Lincolnshire COUNTY COUNCIL
Working for a better future

County Offices
Newland
Lincoln
LN1 1YL

2 October 2018

Adults and Community Wellbeing Scrutiny Committee

A meeting of the Adults and Community Wellbeing Scrutiny Committee will be held on **Wednesday, 10 October 2018 at 10.00 am in Committee Room One, County Offices, Newland, Lincoln LN1 1YL** for the transaction of the business set out on the attached Agenda.

Yours sincerely

Keith Ireland

Keith Ireland
Chief Executive

Membership of the Adults and Community Wellbeing Scrutiny Committee (11 Members of the Council)

Councillors C E H Marfleet (Chairman), Mrs E J Sneath (Vice-Chairman), Mrs P Cooper, R J Kendrick, Mrs J E Killey, Mrs C J Lawton, A P Maughan, Mrs M J Overton MBE, C E Reid, M A Whittington and 1 Conservative Vacancy

ADULTS AND COMMUNITY WELLBEING SCRUTINY COMMITTEE AGENDA
WEDNESDAY, 10 OCTOBER 2018

Item	Title	Pages
1	**Apologies for Absence/Replacement Members**	
2	**Declarations of Members' Interests**	
3	**Minutes of the meeting of the Adults and Community Wellbeing Scrutiny Committee held on 5 September 2018**	5 - 14
4	**Announcements by the Chairman, Executive Councillor and Lead Officers**	
5	**Integrated Lifestyle Support Services** *(To receive a report by Carl Miller, Commercial and Procurement Manager – People Services, which invites the Committee to consider a report on the commissioning and procurement of Integrated Lifestyle Support Services (ILS), which is due to be considered by the Executive Councillor for Adult Care, Health and Children's Services between 12 and 19 October 2018)*	15 - 84
6	**Community Wellbeing Commissioning Strategy** *(To receive a report by David Stacey, Programme Manager (Strategy and Performance) which provides the Committee with details of the current Community Wellbeing Commissioning Strategy 2017-2020)*	85 - 104
7	**Carers Commissioning Strategy** *(To receive a report by Emma Krasinska, Carers Lead, Adult Care and Community Wellbeing, which provides the Committee with an opportunity to consider the Carers Commissioning Strategy 2016-2018)*	105 - 118
8	**Adult Frailty and Long Term Conditions Commissioning Strategy** *(To receive a report by Carolyn Nice, Assistant Director Adult Frailty and Long Term Conditions, which provides the Committee with details of the current Adult Frailty and Long Term Conditions Commissioning Strategy 2016 – 2019)*	119 - 130
9	**Lincolnshire Joint Strategy for Dementia** *(To receive a report by Carolyn Nice, Assistant Director Adult Frailty and Long Term Conditions, which provides the Committee with an opportunity to consider the refreshed Joint Strategy for Dementia for 2018-2021 which had been developed and co-produced with strategic partners, people who live with dementia, their families and carers to provide a strategic framework around dementia for the next three years)*	131 - 158

10	**Adult Care & Community Wellbeing 2018/19 Outturn Projection** *(To receive a report from Steve Houchin, Head of Finance, Adult Care and Community Wellbeing, which provides the Committee with the opportunity to consider the budget outturn projection for 2018/19)*	159 - 168
11	**Adults and Community Wellbeing Scrutiny Committee Work Programme** *(To receive a report by Simon Evans, Health Scrutiny Officer, which provides the Committee with the opportunity to consider its work programme for the coming year)*	169 - 174

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

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

Contact details set out above.

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www.lincolnshire.gov.uk/committeerecords

ADULTS AND COMMUNITY WELLBEING SCRUTINY COMMITTEE
5 SEPTEMBER 2018

PRESENT: COUNCILLOR C E H MARFLEET (CHAIRMAN)

Councillors Mrs E J Sneath (Vice-Chairman), R J Kendrick, Mrs J E Killey, Mrs C J Lawton, A P Maughan and C E Reid

Officers in attendance:-

Lorraine Abbott (Expert by Experience, South West Lincolnshire CCG), Dave Culy (Lincolnshire Safeguarding Adults Board Manager), Simon Evans (Health Scrutiny Officer), Justin Hackney (Assistant Director, Specialist Adult Services), Theo Jarratt (County Manager, Performance Quality and Development), Tracy Perrett (County Manager - Hospitals and Special Projects, Adult Care and Community Wellbeing), Mick Skipworth (Commissioning Officer, Specialist Services) and Rachel Wilson (Democratic Services Officer)

20 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

Apologies for absence were received from Councillor Mrs M J Overton MBE and Councillor M A Whittington.

It was also noted that Councillor M T Fido had stood down from the Committee leaving a vacancy.

An apology for absence was also received from Councillor Mrs P A Bradwell, Executive Councillor for Adult Care, Health and Children's Services.

21 DECLARATIONS OF MEMBERS' INTERESTS

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

22 MINUTES OF THE MEETING OF THE ADULTS AND COMMUNITY WELLBEING SCRUTINY COMMITTEE HELD ON 4 JULY 2018

RESOLVED

That the minutes of the meeting held on 4 July 2018 be signed by the Chairman as a correct record.

23 ANNOUNCEMENTS BY THE CHAIRMAN, EXECUTIVE COUNCILLOR AND LEAD OFFICERS

The Chairman advised that there had been some debate nationally about whether the Government's Green paper on social care for older people would actually be released in the autumn of 2018. It was also commented that the suggestion of setting up ISA's to pay for future care needs would not be feasible for those on low incomes.

Another member commented that they had been looking into approaches that other countries had taken in relation to care for older people. For example, in Japan, everyone over 40 paid a tax which paid for care. It was noted that there were various approaches that could be taken but something would need to be done to change the way that care was provided in this country in order to cope with the increasing demand.

24 SPECIALIST ADULT SERVICES COMMISSIONING STRATEGY 2018 - 2021

Consideration was given to a report which provided the Committee with details of the current Specialist Adult Services Commissioning Strategy 2018-2021. It was noted that the Council was a Commissioning Council and was organised in line with 17 Commissioning Strategies, which were in different stages of implementation and review.

It was highlighted that there was a joint commissioning approach in terms of this strategy, involving several partners, but particularly the NHS. It was also noted that there were joint strategies in place. In relation to the Specialist Adult Services Commissioning Strategy, it was noted that the Council was the lead for this, and also that officers worked very closely with the Learning Disabilities Partnership. Members were advised that a technical version and an easy read version of the document had been produced. It was noted that the work programme for the next couple of years for the Strategy was set out in Appendix One of the document (p.36-37 of the agenda pack).

Lorraine Abbott was introduced to the Committee, and provided a brief summary of some of the work that she had been involved in. She was an Expert by Experience and had been working with the CCG for two years, and had been a member of the Learning Disabilities Partnership for 10 years, as well as also chairing the Board. She mainly worked with people with mental health issues.
Officers advised that Lorraine had made a significant contribution over the years in terms of how the authority worked to make services better for people with learning disabilities. Work had been undertaken to break things down into understandable sections and develop different ways of talking about things such as direct payments.

Lorraine informed the Committee she had been involved in the annual health care strategy, as people with learning disabilities often missed annual health checks as the GP's lists tended not to record whether individuals had a learning disability, and they may not push themselves forward to say they are entitled to a health check.

Members were provided with the opportunity to ask questions to the officers present in relation to the information contained within the report and some of the points raised during discussion included the following:

- It was confirmed that many people with learning disabilities would be registered with GP's, but they may not be coded to say that the person had learning disabilities. It was also possible that the GP surgeries were not signed up to the annual health check scheme. CCG's were being asked to assert pressure on GP's to sign up for the annual health check scheme. It was noted that this was continually raised by the Learning Disabilities Partnership as an issue.
- It was commented that it was good to hear that the Experts by Experience were making a real difference and were highly involved in service development.
- It was noted that the commissioning strategy read very well. It was noted that Appendix 1 mapped out a direction of travel. It was suggested that a summary should be included which set out what had been achieved during the year.
- In terms of promoting the take up of direct payments, it was commented that there was a limitation of what could be achieved as it would not be a suitable way for some people to manage their finances. There was agreement that there people should be given a choice on whether they wanted to switch to direct payments.
- One of the Key Commissioning Actions highlighted in Appendix One was to 'agree and implement a new operating model for In-House Day Services'. It was commented that the day care model and community hubs would be a good approach to take.
- It was commented that some residential homes were boring for adults with learning disabilities (for example those adults who had to spend some time in a residential placement for medical reasons) as there were few activities or opportunities to mix with people in their own age group. It was noted that the activities offered could be strengthened through the contract management process.
- It was queried whether the voluntary sector had a part to play, and it was confirmed that it was a possibility and it was something that the commissioning teams were exploring.
- Links with the Managed Care Network was something that officers were keen to expand, particularly for working age adults in residential placements.
- There was a need for residential homes to be more of a part of the local community.
- It was queried whether there was a need for contracts to be more specific about the activities which would be provided, however, it was commented that the more detail which was specified made it more likely that costs would rise.
- It was thought that it would be beneficial to highlight some examples of good practice, as activities did vary from provider to provider.

RESOLVED

That the Committee note the content of the current Specialist Adult Services Commissioning Strategy and provided the following feedback for the Executive:

- The importance of annual NHS/GP health checks for people with learning disabilities
- A request for a brief annual report or position statement on this strategy (as well as other commissioning strategies)
- Consideration to be given to the new operating model for in house day services
- Support for strengthening the specification of residential care as part of the contract re-provision, possibly to address issues such as boredom for patients
- A recommendation for wider community engagement on changes to provision.

25 ADULT SAFEGUARDING COMMISSIONING STRATEGY

Consideration was given to a report which provided the Committee with details of the current Adult Safeguarding Commissioning Strategy. The report also provided information on the key strategic aims recently identified in the Lincolnshire Safeguarding Adults Board (LSAB) Strategy which would be considered when the Council refreshed the Adult Safeguarding Commissioning Strategy in 2019.

Members were provided with the opportunity to ask questions to the officers present in relation to the information contained within the report and some of the points raised during discussion included the following:

- Safeguarding ambassadors were being developed.
- Work was being carried out around prevention and early intervention to try and prevent low level concerns coming in as higher level concerns.
- Making Safeguarding Personal – it was highlighted that this was more about the outcomes that people wanted to achieve rather than the processes. However, it was noted that adults did have the right to make unwise decisions.
- It was queried what would happen if a person did not want support. It was acknowledged that this was a difficulty which could be faced, and there was a need to ensure that all agencies had done everything they possibly could.
- It was noted that for children, where it was not a protection issue, a 'Team around the Child' could be put in place, but there was nothing similar in terms of adult care. It was hoped that something like this could be developed. There was often a lot of low level activity that was not necessarily being co-ordinated.
- It was commented that in rural areas, people tended 'to keep an eye on' their neighbours.
- In terms of those elderly people who did not want support, if they were in private housing health and social care colleagues did not have the right to enter the property to determine whether the person needed help.
- A lot of work was being undertaken with district councils, as a lot of frontline staff did not always know where to go for information, and it was planned to create a web portal.
- It was queried whether those people who visited people daily, such as the post man for example, would know to raise concerns if they saw a person's post piling up. There was a need to develop an early intervention and prevention network.

- In terms of alleged abuse referrals, it was queried whether there was a link between inconclusive and whether the perpetrator was known to the individual, but it was concluded that this was not generally the case, and those reports which were listed as inconclusive tended to be where there was no evidence or the person withdrew their complaint.
- If a referral reached the threshold for a Section 42 enquiry, it was important to first establish the facts, and in 60% of cases no further action was required.
- It was noted that the area of higher risk was those people in their homes and care was not being delivered. If there was no lead professional in a person's life, they were more vulnerable to fraud or neglect and there may be unreported crimes.
- It was queried what happened when a person was deemed to have the capacity to make decisions, but they were not making decisions of their own volition. Members were advised that the person conducting the enquiry under Section 42 would have conversations with the person on their own.

RESOLVED

That the content of the current Adult Safeguarding Commissioning Strategy be noted, and the feedback on the importance of the following items be passed to the Council's Executive:

- Making Safeguarding Personal
- Improve new ways of working
- Continue the evaluation of safeguarding
- How can early intervention and prevention be included within safeguarding practices
- There had been significant improvements in the last few years.

26 LINCOLNSHIRE COUNTY COUNCIL ADULT CARE WINTER PLAN

It was reported that Lincolnshire County Council worked with colleagues from across the health and care system throughout the year to ensure the flow of people through the hospitals and community was maintained. The pressure on the system over the winter period would very often increase and as a result additional focus was placed on increasing support over this period. Winter monies and additional funding were normally made available via the Department of Health and Social Care which were targeted towards supporting the system during this period. During the coming year, in consultation and partnership with colleagues and organisations from across the health and care system, the Council would further explore, support and deliver:

- A rapid response service to support admission avoidance and timely discharge from hospital;
- Implement specific support for care homes, including the deployment of telemedicine and direct access to other urgent care services via clinical assessment.
- The County Council would work with the reablement and home care providers to increase capacity across the County in line with demand.

Members were provided with the opportunity to ask questions to the officers present in relation to the information contained within the report and some of the points raised during discussion included the following:

- It was noted that this was the Lincolnshire County Council part of a wider plan.
- It was felt that Lincolnshire had been quite proactive in terms of adult care for the last couple of years.
- A lot of work was being undertaken around hubs at acute sites, in Lincoln, Boston and Peterborough as well as Scunthorpe and Grimsby. It was also noted that there were staff at Lincoln who were dedicated to Northern Lincolnshire and Goole acute hospital sites.
- It was commented that it looked like a good plan was in place, and that it could get representatives from different organisations around the table was also positive
- When discharging from hospital, it was queried whether there was confidence that the system would have capacity, and members were assured that staff would ensure that the necessary services were available to ensure a smooth transition.
- It was acknowledged that there were added pressures from winter weather, but it was queried whether there had been any added pressure on health care due to the warm summer. Members were advised that there had been spikes, but there was the capacity to maintain the service as staff were able to draw on existing capacity from other areas of the organisation.
- It was highlighted that joint delays had increased from May to June 2018 and it was noted that this was due to some preliminary referrals, and it was possible that some patients were being referred too early, and this was something that officers were conscious of. A lot of hard work went into keeping the number of delays as low as possible, and work was underway to resolve the current issue.
- Members were advised that it was not always in a person's best interest to go into a residential home after leaving hospital as there was a risk they may not get back to their own home. Therefore, it would sometimes take a little longer to ensure the right care package was set up for a person when they left hospital so they could go back to their own home.
- The Commercial Team worked very hard to get care packages in place and increase capacity, and interim beds could be offered, but a person did not have to accept this. Officers agreed to add in some narrative around this in future in relation to delayed transfers of care.

RESOLVED

That the Committee supported the proposed approach to winter pressures as set out in the report.

27 ADULT CARE AND COMMUNITY WELLBEING QUARTER 1 2018/19 PERFORMANCE REPORT

Consideration was given to a report which presented performance against Council Business Plan targets for the directorates as at the end of Quarter 1 2018/19.

Members were advised that there had been three indicators highlighted by the Overview and Scrutiny Management Board. It was also highlighted that there were some areas where no data was available, particularly in relation to Public Health as there were new indicators in place. it was also noted that for some of the measures there was no current data due to a time lag in reporting times.

Members were provided with the opportunity to ask questions to the officers present in relation to the information contained within the report and some of the points raised during discussion included the following:

- In terms of number of carers supported, owing to increases in overall population 10,550 carers would need to be supported by the end of March 2019 in order to achieve this target. It was noted this target had been increased from the previous year, and members were informed that a further 494 carers would need to be provided with support for the target to be achieved.
- It was commented that there were a lot of people who were not on the carer's register who probably should be. It was also noted that the information in relation to carers was not analysed by age, the work carers up to age 30, were doing would impact on their lives later on. It was noted that this information could be analysed into age bands in the future, however, it was also noted that the statistics did include those carers under the age of 18 who were supported by the Carers Service.
- It was commented that the focus on this committee was more about the adult, and was it the role of Children's Services to ensure that young carers were supported. Members were advised that there were a number of projects going on around supporting working age carers.
- In terms of the target: 'Carers who had as much social contact as they would like', it was noted that this target had been missed by a very narrow percentage. It was noted that another survey of carers would be undertaken in November 2018. However, it was noted that the older the carer, the greater the tendency to state they were happy with the level of social contact. Work was ongoing to determine what the needs of carers were.
- The target 'Adults who received a direct payment' – there would be a need to increase this number by around 240 people over the course of the next three months. It was acknowledged that this was an ambitious target.
- It was suggested whether there was a need for support for carers to be promoted better by all, including strategic partners.
- It was noted that LPFT had been through a significant staffing review, including a recruitment process, and were now back up to capacity in terms of operational teams.
- 'People in receipt of long term support who have been reviewed' - it was commented that it was good to see that this was now on track.
- 'Adults aged 18-64 with a mental health need in receipt of long term support who have been reviewed' – it was noted that this measure was not on target and it was queried what the Council's duty in relation to this was. It was noted that this was set out in the Care Act, and there was confidence that

performance would increase for next quarter, as there were penalties if the target was not met.

- The target: 'Safeguarding enquiries where the 'source of risk' is a service provider' – it was noted that there had been a change to the way this was recorded. It was also this that this was the first occasion in which enquiries investigated by the providers had been included. This was seen as positive that providers felt able to share these incidents with the authority.
- It was commented that if officers did not feel that the right indicators were being measured then alternatives should be brought to the Committee. It was noted some of the indicators were set nationally, but they were not always the best way to measure quality of service.

RESOLVED

That the performance information presented be noted.

28 LINCOLNSHIRE SAFEGUARDING BOARDS SCRUTINY SUB-GROUP - UPDATE

Consideration was given to a report which provided the Committee with an overview of the activities of the Lincolnshire safeguarding Boards Scrutiny Sub-Group, in particular the Sub-Group's consideration of adult safeguarding matters. The Committee also had the opportunity to consider the draft minutes of the Scrutiny Sub-Group held on 9 July 2018.

The Committee discussed the role and direction of the Sub-Group going forward, and agreed that it was positive that a member of the Sub-Group attended the Lincolnshire Safeguarding Adults Board (LSAB), and that good information sharing was taking place. It was highlighted that the Independent Chair of the LSAB did value the scrutiny role of the Sub-Group. The Committee looked forward to the Sub-Group developing its activities in the coming year.

It was queried why there was a representative on the Sub-Group from the Police and Crime Commissioners office rather than a representative from Lincolnshire Police, as the latter might have information on the operational activity, and it was noted that there was a Police representative on the LSAB and the role of the Sub-Group was to scrutinise the LSAB.

RESOLVED

That the work of the Lincolnshire Safeguarding Scrutiny Sub-Group be noted.

29 ADULTS AND COMMUNITY WELLBEING SCRUTINY COMMITTEE WORK PROGRAMME

Consideration was given to a report which provided the Committee to comment on the content of its work programme.

It was noted that the Committee may want to look at in house provision of day care and community hubs in the future.

RESOLVED

That the work programme as presented the noted.

The meeting closed at 12.15 pm

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Lincolnshire COUNTY COUNCIL Working for a better future

Policy and Scrutiny

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

Report to:	**Adults and Community Wellbeing Scrutiny Committee**
Date:	**10 October 2018**
Subject:	**Integrated Lifestyle Support Services**

Summary:

This item invites the Adults and Community Wellbeing Scrutiny Committee to consider a report on the commissioning and procurement of Integrated Lifestyle Support Services (ILS), which is due to be considered by the Executive Councillor between 12 and 19 October 2018. The views of the Scrutiny Committee will be reported to the Executive, as part of its consideration of this item.

Actions Required:

(1) To consider the attached report and to determine whether the Committee supports the recommendation(s) to the Executive Councillor set out in the report.

(2) To agree any additional comments to be passed to the Executive Councillor in relation to this item.

1. Background

The Executive Councillor is due to consider a report entitled Integrated Lifestyle Support Services between 12 and 19 October 2018. The full report to the Executive Councillor is attached at Appendix 1 to this report.

2. Conclusion

Following consideration of the attached report, the Committee is requested to consider whether it supports the recommendations in the report and whether it wishes to make any additional comments to the Executive. The Committee's views will be reported to the Executive.

3. Consultation

a) Policy Proofing Actions Required

Not applicable.

4. Appendices

These are listed below and attached at the back of the report	
Appendix 1	Report to the Executive Councillor – Integrated Lifestyle Support Services

5. Background Papers

Document title	Where the document can be viewed
The documents referred to in the Commissioning Plan in Appendix A	Public Health

This report was written by Carl Miller, who can be contacted on 01522 553673 or carl.miller@lincolnshire.gov.uk.

Lincolnshire COUNTY COUNCIL *Working for a better future*

Executive Councillor

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

Report to:	**Councillor Mrs P A Bradwell OBE, Executive Councillor for Adult Care, Health and Children's Services**
Date:	**Between 12 - 19 October 2018**
Subject:	**Integrated Lifestyle Support Services**
Decision Reference:	**I016508**
Key decision?	**Yes**

Summary:

The Council currently commissions a range of services for prevention and management of unhealthy lifestyles. These services are commissioned to address single lifestyle issues or with a particular intensive focus, such as smoking cessation, NHS Health Checks and alcohol treatment services.

The conclusion of the current Local Stop Smoking Service provides an opportunity to develop a more holistic approach which supports people with multiple unhealthy behaviours to improve their health and wellbeing through the commissioning of an Integrated Lifestyle Support (ILS) service.

Alongside smoking, obesity has been identified as the single most significant public health challenge facing society. Being overweight or obese increases the risk of developing chronic diseases such as type 2 diabetes; heart disease; stroke and some cancers with a consequent demand on health and care services.

The ILS service will provide adults in Lincolnshire with high quality accessible information and direct support focusing on the four lifestyle behaviours with the greatest impact on health and wellbeing:

- Smoking of tobacco
- Physical inactivity
- Obesity (food, nutrition and a healthy weight) and
- Excess alcohol consumption.

This report seeks to present the case for commissioning an Integrated Lifestyle Support Service (ILS) focused on improving levels of physical activity, reducing weight and BMI, quitting smoking and drinking within safe limits; and the proposed model for procurement and delivery of the service .

Recommendation(s):

That the Executive Councillor:

1. Approves the commissioning of an Integrated Lifestyle Support service, and the undertaking of procurement to establish a contract, to be awarded to a single provider of a county-wide service effective from 1 July 2019.

2. Approves the scope of the commissioned service as set out in paragraph 2.7 of the Report.

3. Delegates to the Executive Director of Adult Care and Community Wellbeing, in consultation with the Executive Councillor for Adult Care, Health and Children's Services, the authority to determine the final form of the contract, to approve the award of the contract and entering into the contract, and any other legal documentation necessary to give effect to the said contract.

Alternatives Considered:

1. Negotiate a revised contract with the current provider

   The Council has an existing contract for Local Stop Smoking Services, which will form part of the scope of the proposed Integrated Lifestyle Support Service. This contract contains provision to extend through to 31 March 2020. However this is not considered to be a viable option for the following reasons:

   a. In incorporating wider behavioural support services, the associated changes to the contract scope would constitute a substantial modification within the interpretation of Public Contract Regulations 2015 and as a consequence would fall outside of the conditions required for a lawful contract modification.
   b. The current service provider has indicated that they are exiting the Public Health services market at the end of the current agreement

2. To do Nothing

   Lincolnshire County Council has a statutory duty under the Health and Care Act (2012) to protect and promote health and to reduce health inequalities. Addressing smoking prevalence is the single most effective way of discharging the Public Health duty, alongside obesity, which is also a major public health challenge. The option to do nothing is not in alignment with the Governments vision to create a "Smokefree Generation" and ceasing delivery of the Local Stop Smoking Service will bring a risk of reputational damage to the Council.

   Any short-term savings realised by Lincolnshire County Council would soon become insignificant compared with the greater long-term social

and health care costs associated with continued smoking, physical inactivity, obesity and excess alcohol consumption, and the associated long-term negative impact on health to both the NHS and Lincolnshire County Council.

3. To re-commission and procure a stop smoking service in isolation

   Clustering of risky behaviours is most common for tobacco smoking and hazardous alcohol use, and tobacco smoking and poor diet. This is followed by poor diet and physical inactivity and poor diet and hazardous alcohol use. Interventions targeting a moderate number of health risk behaviours (two to three) are more effective than those targeting only one, or those tackling more than three behaviours.

Reasons for Recommendation:

1. Scope and potential benefits of proposed service

   An effective Integrated Lifestyle Support Service can become a fundamental part of the preventative care and support system in Lincolnshire and play a significant role in reducing the burden on the overall healthcare system. By providing appropriate interventions addressing the four lifestyle behaviours with the greatest impact on health and wellbeing, it will help to decrease the need for longer-term and higher cost social care and health services, and reduce pressure on an already overburdened system.

2. The recommendation addresses and supports statutory requirements under the Health and Care Act (2012), which places specific duties on the county council to protect and promote health and reduce health inequalities, and under the Care Act 2014 for Local Authorities to enable access to services that contribute towards preventing or delaying the development of health and care needs.

3. The alternatives considered have been deemed unsuitable in delivering the required outcomes of the service.

Background

1. Strategic Drivers

1.1. Legislation, National and Local Policies

1.1.1. Nationally the drive is towards preventing illness, tackling unhealthy behaviours and helping people to remain in good health for as long as possible. The unprecedented increase in the demand for health and care services escalates the need to look for prevention opportunities. The Wellbeing Commissioning Strategy sets out the council's intentions to

provide interventions which reduce risks to health and tackle the impact of disease across primary, secondary and tertiary levels; an approach supported by the Lincolnshire Joint Health and Wellbeing Strategy which emphasises prevention and early intervention, delivering transformational change by and shifting the focus away from treating ill health and disability towards prevention and self-care.

1.1.2. The Health and Care Act (2012) places specific duties on the county council to protect and promote health and reduce health inequalities. Smoking cuts life expectancy by 10 years and is the biggest cause of premature mortality, with around 80,000 deaths in England each year. Smoking reduction services are the single most effective way of discharging the council's duty to tackle poor health.

1.1.3. Care Act (2014) emphasises the need for prevention as a way of promoting wellbeing; preventing, reducing or delaying need; providing information and advice where appropriate. The introduction of an ILS service supports the council to meet its duties under the Care Act to prevent, delay or reduce the development of needs for care and support.

1.1.4. Further analysis of strategic and policy drivers for the services are contained in the Commissioning Plan at Appendix A.

1.2. **Level of Need**

1.2.1. It is estimated that around 80% of deaths from major diseases, for example cancer and heart disease, are attributable to lifestyle factors such as smoking, excess alcohol consumption, lack of exercise and an unhealthy diet.

1.2.2. In Lincolnshire, smoking amongst adults is significantly higher than the national average (17.7% in 2016) accounting for 106,000 smokers, the third highest in the East Midlands and the highest of its nearest 16 statistical neighbours; accounting for 4,023 deaths and 17,299 potential years of life lost due to smoking.

1.2.3. All four of Lincolnshire's CCGs rank within the top five in the East Midlands for obesity prevalence, an estimated 27% of the population having a BMI over 30, accounting for 168,000.

1.2.4. A quarter of Lincolnshire's adult population is considered physically inactive (24.5%), significantly higher than nationally, the second highest in the East Midlands and the highest amongst Lincolnshire's 16 statistical neighbours, accounting for 132,000 adults inactive in the county.

1.2.5. Although alcohol consumption is broadly in line with national figures and the third lowest in the East Midlands, nearly a quarter (22.1%) of adults in Lincolnshire in 2011- 2014 were drinking over 14 units of alcohol a week, accounting for 132,000 adults.

1.2.6. The higher levels of unhealthy behaviours contribute to increased levels of disease, disability and premature mortality and subsequent burdens on the health and care system. In Lincolnshire in 2016/17 there were:

- 17,363 people on the stroke disease register;
- 32,874 people on the coronary heart disease (CHD) register;
- 49,386 people on the diabetes register;
- 128,785 people on the hypertension register.

1.2.7. Between 2014 and 2016, 1,775 people aged under 75 years died from cardiovascular diseases and more than two thirds of these were considered preventable.

1.2.8. The financial burden to the economy:

- Cardiovascular disease is estimated to cost the UK economy £29.1bn each year.
- The average combined NHS and social care cost for each person that has a stroke is about £22,000 a year and £45,000 over 5 years.
- The majority of dementia costs per year are due to informal care at £11.6bn (44.2%), with social care costing £10.3bn (39.0%) and healthcare cost £4.3bn (16.4%). The total cost is over £26bn.
- Severely obese people are 3 times more likely to need social care than those of a healthy weight, with an estimated national cost to social care of £352 million.

1.2.9. The Council currently commissions a range of services for prevention and management of single lifestyle issues or with a particular intensive focus, such as smoking cessation, NHS Health Checks and alcohol treatment services.

1.2.10. Evidence suggests that many unhealthy behaviours such as smoking, poor diet, hazardous alcohol use and physical inactivity tend to cluster together. In England around a quarter of people are engaged in 3 or more of these behaviours, and only around 6% engage in none of them.

1.2.11. There is evidence that a number of behaviours cluster within individuals and that this may be related to socio-economic characteristics, therefore integrating services across health behaviours may not only reduce wastage by treating common underlying patterns but also reduce health inequalities.

1.2.12. Clustering of risky behaviours is most common for tobacco smoking and hazardous alcohol use, and tobacco smoking and poor diet. This is followed by poor diet and physical inactivity and poor diet and hazardous alcohol use. Interventions targeting a moderate number of health risk behaviours (two to three) are more effective than those targeting only one, or those tackling more than three behaviours.

2. Current Services

2.1. The Council currently commissions a local stop smoking service (LSSS). In 2015 the contract for the service was awarded to North51 to provide a smoking cessation service, covering a maximum period of 5 years. Their Quit51 stop smoking service operates a community model of provision encompassing a core service alongside engagement with a network of sub-contracted providers offering behavioural interventions linked with medication to support people to quit smoking.

2.2. Smoking cessation services are measured for outcomes based on the level of 4-week smoking quits (Carbon Monoxide validated and non-validated) going through the service, as outlined in the Public Health England guidance. The Lincolnshire's Tobacco Control Strategy 2013 - 2018 included an ambition to secure up to 7,000 4-week smoking quits annually in order to contribute to the reduction in smoking prevalence within the county.

2.3. Based on performance for the LSSS in 2017/18, 5,207 people set a quit date, resulting in 2,351 4 week quits, a quit rate of 44.2% (down on the previous year's performance of 48.6%). Performance against the council's 4 week quit maximum capacity of 3,169 quits was 74% for the smoking cessation service.

2.4. Bionical, the parent company of North51 have stated that they are exiting from the provision of public health contracts and as such following the end of the current contract will not be submitting a tender for the new service. Agreement has been given to extend the current LSSS contract to 30 June 2019 to allow sufficient time to procure a new integrated lifestyle based service.

2.5. In addition, the council also commissions the following services aimed at preventing and managing unhealthy lifestyles; NHS Health Checks and a Substance Misuse Treatment Service, which provides specialist structured interventions to people with higher levels of alcohol dependency. Whilst neither of these services is included within the scope of the Integrated Lifestyle Support (ILS) service, both will provide referral routes in and out of the ILS and therefore form key dependencies.

2.6. The council does not currently commission any services to address weight management, physical inactivity, obesity or lower level excess alcohol consumption.

2.7. The need to re-procure the LSSS has provided an opportunity to investigate a more holistic approach which supports people with multiple unhealthy behaviours to improve their health and wellbeing through the commissioning of an ILS service. The introduction of an ILS in Lincolnshire will provide high quality, accessible information and support to eligible adults to help them adopt and maintain healthier lifestyles. It will focus on the four lifestyle behaviours that have the greatest impact on health and wellbeing:

- Smoking of tobacco
- Physical activity
- Food, nutrition and a healthy weight
- Excess alcohol consumption.

3. Market and Stakeholder Engagement

3.1. A process of market and stakeholder engagement has been undertaken to test whether the service proposed and described in section 4 is viable, affordable, deliverable and attractive potential providers. A PIN notice was published and a questionnaire issued to responders' that described the principals of the proposed service, covering scope, structure, demand, and budget. This was followed up with a market engagement event.

3.2. In both cases, feedback was sought on the market's likely interest and capacity to undertake such a service, and their preferred approach to a number of important issues impacting on the commercial model, including contract duration, coverage, mobilisation, performance management and payment mechanism. This information was used to support and inform the development of the commercial approach described below.

3.3. Further description and analysis of the market and stakeholder engagement undertaken is contained in the Commissioning Plan at Appendix A.

4. Commercial Approach

4.1. Proposed Contract Scope

4.1.1. The countywide ILS will provide a service to an individual for up to 12 months, which may include: information, sign posting, goal setting, action planning and support tailored to the client's needs. The service will be designed to change and promote sustainable lifestyle change and behaviours. This will be enabled through access to stop smoking services, extended brief interventions for alcohol, diet and nutrition, and physical activity. Individuals should be navigated to and/or provided an integrated package of service provision. The service will offer continuation activities from within local communities to build upon community resilience and prevent relapse.

4.1.2. A diagram illustrating the proposed delivery model is shown in Appendix B.

4.1.3. The service will target eligible adults aged 18 and over. They will be referred into the service through a single point of contact via the following pathways:

- People with long term health conditions, will be accepted where their GP or other health or care professional believes a lifestyle change will improve their condition.
- At risk adults who have undertaken a NHS Health Check for CVD Prevention
- People, who might require, in future, support for smoking cessation and/or weight management prior to surgery.

- Eligible carers identified through primary care or a carer's assessment.
- People who smoke and seek help to stop, particularly pregnant women.
- The Lincolnshire County Council workforce with any of the above.

4.1.4. Estimates on the scale of behaviours within the proposed criteria show the potential size of the target group is substantial. The service is looking to deliver 10,000 behavioural change outcomes per year – this can be multiple outcomes for one individual. Cost and demand analysis has been undertaken, supported by the market and stakeholder engagement process, and this indicates that the level of desired outcomes is achievable with the indicative service throughput and within the constraints of the available budget (described in more detail at Appendix A).

4.1.5. The outcomes and measures to be delivered by the service are;

- Reduction in obesity prevalence (measure: 5% weight loss).
- Increased participation in physical activity (measure; moving from inactive to active).
- Reduction in smoking prevalence (measure: 4 weeks quit status).
- Increased number of people drinking sensibly (measure: less than 14 units per week or reduce alcohol consumption by 50%).
- People supported from areas in Lincolnshire that have the greatest need.
- Percentage of people supported to eat five portions of fruit and vegetables on a 'usual' day.
- Percentage improvement in self-reported wellbeing.

4.2. **Contract Structure**

4.2.1. A single provider model for a countywide service with a single point of contact is proposed. A requirement to develop networks and a partnership approach to ensure that all of the components of the ILS are delivered using all appropriate means, will also enable the service to be flexible and responsive to needs geographically.

4.2.2. The core service aim will be to deliver high quality; evidence based behavioural support interventions to the local eligible population. The Service Provider will be required to work in collaboration with the Council and the NHS to tailor and deliver its services.

4.3. **Payment and Performance Management**

4.3.1. An affordable service that meets the Council's obligations in carrying its duties is essential. The proposed annual funding for the service is £2.75m (as described at para 5.4) and the final cost of the service will be determined via competition.

4.3.2. A full Payment by Results (PbR) payment mechanism for behavioural support, as adopted in the current LSSS contract is intended to incentivise and reward positive performance, but has proved to be unsustainable for the provider.

4.3.3. It is therefore proposed that the payment mechanism for the new contract should focus on a core or block payment related to delivery of core contract activity, with the addition of performance related payment linked to the delivery of contract outcomes. This will allow the provider greater financial viability but retain an incentive to drive improvements in the delivery of the outcomes and the performance of the contract. The pharmacotherapy costs component will remain an activity-based payment for the products supplied.

4.3.4. A clear governance, reporting and monitoring structure will be incorporated that will allow for efficient coordination of activities as well as gateways to enable any new initiatives to be introduced.

4.3.5. Contract performance will be driven through a performance framework linked to manageable, measurable and achievable targets aligned to the agreed key performance indicators. In this way the provider will be accountable against the required minimum activity expectations and the qualitative outcomes. The detail of the payment and performance mechanism is being finalised based on analysis of feedback from the Market and stakeholder Engagement, but it is anticipated that service credits will be levied where performance falls short.

4.4. **Contract Commencement and Duration**

4.4.1. An extension to the Local Stop Smoking Service Contract of 6 months has been agreed to allow for the procurement and effective mobilisation of the new contract, which will commence on 1 July 2019.

4.4.2. The proposed contract term is three years with options to extend by up to a further two years (3+1+1). Evidence from market engagement feedback suggests that this is an acceptable term for the arrangement and would provide sufficient financial assurance for the provider.

4.5. **Tender Process**

4.5.1. The Procurement will be undertaken in accordance with regulations 74 to 76 of the Public Contract Regulations 2015 under "Light Touch Regime" utilising a Restricted Procedure method. The ultimate decision as to which provider is awarded the single provider status will be based on their evaluation performance.

4.5.2. The Invitation to Tender (ITT) evaluation will focus on service quality and the capability of the provider and any organisations they may wish to form sub-contracting arrangements with to deliver the required work and quality outcomes across the county set against clearly defined financial budgetary controls.

4.5.3. The Invitation to Tender Document will include the following:

- A specification that is clear in scope, interpretation and expectations;
- Full terms and conditions;
- Appropriate award and evaluation criteria;
- A realistic, appropriate and robust performance management framework; and
- An emphasis on partnership working and effective referral/signposting mechanism.

4.5.4. Provisional Tender Timeline

Issue the ITT	5 November 2018
Evaluation period	28 January 2019 to 15 February 2019
Standstill period	11 March 2019 to 21 March 2019
Contract Award	25 March 2019
Mobilisation period	14 weeks
Go Live	1 July 2019

5. Procurement implications

5.1. Under the Public Contracts Regulations (PCR) 2015 activities relating to social care are generally dealt with under a 'Light Touch Regime' (LTR) which conforms to the general principles of the EU Procurement Directive but does not impose any strict procedural requirements. Training services are also captured under this regime.

5.2. While this regime allows for a much greater degree of flexibility as well as unique exceptions it does not mean the Council is free to award contracts without any regard to competition

5.3. The threshold at which LTR contracts must be formally competed for is procurements is €750,000 or approximately £640,000.

5.4. The financial envelope for the Lincolnshire Integrated Lifestyle Support Services is £2,750,000 per annum. The Council currently spends £1,250,000 annually on a stop smoking service, and will commit a further £1m from the public health grant (3% of the budget). In addition Lincolnshire Clinical Commissioning Groups (CCGs) have committed to provide a further £500,000 through a Section 256 Agreement.

5.5. Procuring the service will allow:

- The Council to ensure the funding provided to the Provider is part of a legally compliant and effective commercial arrangement

- A clear governance and reporting structure that will allow for efficient coordination of activities as well as gateways to enable any new initiatives
- The provider to operate with greater clarity with regard to outcomes, objectives, and the agreed scope of work.

5.6. Subject to the maximum available budget, the final cost of the service to be determined via competition.

5.7. It is the intention to issue a OJEU Notice for publication on 5 November 2018 and a Contract Award Notice will be issued on any award to a successful bidder.

5.8. To verify that there will be sufficient competition within the procurement, a Prior Information Notice was published on 12 April 2018. This initiated the process of pre-tender market engagement and enabled us to use a questionnaire to support the development of the specification. Suppliers were also invited to a Market Engagement day held on the 15th August 2018.

5.9. In carrying out this procurement the Council will ensure the process utilised complies fully with the EU Treaty Principles of Openness, Fairness, Transparency and Non-discrimination.

5.10. The procurement process shall conform with all information as published and set out in the OJEU Notice.

5.11. All time limits imposed on bidders in the process for responding to the OJEU Notice and Invitation to Tender will be reasonable and proportionate.

5.12. The Procurement will be carried out in line with the provisional timetable summarised at paragraph 4.5.4.

6. Public Services (Social Value) Act 2012

6.1. The Public Services (Social Value) Act came into force in January 2013. Under the Act the Council must before starting the process of procuring a contract for services consider two things. Firstly, how what is proposed to be procured might improve the economic social and environmental wellbeing of its area. Secondly, how in conducting the process of procurement it might act with a view to securing that improvement. The Council must only consider matters that are relevant to the services being procured and must consider the extent to which it is proportionate in all the circumstances to take those matters into account. In considering this issue the Council must be aware that it remains bound by EU procurement legislation which itself through its requirement for transparency, fairness and non-discrimination places limits on what can be done to achieve these outcomes through a procurement.

6.2. An effective Integrated Lifestyle Support Service will have the potential to reduce the burden of disease e.g. respiratory, cardiovascular, cancer to help relieve the pressure on acute hospitals, care homes and the wider health

system. The effects can be felt in the short term through reduced activity in primary care, fewer outpatients and emergency admissions to hospitals for people who have lost weight, stopped smoking and reduced their alcohol consumption. Furthermore there is a direct relationship with adult smoking and children smoking behaviour, a reduction in adult smoking contributes to a decline in children's smoking rates. Consideration will be given through the design of the procurement as to how wider social value can be obtained – e.g. through apprenticeships or the use of local service providers.

6.3. Under section 1(7) of the Public Services (Social Value) Act 2012 the Council must consider whether to undertake any consultation as to the matters referred to above. The service and the value it delivers are well understood. This is not a statutory service and it is unlikely that any wider consultation would be proportionate to the scope of the procurement.

7. Legal Issues:

Equality Act 2010

Under section 149 of the Equality Act 2010, the Council must, in the exercise of its functions, have due regard to the need to:

* Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Act
* Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it
* Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The relevant protected characteristics are age; disability; gender reassignment; pregnancy and maternity; race; religion or belief; sex; and sexual orientation

Having due regard to the need to advance equality of opportunity involves having due regard, in particular, to the need to:

* Remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic
* Take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it
* Encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low

The steps involved in meeting the needs of disabled persons that are different from the needs of persons who are not disabled include, in particular, steps to take account of disabled persons' disabilities.

Having due regard to the need to foster good relations between persons who share a relevant protected characteristic and persons who do not share it

involves having due regard, in particular, to the need to tackle prejudice, and promote understanding.

Compliance with the duties in section 149 may involve treating some persons more favourably than others.

The duty cannot be delegated and must be discharged by the decision-maker. To discharge the statutory duty the decision-maker must analyse all the relevant material with the specific statutory obligations in mind. If a risk of adverse impact is identified consideration must be given to measures to avoid that impact as part of the decision making process.

7.1 The key purpose of the service is to support people with weight management, to stop smoking, to be more active, to eat well and reduce their alcohol intake.

7.2 Smoking is linked to health inequalities and people who smoke the most tend to come from characteristic groups those from e.g. LGBT, pregnant women and long term health and disabilities. The providers' ability to provide services which advance equality of opportunity will be considered in the procurement and providers will be obliged to comply with the Equality Act.

7.3 An Impact Assessment has been completed and copy of it is appended to this report at **Appendix C**. It is emphasised that whilst the core model of the current LSSS will change to include multiple intervention opportunities, the client journey will not be adversely affected and the service will remain open to all groups regardless of protected characteristic.

7.4 There is a risk that a change of provider will impact on persons with a protected characteristic arising out of the employment impact on staff. The staff employed by the current provider will be affected by the end of the current contract. Mitigating factors will relate to the legal protections that will be in place through TUPE, if it applies, and general employment laws. The contract that will be entered into will also contain clauses requiring the contractor to comply with the Equality Act.

7.5 In these circumstances it is open to the Executive Councillor to conclude that having considered the duty it considers that if appropriate steps are taken to keep matters under review and address issues as they arise through the procurement process that any potential there is for differential impact or adverse impact can be mitigated.

8 Joint Strategic Needs Analysis (JSNA and the Joint Health and Wellbeing Strategy (JHWS)

The Council must have regard to the Joint Strategic Needs Assessment (JSNA) and the Joint Health & Well Being Strategy (JHWS) in coming to a decision.

8.1 The new Joint Health and Wellbeing Strategy (JHWS) for Lincolnshire, agreed by the Lincolnshire Health and Wellbeing Board in June 2018, has a strong emphasis on prevention and early intervention, with a clear aim to

deliver transformational change which shifts the focus from treating ill health and disability to prevention and self-care.

8.2 The ILS will support a number of these themes and priorities and so will be an important part of ensuring the delivery of the aims and objectives of the JHWS. The overarching themes of the JWHS are to:

- embed prevention across all health and care services;
- develop joined up intelligence and research opportunities to improve health and wellbeing;
- support people working in Lincolnshire through workplace wellbeing and support them to recognise opportunities to improve their health and wellbeing;
- harness digital technology to provide people with tools that will support prevention and self-care;
- ensure safeguarding is embedded.

8.3 This is in line with Health in All Policies (HiAP - Public Health England, 2016), which advocates a collaborative and systematic approach to ensure health and wellbeing considerations are incorporated into local policy making. The approach is based on the recognition that many of the most pressing health and care challenges, for example the increase in people living with chronic and long term illnesses, an ageing population, and growing health inequalities, are highly complex and often linked to wider social, cultural and economic determinants of health.

8.4 The ILS will address this through targeting people with multiple behavioural factors which place them at heightened risk of developing long term complex illnesses linked to their lifestyle.

9. Crime and Disorder

Under section 17 of the Crime and Disorder Act 1998, the Council must exercise its various functions with due regard to the likely effect of the exercise of those functions on, and the need to do all that it reasonably can to prevent crime and disorder in its area (including anti-social and other behaviour adversely affecting the local environment), the misuse of drugs, alcohol and other substances in its area and re-offending in its area

9.1 In commissioning a service that delivers positive outcomes for individuals by addressing the lifestyle behaviours with the greatest impact on health and wellbeing, the Integrated Lifestyle Support Service may contribute indirectly to the achievement of obligations under section 17.

10. Conclusion

10.1 An effective Integrated Lifestyle Support Service can become a fundamental part of the preventative care and support system in Lincolnshire and play a significant role in reducing the burden on the overall healthcare system. By providing appropriate interventions addressing the four lifestyle behaviours with the greatest impact on health and wellbeing, it will help to decrease the need for longer-term and higher cost social care and health services, and reduce pressure on an already overburdened system.

10.2 The conclusion of the current Local Stop Smoking Services contract means a procurement process needs to commence in 2018. Developing a service scope, payment, and performance management mechanism informed by extensive market engagement will help to ensure a sustainable service that will provide vital support to people with a range of health related outcomes in Lincolnshire.

10.3 The focus of the procurement will be to establish a single provider for the county that will be able to fully meet the quality requirements set out by the Council, guarantee that they are able to properly meet demand, manage the wider subcontractor market effectively as appropriate, and ultimately to strengthen the market for delivery of preventative health and care services in Lincolnshire.

Legal Comments:

The Council has the power to enter into the proposed contract.

The decision is consistent with the Policy Framework and within the remit of the Executive Councillor.

Resource Comments:

This report seeks to present the case for commissioning an Integrated Lifestyle Support Service (ILS) focused on improving levels of physical activity, reducing weight and BMI. I can confirm that the Council has a budget of £2.750m to fund the service from a range of sources including existing stop smoking service (£1.250m), existing funds available via the Public Health Grant (£1.000m) and a commitment from Lincolnshire Clinical Commissioning Groups to provide £0.500m per annum. I can also confirm that current commissioning intentions and delegated approvals recommended within this report meet the criteria set out in the Councils published financial procedures.

Consultation

Has The Local Member Been Consulted?

N/A

Has The Executive Councillor Been Consulted?

Yes

Scrutiny Comments

This report will be considered by the Adults and Community Wellbeing Scrutiny Committee on 10 October 2018. The comments of the Committee will be reported to the Executive Councillor prior to reaching her decision.

Has a Risks and Impact Analysis been carried out?

Yes

Risks and Impact Analysis

Attached at Appendix C

Appendices

These are listed below and attached at the back of the report:
Appendix A – Commissioning Plan Appendix B – Delivery Model Diagram Appendix C – Equality Impact Assessment

Background Papers

Document title	Where the document can be viewed
The documents referred to in the Commissioning Plan in Appendix A	Public Health

This report was written by Carl Miller who can be contacted on 01522 553673 and/or by email at carl.miller@lincolnshire.gov.uk .

Commissioning Plan

Integrated Lifestyle Support Service

Prepared by:

Alison Christie

Document Control	
These are the mandatory fields within the document control section that must be completed to ensure the defined approval process is followed and appropriate assurance is provided.	
Version	
Version Number:	*0.8*
Version Date:	*13 August 2018*
Description of Change:	*Updated risk register*
Sponsor Approval	
Name:	*Robin Bellamy*
Position:	*Wellbeing Commissioning Manager*
Date:	*13 August 2018*

Contents

Guidance

2.2 Develop Commissioning Plan G

1. Executive Summary

The Health and Care Act (2012) places specific duties on the county council to protect and promote health and reduce health inequalities. Smoking cuts life expectancy by 10 years and is the biggest cause of premature mortality, with around 80,000 deaths in England each year. Smoking reduction services are the single most effective way of discharging the council's duty to tackle poor health.

Alongside smoking, obesity has been identified as the single most significant public health challenge facing society. Being overweight or obese increases the risk of developing chronic diseases such as type 2 diabetes; heart disease; stroke and some cancers with a consequent demand on health and care services.

Nationally the drive is towards preventing illness, tackling unhealthy behaviours and helping people to remain in good health for as long as possible. The unprecedented increase in the demand for health and care services escalates the need to look for prevention opportunities. The Wellbeing Commissioning Strategy sets out the council's intentions to provide interventions which reduce risks to health and tackle the impact of disease across primary, secondary and tertiary levels; an approach supported by the Lincolnshire Joint Health and Wellbeing Strategy which emphasises prevention and early intervention, delivering transformational change by and shifting the focus away from treating ill health and disability towards prevention and self-care.

Lincolnshire County Council currently commissions a range of services supporting prevention and the management of unhealthy lifestyles. These address single lifestyle issues or have a specific focus, such as smoking cessation, NHS Health Checks and alcohol treatment. The need to re-procure the Stop Smoking Service (SSS) provided an opportunity to investigate a more holistic approach to supporting people with multiple unhealthy behaviours through the commissioning of an Integrated Lifestyle Support (ILS) service.

The ILS service will provide adults in Lincolnshire with high quality accessible information and direct support focusing on the four lifestyle behaviours with the greatest impact on health and wellbeing:

- Smoking of tobacco
- Physical inactivity
- Obesity (food, nutrition and a healthy weight) and
- Excess alcohol consumption.

Evidence from the Joint Strategic Needs Assessment shows that:

- The smoking prevalence rate in Lincolnshire is 16.3%, significantly higher than national and regional averages.
- 63.7% of adults in Lincolnshire are estimated to be overweight or obese significantly worse than the average for England though broadly comparable to neighbouring areas in the East Midlands.
- 24.5% of Lincolnshire's adult population were considered physically inactive, significantly higher than nationally, and second highest in the East Midlands.
- Around 21% of adults in Lincolnshire are drinking alcohol at levels that pose some risk to their health.

Evidence suggests an adult in mid-life who smokes, drinks to excess, is inactive and eats unhealthily is four times more likely to die early. In England around 25% are engaged in 3 or more of these behaviours, and only 6% engage in none. The most vulnerable and disadvantaged are more likely to lead an unhealthy lifestyle.

Changing health behaviour requires a range of approaches that combine tiers of interventions addressing the individual, the community and the population. The ILS service will focus on supporting individual behaviour change within this broader context of local communities and the wider population. Evidence shows that people who are motivated to make changes in their behaviour and receive appropriate professional support significantly increase their chances of success.

The countywide ILS service will provide tailored individual support for up to 12 months. The service will promote sustainable lifestyle change and behaviours through access to stop smoking services, brief interventions for alcohol, diet and nutrition, and physical activity. These activities will be provided from within local communities to build community resilience and prevent relapse.

The service will target eligible adults aged 18 and over. They will be referred into the service through a single point of contact via the following pathways:

- People with long term health conditions, will be accepted where their GP or other health or care professional believes a lifestyle change will improve their condition.
- At risk adults who have undertaken a NHS Health Check for CVD Prevention
- People, who might require, in future, support for smoking cessation and/or weight management prior to surgery.
- Eligible carers identified through primary care or a carer's assessment.
- People who smoke and seek help to stop, particularly pregnant women.
- The Lincolnshire County Council workforce with any of the above.

Estimates on the scale of behaviours within the proposed criteria show the potential size of the target group is substantial. Funding for the service is £2,750,000 comprising; £1,249,000 current spend on the stop smoking service, a further £1m from the public health grant and £500,000 from the Lincolnshire Clinical Commissioning Groups through a Section 256 Agreement. The service is looking to deliver 10,000 behavioural change outcomes per year – this can be multiple outcomes for one individual.

The outcomes and measures to be delivered by the service are;

- Reduction in obesity prevalence (measure: 5% weight loss).
- Increased participation in physical activity (measure; moving from inactive to active).
- Reduction in smoking prevalence (measure: 4 weeks quit status).
- Increased number of people drinking sensibly (measure: less than 14 units per week or reduce alcohol consumption by 50%).
- People supported from areas in Lincolnshire that have the greatest need.
- Percentage of people supported to eat five portions of fruit and vegetables on a 'usual' day.
- Percentage improvement in self-reported wellbeing.

Estimation on the potential pool of people in Lincolnshire with unhealthy lifestyle behaviour has been modelled based on a number of assumptions from Public Health England and the Kings Fund. This approach will be tested, as far as possible, as part of the market engagement phase and, if necessary with further benchmarking work with other commissioners. This will include whether there is sufficient funding to deliver 10,000 behavioural change outcomes per year.

Agreement is in place to extend the existing stop smoking service by a further six months to allow sufficient time to procure and mobilise the new ILS service. The contract for the new ILS service is due to be awarded in January 2019, with the new service going live in May 2019.

2. Background and Introduction

The *Health and Care Act (2012)* places specific duties on the county council to promote and improve the health and wellbeing in Lincolnshire as well as taking steps to reduce health inequalities. Health improvement measures could include: giving information and advice, providing services to promote healthy living and incentivising people to live more healthily.

Smoking remains the biggest cause of premature mortality in England, accounting for around 80,000 deaths each year and approximately 1,250 in Lincolnshire. On average a smoker reduces their life expectancy by 10 years and has an increased risk of developing more than 50 health conditions. Therefore reducing smoking prevalence is the single most effective way of discharging the Public Health duty. Alongside smoking, obesity is also a major public health challenge. Being overweight or obese increases the risk of developing chronic disease such as type 2 diabetes, heart disease, stroke, liver disease and some cancers. The burden on the health and care system will only increase unless interventions are put in place to tackle unhealthy behaviours.

The Council currently commissions a local stop smoking service (LSSS). In 2015 the contract for the service was awarded to North51 to provide a smoking cessation service, covering a maximum period of 5 years. Their Quit51 stop smoking service operates a community model of provision encompassing a core service alongside engagement with a network of sub-contracted providers offering behavioural interventions linked with medication to support people to quit smoking. The central functions include:

- Co-ordination, support and administration of core and network activities
- Management and responsibility of a core team of specialist smoking cessation advisors
- Networked smoking cessation with affiliated/contracted providers
- Hub telephone support
- Training – professional development, brief interventions and service awareness
- Promotions and social marketing initiatives.

Smoking cessation services are measured for outcomes based on the level of 4-week smoking quits (Carbon Monoxide validated and non-validated) going through the service, as outlined in the Public Health England guidance. The Lincolnshire's Tobacco Control Strategy 2013 - 2018 included an ambition to secure up to 7,000 4-week smoking quits annually in order to contribute to the reduction in smoking prevalence within the county.

Based on performance for the LSSS in 2017/18, 5,207 people set a quit date, resulting in 2,351 4 week quits, a quit rate of 44.2% (down on the previous year's performance of 48.6%). Performance against the council's 4 week quit maximum capacity of 3,169 quits was 74% for the smoking cessation service.

Bionical, the parent company of North51 have stated that they are exiting from the provision of public health contracts and as such following the end of the current contract will not be submitting a tender for the new service. Agreement has been given to extend the current LSSS contract to 30 June 2019 to allow sufficient time to procure a new integrated lifestyle based service.

In addition, the council also commissions the following services aimed at preventing and managing unhealthy lifestyles; NHS Health Checks and a Substance Misuse Treatment Service, which provides specialist structured interventions to people with higher levels of alcohol dependency. Whilst neither of these services are included within the scope of the

Integrated Lifestyle Support (ILS) service, they will provide referral routes in and out of the ILS and are therefore key dependencies.

The council does not currently commission any services to address weight management, physical inactivity, obesity or lower level excess alcohol consumption.
The need to re-procure the LSSS has provided an opportunity to investigate a more holistic approach which supports people with multiple unhealthy behaviours to improve their health and wellbeing through the commissioning of an ILS service. The introduction of an ILS in Lincolnshire will provide high quality, accessible information and support to adults in Lincolnshire to help them adopt and maintain healthier lifestyles. It will focus on the four lifestyle behaviours that have the greatest impact on health and wellbeing:

- Smoking of tobacco
- Physical activity
- Food, nutrition and a healthy weight
- Excess alcohol consumption.

3. Summary of Requirements

3.1 National Strategies and Policies

Health in all Policies (Public Health England, 2016) advocates a collaborative and systematic approach to ensure health and wellbeing considerations are incorporated into local policy making. The approach is based on the recognition that many of the most pressing health and care challenges, for example the increase in people living with chronic and long term illnesses, an ageing population, and growing health inequalities, are highly complex and often linked to wider social, cultural and economic determinants of health. The ILS will address this through targeting people with multiple behavioural factors which place them at heightened risk of developing long term complex illnesses linked to their lifestyle.

NHS Five Year Forward (NHSE 2014) highlights the current issues faced by the NHS and associated services and promotes the need for greater opportunities for better health through an increased focus on prevention and self-care. The ILS will support this aim by helping people to make healthier lifestyle choices and behavioural changes. The outcome of the approach will be to improve health and wellbeing and reduce health inequalities thereby reducing or delaying the need for costly health and social care services.

Action on cardiovascular disease: getting serious about prevention (PHE, 2016) provides an overview of the impact of CVD and outlines Public Health's role in prevention. As a result of this publication, commitments to CVD prevention have gathered momentum and it has become a priority for the NHS Prevention Board; as a result it features prominently in the *Next Steps on the NHS Five Year Forward View (2017)* and the NHS *RightCare Programme.*

Care Act (2014) emphasises the need for prevention as a way of promoting wellbeing; preventing, reducing or delaying need; providing information and advice where appropriate. The introduction of an ILS service supports the council to meet its duties under the Care Act to prevent, delay or reduce the development of needs for care and support.

Transforming the delivery of Health and Social Care – the case for fundamental change 2012 explains the need to focus on preventing illness, tackling risk factors, helping people remain in good health, supporting people to live in their own homes and integrating care around the needs of people and populations. The ILS supports this through targeting

specific individuals with risk factors that suggest they may be at risk of future need for more costly health and care support.

NICE have published a number of relevant guidance documents which provide information and best practice guidance to inform service design and delivery. This includes:

- NICE Guidance: Behaviour Change – Individual Approaches, 2014 [PH49]
- NICE Guidance; Nutrition Support in Adults, 2012 [QS24]
- NICE Guidance: Alcohol use disorders – prevention, 2010 [PH24]
- NICE Guidance: Weight management – lifestyle services for overweight or obese adults, 2014 [PH53]
- NICE Guidance: Smoking: supporting people to stop, 2013 [QS43]
- NICE Guidance: Smoking Harm Reduction, 2013 [PH45]

3.2 Local Strategies

The *Wellbeing Commissioning Strategy* sets out the council's intention to improve and protect the health and wellbeing of people in Lincolnshire. This can best be achieved when people are supported to be independent, make healthier choices and live healthier lives. The council's approach to prevention and early intervention is illustrated in Figure 1. A key component of the strategy is to work in collaboration with the NHS to address risky lifestyle behaviours. The ILS will support people across the range and levels of prevention set out below. The approach to prevention aims to provide interventions which reduce risks to health and wellbeing and tackle the impacts of disease:

- **Primary prevention** aims to prevent a condition or disease developing e.g. through promoting health behaviours;

- **Secondary prevention** aims to reduce the impact of a condition that already exists – this can include early detection and management, and lifestyle programmes to improve healthier behaviours and slow progression of the condition;

- **Tertiary prevention** aims to reduce the impact of long term illness e.g. through rehabilitation programmes and long term condition management programmes which aim to maximise capacity for living well.

Figure 1: Community Wellbeing Commissioning Strategy, 2017-2020

The new *Joint Health and Wellbeing Strategy (JHWS)* for Lincolnshire, agreed by the Lincolnshire Health and Wellbeing Board in June 2018, has a strong emphasis on prevention and early intervention, with a clear aim to deliver transformational change which shifts the focus from treating ill health and disability to prevention and self-care. The ILS support a number of these themes and priorities and so will be an important part of ensuring the delivery of the aims and objectives of the JHWS. The overarching themes of the JWHS are to:

- embed prevention across all health and care services;
- develop joined up intelligence and research opportunities to improve health and wellbeing;
- support people working in Lincolnshire through workplace wellbeing and support them to recognise opportunities to improve their health and wellbeing;
- harness digital technology to provide people with tools that will support prevention and self-care;
- ensure safeguarding is embedded.

The priorities in the JHWS are focused on the areas identified from the JSNA as being the most important health and wellbeing issues facing the county. These are:

- Carers
- Dementia
- Housing and Health
- Mental Health (Adults)
- Mental Health and Emotional Wellbeing (Children & Young People)
- Physical Activity
- Obesity

3.3 The Level of Need in Lincolnshire

Joint Strategic Needs Assessment (JSNA) for Lincolnshire is an overarching needs assessment for Lincolnshire, detailing key issues for the population and providing the evidence base for service planning and commissioning. Below is a summary of the evidence from the relevant JSNA topics linked to the lifestyle behaviours that will be addressed by the ILS service.

3.4.1 Smoking (JSNA Reduced Smoking in Adults topic)

Tobacco is the single largest cause of preventable ill health and premature death in the UK and smoking increases a person's risk of developing more than 50 serious health conditions. Smoking accounts for over one third (35%) of respiratory deaths; over one quarter (27%) of cancer deaths; and about one seventh (13%) of all cardiovascular disease deaths.

In 2017, the smoking prevalence rate in Lincolnshire was significantly higher than the national and East Midlands average prevalence; 16.3% for Lincolnshire, 15.7% East Midlands and 14.9% England[1].

Because smoking prevalence is based on survey data caution needs to be taken when looking at estimates at district level due to lower numbers of people surveyed. However it would appear from this data that prevalence is likely to be highest in Boston and lowest in South Kesteven.

[1] PHE Local Tobacco Control Profiles

Smoking during pregnancy can have adverse outcomes for maternal and child health, contributing to miscarriage, stillbirth, premature birth, low birth weight, sudden infant death and other chronic conditions which can impact on a child's development.

Smoking at the time of delivery continues to be a challenge for Lincolnshire with historically poor data quality. As of December 2017, the range of smoking in pregnancy across CCGs was 13.8% to 17.7%, in contrast with the national figure of 10.7%.

Smoking remains the leading cause of health inequalities with the most disadvantaged and vulnerable groups within society having the highest smoking rates. This very high smoking rate is one of the most significant causes of the difference in health and life expectancy between areas of high deprivation and areas of low deprivation.

3.4.2 Obesity and Weight Management (JSNA Obesity topic)

Being overweight or obese greatly increases the risk of developing type 2 diabetes, hypertension, cardiovascular disease, liver disease and some forms of cancer. Being overweight or obese is therefore associated with increased disability, reduced quality of life and premature death.

All four of Lincolnshire's Clinical Commissioning Groups (CCG) rank within the top five in the East Midlands for obesity prevalence, with 75,885 people on the obesity register and an estimated 27% (161,931 people) of the population having a BMI over 30. Lincolnshire has a hospital admission rate for obesity of 5 per 100,000 population, similar to the regional average.[2]

The percentage of adults estimated to be overweight or obese in Lincolnshire is 63.7%, significantly worse than the England level and broadly comparable to other neighbouring areas in the East Midlands. However within Lincolnshire this ranges from 60.7% in Lincoln to 67.8% in East Lindsey[3].

The NHS Health Check Programme locally assesses adults aged 40-74 years for cardiovascular disease risk that includes BMI. The assessment has identified, that of the adults screened as part of a health check, 66% have excess weight and 28% are obese.

National estimates for the levels of morbid obesity when applied to Lincolnshire suggest that there may be 11,500 adults with a BMI over 40 and 800 with a BMI over 50.[4]

3.4.3 Physical Activity (JSNA Physical Activity topic)

According to Public Health England, physical inactivity is one of the country's most urgent challenges. Without action the burden upon the health and care sector could destabilise services and have a major impact on people's mental and physical health.

Numerous national policies and NICE guidance evidences the value of regular physical activity. Physical inactivity directly contributes to morbidity and premature mortality, as well as obesity. Regular physical activity can improve health outcomes with or without weight loss. Revised physical activity guidance recommends adults achieve a minimum of 150 minutes of moderate activity, linked with at least two muscle strengthening activities and

[2] Health Survey for England 2017: Adult overweight and obesity, QOF
[3] Public Health Outcomes Framework
[4] Clinical Commissioning Policy: Complex and Specialised Obesity Surgery, NHS Commissioning Board, 2013

efforts to minimise sedentary behaviour every week. Moderate activity can be achieved through brisk walking, cycling, gardening, housework as well as sport and exercise.

In 2016/17, 24.5% (accounting for 146,938 people) of Lincolnshire's adult population were considered physically inactive, significantly higher than nationally (22.2%), the second highest in the East Midlands and the highest amongst Lincolnshire's 16 statistical neighbours. Within Lincolnshire, South Holland has nearly a third (31.9%) of adults considered inactive, the highest in the East Midlands. Boston (28.2%) and East Lindsey (27.1%) are also significantly higher than the national average and in the top 10 highest inactive populations in the East Midlands.[5]

3.4.4 Alcohol (JSNA Substance Misuse topic)

Alcohol consumption can be linked to 60 different medical conditions including liver disease, hypertension, depression, stroke, cardiovascular problems and cancers. It also contains large amounts of sugar which can be linked to weight problems and alcohol related diabetes. It is recommended that no more than 14 units of alcohol are consumed regularly per week which should be spread over 3 or more days with several drink free days per week.

In Lincolnshire, there were 14,398 hospital admissions for alcohol related conditions during 2016/17 which is 1,811 per 100,000 population. Around 22.1% (132,544 people) are drinking at levels that pose some level of risk to their health, with 6,807 of these dependent on alcohol which requires specialist treatment.

In January 2016 the Chief Medical Officer issued revised guidance on alcohol consumption which advises that in order to keep to a low level of risk of alcohol-related harm adults should drink no more than 14 units of alcohol a week. Based on the Health Survey for England, Public Health England estimate that 22.1% of adults in Lincolnshire drink over 14 units of alcohol per week. Whilst this is the second lowest in the region, household surveys are known to under-estimate alcohol consumption and some individuals who don't currently exceed government guidelines might have drunk at risky levels in the past and hence remain at risk of developing alcohol-related conditions.[6]

3.4 Literature Review

In a report commissioned by the Kings Fund*, 'Clustering of unhealthy behaviours over time: implications for policy and practice' (Buck and Frosini, 2012)* evidence suggests that many unhealthy behaviours such as smoking, poor diet, hazardous alcohol use and physical inactivity, tend to cluster together. Yet services and policies designed to help people change their behaviour tend to take a silo approach, addressing these behaviours in isolation, and not recognising that many people experience more than one behaviour simultaneously.

An adult in mid-life who smokes, drinks to excess, is inactive and eats unhealthily is four times likely to die early than someone who does none of these. In England around a quarter of people are engaged in 3 or more of these behaviours, and only around 6% engage in none of them. It is estimated that around 80% of deaths from major diseases, for example cancer and heart disease, are attributable to unhealthy lifestyle risk factors.

According to the World Health Organisation, the eight key risk factors (alcohol use, tobacco use, high blood pressure, high body mass index, high cholesterol, high blood glucose, low fruit and vegetable consumption and physical inactivity) account for as much as 61% of all

[5] Public Health Outcomes Framework
[6] Local Alcohol Profiles for England

cardiovascular deaths and over a quarter of all coronary heart disease (CHD) and is the leading cause of death worldwide.

Research suggests tackling the behaviours and risk factors that contribute to major disease such as cardiovascular disease, metabolic diseases and cancer is possible with a range of primary, secondary and tertiary prevention approaches, including lifestyle programmes, at scale. NICE guidance *PH6 on 'Behaviour change: general approaches' (2007)* points towards there being overwhelming evidence that changing people's health related behaviours can have a major impact on some of the largest causes of mortality and morbidity.

There is strong evidence to show that positive changes to behavioural risk factors during adult life will reduce an individual's risk of early death and ill health, including dementia, disability and frailty in later life. Emotional and mental health is also an important contributing factor to people's overall health and wellbeing.

The greater the number of unhealthy lifestyle behaviours the greater the risk of ill health and early death. Evidence suggests that the most vulnerable and disadvantaged are more likely to lead an unhealthy lifestyle leading to a higher risk of ill health. The strong link between deprivation and ill health underlines the importance of tackling the underlying determinants of unhealthy behaviours as well as the behaviours themselves. Therefore, individual level interventions aimed at changing unhealthy behaviours need to be complemented by interventions at a population, community and organisational level, such as public campaigns to raise awareness and prompt behaviour change.

Alongside this, there is strong evidence relating to the motivation to change (Lai et al. 2010; Ruger et al. 2008), and changing the context in which someone makes a decision – nudge interventions (Thaler and Sunstein, 2008). For any change in behaviour to occur, a person must:

- be physically and psychologically capable of performing the necessary actions;
- have the physical and social opportunity - people may face barriers to change because of their income, ethnicity, social position or other factors. For example, it is more difficult to have a healthy diet in an area with many fast food outlets or no shops selling fresh food;
- be more motivated to adopt the new behaviours, rather than continuing with old habits.

The COM-B Behaviour Change Model, recommended by NICE guidance [PH49] on '*Behaviour Change: individual approaches'* (2014) focuses on:

- goals and planning;
- work with the client to agree goals for behaviour and the resulting outcomes;
- develop action plans and prioritise actions;
- develop coping plans to prevent and manage relapses;
- consider achievement of outcomes and further goals and plans.

In conclusion, research estimates that 25% of the population engages in 3 or more unhealthy behaviours which significantly increases their risk of developing a long term condition(s) or disability. A review of academic literature and best practice suggests that addressing multiple lifestyle behaviours in a holistic way rather than in isolation offers an effective model. However, the greatest impact is achieved when interventions are sequenced; delivered as a plan of interventions developed with the individual seeking behavioural change. Therefore any behavioural change model needs to be flexible to take

account of the overlaps between the issues for individuals and look for opportunities to optimise common management approaches across a period of up to 12 months.

3.5 Engagement

3.5.1 User Engagement

From the evidence provided in section 3.4, there is a compelling case to show that by focusing on interventions that address multiple behavioural risk factors rather than on a single health related lifestyle issue provides a more holistic approach to supporting people identified as being at risk of developing co-morbidities or dying prematurely. Existing examples (see section 3.5) from elsewhere in the county provide a proven model of delivery to inform the development of the ILS in Lincolnshire.

Given this and based on advice from the council's Community Engagement Team (CET), no direct service user engagement has been undertaken to inform the development of the model. However, a recommendation of the CET is that once the contract is awarded, as part of the mobilisation phase, the service provider engages with service users to help inform how the service will be rolled out into different communities across the county.

In addition, once the service is operational, the service provider will also be expected to engage service users in ongoing evaluation of the service and to inform service improvements and developments.

3.5.2 Stakeholder Engagement

As part of developing the Joint Health and Wellbeing Strategy, a series of stakeholder engagement events were held between June to August 2017 to gather views from key stakeholders, partners and public on what the health and wellbeing priorities should be for Lincolnshire, based on the evidence in the JSNA. Over 400 people, representing 80 organisations or groups, took part in the exercise. The clear message from the engagement was the need for preventative action which prevents, reduces or minimises the escalation of health and care needs in the future. Section 3.2 details the Joint Health and Wellbeing Strategy themes and priorities, and a full report on the engagement findings is available to view on the council's website.

Preliminary engagement with key stakeholders, including primary care providers, the Lincolnshire Carers Services and Arden and Gems, was undertaken in June 2018 regarding the referral pathways. The purpose of this exercise was to gather initial feedback on how people identified 'at risk' would be referred into the ILS. Information gathered as part of this process has been used to shape the proposed model and approach. However, following market engagement further engagement and testing may be required with potential referral partners to validate all the assumptions set out in Section 4.

A formal stakeholder engagement exercise, primarily aimed at primary care partners and the Lincolnshire Carers Service, is planned for late summer 2018. The purpose will be to raise awareness of the proposed approach, seek buy-in and support, and further test the assumptions around the eligibility criteria, volume of interventions and referral pathways. A Stakeholder Communication and Engagement Plan is being developed for this phase of engagement.

3.5.3 Market Engagement

Initial market engagement has been undertaken to test whether the service proposed is viable, affordable, deliverable and attractive to potential providers. A PIN notice was published and a questionnaire issued to responders that described the principles of the proposed service, covering scope, structure, demand and budget. Feedback was sought on the market's likely interest and capacity to undertake such a service.

In total fourteen providers responded to the ILS pre-market engagement questionnaire, of which eight appear to operate services linked to both support to stop smoking and wider lifestyle support. Whilst the level of information provided does not allow for detailed evaluation of their capability, it is indicative of a good level of interest in the market and the potential likelihood of a good level of competition in any resulting tender process.

Ten of the fourteen interested providers indicated a preference for a contract with an initial term of 5 years with an option(s) to extend. A question was posed about the viability of a shorter 3+1+1 term, and whilst this was generally acknowledged to be viable, concerns were raised. Ability to offset the costs of set up and mobilisation (including property acquisition, IT and infrastructure, TUPE and recruitment) was the main reason for concerns about a shorter term, but staff stability, service development and innovation in the delivery model, and the development of trusting relationships with other local service providers, including the NHS, and residents were also key factors in the preference for a minimum 5 year term.

Based on information supplied, eight of the fourteen interested providers appear to have the capability to provide the full range of the Integrated Lifestyle Support services; however it's unclear in most cases how countywide coverage would be achieved at this stage. Where providers noted that they are unable to provide the whole range of services themselves, there was an appetite to work as a prime provider and in partnership with specialist providers as sub-contractors to deliver the full scope of services.

In response to a request to identify potential challenges in an integrated delivery model, several key points were identified. These included factors linked to the delivery of a broad range of support that could add cost (such as out of hours coverage, training needs across a range of disciplines and the management of a large number of sub-contractors); and the need to preserve specialisms, such as stop smoking service delivery in line with NCSCT and NICE guidance and the multiple ways in which support for quitting can be utilised.

The market was generally positive about the deliverability of an Integrated Lifestyle support service and the feedback around this question suggested that the annual budget and volumes indicated were achievable. However two providers did raise concerns over viability, suggesting that the funding for the volumes indicated was not viable and would only attract low quality providers who bid on the basis of an intention to challenge/change contract targets. There was an associated suggestion that there are clear fixed costs associated with delivery of individual preventative health services and setting of delivery volumes that are proportionate to the contract budget. Further, letting the market propose delivery volumes within the available budget so that the contract is realistic and achievable would be the best course of action. Further face to face market engagement, to test the volume and cost assumptions, will take place on 15 August 2018 to feed into the finalisation of the specification document.

The preferred model for nine of the fourteen is a block payment model with variations, ranging from total block payment to block for mobilisation and fixed costs based on activity, with supplier's keen to manage their exposure to financial risk by ensuring payments are at a level and frequency to cover their costs of delivery. The majority were also positive about a performance linked payment incentivisation element based on delivery of outcomes. Much of

the feedback requested a shared approach to risk, taking into account the specialist nature of some of the work, and investment required to realise outcomes, particularly for the most vulnerable.

Some helpful feedback was provided about specific measures of quality and performance that could be incorporated. However the most noticeable feature of feedback in this section was the significance of an IT system capable of capturing, monitoring and reporting measures and outcomes from across the range of services and outcomes in scope. This highlights the importance of clearly specifying any system requirements we may have, as well as management information requirements, in the tender documents.

A report on the pre market engagement is shown in Appendix A.

3.5 Review of delivery models in other local authority areas

As part of scoping and developing this commissioning plan, views were sought from other providers and commissioners of similar lifestyle services to learn from their experiences and to inform the development of Lincolnshire's specification. Within the timeframe, interviews were held with four commissioners and one provider (Derby City, Derbyshire, Norfolk and Gloucestershire); however, one of the commissioners was less developed than the Lincolnshire model.

The services reviewed as part of the benchmarking exercise varied in structure, delivery and size. A report on the benchmarking exercise is shown in Appendix B and the key points are summarised below:

3.5.1 Eligibility & Referral pathways:

- All those interviewed use a combination of professional and self-referral.
- 2 providers started with a professional only referral pathway but stated it did not work and strongly advised us not to take this route
- Can take up to 3 years to get all partners on board for a new service and around 6 months for a recommissioned one
- Criteria needs to be well defined

3.5.2 Volume and Demand (modelling/trajectory)

- Provider figures would indicate a budget requirement of £2.7 to £3.5m for 10,000 outcomes depending on model and intensity of the programme
- There was a mix of opinions on smoking groups ranging from 'we are going to run them' to 'they don't work'
- One commissioner was predicting needing 16,000 clients to get 10,000 outcomes
- Some services provided Health Checks and some signposted back to GP's

3.5.3 Delivery Model

- All providers have locality based staff who are generic and can provide multiple services
- There is a mixture of smoking services with some being direct delivery of NRT and some not. Direct delivery was achieving the better outcomes
- Most services have a separate access system for smoking clients
- All services deliver an assessment online
- Physical activity elements are mixed with some being delivered in house and others outsourced, those with outsourced provision are more comprehensive but also more expensive
- Some provided support for up to 12 months

- All providers only allowed each person to access weight management services once
- Most providers use a 8-12 week weight management programme, some more structured and intense than others depending on budget
- Some services use volunteers some do not
- Workplace services vary across each provider, some are comprehensive and have dedicated staff and some smaller or are only in the early stages of development

3.5.4 Relationships (commissioner/provider, provider/primary care etc)

- In house services vary from informal management processes to formal contracts similar to those outsourced
- Making specialist staff generic can be problematic
- Relationships with Primary Care are sensitive and take time to develop

3.5.5 IT Systems and Performance Management

- All services advised to invest in good IT systems
- All services are outcome focussed
- Single case management systems seem to work best although most use a separate one for smoking due to difference in reporting and access for this service. Those who aren't using a single data management system want one
- Smoking systems include Quit Manager and Theseus

3.5.6 Finance and Payment mechanism

- PbR has been used by most commissioners but all scrapped it as unworkable
- Direct supply of NRT works well
- Champix is done both in house or in partnership with primary care

3.5.7 Procurement and mobilisation

- There is a mix of in house and outsourced services, both have advantages and disadvantages
- Two authorities brought services in house to avoid tendering and the third stated a 5+2 contract was the minimum they would consider due to the complexity and long lead in periods
- TUPE eligibility is an issue if changing from specialist roles to generic workers
- Dialogue process may be beneficial during the tender process
- Flexibility is required within the contracts to enable services to adapt and develop as they mature

Although, due to time constraints, it was only possible to contact a limited number of other local authorities there is still valuable learning to be gained from this exercise. A professional referral route only is unlikely to bring the required results as it takes a long time to get a new service fully functional. Investment in a good front facing electronic system is highly recommended. All the areas interviewed use outcomes and generic workers but stated services evolve as the service becomes established and a flexible commissioning approach will therefore provide the best results.

If after the market engagement, further work needs to take place to scope the service there may be a requirement to engage again with other commissioners to help finalise the delivery model. This may include the need for further benchmarking on the level of demand, take up rates, cost and deliverability.

4 Recommended Model for Future Delivery

The case for commissioning an integrated lifestyle support service and the principles of the proposed delivery model were considered by the Commercial Board on 31 May 2018. The evidence presented in the report, alongside the positive market interest demonstrated the strong potential for the service. Following consideration of the options, the Board agreed the option to proceed with the commissioning and procurement of the ILS as a 3+1+1 contract.

4.1 Delivery Model

The countywide ILS will provide a service to an individual for up to 12 months, which may include: information, sign posting, goal setting, action planning and support tailored to the clients needs. The service will be designed to change and promote sustainable lifestyle change and behaviours. This will be enabled through access to stop smoking services, extended brief interventions[7] for alcohol, diet and nutrition, and physical activity. Individuals should be navigated to and/or provided an integrated package of service provision. The service will offer continuation activities from within local communities to build upon community resilience and prevent relapse.

A diagram illustrating the proposed delivery model is shown in Appendix C.

Specifically the model will:

- Deliver a differentiated offer, which encourages people to self-care. This could be based on a digital platform (for example; website based, applications, social media), which could be supplemented with telephone and face to face assistance, where appropriate. This approach is in line with the Customer's IMT Strategy.
- Deliver information advice and support across the range of lifestyle behaviours via a single point of access and assessment, which may include a single telephone number, email and website (aligned and utilising the Library of Information)
- Assess people's level of need and motivation to change their behaviour using an evidence-based approach.
- Provide health coaching and behaviour change support for those in most need, across a number of behaviours.
- Connect people and families to local community assets and services, such as local voluntary programmes, groups and commercial services to support healthier lifestyles, and will provide up to date local information on current activities and events available, to which people can be signposted to support their behaviour change.

The central function of the ILS will be to deliver an evidence based, accessible, needs led integrated behaviour change programme (in line with NICE Guidance PH49) which will include the:

- Provision of enhanced behaviour change support for the targeted population. This support should consider; digital support, face to face, and group work interventions covering a time period that is conducive with long term lifestyle changes or similar to accommodate client based goals.
- Delivery of information and support across the range of lifestyle behaviours via a single point of access which should include digital, telephone and inter-personal interventions

[7] The term 'brief intervention' is defined by NICE in the relevant guidance for each specific behavioural topic area.

- Signposting to existing services and connect people to the use of community assets to support and facilitate self-care and self-management, for both the eligible and those not eligible for direct service provision (see an example model in Appendix C).
- Targeted public health promotion with the customer and partners for public health campaigns, for example PHE's One You campaign.
- Deliver Making Every Contact Count (MECC) training for front-line staff and volunteers involved in supporting healthy lifestyles.

4.2 Referral Pathways

The service will provide referral pathways for eligible adults, aged 18 and over, who are identified as having at risk status with one or more unhealthy behaviours (smoking, obese, inactive, excessive alcohol consumption), following a NHS Health Check (for people aged 40 -74), carers assessment, clinical referral or self-referral. The referrals will be directed through a single point of contact (via website, email or telephone) to ensure ease and parity of access.

Market engagement and any follow up work with stakeholders and potential referral partners will provide an opportunity to test our assumptions about using the following referral pathways:

a) People with long-term health conditions, whose condition is likely to be made worse by unhealthy behaviours, these conditions include; diabetes, cardio vascular disease risk, liver disease, musculoskeletal conditions and coronary heart disease. Referrals for long term conditions clients will be accepted where it is felt (by the treating clinician or similar) that a lifestyle change will improve their condition and unhealthy behaviours.
    i. The provider will be required to establish a referral pathway with Primary and Secondary care services within Lincolnshire to facilitate these referrals through the single assessment point.

b) At-risk adults who have undertaken a NHS Health Check for CVD Prevention, as defined within the NHS health check criteria, enabling primary care staff to refer directly into the ILS.
    ii. The provider will be required to establish a referral pathway between Primary and Secondary care services within Lincolnshire to facilitate referrals through the single assessment point post NHS Health Check.

c) People who are engaged with the NHS's health optimisation policy regarding the future requirement for support for smoking cessation and/or weight management prior to surgery.
    iii. The provider will be required to establish a referral pathway from the Clinical Assessment Service (CAS) for the purpose of pre-elective surgery health optimisation through the single assessment point.

d) Carers being supported by Lincolnshire who may be obese, a smoker, inactive or drink to excess. Carers identified through primary care systems, e.g. NHS, Health Checks and carers that are being supported by Lincolnshire Carers Service will have the opportunity to be referred, if eligible through their unhealthy behaviour(s).
    iv. The provider, in conjunction with the Lincolnshire Carers Service, will be required to develop and implement an online self-referral form and telephone contact for this pathway; ensuring carers can access the service

without the need for clinical input and referral through the single assessment point.

e) People who smoke and seek help to stop smoking, particularly pregnant women. A specific referral pathway would need to be established with midwifery services in Lincolnshire to facilitate this component. National and local referral routes exist to refer smokers into a service (e.g. National Quitline and Maternity Services). It is expected that the introduction of CQUIN9 'Risky Behaviours' in 2018 will generate a substantial number of eligible referrals through secondary and primary care; the provider will be required to further develop relationships with the NHS Trusts and CCGs in order to maximise on this potential.
    v. The provider will be required to develop and implement an online self-referral form and telephone contact for this pathway; ensuring people who smoke can access the service without the need for clinical input and referral through the single assessment point.

f) The Lincolnshire County Council workforce with any of the above. The ILS in collaboration with the Customers Occupational Health and staff wellbeing services will develop suitable sign posting routes into the ILS for individuals who display with one or more of the targeted unhealthy behaviours.
    vi. The provider will be required to develop and implement an online self-referral form and telephone contact for this pathway; ensuring LCC staff can access the service without the need for clinical input and referral through the single assessment point.

4.3 Eligibility Criteria

4.3.1 Professional Pathway Criteria

Eligible
Adults aged over 18 who take part in one or more unhealthy behaviour who:

- Are diagnosed with one or more long-term health conditions, including; diabetes, cardio vascular disease risk, liver disease, musculoskeletal conditions and coronary heart disease.
- Are at risk (defined by Q-risk score) adults who have undertaken a NHS Health Check for CVD Prevention.
- Are engaged with the NHS's health optimisation policy regarding the future requirement for support for smoking cessation and/or weight management prior to surgery.

Ineligible
If a client fits any of the criteria below they may not join the programme:

- An unstable condition.
- Identified as not motivated to change using an approved assessment tool.
- Any medical problem which severely restricts exercise or compliance with the programme, for example; type of neurological condition.
- Individuals, where upon assessment are deemed to have a level of need significantly in excess of service capabilities, and not ready to change an unhealthy behaviour. These will be reviewed on a case by case basis with clients/or sign posting organisation informed of the rationale, if the referral is

appropriate. This approach will also be in line with motivational interviewing guidance.

4.3.2 Self-Referral

Eligible
Adults aged 18 and over, or who are smokers, who:

- Are carers and registered with the Lincolnshire Carers Service who may be obese, drink beyond recommended limits, a smoker or inactive.
- People who smoke and seek help to stop smoking, particularly pregnant women.
- All smoking adults (16+) that live and/or work in Lincolnshire.
- Smokers under 16 with parental consent or if competent under 'Fraser Guidelines'.
- The LCC workforce with any of the four targeted unhealthy behaviours.

Ineligible
Any person who sits outside of the eligibility criteria.

4.4 Potential scale of behaviours and people within the proposed criteria

The following calculations have been modelled to show the potential pool of people in Lincolnshire with unhealthy lifestyle behaviours. This is potentially an over estimation as actual evidence for the number of multiple behaviours that someone has is not available; therefore it is likely that someone will appear on more than one register. Future monitoring through the ILS service will help to identify the scale of multiple behaviours and enable more accurate estimates of the number of people who can potentially benefit from this service.

Based on these estimates, the potential size of the target group is substantial. Therefore in order to translate the multiple behaviours into the number of potential people that will need to engage with the ILS service further modelling and assumptions have been applied to each priority target group. These are explained in further detail below. Market engagement will need to test if these figures are too large and seek views on how we manage the size of the target group. This will include validating the eligibility criteria in section 4.3 to ensure the service delivers at least 10,000 outcomes per year.

4.4.1 Long Term Conditions

This table is for the Lincolnshire population on selected disease registers (taken from QOF – 2016.17). Each group has then had the general Lincolnshire prevalence of behaviours applied as a proxy for the behaviours which exist within the cohort, as no data is available on the specific behaviours of people on disease registers. This suggests the total estimated number of behaviours that exist within people on each disease register.

	Total people on disease register	*Potential smokers (at 16.3%)*	*Potential obese (at 27%)*	*Potential inactive (at 24.5%)*	*Potential excess alcohol (at 22.1%)*	*Estimated total number of behaviours*
Atrial Fibrillation	*18,726*	*3,052*	*5,055*	*4,587*	*4,318*	*17,012*
Coronary Heart Disease	*33,424*	*5,448*	*9,024*	*8,189*	*7,386*	*30,047*
Cardiovascular Disease - Primary Prevention	*5,464*	*891*	*1,475*	*1,338*	*1,207*	*4,911*
COPD	*17,487*	*3,052*	*5,056*	*4,588*	*4,138*	*16,834*
Heart Failure	*9,123*	*1,847*	*2,463*	*2,235*	*2,016*	*8,561*
Hypertension	*128,785*	*20,992*	*34,766*	*31,547*	*28,457*	*115,762*
Peripheral Arterial Disease	*5,641*	*919*	*1,523*	*1,382*	*1,246*	*5,070*
Stroke and Transient Ischaemic Attack	*17,607*	*2,870*	*4,753*	*4,313*	*3,891*	*15,827*
Diabetes	*49,386*	*8,050*	*13,334*	*12,099*	*10,914*	*44,397*
Osteoporosis	*2,304*	*376*	*622*	*564*	*509*	*2,071*
Rheumatoid Arthritis	*5,506*	*897*	*1,486*	*1,348*	*1,216*	*4,947*
Total	***293,453***	***48,394***	***79,557***	***72,190***	***65,298***	***265,439***

On the hypertension register alone this suggests over 115,000 behaviours, providing assurance that the criteria would not limit the potential for a provider to access sufficient suitable clients to fulfil outcomes targets. In total there are likely to be around 265,439 behaviours across all registers, however it would be assumed that some people would appear on more than one register which would overestimate the total pool.

In order to estimate the possible number of people on more than one disease register the findings from Public Health England's report into multi-morbidity[8] has been used. Based on this report, the average multi morbidity prevalence across Lincolnshire is 26.2%. Modelling this prevalence rate to the 265,439 behaviours figure means that potentially 69,545 people are likely to have multiple long term conditions and therefore appear on more than one disease register. Assuming these are therefore double entries, the possible total behaviour figure is 195,894. By then applying the Kings Fund's modelling assumption (see section 3.4 – 25% of people are engaged in 3 or more behaviours), the potential number of people in this cohort engaged in 3 or more behaviours is estimated to be 48,973.

4.4.2 Health Checks

Using the most recent data for 2017-18[9], 39,085 people were offered an appointment and 25,023 people received one (64% take up rate, higher than the national average). Applying general population behaviour rates suggests a pool of 22,675 behaviours may exist within the 25,023 clients.

[8] Prevalence of multi-morbidity by local areas in England (derived from observed prevalence estimates provided by Barnett and colleagues) (2017)
[9] https://www.healthcheck.nhs.uk/commissioners_and_providers/data/

	People receiving a health check in 2017/18	*Potential smokers (at 16.3%)*	*Potential obese (at 27%)*	*Potential inactive (at 24.5%)*	*Potential excess alcohol (at 22.1%)*	*Estimated total number of behaviours*
Health checks	*25,023*	*4,079*	*6,756*	*6,310*	*5,530*	*22,675*

By then applying the Kings Fund modelling assumption (as referenced in section 4.4.1), the potential number of people in this cohort with 3 or more behaviours is estimated to be 5,671.

4.4.3 Health Optimisation

Hospital Episodes Statistics (HES) provide data on the number of people who receive hospital treatment. Based on the inpatient treatment codes which pertain to hip and knee replacements, in Lincolnshire the number of people during 2015/16 who received a hip or knee operation was 1,067. This however is likely to be an over estimation as the HES codes may also take account of more general hip and knee operations which are not covered by the health optimisation policy.

As the health optimisation policy will apply to people requiring support for weight management and/or smoking cessation prior to surgery, the Kings Fund modelling assumption has not been applied to this cohort, therefore estimated number of people is 1,067

4.4.4 Carers

In 2016/17, the number of unpaid adult carers known to the council was 20,300, although only 8,100 received a service[10]. Applying general population behaviour rates suggests a pool of 7,281 behaviours may exist within the 8,100 clients

	Total carers	*Potential smokers (at 16.3%)*	*Potential obese (at 27%)*	*Potential inactive (at 24.5%)*	*Potential excess alcohol (at 22.1%)*	*Estimated total number of behaviours*
Unpaid Carers receiving a service from the council	*8,100*	*1,320*	*2,187*	*1,984*	*1,790*	*7,281*

By then applying the Kings Fund modelling assumption (as referenced in section 4.4.1), the potential number of people in this cohort with 3 or more behaviours is estimated to be 1,820.

4.4.5 Pregnant Women who smoke

7,302 Lincolnshire women gave birth in 2016. As the criteria is only for smoking in pregnancy, the applied behaviour rate at 17.7% (the smoking prevalence rate for 2016 has been applied rather than the 2017 rate of 16.3%, as it collates with the birth year) would equate to 1,292 potential behaviours. This is likely to be an overestimation as many will give up smoking upon becoming pregnant without the need for supportive services. However, Smoking at Time of Delivery data is only an indicator of those still smoking at the end of pregnancy and therefore underestimates due to all of those for whom service intervention supported them to quit.

[10] Source: JSNA Carers topic

The Kings Fund modelling has not been applied to this cohort as it is only dealing with a single behaviour. Therefore the potential number of people in this cohort is estimated to be 1,292.

4.4.6 Lincolnshire County Council Workforce

Although total employment fluctuates, there are around 4,500 within the LCC workforce. Applying general population behaviour rates suggested an estimated 4,047 behaviours may exist within a cohort of 4500 clients.

	Approximate workforce	*Potential smokers (at 16.3%)*	*Potential obese (at 27%)*	*Potential inactive (at 24.5%)*	*Potential excess alcohol (at 22.1%)*	*Estimated total number of behaviours*
LCC Staff	*4500*	*734*	*1215*	*1103*	*995*	*4047*

By then applying the Kings Fund modelling assumption (as referenced in section 4.4.1), the potential number of people in this cohort with 3 or more behaviours is estimated to be 1,012.

Based on all the modelled assumptions detailed above, the total overall possible behaviour pool is 301,801 of which 59,835 people will potentially have 3 or more behaviours. Based on evidence from the LSSS, a 50% depreciation rate[11] has been applied in order to estimate the potential number of people who will need to engage with the ILS in order to achieve at least 10,000 outcomes.

Target cohort	*Potential population size*	*Number of invitations (if applicable through professional referral pathway) (based on 50% invited)*	*Number of people engaging with the ILS and setting outcome targets (based on a 50% drop off rate)*	*Potential number of people who achieve an outcome (based on a 50% drop off rate)*	*Potential range of outcomes that could be achieved*
Long term conditions	*48,973*	*24,500*	*12,250*	*6,125*	*6,125 – 18,375*
Health checks	*5,671*	*2,800*	*1,400*	*700*	*700 – 2,100*
Health optimisation	*1,067*		*534*	*267*	*267 – 801*
Carers	*1,820*		*910*	*455*	*455 – 1,365*
Pregnant women who smoke	*1,292*		*646*	*323*	*323*
Workforce	*1,012*		*506*	*253*	*253 – 759*
Totals	***59,835***		***16,246***	***8,123***	***8,123 – 23,723***

[11] 50% of people identified as eligible for the service will engage and set an outcome target, of those that set a target only 50% will then go onto achieve it.

From this assumption, an estimated 16,246 people will need to be engaged with the potential of achieving between 8,123 (ie one person achieving one outcome) to 23,723 outcomes (ie one person achieving 3 or more outcomes).

The estimated number of people that will potentially need to be engaged to achieve at least 10,000 outcomes corresponds with feedback from another commissioner which also predicted needing 16,000 clients to achieve the same level of outcomes. Subject to feedback from the market, it may be necessary to do further testing with other commissioners and potential referral partners to validate these assumptions and to test whether the allocated funding will be sufficient to engage enough people to deliver the expected number of outcomes.

4.5 Costs

The table below shows the estimated costs for the ILS service. These figures have been calculated using known information from the existing stop smoking service for the cost and demand of pharmacotherapy treatment. In addition, the unit cost of sending an invitation letter is based on the data from NHS Health Checks. The potential number of letters that may need to be sent is based on the assumptions that 27,300 referrals will be made through the professional pathway as a result of being on a disease register or following a health check (see last table in section 4.4). Taking into account these estimated costs, the amount of potential funding available for delivery the lifestyle behaviour support element of the ILS is £1,565,610. This equates to £156.56 per outcome or £192.74 per individual (based 8,123 people achieving one or more outcomes).

Market engagement, along with any further benchmarking with other commissioners, will provide an opportunity to test the predicted costings set out in the table below. In addition to testing whether there is sufficient funding to deliver at least 10,000 outcomes, the market will be asked to feedback on the potential infrastructure and digital support costs.

Activity	Potential number	Unit Cost	Total
Infrastructure			£100,000
Digital Support			£50,000
Lifestyle Behavioural Support	10,000		£1,565,610
Pharmacotherapy NRT*	3,711	£110	£408,210
Pharmacotherapy – Champix*	2,474	£220	£544,280
Invitations**	27300	£3	£81,900
Total			**£2,750,000**

*****Based on validate data from the current stop smoking service

** Based on current costs for NHS Health Check letters – ie search cost for Arden and Gems and the and cost of sending invite to client

4.6 Funding

The Council currently spends £1,249,000 annually on a stop smoking service, and commits no public health grants towards tackling obesity. We will commit a further £1m from the public health grant (3% of the budget). In addition Lincolnshire Clinical Commissioning Groups (CCGs) have committed to provide a further £500,000 through a Section 256 Agreement. The total budget for an ILS service is therefore £2,750,000 per annum.

4.7 Benefits

A countywide branded ILS approach would:

- Significantly increase activity resulting in substantial behaviour change over the life the contract.
- Improve health and reduce health inequalities.
- Reduce cost to public services.
- Reduce the need for health and care interventions.
- Reduced morbidity and mortality deemed preventable.
- Improve opportunities for engagement within communities, thereby reducing social isolation.
- Improve productivity and reduce absenteeism.
- Offer multiple effects to family members, partners and children of clients through a whole system approach.
- Satisfy obligations within the public health grant to tackle obesity.

4.8 Measures and Outcomes

- Deliver 10,000 outcomes per year – this can be multiple outcomes for one individual.
- Reduction in smoking prevalence (measure: 4 weeks quit status).
- Reduction in obesity prevalence (measure: 5% weight loss).
- Increased participation in physical activity (measure; moving from inactive to active).
- Increased number of people drinking sensibly (measure: less than 14 units per week or reduce alcohol consumption by 50%).
- People supported from areas in Lincolnshire that have the greatest need.
- Increased number of people supported to eat five portions of fruit and vegetables on a 'usual' day.
- Percentage improvement in self-reported wellbeing.

4.9 Key Risks

A full risk register has been developed for the ILS which will be kept under constant review, a copy of the register can be found in Appendix E. Top five risks identified are:

Risk Title	Probability	Impact	Score	Mitigation / Update
Lack of CCG commitment regarding budget	3	3	9	Section 256 agreement drafted. Not yet signed. To be escalated to Project Board
Lack of clarity around Health Optimisation policy and lack of joined up approach with all four CCG's	3	3	9	Contact made with LWCCG. To be escalated to Project Board
Lack of engagement from key referrers	3	3	9	Increase volume of direct engagement with key referrers (e.g. General Practice via LMC, Practice Manager and GP's)
Failure to attract suitable bidders	2	3	6	Further market engagement planned for 15th August 18 following further development of commissioning plan and service specification. Good level of interest.
Failure to accurately cost	2	3	6	Finance are part of the Project

the service				Team. Assumptions to be tested as part of market engagement.

Risk Scoring
Probability: 1 – Hardly ever; 2 – Possible; 3 – Probable; 4 – Almost certain
Impact: 1 – Negligible; 2 – Minor; 3 – Major; 4 - Critical

4.10 Dependencies

4.10.1 Wellbeing Service

Lincolnshire County Council commissions a Wellbeing Service which is designed, following an assessment, to offer a range of services to promote independent living. The service is preventative, enhances wellbeing and aims to reduce or delay escalation into statutory support services. The Wellbeing Service is not a behavioural support service therefore there is no duplication is service provision. However, the Wellbeing Service does report on a number of health and wellbeing outcomes which the ILS will help to deliver.

4.10.2 Substance Misuse Treatment Service

Lincolnshire County Council commissions a specialist community alcohol and drug treatment service which provides a personal recovery plan tailoring treatment to meet individual needs. This work may include brief talking therapies or more complex structured treatment and clinical services such as opiate substitute medication or alcohol/drug detoxification. Whilst the ILS includes providing support and interventions to help people manage their alcohol levels, if the level of support needed is beyond low level support and interventions (ie requiring more than 4 sessions), then individual may need to be referred into the structured treatment service for more specialist support.

4.10.3 NHS Health Checks

The proposed model for the ILS does not include the commissioning of the NHS Health Check programme as this is commissioned separately in line with national guidance. However, the Health Check mechanism will be an important referral route into the ILS service, specifically for adults aged 40-74 who are identified as being at risk as a result of having a health check.

4.10.4 Making Every Contact Count (MECC) (HEE, 2016)

MECC is an approach to behaviour change that utilises the many day to day interactions that organisations and individuals have with other people in order to support them to make positive changes to their physical and mental health and wellbeing. It encourages opportunistic concise healthy lifestyle information which enables people to engage in conversations about their health at scale across organisations and populations. The successful provider will be required to train any front line staff and volunteers in MECC.

4.10.5 Primary Care including Neighbourhood Teams

The professional referral pathways (people with a diagnosed long term condition included on a disease register, following an NHS Health Check or through the Health Optimisation policy) are dependent on GPs/primary care identifying appropriate individuals with risk behaviours and referring them into the ILS service through the single point of contact. The successful provider will be required to establish referral mechanisms to enable primary care professionals to refer into.

4.10.6 Midwifery Service

A specific referral pathway would need to be established with midwifery services in Lincolnshire to facilitate this component. National and local referral routes exist to refer smokers into a service (e.g. National Quitline and Maternity Services). It is expected that the introduction of CQUIN9 'Risky Behaviours' in 2018 will generate a substantial number of eligible referrals through secondary and primary care; the provider will be required to further develop relationships with the NHS Trusts and CCG's in order to maximise on this potential.

4.10.7 Carers First/Lincolnshire Carers Service

The Lincolnshire Carers Service is delivered in partnership by Lincolnshire's Service Centre and Carers FIRST. The Carer's Assessment Tool (Carer's Star) includes a health element which could highlight any specific unhealthy behaviours of the carer. Carers FIRST already have access to Mosaic to enable them to directly refer into the Carer's Service system. The provider will need to work with the Lincolnshire Carers Service to establish an appropriate self-referral mechanism for carers following a carer's assessment.

4.10.8 Diabetes Prevention Programme

The Diabetes Prevention Programme is a primary prevention intervention targeting people who are pre-diabetes and not yet identified on the diabetes disease register. Whereas, the ILS is a secondary prevention intervention which will target people that have already been diagnosed as having diabetes. Following the initial assessment, the ILS will be able to signpost people identified as being pre-diabetic and outside of the scope of the ILS to the Diabetes Prevention Programme but there will be no direct referral route from the Diabetes Prevention Programme into the ILS.

5 Impact Assessment

An initial Impact Assessment has been completed to assess the positive and adverse impacts of the proposed change on people with protected characteristics and identify ways of mitigating or eliminating any adverse impacts. A copy of the Impact Assessment is provided in Appendix F and includes the following key impacts:

Positive impacts:

- The ILS will increase levels of weight loss and physical activity, and as result will reduce the risk of developing long term conditions including type 2 diabetes, CVD, and some cancers for the targeted population.
- People with long term conditions, who have an increased risk of disability, will be supported to make lifestyle changes.
- The ILS will improve health and reduce health inequalities for adults aged 40-74 in Lincolnshire who are identified as 'at risk' following a NHS Health check, social care assessment or other clinical referrals.

Negative impacts:

- Significant proportions of the adult population outside of the target age range for NHS Health Checks (40-74 years) are overweight/obese, inactive or are smokers. Consequently, if the service reaches its capacity within the target age group, younger and old people risk not having their needs adequately addressed.
- People with a learning disability also have complex health needs, co-morbidities, higher rate of premature mortality than the population as a whole and as a result appear on the disease registers. They are also more likely to be inactive and obese.

If the ILS is not targeted appropriately or made accessible to people with a learning disability then the health inequalities may be exacerbated. One of the main referral routes for the ILS will be through the NHS Health Check; these are aligned with the delivery of the personal health checks for people with learning disabilities; however, less than 30% of adults in Lincolnshire with a learning disability currently access their health check.

- Levels of overweight and obesity are higher in men than in women; however, only 14% of referrals to previously commissioned weight management services were for men. If the ILS weight management services are not accessible or attractive to men it is possible that this health inequality may increase.

The Impact Assessment will be kept under review throughout the commissioning process and updated accordingly. Feedback from ongoing engagement with key stakeholders as part of developing the proposed model, as well as market engagement with providers through a Supplier Day in August will be gathered and used to inform any changes.

A Privacy Impact Assessment will also need to be undertaken as part of the mobilisation phase to ensure robust mechanisms are in place to transfer service data from the current stop smoking service to the ILS.

6 Managing the Changes

A Governance Board has been set up to provide overall responsibility and oversight for the commissioning work. Membership includes the Executive Councillor for Adult Care, Heath and Children's Services; Executive Councillor for NHS Liaison and Community Engagement, Director of Public Health and senior officers from Public Health and the Commercial Team – People Services.

An ILS Project Team has been established to oversee the commissioning, pre-procurement, procurement and mobilisation of the new service. This group is made up of representation from Public Health, the Commercial Team – People Services and Finance.

Public Health also continues to be in dialogue with other key stakeholders and referral partners to ensure all the evidence is gathered to inform the development and future delivery of the ILS.

Agreement has been reached to extend the current stop smoking service contract for a further six months, so the service is now due to end on 30 June 2019. This extension builds capacity into the project plan by allowing time for a longer mobilisation period to ensure a smoother transition and hand over between the two services.

7 Key Milestones

Activity/Milestone	Deadline	Progress
Commissioning Plan written	31 July 2018	Completed
First Impact Assessment	31 July 2018	Ongoing
Draft Specification written	31 July 2018	Completed
Market Engagement	15 August 2018	Started
Procurement Plan written	7 September 2018	To commence

Final Specification written	30 September 2018	Started
Adult Care & Community Wellbeing Scrutiny	10 October 2018	To commence
Executive Councillor decision	17 October 2018	To commence
Contract Notice	October 2018	To commence
ITT Period	Oct – Nov 2018	To commence
ITT Evaluation	Nov – Dec 2018	To commence
Award contract	w/c 7 January 2019	To commence
Implementation/Mobilisation	Feb – May 2019	To commence
Go live	May 2019	To commence

8 Appendices

Appendix A – Pre Market Engagement Summary

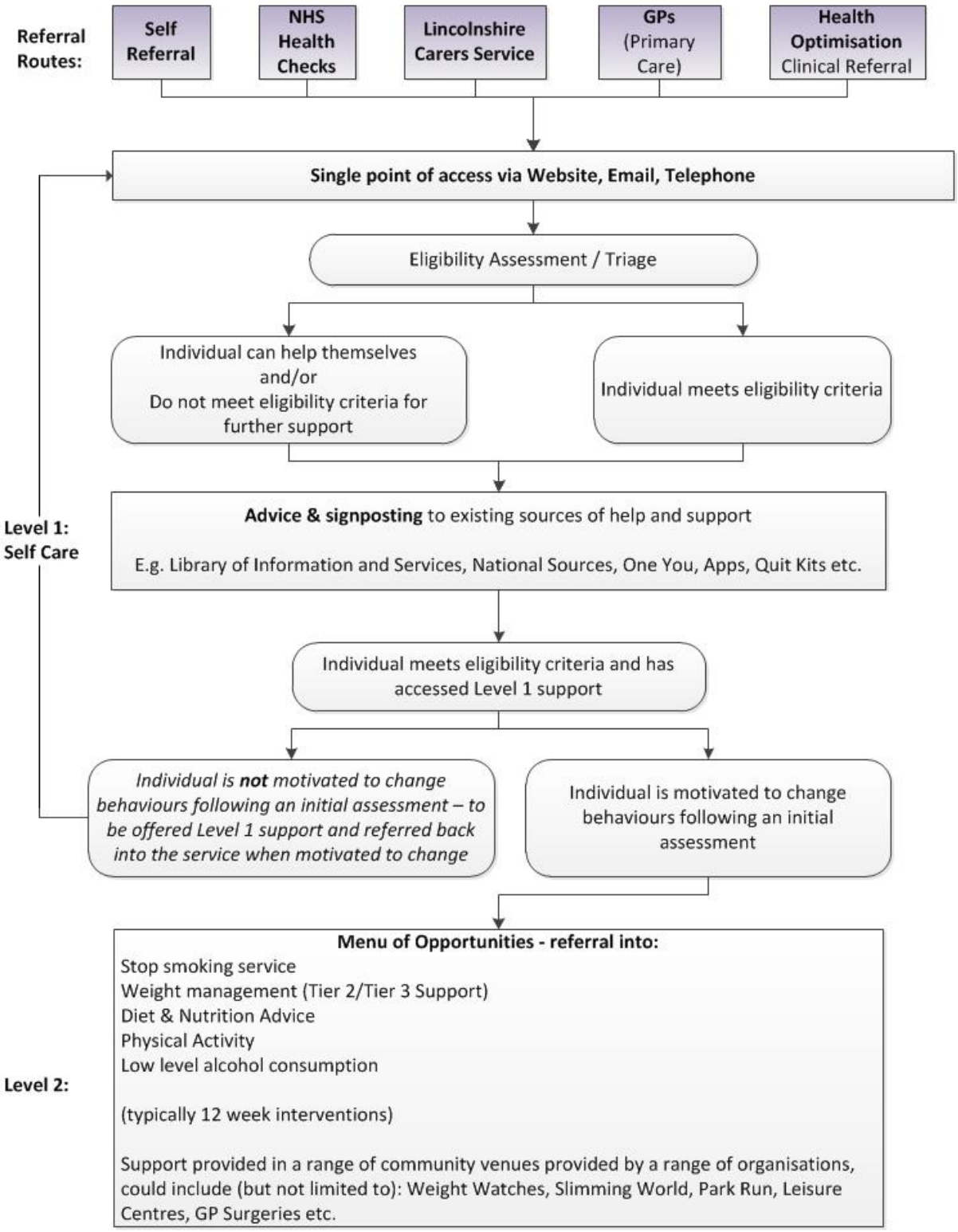
Pre-Market Engagement Summar

Appendix B – Benchmarking Report

ILS Benchmarking Report_Appendix B.d

Appendix C

Lincolnshire's Integrated Lifestyle Support Service



At any point the service can refer out to existing intensive support programmes where clients meet the eligibility criteria, e.g. Substance Misuse Treatment Service, Wellbeing Service

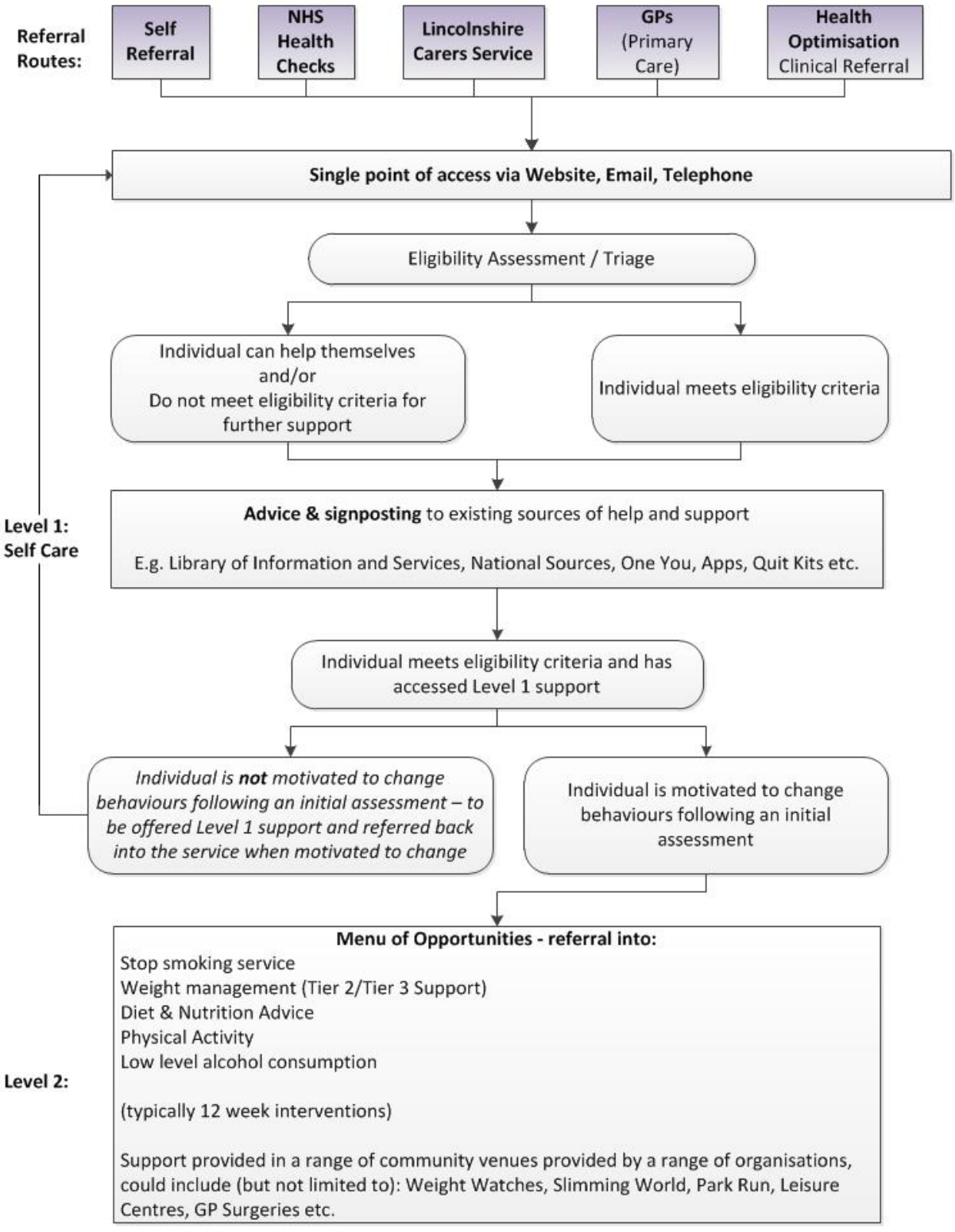
Appendix D – ILS Risk Register

20180813_ILS Risk Log.xls

Appendix E – ILS Equality Impact Assessment

ILS EIA_v0.2_30072018.

Lincolnshire's Integrated Lifestyle Support Service



At any point the service can refer out to existing intensive support programmes where clients meet the eligibility criteria, e.g. Substance Misuse Treatment Service, Wellbeing Service

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Equality Impact Analysis to enable informed decisions

The purpose of this document is to:-

I. help decision makers fulfil their duties under the Equality Act 2010 and
II. for you to evidence the positive and adverse impacts of the proposed change on people with protected characteristics and ways to mitigate or eliminate any adverse impacts.

Using this form

This form must be updated and reviewed as your evidence on a proposal for a project/service change/policy/commissioning of a service or decommissioning of a service evolves taking into account any consultation feedback, significant changes to the proposals and data to support impacts of proposed changes. The key findings of the most up to date version of the Equality Impact Analysis must be explained in the report to the decision maker and the Equality Impact Analysis must be attached to the decision making report.

****Please make sure you read the information below so that you understand what is required under the Equality Act 2010****

Equality Act 2010

The Equality Act 2010 applies to both our workforce and our customers. Under the Equality Act 2010, decision makers are under a personal duty, to have due (that is proportionate) regard to the need to protect and promote the interests of persons with protected characteristics.

Protected characteristics

The protected characteristics under the Act are: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation.

Section 149 of the Equality Act 2010

Section 149 requires a public authority to have due regard to the need to:

- Eliminate discrimination, harassment, victimisation, and any other conduct that is prohibited by/or under the Act
- Advance equality of opportunity between persons who share relevant protected characteristics and persons who do not share those characteristics
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The purpose of Section 149 is to get decision makers to consider the impact their decisions may or will have on those with protected characteristics and by evidencing the impacts on people with protected characteristics decision makers should be able to demonstrate 'due regard'.

Decision makers duty under the Act
Having had careful regard to the Equality Impact Analysis, and also the consultation responses, decision makers are under a personal duty to have due regard to the need to protect and promote the interests of persons with protected characteristics (see above) and to:-

(i) consider and analyse how the decision is likely to affect those with protected characteristics, in practical terms,
(ii) remove any unlawful discrimination, harassment, victimisation and other prohibited conduct,
(iii) consider whether practical steps should be taken to mitigate or avoid any adverse consequences that the decision is likely to have, for persons with protected characteristics and, indeed, to consider whether the decision should not be taken at all, in the interests of persons with protected characteristics,
(iv) consider whether steps should be taken to advance equality, foster good relations and generally promote the interests of persons with protected characteristics, either by varying the recommended decision or by taking some other decision.

Conducting an Impact Analysis

The Equality Impact Analysis is a process to identify the impact or likely impact a project, proposed service change, commissioning, decommissioning or policy will have on people with protected characteristics listed above. It should be considered at the beginning of the decision making process.

The Lead Officer responsibility
This is the person writing the report for the decision maker. It is the responsibility of the Lead Officer to make sure that the Equality Impact Analysis is robust and proportionate to the decision being taken.

Summary of findings
You must provide a clear and concise summary of the key findings of this Equality Impact Analysis in the decision making report and attach this Equality Impact Analysis to the report.

Impact – definition

An impact is an intentional or unintentional lasting consequence or significant change to people's lives brought about by an action or series of actions.

How much detail to include?
The Equality Impact Analysis should be proportionate to the impact of proposed change. In deciding this asking simple questions “Who might be affected by this decision?” "Which protected characteristics might be affected?" and “How might they be affected?” will help you consider the extent to which you already have evidence, information and data, and where there are gaps that you will need to explore. Ensure the source and date of any existing data is referenced.
You must consider both obvious and any less obvious impacts. Engaging with people with the protected characteristics will help you to identify less obvious impacts as these groups share their perspectives with you.

A given proposal may have a positive impact on one or more protected characteristics and have an adverse impact on others. You must capture these differences in this form to help decision makers to arrive at a view as to where the balance of advantage or disadvantage lies. If an adverse impact is unavoidable then it must be clearly justified and recorded as such, with an explanation as to why no steps can be taken to avoid the impact. Consequences must be included.

Proposals for more than one option If more than one option is being proposed you must ensure that the Equality Impact Analysis covers all options. Depending on the circumstances, it may be more appropriate to complete an Equality Impact Analysis for each option.

The information you provide in this form must be sufficient to allow the decision maker to fulfil their role as above. You must include the latest version of the Equality Impact Analysis with the report to the decision maker. Please be aware that the information in this form must be able to stand up to legal challenge.

Background Information

Title of the policy / project / service being considered	Integrated Lifestyle Service (ILS)	**Person / people completing analysis**	Sarah Chaudhary
Service Area	Public Health Division	**Lead Officer**	Robin Bellamy
Who is the decision maker?	Derek Ward in conjunction with Executive Councillor for Adult Care, Health and Children's Services	**How was the Equality Impact Analysis undertaken?**	Desk Based – review of latest JSNA and national data. Review of most recent related service data
Date of meeting when decision will be made	01/01/2019	**Version control**	0.2
Is this proposed change to an existing policy/service/project or is it new?	New	**LCC directly delivered, commissioned, re-commissioned or de-commissioned?**	Commissioned
Describe the proposed change	The Integrated Lifestyle support (ILS) service will provide high quality and accessible information and support to adults in Lincolnshire to help them adopt and maintain healthier lifestyles. It will focus on the four lifestyle behaviours that have the greatest impact on health and wellbeing: • Smoking of tobacco • Physical inactivity • Excess alcohol consumption, and • Food, Nutrition and a healthy weight The ILS will support adults who have unhealthy behaviours with information and digital and face-to-face support to enable behaviour change.		

	The service will provide a referral pathway for adult service users, primarily aged 40-74, who are identified as having a status "at risk" and with one or more unhealthy behaviours (smoking, obese, inactive, excessive alcohol consumption) following an NHS Health Check, social care assessment or other clinical referral(s): The service will target; • People with long-term health conditions, whose condition is made worse (or likely to be made worse) by unhealthy behaviours, these conditions include diabetes, CVD risk, liver disease, musculoskeletal conditions and coronary heart disease • At-risk adults who have undertaken a NHS Health Check for CVD Prevention. • People who are engaged with the NHS's health optimisation policy regarding the future requirement for support for smoking cessation and/or weight management • Carers being supported by LCC who may be obese, a smoker or inactive. • People who smoke and seek help to stop smoking, particularly pregnant women who smoke tobacco. • The Lincolnshire County Council workforce with any of the above.

Evidencing the impacts

In this section you will explain the difference that proposed changes are likely to make on people with protected characteristics.
To help you do this first consider the impacts the proposed changes may have on people without protected characteristics before then considering the impacts the proposed changes may have on people with protected characteristics.

You must evidence here who will benefit and how they will benefit. If there are no benefits that you can identify please state 'No perceived benefit' under the relevant protected characteristic. You can add sub categories under the protected characteristics to make clear the impacts. For example under Age you may have considered the impact on 0-5 year olds or people aged 65 and over, under Race you may have considered Eastern European migrants, under Sex you may have considered specific impacts on men.

Data to support impacts of proposed changes

When considering the equality impact of a decision it is important to know who the people are that will be affected by any change.

Population data and the Joint Strategic Needs Assessment

The Lincolnshire Research Observatory (LRO) holds a range of population data by the protected characteristics. This can help put a decision into context. Visit the LRO website and its population theme page by following this link: http://www.research-lincs.org.uk If you cannot find what you are looking for, or need more information, please contact the LRO team. You will also find information about the Joint Strategic Needs Assessment on the LRO website.

Workforce profiles

You can obtain information by many of the protected characteristics for the Council's workforce and comparisons with the labour market on the Council's website. As of 1st April 2015, managers can obtain workforce profile data by the protected characteristics for their specific areas using Agresso.

Positive impacts
The proposed change may have the following positive impacts on persons with protected characteristics – If no positive impact, please state *'no positive impact'.*

Age	**Evidence:** The service will be targeted at people aged 40 – 74, which is also the age range to which NHS Health Checks are available. NHS Health Checks will provide one of the main referral routes for the ILS. NHS Health Check uptake is highest for females aged 60 – 69 and lowest for those aged 40 – 44. For males the highest uptake is at 65-69 years and lowest at 40 – 44 years Smoking: within existing stop smoking services, during 2016 – 17, the largest proportion of people setting a quit date was amongst the 45 – 59 age range (1443); with 1285 coming from the 18-34 year old range. Benefits from quitting smoking for different age groups are as follows; • At 30, 10 years of life expectancy gained • At 40, 9 years of life expectancy gained • At 50, 6 years of life expectancy gained • At 60, 3 years of life expectancy gained • There is rapid benefit after the onset of life threatening disease; people who quit after having a heart attack reduce their chances of having another heart attack by 50% Physical Activity and Weight: long term conditions are positively correlated with age; physical inactivity (especially after 75) and obesity (until age 75) are also related to ageing. In 2014 – 15 the commissioned Weight Watchers services received the following referrals; • 34% aged 50 – 64 • 21% aged 40 – 49 • 19% aged 25-39 • 22% aged 65+ • 4% aged <25 59% of all referrals achieved a weight loss of 5% or above In 2015 – 16 the commissioned Exercise Referral scheme received the following referrals; • *850 – aged 40 - 49 • *840 – aged 50 -59 • *780 – aged 60 – 69

	• *520 - aged 30 – 39 • *490 – aged 18 – 29 • *400 – aged 70 – 79 • *50 – aged 80 – 89 There was a completion rate of 64% for all referrals. The highest completion rate was for those aged 60 – 69. Alcohol: the relationship between alcohol related harm and age is complex; the average age of people receiving alcohol treatment services is 42, the highest rate of hospital admission for alcohol related harm is amongst 35-44 year olds and people aged 55-64 are most likely to drink at a higher risk level; however, people under the age of 24 are more likely to binge drink. **Impact:** Smoking: the largest proportion of people setting quit dates within current stop smoking services is in the 45-59 age range. Successful quitters will gain an average of 3 – 9 years life expectancy; as this age group is within the population targeted by the ILS there is likely to be a positive impact. Weight and Physical Activity: positive impact in terms of weight loss and increased physical activity (and consequent reduction of risk for a number of long term conditions including type 2 diabetes, CVD and some cancers) for those within the targeted age range of the ILS, as the risk of inactivity and excess weight increases with age. Alcohol: there is likely to be a positive impact for people within the target age range of the ILS as they are more likely to drink at risky levels.
Disability	**Evidence:** In Lincolnshire, 10000 people aged 18 – 64 have a serious physical disability and 82 000 > 65 have a physical disability that limits their life to some extent (JSNA: physical disability and sensory impairment). There are 15 000 people in Lincolnshire with learning disability Smoking Smoking causes a wide range of diseases. Some of these long term conditions lead to disability e.g. loss of limbs due to peripheral vascular disease; diminished lung capacity due to COPD. Low birth weight due to smoking is linked to both learning disability and physical disability. People with mild to moderate learning disability and low risk perception who smoke are less likely to quit without support, leading to a shorter life expectancy. Physical Activity and Obesity

	Both learning disabled and physically disabled people are less than half as likely as the population as a whole to be active (JSNA physical activity). Over 80 people recorded on referral forms as having learning disabilities participated in the commissioned Exercise Referral scheme in 2015 – 16. Although referrals were made for a range of physical health conditions, it is not clear whether these would come within the definition of physical disability used within the Physical Activity and Sensory Impairment JSNA Learning disabled people are more likely to be obese than the general population (PH Profiles). The previously commissioned Weight Watchers scheme did not collect data on disability status Obesity and physical inactivity are risk factors for a number of long term conditions including CVD and Type 2 diabetes which increase the risk of disability Alcohol: local data regarding alcohol consumption amongst people with disabilities is unavailable. **Impact:** Smoking: positive impact as people with LTCs (and therefore at an increased risk of disability) are a targeted population Weight management and physical activity: positive impact as people with LTCs (and therefore at an increased risk of disability) are a targeted population and people with disabilities are more likely to be overweight and inactive Alcohol: no positive impact based on available evidence
Gender reassignment	**Evidence:** **Smoking**: Gender transition surgery can often require individuals to give up smoking as smoking is a significant risk factor during and after any surgery. Smokers are 38% more likely to die after surgery (Turan et al**,** 2011) and more likely to experience wound infection (Sørenson, 2012).) Local data describing obesity, overweight, physical activity and drinking alcohol at risky levels are unavailable for this population **Impact:** Positive impact of quitting smoking on surgical outcomes No impact ascertainable from local data with respect to weight management, physical activity and alcohol

Marriage and civil partnership	No local data available regarding the behaviours included within the ILS and these population groups No positive impact ascertainable from available data
Pregnancy and maternity	**Evidence:** Smoking: the Tobacco Advisory Group (TAG) of the Royal College of Physicians (RCP) reviewed the evidence available on the adverse effects of active and passive smoking amongst pregnant women. It states: 'Active maternal smoking causes up to 5,000 miscarriages, 300 perinatal deaths, 2,200 premature singleton births and 19,000 babies to be born with low birth weight in the UK each year; these adverse effects are entirely avoidable". Data collected in 2013/14 by United Lincolnshire Hospital Trust (ULHT) suggests that the smoking prevalence in pregnancy at booking is 18%, equating to approximately 1,300 women, reducing to 15%, 1,080 at delivery, significantly higher than the England average of 11.4% and East Midlands average of 13.7%. However data collection issues have meant that the national reporting of smoking at time of delivery (SATOD), (the national indicator) for Lincolnshire is currently unreliable and has been estimated for the past two years. Weight, Physical Activity and Alcohol: local data unavailable with respect to pregnant women **Impact:** Smoking: Positive impact as pregnant women are one of the targeted populations Weight management, physical activity and alcohol: potential positive impact if pregnant women who are targeted as smokers also engage in with weight, physical activity and alcohol services
Race	**Evidence:** Smoking: the ethnic profile of the smoking population has changed considerably in recent years as a consequence of migration from a number of countries with high smoking prevalence as well as continued increases in the 'mixed' ethnicity population which has traditionally had high smoking rates. Analysis of data from the Integrated Household Survey (2009-10 and 2011-12) and the GP Patient Survey (2012) indicated that among UK born groups, smoking prevalence is highest among 'White and Black African' men (36%) and 'White and Black Caribbean' women (37.5%). Among non-UK born men, prevalence is highest in the 'White and Black African' (31.9%) and Bangladeshi (31.5%) groups while for non-UK born women, rates are highest in the 'Other White' group (20.9%). Smoking prevalence is substantially higher among migrants from East European countries, Turkey and Greece, compared with most other non-UK born groups. Smoking rates are highest in the Gypsy or Irish Traveller group, 49% (of 162) and 46% (of 155) for males and females respectively.

	In 2016/17 the Lincolnshire stop smoking service had 2,312 people go through the service and set a quit date, the biggest proportion of these were 'White British' (88%) followed by 'Other White' at (0.07%). Other ethnicities were very small numbers (below 10). More work needs to be done to engage with ethnic smokers to help them quit smoking. Weight management and physical activity: no data is available within the Lincolnshire JSNAs or their supplementary data documents regarding the levels of obesity or physical inactivity by ethnic group. Similarly uptake data from previously commissioned weight management and physical activity services is not broken down by ethnicity. Nationally, black, and white British adults are most likely to be overweight or obese. And Asian, black and 'other' adults are most likely to be inactive (PH Profiles) People from Asian backgrounds are known to have an increased risk of type 2 diabetes at a lower BMI than the population as a whole. Consequently there will be a lower weight threshold for their eligibility into weight management services. services Alcohol: local data not broken down by ethnic group **Impact:** Smoking: positive impact on those ethnic groups whose smoking prevalence is higher than the population as a whole. Weight management: positive impact as eligibility thresholds for weight management support will be lower than for the population as a whole Alcohol: no positive impact based on available evidence
Religion or belief	**Evidence** Local data on those behaviours that come within the ILS are not broken down by religion **Impact** No positive impact based on available data
Sex	**Evidence:** Smoking: results of the Annual Population Survey (APS) for England 2016 show that the prevalence of cigarette smoking is higher for men (17.7%) than women (14.1%) however a higher proportion of women 61.4% quit smoking in 2016 than men 60.7%. Physical activity: levels of inactivity are higher for women than for men (JSNA Physical Activity, PH Profiles)

	Weight: levels of overweight and obesity are higher in men than in women (PH Profiles); however, only 14% of referrals to previously commissioned weight management services were for men. Alcohol: Women are significantly less likely to be admitted to hospital for alcohol related liver disease than men and to drink at higher risk levels **Impact:** Smoking: potential positive impact for men as smoking prevalence is higher Weight: potential positive impact for men as prevalence of excess weight is higher Physical Activity: Potential positive impact for women as inactivity levels are higher Alcohol: potential positive impact for men as prevalence of risky drinking levels is higher
Sexual orientation	**Evidence** Smoking: national data taken from the Integrated Household Survey for 2014 shows that lesbian and gay people are much more likely to smoke than the general population (Gay /Lesbian smoking prevalence 25.3% v Heterosexual 18.4%). Whilst there is a lack of research on smoking among bisexual and trans people, surveys do show both bisexual and trans people are more likely to smoke (Stonewall, 2012; Rooney, 2012). Young LGB people are also more likely to smoke, to start smoking at a younger age and smoke more heavily (Corlissetal, 2013). Whilst there is a lack of robust evidence to confirm the best approach to tackling the issue of smoking within the LGBT community, where studies have been undertaken the evidence suggests that current SS services are as effective within the LGBT community as with non-LGBT people. Therefore consideration should be focused on engagement of this community and offering support in settings that are already accessible and appropriate for LGBT communities. Weight, Physical Activity and Alcohol: Local data are not broken down by sexual orientation. Previously commissioned services did not provide any data around sexual orientation **Impact:** Smoking: potential positive impact for non-heterosexual population as smoking prevalence is higher Weight, Physical Activity, Alcohol: no positive impact based on available data

If you have identified positive impacts for other groups not specifically covered by the protected characteristics in the Equality Act 2010 you can include them here if it will help the decision maker to make an informed decision.
.As the target populations for the ILS include carers and Lincolnshire County Council staff, there is likely to be a positive impact for these groups. If the service is based on the principles of proportionate universalism there is potentially positive impact for economically disadvantaged populations, especially as these are more likely to be overweight and inactive, to smoke, and to suffer disproportionate harm from excessive alcohol consumption

Adverse/negative impacts
You must evidence how people with protected characteristics will be adversely impacted and any proposed mitigation to reduce or eliminate adverse impacts. An adverse impact causes disadvantage or exclusion. If such an impact is identified please state how, as far as possible, it is justified; eliminated; minimised or counter balanced by other measures.
If there are no adverse impacts that you can identify please state 'No perceived adverse impact' under the relevant protected characteristic.

Negative impacts of the proposed change and practical steps to mitigate or avoid any adverse consequences on people with protected characteristics are detailed below. If you have not identified any mitigating action to reduce an adverse impact please state *'No mitigating action identified'*.

Age	**Evidence** Weight / Physical Activity: significant proportions of the adult population outside the target age-range of the service are overweight and inactive. At least 23% of participants in the previous commissioned weight management service were outside the target age group (in fact the figure is likely to be higher as the 65+ category was not broken down further). At least 27% of participants in the previously commissioned Exercise Referral service were outside the ILS target group (again the figure is likely to be higher as the 400 people aged 70-79 who accessed the scheme was not broken down further) Smoking: 1285 people aged 18-34 have set quit dates as part of the existing Stop Smoking Service. Younger people have the most to gain (in terms of increased life expectancy) from quitting smoking Alcohol: young people (16 – 24 years) are more likely to binge drink than those within the ILS target population, significantly more so than those aged over 65 **Impact** if the service reaches its capacity within the target age-group, younger people and very old people risk not having their needs adequately addressed **Mitigating factors**

	These negative impacts can be mitigated through effective communications about the availability of free electronic support sources such as One You and through comprehensive use of opportunistic, brief advice and system-wide adoption of the Making Every Contact Count (MECC) approach
Disability	**Evidence** Nationally, learning disabled people have far higher rates of premature mortality than the population as a whole (DH / CIPOLD 2013). People with learning disability are also more likely to be inactive and obese. **Impact** If the proposed ILS is not targeted effectively enough at, or if its services are not accessible to learning disabled people then these inequalities may be exacerbated. **Mitigating factors** One of the main referral routes for the ILS will be through NHS Health Checks; these are aligned with the delivery of personal health checks for people with learning disabilities; however, <30% of LD adults currently access their health check - better promotion and reach of health check services would potentially allay negative impacts
Gender reassignment	No perceived adverse impact
Marriage and civil partnership	No perceived adverse impact
Pregnancy and maternity	No perceived adverse impact
Race	No perceived adverse impact

Religion or belief	No perceived adverse impact
Sex	**Evidence** Weight: levels of overweight and obesity are higher in men than in women; however, only 14% of referrals to previously commissioned weight management services were for men. **Impact** If ILS weight management services are not accessible or attractive to men it is possible that this inequality increases **Mitigating factors** Effective promotion, design and delivery of weight management services to ensure their accessibility to men. Evidence may be available from other areas of the country where weight management services have successfully engaged men
Sexual orientation	No perceived adverse impact

If you have identified negative impacts for other groups not specifically covered by the protected characteristics under the Equality Act 2010 you can include them here if it will help the decision maker to make an informed decision.

Stakeholders

Stake holders are people or groups who may be directly affected (primary stakeholders) and indirectly affected (secondary stakeholders)

You must evidence here who you involved in gathering your evidence about benefits, adverse impacts and practical steps to mitigate or avoid any adverse consequences. You must be confident that any engagement was meaningful. The Community engagement team can help you to do this and you can contact them at consultation@lincolnshire.gov.uk

State clearly what (if any) consultation or engagement activity took place by stating who you involved when compiling this EIA under the protected characteristics. Include organisations you invited and organisations who attended, the date(s) they were involved and method of involvement i.e. Equality Impact Analysis workshop/email/telephone conversation/meeting/consultation. State clearly the objectives of the EIA consultation and findings from the EIA consultation under each of the protected characteristics. If you have not covered any of the protected characteristics please state the reasons why they were not consulted/engaged.

Objective(s) of the EIA consultation/engagement activity
To understand the impact that the ILS will have on the different populations who would benefit from accessing lifestyle support services. To gain further evidence throughout the lifespan of the service about how to mitigate any negative impacts and enhance positive effects with respect to protected populations

Who was involved in the EIA consultation/engagement activity? Detail any findings identified by the protected characteristic

Age	This was a desk exercise and people from this protected characteristic have not been approached.
Disability	This was a desk exercise and people from this protected characteristic have not been approached.
Gender reassignment	This was a desk exercise and people from this protected characteristic have not been approached.
Marriage and civil partnership	This was a desk exercise and people from this protected characteristic have not been approached.
Pregnancy and maternity	This was a desk exercise and people from this protected characteristic have not been approached.
Race	This was a desk exercise and people from this protected characteristic have not been approached.
Religion or belief	This was a desk exercise and people from this protected characteristic have not been approached.

Sex	This was a desk exercise and people from this protected characteristic have not been approached. .
Sexual orientation	This was a desk exercise and people from this protected characteristic have not been approached.
Are you confident that everyone who should have been involved in producing this version of the Equality Impact Analysis has been involved in a meaningful way? The purpose is to make sure you have got the perspective of all the protected characteristics.	Prior to commissioning the EIA will be based on professional assumptions derived from the available evidence; these assumptions will be tested with service users throughout the lifespan of the ILS
Once the changes have been implemented how will you undertake evaluation of the benefits and how effective the actions to reduce adverse impacts have been?	We will work with the Community Engagement team and the new provider to review the service and any impact on users. Any negative impacts will be identified and plans put in place to mitigate their effects

Further Details

Are you handling personal data?	No If yes, please give details.

Actions required Include any actions identified in this analysis for on-going monitoring of impacts.	**Action**	**Lead officer**	**Timescale**
	.Impacts will be monitored through the commissioning and contract management process, including an early piece of work by the provider to test this first version of the EIA and identify any mitigating factors	Alison Christie	Annual review by provider
Signed off by	Robin Bellamy	**Date**	30/07/2018

Lincolnshire COUNTY COUNCIL Working for a better future

Policy and Scrutiny

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

Report to:	**Adults and Community Wellbeing Scrutiny Committee**
Date:	**10 October 2018**
Subject:	**Community Wellbeing Commissioning Strategy**

Summary:

Lincolnshire County Council is a Commissioning Council and is organised in line with 17 Commissioning Strategies. These Commissioning Strategies are in different stages of readiness. This report has been produced to provide Adults and Community Wellbeing Scrutiny Committee with details of the current Community Wellbeing Commissioning Strategy 2017-2020.

Actions Required:

To note the content of the current Community Wellbeing Commissioning Strategy and to provide feedback that can be considered by the Council's Executive.

1. Background

The purpose of this commissioning strategy is to improve and protect the health and wellbeing of people in Lincolnshire. We think this can be best achieved when people are supported to be independent, make healthier choices and live healthier lives.

To achieve this we are committed to:

- Working with our partners, providers and the public to understand the needs of people living and working in Lincolnshire and the ability and capacity of our providers and partners to meet those needs;
- Involve our customers in the development of public health in Lincolnshire by adopting a co-production approach whilst being clear and explicit about what we can and cannot do for them;
- Improve outcomes for individuals by developing an overarching performance framework based on outcomes and manage everything we do through a clear and transparent set of operating procedures.

Prevention and Public Health

This commissioning strategy supports a number of statutory requirements, whilst being clear that prevention is everyone's business.

The Care Act 2014 helps to improve people's independence and wellbeing. It makes clear that local authorities must provide or arrange services that help prevent people developing needs for care and support or delay people deteriorating such that they would need ongoing care and support. Many aspects of this commissioning strategy directly and indirectly support this requirement.

The Health and Social Care Act 2012 placed a responsibility on local authorities for a number of public health functions that previously sat within the NHS. Broadly speaking there is a requirement on local authorities to improve and protect the health of their residents. Specific requirements include the commissioning of sexual health services and NHS health checks as well the provision of public health advice to the NHS.

Position Statement

1. Overall Status of the Community Wellbeing Commissioning Strategy

During 2017/18 Lincolnshire County Council:

- Re-commissioned the Wellbeing Service, which went live across Lincolnshire in April 2018;
- Continued to commission a high performing NHS Health Check service (Lincolnshire continued to be in the top quintile nationally in 2017/18);
- Worked with our Alcohol and Drug Treatment service provider to maintain performance at a level commensurate to the reduced budget the service is now delivered with;
- Prepared for re-commissioning stop smoking service which are now covered by the Integrated Lifestyle Support Service commissioning (see section below);
- Continued to ensure equipment and telecare services are delivered to people to support them to remain safe and well in their own homes;
- Ensured housing related support providers continue to assist people in their own homes and in accommodation based services;
- Managed our Integrated Sexual Health service provider to ensure they have delivered one of the highest performing chlamydia testing services in the country;
- Re-commissioned local healthwatch services.

2. Changes and updates

Integrated Lifestyle Support Service (ILS)

The most significant change to the Community Wellbeing Commissioning Strategy since it was drafted has been the development of an Integrated Lifestyle Support Service (ILS).

The Wellbeing Commissioning Strategy sets out the council's intentions to provide interventions which reduce risks to health and tackle the impact of disease. This approach is supported by the Lincolnshire Joint Health and Wellbeing Strategy which emphasises prevention and early intervention, delivering transformational change by shifting the focus away from treating ill health and disability towards prevention and self-care.
To address this, the ILS service will provide adults in Lincolnshire with high quality accessible information and direct support focusing on the four lifestyle behaviours with the greatest negative impact on health and wellbeing:

- Smoking of tobacco
- Physical inactivity
- Obesity (food, nutrition and a healthy weight) and
- Excess alcohol consumption

The planned re-commissioning of stop smoking services has changed and is now incorporated into the ILS Service.

Joint Health and Wellbeing Strategy (JHWS)

In June 2018 the new JHWS was agreed and published by the Health and Wellbeing Board for Lincolnshire (HWB) following a period of extensive engagement and development. It has identified key aims which align closely to the scope of this commissioning strategy. These include the need for the JHWS to:

- have a strong focus on prevention and early intervention;
- ensure a focus on issues and needs which will require partnership and collective action across a range of organisations to deliver;
- deliver transformational change through shifting the health and care system towards preventing rather than treating ill health and disability;
- focus on tackling inequalities and ensuring equitable provision of services that support and promote health and wellbeing.

It will be necessary to review the Community Wellbeing Commissioning Strategy in light of the new JHWS.

3. Next Steps

Over the next six months we will:

- Commission the ILS Service in readiness for it to go live in 2019;
- Review housing related support services in line with contract end dates;
- Review the Community Wellbeing Commissioning Strategy to ensure its alignment to the newly published Joint Health and Wellbeing Strategy;
- Work with other commissioning leads across Adult Care and Community Wellbeing as well wider LCC colleagues to ensure the

interdependencies between this strategy and other strategies are fully understood and referenced.

2. Conclusion

A Commissioning Strategy has been developed by lead commissioners which now needs to be formally considered by the Council's Executive informed by comments and feedback from the Adults and Community Wellbeing Scrutiny Committee.

3. Consultation

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

No

b) Risks and Impact Analysis

The Commissioning Strategies are considered as part of the wider Council's Risk Management Framework and Audit Cycle. The areas of commissioning responsibility are also considered via peer review.

A supplementary risk and impact analysis in relation to this commissioning strategy will also be completed once feedback is received from scrutiny.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Community Wellbeing Commissioning Strategy 2017-2020

5. Background Papers

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

This report was written by David Stacey, who can be contacted on 01522 554017 or david.stacey@lincolnshire.gov.uk.

Community Wellbeing Commissioning Strategy

2017 – 2020

Lincolnshire COUNTY COUNCIL

Working for a better future

Contents

Health and Wellbeing in Lincolnshire

Introduction

The purpose of this commissioning strategy is to improve and protect the health and wellbeing of people in Lincolnshire. We think this can be best achieved when people are supported to be independent, make healthier choices and live healthier lives.

To achieve this we are committed to:

- Working with our partners, providers and the public to understand the needs of people living and working in Lincolnshire and the ability and capacity of our providers and partners to meet those needs;
- Involve our customers in the development of public health in Lincolnshire by adopting a co-production approach whilst being clear and explicit about what we can and cannot do for them;
- Improve outcomes for individuals by developing an overarching performance framework based on outcomes and manage everything we do through a clear and transparent set of operating procedures.

In order to achieve the purpose of the strategy we will take different approaches to different issues. In some cases we will want to buy specific, good value for money services for local people to help them overcome specific problems.

In other cases we will want to influence other organisations and local people to do things that are good for community wellbeing like advising the NHS on what services local people need.

Finally, we will work with other agencies which have a responsibility to protect people from diseases like cancer, environmental and biological hazards and emergencies to assure ourselves that their work is effective.

Aim 1: People are supported to live healthier lifestyles

Priorities

People understand how to maximise their wellbeing through making healthier choices about diet, smoking, alcohol and keeping active.

People with drug and alcohol problems are helped to reduce the harm they do to themselves and others and move towards living drug and alcohol free lives.

Measures

Percentage of alcohol users that left drug treatment successfully who do not re-present to treatment within 6 months

People aged 40 to 74 offered and received an NHS health check

People supported to Stop Smoking

We will commission:

- High Quality alcohol and drug treatment services
- Services which support people to recover from alcohol and drug misuse and lead meaningful and productive lives in society
- Stop smoking and tobacco control services that raise awareness about the harms of tobacco and encourage and support smokers to quit smoking
- NHS Health Checks to identify people at risk of stroke, kidney disease, heart disease, type 2 diabetes or dementia
- All of our services in such a way as to promote good mental wellbeing outcomes for people

We will work with others to:

- Support the development of the Self Care Strategy to ensure people in Lincolnshire are empowered to improve and maintain their health and wellbeing
- Promote lifestyle interventions to contribute to the prevention of vascular dementia
- Promote responsible drinking and prevention alcohol and drug related harm
- Support targeted diabetes prevention programmes to support people to better manage their diabetes
- Prevent, identify and manage obesity within our population

Aim 2: People are able to live life to the full and maximise their independence

Priorities

We will work with others to help people access housing that supports their wellbeing and independence.

People will have access to information and resources that help them to take more care of themselves and their families.

People will have access to preventative services when their independence becomes challenged, including the Wellbeing Service; Community Equipment Services and help to access community and voluntary sector organisations.

Measures

Percentage of people supported by the Wellbeing Service to improve their outcomes

People supported to sustain suitable housing

People supported by Integrated Community Equipment Services to improve their outcomes.

We will commission:

- Housing related support services that continue to assist people to secure and maintain their independence in suitable housing
- A Wellbeing Service that enhances peoples wellbeing, and reduces or delays escalation to statutory health and care services
- Integrated Community Equipment Services

We will work with others to:

- Progress the wider Housing for Independence agenda
- Develop a network of support services that tackle social isolation
- Provide co-ordinated falls prevention services to reduce the number of falls in older people
- Review and subsequent development of a falls prevention programme

Aim 3: Peoples Health and Wellbeing is protected

Priorities

We will work with others to support people at risk from domestic abuse to have access to a full range of prevention and support services, helping them to protect themselves from future harm.

We will work with other agencies to make sure local people are protected from infectious diseases through immunisation and vaccination and effective outbreak control.

We will work with other agencies to make sure local people have access to national screening programmes for diseases that can be better treated when found early.

We will work with other agencies to make sure that the NHS is able to respond effectively in times of emergency to support local people to avoid harm and return to normal as quickly as possible.

People have healthy sexual relationships and can access value for money services to support them to do so

Measures

Chlamydia diagnoses (per 100,000 15-24 year olds)

We will commission:

- An effective integrated sexual health service, doing so jointly with NHS England to ensure HIV treatment and care is also delivered as part of this service
- Domestic Abuse floating support services

We will work with others to:

- Develop and implement joint clinical governance and assurance systems across the Council
- Review and improve the delivery of the Health Protection Framework for Lincolnshire
- Effectively protect the public from communicable disease and other hazards
- Support work to prepare for, respond to and recover from emergencies
- Seek and maintain assurance that immunisation and vaccination as well as screening programmes are effective in protecting the health of the public.

Aim 4: Work with others to promote community wellbeing

Priorities

We will identify the causes and potential causes of local people losing wellbeing and independence and promote action by others to address these.

We will provide advice to the NHS on what local people need to achieve the best possible health and wellbeing.

Measures

Number of Health and Social Care staff trained in Making Every Contact Count (MECC)

We will commission

- A Healthwatch Lincolnshire service which promote, support and enable the involvement of people in the commissioning, provision and scrutiny of local care services :
- A programme of work to support delivery of MECC across the health and care workforce

We will work with others to:

- Review the use of the Public Health Grant in preparation for national changes to the ring-fence or mandation
- Promote further integration with the NHS through maximising opportunities to pool funding and co-commission across the health and care system
- Develop and implement a programme which continually improves the advice provided by the Council on protecting and improving the health of the population
- Develop a framework and resources that support evidence-based practice and decision-making across the Council and its partners
- Gain consensus for a focus on commissioning for children, moving towards a commissioning hub model
- Continue to improve and promote the public health role that the Council has under the Health and Social Care Act 2012
- Develop and support components of the STP where appropriate
- Analyse the health needs of the population through the Joint Strategic Needs Assessment and specific Health Needs Assessments
- Develop and implement the Joint Health and Wellbeing Strategy for Lincolnshire through supporting the work of the Health and Wellbeing Board
- Influence the NHS to commission weight management and smoking cessation services at scale for people on disease registers or receiving disease management interventions;
- Influence Sports England, Active Lincolnshire and leisure services to make Lincolnshire a great place for people to be active enough to make a difference to their own health

Key Commissioned Activities

Lincolnshire County Council is committed to commissioning for outcomes based on our communities' needs and we commission a wide range of preventative and health based services within this commissioning strategy.

Customer, patient, service user and stakeholder engagement has been critical in developing these services from the needs analysis phase through to the procurement stages of commissioning.

As well as being responsible for directly commissioning services we also have a number of integrated commissioning arrangements with the NHS and DCLG.

The core commissioned services covered by this commissioning strategy are shown below

Lincs Community Alcohol & Drug Treatment (£4.9m per annum)

Lincolnshire County Council is responsible for the commissioning of substance misuse treatment services across Lincolnshire. This is a holistic substance misuse system which started in October 2016 and aims to provide an integrated treatment system for drugs and alcohol which will more effectively meet the needs of the local population.

The treatment system will be outcome and recovery focused. The expectations for recovery and reintegration are explicit and characterised by the ability to motivate and support clients to achieve short and longer term goals and move through the treatment system into mainstream health provision free from dependence.

The treatment service will be supported by the recovery service, which will wrap around treatment, offering support to people before, during and after treatment by building a recovery community across the county. It will provide a supportive environment to help those in recovery address any remaining issues as well as prevent those accessing recovery services from escalating their substance misuse to a level that may require formal treatment.

In 2016/17 the service delivered support to 2,938 people for drug and alcohol issues of which 494 people successfully completed their treatment during the year.

Wellbeing Service (£4.4m per annum)

The Wellbeing service was launched in April 2014 and is a Countywide Service that forms part of a wider Wellbeing Network; focussing on Prevention and Early Intervention. Its focus is to bring together preventative services in order to develop a customer driven delivery model where individuals and communities are active in meeting their own care needs and supporting their independence. The programme has been a success for its users with over 90% of people receiving the service saying they would recommend it to others.

This approach offers service users tailored support to meet individual people's needs. People have access to a range of simple equipment aids for daily living, TeleCare, and other practical support at home. This applies whether that home is the family home or supported housing, rented or owned.

The Wellbeing Service includes five elements:

- Trusted Assessment;
- Installation of Equipment, Minor Adaptations and TeleCare installation;
- A Short Term Intervention of Generic Support;
- Resettlement / Home from hospital service;
- A Response Service.

The service is currently being recommissioned to ensure countywide consistency of the delivery model, key stakeholders are able to realise the full potential of the service and that it is embedded within key referral pathways. The new service will build upon the success of the first four years of this important service.

During 2016/17 the Wellbeing service undertook 5,399 assessments and delivered 8,885 units of support including generic support, telecare and small aids and adaptations. Of the users supported the Wellbeing Service improved 87% of outcomes identified including economic wellbeing, participation in work and training, establish social relationships, being healthy and staying safe.

Lincolnshire Integrated Sexual Health Service (LISH) (total yearly spend £5.1m of which LCC contribution is £3.8m)

We commission this service in collaboration with NHS England. The integrated sexual health and HIV service model aims to improve sexual health by providing access to services through 'one stop shops', where the majority of sexual health and contraceptive needs can be met at one site by one health professional.

HIV Diagnosis, therapy and support is provided in a variety of ways with a Section 75 Agreement in place with NHSE for Anti Retro Viral Therapy and individual and family support, alongside diagnosis, treatment and ongoing .

It also brings together level 2 and 3 GUM/HIV/sexual health and community contraception, psycho-sexual therapy (sexual health aspects), the National Chlamydia Screening programme and C Card for young people and sexual health promotion to provide one integrated sexual health service countywide.

75 GP practices are contracted to deliver Long Acting Reversible Contraception (LARC). This provides women in Lincolnshire with greater and more effective contraceptive choices such as Implants and Intra Uterine Devices. Advice on protection and prevention of transmission of STI's is provided as required.

Lincolnshire Sexual Health Services provided chlamydia tests to over 18,000 people aged 15-24 during 2016/17 (21% of the population in that age group). Finding positive results in 9.1% of cases resulted in a detection rate (per 100,000 people) of 1,941 which is the 3rd best detection rate amongst our 15 other comparator local authority areas and is a better detection rate than both East Midlands and England rates during 2016/17.

Housing Related Support Services (Total yearly spend £3.6m per annum of which LCC contribution is £3.1m)

The accommodation based Housing Related Support services provide Emergency and Non-Emergency assistance to prevent vulnerable people from rough sleeping and experiencing homelessness. The service(s) are required to meet an individual's

immediate housing need that may have arisen due to an emergency or crisis situation, supporting them to regain their independence.

Working alongside the accommodation based support is the Countywide Floating support service. The floating support service works across all housing tenures within the County to enable people with a range of support needs to maintain and sustain their accommodation and independence and/ or gain access to independent accommodation. This service also works with rough sleepers throughout the County to support them off the streets into accommodation, and connects them with other support services.

This commissioned service also provides domestic abuse refuge accommodation which delivers housing related support to those aged 16 and over experiencing or at risk of domestic abuse who are unable to return to their own home. Refuge accommodation is delivered from existing purpose built accommodation located within East Lindsey and City of Lincoln.

A social impact bond is currently being delivered through the LCC commissioned Housing Related Support contract. This is fully funded by DCLG and payment is linked to outcomes achieved for entrenched rough sleepers within the service (estimated total value is £1.3m).

During 2016/17 Housing Related Support services supported a total of 2,494 people of which 396 were supported via our commissioned rough sleeper service, 934 were supported in accommodation based services and 1,164 were supported within Floating Support services. Within all of these services 93% of people were supported to achieve their identified outcomes.

Domestic Abuse Floating Support Services (£517k per annum)

We commission a Domestic Abuse Support Service which works with standard and medium risk victims of domestic abuse across the County (using the Domestic Abuse, Stalking and Harassment (DASH 2009) risk assessment tool). The aim of the service is to ensure that all victims of domestic abuse are able to access services in their local area in order to support early intervention and enable victims to live their lives free of controlling, coercive or threatening behaviour, violence, abuse or even death.

The services work across a wider domestic abuse network including the domestic abuse refuge element of the housing related support services.

These services supported 1,783 people of which 96% of identified outcomes were achieved for users.

Stop Smoking Services (£1.1m per annum)

To support people who are seeking to quit smoking we commission a community dispersed tiered model of provision encompassing a core service and engagement with a network of sub-contracted providers providing behavioural interventions linked with pharmacological supplies. Across the county over 170 practitioners through 90 sites support nearly 5,000 people annually to try and stop smoking

The central functions include:

- Co-ordination, support and administration of core and network activities

- Management and responsibility of core team of specialist smoking cessation advisers
- Networked smoking cessation with affiliated/contracted providers
- Hub telephone support
- Training – professional development, brief interventions and service awareness
- Promotions and social marketing initiatives.

Tobacco control related activity that supports the smoking quit targets is primarily the Smoke Free Homes & Cars programme; this encompasses working with partners:

- To refer clients to smoking cessation services, fire service, etc.
- To engage the public to make their homes and their vehicles smoke-free

Healthwatch (£300k per annum)

Lincolnshire County Council commission a local Healthwatch as a requirement of The Health and Social Care Act 2012. Local Healthwatch organisations, whilst not statutory bodies, have statutory duties and powers under the Act to promote and support the involvement of people in the commissioning, provision and scrutiny of local care services; enable people to monitor standards of local care services and whether, and how, these can be improved; obtain the views of people about their needs for, and their experiences of, local care services; and make views, reports and recommendations about how local care services could or ought to be improved, to persons responsible for commissioning, providing, managing or scrutinising local care services.

In 2016/17 Healthwatch Lincolnshire had 462 members (either associated or full members) and had 96,000 contacts with residents in Lincolnshire including through promotional activities, website contacts, surveys and questionnaires and social media contacts. One of the most important roles of Healthwatch Lincolnshire is to ask health and care service providers what changes they are putting in place as a result of patient and carer feedback. This is undertaken on a regular basis to allow the tracking of the impact Healthwatch Lincolnshire are having on service developments, commissioning and delivery.

Integrated Community Equipment Services (Total yearly spend £5.8m of which £2.7m is LCC contribution)

ICES is an Integrated Community Equipment Service which incorporates several strategic partner organisations including Lincolnshire CCGs, Lincolnshire Community Health Trust, United Lincolnshire Hospital Trust, Lincolnshire Partnership Foundation Trust and Lincolnshire County Council.

The service provides equipment to people of all ages (including children) to enable them to be more independent in their lives whilst living in the community within county of Lincolnshire. ICES also subcontract the telecare monitoring provision and will take on responsibility for installing telecare equipment from 1st April 2018.

In 2016/17 Adult Care received 3,000 requests from new clients for ongoing low level support (this includes equipment, telecare and

professional support). During 2016/17 4,800 people in total received ongoing low level support.

NHS Health Checks (£734k per annum)

The 'NHS Health Check' Programme is a mandated service that the Council must commission as part of its public health functions. The Health Check itself offers preventative checks to people aged 40-74 years to assess their risk of vascular disease (heart disease, stroke, diabetes and kidney disease) followed by appropriate management and intervention, e.g. medical intervention and/or referral and signposting to lifestyle services.

One fifth of the eligible population is invited each year and the cycle repeats every 5 years. Our targets are to remain on track to invite 100% of our eligible population by the end of the first 5 year cycle and to show an improvement in uptake year on year. This performance is reported directly to Public Health England and forms part of Lincolnshire County Councils quarterly performance updates.

In 2016/17 41,835 people were offered an NHS Health Check in Lincolnshire of which 28,414 people received a check. 68% of people receiving the NHS Health Check is significantly higher level of performance than either the England level (50%), East Midlands (58%) and the average of our comparator local authority areas (51%).

Measuring the impact our services have

Our commissioned services are monitored through robust contract and performance management arrangements, which include service reviews and understanding people's experience of services. All of our commissioned services include a full range of key performance indicators through which we ensure providers deliver cost effective services and achieve good outcomes for people. The specific measures included in the Community Wellbeing Commissioning Strategy reflect the key outcome measures as set out in the Council Business Plan.

How we decide what measures to track is based on a performance framework that includes some core principles such as we collect performance information which is primarily driven by 'outcomes', we only collect performance data that is absolutely necessary either due to legal requirements of based on clear business need, that we undertake a robust feasibility and baselining assessment including involvement of key stakeholders where appropriate.

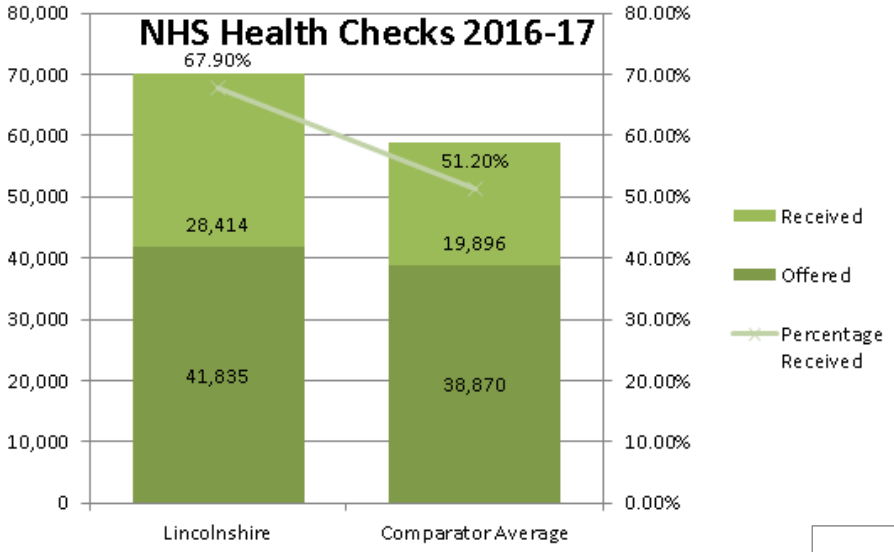
When we set our targets for this Community Wellbeing Commissioning Strategy and the Council Business Plan our approach is, wherever possible, evidence based, e.g. setting targets based on expert technical advice or published research evidence about what a good level of performance looks like.

Overall we strive to set and agree targets which are linked to a sound evidence base, are outcome focused and are focused on the key strategic objectives for the business which either aim to:

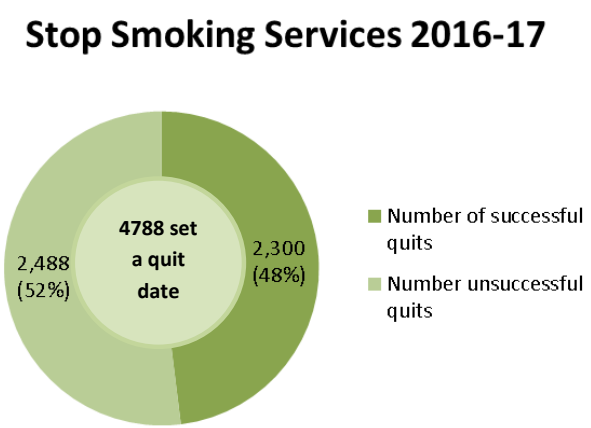
- Improve our performance
- Maintain our current performance
- Ensure our performance exceeds an acceptable baseline

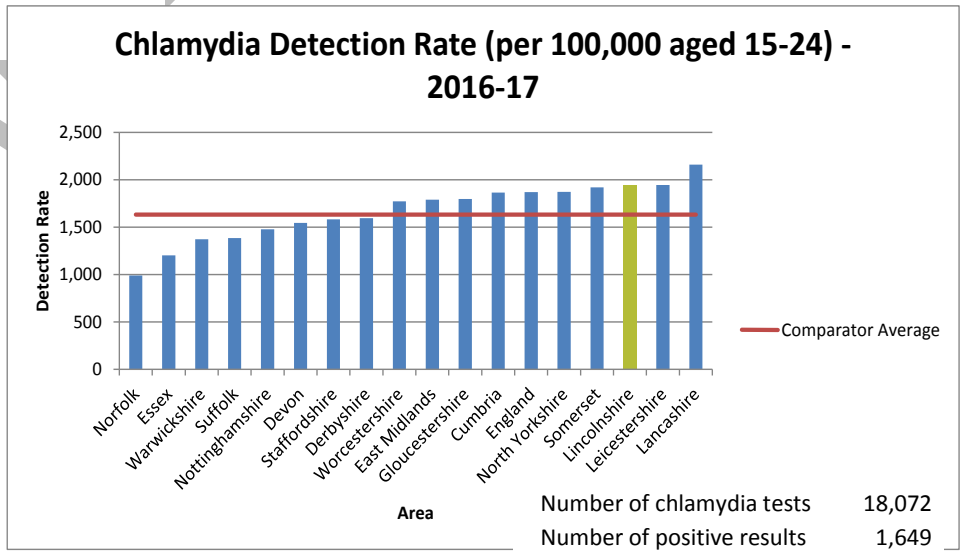
Some examples of how the services we commission are set out in the infographic below and further more detailed commentary is provided in the Council Business Plan And Performance Dashboard that is available on our Lincolnshire Research Observatory here: http://www.research-lincs.org.uk/CBP-website-update.aspx

Community Wellbeing Commissioning Strategy



Wellbeing Service (2016/17)	
Assessments	5,399
Services provided	8,885
Outcomes achieved	16,253
Percentage of outcomes achieved	87%





Number of chlamydia tests	18,072
Number of positive results	1,649
Detection rate (per 100,000)	1,941

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Lincolnshire COUNTY COUNCIL Working for a better future

Policy and Scrutiny

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

Report to:	**Adults and Community Wellbeing Scrutiny Committee**
Date:	**10 October 2018**
Subject:	**Carers Commissioning Strategy**

Summary:

Lincolnshire County Council is a Commissioning Council and is organised in line with 17 Commissioning Strategies. These Commissioning Strategies are in different stages of readiness. This report has been produced to provide Adult Care and Community Wellbeing Scrutiny Committee with details of the current Carers Commissioning Strategy 2017-2020.

Actions Required:

To note the content of the current Carers Commissioning Strategy and to provide feedback that can be considered by the Council's Executive.

1. Background

The purpose of this commissioning strategy is to support the health and wellbeing of carers of all ages in Lincolnshire.

We think this can be best achieved when carers are:

- recognised early in the caring journey by health and care professionals
- well informed
- valued as an expert and equal partner in care
- supported by their employer, GP, schools, college and universities, in their communities, as well as by formal services to balance their caring role with having a life of their own.

To achieve this we are committed to:

- **Aim 1: Early Help.** Providing early help is more effective in promoting the wellbeing of carers than reacting in a crisis. Early help means providing support as soon as the caring role starts, from the point of diagnosis through to the end of the caring role.

- **Aim 2: Collaboration.** Working together with our partners in Health, Schools and the Further Education sector to improve outcomes for carers of all ages, using whole family approaches.

- **Aim 3: Assurance.** To confirm that what we do makes a difference.

- **Aim 4: Workforce development.** To ensure that all partners supporting carers have an appropriately skilled workforce.

Statutory Support to Carers

This commissioning strategy supports a number of statutory requirements, whilst being clear that helping to identify and support carers is everyone's business: employers, GP's, hospitals, pharmacies, schools, further and higher education organisations, the voluntary sector – as well as formal statutory services.

The Care Act 2014 gave carers a statutory right to assessment and support, and established parity of esteem with those they look after. The Children and Families Act 2014 also gives young carers and parent carers the right to an assessment and support. Local authorities have a duty to offer an assessment where the carer has the appearance of need. Together, both pieces of legislation pave the way for 'whole family approaches' and make it clear that local authorities should take a one Council approach to ensuring that the needs of all family members are met.

The Care Act 2014 also helps to improve people's independence and wellbeing. It makes clear that local authorities must provide or arrange services that help prevent people developing needs for care and support or delay people deteriorating such that they would need ongoing care and support. Many aspects of this commissioning strategy directly and indirectly support this requirement.

Position Statement

1. Overall Status of the Carers Commissioning Strategy

The Carers Commissioning Strategy is at a Review phase.

Between 2016-18 Lincolnshire County Council has:

- Re-commissioned the Lincolnshire Carers Service, which is delivered by two providers: Serco Customer Service Centre and Carers FIRST. Carers FIRST began delivering county wide, community based, statutory support for carers, from June 2016.
- Commenced carers in-reach services in Lincolnshire's acute hospitals, and extended this across all of Lincolnshire's community hospitals with iBCF investment.
- Invested iBCF funding to continue and expand the successful Carers Quality Award through local charity EveryOne.
- Commenced delivery of the Department of Health sponsored Employers for Carers project in partnership with Carers UK.

- Improved information for carers on LCC Connects and the Lincolnshire Service Directory.
- Invested iBCF funds in the Health Engagement project which operationalises the NHS Commitment to Carers. Carers FIRST are embedded with all Neighbourhood Teams, and are engaging with Primary Care and health providers to deliver an integrated approach to the identification, assessment and support of carers' health and wellbeing needs.
- Continued to deliver the Children's Society Young Carers in Schools Programme.
- Launched the Carer Friendly element of the Healthy Living Pharmacy programme, engaging with 122 of Lincolnshire's pharmacies.
- Signed the Supporting Young Carers and their Families Memorandum of Understanding between Children's and Adult Services; and subsequently adopted this as Lincolnshire Safeguarding Children Board policy.
- Developed a service offer to support families of substance misusers within mainstream carers services.
- Developed Carers Practice Standards, and implemented as Business As Usual a broad range of Quality Assurance (QA) activities including: monthly multi-agency QA case based action learning; annual service review; carer customer experience.
- Invested significantly in workforce development from statutory assessment and safeguarding to person centred good practice using strengths based approaches in support planning (Integrated Personalised Commissioning programme) and joint Public Health training such as Making Every Contact Count (MECC).

2. Changes and updates

- The Carers Commissioning Strategy Delivery Plan is updated annually. The aims and strategic themes remain relevant throughout.

- The strategic agenda for Carers now sits within Public Health. This offers a unique opportunity for Lincolnshire's Health and Care system to improve the preventative offer to support the health and wellbeing of carers.

- An immediate new opportunity is the commissioning of the Integrated Lifestyle Service (ILS). This will target carers as a priority group to be supported. In addition, carers may be offered a Health Check and are a priority group for the Flu Vaccination campaign.

- Carers are a priority in the Joint Health and Wellbeing Strategy (JHWS). The JHWS Carers Delivery Plan focuses on actions which require an integrated/ joint approach by a wide range of agencies to support carer health and wellbeing.

3. Next Steps

- To refresh the Carers Commissioning Strategy 2019-21. Members are invited to contribute their views and priorities for the next three years.
- To extend the contract with Carers FIRST, within current contract terms, to June 2021.
- To consider the on-going role of Serco in relation to supporting carers in view of the proposal to extend their contract.

2. Conclusion

A Commissioning Strategy has been developed and delivered by lead commissioners. It now needs to be formally considered by the Council's Executive and informed by comments feedback from the Adults and Community Wellbeing Scrutiny Committee. Feedback will inform the refresh of the Carers Commissioning Strategy 2019-21.

3. Consultation

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

No

b) Risks and Impact Analysis

The Commissioning Strategies are considered as part of the wider Council's Risk Management Framework and Audit Cycle. The areas of commissioning responsibility are also considered via peer review.

A supplementary risk and impact analysis in relation to this commissioning strategy will also be completed once feedback is received from scrutiny.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Carers Commissioning Strategy 2016-2018

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 Emma Krasinska, who can be contacted on 01522 554008 or emma.krasinska@lincolnshire.gov.uk.

Carers Commissioning Strategy
2016 -18

Lincolnshire COUNTY COUNCIL
Working for a better future

Contents

Introduction

This Carers Commissioning Strategy 2016-18 reaffirms our commitment to recognising, valuing and supporting a greater number of Lincolnshire's carers. This strategy, which builds upon the foundations and priorities of the 'Joint Carers Strategy 2014-18 'And how are you?', provides our response to the lives and aspirations of unpaid carers in Lincolnshire.

While we wish to support people to take up and sustain a caring role we also acknowledge that caring can result in poorer outcomes in terms of health and wellbeing, finance and employment for the carer. Adult Care, as the lead for this strategy, aims to work with a range of strategic partners such as our colleagues in Children's Services, Public Health and the wider NHS to ensure carers are able to access early help and support that will enable them to care safely with confidence. We will also work in partnership to identify young carers to offer support and advice as well as helping them to avoid taking on inappropriate caring roles.

In recognition of the importance of the Carers Service we will continue to invest and financially support this area going forward. Although there are many current financial constraints and pressures being enforced upon the Council through Government funding cuts and reductions, the Carers budget for 2016/17 will remain at the same level as last year at £2,04 million for the year.

While we are committed to supporting the caring population of Lincolnshire we also need to work with local communities to encourage families to take increasing personal responsibility for their wellbeing, management of long term conditions and planning for the future. This includes taking responsibility for caring for our families and friends.

In Lincolnshire we have 79,262[1] carers who save the local health and social care economy an estimated £1,558 million by annually providing unpaid care to their families and friends who live with ill-health, frailty or a disability[2]. Without this support Lincolnshire's health and care system would not cope. As such we recognise the importance of the relationship public agencies have with people as carers.

We know that carers who feel well informed and supported are more able to sustain their caring role and the ability of the person they care for to live where they want to be – typically at home, amongst family and friends. Providing support can also reduce or delay costly impacts on primary and acute health services, and long term social care.

By improving the rights of carers in England, through the implementation of the Care Act 2014 and Children and Families Act 2014, the government has acknowledged the valuable contribution many carers make towards enabling people to live in the community while receiving care at home.

Identifying and supporting carers is therefore a shared priority for health and care at both a local and national level. This strategy and the accompanying delivery action plan will play a vital role in ensuring partners work together to achieve improved outcomes for Lincolnshire's carers.

Glen Garrod
Executive Director for Adult Care
Lincolnshire County Council

[1] Population and caring hours taken from Census 2011 (Office for National Statistics).
[2] Estimated savings p.9 'Valuing Carers 2011" by Leeds University and Carers UK.

The Lincolnshire caring population

The Census 2011 identifies that there are 79,262 unpaid carers in Lincolnshire. The following breakdown details the caring population for each of Lincolnshire's Clinical Commissioning Groups (CCGs).

Lincolnshire West CCG

24123	Carers
538	Young carers (aged up to 15)
435	Young carers (aged up to 15) caring 0-19 hours a week
1224	Young carers aged 16-24
151	Young carers aged 16-24 caring more than 50 hours a week
5715	Older carers aged 65 and over
16646	Adult carers aged 25-64
5788	Adults caring more than 50 hours a week
37%	% of above who are aged 65 and over
26123	Carers predicted by 2018

Lincolnshire East CCG

27475	Carers
661	Young carers (aged up to 15)
543	Young carers (aged up to 15) caring 0-19 hours a week
1223	Young carers aged 16-24
152	Young carers aged 16-24 caring more than 50 hours a week
7747	Older carers aged 65 and over
17844	Adult carers aged 25-64
7941	Adults caring more than 50 hours a week
43%	% of above who are aged 65 and over
29753	Carers predicted by 2018

Lincolnshire South West CCG

13167	Carers
297	Young carers (aged up to 15)
247	Young carers (aged up to 15) caring 0-19 hours a week
515	Young carers aged 16-24
48	Young carers aged 16-24 caring more than 50 hours a week
3353	Older carers aged 65 and over
9002	Adult carers aged 25-64
3124	Adults caring more than 50 hours a week
42%	% of above who are aged 65 and over
14259	Carers predicted by 2018

Lincolnshire South CCG

14497	Carers
314	Young carers (aged up to 15)
256	Young carers (aged up to 15) caring 0-19 hours a week
559	Young carers aged 16-24
64	Young carers aged 16-24 caring more than 50 hours a week
3833	Older carers aged 65 and over
9791	Adult carers aged 25-64
3345	Adults caring more than 50 hours a week
45%	% of above who are aged 65 and over
15699	Carers predicted by 2018

Caring Commitment

69% of people supported are aged 65 and over[1]

Physical disability (57%), long standing illness (45%) and problems connected with ageing (37%) are the most common reasons for support[1]

85% of carers co-habit with the person they support[1]

36% of carers provide more than 100 hours of care per week[1]

Health and Wellbeing

82% of carers do not spend enough time doing things they value or enjoy[1]

72% of carers do not have enough control over their daily lives[1]

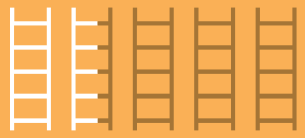
14% of carers feel they are neglecting themselves[1]

14% of carers have some worries about their personal safety[1]

62% of carers have a disability or long standing illness[1]

Finance and employment

19% of carers are not in paid employment because of their caring responsibilities[1]



Carers UK report that 34% of carers have missed out on the chance of promotion[2]

Carers UK report that 26% of carers have taken out a loan or fallen into debt because of their caring role[2]

Carers UK report that 67% of carers face higher transport costs because they care[3]

ASCOF (Adult Social Care Outcomes Framework)

65% of carers who find it easy to find information about services

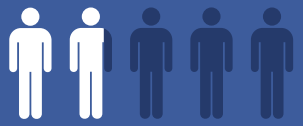
CIPFA*: 64%

71% who feel involved or consulted in discussions about the person they care for

CIPFA*: 71%

49% of carers who are satisfied with social services

CIPFA*: 42%



37% of carers have as much social contact as they would like

CIPFA*: 35%

[1] Results of Survey of Adult Carers in England (SACE) 2014-15 for Lincolnshire. 520 respondents (95% level, +/-5% confidence interval)
[2] Carers Week 'Prepared to Care?' report
[3] Carers UK The Caring and Family Finances Inquiry
*Lincolnshire's CIPFA (Chartered Institute of Public Finance and Accountancy) benchmarking group contains 16 local authorities who share similar socio economic characteristics.

Aim 1: Early help and support

Providing early help is more effective in promoting the wellbeing of carers than reacting in a crisis. Early help means providing support as soon as the caring role starts, from the point of diagnosis through to the end of the caring role.

Priorities

- Empower carers to be adequately prepared and supported for the role as it develops
- Support carers to look after their own physical and mental wellbeing, including developing coping mechanisms
- Help carers to access the information, advice and support they need including financial and entitlements
- Support carers to care effectively and safely for themselves and the person they support
- Support carers to plan for the future, including emergencies, to make choices about their lives such as combining care and employment
- Ensure carers and professionals recognise carers and the role and know where to go for information, advice and support
- Improve self-serve options for carers and connect them to local services and the community
- Young carers to be identified and supported through the Early Help service arrangements

Year 1 (2016-17) Milestone:

- Create and implement an Information and Advice Plan

I am prepared and have a system in place so that I can get help at an early stage to avoid a crisis

Aim 2: Collaboration

Work together to improve carers outcomes

Priorities

- Work with partners to provide an integrated and seamless carers journey that allows for the whole family approach
- Work with partners to ensure appropriate support is in place for the person being cared for to reduce the impact on the caring role
- Work with health and care professionals to ensure carers are listened to from the outset and involved in the care of the person they support
- Ensure the health needs of carers are recognised by GP's and that carers can access timely emotional support and counselling when necessary
- Encourage information sharing and collaboration with professionals and agencies
- Work with strategic partners to ensure early/earlier identification of carers from the point of diagnosis and signpost to appropriate support and services
- Work together to identify young carers and prevent them from taking on inappropriate caring roles
- Work with the education sector to ensure young carers are identified and have a supportive learning environment which is sensitive to their needs and promotes educational attainment
- Engage and co-produce with carers to develop and improve services

Year 1 (2016-17) Milestone:

- Working with health, schools and the further education sector we will create and implement a strategic plan that will promote the early identification of carers to enable them to access timely and appropriate support.

I feel respected, included and involved

Aim 3: Assurance

Confirm what we do makes a difference

Priorities

- Through a phased approach meet our Care Act 2014 and Children and Families Act 2014 duties and responsibilities.
- Commission services that have a single point of contact and offer a wide range of support that enables carers to manage the caring role
- Improve our understanding of the local themes, trends and population around carers to influence and shape preventative measures and support services
- Target resources to meet needs
- Promote ways for carers to have time for rest or recreation and ensure that carers at risk of breakdown get the breaks they need
- Through a process of local audits and scrutiny, monitor legislative and practice standards
- Co-production – work with carers to produce a good range of information and advice that meets their needs
- Review and improve systems and processes to ensure effective delivery of service and measuring of outcomes
- Ensure the strategy's delivery action plan has appropriate governance which is accountable for its progress

Year 1 (2016-17) Milestone:

- Create and implement a Quality Assurance Framework

I am satisfied with the support I receive

Aim 4: Workforce development

Ensure we have an appropriately skilled and effective workforce

Priorities

- Develop and deliver a workforce development strategy and delivery plan and monitor this through quality assurance
- Enable learning that is easy to access and is of high quality
- Enable all partners supporting carers to retain a skilled and qualified workforce
- Link workforce development strategy with other organisations and service area workforce plans to ensure carers are recognised and supported.

Year 1 (2016-17) Milestone:

- Review the outcome of Year 1 of the workforce development strategy and identify priorities and create and implement a further workforce development delivery plan.

I am recognised and well supported

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Lincolnshire COUNTY COUNCIL Working for a better future

Policy and Scrutiny

Open Report on behalf of Glen Garrod, Executive Director of Adult Care and Community Wellbeing	
Report to:	**Adults and Community Wellbeing Scrutiny Committee**
Date:	**10 October 2018**
Subject:	**Adult Frailty and Long Term Conditions Commissioning Strategy**

Summary:

Lincolnshire County Council is a Commissioning Council and is organised in line with 17 Commissioning Strategies. These Commissioning Strategies are in different stages of readiness. This report has been produced to provide the Adult and Community Wellbeing Scrutiny Committee with details of the current Adult Frailty and Long Term Conditions Commissioning Strategy 2016 - 2019. The report contains the key strategic aims of the Strategy and what has been achieved since the implementation in 2016.

Actions Required:

(1) To note the content of the current Adult Frailty and Long Terms Conditions Commissioning Strategy and to provide feedback that can be considered by the Council's Executive.

(2) To provide feedback to Officers for use in the new Strategy due in 2019.

1. Background

The purpose of this Commissioning Strategy is to outline the Local Authority's intentions in Adult Care Commissioning for Adult Frailty and Long Term Conditions across Lincolnshire. The key commissioning intentions focus on supporting people to live in their own homes for as long as they wish by developing high quality, personalised services that are flexible, responsive and give people choice and control over how their care and support is provided.

The Strategy and associated activities support people with eligible needs as outlined by the Care Act 2014. The customer groups supported by this Strategy are Older People, People with Physical Disabilities and People with Sensory Impairments. It is acknowledged that this Strategy requires updating and refreshing as it is due to conclude in 2019. Feedback from the Scrutiny Committee is welcomed as this will inform and support the development of the new Strategy.

Overall the Strategy has achieved its aims and performance has continued to improve in key areas as reported through the end of year Council Business Plan performance, examples of which are:

- Permanent admissions to residential and nursing homes aged 65+ has exceeded the target.
- Adults who receive a direct payment has exceeded the target
- People in receipt of long term support who have been reviewed has exceeded the target.
- Delayed Transfers of Care from Hospitals attributable to Social Care has continued to reduce.
- Partnerships with District Councils and Greater Lincolnshire are beginning to deliver on housing and accommodation for Older People and people with Long Term Conditions.

The new Strategy will focus on key priorities for the Council, local people and build on the successes which the 2016-19 Strategy has highlighted.

2. Conclusion

A Commissioning Strategy has been developed by Lead Commissioners which needs to be formally agreed by the Council's Executive. A refreshed version of the Strategy will be produced in 2019 and in line with feedback from Scrutiny and the Council's Executive.

3. Consultation

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

No

b) Risks and Impact Analysis

The Commissioning Strategy is considered as part of the wider Council's Risk Management Framework and Audit cycle. The areas of commissioning responsibility are also considered via Peer Review.

A supplementary risk and impact analysis in relation to this Commissioning Strategy will also be completed once feedback has been received from the Scrutiny Committee.

4. Appendices

These are listed below and attached at the back of the Report	
Appendix A	Adult Frailty and Long Term Conditions Commissionig Strategy

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 Carolyn Nice, who can be contacted on 01522 553762 or carolyn.nice@lincolnshire.gov.uk

Adult Frailty and Long Term Conditions: Commissioning Strategy 2016-2019

Lincolnshire COUNTY COUNCIL
Working for a better future

Contents

Introduction

The purpose of this Commissioning strategy is to outline the local authority's intentions in Adult Care Commissioning for Adult Frailty and Long Term Conditions across Lincolnshire. The key commissioning intentions focus on supporting people to live in their own homes for as long as they wish by developing high quality, personalised services that are flexible, responsive and give people choice and control over how their care and support is provided.

The strategy and associated activities support people with eligible needs as outlined by the Care Act 2014. The customer groups supported by this strategy are Older People, People with Physical Disabilities and People with Sensory Impairments.

The Joint Health and Wellbeing Strategy (JHWS) provides the context and structure for how partners across Lincolnshire can add value by working together differently. This includes collaboration between commissioning authorities, partners, providers and people in our communities. The JHWS sets out five strategy themes for 2013-2018 and helps inform Adult Care's Commissioning Intentions[1].

The population of Lincolnshire is one of the most dispersed in the country and this represents challenges for providing a consistent range of quality services. It is predicted that the elderly population in Lincolnshire will increase by 3.4% in the next 10 years, and the rate of increase in people aged over 85 is particularly pronounced with an expected increase of 52.4%[2].

Nationally, pressure on social care is increasing, and providing necessary services for older people and people with long term conditions poses a significant challenge. The need for care and support is rising and there has been a long term reduction in funding for local councils from central government so services have increasingly had to be managed in this context. We recognise that meeting the challenges ahead requires a collective response and we will continue to work closely with partners (such as the Police and NHS) to develop the solutions the market needs using key drivers such as the Better Care Fund (BCF).

The council will continue to prioritise quality and safeguarding and encourage providers to improve consistency and supply of service. We aim to continue to find more creative ways of improving services and building relationships with our strategic partners such as the NHS and care providers.

Pete Sidgwick
Assistant Director, Adult Care
Adult Frailty and Long Term Conditions

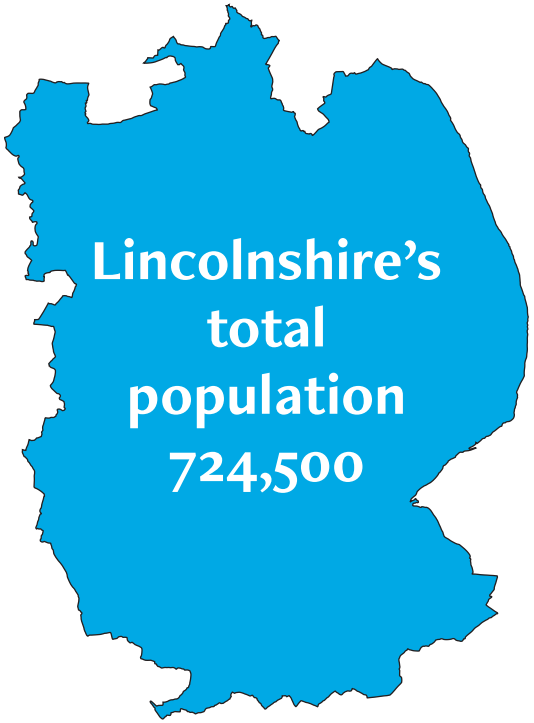
[1] www.lincolnshire.gov.uk/residents/public-health/behind-the-scenes/policies-and-publications/joint-health-and-wellbeing-strategy/115339.article
[2] www.lincolnshire.gov.uk/residents/adult-social-care/for-providers/key-documents/market-position-statement/127863.article

Key Facts

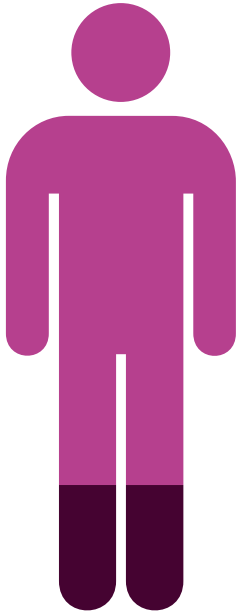
13,675 older people supported by adult care

2,115 people with physical disabilities supported by adult care

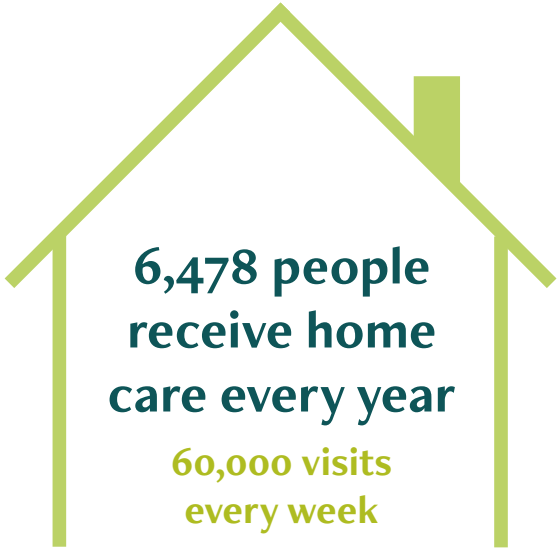
55% of people seen by reablement went on to live independently with no ongoing services



12% population live within 20% of the most deprived areas of Lincolnshire



20.7% of the population is aged over 65



£96m spent on services for older people

80.3% of people who use our services say they have control over their daily life

£14m spent on services for people with a physical disability

Aim 1: 'To enhance the quality of life for people with care and support needs'

Priorities

- Helping people manage their own support as much as they wish, so that they are in control of what, how and when support is delivered to match their needs
- Carers are supported to balance their caring roles and maintain quality of life
- People with care and support needs are able to find employment, maintain a family life, contribute to community life and avoid loneliness or isolation

Key Measures

- The number of people using services with control over their daily life, taken from the Adult Social Care User Survey.
- The number of clients in receipt of long term support who receive a direct payment.

We will

- Continue to commission services that support people to remain living independently
- Ensure that everyone has a personal budget to plan and manage their own support.
- Promote the use of direct payments and support people who want to take their personal budget as a direct payment
- Continue to work with partners to develop dementia friendly communities
- Review respite provision across the county to ensure it is meeting the requirements of both people who use services and their carers
- Enhance the range of Day opportunities available and support people to identify opportunities in their own communities
- Continue to support people with sensory impairment, with access to a specialised service
- Endeavour to secure adequate budgets to support the homecare sector and work closely with providers of care to improve the image of the role of the care worker. Increase the level of qualifications and recruitment.
- Explore the best way of managing care that recognises people's assets and the support provided by carers

Aim 2: 'To delay and reduce the need for care and support'

Priorities

- Adults with care and support have the opportunity for the best health and wellbeing throughout their life, and have access to support and information to help them manage their care needs
- Health and care organisations working in partnership to achieve earlier diagnosis, intervention and re-ablement so that people and their carers are less dependent on intensive services
- When people develop care needs, they receive care and support in the most appropriate setting (most often at home) which enables them to regain their independence

Key Measures

- A reduction in the number of permanent admissions to residential and nursing care homes of people aged 65 and over
- An increase in the number of requests for support for new people where the outcome was universal services or signposting

We will

- Continue to invest in re-ablement services to increase the number of people who can access the services and the proportion of people who are supported to regain their independence
- Maximise the benefits of telecare to support people to be less dependent on intensive services
- Work jointly with the NHS to develop intermediate care services that maintain peoples independence for as long as possible
- Ensure that after a hospital admission people, are supported in a timely way to return to independence, as soon as is appropriate
- Provide accessible information and advice to enable people and their carers to make informed decisions and plan for the future
- Utilise short term care and respite to support people and their carers to maintain their caring role
- When we commission services, we will work with providers to ensure carers and their needs are identified at an early stage
- Ensure that opportunities already available in communities are utilised to support the wellbeing of individuals
- Work with partners to ensure a strategic approach to Housing for older people and people with long term conditions

Aim 3: 'To ensure that people have a positive experience of care and support'

Priorities

- People who use health and social care and their carers are satisfied with their experience of care and support services
- Carers feel that they are respected as equal partners throughout the care process
- People and their families know what choices are available to them locally, what they are entitled to and who to contact when they need help
- People with care and support needs are treated with respect and dignity. Support is sensitive to the circumstances of each person.

Key Measures

- A reduction in the number of delayed transfers of care from hospital
- An increase in the number of people in receipt of long term support who have been reviewed

We will

- Develop our approach to co-production and identify opportunities for older people and younger adults with sensory and physical disabilities, and their carers to actively contribute to service development and redesign
- Continue to engage with the provider market in Lincolnshire and beyond, to stimulate a diverse range of appropriate high quality services
- Continue to improve the information we provide about the care and support services available to people
- Ensure, through quality assurance, that people's experience of care services is used to inform the care and support we commission
- Ensure that services we commission can demonstrate dignity in care
- Continue to develop robust contract monitoring and quality assurance across all commissioned services
- Work with NHS commissioners and care regulators to ensure that services are sustainable and safe, through the sharing of intelligence and joint working
- Work with NHS and other partners to ensure that quality and dignity of care is maintained when people are at the end of their life

Key Commissioned Activities

As we commission independent providers to supply nearly all of our services, we expect that these services meet certain standards to ensure we meet our legal duties. We set out clear requirements through our contracts and specifications. These are increasingly outcomes-based, which helps to ensure that we continue to commission high quality services to meet people's needs.

Once a service is commissioned we monitor our contracts and undertake service reviews which include understanding people's experience of the service. This helps us to take action when needed to rectify any problems and to further develop our services, understand our market and support our communities.

Information and Advice

We have commissioned a Care and Wellbeing Hub providing information and advice on care and support services in Lincolnshire. Last year, over 20,000 people were supported with information and advice services via contact with the Hub. In addition, we provide information and advice services through our website MyChoiceMyCare[3], which gets an average of 3,000 users each month.

Home Based Reablement (£4m)

Re-ablement provides services for people with poor physical health to help them accommodate their illness by learning or relearning the skills necessary for daily living. We have been actively redesigning models of care support for frail elderly people in the community in order to avoid and/or reduce the length of stay in hospital. Our county-wide re-ablement service, which was recommissioned in Autumn 2015, is a short-term intensive service that supports people in their own home to improve their ability to stay independent.

[3] http://mychoicemycare.org.uk/

Home Care (£22m)

Through our contracted services we currently provide 5,100 hours per day of care to people in their own homes, this equates to 60,000 visits per week. It was recognised that we needed to change how we provided home care services to enable us to contract manage and monitor more effectively the quality of service we provided to people in Lincolnshire. In September 2015 we moved to a new model of contracting which allows us to work closely with the prime provider in each area of the county to ensure cost and quality of care is managed effectively. This has enabled more certainty for the providers, which will allow them to explore how they can move towards an outcomes based homecare service, over the life of the contract.

Respite Care (£7m)

We are currently reviewing the provision of respite and short breaks, we will be examining the quantity and quality of existing services to ensure that they can meet current and future demands and that they are good value for money.

Day Opportunities (£.7m)

We are reviewing the day opportunities available to people across the county. We will seek to ensure that people can access a range of opportunities which offers choice and allows the support people need to be personalised to their needs. We will also look at how people can find out and access activities that are going on in their own community.

Dementia Services

Local information about dementia can be found in the Lincolnshire Joint Strategy for Dementia 2014-17[4]. A review of the Action Plan for the Joint Strategy for Dementia will be undertaken in the autumn and a report will be produced to provide feedback on progress in Lincolnshire.

Adult Care has recently commissioned a Dementia Family Support Service, which is provided by the Alzheimer's society. This new service model will provide information, advice and on-going support to families after diagnosis through to end of life. We will review the service after 6 months of implementation to ensure the service is 'fit for purpose' and provide assurances that this new service is effective in its delivery.

Residential and Nursing Care (£67m)

There are 279 care homes in Lincolnshire, 186 for older people and 93 for people aged 18-64 with disabilities. There are approximately 6,096 people age over 65 in care homes and 1,127 aged 18-64. 3,500 of clients are funded by Adult Care. Whilst CQC has a key role for ensuring providers meet the fundamental standards of quality and safety, we also have a responsibility to assure ourselves of the safety and effectiveness of commissioned services. Under the current contract every Care Home receives a minimum of an annual contract monitoring visit to review contract compliance and the quality of care.

A new Framework agreement for Residential and Nursing Care homes was implemented in 2015. We recognise that not all providers are the same and with over 270 Care Homes in Lincolnshire we need to target our resources effectively. A risk matrix tool is used to identify those at high risk of delivering poor quality care and these will have more frequent visits and action plans in place. This and other sources of information help us to monitor the quality of the services. We will be working closely with the local care sector association, LINCA to identify future market development.

Direct Payment Service (£11m)

Demand for personalised social care is growing in Lincolnshire. Many people who use personal assistants take a Direct Payment to pay for the service they

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[4] www.lincolnshire.gov.uk/residents/adult-social-care/strategies-policies-and-plans/joint-dementia-strategy-2014-%E2%80%93-2017/121668.article

receive. Currently 5,725 people and carers are in receipt of a Direct Payment and this is expected to grow which will in turn increase the demand for personal assistants.

In October 2015 we commissioned a Direct Payment support service in order to respond to requirements of the Care Act 2014 and increasing demand for the service. A review of the service in 2016 will examine activity levels across the service to ensure that the uptake of direct payments is being actively promoted, particularly with people with physical and sensory impairments.

Sensory Impairment (£0.6m)

The service commissioned by Lincolnshire County Council is a preventative and re-ablement service for both adults and children with a sensory impairment, both cognitive and acquired and their associated disabilities.

The service was recently recommissioned and from 1 April 2016, 'Action on Hearing Loss' will be the prime provider working in partnership with Lincoln and Lindsey Blind Society (LLBS) and South Lincolnshire Blind Society (SLBS), known locally as Lincolnshire Sensory Services. The new service will increase the number of people who are sensory impaired to retain their independence, it will assist in reducing social isolation, encourage better use of technology and have an integrated approach to working with health organisations and other partners.

The sensory impairment service contributes towards Lincolnshire County Council achieving positive outcomes for people in alignment with the Adult Social Care, Public Health and Children's Outcomes Framework.

It is estimated that there are 90,000 people in Lincolnshire with a moderate, severe, or profound, hearing impairment and this number will rise to 126,000 by 2030.

It is estimated that there are 270 people aged 18-64 in Lincolnshire with a serious visual impairment and 14,000 people aged 65 and over with a moderate or severe visual impairment.

Extra Care Housing

There are currently eight extra care schemes with a total of 288 units in Lincolnshire. The needs assessment conducted in 2014 clearly identified that this was insufficient to meet the demand in the county. We are currently in the process of procuring extra care developments across the county through a new type of contract where we will provide identified gap funding to the development of schemes. In addition to this, Adult Care will be working with Public Health and District colleagues to develop a Preventative Housing Strategy, which will further the aim of meeting peoples need in their own homes. For a further analysis of the need for extra care housing, see our market position statement[5].

[5] www.lincolnshire.gov.uk/residents/adult-social-care/for-providers/key-documents/market-position-statement/127863.article

Lincolnshire COUNTY COUNCIL Working for a better future

Policy and Scrutiny

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

Report to:	**Adults and Community Wellbeing Scrutiny Committee**
Date:	**10 October 2018**
Subject:	**Lincolnshire Joint Strategy for Dementia**

Summary:

The Joint Strategy for Dementia 2018 - 2021 is a refresh of the existing Joint Strategy for Dementia Care 2014 – 2017 and has been developed and co-produced with our strategic partners, people who live with dementia, their families and carers to provide a strategic framework around dementia for the next three years.

The Strategy refresh sets out our vision and details our achievements since the implementation of the Lincolnshire Joint Strategy for Dementia 2014 - 2017.

The Strategy has also been presented at the Lincolnshire Health and Wellbeing Board.

Actions Required:

(1) To support the draft Lincolnshire Joint Strategy for Dementia (Appendix A).

(2) To agree to a summary document for the Strategy to be developed.

1. Background

The Lincolnshire Joint Strategy for Dementia 2014 - 2017 was produced by the Council in partnership with the four Clinical Commissioning Groups (CCGs), NHS trusts, and voluntary sector agencies.

The Dementia Officers Group has provided governance for the 2014 - 2017 Strategy to ensure that progress has been made on the priorities set; this governance will continue and will form a Sub Group that reports to the Health and Wellbeing Board.

The Council has, with support and engagement from the Clinical Commissioning Groups (CCGs) and other partners, refreshed and updated the Strategy for the period 2018 - 2021.

The refreshed Joint Strategy sets out the Partnership's priorities for the next three years and what they will do to be able to achieve these. The aim is to improve services for people with dementia, and their families, at all stages of the dementia journey.

The Strategy contains:

- The national and local policy context;
- Lincolnshire's achievements since 2014;
- The aims for the next three years and how we intend to achieve these.

Design and Publication

The Council's Communications Team will manage the process of graphic design, publication, and publicity to ensure corporate standards and processes are adhered to.

The text of the Joint Strategy must be agreed by all relevant partners before graphic design can be concluded. Subsequent publication will be in electronic and printed form.

A summary version of the Joint Strategy will also be produced, taking into account best practice guidance, and with people who live with dementia, their families and carers involvement.

2. Conclusion

Dementia is one of the most pressing national and local challenges for Health and Social Care Services.

Dementia continues to be a priority for Health and Social Care Commissioners.

The Association of Directors of Adult Social Services and the Local Government Association have endorsed the Prime Minister's Challenge on Dementia 2020.

The Strategy supports the Lincolnshire Sustainability and Transformation Partnership, and the NHS Five Year Forward View.

3. Consultation

Engagement Activity

The Council has worked with Strategic Partners, particularly CCGs and NHS England to ensure the Joint Strategy accurately reflects current national and local priorities.

The Council was represented at a joint CCG Dementia Workshop in September 2017 which focused on dementia diagnosis, clinical services, and action planning.

The CCG Workshop (led by South-West Lincolnshire CCG, with support from NHS England), recommended the setting up of a Sub Group of the Lincolnshire Health and Wellbeing Board to ensure delivery of the objectives and actions of the Joint Strategy.

South-West Lincolnshire CCG and NHS England have nominated managers with delegated authority to agree the refreshed Joint Strategy.

The Council has engaged with local groups of people with personal experience of Dementia. Their comments on living with Dementia have supported and been recognised when developing the refreshed Strategy.

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

No

b) Risks and Impact Analysis

N/A

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Lincolnshire Joint Strategy for Dementia

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 Paul Herniman, who can be contacted on 01522 554219 or paul.herniman@lincolnshire.gov.uk.

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Lincolnshire Joint Strategy for Dementia
2018-2021
Draft V4.9
Lincolnshire
COUNTY COUNCIL
Working for a better future
NHS

Contents

Foreword

We are pleased to launch our strategy refresh which sets out our vison and details our progress and achievements since the implementation of the Lincolnshire Joint Strategy for Dementia 2014 - 2017 and also provides information on our priorities for Dementia services in Lincolnshire over the next three years. This work has been led by Lincolnshire County Council, and the Lincolnshire Clinical Commissioning Groups which are the agencies responsible for delivery of the Strategy.

Good progress has been made since 2014 but there is scope for more to be done to support people following a Dementia diagnosis**. We remain committed to the vision to support people to live healthy lives in order to reduce the risk of developing dementia, improve identification and early diagnosis to ensure that people can be better enabled to live well with Dementia through provision of meaningful support and services. By continuing to pursue our objectives and priority areas we will be able to support more people following a diagnosis and in turn support them to live at home, independently, for longer.**

Carers of people with Dementia, most often family members, are at risk of isolation, and those providing high levels of care are more likely to experience ill-health, according to the Carers' Trust report A Road Less Rocky (2013). This strategy refresh continues to advocate priorities that will help ensure both people with Dementia, and their carers, are offered support, information and advice that supports them and those around them throughout their Dementia journey.

The summary of key aims in this strategy provides the framework by which we will set, monitor and report on further improvements.

Dementia is one of our most significant health and social care priorities, both nationally and in Lincolnshire, as it has far reaching effects on people who live with the condition, their carers, family, friends, communities, businesses, health, social care and voluntary services. NHS England has reported there is also a considerable economic cost associated with the disease, estimated at £23 billion a year nationally, a figure predicted to triple by 2040. This is more than the cost of cancer, heart disease and stroke combined.

We will continue to raise awareness and develop and commission services that support people with Dementia to live well by accessing activities and services which help their physical and emotional wellbeing as well as the wellbeing of their family, friends and carers. We will also continue to promote the benefits of a healthy lifestyle, recognising that what is good for the heart is good for the brain, and can in some instances slow the progression of the disease.

The impact of Dementia can be far-reaching, but by increasing awareness and understanding of Dementia among both the public and among professionals we can make a real difference to improving the lives of people living with Dementia and also support those who care for them. Our commitment to the people of Lincolnshire is to do all we can to ensure access to care and support for those who need it.

Cllr Mrs Patricia Bradwell

Deputy Leader of Lincolnshire County Council, Executive Councillor for Adult Care and Health Services, Children's Services

Glen Garrod

Executive Director of Adult Care and Community Wellbeing Lincolnshire County Council

John Turner

Interim Chief Officer, South West Lincolnshire Clinical Commissioning Group (for Lincolnshire CCGs)

1. Introduction

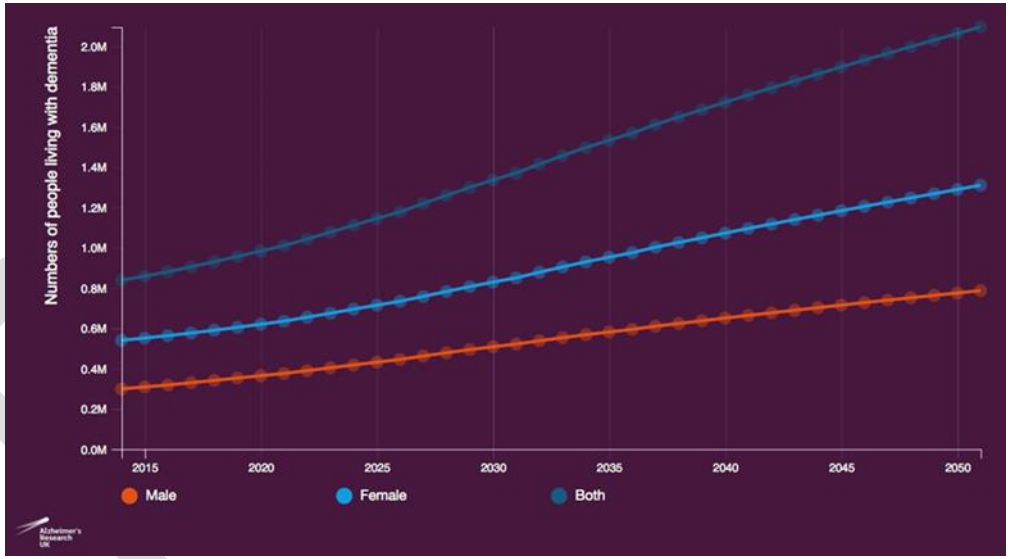
The purpose of this Strategy is to:

- Acknowledge the achievements of the Lincolnshire Joint Strategy for Dementia 2014 -2017.
- Update the Joint Strategy and set out Lincolnshire's vision for 2021.
- Identify key actions which will be undertaken to improve support and care for people with Dementia and their carers to realise our vision for 2021.
- Emphasise the need for a whole system approach across the NHS, Adult Social Care, Public Health, the independent and voluntary sector, and beyond, in order to identify the needs of people with Dementia, and those at risk of Dementia, and their families from diagnosis to the end of life.
- Promote the objective of a "Dementia-friendly" Lincolnshire by supporting the Dementia Action Alliance.

National View

Dementia is a progressive condition, and at present there is no cure or practicable means for screening people before symptoms emerge. Dementia continues to represent a public health challenge. Projections have calculated there were 850,000 people with Dementia in the UK in 2015 (Alzheimer's Society, 2014) and an estimated 46.8 million worldwide in 2015 (Alzheimer's Disease International, 2017). These numbers are set to rise, with it anticipated there will be over one million people with Dementia in the UK by 2021 and over two million by 2051 if no action is taken and current trends continue (Alzheimer's Society, 2014).

The graph below shows projections of dementia prevalence in the UK:



(Source: Alzheimer's Research UK)

Dementia can have a profound impact on people's sense of identity, behaviour, mood, and wellbeing, as well as all aspects of their relationships with others and their ability to manage everyday activities. The impact of dementia is not confined to people who directly experience the condition. It also has a major effect on their families and friends, and ultimately dementia has implication for everyone in society. As awareness and understanding of the personal and social impact of dementia has increased, a psychosocial approach has helped move from a narrow focus on disease alone to thinking about dementia in terms of disability. By highlighting the person rather than the disease leads to an emphasis on what helps people to live well with Dementia.

In 2015, Dementia replaced ischaemic heart diseases as the leading cause of death in England and Wales, accounting for 11.6% of all deaths registered in 2015 (Source: Office of National Statistics). It remains the leading cause of death for men and women over 80.

It is estimated that Mild Cognitive Impairment (MCI) affects between 5% and 20% of people aged over 65. Research suggests that 10% to 15% of people who had MCI with gradual memory loss went on to develop Dementia – usually Alzheimer's disease. Early work with people with MCI on improving their lifestyle can help to reduce the risk of MCI progressing to Dementia and may also provide them with wider health benefits. (Source: Alzheimer's Society)

The Lancet Commission has reported a range of potentially modifiable risk factors for Dementia that may account for approximately 35% of the risk of getting Dementia. (Source: The Lancet). These risk factors are:

- Low levels of education
- Midlife hearing loss
- Physical inactivity
- High blood pressure (hypertension)
- Type 2 diabetes
- Obesity
- Smoking
- Depression
- Social isolation

National Strategy

The NHS Mandate 2017-2018 states the ambition to:

- Deliver the actions as outlined in the Challenge on Dementia 2020 Implementation Plan
- Maintain a minimum of two-thirds diagnosis rates for people with Dementia.
- Continue to develop evidence based framework for a national treatment and care pathway and agree an affordable implementation plan for the 2020 Dementia Challenge, including improving the quality of post-diagnosis treatment and support.

In 2016, the new government re-committed to the policy as the Prime Minister's Challenge on Dementia 2020.

The Government's vision for 2020 and key aspirations are:

- **High quality, meaningful care** following diagnosis through to end of life care.
- **Public awareness and understanding** of the risk of developing Dementia is improved, and how people can **reduce risk by living more healthily**.
- GPs will play a leading role in ensuring **coordination and continuity** of care. Training will also need to be provided for all NHS staff on Dementia.
- National and local government will support the **Dementia Action Alliance** to help create a dementia-friendly community. Funding for Dementia research being **doubled by 2025**

The new national changes will help people plan for the future and put people more in control of the care they receive. Listed below is further information and guidance in relation to Dementia.

NICE has released specific guidance relating to mid-life approaches to delaying the onset of Dementia.

NICE Dementia Guidance on assessment, management and support for people living with dementia and their carers.

Supporting NICE guidance, the National Collaborating Centre for Mental Health (NCCMH) has published:

- The Dementia Care Pathway (2018) which gives improvements in the delivery and quality of care and support for people living with Dementia and their families.

Dementia: Applying All Our Health) which sets out key prevention messages at a population, community, family and individual level which may help reduce the risk of Dementia (Source: Public Health England)

2. Key Facts

Dementia is now one of the top **5** underlying causes of death in the UK

2 in 3 people with **Dementia** are female

1 in 3 people born in the UK in **2015** will develop **Dementia** in their lifetime

850,000 people are estimated to be living with **Dementia** in the UK

Dementia is the leading cause of death for men and women over **80** years old

1 in 14 people over **65** have **Dementia** in the UK and **1 in 79** of the whole population

Dementia is estimated to cost **£26.3** billion per year

In **2014** the number of people **65+** with **Dementia** in Lincolnshire was estimated at over **11,000**

Number of people in Lincolnshire estimated to have **Dementia** before **65** is **200** people

By **2020** the projected number of people living with **Dementia** in Lincolnshire is estimated at over **13,000**

64% of adults in Lincolnshire are **overweight or obese**

1 in 4 adults in Lincolnshire are **physically inactive** compared to 1 in 5 across England

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

In **2016/17**, **16.4%** of the population in Lincolnshire was recorded as having Hypertension (high blood pressure) compared to **13.8%** across England

Older people who are lonely are **1.63** times more likely to have **Dementia**

In **2015-16**, **£4.18M** was spent by LCC on short term and long term care for people with memory or cognition problems

62,000 adults are registered with **depression** in Lincolnshire

In **2015-16**, **£350,000** was also allocated to the Dementia Family Support Service and included a contribution of **£50,000** to the Dementia Support Network

3. Lincolnshire Context

Lincolnshire's Health and Wellbeing Board brings together key people from health and social care to work together to reduce inequalities and improve the health and wellbeing of the people of Lincolnshire. The Board has recently undertaken extensive engagement regarding its Joint Health and Wellbeing Strategy (JHWS) for Lincolnshire. Dementia has been identified as a priority area and this Joint Strategy reflects that fact with a number of priorities and actions which are directly related to the JHWS. The JHWS is available here.

The Lincolnshire Joint Strategy for Dementia 2014 – 2017 set out a plan to improve and to support people with Dementia their families and carers. Much has been achieved, and we will continue to address how we improve these things in our refreshed strategy.

In Lincolnshire, our achievements have included:

- The Dementia Family Support Service (DFSS) was developed and commissioned in October 2015 by Lincolnshire County Council. This service has helped over 3,200 people with Dementia and their Carers in Lincolnshire.
- There are now eight local Dementia Action Alliances in Lincolnshire covering all districts of the county. All those signed up to the DAA are working towards becoming Dementia friendly by actively contributing to raising awareness and understanding of Dementia. Developing Dementia-friendly environments, reducing stigma and developing positive attitudes towards the delivery of services.
- The Dementia Action Alliance acts as the formal partnership to progress the Dementia Friendly Communities. An accreditation process administered by the national DFC programme has to date recognised Lincoln, Boston, Skegness, Grantham, and Bourne under the scheme.
- Work has been undertaken on improving elements of the pathway, specifically on diagnosis.
- There are over two million Dementia Friends nationally with just over 19,000 in Lincolnshire**,** alongside 140 active Dementia Friends Champions. Lincolnshire County Council and Lincolnshire CCGs have led a number of awareness campaigns and targeted promotional work to help increase the number of Dementia Friends in Lincolnshire and will continue to do so across the lifetime of this strategy.
- United Lincolnshire Hospitals NHS Trust (ULHT) is a member of the Dementia Action Alliance and is committed to supporting the Dementia Friendly Hospital Charter.
- ULHT has also developed a tool that will support emergency and admissions to ensure a tailored stay in hospital. This has been undertaken in partnership with the Alzheimer's Society, Carers FIRST Lincolnshire, and Commissioners.
- In Lincolnshire organisations have developed a Frailty Pathway which includes tools to identify and support dependency across services.
- Lincolnshire Partnership NHS Foundation Trust (LPFT) provides a Dementia and Specialist Older Adult Mental Health Service for people needing help with suspected or diagnosed Dementia, as well as adults aged 65 years with complex mental health problems and other specialist needs.
- LPFT was the first NHS trust in England to sign up as a Dementia research 'Champion'.
- The Managed Care Network is an alliance of mental health groups and organisations that provide activities and services to give people support, structure and choice in their lives, and which includes dementia in its

terms of reference. At present MCN supports local Dementia projects in the Boston, Spalding, Stamford, and Gainsborough localities.

- We have engaged with people with Dementia their families and carers, in developing this Strategy, and will continue to do so to ensure we listen and take account of their experience and what they feel is needed to improve care and support.

The Picture for Lincolnshire

Dementia profiles for Lincolnshire evidence that a number of risk factors are worse than at both national and regional levels. These include inactive adults (doing less than 30 minutes of moderate intensity exercise each week) and adults who are overweight and obese. Prevalence of a number of conditions which are risk factors for Dementia are also higher in Lincolnshire including hypertension, stroke, diabetes, CHD and depression (Source: Public Health England, Dementia Profiles).

According to estimates, there were 11,289 people aged 65 and over with Dementia living in Lincolnshire in 2015, with 62% of people experiencing Dementia were estimated to be females. This gender inequality is caused by two factors: late onset of Dementia is estimated to be higher in females than males, plus women live longer than men which increases their risk of developing Dementia in older age (Source: Projecting Older People Population Information).

This table demonstrates the projected increase in the number of people with Dementia aged 65+ by district:

(Source: POPPI)

District	2017	2035
Boston	1017	1607
East Lindsey	2643	4378
Lincoln	1077	1798
North Kesteven	1797	3227
South Holland	1590	2656
South Kesteven	2184	4164
West Lindsey	1434	2555
Lincolnshire	11688	20427

The number of people aged 65 and older experiencing Dementia in Lincolnshire is projected to increase, at the same time the rates of Dementia prevalence are projected to increase to 8.2% of people aged 65+ or 2.3% of the total Lincolnshire population (Source POPPI).

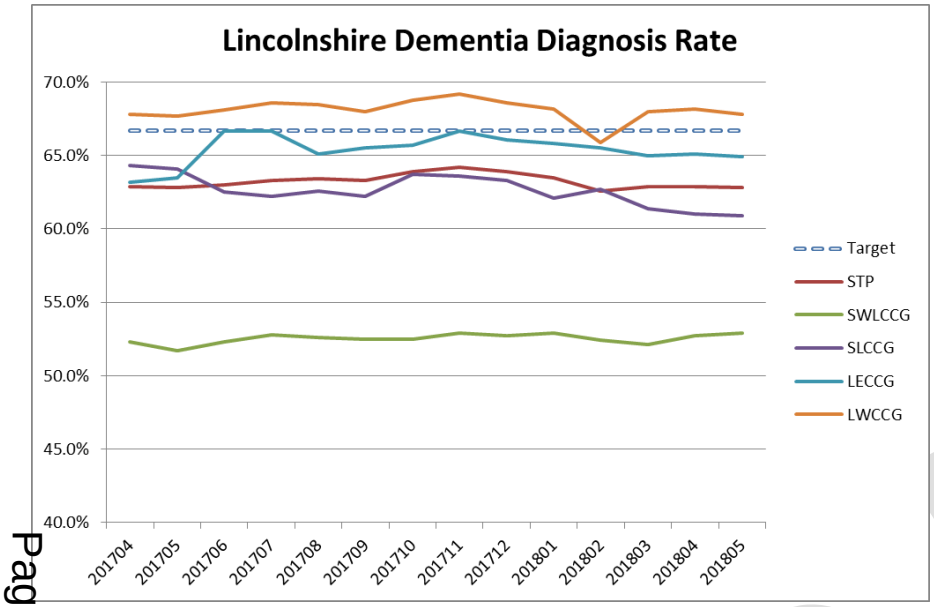
Applying national prevalence rates to the total number of patients registered at each Clinical Commissioning Group (CCG), Lincolnshire East CCG has the highest estimated rate at 4,104 (1.68%), which reflects the older age profile of its population (Source: Public Health).

From April 2017 the way NHS England calculates Dementia diagnosis rates has changed. Formerly, prevalence estimates were applied to Office of National Statistics population estimates. Instead they will be applied to registered populations from GP lists. Because of these changes it is not always useful to draw direct comparison between Dementia data published by NHS England in 2017/18 and earlier data sets, or those from other sources.

The growing proportion of people with Dementia will continue to represent a challenge to all aspects of health and social care provision. Therefore it is important that we work together in local communities to develop and ensure new and innovative ways to support people with dementia and their Carers

Fully addressing diagnosis aims requires a strategic approach. A self-assessment by the Lincolnshire CCGs in 2017 has identified areas of variation across clinical pathways which suggest an opportunity to share learning and pathways across CCGs. Work has been undertaken on improving elements of the pathway, specifically on diagnosis; however,an integrated countywide pathway for Dementia care has yet to be developed.

The graph below compares diagnosis rates from April 2017 to May 2018:



(Source: Lincolnshire STP)

Dementia Research

All three of Lincolnshire's NHS Trusts and Lincolnshire County Council have pledged to be Join Dementia Research champions – the first time a whole county has promised to get behind the national campaign.

Join Dementia Research (JDR) is a nationwide online and telephone service that makes it easier for people to register their interest in volunteering for vital Dementia research.

County	JDR Registration numbers
Lincolnshire	290
Nottinghamshire	841
Derbyshire	650
Leicestershire	503
Northamptonshire	364

Nationally, there are more than 7,500 Join Dementia Research participants, and 165 studies have used the service as a way to find suitable volunteers. In Lincolnshire, 290 volunteers have signed up to JDR. The table below compares this figure with other authorities in the East Midlands. (Source: Research, Innovation and Effectiveness Department, LPFT)

A new recommendation from the National Institute for Clinical Excellence included in the NICE dementia guidelines June 2018 makes clear that health and care professionals should help people living with dementia and their carers find out about opportunities to take part in research, and empower them to make their own decisions about getting involved. One straightforward way to do this is to provide information about Join Dementia Research.

NICE evidence-based guidance remains central to improving awareness, prevention, early diagnosis and dementia care and support in Lincolnshire.

Enabling Research in Care Homes (ENRICH)

Improving the lives and health of older people living in care homes is a major UK government priority. ENRICH is a key part of the Government's Challenge on Dementia 2020 and LPFT help make this happen by improving the consistency of support for research outside the NHS. LPFT have worked with Lincolnshire Care Association (LinCA) and directly with homes to promote ENRICH, and now have the largest number of homes registered in the East Midlands.

LPFT have also completed one national research study, Agitation and Quality of Life in Care Homes (University College London), which involved three Lincolnshire care homes. The results of this large programme are currently awaiting publication.

4. Where we want to be in 2021: Our Vision

Over the next three years, to meet the aspirations of **National Dementia Policy**, and achieve our **Joint Strategy's Key Priorities** we commit to working with **Strategic Partners** across Lincolnshire and **National Partners**. We will adopt NICE Dementia Guidance (NG97).

"Next Steps on the NHS Five Year Forward View", published in March 2017, states that Sustainability and Transformation Partnerships (STPs) will be the main vehicle for health, social care and local government leaders to plan integrated service provision. The Lincolnshire Sustainability and Transformation Partnership have published its plans.

The refreshed Lincolnshire Joint Strategy for Dementia will be aligned to national policy. We will have robust processes to ensure monitoring and reporting of policy compliance. The Prime Minister's Challenge highlighted risk reduction as there is a growing evidence to reduce an individual's risk of dementia by supporting them to live healthier lives. Around a third of Alzheimer's disease diagnoses worldwide might be attributed to potentially modifiable risk factors.

We will deliver our prevention commitments as per the Joint Health and Wellbeing Strategy for Lincolnshire 2018. This will include:

- Improving timely identification and diagnosis
- Developing a prevention programme for vascular dementia increasing awareness of dementia across the population.
- We want to improve the experiences of people with dementia.
- Every person with dementia will have meaningful care from diagnosis to the end of life.
- We will ensure that people with dementia and their family carers are supported to live well no matter what stage of their illness.
- We will commit to extending support for and engagement with, Third Sector organisations working with people and families affected by Dementia.
- We will continue to work with NHS England, Alzheimer's Society and partners to ensure as many people affected by dementia as possible benefit from personalised support following diagnosis.

- We will use the National Dementia Statements, ensuring that we listen to people affected by dementia and gather evidence to better understand their experiences at every stage of the dementia journey. The new Dementia Statements reflect the things people with dementia say are essential to their quality of life:

  - ✓ *We have the right to be recognised as who we are, to make choices about our lives including taking risks, and to contribute to society. Our diagnosis should not define us, nor should we be ashamed of it.*
  - ✓ *We have the right to continue with day-to-day and family life, without discrimination or unfair cost, to be accepted and included in our communities and not live in isolation or loneliness.*
  - ✓ *We have the right to an early and accurate diagnosis, and to receive evidence based, appropriate, compassionate and properly funded care and treatment, from trained people who understand us and how dementia affects us. This must meet our needs, wherever we live.*
  - ✓ *We have the right to be respected, and recognised as partners in care, provided with education, support, services, and training which enables us to plan and make decisions about the future.*
  - ✓ *We have the right to know about and decide if we want to be involved in research that looks at cause, cure and care for dementia and be supported to take part.*

(Source: National Dementia Declaration: Dementia Statements, 2017)

Integrated Personal Commissioning (IPC)

Lincolnshire is an Integrated Personal Commissioning demonstrator site, with Dementia being an identified cohort for IPC delivery.

IPC is a nationally led, locally delivered programme that is supporting healthcare empowerment and the better integration of services across health, social care and the voluntary and community sector.

Through IPC, people, carers and families with a range of long-term conditions and disabilities are supported to take greater control over what services support them and who provide them.

Lincolnshire local authority and NHS partners have worked with the Alzheimer's Society, and other experts to focus on effective personalised care and support planning for people with dementia, incorporating a trial of a pioneering approach to individual asset mapping called Dementia Capital Networks. LCC and partners have also worked with Community Catalysts CIC to understand what is available to people and how a diverse local care market can be supported to thrive.

Alison's Story

Alison lives with dementia and participated in the IPC Dementia Capital Networks pilot project (DCN).

Alison had hobbies and interests but health issues were affecting her wellbeing. She took part in a DCN conversation to improve care and support planning by maximising the role of the person with dementia alongside family, social, and community resources.

Alison found the conversation a relaxed friendly experience, allowing time to talk about the things that really mattered to her: "*I felt listened to - a lovely, friendly, caring person, easy to talk to. What she said she would do was done… and no complicated words! I prefer this type of conversation and having this done in your own home feels relaxed and safe."*

Alison's family also found the DCN conversation made more things seem possible than before: "*Really good you came out and did the map as it is not until it's laid out in front of you do you really see things, the different areas, and access some areas we did not realise. It's good to talk something through and see things from a different perspective, it's a huge thing."*

DCN allowed Alison time and opportunity to share what was really important to her with family and friends and the Alzheimer's Society Dementia Support Worker. As a result of this person centred approach a four day holiday with the family was booked and the family worked to overcome the things that were getting in the way of Alison going shopping. Additional benefits entitlement was identified and a referral to Occupational Therapy Service made, all combining to provide Alison with a range of adaptions to her home, support and mobility. Most changes were delivered for low cost and brought her social network closer to find solutions for themselves.

Despite the conversation acknowledging concerns, Alison felt DCN helped her turn these into practical actions that were both reassuring and empowering: "*There are lots of vulnerable people out there, but I'm not one of them!"*

(Source: Alzheimer's Society)

5. Key Aims

The following key aims summarize the priorities and outcomes necessary to meet our objectives:

- Raise awareness and prevention by promoting healthy living among the public and professionals
- Improve diagnosis rates
- Following diagnosis to support more people to live at home independently for longer
- Enable people to live well with Dementia

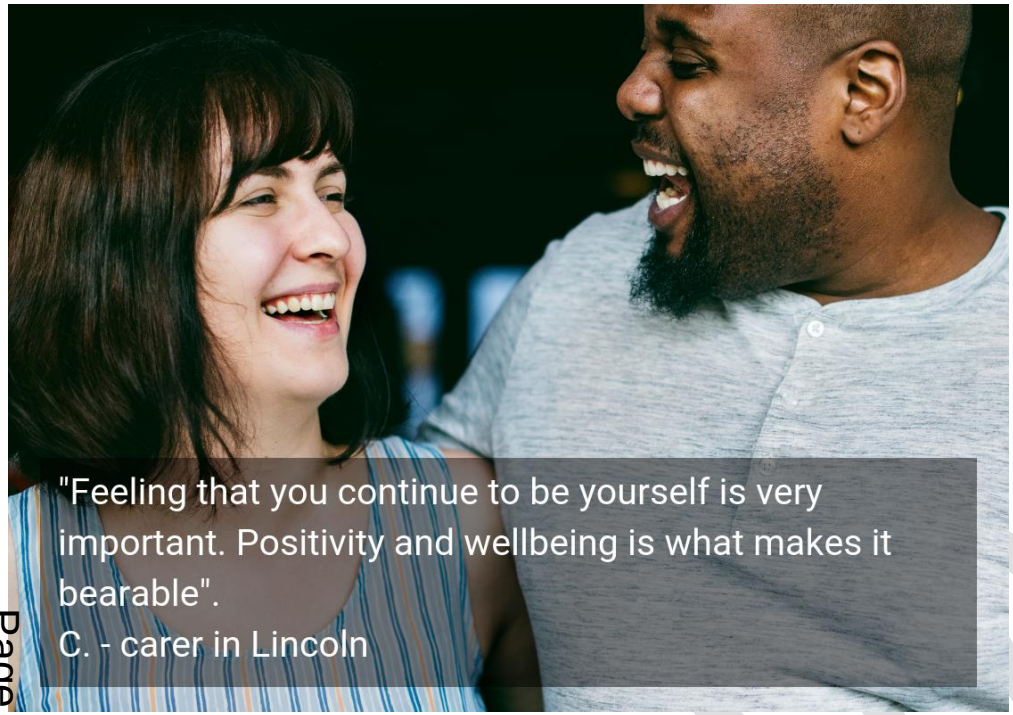
Aim 1 – Raise awareness and prevention by promoting healthy living among the public and professionals

Priorities

1. We want to improve awareness of how healthy lifestyle choices can reduce personal risk of developing dementia.
2. Reduce the risk factors for Dementia across the county by actively promoting healthy lifestyle services focused on key risk factors.
3. Improve awareness and skills needed to support people with Dementia and their carers in all areas of health and social care.
4. Identify opportunities for improved integrated Neighbourhood Team working.
5. Active involvement in, and support for, the Lincolnshire Dementia Action Alliance and the national Join Dementia Research programme.
6. Support the Sustainability and Transformation Partnership (STP) and Lincolnshire Health and Wellbeing Board (LHWBB) governance frameworks which ensure clear accountability for the delivery of the Joint Dementia Strategy.

We will

- The Lincolnshire Health and Wellbeing Board, through its new Joint Health and Wellbeing Strategy 2018, will develop a prevention programme focused on Dementia
- Create a Dementia sub-group that reports to the Lincolnshire Health and Wellbeing Board on implementation of the strategy action plan.
- Develop a strategy action plan with designated tasks and timescales.
- Promote healthy living to 40-74 year olds.
- Include Dementia awareness and signposting for 65+ in the NHS Health Check programme.
- Reduce psychosocial risk factors such as loneliness and depression.
- Incorporate dementia risk reduction and brain health promotion measures in other policy work streams for pre-disposing conditions such as cardiovascular disease and diabetes.
- Ensure appropriate Dementia training continues to be made available to health and social care staff on a sustainable basis.
- Promote '*Join Dementia Research*' among professionals and the public.
- Promote work undertaken by the Dementia Action Alliances.
- Promote the police-led Herbert Protocol to help keep vulnerable people safe.
- Hold an event to publicise and promote Lincolnshire's Joint Dementia Strategy.
- Promote Dementia Friends Campaign and support communities to become dementia - friendly including businesses, and health and care settings.



Outcome Measures

- Increased numbers of Dementia Friends in Lincolnshire.
- Greater awareness of Dementia strategy among the public and professionals reflected through surveys, feedback, and public events.
- Increased participation in Dementia research.
- Health & Wellbeing Board reporting requirements
- Annual reports – Dementia Strategy action plan

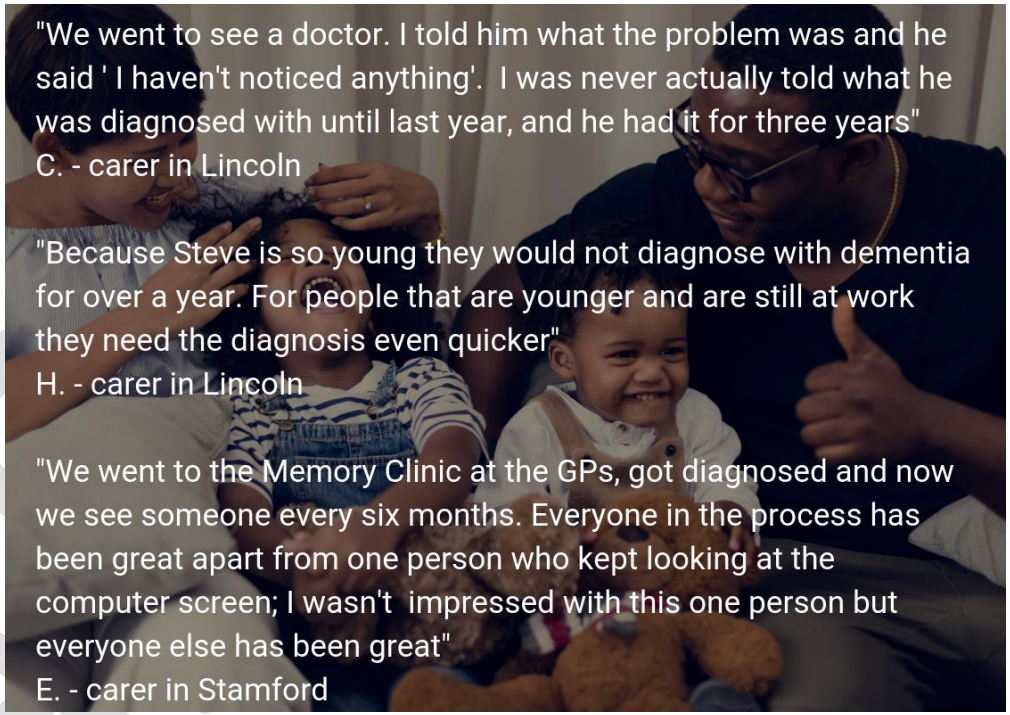
Aim 2 – Improve diagnosis rates

Priorities

1. We want to improve care by increasing Dementia diagnosis rates in line with national targets. We also want to ensure that we increase the number of people being diagnosed, and starting treatment or accessing interventions within six weeks of referral.
2. Achieve equity of access to diagnostic services by examining variations in waiting times and capacity.

We will

- Implement a countywide pathway for identification, referral, and timely diagnosis.
- Identify opportunities for jointly commissioning post-diagnostic support.
- Develop pathways to ensure people have access to appropriate post-diagnostic care and support.
- Focus on Mild Cognitive Impairment (MCI) as this represents a high-risk cohort who could potentially benefit through life-style education and social prescribing.



Outcome Measures

- Diagnosis rates meeting national targets in line with the NHS Mandate, Five Year Forward View, and the objectives of 'The Prime Minister's Challenge on Dementia 2020.
- Waiting time data.

Aim 3 – Following diagnosis to support more people to live at home independently for longer

Priorities

1. Improve the quality of post-diagnostic treatment, intervention and support available for people with Dementia and their carers to enable them to optimise independence and quality of life.
2. Ensure that people diagnosed with Dementia access timely intervention, social support and signposting.
3. Greater integration with the Frailty pathway and awareness of Dementia in multi-agency Neighbourhood Teams.
4. Agree and implement palliative care pathways for people with Dementia.

We will

- Develop service specifications for an integrated countywide Dementia pathway, taking into account NICE and NCCMH guidance.
- Design pathways around people with Dementia, taking into account, emergency hospital admission and Advance Care Planning.
- Pilot an Admiral Nursing service for people diagnosed with Dementia in Lincolnshire.
- Work with health and care professionals to ensure carers are listened to from the outset, and involved in the care of the person they support.
- Address unique palliative care aspects of people with Dementia when commissioning of end of life care.
- Embrace Neighbourhood Working.

Outcome Measures

- Published countywide Dementia pathway.
- Numbers of people accessing post-diagnosis support.
- Increased number of people with dementia having an integrated care and support plan

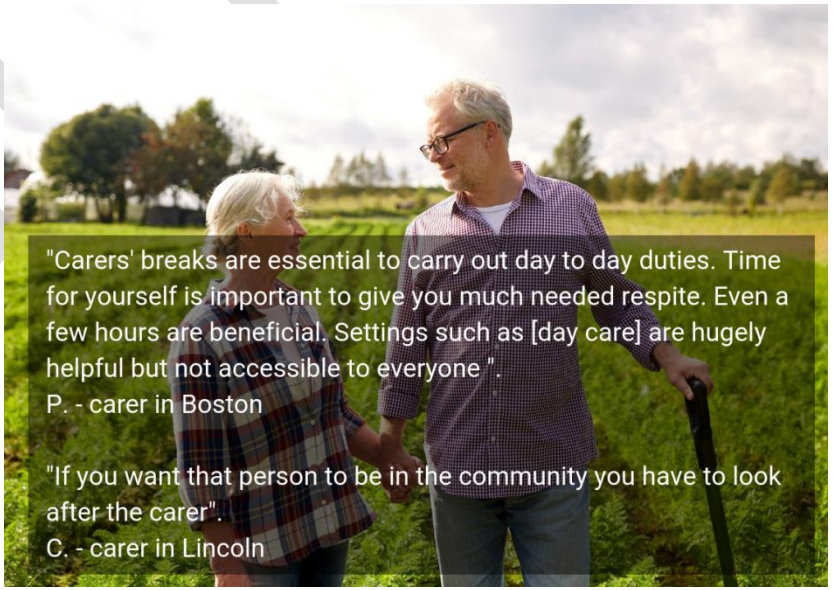
Aim 4 – Enable people to live well with Dementia

Priorities

1. Commission community based social support services for people with Dementia to live well and to support the wellbeing of families and carers. Ensure that people with lived experience of dementia are consistently involved in the governance and oversight of the Joint Dementia Strategy and its associated plans.
2. Standardise the Memory Assessment and Management Service (MAMS) model across the county to improve patient outcomes.
3. Reduce the amount of antipsychotic medication prescribed to people with dementia, reassessing a person prescribed antipsychotic medication every six weeks (NICE Guidelines June 2018, Dementia: assessment, management and support for people living with dementia and their carers).
4. Ensure people living with dementia who have sleep problems have access to a personalised multicomponent sleep management approach. (NICE 2018).
5. Ensure the sustainability of future support provision for people with Dementia and their families. Develop resilience and build community capacity.

We will

- Work with partners to provide an integrated and seamless carers journey that allows for the whole family approach.
- Work together to ensure a fully coordinated approach and deliver an agreed strategy action plan.
- Commission a post-diagnosis family support service to succeed the current DFSS agreement which will help promote resilience, healthy lifestyles, and physical and mental wellbeing.
- Promote and deliver the Joint Health and Wellbeing Strategy which acknowledges Dementia as a priority and emphasises prevention and early intervention.
- We will support the Integration agenda for people in Lincolnshire who access social care to have a joint health and social care assessment but critically to have a joint health and care plan where needed.



Outcome Measures

- Jointly Commission Services by CCGs and LCC.
- Evaluation of the MAMS service and outcomes.
- Improved outcomes for people with Dementia and their carers through data gathered from the Adult Social Care User Survey, Carers Survey and Commissioned Services.
- Number of people supported with dementia at home by integrated Neighbourhood Teams.
- Reduction in the amount of antipsychotic medication prescribed to people with dementia.
- Number of people with dementia dying at their usual place of residence.
- Number of people with dementia having an annual health check.
- Number of people with dementia that have a joint health and care plan.

6. Partnerships

Dementia Officers Group

The Dementia Officers Group is a special interest group of commissioners and providers which promotes good practice in Dementia care and support. Membership consists of staff from the statutory health and social care agencies as well as representatives from voluntary sector organisations. The group is chaired by an officer with responsibility for commissioning or providing Dementia services either for the NHS or local authority.

The group has drawn attention to the commitment in the Lincolnshire Joint Strategy for Dementia 2014 - 2017 to set up a Dementia Sub-Committee to be responsible for strategy implementation and governance. The Dementia Officers Group considers itself to be in a strong position to assume a more formal governance role towards this Dementia strategy.

The Alzheimer's Society

We have welcomed and worked with The Alzheimer's Society in Lincolnshire; they have been involved and supported in the following ways:

- The Sustainability and Transformation Plan for Lincolnshire (STP) to ensure it reflects sufficient Dementia commitment, and to continue to support and develop activity around local Dementia Action Alliances to encourage greater Dementia awareness.
- The Alzheimer's Society is represented on the CCG Dementia sub-group with representation from GP leads, NHS England and LPFT.
- Dementia leads in ULHT hospitals to develop a Dementia Care Bundle to improve patient outcomes.
- Primary Care teams across Lincolnshire to offer free training on Dementia.
- The Lincolnshire Integrated Personal Commissioning (IPC) demonstrator project to support people affected by Dementia at the centre of health and social care.
- Neighbourhood Teams and Memory Assessment clinics with the aim, over the next three years, of having a specialist Dementia support worker holding their own caseload as an integral member of the team.

The Alzheimer's Society has also invested in a range of support services in Lincolnshire future plans include promoting the 10 point plan for integrated dementia care and scoping a partnership project with NHS England's national Personalised Care Group team:

- End of Life Care Providers Group which is made up of seven health and social care organisations make up membership of the Lincs and Borders
- St Barnabas Hospice host the Lincolnshire Palliative Care Co-ordination Centre (PCCC) which is an administrative centre which matches care needs with care providers for patients needing palliative care.

7. Acknowledgements

This Joint Strategy acknowledges the contributions of:

- Lincolnshire County Council
- Lincolnshire Clinical Commissioning Groups
- NHS England
- Service users, patients, and carers
- Alzheimer's Society
- Lincolnshire Partnership NHS Foundation Trust
- United Lincolnshire Hospitals NHS Trust
- Lincolnshire Community Health Services NHS Trust

8. Sources & Useful Links

Alzheimer's Society
www.alzheimers.org.uk

Carers Survey (2017), Adult Social Care, Lincolnshire County Council
Internal Lincolnshire County Council Report

Dementia Action Alliance
www.dementiaaction.org.uk

Dementia Family Support Service
https://www.alzheimers.org.uk/homepage/168/dementia_connect#!/detail/a0z7000001gcTcWAAU?lng=-0.5456245999999965&lat=53.2315311

Dementia Friends
www.dementiafriends.org.uk

Herbert Protocol
www.lincs.police.uk/reporting-advice/missing-person

Join Dementia Research
www.joindementiaresearch.nihr.ac.uk

Joint Health & Wellbeing Strategy, Public Health, Lincolnshire County Council
https://www.lincolnshire.gov.uk/health-and-wellbeing/information-for-professionals/health-data-policies-and-publications/joint-health-and-wellbeing-strategy/115339.article

Joint Strategic Needs Assessment
www.research-lincs.org.uk/Joint-Strategic-Needs-Assessment.aspx

Lincolnshire Community Health Services NHS Trust
www.lincolnshirecommunityhealthservices.nhs.uk

Lincolnshire County Council
www.lincolnshire.gov.uk/

Lincolnshire County Council – Market Position Statement
https://www.lincolnshire.gov.uk/residents/adult-social-care/for-providers/key-documents/market-position-statement/127863.article

Lincolnshire County Council – Local Account
https://www.lincolnshire.gov.uk/residents/adult-social-care/strategies-policies-and-plans/adult-care-local-account/114719.article

Lincolnshire Partnership NHS Foundation Trust
www.lpft.nhs.u/

Lincolnshire Research Observatory
www.research-lincs.org.uk/Home.aspx

NHS Digital
https://digital.nhs.uk

NHS Lincolnshire East Clinical Commissioning Group
https://lincolnshireeastccg.nhs.uk

NHS South Lincolnshire Clinical Commissioning Group
https://southlincolnshireccg.nhs.uk

NHS Lincolnshire West Clinical Commissioning Group
http://www.lincolnshirewestccg.nhs.uk

NHS South West Lincolnshire Clinical Commissioning Group
http://southwestlincolnshireccg.nhs.uk

National Collaborating Centre for Mental Health (NCCMH)
https://www.rcpsych.ac.uk/members/nccmh.aspx

Prime Minister's Challenge on Dementia 2020
https://www.gov.uk/government/publications/prime-ministers-challenge-on-dementia-2020

Projecting Older People Population Information
http://www.poppi.org.uk

Social Care Institute of Excellence: building social capital
https://www.scie.org.uk/publications/windowsofopportunity/interventions/buildingsocialcapital.asp

United Lincolnshire Hospitals NHS Foundation Trust
https://www.ulh.nhs.uk

Public Health England Dementia Profile

https://fingertips.phe.org.uk/profile-group/mental-health/profile/dementia/data#page/1/gid/1938133052/pat/15/par/E92000001/ati/120/are/E54000013

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Lincolnshire COUNTY COUNCIL
Working for a better future

Policy and Scrutiny

Open Report on behalf of Glen Garrod, Executive Director Adult Care and Community Wellbeing	
Report to:	**Adults and Community Wellbeing Scrutiny Committee**
Date:	**10 October 2018**
Subject:	**Adult Care & Community Wellbeing 2018/19 Outturn Projection**

Summary:

The Adult Care & Community Wellbeing (AC&CW) net budget is £221.288m. The Gross figure for Adult Care for 18/19 is £281.804m. Based on current information available to 31 August 2018 it is estimated that AC&CW will produce a breakeven budget for the financial year 2018/19. The increasing strategic importance of the Better Care Fund (BCF) has also meant that the impact to AC&CW now has to be reflected in service budgets.

Actions Required:

Adults and Community Wellbeing Scrutiny Committee is asked to note the budget outturn projection for 2018/19.

1. Background

Adult Care & Community Wellbeing (AC&CW) is organised into five commissioning strategies, these being:

- Adult Frailty & Long Term Conditions
- Specialist Services (Mental Health, Autism and Learning Disability)
- Safeguarding Adults
- Carers
- Community Wellbeing

An analysis of the AC&CW budget and projected outturn for 2018/19 is illustrated below and includes the impact of the Better Care Fund (BCF). Based on current information available to 31 August 2018 it is estimated that AC&CW will produce a breakeven budget for the financial year 2018/19.

	Revised Net Revenue Budget	Expenditure to 31 Aug 18	Year End Forecast to 31 Mar 19	Year End Forecast Variance
	£	£	£	£
Adult Frailty and Long term Conditions	120,705,199	21,293,487	120,455,199	-250,000
Adult Specialties	65,807,815	36,528,232	66,057,815	250,000
Adult Safeguarding	4,936,772	1,581,285	4,936,772	0
Adult Care Carers	2,464,492	1,164,068	2,464,492	0
Public Health	27,374,026	9,470,831	27,374,026	0
Adult Care & Community Wellbeing	**221,288,304**	**70,037,904**	**221,288,304**	**0**

A more detailed version of the analysis can found in Appendix A.

As with the arrangements described in the 2017/18 papers the Better Care Fund budgets are now incorporated into the base budget.

The report will look at each area in turn.

2. Adult Frailty & Long Term Conditions (AF&LTC)

The Adult Frailty & Long Term Conditions Strategy brings together Older People and Physical Disability services as well as hosting the budgets for back office functions in Infrastructure budgets. This Commissioning Strategy aims to ensure that eligible individuals receive appropriate care and support that enables them to feel safe and live independently. Activities within this area include:

Reablement
Domiciliary Care (Home Support)
Direct Payments
Community Support
Extra Care Housing
Residential Care including Block Beds
Dementia Support Services
Assessment & Care Management and Social Work Service
Adult Care Infrastructure

The current budget for this Commissioning Strategy is £120.705m

Older People Services

Direct Payments budget is £9.2m for Older Persons and current activity is showing a reduction from the end of 2017/18, it is projected the budget line will underspend by £0.794m as at end of 2018/19. The client numbers were 1,147 as at the end of March, as at the end of August 2018 there are 884, but there are further annual payments to be made along with some new cases so this figure will increase. The current average cost per case is £7,651 per annum.

Home Support budget for 2018/19 is £19.2m, the average weekly hours as at August 2018 are 2,373 (2,349 at the end of March), this budget line also includes all expenditure for Extra Care Housing. The current projection is that this budget line will be on target as at the end of 2018/19.

Long term & short term care budget for 2018/19 is £75.4m and expenditure remains stable with a forward focus on reduction of LTC placements. It is projected that the budget will be on target as at the end of 2018/19.

Physical Disability Services

The PD Direct Payments budget of £8.9m was increased in 2018/19 to allow for the pressures from an increase in service needs for those working age Adults with a Physical Disability. The number of direct payments clients is 676 as at the end of August 2018, this was 668 at the end of 2017/18 so there has only been minimal growth. Therefore, currently projecting a £0.500m underspend.

Home Support/Supported Living have both seen growth in hours, the combined budget is £2.696m and the projected overspend is £0.9m, but this is offset in some part by the projected underspend in Direct Payments.

Residential/Nursing budget for PD is £4.6m, there is reduced activity on short term placements. Overall on Residential/Nursing placements it is expected to be on target by year end 2018/19.

Other Budgets

Other budgets totalling £16.171m with AF&LTC (Service) include Care Beds which are purchased via a block contract, Workforce Development (Training) budget of £0.309m as well as the Reablement service and costs relating to the remaining in-house Day Care Service in Stamford which has a budget £0.113m. Also the Assessment & Care Management staffing budget is included in Older Persons area which is £13.269m.

Analysis to the end of August 2018 suggests that the above mentioned areas will balance their budgets at the end of the financial year.

Infrastructure

The infrastructure budget currently includes expenditure in relation to the Executive Director for AC&CW, along with individual Heads of Service costs as well as budgets for Policy and Service Development, Performance and Brokerage Teams.

The current budget for this element of the AF&LTC for 2018/19 is £10.231m, at this time it is considered that it will produce an underspend of £0.250m of the total budget.

As Adult Care continues to incur a number of both one off and new continuing pressures each year, we also hold an unallocated expenditure budget within the Directors area to ensure these pressures can be met wherever possible.

Whilst there are a number of lines of expenditure already earmarked to be supported, it is anticipated at this stage of the year that approximately £0.250m of this budget will be unspent this financial year.

Agreed areas of additional spend for 2018/19 as at August 2018 include additional cost for additional Advocacy support, support to Corporate services and further Commercial Team support.

3. Specialist Adult Services

This Commissioning Strategy aims to ensure that eligible Adults with Learning Disability, Autism and/or Mental Health needs receive appropriate care and support that enables them to feel safe and live independently. Activities within this area include:

- Residential and Nursing Care
- Community Supported Living
- Homecare
- Direct Payments
- Day Services
- Respite Services
- Shared Lives
- Transport
- Assessment and Care Management and Social Work Service
- Section 75 Agreement with Lincolnshire Partnership Foundation Trust for Mental Health Services

Learning Disability Services

The Adult Learning Disabilities service is administered via a Section 75 Agreement between the Council and NHS Commissioners in Lincolnshire. This is funded via a combination of Council funding, CCG contributions and BCF income.

The total budget which also includes costs for the Council's in-house Day Care service for 2018/19 is £65.808m, which includes an additional £2.2m into base budget from BCF. Current estimates suggest that the budget will breakeven for the year. However, we are seeing a number of high cost placements being made in both Learning Disabilities and Mental Health that may have an effect on the budget during the year, but as we have also had a number of attritions to date, and an increase in income, we are at present projecting a balanced budget for the year.

Part of the LD Section 75 is with Health and the four Lincolnshire Clinical Commissioning Groups (CCGs) amounting to £11.9m relating to all service users with continuing Health Care that are either Joint funded with Social Care, or fully funded through Health. Whilst we currently have an overspend of over £1m within this area, this will be dealt with via the risk share arrangements within the S75 Agreement. Hence this overspend is currently not being reported as a pressure against the LCC budget.

The budget for in house day services excluding Stamford Day Centre is £2.3m. Direct payments within the Learning Disabilities budget are currently under pressure due to higher than anticipated increases in new packages. We have also built in an estimate for the additional cost of night rate payments that will affect clients who employ personal assistants using their direct payment.

Whilst growth in service users and costs has been built into the budget for Supported Living for 2018/19, we are seeing a higher than expected increase in care packages being approved so far to date, which again may result in a pressure on this budget for the year.

Residential activity has seen an increase in new placement costs compared to those leaving the service this year. To date we have had eight new placements, all of which have higher needs than the four lower cost de-commitments in year. If this trend continues then again we will see pressures mounting in the later part of the year.

The current projection for income is to receive £1.013m more income than budget for 2018/19. Some of this is made up from the additional Supported Living client's contributions and additional direct payment refund.

Mental Health

The current budget for Mental Health is £6.1m for 2018/19. LCC have a S75 Partnership Agreement set up with Lincolnshire Partnership Foundation Trust (LPFT) to provide this service on behalf of LCC.

Demographic growth and inflationary increases around all of the Community Care packages in year has created further pressures on this budget this year. LCC are currently working very closely alongside LPFT to ensure any higher than average cost placements are being challenged and that these packages are being checked for any Continuous Health Care element, to ensure this is reclaimed from Health and reduce costs to Social Care. However, due to this years rate increases from Providers, the increase in the National Living Wage and the number of high cost packages that have entered the service this year, Mental Health Community Care budget is currently projecting an overspend of £0.250m for 18/19. There may be further pressures on this budget during the second half of the year if we continue to see the rise in high cost packages.

There is also an ongoing stringent review of the LPFT staffing structure in year. The current structure was set up in 2012 when the S75 was first signed. This now needs to be restructured to be able to meet and cope with the increasing demand and complex nature of this service. It is not yet known whether this change will cause any further pressure on this budget for 2018/19.

4. Safeguarding

The current budget for Safeguarding for 2018/19 is £4.936m, which has been increased in year by £700k which came from a successful bid from the Adult Care 1% carry forward from 2017/18. It is now envisaged that this budget will cover all of the additional costs for the increased Best Interest Assessments still coming through each month.

Whilst work was carried out last year to significantly reduce the backlog of Deprivation of Liberty Safeguarding (DoLS) Assessments and Reviews in the system, the volume of new Assessments we are receiving each month is still very high. It is expected that this volume will continue whilst the Cheshire West Judgement is still in place.

This high volume continues to put pressure on the Mental Health Capacity Team to ensure that all Best Interest Assessments and Reviews are completed on time so that backlogs are monitored and kept to a minimum.

5. Community Wellbeing

The current budget for Community Wellbeing is £27.374m.

Services are delivered as part of the Council's statutory obligation to improve the public health of local populations as per the Health and Social Care Act, in addition there also a number of non-statutory services which the Council deliver.

Community Wellbeing services include:

- Health Improvement Prevention & Self-Management
- Public Health Statutory Services
- Wellbeing Service
- Sexual Health
- Housing Related Service
- Prevention & Treatment of Substance Misuse

Based on information received to the end of August 2018/19, it is projected that this area will be within budget and breakeven for the year. Whilst there are overspends within the Wellbeing Services relating to the Integrated Community Equipment of £0.428m, it has been offset by underspends within the Sexual Health area (£0.110m). Domestic Abuse supported Housing (£0.115m), and the support to Vulnerable People services (£0.200m).

6. Carers

The current budget for Carers for 2018/19 is £2.464m.

The Carers Strategy aims to prevent or delay ongoing care needs by supporting Adult carers so they are able to sustain their caring role, reducing the need for costly services in primary and acute care, and long term Social Care.

The Strategy is also responsible for services provided to young carers helping to prevent inappropriate caring, helping to reduce the negative impact on the Child's wellbeing and development by ensuring adequate support for the Adult and to support the Child to fulfil their potential.

Carers FIRST contract (£1..059m) continues to promote a focus on early identification and support of carers providing a wide range of services, including carers universal support services, community networks, information and advice as well as statutory assessments. This increase has been delivered within the allocated budget.
There is also a budget of £0.750m relating to Personal Budgets through Direct Payments to Carers which is also within budget for the year.

7. Better Care Fund

The Lincolnshire Better Care Fund (BCF) is a framework agreement between Lincolnshire County Council and the Lincolnshire Clinical Commissioning Groups (CCGs) and looks to pool funds from those organisations to help support the national and local objective of closer integration between the Council and the CCGs.

The total pooled amount in 2018/19 is £232.123m which includes £56.164m that was allocated to the Lincolnshire BCF from the Department of Health and Social Care. The BCF has recently been reviewed which has resulted in minor changes to BCF expenditure plans. These have been agreed by the Lincolnshire Joint Executive Team, with confirmation issued to the regional Better Care Support Team confirming the changes. The nationally directed changes to Non-Elective Admissions and Delayed Transfers of Care metrics have also been noted and included within the local performance monitoring for 2018/19.

Lincolnshire's fund is one of the largest in the country and includes pooled budgets for Learning Disabilities, Children and Adolescence Mental Health Services (CAMHS) and Community Equipment plus 'aligned' Mental Health funds from the County Council and the four CCGs.

In addition to the continuation of existing pooled funds, there are a number of other funding streams, these increases result from:

- Inflationary increases in CCG funding, and as a result in the CCG funding for the Protection of Adult Care Services

- The addition of the iBCF funding that was announced in the Chancellor's November 2015 budget totalling £14.249m in 2018/19

- The announcement of iBCF Supplementary funding in the Chancellor's March 2017 budget totalling £9.609m in 2018/19

Overall BCF funding from central government has increased by £6.772m in 2018/19

There is a requirement to ensure that the funding has a positive impact on performance in the areas of Delayed Transfers of Care, Non-Elective Admissions, Residential Admissions and positive outcomes following Reablement, these have been reflected in our plans.

8. Income

The income target for Adult Frailty & Long Term Conditions for 2018/19 is £37.710m. For Residential/Nursing placements the income target is £26.2m which represents 69% of the total income expected to be received, current projections indicate that income will be on target as at financial year end.

£4.2m of the residential/nursing income is property debtor income. There are currently 107 service users with an active Deferred Payment Agreement which represents £2.5m of the property debtor figure. There have been 16 deferred payment cases repaid totalling £0.371m and 39 other property cases totalling £0.467 have been repaid in 2018/19 to date.

Non Residential income target is £11.5m. £1.8m of this income is expected to be received through the audit of Direct Payments recovering surplus on accounts, the other income will be for service user contribution for Direct Payments and Home Support. Current projections indicate that the income will be on target as at financial year end.

In 2017/18 there was £0.903m which is 2.4% written off from £37.2m income outturn, once debts are outstanding for 365 days a bad debt provision is put in place to mitigate the risk to future years income should it proceed to write off.

Specialist Adult Services income target for 2018/19 is £16.15m of this £11.9m is S75 income received from Health. Service user income and income from other local authorities equates to £4.25m. Residential Income represents £2.3m which is 54% of the service user income target; current projection is for a small shortfall of £0.014m.

Non Residential and Other LA income target is £1.9m and the projection figure for year end is £2.8m, the additional income is largely down to additional service user contribution for Direct Payments, Supported Living and recovering surplus funds through Direct Payment Audits.

Income collection rates for Adult Care in Lincolnshire are reported at 79% collected within 30 days and 16% collected in 31-60 days for 2017/18. Year to date 2018/19 show position continues to be stable at 76% for 1-30 days and 19% for 31-60 days, 95% of debt is collected within 60 days.

9. Capital

Adult Care and Community Wellbeing currently have a capital reserve of £12.653m of which the majority will be used to fund options around the development of the Council's Extra Care Housing Strategy, and the potential development for additional building base capacity within Learning Disabilities services.

10. Conclusion

The Adult Care and Community Wellbeing outturn is projected to be £221.280m, producing a break even budget for the year. This being the case it would be the seventh year in succession that Adult Care & Community Wellbeing has been able to live within its budget allocation.

11. Consultation

a) Policy Proofing Actions Required

n/a

12. 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 Paul Collins and Emma Farley, who can be contacted on 01522 550504 or paul.collins@lincolnshire.gov.uk.

Appendix A Adult Care & Community Wellbeing Budget Monitoring Report		Annual Budget (£m)	Projected Outturn (£m)	Over/(Under) Spend (£m)	%
AF&LTC (Service)	Staffing (OP/PD)	13.269	13.269	-	0.00%
	Residential Services (OP/PD)	80.071	80.071	-	0.00%
	Domicilliary Care Services (OP/PD)	22.400	23.300	0.900	4.02%
	Direct Payments (OP/PD)	18.188	16.894	- 1.294	-7.11%
	Reablement	4.274	4.274	-	0.00%
	Day Care (OP/PD)	0.503	0.503	-	0.00%
	Transport (OP/PD)	0.351	0.351	-	0.00%
	Other Expenditure (OP/PD)	9.128	9.128	-	0.00%
	Income (OP/PD)	- 37.710	- 37.316	0.394	-1.04%
	Sub Total	*110.474*	*110.474*	-	0.00%
AF&LTC (Infratructure)	Home Support Brokerage	0.499	0.499	-	0%
	Adult Care Performance & Intelligence Team	1.496	1.496	-	0%
	Quality Assurance & Business Improvement Teams	0.803	0.803	-	0%
	Other Back Office and Senior Management Staffing Costs	6.447	6.197	- 0.250	-4%
	Contracted Services	0.916	0.916	-	0%
	Income	0.070	0.070	-	0%
	Sub Total	*10.231*	*9.981*	- *0.250*	-2.44%
Specialist Adult Services	Staffing (LD)	2.983	2.983	-	0%
	Residential Services (LD)	30.385	30.385	-	0%
	Domicilliary Care Services (LD)	25.235	25.235	-	0%
	Direct Payments (LD)	9.436	9.436	-	0%
	Day Care (LD)	1.389	1.389	-	0%
	Transport (LD)	0.861	0.861	-	0%
	Other Expenditure (LD)	2.990	2.990	-	0%
	Service User Income (LD)	- 4.251	- 4.251	-	0%
	NHS Income (LD)	- 11.900	- 11.900	-	0%
	Mental Health Services (LD)	6.100	6.350	0.250	4%
	In House Day Care Services (LD)	2.580	2.580	-	0%
	Sub Total	*65.808*	*66.058*	*0.250*	0.38%
Carers	Carer Personal Budgets	0.750	0.750	-	0%
	Carers First contract	1.059	1.059	-	0%
	Carers Development	0.578	0.578	-	0%
	Other Contracts	0.077	0.077	-	0%
	Sub Total	*2.464*	*2.464*		0.00%
Safeguarding Adults	Mental Health Capacity Act	3.051	3.051	-	0%
	Safeguarding Team	1.361	1.361	-	0%
	Emergency Duty team	0.464	0.464	-	0%
	Safeguarding Board	0.060	0.060	-	0%
	Sub Total	*4.936*	*4.936*	-	0.00%
Community Wellbeing	Health Improvement & Prevention	2.737	2.737	-	0%
	Public Health Statutory Service	3.599	3.599	-	0%
	Wellbeing Services	6.341	6.341	-	0%
	Sexual Health Services	5.528	5.528	-	0%
	Housing Related Support	3.752	3.752	-	0%
	Substance Misuse	5.417	5.417	-	0%
	Sub Total	*27.374*	*27.374*	-	0.00%
Total Adult Care & Community Wellbeing		**£ 221.288**	**£ 221.288**	**£ -**	**0.00%**

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Lincolnshire COUNTY COUNCIL
Working for a better future

Policy and Scrutiny

Open Report on behalf of Keith Ireland, Chief Executive

Report to:	**Adults and Community Wellbeing Scrutiny Committee**
Date:	**10 October 2018**
Subject:	**Adults and Community Wellbeing Scrutiny Committee Work Programme**

Summary:

This item enables the Committee to consider its work programme, which is reviewed at each meeting. Members of the Committee are encouraged to highlight items that could be included for consideration.

This item also invites the Committee to consider whether to establish a working group to review the information prepared by organisations such as the Local Government Association and the County Councils Network, in anticipation of the Government's publication of the Green Paper on *Care and Support for Older People*.

Actions Required:

(1) To review, consider and comment on the work programme; and highlight any additional scrutiny activity which could be included for consideration in the work programme.

(2) To consider whether to establish a working group, comprised of members of the Committee, to review the information prepared by the Local Government Association, the County Councils Network and any other relevant body, in anticipation of the Government's Green Paper on the *Care and Support for Older People*.

1. Background

Today's Work Programme

Set out below are the items on the Committee's agenda today: -

10 October 2018 – 10.00am	
Item	*Contributor(s)*
Integrated Lifestyle Support Services *(Executive Councillor Decision – Between 12 and 19 October 2018)*	Derek Ward, Director of Public Health

10 October 2018 – 10.00am	
Item	*Contributor(s)*
Community Wellbeing Commissioning Strategy	Derek Ward, Director of Public Health
Carers Commissioning Strategy	Emma Krasinska, Carers Lead, Adult Care and Community Wellbeing
Adult Frailty and Long Term Conditions Commissioning Strategy	Carolyn Nice, Assistant Director, Adult Frailty and Long Term Conditions
Lincolnshire Joint Strategy for Dementia	Carolyn Nice, Assistant Director, Adult Frailty and Long Term Conditions
Adult Care and Community Wellbeing - Budget Monitoring 2018-19	Steve Houchin, Head of Finance, Adult Care and Community Wellbeing

28 November 2018 – 10.00am	
Item	*Contributor(s)*
Wellbeing Service – Update Report, including: Telecare	Robin Bellamy, Wellbeing Commissioning Manager, Adult Care and Community Wellbeing
Adult Care and Community Wellbeing Quarter 2 2018-19 Performance	Theo Jarratt, County Manager, Performance, Quality and Development
Adult Care and Community Wellbeing – Digital Developments	Emma Scarth, Head of Business Intelligence and Performance
Government Green Paper on Care and Support for Older People	To be confirmed.
Lincolnshire Safeguarding Boards Scrutiny Sub-Group Minutes - 18 October 2018	Democratic Services

16 January 2019 – 10.00am	
Item	*Contributor(s)*
Adult Care and Community Wellbeing Budget Proposals 2019/20	Steve Houchin, Head of Finance, Adult Care and Community Wellbeing

27 February 2019 – 10.00am	
Item	*Contributor(s)*
Adult Care and Community Wellbeing Quarter 3 2018-19 Performance	Theo Jarratt, County Manager, Performance, Quality and Development

Potential Items for Inclusion in Work Programme

- National Carers Strategy
- Joint Commissioning Arrangements.
- Alcohol Harm and Substance Misuse Services

Executive Forward Plan

The Executive's most recent forward plan, published on 31 August 2018, does not include any items within the remit of this Committee.

At – A – Glance Work Programme

An at-a-glance work programme set out in Appendix A, which shows the items previously considered.

2. Government Green Paper - *Care and Support for Older People*

The work programme for 28 November provisionally lists an item on the Government Green Paper on *Care and Support for Older People*, publication of which is anticipated during the late autumn. In advance of this, two local government organisations have published their own policy papers: -

- *Sustainable County Social Care – A Green Paper that Delivers A New Deal for Counties* (The County Councils Network: 27 July 2018)

- *The Lives We Want to Lead – The LGA Green Paper for Adult Social Care and Wellbeing* (The Local Government Association: 31 July 2018)

The County Council has responded to each of these policy papers. In advance of the publication of the Green Paper, the Committee may wish to establish a working group to review the content of the above in advance, as well as the County Council's responses. The working group could also consider any relevant reports published by other organisations, for example, the report by Independent Age entitled: *A Taxing Question: How to Pay For Free Personal Care*. Independent Age is a charity which provides advice and support for older people. Reviewing these documents would help develop knowledge and understanding of this complex topic.

3. Conclusion

Members of the Committee are invited to review, consider and comment on the work programme and highlight for discussion any additional scrutiny activity which could be included for consideration in the work programme.

The Committee is also invited to consider whether to establish a working group to review the information prepared by the Local Government Association, the County Councils Network and any other relevant body, in anticipation of the Government's Green Paper on the *Care and Support for Older People*.

4. Consultation – Not applicable

5. Appendices – These are listed below and set out at the conclusion of this report.

Appendix A	Adults and Community Wellbeing Scrutiny Committee – At-A-Glance Work Programme

6. Background Papers

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

This report was written by Simon Evans, Health Scrutiny Officer, who can be contacted on 01522 553607 or by e-mail at Simon.Evans@lincolnshire.gov.uk

APPENDIX A

ADULTS AND COMMUNITY WELLBEING SCRUTINY COMMITTEE AT A GLANCE WORK PROGRAMME

KEY
✓ = Item Considered
= Planned Item

	2017				2018							
	15 June	26 July	6 Sept	29 Nov	10 Jan	14 Feb	11 Apr	30 May	4 July	5 Sept	10 Oct	28 Nov
Meeting Length - Minutes	135	170	146	150	245	120	200	185	135			
Adult Care and Community Wellbeing Corporate Items												
Better Care Fund		✓										
Budget Monitoring and Proposals Items			✓		✓				✓			
Care Quality Commission Update				✓								
Contract Management and Procurement					✓							
Introduction	✓											
IT Updates					✓							
Joint Strategic Needs Assessment	✓											
Local Account				✓								
Quarterly Performance Reports		✓	✓	✓			✓		✓	✓		
Residential and Nursing Care Fee Levels						✓						
Strategic Market Support Partner			✓									
Winter Planning										✓		
Adult Frailty, Long Term Conditions and Physical Disability												
Care and Support for Older People – Government Green Paper												
Commissioning Strategy												
Dementia Strategy												
Homecare Customer Experience Survey									✓			
Payment Arrangements for Residential Care / Residential Care with Nursing						✓			✓			
Review Performance									✓			
Adult Safeguarding												
Commissioning Strategy										✓		
Safeguarding Boards Scrutiny Sub Group				✓		✓		✓		✓		
Carers												
Commissioning Strategy												
Community Wellbeing												
Director of Public Health Annual Report								✓				
Director of Public Health Role								✓				
Domestic Abuse Services			✓									
Healthwatch Procurement								✓				
NHS Health Check Programme							✓					
Stop Smoking Service					✓							
Wellbeing Commissioning Strategy												
Wellbeing Service												
Housing Related Services												
Extra Care Housing						✓						
Supported Housing						✓						

KEY

✓ = Item Considered

= Planned Item

	2017				2018							
	15 June	26 July	6 Sept	29 Nov	10 Jan	14 Feb	11 Apr	30 May	4 July	5 Sept	10 Oct	28 Nov
Specialist Adult Services												
Commissioning Strategy										✓		
Managed Care Network for Mental Health							✓					
Shared Lives							✓					