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, 20 January 2016 at 10.00 am in Council Chamber, 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
6	**Lincolnshire Integrated Volunteer Emergency Service (LIVES)** *(To receive a report from Lincolnshire Integrated Volunteer Emergency Service (LIVES) which provides information on the emergency response service, provided by trained volunteers, to medical emergencies throughout Lincolnshire. The service supported the service provided by the East Midlands Ambulance Service as the statutory ambulance service provider. Dr Simon Topham (Clinical Director – LIVES), David Hickman (Training Manager – LIVES) and Stephen Hyde, Marketing and Fundraising Manager – LIVES) would be in attendance for this item)*	31 - 34
7	**Cancer Services in Lincolnshire** *(To receive a report from Sarah-Jane Mills (Director of Development and Service Delivery – Lincolnshire West Clinical Commissioning Group) which invites the Committee to consider and comment on the progress with regards to the development of Cancer services throughout Lincolnshire. Sarah-Jane Mills (Director of Planned Care and Cancer Services – Lincolnshire West Clinical Commissioning Group) will be in attendance for this item)*	35 - 44
	LUNCH – 1.00pm	
8	**Lincolnshire Recovery Programme** *(To receive a report from Jim Heys (Locality Director (Midlands and East (Central Midlands) – NHS England) and Jeff Worrall (Portfolio Director – Trust Development Authority) which asks the Committee to consider and comment on the content of the report and, in particular, focus on the extent of the positive outcomes of the Lincolnshire Recovery Board to-date. Jim Heys (Locality Director (Midlands and East (Central Midlands) – NHS England) and Jeff Worrall (Portfolio Director – Trust Development Authority) will be in attendance for this item)*	45 - 48
9	**Delivering the Forward View: NHS Planning Guidance 2016/17 - 2020/21** *(To receive a report from Simon Evans (Health Scrutiny Officer) which provides information on the NHS publication "Delivering the Forward View: NHS Planning Guidance 2016/17 – 2020/21" published on 22 December 2015 and intended for Commissioners, NHS trusts and NHS foundation trusts)*	49 - 54
10	**Work Programme** *(To receive a report by Simon Evans (Health Scrutiny Officer) which invites the Committee to consider its' work programme for the coming months)*	55 - 60

Tony McArdle
Chief Executive
12 January 2016

HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE
16 DECEMBER 2015

PRESENT: COUNCILLOR MRS C A TALBOT (CHAIRMAN)

Lincolnshire County Council

Councillors R C Kirk, S L W Palmer, Mrs S Ransome, Mrs J M Renshaw, T M Trollope-Bellew and Mrs S M Wray

Lincolnshire District Councils

Councillors G Gregory (Boston Borough Council), Mrs P F Watson (East Lindsey District Council), M Wilson (City of Lincoln Council), C J T H Brewis (South Holland District Council (Vice-Chairman)) and Mrs R Kaberry-Brown (South Kesteven District Council)

Healthwatch Lincolnshire

Dr B Wookey

Also in attendance

Andrea Brown (Democratic Services Officer), Dr Kakoli Choudhury (Consultant in Public Health Medicine), Simon Evans (Health Scrutiny Officer), Jonas Gibson (Commissioning and Development Manager), Dr Peter Holmes (Chairman - Lincolnshire East Clinical Commissioning Group), Gary James (Accountable Officer - Lincolnshire East Clinical Commissioning Group), Lynne Moody (Director of Quality and Executive Nurse - South Lincolnshire Clinical Commissioning Group) and Catherine Southcott (Commissioning Officer)

62 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

Apologies for absence were received from Councillors D P Bond (West Lindsey District Council), J Kirk (City of Lincoln Council) and T Boston (North Kesteven District Council).

The Chief Executive reported that under the Local Government (Committee and Political Groups) Regulations 1990, he had appointed Councillor M Wilson to the Committee in place of Councillor J Kirk (City of Lincoln Council) for this meeting only.

63 DECLARATIONS OF MEMBERS' INTERESTS

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

In relation to Item 5 – *Children and Adolescent Mental Health* Services, Councillor Mrs J M Renshaw asked the Committee to note that she had a grandchild who benefitted from Children's Services in prevention.

64 CHAIRMAN'S ANNOUNCEMENTS

The Chairman welcomed everyone to the Committee and reported, with sadness, that Lynne Moody (Director of Quality and Executive Nurse for South Lincolnshire CCG) had announced she would be retiring in March 2016. The Chairman went on to make the following announcements:-

i) United Lincolnshire Hospitals NHS Trust – Retirement of Chairman

On 27 November 2015, the Chairman of United Lincolnshire Hospitals NHS Trust, Ron Buchanan, announced his retirement in March 2016 following two years in the role. A replacement Chairman was being sought and a requirement for the successful candidate was to have *"experience of leading organisational change to achieve improvement, proven governance and financial skills, and an understanding of the challenges facing NHS healthcare providers"*. The Chairman felt that this would be a challenging role and looked forward to the appointment of the new Chairman.

ii) United Lincolnshire Hospitals NHS Trust – Meetings

On 27 November 2015, the Chairman met with Kevin Turner in his role as Acting Chief Executive of United Lincolnshire Hospitals NHS Trust. This was the final meeting with Kevin Turner in his role as acting Chief Executive as Jan Sobieraj formally took up the appointment as substantive Chief Executive of the Trust on 7 December 2015.

Kevin took on the Acting Chief Executive role in July 2015, following the retirement of Jane Lewington. The Chairman intended to write to Kevin to formally thank him, on behalf of the Committee, for his contributions to the work of the Committee over the last few months, in particular for his candour and openness at meetings of the Committee.

On 10 December 2015, the Chairman met with Jan Sobieraj, Chief Executive of the Trust, where a number of issues were discussed, including recruitment and retention of staff, the financial position of the Trust and the importance of providing services to patients.

iii) Treatment for Anxiety and Depression in Lincolnshire

A report by the Health and Social Care Information Centre was released on 7 December 2015, entitled the *Psychological Therapies Annual Report*, which

highlighted the fact in Lincolnshire the improvement rate for anxiety and depression was far higher than the national average of 60.8%. The services provided in the Grantham and Sleaford areas had seen a treatment improvement rate of 76.8% which was the highest in the country. These therapy services were provided by Lincolnshire Partnership NHS Foundation Trust and it was positive to see Lincolnshire recording the highest figure in the country.

iv) East Midlands Congenital Heart Centre

The Chairman was pleased to report that the East Midlands Congenital Heart Centre had continued to develop its services in line with NHS England's commissioning standards, following the New Congenital Heart Disease Review.

A Consultant Congenital Cardiac Surgeon had been newly appointed to replace a surgeon who had recently left the Centre. This Consultant would be working alongside two existing Congenital Cardiac Surgeons bringing the Centre's complement of surgeons to three. Additionally, two Paediatric Cardiology Consultant posts had been filled, specialising in intervention and MRI respectively.

Work was underway to physically expand the unit to ascertain how extra beds could be accommodated within the Unit. This included plans to use the existing parent accommodation for beds in the Unit with the refurbishment of some nearby rooms for use as the new parents' rooms. Heart Link had agreed to refurbish the rooms and provide new carpets if the rooms were decorated.

On 14 January 2016, the Chairman would be attending the next Stakeholder Meeting at Glenfield Hospital where some of the artistic impressions of the proposed changes would be shared by the architects.

v) Healthwatch Lincolnshire – Views on Children and Adolescent Mental Health Services

It had been intended for the Committee to receive a report from Healthwatch Lincolnshire providing their views of Children and Adolescent Mental Health Services (CAMHS), however the item was removed from the agenda following the agenda planning meeting on 3 December 2015 as the Chairman felt it did not give a balanced view in relation to commissioners and providers. This item would be rescheduled for February 2016.

vi) St Barnabas Hospice – Chief Executive

On 15 December 2015 the Chairman met with Chris Wheway who had been recently appointed as Chief Executive of St Barnabas Hospice. The discussion included developments at St Barnabas and it was agreed that the Committee would receive a general presentation on St Barnabas' contribution to palliative and end of life care at the meeting in March 2016.

vii) Health Scrutiny Committee Training – 18 November 2015

The Chairman thanked Gary James (Accountable Officer – Lincolnshire East CCG), for his support at the Committee training session. The session had been well attended with 13 members and two replacement members in attendance. Suggestions for future training sessions would be discussed during Item 9 – *Work Programme*.

65 MINUTES OF THE MEETING OF THE COMMITTEE HELD ON 18 NOVEMBER 2015

RESOLVED

That the minutes of the meeting held on 18 November 2015 be approved and signed by the Chairman as a correct record.

66 CHILDREN AND ADOLESCENT MENTAL HEALTH SERVICES

A report by Andrew McLean (Children's Services Manager for Commissioning) was considered which described the overview of the commissioning of the Child and Adolescent Mental Health Service (CAMHS). This included funding, performance monitoring, local need and delivery against national benchmarking. The report also included the proposed revised model of delivery following successful application for Local Transformation Planning NHS England Funds.

Jonas Gibson (Commissioning Manager and Contract Lead for CAMHS – Lincolnshire County Council), Catherine Southcott (Commissioning Officer – Lincolnshire County Council) and Amanda Newman (CAMHS Team Leader – Lincolnshire Partnership NHS Foundation Trust) were all in attendance for this item of business.

Members were given an overview of the report which included the background to Children's and Adolescent Mental Health Service (CAMHS). The service provided highly specialist mental health services delivered by clinical experts from Lincolnshire Partnership NHS Foundation Trust (LPFT) and was funded by Lincolnshire County Council and the four Clinical Commissioning Groups (CCGs).

The structure of CAMHS was on a four tier basis with Tier 1 being access to universal support services through to Tier 4 which supported inpatient specialist, acute needs.

Tier 1 services were available to all children and young people and were provided by Primary Care and universal service professionals, i.e. General Practitioners, Health Visitors and School Nurses and other support groups or helplines. These services offered general advice and treatment for less severe problems; promoted good mental health; aided the early identification of problems and referred to more targeted or specialist services. In addition, schools played a vital role at this level.

Lincolnshire County Council Children's Services had the delegated lead responsibility from the CCGs for CAMHS at Tiers 2 and 3 which was agreed in the form of a Section 75 Agreement and due to expire on 31 March 2018. Services for Tier 2 CAMHS for children and young people experiencing moderately severe mental health problems included:-

- 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)

Services for Tier 3 CAMHS for children and young people with more severe complex and persistent mental health needs included:-

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

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

CAMHS was available to 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 were required to meet in order to access support. CAMHS delivered by LPFT provided 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 ongoing treatment and management of more severe, long term and/or complex mental health conditions.

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

The service formed part of the 'children are healthy and safe' commissioning strategy and the Children's Services strategic objectives of ensuring children and young people were "Healthy and Safe" and "Ready for Adult Life" Lincolnshire County Council also commissioned "Kooth", an online counselling service for young people aged 11-25 as part of the Universal Offer. The service was available 24/7 for young people with emotional or mental health concerns. The service helped young people manage their emotional wellbeing concerns at the earliest opportunity before those problems escalated further resulting in the potential need for more specialist service intervention.

The current core CAMHS funding was split between Children's Services (£724,589) and the CCGs (£4,843,532) and formed the S75 Agreement. This gave a total value of £5,568,121 per annum which was then contracted to LPFT. Further bids for funding and grants had been submitted and awarded, including the Better Care Fund (£350,000), non-recurrent Parity of Esteem money and Local Transformation money, during the contract period. These funds had been used to support specific developments.

Governance arrangements were intended to provide a framework for delivery of multiple working strands, including CAMHS, to monitor the achievement of the priorities of the Health and Wellbeing Strategy. The arrangements reflected the changing commissioning landscape and would enable health and social care commissioners to have joint engagement and ownership of joint commissioning arrangements.

Lincolnshire County Council and the CCGs had jointly funded a Chief Commissioning Officer post to oversee the joint commissioning arrangements between the two bodies. The post was a key link in the joint commissioning arrangement of CAMHS. The contract which monitored CAMHS sat within the Children's Commissioning Team and oversaw all aspects of commissioning arrangements for 0-25 years. Within the Commissioning Team, a dedicated CAMHS Officer undertook quarterly performance monitoring reviews as part of the ongoing contract management meetings which included representatives from Lincolnshire County Council, CCGs, LPFT as well as the Chief Commissioning Officer. The strategic oversight of CAMHS was also presented through the Health and Wellbeing Board.

Performance of the existing CAMHS contract was closely monitored. Stakeholder engagement, financial information, business continuity planning and Care Quality Commission (CQC) Reporting was also reviewed annually.

In comparison to the historic national target wait of 18 weeks, the waiting times for Lincolnshire CAMHS were significantly reduced in order to strive to achieve a better outcome for the young people of Lincolnshire. Targets for Tier 2 service wait remained the same at 6 weeks, Looked After Children wait remained the same at 4 weeks and Youth Offending Services wait remained the same at 4 weeks (although this saw an actual 6 week wait in 2015/16). Tier 3 Services wait had been reduced from 12 weeks to a target of 6 weeks despite an actual performance of 3 weeks wait in 2015/16.

It was acknowledged that the reduced waiting times for 2016/17 were ambitious but reflected 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. The target times were based on two response rate targets: Degree of Urgency and Specific Service Requirement. The young person would always be subjected to the quicker of the two response targets based on their individual need. Degree of Urgency would fall into one of three categories: Emergency, Urgent or Routine.

The total number of referrals received into the service during 1 April 2014 to 31 March 2015 was 4,569 which was slightly reduced from the previous year. For the first three months of this financial year 1,093 referrals were received and 1,586 face to face contacts made.

Within the new CAMHS model, referrals could be made by any professional or agency working with the child or young person through the Single Point of Referral (SPR) mechanism. This mechanism would also support self-referral, by children, young people and their parents/carers. Inappropriate referrals could be identified earlier and redirected to Universal Services.

In 2014/15 patient experience had been measured through a number of mechanisms, including patient and parent questionnaires. The number of returns for young people for the period 1 January to March 2015 was 172 with an overall satisfaction rate of 89.12%, in comparison to the previous quarter which was 90.04%. As part of performance information, LPFT detailed feedback from stakeholder questionnaires measuring the individual experience and satisfaction rate of service users. Negative comments were addressed through the contract management process and tracked for continuous service delivery improvement. Comments were also provided to each locality team for consideration and discussion. More generic issues were addressed on "You said – We did" boards within reception areas.

LPFT also supported Lost Luggage, a group of young people who were actively involved in the work of LPFT. The group met outside school hours, explored creative and fun ways of enabling young people's voices to be heard. Lost Luggage had already championed an anti-stigma message by producing a DVD, a radio jingle and were involved in drama projects and performances at the Drill Hall in Lincoln.

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

As a result of this announcement, NHS England provided an opportunity to bid for funding for CAMHS which met the proposals above, in addition to some further work streams on perinatal services, community eating disorder services and clinical training. A Local Transformation Plan was submitted which identified the work to be undertaken with other agencies, including Schools, Police, CAMHS Provider and Public Health to use a multi-agency approach to improve outcomes. The bid was written on behalf of Lincolnshire County Council and all Clinical Commissioning Groups in Lincolnshire and had progressed through the Women & Children's Board, Health and Wellbeing Board and East Midlands NHS Specialised Commissioning. The bid was successful in securing £1.4m per year, over five years pending tracking, and would total a minimum of £7m additional income.

It was intended to commission an integrated new model of service delivery for Lincolnshire CAMHS based on a robust specification which combined the following:-

- A non-tier system which included a Community Based Eating Disorder Service, Tier 3+ provision which would operate a 24/7 service for those in crisis and give particular support for vulnerable groups to reduce health inequalities. This was expected to commence on 1st April 2016;
- 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 at CAPA approach;
- A model which 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 service was a transformation programme delivered by NHS England which aimed to improve existing CAMHS working in communities and would include identification of clinical and non-clinical staff for IAPT training;
- Establishment of a Single Point of Referral (SPR) so all referrals were received into a daily triage function, prioritising referrals within stretching and ambitious wait times, including a four hour response time for emergency referrals;

To date, Lincolnshire had:

- Undertaken stakeholder consultation with over 55 local groups;
- Implemented a further Section 75 Agreement between the Local Authority and CCGs;
- Revised the CAMHS specification;
- Participated in East Midlands review of readiness to implement "Future in Mind", which resulted in an internal action plan which was shared with key stakeholders such as Chief Commissioners for Learning, LPFT and CCGs;
- A gap analysis was undertaken between the existing and proposed service and areas of priority identified;
- Commissioned Perinatal Specialist Teams to provide a specialised service for the prevention and treatment of Serious Mental Illness in the antenatal and postnatal 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 to be given to vulnerable groups, including reduced wait times;
- Identified how to 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 challenging behaviour, a Physical Disabilities Support Service with Autism and Learning Disabilities Service to support the needs of pupils across the county;
- Commenced a review of the services which support Readiness for School and Child's Health priorities including Health Visiting, School Nursing and services delivered from Children's Centres as part of a holistic package of support for Children & Young People;
- Applied for Schools Pilot funding which, despite being unsuccessful, showed engagement of schools to support mental health services and the commitment to the ethos within that bid remained;
- Provided development and consultation days to support frontline practitioners through training days on mental health issues such as reducing stigma;
- Started to develop a web-based universal access offer making it clear to service users and their families what services could be expected and how to access CAMHS. The planned "go live" date was January 2016; and
- Attained Local Transformation Planning money.

Other highlights of the new model were to include:-

- Extended opening hours;
- Crisis support;
- A professional advice line between 9am and 5pm;
- 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 to ensure that demand and capacity be proactively managed to minimise waiting; and
- Flexible service delivered in line with views of young people.

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

- The new tierless service was to concentrate on the needs of the person rather than multi-agency services working in silos. Focus had been on providing a service where both demand and capacity could be managed;
- It was acknowledged that there were areas of deprivation in the county including the coastal ribbon and that was a key consideration when managing the demand in future. Teams had already started to be moved to match the demand as the issue had previously been recognised;
- There was still a process in place to follow for patients and performance management formed part of that process. Some of the work undertaken in Lincolnshire in respect of performance management was being rolled out nationally. Performance information was received from LPFT on a quarterly basis and one outcome had a stakeholder input. Continuous improvement was included as was finance and productivity to ensure the service was managed efficiently within the budget available. This information was then reported to the Chief Commissioning Officer on a quarterly basis;
- Although schools had committed to primary care in respect of CAMHS, it was reported that some schools were not active in utilising the service. It was acknowledged that further work would be required within these particular schools;
- It was suggested that some high performing schools had correlation between self-harm and eating disorders, etc. CAMHS were struggling to engage the schools acknowledgement and it was felt that because young people were academically able, these issues were overlooked;
- Work had been ongoing over approximately two years to consider improvements to the service. Additional money received by CAMHS was referred to. It was explained that the bid submitted was a detailed report of the transformation to take place within Lincolnshire and was a joint vision of that service. The bid had been well received by NHS England and one of very few who were successful without requiring submission of further information;
- The Committee noted their concern that the report did not give assurance of seamless working between services;
- The figures noted within the table on page 25 of the report included emergency assessments required to be undertaken within 24 hours and routine assessments within 72 hours. It was suggested that the emergency figures be removed and reported separately as the figures were not accurate at present;
- The Committee requested how many routine assessments were meeting performance deadlines without including the emergency figures;
- The difference between CAMHS and Adult Social Care services was considerably different as children and families received a more intensive service with CAMHS which was not provided by Adult Services. The transition pathway was being reviewed nationally as it was acknowledged that there was

a gap in service. Integrated team meetings within Adult Services had been implemented to handover casework as the transition process started at 17.5 years.

- Concern was raised about the families and their anxieties during this change. They had come to trust their support workers so the transition and re-engagement with a new team was encouraged to be done in a sensitive manner;
- NICE guidelines included pathways for suicidal thoughts and self-harm with the Adult Crisis Team seeing 16 year olds in liaison with CAMHS. It was explained that despite some medical consultants occasionally struggling with suicidal thoughts these young people still required help. The more often young people presented with suicidal thoughts or self-harm the more they were at risk. It was also stressed that young people who were more vocal than others or caused issues at school were often as much at risk as those who withdraw. United Lincolnshire Hospitals NHS Trust (ULHT) had made good progress with their pathways in this area and CAMHS had provided out-of-hours on-call assessment services to assist with safe discharges more timely;
- Self-harm issues within A&E were also being addressed with qualified self-harm nurses on duty working alongside ULHT staff;
- Concern was raised that a lack of clear service areas, without a tierless system, would not highlight where performance targets may not be met or any gaps in service;
- Certain measures were required to be monitored within national guidance. In relation to clinical measures a decision was required on what the key measures should be. Sufficient training to ensure staff had good levels of understanding in these areas was essential. It was agreed that patients should have the ability to rate their service as their mental health was so important;
- Clarity of the table on page 25 of the report was requested with a clear explanation of the content of that table. The Committee were unhappy that the report was not clear enough to enable them to scrutinise it sufficiently.

The Chairman thanked Officers for their attendance. Although acknowledged that this report was an introduction to CAMHS, the Chairman expressed the Committee's disappointment at the lack of detail within the report. A request was made that a further, detailed, report be presented to the Committee at its' meeting in June or July 2016 to provide performance information following the commencement of the contract for a tierless service on 1 April 2016.

RESOLVED

1. That the report and comments made be noted; and
2. That an update and report on progress of performance since the commencement of the tierless service on 1 April 2016 be scheduled for a future meeting of the Health Scrutiny Committee for Lincolnshire.

67 LINCOLNSHIRE EAST CLINICAL COMMISSIONING GROUP - GENERAL UPDATE

A report by Gary James (Accountable Officer – Lincolnshire East Clinical Commissioning Group) which provided 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 had been involved with.

Gary James (Accountable Officer – Lincolnshire East Clinical Commissioning Group) and Dr Peter Holmes (Chairman – Lincolnshire East Clinical Commissioning Group) were both in attendance for this item.

Members were given an overview of the report which provided information on the development within Lincolnshire East Clinical Commissioning Group. The CCG currently had 30 member practices which were structured across three localities covering over 1,060 square miles. The locality structure was fundamental to how the CCG operated and member practices were embedded within the localities and communities which they served.

The CCG covered a population of 243,650 although a greater population growth than the national average had been experienced since the 2001 census. There had been substantial inward migration into the CCG area of older people from industrial centres from the Midlands and this had influenced the age structure of the populations and the prevalence of long term health conditions. 24.7% of the population were aged 65 years or older in comparison to England as a whole which was 16.9%. 23.7% of the population within Lincolnshire East had a limiting long term illness or disability which was significantly higher than the England average of 17.6%.

A number of areas had been the focus of the CCG, including the following:-

- Mental Health: Dementia
- Care for the Over 75s
- Neighbourhood Teams
- Integrated Urgent Care
- Care Home Projects
- Community Hospitals
- Optimising Prescribing in Primary Care
- C2 Evaluation and Future
- Caravan Dwellers

The lead commissioning responsibilities included:-

- United Lincolnshire Hospitals NHS Trust
- Urgent Care and System Resilience
- Information Management and Technology

When the CCG was authorised, NHS England had responsibility for commissioning all primary care services including GP services, pharmacies, optician services and dental services. In 2014/15 NHS England gave CCGs the opportunity to take on the

commissioning responsibility for GP services. The rationale being 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 remained with NHS England but these were delegated to CCGs through the co-commissioning arrangements.

Lincolnshire East CCG achieved full delegated responsibility for GP services. Appropriate governance arrangements had been implemented to manage any conflict of interest. The CCG also had a Primary Care Commissioning Committee (PCCC) which was a formal committee of the governing body. No GP's within the Lincolnshire East CCG sat on the PCCC which was composed of Governing Body lay members and CCG officers. These meetings were held in public.

Priorities for primary care commissioning would be to develop a primary care strategy detailing the direction of travel and models for GP services in the future.

The delivery of the NHS Constitution standards for Accident & Emergency, ambulance services and cancer had deteriorated during 2015/16. The planned care standard had been redefined in terms of incomplete patient pathways and was being met overall (94% against a target of 92%). Challenges remained at speciality level including urology, plastic surgery and neurology. Steps were being taken 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 had shown improvement in recent months but A&E performance remained a challenge. At CCG level performance was 94.95% against a target of 95%. However, at ULHT specifically, performance for CCG patients was 89.3%.

In relation to Financial Management, the CCG had a total commissioning allocation of £368 million with each CCG 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

It was reported also that, out of 211 CCGs, they were rated as below:-

- Diabetes – 6th worst
- Coronary Heart Disease – 2nd worst
- Hypertension – 5th worst
- Chronic Kidney – 5th worst
- Stroke – 4th worst

Focus was on dementia in primary and secondary care which was both challenging and controversial. Alongside diagnosis rates, the CCG were trying to provide a better process of diagnosis rates. For dementia patients and those with long term

conditions, a more structured care pathway was required for those elderly and frail patients.

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

- Despite being involved in the countywide strategy for dementia care, it was felt that this may lack local flexibility. Although countywide focus was on diagnosis, care navigators and a structured organised care network, it was acknowledged that the service needs in one area may be very different to that in another therefore local flexibility was required;

At this stage of the meeting, Councillor Mrs P F Watson declared an interest on page 34 of the report, *C2 Evaluation and Future*, and the project with East Lindsey District Council, due to her involvement in the project in her capacity as a Trustee and Director of Magna Vitae.

- Recruitment into General Practice remained a challenge but if practices were able to recruit a full cohort of staff, including administration, nurses and GPs then this model would allow more experienced clinicians to deal with more complex patients. However, not all surgeries had the same view on that type of model so discussions were starting with these practices;
- It was suggested that many patients from the Louth and Mablethorpe areas travelled to Grimsby Hospital rather than ULHT. This was acknowledged but reported that Grimsby Hospital was also not meeting their A&E target;
- IT services in relation to electronic discharged required improvement;
- In relation to caravan and chalet residents on the east coast, these were complex patients as two types of temporary residency registration were available. Practices registering a resident on a permanent basis required a considerable amount of paperwork to be completed;

Before taking a question from Councillor Gregory, the Chairman sought assurance that this was not in relation to ULHT given his pecuniary interest as an employee of ULHT. Councillor Gregory assured the Chairman that his question did not relate to his pecuniary interest.

- Budgets were calculated and adjusted taking into consideration morbidity in those areas. The prescribing budget would also be considered alongside performance;
- Although it appeared that Neighbourhood Teams were a new initiative, this was not the case. The section within the report described how the Neighbourhood Teams worked, something which had not previously been reported;
- In relation to Neighbourhood Teams, some East Lindsey practices were nearer to Louth than Skegness so the boundaries were changed to make them closer to the localities;
- Holbeach was in an unusual situation where they had two practices in two separate CCG areas (Lincolnshire East CCG and South Lincolnshire CCG). Engagement with two District Councils was also required in this instance. It

was reported that one practice was looking to move premises although it was unclear if it would remain as it was or if both practices would move into one CCG area.

The Chairman thanked both Gary James and Dr Peter Holmes for the presentation which had been well received and requested that a future update be scheduled for a future meeting of the Committee.

RESOLVED

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

68 RESPONSE OF THE HEALTH SCRUTINY COMMITTEE TO THE JOINT STRATEGIC NEEDS ASSESSMENT REVIEW

A report by Simon Evans (Health Scrutiny Officer) was considered which provided the proposed draft response, produced by the established working group, for the approval of the Committee as part of the stakeholder engagement phase.

Members were given an overview of the report, following the meeting of the Task & Finish Group on 11 November 2015. It was reported that some factual amendments were required. This information would be circulated to the Committee with the relevant amendments included as track changes to enable the changes to be clearly seen. These amendments have been noted below:-

1. Introduction – second sentence to read – *The Health Scrutiny Committee for Lincolnshire understands that there will be further opportunities for the Committee to contribute, for example during a further engagement phase on the interpretation of the JSNA and suggestions for priorities for inclusion in the Joint Health and Wellbeing Strategy in 2017.*
2. Introduction – third sentence to read – *The Committee also acknowledges that the JSNA is a key evidence base in the development of the Joint Health and Wellbeing Strategy.*
3. Involvement in Stakeholders – third sentence to read – *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 continued maintenance and interpretation of the JSNA.*
4. Involvement in Stakeholders – second paragraph to read – *The Health Scrutiny Committee believes that the views of the voluntary sector must be taken in to account, as these organisations see services from a different viewpoint. They may also have data that could inform the JSNA.*
5. Data and Specific Topics – first bullet point to read – *neurological conditions, where there is a need for adequate evidence to establish whether services in Lincolnshire meet need and to ensure that commissioning decisions fully take account of the needs of people with such conditions.*
6. Data and Specific Topics – second bullet point to read – *cancer, where there should be more evidence to support an emphasis on prevention and the*

appropriate funding for such services as the early prevention and detection of cancer.

7. Data and Specific Topics – third bullet point to read – *childhood obesity, where more evidence 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.*
8. Data and Specific Topics – fourth bullet point to read – *rural isolation, where contextual intelligence could be better integrated into the JSNA and used to support improved implementation of services.*
9. Data and Specific Topics – final paragraph – *The Committee also supports the intention for the restructuring of the JSNA to provide a more flexible approach to the existing 35 topic commentaries.*

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

At this point of the meeting, the Chairman declared an interest due to her participation in a research project with Durham University regarding public health budgets.

- Within the draft response, it was suggested that the Committee believed that public health funding be ring-fenced for public health activities as this often supported prevention. Following discussion regarding the possibility of absorbing that budget in to other County Council areas, the Chairman requested a vote to formally document the decision of the Committee. It was agreed that the comment to continue to ring-fence this budget remain in the final response;
- It was suggested that the third bullet point under *Data and Specific Topics* include the word "urgent" prior to "further action". The Committee voted on this amendment which was unsuccessful;

RESOLVED

1. That the report and comments be noted;
2. That the comment under *Resources* that *"The Health Scrutiny Committee believes that the ring-fence should remain"* be included within the final response; and
3. That the final response, with the reported factual amendments, be approved and submitted on behalf of the Health Scrutiny Committee for Lincolnshire.

69 DRAFT CLINICAL STRATEGY PRIORITIES OF LINCOLNSHIRE PARTNERSHIP NHS FOUNDATION TRUST: JOINT STATEMENT OF THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE AND HEALTHWATCH LINCOLNSHIRE

A report by Simon Evans (Health Scrutiny Officer) was considered which presented 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.

Members were advised that a working group to review the draft priorities of Lincolnshire Partnership NHS Foundation Trust was established and met on 12 November 2015. The final statement was submitted to the Trust on 26 November 2015 on behalf of the Committee and Healthwatch Lincolnshire.

The report which the Committee considered on 21 October 2015 listed seven draft priorities (noted below) which the working group further considered. The working group involved Councillors Mrs C A Talbot and S W L Palmer and Sarah Fletcher, Chief Executive of Healthwatch Lincolnshire.

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

The Committee did not make any additional comments on the draft response.

RESOLVED

1. That the joint statement, at Appendix A to Agenda Item 8, of the Health Scrutiny Committee for Lincolnshire and Healthwatch Lincolnshire to the Draft Priorities of Lincolnshire Partnership NHS Foundation Trust submitted to the Trust on 26 November 2015 be noted; and
2. That a further opportunity for the Committee to comment on the content of the clinical strategy of Lincolnshire Partnership NHS Foundation Trust be presented to the Health Scrutiny Committee for Lincolnshire in February 2016.

70 WORK PROGRAMME

The Committee considered its work programme for forthcoming meetings.

The Health Scrutiny Officer advised that the meeting in January would be all day with the afternoon session including contributions from the Trust Development Authority (TDA) and NHS England – Midlands and East (Central Midlands) on the Lincolnshire Recovery Programme Board.

The Chairman noted that a Cancer Summit had taken place in February 2015 prior to Sarah-Jane Mills (Director of Planned Care and Cancer Services – Lincolnshire West Clinical Commissioning Group), the former Chief Executive of St Barnabas, being appointed.

It was reported that an enquiry had been made by a member of the public in relation to the Men Behaving Badly initiative. Following discussion, it was agreed that this query be referred to Public Health as it was within their remit.

RESOLVED

That the contents of the work programme be approved.

The Chairman took the opportunity to wish the Committee a very happy Christmas and a peaceful New Year.

The meeting closed at 1.04 pm

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

Open Report on behalf of Sue Noyes, Chief Executive,
East Midlands Ambulance Service NHS Trust

Report to:	**Health Scrutiny Committee for Lincolnshire**
Date:	**20 January 2016**
Subject:	**East Midlands Ambulance Service (EMAS) - Improvements and Performance**

Summary:

This report outlines the key areas of performance within the East Midlands Ambulance Service (EMAS) and in particular the Lincolnshire Division. This also includes an update on the work and ongoing projects being carried out to enhance and support performance.

Actions Required:

To consider and comment on the performance summary, the ongoing work and the progress undertaken.

1. Purpose

This report provides the Health Scrutiny Committee for Lincolnshire with an update on the performance of the East Midlands Ambulance Service NHS Trust (EMAS). In November 2015, EMAS was inspected by the Care Quality Commission (CQC), and the outcomes of the inspection are expected in early 2016.

EMAS Response Time Performance – Quarter Two (July, August and September 2015)

The Lincolnshire Division achieved the Red 1 target (76.56%) for Quarter. Red 2 has been a challenge and the Division fell short of the required target by 1.44%. Quarter 2 response time performance is detailed in Table 1 of this report. Table 2 sets out the handover delays at hospitals, **which are subject to validation**. Overall activity compared with quarter two for 2014/15 has increased by 6%. Tables 3 and 4 show the number of calls received and responses undertaken during Quarter 2.

Table 1

Quarter Two 2015-16 (July, August, Sept 2015)	Performance - Incidents (Response)									Performance - Telephony		Performance - Monitoring	
	RED 1 *(75%)*	RED 2 *(75%)*	RED *(75%)*	RED 1 *(95%)*	RED 2 *(95%)*	RED *(95%)*	GREEN 1 *(85%)*	GREEN 2 *(85%)*	URGENT *(90%)*	GREEN 3 *(85%)*	GREEN 4 *(85%)*	GREEN 3 (85%)	GREEN 4 (85%)
Lincolnshire Division	**76.56%**	**73.56%**	**73.71%**	**96.07%**	**85.99%**	**86.50%**	**80.10%**	**75.78%**	**72.95%**	**88.82%**	**99.07%**	**90.06%**	**98.97%**
NHS Lincolnshire East CCG	68.66%	70.81%	70.72%	94.03%	79.71%	80.35%	75.96%	69.31%	68.44%	91.06%	99.17%	85.96%	97.69%
NHS Lincolnshire West CCG	87.50%	82.37%	82.67%	97.49%	93.63%	93.86%	86.89%	86.08%	81.33%	91.11%	99.12%	93.28%	100.00%
NHS North East Lincolnshire CCG	80.67%	77.35%	77.53%	98.00%	90.27%	90.68%	82.99%	78.79%	70.50%	87.14%	99.61%	100.00%	100.00%
NHS North Lincolnshire CCG	77.67%	74.85%	74.99%	99.03%	90.71%	91.11%	81.82%	79.49%	70.41%	83.10%	98.71%	87.23%	98.72%
NHS South Lincolnshire CCG	61.64%	61.29%	61.31%	90.41%	79.48%	79.95%	77.37%	65.50%	74.85%	92.86%	98.22%	73.58%	98.81%
NHS South West Lincolnshire CCG	73.86%	66.76%	67.18%	95.45%	79.94%	80.87%	79.80%	71.51%	74.13%	84.78%	99.45%	92.68%	100.00%

- Red 1 – Immediately life threatening calls, for example cardiac arrest patients who are not breathing and do not have a pulse, and other severe conditions such as airway obstruction. Red 1 patients account for less than 5% of all ambulance calls. Response time: 8 minutes from call received and 19 minutes for conveying resource to scene.
- Red 2 –Life threatening calls, such as cardiac chest pains. Response time: 8 minutes from call received and 19 minutes for conveying resource to scene.
- Green 1 – Serious, but not life threatening. Response time of 20 minutes from call received.
- Green 2 – Serious, but not life threatening and with no serious clinical need: Response time of 30 minutes of call received.
- Green 3 – Non-life threatening non-emergency call. Telephone assessment within 20 minutes of call received.
- Green 4 – Non-life threatening non-emergency call. Telephone assessment within 60 minutes of call received.

Table 2

Handover Delays at Hospitals
Quarter 2 - 2015/16 (Figures Subject to Validation)
(Figures for Quarter 2 - July, August and September 2015)

Hospitals	No Of Usable Handover Times	Handovers Over 15mins	% Delayed over 15	Handovers Over 20mins	% Delayed over 20	Handovers Over 30mins	% delayed over 30	Handovers Over 45mins	% Delayed over 45	30 To 59 minutes	1 To 2 Hours	2 to 4 Hours	4 to 6+ Hours
Boston Pilgrim Hospital	6161	2763	45%	1862	30%	927	15%	394	6%	721	208	3	0
Grantham and District Hospital	1269	655	52%	451	36%	205	16%	73	6%	183	34	3	0
Grimsby Diana Princess Of Wales	5606	3272	58%	2297	41%	1064	19%	312	6%	983	85	2	0
Lincoln County Hospital	7959	5009	63%	3571	45%	1647	21%	612	8%	1406	254	25	0
Peterborough City Hospital	2439	1025	42%	643	26%	243	10%	73	3%	230	19	2	0
Scunthorpe General Hospital	4260	2421	57%	1738	41%	834	20%	312	7%	700	138	5	0
Skegness and District Hospital	199	68	34%	33	17%	12	6%	1	1%	13	0	0	0
Grand Total	**27893**	**15213**	**55%**	**10595**	**38%**	**4932**	**18%**	**1777**	**6%**	**4236**	**738**	**40**	**0**

Notes

1. The table shows pre-hospital handover times only, which are not expected to exceed 15 minutes. The pre-hospital handover time refers to the time between the arrival of the ambulance at the hospital and the transfer of the patient to the care of the hospital. For Quarter 2 as a whole the average pre-hospital handover time was 20 minutes and 9 seconds. In total over 36,000 hours of ambulance time was lost as a result of exceeding the 15 minute limit.
2. The table does not show post-handover times. This refers to the 15 minutes, where the crews are expected to clean the ambulance; complete any forms; and generally make the ambulance ready for the next call. The pre-hospital handover time and the post-handover time, taken together represent the turnaround time. For Quarter 2, the average post-handover time was 13 minutes and 50 seconds. If the average pre-handover time of 20 minutes and 9 seconds is added to the post-handover time of 13 minutes and 50 seconds, an average turnaround time for the quarter of 33 minutes and 59 is calculated.

Table 2

	Number of Calls Received – Quarter Two (2015-16) (July, August and September 2015)									
	Red 1	**Red 2**	**Red**	**Green 1**	**Green 2**	**Green 3**	**Green 4**	**Urgent**	**Routine**	**TOTAL**
Lincolnshire Division	**819**	**16791**	**17610**	**4335**	**13762**	**1429**	**4091**	**3986**	**85**	**45298**
NHS Lincolnshire East CCG	196	4745	4941	1338	3645	391	1132	1305	25	12777
NHS Lincolnshire West CCG	202	3410	3612	638	2939	291	857	780	28	9145
NHS North East Lincolnshire CCG	161	3135	3296	709	2367	269	638	334	11	7624
NHS North Lincolnshire CCG	105	2235	2340	603	1806	180	571	601	20	6121
NHS South Lincolnshire CCG	72	1793	1865	575	1649	169	479	402	0	5139
NHS South West Lincolnshire CCG	83	1473	1556	472	1356	129	414	564	1	4492

1. This table shows the number of calls received in each category, by CCG area. The figures exclude calls transferred from 111.

Table 3

	Number of Responses Made– Quarter Two (2015-16) (July, August and September 2015)									
	Red 1	**Red 2**	**Red**	**Red 1 19**	**Red 2 19**	**Red 19**	**Green1**	**Green2**	**Urgent**	**Reportable Incidents with a response (Total)**
Lincolnshire	**815**	**15230**	**16045**	**814**	**15185**	**15999**	**4422**	**13439**	**3438**	**37344**
NHS Lincolnshire East CCG	201	4286	4487	201	4263	4464	1360	3412	1106	10365
NHS Lincolnshire West CCG	200	3210	3410	199	3205	3404	671	3110	691	7882
NHS North East Lincolnshire CCG	150	2658	2808	150	2651	2801	670	2051	278	5807
NHS North Lincolnshire CCG	103	2068	2171	103	2067	2170	594	1828	534	5127
NHS South Lincolnshire CCG	73	1612	1685	73	1608	1681	632	1655	342	4314
NHS South West Lincolnshire CCG	88	1396	1484	88	1391	1479	495	1383	487	3849

1. This table shows the number of Incidents with a response (with a resource to scene) within the EMAS CCG area. therefore, the basis of performance calculations shows the number of ambulance responses made in each category.

Overview

Staff engagement and recruitment has seen greater emphasis, being mobilised through an NHS initiative termed “Listening into Action” that is being led personally by our Chief Executive, Sue Noyes.

Staff recruitment and the workforce plan are fully committed for the current financial year with new staff joining the service from April 2015 to March 2016.

EMAS has noted that inter facility transfers (IFTs) from Grantham and District Hospital have increased by 23% compared with 2014/15. To establish the reason for the increased number of IFTs from Grantham, a review is being undertaken. In addition to establishing the reasons for the increase, it will identify what actions need to be taken to mitigate the impact on performance in the South Lincolnshire and South West Lincolnshire CCG areas. When the findings are available, they can be made available to the Committee.

The Division has worked closely with United Lincolnshire Hospitals NHS Trust (ULHT) to proactively manage handover delays but this is an ongoing issue and being reviewed under the ULHT recovery plan. In December 2015, the Division deployed a clinical navigator within Pilgrim Hospital to liaise with ULHT staff to signpost patients efficiently and free up EMAS resources to respond to calls. The impact of this initiative will be reported to the Committee, when the information is available. Hospital Ambulance Liaison Officers (HALOs) will continue to be deployed to all sites where pressures are identified.

The CQC visited EMAS in November 2015 and the report on findings should be available in early January 2016.

EMAS is actively engaged in supporting the ULHT recovery plan.

2.1 Performance Summary

The Committee is asked to consider the areas of work being carried out and the direct effect they are having on Ambulance Service performance within Lincolnshire. Although in the present contract, EMAS are not commissioned to achieve national standards within Lincolnshire, the Commissioners within Lincolnshire do expect to see a continuous improvement towards national standards.

The Trust is active with Healthwatch Lincolnshire and has formed an EMAS Healthwatch Task Group to look at and action initiatives in response to local needs.

Engagement with both System Resilience Groups (SRGs) and Urgent Care Working Groups is well established and representation and participation is regular and inclusive.

Work on unique initiatives with partner organisations such as Clinical Commissioning Groups (CCGs); the Integration Executive; Local Resilience Forum (LRF); and others are on-going in support of the improvements necessary for the wider Lincolnshire health economy.

Pro-active work on hospital delays with ULHT staff has shown improvement, but there is a lot more work to do in this area.

External expert and consultant support, advice, critique and audit has been sourced and the results of this work and findings shared with commissioners to ensure the EMAS plan is robust and sufficiently focussed to deliver the required outcomes. Commissioner feedback on this has been very positive and supportive through their attendance at all relevant Board and Working Group meetings.

The development of:

- Mental Health Car Initiative;
- Mobile Incident Unit, Butlins, Skegness;
- Clinical Assessment Car Initiative;
- South Lincolnshire Investments/Initiatives;
- Joint Ambulance Conveyance Project (JACP) – Stamford, Woodhall Spa and Long Sutton;
- Clinical Navigator Role at Pilgrim Hospital in Boston; and
- Addressing patient handover delays at the acute trusts.

2.2 Joint Ambulance Conveyance Project Data

Introduction

Lincolnshire Fire and Rescue (LFR) and EMAS have developed a pilot project aimed at improving the quality of service and outcomes for patients in Lincolnshire. The project is called the Joint Ambulance Conveyance Project (JACP). The JACP builds on LFR's existing co-responder scheme, run in partnership with EMAS and Lincolnshire Integrated Voluntary Emergency Service (LIVES), in which on-call retained firefighters from 21 stations already respond to medical emergencies, delivering first aid, providing oxygen therapy and administering defibrillation and cardiopulmonary resuscitation.

The JACP involves some co-responders being mobilised to medical incidents in an ambulance vehicle. At the same time, an EMAS paramedic also responds to the incident in a fast response car. The paramedic assesses if the patient needs to go to hospital and, if so, travels with the patient in the ambulance providing any necessary treatment on route. The main difference between the standard practice and the JACP is that LFR staff have the capability of conveying a patient to hospital rather than having to wait at the scene until an EMAS ambulance arrives.

The pilot is being run from Long Sutton, Stamford and Woodhall Spa fire stations. These locations were selected as the retained firefighters at these stations already co-respond.

JACP Activity

The following table shows JACP performance for Quarter 2 (July, August and September 2015) for the three fire stations combined:

Number of Co Responder Incidents attended	**270**
Number of Non Conveyances	**73**
Number of Conveyances	**197**
Incidents transported by FRV	**18**
Incidents transported by DCA	**107**
Incidents transported by JACP	**64**
Incidents transported by other resource	**8**
Conveyance rate	**73%**
FRV conveyances	**9%**
DCA conveyances	**54%**
JACP conveyances	**32%**
OTHER conveyances	**4%**

2.3. LIVES First Responder Performance

LIVES Call Out Information (April - November 2015)

Red 1 Contribution to Performance by Resource

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Commmunity First Responder *	0.82%	1.43%	1.11%	1.13%	1.43%	1.55%	1.93%	1.06%
Lives Responder Scheme	2.27%	1.63%	1.41%	2.45%	2.77%	1.94%	2.77%	2.02%

Red 2 Contribution to Performance by Resource

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Community First Responder *	1.57%	1.79%	1.40%	1.14%	1.37%	1.32%	1.47%	1.39%
Lives Responder Scheme	1.78%	1.48%	1.40%	1.68%	1.96%	1.56%	1.65%	1.61%

LIVES arrivals on scene for Q2

Resource Type/s	Allocated	Mobilised	Arrive At Scene
Q2 2015/16	**6084**	**5369**	**4877**
Lives Responder Scheme	**6084**	**5369**	**4877**
Grand Total	**6084**	**5369**	**4877**

2.4 Toughbook Usage Update

EMAS has been operating the current version of toughbooks since 2009. The system needs to be refreshed to ensure staff are able to access the information needed and EMAS can capture information in line with national guidance. Lincolnshire's current usage of toughbooks has been very low. The main reasons for toughbooks not being used are:-

1. Staff not confident in use – Action: Train the Trainer sessions have been arranged at our Training Centre;
2. Toughbooks not being charged – Action: Separate chargers and spare batteries are currently being supplied for placement at stations and hospitals for crews to swap flat batteries;
3. Toughbooks not being available – Action: Lincolnshire will have a number of spare devices and the swap out process is currently being reviewed;
4. Toughbooks not working – Action: Nominated leads who can provide additional support and training if required to identify problems with Toughbooks.

There are on-going issues with RFID [*Radio Frequency Identification*] tags fitted to toughbooks, as we have found a number are missing. These have either been left on toughbooks which have been returned or removed and not replaced on replacement toughbooks.

An upgrade is planned and the intention will be to support and encourage a more consistent use of the electronic patient record. The planned upgrade to the latest version of our electronic patient record is currently underway. All toughbooks will be replaced with one of the upgraded devices. This upgrade will include additional functionality to refresh and update the patient report and also to allow access to other sources of information such as GRS/e-mail, patients' demographic search and if required access to the patients' summary care record.

The initial screen when logging into the Toughbook will appear with a red background as opposed to the current blue background. This is to allow easy identification of those devices which have been updated and will not affect the Toughbooks operation.

2.5 Fleet Strategy

EMAS's Fleet Services Strategy was agreed by the EMAS Board in March 2015 and highlights the case for investment in the EMAS fleet to respond to a range of challenges. EMAS has committed to invest between £19m - £24m in the next five years on new vehicles. This investment will ensure that the age profile of the EMAS fleet is reduced to seven years by the end of financial year 2018/19.

Another objective is to improve our spare capacity numbers of our vehicles. Lincolnshire currently has the highest spare capacity at 40% compared to other Divisions at 33%.

Phase 1 of the Double Crewed Ambulance (DCA) replacement programme has been completed with the first 29 DCAs all delivered, commissioned and operational within Divisions. Phase 2 of the DCA replacement programme for the next 30 DCAs is now underway. Lincolnshire will be receiving two (based at Boston and Lincoln stations) plus an extra three Fast Response Vehicles (FRVs).

The allocation of the ambulances to the Lincolnshire has been identified from the age profile of all the ambulances. The Lincolnshire Division received 46% of the new vehicles in 2012 and does not have the same aging vehicles as other Divisions. For example, in 2010 EMAS introduced 91 new ambulances (Vauxhall Movanos) and the Division Lincolnshire received 26 of these. In 2012 EMAS introduced 80 new ambulances (Peugeot Boxers) and Lincolnshire received 37.

3. Consultation

This is not a 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.

All sources of information and data referred to in this report can be found at:
www.emas.nhs.uk.

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Lincolnshire COUNTY COUNCIL		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 by
Lincolnshire Integrated Volunteer Emergency Services (LIVES)

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**20 January 2016**
Subject:	**Lincolnshire Integrated Volunteer Emergency Service (LIVES)**

Summary:

The Lincolnshire Integrated Volunteer Emergency Service (LIVES) is a registered charity, which provides an emergency response by trained volunteers to medical emergencies throughout Lincolnshire. We deliver two responses to emergencies. The majority is in the form of a locally-based trained lay volunteer Community First Responder giving timely life-saving interventions, but also could be Medic First Responder (qualified healthcare professional) providing advanced or critical medical care. Our service supports the service provided by the East Midlands Ambulance Service NHS Trust as the statutory ambulance service provider with whom we have a Service Level Agreement. We are at a watershed in our development and are looking to develop into other areas of Health and Social Care to contribute to the resilience of individuals within the communities of Lincolnshire and level up health inequality brought about by rurality.

The following LIVES personnel will be attending the Committee: -

- Dr Simon Topham, Clinical Director
- David Hickman, Training Manager
- Stephen Hyde, Marketing and Fundraising Manager

Actions Required:

(1) To consider and comment on the information presented on Lincolnshire Integrated Volunteer Emergency Service (LIVES).

1. Background

Introduction

The LIVES Charitable Objectives are:

> *To provide Immediate Medical Care to any person injured in an accident or involved in any medical emergency in the area of Lincolnshire, North-East Lincolnshire or any area reasonably close to. To advance the principle of Pre-Hospital Emergency Care on a national basis; providing advice and guidance in all aspects of such care, including the delivery of training and provision of approved emergency equipment.*

There are over 160 responder groups across Lincolnshire, with around 700 active LIVES Community First Responders and LIVES Medics. LIVES has responded to around 17,000 emergency calls the last few years, and this number is set to increase over the coming years.

LIVES has just appointed its first Chief Executive Officer, who will be in post from 1 April 2016. Having grown steadily over its 45 year history, LIVES has now reached the level where strategic development is required to respond to the ever-growing demand for Health and Care within a resource-limited NHS. LIVES feel that they can provide far more to the people of Lincolnshire than at current, and can mobilise a far wider volunteer base to provide the 'big society'. One example is a project designed to provide a one and a half hour emergency first person on scene training lesson, (chocking, recovery position, catastrophic bleed and CPR) to all year 10 students throughout Lincolnshire.

The following information provides an outline of the responder and medic roles.

LIVES Responders

When a 999 call is made within the Responder's local area, East Midlands Ambulance Service (EMAS) despatch an emergency ambulance with a response category determined by the AMPDS computer-based triage system. At the same time EMAS Community First Responder (CFR) desk will activate the LIVES Responder who is 'on-duty'. LIVES Responders are dispatched using a response 'isochrones map' determined by an ability to get to the patient within six minutes. Because of being embedded in their community, the Responder very often arrives first on the scene (currently 86% CFRs arrive first) and can begin to treat the patient by:

Following a Danger, Responsiveness, Airway, Breathing, Circulation model (DR-ABC). This schema leads to the Responder:

- clearing and controlling the airway of an unconscious patient;
- providing resuscitation and defibrillation;
- giving oxygen therapy;
- controlling any bleeding;
- taking observations; Blood pressure, Blood glucose, Temperature, Respirations and Pulse.
- being the 'eyes and ears' of the ambulance service and feed back information to control if the situation is not as initially expected.

- making the patient feel more comfortable and at ease; reassuring worried relatives and taking charge of the situation;
- using local knowledge to ensure that the ambulance can find the location quickly.

In cases where the patient has suffered a cardiac arrest and has stopped breathing, the Responder follows Resuscitation Council guidelines to optimise the chance of survival. In this situation, the patient's heart needs to receive a shock (defibrillation) as quickly as possible, ideally within the first five to ten minutes of collapse. The earlier this can happen, the better the patient's chance of survival. First Responders carry a defibrillator, which can deliver a controlled shock in an attempt to correct the patient's heart rhythm. A defibrillator costs approximately £1,000, but it can mean the difference between life and death for some people.

The 999 calls where the Responders make the biggest, most obvious differences are to the calls coded by the AMPDS system as Red 1 or Red 2 calls. These are 999 calls which have been deemed "serious and/or life threatening". EMAS aims to be at these calls within 8 minutes, but as these calls require medical help to arrive as quickly as possible, LIVES Responders can shave off vital minutes due to their unique position within the community.

Examples of Red calls are:

- signs of cardiac arrest;
- unconsciousness and collapse;
- chest pains (for example, heart attack and acute angina);
- breathing difficulties (for example, asthma);
- diabetic emergencies (for example, hypoglycemia);
- fitting or convulsions (for example epilepsy);
- stroke;
- anaphylaxis (severe allergic reaction);
- choking.

More than 70% of cardiac arrests occur out of hospital. For this reason, the ability of a LIVES Responder to get to a patient quickly and administer basic life support and early defibrillation until the ambulance arrives is vital, especially in rural areas where an ambulance cannot always reach the scene straight away.

Medics

LIVES medics have been voluntarily providing advanced pre-hospital emergency care since the inception of the charity in the early 1970s. These members are qualified healthcare professionals; doctors, nurses, paramedics and technicians, who freely offer their spare time to respond to 999 calls when available.

The LIVES medic role is twofold:

1. Timely Response - Providing a first responder service to the local community in the same way as their lay First Responder counterparts.
2. Adding Value – LIVES Medics provide advanced or critical care intervention, taking skills above and beyond those provided by the statutory ambulance service.

Medics may attend the following incidents:

- life-threatening medical emergencies;
- cardiac arrest;
- paediatric emergencies;
- road traffic collisions;
- major trauma;
- major incidents;
- responding to requests for on-scene advanced clinical support.

LIVES medics offer skills appropriate to their level of professional training. The highest level medic members are able to offer some or all of the following skill sets:

- advanced airway management, and management of the difficult airway; including pre-hospital emergency anaesthesia ("medically-induced coma")
- on-scene chest surgery;
- advanced ventilatory strategies;
- advanced vascular access techniques;
- sedation and advanced analgesia;
- senior clinical support and decision making;
- major incident management; and
- further critical care interventions.

Issues for the Committee

The Committee is invited to explore the following issues:

- the number of Responders, and their recruitment, training and retention;
- the need to re-visit the aims registered with the charities commission in a changing world with a view to broadening the remit of LIVES Responders to deal with a wider range of less 'urgent' health and social care needs.
- support from and liaison with the East Midlands Ambulance Service;
- funding issues (in particular support from the Lincolnshire CCGs and NHS England); and
- the impact of the new commissioning arrangements on LIVES.

2. Conclusion

The Committee is requested to consider the information on LIVES.

3. Consultation

This is not a consultation item.

4. Background Papers - None

This report was written LIVES Clinical Director, Dr Simon Topham, who can be contacted at drtopham@lives.org.uk

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 by Sarah-Jane Mills, Director of Development and Service Delivery, NHS Lincolnshire West Clinical Commissioning Group

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**20 January 2016**
Subject:	**Cancer Services in Lincolnshire**

Summary

The provision of a comprehensive range of service to promote improved outcomes for people affecting by Cancer remains a priority for Lincolnshire. The prevalence and outcomes for local residents are in line with the national average. The development of local services is co-ordinated by Lincolnshire West Clinical Commissioning Group.

The strategic framework for the development of local services reflects the recommendations of the National Cancer Strategy and has been developed to reflect local priorities, challenges and the outcomes of the Cancer Summit in February 2015.

All key stakeholders and partners are fully engaged in a comprehensive programme of work that aims to raise awareness, facilitate early referral, improve outcomes and provide holistic care for those living with or beyond cancer.

New ways of working within United Lincolnshire Hospitals NHS Trust (ULHT) have supported significant improvement in local performance. The work undertaken has been actively facilitated by strong clinical engagement both from ULHT and Primary Care. This provides a strong foundation for the continued development of services and design of new ways of working that will facilitate improved outcomes.

Actions Required

To consider and comment on the progress with regards the development of Cancer Services throughout Lincolnshire**.**

1. Background

Cancer remains one of the national priorities for the NHS. In 2015 an updated Cancer Strategy *Achieving World Class Cancer Outcomes* was published by the Independent Cancer Taskforce. The Strategy sets out a vision for what cancer patients should expect from the health service. The six overarching objectives of the national strategy are:

- Spearhead a radical upgrade in prevention and public health
- Drive a national ambition to achieve earlier diagnosis
- Establish patient experience as being on a par with clinical effectiveness and safety
- Transform our approach to support people living with and beyond cancer
- Make the necessary investments required to deliver a modern high-quality service
- Overhaul processes for commissioning, accountability and provision.

The Lincolnshire Health and Care System remains committed to driving the continued improvement of cancer services and has established a network with key stakeholders, co-ordinated by Lincolnshire West CCG, to further promote the development of services for local people.

This report provides an overview of progress during the last twelve months and sets out the priorities for the coming year.

2. Local Data

The prevalence of cancer locally and outcomes are broadly in line with the national average. Details for each of the four Lincolnshire CCGs are given in Table One below.

Table One Local Cancer Data

CCG	Prevalence (Number of people living with and beyond cancer up to 20 years after diagnosis)	Incidence (new cancer diagnosis per 100,000 each year)	Mortality (number of cancer deaths per 100,000 each year)	1 year survival rates	Overall patient experience (National average 88%)
Lincolnshire East	8,200 (estimated to rise to 15,900 by 2030)	626 (similar to national average)	293 (similar to national average)	69% (similar to national average)	83%
Lincolnshire West	6,900 (estimated to rise to 13,400 by 2030)	612 (similar to national average)	297 (similar to national average)	68% (similar to national average)	80%

CCG	Prevalence (Number of people living with and beyond cancer up to 20 years after diagnosis)	Incidence (new cancer diagnosis per 100,000 each year)	Mortality (number of cancer deaths per 100,000 each year)	1 year survival rates	Overall patient experience (National average 88%)
South Lincolnshire	4,600 (estimated to rise to 8,900 by 2030)	591 (similar to national average)	264 (similar to national average)	71% (similar to national average)	89%
South West Lincolnshire	3,700 (estimated to rise to 7,200 by 2030)	629 (similar to national average)	267 (similar to national average)	68% (similar to national average)	82%

(Source: Data extract from Cancer Commissioning Tool Kit)

United Lincolnshire Hospitals NHS Trust (ULHT) is the primary provider of Cancer Services for Lincolnshire and, on the basis of the number of patients treated, is in the top ten list of cancer treatment providers in England, as shown in Table 2 below.

Table 2 shows the top ten (out of 155) Trusts for the number of patients treated on the 62 Day pathway.

Trust	Total Patients Treated
Leeds Teaching Hospital NHS Trust	1990
University Hospitals of Leicester NHS Trust	1944
East Kent Hospitals University NHS Foundation Trust	1897
Oxford University Hospitals NHS Trust	1878
Nottingham University Hospitals NHS Trust	1822
The Newcastle Upon Tyne Hospitals NHS Trust	1799
Heart of England NHS Foundation Trust	1742
Sheffield Teaching Hospitals NHS Foundation Trust	1706
United Lincolnshire Hospitals Trust	1691
Gloucestershire Hospitals NHS Foundation Trust	1680

(Source: Open Exeter, Jan – Dec 2014)

3. Progress against the key priorities for the Lincolnshire Cancer Improvement Plan

3.1 Screening

Bowel Screening

Bowel screening in Lincolnshire works well. The proportion of people aged 60-74 attending bowel cancer screening in Lincolnshire is 61.2%. This is higher than the East Midlands average 60.3% and higher than the national average of 58.3%.

(Source - Cancer Research UK)

The minimum standard for uptake is 52% and the target is 60%.

Bowel scope screening began in the Louth area and will be phased in across Lincolnshire during the next 3 years (men & women will attend for bowel screening aged 60 years); NHS bowel scope screening is a relatively new test to help prevent bowel cancer. Bowel scope screening is a one-off test offered to men and women at the age of 55. Bowel scope screening or flexible sigmoidoscopy is used to find and remove small growths called polyps from the bowel. Polyps do not usually cause symptoms, but some might turn into cancer if they are not removed.

The Screening & Immunisation Team are working with both Lincolnshire & Leicestershire Screening Teams and both Learning Disability Teams to produce a DVD on bowel scope for people with Learning Disabilities to access the Bowel Scope Screening programme. This will be launched at the end of April 2016.

Cervical Screening

The provision of cervical screening is a complex pathway as it involves a number of different teams / organisations. Women are invited by age band: 25-49 are automatically invited every 3 years. The first invites are sent out at 24 years 6 months. Women aged 50-64 are automatically invited every 5 years.

The Cervical Screening Programme, England Statistics for 2014-15 (published November 2015) reported the following coverage data:

The national standard is 80% coverage.

	25-49 years	**50-64 years**	**25-64 years**
England	71.2%	78.4%	73.5%
East Midlands region	74.3%	80.4%	76.3%
Lincolnshire	74.7%	79.7%	76.5%

Overall Lincolnshire for this reporting period is above the national average for 25-49 year olds and overall for 25-64 years. However, uptake amongst younger women between the ages of (25-34) is better than the national average. This is believed to be linked to the *Pink Pants* campaign facilitated by Early Prevention of Cancer (EPOC).

Finally a key standard for cervical screening is the two week turnaround for all result letters. The national standard is 98≥%, being sent out within 14 days of the cervical screening sample being taken. There was a significant issue with this standard during the summer due to the conversion the laboratory from SurePath Technology to Thin prep technology including sample takers.

This standard is now on track and the latest data from Screening Quality Assurance Service Midlands and East reported that for November 2015; one CCG is at 99%, two are at 97% and one at 95% out of the four.

The Screening & Immunisation Team are supporting key partners to encourage ladies to attend this screening.

Breast Screening

The provision of breast screening is provided by UHL across 3 sites: Lincoln County, Pilgrims (Boston) and Grantham.

Women are invited every 3 years between the ages of 50-71 and importantly women are encouraged to self-refer after the age of 71 by the breast screening unit. There is also a nation breast screening age extension trial for women aged 47-49 and 71-73 which has been rolled out across Lincolnshire. The outcome of this trial will be available in 2020.

The national breast screening annual report from April 2014 – March 2015 will not be available until February 2016. The national standard for coverage is: Minimum standard 70%, target is 80% (for age range 53-70 years). Local unit data for the unit uptake rate for April 2015 – September 2015 (50 – 70 years) is 71% and for October it is 76%.
Finally Higher Risk screening for Lincolnshire women was implemented in September 2015 and women are screened and assessed at Nottingham Breast Screening Unit.

3.2 Access

The NHS Constitution indicates that Patients have the right to access services within maximum waiting times. The standards for cancer services are:

- 14 days – From urgent GP referral for suspected cancer to first appointment
- 31 days – From the decision to treat to the start of treatment
- 62 days – From urgent GP referral for suspected cancer to the first treatment

National Performance

In the 2014/15 Annual report published by NHS England, national performance was reported as follows:

Two week waits (14 days) Target 93%

The percentage of patients who were seen by a specialist within 14 days of being urgently referred for suspected cancer by their GP was 94.2%

The percentage of patients who were seen by a specialist within 14 days of being urgently referred by their GP with exhibited breast symptoms (where cancer was not initially suspected) was 93.3%.

31-day waits for first treatment for all cancers Target 96%

The percentage of patients receiving a first definitive treatment for cancer who began that treatment within 31 days was 97.7%

62-day waits for all cancers Target 85%

The percentage of patients who received a first treatment for cancer within 62 days following an urgent GP referral for suspected cancer was 83.4%.

Local Performance

Whilst the primary provider for Lincolnshire residents is United Lincolnshire Hospitals NHS Trust (ULHT), patients also access services provided by Peterborough and Stamford Hospitals NHS Foundation Trust (PSHFT), Nottingham University Hospitals NHS Trust (NUH), Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) and Queen Elizabeth Hospital, King's Lynn (QEH). Patients with complex needs requiring specialist treatments will be referred to specialist tertiary centres although they may access some of their treatments in local communities.

The average performance from January 2015 – October 2015 for these hospital trusts is as follows. The percentage quoted is for all patients not just for Lincolnshire residents.

	2 week wait	**2 week wait – breast symptomatic**	**31 day – first treatment**	**62 day**
Standard	93%	93%	96%	85%
National Average	93.6%	92.9%	97.3%	81.9%
ULHT	90.2%	79.7%	97.1%	73%
NUH	90.9%	91.1%	96.9%	80.1%
NLAG	97.9%	96.2%	99.7%	85.1%
PSHFT	95.6%	95.8%	99.7%	87.8%
QEH	97.4%	96.3%	98.1%	80.9%

A national improvement programme to support delivery of the 62 day standard was introduced by NHS England in July 2015. Lincolnshire West CCG, as the federated lead for Lincolnshire, has worked closely with ULHT to co-ordinate and facilitate the

local Improvement Plan. The local Plan reflects the discussions at the Cancer Summit in February 2015 and focuses on improvement of services for four main tumours, namely, Lung, Urology, Lower Gastrointestinal and Breast.

To further support the Improvement Plan, ULHT invited the National Intensive Support Team and secured additional service improvement capacity from the East Midlands Strategic Clinical Network.

The key themes of the Improvement Plan are:

- Improve access within 14 days
  - Arrangements for booking patients in Lung, Head & Neck & Lower Gastrointestinal clinics have all been refreshed. Since introducing these new arrangements the standard has not been failed due to lack of capacity.
  - Staff within Urology, Lung and Colorectal teams contact patients directly if the patient is unable to attend the appointment they have been offered and another within target cannot be identified.
  - Additional capacity has been provided to support the breast services.

- Improve access to diagnostic tests:
  - One stop diagnostic clinics have been introduced for patients referred with suspected Lung cancer.
  - Triaged 'Straight to Test' pathways are being introduced for patients suspected of having Lower and Upper Gastrointestinal tumours.

- Review and refresh systems and processes to facilitate efficient management of patients on a cancer pathway:
  - Clinical case management meetings have been established to support patients referred to Urology, Lower GI and Head & Neck.
  - Internal Patient Treatment List (PTL) management arrangements have been reviewed and updated.
  - Operating policies have been updated and relaunched.
  - Multi-disciplinary teams are reviewing their working practises to support timely access to treatment.
  - Strategic Clinical Network Clinical pathways are being implemented both with local teams and colleagues in tertiary centres.

- Recruit to the Lead Cancer Nurse post
  - Lead Cancer Nurse joined the Trust in November 2015.

The impact of the Improvement Plan on performance at ULHT is as follows:

	2 week wait	**2 week wait – breast symptomatic**	**31 day – first treatment**	**62 day**
Standard	93%	93%	96%	85%
National average	93.6%	92.9%	97.3%	81.9%
Year to Date Average	90.2%	79.7%	97.1%	73%
September	88.9%	81.8%	98.4%	70.3%
October	91.8%	87.8%	99.1%	74.1%
November (forecast)	**95.7%**	**93.8%**	**98.6%**	**82%**

3.3 Support for People Affected by Cancer

The impact for patients and their families will vary from person to person. As such the support available in the community is varied and has been largely influenced by the development of self-help groups or through independent initiatives pump primed by Macmillan. An application has been made to Macmillan to fund a Project Manager to work with the patients, their families, cancer specialists, neighbourhood teams, GPs and local communities to develop an integrated menu of services to support recovery.

3.4 Palliative and End of Life Care Services

In July 2008 the Department of Health published a national End of Life Care Strategy. This strategy built on the recommendations outlined in NICE guidance for Supportive and Palliative care but emphasised that effective palliative and end of life care services should be available to all people regardless of location or diagnosis. Given this, a dedicated Palliative and end of life care strategic development group has been established to support the continued improvement of services for people in Lincolnshire.

The work programme has included:

- Re-design of community service provision to provide 24 hour access to specialist support.
- Introduction of EPaCCS [Electronic Palliative Care Coordination Systems] – an IT solution to support access to patients' advanced care plan in all settings.
- Continued provision of education to staff in all settings.
- Contributed to the development of a county wide / cross organisational Do Not Attempt Resuscitation Policy.
- Developing arrangements to facilitate improved access to palliative care medicines in the community.
- Continued development of supportive palliative care services in the community.

3.5 Investment in Modern High Quality Services

In the last year the following new investments have been commissioned:

- A Chemotherapy Bus - The development of Chemotherapy Closer to Home Services in Lincolnshire is being delivered and developed via a Chemotherapy Bus, with the potential to improve patient experience and choice by reducing travel and waiting times for chemo delivery.
  The bus is equipped with 4 chairs, refrigerated storage for drugs, a toilet and a quiet seating area for patients and carers.

Medical, nursing and pharmacy services are provided by ULHT. Two chemotherapy trained nurses are required to staff the unit per day, working on a rotational basis from the chemo suite teams.

29 treatment regimes have been identified that are suitable for delivery in a community setting, risk stratified as 11 low and 18 medium, with initial assessment and first cycle of treatment being made at the main centres.
The mobile unit is currently utilised at Grantham Hospital (and on the Lincoln Hospital site for additional capacity) and a roll out plan is in place now that Louth and Skegness sites have established the electrical coupling required. This plan has been somewhat delayed due to chemotherapy trained staffing shortages.

- A new LINAC machine (to provide radiotherapy treatment) at ULHT, (a second machine is due to become operational in 2016).

4. Continued development of local Cancer services.

The development of Cancer Services is both a local and national priority. The Lincolnshire improvement framework aim to promote and facilitate the development of cancer services in line with the strategy for England "Achieving World Class Cancer Outcomes" which sets out a vision for what patients should expect from the health service.

Our approach will be to build on the improvements that we have made in the last twelve months. The focus will on developing and implementing a work programme that will deliver real and sustainable improvements that are centred on the needs of patients and informed by active engagement of clinicians and other key stakeholders. Our continued success will require us to develop services that are built on strong evidence, promote new ways of working, embrace innovation and recognise the ambition of local clinicians to deliver excellence.

The objectives of our improvement plan will be:

- To work with local communities to increase the number of people who attend the screening programme.
- To develop community services to support people affected by cancer so that they may be partners in their care and treatment, both during and beyond treatment.
- To improve access to diagnostic services in order to support referral to diagnosis in 4 weeks.
- To work with the East Midlands Clinical Network and other partners to support the development and implementation of best practise clinical pathways.
- To continually improve the systems, processes and policies so as to facilitate the proactive management of patients on their cancer pathway.
- To support the continued development of palliative and end of life care services.

During the next six months our key actions are:

- Support continued improved performance against the national waiting time standards.
- Where appropriate support direct access to diagnostic investigations.

- Work with colleagues in public health to gather information that will further support our understanding of issues for the local population.
- Secure funding to support the appointment of a Project Manager to lead the development of community based cancer support services.
- Develop links with tertiary centres to facilitate the review of clinical pathways and where appropriate explore the development of formal alliances.
- Review & consider the Danish model with respect to utilising different diagnostic strategies to facilitate access for patients at high risk of cancer.
- To work with key stakeholders to develop sustained improved access to breast services.

5. Conclusion

Improving cancer services for the people of Lincolnshire remains a top priority. Local plans have been developed to reflect local challenges and the National Cancer Strategy. The key areas of focus include:

- Raising awareness.
- Encouraging people to take up the opportunity of screening.
- Improving access to local services.
- Supporting the continuous improvement of acute cancer treatments, at ULHT, other hospitals used by Lincolnshire people and tertiary centres.
- Promoting the development of services to support people living with and beyond cancer.
- Reinforcing and enabling the continued development of palliative and end of life care services.

6. Background Papers

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

http://www.cancerresearchuk.org/sites/default/files/achieving_world-class_cancer_outcomes_-_executive_summary.pdf

Data extracts from the Cancer Commissioning Toolkit.

This report was written by Sarah-Jane Mills, Director of Development and Service Delivery, NHS Lincolnshire West Clinical Commissioning Group, who can be contacted on 01522 515330 or Sarah-Jane.Mills@Lincolnshirewestccg.nhs.uk

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 NHS England and the Trust Development Authority

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**20 January 2016**
Subject:	**Lincolnshire Recovery Programme**

Summary
The purpose of the Lincolnshire Recovery Programme is to oversee the delivery of the NHS Constitutional Standards; improvements in the quality of care; and actions to address financial balance within the Lincolnshire health economy. There is a monthly Programme Board, whose membership includes:

- all the Accountable / Chief Officers from the four Lincolnshire Clinical Commissioning Groups (CCGs);
- all the Chief Executives from the three main Lincolnshire providers (Lincolnshire Community Health Services NHS Trust; Lincolnshire Partnership NHS Foundation Trust; and United Lincolnshire Hospitals NHS Trust);
- senior officers from NHS England and the Trust Development Authority (TDA); and
- a senior officer from Lincolnshire County Council.

Actions Required:

To consider and comment on the content of the report, in particular focusing on the extent of the positive outcomes of the Lincolnshire Recovery Programme to date.

1. Background

The Lincolnshire Recovery Programme (LRP) has been developed to provide a senior level coordinating programme structure that supports performance improvement and the further development of a clinically safe and financially sustainable health and care model across Lincolnshire.

The aims of the LRP are to: -

- improve United Lincolnshire Hospitals NHS Trust's (ULHT's) performance against the NHS Constitutional standards so that all required targets are achieved;
- continue to improve quality within ULHT and across the health community;
- develop a financial strategy and plan to deliver improvements to the financial position across Lincolnshire; and
- design an underpinning workforce/Organisational Development strategy and plan.

The Lincolnshire Recovery Programme Board is jointly chaired by NHS England and the Trust Development Authority.

NHS England and the Trust Development Authority

NHS England leads the National Health Service (NHS) in England. It sets the priorities and direction of the NHS, for example in strategies such as the *Five Year Forward View.* NHS England is organised into four regional teams. Lincolnshire is in the Midlands and East Regional Team area. The Regional Teams provide support to Clinical Commissioning Groups (CCGs), in areas such as healthcare commissioning and delivery; they provide professional leadership on finance, specialised commissioning, human resources and organisational development. In addition to working with CCGs, the Regional Teams work closely with local authorities, health and wellbeing boards as well as GP practices.

The NHS Trust Development Authority (TDA) is responsible for providing leadership and support to the non-Foundation Trust sector of NHS providers, currently 86 NHS Trusts. The TDA has four key functions:

- Monitoring the performance of NHS Trusts, and providing support to help them improve the quality and sustainability of their services
- Assurance of clinical quality, governance and risk in NHS Trusts
- Supporting the transition of NHS Trusts to Foundation Trust status
- Appointments to NHS Trusts of chairs and non-executive members and trustees for NHS Charities where the Secretary of State has a power to appoint.

With effect from April 2016, the TDA will merge with Monitor, whose role includes the regulation and performance management of NHS Foundation Trusts, to form a new organisation, which will be called NHS Improvement.

Purpose of the Lincolnshire Recovery Programme Board

1. To oversee achievement of the programme aims for an initial period of twelve months from July 2015, after which time those responsible for health and care system delivery will be in a position to no longer require this level of intervention.

2. To agree a programme structure that holds senior leadership from all represented organisations to account and oversee high level intervention and support.

3. To ensure that the boards of each organisation represented are signed up to the LRP aims and programme structure.

4. To accept recommendations from the Operational Programme Group with regards to the scope and expected outcomes from the programme work streams.

5. To act upon exception reports and items for escalation from the Operational Programme Group, in order to ensure the programme aims are achieved.

6. To ensure that dependency issues between the LRP and the Lincolnshire Health and Care (LHAC) Programme are managed in a manner that avoids duplication between the programmes or adverse impacts on either programme.
7. To identify the need for additional support to facilitate achievement of the Programme aims and agree approaches for securing the support.

2. Conclusion

Outcomes of the programme to date include:

1. The delivery of the Referral to Treatment (RTT) incomplete standard of 92%. *(The Department of Health introduced this operational standard from April 2012 onwards. Incomplete pathways are the waiting times for patients waiting to start treatment at the end of the month. These are also often referred to as waiting list waiting times and the volume of incomplete RTT pathways as the size of the RTT waiting list.)*

2. ULHT is on track to deliver the 62 day cancer standard with a 12% improvement from 70% achievement (Sept) to 82% (Nov) against a national standard of 85%.

3. The A&E standard (95% within 4 hours) varies by site and is the subject of intense support from all parties. A revised trajectory for delivery is being developed. Current year to date delivery is 88%.

4. ULHT is currently forecasting a deficit position of £59 million against a planned deficit of £40 million, which is a £19 million adverse variance. The system is developing plans to be presented to the LRP Board on 8 January 2016 to address the current deficit position.

5. The LHAC programme also reports on progress to the LRP, although this is subject to a separate governance and decision making structure.

3. Consultation

This is not a 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 Jim Heys, NHS England, Locality Director – Midlands and East (Central Midlands) and Jeff Worrall, Portfolio Director, Trust Development Authority, who can be contacted via Jim.Heys@nhs.net and Jeff.Worrall@nhs.net

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:	**20 January 2016**
Subject:	**Delivering the Forward View: NHS Planning Guidance 2016/17 – 2020/21**

Summary:

On 22 December 2015, NHS England, NHS Improvement (Monitor and the Trust Development Authority) and other NHS national organisations published *Delivering the Forward View*: *NHS Planning Guidance 2016/17 – 2020/21*, which sets out the expectations for all local health systems to deliver the NHS Five Year Forward View. In addition to the Government's Mandate to NHS England, there is requirement for nine "Must Do's", which each local health system must deliver during 2016/17.

The Committee is requested to consider *Delivering the Forward View*: *NHS Planning Guidance 2016/17 – 2020/21* in the context of the development of its work programme over the coming months.

Actions Required:

The Committee is invited to consider *Delivering the Forward View*: *NHS Planning Guidance 2016/17 – 2020/21*and to bear the document in mind as it considers its work programme over the coming months.

1. Background

On 22 December 2015, *Delivering the Forward View*: *NHS Planning Guidance 2016/17 – 2020/21* was published. The guidance was prepared by NHS England, NHS Improvement (Monitor and the Trust Development Authority), the Care Quality Commission, Health Education England, the National Institute of Health and Care Excellence and Public Health England. Building on the NHS Five Year Forward

View, *NHS Planning Guidance 2016/17 – 2020/21* requires two connected plans from the local NHS:

- A five year Sustainability and Transformation Plan (STP)
- A one year Operational Plan for 2016/17

Delivering the Forward View: *NHS Planning Guidance 2016/17 – 2020/21* states that this planning process has been put forward to execute three interdependent tasks:

- implementing the Five Year Forward View;
- restoring and maintaining financial balance; and
- delivering core access and quality standards for patients.

Additionally, the guidance report expands by setting out nine 'must dos' priorities for 2016/2017 for every local system.

Finally, the report also outlines the financial implications and expectations over the next few years, with transformation funding, allocations, financial balance, efficiency assumptions and business rules all included within the document.

Delivering the Forward View: *NHS Planning Guidance 2016/17 – 2020/21* is available at the following link:

https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf

2. Sustainability and Transformation Plans (STPs)

Health and Care systems have been asked to come together and create their own ambitious local blueprint which will enable the implementation of the Forward View. Sustainability and Transformation Plans (STPs) will cover the period between October 2016 and March 2021, and will be subject to formal assessment in July 2016 following their submission in June 2016.

The most important initial task of the STP is to create a clear overall vision and plan for each area, including a local financial sustainability plan. Sustainability and Transformation Plans will require "strong place-based planning with system leadership and an open process inclusive towards all areas of CCG and NHS England commissioning activities." The STPs will become the single application and approval process for being accepted onto programmes with transformational funding for 2017/18 onwards.

The Spending Review provided additional dedicated funding streams for transformational change, building up over the next five years. This protected funding is for initiatives such as the spread of new care models through and beyond the vanguards, primary care access and infrastructure, technology roll-out, and to drive clinical priorities such as diabetes prevention, learning disability, cancer and mental health.

Many of these streams of transformation funding form part of the new wider national Sustainability and Transformation Fund (STF). The most compelling and credible STPs will secure the earliest additional funding from April 2017 onwards.

The STP will be the 'umbrella plan', holding underneath it a number of different specific delivery plans. The first critical task is for local health and care systems to consider their transformation footprint – the geographic scope of their STP. They must make proposals by Friday 29 January 2016, for national agreement, after consultation with local authorities.

3. National Must Do's

Delivering the Forward View: *NHS Planning Guidance 2016/17 – 2020/21* outlines its ambitions for the next few years. There is a goal that by March 2017, 25% of the population will have access to acute hospital services that comply with four priority clinical standards on every day of the week and 20 percent of the population will have enhanced access to primary care.

Moreover, it sets the target of dealing with the main challenges posed by the seven day services which include reducing excess deaths by increasing the level of consultant cover and diagnostic services available in hospitals at weekends; improving access to out of hours care; and improving access to primary care at weekends and evenings.

The nine "Must do's" for 2016/17 for every local system are as follows:

1. Develop a high quality and agreed **STP**, and subsequently achieve what you determine are your most locally critical milestones for accelerating progress in 2016/17 towards achieving the triple aim as set out in the **Forward View**.

2. Return the system to **aggregate financial balance**. This includes secondary care providers delivering efficiency savings through actively engaging with the Lord Carter provider productivity work programme and complying with the maximum total agency spend and hourly rates set out by NHS Improvement. CCGs will additionally be expected to deliver savings by tackling unwarranted variation in demand through implementing the RightCare programme in every locality.

3. Develop and implement a local plan to address the **sustainability and quality of general practice**, including workforce and workload issues.

4. Get back on track with **access standards for A&E and ambulance waits**, ensuring more than 95 percent of patients wait no more than four hours in A&E, and that all ambulance trusts respond to 75 percent of Category A calls within eight minutes; including through making progress in implementing the urgent and emergency care review and associated ambulance standard pilots.

5. Improvement against and maintenance of the NHS Constitution standards that more than 92 percent of patients on non-emergency pathways wait no

more than 18 weeks from **referral to treatment**, including offering patient choice.

6. Deliver the NHS Constitution **62 day cancer waiting standard**, including by securing adequate diagnostic capacity; continue to deliver the constitutional two week and 31 day cancer standards and make progress in improving **one-year survival rates** by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.

7. Achieve and maintain the **two new mental health access standards**: more than 50 percent of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral; 75 percent of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within six weeks of referral, with 95 percent treated within 18 weeks. Continue to meet a **dementia diagnosis** rate of at least two-thirds of the estimated number of people with dementia.

8. Deliver actions set out in local plans to transform care for people with **learning disabilities**, including implementing enhanced community provision, reducing inpatient capacity, and rolling out care and treatment reviews in line with published policy.

9. Develop and implement an affordable plan to make **improvements in quality** particularly for organisations in special measures. In addition, providers are required to participate in the annual publication of **avoidable mortality** rates by individual trusts.

4. Operational Plans 2016/2017

Delivering the Forward View: *NHS Planning Guidance 2016/17 – 2020/21* states that a primary task for local system leaders is to run a "shared and open-book operational planning process for 2016/17". All of these plans will need to include:

- how they intend to reconcile finance with activity (and where a deficit exists, set out clear plans to return to balance);
- their planned contribution to the efficiency savings;
- their plans to deliver the key must-dos;
- how quality and safety will be maintained and improved for patients;
- how risks across the local health economy plans have been jointly identified and mitigated through an agreed contingency plan; and
- how they link with and support with local emerging STPs.

5. Funding Allocations

NHS Planning Guidance 2016/17 – 2020/21 states that NHS England's allocations to commissioners are intended to achieve:

- greater equity of access through pace of change, both for CCG allocations and on a place-based basis;
- closer alignment with population need through improved allocation formulae including a new inequalities adjustment for specialised care, more sensitive adjustments for CCGs and primary care, and a new sparsity adjustment for remote areas; and
- faster progress with strategic goals through higher funding growth for GP services and mental health, and the introduction of the Sustainability and Transformation Fund

In line with their strategic priorities, overall primary medical care spend will rise by 4-5 percent each year. Specialised services funding will rise by 7 percent in 2016/17, with growth of at least 4.5 percent in each subsequent year. The relatively high level of funding reflects forecast pressures from new NICE legally mandated drugs and treatments.

To support long-term planning, NHS England has set firm three year allocations for CCGs, followed by two indicative years. For 2016/17, CCG allocations will rise by an average of 3.4 percent, and the report outlines the promise that no CCG will be more than five per cent below its target funding level.

To provide CCGs with a total place-based understanding of all commissioned spend, alongside allocations for CCG commissioned activities, they will also publish allocations for primary care and specialized commissioned activity. NHS England will in principle support any proposals from groups of CCGs, particularly in areas working towards devolution who wish to implement a more accelerated cross-area pace-of-change policy by mutual agreement.

6. Returning to a Financial Balance

During 2016/17 the NHS trust and foundation trust sector will be required to return to financial balance. £1.8 billion of income from the 2016/17 Sustainability and Transformation Fund will replace direct Department of Health (DH) funding. Quarterly release of these Sustainability Funds to trusts and foundation trusts will depend on achieving recovery milestones for:

- deficit reduction;
- access standards; and
- progress on transformation.

Delivering the Forward View: *NHS Planning Guidance 2016/17 – 2020/21* states that Trusts need to focus on cost reduction not income growth; and there needs to be far greater consistency between trusts' financial plans and their workforce plans in 2016/17. Workforce productivity will therefore be a particular priority as just a one per cent improvement represents £400 million of savings.

Capital investments proposed by providers should be consistent with their clinical strategy and clearly demonstrate the delivery of safe, productive services with a business case that describes affordability and value for money.

Given the constrained level of capital resource available from 2016/17, there will be very limited levels of financing available and the repayment of existing and new borrowing related to capital investment will need to be funded from within the trust's own internally generated capital resource in all but the most exceptionally pre-agreed cases.

2. Conclusion

The Committee is invited to consider *Delivering the Forward View*: *NHS Planning Guidance 2016/17 – 2020/21*and to bear the document in mind as it considers its work programme over the coming months

3. Consultation

This is not a 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 Simon Evans, who can be contacted on 01522 553607 or via Simon.Evans@lincolnshire.gov.uk

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

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

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**20 January 2016**
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

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 Paul Martin, HQ Manager and Treasurer, Lincolnshire Integrated Voluntary Emergency Service Stephen Hyde, Marketing and Fundraising Officer, Lincolnshire Integrated Voluntary Emergency Service	Status Report
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 NHS England – Midlands and East (Central Midlands) Jeff Worrall, Portfolio Director, NHS Trust Development Authority	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

17 February 2016		
Item	**Contributor**	**Purpose**
Adult Psychology Service – Developments in Provision	Dr John Brewin, Chief Executive, Lincolnshire Partnership NHS Foundation Trust (to be confirmed)	Status Report
Lincolnshire Partnership NHS Foundation Trust – Draft Clinical Strategy 2016-17	Chris Higgins, Deputy Director of Strategy and Business Planning, Lincolnshire Partnership NHS Foundation Trust	Consultation
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 (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
Universal Health Ltd: Four Lincolnshire GP Surgeries	Dr John Brewin, Chief Executive, Lincolnshire Partnership NHS Foundation Trust A Representative from Lincolnshire and District Medical Services Ltd	Status Report
Urgent Care – Constitutional Standards Recovery and Winter Resilience	Sarah Furley, Urgent Care Programme Director, Lincolnshire East Clinical Commissioning Group	Update Report

16 March 2016		
Item	**Contributor**	**Purpose**
St Barnabas Hospice – Palliative Care and End of Life Care	Chris Wheway, Chief Executive, St Barnabas Hospice Trust	Status Report
South Lincolnshire CCG Update	Caroline Hall, Acting Chief Officer, South Lincolnshire Clinical Commissioning Group	Update Report

20 April 2016		
Item	**Contributor**	**Purpose**
Boston West Hospital	Carl Cottam, General Manager, Boston West Hospital. Sue Harvey, Matron, Boston West Hospital.	Status Report

18 May 2016		
Item	**Contributor**	**Purpose**

Items to be programmed

- 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
- Lincolnshire West CCG Update on Delegated Commissioning

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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