Greater Lincolnshire
Local Enterprise Partnership

Greater Lincolnshire LEP Health & Care Enterprise Board

6th September 2019

Boole Technology Centre, Lincoln Science & Innovation Park

Paper 0 - Agenda

Time	Item and brief description	Lead	Status
10.15	Arrival and Networking	Andrew Brooks	
10.30	Welcome and Formal Introductions	Dean Fathers	
10.45	Context of progress since the last event	Dean Fathers	Verbal update
10.55	Discussion of infographic refresh	Dean Fathers/Andrew Brooks	Verbal Update
11.05	Position Paper for Government	Richard Parish/Andrew Brooks	Paper 1
11.25	Local Industrial Strategy Discussion	Ruth Carver/James Baty	Verbal update and discussion
11.55	Future funding requirements for capital projects, research knowledge transfer and business support	Dean Fathers	Board discussion
12.15	Any Other business	Dean Fathers	
12.20	Date and time of next meeting	Dean Fathers	
12.30	Lunch		
1.30	Close		

Attendees: Dean Fathers (Chair), Glen Garrod, Jacqui Bunce (for John Turner), Professor Richard Parish, Roz Way, Dan Hayes, Tom Blount, James Brindle, Nikki Cooke, Melanie Weatherly, Helen Shaw, Rachel Linstead, Joanne Metcalf, Joanne Wright, Nury Moreira

Apologies: Professor Tanweer Ahmed, Chris Wheway, John Turner, Darren Clark

Officers: Ruth Carver, James Baty, Andrew Brooks

Parking Arrangements - Large car park available

Paper 1
Local Industrial Strategy

1 Summary

National Overview

1.1 On 7 January, the NHS long-term plan (formerly known as the 10-year plan) was published setting out key ambitions for the service over the next 10 years.

For nearly a decade, the NHS has experienced a significant slowdown in funding growth, while demand for services – and the cost of delivering those services – has grown rapidly. Cuts to public health and social care funding have added further pressure. As a result, NHS performance has declined. Key waiting time targets are being consistently missed and the finances of NHS providers have deteriorated rapidly; in 2017/18, the year-end aggregate provider overspend was £960 million. Workforce shortages are widespread, with more than 100,000 whole-time equivalent staff vacancies in hospitals, including more than 40,000 nurse vacancies. Last year's winter crisis – the effects of which were still being felt well into the summer – underlined the fragile state of the service.

In June 2018, the Prime Minister announced a new five-year funding settlement for the NHS: a 3.4 per cent average real-terms annual increase in NHS England's budget between 2019/20 and 2023/24 (a £20.5 billion increase over the period). To unlock this funding, national NHS bodies were asked to develop a long-term plan for the service. The resulting document, the NHS long-term plan, was published on 7 January 2019.

This settlement represents a substantial improvement on the funding growth the NHS has seen since 2009/10, which has averaged approximately 1 per cent a year in real terms. Yet it remains below the average increases of 3.7 per cent a year since the NHS was founded and is less than the 4 per cent annual increases we and others have argued are necessary to meet rising demand and maintain standards of care.[1]

2 Lincolnshire Context

2.1 Lincolnshire is a very rural environment, with a distributed pattern of 22 towns and a lack of critical population mass, which does not fit the standard pattern for NHS provision, which is focused on urban concentrations of service delivery. The dispersed population pattern also makes it relatively more expensive to deliver adult social care as a consequence of the travel times involved in accessing those who are being cared for. Lincolnshire is typical of many rural settings where the following characteristics pertain:

80% of rural residents live within 4km of a GP surgery, compared with 98% of the urban population and only 55%of rural households compared to 97% of urban households are within 8km of a hospital.[2]

The ratio of NHS staff in the 10 most rural STP areas compared to England is 1: 1.45 and there are exceptionally acute shortages in Doctors, Midwives and Consultants.[3]

The 7 most rural hospitals in England – including Pilgrim Hospital in Boston (3% of the total) account for 23% of all debt in the sector.[4]

[1] The NHS Long Term Plan Explained, Charles, Ewbank, McKenna and Wenzel, Kings Fund January 2019
[2] Public Health England – Midlands Rural Seminar July 2018
[3] Rural Workforce Issues in Health and Care, Green, Bramley, Annibal and Sellick, University of Birmingham October 2018
[4] Rural health care, A rapid review of the impact of rurality on the costs of delivering health care, Palmer, Appleby and Spencer, January 2019

Rural areas have a proportionately higher share of older people with more significant costs associated with health care. More than 40% of spending in the NHS is devoted to people over 65[5]. The proportion of Lincolnshire's population over 65 is predicted to grow from 23% to 30% from 2016 to 2041 compared to an England position of 18 to 24%.

Finally Adult Social Care is increasingly unaffordable across England and represents a disproportionately high proportion of the overall County Council budget. From 2013-18 the proportion of the Council's gross budget spent on adult social care has risen from 29 to 42%[6].

3 Strategic Context

3.1 The Industrial Strategy (2017) identifies a number of economic development opportunities around health and care and it highlights an ageing society as one of its grand challenges. It does not however make any direct linkages between the rural settings and the distinctive challenges and opportunities in relation to either health and care or the ageing society.

Greater Lincolnshire LEP identifies Health and Care as a key opportunity area on the basis of its scale in terms of employment and value. It states:

Our growing and ageing population and dispersed towns and villages are driving opportunities for economic growth in Greater Lincolnshire's health and care sector, which currently employs 58,000 people and is worth £2bn per annum to our economy.

Opportunities include developing and embedding innovation across the NHS, through the new Schools of Life Sciences and Pharmacy at the Lincoln Science and Innovation Park, deploying assistive technology, and ensuring our housing stock can meet the 'whole life' needs of residents.

The University of Lincoln and Lincolnshire County Council are working together on the opening of a post-graduate medical facility, and our Further Education sector is working on vocational skills within the sector.[7]

Additional key developments/opportunities include:

The announcement of a new medical school for the University of Lincoln in March 2018 which will build to 400 students over 5 years bring crucial critical mass to the learning and development infrastructure around health and care in the County. The first intake is planned for September 2019.

The establishment of the National Centre for Rural Health and Care in Lincolnshire as an independent body but with links to both the University of Lincoln, who have just appointed a Global Chair in Rural Health and Care to work alongside the Centre brings a focus for national expertise in rural health and care to Lincolnshire. The Centre is currently hosted within Bishop Grosseteste University with which it has a research partnership. It has approaching 70 trusts in membership across England and provides the secretariat for a Parliamentary Inquiry into Rural Health and Care.

[5] Ageing Britain: two-fifths of NHS budget is spent on over-65s, Robineau, Guardian, 1/2/16
[6] Lincolnshire County Council 2018
[7] Greater Lincolnshire LEP 2019

Finally Lincolnshire is an accelerator site within an NHS England programme to build closer linkages between the Voluntary and Community Sector and the Sustainability and Transformation Partnerships as they move towards the development of Integrated Care Systems. In this context there are real opportunities to develop the County as national exemplar of multi-agency working in the context of the implementation of the NHS Long Term plan.

4 Challenges and Opportunities

4.1 There are real opportunities to develop the LIS to take realise the potential of the Health and Care sector through the lens of the four grand challenges as set out below:

1. Use data, Artificial Intelligence and innovation to transform the prevention, early diagnosis and treatment of chronic diseases by 2030 – The National Centre for Rural Health and Care has already begun the process in conjunction with East Midlands Academic Health Science Network of identifying the opportunities to apply technology including AI to deliver prevention, diagnosis and treatment of chronic diseases in rural settings. A major innovation event, supported by the Lincolnshire Growth Hub on 6 December 2019 was held in Lincoln and generated a significant number of innovation proposals. Three innovations are being progressed namely:

- Increasing social connections for families to reduce loneliness and mental health issues
- Point of care testing in primary care
- Development of the remote cardiac rehabilitation solution to help patients with cardio-vascular disease improve their wellbeing without having to travel long distances for weekly therapy.

These initiatives are being piloted in Lincolnshire and Derbyshire. More widely against the background of preparations for the implementation of the Integrated Care System for Lincolnshire and alongside the evolution of Primary Care Networks in the County the Lincolnshire STP has developed an innovative web based social prescribing platform, which helps to both support users and strategically align providers across the county. This system is called VitruCare.

In addition to these developments there are opportunities to build on the potential offered at the University of Lincoln in terms of developing and embedding innovation across the NHS, through the new Schools of Life Sciences and Pharmacy at the Lincoln Science and Innovation Park, The establishment of the new Medical School provides a very potent opportunity to widen the appeal of Science and Innovation Park as a national centre for organisations interested in research and technology in terms of addressing rural health inequalities. The University has also begun discussions with partners in Australia and Canada about positioning itself in relation to Rural Health and Care as the "Know How" organisation at the heart of a Rural Health and Care Alliance and this could be significantly enhanced with LEP engagement.

2 Ensure that people can enjoy at least 5 extra healthy, independent years of life by 2035, while narrowing the gap between the experience of the richest

and poorest – at a recent Grand Challenge National Workshop[8] the key issues around this theme were identified as:

- health and care, homes,
- families and communities
- Work, learning and purpose
- Finance and economy

The interplay of housing, community and personal resources underpin the viability of many individuals in the context of health and care in Lincolnshire.

4.2 Housing

Whilst housing in relatively affordable in Lincolnshire, the dispersed nature of the housing stock and the limited amount of extra-care housing in the County provide challenges in terms of supporting vulnerable people to live in their own homes for as long as possible. It is clear that better health outcomes are achieved when this does happen. A relatively recent Housing Lin Study[9] for example identified that people had a range of functional abilities on moving [into Extra Care Housing] and were generally less dependent than people moving into residential care.

The Lincolnshire JNSA identifies that whilst from a percentage basis the number of older people challenged in terms of their health and housing needs is not exceptional it still represents a significant number of people:

"The growth in the number of people over 65 presents the greatest challenge and requires a range of accommodation and support solutions including different types of specialist and housing-related support (HRS). It also requires a broadening of understanding about the options which for many are either to stay where they are or to 'go into a home', the latter having quite negative connotations.

Across Lincolnshire, the total population aged 65 and over with a limiting long term illness whose day to day activities are limited a little and a lot is projected to increase from an estimated 84,301 in 2017 to an estimated 123,865 in 2035, which is around 47% of that population. This is slightly lower than the national rise of 49% and the regional figure of 51%. (POPPI - http://www.poppi.org.uk)"[10]

4.3 Community

In terms of community it is clear that the statutory sector cannot underpin the full viability of the ageing population on its own. This was acknowledged by NHS England/NHS Improvement in its recent publication The Principles for VCSE Engagement, which outline how NHS England/NHS Improvement and the Voluntary and Community sector and Social Enterprises should work together to ensure that partnership working and co-production are fully embedded.

[8] Catherine Davis Deputy Director, Ageing Society Grand Challenge at Department of Health & Social Care, Local Industrial Strategy and Ageing Society Grand Challenge Workshop, Leeds, 15th Aug 19

[9] Improving housing with care choices for older people: an evaluation of extra care housing. Netten, Darton, Bäumker and Callaghan

[10] Lincolnshire Research Observatory JSNA Topic: Housing & Health, June 2018

In Lincolnshire the VCS sector has been working together under the banner of the Voluntary Engagement Team (VET) to enable more effective engagement and delivery of health and care outcomes reaching out to the statutory sector. There are a number of key elements connected with this work: the development of a VCS/Statutory Sector Memorandum of Understanding, the development of a collective brand to recognise buy into the MoU, the development of a capacity building programme for smaller VCS organisations and the development of a new overall governance structure for the partnership. Initial estimates suggest approaching 2500 VCS bodies in Lincolnshire with up to 1000 having some role in helping to address health challenges and underpin the delivery of this grand challenge.

4.4 Personal Resources

In terms of personal resources and ageing the JSNA identifies:

"The number of people aged 65 or more is expected to rise significantly in the next 25 years and there is likely to be an increasing number of people suffering from depression, isolation and dementia. By 2030 it is projected 85,718 people over the age of 65 will live alone, which will be well above the 58,812 in 2014. (Source: LRO, 2014). Older people are less likely to be homeless: only 3% of homeless people nationally were aged over 65 in 2014 (Source: DCLG P1E table 781, 2015). They are also less likely to be living in overcrowded homes but many may be living in family homes that are large and difficult to maintain. Some older people live with family members with no legal right to remain if their circumstances change. This may work well for many, but may also leave them vulnerable if the family is no longer able or willing to accommodate them."[11]

In summary the LEP can play a role in supporting the diversification of the specialist housing stock, enhancing the capacity of the VCS sector and working with agencies to address the financial vulnerability of the over 65s in response to the health component of the ageing society grand challenge.

3. ***At least halve the energy use of new buildings by 2030 and establish the world's first net-zero carbon industrial cluster by 2040 and at least 1 low-carbon cluster by 2030*** – The Lincolnshire JNSA identifies:

It is difficult to monitor trends in housing conditions as condition surveys are undertaken around every 5 years and the methodologies and standards change. Between the 2009 Lincolnshire Private Sector House Condition Survey and the 2014 BRE housing stock modelling the following conclusions can be drawn:

1. There were 65,700 private sector homes (24.1%) containing serious (Category 1) hazards in 2009 and this remained virtually the same in 2014 (24.0%). In 2018, there were 52,500 homes (18%) containing Category 1 hazards.
2. The mean SAP (energy rating on a scale of 0 (poor) to 100 (good)) for private sector housing in 2009 was 52 in Lincolnshire, which is higher than that found nationally (49). The 2014 BRE stock modelling used a simple SAP methodology and estimated the average rating to be 51. In 2018, the average rating was estimated at 57 (nationally it was estimated to be 60).

[11] Ibid

3. Between the censuses of 2001 and 2011 the number of households without central heating reduced from 16,376 to 6,185.

This sets out a clear agenda for the LEP in working with the construction sector to look at innovative solutions to tackling the challenge of energy inefficient housing and health. PHE data helps provide a more rounded picture of this challenge facing Lincolnshire in the context of a poor quality and expensive housing stock[12]. It tells us:

- Rural house prices are 26% higher than in urban areas and are on average less affordable
- Around 50% homes in the most rural areas and villages are classified as 'non-decent' compared to around 30% in small towns and urban areas.
- Around 50% houses in the most rural areas and 25% in village centres are 'energy inefficient' compared with 7% in urban areas.
- 2 in 5 homes in rural areas are off the gas grid and have to rely on expensive fuel options

4. ***Put the UK at the forefront of the design and manufacturing of zero emission vehicles, with all new cars and vans effectively zero emission by 2040*** - The dispersed settlement pattern in Lincolnshire and its resulting distribution of vulnerable people from a health and care position lead to a more significant carbon footprint than in many more urban settings. This manifests itself in terms of both acute care journeys and more routine treatment and support for vulnerable people, particularly in terms of adult social care.

   There is scope to build a zero emissions agenda into the development of new transport approaches to the delivery of health and care in Lincolnshire taking account of its additional carbon footprint driven by the sparsely populated nature of the county. A current study of rural mobility challenges for Midlands Connect by the University of Lincoln has identified a number of travel options relevant to rural travel in future scenarios. This provides a very useful starting point for assessing options in this context. It has identified the following emerging issues/opportunities:

   - Co-ordination of transport budgets, infrastructure and existing transport provision: Maximise the value of what's already there
   - Digital mechanisms to reward providers of lift-shares (UBER) - digital payment infrastructure that tracks per mile travelled in a registered car share. Automated payments on a cost-share basis. Rates set by the scheme to avoid profiteering. Scheme provides safeguarding and vetting of participants.
   - Vehicle loan schemes e.g. wheels to work. Broaden the scope, capitalise on the added value of these schemes.
   - Tackling "The last mile": Create transport hubs/interchanges; Make waiting more social, comfortable or usable time Integrate transport information & potentially other rural info hubs e.g. https://mobihubs.eu/
   - E-learning; E-health and Tele-working: Infrastructure and support to mainstream these technologies and use across rural places - check-in system for homeworkers to use local business hubs - "help points" to empower tech adopters
   - Goods delivery: Identify opportunities for village retailers to provide distinctive offers: align rural services with delivery hubs.

[12] Public Health England – Midlands Rural Seminar July 2018

- Rural tourism & eco-tourism. Link rural attractions more effectively & use smart data techniques to model tourist travel demands
- Behavioural shifts: incentivise public transport use – wifi on buses
- Autonomous drones to fly people everywhere...

All these issues provide a context for innovation in terms of the health and care agenda in Lincolnshire as an incubator for the design and deployment of zero carbon vehicles.

5 Additional Context and Issues

5.1 The Long Term Plan

The NHS Long Term Plan effectively sets the agenda for the health part of the health and care equation. It should not be seen as the only driver however as private sector and self funded activities also form part of the wider context. It is however crucially important.

The plan sets clinical priorities (Cancer, Cardiovascular, maternity, neo-natal, mental health, stroke, diabetes and respiratory illness). It puts an enhanced focus on community activities backing them with additional resources and creating the core building block for community led interventions centred on GPs through Primary Care Networks based on population thresholds of around 50,000 people. The plan renews previous commitments to address mental health challenges with a particular focus on young people.

The plan introduces a number of innovations in terms of acute services including the roll out of Urgent Treatment Centres and Same Day Emergency Care. It commits to further activity to reduce the challenged of delayed discharges. The plan identifies workforce as the greatest challenge facing the NHS and commits to actions including a renewed commitment to provide 1500 additional medical school places, increase levels of staffing in other key professions and enhance the support and engagement of volunteers.

The plan makes a significant commitment to digital provision of services. By the end of the 10 year period covered by the plan the vision is for people to be increasingly cared for and supported at home. The plan also commits to enhancing leadership support and deepen the culture of care and compassion within the NHS. It makes a renewed statement about the importance of patient involvement.

Of particular relevance to the plan is the commitment to the development of enhanced cross working through the development of Integrated Care Systems by April 2021 to replace the current STPs. The plan also has a very strong focus on population health and the planning and development of activities to tackle health inequalities.

Disappointingly the plan makes very limited reference to rural issues subsuming this agenda more generically within the context of place based planning to address health inequalities.

5.2 Interim People Plan

The Interim People Plan (June 2019), led by Baroness Dido Harding Chair of NHS Improvement, takes on the acknowledgement of workforce as the greatest challenge facing the NHS. It sets out 5 key priorities:

1. Making the NHS the best place to work – through policies which are positive and inclusive
2. Improving leadership – through investment in leadership programmes of development and support
3. Addressing the acute nursing shortage – through a range of focused training and recruitment interventions
4. Providing 21 Century Care – through embracing technology
5. Developing a new operational model – linked to the implementation of the ICS agenda

Most positively within this document is the acknowledgement of the need for a programme of targeted interventions to address the shortage of GPs and other professions specifically in rural and coastal settings.

5.3 Our Response (Workforce)

Considering the issues not emerging in detail from the lens of the Grand Challenges in relation to the Greater Lincolnshire LEP focus on health and care we believe that our additional priority emerging from these documents should be on supporting workforce interventions. The National Centre for Rural Health and Care recently wrote to Baroness Harding in the context of the rural priorities within the Interim People Plan and we believe the issues it identified (set out below) provide a very clear focus for the development of local action. Namely:

There are fewer NHS workers per head of population in rural areas as a consequence of recruitment and retention issues – this needs to be addressed as it is a major driver of rural health inequalities. The situation is exacerbated by the fact that rural local authorities also have less to spend per head of population on the provision of social care.

These challenges can be tackled in part by increasing the scale of the new roles which have arisen over the last decade for example, prescribing pharmacists, physician associates and nursing associates. This will help to broaden the pool of professionals available in rural settings.

A second area of focus could involve developing opportunities for entry to and personal development within key professions through non-traditional routes. A number of Royal Colleges have made some strides in this direction but they need to be encouraged to significantly scale up their work around these activities. In rural areas this could unlock a considerable reservoir of skill and talent from people who don't fit the traditional entry profile for health and care.

A third area of action should involve recognising, particularly in view of the increasing acuity of home care, the value of social care as a profession in terms of training, development and parity of esteem for individuals working in these settings. In rural areas this would increase the capacity and range of workers to address the additional challenges faced due to the dispersed nature of vulnerable people.

Fourthly we believe more focus should be given to significantly and rapidly embracing the concept of a whole community approach to delivering health and care. Part of this agenda, will be delivered by the roll out of Primary Care Networks. On their own they will not make enough difference. Strategies for engaging the Voluntary and Community Sector more substantively in prevention and community

care are important. Initiatives such as Healthier Fleetwood are examples of great practice: http://www.healthierfleetwood.co.uk/ Where, as a consequence of sparsity, there are fewer resources to support individuals, initiatives such as this enhance joint working and more effectively align all the assets in a community.

Finally there is no evidence of rural proofing in the way the NHS applies itself to its workforce strategies. The National Centre for Rural Health and Care is currently developing a rural proofing toolkit for health and social care and we would welcome the opportunity to engage with the NHS in more detail as this work proceeds

6 Place Perspectives

The Joint Strategic Needs Assessments for Lincolnshire, North and North East Lincolnshire identify a number of key health hotspots. Coastal settings are particularly challenged in terms of:

- A skewed ageing demographic profile
- A lack of clinical staff
- A significantly higher than average level of poor health behviours

There are also pockets of poor health outcomes in the major settlements in the LEP area in Grimsby, Lincoln and Scunthorpe.

Overall there is a clear North and East versus South and West divide in terms of relatively poor and better health outcomes in the LEP geography.

On the most positive side of the equation Lincoln has a significant cluster of medical expertise including at the University of Lincoln a School of Life Sciences and Pharmacy, a new Medical School and a Science and Innovation Park. The City is also host to the National Centre for Rural Health and Care.

7 Next Steps

7.1

	Actions to be taken by Greater Lincolnshire LEP and partners	**How government could assist in this theme**
Workforce	Enhanced activities to align the activities of the LEP Employment and Skills Board and the Lincolnshire Workforce Action Board within the NHS – to plan and implement innovative activities to address the workforce challenges facing the LEP area.	

Innovation	Develop Lincolnshire as an international centre for innovation (in terms of technology, systems and digital) in the context of rural health and care in partnership with East Midlands AHSN and the National Centre for Rural Health and Care.	
Business Development/ Organisational Development	A programme of business development to build the capacity and capability of those VCS organisations crucial to the effective roll out of the ICS agenda in Greater Lincolnshire.	
Housing	Support actions to address the poor quality of the current housing stock where it exists and to look at work to help bring forward an adequate supply of housing opportunities particularly in relation to extra-care which will enable more people to live sustainability at home for longer	
Transport	Explore Lincolnshire as a test bed for the trialling of zero carbon transport solutions to address the significant travel requirements associated with its distributed pattern of those receiving health and care support	

Inequalities	Develop a pattern of planned interventions in partnership with the NHS to look at solutions to addressing the prevention agenda where it is most prevalent in settings such as the Lincolnshire Coast and our main towns/City	

7.2 How we want to work with HMG

Working with HMG will add value to our Health and Care programme by ensuring that the actions we deliver locally are aligned with government investment and policy. This will enable Greater Lincolnshire to both secure support for its interventions, and to act as a testbed for the rural health and care sector development programmes which could then be utilised in other LEP areas.

The LEP is keen to build on its established links in HMG to develop the additional and focused interventions highlighted in this paper. These will allow Greater Lincolnshire to take the lead with government on delivering the transformational change needed in the delivery of the Long Term Plan in the context Health and Care in Lincolnshire. This will directly benefit Greater Lincolnshire's productivity through reducing health inequalities and helping realise the ambition around longer and better life expectancy linked to the Ageing Society Grand Challenge in the Industrial Strategy.

Greater Lincolnshire is keen to engage with the following government departments and agencies for the Health and Care agenda part of the LIS:

- DHSC with a focus on addressing the workforce challenges (in the context of the Interim People Plan) and realising the opportunities around the digital and technology agenda set out in the Long Term Plan
- DEFRA, with a focus on the development of a rural health and care rural proofing toolkit which could be piloted in Lincolnshire
- BEIS, with a focus on teams responsible for Universities around the development of our innovation proposals
- DfE, with a focus on workforce development
- DfT about the development of Lincolnshire as a test bed for the trialling of zero carbon transport solutions to address the significant travel requirements associated with its distributed pattern of those receiving health and care support.

7.3 Wider Partnership Opportunities

Through the national perspective of the National Centre for Rural Health and Care we are aware of opportunities to partner with other areas who have piloted successful approaches to a number of the challenges set out above namely:

Shropshire Council in relation to its consideration of the role modular housing can play to respond to the specific housing needs of older people

Somerset Council in relation to the development of micro-business approaches to the provision of adult social care in rural settings

We propose to pursue these joint working and learning opportunities in more detail