County Offices
Newland
Lincoln
LN1 1YL

27 January 2020

Lincolnshire Health and Wellbeing Board

A meeting of the **Lincolnshire Health and Wellbeing Board** will be held on **Tuesday, 4 February 2020 at 2.00 pm in Committee Room One, County Offices, Newland, Lincoln LN1 1YL** for the transaction of the business set out on the attached Agenda.

Yours sincerely

Debbie Barnes OBE
Chief Executive

MEMBERS OF THE BOARD (*)

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

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

District Council: Councillor Donald Nannestad

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

Healthwatch Lincolnshire: Sarah Fletcher

NHS E/I: Hayley Jackson

Police and Crime Commissioner: Marc Jones

Lincolnshire Co-Ordinating Board: Elaine Baylis

LINCOLNSHIRE HEALTH AND WELLBEING BOARD AGENDA
TUESDAY, 4 FEBRUARY 2020

7 Information Items

7a	**The Lincolnshire Better Care Fund (BCF)** *(To receive a report from Glen Garrod, Executive Director Adult Care and Community Wellbeing, which provides an update on Lincolnshire's Better Care Fund (BCF) plan)*	103 - 114
7b	**Half Yearly Update on Health Protection Arrangements** *(To receive a half yearly report from the Health Protection Board, which provides reassurance that appropriate health protection measures are in place for Lincolnshire. Derek Ward, Director of Public Health will be in attendance for this item)*	115 - 118
7c	**An Action Log of Previous Decisions** *(For the Health and Wellbeing Board to note decisions taken since June 2019)*	119 - 120
7d	**Lincolnshire Health and Wellbeing Board Forward Plan** *(This items provides the Board with an opportunity to discuss matters for future meetings, which will subsequently be included in the forward plan)*	121 - 122

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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.

All papers for council meetings are available on:
www.lincolnshire.gov.uk/committeerecords

LINCOLNSHIRE HEALTH AND WELLBEING BOARD
24 SEPTEMBER 2019

PRESENT: COUNCILLOR MRS S WOOLLEY (CHAIRMAN)

Lincolnshire County Council: Councillors C N Worth (Executive Councillor Culture and Emergency Services), Mrs W Bowkett, C E H Marfleet, C R Oxby and N H Pepper and Councillor Dr M E Thompson (Observer)

Lincolnshire County Council Officers: Glen Garrod (Executive Director of Adult Social Services) and Professor Derek Ward (Director of Public Health)

District Council: Councillor Donald Nannestad (District Council)

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

Healthwatch Lincolnshire: Sarah Fletcher

NHS E/I: Hayley Jackson

Police and Crime Commissioner: Marc Jones

Lincolnshire Co-Ordinating Board: Elaine Baylis

Officers In Attendance: Alison Christie (Programme Manager, Health and Wellbeing Board), Semantha Neal (Chief Commissioning Officer), Heather Sandy (Interim Director of Education), John Turner (Senior Responsible Officer, Lincolnshire Sustainability and Transformation Partnership), Rachel Wilson (Democratic Services Officer) (Democratic Services) and Kevin Johnson (Acting Commissioning Manager - Commercial)

11 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

Apologies for absence were received from Councillor Mrs P A Bradwell OBE and Debbie Barnes OBE, Head of Paid Service/Executive Director Children's Services.

It was noted that Heather Sandy, Interim Director of Education, was in attendance in place of Debbie Barnes OBE, Head of Paid Service/Executive Director Children's Services.

12 DECLARATIONS OF MEMBERS' INTEREST

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

13 MINUTES OF THE MEETING HELD ON 11 JUNE 2019

RESOLVED

That the minutes of the meeting held on 11 June 2019 be signed by the Chairman as a correct record.

14 ACTION UPDATES

There were no action updates to report.

15 CHAIRMAN'S ANNOUNCEMENTS

The Chairman's announcements were set out at agenda item 5 of the agenda pack. In addition, the Chairman advised that Jo Churchill, a former Lincolnshire County Councillor had been appointed as Parliamentary Under Secretary of State for Prevention, Public Health and Primary Care and it was hoped that she would be able to work with the Lincolnshire Health and Wellbeing Board in the future.

16 DECISION ITEMS

16a The Lincolnshire Better Care Fund (BCF)

Consideration was given to a report which included the Better Care Fund (BCF) 'Narrative Plan' for 2019/20. It was reported that as with previous plans this must be agreed by the Board prior to submission. The Plan would also be approved by the Executive Director of Adult Care and Community Wellbeing in consultation with the relevant Executive Councillors on behalf of the County Council. The plan was in the process of being considered by the Clinical Commissioning Group's (CCG's). The report also provided an analysis of the latest performance concerning the BCF metrics.

The Executive Director for Adult Care and Community Wellbeing introduced the report and highlighted that whilst the Board received regular updates on the BCF as an information item, this report included the narrative plan that was to be submitted to government for approval to allow the authority to spend the money from April 2019 – 2020. The time frame for approvals did not always match with the reality of when the funding was to be spent.

It was highlighted that there would be a sizeable loss if the Government did not continue with the BCF in some form. The narrative plan that was contained within the report was set against the template provided by the government. A final decision was expected in November 2019 and it was expected that it would be processed and approved without undue delay. The end of the BCF had been moved back from March 2020 to March 2021 and so would continue for a further year. This would allow the government time to come up with a longer term solution.

The narrative plan for Lincolnshire had been subject to NHS, district council and county council involvement. It reflected the narrative plan that was agreed the

previous year as part of a two year programme. It was noted that the conditions that went with the BCF had not changed for a number of years. There were three main conditions – to protect social care, to ensure the supply of social care services and to support the NHS with the provision of out of hospital care.

Expectations from government had been reduced and there was now more of a focus on Delayed Transfer of Care (DTOC) which had a high profile on the national agenda. It was reported that Lincolnshire was in a good place for meeting some of these conditions. It could be expected that subject to national changes, the funding would be used to further integration from 2020/21 onwards. Lincolnshire had one of the largest pooled budgets in the country.

The signatories were the four CCG's, the County Council and the Health and Wellbeing Board. The decision to approve this was critical due to the necessity of the funding which was used to underwrite the base budgets as well as some new investments. The Plan needed to be submitted by 27 September 2019. It was currently going through the CCG's decision making processes and Councillor Mrs P A Bradwell OBE, Executive Councillor for Adult Care, Health and Children's Services would sign on behalf of the County Council.

The Board was 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 commented that a lot of issues were due to a lack of communication and there was a need to work with the hospitals. It was noted that East Lindsey had dedicated discharge workers.
- It was highlighted that the County Council placed people out of county as well as in private hospitals which made it difficult to co-ordinate care for leaving hospital.
- It was queried how many people came into Lincolnshire for care from out of county and the Board was advised that Lincolnshire was a net exporter, and the numbers of those coming in from out of county were relatively low. It was acknowledged that out of county placements did cause issues, however, this was a challenge across the country.
- It was noted that when people had elective surgery they could choose to go to a private hospital for NHS care.
- It was queried what was being done to improve the position, and the Board was advised that discussions were taking place with NHS colleagues about this. It was noted that there were some patients who were placed in London hospitals.
- There was a need for a proactive date of discharge, as not all out of county hospitals would provide this. If there was not a predicted date of discharge, this could cause a delay of 12 - 24 hours for the patient leaving hospital.
- It was commented that there was not just one thing that would resolve this. Credit should be given to colleagues for the achievements made so far.

RESOLVED

That the Lincolnshire Health and Wellbeing Board approves the BCF Narrative Plan for 2019/20 and notes the update to performance activity.

17 DISCUSSION ITEMS

17a Lincolnshire NHS Healthy Conversation 2019 - General Update

The Health and Wellbeing Board received an update from John Turner, Accountable Officer, Lincolnshire Clinical Commissioning Groups, which provided a summary of the Healthy Conversation 2019 campaign and detailed the activity to date, feedback and results as well as next steps in the campaign.

It was reported that the campaign had commenced in March 2019 and would conclude on 31 October 2019. The final engagement events were due to take place in Grantham and Boston. Feedback received from the public had been taken on board.

The Board was 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 essential to set out the things which were important to Lincolnshire.
- The two further workshops were due to take place in Grantham on 9 October 2019 and Boston on 10 October 2019. The details of these sessions would be released shortly.
- The Healthy Conversation 2019 exercise had been quite informative, and as these events were brought to a conclusion, there was a need to keep the conversation going on a permanent basis across the county. Therefore, people were being recruited to sit on a citizens panel as a number of people at events had indicated that they would be interested in getting involved. It was suggested that an update could be brought back to the Board when the Panel was more fully developed.
- In relation to the Citizens Panel, it was noted that there was a need for reassurance that there was still a place for Patient Participation Groups and that their work would not be duplicated.
- There were local priorities as well as national ones. Travel and transport were significant issues for patients in Lincolnshire. There was real support for integrated care across the county.
- It had been pleasing to see how open people had been about their willingness to engage virtually with health services.
- It was commented that there seemed to be more events towards the south of the county. The Board was advised that the nine largest towns in the county had been visited, and due to some of the local issues which had been raised, it had been considered appropriate to return for more in depth events.

RESOLVED

That the progress on the delivery of the Health Conversation 2019 campaign be noted.

17b Joint Health and Wellbeing Strategy Housing and Health priority

Consideration was given to a report by Councillor Wendy Bowkett, Chairman of the Housing, Health and Care Delivery Group which highlighted progress made against the objectives in the Joint Health and Wellbeing Strategy Housing and Health delivery plan. It was reported that good progress had been made, setting the foundations for concerted, joint action by a range of partners who would meet during the autumn to develop and extend the delivery plan, with a focus on accelerating progress.

The Health and Wellbeing Board was guided through the report and 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:

- When the Joint Strategic Needs Assessment (JSNA) was out for consultation, one issue that was repeated was the need for good quality housing, and it was subsequently made a priority. Districts were asked to lead, and the Health and Wellbeing Board was grateful for all the work they had done as well as taking on the challenge and working with colleagues and districts.
- It was commented that there was some good work taking place.
- The importance of incorporating green spaces into new build estates was highlighted as a person's environment could affect their wellbeing.
- A single point of contact for DFG's was proposed as people often went to the County Council or were referred through occupational health, rather than going to the district council. The aim was to make it easier for people to understand.
- One councillor highlighted that they had carried out a piece of work in relation to new builds, to determine what the costs were to make slightly wider doorways, lower windows etc., and it was found that the costs would be negligible. It was queried whether anyone had adopted this. It was noted that it was dependent on who was building the houses.
- The district and county councils had a duty to ensure that any planning permission was granted appropriately. It was queried whether there was anything to prevent planning authorities from specifying that new builds had to incorporate features such as wider doorways and corridors. It was noted that houses were predominantly built by private developers and so there was a market element involved. It was also noted that the government policy was that if there were no planning objections then the permission should be granted. This was not something which could prevent a development from going ahead.
- It was highlighted that there were people who had spent their whole life in the same house and community, and if they were able to adapt their property they would be able to stay in their own home for much longer. Planning rules did not always support the development of a range of new properties, for example in a small village, which might enable someone to remain there in later life.

- There was a need to ensure that houses were designed around being homes for life. It was a very simple thing to accomplish, if it was incorporated into the building process at the right time.

RESOLVED

1. That the report and progress made to date be noted.
2. That the direction of travel to further develop the Housing and Health priority delivery plan be supported.

17c Advancing our health: prevention in the 2020s Green Paper

Consideration was given to a report by Derek Ward, Director of Public Health, which set out a proposed response to the consultation on the Prevention Green Paper. It was reported that on 22 July 2019, the government published its Prevention Green Paper setting out how it planned to embed the principle of 'prevention is better than cure' in order to transform the nation's health over the next decade. The Green Paper posed a number of specific questions and asked for views on the proposals by 14 October 2019.

The Board was advised that the draft response attached was on behalf of Lincolnshire County Council, and there was a need to consider if the Health and Wellbeing Board would like to send a separate response. There was support for a separate response to be sent, and it was suggested that if members had any points they wanted to see included they should send them by e-mail to Alison Christie by 1 October 2019.

When considering if there were any further points that should be included, members were advised to not be constrained by the question itself. If they sent in the comments, officers would work them into the response.

RESOLVED

1. That the draft response to the Prevention Green paper be noted;
2. That a response be sent on behalf of the Health and Wellbeing Board, and any comments for inclusion should be sent to Alison Christie by 1 October 2019.
3. That the Chairman of the Board sign off the response prior to submission on 14 October 2019.

18 INFORMATION ITEMS

18a Children's Emotional Wellbeing and Mental Health

The Health and Wellbeing Board received a report from Kevin Johnson, Senior Commissioning Officer, which provided an update on the Joint and Health and Wellbeing Children and Young People's (CYP) Mental Health and Emotional Wellbeing priority, in particular the re-commissioning of Child and Adolescent Mental Health Services (CAMHS). The report outlined the breadth of mental health provision for CYP as well as providing key updates for the Health and Wellbeing Board around

the neurodevelopmental pathway (ASD/ADHD and other neurodevelopment disorders); mental health support teams in schools trailblazer; development of the new CYP Emotional Wellbeing and Mental Health Strategy; and refresh of the Lincolnshire Local Transformation Plan (LTP) for CYP mental health.

The Board was guided through the report and provided with an 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:

- Concerns were raised regarding the number of families making contact with Healthwatch who were in crisis and were not receiving support as they could not get a diagnosis for their child. Waiting times of between 15 – 18 months were being reported. The Board was advised that a lot of services had been put in place, including an outreach service that would support families without a diagnosis. It was acknowledged that there was a significant waiting list and was something that was being looked at with LPFT.
- It was highlighted that one of the challenges was people being on waiting lists and then not receiving a diagnosis. People should be assessed for need, and if professionals were meeting the needs of the child then a diagnosis would not be relevant.
- It was commented that one thing which was not mentioned was the effects of divorce and break-up of families on children and young people, which could be significant. The Board was advised that there was an emotional wellbeing pathway, which had been designed with young people, and one aspect of this was about resilience.
- It was noted that children went through phases, and there was a need to have a 'pick up' system, for when they were ready to re-engage. It was important that young people were able to reconnect with education/college.
- Concerns were raised regarding the referral time to be seen by a doctor.
- It was noted that the work to provide young people's educational mental health practitioners was excellent.
- It was highlighted that the way this team worked to promote integration was very important, and there was a cross organisational approach. There was a need to maintain and further develop the authority's joint approach.

RESOLVED

That the report be noted.

18b An Action Log of Previous Decisions

The Board received a report which noted the decisions taken since June 2019.

RESOLVED

That the report for information be noted.

18c Lincolnshire Health and Wellbeing Board Forward Plan

The Board received and considered its forward plan.

It was queried whether the Board could have a report on pain relief clinics, however it was felt this more of a scrutiny issue. It was reported that this had been picked up by the CCG's and the Chairman of the Health Scrutiny Committee for Lincolnshire was aware of the issues.

RESOLVED

That the report for information be received.

The meeting closed at 3.38 pm

Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

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

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**4 February 2020**
Subject:	**Presentation on the Director of Public Health Annual Report**

Summary:

The Director of Public Health Annual Report is an independent statutory report on the health of the people of Lincolnshire. This year's report is on the burden of disease in Lincolnshire.

Actions Required:

The Health and Wellbeing Board is asked to receive the report and presentation, and to note its contents.

1. Background

One of the statutory duties of each local authority director of public health is to produce an independent report on the state of the health of the people they serve on an annual basis. Local authorities have a statutory duty to publish the report. As the reports are aimed at lay audiences, the key feature of the reports must be their accessibility to the wider public.

The 2019 Director of Public Health Annual Report, attached as Appendix A, is focused on the burden of disease in Lincolnshire. The report uses the Global Burden of Disease (GBD) methodology. The GBD is a study into how disease affects populations in terms of both morbidity and mortality. It also provides the ability to look at the major risk factors behind causes of morbidity and mortality. This can be used to drive change in order to improve the population's health.

The full annual report document has been published on the Council's website. To support the published document, a video and slide deck has also been produced and these will be presented to the Board at the meeting.

2. Conclusion

The Director of Public Health has a statutory duty to produce an annual report on the health of the people of Lincolnshire. The Health and Wellbeing Board is therefore asked to note the contents of the report and presentation.

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

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

The JSNA has been utilised in the preparation of this report. As a result of the Director of Public Health Annual Report, information on the GBD has been included in relevant JSNA chapters.

4. Consultation

This is not applicable as this is a professional independent report which considers the health of the entire Lincolnshire population.

5. Appendices

These are listed below and attached at the back of the report	
Appendix A	The Director of Public Health Annual Report 2019 – The Burden of Disease in Lincolnshire.

6. Background Papers

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

This report was written by Aiden Vaughan, who can be contacted on 01522 550657 or aiden.vaughan@lincolnshire.gov.uk

The Burden of Disease in Lincolnshire

The Director of Public Health Annual Report 2019

Lincolnshire COUNTY COUNCIL

Working for a better future

Contents

Foreword

It is a great pleasure to present my first annual report as the Director of Public Health (DPH) for Lincolnshire. This report covers the period of mid 2018 through to 2019 as a transition year from the previous DPH, Tony McGinty. I would like to pass on my thanks to Tony for doing an excellent job and supporting me in my new post. I also want to thank the team who did a lot of the work on this report. Although this is the DPH report, it is very much a team effort and I am immensely grateful to everyone who has contributed.

In this, my first report, I very much wanted to describe the health and illness experienced in Lincolnshire, but in a different way. This is important for two reasons. Firstly, as the new DPH I want to fully understand the diseases that are causing death and disability in the county, in order to tackle them. Secondly, the health and care system has become a victim of its own success. Over the past 50 years, we have seen a fundamental shift in how we support people with disease. Conditions that would once have killed are now treated as chronic diseases and people can expect to live a long time with multiple conditions. But the way we describe disease at a population level is still very much focussed on what people die from. We talk about mortality rates or life expectancy.

We need to change how we measure illness at a population level to reflect the changes that we are experiencing. We need to refocus on how we can help people to live for as long as possible in good health – "healthy life expectancy".

For the first time at a Lincolnshire level, the Global Burden of Disease (GBD) gives us an opportunity to describe illness and mortality using a standard measure. For the first time we can ask ourselves does cancer cause more ill health and years of life lost than heart disease? For the first time we can measure just how big an impact mental ill-health has on the people of the county and compare that to the impact of early deaths from stroke. This is the challenge we have tackled in this report. And it has thrown up a few surprises.

Whilst measuring ill-health and mortality in a different way is important, acting on the causes of the ill-health is vital. I have included a section in the report describing how we can address these causes. I have also included a section on the key risk factors that drive the burden of disease. I will work with partners across the county to tackle the causes and risk factors. I will report back on progress in the DPH report for 2020.

Finally, we have produced some videos to accompany this report. I would be interested in comments on whether you find these helpful and useful in describing the findings we report here, which can be emailed to PublicHealthDivision@lincolnshire.gov.uk

Derek Ward,
Director of Public Health

1. Introduction

An individual's view of their own health and the impacts of illness is very personal. It is influenced by a wide range of factors including the support of friends and families, the health and care services they receive, and the wider environment within which they experience their illness. In contrast, measures of overall population health or illness must be objective and numerical in nature in order to understand patterns and trends, to benchmark geographic areas or cohorts of the population, and to evaluate the impact of interventions and services on health outcomes.

Most commonly, these measures are based upon the causes of death and measures of premature mortality within the population. Over the last 100 years in England, medical breakthroughs and improved living conditions and behaviours have seen people living longer than ever before. However since 2011, improvements in mortality rates and life expectancy have slowed (Source: Public Health England). The current life expectancy at birth (2015-17) in Lincolnshire is 79.4 years for males and 82.9 years for females, broadly similar to the England values of 79.6 years and 83.1 years respectively (Source: Public Health England).

Nationally, the leading cause of death has also changed over time, with a decrease of around 50% in deaths from heart disease and stroke over the last 15 years, and increases in Alzheimer's, dementia and suicide (Source: Public Health England). In Lincolnshire, the leading causes of death in under 75s are cancer (41%), cardiovascular disease (CVD) (24%) and respiratory disease (9%). In the 75 plus population they are CVD (29%), cancer (22%), then respiratory disease (14%), with CVD and cancer switching positions between these two age groups. (Source: Civil Registration data)[1]

Although mortality-based measures are useful in understanding causes of death and inequalities in life expectancy, they do not describe the impacts of living with ill-health, or conditions which may severely limit everyday life but which do not necessarily cause early death. Measuring healthy life expectancy goes some way to bridging this gap. Healthy life expectancy describes the number of years a person can expect to live in good health, without disability or

1. Civil Registration Data, 2018/19, NHS Digital

life limiting illness. In Lincolnshire, healthy life expectancy at birth for males is 61.7 years and for females is 62.4 years. Looked at another way, this means that men can expect to live for 17.7 years with one or more serious health conditions before they die and women will live for more than two decades (20.5 years) before they die. Nationally the difference is 16.2 years in males and 19.3 years in females. (Source: Public Health England)

Keeping people fit and healthy for as long as possible is important to the individual, the economy and wider society. Ill-health causes disengagement with the labour market and with activities such as volunteering and caring roles. This impacts upon personal income, self-worth and can result in isolation, which themselves contribute further to ill-health, as well as meaning that others, including public services, may need to fill the gap. Measures of health which consider years lived with ill-health and disability, as well as life expectancy, start to describe the 'burden' of disease.

The NHS Long Term Plan sets out how the NHS will strengthen its contribution to prevention and health inequalities and make improvements in quality and outcomes across a number of major conditions. The Plan highlights how the Global Burden of Disease (GBD) study has guided the renewed prevention priorities (for example, smoking and obesity) and the major conditions to tackle (for example, cancer and cardiovascular disease).

The GBD was created in 1991 and is devised through epidemiological research. The aim is to produce measurable and comparable health outcome data, known as Disability-Adjusted Life Years (DALYs). DALYs are calculated by adding together the number of years lost due to premature mortality (YLL) and the number of years lived with a disability (YLD), using a standard life expectancy age, in this instance derived from Japanese life expectancy.

In 2016, local authority data for GBD was introduced, making it possible to compare Lincolnshire nationally and globally. The data in this report is from the most recent iteration in 2017.

2. Lincolnshire's Burden of Disease

The GBD is divided into four tiers of hierarchy, with level 1 being the broadest grouping and level four breaking conditions down into specific illnesses recognised in the International Classification of Disease (ICD) Version 10. An example for ischaemic stroke is shown below:

- Level 1 – non communicable disease
- Level 2 – cardiovascular disease
- Level 3 – stroke
- Level 4 – ischemic stroke

For this report, level 3 data is used as this provides policy makers and health professionals with sufficiently detailed, but meaningful and robust, intelligence upon which to make decisions.

2.1 Mortality (Years of Life Lost)

Years of life lost (YLL) is the estimated difference between age at death and standard life expectancy. For a whole population it is generally presented as a rate per 100,000 people so that data can be compared for areas with different sized populations.

In Lincolnshire, the rate of all cause, age and sex YLL is higher than regionally and nationally. Whilst it decreased from 21,001 per 100,000 people in 1990 to 14,893 per 100,000 in 2012, the trend reversed, increasing to 15,932 per 100,000 by 2017. This can be seen in Figure 1.

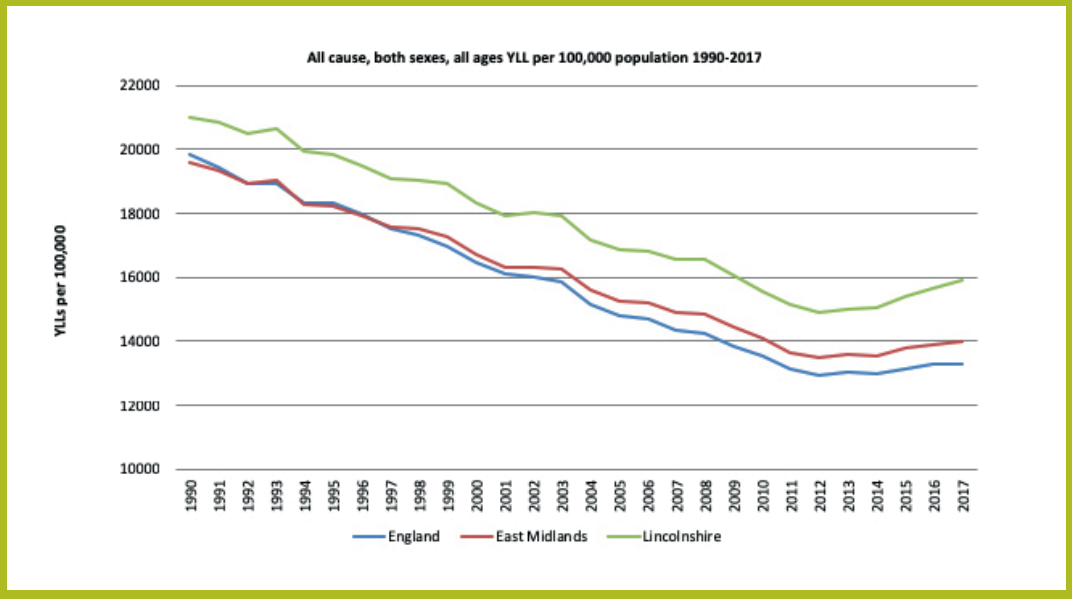


Figure 1: All Cause, Age and Sex YLL per 100,000 People, 1990 – 2017

Table 1: Main Causes of YLL in Lincolnshire, 2017, and Percentage Change over Time
All age and sex YLL per 100,000 people

Condition	Rate	Percentage	YLL	% Change from 1990	% Change from 2010
Ischemic heart disease	2,331	14.6%	17,737	-60.1%	-2.4%
Lung cancer	1,161	7.3%	8,833	-16.2%	2.5%
Stroke	933	5.6%	7,092	-46.6%	-3.6%
Chronic obstructive pulmonary disease (COPD)	909	5.7%	6,917	11.7%	6.5%
Alzheimer's	906	5.7%	6,894	58.4%	14.1%
Lower respiratory infection	628	3.9%	4,778	-0.2%	11.6%
Colorectal cancer	591	3.7%	4,493	-18.0%	1.4%
Breast cancer	486	3.1%	3,701	-30.5%	1.3%
Self-harm	370	2.3%	2,814	-15.4%	10.2%
Pancreatic cancer	353	2.2%	2,689	28.8%	9.1%

Table 1 shows, that in 2017, ischemic heart disease (IHD) was by far the highest cause of YLL in Lincolnshire. In terms of change, a negative figure shows a decrease in YLL and a positive one shows an increase. The main conditions that result in YLL have remained largely unchanged since the GBD was first published, with the exception of Alzheimer's disease, which has increased and been in the top five conditions from 2002 onwards. Since 1990, YLL from ischemic heart disease has decreased by over 60% however Alzheimer's has increased by nearly the same proportion. There are also some differences between males and females; for example, the rate for Alzheimer's in females is much higher, at 4,204 per 100,000, than in males, where it is 2,690 YLLs per 100,000. YLL for lung cancer is higher in males, at 5,819 per 100,000, than it is in females, at 3,644 per 100,000.

2.2 Morbidity (Years Living with Disability)

Years living with disability (YLD) is calculated by multiplying the prevalence of each cause and its consequences, by a disability weighting, corrected for comorbidity. Local data on YLD are more difficult to evaluate because they are similar for many important conditions across local areas, and uncertainty around weights also reduces the accuracy of YLD. (Source: The Lancet). Despite these limitations, for the first time, YLD allows us to compare the burden of disease across different conditions using a standard measure. It also allows us to compare how much burden of disease is due to people living with disabling conditions to how many years of life are lost from those conditions.

YLD shows a steady increase from 13,117 per 100,000 people in 1990 to 14,788 per 100,000 people in 2017, and Lincolnshire's rate is increasing more quickly than regionally and nationally, as shown in Figure 2.

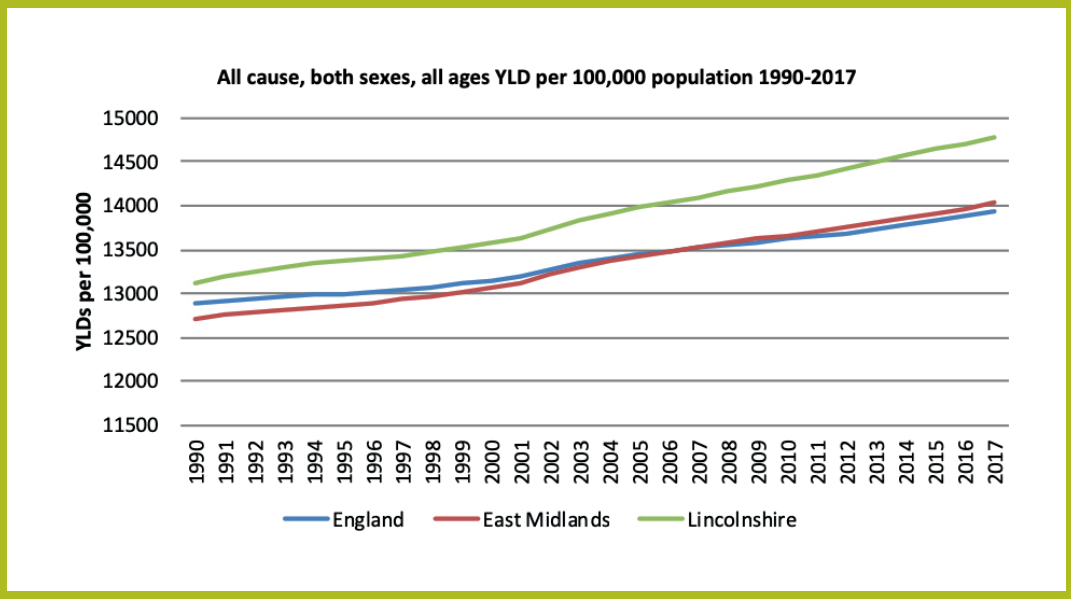


Figure 2: All Cause, Age and Sex YLD per 100,000 People, 1990 – 2017

Table 2 shows the main causes of YLD in Lincolnshire and the percentage change from 1990 - 2017. The top five conditions are unchanged since 1990, but again there are some interesting differences between males and females, for example, diabetes is the second highest cause of YLD in males (666 per 100,000) but only the eighth highest in females (554 per 100,000).

Table 2: Main Causes of YLD in Lincolnshire, 2017, and Percentage Change over Time
All age and sex YLL per 100,000 people

Condition	Rate	Percentage	YLDs	% Change from 1990	% Change from 2010
Low back pain	1,932	13.1%	14,702	18.7	6.4%
Headache disorders	881	6.0%	6,705	-1.7%	-1.3%
Depressive disorders	718	4.9%	5,459	-4.4%	0.1%
Neck pain	714	4.8%	5,429	32.5%	6.4%
Age-related hearing loss	628	4.2%	4,780	27.9%	6.6%
Diabetes	608	4.1%	4,628	77.6%	21.5%
Chronic Obstructive Pulmonary Disease (COPD)	585	4.0%	4,450	32.9%	-4.0%
Falls	569	3.8%	4,326	39.2%	8.8%
Anxiety disorders	407	2.8%	3,093	-0.4%	-1.3%
Oral disorders	388	2.6%	2,952	-6.9%	9.0%

2.3 Overall Burden of Disease

Disability-adjusted life years (DALYs) compare the overall burden of disease in populations, viewing mortality and morbidity in equal measure and underpinning the GBD. DALYs are calculated by adding together the number of years lost due to premature mortality (i.e. years of life lost) and the number of YLD, as shown in Figure 3. They can also be used to compare the burden of individual diseases and conditions in the population.

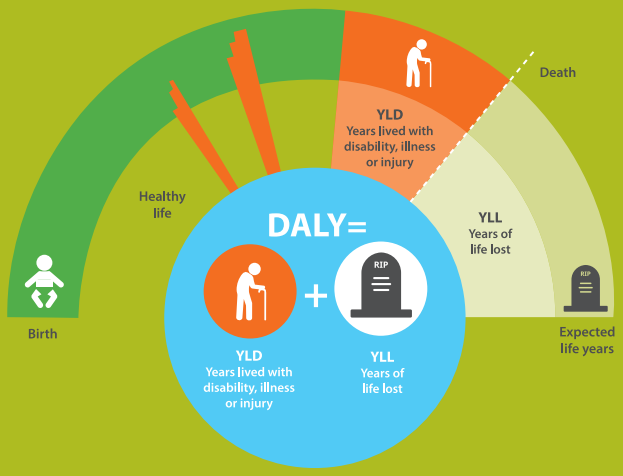


Figure 3: Measure of Disease Burden (DALYs)
Source: Public Health England

Since inception of the GBD in 1990, Lincolnshire's DALY rate has slowly reduced from 34,117 per 100,000 people, to 29,307 per 100,000 in 2012. However, the trend started to reverse and in 2017, Lincolnshire had a DALY rate of 30,721 per 100,000 people, higher than the East Midlands and England, as shown in Figure 4. This equates to a total of nearly a quarter of a million (233,716) DALYs experienced by the people of Lincolnshire in 2017.

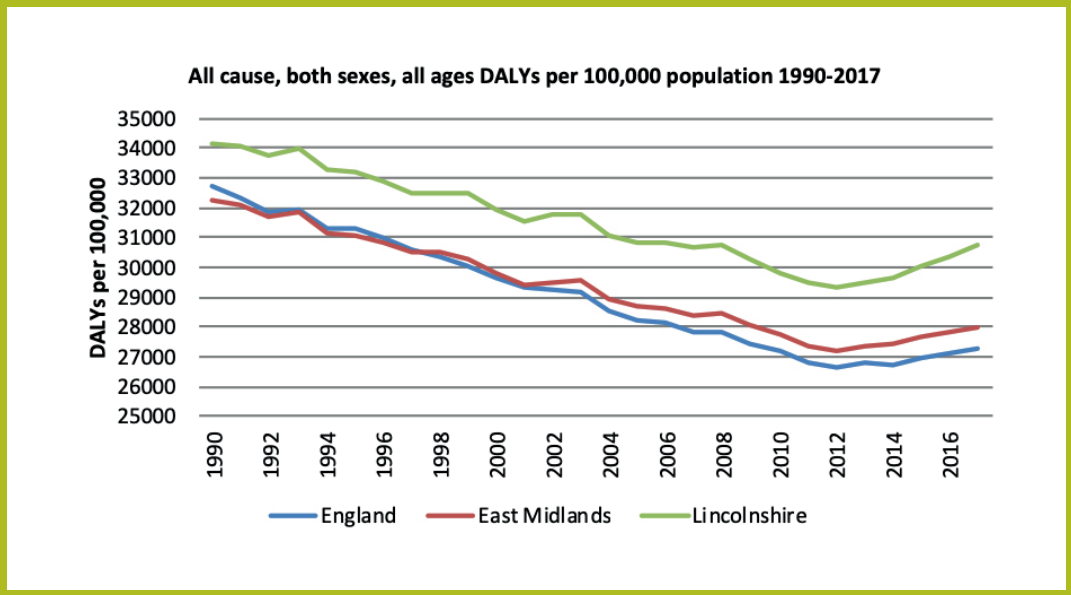


Figure 4: All Cause, Age and Sex DALYs per 100,000 People, 1990 – 2017

The main causes of DALYs in Lincolnshire and the percentage change from 1990-2017 and 2010-2017 are provided in Table 3.

In 2017 the greatest cause of DALYs in Lincolnshire was IHD with 2,455 per 100,000 people. This accounts for 8% of all Lincolnshire DALYs. The top five causes of DALYs have remained unchanged in Lincolnshire since the GBD began in 1990; however there have been decreases in lung cancer, stroke and ischemic heart disease. Increases have been seen in low back pain and COPD.

Table 3: Main Causes of DALYs in Lincolnshire, 2017, and Percentage Change over Time
All age and sex YLL per 100,000 people

Condition	Rate	Percentage	DALYs	% Change from 1990	% Change from 2010
Ischemic heart disease	2,455	8.0%	18,678	-59.0%	-2.1%
Low back pain	1,932	6.3%	14,702	18.7%	6.4%
Chronic obstructive pulmonary disease (COPD)	1,494	4.9%	11,367	19.1%	2.1%
Stroke	1,212	4.0%	9,221	-38.8%	0.3%
Lung cancer	1,183	3.6%	9,004	-15.6%	2.7%
Alzheimer's	1,309	3.7%	8,666	55.4%	13.2%
Headache disorders	881	2.9%	6,705	-1.7%	-1.3%
Diabetes	763	2.5%	5,805	23.6%	16.7%
Depressive disorders	718	2.4%	5,459	-4.4%	0.1%
Neck pain	714	2.31%	5,429	32.5%	6.4%

Again, there are some differences between the sexes. Notably, males have more than double the number of DALYs for ischemic heart disease (3,379 per 100,000) than females (1,581 per 100,000), and whilst low back pain is the second highest cause of DALYs overall, it is the highest cause in females (2,100 per 100,000).

In order to understand the causes of all conditions, GDB data is best depicted in a treemap, as shown in Figure 5. This uses colour representation: blue - all non-communicable diseases; red - communicable, maternal, neonatal, and nutritional diseases and injuries; and green - external causes. The shade variation further represents how much each condition has changed since 1990, with a darker shade indicating an increase in the condition. The area of the rectangle denotes the total burden of the condition in Lincolnshire.

The treemap shows that the Lincolnshire burden is largely comprised of non-communicable diseases (in blue) with a smaller proportion of communicable, maternal, neonatal, and nutritional diseases and injuries. The greatest burden is seen to be a non-communicable disease, IHD, and this is a very similar picture to nationally.

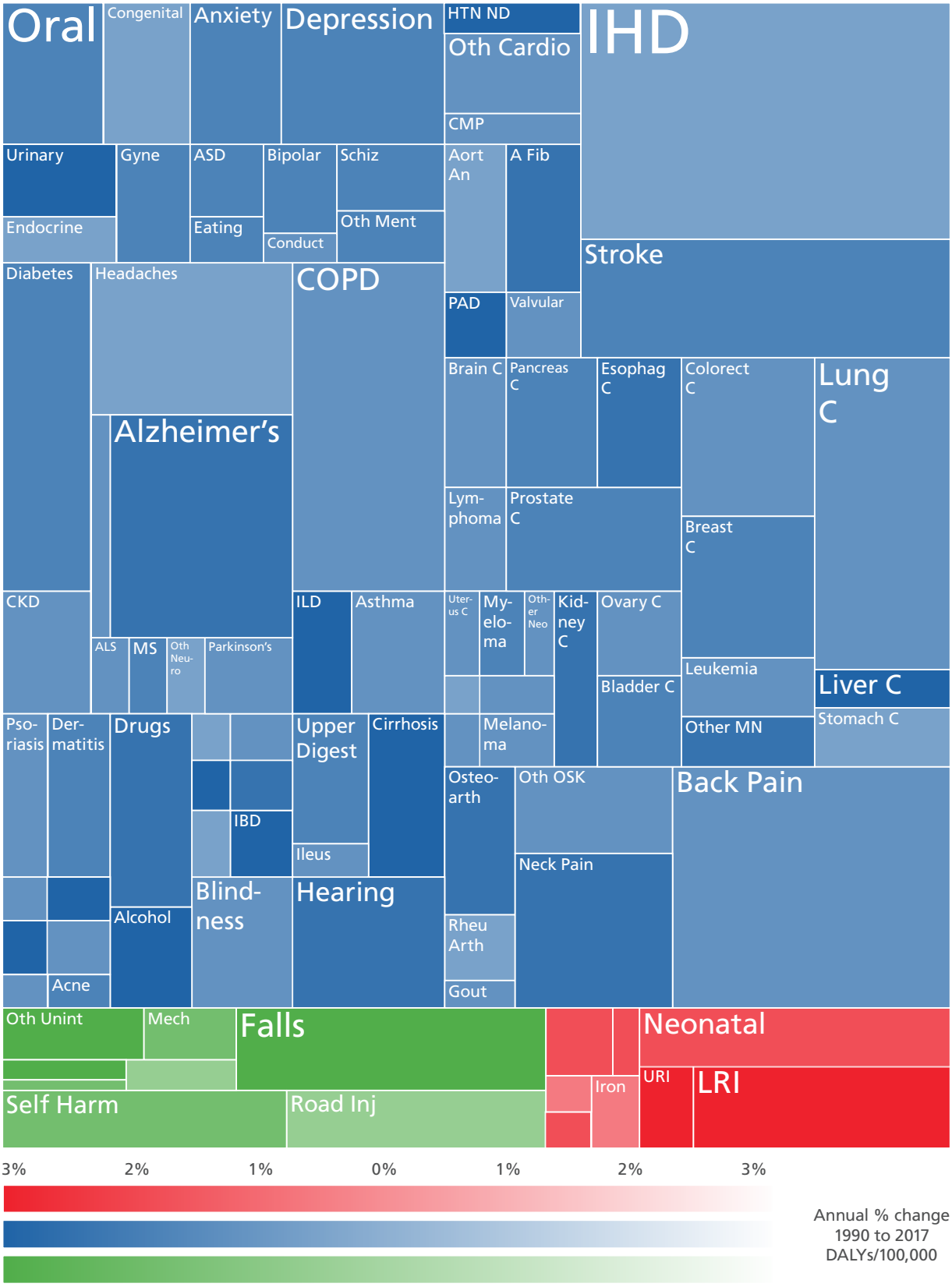


Figure 5: Level 3 GBD data for Lincolnshire, All age and sex DALYs, 2017

2.4 Risk Factors for Disease Burden

The GBD analyses risk factor exposure and attributable risk across three broad areas: behavioural, environmental and metabolic risks. Table 4 shows the specific risks that are within each category. It should be noted that not all disease burden has an attributable risk.

Table 4: Risk factor breakdown		
Behavioural	**Metabolic**	**Environmental**
Malnutrition, dietary risk, tobacco, alcohol use, unsafe sex, drug use, low physical activity, domestic violence and childhood maltreatment	High blood pressure, high fasting glucose plasma, high body mass index, high cholesterol, impaired kidney function and low bone mineral density	Air pollution, Unsafe water, unsafe sanitation, handwashing, occupational risks and other

For the overall burden of disease, the majority of Lincolnshire's risk factor exposure and attributable risk is classified as 'behavioural' at just over 50%. This is important in shaping prevention and intervention activities. Figure 6 shows the total number of DALYs (in 2017) for the three main risk factors.

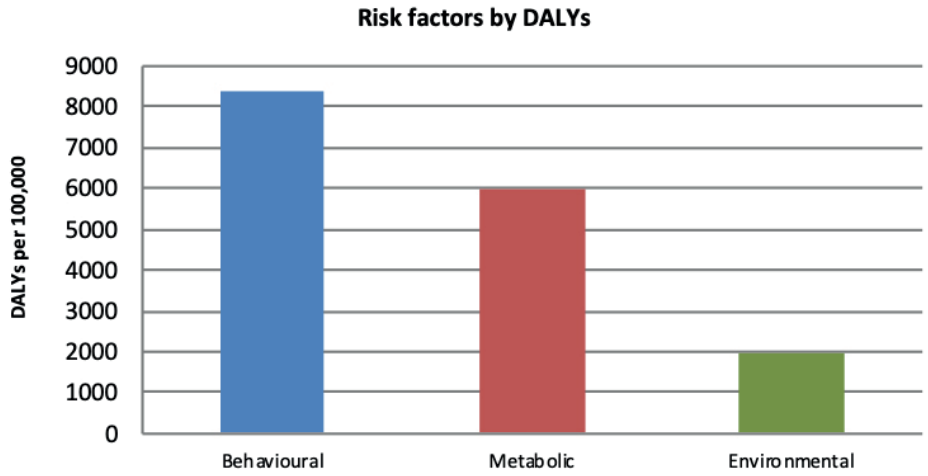


Figure 6: Total DALYs by Risk Factor for Lincolnshire, 2017

DALYs can be attributed to one risk factor or to a number of combined risk factors, and Figure 7 shows a more detailed picture. For attributable risk factors in DALYs, behavioural factors have the highest proportion of the risk attributable burden, with just over 40%. Next highest is metabolic factors alone, followed by risk that is attributable to behavioural and metabolic factors combined. Only 6.9% of DALYs have been attributed to environmental factors alone.

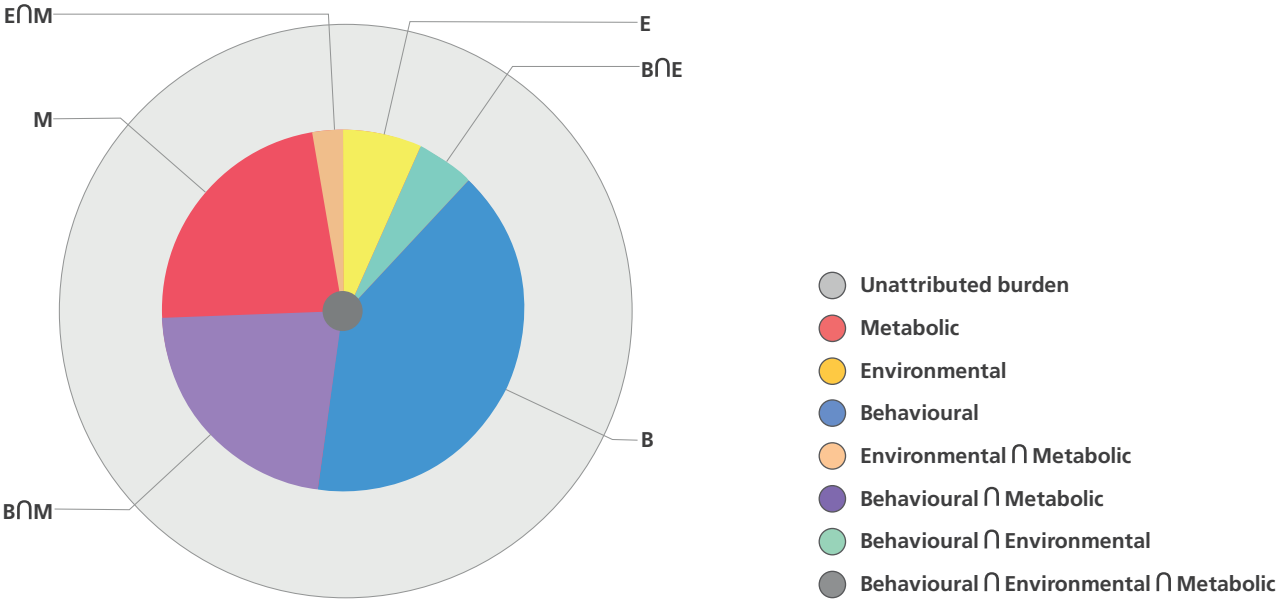


Figure 7: All Cause, Age and Sex DALYs Attributable to Risk Factors, 2017

It should be noted that only 40% of the burden of disease for DALYs has been attributed to any risk factor for many different reasons, such as a lack of research and the limitations of the modelling used. The grey circle around the chart represents the amount of unattributed risk.

With CVD being the main cause of DALYs in Lincolnshire, a similar in depth analysis has been carried out for this condition. Figure 8 shows that behavioural and metabolic risk factors combined are the primary drivers of this condition. It also shows that the unattributable risk is considerably lower for CVD than for all causes of DALYs, due to the amount of research that is available on the condition.

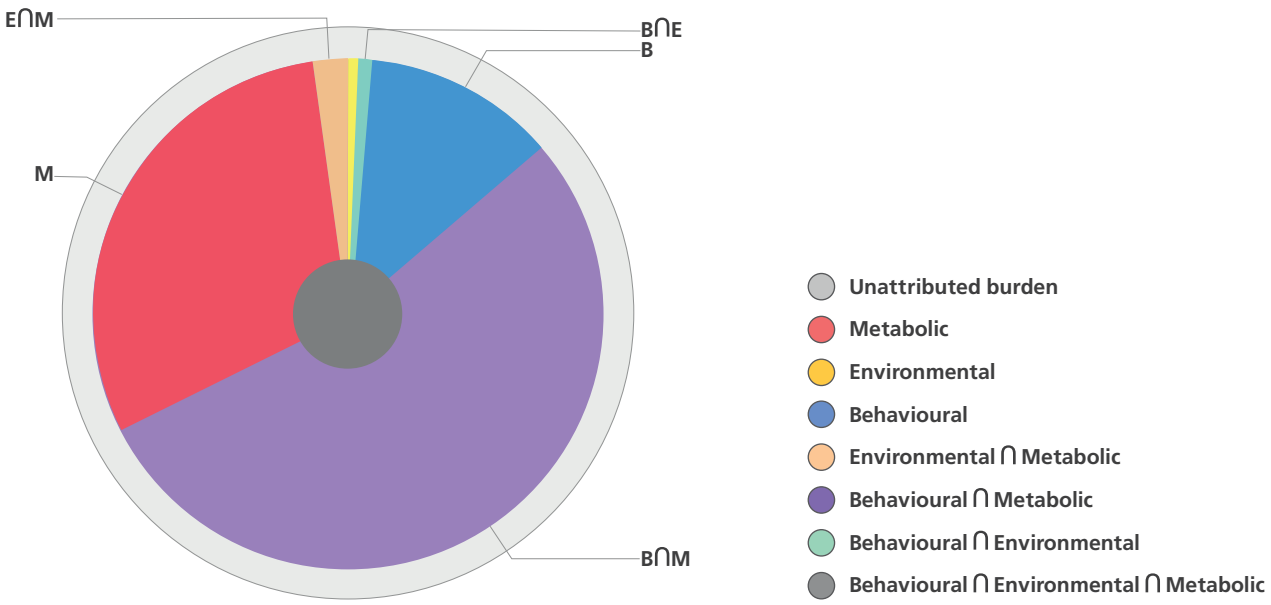


Figure 8: Cardiovascular Disease, all Age and Sex DALYs Attributable to Risk Factors, 2017

Examining individual risk factors more specifically; Figure 9 shows a breakdown of the greatest specific risk factors and their impact on burden of disease. The top five risk factors for DALYs in Lincolnshire are smoking, high blood pressure, high body mass index, high fasting plasma glucose and high cholesterol. Just these five factors account for 40% of all attributable risk, equating to 12,266 DALYs per 100,000 people, and 94,316 DALYs for the population in total.

Whilst the number of DALYs attributed to smoking in Lincolnshire has reduced by nearly half (47.9%) since 1990, it still remains the greatest risk factor (at 3,488 DALYs per 100,000 people). Smoking is the largest contributor to cancer, CVD and respiratory disease. For CVD alone, the greatest individual risk factor is high blood pressure.

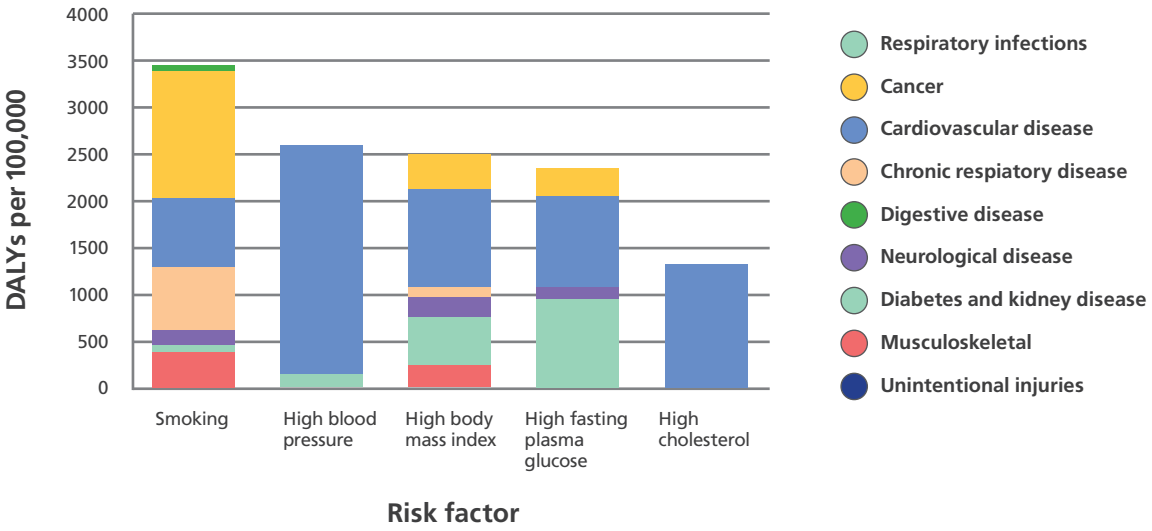


Figure 9: Attributable Risk Factors and their Impact on Burden of Disease, Lincolnshire, 2017

3. Implications of the GBD Study for the Health and Care System in Lincolnshire

The GBD study provides a unique perspective on health and identifies the need to address those conditions that not only contribute to the main causes of mortality, but are also causing the greatest overall burden of disease.

Whilst life expectancy has increased for the people of Lincolnshire, those extra years of life are not always spent in good health. An increasing proportion of people are living with multiple long term conditions, some for decades. There is a national ambition to improve healthy life expectancy, whilst closing the gap between the richest and poorest (Source: Dept. of Health and Social Care). The gap between overall life expectancy and healthy life expectancy has been identified as the 'window of need' and the aim of preventative interventions is to extend the period of healthy life expectancy, therefore reducing this window of need (Source: Public Health England).

Having an understanding of the risk factors that contribute to the disease burden enables interventions to be focussed on these, using the evidence on interventions that will have most impact. The GBD shows the contribution that addressing behavioural, metabolic and environmental/occupational risk factors can make in reducing the conditions which cause the greatest burden to our population. It will require a radical approach to prevention to have a real impact on reducing the occurrence of problems in the first place and, when they do arise, to support people to manage them as effectively as possible. This new approach is a key element of the national NHS Long Term Plan which is reflected in the development of the Lincolnshire Long Term Plan. The NHS Long Term Plan has a commitment to prevention, with a move away from a system that simply treats illness, into one that helps to keep people healthier for longer. Smoking, obesity, diet, alcohol and air pollution are some of the public health priorities in the plan.

The Lincolnshire GBD data does not enable identification of health inequalities at the local level, however the overall GBD data does show inequalities that take place across England and those areas experiencing poorer health, lower life expectancy and earlier onset of chronic disease and disability (Source: Public Health England). The Lincolnshire Joint Strategic Needs Assessment (JSNA) provides additional intelligence on health inequalities across many of the diseases causing the greatest burden for example, diabetes, CVD and COPD, as well as on the main risk factors, for example, smoking and physical inactivity.

The changing epidemiology evidenced in the GBD study presents a challenge to health and social care systems. The GBD identifies some conditions where the burden of disease has increased, for example, musculoskeletal (MSK) conditions (back and neck pain), Alzheimer's and diabetes. A fundamental shift is required in the system to support population level interventions to address the causes and effects of these conditions, which may have previously received less focus. The development of new Integrated Care Systems (ICS) provide opportunities to develop a system wide approach to prevention and health and social care provision for those conditions causing the greatest burden within our population.

The Joint Health and Wellbeing Strategy (JHWS) for Lincolnshire aims to inform and influence decisions about the commissioning and delivery of health and social care services. This helps to ensure that they are focused on the needs of the people who use them and tackle the factors that affect everyone's health and wellbeing. The aims, themes and priorities of the JHWS, as shown in Figure 10, all support actions to address the main causes of disease burden for the Lincolnshire population.

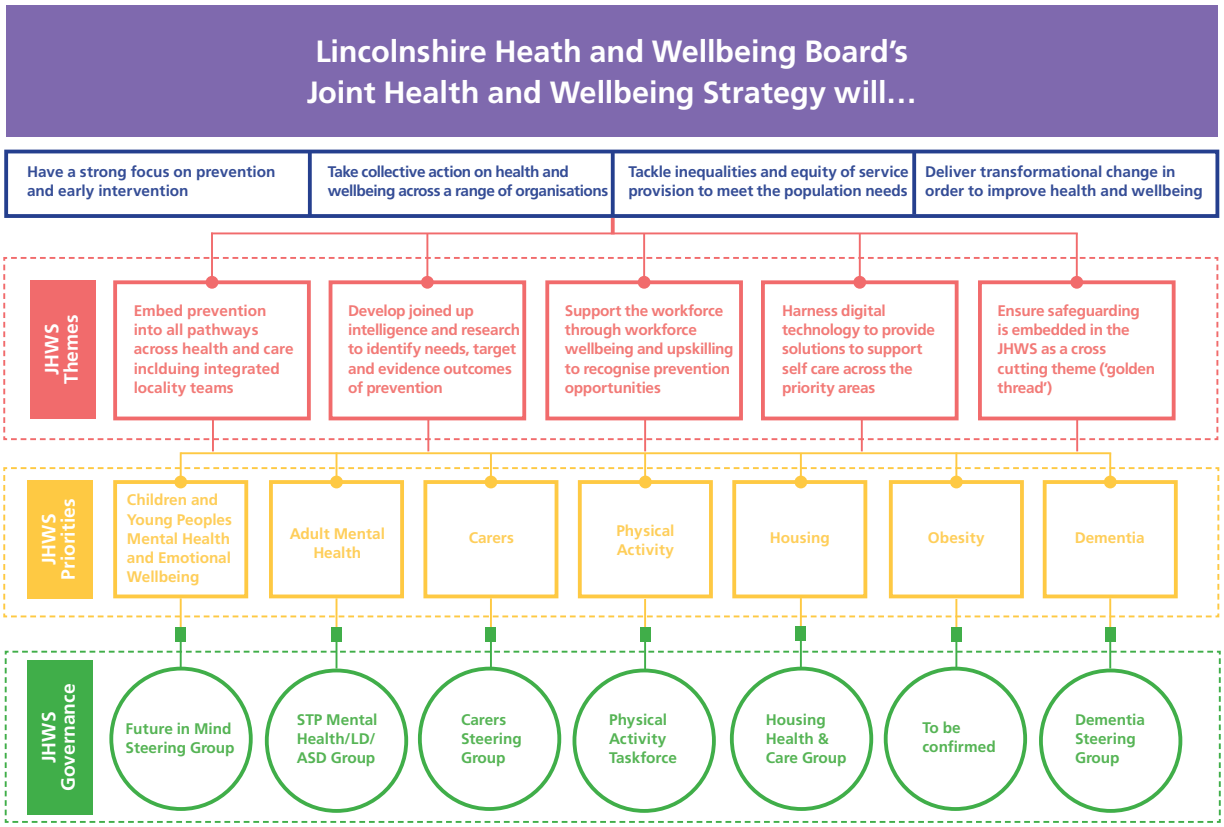


Figure10: Overview of Lincolnshire's Joint Health and Wellbeing Strategy (2018)

3.1 Addressing the Causes of Disease Burden

3.1.1 Cardiovascular Disease

CVD (heart disease and stroke) continues to dominate in the GBD and shows the need for ongoing systematic programmes to reduce CVD risk factors, especially behavioural (for example, smoking) and metabolic (for example, high blood pressure). Whilst given less of a focus in this annual report, the importance of addressing environmental risk factors is also essential, for example, air quality.

Whilst mortality from CVD has almost halved over recent decades, it still causes a quarter of all deaths. The condition is strongly associated with health inequalities, and those living in England's most deprived areas are almost 4 times more likely to die prematurely from CVD than those in the least deprived. There are a number of contributing factors associated with CVD, many of which are considered modifiable lifestyle risks, including, high blood pressure (hypertension), smoking, high cholesterol, obesity, physical inactivity, excessive alcohol consumption and a poor diet. The impact of CVD on the health and social care sector is significant. The NHS Rightcare CVD prevention pathway is an evidence-based, prevention and treatment pathway that identifies a number of high impact interventions in addition to cross cutting interventions to prevent CVD. Some of these include:

- Maximise NHS Health Check uptake and follow up.
- Embed CVD prevention within health and wellbeing initiatives.
- Challenge unwarranted variation and drive quality improvement in detection and management of the high risk conditions, for example high blood pressure
- Ensure interventions and referral pathways specifically target communities with historically poorer outcomes.

Further information is available in the JSNA Cardiovascular Disease topic.

3.1.2 Musculoskeletal Conditions

MSK conditions, for example, low back pain and neck pain, together cause the greatest disease burden in Lincolnshire. There are multiple risk factors that can increase susceptibility to MSK problems, including age, being overweight or obese, lack of physical activity and smoking. Two factors that often coincide are increasing age and reduced physical activity.

The evidence for providing cost-effective interventions for preventing and treating MSK conditions is overwhelming (Source; Public Health England), and includes:

- Physical Activity – The Chief Medical Officer has set guidelines for physical activity. Adults should aim to be active daily and should include muscle strengthening activities on at least two days a week, but any strengthening activity is better than none.
- Maintain a healthy weight and balanced diet – This can reduce the risks of developing conditions such as back pain and osteoarthritis of the knee.
- Smoking - Smoking has a negative impact on bone mineral density.

Further information is available in the JSNA Musculoskeletal (MSK) Conditions topic.

3.1.3 Chronic Obstructive Pulmonary Disease

COPD is a progressive disease, with symptoms including breathlessness and persistent coughs, and is a leading cause of disease burden in Lincolnshire. Like many long term conditions, it is known that there is a proportion of the population living with COPD, but not yet diagnosed. Smoking is the biggest risk factor for COPD.

A number of the NHS Rightcare pathways support work on COPD. This includes a number of opportunities, for example, in relation to early detection/accurate diagnosis of COPD and long term condition management. In addition to detection, management and treatment, prevention is essential, which includes interventions in relation to physical activity, smoking and air quality.

Further information is available in the JSNA Chronic Obstructive Pulmonary Disease topic.

3.1.4 Alzheimer's disease

Alzheimer's disease is the most common cause of dementia, affecting around six in every 10 people with dementia. Alzheimer's may also occur with other types of dementia, such as vascular dementia (Source: Alzheimer's Research UK). Some of the risk factors for Alzheimer's are the same as for CVD. Therefore addressing some of the behavioural (e.g. smoking) and metabolic preventative interventions for CVD (e.g. management of high blood pressure), will also address the prevention of Alzheimer's disease.

Further information is available in the JSNA Dementia topic.

3.1.5 Headaches

A headache is a common symptom associated with many conditions. Headaches can be categorized into primary headaches, which are not associated with an underlying condition, for example, tension type headaches and migraines; and secondary headaches which occur as a result of other causes, for example, trauma, infection. The majority of headaches are primary. Most people self-manage their headaches but it is one of the most common reasons for primary care consultations (Source: NICE).

Although limited, some information on headaches is provided in the JSNA Neurological Conditions topic.

3.1.6 Depression

Depression is characterised by persistent low mood and/or loss of pleasure in most activities and a range of associated emotional, cognitive, physical, and behavioural symptoms. The cause of depression is unknown but is likely to result from complex interaction of biological, psychological, and social factors. Depression can exacerbate the pain, disability, and distress associated with a range of physical diseases. Depression can impair a person's ability to function for example, in employment and relationships (Source: NICE). The NHS Every Mind Matters resource provides some tips on how to look after our mental health and wellbeing.

Further information on depression is provided in the JSNA Mental Health (Adults) topic.

3.2 Addressing the Risk Factors

The identification of risk factors linked to disease burden emphasises the importance of a broad approach to enable behavioural, metabolic and environmental risks to be addressed. Interventions for one risk factor will address multiple causes of disease burden, for example, addressing high blood pressure will impact on heart disease, stroke and Alzheimer's. There is a need for an approach that prevents the onset of risk factors/disease (primary prevention), whilst also diagnosing and managing risk factors/disease (secondary and tertiary prevention).

Apart from smoking, metabolic factors account for the leading causes of overall DALYs. High blood pressure is second to smoking.

3.2.1 Smoking

Smoking remains the greatest single contributor to health inequalities, accounting for half the difference in life expectancy between those living in the most and least deprived communities. Lincolnshire's smoking prevalence in adults is gradually reducing and continues to mirror the trend across England. There are geographic differences across the county in terms of prevalence and diseases/deaths attributable to smoking, along with inequalities relating to factors such as deprivation, mental health and pregnancy.

A range of interventions are needed to address the health consequences of smoking. These include prevention (particularly in young people and pregnant women), supporting people to quit, eliminating the variation in smoking rates (for example, the higher rate amongst people with a serious mental illness) and effective enforcement.

Further information is available in the JSNA Smoking Reduction in Adults topic.

3.2.2 Physical Inactivity

Physical inactivity contributes to many diseases and premature deaths, including heart disease, strokes, diabetes and certain cancers. Regular physical activity can help to prevent and manage many chronic conditions and has an important role in good mental health. Within the county's adult population, Lincolnshire is identified as one of the most inactive areas in England. The Blueprint for Creating a More Active Lincolnshire focuses on four main areas that will have the greatest potential to change physical activity levels across Lincolnshire.

Further information is available in the JSNA Physical Activity topic.

3.2.3 High Blood Pressure (hypertension)

High blood pressure is amongst the top risk factors for years of life lost in England. It is the second highest attributable risk factor causing overall burden of disease in Lincolnshire. Improving the detection and treatment of hypertension is one of the national ambitions to prevent CVD. Achieving these ambitions requires a whole system approach across Local Authorities, Clinical Commissioning Groups, General Practice, Pharmacists and Community settings.

Nationally, those in the most deprived communities are 30% more likely to have high blood pressure. It is essential that interventions to reduce a person's risk of developing high blood pressure continue to take place across the health and care system, i.e. primary prevention. This includes interventions on diet, alcohol, weight, physical activity and smoking.

The role of secondary prevention, detecting disease and risk factors to prevent deterioration, is critical. Optimally managing people with identified high blood pressure is a key intervention for CVD prevention. The 'Size of the Prize in CVD Prevention in Lincolnshire' identifies the heart attacks and strokes averted, and money saved, by optimizing treatment in hypertension.

Initiatives like, 'Know your Numbers!' (the Blood Pressure UK awareness campaign), encourages adults to know their blood pressure and take the necessary actions to maintain healthy blood pressure. Promotion of this campaign across the health and social care system can help to achieve the CVD prevention ambitions.

The NHS Rightcare CVD Prevention Pathway identifies interventions across a number of the leading risk factors, including hypertension. High Value Interventions include identifying and targeting people with possible undiagnosed and untreated hypertension. Maximising the NHS Health Check Programme uptake and follow up is a key intervention.

4. Conclusion

For the first time we have been able to use Global Burden of Disease methodology to create new intelligence, helping us to understand the greatest burdens of disease in Lincolnshire. This has allowed us to compare the impacts of diseases and conditions that people die from, with those that people can live with for many years.

The picture which has emerged is one which is recognised, in part. Whilst life expectancy has increased, the period of time that people live with disabilities has also increased. The biggest killers are ischaemic heart disease, lung cancer, stroke, and COPD. However, close behind these is Alzheimer's, accounting for nearly 6% of all Years of Life Lost in Lincolnshire. When it comes to Years Lived with Disability the picture is very different. Low back pain, headache disorders, depressive disorders, neck pain and age related hearing loss are the top five causes. Diabetes and COPD also rank highly, as do falls, anxiety disorders, and oral disorders.

When premature mortality and disability data are combined to compare the overall burden of disease, the greatest single burden in Lincolnshire is ischaemic heart disease, and second is lower back pain. However, when lower back pain and neck pain are combined they become the greatest cause of Disability Adjusted Life Years in Lincolnshire.

So whilst heart disease and cancers are the big killers, lower back and neck pain (MSK), mental health issues and Alzheimer's disease are all key challenges we have to tackle at a Lincolnshire level because of their overall impact.

A fundamental shift is needed to refocus our shared efforts, requiring an emphasis on prevention and early detection, and informed by evidence of the most common risk factors driving ill-health. Unsurprisingly, the single greatest risk factor is smoking, and other key factors are high blood pressure, high body mass index and high cholesterol, which are all risks that we can do something about and which we have discussed in this report.

We will use the Health and Wellbeing Board and the NHS Long Term Plan to tackle the causes and risks of illness in Lincolnshire, and will report back on our progress in next year's Director of Public Health report.

Lincolnshire COUNTY COUNCIL

Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of Lincolnshire Whole Systems Healthy Weight Partnership

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**4 February 2020**
Subject:	**Whole Systems Approach to Healthy Weight**

Summary:
This paper provides an update on progress in developing a whole systems approach to healthy weight and how Lincolnshire's Whole Systems Healthy Weight Partnership is contributing to the delivery of the Joint Health and Wellbeing Strategy (JHWS) Healthy Weight priority.

Key developments to date include:

- Establishing, Lincolnshire's Whole Systems Healthy Weight Partnership in February 2019. The partnership agreed that their focus would be on healthy weight rather than obesity. The partnership includes county and district councillors and senior managers within Clinical Commissioning Groups, Children's Services, School Head Teachers and the University of Lincoln.
- The partnership agreed to establish a whole systems approach to healthy weight. Two workshops have been delivered by the partnership (5 June 2019 and 29 October 2019) working with a range of stakeholders to identify the causes of obesity in Lincolnshire and developing a systems map.

Actions Required:
The Health and Wellbeing Board is asked to note progress made by the Lincolnshire's Whole Systems Healthy Weight Partnership and how this is contributing to delivering the healthy weight priority of the Joint Health and Wellbeing Strategy

1. Background

The increasing prevalence of overweight and obesity in the population is becoming a major public health crisis due to the association with serious chronic diseases such as type 2 diabetes; heart disease; stroke; liver disease and some cancers. Being overweight or obese is associated with increased disability, reduced quality of life and premature death. Obesity is estimated to be the third largest risk factor contributing to premature deaths (World Health Organisation, 2018). This rising burden of ill-health is influenced by deprivation, social, environmental and economic factors.

Tackling the causes and consequences of obesity fits with the principles and policies of Lincolnshire's Joint Health and Wellbeing Strategy. A whole systems approach to tackling obesity seeks to align actions by the range of interested parties and organisations to enhance our collective effectiveness. A single plan with system wide ownership and responsibilities is a key goal we are seeking to achieve.

A national whole systems approach to obesity programme was launched in 2015. Overseen by Public Health England, the Local Government Association, and the Association of the Directors of Public Health, the programme is seeking to develop local authority-led work that can make a significant difference to the increasing prevalence of overweight and obesity in the population. In Lincolnshire, North Kesteven was a pilot area and like other areas spent a great deal of time securing buy-in and agreeing shared commitment to the agenda. The pilot sites shared their learning through guidance and a toolkit. Leeds Beckett University has evaluated the programme, and reviewed and developed the evidence base for effective whole systems working on obesity by working with local authority pilot and pioneer sites.

Using the whole systems approach toolkit, development work follows a specific path, with a focus on identifying the local influences on obesity, what is already happening, barriers and enablers for change, and developing specific actions to reduce obesity and improve wellbeing:

Appendix A provides a diagrammatic outline of the step by step process for implementing a whole systems approach created by Leeds Beckett University as part of the whole systems approach to obesity pilot. Lincolnshire is working its way through each step.

1.1 Progress to date in Lincolnshire:

1.1.1 ***Set up phase –*** Lincolnshire Whole System Healthy Weight Partnership was formed in February 2019. The partnership includes county and district councillors and senior managers within Clinical Commissioning Groups, Children's Services, School Head Teachers and the University of Lincoln.

1.1.2 ***Building the local picture (Workshop One) –*** reviewing the consequences of obesity, the fit with local priorities, starting to think about and map a system interaction, and to build connections between partner organisations.

On 5 June 2019, the Partnership held a workshop event, attended by over seventy delegates, to explore why healthy weight is important to Lincolnshire. The workshop heard from experts from Leeds Beckett University about the theory and context behind Public Health England's whole system approach to obesity approach to healthy weight. The intention is that local councils will use the 'toolkit'

developed by Leeds Beckett University to deliver a consistent whole systems approach throughout the country. The scale of the issue was identified and delegates mapped the positive effects of healthy weight as well as causes and actions to tackle obesity.

Lincolnshire's 'Workshop One' identified the key local factors and created individual themed maps. The emerging Lincolnshire themes were:

- Education
- Family
- Income
- Mental Health
- Rurality
- Transport
- Environment and Open Space
- Food Availability
- Lifestyle
- Physical Activity
- Safety
- Work

1.2 Mapping the local systems:

1.2.1 ***Creating a comprehensive systems maps*** **-** The core team used the themed systems maps to form one collated map. The Lincolnshire System map is attached in Appendix B.

1.2.2 Action Mapping

A prerequisite to developing a local whole systems approach is having an overview of actions currently being undertaken. An action mapping tool was created by Leeds Beckett University and the whole systems approach to obesity pilot teams. The tool creates an opportunity to systematically record information related to local actions on obesity and aligns them to the perceived causes of obesity. As part of the national pilot Leeds Beckett developed the perceived causes of obesity from two sources, running facilitated workshops with the pilot sites and from those included in the Foresight Report. The causes were then coded against the wider determinants of health model. The model maps the relationship between the individual, their environment and health. Individuals are placed at the centre, and surrounding them are the various layers of influences on health – such as individual lifestyle factors, community influences, living and working conditions, and more general social conditions. 226 causes were coded against the wider determinants of health model layers. These can be seen in the Appendix C diagram in red.

The Lincolnshire team mapped the current countywide interventions against the wider determinants of health model (green on the diagram in Appendix B) to allow the team to understand how the current interventions support the Healthy Weight priority locally. Collating actions into one document helped to show the breadth of the current action. Actions involving services commissioned or provided at a county level have been mapped, but this work has not been extended to lower level geographies at this point, for example districts-level specific interventions.

Please see Appendix C for the Action Map and Appendix D for the Lincolnshire systems map with current actions overlaid.

Identifying Opportunities to Alter the Existing System (Workshop Two) – checking and amending the systems map, prioritising areas for action, starting an action plan.

On 29th October 2019, the partnership held the second workshop event, attended by over 30 delegates, to progress the themes that had been created from workshop one. The aim was to build on the contributions from the first workshop, understand who else we need to get involved based on the themes; provide the understanding that it is the collective impact of aligned working around a common goal that will help alter the system.

A final action at the second workshop was to start working on the obesity action register using the action scale model created by Leeds Beckett. The action scale model has four levels and is an aid to help understand where we can intervene in a system, and what level of action will have greatest leverage for change. This will over the next couple of months be progressed and used as a starting point for action on a range of emerging goals.

1.3 Next steps for consideration:

Action phase

- Themed meetings to be arranged to review opportunities to address identified priorities
- Work with local districts to use the action mapping tool to progress the countywide action map.
- Prioritise areas to intervene with the themes
- Develop collaborative and aligned actions across the sub groups using the action scales framework developed by Leeds Beckett.
- Wider network meetings to update on progress and agree next steps collectively

2. Conclusion

The Lincolnshire Whole Systems Healthy Weight Partnership has a developing role in the approach to addressing obesity.

The Healthy Weight priority needs to be a system-wide priority for Lincolnshire and the whole systems approach is intended to gain consensus and establish a strategic direction for the Healthy Weight priority. Over the coming months sub groups will be established around the themes and using the whole systems approach action scale model, we will understand what actions are currently being taken and identify areas in the theme where we can intervene to effect change. In this instance an action is any concerted and intentional effort to change the functioning of the system, or an aspect of the system.

Our action map shows that we already work on a wide range of areas such as oral health, and road safety, and mental health, but if agendas are aligned with other action in the system we could have an enhanced impact on healthy weight.

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

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

Healthy weight is a theme of the Joint Health and Wellbeing Strategy and there is a JSNA topic that is currently in the process of being refreshed

4. Consultation

None required

5. Appendices

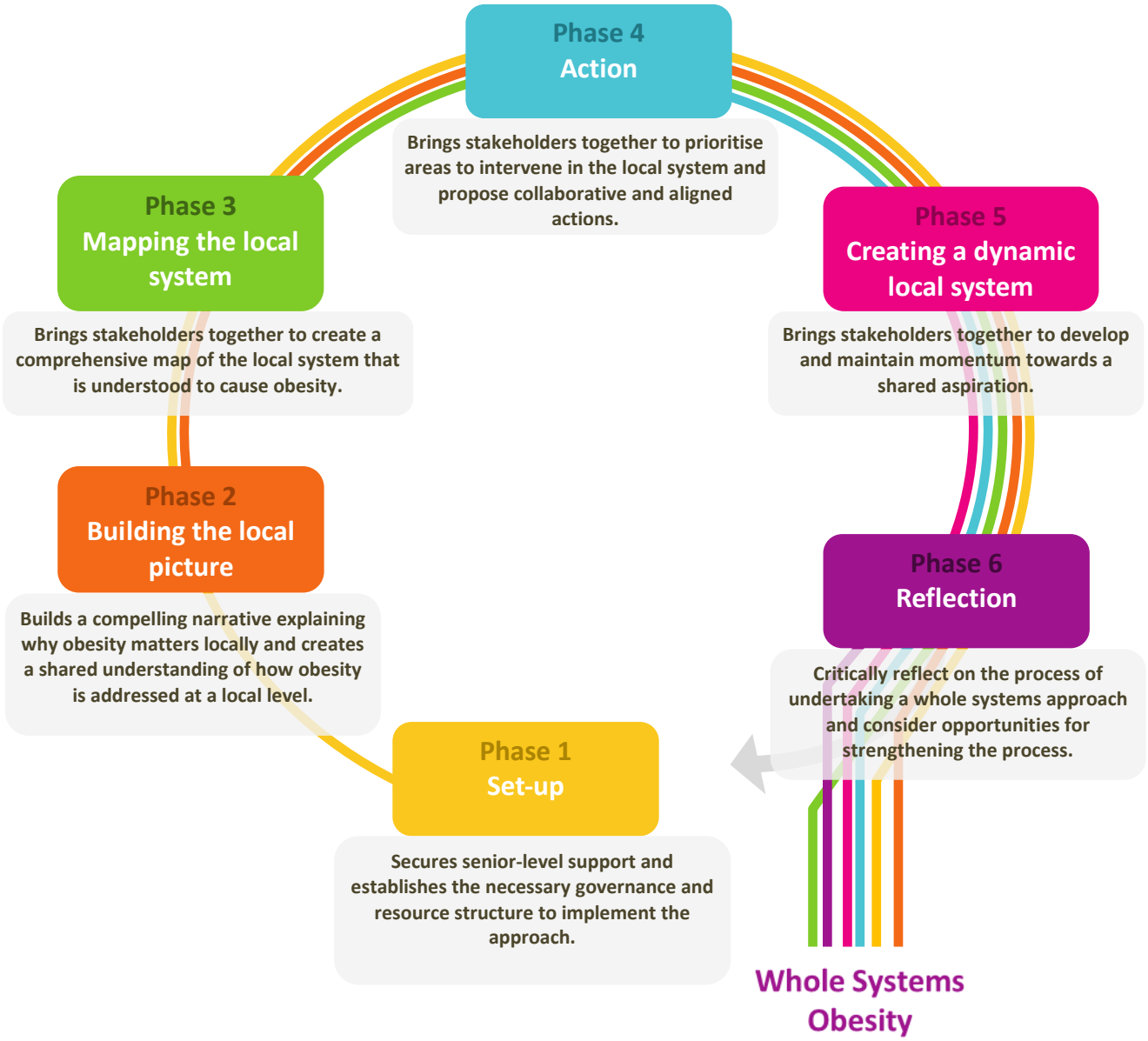
These are listed below and attached at the back of the report	
Appendix A	Process for implementing whole systems approach:
Appendix B	System Map for Lincolnshire
Appendix C	Action Map
Appendix D	Lincolnshire systems map with current actions overlaid.

6. Background Papers

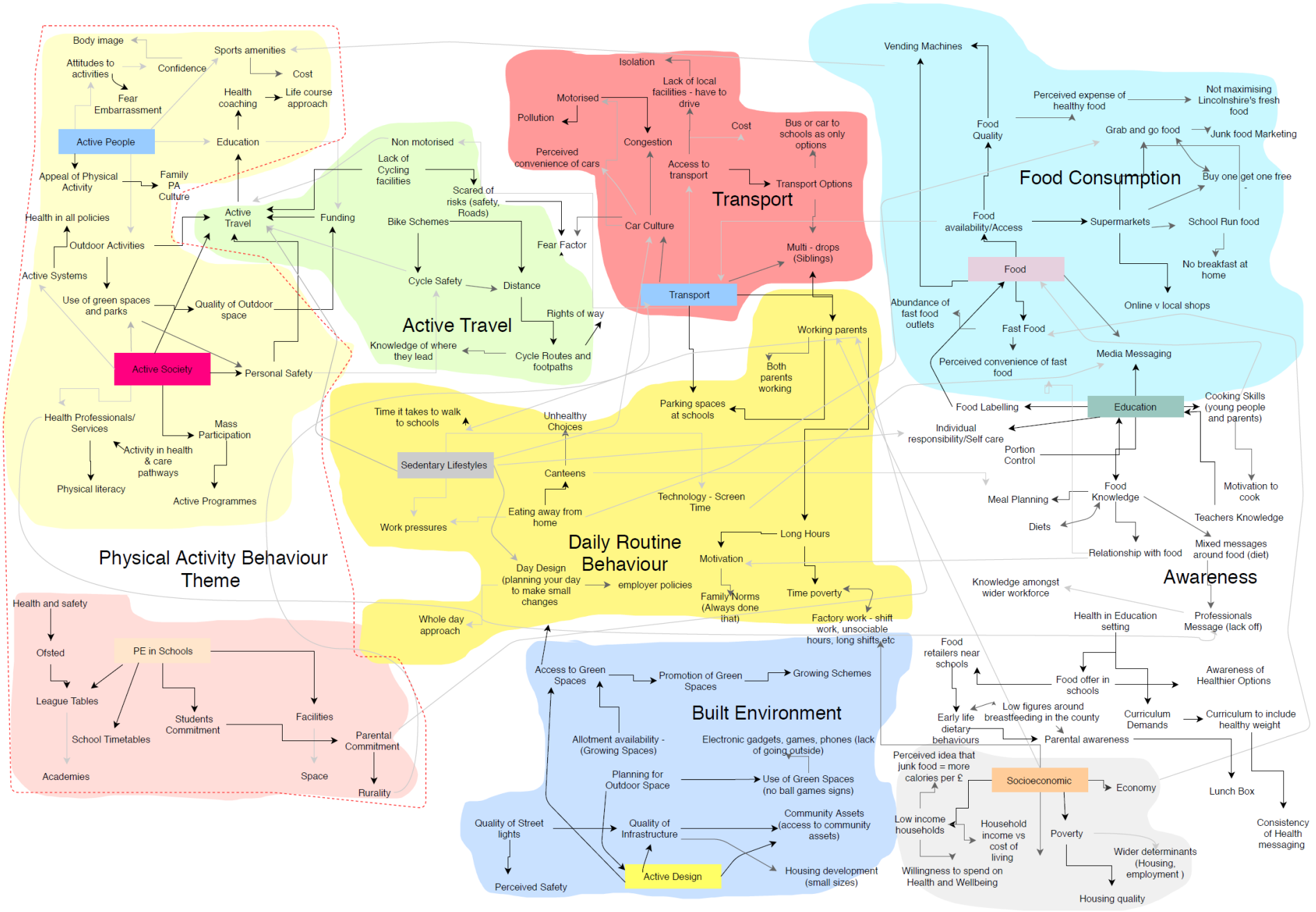
Document details	Where it can be accessed
Foresight Report – Tackling Obesities: Future Choices Project Report 2nd Edition (2007)	https://www.gov.uk/government/publications/reducing-obesity-future-choices
Dahlgren G, Whitehead M. Policies and strategies to promote social equity in health. Stockholm, Sweden: Institute for future studies; 1991.	https://core.ac.uk/download/pdf/6472456.pdf

This report was written by Rachel Belcher, Senior Public Health Officer, who can be contacted on (01522 552920 or (rachel.belcher@lincolnshire.gov.uk)

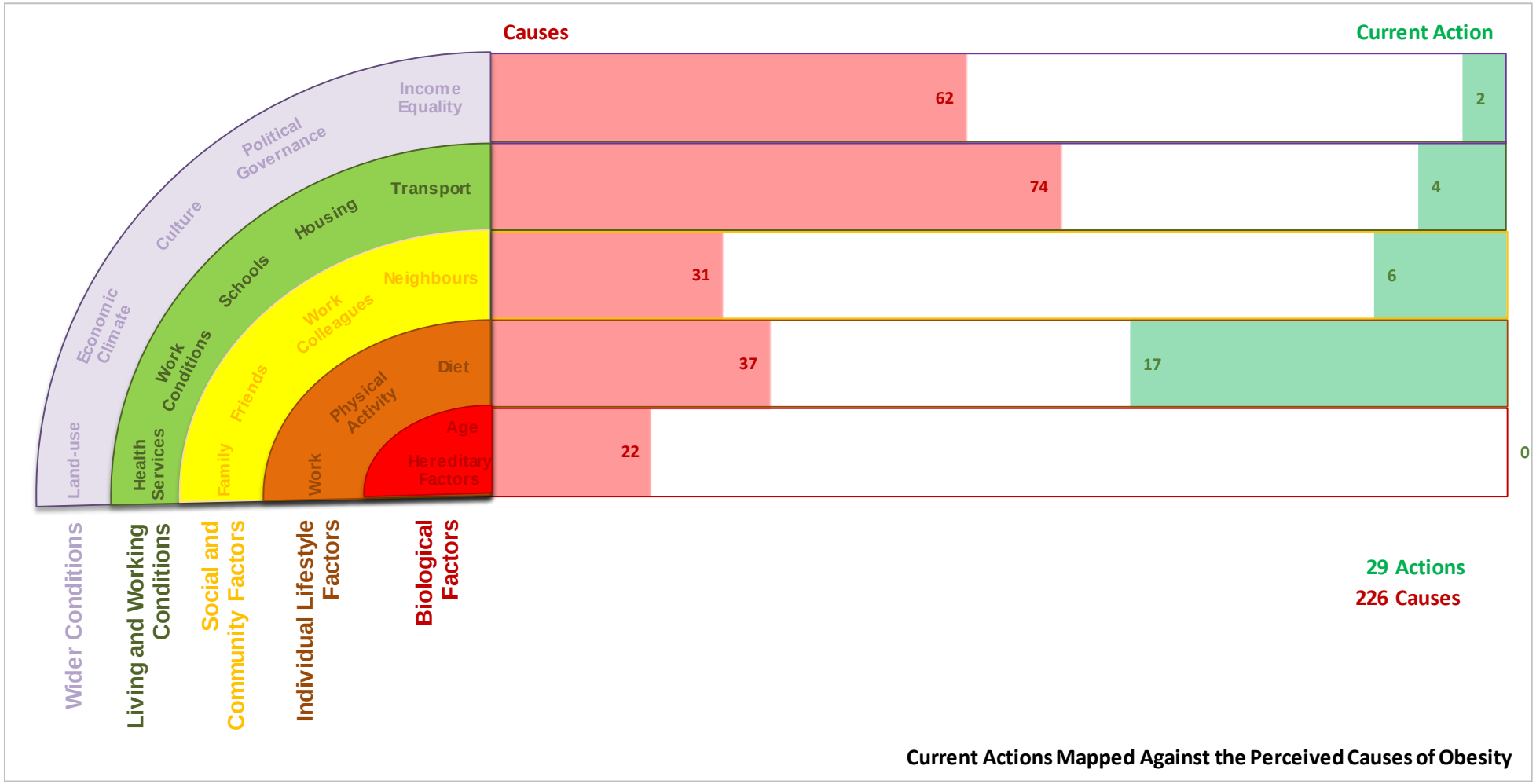
Appendix A: Process for implementing whole systems approach:



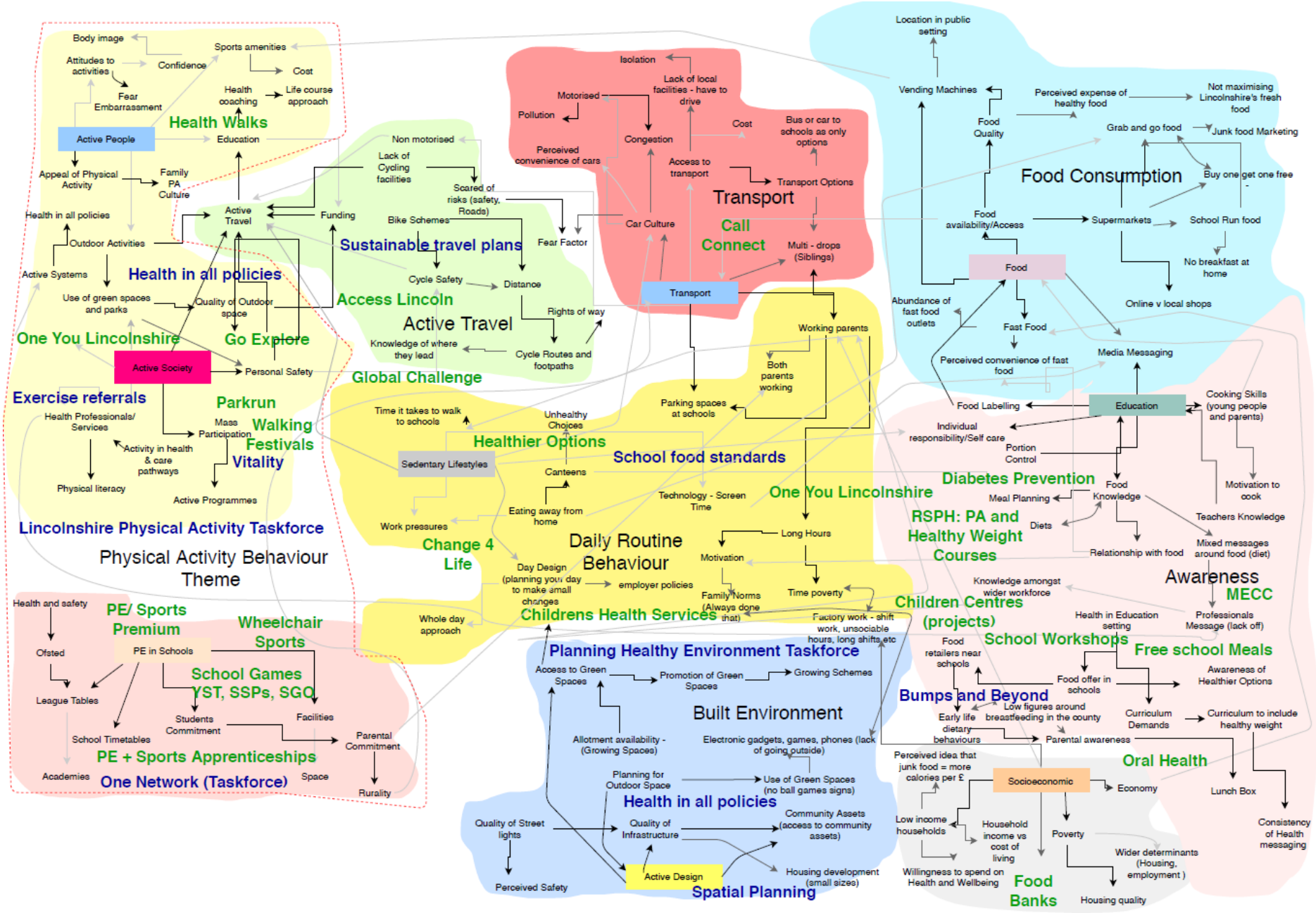
Appendix B: System Map for Lincolnshire



Appendix C: Action Map



Appendix D: Lincolnshire systems map with current actions overlaid.



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Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of the Carers Delivery Group

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**4 February 2020**
Subject:	**Joint Health and Wellbeing Strategy Carers Priority Update**

Summary:

This report highlights progress made against the objectives in the Joint Health and Wellbeing Strategy Carers Priority Delivery Plan. Good progress has been made on delivering the Carers Priority, which is set out below.

For 2020, the Carers Delivery Group has reviewed and extended its membership to include a wider range of organisations and support a multi-agency 'system led' approach to support carers. The group has reviewed and refreshed the Carers Delivery Plan, retaining the four objectives: Early Help, Collaboration, Assurance and Workforce Development. The Group has agreed a Memorandum of Understanding to underpin the commitment of its members but also for wider adoption in Lincolnshire (Appendix A).

These developments have set firm foundations for concerted, system led, joint action to accelerate progress to reach and support more carers, from an earlier point in their caring role, in line with the Care Act (2014), Children and Families Act (2014) and the NHS Long Term Plan.

Actions Required:

The Health and Wellbeing Board (HWB) is asked to:

- Note the report, progress made to date and next steps.
- Support the achievement of the refreshed Carers Priority Delivery Plan (Appendix B)
- Champion a System Led approach to supporting carers and to support the implementation of the NHS Long Term Plan by:
    - Asking their own organisations to:
        - sign the 'Commitment to Carers' Memorandum of Understanding (Appendix A)

- sign up to achieving the Carer Quality Award, if not already underway
- identify and support young carers and their families' needs
- support the establishment of Carers Champions in their own organisations
- support their own staff in a caring role by signing up to 'Employers for Carers', conducting a benchmarking survey of staff in a caring role and developing a staff carers' network

- Asking service providers and partner agencies to adopt these initiatives
- Asking all NHS partners including Primary Care Networks (PCNs) and General Practice (GPs) to sign up to GP Quality Markers

1. Background

1.1 The HWB is required to prepare and publish a Joint Health and Wellbeing Strategy (JHWS) to inform and influence organisations, so that decisions are focused on people's needs and tackle the factors that affect health and wellbeing.

1.2 Supporting Carers was identified as one of seven priorities when the Strategy was revised in 2018. The Carers Delivery Group oversees work that supports this Priority through the Carer Delivery Plan.

1.3 Nationally, local Health and Care systems are encouraged to take a 'System Led' approach to identify and support carers. The NHS Long Term Plan reaffirms its 'Long Term Commitment to Carers', by re-iterating its pledge to maintaining focus on identifying and supporting carers.

1.4 Lincolnshire **JHWS Carers Priority Objectives**

1. **Improve early identification of carers in health settings from the point of diagnosis and signpost to appropriate support.**

2. **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**

3. **Ensure young carers are identified in the education sector with supportive learning environments that are sensitive to their needs and promotes educational attainment.**

4. **Carers are supported to look after their own physical and mental wellbeing, including developing coping mechanisms.**

5. **Carers are supported to plan for the future, including emergencies, to make choices about their lives, such as combining care and employment.**

6. **Improved understanding of the local intelligence to influence and shape preventative measures and support for carers.**

Progress Report

Objective 1: Improve early identification of carers in health settings from the point of diagnosis and signpost to appropriate support.

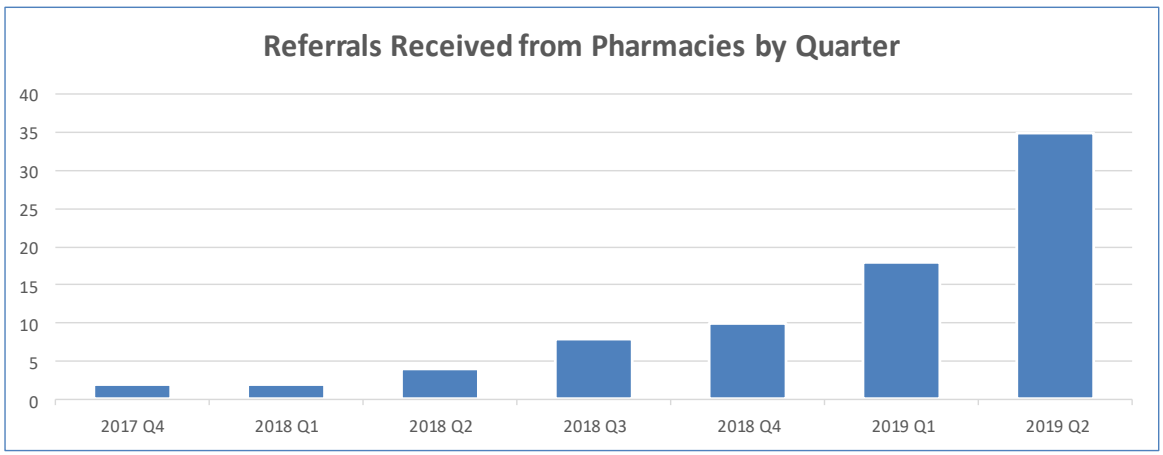
1.1 Carer Friendly Pharmacy Programme

This project aimed to establish Healthy Living Pharmacies as a knowledgeable point of contact to help identify and support carers, in collaboration with the Lincolnshire Pharmaceutical Committee. Led by Carers FIRST, this was achieved through training Pharmacy Health Champions, issuing of targeted publicity materials and on-going information and advice about services available to support carers of all ages, including young carers. All of Lincolnshire's 119 Community Pharmacies were invited to take part in the programme with 117 engaged, having accessed Carer Awareness Training and displaying carer literature within their settings.

Results include:

- 156 Trained Pharmacy Health Champions receiving monthly updates from Carers FIRST on relevant topics and national campaigns to support their ability to pro-actively identify and assist carers.
- Creation of bespoke pharmacy staff toolkit to assist staff to signpost adult and young carers.
- Direct referrals to the Lincolnshire Carers Service via PharmOutcomes.
- Increasing numbers of PharmOutcomes referrals direct to the Lincolnshire Carers Service (Figure 1. below) with 101 to date, 2 for young carers[1], from just under 40 pharmacies.
- Trial of targeted promotional approaches such as home delivery customers.
- Targeting of flu vaccinations via voucher scheme[2].
- 44 pharmacies registered to undertake the Carer Quality Award (see below).

Figure 1: Referrals received from Pharmacies to the Carers Service



Next steps:

- To promote and improve the identification and signposting of young carers.

[1] Please see Appendix A for relevant examples of how this project has enabled individuals to access support in times of need.

[2] Uptake data not yet available

- Although the project is drawing to a close, on-going work with pharmacies will be embedded in 'place-based' work across integrated neighbourhood working/PCNs, enabling referral pathways and information and awareness raising to continue.

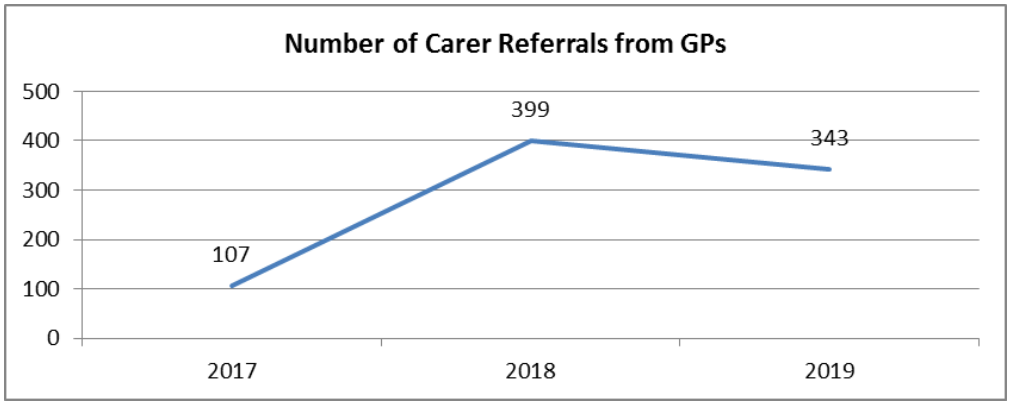
1.2 Carers FIRST Health Engagement: Primary Care

The Carers FIRST Health Engagement Co-ordinator works with primary care to ensure the carers and young carers support offer to health partners is consistent and fosters their engagement in the development of support to carers. Strong multi-agency relationships have been forged across primary care, Carers FIRST Locality teams. All GP practices and Patient Participation Groups (PPGs) have been contacted.

Results include:

- Engagement with 59 GP practices; relationships built with PPGs and Practice Managers (Cluster meetings attended).
- 7 GP practices now offer monthly Carer Health and Wellbeing Clinics.
- Developed E-referral form to assist direct GP referral.
- Digital Carers Awareness-raising information on screen.
- Positive impact on direct referrals from GP practices illustrated in Fig 2 below[3].
- Engagement with 'cross-border' GP practices.

Figure 2: GP Referrals to the Lincolnshire Carers Service (to September 2019)



Next steps:

- Encourage all GP practices to adopt **NHSE GP Carer Quality Markers**, in line with the NHS Long Term Plan. See Objective 2 below.
- Encourage remaining GP practices to undertake the **Carer Quality Award** (see below) which is an enabler to the above GP Quality Markers.
- Support Primary Care through 'Communities of Practice'.
- Ensure the Social Prescribing offer includes and works for carers.

1.3 Neighbourhood Teams and multi-disciplinary working

Carers FIRST are core members of all 13 Neighbourhood Teams, with strong multi-disciplinary working relationships established.

[3] Please note: indirect referrals through signposting and self-referral are not captured here. The actual number is likely to be greater, especially as the service is now promoted in waiting room digital screens

Next steps:

- Review and consolidate the offer within the design of Neighbourhood Teams, particularly in the context of the forthcoming re-commissioning of the Carers Service.
- Undertake a 100 day challenge to consolidate and develop Whole Family Approaches (Grantham Neighbourhood Team, Association of Directors of Adult Social Services (ADASS) Carers Sector Led Improvement Programme).
- Participate and support NHS Personalisation programme, to help ensure a 'Think Carer' approach.

1.4 Carers FIRST Hospital In-Reach Service

Lincolnshire Carers Service workers are now embedded within Hospital Social Work teams and work collaboratively with partner organisations across acute hospitals and multiple wards to support over 1,000 unique carers each year. Carers FIRST staff provide immediate vital practical and emotional support to carers often as they first encounter a caring role. Through pro-active case finding, weekly ward drop-ins and liaison with a wide variety of health and care practitioners and teams, the offer often involves informal advocacy, helping the carer's voice to be heard and needs addressed, for example at multi-disciplinary team meetings. They support discharge planning, often completing an initial carer triage within the hospital to handover to community based carers support. The work enables safer, more robust discharges, and more confident, supported carers.

Carers FIRST community teams also liaise with the Carers FIRST Hospital In-Reach Service, to support carers who are known to the service during a hospital admission (their own, or of the adult they care for), providing seamless support to the carer during these stressful times.

Results include:

- The Carers First Hospital In Reach service supports over 1,000 unique Carers[4] each year, of whom
  - 70% are new to the Carers Service
  - 81% receive on-going support from the Carers Service
  - 69% have eligible needs which meet Care Act criteria
- Strong collaborative relationships with sister services (Patient Advice Liaison Service (PALS), Macmillan, Stroke Association, St. Barnabas, Wellbeing Service and Housing In reach).
- Membership of the United Lincolnshire Hospital Trust (ULHT) Patient Experience Group to represent the carer's voice.
- Offering joined up support at monthly Health and Wellbeing Joint Clinic at Johnson Hospital in Spalding, with St Barnabas, DWP and Wellbeing Lincs.
- Supporting development of the Carers Information and Advice Hub in Pilgrim Hospital.
- Finalist for 3 national awards in 2018-19: HSJ 'System Led Support for Carers', and Local Government Chronicle Awards for Public/Private Partnership and Health and Social Care[5].

Next steps:

- Consolidate the current service.
- Develop a network of Carers Champions within the hospitals.

[4] Video testimonials available
[5] Presentation available.

- Develop the model with partners, securing additional funding as necessary, to extend coverage to all wards, including Outpatients, Accident & Emergency, Paediatrics and Maternity, and to increase frequency of attendance in the community hospitals.

1.5 NHS 'Commitment to Carers': System Led Support for Carers
As set out above, work by the Lincolnshire Carers Service and local charity EveryOne to support health to put the principles of the 'Commitment to Carers' into practice has resulted in good progress.

Operationally, it may now be hoped that the case for the benefit of identifying and supporting carers, of all ages, has been made.

With plans for an Integrated Care System (ICS), local implementation of the NHS Long Term Plan, national recognition of good integrated carers practice, the placing of Carers as a Priority within the JHWS and a refreshed Carers Delivery Plan for 2020, it now feels like the right moment for Lincolnshire to take the next step of a system-led 'Long Term Commitment to Carers' through a Memorandum of Understanding (MOU), attached in Appendix A.

Next steps
- The Health and Wellbeing Board to champion System Led Support for Carers, by signing a MOU: 'Long Term Commitment to Carers', agreeing to support the identification and support carers of all ages in Lincolnshire by all member organisations.
- Offer to support signatory organisations through the Carer Quality Award, Employers for Carers, full access to the Lincolnshire Carers Service and the development of networks of Carer Champions and 'Communities of Practice'.

Objective 2: 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.

2.1 Carer Quality Award
The work of EveryOne, through the Carer Quality Award (CQA) has helped many local health practitioners to improve their identification and support of carers. 42% of Lincolnshire's GP practices now have an up to date Carers Register. The well-received Carer Awareness training linked to the Award is the primary vehicle to support health and care professionals to understand the importance of identifying carers and to listen to, and work with them as respected and equal partners in care. Originally commissioned by the Health and Wellbeing Board, the Award offers an effective bespoke tool to assist health organisations to realise the clinical, practical and organisational benefits of identifying, listening to and supporting carers.

To achieve accreditation, practice staff attend Carer Awareness training and identify a Carers' Champion. Practices will maintain an up to date Carers Register and provide a dedicated Carers Information Board. Good practices will ask how carers are managing, listen, respond, and signpost and refer to support. They may offer double and fast tracked appointments for carers and can target Health Checks and flu vaccinations. Benefits to practices include increased patient/carer satisfaction, positive evidence for CQC

inspection and the forthcoming GP Carer Quality Markers. Practices testify to its value[6]. Accreditation is kept up to date with annual re-accreditation.

Carer Quality Award, 2015 – current date

Results to date

By CCG	Achieved	Working Towards	Initial Steps	Not Engaged	% Achieved / Working Towards
West CCG	7	2	7	21	**24.3%**
East CCG	8	3	6	9	**42.3%**
South CCG	7	2	2	4	**60.0%**
South West CCG	13	0	1	7	**61.9%**
Lincolnshire	**35**	**7**	**16**	**41**	**42.4%**

- 42% of Lincolnshire GP practices have achieved the Award or are working towards it.
- South West Lincolnshire and South Lincolnshire Clinical Commissioning Groups (CCGs) excel: 67% and 60% of practices respectively have achieved the Award or are working towards it.
- Exemplars include New Springwells Surgery and Ancaster Practice.
- Positive testimonials from GP practice staff about the value of the Award.
- Heath organisations, Lincolnshire Partner Foundation Trust (LPFT), Lincolnshire East CCG, South West Lincolnshire CCG, North West Anglia Foundation Trust have achieved the Award. ULHT and Lincolnshire Community Health Services (LCHS) are working towards it.

Next steps:

- Encourage remaining GP practices and health organisations to undertake or complete the Award, which is an enabler for the GP Quality Markers below.
- Encourage all GP practices to adopt GP Carer Quality Markers, in line with NHS Long Term Plan.
- Increase numbers of young carers identified in primary and acute health care (3 young carers referred to Young Carers Services in the past 5 years).
- Horncastle Surgery and Dr Mughal to lead a Quality project to implement and promote the GP Carer Quality Markers with a particular emphasis on young carers.
- Showcase Carers Primary Care good practice and its benefits at future Local Medical Committee (LMC) conference event.
- Ask Lincolnshire's CCG Governing Bodies to encourage all Lincolnshire's GP practices to undertake the CQA and to achieve the new **NHSE GP Quality Markers**[7].
- Contribute to the curriculum at the new Lincoln Medical School.

Objective 3: Ensure young carers are identified in the education sector with supportive learning environments that are sensitive to their needs and promote educational attainment.

3.1 Supporting Young Carers in Schools

Work by the Early Help Young Carers Lead engaging with Lincolnshire schools has successfully increased the identification of young carers. Many schools, including the increasing numbers which participate in the Young Carers in Schools Programme, now provide high quality support: such as a Young Carers' champion (teacher), trained pastoral support and Young Carer support groups. However the above Children's Society

[6] Testimonial evidence available
[7] Briefing paper available

Programme is not the only route to offering good support. Early Help colleagues encourage a bespoke approach for Lincolnshire according to need. The Early Help Young Carers Lead supports schools with Assessments, Children/Young People Plans, and Safety Plans, establishing and maintaining Young Carer support groups, multi-agency professional working and services to improve outcomes for young carers.

Results include:

- The majority of Lincolnshire schools now have a named contact for young carers.
- More young carers than ever before being referred through schoo1.
- 53 schools participate in the Young Carers in Schools programme.
- 13 schools have achieved a Bronze Award and one has achieved Silver.

Next steps

- Continue to provide bespoke support for schools appropriate to Lincolnshire and encourage remaining schools to engage.
- Take a 'place based' approach to identifying and supporting young carers, linking with GP practices and pharmacies, as well as local adult services.

Objective 4: Carers are supported to look after their own physical and mental wellbeing, including developing coping mechanisms.

4.1 Carers Star

Carers FIRST use the 'Carer's Star' to monitor the health and wellbeing of carers. Supporting the health and wellbeing of carers is a primary goal of the service and grounds for eligibility under the Care Act. Many different elements of the carer's support package may contribute to health and wellbeing outcomes. Reviews[8] of support for over 1,400 carers during 2018-19 showed:

- 21% have an improved health outcome score.
- 60% of carers showed no change.

Research by the University of Kent found that an outcome of 'no change' should be considered a positive, as support from the service prevented a deterioration of wellbeing.

4.2 NHS Health Checks

NHS Health Checks are commissioned by Public Health who has identified carers as a priority group. It is however, not possible at this time, to monitor specific uptake by carers.

4.3 One You / Integrated Lifestyle Service (ILS)

Carers are a priority group to access the ILS, a new service commissioned by Lincolnshire County Council (LCC) and co-funded by the CCGs which went live in July 2019. Good working relationships and mutual referral pathways have been established between the Lincolnshire Carers Service and the ILS, with a follow up due in spring 2020. Referral uptake will be reported upon in subsequent reports.

4.4 Substance Misuse/ Addaction

Strong working relationships and mutual referral pathways are in place between the Lincolnshire Carers Service and Addaction. Carer FIRST is well placed to identify hidden substance misuse amongst the caring population. The service also supports families of substance misusers.

[8] Either at the initial 12-16 week light touch review or at annual review.

Next steps

- Identify uptake of Health Checks by carers.
- Encourage carers to self-register on their GP's Carers Register with the appropriate read code.
- Promote, support and monitor up take of services between the ILS and Lincolnshire Carers Service.

Objective 5: Carers are supported to plan for the future, including emergencies, to make choices about their lives, such as combining care and employment.

5.1 Employers for Carers

Latest research indicates that 1 in 7 people juggle working with caring. Across the UK, 2.6m people have given up work to care, and a further 2m have reduced their hours to care.

LCC has signed up to national initiative 'Employers for Carers' (EfC) hosted by Carers UK and sponsored by the Department for Health and Social Care (DHSC). It encourages employers to develop carer friendly workplaces. LCC's umbrella membership enables the local authority to reach and support working carers in their own workforce, through enabling small to medium sized enterprises and other employers (e.g. District Councils, health organisations) to access the initiative. Local authorities sign up as the key subscriber and then make EfC's resources available free to health partners and small or medium sized enterprises (SMEs), offering added value at no additional cost.

In a recent LCC Employee Carer survey carried out over the summer, staff reported that flexible working, an understanding and supportive manager as well as adequate support for the person looked after, are key to successfully juggling work and care.

Results to date:

- 75 employers signed up to Employers for Carers.
- 51 businesses have named Carer Champions.
- Networking with main business infrastructure organisations.
- Employer Benefit Calculator developed with Lincolnshire Open Research and Innovation Centre (LORIC) (Bishop Grosseteste University).
- LCC Staff Carer Network established; benchmarking Employee Survey.
- Lincolnshire Community Health Services and Lincolnshire Partnership Foundation Trust (LPFT) have established staff carer networks.
- LPFT, United Lincolnshire Hospitals Trust, North West Anglia Foundation Trust, Lincs East, and South Lincs have all signed up to EfC.

5.2 Carers Emergency Response Service

This service continues to be popular with carers with over 7800 emergency response plans in place. It offers peace of mind and can assist in an emergency, as it did for 12 families in 2017-18. The service is currently being reviewed.

Next steps

- Review and update the service, align with related offers and re-launch.

Objective 6: Improved understanding of the local intelligence to influence and shape preventative measures and support services for carers.

6.1 Carers Joint Strategic Needs Assessment (JSNA)

The all age Carers JSNA topic is updated annually. The refreshed version has been reviewed and updated to strengthen the evidence base in relation to the needs and experiences of carers in Lincolnshire. It can be found here[9]. Key messages are:

- Lincolnshire will have an estimated 88,000 carers by 2021.
- Adults aged 55-64 are most likely to care for others – prime employment years.
- The most rapidly rising cohort of carers is carers aged 85 and over[10].
- The GP Patient Survey 2019 tells us that more carers (61%) are likely to report a long term health condition, illness of disability than non-carers (50%), and particularly so for younger carers.
- Younger carers were more likely to report on-going problems with back and joint pain, respiratory problems, mental health and isolation (GP Patient Survey 2019).

Evidence from the 2018-19 DHSC **Survey of Adult Carers in England** (Appendix B) reinforces the need for primary care to further develop its role in supporting carers. Many Lincolnshire respondents stated that their GP didn't know they were a carer and that they see their GP as an important professional to whom they would disclose concerns about their own safety.

A regular Carers policy and research update is curated by Public Health Librarians and circulated to partners countywide and across the region.

2. Conclusion

There has been good progress against the Carers Priority Delivery Plan to date. The plan has been reviewed and refreshed, informed by the NHS Long Term Plan, retaining the current objectives but including a wider range of actions, which build on and develop previous work.

The refreshed plan aspires to achieve greater impact for patients, carers and organisations through co-ordinated system led actions. The proposed multi-agency MOU, attached as Appendix A seeks to strengthen joint working. Whilst there is much more to be done, there is also an appetite to go further, working smarter and working together.

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

This report relates to the delivery Carers Priority of the JHWS and the progress made in improving outcomes. The Carers Delivery Group 'owns' the JSNA Carers topic.

4. Consultation

None

[9] www.research-lincs.org.uk/jsna-Carers

[10] Carers UK and Age UK, Caring into Later Life (2015)

5. Appendices

These are listed below and attached at the back of the report	
Appendix A	Commitment to Carers' Memorandum of Understanding: Supporting an Integrated Approach to Identifying and Supporting Carers
Appendix B	Survey of Adult Carers in England
Appendix C	Draft Refreshed Carer Priority Delivery Plan

6. Background Papers

Document	Where it can be accessed
Supporting carers in general practice: a framework of quality markers	https://www.england.nhs.uk/publication/supporting-carers-in-general-practice-a-framework-of-quality-markers/
NHS Commitment to Carers	https://www.england.nhs.uk/commitment-to-carers/
NHS Long Term Commitment to Carers	https://www.england.nhs.uk/blog/our-long-term-commitment-to-carers/

This report was written by Emma Krasinska who can be contacted on 01522 554008 or emma.krasinska@lincolnshire.gov.uk

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Lincolnshire's Long Term Commitment to Carers: A Health and Wellbeing Memorandum of Understanding

Supporting an integrated approach to the identification and support of Carers' health and wellbeing needs

1. Introduction

This Memorandum of Understanding (MOU) sets out an agreement to take an integrated approach to identifying and supporting adult carers and young carer's health and wellbeing needs between all relevant organisations across Lincolnshire's Health, Care and Housing system. The document is based on a template from NHS England and others.

For the purposes of this MOU, the following definitions of carers and young carers will be adopted:

"A carer is someone who provides or intends to provide unpaid care for another adult [1]"

"A young carer is a person under 18 who provides or intends to provide care for another person of any age who is physically or mentally ill, disabled or misuses substances.[2]"

The State of Caring 2018 report by Carers UK showed that the majority of carers are struggling with their mental and physical wellbeing as a result of caring.

There are an estimated 84,000 carers in Lincolnshire who contribute a vital role within the health and wellbeing system of the county.

The 2011 census reported that Lincolnshire had:

- Over 79,0000 carers
- 20,000 carers caring more than 50 hours a week
- 53,000 carers of working age
- 1,800 are young carers[3]

Research by the University of Leeds and Carers UK shows that carers save Lincolnshire an estimated £1,677 million a year[4].

For more information on carers, see the Joint Strategic Needs Assessment chapter on Carers here[5]:

[1] Care Act 2014
[2] S.96 Children and Families Act 2014
[3] Research in 2010 by Nottingham University and BBC indicates numbers could be four times as high
[4] Valuing Carers, 2015
[5] http://www.research-lincs.org.uk/jsna-Carers.aspx

The Care Act (2014) was designed to improve support for carers. The Act gives carers parity of esteem with the person to whom they provide care and introduces a general duty to promote wellbeing and prevent escalation of need.

The Children and Families Act (2014) aimed to improve support for young carers and parent carers by strengthening their right to have an assessment of their needs. A young carer becomes vulnerable when their caring role risks impacting upon their emotional or physical wellbeing or their prospects in education and adult life.

Both Acts created new duties to provide information and preventative support to carers and young carers. The legislation also places a new duty on the NHS to co-operate with the local authority in implementing these duties.

Several key NHS documents highlight the need to improve support for carers including the NHS Constitution, the NHS Five Year Forward Plan, as well as NHS England's 'Commitment to Carers' and guidance on 'Commissioning for Carers' and 'Integrated Personalised Commissioning'

This MOU aims to help improve carer experience and outcomes through enhanced joint working.

2. What Carers Can Expect

Lincolnshire should be a place where carers are recognised, valued and supported, both in their caring role and as individuals. Carers in Lincolnshire should be able to:

- Be identified as a carer as early as possible, be informed and respected and included by health and social care professionals.
- Have choice and control about their caring role
- Be able to stay well and healthy themselves
- Have their own needs and wishes as an individual recognised and supported
- Be socially connected and not isolated
- Be able to access education, employment or help to remain in work
- Have their religious and cultural needs respected
- Have contingency and emergency plans in place

Young carers and young adult carers should be able to thrive and develop educationally, personally and socially, and be protected from excessive or inappropriate caring roles.

These expectations should apply equally to all carers. Partners will therefore endeavour to reach out to hidden and hard to reach carers.

3. Working Together To Support Carers

By signing this MOU, partners agree to co-operate with each other, to promote the wellbeing of individual Carers, and to adopt a whole family approach in their work to support local Carers of all ages, in order to:

a. maintain the independence and physical and mental health of Carers and their families

b. empower and support Carers to manage their caring roles and have a life outside of caring

c. ensure that Carers receive the right support, at the right time, in the right place

d. identify hidden carers such as young carers and working carers, and those who are seldom heard, such as those from Black and minority ethnic groups, armed forces and veterans, LGBTI, gypsy and traveller etc.

e. respect Carers' decisions about how much care they will provide and decisions about not providing care at all

f. ensure that staff working with carers are appropriately trained and 'carer aware'.

g. ensure that young carers are identified and protected from inappropriate care.

4. Key Principles

This integrated approach to identifying and supporting Carers' health and wellbeing needs rests on a number of supporting principles, informed by what matters to local carers and the key policy and guidance documents cited above.

Partners to the Memorandum of Understanding agree that:

Principle 1 - We will take a pro-active approach in all organisations to identify, register (in Primary Care) and help carers maintain their health and wellbeing. In line with the NHS Long Term Plan, Primary Care partners are actively encouraged to sign up to the GP Carers Quality Markers.

Principle 2 - Carers will be respected and listened to as expert care partners, and through 'a different conversation', will be actively involved in care planning, shared decision- making and reviewing services.

Principle 3 - We will take a community and peer approach to build knowledge and connections, ensure support needs are assessed and met in an integrated way, accessing appropriate services and support both for themselves and the person they look after.

Principle 4 - Carers will be empowered to make choices about their caring role,

Principle 5 - The support needs of Carers who are more vulnerable or at key transition points will be identified early.

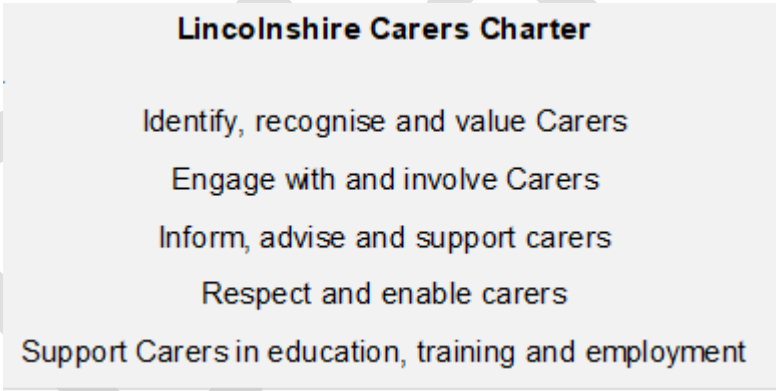
Principle 6 - Young carers, young adult carers and carers of working age will be identified and supported in accessing and maintaining education and employment, including the workforce of signatory partners.

Principle 7 - Carers will be supported by information sharing (with their consent) between health, social care, carer support organisations and other partners to this agreement.

Principle 8 - The staff of partners to this agreement will be aware of the needs of carers and of their value to our communities.

5. The Lincolnshire Carers Charter

The principles above are rooted in the Lincolnshire Carers Charter which was co-created by local carers, based on what is most important to them. Partners to this MOU are actively encouraged to sign up to the Charter putting its principles into practice by undertaking the Carer Quality Award. This provides agencies with bespoke support and training needed to develop policy and practice to improve support for carers both as users of their services and as employees / volunteers – and to help implement this Memorandum of Understanding.



6. Thinking Carer Across The System

Implementation of this MOU is linked to the delivery of the Joint Health and Wellbeing Strategy Carers' Priority. This is 'co-produced' and links the views of Lincolnshire carers to legislation and national policy that underpin carers' rights.

The Health and Wellbeing Carers Priority Delivery Plan promotes a whole family, whole system approach to supporting carers, including the recognition of young carers. By supporting carers, we are also supporting the person who is receiving care. No one should have to care alone.

Other partners, such as schools and colleges, also play a key role in identification and support of young carers and their families, for example through the Young Carers in Schools programme.

In order to ensure that carers receive the right support, at the right time, and in the right place, a carer who indicates that they require additional support or that their capacity or willingness to continue caring is diminished, should be referred to the Lincolnshire Carers Service to have their immediate needs addressed.

Where a carer indicates they have a health need during an interaction with the NHS, this health need should be addressed as soon as possible, after which the healthcare practitioner should initiate a discussion about the carer's wider support needs and consider referral as required to the Lincolnshire Carers Service.

Partnership working and co-operation is key to providing a joined up, seamless service. This will include joint working between the local authority, the NHS, voluntary organisations, education, public health, housing and local communities to support carers.

As health and social care develop more integrated approaches to delivering care and support, we will work to develop local data and information sharing processes between agencies. This will help ensure that information follows the carer across their own care and support pathway, without them constantly having to re-tell their story. We will explore initiatives such as Carer Passports that may assist such approaches.

Carer friendly employment practices will be promoted within partners own organisations. Partners to this MOU are actively encouraged to sign up to and help promote Employers for Carers[6].

7. Governance and Continuous Improvement

Actions arising from this MOU are included in the Carers Priority Delivery Plan, delivered by the Carers Delivery Group, reporting to the Health and Wellbeing Board. The Delivery Group will:

- continue to review, evaluate and identify improvements to supporting carers, reporting these to the Health and Wellbeing Board.

- involve Carers, in recognition that they are 'experts by experience', in monitoring and reviewing services, and when seeking to redesign, commission or procure Carer support services.

- continue to offer programmes for learning and development through the Lincolnshire Carers Quality Award and Employers for Carers to raise awareness and understanding of the needs of Carers and their families, and of local services.

- continue to support workforce development and assure the quality of services through the provision of appropriate training and support for those undertaking Carers needs assessments to have the necessary knowledge and skills.

[6] Free membership is offered to Lincolnshire Health providers through Lincolnshire County Council's Umbrella Subscription.

This will include ensuring that practitioners in the local authority and partner agencies are aware of the specific requirements concerning carers in the Care Act 2014 and young carers and parent carers in the Children and Families Act 2014, and accompanying Guidance and Regulations. This also includes subsequent carer specific guidance and policy, such as updates to guidelines for Continuing Healthcare (2018).

9. Our Commitment to Carers in Lincolnshire

This MOU has been signed by the following organisations:

1. Commissioners and providers of NHS-funded care:
   - Lincolnshire CCG's (NHS Lincolnshire West CCG; NHS Lincolnshire East CCG; NHS Lincolnshire South CCG; NHS Lincolnshire South West CCG)
   - United Lincolnshire Hospitals Trust (ULHT)
   - Lincolnshire Partnership Foundation Trust (LPFT)
   - Lincolnshire Community Healthcare Services (LCHS)
   - Primary Care Networks
   - Lincolnshire Pharmaceutical Committee
   - East Midlands Ambulance Service (EMAS)
2. Other partners such as Housing, Wellbeing, Employment and Education
3. Local Voluntary and Community Sector partners: including any service that provides direct support to carers and is under contract / grant agreement with any of the above named organisations. Such organisations will be expected to sign-up to this MOU as a contractual obligation.
   - Healthwatch Lincolnshire
   - St Barnabas Hospice
   - The Alzheimer's Society
   - Macmillan
   - Stroke Association
   - Voluntary Centre Services
   - Lincolnshire Community and Voluntary Service
4. The Lincolnshire County Council, including
   - Lincolnshire County Council, Adult Care and Community Wellbeing
   - Lincolnshire County Council, Public Health
   - Lincolnshire County Council, Children's Services
5. Locally commissioned Carers Support services:
   - Carers FIRST
   - SERCO (Customer Service Centre & CERS)
   - EveryOne
6. Higher and Further Education Providers

Signatories

Name and title	Organisation	Signature
Glen Garrod – Executive Director of Adult Social Care and Wellbeing	Lincolnshire County Council	
Etc.		

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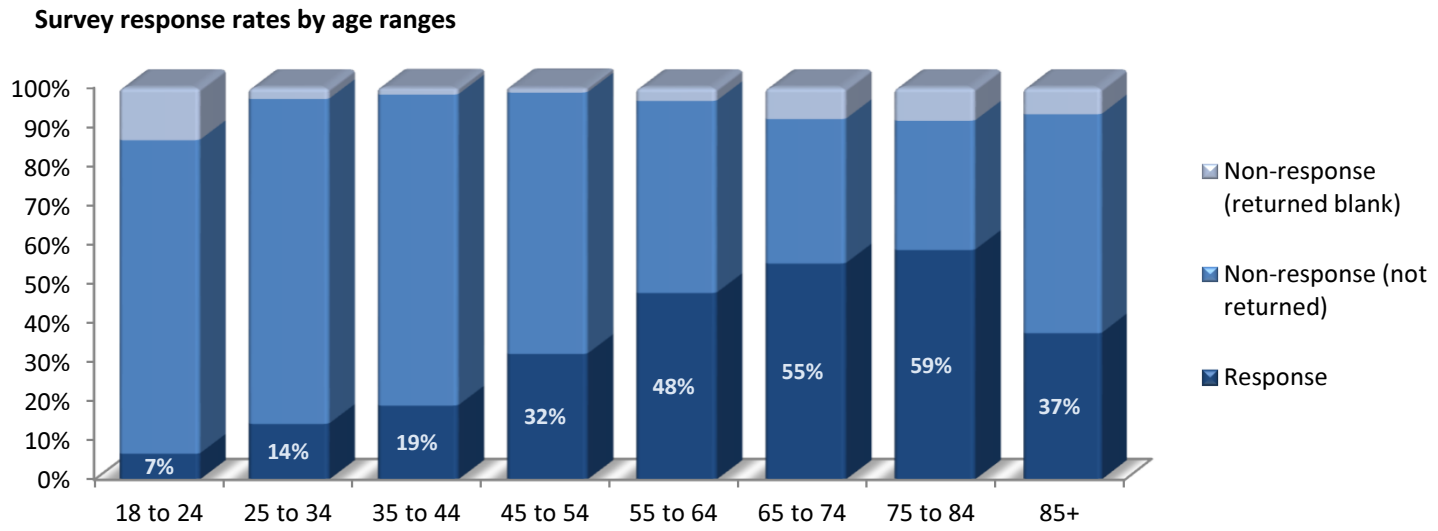
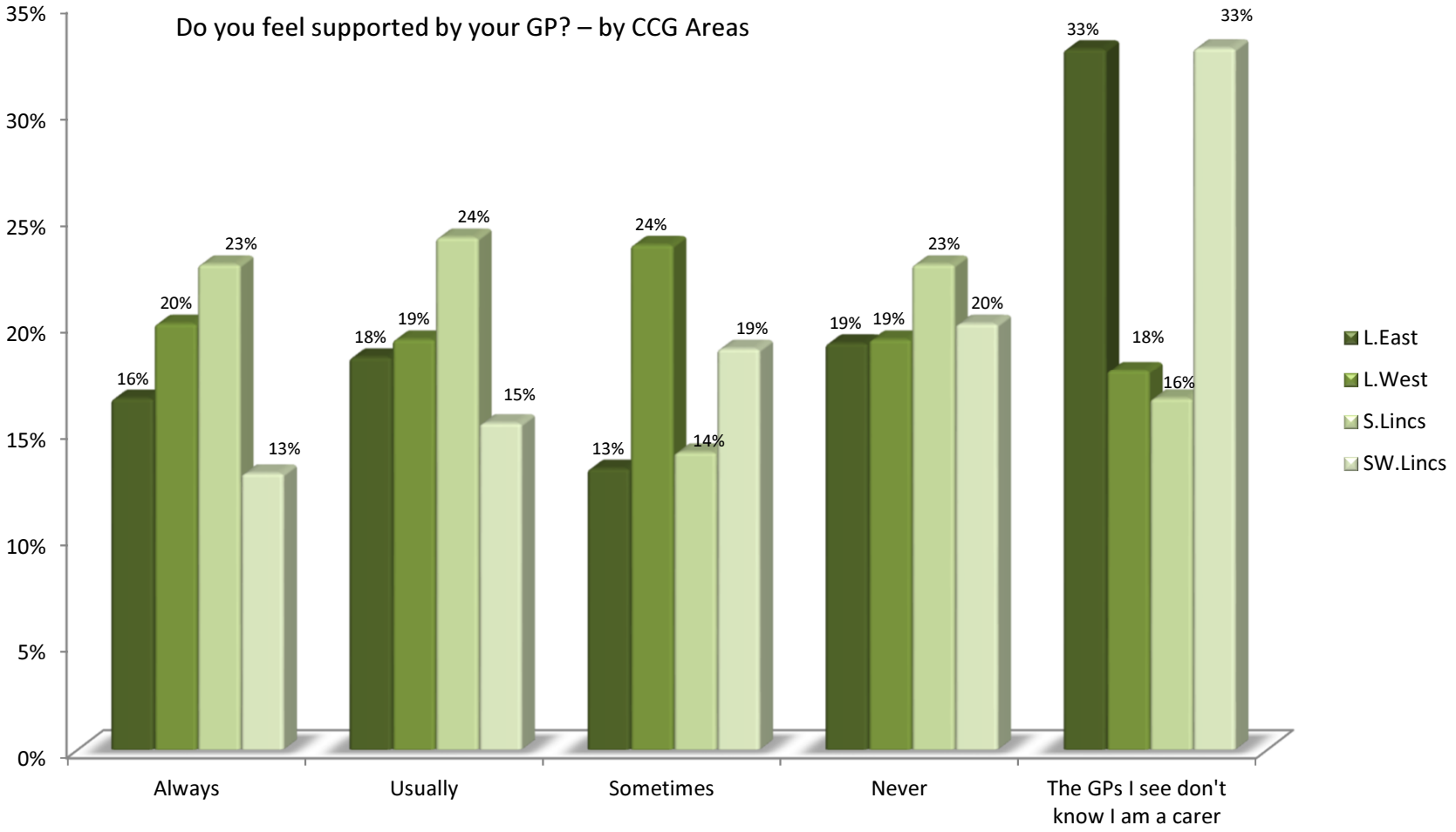
Department of Health bi-annual Survey of Adult Carers in England 2018 – 2019

The Survey Cohort

- 10238 carers reported for 2018-19 Quarter 2 (SALT)
- 1058 carers chosen at random to form the survey cohort
  - Over 18's looking after an over 18
- 462 carers responded to the survey
  - 43.7% response rate

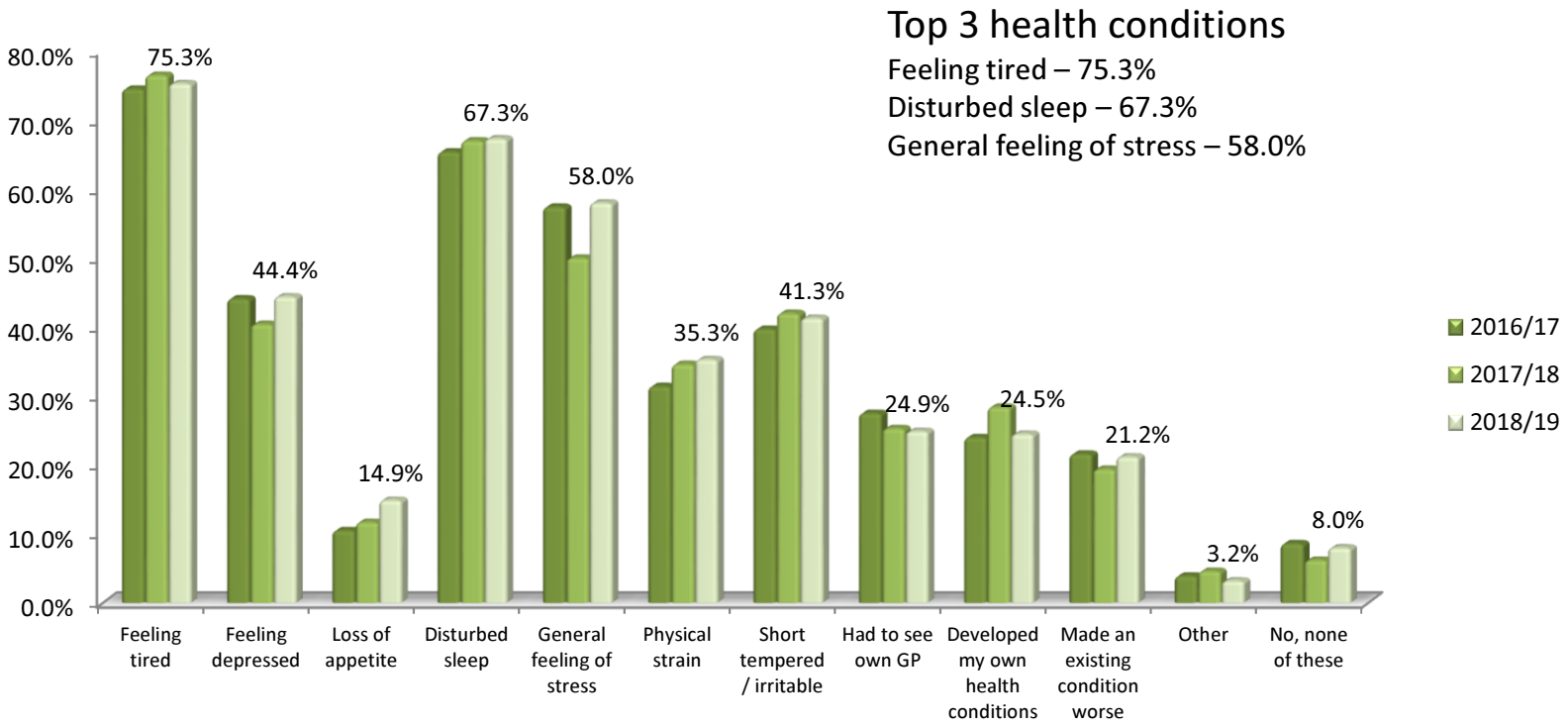


Identification and support by GP

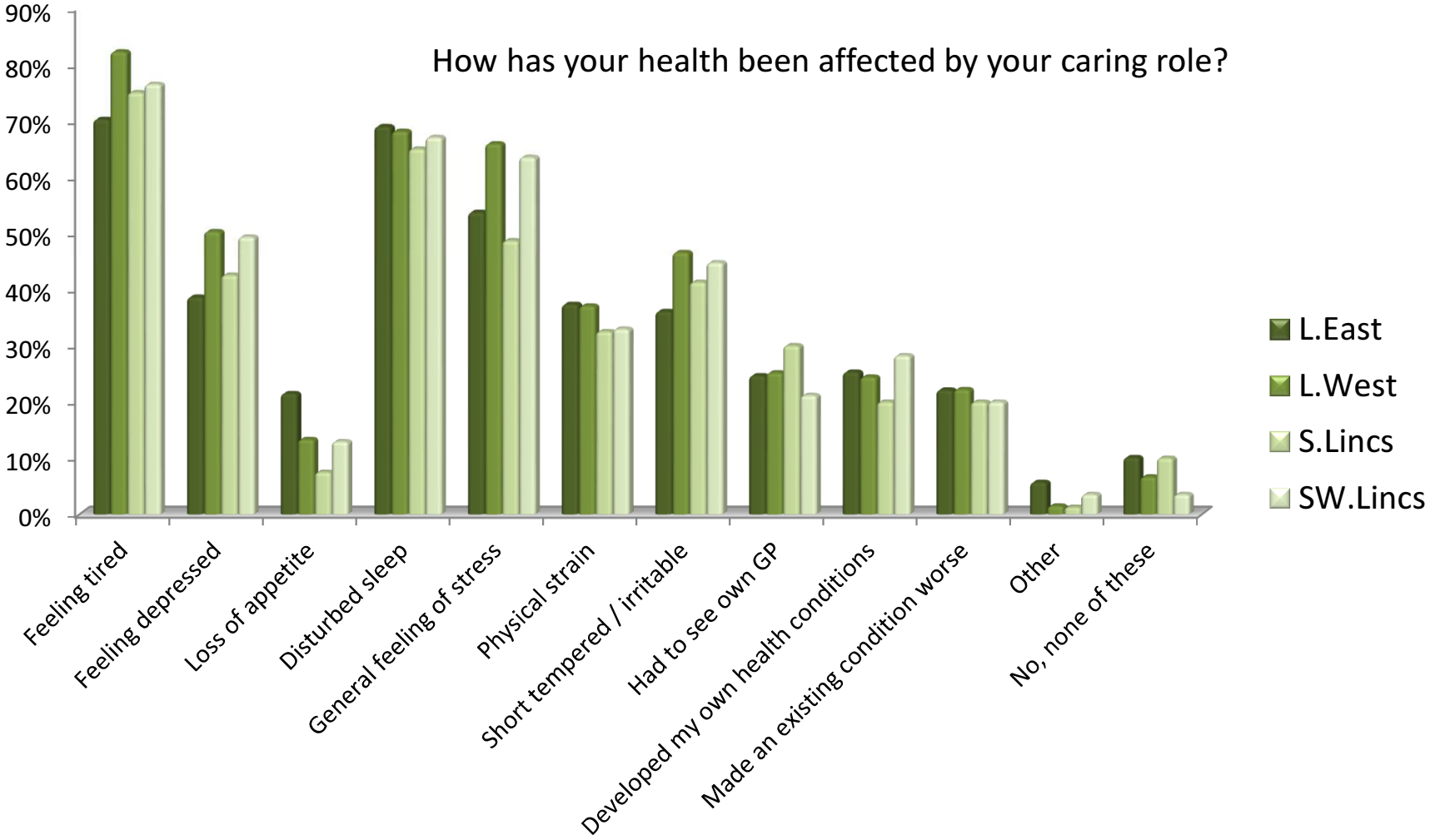


Impact on Carers Health

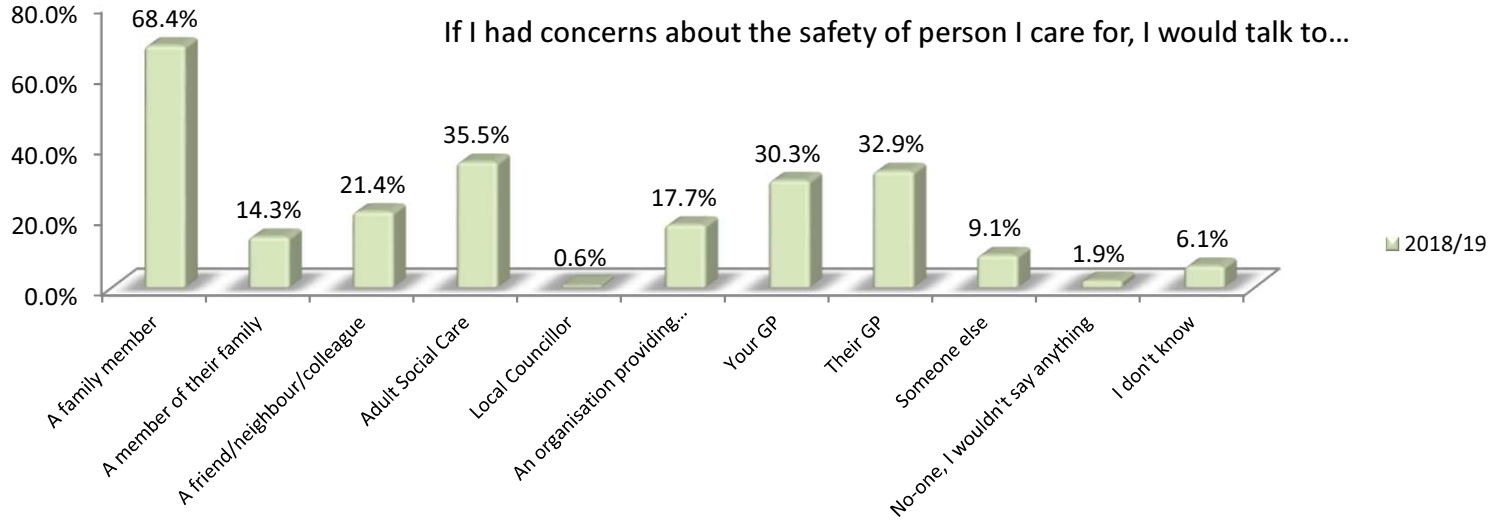
How has your health been affected by your caring role?



Impact on Carers Health – by CCG



Safety


If I had concerns about the safety of person I care for, I would talk to…
80.0%
60.0%
40.0%
20.0%
0.0%
68.4%
14.3%
21.4%
35.5%
0.6%
17.7%
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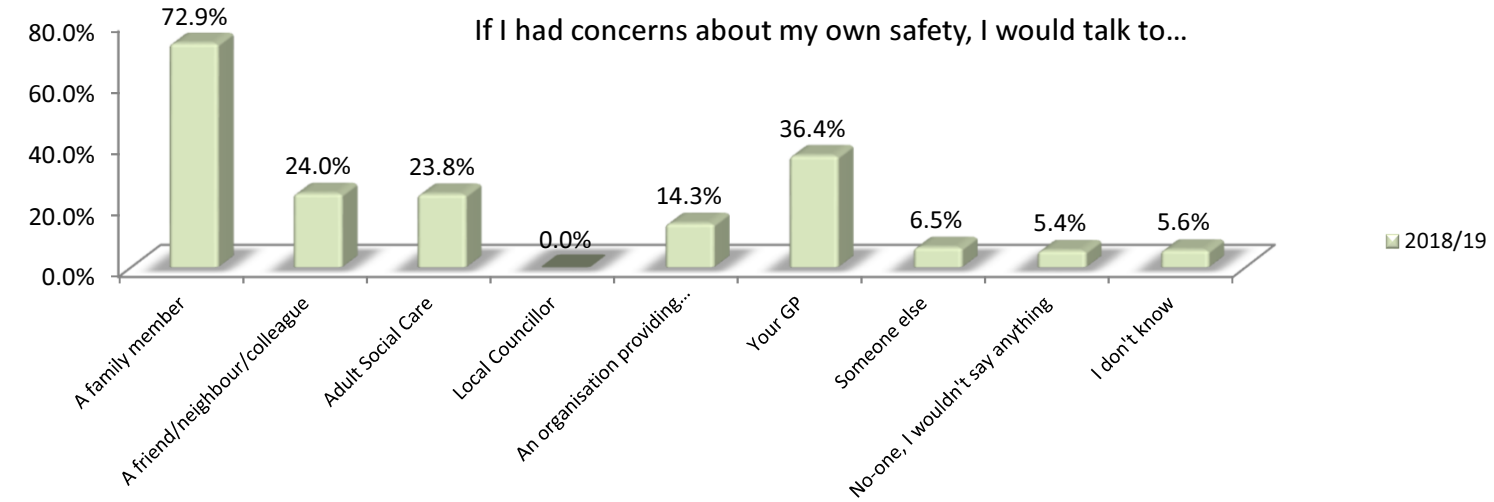
32.9%
9.1%
1.9%
6.1%
A family member
A member of their family
A friend/neighbour/colleague
Adult Social Care
Local Councillor
An organisation providing…
Your GP
Their GP
Someone else
No-one, I wouldn't say anything
I don't know
2018/19


If I had concerns about my own safety, I would talk to…
80.0%
60.0%
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20.0%
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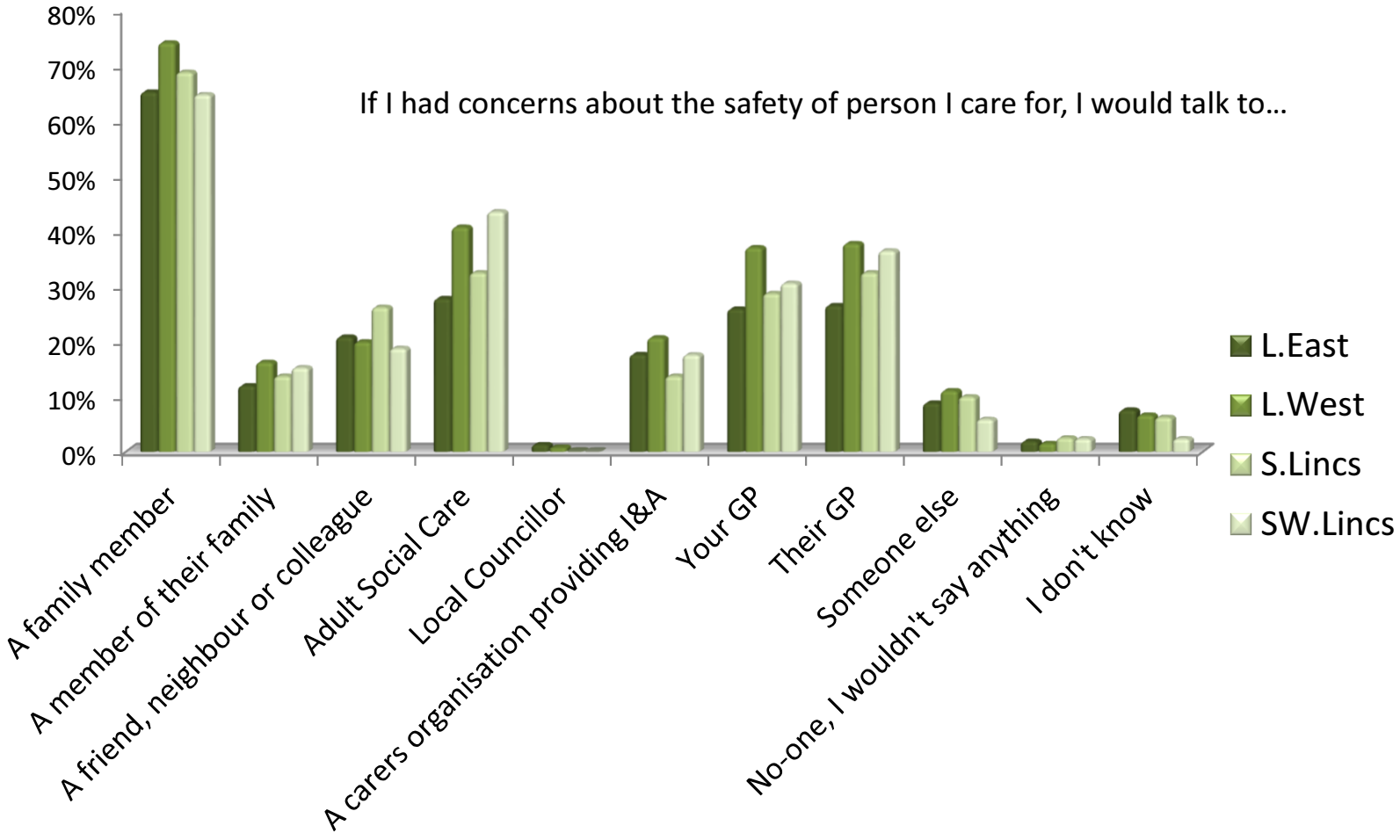
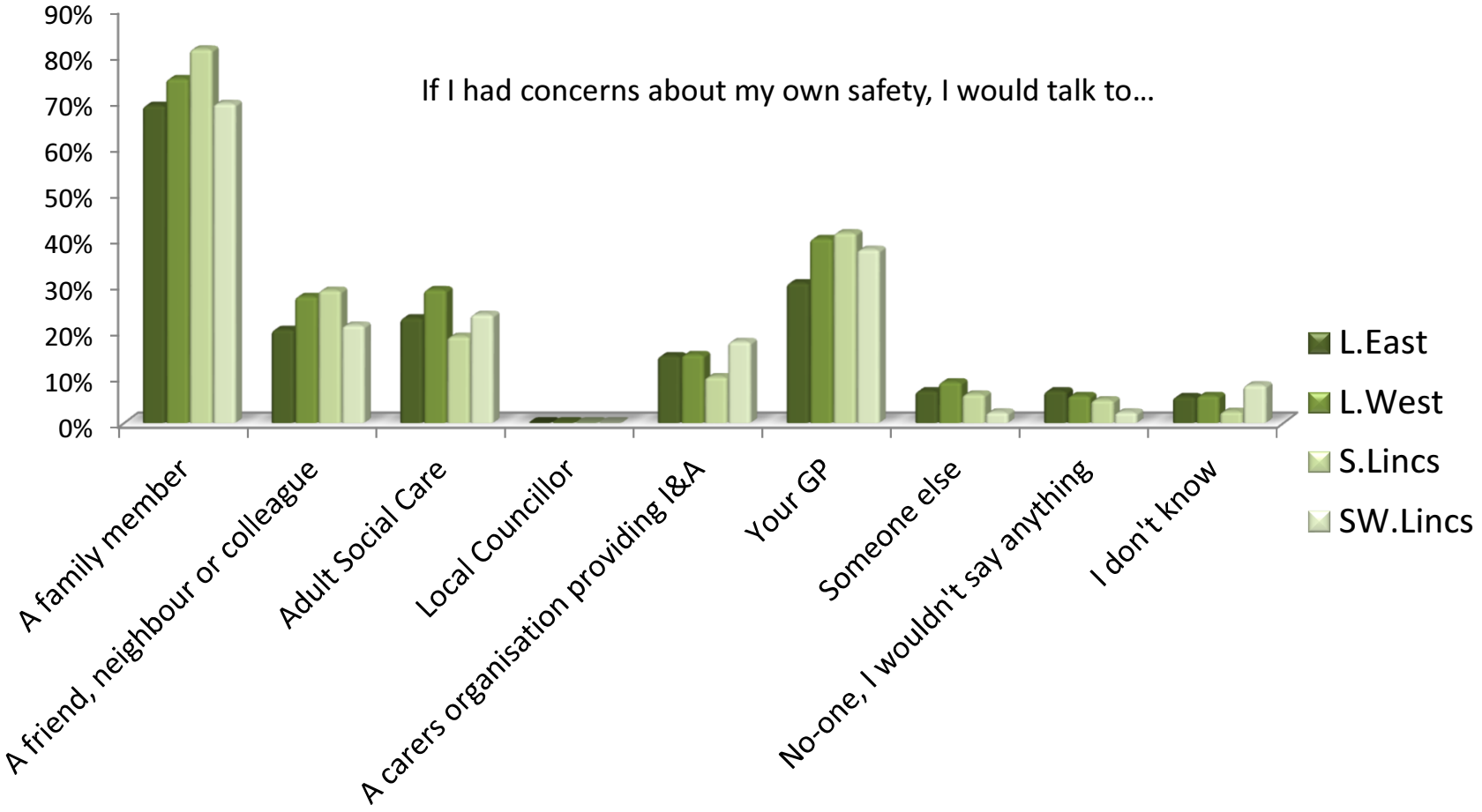
72.9%
24.0%
23.8%
0.0%
14.3%
36.4%
6.5%
5.4%
5.6%
A family member
A friend/neighbour/colleague
Adult Social Care
Local Councillor
An organisation providing…
Your GP
Someone else
No-one, I wouldn't say anything
I don't know
2018/19

Safety – by CCG – Cared for adult



Safety – by CCG - Carer



Joint Health and Wellbeing Strategy: Carers Priority

Delivery Action Plan 2019-21

Introduction and Background

This refresh of the Carers Delivery Action Plan sets out how Lincolnshire County Council and partners will deliver the Carers Priority of the Joint Health and Wellbeing Strategy from 2019-21. It represents the views and priorities of local carers, and the commitment of the wider Health and Care system to work together to support carers of all ages in the county. It has been co-produced by members of the Carers Delivery Group and informed by the Carers National Action Plan (2018) and NHS Long Term Plan (2019).

Our **Aims**:

1) **Early Help:** Identify and help carers at the earliest opportunity
2) **Collaboration:** Work together with partners to improve outcomes for carers
3) **Assurance:** Offer high quality services and check they make a difference to carers
4) **Workforce:** Develop and support Carer Aware workforces

Our values are to listen to, learn from and work with carers to deliver support that works for them and their families. We aim to offer prompt, friendly, helpful services for carers that are easy to use and that make a difference. We work to ensure that carers are supported in their own health, wellbeing and quality of life, and are treated as equal, valued and respected partners in care. We will collaborate closely with partners to join up services, reduce complexity and duplication in order to offer effective support in ways that make sense to families.

An All Age Delivery Plan: Young Carers will be incorporated into all the priorities and projects as appropriate of this all age Delivery Plan.

Joint Health and Wellbeing Strategy (JHWBS) Carers are one of 6 key priorities of the JHWBS. The Carers' Commissioning Strategy has now been replaced by the Joint Health and Wellbeing Strategy, which sets out 'whole system' strategic priorities to support carers. This live Plan will be delivered principally by the Lincolnshire Carers' Service, Lincolnshire County Council and signed up key partners in Health, the community, public and private sector. New partners are invited to include their carer-supporting actions, which should be informed by the JHWBS and the Carers JSNA, within this Delivery Plan. Progress against actions will be reviewed quarterly by the multi-agency Carers Delivery Group, which is in turn accountable to the Joint Health and Wellbeing Board, where an annual report is due each June.

Aim 1: Early Help: Identify and help carers at the earliest opportunity

Early help supports the wellbeing and resilience of carers more effectively than reacting in a crisis. We aim to extend the reach of Carers Support by working with partners in Health, Education, Housing and Employers to identify people in a caring role.

Key areas of focus	• **Work with partners in the community to identify and support carers** • **Help people to recognise their own caring role** • **Empower carers to be adequately prepared for the caring role as it develops**
Is it working? **As a result , we want carers of all ages to be able to say:**	"I recognise I am in a caring role" "I know how to find useful information and advice, in a range of places I go to" "I understand my rights as a carer" "As a young carer, I am identified by my GP, local pharmacy and at the hospital"

Topic	Work programmes	Milestones	Indicators of Success
1.1 Information and Advice **Provide and promote engaging, helpful information and advice, using different media, across a range of channels** **Develop the Digital Offer to Carers including self-serve**	**Connect to Support** **LCC Digital Roadmap** **Children's Local Offer** **Carers FIRST** **Carers Engagement and Communications Group**	❖ Digital Resource for Carers launched ❖ Carers Online Forum launched ❖ Annual review of Carer Information and Advice ❖ Pilot Howz with LCC staff carers	❖ Digital information is well received and used ❖ ASCOF 3D2
1.2 Early Identification of Carers, including Young Carers **Build on success of Carer Quality Award to ensure countywide early identification of carers of all ages by Primary Care, Community, Specialist and Acute Health Care, Social Care, Pharmacies, Schools,**	**Carer Quality Award / Carer Awareness** **Carer Friendly Healthy Living Pharmacies** **Young Carers in Schools** **Early Help**	❖ Health services and employers accredited with Carers Quality Award ❖ MECC trained agencies ❖ Schools with Bronze, Silver and Gold Awards	❖ Health referrals to Young Carers and Carers Services ❖ Identification of Young Carers by Adult Care ❖ Take up of Young Carer Card ❖ Take up of Flu vaccination by Carers

Home Schooling, Further and Higher Education, Employers and Housing. **Continual programme of engagement with partners, carers and the public to raise awareness.** **Awareness raising campaigns to help carers self -identify**	**Make Every Contact Count** **Public Health targeted campaigns** **Carers Communications and Engagement Plan**	❖ Young Carer's Day ❖ Multi-agency Carers' Week ❖ Carers Rights Day ❖ Carers included in targeting of mainstream campaigns	❖ Numbers of carers supported
1.3 Social Prescribing **Ensure carers benefit from Social Prescribing to be connected to self-care, community and local services.**	**NHSE Personalisation Programme**	❖ Clear referral pathways established ❖ Shared Workforce Development offer	❖ Number of carers identified and supported by social prescribers ❖ Good practice case studies NHSE measures
1.4 Employment for Carers **Support carers of working age to access and balance caring and employment.** **Support employers (SME's, Health and public sector) to retain staff in a caring role through Employers for Carers.**	**Umbrella Membership of Employers for Carers (EfC)** **Employee Health and Wellbeing Strategy** **Employers for Carers in the community** **Employment Support for Carers** **Greater Lincolnshire Move project** **Adult Care Workforce and Carers project**	❖ LCC signed up to EfC ❖ Business Infrastructure agencies champion EfC ❖ Staff Carer Networks established	❖ Number of organisations signed up to EfC ❖ Carers, including young adult carers, supported with employment goals

Aim 2: Collaboration

Work together with partners to improve outcomes for carers and their families

Key areas of focus	• **Take a 'System Led' approach to pro-actively identify and support carers** • **Joined up multi-agency working to make sure that support makes sense for families** • **Work with partners to encourage inclusive, accessible, Carer Friendly Communities**
Is it working? **As a result , we want carers of all ages to be able to say:**	"I feel valued and respected as an equal partner in care" "I feel included and involved in decisions about the care of the person I look after" " I am seen as a person with my own health and wellbeing needs by professionals"

Action	Work programme	Milestones	Indicators of Success
2.1 System Led Support for Carers **Lincolnshire takes a 'System Led' approach to identify and support carers' health and wellbeing needs.** **Health, Social Care and Housing providers and commissioners pledge to recognise, value, identify and support carers of all ages, including in their own workforce.** **Build on the success of the Carer Quality Award, Employers for Carers and Carer Friendly Healthy Living Pharmacy initiatives.**	**Joint Health and Wellbeing Strategy: Carers Priority** **Integrated Care** **NHSE Personalisation** **NHSE GP Quality Markers scheme** **Employers for Carers** **Neighbourhood Teams** **Carer Quality Award** **Healthy Living Pharmacies** **Housing for Independence**	❖ 'Commitment to Carers' Memorandum of Understanding is ratified by Joint Health and Wellbeing Board. ❖ Health, Housing and Community Sector partners pledge their support for carers by sign up to the MOU, Carer Quality Award and Employers for Carers ❖ 'Commitment to Carers' is evident in strategic plans of System partners. ❖ GP practices accredited with CQA and NHSE GP Quality Markers.	❖ Increased number of carers, including Young Carers, on Primary Care Carers Register ❖ Increasing number of referrals from Health, including for Young Carers ❖ Positive GP Patient Carer Surveys and CQC inspections ❖ Carers' needs are identified and supported within Universal Personalised Care ❖ Increased take up of flu vaccination. ❖ Carers needs, including young carers, are considered in Housing.

		❖ Network of Carer Friendly Healthy Living Pharmacies with trained health champions and information for carers.	
2.2 Joined Up, Whole Family Approaches **Work with Social Care, Health and Community sector partners to make sure support for families is joined up and effective.** **Participate in national ADASS Carers Sector Led Improvement Programme, with an East Midlands focus on Whole Family Approaches.**	**ADASS Carers SLI Programme** **Neighbourhood Teams** **NHSE Personalisation Programme**	❖ ADASS Multi-agency self-assessment ❖ Deep dive into Whole Family Approaches ❖ Development of tools and resources ❖ Carers included within NHSE Personalisation programme. ❖ Carer Personal Health Budgets ❖ Regional event	❖ More efficient and effective joined up support that makes sense to the whole family. (ASCOF 3C, 3B and 1D) ❖ Improved identification and support for young carers ❖ Carers able to maintain or return to employment. ❖ Improved team networks and relationships ❖ Good practice case studies
2.3 Carer Friendly Communities **Work with a wide range of partners to improve understanding, opportunities, networks and access to services for carers of all ages**	**Physical Activity** **Place Based Public Health**	❖ Referral pathways to services ❖ Community assets mapped and maximised to meet carer needs	❖ A wide range of partners support carers on a local basis ❖ Strong local networks

Aim 3: Assurance

Offer high quality services and check they make a difference to carers

Key areas of focus	• **Meet Care Act (2014) and Children and Families Act (2014) responsibilities.** • **Meet carers' needs effectively and efficiently** • **Listen to and work with carers to improve the offer** • **Continual improvement** • **Measure what matters**
Is it working? **As a result , we want carers of all ages to be able to say:**	"My own health and wellbeing needs have been considered and met" "I am satisfied with the support I have received " "I am able to balance working with caring " "I am listened to and can get involved with improving services" "As a young adult carer, I know I can get the help I need from either the Young Carers Service and Carers FIRST" "Being a young carer hasn't stopped me from making progress in my education and training for a career" "I feel in control of my caring role and can make choices" "I have an emergency response plan in place and keep it updated"

Action	Work programme	Milestones	Indicators of success
3.1 The Carer's Offer **Provide a high quality, statutory Carers Support Service that offers an effective and efficient range of practical and emotional support that helps put carers in control of their caring role.** **Provide a range of support that is preventative and universal, that is personalised and targeted, and able to respond in a crisis.**	**The Lincolnshire Carers Service: Carers FIRST, CSC Serco** **Early Help: Young Carers** **Contract management** **Commissioning**	❖ Positive annual service review ❖ Positive take up of service offer ❖ Evidence of service innovation and adapting to need ❖ Evidence of carer contingency plans	❖ Numbers of carers supported ❖ SALT data ❖ Carer satisfaction ❖ Carer outcomes ❖ Support is timely ❖ Support is kept under review (Council Business Plan Measure 121)

Support Young Carers through the Early Help Offer and the Children's Society Young Carers in Schools Programme. **Ensure effective transition of young carers to adult service.** **Take an evidence based approach to inform innovation and develop the offer, addressing unmet need, in co-production with carers and staff.**			❖ Prevent NEET in young adult carers ❖ Take up of Young Carer card ASCOF 1D and 112
3.2 Ensure a high quality service that meets carer needs **Implement effective and efficient internal and external programme of Quality Assurance.** **Assure delegated statutory duties, quality of practice and impact where customer experience and carer journey is central.** **Benchmark and evaluate the Lincolnshire Carer's Offer in order to inform re-commissioning of a new Carers Service in 2021.** **Continually improve understanding of the diversity of carers' needs, service trends and population to shape effective preventative support.**	**Contract Management** **LCC Quality Assurance** **Practice Development** **Corporate Audit** **Provider Quality Assurance** **Continuous Improvement Group** **Joint Strategic Needs Assessment**	❖ Implement Provider Quality Assurance ❖ Evidence of application of learning to continual improvement. ❖ Annual Service Review ❖ Young Carers Service Review ❖ Review of Carers Emergency Response Service ❖ Annual update of Carers JSNA ❖ New service design informed by lessons learned from evaluation.	❖ Carers needs are met ❖ Carers are satisfied ❖ Positive outcomes for carers reported ❖ Council Business Plan Measure 121 ❖ Positive service performance reported ❖ ASCOF 1D
3.3 Carer Voice **Work with carers to continually improve service delivery, multi-agency co-operation and understand unmet need.** **Offer carers opportunities to inform, review and shape service design.**	**Carer Engagement** **Staff Carer Networks** **Co-production**	❖ Carer Forum established ❖ Engagement activities ❖ Range of co-production opportunities including carer led activities	❖ Customer feedback loop ❖ Evidence of service improvement as a result of customer feedback, engagement and co-production

Aim 4: Workforce Development

Ensure we have an appropriately skilled workforce within the Carers Service, Social Care and other agencies to effectively identify and support carers

Key area of focus	• **Enable all partners supporting carers to retain a skilled and qualified workforce, confident in taking a whole family approaches and application of the Care Act (2014)**		
Is it working? **As a result , we want carers of all ages to be able to say:**	**"I feel listened to and that my needs are understood"** **"I feel supported"** **"I feel satisfied with my support"**		
Action	**Work programme**	**Milestone**	**Indicators of success**
4.1 Carers' Service **Deliver Carers' Service Workforce Development to ensure high quality service delivery that responds to changing needs and contexts (statutory/ digital and technological/ policy/ financial etc.)**	**Carers Workforce Development** **Lead and Principle Practitioners** **Workforce Development of partners: Adult Care, Public Health, Personalisation and Integrated Care etc.**	❖ Annual provider workforce development plan informed by assurance activities, changes in policy and technology. ❖ Evidence of attendance ❖ Evidence of supervised reflective practice ❖ Evidence of a multi-agency joint shared approach to workforce development for the Carers Service (offered and received) ❖ Audit	❖ Satisfactory service review and audit ❖ Satisfactory quality assurance ❖ Evidence of continual service improvement ❖ Evidence of responsiveness to changes in policy, good practice and technology. ❖ Evidence of innovation ❖ Evidence of strengthened professional networks and relationships
4.2 Social Care	**Workforce Development (Adult Care)**	❖ Adult Care practitioners trained	❖ Evidence of 'Think Carer' and whole family

Workforce development offer to adult social care practitioners. **Develop joint approach to contingency planning.** **Work with Safeguarding to keep carers safe and to strengthen preventative approach to safeguarding and risk management.**	**Lead and Principle Practitioners** **Safeguarding** **ADASS Carers Sector Led Improvement Programme** **Carer Quality Award**	❖ Adult Care Practice Manual updated ❖ Occupational Therapists trained ❖ Lead Practitioner for Carers ❖ Adult Care Carer Champions ❖ 'Think Carer' event at annual Joint Social Care conference ❖ Joint work with Safeguarding ❖ Contingency plans in place	approaches with combined assessments and joint support plans ❖ Young Carers identified ❖ Customer (ASCOF) and staff satisfaction ❖ Adult Care achieves Carers Quality Award ❖ Carer contingency plans ❖ Strengthened professional networks and relationships
4.3 Communities of Practice **Develop and support a network of Carer Champions and 'communities of practice' within the Carers Service, Social Care and Integrated multi-agency Health, Care and other settings**	**Workforce Development** **Quality Assurance** **Lead and Principle Practitioners**	❖ Establish Practice Development Group for Carers Service workers. ❖ Regular meetings ❖ Informed by case work, QA, carer feedback and national policy/ research/ good practice.	❖ Valued by staff ❖ Standards maintained and raised. ❖ Informs workforce development priorities.
4.4 Carer Learning **Develop a clear and easy to access Carer Learning offer with partners**	**Carer Learning** **Recovery College** **Digital Roadmap**	❖ Digital Carer Learning ❖ Carer Learning offer at Recovery College ❖ Moving and Handling ❖ Easy signposting online to partners' offer	❖ Good take up of courses ❖ Courses well received
4.5 Mosaic **Improve joint multi-agency working through developing Mosaic workflow.**	**Mosaic**	❖ Align Carers workflow ❖ Multi-agency staff trained	❖ Increased efficiency ❖ Increased visibility of joint work ❖ Effective internal referrals ❖ Staff satisfaction ❖ Improved reporting

Appendix 1: Glossary and Acronyms

ADASS – Association of Directors of Social Services
ASCOF - Adult Social Care Outcomes Framework
iBCF – integrated Better Care Fund
CQC – Care Quality Commission
CPD – Continuing Professional Development
DHSC – Department of Health and Social Care
EfC – Employers for Carers
ICS – Integrated Care System
JSNA – Joint Strategic Needs Assessment
LCC – Lincolnshire County Council
LCHS – Lincolnshire Community Health Services
LPFT – Lincolnshire Partnership Foundation (Mental Health) Trust
QA - Quality Assurance
QAF – Quality Assurance Framework
SACE – Survey of Adult Carers in England – biannual survey carried out by Department of Health and Social Care
SLI – Sector Led Improvement
UPC – Universal Personalised Care

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of East Lindsey District Council

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**4 February 2020**
Subject:	**Better Ageing in Rural Areas: Learning from East Lindsey**

Summary:
The increasing ageing population means that by 2037, a quarter of the total UK population will be over 65. Lincolnshire, and in particular East Lindsey will continue to have a higher than national average number of older residents. Projected numbers state that by 2041 30% of the population of Lincolnshire will be over 65; while in East Lindsey 40% of people will be over 65. This has implications for future service delivery and the local economy. Rurality makes the challenge to support Lincolnshire residents to maintain independence even greater (4th largest county in England and Wales, where 95% is rural and 52% of the 65+ population live in rural areas).

Working with people in and approaching later life, it is possible to achieve positive health and wellbeing outcomes. This report presents an overview of two established programmes of work in East Lindsey where there is a particular focus and emphasis on supporting and enabling Better Ageing across rural and coastal communities:

- TED in East Lindsey
- Age Friendly East Lindsey

This report also provides the Lincolnshire Health and Wellbeing Board with information about the work of the Centre for Ageing Better (CfAB) and Lincolnshire's engagement with an opportunity to work as a strategic partner of the CfAB in a Rural Locality Partnership arrangement.

Actions Required:

The Lincolnshire Health & Wellbeing Board is asked to:

- Note the outcomes to date from the work that is underway in East Lindsey to support and enable Better Ageing
- Consider opportunities to extend learning across Lincolnshire
- Support continued dialogue with the Centre for Ageing Better (CfAB) to develop a positive working relationship and benefit from their expertise.

1. Background

1.1 Context

The increasing ageing population means that by 2037, a quarter of the total UK population will be over 65. Lincolnshire, and in particular East Lindsey will continue to have a higher than national average number of older residents. Projected numbers state that by 2041 30% of the population of Lincolnshire will be over 65; while in East Lindsey 40% of people will be over 65. (Office for National Statistics 2017) This has huge implications for future service delivery and the local economy.

The way in which we can best support an ageing population is of local and national interest. It creates a challenge regarding demand on public services but also an opportunity to embrace and support an ageing population to maintain health, wellbeing and independence and to maximise economic activity.

Nationally, it is estimated that 1.2 million people aged over 50 are severely socially excluded, having little or no engagement with their communities or with society in general; for Lincolnshire this equates to over 15,000 people. Additionally, it is reported that 48% of adult social care users don't receive as much social contact as they would like (Public Health England), and being lonely and cut off from family and friends is known to increase the risk of frailty by 85% (Gale, Westbury, et al., 2017).

Rurality makes the challenge to support Lincolnshire residents to maintain independence even greater (4th largest county in England and Wales; 95% is rural and 52% of the 65+ population live in rural areas).

In Lincolnshire:

- 4th largest county in England and Wales where 95% is rural. Rural areas are generally sparsely populated
- 48% households in rural areas compared to 18% nationally
- 10% of residents are aged 75+ compared to 7.8% nationally
- 52% of older people (aged 65+) live in rural areas
- 14% of population live in top 20% deprived LSOAs; 12% experience fuel poverty
- +75 population is expected to increase by 88% between 2016 and 2041
- Rural challenges: sparsity, limited road networks, poor transport infrastructure & digital access, social isolation, higher cost of delivering services
- Coastal challenges: deprivation, health inequalities, low paid seasonal work and related low pensions
- Track record of innovation through collaboration
- Local Enterprise Partnership, Local Industrial Strategy: priority to support people to live well for longer in rural areas
- Tourism offer varied – coastal, heritage, AONB – high % coastal visitors are older persons
- Cultural and inward migration of older people; pressure on community integration
- JSNA Overview of Health and Wellbeing in Lincolnshire 2019

In East Lindsey:

Older people make up a significant proportion of the East Lindsey population and are an important part of our economy. Some 26% East Lindsey residents are over 65. Population projections show a projected year on year increase indicating continued relevance of a focus on ensuring services and policies meet the needs of an ageing population. Additionally, it has been identified that the highest proportion of visitors to East Lindsey are 55 – 64 years of age.

Part of the national 'Ageing Better' Programme, TED has been delivered in East Lindsey since 2015 and has been successful in achieving its objectives (primarily in reducing isolation and loneliness within an ageing population), developing and delivering innovative programmes of work and contributing effectively to the national programme.

East Lindsey District Council (ELDC) has taken a proactive approach to supporting and enabling Better Ageing and has become the first District Council in the country to join the UK Network of Age Friendly communities; marking part of a longer term commitment to become part of the global network of 'Age Friendly Communities' as recognised by the World Health Organisation (WHO). The Age Friendly concept is built on the evidence of what supports healthy and active ageing in a place, allowing more people to live independent lives and contribute to their communities for longer. In addition, by committing to be age friendly there is greater scope for multi-agency and multi-level collaboration and integration to make best use of resources, and an enhanced preventative approach and focus on wellbeing; thereby reducing crisis demand on services.

It has been recognised that the strategic and operational partnerships (and associated work / activity) that ELDC is part of, plus the delivery of TED and its outcomes means that East Lindsey is already on its 'Age Friendly' journey. This is considered important to best meet the needs of East Lindsey's population in future years and to ensure this work is firmly embedded and recognised as part of its contribution to the wider strategic landscape for Lincolnshire. Using the same test and learn approach that has been integral to the TED programme, this could provide a blueprint for other areas to take their own steps to become Age Friendly.

1.2 TED in East Lindsey

TED is delivered as part of a £78 million National Lottery funded 'Ageing Better Programme' (2015 – 2021). The TED programme in East Lindsey is one of 14 Ageing Better partnerships across England.

Delivered in East Lindsey since 2015, TED has been successful in achieving its objectives (primarily in reducing isolation and loneliness within an ageing population), developing and delivering innovative programmes of work and contributing effectively to the national programme. TED is a partnership of older people and voluntary and public sector organisations, led by Community Lincs (now part of Lincolnshire YMCA), working closely with partners and communities in East Lindsey to reduce social isolation and loneliness that many older people in the district experience.

Ageing Better is one of five major programmes set up by The National Lottery Community Fund to 'test and learn' from new approaches to designing services which aim to make people's lives healthier and happier. Taking a test and learn approach, whilst sharing and benefiting from learning across the wider partnership; TED has gained increasing momentum and impact over the course of its delivery.

Programme Outcomes:

Older people will be better connected with volunteering, social, leisure and health improving activities leading to an enhanced quality of life
More older people in East Lindsey will report that they do not feel lonely or isolated
More older people in East Lindsey will feel positive about the opportunities that getting older presents
Older people In East Lindsey will have more opportunities to influence the design and delivery and evaluation of services and businesses available to them

The TED programme consists of a number of different strands of activity:

Friendship Groups & Activities https://tedineastlindsey.co.uk/friendship-groups/	Designed to bring people together in a social setting. TED has seen the benefit of this in enabling friendships to develop and the ability to share ideas and community resilience. The aim of the groups are to welcome and encourage anyone over the age of 50 to get involved with their local community, meet new people, and take part in social activities. Friendship groups are volunteer led with support provided by the TED Friendship Officer. Volunteers are encouraged to plan activities, outings and engage other members of the group to ensure the groups success and longevity. A Friendship Group Toolkit is in development.
Age Friendly Business Accreditation https://tedineastlindsey.co.uk/age-friendly-business/	The Age Friendly Business Accreditation is regarded as a best practice aspect of the TED programme. It is an award scheme that recognises local businesses who have a positive approach to ageing. Using a business development model and in accordance with specific criteria (assessments and mystery shopping are carried out by trained volunteer assessors); successful businesses receive an accreditation certificate and a sticker to place in their window to show that they have achieved the quality award. To date, over 100 businesses have become recognised as Age Friendly in East Lindsey including; Wilkinson's, Lincolnshire Co-op, Greggs, Sports Direct, Hildreds Shopping Centre, Hunts Coaches, Barclays, Nationwide, Solicitors, Estate Agents and Cafes) with continued demand and a current list of business awaiting assessment. An Age Friendly Business Toolkit is in development.
TED Network	Providing support for local groups to enable them to apply for funding
Research, Learning and Evaluation	Research undertaken by TED contributes (via the Big Lottery) to one of the largest studies of social isolation in older people in the UK. TED is taking a test and learn approach, which provides flexibility to deliver in a range of styles. Through this we can share ideas that have been successful and areas that the project has learnt from. Ageing Better Projects are being evaluated locally and nationally with the national evaluation being led by Ecorys who were selected by The National Lottery Community Fund as an impartial organisation. Ecorys are analysing the interventions and the difference the programme makes for participants and examine the delivery models that are effective and the sustainability for wider programme delivery. TED also ensures a more local analytical focus; looking at the needs of each East Lindsey locality and seeking to inform and influence provision of local services, integration of local services and informing TED commissioning. A number of academic TED learning reports have been published. In 2019, TED commissioned a strategic evaluation partner to identify key learning themes from TED's delivery to date with a focus on ensuring sustainability and legacy of the work and to inform planning of future services with a focus on loneliness and isolation amongst older people. The contract was awarded to Rose Regeneration in partnership with Lincoln

	International Business School. Initial findings will be presented at a learning conference during 2020. Local evaluation was also externally commissioned during 2019 and this contract awarded to HART Research, part of the University of Lincoln. This learning partner has been responsible to the learning reports published to date and these will continue to be produced regularly throughout the course of programme delivery
Commissioned Services	Local research and evidence base informs TED commissioning priorities. TED commissions a range of services in line with the following evidence based themes: • Men's Activities • Befriending • Digital Access and Support • Health & Wellbeing • Advocacy & Advice Projects run to January 2021 and are delivered by partners including Citizens Advice Lindsey, Carers First, Magna Vitae, Age UK Lindsey and Lincs Digital.

Data collected through the national Ageing Better Programme has revealed that:

- 50% of people over the age of 75 live alone, with many reporting that television is their main form of company
- 17% of older people stated that they go for a week without speaking to a friend, family member or neighbour
- 11% reported that they can go for more than a month at a time without any form of social interaction
- 1.8 million people (Ageing Better Knowledge and Learning Briefing) aged over 75 say that their feelings of loneliness are out of control, with one in four worrying about how often they feel lonely
- Loneliness has been linked to an increase in risk of death by 29%
- Ageing Better and TED have also begun to identify links between those who experience loneliness and isolation and an increase in ill health, an increased risk of mortality, higher rates of emergency admissions, re-admittance to hospital and earlier entry into care homes. Loneliness and isolation are also linked to depression and poor cardiovascular health.
- All of these put greater pressures on local services and health provision as well as having a detrimental effect on the local economy

Analysis from the Ageing Better Programme indicates that interventions which are aimed at reducing social isolation and loneliness have the potential to have significant impact.

Locally, TED participants report that they are now much more actively involved in their communities with:

- 76% of individuals having more social contact following participation in TED activities and;
- 75% increasing their participation in social activities as a result of TED.

Ageing Better is also indicating early, positive effects on health and mental wellbeing with participants' wellbeing score rising from 20.9 at entry to 23.8 recorded on the Short Warwick-Edinburgh Mental-Wellbeing Scale by TED participants at follow up.

Ageing Better participants also rate their own health on a scale of 0 to 100, and average scores have improved for TED participants from 60.6 at entry to 69.37 at follow up.

A statistically significant number of TED participants have also reported feeling less socially isolated and lonely after taking part in TED. This is based on a survey they complete to measure their loneliness and other outcomes before and after taking part in TED activities (based on UCLA17 and De Jong Gierveld scales (DJG) 18)

TED has created a number of new volunteering opportunities, and has worked with over 500 volunteers over the last 18 months. Between them these volunteers have contributed over 8000 hours of their time, equating to a financial value in excess of £60000. These volunteers have reported a range of benefits to their own health and wellbeing as well as the development of new skills, and a greater appreciation of social isolation and loneliness in their communities.

TED Delivery Statistics

- 10,372 people supported through TED
- 2,802 people have attended 600 TED events
- 2,195 people have attended TED Lunch Clubs
- 33 new community based groups have been created and a further 104 community based groups have received support
- 1,094 volunteers have been recruited and trained and have contributed 11,858 volunteer hours (with a financial equivalence of £92,748)
- 296 people have received Befriending services/support
- 391 older men have been engaged in social activities
- 428 have accessed physical activity and nutritional advice sessions
- 1,241 people have attended 102 training sessions including Digital Skills
- 243 people have received 1:1 support including specialist advice and advocacy services
- 100+ Age-friendly Businesses
- 7 Friendship Groups established in local communities

TED Learning Reports

Working closely with the University of Lincoln, a number of learning reports have been developed and have been published to date. These include:

Learning Report	Key Finding(s)
The role of housing in reducing social isolation and loneliness in East Lindsey	• TED activities delivered through sheltered housing schemes have been successful in reaching and engaging older adults who are lonely, vulnerable and or socially isolated • Social housing settings provide clean, accessible facilities for the development of community hubs, incorporating opportunities for multi-agency support and intergenerational activities • TED service users and volunteers reported feeling safe attending sessions in familiar, age friendly purpose built housing venues located in close proximity to their homes
Increased inclusivity and reaching and engaging people who are LGBTQ+	• Older LGBTQ+ people are at particular risk of social exclusion and or loneliness and it is therefore important for TED staff, delivery partners and volunteers to feel confident working with LGBTQ+ individuals and communities • There is greater need for agencies to form connections with local LGBTQ+ community groups, including promoting and advertising current services/offers. • TED data indicates that current interventions only reach and engage a

	small number of LGBTQ+ people who are aged 50 and over and who live in rural East Lindsey • Obtaining accurate data about gender and sexuality is difficult due to the stigma which still exists around sexual orientation and gender identity • There is a lack of support services for older LGBTQ+ people in East Lindsey
Engaging lonely/socially isolated older people	• Identifying and removing barriers enables people to get involved. Barriers have been identified in relation to engaging older people include: transport, lack of confidence when first attending group sessions, and the practicalities of attending TED sessions whilst managing caring responsibilities. Awareness of these barriers is essential, particularly in planning events and activities. • Using the right language is key to getting people involved - people may not see themselves as 'old', 'isolated' or 'lonely' • Intergenerational approaches can be a positive way to engage participants who chose not to become involved in activities that are defined as being for 'older people' • It takes time and a variety of approaches to build the relationship, confidence and trust to create the connections required to reach the most isolated • Involvement in volunteering or social action can play an important role in tackling loneliness and isolation • Social infrastructure is not naturally occurring and therefore requires direct investment and support
Age-Friendly and Accessibility	• Place' encounters can heighten the sense of bodily vulnerability that many older adults experience. Therefore, Age-friendly facilities are important to participants. • Activities should be local. This is particularly important for those who have mobility and health needs. • Asset based community development plays is an essential element of any work to address social isolation – successful interventions include building on what is already there
Engaging Businesses	• Local businesses offer places and opportunities to meet, as well as essential services to older people who may not be able to travel. • Businesses have the opportunity to facilitate (social) connections within a community • Simple improvements such as making some basic accessibility alterations and providing clearer signage can have a huge impact for older customers. • Businesses often have assets that they can offer to the wider community, which can benefit older people and boost their company's profile. In East Lindsey this has resulted in two Age Friendly Businesses hosting regular Friendship Groups
Supporting and engaging older men in East Lindsey	• More women are involved with the TED programme with 59% of people identifying as female and 39% male • Older men gravitate towards specific activities, learning a new or utilising an old skill, rather than socialising or chatting and will connect with each other over time and through the shared experience of that activity • Older men are more engaged when there is no pressure to do all of a set activity; allowing instead participate at their own pace, including the option of sitting and watching others • Older men are more likely to attend events/sessions which require with no minimum commitment each week. Drop in sessions have been particularly successful

	• Older men often have preconceived ideas about local venues, for example as being 'for women' or 'for old people'. These perceptions may make them less likely to engage with activities taking place in these venues • Older men may take a longer time to 'open up' within a new group. For activities that only last a few weeks, with a set end date, it can mean that the activity finishes just at the point when the individual is feeling comfortable
Supporting male carers in East Lindsey	• In East Lindsey there are approximately 1,232 registered carers aged 50+yrs, of whom 444 (36%) are male • Social isolation is a significant challenge for male carers with many being unable to maintain relationships with friends and family due to their caring responsibilities • Male, older carers can become consumed with their caring role and many prioritise the needs of the cared for; putting their own interests to one side. The consequences of this are that the physical and mental health of a male carer can deteriorate • Wellbeing groups aimed at male carers are successful in providing support and opportunities to connect with other carers experiencing similar situations reducing their feelings of loneliness • Older carers can be hard to reach. Many don't self-identify as carers and consider their role to be just a part of being a "father", "mother", "brother" or "sister" • Older generations are less likely to access services because of pride, they don't expect any help, reluctance to accept support due to its perception it's a sense of failure and weakness and/or they are fearful the cared for maybe taken from them • 1-2-1 support, groups and activities support male, older carers gain confidence, self-esteem skills and knowledge to make informed, positive future life choices and improve their access to opportunities including re-engagement provision for those who aren't ready, feel embarrassed or lack confidence to access mainstream provision
The role of Friendship Groups in tackling isolation and loneliness	• TED Friendship Groups, especially in rural areas, are a vital source of support • TED Friendship Groups provide a safe space for older people to meet others and socialise • Through taking an asset based community development approach, Friendship Groups can be self-sustaining • TED Friendship Groups have experienced particular success where they have collaborated with local businesses that have regular contact with vulnerable people in the community • The quality and quantity of relationships matter, but you can't manufacture friendship traditional befriending approaches don't work for everyone, however Friendship Groups can offer an alternative, group based befriending offer

<u>TED Commissioning</u>

- 14 commissioned partners (outside of core delivery) with 5 of those still running services until Jan 2021
- 25 commissioned projects (outside of core delivery) with 7 still running until Jan 2021
- £666,863 – value of commissioning in East Lindsey (of direct service delivery to older people) to other (third sector) organisations

- TED funding and commissioning activity has also created a number of employment opportunities in Lincolnshire, equating to approx. 20 FTE roles

Feedback from Big Lottery *"I have been particularly impressed over the last 18 months by the strategic vision and partnership approach taken by the TED Ageing Better programme locally in developing the conditions for real systems change. An example of this is the joint approach now being taken by TED Ageing Better and East Lindsey District Council around their joint plans for the creation of an Age Friendly Community. This is just one of a series of initiatives taking place locally with a range of partners which has real potential impact"*

1.3 Age Friendly East Lindsey

Working closely with Community Lincs (Lincolnshire YMCA) and having recently become the first District Council in the country to join the UK network of Age Friendly communities; ELDC has demonstrated its commitment to support people to live healthier, more active lives as part of its commitment to Better Ageing. ELDC has also developed its portfolio structure, introducing in 2019 a portfolio committed to supporting Better Ageing

<u>Age Friendly Communities</u>

Across the world, people are living much longer. However for many people these extra years are not necessarily healthy or happy. There are multiple factors that contribute to how people experience their older years. There are also many ways in which communities can improve the experience of people as they age. The World Health Organisation (WHO) developed a framework for areas to assess their "Age-Friendliness" after identifying the elements in a community that "support active and healthy ageing" (2006). Originally focused on urban/ city environments, in recent years the focus has expanded to include other types of community.

The 'age friendly' concept is built on evidence of what supports healthy and active ageing in a place, allowing more people to live independent lives and contribute to their communities for longer. Age Friendly communities are able to demonstrate that they:

- Are places that foster healthy and active ageing
- Enable people to stay in places on their choosing as they age and continue to play a active role in their communities for as long as possible
- Minimise barriers to participation as abilities decline

Becoming an Age Friendly area is not about achieving a standard, but is about taking the decision to make improvements at a pace appropriate to the specific area. It is a long term commitment to make improvements in line with the 'Eight Domains of Age Friendly', following an ongoing cycle of Engagement, Planning, Delivery and Evaluation. It also involves regular sharing of good practice with the WHO network of Age Friendly Cities & Communities. The 'eight domains' of the framework are:

• Outdoor Spaces & Buildings • Transportation • Housing • Social Participation • Respect & Social Isolation • Civic Participation & Employment • Communication & Information • Community Support & Health Services	

The Age Friendly Community process is set out below:

Local Authority application to join the UK Network of Age Friendly Communities
Carry out baseline assessment against 8 specified 'domains'
Build evidence base and develop an action plan (partnership / collaborative approach)
Local Authority (Executive) application to World Health Organisation (WHO) to join international network of Age Friendly Communities *"Written commitment to actively work towards becoming a great place to grow old in, for all of its residents. This is done with the support and engagement of older people and relevant stakeholders"*
Continue to develop and deliver at a local level, whilst benefiting from national and international network and best practice – continuous improvement

To apply for Age Friendly Status, an area must provide evidence of leadership and political commitment to work towards becoming a great place for older people to live. There needs to be a willingness among senior managers to work towards a community that fosters healthy and active ageing.

The Centre for Ageing Better (CfAB) is an official UK affiliate of the WHO and offer guidance and support to those communities who want to commit to and achieve Age Friendly Status in the UK. They also manage the UK Network of Age Friendly Communities. Following a successful application, East Lindsey became a member of the UK Network in September 2019. https://www.ageing-better.org.uk/

Jointly funded by ELDC and Community Lincs, an Age-Friendly Principal Officer (Jane Berni) was appointed in 2019. The Councils Executive Board has also been expanded to incorporate a Better Ageing portfolio. Cllr William Gray has been appointed as Portfolio Holder for Better Ageing.

The Age Friendly Principal Officer is currently working with colleagues across the Statutory and Voluntary sectors to create a Baseline Profile in line with the requirements of the WHO. The assessment is centred on eight domains of age friendly which provide a framework for understanding needs and preferences as well as barriers, local priorities and opportunities for healthy, active ageing.
"The eight domains of age-friendly are all the aspects of community life that need to be considered when making your plans. All eight domains interlink but can be broken into two spheres covering the social and the built environment" (Centre for Ageing Better)

The profile in the form of a Baseline Survey document will be published in June 2020. At this time an application will be made to the WHO for 'Age Friendly Status' as part of the global network of age friendly communities. The process of creating an 'Age Friendly Strategy' with partner agencies will also begin, aligned closely with a local health and wellbeing strategy. It is expected that the Strategy will be launched in February 2021.

The process of becoming Age Friendly begins with a self-assessment; completed using a collaborative approach at both an operational and strategic level and taking account of services, local communities, policies etc.

1.4 National Centre for Ageing Better and Rural Locality Partnership Opportunity

The Centre for Ageing Better (CfAB) is a national charity, funded by an endowment from The National Lottery Community Fund as part of the 'What Works Network' of organisations (https://www.gov.uk/guidance/what-works-network). The Network is one part of a wider What Works initiative, launched by the Cabinet Office and HM Treasury in 2013, to improve outcomes and productivity across the public sector through the better use of evidence. The CfAB has a national lead through this network on 'improving lives of older people'.

Coordinated by the What Works Team in the Cabinet Office; the network seeks to provide the best evidence of 'what works' to the people who make decisions about public services. The work of the network supports more effective and efficient services across the public sector at national and local levels. It aims to improve the way government and other public sector organisations create, share and use (or 'generate, translate and adopt') high quality evidence in decision-making and in providing independent, evidence based and practical advice.

Using an evidence based approach, the Centre for Ageing Better (CfAB) works collaboratively to bring about lasting changes in society that make a difference to people's experience of later life, now and in the future. In practice, this means taking an evidence based approach to finding ways to ensure more people in fulfilling work, in good health, living in safe, accessible homes and connected communities. Working to support people approaching later life, it is possible to achieve positive health and wellbeing outcomes.

CfAB Vision: "a society where everybody enjoys a good later life"

- By 2040, we want more people in later life to be in good health, financially secure, to have social connections and feel their lives are meaningful and purposeful
- To achieve real and significant impact, we will focus on where we can make the biggest difference – those approaching later life, a life stage between mid-life and later life

CfAB Priority Goals [evidence based priorities] for people approaching later life to:

- Live healthier, more active lives, reducing the risk of poor health, delaying onset, progression and impact of disease and disability
- Be in good quality work for longer, boosting savings and delaying drawing pensions
- Live in safe, accessible and adaptable homes, remaining independent and active for longer

- Live in communities where social relationships flourish, making it easier to build and maintain close connections as well as wider everyday contact

See Appendix A for further information.

The CfAB 2018 strategy, 'Transforming Later Lives' has a specific focus on helping people who are currently approaching later life and particularly those who are at risk of missing out on a good later life. It can be accessed here

1.5 Rural Locality Partnership Opportunity

In 2019, the CfAB released an opportunity for a rural area to become its Rural Strategic Partner (alongside Greater Manchester and Leeds with whom the CfAB has had longstanding and effective 'Urban' Strategic Partnerships). It is envisaged that through a strategic rural partnership, it will enable the CfAB to better understand, and find way to address the issues faced by older residents living in **rural and coastal** areas. The CfAB note that *"…we need to know 'what works' in the different types of places we live in. We need to build a deeper understanding of how rural places overcome challenges as well as maximise the opportunities of our longer lives; across all our priorities on homes, communities, work and health*".

The CfAB is now looking to expand its reach and to apply its 'what works' approach to a rural area. The CfAB is particularly interested in area that is both coastal and rural.

Through a strategic partnership approach, the CfAB works with local authorities to:

- *Adopt a joined up,* ***strategic approach to ageing*** *(cross-department, multi-level)*
- ***Apply what works*** *across our priority goals, and learn from local implementation about how to scale and spread*
- *Where we don't know what works,* ***test and innovate****; generating and sharing learning locally, regionally and nationally*
- *Extend* ***reach and impact***

Some of the ways the CfAB work with strategic locality partners includes:

- *Generating and sharing evidence of 'what works' and providing support to translate this to evidence*
- *Sharing local good or innovative practice with regional or national networks, including central government*
- *Facilitating connections with third parties that are of mutual benefit*
- *Providing strategic advice and acting as a critical friend on ageing issues*
- *Resources including (non-delivery) funding, expertise, facilitation or convening meetings / events [examples of how we can support our partners with direct resources includes posts to coordinate the partnership activity, supporting pilots and evaluations]*
- *Capacity to deliver on joint goals, e.g. through appointing a partnership manager hosted in the partner authority*

With the support and engagement of a wide range of partners and with the agreement of Lincolnshire's Housing, Health & Care Delivery Group; an expression of interest for Lincolnshire to become the 'Rural Strategic Partner of the National Centre for Ageing Better' was submitted in August 2019.

As one of 11 longlisted areas from across the country, a number of Lincolnshire stakeholders met with representatives of the CfAB during October 2019 to discuss the opportunity for a future

strategic partnership arrangement. This led to Lincolnshire being shortlisted alongside three other areas.

The CfAB intends to select one rural locality partner with whom they wish to develop a mutually agreed strategic partnership arrangement, supported by a Memorandum of Understanding.

Lincolnshire is currently one of two areas in a final shortlist and senior leaders are due to meet with the CfAB in January 2020 to conclude the selection process. If Lincolnshire is selected as the preferred partner, it is proposed that the Health & Wellbeing Board plays a key role in leadership and governance of the partnership arrangement whilst also ensuring a strong and effective link with the Greater Lincolnshire Local Enterprise Partnership.

The Centre for Ageing Better reported that they were struck by the quality and depth of system leadership, collaboration, innovation and good practice across Lincolnshire and impressed with the emphasis and commitment to ensure people are enabled to live and age well across the county. They describe their confidence in there being a range of exciting opportunities to work with Lincolnshire. They were particularly impressed with the stakeholder meeting, subsequent telephone meeting and the documentation shared with them. Regardless of the outcome, they are keen to work with Lincolnshire - even if outside of a strategic partnership.

The CfAB has published an Impact Review (2018/19) which review details some key evidence of the impact of its work. It also highlights some of the work achieved through the existing strategic partnerships (Leeds and Greater Manchester). The Impact Report can be accessed here

2. Conclusion

Whilst an ageing population presents challenges, it is possible to work proactively and positively to maximise health, wellbeing, independence and community resilience whilst also maximising economic activity and outcomes. Positive work and outcomes in East Lindsey have been accelerated through the Big Lottery Ageing Better programme and provides an evidence and learning base that offers insight and a blueprint for supporting and enabling Better Ageing across Lincolnshire.

This report has provides information about the work of the Centre for Ageing Better (CfAB) and Lincolnshire's engagement with an opportunity to work as a strategic partner of the CfAB in a

Rural Locality Partnership arrangement. It is proposed that a further report focussed on this opportunity will be provided to members of the Health and Wellbeing Board at a later date.

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

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

All of the JHWS priority areas can be approached with regard to the needs of people approaching later life to support them to age well. Through the lens of Better Ageing, we are able to develop a best practice approach to the priority areas agreed in the JHWS.

4. Consultation

Members of the Housing, Health & Care Delivery Group were consulted prior to submission of the expression of interest for the CfAB Rural Locality Partnership.

5. Appendices

These are listed below and attached at the back of the report	
Appendix A	CfAB Priorities

6. Background Papers

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

This report was written by Michelle Howard (Assistant Director, People - East Lindsey District Council) who can be contacted on 01507 613216 or michelle.howard@e-lindsey.gov.uk

Fulfilling work

Our aim is for more people aged 50 and over to be in fulfilling work by:

- Improving workplace practices to help people remain in work for as long as they want
- Improving support for people seeking to return to work
- Supporting healthy working lives

Our goal is 1 million more people aged 50 to 69 in fulfilling work by 2022

Safe and accessible homes

Our aim is for more people to live in safe and accessible homes by:

Improving the condition and accessibility of existing housing

Increasing the diversity of suitable homes for people approaching later life who choose to move

Making information and advice more easily available to help people approaching later life make good housing choices

Our goal is that by 2030 there will be one million fewer homes defined as hazardous and half of all new homes will meet accessibility standards

Healthy Ageing

Our aim is for more people to reach later life in good health and free of disability.
That will require:

- Persistent and coordinated actions by a wide range of actors nationally
- Changes to structural and environmental factors influencing health locally
- Effective interventions to influence individuals to adopt healthy behaviours

Our goal is for people to have five more years free of preventable disability, and to reduce the gap between the richest and poorest people in disability-free life expectancy by 2035

Communities

Our aim is more people approaching later life to be living in connected communities by:

- Creating the social infrastructure and physical environment for social connections to thrive
- Removing barriers to participation and creating opportunities for people to do the things they enjoy and matter to them

By 2030, we want to see an increase in the proportion of people aged 50+ who report they feel they strongly belong to their neighbourhood

Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of Glen Garrod

Executive Director Adult Care and Community wellbeing

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**4 February 2020**
Subject:	**The Lincolnshire Better Care Fund (BCF)**

Summary:

This paper provides the Lincolnshire Health and Wellbeing Board (HWB) with an update on the Lincolnshire Better Care Fund performance for Q2.

Actions Required:

The Lincolnshire Health and wellbeing Board are asked to note the content of the report.

1. Background

The Lincolnshire BCF plan was endorsed by the HWB on 24 September 2019 and submitted to NHS England for approval on 27 September 2020. The plan submitted was a total of £254m, which included iBCF and winter pressures grant funding.

On the 8th January 2020 the Lincolnshire health and care system received confirmation that our BCF plan had been approved without conditions for 2019/20 (appendix b). The confirmation was however expected week beginning 18 November 2019. Due to this delay, section 75 agreements are now not required to be in place until February 2020.

The key performance elements of the BCF plan relate to:

- Non-elective admissions. This is the total number of specific acute non-elective spells per 100,000 population.
- Delayed transfers of care. This is the total daily delays from hospital for people aged 18 and over.

- Residential admissions. Long term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population.
- Reablement. Proportion of older people (age 65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services.

Appendix A contains the Lincolnshire Better Care Fund performance report for Q2. Permanent admissions to care homes has achieved the target at 328 admissions. Delayed transfers of care has achieved the measure of 4,652 delayed days, which is less than the target of a maximum of 5,399. Unfortunately non-elective admissions continue to underperform with 22,505 admissions which is over the target of 18,491.

Lincolnshire County Council and CCG Officers have started a programme to review BCF schemes in preparation for submitting the plan in 2020/21. This is subject to national conditions being confirmed.

2. Conclusion

The Lincolnshire Health and Wellbeing Board are asked to note the information provided within this report.

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

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

4. Consultation

None required

5. Appendices

These are listed below and attached at the back of the report	
Appendix A	Lincolnshire BCF Q2 Performance Report
Appendix B	BCF Approval Letter

6. Background Papers

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

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Better Care Fund - 2019/20

Performance Report

Quarter 2

Produced November 2019

Performance Alerts for main Health & wellbeing Board measures only

Performance is on or ahead of target	4
Performance is behind target, with no improvement	1
Performance is behind target, with some improvement	0
Performance is not reported in this period	1
Total Health & Wellbeing Board measures	6

Produced by Lincolnshire County Council, Adult Care Performance & Intelligence Team
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A detailed analysis of the BCF measures is provided later in this report, showing baselines, trends, measure calculations and targets, with charts where appropriate.
Guidance is also provided for each measure below the measure descriptor for ease of reference.

Polarity	Indicator Description	Responsibility	Previous Years		Current Year				
					2019/20 Q1				
			2017/18	2018/19	Actual	Y/E forecast	Target	Trend~	Alert
Health and Wellbeing Better Care Fund Measures									
Smaller is Better	1. Total non-elective admissions into hospital : General and Acute IN QUARTER	Carol Cottingham (NHS)	20,750 (Q4)	21,789 (Q4)	22,505	n/a	18,491	⇔	Not Achieved
Smaller is Better	2. Permanent admissions to residential and nursing care homes in the year - aged 65+ **ASCOF 2A part 2**	Carolyn Nice (LCC)	1,020	1,005	328	656	575	⇩	Achieved
Bigger is Better	3. % people (65+) at home 91 days after discharge from hospital into Reablement/rehabilitation **ASCOF 2B part 1** REPORTED YEARLY	NHS / Tracy Perrett (LCC)	81%	88%	Annual Measure reported in Q4 only				Not reported in period
	3a social care only	Tracy Perrett (LCC)	83%	89%	93%	n/a	80%	⇔	Achieved
Smaller is Better	4 (i) . Delayed transfers of care: **Total** delayed days from hospital, aged 18+ IN QUARTER	NHS / LCC	6,198 (Q4)	4,848 (Q4)	4,652	n/a	5,399	⇔	Achieved
Smaller is Better	4 (ii). NEW Oct-18* Delayed transfers of care: Average delayed days per day from hospital, aged 18+ IN MONTH	NHS / LCC	74.5 (annualised)	48.5 (Mar-19)	53.3	n/a	58.7	⇔	Achieved
iBCF Measures									
	5. Number of home care packages provided in the year	LCC	4,581	4,611	3,802	tbc	n/a	⇩	n/a
	6. Total number of paid hours of homecare provided in the year	LCC	1,456,768	1,397,019	707,809	1,415,618	n/a	⇔	n/a
	7. Number of funded care home placements at the end of the period	LCC	3,271	3,296	3,194	n/a	n/a	⇔	n/a
	8. Number of new funded clients with LD	LCC	-	-	42	n/a	n/a	n/a	n/a
	9. Number of new managed care networks projects: Estimated number of direct beneficiaries	LCC	2,393	0	2,784	n/a	n/a	n/a	n/a
Local Measures									
Bigger is Better	10. Social Care Reablement hours delivered in the year	LCC	128,272	123,699	56,151	112,302	n/a	⇩	n/a
Bigger is Better	11. Reablement - % episodes completed in the year where the person was reabled to no service **(LCC Council Business Plan)**	LCC	87%	88%	91%	n/a	95%	⇔	Achieved
Bigger is Better	12. 7 Day Services - % patients discharged to Social Care at the weekend IN QUARTER	LCC	12.4%	12.5%	13.4%	n/a	n/a	⇔	n/a
Bigger is Better	13. Carers Supported by Lincolnshire Carers Service in the last 12 months, per 100k population (**LCC Council Business Plan)**	LCC	1,631	1,692	1,734	n/a	1,730	⇔	Achieved
Bigger is Better	14. Trusted Assessors: Hospital bed days saved in the year		-	3,560	2,562	5,124	-	n/a	n/a
Bigger is Better	15. Make Every Contact Count: Staff trained in the year **(LCC Council Business Plan)**	LCC	1,258	1,126	133	266	200	⇩	Not Achieved

Notes:

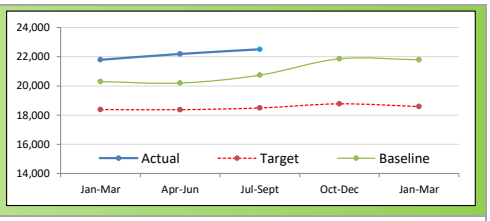
* the DTOC measure and targets were amended with effect from 01 October 2018 to move away from quarterly monitoring of total delays to monthly monitoring of average days per day.

~ Y/E forecast is used where appropriate else the 18/19 Q4, the trend is within a +/-5% tolereance.

Health and Wellbeing Board Measures

1: Total non-elective admissions in to hospital (general and acute)

Definition: The total number of emergency admissions for people of all ages where an acute condition was the primary diagnosis, that would not usually require hospital admission.
Frequency / Reporting Basis: Monthly / Cumulative within quarter only
Source: MAR data (Monthly NHS England published hospital episode statistics)



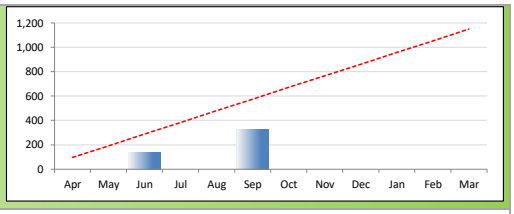
Performance observations from the data: Non elective admissions have increased by 8.52% when compared to the same period last year. Compared to Q1 there has been a 1.43% increase in non-elective admissions, 22,188 to 22,505.

Prior Year		2018/19											
		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
In Month		6,640	6,976	6,581	6,937	7,015	6,786	7,275	7,305	7,275	7,696	6,764	7,329
In Quarter (cumulative)		6,640	13,616	20,197	6,937	13,952	20,738	7,275	14,580	21,855	7,696	14,460	21,789

Current Year		2019/20											
		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
In Month		7,316	7,718	7,154	7,939	7,380	7,186						
In Quarter		7,316	15,034	22,188	7,939	15,319	22,505						
HWB NEA Plan - Target		6,125	12,250	18,375	6,164	12,327	18,491	6,258	12,516	18,774	6,196	12,392	18,588
Actual reduction (negative indicates an increase)	number	-1,191	-2,784	-3,813	-1,775	-2,992	-4,014	6,258	12,516	18,774	6,196	12,392	18,588
	%	-16.28%	-18.52%	-17.18%	-22.36%	-19.53%	-17.84%						
Performance		Not Achieved	Not Achieved	Not Achieved	Not Achieved	Not Achieved	Not Achieved						

2: Admissions to residential / nursing care homes - aged 65+ (ASCOF 2A part ii)

Definition: The total number of admissions to permanent residential or nursing care during the year (excluding transfers between homes unless the type of care has changed from temporary to permanent)
Frequency / Reporting Basis: Monthly / Cumulative YTD
Source: Mosaic data: Local Adult Care Monitoring (LTC admissions report & SALT return).
Note: Figure reported cumulatively



Performance observations from the data: There has been 191 new admissions to residential/nursing since Q1 however this figure will include backdated admissions from Q1 itself. This has brought the cumulative admissions into residential/nursing up to 328 which are still below the target of 575 by 247. This time last year there were 460 admissions which is a decrease of 132 (28.7%).

Prior Year	2018/19											
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
In Quarter			296			164			172			373
Cumulative YTD			296			460			632			1,005

Current Year	18/19	2019/20											
		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
In Quarter	**1,005**			137			191						-
Cumulative YTD	**1,005**			137			328						
Target (admissions)				**288**			**575**						
Performance				Achieved			Achieved						

3: % people (65+) at home 91 days after discharge from hospital into Reablement/rehabilitation (ASCOF 2B part 1) UPDATED YEARLY - Includes NHS and Social Care service

Definition: The percentage of older people (within a 3 month sample period) discharged from an acute or non-acute hospital to their own home/residential or nursing care home/ extra care housing for rehabilitation, where the person is at home 91 days after their date of discharge from hospital.
Frequency / Reporting Basis: Yearly - ASCOF 2B part 1
Source: Mosaic Reablement data and LCH data for Q3

Observations from the data: This measure is reported on an annual basis in quarter 4.

	18/19	2019/20											
		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Numerator	451			-			-			-			
Denominator	513			-			-			-			
Value	87.91%			-			-			-			
Target	**80.0%**			**-**			**-**			**-**			**80.0%**
Performance	Achieved												

3a: % people (65+) at home 91 days after discharge from hospital into Reablement/rehabilitation - SOCIAL CARE REABLEMENT SERVICE ONLY
Definition: The percentage of older people (within a 3 month sample period) discharged from an acute or non-acute hospital to their own home/residential or nursing care home/ extra care housing for rehabilitation, where the person is at home 91 days after their date of discharge from hospital. Q1 data will be clients discharged between January-March, Q2 will be clients discharged between April-June etc.
Frequency / Reporting Basis: Quarterly
Source: Mosaic data: Reablement

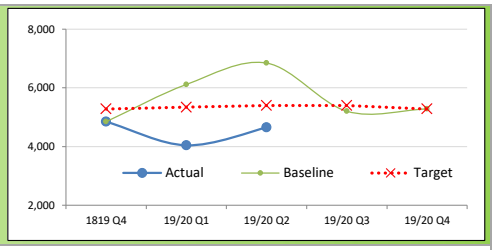
Observations from the data: Between April 19 to June 19, 683 episodes of reablement occurred after the client being discharged from a hospital with social care involvement. Of these 683 episodes 93% were still at home 91 days after being discharged (Q2). This is a 1% decrease from the previous quarter which related to hospital discharges between January 19 and March 19, however is still over the target of 80%. The 18/19 end figure relates to discharges that occurred between October 18 to December 18 (Q3) and where they were 91 days afterwards (Q4), the figure here is lower due to a new provider (Liberatas) taking over the contract for reablement in December 18.

	18/19 Social Care Only	2019/20											
		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Numerator	377			569			635						
Denominator	422			608			683						
Value	89%			94%			93%						
Target	**80.0%**			**80.0%**			**80.0%**						**80.0%**
Performance	Achieved			Achieved			Achieved						

4: Delayed transfers of care (delayed days) from hospital for adults aged 18+

Definition: The number of delayed transfers of care (days) for adults who were ready for discharge from acute and non-acute beds. This changed to average delayed days per day from October 2018. Both have been reported below.
Frequency / Reporting Basis: Monthly / Cumulatively within the quarter
Source: NHSE Published Delayed Days Report (Sitrep)

Table note: In the analysis by delay reason below, the organisation that the delay reason is attributable to in included in parentheses i.e. NHS, SSD, NHS or SSD, BOTH. This measure has evolved over time from rate per 100,000 to total days and now performance is judged based on average bed days per month.



Performance observations from the data: In 1819 Q2 there were 6,848 delays which have decreased by 32.07% to 4,652 in 1920 Q2. There has been a 15.12% increase in delayed days compared to 4,041 in Q1. In Q1 there were 431 delays for non-acute sites which in Q2 had increased by 124.83% to 969. Acute sites have increased by 2.02% from 3610 in Q1 to 3683 in Q2. NHS delays have increased by 29.46% from 2882 to 3731 in Q2, whereas social care delays have decreased by 28.81%, 427 to 304. Lincolnshire has achieved its target of 58.7 delays per day for this financial year.

Prior Year

	2018/19											
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Days Delayed in Quarter	2,039	4,175	6,117	2,174	4,508	6,848	1,784	3,549	5,203	1,587	3,344	4,848
Target (days)	**2,096**	**4,125**	**6,087**	**1,895**	**3,723**	**5,483**	**1,819**	**3,580**	**5,400**	**1,819**	**3,463**	**5,282**

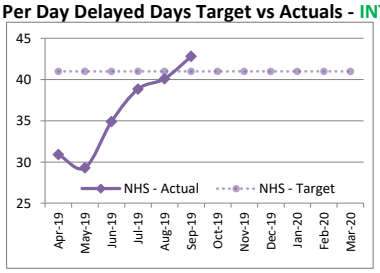
Current Year

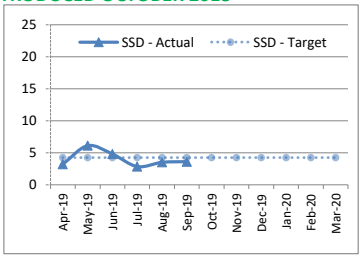
	Qtr 4 1819	2019/20										
		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Average Per Day	48.5	40.8	46	46.4	46.9	51.6	53.3						
In month	1,504	1,224	1,426	1,391	1,453	1,601	1,598						
In Quarter (cumulative)	4,848	1,224	2,650	4,041	1,453	3,054	4,652	-	-	-	-	-	-
Target (days)	**5,282**	**1,761**	**3,580**	**5,340**	**1,819**	**3,638**	**5,399**	**1,819**	**3,580**	**5,399**	**1,819**	**3,462**	**5,282**
Performance	Achieved	Achieved	Achieved	Achieved	Achieved	Achieved	Achieved						

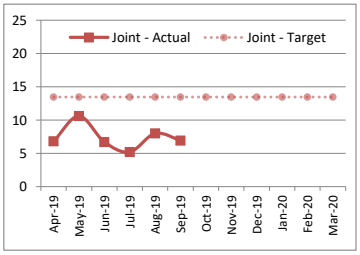
by Type of Care

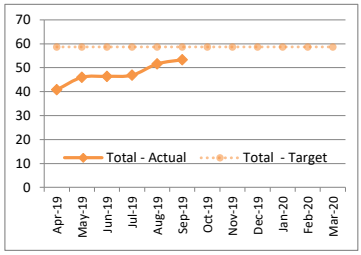
	18/19 Q4	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Acute	4,258	1,095	1,239	1,276	1,224	1,338	1,121						
Non Acute	590	129	187	115	229	263	477						
Total	**4,848**	**1,224**	**1,426**	**1,391**	**1,453**	**1,601**	**1,598**	-	-	-	-	-	-

Per Day Delayed Days Target vs Actuals - INTRODUCED OCTOBER 2018







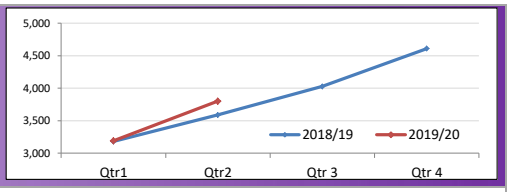


Average days	1819	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
NHS - Actual	32.7	30.9	29.3	34.9	38.8	40.1	42.8						
NHS - Target	41	41.0	41.0	41.0	41.0	41.0	41.0	41.0	41.0	41.0	41.0	41.0	41.0
Performance	Achieved	Achieved	Achieved	Achieved	Achieved	Achieved	Not Achieved						
SSD - Actual	4.6	3.2	6.1	4.8	2.8	3.5	3.6						
SSD - Target	4.2	4.2	4.2	4.2	4.2	4.2	4.2	4.2	4.2	4.2	4.2	4.2	4.2
Performance	Not Achieved	Achieved	Not Achieved	Not Achieved	Achieved	Achieved	Achieved						
Joint - Actual	11.2	6.8	10.6	6.7	5.2	8.0	6.9						
Joint - Target	13.5	13.5	13.5	13.5	13.5	13.5	13.5	13.5	13.5	13.5	13.5	13.5	13.5
Performance	Achieved	Achieved	Achieved	Achieved	Achieved	Achieved	Achieved						
Total - Actual	**48.5**	**40.8**	**46.0**	**46.4**	**46.9**	**51.6**	**53.3**						
Total - Target	**58.7**	**58.7**	**58.7**	**58.7**	**58.7**	**58.7**	**58.7**	**58.7**	**58.7**	**58.7**	**58.7**	**58.7**	**58.7**
Performance	Achieved	Achieved	Achieved	Achieved	Achieved	Achieved	Achieved						

iBCF Measures

5: Number of Home Care packages provided in the reporting year

Definition: Cumulative YTD number of all clients who have received a permanent home care package during the year
Frequency / Reporting Basis: Monthly / Cumulative within quarter only
Source: Brokerage weekly service returns

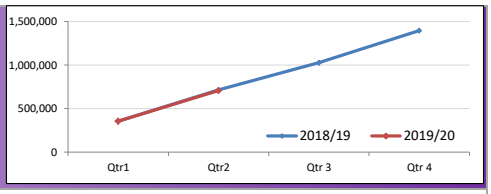


Observations from the data: The number of clients who had home care during the year has increased by 19.15% since last quarter and is higher than this time last year by 213 clients. This could highlight that more clients are receiving home care instead of being placed into a care home setting.

Prior Year		2018/19											
		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Clients in receipt of homecare (YTD)				3,179			3,589			4,028			4,611

Current Year		2019/20											
		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Clients in receipt of homecare (YTD)				3,191			3,802						

6: Total number of paid hours of Home Care provided in the quarter
Definition: Cumulative YTD number of all paid hours of homecare delivered
Frequency / Reporting Basis: Monthly / Cumulative within quarter only
Source: Brokerage weekly service returns

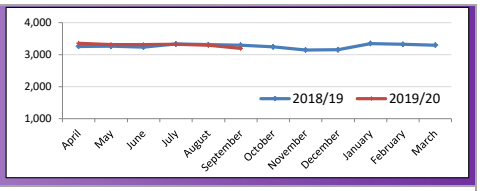


Observations from the data: For Q1 and Q2 paid hours for home care is very similar to last year, there is a 0.93% decrease between Q2 1819 and the current Q2.

Prior Year		2018/19											
		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Hours Delivered				357,266			714,479			1,028,275			1,397,019

Current Year		2019/20											
		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Hours Delivered				355,248			707,809						

7: Number of funded care home placement at the end of the period
Definition: Number of clients that are in a social care wholly or part funded care home placement at the end of the period.
Frequency / Reporting Basis: Monthly / Snapshot
Source: BO Report - Long Term Care (Summary)



Observations from the data: At the end of Q2 (September 19) the number of clients in a care home setting has decreased 2.98% from this time last year, 18.72% (598) of these are between 18-64 and out of these this 110 are in a nursing setting. The remaining 81.27% (2596) are 65+ with 616 in a nursing setting. Since August the number of clients in care home settings has been decreasing each month which follows a similar pattern to last year.

Prior Year		2018/19											
		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Care Home Placements (YTD)		3,258	3,261	3,238	3,333	3,310	3,292	3,240	3,147	3,151	3,349	3,321	3,296

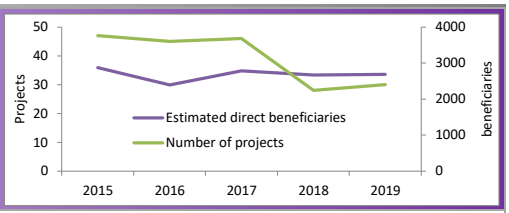
Current Year		2019/20											
		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Care Home Placements (YTD)		3,356	3,317	3,311	3,322	3,295	3,194						

8: Number of newly funded clients with LD
Definition: Number of new LD starters within the service each quarter
Frequency / Reporting Basis: Quarterly
Source: Finance Team - Adult Care & Community Wellbeing

Observations from the data: This is a new measure which looks at the number of clients that are newly being funded by the LD service recorded by the finance team; in Q1 there were 35 new starters, and in Quarter 3 there were 42. In the current quarter 61.9% of new clients were aged 18-25.

		2019/20											
by Age Group		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
18-25		3	7	5	12	8	6						
26-40		6	2	2	3	1	1						
41-64		1	3	3	3	4	3						
65+		2	0	0	1	0	0						
In month		**12**	**12**	**10**	**19**	**13**	**10**						
In Quarter (cumulative)		**12**	**24**	**34**	**19**	**32**	**42**						

9: Number of new managed care networks projects
Definition: Number of projects supported by the managed care network and estimated direct beneficiaries.
Frequency / Reporting Basis:
Source: LPFT, Managed Care Network Administrator



Observations from the data: This is a new reported measure, currently there are 30 projects running that are being supported by the managed care network. For this contract year there has been an estimated 2,683 beneficiaries and for the past 5 years (2015-present) there has been 13,404 estimated beneficiaries from these projects. In the managed care network wave 8 report, they reported that in Q2 (Jan-March) 159 beneficiaries were asked how they felt their wellbeing was before and after attending the project on a scale of 1-10 (1 being the lowest), before attending the project 139 rated their wellbeing between 1-5 out of 10. After attending the project however 142 rated their wellbeing between 6-10 out of 10.

Contract End	Sep-15	Sep-16	Sep-17	Sep-18	Sep-19	Sep-20
Number of projects	47	45	46	28	30	
New Projects	**14**	**9**	**19**	**8**	22	
Estimated direct beneficiaries	**2,875**	**2,393**	**2,784**	**2,669**	2,683	

Local Measures

10. Number of Reablement Hours Delivered in the period
Definition: Total number of face to face contact hours delivered
Frequency / Reporting Basis: Quarterly (Cumulative)
Source: Reablement Provider Contract KPI's

Observations from the data: In Q2 Libertas has continued to remain on target for their contractual expectations for number of hours delivered. When reviewing purely reablement hours in Q2 there has been a 3,506 decrease compared to Q1 however, due to Libertas only taking over the contract in December 2018 it is not possible to compare the providers performance for the same period last year. It should be noted that contact hours delivered in Q2 still remain higher than those reported for the previous provider in 2018, with Libertas also providing 30.25% more overstayers hours with 6446 delivered in Q2 compared to 4949 in Q1.

Current Year	18/19	2019/20											
		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Hours delivered (in month)	-	10,655	9,970	9,187	8,888	9,051	8,400						
Hours delivered (in quarter)	-	10,655	20,625	29,812	8,888	17,939	26,339						
Hours delivered (YTD)	-	10,655	20,625	29,812	38,700	47,751	56,151						

11. Reablement: % of people reabled to no service, or a lower service (ASCOF 2D)
Definition: % of concluded episodes of reablement for NEW clients where the sequel to reablement is no support or support of a lower level
Frequency / Reporting Basis: Quarterly / Cumulative YTD
Source: Short & Long Term Return (SALT STS002a)/ (CBP 124)

Observations from the data: Number of episodes that resulted in "reabled to lower services or no services" has dropped to 91.4% in Q2, however is still on target. As this is measure takes a cumulative position, it is possible that those who are reabled to no service in Q1 may subsequently require services in Q2 decreasing overall performance.

Current Year	18/19	2019/20											
		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Numerator	2,350			620			1,210						
Denominator	2,661			632			1,324						
Actual	88.3%			98.1%			91.4%						
Target	95%			95%			95%						
Performance	Not Achieved			Achieved			Achieved						

12. 7 Day Services: % of hospital discharges to Social Care which occur at the weekend
Definition: Of the total number of patients discharged from hospital to a Social Care hospital team, the % that were discharged at the weekend
Frequency / Reporting Basis: Quarterly / Cumulative (in quarter)
Source: BO Report - Hospital Discharges

Observations from the data: 13.4% of all hospital discharges occurred at the weekend in Q2 which is a 1.1% increase from last quarter. In Q2 450 discharges occurred at the weekend which is 61 more discharges when compared with Q1.

Current Year	18/19	2019/20											
		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
	Q4			Q1 1920			Q2 1920			Q3 1920			Q4 1920
Numerator	404			389			450						
Denominator	3,222			3,154			3,360						
Actual	12.5%			12.3%			13.4%						

13. Carers Supported by Carers Service and Adult Care
Definition: The total number of Carers Supported by Lincolnshire County Council in the last 12 months
Frequency / Reporting Basis: Quarterly / Rolling 12 month period
Source: Council Business Plan (Carers Strategy) (SALT LTS003 total)

Observations from the data: In the 12 month period up to 30 September 2019 over ten thousand (10,578) carers of adults have been supported by the Carers Service and Adult Care which has meant this measure as continually achieved its target this year.

Current Year	2018/19	2019/20											
		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Numerator	10,324			10,481			**10,578**						
Denominator	6.10			6.1			6.1						
Actual	**1,692**			**1,718**			**1,734**						
Target	1,730			1,730			1,730						
Performance	Achieved			Achieved			Achieved						

14. Trusted Assessors: Hospital Bed Days Saved
Definition: The number of assessments completed by workers, actual discharges that have taken place and total bed days saved by workers
Frequency / Reporting Basis: Quarterly
Source: Lincolnshire Care Association

Observations from the data: In Q2 the trusted assessors have saved 1,393 days which brings the cumulative total up 2,562 days saved. There were 23.3% (598) more assessments completed this quarter compared to Q1 (485).

Current Year	2018/19	2019/20											
		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Completed Assessments	1,468			485			598						
Actual Discharges	980			298			337						
Bed Days Saved (in quarter)	-			**1,169**			**1,393**						
Bed Days Saved (YTD)	**3,560**			**1,169**			**2,562**						

15. Making Every Contact Count
Definition: The total number of front line staff and volunteers who have been trained on Making Every Contact Count (MECC) during the year.
Frequency / Reporting Basis: Quarterly / Cumulative
Source: Council Business Plan (Wellbeing Strategy)

Commentary: At the end of 2018-19 it was agreed to change the way that MECC is delivered in order to maximise its sustainability when current funding streams end. Therefore a reduced target of 400 people attending face-to-face MECC training was agreed with PHMT. The end of Q2 is the end of BCF funding for this project as the project assistant that was being funded with these funds is now directly funded by Public Health. At present 133 staff/volunteers have been trained which is 33.25% of the end target.

Current Year	2018/19	2019/20											
		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Staff trained (YTD)	1,126			78			133						
Target	1,000			100			200			300			400
Performance	Achieved			Not Achieved			Not Achieved						

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NHS England
Skipton House
80 London Road
London
SE1 6LH

neil.permain1@nhs.net

08 January 2020

To: *(by email)*

Cllr Sue Woolley	Chair, Lincolnshire Health and Wellbeing Board
John Turner	Clinical Commissioning Group Accountable Officer (Lead)
Sarah-Jane Millls	Additional Clinical Commissioning Group(s) Accountable Officers
Debbie Barnes	Local Authority Chief Executive

Dear Colleagues

BETTER CARE FUND 2019-20

Thank you for submitting your Better Care Fund (BCF) plan for regional assurance and approval. We recognise that the BCF has again presented challenges in preparing plans at a late stage and at pace and we are grateful for your commitment in providing your agreed plan.

I am pleased to let you know that, following the regional assurance process, your plan has been classified as '**Approved**'. The Clinical Commissioning Group (CCG) BCF funding can therefore now be formally released subject to the funding being used in accordance with your final approved plan, and the conditions set out in the BCF policy framework for 2019-20 and the BCF planning guidance for 2019-20, including transfer of funds into a pooling arrangement governed by a Section 75 agreement. Your Section 75 agreement should aim to be confirmed by the end of January 2020.

These conditions have been imposed through the NHS Act 2006 (as amended by the Care Act 2014). If the conditions are not complied with, NHS England is able to direct the CCG(s) in your Health and Wellbeing Board area as to the use of the funding.

The Disabled Facilities Grant (DFG), the improved Better Care Fund (iBCF) and the Winter Pressures grant are also pooled along-side the CCG allocations. The DFG, iBCF and Winter Pressures grants are paid directly to local authorities via a Section 31 grant from the Ministry of Housing, Communities and Local Government. These

grants are subject to grant conditions set out in their respective grant determinations made under Section 31 of the Local Government Act 2003, as specified in the BCF Planning Requirements.

Ongoing support and oversight will continue to be led by your local Better Care Manager (BCM). Following the assurance process, we are asking all BCMs to feedback identified areas for improvement in your plan and share where systems may benefit from conversations with other areas.

Once again, thank you for your work and best wishes with implementation and ongoing delivery.

Yours sincerely,

Neil Permain
Director of NHS Operations and Delivery and SRO for the Better Care Fund

NHS England and Improvement

Copy (by email) to:

Glen Garrod	Local Authority Director of Adult Social Services (or equivalent)
Carolyn Nice	Local Authority Assistant Director of Adult Social Services (or equivalent)
Gareth Everton	Better Care Fund Lead Official
Andrew Crookham	LA Section 151 Officer
Dale Bywater	Regional Director of Delivery, NHS England Midlands Region
Jeffrey Worrall	Director of Performance & Improvement
Rosie Seymour	Programme Director, Better Care Support Team, NHS England
Wendy Hoult	Better Care Manager, Midlands

Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

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

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**4 February 2020**
Subject:	**Half Yearly Update on Health Protection Arrangements**

Summary:

The Health Protection Board (HPB), along with the Lincolnshire Health Resilience Partnership (LHRP) is accountable to the Health and Wellbeing Board for ensuring that appropriate arrangements are in place for the protection of the health of local people from a range of threats.

This report provides a brief update, by exception, to the Health and Wellbeing Board so it can satisfy itself that the health protection functions in Lincolnshire are robust.

Actions Required:

1. Note the overall good position of the health protection arrangements within Lincolnshire.

2. Note the areas of health protection service facing challenge.

1. Background

The 2012 NHS Act updated the arrangements for protecting the health of local populations; created new agencies with responsibilities to the people of Lincolnshire and moved around some of the functions previously residing in the NHS.

Regulation requires the Director of Public Health to have in place mechanisms to provide assurance to the Local Authority that the arrangements are in place across this complex system.

The two main governance groups are the Lincolnshire Health Resilience Partnership and the Health Protection Board which oversee emergency planning and response and broader health protection respectively.

The commissioning and delivery mechanisms are as complex as the service areas within the Health Protection Board's purview and include:

- Cancer and other screening programmes delivered by the NHS and general practices and commissioned by NHS England; and

- Immunisation and vaccination programmes delivered by general practices and a range of NHS organisations.

The overall governance of health protection arrangements lies with the Health and Wellbeing Board.

Overall, the assurance level for health protection function is rated as 'full' as the governance arrangements are well resourced, well attended and the plans that are in place are contemporary and either used or exercised on a regular basis.

However, there are some areas within the programmes where performance is challenging. Of particular note are:

- Immunisation programmes for children aged 0-5 years continue to underperform against national standards, however performance is in line with that for England.

- One of the patient experience standards for cervical cancer screening is underperforming. The turnaround time for results to be provided is slower than the national standard.

- The breast screening service in Lincolnshire is failing to offer screening to local women at the frequency specified in national standards.

To ensure continuous improvement and resilience, the County Council and Clinical Commissioning Groups (CCGs) are proposing to unify their two stand-alone health protection teams into one larger and more resilient team.

The Programme Boards for each of these programmes are well aware of these issues and are at various stages of improvement planning or contractual action with service providers.

2. Conclusion

The health protection arrangements within Lincolnshire are in good standing, with some challenges which are being proactively managed.

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

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

The JSNA has a number of topic areas which health protection programmes actively contribute to, including: cancers; child and maternal health; cardio vascular disease and immunisation and vaccination.

4. Consultation

None required.

5. Appendices

No appendices

6. Background Papers

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

This report was written by Tony McGinty, Consultant in Public Health, who can be contacted at tony.mcginty@lincolnshire.gov.uk

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Health and Wellbeing Board – Decisions from 11 June 2019

Meeting Date	Minute No	Agenda Item & Decision made
11 June 2019	**1**	**Election of Chairman** That Councillor Mrs S Woolley be elected as the Chairman of the Lincolnshire Health and Wellbeing Board for 2018/19
	2	**Election of Vice-Chairman** That Dr Kevin Hill be elected as the Vice-Chairman of the Lincolnshire Health and Wellbeing Board for 2019/20
	5	**Minutes** That the minutes of the Lincolnshire Health and Wellbeing Board meeting held on 26 March 2019, be confirmed by the Chairman as a correct record.
	6	**Action Updates from the previous meeting** That the completed actions as detailed be noted.
	8a	**Terms of Reference, Procedural Rules, Roles and responsibilities of Core Board Members** That the Terms of Reference, Procedure Rules and Board Members Roles and Responsibilities be agreed.
	9a	**Health and Wellbeing Board Annual Report** That the Board: • Note the information provided in the annual report; • Note comments made on the way the JHWS was reported; • Note that the JHWS remained focused on the key health and wellbeing issues facing Lincolnshire.
	9b	**Clinical Commissioning Groups – Developing Management Arrangements** That the following be noted by the Health and Wellbeing Board: • The initial and developing executive and staffing arrangements • The emerging joint governing body arrangements • The emerging joint governance committee arrangements • The early consideration of the national NHS Long term Plan commitments to the development of integrated care systems, strategic commissioning and the future roles of CCGs; and • The developing arrangements with the new NHS England/Improvement Midlands Regional Team
	9c	**Lincolnshire NHS Healthy Conversation 2019 – General Update** That the progress on the delivery of the Healthy Conversation 2019 campaign be noted.
	9d	**Health Protection Board Assurance for 2018/19** That the governance and assurance arrangements in place for the protection of the health of the people of Lincolnshire be noted; That the challenges within the health protection programmes in Lincolnshire, and the plans to address them be noted; That the plan to report to the Board twice yearly on this area of service be approved.

	9e	**Lincolnshire Physical Activity Taskforce Launch of "A Blueprint for Creating a More Active Lincolnshire"** That the Health and Wellbeing Board notes the progress made by the Lincolnshire Physical Activity Taskforce, the production of 'A Blueprint for Creating a More Active Lincolnshire' and the development of a collaborative approach to increasing physical activity levels across Lincolnshire.
	10a	**Better Care Fund 18/19 Quarter 4 Update** That the BCF report update be noted.
	10b	**An Action Log of Previous Decisions** That the report for information be noted.
	10c	**Lincolnshire Health and Wellbeing Board Forward Plan** That the report for information be received.
24 September 2020	**16a**	**The Lincolnshire Better Care Fund (BCF)** That the Lincolnshire Health and Wellbeing Board approves the BCF Narrative Plan for 2019/20 and notes the update to performance activity.
	17a	**Lincolnshire NHS Healthy Conversation 2019 – General Update** That the progress on the delivery of the Health Conversation 2019 campaign be noted.
	17b	**Joint Health and Wellbeing Strategy Housing and Health priority** 1. That the report and progress made to date be noted. 2. That the direction of travel to further develop the Housing and Health priority delivery plan be supported.
	17c	**Advancing our health: prevention in the 2020s Green Paper** 1. That the draft response to the Prevention Green paper be noted; 2. That a response be sent on behalf of the Health and Wellbeing Board, and any comments for inclusion should be sent to Alison Christie by 1 October 2019. 3. That the Chairman of the Board sign off the response prior to submission on 14 October 2019.
	18a	**Children's Emotional Wellbeing and Mental Health** That the report be noted.
	18b	**An Action Log of Previous Decisions** That the report for information be noted.

Lincolnshire Health and Wellbeing Board Forward Plan February 2020 to June 2020

Items for the Lincolnshire Health and Wellbeing Board are shown below:

4 February, 2pm, Committee Room 1, County Offices, Lincoln		
Item & Rationale	**Presenter/Contributor**	**Purpose**
Director of Public Health Annual Report To receive a presentation by the Director of Public Health on his annual report on the health of Lincolnshire's population. The report is publicly available to view at https://www.lincolnshire.gov.uk/directory-record/63956/director-of-public-health-annual-report-2019	Derek Ward Director of Public Health	Discussion
Joint Health and Wellbeing Strategy Healthy Weight Priority – update To receive an update from the Healthy Weight Partnership on the development of the whole system approach to tackling obesity in Lincolnshire	Derek Ward, Director of Public Health	Discussion
Joint Health and Wellbeing Strategy Carers Priority – update To receive an update from the Carers Delivery Group on the delivery of key areas of work within the Carers Priority Delivery Plan	Sem Neal, Chief Commissioning Officer, Prevention & Early Intervention and Emma Krasinska, Programme Manager	Discussion
Better Ageing in Rural Areas – learning from East Lindsey To receive a report on behalf of East Lindsey District Council and Community Lincs which presents an overview of the TED and Age Friendly projects in East Lindsey, as well as provide information on the Centre for Ageing Better (CFAB) and the opportunity for Lincolnshire to become a Rural Strategic Partner.	Michelle Howard Assistant Director, People East Lindsey District Council	Discussion
Better Care Fund – Quarterly Update To receive a report which provides the Lincolnshire Health and Wellbeing Board with an update on Lincolnshire's BCF plan.	Glen Garrod Executive Director Adult Care and Community Wellbeing	Information
Health Protection Board update To receive the half yearly update from the Health Protection Board providing reassurance that appropriate health protection measures are in place for Lincolnshire.	Tony McGinty Consultant Public Health	Information

Lincolnshire Health and Wellbeing Board Forward Plan February 2020 to June 2020

Planned items for future Lincolnshire Health and Wellbeing Board are shown below:

24 March 2020, 2pm, Committee Room 1, County Offices, Lincoln		
Item & Rationale	**Presenter/Contributor**	**Purpose**
Lincolnshire Pharmaceutical Needs Assessment To receive a report from the PNA Steering Group asking the Lincolnshire Health and Wellbeing Board to agree the process and timescales for reviewing the PNA 2021	Chris Weston, Consultant Public Health & Chairman of the PNA Steering Group	Decision
Clinical Commissioning Groups - Update To receive a report on behalf of the Clinical Commissioning Groups on current developments and future plans.	John Turner, Chief Accountable Office	Discussion
NHS Healthy Conversation 2019 – Final Report To receive a report on behalf of the Lincolnshire Health System on the Healthy Conversation 2019, an engagement exercise with partners, stakeholders, patients and the public on future options for change.	John Turner, Chief Accountable Office and Charley Blyth, Director of Communications and Engagement	Discussion
Neighbourhood Working – update To receive an update report on neighbourhood working in Lincolnshire including information on the Care Portal and Social Prescribing project funded by the Health and Wellbeing Grant Fund.	Sarah Jane Mills and Kirsteen Redmile	Discussion
JHWS Dementia Priority – update	TBC	Discussion
JHWS Mental Health (Adults) – update	TBC	Discussion
Better Care Fund – Quarterly Update To receive a report which provides the Lincolnshire Health and Wellbeing Board with an update on Lincolnshire's BCF plan.	Glen Garrod Executive Director Adult Care and Community Wellbeing	Information
9 June 2020, 2pm, Committee Room 1, County Offices, Lincoln		
Item & Rationale	**Presenter/Contributor**	**Purpose**
AGM - Election of Chairman and Vice Chairman		Decision
Terms of Reference and Procedural Rules, roles and responsibilities of core Board members To receive a report which asks the Board to review the Terms of Reference and Procedural Rules	Alison Christie, Programme Manager Health and Wellbeing	Decision

Items to be programmed:

- **Green Paper on Social Care for Older People**
- **Medical School Overview and Update**
- **Joint Strategic Asset Assessment**
- **Digital Maturity in Care Providers**
- **CQC – State of Care Report**