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Lincolnshire COUNTY COUNCIL *Working for a better future*		**THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE**	
Boston Borough Council	East Lindsey District Council	City of Lincoln Council	Lincolnshire County Council
North Kesteven District Council	South Holland District Council	South Kesteven District Council	West Lindsey District Council

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Democratic Services
Lincolnshire County Council
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Newland
Lincoln LN1 1YL

A Meeting of the Health Scrutiny Committee for Lincolnshire will be held on Wednesday, 23 July 2014 at 10.00 am in Committee Room One, County Offices, Newland, Lincoln LN1 1YL

MEMBERS OF THE COMMITTEE

County Councillors: Mrs C A Talbot (Chairman), R C Kirk, C E H Marfleet, S L W Palmer, Miss E L Ransome, Mrs S Ransome, T M Trollope-Bellew and Mrs S M Wray

District Councillors: Dr G Samra (Boston Borough Council), N D Cooper (East Lindsey District Council), C Burke (City of Lincoln Council), Miss J Frost (North Kesteven District Council), C J T H Brewis (South Holland District Council (Vice-Chairman)), Mrs R Kaberry-Brown (South Kesteven District Council) and M G Leaning (West Lindsey District Council)

Healthwatch Lincolnshire: Dr B Wookey

AGENDA

Item	Title	Pages	Estimated Time
1	**Apologies for Absence/Replacement Members**		
2	**Declaration of Members' Interests**		
3	**Chairman's Announcements**		
4	**Minutes of the Meeting held on 25 June 2014**	5 - 16	

Item	Title	Pages	Estimated Time
5	**Burton Road GP Surgery, Lincoln** *(To receive a report by Di Pegg (Head of Primary Care, NHS England, Leicestershire and Lincolnshire Area Team), which invites the Committee to consider and comment upon the update on the future arrangements for the Burton Road Surgery and the current state of progress. David Sharp (Director) and Di Pegg (Head of Primary Care) of NHS England, Leicestershire and Lincolnshire Area Team, will both be in attendance)*	17 - 26	10.15 am
6	**Care Quality Commission - Review of Health Services for Children Looked After and Safeguarding in Lincolnshire** *(To receive a report by Jan Gunter (Designated Safeguarding Nurse, South West Lincolnshire Clinical Commissioning Group), which invites the Committee to consider and comment on the 'Review of Health Services for Children Looked After and Safeguarding in Lincolnshire', published by the Care Quality Commission on 21 February 2014, the associated Action Plan and any progress to date. The Designated Safeguarding Nurse will be in attendance)*	27 - 92	11.30 am
7	**Healthy Lives, Healthy Futures - A Consultation by North Lincolnshire and North East Lincolnshire Clinical Commissioning Groups** *(To receive a report by Simon Evans (Health Scrutiny Officer), which invites the Committee to determine whether it wishes to respond to the 'Healthy Lives, Healthy Futures' a consultation by North Lincolnshire and North East Lincolnshire Clinical Commissioning Groups and then to establish a working group to draft a response)*	93 - 100	12.30 pm
8	**Local Authority Health Scrutiny - Guidance to Support Local Authorities and Their Partners to Deliver Effective Health Scrutiny** *(To receive a report by Simon Evans (Health Scrutiny Officer), which invites the Committee to consider and comment on the content of 'Local Authority Health Scrutiny – Guidance to Support Local Authorities and Their Partners to Deliver Effective Health Scrutiny', issued by the Department of Health on 27 June 2014)*	101 - 108	12.40 pm
9	**Quality Accounts 2014** *(To receive a report by Simon Evans (Health Scrutiny Officer), which invites the Committee to note the statements on eight Quality Accounts, relating to providers of local NHS-funded services)*	109 - 130	12.50 pm

Item	Title	Pages	Estimated Time
10	**Work Programme** *(To receive a report by Simon Evans (Health Scrutiny Officer), which invites the Committee to consider its work programme for the coming months)*	131 - 138	12.55 pm

Tony McArdle
Chief Executive
15 July 2014

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Lincolnshire COUNTY COUNCIL
Working for a better future

HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE
25 JUNE 2014

PRESENT: COUNCILLOR MRS C A TALBOT (CHAIRMAN)

Lincolnshire County Council

Councillors R C Kirk, S L W Palmer, Miss E L Ransome, Mrs S Ransome, T M Trollope-Bellew and Mrs S M Wray.

Lincolnshire District Councils

Councillors Dr G Samra (Boston Borough Council), C Burke (City of Lincoln Council), Miss J Frost (North Kesteven District Council), C J T H Brewis (South Holland District Council (Vice-Chairman)), Mrs R Kaberry-Brown (South Kesteven District Council) and M G Leaning (West Lindsey District Council).

Healthwatch Lincolnshire

Dr B Wookey.

County Councillors B W Keimach (Executive Support Councillor for NHS Liaison and Community Engagement), R B Parker (who was seeking permission to speak in relation to an issue in his division), R Hunter-Clarke and Mrs J M Renshaw and District Councillor J Kirk (City of Lincoln Council) were also in attendance.

Also in attendance

Simon Evans (Health Scrutiny Officer), Nicole Hilton (Head of Community Engagement & Vulnerable People), Dr Suneil Kapadia (Medical Director, United Lincolnshire Hospitals NHS Trust), Andy Leary (Director of Finance and Commissioning, NHS England Leicestershire and Lincolnshire Area Team), Lynne Moody (Executive Nurse & Quality Lead, South Lincolnshire Clinical Commissioning Group), Di Pegg (Head of Primary Care, NHS England Leicestershire & Lincolnshire Area Team), Tracy Pilcher (Executive Nurse, Lincolnshire East Clinical Commissioning Group), Caroline Walker (Interim Chief Executive), Chris Wilkinson (Director of Care Quality and Chief Nurse) and Catherine Wilman (Democratic Services Officer).

12 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

Apologies were received from Councillor C E H Marfleet and District Councillor N D Cooper.

13 DECLARATION OF MEMBERS' INTERESTS

No interests were declared.

14 CHAIRMAN'S ANNOUNCEMENTS

The Chairman welcomed Councillor Chris Burke to his first meeting of the Health Scrutiny Committee for Lincolnshire as the representative of the City of Lincoln Council.

i East Midlands Ambulance Service – Additional Information

The Chairman referred to Minute 7 of the minutes from the last meeting which related to Improvements and Performance of the East Midlands Ambulance Service. Information on three outstanding questions in the minutes was emailed to members of the Committee on 2 June. On the same evening, this information had been forwarded to a member of the public by one of the recipients of the email.

Whilst it had been subsequently clarified that the information provided by EMAS and included in the email was in the public domain, the Chairman expressed her disappointment that someone had shared this information without first checking whether it was of a public or confidential nature. Furthermore, the Chairman was worried that this would have an impact on what colleagues from the NHS would share with the Committee in future, as they may fear that information would be passed on indiscriminately. She acknowledged that most members of the Committee exercised discretion with the information which they received, but she urged all members to adopt a discreet approach in the future.

ii East Midlands Ambulance Service – Estates Strategy Clarification

The Chairman again referred to Minute 7 of the minutes from the meeting on 21 May. Since the publication of these minutes, Sue Noyes had asked the Chairman to clarify that the estates programme had been paused at the end of 2013 whilst the organisation focused on stabilisation of response times. The estates strategy was currently being reviewed, taking account of the feedback received from staff and the public. EMAS would make a statement at the end of June, with a revised estates strategy being prepared for September 2014. In the meantime, community ambulance stations, which provided facilities for crews to stop off at whilst they were out on the road, were continuing to be implemented.

iii New Review of Congenital Heart Services

On Friday 30 May, the NHS England Congenital Heart Services Review Team visited the East Midlands Congenital Heart Centre at Glenfield Hospital in Leicester as part of the new Review of Congenital Heart Services. The Review Team from NHS England had been visiting all congenital heart centres in England. These visits had been an opportunity for the Review Team to update the clinical teams, patients and parents about the review; to hear from each Trust about their particular functions; and to listen to staff and patients.

The Chairman had been advised that the visit to Glenfield had gone well and was a good opportunity to meet the key people leading the review. This was in the light of the Ministerial announcement about the delay to the consultation period of the review as there had been some slippage in the timetable.

A further meeting would be arranged at the end of July or early August by the University Hospitals of Leicester NHS Trust to consider its plans for expansion of the unit.

iv New Heart Device in Lincolnshire

On 23 May, United Lincolnshire Hospitals NHS Trust announced that a new device to help monitor a patient's heart had been used for the first time in Lincolnshire at Lincoln County Hospital.

Currently, heart monitoring devices required surgical implantation in a procedure that could take up to 45 minutes. Patients then had to attend hospital for their device to be monitored. However, a team at the Lincolnshire Heart Centre (LHC) at Lincoln County Hospital had implanted the first of a new type of device that is “injected” into the chest wall under local anaesthetic in a procedure that takes approximately 15 minutes.

The new technique had many advantages including less pain and discomfort for the patient, smaller scars and a shorter hospital stay. The new devices would allow cardiologists to monitor patients' hearts remotely via the mobile phone network, which would mean fewer trips to hospital and earlier identification of serious heart rhythm abnormalities.

v Quality Accounts

The Joint Health Scrutiny Committee and HealthWatch Lincolnshire Quality Accounts Working Group had been compiling statements on the quality accounts of eight local providers of NHS funded services. The final two statements would shortly be prepared on St Barnabas Hospice Trust and Boston West Hospital. All Committee statements would be circulated with the agenda for the next meeting.

vi Care Data - “Better Information Means Better Care”

In April 2014, the Committee considered an item on care data and agreed that the Chairman would write to Tim Kelsey, National Director for Patients and Information at NHS England, outlining the Committee's concerns. The Chairman had received a reply, which confirmed that NHS England was currently in a “listening” phase for the project and was receiving views from a range of groups.

In her letter, the Chairman had suggested that communication with patients be by letter rather than in the form of leaflet or flyer. Mr Kelsey stated that a letter was one method, which was being considered for implementation. The Committee also asked Mr Kelsey to consider the independent status of the Confidentiality Advisory Group, in

particular the need for lay member involvement. Mr Kelsey referred to the membership of the Confidentiality Advisory Group being defined in law, but supported the need for the Group to be independent. The Committee also raised the issue of accessibility and security of data. In response, Mr Kelsey had stated that the Health and Social Care Information Centre implemented "industry standard best practice" in its systems and would continue to do so.

On 17 June, a review report on previous releases of data by the former NHS Information Centre between April 2005 and March 2013 was submitted to the Health and Social Care Information Centre Board. This followed earlier reports in the national media on the release of data. The review report concluded that the system did not have the checks and balances needed to ensure that appropriate authority was always in place before data was released and there were too many disparate and disjointed processes for the sharing of data. As a result of these findings, nine recommendations were made, which had been accepted by the Health and Social Care Information Board.

vii Northern Lincolnshire and Goole NHS Foundation Trust

On 19 June, the Scunthorpe Telegraph reported on a series of care concerns, which mainly related to Scunthorpe General Hospital following the releas of information by North Lincolnshire Clinical Commissioning Group. The investigation indicated that one patient had died at Scunthorpe General and a second patient at Diana, Princess of Wales Hospital, Grimsby.

Northern Lincolnshire and Goole NHS Foundation Trust, which ran the two hospitals, stated that it was part way through a very thorough internal investigation into a potential small cluster of patient incidents, which would conclude in early July 2014. The Trust also stated that patient safety and good quality care was a priority for every employee at its hospitals and all its internal audits and external inspections had shown it met Care Quality Commission standards.

viii NHS Choices Website

On 24 June, the Department of Health launched a new microsite within the NHS Choices website, which provided patient safety information about each hospital in England. The seven safety indicators:

- Infection control and cleanliness;
- Compliance with Care Quality Commission standards;
- Whether the hospital is recommended by its staff;
- Safe staffing;
- Whether patients are assessed for bloodclots;
- Whether the hospital has any NHS England patient safety notices;
- Open and honest reporting.

The webpage from which information could be found was www.nhs.uk/safety/search/

15 MINUTES OF THE MEETING HELD ON 21 MAY 2014

RESOLVED

That the minutes of the meeting held on 21 May 2014 be agreed as a correct record and signed by the Chairman subject to the addition of the following wording in Minute 3, as follows:

"Councillor Miss E Ransome was appointed as a permanent member replacing Councillor C E D Mair".

16 NHS ENGLAND: LEICESTERSHIRE AND LINCOLNSHIRE AREA TEAM DIRECT COMMISSIONING RESPONSIBILITIES

Consideration was given to a report which presented information on the activities of NHS England, Leicestershire and Lincolnshire Area Team.

Andy Leary, Director of Finance and Commissioning and Di Pegg, Head of Primary Care both from NHS England Leicestershire and Lincolnshire Area Team were present for this item.

Andy Leary gave an introduction to NHS England and his role within it. During this, the following points were noted:

- NHS England was a national organisation with one strategic board. Its operating base was in Leeds;

- There were four regional tiers with 27 area teams in total. The Leicestershire and Lincolnshire Area Team came under the Midlands and East tier along with 7 other area teams;

- The national team covered a number of directorates:
    - Operations and Delivery;
    - Nursing;
    - Informatics (information management, knowledge management, information and communication technology);

- Each area team had three fundamental roles:

    - Direct commissioning of hospital care services - £1.4billion of funding which was mainly spent on specialist services. Services came from a range of organisations and also from hospitals. Ten area teams undertook a commissioning role across the country;

    - Primary Care – paramedical, pharmaceutical, ophthalmic and dental services came under this heading for which £400million was available. These services were returned to NHS England in 2013 when some services were transferred to local government;

- System Convener – This role was as a system leader/manager, improving the quality of care for NHS organisations.

- The Area Team was represented on the Health and Wellbeing Board and participation with the Lincolnshire Health and Care Programme. They had also developed relationships with other organisations like Healthwatch.

In response to questions from the Committee, the following was confirmed;

- GP appointment waiting times were monitored jointly with the CCGs in Lincolnshire to ensure timings at surgeries were satisfactory;
- The size of the area teams had been determined to a greater extent by population;
- Measuring the effect of NHS England on the healthcare received by people in Lincolnshire was not undertaken directly by NHS England. However the CCGs had a range of clinical indicators to measure whether improvements were being made;
- Members felt that there were a number of complexities within the NHS England organisation within the NHS;
- NHS England had a responsibility to ensure the services commissioned provided patient care to the same standards in all geographical areas;
- The Care Quality Commission existed as a national body to ensure that healthcare providers were meeting national standards. The CQC had an inspection and enforcement role. NHS England's role was to contract providers to do a certain job, with a certain amount of money in a certain time period. It would be CQC's role to take action if standards were not being met.

The Chairman reflected that the Government had spent some £4 billion on reorganising the NHS, however the system seemed even more confusing than before and accountability was not always clear. Andy Leary responded that there was a mandate between NHS England and the Department of Health and essentially, NHS England was required to ensure the mandate was delivered.

The Committee agreed to invite David Sharp, the Director of the Leicestershire and Lincolnshire Area Team at NHS England to a forthcoming Committee, to cover broader Area Team issues.

RESOLVED

1. That the information presented in the report on the activities of NHS England Leicestershire and Lincolnshire Area Team be noted;

2. That David Sharp be invited to a forthcoming meeting of the Committee.

17 BURTON ROAD SURGERY, LINCOLN

Consideration was given to a report which outlined the details of the consultation on the future arrangements for the Burton Road Surgery in Lincoln, which had approximately 2,700 patients at the end of May 2014. Andy Leary and Di Pegg from

NHS England were present for this item.

The Chairman expressed her disappointment at how the closure of Burton Road Surgery had been handled. An initial letter, dated 27 May 2014, outlining closure plans for the surgery, had been sent to patients registered at the surgery addressed to “The Occupier”. However, following this, a statement had been released by NHS England on 5 June 2014, stating they had not yet made a final decision to close it. At no point had a consultation with patients been conducted.

At a meeting of Lincoln City Council the previous day, a motion had been passed urging NHS England to examine alternatives to the closure, ensure all patients were kept informed, carry out meaningful consultation and ensure decisions made were transparent.

The Committee felt:

- The way in which NHS England had dealt with the situation was unacceptable;
- There appeared to be a lack of preparation for meeting with the Committee, with no facts or figures to hand;
- If patients had been informed the practice was closing, what incentive would there have been to respond to a consultation;
- There was a duty of care to patients, to ensure they were able to reach an alternative surgery easily and safely;
- The other contracts coming to an end needed attention to ensure the same pattern was not repeated;
- As the provider of the service, Lincolnshire Community Health Services (LCHS) was not present to provide its views of the situation.

It was agreed that Councillor R B Parker, County Councillor for Lincoln West, the division in which Burton Road Surgery was located, would be permitted to address the Committee:

- Ordinary people felt powerless when confronted by the NHS. It had a heavily managerial framework, but there were not many references to value;
- If there had been no other services in the area, would the contract still have come to an end?;
- The initial letter began with the words “after careful consideration...” however, this didn't seem to be the case;
- As well as the letters not being personally addressed, there were some patients of the surgery who didn't receive a letter at all;
- If there were substantial changes to delivery of services, surely another decision process needed to be gone through.

Following extensive questioning to the NHS England representatives, the following was confirmed:

- The contract for Burton Road Surgery was time limited and originally due to expire in March 2014. NHS England had sought to negotiate an extension to

the contract, until 1 October 2014, for this surgery and four others in the same situation;

- LCHS were the current providers of the service;
- During the time of the extension, NHS England would seek an alternative provider or find another surgery willing to take over as caretakers until an alternative provider could be found. Once this situation was clearer, another consultation exercise would be undertaken;
- Di Pegg agreed that communication with the public and patients of the surgery could have been handled better;
- A decision had been made to continue accepting new patients at the surgery so it would be more attractive to a potential new contractor;
- The NHS England representatives would be meeting with existing practices in the area to inform them of the circumstances;
- Approximately 200 patients had moved to other GP surgeries;
- On being informed that the contract was coming to an end, earlier than expected, NHS England tried to act quickly in the three months they were given. In hindsight, they admitted they had not handled it well. Their main aim was to have a service ready by 1 October 2014.

It was agreed that the Committee would make a response to the consultation, outlining the Committee's concerns.

In conclusion, the Committee agreed for the Chairman to request an urgent meeting with Dr David Sharp, Director of Leicestershire and Lincolnshire Area at NHS England and Andrew Morgan, Chief Executive of LCHS.

RESOLVED

1. That the Committee submit a response to the consultation expressing its concerns over the proposed closure and supporting the retention of GP services from Burton Road Surgery;

2. That Andrew Morgan and David Sharp be invited to attend the next meeting of the Committee on 23 July;

3. That the Chairman convenes an urgent meeting with Andrew Morgan, Chief Executive of LCHS and Dr David Sharp of NHS England.

18 UNITED LINCOLNSHIRE HOSPITALS NHS TRUST - A FIVE YEAR STRATEGY FOR CLINICAL SERVICES AT UNITED LINCOLNSHIRE HOSPITALS NHS TRUST - 2014-2019

On 4 March 2014, United Lincolnshire Hospitals NHS Trust (ULHT) Board approved a Five Year Strategy for Clinical Services at United Lincolnshire Hospitals NHS Trust – 2014-2019. Dr Suneil Kapadia, the Medical Director for the Trust was welcomed to the meeting and presented the five year strategy to the Committee.

The presentation covered the following areas:

- The case for change: ULHT models of clinical care had to change;
- Future service model;
- Areas currently under pressure;
- Clinical Strategy for ULHT: to focus on emergency care in order to reconfigure services;
- Emergency care networks;
- Emergency Centres and one Major Emergency Centre;
- Interdependencies with Major Emergency Centre;
- Interdependencies with Emergency Centres;
- Interdependencies with Urgent Care Centres;
- Less critical services;
- Clinical strategy for ULHT;
- Our assumptions;
- Priorities.

In response to questions from Members, the following was confirmed by Dr Kapadia and Tracy Pilcher:

- Community hospitals did not come under ULHT's remit. They were run by LCHS. The Strategy dealt with acute services and was attempting to balance services between district, general and community hospitals;
- There was a funding deficit across Lincolnshire. Lincolnshire Health and Care Programme was developing proposals to redesign health services in Lincolnshire;
- Staff preferences would be taken into account if moving services to a different location meant moving long-serving staff also;
- Representatives from the CCGs attended meetings to ensure residents' views were heard.

The Chairman thanked Dr Kapadia for attending the Committee.

RESOLVED

That consideration be given to the content of *A Five Year Strategy for Clinical Services at United Lincolnshire Hospitals NHS Trust – 2014-2019.*

19 CLINICAL COMMISSIONING GROUP - ANNUAL REPORTS AND ACCOUNTS 2013-2014

Consideration was given to a report which provided information on the four Annual Reports and Accounts of the Clinical Commissioning Groups in Lincolnshire.

The Annual Reports were physically substantial documents and Members were advised to only read the report which related to their areas.

RESOLVED

1. That the publication of the Annual Reports and Accounts of the four Clinical Commissioning Groups in Lincolnshire be noted;

2. That the content of the patient focused elements of the Annual Reports and accounts be used to inform the Committee's work programme.

20 WORK PROGRAMME

The Committee considered its work programme for the Committee's meetings over the next few months.

It was noted that the Lincolnshire and Nottinghamshire Air Ambulance would be invited to Committee to see how their work affected ambulance response times in Lincolnshire.

Lincolnshire Health and Care needed to be removed from the work programme as it was unlikely to be ready for consultation by September 2014. However, one element of the Lincolnshire Health and Care Programme would continue and that was the implementation of neighbourhood team pilot sites which were at Stamford, Skegness, Sleaford and Lincoln City South. There would be no need for a full three month consultation on these proposals, if other elements of the programme did not go forward.

RESOLVED

That the work programme and changes made therein be noted.

NOTE: At this stage in the proceedings, the Committee adjourned for lunch. On return, the following Members were in attendance: -

County Councillors

Councillors Mrs C A Talbot (Chairman), R C Kirk, Miss E L Ransome, Mrs S Ransome, S L W Palmer, T M Trollope-Bellew, Mrs S M Wray.

District Councillors

Councillors C J T H Brewis (Vice-Chairman) South Holland District Council), C Burke (City of Lincoln Council), Miss J Frost (North Kesteven District Council), Mrs R Kaberry-Brown (South Kesteven District Council), M Leaning (West Lindsey District Council) and Dr G Samra (Boston Borough Council).

Councillor B W Keimach (Executive Support Councillor NHS Liaison, Community Engagement) was also in attendance.

Officers in attendance

Simon Evans (Health Scrutiny Officer), Caroline Walker (Interim Chief Executive, Peterborough and Stamford Hospitals NHS Foundation Trust), Chris Wilkinson (Director of Care Quality and Chief Nurse, Peterborough and Stamford Hospitals NHS Foundation Trust) and Catherine Wilman (Democratic Services Officer).

21 PETERBOROUGH AND STAMFORD HOSPITALS NHS FOUNDATION TRUST: UPDATE ON DEVELOPMENTS AND ENFORCEMENT ACTIONS

Consideration was given to a report which provided an update on developments and enforcement actions following a CQC inspection at Peterborough and Stamford Hospitals NHS Foundation Trust, as requested by the Committee.

Caroline Walker, Interim Chief Executive and Chris Wilkinson, Director of Care Quality and Chief Nurse both from Peterborough and Stamford Hospitals NHS Foundation Trust were present for this item.

The Committee received a presentation, which covered the following points:

- Action planning process;
- Ensuring safe services;
- Ensuring effective services;
- Ensuring services are caring;
- Ensuring responsive services;
- Ensuring well led services;
- CQC Action Plan Steering Group.

A table contained in the report showed how services had been rated by CQC. All services provided at Peterborough City Hospital and Stamford Hospital had been rated either 'good' or 'requires improvement', with the majority being rated as 'good'. There had been no areas rated with 'non-compliance' or 'requiring immediate change'.

CQC had produced one report per site and one overarching report for the Trust as a whole.

Inspectors had highlighted particular examples of good practice which were:

- Orthopaedic;
- Maternity debrief after birth;
- Mortuary/bereavement services;
- Critical care around ventilator acquired pneumonia;
- 'Flooding the ward' initiative.

During the presentation and discussion that followed, the points below were noted:

- Software to monitor patient bells was being installed which would record details of how long it took for a patient's bedside alarm to be answered and would provide data on each individual bell. It would not be able to tell if a bell

call had been cancelled without a visit, however this would be picked up by intentional rounding in which nurses would visit every patient at hourly intervals;

- Discussion took place regarding patient falls and it was noted that national evidence had seen that falls could not be prevented or predicted. The Trust had attempted to reduce the number of falls and the harm done by installing low rise beds and crash mats in single rooms;
- The Trust provided a multi-faith service with a chaplaincy and had recently employed Muslim representation. In addition, volunteers helped to get patients to chapel and volunteer sitters could be with people at end of life whose families may not be able to be with them;
- Patients could be discharged during the night if necessary and this could help both incoming and outgoing patients; a significant number of overnight discharges were children, as it was better to discharge them home following treatment rather than keep them in hospital unnecessarily;
- Medi-Rest held the contract for cleaning in the hospitals and their work was checked and monitored by the Facilities Team.

Discussion took place regarding the future of the hospital site in Stamford. Architects and building contractors were currently ready and waiting for further instruction once a decision had been made. The site had a mixture of listed and new buildings with an area in the centre which was not fit for use. Some buildings may need to be demolished.

It was agreed a further update could be brought to the Committee at its November meeting.

RESOLVED

That consideration be given to the content of the report and that a further update be brought to the Health Scrutiny Committee for Lincolnshire in November 2014.

The meeting closed at 3.25 pm.

Lincolnshire COUNTY COUNCIL *Working for a better future*		**THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE**	
Boston Borough Council	East Lindsey District Council	City of Lincoln Council	Lincolnshire County Council
North Kesteven District Council	South Holland District Council	South Kesteven District Council	West Lindsey District Council

Open Report on behalf of David Sharp, Director, NHS England Leicester and Lincolnshire Area Team

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**23 July 2014**
Subject:	**Burton Road GP Surgery, Lincoln**

Summary:

The Area Team is considering all available options for the future provision of services at the Burton Road GP Surgery and these include:

- To actively work to see if there is a provider willing to provide the service on an interim caretaking arrangement, which would to allow the Area Team more time to listen and fully consider the views of patients;
- To go out to procurement to see if there is a provider willing to provide the service under an APMS [Alternative Provider of Medical Services] contract;
- To work to close the surgery (as indicated in the letter to patients, dated 27 May 2014) and then help patients to choose another GP practice in the area.

Actions Required:

(1) To consider and comment upon the update on the future arrangements for the Burton Road Surgery and the current state of progress; this is to secure an interim caretaking arrangement from the 1st October 2014.

(2) To ascertain, in the event of no interim provider for the GP surgery being found, what the future prospects are for patients of Burton Road GP Surgery.

1. Burton Road Surgery Lincoln

Background

Leicestershire and Lincolnshire Area Team commissions primary medical services via a number of Alternative Provider of Medical Services (APMS) contracts, which are fixed term contracts. Services delivered from The Burton Road Surgery are provided under an APMS contract. The future provision of these services has been under consideration by the Area Team and as part of that work there has been a review of the current services delivered by these APMS providers.

Leicestershire and Lincolnshire Area Team first wrote to patients registered at the Burton Road Surgery on the 27 May 2014. In that letter they notified patients that the contract for their GP services was due to end and advised them of the closure of the practice on the 30 September 2014.

However, the Area Team also explained that they were seeking patient views about this change and offered the chance to attend two drop-in sessions (both provided on 3 June) and to complete a patient questionnaire (available on line or from the Burton Road Surgery) by 27 June 2014. The closing date for receipt of completed questionnaires was subsequently extended to 4 July 2014.

At the drop-in sessions the Area Team heard from patients how much they value the current service and the Burton Road practice team. The Area Team also acknowledged that their original letter to patients of the surgery had caused confusion and apologised for this.

The Area Team agreed to send a second letter personally addressed to keep patients updated about their future GP services and this was sent on Friday 20 June 2014. A copy of the letter is attached for reference (Appendix A).

The Area Team Director attended a public meeting on 7 July 2014. The media statement, issued following this meeting, is attached for information (Appendix B).

Current Situation

The Area Team is considering all available options for the future provision of services at the Burton Road GP Surgery and these include:

- To actively work to see if there is a provider willing to provide the service on an interim caretaking arrangement, which would to allow the Area Team more time to listen and fully consider the views of patients;

- To go out to procurement to see if there is a provider willing to provide the service under an APMS contract;

- To work to close the surgery (as indicated in the letter to patients, dated 27 May 2014) and then help patients to choose another GP practice in the area.

The Area Team has been keen throughout this process to ensure that patients have had a real opportunity to present their views on the surgery and the proposed future service options. They have asked for expressions of interest from practices that fall within the Burton Road Surgery boundary who may be interested in providing services from the 1 October 2014 on an interim caretaking arrangement. This will enable NHS England to identify the most suitable provider(s) for any short-term caretaking requirement. Interest has been received and the Area Team awaits a formal application for consideration through a 'due diligence' process.

A further patient consultation exercise is planned and the timing of this will be determined once the Area Team knows whether the option to have a caretaker practice is feasible.

However, it is important that the Area Team clearly explains to patients that the option to secure a caretaker practice and the option to procure a new provider may mean that services are delivered from different premises and may impact upon the current practice team.

Once patient consultation has been completed and the Area Team has made a final decision on the outcome of Burton Road Surgery, then they would plan to offer further drop-in sessions for patients.

Capacity

In terms of the capacity of neighbouring practices to accept patients registered with the Burton Road Surgery, there is on-going dialogue with the practices. A meeting was held with all the neighbouring practices on 25 June 2014 and the Area Team will advise practices of any additional support available to them. In addition they are keeping the Lincolnshire Local Medical Committee and the local Clinical Commissioning Group informed of the situation. Patient movements are being regularly monitored by the Area Team in order to understand the impact on neighbouring practices; hence any early indications of any unforeseen problems will be detected. The current practice list size is 2,349 (as at 8 July 2014) and a breakdown of the Burton Road Surgery patient list size is attached at Appendix C. The distribution of Burton Road Surgery patients is attached at Appendix D.

Timeline

The key milestones leading up to the 1st October 2014 are as follows:

- Securing interim caretaking arrangements – an outcome should be known by 1 August 2014;
- Patient consultation on the options for future service provision - due to commence after 1 August for a six week period;
- Informed by the outcome of the patient consultation exercise, a decision on the future provision of services for the surgery's patients will be made by the end of September 2014.

2. Conclusion

The Committee is asked to consider and comment on the update on the future arrangements for the Burton Road Surgery and the current state of progress; this is to secure an interim caretaking arrangement from the 1 October 2014.

3. Consultation

NHS England is in the process of identifying the most suitable provider(s) for any short-term caretaking requirement. A further patient consultation exercise is planned and the timing of this will be determined once the Area Team knows whether the option to have a caretaker practice is feasible.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Letter to Burton Road GP Surgery Patients - 20 June 2014
Appendix B	Media Statement 9 July 2014
Appendix C	Burton Road Surgery - Patient List Size Breakdown By Gender and Age
Appendix D	Distribution of Burton Road Surgery Patients

5. Background Papers

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

This report was written by Di Pegg, who can be contacted via Di.Pegg@nhs.net

APPENDIX A

(Leicestershire & Lincolnshire Area)
Cross O Cliff Court
Bracebridge Heath
LINCOLN
LN4 2HN

Tel: 01522 513355
Fax: 01522 515382

Dear

Re: Burton Road Surgery, 181 Burton Road, Lincoln, LN1 3LT

This letter is an update to the recent letter dated 27th May 2014 about the review being carried out into how GP services will be provided for patients of the Burton Road Surgery in the future.

NHS England has already heard from a number of patients about how much they value the current service and the Burton Road practice team. It has also become clear that our original letter to patients of the surgery has caused some confusion and we want to put that right.

We are currently exploring the options available to us to provide future services. One option is to close the surgery and we would then help patients to choose another practice in the area. Another option is to see if there is a provider willing to provide the service, which may be delivered from different premises and may impact on the current practice team. This would allow NHS England time to listen and fully consider the views of patients before making a final decision on the future provision of services from Burton Road Surgery.

We are keen throughout this process to ensure that patients have had an opportunity to present their views on the surgery and the proposed future service options.

We would like to remind you if you have not already done so you can do so via a questionnaire which is available on line at https://www.surveymonkey.com/s/VT7VKXJ or by picking up a copy from the Burton Road surgery itself. There is room at the end of the questionnaire to add comments and we would encourage patients to take this opportunity to share their views with us.

Our priority remains to ensure the best possible solution is found for the provision of services for the surgery's patients. We would like to reassure you that all patients' views will be fully considered before any final decision is taken.

We will be in contact with you again soon so that you know what is happening about future GP services for patients of the Burton Road Surgery.

If you have any questions about the content of this letter, please contact the team on 0116 295 7610 or 0116 295 0829 (Monday to Friday 9am to 5pm) or email your query to england.leiclincsmedical@nhs.net

Yours Sincerely

Judy Patrick
Medical and Pharmacy Lead Lincolnshire

Wednesday 9 July 2014

STATEMENT

Dr David Sharp, Area Director for NHS England (Leicestershire and Lincolnshire) said:

"I appreciated the opportunity to hear directly from patients about their concerns regarding Burton Road at the meeting on Monday evening (7 July).

"As I explained at the meeting, I am concerned to ensure patients understand our plans for primary care services in Lincolnshire. Our priority is to ensure the best possible solution is found for the provision of future services for the surgery's patients, and I want everyone to be clear about the reasons behind any decisions moving forward.

"Both NHS England and Lincolnshire Community Health Services NHS Trust are committed to working together to make sure that patients are consulted and remain clearly informed about what is happening with the Burton Road Surgery. We will be undertaking a further consultation process with patients after my presentation to the Health and Scrutiny Committee for Lincolnshire on 23 July. "

ENDS

Notes to editors

NHS England is the body which leads the NHS in England. Its main aim is to improve the health outcomes for people in England, and it will set the overall direction and priorities for the NHS as a whole.

For further information, please e-mail media.hub@nmecomms.nhs.uk or call 07824 463578.

APPENDIX C

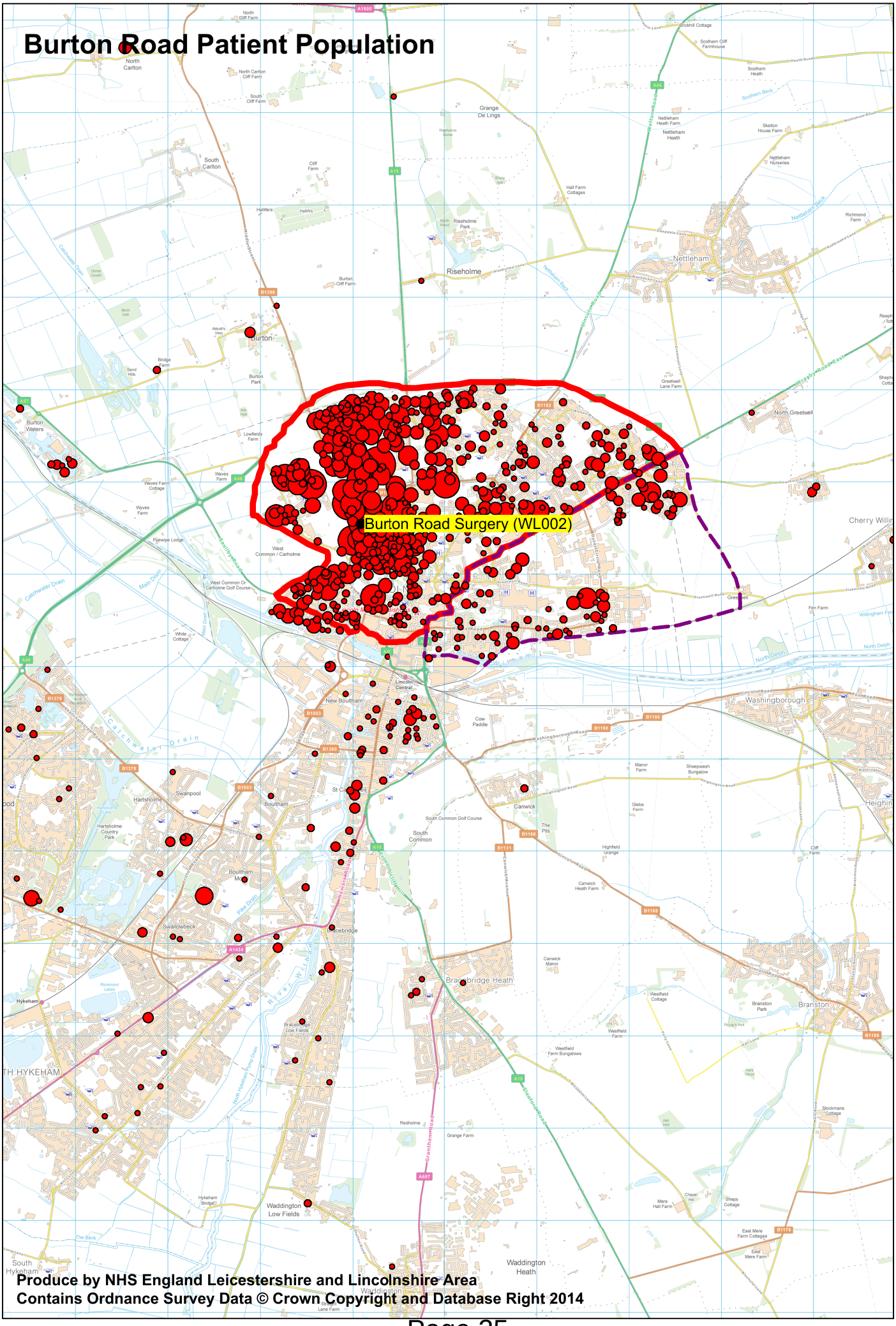
Appendix C - Burton Road Surgery Patient List Size Breakdown – By Age and Gender

Patient List Size Breakdown as at 1st April 14			00-04	05-14	15-24	25-34	35-44	45-54	55-64	65-74	75+	Total	%Total
Burton Rd.	C83615	Females	83	128	168	259	172	171	160	114	110	1365	49%
		Males	91	149	142	269	192	188	165	111	89	1396	51%
		Total	174	277	310	528	364	359	325	225	199	2761	
			6%	10%	11%	19%	13%	13%	12%	8%	7%	100%	

Patient List Size Breakdown as at 8th July 14			00-04	05-14	15-24	25-34	35-44	45-54	55-64	65-74	75+	Total	%Total
Burton Rd.	C83615	Females	72	114	149	234	149	148	123	76	62	1127	48%
		Males	75	141	136	255	173	164	137	87	54	1222	52%
		Total	147	255	285	489	322	312	260	163	116	2349	
			6%	11%	12%	21%	14%	13%	11%	7%	5%	100%	

Change in Patient List Breakdown between 1st April and 8th July 2014		00-04	05-14	15-24	25-34	35-44	45-54	55-64	65-74	75+	Total
	Variance	-27	-22	-25	-39	-42	-47	-65	-62	-83	-412
	Percentage	16%	8%	8%	7%	12%	13%	20%	28%	42%	15%

Burton Road Patient Population



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Lincolnshire COUNTY COUNCIL Working for a better future		THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE	
Boston Borough Council	East Lindsey District Council	City of Lincoln Council	Lincolnshire County Council
North Kesteven District Council	South Holland District Council	South Kesteven District Council	West Lindsey District Council

Open Report on behalf of Jan Gunter, Designated Safeguarding Nurse, South West Lincolnshire Clinical Commissioning Group

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**23 July 2014**
Subject:	**Care Quality Commission - Review of Health Services for Children Looked After and Safeguarding in Lincolnshire**

Summary:

To inform the Health Scrutiny Committee for Lincolnshire of:

- the *Review of Health Services for Children Looked After and Safeguarding in Lincolnshire,* published by the Care Quality Commission (CQC) on 21 February 2014 [Appendix A to this report];
- the associated action plan submitted to the CQC on 21 March 2014 in response to the recommendations of the CQC's report [Appendix B]; and
- the progress update against the action plan, dated July 2014 [Appendix C to this report].

Actions Required:

(1) To consider and comment on the *Review of Health Services for Children Looked After and Safeguarding in Lincolnshire,* published by the Care Quality Commission (CQC) on 21 February 2014 [Appendix A to this report];

(2) To consider and comment on the associated action plan submitted to the CQC on 21 March 2014 in response to the recommendations of the CQC's report [Appendix B]; and

(3) To consider and comment on the progress update against the action plan (dated July 2014) [Appendix C to this report]

1. Background

This report records the findings of the review of health services in safeguarding and looked after children services in Lincolnshire. It focuses on the experiences and outcomes for children within the geographical boundaries of the local authority area and reports on the performance of health providers serving the area including NHS trusts, Clinical Commissioning Groups (CCGs) and the Local Area Team of NHS England.

Where the findings relate to children and families in local authority areas other than Lincolnshire, cross boundary arrangements have been considered and commented on. Arrangements for the health related needs and risks for children placed out of the area are also included.

The review was conducted under Section 48 of the Health and Social Care Act 2008 which permits CQC to review the provision of NHS healthcare and the exercise of functions of NHS England and Clinical Commissioning Groups

- The review explored the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements within health for all children.

- The focus was on the experiences of looked after children and of children and their families who receive safeguarding services.

- It looked at the role of healthcare providers and commissioners; the role of healthcare organisations in understanding risk factors, identifying needs, communicating effectively with children and families, liaising with other agencies, assessing needs and responding to those needs and contributing to multi-agency assessments and reviews.

The contribution of health services in promoting and improving the health and wellbeing of looked after children including carrying out health assessments and providing appropriate services.

Further, it checked whether healthcare organisations were working in accordance with their responsibilities under Section 11 of the Children Act 2004. This includes the statutory guidance, Working Together to Safeguard Children 2013.

2. Conclusion

The CQC review was undertaken in November 2013 which included a site visit for one week by two inspectors. The review included case file tracking of the child's journey of a 10 highly complex cases involving a number of health agencies plus 53 cases that were dip sampled from case records and then tracked though each service they encountered across health including primary care.

The review identified areas of good practice, specifically around the interface between CAMHS [Child and Adolescent Mental Health Services] and adult mental health services and the screening tools and vulnerability risk assessments utilised in the community services. The review also identified good partnership working and

professional challenge. The review did not identify any issues that were unknown to commissioning and provider services:

- Capacity of the designate professionals for safeguarding and looked after children for strategic leadership and commissioning planning.
- Paediatric expertise within unscheduled care / A&E settings
- The self- harm pathway is not embedded in practice
- Variance in quality of the statutory health assessment for looked after children
- The impact of externally placed children in independent care settings on local resources.

Recommendations:

- There were 25 recommendations made across 9 themes for both commissioning and provider organisations across Lincolnshire and NHS England Area Team.
- All themes include all four CCGs and are therefore being managed collaboratively and in association with NHS provider organisations.
- There are 45 strategic actions planned and included in Appendix B of this report to address the recommendations which have been accepted.
- The action plan is being co-ordinated through the Federated Safeguarding Service Team.
- The action plan is RAG [Red, Amber, Green] rated locally to monitor progress. There were no areas rated as Red on submission of the action plan to the CQC.

Whilst being a health review, it was acknowledged by the CQC that some recommendations require effective partnership working with the local authority.

3. Consultation

Patients and staff were consulted during this review in line with CQC methodology.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	*Review of Health Services for Children Looked After and Safeguarding in Lincolnshire,* published by the Care Quality Commission on 21 February 2014.
Appendix B	Action Plan in Response to CQC Report
Appendix C	Progress against the Action Plan

5. Background Papers

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

This report was written by Jan Gunter Designated Safeguarding Nurse South West Lincolnshire CCG, who can be contacted on jan.gunter@southwestlincolnshireccg.nhs.uk

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Review of Health Services for Children Looked After and Safeguarding in Lincolnshire

Children Looked After and Safeguarding
The role of health services in Lincolnshire

Date of Review:	**4th November 2013 – 8th November 2013**
Date of Publication:	**21st February 2014**
CQC Inspector names:	**Lynette Ranson, Jan Clark, Lea Pickerill**
Provider Services Included:	**Lincolnshire Community Healthcare Services, Lincolnshire Partnership NHS Foundation Trust United Lincolnshire Hospitals NHS Trust**
CCGs included:	**Lincolnshire West CCG; South Lincolnshire CCG; South West Lincolnshire CCG; Lincolnshire East CCG**
NHS England Area:	**Leicestershire and Lincolnshire Area Team**
CQC Region:	**Central East**
CQC Regional Director:	**Dr Andrea Gordon**

Contents

Summary of the review

This report records the findings of the review of health services in safeguarding and looked after children services in Lincolnshire. It focuses on the experiences and outcomes for children within the geographical boundaries of the local authority area and reports on the performance of health providers serving the area including NHS trusts, clinical commissioning groups (CCGs) and the local area team (AT) of NHS England.

Where the findings relate to children and families in local authority areas other than Lincolnshire, cross boundary arrangements have been considered and commented on. Arrangements for the health related needs and risks for children placed out of the area are also included.

About the review

- The review was conducted under Section 48 of the Health and Social Care Act 2008 which permits CQC to review the provision of NHS healthcare and the exercise of functions of NHS England and Clinical Commissioning Groups

- The review explored the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements within health for all children.

- The focus was on the experiences of looked after children and of children and their families who receive safeguarding services.

- We looked at
  - the role of healthcare providers and commissioners.
  - the role of healthcare organisations in understanding risk factors, identifying needs, communicating effectively with children and families, liaising with other agencies, assessing needs and responding to those needs and contributing to multi-agency assessments and reviews.
  - the contribution of health services in promoting and improving the health and wellbeing of looked after children including carrying out health assessments and providing appropriate services.

- We also checked whether healthcare organisations were working in accordance with their responsibilities under Section 11 of the Children Act 2004. This includes the statutory guidance, Working Together to Safeguard Children 2013.

How we carried out the review

We used a range of methods to gather information both during and before the visit. This included document reviews, interviews, focus groups and visits. Where possible we met and spoke with children and young people and families. This approach provided us with evidence that could be checked and confirmed in several ways.

We tracked a number of individual cases where there had been safeguarding concerns about children. This included some cases where children were referred to social care and also some cases where children and families were not referred, but where they were assessed as needing early help and received it from health services. We also sampled a spread of other such cases.

Our tracking and sampling also followed the experiences of looked after children to explore the effectiveness of health services in promoting their well-being.

In total we took into account the experiences of 53 children and young people.

Context of the review

Lincolnshire is the fourth largest county in England with an estimated population of 718, 000, of whom 22% are aged under 19 years. Approximately seven per cent of school age children speak English as a second language but in the Boston district, about one third of the population using local health services are from an eastern European country. The county has a spread of both urban areas and very rural, isolated areas. The percentage of children living in poverty ranges from 10% in a southern district to 24% in Lincoln. Approximately 580 children are looked after by Lincolnshire and another 400 have been placed in Lincolnshire by other local authorities. Approximately 400 Lincolnshire children are currently subject to a child protection plan.

Commissioning and planning of health services is led through the Children and Young People's Strategic Partnership, with the four CCGs and Lincolnshire county council as the lead commissioners. Acute hospital services are also commissioned jointly by the CCGs and are provided by the United Lincolnshire Hospitals NHS trust (ULHT). Lincolnshire community healthcare services (LCHS) provide health visiting, school nursing and children's therapy services, the looked after children's health service, sexual health services, two minor injuries units, two 24 hour access urgent care centres and a walk in centre. Health services for children with disabilities are provided through integrated arrangements between the council and CCGs, and joint funding arrangements are in place. Child and adolescent mental health services (CAMHS) and a targeted adolescent mental health service which works in partnership with schools are provided through integrated arrangements between the council and Lincolnshire Partnership NHS Foundation trust. A specialist mental health nurse works with the Barnados leaving care service in providing a care leavers' CAMHS transition service.

The last inspection of health services for Lincolnshire's children took place in June 2010 as a joint inspection, with Ofsted, of safeguarding and looked after children's services.

The report

This report follows the "child's journey" reflecting the experiences of children and young people or parents/carers to whom we spoke, or whose experiences we tracked or checked. A number of recommendations for improvement are made at the end of the report.

What people told us

We heard from several foster carers about their experiences of looked-after children's health assessments and reviews.

One parent told us how his child is deteriorating because of lack of physiotherapy input. The foster carers told us that they tell the GP as part of the health review and then nothing happens.

Another foster carer had better experiences; *"I have a 30 mile round trip to see the GP who does the health review. She is interested and doesn't just tick the boxes."*

We heard a lot of praise from carers for a particular consultant paediatrician: *"She really listens and treats you with respect*".

Sadly, we also heard some young people and carers' very poor experiences of health practitioners. One young person told us: *"health staff don't talk to you."*

"Some health professionals don't want to speak to foster carers. They say 'I need to speak to a professional".

"We had to use A&E over the Christmas period, we were told to go home with an inhaler. This is for a child who was deteriorating with his shunt. They wouldn't listen to his foster carers".

Others commented on a range of communication and health planning issues impacting on children's health:

"We wait too long for essential equipment. His current wheel chair means he can't wear winter clothes because he won't fit in the chair"

"There is no numbing cream for his eyes in the local hospital so we have to travel to Boston Hospital".

"We have been waiting for important emergency surgery that couldn't proceed because of getting consent. This is for a child who has complex health needs"

Another foster carer told us: *"Getting the right equipment is difficult and we are told it's because of the budget. Why should our children suffer?"*

Foster carers we met were in universal agreement that the health professionals they meet do not understand the added needs of a looked-after child.

"I haven't been able to get support or training for family members to be able to tube feed my foster child. This means I have to be there to do every feed myself, even though other family members would like to give me a break". (Foster carer of a child with complex health needs"

One foster carer said how their 14 year old foster child was well supported by a nurse who made weekly visits and arranged for CAMHS and the smoking cessation service. However, the foster carer did not get any support or training.

We heard that the blue book, the local hand held record of looked after children's health history, hadn't been rolled out in a way that made it effective: *"The only reason he (the child) has his health history is because I save everything. GPs and other health professionals won't fill in the blue book, it's a complete waste of time*."(foster carer of a child)

The Child's Journey

This section records children's experiences of health services in relation to safeguarding, child protection and being looked after.

1. Early help

1.1 General practitioners (GPs) have an important role in early help in pregnancy as they are often the first point of contact for pregnant women in Lincolnshire; the information GPs send to midwifery is variable and doesn't always ensure midwives have all the relevant information where early help might be needed. A new booking format has recently been introduced which carries more information and also gives more information to the mother and this should improve mothers' access to early help.

1.2 Systems such as antenatal chronologies are in place to help early identification and monitoring of safeguarding risks in pregnancy. We saw a range of cases where midwives appropriately identified risks to protect unborn babies. However, some risks may be missed when these systems are not consistently used as in a case we saw:

Some concerns had already been identified as the mother to be hadn't disclosed at booking that an older child was placed with another family member; this part of the system worked well. However, the key antenatal chronology was not completed. It was unclear whether the community midwife was notified when the mother failed to attend her first scan, which is important to ensure prompt follow-up.

1.3 Many children, young people and their families are helped by preventative and targeted support from health staff in seven local multi-agency teams in co-located bases such as community hospitals, health centres, children's centres' and GP's surgeries. Co-location helps handover arrangements between midwives and health visitors which are generally effective and consistent in protecting vulnerable babies.

1.4 Community midwifery services try to maintain the same midwife throughout pregnancy as this gives mother and baby continuity but capacity problems mean this isn't always the case. Never the less, we saw examples where pre-birth maternity care is very effective in identifying the need for support at an early stage.

We saw an exemplar case of obstetric care of a pregnant teenager. Risks were discussed with her with great sensitivity and the young person was given time to reflect and consider her options. The maternity record is clearly written and of excellent quality.

1.5 Vulnerable women or those for whom an increased level of risk has been identified are visited by community midwives for up to 10 days post natal, which is also good practice in protecting mothers and babies. Joint ante natal visits are common and the community midwife's final visit is usually a joint visit with the health visitor. We heard about some effective partnership work between health practitioners, social care, children's centres and schools to support families.

1.6 The well regarded peri-natal mental health service works with health visitors and school nurses to support improved outcomes for women in Gainsborough and Lincoln. Lack of service for new mothers in other areas of Lincolnshire is an acknowledged gap as the value of perinatal services is recognised; in the last two serious case reviews, workers had contacted peri-natal health for advice about the new mothers' mental health (recommendation 5.2). Many parents in the county access and benefit from IAPT[1] services to help manage anxiety and depression. The service works closely with the mother and baby unit (in Nottingham) and helps support gaps in local peri-natal services.

1.7 Although some health visitors and GPs work well together to identify families who might need help, this isn't consistent across the county. There is no agreed system in place, for instance for regular formal joint meetings between GPs and health visitors or school nurses (recommendation 4.2).

1.8 The needs of children in families where their parents have mental ill health are properly recognised through highly effective `*think family*` systems across adult mental health services. Safeguarding screening tools are embedded in mental health services working with adults and parents, ensuring that all adults accessing services are routinely questioned about children in their families so that the children's needs can be taken into account at an early stage.

The IAPT early help mental health service helps many parents and ensures that risks to all children in the household are picked up, rather than just those for whom the adult has parental responsibility. The screening tool it uses is good practice. With the introduction of the IAPTus management information system, an already very sound system is being further strengthened.

[1] Improving Access to Psychological Therapies (IAPT) provides access to brief counselling interventions

1.9 School nurses are engaged with all schools and provide school drop in sessions. They are kept up to date about current issues and risks, in order to offer early help, information and advice about issues that trouble young people. However, there is no countywide use of a substance use screening tool to assess young people's drug and alcohol use as part of any other needs assessments. Using a recognised screening tool to identify young people who might need more targeted help could improve their early access to services.

1.10 We found a general lack of clarity about any referral pathway from health services to Young AddAction which offers specialist help to young people who misuse drugs or alcohol (recommendation) A&E departments are also in a very good position to identify young people who are putting themselves at risk through drug or alcohol use. We heard that this is being addressed with a multi-agency protocol which is awaiting ratification by the LSCB. (recommendation 3.2).

1.11 Accident and emergency (A&E) staff make an otherwise fairly comprehensive assessment of the child or young person on admission, including details of parents. There are though, inconsistencies in clarifying who has parental responsibility. At Grantham A&E, children are prioritised and almost always seen within 15 minutes. The clinical triage notes indicate if the presenting injury or condition is consistent with the explanation offered. A note is also made of who is accompanying the child to the department. In A&Es and the minor injuries unit (MIU) we visited, we saw good safeguarding risk assessment by most clinicians.

Spalding MIU identified and responded appropriately to safeguarding risks, notifying the health visitor, social care and MARAC about domestic violence witnessed by children and informing the parent about the referral being made.

1.12 In case sampling at three acute care locations we saw that onward referral systems to ensure young people have access to early help are not robust. At the Pilgrim Hospital at Boston, A&E actions are not routinely recorded in the paediatric liaison nurse (PLN) folder and CAS cards are often left in a pile to await the PLN's twice weekly visit. Although the PLN and acute trust named nurse are working together to try to address this, compliance with the agreed safeguarding discharge protocol remains low. At Grantham we also saw a lack of clarity about cases referred to the PLN and their outcomes (recommendation 3.1).

At the Pilgrim hospital's A&E we saw good work from staff in assessment of risks, effective questioning of the incident and treatment of an 18 month old little girl who had swallowed a small amount of oven cleaner. This case wasn't entered into the PLN liaison book however, to ensure there would be community follow up.

1.13 Young AddAction provides a good quality, easily accessible drug and alcohol specialist service for young people that thoroughly assesses risks and engages young people very flexibly. On one file we were impressed how the Young AddAction service responded to the parent's concerns whilst respecting the views of the young person.

1.14 We saw examples of the work of the `vulnerable children's team' (VCT) which provides a specialist health service to meet the health needs of vulnerable children and young people, including children in public care (0-19 years of age) within Lincolnshire and those at risk of social or educational exclusion.

1.15 Where community health services are using the same IT system, information sharing about children at risk is supported across a range of services. This helps health staff to respond to the needs of individual children. As a result of the shared information system, regular liaison between MIUs and school nurses is now routine practice and enables improved understanding of concerns about young people in the county.

1.16 Where risks to the health, safety, development and wellbeing of children are identified we found timely and appropriate follow up to ensure the child's health needs are met, particularly among health visitors and school nurses. We heard that progress is on track to meet national health visitor targets, although case loads and capacity are variable currently and there is widespread use of nursery nurses in order to deliver the core offer. Unless there are child protection or child in need plans to mitigate risks to the child and mother, new born babies are handed over to nursery nurses for the universal service after 6 weeks; this potentially impacts on the ability to identify early needs for help.

1.17 Integrated GUM, sexual health services and family planning are provided in one stop clinics across Lincolnshire. Dedicated clinics for young people are not provided, but reception staff make sure that young people are seen by experienced staff. Clinical guidelines reflect national policy in that any young person aged 13 or under as well as any young person or adult with additional vulnerability is referred to children's social care.

1.18 Agencies are working together to try to increase understanding and develop provision to meet the health needs of eastern European migrants and their children. We saw how mothers are supported by obstetric consultants who are sensitive to patient's ethnicity and ensure interpreting services are provided as required. Midwives and community services have taken steps to better meet the needs of the Polish community in the Boston district including information leaflets and recruiting a Polish speaking midwife in each area of the county; some midwives have developed a glossary of Polish terms to help them in working with this community. The community services named nurse lead for diversity is very involved in developing greater understanding of cultural norms and ensuring that potential risks to the wellbeing of children in migrant communities are recognised and addressed.

1.19 We heard from several sources including Healthwatch about the impact of the shortage of paediatricians in Lincolnshire. All paediatricians in Lincolnshire are currently employed by the acute hospital trust. We heard that around the county it is hard for a child to get a paediatric referral and children have to wait for appointments which often impacts on their well-being. The limitations of available paediatric resources impact on children entering into care who may have complex or hidden needs (recommendation 1.3). Only the 10% who are being considered for adoption are seen by a paediatrician for their initial health assessment, all others are seen by GPs and then have to join waiting lists if more specialist assessment is needed. Some children and foster carers told us that they are not always listened to when they see a paediatrician.

1.20 We saw consistently determined efforts across health services to engage young people and families who are challenging or hard to engage. Non-attendance at clinical appointments is well followed up by most partners. GPs told us that they hear about missed hospital appointments but could be better engaged about risks in families if they were also informed about missed community health appointments.

1.21 The school health service has good engagement with schools countywide. Practitioners identify needs effectively and target additional drop in work at schools where young people are most at risk. We saw some effective individual work too, for example, a teenager in a very chaotic family for whom engagement and support from the school nurse is instrumental in ensuring his fundamental needs are met.

1.22 Staffing turnover and reducing capacity in the school health service presents a threat to continuing the current level of engagement which is helping to safeguard all school age children, for example capacity in the north east sector, where there are high levels of need, has been significantly challenged during 2013.

1.23 Vulnerable children and families in Lincolnshire benefit from the range of children's centres and also have access to some health-led early help services which are effective in delivering positive outcomes; in particular the young expectant parents group (YEP) run by community midwives is accessible to all young parents. The 10 week course starts and finishes at different times ensuring there is no delay in young parents starting with the group. Young people can attain a qualification equivalent to a GCSE. Recently a YEP cycle has run for a small group of five 14 year old young people who all joined at the same time. Young people feedback that they found this highly supportive and helpful.

1.24 The number of teenage pregnancies has reduced year on year, as in most parts of England though latest data shows that the rate of 1.7 is worse than the rate for the East Midlands region and the England average rate of 1.3. Teenage pregnancies are highest in the Lincoln area although we did not see targeted activity to address this or the impact on the life chances of these young parents and their children.

2. Children in Need

2.1 Midwives carry out thorough assessments of risk and where concerns are identified, these are shared early. Vulnerable mothers are supported by targeted ante natal care from health visitors from 26 weeks currently though this is changing and will be available as soon as a pregnancy is confirmed.

2.2 Children in need and their families are helped by multi agency team around the child (TAC) groups based on the common assessment framework (CAF). This is an embedded model of supporting children in need and may be led by a range of professionals including health staff and schools. This is delivering good outcomes where parents are in agreement with the setting up of a TAC. We saw a good example where a child protection plan was replaced by a child in need plan when the child moved into the county and the child is supported by a TAC in which her school nurse is an active partner.

2.3 Young people who may be reluctant to engage with CAMHS services are supported to access the service by a sensitive policy on non-attendances. We saw examples where workers sought to engage the young person for as long as possible and used different routes to try to do so rather than closing the case. Effective and separate work can be done with parents or foster parents to support them when a child is working through difficult issues supported by CAMHS.

We saw an exemplar case of effective, sensitive support by health services in Lincolnshire for a young person who had suffered serious sexual exploitation before being placed in Lincolnshire by another council

2.4 The contraception and sexual health service (CASH) appropriately explores risks to identify safeguarding concerns and potential sexual exploitation of young people. This includes asking the young person for the age and name of their partner and whether sex had been consensual. Services ensure that children aged 13 and under are identified as being potentially at risk by an automatic flag on the CASH database. All cases of concern had been referred to children and families social care. However, we did see a number of cases where children aged 13 and under had a contraceptive implant in situ and the CASH could not identify the source of these implants. This indicates that some GPs or other family planning practitioners are unaware of guidance and policy to safeguard these vulnerable young people (recommendation 4.2).

2.5 CAMHs employ some very good self-assessment tools and aids in working with young people to enable them to explore their emotional journey and to assess their progress and personal growth. Many young people have timely access to services, especially at tier 3 where the average wait is just over three weeks. However, increased demand and holiday arrangements led to some delays during several months in 2013, for example for tier 2 primary CAMHS, 61% were seen within the six week target (recommendation 5.1).

2.6 Significant numbers of young people in Lincolnshire have complex needs including self-harming behaviours. The most recent national data set on hospital admissions as a result of self-harm reported a rate of 127 (or 177 admissions), significantly higher than the England average rate of 115 and with increased numbers being seen since this data.

2.7 Many of the young people presenting at A&Es in Lincolnshire have been placed by other councils without first ensuring their health needs can be met in Lincolnshire. We saw several cases where health professionals in Lincolnshire had worked hard to engage with and try to ensure that young people received appropriate help.

2.8 Problems in access pathways from A&E services to CAMHS were flagged as an issue in the SLAC inspection in 2010. The LSCB has since co-ordinated work to simplify pathways. A case example suggested further exploration by commissioners would be warranted to ensure effective planning for Lincolnshire children returning from out of county placements ensures there are smooth and robust pathways to support them. The self-harm pathway of overnight admission to a paediatric ward and assessment by CAMHS is providing good support to many children and young people. However, there continue to be cases where this pathway does not work well and children's access to appropriate support is delayed as professionals try to balance these needs with the needs of other children on the paediatric wards (recommendation 9.1)

2.9 These cases are usually resolved through the intervention of the CAMHS consultant liaising directly with the paediatric consultant. We heard that work is in hand across partnership agencies to resolve this long standing issue including a trial at Lincoln hospital which is providing two additional members of staff to provide additional support where young people are admitted to the paediatric ward for CAMHS assessment. Use of the self-harm pathway at Pilgrim Hospital is also being closely monitored by the named nurse as it has not always worked effectively (recommendation 3.1).

3. Child Protection

3.1 Most health professionals recognise safeguarding thresholds and their professional accountabilities for keeping children and young people safe. School nurses, for example, understand their role in safeguarding and make appropriate referrals when they identify concerns. In one case we saw that a school nurse took appropriate actions in making a safeguarding referral when a 12 year old child disclosed sexual activity and concerns about a possible sexually transmitted disease (STD).

3.2 Health professionals are making prompt referrals to social care when they have concerns about risks to children. However, we saw a common theme across a number of services with examples as in the following paragraphs where risks to children are not being clearly articulated and health managers are not quality assuring referrals to support practice development in this key area (recommendation 7.2).

3.3 Most referrals from midwives to social care about pre-birth concerns are made electronically but not routinely printed off and placed on the mother's record. This approach means the named midwife or supervisory staff are unable to review and audit the quality of referral to ensure that the risks to the unborn are clearly articulated. Some midwives do print and file their referrals and this practice is to be encouraged (recommendation 7.2).

3.4 Midwives are skilled at identifying unborn babies who might be at risk, they are making early referrals to social care and alerting the named midwife. The recent introduction of a pre-birth protocol is a positive development but its effectiveness had not yet been reviewed by partners (recommendation 7.4). This review identified areas for development in the protocol to ensure health staff including GPs and midwives will in future be involved in core assessments through early establishment of a TAC[2] where concerns are raised about risks to unborn babies as this strengthens the involvement of health staff (recommendation 8.1).

The mother to be, a looked after child with complex needs herself, was well known to a range of health professionals who were concerned that her chaotic and risky lifestyle represented risks to the wellbeing of the unborn baby. These risks were inadequately identified in the notification to the named midwife. Though the poor history of the young woman was set out, concerns in relation to her ability to parent the child effectively and the likely early delivery were not mentioned (recommendation 7.2).

The core assessment inaccurately attributed the midwife as having "no concerns" despite high levels of concern among professionals familiar with the expectant mother. This case highlighted areas for development within the pre-birth protocol to ensure early multi agency involvement in decision making. We referred the case *back for review and appropriate action was taken (recommendation 7.4)*.

[2] Team around the child

3.5 We reviewed a case where concerns about parenting capacity have been present since before the first child's birth three years ago. This case demonstrates a cluster of known risk factors including missed appointments, avoidance, deteriorating mental health, increasing misuse of alcohol, problematic living conditions, and risks from a large dog. Whilst there have been diligent attempts at engagement with the mother, health records we saw lacked clear assessments about the impact on the wellbeing and development of the small child or the then unborn baby and a lack of clear planning. We saw no evidence of multi-agency meetings prior to the second baby's birth or of decision making about parenting capacity or risks to the baby or young child. Although a TAC was suggested recently, as concerns multiplied, the protocol requires the agreement of the family. In this case when the parent declined a TAC, there was a further period of slippage during which concerns increased. The case had recently been escalated to child protection.

3.6 Identifying risks to children through the use of a vulnerability and resilience matrix is a good model is now being used in health visiting and, we heard, more widely in other agencies undertaking assessments of risk. This can support practitioners to evaluate a case more effectively and to make good quality referrals to children's social care. The very newly implemented electronic version should further help community health practitioners to make referrals which set out risks more clearly. Some staff are currently unclear on the expected usage of the electronic matrix however (recommendation 8.1).

3.7 Another of the cases we saw involved long standing neglect which has continued for many years despite CP and CIN plans but the mother's behaviours and needs impact on her ability to parent her children. Since recent re-escalation to child protection brought an experienced school nurse's involvement to the family, she has used considerable skills to win acceptance of the mother and has started to address the son's unmet health needs.

3.8 We also saw an example case where the GP took prompt and appropriate safeguarding action in response to a disclosure that a child had witnessed a domestic violence incident. The GP did not however, clearly articulate the risks to the child in his report to conference (recommendations 4.1, 7.2).

3.9 Overall, GPs are keen to improve their safeguarding practice and positive progress has been achieved under the leadership of a very committed named GP. GPs recognise how important it is for the GP to attend child protection meetings if possible. Short notice periods and scheduling during surgery times are obstacles to improving GP attendance. Alternative means of securing GP participation such as teleconferencing have not been explored.

3.10 Where child protection plans are in place and adult mental health, including peri-natal mental health, are engaged with the parent, practitioners are very clear on their role in protecting the child. We saw an example where adult mental health practitioners were actively ensuring that the mother was compliant with the child protection plan and reported this back to conference.

3.11 We saw a `*think family*` approach in the work undertaken by LPFT's Drug & Alcohol Recovery Team (DART) with adults who misuse drugs and alcohol and who have children. Risk assessments, screening tools and a parenting check list ensure there is a joint focus on the needs of any children present in the family. We also saw good examples of contingency planning within recovery plans should a client fail to engage which is good practice.

3.12 However, outside of formal safeguarding meetings and conferences there was some evidence that the Drug and Alcohol Recovery Team (DART) workers did not always share information and concerns with other agencies in a timely manner. Other agencies who are monitoring risks to children are often reliant upon the client passing on and disclosing information that may be unreliable. We saw a lack of consultation between the adult drug and alcohol service and midwives for their clients. In one case we saw, the woman had disclosed on going substance misuse to the drugs worker but this information had not been shared with the midwife. This means that the midwife was not aware of information that could impact on the safety and wellbeing of the mother and the unborn baby (recommendation 7.3).

3.13 The drugs and alcohol team advised us that they are not asked to provide information to children in need meetings involving parents who receive support from their service. They also advised us that they are not consistently invited to relevant child protection meetings and often experience late receipt of minutes of CP meetings (recommendation 7.3). We heard that work is underway between LPFT and children's service managers in respect of drug and alcohol issues for parents based on the Ofsted/CQC 2013 report, "*What about the children*?"

3.14 Health professionals routinely participate in strategy meetings when they are invited; the expert knowledge about the child from school nursing, health visiting and midwifery can be instrumental in decision making about the level of intervention likely to deliver the best outcome for the child. Pressures on the school health service and the skill mix of a very limited number of more senior nurses, risks capacity for this valuable part of the role.

3.15 Health professionals prioritise attendance at child protection conferences and core groups and prepare reports as needed. Some reports lack the detail that would make the best contribution to multi-agency decision making. GPs are unclear what information to include when they submit reports. There is no agreed report template which they would find helpful and which would optimise their professional contribution to case conferences (recommendation 4.3).

3.16 Resources available to young people in the county aged 16 or under who have significant mental health needs include T4 CAMHS in-patient service provision. Young people are sometimes placed out of county in accordance with NHS England's commissioning protocol either to suit their circumstances or when the local places are already full. It is rarely necessary to admit a young person aged 16-17 to an adult ward. Though we noted from Trust papers that this had occurred on two occasions in 2013, reports provide assurance that both of these young people were supported by appropriate safeguards.

CAMHS are providing good support to a young person who had experienced significant abuse resulting in criminal proceedings. The tier 3 CAMH service liaises carefully with other agencies including the Crown Prosecution Service (CPS) to ascertain whether outside issues are likely to impact on the child's mental health and to take the work at the child's pace. This is more likely to result in positive outcomes for the young person.

3.17 Where child protection plans are in place and adult mental health, including peri-natal mental health, are engaged with the parent, practitioners are very clear on their role in protecting the child. We saw an example where adult mental health practitioners were actively ensuring that mother was compliant with the child protection plan and reported this back to conference.

3.18 Our case sampling in A&E identified that processes and arrangements do not currently ensure that A&E attendances by children for whom risks are identified will be robustly followed up. This is especially important where children move between areas or live out of county. We saw an example of a young person for who effective follow up was required but the notification was a brief, routine, system-generated letter to a GP although staff have the option to provide individualised information. In cases of risk and self-harm, these arrangements are insufficient to alert receiving primary care team (recommendation 3.1):

A 13 year old girl from a neighbouring county was brought to Grantham A&E after taking a deliberate and significant overdose of medication to harm herself. Staff also identified previous self-harm and did a good job of triage, assessment, gleaning important information and alerting receiving hospitals. Some inconsistencies in the circumstances needed more exploration but suggested additional concerns. The case number was added to the PLN's list for her next weekly visit. A routine PAS system generated letter to her GP contained insufficient details to prompt any special follow up.

3.19 Young people from 14 years old are well supported by the sexual assault referral centre (SARC) at Spring Lodge, Lincoln when they need to access this service. Effective work by the ISVA[3] ensures the young person receives appropriate aftercare.

3.20 We saw some good, persistent work by skilled community health practitioners to promote the health of children in vulnerable families and children subject to child protection plans. In one case, since the school nurse's involvement as part of the core group, she has successfully gained the trust of the mother and has started to address the child's unmet health needs by getting him registered with a GP and dentist. We also saw an example of good multi-agency working to explore strategies to manage a child at high risk of serious self-harm. An appropriate out of area placement has been secured and the child is doing well.

[3] LPFTs Independent Sexual Violence Advisors (ISVA) service

3.21 Barnados are commissioned to provide an effective care leaver service. All young people have a pathway plan which includes a health component but a positive new development, also provided by Barnados, is the CAMHS transition service. This has been particularly effective in helping young people who have left care to overcome often long standing and unresolved emotional and mental health concerns. The Barnados services working closely with the vulnerable children's nurses and also act as advocates for young people. We saw a number of examples of the impact of this work, including:

Case example: *Barnados worked closely with the community mental health team to successfully maintain a female care leaver in education. A positive outcome from multi-agency working.*

Case example: *A young male care leaver with autism. Helped into supported living and employment. Targeted CAMHS was able to clarify which of his needs were down to the autism and which were functional mental health issues. As a result, he was able to access the right level of support.*

3.22 Care leavers have not until now had the support of a dedicated pathway to ensure that their needs and those of their unborn or new babies are addressed. However, having identified an increasing number of pregnancies amongst care leavers, the looked-after child health team and Barnados are putting together a work plan for this (recommendation 2.4).

4. Looked after Children

4.1 The number of children in the care of Lincolnshire county council has steadily risen since 2010, to approximately 580. Additionally, children in the care of other local authorities are increasingly being placed in new private sector care homes within Lincolnshire, currently about 400 children. Assuring the health and wellbeing of such a large number of children, many of whom have complex needs is a significant challenge. Health agencies are fully involved in the safeguarding partnership's work to identify themes and seek resolutions. This is most notable in last year's project in which analysis of intelligence about a cohort of children most frequently reported as missing identified and intervened in respect of child protection and sexual exploitation concerns for all. The continued influx of children placed by other areas into private residential services in Lincolnshire without first ensuring their complex health needs can be met is presenting a particular challenge to a range of local services.

4.2 Whilst there is a protocol for moderate to high scores in strengths and difficulties questionnaires to be reviewed, there are no arrangements to monitor this or to collate outcomes to ensure that children in care are receiving the right services to meet their needs. The arrangements needed to be strengthened by developing monitoring and audit to ensure that individual SDQ scores of 14 or above are reviewed by specialist professionals; that changes to the health care plans are considered and implemented where necessary and that there is more visible tracking of subsequent scores to indicate outcomes of interventions (recommendation 2.1). Since this review, children's services re-launched the SDQ review group and procedure to monitor children with scores over 14 at a children's services team managers' meeting. Attendance at the group includes educational psychologist, CAMHs, LACES (education services) and LAC managers. This is in its early stages and should be monitored for process and outcomes, including the involvement of practitioners who undertake assessments and reviews.

4.3 We found that more needs to be done to ensure the link of general health and mental health evaluations in order to provide timely specialist help. The SDQ[4] scores of a high proportion of young people who have been in care for longer than a year indicate concerns deserving closer analysis and attention given that they are significantly higher than national averages. The designated doctor has flagged up the need to ensure that health reviews take into account all available information about the holistic health needs of looked after children including their emotional wellbeing but progress is slow (recommendation 2.1).

4.4 The specialist vulnerable children's team has oversight of the health needs of children and young people as they move through care. We identified positive relationships with children and young people and the VCNs effectively engage with children and co-ordinate their support. Outreach work by VCNs and CASH staff in some children's homes is valued by care staff.

[4] SDQ – strengths and difficulties questionnaire, an annual national survey to assess the emotional well-being of young people who have been in care for one year or more

4.5 Management of the extensive volume of health assessments is supported by a co-ordinator and administrative staff. Even so, children's initial health assessments (IHAs) are too often affected by delays, often as a result of late notification of placements by social care staff. GPs are being encouraged to direct requests for health assessments for children placed by other areas through the co-ordinator but at present there is no reliable system to ensure oversight and quality assurance of these assessments (recommendation 2.5).

4.6 Looked after children can access support from a dedicated primary CAMHS service which engages well with a range of other health practitioners who support the child. We saw examples where children are benefitting from imaginative child focused interventions which move at the child's pace, providing every opportunity for the child to evaluate their own progress.

4.7 Unfortunately with the increased number of children in care locally, demand for the looked-after children primary CAMH service can outstrip supply. At times children wait longer than the four week target for initial appointments; as many were waiting as were being seen in some periods. In August 72.5% of looked after children were seen within four weeks, compared to the 95% target. This worsened in September when only 49% of looked-after children who were referred were seen within 4 weeks. LPT monitors performance closely and ensures that commissioners of CAMHS services are aware of difficulties. Positively, we understand that some additional resources were found to increase service capacity during 2013 (recommendation 5.1).

4.8 Care leavers who have accessed CAMHS and meet adult service thresholds have a seamless transition pathway from CAMHS, as CAMHS and adult mental health have the same provider. A looked-after child can usually access CAMHS up to the age of 18 with a transition starting at 17.5 although this can be extended for example, to support a young person moving onto university. This is good practice.

4.9 Work has been done to improve compliance with statutory expectations that all children and young people coming into care benefit from a timely assessment of their health (an initial health assessment) and a comprehensive plan to meet their health needs. More children are having their health needs assessed within the statutory timeframe but this is from a low base and less than half (40 – 45%) of children entering care have an assessment within the timeframe with some considerably delayed. Recently introduced reporting now clearly sets out points of delay and this has assisted the improvement. Even so, the reasons for delays are not always clearly set out or understood.

4.10 The quality of GP initial and review health assessments is highly variable and is a priority area for development. From examples of very good practice, reflecting a comprehensive assessment of the child's health and wellbeing and highly reflective of the child as an individual; we have seen assessments of unacceptably poor quality: hand written and mainly illegible containing the most basic information, with no sense of the child as an individual and no attempt to reflect the voice of the child. Despite the efforts of a highly committed designated doctor, the quality assurance process for health assessments and reviews lacks rigor and is not sufficiently robust (recommendation 2.5).

4.11 The quality of health plans is also very variable. Some are comprehensive and child centred with good efforts made to engage children, others are not. Some good assessments are weakened by poor quality health plans which lack measurable objectives, timescales and accountabilities (recommendation 2.5).

4.12 It has been recognised for a number of years that looked after children have not had the quality of health support service which they need :

Several foster carers we met felt that their role in supporting and advocating for children with disabilities was not recognised by health professionals. They are not routinely sent copies of the child's assessments or health plans and are often excluded from assessments, reviews and important discussions about health needs. One foster carer told us how health professionals had held an end of life discussion about the child she has fostered since infancy and had not included her.

4.13 A looked after child's health plan should identify the health support each child needs and be reviewed and revised after each assessment. However, foster carers told us about their experiences of the ineffectiveness of arrangements in meeting the children's needs.

4.14 They explained how assessments and reviews are stand alone, not linking into other medical assessments and appointments. Case files also showed that reviews and health plans could have greater impact if all available information, such as annual and specialist SDQ's, or updates from specialists was drawn together in advance, so that all needs including emotional well-being are considered at the time of the health review.

4.15 Looked after children have good access to primary care, they are promptly registered with GPs and dental checks and immunisations are arranged for almost all looked after children. Community health staff use IT to record heights, weights and immunisations which helps to track progress and identifies gaps.

4.16 The records we saw showed that most health reviews are episodic and are not informed by the previous review although these are routinely sent to the GP to inform the current assessment. The child's own GP is not asked to contribute their often extensive knowledge of the child before the review. As we saw and heard from foster carers, where other services such as paediatricians or other specialists, CAMHS or therapies such speech and language SALT are involved with the child, their knowledge of the child is not contributing progress information to the health review (recommendation 2.5). We heard from a foster carer about their concerns that health reviews give insufficient attention to the health needs of young people with disabilities who will be leaving care: *"There is no preparation for young people turning 18. I told my young person about the birds and the bees.*"

"Now he does get fast tracked to the paediatric ward but it has taken ages and lots of admissions for that to happen."

4.17 The high numbers of children placed into Lincolnshire from other areas challenge all facets of the service. School nurses demonstrate dogged determination in obtaining information from professionals in other placing authorities about children for who there are safeguarding concerns. Diminution of the capacity of school nursing risks losing the most effective part of the safeguarding system in its reach to school age children.

4.18 Looked-after children are well supported by knowledgeable and committed vulnerable children's specialist nurses. They work closely with residential staff, foster carers and a wide range of other professionals and are well regarded.

4.19 There are significant difficulties in ensuring that appropriate equipment to meet the assessed needs of looked-after children with complex disabilities is provided in a timely way. This is a long standing frustration for foster carers. One told us that as her foster child has outgrown his wheelchair, he cannot wear his winter coat when he goes out as he cannot fit in the chair. These difficulties are indicators that health services and health care plans are not effectively supporting looked after children's health needs (recommendation 2.2 &2.5).

"We got him a new chair and it took four and a half months for someone to come out and fit the parts so he could use it." (foster carer of a child with disabilities)

"Depends on the social worker in terms of what support you get. Therapy support helps you maintain the placement".

4.20 We saw case examples where help for young people was delayed because the access pathway for the looked-after child CAMHS service does not accept referrals from the vulnerable children and young people specialist team. They often know the child best and in some cases this would have expedited a child's access into a service likely to result in good outcomes. We understand this was addressed following our review.

4.21 Insufficient attention is paid to ensuring that care leavers have access to their full health history and this is an issue which is of great importance to many young people who leave care. While the provision of the blue book has the potential to provide a comprehensive health history for when the young person leaves care, foster carers told us that most health professionals, GPs, dentists and specialists are reluctant to make entries, diminishing its value to the young person (recommendation 2.3).

5. Management

This section records our findings about how well led the health services are in relation to safeguarding and looked after children.

5.1 Leadership and Management

5.1.1 CCGs and NHS England's area team (AT) provide good leadership to continuously improve health safeguarding and children looked after arrangements.

5.1.2 Lincolnshire's CCGs have put in place a reporting and accountability framework for safeguarding children, including those who are looked after. This has the potential to deliver improvements and ensure effective governance. There is a shared acknowledgement of the challenges and priorities for improvement. Strengthened governance arrangements are in place for the early identification of learning points from serious case reviews (SCRs) for monitoring and evaluation and to ensure timely action is taken to improve services.

5.1.3 At the time of the SLAC in 2010 completion of health assessments was poor. Revised arrangements were developed to recruit GPs on local extended contracts for this work. This has involved a great deal of work and has improved access to health assessments though such a disparate service has struggled to achieve the expected quality and more sustainable arrangements are needed. Senior managers recognise that more needs to be done to secure quality across their responsibilities for both safeguarding and health care for children who are looked after (recommendation 1.2).

5.1.4 Challenges to the leadership resource for the significant task of driving both safeguarding and looked after children's health agendas across a large county is recognised by the CCGs. An external review has been commissioned. The designated professionals all have limited capacity to develop and drive comprehensive plans for changes across the health economy (recommendation 1.1). We found that they are all respected and committed professionals working hard to address challenges many of which are long standing and require more strategic solutions.

5.1.5 Prompt investigative action has been taken in response to our concerns about a case we sampled at A&E where an inadequately managed discharge from an out of county in-patient mental health unit resulted in the child self-harming and requiring emergency treatment.

5.1.6 Information technology is increasingly supporting timely and effective exchange of information especially in the community. Increased use of NHS secure internet and more electronic records has speeded up notification processes. As in many areas, lack of connectivity between the main health providers remains a barrier to effectiveness. Wide use is made of electronic records in many services but LPFT, ULHT and CASH all use different systems which cannot connect. A bid to link these health service data bases is with NHS England.

5.1.7 There are some strengths here, for instance the data base used in community services, therapies, by community paediatricians based in ULHT, and all but one of the looked-after children GPs. Not all GPs use the system, but where they do they can enable other LCHS staff to view specific records. The community health data base has also been provided for read-only use by A&E staff in the acute hospitals. However, A&E and other key health professionals do not have direct access to terminals with the social care data base which is possible in many other areas of the country. This means staff need to make phone calls to check whether children and families are known to social care and it is acknowledged that there can be difficulties in making timely contact in this way. Positively, health partners have been consulted in relation to social care's planned system upgrade.

5.1.8 The use of audits has contributed to improvements in the quality of some looked-after children's health assessments but overall quality remains inconsistent.

5.1.9 There remain unmet pressures on capacity and skill mix for carrying out health assessments compared to the volume of work and complexity of needs of children coming into care. The 2011/12 Annual Report on the health of looked after children highlighted the variability in the quality of health assessments and health care plans and recommended that community paediatricians should undertake IHAs (recommendation 1.2). Children and young people have not benefitted from any progress towards this recommendation though audit evidence was used recently to request a review of arrangements for IHAs at safeguarding steering group.

5.1.10 Strategic partnership working is good. Health strategic leads describe positive relationships across the partnership and particularly with the director of children's services who also has a health background. Strategic leads meet regularly and partners are able to have a mature dialogue about a range of issues and common themes. Strategic managers identify an improved connectivity between strategic management and frontline operational staff. Operational managers are increasingly seeking multi agency solutions when issues are identified though some intransigent problems have yet to be resolved fully. CASH services in Lincolnshire are not formally represented in the partnership that is addressing sexual exploitation and this is a gap since the service will be able to contribute strategically and in respect of operational issues and individual cases (recommendation 4.2).

5.1.11 We heard about an example where the named GP was able to liaise with social care when an issue was identified by GPs. As a result, social care's processes were amended to ensure that GP calls are now logged to contribute to risk assessment about children and their families.

5.1.12 Partnerships with and in CAMH services are improving but case examples showed a range of issues where better coordination between services could improve outcomes for young people and their families. This is evident where support for young people who attend A&E's with emotional, behavioural and mental health needs continues to be inconsistent as professionals struggle to reconcile the needs of different groups of children. We also saw the significant impact of poor discharge arrangements and communication from an external T4 CAMHS which failed to ensure that local services are in place (recommendation 5.3).

5.1.13 Families with foster children told us how better co-ordination between health professionals would benefit the young people by ensuring their health needs are fully taken into account.

5.1.14 We saw little evidence that the views of children, their families and carers are regularly heard and taken into account. Much more focus is needed to ensure that children and young people are encouraged to regularly share their views and experiences in evaluating the quality and impact of local health services (recommendation 7.1).

The community health trust's recently strengthened arrangements for safeguarding leadership were bringing the important health perspective to child protection strategy discussions. Through a rota system, the county-wide team of deputy named nurses is available at any time and this is an imaginative response in a large county area.

5.1.15 We found that health professionals recognise the value of team around the child work but in some areas of work, capacity issues prevent their involvement, with this being a particular issue for staff employed by ULHT. Capacity within the ULHT safeguarding team generally has been flagged up in CQCs compliance inspection of this trust. The children's safeguarding team of two health professionals liaises with the named midwife team and the adult team. Operating across several disparate sites and ensuring an effective safeguarding partnership with other providers adds to the challenges of the role.

5.2 Governance

5.2.1 Each trust has governance arrangements in place which include regular reporting on local safeguarding arrangements.

5.2.2 NHS England and the four CCG's have given high priority to the work needed to continuously improve safeguarding and children in care health services. The priorities for safeguarding are currently clearer than for children in care. Through a memorandum of understanding between the four CCGs, this work is led by Southwest Lincolnshire CCG, its chief nurse, and the designated professionals.

5.2.3 Progress has been made in some areas and the designated nurse for safeguarding and looked-after children is providing strong leadership. However, she and other designated professionals have insufficient capacity for strategic planning, comprehensive quality assurance of operational delivery and ensuring continuous improvement (recommendation 1.1).

5.2.4 The capacity of the looked-after children health team has not kept pace with the growth in numbers of looked-after children in the county, including high numbers of children placed by other councils and the complexity of needs. Well over 1000 health assessments and reviews are required each year, with significant preparatory and follow up work including quality assurance of the assessments and health plans. Although efficiently supported by the co-ordinator and administrative support, the designated doctor's allocated one session per week is inadequate to deliver the strategic role and quality assurance work. The designated nurse role is also challenged in seeking to deliver the full statutory role with approximately one third of a post for LAC work and one third for children's safeguarding leadership. These pressures impact on capacity to drive and embed quality standards across the large county (recommendation 1.1 and 1.2).

5.2.5 We found that performance reporting arrangements around the holistic health needs of all looked-after children, the services to meet their needs and the outcomes that are achieved is insufficient to ensure that looked-after children receive the help they need (recommendation 2.2). The format of the annual report on the health of looked-after children is quite narrow in scope. This misses the opportunity to set out the full picture of their needs and outcomes and to identify key issues that are of concern to looked-after children generally or to local children in particular. Limited performance reporting about needs, outcomes and gaps in services for looked-after children impacts on the ability to make robust plans to deliver improvements. Information about the health needs of looked-after children with long term conditions is not currently collated from their individual health assessments. This results in a lack of oversight of the capacity of services to meet their current needs and that their health needs are recognised in transition planning for their future. This remains an outstanding action although identified by the looked-after children service to be addressed during 2012/2013 (recommendation 1.2).

5.2.6 The community trust provides paediatric liaison nurses (PLNs) in A&E departments run by ULHT and at the minor injuries units (MIUs). In some locations we found un-explained gaps in referrals to the PLN and a lack of managerial oversight or quality assurance. As a result, it is not clear that staff across acute services properly regard this as a whole system approach and there are inherent risks that children are not effectively protected. The addition of the new MIU at Peterborough to the portfolio of the paediatric liaison service has added significant pressure on the capacity of the service, which is already stretched (recommendation 3.3).

5.2.7 Within ULHT strengthening of safeguarding has started to progress with the appointment of an interim named midwife, a new post currently at Band 7 created in response to a serious case review as the role did not exist before March 2013. The named midwife post is an integrated role within ULHT, supported the safeguarding leads for adults and children. Managers recognise that the role requires the greater seniority and experience of a Band 8 midwife and a business case is being developed to seek appropriate recruitment of suitably qualified midwife. The current post holder is doing a good job from a zero base but has insufficient experience in safeguarding to put in place a fully robust framework and monitoring for effectiveness and quality.

5.2.8 Midwifery services are being reconfigured to best meet local need with the Louth community midwife team being transferred to Grimsby hospital. This makes good sense as most deliveries in that area happen at Grimsby hospital. The Grantham stand-alone unit is to close in February. This has been subject to consultation and services will move to Lincoln site to focus resources where most required.

5.2.9 The LPT safeguarding consultant named nurse oversees safeguarding activity in CAMHS, SARC, DART and adult mental health. She provides strong and effective leadership and has put a good system in place. The LCHS's safeguarding team also operates very effectively in most areas of work and makes good use of its management information.

5.2.10 The oversight and clinical governance of safeguarding in A&E and MIU locations we visited is not fully effective. Paediatric liaison arrangements lack a systematic, county wide approach. The paediatric liaison nurse records any actions she takes on her visits to review CAS Cards and holds this data. Recognised safeguarding issues within ULHT and LCHS are cascaded upwards through the Trust's Safeguarding Committee's and downwards via the Trust's Safeguarding Champions Network / deputy named nurses. However, the details of PLN activity are held by the PLN. It is not collated to provide useful performance information which ULHT and LCHS could use to monitor departmental and clinicians' safeguarding practice, identify trends and drive continuous improvement and is not subject to reporting through clinical governance arrangements (recommendation 3.3).

5.2.11 A&E staff routinely seek advice and guidance from the ULHT safeguarding team when they have concerns about individual children. We saw examples of recent improvements by the named nurses which are helping to strengthen safeguarding systems. Where staff do identify safeguarding concerns, the advice sheets then generated by the ULHT safeguarding team provide a useful audit trail of the issue and the advice or instructions given to address the safeguarding concern.

5.2.12 Arrangements are not in place to collate the health needs of looked-after children or to track their access to treatment and subsequent outcomes (recommendation 2.2). We heard about children waiting unacceptably long times for a range of services and equipment. Collation of this data would help to inform commissioning and ensure that there are appropriate, effective services in place.

5.3 Training and Supervision

5.3.1 Safeguarding champions provide a structure for sharing learning within their localities and teams. A&E at Grantham has particularly strong leadership from its A&E sister who is very well respected. As a safeguarding champion she has brought in bespoke training which has helped to skill up all the staff. Her leadership helps to mitigate for against any systems difficulties and she personally takes a role in ensuring issues are followed up.

5.3.2 Ensuring that health practitioners are trained to levels of safeguarding competence commensurate with their roles remains a priority challenge for some services. Since the previous inspection, additional investment by the LCSB has increased the availability of multi-agency safeguarding training. We saw how health staff are taking advantage of the programme, using on line booking arrangements to access targeted training to fit their roles.

5.3.3 Health visitors and school nurses are well trained in safeguarding and looked after children work and their competencies are checked to support compliance with *Working Together* and intercollegiate guidance.

5.3.4 There is now a clear grip on safeguarding training requirements for all staff of the acute trust following a period when compliance and oversight of safeguarding training was poor. This remains a priority area for improvement at ULHT and is being well monitored. As additional staff are recruited, more are able to be released for training. A good trust wide initiative by ULHT's safeguarding practitioner, in conjunction with the PLNs, is open surgeries / workshops allowing all A/E staff to access advice and guidance. These are aimed at developing safeguarding practice and confidence in addition to offering reiteration of the Safeguarding / PLN Teams' roles, unfortunately, take up is low.

5.3.5 It is not clear whether safeguarding training at level 1 is fully equipping reception staff at A&Es and MIUs to undertake risk assessment involving a high proportion of children, as they are doing on a day to day basis. Examples were given however, of cases where reception staff had identified safeguarding risks and had acted promptly in notifying clinical staff of their concerns.

5.3.6 We visited three emergency care centres which treat both children and adults and asked about arrangements to ensure staff had appropriate training to equip them to nurse children. Grantham hospital A&E is usually able to offer nursing care by at least one paediatric –trained nurse at all times. However, arrangements to ensure staff working with children across the acute trust (ULHT) and in the MIUs can access and maintain EPLS training are not sufficiently rigorous and practitioners are overdue essential refresher training (recommendation 3.4).

5.3.7 The NHS England area team (AT) and CCG leadership are working together to secure a sustainable approach to safeguarding training arrangements for GPs and this is recognised as a current area of risk. The county initially undertook a series of level 3 training sessions to cover all GPs between 2010 and 2011 but for about one third of all of those who attended then, that training is now over three years old. Training sessions for GPs are available from ULHT or the LCSB and attended by some GPs.

5.3.8 A new system is being put into place to track individual GP's training needs and attendance and ensure that arrangements are also in place for practice staff. Work is also starting, with the NHS England area team, to develop a university accredited training programme for primary care practitioners alongside an in-house programme and this is very positive.

5.3.9 Safeguarding supervision is at an early stage of implementation in some health services. However, LCHS performs well overall, with very good visible performance management information across a range of safeguarding themes including safeguarding supervision which is reported quarterly. Compliance with planned supervision in the summer quarter was 91.08%. Health visitors are routinely receiving quarterly 1:1 and also group supervision. All LPFT staff discuss safeguarding at every managerial supervision session which is a minimum of 6 weekly.

5.3.10 In some other service areas such as the MIUs (LCHS) and in midwifery (ULHT), supervision is a recent introduction which is not embedded. It is early days for group supervision and no individual supervision is in place. Although there are safeguarding champions in midwifery services, there are no safeguarding supervisory staff other than the named midwife. There are no formal safeguarding supervision arrangements for A&E staff at ULHT (recommendation 6.1). Without regular formal supervision as set out in statutory guidance, practitioner's annual appraisal cannot be fully informed as part of a robust workforce development model.

Recommendations

1. Lincolnshire West CCG; South Lincolnshire CCG; South West Lincolnshire CCG; Lincolnshire East CCG should:

1.1 Review the leadership capacity for safeguarding children and children in care to fully meet statutory requirements and secure the timely delivery of quality services for safeguarding children and children who are looked after.

1.2 Ensure commissioning governance and assurance provide effective scrutiny of the experiences and impact of local health services in delivering improved outcomes for children and young people who are looked after.

1.3 Use the opportunity of the local strategic review to consider the commissioning of specialist paediatric care and ensure its effectiveness in enabling children who have specialist needs to have access to timely, child centred assessment and treatment.

2. Lincolnshire West CCG; South Lincolnshire CCG; South West Lincolnshire CCG; Lincolnshire East CCG and LCHS should :

2.1 Ensure the emotional wellbeing and mental health of children in care is fully addressed in health care assessments, reviews and health plans.

2.2 Regularly report on child health outcomes for children in care, proactively identifying local trends, and robustly addressing risks to their health and wellbeing.

2.3 Fully implement holistic health summaries for young people leaving care and ensure they are responsive to their individual wishes and needs.

2.4 Ensure that arrangements are put into place to provide consistent support for looked after young people and care leavers who become pregnant or become parents.

2.5 Ensure that all children in care have prompt and high quality, holistic assessments of their needs and regular reviews followed by SMART health plans that ensure their needs are met.

3. Lincolnshire West CCG; South Lincolnshire CCG; South West Lincolnshire CCG; Lincolnshire East CCG, LCHS and ULHT should:

3.1 Ensure that discharge pathways from MIUs, A&Es and other settings are effective in ensuring the sharing of information about risks and involving appropriate professionals to secure best outcomes for the young people.

3.2 Ensure that opportunities are maximised to offer young people help through drug and alcohol support services by embedding the LSCB led multi-agency protocol which provides clear referral pathways from health services including urgent care settings to Young Addaction .

3.3 Review paediatric liaison capacity, seniority and clinical governance arrangements to ensure that robust, effective arrangements are in place across all services so that risks to children are effectively identified and followed up.

3.4 Ensure all children and young people requiring urgent care in the MIUs and Accident and Emergency Departments are cared for by appropriately trained nursing staff with updated specialist paediatric skills.[5]

4. NHS England, Lincolnshire West CCG; South Lincolnshire CCG; South West Lincolnshire CCG; Lincolnshire East CCG and LCHS should:

4.1 Ensure that GPs are properly equipped and competent for their roles in safeguarding, child protection and meeting the needs of children in care through robust development opportunities.

4.2 Ensure that GPs and others who may provide contraceptive services to young people are aware of the law in relation to the age of consent, particularly in relation to their responsibilities where a girl is under 13 years of age.

4.3 Ensure there are robust local systems for GPs to regularly share information about children and families where risks are identified.

[5] *"In district general hospital mixed emergency departments, a minimum of one registered children's nurse with trauma experience and valid EPLS/APLS training must be available at all times"* (RCN and RCPCH 2010; RCPCH, 2012).

5. NHS England, Lincolnshire West CCG; South Lincolnshire CCG; South West Lincolnshire CCG; Lincolnshire East CCG and LPFT should:

5.1 Continue to work in partnership to ensure that commissioning and operational arrangements enable children needing CAMH services to have timely access to early help, specialist assessment and treatment.

5.2 Ensure that mothers and their babies in all areas of Lincolnshire have access to perinatal mental health services to secure effective early intervention and support.

5.3 Review arrangements for young people placed out of county so that discharge protocols from or between CAMH tier 4 services and to other services ensure that these young people receive the support they need. .

6. Lincolnshire West CCG; South Lincolnshire CCG; South West Lincolnshire CCG; Lincolnshire East CCG, and ULHT should:

6.1 Ensure an appropriate system of supervision is in place for all staff who are involved in safeguarding and child protection work, including urgent care and midwifery, in line with inter-collegiate professional requirements.

7. Lincolnshire West CCG; South Lincolnshire CCG; South West Lincolnshire CCG; Lincolnshire East CCG, LCHS, ULHT and LPFT should:

7.1 Expand opportunities for listening to and learning from the experiences of young people and their families/carers, actively engaging them in service improvements.

7.2 Ensure that robust arrangements are put in place to assure the quality of referrals by health professionals and ensure that children for whom risks are identified receive prompt support.

7.3 Ensure, through working with partners, that staff across all health disciplines including adult drug and alcohol services are fully engaged in robust, consistent information sharing about children and their families for whom risks or concerns are known.

7.4 Ensure that the pre-birth protocol is audited for effectiveness in all cases including those where there is a known high degree of risk around the expectant mother

8. LCHS:

8.1 Ensure that all relevant staff are properly equipped prior to any roll out of new policies or systems including the electronic version of the vulnerability assessment matrix, to ensure use is consistent and effective.

9. NHS England and Lincolnshire West CCG; South Lincolnshire CCG; South West Lincolnshire CCG; Lincolnshire East CCG should:

9.1 Review commissioning strategies, local needs analyses and pathways to ensure children benefit from sufficiency of CAMHs provision, including tier 4, tier 3+ and community based alternatives to in-patient care, to facilitate care close to home and to ensure that other young children on paediatric wards are not put at risk of harm or distress

Next steps

An action plan addressing the above recommendations is required from South West Lincolnshire CCG on behalf of the federation within 20 working days of receipt of this report. Please submit your action plan to CQC through childrens-services-inspection@cqc.org.uk. The plan will be considered by the inspection team and progress will be followed up through CQC's regional team.

Appendix B

NHS South West Lincolnshire Clinical Commissioning Group
NHS Lincolnshire West Clinical Commissioning Group
NHS South Lincolnshire Clinical Commissioning Group
NHS Lincolnshire East Clinical Commissioning Group

CQC Review of Health Services for Looked After Children and Safeguarding in Lincolnshire

Date of Review: 4th - 8th November 2013
Action Plan submitted: 21st March 2014
Author: Jan Gunter Designate Consultant Nurse for Safeguarding Children and Adults.

CQC Review of Health Services for Looked After Children and Safeguarding in Lincolnshire					
Recommendations	**Current Position in Lincolnshire**	**Actions Proposed**	**Agency**	**Named Person**	**Time Scale**
1. Lincolnshire West CCG; South Lincolnshire CCG; South West Lincolnshire CCG; Lincolnshire East CCG should:					
1.1 Review the leadership capacity for safeguarding children and children in care to fully meet statutory requirements and secure the timely delivery of quality services for safeguarding children and children who are looked after.	**The recommendation specifically relates to 5.1.4 5,2,3 and 5,2.4 of the CQC report regarding capacity of the safeguarding leadership p including leadership for looked after children:** Lincolnshire currently operates a federated safeguarding service, hosted by South West Lincolnshire CCG on behalf of all four CCG's in the county, the other CCGs being West Lincolnshire CCG, Lincolnshire East CCG, and South Lincolnshire CCG. Leicestershire and Lincolnshire Area Team are overseeing an external review of the role function and capacity of the Designated Professionals and Named Doctors across both Counties. The CCG's have collaboratively funded the external review of the designated professionals and named doctor statutory role and function in the context of the new NHS recognising that there is insufficient capacity in the hosted service. All relevant professionals have been interviewed and a draft report has been submitted. The Area Team is currently awaiting the final report from the externally commissioned author.	The draft review report identifies additional capacity requirements for Lincolnshire. The external review report will be presented to the CCG collaborative in May 2014 for endorsement, with an associated business case to increase resource and capacity in accordance with the report recommendations and to proceed with recruitment.	SWCCG (Host) in collaboration with LECCG, SLCCG and WLCCG	Executive Nurses for each CCG: Sharon Robson, Wendy Martin, Tracey Pilcher, Lynne Moody	May-14

CQC Review of Health Services for Looked After Children and Safeguarding in Lincolnshire					
Recommendations	**Current Position in Lincolnshire**	**Actions Proposed**	**Agency**	**Named Person**	**Time Scale**
	It has been acknowledged that there is insufficient capacity for the designated professionals to proactively drive the safeguarding and looked after children services in the new NHS. Commissioning for needs led services is dependent upon understanding the health profile of the child population and the needs of the looked after children residing in Lincolnshire. Public health data, the Looked After Children's database and the Local authority system of reporting are separate systems. Data from each is brought together in the form of annual reports. The Annual reporting of the Health and Wellbeing of Looked-after Children is developing, and integrating with the LA from 2014/15 to demonstrate the health profile of looked-after children more robustly in support of evidence based commissioning. There is a Looked After Steering Children's Steering Group established who are overseeing the annual report development and reporting of progress is required at each bi-monthly meeting. Quarterly reporting is required the LA Senior Management Team, the Children's and Young people's Strategic partnership (for corporately parented looked after children), to the LSCB for those looked after children externally placed and within health to the Strategic Safeguarding Steering Group.	The Looked-after Children Steering Group is overseeing the development of the revised Annual Report and reports into the Strategic Safeguarding Steering Group where progress will be monitored quarterly. The integrated annual report will be delivered to the Lincolnshire County Council / Directorate Management Team for LAC corporately parented. The management team receive quarterly reports of the achievement and quality of the statutory health assessments. The LSCB will receive quarterly reports of all LAC externally placed to ensure strategic oversight. The recruitment process for staff within the community health services has started.	SWCCG (Host) in collaboration with LECCG, SLCCG and WLCCG and LCHS (for backroom function - reporting etc.) and staff	Designated Doctor Dr F Johnson Designated Nurse Jan Gunter	7 Months (October 2014)
	The service specification for looked after children's statutory health assessments has been reviewed and updated by the designated professionals. LCHS has commenced recruitment to increase capacity within the vulnerable children and young people's team in support of the increased activity currently required. The Designated Professional's review has in the draft report recommended increased capacity for the designates for looked after children. The external review report on completion is, as detailed above, awaited. A service specification has being written by the Designated Doctor and the Designated Nurse including the current statutory health assessment level of need.	The designated professional roles and capacity is included in the external review and will be presented to the CCG collaborative as above. With regard to capacity for statutory health plans. An options appraisal is almost complete and will be presented to the Strategic Safeguarding Group in May 2014. LCHS have commenced recruitment in response to the additional requirement within the vulnerable children and young people's team.	SWCCG (Host) in collaboration with LECCG, SLCCG and WLCCG and LCHS (for backroom function - reporting etc.)	Designated Doctor Dr F Johnson Designated Nurse Jan Gunter	May-14

CQC Review of Health Services for Looked After Children and Safeguarding in Lincolnshire					
Recommendations	**Current Position in Lincolnshire**	**Actions Proposed**	**Agency**	**Named Person**	**Time Scale**
1.2 Ensure commissioning governance and assurance provide effective scrutiny of the experiences and impact of local health services in delivering improved outcomes for children and young people who are looked after.	**The recommendation specifically relates to 5.1.3, 5.1.9 and 5.2.4 or the CQC report relating to the capacity and quality of statutory health assessments for Looked-after Children (LAC):** Currently a Locally Enhanced Service (LES) for the statutory health assessments has been provided by GPs and Nurses who have undertaken additional training. The Designated and named professionals have been involved in the additional training which has been led by the Designated Doctor, a Community Consultant Paediatrician and delivered through the Named Nurse and her team. The training has been well attended and evaluated. The GPs involved in the LES have stated that the additional training they have received has impacted positively on their practice when dealing with children in the general population. The LES however, had been acknowledged as producing variable quality and capacity issues and a review of the service had been proposed prior to the CQC review. Accordingly the service specification has been revised by the designated professionals and an options appraisal is being developed to meet current and projected increase in demand for presentation to the CCG collaborative.	The service specification proposes that Initial Health Assessments (IHA) for children under 5 years to be completed by Paediatric Consultants, IHAs for children over 5 years for suitably skilled medical practitioners, which could incorporate those GPs who have a special interest or paediatricians and Review Health Assessments (RHAs) to become a nurse led service. There is an options appraisal being prepared to address capacity and access issues and improve quality and consistency which will be presented to the Strategic Steering Group in May 2014	SWCCG (Host) in collaboration with LECCG, SLCCG & WLCCG	Designated Doctor Dr F Johnson Designated Nurse Jan Gunter	May-14
	The service is currently being provided by GPs and Nurses who have undertaken additional training. As detailed above the specification is being revised to reflect current need and an options appraisal being drawn up for presentation to the SSG. Using community paediatrician's for the under 5 years of age IHA is incorporated within the option appraisal. The capacity to undertake safeguarding and quality audits has also been incorporated in the service specification.	The service specification and the option appraisal will be presented to the CCG collaborative in May 2014	SWCCG (Host) in collaboration with LECCG, SLCCG & WLCCG	Executive Nurses for each CCG: Sharon Robson, Wendy Martin, Tracey Pilcher, Lynne Moody	6 months (September 2014)

CQC Review of Health Services for Looked After Children and Safeguarding in Lincolnshire					
Recommendations	**Current Position in Lincolnshire**	**Actions Proposed**	**Agency**	**Named Person**	**Time Scale**
	The lack of capacity within the vulnerable children and young people team has been acknowledged and a business case approved within LCHS to recruit further nursing capacity into the team. The capacity of the designated professionals role and function has been reviewed externally as detailed above and within the draft report identifies additional resource is required, and the final report is awaited. It is widely acknowledged that capacity within safeguarding and looked-after children requires strengthening and has the commitment of the CCGs.	The active phase of recruiting additional nurses to the VCYPT has commenced within LCHS. The looked after children's health assessments specification is forming the basis of the contracts to undertake the work and for review health assessments to become a nurse led service.	LCHS	Michelle Johnstone	01/05/2015

CQC Review of Health Services for Looked After Children and Safeguarding in Lincolnshire					
Recommendations	**Current Position in Lincolnshire**	**Actions Proposed**	**Agency**	**Named Person**	**Time Scale**
1.3 Use the opportunity of the local strategic review to consider the commissioning of specialist paediatric care and ensure its effectiveness in enabling children who have specialist needs to have access to timely, child centred assessment and treatment.	T**he recommendation specifically relates to 1.19 of the CQC report relating to the access of paediatricians (LAC):** ULHT has 5 Consultant Paediatricians located at Pilgrim Hospital, Boston; 7 located at Lincoln County Hospital and 7 Community Consultant Paediatricians (one of whom has specific responsibility as the Designated Doctor for LAC). Lincolnshire was identified as having sufficient acute Consultant paediatricians in the 2009 paediatric review whilst slightly under established for community paediatricians. These have since been recruited to and incorporate specialist function within each role. Alongside all services in Lincolnshire the paediatric service is being reviewed within the Sustainability Framework. Where children with a plan for adoption are undergoing an adoption medical as required by the regulation, the large majority of cases, more than 80%, have adoption medicals undertaken by paediatricians. The two medical advisors contracted to undertake this work demonstrably respond at short notice to comply with completion timescales for care proceedings. Where Paediatric input is, at an early stage, flagging up issues which require further scrutiny, e.g. parental substance misuse or potential chromosomal abnormalities which are followed up promptly. Social care regularly pay for additional investigation / testing around these issues, with agreed timescales for completion. This information is critical to matching. The management team are made aware of any delays in access to specialist services and subsequent delay in the child's journey that compromise legal proceedings. There is no waiting list to see the Adoption Medical Advisors.	The Designated professionals for LAC have reviewed and updated the service specification and are developing the options appraisal for service delivery. Lincolnshire is reviewing all services within the Sustainable Services Review which included the whole paediatric service. With regard to statutory health assessments for looked after children, the preferred option is to develop clinics for children to undertake their IHA's and it is planned to then bring together the adoption medical service together with the initial health assessments within a clinic setting to improve quality, timeliness and consistency. for children's access to paediatrician's.	SWCCG (Host) in collaboration with LECCG, SLCCG & WLCCG	Accountable Officers	May 2015 1 year
2. Lincolnshire West CCG; South Lincolnshire CCG; South West Lincolnshire CCG; Lincolnshire East CCG and LCHS should :					

CQC Review of Health Services for Looked After Children and Safeguarding in Lincolnshire					
Recommendations	**Current Position in Lincolnshire**	**Actions Proposed**	**Agency**	**Named Person**	**Time Scale**
2.1 Ensure the emotional wellbeing and mental health of children in care is fully addressed in health care assessments, reviews and health plans.	**The recommendation specifically relates to 4.3 of the CQC report relating to the follow up of the Strengths and Difficulties Questionnaire (SDQ):** Recently a mechanism to ensure follow up of pathways within CAMHS has been introduced. This is with regard to children scoring 14 or over with in SDQ and is identified as requiring a review within the S75 agreement. There is currently an absence of audit evidence regarding this aspect of CAMHS services which has been recognised and an SDQ group has been specifically formulated to address the issues identified. The group has already met and the Designated Doctor for Looked After Children is proactively working with. The group is represented at the Looked After Steering Group and reports will be received there.	The S75 arrangement will be reviewed to ensure there is the ability for the SDQ group to review scores over 14 and follow into the GP health assessment. The success is dependent on collaboration and receipt of data from CAMHS current section 75 arrangements. A Process is being developed for practitioners feedback regarding SDQ scores and access into CAMHS The initiatives will monitored through audit.	The LA & LPFT working collaboratively with providers	Janice Spencer & Liz Bainbridge	3 months (June2014) Quarterly reporting from audits thereafter.
2.2 Regularly report on child health outcomes for children in care, Proactively identifying local trends, and robustly addressing risks to their health and wellbeing.	**The recommendation specifically relates to 4.19 and 5.2.5 of the CQC report relating to the timely access to equipment, specifically wheelchairs**: The provision of equipment services are currently contracted through Millbrook. The contract explicitly incorporates and covers children's equipment including wheelchairs. The parents contact the provider directly who will initiate a new assessment and provide a wheelchair based upon the assessment. There is no evidence of a waiting list and the contract is performance managed.	Review of database and performance measures currently being carried out increase of data fields to incorporate long-term conditions and social environment. There is a review of the wheel Chair service being planned. This will include performance management of contract and quality assurance.	SWLCCG - Lead	Colin Warren	3 months

CQC Review of Health Services for Looked After Children and Safeguarding in Lincolnshire					
Recommendations	**Current Position in Lincolnshire**	**Actions Proposed**	**Agency**	**Named Person**	**Time Scale**
	The recommendation specifically relates to 4.19, 4.5, 5.2.5 and 5.2.12 of the CQC report regarding performance reporting of the holistic health needs of looked after children and tracking of outcomes: It is acknowledged that the Looked After Children Annual Health Report has been limited in scope. The data sources required to demonstrate a full health profile is limited and not integrated. Recent developments have enabled improved and more robust data regarding initial health assessments. Data fields on SystmOne are being continually improved to incorporate health information and are currently prioritising long term conditions identification and reporting. The annual health report template has been changed to incorporate health conditions and their prevalence and will be integrated with the LA annual report, based upon evidence from the LAC and their carers. The process is being driven by the LAC Steering Group and being reported against bi-monthly.	Reporting systems in both health and the e LA are under further development with regards to reporting the health issues and inequalities experienced by LAC. the plan is to incorporate wider health determinants and outcomes of interventions for LAC. WLCCG are the lead CCG for the county in this area. The specification for LAC services has been reviewed and updated by the Designated professionals from which the contracts will be agreed and performance managed against.	SWCCG (Host) in collaboration with LECCG, SLCCG & WLCCG	Designated Doctor Dr F Johnson & Designated Nurse Jan Gunter	6 months (September 2014)
	The extrapolation of data from SystmOne is under further development. Reporting of long term conditions will be possible for 14/15. The follow-up of the health care plan, attendance at referrals and outcomes recording for children is being developed in association with the local authority by strengthening the use of the Red and Blue Books (Red book is the Child Health Record and Blue Book is the Looked After Children record). Therein the recording of health assessments within the books is now a component of the revised specification, and monitoring of progress to been overseen by the independent reviewing officers (within social care) who quality assure the care management of children regularly in-between statutory health assessments	There is a re launch of the use of the Blue Book and Red Book in the context of Looked-after Children health assessments across health and social care. Within the new contracts being drawn up there is a requirement for all health practitioners to record each contact in the books and complete the IHA / RHA components within the Blue Book. There is a need to develop a Service Level Agreement with the LA for the IRO to quality assure the progress. SLN review was mentioned. Closer working with Health watch is planned to explore emerging themes and healthwatch will contribute to collating evidence. LCC are reviewing the purchasing arrangements with regard to these issues.	SWCCG (Host) in collaboration with LECCG, SLCCG & WLCCG working with the LA	Designated professionals, Dr F Johnson & Designated Nurse Jan Gunter	6 months (September 2014)

CQC Review of Health Services for Looked After Children and Safeguarding in Lincolnshire					
Recommendations	**Current Position in Lincolnshire**	**Actions Proposed**	**Agency**	**Named Person**	**Time Scale**
2.3 Fully implement holistic health summaries for young people leaving care and ensure they are responsive to their individual wishes and needs.	**The recommendation specifically relates to 4.21 of the CQC report regarding health summaries for children leaving care:** Currently all children in care receive a Blue Book which is the comprehensive health record for the child's length of time spent in care. It is acknowledged that this and the Red Book - Child Health record requires further embedding to improve the health history of each child.	As detailed above there is a plan to relaunch the Red and Blue Books as the comprehensive / contemporaneous record of the LAC health. In addition a template for a health summary is under development. The responsibility of the leaving care summary will sit with the nurse led service managing the RHAs and has been made explicit within the LAC service specification and will be performance managed through the contracts	SWLCCG (host) in collaboration with LECCG, SLCCG, WLCCG	Designated Professionals, Dr F Johnson & Designated Nurse Jan Gunter	6 Months (September 2014)
2.4 Ensure that arrangements are put into place to provide consistent support for looked after young people and care leavers who become pregnant or become parents.	**The recommendation specifically relates to 3.22 of the CQC report regarding dedicated pathways regarding pregnancies in children leaving care**: Currently Barnardos are commissioned to deliver this in Lincolnshire. Once the young person informs their Barbardos leaving care worker that they are pregnant or becoming a father, it is recorded on the system electronically. The outcome is then recorded under categories that include: deceased, adopted, fostered, living with care leavers or other. The leaving care worker works in accordance with the Multi-agency Pre Birth protocol in partnership with children's services and health to meet the needs of the young person and child	A care leavers pathway is under development that will require all young people leaving care who are expectant or actual parents will have the support of a TAC to ensure that agencies are working effectively together to support the family. Reporting against the pathway outcomes will inform future commissioning	LA CCG'S & LCHS	Janice Spencer & Jean Burbidge	NA LCHS barnados lead through LA commissioning – LCHS has no control.

CQC Review of Health Services for Looked After Children and Safeguarding in Lincolnshire					
Recommendations	**Current Position in Lincolnshire**	**Actions Proposed**	**Agency**	**Named Person**	**Time Scale**
2.5 Ensure that all children in care have prompt and high quality, holistic assessments of their needs and regular reviews followed by SMART health plans that ensure their needs are met.	**The recommendation specifically relates to 4.1, 4.5 4.11, 4.16 and 4.19 of the CQC report regarding the resource capacity and quality of health plans for looked after children:** The current provision within LCHS for managing the backroom function and provision of review health assessments for children has not keep pace with the significant recent increase in the total number of LAC internal (from within Lincolnshire) and externally through placing authorities) The revised specification for LAC health assessments incorporates the increased activity and projected increase in demand and includes the requirement of quality assurance provision of health assessments which will be performance managed against the contract. Audit has consistently demonstrated health assessments carried out by VCYP team are prompt and of a high quality. LCHS provide database countywide backroom functions.	LCHS are currently in the process of recruiting additional staff to the VCYPT in response to the required need. Included in the recruitment is a post for a nurse to quality assure the health assessments. There is an options appraisal being submitted to the CCG collaborative regarding the pathway of IHAs Reference to quality of GP assessments Reporting of capacity issues is to be incorporated into the quarterly reporting to inform commissioning and quality assurance process. Oversight within health will be managed through the Safeguarding Steering Group and within the LA through LCC and the Corporate Parenting Group.	CCG commissioning LCHS provider	Michelle Johnstone	Apr-14
	A review of the service had already been proposed for the statutory health assessments due to acknowledged variability of quality. As detailed above in 4.0 the service specification for LAC has been reviewed by the designated professionals and quality assurance capacity is explicitly included to ensure consistency and quality of the assessment and subsequent health plan. The issues of electronic reporting, quality assurance and reduced variability. The ensuing contracts raised to undertake this work will be performance managed against the specification. An option appraisal is being prepared by the designated professionals for presentation to the CCG collaborative regarding a new pathway for LAC health assessments. The preferred option being proposed to the CCG collaborative includes the use of Community Paediatricians for Initial health assessments, especially for the younger children. The evidence from the reviews of the needs of the looked-after children population will inform the commissioning in the future.	The LAC specification has been reviewed by the designated professionals. WLCCG is overseeing the contracts development which will be used to performance manage the delivery of the service. Reporting will be via the Quality Surveillance Group and Quality and Patient Experience Committees for each CCG. Reporting quarterly within health, to the CPYSP/LCC for those LAC corporately parented and to the LSCB for those placed by external authorities	CCG commissioning + provider organisations	Designated Doctor Dr F Johnson Designated Nurse Jan Gunter	3 months

CQC Review of Health Services for Looked After Children and Safeguarding in Lincolnshire					
Recommendations	**Current Position in Lincolnshire**	**Actions Proposed**	**Agency**	**Named Person**	**Time Scale**
	A review of the service had already been proposed for the statutory health assessments due to acknowledged variability of quality. As detailed above in 4.10 and 4.11 the service specification for LAC has been reviewed by the designated professionals and quality assurance capacity is explicitly included to ensure consistency and quality of the assessment and subsequent health plan. The issues of electronic reporting, quality assurance and reduced variability. The ensuing contracts raised to undertake this work will be performance managed against the specification. An option appraisal is being prepared by the designated professionals for presentation to the CCG collaborative regarding a new pathway for LAC health assessments. The preferred option being proposed to the CCG collaborative includes the use of Community Paediatricians for Initial health assessments, especially for the younger children. The evidence from the reviews of the needs of the looked-after children population will inform the commissioning in the future.	The LAC service specification has been reviewed and delivered to WLCCG. Contracts being raised and taken up to deliver the service will be performance managed through the contracting teams and Quality and Patient experience committees for each CCG. Reporting quarterly within health, to the CPYSP/LCC for those LAC corporately parented and to the LSCB for those placed by external authorities	WLCCG	Designated Doctor Dr F Johnson Designated Nurse Jan Gunter	3 months
	A review of the service had already been proposed for the statutory health assessments due to acknowledged variability of quality. As detailed above in 4.10 and 4.11 the service specification for LAC has been reviewed by the designated professionals and quality assurance capacity is explicitly included to ensure consistency and quality of the assessment and subsequent health plan. The issues of electronic reporting, quality assurance and reduced variability. The ensuing contracts raised to undertake this work will be performance managed against the specification. An option appraisal is being prepared by the designated professionals for presentation to the CCG collaborative regarding a new pathway for LAC health assessments. The preferred option being proposed to the CCG collaborative includes the use of Community Paediatricians for Initial health assessments, especially for the younger children. All health practitioners have been reminded of the need to look back in children's records to the previous entries to ensure continuum of care. The evidence from the reviews of the needs of the looked-after children population will inform the commissioning in the future.	The LAC service specification has been reviewed and delivered to WLCCG. The LAC health care co-ordinator will request reports from allied health professionals involved with the child in preparation for the RHA and the quality assurance post within LCHS will monitor through audit. Contracts being raised and taken up to deliver the service will be performance managed through the contracting teams. Reporting quarterly within health, to the Quality and Patient experience committees for each CCG, the Safeguarding Steering Group and LAC Steering Group, externally to the CPYSP/LCC for those LAC corporately parented and to the LSCB for those placed by external authorities	WLCCG	Designated Doctor Dr F Johnson Designated Nurse Jan Gunter	3 Months

CQC Review of Health Services for Looked After Children and Safeguarding in Lincolnshire					
Recommendations	**Current Position in Lincolnshire**	**Actions Proposed**	**Agency**	**Named Person**	**Time Scale**
	The provision of equipment services are currently provided through Millbrook. The contract makes explicit that children's equipment is incorporated and covered by the contract. A parent makes contact with the provider directly who then arranges an assessment of need. Equipment is then provided in accordance with the assessment findings. The contract is performance managed.	Review of database and performance measures currently being carried out increase of data fields to incorporate long-term conditions and social environment. There is a review of the wheel Chair service being planned. This will include performance management of contract and quality assurance.	SWLCCG - Lead	Colin Warren	3 months
3. Lincolnshire West CCG; South Lincolnshire CCG; South West Lincolnshire CCG; Lincolnshire East CCG, LCHS and ULHT should:					

CQC Review of Health Services for Looked After Children and Safeguarding in Lincolnshire					
Recommendations	**Current Position in Lincolnshire**	**Actions Proposed**	**Agency**	**Named Person**	**Time Scale**
3.1 Ensure that discharge pathways from MIUs, A&Es and other settings are effective in ensuring the sharing of information about risks and involving appropriate professionals to secure best outcomes for the young people.	**The recommendation specifically relates to 1.12, 2.9 and 3.18 of the CQC report regarding onward referrals from unscheduled care settings including the self harm pathway:** WLCCG are the lead CCG for the acute Trust and LECCG act as lead CCG for LCHS through which the 2 Paediatric Liaison Nurses (PLN) are employed and have been judged as Good practice. They provide an 'in hours' service. Within LCHS a discharge pathway for children within and across unscheduled care settings that LCHS manage has been reviewed and this now incorporates a management review of all child attendees on daily basis to ensure appropriate action and onward referral has been taken irrespective of site. ULHT support full integration of the PLN role within each A&E site. It is acknowledged that there needs to be collaborative working model between LCHS ULHT and commissioning to ensure appropriate provision of this role.	Quarterly performance reporting to ensure continued quality is now required. A discharge pathway review is planned within ULHT on each site ED to review and clarify discharge pathway for children. Full ULHT Action is below. Quarterly performance reporting to ensure continued quality. LCHS are prioritising their unscheduled care provision.	LCHS	Michelle Johnstone Head of Safeguarding LCHS	Completed LCHS
	The PLN process is in place within A/E and Paediatric areas. Staff members have access to PLN Discharge Criteria. ULHT ED are committed and working to develop a consistent approach for sharing information with the PLNs	Each ULHT ED site will agree a Pathway for referral to PLN which prevents delays and inappropriate referrals.	ULHT	PLN SG Practitioner Named Nurse SG ED Matrons Medical Director	Jun-14
	SWLCCG is the lead CCG for MH services working closely with the Local Authority who commission CAMHS through a S75 agreement. A revised Self-Harm Pathway (SHP) has been signed off between the Executive nurses for LPFT and LCHS and the LSCB. It is acknowledged that currently the self- harm pathway was not been fully embedded and therefore could work more effectively. Auditing and monitoring reports are awaited. A proposal of tracking cases for the SHP has been given for quality audit purposes and the SHP will be performance managed. ULHT support the SHP and are actively developing the internal mechanism for implementing the pathway recommendations. Acknowledged that these Patients are ULHT patients with a need for LPFT input.	ULHT will embed the SHP and identify where the child is to be paediatrically assessed and mental health assessment is required / completed in accordance with NICE guidance ULHT will manage performance internally (via Datix). WLCCG will performance manage as lead CCG through the contracting quality meetings. For children presenting through A&E that require admission (without a physical health need) there will be quality assurance that both paediatric and mental health assessment occurs prior to decision on best place of safety / admission. There has been additional investment from the CCGs into LPFT (with CAMHS and HIPS) to support this pathway.	ULHT LA / LPFT	Safeguarding Lead ULHT & Karen Berry Interim Director for Operations LPFT	Jun-14

CQC Review of Health Services for Looked After Children and Safeguarding in Lincolnshire					
Recommendations	**Current Position in Lincolnshire**	**Actions Proposed**	**Agency**	**Named Person**	**Time Scale**
	Discharge letters are system-generated but there is a facility for staff to add additional relevant information in a 'free text' section. .	A/E staff to include any safeguarding concerns or safeguarding actions taken within 'free text' box on discharge letter. ULHT will ensure that A/E staff are aware of the need to include any safeguarding concerns or actions taken within 'free text' box on discharge letter. Staff will be informed by letter to Clinical Leads and Matrons; with inclusion in training going forward.	ULHT	Safeguarding Lead A&E Consultant Nurses and Clinical Directors	Mar-14
3.2 Ensure that opportunities are maximised to offer young people help through drug and alcohol support services by embedding the LSCB led multi-agency protocol which provides clear referral pathways from health services including urgent care settings to Young Addaction.	**The recommendation specifically relates to 1.1 of the CQC report regarding referrals from A&E departments to drugs and alcohol services:** A pathway of referral into Addaction has been developed by the LSCB which was awaiting ratification at the time of the inspection. This pathway has now been ratified. Referral pathways for accessing young Addaction and relevant literature has been disseminated to all A&E staff through organisational team briefs (delivered monthly by line manager) and team meetings.	There is a plan in place to monitor by number of appropriate referrals into the service and audit outcomes. There is also a programme of back to floor visits by appropriately skilled staff. Feedback will be through the clinical governance processes. The designated nurse will receive a report.	ULHT	Chair of Safeguarding Committee via Named Nurse Safeguarding	Apr-14
3.3 Review paediatric liaison capacity, seniority and clinical governance arrangements to ensure that robust, effective arrangements are in place across all services so that risks to children are effectively identified and followed up.	**The recommendation specifically relates to 5.2.6, and 5.2.10 of the CQC report regarding the paediatric liaison service:** WLCCG are the lead CCG for the acute Trust and LECCG act as lead CCG for LCHS through which the PLNs are employed. There are 2 Paediatric Liaison Nurses (PLN) employed by LCHS and have been judged as Good practice. They provide an 'in hours' service. Within LCHS a discharge pathway for children within and across unscheduled care settings that LCHS manage has been reviewed and this now incorporates a management review of all child attendees on daily basis to ensure appropriate action and onward referral has been taken irrespective of site. ULHT support full integration of the PLN role within each A&E site.	Current establishment remains the same at Band 6 provision is currently under review with the growth of unscheduled care provision within LCHS and the demands on the capacity and the efficient working of the role will be prioritised according to LCHS establishments.	LCHS	Michelle Johnstone	Apr-14

CQC Review of Health Services for Looked After Children and Safeguarding in Lincolnshire					
Recommendations	**Current Position in Lincolnshire**	**Actions Proposed**	**Agency**	**Named Person**	**Time Scale**
3.4 Ensure all children and young people requiring urgent care in the MIUs and Accident and Emergency Departments are cared for by appropriately trained nursing staff with updated specialist paediatric skills.5	**The recommendation specifically relates to 5.3.6 of the CQC report regarding capacity of appropriately trained staff to provide paediatric care in A&E and MIU departments:** LCHS have in place training for the MIU which can be demonstrated through compliance via mandatory training matrix	Regular audit and quarterly reporting through the clinical governance process	LCHS	Michelle Johnstone	Completed
	Within ULHT EPLS training is available to staff working in A&E. There are Attendance Criteria Pathways in existence to ensure patients attend an emergency department on a site relevant to their level of dependence.	Staff to be released to access EPLS training. Managerial oversight required to monitor compliance.	ULHT	A/E Matrons, Nurse Consultant and Clinical Directors for Child division and Emergency Care.	Jun-14
4. NHS England, Lincolnshire West CCG; South Lincolnshire CCG; South West Lincolnshire CCG; Lincolnshire East CCG and LCHS should:					

CQC Review of Health Services for Looked After Children and Safeguarding in Lincolnshire					
Recommendations	**Current Position in Lincolnshire**	**Actions Proposed**	**Agency**	**Named Person**	**Time Scale**
4.1 Ensure that GPs are properly equipped and competent for their roles in safeguarding, child protection and meeting the needs of children in care through robust development opportunities.	**The recommendation specifically relates to 3.8 and 1.7 of the CQC report regarding GPs being equipped and competent in safeguarding roles:** Since April 2013 NHS England commissions primary care / GP services. All GPs are required to have the requisite competence and skill to provide for their patients including safeguarding issues incorporating domestic violence. MARAC training has been incorporated into safeguarding training for a number of years. They are performance managed through evidence of appraisal and evaluation. Support and advice systems for GPs are currently being reviewed- NHS England and the Local CCGs are exploring the current provision, and will negotiate appropriate training and development opportunities within this review.GP A Database is being is being created, and currently survey monkey has gone out to all GP's regarding their safeguarding training, including domestic abuse training and is awaiting response.	LCHS employed GPs are subject to the same training matrix as other employees of LCHS . Mapping of the safeguarding training requirements for all GPs across Lincolnshire is being undertaken. The outcome of which will inform commissioning of prioritised training needs	LCHS, NHS England,	Pam Palmer NHS England Tracy Pilcher Executive Nurse LECCG & Michelle Johnstone Head of Safeguarding LCHS	LCHS Completed NHS England 6 months
4.2 Ensure that GPs and others who may provide contraceptive services to young people are aware of the law in relation to the age of consent, particularly in relation to their responsibilities where a girl is under 13 years of age.	It is acknowledged that there is an absence of an agreed system of communication between health professionals including HVs and GPs. HVs are no longer based in GP surgeries and operate corporate caseloads. PP to send in narrative. It is acknowledged that there are gaps wider than LCHS HVs including ULHT and LA. This is a large piece of work. The LSSR neighbourhood teams include key workers who are essential to improving communication.	Neighbourhood Key workers will be proactive in engaging with GPs as part of the implementation of the LSSR framework.	NHS England & LCHS	Pam Palmer & Michelle Johnstone	May-15
	The recommendation specifically relates to 2.4 and 5.1.10 of the CQC report regarding the competence and profile / exposure of contraception and sexual health services across the partnership arrangements: Fraser competencies and age of consent are included within level 3 safeguarding training. This also includes the practitioners' responsibility in relation to sexual abuse/child sexual exploitation. Focusing on responsibilities and legal implications all GPs and sexual health service practitioners attend level 3 safeguarding children training. Following this review an enquiry was undertaken within LCHS who manage the service and no evidence could be found to identify the children aged under 13 or under. Thus tracking of the child and services accessed has proved impossible.	The Fraser competencies , practitioner responsibilities and legal implications of very young people requiring sexual health services will remain on the safeguarding children level 3 programme to remind professionals on a regular basis	NHS England CCGs LCHS	Pam Palmer NHS England Tracy Pilcher Executive Nurse LECCG & Michelle Johnstone Head of Safeguarding LCHS	Completed

CQC Review of Health Services for Looked After Children and Safeguarding in Lincolnshire					
Recommendations	**Current Position in Lincolnshire**	**Actions Proposed**	**Agency**	**Named Person**	**Time Scale**
	There is an acknowledged need to expose CASH services positively and ensure that the service is represented appropriately at partnership meetings	CASH has identified staff to attend Sexual Exploitation meetings/training. Requirements to work in partnership arenas and develop effective partnerships will be included in Job Descriptions and contracts	LCHS	CASH lead	With immediate effect
4.3 Ensure there are robust local systems for GPs to regularly share information about children and families where risks are identified.	**The recommendation specifically relates to 3.15 of the CQC report regarding GP contribution in sharing information for safeguarding:** There is a template currently under review in line with E signs of safety common template referral process which is being developed by the LCC. A Pilot project is being undertaken regarding the Signs of Safety Approach which is bring lead by LA and is under development, this will include GP's as all health professionals working with social workers adopting the approach.	There is currently a template for professionals to complete for CP conferences this is utilised by LCHS,, ULHT, LPFT which will be rolled out for all GPs and provide consistency	LA CCG'S LAT	Designated Nurse Jan Gunter	Complete
5. NHS England, Lincolnshire West CCG; South Lincolnshire CCG; South West Lincolnshire CCG; Lincolnshire East CCG and LPFT should:					
5.1 Continue to work in partnership to ensure that commissioning and operational arrangements enable children	**The recommendation specifically relates to 2.5 and 4.7 of the CQC report regarding capacity &E and MIU departments**: There is an acknowledged shortfall nationally within CAMHS . CAMHS within Lincolnshire are commissioned by the LA incorporating a S75 agreement.	The Local Authority NHS England and CCG Commissioners meet throughout the year as a joint body to discuss mental health commissioning and operational arrangements.	NHS England, CCG	Pam Palmer, Sally savage LA Lead CCG representative	May 2015 1 year

CQC Review of Health Services for Looked After Children and Safeguarding in Lincolnshire					
Recommendations	**Current Position in Lincolnshire**	**Actions Proposed**	**Agency**	**Named Person**	**Time Scale**
needing CAMH services to have timely access to early help, specialist assessment and treatment.	Tier 3 CAMHS being reviewed through procurement process procuring by 2015. Well performance managed contract			Pam Palmer NHS England, Sally Savage Children's Commissioner in the LA, Colin Warren Lead CCG representative	
5.2 Ensure that mothers and their babies in all areas of Lincolnshire have access to perinatal mental health services to secure effective early intervention and support.	**The recommendation specifically relates to 1.6 of the CQC report regarding capacity of perinatal mental health service:** Adopting specification procurement 2014/15 in discussions with LPFT have commenced. It is acknowledged that there is insufficient capacity within the Perinatal Nursing Service. The issue has been prioritised in the associated submitted business plan. All women are seen by mental health staff, receive care but not by Perinatal specialist nurses.	NHS England has recommended that all CCG's within the region adopt the Perinatal Clinical Network devised service specification. NHS England and CCG's Commissioners meet throughout the year as a regional body to discuss mental health commissioning and operational arrangements and this includes Perinatal Services.	NHS England	Pam Palmer	May 2015 1 year
5.3 Review arrangements for young people placed out of county so that discharge protocols from or between CAMH tier 4 services and to other services ensure that these young people receive the support they need.	**The recommendation specifically relates to 5.1.12 of the CQC report regarding capacity of A&Es to manage care for children from or in-between T4 CAMHS provision:** Currently within NHS England Local Area Team there are 2 co-coordinators in post to manage and co-ordinate Tier 4 placements	NHS England has two CAMHS Case Managers who assist local care co-ordinators to fulfil this function.	NHS England	Pam Palmer NHS England	Completed

CQC Review of Health Services for Looked After Children and Safeguarding in Lincolnshire					
Recommendations	**Current Position in Lincolnshire**	**Actions Proposed**	**Agency**	**Named Person**	**Time Scale**
6. Lincolnshire West CCG; South Lincolnshire CCG; South West Lincolnshire CCG; Lincolnshire East CCG, and ULHT should:					
6.1 Ensure an appropriate system of supervision is in place for all staff who are involved in safeguarding and child protection work, including urgent care and midwifery, in line with inter-collegiate professional requirements.	**The recommendation specifically relates to 5.3.10 of the CQC report regarding supervision of staff working in safeguarding:** LCHS have an up to date safeguarding supervision policy in place and staff are performance managed against compliance. Within ULHT Safeguarding Supervision is available to all staff on an individual and group basis; with the Named Midwife, Named Nurse for Safeguarding and other Senior staff members trained to deliver. The uptake of staff is recorded. Currently there is not a formal Policy for Safeguarding Supervision in place. However the Safeguarding Supervision Policy has been written and is out for consultation. The Governance/Monitoring arrangements are documented within the policy.	LCHS Completed Draft Safeguarding Supervision Policy is to be presented to ULHT Safeguarding Committee for comments/approval in April 2014.	ULHT	Elaine Todd Named Nurse for Safeguarding	Apr-14
7. Lincolnshire West CCG; South Lincolnshire CCG; South West Lincolnshire CCG; Lincolnshire East CCG, LCHS, ULHT and LPFT should:					

CQC Review of Health Services for Looked After Children and Safeguarding in Lincolnshire					
Recommendations	**Current Position in Lincolnshire**	**Actions Proposed**	**Agency**	**Named Person**	**Time Scale**
7.1 Expand opportunities for listening to and learning from the experiences of young people and their families/carers, actively engaging them in service improvements.	**The recommendation specifically relates to 5.1.14 of the CQC report regarding hearing the child's voice**: All NHS and social care agencies are CA Section 11 compliant. A mystery shopper exercise was undertaken, overseen by the LA and involving young people. The feedback resulted in accepted actions being put into place. Lincolnshire Young Inspectors joined with the teenage pregnancy team to carry out a C-Card mystery shopping exercise. May 2013 with revisits to establish if actions had been put in place October 2013. Sixteen venues were then selected from across the county and a mix of registration and pick up points were visited. The young inspectors said "Overall we found the venues were welcoming and accessible and staff members are friendly. At the end of the mystery shops, the young people came together to share their experiences and make an active contribution to a report including recommendations for change. These included staff being re-trained, new and updated guidance for C-Card Venues and improvements to C- Card Mobile. The recommendations have had a significant impact on improving the overall service. CAMHS information submitted at time of inspection. CCG Executive Nurses supported this submission as evidence in response to CQC. LPFT have outstanding data from every session regarding the outcomes and experience of children and this is transferred in to service need and development with commissioners.	Currently in place: Interview panels Local authority tell us survey which incorporates health Voice of the child survey/questionnaire included on assessment template	LCC LCHS LPFT ULHT	Janice Spencer AD LCC, Sue Cousland Chief Nurse LCHS, Eiri Jones ULHT, Julie Hall DON LPFT	Complete
	Healthwatch Lincolnshire is currently working with schools, colleges and other young people's activities to support 7.1. We have designed a questionnaire for the young people to complete to provide some baseline data on current young people's perception of access and support to health and social care.	Healthwatch will be facilitating sessions to ensure young people (11 - 18 years) understand their voice is important.	Healthwatch Lincolnshire	Tim Barzycki	February - April 2014 and ongoing

CQC Review of Health Services for Looked After Children and Safeguarding in Lincolnshire					
Recommendations	**Current Position in Lincolnshire**	**Actions Proposed**	**Agency**	**Named Person**	**Time Scale**
	Exits cards available for patients to complete, but often completed by parents rather than the children and young people.	ULHT's Children and Young People Strategic Board to consider potential options available for capturing patient feedback. Trust's Children and Young People Strategic Board to consider potential options available for capturing patient feedback. Patient Experience team to work with the relevant Services and provide assurance via the Patient Experience Committee.	ULHT	C&YPSB Members and Paediatric Matrons	Jun-14
7.2 Ensure that robust arrangements are put in place to assure the quality of referrals by health professionals and ensure that children for whom risks are identified receive prompt support.	**The recommendation specifically relates to 3.2, 3.3 and 3.8 of the CQC report regarding timeliness and appropriateness of referrals:** The CAMHS LAC referral pathway has been amended to include LCHS Vulnerable Children's Nurses as accepted referrers. within the CQC report LCHS is recognised as providing good appropriate referrals	To carry out audit of referrals into children's services on a quarterly basis as a quality assurance process.	LPFT LCHS	Michelle Johnstone	Apr-14
	3.3 was specific to midwives. Midwives file a copy of the referral (SAF) form into the patient's records to allow quality assurance of referrals made.	Ongoing quality audit	ULHT	Named MW	Complete
	The notification of referral process in other areas does offer the ability to QA referrals made to CSC	The Safeguarding Children Policy/referral Pathway is to be reviewed and amended to adopt similar process to that used in Midwifery	ULHT	Elaine Todd Named Nurse Safeguarding	Jun-14
	All GPs are required to have the requisite competence and skill to provide for their patients including domestic violence. MARAC training has been incorporated into safeguarding training for a number of years. A database of GP safeguarding training has been created and is currently being populated to aid prioritising of commissioning need. NHS England hold the GP's to account contractually. Safeguarding Children Training evidence is a requirement of appraisal and evaluation.	Completion of the database, and performance management of GPs through the Area Team	NHS England	Pam Palmer NHS England	May 2015 1 year

CQC Review of Health Services for Looked After Children and Safeguarding in Lincolnshire					
Recommendations	**Current Position in Lincolnshire**	**Actions Proposed**	**Agency**	**Named Person**	**Time Scale**
7.3 Ensure, through working with partners that staffs across all health disciplines including adult drug and alcohol services are fully engaged in robust, consistent information sharing about children and their families for whom risks or concerns are known.	**The recommendation specifically relates to 3.12 of the CQC report regarding timely sharing of information from the Drug and Alcohol Recovery Team (DART):** The DART management team have embedded a set of additional safeguarding children actions. There are Safeguarding Champions established within DART. The CQC inspector's example has been added to DART and all other safeguarding children training in line with CQC report. LPFT and Children's Services have completed an audit on DART and AMH cases with a multi-agency action plan. LPFT have developed an action plan in response to "What about the children 2013" managed via Safeguarding and Mental Capacity Committee. In relation to midwives LCHS were recognised within the report as performing well	LPFT Safeguarding Team to send out information to all LPFT services regarding sharing information with other agencies and Lead Professionals directly and not via the service user.	LCHS LPFT	Liz Bainbridge &Michelle Johnstone	LPFT 3 months
	'Think Family' approach is incorporated into all levels of Safeguarding Training. It is discussed in both Safeguarding Supervision and in advice offered by the Safeguarding Team. The Trust's Safeguarding Champions Network has been revised in order to address issues relevant to children and adults. The Safeguarding site on the Intranet has a link to the relevant SCIE 2012 'Think Child, Think Parent, Think Family' report.	Think family approach to be more robustly embedded within the SG Children and Young people Policy.	ULHT	Named Nurse Safeguarding	Jun-14
7.4 Ensure that the pre-birth protocol is audited for effectiveness in all cases including those where there is a known high degree of risk around the expectant mother	**The recommendation specifically relates to 3.4 of the CQC report regarding the understanding and embedding of the Multi Agency Pre Birth Protocol:** The LSCB have developed a multi-agency audit framework and the multi-agency audit agenda commences in April 2014 which will includes audit of the impact of the pre-birth protocol.	Health agencies including LPFT, LCHS, ULHT and the CCGs are working alongside partner agencies to support the multi-agency audit program. An audit has been carried out by children's services and monitored via the LSCB	LSCB	Andy Morris	6 months
LCHS:					

CQC Review of Health Services for Looked After Children and Safeguarding in Lincolnshire					
Recommendations	**Current Position in Lincolnshire**	**Actions Proposed**	**Agency**	**Named Person**	**Time Scale**
8.1 Ensure that all relevant staff is properly equipped prior to any roll out of new policies or systems including the electronic version of the vulnerability assessment matrix, to ensure use is consistent and effective.	**The recommendation specifically relates to 3.6 of the CQC report regarding identification and recognition of vulnerability, specifically utilising the electronic vulnerability matrix within LCHS:** LSCB and the CCGs seek assurance from NHS providers that all relevant staff are properly equipped prior to any roll out of new policies or systems in general and all agencies are compliant and tested through the CA S11 audit and Markers of Good Practice. This recommendation is specific to LCHS regarding the electronic version of the vulnerability assessment matrix, to ensure use is consistent and effective.	LCHS: All new policies and processes/systems have an identified implementation plan. This includes training and audit. This will also be assessed through back to floor visits and record keeping audit.	LCHS	Michelle Johnstone Head of Safeguarding LCHS	Completed
9. NHS England and Lincolnshire West CCG; South Lincolnshire CCG; South West Lincolnshire CCG; Lincolnshire East CCG should:					

CQC Review of Health Services for Looked After Children and Safeguarding in Lincolnshire					
Recommendations	**Current Position in Lincolnshire**	**Actions Proposed**	**Agency**	**Named Person**	**Time Scale**
9.1 Review commissioning strategies, local needs analyses and pathways to ensure children benefit from sufficiency of CAMHs provision, including tier 4, tier 3+ and community based alternatives to in-patient care, to facilitate care close to home and to ensure that other young children on paediatric wards are not put at risk of harm or distress	**The recommendation specifically relates to 2.8 of the CQC report regarding the pathway from A&E services to CAMHS:** CAMHS services are commissioned by the Local Authority via a S75 agreement. A revised Self-Harm Pathway (SHP) has been signed off between the mental health services provider (LPFT) and the acute trust (ULHT). The SHP has been signed off with the LSCB and Executive Nurses for both Trusts who are overseeing the implementation. Currently it is acknowledged that the self -harm pathway was not been fully embedded and could work more effectively. Auditing and monitoring reports are awaited. A proposal of tracking cases for the SHP has been given for quality audit purposes and the SHP will be performance managed. ULHT support the SHP and are actively developing the internal mechanism for implementing the pathway recommendations. Acknowledged that these Patients are ULHT patients with a need for LPFT input. NHS England commission T4 services and performance manage the contracts with providers.	The actions specific to the SHP have been described earlier at 3.1. The commissioning pathways for all services now sit within the Lincolnshire Sustainable Services Review Framework to ensure that needs led commissioning provides quality services for the Lincolnshire populace. The framework is being managed at the highest level across health and social care	The LA NHS England	Justin Hackney AD LA + accountable officers for the CCGs.	1 year

NHS Lincolnshire East Clinical Commissioning Group
NHS South West Lincolnshire Clinical Commissioning Group
NHS South Lincolnshire Clinical Commissioning Group
NHS Lincolnshire West Clinical Commissioning Group

Appendix C

PROGRESS AGAINST THE LINCOLNSHIRE CQC ACTION PLAN:

JULY 2014

CQC FINDINGS:	REC REF:	ORGANISATION	PROGRESS	COMPLETION / REVIEW
Capacity of the designate professionals for safeguarding and looked after children for strategic leadership and commissioning planning.	Section 1.	LINCOLNSHIRE CLINICAL COMMISSIONING GROUPS	The external review of the roles and responsibilities of the designated professionals commissioned through NHS England Area Team and the Clinical Commissioning Groups across Lincolnshire is now completed and the final report for sign off is imminent. Therein the increased capacity for the safeguarding team is being finalised and is supported by all 4 CCGs to include: • The Designated Consultant Nurse for Safeguarding Children and Adults (including Looked After Children) • Deputy Designated Nurse for Safeguarding Adults • Deputy Designated Nurse for Safeguarding Children (including Looked After Children) • Safeguarding Practitioner for Safeguarding Adults (including Care Homes) • Safeguarding Practitioner for Safeguarding Children • Safeguarding Project Manager / Administration • Increased capacity for the Designated Doctor for Safeguarding Children • Increased Capacity for the Designated Doctor for Looked After Children All roles within the review have been benchmarked against the revised WT2013 and the Revised Intercollegiate Documents for Safeguarding Children and for Looked After Children. Job Descriptions are in draft form and ready for submission for JAQ purposes regarding Banding.	September 2014

CQC FINDINGS:	REC REF:	ORGAN ISATION	PROGRESS	COMPLETION / REVIEW
Paediatric expertise within unscheduled care / A&E settings	Section 3.	ULHT	The workforce profile for paediatric skill and competence has been requested from ULHT and is awaited. The level of training compliance in safeguarding children and adults has been requested from ULHT. ULHT Director of Nursing is aware, and meets regularly with the Designated Nurse. ULHT has recently faced challenges in safeguarding leadership to drive progress and has recently been successful in: • Appointing a Named Lead for Safeguarding Adults • Appointing a Named Midwife. • Providing a secondment opportunity for the Named Nurse for Safeguarding Children, whilst the current position holder is on maternity leave. • Interviews in early July for a replacement specialist practitioner in safeguarding children have proved successful. The Paediatric Liaison Nurse embedding into ULHT is under development with engagement from ULHT senior Management Team, Paediatric Clinicians and the unscheduled care team to ensure effective communication to safeguard children through transition from acute services into the community.	August 2014
The self- harm pathway is not embedded in practice	Section 3.	ULHT LPFT CCGs LA	• CAMHS are commissioned by the LA under a S75 arrangement • The pilot of the Hospital Intensive Psychological Services (HIPS) at Lincoln Site ULHT has been independently evaluated. Due to poor outcomes the service will not be commissioned at Lincoln or Pilgrim hospitals. The Local Authority under the S75 agreement is leading a pathway review. The existing pathway remains in place with a protocol and escalation process to manage risks and issues identified and appropriate training is taking place to enable staff to manage patients admitted to secondary care who are self-harming. • The pathway re-development is being overseen by the Director of Children's Services and the Children's Commissioner. The next meeting in July includes commissioners, and clinicians. • The Clinical Directors from LPFT and ULHT are involved and ULHT have confirmed that the self-harm pathway practice will be standardised across both A&E sites. • Access to T4 beds is a national problem, previously managed locally,	September 2014

CQC FINDINGS:	REC REF:	ORGAN ISATION	PROGRESS	COMPLETION / REVIEW
			discussions of this aspect of specialised commissioning are ongoing, alongside the developments of T3+ services which operate well in NEL and support local service provision in the community.	
Variance in quality of the statutory health assessment for looked after children	Section 2.	CCGs	• An audit of Statutory Health Assessments has been undertaken and identified that all looked after children with health issues were referred to appropriate specialist services. • The Designated and Named Nurse for LAC are meeting with Foster carers regarding their access to health services, especially equipment. • Review Health Assessments, a KPI for the LA exceeded the target of 95% 2013/14 with 96.8% achieved and 2% refusal. • The quality of Review Health Assessments has remained of consistent high quality delivered through LCHS Vulnerable Children and Young People Team which has recently recruited additional staff to expand the service to incorporate increased activity. • The recent ability to report Initial health assessments being undertaken within the statutory timescale shows improvement at 48% but remains poor. A proposal to improve the achievement, quality and consistency of initial health assessments has been prepared by the Designated Nurse and Doctor for LAC and the Executive Nurse for SLCCG as Lead commissioner for children's services will deliver the proposal to the CCG collaborative in July: o Initial health Assessments will be conducted by Consultant Paediatrician's (ULHT) (IHAs must be performed by a medically qualified person). o The service will bring together the statutory health assessments of LAC and Adoption Medicals (LA) o The service will be delivered within the national tariff. • The current locally enhanced service (LES) arrangements with GPs with additional training will be served notice in accordance with contractual requirements.	September 2014

CQC FINDINGS:	REC REF:	ORGAN ISATION	PROGRESS	COMPLETION / REVIEW
The impact of externally placed children in independent care settings on local resources	Section 2	CCGs LA LSCB partnership	• Lincolnshire County Council are Corporate Parents for Lincolnshire Children placed in care. • Externally placed looked after children are corporately parented by their placing authority – often many miles away. • There are currently 384 children placed in Lincolnshire by external authorities. Lincolnshire has approximately 30 placed externally. • Despite the statutory requirement to do so, placing authorities do not liaise with health services prior to placement to assess the suitability of the placement for children, some with complex care needs. • A number of children are placed in independent care homes that Lincolnshire have no contractual relationships with. • LSCB has included externally placed looked after children within its Business Plan and quarterly reporting of their health issues is now required. • Re-design of current document for the statutory health assessments for all looked after children is in its final stages in this county and will have the capability to be reported against through Public Health England, disaggregated between those Corporately Parented within Lincolnshire and those externally placed. The data will inform on the impact on health services these children place and will be reported through the annual report. • The placing authority can be invoiced for targeted / specialist services only, e.g. CAMHS.	December 2014

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Lincolnshire COUNTY COUNCIL *Working for a better future*	**THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE**		
Boston Borough Council	East Lindsey District Council	City of Lincoln Council	Lincolnshire County Council
North Kesteven District Council	South Holland District Council	South Kesteven District Council	West Lindsey District Council

Open Report on behalf of Richard Wills, the Director Responsible for Democratic Services

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**23 July 2014**
Subject:	**Healthy Lives, Healthy Futures – A Consultation by North Lincolnshire and North East Lincolnshire Clinical Commissioning Groups**

Summary:

On 30 June 2014, North Lincolnshire and North East Lincolnshire Clinical Commissioning Groups launched their *Healthy Lives, Healthy Futures* consultation, which affects the provision of services at Northern Lincolnshire and Goole NHS Foundation Trust. This report gives an outline of the consultation content. The Committee is invited to determine whether it wishes to respond and then to establish a working group to draft a response.

Actions Required:

(1) To determine whether to respond to the *Healthy Lives, Healthy Futures* consultation, on Hyperacute Stroke Services, and Ear, Nose and Throat Services provided at Northern Lincolnshire and Goole NHS Foundation Trust.

(2) If the Committee determines it wishes to participate, to establish a working group of committee members to consider the consultation in detail, to draft a response to the consultation, which would be confirmed by the Committee at its next meeting on 17 September 2014

1. Background

On 30 June 2014, North Lincolnshire and North East Lincolnshire Clinical Commissioning Groups launched a consultation on their *Healthy Lives, Healthy Futures*, which affects the provision of services at Northern Lincolnshire and Goole NHS Foundation Trust (NLaG), in particular

Scunthorpe General Hospital, and Diana, Prince of Wales Hospital, Grimsby. The consultation relates to Hyperacute Stroke Services and Ear, Nose and Throat services and the consultation period closes on 26 September 2014.

NLaG is the closest acute hospital trust for 81,000 of Lincolnshire East CCG residents; and for 34,000 of Lincolnshire West CCG residents. In the light of this the Committee may consider that it is appropriate to consider making a response to the consultation.

Overview of the Consultation

The consultation document is available on the following website: -

http://www.healthyliveshealthyfutures.nhs.uk/publications/

The introduction to the consultation document states the following: -

"Healthy Lives, Healthy Futures is the review of health and social care services in North and North East Lincolnshire. It is led by two Clinical Commissioning Groups (CCGs), North Lincolnshire CCG and North East Lincolnshire CCG, working with all our local health and care partners. The review is linked to similar programmes within the East Riding of Yorkshire and Lincolnshire. This is the first set of services proposed for change that require public consultation. Our programme will continue over the next five to ten years and these consultation areas are part of a much wider piece of work. The review is driven by national best practice recommendations around the services we offer, and is aimed at ensuring that we develop a health and social care system that delivers safe, high quality and affordable services for many years to come."

In the spring of 2014 we publically shared our emerging thinking to give people a flavour of the services we're considering changing and what we believed may need to change in the future. The response to this was positive and we immediately started to make service improvements wherever that was possible.

At that time we also shared information about three service areas that could result in large scale change, and may require public consultation. These were Hyper-Acute Stroke, Ear Nose and Throat (ENT) Inpatient Surgery and Children's Surgery. We are doing more work to refine options for Children's Surgery, therefore we are not consulting on this now but we do have a clear outline of what we feel needs to change for Hyper-Acute Stroke and ENT Inpatient Surgery. The purpose of this document is to fully explain the options we have considered, what our preferred option are and why we came to that decision.

The consultation document focuses on two services.

Hyperacute Stroke Services

The consultation document includes the following information on hyperacute stroke services

"Why we need to change

When a person has a stroke we know that the first few hours after the stroke are critical. If the right treatment can be given to the person during these first few hours they will have a much better chance of surviving the stroke and recovering from it.

There are two critical time periods after having a stroke:

- *The first 4.5 hours after a stroke are important - during this time some patients may benefit from being given a powerful clot-busting medication that can dissolve the clot that caused the stroke - this is called thrombolysis treatment.*

- *The first 72 hours after a stroke are important - evidence shows us that if patients receive the right medication, are monitored very closely and start having therapy treatments they are much more likely to make a better recovery and be less disabled by the stroke in the long term.*

The treatment that should be given during this first 72 hours is called Hyper-Acute Stroke care. This is the recommendation of national organisations like the Royal College of Physicians (RCP) and the National Institute for Health and Care Excellence (NICE), as well as the Government. We want anyone living in our area that has a stroke to be able to get the right treatment as quickly as possible, any time of the day or night. This means Hyper-Acute Stroke care needs to be provided 24 hours a day, 7 days a week (24/7).

To do this we need to have teams of specialist staff working around the clock. We also need to provide the right equipment to help staff make decisions about how best to treat each patient. One of the pieces of equipment that is essential in Hyper-Acute Stroke care is a CT (Computerised Tomography) scanner which takes pictures of the brain. This needs to be available and working 24 hours a day and can only be operated by people with the right training.

If any hospital is going to provide Hyper-Acute Stroke care it must be able to do this safely. This means having staff with the right skills and experience who are continually training and practising, making sure they keep their skills up to date by regularly treating patients who have just had a stroke.

In November 2013 we temporarily changed arrangements temporarily for Hyper-Acute Stroke care to centralise the service on the Scunthorpe General Hospital [SGH] site and combine the two services that were previously operating at SGH and Diana, Princess of Wales Hospital [DPOW]. We had to do this for safety reasons and it had to be done quickly as recommended by the Keogh review which visited Northern Lincolnshire and Goole NHS

Foundation Trust. Before November 2013 Hyper-Acute Stroke care was available at both hospital sites only during weekdays. Since November 2013 it has been available at the SGH site 24/7. Both sites still treat stroke patients after the first 72 hours (i.e. patients from Grimsby are transferred back to DPOW for their on-going care) and Goole District Hospital (GDH) still provides on-going rehabilitation care for stroke patients.

We are not the only health community reviewing stroke care. Stroke services are currently being reviewed across the whole Yorkshire and Humber area, and we plan to continue working together on this wider review over the next 2-3 years. As plans emerge, we may need to have further discussions about the future of stroke care in Northern Lincolnshire. In the meantime, we believe that Hyper-Acute Stroke care needs to be available to everyone living in our area and this needs to be available 24/7. We have developed options that will achieve this aim, and fit with the direction of travel we feel the regional review will take.

Options for Hyper-Acute Stroke Services

The options we have been looking at for the delivery of Hyper-Acute Stroke care are:

S1. *To have 24/7 Hyper-Acute Stroke care at Scunthorpe General Hospital and Diana, Princess of Wales Hospital, Grimsby.*

S2. *To have 24/7 Hyper-Acute Stroke care at Scunthorpe General Hospital only, as it is at the moment.*

S3. *To move Hyper-Acute Stroke care to Diana, Princess of Wales Hospital, Grimsby only.*

S4. *To move Hyper-Acute Stroke care to another hospital, for example Hull or Doncaster.*

The number of emergency admissions for stroke from within Northern Lincolnshire during the full year April 2011 to March 2012 was 335 people. A small number of stroke patients from the East Riding and also Lincolnshire have also been treated at Northern Lincolnshire and Goole Foundation Trust.

<u>The preferred option is Option S2</u>.

There are a number of reasons why Option S2 is our preferred option at this time:

- *We have in place the right number of trained specialist staff at Scunthorpe, the service is working well and patients are getting safe and high quality care, 24/7.*

- *Patients and their families who have used Hyper-Acute Stroke services at Scunthorpe have been happy with how they have been treated – we have had positive feedback from patients that have been through the service.*

- *All the equipment we need is at Scunthorpe; there are two CT scanners already on site. Significant investment would be required to move the service to Grimsby which we do not have available.*

Although the journey times are longer for North East Lincolnshire residents when we have asked local people they have said that they would rather travel further if it means they get a safer, better quality service. As this only affects Hyper-Acute Stroke care the extra journey times are only for the first 72 hours; most North East Lincolnshire patients will go back to Grimsby after this.

Ear, Nose and Throat Services

The consultation document includes the following information on Ear, Nose and Throat Services

Why we need to change

If a person has a problem with their ear, nose or throat they will usually attend their GP in the first instance. If the GP is not able to resolve the problem for them, they may be referred to the hospital to see a specialist. This will usually start with an outpatient appointment, and could involve treatment at that time, otherwise they may require an operation. ENT surgery is undertaken by a qualified ENT surgeon and a supporting clinical team. Sometimes patients have to stay overnight for their surgery which is called inpatient surgery, but most ENT surgery is done in a single day without the person needing to stay in hospital overnight; which we call day surgery.

A small number of people have ENT problems that need to be treated as an emergency. If so, they are most likely to go to an A&E department at their local hospital and if necessary be seen by an ENT specialist. Occasionally a person may need to have an emergency operation. Although most ENT surgery is not an emergency and is planned in advance, there still needs to be a specialist available 24/7 in case an emergency patient comes in or if someone who has had an operation gets poorly while they are still in hospital.

At the moment outpatient clinics, day surgery, emergency and planned surgery is available at both SGH and DPOW. The emergency part of the service is shared between senior doctors working at both sites. There are not enough senior doctors to have someone available at both sites all the time, which means there is one senior doctor covering both sites in the evenings and weekends.

The ENT surgical team has raised concerns that this arrangement is not as safe as it should be and does not follow national or regional guidance. The ENT specialist doctor covering for emergencies cannot be on both sites at once and alternating sites is not appropriate as a long term service model. This is not popular with staff, and means patients have to be transferred between sites depending on when and where they arrive at A&E. It is important that we have safe, high quality services for all our local residents and this is the reason we need to change how ENT inpatient surgical services are organised.

Options for ENT Inpatient Surgery

Over the last few months we have been looking at how ENT Inpatient Surgery care will be organised in the future. The options we have been looking at are:

E1. *To carry on with all inpatient ENT surgery care being available at both sites and with emergencies being covered in the same way as now.*

E2. To move all ENT Inpatient Surgery to DPOW only. Outpatient clinics and day surgery would still be available at both sites. Patients needing emergency ENT care would have to be treated at DPOW.

E3. To move all ENT Inpatient Surgery to SGH only. Outpatient clinics and day surgery would still be available at both sites. Patients needing emergency ENT care would have to be treated at SGH.

E4. To move all ENT Inpatient Surgery apart from day surgery to another hospital, for example, Hull or Doncaster. Outpatient clinics and day surgery would still be available at SGH and DPOW. Patients needing emergency ENT care would have to go to another hospital outside our local area.

Most ENT surgery is undertaken as day case, which is not proposed for change in any of the options.

<u>The preferred option is option 2</u>.

There are a number of reasons why Option E2 is our preferred option:

- *It will be a safer way to run ENT inpatient services than the current service, especially when there are emergencies.*
- *Local residents will still be able to have ENT inpatient surgery in our local area if they need it.*
- *More planned and emergency ENT inpatient surgery is done at Grimsby than at Scunthorpe now so moving extra work to Grimsby will be easier and more cost effective than moving extra work to Scunthorpe.*
- *There is more space at Grimsby for extra ENT beds and it will not cost much to set these up.*
- *There will be minimal disruption to other hospital services if ENT inpatient surgery is moved to the Grimsby site.*

Although the journey times are longer for Northern Lincolnshire residents when we have asked local people they have said that they would rather travel further if it means they get a safer, better quality service. People who have had ENT inpatient surgery do not usually have to stay in hospital for a long time; most people will only stay for one to two nights.

2. Conclusion

The Committee is invited to consider whether to respond to the *Healthy Lives, Healthy Futures* consultation, on Hyperacute Stroke Services, and Ear, Nose and Throat Services provided at Northern Lincolnshire and Goole NHS Foundation Trust. If the Committee determines that it wishes to participate in the consultation, it is invited to establish a working group of committee members to consider the consultation in detail; to draft a response to the consultation, which would be confirmed by the Committee at its next meeting on 17 September 2014

3. Consultation

The Committee is being asked whether it wishes to respond to the Healthy Lives, Healthy Futures consultation, which has been launched by North Lincolnshire and North East Lincolnshire Clinical Commissioning Groups.

4. Appendices – None

5. Background Papers

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

This report was written by Simon Evans, who can be contacted on 01522 553607 or simon.evans@lincolnshire.gov.uk

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Lincolnshire COUNTY COUNCIL Working for a better future	THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE		
Boston Borough Council	East Lindsey District Council	City of Lincoln Council	Lincolnshire County Council
North Kesteven District Council	South Holland District Council	South Kesteven District Council	West Lindsey District Council

Open Report on behalf of Richard Wills, the Director Responsible for Democratic Services

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**23 July 2014**
Subject:	**Local Authority Health Scrutiny – *Guidance to Support Local Authorities and Their Partners to Deliver Effective Health Scrutiny***

Summary:

On 27 June 2014, the Department of Health issued guidance to local authorities on their health overview and scrutiny function. The Department of Health states that "the guidance needs to be conscientiously taken into account", but it is not a substitute for the legislation. This report highlights the key elements in the guidance.

Actions Required:

(1) To consider and comment on the content of *Local Authority Health Scrutiny – Guidance to Support Local Authorities and Their Partners to Deliver Effective Health Scrutiny*, issued by the Department of Health on 27 June 2014.

(2) To note that the Committee and the four Clinical Commissioning Groups in Lincolnshire have approved a protocol to support joint working, which covers consultations by the Clinical Commissioning Groups on substantial developments and substantial variations in local health service provision.

1. Background

Issue of Non-Statutory Guidance by the Department of Health

On 27 June 2014, the Department of Health issued guidance to local authorities on their health overview and scrutiny function, entitled *Local Authority Health Scrutiny – Guidance to Support Local Authorities and Their Partners to Deliver Effective Health Scrutiny*.

The guidance is available at the following link: -

https://www.gov.uk/government/publications/advice-to-local-authorities-on-scrutinising-health-services

The guidance is non-statutory, but the Department of Health states that the guidance 'needs to be conscientiously taken into account'.

Key Messages

The Department of Health has identified 'Key Messages' in the guidance, which are reproduced below:

- *The primary aim of health scrutiny is to strengthen the voice of local people, ensuring that their needs and experiences are considered as an integral part of the commissioning and delivery of health services and that those services are effective and safe. The new legislation extends the scope of health scrutiny and increases the flexibility of local authorities in deciding how to exercise their scrutiny function.*

- *Health scrutiny also has a strategic role in taking an overview of how well integration of health, public health and social care is working – relevant to this might be how well health and wellbeing boards are carrying out their duty to promote integration - and in making recommendations about how it could be improved.*

- *At the same time, health scrutiny has a legitimate role in proactively seeking information about the performance of local health services and institutions; in challenging the information provided to it by commissioners and providers of services for the health service ("relevant NHS bodies and relevant health service providers") and in testing this information by drawing on different sources of intelligence.*

- *Health scrutiny is part of the accountability of the whole system and needs the involvement of all parts of the system. Engagement of relevant NHS bodies and relevant health service providers with health scrutiny is a continuous process. It should start early with a common understanding of local health needs and the shape of services across the whole health and care system.*

- *Effective health scrutiny requires clarity at a local level about respective roles between the health scrutiny function, the NHS, the local authority, health and wellbeing boards and local Healthwatch.*

- *In the light of the Francis Report, local authorities will need to satisfy themselves that they keep open effective channels by which the public can communicate concerns about the quality of NHS and public health services to health scrutiny bodies. Although health scrutiny functions are not there to deal with individual complaints, they can use information to*

get an impression of services overall and to question commissioners and providers about patterns and trends.

- *Furthermore in the light of the Francis Report, health scrutiny will need to consider ways of independently verifying information provided by relevant NHS bodies and relevant health service providers – for example, by seeking the views of local Healthwatch.*

- *Health scrutiny should be outcome focused, looking at cross-cutting issues, including general health improvement, wellbeing and how well health inequalities are being addressed, as well as specific treatment services.*

- *Where there are concerns about proposals for substantial developments or variation in health services (or reconfiguration as it is also known) local authorities and the local NHS should work together to attempt to resolve these locally if at all possible. If external support is needed, informal help is freely available from the Independent Reconfiguration Panel (IRP) and/or the Centre for Public Scrutiny. If the decision is ultimately taken to formally refer the local NHS's reconfiguration proposals to the Secretary of State for Health, then this referral must be accompanied by an explanation of all steps taken locally to try to reach agreement in relation to those proposals.*

- *In considering substantial reconfiguration proposals health scrutiny needs to recognise the resource envelope within which the NHS operates and should therefore take into account the effect of the proposals on sustainability of services, as well as on their quality and safety.*

- *Local authorities should ensure that regardless of any arrangements adopted for carrying out health scrutiny functions, the functions are discharged in a transparent manner that will boost the confidence of local people in health scrutiny. Health scrutiny should be held in an open forum and local people should be allowed to attend and use any communication methods such as filming and tweeting to report the proceedings. This will be in line with the new transparency measure in the Local Audit and Accountability Act 2014 and will allow local people, particularly those who are not present at scrutiny hearing-meetings, to have the opportunity to see or hear the proceedings.*

Description of the Existing Legislation

Much of the guidance sets out the legislative position. For example, one section describes elements of the previous legislative framework (prior to the Health and Social Care Act 2012), which remain unchanged. These include:

- Health scrutiny remains the function of upper tier local authorities, but with provisions enabling the participation of district councils.
- Members of the Executive may not be members of an overview and scrutiny committee.

- NHS organisations are required to:
  - provide information about the planning, provision and operation of health services, as reasonably required by the health scrutiny function;
  - attend local authority health scrutiny meetings;
  - consult on any proposed substantial developments or variations in the provision of the local health service; and
  - respond to reports and recommendations submitted to them by the health scrutiny function, following an in-depth scrutiny review.
- NHS organisations remain under duties to consult and involve patients and the public, which are in addition to the duties to consult with the health scrutiny function.

The guidance also sets out the key changes from the previous legislation:

- Local authorities are now responsible for many aspects of the public health function and may be subject to scrutiny for this. *(Lincolnshire County Council has determined that the Community and Public Safety Scrutiny Committee undertakes this role.)*
- The health scrutiny function rests with the Council and the Council may decide how it is discharged, for example by
  - the Council meeting itself,
  - a health overview and scrutiny committee,
  - a committee of the Council (for local authorities not operating executive arrangements),
  - a joint health overview and scrutiny committee, or
  - another local authority.

  (Lincolnshire County Council has established the Health Scrutiny Committee for Lincolnshire to undertake its health scrutiny function.)
- The health scrutiny function may not be delegated to an officer.
- The scope of the health scrutiny function has been extended to cover the full range of commissioners and providers of NHS-funded services, who are referred to as "responsible persons". The responsible persons are:

  - Clinical Commissioning Groups (CCGs)
  - NHS England
  - Local authorities (insofar as they may be providing health services to CCGs, NHS England or other local authorities).
  - NHS trusts and NHS foundation trusts.
  - GP practices and other providers of primary care services (previously not subject to specific duties under health scrutiny regulations as independent contractors, they are now subject to duties under the new Regulations as they are providers of NHS services).
  - Other providers of primary care services to the NHS, such as pharmacists, opticians and dentists.
  - Private and voluntary sector bodies commissioned to provide NHS or public health services by NHS England, CCGs or local authorities.

- Powers of referral from Healthwatch – Healthwatch may make referrals to the health scrutiny function.
- Changes to the consultation provisions are detailed below.

Conflicts of Interest

The guidance includes the following provisions on conflicts of interest, which are reproduced in full:

"3.1.24 Councils should take steps to avoid any conflict of interest arising from councillors' involvement in the bodies or decisions that they are scrutinising. A conflict might arise where, for example, a councillor who was a full voting member of a health and wellbeing board was also a member of the same council's health scrutiny committee or of a joint health scrutiny committee that might be scrutinising matters pertaining to the work of the health and wellbeing board.

3.1.25 Conflicts of interest may also arise if councillors carrying out health scrutiny are, for example:

- *An employee of an NHS body.*
- *A member or non-executive director of an NHS body.*
- *An executive member of another local authority.*
- *An employee or board member of an organisation commissioned by an NHS body or local authority to provide services.*

3.1.26 These councillors are not excluded from membership of overview and scrutiny committees, and, clearly, where the full council has retained the health scrutiny function, they will be involved in health scrutiny. However they will need to follow the rules and requirements governing the existence of interests in matters considered at meetings. Where such a risk is identified, they should consult their monitoring officer for advice on their involvement."

Consultation

As with the previous guidance, a key element is the section on consultation on substantial reconfiguration proposals. The guidance sets out the key elements of the consultation arrangements:

- With increasing integration of health and social care, many proposals may be joint NHS-local authority proposals, with the involvement of the health and wellbeing board at an early stage.
- "Substantial development" and "substantial variation" are not defined in the legislation, as previously. Joint protocols are recommended between the commissioners and health scrutiny committees. *(The Health Scrutiny Committee and the four Clinical Commissioning Groups in Lincolnshire have approved a protocol to support joint working, which covers elements of consultation.)*
- Commissioners (not providers) are responsible for undertaking consultation. Where providers have a development under

consideration, they will need to inform the commissioners at an early stage. Commissioning responsibilities for NHS services rest with CCGs and NHS England.

- Commissioners must advise the health scrutiny function of the date by which it requires comments on the health consultation and the date on which they intend to make a decision whether to proceed with the proposal.
- The health scrutiny function may make comments on any consultation proposal, and these comments may include a recommendation. Where a recommendation is included and the commissioner disagrees with that recommendation, the commissioner must notify the health scrutiny function of the disagreement. Steps must be taken to resolve the disagreement.
- Referrals to the Secretary of State may be made largely on the similar grounds as previously, which are:
  - It is not satisfied with the adequacy of content of the consultation.
  - It is not satisfied that sufficient time has been allowed for consultation.
  - It considers that the proposal would not be in the interests of the health service in its area.
  - It has *not* been consulted, and it is not satisfied that the reasons given for not carrying out consultation are adequate.

- Every effort must be made to resolve any disagreement between the Health Scrutiny Committee and the commissioners. Only commissioners, such as NHS England and CCGs, may be subject to referral. Where referrals are made to the Secretary of State for Health, they must be supported by evidence.

<u>Delegation of Referrals to Health Overview and Scrutiny Committees</u>

As stated above, referrals may be made to the Secretary of State in relation to proposals from CCGs and NHS England, where there is a disagreement which cannot be resolved locally. The guidance includes a statement in paragraph 4.7.6 to the effect that the power to make a referral to the Secretary of State may also be delegated to a health overview and scrutiny committees. In the light of this, the previous legal advice has been reviewed and it is now possible for such power to be delegated by the County Council to an overview and scrutiny committee.

2. Conclusion

The Committee is invited to consider and comment on the content of *Local Authority Health Scrutiny – Guidance to Support Local Authorities and Their Partners to Deliver Effective Health Scrutiny*, issued by the Department of Health on 27 June 2014.

In relation to the suggestion in the guidance that there should be a protocol between the four CCGs and the Committee, the Committee is invited to note that a protocol is already in place.

3. Consultation

This is not a consultation, although elements of *Local Authority Health Scrutiny – Guidance to Support Local Authorities and Their Partners to Deliver Effective Health Scrutiny* cover the arrangements for consultation by Clinical Commissioning Groups and NHS England with the local authority health scrutiny function.

4. Appendices – None

5. Background Papers

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

This report was written by Simon Evans, who can be contacted on 01522 553607 or simon.evans@lincolnshire.gov.uk

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North Kesteven District Council	South Holland District Council	South Kesteven District Council	West Lindsey District Council

Open Report on behalf of Richard Wills, the Director Responsible for Democratic Services

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**23 July 2014**
Subject:	**Quality Accounts 2014**

Summary:

Every year each provider of NHS-funded services is required to prepare a *Quality Account*, which includes the provider's priorities for the coming year; progress with priorities for the previous year; and other prescribed information. The Health Scrutiny Committee is one of the organisations entitled to submit a statement on the draft *Quality Account* of each local provider. This report provides the Committee with information on the Quality Account statements, which were prepared on the Committee's behalf during April, May and June 2014. In four instances, joint statements were prepared with Healthwatch Lincolnshire, with a further four statements prepared on behalf of the Health Scrutiny Committee alone.

Actions Required:

(1) To note the statements on eight Quality Accounts, relating to providers of local NHS-funded services.

1. Quality Accounts 2014

Legislative Requirements

Since 2010, each provider of NHS-funded services has been required to prepare an annual document entitled the *Quality Account*, which has to include:

- three or more **priorities for improvement** for the coming year;
- an account of the progress with the **priorities for improvement** in the previous year; and

- details of:

  - the types of NHS funded services provided;
  - any Care Quality Commission inspections;
  - any national clinical audits;
  - any Commissioning for Quality and Innovation (CQUIN) activities;
  - general performance and the number of complaints; and
  - mortality-indicator information.

Each provider also has to share their draft Quality Account with: -

- their local Health Overview and Scrutiny Committee;
- their local Healthwatch Organisation; and
- their relevant Clinical Commissioning Group (defined as the Clinical Commissioning Group with "the largest number of persons to whom the provider has provided relevant health services during the reporting period").

Each one of the above is entitled to prepare a statement of up to 1,000 words in length, which has to be included in the final published version of the *Quality Account*.

Arrangements for 2014

On 19 March 2014, the Health Scrutiny Committee agreed that it would make statements on the following eight *Quality Accounts* for 2013-2014 from local providers:

- Boston West Hospital (Ramsay Healthcare)
- East Midlands Ambulance Service NHS Trust
- Lincolnshire Community Health Services NHS Trust
- Lincolnshire Partnership NHS Foundation Trust
- Northern Lincolnshire and Goole NHS Foundation Trust
- Peterborough and Stamford Hospitals NHS Foundation Trust
- St Barnabas Hospice
- United Lincolnshire Hospitals NHS Trust

The Committee established a joint working group with Healthwatch Lincolnshire to prepare joint statements on each Quality Account. The joint working group prepared four of the eight statements. The remaining four statements were submitted on behalf of the Health Scrutiny Committee alone.

The eight Quality Accounts listed above totalled 540 pages in length, and contained approximately 150,000 words. Owing to national requirements on what should be included, the Quality Accounts were generally longer this year than in previous years, and providers were generally requesting statements on their Quality Accounts in a shorter time period. For this reason, it was not always possible for the working group to meet and compile a joint statement.

Final Version of the Quality Accounts

The final versions of the full Quality Account documents are available at the following website links:

Boston West Hospital (Ramsay Healthcare)
http://www.bostonwesthospital.co.uk/pdf/QA%2013%2014%20BWH%20Final.pdf.

East Midlands Ambulance Service NHS Trust
http://www.nhs.uk/Services/Trusts/Overview/DefaultView.aspx?id=29233

Lincolnshire Community Health Services NHS Trust
http://www.nhs.uk/Services/Trusts/Overview/DefaultView.aspx?id=29671

Lincolnshire Partnership NHS Foundation Trust
http://www.nhs.uk/Services/Trusts/Overview/DefaultView.aspx?id=2730

Northern Lincolnshire and Goole NHS Foundation Trust
http://www.nhs.uk/Services/Trusts/Overview/DefaultView.aspx?id=1726

Peterborough and Stamford Hospitals NHS Foundation Trust
http://www.nhs.uk/Services/Trusts/Overview/DefaultView.aspx?id=2008

St Barnabas Hospice
http://www.nhs.uk/aboutNHSChoices/professionals/healthandcareprofessionals/quality-accounts/Pages/quality-accounts-2013-2014.aspx

United Lincolnshire Hospitals NHS Trust
http://www.nhs.uk/Services/Trusts/Overview/DefaultView.aspx?id=1990

2. Conclusion

The Committee is invited to note the statements on the eight Quality Accounts from local providers of NHS-funded services.

3. Consultation

The Health Scrutiny Committee is one of the three statutory organisations (as cited in the *National Health Service (Quality Accounts) Regulations 2010*, as amended), to whom providers of NHS-funded services are required to submit their draft Quality Account.

4. **Appendices** – These are listed below and attached at the end of the report.

Appendix A	**Boston West Hospital** – Statement by the Health Scrutiny Committee for Lincolnshire on Quality Account.
Appendix B	**East Midlands Ambulance Service NHS Trust** - Statement by the Health Scrutiny Committee for Lincolnshire on Quality Account.
Appendix C	**Lincolnshire Community Health Services NHS Trust** – Joint Statement the Health Scrutiny Committee for Lincolnshire and Healthwatch Lincolnshire on Quality Account
Appendix D	**Lincolnshire Partnership NHS Foundation Trust** - Joint Statement the Health Scrutiny Committee for Lincolnshire and Healthwatch Lincolnshire on Quality Account
Appendix E	**Northern Lincolnshire and Goole NHS Foundation Trust** - Joint Statement the Health Scrutiny Committee for Lincolnshire and Healthwatch Lincolnshire on Quality Account
Appendix F	**Peterborough and Stamford Hospitals NHS Foundation Trust** - Statement by the Health Scrutiny Committee for Lincolnshire on Quality Account.
Appendix G	**St Barnabas Hospice Trust** - Statement by the Health Scrutiny Committee for Lincolnshire on Quality Account.
Appendix H	**United Lincolnshire Hospitals NHS Trust** - Joint Statement the Health Scrutiny Committee for Lincolnshire and Healthwatch Lincolnshire on Quality Account

5. **Background Papers**

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

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Lincolnshire COUNTY COUNCIL *Working for a better future* **HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE**	**Statement on Boston West Hospital's *Quality Account* for 2013/14**

This statement has been prepared by the Health Scrutiny Committee for Lincolnshire.

Progress on Priorities for 2013-14

We are pleased with the progress by Boston West Hospital on its priorities for 2013-14, in particular its participation in the dementia screening programme and the outcomes of the Patient-Led Assessment of the Care Environment.

Priorities for 2014-15

We support Boston West Hospital's priorities for 2014-15, and look forward to progress on these priorities leading to improvements in the patient experience and patient safety.

Engagement with the Health Scrutiny Committee

Three members of Health Scrutiny Committee visited Boston West Hospital in 20 January 2014. They found the visit a positive experience and the member of the Committee who wrote the report of the visit said: "*The hospital is a happy, clean, well run environment where I would feel very happy to receive treatment."*

The report is set out below:

> *"Sue Harvey, the Matron, and Heather Emmerson, the Liaison Officer, gave us a guided tour of the hospital and explained that Ramsay Health Care had taken over the hospital from Capio, and changed the name last year to Boston West Hospital.*
>
> - *Ramsay Health Care have hospitals in Australia, France and a sister hospital (The Fitzwilliam) in Peterborough, with others across England.*
> - *They offer NHS-funded and private health care.*
> - *Day Case only services are commissioned by the CCGs and NHS, 95% by the 'Choose and Book' system.*
> - *They offer consultant-delivered care, short waiting times (4 – 6 weeks), and a choice of time and date.*
> - *All patients are assessed to make sure they are suitable for day case surgery. Not all patients are suitable.*
> - *If necessary a patient could be transferred to Pilgrim Hospital for critical care – one case in the past five years.*
> - *Boston West mainly performs orthopaedic and ophthalmic surgery, but also offers some urology, gynaecology and pain management services. Boston West also provides General Surgery and Gastroenterology Services.*
> - *MRI – diagnostic imaging is on a Friday.*

Consulting Rooms

- *Hand sanitisers are available and are used by staff and patients, outside every door.*
- *There are five outpatient consulting rooms and one nurse in attendance.*
- *Nurses room at end of corridor.*
- *Reasonably bright and comfortable, two of the five rooms have a window.*
- *The consultant and staff on duty seemed happy with the system.*

Autoclave (Sterilising Unit)

- *Surgical items from both the Fitzwilliam and Boston West are sterilised on site.*
- *All items are scanned in and can be tracked from source.*
- *All items are sterilised, packed and then steamed at high temperature.*
- *Distributed back to source and good for up to a year if unopened.*

Surgery

- *200 – 250 patients per month receive services from the day hospital.*
- *Two admission bays.*
- *Surgery is on a rolling basis, patients arriving every half hour or so.*
- *Patient lockers accessible from two sides.*
- *There is one operating theatre, with full time anaesthetist in attendance.*
- *All procedures follow the NICE and day surgery guide lines.*
- *2 bed recovery bay with one to one nursing.*
- *45 minutes – 1 hour in recovery bay, then into a recliner prior to leaving.*
- *24 hour help line available once a patient has been discharged.*
- *A knee surgery patient: in by 7.30am, in theatre by 8am, home before 11am.*

Staffing

- *Staff are recruited from the area.*
- *Staff are able to gain wide experience and progress within Ramsay Health.*
- *They have a customer excellence award system, Bronze, Silver and Gold,*
- *Assessment forms are given to patients, to help assess the patient journey.*

General Comments

- *The hospital is a happy, clean, well run environment where I would feel very happy to receive treatment.*
- *There are well qualified experienced surgeons and staff."*

Achievements

We congratulate Boston West Hospital on the following achievements during the last year:

- the high cleanliness rating from Patient-Led Assessments of the Care Environment;
- the absence of any MRSA infection (making a total of three years without MRSA);
- the introduction of a new procedure in colo-rectal surgery; and
- the 99% patient satisfaction score.

Conclusion

We are grateful for the opportunity to make a statement on Boston West Hospital's Quality Account. We congratulate the Hospital on its improvements and achievements during the last year. The Committee would like to continue maintaining links with the Hospital during the coming year.

Lincolnshire COUNTY COUNCIL *Working for a better future* **HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE**	**Statement on East Midland Ambulance Service Trust's *Quality Account* for 2013/14**

This statement has been prepared by the Health Scrutiny Committee for Lincolnshire, which scrutinises and reviews NHS-funded health services in the administrative county of Lincolnshire.

Performance During 2013-14

The Health Scrutiny Committee for Lincolnshire notes the improvements arising from the Trust's priorities for 2013-14. In relation to Priority 1 (Improving Cardiac Arrest Outcomes), the Committee notes that a number of actions have taken place, but would like to see the results of these actions quantified in actual improvements in the number of patients who experienced a 'Return of Spontaneous Circulation' following a cardiac arrest.

Priorities for 2014-15

The Health Scrutiny Committee for Lincolnshire strongly supports the inclusion of Priority 4 (Improving Ambulance Response Times) and the proposed measures to bring about these improvements. However, we would request clarity whether national response times will be delivered at Trust, Divisional or Clinical Commissioning Group level. We are pleased that this priority includes working with Clinical Commissioning Groups to reduce the number of instances elderly patients in care homes may be conveyed to hospital unnecessarily. The importance of working with Clinical Commissioning Groups is also reflected in Priority 1 (Equity of Access to Stroke Care and Reducing Unplanned Admissions), which we also support.

Clinical Commissioning Groups

We are pleased that the Lincolnshire Division of the Ambulance Service has worked closely with the four Clinical Commissioning Groups in Lincolnshire to improve its services and we commend the Trust for its initiatives such as the emergency care practitioner assessment unit; the cycle response unit in Skegness; and dedicated crews to convey patients referred by GPs.

Engagement with the Health Scrutiny Committee for Lincolnshire

We are pleased that senior managers from the East Midlands Ambulance Service prepare reports for and regularly attend meetings of the Health Scrutiny Committee for Lincolnshire. During the current year, the Committee will be holding four-monthly performance monitoring sessions, which will enable the Committee to seek reassurance that the Ambulance Service is seeking to improve its services to Lincolnshire residents.

The Committee recognises the efforts made by the Trust to engage with the wider public and the staff. The Committee supports these efforts, and looks forward to this continuing during 2014/15, throughout all parts of the EMAS area.

Being the Best

In August 2013, the Secretary of State for Health accepted the advice of the Independent Reconfiguration Panel and decided not to proceed to a full review of the Ambulance Service's *Being the Best* initiative, which had been the subject of a referral to the Secretary of State by the Health Scrutiny Committee for Lincolnshire. The *Being the Best* initiative related to the proposed reconfiguration of ambulance stations. The Health Scrutiny Committee did not accept the premise that *Being the Best* would lead to improved ambulance response times. For this reason, the Committee is pleased that the Trust is now changing its emphasis from delivering an estates strategy to improving services for patients, including ambulance response times, as part of its *Better Patient Care* programme.

Care Quality Commission Inspection

We are disappointed that the Care Quality Commission (CQC) found that the Trust was not compliant in four areas inspected in January 2014. We look forward to the Trust using its action plan to meet the requirements set by the CQC, so that it is compliant as soon as possible.

Conclusion

We look forward to continued engagement with the East Midlands Ambulance Service and note that response time improvements have been made in most of Lincolnshire. We also look forward to improvements in the South Lincolnshire Clinical Commissioning Group area.

HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE	**HEALTHWATCH LINCOLNSHIRE**

Statement on Lincolnshire Community Health Services NHS Trust Trust's *Quality Account* for 2013/14

This statement has been prepared jointly by the Health Scrutiny Committee for Lincolnshire and Healthwatch Lincolnshire.

Priorities for 2014-15

The Health Scrutiny Committee for Lincolnshire and Healthwatch Lincolnshire support the Trust's seven priorities for 2014-2015. We understand that these priorities have been selected from a longer list and represent the areas on which the Trust would like to focus in the coming year.

We congratulate the Trust in presenting its targets for each of these priorities in the form of actual numbers, as well as percentage figures. This provides clear information to members of the public on what the Trust is aiming to achieve. We would like to suggest that the Quality Account make clear whether the each priority applies to community hospitals or staff working in the community, or both.

The priority to *Increase Patient Facing Time Through "Time to Care"* is welcomed, but we recognise that travelling around a rural county such as Lincolnshire presents a challenge to staff in terms of maximising patient contact time. We look forward to progress on this priority. We would like to stress the importance of meaningful patient contact time, with staff giving each patient as much attention as possible.

We strongly support the priority to *Reduce Harm from Falls in Community Hospitals*. We note the work in hand to address the causes of harmful falls.

We note that the target for *Reducing Medication Errors Resulting in Harm in Community Hospitals* is 10% for all medication errors, compared to a target of 25% for medication errors causing harm. We note that most medication errors do not cause harm to patients. However, we would like the 10% reduction target to be set higher, if this is possible. We would like to emphasise that the inappropriate use of abbreviations, poor handwriting and the need for translation, are all areas that could help reduce errors in medication.

We understand that the priority for the *Reduction of Pressure Ulcers* applies to patients in both community hospitals and under the care of the Trust's staff in the community. We are pleased to see the 50% target being applied to Grade 3 and Grade 4 pressure ulcers. Achieving this target will lead to significantly improved outcomes for patients and we look forward to the Trust making progress in this area.

For the *Friends and Family (Net Promoter)* priority, we made a comment on the draft Quality Account that we would like to see the targets for a 15% sample size from service

users and a 75% positive rating for the Trust also expressed in the actual number of patients. We also suggested that consideration be given to a larger sample size than 15%.

We note that the *Safe Staffing Levels* priority for community hospitals will be based on Royal College of Nursing guidelines and the Trust was devising a formula for determining the number of staff in the community.

Progress on Priorities for 2013-14

We would like to compliment the Trust with its progress on its 2013-2014 priorities, which has included progress with the delivery of outcome measures for core community services; and improvements to clinical record keeping.

In relation to the priority on the *Elimination of Pressure Ulcers*, we accept that there has been a 25% reduction overall, but this had not been as good as intended. As stated above, we support the 50% target for a reduction in Grade 3 and Grade 4 pressure ulcers during the coming year. We also note that the Trust has been providing training to residential and care homes on how to reduce the incidence of pressure ulcers.

We are saddened to hear that there was one death as a result of a fall in one of the wards at Johnson Hospital during the last year. We have been advised of the action taken by the Trust in response to this, for example reviewing the staffing levels and practices on the ward in question.

Engagement

The Health Scrutiny Committee has received information from the Trust during the last on its contribution to End of Life Care in Lincolnshire. For the coming year, the Committee would like to engage with the Trust, in particular on its contribution to the Lincolnshire Health and Care programme.

Healthwatch Lincolnshire has established communication channels with the Trust and plans to carry out 'Enter and View' visits to the Minor Injury Units at Skegness Hospital and John Coupland Hospital, Gainsborough in the coming year.

Conclusion

We are grateful for the opportunity to make a statement on the Trust's draft Quality Account. Both the Health Scrutiny Committee for Lincolnshire and Healthwatch Lincolnshire will be seeking more engagement with the Trust during the coming year on the progress with its priorities.

Lincolnshire COUNTY COUNCIL *Working for a better future* **HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE**	healthwatch Lincolnshire

Statement on Lincolnshire Partnership Foundation Trust *Quality Report* for 2013/14

This statement has been prepared jointly by the Health Scrutiny Committee for Lincolnshire and Healthwatch Lincolnshire.

Priorities for 2014-15

The Health Scrutiny Committee for Lincolnshire and Healthwatch Lincolnshire support the Trust's nine priorities for 2014-15 and the rationale for their inclusion, which builds on the Trust's Quality Principles. In delivering these priorities, the Trust will need to balance the declining availability of NHS resources, which is being addressed in part by the Lincolnshire Health and Care Programme, with the need for continuing high quality patient services.

We also acknowledge the involvement of patients and carers in the development of these priorities, as well as Healthwatch Lincolnshire.

As the Trust delivers these priorities in the coming year, we would like to emphasise that their application to both functional and organic patients. We also appreciate that proposals should be brought forward in the coming year, to address the issue of older adult organic and functional inpatients being treated on the same wards.

Priorities for 2013-14

We welcome the Trust's progress with its priorities for 2013-14. In particular, we would like to highlight the Trust's launch of a new Hospital Intensive Psychiatric Service at Lincoln County Hospital, and the county wide implementation of the Single Point of Access, as well as the reorganisation of the adult community mental health teams.

We would also like to highlight the "Safety Thermometer, which includes initiatives to reduce the number of falls of frail patients, as well as aiming to reduce the number of pressure ulcers.

Commissioning – Lincolnshire Health and Care Programme

The Lincolnshire Health and Care Programme will be aiming to ensure that the anticipated funding gap of £105 million in 2018 across health and social care in Lincolnshire will be addressed. We would like to see the continued involvement of the Trust with the commissioners of NHS funded services on the development and implementation of the Programme. We cite the proposed introduction of neighbourhood teams as one key element in the Programme, which we support.

Friends and Family Test

We note that the Friends and Family Test is of growing importance in measuring patient satisfaction, and that the Trust's performance is detailed in sections 2b.7, 2b.8 and 2b.9 of the Quality Report. We emphasise the importance of seeking higher levels of Friends and Family Test comments from patients and the inclusion of information on the number of patients responding to the FFT, in the context of the overall number of patients treated.

Francis Report

In 2013, we highlighted the importance of the Francis Report and asked providers how they were going to respond to the recommendations from the Francis Report We are therefore pleased to note that the Trust has completed 90 of the recommendations from the Francis Report, with a further 18 being implemented.

Awards and Achievements

We commend the Trust on its awards and achievements during the last year, which are detailed in section 3.8 of the report, which included the Trust being compliant with all Care Quality Commission inspections. We note that the Trust is benchmarked with other mental health trusts and that this benefits the Trust in seeking to learn and improve its services.

Conclusion

In terms of the overall content of the Quality Report, we recognise that the Trust has to balance the requirements in the regulations and guidance, with the need to make the document accessible to the public. In this regards, we suggest that there is an executive summary of the key elements, such as the Trust's priorities, and how they directly benefit patients, their families and carers.

The Health Scrutiny Committee and Healthwatch Lincolnshire look forward to continuing engagement with the Trust, and its continued improvement in the services provided to patients. The Health Scrutiny Committee will be considering how to focus on the priorities for the coming year as part of its work programme.

HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE	**HEALTHWATCH LINCOLNSHIRE**

Statement on North Lincolnshire and Goole NHS Foundation Trust *Quality Account* for 2013/14

This statement has been jointly prepared by the Health Scrutiny Committee for Lincolnshire and Healthwatch Lincolnshire.

The Health Scrutiny Committee for Lincolnshire and Healthwatch Lincolnshire welcome the opportunity to make a statement on the Quality Account for Northern Lincolnshire and Goole NHS Foundation Trust. It is the first time that each body has made a statement on the Trust.

Progress on Priorities for 2013-14

We commend the Trust where it has met its targets for last year's priorities, for example, the National Early Warning Score, reducing falls, and reducing pressure ulcers. We also note the Trust's progress in reducing the levels of mortality to within the 'expected range'.

Priorities for 2014-15

We support the Trust's 22 priorities for improvement in the coming year, and recognise that in most instances these priorities build on the previous year's progress, with more onerous target being set by the Trust, which we commend. We also note that the priorities and the relevant targets have been developed in discussion and agreement with patient focus groups, professionals and governors. We are pleased that that routine monthly monitoring of the priorities takes place and information on progress is accessible via the internet.

We would like to highlight the following priorities in particular:

- elimination of all repeat falls – We acknowledge the Trust's progress in this area to date, and feel that this is very important for patients.
- a 50% reduction in pressure ulcers – We recognise that some patients are admitted with pressure ulcers, but we strongly believe that pressure ulcers should not be acquired while a patient is in hospital.

Presentation and Content

We acknowledge that the regulations and guidance make the Quality Accounts far too onerous for a lay person to read. For this reason, we suggest an 'at a glance summary' to help members of the public. We also suggest that where possible actual numbers are used, rather than percentages, as this would also make the document more accessible.

Francis Report

We welcome the Trust's commitment to taking forward the recommendations in the Francis Report and suggest that the Quality Account makes reference to the actions already implemented, in particular those directly affecting patient care and experience, as well those actions where further work is required.

Keogh Review and Care Quality Commission

We acknowledge the Trust's progress in meeting all the actions arising from the 'Keogh' inspection in June 2013. Furthermore, we also acknowledge that the Trust, as of December 2013, was compliant with all the actions requested by the Care Quality Commission.

Conclusion

The Health Scrutiny Committee for Lincolnshire and Lincolnshire Healthwatch are pleased to have had an opportunity to make a statement on the Quality Account, and congratulate the Trust on the progress and achievements in the last year. We strongly support the strengthening of priorities across all the three areas of clinical effectiveness, patient safety and patient experience.

We look forward to working more closely with Northern Lincolnshire and Goole NHS Foundation Trust in the future and seeing how their new priorities are realised in 2014-15. This is with specific recognition to the growing patient numbers from Lincolnshire Clinical Commissioning Groups accessing services at the Trust, which results in funds in excess of £24 million being invested in the Trust.

Lincolnshire COUNTY COUNCIL *Working for a better future* **HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE**	**Statement on Peterborough and Stamford Hospitals NHS Foundation Trust** ***Quality Account* for 2013/14**

This statement has been prepared by the Health Scrutiny Committee for Lincolnshire.

During the last year, the Health Scrutiny Committee has engaged with Peterborough and Stamford Hospitals NHS Foundation Trust on the following three dates:

- 10 July 2013
- 23 October 2013
- 19 March 2014

In addition on 10 July 2013, members of the Committee visited Stamford and Rutland Hospital and were impressed by the quality of the provision there and the commitment of staff at the Hospital.

The Committee welcomed the invitation to attend the stakeholder event held by the Trust on 8 May 2014 to consider the first draft of the Quality Account. The Committee was duly represented at this event by one of its members. However, in view of the short time available to submit comments on the final draft of the Quality Account, it has not been possible for the Committee to consider the report in any detail. For example, the Committee cannot make any comment on whether it would support the Trust's priorities for 2014-2015.

The Health Scrutiny Committee for Lincolnshire would like to continue engaging with the Trust, particularly in relation to the quality of services provided to Lincolnshire patients. This is pertinent following the Care Quality Commission report on Peterborough City Hospital, published on 16 May 2014. The Committee would also like to be involved further on the plans for the development of services at Stamford and Rutland Hospital, which the Committee supports on the basis that they will lead to increased healthcare provision at the Hospital.

Finally, the Committee would like to emphasise that maintaining high quality services to patients remains its paramount concern and that this should not be overlooked at a time when the Trust is seeking to deliver on Cost Improvement Programme commitments to reduce its structural deficit.

Lincolnshire COUNTY COUNCIL *Working for a better future* **HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE**	**Statement on St Barnabas's *Quality Account* for 2013/14**

This statement has been prepared by the Health Scrutiny Committee for Lincolnshire.

Priorities for 2013-14

The Committee welcomes the Trust's progress with its three priorities for 2013/14. In particular, the Committee is pleased with the development of a six bed Hospice within a Hospital at Grantham and District Hospital, which we believe will be essential for the people in the surrounding area. We look forward to the Hospice within a Hospital opening in the coming year.

Priorities for 2014-15

We support St Barnabas's three priorities for improvement in 2014-15. We would like to emphasise our support for the development of specific measures to reduce pressure damage for palliative care patients. Achievement of this priority will clearly benefit patients and reflects one of the key themes for health care.

Engagement with the Health Scrutiny Committee for Lincolnshire

On 21 March 2014, four members of the Health Scrutiny Committee visited the St Barnabas Hospice In-patient Unit in Lincoln. The members of the Committee concluded that the visit was a very positive and encouraging experience, reinforced by open and honest conversations with staff, patients and relatives.

Here is the report of the visit:

> *"The St. Barnabas In-Patient unit is located in Lincoln and offers the following services:-*
>
> - *Palliative Care Inpatient Unit*
> - *Welfare Benefit Support and Advisory service*
> - *Physiotherapy*
> - *Occupational Therapy*
> - *Lymphoedema Clinic*
> - *Bereavement Support*
>
> *"The Mission Statement is "St Barnabas provides specialist palliative and end of life care so that everyone can access and receive the support they need to live well and ease the process of dying."*

"The unit is an 11 bed unit with two rooms of four beds (one for male patients and one for female patients) and three separate one bed rooms. The unit has a conservatory which includes a children's play area and has a television. There is a separate lounge from the main ward area. There is also a large balcony area overlooking the gardens.

"Admission to the unit is normally for a relatively short period of time, typically ten or eleven days during which time the patient is 'stabilised' before returning home. Care is integrated with an outreach team when the patient is at home, called 'Hospice at Home', which embraces physical needs, emotional needs, social support and spiritual support. This is supported by the Palliative Care Co-ordination Centre (PCCC), which is open 365 days a year at the Nettleham Road unit, 9am to 6pm Monday to Friday and 9am to 5pm Saturday and Sunday and Bank Holidays.

"Food is prepared from scratch in a kitchen on the premises. The range of choices is very wide, with the patient being served nutritious and tasty food.

"The hospice was very clean and staff were obviously happy in their work. Each shift has a nursing sister in charge wearing a navy blue uniform. It was said sight of this uniform was reassuring for patients and visitors.

"Visiting times are open with a recommended 'quiet time' of 14.20-15.30, as much to give visitors respite as patients.

"In terms of quality and governance St Barnabas are inspected by the Care Quality Commission (CQC) and as a charity is regulated by the Charity Commission. The most recent CQC report states that St Barnabas met all of the required criteria with many very positive comments from patients, relatives, staff and volunteers."

A representative from St Barnabas also attended the Health Scrutiny Committee in October 2013, as part of an item on palliative and end of life care.

We look forward to continuing engagement with the Committee in the coming year.

Presentation and Accessibility of Information to the Public

We believe that the Quality Account is well-presented and accessible to members of the public and provides a clear guide on the activities of the St Barnabas.

Care Quality Commission

We note that St Barnabas received an unannounced inspection from the Care Quality Commission on 10 January 2014 and we are pleased that St Barnabas was compliant with all the standards inspected. We congratulate St Barnabas on this achievement.

Conclusion

We would like to congratulate St Barnabas Hospice on its achievements over the last year, in particular the developments at Grantham and District Hospital and we look forwards to further achievements in the coming year.

HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE	**HEALTHWATCH LINCOLNSHIRE**

Statement on United Lincolnshire Hospitals NHS Trust's *Quality Account* for 2013/14

This statement has been jointly prepared by the Health Scrutiny Committee for Lincolnshire and Healthwatch Lincolnshire.

Priorities for 2014-15

The Health Scrutiny Committee for Lincolnshire and Lincolnshire Healthwatch support the Trust's five priorities for 2014-15 and accept the rationale and process for their selection. We would like to see targets for these priorities expressed in actual numbers, in addition to the percentage figures, as this would be clearer for the general public. For example, we would like the Trust to set a figure for the number of Friends and Family responses it would like to receive in the coming year.

On priority 1 (*Learning from Feedback and Complaints)*, we urge the Trust to issue as many Friends and Family forms as possible*,* to increase the actual number of responses. We urge that that forms are always made available to patients in Accident and Emergency as well as to patients receiving elective care. We would also like the Trust to compare its response rate with other hospital trusts, as well as the answer to the question.

On priority 3 (*Reducing Errors in Medication*), we would like to emphasise that the inappropriate use of abbreviations, poor handwriting and the need for translation, are all areas that could help reduce errors in medication. The most important measure is to reduce the number of medication errors that cause harm or delay an improvement in the patient's health.

We note that by limiting the number of priorities to five, previous priorities, such as *Improving Safe Discharge* and *Reducing Healthcare Associated Infection*s, have had to be omitted. We firmly believe that *Improving Safe Discharge,* including liaison with other NHS and community bodies, should remain as a key priority, as this will support the delivery of key elements in the Lincolnshire Health and Care programme.

Whilst we have been reassured by the Trust that it is not going to lose sight of *Improving Safe Discharge* and *Reducing Healthcare Associated Infection*s, we would like to emphasise our view that these two initiatives should remain priorities for the Trust.

Review of Progress on Priorities for 2013-14

The Health Scrutiny Committee for Lincolnshire and Lincolnshire Healthwatch strongly supported the priorities for 2013-14. In relation to the *Reducing the Hospital Standardised Mortality Rate* priority, we are pleased that Trust has made good progress in reducing its mortality rate towards the national average figure and will no longer be considered a statistical outlier.

We are pleased the progress made with priority 4 (*Improving Safe Discharge*), with initiatives such as the planning for the discharge of the patient within 24 hours of admission; and piloting revised social worker arrangements at Pilgrim Hospital. We believe these initiatives will support the delivery of the Lincolnshire Health and Care Programme. As started above, we would like work on this priority to be carried forward into the coming year.

The targets for the priority to *Reduce Healthcare Associated Infections* have not been met, owing to 76 Clostridium Difficile and four MRSA infections being recorded. As stated above, we would not like the importance of reducing healthcare associated infections being lost.

CQUIN

The Health Scrutiny Committee for Lincolnshire and Lincolnshire Healthwatch are grateful to the Trust for presenting a draft version of the Quality Account to them. At the draft stage, we suggested that more detail should be included in the CQUIN [Commissioning for Quality and Innovation] section of the Quality Account.

Keogh Review

The Health Scrutiny Committee for Lincolnshire and Lincolnshire Healthwatch recognise that Trust has been focused during the last year in delivering its action plan in response to the Keogh Review, published in June 2013.

Engagement with the Health Scrutiny Committee and Healthwatch Lincolnshire

Senior managers from the Trust have attended the Health scrutiny Committee on a number of occasions during 2013-14, covering topics such as Nurse Recruitment;

In addition, in November and December 2013 members of the Committee visited Accident and Emergency and two wards at Lincoln County Hospital, and Pilgrim Hospital, Boston. A report of each of these two visits was passed to the Trust.

In February 2014, members of the Committee visited Grantham and District Hospital, to see the potential developments arising from the *Shaping Health for Mid-Kesteven* programme.

Healthwatch Lincolnshire undertook a programme of Enter and View visits during January 2014 at Accident and Emergency Departments at Grantham and District Hospital; Lincoln County Hospital; and Pilgrim Hospital, Boston. The outcomes of these visits were compiled into a report which made ten recommendations to the Trust. The Trust's full response will be available soon.

Conclusion

The Health Scrutiny Committee for Lincolnshire and Lincolnshire Healthwatch are pleased to have had an opportunity to make a statement on the Quality Account, and congratulate the Trust on its progress and achievements in the last year.

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Lincolnshire COUNTY COUNCIL *Working for a better future*		**THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE**	
Boston Borough Council	East Lindsey District Council	City of Lincoln Council	Lincolnshire County Council
North Kesteven District Council	South Holland District Council	South Kesteven District Council	West Lindsey District Council

Open Report on behalf of Richard Wills, the Director Responsible for Democratic Services

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**23 July 2014**
Subject:	**Work Programme**

Summary:

This item invites the Committee to consider and comment on its work programme.

The Committee is also invited to consider its meeting arrangements in advance of the General Election on 7 May 2015.

Actions Required:

(1) To consider and comment on the content of the work programme.

(2) To hold a meeting of the Committee on 11 March 2015 instead of 18 March 2015.

(3) To cancel the meeting of the Committee scheduled for 22 April 2015.

1. The Committee's Work Programme

The work programme for the Committee's meetings over the next few months is attached at Appendix A to this report, which includes a list of items to be programmed.

Set out below are the definitions used to describe the types of scrutiny, relating to the proposed items in the work programme:

Budget Scrutiny - The Committee is scrutinising the previous year's budget, the current year's budget or proposals for the future year's budget.

Pre-Decision Scrutiny - The Committee is scrutinising a proposal, prior to a decision on the proposal by the Executive, the Executive Councillor or a senior officer.

Performance Scrutiny - The Committee is scrutinising periodic performance, issue specific performance or external inspection reports.

Policy Development - The Committee is involved in the development of policy, usually at an early stage, where a range of options are being considered.

Consultation - The Committee is responding to (or making arrangements to respond to) a consultation, either formally or informally. This includes pre-consultation engagement.

Status Report - The Committee is considering a topic for the first time where a specific issue has been raised or members wish to gain a greater understanding.

Update Report - The Committee is scrutinising an item following earlier consideration.

Scrutiny Review Activity - This includes discussion on possible scrutiny review items; finalising the scoping for the review; monitoring or interim reports; approval of the final report; and the response to the report.

In considering items for inclusion in the Committee's work programme, Members of the Committee are advised that it is not the Committee's role to investigate individual complaints or each matter of local concern.

March and April Committee Meetings 2015

On 6 April 2010, the Department of Health issued detailed guidance to NHS organisations in the run up to the last General Election on 6 May 2010. As a result of this guidance the scheduled meeting of the Health Scrutiny Committee on 21 April 2010 was cancelled. The 2010 guidance advised employees of all NHS organisations against attending public meetings, including any meetings with question and answer sessions, which entertained any possibility that their statements, no matter how impartial, might be misconstrued.

Parliament has already determined that the General Election will take place on 7 May 2015. There is no reason to assume that the guidance from the Department of Health will be significantly different for 2015. For this reason the following changes are proposed to the Committee's programme:

- moving the date of the March meeting from 18 March to 11 March (to avoid the pre-Election 'purdah' period as far as possible); and
- cancelling the scheduled meeting on 22 April 2015, on the basis that this meeting would be taking place inside the .

2. Conclusion

The Committee is invited to consider and comment on the content of the work programme and to consider its meeting arrangements for March and April 2015, in advance of the General Election on 7 May 2015.

3. Consultation

There is no consultation required as part of this item.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Health Scrutiny Committee Work Programme

5. Background Papers

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

This report was written by Simon Evans, who can be contacted on 01522 553607 or simon.evans@lincolnshire.gov.uk

APPENDIX A

HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE
WORK PROGRAMME

Chairman: Councillor Mrs Christine Talbot
Vice Chairman: Councillor Chris Brewis

23 July 2014		
Item	**Contributor**	**Purpose**
Burton Road Surgery, Lincoln.	David Sharp, Director Leicestershire and Lincolnshire Area Team, NHS England Andrew Morgan, Chief Executive, Lincolnshire Community Health Services NHS Trust	Update Report
Children Looked After and Safeguarding – Review of Health Services and Safeguarding – Report by the Care Quality Commission	Jan Gunter, Consultant Nurse Safeguarding Children and Adults, Federated Safeguarding Service	Status Report
Healthy Lives, Healthy Futures Programme *(North Lincolnshire and North East Lincolnshire)*	Simon Evans, Health Scrutiny Officer	Consultation
Local Authority Health Scrutiny – *Guidance to Support Local Authorities and Their Partners to Deliver Effective Health Scrutiny*	Simon Evans	Status Report
Quality Accounts 2013-14 – Final Statements	Simon Evans	Status Report

17 September 2014		
Item	**Contributor**	**Purpose**
East Midlands Ambulance Service – Performance and Improvements	Sue Noyes, Chief Executive, East Midlands Ambulance Service NHS Trust	Update Report
United Lincolnshire Hospitals NHS Trust – Action Plans in Response to Care Quality Commission Reports (Published 10 July 2014)	Jane Lewington, Chief Executive, United Lincolnshire Hospitals NHS Trust To be confirmed	Update Report
Health Education East Midlands – Impact in Lincolnshire	To be confirmed	Update Report
New Review of Congenital Heart Services – National Consultation	To be confirmed.	Consultation
Complaints Overview Report	Simon Evans	Status Report

22 October 2014		
Item	**Contributor**	**Purpose**
Healthwatch Lincolnshire Update	Sarah Fletcher, Chief Executive Officer, Healthwatch Lincolnshire	Update Report
Lincolnshire Joint Health and Wellbeing Strategy – Performance Assurance Framework	To be confirmed	Update Report
Public Health Annual Report and Action Plan on Suicide and Self-Harm in Lincolnshire	Nicole Hilton, Head of Community Engagement and Vulnerable People, Lincolnshire County Council	Status Report

26 November 2014		
Item	**Contributor**	**Purpose**
Lincolnshire West Clinical Commissioning Group	Dr Sunil Hindocha, Chief Clinical Officer, and Sarah Newton, Chief Operating Officer, Lincolnshire West Clinical Commissioning Group	Update
Peterborough and Stamford Hospitals NHS Foundation Trust	To be confirmed.	Update

Health Scrutiny Committee – Annual Work Programme

Dates	Item
May, June and July 2014	<u>Items Considered</u> • Drafting and Finalising Quality Account Statements *(Completed via Working Group – 27 June 2014)* • Final Quality Account Statements Circulated *(23 July 2014)* • Clinical Commissioning Group – Annual Reports *(25 June 2014)* • East Midlands Ambulance Service – Quarterly Response Time Performance *(21 May 2014)* • Children Looked After and Safeguarding – Review of Health Services and Safeguarding – Report by the Care Quality Commission *(23 July 2014)* <u>Items Not Considered</u> • The New Review of Congenital Heart Surgery Services – Consultation ***(Now expected September 2014)*** • Joint Health and Wellbeing Strategy 2013 - 2018 Theme 1: Promoting Healthier Lifestyles • Joint Health and Wellbeing Strategy 2013- 2018 Theme 3: Delivering High Quality Systematic Care for Major Causes of Ill Health and Disability ***(These two Joint Health and Wellbeing Strategy items will be programmed after 22 October 2014, following an item on the Strategy's Performance Assurance Framework.)*** • Complaints Overview Report ***(This will now be considered in September.)*** • Outline of Mental Health Services ***(This item will be rescheduled for a later meeting.)***

Dates	Item
September, October, November, and December 2014	• United Lincolnshire Hospitals Trust – Outcome of Re-inspection by the Chief Inspector of Hospitals • New Review of Congenital Heart Surgery Services Update • Lincolnshire Partnership NHS Foundation Trust – Update on Clinical Strategy • Joint Health and Wellbeing Strategy 2013- 2018 Theme 2: Improve the Health and Wellbeing of Older People. • Joint Health and Wellbeing Strategy 2013- 2018 – Theme 4 - Improve Health and Social Outcomes for Children and Reduce Inequalities • East Midlands Ambulance Service – Quarterly Response Time Performance • Complaints Overview Report • Infection Control in Hospitals
January, February March, and April 2015	• Annual Report of the Director of Public Health 2014 • Arrangements for Quality Accounts 2015 • Joint Health and Wellbeing Strategy 2013- 2018 – Theme 5 - Tackling the Social Determinants of Health • East Midlands Ambulance Service – Quarterly Response Time Performance • Complaints Overview Report

For more information about the work of the Health Scrutiny Committee please contact Simon Evans, Health Scrutiny Officer, on 01522 553607 or by e-mail at simon.evans@lincolnshire.gov.uk

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