County Offices
Newland
Lincoln
LN1 1YL

1 March 2021

In accordance with the powers granted by the Local Authorities and Police and Crime Panels (Coronavirus) (Flexibility of Local Authority and Police and Crime Panel Meetings) (England and Wales) Regulations 2020 this will be a virtual meeting.

Lincolnshire Health and Wellbeing Board

A meeting of the **Lincolnshire Health and Wellbeing Board** will be held on **Tuesday, 9 March 2021 at 2.00 pm as a Virtual - Online Meeting via Microsoft Teams** for the transaction of the business set out on the attached Agenda.

Access to the meeting is as follows:

Members of the Lincolnshire Health and Wellbeing Board and officers of the County Council supporting the meeting will access the meeting via Microsoft Teams.

Members of the public and the press may access the meeting via the following link: https://lincolnshireintranet.moderngov.co.uk/ieListDocuments.aspx?CId=488&MId=6082 there a live feed will be made available on the day of the meeting.

Yours sincerely

D Barnes

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: Heather Sandy (Executive Director of Children's Services), Glen Garrod (Executive Director of Adult Care and Community Wellbeing) and Professor Derek Ward (Director of Public Health)

District Council: Councillor Donald Nannestad

Lincolnshire Clincial Commissioning Group: John Turner (Lincolnshire Clinical Commissioning Group)

Healthwatch Lincolnshire: Mike Hill

NHS E/I: 1 Vacancy

Police and Crime Commissioner: Marc Jones

Lincolnshire Co-Ordinating Board: Elaine Baylis

Associate Member (Non-Voting): Jason Harwin (Lincolnshire Police)

LINCOLNSHIRE HEALTH AND WELLBEING BOARD AGENDA
TUESDAY, 9 MARCH 2021

Item	Title	Pages
1	**Apologies for Absence/Replacement Members**	
2	**Declarations of Members' Interest**	
3	**Minutes of the Lincolnshire Health and Wellbeing Board meeting held on 1 December 2020**	7 - 16
4	**Action Updates from the previous meeting** *(For the Board to consider actions arising from the previous meeting)*	17 - 20
5	**Chairman's Announcements**	21 - 26
6	**Decision Item**	
6a	**Changes to the Lincolnshire Health and Wellbeing Board Terms of Reference to incorporate the functions of the Integrated Care System Partnership Board** (*To receive a report from Councillor Mrs Sue Woolley, Chairman of the Lincolnshire Health and Wellbeing Board and John Turner, Chief Executive, NHS Lincolnshire Clinical Commissioning Group, on the proposal to change the Health and Wellbeing Board's Terms of Reference to incorporate the functions of the Integrated Care System Partnership Board)*	27 - 42
7	**Discussion Items**	
7a	**Covid-19 Update** *(To receive a verbal update from Derek Ward, Director of Public Health, on the current Covid-19 position in Lincolnshire)*	Verbal Report
7b	**Director of Public Health Annual Report 2020** *(To receive a report from Derek Ward, Director of Public Health, which presents the Board with the Director of Public Health's Annual Report, which focusses on Covid-19 and the impact of the disease on health and wellbeing in Lincolnshire)*	43 - 64
7c	**Integrated Care System Update** *(To receive an update report from John Turner, Chief Executive, NHS Lincolnshire Clinical Commissioning Group, on the progress being made on the Integrated Care System in Lincolnshire)*	65 - 68

7d	**Suicide Prevention Strategy and Action Plan** *(To receive a report from Dr Kakoli Choudhury, Public Health Consultant and Shabana Edinboro, Acting Programme Manager, Public Health, which advises the Board on the progress being made towards the implementation of the Suicide Prevention Action Plan)*	69 - 90
7e	**Reforming the Mental Health Act White Paper** *(To receive a report from Sarah Connery, Acting Chief Executive, Lincolnshire Partnership NHS Foundation Trust, which provides the Board with a summary of the 'Reforming the Mental Health Act White Paper' and details of the consultation questions)*	91 - 106
7f	**Mental Health Services in Lincolnshire** *(To receive a presentation from Sarah Connery, Acting Chief Executive, Lincolnshire Partnership NHS Foundation Trust, which updates the Board on Mental Health Services in Lincolnshire)*	107 - 116
8	**Information Items**	
8a	**Implementing a Population Health Management Approach in Lincolnshire** *(To receive an update report from Derek Ward, Director of Public Health, on the progress made towards implementing a Population Health Management approach in Lincolnshire)*	117 - 124
8b	**Better Care Fund 2021/22** *(To receive a report from Gareth Everton, Head of Integration and Transformation, which confirms the national requirements for the Better Care Fund 2021/22)*	125 - 128
8c	**An Action Log of Previous Decisions** *(For the Board to note decisions taken since June 2020)*	129 - 132
8d	**Lincolnshire Health and Wellbeing Board Forward Plan** *(This item provides the Board with a copy of the Lincolnshire Health and Wellbeing Board Forward Plan for the period March 2021 to December 2021)*	133 - 136

Democratic Services Officer Contact Details

Name: **Katrina Cope**

Direct Dial **01522 552104**

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

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

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

Contact details set out above.

All papers for council meetings are available on:
https://www.lincolnshire.gov.uk/council-business/search-committee-records

This page is intentionally left blank

LINCOLNSHIRE HEALTH AND WELLBEING BOARD
1 DECEMBER 2020

PRESENT: COUNCILLOR MRS S WOOLLEY (CHAIRMAN)

Lincolnshire County Council: Councillors 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: Glen Garrod (Executive Director of Adult Care and Community Wellbeing), Professor Derek Ward (Director of Public Health) and Janice Spencer OBE (Assistant Director – Safeguarding).

District Council: Councillor Donald Nannestad (District Council).

Lincolnshire Clinical Commissioning Group: John Turner (Lincolnshire Clinical Commissioning Group).

Healthwatch Lincolnshire: Mike Hill.

Police and Crime Commissioner: Marc Jones.

Associate Member (non-voting): Bill Skelly (Chief Constable, Lincolnshire Police).

Officers In Attendance: Alison Christie (Programme Manager, Strategy and Development), Dr Sunil Hindocha (Clinical Director of Marina Primary Care Network, (PCN) and Chair of the Lincolnshire PCN Alliance) (GP Commissioning Group), Janet Inman (Non-Executive Director NHS Lincolnshire CCG), Semantha Neal (Assistant Director, Prevention and Early Intervention), Kirsteen Redmile (Lead Change Manager, Integrated Care, STP System Delivery Unit), Katrina Cope (Senior Democratic Services Officer) (Democratic Services) and Sarah Stringer (Transformation Manager, East Locality).

21 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

Apologies for absence were received from Heather Sandy (Executive Director of Children's Services), Elaine Baylis, (Lincolnshire Co-ordinating Board) and Jason Harwin, (Associate Member – Lincolnshire Police).

The Board noted that Janice Spencer (Assistant Director – Safeguarding) had replaced Heather Sandy (Executive Director of Children's Services) and Bill Skelly, (Chief Constable, Lincolnshire Police) had replaced Jason Harwin (Deputy Chief Constable, Lincolnshire Police – Associate Member) for this meeting only.

22 DECLARATIONS OF MEMBERS' INTEREST

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

23 MINUTES OF THE LINCOLNSHIRE HEALTH AND WELLBEING BOARD MEETING HELD ON 29 SEPTEMBER 2020

RESOLVED

That the minutes of the Lincolnshire Health and Wellbeing Board meeting held on 29 September 2020 be agreed and signed by the Chairman as a correct record.

24 ACTION UPDATES FROM THE PREVIOUS MEETING

RESOLVED

That the Action Updates presented be received.

25 CHAIRMAN'S ANNOUNCEMENTS

The Chairman advised the Committee that Brendan Hayes, the Chief Executive of Lincolnshire Partnership Foundation Trust (LPFT) had announced that he was retiring. The Chairman on behalf of the Board wished Brendan a long and happy retirement.

26 DECISION ITEMS

26a Health and Wellbeing Review - proposal to incorporate the functions of the anticipated Lincolnshire Integrated Care System Partnership Board

The Chairman introduced this item and advised that the report presented provided the Board with proposals to incorporate the functions of the anticipated Lincolnshire Integrated Care System Partnership Board (ICSPB) with the Lincolnshire Health and Wellbeing Board (HWB). The Chairman highlighted that since the publication of the report, further guidance had been received from NHS England and NHS Improvement (NHSE/I) concerning the next steps for Integrating Care Systems, and that as a result, minor amendments would be need to be made to two of the recommendations presented on page 17 of the report to take into account the said guidance.

The Chief Executive of Lincolnshire NHS Clinical Commissioning Group presented the report, making reference to the obvious areas of overlap between the role of the HWB and the emerging role of the ICSPB. The Board was advised that there was no national model for how HWBs and ICSPBs should work together, other than an expectation that local leaders from the health and care system would agree arrangements that responded to needs and requirements of their local area. The

Board was advised further that there was a consensus across the local health and care system for the need to develop an approach that worked for Lincolnshire.

It was reported that the proposed new board would provide an overarching strategic partnership for the health and care system. The Board would be supported by a series of operational boards that would deal with day to day management and provide assurance to the strategic board. It was reported that further work was still needed to develop a terms of reference, mode of operation and to agree governance arrangements.

It was highlighted that the approach being taken in Lincolnshire was a bold evolutionary step, which was not actively being considered elsewhere in the country. As such, it put Lincolnshire in the vanguard of thinking and offered a potential model for other areas to replicate. Details relating to the advantages of the approach were shown on pages 18 and 19 of the report.

The Board noted that as the guidance from NHSE/I was still being considered it was felt that at this stage the Board would only be able to support the proposed alignment, and consider the membership as detailed in section 1.3 of the report. It was agreed that a copy of the new guidance document would be forwarded on to all members of the Board.

During discussion, the Board raised the following points:

- Confirmation of the implementation date for the ICSPB. The Board was advised that a ICSPB needed to be in place for 1 April 2021;
- Membership as detailed at section 1.3. Confirmation was given that as a result of the new guidance, no agreement would be taken relating to membership. The Board noted that further work would be done to draft the proposed Terms of Reference for the integrated working arrangements; and that an Extra-ordinary meeting of the Board would be arranged for the start of February 2021, to allow for further discussions, prior to Board's March meeting;
- Involvement of the voluntary sector – The Board noted that involvement of the voluntary sector would be considered; and
- Support was extended to the proposed integrated working.

The Chairman advised that as a result of the recent publication of the next steps guidance on Integrated Care Systems issued by the NHSE/I, it was proposed to amend recommendations (b) and (d) as shown on page 17 of the report.

It was proposed and seconded to amend (b) to:

(b) to; 'Confirm it supports the proposal to align the functions of the anticipated ICSPB with the HWB.'

And; (d) to: 'Consider and comment on the proposed membership set out in Section 1.3'.

RESOLVED

a. That the report presented be noted.

b. That support be given to the proposal to align the functions of the anticipated ICSPB with the HWB.

c. That officers develop revised terms of reference and for these to be presented to the Board meeting in March.

d. That the comments raised by the Board on the proposed membership be taken into consideration.

26b Lincolnshire Homes for Independence Blueprint

Consideration was given to a report, which provided the Board with the Lincolnshire Homes for Independence Blueprint from the Housing, Health and Care Delivery Group (HHDCG), which sought to provide a high level vision for the provision of a greater range of housing options for those who needed additional support, and better integrated services to promote and sustain independent living.

The Chairman invited Councillor Mrs Wendy Bowkett, Chairman of the Housing, Health Care Delivery Group and Sem Neal, Assistant Director for Prevention and Early Intervention, Public Health to present the report, which was detailed on pages 23 to 60 of the report pack.

It was highlighted that the majority of homes that people currently lived in may not be suitable for their needs long term, as needs changed over time. It was noted that more could be done to help people remain in their own homes. The blueprint was aimed to help people remain living in their current home; or finding a home for life, which included encouraging new-build properties to make provision for accessibility in later life, should the need arise.

The Board noted that the development of the blueprint was the first step in agreeing across local government, NHS organisations, social housing providers and communities, the standards wished to be achieved in Lincolnshire.

Attached at Appendix A to the report was a copy of the Lincolnshire Homes for Independence Blueprint; and Appendix B provided the Board with a copy of the Draft Housing, Health and Care Delivery Group Delivery Plan. It was noted that Appendix B detailed the collaborative actions required to tackle the objectives outlined in the blueprint. It was noted further that the delivery objectives in the blueprint had been derived from the JSNA topics on 'Housing Standards' and 'Insecure Homes and 'Homelessness'.

Thanks were extended to everyone involved in the Lincolnshire Homes for Independence Blueprint.

During discussion, the Board raised the following points:

- Support was extended to the proposed blueprint;
- The need for the police to be involved in the implementation of the blueprint; and
- The need to ensure that housing was sustainable for the future; and that there were examples of successful sustainable housing projects in other parts of the country.

RESOLVED

1. That the Lincolnshire Homes for Independence Blueprint be endorsed.

2. That relevant partners be recommended to adopt the blueprint through the appropriate decision-making process for their organisation.

27 DISCUSSION ITEMS

27a Covid-19 Update

The Chairman invited Derek Ward, Director of Public Health, to provide an update on the current Covid-19 position in Lincolnshire.

The Board was advised that there had been a steady rise in the rate of Covid-19 cases through October to mid-November 2020, and that there had been a lot of variation across the districts.

However, since 20 November, there had been a slow but steady reduction in the rates of infection across the county; again there was some variance at district level. The Board was advised that the rate of infection had increased in Boston; and that this was as a result of two significant care home outbreaks; and a significant school outbreak.

The Board was advised that once out of lockdown, the whole of the county would be placed in tier level three. The Government was then due to review the tiering system again on 16 December 2020.

It was reported that Lincolnshire County Council Public Health were working with City of Lincoln Council and the Universities to arrange testing for students wishing to return home. It was highlighted that the testing would pick up those students who did not have any symptoms. It was also highlighted further that this would increase the number of positive cases in Lincoln, testing those asymptomatic.

The Board noted that the NHS was also instigating a similar model for NHS staff, to identify any staff who were Covid-19 positive, but were not showing any symptoms.

The Chief Executive of Lincolnshire CCG advised that all services in the health and care sector were under strain; and that the NHS was in a very challenging position currently. The Board noted that integrated working across all agencies during the

pandemic had been exceptional as had the support received from the Lincolnshire Resilience Forum.

It was highlighted that the NHS were keen to stress that even in a pandemic, they were open for the people of Lincolnshire.

The Board noted that the flu vaccination uptake in Lincolnshire was the highest in the East Midlands area, and praise was extended to all those involved in the flu vaccination campaign. It was noted further that arrangements were being made in readiness for the Covid-19 vaccines, once approved.

During discussion, the Board raised the following points:

- Concern was expressed regarding the availability of flu vaccines along the coast. The Chief Executive of the Lincolnshire CCG advised that he was aware of some issues, but felt these had been rectified as a delivery of flu vaccines had been received in the county during the previous week. Reassurance was given that the matter would be followed up;
- Families being unable to visit relatives in care homes, and whether this would change before Christmas. The Board was advised that access was the responsibility of the individual care homes;
- Some discussion was had regarding the proposed tier three and the implications for Lincolnshire as a whole;
- Underlying mental health issues resulting from the pandemic. Some members highlighted that extra funding needed to be made available to deal with mental health issues, or a re-organisation of existing resources. The Board noted that prior to the pandemic Lincolnshire had been successful in securing funding for mental health transformation, and that there had also been commitment at a national level as well to build on the broad range of support provided across the county. A suggestion was made as to whether more could be done to help those suffering isolation with the assistance of community volunteers;
- Bed occupancy. The Board noted that there were significant challenges for the NHS at the moment, as the number of positive in-patient cases had doubled in number, compared to the peak of the first wave. It was highlighted that there was also concerns regarding staffing levels, as the number of staff testing positive or self-isolating was increasing;
- Increasing rates for the City of Lincoln – The Board was advised that the infection rate for the City of Lincoln would increase as a result of the asymptomatic testing of students, but the rate would then drop thereafter. There was a realisation that any messages communicated needed to be as simple as possible.

The Chairman on behalf of the Board extended thanks to the Director of Public Health for his update.

RESOLVED

That the update be received.

27b Social Prescribing

The Chairman welcome to the meeting Sarah Stringer, Transformation Manager, East Locality, Kirsteen Redmile, STP Lead Change Manager Personalisation and Dr Sunil Hindocha, Clinical Director of Marina Primary Care Network, (PCN) and Chair of the Lincolnshire PCN Alliance.

Dr Sunil Hindocha introduced the item and advised the Board that since the Health and Wellbeing Board had first awarded £369,016 'proof of concept' funding for social prescribing, significant progress had been made in the strategic ambition as outlined in the Joint Health and Wellbeing Strategy (JHWS) and in the NHS Long Term Plan to create an embedded Social Prescribing service. Details relating to the local model were shown on pages 63 and 64 of the report.

Appendix A to the report provided the Board with an update report on the service from April to September 2020.

It was reported that in the first two quarters of 2020, the countywide service had received over 700 new referrals to the existing caseload of 660 referrals at the start of April 2020. It was highlighted that there had been an increase in the number of referrals from LPFT during lockdown. The Board noted that the Link Worker Team had carried out almost 24,000 support activities during the first half of the year, ranging from telephone calls, liaison with services etc.

The Board was also advised that contact was also being made through the new Vitrucare video call platform. The platform enabled the link workers the opportunity to link and support participants virtually. A screen shot of a platform and the variety of tiles available to a social prescribing participant was detailed on page 70 of the report pack.

It was reported that there needed to be a firm commitment to social prescribing across the county, not just at Primary Care Network (PCN) level. It was highlighted that in order to develop a single offer, contract security and stability would need to be reached to allow both staff and the model time to embed and mature. It was highlighted that there would also need to be the opportunity to share resources both at an operational and strategic level.

The Board noted that social prescribing was now embedded in the NHS offer, as it formed part of the NHS's ten high impact action.

During discussion, the Board raised the following points:

- That there needed to be a joined up approach to avoid overlap and duplication across the county;
- Some members welcomed the report presented and expressed their thanks to the presenters; and
- The need to ensure that there was a central point from which participants could be directed from.

RESOLVED

1. That the progress made in social prescribing from both the original proof of concept and new funding streams, and to sign off completion of the proof of concept project be noted.

2. That the ambitions for the services/new national expectations against the current risks and mitigations as detailed in the report be received.

3. That the Board reviews what further support and influence the Board can provide across all organisations to further commit funding in order to mitigate short-term risks, as the Social Prescribing Link worker model grows in maturity, but also to review how as a system Lincolnshire supports community development initiatives to ensure there are services and activities available for Social Prescribing to refer to (particularly in light of the impact of Covid-19).

4. That future responsibility be delegated to the Personalisation Board to monitor further updates on this service and agree the Personalisation Board will in turn report by exception back to the Health and Wellbeing Board as required.

28 INFORMATION ITEMS

28a An Action Log of previous decisions

RESOLVED

That the Action Log of Previous Decisions as presented be noted.

28b Lincolnshire Health and Wellbeing Board Forward Plan

During consideration of the Board's Forward Plan, reference was made to a recent communication from the Rt Hon Robert Jenrick MP, Secretary of State for Housing, Communities and Local Government, which had made reference to funding for public sector infrastructure totalling £100 billion. It was agreed that a copy of said letter would be forwarded on to the Chief Executive of Lincolnshire Clinical Commissioning Group to investigate further, to see if the letter referred to new funding or to funding already committed. The Board noted that Lincolnshire had been successful in securing funding through the year and that an update regarding this matter could be made available to Board members for a future meeting.

The Chairman advised that arrangements would be made for an extra-ordinary meeting of the Health and Wellbeing Board in late January/early February 2021, to consider the proposal around the alignment of the of the HWB with the ICSPB.

RESOLVED

1. That the Lincolnshire Health and Wellbeing Board Forward Plan up to 7 December 2021 be received.

2. That an Extra-ordinary meeting of the Lincolnshire Health and Wellbeing Board be arranged for late January/early February 2021 to discuss the alignment of the HWB with the ICSPB.

The meeting closed at 4.06 p.m.

This page is intentionally left blank

Meeting Date	Minute No	Agenda Item & Action Required	Update and Action Taken
11.06.19		**No update to report**	
24.09.19	**17c**	**Advancing our health: Prevention in the 2020's Green paper** 1. 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 2. That the Chairman of the Board sign off the response prior to submission on 14 October 2019	A formal response on behalf of the Lincolnshire Health and Wellbeing Board to the Advancing our health: Prevention in the 2020's Green Paper was submitted on 4 October 2019.
04.02.20	**22**	**Action Updates** That a copy of the Action Updates be circulated to members' of the Board following the meeting.	A copy of the Action Updates were sent to all members' of the Board on 7 February 2020
	23	**Chairman's Announcements** That a copy of the Chairman's Announcement be circulated to members' of the Board following the meeting.	A copy of the Chairman's Announcements was sent to all members' of the Board on 7 February 2020.
09.06.20		**No update to report**	
29.09.20	**15a**	**Health and Wellbeing Board Review and Refocus** That agreement be given by the Lincolnshire Health and Wellbeing Board to: • Review the purpose, membership and priorities, as detailed in the report; • Receive a further report on the outcome of the review at the next meeting of the Board scheduled for 1 December 2020; • Make recommendations to Lincolnshire County Council on proposed changes to the Council's Constitution with regards to the Lincolnshire Health and Wellbeing Board.	Two review workshops have been facilitated by the LGA looking at the future purpose and membership of the HWB. A proposal paper is being presented to the HWB on 1 December on merging the role of the HWB with that of the Integrated Care System Partnership Board. The review of the priorities is currently on hold due to the COVID-19 second wave and their capacity of key colleagues to support any review work. This second phase will be progressed in early 2021 once the review of purpose and membership has concluded.

29.09.20	**16e (4)**	**Centre for Ageing Better – Rural Strategic Partnership** That each constituent member organisation of the Board to seek formal commitment from their organisation to work together to achieve the aims of the Partnership.	• The Steering Group is currently developing a Partner Commitment for agencies to formally adopt to show their commitment • An engagement plan will be developed alongside this commitment to ensure that partners are kept up to date and are able to contribute fully to the work of the partnership • The new Partnership Manager comes into post on 16 November – these tasks will be part of her work plan once her induction tasks are completed
01.12.20	**26a**	**Health and Wellbeing – proposal to incorporate the functions of the anticipated Lincolnshire Integrated Care System Partnership Board** It was agreed that a copy of the new guidance from NHSE/NHSI would be forwarded to all members of the Board c. That officers develop revised terms of reference and for these to be presented to the Board meeting in March.	The guidance from NHSEI on the Integrated Care Systems was circulated to Board Members following the meeting. Revised terms of reference have been drafted for discussion at the extraordinary HWB meeting on 9 Feb before being formally presented for endorsement at the HWB March meeting. The revised terms of reference will still be subject to approval by Full Council as changes will be required to the Constitution.
	26b	**Lincolnshire Homes for Independence Blueprint** 2**.** That relevant partners be recommended to adopt the blueprint through the appropriate decision-making process for their organisation.	The Chair of the Housing, Health and Care Delivery Group has emailed all partners asking them to provide an update on progress through the HHCDG. The expectation is that all partners will have adopted the Blueprint by March 2021.
	27a	**Covid-19 Update** Concern was expressed regarding the availability of flu vaccines along the coast. The Chief Executive of the Lincolnshire CCG advised that he was aware of some issues, but felt these had been rectified as a delivery of flu vaccines had been received in the county during the	

		previous week. Reassurance was given that the matter would be followed up.	
	27b	**Social Prescribing** **3.** That the Board reviews what further support and influence the Board can provide across all organisations to further commit funding in order to mitigate short-term risks, as the Social Prescribing Link worker model grows in maturity, but also to review how as a system Lincolnshire supports community development initiatives to ensure there are services and activities available for Social Prescribing to refer to (particularly in light of the impact of Covid-19).	This will be reviewed as part of the work to refocus the Health and Wellbeing Board following Covid -19.
	28b	**Lincolnshire Health and Wellbeing Board Forward Plan** During consideration of the Board's Forward Plan, reference was made to a recent communication from the Rt Hon Robert Jenrick MP, Secretary of State for Housing, Communities and Local Government, which had made reference to funding for public sector infrastructure totalling £10 billion. It was agreed that a copy of said letter would be forwarded on to the Chief Executive of Lincolnshire Clinical Commissioning Group to investigate further, to see if the letter referred to new funding or to funding already committed. 2.That an Extra-ordinary meeting of the Lincolnshire	This refers to measures announced by the Chancellor as part of the Spending Review on 25 November 2020. A statement from Secretary of State for Housing, Communities and Local Government confirmed a package of investment to build more homes, end rough sleeping and support and level up communities across England in light of Covid. This includes: • £7.1bn National Home Building Fund to build more affordable and sustainable homes • Funding to level up and strengthen communities, including new £4bn Levelling Up Fund • More money for councils, with access to an additional £2.2bn to deliver services and £3bn to help tackle the pandemic • An extra £254m to tackle homelessness and rough sleeping • £70m to implement new laws to improve building safety. An Extra-ordinary meeting of the Lincolnshire Health and Wellbeing Board was scheduled for 9 February 2021 but subsequently cancelled due to the

		Health and Wellbeing Board be arranged for late January/early February 2021 to discuss the alignment of the HWB with the ICSPB.	forthcoming publication of the White Paper.

Lincolnshire Health and Wellbeing Board – 9 March 2021

Chairman's Announcements

COVID-19 Vaccination Programme

The COVID19 Vaccination programme is a collaborative programme that is being supported by all health and care partners. In Lincolnshire, we began vaccinating people on the 8 December when Lincoln County was established as one of the first Hospital Hubs in the country. As the National programme has been rolled out, Lincolnshire has been at the forefront of establishing local provision. The current services are as follows:

Vaccination Service	Locations
Hospital Hub – Paused, awaiting start of second vaccination roll out	Lincoln County
	Pilgrim Hospital
Local Vaccination Services (LVS) – provided by Primary Care. The arrangements for local service provision are influenced by the vaccine that the LVS receives. The services provided by the LVS include provision at the designated site, home visits for residents that are housebound, outreach clinics to care homes and outreach clinics at local practices to facilitate local access.	Apex Rustons Sports and Social Club
	Boston The Sidings Medical Practice
	East Lindsey Louth County Hospital
	First Coastal Site 1 The Storehouse, Skegness
	Four Counties St Marys Medical Practice, Stamford
	IMP Lincolnshire Showground
	K2 Grantham & Sleaford Table Tennis Club, The Meres, Grantham
	Marina Portland Medical Practice, Lincoln
	SOLAS Franklin Hall, Spilsby
	South Lincoln Healthcare Waddington
	South Lincs and Market Deeping & Spalding PCNs Springfields, Spalding
	Trent Care Network John Coupland Hospital, Gainsborough
	First Coastal Site 2 Mablethorpe
Vaccination Centres – providing appointments for people booking through the national booking system and designated groups e.g. Health & Social Care workforce	Boston - Princess Royal
	Lincoln – Lincolnshire Showground

The order in which people are offered the vaccine is based on advice from the Joint Committee on Vaccination and Immunisation (JCVI). The programme plan to offer all people in Cohorts 1 – 4 (see below) by 15 February 2021 has been completed. People who were unable to receive a vaccine, because they had been diagnosed within the last 4 weeks with COVID19, were too unwell or didn't want to accept the vaccine at that time will be offered further opportunities to have the vaccine.

Our aim is to ensure that we facilitate as high an uptake of vaccination as possible amongst all communities. To achieve this, the vaccination team and our PCNs will be working with community partners to establish links with people with health vulnerabilities and who are susceptible to health

and related inequalities. The vaccination programme in Lincolnshire has now begun providing vaccine to Cohorts 5 & 6

Cohort	
1 – 4	All residents in a care home for older adults and their carers All those 80 years of age and over and frontline health and social care workers All those 75 years of age and over All those 70 years of age and over and clinically extremely vulnerable individuals
5 - 6	All those 65 years of age and over 6 All individuals aged 16 years to 64 years with underlying health conditions which put them at higher risk of serious disease and mortality

Healthwatch Lincolnshire Vaccination Information Webinar

On 21 January 2021, Healthwatch Lincolnshire held a Covid-19 Vaccination Information Webinar, during which members of the Lincolnshire Vaccination Team responded to questions put forward by the public. The webinar is available on demand via either www.facebook.com/hwlincs or https://youtu.be/4PkKB7IE_-w

White Paper: Integration and Innovation – working together to improve health and social care for all

This White Paper published by the Department of Health and Social Care on 11 February 2021 sets out the legislative proposals for the forthcoming Health and Care Bill. It builds on the direction of travel set out in the NHS Long Term Plan (2019) and the Integrated Care System consultation document issued in November 2020. It recognises the progress that has been made during Covid-19 to remove barriers preventing integration and collaboration. Learning from the pandemic has therefore also helped shape the thinking to meet the Government's goal of delivering joined up care for everyone in England. A briefing paper summarising the key proposals is attached in Appendix A.

Lincolnshire Partnership NHS Foundation Trust – Appointment of Chair

On 25 January 2021, Lincolnshire Partnership NHS Foundation Trust (LPFT) announced that Kevin Lockyer would be taking up the position of Chair of the Trust from 1 May 2021. Kevin Lockyer has been a non-executive director at Lincolnshire Community Health Services NHS Trust since 2015 and has experience in the criminal justice system; housing; and public and voluntary sectors.

The Trust's current Chair, Paul Devlin, will be stepping down after six years in the role, when his term of office expires on 30 April 2021.

Older People and Frailty Mental Health Services

LPFT are asking for views as part of a new consultation on recent changes to local mental health service for older people. LPFT have been piloting a new home treatment approach over the last two years, following the major refurbishment of one of its older adult mental health wards in Lincoln. This new consultation seeks to hear from patients, carers and their families about the service they now receive and whether it meets their needs.

Details on the survey and more information about the proposals are available at www.lpft.nhs.uk/older-people-mental-health-consultation. The consultation closes on 31 March 2021.

Appendix A

BRIEFING NOTE
INTEGRATION AND INNOVATION: WORKING TOGETHER TO IMPROVE HEALTH AND SOCIAL CARE FOR ALL WHITE PAPER

1. PURPOSE

This briefing provides a summary of the White Paper published by the Department of Health and Social Care (DHSC) on 11 February 2021 which sets out the legislative proposals for a Health and Care Bill. It builds on the direction of travel set out in the NHS Long Term Plan (2019) and ICS consultation document issued in November 2020. It recognises the progress that has been made during Covid to remove barriers preventing integration and collaboration. Learning from the pandemic has therefore also helped shape the thinking to meet the Government's goal of delivering joined up care for everyone in England.

2. THE ROLE OF LEGISLATION

In 2019, the NHS Long Term Plan set out the priorities for health and care over the next ten years, including legislative changes which form the foundation of this White Paper. The measures are designed to make it easier for NHS organisations and wider partners to work together to tackle the issues that matter the most to the people they serve. The pandemic has highlighted that neither the NHS nor local government can address all the challenges facing whole population health on their own. The ambition to reduce inequalities and support people to live longer, healthier and more independent lives will need joint effort.

The proposals aim to create a new framework that builds on the changes already made by the health and care system due to Covid-19, so the system is able to tackle the challenges of the future. Beyond the legislative proposals set out in this document, there are several other changes to the health and care system – including improved data sharing, financial arrangements to support integration and improvements to public health services – that the proposals are designed to support and to align with.

3. PROPOSALS FOR LEGISLATION

3.1 Working together and supporting integration: enabling different parts of the health and care system to work together effectively, in a way that will improve outcomes and address inequalities.

The Covid-19 pandemic has demonstrated the importance of different parts of the health and care system working together. Legislation will be introduced to support integration, both within the health service, and between the health service and local government (specifically from a public health and adult care perspective). This involves:

- Legislating for **every part of England to be covered by an Integrated Care System (ICS)** to formally recognising the need to bring together NHS organisations, local government and wider partners at a system level to deliver more joined up approaches to improving health and care outcomes. Health and Wellbeing Boards will remain in place and will continue to have an important responsibility at place level to bring partners together. The ICSs will also need to take account of the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy
- A new **duty to collaborate** across the health and care system.
- Introducing a **triple aim duty** on health bodies, including ICSs, which ensure they pursue simultaneously the three aims of better care for all patients, better health and wellbeing for everyone, and sustainable use of NHS resources.
- Introducing a power to impose **capital spending limits on Foundation Trusts.**

- Implementing NHS's recommendations to **remove barriers to integration through joint committees, collaborative commissioning approaches and joint appointments,** as well as the recommendation to preserve and strengthen the right to **patient choice** within systems.
- Ensuring more **effective data sharing** across the health and care system to enable the digital transformation of care pathways.

3.2 Stripping out needless bureaucracy: turning effective innovation and bureaucracy-busting into meaningful improvements for everyone, learning from innovation during Covid-19.

The Government wants to remove unhelpful 'rigidities' in the current legislation, where they fail to enhance accountability, or necessitate complex or bureaucratic workarounds making it difficult for the system to integrate. The pandemic has shown that health and care can quickly adapt and remove unnecessary bureaucratic barriers to deliver better outcomes. The DHSC's paper, Busting bureaucracy: empowering frontline staff by reducing excess bureaucracy in the health and care system in England, sets out the Government's strategy for reducing excess bureaucracy. These actions are being taken forward through a variety of different projects, some led by the department, some by regulators and some by other bodies across the health and care system. In addition, legislation will be used to remove much of the transactional bureaucracy, specifically:

- The NHS should be able to make decisions on how it organises itself **without the involvement of the Competition and Markets Authority (CMA).**
- Reforming **how health care services are arranged by creating a bespoke health services provider selection regime** which will give commissioners greater flexibility in how they arrange services than at present. The NHS will be consulted on the new regime shortly.
- New flexibilities will be reinforced by changes to the **tariff to enable the tariff to work more flexibly within system approaches.**
- Giving the Secretary of State powers to **create new trusts** to ensure alignment within an integrated system where that is helpful.
- The Government is also proposing to **remove Local Education Training Boards (LETBs)** from statute to give Health Education England (HEE) more flexibility to adapt its regional operating model over time.

3.3 Enhancing public confidence and accountability: ensuring that we have the right framework for national oversight of our health system, that national bodies are streamlined, with clear roles and responsibilities, and that the public and Parliament can hold decision makers to account.

The pandemic has highlighted the need for balance between national action with local autonomy. The adaptations of recent years have led to the concentration of decision-making in a relatively small number of national NHS bodies. To address this imbalance, legislative changes will give ICSs a stronger role and provide greater clarity about the role of Government and of Parliament. DHSC will have a critical role to play in overseeing the health and care system and in ensuring strong alignment and close working between public health, healthcare and social care. Specifically:

- NHS England and NHS Improvement will be formally merged into a **single legal organisation** with increased scope and centralised decision-making capacity**.** DHSC will also put in place a mechanism to ensure the new body can be held to account in an appropriate way.
- Recognising the evolution of NHSE, the introduction of a **complementary proposal to ensure the Secretary of State for DHSC has appropriate intervention powers** with respect to relevant functions of NHSE. This will support the Secretary of State to make

structured interventions to set clear direction, support system accountability and also enable the government to support NHSE align its work with wider priorities for health and social care.

- Introduction of a **more flexible mandate for NHSE** which will enable the Secretary of State to set its objectives.
- A new provision to **allow the Secretary of State to intervene in service reconfiguration change where required**.
- Measures to **ensure a more agile and flexible framework for national bodies** that can adapt over time and measures to remove the unnecessary **3-year time limit for Special Health Authorities from legislation.**
- A new duty for the Secretary of State to publish a report every Parliament to provide **greater clarity around workforce planning responsibilities.**

3.4 Additional proposals to support social care, public health, and quality and safety

The Government is proposing a number of further measures which are in addition to those put forward by the NHS. The proposals are not intended to form a coherent reform package in themselves but are intended to address specific problems or remove barriers to delivery, maximise opportunities for improvement, and have in some cases been informed by the experience of the pandemic.

a) Social Care – the Government will bring forward measures on:
- **system assurance and data** to ensure there are appropriate levels of oversight on the provision and commissioning of social care.
- **a payment power** which corrects a limitation in existing legislation preventing the Secretary of State for HSC making emergency payments directly to all social care providers.
- **greater flexibility as to what point assessments for care can be made.**
- **creating a standalone power for the Better Care Fund**, separating it from the NHS mandate setting process.

b) Public Health - the Government will bring forward measures to:
- make it easier for the Secretary of State to **direct NHS England to take on specific public health functions** (complementing the enhanced general power to direct NHS England on its functions)
- help **tackle obesity** by introducing further restrictions on advertising high fat, salt and sugar foods
- give ministers new powers to alter certain food labelling requirements to support consumers to make more informed choices.
- **streamline the process for the fluoridation of water in England** by moving the responsibilities, including consultation responsibilities, from local authorities to central government.

c) Safety and Quality - the Government will bring forward measures to:
- put the **Healthcare Safety Investigation Branch (HSIB)** on a statutory footing to improve the current regulatory landscape for healthcare professionals.
- establish a **statutory medical examiner system** within the NHS to scrutinise all deaths which do not involve a coroner.
- allow the Medicines and Healthcare products Regulatory Agency (MHRA) to develop and maintain publicly funded and operated medicine registries so that we can provide patients and their prescribers, as well as regulators and the NHS, with the evidence they need to make evidence-based decisions.
- enable the Secretary of State to set **requirements for hospital food.**
- **implement comprehensive reciprocal healthcare agreements** with countries outside the EEA.

4. CHAPTER THREE: DELIVERING FOR ALL

The legislative proposals are designed to support and accelerate change in the health and care system and need to sit alongside the use of non-legislative means such as having the right workforce in place, setting out clear guidance and getting the incentives and financial flows right. The proposals are not intended to address all the challenges by the health and care system. The Government is undertaking broader reforms to social care, public health and mental health which are not included in this White Paper.

DHSC recognises the significant pressures faced by the social care sector and remain committed to reform. Our objectives for social care reform are to enable an affordable, high quality and sustainable adult social care system that meets people's needs, whilst supporting health and care to join up services around people. A broad range of options are being explored for how best to accomplish these reform objectives, and we have committed to bringing forward proposals this year.

In due course the Government will also publish proposals on the future design of the public health system. These proposals will draw on the learning from Covid-19 and on the need to ensure we have a public health system fully fit for the future. The factors which prevent poor health are shaped by many different parts of government, public services and the broader health system. So rather than containing health improvement expertise within a single organisation, driving change in the future will mean many different organisations having the capability and responsibility for improving health and preventing ill health.

On current timeframes, and subject to Parliamentary business, the legislative proposals for health and care reform outlined in the White Paper will begin to be implemented in 2022.

5. IMPLICATIONS FOR LINCOLNSHIRE

The focus for this potential White Paper is to bring forward legislation to deliver the ambitions set out in the NHS Long Term Plan (2019) to introduce ICSs across all areas in England to enable closer integration and collaboration between health and care. In addition, there is a very clear expectation that Ministers wish for greater leverage both on the NHS and also social care. There are no surprises in the potential White Paper as far as how it will impact on the approach being taken in Lincolnshire through the Better Lives Lincolnshire Alliance, which includes extending the functions of the Lincolnshire Health and Wellbeing Board to include the functions of the ICS Partnership Board. However, the additional leverage and oversight by Ministers may generate further reform along with a system for inspection of social care departments and, separation of the BCF from the NHS mandate. As such proposals generate the potential for significant impact that is neither clear or fully understood.

Prepared by:
Public Health Division

15 February 2021

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of Cllr Woolley, Chairman of the Lincolnshire Health and Wellbeing Board and John Turner, Chief Executive, Lincolnshire NHS Clinical Commissioning Group

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**9 March 2021**
Subject:	**Changes to the Lincolnshire Health and Wellbeing Board Terms of Reference to incorporate the functions of the Integrated Care System Partnership Board**

Summary:

This report proposes changes to the Health and Wellbeing Board's Terms of Reference to incorporate the function of the Integrated Care System Partnership Board. This discussion was deferred from the Board meeting on 1 December 2020 as a consultation document on Integrated Care Systems (ICSs) had been published by NHSEI on 26 November 2020.

The Integration and Innovation: working together to improve health and social care for all White Paper published by the Department of Health and Social Care on 11 February 2021 sets out proposals to increase integration and joint working across the health and care system. The legislative reform includes the setting up of statutory Integrated Care Systems (ICSs) in every part of England.

Actions Required:

The Health and Wellbeing Board is asked to:

1. endorse the revised Terms of Reference set out in Appendix A

2. recommend the changes to Full Council to enable the necessary changes to be made to the Council's Constitution.

1. Background

1.1 Establishing Integrated Care Systems (ICS) in Law

The ICS guidance, published on 26 November 2020 and the White Paper announced on 11 February 2021, build on the route map set out in the NHS Long Term Plan for health and care to join up locally around people's needs. The White Paper formally sets out proposals for legislative reform of the NHS in a forthcoming Health and Care Bill. Aim of the changes is to provide joined up care for everyone in England. Instead of working independently, every part of the NHS, public health and social care system should seek ways to connect, communicate and collaborate so that the health and care needs of the local population are met.

The proposals include establishing statutory Integrated Care Systems (ICSs) made up of an ICS NHS Body and an ICS Health and Care Partnership (ICSHCP) to strengthen integration and collaboration. This dual structure recognises that there are two forms of integration required:

- firstly, within the NHS to remove some of the barriers to collaboration and to make working together across the NHS an organising principle; and
- secondly, between the NHS and others, principally local authorities, to deliver improved outcomes to health and wellbeing for local people.

The ICS NHS body will merge some of the functions currently being fulfilled by non-statutory Sustainability and Transformation Partnership (STP)/ICS with the functions of the Clinical Commissioning Group (CCG). The ICS will also have an important role in addressing broader health outcomes by working in partnership through the ICSHCP. This body will be responsible for developing a plan that addresses the wider health, public health and social care needs of the system – the ICS NHS body and local authorities will have to have regard to the plan when making decisions.

The ICS will also be required to work closely with the local Health and Wellbeing Board (HWB), as HWBs have the experience as 'place based' planners. The ICS NHS Body will be required to have regard for the Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy (JHWS). The White Paper refers to ICSs needing to think about how they can align their allocation functions with place, for example through joint committees, though this is for local determination.

It is expected the legislative changes outlined in the White Paper will come into effect in April 2022.

1.2 The Approach in Lincolnshire

The Lincolnshire Health and Care System Leaders, working together and across the system, believe that, based on track record and evidence, Lincolnshire's ICS can best function and deliver outcomes for the Lincolnshire population by working within, and evolving, the arrangements and approaches which are already in place. Central to this is the proposition to incorporate the functions of the ICS Partnership Board (ICSPB) into the Lincolnshire HWB. The advantages of this approach are:

- It builds on the strong partnership working ethos cultivated through the HWB since 2013.

- The moves towards population health management will ensure place based and neighbourhood working is focused on delivering outcomes based on the needs of the population.
- It ensures a continued focus on the wider determinants of health which have an impact on an individual's health and wellbeing.
- The coterminous boundary offers Lincolnshire advantages over other areas and maximises the opportunity to work collaboratively.
- It reflects a genuine desire across the local health and care system to develop innovative ways of working and to capitalise on the advances made during the Covid-19 pandemic.

1.3 Changes to the HWB Terms of Reference

A detailed discussion on the proposal to incorporate the functions of the ICSHCP with the HWB was delayed at the HWB meeting on 1 December 2020. The Board agreed more time was needed to review the guidance and understand the implications for Lincolnshire. However, a request was made for officers to develop revised terms of reference, taking account of the ICS guidance, to be discussed at the next meeting of the HWB. The revised terms of reference are provided in Appendix A.

The main changes to highlight are:

- Section 2 Context – this section has been added to provide the rationale and context for the revised terms of reference

- Section 3 Objectives – the objectives have been updated to emphasise the ambition of the Joint Health and Wellbeing Strategy and to reflect the purpose of ICSs.

- Section 4 Functions and Responsibilities of the Board – the current statutory functions of the HWB are shown in points 4.1 and 4.2. Points 4.3 to 4.5 have been added to reflect the ICSPB functions.

- Section 5 Membership – the membership has been updated to reflect:
    - the ICS guidance which includes representation from all local NHS providers in addition to the clinical commissioning group and wider community representation.
    - each of the NHS Trusts Chairs and Chief Executives will be members of the HWB.
    - representation from Lincolnshire Police, NHSEI, and the voluntary and community sector are suggested as associated members.

- Section 7 Accountability – points 7.3 to 7.9 have been added or updated to reference the proposed changes.

- Section 11 Quorum – point 11.2 this has been updated to reflect the change in membership.

Other than minor grammatical or wording changes, the remaining sections in the terms of reference are unchanged.

Subject to the HWB endorsing the changes, the revised terms of reference will need to be reflected in the Council's Constitution and agreed by Full Council. It is anticipated that this will happen in the new municipal year. The first meeting of the HWB under the new terms of reference is scheduled to take place on 8 June 2021. This arrangement will need to be kept under review as the new legislation comes into play and ICSs become a statutory entity.

2. Conclusion

Every area is required to have an ICS by April 2021 with an overarching board in place to provide a strategic steer and to oversee the work of the local integrated health and care system. The proposal to incorporate the function of the ICSPB with the HWB puts Lincolnshire in a unique position and at the forefront of partnership working.

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

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

ICSs will have a statutory duty to have regard for the Joint Strategic Needs Assessment and Joint Health and Wellbeing Board.

4. Consultation

In line with the requirements of the Health and Care Act 2012, the HWB is included as part of the process.

5. Appendices

These are listed below and attached at the back of the report	
Appendix A	Lincolnshire Health and Wellbeing Board Terms of Reference and Procedural Rules

6. Background Papers

Document	Where it can be accessed
Integrating Care: Next steps to building strong and effective integrated care systems across England	NHS England » Integrating care: Next steps to building strong and effective integrated care systems across England
Integration and Innovation: working together to improve health and social care for all White Paper	Integration and innovation: working together to improve health and social care for all (HTML version) - GOV.UK (www.gov.uk)

This report was written by Alison Christie, Programme Manager Strategy and Development, who can be contacted alison.christie@lincolnshire.gov.uk

Appendix A

LINCOLNSHIRE HEALTH AND WELLBEING BOARD
Terms of Reference and Procedural Rules

1. PURPOSE

1.1 This document sets out the agreed principles and way of working for the Lincolnshire Health and Wellbeing Board which includes acting as the Integrated Care System Partnership Board (ICSPB) from April 2021.

1.2 It reflects the strong and effective partnership working across the health and care system and a commitment to the joint endeavour to deliver better health outcomes to the people of Lincolnshire.

2. CONTEXT

2.1 The Lincolnshire Health and Wellbeing Board (the Board) is established as a consequence of Section 194 of the Health and Social Care Act 2012 as a committee of Lincolnshire County Council.

2.2 Lincolnshire has a long history of strong and effective joint working to address the factors that determine health throughout the life course, and to seek to reduce demand on health and care services in a more preventative and proactive way.

2.3 The introduction of an Integrated Care System (ICS) in Lincolnshire is the next step on the evolution of partnership working. Health and Care System Leaders agree the ICS can best deliver outcomes for Lincolnshire by the Board fulfilling the role of the ICSPB.

2.4 The advantages of this approach are seen to be:

2.4.1 It builds on the strong partnership working ethos cultivated through the Board since 2013.

2.4.2 The move towards population health management will ensure place based and neighbourhood working is focused on delivering outcomes based on the needs of the population.

2.4.3 It ensures a continued focus on the wider determinants of health which have an impact on an individual's health and wellbeing.

2.4.4 The coterminous boundary offers Lincolnshire advantages over other areas and maximises opportunities to work collaboratively.

2.4.5 It reflects a genuine desire across the local health and care system to develop innovative ways of working and to capitalise on the advances made during the Covid-19 pandemic.

3. OBJECTIVES

3.1 To provide strong local leadership across the health and care system to improve the health and wellbeing of Lincolnshire's population.

3.2 To maximise opportunities and circumstances for joint working and integration of services and make the best use of existing opportunities and process to prevent duplication or omission within Lincolnshire.

3.3 To work collaboratively to address the wider determinants of health – the physical, cultural, social and political environment in which we live – which impact on an individual's health outcomes.

3.4 To promote transformational change through shifting the health and care system towards preventing rather than treating ill health and disability by promoting self-care and healthy living.

3.5 To maximise the opportunities and resources available to Lincolnshire by integrating services.

3.6 To reduce current inequalities in the provision of healthcare and close the gap.

3.7 To ensure a focus on issues and needs which will require partnership and collective action across a range of organisations to deliver.

4. FUNCTIONS AND RESPONSIBILITES OF THE BOARD

4.1 To deliver the functions of a Health and Wellbeing Board as set out in Section 195 and 196 of the Health and Social Care Act 2012 as follows:

4.1.1 To encourage persons who arrange for the provision of any health and social care services in the area to work in an integrated manner.

4.1.2 To provide advice, assistance or other support, as it thinks appropriate, for the purpose of encouraging joint commissioning.

4.1.3 To prepare and publish a Joint Strategic Needs Assessment (JSNA) on the local population.

4.1.4 To prepare and publish a Joint Health and Wellbeing Strategy (JHWS)

4.2 To produce the Pharmaceutical Needs Assessment (PNA) in accordance with the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 (SI 2013/349) and liaising with NHS England and Improvement (NHSE&I) to ensure recommendations or gaps in services are addressed.

4.3 To provide the overarching strategic partnership for the health and care system, setting the vision and strategy.

4.4 To provide oversight of the work undertaken by the member partners to take forward the Lincolnshire ICS to deliver the 'triple aim' duty for all NHS organisations of better health for the whole population, better quality care for all patients and financially sustainable services for the taxpayer.

4.5 To provide a system wide governance forum, including NHS, local government and wider partners, to enable collective focus and direction to the responsibilities and decision making of the individual partners.

5. MEMBERSHIP

5.1 The membership of the Board will comprise the following *(* denotes statutory members of the Health and Wellbeing Board as required by Section 194 of the Health and Social Care Act 2012*[1]):

- The Executive Councillor for NHS Liaison, Community Engagement
- The Executive Councillor for Adult Care, Health and Children's Services
- Six further County Councillors
- The Director of Public Health*
- The Executive Director of Children Services*
- The Executive Director of Adult Care and Community Wellbeing*
- Chair, NHS Lincolnshire CCG
- Chief Executive, NHS Lincolnshire CCG
- Chair, Primary Care Network Alliance
- Chair, United Lincolnshire Hospitals NHS Trust
- Chief Executive, United Lincolnshire Hospitals NHS Trust
- Chair, Lincolnshire Partnership Foundation NHS Trust
- Chief Executive, Lincolnshire Partnership Foundation NHS Trust
- Chair, Lincolnshire Community Health Services NHS Trust
- Chief Executive, Lincolnshire Community Health Services NHS Trust
- One designated District Council representative
- The Police and Crime Commissioner for Lincolnshire
- A designated representative of Healthwatch Lincolnshire*

5.2 Associate Members[2] of the Board are as follows:

- A designated representative from NHSEI
- Chief Constable/representative, Lincolnshire Police
- A designated representative for the Voluntary and Community Sector

5.3 The Board will confirm the representative nominations by the partner organisations at the Annual General Meeting.

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

5.5 Each non statutory member of the Board shall nominate a named substitute and provide details to the LCC Democratic Services Officer.

5.6 Two working days advance notice that a substitute member will be attending a meeting of the Board needs to be given to the LCC Democratic Services Officer.

---

[1] In addition to the positions highlighted, statutory membership of the Health and Wellbeing Board also includes at least one elected Councillor from the upper tier authority, nominated by the Leader of the Council, and at least one representative from each Clinical Commissioning Group whose area falls within or coincides with the local authority area.

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

5.7 Substitute members will have the same powers as Board Members.

6. CHAIR AND VICE CHAIR

6.1 The Board shall elect the Chair and Vice Chair at each AGM

6.2 The Chair and Vice Chair will not be from the same organisation.

6.3 The appointment will be by a majority vote of all Board Members/substitutes present at the meeting and will be for a term of one year.

7. ACCOUNTABILITY

7.1 The Board carries formal delegated authority to carry out its functions under Section 195 and 196 of the Health and Social Care Act 2021 from the County Council.

7.2 Save for the statutory functions referred to in paragraph 7.1 the Board will not have decision-making powers and will not exercise any functions of any other partner body. It will discharge its responsibilities by means of recommendation to the relevant partner organisations, who will act in accordance with their respective powers and duties to improve health and wellbeing of the people living in Lincolnshire.

7.3 NHS Members will ensure that they keep their organisation advised on the work of the Board.

7.4 The District Council Member will ensure that they keep all District Councils advised on the work of the Board.

7.5 Board members bring the responsibility, accountability and duties of their individual roles to the Board to provide information, data and consultation material appropriate to inform the discussions and decisions. A copy of the health and care system structure is shown in Appendix A.

7.6 The arrangements for the Board to fulfil the role of the ICSPB do not affect the role and functions of the Health Scrutiny Committee for Lincolnshire.

7.7 The Board will report to Full Council and NHSEI via the Regional Team as required.

7.8 The Board will provide information to the public through publications, local media, and wider public activities and by publishing the minutes of meetings on the County Council website and Lincolnshire's Integrated Care System website.

7.9 When required the members of the Board will take place in round table discussions with the public, voluntary, community, private and independent sectors to ensure there is a 'conversation' with Lincolnshire communities about health and wellbeing.

8. ROLES AND RESPONSIBILITIES OF BOARD MEMBERS

8.1 To work together effectively to ensure the delivery of the functions and shared objectives are met for the benefit of Lincolnshire's communities.

8.2 To work collaboratively to build a partnership approach to key issues and provide collective and shared leadership for the communities of Lincolnshire.

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

8.4 To champion the work and partnership approach in wider networks and in the community.

8.5 To ensure that there are communication mechanisms in place within the partner organisations to enable information about the priorities and recommendations are disseminated and appropriate action is taken to ensure the shared objectives are met.

8.6 To demonstrate commitment by prioritising attendance at meetings and development sessions.

8.7 To demonstrate commitment by prioritising activity in between meetings, such as responding to email communications and providing information within set deadlines.

8.8 To treat each other as equals, with respect and demonstrate that they value the contribution of others by listening and responding and encouraging real dialogue.

8.9 To act in accordance with the Board Member's roles and responsibilities listed in Appendix B.

9. BOARD MEETINGS

9.1 The Board will meet in public no less than four times per year including an AGM.

9.2 Additional meetings of the Board may be convened with the agreement of the Chair and Vice Chair.

9.3 The Board will hold development or wider partnership events as required. These meetings will be held in private.

9.4 All papers are to be sent to the Programme Manager Strategy and Development no later than 15 working days before the date of the scheduled meeting for approval with the Chair and Vice Chair. The appropriate committee report template should be used.

9.5 All finalised agenda items or reports to be tabled at the meeting will be sent by the Programme Manager Strategy and Development to the Democratic Services Officer no later than seven working days in advance of the next meeting. No business will be conducted that is not on the agenda.

9.6 Democratic Services will circulate and publish the agenda and reports at least five clear working days prior to the meeting. Exempt[3] or Confidential[4] Information shall only be circulated to Core Members.

[3] Exempt Information is information falling within any of the descriptions set out in Part I of Schedule 12A of the Local Government Act 1972 subject to the qualifications set out in Part II and the interpretation provisions set out in Part III of the said schedule. In each case, read as if references there in to 'the authority' were references to 'the Board' or any of the partner organisations.

10. PROCEDURE AT MEETINGS

10.1 Members of the public may attend all formal meetings of the Board subject to the exceptions in the Access to Information Procedure Rules as set out in Part 4 of Lincolnshire County Council's Constitution.

10.2 Only Board members, or their substitute, are entitled to speak through the Chair. Associate Members and the public are entitled to speak if pre-arranged with the Chair before the meeting.

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

10.3.1 Ensuring adequate access to Board meetings.

10.3.2 To include a work programme of planned future work on the agenda.

10.3.3 Reports and presentations are in a style that is accessible to the wider community, and of a suitable length, so that their content can be understood.

10.3.4 Enabling the recording of meetings to assist the secretariat in accurately recording actions and decisions.

11. QUORUM

11.1 Any full meeting of the Board shall be quorate if not less than a third of the Board membership are present.

11.2 This third should include the following:

- Either the Board Chair or Vice Chair, and in addition
- A Lincolnshire County Council Executive Councillor
- An NHS Chair

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

12. DECLARATIONS OF INTEREST

12.1 At the start of all meetings, all core members who are members of Lincolnshire County Council shall declare any interest in accordance with the Member's Code of Conduct which is set out in Part 5 of the Lincolnshire County Council's Constitution

13. VOTING

[4] Confidential Information is information furnished to partner organisations or the Board by a government department upon terms (however expressed) which forbid the disclosure of the information to the public.

13.1 Each core member or substitute member shall have one vote.

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

13.3 Decisions of the Board will be as recommendations to the partner organisations to deliver improvements in the health and wellbeing of the population of Lincolnshire.

14. CONDUCT OF MEMBERS AT MEETINGS

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

14.2 When at Board meetings or when representing the said Board, in whatever capacity, a member must uphold the seven Nolan Principles of Public Life:

- Selflessness
- Integrity
- Objectivity
- Accountability
- Openness
- Honesty
- Leadership

15. MINUTES

15.1 Democratic Services shall minute the meetings and produce and circulate an action log as part of the agenda to all core members.

15.2 Democratic Services will send the draft minutes to the Director of Public Health, Chief Executive of NHS Lincolnshire CCG and lead officers within ten working days of the meeting for comment.

15.3 The draft minutes, following comment from relevant officers (point 15.2 above), will be circulated to core members.

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

15.5 LCC Democratic Services will publish the minutes, excluding Exempt and Confidential Information, on the Lincolnshire County Council website.

16. OFFICER AND ADMINSTRATIVE SUPPORT

16.1 Appropriate officer and administrative support to be provided by Lincolnshire County Council and NHS Lincolnshire CCG.

17. EXPENSES

17.1 Partnership organisations are responsible for meeting the expenses of their own representatives.

18. OPERATIONAL/WORKING SUBGROUPS

18.1 With the agreement of the Board, operational/working subgroups can be set up to consider specific issues or areas of work to support the activities of the Board. Operational/working subgroups will be responsible for arranging the frequency and venue of their meetings.

18.2 Any recommendations of the operational/working subgroup will be made to the Board who will consider them in accordance with these terms of reference.

19. REVIEW

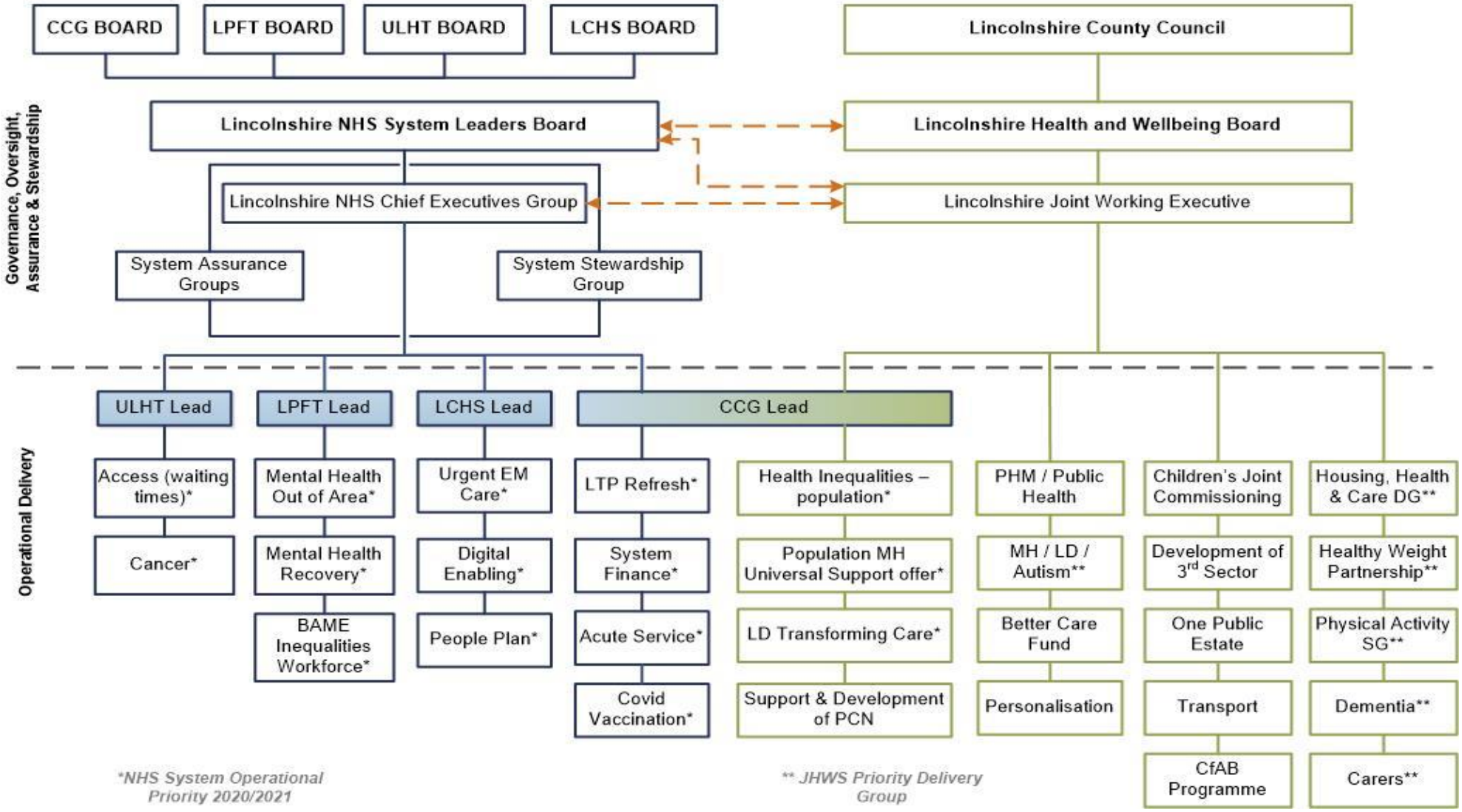
19.1 This document will be reviewed on an annual basis and confirmed at the AGM, or earlier if necessary.

19.2 Any amendments shall only be included by unanimous vote.

Signature:	Signature:
Chair Lincolnshire Health and Wellbeing Board	Vice Chair Lincolnshire Health and Wellbeing Board
Date:	Date:

Appendix A

HEALTH AND CARE SYSTEM IN LINCOLNSHIRE



Appendix B

Key roles and responsibilities of individual core board members

Core Member	Key Roles and Responsibilities
Lincolnshire County Council Executive members	• Report any issues raised by the public to the Board • Report any issues raised by other councillors to the Board • Provide strategic direction in relation to Lincolnshire's Joint Health and Wellbeing Strategy • Report publicly on the work and progress of the Board • Report to Executive on the work and progress of the Board • Promote and ensure co-production of all commissioning plans and proposals
Lincolnshire County Councillor	• Report publicly on the work and progress of the Board • Report any issues raised by the public to the Board • Report any issues raised by other councillors to the Board
Director of Public Health	• Update the Board on public health related matters • Ensure Lincolnshire is addressing health inequalities and promoting the health and wellbeing of all Lincolnshire residents • Lead the revision and publication of the JSNA • Lead the revision and publication of the Joint Health and Well-being Strategy
Adults and Children's Executive Directors	• Report on commissioning activity to the Board • Provide relevant information requested by the Board • Contribute to the creation of the JSNA • Have regard to the JSNA and the JHWS when developing commissioning and budget proposals • Report Board activity to assistant directors and heads of service
NHS Lincolnshire Clinical Commissioning Group	• Ensure that the Clinical Commissioning Group members/partners directly feed into the JSNA • Have regard to the JSNA and the JHWS when developing commissioning and budget proposals • Report commissioning activity to the Board • Report Board activity to other Clinical Commissioning Group members
Lincolnshire Healthwatch representative	• Reflect the public's views acting as the patient's voice to report any issues raised by the public to the Board • Promote community participation and co-production in support of activity • Ensure evidence from Healthwatch is fed into JSNA evidence base

Core Member	Key Roles and Responsibilities
	• Report on and from Healthwatch England • Ensure the JHWS reflects the need of Lincolnshire's population • Provide reports to the Board on issues raised by providers or the public of Lincolnshire
District Council representative	• Promote the Board's intentions to District Council partners • Ensure evidence from the District Council is fed into JSNA evidence base • Feedback any issues raised by partner districts or the public to the Board
NHS England representative	• Update the Board on any national commissioning issues which will affect Lincolnshire's JHWS • Feedback on any issues raised by the Board affecting Lincolnshire to NHSEI • Report on direct commissioning activity • Have regard to JSNA and JHWBs when developing commissioning and budget proposals • Provide strategic direction in relation to Lincolnshire JHWS • Provide an opportunity for issues that fall within the Regional Team's remit to be reported at a meeting held in public.
Office of the Police & Crime Commissioner	• Update the JHCPB on any relevant commissioning intentions or issues • Provide a strategic link between the HWB agenda and community safety • Highlight any areas of mutual interest and benefit • Have regard to JSNA and JHWBs when developing commissioning and budget proposals
NHS Provider Organisations	• Provide a strategic link between the Board and the STP programme • Have regard to the JSNA and the JHWS • Provide insight and perspective from the wider NHS in Lincolnshire
Voluntary and Community Sector	• Reflect the public's views acting as a voice to report any issues raised by the public to the Board • Promote community participation and co-production in support of activity

This page is intentionally left blank

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

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

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**9 March 2021**
Subject:	**Director of Public Health Annual Report 2020**

Summary:

The purpose of this report is to present the Director of Public Health's Annual Report. This year's report is on Covid-19 and the impact of the disease on health and wellbeing in Lincolnshire.

Actions Required:

That the Health and Wellbeing Board receives the Annual Report from the Director of Public Health and notes its content.

1. Background

Directors of Public Health in England have a statutory duty to produce an independent report on the state of 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 must be their accessibility to the wider public.

The 2020 Director of Public Health Annual Report, attached as Appendix A, is focused on Covid-19 and its impact, so far, on Lincolnshire. The pandemic has highlighted many of the inequalities that exist in our communities. The longer-term impacts of the disease are likely to be with us for some time. Specifically, increasing number of people experiencing depression, anxiety, loneliness and mental health issues coupled with ongoing economic uncertainty which will impact on people's lives in terms of employment, loss of income and future opportunities for younger adults; and the increasing fatigue of having to live with the disease especially for the most vulnerable.

The Annual Report has been published on the council's website.

2. Conclusion

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

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

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

This report is an independent professional view of the state of health of the people in Lincolnshire by the Director of Public Health. It has therefore drawn form a wide range of evidence, including but not limited to, the JSNA. The analysis and conclusions are designed to inform and support the ongoing delivery of the JHWS.

4. Consultation

The report is just for noting.

5. Appendices

These are listed below and attached at the back of the report	
Appendix A	Director of Public Health Annual Report 2020

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 Alison Christie, who can be contacted on alison.christie@lincolnhire.gov.uk

The impact of Covid-19 on Lincolnshire

Director of Public Health Annual Report 2020

Lincolnshire COUNTY COUNCIL
Working for a better future

Contents

Foreword 2

1 Introduction and Context 3
1.1 About Lincolnshire 3
1.2 Coronavirus Disease 3

2 Impact of Covid-19 in Lincolnshire 4
2.1 Positive Cases 4
2.2 Testing (Pillar 1 and Pillar 2) 4
2.3 Hospital Admissions 6
2.4 Deaths 6
2.5 Care Homes 7
2.6 Schools and Education 8
2.7 Community/Workplaces 8
2.8 Personal Protective Equipment 9
2.9 How Lincolnshire compares to the rest of England 10

3 Multi Agency Response to Covid-19 in Lincolnshire 12
3.1 Lincolnshire Resilience Forum 12
3.2 Legal and Regulatory Framework 12
3.3 Local Outbreak Management Response 13
3.4 Governance 14

4 Future Planning and Response 15
4.1 System Co-ordination Centre (SCC) Cell 15
4.2 Contact Tracing 15
4.3 Testing Sites 15
4.4 Covid-19 Vaccine 15
4.5 NHS Services 16

5 Longer Term Health and Wellbeing Implications of Covid-19 17

6 Conclusion 19

Foreword

Welcome to this, my second annual report as Director of Public Health for Lincolnshire. I must admit that the topic for this year's report is one I never hoped to have to write.

As we are all only too well aware, we are in the middle of a global pandemic that we have not seen for more than a century. It's brought huge challenges for us all and unsurprisingly has been the main focus of our work for most of this year. Which is why this report is a cut down version and without the broader look at health in the county than would normally be the case.

We've had to endure the difficult restrictions of lockdown and our way of life has been affected like never before. But the response of the people of Lincolnshire has been magnificent, with overall lower rates throughout the long months of the pandemic due to our residents sticking to the rules and restrictions, together with the support of a robust and well established health protection system. But as we've seen in many areas, the picture can change very rapidly and we continue to face big challenges with rising infection rates as more testing is carried out and the virus takes hold again in the winter.

Amidst the challenges there are positives. Science is starting to come to our aid, with more testing capacity, more rapid testing, and the hopes of a new vaccine. And the pandemic has done what all emergencies do in Lincolnshire – it has brought people together in a tremendous community spirit - socially distanced of course – as volunteers, neighbours and friends help those who are most vulnerable.

Our Lincolnshire Local Resilience Forum – bringing together the county's emergency services, health, local authorities, the voluntary sector and other partners – has played a major part in the response, supporting residents through the pandemic. Schools and their staff have endured the most difficult of times to ensure children continue their education in the safest way possible. Care homes and their staff have gone the extra mile to look after some of our most vulnerable older people. And we mustn't forget the magnificent response from NHS staff in the most trying of circumstances.

It has been a privilege to be part of this county response to the pandemic and to work alongside the best public health support network in the country. We aren't out of the woods yet. At the time of writing we are in lockdown 2 and we have a difficult winter period still ahead. So we need to stay focused and keep going, however difficult that may seem.

I said in my first meeting about Covid on the last day of January 2020 that this would be a marathon and not a sprint. We are entering the final quarter so we need to redouble our efforts to protect ourselves, our loved ones and each other. Remember the hands, face, space guidance and let's make sure we minimise the risk of catching or passing on the infection.

I'd just like to finish by thanking the team who put this report together. Although it's my report, it is very much a team effort and I am immensely grateful to all those who have contributed.

I hope the report will give you a better understanding of the pandemic and its effects on Lincolnshire. It reflects the tremendous work that has gone on in the background by so many, and for which I am hugely thankful.

Derek Ward
Director of Public Health

1. Introduction

1.1 About Lincolnshire

1.1.1 Population

Lincolnshire is a largely rural county with a population 761,224 of *(Source: ONS 2019 mid-year estimate)*, with a 49% male and 51% female breakdown. Lincolnshire has an ageing population with 23% of residents over the age of 65. Although the age distribution across the districts is proportionally similar, there are some noticeable differences as illustrated in Table 1.

Table 1: Population breakdown by age group
(Source: ONS 2019 mid-year estimate)

	0–19(%)	20–64(%)	65+(%)
Lincolnshire	21	55	24
Boston	23	56	21
East Lindsey	19	51	30
Lincoln	24	61	15
North Kesteven	21	55	24
South Holland	21	54	25
South Kesteven	22	54	24
West Lindsey	21	54	25

1.1.2 Deprivation

The 2019 Index of Multiple Deprivation (IMD) shows overall deprivation, and ranks Lincolnshire 91th out of 151 upper-tier local authorities in England, where 1st is the most deprived. Levels of deprivation vary across the county, which has an influence on health and wellbeing needs.

The general pattern of deprivation across Lincolnshire is in line with the national trend, in so much that the urban centres and coastal strip areas show higher levels of deprivation than other parts of the county. The Lincolnshire coastline, particularly the towns of Skegness and Mablethorpe, are amongst the most deprived 10% of neighbourhoods in the country.

1.1.3 Healthy Life Expectancy

Healthy life expectancy is the average life in good health, that is to say without irreversible limitation of activity in daily life or incapacities. Latest figures for 2016-2018 show that healthy life expectancy at birth in Lincolnshire is 62.8 years for men and 62.5 years for women. Both are comparable to the national equivalents of 63.4 years for men and 63.9 years for women. Longer term trends for Lincolnshire reveal that healthy life expectancy has reduced, from 64.4 years for men in 2009-2011, and from 65.2 years for women in 2009-2011.

In Lincolnshire, the inequality gap in male healthy life expectancy at birth between 2009 and 2013 was 11.9 years, and the gap for female healthy life expectancy at birth was 10.9 years. *(Source: Public Health England, Fingertips)*

1.2 Coronavirus Disease

Coronavirus disease 2019 (Covid-19) is caused by SARS-CoV-2, a newly emerging coronavirus, that was first recognised in Wuhan, China, in December 2019. The disease can be easily transmitted person to person by close contact through respiratory droplets; by direct contact with infected persons; or by contact with contaminated objects and surfaces. The incubation period for Covid-19, which is the time between exposure to the virus (becoming infected) and showing symptoms, is, on average 5 to 6 days, but can take up to 14 days. The distinctive symptoms of coronavirus (Covid-19) are a high temperature, a new continuous cough and the loss or change to the sense of smell or taste.

The World Health Organisation (WHO) reports[1] most people with Covid-19 will develop only mild (40%) or moderate (40%) symptoms and will recover without requiring specialist treatment. Approximately 15% of people will develop severe disease which requires oxygen support, and 5% will develop critical disease with complications such as respiratory failure, acute respiratory distress syndrome (ARDS), sepsis and septic shock, and multi organ failure. Older age, smoking and underlying long term conditions such as diabetes, hypertension, cardiac disease, chronic lung disease and cancer, are significant risk factors.

1. World Health Organisation. Clinical Management of Covid-19 Interim Guidance. May 2020 https://www.who.int/publications/i/item/clinical-management-of-Covid-19

2. Impact of Covid-19 in Lincolnshire

2.1 Positive Cases

Chart 1 – Total Confirmed Positive Cases

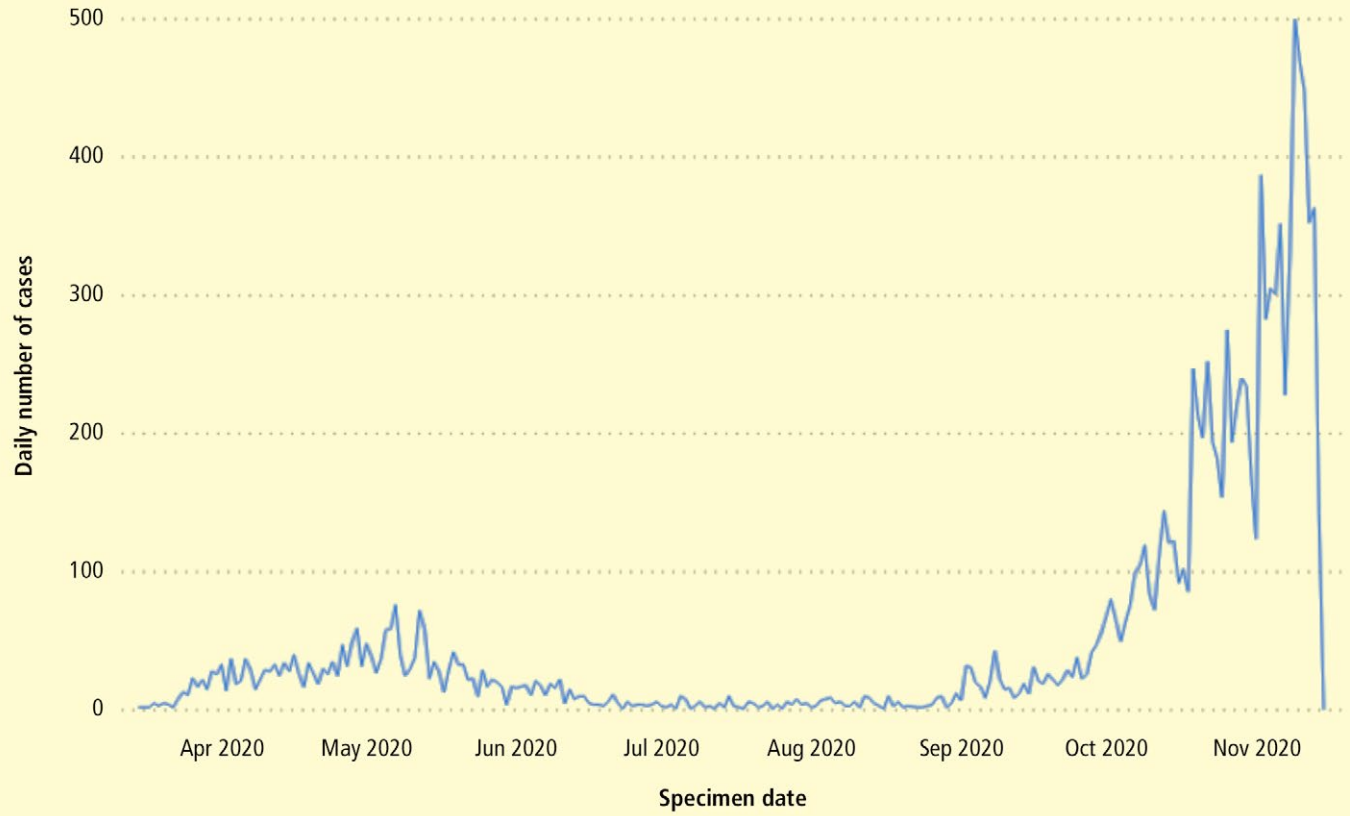
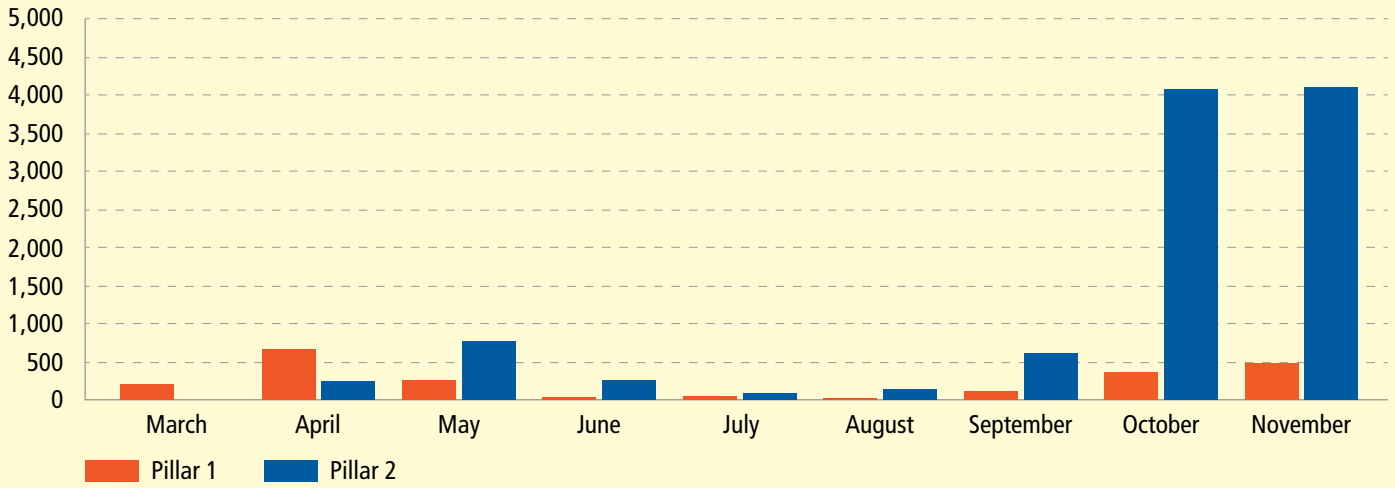


Chart 1 shows the number of positive cases each day in Lincolnshire since March 2020. As of 16 November 2020, there have been 12,414 recorded cases. The first peak was seen in May, with the highest daily figure being 76. Over the summer period the rate of positive cases fell and remained relatively stable. From September, rates have started to rise again, with the current highest daily figure of 500 being recorded on 9 November 2020. It is important to note that the testing available in the first wave of the pandemic was far more limited than later in the year, so comparisons across the two waves are difficult.

2.2 Testing (Pillar 1 & Pillar 2)

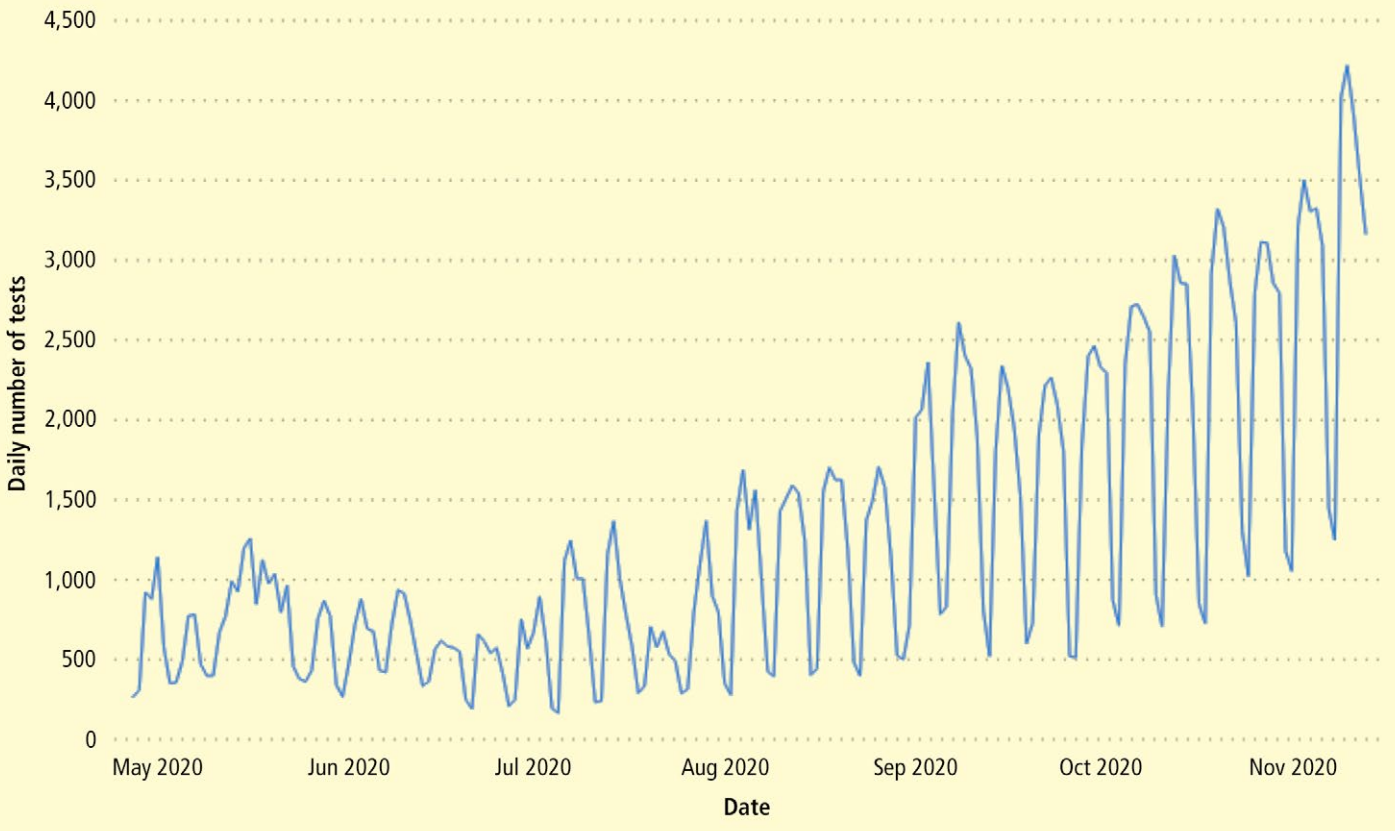
Testing for Covid-19 is organised in two ways, described as 'Pillars'. Pillar 1 testing (swabbing processed by PHE labs and NHS hospitals, for those with a clinical need and health and care workers) was the only source of testing to begin with when Covid-19 was first recorded in Lincolnshire with Pillar 2 testing (the national programme for the wider population) started to be recorded in May. As shown in Chart 2, positive cases identified from both forms of testing reduced over the summer months due to the low incidence rate. From May, Pillar 2 testing has resulted in finding most positive cases which has also been seen regionally and nationally.

Chart 2 – Pillar 1 v Pillar 2 Monthly Testing Figures (positive cases only)



In Lincolnshire there have been a total of 256,365 Pillar 2 tests undertaken as of 13 November 2020 (NHS Digital's secure dashboard). With regards to Pillar 2 testing the number undertaken in Lincolnshire during the Covid-19 pandemic is highlighted in Chart 3:

Chart 3 – Total Pillar 2 Tests

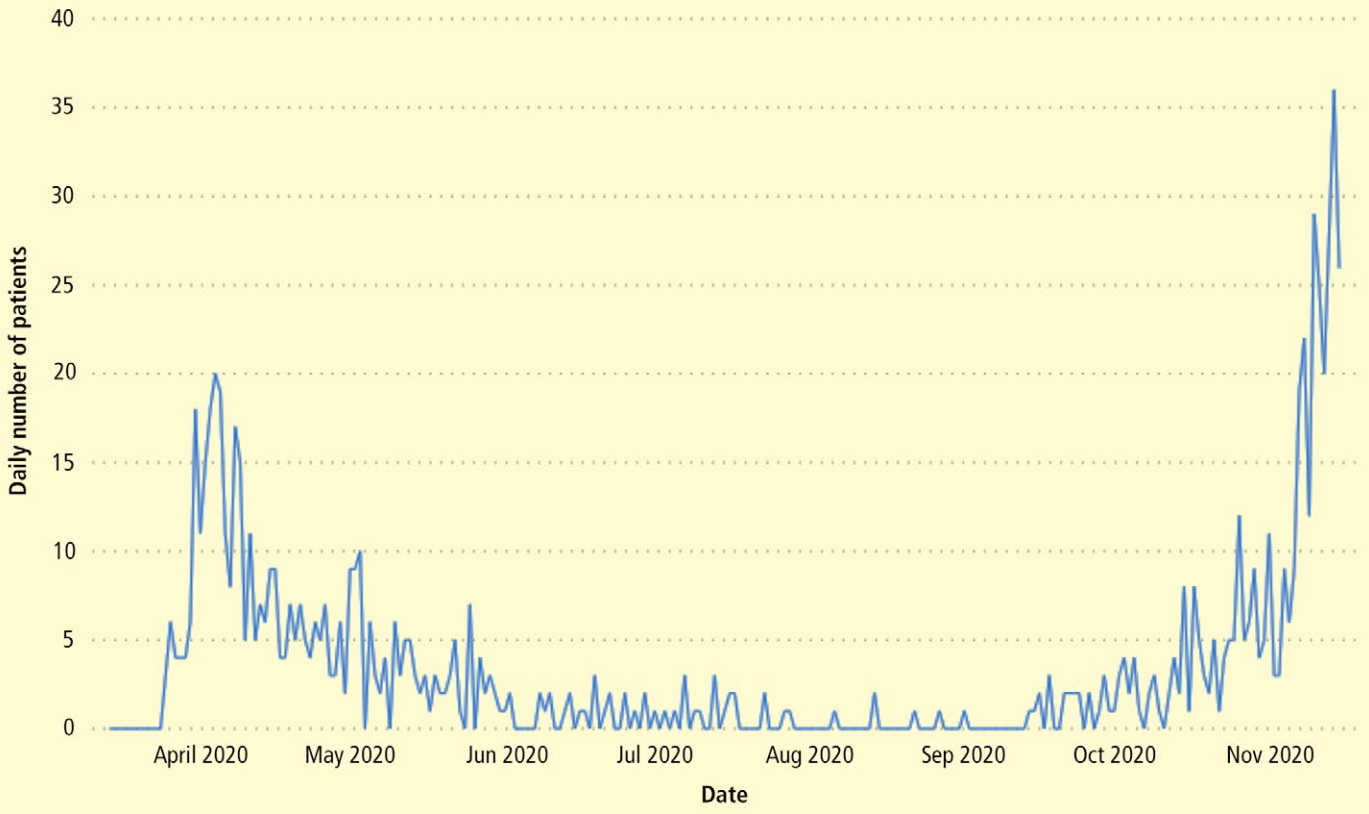


The number of Pillar 2 tests has continually risen across the year with the exception of June and July. The reason for the daily fluctuations in testing counts is due to a higher number of people accessing testing on weekdays compared to weekends.

2.3 Hospital Admissions

When looking at hospital admissions the first wave of Covid-19 in Lincolnshire, the month of April saw the highest amount of hospital admissions/diagnosis for COVD-19. The highest daily figure saw 20 admissions/ diagnosis in one day. Numbers dropped from May and continued to remain low during the summer before patient numbers began to rise from October. Since then the highest daily figure is 36 admissions/diagnosis in one day. This is illustrated in the Chart 4.

Chart 4 – United Lincolnshire Hospital Trust Patients Admitted or Diagnosed with Covid-19 within last 24 hours



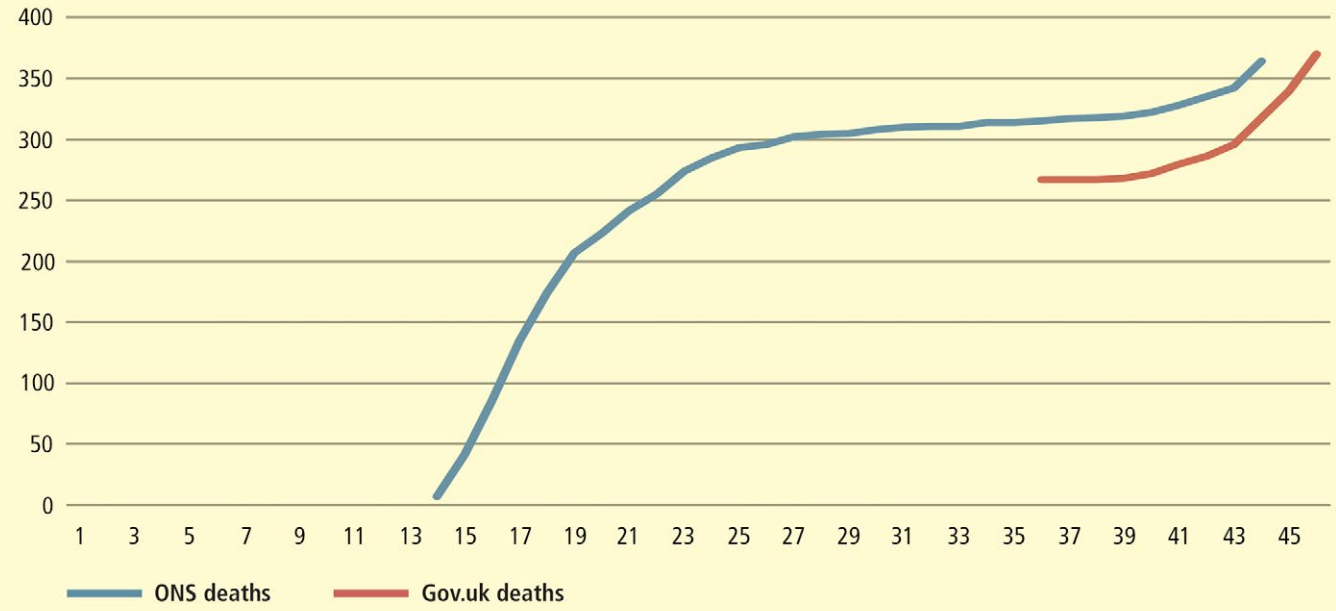
2.4 Deaths

Sadly, in some instances people do not recover from the illness caused by Covid-19. It is important we understand the number of deaths whilst recognising that each of these numbers represent an individual and family affected.

There have been two definitions of how deaths are recorded. ONS has continued to update Covid deaths each week with any mention of Covid on the death certificate whereas the national figures were altered and released as of 25 August 2020 to only include deaths with Covid diagnosed up to 28 days before death.

According to ONS as of 10 November 2020 Lincolnshire has seen 364 Covid deaths. The national figures released on https://coronavirus.data.gov.uk/deaths shows that Lincolnshire has had 370 deaths as of 13 November 2020. As illustrated in Chart 5 overleaf.

Chart 5 – Weekly Covid-19 Deaths in Lincolnshire by Source

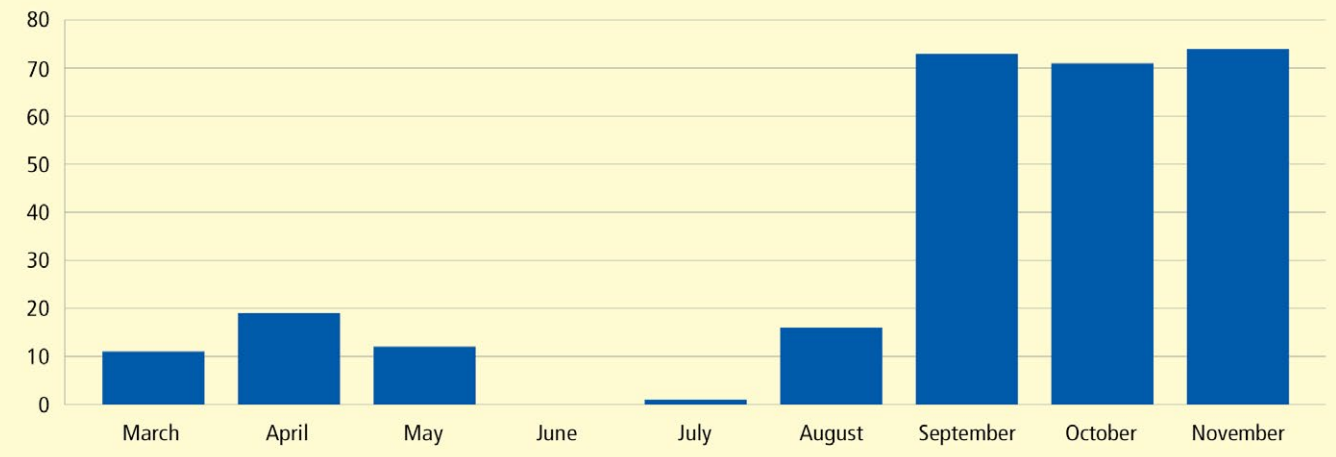


2.5 Care Homes

Across England, people living in long term care homes have been badly affected by the illness and the restrictions placed on them to limit family visiting. The care sector has been at the frontline, along with our hospitals, in responding to the pandemic.

An outbreak of an infectious disease is where two or more cases are reported in one place during a short time period. In some instances, these cases might not be linked to each other, but a response is needed to ensure onward spread is limited. There have been 277 Care Homes reporting an outbreak during the Covid-19 Pandemic in Lincolnshire as reported by the Health Protection Team (as of 16 November 2020). June and July saw very few outbreaks, with September and November having the most outbreaks in a month with 73 and 74 respectively, as illustrated in Chart 6.

Chart 6 – Care Home Outbreaks in Lincolnshire

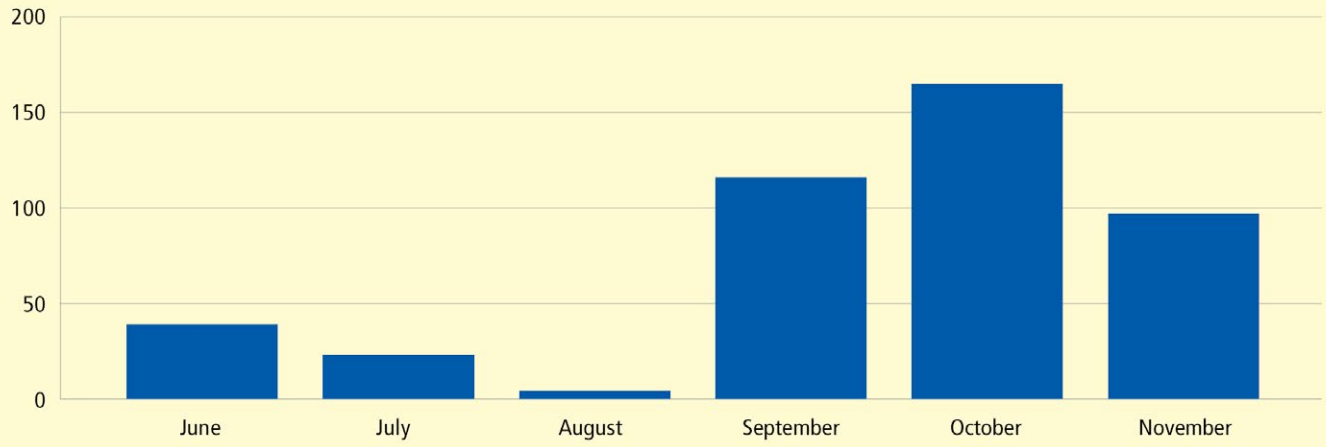


2.6 Schools and Education

Disruption to education is a long term risk to the health and wellbeing of children. Although schools closed during the first wave of the pandemic, apart for children of key workers, the plan is to prioritise them remaining open through the autumn and winter period.

There have been 444 reports of outbreak by 312 education settings during the Covid-19 Pandemic in Lincolnshire as reported by the Health Protection Team (as of 16 November 2020). The first outbreak was reported in June. As shown in Chart 7, October has by far seen the highest number of outbreaks, with 165, with a huge rise seen from September due to schools fully reopening in September.

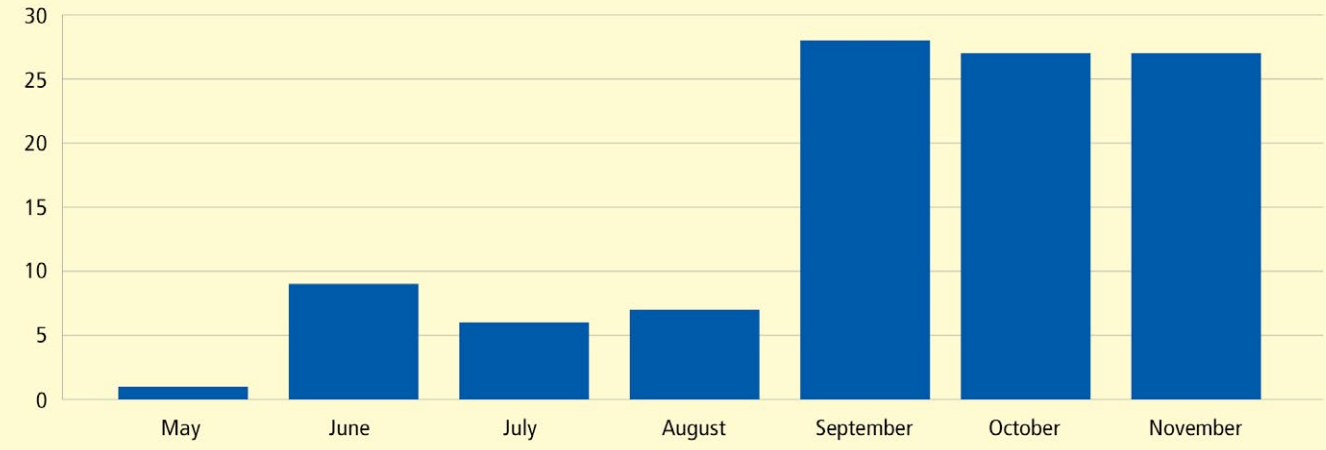
Chart 7 – School Outbreaks in Lincolnshire



2.7 Community/Workplace settings

There have been 105 community/workplaces reporting an outbreak during the Covid-19 Pandemic in Lincolnshire managed by PHE (as of 16 November 2020). October recorded the most outbreaks with 28 as shown in Chart 8.

Chart 8 – Community/Workplace Outbreaks in Lincolnshire

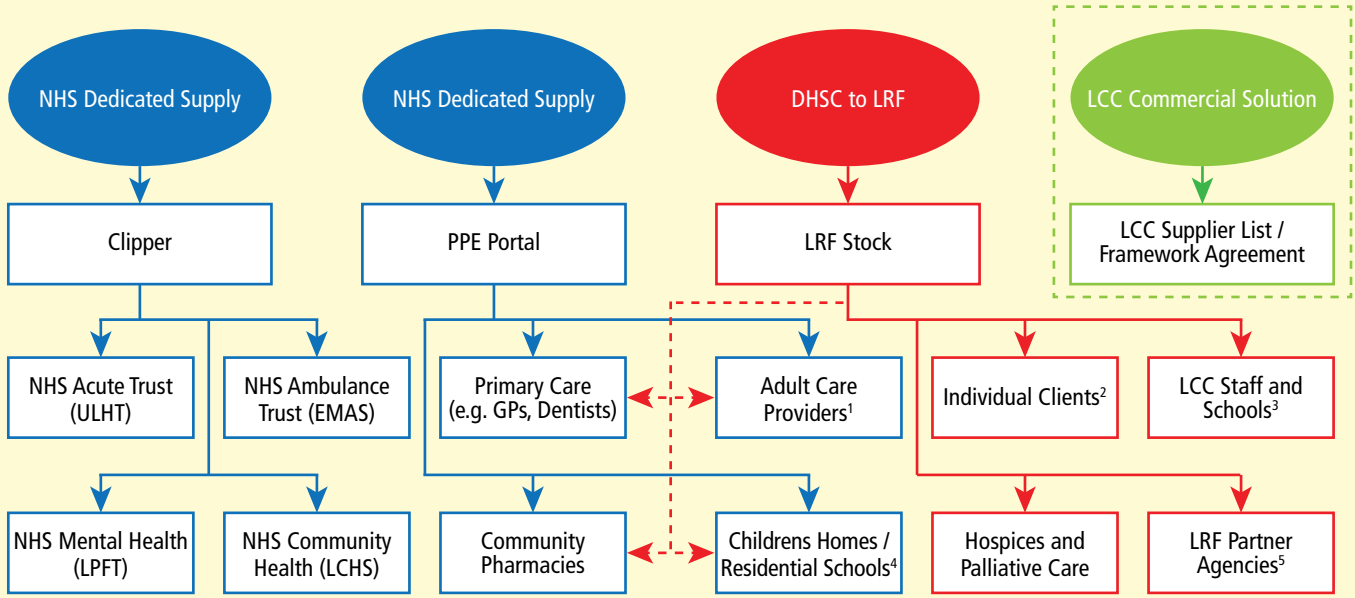


2.8 Personal Protective Equipment (PPE)

As Covid-19 is spread through droplets and close contact it is essential that those roles which require this type of contact use the right personal protective equipment as described in government guidance. Since early April 2020 the Department of Health and Social Care has regularly delivered PPE to the Lincolnshire Resilience Forum (LRF). The purpose of this has been to support health and care agencies with emergency need for PPE as a result of issues with their normal supply chain. This stock has been provided free of charge and issued based on the clear clinical need for staff to wear PPE to deliver their services. Given the resilience of the national supply chain (largely due to 70% of PPE now being produced by UK manufacturing firms), Government continues to issue PPE to the LRF both for day to day requirements in social work, education and child care settings as well as to continue to support local emergency need, e.g. due to local outbreaks.

There remains in place a variety of routes for organisations to access PPE as part of the new resilient supply chains and these are shown in Figure 1:

Figure 1: PPE Supply and Distribution Arrangements (September 2020)



1. Adult social care homes and domiciliary care settings.
2. Individual continuing health care patients and direct payment recipients/personal assistants.
3. Staff employed by LCC who require PPE as part of undertaking their role, maintained schools, academies and early years settings.
4. Children's care homes, secure children's care homes and children's residential special schools.
5. This also includes Mental Health Community Care Services, Domestic Violence Refuges and Rough Sleeping Services.

This line denotes that if these agencies cannot get the PPE they need through wholesaler routes or the PPE portal, they can still contact the LRF for emergency support.

To date the LRF has received in excess of 3 million items of PPE to support the emergency response. The LRF continues to manage its stocks in a prudent way to ensure it is able to continue to support partner agencies in the most urgent need for PPE due to a breakdown in their normal supply chain alongside provision of PPE to social work teams, etc. As a result of this the LRF still holds a stockpile of 2 million items of PPE in order to support the health and care system through the winter, local outbreaks of Covid-19 and the second wave of wider community-based infection. Table 6 shows the PPE distributed by the LRF in Lincolnshire thus far.

Table 6: LRF PPE volumes and usage – April 2020 to October 2020

PPE Item	Current volumes	Volume used	Daily usage
Gloves	949,690	-491,610	-2,574
Face masks	724,170	-239,422	-1,254
Eye protection (goggles, glasses and visors)	54,923	-98,692	-517
Aprons	249,600	-168,600	-883
Gowns	1,110	-4,700	-25
Coveralls	18,752	-570	-3
Alcohol hand sanitiser	7,006	-1,626	-9
Clinical waste bags	24,200	-1,850	-10
Body bags	1,104	-504	-3
Total	**2,030,555**	**-1,007,574**	**-5,275**

2.9 How Lincolnshire compares to the rest of the East Midlands and England

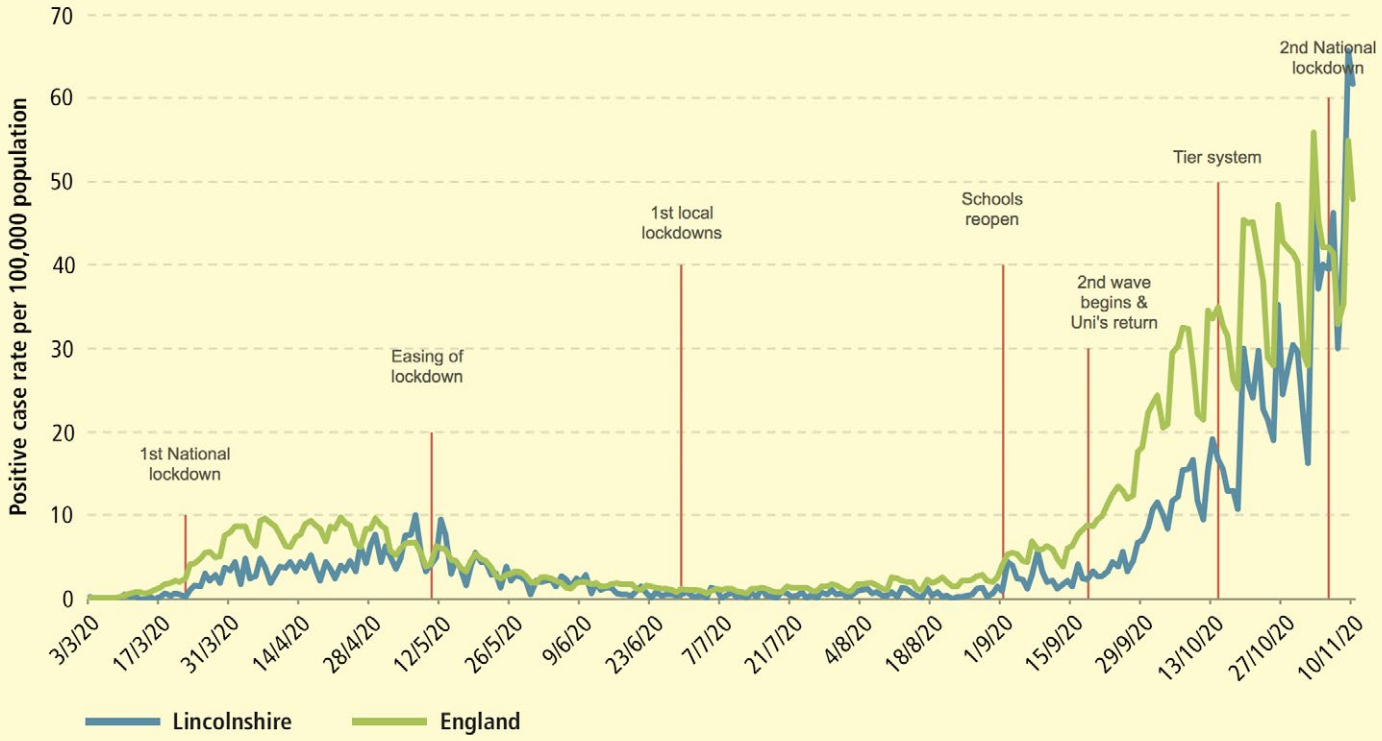
We need to be able to understand how we compare to other areas in the region and country. One measure that is frequently used and helps comparison is the rate of cases per 100,000 people over a 7 day period. We also have the rate of people over 60 years reported in a similar way as this helps comparison and tracking the pattern of the pandemic.

As of the 16 November 2020 there have been a total of 12,414 confirmed Covid-19 cases across Lincolnshire. There have been 116,548 in the East Midlands and 1,174,293 nationally. The first case was recorded on 30 January 2020 in England, 21 February 2020 in the East Midlands and on 3 March 2020 in Lincolnshire.

The rate of new cases in Lincolnshire has largely mirrored that of the national picture albeit with a one to two-week lag. Lincolnshire reached its first peak in cases during the weeks towards the end of April through to the start of May; reaching the highest daily confirmed cases of 76. As seen nationally, data quality issues were present at the beginning of the outbreak, however improvements have been continuously made over time which now makes it easier to inform local and national pictures with more confidence

On 10 May 2020 a conditional re-opening was introduced in the county. Again, Lincolnshire reflected the slowdown in daily confirmed cases seen elsewhere in the country between June through to the start of September, which coincided with a wider re-opening nationally on 4th July 2020. It was from this point onwards that the number of confirmed Covid-19 cases began to rise again which appeared to coincide with national easing of lockdown measures and schools reopening. Although daily cases have exceeded those of the first peak seen in April/May it should be noted that mass testing was introduced locally at the end of May; therefore making it much easier for the general public to access a test and resulting to a greater number of cases being identified. The dates are illustrated, along with the daily case rates (per 100,000 people) in Lincolnshire with a national comparison in Chart 9 overleaf.

Chart 9 – Daily cases per 100,000 population in Lincolnshire and England



3. Multi Agency Response to Covid-19 in Lincolnshire

3.1 Lincolnshire Resilience Forum (LRF)

The multi-agency Strategic Coordination Group (SCG), under the LRF was stood up in late January, and had its first precautionary meeting on 31st January 2020. This helped to provide leadership and co-ordination among all the partner organisations in providing a system-wide response to combatting the local infection. It helped to organise local testing centres, including mobile testing centres, support the most vulnerable during shielding, provide logistical support, assist with communications to the public, steer environment health and district activities, and provide an overall system response to local Covid-19 outbreaks. The SCG declared an emergency on 19th March 2020 and the county went into lockdown along with the rest of the UK on 24th March 2020. The restrictions helped in markedly reducing transmission of the disease. To support the emergency the LRF established several key support cells which had clear remits within the response. These cells included; a Community and Volunteer Cell which focussed on supporting those most vulnerable within the county, a Health and Care cell which had oversight of the health and care system as a whole, a Warn and Inform cell which assisted in supplying the public with key messages, and several others.

The Community and Volunteer Cell (CVC) of the Lincolnshire LRF has been operational since late March 2020. The cell continues to serve its role as a vital interface between the LRF, district councils, community and volunteer groups and the wider offer formulated by the Wellbeing Service, provided by Wellbeing Lincs, within the county. At the commencement of the pandemic, the core aim of the cell was to evaluate the community impact from the Covid-19 incident, including self-isolation and shielding, and coordinate and organise voluntary organisations, spontaneous volunteers and community assets and support. There is a plan in place to support them, which will be updated as new guidance become available.

As the epidemic began to reduce over the summer months the LRF formally stood down its emergency response, and the majority of organisations continued their work in supporting the epidemic as they normally would. However when cases began to rise again as the government lifted the lockdown restrictions and community interaction increased the LRF returned to its emergency response on the 28 September. The strength of this multi-agency response is one of the main driving forces in continuing to respond in a proactive and coordinated manner to the rising cases across Lincolnshire.

3.2 Legal and Regulatory Context

The Director of Public Health (DPH) retains primary responsibility for the health of their communities. This includes being assured that the arrangements to protect the health of the communities, which they serve, are robust and are implemented.

The existing legal responsibilities and powers for managing outbreaks of communicable disease, which present a risk to the health of the public, requiring urgent investigation and management sits:

- with Public Health England (PHE) under the National Health Service Act 2006 as amended by the Health and Social Care Act 2012;
- with the DPH under the National Health Service Act 2006 as amended by the Health and Social Care Act 2012;
- with the District Councils under the Public Health (Control of Disease) Act 1984 and Regulations made under it;
- with Magistrates' Courts under the Public Health (Control of Disease) Act 1984 and Regulations made under it;
- with NHS CCG to collaborate with DPH and PHE to take local action (e.g. testing and treating) to assist the management of outbreaks under the Health and Social Care Act 2012;
- with other responders specific responsibilities to respond to major incidents as part of the Civil Contingencies Act 2004, and;
- in the context of Covid-19, with the Secretary of State for Health and Social Care as part of the Coronavirus Act 2020.

- With Lincolnshire County Council under the Health Protection (Coronavirus, Restrictions) (England) (No 3) Regulations 2020.

This underpinning context gives local authorities (Public Health and Environmental Health) and PHE the primary responsibility for the delivery and management of outbreaks of infectious diseases.

On 14 July 2020, the wearing of face coverings became mandatory in all public indoor settings in England, the exception of work places and venues that serve food. This measure is in addition to government advice to:

- wash your hands;
- follow social distancing rules;
- work from home where you can effectively do so.

On 12 October 2020, the government introduced Covid Alert Levels in England as a way of controlling the spread of infection by imposing localised restrictions based on a three tier approach. The alert levels have been set at medium, high and very high.

In response to a sharp rise in Covid-19 case numbers across the whole of the UK and Europe, the government announced new national restrictions in England from 5 November 2020 until 2 December 2020. The measures are aimed at fighting the spread of the virus, protecting the NHS and saving lives. The restriction measures:

- Require people to stay at home, except for specific purposes.
- Prevents gathering with people from different households, except for specific purposes.
- Closes certain businesses and venues.

From 5 November, the national restrictions replace the local restrictions under the Covid Alert Levels. The new restrictions will apply nationally across England for four weeks. At the end of the period, the government is anticipating a return to localised Covid Alert Levels based on the latest data.

3.3 Local Outbreak Management Response

National guidance stresses the key role of local government in identifying and managing infections. The Contain Framework, issued by the government in July 2020, gives clear responsibility to upper tier local authorities to develop leadership and oversight to local plans and measures to contain the further spread of infection. In line with government requirements, Lincolnshire County Council published a local Covid-19 Outbreak Management Plan on 1 July 2020. The plan sets out the local outbreak management system.

Lincolnshire is unusual in the East Midlands in that it has its own well-established Health Protection Team (HPT). This is a small team within Public Health, which works closely with Lincolnshire CCG HPT, Public Health England East Midlands (PHEEM) and Environmental Health Officers (EHOs) in the district councils.

The primary objective in the management of an outbreak is to protect public health by identifying the source of an outbreak and implementing necessary control measures to prevent further spread or recurrence of the infection. This should be underpinned by a risk assessment, with regular re-assessment of the risk.

Since the beginning of the pandemic in late January, preventative public health messages have been widely pursued across our LRF partnership. These have sought to clarify and amplify national messages, ensure consistency across partners and build an early 'trusted voice' in local media. The public health messages include the following:

- Frequent hand washing and use of hand gels;
- Staying at home;
- Social distancing;
- Shielding of extremely vulnerable and other vulnerable people;
- Appropriate use of personal protective equipment (PPE).

Other preventative measures, which have been used to reduce transmission of the disease, are:

- early identification and appropriate management of outbreaks;
- early diagnosis and isolation of suspected and confirmed cases of Covid-19.

All districts have been carrying out functions to provide on the ground advice, guidance and support to businesses which can operate under the current restrictions. They have also been carrying out direct enforcement duties to follow up on complaints and, where necessary, will prevent premises from operating to prevent further spread of the disease.

The Outbreak Management Plan identifies high risk settings in the county in order to provide these settings with targeted advice to enable them to take steps to prevent infection and respond in the case of positive cases. This advice has been captured in a series of action cards, one for each of the high risk settings within Lincolnshire. These actions cards help in guiding the responses of individuals within the setting itself and the various professionals who may be called in to co-ordinate or take part in an outbreak response.

In accordance with good health protection practice the main emphasis of the response is to give advice and guidance to settings, thereby assisting them to help contain the outbreak. The aim is therefore to work through persuasion and co-operation in getting agreement to take voluntary actions necessary to prevent further spread of the infection. Where this is not possible and it is considered necessary to enforce the taking of necessary action, the Local Outbreak Engagement Board (LOEB) will consider recommending to one or more of the local agencies that they use any of the legal powers available to them to ensure action is taken. This will include the giving of Directions under the Health Protection (Coronavirus, Restrictions) (England) (No 3) Regulations 2020 and the making of applications to the Magistrates' Courts on an urgent basis to obtain necessary orders where appropriate.

3.4 Governance

3.4.1 Local Outbreak Engagement Board

The Lincolnshire Outbreak Engagement Board (LOEB) for Lincolnshire provides political ownership and governance for the local outbreak management response and to ensure consistent messaging with Lincolnshire's population by overseeing public facing engagement and communication. The LOEB discharges its responsibilities by means of recommendations to appropriate governance boards and relevant partner organisations. It provides progress reports and updates, as required, to the meeting of the Lincolnshire Council Leaders, including District Council leaders, Chief Executives and Police and Crime Commissioner. The LOEB is chaired by the Leader of LCC. Other members of the Board include District Councils Leaders, the Police and Crime Commissioner, NHS representatives from CCG and NHS providers, Healthwatch Lincolnshire and Greater Lincolnshire Local Enterprise Partnership

3.4.2 Covid-19 Health Protection Board

A Covid-19 Health Protection Board (HPB) for Lincolnshire is made up of senior officers from all relevant partner organisations and is chaired by the DPH. The Covid-19 HPB acts as the advisory board for the LOEB.

3.4.3 Outbreak Management & Contact Tracing Sub Cell

A Covid-19 outbreak management and contact tracing sub-cell has been set up under Lincolnshire LRF System Coordination Cell (SCC) to oversee the implementation of outbreak management plan; to develop setting-specific action plans and to develop the work plan and risk register. It is chaired by the Public Health lead for outbreak management and contact tracing, and its members are senior officers from relevant public sector organisations. It reports to the SCC Cell of the LRF and to the Covid-19 HPB.

4. Future Planning and Response

As the country sees a rise in the number of Covid-19 cases, Lincolnshire is also seeing a similar pattern. In early October we saw an increase in the number of cases detected each day across the western corridor of the county, primarily across the city of Lincoln, Gainsborough, and in the Kesteven areas. These increases have now also developed across the rest of Lincolnshire, with the current rate of positive cases (as of 16 November 2020) across the county now standing at 279.2 per 100,000 population (7-day average). The current rates per 100,000 population (7-day average) for each district (as of 16 November 2020) are:

- Boston – 383.4
- East Lindsey – 443.8
- City of Lincoln – 344.4
- North Kesteven – 249.8
- South Holland – 156.8
- South Kesteven – 167.1
- West Lindsey – 215.3

As the Covid-19 trend within Lincolnshire continues to rise several key pieces of work continue to be developed, as described below.

4.1 System Co-ordination Centre (SCC) Cell

As the Public Health response continued to develop and increase during September, a system co-ordination centre was developed as part of the LRF cell structure. The SCC has an operational level oversight of the response. This includes directing both the Council's and the LRF's responses to the rising case numbers, and liaising and coordinating with key stakeholders such as; the health protection team, district councils, PHE, communications, and the third sector, to ensure a system response is delivered accordingly. The SCC will ensure that as the pressure on the system increases into winter that resources from the Public Health division are diverted to the Covid-19 response as and where necessary.

4.2 Contact Tracing

The NHS Test and Trace system was launched in June 2020 and continues to have a positive affect across the county, achieving over an 80% success rate of following up positive cases. However with the likely increase in demand on this system in the coming weeks and months the Lincolnshire Public Health team, led by the SCC, have now begun to develop a local model to support the national NHS system. The local model will allow the Council to follow up cases that the national model is unable to track within 24 hours, and offer support and guidance with a local flavour where needed. This will allow the response to follow up outbreaks more proactively and provide advice and guidance in a more timely manner.

4.3 Testing Sites

To support the regional testing site at the Lincolnshire Showground, and in addition to the Pillar 1 testing programme, the Department for Health and Social care continue to offer testing provision through local testing sites. Lincolnshire currently has a local testing site which will remain in situ as a minimum for the following 6 months at the University of Lincoln, supporting access to Covid-19 testing where individuals from both the University and the local communities have symptoms and require a test. As of the 25 October approval for local testing sites in Grantham and Gainsborough has been received. Additional proposals for a site in Boston and one along the coast continue to be drawn up by the SCC and the appropriate district council.

The mobile testing units will continue to provide additional testing capacity across the county on a rotational basis, covering Skegness, Spalding, Grantham, and Boston. These test sites are currently testing on average approximately 14,000 people per week across Lincolnshire.

4.4 Covid-19 Vaccine

Advances within Lincolnshire nationally and globally continue to look positive in the development of a Covid-19 vaccine. Whilst there is no confirmed vaccine for the UK yet, all the signs remain positive that there may be a vaccine very late in 2020 or early 2021. Prioritisation of the vaccine has yet to be confirmed but it is looking very likely that this will be aimed at those most susceptible to the virus and key workers who support those with Covid-19. Lincolnshire is developing plans for a mass roll out of the vaccine to the wider population in the middle part of 2021.

4.5 NHS Services

From August 2020, the NHS issued guidance[2] asking local NHS systems to develop a detailed response on how NHS services would be restored. NHS Lincolnshire presented a report to the Lincolnshire Health and Wellbeing Board on 29 September 2020 on the arrangements being put in place for the county. Restoring NHS services as fully and as quickly as possible is a huge challenge to the NHS. There is a strong recognition that joint partnership working across local government, care homes, the voluntary sector, NHS and other partners will be essential. The restoration of services is being done against the backdrop of:

- continuing to manage the ongoing Covid-19 pandemic situation with partners
- anticipated increase in demand due to additional winter pressures
- EU exit arrangements which individually and collectively may present service capacity and supply chain challenges.

Emphasis for the Lincolnshire Health and Care system is:

- Delivering the enhanced flu vaccination campaign
- Ensuring arrangements are in place to deliver a Covid vaccination, when available
- Managing urgent and emergency care services
- Elective care recovery
- Cancer care recovery
- Restoration of all diagnostic services, and
- Primary care services being fully available.

2. NHSEI. Implementing phase 3 of the NHS response to the Covid-19 pandemic. Aug 2020 https://www.england.nhs.uk/publication/implementing-phase-3-of-the-nhs-response-to-the-Covid-19-pandemic/

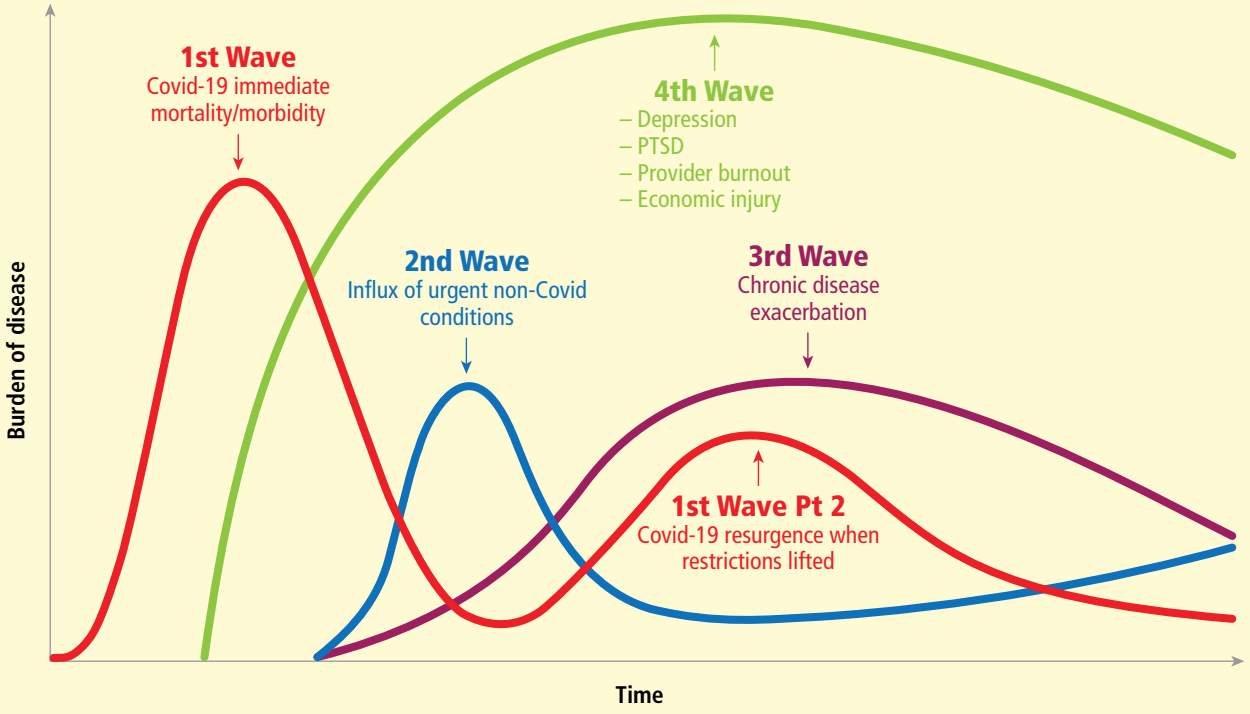
5. Longer Term Health and Wellbeing Implications of Covid-19

The Covid-19 pandemic continues to have a big impact on everyone's life. Restrictions on social interaction; local lockdown measures; loss of jobs and employment opportunities; and financial hardship are set to be in place for some time. Covid has exposed a number of inequalities in our society and the burden of the disease has not been felt evenly across our communities. The virus has had a disproportional impact on certain sections of the population, including those living in the most deprived neighbourhoods, people from Black, Asian and minority ethnic communities, older people, men and those who are obese or have a long term condition. A review by PHE[3] found that Covid-19 has replicated existing health inequalities and in some cases, increased them. This is supported by a survey undertaken by the NHS Confederation[4] which finds that the pandemic has exacerbated inequalities, disproportionately affected particular groups and exposed disparities in our communities.

The full impact of the disease is yet to be fully felt. The resilience of individuals, households and communities will influence their capacity and ability to recover as well as the length of time this will take. Figure 2 represents the impacts of the pandemic as a series of waves. The first wave is the immediate health impact of responding to the spread of the virus and the increase in deaths and long-term health conditions. The second and third wave is urgent non-Covid conditions and patients with exacerbated chronic disease, arising from the disruption of health and care services. The final wave is the wider burden on the health of individuals resulting from the Covid-19 restrictions and control measures. The lasting impact of Covid-19 will be increasing levels of depression, anxiety, isolation and loneliness coupled with poor economic and employment prospects[5].

Figure 2: Expected Covid-19 burden of disease over time

Credited to Tseng, Victor [@VectorSting]



3. Public Health England. Disparities in the risk and outcomes of Covid-19. August 2020 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/908434/Disparities_in_the_risk_and_outcomes_of_Covid_August_2020_update.pdf
4. NHS Confederation. Health Inequalities – Time to Act. September 2020 https://www.nhsconfed.org/resources/2020/09/health-inequalities-time-to-act
5. Health & Equity in Recovery Plans Working Group under the remit of the Champs Intelligence & Evidence Service. Direct and indirect impacts of Covid-19 on health and wellbeing. July 2020 https://www.ljmu.ac.uk/~/media/phi-reports/2020-07-direct-and-indirect-impacts-of-Covid19-on-health-and-wellbeing.pdf

In England and Wales, the majority of deaths involving Covid-19 have been among people aged 65 years and over *(Source: ONS)*. Across all age groups, males had a significantly higher rate of death due to Covid-19 than females; the age standardised mortality rate (ASMR) for males in England was 250.2 deaths per 100,000 males compared with 178.5 per 100,000 females *(Source: ONS)*. Provisional analysis by the ONS also shows the mortality rate for deaths was highest among males of Black ethnic background at 255.7 deaths per 100,000 population and lowest among males of White ethnic background at 87.0 deaths per 100,000 *(Source: ONS)*. The pattern for females is similar, with the highest rates among those of Black ethnic background (119.8) and lowest among those of White ethnic background (52.0).

Of the deaths that occurred between March and May 2020, 91% had at least one pre-existing condition, while 9% had none. The most common pre-existing conditions were dementia and Alzheimer disease; heart disease; diabetes and respiratory conditions. *(Source: ONS)*. In England, the age standardised mortality rate for deaths involving Covid-19 in the most deprived areas was 3.1 deaths per 100,000 population; this is more than double the mortality rate in the least deprived areas (1.4 deaths per 100,000 population) *(Source: ONS)*.

The redeployment of resources and staff during the first wave caused significant disruption to health and care services. The suspension of routine clinical care resulted in limited care for people with long term or chronic conditions and an increase in undiagnosed conditions. The impact of this is likely to be a surge in post Covid-19 morbidity. Estimates suggest the overall waiting list for treatment in England could increase from 4.2m (pre Covid-19) to over 10m by the end of 2020/21[6].

Many of the wider determinants of health; such as housing, employment, debt and personal relationships have an impact on an individual's overall wellbeing and their ability to deal with increasing levels of uncertainty. Analysis of mental health services suggests that during the peak of Covid-19 there was a 30 – 40% drop in mental health referrals[7]. Anecdotal evidence from providers suggests referrals to mental health services are now rapidly increasing and are likely to exceed pre Covid levels. Services are expecting to see:

- increasing demand from people who would have been referred to services if it were not for the pandemic;
- people needing more support due to the deterioration of their mental health during the pandemic;
- new demands from people needing support due to wider impacts such as self-isolation, increases in substance misuse and domestic abuse;
- a rise in the number of health and care workers needing support due to increasing levels of stress and staff burnout.

Shielding measures, in place for the most clinically extremely vulnerable during the first surge of infection between April to July, has caused the levels of loneliness and social isolation, and mental health issues to rise. Social distancing measures reduced the opportunity for people to socialise, connect with families, neighbours, or friends, and take part in physical activity, which we know are all conducive to good overall health. The Local Government Association[8] highlight loneliness and social isolation as a serious public health concern, referring to the fact that it leads to higher rates of premature mortality comparable to those associated with smoking and alcohol consumption. In Lincolnshire there has been a strong partnership response across local government with the voluntary and community sector to support vulnerable people.

6. Academy of Medical Sciences. Preparing for a challenging winter 2020/21. July 2020 https://acmedsci.ac.uk/file-download/51353957
7. NHS Confederation. Mental Health Services and Covid-19 – preparing for the rising tide. Aug 2020 https://www.nhsconfed.org/resources/2020/08/mental-health-services-and-Covid19-preparing-for-the-rising-tide
8. LGA. Loneliness, social isolation and Covid-19 – Practical advice. May 2020. https://www.local.gov.uk/loneliness-social-isolation-and-Covid-19-practical-advice

6. Conclusion

We have written this report in the middle of a global pandemic and it is likely that we will continue to face a number of challenges over the coming months before life can return to some form of normality. The figures, policy and guidance referenced in this report reflect the situation at the time of writing and we recognise that this information will be out of date by the time it is published. But it is important that we capture the current position and let the people of Lincolnshire know how partners are responding to the crisis. We have and will continue to communicate messages through TV, radio, newspaper interviews and through the county council's social media channels. For the most up to date data described in this report please look at the government website - https://coronavirus.data.gov.uk

We are continuing to deliver a multi-agency response in Lincolnshire. Working in partnership with our districts, NHS services, police and the voluntary and community sector has proven to be a particular strength in managing outbreaks. We are all focussed on keeping the people of Lincolnshire safe. We don't yet know what the medium and long terms impacts of Covid-19 will be on the county, but this is something we will be working on as we start to come out of the pandemic. Along with our partners, we will be doing everything we can to minimise the impact on the people of Lincolnshire.

We all have a role to play in helping to prevent the spread of the disease. Please look after yourselves, your loved ones and each other. And please remember:

Hands, Face, Space

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of John Turner, Chief Executive, NHS Lincolnshire Clinical Commissioning Group

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**9 March 2021**
Subject:	**Integrated Care System Update**

Summary:

Lincolnshire Integrated Care System (ICS) designation application

The NHS Long Term Plan published in 2019 set out an ambition for greater collaboration between partners in health and care systems to help accelerate progress in meeting the most critical health and care challenges – through the establishment of Integrated Care Systems (ICSs).

The NHS Long Term Plan set the target that by April 2021 ICSs will cover the whole country, growing out of the current network of Sustainability and Transformation Partnerships (STPs). This is still the expectation even though the focus of all health systems has been and still is on managing and responding to the coronavirus pandemic.

Since November 2020 the Lincolnshire STP has completed three rounds of designation application feedback with the NHSEI regional team, including a focused discussion at the NHSEI December System Quality Review Meeting (SQRM) with the Lincolnshire Chief Executives.

The initial focus of NHSEI in their feedback was on the proposed Lincolnshire ICS governance and partnership board arrangements, appointment of an independent chair and place-based arrangements. Latterly the focus of NHSEI has been on how becoming an ICS will support the Lincolnshire system to tackle its systemic challenges (finance and workforce in particular) and move out of special measures.

The final submission of the Lincolnshire ICS designation application to the NHSEI regional team was made on the 15 February, ahead of a submission nationally. It is anticipated Lincolnshire will receive ICS designation by April 2021.

Actions Required:

The Lincolnshire Health and Wellbeing Board is asked to note the content of this report and comment on the progress being made in Lincolnshire.

Background

Since 2016, health and care organisations have been working together in every part of England in sustainability and transformation partnerships (STPs). When these were established, they were described as a pragmatic way to join up planning and service delivery across historical divides: primary and specialist care, physical and mental health, health and social care. They were also identified as being able to help prioritise self-care and prevention so that people can live healthier and more independent daily lives.

In 2018 there was an evolution of STPs, when 14 Integrated Care Systems (ICSs) were agreed to accelerate the work started by STPs. The NHS Long-Term Plan published in 2019 confirmed that all STPs are expected to mature so that every part of England is covered by an integrated care system by 2021.

The NHS Long Term Plan described ICSs as being central to its delivery, as they would bring together local organisations to redesign care and improve population health, creating shared leadership and action. To support this process NHSEI developed a set of 'consistent operating arrangements for ICSs' that would be used to assess system maturity. These are set around the following three areas:

- System Functions;
- System Planning; and
- System Leadership and Governance

Current Position

At the start of 2020 the NHS in England faced, as did all health systems across the world, the greatest challenge it had ever done so in the coronavirus pandemic. As part of its response the NHS suspended business as usual activities and went into Emergency Preparedness, Resilience and Response (EPRR) mode.

Towards the back end of 2020 some 'business as usual' started to return, and as part of this the Lincolnshire STP was asked to submit a first draft of its ICS designation application in November 2020.

Since this first submission the Lincolnshire STP has completed three rounds of ICS designation application feedback with the NHSEI regional team, including a focused discussion at the NHSEI December System Quality Review Meeting (SQRM), meeting with the Lincolnshire Chief Executives (the Lincolnshire LA Chief Executive was also in attendance).

The initial focus of NHSEI on the Lincolnshire ICS application was on the proposed governance arrangements, specifically:

- The proposed partnership board arrangements – and that the partnership board arrangements for the Lincolnshire ICS would be aligned into the Lincolnshire Health and Wellbeing Board and how this would work in practice;
- Appointment of an independent chair – and some concerns that Lincolnshire was not looking to recruit a new independent Chair into the system; and
- Place-based arrangements – and the proposal that there would be one 'place' in Lincolnshire that would be coterminous in its boundary with the definition of the Lincolnshire Integrated Care System.

Having had a number of discussions with the NHSEI regional team on the proposed Lincolnshire ICS governance arrangements, including at NHS and LA Chief Executive level, a shared understanding and acceptance has emerged.

Conclusion

A shared understanding has been reached with NHSEI on the proposed governance arrangements for the Lincolnshire ICS. This includes recognition that once the future of putting ICSs on a statutory footing (as highlighted in the recent consultation document) has been confirmed in 2021/22 these will need to be reconsidered. The Lincolnshire ICS designation will reflect the work happening in the system to ensure a solid foundation for system working and recovery in the longer term.

The final submission of the Lincolnshire ICS designation application was made on the 15 February, it is anticipated designation will be received by April 2021.

Next steps

The NHSEI regional team will review all ICS submissions at an Executive Meeting on 22 February 2021. If supported a recommendation will be made to the National NHSEI executives to support the Lincolnshire ICS designation.

The national NHSEI team will review all ICS designations in March, the exact date is unknown.

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 Pete Burnett who can be contacted on 07814 515180 or peter.burnett4@nhs.net

This page is intentionally left blank

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

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

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**9 March 2021**
Subject:	**Suicide Prevention Strategy and Action Plan**

Summary:

This report informs the Lincolnshire Health and Wellbeing Board of the Suicide Prevention Strategy and Action Plan, and the progress being made towards the implementation of the Suicide Prevention Action Plan to date.

Actions Required:

Lincolnshire Health and Wellbeing Board is asked to:

- Note and discuss the contents of the report and the appendix
- Continue to support the work Public Health division are leading on for Suicide Prevention

1. Background

This report informs the Lincolnshire Health and Wellbeing Board of the Suicide Prevention Strategy and Action Plan, and the progress being made towards the implementation of suicide prevention action plan to date. The Adult Care Specialists Team lead on a number of workstreams that support the mental health agenda. However this report focuses on the area of work that the Public Health Division are leading on, which are the steps being taken to reduce the number of suicides among Lincolnshire residents.

The Suicide Prevention Strategy 2020/23 and Action Plan 2020/21 were published in October 2020 and can be found on the Lincolnshire Research Observatory. The Suicide Prevention Action Plan covers the period from October 2020 to September 2021.

The Strategy and Action Plan have been produced in collaboration with the Suicide Prevention Steering Group (SPSG), which is a system-wide, multi-agency partnership consisting of statutory and non-statutory organisations, which are interested in and are involved in reducing suicides among Lincolnshire residents. The Action Plan is currently being worked through with the SPSG members and the latest progress report can be found in Appendix A.

Progress on delivery of the suicide prevention action plan

- Under 1.1 of the action plan, an engagement session with people with lived experience, took place on Friday 8 January 2021 to obtain feedback around supporting males around mental health and suicide prevention. The feedback has been used to feed into the Community Suicide Prevention Innovation Fund Market engagement event on 12 January 2021
- Under 1.3 of the action plan, Lincolnshire County Council now has a contract with an organisation called Harmless/The Tomorrow Project to provide a low level Suicide Bereavement Support Service in Lincolnshire. The contract started on 21 December 2020 and lasts for 6 months until 21 June 2021
- Under 2.1 of the action plan, work is well underway to use the transformation funding from NHS England and Improvement to reduce male suicides and support males that self-harm. Engagement with people with lived experience has taken place to understand how males like to be helped and supported. The Community Suicide Prevention Innovation Fund has been confirmed and engagement with the market has taken place to make organisations aware of this funding and what the money can be spent on. There is a lot of interest in this funding within the community and it is positive that there will be further support out in the community for males to access in the new financial year
- Under 4.2 of the action plan, information on any deaths that are suspected suicides are sent through to Public Health Intelligence Team from Lincolnshire Police on a weekly basis and these are uploaded to a master database and mapped. However, due to resources being redeployed to Covid-19 work, this task is behind schedule and no detailed analysis has been conducted from the data received. We are exploring options for the Real Time Surveillance work to be managed by a third party.

Impact of Covid-19 on delivery of the action plan

Broadly the progress on the Action Plan has been good despite the pandemic. The majority of the actions are on track. The two actions, which are Red, are:

1.2. Identify/develop clear pathways of support for both individuals and professionals and
4.2. Develop Real Time Surveillance

Both of these actions have suffered from re-deployment of staff to Covid-19 response. Hence, their delivery dates need to be adjusted, and in the case of the latter, we are planning to contract it out for a short period of time.

The one action, which is **Yellow**, is:

4.1. Explore alternative data sources to gather intelligence to aid prevention of suicidal behaviours

This is due to current time commitment of Intelligence Teams across the system on Covid-19 response and as a result the delivery date may need to change.

2. Conclusion

Work around Suicide Prevention has been moving at pace during 2020 due to Covid-19 and the impact that this has had on the mental health of Lincolnshire residents. Lincolnshire is in a very good position moving forward, with different funding streams available for Lincolnshire to bid for as a system to support people with their mental wellbeing, which includes Suicide Prevention funding.

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

The Council and Clinical Commissioning Group must have regard to the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy. The Suicide Prevention work sits under the Mental Health (Adults) priority area of the Joint Health and Wellbeing Strategy. Within the action plan for the Mental Health (Adults), one of the key deliverables is to "Implement a Suicide Prevention Programme," this Strategy and Action Plan sets out the programme of work around Suicide Prevention. There is also a Joint Strategic Needs Assessment for Suicide, which depending on Covid-19, looking to start to review the topic from May/June 2021 and the new Strategy and Action Plan will be featured within the update.

4. Consultation

The Suicide Prevention Strategy and Action Plan has not undergone formal consultation; however it has been co-produced with partners across the system through the Suicide Prevention Steering Group (SPSG).

Since 12 February 2020, the draft Strategy has been going through the agreed governance route for sign off. Public Health colleagues have attended the following meetings and comments have been collated. Partners were asked to endorse the Strategy and agree to continue work on the Action Plan:

- Wednesday 12 February 2020 – Lincolnshire Corporate Leadership Team
- Tuesday 25 February 2020 – Mental Health, Learning Disabilities and Autism Board
- Monday 9 March 2020 – Lincolnshire Safeguarding Adults Board
- Thursday 12 March 2020 – Lincolnshire Safeguarding Children Partnership
- Wednesday 21 July 2020 – Lincolnshire Corporate Leadership Team

(Please note the Health and Wellbeing Board was due to take place on 24 March, however this was cancelled due to COVID-19 guidance).

5. Appendices

These are listed below and attached at the back of the report	
Appendix A	Suicide Prevention Action Plan 2020/21 Progress Report Oct 20-Jan 21

6. Background Papers

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

This report was written by Shabana Edinboro, who can be contacted on 07876 395710 or shabana.edinboro@lincolnshire.gov.uk

LINCOLNSHIRE'S SUICIDE PREVENTION ACTION PLAN 2020-2021

The Lincolnshire Suicide Prevention Action Plan has been developed to achieve the vision and priorities set within the Lincolnshire Suicide Prevention Strategy.

It is our intention to review this action plan at each Suicide Prevention Steering Group (SPSG).

The five priorities areas for this action plan stated within the Strategy are indicated below with clearly identified tasks for year one:

RAG Rating Key

	On Plan, no concerns
	On Plan, but concerns or behind plan and no concerns
	Behind plan and concerns

1. Develop a Core Local Offer

ID	Task	How will this be achieved?	Lead	Planned Completion Date	Progress To Date	RAG Rating
1.1	Ensure co-production with those with lived experience throughout the work around Suicide Prevention.	a) Those with lived experience are represented at the SPSG b) Regular engagement sessions are held with those with lived experience to ensure the action plan is updated to reflect the needs of those who need support	Public Health	December 2020	People with lived experience have been engaged with during the development of the Suicide Prevention Strategy and Action Plan. An engagement session with people with lived experience took place on Friday 8th January 2021 to obtain feedback around supporting males' mental health and suicide prevention. The feedback has been used to feed into the Community Suicide Prevention Innovation Fund that is available to community groups around the county to support male suicide prevention. The event was run by the SHINE Network	

					and Public Health	
1.2	Identify/develop clear pathways of support for both individuals and professionals.	a) Produce and publish a visual pathway to services with a "no wrong door" approach linking in with the Mental Health Hub b) Identify any gaps in services c) Promote helplines i.e. Samaritans; 101 d) Identify and promote apps and web-based support	Public Health	March 2021	The first Pathway Task and Finish group took place on 12th August 2020, which was very productive. As the conversation progressed it became clear that we have a lot of information already produced in different documents and formats and what we need to do is put the information into one document. Due to Public Health resources being redeployed to Covid-19 work, this task is behind schedule and will be delayed by two months. Public Health are aiming to have a draft pathway by May 2021.	
1.3	Identify support available for families and those bereaved by suicide	a) Map the current services available to those that have experienced bereavement by suicide including trauma support b) Develop clear pathways to these services c) Talk to those bereaved by Suicide and obtain feedback from their experiences and identify any gaps in provision d) Order and distribute "Help is	Public Health	May 2021	Under A and B, Public Health are in the process of mapping all the current services available to people in Lincolnshire, both locally and nationally around, generic bereavement support, suicide bereavement support and trauma support. Once gathered, this will be added to the Connect to Support website and developed into an electronic document that will be shared with all partners. All services will state the clear pathways and referral criteria. Under C, Public Health are exploring ways in which to conduct engagement with those that are bereaved through a suicide. Lincolnshire County Council Public	

		at Hand booklet" e) Explore options for commissioning a suicide bereavement support service for those bereaved through suicides			Health now have a contract with an organisation called Harmless/The Tomorrow Project to provide a low level Suicide Bereavement Support Service in Lincolnshire. The contract started 21st December 2020 for 6 months, until 21st June 2021. The following will be provided by Harmless: The aim of the service is to provide an initial Suicide Bereavement response to those bereaved by suicide. The Lincolnshire Coroner's Office, the Public Health Suicide Prevention Lead and Lincolnshire Police can refer into this service only, for those recently bereaved due to a death through a suicide. The service will provide a coordinated response for each deceased household, by offering the following support: 1.Provide initial contact within 72 hours of referral 2.Complete an assessment of need 3.Provide information, advise, guidance and sign-posting 4.Send the 'Help is at Hand' booklet to the primary member of the bereaved household (Supports part D of the task) Referrals can be made via Lincolnshire Police, the Lincolnshire Coroner's Office and Public Health only, as this is a temporary, low level support service. Under E, Public Health will start to explore options to commission a suicide	

					bereavement support service in April based on the Harmless/The Tomorrow Project contract. However funding from NHS England and Improvement for a Postvention service until 2022/23 in Lincolnshire.	

2. High Risk Groups

ID	Group	How will this be achieved?	Lead	Planned Completion Date	Progress To Date	RAG Rating
2.1	Males	a) Submit a bid to NHSE/I for Suicide Prevention Wave 3 money to support the work around males and suicide prevention b) Once funding has been secured develop an agreed approach to supporting males around suicide prevention	SHINE	February 2021	Task A is complete and funding secured. Lincolnshire were successful in securing Wave 3 Suicide Prevention funding of £151,000 each year for 3 years. This money will be spent on Males. SHINE are taking the lead on Task B. The following is an update on progress since last update: 1. Project Brief approved 2. Governance – Multi-Agency Project Board meetings held monthly to oversee development and delivery of projects. 3. Grant Agreement and associated papers approved 4. Recruitment process for SHINE staff - Project Manager interviews on 13 January & deploying resources to support project development and delivery working	

					with partner agencies through Development Consultant 5. Engagement with people with lived experience and organisations underway and will inform investment programme for the development of mutual support groups and awareness raising 6. Community Suicide Prevention Innovation Fund engagement has been started with the market and an event took place on 12th January 2021. A lot of interest of the funding in the community.	
2.2	People who self-harm	a) Develop an agreed approach to support people who self-harm b) Implement the "Self-harm and suicide prevention framework" created by Health Education England (HEE) and the National Collaborating Centre for Mental Health (NCCMH) c) Implement good practice based on NICE Guidance CG16 "Self-harm in over 8s: short-term management and prevention of recurrence" and NICE Guidance CG113 "Generalised anxiety	SPSG Task and Finish Group	May 2021	The SPSG Self-Harm Task and Finish group have met up three times and have outlined the work that is required under task 2.2. The draft approach will be ready for March and will be shared with the SPSG for comments.	

		disorder and panic disorder in adults: management "				
2.3	Support towards a safe, decent and secure environment for those in prison to reduce the risk of self-inflicted death amongst prisoners and reduce levels of self-harm in custody	a) Have a comprehensive suicide prevention protocol in place. This will include: - Implement effective screening for signs of increased risk self-harm or suicide, particularly during early days in custody, and ensuring interventions are in place to manage and reduce this risk - Providing prisoners with meaningful activities in line with their individual resettlement and criminogenic needs - Support prisoners to develop and maintain pro social support networks including family and community organisations - Ensuring prisoners live in a decent and clean environment -Implement a holistic safety framework for HMP Lincoln in line with national safety framework	HMP Lincoln	September 2021	The following is an update on progress to date: • Risk screening is undertaken via a combination of HMP reception protocols and locally commissioned and funded partnership screening with Lincolnshire Action Trust (LAT) called “SPARC+”. SPARC+ screens for signs of finances risk prior to arrival at HMP Lincoln in court custody suites and flags alerts to HMP Lincoln teams so that bespoke support can be given on arrival. This is further enhanced via an induction process (currently 14 days due to Covid-19 cohorting process) which supports those newly into custody in a separate environment and helps them adjust to custodial living/community • All prisoners are offered the opportunity to engage in meaningful activity in custody either in workshops or education. This is allocated as part of their pathway which is designed in consultation with their prison offender manager who manages there sentence plan • HMP Lincoln have in place a families and significant other strategy which set out the actions HMP/YOI Lincoln, and its partners will take to develop and build family	

					ties and support networks • HMP Lincoln delivers a clean environment despite a Victorian setting. This year the governor has secured additional £20m of funding to deliver decency improvement across the site from including heating, windows, showers, flooring etc. HMP and the regional director undertake regular decency checks and positive feedback is received from these sources and also from prisoners during annual measuring the quality of prisoner life (MPQL) survey • Local framework has been created and is undergoing consultation and competitive analysis prior to publishing. • Local framework for suicide and self-harm now in place and providing strategy delivery for HMP/YOI Lincoln • Due to national Covid pandemic (and local outbreak site during December) and HMPPS Covid control regime men in custody at HMP/YOI Lincoln are experiencing extended periods do in cell confinement to limit contact. To limit the effects of this confinement on wellbeing and anxiety related self-harm, HMP/YOI Lincoln has implemented a "1st time fix" programme to identify and resolve issues at the earliest opportunity.	

					• Activity packs have been created and are given to the men in custody on regular basis to provide in cell distraction activates • Virtual visits via “purple visits” has been implemented at HMP/YOI Lincoln to provide men with the opportunities to keep in contact with their families and support networks during Covid restrictions • Nottingham Healthcare trust (healthcare providers) have gained additional funding to operate a new self-harm pathway which focuses on those men who self-harm and ways to support them and reduce further self-harm taking place.	
2.4	Reduce suicides of mental health patients within both the community and in-patient settings supporting the zero suicide ambition	a) Work closely with Lincolnshire Partnership NHS Foundation Trust (LPFT). Follow LPFT Suicide Prevention Strategy to support them in: - delivering the LPFTs inpatient zero suicide ambition plan year on year aims developing and implementing an LPFT community	LPFT	March 2021	The Trust launched its 2020 – 2023 Suicide Prevention Strategy in September 2020 setting out its vision for patients and their families/carers who access our services. The Covid-19 pandemic has impacted on some progress of the Inpatient Zero Suicide Ambition Plan as resources needed to focus upon the resilience response. Due to this the Trusts Clinical Advisory Group agreed that the innovative work within the action plan be suspended whilst those actions which had been completed could become more embedded. There does not appear to have been an increase in suicide during the period March 2020 to October 2020 but the Trust remains alert particularly heading towards the	

		zero suicide ambition plan			winter months, on-going pandemic and increasing risk of recession. A key part of meeting the strategy is the development of a the strategy is the Community Zero Suicide Ambition Plan this important piece of work has been progressing with key stakeholders and it is anticipated that a final plan will be formulated during quarter 3 of 2020/21.	
2.5	Those suffering during the COVID-19 pandemic	a) Work with the relevant organisations that support the various groups of people being adversely affected by the COVID-19 pandemic	SPSG	Ongoing	No concerns to report at the moment. **Action:** All SPSG members to raise any concerns to Samantha Long MSO to Kakoli Choudhury or during SPSG meetings.	

3. Children and Young People

ID	Task	How will this be achieved?	Lead	Planned Completion Date	Progress To Date	RAG Rating
3.1	Promote positive mental health and emotional resilience	a) Work with schools, colleges and universities to raise awareness of mental ill health b) Training to early years providers, schools staff, colleges and future teachers/childcare providers on early warning signs,	Children Services/ Academies / Schools/ further and higher education	Ongoing Ongoing Operational from Jan 2021	The following is an update on progress to date for task a: • CAMHS, Healthy Minds Lincolnshire and MHSTs created online resources, videos and workshops to support CYP's emotional wellbeing and mental health concerns, parents/carers and professionals. • Resources available to schools via Kyra Teaching School – Mobilise Project	

		supporting and signposting of emotional/mental ill health and suicidal behaviours c) Mental Health Support in Schools roll-out in Lincoln and Gainsborough areas			• Partnership working with Lincoln University re. The Office for Students Project continues with both LCC and LPFT represented on the Steering Group. • Children's Commissioning Team in collaboration with CYP and other stakeholders developed the "Here to Help" pocket-sized information leaflet that gives information about CYPMH services including crisis. 6,000 leaflets were distributed to Lincolnshire secondary schools in September 2020. The following is an update on progress to date for task b: • Wellbeing for Education Return training which is DfE funded project in response to Covid-19 is being rolled out to all state-funded education settings which pupils aged 5 to 18 years, with on-going support for education settings up until end of March 2021. Healthy Minds Lincolnshire is acting as lead on behalf of the Council and training being delivered by Healthy Minds Lincolnshire in partnership with other key LCC and commissioned services. • Online workshops, resources and videos created by LPFT (CAMHS, Healthy Minds Lincolnshire and MHSTs) to support CYP's emotional wellbeing and mental health	

					concerns. Healthy Minds Lincolnshire utilising workshops and online resources to provide training to education staff on how to use these within their own settings. • Healthy Minds Lincolnshire dedicated professionals resource hub is also available. • Kyra Teaching School through Mobilise Project supporting the Recover Lincolnshire initiative, including Recovery Curriculum: Reconnection, Re-engagement and Re-set and Building Resilience. The following is an update on progress to date for task c: • MHSTs in Lincoln and Gainsborough continue to work towards becoming fully operational from January 2021. • Education Mental Health Practitioners (EMHPs) completed their training with Derby University at the end of December 2020, with results of final submissions pending (anticipated that outcome of final submissions will be known by March 2021) • Lincolnshire successful in a second bid for MHSTs in Boston and Skegness (and surrounding area). These teams commenced their induction with LPFT 4th January 2021 and will commence their training year with Derby University	

					from end of January/beginning of February 2021. Upon successful completion of training it is anticipated that teams will be fully operational from January 2022.	
3.2	Continue to provide and further improve the outstanding mental health support on offer in Lincolnshire	a) Effective contract management of the Healthy Minds Lincolnshire, Kooth online Counselling and CAMHS contracts b) Review of Healthy Minds Lincolnshire and other emotional/behavioural support commissioned by Lincolnshire County Council	Children's Services / LPFT	Ongoing December 2021	The following is an update on progress to date for task a: • Contract management of Services continues to take place. . The following is an update on progress to date for task b: • Review has continued during Covid-19 and is still on-going. Covid-19 has impacted on the timescales of the review and these are currently being revisited.	
3.3	Ensure effective response when children are in crisis	a) Develop more effective mental health risk identification across CAMHS and social care to prevent escalation to point of hospitalisation b) Work with regional and local partners on New Models of Care to provide 'hospital in the home' care to children instead of admission to out of county MH inpatient units c) Develop more responsive 24/7 crisis	Children's Services / CCGs / LPFT / Regional provider collaborative / NHSE	December 2020 March 2021 March 2022	The following is an update on progress to date for task a: • A more effective tracking spreadsheet is now in place that allows multi-agency discussion about CYP judged at risk of MH inpatient admission by CAMHS colleagues at the monthly joint Complex Case meetings. The next step is to refine and align this with Transforming Care dynamic risk assessment. The following is an update on progress to date for task b: • The Community Crisis and Enhanced Treatment Team is now fully operational and successfully	

		response for children as part of the local NHS five-year plan			supporting CYP with intensive treatment in the community to prevent inpatient admission for General Adolescent Unit (GAU) beds. CYP inpatient admissions remains low, they are also supporting eating disorder patients in the community who are recovering but still require nasogastric tube feeding. Continued monitoring of the implementation of these new arrangements is required as contractual responsibility changes from NHS England to the new Provider Collaborative model. The following is an update on progress to date for task c: • Complete. Through the implementation of the New Model of Care for CYP Tier 4 crisis and work around 24/7 telephone access in response to Covid, Lincolnshire has an effective and responsive crisis provision in place.	
3.4	Evaluate the impact of the new assessment form for young people in Lincolnshire Secure Unit that self-harm or are suicidal	a) Task How will this be achieved? Type of Engagement Lead Planned Completion Date b) Evaluate the impact of the new assessment form for young people in Lincolnshire Secure Unit that self-harm or are suicidal	Children Services	September 2021	The following is an update on progress to date: • All training completed for staff on the theories behind self-harm and suicide, along with how to complete the new 'Suicide and Self-Harm Keep Safe (yellow) assessment form'. An audit process of the assessment has been finalised. • Staff feedback on the training was	

		Ensure, following training, that the new assessment (yellow form) is used as required. c) Consistently review the use of the form and capture information and feedback for evaluation. d) Complete evaluation and identify any improvements. e) Make changes and improvements if needed based on lessons learnt.			positive, particularly the additional section for the teachers in school to complete. All further follow up actions complete. • Staff want to ensure the young person's voice is considered. A leaflet for young people has been produced to explain the new process and to assist their understanding of how they will be involved in decision making to keep them safe. • The new assessment has been undertaken on two young people. Both had the opportunity to feedback but declined. Further conversations with young people are taking place. • Engagement with school was positive. Agreement that young person should not being automatically excluded from lessons due to self-harm or suicidal thinking and that risk assessment should help inform what activities young people are able to take part in. • Care staff have been thinking more flexibly about helping young people create 'safer room environments' so that instead of removing items from rooms they can keep items that help them soothe. The healthcare team have also been creating self soothe boxes with young people.	

4. Intelligence

ID	Task	How will this be achieved?	Lead	Planned Completion Date	Progress To Date	RAG Rating
4.1	Explore alternative data sources to gather intelligence to aid prevention of suicidal behaviours	a) Set up Suicide Prevention Data Review sub group b) Determine the different types of data sources available including any interventions and attempted suicides	Public Health	March 2021	The first Data Task and Finish Group took place on 14th January 2021, were the group discussed the different types of data they collect and as a group will think about how this information can be used to support the suicide prevention work and will be discussed further at the next Task and Finish group meeting.	
4.2	Develop Real Time Surveillance	a) Conduct a pilot through Lincolnshire Police data b) Confirm final protocols and procedures based on the findings from the pilot c) Phased inclusion of data from additional sources with established information sharing agreements with each organisation i.e. EMAS, A&E, British Transport Police d) Use the intelligence to identify themes and where resources need to be targeted	Public Health	June 2021	The Real Time Surveillance (RTS) project has been up and running since January 2020 with Lincolnshire Police and has been going very well. Information on any deaths that are suspected suicides are sent through to Public Health from Lincolnshire Police on a weekly basis and uploaded to a master database and mapped. The information is then shared with Public Health Suicide Prevention leads. The RTS work will expand to other data sources and organisations in a planned way, yet to be determined by the Data Task and Finish Group. Due to Public Health resources being redeployed to Covid-19 work, this task is behind schedule and no detailed analysis has been conducted from the data received from Lincolnshire Police.	

					Public Health are exploring options for the RTS work to be managed by a third party.	

5. Awareness and Training

ID	Task	How will this be achieved?	Lead	Planned Completion Date	Progress To Date	RAG Rating
5.1	Develop a communications plan for suicide prevention in Lincolnshire	a) Produce a communications plan for Suicide Prevention in Lincolnshire b) Identify national suicide prevention campaigns i.e. Time to Change c) Agree campaign materials i.e. suicide SAFE material or national material	Public Health	February 2021	The Communication Plan has been drafted and will be discussed at the next SPSG on 3rd February 2021. Information and material already produced are being gathered and will be created into one document.	
5.2	Develop a Suicide Prevention Website	a) Work with Connect to Support Lincolnshire to create a Suicide Prevention website for all to recognise suicide signs and provide early intervention, prevention, support and signposting resources	SPSG Task and Finish Group	June 2021	Discussions have taken place with Connect to Support Lincolnshire who are happy to develop a dedicated page on Suicide Prevention. Reviews of other websites have been undertaken and material being gathered. This will be shared with the SPSG once recommendations have been made.	
5.3	Identify training available to recognise suicidal signs and provide early	a) Identify the training available, including online training b) Explore delivery options for provision of Suicide Prevention	Public Health	July 2021	The Zero Suicide Alliance (ZSA) provide access to a free online training resource which is accessible and useful for any member of the community. It can be accessed here: https://www.zerosuicidealliance.com/tr	

	intervention, prevention, support and signposting	and Intervention training c) Ensure this links with the countywide Mental Health workforce training programme			aining Covid-19 has prevented face to face training for several months and this looks set to continue into 2021. The ZSA training is online and the MHFA training will also be facilitated via an IT platform until such time as face to face training can safely resume. The roll out of Mental Health First Aid (MHFA) within the county has been affected by Covid-19 since March 2020. A very small number of courses have taken place with reduced numbers of delegates to ensure safety of all. Regrettably we are not undertaking any MHFA courses at the moment. However, during the past couple of months, the MHFA sub group of the MH Crisis Care Concordat put out an Expression of Interest within the county to current MHFA trainer organisations to seek interest to deliver an agreed number of course places to the health and care sector in Lincolnshire between now and June 2021. The contract has been awarded and an announcement will be made on who the successful provider is. With the support of LCC, an online booking and recording system will be used to enable accurate recording and	

					reporting of activity. The aim of the training is to maximise opportunity for individuals to receive this training and work with confidence within our community, addressing immediate MH needs of individuals, as well as supporting those in the workplace to identify and manage their own and others mental wellbeing. LPFT have also developed an in-house training package for clinicians that cover suicide and self-injury and this has begun to be delivered via TEAMS within the Trust, following a pilot programme within inpatient areas during 2020.	

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of the Lincolnshire Health and Care System

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**9 March 2021**
Subject:	**Reforming the Mental Health Act White Paper**

Summary:

This report presents a briefing paper which provides a summary of the Reforming the Mental Health Act White Paper and details of the consultation questions.

Actions Required:

The Lincolnshire Health and Wellbeing Board is asked to:

- Note the content of the briefing note and consultation questions in the attached Appendices 1 and 2.
- Note and approve the proposed system response to the consultation in Appendix 3.
- Consider if it has any feedback on the consultation questions that is wishes to be included in the final submission.

1. Background

Issued by the Department of Health and Social Care (DHSC) on 13 January 2021, the White Paper proposes a substantive programme of legislative reform to give people greater control over their treatment, and ensure they are treated with dignity and respect. It includes steps to improve how people with learning disability and autistic people are treated in law and reduce the reliance on specialist inpatient services for this group.
The White Paper responds to recommendations in the report of the Independent Review of the Mental Health Act.

It is arranged around three discrete parts:

- Part 1: proposals for reform of the Mental Health Act and the plans for legislative change.
- Part 2: proposals and ongoing work to reform policy and practice to support implementation of the new Mental Health Act to improve patient experience
- Part 3; the government's response to the recommendations made by the Independent Review of the Mental Health Act.

A summary of the White Paper is provided in the attached Appendix 1. The paper also includes a series of questions on the implementation and impact of the proposed reforms which the government is seeking views on (appendix 2). Feedback from the consultation will be used to inform the final drafting of the revised Mental Health Bill. The consultation period runs for 14 weeks and concludes on 21 April 2021.

As part of our system collaboration, it was agreed that key stakeholders would work together on a system response- as opposed to submitting (potentially conflicting) individual organisational responses. This is seen as an important reflection of how we are operating as an integrated health and care system.

Following a period of engagement led by Lincolnshire Partnership NHS Foundation Trust, Lincolnshire County Council and the NHS Lincolnshire Clinical Commissioning Group a proposed submission has been agreed and is included in Appendix 3. This engagement has had input from East Midlands Ambulance Service, Lincolnshire Police, primary care, third sector, voluntary and wider community services.

The paper being presented to the Health and Wellbeing Board before the close of the consultation period allows a window of opportunity for further input as well as an opportunity for formal approval of the submission.

2. Conclusion

The Mental Health Act white paper is an important and well overdue review of the legislation- with a key focus on improving the patient experience in each part of the pathway. Mental Health is a priority in the Lincolnshire's Joint Health and Wellbeing Strategy and a key area of focus in the NHS Long Term Plan. The proposals resonate with the Lincolnshire vision of integrated care close to home, ill health prevention through person centred care and health equality.

The system has responded swiftly and collegiately to agree a joint consultation response.

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

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

Relevant evidence from the JSNA has been used to inform the consultation response. Mental Health is a priority in the Joint Health and Wellbeing Strategy, and a key area of focus in the NHS Long Term Plan.

4. Consultation

The government is seeking views on the implementation and impact of the proposed reforms to inform the final drafting of the revised Mental Health Bill. The consultation period concludes on 21 April 2021.

The Lincolnshire Health and Wellbeing Board is requested to agree a system response to the consultation arrangements for responding to the consultation and who should be the SRO for the Council.

5. Appendices

These are listed below and attached at the back of the report	
Appendix 1	Briefing Paper
Appendix 2	Consultation Questions
Appendix 3	Proposed Lincolnshire Health and Care System Response – **TO FOLLOW**

6. Background Papers

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

This report was written by Sarah Connery, who can be contacted on (01522 307191) or sarah.connery@nhs.net.

BRIEFING PAPER
REFORMING THE MENTAL HEALTH ACT WHITE PAPER

INTRODUCTION

This briefing provides a summary of the key proposals outlined in the Reforming the Mental Health White Paper issued by the Department of Health and Social Care (DHSC) on 13 January 2021. The White Paper responds to recommendations in the Independent Review of the Mental Health Act.

The paper includes a series of questions (summarised in Appendix 2) on the implementation and impact of the proposed reforms which the government is seeking views on to inform the final drafting of the revised Mental Health Bill (consultation ends 21 April 2021).

PART 1: PROPOSALS FOR REFORM OF THE MENTAL HEALTH ACT

Part 1 sets out the changes the government plans to make to the MHA to ensure the legislation works better for people.

1. New Guiding Principles

The following principles will be introduced to drive a more person-centred system, in which choices made by patients have weight and influence, where care must have a therapeutic benefit for the patient, and where the powers of the act are only used when absolutely necessary. These principles will apply to all professionals involved in the care of people under the act and will be embedded into future revisions of the Act's Code of Practice.

- *Choice and autonomy* - ensuring service users' views and choices are respected and represented in advance and that they are involved in care and treatment plans and have enhanced opportunities to challenge treatment decisions.

- *Least restriction* – ensuring the Act's powers are used in the least restrictive way by strengthening and clarifying the criteria used to detain and treat an individual. Discharge planning will become a key part of care planning to ensure people are detained for the shortest possible time.

- *Therapeutic benefit* - ensuring patients are supported to get better and discharged as quickly as possible.

- *The person as an individual* – ensuring patients are viewed and treated as individuals with enhanced rights to Independent Mental Health Advocates and improved access, experience and outcomes for people from BAME backgrounds.

2. Clearer, Stronger Detention Criteria

Revisions are proposed to the detention criteria to ensure any detention only takes place when it is absolutely appropriate. The revised criteria is based on:

Therapeutic Benefit - greater emphasis to be given to if detention and interventions would be beneficial to a person's health and recovery as well consideration of the patient's

wishes and preferences. For a person to be detained under section 3 of the Act the following must be demonstrated:

- the purpose of care and treatment is to bring about a therapeutic benefit
- care and treatment cannot be delivered to the individual without their detention
- appropriate care and treatment is available

Discharge decisions should include an assessment about whether the hospital or an alternative community setting provides the most therapeutic package of care with the presumption that care should always be delivered in the least restrictive setting possible.

Substantial likelihood of significant harm - amendments are proposed to sections 2 and 3 of the Act, to stipulate that for someone to be detained the evidence must demonstrate that there is substantial likelihood of significant harm to the health, safety or welfare of the person, or the safety of any other person. New statutory Care and Treatment Plan will be required with the aim of improving transparency and to help tackle the culture of risk aversion.

3. Giving Patients More Rights to Challenge Detention

A review of the decision to detain a patient under section 3 of the Act should increase to three times within the first year – as opposed to the current two times.

Increased access to the MHT which provides independent scrutiny of detention decisions. For patients detained under:

- Section 2 will have 21 days instead of 14 days to appeal their detention.
- Section 3 will have 3 opportunities to appeal to the MHT in the first 12 months of detention, an increase from the current 2.

New statutory powers will be given to Independent Mental Health Advocates (IMHAs) to apply to the MHT to challenge a patient's detention on their behalf – this is in addition to the nominated person or nearest relative. Automatic referrals to the tribunal are also being considered. The MHT will review applications for discharge against the new detention criteria and new statutory care and treatment plan.

Automatic referral to tribunals when a Community Treatment Order (CTO) is revoked will be removed.

The role of the MHT will be extended to give it power to grant leave, transfer patients and to direct services in the community. New legislation will place an obligation on health and local authorities to take all reasonable steps to follow the MHT's decision. Hospital managers' panels for discharge case hearings will be removed and this function transferred to the MHT.

4. Strengthening the Patient's Right to Choose and Refuse Treatment

Patients will be given greater influence over decisions about their care and treatment – to include:

- *Advance Choice Documents (ACDs)* **-** these will enable people to set out in advance the care and treatment they would prefer, and any treatments they wish to refuse, in the event they are detained under the Act and lack the relevant capacity to express

their views at the time. It will be a legal requirement that ACDs are considered when a patient's care and treatment plan is developed.

- *Care and Treatment Plans* **-** these will set out the patient's care and treatment, including how this takes into consideration the wishes and preferences of the patient, and critically the rationale when a person's wishes have not been followed. Care and treatment plans will be a legal requirement for all patients, and there will be a legal time limit within which plans will need to be in place

- *Revised Part 4* **-** this will provide a new legal framework for consent to and refusal of medical treatment, setting out the process which must be followed to ensure wishes and preferences are taken into consideration, and limiting the circumstances where a patient's views, and treatment refusals, can be overruled.

- *Enhanced role of the MHT* **-** this will give patients a new route to challenge their treatment, where their choices have not been followed, by introducing a new role for the tribunal.

5. Improving the Support for People Who Are Detained

Nominated Person – a new statutory role called a 'Nominated Person' (NP) will replace the current 'Nearest Relative' (NR). They will have the same rights and powers to act in the best interests of the patient as NRs along with the following additional powers:

- have the right to be consulted on statutory care and treatment plans, to ensure they can provide information on the patient's wishes and preferences
- be consulted, rather than just notified, as is the case now, when it comes to transfers between hospitals, and renewals and extensions to the patient's detention or CTO
- be able to appeal clinical treatment decisions at the tribunal, if the patient lacks the relevant capacity to do so themselves and the appeal criteria are met
- have the power to object to the use of a CTO if it is in the best interests of the patient

People with the relevant capacity will have the right to opt out and not have a nominated person, if that is their preference. Young People aged 16 or 17 will have the same right to choose a NP as an adult.

The AMHP's power to apply to displace a nearest relative will be replaced by temporary overruling a nominated person's objection to admission. Considerations are being made to place the power to overrule or displace a nominated person with the tribunal rather than the County Court as it currently stands.

Advocacy – the current IMHA role will be expanded to include supporting patients to take part in care planning; helping individuals to prepare ACDs; power to challenge a particular treatment where they have a reason to believe it is not in the patient's best interest and power to appeal to the MHT on the patient's behalf.

Steps to improve the quality of advocacy services will be made through improved training that focuses on the legislation, supporting autistic patients and those with a learning disability and culturally appropriate advocacy for people from BAME backgrounds. Considerations are being made to professionalise the IMHA role.

6. Community Treatment Orders (CTOs)

CTOs will be reformed so that they can only be used where there is a strong justification, they are reviewed more frequently and by more professionals, are time limited, and that people subject to them really need them to receive a genuine therapeutic benefit. A new criteria for using CTOs will demand strong justification for their use, frequent reviews and by more professionals, time limited and that people subject to them really need them to receive a genuine therapeutic benefit.

In addition to the current AMHP and RC having responsibility to make a CTO, the community supervising clinician who will work with the patient in the community will need to be involved in decision making. CTOs will end after a period of 2 years unless the patient relapses or deteriorates during that period.

7. The Interface Between the Mental Health Act and the Mental Capacity Act

Deprivation of Liberty Safeguards (DoLS)/Liberty Protection Safeguards - currently, AMHPs may consider detaining individuals that lack capacity under the MHA or make them subject to DoLS. This is being revised to take account of the new Liberty Protection Safeguards (LPS). Where LPS provides a better alternative for the patient, it could streamline the process for example if arrangements for detention are mainly taking place in an NHS hospital, the hospital's Trust will be able to authorise deprivation of liberty under the LPS without any necessary involvement from a local authority. Considerations are being made to include options to consent to informal hospital admissions as part of advanced decisions.

Accident and Emergency (A&E) - the government intends to improve the powers available to health professionals in A&E departments so that individuals in need of urgent mental health care, stay on site, pending a clinical assessment. Currently, the police are used too often in these situations. LPS would enable A&E health professionals to deprive a person of their liberty and use holding powers to provide life-sustaining treatment or to prevent a serious deterioration in their condition only if they lack capacity and are over 16. Considerations are being made to extend holding powers under section 5 of the MHA for this purpose. Extending section 5 would provide hospitals with the power to hold a person with the relevant capacity, who wants to leave A&E.

8. Care for Patients in the Criminal Justice System

Reform to Part 3 of the Act - Part III of the act is guided by the principle that those who have committed a criminal offence should be able to access equivalent medical care and treatment to civil patients. That means that Part III patients will benefit equally from the majority of proposed reforms to the act – the following areas will differ:

- criteria for detention under the Act – where the proposal to apply the reformed criteria to part 3 patients, to ensure changing the threshold does not make it harder for those subject to the criminal justice system to access the care and treatment they need
- a nominated person for a part 3 patient will have limited powers
- tribunal powers, and automatic referrals to the tribunal – will differ
- changes proposed to the detention criteria for individuals with a learning disability and autistic people will not apply to part 3 patients

Secure transfers - to speed up transfer from prison or immigration removal centre (IRC) to mental health inpatient settings, a statutory 28-day time limit will be introduced, split into two sequential, statutory time limits of 14 days each. First from the point of initial referral to the first psychiatric assessment, and then from the first psychiatric assessment until the transfer takes place.

Views are being sought on where a new prison/IRC transfers and remissions co-ordinator role might sit. One option is to expand the remit of AMHPs. The preferred option is to create an entirely new role to sit in NHSEI or across NHSEI and HMPPs. This will be a designed role to manage the process of transferring people from prison/IMC to hospitals when they require inpatient treatment.

Consideration is also being given to the role of the IMHA and how best to provide advocacy support for individuals awaiting transfer.

Prison as a place of safety - viable alternatives are being explored to identify a timely pathway to transfer people directly from court to a healthcare setting where a mental health assessment and treatment can be provided.

Restricted patients – There is currently no effective legislative mechanism to continuously supervise restricted patients while taking care to safely manage the potential risk they may pose (violent, dangerous, or inappropriate sexual behaviour). The introduction of 'supervised discharge' is being proposed which would enable discharge of a restricted patient with conditions amounting to a deprivation of that person's liberty, in order to adequately and appropriately manage the risk they pose. Measures will also be put in place to address concerns that victims of unrestricted patients do not always receive timely, accurate information about key developments in the offender's case.

9. People with a Learning Disability and Autistic People

Reducing inappropriate admissions - the government wants to limit the scope to detain people with a learning disability (LD) or autistic people under the act. Revisions to the MHA will make it clear that for the purposes of the Act autism or a LD are not considered to be mental disorders warranting compulsory treatment under section 3. The changes would allow for the detention of people with LD and autistic people for assessment under section 2 when their behaviour is a substantial risk of significant harm to self or others (as for all detentions) and a probable mental health cause to that behaviour warrants assessment in hospital.

The assessment should seek to identify the driver of this behaviour. Detention under section 2 for assessment on the basis of distressed behaviour should only be considered after all alternatives to de-escalate have been considered.

Care (Education) and Treatment Reviews (CETRs) are expected to be carried out in advance of a detention. A new statutory requirement will be introduced for Responsible Clinicians to consider the findings and recommendations made as part of a CETRs in the patient's care and treatment plan.

Ensuring an adequate supply of community services - views are sought on the creation of new duties on local authorities and Clinical Commissioning Group commissioners to ensure an adequate supply of community services for people with LD and autistic people with the intention of reducing the use of and need for mental health inpatient services.

A new duty will also be placed on commissioners to ensure every local area understands and monitors the risk of crisis at an individual level on people with a LD and autistic people in the local population. The aim would be to enable better planning for provision and to avoid unnecessary admissions to inpatient settings.

Views are also sought on how pooled budgets for services with people with a LD and autistic people under Section 75 of the NHS Act 2006 could also be improved.

10. Children and Young People

The rights of children and young people will be strengthened to ensure they are involved in decisions about their care, can challenge decisions and ensure they are only detained for treatment in hospital when it is absolutely necessary. The proposed reforms to the children and young people service will be delivered through the NSH Long Term Plan:

- A full crisis care service by 2023/24 which will combine crisis assessment, brief response, and intensive home treatment functions. This will be available nationally on a 24/7 basis.
- A new approach to young adult mental health services for people aged 18-25 to support the transition to adulthood.

The legislative changes affecting adults – to have ACDs, care and treatment plans and to choose a NP – will also apply to children and young people detained under the Act. The requirement to have a care and treatment plan will become statutory for all children and young people receiving inpatient care.

The Mental Capacity Act Code of Practice will be improved to provide guidance on how practitioners assess competence. Including how the Mental Health Act can make it clear that the MCA should provide the only test of the capacity of 16- and 17-year olds. 16- and 17-year olds who lack capacity will not be admitted on the basis of parental consent. For under 16s, although the MCA does not apply to children under 16, the MCA's functional test will be used as a formal test to assess 'Gillick competence' to standardise the assessment and have clearer evidence.

11 The Experiences of People from BAME Backgrounds

To address inequalities, an enhanced patient voice, support by advocacy, coupled with a greater reliance on evidence, increased scrutiny of decisions and improved patient's right to challenge, are intended to address the disparity in outcomes, and in turn detentions. The Patient and Carer Race Equality Framework (PCREF) will support NHS mental healthcare providers and local authorities to improve access and engagement in the community. Advocacy will include culturally appropriate advocacy services.

The NHS Long Term Plan outlines the commitment to introduce new mental health transport vehicles to reduce inappropriate ambulance conveyance or conveyance by police. Police conveyance has been established to be associated with many tragic cases involving conveyance of black people.

PART 2: REFORMING POLICY AND PRACTICE AROUND THE NEW ACT TO IMPROVE PATIENT EXPERIENCE

Part 2 describes how the government and the NHS will work with partners to bring about an overall culture change within mental health services.

- ***NHS Long Term Plan (LTP)*** – includes 'radical transformation' of mental health services backed by an additional £2.3bn of new investment a year by 2023/24. A key ambition is to provide integrated models of mental health care across primary, community and secondary care services and to improve therapeutic services. It also seeks to reduce lengths of stay in all adult acute inpatient mental settings to 32 days or fewer by 2023/24.

- ***Quality improvement (QI) programme*** – to be led by NHSEI and HEE, the QI programme will support the system to address issues around quality, patient experience, leadership and culture.

- ***Suicide*** – the NHS LTP outlines how suicide reduction remains a high priority. The Mental Health Safety Improvement Programme will focus on reducing 'absent without leave' episodes, the risk of suicide of staff working within the healthcare system, and suicide in acute general hospitals.

- ***The physical ward environment*** – commitment to eradicate dormitory provision, ensuring every person admitted to a mental health hospital has the dignity and privacy of their own bedroom and en-suite.

- ***Role of the Care Quality Commission*** – over the next year the CQC will be working with services, families, staff and other stakeholders to improve the way they regulate services. This will include a commitment to change the methodology, updating internal guidance and inspection assessment frameworks, and to review how it assesses all wards in mental health and learning disability services. The CQC's monitoring role may also be extended to consider the effectiveness of local joint working by assessing how the Act and Code is working in local areas, rather than looking at services in isolation.

- ***Supporting people in the community*** – the focus will be shifted from reactive care to preventative measures and early intervention in the community The NHS Mental Health Implementation Plan 2019/20 to 2023/24 provides details on the commitment to expand services for people with severe mental illnesses, delivered through new models of integrated primary, secondary and social care, information about how funding will be spent.

- ***Care planning in the community*** – reviewing how existing care plans interlink to understand how any new statutory care plan could work in practice, while also conducting work to explore how we can ensure that quality of care planning is consistently high, with limited variation. This will include exploring what further information, guidance and support we can provide to commissioners on care planning and the practicalities and implications that placing care planning on a statutory footing would have on the workforce.

- ***Section 117 National Guidance*** – the guidance will be improved to provide greater clarity on how budgets and responsibilities should be shared to pay for section 117

aftercare. A clear statement will also be included in the new Code of Practice of the purpose and content of section 117 aftercare.

- ***Supporting people in a mental health crisis*** – emergency mental health services will be available for people when they need them, whether before or during a crisis to prevent detention under the Act. To support the Covid-19 response, NHSEI asked all areas to ensure urgent mental health advice and support is available to people of all ages through open access NHS 24/7 telephone help lines – this was in place by May 2020. The wider objective remains that by 2023 to 2024, the whole country will have crisis care support available at all times of the day and night, for people of all ages, fully accessible via NHS 111.

- ***Use of Police custody -*** Sections 135 and 136 of the Act will be updated to remove police stations as designated places of safety by 2023 to 2024 to ensure that people in a crisis are taken to a clinical environment. Funding is being considered to increase health based places of safety in areas that need them. A national agreement between mental health services, social care and the police will be established to ensure that people detained under section 136 are safely and effectively transferred into health services in a timely way.

- ***Ambulance conveyance*** – the LTP has a commitment to improve the capacity and capability of the ambulance service to meet mental health demand. Mental health professionals will deliver mental health specific initiatives and extra capacity in ambulance services, (integrated urgent care telephone triage control rooms training and education of ambulance staff).

- ***The mental health workforce*** – reviewing the national support requirements, including on training on the changes to the Act, and supporting meaningful co-production and the development of expert-by-experience leadership roles within providers and local systems.

  The level and staff skill mix on acute inpatient mental health wards will be improved through the development of new roles and by increasing access to multi-disciplinary staff groups such as peer support workers, psychologists, social workers, occupational therapists and other allied healthcare professionals. Additional workforce will be required: expanding role of responsible clinician, advocates, Approved Mental Health Professionals, second opinion appointed doctors and expansion of community mental health and crisis services. Training the future mental health workforce is being prioritised.

- **Improving staff morale -** Improving staff morale: additional support around wellbeing to help address the unprecedented challenges faced by professionals including pressures from Covid-19.

- ***Digital*** - The Mental Health (Hospital, Guardianship and Treatment) (England) (Amendment) Regulations 2020 in October 2020, which came into force on 1 December 2020, amended legislation to allow for the electronic communication of forms.

Appendix 2

Consultation Questions

We propose embedding the principles in the MHA and the MHA Code of Practice. Where else would you like to see the principles applied to ensure that they have an impact and are embedded in everyday practice?
We want to change the detention criteria so that detention must provide a therapeutic benefit to the individual. Do you agree or disagree with this proposal?
We also want to change the detention criteria so that an individual is only detained if there is a substantial likelihood of significant harm to the health, safety or welfare of the person or the safety of any other person. Do you agree or disagree with this change?
Do you agree or disagree with the proposed timetable for automatic referrals to the Mental Health Tribunal? (set out in Appendix B) I. Patients on a section 3 II. Patients on a community treatment order (CTO) III. Patients subject to Part III IV. Patients on a conditional discharge
We want to remove automatic referral to a tribunal received by service users when their community treatment order is revoked. Do you agree or disagree with this proposal?
We want to give the Mental Health Tribunal more power to grant leave, transfers and community services. We propose that health and local authorities should be given 5 weeks to deliver on direction by the Mental Health Tribunal. Do you agree or disagree that this is an appropriate amount to time?
Do you agree or disagree with the proposal to remove the role of the manager's panel in reviewing a patient's case for discharge from detention or a community treatment order?
Do you have any other suggestions for what should be included in a person's advance choice document?
Do you agree or disagree that the validity of an advance choice document should depend on whether the statements made in the document were made with capacity and apply to the treatment in question, as in the case under the Mental Health Capacity Act?
Do you have any other suggestions for what should be included in a person's care and treatment plans?
Do you agree or disagree that patients with capacity who are refusing treatment should have the right to have their wishes respected even if the treatment is considered immediately necessary to alleviate serious suffering?
Do you agree or disagree that in addition to the power to require the responsible clinician to reconsider treatment decisions, the Mental Health Tribunal judge (sitting alone) should also be able to order that a specific treatment is not given?
Do you agree or disagree with the proposed additional powers of the nominated person?
Do you agree or disagree that someone under the age of 16 should be able to choose a nominated person (including someone who does not have parental responsibility for them), where they have the ability to understand the decision (known as 'Gillick competence')?
Do you agree with the proposed additional powers of Independent Mental Health Advocates?
Do you agree or disagree that advocacy services could be improved by: I. Enhanced standards II. Regulation III. Enhanced accreditation IV. None of the above, but by other means
How should the legal framework define the dividing line between the Mental Health Act and the Mental Capacity Act so that patients may be subject to the powers which most appropriately meet their circumstances?
Do you agree or disagree that the right to give advance consent to informal admission to a mental health hospital should be set out in the MHA and the MHA code of practice to make clear the availability of this right to individuals?
We want to ensure that health professionals are able to temporarily hold individuals in A&E when they are in crisis and need a mental health assessment, but are trying to leave A&E. Do you think

amendments to section 4B of the Mental Capacity Act achieve this objective, or should we also extent section 5 of the MHA?
To speed up the transfer from prison or IRC to mental health inpatient settings, we want to introduce a 28-day time limit. Do any further safeguards need to be in place before we can implement a statutory time limit for secure transfer?
We want to establish a new designated role for a person to mange the process of transferring people from prison or an IRC to hospital when they require inpatient treatment for their mental health. Which of the following option is the most appropriate to achieve this? I. Expanding the existing approved mental health professional role in the community so they are responsible for managing prison/IRC transfers II. Creating a new role within NHSEI or across NHSEI and Her Majesty's Prison and Probation Service to manage the prison/IRC transfer process III. An alternative approach
Conditionally discharged patients are generally supervised in the community by a psychiatrist and a social supervisor. How do you think that the role of social supervisor could be strengthened?
For restricted patients who are no longer therapeutically benefiting from detention in hospital, but whose risk could only be managed safely in the community with continuous supervision, we think it should be possible to discharge these patients into the community with conditions that amount to a deprivation of liberty. Do you agree or disagree that this is the best way of enabling these patients to move from hospital into the community?
We propose that a 'supervised discharge' order for this group of patients would be subject to annual tribunal review. Do you agree or disagree with the proposed safeguard?
Beyond this, what further safeguards do you think are required?
Do you agree or disagree with the proposed reforms to the way the MHA applies to people with learning disability and autistic people?
Do you agree or disagree that the proposed reforms provide adequate safeguards for people with a learning disability and autistic people when they do not have a co-occurring mental health condition?
Do you expect that there would be unintended consequences of the proposals to reform the way the MHA applies to people with a learning disability and autistic people?
We think that the proposal to change the way that the MHA applies to people with a learning disability and autistic people should only affect civil patients and not those in the criminal justice system. Do you agree or disagree?
Do you expect that there would be unintended consequences on the criminal justice system as a result of our proposals to reform the way the MHA applies to people with a learning disability and to autistic people?
Do you agree or disagree that the proposal that recommendations of a CTR for a detained adult or of a CETR for a detained child should be formally incorporated into a care and treatment plan and responsible clinicians required to explain if recommendations aren't taken forward, will achieve the intended increase compliance with recommendations of a CETR?
We propose to create a new duty on local commissioners to ensure adequacy of supply of community services for people with a learning disability and autistic people. Do you agree or disagree with this?
We propose to supplement this with a further duty on commissioners that every local area should understand and monitor the risk of crisis at an individual-level for people with a learning disability and autistic people in the local population through the creation of a local 'at risk' or 'support' register. Do you agree or disagree with this?
What can be done to overcome any challenges around the use of pooled budgets and reporting on spend on services for people with a learning disability and autistic people?
How could the Care Quality Commission support the quality (including safety) of care by extending its monitoring powers?
In the impact assessment we have estimated likely costs and benefits of implementing the proposed changes to the Act. We would be grateful for any further data or evidence that you think would assist the departments in improving the methods used and the resulting estimates. We are interested in receiving numerical data, national and local analysis, case studies or qualitative accounts, etc that might inform what effect the proposals would have on the following: • Different professional groups in particular:

- how the proposals may affect the current workloads for clinical and non-clinical staff, IMHAs, approved mental health professionals, MHTs, SOAD etc
- whether the proposals are likely to have any other effects on specific interested groups that have not currently been considered

- Service users, their families and friends, in particular:
  - How the proposal may affect health outcomes
  - Ability to return to work or effects on any other daily activity
  - Whether the proposals are likely to have any other effects on specific interested groups that have not currently been considered
  - Any other impacts on the health and social care system and the justice system more broadly.

To follow

This page is intentionally left blank

Lincolnshire Partnership
NHS Foundation Trust

Mental Health Services in Lincolnshire

Sarah Connery

Acting Chief Executive

LPFT

9th March 2021

The people we serve

Lincolnshire Partnership
NHS Foundation Trust

50 sites

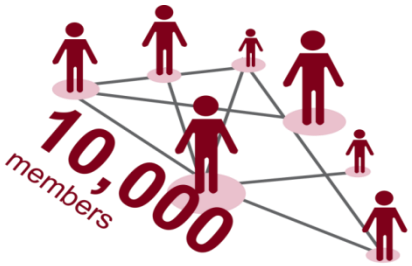
Community and hospital

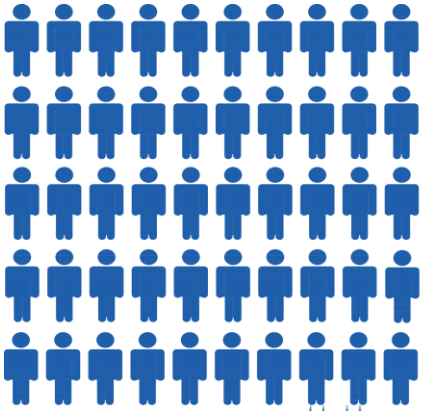
756,000
Lincs population

160,000
NE Lincs population

Ratings	
Overall trust quality rating	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Outstanding ☆

NHS
Lincolnshire Partnership
NHS Foundation Trust





360,000
appointments

50,000
Service users

2,500
staff

Supporting people to live well in their communities

Lincolnshire Partnership
NHS Foundation Trust

Our services

Adult inpatient and urgent care

- Acute inpatient
- Psychiatric intensive care
- Mental health rehabilitation
- Low secure forensic inpatient
- Crisis and home treatment
- Clinical decisions unit
- Police call centre
- Urgent response vehicle

Adult community

- Steps2change (improving access to psychological therapies)
- Community mental health
- Community forensic
- Psychological therapies
- Community Perinatal
- Early intervention in psychosis
- Veterans mental health
- Social care
- Personality and complex trauma
- Managed Care Network

Lincolnshire Partnership
NHS Foundation Trust

Our services

Specialist

- Children and adolescent community mental health
- Healthy Minds Lincolnshire
- Mental health support teams for schools
- Learning disabilities
- Autism assessment
- Eating disorders
- Sexual assault referral centre
- Dietetics
- Health services for Lincolnshire Secure Unit

Older People and Frailty

- Inpatient – cognitive and functional
- Community
- Mental health hospital liaison
- Neuropsychology
- Physical healthcare psychology
- Mental health home treatment
- Dementia home treatment
- Dementia support service

Our purpose & vision

NHS
Lincolnshire Partnership
NHS Foundation Trust

Our vision

To support people to live well in their communities

It starts with me...

Compassion
Acting with kindness

Pride
Being passionate about what we do

Integrity
Leading by example

Valuing everybody
Using an inclusive approach

Innovation
Aspiring for excellence in all we do

Collaboration
Listening to each other and working together

Covid Response

Lincolnshire Partnership
NHS Foundation Trust

mhm mentalhealthmatters

NHS

SUPPORTING YOU WITH YOUR MENTAL WELLBEING DURING COVID-19

The current pandemic is difficult for us all and more people may be experiencing stress, anxieties, or low mood and not know where to turn for support.

Below is a quick guide to some of the resources available in Lincolnshire to support people struggling with their mental wellbeing.

24/7 mental health helpline
Call 0800 001 4331
For people who are feeling low, anxious or stressed and think that talking to another person may help them cope. The mental health helpline in Lincolnshire is open 24/7. The team can also help signpost to other support where necessary.

Here4You advice line
For children, young people and their families
Call 01522 309120 (open 24/7)
The advice line offers support for young people's emotional wellbeing and mental health. It is available to children, young people, parents, carers and professionals in Lincolnshire. For more information about the Here4You advice line and children and young people's services visit www.lpft.nhs.uk/young-people/here4you
Self-help guides are also available at www.lpft.nhs.uk/young-people

steps2change talking therapies
Self-refer at www.steps2change.nhs.uk
Anyone over the age of 16 can self-refer or contact their GP for a referral to our steps2change talking therapies service. steps2change continue to offer telephone and video appointments, webinars, as well as a range of online and self-help therapies.

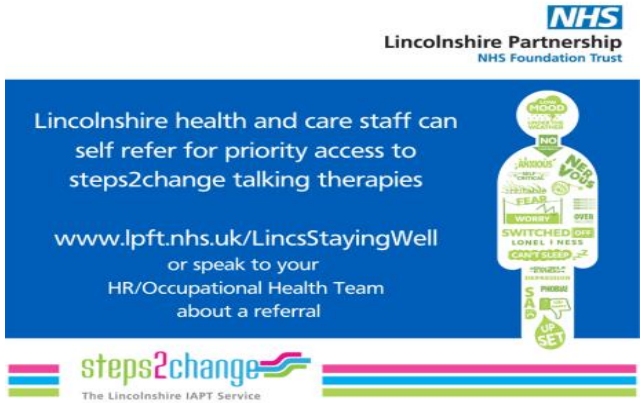
Lincolnshire's Recovery College
Join free educational courses on mental health and wellbeing
People over the age of 16 can access free educational courses on mental health and wellbeing through the Lincolnshire Recovery College. Their courses are designed and delivered by people with lived experience of mental ill health, qualified trainers and health professionals. Visit www.lpft.nhs.uk/recovery-college

www.lpft.nhs.uk

- Reduced capacity – teams innovated to deal with demand
- Safety the priority
- Digital first – not digital only approach
- 7 day community team working
- Performance maintained with focus on Out of Area impacts

Covid Response- Mutual Aid

Lincolnshire Partnership
NHS Foundation Trust



Supporting people to live well in their communities

Horizon Scan

Lincolnshire Partnership NHS Foundation Trust

- Increased demand driven by Covid
- Community Transformation- click to find out more Lincolnshire Community Mental Health Transformation on Vimeo
- Upskilling citizens, carers and other professionals- demystifying Mental Health
- Integrated placed based teams
- Population Health Management and Health Equality
- Eradicating Dormitory Wards
- Patient and Carer Experience- person centred and high quality

Lincolnshire Partnership
NHS Foundation Trust

Any questions?

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of Derek Ward, Director of Public Health, Lincolnshire County Council & John Turner, Chief Executive, NHS Lincolnshire Clinical Commissioning Group

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**9 March 2021**
Subject:	**Implementing a Population Health Management Approach in Lincolnshire**

Summary:
This paper is provided for information, and it updates on progress towards implementing a Population Health Management (PHM) approach in Lincolnshire

Actions Required:
To review the content of the report which provides background to the programme, governance arrangements, progress to date and workstreams over the coming months.

1. Background

1.1 Context

Health and care services are under unprecedented, unsustainable demand. With systems currently designed to treat, manage and care for those who become ill, pressures can only be addressed through prevention and intervention in the causes of ill-health, alongside improvements in effectiveness and efficiency of care pathways. There is a need to move to a system designed to enhance population health and tackle inequalities, optimising health over an individual's life span and across populations and generations.

Population Health Management (PHM) allows us to do this. It requires a shift in culture, alongside new processes, systems and intelligence. It also requires joint working, outside of health and care, for example with economic partners, district councils, communities, businesses, the voluntary sector and all those who influence the wider determinants of health. Tackling wider determinants and health inequalities, using epidemiology to inform decisions on need, supply and demand, quality, effectiveness and efficiency is the basis

of public health practice, and it is important that this area of expertise is engaged in the implementation of PHM across health and care systems.

Bringing the right people together to talk about their population, informed by intelligence, can only be achieved with the necessary infrastructure of data, systems and governance, but it will only be successful if the right culture is in place. As a result PHM needs to be embedded in all ICS plans at the core and a defined strategy to deliver PHM is a prerequisite for systems applying to become an ICS.

1.2 Benefits

At the programme level, PHM:

- Supports the development and use of appropriate, effective, transformative treatment and intervention.
- Facilitates individual and population prevention, and better targeting.
- Provides the intelligence to design new models of care to target the right conditions and risks, in the right way, at the right time.
- Evaluates pathways and services, to support effective joint commissioning, decommissioning and transformation.
- Drives major system change.
- Improves health outcomes and makes best use of collective resources.

At the individual level, PHM:

- Enables personalised care for those whose needs are not met by existing care models, for example due to issues of accessibility related to transport, financial exclusion, digital exclusion, work or caring responsibilities.
- Measures what matters to patients and considers individual desired outcomes when planning interventions.
- Allows identification of rising risk individuals for the provision of personalised support before the condition or incident presents, for example in falls prevention.
- Tackles issues of health inequality and service inequity to ensure that those most in need can access the prevention and treatment support that they need.

1.3 Enabling PHM Implementation

In areas that have successfully implemented PHM, engagement with the right stakeholders to build a robust infrastructure and to take the necessary actions has been important. During implementation this helps to identify the needs, systems, data and information assurance arrangements that exist, and those that are required. Early adopters and sector specialists such as the Kings Fund have identified the importance of Local Authority Public Health in the PHM agenda. Shared devolved budgets have also been important, allowing finance to be secured and ring-fenced, and the most appropriate, effective development, procurement and delivery routes to be accessed. We continue to work with a number of early adopters to support PHM development in Lincolnshire by sharing knowledge, frameworks and resources developed on their own implementation journeys.

The stages involved in full implementation include:

Leadership-Stakeholders:

- Identify key stakeholders and decision makers from across the system (eg representatives from public health, PCNs, CCG, providers (including 3rd sector), including commissioners, clinical leads & intelligence leads)
- Identify Support Organisations (eg for Lincolnshire, the Midlands Decision Support Unit)
- Form a PHM Board
- Create a shared drive, visions, goals and language
- Define a small scale project based on one geographic area and project focus as proof of concept

Information Assurance:

- Identify organisations which need to share data
- Create an IA Framework by identifying the legal basis and developing an overarching IA agreement and& privacy notice
- Establish relationships with the local Data Services for Commissioners Regional Offices (DSCRO) to navigate IA concerns, and engage with NHSD.

Systems:

- Identify and evaluate existing key systems and understand gaps
- Identify a preferred model for delivery and management of a joined IT platform and data warehouse which may include new development or procurement activity
- Develop common information and coding standards and shared, or fully interoperable, IT systems to support the real-time exchange of information throughout a person's health journey, for example including referral requests, delivered care and outcomes, social care assessments and discharge summaries
- Identify tools to support the analysis, interpretation and visualisation of intelligence

Intelligence:

- Identify key data resources from across the ICS, carry out data mapping and identify gaps in data resources and potential solution to fill these
- Data security- Identify how and when pseudonymised and identifiable approaches will be used, by whom and for what purposes
- Create data flows
- Develop a model for intelligence delivery and identify those who will carry out analysis, synthesis, interpretation and provision of intelligence, for example acting as an intelligence or decision making hub
- Create an analytics community- bringing together a wide range of analysts that begin to share learning and network, and identify training needs
- Develop an intelligence driven PHM model and metrics for modelling (both qualitative and quantitative) and to support impact measurement at population, clinical and patient level and in the short, medium and longer-term
- Mobilise and develop a culture of using intelligence to inform decisions on resource prioritisation, system planning and direct care, for example undertaking business intelligence workshops jointly with clinicians and analysts

Resources:

- Management, Leadership and governance
- Stakeholder Leads
- Communications and Engagement
- Intelligence and analytics
- Systems and support

- Information assurance
- Change management
- Personalised care leads and strategists
- A combined, devolved budget
- Identify relevant funding streams and secure funding

Risk management:

- Data protection impact assessment & Ethics assessment
- Equality impact assessment
- Financial impact assessment

1.4 Governance

Engagement of the right stakeholders in key decisions and direction throughout the programme is essential in building a robust infrastructure and making the cultural changes required. Stakeholders will evolve through implementation and into 'business as usual' operation, with initial engagement required from organisations across the ICS. As the programme moves to 'business as usual' operation, and begins to deliver new approaches to prevention, intervention, and treatment pathways, wider stakeholders must be engaged including, for example, district councils, economic partners, clinicians and the third sector. Decisions must be evidence-informed, in line with population health intelligence and public health practice.

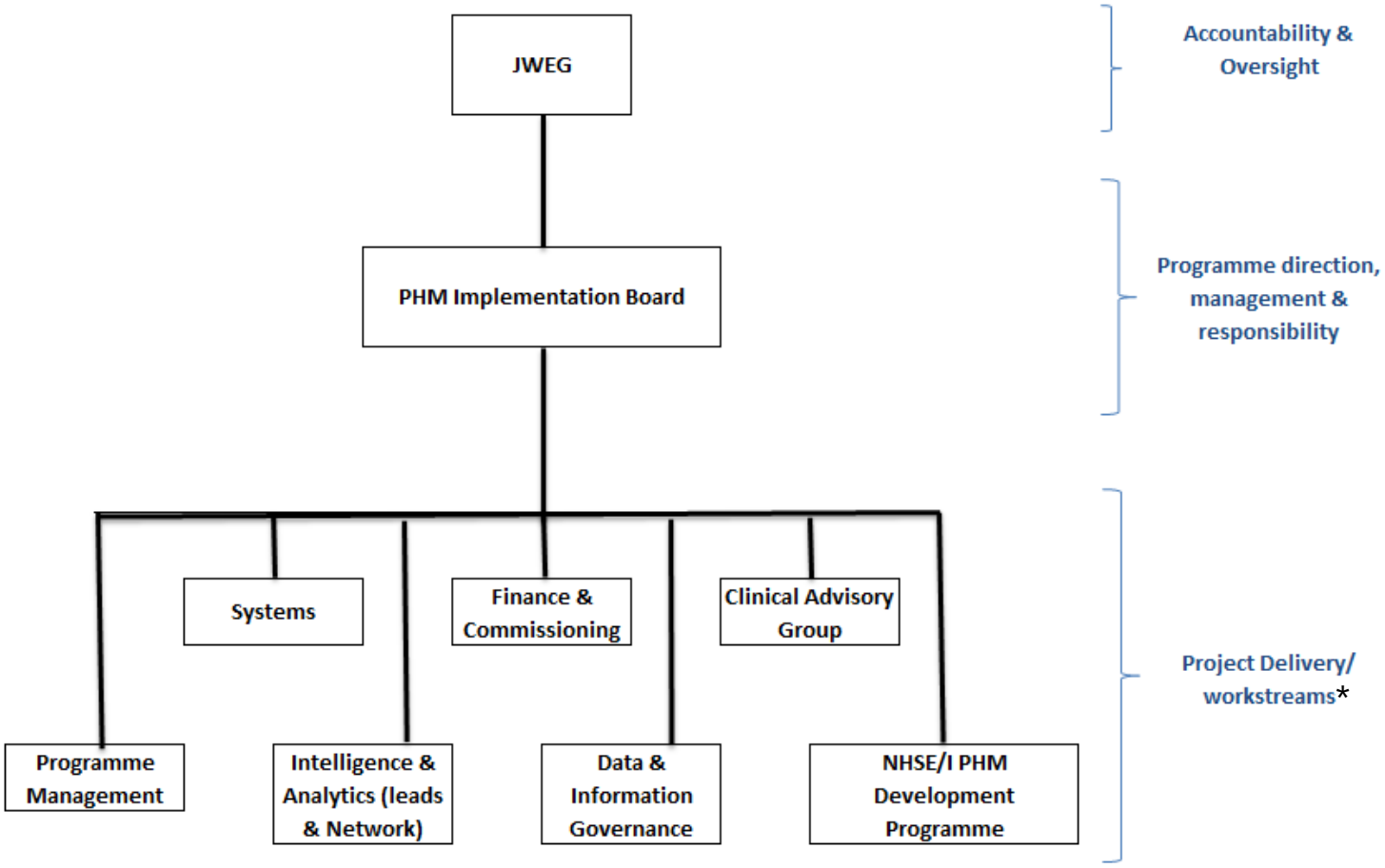
Lincolnshire's Joint Working Executive Group (JWEG) will provide accountability and oversight of PHM implementation at the current time, and Lincolnshire's Director of Public Health will be the lead officer for the programme. This will help to align PHM with the Long Term Plan (LTP) of the ICS and its programmes on health inequalities and personalisation, with public health evidence and practice.

The governance structure for implementation will be made up of project delivery working groups which report to a PHM Implementation board of ICS stakeholders, reporting periodically to JWEG. Project delivery working groups will evolve as required during implementation, often taking a 'task and finish' approach, however an example of potential groups is included in the figure 1, below. PHM Implementation Board core membership has been agreed as follows:

Senior Responsible Officer (Chair), Director of Public Health, Lincolnshire County Council	Derek Ward
Lincolnshire County Council Lead	Katy Thomas
Lincolnshire CCG & Finance lead	Matt Gaunt
ICS PHM lead	Vic Townshend
ICS Integrated Community Care lead	Sarah-Jane Mills
ICS Health Inequalities lead	Sandra Williamson
ICS Personalisation lead	Kirsteen Redmile
LCHS PHM lead	Sam Wilde
LPFT PHM lead	Jane Marshall
ULHT PHM lead	Mark Brassington
PCN lead	Martin Kay
Lincolnshire County Council Adult Social Care lead	Roz Cordy/Justin Hackney

The Implementation Board will also be attended by invitees from project delivery groups and deliver partners as implementation progresses, as required.

Figure 1: PHM Implementation Governance Structure:



** Example working groups, operating as required during implementation*

A number of project working groups are already in operation:

- Programme management meetings between the ICS lead, LCC lead and PHM Senior Project Officer are on-going on a fortnightly basis to coordinate all activity within the implementation programme.
- Similarly, the NHSE/I PHM Development Programme group meets fortnightly to manage all activity associated with this workstream.
- The Intelligence and Analytics Leads group is formed and soon to have its first meeting, after which it will meet regularly to coordinate our Analyst Network, PHM skills development and joint working.
- The Data and Information Governance group has also convened for the first time, concentrating initially on putting in place the IG framework required for the NHSE/I development programme to take place.

Programme governance requirements and Board membership will be reviewed regularly to enable a smooth transition between implementation and business as usual PHM delivery as the programme progresses.

1.5 Current Workstreams

Work in relation to PHM is currently taking place across a number of workstreams, including with the health inequalities programme, the care portal, modelling of outcomes from cancer pathways and joint work with economic colleagues and the Joint Biosecurity

Centre on the economic impact of Covid-19 on coastal tourist resorts and small and medium sized market towns. In relation to implementation specifically, work is taking place across three broad areas:

- *NHSE/I PHM Development Programme:*

We have successfully applied to wave 3 of the NHSE/I PHM development programme. This is an externally supported action learning programme, which will take place throughout 2021, working to link local data and build analytical skills, find rising risk cohorts, risk stratify backlogs, evaluate interventions and design and deliver new models of care. Five PCNs, covering communities across coastal, rural and urban areas of the county, have initially been engaged to take part in the programme, in the form of action learning sets. Through these, they will identify a cohort of patients to work with, engage with them to deliver interventions, gather patient stories, and share pseudonimised data. Readiness work has already begun, which will deliver some aspects of PHM implementation in areas such as engagement with primary care and putting in place the required information governance frameworks. The development programme will also deliver contracting and finance intelligence for Lincolnshire as a whole and help to put in place plans for sustaining momentum and progress after the programme has ended.

Whilst fairly narrow in terms of the wider intentions of PHM delivery, the Development Programme will help to engage primary care, facilitate IG and data sharing with primary care partners and deliver some immediate change in relation to treatment pathways within the NHS.

- *Midlands Decision Support Unit:*

Since late 2019, we have been engaged with the Midlands DSU. This facilitates networking with other areas in the process of PHM development, allows us to access support in implementing PHM and training opportunities for analysts across our system and to shape the Midlands DSU work programme. We have identified analysts across the Lincolnshire system and provided access to on-going, free, training opportunities at varying levels of time requirements from staff as well as networking and peer support opportunities. The Midlands DSU have released analytical outputs that support local work, including an analytical tool for modelling local mental health service demand following the pandemic, and the recent report by The Health Foundation on the impact of COVID-19 on spending requirements, which their contributed to.

We are currently working closely with the Midlands DSU, Midlands and Lancashire CSU and other ICSs in the Midlands to support our work around partnership development, finance, skills mapping and the development of our analyst network. Work with the Midlands DSU will help us to refine our intelligence model whilst bringing together analytical skills and resources and providing opportunities for skills development.

- *Parallel Work:*

In parallel with these areas of work there are a number of workstreams that must also take place. Our final PHM delivery model, IT systems, data linkages and financial models must be developed and agreed, and IG frameworks must be established with wider partners across health and care, and outside of it. As we move from implementation to business as usual delivery we need to engage wider stakeholders who can examine the resulting evidence, talk about the population of Lincolnshire, and make evidence informed decisions. This will include health and care system partners but also district councils, the voluntary sector, economic colleagues, the Greater Lincolnshire Local Enterprise

Partnership (GLLEP) and more. This will ensure that the programme can move from addressing some short term treatment pathway change within the NHS, to truly address prevention and early intervention through tackling the wider determinants of health and working jointly.

Programme plans will be kept under review to accommodate the pressures that partners are under in responding to the Covid-19 pandemic, and activities and joint progress will take into account the ability of partners to engage at various points in the programme.

2. Conclusion

PHM implementation is a vital and on-going programme of work, which the Board will receive regular updates on, as required throughout the programme.

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

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

The PHM Implementation programme will put in place the required PHM strategy and delivery model for Lincolnshire. This will add to the available evidence base of the JSNA, for example on pathway effectiveness for specific cohorts, service equity and health inequality, in ways that have never been possible before due to new system and data linkages. It will therefore also help the Board to deliver against the JHWS.

4. Consultation

Consultation has taken place with ICS partners via JWEG. No public consultation has been required in relation to PHM implementation itself.

5. Appendices

These are listed below and attached at the back of the report	
None.	

6. Background Papers

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

This report was written by Katy Thomas, who can be contacted at:
katy.thomas@lincolnshire.gov.uk

This page is intentionally left blank

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:	**9 March 2021**
Subject:	**Better Care Fund 2021/22**

Summary:
The report confirms the national requirements for the Better Care Fund (BCF) in 2021/22. Although the BCF policy statement 2021/22 has not been confirmed, there is an expectation of a further 12 months roll on with limited national planning assurance required. Funding levels for 2021/22 have been confirmed with direct awards at the same level and NHS contributions increased by 5.3%.

Actions Required:

For information.

1. Background

The Better Care Fund (BCF) is a programme spanning both the NHS and local government which seeks to join-up health and care services, so that people can manage their own health and wellbeing and live independently in their communities for as long as possible. The BCF has been created to improve the lives of some of the most vulnerable people in our society, placing them at the centre of their care and support, and providing them integrated health and social care services, resulting in an improved experience and better quality of life.

The BCF represents a unique collaboration between NHS England, the Ministry of Housing, Communities and Local Government (MHCLG), Department of Health and Social Care (DHSC) and the Local Government Association. Nationally the four partners

work closely together to help local areas plan and implement integrated health and social care services across England, in line with the vision outlined in the Long Term Plan.

Each year a Better Care Fund Policy Statement is released which confirms how local authorities and clinical commissioning groups should proceed with finalising plans and pooling agreements for funding under the BCF and sets out the national conditions for the Fund. Over the previous three years there has been continued national debate as to the future of the BCF, which will be addressed by a long term, multi-year spending review. For a multitude of reasons this has not happened yet and one year roll overs have been agreed in recognition of single year spending reviews.

National/regional assurance of local system plans have been proportionate, with the 2019/20 plans having a light touch regime and 2020/21 not having any NHSEI oversight or assurance. There is however a requirement for an end of year financial return, which will confirm the BCF conditions have been met. The HWB will be updated on the requirements for 2021/22 once the BCF policy statement for 2021/22 is released.

The BCF is specifically mentioned within the Government White Paper for NHS and social care reform released 11 February 2021. There are plans for a standalone legal basis for the Better Care Fund and the impact of this will need to reviewed once further information is made available.

The Lincolnshire BCF is often reported as a single value; however, comprises several sections of which some are statutory, and some are additional. In terms of the three minimum contributions:

- The Government have confirmed that the IBCF (improved better care fund) will have 0% uplift in 2021/22.
- The CCG contribution will increase on average by 5.3%. This will differ between individual CCGs but mirror their base budget increases in funding.
- The Disabled Facilities Grant (DFG) allocation has increased by 13.47% to £6.98m.

2. Conclusion

The BCF policy statement has yet to be published which will confirm the planning and reporting requirements for 2021/22. It has been confirmed that 2021/22 will be a further roll over of the existing BCF local plans and the financial settlements have been confirmed. There is an expectation that further work will be required in 2021/22 to produce a multi-year BCF plan once a long term spending review has been completed.

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

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

4. Consultation

None required.

5. Appendices

None provided.

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 Gareth Everton, Head of Integration and Transformation, who can be contacted on 07990 785126 or gareth.everton@lincolnshire.gov.uk

This page is intentionally left blank

Health and Wellbeing Board – Decisions from 9 June 2020

9 June 2020	**1**	**Election of Chairman** That Councillor Mrs S woolley be elected as the Chairman of the Lincolnshire Health and Wellbeing Board for 2020/21.
	2	**Election of Vice-Chairman** That John Turner be elected as the Vice-Chairman of the Lincolnshire Health and Wellbeing Board for 2020/21.
	5	**Minutes of the Lincolnshire Health and Wellbeing Board Meeting held on 4 February 2020** That the minutes of the Lincolnshire Health and Wellbeing Board meeting held on 4 February 2020 be agreed and signed by the Chairman as a correct record.
	6	**Action Updates** That the Action Updates presented in the report be noted.
	7	**Chairman's Announcements** That the Chairman's Announcements be received.
	8a	**NHS Lincolnshire CCG Update** That the update from the Chief Executive of Lincolnshire Clinical Commissioning Group be received.
	8b	**Healthwatch Lincolnshire COVID-19 Barometer Campaign** That the preliminary results of the first six weeks of the Barometer survey be received and that consideration be given by the Board to any impact to current Joint Health and Wellbeing Strategy priorities.
	9a	**Lincolnshire Health and Wellbeing Forward Plan** That the Lincolnshire Health and Wellbeing Board Forward Plan to December 2020 as presented be noted.
29 September 2020	**12**	**Minutes of the Lincolnshire Health and Wellbeing Board Meeting held on 9 June 2020** That the minutes of the Lincolnshire Health and Wellbeing Board meeting held on 9 June 2020 be agreed and signed by the Chairman as a correct record.
	13	**Action Updates** That the Action Updates presented in the report be noted.
	14	**Chairman's Announcements** That the Chairman's Announcements be received.
	15a	**Health and Wellbeing Board Review and Refocus** That agreement be given by the Lincolnshire Health and Wellbeing Board to: • Review the purpose, membership and priorities, as detailed in the report; • Receive a further report on the outcome of the review at the next meeting of the Board scheduled for 1 December 2020; • Make recommendations to Lincolnshire County Council on proposed changes to the Council's Constitution with regards to the Lincolnshire Health and Wellbeing Board.
	16a	**Covid-19 Update** That the verbal update from the Director of Public Health be received.

	16b	**NHS Lincolnshire Clinical Commissioning Group – Update on New Arrangements** That the update report concerning NHS Lincolnshire CCG – new arrangements as presented be noted.
	16c	**COVID-19- NHS recovery Planning** That the Covid-19-NHS recovery Planni8ng report as presented be received.
	16d	**Care Quality Commission (CQC) feedback on Provider Collaboration during the Pandemic** 1. That the Care Quality Commission Feedback on Provider Collaboration during the pandemic be received. 2. That support be given by the Board to the approach taken in working together across the health and care system in the county.
	16e	**Centre for Ageing Better – Rural Strategic Partnership** 1. That confirmation of the relationship between the Centre for Aging Better and Lincolnshire, including the proposed governance arrangements be noted. 2. That the vision and goals for the Partnership as detailed in the report presented be noted. 3. That the developing priorities as detailed in the report presented be noted. 4. That each constituent member organisation of the Board to seek formal commitment from their organisation to work together to achieve the aims of the Partnership.
	18	**Better Care Fund (BCF)** That the Better Care Fund (BCF) report presented be noted.
	19	**An Action Log of Previous Decisions** That the Action Log of previous decisions presented be noted.
	20	**Lincolnshire health and Wellbeing Board Forward Plan** That the Lincolnshire Health and Wellbeing Board Forward Plan up to 30 March 2021 as presented be noted.
1 December 2020	**23**	**Minutes of the LHWBB meeting held on 29 September 2020** That the minutes of the Lincolnshire Health and Wellbeing Board meeting held on 29 September 2020 be agreed and signed by the Chairman as a correct record.
	24	**Action Updates from the Previous Meeting** That the Action Updates presented be received.
	26a	**Health and Wellbeing Review – proposal to incorporate the functions of the anticipated Lincolnshire Integrated Care System Partnership Board** a. That the report presented be noted. b. That support be given to the proposal to align the functions of the anticipated ICSPB with the HWB. c. That officers develop revised terms of reference and for these to be presented to the Board meeting in March. d. That the comments raised by the Board on the proposed membership be taken into consideration.
	26b	**Lincolnshire Homes for Independence Blueprint** 1. That the Lincolnshire Homes for Independence Blueprint be

		endorsed. 2. That relevant partners be recommended to adopt the blueprint through the appropriate decision-making process for their organisation.
	27a	**Covid-19 Update** That the update be received.
	27b	**Social Prescribing** 1. That the progress made in social prescribing from both the original proof of concept and new funding streams, and to sign off completion of the proof of concept project be noted. 2. That the ambitions for the services/new national expectations against the current risks and mitigations as detailed in the report be received. 3. That the Board reviews what further support and influence the Board can provide across all organisations to further commit funding in order to mitigate short-term risks, as the Social Prescribing Link worker model grows in maturity, but also to review how as a system Lincolnshire supports community development initiatives to ensure there are services and activities available for Social Prescribing to refer to (particularly in light of the impact of Covid-19). 4. That future responsibility be delegated to the Personalisation Board to monitor further updates on this service and agree the Personalisation Board will in turn report by exception back to the Health and Wellbeing Board as required.
	28a	**An Action Log of previous decision** That the Action Log of Previous Decisions as presented be noted.
	28b	**Lincolnshire Health and wellbeing Board Forward Plan** 1. That the Lincolnshire Health and Wellbeing Board Forward Plan up to 7 December 2021 be received. 2. That an Extra-ordinary meeting of the Lincolnshire Health and Wellbeing Board be arranged for late January/early February 2021 to discuss the alignment of the HWB with the ICSPB.

This page is intentionally left blank

Lincolnshire Health and Wellbeing Board Forward Plan March 2021 to December 2021

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

09 March 2021, 2pm, TBC		
Item & Rationale	**Presenter/Contributor**	**Purpose**
Changes to the Health and Wellbeing Board Terms of Reference to include the functions of the Integrated Care System Partnership Board To receive a report from Cllr Woolley and John Turner asking the Board to confirm the changes to the Terms of Reference and recommend changes to the Council's Constitution to be formally agreed by full Council early in the new municipal year.	Cllr Woolley, Chair HWB & John Turner, Chief Executive NHS Lincolnshire CCG & Vice Chair HWB	Decision
COVID-19 Update To receive a verbal update on the current situation in Lincolnshire	Derek Ward, Director of Public Health and John Turner, Chief Executive NHS Lincolnshire CCG	Discussion & Information
Director of Public Health Annual Report 2020 To receive a report from Derek Ward on the Director of Public Health Annual Report. This is an independent assessment of health and wellbeing in Lincolnshire by the DPH. This year's report focuses on Covid-19 and the impact on the people of Lincolnshire.	Derek Ward Director of Public Health	Discussion
Integrated Care System Update To receive a report updating the Board on the development of Integrated Care Systems.	John Turner, Chief Executive NHS Lincolnshire CCG	Discussion
Suicide Prevention Strategy and Action Plan To receive a report on the Suicide Prevention Strategy and Action Plan and provide assurance on the work that is being done in Lincolnshire to prevent suicides.	Kakoli Choudhury, Consultant Public Health and Shabana Edinboro, Programme Manager	Discussion
System Response to the Reforming the Mental Health White Paper To receive a draft system response to the Reforming Mental Health White Paper consultation.	Glen Garrod, Executive Director and Sarah Connery, Interim CX LPFT	Discussion
Mental Health Services in Lincolnshire To receive a presentation from the Interim Chief Executive on the role and responsibilities of the Lincolnshire Partnership Foundation NHS Trust.	Sarah Connery, Interim CX LPFT	Discussion & Information
Better Care Fund update To receive an information report on behalf of the Executive Director for Adult Care and Community Wellbeing, on the BCF.	Gareth Everton Head of Integration and Transformation	Information
Population Health Management Governance To receive a report on behalf of the Population Health Management Implementation Board which provides details on the PHM work programme and governance.	Katy Thomas	Information

Lincolnshire Health and Wellbeing Board Forward Plan March 2021 to December 2021

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

8 June 2021, 2pm, TBC		
Item & Rationale	**Presenter/Contributor**	**Purpose**
Annual General Meeting – election of Chairman and Vice Chairman		
New look Joint Strategic Needs Assessment To receive an update from the Director of Public Health on the changes being made to the way the JSNA will be published	Alison Christie Programme Manager	Decision
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 2022	Alison Christie, Programme Manager on behalf of the PNA Steering Group	Decision
The importance of community beds in transitional care both for covid positive and covid negative patients and the positive impact these have on the acute hospital trusts *Detail to be confirmed*	Roz Cordy, Assistant Director and Tracy Perrett Head of Hospitals and Special Projects	Decision
Rural Proofing for Health Toolkit To receive a report on behalf of the Executive Director for Adult Care and Community Wellbeing on the Rural Proofing for Health Toolkit developed by Rural England. The toolkit has been created to help organisations working in the health and care sector address the needs of their local rural populations when they develop or review strategies, initiatives, or service plans.	Sean Johnson Programme Manager Public Health Division	Discussion
Better Care Fund update To receive an information report on behalf of the Executive Director for Adult Care and Community Wellbeing, on the BCF.	Gareth Everton Head of Integration and Transformation	Information

28 September 2021, 2pm, TBC		
Item & Rationale	**Presenter/Contributor**	**Purpose**
Lincolnshire Pharmaceutical Needs Assessment To receive a report on the PNA and agree the draft document for consultation	Alison Christie, Programme Manager on behalf of the PNA Steering Group	Decision
Better Care Fund update To receive an information report on behalf of the Executive Director for Adult Care and Community Wellbeing, on the BCF.	Gareth Everton Head of Integration and Transformation	Information

7 December 2021, 2pm, TBC		
Item & Rationale	**Presenter/Contributor**	**Purpose**
Lincolnshire Pharmaceutical Needs Assessment To receive a report on the outcome of the statutory consultation exercise	Alison Christie, Programme Manager on behalf of the PNA Steering Group	Decision
Better Care Fund update To receive an information report on behalf of the Executive Director for Adult Care and Community Wellbeing, on the BCF.	Gareth Everton Head of Integration and Transformation	Information

This page is intentionally left blank