County Offices
Newland
Lincoln
LN1 1YL

5 June 2023

Lincolnshire Health and Wellbeing Board

A meeting of the **Lincolnshire Health and Wellbeing Board** will be held on **Tuesday, 13 June 2023 at 2.00 pm in the Council Chamber, County Offices, Newland, Lincoln LN1 1YL** for the transaction of the business set out on the attached Agenda.

Yours sincerely

Debbie Barnes OBE
Chief Executive

MEMBERS OF THE BOARD (Voting):

Lincolnshire County Council: Councillors: Mrs S Woolley (Executive Councillor NHS Liaison, Integrated Care System, Registration and Coroners) (Chairman), Mrs W Bowkett (Executive Councillor Adult Care and Public Health), Mrs P A Bradwell OBE (Executive Councillor Children's Services, Community Safety, Procurement and Migration), W H Gray, R J Kendrick, C E H Marfleet and Mrs S Rawlins , 1 vacancy

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 Richard Wright

Lincolnshire Integrated Care Board: Sir Andrew Cash and John Turner (Vice-Chairman)

Healthwatch Lincolnshire: Dean Odell

Police and Crime Commissioner: Philip Clark

Lincolnshire Partnership Foundation NHS Trust: Kevin Lockyer and Sarah Connery

United Lincolnshire Hospitals NHS Trust: Elaine Baylis and Andrew Morgan

Lincolnshire Community Health Services NHS Trust: Elaine Baylis and Maz Fosh

Primary Care Network Alliance: Dr Kevin Thomas

ASSOCIATE MEMBERS (Non-Voting):
Julia Debenham, Lincolnshire Police
Professor Neal Juster, Higher Education Sector
Adrian Perks, NHS E/I
Emma Tatlow, Voluntary and Community Sector
Professor Neal Juster, Greater Lincolnshire Local Enterprise Partnership

LINCOLNSHIRE HEALTH AND WELLBEING BOARD AGENDA
TUESDAY, 13 JUNE 2023

8d	**NHS Joint Forward Plan** *(To receive a report from the NHS Lincolnshire Integrated Care Board, which asks the Board to consider whether the Joint Forward Plan takes proper account of the Joint Local Health and Wellbeing Strategy. Pete Burnett, Director of Strategic Planning, Integration and Partnerships will be in attendance for this item)*	95 - 100
9	**Information Items**	
9a	**Joint Local Health and Wellbeing Strategy Annual Assurance Reports** *(To receive a report from Derek Ward, Director of Public Health, which invites the Board to receive and comment on the information provided in the Joint Local Health and Wellbeing Strategy Annual Assurance Reports to assure progress is being made to improve health and wellbeing in Lincolnshire. Alison Christie, Programme Manager will be in attendance for this item)*	101 - 166
9b	**Evaluation of the Integrated Lifestyle Service, 'One You Lincolnshire'** *(To receive a report from Derek Ward, Director of Public Health, which provides the Board with information on the evaluation of the Integrated Lifestyle Service, 'One You Lincolnshire'. Andy Fox, Consultant Public Health will be in attendance for this item)*	167 - 264
9c	**An Action Log of Previous Decisions** *(For the Board to note decisions taken since 14 June 2022)*	265 - 268
9d	**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 13 June 2023 to 11 June 2024)*	269 - 272

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

- Business of the meeting
- Any special arrangements

Contact details set out above.

Please note: This meeting will be broadcast live on the internet and access can be sought by accessing Agenda for Lincolnshire Health and Wellbeing Board on Tuesday, 13th June, 2023, 2.00 pm (moderngov.co.uk)

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

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LINCOLNSHIRE HEALTH AND WELLBEING BOARD
28 MARCH 2023

PRESENT: COUNCILLOR MRS S WOOLLEY (CHAIRMAN)

Lincolnshire County Council: Councillors Mrs W Bowkett (Executive Councillor Adult Care and Public Health), Mrs P A Bradwell OBE (Executive Councillor Children's Services, Community Safety, Procurement and Migration), W H Gray and Mrs S Rawlins.

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 Richard Wright.

Lincolnshire Integrated Care Board: John Turner (Vice-Chairman).

Healthwatch Lincolnshire: Dean Odell.

Lincolnshire Partnership Foundation NHS Trust: Kevin Lockyer.

United Lincolnshire Hospitals NHS Trust: Andrew Morgan.

Associate Members (non-voting): Julia Debenham (Lincolnshire Police), Emma Tatlow (Voluntary and Community Sector) and Pat Doody (Greater Lincolnshire Local Enterprise Partnership).

Officers In Attendance: : Michelle Andrews (Assistant Director – ICS), Peter Burnett (Director of Strategic Planning, Integration and Partnerships, NHS Integrated Care Board), Alison Christie (Programme Manager, Strategy and Development), Katrina Cope (Senior Democratic Services Officer) (Democratic Services), Andy Fox (Public Health Consultant), Nikita Lord (Programme Manager – Better Care Fund) and Phil Huntley (Head of Public Health Intelligence).

26 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

Apologies for absence were received from Councillor R J Kendrick, Elaine Baylis (Chair, United Lincolnshire Hospitals NHS Trust and Lincolnshire Community Health Service NHS Trust), Sir Andrew Cash (Chair, Lincolnshire Integrated Care Board), Sarah Connery (Chief Executive, Lincolnshire Partnership Foundation NHS Trust), Maz Fosh (Chief Executive, Lincolnshire Community Health Service NHS Trust), and Philip Clark (on behalf of the Police and Crime Commissioner).

27 DECLARATIONS OF MEMBERS' INTEREST

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

28 MINUTES OF THE HEALTH AND WELLBEING BOARD MEETING HELD ON 6 DECEMBER 2023

RESOLVED

That the minutes of the Lincolnshire Health and Wellbeing Board meeting held on 6 December 2022 be agreed and signed by the Chairman as a correct record.

29 ACTION UPDATES

RESOLVED

That the Action Updates presented be received.

30 CHAIRMAN'S ANNOUNCEMENTS

The Chairman advised that the Local Government Association in conjunction with the NHS were currently conducting some 'dummy runs' regarding the new Care Quality Commission (CQC) inspection regime for Adult Social Care. It was noted that the Chairman had been involved in some such tests, which had proven useful in being able to see what was happening in other parts of the country, and for sharing good practice.

RESOLVED

That the Chairman's announcements presented be noted.

31 DECISION ITEM

31a Joint Strategic Needs Assessment for Lincolnshire

Consideration was given to a report on behalf of the Director of Public Health, which asked the Board to approve the Joint Strategic Needs Assessment (JSNA), prior to its publication on 31 March 2023.

The Chairman invited Phil Huntley, Head of Public Health Intelligence to present the item to the Board.

In a short presentation, reference was made to: the background for the JSNA, and the legal requirement to have a JSNA; the life course approach taken regarding the JSNA factsheet, which were Start Well, Live Well, and Age Well; examples of the type of information that

would be available on the Lincolnshire Health Intelligence Hub, along with what else was new which included the provision of a JSNA glossary, FAQ's and the JSNA in picture format.

The Board was reminded that the JSNA was not a static document and was continually being updated and that any input was welcomed, as everyone had collective responsibility.

The Head of Public Health Intelligence extended his thanks to all Public Health Staff involved in creating the new JSNA for Lincolnshire.

During consideration of this item, the following points were noted:

- Confirmation was given that data would be reviewed by topic experts, and would also be reviewed as part of a rolling programme;
- It was noted that once approved the link would be made available to the Lincolnshire Health Intelligence Hub;
- It was noted that the working age group 16 - 64 was specific for that group and was nationally reported. It was reported that the working age definition was set by the Office for National Statistics, and it was recognised that people worked beyond that age;
- Confirmation was given that community and voluntary sectors would be included in the Communication plan; and
- It was reported that the JSNA did not refer to project authors, contact would be made via a contact email group. Officers agreed to also consider including a contact telephone number.

The Chairman on behalf of the Board extended thanks to officers for all their hard work in creating the new JSNA.

RESOLVED

1. That the new Joint Strategic Needs Assessment (JSNA) for Lincolnshire be approved and adopted.

2. That confirmation be given to the new JSNA being used as the evidence base to inform the refresh of the Joint Health and Wellbeing Strategy.

32 DISCUSSION ITEMS

32a The Director of Public Health's Annual Report 2022 - The Diverse Communities of Greater Lincolnshire

The Board considered the annual report from the Director of Public Health, which was the first annual report for the whole of Greater Lincolnshire. The report highlighted the diverse

communities of Greater Lincolnshire and the significant challenges that it posed in preventing ill health and improving life expectancy.

Appendix A to the report was a copy of the Director of Public Health Annual Report for 2022 for the Board to consider.

The Chairman invited Derek Ward, Director of Public Health, to present his report. The Board noted that the four dominant 'types' of community in Greater Lincolnshire had been identified which were urban centre, urban industrial, coastal community and rural market towns. It was noted that whilst each community faced its own challenges to different health outcomes, there were commonalities of challenge.

During consideration of this item, the following comments were noted:

- That information was available at district level and could be broken down against each of the four identified communities, and that this information could be shared with district councils;
- Confirmation was given that the report was being publicised wherever it was thought best for the public document to be shared;
- It was reported that as no-one else was using the methodology adopted by the council, and that similar information could be used to compare against;
- That links to the Crime and Disorder Partnership were very important and the Director of Public Health offered to provide a presentation to the team at Lincolnshire Police;
- The benefits of the coast and the countryside on the wellbeing of individuals; and
- The Director for Public Health confirmed that the public report was able to help other decisions makers.

RESOLVED

That the Director of Public Health's Annual Report – The Diverse Communities of Greater Lincolnshire be received and noted.

32b NHS Joint Forward Plan

Consideration was given to a report from the NHS Lincolnshire Integrated Care Board, which set out the process for finalising the Joint Forward Plan, and the statutory role of the Health and Wellbeing Board to provide assurance that the Plan took account of the Joint Health and Wellbeing Strategy.

The Chairman invited Pete Burnett, Director of Strategic Planning, Integration and Partnership to present the report to the Board.

In guiding the Board through the report, reference was made to: the background behind the First Joint Plan (JFP); the requirements of the JFP; NHS England guidance and the three

principles of the JFP, and its function; the relationship between the NHS Lincolnshire JFP and Lincolnshire's HWB and ICP; and an overview of the approach to developing Lincolnshire's NHS JFP.

Appendix A to the report provided a copy of the Lincolnshire NHS Strategy 5 Year Plan – Communications and Engagements Activity Report for the Board to consider.

In conclusion, the Board noted that following the second workshop in April 2023, the JFP would be developed sufficiently to allow targeted public engagement activity to be undertaken ahead of the JFP being presented to the Health and Wellbeing Board at its 13 June 2023 meeting.

During consideration of this item, the following comments were noted:

- To ensure an inclusive and co-produced approach to develop the JFP, a Steering Group had been established with membership from the Integrated Care Board (ICB), NHS Partners, LCC Healthwatch and residents. It was noted that a significant amount of engagement had been carried out at the start of the process, details of which were contained within Appendix A to the report;
- Confirmation was given that Lincolnshire's outputs for residents had been captured and would continue to be captured;
- To make sure that the direction of travel and the five-year JFP worked together, balancing expectations and local need;
- That with all services working together would ensure that the JFP would come together and be realised; and
- That primary care needed to provide more care and support in the community. This would then remove some of the pressure on Urgent and Emergency Care.

RESOLVED

1. That the current position and the requirement for the NHS to develop a Joint Forward Plan be noted.

2. That the requirement to involve the Health and Wellbeing Board (HWB) in preparing or revising the JFP be noted.
3. That the need to share a draft with the HWB, and consulting with the HWB on whether the JFP takes proper account of each relevant joint local health and wellbeing strategy be noted.

32c Healthy Weight Priority Update

The Board considered a report from the Healthy Weight Partnership, which provided a summary of the activity and work in progress for the healthy weight priority in the Joint Health and Wellbeing Strategy.

Appendix A provided a copy of the Terms of Reference for the Healthy Weight Partnership for the Board to consider.

The Chairman invited Andy Fox, Consultant Public Health to present the item to the Board.

In guiding the Board through the report, reference was made to: Healthy Weight Programme focus prior to Covid-19; Lincolnshire's Joint Strategic Needs Assessment theme on healthy weight; the Child & Family Weight Management Service; and the Healthy Weight Partnership Group Actions from 23 February 2023.

RESOLVED

That the contents of the report presented and partners contributions to the work of the Healthy Weight Partnership be noted.

32d Let's Move Lincolnshire - Physical Activity Priority Update

The Board considered a report from Active Lincolnshire, which provided an update on Let's Move Lincolnshire, the physical activity priority of the Joint Health and Wellbeing Strategy.

The Chairman invited Emma Tatlow, Chief Executive Active Lincolnshire to present the item to the Board.

Reference was made to: the national alignment with local need across the six strands; progress made across the six strands; and future priorities.

In conclusion, it was noted that there was a commitment to collaboration across the system, and that the long-term outcomes of the work being carried out would have a significant impact on the health and care sector and pressures on the system, and the health and wellbeing of the population. It was highlighted that there was requirement for a long-term vision to bring about systematic change, enabling residents to live more active lives whilst retaining an agile and flexible approach responding to local need and changing circumstances.

It was agreed that the request for a representative on Let's Move Lincolnshire Executive Committee would be dealt with outside of the meeting, to enable a representative with relevant expertise to be sought.

RESOLVED

1. That support be given to advocate for and support the embedding of the Let's Move Lincolnshire Strategy.

2. That support be given to Active Lincolnshire to encourage all organisations to embed physical activity at system level in relevant policies, contracts, commissions, planning and decisions.

3. That recognition be given that capacity, collaboration, and future investment across the system is needed to support the on-going implementation of the Let's Move Lincolnshire Strategy.

33 INFORMATION ITEMS

33a The Lincolnshire Better Care Fund 2023/24 and update on the Discharge Fund

Consideration was given to a report from Glen Garrod, Executive Director – Adult Care and Community Wellbeing, which provided the Board with an update on the Better Care Fund (BCF), the Discharge Fund and the Quarter 4 BCF performance report.

The Chairman invited Glen Garrod, Executive Director – Adult Care and Community Wellbeing to present the item to the Board.

The Executive Director extended his thanks to Nikita Lord, Programme Manager for the BCF for all her hard work and support and wished her well in her new role.

The Board noted that the BCF Framework for 2023/24 and 2024/25 had not yet been published. It was noted that the BCF Policy Framework would confirm the funding and conditions for 2023/25 and the planning and reporting requirements for 2023/24. It was noted further that the framework to be announced covered a two-year period (as opposed to the more familiar one-year roll-forward) and would allow for slightly more strategic planning across the system. Details of the anticipated two key priorities and four national conditions from the BCF Framework were shown on page 80 of the report pack.

The Board was updated on the eight schemes receiving discharge funding, details of which were shown on page 81 of the report pack. It was noted that overall, all schemes had progressed well within the short four-month timeframe.

It was noted further that a full spend report on the Discharge Fund would be included in the year end BCF submission which was due to be submitted in May 2023.

Appendix A provided a copy of the Quarter 4 BCF performance report for the Board to note.

RESOLVED

1. That the update provided on the Better Care Fund be noted.

2. That the update provided on the Discharge Fund be noted.

3. That the Quarter 4 performance attached at Appendix A to the report be noted.

34 AN ACTION LOG OF PREVIOUS DECISIONS

RESOLVED

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

35 LINCOLNSHIRE HEALTH AND WELLBEING BOARD FORWARD PLAN

The Chairman invited members of the Board to contact either Alison Christie, Programme Manager or Michelle Andrews, Assistant Director ICS if they had any items they wished to be included in the Health and Wellbeing Board Forward Plan.

RESOLVED

That the Lincolnshire Health and Wellbeing Board Forward Plan as presented be noted.

The meeting closed at 4.11 pm

Meeting Date	Minute No	Agenda Item & Action Required	Update and Action Taken
14 .06.22	**8b**	**Better Care Fund Final Report 2021/22** That a excel copy of the Spreadsheet would be circulated to members after the meeting	A copy of the excel spreadsheet was sent out to all members of the HWB on 20 June 2022.
17.09.22	**16b**	**Better Care Fund report 2022/23** Before the next BCF cycle a development session should be arranged to allow for a more comprehensive look into the workings of the BCF.	A BCF briefing was held on 6 December 2022, prior to the HWB meeting at 2pm.
06.12.22		**No Actions**	
28.03.23		**Lincolnshire Health and Wellbeing Board Forward Plan** Members of the Board were invited to contact either Alison Christie, Programme Manager or Michelle Andrews, Assistant Director ICS if they had any items they wished to be included in the Health and Wellbeing Board Forward Plan.	Updated Forward Plan presented at each meeting.

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LINCOLNSHIRE HEALTH AND WELLBEING BOARD – 13 JUNE 2023
CHAIRMAN'S ANNOUNCEMENTS

Achieving Smokefree 2030 – cutting smoking and stopping underage vaping

In April, the government announced plans to make the country smokefree by 2030. It includes the following measures:

- A 'swap to stop' scheme to encourage smokers to make the switch to vaping by providing starter vape kits and behavioural support.
- Financial incentives for pregnant smokers who quit. The initiative will also include vouchers along with behavioural support to assist in a stop smoking attempt.
- A new 'illicit vapes enforcement squad' which will be backed by £3 million of government funding with the intention of enforcing the rules on vaping and tackling illegal sales. The enforcement squad will be led by Trading Standards and will work across the country undertaking projects such as test purchasing and powers to remove illegal products.

The announcement also included a call for evidence on youth vaping to look at ways to reduce the number of children (people aged under 18) accessing and using vape products. The open consultation closed on 6 June 2023.

Lincolnshire County Council submitted a response giving details of the collaboration between Lincolnshire Public Health and Children's Services to deliver health improvement initiatives in schools linked to smoking and vaping.

Major Conditions Strategy – Call for Evidence

On 17 May 2023, the government announced a call for evidence on how best to prevent, diagnose, treat and manage 6 major conditions to inform the development of a major conditions strategy. The six major health conditions are cancer, cardiovascular disease including stroke and diabetes, chronic respiratory diseases, dementia, mental ill health, and musculoskeletal disorders. Recognising the pressure these conditions are putting on the NHS, the government is seeking views on a new strategy to tackle which will focus not only on treatments but also on prevention.

The call for evidence is open for 6 weeks and closes on 27 June 2023.

Adult Social Care Reform

On 4 April 2023, the government published, 'Next steps to put people at the heart of care'. This plan follows the December 2021 White Paper, 'People at the heart of care' and sets out how the government intends to build on the progress made in the intervening period in implementing certain White Paper proposals, as well as introducing new commitments. The plan focuses on the following key areas:

- Improving access to care and support
- Recognising skills for careers in care
- Digital transformation in adult social care
- Personalising care through stronger data
- Improving transparency and accountability
- Supporting people to remain independent at home.
- Driving improvement and innovation

- Joining up services to support people and carers.

COVID-19 Spring Vaccination Programme – update from the Integrated Care Board

Since the launch of the COVID-19 vaccination programme in Lincolnshire, at the end of 2020, more than 1.3 million COVID-19 vaccinations have been given in the county, including more than 304,000 as part of the autumn booster vaccination programme towards the end of 2022.

The unprecedented drive over the last two years to enable people to get vaccinated has been helped enormously by the willingness of Lincolnshire people to come forward for their COVID-19 vaccinations. It has also highlighted the successful partnership working between the NHS and its partner organisations in the county.

We have worked closely with our Primary Care Networks (PCNs) and community pharmacies, who have already played a critical role in the vaccination programme to-date, delivering the bulk of the vaccinations with support from our vaccination centres.

Longer-term, the COVID-19 vaccination programme will be a recurrent part of the NHS's annual vaccination and immunisation programme, which will enable us to deliver the COVID-19 vaccination alongside the flu and pneumococcal vaccines.

Where we are now:
Earlier this year the Joint Committee on Vaccination and Immunisation (JCVI) confirmed its advice for a 2023 spring coronavirus (COVID-19) vaccination programme.

The spring vaccine has been offered to:

- **Adults aged 75 years and over**
- **Residents in care homes for older adults**
- **Individuals aged 5 years and over who are immunosuppressed.**

Eligible individuals will be offered the vaccine around six months after their previous dose and not less than 91 days since their previous dose. The spring vaccination programme will bridge the gap to the planned autumn programme later in 2023. The spring vaccination programme started on 3 April 2023, with vaccination of care home residents, and will then expand from 17 April to adults aged 75 years and over and individuals aged 5 years and over who are immunosuppressed. The spring vaccination programme ends on 30 June, as will the current/ongoing primary dose 'evergreen' vaccination offer of primary 1st and 2nd doses. People aged 16 and over who are yet to have their primary doses were encouraged to have their first dose by 5 May, in order to allow sufficient time to then administer their second dose by 30 June.

Following the closure at the end of 2022 of the vaccination centre in Boston, from 17 April a vaccination centre was opened in Wainfleet, at the Wainfleet Medical Practice.

As in previous rounds of the COVID-19 vaccination programme, the 'grab a jab' pages on the NHS Lincolnshire ICB website continue to promote the spring vaccine, particularly details of scheduled vaccination sessions which can be booked, as well as outreach sessions. Our key message remains just the same now as when we started – if you are eligible, please get your covid vaccination as soon as you can. The COVID-19 spring vaccine presents an opportunity to top up your protection against covid and serious illness, hospitalisation, or death.

Lincolnshire COUNTY COUNCIL Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

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

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**13 June 2023**
Subject:	**Lincolnshire Health and Wellbeing Board Terms of Reference and Membership Review**

Summary:

The Lincolnshire Health and Wellbeing Board (HWB) is required to review its governance arrangements annually. This paper asks the HWB to re-affirm the Terms of Reference and consider changes to the Board's membership.

Actions Required:

The HWB is asked to:

- Endorse the Terms of Reference and the governance documents attached as Appendix A.
- Agree proposals to reduce the number of NHS representatives and county councillors, as set out in the report, and to recommend the changes to full Council on 15 September to enable the relevant changes to be made to the Council's Constitution.
- Reaffirm the selection of associate members for one year, in accordance with section 5.4 of the Terms of Reference.
- Endorse the recommendation to extend associate membership to a representative from the care sector.

1. Background

1.1 Terms of Reference

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

- To encourage persons who arrange for the provision of any health and social care services in the area to work in an integrated manner;
- To provide advice, assistance or other support, as it thinks appropriate, for the purpose of encouraging joint commissioning;
- To prepare and publish a Joint Strategic Needs Assessment (JSNA) on the local population;
- To prepare and publish a Joint Local Health and Wellbeing Strategy (JLHWS).

The Health and Care Act 2022 does not change these core functions. The statutory duties for the HWB to prepare and publish the JSNA and JLHWS remain, and are supplemented by a new role, given to the HWB by the 2022 Act. In particular, as a consultee on the development of the Integrated Care Board's (ICB) NHS Joint Forward Plan.

In line with the legislation, the Board was constituted as a formal committee of the County Council in April 2013. The Terms of Reference and Procedural Rules were formally adopted by the Board in September 2013 and subject to annual review. The amended Terms of Reference and Procedural Rules, along with Board Member's Roles and Responsibilities showing the proposed revisions, are provided in Appendix A.

1.2 Membership

To fulfil the shared ambition of aligning the HWB with the Integrated Care Partnership (ICP), last year the Board agreed to mirror the membership and review again, in 2023, as arrangements mature. In 2022, membership was extended to include both the chairs and chief executives of the NHS provider organisations. To ensure efficient use of capacity, NHS partners have asked to review this arrangement with a view to reducing the number of NHS representatives on the HWB. Following discussions between the county council and health colleagues, it is proposed to reduce the number of county councillors by two and reduce health representatives by four.

Section 5.1 of Appendix A provides full details of proposed changes. Subject to the HWB approving these proposals, the changes will then be recommended to full Council on 15 September 2023 to enable relevant changes to be made to the Council's Constitution.

1.3 Associate Membership

Associate member status is for those individuals that want to be involved with the work of the HWB, but who are not designated core members. The HWB has authority to invite associate members to join and to approve their membership. Associated members do not have voting rights at HWB meetings. Section 5.4 of the Terms of Reference determines the length of associate membership as one year. Continued membership is subject to re-selection at the next Annual General Meeting.

The HWB is therefore asked to reconfirm associate membership as follows:

- A designated representative from NHSEI
- Chief Constable/representative, Lincolnshire Police
- A designated representative for the Voluntary and Community Sector
- A designated representative from Higher Education
- A designated representative from the Greater Lincolnshire Local Enterprise Partnership

The HWB is also asked to consider extending associate membership to a representative from the care sector. Representation from this sector would fill a gap for both the HWB and ICP. The health and care system in Lincolnshire faces many challenges, not least an ageing population with multiple complex conditions, it is necessary, therefore, the voice and perspective of the care sector is included in system discussions.

2. Conclusion

The HWB is asked to endorse the governance document attached as Appendix A and recommend the changes in membership to full Council on 15 September 2023 to enable the necessary changes to be made to the Council's Constitution.

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

The Council, NHS Lincolnshire Integrated Care Board and the Lincolnshire Integrated Care Partnership must have regard to the Joint Strategic Needs Assessment (JSNA) and Joint Local Health and Wellbeing Strategy (JLHWS).

The HWB is responsible for producing both the JSNA and JHWS.

4. Consultation

Not applicable

5. Appendices

These are listed below and attached at the back of the report	
Appendix A	Health and Wellbeing Board Terms of Reference, Procedural Rules, Board Member's Roles and Responsibilities.

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, Programme Manager, who can be contacted on alison.christie@lincolnshire.gov.uk

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LINCOLNSHIRE HEALTH AND WELLBEING BOARD

TERMS OF REFERENCE and PROCEDUAL RULES

June 2022~~2~~3

Next review date June 2023~~3~~4

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.

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.

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, requiring 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 Local Health and Wellbeing Strategy (JLHWS)

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 (NHSEI)~~ Integrated Care Board (ICB) to ensure recommendations or gaps in services are addressed.

4.3 To fulfil its role under section 14Z54 of the National Health Service Act 2006 and in particular to:-

4.3.1 give its opinion to the ~~Integrated Care Board (~~ICB~~)~~ on whether the draft NHS Joint Forward Plan~~ICB 5 year plan~~ (or any draft revision to the plan) takes proper account of the JLHWS~~local joint health and wellbeing strategy~~ under section 14Z54(5)(a); and

4.3.2 determine whether to give that opinion to NHS England under section 14Z54(5)(b).

4.4 To determine whether to give to NHS England its opinion on whether the published ICB NHS Joint Forward Plan~~5 year plan~~ takes proper account of the local joint health and wellbeing strategy under section 14Z55 of the National Health Service Act 2006.

4.5 To fulfil its role as consultee in respect of the ICB's annual review of the steps that the ICB has taken to implement the JLHWS~~joint local health and wellbeing strategy~~ under section in accordance with section 14Z58 of the National Health Service Act 2006.

4.6 To respond to consultation by NHS England on any steps that the ICB has taken to implement the JLHWS~~any joint local health and wellbeing strategy~~ as part of NHS England's annual performance assessment of the ICB under section 14Z59 of the National Health Service Act 2006.

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, Registration and Coroners
- The Executive Councillor for Children's Services, Community Safety and Procurement

[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.

- The Executive Councillor for Adult Care and Public Health
- ~~Five~~ Three 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 Integrated Care Board
- Chief Executive, NHS Lincolnshire Integrated Care Board
- Nominated representative ~~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
- A designated representative from Higher Education
- A designated representative from the Greater Lincolnshire Local Enterprise Partnership
- A designated representative from the Care 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.

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

6. CHAIR AND VICE CHAIR

[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.

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 4 above 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.

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

7.7 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.

7.8 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 A.

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 Public Health 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 Public Health 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.

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

[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.

[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 or information the disclosure of which would breach any enactment.

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 Lincolnshire Integrated Care Board Representative

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

13.1 Each core member or substitute member shall have one vote. Associate members do not have voting rights at HWB meetings.

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 Except in relation to the matters referred to in Section 4 above, 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 the NHS Lincolnshire Integrated Care Board 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.

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 a majority vote.

Signature:

Chair
Lincolnshire Health and Wellbeing Board

Date:

Signature:

Vice Chair
Lincolnshire Health and Wellbeing Board

Date:

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 JLHWS.
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 Integrated Care Board (ICB)	• Ensure that the ICB members/partners directly feed into the JSNA • Have regard to the JSNA and the JLHWS when developing commissioning and budget proposals • Report commissioning activity to the Board Report Board activity to other ICB 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 • Report on and from Healthwatch England • Ensure the JLHWS 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.
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 JLHWS 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 JLHWS

Core Member	Key Roles and Responsibilities
	Provide insight and perspective from the wider NHS in Lincolnshire.

Associate Members – *individuals wanting to be involved with the work of the HWB, but who are not designated as core members*.	Key Roles and Responsibilities
NHS England Representative	• Update the Board on any national commissioning issues which will affect Lincolnshire's JLHWS • Feedback on any issues raised by the Board affecting Lincolnshire to NHSEI • Report on direct commissioning activity Have regard to JSNA and JLHWS when developing commissioning and budget proposals.
Chief Constable/ Representative, Lincolnshire Police	• Update the Board on any community safety issues which will affect Lincolnshire's JLHWS • To support joint working on cross cutting agendas, for example mental health and substance misuse • To support partnership working and system integration To support the JSNA and JLHWS.
Voluntary and Community Sector	• To act as the representative for the wider voluntary and community sector in Lincolnshire. • Establish networks and mechanisms to feedback to the wider 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.
Higher Education	• To act as the representative for the higher education sector in Lincolnshire. • To support partnership working and system integration Promote participation and co-production in support of activity.
Greater Lincolnshire Local Enterprise Partnership	• To act as the representative for the business and enterprise sector in Lincolnshire. • To support partnership working and system integration • Promote participation and co-production in support of activity.
Care Sector	• To act as the representative for the care sector in Lincolnshire • To support partnership working and system integration • Promote participation and co-production in support of activity.

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LINCOLNSHIRE HEALTH AND WELLBEING BOARD

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

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**13 June 2023**
Subject:	**Joint Engagement – Joint Strategic Needs Assessment (JSNA) Prioritisation Exercise and Recommendations**

Summary:

In March 2023, the joint engagement approach to inform the review of the Joint Local Health and Wellbeing Strategy (JLHWS) and the next iteration of the Integrated Care Strategy was agreed. This report provides a summary of the Joint Strategic Needs Assessment (JSNA) prioritisation exercise and asks the Health and Wellbeing Board (HWB) to consider the recommendations detailed in Appendix A.

Actions Required:

- The Health and Wellbeing Board is asked to agree the following recommendations presented in Appendix A:
- **Recommendation 1** – The revised JLHWS should have no more than seven priorities, therefore JSNA topics receiving the lowest support (numbered 8 to 13 in Table 2) should not be progressed as priorities.
- **Recommendation 2** – Mental Health & Emotional Wellbeing, Healthy Weight and Physical Activity remain priorities in the JLHWS.
- **Recommendation 5 -** Considering aspects of the JSNA factsheets on Homelessness, Housing Standards and Unsuitable Homes and the importance to the health inequalities agenda, it is recommended that Housing and Health remains a priority theme but re-named Homes for Independence.
- **Recommendation 7 –** The revised JLHWS is developed using a life course approach to reflect the new JSNA.

- The Health and Wellbeing is asked to provide a steer on the following recommendations presented in Appendix A:

- **Recommendation 3** – Dementia remains a priority in the JLHWS as either:
    - Option 1 – a stand-alone priority, or
    - Option 2 - part of the Mental Health priority, if the decision is to follow a life course approach.
- **Recommendation 4** – The preferred option for drugs and alcohol
    - Option 1 – Include Drugs and Alcohol as a priority in the JLHWS and engage with the SLP Priority Group to understand the areas of focus for the JLWHS.
    - Option 2 – Not to include Drugs and Alcohol as a priority in the JLHWS and confirm appropriate partnership governance and reporting mechanisms are in place to provide assurance for this agenda.
- **Recommendation 6 –** based on the outcome of the prioritisation exercise, should Carers remain a priority in the JLHWS.

- The HWB is asked to agree the next steps as set out in section 1.2.

1. Background

1.1 Context

As previously reported, the HWB has a statutory duty to prepare a JLHWS based on the evidence of need identified in the JSNA. Lincolnshire's new JSNA was published at the end of March 2023. The joint engagement exercise takes a phased approach to inform the review of the JLHWS and next iteration of the integrated care strategy by:

- Using the evidence from the new JSNA to
    - Reaffirm the current priorities in the JLHWS.
    - Identify any further areas of concern.
    - Consider alterations to the priorities in the JLHWS.
- Gathering the views of partners from across the system on how to increase collaboration to address the JLHWS priorities and meet the ambition in the integrated care strategy.

The JSNA prioritisation phase began in early April with a desktop exercise to map all 36 JSNA topics according to their potential impact on the Lincolnshire population and the recent direction of travel (improving or worsening). A prioritisation workshop was held on 27 April 2023 with representative from the organisations on the HWB to consider the outcomes from the desktop mapping exercise.

Appendix A provides a summary of the JSNA prioritisation phase and makes seven recommendations for the HWB to agree or provide a steer.

In preparing the report, specific lead officers and delivery groups were contacted to inform the recommendations.

1.2 Next Steps

Appendix A recommends five of the current seven JLHWS priorities should remain priorities in the revised document and asks the HWB to consider options for the remaining two priorities (Dementia and Carers). The only new potential priority area the HWB is asked to consider is Drugs and Alcohol.

Based on the recommendations, it is unlikely the priorities in the JLHWS will change significantly. The Council's Community Engagement Team have previously advised that public engagement should be focused on matters that have not been decided and could therefore still be influenced or changed by public

feedback. There is little point in undertaking community engagement exercises if there is little to influence or change as this potentially raises expectations that are unlikely to then be met. Therefore, unless the HWB identifies any additional JSNA topics for consideration, the proposal is to not undertake a formal public engagement exercise.

Engagement with stakeholders and partners will continue over the next three months to socialise the review and gather wider feedback. This will include working with the delivery groups to update the objectives and outcomes under each priority, as well as looking at mid to longer term planning. The delivery plans for 2023/24 are being reported to the HWB in item 9a.

2. Conclusion

The HWB is asked to consider the recommendations in Appendix A.

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

The Council, NHS Lincolnshire Integrated Care Board and the Lincolnshire Integrated Care Partnership must have regard to the Joint Strategic Needs Assessment (JSNA) and Joint Local Health and Wellbeing Strategy (JLHWS).

This paper details the process to review the JLHWS based on the needs identified in the JSNA.

4. Consultation

Detailed in Appendix A.

5. Appendices

These are listed below and attached at the back of the report	
Appendix A	Joint Engagement Approach 2023 – Analysis of Prioritisation Exercise and Recommendations
Appendix B	JSNA Prioritisation Workshop – April 2023 Poll Results

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 Alison Christie, Programme Manager, who can be contacted on alison.christie@lincolnshire.gov.uk

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Appendix A

Joint Engagement Approach 2023

Joint Local Health & Wellbeing Strategy and Integrated Care Strategy

Analysis of Prioritisation Exercise and Recommendations

Report produced by Public Health May 2023

1. Background and Context

The Joint Local Health and Wellbeing Strategy (JLHWS) is a document that aims to inform and influence decisions about the commissioning and delivery of health and social care services in Lincolnshire, so that they are focused on the needs of the people who use them and tackle the factors that affect everyone's health and wellbeing.

The production of the JLHWS is a legal requirement under the Health and Social Care Act 2012, and the responsibility for producing it rests with the Lincolnshire Health and Wellbeing Board (HWB).

The HWB is also responsible for producing the Joint Strategic Needs Assessment (JSNA). The JSNA reports on the health and wellbeing needs of the people in Lincolnshire. It brings together detailed information on local health and wellbeing needs and looks ahead at emerging challenges and projected future needs. The JSNA forms the evidence base for the JLHWS.

Lincolnshire's current JLHWS was agreed by the HWB in June 2018 following a year-long engagement and development process. A summary of the JLHWS showing the delivery arrangements is summarised in Figure 1 below.

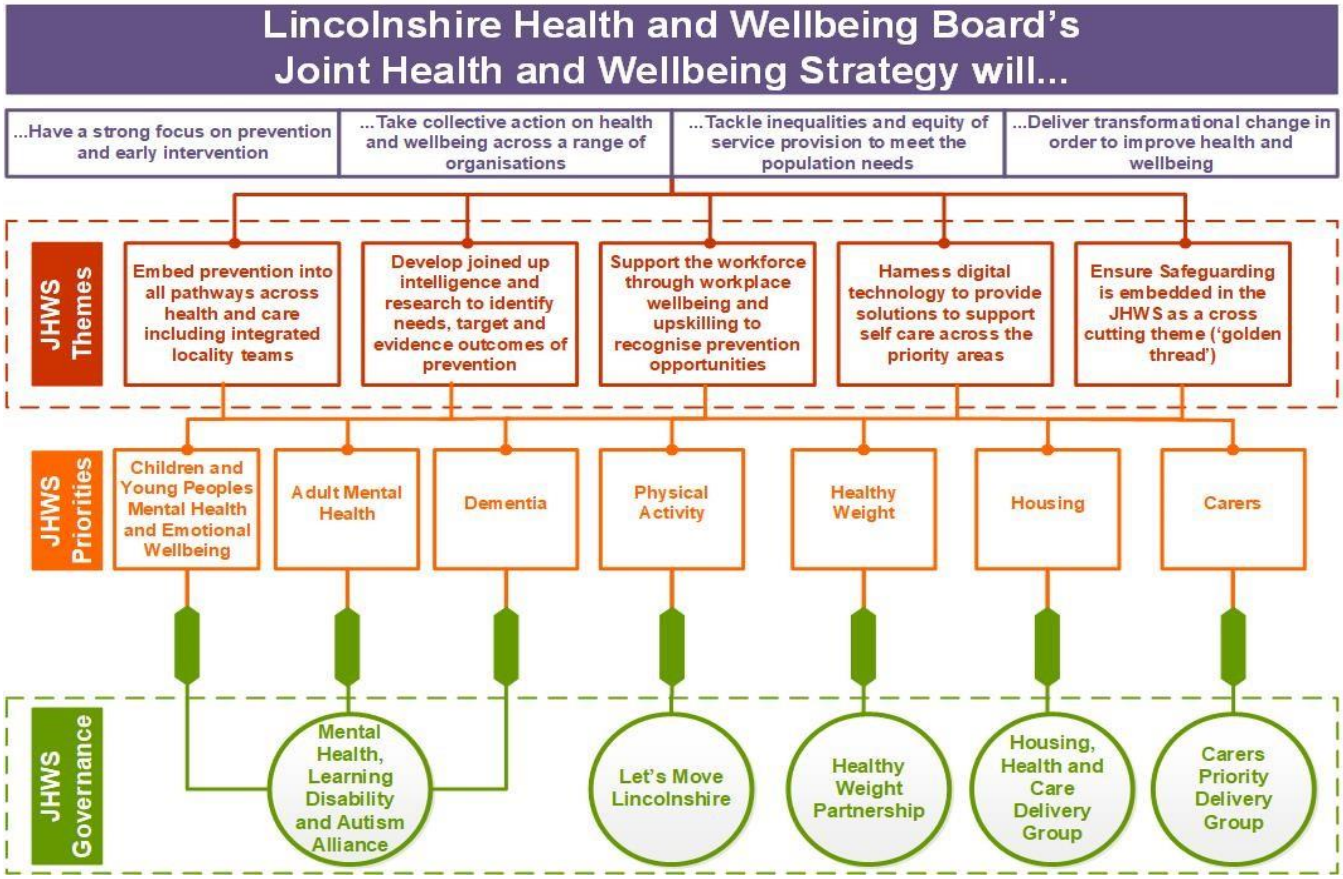


Figure 1: Joint Local Health and Wellbeing Strategy for Lincolnshire overview (updated Dec 2023)

It is important to note that the current strategy has no set end date. This was a conscious decision in 2018 to allow partners to focus on the long-term aspirational aims and objectives as well as short term actions. It was also to enable the HWB to respond to changing health and wellbeing needs as evidence is updated in the JSNA, so the strategy is a live document.

In December 2022, the JHWS was 'refreshed' to acknowledge the introduction of Integrated Care Systems (ICSs) from July 2022 and recognise the impact of Covid-19 had on the health and care system. These, predominantly cosmetic changes, were done on the understanding that a more fundamental review will take place during 2023 following the publication of the new JSNA in March 2023.

2. Joint Engagement Approach

The Health and Care Act 2022 introduced Integrated Care Systems (ICSs) from July 2022. As part of ICS arrangements, the Act requires that Lincolnshire Integrated Care Partnership (ICP) prepares and publishes an integrated care strategy setting out how assessed needs can be met by partners across the health and care system.

Due to Lincolnshire's ICS area being coterminous with the HWB, the local ambition is to align, as far as possible, the integrated care strategy with the JLHWS. This agreed approach connects the strategies, avoiding duplication, or gaps, between the two. Each will maintain their own identity, the JLHWS focusing on "what" the identified needs are; and the integrated care strategy setting out "how" we collectively address identified needs, as a system.

In March 2023, the HWB and ICP agreed a joint engagement approach to inform the review of the JHWS and the next iteration of the integrated care strategy. The focus of the approach is to engage key stakeholders, partners, and the voluntary and community sector to gather their views and perspectives on the health and wellbeing priorities in Lincolnshire. The objectives are to:

- Use the evidence from the new Joint Strategic Needs Assessment (JSNA) to:
    - reaffirm the current priorities in the JLHWS.
    - identify any further areas of concern.
    - consider alterations to the priorities in JLHWS.
- Gather views on how partners in the health and care system can increase collaboration to address JHWS priorities and meet the ambition of the integrated care strategy.

The joint engagement timeframe:

Timeframe	Activity
Phase 1 – Prioritisation and engagement with partners and stakeholders	
28 March 2023	• **JSNA signed off by HWB –** the online resource will go live following the HWB. • **Agreement of the overall engagement approach for the JHWS / ICP Strategy at the HWB / ICP meeting -** this will ensure transparency, as well as raising awareness amongst key partners on the HWB / ICP
Early April 2023	**Desktop exercise to map JSNA** to feed into the prioritisation workshop(s)
Late April 2023	**Prioritisation Workshop with representatives from the organisations on the HWB/ICP to shortlist the JNSA** – using outcomes from the desktop mapping exercise
April 2023	**Health Scrutiny Committee –** present report on engagement approach during 2023
April – July 2023	**Engagement with key stakeholders and partners –** including Healthwatch, districts, voluntary & community organisations, JHWS priority delivery groups. Wherever possible, existing partnership meetings and engagement opportunities to be used
June 2023	**Report to HWB/ICP –** update report on the outcome of the prioritisation workshops and feedback to date from partners and stakeholders Based on emerging outcomes from Phase 1, HWB/ICP to decide either: a) public engagement (Phase 2) is required – *what things can the public influence and/or change?* Or b) communication and awareness raising exercise if required

Phase 2 – Public Engagement and/or Communication – subject to outcome of phase 1	
June – Sept 2023	**Engagement/communication exercise with the public**
June – Sept 2023	**Online survey**
Phase 3 – Produce final documents and sign off	
September 2023	**HWB / ICP** – update report on activities/feedback to date
Sept - Oct 2023	**Analyse feedback & produce engagement summary documentation**
Oct 2023	**HWB/ ICP workshop** – to finalise the aims and priorities for JHWS and ICP Strategy
Oct / Nov 2023	**Report to Health Scrutiny Committee** – to ask the committee to comment on the draft strategies prior to final approval in December
Oct / Nov 2023	**Report to LCC and ICB governance**
Dec 2023	**HWB / ICP sign off JHWS & ICP Strategy**

3 PHASE 1 - Prioritisation and engagement with partners and stakeholders

3.1 Desktop Mapping and Prioritisation Exercise

A simplified evidence-based prioritisation methodology was agreed by the HWB and ICP in March 2023. The approach uses the matrix shown in Figure 2, to map the health and wellbeing issues identified in the JSNA according to their potential impact on Lincolnshire's population and the recent direction of travel (improving or worsening).

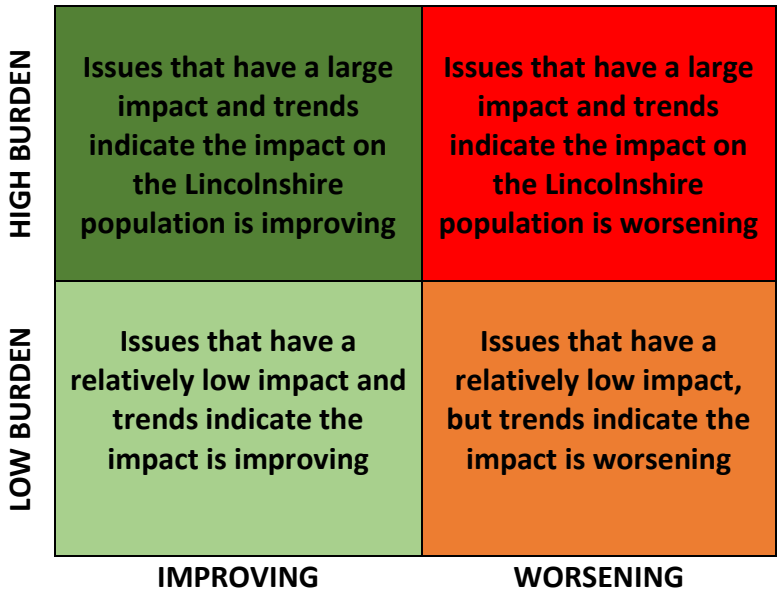


Figure 2 – Prioritisation Matrix

The desk top mapping exercise was completed by the Public Health Intelligence team in early April 2023 using the following criteria:

- Disability Adjusted Life Years (DALYs)[1] – using the Global Burden of Disease Level 2 rates for Lincolnshire, each JSNA topic was reviewed and assigned cumulative DALYs. This then allowed the 36 topics be to be compared and ranked according to the level of burden or impact on the population.
- To measure the direction of travel, 379 OHID fingertips indicators, each with trend analysis, linked to the 36 JSNA topics were reviewed to give an overall positive, negative or zero change ranking for each factsheet.

[1] Disability Adjusted Life Year is measure of overall disease burden, expressed as the cumulative number of years lost due to ill-health, disability, or early death.

Using the combined rankings, each JSNA topics was then plotted on the matrix, see Appendix 1. This exercise highlighted:

- 12 JSNA topics are high burden and worsening.
- 6 JSNA topics are high burden but improving.
- 1 JSNA topic is high burden with no change.
- 7 JSNA topics are low burden and worsening.
- 8 JSNA topics are low burden and improving.
- 2 JSNA topics are low burden and no change.

The 12 high burden and worsening JSNA topics, in rank, are shown in Table 1. The top three topics are current priorities in the JLHWS, and Unsuitable Homes is part of the Housing and Health priority.

JSNA Topic	DALY RATE SUM	DALY RATE SUM RANK	FINGERTIPS FINAL RANK	OVERALL FINAL	Start Well	Live Well	Age Well
Healthy Weight	22,627.85	35	33	High Burden - Worsening	☑	☑	
Physical Activity	21,229.66	34	28	High Burden - Worsening	☑	☑	
Mental Health	17,670.77	33	24	High Burden - Worsening	☑	☑	
Respiratory	15,711.94	32	19	High Burden - Worsening		☑	
Environment	15,709.22	31	19	High Burden - Worsening		☑	
Diabetes	12,321.94	28	25	High Burden - Worsening		☑	
Neuro	12,038.76	27	24	High Burden - Worsening		☑	☑
Cardiovascular	11,387.39	26	21	High Burden - Worsening		☑	
Oral Health	9,536.21	24	25	High Burden - Worsening	☑	☑	
Drugs and Alcohol	7,886.87	22	36	High Burden - Worsening		☑	
Unsuitable Homes	7,607.29	21	19	High Burden - Worsening		☑	☑
Early Years	6,035.31	19	35	High Burden - Worsening	☑		

Table 1 – High burden – worsening JSNA topics

3.2 Health and Wellbeing Prioritisation Workshop

Nominated lead officers from the member organisations (see Appendix 1) on the HWB attended a workshop on 27 April 2023, to review and discuss the outcome of the desktop mapping and prioritisation exercise. The session specifically focused on the topics ranked as high burden and worsening.

A multiple-choice poll was held with attendees to gauge their initial views (full results shown in Appendix B). The majority (72%) agreed with the prioritisation mapping (Appendix 2) and felt it reflected the current position in Lincolnshire. However, whilst 83% stated they would not expect to see any JSNA topics ranked lower, 88% said would they expected to see certain JSNA topics ranked higher. This feedback was explored further in small discussions groups. Attendees were asked to consider:

- Which current JLHWS priorities need to change – do any need to be removed?
- Which JSNA topics should be considered as a priority in the reviewed JLHWS?
- How much influence or impact, especially for those topics mapped as high burden and worsening, can partners have on making improvements – is it the sole responsibility of one organisation, or does it require a partnership approach?

Summary of Key Point from Group Discussions:

- Mental Health, Physical Activity and Healthy Weight should remain priorities to address the many of the longer-term impacts of Covid-19.

- Drugs and alcohol consumption increased during the pandemic, so should be considered as a potential new priority.
- Autism and Dementia should be ranked higher.
- Due to Lincolnshire' ageing population, frailty was identified as an increasing challenge for our health and care system. However, frailty is not a standalone JSNA topic, although aspects of this agenda are considered in topics such as Falls and Dementia. Frailty should be considered as part of the Integrated Care Strategy.
- Surprising to learn Musculoskeletal Conditions (MSK) did not rank higher given it was as an area of concern in the Director of Public Annual Report (2019) – the Burden of Disease in Lincolnshire. In the prioritisation exercise, MSK was ranked as 'low burden' and 'worsening' and therefore did not feature in the top 12 prioritised JSNA topics. Light of the concerns highlighted in the DPH Annual Report, the HWB could consider MSK as a potential priority. In which case, consideration would need to be given to the benefit of including MSK and how wider partners can contribute to the agenda.
- Housing is seen as an important topic with general support for focusing on Unsuitable Housing.
- Support for Carers is no longer a high priority for the JLHWS because there was a view that significant progress has been made since 2018 with more support and services now in place.
- Consensus view that the JLHWS should remain focused on prevention and the wider determinants of health across the whole life course.
- Prevention promotion and services should be targeted to areas with the greatest inequalities.
- The JLHWS should follow a life course approach, to reflect the new JSNA and consideration given to broaden the life course definitions to include 'Dying well'.
- Services need to 'empower' people to look after their own health and wellbeing.
- Community Assets – how do these fit in?

Following group discussions, attendees were asked to identify which three JSNA topics from the list of high burden and worsening topics, they thought were the greatest priority for the Lincolnshire System. 'Other' was also given as an option. The results are shown in Table 2.

1. Mental Health	85%
2. Healthy Weight	50%
3. Drugs and Alcohol	35%
4. Unsuitable Homes	35%
5. Other* - Dementia	30%
6. Physical Activity	25%
7. Early Years Development	20%
8. Environment	15%
9. Respiratory Conditions	10%
10. Diabetes	5%
11. Cardiovascular Disease	5%
12. Oral Health	5%
13. Neurological Conditions	0%

Table 2 – Results of poll asking for top 3 JSNA topics.

* There was support for Dementia to be considered as high priority.

The following points were also raised, but these are not specific JSNA topics:

- Frailty
- Personal responsibility/self help
- 'Dying well'

Attendees felt these were important issues which need an integrated approach across the health and care system; therefore, it is proposed this feedback is considered as part of developing the next iteration of the Integrated Care Strategy

The majority (85%) felt the number of priorities in the revised JLHWS should either remain the same (seven) or *be less*. Therefore, it is proposed that the JSNA topics identified as high burden and worsening but which received the lowest support should not be considered for inclusion in the revised JHWS. These are:

- Early Years Development
- Environment
- Respiratory Conditions
- Diabetes
- Cardiovascular Disease
- Oral Health
- Neurological Conditions

4 Conclusions and Recommendations

Recommendation 1 – The revised Joint Local Health and Wellbeing Strategy should have no more than seven priorities, therefore JSNA topics receiving the lowest support (numbered 8 to 13 in Table 2) should not be progressed as priorities.

Recommendation 2 – Mental Health & Emotional Wellbeing[2], Healthy Weight and Physical Activity remain priorities in Lincolnshire's Joint Local Health and Wellbeing Strategy.

The desktop mapping exercise ranked Mental Health, Healthy Weight, and Physical Activity as the top three for high burden and worsening. The stakeholder workshop supported this view, ranking all three of these JSNA topics in the top six.

Good mental health and wellbeing are fundamental for a happy and healthy life. Mental health problems can significantly affect any individual, their family, the community and wider society. The number of new referrals to specialist mental health services in Lincolnshire was higher than the national average in all age groups for 2019/20 (the most recent year for which data is available). We know rates of referrals have been impacted by the Covid-19 pandemic. Lincolnshire has seen significant increases in the number of referrals in the last two years.

Being overweight or obese is a major public health concern directly associated with serious illnesses including type 2 diabetes, heart disease and some cancers. Obesity and overweight are also linked to musculoskeletal and mental health problems. Prevalence of excess weight and obesity amongst adults and children in Lincolnshire tends to be above the England average, although there is considerable variation across the county.

Physical activity has been described as 'the miracle cure'. Being active has enormous health and wellbeing benefits. Regular exercise can prevent dementia, type 2 diabetes, some cancers, depression, heart disease and other common serious conditions – reducing the risk of each by at least 30%. Physical activity lowers risk of depression by up to 30% and can boost self-esteem and mood. Lack of physical activity is an important factor related to obesity. In Lincolnshire, 42% of adults fail to meet the Chief Medical

[2] This will mean the current Mental Health and Emotional Wellbeing (Children and Young People) and Mental Health (Adults) priorities will be combined into a single priority.

Officers physical activity guidelines (150 minutes of moderate intensity physical activity per week), with many adults being completely inactive (doing less than 30 minutes a week). This has remained relatively consistent and is worse than the national and regional averages.

Recommendation 3 – Dementia remains a priority in Lincolnshire's Joint Local Health and Wellbeing Strategy either as a stand-alone priority or as part of the Mental Health priority, if the decision is to follow a life course approach.

Although Dementia was ranked low burden and unchanged, the stakeholder workshop felt dementia remains an important issue given Lincolnshire's ageing population profile. Dementia profoundly affects individuals with their family feeling pressure and anxiety to provide vital care and support. The prevalence of dementia makes it one of the most pressing challenges for health and care services in the UK and Lincolnshire. Currently 6.8% of people aged 65 or over in Lincolnshire are living with dementia and projections suggest this figure is likely to double by 2040.

Recommendation 4 – The HWB is asked to consider the options for drugs and alcohol and provide a steer on its preferred option for the next stage of strategy development.

The desktop mapping exercise ranked Drugs and Alcohol tenth for high burden and worsening, but stakeholders ranked it third in the workshop. Drug and alcohol harm is multi-faceted, and every drug (including alcohol) has a different harm profile. During the pandemic depression, anxiety, and social isolation were all related to increases in alcohol consumption and substance misuse. Lincolnshire's treatment services have seen levels of dependency increase since Covid-19, and more users present with complex issues. Impacts of drug and alcohol use include dependence, a range of physical and psychological health impacts (cancer, cirrhosis, heart disease, psychosis, paranoia, self-esteem issues). Drug and alcohol use is linked to the loss of relationships, and tangibles such as housing and employment. For a drug user's family and friends, there is increased risk of injury through mechanisms such as foetal harm, transmission of blood borne viruses, domestic violence, and road crashes. For wider society there is harm from crime, economic costs, and disruption to community cohesion.

The Safer Lincolnshire Partnership (SLP) has identified drugs and alcohol misuse as a strategic priority, and the SLP Priority Group is operating as Lincolnshire's Combating Drugs Partnership (known locally as the Drugs and Alcohol Partnership). The SLP arrangements are well established with clear governance and strong working relationships across all strategic partners including health, the Police, and local authorities. This is a high-profile cross cutting agenda, which is broader than commissioned treatment services and requires a partnership approach. It has significant impact and relevance to both the health and care system and the crime and safety arena. Therefore, proposals for consideration are:

a) Option 1 – Include Drugs and Alcohol as a priority in the JLHWS and engage with the SLP Priority Group to understand the areas of focus for the JLWHS.
b) Option 2 – Not to include Drugs and Alcohol as a priority in the JLHWS and confirm appropriate partnership governance and reporting mechanisms are in place to provide assurance for this agenda.

Recommendation 5 - Considering aspects of the JSNA factsheets on Homelessness, Housing Standards and Unsuitable Homes and the importance to the health inequalities agenda, it is recommended that Housing and Health remains a priority theme but re-named Homes for Independence.

Unsuitable Homes was ranked eleventh for high burden and worsening, but fourth in the stakeholder workshop. Housing and Health is currently a priority in the JLHWS and is being progressed by the Housing, Health and Care Delivery Group, a partnership forum specifically established by the HWB. Evidence shows

that living in familiar, safe, accessible, warm accommodation that we call 'home' is more likely to promote mental and physical wellbeing, and to reduce hospital admissions, social isolation, and loneliness. Our vision is for people to live independently, stay connected and have greater choice in where and how they live.

The proposed refocused priority will not address all aspects of housing but identifies those who may need extra help to maintain their wellbeing and independence e.g., those with health and care needs, those moving from a hospital inpatient or other facilities, and care leavers amongst others. There are three main areas of focus:

a) Ensuring homes are safe, warm, and dry to reduce accidents such as falls and to prevent illness, especially respiratory conditions, for people of all ages.
b) Maximising levels of independence for people with care and support needs (e.g., frail older people and people with mental health issues, dementia, learning disabilities, and autism). This includes providing appropriate small aids, equipment, and adaptations to meet people's needs through streamlined mechanisms and processes.
c) Preventing homelessness and rough sleeping by addressing the underlying causes leading to homelessness.

Recommendation 6 – the HWB is asked to give a steer on whether Carers should remain a priority in the JLHWS.

Carers is currently a priority in the JLHWS but did not feature in the top 12 high burden and worsening topics. In the desktop mapping exercise carers was identified as high burden and improving, and young carers as low burden improving. There are currently an estimated 79,262 unpaid family carers in Lincolnshire. Given the county's aging population, this number is predicated to increase. There is a significant impact on the health and wellbeing of a person in a caring role. Carers are twice as likely to suffer poor health compared to the general population, primarily due to a lack of information and support, financial concerns, stress, and social isolation. Evidence shows that two thirds of unpaid carers are female providing on average 50 hours of care per week. The risk of carer failure represents a potentially significant pressure on health and care services.

The Carers Delivery Group met on 11 May 2023 and were asked to discuss the outcome of the prioritisation exercise. Based on feedback from carers, the general census was the mapping exercise does not accurately reflect the current experience and position for carers. Many carers report the Covid-19 pandemic has had a considerable impact on their health and wellbeing, with the burden of caring getting worse. People are waiting longer to get support and finding it difficult to access paid packages. This situation is being further exacerbated by the cost of living crisis which is placing additional pressures on carers. The view of the Delivery Group is carers should remain a priority to ensure, as a system, the needs and support to carers are addressed.

Recommendation 7 – The revised Joint Local Health and Wellbeing Strategy is developed using a life course approach to reflect the new Joint Strategic Needs Assessment.

There was overwhelming support (90%) from the participants at the workshop for the revised JLWHS to follow a life course approach to reflect the JSNA.

APPENDIX 1

JSNA PRIORITISATION WORKSHOP – 27 APRIL 2023

Representatives from the following organisations and services attended.

City of Lincoln Council

Healthwatch Lincolnshire

Lincolnshire County Council – Adult Care

Lincolnshire County Council – Children's Services

Lincolnshire County Council – Public Health

Lincolnshire Foundation NHS Partnership Trust

Lincolnshire Police

NHS Lincolnshire Integrated Care Board

North Kesteven District Council

Primary Care Network Alliance

South and East Lincolnshire Councils Partnership

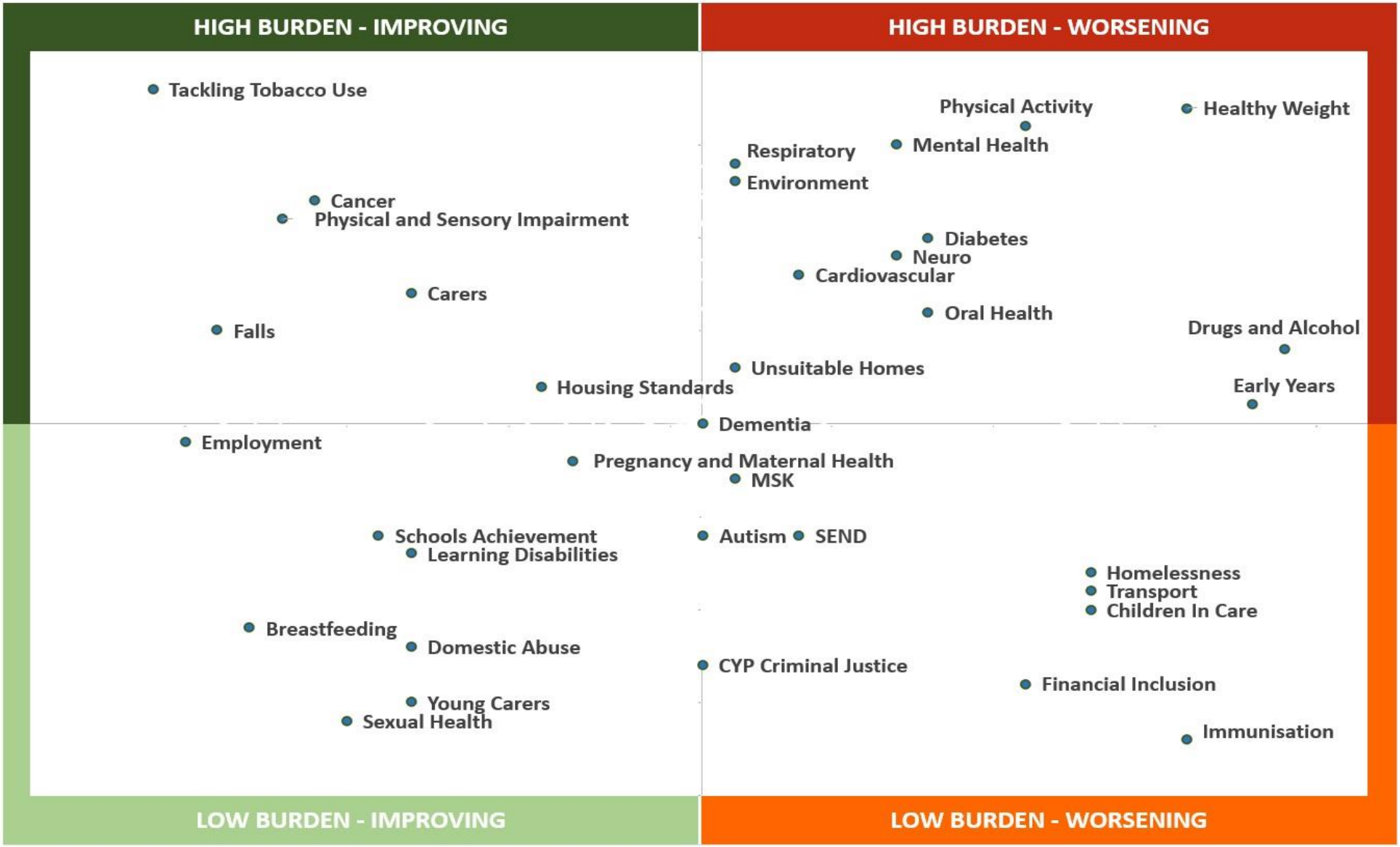
United Lincolnshire Hospitals NHS Trust

University of Lincoln

Voluntary and Community Sector

West Lindsey District Council

JSNA Mapping and Prioritisation Exercise **Appendix 2**



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JSNA Prioritisation Workshop - April 2023

25 Apr - 11 May 2023

Poll results

slido

Table of contents

1. Do these priorities reflect the current position across Lincolnshire?

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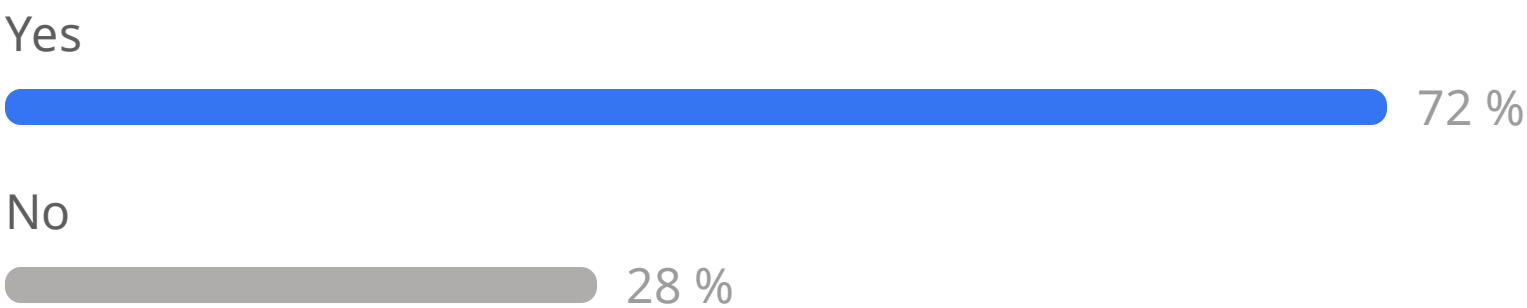

2. Are there any you would expect to be a higher priority?

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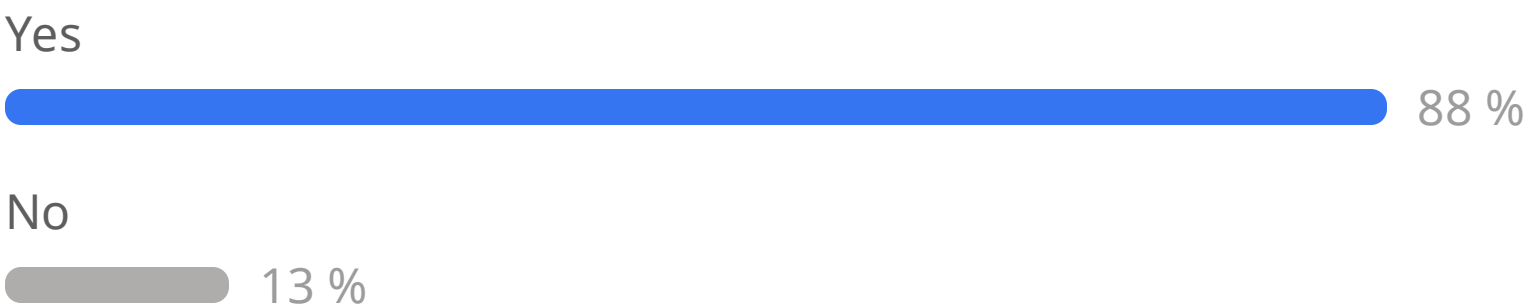

3. Are they any you would expect to be a lower priority?

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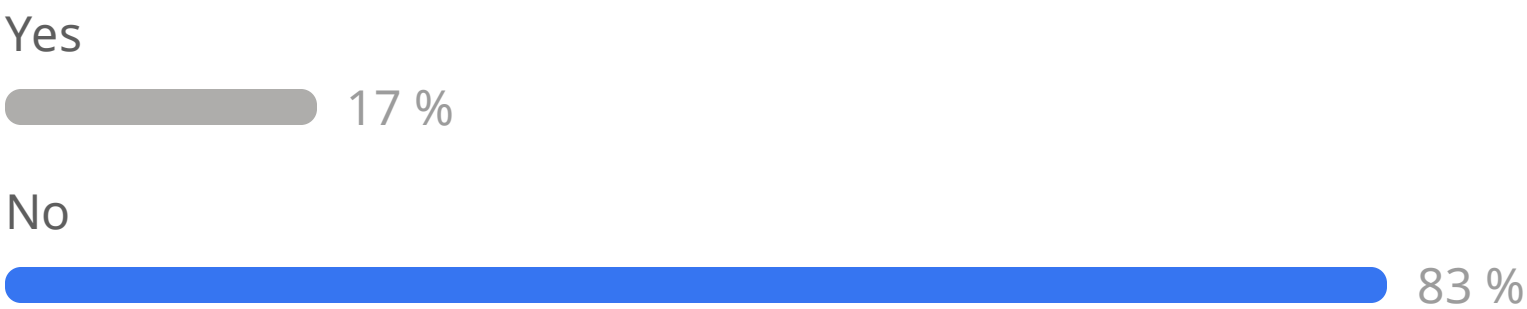

4. Based on the analysis and discussion today, which 3 JSNA areas do you think are the greatest priority for the Lincolnshire system from the 12 presented?

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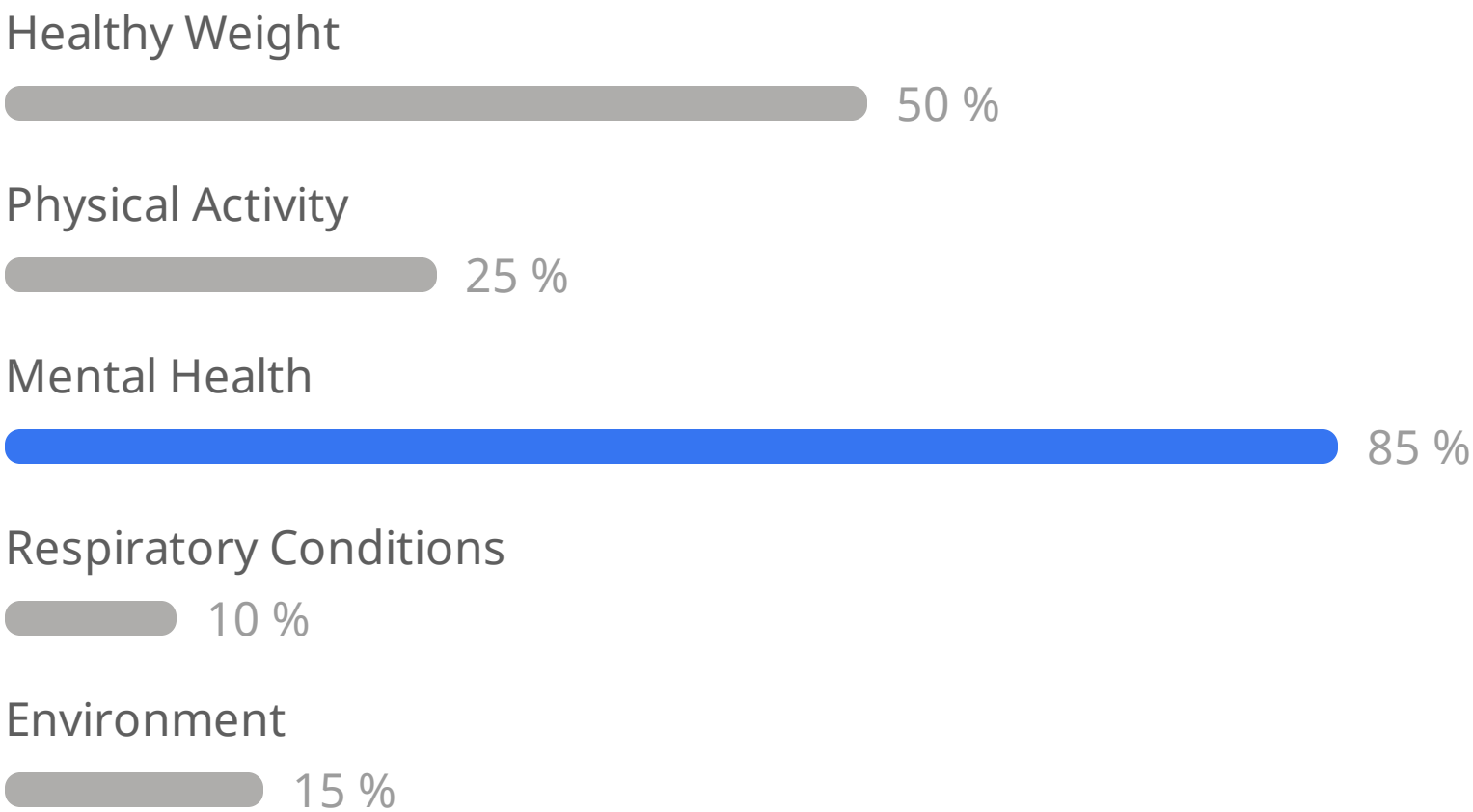
(1/3)



4. Based on the analysis and discussion today, which 3 JSNA areas do you think are the greatest priority for the Lincolnshire system from the 12 presented?

0 2 0

(2/3)

Diabetes

5 %

Neurological Conditions

0 %

Cardiovascular Disease

5 %

Oral Health

5 %

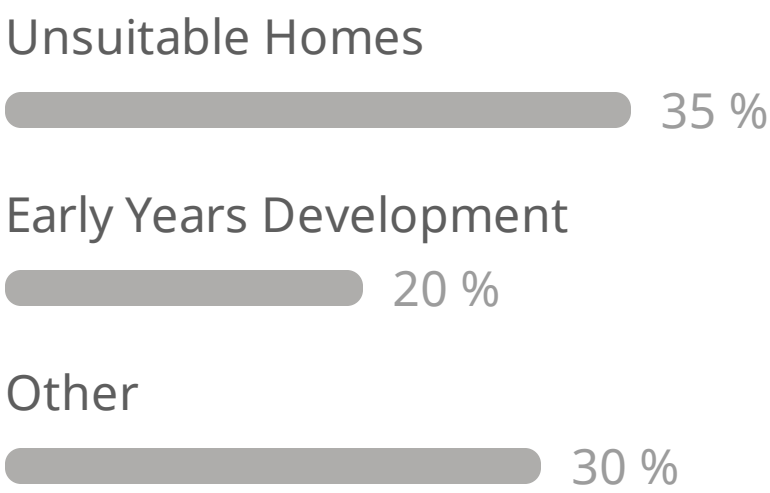
Drugs & Alcohol

35 %

4. Based on the analysis and discussion today, which 3 JSNA areas do you think are the greatest priority for the Lincolnshire system from the 12 presented?

0 2 0

(3/3)



5. Should the new JHWS follow the life course approach to reflect the JSNA?

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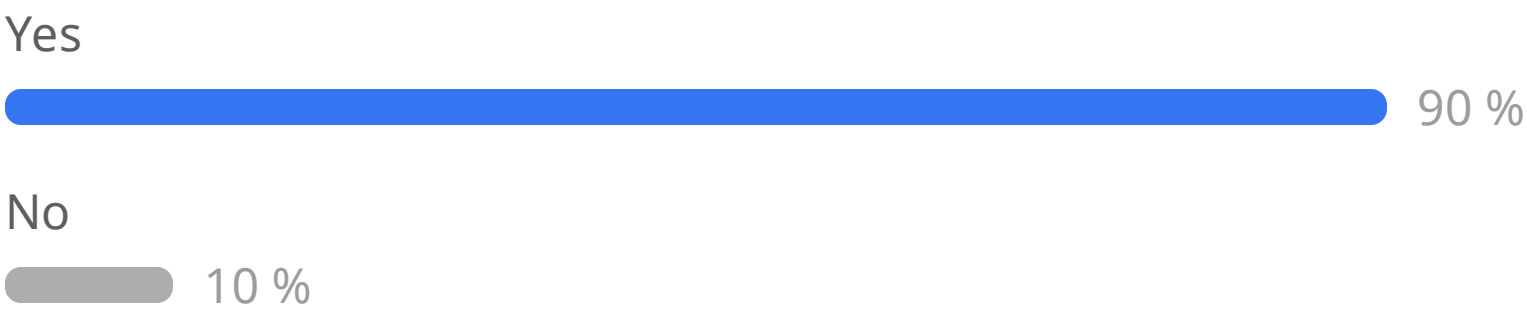

6. Currently there are seven priorities within the JHWS – does this feel the right number or should it be more or less within the revised strategy?

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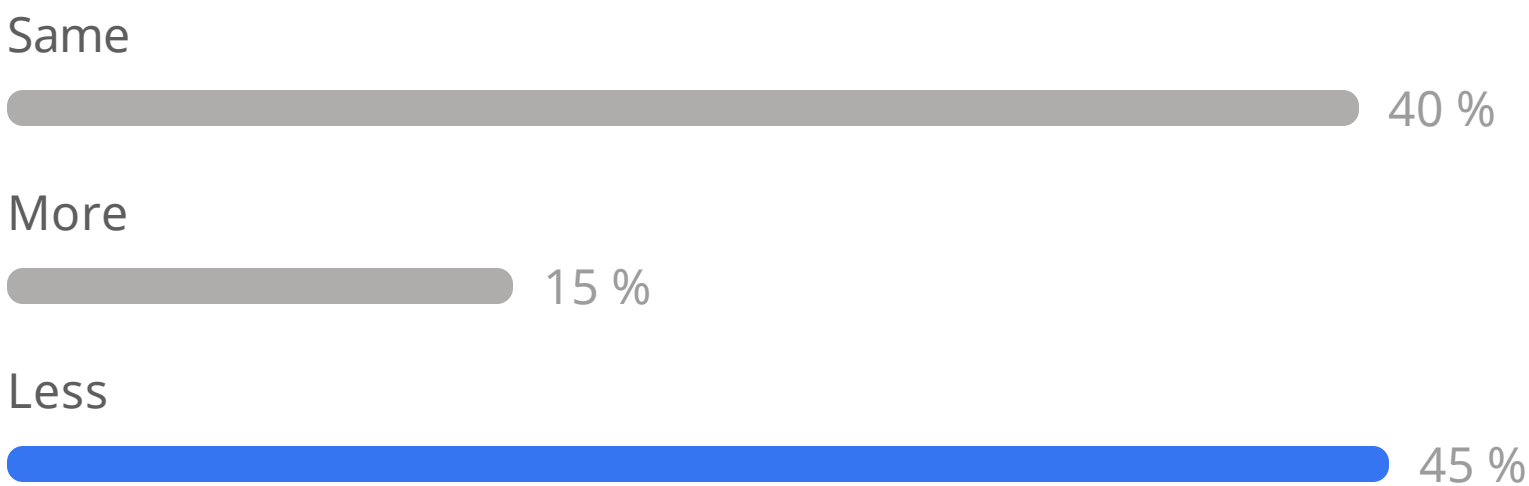

Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

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

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**13 June 2023**
Subject:	**Lincolnshire Better Care Fund Planning and Narrative Report 2023-25**

Summary:
The Better Care Fund (BCF) is a national programme with a prescribed policy and planning framework. The BCF planning guidance for 2023-2025 (for two years) was published 5 April 2023 with a deadline for submission 28 June 2023. Attached to this report are the two documents required as part of the Lincolnshire BCF submission:

•The BCF Planning Template – This spreadsheet document forms part of the BCF plan submission and highlights the difference sources of funding (income) and Lincolnshire BCF schemes (Expenditure) alongside metric ambitions and capacity and demand planning across the System. Key Lines of Enquiry set out at Tab 7. These will be used to assure the BCF plan.

•BCF Narrative Plan Template – a narrative plan must be submitted alongside the BCF Planning Template.

Actions Required:
For decision. The HWB is asked to approve the 2023/25 Lincolnshire BCF plan and narrative plan ahead of submission on 28 June 2023.

1. Background

The governance for the Better Care Fund (BCF) is prescribed within the BCF policy framework and includes that The Lincolnshire Health and Wellbeing Board (HWB) is required to approve all plans and reports regarding the BCF before they are submitted to Regional leads for assurance.

For the past 5 years the national BCF planning, and assurance framework has been "rolled on" with the planning framework and reporting requirements being confirmed within year. This year the policy framework and planning requirements have been released in early April and allowed earlier planning although the plans attached are still concerned with current financial year expenditure. The policy

framework and planning requirements however are multi-year and requires a two-year plan, 2023-2025 with more regular reporting on activity and spend.

In 2022-23 we were required to submit capacity and demand information looking at the different pathways within the hospital and the community. For this year, capacity and demand sits within the main BCF Planning document and will go towards overall assurance. Core metrics for the BCF Plan remain mainly unchanged however there is the addition of a new metric on falls.

The narrative plan for this submission covers key priorities including discharge, intermediate care, housing and unpaid carers; which the policy framework also drew particular attention to.

Financial information

The Lincolnshire BCF has a proposed value for £348.1m in 2023/24. The income is comprised of:

Source	Amount	Detail
Minimum ICB Contribution	£65.30m	NHS publish allocations for each ICB from the national ringfence. Funding from the NHS to support adult social care such as reablement, carers' breaks, implementation of the Care Act.
iBCF	£34.30m	Grant funding direct to LCC for the purposes of meeting adult social care needs, reducing pressures on the NHS, supporting discharge, and ensuring the social care provider market is supported.
DFG (Disabled Facilities Grant)	£6.98m	Ringfenced funding which must be paid direct to the districts in full, unless agreed that the capital fund can be used for other purposes to meet the needs of disabled people
LCC held budgets (additional contributions)	£107.0m	Additional payments included within the section 75 agreement.
ICB held budgets (additional contributions)	£127.0m	Additional payments included within the section 75 agreement.
Discharge Fund (ICB & LCC)	£7.49m	Grant funding issued to ICB and LCC for the purpose of supporting discharge and system flow schemes.

There are 30 individual schemes funded within the Lincolnshire BCF, however these can be grouped into themes as below:

Summary by service provided	**2022-23 Outturn**	**2023-24 Budget**	**2024-25 Budget**
Learning disabilities	89.143	106.081	108.520
Adult mental health services	90.454	130.166	130.481
Social care workforce	22.805	22.805	22.805
Social care provider market	21.910	21.910	21.910
Intermediate care	13.028	12.228	12.228
Child & adolescent mental health services	14.050	16.552	17.108
Proactive care	10.302	10.660	11.047
Disabled facilities grant	6.976	6.976	6.976
Integrated community equipment	6.250	6.881	6.881
Adult social care seasonal pressures	3.489	3.489	3.489
Transitional beds	2.750	2.750	2.750

Integrated staffing	0.112	0.112	0.112
Surge capacity	0.179	0.000	0.000
New Discharge Fund	4.953	7.487	11.501
Total	**286.401**	**348.097**	**355.808**

Note : The table above shows the Better Care Fund Contribution to the services, not the full cost of the services across Lincolnshire.

2. Conclusion

The Lincolnshire Better Care Fund is one of the largest pooled funds in the Country. Of this 63% is non-mandatory contributions from the ICB/LCC into jointly commissioned services such as learning disabilities and adult mental health services. Lincolnshire has a well-established approach which relies to a greater extent on externally commissioned providers for service delivery and therefore much of the BCF is committed in existing contracts. The multi-year BCF policy framework that has been introduced for 2023-25 will support the transformation agenda and transition to the place-based arrangements described within the integration white paper. The increased focus on discharge, housing, carers and intermediate care aligns with priorities across the Lincolnshire System.

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

The Council, NHS Lincolnshire Integrated Care Board and the Lincolnshire Integrated Care Partnership must have regard to the Joint Strategic Needs Assessment (JSNA) and Joint Local Health and Wellbeing Strategy (JLHWS).

The BCF schemes within the plan, directly contribute to addressing health inequalities and the JLHWS.

4. Consultation

None required.

5. Appendices

These are listed below and attached at the back of the report	
Appendix A	Lincolnshire BCF Plan 2023-25
Appendix B	Lincolnshire BCF Narrative Report 2023-25

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 Paul Summers, who can be contacted on paul.summers@lincolnshire.gov.uk

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Appendix A

Better Care Fund - 2022/23

Performance Report

Month - March

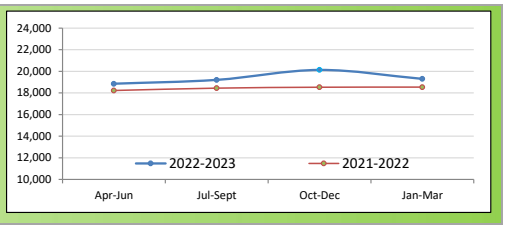
Produced -29th May 2023

Produced by Lincolnshire County Council, Adult Care Performance & Intelligence Team
ASC_Performance@lincolnshire.gov.uk

Health and Wellbeing Board Measures

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

Definition: The total number of emergency admissions for people of all ages where an acute condition was the primary diagnosis, that would not usually require hospital admission.
Frequency / Reporting Basis: Monthly / Cumulative within quarter only
Source: MAR data (Monthly NHS England published hospital episode statistics)
Note: Data Source changed therefore data no longer uploaded to NHS Digital

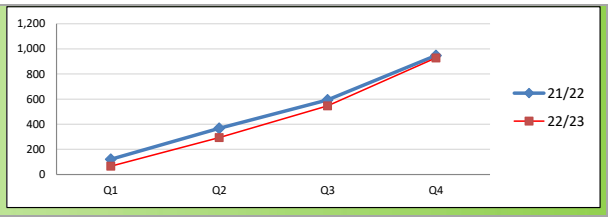


Prior Year	2021/2022											
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
In Month	5,840	6,171	6,218	6,411	5,926	6,109	6,163	6,018	6,351	6,250	5,874	6,419
In Quarter (cumulative)	-	-	18,229	-	-	18,446	-	-	18,532	-	-	18,543

Month -		2022/2023											
		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
In Month		6,117	6,531	6,208	6,472	6,376	6,365	6,528	6,879	6,725	6,461	6,271	6,573
In Quarter		-	-	18,856	-	-	19,213	-	-	20,132	-	-	19,305
Actual reduction (negative indicates an increase)	number	302	-414	323	-264	96	11	-163	-351	154	264	190	-302
	%	4.94%	-6.34%	5.20%	-4.08%	1.51%	0.17%	-2.50%	-5.10%	2.29%	4.09%	3.03%	-4.59%

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

Definition: The total number of admissions to permanent residential or nursing care during the year (excluding transfers between homes unless the type of care has changed from temporary to permanent)
Frequency / Reporting Basis: Monthly / Cumulative YTD
Source: Mosaic data: Local Adult Care Monitoring (LTC admissions report & SALT return).
Note: Figure reported cumulatively**.**
This is an Snapshot at reporting period end and may not be an accurate figure due to backdating of services



Prior Year	2021/2022											
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
In Quarter			121			246			347			600
Cumulative YTD			121			367			593			947

Current Year	2022/2023											
	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
In Quarter			66			228			319			381
Cumulative YTD			66			294			547			928

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

Definition: The percentage of older people (within a 3 month sample period) discharged from an acute or non-acute hospital to their own home/residential or nursing care home/ extra care housing for rehabilitation, where the person is at home 91 days after their date of discharge from hospital.
Frequency / Reporting Basis: Yearly - ASCOF 2B part 1
Source: Mosaic Reablement data and LCH data for Q3
Note: Due to backdating from external provider the figure may be lower that actual figure**.** This is using LCH Data and an external source for Reablemt and some People cannot be traced to a Mosaic number. These People are then classified as **Not at Home**. This accounts for 55 People for LCH and 7 People for Reablement

	22/23	2022/2023											
		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Numerator	107			62			90			78			795
Denominator	125			71			113			88			1,011
Value	86%			87%			80%			89%			79%

3a: % people (65+) at home 91 days after discharge from hospital into Reablement/rehabilitation - SOCIAL CARE REABLEMENT SERVICE ONLY
Definition: The percentage of older people (within a 3 month sample period) discharged from an acute or non-acute hospital to their own home/residential or nursing care home/ extra care housing for rehabilitation, where the person is at home 91 days after their date of discharge from hospital. Q1 data will be clients discharged between January-March, Q2 will be clients discharged between April-June etc.
Frequency / Reporting Basis: Quarterly
Source: Mosaic data: Reablement
Note: Due to backdating from external provider the figure may be lower that actual figure. This is using external source for Reablement and some people cannot be traced to a Mosaic number. These people are then classified as **Not at Home**. This accounts for 7 people for Reablement

	22/23 Social Care Only	2022/2023											
		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Numerator	107												488
Denominator	125												555
Value	86%												88%

3b: % people (65+) at home 91 days after discharge from hospital into Reablement/rehabilitation - COMMUNITY REHAB SERVICE ONLY
Definition: The percentage of older people (within a 3 month sample period) discharged from an acute or non-acute hospital to their own home/residential or nursing care home/ extra care housing for rehabilitation, where the person is at home 91 days after their date of discharge from hospital. Q1 data will be clients discharged between January-March, Q2 will be clients discharged between April-June etc.
Frequency / Reporting Basis: Quarterly
Source: Hospital
Note: This is using LCH Data and some people cannot be traced to a Mosaic number. These people are then classified as **Not at Home.** This accounts for 55 Persons

	22/23 Social Care Only	2022/2023											
		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Numerator	-			-			-			-			307
Denominator	-			-			-			-			456
Value	-			-			-			-			67%

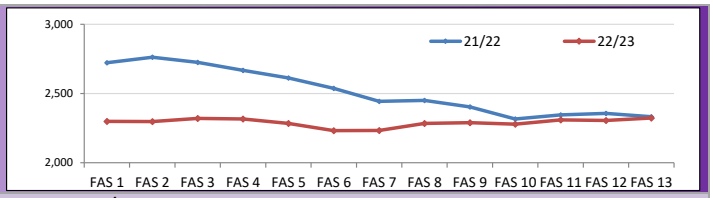
3c: % people (65+) at home 91 days after discharge from hospital into Reablement/rehabilitation - OFFER RATE ONLY
Definition: The percentage of older people (within a 3 month sample period) discharged from an acute or non-acute hospital to their own home/residential or nursing care home/ extra care housing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

	22/23 Offer Rate Offer Only	2022/2023											
		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Actual	-			-			-			-			-
Target	-			-			-			-			-
Performance	-			-			-			-			-

iBCF Measures

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

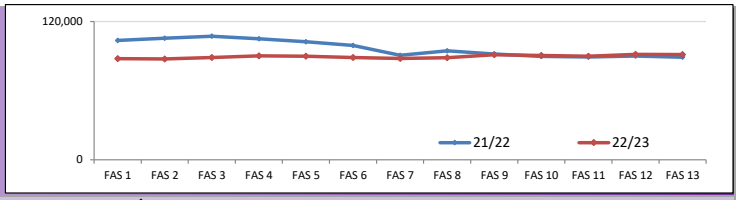
Definition: Cumulative YTD number of all clients who have received a permanent home care package during the year
Frequency / Reporting Basis: Split by Financial Activity Statement (April -March)
Source: Brokerage weekly service returns
Note:Changed from Monthly breakdown to Financial Activity Statement due to how the data is recorded



Prior Year	2021/2022												
	FAS 1	FAS 2	FAS 3	FAS 4	FAS 5	FAS 6	FAS 7	FAS 8	FAS 9	FAS 10	FAS 11	FAS 12	FAS 13
Clients in receipt of homecare (YTD)	2,723	2,762	2,725	2,667	2,613	2,537	2,444	2,450	2,403	2,316	2,345	2,357	2,332

Current Year	2022/2023												
	FAS 1	FAS 2	FAS 3	FAS 4	FAS 5	FAS 6	FAS 7	FAS 8	FAS 9	FAS 10	FAS 11	FAS 12	FAS 13
Clients in receipt of homecare (YTD)	2,299	2,297	2,320	2,316	2,284	2,232	2,233	2,284	2,290	2,279	2,310	2,306	2,323

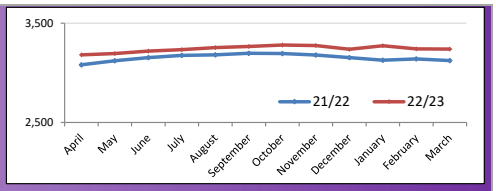
5: Total number of paid hours of Home Care provided in the quarter
Definition: Cumulative YTD number of all paid hours of homecare delivered
Frequency / Reporting Basis: Split by Financial Activity Statement (April -March)
Source: Brokerage weekly service returns
Note:Changed from Monthly breakdown to Financial Activity Statement due to how the data is recorded



Prior Year	2021/2022												
	FAS 1	FAS 2	FAS 3	FAS 4	FAS 5	FAS 6	FAS 7	FAS 8	FAS 9	FAS 10	FAS 11	FAS 12	FAS 13
Hours Delivered	103,640	105,569	107,226	105,080	102,475	99,264	90,720	94,501	91,833	89,778	89,179	89,976	89,012

Current Year	2022/2023												
	FAS 1	FAS 2	FAS 3	FAS 4	FAS 5	FAS 6	FAS 7	FAS 8	FAS 9	FAS 10	FAS 11	FAS 12	FAS 13
Hours Delivered	87,847	87,534	88,785	90,157	89,851	88,787	87,930	88,655	91,125	90,548	89,816	91,495	91,313

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



Prior Year		2021/2022											
		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Care Home Placements (YTD)		3,081	3,121	3,153	3,175	3,182	3,197	3,194	3,179	3,153	3,127	3,141	3,124

Current Year		2022/2023											
		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Care Home Placements (YTD)		3,181	3,195	3,218	3,233	3,255	3,265	3,280	3,274	3,237	3,273	3,242	3,240

7: Number of newly funded clients with LD
Definition: Number of LD starters that have started a new service within each quarter.
Frequency / Reporting Basis: Monthly
Source: Finance Team - Adult Care & Community Wellbeing

		2022/2023											
by Age Group		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
18-25		5	6	2	12	9	15	3	8	0	3	1	1
26-40		9	1	1	0	2	1	4	4	0	4	1	0
41-64		16	4	2	1	3	1	0	2	0	2	0	0
65+		7	0	0	1	1	0	0	0	0	1	0	0
In month		**37**	**11**	**5**	**14**	**15**	**17**	**7**	**14**	**0**	**10**	**2**	**1**
In Quarter (cumulative)		**37**	**48**	**53**	**67**	**82**	**99**	**106**	**120**	**120**	**130**	**132**	**133**

Local Measures

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

Current Year	2021/22	2022/2023											
		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Hours delivered (in month)		11687	13215	12600	12143	12311	11662	12241	12906	13062	12349	10585	12,348
Hours delivered (in quarter)		11,687	24,902	37,502	12,143	24,454	36,116	12,241	25,147	38,209	12,349	22,934	22,933
Hours delivered (YTD)		11,687	24,902	37,502	49,645	61,956	73,618	85,859	98,765	111,827	124,176	134,761	147,109

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

Current Year	2021/22	2022/2023											
		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Numerator	1697			287			784			1,488			1972
Denominator	1872			298			824			1,593			2175
Actual	90.7%			96.3%			95.1%			93.4%			90.7%
Target	95%			95%			95%			95%			95%

10. 7 Day Services: % of hospital discharges to Social Care which occur at the weekend
Definition: Of the total number of patients discharged from hospital to a Social Care hospital team, the % that were discharged at the weekend
Frequency / Reporting Basis: Monthly
Source: BO Report - Hospital Discharges
Note: Includes all clients who had a hospital workflow on mosaic including those clients who passed away in hospital

Current Year	2021/22	2022/2023											
		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Numerator	1,403	118	112	97	113	97	82	102	96	91	100	70	72
Denominator	9,818	756	845	829	760	782	710	773	773	741	702	651	715
Actual	14%	16%	13%	12%	15%	12%	12%	13%	12%	12%	14%	11%	10%

11. Hospital Discharges With Social Care Team Involvement
Number of discharges
Definition: Discharged clients where social care teams help facilitate the discharge
Frequency / Reporting Basis: Monthly
Source: BO Report: Hospital Discharges
Note: Includes all clients who had a hospital workflow on mosaic including those clients who passed away in hospital

Current Year	2021/22	2022/2023											
		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
18-64	901	4	3	2	6	5	8	1	6	11	6	4	8
65+	8,910	753	843	826	760	781	706	774	774	758	696	647	704
Unknown	7	-	-	1	-	-	-	2	1	-	-	-	3
Total Number	9,818	757	846	829	766	786	714	777	781	769	702	651	715
% of 65+	91%	99%	100%	100%	99%	99%	99%	100%	99%	99%	99%	99%	98%

12. Discharges into planned pathway routes
Definition: The pathway that a client has been discharged from hospital into. Pathway definitions are Pathway 0- : simple discharge, no input from health / social care, Pathway 1-:support to recover at home; able to return home with support from health and/or social care,Pathway 2: Rehabilitation in a bedded setting, Pathway 3:For people who require bed-based 24-hour care
Frequency / Reporting Basis: Monthly
Note: Includes all clients who had a hospital workflow on mosaic including those clients who passed away in hospital

Current Year	2021/22	2022/2023											
		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Discharges into Pathway-0	2,150	200	224	208	226	185	163	199	195	157	149	143	153
Discharges into Pathway-1	4,021	281	312	320	254	296	266	258	288	275	261	261	270
Discharges into Pathway-2	402	37	45	37	37	39	34	49	48	49	39	27	38
Discharges into Pathway-3	1,860	130	146	140	127	145	112	145	152	152	131	105	128
Other	1,385	109	119	124	122	121	139	126	98	136	122	115	126

13. Capacity of planned pathway routes

Definition: The expected capacity to be discharged into the pathways vs the actual pathway route. Pathway definitions are Pathway 0-: simple discharge, no input from health / social care, Pathway 1-:support to recover at home; able to return home with support from health and/or social care,Pathway 2-: Rehabilitation in a bedded setting

Frequency / Reporting Basis: Monthly

Note: Includes all clients who had a hospital workflow on mosaic including those clients who passed away in hospital

Current Year	2021/22	2022/2023											
		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Expected Capacity into Pathway- 0	-	-	-	-	-	-	-	-	-	-	-	-	-
Actual Capacity into Pathway- 0	22%	26%	26%	25%	30%	24%	23%	26%	25%	20%	21%	22%	21%
Expected Capacity into Pathway- 1	-	-	-	-	-	-	-	-	-	-	-	-	-
Actual Capacity into Pathway- 1	41%	37%	37%	39%	33%	38%	37%	33%	37%	36%	37%	40%	38%
Expected Capacity into Pathway- 2	-	-	-	-	-	-	-	-	-	-	-	-	-
Actual Capacity into Pathway- 2	4%	5%	5%	4%	5%	5%	5%	6%	6%	6%	6%	4%	5%
Expected Capacity into Pathway- 3	-	-	-	-	-	-	-	-	-	-	-	-	-
Actual Capacity into Pathway- 3	19%	17%	17%	17%	17%	18%	16%	19%	19%	20%	19%	16%	18%

14. Carers Supported by Carers Service and Adult Care

Definition: The total number of Carers Supported by Lincolnshire County Council in the last 12 months

Frequency / Reporting Basis: Quarterly / Rolling 12 month period

Source: Corporate Plan (Carers Strategy) (SALT LTS003 total)

Current Year	2021/22	2022/2023											
		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Actual	1,613			1,480			1,564			1,634			1,579
Target	1,730			1,730			1,730			1,730			1,730
Performance	-7%			-14%			-10%			-6%			-9%

15. Trusted Assessors: Hospital Bed Days Saved

Definition: The number of assessments completed by workers, actual discharges that have taken place and total bed days saved by workers

Frequency / Reporting Basis: Quarterly

Source: Lincolnshire Care Association

Notes: End of June and July data not recieved. Bed Days Saved not recorded due to Covid and never restarted

Current Year		2022/2023											
		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Completed Assessments		166	199	112	0	209	175	289	239	197	229	142	-
Actual Discharges		89	105	47	0	98	99	117	106	86	120	78	-
Bed Days Saved (in quarter)													
Bed Days Saved (YTD)													

HM Government

NHS England

BCF narrative plan template

This is a template for local areas to use to submit narrative plans for the Better Care Fund (BCF). All local areas are expected to submit narrative BCF plans. Although the template is optional, we ask that BCF planning leads ensure that narrative plans cover all headings and topics from this narrative template.

These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 25 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

Cover

Health and Wellbeing Board(s).

Lincolnshire

Bodies involved strategically and operationally in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils).

In Lincolnshire the BCF represents a mature programme with engagement and coproduction throughout either on an individual scheme basis or at programme level. The following bodies have been involved in the production of the plan:

- NHS Provider Organisations: Lincolnshire Community Health Services (LCHS); Lincolnshire Partnership Mental Health Foundation Trust (LPFT); the Primary Care Network Alliance (PCN), and United Lincolnshire Hospitals Trust (ULHT).

- Commissioning organisations: Lincolnshire NHS Integrated Care Board (ICB) and Lincolnshire County Council (LCC).

- Lincolnshire Health and Wellbeing Board and Housing, Housing, Health and Care Delivery Group (HWB Sub Group). Including Social Housing Providers (Lincolnshire Housing Forum), NHS organisations, 7 District Councils (City of Lincoln, West Lindsey, East Lindsey, Boston, South Holland, North Kesteven and South Kesteven), Adult Social Care, the Third Sector and the Private Rental Sector.

- Voluntary Engagement Team (VET) . Collaboration of Voluntary and Charitable organisations in Lincolnshire. VET are represented at the HWB, Lincolnshire Health and Care Provider Collaborative (LHCC) and the ICS Board. Representation includes St Barnabas (Hospice) and Age UK.

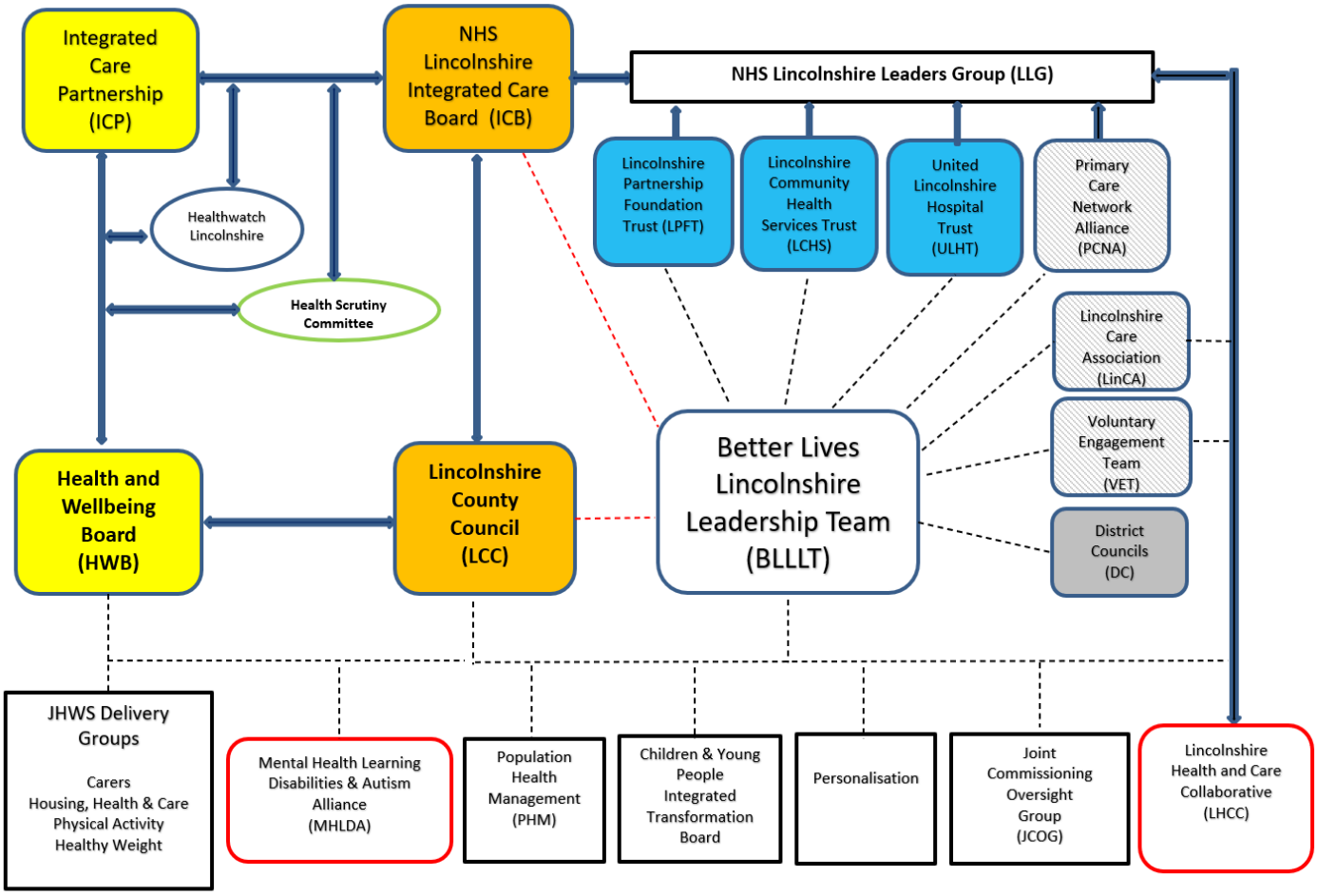
- Lincolnshire Care Association (LinCA). LinCA represents the social care providers in the County and has representation at the LHCC and ICS Board.

How have you gone about involving these stakeholders?

Lincolnshire has a history of successfull BCF planning and delivery with oversight from the health and wellbeing board. The level of ambition to build integrated services utilsing the BCF is evident through the level of pooled budget, significantly above the minimum required. Throughout 22/23 there has been continuous involvement and joint working across the stakeholders and schemes and objectives have been co-produced. Throughout the winter of 22/23 in particular stakeholders have worked closely together across the system to support and deliver the discharge fund and objectives within. This has continued within the BCF planning for 23/25

Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.



Executive summary

This should include:

- Priorities for 2023-25
- Key changes since previous BCF plan.

A predominately rural county, Lincolnshire is the fourth largest county in England with a population of 768,364 residents (2021 census). With strong agriculture, manufacturing, food and tourism sectors, Lincolnshire has no motorways, little dual carriageway and 80km of North Sea coastline. Our population is on average older than the population of England. It also has a higher proportion of adults over the age of 75 and the number in this age range is expected to double over the next 20 years. Year-to-year increases in the size of this ageing population are one of the key planning assumptions for Lincolnshire's health and care system.

The combination of an ageing population, increasing complexity of needs, a rural geography and areas of high socioeconomic deprivation as indicated in the recent Director of Public Health Annual Report. This defines the specific challenge of commissioning and delivering high-quality and effective health, social care and preventative services in Lincolnshire.

Ethnicity

• The diversity of the population is gradually increasing as a result of new and emerging communities. From the latest ethnicity data from 2021, 89.2% of residents identify themselves as White British, with 6.1% identifying themselves as Other White and 4.7% identifying as Other Ethnic Groups. This is also shaped by the presence of Ukrainian guests (over 1,000) and other groups from the international community.

Deprivation

• Urban areas and particularly the coast suffer higher deprivation, although there are pockets of deprivation across the county, including in rural areas which frequently suffer from issues of accessibility.

• Lincolnshire has 335,550 households. 21% of private housing stock is estimated to have a serious hazard likely to cause illness or harm. Improving the availability of housing for people with particular needs is a form of collective endeavour.

• There are around 200 caravan sites, and nearly 25,000 static caravans on the Lincolnshire coast (the largest concentration in Europe) with a permanent population of over 6,000 people. There are also smaller static caravan sites across other areas of the county; A report by Centre for Regional Economic and Social Research suggested 40% of caravan dwellers were in effect full-time residents in East Lindsey and that some others spent 40-50% of the year in their caravan. The report also suggested that 31% of local caravan residents were living with long-standing illness, disability or infirmity and nearly a quarter surveyed had health issues affecting mobility. 11% stated that they accessed local GPs as a 'temporary resident'.

Economy & Employment

• Lincolnshire has strong agriculture, manufacturing, food and tourism sectors, however these tend to provide lower paid and lower skilled employment than the national average. Lincolnshire as a whole is the largest single contributor to agricultural production in England, providing nearly 30% of the field vegetable crops in the country from its arable land.

• Unemployment in Lincolnshire is below national rates, however there is significant seasonal employment in relation to the strong horticulture and tourism sectors, particularly in the east and south of the county. Lincolnshire has one of the fastest growing rates of carers in the UK. Between 2001 and 2015, the county experienced a 27.5% increase in the number of carers, compared to the general rate of population growth of 6.2%.There are estimated to be over 84,000 unpaid carers in the county

Education

• Lincolnshire's school level attainment is broadly in line with national figures, and above regional figures, at GCSE level , and above both national and regional figures at A' level; The proportion of the working age population in the county qualified to NVQ level 3 and higher is below regional and national averages.

Priorities for 2023 – 2025

- Intermediate Care Ambitions – as defined by the recently agreed business case (see later)

- Housing – for both working age adults and older people and includes equipment and adaptations (DFGs)

- Home First – supporting Discharge. Which remains work in progress but overlaps significantly with the other priorities. These represent a composite mutually reinforcing agenda.

- Further utilisation of the opportunities provided by digital technology – notably Techology Enabled Care (or TEC) which is led by the Director of Public Health as part of a wider digital roadmap which includes shared records.

National Condition 1: Overall BCF plan and approach to integration

Please outline your approach to embedding integrated, person centred health, social care and housing services including:

- Joint priorities for 2023-25
- Approaches to joint/collaborative commissioning
- How BCF funded services are supporting your approach to continued integration of health and social care. Briefly describe any changes to the services you are commissioning through the BCF from 2023-25 and how they will support further improvement of outcomes for people with care and support needs.

Priorities for 2023 – 2025 (see also above)

- Intermediate Care Ambitions

- Housing

- Home First – supporting Discharge

- Further utilisation of the opportunities provided by digital technology

Reduce the pressures on urgent & emergency care by building capacity across the system – providing the right care, at the right time, in the right place.

The above priorities will help us use our collective resources more effectively and equitably – thinking increasingly system not service. They will be further supported through a number of underpinning developments which includes:

- More Personalised care and services though strengths based practice and co-production – in both home based, specialist and acute settings.

- Housing, Occupational Therapy (increasingly aligned across employing bodies) and improved use of equipment and adaptations

- Population health management to help define the optimum configuration of services and levels of provision in better meeting inequalities.

National Condition 2

Use this section to describe how your area will meet BCF objective 1: **Enabling people to stay well, safe and independent at home for longer.**

Please describe the approach in your area to integrating care to support people to remain independent at home, including how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to help people to remain at home. This could include:

- steps to personalise care and deliver asset-based approaches
- implementing joined-up approaches to population health management, and proactive care, and how the schemes commissioned through the BCF will support these approaches
- multidisciplinary teams at place or neighbourhood level, taking into account the vision set out in the Fuller Stocktake
- how work to support unpaid carers and deliver housing adaptations will support this objective.

Personalised care and Strengths Based Approaches- Maximising independence through changing culture, behaviour and practice

Having been influenced by the work of both Think Local Act Personal and Social Care Futures our vision is that 'people stay as healthy, safe and independent as possible during all stages of their life'. We have progressed an ambitious Improvement Programme which extends beyond Adult Care. Co-produced with and delivered by our workforce, partners, people with lived experience it is embedding personalised, strengths-based approaches which are based on applied behavioural science and are empowering frontline practitioners and those they support.

Our Initial Conversation Model has resulted in people having the right conversation at the right time, being supported earlier in their journey and this has freed up practitioners to provide support where it is needed most. We have applied Strengths Based and Behavioural Approaches in over 55 teams across Adult Care, the Wellbeing Service, the Acute Trust, LPFT, Occupational Therapy Services, and will be a core part of our developing Intermediate Care Layer and Trusted Reviewer model.

First workshops have also been delivered to over 500 practitioners across 55 teams including our system partners. Using these approaches Practitioners report a positive impact in over 90% of cases. TEC Practitioners report improved independence, an increase in the number of people having conversations about TEC with 60% of conversations exploring how TEC can promote independence with 30% of people planning to use TEC. Adult Care and our partners are delivering better outcomes for people, with a more empowered workforce which has resulted in quicker, more proportionate assessments, improved use of community assets, TEC and a reduced reliance on state funded provision.

Adult Care has funded a 6-month programme In the Acute Trust on a ‘proof of concept’ basis which the Trust has agreed to extend. This work involved a behavioural programme supported by IMPOWER consultants developing a set of 6 interventions to apply Strengths Based Approaches and collaborative working across Lincoln County Hospital, Boston Pilgrim and Community Hospital Therapy Teams and Discharge Coordinators. Clinicians have reported a positive impact and it has supported improved inter-ward transfers and discharges, unblocking delays. There has been an increase in patients discharged from MAEU, regular flow focused rounds across assessment units and greater ward leadership and collaboration.

Adult Care is a key a stakeholder and joint funder of the ICS ‘It’s all about people’ programme board, which brings together and oversees the programme of work and projects that relate to embedding personalised strength-based approaches and ways of working across and into Lincolnshire ICS. Initial Conversation and Personalised Strengths Based Approaches have been identified as a system priority. The SRO is also the Chair of LVET (a collaboration of 3rd sector colleagues) and oversees key elements of the programme which include the co-production of ‘Our Shared Agreement’, which articulates what a new relationship between people and health care should feel like. The programme has provided accredited learning and development in Personalisation to over 2000 practitioners (mostly health professionals), and over 1000 practitioners have subscribed to Lincolnshire Person Centred Learning network. We have also upskilled 10 practitioners who have been trained to deliver Shared Decision Making and Personalised Care and Support Planning training to 500 practitioners.

Our co-production programme delivered with the ‘Everyone Co-production Network’ is in progress, embedding co-production at all levels of Adult Care. We are also developing the Lincolnshire ICS co-production Strategy as a co-sponsor alongside the CEO of the ICB, working with system leads to understand what it would take for Lincolnshire to become a national leader/exemplar in co-producing health and care. This includes using current good practice and evidence to identify what the system needs to do to embed co-production. Across the ICS over 400 people with lived experience and 70 clinicians / practitioners have been involved in co-production.

National Condition 2 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support people in the community. This should include:

- learning from 2022-23 such as
    - where number of referrals did and did not meet expectations
    - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - patterns of referrals and impact of work to reduce demand on bedded services – e.g. admissions avoidance and improved care in community settings, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified
    - where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?

how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

An joint analysis of this service has been underway with the support of IMPOWER. The results have identifed significant opportunities for further improvements. There are 7 forms of service in Lincolnshire which constitute different elements of an Intermediate Care layer either commissioned by the County Council and/or the Integrated Care Board. 80% of the services are bed based and in total there are 279 intermediate care beds across the County. These beds are commissioned differently with variable prices, furthermore there is no consistency in the model for example the beds in community hospitals are nursing led whereby the reablement service is led by social care workers.

On average, 940 people receive a service from Intermediate Care services per month. 55% of people leave intermediate care services with no or some sort of package of care back to the community. As such some of the service elements are performing well.

National Condition 2 (cont)

As a system Lincolnshire spent £34m on Intermediate Care services in 2022/23 which represents a major investment. Following the recent review, a decision was made to start a transformation programme to move from the current bed based and fragmented model to a more integrated community based approach, led by therapists.

This is a three years programme (starting June 2023) looking at setting up multi disciplinary teams in the community to support step up and step down pathways under the banner of Home First ideology.

Describe how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25, and how these services will impact on the following metrics:

- unplanned admissions to hospital for chronic ambulatory care sensitive conditions
- emergency hospital admissions following a fall for people over the age of 65
- the number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population.

Within Falls Prevention we are making use of an evidence based programme, provided by ‘One You’ Lincolnshire, to improve balance, maintain independence and increase strength for those who have fallen or at risk of a fall and subsequent ambulance call outs etc,. This

pilot programme over the course of 15 months is aiming to work with 400 people with a 24 week programme with people over 65, in cohorts of 12-14 people.

People will be assessed by a health care professional and the offer is for an hour per week of face to face strengths training but also includes a social aspect. This social aspect not only gives people the opportunity to socialise but the trained instructor will provide elements of health promotion, for example digital literacy or healthy eating. People will also be supported to undertake an hour of activity in their own time as well, utilising printed materials where tasks are demonstrated, videos and digital resources.

The programme has had a soft launch recently ahead of a full launch in July when additional instructors are trained. The programme will be independently evaluated by the University of Bristol and this evaluation will include how this programme is rolled out within a rural area and the barriers faced but also are people keeping active after they have attended the programme.

A secondary evaluation is also planned alongside Population Health Management analysis. This evaluation will flag people who have been through the falls programme and measure this cohort of people against those who haven't; monitoring for falls admissions at the acutet for example.

Primary Care colleagues are providing support, for example the South Rural PCN have an OT working with the service. Across the PCN footprint analysis has been completd to map out across the 400 people/30 programmes where the programmes need to be targeted for example, on the Lincolnshire Coast we know people are at greater risk of a fall.

National Condition 3

Use this section to describe how your area will meet BCF objective 2: **Provide the right care in the right place at the right time.**

Please describe the approach in your area to integrating care to support people to receive the right care in the right place at the right time, how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to support safe and timely discharge, including:

- ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support, in line with the Government's hospital discharge and community support guidance.

- How additional discharge funding is being used to deliver investment in social care and community capacity to support discharge and free up beds.

- Implementing the ministerial priority to tackle immediate pressures in delayed discharges and bring about sustained improvements in outcomes for people discharged from hospital and wider system flow.

Active Recovery Beds - Active Recovery Beds describe a pathway for a facility where people are ready to be discharged from hospital but are not ready to return to their former home or level of independence. They may require time, support, care and potentially therapies to enable them to be re-abled to return home. Active Recovery Beds will focus on the rehabilitation and enablement of eligible patients for the duration of their stay with the aim of minimising their reliance on longer term funded care in their home environment on discharge.

The Active Recovery Bed service aligns with the desired 'home first' approach to care for residents of Lincolnshire, supporting a person's transfer to the most appropriate setting and including an element of reablement that cannot be provided in a person's own home for a short period of time. The level of reablement service provided to each person during their Active Recovery Bed stay will be based on a detailed individual care plan with input from a Multi-Disciplinary Team including the care provider, social work practitioner and health professionals.

The core principle of the service is to maximise independence and enable the person to resume living at home safely in a time-efficient manner and where possible with a reduced package of care to what would have been required upon hospital discharge. The Active Recovery Bed service is not intended for all hospital discharges. The focus of the service is to support those with complex needs requiring an integrated response, and who can improve to enable them to live at home independently with a reduced package of statutory care.

The service will also be accessible to those in the community where a short period of stay in a bed-based reablement setting would prevent an unnecessary acute hospital admission.

National Condition 3 (cont)

This means the service will also be available for use by community services such as the Falls Response Service and East Midlands Ambulance Service. During the winter of 22/23 Active Recover Beds were procured as part of discharge monies and throughout that time 85% of referrals were accepted. Of those individuals discharged from the service, 18.3% were discharged home with no on-going care and 33% were discharged home with LCC home care or HBRS and within that 33%, 60% went home with reduced needs.

Set out the rationale for your estimates of demand and capacity for intermediate care to support discharge from hospital. This should include:

- learning from 2022-23 such as
    - where number of referrals did and did not meet expectations
    - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - patterns of referrals and impact of work to reduce demand on bedded services – e.g. improved provision of support in a person's own home, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified
- planned changes to your BCF plan as a result of this work.
    - where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?

- how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

The rational for the estimated demand is based on the number of referrals from step down pathway.

In average 940 people in Lincolnshire are receiving intermediate services per month of whom 51% are successfully moving back home with no or some home care support. The majority of Intermediate Care services are bed based and the utilization of these beds are between 75% to 80%.

In Lincolnshire, there are two community based intermediate care teams: Home First and D2A services. In order to improve the outcome for people needing Intermediate Care, a new initiative was set up in December 2022: Active Recovery Beds. This scheme provides a therapy led bridging service between hospital and home, currently 80% of people who received this service are discharged back home with no or less support.

There is a need for shifting the focus from bed based intermediate care service to community based to support both step up and step down pathways. The demand for Intermediate Care services is growing therefore a review was commissioned to ensure readiness for the future.

The outcome of this review has been summarized in the presentation. Attached.

National Condition 3 (cont)

Set out how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25 and how these services will impact on the following metrics:

- Discharge to usual place of residence

It became apparent during October and November 2022 that a number of Older Adults were spending several hours in the Emergency Department (ED) which on occasions led to hospital admission. Lincolnshire Reablement Service, alongside Adult Social Care, Lincolnshire Community Health Service In-reach Team and ULHT therapists working together co-produced and supported the Reablement Team in identifying patients that could return home, once signed off from ED, with up to 48 hours support in their own home.

During this time independence would be promoted and the right equipment would be put in place. In the past 6 months, 156 patients have received this service, with 32 progressing to no service at all leading up to 48 hours and 44 continued with the reablement services for a few more days, then needing no further input. The remaining patients either declined the service once home or needed ongoing support but with reduced packages of care. The success of this service has led to further discussions with the reablement service with a view to further expansion.

National Condition 3 (cont)

Set out progress in implementing the High Impact Change Model for managing transfers of care, any areas for improvement identified and planned work to address these.

Following on from successful collaboration between partners during the Covid Pandemic and exploration of transfer of care hubs already in place in some parts of the country, Transfer of Care Hubs opened at Lincoln County Hospital and Pilgrim Hospital Boston on 28th June 2022. The hubs consist of staff from Adult Social Care (ASC), United Lincolnshire NHS Hospital Trust (ULHT), Lincolnshire Reablement Service (LRS) which is commissioned by Lincolnshire County Council and Lincolnshire Community Health Service (LCHS). Other partners such as Age UK, Lincolnshire Partnership Foundation Trust, Housing Team and Neighbourhood Teams join the hubs virtually.

Staff triage all referrals who are medically optimised and identify their discharge Pathway - 0 to 3. If one area is busier than another, then a trusted assessor model can be implemented for example, if the representative of LCHS requires more information, if necessary, the ASC rep can support by visiting the patient on their behalf.

Whilst cases have been triaged, utilizing a strengths-based approach, some patients have been identified as not requiring services or the request has been amended to ensure the appropriate services are put in place. For those receiving support from ASC, enough information is gathered to ensure a package of care is available on discharge from hospital but a review is undertaken in the customers own home to ensure the right services are in place, at the right time, in the right place, hence ‘Discharge to Assess’.

To progress the hub to the next stage of the model for Lincolnshire, an external organization, IMPOWER facilitated an away day to identify the next steps and workstreams required to move the hubs forward. The long-term goal of the Hub is that all discharges from acute and community hospitals within Lincolnshire and Lincolnshire residents in out of county hospitals will be triaged via the hub teams and transport will also be co-ordinated from the hubs. Next steps also include recruiting staff into integrated leadership roles within the transfer of care hub to provide oversight and quicker escalation of complex cases thus reducing any delayed discharges.

National Condition 3 (cont)

Please describe how you have used BCF funding, including the iBCF and ASC Discharge Fund to ensure that duties under the Care Act are being delivered?

Lincolnshire has a strong track record of partnership working under section 75 arrangements. Working with partners across the spectrum of care enables the focus to be on the individual's journey, shaping the market to meet their needs and maximising the resources available.

The funding is being used to support initiatives that promote community-based care, enable people to live as independently as possible and invest in prevention and early intervention. Should they need to go into hospital, the funding is being used to support a prompt discharge with the appropriate package of care in place. Funding is being used to improve the information and advice provided to people in receipt of care with a focus on ease and timeliness of access.

Some of the initiatives, aligned to the duties under the Care Act, which best highlight how Lincolnshire is using BCF funding are detailed below.

- Learning Disability Services

The Community Learning Disability Team in Lincolnshire provides integrated health and social care provision. The BCF is the vehicle used to pool the funding for packages of care and provide one flow of funding into providers for both health and social care packages.

- Shaping the market (homecare and reablement)

Under the Care Act a local authority must promote the efficient and effective operation of a market in services for meeting care and support needs. Lincolnshire has utilised BCF funding to increase the rate paid for both non-residential and residential care to reflect providers cost of care, informed by the completion of a market assessment.

- Initial conversation

Strengths Based and Behavioural Approaches are being applied in over 55 teams across Adult Care, the Wellbeing Service, the Acute Trust, LPFT, Occupational Therapy Services, and will be a core part of our developing Intermediate Care Layer and Trusted Reviewer model. Our Initial Conversation Model has resulted in people having the right conversation at the right time, being supported earlier in their journey, provided information and advice and this has freed up practitioners to provide support where it is needed most.

Workshops have been delivered to over 500 practitioners across 55 teams including our system partners. Using these approaches Practitioners report a positive impact in over 90% of cases.

- Co-production

Our co-production programme delivered with the 'Everyone Co-production Network' is in progress, embedding co-production at all levels of Adult Care. We are also developing the Lincolnshire ICS co-production Strategy as a co-sponsor alongside the CEO of the ICB, working with system leads to understand what it would take for Lincolnshire to become a national leader/exemplar in co-producing health and care. This includes using current good

practice and evidence to identify what the system needs to do to embed co-production. Across the ICS over 400 people with lived experience and 70 clinicians / practitioners have been involved in co-production.

- Transfer of Care Hub and Discharge to Assess.

Following on from successful collaboration between partners during the Covid-19 pandemic and exploration of transfer of care hubs already in place in some parts of the country, Transfer of Care Hubs opened at Lincoln County Hospital and Pilgrim Hospital Boston on 28th June 2022. The hubs consist of staff from Adult Social Care (ASC), United Lincolnshire NHS Hospital Trust (ULHT), Lincolnshire Reablement Service (LRS) which is commissioned by Lincolnshire County Council and Lincolnshire Community Health Service (LCHS). Other partners such as Age UK, Lincolnshire Partnership Foundation Trust, Housing Team and Neighbourhood Teams join the hubs virtually.

- Active Recovery Beds

In December 2022 60 Active Recovery Beds were commissioned to meet an identified need for people being discharged from hospital. This service affords customers time, post discharge to recover and commence reablement to support them back to a level of independence, thus reducing the need for large packages of care and promoting self-support and independence.

- Hospital Discharge Reablement Service:

This Service involves customers being identified in the Emergency Department (ED) who, with additional support, could be discharged home from the ED with the reablement service. The service involves the reablement team taking customers home and supporting them for up to 48 hours, ensuring the right equipment is in place and actively encouraging customers to become independent.

As of 10th May 2023, 156 customers have received this service since it started 5 months ago, with 32 progressing to no service at all after 48 hours and 44 continued with the reablement services for a few more days.

- Pathway 1 Discharge to Assess

All customers that require support to remain living at home are initially reviewed in the transfer of care hub for a hybrid service provided by Lincolnshire Reablement Service and Lincolnshire Community Health Service. This joint service provides a mixture of both rehabilitation and reablement, with the goal of achieving identified outcomes and independence.

Supporting unpaid carers

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

There are a range of BCF schemes in Lincolnshire which support unpaid carers. Some are directly providing short breaks and identified within the plan, however all services are working to identify unpaid carers and provide appropriate support.

- BCF funded primarily the Health Team (including Hospital in Reach at Boston, Lincoln and Grantham)
- In addition, support was provided to increase the management team by one, to support the monitoring, evaluation and approval of personal budgets under £1000
- An additional Benefits Advisor was employed in order to manage demand and reduce waiting times

Health Community Support Advisors (CSAs)

From January 2018 to the 31st of March 2022 , the Carer's First Health team in Lincolnshire supported over 3,227 carers. These carers have been identified from the following health settings/organisations:

- United Lincolnshire Hospital Trust (ULHT Acute & Community Hospitals)
- General Practice/Primary Care Networks
- Neighbourhood Teams
- Voluntary Health Services
- Lincolnshire Community Health Services
- Palliative and End of Life Services
- Mental Health Services

Carers First Health CSA's are co-located within a range of Health settings in order to engage directly with informal carers.

During the pandemic lockdowns the team worked flexibly to support Hospital Discharge and remote and community based Carer Wellbeing Support to 940 Carers.

Benefits Advisors

Carers First has a well-developed Benefits Advice Service delivered by a team of three trained and experienced Welfare Benefits Advisers. They provide group/1-2-1 benefits workshops, benefits checks, form completions, appeals and income maximisation including applications for additional grants alongside website info/tools e.g. the Turn2us benefits calculator is embedded on Carers First website.

This dedicated team has helped Lincolnshire Carers gain an additional £5.8m in benefits since December 2017. Additionally, membership of Carers Trust has enabled Carers First to secure £66,942 for Lincolnshire Carers over the last three years to pay for items such as washing machines, cookers, beds, food, carers breaks and transport costs and Carers First is a District Council selected referrer to the Household Support Fund.

Carers Personal Budgets (Additional Manager supported by BCF)

Carers First is a strategic partner and highly experienced at assessing needs and has processed, monitored and evaluated £2.6m in Carers Personal Budgets to date in a timely manner.

A new Carers contract is in place from 2023 and BCF funding provides top-up support to this contract to achieve early identification of carers working alongside health and care partners. NHS providers will be supported to fulfil the NHS Long Term Commitment ro Carers within the ICS by supporting across the system to develop strategic and operational relationships, offering advice, guidance and securing system led support for Carers, this includes:

1. Primary Care: support and advice to develop and maintain systems and processes to identify and support adult Carers, such as: GP Carer registration; Carer Registers in Primary Care; preventative health promotion initiatives including vaccination campaign and health checks; pop up or drop-in Carer surgeries/ clinics

2. Secondary Care: support and advice to develop and maintain systems, processes and practice to identify adult Carers including provision of service information, Carer identification at admission, in-patient and out-patient settings and other support for Carers.

3. Health and Care Higher Education: influencing and supporting curriculum content to help influence and educate future professionals ahead of qualification (nursing, medicine, social work, therapies etc.), including Lincoln School of Health and Social Care and Lincoln Medical School. This also includes potential support for student placements or internships or contributing to research and student projects.

Collaboration with colleagues will also support initiatives to improve the identification and support of Young Carers and Young Adult Carers. Health partners will have their offer complemented with information and access to relevant resources, case studies and good practice, co-producing training and helping to implement good practice across the system.

Between 1 April 2022 and 31 March 2023, support was provided to 9582 carers including 2936 new carers. This support can include providing a direct payment or providing information and advice. In addition, 456 carers were supported with respite care or direct support for the cared-for-person. This highlights Lincolnshires penetration rates into the wider carer community which suggests Lincolnshire has a higher level than a number of other Councils eg. Derbyshire/Essex.

Disabled Facilities Grant (DFG) and wider services

What is your strategic approach to using housing support, including DFG funding, that supports independence at home?

In partnership with the Good Home Alliance we are looking to implement a trusted assessment role to support a range of identified cohorts. The trusted assessment role would look to identify any issues with an individuals current home so they can be supported to live independently, safe, warm and well. Cohorts of people would include those with long term disabilities where homes require adaptions, mental health as well as supporting Core20plus cohorts such as travellor communities.

The aim of this partnership would be more than a signposting service, with trusted assessors keeping a casework style role for as long as necessary until an individual no longer requires support. For some individuals it will mean a more permanent support role but still with the aim of supporting a person to live independently by helping them to develop skills to do so.

Whilst there is a number of services available to support people with their independence at home, we recognise that navigating and identifying these services can be difficult. We therefore aim to set-up self-help within the Good Home Alliance via Connect2Support. This would include a healthy home assessment that people could complete for themselves, or via family members and friends, to help identify issues within the home or that there is a requirement for support from someone within the system e.g. district nurse or fire officer. A person could also be supported by these individuals to undertake the assessment or additionally a trusted assessor can support.

DFG delivery guidance for local authorities provides examples of good practice for local strategic collaboration. Lincolnshire's Health and Wellbeing Board created the Housing Health and Care Delivery Group (HHCDG) for this purpose. This forum brings together adult care, public health, district council housing leads and the NHS and considers DFG and discretionary housing assistance in the wider context of enabling people to live independently in a home of their own for as long as possible. HHCDG is supported in overseeing the DFG by the Lincolnshire Housing and Health Network and the Lincolnshire Healthy and Accessible Homes Group.

Additional information (not assured)

Have you made use of the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO) to use a portion of DFG funding for discretionary services? (Y/N)

District councils have each adopted a policy for discretionary financial assistance under the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002. For the most part this is used to top-up the DFG and/or help applicants meet an assessed contribution. Discretionary assistance accounted for around thirteen per cent of total spend in 2022/23. However, increasing demand and costs for disabled adaptations has left none for discretionary assistance in one district's case. Some district councils offer grants or loans for other forms of discretionary housing assistance, e.g., warm homes grants. But there is currently disparity between districts and the Housing Health and Care Delivery Group (HHCDG) is seeking to achieve greater consistency. There is a common housing assistance policy in development with all district councils due to adopt it in 2023/24. This will still allow individual district councils flexibility to award assistance for other purposes and to avoid fettering discretion.

If so, what is the amount that is allocated for these discretionary uses and how many districts use this funding?

Equality and health inequalities

How will the plan contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include

- Changes from previous BCF plan
- How equality impacts of the local BCF plan have been considered
- How these inequalities are being addressed through the BCF plan and BCF funded services
- Changes to local priorities related to health inequality and equality and how activities in the document will address these
- Any actions moving forward that can contribute to reducing these differences in outcomes
- How priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5.

We have an obligation to take action to eliminate discrimination, advance equality of opportunity and foster good relations under the Equality Act 2010, public sector equality duty (2011) and reduce inequalities for the population it serves as part of the requirements of the Health and Social Care Act 2012.

Within the Health Inequalities Framework for Action we are continuining to see a year-on-year improvement in addressing health inequalities by narrowing the gap in healthcare outcomes within Lincolnshire.

We will achieve this through action to address:

• Wider determinants: Actions to improve ‘the causes of the causes’ such as increasing access to good work, improving skills, housing and the provision and quality of green space and other public spaces and best start initiatives.

• Prevention: Actions to reduce the causes, such as improving healthy lifestyles – for example stopping smoking, a healthy diet and reducing harmful alcohol use and increasing physical activity. This is supported by the re-commissioning of ‘One You Lincolnshire’ and the Child and Family Weight Programme which is into year two and is still performing well. The programme is getting good engagement and uptake and analysis can point to it being a positive preventative programme.

• Access to effective Treatment, Care and Support: Actions to improve the provision of and access to healthcare and the types of interventions planned for all

For 2023 we are introducing the concept of a health inequalities hub via the LA and ICB with the LA Public Health Team leading the way with developing some of this work the Hub. The early work of the Hub will look at demand management, particularly within CORE20PLUS groups who typically may not access preventative services and are not empowered to engage until they are attending at UEC. Looking at reducing demand across the system, from childrens to older age and understanding their barriers to access, the Hub will look to focus on service delivery and five things that can be done now to lower those barriers.

Population health management data, service level data, service user feedback and engagement and clinical perspectives will provide a wider evidence base to support the five things we can do now. The aim is to the support health equity assessments and use the evidence base to inform them to drive some deliverable, tangible system change.

This approach is joint across the system, looking to understand all data to help reduce the demand on UEC and inform system delivery.

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of NHS Lincolnshire Integrated Care Board

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**13 June 2023**
Subject:	**NHS Joint Forward Plan**

Summary:

The Health and Care Act 2022 requires the Lincolnshire Integrated Care Board (ICB) and their partner trusts to prepare a first Joint Forward Plan (JFP) before the start of the financial year.

For the first year, ICBs are required to publish and share the final plan by 30 June 2023. NHSE have developed and published guidance to support the ICB and partner trusts in undertaking this work. It sets out a flexible framework for JFPs to build on existing system strategies and plans, in line with the principles of subsidiarity.

NHS England will review and comment on draft JFPs and expect ICBs and their partner trusts to produce a first draft for consultation by 31 March 2023, with a view to publishing a final version by 30 June.

The guidance makes it clear that each system has significant flexibility to determine their JFP's scope as well as how it is developed and structured. At a minimum, it should describe how the ICB, and its partner trusts intend to arrange and/or provide NHS services to meet their population's needs.

Actions Required:

The Health and Wellbeing Board is asked to note the following:

- The requirement for the NHS to develop a Joint Forward Plan
- The requirement to involve the Health and Wellbeing Board in preparing or revising the Joint Forward Plan.

The Health and Wellbeing Board is asked provide its opinion on:

- On whether the Joint Forward Plan takes proper account of the Joint Local Health and Wellbeing Strategy.

1. Background

The Health and Care Act 2022 requires the Lincolnshire Integrated Care Board (ICB) and their partner trusts to prepare a first Joint Forward Plan (JFP) before the start of the financial year. For the first year, ICBs are required to publish and share the final plan by 30 June 2023.

NHSE have developed and published guidance to support the ICB and partner trusts in this exercise. It sets out a flexible framework for JFPs to build on existing system strategies and plans, in line with the principles of subsidiarity.

NHS England will review and comment on draft JFPs and expect ICBs and their partner trusts to produce a first draft for consultation by 31 March 2023, with a view to publishing a final version by 30 June. The guidance doesn't explicitly reference Primary Care, but we recognise the importance of their involvement throughout the development of the document.

2. Requirements

In developing the JFP, ICBs have a statutory duty to have regard to the integrated care strategy, Joint Local Health and Wellbeing Strategies (JLHWSs) and Joint Strategic Needs Assessments (JSNAs) when exercising any relevant functions. The JFP will also outline how objectives in the government mandate regarding the ambitions in the NHS Long Term Plan and NHS planning guidance will be addressed.

In developing the JFP the ICB are expected to work with their ICPs; primary care partners; local authorities; the voluntary, community and social enterprise sector; NHS collaboratives, networks and alliances; and people and communities.

ICBs and their partner trusts must review the JFP and either update or confirm it annually before the start of each financial year.

3. Overview of approach to developing Lincolnshire NHS JFP

<u>Steering Group</u>

To ensure an inclusive and coproduced approach to develop the Joint Forward Plan, a Steering Group has been established with membership from the ICB, NHS partners, LCC, Healthwatch and residents. The steering group's role is to:

- Be a partner in developing the Lincolnshire NHS JFP, not a participant.
- Inform, shape and own the process for developing the JFP.
- Champion the development of the JFP within organisations and with stakeholders
- Facilitate inputs to the JFP from organisations and stakeholders.

<u>Workshop 1</u>

A workshop was held on 8 March 2023 to agree the NHS Lincolnshire system's strategic priorities and commitments for the next five years (aligned to agreed ICS ambition and aims). To ensure the workshop achieves its objective, targeted work was undertaken with the public and NHS organisations to help develop a long list of potential priorities.

Sessions were run with each NHS organisations executive team, the Clinical Care Directorate, and the Primary Care Advisory Group to gain a range of views on what they believed the key priorities should be.

Healthwatch and NHS Engagement Team also undertook a number of activities to gain an understanding of the public's view's, activities included:

- Two Healthwatch run webinars
- Healthwatch online survey - 1028 responses
- 20 engagement events attended across Lincolnshire, talking to 254 people
- Engagement sent to over 9000 people
- Engagement sent to over 13,000 staff through organisation comms
- Shared via other partner organisations
- Attended community events across Lincolnshire to target people who do not usually engage with the NHS
- Focussed on areas with high levels of deprivation and health inequalities
- Supported patients to get involved who would not be able to access the survey online
- 388 responses to the Experiences of Care survey

Following the workshop, the notes from the round table discussions and results from the polls were analysed by the Steering Group and there was a clear consensus on strategic themes and the 5 core priorities which are:

- Strategic themes – Excellence, Innovation and Integration

- Priority 1: A new partnership with the public
- Priority 2: Living well and staying well (Prevention)
- Priority 3: Access
- Priority 4: Integration community care
- Priority 5: People

<u>Priority Development</u>

Working groups were put together to develop the priorities. These were made up of senior colleagues already leading on elements of work related to each of the priorities. Meetings were held with each working group with the expectation being they would develop the priority to identify the core ambition for the next 5 years in Lincolnshire with consideration for the local need, national requirements and plans already developed. The core elements for each priority that was identified were as follows:

- Priority 1: A new partnership with the public
    - Our Shared Agreement
    - Shared decision making
    - Co-producing services together
    - Supported self-care and self-management
- Priority 2: Living well and staying well (Prevention)
    - Preconception, infancy and early years (0 to 5)
    - Childhood adolescence (5 to 19)
    - Working age (16 to 64)
    - Ageing well
- Priority 3: Access
    - Developing services that align with the needs of the population
    - Developing the multi-disciplinary team
    - Simplifying the process for accessing health care
    - Helping the population to understand the health care they need and how best to access the right person

- Priority 4: Integration community care
    - Increasing the primary care offer
    - Embed a single hub to access step up/down care through
    - Integrating our services around the person
    - Integrating our workforce to create outstanding, responsive care
- Priority 5: People
    - Valuing our people
    - Growing our people
    - Developing our people
    - Retaining our people

Workshop 2

The developed priorities were presented to a second system workshop on 26 April 2023 to act as a 'confirm and challenge' session to test the ambition and the planned approach over the next 5 years. At the workshop a lead from each working group presented the core elements of the developed priority with attendees then taking part in roundtable discussion to evaluate and feedback on the material presented. The priorities were well received, strongly critiqued and the feedback provided was collated from each round table discussion to help shape them further.

Document Development

Following the second workshop the collated feedback from each of the round table discussions was shared with the working groups. They were requested to review and amend the information received and refine the priority further.

The final versions of the developed priorities have been shared with a copy writer who has been commissioned to ensure the final published document is truly public facing. Between the 17th- 26th May the copy writer is drafting the document with the refined information being shared with the working groups to ensure that the main element for each priority is captured.

The design of the document will be similar to the one used for the Integrated Care Strategy to ensure alignment in style as well as content. The aim is to show the Joint Forward Plan as part of a suite of documents with the Integrated Care Strategy and the Joint Health and wellbeing Strategy.

The expectation is that this work is completed by the 2 June 2023 ahead of the public and stakeholder engagement.

Public and Stakeholder Engagement

Public and stakeholder engagement will take place between the 5th and 16th June, focused on the 5 priorities and to seek further feedback and views on the priorities ahead of the document being finalised. This will include engagement with the Health and Wellbeing Board (HWB) and the NHS System Non-Executive Directors. A draft version of the document will be shared with NHSE on the 26 May 2023 with a session taking place in June to receive feedback from regional colleagues.

Following the engagement work the document will be refined further to reflect the feedback received, with the final version being ready for approval by 30 June 2023.

4. Joint Strategic Needs Assessment and Joint Local Health & Wellbeing Strategy

The Council, NHS Lincolnshire Integrated Care Board and the Lincolnshire Integrated Care Partnership must have regard to the Joint Strategic Needs Assessment (JSNA) and Joint Local Health and Wellbeing Strategy (JLHWS).

The JSNA and JHWS have been used to inform the development of the Joint Forward Plan. Professor Derek Ward presented on the 'Population Health Need' for Lincolnshire

5. Conclusion

The HWB is asked to note the requirements and approach to developing the NHS JFP and provide an opinion on whether the JFP takes proper account of JLHWS.

6. Consultation

Targeted engagement with the public took place as described in the report prior to the first workshop and further engagement is taking place between the 5 and 16 June 2023.

7. Appendices

None.

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

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Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

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

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**13 June 2023**
Subject:	**Joint Local Health and Wellbeing Strategy Annual Assurance Reports**

Summary:
This report presents the annual assurance reports for each priority area of the Joint Local Health and Wellbeing Strategy. This forms part of the Board's arrangements to assure progress is being made to improve health and wellbeing in Lincolnshire.

Actions Required:
The Health and Wellbeing Board is asked to note and comment on the information provided in the annual assurance reports presented as Appendices A to G.

1. Background

The Lincolnshire Health and Wellbeing Board (HWB) has a statutory duty to produce a Joint Local Health and Wellbeing Strategy (JLHWS) to meet the needs identified in the Joint Strategic Needs Assessment (JSNA). In addition, the HWB has an ongoing role to assure its own members and partners that progress is being made on delivering improvements in health and wellbeing outcomes whilst also reducing health inequalities.

Following a year-long engagement and development process, Lincolnshire's current JLHWS was agreed by the HWB in June 2018 (the document was republished in December 2022 after a review of cosmetic changes). The JLHWS identifies seven priorities:

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

In December 2022, the Board agreed to adopt themed HWB meetings, each priority reporting to the HWB at least once a year. In addition, the HWB reaffirmed the requirement to produce an annual assurance report for each JLHWS in time for the HWB's Annual General Meeting (AGM) in June.

The assurance reports are presented in Appendices A to G. Each report comprises a current position statement, what's worked well during 2022/23, and an overview of activities that have been progressed over the past year and then outcomes and proposals for 2023/24.

2. Conclusion

The HWB has a statutory duty to produce a JLHWS and part of the Board's on-going role is to seek assurance that progress is being made to deliver improved health and wellbeing outcomes, whilst also reducing health inequalities. The HWB is therefore asked to consider the information provided in the annual assurance reports, attached as Appendices A to G.

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

The Council, NHS Lincolnshire Integrated Care Board and the Lincolnshire Integrated Care Partnership must have regard to the Joint Strategic Needs Assessment (JSNA) and Joint Local Health and Wellbeing Strategy (JLHWS).

This report provides an update on the progress in delivering the JLHWS.

4. Consultation

The annual report provides an update on engagement activities undertaken by each JHWS delivery groups.

Each JWHS delivery group was engaged as part of producing the annual report.

5. Appendices

These are listed below and attached at the back of the report	
Appendix A	JLHWS Annual Assurance Report – Carers Priority
Appendix B	JLHWS Annual Assurance Report – Dementia Priority
Appendix C	JLHWS Annual Assurance Report – Healthy Weight Priority
Appendix D	JLHWS Annual Assurance Report – Housing Priority
Appendix E	JLHWS Annual Assurance Report – Mental Health (Adults) Priority
Appendix F	JLHWS Annual Assurance Report – Mental Health and Emotional Wellbeing (Children and Young People) Priority
Appendix G	JLHWS Annual Assurance Report – Physical Activity Priority

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, Programme Manager, who can be contacted on alison.christie@lincolnshire.gov.uk

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Joint Local Health and Wellbeing Strategy for Lincolnshire
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CARERS JLHWS PRIORITY **Appendix A**

Position Statement

Unpaid Carers

Across the UK, 6.5 million people are carers, supporting someone who is older, disabled or seriously ill. That is, 1 in 8 adults who care, unpaid, for family or friends (Source: Carers UK). There are an estimated 70,391 unpaid family carers in Lincolnshire (Source: Census 2021). Given the county's ageing population, this number is predicted to increase. The value of labour for Lincolnshire's unpaid carers of all ages is estimated at £1,677 million – more than seven times the annual budget of Lincolnshire's Adult Social Care.

The Joint Local Health and Wellbeing Strategy Carers Priority was developed with carers and sets out the county's commitment to work with carers to understand their needs, and as partners, to collaborate to support the health and wellbeing of all carers in Lincolnshire.

During the COVID 19 pandemic the Carers Priority Delivery Group was stood down due to work pressures on all part of the system. In January 2023 the group was reformed with Councillor Sneath chairing this. Membership has been revised and the group now includes members from all parts of the NHS with Lincolnshire County Council and other partners.

Work is in hand to formalise a new action plan, informed by evidence from the refreshed JSNA topic and national census data. Partners are tasked with making quarterly reports to the NHSE&I on progress in delivering the national NHS Commitment to Carers. Lincolnshire's approach is held as best practice in ensuring that responses are completed collectively providing a system-wide overview and evidencing the strength of local relationships.

What we said we would do in 2022/23

Priorities for 2022/23

- Re-launch the Delivery Group, with a new Chairman and revised membership
- Develop and agree a Carers Memorandum of Understanding for Lincolnshire
- Update the Carers JSNA topic to provide a robust evidence base to inform action
- Work together to achieve the NHS Commitment to Carers
- Maximise support for carers working in partner agencies as exemplars for other organisations
- Ensure that support for Carers is integrated across the Integrated Care System (ICS)
- Embed strengths-based approaches and tools in all carers services and processes
- Embed a Whole Family Approach across all agencies
- Use the White Paper Key principles to embed Choice – Control – Living Independently

What's Working Well – key Achievements 2022/23

Carers Priority Delivery Group

The first three meetings (to May) of the re-formed group chaired by Councillor Sneath have been very well attended by partners across the health and care system. There is a strong commitment to work together and evidence of initiatives in individual organisations which can be extended across the wider system to ensure

more consistent approaches for carers. Several group members are involved in regional and national groups and initiatives which is ensuring that Lincolnshire organisations are aware of and can quickly adopt best practice to improve outcomes locally.

The Group's approach to completing the quarterly returns to NHSE&I has been recognised as good practice. As well as using the reporting tool to record work during the previous quarter, the group is using this proactively to plan work which will ensure that the commitment is embedded in practice and delivers outcomes.

Integrated Care Board (ICB)
The ICB has appointed a full-time project officer to support the carers initiatives around raising awareness of what support is available for carers within Lincolnshire, developing a digital platform for carers to network, share resources, create signposting opportunities and give carers a voice that is valued within our organisations. This sits alongside establishing a training mechanism for managers to support their staff meaningfully and appropriately.

ICB colleagues are working with Timewise, to secure the Timewise Flex Positive Accreditation. This will provide each NHS provider organisation with the support, guidance and challenge needed to develop a robust, sustainable flexible working strategy and culture thereby supporting carers in the workforce to manage work and caring roles.

The ICB supported a successful bid by the Lincolnshire charity Every-One to NHS Charities Together Community Partnership to fund a project called *Supporting Resilience and Wellbeing in NHS staff who are informal carers.* Through this, Every-One is facilitating monthly co-production sessions with NHS staff with caring responsibilities and other professionals. The funding has also been used to recruit an 18-month post to support carers across Lincolnshire NHS organisation. The post holder commenced in post at the end of March and will facilitate learning from existing good practice activity; engage NHS staff who have caring responsibilities directly, via networks and through involvement in the separately funded NHS staff with caring responsibilities co-production group; support managers in understanding policies and sharing good practice to enable them to appropriately support staff; raise awareness of and sign up to the carers passport; and share what is learned with other public sector bodies in Lincolnshire through the Delivery Group.

Lincolnshire Partnership Foundation Trust (LPFT)
LPFT has led the way in recent years with its work to support carers. This year, the organisation has:

- Launched new Staff Carer Passport which will supporting working Carers to remain in employment with reasonable adjustments and early identification.
- Launched the new About My Relative Document giving peace of mind to the Carer and making the care more person centred.
- Through its Carers Council, developed new leaflets on Bereavement Common Reactions, Ambiguous Grief, Prolonged Grief, Trauma, Safety Planning, Deliberate Self Harm and Trauma Informed Care. These are going to print shortly and will be available on the Carers Website
- Three carers have been involved in training the new Psychological Informed Practitioners in Carers Awareness.
- Carers First delivered a Carers Awareness session to staff and have two more booked in, to raise awareness of the value of being a carer and the support available to them.

Lincolnshire County Council (LCC)
In October 2022, LCC mobilised the newly commissioned Lincolnshire Carers Service. The Service is delivered by two existing service providers, Serco and Carers First in a revised service model. All interactions with carers are 'strengths-based conversations' which help people to identify and draw on their own abilities and support networks, providing additional support as appropriate. This aligns with wider Adult Care practice.

The single point of contact is through LCC Customer Service Centre (CSC) Care and Wellbeing Hub which:

- Provides information, advice and guidance
- Supports a Next Steps Plan (measuring the starting point for carer outcomes)
- Ensures Next Steps follow ups (measuring the finishing point for carer outcomes).
- Makes onward referrals to Carers First for those requiring statutory Carers Assessment and Universal Offer where the carer requires support in addition to the advice and information already provided.

Services provided by Carers First include:

- Carer Identification: raising awareness and promoting early identification by referral partners, support to employers and health partners including developing staff carer networks with employers.
- Universal Offer (including peer support, wellbeing advice, access to learning, signposting, volunteering opportunities, carer learning, carer wellbeing activities and support to access community groups) and an annual follow up for this support.
- Carers Statutory Assessments, Support Plans and Reviews
- Personal Budgets for eligible carers
- 1:1 benefits advice and 1:1 employment support for eligible carers
- Hospital In-reach services, providing support at the earliest point of need
- Tailored support for Young Adult Carers
- Promotion of the Carers Emergency Response Service (CERS)

Carers First

In the last year, Carers First has:

- Supported 5,667 unique carers, from all parts of the county.
- Identified and supported 2,947 new carers, seeking to provide the right level of support as early as possible.
- Delivered 1,002 Wellbeing Group sessions involving 903 unique carers, receiving good feedback on all groups and programmes. Carers indicated that they prefer a blend of activity, learning and social interaction with their peers.
- Provided benefits advice to 949 carers. Given the cost-of-living crisis this service is used widely and within community and online.
- Referred 1,498 carers to other services to support their wider needs where Carers First is not best placed to meet these.
- Supported 239 carers to benefit from carer learning. Carer learning provides an opportunity to learn from experts, including other carers, when a caring role begins or is first recognised.
- Enabled all staff to complete Strength Based Approach Training to support our whole family approach.
- Enabled all staff to undertake Care Act Training to improve their understanding of statutory duties and responsibilities, especially when undertaking assessments.
- Provided 46 carer awareness events and activities in collaboration with partners, including a partnership programme with Lincoln Prison and Probation Service: what is a carer, how do we identify a carer and how to identify the support they may need.
- Recruited 34 volunteers to support ‘check in and chat’ and ‘telephone befriending’.
- Successfully engaged with 79 new male carers through the ‘Men Care 2’ programme. Currently only 32% of Lincolnshire carers known to the service are male compared with 68% female. Only 13% of the Wellbeing Groups attract males, and men are generally less likely to talk about their caring situation, but the men’s groups are turned this around.

- Continued to strive for continuous improvements through their Quality Assurance Framework and embedded Reflective Practice sessions.
- Supported a range of digital developments:
    - Held 11 carer co-production events to inform service improvements.
    - Increased website sessions by 173%, from 31,042 in Q4 21-22 to 84,799 in Q4 22-23.
    - Increased website users by 200% from 20,952 in Q4 21-22 to 62,872 in Q4 22-23.
    - The website is continuously under improvement and being developed to increase a positive user experience.
    - Increased visits to the help and advice pages by 47%, from 18,923 in Q4 21-22 compared to 27,758 in Q4 22-23.
    - Increased Carers First social media followers by 36% across all channels compared to Q4 21-22, with an additional 148% increase in reach.
    - Increased Carers First Lincolnshire Facebook page followers by 52%

What is the outcome?

The refreshed Delivery Group, with a new chairman, clear Terms of Reference, underpinned by the draft MOU creates the infrastructure to align how we support carers, creating greater consistency and quality of experience for carers. The development of a delivery plan for 2023/24 creates a focus for action, under three agreed areas:

- Whole Family Approaches
- Digital Opportunities
- Employment

The NHSE&I provides a planning and evaluation to support collaborative work to achieve the NHS Commitment to Carers across Lincolnshire's health and care system.

The actions of individual organisations set out above demonstrate individual organisation contributions to improve outcomes for carers. Extending these across organisations creates a system that becomes more understanding of and understandable to carers enabling them to secure the support that they need at the time that they need it.

The significant increase in digital activity suggests more carers seeking to self-help, through information which is available 24/7, which makes it easier to access alongside a busy home and or work life.

Carers First Evaluations 22/23 Outcomes from Carer:

- 87% Maintained/improved their Caring situation
- 89% Felt more confident and informed
- 91% Felt more resilient in their caring role
- 79% An improvement in their lives
- 94% Would recommend Carers First

Carer Feedback on support Groups:
"They also offer social contact with others and offer fun things to do, e.g. quizzes, thereby helping to improve the carers mental health."
"Facts and fun for everyone."
"I attended the finance benefits workshop which was very informative."

Carer Feedback on Service staff

"I am so grateful for this service. I am at the beginning of this dementia journey for my husband and this support has been invaluable in keeping me going. Thank you so much."
"Professional, friendly and helpful."
"My support worker is amazing and has helped me through very difficult situations."
"Both the support workers I am in contact with are fantastic, couldn't manage half as well without them."
"They are always patient and treat you as though you are their only client."
"I feel more confident when they listen and care."

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CARERS JHWS PRIORITY - PLANS FOR 2023/24

Action	How will we know it's working?	Relevant Strategy / Action Plan	To be delivered by	Lead Organisation	Lead Officer
Plan on a page to be published and communicated across the system	When we complete next years assurance reporting	JLWHS	Sept 2023	Carers Priority Group	Lisa Loy
Officially sign off MOU and promotion of the Lincolnshire Carers MOU	Evidence of its use to promote a more integrated approach to supporting Carers. The Carers delivery board will use a activities template asking for narrative when its used and how.		Review March 2024	Carers Priority Group	Lisa Loy
Seek owners for the three top priorities. • Employment /Workforce • Whole Family approaches • Digital	Activity update from each working group on a quarterly basis.		Review March 2024	Carers First LCC Other leads to still be confirmed	Lisa Loy Malcom Ryan
NHSE&I System Survey Ensure a collaborative robust process is established	Maturity Matrix		On- going	Carers Priority Group	Lisa Loy
National Commitment to Carers ambitions by 2024. As a collective group identity and agree which ones Lincolnshire can adopt and measure progress	Capturing evidence of outcomes relating to the 5 ambitions.			Carers Delivery Group	
Develop and launch digital platform	Number of users, user feedback, growth in network	ICS System Carers Plan	Launch In June	ICS	Jo Rouston
Define standardised definition of "what is carer"	Improvement in carers support in each organisation. Recognition of carers who didn't see themselves as carers. Standardised Processes and Policies to support Carers	ICS System Carers Plan	June	ICS	Jo Rouston

Joint Local Health and Wellbeing Strategy for Lincolnshire
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DEMENTIA JLHWS PRIORITY **Appendix B**

Position Statement

The Dementia Expert Reference Group (DERG) was stepped down July 2022 and new Dementia Programme Board (DPB) was launched in September 2022.

As agreed, and governed by the Mental Health, Dementia, Learning Disability and Autism (MHDLDA) executive, the new Lincolnshire Dementia Programme Board role is to both realise and, with cross organisational collaboration, develop, drive, and coordinate the delivery of the Lincolnshire Dementia Strategy. Herein, the primary objective of the Board is to deliver the programme implementation and work collaboratively, across statutory and non-statutory commissioners, providers and with people with dementia and their families and carers. To do this within the broader Health and Care system to address health inequalities and social determinants of dementia within a population health management framework. Key milestones to date include:

DPB Governance structure/Terms of Reference (ToR) completed/ratified

- Alignment under/accountable to MHJDG > MHDLDA
- Membership reviewed and expanded – to ensure inclusion of all key partnerships (expansion still in progress)
- Co-production working group/input, Every-One commissioned to support and supply
- Engagement plan to be developed

The System Responsible Officer (SRO) for Dementia is now Steve Roberts, Associate Director of Operations for Older People and Frailty Division, Lincolnshire Partnership Foundation NHS Trust (LPFT). Funding was secured for the Dementia Transformation Programme Lead, funded, and hosted by LPFT, but will be system facing lead for the DPB working to the SRO. The post has been successfully recruited to as of March 2023 and represents a new full-time resource, working in partnership with organisational leads, to lead on the DPB aligned strategy including service development and delivery.

Dementia Diagnosis Rate (DDR)
The DDR is an NHSEI Nationally reportable target currently set at 66.7% of people over 65 they estimate to have dementia to have a formal diagnosis of dementia. As has been the picture both Nationally and Regionally, DDR rates declined during the pandemic. Lincolnshire DDR for February 2023 was 61.7%, comparable with the National average of 62%. From October 2022 NHS England have provided a new data set for DDR and this has affected the data and publication dates.

There are a few reasons for the fall in the number of people being diagnosed during the pandemic, these include:

- Reduced capacity in/access to Primary Care due to vaccination programme and pandemic restrictions.
- Difficulty accessing patients/services due to isolation/health risk management
- Reduced deliverable service capacity (due to access restrictions, staffing impacts of pandemic with subsequent backlog of referrals in secondary care)
- Reduction of people leaving home/going to their GP with memory concerns with associated 'post-pandemic' referrals beyond service capacity.

Prior to the pandemic Lincolnshire has struggled to meet and sustain the overall Lincolnshire DDR. However, attainment within county has evidenced locality specific variation seen across 'CCG localities',

(now Integrated Care Board (ICB)) with the former West CCG (Clinical Commissioning Group) attaining the DDR with the other 3 sectors falling below target to differing degrees. **DDR recovery plan and action log is in place for 23/24 with a key aim of both moving towards overall DDR attainment but to attain greater equity of attainment across all Lincolnshire Primary Care Networks (PCNs).**

What we said we would do in 2022/23

Implementation of the recommendations of the CCG (now ICB)/LCC Dementia Service Review (DSR) 2021.

Engagement on the priorities from the Dementia Service Review completed in 2021 has been undertaken with people affected by dementia and stakeholders across the system and the key themes have been highlighted. The refresh of the Joint Dementia Strategy for Lincolnshire has recently begun and will take account of these. The new Strategy will set out how the Integrated Care System (ICS) [health, social care, and the voluntary and third sector] will work collaboratively to improve the lives of people with dementia and families and carers. A Dementia Strategy action plan with clear deliverables will be produced alongside the strategy to ensure that it is a 'living document' with clearly auditable actions and associated outcomes. Importantly, due to the developments in terms of the creation of the DPB and its alignment within the system governance systems, there is now a clear route via which the new Dementia Strategy (encompassing the DSR recommendations) can be progressed in terms of system prioritisation (and associated risk ownership) and delivery (in terms of cross organisational change and required funding).

Digital Self-Service Portal

The Digital Memory Assessment and Management Service (DMAMS) pilot funded by NHSE/I DDR Recovery Funding was completed and its outcomes used to inform a substantive business case that was recently supported and funded for 10 new Memory Assessment Practitioner posts (MAP). These dedicated posts, learning from the DMAMS pilot, will work digitally and in clinic-based settings (to enable real-time inputting of assessments) and target across countywide waits and referrals (postcode agnostic) with an initial aim of addressing locality-based variance in wait times. These posts are currently supported by dedicated Consultant time to undertake the diagnosis element. In addition, the development of an Artificial Intelligence (AI) assisted 'Virtual Assistant' self-service portal for the DMAMS 'front-end' continued to be developed throughout the year in partnership between LPFT, Access UK and EBO Ltd.

What's Working Well – key Achievements 2022/23

Development of a Lincolnshire Dementia Programme Board: ICS agreement to recognise the formation of a Lincolnshire Dementia Programme Board and alignment within the MHLDA governance and reporting structure. Identification of an SRO and then funding and appointment of a Programme Lead and identification of leads from all key organisations and stakeholder on the new DPB.

Incorporating 'D' to acknowledge Dementia as part of the Mental Health Learning Disability and Autism Board (MHLDA): MHLDA agreement to formally recognise the parity and importance of the dementia agenda in Lincolnshire with all other agendas under its remit and add an additional 'D' to the executive group title – now the MH**D**LDA.

Reduce Antipsychotic (AP) Prescribing in Dementia: In line with the National priority, a cross organisational task and finish group (LPFT, ICS, Primary Care, Arden & GEM) has been running and has reduced AP prescribing in dementia back to the targeted pre-pandemic levels.

Public Health/Prevention agenda: In line with current research, prevention identified as key DPB priority following December prioritisation meeting. Public Health (PH) team (led by Lucy Gavens: Public Health consultant/ Strategic Lead) have been/are working as key members of the DPB presented at/to March DPB > to identify/agree key PH priorities/focus to progress in the next 12 months. Based on current National Institute for Clinical Excellence/World Health Organisation (NICE/WHO) identified dementia modifiable risk factors/dementia risk reduction policy (see attached).

ModRiskFact.docx

We have established a task and finish group to work collaboratively as a system to look at what this means for Lincolnshire.

Dementia Home Treatment Team (D-HTT): ongoing work to implement the approved extension and expansion of the D-HTT to provide 'Hospital at Home' alternative for avoidable admissions. The D-HTT continues to support people home and has reduced dementia-related admissions for complex needs by over 50%.

Digital MAMS: DMAMS pilot completed. Identified the value of digital as an *additional* service access and provision option. Subsequent business case to increase the number of remote practitioners to support access to timely assessment, diagnosis and support for the MAMS service approved and currently recruiting.

Young Onset Dementia: Whilst not included in DDR statistics, development of a LPFT specialist Young Onset Dementia (YOD) pathway is underway; to address the specific needs of this complex patient group. Lincolnshire has a higher-than-average YOD population. Younger people with dementia experience a range of challenges, which are often different to those that older people face.

Parkinsons Disease Dementia (PDD): established joined up referral and support pathway for direct access and co-working between LCHS (Lincolnshire Community Health Services) Parkinson's Specialist Nurses and LPFT MAMS's. Further pathway development underway involving neuropsychology and pharmacy leads.

Digital Self-Service Portal (Virtual Assistant): The Digital MAMS Virtual Assistant, this is now at the final testing phase and will go-live very shortly. The VA is an AI driven 'clinical front end' that will support people able to do so to directly start their assessment and access information and will initially link in with the MAP workers to develop the proficiency of the system and provide user feedback and adjustments.

System Working: as part of the DPM remit and development, commencement of cross cross-system/organisational working to join up clinical pathways and workstreams for enhanced bi-directional outcomes. Discussions underway between dementia services/DPB and Frailty agenda, Enhanced Health in Care Homes (EHCH) agenda, Virtual Wards agenda. Also, key engagement with Voluntary and Community Social Enterprise (VCSE) to look at development of aligned working.

What is the outcome?

Lincolnshire Dementia Service System Review:
As part of the Dementia Services Review July – November 2021 commissioned by Lincolnshire County Council and Lincolnshire Integrated Care Board (ICB) (former CCG), a survey was taken across Lincolnshire on peoples experience of the services being provided across the system – work is being undertaken to revisit and build on this feedback and its associated recommendations as part of a more comprehensive Lincolnshire Dementia Strategy.

'Every-One' have been funded for a period to undertake work for the ICS. Every-One are an organisation who have expertise and are committed to engagement and coproduction. They are working across Lincolnshire to develop an expert reference group and to facilitate meaningful engagement and support people affected by dementia to be involved in coproducing, developing and the implementation of the new Lincolnshire Dementia Strategy and action plan.

Establishment of DPB and incorporating 'D' to acknowledge Dementia as part of the Mental Health Learning Disability and Autism Board (MHLDA):
Having the new governance and structure has brought dementia into parity with other key delivery boards (e.g., MH Transformation, Learning Disability & Autism). For the first time has provided a singular recognised platform from which the agenda can operate and be held accountable, and in-turn be supported by the broader ICS. Following this achievement/agreement a formal request was made by the new DPB to the MHLDA that it also incorporates Dementia into the executive groups title. This was approved with the MHLDA which is now subsequently titled the MH'D'LDA. This represents a key commitment being made to dementia in terms of parity and focus within and under the MHDLDA umbrella. Within this new structure several substantive investments in secondary dementia care have been achieved (first investment in over 15 years). This has included additional investment in Memory Assessment Services, older adult psychology, and additional medical support for the D-HTT. Current cases of need to support the delivery of VCSE delivered support functions are underway.

Reduce Antipsychotic (AP) Prescribing in Dementia:
As a result of the T&F Group we have seen a reduction in AP prescribing to pre-pandemic levels via review and development across prescribing, review requirements, service user information, GP information at discharge and updating and training of the associated clinical pathways (in primary and secondary care) for the management of challenging behaviours in dementia. Quality improvement project (potential for prescribing savings but secondary to quality improvement). Despite meeting the required target, the working group is continuing as variations in practice remain in the county and further improvements and outcomes are identified.

Lincolnshire ICS is now below pre-Covid levels and only slightly above National Average for antipsychotic prescribing for dementia patients – see tables below. The project presented to the Regional Dementia forum as a quality improvement project and received interest and positive feedback from NHSE and other systems across the region.

Anti-Psychotic Data Lincolnshire ICB

Jan 2020-Dec 2020

Locality		Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
	National Average	*9.4%*	*9.5%*	*9.7%*	*10.0%*	*9.8%*	*9.8%*	*9.7%*	*9.7%*	*9.8%*	*9.9%*	*10.0%*	*10.1%*
LICB	*LICB*	**10.7%**	**10.5%**	**10.4%**	**10.4%**	**10.6%**	**10.8%**	**11.0%**	**10.5%**	**10.8%**	**11.1%**	**11.4%**	**10.8%**
	Anti-Psychotics	*837*	*824*	*811*	*808*	*814*	*829*	*847*	*813*	*837*	*861*	*876*	*837*
	Dementia (all ages)	*7849*	*7837*	*7828*	*7737*	*7674*	*7671*	*7733*	*7761*	*7746*	*7777*	*7713*	*7746*

Jan 2021 – Dec 2021

Locality		Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
	National Average	10.1%	10.1%	10.0%	10.0%	10.0%	10.0%	10.1%	10.0%	10.0%	9.3%	9.3%	9.2%
LICB	LICB	11.2%	11.0%	11.2%	11.0%	11.1%	11.1%	10.7%	11.0%	11.2%	9.7%	9.5%	9.5%
	Anti-Psychotics	833	810	829	816	829	833	817	834	850	736	718	711
	Dementia (all ages)	7418	7371	7398	7413	7454	7520	7619	7604	7575	7551	7535	7497

Sharp drop between Sept and Oct

Jan 2022- March 2023

>>>> New data collection process started - all practices not submitting yet

Locality		Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
	National Average	9.2%	9.2%	9.2%	8.8%	8.9%	8.9%	8.9%	8.9%	9.0%	9.0%	9.1%	9.1%	9.0%	8.9%	9.1%
LICB	LICB	9.5%	9.5%	9.7%							9.4%		9.3%	9.4%	8.8%	9.3%
	Anti-Psychotics	712	714	730							637		682	694	674	740
	Dementia (all ages)	7498	7500	7549	5303	5440	5474	5550	5794	5943	6765	7525	7312	7416	7651	7929

No published data April - Sept 22 and Nov 2022

Audits across LPFT and primary care have been undertaken to gain a clear understanding of changes that need to be implemented to support the continued reduction of inappropriate prescribing, this has informed LPFT's review of their Behavioural Psychological Symptoms of Dementia (BPSD) protocol, the development of AP initiation, and review templates and training delivery for clinical staff. The recent development and recruitment of a new Pharmacy Lead for the LPFT Older People and Frailty Division, has also occurred with a key portfolio around further progression of AP review and management, interfacing with Primary Care partners. Discussions are also underway regarding what education is required for Primary, Secondary Care and Care Homes to complement the work to date.

The recent successful funding and recruitment of specialist psychology (Consultant Psychologist) due to commence end of May 2023 will also have a key remit in the development, training, and provision of non-pharmacological approaches (I.e., 'first-line' alternatives to AP's) for people with dementia presenting with complex behaviours that challenge. An additional 7 psychology posts have also been recruited to start to bring OP/dementia services into parity with working age adult resources that will further enable the development and delivery of psychologically focused support for people with dementia and their carers.

Public Health/Prevention agenda:
The task and finish group are currently developing the action plan for the offer/resources that can be used across all our health on reducing the risk factors of getting dementia and delaying the onset of dementia, encouraging people to age well, and have targeted campaigns to raise awareness of risk of dementia, disability, and frailty. For the resource to support to health and care professionals to promote and have evidence-based conversations with people on reducing the risks of dementia. Access to support for people to make lifestyle changes to reduce their risk of frailty and dementia. A business case to secure funding to support dementia specific Public Health activity is currently underway.

Dementia Home Treatment Team (D-HTT):
Expanded model agreed and key specialist roles to expand clinical remit underway. This will expand the team's capacity in terms of both total caseloads, but also its ability to care for and manage more complex cases and work across organisations and other teams to do so (e.g., Virtual Wards, Frailty Services etc.). This will further enhance patient outcomes and support key admission avoidance (and earlier step-down) to both LPFT and ULHT beds. It will also enable closer working with EMAS and community services to support potential escalations

Team expansion progressing well with several successful recruitments as below:

- Lead Consultant Psychologist – to lead on development and training for non-medical approaches to dementia care and management appointed (pending start date)
    - Once in post will enable recruitment of B7 clinical psychologist

- Lead OT – to expand capacity to assess functional capacity and support in rehabilitation - in post
- Lead pharmacist – to provide expert medicines management appointed: commences 01/02/23
- Physicians Associate – to enhance/provide more specialist physical health care.
- RGN's – to enhance physical health care support – appointed/awaiting commencement
- Physician's Associate (PA): JD completed, about to progress to advert
- Band 4 Transitional workers (x2) – to support transitions into and out of team - recruited
- Additional SAS (specialty and specialist) doctor (see LPFT/ICB BP Round below) - dedicated medical support
- Advanced Clinical Practitioner - to provide senior clinical leadership and training -aligning to pathway
- Additional core staff: registered practitioners and support workers

Digital MAMS:
Following successful business case (see above) recruitment has been completed with 10 additional Memory Assessment practitioner posts and x2 Consultant psychiatrist posts funded and coming online to expand service capacity and support those on the waiting list for access to Memory Assessment Services.

The Division has built on the original D-MAMS project into phase two taking the success of the digital work but recognising that not everyone wants to access an online memory assessment. An extension of this work has been to recruit staff into Memory Assessment Practitioner Posts which offers a county wide service. The practitioner posts have started to support teams where there are longer waits (countywide variance) and provide assessment and diagnostic service with transfer back into Community Mental health Team for ongoing support with titration of medication and monitoring. Though not yet at full recruitment, this is starting to positively impact waits and service access and has seen a reduced time from first appointment to diagnosis. The service model will continue to develop through the coming year with discussions planned with NHSEI to look at the modelling of a 'dedicated Memory Assessment Service' in-line with other regional providers.

Young Onset Dementia:
A core working group has been established, to specifically look at memory assessment and management for people with suspected young onset dementia (YOD). The work will include the development of a YOD specific clinical pathway and associated post diagnostic support.
The group has so far worked with Nottingham to look at how they have developed their young onset dementia pathway and associated resources this will support the development of the pathway for Lincolnshire. Co-working with LPFT neuropsychology services for specialist input, the alignment of a dedicated Consultant psychologist to the pathway and co-working with the Alzheimer's Society to align some dedicated YOD support (in terms of information, resource access and an aligned support worker).
The aim of having a specialist YOD pathway for Lincolnshire would be to ensure timely and appropriate diagnosis, it will also support the development of age-appropriate support and care for people including information, resources and advice on the issues specifically faced by working age adults, that can help them remain active and living well in the community.

Digital Self-Service Portal (I.e., Virtual Assistant):

The Virtual Assistant project aims to enable service users and carers who chose to use this additional service access route (I.e., digital) to commence their assessment immediately upon access; with self-completion of certain assessments and information, assisted by an AI assistant, that will reduce the assessment time and enable co-produced completion of the patient information and associated care-plans. It will also support early screening to enable timelier signposting to other services and or to a more appropriate clinical pathway if/as indicated. Following extensive work over the past year the VA is now in its

final stages of completion and will be piloted within the DMAMS team in the coming quarter. If successful and following further work this could lead to the development of enhanced digital resources and potential self-referral routes.

DEMENTIA JHWS PRIORITY - PLANS FOR 2023/24

Action	How will we know it's working?	Relevant Strategy / Action Plan	To be delivered by	Lead Organisation	Lead Officer
To have a new Joint Dementia Strategy and action plan with staged and deliverable goals. Key focus of the new strategy will be; • Prevention of avoidable cases of dementia • Improving experience of people being diagnosed and living with dementia • Championing participation, innovation, and research The plan will be overseen and supported by the Lincolnshire Dementia Programme Board and its constituent members. The goals will have assigned responsible leads for delivery and reporting to the DPB and the MHDLDA board.	People's experience of being diagnosed and living with dementia improved Reduced the number of people experiencing crisis and inappropriate hospital admissions Improved access to services for frail people and people with dementia in all areas of the County Developed Frailty and Dementia core competencies and have a workforce that feels supported Surveys, case studies, patient and customer feedback, and evidence-based practice/data.	The new Joint Strategy for Dementia in Lincolnshire and Action Plan	DPB	LPFT/ICB/LCC	Gina Thompson
To have an established DPB subgroup from the Voluntary, Community and Social Enterprise (VCSE) to support the development of the strategy and delivery of the action plan. To establish a cooperative cross service approach to the provision of dementia support within Lincolnshire that enables a 'collaborative network' approach.	Improved access to personalised pre and post diagnostic support and carer support, at the point of diagnosis to end of life care, by working in partnership with Primary and Secondary Care and Voluntary, Community and Social Enterprise (VCSE) Surveys, Carers	The new Joint Strategy for Dementia in Lincolnshire and Action Plan	VCSE	LPFT	Gina Thompson Katie Faherty
Have an established network of people with lived experience to ensure greater engagement in understanding the needs of people living with dementia, families, and	Having a strategy and action plan that has been coproduced by people with lived experience that identifies the needs of people and local	Dementia Strategy/Action Plan	Colin Hopkirk Every-One	LPFT	Colin Hopkirk Gina Thompson

Action	How will we know it's working?	Relevant Strategy / Action Plan	To be delivered by	Lead Organisation	Lead Officer
carers, that supports the codesign and delivery strategy/action plan, and services.	communities, and that addresses the health inequalities across Lincolnshire				
Recovery of Dementia Diagnosis Rate (DDR)	Increase in DDR across Lincolnshire as recorded by dementia QoF.	DDR Plan on a page, Action log and Risk register.	Andy Rix (ICS SRO), Steven Roberts (DPB SRO and LPFT AD) and Sara Brewin (ICS MH Transformation Lead)	ICB	Sara Brewin Katie Faherty
Reduction of Inappropriate prescribing of Antipsychotics for dementia patients	Reduction in prescribing rates In line with National average Maintaining/improving rate of pre-covid level	Plan on a page, Action log and Risk register	AP and Dementia Task and Finish Group	ICB and LPFT	Katie Faherty
Prevention Strategy- to have policies and a prevention offer/resources across all our health on reducing the risk factors of getting dementia and delaying the onset of dementia. Support to health and care professionals prevent ill health and promote wellbeing	Increased number s of people being referred to and accessing support from commissioned service/s One-You Lincolnshire. Social prescriptions to encourage people identified at risk to engage in a range of social activities Targeted Resources and campaigns for people at risk of developing frailty and dementia. Case Studies and evidence-based feedback from H&C services	Prevention Action plan and Dementia Strategy	Prevention Task & Finish Group DPB	Public Health	Paul Johnson PH Gina Thompson
To develop a specialist Young Onset Dementia pathway for Lincolnshire that better supports working age adults diagnosed with YOD	Case studies, patient and customer feedback, and evidence-based practice/data Development of age-appropriate services and support	Dementia Strategy/Action Plan	DPB	LPFT T&F Group for YOD	Dawn Parker

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HEALTHY WEIGHT JLHWS PRIORITY **Appendix C**

Position Statement

Healthy weight remains a priority for the Joint Health and Wellbeing Board and the Integrated Care Partnership. Nearly two thirds of Lincolnshire's adult population is overweight. Being overweight is a key risk for some conditions such as type two diabetes, coronary vascular disease (CVD), some cancers and can also be a risk factor for musculo-skeletal conditions. Preventing the onset of unhealthy weight gain and helping people enjoy being fitter and more active are some of the key preventative actions to enable more Lincolnshire people benefit from long term good health.

One You Lincolnshire is the county's commissioned provider of targeted healthy adult weight management services, part of an integrated healthy lifestyle offer (encompassing healthy weight, moving more, stopping smoking and drinking less). This preventative service is fundamental to improving the health inequalities experienced by many of our vulnerable or deprived communities, due to interacting socio-economic, physical, cultural, environmental reasons.

One You Lincolnshire commenced a new Child Weight Management service, Gloji Energy, targeting children and families in the communities of greatest deprivation in Lincolnshire.

An evaluation by the University of Lincoln, has found that One You Lincolnshire is exceeding national benchmarks for weight management interventions and is positively addressing health inequalities through targeting lower socio-economic groups.

Referral pathways remain through Primary Care and health professionals. Self-referrals introduced during the pandemic remain in place due to their success.

Governance for Healthy Weight - the Healthy Weight Partnership (which reports to the Joint Health and Wellbeing Board) has reconvened since the pandemic, with a refreshed all age terms of reference and membership.

What we said we would do in 2022/23

One You Lincolnshire

The adult weight management pathway of the integrated healthy lifestyle service continues to recover well post Covid, achieving record numbers of both referrals and outcomes. The service has returned to its face-to-face offer, and also maintained a strong digital and hybrid offer, to enable greatest reach and flexibility for client groups.
OYL continue to run specialist schemes directly addressing health inequalities and hard to reach groups such as:

- Gloji Mind+: a holistic one to one healthy lifestyle programme for people with mental health problems, addressing healthy weight, moving more and drinking less
- Man V Fat Football Leagues in Lincoln and Boston targeted at male obesity. Lincoln now has a double league, meaning it has become the second largest Man v Fat football league in the UK
- Gloji Digital – 38% of clients on this online pathway have achieved a 3% loss of bodyweight, exceeding national guidance.
- Gloji Gym and Gloji Man V Fat Gym – online offer

- Gloji Groups – a holistic hybrid offer, addressing the 5 pillars of nutrition, activity, sleep, mind and alcohol
- Work based health MOTs with a view to referring eligible clients into the service
- Support to unpaid family carers of all ages

Gloji Energy from One You Lincolnshire – the new Child and Family Weight Management Service

The new Child Weight Management service – Gloji Energy – funded by LCC for two years and delivered by One You Lincolnshire, commenced in September 2022. It takes a holistic approach to children's overall wellbeing and targets schools, children and families in Lincolnshire's most deprived communities. It will therefore also support the JHWS' Emotional Wellbeing and Mental Health (Children and Young People) and Physical Activity priorities. The service aligns closely to a range of services, in particular the National Child Measurement Programme (NCMP) and the Holidays Activities and Food (HAF) programme.

Holiday Activities and Food Programme (HAF)

The HAF programme is a government funded initiative that provides free holiday clubs in Lincolnshire over the summer, Christmas and Easter holidays. Managed by LCC, it is designed to ensure a high-quality, enjoyable experience for children and young people providing healthy and nutritious meals and physical activity. Children and young people who attend HAF clubs develop a greater understanding of food, nutrition and other health-related issues, make new friends and have the opportunity to take part in fun and engaging activities. Whilst not principally concerned with weight management, it supports key public health functions such as reducing obesity and supporting healthy weight in children, through placing a strong focus on healthy eating and physical activity.

HAF is for children and young people from Reception to Year 11 in receipt of benefits related free school-meals, with some additional discretionary targeting of other groups of children with needs, such as children at risk of school exclusion, young carers, children in care, home educated children, special educational needs etc. There is a wide geographical range of clubs available across Lincolnshire with thousands of children benefiting from happy, healthy holidays. Clubs provide a range of physical activity, enrichment opportunities, nutrition and healthy lifestyles workshops including oral health packs and water bottles, as well as healthy food which is compliant with School Food Standards. HAF providers also signpost families to other support services where required e.g. Gloji Energy.

National Child Measurement Programme

The NCMP recommenced in the 2021- 2022 school year. The aim of the programme is to highlight issues around healthy living and how to make changes to reduce the number of children with overweight or very overweight BMI. It is offered to all children within reception and year 6 at primary school and parents have the option to opt their child out. Pre-measurement letters are sent to schools after the half term October break, and measurements take place from January to May/June of that school year.

In 2022-3 the programme was able to make referrals for the first time to a new specialist service, Gloji Energy, delivered by One You Lincolnshire. Information about the new service and advice is shared in both the pre-measurement and results letter with parents so they may contact Gloji Energy directly. Contact details of children with a BMI of overweight or very overweight are also shared so the family can be contacted direct, enabling the family and specialist service to engage in healthy lifestyles and changes they may wish to make for their child.

Gloji Energy will share data with the NCMP to evidence engagement and uptake rates of those referred in. It is envisaged that outcome measures may become apparent in future NCMP trends in Lincolnshire.

NHS Health Checks

In Lincolnshire, NHS Health Checks are provided by General Practices. The programme aims to improve the health and wellbeing of adults aged 40-74 years through the promotion of early awareness, assessment and management of major health risk factors, in particular cardiovascular disease (CVD) and diabetes. Individuals having an NHS Health Check are supported to understand what their risks means for them and to consider what changes might help them reduce their risk. This may include accessing healthy lifestyle services, for example in relation to weight management, being more active and stopping smoking. There are a range of services to which people can be referred/signposted following an NHS Health Check, including One You Lincolnshire or the NHS Digital Weight Management programme.

In 2022/23, 30,816 Lincolnshire people were invited for an NHS Health Check and 18,632 people received one.

NHS Diabetes Prevention Programme (NDPP)

Healthier You is the free NHS Diabetes Prevention Programme, delivered by Xyla Health and Wellbeing and funded by NHSE, designed to empower people likely to develop Type 2 Diabetes, to reduce their risk. The programme can be accessed as a face-to-face, group-based programme or digitally via app coaching, delivered 100% online through partner Oviva. Also offered is a tailored remote service for specialist groups such as hearing and sight impairment and offer a range of languages.

In 2022/23 the NDPP supported 2,329 people in Lincolnshire, nearly twice the number of the previous year (1302).

What's Working Well – key achievements 2022/23

One You Lincolnshire achievements

Lincolnshire's Integrated Lifestyle Service, 'One You Lincolnshire' (OYL) received the results of a two year academic evaluation by the University of Lincoln. Every pathway, including Healthy Weight, outperformed national averages for similar services, with excellent feedback from clients and staff. Progress was made towards addressing health inequalities for Lincolnshire's most deprived communities. 50% of starters are from the 40% most deprived areas for adult pathways.

Weight management targets continued to be greatly exceeded in the third year of the contract, with a combined reduction in bodyweight of 29 tonnes from clients. In total, 8329 people lost weight with OYL in one of its pathways. Slimmers' World continues to be the most popular weight loss pathway that OYL offers.

- A record 2,921 clients lost 5% of their bodyweight (compared with 1068 the previous year).
- Weight management targets were exceeded by 59%.
- 1192 people had 1:1 support from a health coach

Related outcomes including clients moving more, and drinking less:

- 696 people reduced their drinking to within national guidelines (an increase from 273 the previous year)
- 4581 people improved their physical activity status

Referrals continue to recover post covid, with the service experiencing record levels of both referrals and outcomes. Particular effort is put into targeting Lincolnshire's more deprived communities, and to strengthening relationships in primary care.
In terms of preventative 'Healthy Ageing' outcomes, 32% of participants in the Adult Weight Management pathway were aged 60 or over in 2022-23.
(Data source: OYL Year 3 annual report)

Gloji Energy (GE) achievements

Early figures for the new Gloji Energy service (GE), the new Child Weight Management service delivered by One You Lincolshire, appear promising. 75% of starters completed the programme, 65% of children reducing their BMI score, 77% increasing their physical activity levels and 92% increasing their intake of fruit and vegetables.

Roll-out of GE had begun gradually, as an absence of National Child Measurement Programme (NCMP) referral data, due to NCMP suspension during Covid-19, meant there was no existing cohort of children identified as eligible for the weight management programme. As NCMP data for 2023 has now become available, it is expected that delivery will increase significantly. GE also looks likely to make a significant impact on health inequalities: to date 56% of participants on the weight management programme have come from the 30% most deprived LSOAs, and the healthy lifestyle support component of the programme is being delivered wholly in the most deprived localities with families with the greatest levels of need being identified directly by head teachers in schools with the highest proportion of free-school-meal recipients.

Holiday Activities Fund programme achievements

Achievements include a continual growth of the numbers of children participating in HAF since the programme began (final confirmed data for 2022-23 not yet available). There has been a significant reduction of unhealthy drinks brought in from home as a result of providing water bottles and the promotion of water as the drink of choice. There has also been a reduction of packed lunches sent in, with the emphasis being placed on the healthy and nutritious meal provided as part of the HAF experience.

One of the HAF programme's clubs, Lincoln's 'Strong Girl Squad' has achieved regional and national recognition - selected as a finalist for a national award by the Department for Education (DfE). The Squad is a group of female strength and conditioning coaches based at LN CrossFit, who run girls-only weightlifting workshops for girls in years 7 to 11. The squad has been selected as a regional champion for the East Midlands in the inaugural HAF 2023 Awards. National winners are due to be announced in a ceremony at the House of Commons on Thursday 18 May.

NHS Diabetes Prevention Programme (NDPP) achievements

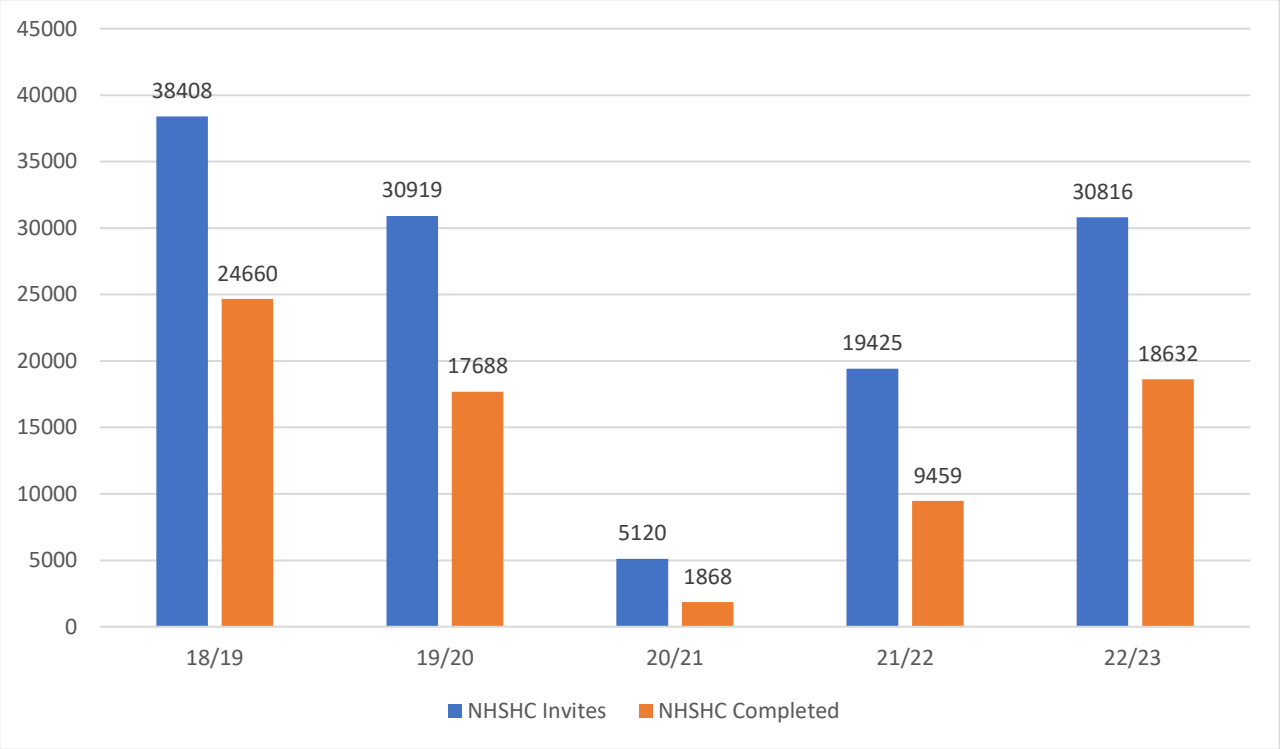
As well as nearly doubling participants from the previous year (see above), a project was also undertaken on the East Coast of Lincolnshire to tackle health inequalities with First Coastal PCN, incorporating Beacon, Marisco and Hawthorn practices which has yielded over 1,000 invite letters being sent out to patients in this most deprived area of Lincolnshire. This resulted in a dramatic uptake of the programme and a significant sustained increase in month-by-month referrals – this is as a result of information sessions about the programme referral criteria and format provided for referring clinicians.

NHS Health Checks achievements

The NHS Health Check programme was significantly impacted during COVID-19. During the last year, recovery has progressed well, with a continual increase in the number of people invited for and receiving an NHS Health Check.

NHS Health Check Activity in Lincolnshire

The figure below shows invitations for an NHS Health Check and completed NHS Health Checks between 2018/19 – 2022/23.



What is the outcome?

One You Lincolnshire

The two year academic evaluation by the University of Lincoln found that outcomes from the integrated lifestyle service exceeded standard care for all four lifestyle risks, including adult weight management. The integrated offer, combined with strong local relationships and an adaptable service was found to increase the likelihood of better outcomes for Lincolnshire residents. All clients on the adult weight management pathway were found to exceed NICE guidelines of 3% loss of bodyweight. The flexible range of support on offer meant that help could be personalised, inclusive and tailored to individual needs, with successful outcomes demonstrated for clients with long term conditions or mental health problems.

Many of the people accessing One You Lincolnshire services are from some of our most vulnerable and disadvantaged groups, and/or live in areas of Lincolnshire with the greatest levels of deprivation. Improving preventative health outcomes for these communities contributes to a greater quality of life for longer. The evaluation showed meaningful progress towards addressing health inequalities.

"The support from One You Lincolnshire has been so helpful, I am absolutely thrilled and could not have done it on my own. These calls with a Health Coach keep you on track - especially in the early days".
Kev's Story - MAN v FAT Football | Healthy Lifestyle Service | One You Lincolnshire

https://www.oneyoulincolnshire.org.uk/latest/one-new-me-tonis-story

Cast study attached at the end of this update.

Holiday Activities Fund

Cllr Mrs Patricia Bradwell OBE, Executive member for Children's Services, said: *"The HAF programme is making a real difference to the lives of thousands of children and young people across the county. Many of our providers really do go above and beyond to give the children and young people an experience to remember, while also explaining the importance of a healthy lifestyle. Strong Girl Squad have provided amazing support to the girls taking part in their club, and I'm delighted that they've been recognised for their efforts."*

Kristen Ingraham-Morgan and Claire Kirk from Strong Girl Squad said: *"Everyone at the Strong Girl Squad is beyond excited to be recognised for this award. We have been so fortunate to work with the incredible HAF team at Lincolnshire County Council, who have supported us since the very beginning, and it has allowed us to create a very special experience for the girls in our club. We are also looking forward to meeting other regional champions and sharing best practice for even better clubs in the future."*

HEALTH WEIGHT JLHWS PRIORITY – PLANS FOR 2023/24

Action	How will we know it's working?	Relevant Strategy / Action Plan	To be delivered by	Lead Organisation	Lead Officer
Gloji Energy, One You Lincolnshire Deliver first year of Gloji Energy, Lincolnshire's new child weight management service	• Overweight and very overweight children attain healthy weights • Families complete the programme • Target schools are engaged • Referral pathway from NCMP works • Feedback on service take up to NCMP • Positive child and family feedback • Referrals from appropriate health and education professionals	Joint Health and Wellbeing Strategy ICP Interim Strategy 2023	One You Lincolnshire	Provider: Thrive Tribe Commissioner: LCC Public Health	Sarah Chaudhary, LCC (SRO, Andy Fox, LCC)
Gloji Energy, OYL Develop plans to evaluate Gloji Energy	• Children and families engage with the Healthy Lifestyle Pathway • Health Inequalities are addressed • Service is effective and valued by children, families and professionals alike	Healthy Weight Priority, JHWS (Healthy Weight Delivery Plan)	One You LIncolnshire	Provider: Thrive Tribe Commissioner: LCC Public Health	Sarah Chaudhary, LCC (SRO Andy Fox)

One You Lincolnshire
Improve referrals and signposting from Primary Care through development of OYL Primary Care Champions and improved referral pathways
	• Referrals and signposting via Primary Care
	• Referrals from:
	  ○ Obesity Register
	  ○ NHS Healthchecks
	  ○ National Diabetes Prevention Programme
			One You Lincolnshire	Thrive Tribe	Alison Jackson, Thrive Tribe

One You Lincolnshire Continue to deliver a programme of adult healthy weight management options	• Weight management targets are met • Health inequalities are addressed • Positive preventative outcomes are achieved: adults engaging with the service improve their healthy weight, drink less and move more • High levels of satisfaction • High levels of sustaining outcomes		One You Lincolnshire	Thrive Tribe	Dan Rogers, Thrive Tribe

Action	How will we know it's working?	Relevant Strategy / Action Plan	To be delivered by	Lead Organisation	Lead Officer
Holiday Activity Fund programme Continue to deliver a high quality Holiday Activity Fund programme	• Maintain or increase engagement of children and young people in club activity • Regional and national recognition for achievements		Holiday Activities Fund	LCC	Denise Horner, LCC
NDPP Continue to deliver a 2023-4 face-to-face, group based programme, tailored remote service for specialist groups and digital service. Update and upskill colleagues in Primary Care on referral criteria, programme format and having difficult conversations. Raise awareness to patient groups of benefits of participation.	• Programme uptake • Patient weight lost • Increased referrals to the programme as a result of: - Primary / Secondary Care invitation. - Patient self-referral, informed by the NHS App - NHS Healthchecks - Initiatives to address health inequalities		Xyla Health & Wellbeing	Commissioner: NHS Lincs ICB, Fiona Thornton	Lisa Marsters, Senior Engagement Lead – Lincolnshire, Xyla Health and Wellbeing
Healthy Weight Partnership Support system wide collaboration to maximise healthy weight in adults and children through the establishment of the Healthy Weight Partnership and an operational officers group	Group membership adds value to individual service activities Members value the group Profile of healthy weight agenda is raised			Lincolnshire County Council	Cllr Sue Woolley (Chair, LCC) and SRO Andy Fox

Case Study 22/09/2022

Name: Sarah Randall **Age:** 52
Pathway with One You Lincolnshire: Gloji Mind+

Current Weight: 101kg **Highest Weight:** 107kg
Weight Lost: 6kg **Change of Body weight –**5.7%
BMI Change: Was 42 Now 39

How did you find out about One You Lincolnshire? And why did you feel it was time to change your lifestyle?
My GP referred me. I've had issues with anorexia aged 12 and with binging since then. I've tried Slimming World, WW and Keto, but my dysfunctional relationship with food was ALWAYS the problem. I never had support and I was on a self-destructive merry-go-round! I have diabetes and I suffer chronic pain. My mental health was failing. When an operation didn't go well, I knew a serious change was needed.

How was your journey with One You Lincolnshire?
I was unsure what to expect. 12 weeks seems so short. Being honest, I didn't think I could change. At the first appointment, Sam was really understanding and non-judgemental. This helped me be really honest with myself. I was surprised at the small targets Sam helped me to set and it was refreshing to meet someone who understood the psychological problem.

What support did you receive?
We had weekly telephone calls about the difficulties, successes and how general life impacted my diet. I began to understand my emotional attachment to food. Sam suggested having "me" moments to take time to taste, smell and savour a treat and that changed my self-loathing after I'd binged on a huge chocolate bar to allowing myself a smaller bar with no guilt. We use tea plates instead of dinner plates. I listen to my body now.

What were your barriers and how were you able to overcome these?
Eating when stressed, binging, feeling miserable then starting all over again. We've had a lot of stress and crisis recently. Normally I would spiral, and hide at home eating rubbish. When my husband suggested less treats I would "colourfully" suggest, in my best Glaswegian style, that he didn't come back without the requested size and number of snacks lol!

I swapped the largest bar of chocolate for a smaller size. By week three, the family saw I was eating less rubbish so we worked on our behaviour as a family. It has been challenging, but little changes are having positive impacts on us all. Sam helped me realise no food is bad. I'm more aware of what I'm eating now, so I can make informed choices, I understand labels, traffic light info and portion control.

What were your goals?
Weight loss. Improving my general health. Managing my diabetes. I hoped to break the emotional attachment I had with food. Sam explained it might take a lot of time, but in 12 weeks, I have learnt the tools to keep chipping away at it.

What did you eat before you lost weight? – Give us a typical day if possible
Breakfast would be a large bowl of crunchy nut cornflakes and I'd finish a box in four days.
Lunch, bacon sandwiches, pot noodle, or tin of soup and buttered bread.
Dinner, a large bowl of chilli with cheese, sour cream, and nacho crisps. Or rib eye steak, fried onions mushrooms and chips.
Snacks would be the largest bar of galaxy caramel, sweet & salty popcorn, a family tray of sticky toffee pudding with custard. Or a full-size tub of haagen dazs ice-cream in one sitting.

What do you eat now? - Give us a typical day if possible- pictures would be great
Breakfast, 2 Weetabix, no sugar, semi skimmed milk with banana, or porridge.
Lunch, a salad or baked potato with mozzarella. I sometimes need reminding I'm not as hungry. If I'm lazy, I'll grab an apple, banana and a nectarine.

Dinner, pork loin with fat trimmed off, broccoli, peas, carrots and baby potatoes. Or half of a roast chicken breast - no skin, with air fryer roasted potatoes.

Snacks. I don't snack every day. Sometimes a scoop of halo ice-cream, but I prefer fresh fruit. And I'm drinking much more water.

What would you say to anyone thinking of joining One You Lincolnshire?
In my opinion, this is far superior to any diet, or weight loss programme out there. Providing you find the right headspace, this programme will work for you. You must be open and honest with yourself and your coach. It's ongoing so you have to invest in it.

How has your life changed now that you have lost weight?
I feel more confident and I'm proud of myself. Chronic pain will always be with me, but it has lessened and I hope that will continue the more weight I lose. Sleep is improving and I have more energy.

Sarah's story – by her One You Lincolnshire healthy lifestyle coach
Sarah made simple changes to her lifestyle and it allowed her to **lose almost 1 stone of body weight** and **change her relationship with food.** Sarah achieved these impressive changes when she joined Gloji Mind+ with One You Lincolnshire.

When I first spoke to Sarah , she was very open and honest about lack of mobility, chronic pain and a tendency to reach for food as a comfort. We agreed on small changes that would be easy to make everyday.
Sarah's reaction was a mixture of relief and disbelief because Sarah had only ever known the "diet culture" of banned foods and sticking to a strict plan. We set realistic and achievable goals and she began began to feel empowered and confident.

Gloji Mind+ isn't just about nutrition, it's about unpicking emotional connections and destructive thought patterns that hold people back. Sarah lost weight, improved her health and reduced levels of pain by learning how to manage her relationship with food.

Sarah has put her all into it and I am so very proud of Sarah for all she has achieved.
Well done Sarah!

HOUSING AND HEALTH JLHWS PRIORITY **Appendix D**

Position Statement

The Housing Health and Care Delivery Group (HHCDG) under the chairmanship of Councillor William Gray continues to oversee a Delivery Plan of actions to meet the objectives for the Housing and Health Priority. These are drawn from the Lincolnshire Homes for Independence Blueprint. Meetings are very well attended by lead councillors and officers from all eight local authorities, with a clear focus and robust discussion on the Delivery Plan actions. A review of membership is in hand following the district council elections. The Health Inequalities lead and the Strategic Estates lead for the NHS Lincolnshire Integrated Care Board (ICB) have joined the group. Their attendance is enabling new discussions about targeted activity in support of those whose housing circumstances negatively impact on their health. Representation from the NHS provider trusts requires further consideration.

The Lincolnshire Housing and Health Network (LHHN) coordinates action to achieve the Delivery Plan for HHCDG. The Network chair role has recently moved from West Lindsey District Council to South Kesteven District Council. Actions are allocated to subgroups each with a named lead. Most recently the Lincolnshire Housing Standards Group has expanded its remit beyond enforcement of housing standards in the private rented sector. The Lincolnshire Homelessness Strategy Partnership under the direction of the Lincolnshire Housing [Homelessness] Partnerships Manager has established four priority action groups (Prevent, Protect, Place and Partnerships) under a Strategic Leads Group.

The Lincolnshire Housing Partnerships Manager is a joint-funded post; other joint-funded roles instrumental in delivering numerous Delivery Plan actions, are:

- The Lincolnshire Healthy and Accessible Homes (Housing) Strategic Lead employed by Boston Borough Council. The previous post-holder has moved on and a new officer will commence for 12 months in late June 2023.
- One additional Public Health Analyst was recruited in October 2022 to increase capacity in the Public Health Intelligence Team and begin to improve housing intelligence.

In addition, a service design consultant from ARK Consultancy was engaged and is funded to June 2023 by the Centre for Ageing Better (AB) to explore the model for a Good Home Alliance funded to improve access to services, and potentially for others to adopt across the country.

These resources have accelerated implementation of the HHCDG Delivery Plan. It is recognised that additional resources may be needed to complete an ambitious programme of work.

What we said we would do in 2022/23

Progress on Delivery Plan actions is reviewed at each HHCDG meeting through a report from the LHHN Chairman and more detailed reports from lead officers, identified on a Forward Plan. Key areas of work during 2022/23 included the following:

<u>Develop a Good Home Alliance and Create a One Stop Shop for Equipment, Aids and Adaptations.</u>
This has progressed well. Starting with a significant programme of co-production with Lincolnshire residents, the service design consultant has led the co-development of a Good Home Alliance across Lincolnshire resulting in eight themes to take forward:

0. Access to information and advice.

1. Healthy home assessment.
2. Energy efficiency/keeping warm.
3. Trusted traders.
4. Financial solutions.
5. Support to commission work.
6. Advice on all options.
7. Practical support.

As part of the Good Home Alliance project, the Centre for Ageing Better have also created a learning network which is comprised of representatives from a number of different local authorities from across the country. The purpose of the learning network is to share best practice and use this to inform the Lincolnshire project, as well as feeding back the work and learning from the Good Home Alliance project in Lincolnshire.

Expand Lincs 4 Warmer Homes (L4WH) to create a comprehensive Home Energy Advice Service.
This was explored by the Greater Lincolnshire Energy Efficiency Network (GLEEN) but has not progressed as initially proposed. The need remains as rises in energy costs and the number of households expected to be in fuel poverty continue to rise. Energy efficiency advice for those who are more susceptible to the cold and who need support to create sustainable warmth is to be progressed as a theme of the Good Home Alliance.

Refresh the Lincolnshire Homelessness and Rough Sleeper Strategy
This has been completed. The Lincolnshire Housing Partnerships Manager led the refresh through the Strategic Leads Group. The Manager has also represented the homelessness strategy partnership group on a task and finish group established in April to progress the second phase of the Team Around the Adult initiative.

Hoarding Protocol Review
This has progressed well. Following a well-attended multi-agency workshop in June 2022, a small working group has reviewed the protocol and is developing a pilot hoarding support service in the First Coastal Primary Care Network area around Skegness, where the highest proportion of identified hoarders are located. The protocol has been deemed fit for purpose in terms of supporting front line workers to identify the issue and refer people who hoard to a single point. The referrals were made to a Hoarding Advocate post in Lincolnshire Fire and Rescue, funded by Public Health, but this has ended and the postholder has returned to a substantive post. NHS Lincolnshire ICB has provided £120,000 funding to LCC for the pilot service as there has been no widespread service to refer people on to for therapeutic support and/or counselling in addition to clearance services and this will be progressed in 2023/24.

BRE Housing Stock Modelling
This is progressing. HHCDG wishes to maintain a picture of housing conditions across all tenures and to be able to cross-reference this with health and other socio-economic data to establish demand and target interventions more effectively. The Public Health Intelligence Team will fulfil this role. To bring the baseline data up to date we need to recommission the BRE [Building Research Establishment] local authorities' statistical information service. It has been challenging to agree an acceptable cost with BRE. Agreement to co-fund this collectively is being sought.

Leads for each action are now reviewing their actions with the relevant subgroups to ensure desired outcomes are specified and have realistic timelines for completion. Many actions are long-term and LHHN will continue to work with the relevant subgroups to define final outcomes, interim milestones / outputs and define success with these, all set out in the Delivery Plan.

New actions identified in 2022/23 include:

- Digital-enabled homes
- Consistent approaches to tackling damp and mould issues across all tenures.
- Housing renewal, with a focus on owner occupiers.
- Planned maintenance programmes, improvements, and responsive repairs in social (Registered Provider) housing.

These will be planned into the revised Delivery Plan.

What's Working Well – key Achievements 2022/23

Good Home Alliance and One Stop Shop for Equipment, Aids and Adaptations

The co-production activity has provided a very clear picture of need in Lincolnshire. The co-design group was formed with a number of local residents who worked with the service designer on various aspects of the project. They were able to give insights and feedback in order to help develop several elements of the work, such as the potential design of a homes section on the Connect to Support website and the structure of the Healthy Home Assessment/Housing MOT. Next steps to move forward the eight themes identified have been endorsed by HHCDG and feature in the Lincolnshire Healthy and Accessible Homes Group work plan.

The One Stop Shop for Equipment, Aids and Adaptations and [single point of] access to information and advice will be one and the same. The pathways are Connect to Support Lincolnshire for self-help (with some support from the Lincs 2 Advice Service) and the Adult Care Customer Contact Centre. There is, however, no wrong front door. Services that are part of a Good Home Alliance (e.g., Lincolnshire Fire and Rescue (SHERMAN and fire safety checks) will need to be integral to it). Connect to Support Lincolnshire will have a new area dedicated to the Good Home Alliance as an information repository and will host the Healthy Home Assessment. A programme of workforce development will ensure that those working with people who need support to accessing information receive information from their existing case-workers.

One of the themes identified in the engagement work for the Good Home Alliance project was around the issue of finding trusted tradespeople. Lincolnshire County Council Trading Standards team are implementing the national Trading Standards approved Buy With Confidence scheme in Lincolnshire, which, once established, will help meet this need. Trading Standards colleagues are also supporting with the development of the homes section of the Connect to Support website to ensure that residents can access useful and trustworthy advice on sourcing tradespeople.

HHCDG has supported piloting a Casework and Advice service. Partners are currently scoping this and identifying resources. Other themes will be progressed once the Casework and Advice element has been piloted.

Home Energy Advice Service

The South and East Lincolnshire Councils Partnership and the Greater Lincolnshire Energy Efficiency Network (GLEEN) have each submitted applications for Government funding to run Local Energy Advice Demonstrator (LEAD) to help inform what is needed and create a long-term solution as part of a Good Home Alliance. The outcome is of these bids is awaited.

Lincolnshire Homelessness and Rough Sleeper Strategy

Following endorsement by HHCDG, the new Lincolnshire Homelessness and Rough Sleeper Strategy was adopted by all district councils and endorsed by Lincolnshire County Council (LCC) at the end of November 2022. The priority themes have action groups to drive achievement of outcomes. The Prevent action group covers protocols to help ensure certain cohorts of people or people leaving certain settings do not become

homeless or remain rough sleeping. The Prison Release Protocol has been in place for all of 2022/23 and its effectiveness will be reviewed. Recommendations from the Prison Protocol pilot review carried out by the University of Lincoln will be taken forward. Work has also been carried out to review the roles of TAA, vulnerable adult's panel and appeals panels to ensure consistency and access to accommodation and support. Progress has been made with a protocol for people with no recourse to public funds, including those who also have and are receiving treatment for Tuberculosis, setting out how to deal with individuals who are not entitled to help meeting accommodation costs. Work is continuing on delivering the Rough Sleeper Accommodation Programme funding four self-contained units in North Hykeham with the support of £82,000 secured from Homes England. The Housing Advisors Programme funding, including £20,000 from the LGA, will be used to procure a consultant to determine a robust evidence base for specialist accommodation and models across the county. The HHCDG receives regular progress updates throughout the year, including updates on the numbers of people homeless in each District area and the efforts made to provide appropriate accommodation.

Lincolnshire Refugee Resettlement Partnership

Colleagues from North Kesteven District Council have convened and chaired the Lincolnshire Refugee Resettlement Partnership since its inception in 2016/17. Membership includes all 8 local authorities, ICB, Police and DWP. The initial workload has expanded from finding homes for a small number of Syrian refugees to include:

- Support to Hong Kong British Nationals from 2021
- Support to Afghan evacuees from August 2021
- Oversight and assurance regarding asylum contingency hotels from October 2021
- Ongoing support to those fleeing Ukraine from March 2022
- Collective responses to proposals for Dispersed Asylum Accommodation
- Seeking a collective understanding following the Home Office announcement in March 2023 of proposals to use RAF Scampton to house Asylum Seekers

The core considerations for HHCDG include the availability of and pressure on housing supply arising from the range of schemes now in play, alongside local demand and existing homelessness pressures, and the safety and compliance of larger-scale housing provision. Partners have gained a wealth of knowledge in a short period of time to be able to assure themselves regarding the health and safety of those accommodated, those working with them and the wider community. This is enabling a 'check and challenge' to new proposals as these emerge.

Extra Care Housing and Specialist Adults Accommodation

Effective collaboration between partners has enabled the following schemes to progress:

- North Kesteven District Council submitted a planning application for The Hoplands on Friday 17 March 2023. This proposed development will feature 40 extra care apartments for older people and 12 community supported living units for working age adults with a disability. Should planning be approved and the required funding awarded, it is proposed the scheme will commence construction towards the end of 2023.

- Prebend Lane, Welton is a partnership with LACE Housing and West Lindsey District Council. This obtained planning approval and was awarded the required funding to support development in March 2023. Construction has started with completion anticipated in December 2024. The development will feature 62 one-bedroom apartments for older people and 10 bungalows available for shared ownership.

- Grange Farm, Market Rasen is a partnership with ACIS Group and West Lindsey District Council. This achieved Executive approval from Lincolnshire County Council in April 2023. Partners are working to develop plans and submit listed building consent ahead of construction commencing in summer 2023. The development will see the refurbishment of Market Rasen House, a former foyer in the centre of Market Rasen to provide 10 self-contained apartments with access to on-site care and support for working age adults with a disability. Alongside providing the specialist housing, Grange Farm will offer a potential social enterprise opportunity. This will focus on delivering learning and independence skills through growing produce and caring for animals.

- Options to deliver possible opportunities within Boston, Spalding, and Horncastle are being explored. The current volatile construction industry and inflationary pressures are impacting Registered Providers capacity to deliver further schemes at this time.

What is the outcome?

The aim of the HHCDG is for people to live independently, stay connected and have greater choice in where and how they live. The needs of those with health and care needs, and those for whom the normal housing market does not routinely cater, are considered in the Lincolnshire Homes for Independence blueprint:

- Children and young people, including children with disabilities, childhood asthma and looked after children leaving care.
- Working-age adults with mental health needs, dementia, learning disabilities, and autism.
- Older adults.
- Homeless people.
- People who hoard.
- Domestic abuse victims.
- Unpaid and family carers.
- Armed Forces personnel and veterans.

Other groups identified through the Inclusion Health and Health Inequalities agendas and Refugee Resettlement may also need consideration going forward, including:

- Gypsies and Travellers.
- People in contact with the criminal justice system.
- Farmers.
- Vulnerable migrants.

We want to better understand needs and opportunities (improve the evidence base) through continual improvement of the Joint Strategic Needs Assessment (JSNA) on:

- Homelessness
- Housing standards, and
- Unsuitable homes.

Delivery outcomes are that the above cohorts of people are either supported to remain living in their current home or people are helped to find and move to a suitable home where they can stay safe and well, warm and connected to other people. In each case it is about maintaining the greatest level of independence possible and reducing demand for care, residential care, and nursing homes. Reducing the need for GP visits, medication, Accident and Emergency attendances, hospitalisation, repeat admission and/or longer stays in hospital than necessary that are associated with housing issues are other positive secondary outcomes.

HOUSING AND HEALTH JLHWS PRIORITY - PLANS FOR 2023/24

Action	How will we know it's working?	Relevant Strategy / Action Plan	To be delivered by	Lead Organisation	Lead Officer
We will review the evidence base and develop analysis to maintain an up-to-date picture of demand for homes with care and support and preferred locations and clarify the priorities for future investment	Accessing resources to support with data gathering; ability to link demand with care and support and delivery; by publishing an extra care housing delivery programme	Homes for Independence Blueprint	Greater Lincolnshire Affordable Housing Group; Lincolnshire Healthy and Accessible Homes Group	Greater Lincolnshire Affordable Housing Group	Chair of the Greater Lincolnshire Affordable Housing Group
We will make a strong case for investment in housing to reduce health and care costs	Understand any reduction in care costs through housing initiatives; by understanding and mapping local services that support independence; greater understanding of any gaps in service and national best practice; the creation of a business case for preventative intervention; development of a HHCDG communication plan	Homes for Independence Blueprint	Lincolnshire Healthy and Accessible Homes Group; Good Home Inquiry Steering Group	Lincolnshire Healthy and Accessible Homes Group	Chair of the Lincolnshire Healthy and Accessible Homes Group
We will improve our understanding of housing conditions in Lincolnshire, the impact on physical and mental health, and the potential cost of poor housing to health, care and society	Greater understanding of housing conditions in Lincolnshire, the impact of poor condition homes; completion of a health impact assessment and a targeted plan to mitigate health impacts of poor condition homes; greater knowledge of extent of damp/mould issues and indoor air pollution	Homes for Independence Blueprint	Lincolnshire Healthy and Accessible Homes Group; Lincolnshire Housing Standards Group	Lincolnshire Healthy and Accessible Homes Group	Chair of the Lincolnshire Healthy and Accessible Homes Group
We will maximise the financial resources available to tackle poor	Measure the impact of improved housing standards on those with specific health conditions;	Homes for Independence Blueprint	Lincolnshire Healthy and Accessible Homes Group;	Lincolnshire Healthy and	Chair of the Lincolnshire Healthy and

Action	How will we know it's working?	Relevant Strategy / Action Plan	To be delivered by	Lead Organisation	Lead Officer
housing standards and ensure they are effectively targeted	development of interventions to support energy efficiency; implementation of a discretionary housing assistance policy; consideration of other sources of financial support such as ethical equity release		Greater Lincolnshire Energy Efficiency Network (GLEEN)	Accessible Homes Group	Accessible Homes Group
We will make best use of enforcement powers available across different organisations to target criminal landlords	Development of a protocol between districts and Trading Standards; broaden protocol relating to HMOs to all housing	Homes for Independence Blueprint	Lincolnshire Housing Standards Group	Lincolnshire Housing Standards Group	Chair of Lincolnshire Housing Standards Group
We will facilitate quality, choice, and diversity of housing for people with care and support needs	Provision of universal housing advice across all services; improvement of housing and hospital interface	Homes for Independence Blueprint	Lincolnshire Healthy and Accessible Homes Group	Lincolnshire Healthy and Accessible Homes Group	Chair of the Lincolnshire Healthy and Accessible Homes Group
We will achieve a proportional move towards maximising independence for working-age adults and older people needing care	Implementation of the Specialist Adult Accommodation Strategy; development of the Accommodation Sourcing Subgroup; review of hoarding protocol and development of pilot service	Homes for Independence Blueprint	Lincolnshire Healthy and Accessible Homes Group	Lincolnshire Healthy and Accessible Homes Group	Chair of the Lincolnshire Healthy and Accessible Homes Group
We will address the underlying causes leading to homelessness whilst still providing appropriate support and housing for those who need it	Development of a joint agency protocol for those with no recourse to public funds	Homes for Independence Blueprint	Lincolnshire Homelessness Strategy Partnership	Lincolnshire Homelessness Strategy Partnership	Chair of the Lincolnshire Homelessness Strategy Partnership

Action	How will we know it's working?	Relevant Strategy / Action Plan	To be delivered by	Lead Organisation	Lead Officer
We will increase units of single person accommodation to house those who would otherwise be sleeping rough	Development of proposals and bids for the Single Homeless Accommodation Programme; delivery of the Rough Sleeper Accommodation Programme	Homes for Independence Blueprint	Lincolnshire Homelessness Strategy Partnership	Lincolnshire Homelessness Strategy Partnership	Chair of the Lincolnshire Homelessness Strategy Partnership
We will strengthen healthcare inclusion services for homeless people across the county	Embed VCS services in mainstream inclusion health services; development of support services for vulnerable people; continue and embed NHS and mental health support following Everyone In	Homes for Independence Blueprint	Lincolnshire Homelessness Strategy Partnership	Lincolnshire Homelessness Strategy Partnership	Chair of the Lincolnshire Homelessness Strategy Partnership
We will ensure services to support people to remain living in their current home complement each other as a system-wide approach	Recruitment of Lincolnshire Strategic Lead; exploration of potential of digital equipment by consideration of combining DFG resources	Homes for Independence Blueprint	Lincolnshire Healthy and Accessible Homes Group	Lincolnshire Healthy and Accessible Homes Group	Chair of the Lincolnshire Healthy and Accessible Homes Group
We will develop a seamless, customer-friendly 'one-stop shop' to deliver cost effective services with the person at the centre	Exploration of the role of the Wellbeing Service; continuation of work to potentially deliver a Good Home Alliance; creation of a one stop shop for aids and equipment; pilot stairlift delivery via LCES, development of a Housing MOT; development of a consistent approach to damp and mould issues across all tenures	Homes for Independence Blueprint	Lincolnshire Healthy and Accessible Homes Group; Lincolnshire Housing Standards Group; Good Home Inquiry Steering Group	Lincolnshire Healthy and Accessible Homes Group	Chair of the Lincolnshire Healthy and Accessible Homes Group
We will make best use of digital technologies to enable homes for life	Greater understanding of the support offered by digital enabled homes	Homes for Independence Blueprint	Lincolnshire Healthy and Accessible Homes Group	Lincolnshire Healthy and Accessible Homes Group	Chair of the Lincolnshire Healthy and Accessible Homes Group

Action	How will we know it's working?	Relevant Strategy / Action Plan	To be delivered by	Lead Organisation	Lead Officer
We will influence delivery of new-build housing to provide greater choice of homes with care and support across all tenures	Influencing local land plan to support housing needs; development of a new build programme to support independence, incorporating extra care, consideration of mechanisms to offer design and build opportunities to those with disabilities and complex needs	Homes for Independence Blueprint	Greater Lincolnshire Affordable Housing Group	Greater Lincolnshire Affordable Housing Group	Chair of the Greater Lincolnshire Affordable Housing Group
We will support more people with care and support needs to access social and private rented homes	Review of working practices between organisations; investigate the feasibility of establishing a Social Letting Agency	Homes for Independence Blueprint	Lincolnshire Healthy and Accessible Homes Group	Lincolnshire Healthy and Accessible Homes Group	Chair of the Lincolnshire Healthy and Accessible Homes Group
We will provide more extra care housing of different levels to meet demand	Progress the extra care housing and build out schemes	Homes for Independence Blueprint	Greater Lincolnshire Affordable Housing Group	Greater Lincolnshire Affordable Housing Group	Chair of the Greater Lincolnshire Affordable Housing Group

<u>Disabled facilities grant (DFG) delivery.</u> The publication of new Government guidance on delivery of DFGs and use of the Better Care Fund for discretionary housing assistance provides a new opportunity for a systematic review of how services are delivered between districts that leads to a consistent approach across the county.

<u>Discretionary housing assistance policy.</u> District councils and the County Council developed a discretionary housing assistance policy to use Disabled Facilities Grant (DFG) funding flexibly to meet related needs for individuals. Whilst this is not yet a common policy across all seven District Councils, it has provided a framework to build on.

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MENTAL HEALTH (ADULTS) JLHWS PRIORITY **Appendix E**

Position Statement

Suicide Prevention

Suicide prevention is a complex system-wide challenge that requires close working between the NHS, Public Health and a range of partner organisations, tailoring evidence of what works to local need and determinants. Suicide prevention is an important ambition that exists in the context of other improvements to mental health services in the NHS Long Term Plan. Suicide devastates families and communities. It is the biggest killer of men aged under 50 and all adults under 35. Suicide is also the leading cause of death for 10–19-year-olds. A suicide death is often the result of the ultimate loss of hope and purpose in life. Whilst the relationship between suicide and mental ill health is well established, many suicides happen impulsively in moments of crisis with a breakdown in the ability to deal with life stresses, such as financial problems, relationship break-up or chronic pain and illness. Only a proportion of those who die by suicide are known to mental health services.

Lincolnshire Suicide Prevention Strategy sets up key priories and actions for the system wide approach and the progress is overseen by the multiagency Suicide Prevention Steering Group.

- Suicide rates remain significantly higher than the England average.
- Rates are highest in men in Lincolnshire, especially of young-middle age.
- Increasing number of children and adults experiencing mental health issues.
- Mitigating the impact of wider economic factors (e.g., cost of living) is important.
- Understanding self-injury as a risk factor for suicide, and how best to respond locally to reduce the risk of future suicide attempts.

Adult Mental Health Community Transformation

The Adult Community Mental Health (CMH) Transformation programme aims to deliver accessible mental health services to adults across a continuum of care that spans the Voluntary and Community Social Enterprise (VCSE) sector, Primary and Secondary care. The overarching premise of the programme is to put the person at the centre and to deliver right care, in the right place at the right time with no cliff edge between services and no wrong door for access.

The countywide programme delivers against the NHS England Roadmap for CMH Transformation and is currently on target to achieve all specified deliverables by March 2024. The programme is delivered and governed within an Alliance framework encompassing NHS Lincolnshire Integrated Care Board, Local Authority, Primary and Secondary Care and importantly in partnership with Experts by Experience. Key milestones for this programme of work are:

- Move away from Care Programme Approach towards Personalised Care
- Embed Trauma Informed Practice and Care Approaches
- Increase access to evidence based psychological therapies
- Recruit and expand the workforce in line with identified Populations and Workforce Profiles
- Embed the routine collection of nationally mandated Patient Related Outcome Measures
- Progress system interoperability for activity across VCSE, Primary and Secondary Care
- Develop Childhood Emotional Neglect/Personality Disorder, Community rehab and Eating Disorder services
- Align models with NHS Talking Therapies, Children and Young People and Perinatal Services.

What we said we would do in 2022/23

Suicide Prevention

- Further development of key processes of responding to suicides and attempted suicides (implementation of cluster response plans, Real Time Suicide Surveillance).
- Implementation and evaluation of Lincolnshire Suicide Bereavement Service.
- Identification and implementation of learning from local and national children and young people suicide mortality review reports.
- Ongoing analysis of data to identify trends, clusters, and emerging risk factors to inform commissioning of services and projects including Wave 3 of the Community Suicide Prevention Innovation Fund.
- Reviewing communication and awareness campaigns.

Adult Mental Health Transformation

- Updated Peter Hodgkinson Centre due to open early 2023.
- Mental Health Assessment Unit will be piloted and evaluated.
- Integrated Place-Based Teams in all 12 neighbourhood areas, covering all 15 Primary Care Networks, each with a complement of Mental Health Practitioner roles, embedded community Mental Health Teams and wider resource including community connectors, social prescribers and peer support workers.
- A fully developed training offer for a wide range of individuals including boundary training, trauma informed care, Mental Health First Aid and Mental Health awareness. We are also developing a primary care tailored package to support upskilling and an informed workforce and will be co-producing a package for carers and care home workers.
- Further investment in the VCSE sector to improve community assets and reduce inequalities.
- Connected community events and development days to enable the workforce to continue to transform.
- A service to support those bereaved as a result of suicide is being procured to ensure countywide access, on the basis of initial pilot provision.
- We are committed to ensuring experts by experience are hard wired into pathway design and investment decisions. We have evolved our co-production group to a wider network with the intent to support all elements of mental health, Learning Disability and autism.

Mental Health

- Develop and begin to monitor outcomes to track delivery against the priorities for 2022-2025.
- Complete our application to the Prevention Concordat for Better Mental Health and deliver against the action plan agreed with the Office for Health Improvement and Disparities. This includes improving our understand of local need two years into the Covid-19 pandemic and ensuring that we have evidence-informed primary, secondary and tertiary prevention in place to reduce need and improve patient outcomes in Lincolnshire.
- Continue to develop, and then implement, new governance arrangements in line with the inception of the Integrated Care Partnership and Board in July 2022.

What's Working Well – key Achievements 2022/23

Suicide Prevention

- Development of the Real Time Suicide Surveillance (RTSS) dashboard allows better monitoring of suspected suicides, identification and response to clusters and emerging trends like new methods or

risk factors. An Information Sharing Agreement is now in place to ensure the continued and proper flow of information. The development of the national system and regional community of practice now supplements RTSS.

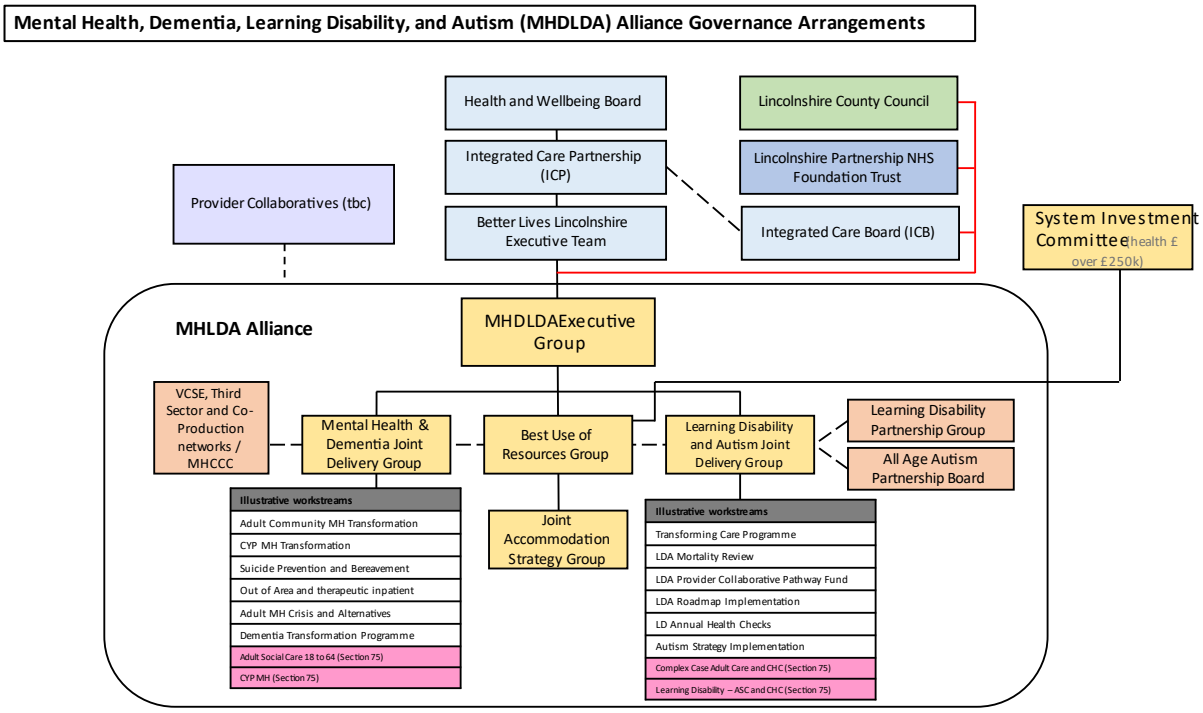
- A new provider for suicide bereavement service has been selected through the NHS lead competitive procurement process. The Amparo service started operating in November 2022 is fully mobilised, and the provider engaged a wide range of partners to spread awareness of the offer.
- Child Death Overview Panel led the review back in 2022. The report was created and shared with key partners. Suicide Prevention Children and Young People (CYP) Task and Finish Group started reviewing Lincolnshire's position against national and local recommendations.
- The latest Suicide Audit was completed and published at the end of 2022 using various data sources such as police data, coroners' information, registered mortality statistics, ambulance callouts and hospital admissions. Suicides in rural and coastal areas and support for people who survived suicide attempts were identified as new focus areas. Findings from the latest audit will also inform the new Suicide Prevention Strategy for Lincolnshire.
- The partner agreed to adopt the NHS "5 Steps to Mental Wellbeing" to frame communication and replace many "Steps to wellbeing" frameworks previously used. Local and national initiatives such as Lincolnshire Football Club videos or Samaritans 'Small Talk saves lives' campaign were shared and supported. Funding was identified to develop branding and resources to support suicide prevention countywide. The resources will be hosted within the 'How Are You, Lincolnshire' website and are expected to be launched in 2023.

Adult Mental Health Transformation

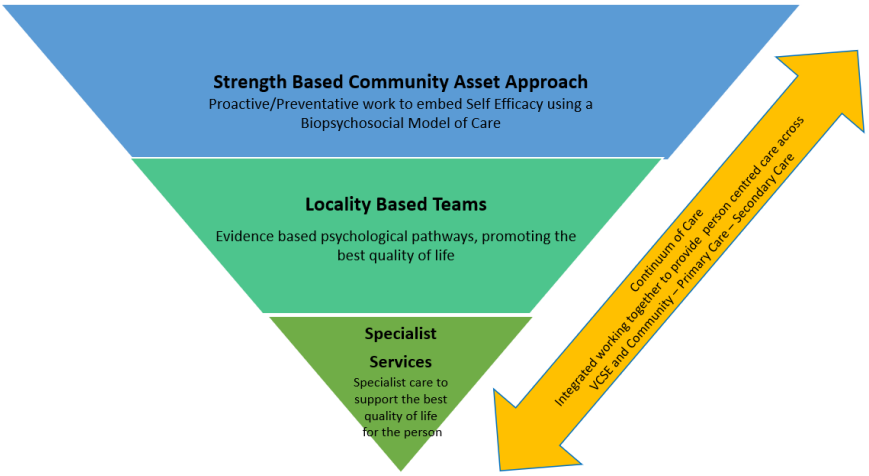
Lincolnshire was one of twelve national Early Implementer sites chosen to deliver Community Mental Health Transformation for adults and older adults. As an early implementer site an ambitious plan was mobilised to ensure that the development and transformation of both new and existing community services was designed, developed and delivered in an integrated manner.

At the heart of this programme has always been people with lived experience; ensuring that services are led by people and not just about people. Experts by experience are embedded across every facet of the programme and as such Lincolnshire is recognised by NHS England as an exemplar site for the work that it has done to realise and embed this new way of working.

The diagram below details the governance in place and highlights the mental health Co-Production Network that the programme has developed to ensure that experts by experience and the VCSE sector are working together to support each other as they work within specifically identified programmes.



The adult mental health community transformation model developed is committed to the delivery of right care, at the right time and in the right place. This has meant that the model of delivery spans the continuum of care, encompassing secondary, primary and VCSE provision and ensuring that services are accessible for people within their own local communities.



The programme has invested in the implementation of new workforce roles such as community connectors, Psychological Intervention Facilitators and Mental Health and Wellbeing practitioners which are being recruited across the County. We also now have a number of senior mental health practitioners in most primary care networks. In addition, we have a comprehensive social prescribing service for those with mental health needs and there has been significant increased investment in to the VCSE to develop and shift the focus towards prevention, as well as widening opportunities for people to self-help and ensure a stronger community-based offer. Co-production is at the heart of everything we do and there is now a fully formed co-production network led by the VCSE with a number of people with lived experience who aid the evaluation, design and development of our programme. Peer support workers are in place, sitting in the VCSE as well as some retained by LPFT, but the roles and their engagement is aligned. All these workstreams are set against the NHS Long Term Plan deliverables and the NHS England Community Mental

Health Transformation Roadmap and more recently is now working towards embedding the NHS Confederation No Wrong Door: A Vision for Mental Health, Learning Disabilities and Autism in 2032.

A web-based navigation service is available via How Are You Lincolnshire (www.haylincolnshire.co.uk) in which people can find a vast array of projects and support for mental health and wellbeing needs.

A training offer, been developed and made available to enhance opportunities for learning, and includes boundary training, opportunities for mental health first aid and suicide awareness as well as resources including the 'leave behind' card and a professional's support card with key information, which have also now been produced.
See: https://www.itsallaboutpeople.info/mental-health-transformation/training and https://www.itsallaboutpeople.info/mental-health-transformation/training/useful-resources

Adult Mental Health - Prevention
We have more recently been approved by the Office for Health Improvement and Disparities (OHID) as a signatory to the Prevention Concordat for Better Mental Health which means that Lincolnshire has been recognised as having many strengths in the drive to reduce health inequalities and the collaboration between partner organisations was recognised as one of its strengths. "*The concordat promotes evidence-based planning and commissioning to increase the impact on reducing health inequalities. The sustainability and cost-effectiveness of this approach is enhanced by the inclusion of action that impacts on the wider determinants of mental health and wellbeing*." https://www.gov.uk/government/publications/prevention-concordat-for-better-mental-health-consensus-statement/prevention-concordat-for-better-mental-health
We will therefore be progressing our action plan during 2023/24.

What is the outcome?

Suicide Prevention
Outcome measurement is a challenge for suicide prevention interventions because of the multifaceted nature not only of the initiatives but also of their outcomes. Suicide rates may be influenced by many factors including a range of personal characteristics as well as socio-economic factors such as economic conditions, prevalence of mental illness and access to support and services.
Outcomes measures can be demonstrated for on the elements of the programme. For example, for funded community projects and commissioned services we collect data on uptake and participation, individual outcomes, participants satisfaction and case studies. Campaigns and promotional activity is measured by number of people reached and engaged.

Adult Mental Health Transformation

- Improved access to preventative services and self-help, reducing the need, where appropriate, for primary care, Accident & Emergency or other crisis services.
- A more informed mental health workforce and society.
- To ensure people who fall in the gaps between GPs and specialist care or are 'bounced' between them with multiple rejected referrals, can be seen quickly and easily.
- Aiming to achieve 'No Wrong Door'- which means any patient accessing services at any point of the pathway will be seen and referred to tie right care at the right time in the right place, breaking down barriers to accessing care when it's needed.
- The intention is to provide evidence-based treatments and access to community support, helping people before they reach crisis point and reduce waiting lists.

Mental Health (Adults) - JLHWS PRIORITY - PLANS FOR 2023/24

Action	How will we know it's working?	Relevant Strategy / Action Plan	To be delivered by	Lead Organisation	Lead Officer
Data and Intelligence – ongoing analysis of Real Time Suspected Suicide Surveillance and other data sources with particular focus on thematic/qualitative analysis and capturing attempted suicides to inform prevention strategy and commissioning decisions.	Timely response and support to communities Range of emerging trends and issues identified and used to inform prevention and commissioning. Annual audit published	Suicide prevention strategy – Lincolnshire County Council	December 2023	LCC - PHI	Marta Kowalczyk
Postvention – Working with partners to fully integrate Amparo (Suicide Bereavement Service) to Lincolnshire system by raising awareness of the offer, strengthening referral pathways and continuedly develop the service to meet population needs.	Increased number of referrals from variety of sources. Positive customer feedback. Service proven to meet expected quality standards set by Support After Suicide Partnership (SASP) framework.	Suicide prevention strategy – Lincolnshire County Council	December 2023	NHS ICB	
Children and Young People (CYP) – to develop a specific response plan to child suicide in Lincolnshire (including clear actions for organisations and lines of communication) and rolled out tiered training model for suicide prevention to Lincolnshire workforce supporting CYP.	A Plan developed with clear lines of communication, and clear actions for organisations to take at an agreed appropriate time. Tiered training model on CYP self-harm/suicide prevention developed and rolled out.	Suicide prevention strategy – Lincolnshire County Council	December 2023	LCC - CICT	
Awareness and training – support development of county wide suicide prevention campaign and online resources developed as part of Wave 3 Suicide Prevention Community Innovation Fund and provide a specific suicide prevention training to professionals and volunteers delivering projects to most at risks groups.	Suicide prevention campaigned developed and adopted across the county by range of organisations. Training commissioned and rolled out increasing awareness and skills in community.	Suicide prevention strategy – Lincolnshire County Council	December 2023	Shine/LCC Public Health	

Action	How will we know it's working?	Relevant Strategy / Action Plan	To be delivered by	Lead Organisation	Lead Officer
To develop and agree next Lincolnshire Suicide Prevention Strategy considering local intelligence and key priorities identified by the national strategy.	Strategy developed, agreed and published			LCC – Public Health	
Strength Based Community Assets Development	Increase in VCSE initiatives, projects and support, capturing outcomes and training offer fully mobilised; expansion of night light cafes.	NHS England Long Term Plan; Mental Health Implementation Plan	Adult Community Transformation Programme	LPFT/ICB	Nick Harwood/ Victoria Sleight/ Sara Brine
Locality Based Mental Health Teams	Integrated Primary Care pathway in place; locality mental health teams fully integrated and constituted	NHS England Long Term Plan; Mental Health Implementation Plan		LPFT	Nick Harwood/ Victoria Sleight
Specialist Services Development	Dedicated focus services rolled out countywide; Early Intervention in Psychosis and Individual Placement and Support services built into the continuum of care	NHS England Long Term Plan; Mental Health Implementation Plan		ICB/LPFT	Nick Harwood
Overarching deliverables including health inequalities and population health management and embedding trauma informed care	Improvement in access, experience and outcomes for all; greater understanding of the drivers behind mental health inequalities and how these are manifested across Lincolnshire; Improved access to physical health checks for those with serious mental illness.	NHS England Long Term Plan; Mental Health Implementation Plan		ICB/LCC (public health)/LPFT	Sara Brine/David Stacey/Victoria Sleight

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Appendix F

MENTAL HEALTH & EMOTIONAL WELLBIENG (CHILDREN & YOUNG PEOPLE) JLWHWS PRIORITY

Position Statement

Half of all life-long mental health problems in the UK start before the age of 14 and three quarters start before the age of 25. For many, the Covid-19 pandemic is likely to have exacerbated their mental health needs. Before the pandemic, the prevalence of mental disorders in children aged 5 to 16 was already increasing from 1 in 9 (2017) to 1 in 6 (2020). Anxieties caused by lockdowns, school closures, isolation from peers, bereavement, and the stresses on families have increased pressures. Nationally, frontline mental health services report a large increase in children and young people (CYP) needing help. Demand modelling suggests that 1.5 million CYP nationally may need mental health support due to the pandemic.

Risk and protective factors for mental health and wellbeing are well documented and include childhood abuse, trauma, or neglect, social isolation or loneliness, experiencing discrimination and stigma, social disadvantage, or poverty, bereavement, or being a long-term carer for someone. Understanding these factors can help us to target prevention activity to support mental health and wellbeing.

CYP's mental health has been a priority in Lincolnshire for many years and continues to grow in line with national and local importance. Lincolnshire has a strong emotional wellbeing and mental health offer, through from CYP public mental health promotion and early intervention to specialist and crisis support.

Evidence **pre-pandemic** showed:

- CYP's mental health needs were **assessed quickly**. Between Apr 2018-Mar 2020, 96% of CYP waited less than 4 weeks to access Healthy Minds Lincolnshire and the average wait for a Child and Adolescent Mental Health Services (CAMHS) assessment was 4.4 weeks (Jan 2020)
- Early intervention services were helping to **reduce referrals to CAMHS** whilst nationally referrals were increasing. Between Apr 2019-Mar 2021, 87% of discharges from Healthy Minds Lincolnshire needed no further support or universal support, only 2% escalated to CAMHS. Referrals to CAMHS reduced by 5% in 2019/20 and urgent referrals by 6%, whilst nationally referrals were increasing
- CYP recovered well and **maintained their emotional wellbeing after discharge.** The average re-referral rate was 7%, there were no re-referrals to CAMHS Eating Disorder Service
- Lincolnshire had **fewer CYP needing inpatient care**. In-patient admissions reduced from 68.9 (per 100k) in 2017 to 58.4 in 2019. Nationally admissions rose to 88.3 in 2019.

During the pandemic up to July 2021 in Lincolnshire:

- There was a 15.7% increase in referrals to CAMHS, whilst nationally these increased by 35%
- CYP Eating Disorder Service referrals increased by more than 250%
- There were 15% more clinical contacts than the national average
- 42% of clinical contacts were face-to-face, higher than the national average
- 22% of clinical contacts were digital, 5% higher than the national average
- More than 95% of education settings took part in the Wellbeing for Education Return training
- 92% of children had an emergency telephone response within 4 hours (national average of 83%), and the average emergency wait was 1.4 hours (the national average was 11 hours)
- The CAMHS Crisis and Enhanced Treatment Team successfully kept 97.7% of accepted referrals out of hospital during 2020/21.
- Inpatient numbers increased to 75.1 per 100,000 CYP but remained below regional/national averages, nationally inpatient numbers increased to 89.5 per 100,000

- In the past ten years, there have been 0-1 completed CYP suicides recorded each year. Between early 2021 and 2022, six suspected/confirmed CYP suicides were reported. A thematic review was completed to gain learning from these sad deaths and actions set to help prevent further CYP suicides.

Since the pandemic, like the rest of the country, Lincolnshire's CYP mental health services have experienced significant challenges. The needs of children are reported to have increased and children are open to services for longer, reducing discharge rates. Pre-pandemic, CYP were open to CYP mental health services on average of circa. 100 days (14.2 weeks), this increased to an average of 150-200 days (21.4-28.5 weeks) since the pandemic. Workforce challenges, particularly the recruitment of highly specialist posts e.g. Psychiatrists and Psychologists, have impacted capacity at a time when it needs expanding. Locally, Lincolnshire Integrated Care Board increased its recurrent funding of CAMHS by £1.2m in 2022/23 to help increase capacity and reduce waiting times. This has had a positive impact as demonstrated below.

A CYP Mental Health Transformation Programme is in progress, jointly led by the Council and Lincolnshire Partnership NHS Foundation Trust (LPFT) with input from CYP and parents/carers with lived experience and other key local and national stakeholders. The Programme and its component workstreams will shape the strategic direction of travel for CYP mental health services. The programme will recommend a future model of CYP mental health services in Lincolnshire which will then be implemented subject to approval.

What we said we would do in 2022/23

Objective	Progress
Build emotional resilience and positive mental health	Good progress
Action on the wider determinants and their impact on mental health and emotional wellbeing	Good progress
Better understanding of self-harm/suicidal intent in young people	Good progress
Greater parity between mental health and emotional wellbeing as experienced for adults and CYP and between mental and physical health	Good progress
Ensure that young people have timely access to appropriate crisis services	Good progress
Families of young people with mental health needs are supported	Good progress
Ensure appropriate support services are in place for pupils with special educational need and/or a disability	Good progress

In 2022/23, we said we would…	We did…
Undertake a comprehensive review of CYP mental health and emotional wellbeing in Lincolnshire, including key learning from the pandemic	A CYP Mental Health Transformation Programme has commenced and is currently in the review phase, due to complete in early 2024. This will result in a programme of transformation that will help ensure we are able to continue providing strong mental health promotion, prevention and support that will meet the needs of CYP in the future.
Establish a Children and Young People's Suicide Prevention Task and Finish Group	A CYP Suicide Prevention group has been established to bring together relevant agencies and improve suicide prevention and response for CYP, families and communities in Lincolnshire. The group has developed and is monitoring a number of actions, including working with the Lincolnshire Safeguarding Children Partnership (LSCP) around actions arising from a Child Death Overview Panel (CDOP) thematic review into CYP suicides.
Increase access to early intervention support to maintain a strong early intervention/prevention	Increased investment in Healthy Minds Lincolnshire by Lincolnshire Integrated Care Board has been agreed. Funding will be used to maintain the countywide mental health prevention and promotion work with education settings and early, low-moderate intervention for CYP and

offer whilst Mental Health Support Teams (MHSTs) are rolled-out	families in Lincolnshire, enabling recruitment to this part of the workforce alongside developing and increasing the workforce as more Mental Health Support Teams are recruited to.
Continue to roll-out Mental Health Support Teams across the county in line with NHS England timescales, building to an estimated 50% coverage by 2024/25	Roll-out of Mental Health Support Teams is continuing. Lincolnshire has four operational teams in Lincoln, Gainsborough area, Boston and Skegness. Three more have been recruited and, once staff complete their training, will go live in Spalding, Sleaford and Grantham areas in 2023/24. An eighth team will be recruited in 2023 to undertake their training in 2024 and go live January 2025 in the South Lincoln/North Kesteven area.
Invest in core and specialist community CAMHS to grow and strengthen our offer by increasing staffing to provide sufficient capacity to meet the increased demand, and growing our Here4You Lincolnshire access team to provide more effective advice and support at the 'front door'	We have increased staffing in CAMHS by over 30 Whole Time Equivalents across the community, eating disorder and peer support teams to provide sufficient capacity to meet the increased demand on specialist mental health services, address waiting lists and reduce waiting times. The Here4You Access Team was mobilised in January 2022 to provide a single point of access for community CYP mental health services. This includes screening and triage of all referrals into CYP mental health services, including self-referrals, and to provide a telephone line where CYP and those supporting them can access meaningful advice, support and signposting information. Recurrent funding has been secured for the team and additional short-term funding to further increase capacity.
Meet the increase demand for Eating Disorder support by increasing workforce capacity and achieve the access and waiting time standard and NHS Long Term Plan targets	A proportion of recurrent investment was allocated to the Eating Disorder Service in 2021/22 to increase the workforce capacity by recruiting a Physical Healthcare Nurse, a Dietitian, a Lead Psychologist, two registered Practitioners and a Systemic Therapist. More investment is required to further increase workforce capacity in order to meet NHS Long Term Plan targets and increased demand. Lincolnshire is on plan to improve Eating Disorder waiting times to target levels during 2023/24.
Increase the scope of the CAMHS Eating Disorder Service to deliver an evidence-based pathway for CYP presenting with Avoidant or Restrictive Food Intake Disorders (ARFID)	Regional pilots, learning and training specifically on Avoidant or Restrictive Food Intake Disorders has been rolled out to providers. Lincolnshire has been developing a pathway specifically for Avoidant or Restrictive Food Intake Disorders, and a comprehensive business case has been developed. Additional funding has been allocated to the Eating Disorder Service in 2023/24, which will support the recruitment of staff and implementation of an evidence-based pathway for CYP.
Implement a seamless physical health care pathway for CYP with an ED that spans primary care though to acute physical health care, offering a choice of how their physical health is monitored	In 2022/23, CYP-EDS secured GP time to support the physical healthcare monitoring required within the service, which has been very effective and eliminated all previous issues. System wide working has already been successful in establishing and building good working relationships between the mental health provider and the acute hospital provider in Lincolnshire. Investment is available to strengthen this through Paediatrician sessions with the CYP-EDS team, however so far lack of capacity/interest means this has not progressed.
Improve monitoring for those at risk of admission to specialist mental health inpatient or currently inpatient	We have developed and are currently implementing new processes in Lincolnshire to improve monitoring for those at risk of admission and discharge planning for CYP inpatients. Using a new digital dashboard to review data and information more effectively as part of new Urgent Care Pathway meetings to support discharge planning.
Improve transition and support for 18-25 year olds	Transition Clinical Leads have been recruited into each of the community CAMHS teams and the Eating Disorder Service to review current transition protocols and build strong links with adult mental health services, link with Primary Care Networks and local communities to

	understand the wider support offer, provide support in the community and remotely to ensure that CYP feel supported as they transition.
Implement Keyworking for CYP with a Learning Disability or Autistic CYP who are at risk of admission to a specialist inpatient provision	The Lincolnshire CYP Keyworker team went live from April 2023, consisting of keyworker practitioners and support, peer support and admin. The team work closely with CYP and families to advocate on their behalf to ensure they feel supported throughout their involvement with services at a time of crisis, ensuring partners work together effectively and that CYP are considered holistically and feel informed, supported and happy with the agreed outcomes, plans and delivery throughout their recovery.

What's Working Well – key Achievements 2022/23

- Lincolnshire Partnership NHS Foundation Trust's mental health services for CYP have been rated outstanding by the Care Quality Commission in their last two inspections, most recently in 2020.
- We wanted to make it much easier in Lincolnshire for families and professionals to access advice and support, including making self-referrals for all CYP mental health services, so a new CYP Mental Health Services Access Team was piloted. Professionals, parents or CYP can call the dedicated line to speak to a clinician for advice, information or to self-refer. Joint referral screening takes place across services so families do not have to navigate through different referral pathways. It has helped greatly improved the number of referrals going to the right place first time. Funding has been secured to make this team a recurrent path of the pathway.
- The CYP Mental Health Services Access Team have had made some great progress with joint working across Lincolnshire's County Council's Early Help 'front-door', with a live interface to allow either team to raise any queries about signposting or referral to services.
- Lincolnshire has continued to support the national roll-out of Mental Health Support Teams, recruiting to another three teams during 2022/23, with staff having commenced their training ready for these teams to go live in 2023/24. These will be in the Spalding, Sleaford and Grantham areas, which will mean that there is at least one team in each district area across Lincolnshire.
- Whilst demand overall has increased since the Covid-19 pandemic, referrals in general have become more stable making it easier to forecast and manage. There has been a significant focus on the increase in referral to the CAMHS Eating Disorder Service, where capacity has been increased to meet the new demand and work undertaken to meet the national wait targets for these referrals wherever possible. CAMHS community teams have also seen a significant improvement in the number of CYP waiting for treatment following assessment, and over a 40% reduction in those waiting more than 12 weeks, in line with a trajectory to have no CYP waiting more than 12 weeks by March 2024.
- Lincolnshire secured funding for a digital crisis pilot to take place during 2023/24, to improve support available to families who present in crisis, with access to online counselling support following crisis as an additional part of Lincolnshire's urgent and emergency support offer.
- Lincolnshire County Council has recruited 10 participants in its Early Help service to undertake additional training around support the emotional wellbeing and mental health of CYP to further strengthen Lincolnshire Enhanced Evidence Based Practitioners offer.
- Barnardo's, in partnership with Lincolnshire Partnership NHS Foundation Trust, recruited a Leaving Care Mental Health Worker to support care leavers and their workers to raise awareness and improve planning and support around their mental health needs, which has recently been highlighted in relation to overall support for care leavers in Lincolnshire by Ofsted.
- Additional investment had been made to support commissioning of CYP mental health services, recognising the increasing national focus in this area and the need for greater oversight to ensure services are commissioned and managed to best meet the local population's needs.

What is the outcome?

Outcome	Progress/Impact
Increased awareness of mental health specifically in regard to the needs of CYP	↑
Increased access to emotional wellbeing and mental health support for CYP in Lincolnshire	↑
Children from higher risk groups receive the interventions they need and are supported at times when their mental health and emotional wellbeing is put under strain	↑
Reduction in Accident & Emergency attendances and hospital admissions attributed to self-harm and attempted suicide	↑
Children's needs are reflected in Integrated Care System plans	↑
Young people have access to timely support when in crisis	↑
Parents will have a better understanding of child development and how to nurture resilience and positive emotional mental health	↑

Referrals/Access to CYP Mental Health Services

As at Jan 2023, Lincolnshire is achieving 87% of its local CYP mental health services access target; 7,920 CYP in the last 12 months have received one or more contacts. Mental Health Support Teams in Lincolnshire are performing better than any other area in the region with 3,260 contacts between Feb 2022-Jan 2023. There are a number of local services that will begin reporting their contacts to NHSE which should further help the target to be met and several new services are being explored that will further widen access to services.

Out of 1,217 referrals to Lincolnshire Partnership NHS Foundation Trust's CYP mental health services so far in 2022/23, 93% were accepted for support, with the rest found not appropriate, not needing support following assessment, or more appropriate for other services. Up to the end of December 2022:

- Primary referrers were General Practices (31%), schools (21%), parents/carers (20%), young people self-referral (11%) and internal CYP mental health services (10%).
- 60.7% of referrals were for females and 39.3% males.

Kooth online counselling quarter 3 2022/23 reporting demonstrated:

- The top three presenting issues were anxiety/stress, suicidal thoughts and self-harm.
- 65% of users were female, 27% male and 8% nonbinary; 47% of males presented with suicidal thoughts compared to 26% of females.
- 65% of logins were outside of office hours (9am-5pm), the highest concentration accessing between 5pm-9pm.
- 808 Lincolnshire CYP logged onto Kooth an average of 14 times per CYP, with the largest age group being 13 to 16 years.
- CYP visiting the Kooth platform engaged in various activities:
    - 85% used the messenger function with a counsellor
    - 52% created journals
    - 21% had chats with a counsellor
    - 11% accessed forums, activities and articles.

Waiting Times for CYPMHS

In February 2023, across all Lincolnshire commissioned CYP mental health services, 68.4% of CYP were assessed within 4 weeks (Mental Health Statistical Data Set). This is higher than national and regional data.

There has been a significant focus in Lincolnshire on reducing the treatment waits for core community CAMHS teams since 2021, particularly those CYP waiting over 12 weeks, as at the end of December 2022:

- Waiting times from referrals to treatment were;
    - Healthy Minds Lincolnshire – approximately 18 weeks.
    - Mental Health Support Teams – approximately 6.2 weeks.
    - Community CAMHS – approximately 16 weeks.
- There has been a 36% reduction in number of CYP on the CAMHS waiting list (404 at its peak in May 2022 to 258 in February 2023) and a 42% reduction in CYP waiting more than 12 weeks for CAMHS treatment (from 283 at its peak in February 2022 to 165 at the end of February 2023).
- All CYP and their families waiting for treatment now receive support from Family Support Workers via monthly contact to support, this also includes help such as signposting or self-help whilst waiting.
- The CAMHS Learning Disability team has achieved 100% of their wait to assessment targets in quarter 3 2022/23, has no children waiting for treatment and are above target for wait times.

On average as at quarter 4 2022/23, CYP were open to CYP mental health services for 28.1 weeks.

Average Actual Length of Service (weeks)	**Quarter 4 2022/23**
CAMHS community teams (including Learning Disability team)	49.2
CYP Eating Disorder Service	29.5
Healthy Minds Lincolnshire	17
Mental Health Support Teams	16.8
Average	**28.1**

Impacts and Outcomes of CYP Mental Health Services

- For CYP discharged from CYP mental health services, 59% of those showed a positive change in their outcome by an average score of 5.1.
- 85% of CYP supported by Healthy Minds Lincolnshire did not need any further treatment or were discharged back to universal services, with low re-referral rates maintained.
- 100% of CYP who accessed workshops and provided feedback reported a positive impact on their emotional wellbeing concerns and 100% of parents/carers who accessed workshops said the workshops had had a positive impact on their confidence to better support their child's emotional wellbeing concerns.
- 100% of professionals who accessed training and provided feedback said the training had had a positive impact on their confidence in supporting CYP's emotional wellbeing concerns.
- An average of 87% of CYP who engaged in therapeutic alliance through counselling chat sessions would recommend Kooth to a friend.
- Based on 2021/22 data, Lincolnshire performed better than both the East Midlands and National averages for hospital admissions for mental health conditions under 18 years (76.3 per 100,000) and hospital admissions as a result of self-harm for 10-24 years (332.1 per 100,000).

CYP Mental Health Services Stakeholder Feedback

Young Person after accessing Kooth online counselling:

- *"Thank you honestly, I never think that what I write will affect anyone... so thank you for telling me... you have really helped me along the way, I wouldn't have stood up in front of everyone and spoke, and I would have never shared my poetry without your support... despite everything I am so grateful to have had you by my side... now I am going to be honest with you, and I need you to know just how much you've helped me... I know I wouldn't still be here without you, you've saved my life on more than one occasion you've been the only one to listen without judgement and still treat me like a normal person, and that means more than you can ever imagine... thank you ☺."*

Here4You Access and Advice Line

- *"Helpful advice from professional about what CAMH service would offer for a client. Friendly member of staff who cares about the client! Sent useful resources. Thank you xxx"*
- *"All the things gone smooth and professional. The team explain the next step very clearly."*
- *"The service let me know what was happening at every step, from waiting to speak to a call handler, to waiting to be put through to a practitioner and then what would happen after the initial triage. I felt both listened to and heard and supported also. Both call handler and practitioner were very approachable and professional."*

Healthy Minds Lincolnshire Worries and Fears Group – Young Person

- *"Thank you so much, I wasn't sure if the group was really for me but it's really helped me."*

Healthy Minds Lincolnshire Worries and Fears Group – Parent

- *"I felt I needed to email you to thank you and [XXX] personally for your involvement with the Fears and worry group. G has slept for 29 nights and even though I know we will have sleepless nights in the future we all go to bed not worrying about waking every night. G is so much happier and has continued to do her "happy jar" every day, she has her soothing box which she takes great pride in next to her bed which she says she will never use as she sleeps all night but has it for reassurance. You both demonstrated such positive attitudes to our children and their worries; this has given me a positive outlook for G and her worries and we will continue to move forward together."*

Healthy Minds Lincolnshire 1:1 Support – Young Person

- *"Yes I would come back to you if I needed to and tell my friends about you. [XXX] was great to work with always helpful, knew what to say, what to do and nothing seemed too much for her. At first felt embarrassed but she made me comfortable and showed me everything was going to be ok. Our sessions were fun but also serious. She never JUDGE me EVER , HUGE thumbs up."*

Healthy Minds Lincolnshire 1:1 Support – Parent

- *"The Teams meetings made it convenient for us to fit in and also meant that we didn't have to leave home or go anywhere new that my daughter might have struggled with."*

CAMHS Core Community Team – Young Person

- *"Thank you so much for all your support and everything you have done for me. You never gave up on me especially when I went through my dark patches and pushing you away when you was trying to help me. Without your support I really don't know where I would be right now. You never gave up on me. You're amazing! You have no idea how much your help has meant. Without rain there are no flowers. Thank you so much."*
- *"Thank you so much for your help I would not have been able to leave the house and get my hair cut without you."*

CAMHS Core Community Team – Parent

- *"The strategies and tools [XXX] gave us enabled us to support our daughter through a very difficult time and has given us hope that our daughter will get better. Both myself and my daughter looked forward to our sessions with [XXX] as she made us feel that recovery was achievable even in a very dark time. [XXX] helped my daughter to realise that she is not alone in how she is feeling, and that has made the biggest impact to her. I can't thank [XXX] enough for all the support and compassion she has shown my family, she is exceptional at her job and a true hero of the NHS."*

CAMHS Crisis – Young Person

- *"Thank you so much for literally everything you've done for me. It's truly been a privilege to have had access to such an amazing team/service. Thank you for helping me find my wings to fly again. Forever in your debt."*
- *"The staff listened to me and it felt like they actually wanted to help. I think it's good that the Crisis Team were able to help prevent me going to hospital rather than being involved after going to hospital."*

Complex Needs Service – Young Person

- *"Thank you so much for listening and helping me and [XXX] get to the bottom of it all. He doesn't trust easy but he trusts you. He turned 18 last week and refused to even speak or see his dad. He hasn't seen him since the day he came out of custody. I wish you had been around to help us sooner and maybe things wouldn't have got so bad and troublesome for him and my little family. Your amazing at what you do. Would you pass my thoughts and thanks to [XXX] too when you see her. You've both made a big difference in [XXX's] life and in mine."*

EMOTIONAL WELLBEING AND MENTAL HEALTH (CYP) JOINT HEALTH & WELLBEING STRATEGY PRIORITY - PLANS FOR 2023/24

Action	How will we know it's working?	Relevant Strategy / Action Plan	To be delivered by	Lead Organisation	Lead Officer
Undertake a comprehensive CYP Mental Health Review and Transformation Programme	Highlight reports presented at Programme Oversight Group and escalation reports to Mental Health Joint Delivery Group	Lincolnshire's Local Transformation Plan Lincolnshire Integrated Care System 2023/24 System Plan	Review – March 2024 Transformation – August 2027	LCC (Commissioner) LPFT (Provider)	Charlotte Gray / Eve Baird
Increase investment in early, low/moderate intervention and more preventive and community support for CYP, with growth in use of Voluntary, Community & Social Enterprise (VCSE) sector delivery/ community asset development	Increase in access to CYP mental health services Demonstrate investment in CYP mental health services Pilot CYP grants programme with VCSE sector and increased access via community support	CYP Mental Health Transformation Programme Lincolnshire's Local Transformation Plan Lincolnshire Integrated Care System 2023/24 System Plan	March 2024	LCC (Commissioner) LPFT (Provider)	Kevin Johnson / Amy Butler
Continue roll-out of Mental Health Support Teams in Lincolnshire as part of national programme with schools/colleges	Successful go live of Wave 7 and 8 sites in Lincolnshire, and recruitment to Wave 10 team	Lincolnshire's Local Transformation Plan Lincolnshire Integrated Care System 2023/24 System Plan	March 2024	LCC (Commissioner) LPFT (Provider)	Kevin Johnson / Amy Butler
Further strengthen CAMHS offer with increased capacity to meet demand and address waiting lists	Reduction in number of CYP waiting for support and particularly those waiting more than 12 weeks for treatment	Lincolnshire's Local Transformation Plan Lincolnshire Integrated Care System 2023/24 System Plan	March 2024	LCC (Commissioner) LPFT (Provider)	Kevin Johnson / Amy Butler
Increase eating disorder workforce capacity to respond to the significant increase in volume and acuity of eating disorder referrals, to meet the national access and waiting time standards	Achievement of national waiting time standards for CYP referred to the Eating Disorder Service (4 weeks routine and 1 week urgent)	Lincolnshire's Local Transformation Plan Lincolnshire Integrated Care System 2023/24 System Plan	March 2024	LCC (Commissioner) LPFT (Provider)	Kevin Johnson / Amy Butler
Pilot an evidence-based specialist pathway for CYP with Avoidant or Restrictive Food Intake Disorder	Recruitment to posts and successful implementation of pathway in Lincolnshire	Lincolnshire's Local Transformation Plan Lincolnshire Integrated Care System 2023/24 System Plan	March 2024	LCC (Commissioner) LPFT (Provider)	Kevin Johnson / Amy Butler

Action	How will we know it's working?	Relevant Strategy / Action Plan	To be delivered by	Lead Organisation	Lead Officer
Further improve physical health monitoring for CYP with an eating disorder in Lincolnshire	All CYP are able to access appropriate monitoring	Lincolnshire's Local Transformation Plan Lincolnshire Integrated Care System 2023/24 System Plan	March 2024	LCC (Commissioner) LPFT (Provider)	Kevin Johnson / Amy Butler
Continue to improve transition pathways for 18 to 25-year-old's	Redesigned transition pathways and fewer reports of 18-25-year-olds being discharged purely based on age, supported into appropriate adult provision	Lincolnshire's Local Transformation Plan Lincolnshire Integrated Care System 2023/24 System Plan	March 2024	LCC (Commissioner) LPFT (Provider)	Kevin Johnson / Amy Butler
Continue to implement and embed CYP Complex Needs Service, CYP Keyworking, and Urgent Care Pathway inpatient monitoring and discharge planning	Increased number of complex CYP accessing support via Complex Needs Service Number of CYP with Learning Disabilities and/or Autism at risk of hospital admission or inpatient supported by a Keyworker More effective discharge planning and fewer bed days	Lincolnshire's Local Transformation Plan Lincolnshire Integrated Care System 2023/24 System Plan	March 2024	LCC (Commissioner) LPFT (Provider)	Kevin Johnson / Amy Butler
Improve pathways from primary care through Primary Care Mental Health Practitioner Additional Reimbursement Roles pilot	Number of CYP Additional Reimbursement Roles recruited and number of contacts via Primary Care Networks	Lincolnshire's Local Transformation Plan Lincolnshire Integrated Care System 2023/24 System Plan	March 2024	LCC (Commissioner) LPFT (Provider)	Kevin Johnson / Amy Butler
Oversee digital crisis pilot across Lincolnshire Partnership NHS Foundation Trust CYP mental health services and Kooth	Evaluation and KPIs for pilot No of CYP supported via digital crisis support, improvement in paired outcome scores	Lincolnshire's Local Transformation Plan	December 2023	LCC	Kevin Johnson
Oversee roll-out of Suicide First Aid training to key CYP workforce across Lincolnshire	Evaluation of training by attendees following training and 6 month's post-training	Suicide Prevention Steering Group action plan	August 2024	LCC	Kevin Johnson
Continue to oversee and implement relevant actions to improve CYP suicide prevention	Monitoring of actions as part of CYP Suicide Prevention group and feedback from members/families	Suicide Prevention Steering Group action plan	March 2024	LCC	Kevin Johnson

Joint Local Health and Wellbeing Strategy for Lincolnshire
Annual Assurance Report 2022/23

PHYSICAL ACTIVITY JLHWS PRIORITY **Appendix G**

Position Statement

The refreshed 'Let's Move Lincolnshire' Physical Activity strategy was published in June 2022. The strategy refresh was informed through 6 months of consultation with partners and residents, led by Active Lincolnshire and the University of Lincoln with contributions from members of the HWB, LCC, ICB, District Authorities and a wide range of public sector, CVSE, leisure sector and statutory bodies (over 300 people contributed).

Active Lincolnshire are funded by Sport England to deliver the national 'Uniting the Movement' strategy locally in Lincolnshire, according to local need. Let's Move Lincolnshire brings the local priorities to the forefront based on evidence and insight. It is for partners and stakeholders to deliver against the strategy.

One You Lincolnshire (OYL) is Lincolnshire's integrated lifestyle service, the service commissioned by LCC Public Health. OYL support residents to increase their physical activity levels on its Move More pathway that is made up of various programmes delivered by OYL staff and by partner Leisure providers. Clients access the service via a referral from their Health Care Professional or by the self-referral route, providing they are inactive – currently doing less than 150 minutes of moderate intensity physical activity per week.

Public health, the ICB, District Authorities, leisure and physical activity providers and community and voluntary sector organisations, schools and education providers are all key stakeholders in delivering the strategy.

The strategy identifies 'agile systems' as a priority, recognising the need to enable stakeholder networks to collaborate and work closely and flexibly – enabling opportunities for sharing data, conceiving ideas, problem solving and breaking down barriers for greater shared outcomes for our communities.

The other priority areas agreed in the LML strategy are:

Recover and Reinvent the physical activity sector	Providing the physical activity and sport sector with support for a strong sustainable recovery. Reinventing itself to meet the needs of our diverse communities.
Connecting health and physical activity	Recognising the significant impact of a more active population on the prevention agenda. Supporting health and care system partners to embed physical activity messaging, conversations and signposting across all relevant touch points.
Connected Communities	Using physical activity and sport's ability to make better places to live by building on local strengths and assets, empowering residents to identify and lead change.
Positive Experience for Children and Young People	Providing positive experiences for CYP in school, family and community settings. Addressing the policies, infrastructure, environments and offer that have a negative impact on children and young people's ability to access opportunities to be active.
Active Environments	Addressing the significant challenges across Lincolnshire for residents to access the spaces around them including built facilities, green and blue spaces and public realm, and supporting Active Travel.
Tackling Inequalities	Focus on tackling inequalities; supporting those people who face greater barriers to participation through understanding their needs and breaking down barriers.

Challenges:

Across a complex sector and environment, stakeholders and relationship management is broad and wide ranging. There is a continued need to work across the system in a more coordinated way. All partners are committed to this, however the complex issues, organisational v systemic priorities and different paces at which partners work mean it is something that will require continual effort and shared commitment.

Evaluating and understanding the impact of the system-wide work is challenging across multiple partners and parts of the system.

Active Lincolnshire are a small charity with national funding and are committed to continuing to building relationships with statutory organisations and VCSE sector partners to build capacity to create greater impact. However, capacity to connect across all of the relationships, work strands, information and intelligence together to support reduced duplication, greater impact and shared intelligence is an on-going challenge.

What we said we would do in 2022/23

WE SAID…	WE DID… (Lead partners)*
Focus on health inequalities; supporting those who are inactive or unconfident to be more active	**PH & ICB –** health inequalities steering group **AL –** All work focuses on inequalities and inactive and less active people. Established EDI panel for physical activity sector to better inform and understand lived experiences.
Support the physical activity sector to recover from Covid & be relevant to local need	**AL** – working with NGBs, leisure operators, leisure leads on series of support including Long Covid training package and older adults workshop.
District H&W being strategies to have physical activity as a prioirty	**DA's –** Yes. Active Lincolnshire have worked with District Councils to shape the new Lincolnshire District Council Health & Wellbeing Strategy which is currently adopted as a strategic framework by all seven authorities. A holistic view based on social determinants, the strategy has developed around five 'lever areas' in which they are uniquely positioned in the system to influence and work with partners to deliver sustainable change. Activity and wellbeing is a 'priority lever' with overarching objective aligned to Let's Move Lincolnshire strategy: To address inactivity across the county – improving access and opportunity for all residents to be active and participate.
Increased activities on the LML activity finder	**AL –** Yes, increased activities and users going to the activity finder, Working with Connect 2 Support & Hey Lincolnshire to try & reduce duplication and share information.
Campaigns to promote increased physical activity	**AL** – Let's Move Lincolnshire promotion. 12,000 website visitors in 12 months. (422% increase on year 1).

	PH & AL - Walking & Cycling campaign (Stride & Ride). 5400 website visits. Connecting & sharing messaging with OYL, ICB & Connect 2 Support.
Tackling the impact of Long Covid and health inequalities through the Together Fund	**AL –** Delivered 3rd year of funding. Total investment of £350k and 99 projects funded over 3 years. **CAB & AL:** Sport & physical activity sector workshop; age friendly employers in the sector and a relevant offer for older adults.
Continue to offer a range of high quality, digital, in-person and Leisure Centre based physical activity interventions, that support clients to lead a more physically active lifestyle.	**OYL:** 4581 clients increased physical activity levels. 3480 clients achieved recommended 150 minutes of moderate intensity physical activity per week - a 24.4% increase compared with previous year.
Expand the One you Lincolnshire offer to include a healthy child weight management service	**OYL & PH:** Yes, the service has launched
Launch a new outdoor festival in the Wolds	**ELDC –** Yes the festival launched in 2022 and is running again in 2023, showcasing a wide range of activities across the Wolds.
Mapping activities available to health condition prevalence	**PH & AL –** Work in progress, the mapping continues to build and be promoted via LML website.

PH – Public Health. AL – Active Lincolnshire. DA's – District Authorities. OYL – One You Lincolnshire. ELDC – East Lindsay District Council. CAB – Centre for Ageing Better

What's Working Well – key Achievements 2022/23

RECOVER AND REINVENT

- Building content and growing users of the Lets Move Lincolnshire website and activity finder showcasing all options to be active
- Developed content for free and low-cost activities in response to cost-of-living crisis.
- Supporting physical activity sector conversations about response to Cost of Living
- Training – for the physical activity sector to better support needs of local people, including older adults and Long Covid
- Commissioned LORIC to understand the economic value of the physical activity, leisure and sport sector ; the sector employs 28,000 people across 1200 businesses and 1200 charities and adds GVA
- NGB Collective – Bringing together sport sector to enable them to understand Lincolnshire and build connections for greater collaboration and a more relevant offer
- Coordinating the Leisure Leads and Leisure Operator networks – including environment, cost of living impact, insight and data.
- CAB supported warm places, supporting over 50's to access leisure centres

CONNECTING WITH HEALTH

- OYL Healthy Ageing Department had 8.7k referrals for users over 60; 36% entered the move more pathway.
- LPFT and Shine investing in support for physical activity interventions through funded programme.
- Carers First have engaged with 263 carers in the last year who have benefits from OYL support. Carers first additionally offer regular sessions of walk, & talk, tai-Chi, breathing therapy and more recently have targeted make carers to be more active.
- Active Lincolnshire undertook a Learning exchange with Active Dorset to understand where and how impact can be made in health system; outputs include health e-newsletter; podcasts and blogs. Connected with ICB & PH.
- Contributing to ICB strategy and consultations around importance of physical activity.
- Pre- and post-natal programme with Better Births Lincolnshire; 23 'This Mum Moves' ambassadors trained. New physical activity sessions for pre- and post-natal mums being delivered in community.
- A new 'Long Covid' training course is available on a training platform for physical activity sector to understand how to respond to Long Covid (as part of the NHS CT funded programme)
- Delivered Physical Activity Clinical Champions Training – 37 trained champions.
- University of Lincoln and Centre for Ageing Better conducted research into older adults experiences of engaging in physical activity

CONNECTING COMMUNITIES

- Connected Coast – Towns fund investment led by ELDC committed to improving health and wellbeing for coastal destinations including Campus for Future Living and a new leisure centre in Mablethorpe and Skegness Gateway housing development.
- Working with a wide range of CVSE organisations including YMCA, LVET, advocating and supporting physical activity in their work.
- As part of the shared commitment and place-based work to respond to local needs and work with the community to engage in physical activity, Active Lincolnshire have joined the newly established South & East Lincolnshire Partnership Healthy Living Board. Covering some of the areas of the East Coast with the greatest health inequality and highest rates of physical inactivity, this will help develop new partnership opportunities and projects.

POSITIVE EXPERIENCE FOR CHILDREN AND YOUNG PEOPLE (CYP)

- Invested £330k DfE funding in Opening Schools Facilities for community use across 17 schools.
- Delivered School Games and support the wider School Games Organiser network.
- Commissioned Habit 5 to undertake research to understand youth voice.
- LCC delivering Holiday Activity and Food programme for CYP during school holidays, Active Lincolnshire supporting the physical activity offer.
- Supporting CYP network development to connect conversations and partners, sharing learning and reducing duplication.
- Child Healthy Weight management programme delivered by One You Lincolnshire.

ACTIVE ENVIRONMENTS

- One You Lincolnshire – Miles Better programme providing challenge-based activities for workplaces including LCC, LCHS, LPFT, ICB, PCN & St. Barnabas. 660 sign ups, 302 achieving 150 minutes. Combined weight loss of 337kg and 121 committed to eating more healthily.
- Wheels for Life – Bike donation scheme set up to support people in Transport poverty – 6 hubs trained volunteers to be mechanics.
- Cycling UK Chair Cycling infrastructure and behaviour change network

AGILE SYSTEMS
Stakeholders are working better together through forums and networks including: District Health and wellbeing strategies Lincolnshire Community Strategy and the VCSE Alliance LVET, Involving Lincs CYP Network EDI Physical activity Forum OYL and AL collaborating
TACKLING INEQUALITIES
Established an EDI advisory panel to ensure that the work of Active Lincolnshire and Let's Move Lincolnshire partners is informed by and representative of the needs and experiences of people facing greater barriers to accessing and participating in physical activity, sport and being active. Supported a total of 99 organisations, groups and charities through the 3 years of the Sport England 'Together Fund' grant programme, across all Districts, focussing on groups facing greater barriers to being active: people with disabilities, long term health conditions, minority ethnic communities, lower-socio economic groups. The wheelchair sport programme continues to be enjoyed by community groups, schools, workplaces and has been taken to events such as the Lincolnshire Show, providing an opportunity for disability awareness.

What is the outcome?

The long-term outcomes of a more active population include:

- Reduced mental ill health
- Reduced need for repeat visits to acute services
- Reduced loneliness and isolation

There is not currently any holistic way to collate the impact that the physical activity sector has on these outputs, however the Moving Communities (Sport England) funded database is used by all leisure centres in Lincolnshire and provides the following insight:

'MOVING COMMUNITIES' DATA: (Leisure centre usage):
Apr 2022 – March 2023 compared to April 2021 – March 2022.
Swimming lessons and swimming activities have increased
Outdoor activities and sports hall activities have increased.
Fitness (gym) activities have decreased.

This graph shows access to leisure centres by IMD; Lincolnshire compared to national.

Over the 12 month period, Lincolnshire Leisure centres have generated a total social value of £20.1m, of which £4.2m in physical and mental health value.

Other Outcomes:

Awareness (residents) - Let's Move Lincolnshire website and activity finder:
Promotion of physical activity sessions and offer: 422% increase in website visitors on last year.
18,900 people searching for activities on the activity finder.

Physical Activity Sector Support:
Over 100 physical activity providers engaged with Active Lincolnshire training sessions and support to develop their offer.

Together Fund:
All projects are monitored. 99 projects funded, all with a view to providing sustainable physical activity beyond the life of the funding.
https://www.activelincolnshire.com/news/together-fund-success-in-lincolnshire

HAF and Active Lincolnshire:
The LCC HAF team and Active Lincolnshire working together to provide a good quality, relevant physical activity offer as part of the LCC funded HAF programme.
https://www.activelincolnshire.com/news/collaborate-to-educate

PHYSICAL ACTIVITY JLHWS PRIORITY - PLANS FOR 2023/24

Action	How will we know it's working?	Relevant Strategy / Action Plan	To be delivered by	Lead Organisation	Lead Officer
Delivery of district Health and Wellbeing Strategy priorities for PA (Districts)	Assurance and monitoring by Districts	District HWB strategy	On-going	Districts	
Re-commissioning the Healthy Lifestyle Service (Public Health)	Reporting and monitoring of client data	HWB strategy	March 2024	Public Health	Andy Fox
Embedding PA in health and care systems and pathways (PH, ICB & AL)	Evaluation and impact monitoring	LML & HWB strategy	On-going	Active Lincolnshire	Rachel Edwards
Delivery of Year 2 of Opening Schools Facilities Programme (AL)	Numbers of people using new / updated facilities	LML	March 2024	Active Lincolnshire	Gemma Skaley
Launch of 'Street Tag'; connecting communities through digital trails (AL)	Numbers of people engaging with the trails	LML	March 2024	Active Lincolnshire	Gemma Skaley
Support physical activity sector with training and skills development (AL)	New and relevant physical activity products being made available	LML	March 2024	Active Lincolnshire	Gemma Skaley
Strength & Balance service launching (OYL) for over 60's.	Number of people engaged in the service and reduced falls	HWB strategy	March 2024	One You Lincolnshire	Dan Rogers

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LINCOLNSHIRE HEALTH AND WELLBEING BOARD

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

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**13 June 2023**
Subject:	**Evaluation of the Integrated Lifestyle Service, 'One You Lincolnshire'**

Summary:

This report provides a summary of the findings from the University of Lincoln's evaluation of the Integrated Lifestyle Service (ILS). The report, completed in 2022, and based on data from 24,370 referrals, provides a key resource that will help to inform and shape the recommissioning of the service in 2024.

The evaluation found that the service exceeded current benchmarks for successful service delivery within national guidelines across all four pathways (smoking cessation, weight management, physical activity and alcohol reduction) and surpassed outcomes from Lincolnshire's previous, discrete lifestyle services.

The benefits of an integrated model were illustrated by the fact that a key predictor of successful outcomes was a person's participation in more than one pathway.

Reconfiguration of the ILS in response to COVID-19 pandemic lockdown restrictions did not have a negative impact on its overall reach, however, a decrease in referrals among the most deprived populations was seen and a increase in the bias of take-up towards women.

Actions Required:

The Health and Wellbeing Board is asked to note the contents of this report.

1. Background

1.1 Smoking Cessation

The ILS surpassed its target of 50% quits at four weeks, achieving a 56% quit rate. This is significantly better than Lincolnshire's previous standalone service (46% quit rate) and is well over double the non-supported quit rate (25%). Success was more likely with older clients but was not affected by gender, rurality, ethnicity or deprivation. There was no negative impact seen from attending multiple programmes.

1.2 Alcohol

The alcohol programme received fewest referrals, which was attributed principally to GPs' prioritisation of other referral pathways. However, despite this, there were high rates of alcohol reduction across the service as a whole, with 57% clients on the alcohol or health coaching pathways and 37% of all clients reducing their consumption to target levels.

This compares very favourably with the 10-30% success rate of national brief alcohol interventions. Participation in other pathways, particularly weight management, was strongly predictive of reducing alcohol consumption.

1.3 Diet and Weight Management

Thirty-three percent of clients accessing the weight management (WM) intervention or health coaches lost 5% body weight at 12 weeks. This increased to 40% amongst those who attended a sub-contracted WM provider.

Weight loss was not limited to those on the WM pathway, with 25% clients across the whole service losing 5% body weight. The average weight loss was 6%, the service thus exceeding NICE guidance of 30% achieving 5% loss with an average of 3%.

1.4 Physical Activity

43% of clients on the physical activity or health coaching programmes achieved the target of 150 minutes per week. This easily surpasses the 13-18% success rate of national, non-integrated exercise-referral models.

As with other pathways, high rates of increase in physical activity were recorded across all programmes. Other predictors of success were being female, older, accessing a health-coach and having a long-term condition. However, positive outcomes were less likely for the most deprived populations as well as for the unemployed and long-term sick.

1.5 Access & effect on Inequalities

Participation was heavily biased towards women, who made up 66% of all clients. Ninety-three percent were White-British and there was an even split between rural (51%) and urban (49%) residents.

Thirty-eight percent of referrals were for residents from the 30% most deprived communities, which was significantly short of the target of 50% for this group. However, in large part, this was an effect of the service reconfigurations, namely digital delivery and self-referral, that were made in response to lockdown restrictions. Prior to these changes the most deprived 30% had made up 45% of referrals. Nonetheless this demonstrates that the programme is targeting lower socioeconomic (SE) groups and successfully engaging this population at a higher rate than those in

higher SE groups. This represents evidence of a positive impact on health inequalities, as typically utilisation of preventative services is lower in more-deprived groups.

The majority of participants across the whole service were obese and aged 50+. The ILS was thus reaching an extremely important target group for preventative services, given the heightened risk of long-term ill-health amongst this population. Likewise, there was evidence that the physical activity programme was particularly successful among people with conditions affecting mobility and pain management, both of which are major barriers against exercise amongst people at high risk of deterioration in health.

1.6 Completion

Completion rates varied for each pathway. Weight Management exceeded NICE guidance of 60% with a 70% completion rate. Rates for smoking, health coaching and alcohol were 63, 56 and 46% respectively. Physical Activity data were incomplete so do not provide an accurate figure.

2. Impact of the Lincolnshire Model

2.1 Integration

The benefits of an integrated rather than segregated offer are clearly demonstrated by the number of positive outcomes for people accessing more than one pathway. For physical activity, weight management and alcohol, engagement with more than one programme was a key predictor of success; indeed, for physical activity it was the most important single factor, with participants being 2.7 times as likely to become active as those accessing just one pathway. Even smoking cessation, for which the literature has sometimes suggested integrated models were not suitable, was not negatively affected by engagement in multiple pathways.

2.2 Health Coaching

Health coaching support appears to be an important component of the current offer, being strongly associated with positive outcomes across weight management, physical activity, and alcohol, with those accessing a health coach being over 3.5 times as likely to reduce their alcohol to within target levels.

2.3 Referrals

The qualitative data indicated that relationships with GPs, which have historically been difficult for lifestyle services in Lincolnshire, had significantly improved under the current model. This was evidenced by the 36% of referrals that came directly from primary care. It is likely that a significant proportion of the 39% of self-referrals were also instigated by GPs during non-face-to-face appointments with patients. The high number of self-referrals ensured that the ILS could continue to deliver at volume during Covid, however, as self-referral is more likely to be used by people with higher existing motivation and health-seeking behaviours, it is likely that this contributed to the shift in uptake towards more affluent population groups.

3. Conclusion

Success rates across all lifestyle interventions exceeded national benchmarks, despite the clear challenges to service delivery through the COVID pandemic.

- The overall advantages of an integrated model were demonstrated by the fact that there were no negative implications of participation in multiple programmes and many benefits, including weight loss, increased physical activity and decreased alcohol consumption, amongst people for whom these interventions were not their primary pathway.
- Evidence suggests that the service is positively addressing health inequalities. Outcomes were not affected by socio-economic status, and analysis of service access by deprivation decile highlights that those in lower SE groups were effectively targeted by the service.
- There was a strong bias towards women, and physical activity outcomes and take-up from the most deprived populations fell short of target. It appears though, that these participation patterns were, at least in part, the result of service reconfiguration during lockdowns.
- The findings demonstrate that One You Lincolnshire is an effective model and will contribute to the service's recommissioning process ahead of the contract end date in June 2024.

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

The Council, NHS Lincolnshire Integrated Care Board and the Lincolnshire Integrated Care Partnership must have regard to the Joint Strategic Needs Assessment (JSNA) and Joint Local Health and Wellbeing Strategy (JLHWS).

Healthy Weight is identified as a priority for Lincolnshire in both the Joint Strategic Needs Assessment and the Joint Health & Wellbeing Strategy and is a key part of the overarching Joint Health and Wellbeing Staretgy theme of placing a strong focus on prevention and early intervention.

5. Consultation

Not applicable.

6. Appendices

These are listed below and attached at the back of the report	
Appendix A	Addressing Multiple Unhealthy Risk Factor – An Evaluation of Integrated Care in Lincolnshire

7. 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 Chaudhary who can be contacted at sarah.chaudhary@lincolnshire.gov.uk

The University of Lincoln

Addressing Multiple Unhealthy Risk Factors

An Evaluation of Integrated Care in Lincolnshire

August 2022

Contributors

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Published August 2022

List of Abbreviations

AIC	Akaike Information Criterion
BMI	Body Mass Index
COM-B	Capability, Opportunity, Motivation, Behaviour
GDPR	General Data Protection Regulation
GP	General Practice
ICCs	Intraclass Correlation Coefficients
ICS	Integrated Care Systems
ILS	Integrated Lifestyle Service
LCC	Lincoln County Council
LSOAs	Lower-Layer Super Output Areas
LTHC	Long Term Health Condition
MHC	Mental Health Condition
NCDs	Non-Communicable Diseases
NHS	National Health Service
OR	Odds Ratio
OYL	One You Lincolnshire
QALYs	Quality-Adjusted Life-Years
RE-AIM	Reach, Effectiveness, Adoption, Implementation, Maintenance
TA	Thematic Analysis

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Executive Summary

Introduction

This report presents the independent evaluation findings of One You Lincolnshire (OYL). OYL is an integrated lifestyle service that covers hundreds of county sites, including leisure centres, commercial weight management groups and sub-contracted sites. The service is also delivered over the phone and Microsoft TEAMS. The service supports weight loss, healthy eating, physical activity, alcohol reduction and smoking cessation for Lincolnshire residents from the most deprived areas with long-term health conditions. However, the service is open to all individuals in the county who meet the service's eligibility criteria of over 18 years old (12 years and older for smoking cessation). Clients must have a BMI of 30 or above for weight management pathways. Eligibility also includes less than 150 minutes of moderate physical activity, smoking tobacco and drinking more than 14 units of alcohol per week.

The service has self-directed online tier 1 guidance and tier 2 support that provides 1:1 health coaching and group classes and programmes. The service also partnered with commercial weight loss programmes—for example, Slimming World, Weight Watchers, and Second Nature to provide a range of interventions. OYL and Lincolnshire County Council commissioned the University of Lincoln to undertake the service evaluation. This report captures clients' experience using the service and health professionals involved in referrals and implementation. The effectiveness of the service was also compared to the standard provision of care.

Methods

A RE-AIM evaluation was implemented to have a comprehensive picture of OYL. The evaluation looked at the service's accessibility, effectiveness, implementation, and sustainability. In phase 1 of the evaluation, between July 2020-2021, 53 in-depth interviews were conducted. Participants included clients, health professionals, OYL staff, external

partners and OYL leadership. In phase 2 of the evaluation, between July 2021 – July 2022, secondary data analysis was conducted. 24,370 referrals were nested within 16,354 clients and nested within 128 coaches.

Accessibility

Most clients referred to the service were White British and women. Clients in OYL from deprived LSOAs were likelier to have long-term health conditions and poorer mental health. The underrepresentation of men in the service was explored, and factors such as reduced GP visits, perception of women-dominant weight loss programmes and fears of seeking help affected access. COVID-19 put a considerable strain on primary care. Clinics focused on COVID-19 management, removal of face-to-face contact and, as a result, fewer referrals to OYL via GPs. One major reconfiguration in the service referral process was the introduction of self-referral. The average age of clients became younger and was more women dominant.

There were also fewer referrals from ethnic minorities, long-term unemployed and deprived populations. At a service level, alcohol consumption support had fewer referrals than other OYL pathways. Interviews showed that alcohol-related discussions were not always considered essential to GPs' work. Some GPs viewed alcohol support as challenging to ascertain in clients than more visually presenting risks like obesity and smoking. Coupled with limited time for appointments, GPs were more likely therefore to recommend weight loss and smoking cessation to clients.

Effectiveness

OYL outcomes were better across all pathways compared to previous standard care provisions. For instance, 56% of OYL clients self-reported quitting smoking at four weeks. In contrast to 46% of patients with past Lincolnshire benchmarks. Quitting was more likely in older OYL clients and those with a high confidence score. Additionally, 57% of OYL clients self-reported consuming less than 14 units of alcohol a week or decreased units by 50%. As opposed to 10-30% of patients using national brief alcohol interventions. Using a health coach and being engaged in other pathways increased the likelihood of reducing alcohol

intake for OYL clients. 43% of OYL clients also increased to 150 minutes of moderate activity a week compared to 13-18% on national exercise referral schemes.

Success was more likely for women and clients with LTHC. Using a health coach and participating in additional pathways also increased physical activity success. 33% of clients self-reported losing 5% of body weight after 12 weeks. 40% of Second Nature/Slimming World clients also met the target. Therefore, all OYL clients on weight management exceeded the NICE guidelines of 3% weight loss. Successful weight loss was associated with older clients, consistent attendance, and the use of a health coach.

Interviews highlighted that health coaches' rapport with clients built encouraging, positive relationships. Health coaches were also able to offer support for less referred pathways through weight loss motivations. Client interviews also found that personalised online delivery better-suited individuals with LTHCs. For example, clients with limited mobility could still engage in group activities via video calls. Although, some clients with financial difficulties did struggle with digital service delivery. Nevertheless, most clients achieved meaningful changes. Clients experienced increased confidence, motivation, and self-esteem, critical factors for sustained lifestyle changes.

Working relationships

Most OYL clients trusted GPs. As such, GPs often had access to engage with disadvantaged groups. Focus groups with external partners highlighted the role of OYL as a primary care intermediary. Many external partners viewed OYL as building relationships with GPs, enabling smooth referrals and delivery operations within the service. Although, some primary care staff presented gaps in knowledge of the OYL service model. Interviews with OYL leadership suggested quality assurance was encouraged across team members and working group implementation promoted integration. The relationships between OYL and partners were positive, and consistent communication and trust were highlighted as OYL's key strengths.

Sustainability

The service provided continued access to support throughout the COVID-19 pandemic, and the service-maintained outcome success rates from pre- to post-reconfiguration. Completion rates for most pathways were over 50%, and for 'Drink Less' approached 50%. Move More completion rates appeared lower. However, attendance recording was inconsistent and under-representative for this pathway. There are some evident inequities in the uptake of reconfigured services. Most access seems to be enhanced for those from less deprived areas. As a result, the service did move further from the targeted representation of those from the most deprived areas. Remote access through digital solutions overcame restrictions to in-person delivery. Moreover, more open referral pathways boosted referrals from ~353 per month to ~668 per month. If sustained, outcomes delivered by OYL could lead to savings for the local health and social care system as integrated care may increase disposable income for local communities.

Conclusion

OYL provides crucial evidence on the benefit of clients with multiple unhealthy risk factors as OYL outcomes exceed all standard care across all four lifestyle risks. Despite COVID-19, the service remained adaptable with ongoing success during service reconfiguration. OYL also focused on local relationships making solid links with other organisations in Lincolnshire. OYL created a much more integrated offer for the clients, increasing the likelihood of better outcomes.

x

Chapter 1 Introduction

Background

Globally, non-communicable diseases (NCDs) are predominantly driven by unhealthy lifestyles. Environmental factors account for 71% of deaths yearly (WHO, 2021). Tobacco accounts for more than 7.2 million deaths yearly, and 4.1 million deaths have been attributed to excess salt/sodium intake. More than half of the 3.3 million annual deaths attributable to alcohol use are from NCDs, including cancer, *and* 1.6 million deaths annually can be attributed to insufficient physical activity (Forouzanfar et al., 2016). Common unhealthy behaviours, such as tobacco use, physical inactivity, an unhealthy diet, and the harmful use of alcohol, significantly increase a person's risk of diseases. Illnesses such as obesity, coronary heart disease, and stroke are more likely, increasing the risk of reduced quality of life and premature death. According to Evans and Buck (2018), approximately 70% of adults in the UK have two or more risk factors. Around 40% of the UK's disability-adjusted life years are attributable to tobacco, alcohol consumption, or being physically inactive (Newton et al., 2015).

This RE-AIM evaluation was commissioned in response to a call by Lincolnshire County Council (LCC) and Thrive Tribe, a healthy lifestyle service provider contracted by LCC to deliver One You Lincolnshire (24/01/2020 – tender released). The call sought to evaluate Lincolnshire's integrated healthy lifestyle service and develop an active research methodology to evaluate the impact and outcomes. This study was subsequently commissioned to explore the impact of addressing multiple unhealthy behaviours in individuals in Lincolnshire.

As section 1 (1) of the Care Act states, **care of local authorities must promote the integration of care and promote quality in the provision of services** (Care Act, 2014). As such, Lincolnshire County Council has commissioned One You Lincolnshire to provide an integrated care system at a local level. This evaluation of One You Lincolnshire started in July 2020 and was completed in July 2022. A team of researchers at the University of

Lincoln, led by Professor Ros Kane, conducted the evaluation. Ethics approval was obtained from the Health Regulation Authority on the 22nd of December 2020 (Appendix A).

Research Objectives

This study explored the implementation, quality, and impact of addressing multiple unhealthy behaviours for individuals in Lincolnshire through One You Lincolnshire (OYL). The study objectives were to:

- Identify critical components of good practice of the client pathway, considering views from clients, programme staff, healthy lifestyle service subcontractors, and referral teams that capture vital barriers and facilitators of OYL service implementation and delivery.
- Identify access and acceptability of the service provision within client subpopulations against local population demographics.
- Assess baseline effectiveness of OYL, exploring variables that moderate outcomes such as client, provider, and programme factors compared to service targets and external benchmarks
- We explore the costs associated with delivering OYL in person and service reconfiguration.
- Develop clear recommendations for real-world settings suitable and amendable for service improvement of OYL
- Contribute to the growing body of evidence on the impact of integrated lifestyle service delivery and future quality assurance of service outcomes

Report Structure

In the rest of this chapter, we outline the UK's policy context for integrated lifestyle services. The background includes information on unhealthy lifestyle factors in England and the development of integrated services to **"Make Every Contact Count"** against increasing pressure on primary care services. The current report is reserved for stakeholders involved in the development, delivery, and management of One You Lincolnshire and a wider

audience interested in delivering integrated lifestyle services in community settings. The report, thus, assumes a certain level of knowledge and understanding of lifestyle services and behavioural change models.

Chapter 2 outlines why we used a RE-AIM evaluation approach and applied the principles to evaluating integrated lifestyle services.

Chapter 3 reports the findings of the qualitative interviews and focus groups of One You Lincolnshire. This chapter explores how integrated care was implemented and the perceptions of the barriers and facilitators from participants.

Chapter 4 reports the findings of outcomes for clients using One You Lincolnshire datasets to provide quantitative evidence outputs such as quit smoking and weight loss rates.

Chapter 5 reports the economic evaluation findings that explore the effectiveness and cost-effectiveness of integrated care compared with standard lifestyle services.

Chapter 6 triangulates the evidence generated across the qualitative and quantitative data. We present the findings of this RE-AIM evaluation of the complex factors that decision-makers must consider ensuring quality and effective integrated care for people in Lincolnshire.

Integrated Care

Integrated care is a complicated phenomenon covering many frameworks and delivery processes. According to Kodner and Spreeuwenberg (2002), ***integrated care*** can be defined as a **"coherent set of products and services delivered by collaborating local and regional health care agencies"**. In the UK, integrated care is often interpreted as removing traditional divisions between hospitals and family doctors, physical and mental health, and NHS and council services.

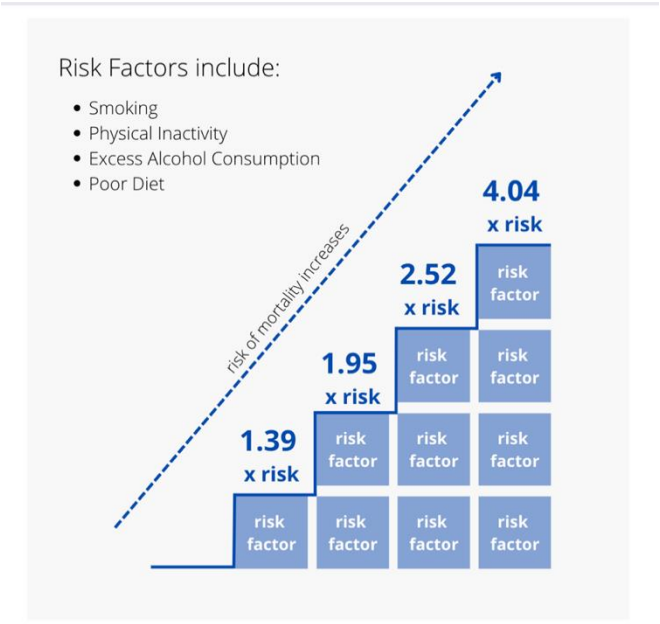
The primary focus of this evaluation is on **"integrated lifestyle services"** (ILS), a term used to capture integrated care in the context of unhealthy risk factor interventions such as

smoking cessation, weight management, healthy eating, physical activity, and alcohol reduction. ILS are often not-for-profit private organisations commissioned by local authorities, which connect local health behaviour providers with primary care services through a single access point. This service model is becoming common as local authorities move towards a preventive, community service approach. Between 2017 and 2019, 14 ILSs were formed across England, increasing to 42 by the time of this study (NHS Digital, 2022).

Multiple unhealthy risk factors

In this report, the term **"multiple unhealthy risk factors"** refers to a simultaneous combination of risk factors (behavioural) that impact individuals and pose a health risk (Evans and Buck, 2018). Research on multiple risk factors has been a focus of public health for over a decade, with compelling evidence suggesting that poor diet, physical inactivity, excessive alcohol consumption and smoking are linked to ill health. After following a cohort for 11 years, Khaw et al. (2008) showed that an individual with four risk factors had a four-fold risk of dying compared with someone who ate well and was active and did not smoke or drink to excess (Figure 1).

Figure 1. Why multiple unhealthy risk factors matter



Adapted from King's Fund. Relative all-cause mortality risk shown applied after an average 11-year follow up in a cohort of adults aged 45-79.

Likewise, individuals from lower socio-economic groups risk having three or four simultaneous behavioural risk factors. In 2018, the King's Fund published a report on multiple unhealthy risk factors. The report identified that although the prevalence of risk factors has been declining among adults in England since 2003, reductions were much more likely to come from higher socio-economic groups (Evans and Buck, 2018). Therefore, lifestyle services must be cognisant of the social determinants underpinning population risk factors and barriers such as financial inequality that may impact accessibility and availability of interventions. The report highlights the research knowledge gap and the need to consider essential questions such as - is it better to attempt a behaviour change simultaneously or sequentially?

One You Lincolnshire

In June 2019, Lincolnshire County Council commissioned Thrive Tribe to deliver an integrated lifestyle support service, focussing on providing high-quality and accessible information and direct support to adults in Lincolnshire. The commission included helping residents adopt and maintain healthier lifestyles, focusing on the four behaviours that have the most significant impact on health and wellbeing: smoking tobacco, physical inactivity, obesity (food, nutrition, and a healthy weight), and excess alcohol consumption.

Local Context

It is estimated that the potential target size for One You Lincolnshire is almost 60,000 eligible adults. Lincolnshire has a smoking prevalence rate higher than the national average of 15.3% (Office for Health Improvement and Disparities, 2021a). The Office for Health Improvement and Disparities (2021a) reported the percentage of adults in Lincolnshire classified as overweight or obese (BMI of over 25 and 30) as 67.6%, worse than the national average of 63.5%.

There have also been efforts to encourage physical activity in the population, with 26.5% of adults categorised as inactive (Office for Health Improvement and Disparities, 2021c).

Additionally, 20.4% of adults drink more than 14 units of alcohol a week in the county (Office for Health Improvement and Disparities, 2021b). Therefore, Thrive Tribe implemented OYL as an ILS to promote sustainable lifestyle changes. The service provides access to stop smoking services and extended brief interventions for alcohol, diet and nutrition, and physical activity through tier 1 and tier 2 support.

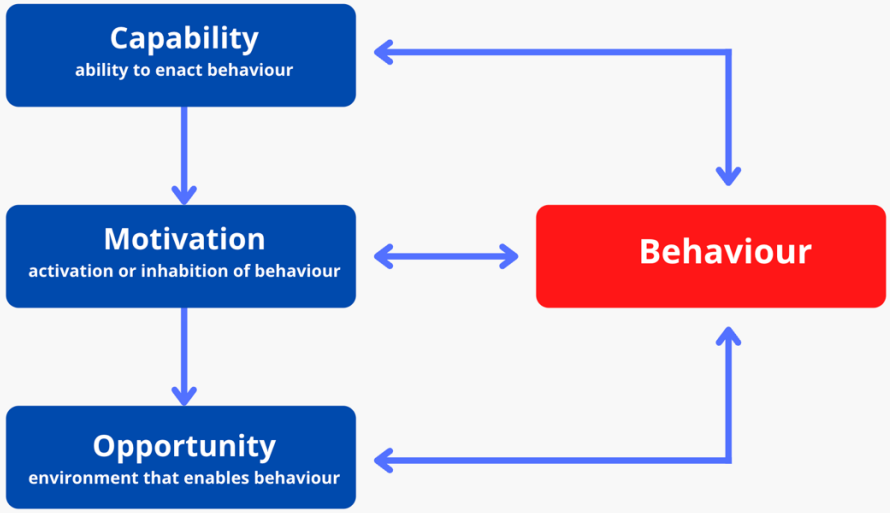
Theory of Change

One You Lincolnshire service design used the COM-B model, which focuses on working through individuals' capability, opportunity, and motivation to change (Michie et al., 2011). COM-B is a valuable framework since it helps connect behaviour change to the broader determinants of health, as shown in Figure 2.

Figure 2. The COM-B Model of Change

The COM-B Model

A fundamental model of change used is the Capability, Opportunity, Motivation, Behaviour Model (COM-B) to identify what needs to change to be effective for a behaviour change intervention. COM-B identifies factors that need to be present for any behaviour to occur capability, opportunity, and motivation, which interact over time so that behaviour can be seen as part of a dynamic system of change (West and Michie).

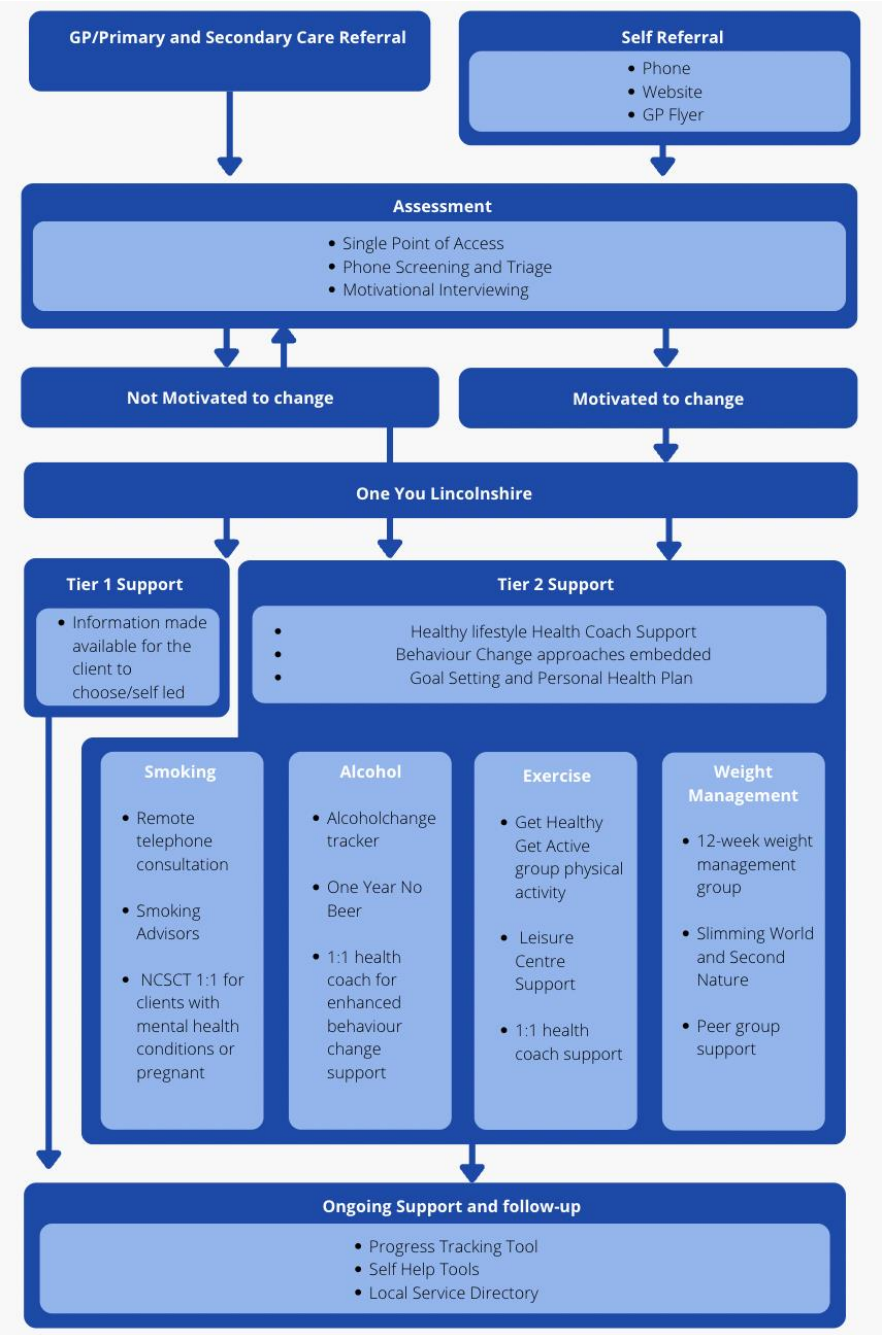


Source: Adapted from Michie et al. (2011)

Client Care Pathway

One You Lincolnshire provides service to eligible individuals for up to 12 months to support them in achieving their health outcomes via health information, signposting, goal setting, action planning, and support tailored to the client's needs (Figure 3).

Figure 3. One You Lincolnshire Client Pathway



Eligibility

All clients using the service are adults 18 years old and over who have been identified as having an at-risk status and one or more unhealthy behaviour (OHID, 2021). One You Lincolnshire eligibility criteria are:

I. People with long-term health conditions made worse by unhealthy behaviours, including obesity (BMI of 30 or above/ 27.5 or above for Black, Asian, and Minority Ethnic clients), diabetes, cardiovascular disease risk, liver disease, musculoskeletal conditions, osteoporosis, coronary heart disease and respiratory diseases.

II. At-risk adults who may have undertaken NHS Health Check for Cardiovascular Disease Prevention or received a Q-Risk score of >10%, enabling the primary care staff to refer them directly to the ILS.

III. People engaged with the NHS's health optimisation about the future need for support for smoking cessation and weight management before surgery.

IV. Carers in Lincolnshire who may be obese with a BMI of 30 or above, smoke, drink to excess or are inactive.

V. Individuals 12 years and over who smoke and are seeking help to stop smoking, including pregnant women, and their partners.

The Impact of COVID-19

This study occurred during COVID-19. The pandemic led to a national lockdown and restrictions between March 2020 and December 2021. Restrictions included a ban on non-essential travel, working from home measures, closing of schools and non-essential shops and social distancing. As the pandemic progressed, lifestyle factors, including obesity and smoking, were correlated with an increased risk of COVID-19 severe illness or related death. At the time of this study, the number of deaths due to COVID-19 was more than 100,000 in the UK (ONS, 2022).

In March 2021, the Department of Health and Social Care released a policy paper, **“COVID-19 mental health and wellbeing recovery action plan"**, which aimed to prevent, mitigate, and respond to the health impacts of the pandemic from 2021 to 2022. The policy outlined the government's proposed Health and Care Bill, which aimed to help local health and care systems deliver higher quality care to their communities by putting integrated care systems on a statutory basis. Additionally, the Department for Digital, Culture, Media and Sport supported Sport England in the implementation of its new 10-year strategy, which focuses on the recovery and reinvention of the sport and physical activity sector from COVID-19, as well as bringing communities together through sport and physical activity.

Chapter 2 RE-AIM Evaluation

Overview of RE-AIM evaluation approach

This evaluation uses the RE-AIM model, developed in 1999 in response to a need for a framework to evaluate public health interventions (Holtrop et al., 2018). The RE-AIM framework was first produced to help evaluators balance internal and external validity when developing, testing, and implementing interventions. The framework's goal is to help maintain programme sustainability in community settings. The RE-AIM dimensions' constitutive definitions are straightforward and appealing to community and clinical organisations (Glasgow et al., 2019).

RE-AIM Principles

In their introduction of the framework, Glasgow et al. (2019) argued that, while reach and efficacy might define the impact of a programme, extra attention should be directed towards the adoption, implementation, and maintenance dimensions (Table 1).

Table 1. RE-AIM dimensions used in this evaluation and the scope of each dimension

RE-AIM Dimensions	Definition
Reach	• WHO is intended to benefit and who participates or is exposed to the intervention?
Effectiveness	• WHAT are the most important benefits you are trying to achieve and what is the likelihood of negative outcomes?
Adoption	• WHERE is the programme or policy applied and WHO applied it?
Implementation	• HOW consistently is the programme or policy delivered, HOW will it be adapted, HOW much will it cost, and WHY will the results come about?

Maintenance	• WHEN will the initiative become operational; how long will it be sustained (Setting level); and how long are the results sustained (Individual level)?

The **Reach** element refers to the number of individuals participating in an intervention, including characteristics like age, ethnicity, and rurality. **Effectiveness** is the impact of an intervention on important outcomes and includes adverse effects, quality of life, and economic outcomes. **Adoption** is the absolute number, proportion, and representativeness of settings and intervention agents who start a programme. **Implementation** refers to the intervention agents' fidelity to and adaptations of intervention and associated implementation strategies, including the consistency of delivery as intended and the time and costs. **Maintenance** is the extent to which a programme becomes routine. Within the RE-AIM framework, maintenance also applies at the individual level and has been defined as the long-term effects of a programme's outcomes (Kwan et al., 2019).

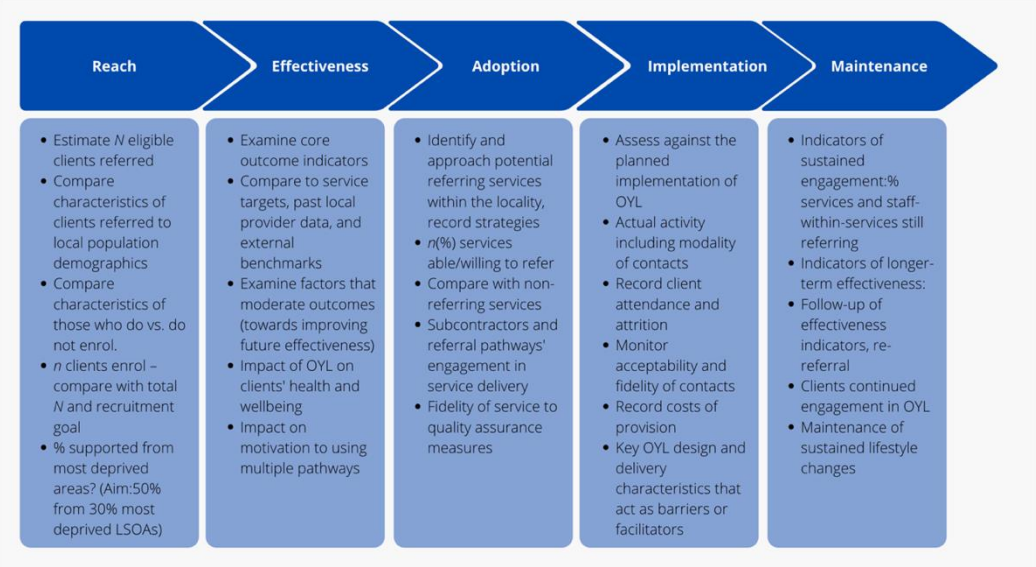
Application to research

One benefit of the RE-AIM framework is that it provides a valuable starting point for determining the public health impact of interventions: **Reach**, captures a given population who participates in a programme and describes their characteristics. **Effectiveness** shows the positive and negative outcomes of the programme. **Adoption** defines the percentage of settings that agree to take part in the programme. **Implementation** indicates if a programme is delivered as intended and its cost; and **Maintenance**, at the individual level, reflects the maintenance of the primary outcomes (Sweet et al., 2014).

RE-AIM challenges researchers to ask questions about complex issues before, during, and after implementing a programme in real-world settings. Among the many RE-AIM strengths are its robust structure and pragmatism, facilitating broad use across settings, populations, and interventions (Harden et al., 2018). Also, the framework supported an agile approach to service improvement. The research team identified areas for improvement during the study, so OYL could be responsive and adapt the service for immediate improvements. A two-year evaluation enabled insights into One You Lincolnshire's implementation and client

engagement. Each RE-AIM outcome measure used in the study is defined below in Figure 4.

Figure 4. Components of the RE-AIM framework in the context of One You Lincolnshire



Chapter 3 Interviews and Focus Groups

Overview

This chapter explored the perspectives of clients, staff and stakeholders in qualitative interviews and focus groups. The methodology used in the research is outlined, and the fieldwork's research design and aim. The results highlighted the impact of the OYL on clients' outcomes and barriers and facilitators to service delivery.

Methodology

Research Design

The study collected qualitative data from January to June 2021. To capture the views of a diverse range of clients, the research team conducted a pre-interview survey to assess the type of support and demographic of potential interviewees. An online survey was designed and delivered using Qualtrics software and asked potential client participants about their demographics, referral routes to the service and pathways they used. The steering group piloted the survey, and changes were adopted where appropriate. All interviews and focus groups (telephone and TEAMS) were conducted using a semi-structured interview guide. Topic guides were developed with the steering group to ensure that questions followed the RE-AIM framework. The whole group reviewed the interview questions for question order and flow appropriateness. Thus, key stakeholders, staff, and clients were allowed to contribute to the interview and focus group guides on its design phase.

Research Setting

One You Lincolnshire operates in 17 areas across the county for face-to-face delivery. A range of interventions is available via online support and remote health coach sessions to all clients who cannot attend in-person support resulting in a complete county offer. Table 2 shows the various activities of each site delivery service.

Table 2. One You Lincolnshire Programmes available at each site grouped by risk factor.

		Lincoln	Grantham	Boston	Spalding	Skegness	Gainsborough	Stamford	Sleaford	Louth	Bourne	M Deeping	Mablethorpe	Horncastle	Holbeach	Ruskington	Long Sutton	Coningsby
Stop Smoking	Health Coach Appointment	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	Specialist 1:1 Stop Smoking	X	X	X	X	X	X	X	X	X	X	X	X	X	X			
	Stop Smoking in Primary Care*	X	X	X	X	X	X	X	X	X	X	X						
	28 Days Telephone Service	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Move More	Specialist 1:1 Sessions with PA instructor*	X	X	X	X	X	X	X	X	X			X					
	Supervised Sessions in Leisure Centre*	X	X[1]	X	X	X	X	X[1]		X	X	X[1]	X	X				
	Group Sessions with PA instructor*	X	X	X	X	X	X	X	X	X	X	X	X					
	Get Healthy Get Active	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Eat Healthy	Lose Weight with OYL	X	X	X	X	X	X	X	X	X	X	X						
	MAN, V FAT Football*	X	X	X	X	X												
	Gloji Online Gym	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	Slimming World/Weight Watchers*	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

Drink Less	Our Path Digital Service	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	Health Coach Session	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	One Year No Beer	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	Alco-change	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

**Delivery model changed due to COVID-19*

1 Did not return after COVID-19

Sampling and recruitment of participants

Between July 2019 and July 2020, OYL had 6,268 clients in its database. The service has eight Service Leads, with 33 Programme Staff ranging from Triage and Support Workers, Health Practitioners, Advisors, and Referral Generation Officers (Appendix B). The service also works with 175 subcontractors across Lincolnshire. Staff were contacted via the research team, and OYL's website and social media advertised a call for client participation. Participants could telephone or email the research team to express their interest. The staff also used a telephone script to advertise the study to clients already engaged in the service. The advertising material was developed collaboratively with OYL, client representatives and the research team. The sample of participants was monitored to ensure diversity such as gender, ethnicity, and carer status across the participation groups. Participation was voluntary, and the recruitment of participants used an opt-in method in line with GDPR (Data Protection Act, 2018).

Inclusion criteria and recruitment

Clients were recruited that met one of the eligibility criteria of the research as follows:

- Not deemed motivated following motivational interviewing
- Not deemed eligible following the health assessment
- Declined support
- Took up tiers 1 or 2 support
- Incomplete attendance or unsustained change
- Complete support and sustained change

Before the researcher made contact, clients were approached via recruitment flyers online and health coaches promoting the study. Interested clients were sent a study information sheet and asked to complete a pre-interview screening survey. The researcher explained that participation was voluntary, and participants could withdraw at any time or refuse to answer questions. Also, participation was anonymous, and no personal information would be shared with One You Lincolnshire. Informed consent was collected before interviews, and if they or someone else was at risk of harm, the interviewer would be obliged to take appropriate action. The participants also received a £10 voucher per interview for sharing their time and experience.

Data collection

Data collection occurred between February 2021 and June 2021 and involved qualitative interviews and focus groups with various participants. 53 participants took part in the study (Table 3). Participants who agreed to the study were given a detailed information sheet and a consent form before data collection. Participants were allowed to book an interview time with the researcher, and the interview was conducted via telephone or Microsoft TEAMS, as preferred by the participant. Only participants who provided informed consent and met the pre-interview screener were included. Participants had the right to revoke, decline, or withdraw consent during data collection. Consent forms (via Qualtrics) were completed before the interview/focus group and stored as PDFs on a secure cloud-based server. The interviews/focus groups were recorded, transcribed, and transcriptions were stored.

Table 3. The number of interviews completed by June 2021.

Individuals Interviewed	February- June 2021
Clients	24
OYL Staff	21
Health Professional	5
Stakeholders	3
Total	**53**

Topic guide

Topic guides were used to ensure a consistent approach to each interview. However, the topic guides were used flexibly, with open and non-leading phrasing to allow participants to give their accounts in their own words and describe their lived experiences. Staff focus groups concentrated on service delivery and implementation, whilst client interviews focused on the perceptions of the service and perceived impact. The interviews and focus groups ranged from 30 to 120 minutes in length.

Ethics

This study was defined as research and obtained Health Regulation Approval (Project IRAS ID 289313) on the 22nd of December 2020 (Appendix A). A steering committee was established and met every 3 months to ensure all the study's practical details were consistently progressing and working well. The study has also been adopted onto the NIHR portfolio (ID 289313).

Analysis

The research team inductively analysed the transcripts using the principles of thematic analysis (TA) proposed by Braun and Clarke (2006). Researchers explored participants lived experiences as situated within a broader socio-cultural context of their health. The research assistant set up a coding log to ensure all data and recruitment files conformed to requirements of anonymity. All interviews were recorded verbatim and transcribed, except one interview conducted over email. Each transcript was reviewed and coded by the original interviewer.

An iterative data analysis process involved all research team members through periodic team meetings where differences in interpretation were discussed. NVivo software (Version 10) facilitated analysis. The qualitative data were thematically analysed, with the codes summarised. A coding frame was developed based upon early rounds of interviews and refined by the research team until an agreed structured/hierarchical coding frame was developed. Summaries of significant findings were generated to identify recurrent themes and compare and contrast findings. The team was careful to consider outlier data, divergent accounts and issues, and commonalities to identify critical themes for the study.

Results

Characteristics of Clients

Twenty-eight responses were recorded, with 24 agreeing to a follow-up interview (Table 4). Most respondents were female (75%), reported their ethnicity as White British (93%) and living with a long-term health condition (82%). A quarter of participants had friends and family support, while 14% had caring responsibilities. However, most participants did not have caring responsibilities (57%). Self-referral was the most common route into the service (39%), followed by GP referrals (36%). Some participants were referred to via social media, word of mouth and work referrals.

Most participants completed their assessment over the phone with the OYL triage team. Once assessed, most participants were offered tier 1 online information support *and* access to tier 2 health coach support (46%). 21% were offered only tier 1 support and 25% only used a health coach for support. Healthy eating was the most common pathway participants engaged with (71%). 46% engaged with a physical activity programme. Smoking cessation and alcohol reduction support were each used by 21% of the participants. Most participants engaged in more than one type of support. 57% signed up for two programmes, often healthy eating, and physical activity. One participant did get referred to three lifestyle programmes. Whilst the remaining 39% of participants engaged in only one lifestyle programme.

Finally, most participants were working towards their goals during the study. A small percentage did not achieve or maintain their changes in the study (4%). 36% of participants indicated that they had maintained their changes. However, when interviewed, some had no longer maintained their changes, suggesting some discrepancies between the screener questions and the follow-up interviews.

Table 4. Characteristics of clients from pre-interview survey

	n	%

Gender	Female	21	(75%)
	Male	7	(25%)
Ethnicity	White British	26	(93%)
	Non-White British*	2	(7%)
Living with a Long-Term Health Condition	Yes	23	(82%)
	No	4	(14%)
	Preferred not to answer	1	(4%)
Carer Status	Had friends or family support them	7	(25%)
	Had caring responsibilities	4	(14%)
	Had friends or family support them AND had caring responsibilities	1	(4%)
	Did not have caring responsibilities	16	(57%)
Referral Route	Self-Referral	11	(39%)
	Via GP	10	(36%)
	Other Route	7	(25%)
Assessment Process	In Person	3	(11%)
	Via Website	5	(18%)
	Via Phone	19	(68%)
	Other Route	1	(4%)
Level of Support	Tier 1 Support Only	6	(21%)
	Tier 2 Support Only	7	(25%)
	Both Tier 1 and Tier 2 Support	13	(46%)
	Did not know	2	(7%)
Type of Support Used**	Healthy Eating	20	(71%)
	Increasing Exercise	13	(46%)
	Reducing Alcohol Consumption	6	(21%)
	Stop Smoking	6	(21%)
Used Integrated Care Support	One Programme Only	11	(39%)
	Two Programmes	16	(57%)
	Three Programmes	1	(4%)
Maintenance of Lifestyle Changes	Maintained changes	10	(36%)
	Currently working on changes	16	(57%)
	Did not maintain changes	1	(4%)

[redacted]	Did not achieve changes	1	(4%)

*Due to the small sample size (n=28), some data were aggregated to ensure anonymity.

**Percentages equal >100 as participants could select multiple responses.

Eligibility, Referrals, and Demand

Lesson 1: Impact of COVID-19 on eligibility, referrals, and demand

Change to client eligibility

A pivotal change to the delivery model of OYL was widening the eligibility criteria for clients. OYL commissioning documents stated that a long-term health condition was an essential requirement. However, the need for a pre-existing condition was removed from March 2020, and access was widened via self-referral routes. The change saw a perceived **"bigger impact on the county"**, as well as fewer referrals from older populations.

Reduced GP referrals

COVID-19 reduced GP referrals because of pressure on primary care centres to divert resources to covid-related care. As such, GP services interacted less with the general population as restrictions prevented patients from attending centres in person. GPs had fewer opportunities to provide OYL leaflets or refer patients. As such, GPs gave patients OYL's phone numbers to the clients, then expected the client would self-refer.

Increased service demand

Despite the reduction in GP referrals, the demand for OYL increased during the pandemic. OYL staff correlated increased demand as a knock-on effect of widening the eligibility criteria. However, the demand for the service was seen in less deprived areas. As the pandemic progressed, some clients' rationale for accessing the service was a response to smoking and obesity being correlated with poorer health outcomes if infected with COVID-19. Some clients viewed the service as a preventive measure to improve their health in

case of a COVID infection. Thus, increased demand for the service resulted in some delays in referrals for clients, with staff mentioning it took **"5–10 days"** to get people triaged.

Lesson 2: Accessibility and inclusion of the service

Targeted client groups

An essential contract requirement of OYL was 50% of clients to be from 30% of the most deprived LSOAs. In Lincolnshire, coastal sites had higher deprivation levels than other areas. OYL staff noted higher inequalities and unemployment rates in sites such as Mablethorpe. Staff saw clients more likely to binge drink and suffer from alcohol addictions in areas with high unemployment rates. In contrast, clients using alcohol support were in full-time employment. Therefore, social determinants were a critical factor in the level of support provided for an individual.

Appropriate referrals

Multiple interviews with staff and stakeholders highlighted the concept of an 'appropriate' referral. The idea of **"getting the right ones"** with the **"right mindset"** was a central identifier of clients being referred and triaged into the service. Determining a client's motivation is crucial to successful health outcomes. Also, there was a sense that GP definitions of 'appropriate' may have differed from OYL's definition. For example, an external smoking cessation partner explained that **"if you are a smoker, the [GP] will say you should give up smoking**". Although correct, staff argued that the referral was not always appropriate at the time. Health professionals referred clients who they **"[did not] know what else to do "**. Therefore, GP identification of a client was based only on lifestyle requirements. As noted in the COM-B model, being a smoker may not have included a person's motivation to engage in a behaviour change (Figure 2).

Barriers for male clients

The demographics of the service across pathways varied but had an average client demographic. Most clients were White British women with underlying health conditions. Such as **"asthma and high blood pressure, osteoarthritis "**. The staff highlighted those pathways such as weight management had a higher proportion of women than other

pathways. Likewise, this study had more female participants than men, reflecting the service demographic. OYL staff were aware of the gender disparity in the service with a **"real priority to try to work out how [to] engage men"**.

The staff mentioned that engaging men in preventive care was difficult across the sector. Often men **"do not engage until the last minute"** to seek care, making engagement in preventive care more challenging for male clients. Consequently, the staff noted that men were more likely to be referred to through GP health checks than self-refer. Both staff and client participants noted that some males felt uncomfortable accessing the service. Some men feared **"admitting that they have got things wrong or want to explore things that scared them"**. Once referred, some men's expectations of weight loss services were gendered. Programmes such as Slimming World were assumed to cater to women and were **"like a women's meetings for women to catch up".**

Lesson 3: Factors impacting hesitancy in referrals

Alcohol support hesitancy

Triage staff noted limited referrals to the Drink Less pathway, with **"few and far between compared to the other pathways"**. A key challenge of the Drink Less pathway is identifying who should be referred. GPs spoke about how drinking habits **"don't come up"** when talking to patients, making it difficult to approach the topic. Similarly, OYL staff noted that the promotion of alcohol brief interventions in primary care was limited - **"how many people walk into a GP surgery and that conversation happens '[are you] drinking 18–20 units per week?"**.

Furthermore, OYL staff discussed the expectations and understanding of the pathway. The **"Drink Less pathway has connotations of people drinking too much"** for health professionals and clients. Clients and referrers often viewed the pathway as alcohol dependency support rather than a brief intervention **"looking at people reducing"** their alcohol consumption. As a result, alcohol support health coaches noted **"an added layer of stigma and stereotyping"** associated with the pathway.

Also, OYL staff highlighted those clients had limited awareness of the impact of alcohol consumption, creating another barrier to accessing the service. For example, potential clients often do not acknowledge drinking when stressed. Health coach leads commented how for individuals who drank over the guidelines of 14 units a week, which was the target group for the pathway, potential clients did not always view excess alcohol consumption as a risk factor that required intervention, with the rhetoric **"Is that an issue?"**. However, some staff spoke about a phenomenon known as the common-sense barrier. A critical challenge - **"people know the alcohol is bad for them, they do not need to be told, and they can stop if they want to"**. Thus, the reasons for low referrals are multifaceted. Coaches suggested careful marketing to clarify the difference between treatment and brief advice as a key recommendation.

Lesson 4: Referral Pathways Routes

Referrals across pathways

Clients had various ways of referring to pathways. The most common route was self-referrals to be triaged by OYL staff to the most appropriate pathways. However, many clients were referred to additional pathways once within the service. Referrals across pathways were a unique feature of the integrated care service. Clients had a single-entry point, as **"many [clients] come through for one pathway, could end up going to two or three"**.

One pathway that benefitted from cross-pathway referrals was the Drink Less programme. Health coaches recognised that clients were not entering the service to reduce drinking. So, pathways such as Healthy Eating were able to highlight that **"alcohol played more of a part than [clients] realised"**. Weight management coaches commented that a part of their role was educating clients on the calories in alcohol. For example, one coach explained, **"there are 600 calories per bottle of wine. So, we are picking [excess drinking] up in different ways"**. Also, publicised and known services such as Slimming World and Weight Watchers were vital marketing tools. Triage staff stated, **"quite a lot of ladies might have heard of Slimming World or Weight Watchers"**. Potential clients were also offered OYL services, resulting in a wider variety of support to access. Nevertheless, some clients were

unaware of access to all pathways through One You Lincolnshire. Staff found that some clients referred via a health professional **"did not even realise that [OYL] are multiple pathway agencies"**.

GP understanding of referrals

GPs had a trusted role within OYL as they referred many clients to the service. However, interviews with GPs and OYL staff revealed that access to the service for clients had challenges. GPs revealed limited understanding of the service and the support on offer. For example, some GPs believed they **"could not refer to the exercise [pathway]"**. OYL staff reiterated that **"ManVFat Football, and Lose Weight [with OYL], were not known that well to GP's"**. Therefore, GPs did seem to have a gap in knowledge of the OYL service model. Some GPs acknowledged forgetting what OYL offered. Instead, GPs would, **"refer to the Addaction"** for alcohol support. When explored further, OYL staff mentioned the limited time GPs had to learn about the service. One OYL staff member concluded, **"you get time to say it is a male weight management programme. It's framed around football, and there are leagues and there are 14 weeks, and it's free, and there's about a 95% success rate to weight loss"**. A short time to explain the service seemed to result in GPs having a brief understanding of the complete service.

Referrals via Secondary Care

Secondary care clinics were also part of the referral route. Referrals via hospitals were **"usually to stop smoking or drinking. Depending on what [clients] had been in hospital for"**. Secondary care referrals were viewed as more complex than primary care referral routes. Secondary care staff had a different referral form to primary care teams as the forms listed **"every single pathway"**. Primary care referrals relied on the OYL triage team to navigate which pathways were most appropriate for a client. In contrast, secondary care staff were **"presented with a very long list of pathways"**. Referring to OYL through secondary care was seen as more laborious and thus less likely to be used. To help identify clients awaiting treatments that required lifestyle changes before operations, OYL staff suggested implementing a **"priority email account "** for **"urgent referrals"**.

Client Motivation, Commitment and Outcomes

Lesson 1: The importance of client motivation

Motivation as a facilitator to behaviour change

Health coaches discussed the importance of the first meeting with a client to set the tone of the service. Coaches would ask questions such as, **"– Tell me about what has motivated you to want to change"**. Coaches viewed motivation as core to behaviour change. One coach stated, **"unless [clients] have intrinsic motivation to change, you help them foster that, it's very unlikely that they're actually going to do it"**. Thus, partners and OYL staff viewed a client's motivation as insightful information. It became a foundation for a client's values for coaches to deliver support aligned with the client's motivations. For example, many clients mentioned COVID-19 as a motivator. The impact of bereavement and **"having a similar health condition"** were identified as reasons for seeking support. Clients described the realisation of **"living quite an unhealthy lifestyle"** as a desire to change their lifestyle.

Coaches, in turn, understood a client's value as wanting to reduce their risk of COVID-19 morbidity as a central motivating factor. Health coaches viewed motivation as active and dynamic, which could be encouraged and strengthened throughout a client's journey. However, for some clients, the pandemic was a demotivator to change. Triage staff mentioned how clients that did not take up support **"diverted their emotional resources into coping"**. As such, coping mechanisms were prioritised during lockdown measures. **"Resources that [clients] otherwise would have put towards moving forward to the cycle of change"** were used to cope. Thus, client motivation was individual and required personalised support from health coaches.

Quality Assurance, Fidelity, and Partner Relationships

Lesson 1: Quality Assurance

Local service ownership and quality champions

Commissioners wanted Thrive Tribe to deliver OYL within the local context to the population. Thrive Tribe leadership was keen to establish local ownership of the service for staff and local partners. Quality champions encouraged staff to embed quality protocols within the service using self-reflection. For quality champions, the role was a voluntary position. A local staff member's duties were to **"support with things like audits"** and **"support on handling complaints and incidents"**. Quality champions ensured **"people were automatically doing that quality assurance themselves, rather than just being an external person that just parachutes in"**.

Leadership wanted to create a national network of quality champions from different service sites. The champions could then share good practices across Thrive Tribe commissioning service. Thrive Tribe leadership believed that quality assurance as a local agenda encouraged staff to **"get more engaged"**. Coaches were encouraged to **"feel a bit more empowered to drive any changes"** and **"feel more part of the whole quality improvement agenda"**. As such, most staff responded to the decision to local ownership as **"really wanting the service to work"**. Thus, staff often viewed quality as decentralised and both leadership and staff responsibility.

Staff Training and continual development

OYL had mandatory staff training to engage with clients and deliver programmes. Mandated training was outlined in centralised Thrive Tribe guidelines and service specifications. Most client-facing staff were required to have **"behaviour change levels one and two"** at recruitment. Pathway leads were then required to have extra training. The training helped leads handle complex caseloads through mental health first aid training. At the time of data

collection, Thrive Tribe had rolled out mental health first aid training for all staff. Also, the culture set by leadership encouraged continual learning and development for staff. The staff mentioned that **"[there is] always something you can improve on no matter how experienced you are or learn a different way of doing something".**

At a local level, each pathway had working groups. The groups shared lessons learned, service challenges and good practices among staff. As well as **"an opportunity to talk with like-minded people"**. Staff felt the groups helped to **"just spark ideas, and enthusiasm, and help people not reinvent the wheel"**. Staff held monthly multidisciplinary meetings alongside intra-pathway groups. The cross-pathway groups were aimed to show that **"staff can learn across the disciplines"**. Groups across the pathway reinforced the integrated nature of the service delivery model.

Lesson 2: Impact of previous service models

Commitment from GPs

Both external partners and OYL staff spoke of OYL service delivery with previous models of care. One key challenge was engaging with GP clinics. External partners stated that GP buy-in for referrals had been difficult before OYL. One reason for poor engagement was **"some huge priorities with surgeries"**. For example, **"CQC inspections have not gone well, or they are having to merge with another surgery. Some fairly hefty managerial things going on".** OYL referral generation staff had dedicated considerable time to rapport building with GPs. As such, GP engagement has improved since the service launch. External providers saw that **"One You Lincolnshire's actual relationship with the GPs had improved".** As a result, GPs had increased **"buy in, and commitment"**. Partners viewed OYL as **"being that sort of interim"** between providers and GP clinics. A vital connection for the service delivery model.

Lesson 3: Relationship with external partners

Contracted partners

One You Lincolnshire had multiple external partners contracted to deliver various client programmes. Partner organisations varied in size of operation, modality, and site location. Partners perceived OYL as a positive relationship. For example, there was a perception that **"they have got a good team"** amongst partners. Partners highlighted effective leadership and consistent communication as positive factors. Many partners stated the importance of good working relationships. Relationships were viewed as fundamental to the success of an integrated service. One partner mentioned, **"If there's going to be an ongoing relationship of any kind, it needs to be reciprocal"**.

Both OYL and partner organisations were responsible for ensuring an ongoing working relationship. OYL was viewed as having strong leadership and **"just a – Can do organisation. Right from the top"**. OYL was viewed as a competent provider, and partners felt OYL was **"very well experienced"**. The experience came from OYL running **"integrated health services for several different authorities"**. External partners valued **"the ability to have somebody else that was putting the referrals through"**. Many partners had found referrals from primary care services difficult. One partner stated, **"sometimes it was tricky to arrange meetings with the GP"**. Also, partners viewed OYL as accessible with consistent communication. For example, OYL spoke to partners **"pretty much on a daily basis by email"**, which built trust and rapport. In contrast, some smaller partners did want increased technical support from OYL. Some partners struggled using online 365 portals during the pandemic. However, these partners acknowledged that low digital literacy within their team affected aptitude.

Staff capacity and post-COVID service delivery

Lesson 1: External Staff Capacity

Administration Tasks

A critical administration task for partners was data sharing of referral rates, clients' progress, and outcomes. OYL collected data to a centralised database that could be used to compare against commissioning targets. Each partner had varying staff capacity to complete the administrative tasks required for each client. Some external staff felt **"a lot of time could be wasted"** filling out client data. Staff preferred to be **"seeing people"** and external staff had limited buy-in on the importance of the administrative tasks. Tasks were viewed as **"time-consuming"** and difficult for coaches to complete alongside daily responsibilities. Some partners adapted to limited capacity by implementing a separate triage role within their service. The new role could then carry out administration tasks on behalf of coaches. These organisations seemed to view administration tasks more positively and valued data collection. Thus, consistent data sharing seemed to correlate to whether a task was viewed as beneficial or time-wasting.

Lesson 2: COVID-19 changes to service delivery

Transition to digital delivery

Six months into OYL implementation, the UK entered lockdown due to the COVID-19 pandemic. Many pathways established as in-person had to transition into online and digital-based operations. OYL leadership stated that a change to service delivery was a significant implementation task. Staff felt **"overwhelmed",** and the transition was **"challenging"**. A critical pathway that COVID-19 affected was Get Healthy Get Active. Pathway leads spoke about the struggle with transitioning sessions into a digital intervention. Yet, leads still wanted to ensure communities were connected to the service across various demographics. Staff reflected on the initial challenges being overcome. As the pandemic progressed, digital resources and tools were better understood. Coaches were able to put in place good practices across programmes, for example implementing bookable systems for clients to access interventions in advance.

Pauses to client progress

Most OYL pathways adapted to online delivery to ensure clients continued using the service. Yet, some clients' progress was interrupted. Coaches mentioned that some clients

who accessed the service **"hadn't completed"**. Staff acknowledged that some clients did not want to continue support using online services. Clients who were less likely to continue using the services were often on the Get Healthy Get Active pathway. Clients did **"not want to come back into a gym"** despite online interventions being available. However, staff highlighted, that **"most of the people on the scheme so far who haven't completed yet, were quite eager to come back"**.

Client Case Studies

Face-to-Face Support

Sam is a White British man with a long-term health condition. His GP referred him to One You Lincolnshire. He was then assessed in person and decided to take up the Stop Smoking pathway with the help of a health coach. Sam also had caring responsibilities for his wife.

The main reason I wanted to stop smoking was the financial implications. If I was to say I smoked four packets of cigarettes a week, I wouldn't be far off the road. Well, it's anywhere between £36 and £45 a week, and you times that by 52 weeks, and you're on your way to £2000. Last year, I told myself I would stop, as the GP kept pestering me via text. I kept the previous text and thought, well, I'll take it. I've got nothing to lose.

I was going a little bit before we were even talking of lockdown. I would have been happier to have carried on face-to-face. One thing to improve is I didn't know where this clinic was. I worked to find this place. One You Lincolnshire needs to be more precise on where they actually are.

I said I wanted to stop smoking but didn't like the patches. The health coach explained how it works. And then, when I got my first lot of tablets, I had to pinpoint I would stop that

day. The health coach said, 'it is your choice,' which is vital. I know what I've been doing for the last 45 years is an addiction. The health coach didn't look down on me or talk down. She was no high and mighty person. ***There was none of this clinical type. All it was, we were having a cup of tea together and talking.***

The health coach played a significant part. I celebrated one year. It hasn't been as hard as I thought it would be, and I could get back in touch with them if there was an issue. Not stopping smoking for a year helped my lungs, and I won't put a burden on the NHS or anybody else.

Online Support

Sarah is a white British woman with a long-term health condition. The cardio rehabilitation clinic referred her to One You Lincolnshire. The triage team assessed her over the phone, and she decided to take up group support for Healthy Eating. Sarah also has carer support from family and friends.

Five years ago, I was very ill, and it turned out that it was heart problems. Gyms didn't understand some of the issues alongside heart problems. For the cardiac people, I said how miserable I felt because I'd gone from walking and doing all sorts to none. So, the clinician put me through the service, saying, "I could refer you to this One You Lincolnshire". I thought, 'this is an approved programme'. I needed to lose weight, but I needed some support because of this constant uncertainty about whether I should be pushing myself.

One You Lincolnshire contacted me and explained the course and how you had to commit to the 12 weeks. I could do a Wednesday morning, Thursday afternoon or whatever. I met my particular group on Thursday afternoon, from 1:30 PM to 2:30 PM, which is quite a long time. ***I prefer doing a Zoom online to sitting in a room in***

the evening while they call out your weights. The first hour was like other weight programmes. You went through it week by week as a topic, but the last half an hour was an exercise class. That was super because you were at home. All you had to do was create a bit of space, and I found it much more manageable.

About 10 or so people and the tutor could share the screen. The coaches encouraged people to join in the presentation, and there would be questions and little quizzes. They also encouraged people to share what had gone well during their week or how they felt. I had to make a weekly goal. That was good because it motivated you. You went through the balance between vegetables and fats, protein, and sugars. But it wasn't ever framed as "you must do this". The expectation was that you were on the programme. You want to make changes to your diet, and you are going to improve your fitness level.

One You Lincolnshire did send out little freebies. There was a measuring cup for portion size. They were smaller than anything on the food packets would suggest!

The health coach was excellent. I spoke to the health coach about this fear of what I can do. They were outstanding. In each class, the coach would say, these are the exercises. He would show you that you could do them sitting, or you could do them standing up. He tried to help you grade it and what it felt like to do moderate or vigorous exercise. It was a psychological acceptance that I could do it, and I felt more confident. I didn't make the total loss that One You Lincolnshire aimed for. But I can still access the online gym, and the health coach said he would call in three or six months to see how I am going.

Integrated Support

Anna is a White British woman with a long-term health condition. She self-referred to One You Lincolnshire, and the team assessed her over the phone. She decided to take up Slimming World, and her health coach offered the Increased Exercise pathway. Anna also had carer support from family and friends.

Since I've hurt my back and can't do much. I've gone from being very active, seeing many people, to my own four walls, 24 hours a day. It was a weblink my doctor gave me to sign up about getting some help with weight loss. I was with the pain clinic, and I was with them for 18 months. I kept telling them that I needed help and exercise. I pressed the link and then went online. I read about what One You Lincolnshire is and what they do and researched it a bit more. The website seemed to draw me in, making me think I needed them more. It could have been the point in my life I thought, 'I've got to do something.

I was really, really nervous that I had to get somebody to listen to me again. The healthcare staff told me my back problem was all in my head, and I didn't want to go down that road again. I had a couple of phone calls with a referral staff member who said, 'there are a couple of options they could do'. I did Slimming World before, so I knew how to do it. I got a free three-month trial, which gave me the push I needed. The health coach got me back into Slimming World, and I did a 12-week free course with them.

Then ***the health coach got me in contact with another lovely lady in the One You Lincolnshire service.*** She got me exercises and all catered for somebody with my lack of ability to do things. So, it's been fantastic. With One You Lincolnshire, it's all been over the telephone, but they've been constant. The health coaches have messaged me to see how things have been progressing. They've been so helpful, and they've listened. It's been nice to have somebody listen to what I need.

For somebody who's never actually seen me, and it's been over the telephone, it's been fantastic. It's been nice to have somebody else support me for what I need, boosting that it's me doing it. We need clarification that we're doing well. I'm exercising, and I'm feeling happier. The health coach always said she could hear the change in me, and I

couldn't have asked for a friendlier bunch of people to help me. One improvement to the service is, if you weren't very active, you could do a face-to-face rather than a phone call. To make sure you're doing the exercises correctly. At the end of the day, you don't want to hurt yourself while you're doing exercise.

I could only do the exercises over a few days when I started doing them, but I can do the exercise programme three times a week now. I can't say I'm more mobile because I'm not. But I went out yesterday, and I can walk a bit further than I would have been able to 18 months ago. My mood since losing weight and exercising more has improved.

Yes. I've still got the pain. But with a change of medication and losing weight, I can do more for myself. It's the motivational aspect they give you to actually want to do something about how you are. I've now come to terms with the fact that I will not be riding my bike again, but I know I can still do things. My broken body isn't going to stop me from enjoying life.

Chapter 4 Secondary Data Analysis

Data Analysis Overview

The aim of phase 2 was to provide quantitative evidence, and the analysis aimed to explore the accessibility, efficacy, and fidelity of the service. In this chapter, anonymised secondary data provided by One You Lincolnshire was used to explore the outcomes of each of the four pathways. Data was collected on client uptake, attendance, and completion across client demographics. Key outcomes were:

- Identify critical components of good practice of the client pathway, capturing the views from clients, programme staff, healthy lifestyle service subcontractors, and referral teams on barriers and facilitators of service implementation and delivery.
- Identify access within client subpopulations against local population demographics.
- Assess baseline effectiveness of OYL. Exploring variables that moderate outcomes such as client, provider, and programme factors compared to service targets and external benchmarks.

Methods

Data collection

One You Lincolnshire collected demographic-identifying variables from 17 sites (Table 2). Anonymised data were transferred to the University of Lincoln team, and data were stored on Microsoft 365, and no files were downloaded before the team cleaned, processed, and

analysed the data. Each site had data for demographics such as age, ethnicity, gender, long-term health conditions, LSOA, and pathways.

Research Design and Analysis

Statistical analysis was performed using SPSS software (v27). Service attendance and completion rates were expressed as frequencies and proportions. Descriptive statistics summarised session attendance as a proportion of total sessions offered/planned. The demographic characteristics of clients were summarised via descriptive statistics. Local population norms were interpreted to understand inequalities in service access and acceptability. A key performance indicator was the percentage of clients supported from the most deprived areas. In line with the service target that 50% of clients were from the 30% of most deprived LSOAs. Service uses such as uptake, attendance and dropout were explored about client demographics. Then service-use indicators regressed to demographic factors. Before applying linear/non-linear models to the data. For effectiveness analysis, client outcomes were coded for attainment and enrolment.

Sample Size

Secondary data analysis was conducted for all available data. A census sampling approach was used, and the dataset size was sufficient for modelling purposes (Bell et al., 2008). The analytic approach produced stable, unbiased estimates with a sample of $\geq$500 level-2 cases, and this criterion was met for all outcomes of interest. In total, 24,370 referrals nested within 16,354 clients nested within 128 coaches were included in the dataset for analysis.

Outcome Measures

Primary outcome analyses focused on self-reported health behavioural outcomes (Table 5). Focal outcomes varied by programme. The outcomes reflected target levels of behaviour for clinically meaningful improvement. Goal achievement indicators were defined as the following:

- Smoking quit status at four weeks

- Alcohol intake reduced to less than 14 units per week or decreased by 50% or more
- Physical activity increased to 150 minutes or more of moderate activity per week
- 5% or more weight loss at 12 weeks

Table 5.Outcome variables and descriptions of codes

Outcome Variables	Coding Description
Smoking Cessation	Quit status at 4 weeks 0 = Not achieved 1 = Achieved
Alcohol Reduction	Intake reduced to <14 units per week or decreased by ≥50% 0 = Not achieved 1 = Achieved
Physical Activation	Physical activity increased to ≥150mins moderate activity per week 0 = Not achieved 1 = Achieved
Weight Reduction	≥5% weight loss at 12 weeks 0 = Not achieved 1 = Achieved

Secondary Outcomes

Secondary outcomes were related to the following:

- Client uptake (0 = programme declined/did not start, 1 = programme commenced)
- Attendance (n of sessions attended, % of sessions attended [as a proportion of all sessions offered])
- Completion (0 = dropped out, 1 = programme completed) rates.

The analysis considered confounders such as client age, gender, ethnicity, socio-economic status, rural/urban, health status and disabilities (Table 6).

Table 6. Tertiary coach-level, secondary client level and primary level referral predictor variables and descriptions of outcomes

Coach Level Variables	Coding Description
Coach ID	Unique ID for coach (clustering variable) †
Client Level Variables	**Coding Description**
Client ID	Unique ID for client (clustering variable)
Age	In Years
Gender	0 = Female 1 = Male‡
Ethnicity	0 = White British 1 = Ethnic minority
Rurality	0 = Urban 1 = Rural
Deprivation	0 = Not living in top-30% most deprived LSOAs 1 = Living in top-30% most deprived LSOAs
Long-term health condition (LTHC)	0 = No LTHC 1 = LTHC
Mental Health Condition (MHC)	0 = No MHC 1 = MHC
Long-term sickness/ disability/unemployment	0 = Not long-term sick and/or unemployed 1 = Long-term sick and/or unemployed
Carer	0 = non-carer status 1 = Carer status
Body Mass Index (BMI)	kg/m^2
Programme Participation	Number of tier-2 programmes attended (0 – 4)
Reported Importance of making change	11-point self-report scale 0 = not important at all 10 = extremely important
Reported Confidence about making change	11-point self-report scale 0 = not confident at all 10 = extremely confident
Referral Level Variables	**Coding Description**
Referral (*n*)	Referral instance (*n*th referral for the same client)
Attendance	Number of sessions attended for this referral instance

† *No coach characteristics were available for modelling*

‡ *Cell-size for other gender identities was too small to model*

Statistical Analysis

For primary effectiveness analyses, client outcomes were coded. Client outcomes included the attainment of enrolled pathways. Secondary analysis used frequencies and proportions to express service attendance and completion rates. Session attendance was defined as a proportion of total sessions offered/planned—demographic characteristics of clients such as completers and non-completers; were also summarised. Client demographics were compared and interpreted against local population norms. Analysis was used to understand any inequalities in service access and acceptability to clients.

A key performance indicator was (and marker of Reach) the percentage of clients supported from the most deprived areas. The indicator was compared against a target that 50% of clients were from the 30% of most deprived LSOAs. Across tier-2 programmes, outcomes were represented as binary variables. Thus, generalised linear mixed modelling was applied for all primary analyses. Models used a binomial distribution and logit link function. Parameters were estimated via the penalised robust quasi-likelihood method—the method accommodated for possible violations of model assumptions. As the data were hierarchical, a three-level model was constructed. Referrals (level 1) nested within clients (level 2), and clients nested within coaches (level 3). Intraclass correlation coefficients (ICCs) were computed to identify the outcome variance at each level. Random intercepts were used to correct for differential outcomes by the client and coach. Predictor variables were examined as fixed effects and presented as odds ratios (OR) with 95% confidence intervals.

Model building

We first examined bivariate models of individual predictor-outcome relationships. Then we built a multivariate model including all significant predictors from bivariate models. Finally, we dropped predictors that were not significant in the multivariate model. We then had a final parsimonious model. Removing weaker/less relevant predictors from the model reduced standard errors for other predictors, enabling more precise estimates of their effects. Model fit was monitored using the Akaike information criterion (AIC). Pairwise deletion, with cases excluded from models in which data were missing on a required variable, was used to manage missing data. We applied linear mixed models for secondary outcomes that were non-binary, such as the percentage weight loss. The models used maximum likelihood estimation, paralleling the generalised linear mixed models' approach.

Results

Table 7 presents descriptive statistics for clients in the dataset. OYL activity was between June 2019 and February 2022 with data for 16,354 clients available. However, data completeness varied across cases and variables. Proportions in Table 7 are expressed as a percentage of valid (non-missing) data for each variable.

Table 7.Client characteristics in quantitative dataset (N unique IDs = 16,354)

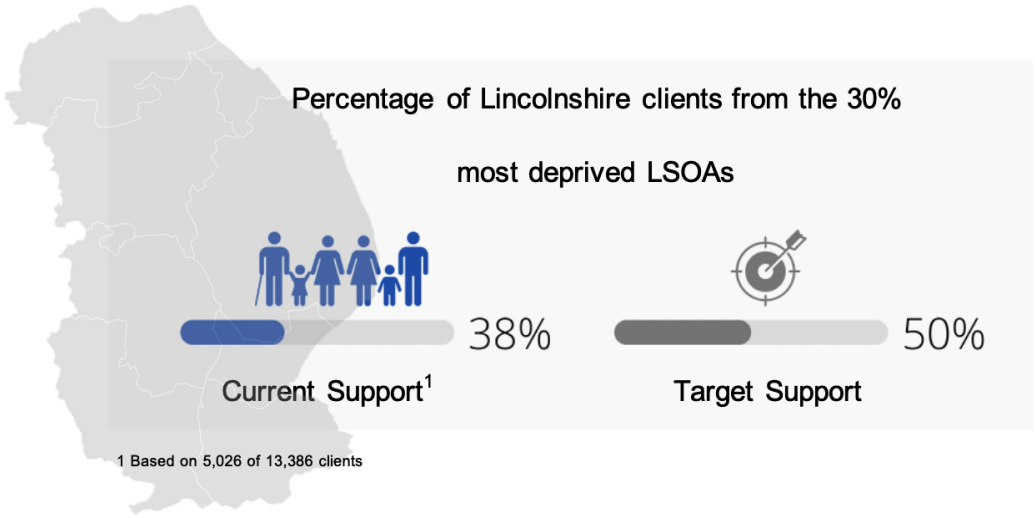
Client Variables		*n*	%
Age	***Mn* 49.6 (SD 15.5)**		
Gender	**Male**	4,694	(32%)
	Female	9,654	(66%)
Ethnicity	**White British**	10,662	(93%)
	Ethnic Minority	829	(7%)
Rurality	**Rural**	5,948	(51%)
	Urban	5,793	(49%)
Deprivation	**Living in top-30% most deprived LSOAs**	5,026	(38%)
	Living in less deprived LSOAs	8,360	(63%)
Long-term health condition	**Yes**	7,272	(72%)
	No	2,767	(28%)
Mental health condition	**Yes**	3,600	(39%)
	No	5,659	(61%)
Long-term sickness and/or unemployment	**Yes**	2,528	(26%)
	No	7,377	(75%)
Carer Status	**Carer**	852	(7%)
	Non-Carer	11,240	(93%)
BMI	***Mn* 34.6 (SD 13.7)**		
Programme participation	***Mn* 1.4 (SD 0.9)**		

Importance of making change	***Mn* 9.2 (SD 1.3)**
Confidence in making change	***Mn* 7.0 (SD 2.4)**

Note. % Reflect proportions for valid (non-missing) data. Percentages may not sum to 100% due to rounding. LSOA = Lower Layer Super Output Area

For evaluative interest in **Reach**, there is evident diversity in the OYL client base. Compared to Lincolnshire population norms, OYL service users represent the broader population. 93% of the Lincolnshire population identified as White British in the 2011 census. However, the service was under-representative of men—48.7% of the Lincolnshire population and older than the county average of 43.2%. Figure 5 shows the percentage of One You Lincolnshire clients from the 30% most deprived LSOAs compared to the commissioning target.

Figure 5.Percentage of One You Lincolnshire clients from the 30% most deprived LSOAs compared to commissioning target



Service outcome effectiveness and predictors

Evaluative results relate to **Effectiveness** across the core outcome indicators, such as Stop Smoking, Alcohol Reduction, Physical Activity, and Weight Loss.

Stop Smoking Pathway

OYL quit smoking was above the target standard of 50%. As shown in Figure 6, for OYL clients engaging with Stop Smoking support and setting a quit date, **56% quit smoking (95% CI = 55-57%)**. Successful quitting was self-reported at four weeks, and data came from 8,124 quit attempts within 6,036 clients. The improved quit rate under OYL has seen Lincolnshire Stop Smoking Services rise from 10th to sixth place in total quits. OYL compares well to available figures from previous stop-smoking services in Lincolnshire. Data from 2017-18 and 2018-19 indicated 46–50% quit rates.

Moreover, the quit rate observed within OYL is comparable to NHS Stop Smoking Services outcomes in England. In the concurrent period (2019-22), NHS outcomes were 51–59%.

OYL rates were more than double the estimated 25% quit rate among self-quitters (Dobbie et al., 2015). Due to the impact of the pandemic and the shift to remote support, Carbon Monoxide verification in the national NHS data has dropped to 2-3%. The proportion of Carbon Monoxide verification in OYL data over this pandemic-affected period was low at 10%. There was no significant effect of COVID reconfiguration on Stop Smoking support. For instance, quit outcomes were similarly for pre- vs post-pandemic, indicating the shift to remote support and reliance on self-report without Carbon Monoxide verification did not inflate positive quit outcomes. For specific target populations, 44% of 685 pregnant women quit smoking with OYL. OYL outcomes were comparable to NHS Stop Smoking Services outcomes of 45-48% over the same period. NHS outcomes had also improved pre-OYL, with a success rate of 38% in pregnant smokers over 2017-18.

Figure 6.Service delivery differences in self-reported successful quit smoking rates

1 https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-nhs-stop-smoking-services-in-england/april-2020-to-march-2021

2 https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-nhs-stop-smoking-services-in-england/april-2019-to-march-2020

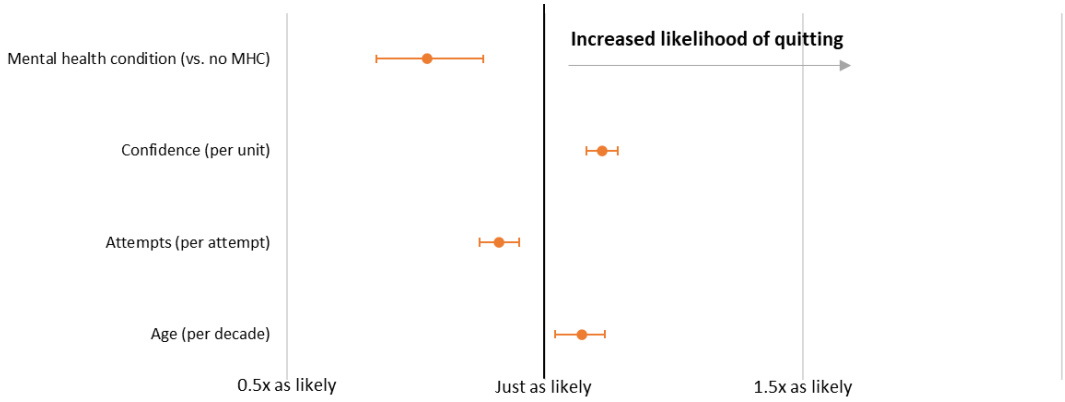
3 Based on 8,124 quit attempts within 6,036 clients

Only a small proportion of variance was accounted for at the level of the coach (2%) or client (6%) for smoking outcomes. Most variances were explainable at the referral level, reflecting variability within clients. Such as that the same client might achieve their quit target on one occasion but not another. When modelling all bivariate predictors together, four variables emerged as independent predictors. Figure 7 shows the predictors for smoking outcomes. At the client level, success was more likely with age. Success was also more likely with reported confidence in the ability to change and perceived self-efficacy.

Yet, less likely in the context of existent mental health conditions (NHS Digital, 2021). For illustration, the quit rate in those aged 40 years and older was 52% compared to 61% in those aged 60 years and older. The quit rate in those with vs without a mental health condition was 51% vs 59%. Clients reporting a confidence score of 7 or more out of 10 in their ability to make a change had a quit rate of 61%. Compared with a quit rate of 50%, those reported a confidence score of 6 or less. At the referral level, success decreased with successive attempts/referrals.

Chaiton et al. (2016) found that individuals who found quitting easier tended to succeed in early attempts. Whereas individuals with repeated unsuccessful attempts, the average success rate diminished over attempts. Adjusting for the predictors above, we observed outcome equalities. Rurality, deprivation, gender, ethnicity, and presence of long-term health conditions did not impact outcomes. Neither did sickness and unemployment status, carer status, and BMI. Smoking outcomes were not significantly related to attending multiple programmes. The reported importance of change and COVID reconfiguration were unrelated to outcomes also.

Figure 7.Likelihood of quitting smoking by client factors and quit attempts whilst using One You Lincolnshire between June 2019 to February 2022

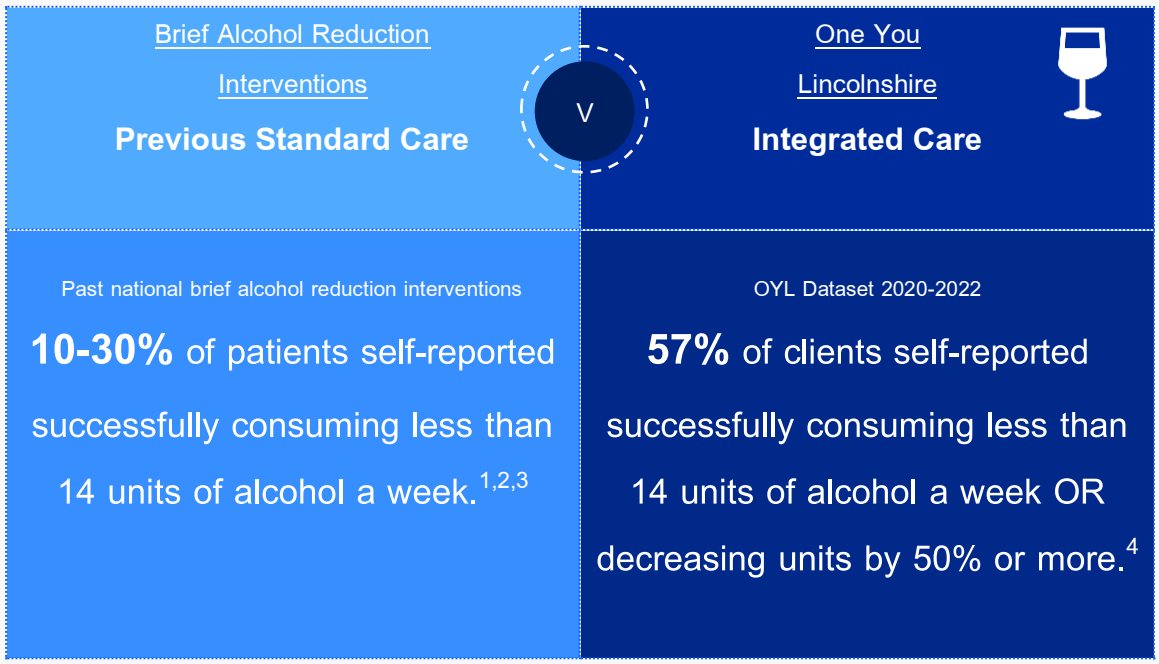


Note. Error bars give 95% Confidence Intervals (CIs) for each observed odds ratio. All effects are statistically significant (95% CIs do not cross the line of equal likelihood).

Alcohol Reduction Pathway

Figure 8 shows **57% reduced alcohol use** (95% CI = 52–61%) via OYL alcohol reduction or health coaching pathways. Data came from 635 reduction attempts within 544 clients. Reduced alcohol use was determined as decreasing intake by 50% or more or to less than 14 units per week. Moreover, across all OYL clients meeting eligibility criteria for alcohol reduction, **37% reduced alcohol use** (95% CI = 35–39%). Data was monitored from 2,351 referrals across 1,599 clients. Benchmark outcomes for brief alcohol reduction interventions were 10–30% (Heather, 2012, O'Donnell et al., 2014). High rates of alcohol reduction were supported across the service. Intention-to-treat analysis showed that clients not in the alcohol reduction pathway still reduced drinking.

Figure 8.Service delivery differences in self-reported successful reduced drinking rates



1 Fleming, M., and Manwell, L.B., 1999. Brief intervention in primary care settings: A primary treatment method for at-risk, problem, and dependent drinkers. Alcohol Research & Health, 23(2), p.128.

2 Heather, N., 2012. Can screening and brief intervention lead to population-level reductions in alcohol-related harm. Addiction Science & Clinical Practice, 7(1), pp.1-14.

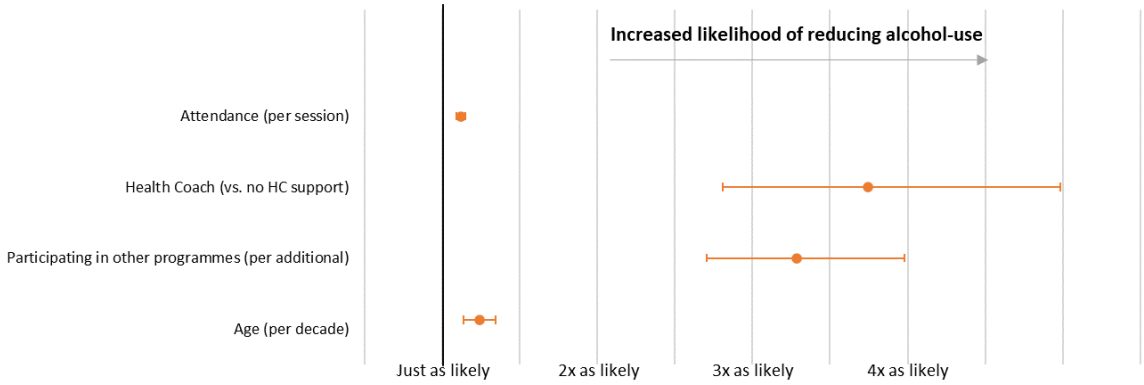
3 O'Donnell, A., Anderson, P., Newbury-Birch, D., Schulte, B., Schmidt, C., Reimer, J. and Kaner, E., 2014. The impact of brief alcohol interventions in primary healthcare: a systematic review of reviews. Alcohol and alcoholism, 49(1), pp.66-78.

4 Based on 2,351 reduction attempts within 1,599 clients

Most outcome variance was accounted for at the coach (19%) and client (11%) levels for alcohol reduction outcomes. In particular, there was evident clustering by the coach. Clustering suggests between-coach differences in outcomes. For example, the

characteristics of coaches may enable successful outcomes. When modelling all bivariate predictors together, three variables emerged (Figure 9). The variables were independent predictors of alcohol reduction outcomes. At the client level, success was more likely with age and participation in other tier-2 programmes. At the referral level, success was more likely following 1:1 health coach input. Adjusting for the predictors above, we observed outcome equalities. Rurality, deprivation, gender, ethnicity, and long-term health conditions did not impact outcomes. Neither did mental health, sickness and unemployment, carer status, and BMI. Alcohol reduction outcomes were not significantly related to the reported change in importance or confidence. COVID reconfiguration was not related either. Predictors suggest equity of outcome after transitioning from in-person to online delivery.

Figure 9.Likelihood of reducing alcohol consumption whilst using One You Lincolnshire between June 2019 to February 2022

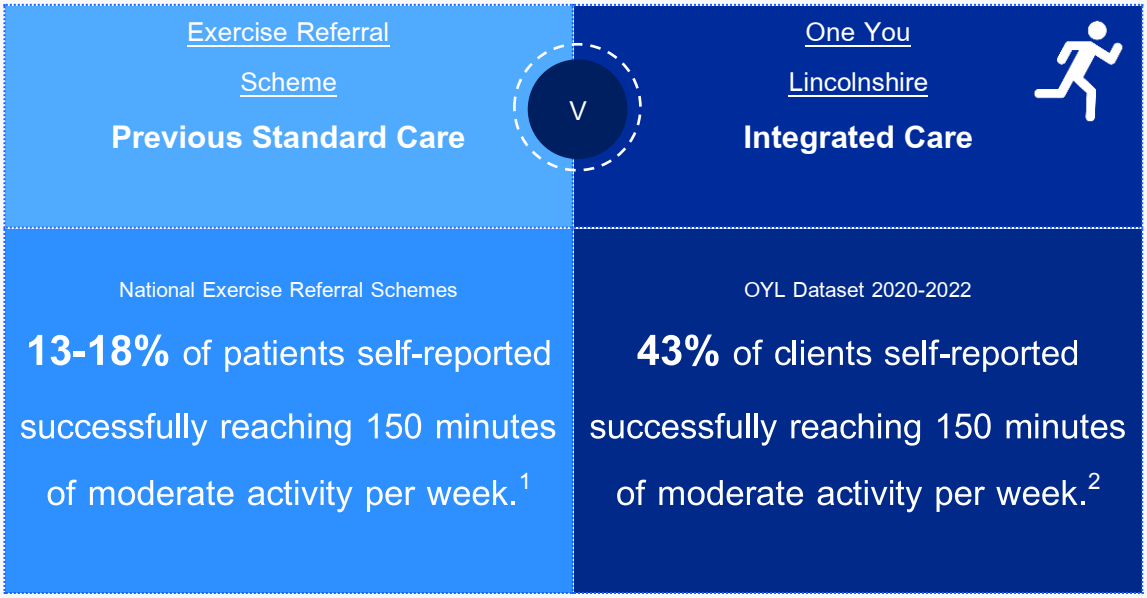


Physical Activity Pathway

As shown in Figure 10, **43% (95% CI = 42–44%) of clients increased physical activity** via physical activity or health coaching pathways. Data came from 7,881 activation attempts within 5,943 clients. A successful outcome was 150 minutes of moderate activity per week. Across all OYL clients meeting the eligibility criteria to become active, **28% (95% CI = 27–29%) were supported to be 'active' by the end of referral**. Eligibility criteria were those who were 'inactive' or 'fairly active' when entering the service. Data was monitored from 16,181 referrals to 10,877 clients. Observed success rates compared to benchmark effectiveness of exercise referral schemes of 13–18% (Williams et al., 2007). High rates of

physical activation were supported across the service. Intention-to-treat analysis showed that clients not in the physical activity pathway still increased physical activation.

Figure 10.Service delivery differences in self-reported successful increased physical activity rates



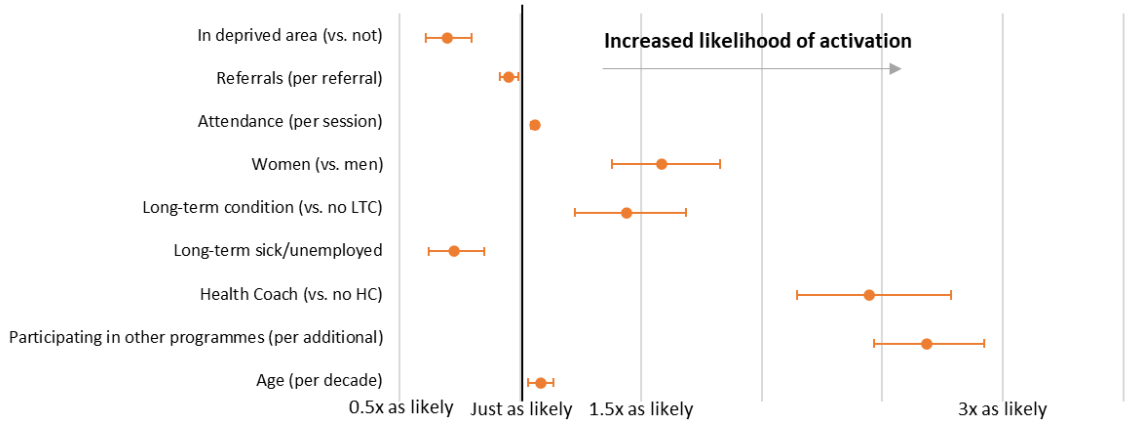
1 Williams, N.H., Hendry, M., France, B., Lewis, R. and Wilkinson, C., 2007. Effectiveness of exercise-referral schemes to promote physical activity in adults: systematic review. British Journal of General Practice, 57(545), pp.979-986.

2 Based on 16,181 activation attempts within 10,877 clients

Most of the variance was accounted for at high levels. There was 27% variance at the coach level plus 24% at the level of the client for physical activity outcomes. The predictors emphasise the value of coach-level and client-level influences on activation outcomes. When modelling all bivariate predictors together, nine variables emerged (Figure 11). The variables were independent predictors of activity outcomes. At the client level, success was more likely with age and participation in other tier-2 programmes, and success was less likely with deprivation, long-term unemployment, and sickness.

Additionally, success was more likely in women and when living with long-term health conditions. At the referral level, success was more likely following 1:1 health coach input. Also, increased attendance and over repeat referrals. As shown in Figure 10, the most influential factors were multi-programme participation. Clients participating in more than one programme were 2.7 times more likely to succeed. Health coach input correlated to 2.5 times as likely to succeed. The factors suggest that integrated delivery potentiated better outcomes across the client base. Adjusting for the predictors above, we observed outcome equalities. Rurality, ethnicity, presence of mental health conditions, carer status, and BMI did not impact outcomes. Physical activation outcomes were not significantly related to changes in importance and confidence. Also, neither was COVID reconfiguration. We observed some inequities in the outcome. Gender and deprivation predictors suggested that some groups were less able to benefit from OYL support in physical activity. Long-term unemployment and sickness, as a marker of disability, also affected outcomes.

Figure 11.Likelihood of increasing physical activity to 150 minutes a week whilst using One You Lincolnshire between June 2019 to February 2022



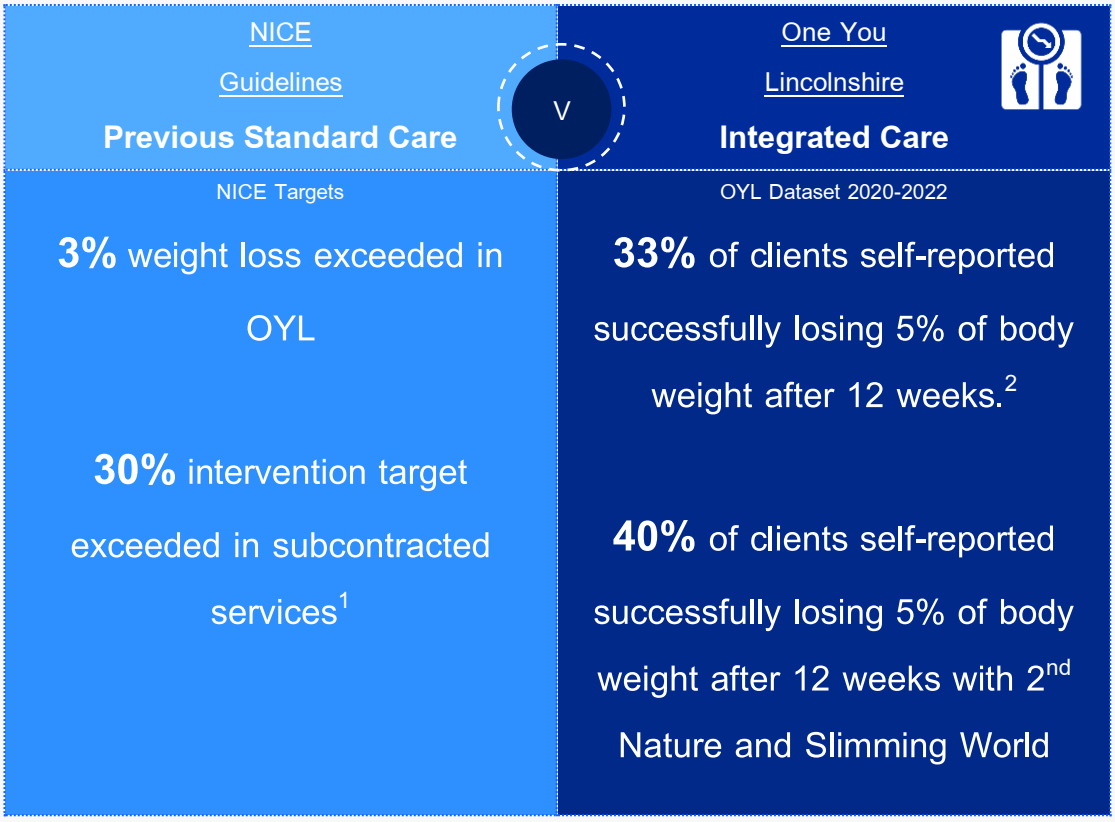
Weight Loss Pathway

As shown in Figure 12, **33% (95% CI = 32–34%) of clients achieved 5% weight loss** via adult weight management or health coaching pathways. Data came from 6,858 reduction attempts within 5,885 clients. Successful weight loss was achieved at 12 weeks following the start of a client's weight management plan. Across all OYL clients meeting the eligibility criteria of a BMI of 30 or above, **25% (95% CI = 25–26%) of clients achieved 5% weight**

loss. On average, clients had a weight reduction of 6%. Data was monitored from 12,915 referrals to 8,201 clients. The success rate of clients opting into the weight management pathway exceeded NICE guidelines (NICE, 2014).

Guideline targets for commissioned weight management services were 30% achieving 5% weight loss. OYL also exceeded the guidance of an average weight loss target of 3%. In a recently published evaluation of UK tier-2 weight management services, it was found that only a minority met the NICE criterion (Ells et al., 2018). The success rate for OYL is comparable to those observed in auditing patients referred to NHS weight loss programmes at 33% (Ahern et al., 2011). OYL also had a better rate (32%) than other integrative programmes in the UK (Birnie et al., 2016).

Figure 12.Service delivery differences in self-reported successful reduced weight rates

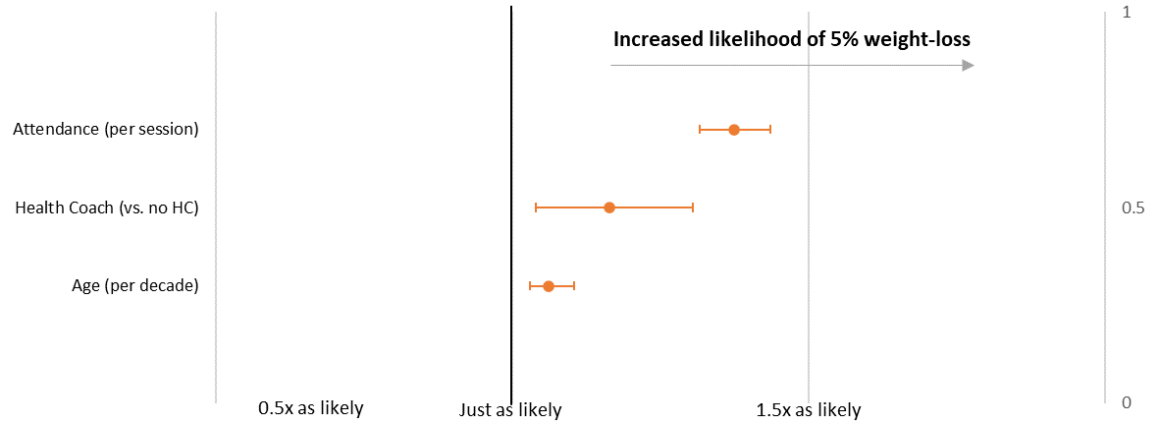


1 https://www.nice.org.uk/guidance/ph53/chapter/1-Recommendations

2 Based on 12,915 reduction attempts within 8,201 clients

For weight loss outcomes, a small amount of variance was accounted for by coach predictors at 3%. A more substantive amount of variance was accounted for by between-client differences at 22%. When modelling all bivariate predictors, three variables emerged as predictors (Figure 13). At the client level, success was more likely with age. At the referral level, success was more likely following 1:1 health coach input and increased attendance. Adjusting for the predictors above, we observed outcome equalities. Rurality, deprivation, gender, and ethnicity did not impact outcomes. Neither did long-term health and mental health conditions or sickness, unemployment status, carer status, and BMI. Weight loss outcomes were not significantly related to a client's importance or confidence in making change, and multi-programme attendance or COVID reconfiguration was also unrelated.

Figure 13.Likelihood of a 5% weight loss whilst using One You Lincolnshire between June 2019 to February 2022



Pathway attendance and completion

Table 8 presents **Implementation**, pathway attendance and completion results. The table shows whether pathway delivery and engagement were consistent with planned provisions. Available 'Move More' data underestimates attendance and completion rates as data on session attendances was not maintained. In contrast, the data for 'Eat Healthy' was more

dependable as the data linked to weekly weight records. The completion rate for Eat Healthy was 70%. OYL exceeded the NICE guidance criterion for weight management programmes of 60% or above for completion.

Table 8.One You Lincolnshire pathway attendance and completion

Tier-2 programme	Standard N sessions offered	Criterion n for completion	Mn attendance	(95% CIs)	% Meeting completion criterion
Stop Smoking	6†	≥5	6.80	(6.70, 6.91)	63%
Move More	12	≥9	4.51	(4.44, 4.57)	26%
Eat Healthy	10	8	8.78	(8.67, 8.88)	70%
Drink Less	6	≥5	4.44	(4.28, 4.60)	46%
Health Coach	4	≥3	3.59	(3.49, 3.69)	56%

Note. *Each referral ID contains a single attendance figure, which may in some cases reflect attendance across multiple programmes. Estimates were obtained by limiting to referrals that only contained outcome data for a single programme but may be inflated.* †*But can range up to 12 sessions as needed.*

COVID-19 reconfiguration

Sustaining outcomes through challenging reconfigurations relates to the **Maintenance** of successful implementation. Effectiveness analyses showed that post-COVID reconfiguration did not significantly affect outcomes. Outcome effectiveness was maintained after transitioning from in-person to remote delivery. We also explored if OYL could maintain equitable access after service reconfiguration. As shown in Table 9, there were significant changes in the characteristics of the client base. There were changes in age, gender, deprivation, ethnicity, and disability. The changes indicated that some subpopulations were less well-represented post-COVID. **Reach** was enhanced through service reconfiguration in some ways. Enabling remote access to services and digital solutions overcame restrictions on in-person delivery. Remote access also allowed more open referral pathways, boosting commenced referrals from ~353 per month to ~668 per month. However, there were some evident inequities in the uptake of reconfigured services. Access seemed to be enhanced

for those from less deprived areas. As a result, the service moved further from the targeted representation of those from the most deprived areas.

Table 9.Significant differences in demographic profile of clients accessing services pre- vs. post-COVID

	Pre-COVID	Post-COVID
	In-person	Remote
Commenced referrals (n)	3,174	15,357
Mean Age	52.1	49.6
% Men	37%	31%
% From most deprived areas	45%	35%
% Ethnic minorities	9%	7%
% Long-term unemployed/sick	30%	24%

Limitations

Limitations must also be acknowledged. As is typical for real-world intervention evaluations, a pre-post design was used with no control group. Furthermore, client outcomes were self-reported using instruments suited to a clinical setting. As such, there was modest validity relative to gold standard research measures. However, the changes in measured health outcomes suggest that behaviour change was achieved. Whilst limitations might be seen as weaknesses for efficacy, the benefits of healthy lifestyles are well known. Hence, the primary contribution of this study relates to implementation outcomes.

Chapter 5 Economic Evaluation

Value Proposition

Definition

A value proposition is a ***"statement of the benefits and value that a service can deliver to its customers and prospective customers" (Barnes et al., 2009)***. Service provision involves contributions from stakeholders, and each stakeholder can be considered a customer receiving a service from another stakeholder. However, the primary customer is the patient. A value proposition differs from an economic evaluation in encompassing a range of value measures (Price and St John, 2019).

Application

The most quoted definition of value in health care is ***"health outcomes achieved per pound spent" (Porter, 2010)***. However, we recognise other dimensions of value in healthcare. Improving quality is integral to pursuing value in healthcare, and Donabedian (2002) advocated for quality healthcare to improve processes and outcomes. Therefore, the value proposition describes the nature of the service and the care pathway to which it contributes.

One You Lincolnshire's Value

Clients accessing OYL's integrated support service adopted healthy lifestyles. OYL success rates exceeded national benchmarks across behavioural outcomes of smoking, physical activity, healthy eating, and alcohol consumption. OYL's services show equities of the outcome. People from ethnic minority groups and rural areas were likely to benefit from integrated support recognising the interdependent nature of health behaviours. Integrated

care had a significant impact on outcomes. Support across pathways from a health coach and participation in multiple pathways increased success rates. Success was seen across weight management, physical activity, and alcohol reduction pathways. For example, the success rate for alcohol reduction clients without a health coach or engagement with multiple pathways was 2%.

Clients with a health coach support and engage with all pathways had a success rate of 75% for alcohol reduction. The synergistic effects of integration represent added value over siloed provisions. The effect translates into incremental cost-effectiveness compared to equivalent funding of a group of isolated providers. OYL serves over 16,000 people in Lincolnshire. The service has been able to pivot in challenging circumstances. Moreover, it continued to provide access to support throughout the COVID-19 pandemic. OYL maintained outcome success rates from pre- to post-reconfiguration. OYL also almost doubled client referral rates. The service has an established and tested infrastructure for regional delivery across different modalities. If sustained, outcomes delivered by OYL will lead to savings for the local health and social care system. As lifestyle-related conditions and disability-adjusted life years are reduced. Smoking cessation and alcohol reduction could increase disposable income within local communities.

Chapter 6 Discussion

Access and referrals to One You Lincolnshire

Overall accessibility to the service

This evaluation explored the reach of One You Lincolnshire (OYL) for eligible clients in the county. Secondary analysis and interviews found that most clients were white British and women. The average age of a client was around 50 years old, and there was an even distribution of clients from both rural and urban settings. Compared to the literature, the demographic of OYL reflected most weight-loss interventions. For example, most clients were white, female and from less disadvantaged groups (Haughton et al., 2018, Jackson et al., 2020). Additionally, most clients at the point of triage had a BMI categorised as obese. A key eligibility criterion of OYL was clients having a long-term health condition. Clients with LTHC are often more at risk of obesity and experience barriers to care (Betts and Froehlich-Grobe, 2017). As such, OYL was able to provide accessibility to a critical target group at risk of ill health.

Barriers for subpopulation groups

The underrepresentation of men in the service was explored in the qualitative interviews. Men reported reduced GP visits, perception of women-dominant programmes, and fear of seeking help. Indeed, a study by Wagner et al. (2007) found that reduced health-seeking behaviours in men were associated with limited health literacy. Literature shows that men were less likely to seek care than women, even with severe health problems (Schlichthorst et al., 2016). Among those aged 21 to 58, men consulted a GP half as often as women, and the difference was not explained by reproductive health reasons (Schlichthorst et al., 2016).

Ethnic minorities were also underrepresented in OYL. Previous lifestyle services also noted fewer minority groups accessing the service (Haughton et al., 2018). For example, Azar et

al. (2020) found that older ethnic minority groups had more significant barriers to services than the general population. Nevertheless, OYL clients that accessed the service were motivated, and most clients have a high confidence score to change and the importance to change at the start. Before the COVID-19 pandemic, most OYL clients were referred to the service via their GP. The use of annual NHS Health Checks was found to be better attended by older individuals (Coghill et al., 2018).

However, COVID-19 put a considerable strain on primary care. Qualitative focus groups highlighted the prioritisation of clinics on COVID-19 management. Also, the removal of face-to-face contact with patients resulted in fewer referrals to OYL via GPs. One major reconfiguration in the service was the introduction of self-referral. Secondary analysis revealed that the demographic of OYL changed with the new reconfiguration. For example, the average age of clients became younger. The demographic also was more women-dominant and had fewer ethnic minorities. Clients who were long-term unemployed and from deprived populations were also less likely to refer to the service. Interviews suggest that COVID-19 resulted in GPs encouraging potential clients to self-refer. Rather than initiating direct referrals, GPs relied on a client's health-seeking behaviour to follow up on the GPs suggestion. As such, groups with lower health-seeking behaviour may have been less likely to self-refer than if referred by GPs. Thus, men may be less likely to self-refer or visit a GP, making referral routes for men into the service difficult.

Meeting Commissioning Targets

Deprived groups live in the poorest neighbourhoods on low incomes. As such, populations often have limited access to safe living and health services. The commissioning target for OYL was 50% of clients from the 30% of most deprived LSOAs. However, OYL's reach was currently 38%. Extensive literature has shown that social inequities impact access to health services. When compared to other lifestyle services, OYL reflected similar accessibility barriers. Individuals living in more deprived neighbourhoods had poorer population health (Coghill et al., 2018). As such, complex health needs were more common in clients from deprived areas. Clients in OYL from deprived LSOAs were likelier to have long-term health conditions and poorer mental health.

Also, clients were more likely to have long-term unemployment, sickness, or substance dependencies. Complex unhealthy lifestyle behaviours may be an indicator of reduced service engagement. One study found that participants with many unhealthy lifestyles were 24% less likely to attend a GP appointment than those without (Feng et al., 2014). As disadvantaged groups are more likely to have complex health needs, they may have been less likely to engage in the referral routes OYL offered. Previous work has shown that unhealthy lifestyles cluster among low socioeconomic groups and deprived populations are less likely to seek primary healthcare. Thus, it is uncertain whether behavioural interventions in primary healthcare are reaching those in most need (Feng et al., 2014).

Barriers to alcohol reduction referrals

Excess alcohol consumption can impact older adults, and drinking has been shown to exacerbate long-term health conditions in older groups (Bareham et al., 2021). The average age of clients in OYL was 50 years old. Thus, alcohol reduction support was beneficial to existing OYL clients. However, OYL had low referrals to the alcohol reduction pathway. Health coach focus groups revealed that time-constrained care affected practitioners' ability to address clients. Previous studies show that alcohol-related conversations were not regularly part of a GP's work (Bareham et al., 2021). In the context of older populations, practitioners were deterred from talking. GPs mentioned concerns about sensitivity to the topic prevented discussions.

Also, competing priorities when addressing older people's complex health needs. GP interviews from this study highlighted the limited promotion of alcohol reduction to clients. Practitioners were more likely to recommend weight management and smoking cessation to clients. Practitioners found diet and smoking behaviours easier to infer than alcohol intake. These findings reflected existing literature on GP engagement with brief alcohol interventions. One study noted that GPs felt that assessing smoking status was 'straightforward'. Practitioners often determined physical activity from appearance, assessing if a patient was overweight (Ampt et al., 2009). In contrast, assessing alcohol intake was only during a formal health check. Therefore, a practitioner's congruence and capacity may influence alcohol pathway referrals. The relationship between patient-GP is thus key for lifestyle interventions (Johnson et al., 2010).

Client Outcomes of One You Lincolnshire

Overall service outcomes

Clients referred to OYL were likely to engage in the service's healthy eating and physical activity pathways. Most clients used one or two pathways whilst in the service, as exampled in the case study of Sarah's story. Sarah discussed how she went to the service for Slimming World. After completing the 12 weeks, she was recommended for physical activity support by the health coach, which she took up. As a result, Sarah could use multiple pathways of the service. A review by Johns et al. (2014) found more significant weight loss in services combining diet and exercise compared to interventions focused on either diet or exercise alone. Therefore, OYL had better outcomes across all pathways than the standard level of care, with a higher percentage of clients meeting targets.

Physical Activity: online delivery, health coach support and deprived groups

28% of clients on the OYL physical activity pathway met the target of 150 minutes of moderate to vigorous exercise weekly. In comparison to 13-18% of patients that had used the national exercise referral scheme. Being a woman and older increased the likelihood of achieving 150 minutes weekly. Long-term health conditions were also more likely to achieve 150 minutes a week. Conditions affecting mobility and pain management were most common in the qualitative findings. The introduction of personalised online delivery may have favoured individuals with LTHCs. As Anna's case study described, online group exercise classes were beneficial for limited mobility. A study by Betts and Froehlich-Grobe (2017) found that limited mobility was a barrier to weight loss and exercise interventions. In-person weigh-ins and inaccessible transport reduced the feasibility of attending and completing interventions. Therefore, OYL presents an opportunity for physical activity for people with impaired mobility and LTHCs and meets the needs of growing evidence of weight-related disparities.

However, studies show that digital services are more likely to undermine disadvantaged groups. Poor access to mobile technology, Wi-Fi, or mobile data has been associated with

low user motivation for behaviour change (Szinay et al., 2020). Thus, online delivery may present opportunities and challenges to OYL delivery. A health coach and better attendance increased the likelihood of successful activity outcomes. McGuire et al. (2019) found that people receiving 1:1 and group support were more likely to engage in physical activity than in group sessions alone. Likewise, frequent meetings were associated with weight loss (Dansinger et al., 2007). OYL clients from more deprived areas with long-term unemployment were less likely to achieve 150 minutes weekly. A systematic review of low-income groups found that whilst people kept up with dietary changes, physical activity was less consistent (Bull et al., 2015). Evidence shows that one of the main reasons for individuals not achieving outcomes was incurred costs (Nagelhout et al., 2017).

Despite data finding that deprived groups were less likely to meet goals, OYL clients showed meaningful changes. After the intervention, interviews found that clients had greater confidence, motivation, and self-esteem. These factors are critical for sustained lifestyle changes (Male et al., 2022). Jong et al. (2020) highlighted that creating a supportive environment for behaviour change was essential for success. Thus, OYL encompasses not only physical activity but psychosocial well-being. However, Baumeister et al. (1998), Vohs and Heatherton (2000) found that human self-regulation draws on limited resources as such single behaviour change may benefit low-income groups. Thus, the most effective modality of lifestyle services may depend on the target group.

Weight loss: commercial programmes, older clients, and person-centred support

OYL exceeded NICE guidance of an average weight loss target of 3%. 33% of clients also achieved 5% weight loss. 40% of clients lost weight with external partners such as Second Nature and Slimming World. Similar studies have found positive outcomes from commercial weight-loss programmes. Allen et al. (2015) found that a 'free' GP referral to services that typically cost people money encouraged participation. Age was a predictor of weight loss, with older clients more likely to achieve losing weight. Also, clients with a health coach who attended more sessions were more likely to achieve a weight loss of 5%. Previous evidence found that 60-year-olds lost more weight than younger individuals and sustained significant weight loss (Svetkey et al., 2014).

Qualitative interviews revealed that clients valued ongoing person-centred support. Rapport with health coaches was viewed as encouraging, with positive relationships among many clients. The health coach interviews mentioned using proactive messaging. Messaging included motivational interviewing. Also, coaches engaged with clients and gave feedback on progress and tips. Celis-Morales et al. (2017) found that people with personalised support consumed less unhealthy food. Health coach interactions may influence client outcomes as higher engagement leads to greater effectiveness. Some clients discussed a preference for online, viewing group sessions as more accessible. To date, few studies have compared health coaching delivery. However, Appel et al. (2011) found improvement in weight with both remote and face-to-face support. Thus, the reconfiguration of OYL service delivery may offer a unique insight into online and face-to-face support.

Alcohol Reduction: age, deprivation, and physical activity

Despite low referral rates to OYL brief alcohol support, clients had successful outcomes. In comparison to 10-30% in standard interventions, 57% of OYL clients drank less than 14 units of alcohol a week. Older clients and 1:1 support were predictors that increased a client's likelihood of achieving the behaviour change outcome. The Royal College of Psychiatrists (2018) recommended that low-risk drinking for people aged 65 and over be drinking no more than 12 UK units per week. Older people are likely to be more sensitive to alcohol-related harm through the effects of ageing and have a higher risk of interactions with prescribed medications (Rao, 2020).

Another predictor was a client being referred to another OYL pathway. Alcohol support was suggested to clients through physical activity or weight loss, and coaches offered support through alcohol reduction for weight loss rather than dependency. Studies have shown that exercise may reduce alcohol consumption among hazardous drinkers (Rasmussen et al., 2021). Indeed, specific exercises may encourage more days of no drinking. For example, one study by Gunillasdotter et al. (2022) found that people who did yoga drank around 5.5 drinks less per week than those in the aerobic exercise group. Interviews revealed that deprived populations used the pathway less. One reason may be that alcohol treatment was often needed for individuals rather than brief advice. Evidence shows that individuals in the most deprived areas are less likely to drink but more likely to engage in heavy episodic drinking. Deprivation is associated with heavy episodic and frequent drinking (Fat et al.,

2017). Health coaches mentioned that the pathway faced stigmatisation, and support for alcohol reduction was still viewed as challenging by health professionals.

However, a key predictor of alcohol reduction was clients being in another pathway. Few scientific reports have investigated the effect of programmes targeting several lifestyle factors. However, one study found similar outcomes to OYL. Lee et al. (2009) showed that at-risk drinkers in integrated care were more likely to access treatment as such drinkers decreased harmful drinking more than those in the specific alcohol referral interventions.

Smoking cessation and mental health

56% of clients quit smoking for four weeks using OYL compared to 46% of patients using the NHS Stop Smoking Service. Older clients with a high confidence score were more likely to quit. In contrast, clients with previous attempts are less likely to quit. Also, clients with mental health conditions were less likely to quit. Studies have shown that changing behaviour is more difficult for service users with mental health conditions **(Bradley et al., 2021).** As such, there is a greater need to focus on confidence-building and readiness to change. As such, an improvement in mental health may significantly impact a client's ability to make physical health changes.

Working Relationships with One You Lincolnshire

Primary care practitioners and capacity

Primary care is crucial in preventive health care activities, with staff promoting smoking cessation, responsible alcohol consumption, weight control and physical activity (Schlichthorst et al., 2016). Studies reveal that GPs often recruit hard-to-reach populations (O'Hara et al., 2015). GPs were identified as a critical element of the OYL service model. Most clients expressed a high trust in GPs. Clients followed GP suggestions, often assuming that "the doctors know best". However, in this study, primary care staff presented some gaps in knowledge of the OYL service model.

Also, GPs expressed having limited capacity and time to engage with the referral process of the service. Health coaches and partners reflected on historical relationships with primary care clinics. Before the introduction of OYL, a key challenge was managerial capacity at primary care clinics, which limited clinics' buy-in to community services. Din et al. (2015) found a reluctance to promote physical activity to patients by GPs. The study identified several barriers to referral—for example, the time constraints placed on GPs. Also, the priority of physical activity about other health promotion activities (Din et al., 2015). As a result, OYL leadership found relationship building a critical need for service initiation and delivery. Interviews showed OYL had worked to gain buy-in from primary care clinics, and partners valued buy-in and viewed it as a critical facilitator for referrals into external programmes.

Quality assurance and data sharing

Quality assurance was a key commissioning strategy the evaluation aimed to evidence. Interviews revealed that quality was embedded into the service design as OYL leadership encouraged buy-in across teams and pathways. All OYL team members had consistent training in behaviour change, and continual learning was also embedded into the organisation. Vangen and Huxham (2000) suggested that trust was imperative for a successful partnership working. Relationships between OYL and service partners were positive, and consistent communication and trust were highlighted as critical strengths of the organisation. One factor that did vary between partners was data sharing. Each partner

organisation had different data-sharing processes and administration capacities. Also, referral routes had varied approaches to referring to the service. These areas may provide opportunities to streamline tasks, as Henderson et al. (2018) found that seamless data sharing between organisations often contributed to a consistent end product.

Service completion and sustainability of One You Lincolnshire

Pathway completion and service configuration

Lifestyle interventions often have sustained low changes reported. Completion and long-term changes were as complex as the factors influencing access to the intervention (Gidlow et al., 2005). However, many studies showed that close adherence to lifestyle modification resulted in a favourable outcome (Oh et al., 2018). OYL had a range of completion rates across the four lifestyle pathways. More than half of clients that took up stop smoking support had still quit four weeks later. Over half of the clients completed their sessions with a health coach, and over a quarter completed the physical activity and weight management programmes. However, there was limited data to explore the reasons for non-completers. Common challenges of non-completion of weight loss programmes were self-monitoring and low mood. Venditti et al. (2014) demonstrated that problem-solving weight loss programmes were associated with better outcomes. The sustainability of OYL can also be looked at through the organisation's ability to withstand risk and change as the service delivered all pathways for Lincolnshire residents during the COVID-19 pandemic.

Chapter 7 Recommendations and Conclusion

Improve access for disadvantaged groups

OYL had good access for most clients entering the service and reflected the demographic of the county. However, some clients were less well represented in the service. There may be a need for improved access for disadvantaged groups, men, and ethnic minorities. Previous studies found that individuals living in deprived areas preferred personalised care (Christensen et al., 2020). The role of the health coach was also valued. Coaches helped handle low moods and lack of motivation among vulnerable groups. Rapport building with a client started at the initial engagement. Coaches were able to address a client's willingness and ability to change. Then throughout the service, address triggers that affect a client's ability to sustain positive change.

As there were few clients from different ethnic groups, further research may be needed to understand rapport building. Social opportunity barriers included cultural identity linked to the consumption of traditional starches—also, the desire to perform physical activity that was culturally acceptable such as walking and dancing. The evaluation also highlighted signposting by health practitioners. Less direct referrals may have reduced the number of clients to reduced alcohol consumption pathways. The role of practitioners is a vital component of the service, and they are necessary for networking, integrating care elements, and showing leadership. The NHS Health Check was a key route into the service. Previous studies have also shown that inviting patients for an NHS Health Check is a predictor of attendance. Verbal, telephone, and enhanced letter invitations are predictors of attendance. In comparison to a traditional letter invite (Coghill et al., 2018). Thus, applying behavioural insights may be more effective at encouraging attendance to the health check and, in turn, OYL.

Innovative promotion of alcohol support

Phase 2 showed that alcohol reduction support had low referrals. Alcohol consumption was challenging for referral routes to promote as there was stigma toward receiving support. However, once on the pathway, clients had significantly improved outcomes compared to standard care. One unique feature of OYL was that most clients on the pathway were referred once in the service. Services supporting substance use have traditionally been delivered separately from other health care services. As substance use is seen as a social problem, prevention support is often not considered a responsibility of the health care systems. Alcohol reduction was promoted positively via weight loss with holistic health benefits. Thus, OYL may want to consider the promotion and social marketing of alcohol reduction.

Streamlining of data

Technology can play a crucial role in supporting integrated care. Electronic health has the potential to support quality, track patients, and identify trends and threats. As OYL had issues with Response 365 and some gaps in data, robust data systems could improve the organisation and usability of clinical data. Data sharing could help patients, health care professionals, and health system leaders coordinate care, promote shared decision-making, and engage in quality improvement efforts. Also, data systems could provide information in many languages, connecting patients with culturally appropriate providers. Exchanging treatment records among health care providers improves treatment and patient safety. However, given known discrimination based on race or substance use disorders, safeguards against inappropriate or inadvertent disclosures are essential when streamlining data sharing. Therefore, protecting confidentiality when exchanging sensitive information must be considered.

Conclusion

Integration is the systematic coordination of general and behavioural health care. Integrating services have been shown to provide a practical approach to supporting whole-person health and wellness. Too many patients fall through the cracks when health care is not well integrated and coordinated across systems. A lack of integration can lead to missed prevention or early intervention opportunities. Single behaviour changes interventions have been successful; however, OYL provides crucial evidence on the benefit of clients with multiple unhealthy risk factors. OYL outcomes exceeded all standard care across all four lifestyle risks and positive qualitative experiences from clients. Despite COVID-19, the service remained adaptable and successfully reconfigured service delivery. OYL was able to focus on local relationships and made strong connections with organisations in Lincolnshire. As such, OYL was able to create an integrated offer for clients, increased the likelihood of better outcomes and has the potential to reduce health disparities.

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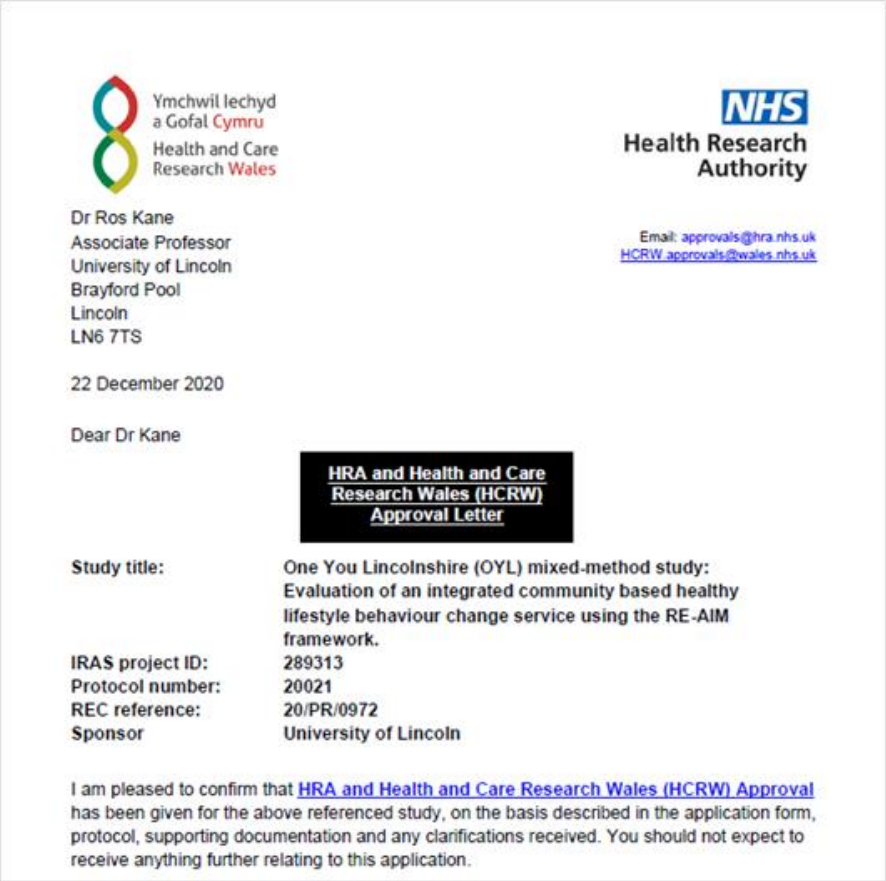
List of Appendices

Appendix A: Health Research Authority (HRA) Approval



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22 December 2020

Dear Dr Kane

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**One You Lincolnshire (OYL) mixed-method study: Evaluation of an integrated community based healthy lifestyle behaviour change service using the RE-AIM framework.**
IRAS project ID:	**289313**
Protocol number:	**20021**
REC reference:	**20/PR/0972**
Sponsor	**University of Lincoln**

I am pleased to confirm that HRA and Health and Care Research Wales (HCRW) Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Appendix B: Sampling and recruitment framework

Participant Group	Sample Size
GP Staff (GPs, social prescribers, nurses)	4
Slimming World/Weight Watchers and Get Healthy Get Active Subcontractors	3
One Year No Beer, 28 Days	3
Adult Weight Management Lead, Alcohol Lead, Physical Activity Lead, Smoking Cessation Lead	4
Senior Triage Officer, Referral Generation Lead, Health Coach Team Lead	3
Adult Weight Practitioner, Man V Fat Coach	3

Triage Worker, Referral Generation Officer	3
Physical Activity Coach, Health Coaches	4
Stop Smoking Advisor, Pharmacy Facilitator	3
Total	30

Participant Group	Sample Size
Carer	2
BAME (Black and minority Ethnic)	2
Long Term Health Condition	2
LCC (Lincolnshire County Council) employees	2
Clients not motivated	2
Clients not eligible for service	2
Clients eligible but do not take up service	2
Tier 1 clients	2
Tier 2 clients	2
Low need support	2
Medium need support	2
High need support	2
Drop out clients	2
Clients that did not maintain sustained change	2
Clients that did maintain sustained change	2
Total	30

Health and Wellbeing Board – Decisions from 14 June 2022

14 June 2022	**1**	**Election of Chairman** That Councillor Mrs S Woolley (Executive Councillor for NHS Liaison, Community Engagement, Registration and Coroners) be elected Chairman of the Lincolnshire Health and Wellbeing Board for 2022/23.
	2	**Election of Vice-Chairman** That John Turner (Chief Executive of NHS Lincolnshire Clinical Commissioning Group) be elected as Vice-Chairman of the Lincolnshire Health and Wellbeing Board for 2022/23.
	5	**Minutes of the Lincolnshire Health and Wellbeing Board meeting held on 29 March 2022** That the minutes of the Lincolnshire Health and Wellbeing Board meeting held on 29 March 2022 be agreed and signed by the Chairman as a correct record.
	6	**Action Updates** That the Action Updates presented be noted.
	7	**Chairman's Announcements** That the Chairman's Announcements presented be noted.
	8a	**Proposed changes to the Health and Wellbeing Terms of Reference** 1. That the changes to the Terms of reference, Procedural Rules and Board Member's Roles and Responsibilities as detailed in Appendix A to the report be endorsed. 2. That the changes be recommended to full Councill on 16 September 2022, to enable the relevant changes to be made to the Council's Constitution. 3. That the update on the development of Lincolnshire's Integrated Care Partnership be noted. 4. That the recommendation to extend Associate Membership to a representative from Higher Education and the Greater Lincolnshire Enterprise Partnership be endorsed.
	8b	**Better Care Fund Final Report 2021/22** That the 2021/22 end of year Better Care Fund return be approved.
	9a	**Integrated Care System Update** That the current position in relation to the ICS legislation be noted.
	9b	**Let's Move Lincolnshire – Physical Activity Strategy** That the direction of the Let's Move Lincolnshire – Physical Activity Strategy refresh and specifically the health and wellbeing outcome be received.
	9c	**Childhood Obesity** That the Childhood Obesity report presented be noted.
	10a	**An Action Log of Previous Decisions** That the Action Log of Previous Decisions as presented be noted.
	10b	**Lincolnshire Health and Wellbeing Board Forward Plan** That the Lincolnshire Health and Wellbeing Board Forward Plan as presented be received.

27 September 2022	**13**	**Minutes of the Lincolnshire Health and wellbeing Board Meeting held on 14 June 2022** That the minutes of the Lincolnshire Health and Wellbeing Board meeting held on 14 June 2022 be agreed and signed by the Chairman as a correct record.
	14	**Action Updates** That the Action Updates presented be noted.
	15	**Chairman' s Announcements** That the Chairman's announcements presented be noted.
	16a	**Lincolnshire Pharmaceutical Needs Assessment 2022** That approval be given to the final Pharmaceutical Needs Assessment 2022 and associated documents for publication by 1 October 2022.
	16b	**Better Care Fund 2022/23** That the 2022/23 Lincolnshire Better Care Fund be approved in retrospect of the submission deadline of 26 September 2022.
	17a	**An Action log of Previous Decision** That the Action Log of Previous Decision as presented be noted.
	17b	**Lincolnshire Health and Wellbeing Board Forward Plan** That the Lincolnshire Health and Wellbeing Board Forward Plan as presented be received.
6 December 2022	**20**	**Minutes of the Lincolnshire Health and wellbeing Board Meeting held on 27 September 2022** That the minutes of the Lincolnshire Health and Wellbeing Board meeting held of 27 September 2022 be agreed and signed by the Chairman as a correct record.
	21	**Action Updates** That the Action Updates presented be noted.
	22	**Chairman's Announcements** That the Chairman's announcements presented be noted.
	23a	**Adult Social Care – Discharge Fund and Update on the Lincolnshire Better Care Fund** 1. That the update on the assurance of the Lincolnshire Better Care Fund Plan be noted. 2. That the Better Care Fund Reporting Template as detailed at Appendix A to the report be approved and that quarterly updates be received by the Board going forward. 3. That the Discharge Fund Plan for both the Integrated Care Board and Lincolnshire County Council ahead of submission on 16 December be approved.
	24a	**Lincolnshire's Joint Strategic Needs Assessment 2023 – Update on Review Process.** 1. That the progress of the JSNA review be noted. 2. That the next stages of the review process as shown in Appendix B be noted. 3. That a further report and presentation be received at the March 2023 meeting to sign off the new JSNA ahead of the online resource going live be agreed.
	24b	**Refresh of the Joint Health and Wellbeing Strategy** 1. That the refreshed Joint Health and Wellbeing Strategy be noted.

		2. That the proposal to undertake a more fundamental review of the Joint Health and Wellbeing Strategy following the publication of the Joint Strategic Needs Assessment and alongside the development of the Integrated Care Strategy be noted. 3. That the proposals to reinvigorate the governance and delivery arrangements sets out in section 1.3 of the report be noted
	24c	**Lincolnshire Ageing Better Rural Strategic Partnership Update** 1. That the work to date of the Lincolnshire Ageing Better Rural Strategic Partnership be noted. 2. That consideration be given to opportunities to engage with the Steering Group and its work programme. 3. That consideration be given on how to promote the Lincolnshire Ageing Better Steering Group within the wider health and care system, identifying appropriate colleagues to connect with the Strategic Partnership Manager as appropriate.
	25a	**Lincolnshire Drug and Alcohol Partnership** 1. That the establishment of the Lincolnshire Drug and Alcohol Partnership and the progress made by the Partnership to date be noted. 2. That annual updates on the progress of the Partnership be received by the Board.
	25b	**An Action Log of Previous Decisions** That the Action Log of Previous Decisions as presented be noted.
	25c	**Lincolnshire Health and Wellbeing Board Forward Plan** That the Lincolnshire Health and Wellbeing Board Forward Plan as presented be noted.
28 March 2023	**28**	**Minutes of the Health and Wellbeing Board meeting held on 6 December 2022** That the minutes of the Lincolnshire Health and Wellbeing Board meeting held on 6 December 2022 be agreed and signed by the Chairman as a correct record.
	29	**Action Updates** That the Action Updates presented be received.
	30	**Chairman's Announcements** That the Chairman's announcements presented be noted.
	31a	**Joint Strategic Needs Assessment for Lincolnshire** 1.That the new Joint Strategic Needs Assessment (JSNA) for Lincolnshire be approved and adopted. 2. That confirmation be given to the new JSNA being used as the evidence base to inform the refresh of the Joint Health and Wellbeing Strategy.
	32a	**The Director of Public Health's Annual Report – The Diverse Communities of Greater Lincolnshire** That the Director of Public Health's Annual Report – The Diverse Communities of Greater Lincolnshire be received and noted.
	32b	**NHS Joint Forward Plan**

		1. That the current position and the requirement for the NHS to develop a Joint Forward Plan be noted. 2. That the requirement to involve the Health and Wellbeing Board (HWB) in preparing or revising the JFP be noted. 3. That the need to share a draft with the HWB, and consulting with the HWB on whether the JFP takes proper account of each relevant joint local health and wellbeing strategy be noted.
	32c	**Healthy Weight Priority Update** That the contents of the report presented and partners contributions to the work of the Healthy Weight Partnership be noted.
	32d	**Let's Move Lincolnshire – Physical Activity Priority Update** 1. That support be given to advocate for and support the embedding of the Let's Move Lincolnshire Strategy. 2. That support be given to Active Lincolnshire to encourage all organisations to embed physical activity at system level in relevant policies, contracts, commissions, planning and decisions. 3. That recognition be given that capacity, collaboration, and future investment across the system is needed to support the on-going implementation of the Let's Move Lincolnshire Strategy.
	33a	**The Lincolnshire Better Care Fund 2023/24 and update on the Discharge Fund** 1. That the update provided on the Better Care Fund be noted. 2. That the update provided on the Discharge Fund be noted. 3. That the Quarter 4 performance attached at Appendix A to the report be noted.
	34	**An Action Log of previous Decisions** That the Action Log of Previous Decisions as presented be noted.
	35	**Lincolnshire Health and Wellbeing Board Forward Plan** That the Lincolnshire Health and Wellbeing Board Forward Plan as presented be noted.

13 June 2023, 2pm, Council Chamber, County Offices, Lincoln		
Agenda Item	**Presenter**	**Purpose**
1. AGM - Election of Chair and Vice Chair	Democratic Services	**Decision** – to elect the Chair and Vice Chair for 2023/4
2. HWB Terms of Reference and Board Membership	Alison Christie, Programme Manager	**Decision** – to receive a report on behalf of the DPH asking the HWB to review and endorse the Terms of Reference and any proposals to change the membership
3. Joint Engagement – JSNA Prioritisation Exercise & Recommendations	Alison Christie, Programme Manager	**Decision** – to receive a report on behalf of DPH asking the HWB to consider the recommendations from Phase 1 of the engagement exercise
4. Better Care Fund	Glen Garrod, Executive Director for ACCW	**Decision** – to receive a report from the Executive Director for ACCW on the Better Care Fund
5. NHS Joint Forward Plan	Pete Burnett, Director of Strategic Planning, Integration and Partnerships	**Decision–** to receive a report on behalf of the ICB asking the HWB to consider whether the JFP takes proper account of the JHWS
6. Joint Health and Wellbeing Strategy for Lincolnshire Annual Report	Alison Christie, Programme Manager and Priority Leads	**Information** – to receive a report on behalf of the DPH which presents the annual Joint Health and Wellbeing Assurance Report
7. Integrated Lifestyle Service (ILS) Evaluation	Andy Fox, Consultant Public Health	**Information** – to receive a report on behalf of the DPH provide information on the evaluation of the ILS

26 September 2023, 2.30pm, Council Chamber, County Offices, Lincoln		
Agenda Item	**Presenter**	**Purpose**
1. Joint Health and Wellbeing Strategy – update	Michelle Andrews, Assistant Director and Alison Christie, Programme Manager	**Discussion** – to receive an update on the review process
2. Carers JHWS Priority	Chair and lead officer (tbc)	**Discussion -** to receive a report on behalf of the Carers Delivery Group providing an update on the Carers priority
3. Housing and Health JHWS Priority	Cllr W Gray, Chair HHCDG & Senior Officer (tbc)	**Discussion -** to receive a report on behalf of Housing, Health and Care Delivery Group providing an update on the Housing and Health priority
4. Better Care Fund	Glen Garrod, Executive Director for ACCW	**Information** – to receive a report from the Executive Director for ACCW on the Better Care Fund

5 December 2023, 2pm, Council Chamber, County Offices, Lincoln		
Agenda Item	**Presenter**	**Purpose**
1. Joint Health and Wellbeing Strategy for Lincolnshire 2023	Michelle Andrews, Assistant Director and	**Decision**

	Alison Christie, Programme Manager	
2. Mental Health and Emotional Wellbeing (CYP) JHWS Priority – update from the Children and Young People Mental Health Transformation Programme	Charlotte Gray, Lincolnshire County Council and Eve Baird, Lincolnshire Partnership Foundation Trust	**Discussion** - to receive a report on behalf of the Children and Young People Mental Health Transformation Programme providing an update on the Mental Health and Emotional Wellbeing (CYP) priority
3. Mental Health (Adults) JHWS Priority – update on the Mental Health Community Transformation Programme	Nick Harwood, Lincolnshire Partnership Foundation Trust	**Discussion** - to receive a report on behalf of the Mental Health Community Transformation Programme providing an update on the Mental Health (Adults) priority
4. Dementia JHWS Priority – update on the Dementia Support Programme	Steve Roberts, Lincolnshire Partnership Foundation Trust	**Discussion** - to receive a report on behalf of the Dementia Support Programme providing an update on the Dementia priority
5. Ageing Better – update on the Lincolnshire Rural Strategic Partnership	TBC	**Discussion**
6. Better Care Fund	Glen Garrod, Executive Director for ACCW	**Information** – to receive a report from the Executive Director for ACCW on the Better Care Fund

12 March 2024, 2pm, TBC		
Agenda Item	**Presenter**	**Purpose**
1. Healthy Weight JHWS Priority – update from the Healthy Weight Partnership	TBC	**Discussion** – to receive a report on behalf of the Healthy Weight Partnership providing an update on the Healthy Weight JHWS priority
2. Physical Activity JHWS Priority – update on Let's Move Lincolnshire update	TBC	**Discussion** – to receive a report on behalf of Let's Move Lincolnshire providing an update on the Physical Activity priority
3. Director of Public Health Annual Report 2023	Derek Ward, Director of Public Health	**Information** – to receive a presentation on the Director of Public Health Annual Report 2023
4. Better Care Fund	Glen Garrod, Executive Director for ACCW	**Information** – to receive a report from the Executive Director for ACCW on the Better Care Fund

11 June 2024, 2pm, TBC		
Agenda Item	**Presenter**	**Purpose**
1. AGM - Election of Chair and Vice Chair		**Decision**
2. Review and endorse HWB Terms of Reference and Board Membership	Programme Manager	**Decision** – to receive a report on behalf of the DPH asking the Board to review and

		endorse the Terms of Reference and any proposals to change the membership
3. Joint Health and Wellbeing Strategy for Lincolnshire Annual Report	Programme Manager	**Discussion** – to receive a report on behalf of the DPH which presents the annual Joint Health and Wellbeing Assurance Report

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