future health and wellbeing needs of the local population. It brings together a wide range of data, information and intelligence into an overarching shared evidence base across health and care. This report provides an overview of Lincolnshire's refreshed JSNA published on the Lincolnshire Research Observatory (LRO) on 9 June 2017.

Actions Required:

The Health and Wellbeing Board is asked to formally adopt the refreshed Joint Strategic Needs Assessment for Lincolnshire and confirm it as the evidence base to inform the development of the new Joint Health and Wellbeing Strategy.

1. Background

Local Authorities and Clinical Commissioning Groups (CCGs) have an equal and joint duty under the Health and Care Act (2012) to prepare a Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS) through the Lincolnshire Health and Wellbeing Board (HWB).

The JSNA is an assessment of the current and future health and care needs of the local population. It brings together a wide range of national and local quantitative and qualitative data and information. It is used by the HWB to inform the development of the JHWS and provides a shared evidence base to support the planning and commissioning of health and care services.

The JSNA is presented as a series of topic commentaries which includes local demographic and service data; evidence from the public, patients and service users; national research and best practice. It also includes an assessment of need which identifies any inequalities, unmet needs or gaps in service provision. Finally it recommends how these gaps and inequalities can be addressed by commissioners in order to improve health and wellbeing outcomes in Lincolnshire.

Lincolnshire's approach to the JSNA

In March 2016 the Board agreed proposals for a fundamental review of Lincolnshire's JSNA and the 35 topics in the 2011 JSNA formed the basis of the review. A multi-agency Steering Group, acting on behalf of the HWB, was established to oversee the review programme. The Steering Group was made up of representatives from each of the Clinical Commissioning Groups, Adult Care, Children's Services, Public Health, Healthwatch and District Councils. The review began in April 2016 and concluded in April 2017.

Expert Panels, made up of representatives from statutory, non-statutory and voluntary sector organisations, were set up for each topic area. These panels, with the support of specialist data analysts, were responsible for conducting the review and developing the new topic commentary. Each commentary was subject to a peer review process and was considered by the JSNA Editorial Board to ensure the information provided was accurate, relevant and free of misleading statements. The JSNA Steering Group signed off the topic commentaries as complete and ready for publishing.

In response to feedback from stakeholders four topics from the 2011 JSNA have been removed, these are: Personalisation; Residential and Nursing Care; Life Expectancy; and Youth Work. In addition the Childhood & Weight Problems topic has been emerged with the Adult Obesity to form an All Age Obesity topic. In addition, five new topic areas have been added; these are: Autism; Dementia; Domestic Abuse, Financial Inclusion; and Mental Health & Emotional Wellbeing of Children and Young People.

The JSNA is published as an online resource available on the Lincolnshire Research Observatory. Each topic page provides links to core data and is accompanied by the expert panel commentary in a standardised format. In addition, the Summary Overview Report (Appendix A) has been produced as a reference document for stakeholders, partners and the public. The 'Topic on a page' (see pages 10 – 45) uses infographics and graphs to provide a summary of the key issues and message in a more accessible and user friendly format.

Continuous improvement

The JSNA is an evolving and continuous process of assessment used to inform the priority setting for the Joint Health and Wellbeing Strategy and commissioning decisions. It is therefore imperative the JSNA is kept under constant review and improvements made to ensure it continues to remain relevant, current and reflecting of the changing needs of Lincolnshire's population. With this in mind, a work programme is being put in place to ensure topics are updated as new data and evidence becomes available. A new partner newsletter will be launched shortly to promote the use of the JSNA and to encourage partners to actively contribute information through 'Calls for Evidence' or by sharing learning and case studies demonstrating how the JSNA has added value.

2. Conclusion

The Health and Wellbeing Board has a statutory responsibility to produce and publish a JSNA for Lincolnshire and to use it to inform the priority setting for the Joint Health and Wellbeing Strategy. This report provides the Board with details on the refreshed JSNA published on the Lincolnshire Research Observatory on 9 June 2017.

3. Consultation

Extensive consultation was undertaken with key stakeholders, partners and representative groups as part of refreshing the JSNA.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Health and Wellbeing in Lincolnshire – JSNA Summary Report 2017

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

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Health and Wellbeing in Lincolnshire

Joint Strategic Needs Assessment Summary Report 2017

Report produced on behalf of the Lincolnshire Health and Wellbeing Board
May 2017

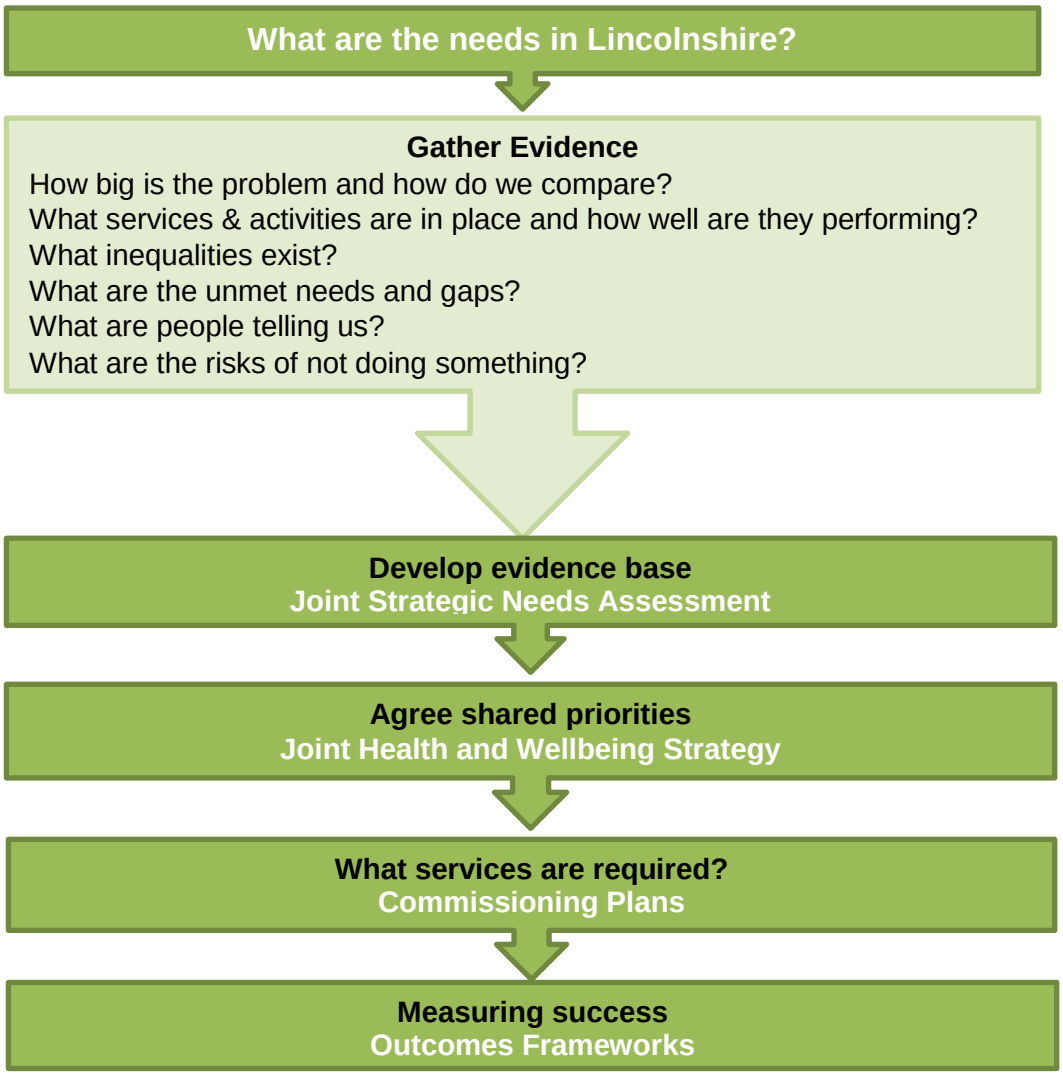
1. Introduction

1.1 Background

The Joint Strategic Needs Assessment (JSNA) for Lincolnshire reports on the health and wellbeing needs of the people of Lincolnshire. It brings together detailed information on local health and wellbeing needs and looks ahead at emerging challenges and projected future needs.

The Health and Care Act (2012) places equal and joint duties on Local Authorities and Clinical Commissioning Groups (CCGs) to publish a JSNA through the Health and Wellbeing Board (HWB). The JSNA is a shared evidence base to inform the planning and commissioning of services and is used by the Board to identify the priorities in the Joint Health and Wellbeing Strategy (JHWS). Figure 1 illustrates this relationship.

Figure 1: Relationship between the Joint Strategic Needs Assessment, the Joint Health and Wellbeing Strategy and Service Commissioning



1.2 How has the 2017 JSNA been developed?

Following formal agreement at the Lincolnshire Health and Wellbeing Board, the process of reviewing the JSNA for Lincolnshire began in April 2016. A multi-agency Steering Group was established to oversee the review process made up of representatives from each of the Clinical Commissioning Groups (CCGs), Adult Care, Children's Services, Public Health, Healthwatch Lincolnshire, District Councils and the voluntary and community sector.

The 35 topics in the 2011 JSNA formed the basis of the review programme. Expert Panels, made up of a cross section of partners, were set up for each of the topic areas. The Panels, with the support of specialist data analysts and the JSNA Team, were responsible for conducting the review and developing the new topic commentaries. The commentaries bring together a wide range of data, information and research providing a narrative on the level of need in Lincolnshire. They also describe what services and activities are currently provided and if there are any gaps. Finally, they set out the risks of not doing something and suggest what needs to happen next.

Each commentary has been peer reviewed by a 'topic expert' to check the information provided is accurate and does not contain irrelevant facts, unwarranted claims or personal views. Final assurance has been provided by a JSNA Editorial Board which has reviewed all the topics against a quality standard prior to recommending each topic to the Steering Group for approval.

Following feedback from stakeholders five topics from the 2011 JSNA have been removed as they are services rather than needs, or because the needs have been incorporated into another topic area. The five topics are Personalisation, Residential & Nursing Care, Life Expectancy, Childhood Obesity & Weight Problems (*now included in an all age Obesity Topic)* and Youth Work.

During the course of the review four new topics areas have been identified and are included in the 2017 JSNA. These are Autism, Dementia, Domestic Abuse and Financial Inclusion. Finally, the Mental Health topic has been split into two topics, one covering children and young people and a separate topic for adults.

The JSNA is published as an interactive web resource on the Lincolnshire Research Observatory (LRO). Each topic page contains the commentary and hyperlinks to a range of national and local evidence sources. Whilst efforts have been made to reduce the use of jargon or highly technical terminology, it is not always possible when dealing with complex issues. Therefore, this summary report has been produced for stakeholders and partners, in addition to the online resource. A 'Topic on a Page' document has been produced for each topic; these provide an overview of the key facts and figures in an 'easier to read' format. These can be found in Section Three of this report and as PDF documents on the LRO.

In addition, a one page summary detailing key facts about health and wellbeing in Lincolnshire based on a life course approach has been developed for partners and stakeholders to use as a reference document. This can be found at the end of this summary report and can also be download from the LRO.

1.3 Keeping the JSNA Current

The JSNA is the 'go to' shared evidence base for Lincolnshire. It not only underpins the Joint Health and Wellbeing Strategy but is also a crucial commissioning tool to support service planning and delivery across the health and care sector. It is therefore essential that the JSNA is kept under constant review and improvements are made to ensure it contains the latest information and evidence which reflects the changing needs of Lincolnshire's population. In order to do this we have set ourselves the following principles:

- **Current -** the JSNA needs to be a continuous process of review. We will therefore put in place a rolling programme of review to ensure each topic area is refreshed and updated as new data and evidence becomes available.

- **Accessible –** we will continue to make the JSNA available to all stakeholders by publishing it on the Lincolnshire Research Observatory (LRO). We have listened to feedback and improved the way people access information on the LRO, and we will continue to seek feedback to identify ways of further improving access to the JSNA.

- **Relevant –** the recent review has resulted in some changes in topic areas to reflect the changing needs of Lincolnshire's population. To ensure the JSNA remains relevant we will work with partners to fill any gaps in our knowledge by identifying new topic areas or undertaking calls for evidence.

- **Partner Driven –** the JSNA is a shared evidence base and not the sole responsibility of one organisation – partnership working is crucial. We will actively seek feedback and provide opportunities for partners to engage in the JSNA process, including the voluntary and community sector. Partners will be kept informed through a range of mechanisms including infographic summaries, an annual update report, regular newsletter and updates on the LRO website.

- **Embedded –** for the JSNA to be effective it needs to be embedded within organisational processes and for there to be a clear link between the use of the JSNA and commissioning decisions. To share learning and promote greater engagement in the JSNA we will encourage partners to share case studies and examples on how the JSNA was been used.

2. Key Facts and Figures about Lincolnshire

Lincolnshire is one of the largest counties in England, with a land area of 5,937 square kilometres. The county has a diverse geography, comprising large rural and agricultural areas, urban areas and market towns, and a long eastern coastline. The population density in Lincolnshire is approximately 124 persons per square kilometre, less than a third of the average for England and Wales.

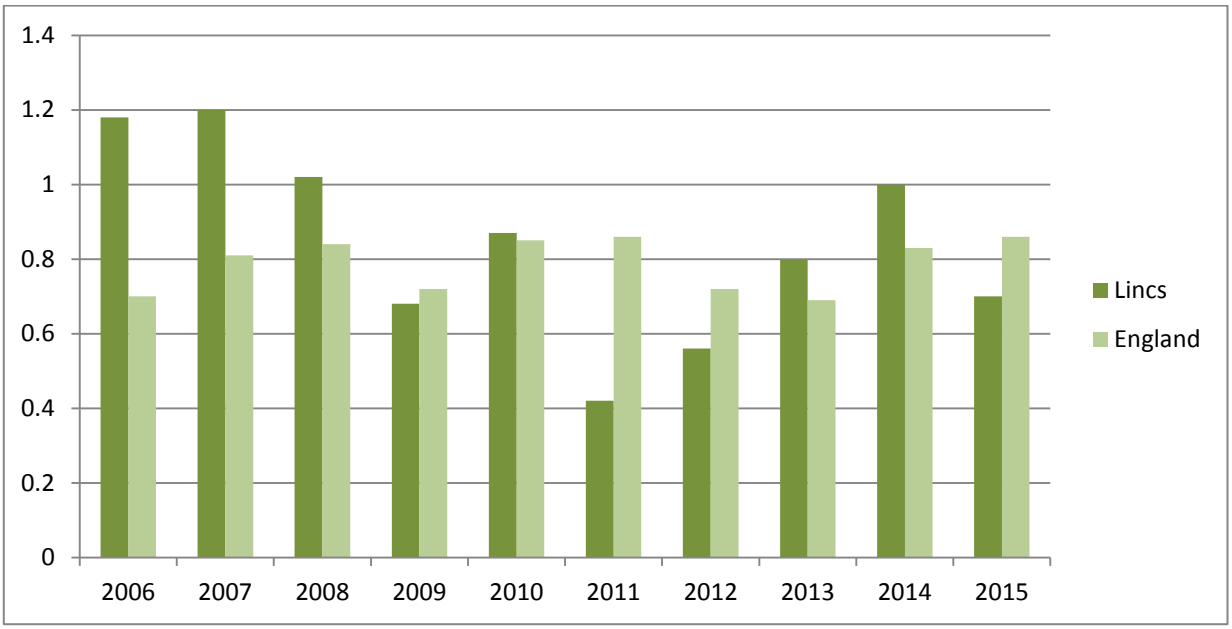
2.1 Population

Population Estimates

- The population of Lincolnshire is currently estimated to be 736,700 (based on ONS 2015 Mid-Year Population Estimates), a rise of 0.7% (5,200 persons) on the previous year.

- Over the past ten years Lincolnshire's population increased by 8.8%, which is higher than both the East Midlands (8%) and England (8.3%). Although the rate of Lincolnshire's population growth has increased in recent years, latest figures show it is below the national rate of growth (See Figure 2).

Figure 2: Annual Percentage Change in Population, Year on Year



Source: Office of National Statistics

Age Profile

- The proportion of young people in Lincolnshire (aged 0-19) has fallen from approximately 23% of the total population in 2005 to 22% in 2015.

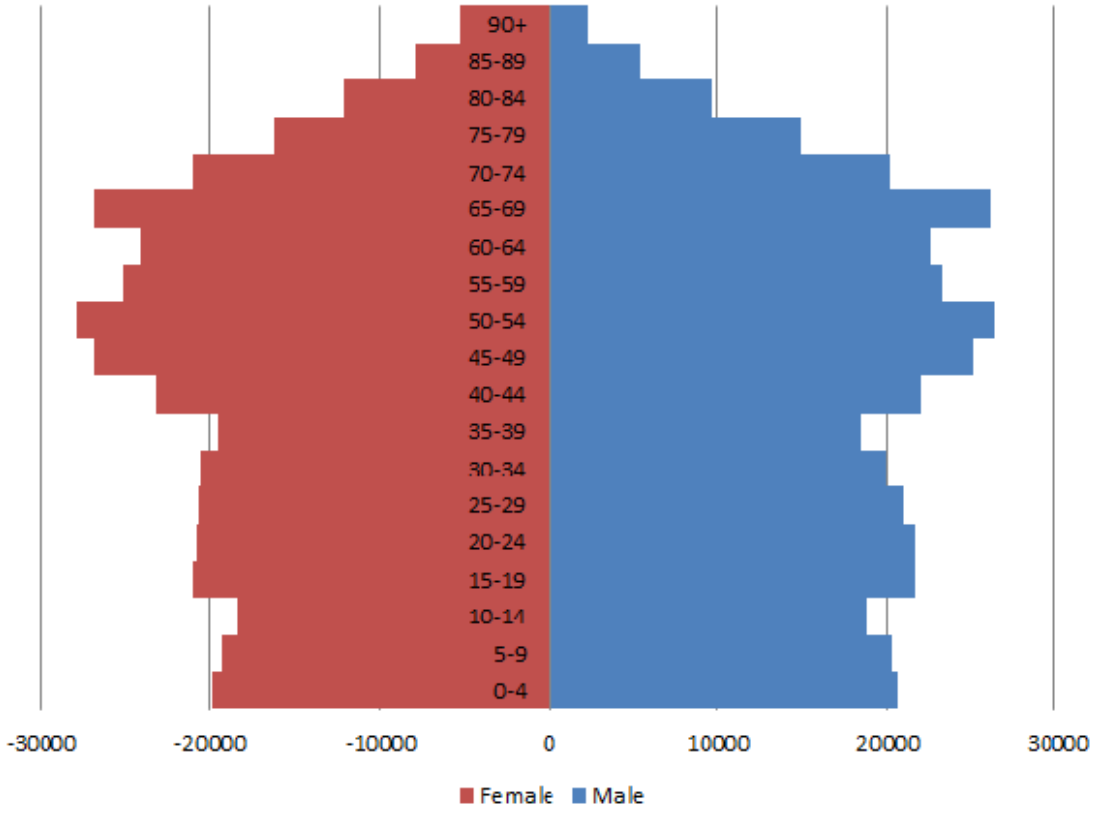
- In contrast, over the same period the number of people aged 65+ has increased by 3% to 22% in 2015 (compared to a 2% increase nationally to 18%). This information highlights the fact that Lincolnshire has a declining younger population and a growing older population (See Figure 3)

Population Projections

- Projections indicate that by 2039 the population growth in Lincolnshire will be 14% which is below the projected national growth rate of 17%, the population in Lincolnshire is projected to increase by approximately 103,000.

- The rate of change is not uniform across the county. Between 2014 and 2039 South Kesteven's population is projected to see the largest growth at 18%, followed closely by South Holland (17%). East Lindsey, however, has a much lower predicted growth rate of 10% (See Table 1).

Figure 3: Age Profile of Lincolnshire (mid-year 2015)



Source: Office of National Statistics

- The trend towards an ageing population profile will continue, with the proportion of people aged 65 and over projected to increase from 22% in 2014 to 30% in 2039.

- Most of the districts will also see a change in the proportion of older people, although figures will vary significantly. Nationally, the number of older people is projected to rise from 18% in 2014 to 24% by 2039. In Boston 21% of the population was aged 65 or over in 2014 and this will rise to 25% in 2039, whilst in West Lindsey 23% of the population was aged 65 or over in 2014, projected to rise dramatically to 32% in 2039.

Table 1: Population Projection Summary

					Change (%) from 2014		
	2014	2019	2029	2039	2019	2029	2039
Lincolnshire	731,500	755,800	801,200	834,700	3	10	14
Boston	66,500	69,600	73,700	76,800	5	11	16
East Lindsey	137,600	140,100	146,200	150,800	2	6	10
Lincoln	96,200	98,600	103,000	106,900	2	7	11
North Kesteven	111,000	115,200	122,700	127,900	4	10	15
South Holland	90,400	94,100	100,700	106,100	4	11	17
South Kesteven	138,000	143,600	154,400	162,400	4	12	18
West Lindsey	91,800	94,700	100,400	103,800	3	9	13

Source: Office of National Statistics

- The number of working age people is projected to fall from 61% of the population in 2014 to 52% in 2039, nationally the trend is 63% to 58%.

- Similarly all local district areas of Lincolnshire are predicted to experience a decrease in the percentage of the population who are working age.

Further information regarding population can be found on the Population Theme Page on the LRO website at www.research-lincs.org.uk/Population.aspx

2.2 Deprivation

The Index of Multiple Deprivation 2015 (IMD) is the official measure of relative deprivation for small areas (or neighbourhoods) in England.

- Lincolnshire has areas that are ranked amongst the most deprived in the country, but also has areas that are ranked amongst the least deprived in the country.

- The general pattern of deprivation across Lincolnshire is in line with the national trend, i.e. that urban and coastal areas show higher levels of deprivation than other areas. Areas that are most deprived tend to be, but are not restricted to, Lincoln and other market towns (e.g. Boston, Gainsborough, Grantham, Sleaford and Spalding). The Lincolnshire coastline, particularly the towns of Mablethorpe and Skegness are amongst the most deprived 10% of neighbourhoods in the country.

- A higher proportion of people in Lincolnshire are now officially ranked as living in England's most deprived areas compared to the previous data release in 2010.

Further information regarding population can be found on the Deprivation and Poverty Theme Page on the LRO website http://www.research-lincs.org.uk/Deprivation-and-Poverty.aspx

2.3 Life Expectancy

- In Lincolnshire, life expectancy at birth has continued to increase. Between 2012 and 2014 life expectancy for both males and females were comparable with the England averages of 79.6 years and 83.2 years respectively. However, the gap in life expectancy between males and females is narrowing. (Source ONS).

- There are variations across the county, for example, female life expectancy at birth is lowest in Lincoln at 82 years and highest in South Kesteven at 84 years, a gap of 2 years. For men, life expectancy at birth is again lowest in Lincoln at 78.2 years and highest in North Kesteven at 81.5 years, a gap of 3.3 years.

- In 2012-2014, healthy life expectancy, which estimates lifetime spent in 'Very Good' or 'Good' health based on how individuals perceive their health, is higher in women in Lincolnshire (65.8 years) than England (64 years). For men, the figure for Lincolnshire (63 years) is similar to the England average (63.4 years).

2.4 Mortality Rates

- The infant mortality rate in Lincolnshire is 3.2 deaths per 1000 live births. This is lower than both the East Midlands and England averages. There is however variation across the county with the highest infant mortality rates experienced in West Lindsey and South Kesteven, with 5.3 and 4.4 deaths per 1000 live births respectively. By contrast Boston, East Lindsey and Lincoln all have infant mortality rates below the Lincolnshire average.

- Since 2011 there has been a slight fall in the number of people in Lincolnshire dying from causes considered preventable, the current rate is 179.2 deaths per 100,000. This is better than both the East Midlands and England averages. However, there is a significant variation across the county with the highest rates being in Lincoln (227.7), Boston (209.1) and East Lindsey (203.6), whilst the lowest rate is in North Kesteven at 138.9 deaths per 100,000.

3. JSNA Topic on a Page

This section provides an overview of the key messages for each of the 35 topics in the 2017 JSNA. The topics have been grouped under six theme headings as shown below. The full JSNA can be found on the Lincolnshire Research Observatory.

Children and Young People

- Breastfeeding
- Educational Attainment (Foundation)
- Educational Attainment (Key Stage 4)
- Looked After Children
- Maternal Health, Pregnancy & the first few weeks of life
- Mental Health& Emotional Wellbeing (Children & Young People)
- Special Educational Needs & Disability
- Teenage Pregnancy
- Young People in the Criminal Justice System

Adult Health and Wellbeing

- Alcohol (Adults)
- Autism
- Carers
- Domestic Abuse
- Drug Misuse
- Learning Disabilities
- Mental Health (Adults)
- Physical Disabilities & Sensory Impairment
- Smoking Reduction in Adults
- Suicide

Older People

- Dementia
- Falls

Healthy Lifestyles

- Food & Nutrition
- Immunisation (All Ages)
- Obesity (All Ages)
- Physical Activity
- Sexual Health

Major Diseases

- Cancer
- Chronic Obstructive Pulmonary Disease
- Coronary Heart Disease
- Diabetes
- Stroke

Wider Determinants of Health

- Excess Seasonal Deaths & Fuel Poverty
- Financial Inclusion
- Housing & Health
- Road Traffic Collisions

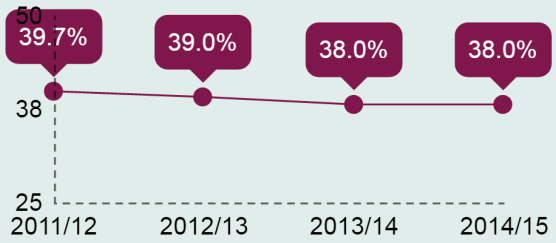
Breastfeeding

Why is this important?

- The World Health Organisation recommends babies should be fed only on breast milk from birth to six months of age.
- Maternal health benefits of breastfeeding include protection against ovarian and breast cancer and reduced risk of osteoporosis.
- Breastfed babies have better health outcomes including lower risk of diabetes, obesity and allergies.

What has changed?

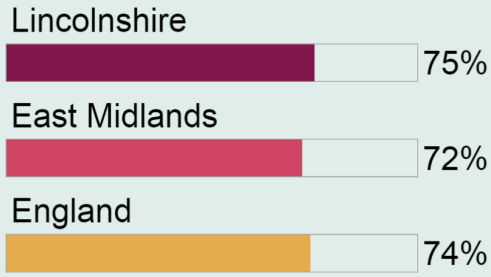
Babies totally or partly breastfed at 6-8 weeks in Lincolnshire



Source: Public Health Pregnancy and Birth Profile

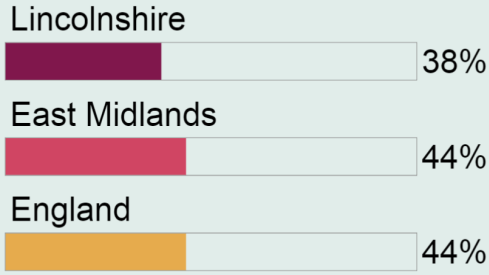
How do we compare?

Women starting breastfeeding in the first 48 hours after birth (2013/14)



Source: Public Health Pregnancy and Birth Profile

Babies totally or partly breastfed at 6-8 weeks (2014/5)



Source: Public Health Pregnancy and Birth Profile

The picture in Lincolnshire

In 2013/14 the lowest breastfeeding start rates were in Lincoln (67%) and West Lindsey (69.7%); the highest were in Boston (84.5%).

In 2014/15 the lowest numbers still breastfeeding at 6-8 weeks were in East Lindsey (33%) and West Lindsey (35%); the highest were in North and South Kesteven (both 41%).

Breastfeeding rates at 6-8 weeks may be linked to areas of deprivation, with women in less deprived areas like North and South Kesteven more likely to continue breastfeeding than in the Boston and Lincoln areas.

Key message

With a wealth of national evidence to support the health benefits of breastfeeding for both mother and baby, there are clear benefits to supporting mothers in the most deprived areas to breastfeed their babies.

It is estimated that nationally the cost to the NHS of treating just 5 illnesses linked to babies not being breastfed is at least £48 million per year, and approximately £6 million per year in Lincolnshire.

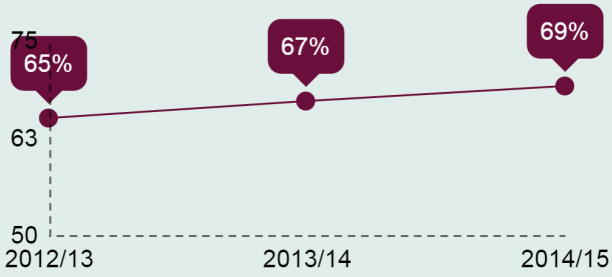
Educational Attainment (Foundation)

Why is this important?

- Lincolnshire County Council Children's Services vision is 'that every child in every part of the county should achieve their full potential'.
- Access to good quality early or pre-school education makes children better prepared and ready to start school.
- Not having access to early or pre-school education means a child can lack basic speech and language skills, and have limited physical wellbeing and motor development compared to their peers.

What has changed?

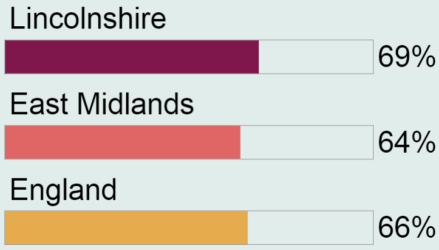
Children reaching a good level of development at the end of the Early Years Foundation Stage



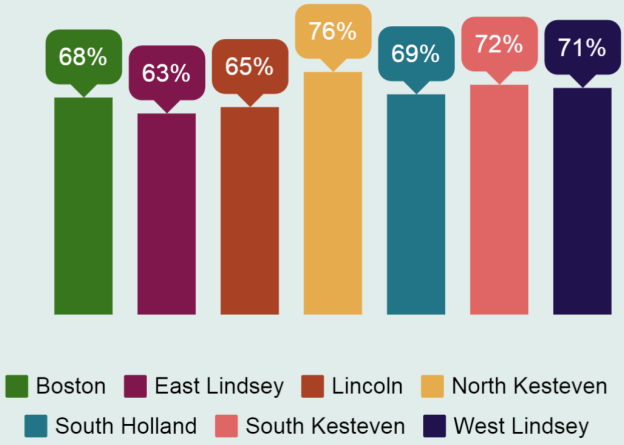
Source: Department for Education

How do we compare?

Children reaching a good level of development at the end of the Early Years Foundation Stage (2014/5)



Breakdown by district (2014/15)



Source: Department for Education

The picture in Lincolnshire

98% of 3 and 4 year olds access their 15 hours per week free early years education place.

Lincolnshire children do better than their regional and national peers in the Early Years Foundation Stage.

Children with English as an Additional Language and children with SEND do not do as well as their peers.

More girls (77%) reached a good level of development at the end of the Foundation Stage compared to boys (62%).

Key message

There is a clear link between Early Years development and future life prospects, therefore it is important to ensure early years provision gives children the best possible start.

It is generally more cost effective to invest in early years interventions that will improve outcomes for children than try to improve outcomes later in life.

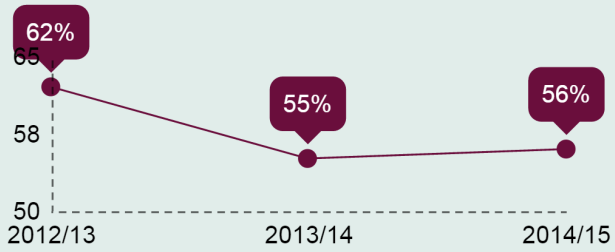
Educational Attainment (Key Stage 4)

Why is this important?

- Raising attainment in secondary schools is important in order to maintain and improve the economic benefits for, and productivity of, communities in Lincolnshire.
- Achieving GCSEs, A levels and completing apprenticeships improve earnings, employability and lifetime productivity.
- There is a strong link between poor educational attainment and increased inequalities.

What has changed?

Pupils achieving at least 5 good grades at GCSE, including English and Maths

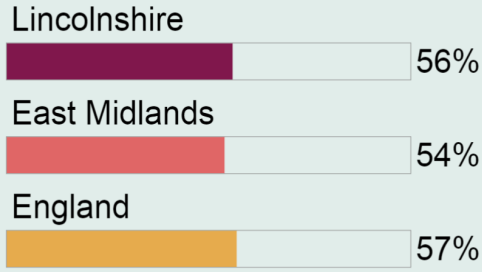


Source: Department for Education

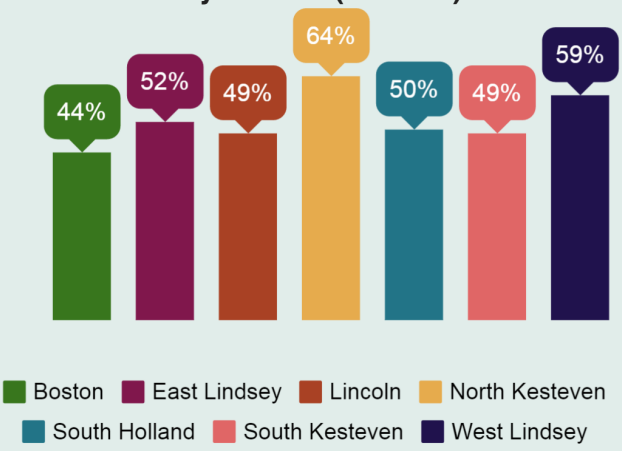
Note - the significant drop between 2012/3 and 2013/14 is due to changes in curriculum in the 2014 exam year.

How do we compare?

Pupils achieving at least 5 good grades at GCSE, including English and Maths (2014/15)



Breakdown by district (2014/15)



Source: Department for Education

The picture in Lincolnshire

30% of children eligible for Free School Meals achieve good GCSE levels compared to 62% of their peers.

Almost two thirds of girls achieve 5 good GCSEs compared to half of boys.

Locally, GCSE attainment for children with English as an Additional Language (45%) was significantly worse than national rates (57%).

Children with SEND achieve similar levels of GCSEs to their peer group nationally, though still not as well as non-SEND students.

Key message

A good basic education is fundamental to a person's ability to make a positive contribution to society. Failure to provide this education has significant social and financial consequences.

Achieving 5 or more good GCSEs has a lifetime productivity impact of £100,000 above average earnings in comparison to someone with no qualifications.

Lincolnshire Joint Strategic Needs Assessment 2017

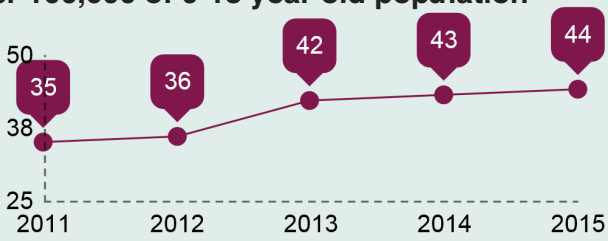
Looked After Children

Why is this important?

- Most children are looked after as a result of neglectful parenting and will have experienced trauma in their lives.
- Looked After Children represent a particularly vulnerable group, at high risk of social exclusion, health inequalities, and poor educational attainment.
- Looked After Children show significantly higher rates of mental health issues, emotional disorders, hyperactivity and autistic spectrum disorder conditions.

What has changed?

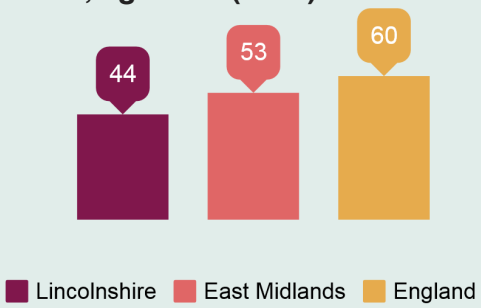
Rate of looked after children in Lincolnshire per 100,000 of 0-18 year old population



Source: Local Authority Interactive Tool (LAIT)

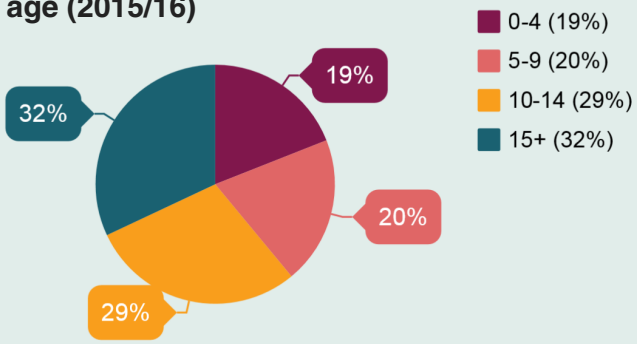
How do we compare?

Looked After Children per 100,000 population, age 0-18 (2015)



Source: Local Authority Interactive Tool (LAIT)

Looked After Children in Lincolnshire by age (2015/16)



Source: Lincolnshire County Council children's social care data

The picture in Lincolnshire

10% of Looked After Children achieved at least 5 good GCSEs compared to 65% of their peers.

In 2015, 84% of care leavers were living in suitable accommodation compared to 81% nationally.

In 2014/15, 96.5% of Looked After Children had an annual Health Assessment compared to 89.7% nationally.

In 2016, 6.8% of Looked After Children have had three or more placements compared to 10% nationally.

Key message

The social and financial costs associated with increased numbers of Looked After Children are very significant, with each placement costing hundreds of pounds per week.

The Local Authority has statutory responsibility as corporate parent to ensure Looked After Children are provided with the best health, education and social opportunities to ensure they fulfil their potential and leave care equipped for adult life.

www.research-lincs.org.uk/jsna-Looked-After-Children.aspx

Lincolnshire Joint Strategic Needs Assessment 2017

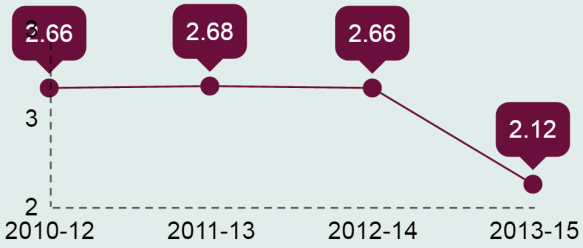
Maternal Health, Pregnancy & the First Few Weeks of Life

Why is this important?

- Good maternal health and wellbeing during pregnancy is essential for a child's health, wellbeing and educational outcomes.
- Access to good quality care reduces the risk of miscarriage and stillbirth, infant and maternal death, low birth weight and premature birth.
- Depression and anxiety are the most common mental ill-health problems during pregnancy and 12 months after the birth.

What has changed?

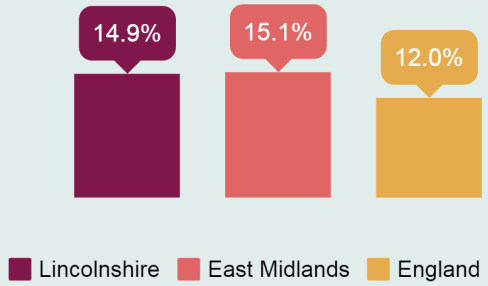
Infant deaths in Lincolnshire within the first 28 days after birth, per 1,000 live births



Source: Public Health Infant Mortality Profiles

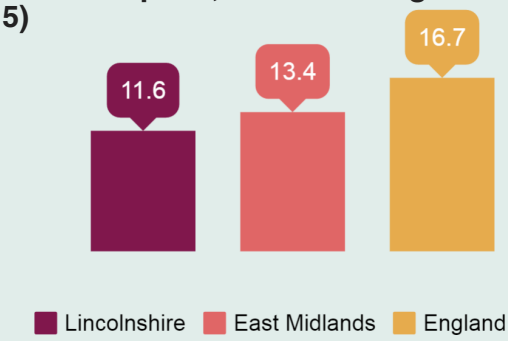
How do we compare?

Smoking rates at time of delivery (2013/14)



Source: Public Health Pregnancy and Birth Profiles

Abortion rate per 1,000 women aged 15-44 (2015)



Source: Public Health Sexual and Reproductive Health Profiles

The picture in Lincolnshire

The General Fertility Rate (GFR) has fallen from 63.2 live births per 1,000 in 2010 for women aged 15-44 in 2014 to 61.1, reflecting regional and national trends.

In 2014 Boston has the highest GFR rate at 71.4 per 1,000 women aged 15-44, and Lincoln City the lowest at 54.4.

Full term babies with low birth weight make up 2.2% of births in Lincolnshire; the England average is higher at 2.9%.

Stillbirth rates are 4.8 per 1,000 births, similar to the England rate of 4.9.

Key message

Good support during pregnancy and early life can help lay foundations for individual health, wellbeing, cognitive development and emotional security for life. Failing to support families during pregnancy and early life to lay the best foundations they can for their children risks increasing levels of obesity, childhood injury, mental ill-health and low educational attainment.

www.research-lincs.org.uk/jsna-Pregnancy-and-Maternal-Health.aspx

Lincolnshire Joint Strategic Needs Assessment 2017

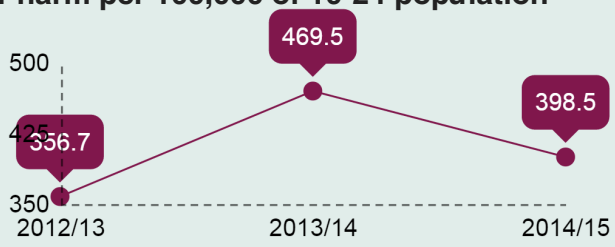
Mental Health & Emotional Wellbeing (Children & Young People)

Why is this important?

- One in ten young people have a mental health problem; the equivalent of three in every classroom.
- Young people with emotional disorders are more likely to smoke, drink and misuse drugs, miss school and fail in their education. As adults they are more likely to earn less money and experience unemployment.
- Young people attending A&E due to a psychiatric condition has more than doubled nationally since 2010.

What has changed?

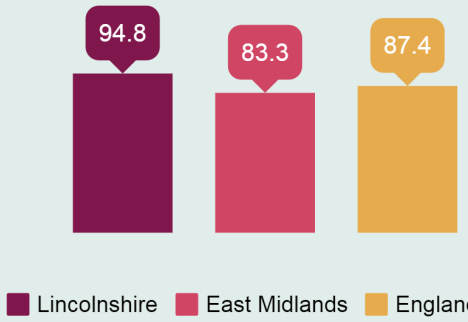
Lincolnshire hospital admissions as a result of self-harm per 100,000 of 10-24 population



Source: Public Health Child and Young People's Mental Health and Wellbeing Profiles

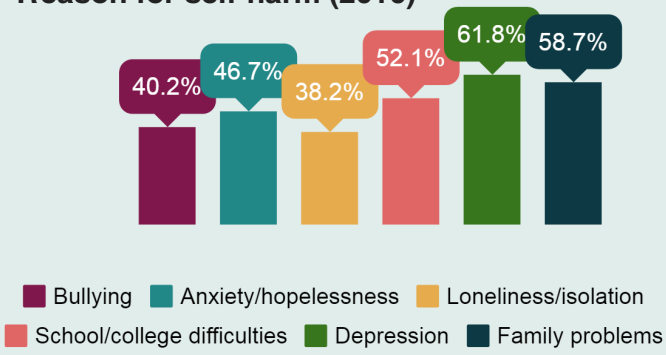
How do we compare?

Child admissions for mental health per 100,000 0-17 population (2014/15)



Source: Public Health Child and Young People's Mental Health and Wellbeing Profiles

Reason for self-harm (2016)



Source: Healthwatch Lincolnshire Mental Health Services survey

The picture in Lincolnshire

Over 3,000 children aged 5-10 years and over 5,000 aged 11-16 years have mental ill-health disorders - 9.4% of 5-16 year olds.

The 2016 Healthwatch Mental Health survey found that 20.5% of young people have self-harmed.

4,427 referrals were made to Lincolnshire Children and Adolescent Mental Health Service (CAMHS) between April 2015 and March 2016.

Key message

Half of all mental health problems have been established by the age of 14, rising to 75% by the age of 24.

A child with good mental health is much more likely to have good mental health as an adult, and to be able to take on adult responsibilities and fulfil their potential. As well as the impact on the individual child and their family, the estimated long term cost to the economy of mental health problems in children and young people is £105 billion a year.

www.research-lincs.org.uk/jsna-Mental-Health-CYP.aspx

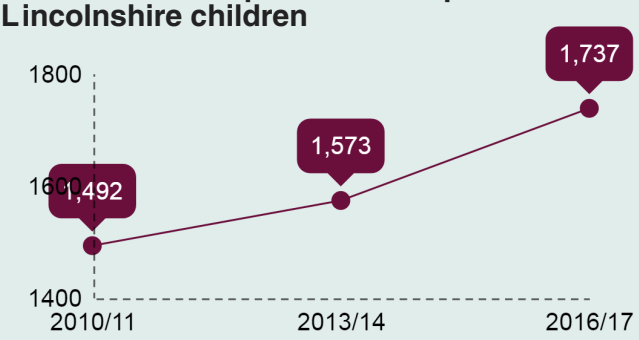
Special Education Needs & Disability

Why is this important?

- Children with Special Educational Needs and Disabilities (SEND) are more likely to live in poverty, achieve educationally below their peers, more likely to be excluded from school, less likely to go on to further or higher education and more likely to be unemployed.
- The annual cost of bringing up a child with SEND is 3 times greater than a child without SEND.

What has changed?

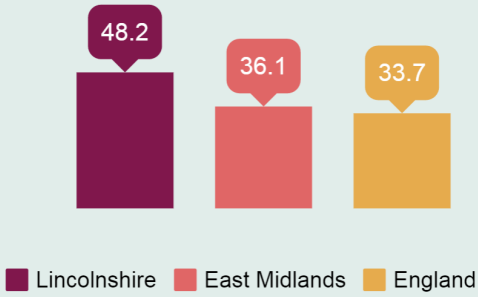
Commissioned special school places for Lincolnshire children



Source: Lincolnshire County Council SEND team

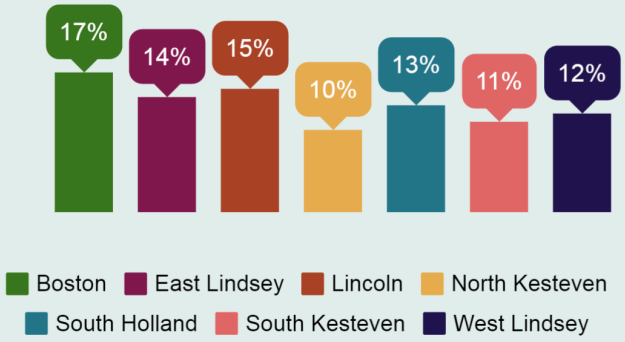
How do we compare?

Children with learning disabilities known to schools per 1,000 population (2014)



Source: Public Health Learning Disability Profiles

Number of Lincolnshire pupils with SEN Support (2016)



Source: Schools Census January 2016 / Lincs Geographical Information System

The picture in Lincolnshire

In 2013/14 just over a third of Looked After Children had a Statement of SEND or EHC plan, compared to 3.1% of the general population.

East Lindsey has the highest percentage (3.4%) of pupils with a Statement of SEND or EHC Plan; South Kesteven has the lowest (2.28%).

In 2011, almost 18% of 0-19 year olds had a long-standing illness, disability or were severely disabled.

16% of children on school registers in 2014/15 were receiving support for their SEND.

Key message

If the needs of children and young people with SEND are not identified, the result would be that children and young people will not have access to the services and support in education, training and employment they need to succeed in adult life.

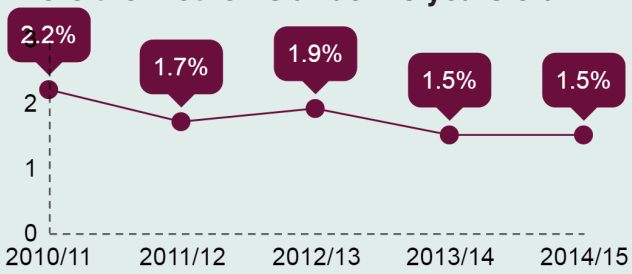
Teenage Pregnancy

Why is this important?

- Young parents are at risk of significantly poorer health and educational outcomes than their peers and in turn, their children may have worse outcomes than their peers.
- Teenagers are ten times more likely to become a parent if they are the daughter of a teenage parent.
- Teenage mothers may be emotionally vulnerable and 2 in 3 experience relationship breakdown during pregnancy or during the 3 years after birth.

What has changed?

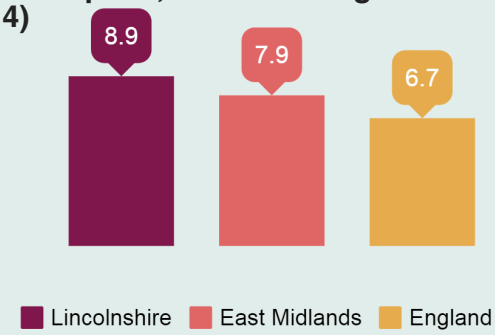
Percentage of total births in Lincolnshire where the mother is under 18 years old



Source: Public Health Teenage Pregnancy Profiles

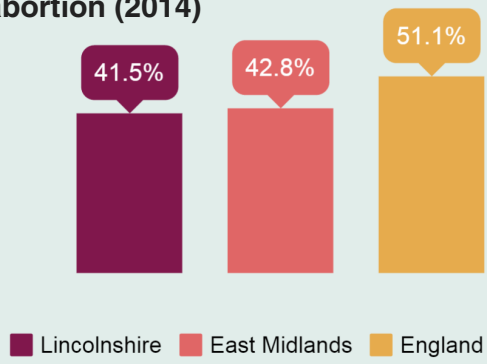
How do we compare?

Birth rate per 1,000 women aged 15-17 (2014)



Source: Public Health Teenage Pregnancy Profiles

Conceptions by under 18 year olds leading to abortion (2014)



Source: Public Health Teenage Pregnancy Profiles

The picture in Lincolnshire

Under-18 conceptions have halved since 1998, the greatest decrease is in Lincoln city, which still remains the highest in the county.

Young people who take risks with sexual health are also likely to demonstrate other risk taking behaviour such as substance and alcohol misuse.

Over 20% of under-18 conceptions occur in the most deprived communities.

1 in 5 girls aged 16-18 not in education, employment or training are teenage mothers and 22% more likely to be living in poverty by the age of 30.

Key message

National research shows children born to teenage mothers have higher rates of infant mortality and have increased risk of low birth weight. Young mothers are less likely to breastfeed than older mothers, which can impact on the child's long term health.

The cost of teenage pregnancy to the NHS is estimated at £63 million a year.

Young People in the Criminal Justice System

Why is this important?

- Children and young people in the youth justice system often have more complex health and wellbeing needs than others in their age group.
- About one third of the Youth Offending Service (YOS) cohort are in contact with Children's Services.
- Young offenders may experience high levels of health needs, a wide range of social problems and the effects of deprivation.

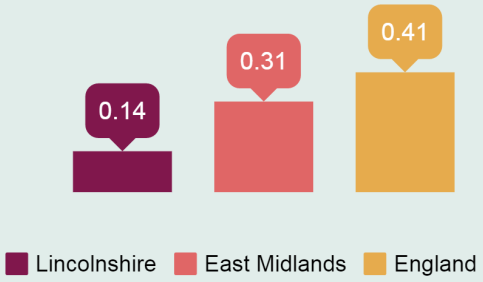
What has changed?

Young people in Lincolnshire receiving their first warning, reprimand or conviction per 100,000 of the 10-17 population

Source: National Child and Maternal Health Intelligence Network - Youth Justice Profiles

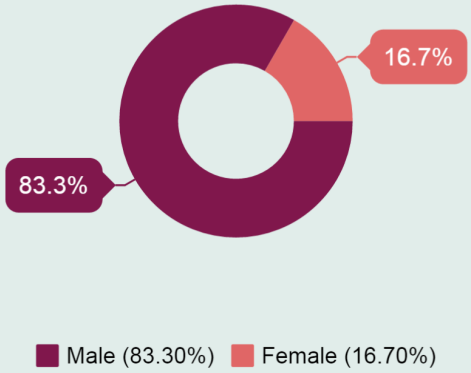
How do we compare?

Young people given a custodial sentence per 1,000 of the 10-17 population (2014/15)



Source: Local Authority Interactive Tool (LAIT)

Lincolnshire young people sentenced by gender (2014/5)



Source: Lincolnshire Youth Offending Team

The picture in Lincolnshire

YOS mainly support white British males aged 15 to 18 years.

Nearly three quarters of young offenders had recently smoked tobacco (3 times the national average). Just over half reported misusing drugs.

In 2014/5, the most common offences by young offenders were violence (28%), theft (17%) and criminal damage (13.7%)

Key message

Children and young people in the youth justice system are more likely to have experienced a range of life challenges which if left unresolved, can lead in later life to mental ill-health problems, unemployment, teenage parenthood, domestic problems, suicide and self-harm and further offending behaviour.

The costs to society are immense - the lifetime cost of crime committed by a single prolific offender is approximately £1.5 million.

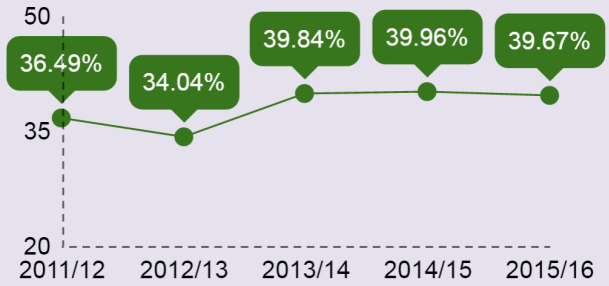
Alcohol (Adults)

Why is this important?

- Excessive drinking by a minority causes significant health and social problems.
- Alcohol misuse contributes to 48 health issues, such as long-term conditions, mental health conditions and accidental injuries.
- Alcohol is linked to almost 1 million violent crimes per year – 44% of all violent crime.

What has changed?

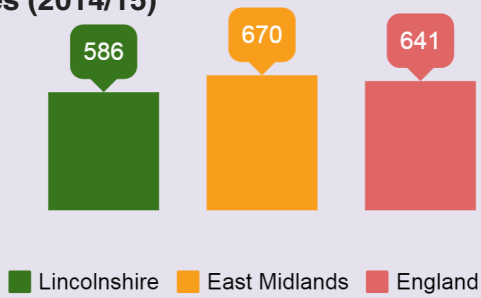
Successful completion of alcohol treatment in Lincolnshire (inc. no return within 6 months)



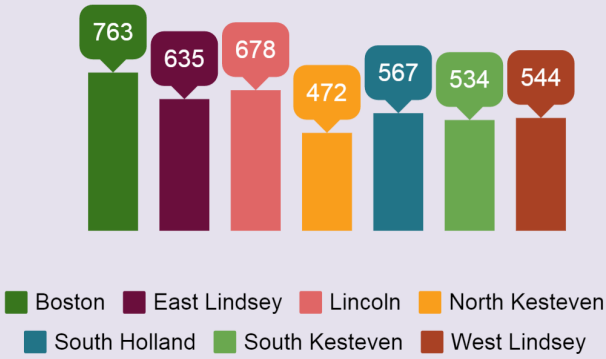
Source: National Drug Treatment Monitoring System (NDTMS)

How do we compare?

Admission episodes for alcohol related conditions per 100,000 population, all ages (2014/15)



Breakdown by district (2014/15)



Source: Public Health Outcomes Framework

The picture in Lincolnshire

The rate of 7.3 per 100,000 alcohol-specific deaths is significantly lower compared to the national rate of 11.6 per 100,000.

It is estimated that almost 19% of adults regularly binge drink.

The highest admission rates for men for alcohol related ill-health are in Boston and East Lindsey. Women are more likely to be admitted in Boston, East Lindsey and South Holland.

Almost two thirds of alcohol-related deaths in 2014 were men.

Key message

Alcohol supply, use and misuse has crime and disorder, economic, excise, family, health, legal and social implications that impact substantially on public services and the population.

Alcohol-related harm is estimated to cost £41.6 million per year in Lincolnshire, and nationally £21 billion per year, with about 17 million working days lost per year due to the effects of alcohol misuse.

Lincolnshire Joint Strategic Needs Assessment 2017

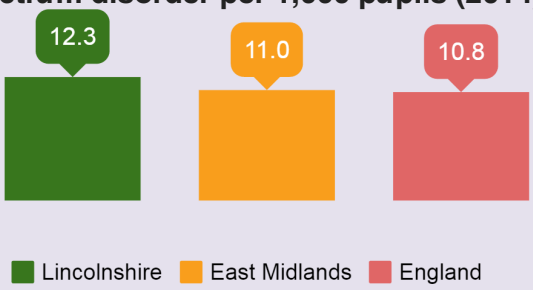
Autism

Why is this important?

- It is estimated that autism affects the lives of 2.8 million people and their families daily.
- Autism costs the UK £32 billion per year; more than the combined costs of heart disease, cancer and strokes.
- Nationally, 85% of autistic people of working age are unwaged.
- Nationally, 50% of autistic people also have a learning disability.

How do we compare?

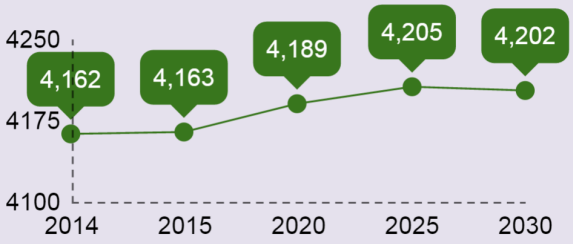
Children known to schools with autistic spectrum disorder per 1,000 pupils (2014)



Source: Public Health Learning Disability Profiles

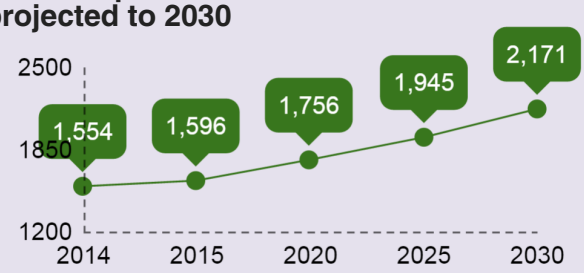
What could change?

Number of people aged 18-64 predicted to have autistic spectrum disorders in Lincolnshire, projected to 2030



Source: www.pansi.org.uk

Number of people aged 65+ predicted to have autistic spectrum disorders in Lincolnshire, projected to 2030



Source: www.poppi.org.uk

The picture in Lincolnshire

- Lincolnshire West CCG has the highest prevalence of autism in Lincolnshire.
- Less than 5% of adults with autism receive support from Adult Social Care.
- 80% of all people with autism are male.
- 72% of people with autism are under the age of 18.
- 66% of school age children with autism go to mainstream schools.

Key message

The nature of autism means many autistic people have, and continue to experience, anxiety, trauma and other psychological conditions as a consequence of the difficulties they encounter in everyday life.

It is estimated that autism costs the country at least £32 billion per year in treatment, lost earnings, care and support for children and adults with this condition.

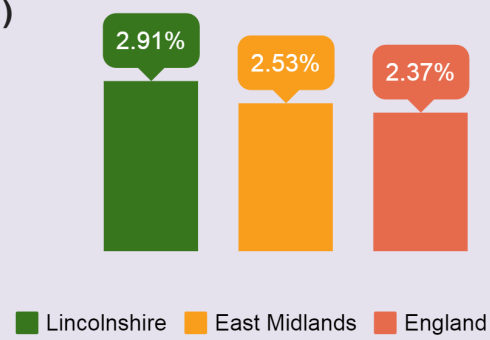
Carers

Why is this important?

- In the UK three out of five people will become a carer in their lifetime.
- Carers provide unpaid support for people living with a range of long term health conditions.
- Lincolnshire has about 84,000 unpaid family carers aged from 5 to 100, who may care for a few hours a week on top of work or education or care full time.

How do we compare?

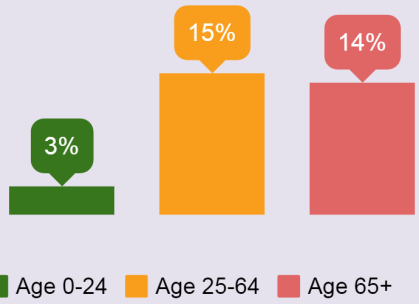
Unpaid carers - percentage of the population (2011)



Source: Public Health Crisis Care Profiles

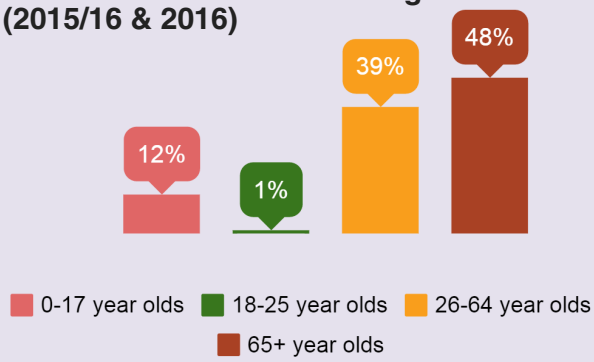
The local picture

Lincolnshire's population who provide unpaid care by age (2011)



Source: 2011 Census

Lincolnshire carers receiving a service (2015/16 & 2016)



Source: 2015/16 SALT data & Oct 2016 Young Carers Register

The picture in Lincolnshire

There are 1,800 young carers aged under 15, and 3,500 young adult carers aged 16-24.

Three quarters of carers say their physical and/or mental health is at risk and 69% report a significant impact on their personal wellbeing.

58% of carers are women, significantly more than the 42% of men.

Carers contributions were 7.6% higher in 2015 than in 2011, reflecting the increasing care needs of the population.

Key message

The value of Lincolnshire's unpaid hours of care is also increasing: estimated at £1,677 million. Nationally, carers provide care to the value of £132 billion every year in the UK – equivalent to spending on the National Health Service.

Leaving carers unsupported increases the personal risk of crisis and breakdown, and increasing costs to health, social care, educational and economic systems.

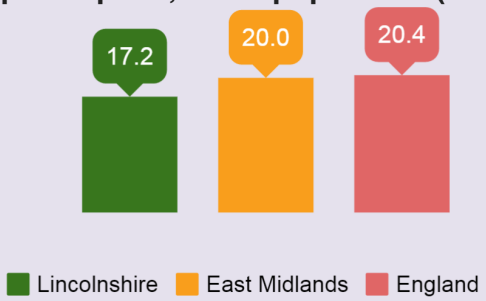
Domestic Abuse

Why is this important?

- Women, young people and people with a disability or long-term illness are more likely to become victims of domestic abuse.
- 2 women are killed every week by a current or former partner and 30 men are killed each year in England.
- Domestic abuse victims are 10 times more likely to attempt suicide and 3 women each week commit suicide after experiencing domestic abuse.

How do we compare?

Incidents of domestic abuse recorded by the police per 1,000 of population (2014/15)



Source: Public Health Outcomes Framework

What has changed?

Reported incidents of domestic violence have increased in Lincolnshire by 36% between 2008/9 and 2014/15.

70% of the increase in incidents reported to the Police since 2011 have occurred in the eastern districts (Boston, South Holland and East Lindsey), despite those districts only accounting for 40% of all domestic abuse incidents in the county in 2011.

The picture in Lincolnshire

In 2015-2016 over 10,000 incidents of domestic abuse were reported to Lincolnshire Police.

1 in 10 Looked After Children have domestic abuse as a factor in their initial assessment.

30% of people affected by domestic abuse are aged 25-34 years old.

In 2015, the highest levels of reported domestic abuse were in Lincoln and East Lindsey, Lincoln being 3 times higher than North Kesteven.

1 in 5 reported police incident domestic abuse victims are male.

Key message

Violence doesn't just have an immediate effect on victim's health, which in some cases is fatal; physical, mental and behavioural health consequences can persist long after the violence has stopped

Including the cost to public services, economic output and the human and emotional costs, domestic abuse is estimated to cost society £15.73 billion per year (based on a 2009 report).

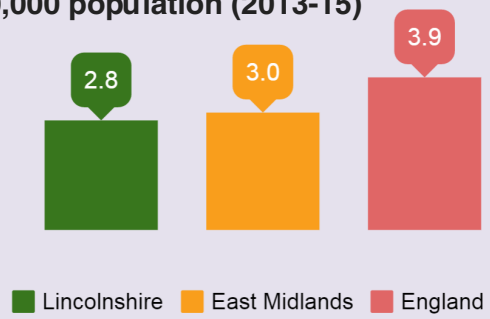
Drug Misuse

Why is this important?

- Drug misuse is a major cause of premature death in the UK. Drug misuse disorder is ranked the third highest cause of death in the 15–49 age group.
- Class A drug use alone generates an estimated £15.4 billion annually in crime and health costs.
- 60% of drug related deaths are people who have had not had treatment and for every £1 spent on drug treatment £2.50 is saved from the public purse.

How do we compare?

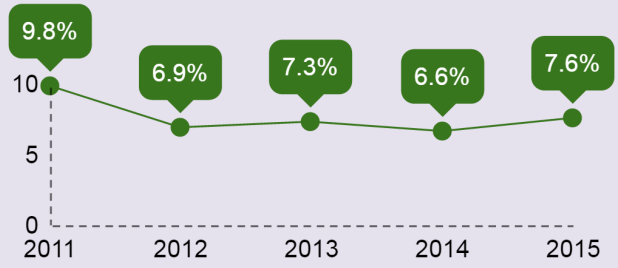
Deaths attributed to drug misuse per 100,000 population (2013-15)



Source: Public Health Profiles

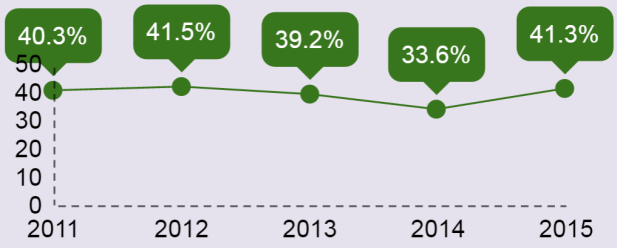
What has changed?

Lincolnshire rates of successful drug treatment (opiate users)



Source: Public Health Profiles

Lincolnshire rates of successful drug treatment (non-opiate users)



Source: Public Health Profiles

The picture in Lincolnshire

Many adults enter drug treatment using multiple substances e.g. heroin and crack (53%) and cannabis (17.5%).

Young people entering drug treatment also use multiple substances e.g. cannabis (81%), alcohol (69%) and Novel Psychoactive Substances (34%).

Men are twice as likely to misuse drugs as women.

Drug related hospital admissions are 321 per 100,000 population in the most deprived areas compared to 67.9 per 100,000 in the least deprived areas.

Key message

It is estimated that drug misuse costs the UK £10.7 billion each year in health service costs, drug-related crime and economic costs such as premature deaths.

In families where substance misuse is an issue there may be multiple and complex needs which include housing, unemployment, education and domestic violence, all of which can create ongoing and lasting problems.

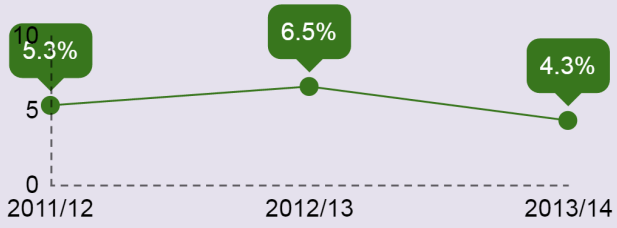
Learning Disabilities

Why is this important?

- It is estimated that there are over 15,000 individuals with a learning disability in Lincolnshire.
- Many people with learning disabilities also have other conditions such as mental ill-health or a physical disability.
- Learning disabilities are not learning 'difficulties'. Learning difficulties includes conditions such as dyslexia which do not affect intellectual ability.

What has changed?

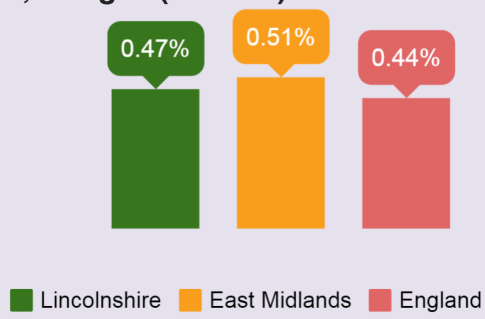
Adults with learning difficulties in Lincolnshire in paid employment



Source: Public Health Learning Disability Profile

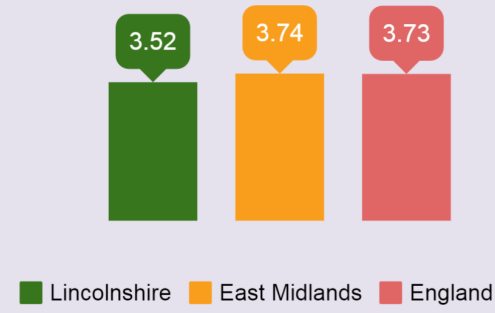
How do we compare?

People with learning disabilities known to GPs, all ages (2014/15)



Source: Public Health Learning Disability Profile

Adults with learning disabilities getting long-term support from Local Authority, per 1,000 of 18-64 year olds (2014/15)



Source: Public Health Learning Disability Profile

The picture in Lincolnshire

Less than 30% of people registered with a GP as having a learning disability had a health check during the previous year.

Individuals with a learning disability that may require community supported living services is predicted to rise from 647 in 2015/16 to around 850 by 2020.

There are currently over 500 adults with learning disabilities supported in long term residential care, at a cost of about £22 million per year.

Key message

Children with more complex needs are coming into the education system; provision needs to be adequate to meet their social care needs in future years.

The likely increase of 3.2% in adults with learning disabilities by 2020, as well as a predicted 11.1% rise in older people, is likely to put considerable pressure on health and social care provision.

Lincolnshire Joint Strategic Needs Assessment 2017

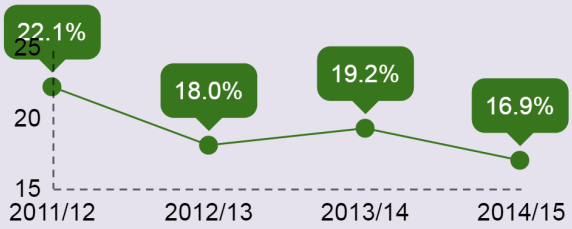
Mental Health (Adults)

Why is this important?

- At any one time, one in six adults has a mental health condition, and those with a long term physical condition or learning disability are most at risk.
- Mental health accounts for almost a quarter of NHS activity but only around 11% of the total expenditure.
- Half of mental health issues are established by the age of fourteen, rising to three quarters by the age of twenty four.

What has changed?

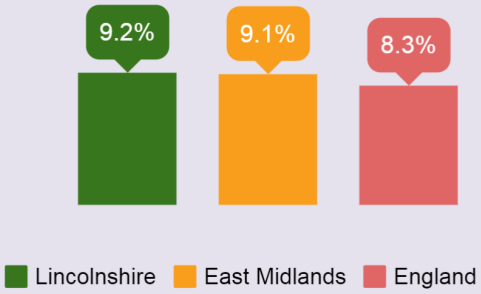
Lincolnshire self-reported wellbeing - people with high anxiety levels



Source: Public Health Profiles (Common Mental Health Disorders)

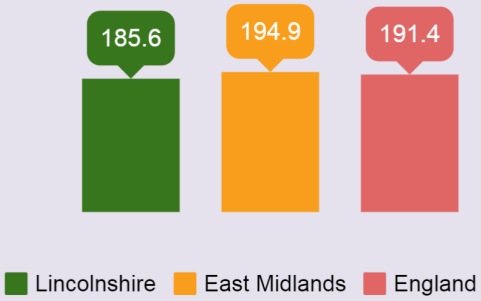
How do we compare?

Patients on GP registers with diagnosis of depression, age 18+ (2015/16)



Source: Public Health Profiles (Mental Health JSNA)

Emergency admissions for intentional self-harm per 100,000 population (2014/15)



Source: Public Health Outcomes Framework

The picture in Lincolnshire

17% of adults aged 16 and over suffer from a common mental disorder, women being more likely to suffer than men.

In 2014/15, there were 2,010 inpatient admissions due to mental health conditions, a rate of 344.2 in every 100,000 adults aged 16 and over.

Rates of depression in Lincolnshire are above average at 9.1% of the population, compared to 8.3% nationally.

Depression, anxiety and self-harm are commonly associated with smoking, substance and alcohol misuse.

Key message

Poor mental health is known to contribute to existing inequalities and can result in negative outcomes for those in need, particularly in relation to education, employment, housing, substance and alcohol dependence and the criminal justice system.

The cost to the economy is estimated at £105 billion a year. This demonstrates the financial implications of not taking mental ill-health seriously.

Physical Disability & Sensory Impairment

Why is this important?

- 15% (60,000) of adults aged 18 to 64 living in Lincolnshire have a long term illness or physical disability.
- 38,000 of adults over 65 have a long term illness or disability that significantly limit their day-to-day activities, whilst a further 44,000 people experience a lesser impact on their day-to-day activities.
- Risk of sensory impairments including hearing and sight loss increase with age.

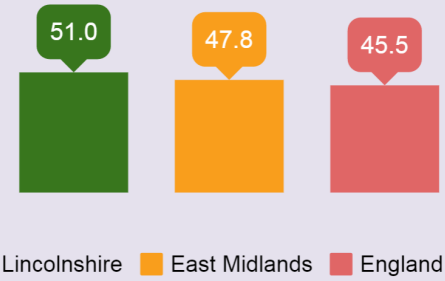
What are the gaps?

There is a significant gap between the 98,000 people over 18 living with a long-term illness or physical disability and the 8,356 who are supported by council-arranged social care services.

Local groups highlight that appropriate infrastructure and access to opportunities are not being fully met across the county.

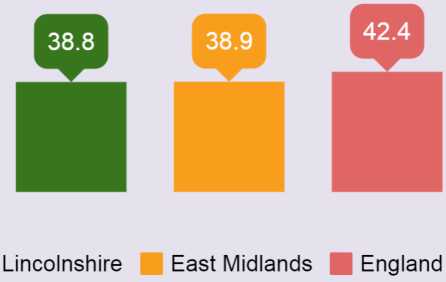
How do we compare?

People in receipt of Disability Living Allowance per 1,000 working age population (2014)



Souce: Public Health Adult Social Care Profiles

Preventable sight loss certifications per 100,000 population, all ages (2014/15)



Souce: Public Health Outcomes Framework

The picture in Lincolnshire

In 2016, 6,000 new requests for support from people aged 18-64, and 25,000 new requests from people aged over 65 were made.

15,000 adults have a moderate or severe visual impairment, projected to rise to 21,000 by 2030, with 32% having a registrable eye condition as listed by the RNIB.

It is estimated 148,500 people live with hearing loss. By 2019, this number is set to grow to 164,000.

19% of families with at least one disabled member live in relative income poverty compared to 15% families with no disabled member.

Key message

People with physical or sensory impairments are more likely to live in poverty and experience problems with housing, transport, hate crime and harassment as well as a lack of support to access opportunities to improve the quality of their life.

The predicted increase in people with a physical disability or a sensory impairment over the next 15 years will have a significant impact on health and social care budgets.

www.research-lincs.org.uk/jsna-Physical-Disabilities.aspx

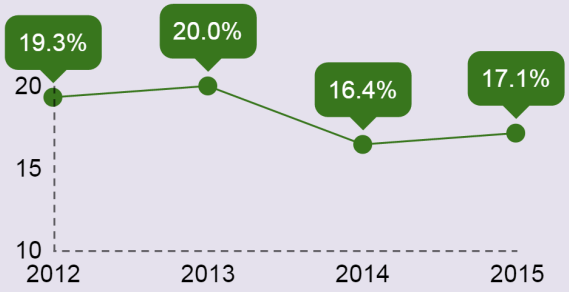
Smoking Reduction in Adults

Why is this important?

- Smoking is the biggest cause of premature death in England, accounting for about 80,000 deaths yearly and approximately 1,300 in Lincolnshire.
- Smoking rates differ across the county as do diseases and deaths linked to smoking.
- There are around 103,000 smokers in Lincolnshire - 17.2% of the population.

What has changed?

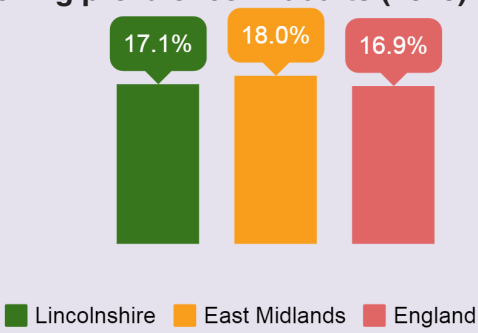
Smoking rates in Lincolnshire for over 18 year olds



Source: Public Health Local Tobacco Control Profile

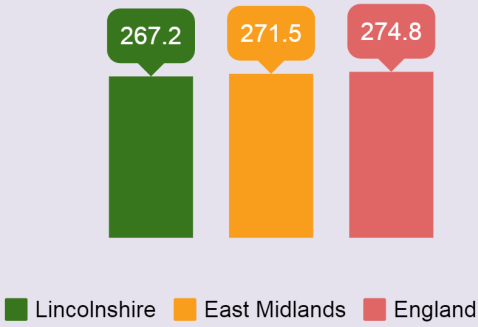
How do we compare?

Smoking prevalence in adults (2015)



Source: Public Health Local Tobacco Control Profile

Deaths attributable to smoking per 100,000 population over 35 years old (2012-14)



Source: Public Health Local Tobacco Control Profile

The picture in Lincolnshire

In 2013/14, United Lincolnshire Hospital Trust (ULHT) estimate 18% of women smoked at the start of pregnancy, dropping to 15% at delivery.

A quarter of adults employed in manual and routine jobs smoke, which is the same as England.

Smoking related hospital admissions are lower than nationally, at 1,567 per 100,000 population compared to 1,671 per 100,000.

About 6% of 15 year olds in Lincolnshire say they smoke regularly.

Key message

Smoking in Lincolnshire is estimated to cost £191.2 million; that is £1,853 per smoker per year. Loss of productivity due to smoking breaks at work represents £77.7 million yearly.

If we ceased provision of stop smoking support and tobacco control activities, the numbers of people presenting with diseases linked to smoking and smoking rates could increase, putting a further burden on our health and social care system.

Suicide

Why is this important?

- The likelihood of a person taking their own life depends on many factors. Major risk factors include mental ill-health, being male, isolation, unemployment, alcohol and drug misuse.
- 3% of premature deaths in Lincolnshire in under 75 year olds are due to suicide, making this the fifth most common cause of premature death in the county.

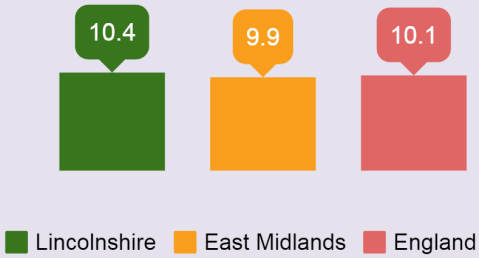
What has changed?

Suicide rate in Lincolnshire per 100,000 population, 10+ year olds

Source: Public Health Suicide Prevention Profile

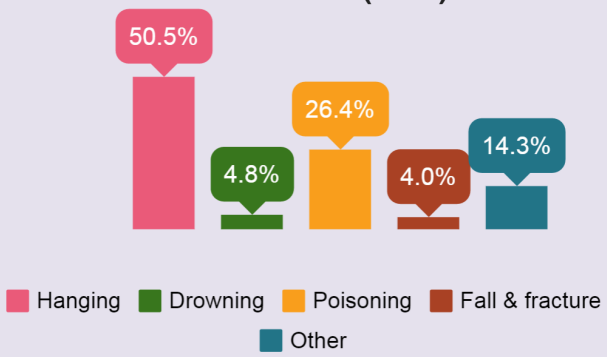
How do we compare?

Rates of suicide per 100,000 population, 10+ year olds (2013-15)



Source: Public Health Suicide Prevention Profile

Method of suicide in England, averaged across males and females (2015)



Source: Office of National Statistics, Suicides in the UK

The picture in Lincolnshire

Suicide is significantly more common amongst males than females - in 2014, 75% of suicides were male.

The majority of deaths due to suicide and undetermined injury were by people aged 40-44.

Suicide rates during 2012-2014 were highest in the 20% most deprived areas at 12.5 per 100,000 population compared to 7.3 per 100,000 population in the least deprived areas.

A quarter of those who completed suicide in 2014/15 had previously attempted suicide.

Key message

Every death by suicide is a tragic loss of life and has a widespread impact. The emotional cost to to those affected by a death by suicide is high, with the average cost of a completed suicide by a working age adult in the UK estimated to be £1.67 million (2009 rates).

According to HM Government 'Prevention suicide in England Strategy 2012', "family and friends of people who have taken their own life are at increased risk of mental health and emotional problems and may be at higher risk of suicide themselves."

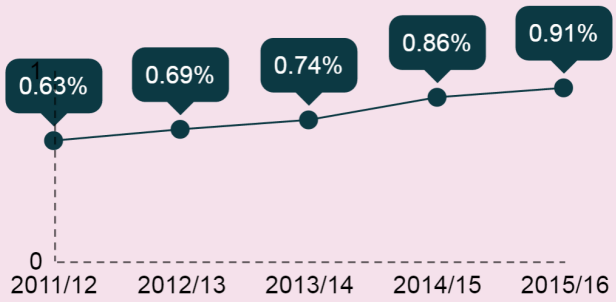
Dementia

Why is this important?

- Dementia is a progressive, terminal disease caused when brain tissue is damaged. Symptoms include: loss of memory, mood changes, and communication and reasoning difficulties.
- Dementia is one of the top five underlying causes of death.
- Dementia is the leading cause of death for men and women over 80 years old.

What has changed?

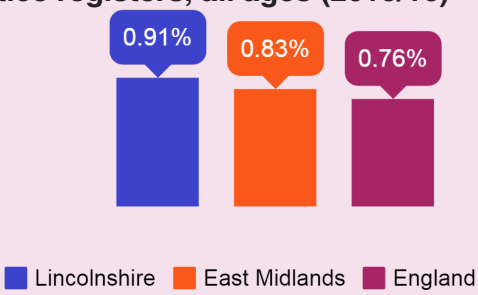
Rates of dementia in Lincolnshire (all ages)



Source: Public Health Dementia Profile

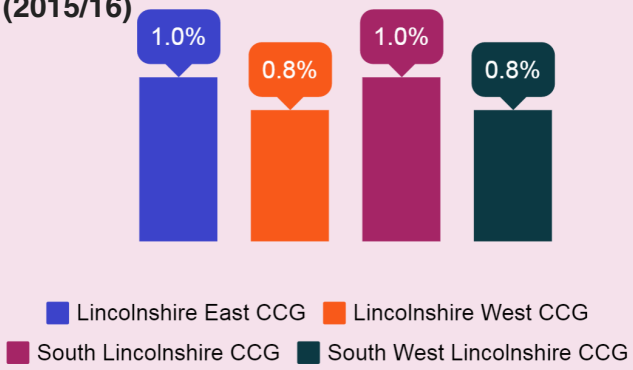
How do we compare?

People with dementia recorded on GP practice registers, all ages (2015/16)



Source: Public Health Dementia Profile

Dementia by Lincolnshire CCG, all ages (2015/16)



Source: Public Health Dementia Profile

The picture in Lincolnshire

6.7% of people over 65 in Lincolnshire were living with dementia in 2015, 1.5% of the population.

By 2030, the numbers with dementia aged over 65 are projected to increase by 65%.

Two thirds of people suffering from dementia are female.

Women are slightly more at risk of developing Alzheimer's disease but are at lower risk of vascular dementia than men.

Older people who are lonely are 1.63 times more likely to have dementia.

Key message

Dementia costs society an estimated £26 billion a year, more than the costs of cancer, heart disease or stroke. This includes over £4 billion in healthcare costs and over £10 billion in social care costs. Unpaid carers save the UK economy £11 billion per year.

Research has also estimated that by 2030, dementia will cost companies more than £3 billion, with the number of people leaving employment to care for people with dementia set to rise by a quarter by 2030.

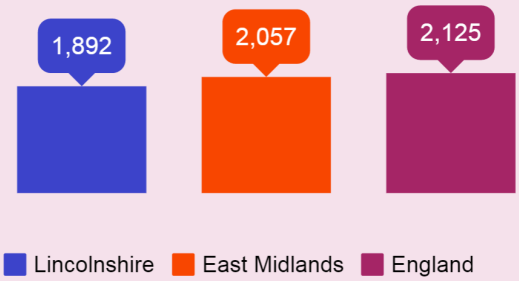
Falls

Why is this important?

- According to the National Institute for Health and Care Excellence (NICE) about one third of people aged over 75, and half of those over 80, will fall at least once a year.
- Falls destroy confidence, increase isolation, reduce independence and can hasten a move into residential care.
- Preventing people from falling is a key challenge for an ageing population.

How do we compare?

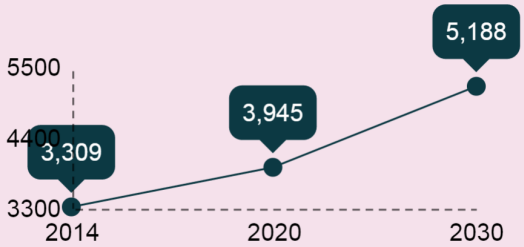
Injuries due to falls in people aged over 65 per 100,000 population (2014/15)



Source: Public Health Outcomes Framework

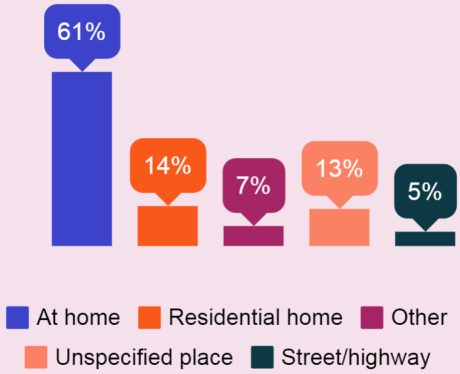
What is happening locally?

Number of Lincolnshire residents aged 65 and over predicted to be admitted to hospital as a result of falls (based on ONS data)



Source: www.poppi.org.uk

Location of fall leading to emergency hospital admission, over 65 years (2011-15)



Source: HSCIC, Hospital Episode Statistics

The picture in Lincolnshire

In 2014/15, falls accounted for 9% of emergency hospital admissions for people aged 65 and over, and 12% for those aged over 80.

Twice as many females as males are admitted to the hospital as the result of a fall.

Hospital admissions in 2014/15 for females aged 65-79 were higher in Lincoln and North Kesteven than in England.

Around 44,000 individuals over 65 years old had at least one fall in 2015; this is estimated to rise to 63,000 by 2030.

Key message

The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and mortality. Falling also affects family members and carers. NICE estimate that falls cost health and social care organisations more than £23.3 billion per year. This is likely to increase in the future, reflecting the ageing population.

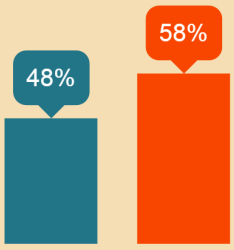
Food and Nutrition

Why is this important?

- Poor diet is a risk factor for stroke, coronary heart disease and some cancers, and a major cause of obesity/excess weight. Being overweight is the main risk factor for type 2 diabetes.
- The factors leading to poor diets are complex; cultural norms, busy lifestyles, marketing practices, food labelling, ability to cook and taste choices.
- Good diet has additional benefits other than losing weight: reduced risk of illness and disease, lowered cholesterol and improved mental wellbeing.

Getting your 5-a-day

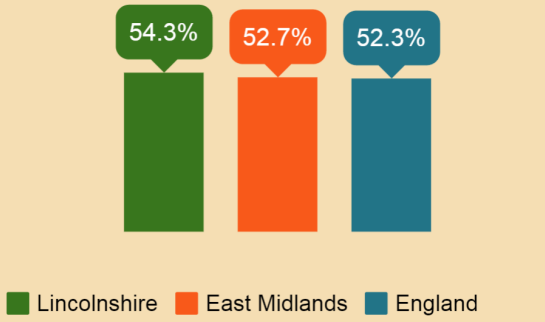
Proportion of children likely to eat at least 5 portions of fruit and vegetables per day



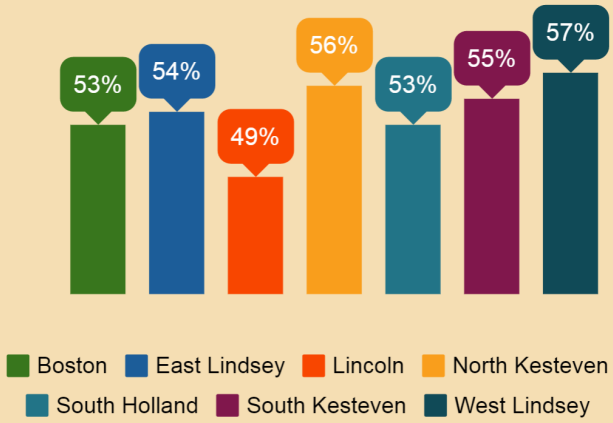
Source: What About YOUth? Survey 2014

How do we compare?

People eating at least 5 portions of fruit and vegetables per day (2014)



Breakdown by district (2014)



Source: Active People Survey – England 2014, Sport England

The picture in Lincolnshire

Half of people in Lincolnshire meet their 5-a-day target for eating fruit and vegetables.

The average number of portions of fruit eaten daily is 2.49 and vegetables 2.37.

Nearly a quarter of children aged 4-5 and over a third of 10–11 year olds in the county are overweight or obese.

For all age groups, at least twice the recommended amount of sugar is consumed. For children aged 4-18 this rises to 3 times the recommended amount.

Key message

Excess calorie intake is the main cause of adult and childhood obesity.

Public Health England estimates the annual national cost of obesity at £27 billion, including £13.3 billion for obesity medication and £5.1 billion in NHS costs. NICE project that the overall cost of obesity could rise to £50 billion by 2050.

Lincolnshire Joint Strategic Needs Assessment 2017

Immunisation (All Ages)

Why is this important?

- Immunisation is one of the most cost-effective public health interventions. Children and vulnerable adults can be protected from serious illness and death. Little lifestyle change is needed for it to be effective.
- Immunisation uptake needs to achieve 95% population coverage to be effective in preventing an epidemic.

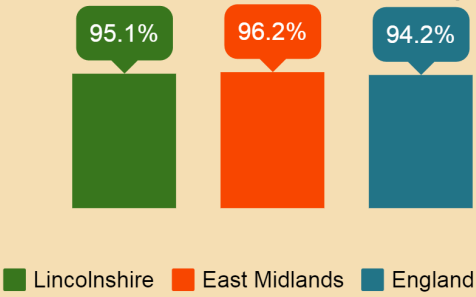
Main inequalities

Immunisation uptake is lower in:

- asylum seekers and migrant workers
- homeless families
- Looked After Children (in Lincolnshire uptake is high)
- children with physical disabilities or learning difficulties
- children of teenage or lone parents
- children not registered with a GP
- younger children from large families
- children in hospital

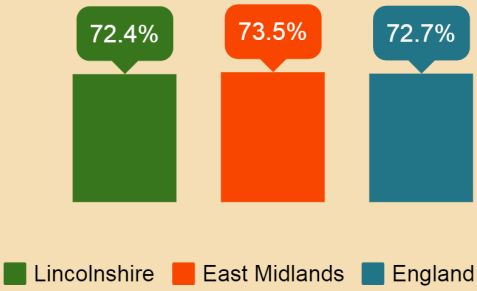
How do we compare?

Vaccination rates at 12 months old (2014/15)



Source: NHS Immunisation Statistics, England, 2014/15

Adult flu vaccination uptake for +65 year olds (2014/15)



Spurce: Public Health Outcomes Framework

The picture in Lincolnshire

Lincolnshire East CCG has the lowest uptake of routine vaccinations for 12 month old children, while South Lincolnshire CCG has the highest rate and exceeds the national average.

MMR uptake is 84.7%, below the rate for East Midlands (91.2%) and England (88.6%) and below the 90%threshold needed for herd immunity.

Uptake of the HPV vaccination for girls aged 12-13 is 93.7%, the second highest in the East Midlands.

Lincolnshire East CCG has the only full GP practice participation for shingles vaccination; but its vaccination rates are the lowest in the county.

Key message

If vaccination levels fall lower than the national vaccine coverage target there is a risk of vaccine-preventable disease occurring.

Direct costs include: outbreak control and outpatient and inpatient care. Indirect costs include: productivity losses from number of sick days, work missed to care for sick children or resulting disability.

Lincolnshire Joint Strategic Needs Assessment 2017

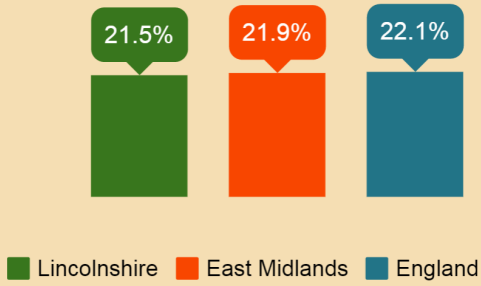
Obesity (Children)

Why is this important?

- Childhood obesity presents immediate and long-term negative effects on a child's physical and social wellbeing, educational attainment and mental health.
- Obese children and adolescents are more likely to be obese in adulthood, consequently at greater risk of adult health problems such as heart disease and Type 2 diabetes, stroke and cancers.

How do we compare?

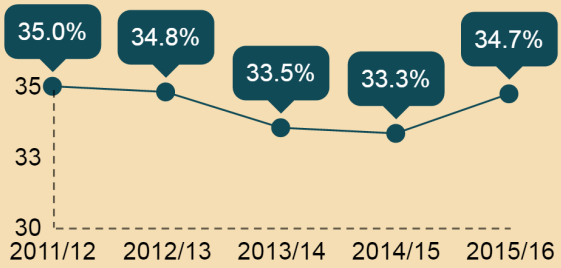
Reception age children overweight or obese (2015/16)



Source: Public Health Outcomes Framework

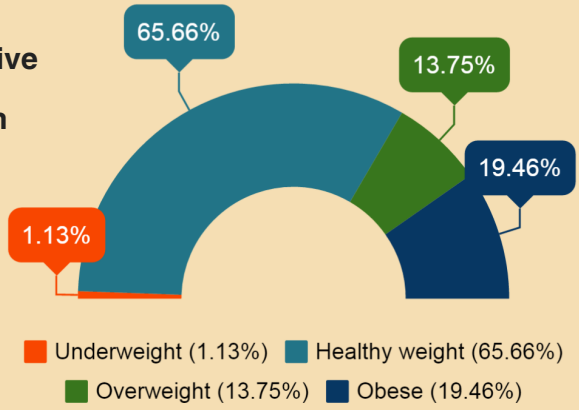
What has changed?

Children in Year 6 who are overweight or obese in Lincolnshire



Source: Public Health Outcomes Framework

Comparative weight of children in Year 6 in 2015/16



Source: National Child Measurement Programme, HSCIC

The picture in Lincolnshire

8% of 4-5 year olds and 19% of 10-11 year olds are reported to be obese.

Boys are more likely to be obese than girls. Children living in the most deprived areas are twice as likely to be obese as those in the least deprived areas.

East Lindsey is worse than the national average for obesity in both 4-5 year old and 10-11 year old cohorts.

In 2014/15 North and South Kesteven had the lowest obesity rates for 10-11 year olds in Lincolnshire.

Key message

Tackling childhood obesity is vital to improve life chances and health outcomes into adulthood.

Public Health England estimates the annual national cost of obesity to be £27 billion including £13.3 billion for obesity medication and £5.1 billion in NHS costs. NICE project that the overall cost of obesity could rise to £50 billion by 2050.

Lincolnshire Joint Strategic Needs Assessment 2017

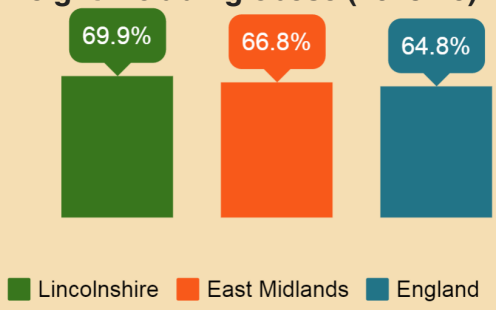
Obesity (Adults)

Why is this important?

- Being overweight or obese is a major public health crisis through its link with serious long-term conditions including: Type 2 diabetes, heart disease, stroke, liver disease and cancer.
- Obesity is estimated as the third largest risk factor for premature death.
- The risk of poor health and well-being outcomes increases sharply with increasing Body Mass Index (BMI).

How do we compare?

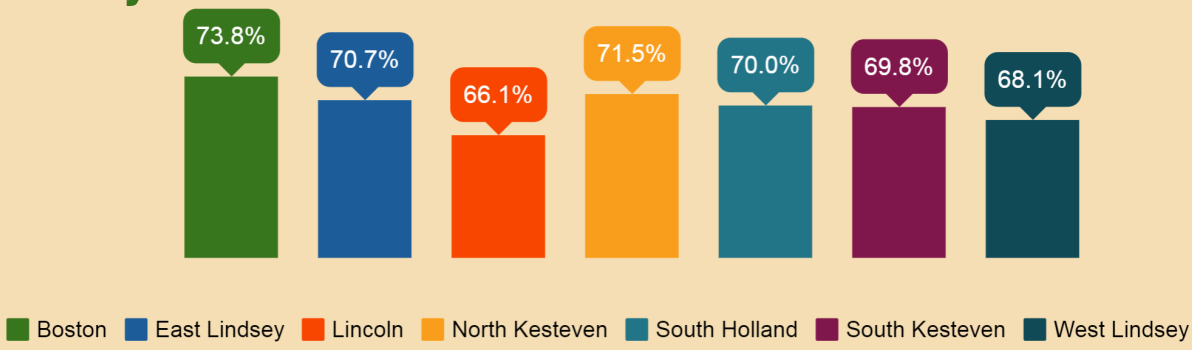
Adults with a BMI over 25.0 classified as overweight including obese (2013-15)



Source: Public Health Outcomes Framework

Breakdown by district

Adults with a BMI over 25.0 classified as overweight including obese (2013-15)



Source: Public Health Outcomes Framework

The picture in Lincolnshire

Lowest rates of obesity are in the 16-24 year age group. Generally the older age groups (both men and women) are higher.

National estimates of levels of morbid obesity suggest that there may be 11,500 adults with a BMI over 40 and nearly 800 with a BMI over 50 in Lincolnshire.

Levels of overweight or obese adults in Boston, South Holland and West Lindsey are among the highest rates in the East Midlands.

There were nearly 6,000 hospital admissions in Lincolnshire related to adult obesity (directly or indirectly) in 2014/15.

Key message

Public Health England estimates the annual national cost of obesity at £27 billion including: £13.3 billion for medication and £5.1 billion NHS costs.

Lincolnshire population trends suggest an increasing mid-life and older population with excess weight. This trend will place an increasing burden upon the NHS locally.

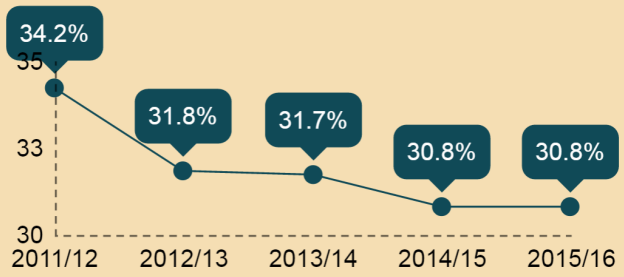
Physical Activity

What is the issue?

- Physical inactivity is the fourth greatest risk factor for premature death. It has a bigger impact than obesity. It is responsible for one in six UK deaths.
- Meeting recommended physical activity levels can cut the risks of: Type 2 diabetes, colon cancer, CHD, stroke, falls and hypertension by at least 30%. Being active reduces the risk of Alzheimer's, osteoarthritis, hip fractures and depression by between 20% and 80%.

What has changed?

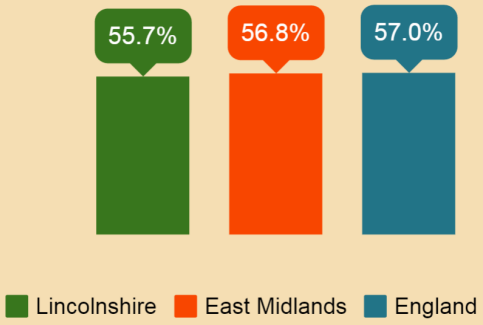
Lincolnshire adults aged 18+ participating in sport at least once per week



Source: Sport England Local Sport Profile

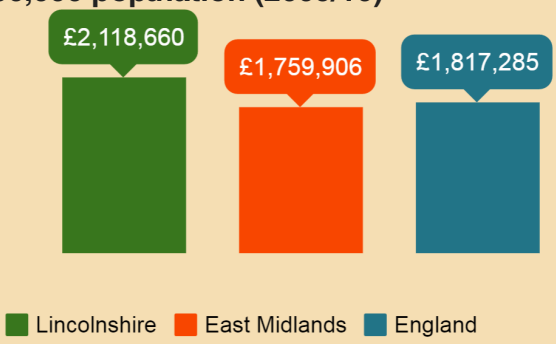
How do we compare?

Adults who are physically active (2015)



Source: Public Health Outcomes Framework

Health cost of physical inactivity per 100,000 population (2009/10)



Source: Sport England Local Sport Profile

The picture in Lincolnshire

By age 15, only 8% of girls achieve the daily recommended minimum of one hour of moderate to vigorous activity.

Activity rates are highest in South Kesteven at 59.1% and lowest in South Holland at 49.2%.

Type 2 diabetes, for which inactivity is a major risk factor, is higher in Lincolnshire than nationally (7.5% compared to 6.4%). East Lindsey has one of the highest rates in England at 9.2%.

Almost half of the adult population in Lincolnshire fail to achieve the recommended minimum 150 minutes of weekly activity.

Key message

Physical inactivity currently costs the NHS and wider society £7.4 billion. These costs will be proportionately higher in Lincolnshire as the local population is less active than that of the country as a whole. Inactivity and hence costs are likely to increase as the population ages.

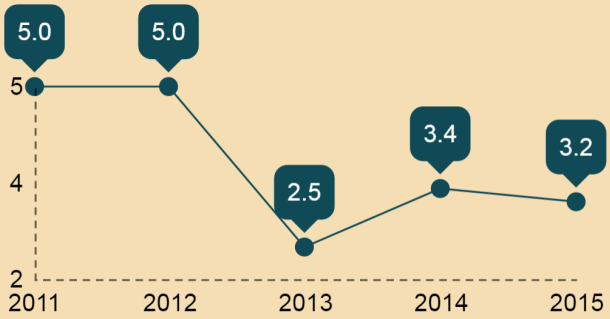
Sexual Health

Why is this important?

- The World Health Organisation defines sexual health as "…a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity."
- Lincolnshire has pockets of deprivation where the uptake of sexual health services and diagnoses are below the national and regional picture.

What has changed?

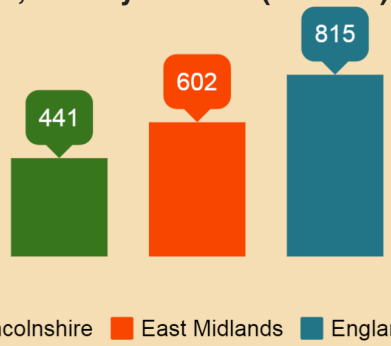
New HIV diagnosis rate per 100,000 population, over 15 year olds



Source: Public Health Sexual and Reproductive Health Profiles

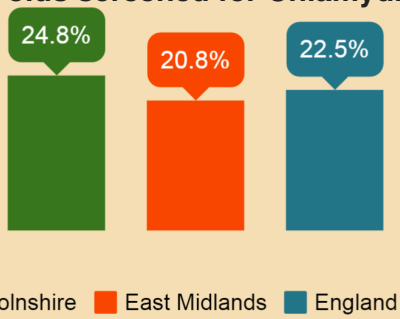
How do we compare?

New sexually transmitted infections (STIs) excluding Chlamydia per 100,000 population, 15-64 year olds (2014/15)



Source: Public Health Sexual and Reproductive Health Profiles

15-25 year olds screened for Chlamydia (2015)



Source: Public Health Sexual and Reproductive Health Profiles

The picture in Lincolnshire

STIs in Lincoln in 2015 had risen to 1,245 cases of new infections per 100,000 population, almost double the England rate.

Chlamydia diagnoses continue to be the most commonly diagnosed STI, representing 48% of new STI diagnoses.

In 2015, there were over 21,000 Chlamydia screens carried out in Lincolnshire, a quarter of the target population of 15-24 year olds.

The rate of HIV tests in England is 67.3 per 100,000 population. In Lincolnshire, South Kesteven has a test rate of 73.4 per 100,000, the lowest rate is in East Lindsey at 57.7.

Key message

Effective sexual health messages that aim to reduce STIs and incidence of HIV will have a positive financial effect, as well as improve mental wellbeing, family life and relationships.

Lack of education and protection messages may continue the trend for people to make poor sexual health choices and increase the transmission of STIs due to practising unsafe sex.

Lincolnshire Joint Strategic Needs Assessment 2017

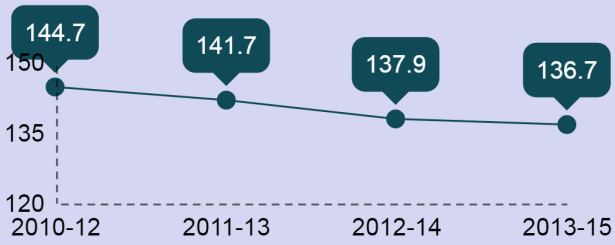
Cancer

Why is this important?

- One in two people are likely to develop some form of cancer in their lifetime and it is the most common cause of death in people under 60 years old.
- Cancer survival rates have risen by 70% over the last 20 years.
- 4 in 10 cancer cases could be prevented by lifestyle changes such as not smoking, cutting back on alcohol, maintaining a healthy body weight, keeping physically active and avoiding excessive sun exposure.

What has changed?

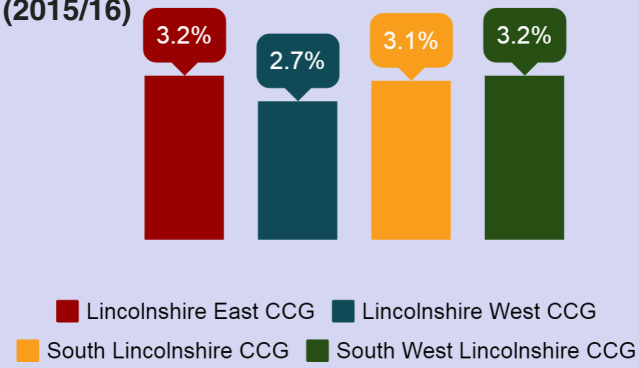
Mortality rate from cancer for under 75 year olds in Lincolnshire per 100,000 population



Source: Public Health Outcomes Framework

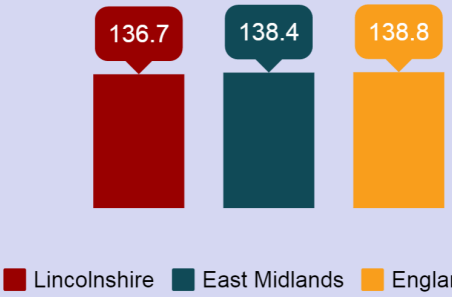
How do we compare?

Cancer prevalence by CCG, all ages (2015/16)



Source: Public Health Cancer Services Profile

Mortality rate from cancer for under 75 year olds per 100,000 population (2013-15)



Source: Public Health Outcomes Framework

The picture in Lincolnshire

New cases of lung cancer are low across Lincolnshire (68.9 per 100,000 population) compared to England (79.7 per 100,000).

Nearly 3,000 people under 75 died prematurely from cancer in Lincolnshire during 2012-14; of these 1,700 could have been prevented.

South West Lincolnshire CCG and Lincolnshire East CCG have higher rates of cancer incidence than the national average.

South Lincolnshire CCG, at 13.4%, has the greatest increase in cancer survival rate from 2004 to 2013.

Key message

More people are presenting late to their doctor with symptoms, leading to poorer outcomes for the patient, resulting in high healthcare costs.

Cancer services cost the NHS approximately £6.7 billion in 2012/13. This growth in cost is projected to rise by about 9% a year, implying a total of £13 billion by 2020/21.

Lincolnshire Joint Strategic Needs Assessment 2017

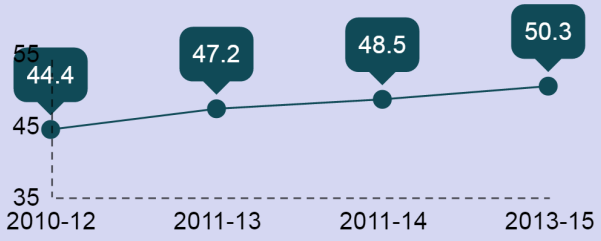
Chronic Obstructive Pulmonary Disease

Why is this important?

- The most common cause of COPD is smoking. Rare causes include fumes, dust and genetic disorders.
- It is estimated that over 3 million people in the UK have COPD and it is undiagnosed in about 2 million of these. 10% of people with COPD are only diagnosed when they go to hospital as an emergency.
- COPD kills about 25,000 a year in England and Wales, around 5% of deaths.

What has changed?

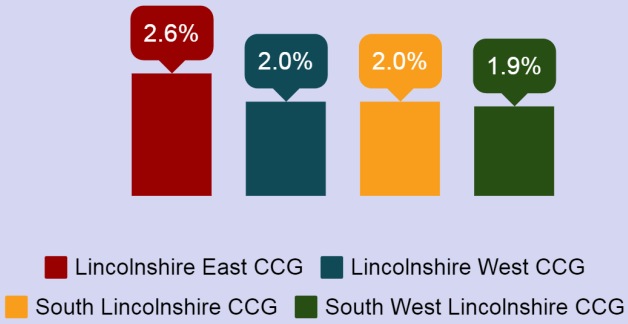
Lincolnshire deaths from COPD per 100,000 population



Source: Public Health Local Tobacco Control Profiles

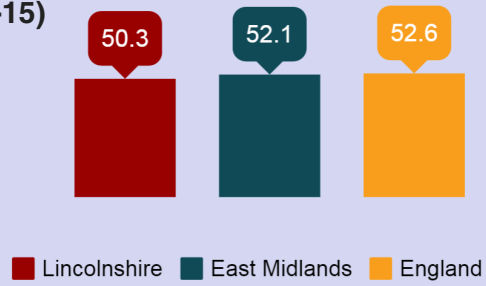
How do we compare?

COPD prevalence by CCG, all ages (2015/16)



Source: Inhale - INteractive Health Atlas of Lung conditions in England

Deaths from COPD per 100,000 population (2013-15)



Source: Public Health Local Tobacco Control Profiles

The picture in Lincolnshire

The prevalence of COPD is significantly higher than the national average (1.9%) in East Lincolnshire CCG (2.5%).

A single COPD related admission to a Lincolnshire hospital costs on average £2,533, with an average length of stay of 7.3 days (2010-11 PHE data).

COPD is linked to social deprivation and it is more common in men. In recent years the rate in women has increased.

94.1% of COPD patients that continue to smoke are offered smoking cessation support and treatments.

Key message

COPD is a progressive, irreversible condition that is increasing in prevalence. It is the second most common cause of emergency admission to hospital. About a third of those admitted to hospital as a result of COPD are readmitted within a month of discharge, creating high NHS costs and a significant disruption to the lives of those with the condition.

The total annual cost of COPD to the NHS is over £800 million. The annual COPD costs in lost productivity to employers and the economy have been put at £3.8 billion. 25% of people with COPD are prevented from working due to the disease.

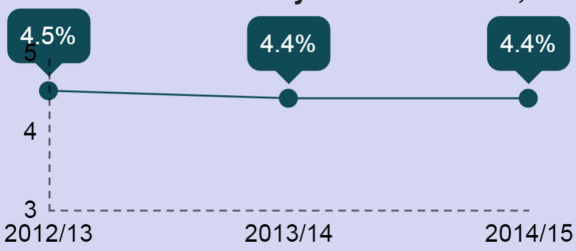
Coronary Heart Disease

Why is this important?

- Cardiovascular disease (CVD) includes diseases of the heart, blood vessels, or both. Coronary Heart Disease (CHD) is the most common cardiovascular disease.
- Deaths from CVD, including CHD, have fallen in recent years, but CVD is still one of the main causes of premature death in the UK.
- Major risk factors of CHD can be changed, treated or controlled including smoking, high blood cholesterol, high blood pressure, physical inactivity, being obese or overweight, and diabetes.

The local picture

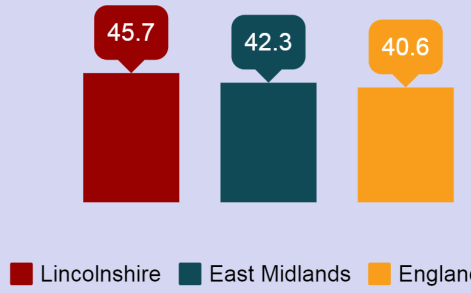
Prevalence of Coronary Heart Disease, all ages



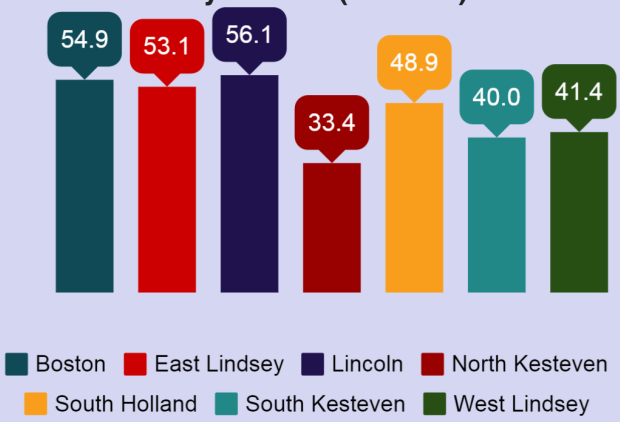
Source: Public Health NHS Health Check - Longer Lives

How do we compare?

Deaths from Coronary Heart Disease in people under the age of 75 per 100,000 population (2013-15)



Breakdown by district (2013-15)



Source: Public Health Profiles

The picture in Lincolnshire

There were 33,293 people on the CHD register in 2014/15.

Deaths from CHD in under 75 year olds in Lincolnshire has dropped dramatically by more than 40% over the past 12 years.

Rates of all cardiovascular conditions in all 4 CCG areas is higher than regionally or nationally; Lincolnshire East CCG has the highest rate.

Preventable deaths from CVD have decreased from 296.7 per 100,000 population in 2001-03 to 164.2 in 2012-14.

Key message

Collectively, vascular diseases (heart disease, stroke, diabetes and kidney disease) affect the lives of more than four million people, and kill 170,000 in the UK every year. These conditions also account for more than half of the mortality gap between rich and poor.

An increase in the number of people, who have to live with disability for a longer period of time, would have an impact on health and social care services and related budgets.

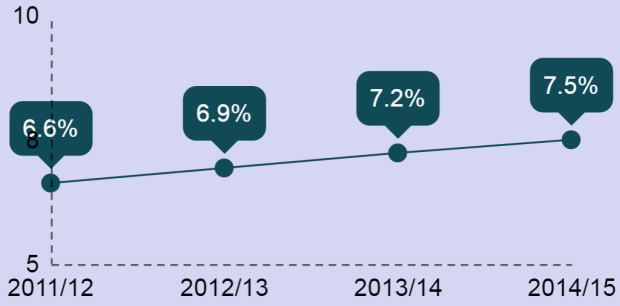
Diabetes

Why is this important?

- Diabetes is one of the most common chronic diseases in the UK and rates of people affected are continuing to increase.
- There are different types of Diabetes - Type 1, Type 2, Gestational (during pregnancy) as well as some specific types.
- Obese adults are five times more likely to be diagnosed with Type 2 diabetes as adults of a healthy weight.

What has changed?

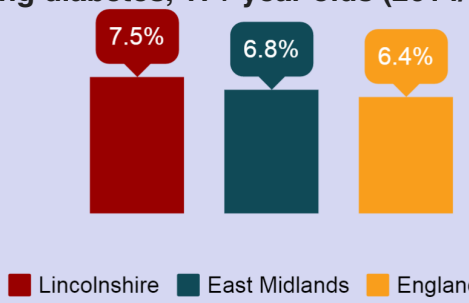
People registered with GP practices in Lincolnshire as having diabetes, 17+ year olds



Source: Public Health Outcomes Framework

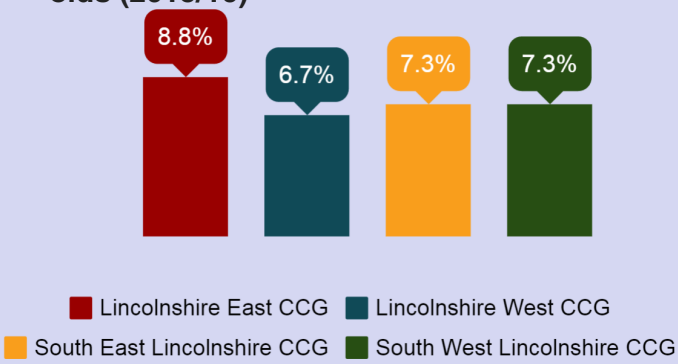
How do we compare?

People registered with GP practices as having diabetes, 17+ year olds (2014/15)



Source: Public Health Outcomes Framework

Prevalence of diabetes by CCG, 17+ year olds (2015/16)



Source: Public Health Diabetes Profile

The picture in Lincolnshire

Obesity is a major risk factor for Type 2 diabetes; 70% of adults in the county are overweight or obese.

Total adult diabetes prevalence in Lincolnshire could be 10.3% by 2035.

12% of the 16+ population have non-diabetic hyperglycaemia (pre-diabetes) and are at risk of developing diabetes and other cardiovascular conditions.

55 under 75 year olds died in Lincolnshire where diabetes was the underlying cause in 2012-14.

Key message

Diabetes accounts for a high proportion of NHS expenditure and can lead to serious health complications if the condition is not managed well. Therefore it is essential that people receive good health care along with the skills and knowledge to enable self-care.

Obesity is the main risk factor for the most common type of diabetes (Type 2) and interventions to reduce obesity continue to be important.

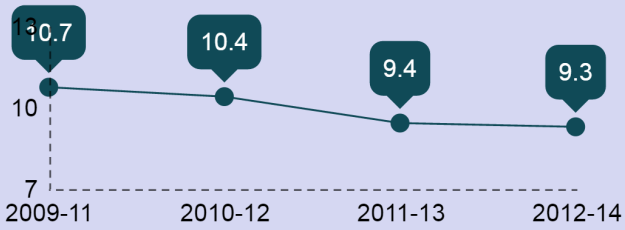
Stroke

Why is this important?

- Stroke is the third commonest cause of death and the most common cause of complex disability in the UK.
- A stroke can occur at any age; a quarter of stroke deaths occur in under 65 year olds.
- Strokes vary in severity and impact, ranging from those resulting in immediate death to TIAs resulting in no ongoing motor or sensory loss.
- Around 80% of strokes are attributable to high blood pressure, smoking, obesity, poor diet and lack of exercise.

What has changed?

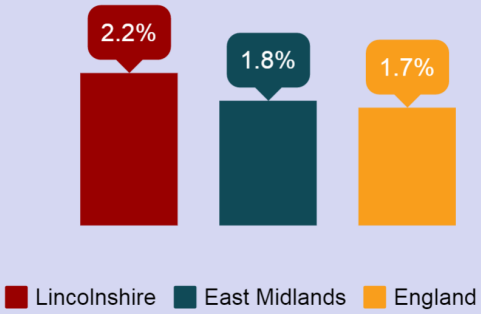
Death rates from stroke in Lincolnshire attributable to smoking per 100,000 population, over 35 year olds



Source: Public Health Local Tobacco Control Profiles

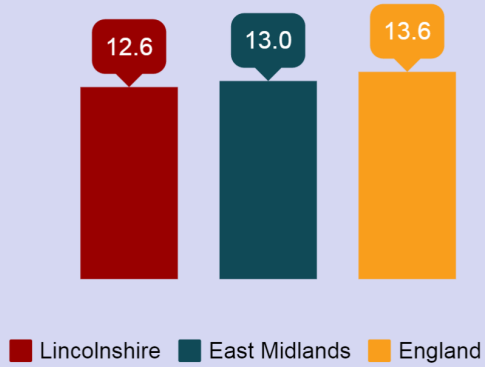
How do we compare?

Prevalence of stroke, all ages (2014/15)



Source: Public Health NHS Health Check

Rate of deaths from stroke per 100,000 population, under 75 year olds (2013-15)



Source: Public Health Profiles

The picture in Lincolnshire

Men have 1.25 times greater risk of stroke than women.

Stroke rates have risen slightly since 2012-13 in each Lincolnshire CCG; excepting South West Lincolnshire which has remained constant.

There were 1,540 deaths as a result of a stroke during 2012-14, of which 286 were people aged under 75.

Deaths from stroke for over 75s per 100,000 population is the highest in Lincolnshire West CCG (632.9) and lowest in South West Lincolnshire CCG (542.2).

Key message

The rate of stroke is expected to increase, rising to 3.1% of the Lincolnshire population living with the consequences of stroke by 2020. This will place a considerable burden not only on health services but on families and carers, and the workforce as a whole.

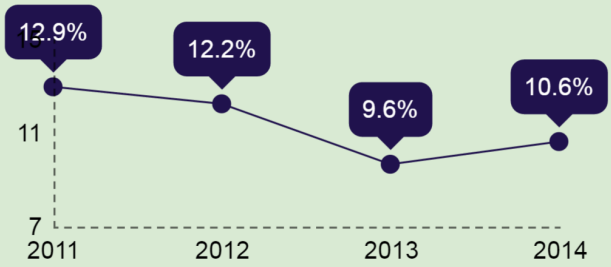
Excess Seasonal Deaths & Fuel Poverty

Why is this important?

- Weather has a direct effect on incidences of: heart attack, stroke, respiratory disease, flu, injuries due to falls and hypothermia.
- The World Health Organisation estimates that about 30% of Excess Winter Deaths are because of fuel poverty.
- For those in the coldest 10% of homes, the death rate rises about 2.8% for every degree Celsius drop in the outside temperature.

What has changed?

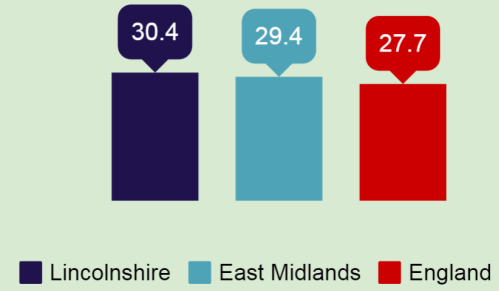
Lincolnshire households experiencing fuel poverty



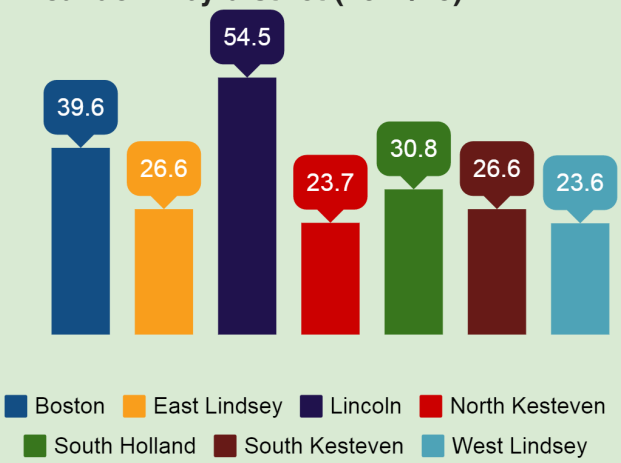
Source: Public Health Outcomes Framework

How do we compare?

Excess winter deaths, all ages (2014/15)



Breakdown by district (2014/15)



Source: Public Health Outcomes Framework

The picture in Lincolnshire

The excess winter death rate for females is 22%, greater than the rate for men at 16% (2012-15).

An average 55% increase in deaths from respiratory disease was seen in winter in the period 2012-15.

In 2014, 45% more people died from dementia and Alzheimer's disease in the winter months.

10.6% are in fuel poverty, the same level as the England average and a little above the East Midlands average of 10.1%.

Key message

Hospital admissions can be increased due to underlying conditions such as chronic obstructive pulmonary disease, heart attacks, stroke and falls, which can be made worse by the cold.

Vulnerable groups such as the elderly, children and people with disabilities are at greater risk from environmental factors which directly impact on their health and wellbeing.

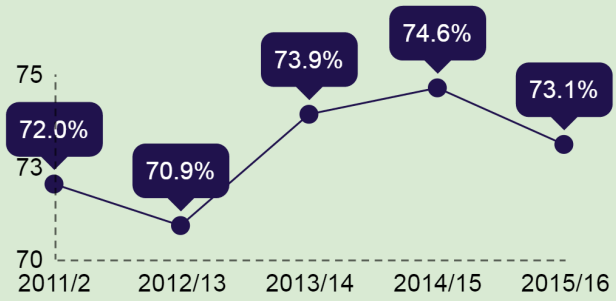
Financial Inclusion

Why is this important?

- Financial exclusion is not just about unemployment, welfare benefits or those without a bank account.
- People are vulnerable to financial exclusion during significant life changes or illness that impact on their ability to cope financially.
- Three quarters of people in debt suffer from stress and anxiety.

What has changed?

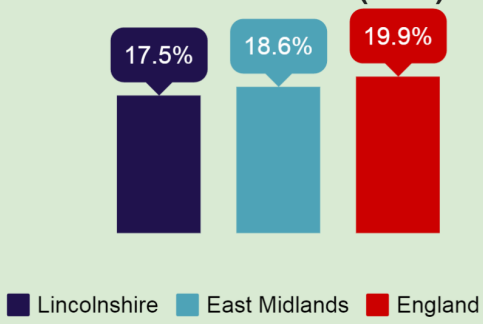
Lincolnshire adults aged 16-64 in employment



Source: Public Health Outcomes Framework

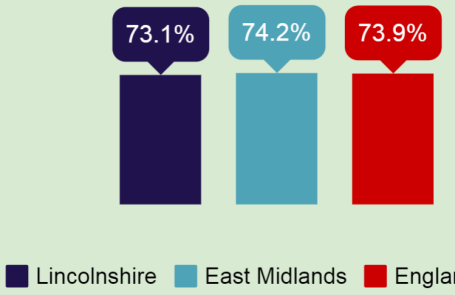
How do we compare?

Proportion of children under 20 years old in low income families (2014)



Source: Public Health Outcomes Framework

Employment rate, age 16-64 (2015/16)



Source: Public Health Wider Determinants of Health Profiles

The picture in Lincolnshire

East Lindsey and Lincoln have significantly more children living in low income families than the national average.

Boston and South Holland have the highest proportion of long-term sickness related inactivity.

There is a significant gap of £10,000 between average earnings in the most deprived areas (£15,640) and the least deprived (£25,933).

Numbers of Employment Support Allowance claimants have increased by 14% (2014-16).

Key message

Not doing something carries potential financial implications for people and support services. Financial advice and support services are cost effective ways to maximise resources in low income households, potentially leading to increased standards of living and reducing poverty.

If financial inclusion support services are not in place there is a risk of homelessness, increase in debt, a rise in fuel poverty, poor nutrition and increased poverty, including child poverty and health and wellbeing.

Lincolnshire Joint Strategic Needs Assessment 2017

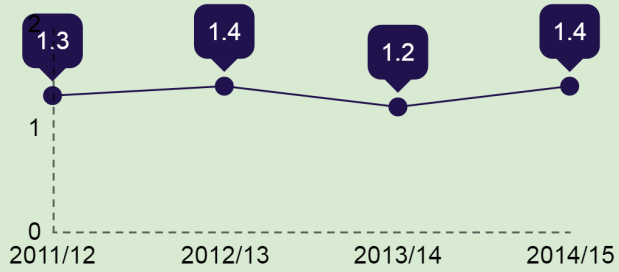
Housing & Health

Why is this important?

- Good quality, safe housing and housing related support has a major part to play in improving and maintaining health and wellbeing.
- Lincolnshire has 335,450 households.
- 21% of private housing stock is estimated to have a serious hazard likely to cause illness or harm.

What has changed?

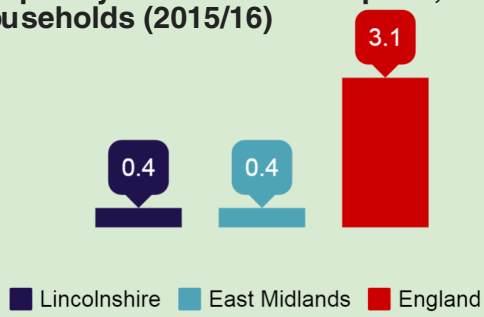
Family homelessness rate in Lincolnshire per 1,000 households



Source: Public Health Child Health Profiles

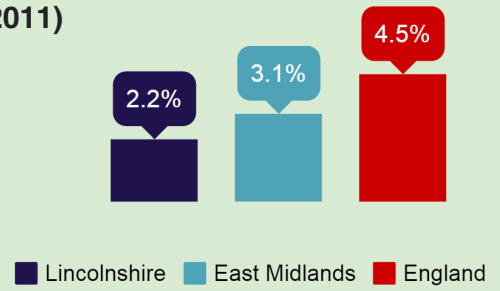
How do we compare?

Statutory homeless households in temporary accommodation per 1,000 households (2015/16)



Source: Public Health Outcomes Framework

Overcrowded households i.e. having fewer bedrooms than the national bedroom standard for the needs of the household (2011)



Source: Office for National Statistics

The picture in Lincolnshire

7% of private sector housing stock is estimated to be in disrepair. The rate is highest in Lincoln (9%) and lowest in North Kesteven (5%).

10% of Lincolnshire homes do not have a heating boiler and 20% have damp problems.

There are 13,563 individuals or households waiting for council housing.

532 households are accepted as homeless, as well as 334 with dependent children.

Key message

Poor housing can lead to and exacerbate physical and mental and in some severe instances can also lead to death.

In 2015, the Building Research Establishment (BRE), suggested the cost to the NHS of poor housing in England was £2 billion per year. If action is not taken to improve the quality and availability of homes the pressures on health and social care budgets can only increase.

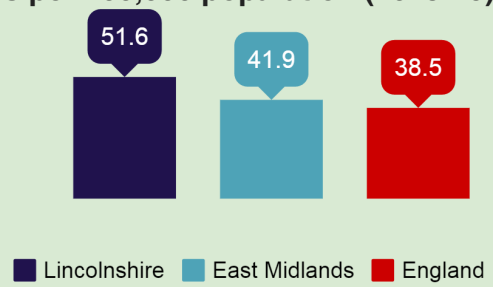
Road Traffic Collisions

Why is this important?

- Road traffic collisions are the single biggest cause of accidental death of young people in the UK aged 15-24.
- The number of fatal casualties has fallen from its peak of 104 in 2003.
- In 2015, 39 people were killed and 281 people were seriously injured in Lincolnshire.
- In 2015, the estimated cost of each casualty was £1.7million.

How do we compare?

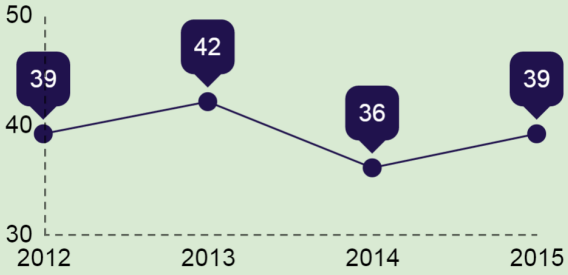
Individuals killed or seriously injured on the roads per 100,000 population (2013-15)



Source: Public Health Outcomes Framework

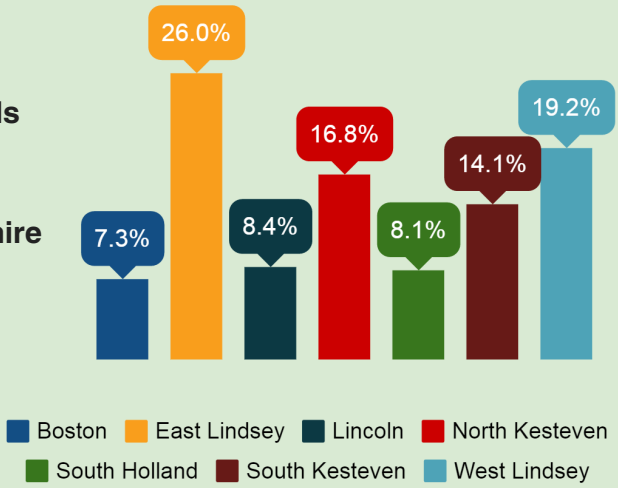
What has changed?

Number of road deaths per year in Lincolnshire



Source: Department for Transport: Reported Road Casualties Great Britain, Annual Report: 2015

Individuals killed or seriously injured in Lincolnshire (2015/6)



Source: Lincolnshire Road Safety Partnership rolling dashboard to 30/09/2016

The picture in Lincolnshire

Road traffic casualties are more likely to be male who represented three quarters of fatal casualties in 2016.

The majority (74%) of killed or seriously injured casualties are on the rural road network.

30% of all fatal collisions are motorcycle riders, despite making up only 1% of road traffic.

Drivers accounted for the majority (68%) of fatal casualties in 2016, followed by vehicle passengers (19%) and pedestrians (13%).

Key message

39 fatal casualties and 281 serious injury casualties in 2015 is unacceptable in terms of human and economic costs, representing a cost of around £125 million to Lincolnshire's economy in 2015.

Health and Wellbeing in Lincolnshire

PRE-BIRTH

- **15%** mothers smoking at birth
- **627** Looked After Children
- **20%** young people have self-harmed

BIRTH

- **7,773** babies born
- **6%** 15 year olds smoke regularly
- **1,567** 15-24s diagnosed with Chlamydia
- **284** under 18 conceptions

WORKING AGE

- **736,700** Lincolnshire population
- **16,537** young people with SEND at school
- **56%** young people gain 5 good GCSEs
- **335,450** households
- **£24,830** average female salary
- **£33,390** average male salary
- **73%** adults are employed
- **17,030** adults have Chronic Obstructive Pulmonary Disease
- **17%** adults smoke
- **866** homeless individuals or households
- **15,000** people with learning disabilities
- **70%** adults overweight or obese
- **33,293** adults with Coronary Heart Disease
- **60,000** adults with long-term illness or disability
- **2,896** deaths from cancer
- **67** deaths from suicide
- **25,500** victims of domestic abuse
- **35,557** households in fuel poverty
- **58** deaths from drug misuse

END OF LIFE

- **83.2 years** average female life expectancy
- **79.6 years** average male life expectancy
- **11,289** adults with dementia
- **16,510** people had a stroke
- **3,199** hospital admissions due to falls
- **72%** uptake of flu vaccination in over 65s

EARLY YEARS

- **75%** mothers start breastfeeding at birth
- **293** first-time young offenders

SECONDARY SCHOOL

- **38%** babies breastfed at 6-8 weeks
- **95%** babies vaccinated at 12 months
- **33%** Year 6 children overweight or obese
- **4,163** adults with autism
- **320** killed or seriously injured on roads
- **19%** adults regularly binge drink
- **3,585** new Sexually Transmitted Infections (STIs)
- **45,298** adults with diabetes
- **84,000** unpaid carers

OLDER PEOPLE

- **65.8 years** average female healthy life expectancy
- **63 years** average male healthy life expectancy

PRIMARY SCHOOL

- **69%** good level of development by end of Foundation Stage
- **18%** children live in low income families
- **1,663** young people with autism in schools
- **22%** Reception children overweight or obese
- **56%** adults are physically active
- **68,465** adults with mental ill-health
- **54%** eat their 5-a-day

Updated March 2017

www.research-lincs.org.uk/joint-strategic-needs-assessment.aspx

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Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**20 June 2017**
Subject:	**Lincolnshire Sustainability & Transformation Plan (STP) Priorities and Update**

Summary:

This paper details the STP priorities for 2017/18 and provides an update on progress against the wider STP including arrangements for public consultation.

Mrs Sarah Furley will deliver a short presentation at the meeting which will provide further detail to the Board.

Actions Required:

The Health and Wellbeing Board are asked to:-

- note the STP priorities
- note the progress to date
- identity further opportunities to support delivery of the STP priorities.

1. Background

The Lincolnshire Sustainability and Transformation Plan (STP) sets out an ambitious programme of work to be completed by April 2021. The plan is aimed at working with a wide range of stakeholders and partners to redefine how care and support is delivered across Lincolnshire to ensure sustainable, accessible services are available for people in the future. The overarching vision for the STP is:

To achieve really good health for the people of Lincolnshire with support from an excellent and accessible health and care service delivered within our financial allocation.

1.1 National Context

Nationally STPs began life as pragmatic vehicles for enabling health and care organisations within an area to chart their own way to keeping people healthier for longer, improving care, reducing health inequalities and managing their money, working jointly on behalf of the people they serve. STPs are a means to an end, a mechanism for delivering the *NHS Five Year Forward View*, available at https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

However STPs are evolving and the *Next Steps On the NHS Five Year Forward View* published in March 2017 starts to develop that thinking, available at https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf
This document concentrates on what will be achieved over the next two years and focuses on improving urgent and emergency care, cancer performance, mental health services and access to primary care. In addition how to help frail and older people stay healthy and independent, avoiding hospital stays where possible.

Nationally STPs are now considered to have moved from a set of proposals (published December 2016) to more concrete plans (Two Year Operational Plans submitted in December 2016) and now the ambition is to accelerate these plans to go further and more fully integrate their services and funding through partnerships of care providers and commissioners in an area (Sustainability and Transformation Partnerships - STPs).

1.2 Lincolnshire STP

1.2.1 Planning / Programme Management

The operational plans submitted in December 2016 do not contain any changes which require public consultation. In the last five months, these plans have been further developed and implementation across a number of programmes has either accelerated or started.
Deliverability of the plans is challenging in some areas and the change management capacity has been mobilised by all NHS organisations who have identified staff to support delivery. Change is at an unprecedented scale for Lincolnshire and with the right kind of support probability of success will be significantly improved.

Further detailed plans have to be submitted to NHS England at the end of June 2017.

1.2.2 Five key priorities for 2017/18

In April 2017, financial forecasting for 2017/18 suggested the financial deficit was greater than anticipated. This figure is currently being refreshed and will be available when the Board meet. To mitigate this risk, the System Executive Team (chief officers from NHS organisations, Local Medical Council and LCC) have identified 5 key priorities that provide the greatest opportunity to improve this financial position as a health system.

These areas are already within the Lincolnshire STP and link to organisational cost improvement and quality plans. The aim is to focus our collective resources and expertise to increase our ability to deliver improvements to patients as well as financial balance. These priorities also reflect those within the *Next Steps On the NHS Five Year Forward View* published in March 2017.

Each priority has a Chief Executive or Accountable Officer identified as the Senior Responsible Officer (SRO).

	5 key prioritises	SRO
1	Integrated Care including • Neighbourhood Teams ❖ Plus supporting the resilience of primary care, i.e. GPFV ❖ Expansion of Transitional Care • Urgent care that will include 3 specific projects; ❖ Integration of services at the A&E front door ❖ Expansion of CAS ❖ Redesigned processes in Emergency Departments	Andrew Morgan Chief Executive, LCHS Jan Sobieraj Chief Executive, ULHT
2	Operational Efficiency Solution – predominantly Carter initiatives focused on reducing variation	Andrew Morgan Chief Executive, LCHS
3	Prescribing across the system and for all care groups	Dr Sunil Hindocha Chief Officer LWCCG
4	Planned Care including Demand Management, MSK, Repatriation and elective care bed optimisation, pathway redesign	Gary James AO LECCG
5	Mental Health Out of County placements	John Brewin Chief Executive LPfT

*CAS – Clinical Assessment Service
** Carter - An independent report for the Department of Health by Lord Carter of Coles published in February 2016, Operational productivity and performance in English NHS acute hospitals: Unwarranted variations

1.2.3 Public Consultation on major service change

Further progress has been made on the options for changes to major services including stroke, maternity and paediatrics, learning disability, urgent and emergency care and some elements of planned care. An event on 25 January 2017 with 135 senior clinicians, leaders and stakeholders looked at a range of options for these services and assessed each option against a set of agreed criteria: quality, access, affordability and deliverability. The presented options were refined to a shorter list.

On 20 February 2017, the East Midlands Clinical Senate undertook an independent clinical review of these refined options for the future of health and care in Lincolnshire. The final report was received on 9 May 2017. This is part of the process which will enable a final agreed set of options to be submitted to NHS England for approval before being put to the public for consultation. Major service change will only be made after full public consultation.

Whilst formal public consultation will not start until later in 2017/18, communication and engagement activities with all stakeholders have continued; purdah has been respected.

1.2.4 NHS Regulators

Following assessment of the STP on 25 April by NHS England and NHS Improvement, the view is that we have made good progress and our STP is well regarded nationally. Our regulators support our focus on the development of Neighbourhood teams and implementing the *General Practice Forward View* (GPFV available at https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf) as these are the bedrock of a sustainable

system. However it is also recognised that it is a high risk plan and there are a number of key areas to be addressed;

- Governance and decision making – STPs are not new statutory bodies. They supplement rather than replace the accountabilities of individual organisations. It is a case of "both the organisation and our partners", as against "either/or". Lincolnshire meets all national requirements in terms of governance arrangements and Appendix A is a diagram of the governance structure. This structure includes the newly formed clinical cabinets whose aim is to improve clinical leadership in acute and primary care.
- Finances – A revised financial position reflecting 2016-17 outturn and relationship to service change options has to be agreed by the end of June so that the system can prioritise which changes will have the greatest financial impact. This links to the major service changes, cost improvement and quality plans and five key priorities.
- Capital – a health and care group has been re-established and is starting to refine the capital requirement in Lincolnshire plus is reviewing all NHS building and is identifying a plan to increase usage aided by integrating teams.

2. Conclusion

Good progress has been made in developing and delivering the STP in Lincolnshire; however the plan remains high risk.

3. Consultation

Public consultation will start later in 2017/18.

4. Appendices

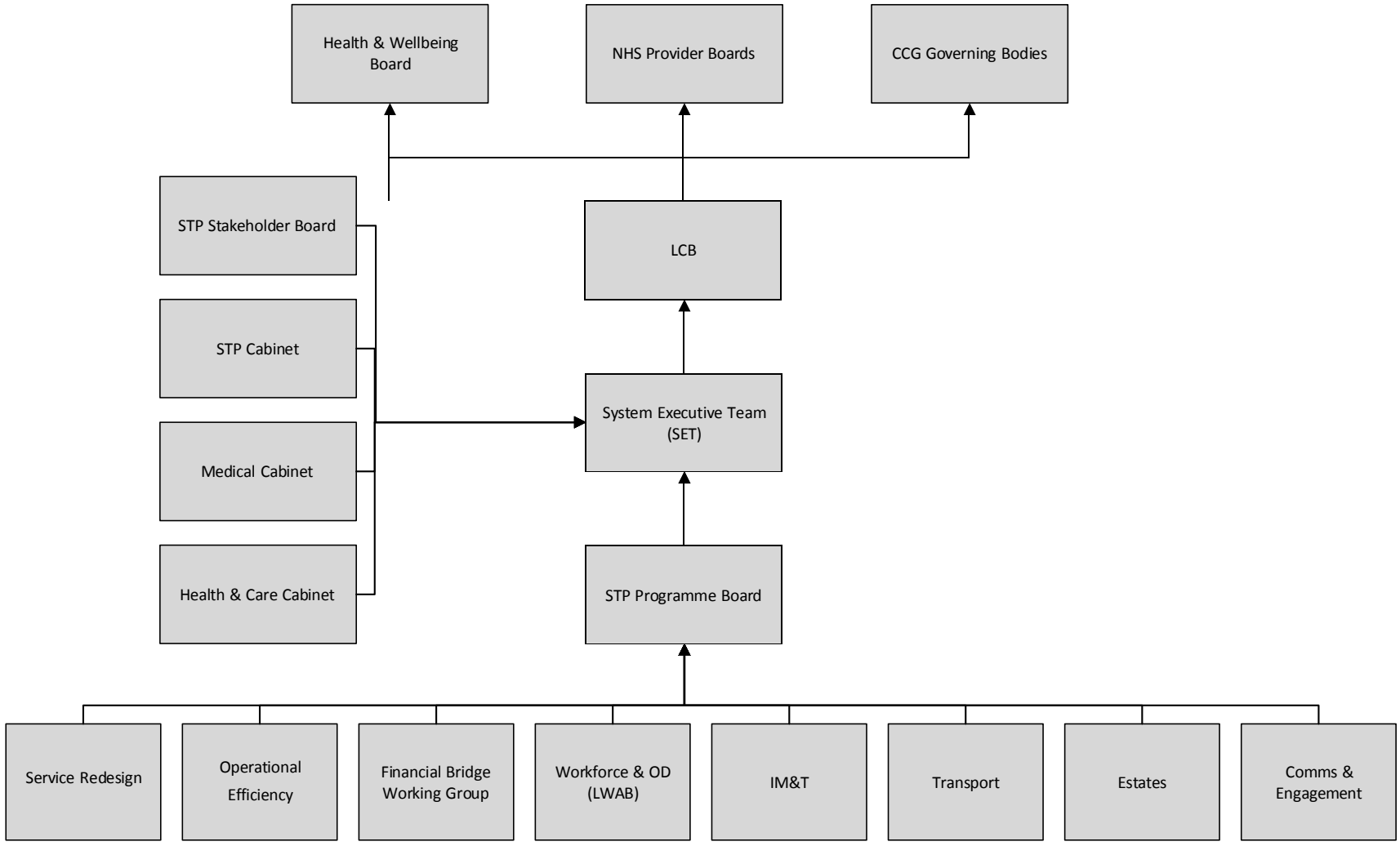
These are listed below and attached at the back of the report	
Appendix A	STP Governance Structure

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 Mrs Sarah Furley who can be contacted on 07964 304558 or e-mail: sarah.furley@lincolnshireeastccg.nhs.uk

Appendix A – STP Governance Structure



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Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

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

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**20 June 2017**
Subject:	**Better Care Fund (BCF) 2016/17 and 2017/18**

Summary:
This report provides the Lincolnshire Health and Wellbeing Board with an update on Lincolnshire's BCF plans including an update on the graduation bid, the additional funding announced by the Chancellor in March 2017, and performance issues both for 2016/17 and the requirements for 2017/18 performance reporting. The paper includes:-

- Appendix A is an LGA/ADASS letter dated 22 March 2017 to top tier council chief executives and directors of adult social services discussing the additional BCF funding
- Appendix B is an NHS letter dated 25 April 2017 to A&E Delivery Board Chairs describing the role of the A&E Board within BCF planning and monitoring
- Appendix C is a performance update which provides the Board with information on performance against the key BCF metrics for the 2016/17 financial year
- Appendix D is a copy of the Memorandum of Understanding to be signed by District/City Councils as part of the DFG transfer 2017/18

Actions Required:
It is proposed that the Health and Wellbeing Board:-

- discuss the paper on BCF performance (Appendix C) for the 2016/17 financial year and note the performance achieved;
- note that given the performance achieved on Non-Elective Admissions in 2016/17 that the £3m Risk Contingency established for this financial year was fully utilised by the CCGs in meeting the extra cost to ULHT;
- note the submission of the Graduation Plan and Lincolnshire's progress at being shortlisted for graduation; and
- note the delays to the timetable for the submission of the BCF Plan and associated BCF Planning Templates, and that an update on these will be presented to the next meeting of the Board.

1. Background

The Lincolnshire Better Care Fund for 2016/17 was £196.5m of which £53.8m was the national allocation. Lincolnshire's fund is one of the largest in the country and this does help us to have some influence at national level. In addition to the £53.8m, there are pooled budgets for Learning Disabilities, CAMHS and Community Equipment plus 'aligned' Mental Health funds from the same organisations. For 2016/17 both Non Elective Admissions (NEA) and delayed transfers of care (DTOC) were a priority, primarily because both nationally and locally NEAs and DTOC have increased and are causing additional financial pressures particularly to NHS partners.

The funding for 2017/18 has increased and the financial section of the paper outlines the major movements. At the same time as the funding has increased, the requirement to ensure that the funding has a positive impact on performance (again particularly in the areas of NEA and DTOC) has also increased given nationally a deteriorating position. The performance section of the paper provides more information on this.

BCF 2017/18 and 2018/19

We have been waiting since December 2016 for final Planning Guidance for 2017/18 and 2018/19. The Guidance is still being held within NHSE as part of the ongoing discussions about health and social care service delivery and its funding. More latterly the general election has impacted on the production of the guidance and it is now expected that the new Ministers at the Department of Health and DCLG will issue the guidance shortly after their appointment. This will enable discussions to take place with key stakeholders and plans to be prepared.

Not surprisingly, given the above, the overall BCF planning timetable has also been delayed and we have not been informed of any of the key deadline dates or when they will be announced. A new simplistic Planning Template has been issued and we are recommended to complete this rather than the 'free-style' version adopted in the original and 2016/17 plans. Work has commenced on this.

What we are seeing, is all areas undertaking wide engagement on the BCF plans, with a message from NHSE that 'Local authorities and CCGs should also be engaging with other partners, including acute trusts, housing authorities and care providers to agree joint approaches to their BCF plan. This should include consideration of the spending and implementation of the Spring Budget 2017 increase in the Improved Better Care Fund (the £2 Billion).'

It is expected that we will have approximately four to six weeks after the national guidance is issued to prepare the BCF Narrative Plan and the associated Planning Templates.

Graduation

Graduation – this is the Government's latest phrase for moving local areas from the BCF to the full integration of health and social care. The benefits of being a 'graduation pilot' are still being determined nationally, though proposed benefits include a reduction in bureaucracy and the need to report to (and be reviewed by) central government.

The Expression of Interest (EoI) for Graduation from the BCF has been submitted within a revised deadline date of 19 May. No decisions will be taken on the pilots to be approved until the new Government is formed, hence we will not know if we are a Graduation pilot until late June at the earliest.

Latest news is that the :-

- Process will involve all partner departments scoring the submitted forms against the criteria set out in the policy framework w/c 22nd May. Moderation will be carried out w/c 29/5 and the Integration Partnership Board (IPB) will need to approve the recommended areas – around 6-10 areas expected.
- Selected areas will be informed as soon as possible after the Election.
- Selected areas will then be involved in a workshop to further develop their proposals and then attend a panel with the IPB for peer challenge.
- A Memorandum of Understanding will be developed regarding graduation for the successful areas and benefits will include no quarterly returns and no further creation of BCF plans.
- Areas not selected from the initial expressions will be supported to graduate in the next wave, expected to be by the end of 2017. Future graduation will be in a planned way, using criteria but not EOIs.

It is being indicated that the Government is proposing to establish (up to 10) 'graduation pilots' and informal soundings indicate that Lincolnshire is now on a national short list of areas under consideration for graduation.

BCF Additional Funding 2017/18 to 2019/20

The Government has committed in both the November 2015 budget and in the Spring 2017 budget to put additional funding into Social Care. The 2015 funding was earmarked for the years 2017/18 - 2019/20 (at that point the last three years of the Parliament) and was termed Improved BCF (iBCF). This funding was back-loaded with the greatest sums to be received in 2019/20.

The Spring Budget 2017 introduced the Supplementary iBCF funding with £2bn being allocated nationally for the three years 2017/18- 2019/20 with over £1bn allocated for 2017/18. The funding comes direct from DCLG to Councils to LCC as a S31 grant, though with a requirement that it is included in the Lincolnshire BCF pooled budget. The additional income is summarised in the following table.

	2017/18	2018/19	2019/20
	£	£	£
iBCF	2,105,730	14,249,039	25,120,225
iBCF Supplementary Funding	15,265,596	9,608,577	4,761,288

This is clearly a significant increase to the BCF funding and to the funding of Adult Care. Attached as Appendix A and Appendix B are letters from the LGA/ADASS and NHSE respectively giving views on how the additional funding should be utilised. The Government has made clear that the funding is to address three priority areas:-

- Pressures within Adult Care
- Market Stabilisation
- DTOC and improvements to performance in this and related areas.

The council has been working closely with health colleagues, and plans for the use of the additional funding will be included in the BCF Narrative Plan. We are though being encouraged by central government to begin investing the funding as quickly as possible, especially so that improvements in DTOC and NEA performance can be delivered before this coming winter.

In addition to revenue funding, Lincolnshire also receives a capital grant specifically for Disabled Facilities Grants (DFGs). The amount received for 2017/18 is £5.291m and the funding will be passported to the 7 District Councils by 30 June 2017. A separate paper on the HWB agenda addresses DFGs in much greater detail. A copy of the Memorandum of Understanding which the District/City Councils are expected to agree is attached as Appendix D.

Protection for Adult Care Services (PACS)
Within the BCF funding received by the CCGs (circa £54.7m for 2017/18) is a sum for the 'Protection for Adult Care Services'. The amounts received by LCC have been £20m and £16.825m in the last two years.

It had been estimated that using national formulae and based on the minimum sum required for 2015/16 plus annual inflation increases, the minimum sum for 2017/18 would have been circa £15.9m and this sum was agreed by the 4 CCGs, by LCC and the HWB. It was understood within the discussions that the CCGs ongoing financial difficulties will make it difficult for them to provide more than the statutory minimum amount for 2017/18 – 2018/19 and that NHSE would be looking for them to justify any additional investment above the minimum.

In discussions on graduation and the BCF Narrative Plan with regional and national NHSE leads we now understand that the minimum sum will be the 2016/17 sum plus an inflationary provision. Discussions are taking place between LCC and CCG officers to clarify any implications, though both parties have agreed to approve whatever the minimum sum is finally set at.

BCF Performance 2016/17
Appendix C is a performance update which provides the Board with information on performance against the key BCF metrics for the whole of 2016/17 with a special focus on performance in the final quarter (ie January – March 2017). It shows:-

- Non Elective Admissions (NEAs) - The BCF plan committed CCGs to a 2.7% reduction in the HWB Plan figures in each quarter of the year. A total of 20,299 admissions were made during Q4, which is 1722 more than the original CCG plans. The level of activity is 11% higher compared to the same period last year. The measure has been marked as not achieved for this month. Only the South CCG have consistently experienced monthly admission rates lower than the HWB Planned reduction, saving 29 admissions in the area this quarter; a 0.8% reduction. All CCGs except the South saw an increase in admissions against plan within Q4.

- Residential Admissions - Within 2016 - 17 there have been 1031 permanent admissions to care homes for older people, which is 49 more than planned for the year. From December the data for this measure has been taken from our finance system, due to the introduction of Mosaic which replaces AIS as the adult care case management system within LCC. The figures provided for this measure are provisional, pending the submission of the statutory SALT return. Overall the number of admissions remains higher than target. This appears to have been caused by discharge pressures in hospitals and an increase in the level of support people are requiring in the community. Work has been undertaken to quality assure the placements and the indication is that we are dealing with a higher level of acuity and therefore the placements are fully justified. We are experiencing a higher level of demand for services generally and a similar proportion of people are being

admitted to care homes as in previous years. Over the 2 previous years, the ratio of people in residential care to community has remained static (1:2) suggesting we are consistently placing people as appropriate.

- Reablement - The data shows that for 75.4% of the of hospital discharges between October and December into reablement services, the service user was still at home 91 days after discharge. The number of discharges into reablement services has fallen from 958 reported in March 16 to 668 reported for the same period this year. Comparing CCG performance, only the South CCG achieved the 80% target, with the East CCG just falling below with 79.8%. Within Lincolnshire, the East CCG has the highest number of hospital discharges resulting in reablement services, followed by the West, and with the South West having the lowest.

- Delayed Transfers of Care (DTOC) - There were a total of 8,341 delayed days for patients in Q4, 916 higher than the target of 7,425 days. The trend throughout the year is quite linear and consistent compared to 2015/16 where delayed days showed a more pronounced increase throughout the year. The proportion of non-acute delays has continued to fall and is now 35% of total delayed days. Social Care delays account for 23%, higher than figures reported throughout Q3, but lower than reported in January (25%). NHS delays account for 71% of delayed days, up from January, but lower that the figures reported in Q3. In terms of delay reasons, 68% of delayed days relate to waiting for further non-acute care, residential or packages in the person's home. The proportion of delays attributed to these reasons is broadly consistent with Q3. As mentioned in previous reports this year, housing delays are higher than usual and the proportion of delays attributed housing has increased steadily throughout the year, peaking within Q3 and now dropping to 4% of delay reasons.

Finance 2016/17
A £3.6m Risk Contingency (of which £3m is joint BCF funding) was established for 2016/17 to address the financial impact of not achieving the NEA target.

The outturn NEA performance shown above and in Appendix C indicates that the entire contingency established for the 2016/17 financial year was fully utilised by the CCGs in meeting the extra cost to ULHT.

As previously reported and approved at an earlier meeting of this Board we are making no allowances for Pay-for-Performance requirements in 2017/18. Discussions are focused on over-arching risk management arrangements rather than a risk contingency.

Performance 2017/18
Alongside the various exhortations that we consult widely on BCF Plan and performance metrics, A&E Delivery Boards Chairs have been sent a letter (see Appendix B) by Jim Heys, NHSE Locality Director emphasising the need for active engagement of the A&E Delivery Board in the BCF planning process particularly around the new National Condition 4 – Managing Transfers of Care. Consideration is taking place on how best to involve the A&E Board in future discussions on the BCF and they have asked that they receive an update on BCF performance metrics at their monthly meeting. The Board has officer representation both from Adult Care and also from the CCG community.

Discussions continue as to whether (or not) to consider whether there should be stretch targets particularly around NEAs and DTOC. The thinking on this is whether the additional

BCF funding should lead Lincolnshire health and social care to expect further improvements in performance in these areas, beyond what is already shown in CCG Operational Plans. This subject needs ongoing discussion to ensure we are comfortable with the targets for NEA and DTOC that are to be included in the BCF Plan.

2. Conclusions

The ongoing delays to the issuing of final BCF guidance and more recently the period of purdah prior to the General Election have led to delays in the finalisation and approval processes to the BCF plans for 2017 - 2019. We have however continued to use this period to develop our plans, and consult and communicate them.

Both the BCF Narrative Plan and the related Planning Templates are likely to be required to be submitted to NHSE around the end of July 2017. We should also by then have heard whether Lincolnshire has been chosen to be a Graduation pilot, and be clearer on the resulting implications.

3. Consultation

Not applicable

4. Appendices

These are listed below and attached at the back of the report.	
Appendix A	LGA/ADASS letter dated 22 March 2017 to top tier council chief executives and directors of adult social services
Appendix B	NHS letter dated 25 April 2017 to A&E Delivery Board Chairs
Appendix C	BCF Performance Report to 31 December 2016
Appendix D	Memorandum of Understanding (DFG)

5. Background Papers

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

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

Local Government Association
Association of Directors of Adult Social Services
Layden House
76-86 Turnmill Street
London
EC1M 5LG

22 March 2017

To: all top tier council chief executives and directors of adult social services

Dear Colleague,

We are writing to you jointly as the LGA and ADASS in relation to the additional £2 billion for adult social care announced in the 2017 Spring Budget.

Ahead of the Budget, the LGA and ADASS worked hard to highlight the scale of pressures facing our care system and their implications, and push for genuinely new additional funding. We have therefore welcomed the £2 billion as a significant step towards protecting services for older and disabled people. However, we have also been clear that short-term pressures remain and the challenge of a long-term solution to the social care crisis is far from over.

Since the Budget, attention has turned to the detail of the conditions that may be attached to the money. These will be set out in a grant determination letter from DCLG to councils, which we expect in April. Alongside this, the BCF policy framework and planning guidance is being amended. This will reflect the additional £2 billion for adult social care as we expect a condition requiring councils to pool all of their additional allocation into their BCF. Although we expect the money to be pooled in this way we also expect that no organisation other than DCLG will be able to impose conditions on the money or direct its use. This will reflect the clear principle that this additional money is for adult social care alone.

We are pressing for maximum flexibility locally. We want the additional funding to be used to meet local needs which vary across the country, and not restricted to older people or particular activities that support hospitals. As far as we understand it, this remains money for social care which should be available immediately to tackle social care pressures. We are seeking urgent clarification on the conditions to minimise any delay.

However, as we are sure you are aware, whilst we push maximum local flexibility it is clear that certain parts of the sector have their own interpretations of how the funding should be spent. Care provider organisations have called for the money to ease their

pressures and, most notably, NHS England and NHS Improvement have written to NHS organisations urging efforts to ensure the new money is used in part to free up in the region of 2,000-3,000 acute beds.

As discussions continue at pace we are keen to ensure you have the information you need to manage local partners' expectations, including pushing back on those expectations that are unrealistic or not in line with latest nationally agreed positions. Therefore, we have set out below our latest understanding of key issues and the associated 'top line' positions we are taking on your behalf.

As we press for maximum flexibility we would welcome your local promotion of these messages, as we would your thoughts on what else we should be saying on your behalf. In this way we can present the most united position both locally and nationally.

Finally, can we reiterate our sincere thanks for the excellent work you are doing in extremely testing circumstances to support older and disabled people. The additional £2 billion is testament to that work and now we need to ensure it can be used for maximum benefit locally.

Yours sincerely,

Mark Lloyd
Chief Executive
Local Government Association

Ray James
Immediate Past President
Association of Directors of Adult Social Services

The Government is saying that councils have received an additional £9.6 billion for adult social care – is this true?

We have not seen anything official from Government that illustrates how this figure is calculated. We know that to date the precept has raised £380m. Our assumption is the following:

	2016/17 £m	2017/18 £m	2018/19 £m	2019/20 £m	TOTAL £m
Adult social care precept as per 2015 Spending Review (with increased flexibility as per Local Government Finance Settlement 2017/18)[1]	381.8	814.2 (1,022.5)	1,289.6 (1,733.7)	1,811.5 (1,804.1)	4,297.1 (4,942.1)
Adult Social Care Support Grant[2]		241.1	0	0	241.1
iBCF funding as per 2015 Spending Review[3]		105	825	1,500	2,430
iBCF funding as per 2017 Spring Budget[4]		1,010	674	337	2,021
					8,989.2 (9,634.2)

The non-bracketed adult social care precept figures are those that appear in the Government's 'core spending power' spreadsheet, as per footnote one below. These figures are based on all councils using the full 6 per cent allowable increase between 2017/18 and 2019/20 by raising 2 per cent in each of the three years.

The bracketed figures represent what happens when all councils levy a 3 per cent precept in years one and two, with zero in the third year. This gives the Government a higher aggregated total and is how we think they arrive at the £9.6 billion figure.

You may also see reference to Government investing £9.25 billion in adult social care. We assume this figure is simply the £9.6 billion figure minus the precept in 2016/17.

You will of course understand that this ignores the impact of local government funding reductions on adult social care.

[1] See here, line 13 of 'Core spending power: supporting information' spreadsheet, 'Potential additional revenue from referendum principle for social care', 20 February 2017.
[2] As above, line 19.
[3] As above, line 15.
[4] See here, line 7 of 'Allocations of the additional funding for adult social care', 9 March 2017.

What are the conditions attached to the £2 billion iBCF grant?

These will be confirmed in April in a grant determination letter from DCLG. At this stage we have a steer from the Budget, which says that the money is intended to:

- Allow councils to take immediate action to fund care packages for more people
- Stabilise the social care market
- Relieve pressure on the NHS locally through getting more people home safely and quickly

The Budget also says that councils will need to "work with their NHS colleagues to consider how the funding can be best spent" and to more consistently embed best practice, particularly on delayed transfers of care.

The exact form these conditions will take is currently being considered. Our latest understanding is that:

- Councils will be required to pool all of their share of the additional £2 billion for adult social care into the local BCF.
- The money is intended for adult social care and will not be subject to the same approval from NHS England as the overall BCF plan.
- Councils will be allowed to spend the money as soon as they have agreed its use with CCGs and subject to the grant conditions.
- Councils will be required to provide quarterly returns and that Section 151 Officers will have to sign off the additional benefit of the funding (as with the precept).

What have the LGA and ADASS been arguing for in discussions?

Whilst recognising the legitimacy and importance of getting care closer to home and supporting people to get home more quickly from hospital we have been arguing for the following:

- Recognition that the £2 billion, whilst a significant step towards protecting services for older and disabled people, cannot deal with all short-term pressures.
- Acknowledgement that 'additional activity' can be defined as much by spending the money on things that would otherwise not have been possible (ie lower than planned reductions, higher than planned provider fees) as it can by 'new' or 'more' things (ie more care packages).
- Flexibility to allow councils to get on and spend their additional resources as quickly as possible on improving outcomes for our most vulnerable residents, in line with the Government's expectation that councils will "take immediate action".
- Recognition that the funding will support the original intentions of the iBCF, which included enabling councils to continue to support a focus on core services (including helping to meet the cost of the National Living Wage),

maintaining services that would not otherwise have been maintained, and investment in new services.

Can the NHS direct the spending of the grant?

DCLG will pay the additional funding directly to councils as a Section 31 grant. This means that the NHS cannot direct how it is spent, nor can it be involved in approving whether councils have met the grant conditions attached to the funding.

A condition of the funding is expected to require councils to pool the funding in the BCF, which requires joint agreement of constituent CCG(s) and council before pooled funds can be spent. Councils are encouraged to engage their CCG(s) to agree the joint priorities of their BCF and ensure the funding is directed to improve outcomes for residents.

Does the money have to be spent on reducing delayed transfers of care from hospital?

We expect the grant conditions to reflect the strong national focus on getting more people home safely and quickly, and the expectation that delayed transfers attributable to social care should fall. The BCF is likely to require councils to work with their CCG(s) to implement best practice in relation to transfers of care.

However, this is not the sole focus of the money, which is also intended to be used to stabilise the provider market and generally to meet adult social care needs. It is our view that local government can best help the NHS in the short and longer term by stabilising the domiciliary care market (and in some areas the nursing home market).

The Budget talks about the funding being "supplemented with targeted measures to help ensure that those areas facing the greatest challenges make rapid improvement". There has also been speculation about the role of CQC. What is the latest on this?

DH/DCLG have committed to engaging with LGA and ADASS on the metrics to be used to assess how effectively each area is addressing the challenges at the interface between social care and health.

We are conscious that Government monitoring of councils' use of the additional £2 billion could be burdensome and bureaucratic and will therefore seek to ensure there is no additional burden of data collection. We will also resist a focus simply on delayed transfers of care.

We are seeking to understand more about the potential role of CQC. If they are to inspect or review local areas that are deemed to be below a certain level of performance (in respect of the health and care interface) then this could undermine rather than complement the sector led improvement approach and we will discuss this, and their methodology, with them.

It would be perverse for councils to have to use this additional funding to cover the costs of any monitoring or reviewing. Where this carries a cost we will argue this must be met from existing departmental budgets.

Sent via email
A&E Delivery Board Chairs

Midlands & East (Central Midlands)
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Grove Park
Enderby
Leicestershire

Tel: 0113 8249637

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25 April 2017

Dear colleagues

Re: Integration and Better Care Fund Planning 2017-2019

I write to draw your attention to the opportunity for Board colleagues to be meaningfully involved in the development of the Integration and Better Care plan(s) for your area.

The Integration and Better Care Fund Policy Framework published on 31 March states at page 29:

> **"National Condition 4 – Managing Transfers of Care**
>
> All areas should implement the High Impact Change Model for Managing Transfer of Care to support system-wide improvements in transfers of care. [Better Care] narrative plans should set out how local partners will work together to fund and implement this … Areas should agree a joint approach to funding, implementing and monitoring the impact of these changes, ensuring that all partners are involved, **including relevant Accident and Emergency Delivery Boards."**

The Integration and Better Care Fund Planning Requirements (the guidance) which underpins the policy framework will be published soon and this will require that bodies responsible for agreeing a Better Care Plan (Local authorities, CCGs and local Health and Wellbeing Boards) should involve providers, including A&E Delivery Boards, in "***agreeing the approach"*** taken to implement the high impact model. This suggests an active engagement of A&E Delivery Boards in the development of these elements of the Better Care plan.

This involvement of the A&E Delivery Board will be essential to realise the national ambition set out in the 'Next Steps on the NHS Five Year Forward View' that "*hospitals, primary and community care and local councils should work together to ensure people are not stuck in hospital while waiting for delayed community health*

and social care …[and]… ensure that the extra £1 billion provided by the Chancellor for investment in adult social care in the March budget is used in part to reduce delayed transfers of care, thereby helping to free up 2000-3000 acute hospital beds – the equivalent of opening 5 new hospitals" (page 15)

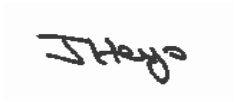
Once the guidance is published, the first submission deadline for Better Care plans will only be around 6 weeks later. This is a challenging timescale to secure involvement of all local partners, so please can I ask you to have an early conversation with your Health and Wellbeing Board colleagues and local Better Care Fund Lead Officers to ensure that necessary Board meetings, or delegated mechanisms, can be appropriately scheduled in this period.

If you have any difficulties in making contact with your local Better Care leads, please contact the East Midlands Regional Better Care Manager, Wendy Hoult, at wendy.hoult@nhs.net

The High Impact Change Model can be found at:
http://www.local.gov.uk/documents/10180/7058797/Impact+change+model+managing+transfers+of+care/3213644f-f382-4143-94c7-2dc5cd6e3c1a

The Integration and BCF Policy Framework is at:
https://www.gov.uk/government/publications/integration-and-better-care-fund-policy-framework-2017-to-2019

Yours sincerely



Jim Heys
Locality Director
Central Midlands

Better Care Fund - 2016/17

Performance Report

Quarter 4 Report

March 2017

Performance Alerts

Performance is on or ahead of target

Performance is behind target, with no improvement

Performance is behind target, with some improvement

Performance is not reported in this period

Performance data not yet available

Total measures

Symbols Key:

CCG NEA Target reduction met ✓

CCG NEA Target reduction not met ✗

Summary

BCF metrics

Achieved	0
Not achieved	5
Improving but not achieved	0
Not reported in period	0
Data not yet available	1
	6

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

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

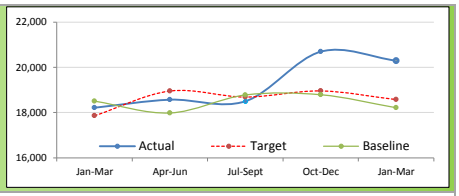
Polarity	Indicator Description	Responsibility	Previous Years		2016/17			
					Current - March 2017			Forecasting
			2014/15	2015/16	Actual	Plan	Alert	Target/Plan (Period)
Health and Wellbeing Better Care Fund Metrics								
Smaller is Better	1. Total non-elective admissions into hospital : General and Acute	NHS	6,034 (average per month)	6,101 (average per month)	20,299	18,080	Not achieved	Quarterly
Smaller is Better	2. Permanent admissions to residential and nursing care homes - aged 65+ **ASCOF 2A part 2**	LCC	938	1,019	1,031	982	Not achieved	Annual
Bigger is Better	3. % people (65+) at home 91 days after discharge from hospital into Reablement/rehabilitation **ASCOF 2B part 1**	NHS / LCC	78.8%	76.0%	75.4%	80%	Not achieved	Annual
Smaller is Better	4. Delayed transfers of care: Delayed days from hospital, aged 18+	NHS / LCC	1,765 (average per month)	2,787 (average per month)	8,341	7,425	Not achieved	Quarterly
Local Performance Metric								
Bigger is Better	5. Percentage of older people leaving hospital who received reablement/rehabilitation services **ASCOF 2B part 2**	NHS / LCC	3.6%	4.2%	2.9%	4.4%	Not achieved	Annual
Local Patient Experience Metric								
Bigger is Better	6. Proportion of people feeling supported to manage their long term condition (local indicator) (%)	NHS	63.8%	63.0%	This data for measure is not yet available.			Annual

Health and Wellbeing Better Care Fund Metrics

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

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

Frequency / Reporting Basis: Monthly / Cumulative within quarter only
Source: MAR data (Monthly NHS England published hospital episode statistics)



Observations from the data:
The BCF plan committed CCGs to a 2.7% reduction in the HWB Plan figures in each quarter of the year. A total of 20,299 admissions were made during Q4, which is 1722 more than the original CCG plans. The level of activity is 11% higher compared to the same period last year. The measure has been marked as not achieved for this month. Only the South CCG have consistently experienced monthly admission rates lower than the HWB Planned reduction, saving 29 admissions in the area this quarter; an 0.8% reduction. All CCGs except the South saw an increase in admissions against plan within Q4.

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

Current Year		2016/17 BCF (Calendar Year)											
		Quarter 1			Quarter 2			Quarter 3			Quarter 4		
		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
In Month		6,122	6,236	6,214	6,183	6,206	6,112	6,818	6,868	7,009	6,884	6,277	7,138
In Quarter		6,122	12,358	18,572	6,183	12,389	18,501	6,818	13,686	20,695	6,884	13,161	20,299
HWB Plan Total		6,318	12,636	18,955	6,229	12,459	18,688	6,320	12,639	18,959	6,192	12,384	18,577
HWB NEA Plan (after reduction) - TARGET		**6,149**	**12,298**	**18,447**	**6,062**	**12,124**	**18,185**	**6,152**	**12,304**	**18,456**	**6,027**	**12,053**	**18,080**
Planned reduction	number	169	339	508	168	335	503	168	335	503	166	331	497
	%	2.68%	2.68%	2.68%	2.69%	2.69%	2.69%	2.65%	2.65%	2.65%	2.68%	2.68%	2.68%
Actual reduction (negative indicates an increase)	number	196	278	382	46	70	188	-498	-1,047	-1,736	-692	-777	-1,722
	%	3.11%	2.20%	2.02%	0.75%	0.56%	1.00%	-7.89%	-8.28%	-9.16%	-11.17%	-6.27%	-9.27%
Performance		Achieved	Improving but not achieved	Improving but not achieved	Improving but not achieved	Improving but not achieved	Improving but not achieved	Not achieved	Not achieved	Not achieved	Not achieved	Not achieved	Not achieved

by CCG

Actual In Quarter	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
East CCG	2,125	4,293	6,481	2,224	4,303	6,417	2,416	4,764	7,236	2,336	4,461	6,886
West CCG	1,908	3,775	5,683	1,814	3,761	5,559	2,129	4,233	6,433	2,154	4,119	6,406
South CCG	1,040	2,250	3,321	1,088	2,209	3,344	1,115	2,308	3,485	1,215	2,312	3,542
South West CCG	927	1,791	2,711	929	1,869	2,815	1,034	2,134	3,170	1,056	2,034	3,106
Other contributing CCGs	122	250	376	127	247	366	124	248	372	123	235	359
Total	**6,122**	**12,358**	**18,572**	**6,183**	**12,388**	**18,501**	**6,818**	**13,686**	**20,695**	**6,884**	**13,161**	**20,299**

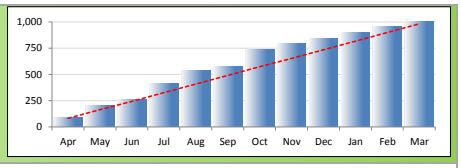
HWB Plan	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
East CCG	2,169	4,337	6,506	2,192	4,385	6,577	2,192	4,385	6,577	2,145	4,289	6,434
West CCG	1,961	3,923	5,884	1,855	3,711	5,566	1,850	3,700	5,550	1,882	3,764	5,646
South CCG	1,180	2,360	3,540	1,160	2,319	3,479	1,211	2,423	3,634	1,190	2,381	3,571
South West CCG	890	1,780	2,670	903	1,806	2,709	945	1,891	2,836	857	1,713	2,570
Other contributing CCGs	118	236	355	119	238	357	121	241	362	119	237	356
Total	**6,318**	**12,636**	**18,955**	**6,229**	**12,459**	**18,688**	**6,320**	**12,639**	**18,959**	**6,192**	**12,384**	**18,577**

Variance from plan (cumulative in Qtr)	monthly increase/reduction	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
East CCG		-44	-45	-25	32	-82	-160	223	379	659	191	172	452
West CCG		-54	-148	-201	-41	50	-7	279	533	883	272	355	760
South CCG		-140	-110	-219	-71	-111	-135	-97	-114	-149	25	-69	-29
South West CCG		37	11	41	26	63	106	89	243	334	199	321	536
Other contributing CCGs		4	14	22	8	9	9	4	6	10	4	-2	3
Total		**-196**	**-278**	**-382**	**-47**	**-70**	**-188**	**498**	**1,047**	**1,736**	**692**	**777**	1,722

% Variance from plan (cumulative in Qtr)	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
East CCG	✗ -2.01%	✗ -1.03%	✗ -0.38%	✗ 1.45%	✗ -1.87%	✗ -2.44%	✗ 10.19%	✗ 8.65%	✗ 10.02%	✗ 8.92%	✗ 4.00%	✗ 7.03%
West CCG	✓ -2.74%	✓ -3.77%	✓ -3.41%	✗ -2.23%	✗ 1.35%	✗ -0.13%	✗ 15.09%	✗ 14.40%	✗ 15.91%	✗ 14.45%	✗ 9.43%	✗ 13.46%
South CCG	✓ -11.83%	✓ -4.65%	✓ -6.20%	✓ -6.14%	✓ -4.77%	✓ -3.88%	✓ -7.98%	✓ -4.72%	✓ -4.09%	✗ 2.07%	✓ -2.88%	✗ -0.81%
South West CCG	✗ 4.17%	✗ 0.61%	✗ 1.55%	✗ 2.88%	✗ 3.50%	✗ 3.91%	✗ 9.41%	✗ 12.86%	✗ 11.77%	✗ 23.27%	✗ 18.72%	✗ 20.86%
Other contributing CCGs	✗ 3.20%	✗ 5.72%	✗ 6.12%	✗ 6.81%	✗ 3.82%	✗ 2.48%	✗ 2.90%	✗ 2.61%	✗ 2.66%	✗ 3.78%	✗ -0.86%	✗ 0.96%
Total	✓ -3.11%	✗ -2.20%	✗ -2.02%	✗ -0.75%	✗ -0.57%	✗ -1.00%	✗ 7.89%	✗ 8.28%	✗ 9.16%	✗ 11.17%	✗ 6.27%	✗ 9.27%

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

Definition: The total number of admissions to permanent residential or nursing care during the year
(excluding transfers between homes unless the type of care has changed from temporary to permanent)
Frequency / Reporting Basis: Monthly / Cumulative YTD
Source: AIS data: Local Adult Care Monitoring (LTC admissions report & SALT return) upto Nov 2016. Local finance system from Dec 2016.
Note: Figure reported cumulatively, so monthly figures show increases in placements recorded & not necessarily within that month



Observations from the data:
Within 2016 - 17 there have been 1031 permanent admissions to care homes for older people, which is 49 more than planned for the year. From December the data for this measure has been taken from our finance system, due to the introduction of Mosaic which replaces AIS as the adult care case management system within LCC. The figures provided for this measure are provisional, pending the submission of the statutory SALT return. Overall the number of admissions remains higher than target. This appears to have been caused by discharge pressures in hospitals and an increase in the level of support people are requiring in the community. Work is being undertaken to quality assure the placements we are making, however the early indication is that we are dealing with a higher level of acuity and therefore the placements are fully justified. We are experiencing a higher level of demand for services generally and a similar proportion of people are being admitted to care homes as in previous years. All the while though, over the 2 years, the ratio of people in res care to community has stayed pretty static (1:2) suggesting we are consistently placing people as appropriate.

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

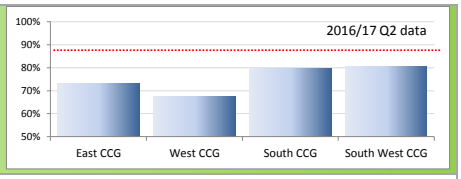
Current Year	2016/17 BCF (Financial Year)											
	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Additions per month	87	120	52	154	123	43	158	63	42	54	62	73
Cumulative YTD	87	207	259	413	536	579	737	800	842	896	958	1,031
Denominator	172,133	172,133	172,133	172,133	172,133	172,133	172,133	172,133	172,133	172,133	172,133	172,133
Rate per 100,000	50.5	120.3	150.5	239.9	311.4	336.4	428.2	464.8	489.2	520.5	556.5	599.0
Target (admissions)	**82**	**164**	**246**	**327**	**409**	**491**	**573**	**655**	**737**	**818**	**900**	**982**
Target (per 100k)	48	95	143	190	238	285	333	380	428	475	523	570
Performance	Not achieved	Not achieved	Not achieved	Not achieved	Not achieved	Not achieved	Not achieved	Not achieved	Not achieved	Not achieved	Not achieved	Not achieved

by CCG

Care home admissions (Cumulative)	2015/16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
East	385	41	90	110	177	223	239	298	322	339	351	380	409
West	339	22	51	61	101	131	144	193	208	219	243	263	283
South	167	13	38	46	61	94	100	127	147	154	167	174	187
South West	106	11	28	42	69	77	85	105	109	112	116	120	129
Not Recorded	22	-	-	-	5	11	11	14	14	18	19	21	23
Total	**1,019**	**87**	**207**	**259**	**413**	**536**	**579**	**737**	**800**	**842**	**896**	**958**	**1,031**
Est. CCG population (aged 65+)	**2015/16**	**Apr-16**	**May-16**	**Jun-16**	**Jul-16**	**Aug-16**	**Sep-16**	**Oct-16**	**Nov-16**	**Dec-16**	**Jan-17**	**Feb-17**	**Mar-17**
East CCG	58,286	62,724	62,724	62,724	62,724	62,724	62,724	62,724	62,724	62,724	62,724	62,724	62,724
West CCG	44,185	47,550	47,550	47,550	47,550	47,550	47,550	47,550	47,550	47,550	47,550	47,550	47,550
South CCG	31,865	34,291	34,291	34,291	34,291	34,291	34,291	34,291	34,291	34,291	34,291	34,291	34,291
South West CCG	25,617	27,568	27,568	27,568	27,568	27,568	27,568	27,568	27,568	27,568	27,568	27,568	27,568
Lincolnshire	**159,953**	**172,133**	**172,133**	**172,133**	**172,133**	**172,133**	**172,133**	**172,133**	**172,133**	**172,133**	**172,133**	**172,133**	**172,133**
Rate per 100,000	**2015/16**	**Apr-16**	**May-16**	**Jun-16**	**Jul-16**	**Aug-16**	**Sep-16**	**Oct-16**	**Nov-16**	**Dec-16**	**Jan-17**	**Feb-17**	**Mar-17**
East CCG	661	65	143	175	282	356	381	475	513	540	560	606	652
West CCG	767	46	107	128	212	276	303	406	437	461	511	553	595
South CCG	524	38	111	134	178	274	292	370	429	449	487	507	546
South West CCG	414	40	102	152	250	279	308	381	395	406	421	435	468
Lincolnshire	**637**	**51**	**120**	**150**	**240**	**311**	**336**	**428**	**465**	**489**	**521**	**557**	**599**

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

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



Observations from the data:
The data shows that for 75.4% of the of hospital discharges between October and December into reablement services, the service user was still at home 91 days after discharge. The number of discharges into reablement services has fallen from 958 reported in March 16 to 668 reported for the same period this year. Comparing CCG performance, only the South CCG acheived the 80% target, with the East CCG just falling below with 79.8%. Within Lincolnshire the East CCG has the highest number of hospital discharges resulting in reablement services, followed by the West, and with the South West having the lowest.

	2015/16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Numerator	728						658						504
Denominator	958						896						668
Value	76.0%						73.4%						75.4%
Target	**80.0%**						**80.0%**						**80.0%**
Performance	Not achieved						Not achieved						Not achieved

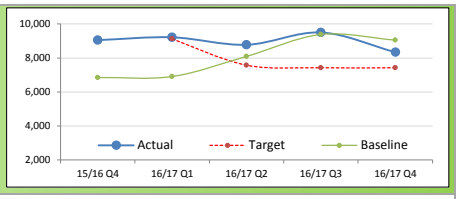
by CCG

Numerator	2015/16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
East CCG	318						241						193
West CCG	157						196						145
South CCG	122						119						88
South West CCG	114						96						77
Not known	17						6						1
Total	**728**						**658**						**504**
Denominator	**2015/16**	**Apr-16**	**May-16**	**Jun-16**	**Jul-16**	**Aug-16**	**Sep-16**	**Oct-16**	**Nov-16**	**Dec-16**	**Jan-17**	**Feb-17**	**Mar-17**
East CCG	403						329						242
West CCG	214						290						211
South CCG	165						149						110
South West CCG	158						119						104
Not known	18						9						1
Total	**958**						**896**						**668**
Actual	**2015/16**	**Apr-16**	**May-16**	**Jun-16**	**Jul-16**	**Aug-16**	**Sep-16**	**Oct-16**	**Nov-16**	**Dec-16**	**Jan-17**	**Feb-17**	**Mar-17**
East CCG	78.9%						73.3%						79.8%
West CCG	73.4%						67.6%						68.7%
South CCG	73.9%						79.9%						80.0%
South West CCG	72.2%						80.7%						74.0%
Total	**76.0%**						**73.4%**						**75.4%**

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

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

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



Observations from the data:
There were a total of 8,341 delayed days for patients in Q4, 916 higher than the target of 7,425 days. The trend throughout the year is quite linear and consistent compared to 2015/16 where delayed days showed a more pronounced increase throughout the year.

The proportion of non-acute delays has continued to fall and is now 35% of total delayed days. Social Care delays account for 23%, higher than figures reported throughout Q3, but lower than reported in January (25%). NHS delays account for 71% of delayed days, up from January, but lower that the figures reported in Q3.

In terms of delay reasons, 68% of delayed days relate to waiting for further non-acute care, residential or packages in the persons home. The proportion of delays attributed to these reasons is broadly consistent with Q3. As mentioned in previous reports this year, housing delays are higher than usual and the proportion of delays attributed housing has increased steadily throughout the year, peaking within Q3 and now dropping to 4% of delay reasons.

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

Current Year	2016/17 BCF (Financial Year)											
	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
In month	3,006	3,227	2,985	3,048	2,856	2,873	3,347	3,212	2,944	3,066	2,588	2,687
In Quarter (cumulative)	3,006	6,233	9,218	3,048	5,904	8,777	3,347	6,559	9,503	3,066	5,654	8,341
Denominator	598,595	598,595	598,595	598,595	598,595	598,595	598,595	598,595	598,595	602,877	602,877	602,877
Rate per 100,000 population	502.2	1,041.3	1,539.9	509.2	986.3	1,466.3	559.1	1,095.7	1,587.6	508.6	937.8	1,383.5
Target (days)	**3,042**	**6,085**	**9,127**	**2,525**	**5,050**	**7,575**	**2,475**	**4,950**	**7,425**	**2,475**	**4,950**	**7,425**
Target (per 100k)	508.2	1,016.5	1,524.7	421.8	843.6	1,265.5	413.5	826.9	1,240.4	410.5	821.1	1,231.6
Performance	Achieved	Not achieved	Not achieved	Not achieved	Not achieved	Not achieved	Not achieved	Not achieved	Not achieved	Not achieved	Not achieved	Not achieved

by Type of Care

	2015/16 Q4	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Acute	6,171	1,806	3,682	5,217	1,530	3,093	4,645	1,926	3,874	5,618	1,921	3,654	5,392
Non Acute	2,881	1,200	2,551	4,001	1,518	2,811	4,132	1,421	2,685	3,885	1,145	2,000	2,949
Total	**9,052**	**3,006**	**6,233**	**9,218**	**3,048**	**5,904**	**8,777**	**3,347**	**6,559**	**9,503**	**3,066**	**5,654**	**8,341**
	2015/16 Q4	**Apr-16**	**May-16**	**Jun-16**	**Jul-16**	**Aug-16**	**Sep-16**	**Oct-16**	**Nov-16**	**Dec-16**	**Jan-17**	**Feb-17**	**Mar-17**
Acute	68%	60%	59%	57%	50%	52%	53%	58%	59%	59%	63%	65%	65%
Non Acute	32%	40%	41%	43%	50%	48%	47%	42%	41%	41%	37%	35%	35%

by Responsible Organisation

	2015/16 Q4	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
NHS	6,184	2,000	4,307	6,157	1,931	4,020	6,163	2,476	4,925	7,016	2,060	3,956	5,898
Social Care (SSD)	2,415	830	1,489	2,226	848	1,370	1,897	596	1,063	1,554	777	1,326	1,890
Both	453	176	437	835	269	514	717	275	571	933	229	372	553
Total	**9,052**	**3,006**	**6,233**	**9,218**	**3,048**	**5,904**	**8,777**	**3,347**	**6,559**	**9,503**	**3,066**	**5,654**	**8,341**
	2015/16 Q4	**Apr-16**	**May-16**	**Jun-16**	**Jul-16**	**Aug-16**	**Sep-16**	**Oct-16**	**Nov-16**	**Dec-16**	**Jan-17**	**Feb-17**	**Mar-17**
NHS	68%	67%	69%	67%	63%	68%	70%	74%	75%	74%	67%	70%	71%
Social Care (SSD)	27%	28%	24%	24%	28%	23%	22%	18%	16%	16%	25%	23%	23%
Both	5%	6%	7%	9%	9%	9%	8%	8%	9%	10%	7%	7%	7%

by Delay Reason

	2015/16 Q4	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
A. Completion of Assessment **(BOTH)**	2,252	473	792	1,180	542	1,020	1,434	281	655	956	336	574	875
B. Public Funding **(BOTH)**	114	13	106	159	46	88	177	33	189	260	19	94	155
C. Awaiting NHS Non-acute care **(NHS)**	1,366	511	1,157	1,654	543	1,099	1,714	825	1,562	2,199	589	1,188	1,727
D. Residential or Nursing Care **(BOTH)**	1,211	612	1,293	2,035	570	1,264	1,794	596	1,187	1,769	717	1,342	1,969
E. Care Package at home **(BOTH)**	2,693	833	1,602	2,275	701	1,294	1,976	871	1,599	2,432	865	1,421	1,954
F. Awaiting Equipment **(BOTH)**	434	133	264	465	79	138	218	80	140	234	44	85	164
G. Patient or Family Choice **(NHS or SSD)**	779	283	638	839	299	511	804	357	598	792	226	463	817
H. Disputes **(NHS or SSD)**	132	73	200	304	76	188	248	31	31	70	116	237	336
I. Housing - **(SSD)**	71	75	181	307	192	302	412	273	598	791	154	250	344
Total	**9,052**	**3,006**	**6,233**	**9,218**	**3,048**	**5,904**	**8,777**	**3,347**	**6,559**	**9,503**	**3,066**	**5,654**	**8,341**
	2015/16 Q4	**Apr-16**	**May-16**	**Jun-16**	**Jul-16**	**Aug-16**	**Sep-16**	**Oct-16**	**Nov-16**	**Dec-16**	**Jan-17**	**Feb-17**	**Mar-17**
A. Completion of Assessment **(BOTH)**	25%	16%	13%	13%	18%	17%	16%	8%	10%	10%	11%	10%	10%
B. Public Funding **(BOTH)**	1%	0%	2%	2%	2%	1%	2%	1%	3%	3%	1%	2%	2%
C. Awaiting NHS Non-acute care **(NHS)**	15%	17%	19%	18%	18%	19%	20%	25%	24%	23%	19%	21%	21%
D. Residential or Nursing Care **(BOTH)**	13%	20%	21%	22%	19%	21%	20%	18%	18%	19%	23%	24%	24%
E. Care Package at home **(BOTH)**	30%	28%	26%	25%	23%	22%	23%	26%	24%	26%	28%	25%	23%
F. Awaiting Equipment **(BOTH)**	5%	4%	4%	5%	3%	2%	2%	2%	2%	2%	1%	2%	2%
G. Patient or Family Choice **(NHS or SSD)**	9%	9%	10%	9%	10%	9%	9%	11%	9%	8%	7%	8%	10%
H. Disputes **(NHS or SSD)**	1%	2%	3%	3%	2%	3%	3%	1%	0%	1%	4%	4%	4%
I. Housing - **(SSD)**	1%	2%	3%	3%	6%	5%	5%	8%	9%	8%	5%	4%	4%

by NHS Trust

	2015/16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
ULHT	4,829	1,303	2,762	3,923	1,149	2,335	3,480	1,476	2,964	4,321	1,453	2,713	4,039
LCHS	2,055	670	1,235	1,694	540	983	1,665	607	990	1,237	143	317	574
LPFT	811	530	1,316	2,307	978	1,828	2,467	814	1,644	2,592	1,002	1,674	2,332
Total*	**7,695**	**2,503**	**5,313**	**7,924**	**2,667**	**5,146**	**7,612**	**2,897**	**5,598**	**8,150**	**2,598**	**4,704**	**6,945**
	2015/16	**Apr-16**	**May-16**	**Jun-16**	**Jul-16**	**Aug-16**	**Sep-16**	**Oct-16**	**Nov-16**	**Dec-16**	**Jan-17**	**Feb-17**	**Mar-17**
ULHT	63%	52%	52%	50%	43%	45%	46%	51%	53%	53%	56%	58%	58%
LCHS	27%	27%	23%	21%	20%	19%	22%	21%	18%	15%	6%	7%	8%
LPFT	11%	21%	25%	29%	37%	36%	32%	28%	29%	32%	39%	36%	34%

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

Local Performance / Patient Experience Metrics

5. The proportion of people aged 65+ offered Reablement services following discharge from hospital (ASCOF 2B part 2)	6. Proportion of people feeling supported to manage their long term condition
Definition: The number of people aged 65+ offered Reablement services following discharge from hospital during October to December, as a proportion of the total number of people aged 65+, discharged alive from hospitals in England between 1 October 2015 and 31 December 2015 **Frequency / Reporting Basis:** Annual **Source**: SALT STS004 / Hospital Episode Statistics	**Definition:** Of the number of people identifying a long-term condition in their responses, the % who responded 'Yes, definitely' or 'Yes, to some extent' to the question 'In the last 6 months, have you had enough support from local services or organisations to help you manage your long-term health condition(s)?'. **Frequency / Reporting Basis:** 6-monthly / results from 2 GP patient surveys in the year are aggregated and reported as an annual figure **Source:** GP Patient Survey
Observations from the data: The provisional outturn for this measure is 2.9% against a target of 4.4%. The denominator for this measure is based on the 15/16 figure as the final 16/17 data on hospital discharges is not yet available.	**Observations from the data:** This data for measure is not yet available.

	2015/16	Q4 2016/17	2015/16	2016/17
Numerator	958	668	3,719	
Denominator	22,830	22,830	5,900	
Value	4.2%	2.9%	63.0%	
Target	**Not monitored in BCF in 2015/16**	**4.4%**	**64.0%**	**66.0%**
Performance	-	Not achieved		

By CCG

Numerator	**2015/16**	**Q2 2016/17**	**2015/16**	**2016/17**
East CCG	403	329	1252	
West CCG	214	290	1018	
South CCG	165	149	767	
South West CCG	158	119	682	
Not known	18	9	0	
Total	958	896	3719	0
Denominator	**2015/16**	**2016/17**	**2015/16**	**2016/17**
East CCG	Data not disaggregated by CCG	Data not disaggregated by CCG	2032	
West CCG			1621	
South CCG			1200	
South West CCG			1047	
Not known			0	
Total	22,830	22,830	5,900	0
Value	**2015/16**	**Q2 2016/17**	**2015/16**	**2016/17**
East CCG	Data not disaggregated by CCG	Data not disaggregated by CCG	61.6%	
West CCG			62.8%	
South CCG			63.9%	
South West CCG			65.1%	
Not known			0.0%	
Total	4.2%	3.9%	63.0%	0

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Appendix D

Housing for Independence

MEMORANDUM OF UNDERSTANDING (MOU) *between*

_ LINCOLNSHIRE COUNTY COUNCIL "Party A"

and

XXXXXXX COUNCIL "Party B"

This is an agreement between “Party A”, hereinafter called The County and “Party B”, hereinafter called The District.

I. PURPOSE & SCOPE

The purpose of this MOU is to identify the agreed roles and responsibilities of the partnership approach to an Integrated System of Housing for Independence (HfI) across Lincolnshire

II. BACKGROUND

The Better Care Fund (BCF) brings together money from a number of health and social care budgets with the aim of ensuring joined-up services that are focused on the individual to help reduce hospital and care admissions, and enable people to return from hospital more quickly. Housing is a key component in identifying suitable solutions to improve outcomes for individuals across Lincolnshire through understanding the relationship between where people live and their health and wellbeing.

In order to ensure the improvements are made and sustained within Lincolnshire an overarching agreement has been negotiated across all eight local authorities through the direct involvement of both local authority tiers working jointly to support integration ambitions as reflected in the DCLG guidance

The governance of this partnership work will be the responsibility of the Housing, Health and Care Delivery Group (HHCDC) through its function as a sub-group of the Lincolnshire Health and Wellbeing Board

The main functions of the HHCDC will be to;

- Oversee and update the countywide Memorandum of Understanding;
- Be responsible for the Housing and Health JSNA topic;
- Be responsible for best use of the Disabled Facilities Grants (DFGs) budget and associated funding from Adult Care and Community Wellbeing
- Agree to support and direct the DFG modernisation of in Lincolnshire;
- Make best use of the performance reporting template to monitor performance and activity related to DFG across Lincolnshire AND report on performance to relevant stakeholders on a regular basis;
- Agree priority work streams to address key housing issues impacting on Lincolnshire, such as delayed transfers of care (DToC);
- Explore future pooled funding arrangements to secure best value for 2018/19.

III. AIM

Through the partnership approach to the Housing for Independence programme we will work together to;

- Understand the unmet and forthcoming need for housing for independence.
- Explore the potential to incorporate housing need into assessment of health and social care need, developing new pathways for defined groups and areas that are not based on adaptation alone.
- Explore partnership with the private sector as well as with the social sector.
- Agree the estate and capital resource that is required and work collaboratively to deliver it.
- Improve knowledge of different parts of the system in all practitioners and improve collaboration including through the provision of training, protocol development and identified contact points.

III. RESPONSIBILITIES UNDER THIS MOU

Both parties agree to undertake the following activities:

- Actively participate and contribute to the Moving Forward with DFG Group
- Undertake a DFG Delivery mechanism review to develop a new model for providing housing adaptations across the health, social care and housing system which will build on lessons from previous review work and also refocuses customer expectation.
- Recognise and adhere to the governance provided by the HHCDC
- Contribute to the HHCDC where required
- Provide performance data to the HHCDC through the performance template in a timely manner.
- Report performance and progress to internal governance and scrutiny where required by own local authority
- Provide evidence for Housing and Health JSNA topic where appropriate
- Develop a process to ensure the District DFG backlog is cleared by the start of the 2017/18 period
- Provide progress updates to the HHCDC on their individual activities listed below

Party A agrees to undertake the following activities;

- Provide project leadership and co-ordination for the Moving forward with DFG Group via the Housing for Independence Manager
- Review its Occupational Therapy services role in the DFG process to identify best practice across the county and develop a uniform process that can be adapted to local need by 31 March 2018
- Determine a prioritisation process for OTs to use when assessing cases in time for 2018/19 budget allocation

Party B Agrees to undertake the following activities

- Provide updates to the HHCDC on progress against local improvement projects
- Have active involvement in a Fast Track hospital discharge process from April 17.
- Ensure DFG Fees are at no more than 15% of the District in year allocation

IV. EFFECTIVE DATE AND SIGNATURE

This MOU shall be effective upon the signature of Parties A and B authorized officials. It shall be in force from xx to 31st March 2018.

Parties A and B indicate agreement with this MOU by their signatures.

Signatures and dates

[insert name of Party A] [insert name of Party B]

_____ _____

_____ Date _____ Date

Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

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

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**20 June 2017**
Subject:	**Lincolnshire Pharmaceutical Needs Assessment**

Summary:

The purpose of this information report is to highlight the responsibility of the Health and Wellbeing Board to publish a Pharmaceutical Needs Assessment (PNA) every three years and to set out the process for developing the next PNA, due for publication in March 2018.

Actions Required:
The Health and Wellbeing Board is requested to note the contents of this report.

1. Background

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

The purpose of the PNA is to:

- identify the pharmaceutical services currently available and assess the need for pharmaceutical services in the future;
- inform the planning and commissioning of pharmacy services by identifying which services should be commissioned for local people, within available resources, and where these services should be;
- inform decision making in response to applications made to NHS England by pharmacists and dispensing doctors to provide a new pharmacy.

The current PNA for Lincolnshire was approved by the HWB in March 2015 and can be accessed on the Lincolnshire Research Observatory. The HWB is required to publish an updated PNA every three years; therefore the new document is due for approval and publication in March 2018.

Governance

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

Consultation

The PNA is subject to a 60 day statutory consultation period which is planned to start in October 2017. Regulation 8 of the Pharmaceutical Services Regulations specifies that that the HWB must consult with the following:

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

The HWB must consult the above at least once during the process of developing the PNA. Those being consulted can be directed to a website address containing the draft PNA document but can, if they request, be sent an electronic or hard copy version.

The intention is to publish the draft PNA on the county council's website to enable views to be gathered from wider partners over and above the statutory consultees.

PNA Structure and Timescales

The regulations and guidance documents stipulate the information to be contained in a PNA. The outline structure for the PNA provided in Appendix B takes account of this guidance.

The impact of the Government's decisions regarding 'Community Pharmacy in 2016/17 and beyond' will emerge during the course of 2017. Therefore the review process will need to take account of these changes as they materialise as well as provide an assessment of the implications in the new PNA.

Appendix B also provides an outline of the key milestones from the project plan. The timescales are challenging and will require capacity and input from a number of partners. It is critical that the statutory consultation period takes place between October and December 2017 to enable us to deliver a finalised PNA for approval by the HWB in March 2018. The PNA Steering Group will be responsible for monitoring the plan and report any issues of concern to the HWB.

2. Conclusion

The HWB has a statutory responsibility to publish a PNA for Lincolnshire. This information reports provides details on the review arrangements and timescales to enable a new PNA to be in place in March 2018.

3. Consultation

Not applicable

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	PNA Steering Group Terms of Reference
Appendix B	PNA Outline Structure and Timescales

5. Background Papers

Document	Where can it be accessed
NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013	http://www.dh.gov.uk/health/2013/02/pharmaceutical-services-regulations/
Pharmaceutical Needs Assessment – information pack for local authority Health and Wellbeing Boards 2013	https://www.gov.uk/government/publications/pharmaceutical-needs-assessments-information-pack
Lincolnshire Pharmaceutical Needs Assessment 2015	http://www.research-lincs.org.uk/UI/Documents/Final%20PNA%20March%202015.pdf

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

Appendix A

LINCOLNSHIRE PHARMACEUTICAL NEEDS ASSESSMENT STEERING GROUP TERMS OF REFERENCE

1. Background

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

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

2. Purpose

The Health and Wellbeing Board (HWB) has the legal responsibility for producing a PNA every three years. A revised PNA for Lincolnshire needs to be published by 1 April 2018.

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

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

3. Role

The PNA SG has been established to:

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

4. Key Functions

- To oversee the PNA process
- To approve the framework for the PNA

- To approve the project plan and timeline, and drive delivery to ensure key milestones are met
- To ensure the development of the PNA meets all statutory requirements
- To determine the localities which will be used for the basis of the assessment
- To undertake an assessment of the pharmaceutical needs of the population including:
    - Mapping current pharmaceutical service provision in Lincolnshire
    - Reviewing of opening hours and location of services
    - Using the JSNA & other profile data to review of the health needs of the population
    - Analysing current and projected population changes in conjunction with existing patterns of service provision
    - Identifying any gaps in service provision and proposed solutions on how gaps can be addressed
    - Consideration of future needs, including housing growth, and its impact on the development of services - in terms of essential, advanced and enhanced service provision.
- To produce a draft PNA for consultation
- To ensure active engagement arrangements are in place
- To oversee the consultation exercise ensuring that it meets the requirements set out in the Regulations
- To consider and act upon formal responses received during the formal consultation process, amending the PNA document as appropriate
- To ensure the Lincolnshire Health and Wellbeing Board is updated on progress and that the final PNA is signed off by the Board by the end of March 2018.

5. Membership

Core membership will consist of:

- Consultant, Public Health (LCC) – Chair
- Programme Manager Health & Wellbeing (LCC) – Project Manager
- Programme Manager Public Health Intelligence (LCC)
- Primary Care Support Contract Manager (NHS England – Leics & Lincs area)
- Chief Executive Officer, Healthwatch Lincolnshire
- Chief Officer, Local Pharmaceutical Committee
- Representative, Local Medical Committee
- Representative, Clinical Commissioning Groups
- PMOS Pharmacist Lead

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

6. Reporting Arrangements

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

7. Frequency of Meetings

The PNA SG will meet, either on a face to face basis or virtually (conference call or email discussion), every 4 – 6 weeks or in accordance with the project plan.

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

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

8. Declarations of Interest

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

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

9. Steering Group Member Responsibilities

Members of the PNA SG will:

- commit to attend meetings regularly
- nominate a deputy, wherever possible, to attend meetings on their behalf in their absence
- actively contribute to the compilation of the revised PNA and any subsequent supplementary statements
- come to meetings prepared with all documents and contribute to the debate
- understand that the discussions at the PNA SG are confidential, unless stated otherwise, and are not to be disclosed to any unauthorised person
- declare any conflicts of interest which might have a bearing on their actions, views and involvement within the PNA SG

10. Review

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

Revised May 2017

Appendix B

PNA Outline Structure and Timescales

Outline Structure

	Contents
	Forward
	Acknowledgements
	Executive Summary
1	**Introduction** 1.1 PNA – description & background 1.2 Overview of NHS pharmaceutical services (statutory framework) 1.3 Overview of Local Pharmacy services
2	**Process** 2.1 Summary of the process & methods used in developing the PNA 2.2 Consultation Process 2.3 Ongoing review and supplementary statements 2.4 Local impact of the new national pharmacy contract (2016)
3	**Understanding local health needs** 3.1 Joint Strategic Needs Assessment 3.2 Health & Wellbeing Board/JHWS 3.3 Sustainable Transformation Plan 3.4 National Outcomes Framework 3.5 National Policy Context 3.6 Characteristics of Lincolnshire's population 3.7 General Health across Lincolnshire – overall assessment linking to health profiles at county, district & local GP practices
4	**Current Provision of NHS Pharmaceutical Services** 4.1 Summary of key findings 4.2 Service Providers – numbers and geographical distribution • Community pharmacies • Dispensing GP Practices • Distance Selling practices • Dispensing Appliance Contractors • Other pharmacy provision e.g. Hospital Pharmacies/prisons? • Comparison with pharmacy provision elsewhere • Consideration of service providers available 4.3 Accessibility • Distance & travel time • Bus Routes • Home Delivery Services • Border Areas • Vulnerable groups: 4.4 Opening hours • Community Pharmacies • Dispensing GP Practices
5	**Role of pharmaceutical providers in addressing health needs** 5.1 Community Pharmacy Essential Services 5.2 Advanced Services • Medicines Use Reviews (MURs) • New medicines service

Key Timescales

Action	Timescale
Assess demographics and key characteristics of Lincolnshire	May – July 2017
Assess population changes & new housing growth	May – July 2017
Draft PNA document	July – Sept 2017
Present draft PNA & consultation plan to Health Scrutiny Committee and HWB	September 2017
60 day statutory consultation period	Oct – Dec 2017
Analyse feedback from consultation	Dec 2017 – Jan 2018
Finalise PNA	Feb 2018
HWB to approve final PNA	March 2018
Publish PNA	30 March 2018

Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

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

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**20 June 2017**
Subject:	**Health and Wellbeing Grant Fund – half yearly update**

Summary:
This information report provides the Health and Wellbeing Board with an update on the Health and Wellbeing Grant funded projects.

Actions Required:
The Health and Wellbeing Board is asked to note the details contained in Appendix A.

1. Background

The Health and Wellbeing Grant Fund for Lincolnshire (the fund) was originally established in 2008 under a Section 256 Agreement between Lincolnshire County Council and NHS Lincolnshire. It was set up to support projects and initiatives which improve health and wellbeing in Lincolnshire. In November 2014 a revised Section 256 Agreement was signed between Lincolnshire County Council and the four Clinical Commissioning Groups which gave responsibility for allocating the remaining money to the Lincolnshire Health and Wellbeing Board.

In March 2015 the Board agreed to allocate £1,316,234.00 of the Health and Wellbeing Grant Fund to ten projects. As previously reported to the Board two projects have been withdrawn and one project, My Rural Life, concluded in January 2016.

Since the last report to the HWB in December 2016, the Let's Get Fizzical project finished in March 2017 and the Connecting Communities project will be concluding at the end of June 2017. A progress report on these and the remaining five grant funded projects is contained in Appendix A.

2. Conclusion

The Health and Wellbeing Board has been given the responsibility for allocating and monitoring the remaining funds in the Health and Wellbeing Grant Fund. This is the third half yearly report on the projects since the funding was agreed by the Board in March 2015 and the Board is asked to note the information contained in Appendix A.

3. Consultation

Not applicable

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Health and Wellbeing Grant Fund – 2016/17 Year-end 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 Alison Christie, Programme Manager Health and Wellbeing, who can be contacted on 01522 552322 or alison.christie@lincolnshire.gov.uk

HEALTH AND WELLBEING GRANT FUND PROJECT – 2016 – 17 Qtr 4 report **Appendix A**

Project Name:	Project Lifetime	Total Allocated	Total claimed	Total remaining	Project Status
Buddy Up (Care Leavers Mentoring Project)	Oct 2015 – Sept 2017	£150,516.00	£131,701.50	£18,814.50	●

Description:	To deliver a two year Care Leavers Mentoring Project across Lincolnshire to improve outcomes for both Care Leavers (CL) and volunteers. Barnardos Volunteer Project is an extension of enhanced support for care leavers. The project aims are to improve outcomes for Care Leavers and Volunteers in the areas below: • Engagement in health services • Engagement in Education, Employment and Training (EET) • Emotional wellbeing • Physical health.
Project Lead:	Barnardo's
Project Update:	The project start date was 01 July 2015, however the Volunteer Co-ordinator started in post in September. Since then the project has received 117 expressions of Interest forms from potential volunteers of which 29 have been recruited, inducted and fully trained to support care leavers, 2 of the volunteer mentors are themselves ex care leavers. All 29 volunteer mentors have been matched with 30 young people and meet on average once a week. Of the 30, all have reported improved health, emotional wellbeing and or social networks; 11 have engaged with Health services; and 30 have engaged with EET services. Outcomes have ranged from: • An ex care leaver volunteer gaining qualifications and experience on her CV has now gained paid employment in the care sector • An Unaccompanied Asylum Seeker with no fluent English has worked with a volunteer, improving their English, so that they no longer require a translator. • A volunteer working with a young person with complex learning difficulties associated with Autism has prevented family breakdown • Another volunteer has supported a care leaver to attend mental health appointments by accompanying them to the appointment and taking care of their toddler whilst in the meetings

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	• A volunteer supporting a young person to attend weight loss classes resulting in a loss of over a stone and increased self-esteem • All young people have an outcomes star showing the distance travelled • Examples include: support to attend Weightwatchers, resulting in 1 stone weight loss. Support to cope with busy environment, resulting in increased independence. Support has also been provided around budgeting, confidence building and emotional wellbeing The uptake of young people accessing the service has not proved as successful as anticipated, due to risk assessments carried out by the leaving care team which has found that some young people are not suitable for the scheme due to their vulnerabilities and challenging behaviours.

Project Name:	Project Lifetime	Total Allocated	Total claimed	Total remaining	Project Status
Let's Get Fizzical	July 2015 – March 17	£40,720.00	£40,720.00	£0 (complete)	●
Description:	Let's Get Fizzical is an award winning project developed by national sports charity StreetGames, which engages inactive children aged 8 – 14 years in sport. Positive Futures is piloting this model in 2 disadvantaged communities in Lincolnshire; Lincoln and Boston.				
Project Lead:	Positive Futures				
Project Update:	The extended programme focused on 3 schools; 1 in Lincoln North; 1 in Lincoln South; and 1 in Boston. This started in January 2017 and ran through until March 2017. Taster sessions were delivered in each school, followed by 9 weeks of after school activities and a hub session in each area. Positive Futures again support with in kind contributions in terms of equipment, venue costs, and project coordination. Through the life of the project: • Taster sessions and follow on activities were delivered in a 14 Primary Schools and 4 Secondary Schools. • 231 participants have made 953 attendances at school based sessions • Weekly community sessions run in 4 locations. • A total of 104 children from the school's program were signposted to our LGP community sessions • 10 sessional coaches trained and employed • 16 volunteers recruited and delivered 210.5 hours between them. Outcomes to date (still being monitored)				

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	• On average 655 of young people increased their steps over the 9 week period
	• 50% have increased their physical activity levels after 6 months
	• The views of teachers, parents and children suggest they are now:
	  ○ More active
	  ○ More confident
	  ○ Better at P.E
	  ○ More engaged with other pupils
	  ○ More motivated to join clubs and community activities
	
	The following factors appear to be important in contributing to the changes experienced by children and young people:
	• The childrens enjoyment and positive views of the sessions
	• The motivational effect of the pedometers
	• The schools commitment and support (beyond just the willingness to 'host a course')
	• The availability of locally accessible community hubs and clubs to be able to continue their activity

Project Name:	Project Lifetime	Total Allocated	Total claimed	Total remaining	Project Status
Diabetes Education & Resources	Jan 2016 – Dec 2018	£169,800.00	£35,978	£133,822.00	●
Description:	With agreement from the H&WB Board, the project has now been extended to deliver: • Support people newly diagnosed with type 2 diabetes by supporting the rollout of the updated Spotlight education course across Lincolnshire • Support people both newly diagnosed and living with type 2 diabetes by working with Diabetes UK to deliver a range of interventions • Patient information packs containing support details produced both by Diabetes UK and Lincolnshire specific information • Living with Diabetes Days • Local Peer Support Groups				
Project Lead:	4 Lincolnshire Clinical Commissioning Groups				
Project Update:	The project suffered a set-back due to the delay with the signing of the NHS standard contract with Diabetes UK. Progress to				

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	date includes: • Updated Spotlight education programme extended across Lincolnshire • Promotional material for Spotlight produced • Patient booklets to support those attending the Spotlight course produced and being used as part of the updated Spotlight course • Finalised locations across Lincolnshire of the Living with Diabetes Days and Peer Support Groups with Diabetes UK. • Developed patient support resources with Diabetes UK • 1506 people have been invited to a Spotlight training event, of which 723 completed both sessions (48%, all of which set a personal target) • 2 living with Diabetes Days have been booked in for June The updated Spotlight course allows participants to invite a family member / carer, therefore reducing the number of diabetic patients able to attend the course. The CCGs are working with LCHS to increase the capacity on the courses.

Project Name:	Project Lifetime	Total Allocated	Total claimed	Total remaining	Project Status
Step Forward	Oct 2015 – Sept 2017	£226,200.00	£ actual and committed) to date is £83,436.30	£142,763.70	●
Description:	To support adults that are unemployed and have a learning disability, autism and/or a mental health condition and help them access employment opportunities, improve their employability and reduce worklessness.				
Project Lead:	Adult Specialist Services through contracted providers				
Project Update:	The Step Forward project was conceived to provide adults with autism, learning disabilities or mental health conditions the support they need to explore the steps necessary to move into employment. The project has been delivered by Boston College with county wide coverage provided by a range of partners: Grantham College, Lincoln College, First College, CLIP, Abbey Access Centre, YMCA and TaylorItex. Where possible, individuals have been given the choice over which provider they work with.				

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	Supporting learners This aspect of the service is provided by Boston College, who sub contract to a number of other providers around the county. It was agreed with Boston College that no further engagements would be made in this CCG area as the target had been exceeded and effort needed to be concentrated on supporting learners through the latter stages of the programme. Lincolnshire West CCG area is slightly behind target but activity in the middle stages of the programme have picked up. Lincolnshire South and Lincolnshire South West CCG areas have improved in terms of the number of learners engaged but is below target for activities in the programme that relate to work experience. Overall performance relating to engagements and the early sessions in the programme is good but learners are still moving through very slowly. It is taking individuals far longer to move through each stage than anticipated by the original profile. Sometimes this is due to their conditions or complex lives, but it is also sometimes due to the level of support required in order that an outcome can be achieved. The progress made by some of the participants has been outstanding and we believe that this project has definitely made a huge positive difference in their lives. We acknowledge that individuals have not always moved off benefits or into permanent paid work, but their engagement in the community and their participation in the work placements have been very beneficial. To date: • 98 learners have engaged with the programme with 45 currently engaged • 7 have accessed employment Case studies evidence: • Increased confidence • Exploring job opportunities through a volunteering role • Increased awareness of timekeeping • Developed further independence • Attended training sessions (something they would never have done before) • Positive job experience • The outcomes star is a visual tool that is helpful when trying to encourage and show people positive changes that have taken place

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Project Name:	Project Lifetime	Total Allocated	Total claimed	Total remaining	Project Status
Assisting low income households into work	Sept 2015 – Sept 2019	£98,000.00	£58,375	£39,625	●

Description:	This project is being undertaken as part of the 'Universal Support Delivered Locally' (USDL) work linked to the national Universal Credit rollout agenda. Adults in low income households will be supported to enhance their skills and helping them to improve their employment prospects and potentially increase their income.
Project Lead:	City of Lincoln in conjunction with Lincoln College
Project Update:	Due to the procurement process, the programme did not start until September 2015. Indicators show that the training programme has proved very popular and uptake for the courses has been high, in response to the high demand the spend profile for the project has been adjusted to take this into account. The ICT/employment skills courses delivered by Lincoln College are self-directed learning in the Community Education Centre, so specific sessions are not delivered – learners are working towards their own individual learning aims with tutor support. This model allows greater flexibility for the learners to work at their own pace and fit around other commitments. To date: • 168 learners have accessed 262 training units • 151 learners have passed courses and gained qualifications • 54 learners have moved into employment • 8 learners have made progression within their current employment, resulting in an increased wage. It is expected that this figure will rise as most learners have only very recently finished their learning and are entering into the tracking period. • Learners have addressed skills gaps and knowledge that was holding them back • Increased confidence and a new job in IT as a result of a the training received • Learners have been able to access courses that they previously could not afford to attend Training has included: • Forklift • IT • Employability skills • Customer service • Prepare work in adult social care

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Project Name:	Project Lifetime	Total Allocated	Total claimed	Total remaining	Project Status
Connecting Communities	July 2015 – June 2017	£120,302.00	£109,967	£10,335	●

Description:	This project is to further establish and embed sustainability into two resident led, fully constituted partnership groups within the hard pressed communities of Wainfleet and Winthorpe, by funding two part time local coordinators to help develop and co-ordinate activities.
Project Lead:	Lincolnshire East Clinical Commissioning Group
Project Update:	The programme went live on 6 July 2015. Two Community Coordinators are in post; one in Wainfleet and one in Winthorpe. **<u>Wainfleet</u>** Good relations have been established with Wainfleet St Mary Parish Council and the community coordinator is supporting them to develop their community assets i.e. refurbishment of their community hall and funding to refurbish the community play park. Three new resident volunteers have shown an interest in supporting Wainfleet Community Partnership (WCP). The Museum and Community Hub group are willing to offer a space within the library building for WCP to have a regular presence there. This will be two days per week and commence in May. This is a very positive step for the Partnership given that the coordinators role comes to an end at the end of June. Service provider partners continue to support in committee roles to allow the coordinator the time and the support she needs to engage with residents. **Activities:** • Partnership supporting the Museum & Community Hub to apply for Charitable status • 4 volunteers will run advice and signposting sessions for residents to include fund raising and lunch clubs have been arranged • 3 holiday clubs have been held for 75 local children, children and their families have been identified as being in need of healthy eating and nutrition education • Community appears to be more connected • Partnership actively campaigned to keep the GPO surgery open **<u>Winthorpe</u>** Winthorpe Community Partnership continues to make steady progress. They have recently received news that their registration to become a CIO charitable Incorporated Organisation has been successful. The partnership is now a registered charity with 6 charity trustees.

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Activities:

- Continue to attend and support monthly partnership meetings
- Continue to support monthly development group meetings to administer lottery funding
- Funding bids have been submitted to continue the coordinator post
- Police Surgeries are now up and running at the community centre to give residents a voice
- Linkages with Skegness Dementia Action Alliance has been established
- Family Stay and Play sessions organised were children are encouraged to try new things, play together and eat lots of free fruit. Parents also stayed and joined in; a total of 59 young people attended
- £1,800 from the Horncastle Health fund was applied for and secured to develop a herb/fruit garden at the Community Centre. Volunteers are now involved in developing the garden and raised beds to grow herbs and fruit
- A local Health and Wellbeing event was organised at the primary school; residents were able to talk to a host of service providers from many different areas including housing: Well-being team; LCC; Health Watch; and many more
- The 5 year Community Plan has been signed off

Local Health Interventions

Both communities are involved in delivering a pilot project in conjunction with the Skegness Neighbourhood Team. The pilot project will take the form of a mobile that will have a range of Health and social care service providers on board and go out into communities to offer information, advice, signposting etc. The aim of the project is to connect with those people who may be isolated or do not, for whatever reason, access or have trouble accessing health and advice services. This activity will take place in May 2017.

Other Activity

The CPSN (Community Partnership Support Network) Service Provider/Partners group continues to meet on a bi-monthly basis to support both Partnerships to move forward. The CPSN now meets on the first Thursday of every other month and has representation from a range of providers and partners. Each network meeting is attended by the chairman of each community partnership and both community coordinators. This partnership would be a good platform to expand the Connecting Communities Developing Assets and Resilience learning and expand this into other areas as we move forward.

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Project Name:	Project Lifetime	Total Allocated	Total claimed	Total remaining	Project Status
Lincs Carers Charter	June 2015 – December 2017	£110,600.00	£100,600	£10,000	●

Description:	To establish a quality standard 'Kite' mark recognisable to all Lincolnshire carers, providers and partners as a way of addressing some of the difficulties caused by rurality, poor transport infrastructure and sparsity of population. It will also ensure a connection with other areas of work, such as Carers & Employment, where SME's will be supported to meet best practice.
Project Lead:	Every-One (formally Lincolnshire Carers & Young Carers Partnership)
Project Update:	The project went live in June 2015 and the Kite Mark award was promptly established. Marketing/Promotional Materials been developed and distributed and the Carers Charter and Award Standards have been written – this is a 6 month process. The Application Process/Pack and accompanying documentation are now complete and in place – Carers and Young Carers were involved in producing the application form and will be represented in the assessment panel: • 14 services have achieved accreditation: ○ Abbeyview Surgery, Crowland (re-accredited Feb 2017) ○ Ermine Academy ○ Lincoln Castle Academy ○ Peterborough City Hospital ○ Wragby Surgery ○ Stamford Hospital ○ Stamford College ○ East Midlands Ambulance Service ○ Washingborough Family Practice ○ Clayton Ward - Lincoln County Hospital ○ St Johns Medical Centre, Grantham ○ Marsh Medical Practice – Manby Practice ○ Marsh Medical Practice - North Somercoates Practice ○ Greyfriars Surgery Boston • 5 more services pending and 48 services working towards the accreditation • 30 organisations have received 2 hour Carer Awareness training, which has enabled those organisations to have a better understanding of the demands on those with a caring responsibility. Examples of this include, staff being offered flexible working arrangement and increased awareness of the demands placed on Young Carers. 481 people have

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	received the training • In excess of 4,500 carers access services from accredited organisations NHS England has expressed an interest in this project as it has been highlighted to them as an example of good practice. On 26 May 2017, Sarwar Khan from NHS England visited Every-One to find out more about the project. This was followed by a visit to Wragby Surgery, where they met the deputy practice manager, carers champion and the older patients lead to find out more about the impact of the award work and awareness training.

Amount available		**£**
		1,328,661.00
Project	**Provider**	
Get Started & Get into Healthy Lives	Prince's Trust	39,999.00
Care leavers mentoring project	Barnardo's	150,516.00
Let's Get Fizzical	Positive futures	40,720.00
Diabetes Education & Resource	4 CCGs	169,800.00
Step Forward	LCC - subcontractor	226,200.00
Assisting Low Income Households	City of Lincoln Council	98,000.00
Connecting Communities	East Lincolnshire CCG	120,302.00
My Rural Life	Sortified CiC	10,096.00
Lincs Carers Charter	Every One (Lincs Carers & Young Carers Partnership)	110,600.00
Total remaining		**362,428.00**

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Health and Wellbeing Board – Decisions from 7 June 2016

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

7 June (continued)	**9e**	**Joint Health and Wellbeing Strategy Theme Updates** That the update be noted.
	10a	**Action Log of Previous Decisions** That the Action Log of previous decisions of the Lincolnshire health and Wellbeing Board be noted.
	10b	**Lincolnshire health and Wellbeing Board – Forward Plan** That the Forward Plan for formal and informal meetings presented be received, subject to a 'Update on the Sustainability and Transformation Plan being added to the agenda for the meeting on 27 September 2016
	10c	**Future Scheduled Meeting Dates** That the following scheduled meeting dates for the remainder of 2016 and for 2017 be noted. 27 September 2016 6 December 2016 28 March 2017 26 September 2017 5 December 2017 (All the above meetings to commence at 2.00pm)
27 September 2016	**13**	**Minutes** That the minutes of the previous meeting of the Lincolnshire Health and Wellbeing Board held on 27 September 2016, be confirmed as a correct record and signed by the Chairman.
	14	**Action Updates from the previous meeting** That the report be noted.
	15	**Chairman's Announcements** That the report be noted.
	16a	**Annual Assurance Report** That the report, comments made by the Board and the responses of officers, be noted.
	16b	**Prioritisation Framework for the Development of the Joint Health and Wellbeing Strategy** That the feedback from the workshop on the Prioritisation Framework be noted and welcomed. That, subject to the amendments identified by the Board in Exercise 2 of Appendix B, for developing the next Joint Health and Wellbeing Strategy for Lincolnshire, the Prioritisation Framework be agreed.
	17a	**Joint Commissioning Board – Update Report** That the report be noted. That the recommendation of the Joint Commissioning Board not to accede to the request from the concerned District Council in connection with their Disabled Fund Grant for 2016/17, be agreed.

	17b	**Lincolnshire Sustainability and Transformation Plan – (including Lincolnshire Health and Care)** That the report be noted.
	19	**An Action log of Previous Decisions** That the report be noted.
6 December 2016	**24**	**Minutes** That the minutes of the previous meeting of the Lincolnshire Health and Wellbeing Board meeting held on 27 September 2016, be conformed and signed by the Chairman as a correct record.
	27a	**Integration Self-Assessment** 1. That the details of the Integration Self-Assessment as detailed in Appendices A and B be noted. 2. That the next steps as detailed below be approved:- Each partner organisation, including all dostric councils, NHS providers and Involving Lincs, share the details of this exercise with their governing body to raise awareness of the feedback and to gain commitment from stakeholders to develop a shared improvement plan to address the issues highlighted through this exercise; Each partner is asked to identify their top three priority areas for improvement (ranked 1 to 3, with 1 being the top priority) and to feed this information back to the Programme Manager , Health and wellbeing by the end of January 2017; The organisational priorities are collated and developed into a ranked long list; A further report is presented to the health and Wellbeing Board in March 2017
	27b	**Better Care Fund** 1. That delegation be given to the Executive Director of Adult Care and Community Wellbeing, in consultation with the Chairman of the Lincolnshire Health and Wellbeing Board, the responsibility to submit the BCF Plans for 2017/18 – 2018/19 2. That the Lincolnshire Health and Wellbeing Board notes that the Joint Commissioning Board is likely to recommend that the Protection of Adult Care Services should be at the minimum amount identified in Planning Guidance to be issued after 12 December 2016, and that the Council are likely to accept this minimum amount (all subject to any material requirements in the national guidance). 3. That the Lincolnshire Health and wellbeing Board defers to the A & E Board target setting; and notes that 'stretch targets' will be set for

		both 2017/18 and 2018/19, notably with respect to Non-elective Admissions (NEA) and Delayed Transfers of Care (DTOC). 4. That agreement be given to the Disabled Facilities Grant paper (detailed at Appendix B), prepared by the Interim Director of Public health should provide a steer on the way forward to address DFGs for 2017/18 – 2018/19; but should take into account the comments raised with regard to amending the proposed target for completing DFGs from self-referral to job completion. 5. That agreement be given to Lincolnshire making an application to be a pilot 'graduation site'. 6. That agreement be given to not progressing any work in developing a contingency sum in the next BCF submission, (Subject to any material requirements in the national guidance).
	27c	**Lincolnshire Clinical Commissioning Groups Draft Operational Plan** That the Lincolnshire Clinical Commissioning Groups Draft Joint Operational Plan on a Page 2017/19 be noted.
	29a	**Health and Wellbeing Grant Fund – Update** That the Quarter 2 information concerning the Health and Wellbeing Grant Fund projects 2016 – 2017 provided in Appendix A be noted.
	29b	**An Action Log of previous Decisions** That the Action Log of previous decisions of the Lincolnshire Health and Wellbeing Board be noted.
	29c	**Lincolnshire health and Wellbeing Board – Forward Plan** That the Forward Plan for informal and informal meetings of the Lincolnshire Health and Wellbeing Board presented be received, subject to the inclusion of the items as detailed above.
7 March 2017	**35a**	**Annual Report of the Director of Public Health on the health of the people of Lincolnshire 2016** That the Annual report on the health of the people of Lincolnshire from the Interim Director of Public Health and the recommendations contained within each chapter be received.
	35b	**Integration Self-Assessment – Next Steps** 1 That the feedback from partners as detailed in Appendix A be noted. 2 That the proposal to focus on: Promoting closer integration between health, care and housing; and Progressing the Proactive Care agenda to include children with disabilities and children with special needs. 3 That delegation be given to the Executive Director of

		Adult Care and Community Wellbeing and the Interim Director of Public Health the responsibility for progressing the Next Steps under Section 1a and 1b of the report presented.
	35c	**Joint Health and Wellbeing Strategy – Engagement Plan** 1..That the approach to engagement and development of the JHWS for Lincolnshire be agreed. 2 That a lead officer be nominated from each of the representative organisations of the LHWB to undertake the prioritisation of the Joint Strategic Needs Assessment (JSNA) evidence. 3 That all members agree to report back to respective Boards and Management Teams, where appropriate, on the progress and approach being taken to the development of the JHWS.
	35d	**Better Care Fund (BCF) 2016/17 and Future Planning** 1 That the BCF performance as detailed at Appendix A for the nine months of 2016/17 be noted. 2 That the performance achieved on Non-Elective Admissions in the first nine months of 2016/17 it is recommended by the Joint Commissioning Board that £3m Risk Contingency established for this financial year will be fully utilised by the CCGs in meeting the extra cost to ULHT be noted. 3 That the Internal Audit Report at Appendix B on performance reporting be noted. 4 That the updated draft Graduation Plan at Appendix C be noted.
	36a	**Service Users with Learning Disabilities** That the report concerning Service Users with Disabilities be noted.
	36b	**NHS Immunisation and Screening for patients in Lincolnshire** 1 That the report concerning NHS immunisation and screening for patients in Lincolnshire be received. 2 That a report from the Health Protection Board concerning immunisation/screening programme performance be received at a future meeting of the Board.
3	**36c**	**District/Locality Update: North Kesteven's Health and Wellbeing Strategy** That the North Kesteven's Health and Wellbeing Strategy, as presented be received.
	37a	**'ACTion Lincs' – Tackling Entrenched Rough Sleeping in Lincolnshire (Social Impact Bonding Funding)** That the report be noted; and that an Action/Deliver Plan relating to ACTion Lincs – Tackling Entrenched Sleeping in Lincolnshire (Social Impact Bond) be received at a future meeting.

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Lincolnshire Health and Wellbeing Board Forward Plan: June 2017 – December 2017

Meeting Dates	Decision/Authorisation Item	Discussion Item	Information Item
6 June 2017 **2pm, Committee Room 1, County Offices**	**Annual General Meeting** Election of Chair and Vice Chair **Terms of Reference and Procedural Rules, roles and responsibilities of core Board members** Review and formal agreement **Alison Christie, Programme Manager Health and Wellbeing** **Housing, Health & Care Delivery Group** To receive a report on the proposed governance arrangements for the Housing, Health and Care Delivery Group **Glen Garrod, Executive Director of Adult Care & Community Wellbeing** **Integration of Services for Children and Young People with a Special Educational Needs and/or Disability** To receive on opportunities to improve outcomes for children and young people with special educational needs and disabilities through integration of commissioning and service delivery **Debbie Barnes, Executive Director Children's Services** **Developing Integrated Neighbourhood Working** To receive a report on the proposals for closing integrated working through Neighbourhood Teams **Carol Cottingham, Director for Service Re-design & Sarah Furley, STP Programme Director** **Joint Strategic Needs Assessment – Overview Report** To receive a report and presentation providing an overview of the topics in the new JSNA published Spring 2017. **Chris Weston, Public Health Consultant – Wider Determinants of Health**	**Lincolnshire Sustainability and Transformation Plan Priorities and Update** To receive an update on the delivery of the STP **Sarah Furley, STP Programme Director** **Better Care Fund 2016/17 and 2017/18** To receive an update on the BCF **Glen Garrod, Executive Director of Adult Care & Community Wellbeing**	**Lincolnshire Pharmaceutical Needs Assessment (PNA)** To receive a report by the PNA Steering Group outline the arrangements for reviewing the PNA (due to be republished in March 2018) **Chris Weston, Public Health Consultant – Wider Determinants of Health** **Health and Wellbeing Grant Fund – Update** To receive a half yearly report on the Health and Wellbeing Grant Fund projects. **Alison Christie, Programme Manager Health and Wellbeing**

Meeting Dates	Decision/Authorisation Item	Discussion Item	Information Item
26 September 2017 **2pm, Committee Room 1, County Offices**	**Development of the new Joint Health and Wellbeing Strategy** To receive the findings of the prioritisation process and stakeholder engagement for the next JHWS. **David Stacey, Programme Manager, Strategy and Performance** **JHWS Annual Assurance Report** To receive a report from the Programme Manager asking the Board to agree the Board's Assurance Report and Theme Dashboards. **Alison Christie, Programme Manager Health and Wellbeing** **Lincolnshire Pharmaceutical Needs Assessment (PNA)** To receive a report by the PNA Steering Group outline the arrangements for the statutory 60 day consultation & presenting the draft PNA document (due to be republished in March 2018) **Chris Weston, Public Health Consultant – Wider Determinants of Health**	**Sustainability and Transformation Plan** To receive an update on the delivery of the STP **STP Programme Director** **Better Care Fund 2017/2018 – 2018/19** To receive an update on the BCF **Glen Garrod, Director of Adult Care & Community Wellbeing** **Carers Strategy & Annual Report** To receive a report on the new Carer's Strategy and to update the Board on the progress being made to meet the needs of Carers as set out in the Care Act 2014. **Emma Krasinska, Commissioning Manager, Adult Care** **District/Locality Items** **East Lindsey Health and Wellbeing Strategy** To receive a report on East Lindsey's new Health and Wellbeing Strategy **Sem Neale, East Lindsey District Council**	
5 December 2017 **2pm, Committee Room 1, County Offices**	**Joint Health and Wellbeing Strategy** A presentation on the early first draft of the new JHWS. **David Stacey, Programme Manager, Strategy and Performance along with relevant Chapter Sponsors/Authors**		

Items to be timetabled

- ACTion Lincs – Tackling Entrenched Rough Sleeping in Lincolnshire (Social Impact Bond) – Action/Delivery Plan
- Health Protection Board – update on performance of vaccination & screening programmes (follow up item to the Healthwatch Report on Immunisation & Screening Services in Lincolnshire)
- Children and Young People's Commissioning Plan 2017 - 2020