| 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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**A Meeting of the Health Scrutiny Committee for Lincolnshire will be held on Wednesday, 16 December 2015 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, S L W Palmer, Miss E L Ransome, Mrs S Ransome, Mrs J M Renshaw, T M Trollope-Bellew and Mrs S M Wray

District Councillors: Dr G Gregory (Boston Borough Council), Mrs P F Watson (East Lindsey District Council), J Kirk (City of Lincoln Council), T Boston (North Kesteven District Council), C J T H Brewis (South Holland District Council (Vice-Chairman)), Mrs R Kaberry-Brown (South Kesteven District Council) and D P Bond (West Lindsey District Council)

Healthwatch Lincolnshire: Dr B Wookey

## AGENDA

| Item | Title | Pages |
|---|---|---|
| 1 | **Apologies for Absence/Replacement Members** | |
| 2 | **Declarations of Members' Interests** | |
| 3 | **Chairman's Announcements** | |
| 4 | **Minutes of the meeting of the Committee held on 18 November 2015** | 3 - 20 |
| 5 | **Children and Adolescent Mental Health Services** *(To receive a report from Andrew McLean (Children's Services Manager for Commissioning) which provides an overview of the commissioning of the Child and Adolescent Mental Health Service (CAMHS), including funding, performance monitoring, local need and delivery against national benchmarking. The report also includes the proposed revised model of delivery following successful application for Local Transformation Planning NHS England Funds)* | 21 - 30 |

| Item | Title | Pages |
|---|---|---|
| 6 | **Lincolnshire East Clinical Commissioning Group - General Update**<br>*(To receive a report from Gary James (Accountable Officer – Lincolnshire East Clinical Commissioning Group) which provides an update in relation to the activities for Lincolnshire East Clinical Commissioning Group (CCG) including the commissioning activities of the CCG and the wider developments the CCG has been involved in)* | 31 - 38 |
| 7 | **Response of the Health Scrutiny Committee to the Joint Strategic Needs Assessment Review**<br>*(To receive a report from Simon Evans (Health Scrutiny Officer) which provides the proposed draft response, produced by the established working group, for the Committee's approval as part of the stakeholder engagement phase)* | 39 - 44 |
| 8 | **Draft Clinical Strategy Priorities of Lincolnshire Partnership NHS Foundation Trust: Joint Statement of the Health Scrutiny Committee for Lincolnshire and Healthwatch Lincolnshire**<br>*(To receive a report from Simon Evans (Health Scrutiny Officer) which presents the joint response of the Health Scrutiny Committee for Lincolnshire and Healthwatch Lincolnshire submitted to Lincolnshire Partnership NHS Foundation Trust (LPFT) on their Draft Priorities)* | 45 - 50 |
| 9 | **Work Programme**<br>*(To receive a report by Simon Evans (Health Scrutiny Officer) which invites the Committee to consider its' work programme for the coming months)* | 51 - 56 |

Tony McArdle
Chief Executive
8 December 2015

**HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE**
**18 NOVEMBER 2015**

**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, Mrs J M Renshaw, T M Trollope-Bellew and Mrs S M Wray

Lincolnshire District Councils

Councillors Dr G Gregory (Boston Borough Council), Mrs P F Watson (East Lindsey District Council), T Boston (North Kesteven District Council), C J T H Brewis (South Holland District Council (Vice-Chairman)) Mrs R Kaberry-Brown (South Kesteven District Council) and Mrs A White (West Lindsey District Council)

Healthwatch Lincolnshire

Dr B Wookey

Also in attendance

Dr Vindi Bhandal (Chairman, South West Lincolnshire CCG), Andrea Brown (Democratic Services Officer), Dr Kakoli Choudhury (Consultant Public Health Adults and Public Health Care), Simon Evans (Health Scrutiny Officer), Sarah Furley (Urgent Care Programme Director, Lincolnshire East CCG), Dr Sunil Hindocha (Chief Clinical Officer, Lincolnshire West CCG), Gary James (Accountable Officer, Lincolnshire East CCG), Allan Kitt (Chief Officer, South West Lincolnshire CCG), Lynne Moody (Director of Quality and Executive Nurse, South Lincolnshire CCG), Sarah Newton (Chief Operating Officer, Lincolnshire West CCG) and Clair Raybould (Head of Commissioning, South West Lincolnshire CCG)

County Councillors B W Keimach and Mrs S Woolley attended the meeting as observers.

54 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

Apologies for absence were received from Councillor D P Bond (West Lindsey District Council) and Councillor J Kirk (Lincoln City Council).

The Chief Executive reported that under the Local Government (Committee and Political Groups) Regulations 1990, he had appointed Councillor Mrs A White to the Committee in place of Councillor D P Bond (West Lindsey District Council) for this meeting only.

Apologies for absence were also received from Chris Weston (Consultant in Public Health).

Notice had also been received that Councillors T Boston and G Gregory would arrive late and asked that their apologies be conferred to the Committee.

55 DECLARATIONS OF MEMBERS' INTERESTS

There were no declarations of Members' interests at this point in the proceedings.

56 CHAIRMAN'S ANNOUNCEMENTS

The Chairman welcomed everyone to the Committee and made the following announcements:-

i) St Barnabas Hospice – Chief Executive

On 30 October 2015, St Barnabas Hospice announced the appointment of Chris Wheway as its new Chief Executive, having replaced Sarah-Jane Mills who was now leading on the Cancer Strategy within Lincolnshire. Chris Wheway had joined St Barnabas after twelve years' experience in the NHS in both Lincolnshire and Derbyshire. The Chairman was scheduled to meet the new Chief Executive in the next few weeks.

ii) Hospice Within a Hospital Award

With delight, the Chairman announced that on 8 November 2015 the Hospice in a Hospital, at Grantham and District Hospital, won the *Building Better Healthcare Award*. The unit at Grantham and District hospital was the first of its kind in the UK and was recognised for its innovative approach to patient experience. The unit was successful as best *End of Life Care Project,* and was recognised for its unique approach of providing care to patients under the responsibility of GPs, but with access to hospital nurses, doctors and therapists. The six-bed community hospice opened in September 2014 as part of a joint venture between St Barnabas Lincolnshire Hospice, United Lincolnshire Hospitals NHS Trust and South West Lincolnshire Clinical Commissioning Group.

iii) United Lincolnshire Hospitals NHS Trust

The Chairman had met with senior managers at United Lincolnshire Hospitals NHS Trust (ULHT) on two separate occasions. On 27 October 2015, a meeting was held with Kevin Turner, Acting Chief Executive, where a briefing was received on some of the system issues which had led to the continued deterioration of the Trust's financial position. On 4 November 2015, a meeting was held with Jan Sobieraj, Chief Executive Designate, where the challenges facing the Trust over coming months were discussed. Jan was due to take on the substantive role as Chief Executive on 7 December 2015.

iv) Lincolnshire Partnership NHS Foundation Trust

On 3 November 2015 the Chairman met with Alan Lockwood, Vice-Chairman, and John Brewin, Chief Executive of Lincolnshire Partnership NHS Foundation Trust (LPFT) to discuss the process for the Care Quality Commission Inspection scheduled between 30 November and 4 December 2015. Approximately 70 inspectors will form the inspection team and would visit the services provided by the Trust. The CQC report was expected to be published no earlier than March 2016.

It was also agreed that two items would be brought forward on to the Work Programme for the meeting scheduled for 17 February 2015. These were Adult Psychology Services and Universal Health.

v) Lincolnshire and Nottinghamshire Air Ambulance

The Lincolnshire and Nottinghamshire Air Ambulance had given a presentation to the Committee in October 2014. Peter Aldrick, who had been the Chief Executive of the Lincolnshire and Nottinghamshire Air Ambulance for sixteen years, would be retiring in January 2016 and Karen Jobling had been appointed as his replacement. Karen had 25 years' experience at senior management level in the charity sector and previously held the post of Executive Director at the World Cancer Research Fund International/UK.

vi) East Midlands Ambulance Service NHS Trust – Inspection by the Care Quality Commission

On 16 November 2015, the Care Quality Commission began its inspection of the East Midlands Ambulance Service, which would continue until the end of the week. The inspection would consist of approximately 100 inspectors to the East Midlands and would be undertaken as part of the CQC's new regime. The CQC would be applying its new inspection regime, based on the five questions, *Are they safe? Are they effective? Are they caring? Are they responsive to people's needs?* and *Are they well-led?*

vii) Accessing Urgent Care in Lincolnshire

United Lincolnshire Hospitals NHS Trust (ULHT) issued a media release on 16 November 2015 which emphasised the available alternatives to attending Accident and Emergency Departments. The media release stated that the patients should not attend A&E if the matter was not serious or life-threatening as many illnesses could be better treated by visiting the local pharmacy, calling 111, visiting the local GP or GP out-of-hours services, attending a walk-in centre or minor injuries unit.

viii) Medical School for Lincolnshire

Page 11 of the minutes of the meeting, of the Health Scrutiny Committee for Lincolnshire, held on 21 October 2015 referred to a letter being prepared to be despatched to the Secretary of State, urging him to establish a medical school in Lincolnshire. The Chairman confirmed that she had put her signature to the letter

and understood that other signatures would be also be added and the letter sent to the Secretary of State by the end of November 2015.

ix) Lincolnshire Community Health Services NHS Trust Headquarters

Lincolnshire Community Health Services NHS Trust (LCHS) was relocating its headquarters from Sleaford to Welton House (Greetwell Place, Lincoln) and to Beech House (Lincoln). All staff from Bridge House, Sleaford, were expected to have moved over to Lincoln by the end of November 2015.

x) Stay Well This Winter

The Committee were reminded that the NHS had launched a national campaign, *Stay Well This Winter*, which provided advice to people over 65 or with long term conditions on how to prepare for winter. The advice covered items such as keeping the home at no less than 18 degrees.

57 MINUTES OF THE MEETING OF THE COMMITTEE HELD ON 21 OCTOBER 2015

RESOLVED

That the minutes of the meeting held on 21 October 2015 be approved and signed by the Chairman as a correct record.

58 UPDATE ON DELEGATED COMMISSIONING ARRANGEMENTS FOR GP SERVICES - LINCOLNSHIRE WEST CLINICAL COMMISSIONING GROUP

A report by Dr Sunil Hindocha (Chief Clinical Officer – Lincolnshire West Clinical Commissioning Group) and Sarah Newton (Chief Operating Officer – Lincolnshire West Clinical Commissioning Group) was considered which described the new responsibility Lincolnshire West Clinical Commissioning Group had for commissioning GP services and the governance arrangements in place to mitigate potential conflicts of interest.

Dr Sunil Hindocha (Chief Clinical Officer – Lincolnshire West Clinical Commissioning Group) and Sarah Newton (Chief Operating Officer – Lincolnshire West Clinical Commissioning Group) were in attendance for this item of business.

Members were advised that commissioning of primary care services had previously been carried out by NHS England, but NHS England had invited all CCG's to take over responsibility for commissioning those services. All four CCGs in Lincolnshire had applied to take on delegated responsibility for GP commissioning. Since 1 April 2015, the CCG had been responsible for carrying out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act, other than those relating to individual GP performance management which had been reserved to NHS England.

The following activities were included:-

- General Medical Services (GMS), Primary Medical Services (PMS) and Alternative Provider Medical Services (APMS) contracts, including the design of PMS, APMS contracts, contract monitoring, contractual action and removing a contract but not the alteration of the Terms and Conditions of any national contract;
- Design, development, introduction and monitoring of newly enhanced services ("Local Enhanced Services" and "Directed Enhanced Services"), and modification or cessation of existing schemes;
- Design and management of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);
- To determine whether to establish new GP practices within the area;
- Approval of practice mergers;
- Decision making on 'discretionary' payment (e.g. returner/retainer schemes).

All CCGs responsible for GP commissioning were required to establish an independent Primary Care Commissioning Committee to exercise and oversee the delegated Primary Care commissioning functions. Lincolnshire West CCG had a committee of 11 members and was chaired by a lay member, as per guidelines, and made up of the following (those with voting rights are indicated with a *):-

- Lay Chair of the CCG*
- Chief Operating Officer or nominated deputy*
- Chief Nurse or nominated deputy*
- Chief Finance Officer or nominated deputy*
- Lay member for Public and Patient Involvement*
- Lay member for Primary Care*
- Secondary Care Clinician Governing Body member*
- NHS England representation
- Clinical Accountable Officer
- GP Clinical Advisor
- The four CCG locality chairs

Since the report had been published, a further lay member had been appointed.

It was further noted that the Conflicts of Interest Policy had been revised in accordance with new guidance and approved as part of the CCGs application to take on delegated primary care commissioning.

The revenue budget for commissioning GP primary care services had been delegated to the CCG along with the budget for GP IT. At present, infrastructure funding had been retained centrally. Some NHS England staff had been assigned to the four Lincolnshire CCGs to support administration but the management allowance for CCG's had been set nationally and had not increased as a result of taking on the additional responsibility. It was reduced by 10% in 2015/16.

CCGs who had taken on responsibility for delegated primary care commissioning were required, as part of the new assurance process, to submit a quarterly

declaration. The declaration for the first quarter of 2015/16 had been included as part of the report.

The Primary Care Commissioning Committee met monthly and had discussed a number of key issues, including:-

- Concordat for the Sharing of Information and the Management of Concerns relating to the Professional and Contractual Performance of Primary Medical Practitioners;
- Estate issues;
- Quality assurance for primary care;
- Quality and Outcomes Framework (QOF) 2013/14 – Heart Failure Indicator Performance by Practice;
- Practice/locality profiles;
- Prescribing and physiotherapy;
- Policy for practices in crisis (including failing practices)
- Individual practice issues;
- Care Quality Commission reports.

Members were given the opportunity to ask questions during which the following points were noted:-

- Annex A to the report provided an accurate picture of delegated functions for Quarter 1. Section 6 of the Self-Certification document required confirmation that an internal audit had been done to ensure the systems and processes were correct. It also required a signature from the Accountable Officer in addition to the Chairman of the Audit Committee;
- Although all CCGs were required to have a framework in place, it was acknowledged that these would be slightly different in each area. For example, Lincolnshire East CCG, South Lincolnshire CCG and South West Lincolnshire CCG operated a joint advisory group, as this was felt to be more time effective for these organisations;
- The ambition was to work better with partners to ensure integrated services at primary care level;
- Within the membership of the Primary Care Commissioning Committee on page 24 of the report, it was noted that there was a Lay Chair of the CCG. The sentence in brackets following this (*or lay vice chair if the chair is a General Practitioner)* was an error and should not have been included as GPs are unable to chair this Committee;

At 10.30am, Councillor T Boston joined the meeting.

- The Primary Care Commissioning Committee was open to the public and the CCG used the media, advertising and stakeholder meetings to promote attendance which had varied from meeting to meeting. It was suggested that posters be put up in each of the GP Practices within the locality to widen awareness of the Committee;
- The CCG continued to work with the Central Lincolnshire Joint Planning Unit as there was a concern about the decreasing workforce, in primary care, and

increasing populations. The infrastructure was being considered with a view to building on the support already available;

NOTE: The Chairman declared a personal interest as a member of the Central Lincolnshire Joint Strategic Planning Committee.

- When asked what influence the CCGs would have over the amount of procedures being performed outside of Lincolnshire, it was reported that at least 73% of patients were treated in acute care within Lincolnshire;
- Patients were able to decide if they would prefer care in a different county although it was acknowledged that this could have a financial implication as Lincolnshire had a lower market forces factor applied as part of the national tariff. It was stressed that the CCGs had no influence over the market forces factor applied as that was a national decision;
- When the responsibility for delegated GP commissioning arrangements was given to the CCGs administration costs were not included. They did, however, receive support from NHS England in 'people' resource;

RESOLVED

1. That the report and comments made be noted; and
2. That an update and report on progress of delegated commissioning be scheduled for a future meeting of the Health Scrutiny Committee for Lincolnshire.

59 SOUTH WEST LINCOLNSHIRE CLINICAL COMMISSIONING GROUP - GENERAL UPDATE

A report by Allan Kitt (Chief Officer – South West Lincolnshire Clinical Commissioning Group) was considered which provided an update on the activities within South West Lincolnshire Clinical Commissioning Group covering urgent care, planned care, primary care and commissioning support in addition to information on mental health and learning disabilities for which South West Lincolnshire CCG was the lead commissioner.

Allan Kitt (Chief Officer – South West Lincolnshire CCG), Dr Vindi Bhandal (GP Chair) and Clair Raybould (Chief Commissioning Manager) were all in attendance for this item of business.

Members were given a brief overview of the report, the aim of which was to update the Committee on developments with South West Lincolnshire CCG. The CCG covered a population of approximately 130,000 and was centred around the market towns of Grantham and Sleaford. Although there was only one practice area within the CCG's area where deprivation was above the national average, the prevalence of disease was significantly higher than the national average. This included cardiovascular disease, diabetes and respiratory disease. Cancer mortality was improving overall with mortality for breast, lung and gastrointestinal better than the national average. Overall, cancer survival rates were worse than the national average despite steady improvement.

The CCG's Strategic Plan had been underpinned by the work consulted on and shared with the Scrutiny Committee and of the Shaping Health for Mid Kesteven Programme. The work had focussed on the following key areas:-

- Urgent Care
    - The Hospice in Hospital was a joint venture between local GPs, St Barnabas Hospice, ULHT and the CCG. It was fully operational at Grantham and District Hospital and was, for the first time, providing local inpatient palliative care;
    - Fifteen new intermediate care beds had been commissioned in partnership with Lincolnshire County Council, Lincolnshire Community Health Services and local GPs. This provided an alternative to hospital admission as well as a means to avoiding unnecessary hospital stays. In order to manage the inevitable winter pressures, it was planned to expand these bed numbers;
    - Close working with ULHT and Lincolnshire Community Health Services had enabled a single integrated reception area to open where Out of Hours, the GP in A&E and the Emergency Assessment Unit (EAU) team worked in partnership;
    - Ambulatory emergency care at Grantham Hospital was now complete and was being made operational for the winter enabling a robust alternative to admission to ensure more patients received a diagnosis and urgent treatment without unnecessary hospital stays;
    - Non-elective admissions across all providers within South West Lincolnshire CCG, including ULHT, Nottingham University Hospitals NHS Trust, Sherwood Forest NHS Foundation Trust, fell by 7% in 2014/15. The CCG's non-elective admissions had fallen between 6% and 7% each year for the past three years and it was not expected that, in light of the aging population and high disease burden, that this would continue;
    - Emergency admission rates for the CCG were significantly lower than the national average although it was reported that admission rates for all Lincolnshire CCG's were lower than average.
- Planned Care
    - Focus was on the delivery of referrals to treatment standards for our patients as significant problems as a result of difficult access at ULHT had been experienced by patients. The CCG now reported that 92% of patients were scheduled to be treated on time and not subjected to any delays;
    - Focus was on improving cancer access following the loss of breast services at Grantham as a result of staff shortages. Despite the current standard of service and access not being satisfactory to the CCG, this had shown a steady improvement, largely as a result of the use of services outside Lincolnshire in both Nottingham and Peterborough;
    - New provider relationships were being developed and access to the independent sector and NHS Trusts outside of Lincolnshire were increasing in an attempt to secure steady access. The CCG was

well placed to access alternative providers due to a lack of capacity in Grantham, Lincoln and Boston;

- A pilot scheme had been launched for a new hearing loss service within Specsavers in Grantham to provide an alternative to current hospital services which were unable to meet demand. The service was expected to enable hospital services to focus on serious cases and give faster local access. An evaluation of the pilot would take place after twelve months and, if successful, would be fully procured.

- Mental Health and Learning Disabilities
  - As the lead CCG for the area, the CCG were leading the work on the deployment of £2m of recurrent investment from the Lincolnshire CCG's on the Parity of Esteem Programme. This was focussed on the delivery of a robust 24 hour 7 day liaison service and response to A&E, working with urgent services and to ensure that the 24 hour and 7 day CAMHS services worked coherently with adult mental health services;
  - Work was ongoing with Lincolnshire Partnership NHS Foundation Trust (LPFT) to manage the impacts for the closure of Long Leys Court Assessment and Treatment Unit and to work closely with them to ensure that high quality safe placement alternatives were located for the remaining service users in that unit;
  - Development of a community based model was being jointly considered with LPFT as an alternative, giving full compliance with requirements of national policy, and was expected to put Lincolnshire at the leading edge of modern learning disability services;
  - Work also continued with LPFT's leadership and clinical teams to deliver improvements set out in a single quality plan which had been reviewed by the Health Scrutiny Committee for Lincolnshire;
- Primary Care
  - Three successful bids had been submitted to the Primary Care Infrastructure Fund, following work with practices in the CCG area, to provide additional consulting and team working space. A programme of building work was currently being rolled out as a result;
  - Development of a quality infrastructure, including quality dashboards and a process based on practice visits by the CCG, was ongoing in conjunction with practices to ensure that they were making best use of resources and delivery high quality services;
  - CQC inspections had taken place with certain practices in the South West Lincolnshire CCG area and work was ongoing with those practices highlighted by the CQC as "requiring improvement" to ensure that issues were improved as soon as possible;
  - There had been investment in practices in care coordination at a local level to ensure that practices were able to provide coordinated and joined up care. This had included provision of non GP resources enabling practices to free time to manage the care of those with the most complex needs;
  - It was reported that South West Lincolnshire CCG had again delivered all of its financial obligations and was awarded the "Best CCG to Work In" by the Health Service Journal and Nursing Times in

2015. This accolade resulted in the CCG being one of the five best NHS organisations to work in nationally which was acknowledged as a significant achievement for the team;

- Close working with partners on the development of the Lincolnshire Health and Care Strategic Outline Case was to continue in the future;

- Commissioning Support
  - Partnership working with South Lincolnshire CCG had resulted in the CCG being the first in the country to successfully access the new national Lead Provider Framework for commissioning support. The framework offered CCG's a choice of accredited providers for 'back office functions' which ranged from payroll to IT support. It was reported that, following a rigorous selection process, Optum had been selected as the new provider of these services. A transition process would commence from the current provider, Greater East Midlands Commissioning Support Unit.

Members were given the opportunity to ask questions during which the following points were noted:-

- Lincolnshire West CCG were leading a piece of work to bring together all organisations who held responsibility for end of life care. This was expected to improve those services by developing an alliance format. Additionally, medical support within hospices were delivered by GPs rather than hospitals which further improved the communication;
- Challenges faced across Lincolnshire were varied and it was acknowledged that health problems as a result of good living could be as complex as those in an area of deprivation;
- The role of Neighbourhood Teams had not been included in the report as it had now become a fundamental part of the service. It was suggested and agreed that future reports should include the explicit role of Neighbourhood Teams to make it clear for both the Committee and the public;
- Emergency units were in place across all three hospitals within Lincolnshire although had differing names. Clarification was received that it was the Emergency Assessment Unit (EAU) in Grantham and the Medical Assessment Unit (MAU) in Lincoln;
- The Ambulatory Care Unit was also able to undertake some of the emergency assessments without admitting patients. The Ambulatory Care Unit was physically located near to A&E and also to the Emergency Assessment Unit (EAU) to ensure the flow of patients was clear and easy for all involved;
- Intelligence and service user voice would be included within the contract monitoring with Lincolnshire Partnership NHS Foundation Trust and all issues addressed within the Quality Improvement Plan. The CCG were confident that the temporary closure of services had not reduced the quality of service but improved them. The ambition was for Lincolnshire to be at the forefront of these types of services;
- Mental health patients picked up by the police were required to be taken to a place of safety under Section 136. The police were working with LPFT to fully develop a suitable and safe pathway;

- It was acknowledged that the report could read that partnership working had ceased due to the language used. It was stressed that partnership working was a continuous process and one which was key to service delivery success;
- It was confirmed that cost efficiencies would arise from Optum undertaking the Commissioning Support Unit functions for the CCG, and there was expected to be a quality gain, the process for awarding the contract was done as part of the National Framework Agreement from NHS England which include ten approved providers, all of which were within the quality and monetary framework requirements;
- Although CQC inspections of GP practices often highlighted poor practice, the Committee was asked to acknowledge that these inspections found examples of good practice, but the aim was to be outstanding;
- The district councillor representing South Kesteven District Council on the Committee asked it to be recorded that the South Kesteven District Council was impressed by the improvements made by the CCG in the area;
- Discussions were ongoing with the Communications Lead to promote to the public how positive these improvements had been. It was though that a paid editorial may be required to ensure that the public were aware of the changes;
- In relation to Neurology, work was ongoing to develop a more community-based, nurse-led, neurology base and proposals around those developments would be presented at a future date. It was anticipated that the Lincolnshire model would change considerably;
- A Cancer Improvement Plan was in development which would be shared with the Committee;
- It had been agreed to open an additional four beds, over and above the 16 already open, as and when needed to support winter pressures. Those beds were in one location which would help to manage staff and ensure efficiency. The beds were also based in the Order of St John Care Home in Grantham and not the hospital as it was more cost effective and efficient to have them set up in this way;
- Grantham's proximity to Nottingham led to more patient availability in Lincolnshire when patients chose to take treatment out-of-county. Although there was a financial pressure it was due to the market forces factor and, on balance, the CCG would prefer that people received the appropriate treatment without delays;

The Chairman thanked officers for their presentation and gave formal congratulations, on behalf of the Committee, on their recent achievements.

RESOLVED

That the report and comments made be noted.

It was agreed to take Item 8 – Work Programme prior to Item 7 – Urgent Care – Constitutional Standards Recovery and Winter Resilience.

60 WORK PROGRAMME

The Committee considered its work programme for the forthcoming meetings.

The Health Scrutiny Officer advised that there were no changes to the published work programme for consideration but asked the Committee to note that the meetings in December 2015 and January 2016 would be all day.

Councillor E L Ransome asked that her apologies for the December meeting be noted.

Further to comments at the last meeting of the Committee, Councillor T M Trollope-Bellew advised that the consultation in relation to Stamford car parking charges closed on 19 November 2015. Following discussion, it was agreed that a representation should be submitted on behalf of the Committee. It was agreed, therefore, that the submission from Stamford Town Council to Peterborough and Stamford NHS Foundation Trust be sought on the Trust's proposals to introduce parking charges at Stamford and Rutland Hospital, with a view to a response being made to the Trust on behalf of the Committee, setting out the Committees opposition to the introduction of parking charges.

RESOLVED

1. That the contents of the work programme be approved; and
2. That the submission from Stamford Town Council to Peterborough and Stamford NHS Foundation Trust be sought on the Trust's proposals to introduce parking charges at Stamford and Rutland Hospital, with a view to a response being made to the Trust on behalf of the Committee, setting out the Committee's opposition to the introduction of parking charges.

61 URGENT CARE - CONSTITUTIONAL STANDARDS RECOVERY AND WINTER RESILIENCE

The Chairman explained that the paper had been presented to the agenda planning meeting on 5 November 2015 where it was requested that the fines and penalties, noted on page 42 of the report, be defined further. In addition to that, the Chairman asked that the Committee note the following points prior to consideration of this item:-

- Tabled 2 on page 40 of the report provided statistics in relation to United Lincolnshire Hospitals NHS Trust. It was confirmed that the table was accurate and the Chairman expected that the figures for 'patients' and 'days' would be further clarified during the presentation;
- A full range of data was readily available on the NHS England website regarding delayed transfers of care, which recorded delays for each NHS Trust, by local authority, as well as by the cause of delay.

Consideration was given to a report from Gary James (Accountable Officer – Lincolnshire East CCG) and Sarah Furley (Urgent Care Programme Director –

Lincolnshire East CCG) which provided information on the Constitutional Standards recovery plan for urgent care and the winter plans.

Gary James (Accountable Officer – Lincolnshire East CCG) and Sarah Furley (Urgent Care Programme Director – Lincolnshire East CCG) were both in attendance and provided members with a detailed overview of the report.

As set out in the NHS Constitution, a minimum of 95% of patients attending at an A&E department in England should be seen, treated and either admitted or discharged within four hours. Recent evidence had shown that there was an increased risk of harm to patients should the four hour A&E standard fall below 90%.

National Context

During Quarter 3 2014/15 (winter 2014) the four hour A&E standard declined to a lower level than at the end of the same period the previous year which had been a sharp decline nationally. Since winter 2014-15, work had been undertaken to identify the factors driving the sudden decline in A&E performance in order to take action and prevent it from recurring this year.

Analysis from a report from Monitor in September 2015 (*A&E Delays: Why did patients wait longer last winter?*) indicated that half of the decline in A&E performance against the four hour target in winter 2014 could be explained by factors such as each hospitals inability to accommodate the increase in A&E attendance. Monitor findings had advocated that measures taken by hospitals and urgent care system to improve patient flow through hospital departments other than A&E may be highly effective in avoiding another sharp decline in performance.

Local Context

Although there had been an improvement nationally in the four hour A&E standard since winter 2014, Lincolnshire had not recovered to the same extent. Figures indicated that England were 94.32%, the East Midlands 94.70% and Lincolnshire at 89.9%.

It was reported that Pilgrim Hospital was running with a higher bed occupancy than other sites and it was acknowledged that medical beds had a higher bed occupancy than surgical beds.

In excess of 100 acute care beds had been closed in ULHT during 2013/14 and this had continued into the first six months of 2014/15 which had previously been reported to the Committee. The beds had been predominantly closed to ensure that safe staffing levels were achieved to enable a sustainable service.

Delayed Transfers of Care (DTOCs) were a significant issue for Lincolnshire as resulted in three main delays – completion of assessment, further non acute NHS care and care packages in own home. In July 2015, there were 1291 lost bed days in ULHT due to delayed transfers of care which equated to approximately 42 beds at 95% bed occupancy, a rate of 4.1%. NHS England wanted the rate to be reduced to

2.5% by the end of September 2015, releasing 17 beds, but it was suggested that this target would not be achieved.

Lincolnshire's Constitutional Standards Recovery Plan

In June 2015, the Trust Development Agency (TDA) and NHS England put the Lincolnshire health system in to a recovery programme and a Constitutional Standards Recovery Plan was developed. This was monitored through a new governance structure, the Lincolnshire Recovery Programme Board, chaired by NHS England and the TDA, which met monthly. The plan covered urgent care, cancer and also Referral to Treatment (RTT) standards.

The urgent care element of the Constitutional Standards Recovery Plan was split into the following critical projects:-

- Pre hospital
- Emergency departments
- Length of Stay (The Patient Flow Bundle – SAFER)
- Out of Hospital Care (Complex discharges and community capacity)

The plan was for the four hour A&E standard to be received by October 2015 and it was reported that this had not been achieved, with the performance at ULHT standing at 85.47%. Additional actions were being finalised in time to be presented at the next meeting of the Lincolnshire Recovery Programme Board on 20 November 2015.

The Emergency Care Improvement Programme (ECIP) was to be in Lincolnshire for the next three months. ECIP were a national clinically led programme that offered intensive practical help and support to urgent and emergency care systems that were failing to recover. They were assisting 28 urgent and emergency care systems across England under the most pressure.

Lincolnshire's Winter Plan

Lincolnshire health and care agencies had developed a winter plan which was to be presented to the System Resilience Group (SRG) on 10 November 2015 for ratification. The following key areas were included within the plan:-

- Anticipate that included Adverse Weather conditions, seasonally related illness;
- Assess that identified risk this winter;
- Prevent that included public communication campaigns, flu prevention, business continuity and maximising the role of Neighbourhood Teams with the Voluntary and Community Sector;
- Prepare which maximised capacity in services and how to maximise availability of staff through reducing sickness. The section also identified responses in case of industrial action and different ways of working, e.g. integrating therapies;

- Respond – Lincolnshire's Escalation and Surge Plan had been refreshed this autumn and detailed the arrangements and procedures which SRG partners in Lincolnshire would utilise in the event of surge and capacity issues, irrespective of cause, affecting one or more partners in order to sustain the provision of high quality responsive care. Within the plan, escalation trigger levels, actions and responsibilities had been clearly defined and shared amongst key stakeholders;
- Recover – the Escalation and Surge Plan also set out de-escalation levels which would support system recovery and a formal post-winter debrief session was planned for April 2016.

Fines and Penalties

Through a contractual mechanism, health commissioners had two types of fines which could be applied to non-achieving organisations. A financial penalty for not achieving an operational standard and a national quality requirement was calculated on a monthly basis and members of the SRG had previously agreed that all urgent care related contractual fines and penalties would be aggregated and made available for application by the SRG as appropriate in-year. A Contract Performance Notice (CPN) which withheld 2% of income until the standard had been achieved was the other penalty which could be applied.

In the event a CPN was issued, commissioners would meet with the receiving provider and a Recovery Action Plan (RAP) agreed. Once that was achieved, the 2% funds which had been withheld would be returned. It was acknowledged that the 2% would have already been committed by the provider as part of the totality of their annual budget which would be spent on that pre-commitment. Should the RAP not be delivered the commissioners had choices available to them on how to reinvest the 2%.

It was accepted that urgent care was a complex adaptive system which was dynamic in terms of its interactions and relationships between professionals, services and organisations. Increased demand was not driving the Lincolnshire urgent care system so it had to be those interactions. The interactions were non-linear meaning small changes in inputs, physical interactions or stimuli could cause large effects or very significant changes in outputs/performance.

Within Lincolnshire there was now a shared understanding that these interactions were detrimental to flow through the acute hospitals, exacerbated by a reduced number of beds and high occupancy, and high numbers of delayed transfers of care, exacerbated by reduced capacity in domiciliary care and reablement services. The Recovery Plan was focussed on improving those interactions and the Winter Plan was focussed on the wider system actions which would impact on system resilience.

Members were given the opportunity to ask questions during which the following points were noted:-

- As of the morning of 18 November 2015, 72 escalation beds had been opened;

- Figures in Table 2 were further explained. The 'Patients' figures were the snapshot figure, based on the number of patients in hospital at midnight on the last Thursday of each month and 'Bed Days' reflected the cumulative total of lost bed days;
- Concern was noted about 'self-funders' within care homes and the potential for the homes to cease taking local authority patients due to the profits involved. It was noted that supply and demand resulted in some care homes increasing their prices in winter 2014. There was not an even spread of these placements, for example, a lot of places were available in the Skegness area but none in Grantham and Sleaford;
- Community hospital beds were running at 13.8% Delayed Transfers of Care (DTOC) rate which was significantly higher than before but consideration was being given to the reason for this figure but it was not expected that there would be any difference between community hospitals and acute hospitals;
- The Committee expressed concern about the number of meetings, boards and groups, which were being held to rectify these issues and asked if they were hindering the process at all. In response, the Committee was advised that most meetings were held monthly and had been effective to-date;
- In relation to 30-day beds the average length of stay had been 33-38 days. The funding was through the NHS and patients were placed in a home of their choice. Care would be delivered by the care home but there were no wraparound care services but patients do have a care manager. The main issue with this service was that patients could be there for the maximum time without receiving the necessary therapies which were necessary to assist recovery. Some patients were also kept in those beds when they should have been sent home so work was on going on transitional care. This project would have to be carefully managed as there were 130 patients in 30-day beds at any one time;
- Lincolnshire County Council had re-procured the reablement service during 2015 with the new provider starting on 3 November 2015 and the statement in the report (page 41) that the procurement of domiciliary care and reablement had, and continued to have, significant negative impact on delayed transfers of care was further explained. Whilst Lincolnshire compared well with other local authorities, during the period of the reprocurement exercise there had been an increase in delays arising from Adult Social Care over the past three months, which might lead to increases in future reporting periods;
- It was agreed that a copy of the Emergency Care Improvement Programme (ECIP) would be forwarded to the Health Scrutiny Officer;
- It was agreed to send the Winter Plan Framework, electronically, to the Health Scrutiny Officer for wider circulation to members;
- Fines would be removed and funds withheld. £267k had been levied in fines in Quarter 1, across the whole system but the fines could then be returned to develop an improvement plan. Once there was evidence that the plan was being implemented the funds would be returned. To keep the partners working together and supporting each other it was stressed to the Committee that blame should not be apportioned, particularly as this could lead to further breakdowns in relationships, thereby providing a worse service for patients;

- New national guidance had been released for delayed discharges in both the acute and community hospitals;
- A suggestion was made to include a definition of particular charts, e.g. Statistical Control Chart, in future reports to assist members and the public;
- Although it may have appeared that the work on the winter plan had commenced in November, too late to address the winter pressures, the Committee were reassured that the process and planning had commenced in February 2015 and had been ongoing until this point;

RESOLVED

1. That the report and comments made on the Constitutional Standards recovery plan for urgent care be noted;
2. That the winter plans be noted;
3. That a future update be added to the Work Programme for March 2016.

The meeting closed at 1.37 pm

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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 Debbie Barnes, Executive Director of Children's Services, Lincolnshire County Council

| | |
|---|---|
| Report to | **Health Scrutiny Committee for Lincolnshire** |
| Date: | **16 December 2015** |
| Subject: | **Children and Adolescent Mental Health Services** |

**Summary:**

This report provides an overview of the commissioning of the Child and Adolescent Mental Health Service (CAMHS), including funding, performance monitoring, local need and delivery against national benchmarking. The report will also cover the proposed revised model of delivery following successful application for Local Transformation Planning NHS England funds. The current contract with Lincolnshire Partnership NHS Foundation Trust (LPFT) ends on 31 March 2016. The new CAMHS will commence on 1 April 2016 until 31 March 2018 with LPFT.

**Actions Required:**

To consider and comment on the content of the report.

## 1. Background

Children's and Adolescent Mental Health Service, or CAMHS as it is normally referred to, provides highly specialist mental health services delivered by clinical experts from Lincolnshire Partnership NHS Foundation Trust (LPFT) and is funded by Lincolnshire County Council and the four Clinical Commissioning Groups (CCGs).

CAMHS is structured on a four tier basis, with Tier 1 being access to universal support services, through to Tier 4 which support inpatient specialist, acute needs.

Tier 1 services are available to all children and young people, which are provided by Primary Care and universal service professionals e.g. General Practitioners, Health Visitors and School Nurses and other support groups or helplines. These services offer general advice and treatment for less severe problems; promote good mental health; aid the early identification of problems and refer to more targeted or specialist services. Schools have a vital role to play at this level.

Lincolnshire County Council Children's Services has the delegated lead commissioning responsibility from the CCGs for CAMHS at Tiers 2 & 3 and is agreed in the form of a Section 75 Agreement, which ends on the 31 March 2018 and are set out below:

Tier 2 CAMHS for children and young people experiencing moderately severe mental health problems. Services include:

- Primary Mental Health Team offering:
    - Free training on understanding mental health concerns for all professionals working with children and young people aged 0-18 in Lincolnshire.
    - Consultation to professionals and families about specific concerns relating to a child.
    - Assessment and treatment for children aged 0-18 with mild to moderate mental health concerns, normally 6-8 sessions. Maximum waiting time from referral to intervention should be 6 weeks.

- Looked After Children Team offering:
    - Training for foster carers, adoptive parents, leaving care workers and residential care staff.
    - Fast track access for assessment and treatment for Looked After Children and care leavers up to age 25. Maximum waiting time from referral to intervention should be 4 weeks.

- Therapeutic Services for Children; Sexually Harmful Behaviours and Victims of Sexual Abuse (including for those with non-diagnosable mental health concerns)

Tier 3 CAMHS for children and young people with more severe, complex and persistent mental health needs. Services include:

- Community Teams providing treatment via a range of therapies. Maximum waiting time from referral to intervention is 12 weeks.
- Forensic Psychology Service providing an assessment of risk and planning treatment for children and young people experiencing mental health issues who also pose a risk to the public or have offended.
- Self-Harm assessment & intervention service that assesses children and young people following admission onto paediatric wards following an incident of self-harm.
- Youth Offending Service providing assessment and treatment of mental health concerns.
- Learning Disability Service for children and young people with profound learning disabilities and mental health concerns.

NHS England Specialised Commissioning has responsibility for commissioning Tier 4 inpatient services.

CAMHS is available for all children and young people in Lincolnshire from birth to the age of 18 years (or 25 years of age for those leaving care services) with referral criteria that service users need to meet in order to access support. The CAMH service delivered by LPFT provides screening, assessment and both short and medium term intervention, stabilisation and resolution for a range of newly emerging or low severity mental health problems in children and young people and on-going treatment and management of more severe, long term and/or complex mental health conditions.

Core CAMHS is a multi-disciplinary community mental health service. The type of help that can be provided may include: family therapy; individual therapy; cognitive behavioural therapy; solution focused brief therapy; group work; psychiatric intervention; psychotherapeutic intervention; counselling, and where necessary, medication.

To ensure a coordinated and holistic approach to supporting children and young people's mental health the service works closely with and provides support to universal services. This includes GPs, Community Paediatricians, A&E, Health Visitors, Schools, School Nurses, Colleges, further education and third sector agencies.

This service forms part of the 'children are healthy and safe' commissioning strategy and the Children's Services strategic objectives of ensuring children and young people are:

- Healthy and Safe
- Ready for Adult Life

As part of the Universal Offer, Lincolnshire County Council also commissions Kooth, an online counselling service, available 24/7 for young people aged 11-25 with emotional or mental health concerns. The service was commissioned for less severe mental health problems that are more likely to be short-lived, but which may affect user's psychological and emotional well-being, causing concern to themselves, their families and friends.

The service helps young people manage their emotional wellbeing concerns at the earliest opportunity before these problems escalate resulting in the possible need for more specialist service intervention.

**Funding**

The current core CAMHS funding is split between Children's Services and the CCGs. Children's Services funding totals £724,589 and the CCGs' funding £4,843,532 (which forms the s75 agreement) giving a total value of £5,568,121 per annum which is then contracted to LPFT. Additional funds and grants, such as the £350,000 Better Care Fund, non – recurrent Parity of Esteem money and Local Transformation money have been bid for and awarded during the contract period to support specific developments.

**Governance Arrangements**

The governance arrangements in place are intended to provide a framework for the delivery of multiple working strands, including CAMHS, to monitor the achievement of the priorities of the Health and Well Being strategy. These arrangements reflect the changing commissioning landscape and will enable health and social care commissioners to have joint engagement and ownership of joint commissioning arrangements providing integrated strategies to improve the health and social care needs of our communities.

Lincolnshire County Council and the four CCGs have jointly funded a Chief Commissioning Officer post to oversee the joint commissioning arrangements between the two bodies. This post is a key link in the joint commissioning arrangement of CAMHS. The contract that monitors CAMHS sits within the Children's Commissioning team. The team oversee all aspects of commissioning arrangements for 0-25 years; including services for Mental Health and Emotional Wellbeing, Public Health Services, The 0-5 Healthy Child Programme, Health Visiting, Looked After Children, Special Education Needs and Disabilities, Learning Disabilities, and Short Breaks. Within the Commissioning Team, a dedicated CAMHS officer undertakes quarterly performance monitoring reviews as part of on-going contract management meetings. These meetings include representation from the Council, CCGs, LPFT and the Chief Commissioning Officer and the strategic oversight of CAMHS is presented through the Health and Wellbeing Board.

**Performance Monitoring**

The performance of the existing CAMHS contract is closely monitored, including;

- Total number of referrals and referrals by source of referrer
- Inappropriate referrals by source of referral
- Referrals discharged in previous 12 months and referrals by reason of referral
- Maximum, Minimum, Average Wait from referral to intervention (broken down by area)
- Number of patients (broken down by area)
- Percentage seen within wait times (broken down by area)
- Wait to offered appointment (broken down by area)
- Face to Face Contacts
- Did Not Attend Rate
- Assessment, Consultation, Liaison and Social-Clinical recorded activity (broken down by area)
- Discharges - End of Care (broken down by area) and Discharges – Ineligible (broken down by area)
- Interventions – Maximum, Minimum, Average Wait (broken down by area) and number of Patients

- Questionnaires for Parents/Carers and for Young People
- Staff Compliance, Training and Sickness and Risk Register
- Overview of the Service Users, including recording Children in Public Care (LAC) those with a Child Protection Plan, those with Common Assessment Framework/ Team Around the Child, and those with Disabilities and Learning Disabilities

On an annual basis we also review stakeholder engagement, financial information, business continuity planning and Care Quality Commission (CQC) Reporting.

In comparison to the historic national target wait of 18 weeks, the waiting times for Lincolnshire CAMHS are significantly reduced. The targets in place strive to achieve a better outcome for Lincolnshire young people.

| Referral To Intervention Wait | 15/16 Target | 15/16 Actual | 16/17 Target |
|---|---|---|---|
| Tier 2 Services wait | 6 week wait | 6.9 week wait | 6 week wait |
| Tier 3 Services wait | 12 week wait | 3 week wait | 6 week wait |
| Looked After Children wait | 4 week wait | 4 week wait | 4 week wait |
| Youth Offending Services wait | 3 week wait | 6 week wait | 3 week wait |

As shown in the table above, there are some changes to the 2016/2017 waiting times for CAMHS. These are ambitious but also realistic to reflect the level of funding being invested versus the greater demand and requirements which must be delivered in order to meet Future In Mind requirements, on which the funding for the transformation bid was targeted. These times will be based on two response rate targets;

- Degree of urgency
- Specific service is required

The young person will always be subject to the quicker of the two response targets, based on their individual need. Degree of urgency will fall into one of the following categories;

- Emergency
  - CAMHS telephone response within 4 hours
  - Face to Face emergency response within 13 hours (24/7)

- Urgent
  - Face to Face within 72 hours

- Routine
  - Face to Face within 6 weeks

In recognition that certain vulnerable groups require quicker access to the service than the six weeks offered for a routine appointment, the above is supported by the following access times;

- Self-Harm Assessment and Intervention Service: 24 hours
- Specialist CAMHS Support to Looked After Children: 4 weeks
- Young People in contact with the Youth Justice System: 3 weeks
- Community Eating Disorder:
    - Face to Face emergency response: 13 hours
    - Face to Face urgent response: 72 hours
    - Treatment start: within 1 week for urgent cases and 4 weeks for routine

There are a number of presentations that will trigger a referral to CAMHS. For 2014/2015 the highest reason for referrals to Tier 2 CAMHS was:

- Anxiety (492 referrals)
- Low Mood (372 referrals)

There is a very similar picture in Tier 3 CAMHS with the highest number of referrals being:

- Anxiety (776)
- Low Mood (623)

The total number of referrals received into the service during the last financial year (1st April 2014 to 31st March 2015) was 4,569 (the previous year this figure was 4,577). The number of referrals received during the first three months of this financial year was 1,093 and during April to June 2015, 1,586 face to face contacts were made. The number of referrals declined during 2014-2015 reduced by 2.5% (740 compared to 858 in 2013/14). The overall percentage of referrals made to the service which were declined was 16%. A young person is declined if they do not meet the criteria to access a specialist mental health service. As an example of this, in order to access Anxiety at Tier 2 CAMHS, a brief description of the symptoms may include;

- Persistent anxiety present for more than 4 weeks
- Inappropriate for the child's stage of development
- Results in substantial distress
- Causes avoidance that interferes significantly with the child's everyday life

In the new CAMHS model through the Single Point of Referral mechanism, referrals can be made by any professional or agency working with the child or young person. In addition, the SPR will support self-referral by children, young people and their parents/carers.

Inappropriate referrals can be identified earlier and re-directed to other named services, called Universal Services that will be able to deal with lower level support and which are able to be accessed by all without a referral, such as on line counselling, Lincolnshire Centre for Grief and Loss, School Nursing, Health Visiting or other support groups or helplines as appropriate

As a snapshot the wait from referral to intervention at Tier 3 has been consistently within the target time period throughout the last financial year. 99% of patients have been seen at Tier 3 within the 12 week target, with the average wait being 3 weeks or less. The average number of open cases held by the whole service each month is 1,912. 66% of the cases are held within Tier 3, 22.5% are within Primary Mental Health with the remaining 11.5% of cases held within the specific teams for vulnerable groups (Looked After Children, Youth Offending Service, Learning Disability, Community Forensic, and Diabetes). The majority

of therapeutic services for post abuse and harmful behaviours are held within Tier 3 services.

In 2014/2015 Patient Experience was measured through a number of mechanisms including patient and parent questionnaires. The number of returns for young people for the period 1 January to 31 March 2015 was 172 with an overall satisfaction rate of 89.12% (the previous quarter satisfaction rate was 90.04%) The number of returns from parents and carers in the same period is 119, with an overall satisfaction rate of 89.87% (the previous quarter satisfaction rate was 92%)

As part of performance information, LPFT details feedback from stakeholder questionnaires which measure the service users individual experience and their satisfaction rate. This feedback provides a full account of all comments given by young people, parents and carers throughout the year. As a snapshot in Q4, young people provided 251 comments of which 227 of these were positive. Parents and carers provided 190 comments, 173 of these were positive. Negative comments are addressed through the contract management process and tracked for continuous service delivery improvement. The comments are also provided for locality team to discuss in team meetings and responses for generic issues are addressed in the "You said – we did" boards placed within reception areas.

As part of their ongoing commitment to Young People, LPFT also support Lost Luggage, the name chosen by a group of young Trust members, who get actively involved in the work LPFT do. Lost Luggage meet outside of school hours and explore creative and fun ways of enabling young people's voices to be heard. They have already championed an anti-stigma message by producing a DVD and radio jingle and have been involved in drama projects and performances at the Drill Hall in Lincoln.

**National Policy Requirements**

On 17 March 2015, NHS England released "Future In Mind" which outlined radical changes for improvements to mental health and emotional wellbeing services for young people nationally. Future In Mind recommended a number of changes under five broad themes;

- Promoting resilience, prevention and early intervention
- Improving access to effective support – a system without tiers
- Care for the most vulnerable
- Accountability and transparency
- Developing the workforce

(Please see Section 5 - Background Papers for the link to the Future In Mind report)

In light of Future In Mind, NHS England announced an opportunity to bid for funding for CAMH services which met the proposals within Future In Mind, in addition to some further work streams on Perinatal services, Community Eating Disorder Services and clinical training. Lincolnshire put forward a Local Transformation Plan identifying the work that would be undertaken with other agencies, including Schools, Police, the CAMHS Provider, and Public Health etc. to use a multi-agency approach to improve outcomes. This bid was written on behalf of Lincolnshire County Council, the four Clinical Commissioning Groups and progressed through the Women & Children's Board, Health and Wellbeing Board and East Midlands NHS Specialised Commissioning.

Lincolnshire was successful in securing £1.4m per year, due to continue over the next five years, pending tracking, totalling a minimum additional £7m income.

**Service Developments**

Lincolnshire intends to commission an integrated new model of service delivery for Lincolnshire CAMHS based on a robust specification that combines;

- A tier-less system that includes a Community Based Eating Disorder Service, Tier 3+ provision that operates 24/7 for those in crisis and particular support for vulnerable groups to reduce health inequalities
- A service built on NICE clinical pathways explicit in the number of interventions provided, frequency of contact and anticipated length of time in treatment incorporating a CAPA approach
- A model that focuses on empowering the voice of young people, delivering evidence based practice and improved outcomes utilising mechanisms such as Child Outcome Research Consortium (CORC), Outcome Orientated CAMHS (OO-CAMHS), Patient Related Outcomes Monitoring (PROM), Strength and Difficulty Questionnaires (SDQ's) and Child Experience of Service Questionnaire (CHI-ESQ)
- Increased support for transitions and behavioural support through the development of multi-agency pathways
- Developing staff through Children and Young People's Improving Access to Psychological Therapies Programme Training (CYP IAPT). This is a service transformation programme delivered by NHS England that aims to improve existing CAMHS working in the community. This will include identifying clinical and non-clinical staff for IAPT training
- Establishing a Single Point of Referral (SPR) so all referrals are received into a daily triage function, prioritising referrals within stretching and ambitious wait times, including a 4 hour response time for emergency referrals.

To date Lincolnshire has;

- Undertaken stakeholder consultation, with over 55 local groups
- Implemented a further Section 75 Agreement between the Local Authority and CCG's
- Revised the CAMH service specification
- Participated in East Midlands review of readiness to implement Future In Mind, resulting in an internal action plan that we have shared with key stakeholders, such as Chief Commissioner for Learning, LPFT and CCGs
- Undertaken a gap analysis between existing and proposed service and identified areas of priority
- Commissioned Perinatal Specialist Teams to provide a specialised service for the prevention and treatment of Serious Mental Illness in the ante-natal and post-natal period supporting Mother and Baby
- Started costing various options for Children and Young People's Improving Access to Psychological Therapies Programme Training

- Clarified the specific support we will give to vulnerable groups, including reduced wait times
- Identified how we will deliver a community based Eating Disorder / Tier 3+ out of hours crisis service
- Developed self-harm, transition and behaviour pathways
- Commissioned a Behavioural Outreach Support Service for pupils displaying behaviour that challenges, a Physical Disabilities Support Service and Autism and Learning Disabilities Service to support the needs of pupils across the county
- Commenced a review of the services which support our Readiness for School and Child's Health priorities including Health Visiting, School Nursing and services delivered from Children's Centres as part of holistic package of support for Children & Young People
- Applied for Schools Pilot funding which despite being unsuccessful, has shown engagement of Schools to support mental health services and we remain committed to the ethos within the bid
- Providing development and consultation days in the model to support front line practitioners through training days on mental health issues such as reducing stigma
- Started to develop a web based universal access offer making clear to service users and their families what services they can expect, how to access CAMHS with a planned "go-live" date of January 2016
- Attained Local Transformation Planning money

Other highlights of the new model include;

- Extended opening hours
- Crisis support
- A 9-5 Professional Advice Line
- Training, consultation, support to Universal Services and Professionals
- More robust support for transitions to Adult Mental Health Services with clearer, optimum treatment journey
- Accessible locations
- Timely services so that demand and capacity are proactively managed to minimise waiting
- Flexible service delivered in line with views of young people

## 2. Conclusion

This report provides the Health Scrutiny Committee with an overview of the CAMHS and the arrangements that have been made to improve the model going forward in order to assure itself, partners and the Council that progress is being made to support the emotional wellbeing and mental health of Lincolnshire's children and young people.

## 3. Consultation

Not Applicable

## 4. Background Papers

The following background papers were used in the preparation of this report:

| Background Paper | Hyperlink Address |
|---|---|
| Future In Mind | Hyperlink (first document in list) |
| Local Transformation Planning Guidance | Hyperlink (first document in list) |
| Access and Waiting Time Standard for Children and Young People with an Eating Disorder | Hyperlink (first document in list) |

This report was written by Catherine Southcott, who can be contacted on 01522 552728 or catherine.southcott@lincolnshire.gov.uk

| Lincolnshire COUNTY COUNCIL Working for a better future | | THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE | |
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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 Lincolnshire East Clinical Commissioning Group

| | |
|---|---|
| Report to | **Health Scrutiny Committee for Lincolnshire** |
| Date: | **16 December 2015** |
| Subject: | **Lincolnshire East Clinical Commissioning Group – General Update** |

**Summary:**

This report provides the committee with an update in relation to the activities for Lincolnshire East Clinical Commissioning Group (CCG). The report will include the commissioning activities of the CCG, as well as providing information on the wider developments that the CCG has been involved in.

**Actions Required:**

The Health Scrutiny Committee is asked to consider the contents of this report.

## 1. Background:

The aim of this report is to update the Health Scrutiny Committee information on the developments within Lincolnshire East Clinical Commissioning Group (CCG). Lincolnshire East CCG has 30 member practices which are structured across three localities covering over 1,060 square miles. The locality structure is fundamental to how the CCG operates and member practices are embedded within the localities and communities that they serve.

The CCG covers a population of 243,650, and since the 2001 census has experienced population growth greater than the national average. There is substantial inward migration into the CCG of older people from industrial centres

from the Midlands. This migration has influenced the age structure of the population and the prevalence of long term health conditions. A total 24.7% of the population are aged 65 years or older, compared to 16.9% for England. Some 23.7% of the population of Lincolnshire East have a limiting long term illness or disability, which is significantly higher than the England average of 17.6%.

**Key Work Programmes**

Over the past year the CCG has focused on a number of areas, which have included the following

Mental Health: Dementia

County wide dementia services are in the process of being reviewed and redesigned to support best practice in service delivery for the needs of patients and their carers. Specific areas of improvement for patients with dementia have been identified and actions have been outlined in the Lincolnshire Joint Strategy for Dementia. To support the delivery of this strategy Lincolnshire East CCG have been looking to standardise primary care led screening for dementia using the CANTAB mobile screening too. The CANTAB mobile screening tool is a brand name, which is described as a sensitive screening tool for healthcare professionals to use to identify the earliest signs of clinical relevant memory impairment indicative of Alzheimer's disease in under ten minutes. It was anticipated that this will lead to increased screening for patients, leading to improved diagnosis and identification of patients with dementia.

Care for the Over 75s

There has been a national drive to focus on the needs of the frail elderly over the age of 75. The CCG chose to approach this by asking its GP practices to innovate and find new solutions and services for the over 75s. The focus was the support and maintenance of people at home and the reduction of admissions. Projects have delivered 3000 additional patient contacts, 800 interventions such as medication changes and the development of over 500 proactive care plans. We are evaluating the projects to determine which have been most effective.

Neighbourhood Teams

Neighbourhood Teams are a development from the Lincolnshire Health and Care programme that aims to introduce a more proactive approach to out of hospital care. The vision is that community staff of all disciplines work in integrated teams focussed on a neighbourhood. Through case-finding, proactive planning and intervention care is moved closer to home and the teams intervene before people become acutely ill or descend into crisis.

The CCG has two neighbourhood teams in place, one focussed on the Skegness area and a second on East Lindsey North (Louth and coast area). We are now deploying the model into the Boston area and finally to East Lindsey Middle and expect all teams to be in place by February 2016. Teams are supported by Care

Navigators who focus initially on the introduction of the Team and then move into a service liaison role.

Integrated Urgent Care

In order to manage patients appropriately and reduce demand on Accident and Emergency care services the CCG has led a review of urgent care services at Pilgrim hospital. This has led to a number of urgent care based initiatives, including the development of a clinical navigator role and GP presence in the Accident and Emergency department. The CCG has also been working to develop a rapid response function at Pilgrim hospital, comprising community staff, adult social care, and mental health staff working together in an integrated manner to identify patients who can be rapidly stepped back into the community, who would otherwise have been admitted to an acute medical unit.

Care Home Projects

The CCG has been working to ensure that we keep patients within their own homes and out of hospital wherever possible. In the Boston Locality the focus has been on primary care practices working with care homes to adopt early interventions, as well as preventative and proactive care to keep people out of hospital, ensuring that patients in these settings receive the same level of care as patients in their own homes. In Skegness the locality has been working on the development of a new care home support team. The service provided by Lincolnshire Community Health Services, has been designed to support patients in care homes by regular patient ward rounds, and the delivery of a comprehensive training programme for care home staff. Whilst this initiative is in the early phases, so far, there has been a 14% reduction in admissions to hospital from the care homes where this service is operating.

Community Hospitals

The CCG has a greater investment in community hospitals than other CCGs in Lincolnshire. We have been working on the future model for our community hospitals and the ways in which they play into the Lincolnshire Health and Care future. The emphasis on care closer to home ought to put our community hospitals into a key position. We have held market engagement events to explore the future service model for Louth Hospital. We are pleased to be able to report that after a long wait NHS Property Services have commenced a significant programme of backlog maintenance and improvement at Louth Hospital. Most of these will be ‘behind the scenes’ improvements but they are essential to keeping Louth Hospital up to standard.

Optimising Prescribing in Primary Care

Across England, prescribing accounts for approximately 10% of the NHS budget. As such it offers the opportunity to make savings in a safe and appropriate manner, by ensuring that patients are taking medication that is appropriate for them. The CCG has introduced Optimise Rx, a practice based software tool, that advises the clinicians on safe prescribing, as well as effectiveness of prescribing.

C2 Evaluation and Future

As well as supporting our patients through medical interventions, the CCG has also been working with the community and in partnership with East Lindsey District Council through C2. C2 is a community based enablement project which works in partnership with communities to establish long term sustainable solutions for locally owned projects focusing on improving health and care. C2 focuses on two communities - Wainfleet and Winthorpe. Initiatives have included a cancer self-help group and luncheon group. The Chairman of the Winthorpe Partnership won carer of the year this year.

Caravan Dwellers

The East coast of the county receives large numbers of visitors to the coastal part of the CCG, including a large community of temporary residents living in static caravans in Skegness and surrounding areas. One of the key challenges is to persuade these temporary residents to register with the local primary care practices, so that the clinician can work with them in a more positive and proactive manner.

**Lead Commissioning Responsibilities**

United Lincolnshire Hospitals NHS Trust

The Lincolnshire commissioning responsibilities are divided between the four CCGs, with each taking the lead role for one or more providers. Until recently Lincolnshire East CCG was the lead commissioner for Lincolnshire Community Health Services NHS Trust, East Midlands Ambulance Service, NSL non-emergency transport services and NHS 111. This changed earlier this year when the CCGs reviewed the lead commissioning areas and as a result Lincolnshire East CCG is now the lead commissioner for United Lincolnshire Hospitals NHS Trust (ULHT). Lincolnshire West CCG (LWCCG) was formerly the lead commissioner for ULHT and the CCGs have in effect exchanged commissioning portfolios. LWCCG have retained some commissioning responsibility for planned care. The CCGs have worked through these changes between September and November.

Our focus has been on building new a commissioning relationship with ULHT in the context of the future of Lincolnshire health services and the next stage of Lincolnshire Health and Care. In particular we would like to build stronger clinical links and leadership with ULHT and have held a clinician to clinician meeting

between CCG clinical leaders (from all four CCGs) and ULHT lead clinicians such as Clinical Directors.

Urgent Care and System Resilience

The CCG has the lead responsibility for urgent care and system resilience including emergency planning, resilience and response (EPRR) which deals with readiness for major incidents. We host the urgent care team on behalf of all four CCGs. The CCG Accountable Officer is the Chairman of the System Resilience Group (SRG) which is the key forum for the leadership of urgent care and EPRR. The SRG is a whole-system group with membership from all commissioners and providers, adult social care, and the independent care sector. The SRG plans both tactical and strategic developments in urgent care. The Urgent Care Team also leads the urgent care programme for the Lincolnshire Health and Care. A major development this year has been the introduction of the Clinical Assessment Service (CAS). The CAS acts as a management focus for patients requiring an urgent response and will incorporate the clinical assessment aspects of NHS 111, EMAS, Out of Hours and provider contact centres.

LECCG was pleased to be a partner in the development of the Joint Ambulance Conveyance Project (JACP) which provides ambulances to retained fire services in order to provide a faster ambulance response to local communities. The project is now at the evaluation stage. We were delighted when the project won the prestigious Health Service Journal Award for acute care in the face of stiff competition, and went on to win in the 'Innovation of the Year' category at the Excellence in Fire and Emergency Awards 2015.

Information Management and Technology

The CCG leads on IM&T for the four Lincolnshire CCGs, including the IM&T enabling workstream of the LHAC programme. Key work programmes include the management of the transition out of the former national Connection for Health programme. In the forthcoming planning round all CCGs will be producing 'Digital Roadmaps' which set out the health community's direction of travel for achieving the Government's digital strategy. This aims to provide greater access for patients to their clinical records, and to move the NHS toward being 'paperless at the point of care' by 2020. The major programme of work this year has been to support the LHAC with IM&T enablers. An integrated telephony system has been commissioned, and a capacity management system which will allow health and social care to build a dashboard of the system capacity across all sectors and locations.

We have also produced a business case for an integrated care portal. This is a technology that will enable all health records for a patient which are held in various locations and systems to be drawn together into a single integrated view. For the first time ever this would allow health professionals to see the whole picture of care for a patient, improving patient management and reducing duplication. A robust patient consent model will be required to allow this to work.

**Primary Care and Primary Care Commissioning**

When the CCG was authorised, NHS England had the responsibility for commissioning all primary care – GP services, pharmacies, optician services and dental services. In 2014-15 NHS England offered CCGs the opportunity to take on the commissioning responsibility for GP services. The rationale was that the local focus of the CCG would enable a more tailored approach to local commissioning and stronger links between the strategic direction of other services commissioned by CCGs with GP services. The statutory responsibility for GP services remains with NHS England, but through these co-commissioning arrangements NHS England delegates this responsibility CCGs.

Lincolnshire East CCG achieved full delegated responsibility for GP services and now has the lead commissioning responsibility for them. In order to do this we have had to set up appropriate governance arrangements to manage any conflict of interest. The CCG has a Primary Care Commissioning Committee (PCCC) which is a formal committee of the governing body. No LECCG GPs sit on the PCCC which is composed of Governing Body lay members and CCG officers. Meetings of the PCCC are held in public.

Priorities for primary care commissioning will be to develop a primary care strategy laying out the direction of travel and models for GP services in the future, and the way in which these dovetail into the NHS Five Year Forward View.
The CCG has introduced enhanced processes for managing GP services including a quality management system and a dashboard of key quality indicators.

**Delivery of NHS Constitution Standards for Patients of Lincolnshire East CCG**

The delivery of the NHS Constitution standards for accident and emergency, ambulance services, and cancer has deteriorated during 2015-16. The planned care standard has been redefined in terms of incomplete patient pathways and is being met overall (94% against a target of 92%). At specialty level there are still challenges in some areas including urology, plastic surgery and neurology. The CCG is taking steps to improve these areas of performance including working with the Emergency Care Improvement Programme (ECIP) to improve A&E performance, and working on improvement programmes and referral to other providers to improve planned care and cancer performance. Planned care and cancer have shown improvement in recent months but A&E performance is still proving challenging. At CCG level performance is 94.95% against a target of 95%, but at ULHT specifically performance for LECCG patients is 89.3%.

All of these standards and performance are published monthly and publicly in the CCG Governing Body papers.

**Financial Management**

The CCG has a total commissioning allocation in 2015-16 of £368 Million. Each CCG is required to:

- Achieve a 1% overall surplus

- Provide for a contingency of 0.5%
- Allocate 1% of resources to be spent non-recurrently
- Stay within a running cost of £21.20 per head of population

The CCG is forecasting a balanced position against its plan and is on target to deliver all of its key metrics with the exception of the underlying surplus. 2016-17 is expected to be extremely challenging financially and the CCG leadership are considering options for reducing expenditure in less effective areas in order to maximise spend on effective services and create headroom for service change and improvement.

## 2. Conclusion

The Health Scrutiny Committee is request to consider and comment on the content of the report.

## 3. Consultation

This is not a direct consultation item.

## 4. 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 Gary James, Accountable Officer, Lincolnshire East Clinical Commissioning Group, who can be contacted on 01522 515347 or Gary. James@lincolnshireeastccg.nhs.uk

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| Lincolnshire COUNTY COUNCIL Working for a better future | | THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE | |
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Open Report on behalf of Richard Wills, the Director Responsible for Democratic Services

| | |
|---|---|
| Report to | **Health Scrutiny Committee for Lincolnshire** |
| Date: | **16 December 2015** |
| Subject: | **Response of the Health Scrutiny Committee to the Joint Strategic Needs Assessment Review** |

**Summary:**

On 16 September 2015 the Health Scrutiny Committee for Lincolnshire considered a paper on the review of the Joint Strategic Needs Assessment, which focused on the stakeholder engagement phase of the review, which began in September and will conclude on 18 December 2015. The Committee agreed to establish a working group to draft a response as part of the stakeholder engagement phase. The proposed draft response is attached at Appendix A to this report.

**Actions Required:**

To consider approving the draft response (attached at Appendix A) of the Health Scrutiny Committee for submission in response to the consultation on the Joint Strategic Needs Assessment.

## 1. Background

As reported to the Health Scrutiny Committee for Lincolnshire on 16 September 2015, the Joint Strategic Needs Assessment (JSNA) is a systematic description of the health and wellbeing needs of the population, which leads to the identification of priorities to improve the health and wellbeing of the community. The statutory responsibility for the development of the JSNA rests with the Lincolnshire Health and Wellbeing Board (HWB).

Review of the JSNA

The procedures through which the JSNA is maintained are currently under review. The full review and implementation is taking place from 2015 to 2017, to feed into the production of the Joint Health and Wellbeing Strategy (JHWS) for 2018-2023, the publishing of which will coincide with the existing JHWS coming to an end on 31 March 2018.

The current phase of the review is the Stakeholder Engagement Phase, taking place until the end of December 2015. The purpose of this phase is to ensure that stakeholders in the JSNA have a shared understanding of the scope and purpose of the review, the opportunity to feed in their views on future content, format and processes and that they are able to become better engaged with the evidence base.

To draft a response on behalf of the Committee on the stakeholder engagement phase, a working group was established, which met on 11 November 2015. Councillors Mrs Christine Talbot, Jackie Kirk and Sue Wray attended the meeting, which was facilitated by three officers from the public health team.

Arising from the meeting, a draft response has been prepared and is attached at Appendix A to the report for the Committee's consideration, and subject to any amendments, approval. The closing date for submissions is 18 December 2015.

Planned Activity and Actions to Date

The following table, which shows the summary project plan for JSNA review and implementation and publication of the JHWS 2018-2023, was reported to the Committee in September and shows that there will be further opportunities for the Committee's involvement, during further consultation phases. .

| Date | Activity |
|---|---|
| Jan-May 15 | Agree the scope of the review |
| June-Dec 15 | Carry out review (to include review of work associated with objectives set out in the project brief and the wider engagement with stakeholders) |
| Jan-Mar 16 | Consult on findings and agree recommendations for refresh of the JSNA. |
| Apr-Mar 17 | Implement recommendations, refreshing and updating the JSNA, including its presentation and processes |
| Apr-Jun 17 | Consult and agree priorities resulting from refreshed JSNA |
| Jul-Dec 17 | Carry out consultation on refreshed Joint Health and Wellbeing Strategy (JHWS) |
| Jan-Apr 18 | Finalise and publish JHWS for 2018–2023 to coincide with existing JHWS coming to an end on 31/3/18 |

## 2. Conclusion

The Health Scrutiny Committee is invited to consider approving the draft response (attached at Appendix A) of the Health Scrutiny Committee for submission in response to the consultation on the Joint Strategic Needs Assessment.

## 3. Consultation

The Health Scrutiny Committee has been consulted as part of the stakeholder engagement phase of the review of the JSNA, and its draft response to the consultation is attached at Appendix A to this report.

## 4. Appendices

| These are listed below and attached at the back of the report | |
|---|---|
| Appendix A | Draft Response of the Health Scrutiny Committee to the Lincolnshire Joint Strategic Needs Assessment Review |

## 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

| Lincolnshire COUNTY COUNCIL *Working for a better future* | **HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE** |
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**Statement from Health Scrutiny Committee for Lincolnshire on the Stakeholder Engagement Phase of the Joint Strategic Needs Assessment Review**

Introduction

The first phase of the review of the Joint Strategic Needs Assessment (JSNA) is the Stakeholder Engagement phase. The Health Scrutiny Committee for Lincolnshire understands that there will be further opportunities for the Committee to contribute as part of the review of the Joint Strategic Needs Assessment, for example during the public consultation phase in early 2016. The Committee also acknowledges that the JSNA is a key document in the development of the Joint Health and Wellbeing Strategy.

Importance and Impact of the JSNA

The Health Scrutiny Committee would like to stress the importance of the JSNA, in the development of the Joint Health and Wellbeing Strategy. It is important that the whole process demonstrates its impact, in effect how the process has made and will make a difference to the population of Lincolnshire. In this regard, outcome measures are particularly important, which the Committee understand will be included in the Joint Health and Wellbeing Strategy.

Clarity of the JSNA

The Health Scrutiny Committee acknowledges that the content of the JSNA is written for a particular purpose and by necessity has to include some clinical language, which is not readily accessible to members of the public. However, the Committee believes that as far as possible the content of the JSNA should be accessible to the public, and should avoid any form of jargon wherever possible.

The Health Scrutiny Committee recognises that the JSNA is largely data driven, but this does not always reflect the human element. The Committee suggests that consideration is given to the inclusion of "case studies", to amplify and support the data which is included.

Involvement of Stakeholders

The Health Scrutiny Committee would like to explore the extent to which the Clinical Commissioning Groups (CCGs) in Lincolnshire engage with the development of the JSNA. Their commitment is essential in terms of providing data, and using the JSNA to inform their commissioning processes. The Committee suggests that to further emphasise this importance, the CCG Council, which comprises the senior

management representatives of each of the four CCGs, should be specifically engaged in the process for the review of the JSNA.

The Health Scrutiny Committee believes that the views of the voluntary sector must be taken into account, as these organisations have a see services from a different viewpoint. They may also have data that could inform the JSNA.

Previously the Committee raised the issue of the representation of district councils on the Steering Group. The Committee understands that this particular issue has been addressed, and looks forward to continued engagement with district councils throughout the consultation phase of the review of the JSNA.

Where stakeholders are engaged in the process, it is important that they receive feedback on their contributions, to encourage them to make further contributions and to feel valued as part of the process overall.

Data and Specific Topics

The Committee makes a specific request that the JSNA review process takes account of the following specific topics:

- neurological conditions, where services in Lincolnshire fall short of what is provided to patients in other parts of the country – more data is required to ensure that commissioning decisions fully take account of the needs of people with such conditions;
- cancer, where there should be an emphasis on prevention and the appropriate funding for such services as the early prevention and detection of cancer;
- childhood obesity, where more data is required on how existing services can impact on the number of overweight or obese children, as this is a topic, where the Health Scrutiny Committee would like to see further action; and
- rural isolation, as so many parts of Lincolnshire are remote from a variety of services.

The Committee also supports the intention for the inclusion in the JSNA of more datasets, over and above the existing 35 public health outcomes and that each data set needs to be less labour intensive in terms of the information format.

Resources

The Health Scrutiny Committee understands that public health funding is ring-fenced for public health activities. Public health services often support prevention, and as a result save money in the future, by reducing demand on 'expensive' acute hospital care. The Health Scrutiny Committee believes that the ring-fence should remain.

In terms of the resources available to the NHS in Lincolnshire, the Committee recognises the particular demographic challenges as well as the cost of new treatments and medicines. However, the Committee believes that all those involved will have to work smarter, using information in documents such as the JSNA to make links, bridge gaps, and use the resources available more effectively.

The impact of any devolution to Lincolnshire is as yet unclear, but it may be something the JSNA and Joint Health and Wellbeing Strategy may need to take account of at a future date.

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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: | **16 December 2015** |
| Subject: | **Draft Clinical Strategy Priorities of Lincolnshire Partnership NHS Foundation Trust: Joint Statement of the Health Scrutiny Committee for Lincolnshire and Healthwatch Lincolnshire** |

**Summary:**

On 21 October 2015 the Health Scrutiny Committee for Lincolnshire considered a paper on the draft priorities, on which Lincolnshire Partnership NHS Foundation Trust was intending to base its 2016-2017 clinical strategy. The Committee established a working group to review the priorities in detail. Healthwatch Lincolnshire participated in the working group, which met on 12 November 2015. The final statement was submitted to the Trust on 26 November 2015 of the Committee and Healthwatch Lincolnshire.

**Actions Required:**

(1) To note that the joint statement (attached at Appendix A) of the Health Scrutiny Committee for Lincolnshire and Healthwatch Lincolnshire to the Draft Priorities of Lincolnshire Partnership NHS Foundation Trust were submitted to the Trust on 26 November 2015.

(2) To note that there will be further opportunities for the Committee to comment on the content of the clinical strategy of Lincolnshire Partnership NHS Foundation Trust.

## 1. Background

As reported to the Health Scrutiny Committee for Lincolnshire on 21 October 2015, Lincolnshire Partnership NHS Foundation Trust (LPFT) is developing its clinical strategy for 2016/17. The clinical strategy sets out the organisation's objectives and actions through a series of agreed priorities.

The report to the Committee on 21 October listed the following seven draft priorities from LPFT:

- Maintain compliance with the Care Quality Commissions (CQC) Fundamental Standards of Care.
- Ensure long-term sustainability for the Trust.
- Improve access to our services.
- Provide better support for people who are discharged or waiting for services.
- Supporting our people to be the best they can be.
- Increase service user and carer involvement in all aspects of service design and delivery.
- Support the Lincolnshire Health and Care (LHAC) programme and promote service integration.

The Committee agreed to establish a working group to consider the priorities in detail. Healthwatch Lincolnshire agreed to participate in the working group to enable a joint statement to be made. The working group met on 12 November, and involved Councillors Mrs Christine Talbot and Steve Palmer; Sarah Fletcher, the Chief Executive of Healthwatch Lincolnshire, together with the Deputy Director of Strategy and Business Planning from LPFT. As a result of the working group, a joint submission was made to LPFT, which is attached at Appendix A of this report.

## 2. Conclusion

The Health Scrutiny Committee for Lincolnshire is requested to note the joint submission from the Committee and Healthwatch Lincolnshire on the seven draft priorities of LPFT, which will inform the Trust's development of its clinical strategy for 2016/17.

## 3. Consultation

The Health Scrutiny Committee has been consulted on the draft priorities of Lincolnshire Partnership NHS Foundation Trust. Together with Healthwatch Lincolnshire, a joint response has been submitted to the Trust, which will be taken into account as the Trust develops its clinical strategy for 2016/17.

## 4. Appendices

| These are listed below and attached at the back of the report | |
|---|---|
| Appendix A | Joint Response of the Health Scrutiny Committee to Draft Clinical Strategy Priorities of Lincolnshire Partnership NHS Foundation Trust |

## 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

| HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE | HEALTHWATCH LINCOLNSHIRE |
|---|---|

**Statement from Health Scrutiny Committee for Lincolnshire and Healthwatch Lincolnshire**
**Lincolnshire Partnership NHS Foundation Trust**
**Clinical Strategy 2016/17– Draft Priorities**

Introduction

On 21 October 2015, the Health Scrutiny Committee for Lincolnshire established a working group to review seven draft priorities, on which Lincolnshire Partnership NHS Foundation Trust was seeking views, prior to developing its clinical strategy for 2016/17. Healthwatch Lincolnshire also participated in the working group, and the following comments have been prepared on behalf of both Health Scrutiny Committee for Lincolnshire and Healthwatch Lincolnshire.

General Comments

The Health Scrutiny Committee for Lincolnshire and Healthwatch Lincolnshire give their overall support to the seven draft priorities. The specific comments on each priority are set out below.

As an overarching theme, Health Scrutiny Committee and Healthwatch Lincolnshire would like to emphasise prevention and early intervention, as this is preferable for service users, and can improve their overall wellbeing and actions to support this are particularly welcome.

The Health Scrutiny Committee and Healthwatch Lincolnshire accept that the seven priorities are not in a particular order. However, we believe that the priorities on *Improving Access to Services*; *Providing Better Support for People Who Are Discharged or Who are Waiting for Services*; and *Increasing Service User and Carer Involvement in all Aspects of Service Design and Delivery* need to be given greater emphasis in the final clinical strategy, as these priorities directly relate to improvements in services for patients.

Compliance with the Care Quality Commission's Fundamental Standards of Care.

The Health Scrutiny Committee and Healthwatch Lincolnshire accept that meeting the Care Quality Commission's five key requirements are a longstanding commitment, and are not solely limited to inspections. However, some of the outcomes of the inspection taking place in November and December 2015 may lead to the development of specific actions.

One of the proposed actions under this priority is the provision of clear information and advice about services offered and where to access them. We believe that primary care services also have a role in supporting this action. Primary care should also be encouraged to promote, for example, specialist GPs or nurse practitioners in the area of mental health and learning disability.

Ensuring Long Term Sustainability of the Trust

The Health Scrutiny Committee and Healthwatch Lincolnshire support the Trust's intention to broaden this priority to ensuring the long term sustainability of health services in Lincolnshire.

Improving Access to Services

As stated above, the Health Scrutiny Committee and Healthwatch Lincolnshire stress the importance of this priority.

The Health Scrutiny Committee and Healthwatch Lincolnshire understand that one of the proposed actions will be adjusted to provide support and training for all primary care (not just GPs), to support mental health and learning disability awareness.

Another proposed action is the provision of a higher level of clinical support to the Managed Care Network. The Health Scrutiny Committee and Healthwatch Lincolnshire look forward to professionals engaging with volunteers and believe that relationships between professionals and volunteers should always be based on respect.

Provision of Better Support for People Discharged from or Waiting for Services

Healthwatch Lincolnshire's own research had identified a high level of dissatisfaction from service users after they had been discharged from the Trust, so this priority is strongly supported, by both the Health Scrutiny Committee and Healthwatch Lincolnshire. Service users' expectations are important and need to be considered and this makes information of key importance.

There is also a view that once services users are "in the system" they are well treated, but while waiting for services, they may feel isolated; and again, once they are discharged, they are always feelings of isolation. This view reinforces the need for this priority. Ideally there could be a tapered discharge, so that service users do not suddenly feel there is no one there to support them.

One of the proposed actions under this priority is the expansion of the volunteer scheme to provide support for those currently engaged in services. This recognises the importance of the third sector, in particular as part of the Managed Care Network. Another proposed action is the creation of a care navigator to support integration and link to the neighbourhood teams. This role would be particularly important for those service users waiting for services.

Supporting Staff

Raising any concerns about services is a key role for staff, and it is important that the Trust has a means of gathering and acting on such information, without fear and favour. The Health Scrutiny Committee and Healthwatch Lincolnshire recognise that staff forums take place every two months, and these provide an opportunity for staff to provide general feedback on service delivery.

Increasing Service User and Carer Involvement in Service Design and Delivery

The Health Scrutiny Committee and Healthwatch Lincolnshire strongly support this priority. It is important that where service users and carers are involved in service design and delivery, their contributions are valued and they are able to see the outcome of their contribution. The Health Scrutiny Committee and Healthwatch Lincolnshire would like the Trust to show how contributions from service users and carers make a difference, to encourage other services users and carers to participate as well.

Supporting Lincolnshire Health and Care (LHAC) and Promoting Service Integration

The Health Scrutiny Committee and Healthwatch Lincolnshire understand that the Trust intends broadening this priority beyond Lincolnshire Health and Care to promoting service integration for patients, irrespective of the provider. Furthermore, as mental health is not a prominent component of the Lincolnshire Health and Care, it would be beneficial to do this. The Health Scrutiny Committee and Healthwatch Lincolnshire acknowledge the progress made so far with the neighbourhood teams.

The Health Scrutiny Committee has previously indicated that it would wish all clinical strategies to meet the aims of Lincolnshire Health and Care and this desire remains.

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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: | **18 November 2015** |
| Subject: | **Work Programme** |

**Summary:**

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

**Actions Required:**

To consider and comment on the content of the work programme.

## 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.

## 2. Conclusion

The Committee is invited to consider and comment on the content of the work programme.

## 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

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

| *16 December 2015* | | |
|---|---|---|
| **Item** | **Contributor** | **Purpose** |
| Child and Adolescent Mental Health Services | Andrew McLean, Children's Service Manager – Commissioning, Lincolnshire County Council | Status Report |
| Lincolnshire East Clinical Commissioning Group - Update | Gary James, Accountable Officer, Lincolnshire East Clinical Commissioning Group | Update Report |
| Response of the Health Scrutiny Committee to the Joint Strategic Needs Assessment Review | Simon Evans, Health Scrutiny Officer | Consultation |
| Draft Clinical Strategy Priorities of Lincolnshire Partnership NHS Foundation Trust: Joint Statement of the Health Scrutiny Committee for Lincolnshire and Healthwatch Lincolnshire | Simon Evans, Health Scrutiny Officer | Consultation |

| *20 January 2016* | | |
|---|---|---|
| **Item** | **Contributor** | **Purpose** |
| East Midlands Ambulance Service NHS Trust | Andy Hill, General Manager – Lincolnshire, East Midlands Ambulance Service. | Status Report |
| Lincolnshire Integrated Voluntary Emergency Services (LIVES) | Dr Simon Topham, Clinical Director, Lincolnshire Integrated Voluntary Emergency Service<br><br>Paul Martin, HQ Manager and Treasurer, Lincolnshire Integrated Voluntary Emergency Service<br><br>Stephen Hyde, Marketing and Fundraising Officer, Lincolnshire Integrated Voluntary Emergency Service | Status Report |

| *20 January 2016* | | |
|---|---|---|
| **Item** | **Contributor** | **Purpose** |
| Lincolnshire Cancer Strategy | Sarah-Jane Mills, Director of Planned Care and Cancer Services at Lincolnshire West Clinical Commissioning Group | Status Report |
| Lincolnshire Recovery Programme Board | Jim Heys, Locality Director<br>NHS England – Midlands and East (Central Midlands)<br><br>Jeff Worrall, Portfolio Director, NHS Trust Development Authority | Status Report |
| Health and Wellbeing Board Annual Report and Joint Health and Wellbeing Strategy – Theme Dashboards | Report of the Working Group<br><br>(to be confirmed) | Status Report |

| *17 February 2016* | | |
|---|---|---|
| **Item** | **Contributor** | **Purpose** |
| United Lincolnshire Hospitals NHS Trust Portfolio Improvement Programme | To be confirmed | Update Report |
| United Lincolnshire Hospitals NHS Trust – Pharmacy Services | Colin Costello, Chief Pharmacist, United Lincolnshire Hospitals NHS Trust | Update Report |
| Universal Health – GP Provision in Lincolnshire | Dr John Brewin, Chief Executive, Lincolnshire Partnership NHS Foundation Trust | Status Report |
| Adult Psychology Service – Developments in Provision | Dr John Brewin, Chief Executive, Lincolnshire Partnership NHS Foundation Trust | Status Report |
| Arrangements for Consideration of Quality Accounts 2015-2016 | Simon Evans, Health Scrutiny Officer. | Status Report |
| Child and Adolescent Mental Health Services – Healthwatch Perspective | Sarah Fletcher, Chief Executive, Healthwatch Lincolnshire<br>(To be confirmed) | Status Report |

| *16 March 2016* | | |
|---|---|---|
| **Item** | **Contributor** | **Purpose** |
| Lincolnshire Partnership NHS Foundation Trust – Outcomes from Care Quality Inspection | Dr John Brewin, Chief Executive, Lincolnshire Partnership NHS Foundation Trust | Status Report |
| Annual Report of the Director of Public Health on the Health of the People of Lincolnshire | Dr Tony Hill, Executive Director of Community Wellbeing and Public Health, Lincolnshire County Council | Status Report |

Items to be programmed

- St Barnabas Hospice
- Reducing Obesity for Adults and Children
- Dementia and Neurological Services
- Exercise Black Swan - Outcomes and Learning
- Queen Elizabeth Hospitals, King's Lynn – General Update Report
- Lincolnshire Health and Care – Strategic Outline Case
- The Prevention Agenda
- Dentistry
- South Lincolnshire CCG General Update
- Lincolnshire West CCG Update on Delegated Commissioning
- Butterfly Hospice

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

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