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, 17 February 2016 at 10.00 am in Committee Room One, County Offices, Newland, Lincoln LN1 1YL

MEMBERS OF THE COMMITTEE

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

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

Healthwatch Lincolnshire: Dr B Wookey

AGENDA

Item	Title	Pages
6	**Universal Health Ltd: Primary Care Practices in Lincoln, Metheringham and Gainsborough** *(To receive a report from Jane Marshall (Director of Strategy – Lincolnshire Partnership NHS Foundation Trust) which provides an update on the services running at GP Practices recently awarded under contracts from NHS England East to Universal Health Ltd. Dr John Brewin (Chief Executive – Lincolnshire Partnership NHS Foundation Trust) and Jane Marshall (Director of Strategy – Lincolnshire Partnership NHS Foundation Trust) will be in attendance for this item)*	49 - 52
7	**United Lincolnshire Hospitals NHS Trust Improvement Portfolio** *(To receive a report from Jan Sobieraj (Chief Executive – United Lincolnshire Hospitals NHS Trust) which provides an update on progress against ULHT Improvement Portfolio and gives an overview of action being taken where risks and issues have been identified. The report also describes the governance arrangement which have been put in place. Jan Sobieraj (Chief Executive – United Lincolnshire Hospitals NHS Trust) will be in attendance for this item)*	53 - 60
	LUNCH 1.00pm – 2.00pm	
8	**Healthwatch Lincolnshire Mental Health Report (November 2015)** *(To receive a report from Sarah Fletcher (Chief Executive – Healthwatch Lincolnshire), which sets out the final report from Healthwatch Lincolnshire on Mental Health Services published in November 2015. The report captures the key themes and promotes the voice of the service user to support the awareness of mental health and the need for improvement of services. Sarah Fletcher (Chief Executive – Healthwatch Lincolnshire) will be in attendance for this item)*	61 - 100
9	**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)*	101 - 106

Tony McArdle
Chief Executive
9 February 2016

HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE
20 JANUARY 2016

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), B Bilton (City of LIncoln Council), Mrs P F Watson (East Lindsey District Council), K Cook (North Kesteven District 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

Mark Brassington (Chief Operating Officer – United Lincolnshire Hospitals NHS Trust), Andrea Brown (Democratic Services Officer), Dr Kakoli Choudhury (Consultant in Public Health Medicine), Simon Evans (Health Scrutiny Officer), Ian Hall (Senior Delivery and Development Manager - Trust Development Authority), Jim Heys (Locality Director Midlands and East (Central Midlands) - NHS England), Andy Hill (Lincolnshire Divisional Manager - EMAS), Stephen Hyde (Marketing and Fundraising Manager - LIVES), Gary James (Accountable Officer – Lincolnshire East CCG), Steve Kennedy (EMAS), Sarah Jane Mills (Director of Development and Services Delivery – Lincolnshire West CCG) Lynne Moody (Director of Quality and Executive Nurse – South Lincolnshire CCG), Dr Simon Topham (Clinical Director – LIVES)

County Councillor B W Keimach attended the meeting as an observer.

71 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

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

The Chief Executive reported that under the Local Government (Committee and Political Groups) Regulations 1990, he had appointed Councillor B Bilton to the

Committee in place of Councillor J Kirk (City of Lincoln Council) and Councillor K Cook in place of Councillor T Boston (North Kesteven District Council) for this meeting only.

Councillor Mrs S Ransome indicated that she would have to leave the meeting at approximately 2.30pm.

The Chairman reminded the Committee that should a Replacement Member be appointed at a meeting they would then be the Member for that meeting. Should the substantive Member join the meeting at a later time, they would be welcome but as an observer only.

72 DECLARATIONS OF MEMBERS' INTERESTS

In relation to Item 7 – *Cancer Services in Lincolnshire*, Councillor G Gregory advised that he was currently serving part of the cancer service (colon cancer) as part of his paid employment with United Lincolnshire Hospitals NHS Trust but felt that this discussion did not relate to his pecuniary interest.

Councillor Mrs P F Watson advised that she was a patient receiving cancer services but would remain for the discussion at Item 7 – *Cancer Services in Lincolnshire*.

Councillor S L W Palmer declared an interest in Item 7 – *Cancer Services in Lincolnshire* as a former patient receiving cancer services within the county.

In relation to Item 5 – *East Midlands Ambulance Service (EMAS) – Improvements and Performance* and Item 6 – *Lincolnshire Integrated Volunteer Emergency Service (LIVES),* Councillor S L W Palmer advised that he was a first responder and coordinator of the LIVES Sutton on Sea Group. When called out, he was active under EMAS.

In relation to Item 7 – *Cancer Services in Lincolnshire,* the Chairman, Councillor C A Talbot, advised that her daughter had received cancer treatment from United Lincolnshire Hospitals NHS Trust (ULHT) twice within the last ten years and had written with her concerns about the treatment received in 2015.

73 CHAIRMAN'S ANNOUNCEMENTS

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

i) Norovirus at Lincoln County Hospital

At various times over recent weeks, several wards at Lincoln County Hospital had been closed to new admissions owing to an outbreak of the norovirus. It was reported that of 15 January 2016, the norovirus outbreak at Lincoln County was declared over as there had not been any associated cases reported for 72 hours. Although three wards were still affected, these were being cleaned and would be fully open within the next few days.

ii) Lincolnshire Community Health Services NHS Trust – Meeting

On 11 January 2016, the Chairman met with Elaine Baylis (Chairman) and Andrew Morgan (Chief Executive) of Lincolnshire Community Health Services NHS Trust (LCHS). Several issues were discussed including progress with the Trust's application for Foundation Trust status. It was understood that the predicted date for the Trust's authorisation and establishment as a Foundation Trust would be late 2016.

Two changes to senior management had been made at LCHS: Danni Cecchini had been appointed as the permanent Director of Finance and Lisa Green had been appointed as Director of Nursing and Operations in place of Sue Cousland, who retired in December 2015.

iii) Healthwatch Lincolnshire – 17 February 2016

The Chief Executive of Healthwatch Lincolnshire, Sarah Fletcher, had contacted the Chairman regarding the content of the item from Healthwatch scheduled for consideration at the Committee on 17 February 2016. It was suggested that the report be an overall Mental Health Report from Healthwatch rather than having a CAMHS focus and to give consideration to CAMHS later in the year.

iv) East Midlands Congenital Heart Centre – Stakeholder Meeting

The first local authority stakeholder meeting of the year for the East Midlands Congenital Heart Centre took place on 14 January 2016 at Glenfield Hospital in Leicester. The Chairman was unable to attend the meeting but advised that NHS England had found overlap in the geographical areas where congenital surgical centres intended to provide a service. In order to address this, NHS England were to divide the country up into 'parts' and then ask the centres to bid for areas to which they wanted to provide the service.

The East Midlands Congenital Heart Centre continued to work towards the national standards. For example, they were on track to complete approximately 330 cases in the coming year; to co-locate their congenital heart services with all other children's services by 2019; and to have four surgeons, each undertaking 125 procedures per annum by 2021. The next stakeholder meeting was scheduled for 17 March 2016.

A full report would be circulated to the Committee.

v) Lincolnshire Integrated Volunteer Emergency Service (LIVES) – Appointment of Chief Executive

Lincolnshire Integrated Volunteer Emergency Service (LIVES) had announced the appointment of their first full-time Chief Executive Officer. Nikki Silver would take up the position with effect from 2 April 2016. Nikki was previously the Deputy Director of Operations, Family and Healthy Lifestyle and Urgent Care at Lincolnshire Community

Health Services NHS Trust (LCHS) and had previously presented to the Committee on 20 May 2015 on School Nursing and Health Visiting services.

vi) United Lincolnshire Hospitals NHS Trust (ULHT) – Appointment of Chairman

At the last meeting of the Committee it was report that Ron Buchanan would retire as Chairman of United Lincolnshire Hospitals NHS Trust in March 2016. The Chairman had been invited to attend a stakeholder event on 21 January 2016 to meet applicants for the Trust's new Chairman. The Chairman would then be asked to provide feedback to the panel prior to the formal interviews.

vii) Hospice within a Hospital, Grantham

The Chairman had been invited to attend the formal opening of the Hospice within a Hospital in Grantham on 21 January 2016. The Hospice was to be opened by the actor, Warwick Davis. Unfortunately, this event coincided with a stakeholder event at Pilgrim Hospital which the Chairman would attend and therefore this invitation had been, regretfully, declined.

viii) Special Care Dentistry Engagement Briefing Report

On 21 December 2015, NHS England Central – East Midlands issued a briefing paper to the Health Scrutiny Committee on Special Care Dentistry. Special Care Dentistry was concerned with the oral health of individuals with a physical, sensory, medical, emotional or social impairment or disability. The briefing paper reported the findings of an engagement exercise with patients during 2015 and would inform NHS England's procurement of the service in the coming year. The Chairman highlighted the fact that engagement activity found that the majority of respondents confirmed that the existing services exceeded their expectations.

The briefing paper would be circulated to the Committee.

ix) Acute Trust Financial Position

Recent coverage in the national press had highlighted the financial challenges faced by acute hospital trusts. The Chairman had requested research be undertaken and had found that, based on figures available in December 2015, the six acute trusts most used by Lincolnshire residents were, between them, predicting a deficit in the current financial year of £220 million. United Lincolnshire Hospital NHS Trust predicted a deficit of £59.9 million which comprised the largest single element of the total. This remained a concern but the Committee looked forward to hearing how these financial challenges could be addressed in the coming year.

The paper would be circulated to the Committee.

x) Delivering the Forward View: NHS Planning Guidance 2016/17 – 2020/21

A key document had been published on 22 December 2015 entitled: *Delivering the Forward View: NHS Planning Guidance 2016/17-2020/21*. The Chairman had

requested a specific report to be prepared on this document and this would be considered by the Committee at Item 9 of the agenda. It was expected that several aspects of the document would affect the future work programme of the Committee.

74 MINUTES OF THE MEETING OF THE COMMITTEE HELD ON 16 DECEMBER 2015

RESOLVED

That the minutes of the meeting held on 16 December 2015 be approved and signed by the Chairman as a correct record.

75 EAST MIDLANDS AMBULANCE SERVICE (EMAS) - IMPROVEMENTS AND PERFORMANCE

A report by Sue Noyes (Chief Executive of East Midlands Ambulance Service NHS Trust) was considered which outlined the key areas of performance within the East Midlands Ambulance Service (EMAS) and, in particular, the Lincolnshire Division. The report included an update on the work and ongoing projects being carried out to enhance and support performance.

Andy Hill (Lincolnshire Divisional Manager – EMAS) and Steve Kennedy (Divisional Support Manager – EMAS) were in attendance for this item of business.

Members were given an overview of the report which provided Quarter Two Performance Data (July, August and September 2015). It was also reported that the Care Quality Commission (CQC) had inspected EMAS in November 2015, the outcomes of which were expected in early 2016.

It was reported that the Lincolnshire Division had achieved the Red 1 target for the quarter (76.56%). This had been challenging with the Division falling short of the required target by 1.44%. Handover delays at hospitals were detailed in Table 2 of the report but it was stressed that these figures were subject to validation. Overall activity in comparison to Quarter Two in 2014/15 had increased by 6%

EMAS had noted that inter facility transfers (IFTs) from Grantham and District Hospital had increased by 23% compared to 2014/15. In order to establish the reason for the increase a review was being undertaken. The review would also identify what actions would be required to mitigate impact on performance in the South Lincolnshire and South West Lincolnshire CCG areas. Once the review was complete, the findings would be made available to the Committee.

Close working with United Lincolnshire Hospitals NHS Trust (ULHT) had resulted in proactive management of handover delays although this remained an ongoing issue which was being reviewed as part of the Recovery Plan for ULHT. December 2015 saw the deployment of a clinical navigator by the Division to Pilgrim Hospital which was to liaise with ULHT staff to efficiently signpost patients thereby freeing up EMAS resources to respond to other calls. The impact of this initiative would be reported to the Committee once available. It was confirmed that Hospital Ambulance Liaison

Officers (HALOs) would also continue to be deployed to all sites where pressures were identified.

An EMAS Healthwatch Task Group had been formed between the Trust and Healthwatch Lincolnshire to consider and act upon initiatives in response to local need. Engagement with both System Resilience Groups (SRGs) and Urgent Care Working Groups was well established with representation and participation being regular and inclusive. Unique initiatives with partner organisations, including CCGs, Integration Executive, Local Resilience Forum (LRF) and others were congoing in support of the improvements necessary for the wider Lincolnshire health economy.

The following initiatives had been developed to improve service and performance:-

- 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, Boston; and
- Addressing patient handover delays within the acute trusts.

In relation to the Joint Ambulance Conveyance Project (JACP) Project Data, Lincolnshire Fire & Rescue (LFR) and EMAS had developed a pilot project aimed at improving the quality of service and outcomes for patients in Lincolnshire. The project had built 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 responded to medical emergencies, delivered first aid, provided oxygen therapy and administered defibrillation and cardiopulmonary resuscitation.

The Fleet Services Strategy was agreed by the EMAS Board in March 2015 and highlighted the case for investment in the EMAS fleet to respond to a range of challenges. A commitment had been made to invest between £19m - £24m over the next five years on new vehicles and would ensure that the age profile of the fleet was reduced to seven years by the end of the financial year 2018/19.

The allocation of ambulances to the Lincolnshire Division had been identified from the age profile of all ambulances within the fleet. Lincolnshire received 46% (37 of 80 acquired) of the new vehicles in 2012 therefore did not have the same aging vehicles as other Divisions.

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

- It was noted that the figures reported in South Lincolnshire were of concern to the Committee. This was acknowledged and explained that there had been 600 hours of resource drift in December 2015 alone for DCA's and solo responders. Work was ongoing to rectify this situation and to more

appropriately utilise the resources available. Specific information on the resource drift in December would be provided to the Committee;

- Turnaround times and delays in hospitals all impacted on response time and in the south of the county in particular. There had been a recruitment drive but the benefit of this would not be felt until mid-March 2016 due to the requirement for newly appointed staff to undergo 750 hours of supernumerary training;
- There had been an increase in handover delays at each of the sites although had seen success at Pilgrim Hospital following the appointment of the Clinical Navigator. This role was designed to detect certain clinical conditions of patients conveyed to hospital and make preparations to avoid the A&E department and transfer immediately to an appropriate ward. It was stressed that this role was navigational but had appeared to have a tremendous amount of success;
- The Clinical Navigator role was not a duplication of the HALO role which had been an ad hoc position which was put in place to support the hospitals. The Clinical Navigator was a new role designed to proactively manage delays;
- Red calls coming through to EMAS from other sources were unable to be downgraded and this had been reflected in a change to the Ambulance Quality Indicators (AQI);
- Figures were requested regarding the number of 111 calls resulting in unnecessary conveyance to A&E. EMAS representatives felt that this information should be available and would take this as an action point to provide to the Committee following the meeting;
- Hear and Treat was a telephony based treatment system that enabled management of lower priority calls, which often resulted in the despatch of a vehicle not being required;
- It was confirmed that the maximum number of ambulances available during peak times was 48 within Greater Lincolnshire with approximately 10 in the East of the County. Shifts were 12 hours from 0630 to 1830hrs and 1830 to 0630hrs. In addition to these ambulances, a further 12 were available to be tied in. Ringfencing vehicles would be difficult but EMAS also had a Clinical Assessment Car and a Mental Health Car in the County which assisted in the appropriate utilisation of resources;
- LIVES were acknowledged and applauded for their voluntary support of the scheme which was reported as a model envied across other ambulance services across the country. It was a model to be nurtured and embellished and rolled out further;
- In relation to the Toughbooks, it was explained that it was a robust working environment so they do suffer some knocks. Despite this, it was acknowledged that the tag system wasn't adequate for the needs of the ambulance service. The new equipment incorporated a different system to the tags, further to hardware development, which was a positive step forward. The model in the south was to be rolled out to the north west and east of the County;
- The table shown at 2.2 on page 27 of the report showed the Quarter 2 performance figures for JACP. The figures were combined data and a full breakdown would be sent to the Committee following the meeting;

- Clarification of the figures in table 1 was provided. RED1 and RED2 data was outcome data which was able to be shared. 95% was the conveyance target with 75% as the response time target. In terms of the survival figures for those calls against national benchmarks, 8 minutes was a target set nationally and there was a lot of ongoing work to ensure allocation of the right response and despatch to that call. Details of this work would also be shared with the Committee following the meeting;
- A job advertisement was currently out, from Lincolnshire Community Health Services (LCHS) for two full-time Clinical Navigators in Lincoln and Boston. The ambulance service was current covering these roles and a meeting was scheduled to discuss the roles in greater detail. Although there was no tangible data of the impact of these roles at present, anecdotal feedback had been positive;
- A&E handover times at Grimsby were a concern for residents in the East Lindsey district. This was acknowledged that a Clinical Navigator would benefit Grimsby but this would be dealt with by the processes North East Lincolnshire;
- Within planning, winter pressures were considered. Rotas needed to be flexed to utilise staff over those particular months. At peak times road accidents become a huge cost to EMAS which was not necessarily as a result of the weather but the increased activity on the roads. EMAS was working with local road safety partnerships to ascertain why the activity had increased;
- Concern was raised about the performance figures and asked how Lincolnshire was performing in relation to other areas within the East Midlands. Other areas in the East Midlands were experiencing the same issues and problems but Lincolnshire appeared to be the highest performing division within EMAS currently, having held its year-to-date RED1 target;
- Although the figures within the South Lincolnshire CCG area were down to 50%, that was a measurement on two jobs alone, one target was reached, the other was not. With such low numbers to measure, the percentage will always be fairly low but it was also stressed that although performance and percentage were important, quality of the service provided was key;
- A suggestion was made to utilise NSL Ambulances (Human Touches) to assist with Inter Facility Transfers (IFT). This was felt to be a valid suggestion as NSL was currently contracted to do non-emergency work. Dedicated Transfer Crews were currently being considered but EMAS would like to run that from their own workforce rather than utilise third parties due mainly to the cost involved but this did highlight the need for dedicated IFT crews;
- The figures throughout the report show the response time of the first person to respond to the call rather than when an ambulance arrived. A breakdown of the data from the arrival of the first responder to the time of arrival of an ambulance capable of conveying the patient was requested;
- "Other Conveyances" on page 27 of the report included figures of self-conveyance but also where third parties had conveyed patients to hospital;
- For future reports, it was requested that Kings Lynn hospital be included within the figures as patients from the South Holland area were often taken to this hospital for treatment;

- In relation to the Recovery Programme at ULHT, the Chief Executive of EMAS had a seat on the Lincolnshire Recovery Board and was proactively supporting the trust with Pathfinder and Clinical Navigators to reduce the amount of patients being taken in. The Chairman requested that this information be included within the report from EMAS for the next scheduled update;
- The work between Healthwatch Lincolnshire and EMAS regarding the potential initiatives of local needs was in the early stages but there was an intention to develop a formal protocol for this. The Chairman requested the findings from this task group be presented to the Committee;
- A number of unique initiatives were mentioned in the report and these were further explained as continued work with CCGs and community teams in terms of projects; paramedics on bikes; Clinical Navigators, etc. Also an Alliance Agreement with CAS was a key piece of work;
- The Committee acknowledged that there was a lot of positive activity but requested the outcomes of the activity.

RESOLVED

1. That the report and comments be noted; and
2. That a further update be scheduled for the meeting of the Health Scrutiny Committee for Lincolnshire on 20 April 2016.

76 LINCOLNSHIRE INTEGRATED VOLUNTEER EMERGENCY SERVICE (LIVES)

A report by Lincolnshire Integrated Volunteer Emergency Service (LIVES) was considered which gave information on the emergency response service, provided by trained volunteers, to medical emergencies throughout Lincolnshire. The service supported the services provided by the East Midlands Ambulance Service as the statutory ambulance service provider.

Dr Simon Topham (Clinical Director – LIVES) and Stephen Hyde (Marketing and Fundraising Manager – LIVES) were both in attendance for this item.

Dr Topham gave a presentation to the Committee which included the following slides:-

- Who are we?;
- Charitable Aims;
- What does this look like?;
- Activity and Performance;
- LIVES Calls (Making a Difference);
- So you short up EMAS then?;
- Finance;
- Clinical Governance;
- LIVES New in the Last Year;
- LIVES The Future;
- Challenges;
- Summary.

The charitable objectives of LIVES were:-

> *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 were over 160 responder groups across Lincolnshire, with approximately 700 active LIVES Community First Responders (CFRs) and LIVES Medics.

LIVES 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 offered skills appropriate to their level of professional. The highest level medic members were 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");
- 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.

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

- Congratulations were given to LIVES for the successful defibrillation rates;
- LIVES had not needed to recruit actively over the last three years as numbers had been maintained. There was a cost to recruitment and funds were limited so could only expand the service when funds allowed. In relation to medics, volunteers were only accepted who were in certain areas of needs to ensure better coverage;
- The resilience of individuals within their own home was not necessarily what happened within an acute situation. Having shadowed a paramedic, it was found that repeat visits were made to the same house for the same reason therefore an acknowledgement that services need to increase communications to ensure better utilisation of resources;

- A suggestion that District Councils may be able to support recruitment of volunteers in their own areas was welcomed. It was reported that the south of the county was a particularly challenging area where new responders were needed;
- During the presentation, LIVES reported that they had responded to 9.3% of all EMAS Red1 calls in Lincolnshire which contradicted the figures quoted by EMAS during their presentation. The Committee requested that the Health Scrutiny Officer seek clarification from both organisations;
- The First Responders were deployed by the Emergency Centre at Bracebridge Heath on contact by the ambulance service so they were aware of the level of responder required and attending the scene. It was explained that if a level 3 responder was deployed but the administration of drugs was required (which only level 4 and up would carry) then they would look to have an EMAS responder go earlier;
- Although first on the scene, responsibility for that patient would be handed over to a medic and finally to an EMAS employed member of staff. If the responder was a doctor they would have a duty of care under the General Medical Council (GMC) to ensure that the patient received the best possible care available;
- Community responders carried adrenaline from level 3 and up;
- There were 28 level 4 responders throughout the county, 17 of which were medics. Level 1 was an introduction to the service so volunteers moved to level 2 within a matter of weeks and these responders provided defibrillation, oxygen therapy and life support. Level 3 responders had additional skills, for example they were trained in attending Road Traffic Collisions;
- The membership had been surveyed to ask for indications of particular interest of care provision so that responders were allocated appropriately for their level of confidence. 180 volunteers had indicated that they wanted to be CAS responders but there was a degree of frustration due to telephony and technology issues for CAS. Should responder be on a CAS call but a RED calls comes in to their area, they would give apologies to the CAS call and attend the RED call, returning to the CAS call afterwards;
- Congratulations were given on the new scheme of engaging with and teaching Year 10 students in Lincolnshire emergency procedures. The training was for bystander CPR within LIVES following successful trials in Sweden, where it was proven that 15/16 year olds could be trained to help collapsed and non-breathing people. 100 students at Boston College had been trained, all of whom confirmed that they would now feel confident in helping someone who had collapsed;
- When asked when this would be rolled out across all schools in Lincolnshire, it was explained that funding was needed to be able to do that, unfortunately. A grant had been acquired for schools in North Lincolnshire and the Committee suggested that the seven Lincolnshire MP's be approached to support this initiative;
- It was thought that Lincolnshire could lead this initiative as LIVES was recognised nationally and, for a minimal amount of funding, could roll this out to all secondary schools across Lincolnshire;

- The Committee were invited to undertake this training. The Health Scrutiny Officer would contact all members and seek to arrange a suitable date;

The Chairman thanked LIVES, on behalf of the Committee, for the work that they and their volunteers do in order to work in partnership with EMAS to deliver a fantastic service for the people of Lincolnshire.

RESOLVED

That the report and comments be noted.

At 12.40pm, Councillor B W Keimach left the meeting and did not return.

77 CANCER SERVICES IN LINCOLNSHIRE

A report by Sarah-Jane Mills (Director of Development and Service Delivery – Lincolnshire West Clinical Commissioning Group) was considered which invited the Committee to comment on the progress with regards to the development of Cancer Services throughout Lincolnshire.

Sarah-Jane Mills (Director of Development and Service Delivery – Lincolnshire West Clinical Commissioning Group) and Mark Brassington (Chief Operating Officer – United Lincolnshire Hospitals NHS Trust (ULHT) were in attendance for this item of business.

The Chairman reminded the Committee that Theme 3 of the Joint Health and Wellbeing Strategy focussed on *Delivering High Quality Systematic Care for Major Cause of Ill Health and Disability*. A key priority in this theme was to reduce mortality rates from cancer and improve the take-up of screening programmes.

The provision of a comprehensive range of services to promote improved outcomes for people affected by Cancer remained a priority for Lincolnshire. The prevalence and outcomes for local residents were in line with the national average and development of local services was coordinated by Lincolnshire West Clinical Commissioning Group. The strategic framework for the development of local services reflected the recommendations of the National Cancer Strategy and had been developed to reflect local priorities, challenges and the outcomes of the Cancer Summit in February 2015.

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

Overall patient experience had a national average of 88% and it was reported that Lincolnshire East CCG scored 83%, Lincolnshire West CCG 88%, South Lincolnshire CCG 89% and South West Lincolnshire 82%.

United Lincolnshire Hospitals NHS Trust (ULHT) were the primary provider of Cancer Services for Lincolnshire and, on the basis of the number of patients treated, was in the top ten list of cancer treatment providers in England.

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 were:-

- Improve access within 14 days;
- Improve access to diagnostic tests;
- Review and refresh systems and processes to facilitate efficient management of patients on a cancer pathway; and
- Recruit to the Lead Cancer Nurse post

The national End of Life Care Strategy built on the recommendations outlined in NICE guidance for Supportive and Palliative Care. As a result, a dedicated palliative and end of life care strategic development group had been established to support the continued improvement of services for people in Lincolnshire. The work programme had included:-

- Redesign of community service provision to provide 24 hour access to specialist support;
- Introduction of EPaCCS (Electronical 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 countywide/cross organisational Do Not Attempt Resuscitation Policy;
- Developing arrangements to facilitate improved access to palliative care medicines in the community; and
- Continued development of supportive palliative care services in the community.

During the last year, two new investments had been commissioned:-

- Chemotherapy Bus – the development of Chemotherapy Closer to Home Services in Lincolnshire was 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 was equipped with four chairs, refrigerated storage for drugs, a toilet and a quiet seating area for patients and carers. Medical, nursing and pharmacy services were provided by ULHT and two chemotherapy trained nurses were required to staff the unit per day, working on a rotational basis from the chemo suite teams.

  29 treatment regimes had been identified which were suitable for delivery in a community setting with risk stratified as 11 low and 18 medium and initial assessment and first cycle of treatment being made at the main centres. The mobile unit was currently utilised at Grantham Hospital (and on the Lincoln Hospital site for additional capacity) and a roll out plan was in place once Louth and Skegness sites had established the electrical coupling required.

The plan had been somewhat delayed due to chemotherapy trained staffing shortages.

- A new LINAC machine, used to provide radiotherapy treatment, had become operational with a second machine scheduled in 2016

The main objectives of the improvement plan were:-

- 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 four weeks;
- To work with the East Midlands Clinical Network and other partners to support the development and implementation of best practice clinical pathways;
- Continually improve the systems, processes and policies so as to facilitate the proactive management of patients on their cancer pathway; and
- To support the continued development of palliative and end of life care services.

The key actions during the next six month were reported as:-

- 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 which would 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 cancers support services;
- Develop links with tertiary centres to facilitate the review of clinical pathways and where appropriate explore the development of formal alliances;
- Review and consider the Danish model with respect to utilising different diagnostic strategies to facilitate access for patients at high risk of cancer; and
- To work with key stakeholders to develop sustained improved access to breast services.

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

- Two elements of work were ongoing to encourage people to take up the opportunity of screening, following work undertaken with the screening team which highlighted some exceptions to the uptake of screening, especially in some areas which were below the national average. The CCG were working to understand how to target that particular group and specific work was being done in relation to people with learning difficulties;
- An observation had been made that if a GP practice endorsed the need to undergo screening then a patient was 10% more likely to have that done. Some work was planned over coming months to find those gaps and work with

local GPs, neighbourhood teams and community teams to promote screening and raise awareness;

- There were two opportunities for older ladies to be self-motivated. Education was the first, with a screening programme to continually reinforce the importance to be included as self-care and for them to take wider responsibility for their own healthcare. Secondly, local GP surgeries could encourage patients to attend for screening on an individual basis;

Councillor Mrs S M Wray declared an interest at this point as she has a close connection with a current cancer patient.

- Although the focus was on early access to services and diagnosis, there was an ongoing piece of work with the Cancer Improvement Group to improved continued access to diagnostics and the framework for reporting to ensure this was prioritised;
- It was reported that CT and MRI were challenged areas which could work better internally and, due to this, there was a specific piece of work ongoing for CT, looking at improving the timeline for repeat scans and availability of reports;
- MRI were working closely with the CCGs to identify providers and have 98% of the market but ULHT were aware of other capacity within the health service who could assist with that pressure. A new MRI machine would also become available once all the necessary check and training had been completed;
- The importance of talking to patients and clinicians to find the pressure points on the system was starting to work and improvements being made. Diagnostics remained a national challenge and work was ongoing with the East Midlands Network on how this could be better delivered;
- A programme of work in relation to radiology across the region and sharing resources in order to reduce delays was due to go live;
- Historically, screening performance for a six month period was below expected standards but from an outcome standard nationally, the Trust were within target and the outcomes in line with the rest of the country. Performance had improved and, in November, the Trust achieved 82.6% against 85% which was above the national average for performance;
- Cancer outcomes were measured on two levels, one year survival and five year survival and all CCGs were within the national average for those outcomes. It was acknowledged that those outcomes could be improved with early diagnosis;
- A suggestion was made to include a date in the reminder letter for self-referrals as this may make people realise that it is for them in particular and not just a blanket reminder. This would hopefully encourage them to diarise the date and be more likely to arrange screening. This suggestion was welcomed and would be taken back to the screening team for further consideration;
- It was unclear when there would be a programme for ovarian cancer screening but further investigation would be done and a response would be provided to the Health Scrutiny Officer to report back to the Committee;

At this point of the meeting, Councillor S L W Palmer advised that he had a serious investigation complaint lodged with ULHT from July 2015.

- A request was made to include actual figures in the report rather than the national average. It was explained that the information presented was how it was received from national colleagues following collation but that they would look at this further to ascertain if comparable figures could be provided;
- Wherever patients felt there was extended waits, they were encouraged to escalate those to the PALS team for investigation;

RESOLVED

1. That the report and comments be noted; and
2. That a further update to the Committee be scheduled for April or May 2016.

NOTE: At this stage in the proceedings, the Committee adjourned for luncheon and, on return, the following Members and Officers were in attendance:-

County Councillors

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

District Councillors

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

Healthwatch Lincolnshire

Dr B Wookey.

Officers in attendance

Andrea Brown (Democratic Services Officer), Kakoli Choudhury (Consultant in Public Health), Simon Evans (Health Scrutiny Officer), Ian Hall (Senior Delivery and Development Manager – Trust Development Authority), Jim Heys (NHS England, Locality Director – Midlands and East (Central Midlands)), Lynne Moody (Director of Quality and Executive Nurse, South Lincolnshire CCG)

78 LINCOLNSHIRE RECOVERY PROGRAMME

A report by Jim Heys (Locality Director (Midlands and East (Central Midlands) – NHS England) and Jeff Worrall (Portfolio Director – Trust Development Authority) was considered which asked the Committee to consider and comment on the content 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 Ian Hall (Senior Delivery and Development Manager – Trust Development Authority) were in attendance for this item.

The Lincolnshire Recovery Programme (LRP) was developed to provide a senior level coordinating programme structure, which supported performance improvement and the further development of a clinically safe and financially sustainable health and care model, across Lincolnshire. The aims of the LRP were to:-

- Improve the performance of United Lincolnshire Hospitals NHS Trust (ULHT) against the NHS Constitutional standards so that all required targets were 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 was jointly chaired by NHS England and the Trust Development Authority.

With effect from April 2016, the TDA would merge with Monitor whose role included regulation and performance management of NHS Foundation Trusts. This new organisation would be known as NHS Improvement.

The purpose of the Lincolnshire Recovery Board was:-

1. To oversee achievement of the programme aims for an initial period of twelve months from July 2015, following which those responsible for health and care system delivery would be in a position to no longer require this level of intervention;
2. To agree a programme structure which held 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 were 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 were achieved;
6. To ensure that dependency issues between the LRP and the Lincolnshire Health and Care (LHAC) Programme were managed in a manner which avoided duplication between the programmes or adverse impact on either programme; and
7. To identify the need for additional support to facilitate achievement of the Programme aims and agree approaches to secure the support;

Outcomes of the programme to date included:-

- The delivery of the Referral to Treatment (RTT) incomplete standard from 92%. The Department of Health had introduced this operational standard in April 2012. Incomplete pathways were the waiting times for patients waiting to start treatment at the end of a month and were also often referred to as waiting list waiting times and the volume of incomplete RETT pathways as the size of the RTT waiting list;
- ULHT was on track to deliver the 62 day cancer standard with a 12% improvement from 70% achievement (September) to 82% (November) against a national standard of 85%;
- The A&E standard of 95% within 4 hours varied by site and was the subject of intense support from all parties. A revised trajectory for delivery was being developed. The current year to date delivery was 88%;
- ULHT was currently forecasting a deficit position of £59 million against the planned deficit of £40 million, which was a £19 million adverse variance. The system was developing plans to be presented to the LRP Board on 8 January 2016 to address the current deficit position; and
- The LHAC programme reported on progress to the LRP although this was subject to a separate governance and decision making structure.

Members were invited to ask questions, during which the following points were noted:-

- Clarification of the difference between the Lincolnshire Recovery Programme Board and the Operational Board Programme Group. The operational group had a slightly broader membership and the board was an opportunity for the accountable officers of each organisation to agree the action plan for the forthcoming 30 days. This groups proved helpful as the members were in a position to ensure what was agreed was delivered and, if not, could be held to account by NHS England and the TDA;
- NHS England and the TDA felt that this structure was the best way for progress to be monitored, through the programme board, on a temporary basis until back on track;
- As a recovery board, it was asked if they were confident that this would be the position in July 2016, following the 12 month Recovery Programme, and would no longer require this level of intervention. The Board were confident that it had been set up for 12 months as it needed to be time limited and not become a substantive part of the management process. It had been clearly stated that this was an interventional recovery programme but the challenge remained around constitutional standards, etc. There was a confidence that those standards would be delivered and expected that all actions would be met although acknowledged that financial sustainability would be ongoing;
- When asked how the deficit would be rectified and when the two authorities would be confident that intervention was no longer required, it was advised that this would need two elements, Trust specific and broader. For the Trust, a number of escalation beds had been opened which increases agency costs (it was stressed that this was not the reason for the increased deficit alone but

was a significant contributing factor). Part of the work of NHS England and the TDA was to close those beds both quickly and efficiently which was both challenging and complex but would assist with reducing the increased deficit;

- Links to other organisations were being developed to reduce the necessity for patients to resort to a hospital setting and this was being monitored as part of the Recovery Board;
- It had become clear through the Recovery Programme Board meetings that recent planning guidance and understanding about what was driving the increasing deficit was being reinforced. Although the deficit was apportioned to ULHT, it was acknowledged that there was a number of contributing factors for consideration and the Recovery Programme Board were undertaking a full analysis to ascertain the key issues to be addressed;
- It was reported that the LHAC could make a lot of progress due to its foundation elements but it was not designed to include guidance on how to reach financial viability. It was suggested that the LHAC could be the first step on the five year plan to reach financial viability;
- Unless secondary care providers were able to reduce delivery costs, the gap would continue to broaden as the NHS Tariff changed each year, generally reduced although there had been some address of that within recent guidance. An additional £1.8bn to the NHS would allow providers to become balanced but there was no more funding after that. Years 2, 3 and 4 would require transformational change to reach financial and clinical sustainability;
- Quarter 3 had started to see the overspend run rate diminish which had been assisted by work done on the immediate management control of the organisation. Fortnightly meetings were ongoing with ULHT in relation to agency staff and the reduction of costs in that area;
- NHS England and the TDA were not aware of the maximum amount of deficit which ULHT could reach without severe implications. The two organisations were in frequent contact with the Department of Health and were unaware that a level had been set at this stage;
- The complexity of the health services was acknowledged and stressed that to get through the recovery programme would require more joined up working between organisations to ensure delivery was more meaningful to patients and users and to provide a simple navigation process for patients;
- The Committee were unclear as to the solutions set out to rectify or improve the situation ULHT were in. It was explained that the LHAC provided guidance for the 50k population within Lincolnshire linking neighbourhood teams, GP practices, etc, which would cover the countywide services but what it did not include was how they linked with other, regional, organisations;
- Having been included within the ECIP issues, South West Lincolnshire had witnessed the flow in wards at Pilgrim Hospital, with commissioners, ECIP, social care, etc, and agreed where improvements could be made to allow safe discharge and streamline the process. Despite being from different organisations, all the right people came together at the same time to improve service delivery and this was the ethos required to sustain improvement within the health service;
- Concern was raised regarding the Comprehensive Spending Review (CSR) and the cuts to the preventative work currently undertaken by local Councils

impacting back on to the NHS. It was explained that the NHS made representations about how funding was allocated, for example the Better Care Fund. Although consideration could be given to certain issues, it was reported that this could not be influenced at this level but that they were issues which would require collective resolution;

- Individuals treated for preventable diseases could save the NHS a considerable amount if they took responsibility for their own personal health and wellbeing. Further suggestions was to widen this responsibility to supermarkets and what they make available (i.e. high sugar content) or pharmaceutical companies;
- Opportunities to improve efficiency whilst improving quality within large complex organisations were always available and the improvements made so far were a good example. The increased spend on agency staff was linked to urgent care flow, reduction of escalation beds and consideration of the budget and any genuine savings which could be made;
- Some patients were brought in to hospital to be told face to face that they had a negative test result but it had been suggested this could be done over the telephone or by post, in the most appropriate way deemed for that particular department. This would then save money and free up appointments for patients who require treatment thereby reducing waiting times. Although a relatively small change, it could see a large difference;
- Winter pressure planning within the NHS usually ran until the end of March therefore plans were in place should services become overwhelmed by escalation procedures;
- Government policy in relation to agency workers was to reduce the number employed and to reduce the cost significantly so that it was comparable with NHS workers;
- A suggestion to open two empty wards within hospitals by Lincolnshire Community Health Services to assist with DTOC rates was made and this was acknowledged as something which the Recovery Programme Board would give consideration too. Patients should be directed to the right place of care the first time and it was the role of the Board to consider all options as part of the wider recovery programme;
- Care and convalescent homes were discussed and encouraged to be reinstated to relieve pressure on hospitals. A range of packages were being made available for individual needs but the range of requirements for individuals was complex. Although there were a number of options within the voluntary sector, it was acknowledged that a number of volunteers were elderly themselves and were not being replaced by younger volunteers thereby causing concern that the voluntary sector may be unable to sustain service delivery in future years;

At 3.35pm, Dr B Wookey left the meeting and did not return.

RESOLVED

1. That the report and comments be noted; and
2. That the outcomes and final submissions be presented to the Committee at its meeting in May 2016.

79 DELIVERING THE FORWARD VIEW: NHS PLANNING GUIDANCE 2016/17 - 2020/21

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

Members were given an overview of the guidance which had been 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 required two connected plans from the local NHS:-

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

The guidance also stated that the planning process had been put forward to execute three independent tasks:-

- Implementing the Five Year Forward View;
- Restoring and maintaining financial balance; and
- Delivering core access and quality standards for patients.

The link for the full document was:-

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

The nine 'must do's' for 2016/17 for every local system were:-

1. Develop a high quality and agreed STP, and subsequently achieve what was determined as the 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 included 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 would 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% of patients wait no more than four hours in A&E, and that all ambulance trusts respond to 75% 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 the maintenance of the NHS Constitution standards that more than 92% of patients on non-emergency pathways should 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% of people experiencing a first episode of psychosis would commence treatment with a NICE approved care package within two weeks of referral; 75% of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme would be treated within six weeks of referral, with 95% 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 rollout out care and treatment reviews in line with published policy; and
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.

To support long-term planning, NHS England had set firm three year allocations for CCGs, followed by two indicative years. For 2016/17, CCG allocations would rise by an average of 3.4% and the report outlined the promise that no CCG would be more than 5% below its target funding level.

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

- Deficit reduction;
- Access standards; and
- Progress on transformation

Members were invited to ask questions, during which the following points were noted:-

- It was requested that the Health Scrutiny Officer email the full guidance document to the members of the Committee;
- The Chairman requested volunteers for a working group of the Committee to further consider this document and the implications for Lincolnshire. Initial came from the Chairman, Vice-Chairman and Councillors J M Renshaw, S M Wray, R C Kirk and S L W Palmer.

RESOLVED

That the report and comments be noted.

80 WORK PROGRAMME

The Committee considered its work programme for forthcoming meetings.

It was anticipated that the CQC would issue their inspection reports in time to be considered at the March meeting of the Committee and it was agreed to add this to the Work Programme.

The Chairman advised that she had been contacted by Sarah Fletcher, Chief Executive of Healthwatch, to gain the views of the Committee in regard to the Mental Health report. Healthwatch have suggested deferring consideration of the CAMHS item until later in the year and to give focus to the Mental Health overview at the meeting of the Committee in February 2016. This suggestion was put to the Committee and agreed.

RESOLVED

That the contents of the work programme, with the amendments noted above, be approved.

The meeting closed at 3.55 pm

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

Open Report on behalf of Lincolnshire Partnership NHS Foundation Trust (LPFT)

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**17 February 2016**
Subject:	**Lincolnshire Partnership NHS Foundation Trust Draft Clinical Strategy 2016-2021**

Summary:

This report sets out the Lincolnshire Partnership NHS Foundation Trust (LPFT) Draft Clinical Strategy 2016-2021 for review and feedback by the Health Scrutiny Committee for Lincolnshire. Members of the Committee will recall that a working group was formed which met on 18 November 2015 with Chris Higgins (Deputy Director of Strategy and Business Planning, Lincolnshire Partnership NHS Foundation Trust) to discuss the draft Clinical Strategy. The joint statement from Healthwatch Lincolnshire and the Health Scrutiny Committee for Lincolnshire on the draft Clinical Strategy was presented to the Committee for consideration at its meeting on 16 December 2015 and is included at Appendix B to this report.

Actions Required:

The Health Scrutiny Committee for Lincolnshire is asked to review LPFT's Draft Clinical Strategy 2016-2021 and consider the following questions:

1. Does the draft strategy identify the right priority areas?
2. Considering current financial constraints, should any of the clinical priorities be prioritised over others?
3. Is the language right for patients, carers, staff and the public?

1. Background

Our clinical strategy is the document that translates the organisation's Mission into the deliverable objectives and actions through a series of agreed priorities.

It sits central to the organisation's governance framework and informs the development of Divisional plans, dependent sub-strategies and the Trust's overarching Integrated Business Plan.

This strategy, which is attached at Appendix A, is the result of work completed since the summer of 2015 where we have spoken with staff, patients and carers, commissioners, partners, our Governors and the public about what they think we should be doing to improve clinical services. It demonstrates our commitment to working together to deliver effective, responsive, caring and safe services.

Our aim is to have a new clinical strategy for 2016/17 and beyond, that not only reflects our ambition to provide the best care possible, but also a strategy that has been co-created with the people who use our services and is aligned to national policy and the best available evidence.

The current clinical priorities are derived from feedback received, local delivery objectives and national policy including:

- No Health Without Mental Health (2012)
- Transforming Care for Learning Disabilities Services (2015)
- National Drug and Alcohol Strategy (2010 – updated 2012)
- Future in Mind for Child and Adolescent Mental Health Services (2013)

The clinical priorities are:

- More people will have good mental health
- More people will have a positive experience of care and support
- More people with mental health & learning disability problems will have good physical health
- People will have better access to services
- Support integrated health and social care in Lincolnshire
- Fewer people will suffer avoidable harm
- Promote recovery and independence
- Support our people to be the best they can be
- Maximise NHS resources
- Ensure our estate is fit for modern healthcare delivery

Further work is planned as part of LPFT's Inspirational Leadership Programme (ILP) in February, where the operational services will be supported to develop their individual service plans that will be included as section 9 of the strategy document.

2. Conclusion

Our Mission is clear; we are all here to:

"Enable people to live well in their communities"

This means working with our partners to join services together so that the patient receives one service to meet their needs; it means using the best available evidence to deliver high quality care; it means working with patients, carers and staff to design

and deliver services together; it means doing what it is right for the people of Lincolnshire.

The final draft strategy will go before LPFT's Board of Directors in March 2016 for final approval. Once approved, the strategy will be published on the Trust's public website and summary versions will be produced that are suitable for our different audiences.

3. Consultation

Not Applicable

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	LPFT Draft Clinical Strategy 2016-2021
Appendix B	Statement from Health Scrutiny Committee for Lincolnshire and Healthwatch Lincolnshire on Lincolnshire Partnership NHS Foundation Trust Clinical Strategy 2016/17– Draft Priorities

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 Jane Marshall, Director for Strategy at LPFT, who can be contacted on 01529 222244 or Jane.Marshall@LPFT.nhs.uk

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Appendix A

Lincolnshire Partnership NHS
NHS Foundation Trust

Clinical Services Strategy

2016 – 2021

'Enabling people to live well in their communities'

Contents **Page**

Dr John Brewin,
Chief Executive

Paul Devlin,
Chair

Forward from the Chair and Chief Executive

We are proud to lead this organisation and to see the positive benefits for patients, carers and families that are being achieved, day in and day out, by our excellent, dedicated and skilled staff.

Our staff teams, both clinical and managerial, deliver this remarkable work. Their well-being, development, training and commitment is of vital importance to the organisation as, working together, we face the unprecedented challenges of continuing to improve outcomes and partnerships across Lincolnshire.

This clinical strategy sets out what we will be doing to continue to deliver safe, caring, responsive and effective services.

In summary, everything we do will be aimed at ensuring: -

- That working together with our patients, we continue to improve their experience of our services and that they tell us when we get it right and when we do not;
- That working together with our staff, we continue to support them to do a good job and to be proud to work at Lincolnshire Partnership NHS Foundation Trust;
- That working together with the Lincolnshire health and care system, we continue to strive for clinically and financially sustainable services to be there when patients, carers and families need them.

We welcome feedback so please tell us what you think about this strategy as we would like to hear your views – please email us at

Dr John Brewin
Chief Executive

Paul Devlin
Chair

1.0 INTRODUCTION

This clinical strategy explains what we are doing to improve services for patients, carers and families. It is one of the ways the organisation ensures that there is a proper focus on continuous development and improvement of clinical services. It forms part of a series of plans that allow the organisation to demonstrate it is accountable and governed well. It is produced and informed by front line staff who work with patients every day and therefore is part of the Clinical Divisions Business Plans as demonstrated in the diagram below: -

Our Purpose is clear; we are here to ***'Enable people to live well in their communities'.***

This means working with our partners to join services together so that the patient receives one service to meet their needs; it means using the best available evidence to deliver high quality care; it means working with patients, carers and staff to design and deliver services together; it means doing what it right for the people of Lincolnshire. This strategy is the result of work completed since the summer of 2015 where we have spoken with patients and carers, staff, commissioners, partners, our Governors and the public about what they think we should be doing to improve clinical services. It demonstrates our commitment to working together to deliver effective, responsive, caring and safe services.

We are committed to ensuring every staff member is supported to achieve their very best, to feel valued and involved and to be themselves inclusive of the protected characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sexual orientation and sex (Equality Act 2010).

2.0 ABOUT LINCOLNSHIRE

Lincolnshire is primarily a rural county, which borders Leicestershire and Rutland, Cambridgeshire, Nottinghamshire, Northamptonshire, North and North East Lincolnshire and Norfolk. It has a large agricultural community but also a population that is prepared to travel to work into neighbouring towns, counties and to the capital. It has an extensive coastline to the East, which attracts an ageing population wishing to retire to the coast and a seasonal population, who visit the main resorts of Skegness and Mablethorpe each year. It is the fourth largest county in England by area and is served by one County Council and seven District Councils.

Quick Facts

Population: 731,700
Area: 2,350 sq. miles
Population density: 300 people/square mile compared to 1010 in England
Geography: No motorways, only 41 miles of dual carriageway out of 5,600 miles of road
Urban areas: Only the City of Lincoln is classified as an urban area across the county
Primary Care: 101 GP practices; 77 dental practices**;** 111 community pharmacies

Key health challenges

Changing demographics: inward migration, increasing birth rate, ageing population
Economic inequalities: low wage economies and areas of deprivation
Children's health and lifestyles: e.g. obesity smoking, sexual health & mental health
Changing health needs: long term health conditions; residential/hospital care; dementia
Inequalities for people with disabilities: including those with learning disabilities
Prevention: relating to smoking, alcohol, obesity and maintaining independence

The most troubling outcome for people with serious mental illness in Lincolnshire is that they are more likely to die prematurely than people with the same condition living in other areas of the country.

Key Financial challenge

Without further annual efficiencies and flat real terms funding, a mismatch between resources and patient needs is predicted of nearly £30 billion a year nationally by 2020/21. So to sustain a comprehensive high-quality NHS, action is needed on three fronts:

1. **Increase Prevention** **2. Improve efficiency** **3. Increase funding**

For Lincolnshire, the financial deficit is predicted to be c£250 million by 2020/21 and so commissioners and providers are working together under the banner of the Lincolnshire Health and Care (LHAC) to plan how the local funding gap can be bridged.

3.0 WHO WE ARE

Our patients and staff are our priorities, along with working in partnership with other organisations to deliver clinically and financially sustainable health and care services for the people of Lincolnshire. We encourage a culture of co-production, both internally and externally. We develop our people, collaborate with partners and strive for continuous learning to ensure the services we provide are the best they can be and that our patients, staff and other stakeholders have the best possible outcomes and experience of care.

Our purpose

'To enable people to live well in their communities'

Our values

- Putting people first
- Respecting people's differences
- Behaving with compassion and integrity
- Having pride in our work
- Working in partnership
- Developing our staff
- Being recovery focused and making a positive difference

Our vision

- To make a difference to the lives of people with mental health, substance misuse problems and learning disabilities.
- To promote recovery and quality of life through effective, innovative and caring mental health and social care services.

Key Facts:

4.0 OUR SERVICES

Our community services are based in the major settlements in the county – Boston, Gainsborough, Grantham, Lincoln, Louth, Skegness, Sleaford, Spalding and Stamford. In-patient services are primarily based in the 3 major conurbations of Boston, Grantham and Lincoln. There is also a county-wide inpatient unit for the Child and Adolescent (CAMHS) service in Sleaford.

Adult Community Mental Health Division

- Adult Community Mental Health
- Steps2Change (IAPT)
- Assertive Outreach
- Support and Treatment for Early Psychosis
- Recovery College
- Volunteer service
- Section 75: Inc. direct Social Care
- Best Interest Assessors
- Community forensic mental health services
- Mental Health Physiotherapy
- Adult psychology
- Dynamic psychotherapy
- Eating Disorders
- Specialist Psychology
- Perinatal Services

Older Adult Mental Health Division

- Dementia Services (community and inpatient)
- Specialist Older Adult Services (community & inpatient)
- Mental Health Hospital Liaison Service
- Neuropsychology
- Psycho-Oncology
- Chronic Fatigue Syndrome

Specialist Services Division

- Learning Disabilities Inpatient and Community Services
- Learning Disabilities Hospital In reach
- Speech and Language Therapy
- Full spectrum of community CAMHS (Tiers 2 and 3)
- CAMHS Inpatient
- Drug and Alcohol Recovery Team
- Community Assertive Support Team (CAST)
- North East Lincolnshire CAMHS
- CAMHS Physical Healthcare/Diabetes Psychology
- Lincolnshire Young Persons Secure Unit (LSU)

Adult Mental Health Inpatient Division

- Single Point of Access
- Adult acute inpatient services
- Crisis Resolution and Home Treatment
- Mental Health Triage Car
- Sexual Assault Referral Centre (SARC)
- Independent Sexual Violence Adviser (ISVA) service
- Mental health inpatient rehabilitation
- Low secure inpatient mental health
- Section 136 Suite
- Veterans Service

Cross Cutting And Primary Care

- Community Support Networks
- Pharmacy support
- Alternative Provider Medical Services (Joint Venture with Primary Care)

5.0 OUR VISION FOR THE FUTURE

The constantly shifting landscape of health and social care in England makes predicting the future an almost impossible challenge. However, it is widely accepted that as the NHS and social care continue to evolve and respond to changing patient expectations, services as they are today, will look very different in 5 years' time.

As indicated in NHS England's Five Year Forward View, national policy will drive a greater emphasis on people taking responsibility for their own health and on the prevention of ill health; new models of care and new payment mechanisms will be introduced where providers are rewarded for improving outcomes for patients. As we live longer the NHS needs to deliver more care to more people and therefore has to be more efficient and productive with a greater focus on building community services closer to where people live, in communities and at home. To achieve this, organisations will change and work together to support the individual person and their family.

The final design of these services is still to be decided, however from what we already know, we are able to set the following principles for how services will be in the next few years:

- A clear focus on population health and on patients as individuals
- A greater level of co-design and co-production of services
- A greater focus on prevention, self-help and early intervention to support healthy lifestyles
- Integration of care pathways and shared resources with other providers
- More services based in and around Primary Care as the first contact point for patients
- Collaboration with the 3rd Sector to increase community capacity and support wellbeing
- Clearly defined packages of care based around delivering improved patient outcomes
- A continued shift of investment from inpatient care to enhanced community support

6.0 NATIONAL CONTEXT

Mental Health

Mental health problems are the largest single cause of illness in the UK, accounting for 23 per cent of the total 'burden of disease'. It is estimated poor mental health costs the UK economy £77 billion per year. Poor mental health will touch us all at some point in our lives; as mental health problems affect one in four people.

Drug and Alcohol

Alcohol is the third biggest risk factor for illness and death

1,200,000 people are affected by drug addiction in their families; mostly in poor communities

Drug use costs the nation £15.4

Alcohol use costs our society £21 billion per year billion per year

Learning Disabilities

It is estimated that in England in 2011 1,191,000 people have a learning disability. This includes 905,000 adults aged 18+ (530,000 men and 375,000 women); People with learning disabilities are 2.5 times more likely to have health problems than other people; People with learning disabilities have an increased risk of early death compared to the general population.

The NHS Plan

The NHS 'Five year forward view' highlights how NHS organisations will have to identify opportunities to integrate with other services to make positive changes to patient care. Participation of and co-production of solutions for the future are needed with local people, local communities, primary care and NHS, voluntary and non-statutory sector organisations, local authorities at district and county level, commissioners and employers working together in a culture to work together to achieve the best possible outcomes for local people.

For 2016/17 the NHS has been issued with a set of National 'must do's' for the year ahead. Whilst some of these are Acute Care focussed, some are specific to the work of LPFT:

- Achieve **financial balance**
- Achieve and maintain the two new **mental health access standards** (Early Intervention in Psychosis and IAPT waiting times)
- Continue to meet **dementia diagnosis targets**
- Deliver plans to **transform care for people with learning disabilities**

7.0 LOCAL DELIVERY OBJECTIVES

Lincolnshire Partnership NHS Foundation Trust is part of the wider health and social care system and actively supports all partners in delivering clinically and financially sustainable services through a joint Sustainability and Transformation Plan.

For patients seen by our organisation, we will develop and deliver services that support parity of esteem of physical and mental health and deliver improved outcomes as set out in:

The cross-government strategy "No Health Without Mental Health" (2012)

- More people will have good mental health
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support
- Fewer people will suffer avoidable harm
- Fewer people will experience stigma and discrimination.

Transforming Care for Learning Disabilities Services (2015)

- Empowering people and families
- Less reliance on inpatient care
- Greater emphasis on community services
- Stronger emphasis on personalised care

National Drug and Alcohol Strategy (2010 – updated 2012)

- Prevent drug and alcohol use from escalating
- Reduce the harm that people cause themselves or others
- Prevent young people from becoming drug or alcohol-dependent adults

Future in Mind for Child and Adolescent Mental Health Services (2013)

- 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

In addition we will do the following: -

- Manage our available resources to ensure staff time is freed up to care for patients
- Support our people to be the best they can be
- Support integrated health and care in Lincolnshire
- Support the increased use of technology
- Ensure our estate is fit for modern healthcare delivery

8.0 CLINICAL PRIORITIES

The priorities provide a framework for service development to drive improvement across the Trust. They will be updated on an annual basis and reviewed quarterly.

Priority	What does this mean?	Intended outcomes
More people will have good mental health	❖ Provide information and support to explain common mental health problems to help to reduce stigma ❖ Secure funding for improving services that support good mental health and parity of esteem between physical health and mental health ❖ Provide more services from primary care settings ❖ Support improvements to people's mental and physical well-being through supporting SHINE and Community Support Networks ❖ Implement liaison services in acute hospitals	❖ People feeling better about managing their mental health ❖ Knowing where to go to get support ❖ Feeling part of a support network that is available to meet the person's needs
More people will have a positive experience of care and support	❖ Embed clinician led co-production in all service designs ❖ Include service users as a standard in interview panels ❖ Increase Peer Support roles in community teams ❖ Actively encourage family and carer involvement in planning patient care ❖ Implement actions to address the findings of the community mental health survey ❖ Remain responsive to feedback with demonstrable actions in response to ideas for improvement	❖ Much greater involvement of experts by experience and volunteers ❖ Greater patient and carer involvement in decision about their care
More people with mental health and learning disability problems will have good physical health	❖ Develop expertise in physical health monitoring for people with mental health and learning disability problems in our care ❖ Work with experts in physical health in a more integrated way, seeking support, training and advice in how to manage physical health problems ❖ Support patients in managing the impact of medications of physical health and side effects of medicines	❖ Improve the physical health of people with mental health and learning disability conditions
People will have better access to services	❖ Develop a directory of services and a "map" of services ❖ Establish a 24 hour help line for mental health issues ❖ Develop a greater range of online resources to support self-help and prevention ❖ 24 hour access to services, 7 days a week as appropriate ❖ Establish clear pathways for Community Support Networks to engage with the Trust ❖ Transform the website to provide better information ❖ Provide support for Lincolnshire GPs on mental health	❖ Clear understanding of how to access and navigate services ❖ Better understanding of mental health ❖ Care available when needed to avoid emergency admission or crisis services
Support integrated health and social care in Lincolnshire	❖ Actively support Lincolnshire Health and Care (LHAC) ❖ Actively support and implement Neighbourhood Teams ❖ Collaborate with other providers by sharing resources and working across organisational boundaries ❖ Create networks with third sector, voluntary and charitable organisations and volunteers	❖ Sustainable services in Lincolnshire ❖ More joined up Mental Health and Physical Health services for patients

Priority	What does this mean?	Intended outcomes
Fewer people will suffer avoidable harm	❖ Foster a positive patient safety culture ❖ Take every opportunity to learn lessons and share learning across the organisation. ❖ Base all service pathways and clinical delivery on evidence based practice. ❖ Role model, visible leadership and clear lines of accountability ❖ Provide safe patient environments for all our clinical services ❖ Ensure effective clinical risk assessment and risk management is a core aspect of patient care	❖ Delivery of safe care at all times and in all settings
Promote recovery and independence	❖ Provide consistent and timely follow-up for people discharged from inpatient care ❖ Provide robust support to Community Care Networks as our partners in care ❖ Act as a core member and support the development of the Neighbourhood Teams ❖ Start discharge planning early to enable a supportive and effective exit from services ❖ Have measureable clinical and patient outcomes in every service	❖ Integrated and joined up care pathways across LPFT services and the wider community ❖ Robust community networks to support people not formally engaged in LPFT services
Support our people to be the best they can be	❖ Ensure staff have a clear line of sight between their role and patient experience ❖ Ensure staff have the right structures and resources to deliver high quality care ❖ Treat each other with respect and role model our values ❖ Providing visible leadership and accessible managers to all staff at all levels ❖ Create service development training plans to ensure that staff have the skills to meet future demands	❖ An engaged and confident staff group ❖ Increased job satisfaction ❖ Better patient outcomes
Maximise NHS resources	❖ Constantly review service delivery and explore more efficient ways of working ❖ Work with commissioners to agree longer-term contracts based on outcomes. ❖ Introduce a standard 'Lean' approach for the Trust ❖ Set financial controls for all services to protect quality whilst encouraging transformation ❖ Work with commissioners to identify and scale down services that lack an appropriate evidence base or clear measurable outcomes	❖ Services that make the best use of public money to ensure the long-term sustainability of high quality clinical care
Ensure our estate is fit for modern healthcare delivery	❖ Share resources and collocate services with other organisations where it makes sense for service users ❖ Invest in the inpatient estate to expand the range of services offered to Lincolnshire residents (PICU) ❖ Reduce inpatient estate where there is evidence that care can be better provided in the community or in partnership with other providers (Older Adults/ Learning Disabilities, Transforming care) ❖ Invest in our acute inpatient environment to create modern and fit for purpose care environments	❖ Improved care environments ❖ Better use of resources ❖ More joined up and integrated care ❖ Local services for local people

9.0 DIVISIONAL/CLINICAL SERVICE PLANS

To be completed at Februay ILP session

Adult Community Mental Health Division	**Adult Mental Health Inpatient Division**
Older Adult Mental Health Division	**Specialist Services Division**

VERSION CONTROL

Version	Author	Date
Draft Clinical Strategy v1.0	Chris Higgins	11/12/15
Draft Clinical Strategy v2.0	Chris Higgins	18/12/15
Draft Clinical Strategy v3.0	Jane Marshall and Chris Higgins	4/01/16
Draft Clinical Strategy v4.0	Jane Marshall	11/01/16
Draft Clinical Strategy v5.0	Jane Marshall and Chris Higgins	19/01/16
Draft Clinical Strategy v6.0	Jane Marshall and Chris Higgins	03/02/16
Ratification		
Ratifying Body and Date Ratified	Board of Directors	
Date of Issue		
Review Date		

HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE	HEALTHWATCH LINCOLNSHIRE

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

Introduction

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

General Comments

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

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

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

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

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

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

Ensuring Long Term Sustainability of the Trust

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

Improving Access to Services

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

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

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

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

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

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

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

Supporting Staff

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

Increasing Service User and Carer Involvement in Service Design and Delivery

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

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

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

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

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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 Lincolnshire Partnership NHS Foundation Trust (LPFT)

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**17 February 2016**
Subject:	**Universal Health Ltd: Primary Care Practices in Lincoln, Metheringham and Gainsborough**

Summary:

This report from Lincolnshire Partnership NHS Foundation Trust (LPFT) will provide an update on the services running at GP Practices recently awarded under contracts from NHS England East to Universal Health Limited. These are the Arboretum and Burton Road Surgeries in Lincoln; Pottergate Surgery in Gainsborough and Metheringham Surgery.

Actions Required:

The Health Scrutiny Committee for Lincolnshire is asked to consider and comment on

1. the update on progress following award of the contracts by NHS England;
2. the services which are now jointly commissioned by West Lincolnshire CCG (from 1st April 2016 under new co-commissioning arrangements);
3. the existing and potential benefits to people in local communities;
4. the challenges and risks.

1. Background

Working together as Universal Health Limited, Lincolnshire Partnership NHS Foundation Trust (LPFT) and Lincolnshire and District Medical Services (LADMS) were awarded four Alternative Personal Medical Services (APMS) contracts in 2015, for mobilisation from 1st April 2015 (and 1st July 2015 in the case of the Burton Road Surgery).

The staff teams (clinical and non-clinical) in the surgeries have ensured that the services continued seamlessly on transfer of the contracts to Universal Health Limited. Patient services continued as did continuity of care along with access being good and waiting times short.

There are challenges with recruiting nursing and medical staff given the shortages, particularly of General Practitioners (GPs) and with the subsequent costs of locum medical cover to ensure services continue to run. However, this is not uncommon across Lincolnshire as the challenges to the ongoing stability of primary care continue.

This report gives an update on the work to date given the importance of stable primary care services for the people registered with those surgeries.

The number of patients currently registered with the four practices (total) is 11,000.

2. Patient experience

Primary care services remain the first port of call for the majority of people and around 90% of mental health provision is undertaken in primary care. As with other services, primary care requires transformation and renewal as the work on developing new care models in response to NHS England's Five Year Forward View continues.

Lincolnshire Partnership NHS Foundation Trust (LPFT) provides Mental Health, Learning Disability and Substance Misuse inpatient and community based services to people of all ages in Lincolnshire. It has effective corporate and clinical governance structures in place; the organisation having been rated consistently highly for quality of care and financial governance.

LPFT has stability in the system and can therefore innovate including stabilising services and turning them round. In creating a Joint Venture company in late 2014, Universal Health Limited, LPFT created a new provider vehicle to transfer, stabilise and transform services; along with the flexibility to secure different workforce and clinical models to integrate care and to work differently, with lower operating costs. Any profit (should it be achieved) is re-invested in local services.

There is a formal Universal Health Board governance structure, with director and non-executive director portfolios. There are separate financial accounts.

Primary care both nationally and locally is struggling to adapt to the changing environment. Small independent businesses may lack the capacity and scale to respond to issues of; increasing demographic demands, co-morbidities, recruitment and retention and falling practice incomes. LPFT can bring (relative) large scale NHS FT infrastructural support services to support primary care non-clinical functions across a number of domains, including; HR, administration, performance reporting, governance systems, financial management and continuous quality improvement.

Equally there are potential future benefits for patients with Mental Health and related conditions; improved access to local Mental Health services without the need for "referral" to secondary care. A significant proportion of LPFT community work could be done in and with practices. The significant physical health difficulties experienced by Mental Health patients can also be addressed through this closer integration.

3. Challenges and risks

Recruitment of staff – the recruitment and retention of skilled, trained staff in primary care is a crucial factor in building resilience and capacity in the system. Recruitment of these staff is increasingly difficult as the workforce profile is changing. The medical staff at these practices are Salaried Doctors rather than GP Partners. Innovative options are needed for the future to ensure that these staff are supported to stay in general practice.

Recruiting new patients – the surgeries are open to new patients wanting to register with a GP. Patients who do not currently have a GP are being encouraged to choose these surgeries as there is capacity to take new patients onto the registered list.

Change – the staff working in the surgeries have been through a period of disruption and change over the last 12 months including facing uncertainty about the future. Retaining good staff and offering opportunities for new staff are priorities for Universal Health.

Offering additional services – the service offer will be developed to offer alternative services in primary care for patients, for example bringing Physiotherapists into the clinical team to assess and advise patients requiring this service.

4. Conclusion

The services are stabilised and patient continuity of care continues. Two of the surgeries (Burton Road and Metheringham) were inspected by the Care Quality Commission in mid-December and the formal reports are awaited.

Now that the mobilisation and initial stabilisation phases are almost complete, the opportunities for transformation and integration of additional services are being pursued.

This is a Lincolnshire solution for the people of Lincolnshire and fits well with the future direction of travel to secure more preventative, community based health and care options for the future.

We are listening to patients and responding to what they want in terms of local services. Below are some examples.

Arboretum Surgery – patients whose cultural background require a female clinician – nursing staff receiving training and support in women's health and sexual health from a specialist GP in sexual health to develop a service. The GP provides back up and support and clinical supervision.

Burton Road Surgery – comment from patient participation group (also shared with CQC on recent inspection (sic) "my family and I have attended this surgery for the last 40 years. I would not go anywhere else as it is the best surgery in the local community. The GPs and Nursing Staff are caring and they would do anything for you".

Burton Road Surgery – patients unaware of services available in Lincolnshire for people with memory loss and depression/anxiety. GPs and practice staff able to navigate on behalf of patients as they are aware of LPFT services.

Metheringham Surgery – a call from a local Care Home, Friday lunchtime, about a distressed person with a UTI who is getting increasingly agitated and aggressive. GP starts his surgery at 3pm on Friday afternoon as planned and makes sure that the patient has a prescription and the care home receive advice on management of the patient's care over the weekend.

Pottergate Surgery – person on the "violent patient" scheme attends the surgery for a repeat prescription and is welcomed by the staff, seen by the GP (experienced in prison health care) and receives a service in the local community as part of universal primary care.

5. Consultation

Not Applicable

6. Background Papers

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

This report was written by Jane Marshall, Director for Strategy at LPFT, who can be contacted on 01529 222244 or Jane.Marshall@LPFT.nhs.uk

Lincolnshire COUNTY COUNCIL *Working for a better future*		**THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE**	
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Open Report on behalf of United Lincolnshire Hospitals NHS Trust (ULHT)

Report to:	**Health Scrutiny Committee for Lincolnshire**
Date:	**17 February 2016**
Subject:	**United Lincolnshire Hospitals NHS Trust - Improvement Portfolio**

Summary:

This report provides an up-date on progress against ULHT Improvement Portfolio and gives an overview of action being taken where risks and issues have been identified. It describes the governance arrangement that have been put in place.

The four key recovery programmes include:

- Quality Improvement
- Workforce and Organisational Development
- Constitutional Standards
- Financial Recovery

Actions Required:

The Health Scrutiny Committee for Lincolnshire is invited to consider and comment on the report.

1. Background

At the United Lincolnshire Hospitals NHS Trust Board meeting on 7 July 2015 the Board agreed the Trust's priorities for 2015/16 alongside a programme management approach to manage the recovery of our performance. A co-ordinated programme approach has been established with full executive support to address the key

recovery streams identified. This paper focuses on the 4 main recovery work streams and outlines progress, highlighting areas of concern:

- Quality Improvement
- Workforce and Organisational Development
- Constitutional Standards
- Financial Recovery

The definitions for the milestone delivery confidence RAG (Red, Amber, Green) ratings are:

Green - Successful delivery is on track and seems highly likely to remain so, and there are no major outstanding issues that appear to threaten delivery significantly.
Amber/Green - Successful delivery appears probable however constant attention will be needed to ensure risks do not materialise into issues threatening delivery.
Amber - Successful delivery appears feasible but significant issues already exist, requiring management attention. These appear resolvable at this stage and if addressed promptly, should not present the project to overrun.
Amber/Red - Successful delivery is in doubt with major risks or issues apparent in a number of key areas. Urgent action is needed to ensure these are addressed, and to determine whether resolution is feasible.
Red - Successful delivery appears to be unachievable. There are major issues on project definition, with project delivery and its associated benefits appearing highly unlikely, which at this stage do not appear to be resolvable.

2. Progress against Identified Priorities

2.1 Quality Improvement Programme (Amber/Green)
Senior Responsible Owner – Michelle Rhodes, Director of Nursing

This programme will embed and sustain the changes delivered in response to the CQC inspections whilst moving into the third phase of the Trust's continuous quality improvement journey. The scope and milestone plan are agreed. This is a well-established programme and the implementation team meets weekly, reporting directly to the Portfolio Improvement Board on risks and issues. A monthly progress report is submitted to Quality Governance Committee with CQC Compliance Notice issues also being report directly to CQC. The main achievements for this programme are:

Louth - The Governance arrangements at Louth have been improved and there is now a Medical and Nursing Lead responsible for leading the newly established Governance Meeting for Louth Hospital with a focus on learning lessons.
Pharmacy – Recruitment to Pharmacy posts has been successful including a new Consultant Antimicrobial Pharmacist.
Outpatient Department - The environment has improved in Lincoln Out-Patient Department with new "self check-in" and a new central reception desk has opened with all staff wearing a uniform. The booking system for follow-up patients to Out Patients has also been improved.
See It My Way – If patients or carers would like to raise concern about services, this is much easier through the new PALS Team and response times have improved.

Currently the main areas of concern where significant issues exist are:

2.1.1 - CQC Compliance Notice - Safeguarding Training (Amber)
Additional safeguarding training has been established to provide sufficient capacity to deliver training to all relevant staff. Although compliance has significantly improved, clinical areas have experienced difficulty in releasing staff to attend training due to site pressures and demands. Work is taking place to explore the possibility of providing an e-learning package to compliment the face to face training. At the end of December 2015 compliance for Safeguarding Level 1 Core Learning was 80% against a trajectory of 95% by 31 March 2016.

2.1.2 – Hospital at Night (Green)
The new Hospital at Night model has been implemented to improve care to deteriorating patients during the night. There is now a focus on implementing the recommendations from Health Education for East Midlands (HEEM) and phase 2 of this project is being developed to maintain a focus on improving night time services.

2.1.3 Control of Infection (Amber)
Significant improvements have been made in delivering control of infection requirements and the team has been restructured. ULHT has now recruited to a new position of Consultant Nurse for Control of Infection who took up post in October 2015. There is an ongoing focus on Hand Hygiene.

A full review of housekeeping, cleaning capability and capacity commenced in December 2015. The report is awaited and a business case will then be developed.

A major outbreak of norovirus was effectively managed during December and January. There were 199 symptomatic patients affecting 16 wards with 11 wards closed during the peak.

2.1.4 Training and Appraisal (Amber/Green)
This project has now moved to the Workforce Improvement Programme and is reporting into the Workforce Programme Board – this is reported in the workforce section below.

2.1.5 - CQC Compliance Notice - Out Patients at Lincoln (Amber/Green)
Environmental improvements have been made in Lincoln Out-Patient Department and Clinic Room standards have been introduced so that all areas are clean, tidy and equipped for use. The booking system for follow-up patients has been improved and there is a full understanding of the number of patients waiting for follow-up appointments with “time critical” patients clearly identified. There is now on-going work taking place to deal with capacity shortfalls to provide sufficient appointments.

In addition to the internal ULHT Quality work, the Chief Executive is the chair of the Lincolnshire Wide Quality Improvement Programme Board which is attended by all stakeholders and has a focus on Lincolnshire Wide Frailty Services, Safeguarding,

CAMHS, Adult Mental Health and Paediatric Commissioning. The next meeting will start to focus on 2016/17 priorities.

2.2 Workforce and Organisational Development (Amber/Red)
Senior Responsible Owner – Ian Warren, Director of Human Resources and Organisational Development

The programme scope outlines the development and implementation of projects to deliver the required improvements in workforce and staffing. The milestone plan and work streams were revised in November 2015 and approved by Improvement Board. A Senior Programme Manager was appointed and the Workforce Programme Board meets fortnightly with monthly reporting to Improvement Board and Workforce & OD Committee. The focus for the revised work streams for this programme include:

2.2.1 - Nursing Workforce Utilisation (Amber/Red)
In October 2015 Monitor and the Trust Development Authority launched a set of rules governing the use of agency staff which meant that any Trust subject to agency spending needed to secure agency staff via an approved framework agreement. These rules also imposed an annual ceiling for total agency expenditure.

Progress has been made with changes affecting an expenditure reduction. This has been achieved by using workforce more effectively. Key performance indicators have been developed which enables areas that require improvement to be easily identified. Members of the Executive Team are providing focussed support and challenge to ensure pace is maintained and issues are unblocked.

A dedicated team has been established to undertake a bank service review to support delivery of the agency cap.

2.2.2 - Medical Workforce Utilisation (Amber/Red)
The agency cap described above also applies to medical agency usage. Progress has been made in relation to controls for agency usage and supporting plans to ensure existing workforce is used effectively. Medical Teams are actively involved for example Orthopaedics at Lincoln have reduced overall expenditure by approx. £600K per annum with a re-organisation of medical rotas.

2.2.3 - Recruitment and Retention (Amber)
There is a CQC Compliance Notice in place for Nurse Staffing Levels. Monitoring systems are in place for staffing levels on all wards and active recruitment is taking place to reduce the vacancy rate.

Plans are in place at local, national and international level to continue to recruit to the vacancy gap. Locally there is active engagement with the University and students. Apprenticeships are in place and open days are being held to attract school leavers.

In January a senior recruitment team went to Manila and successfully recruited 131 candidates who will now go through formal HR checks. A cohort

of 6 of 8 registered nurses arrived in Boston from the European Union on 6th February. More recruitment trips overseas are being planned.

Overall a comprehensive marketing and communications plan is being developed including plans to retain the existing workforce.

2.2.4 - Electronic Staff Record (ESR) (Amber)
This system will improve central management and reporting of workforce details. ESR Supervisor Self Service is being rolled out across the organisation and will enable supervisors / line managers to access real time information for all staff in respect of contract details, core learning compliance, annual leave and absence rates.

2.2.5 - Training and Appraisal (Amber/Green)
At the end of December 2015 the Core Learning Compliance was 78% and Appraisal was 67%. This is a demanding time of year on ward areas and there is a focus on maintaining and improving compliance over the winter period with a view to delivering 95% compliance by 31 March 2016.

2.3 Constitutional Standards (Amber)
Senior Responsible Owner – Mark Brassington, Chief Operating Officer

The programme scope outlines the development and implementation of projects to deliver the required performance improvement against the constitutional standards as set out in the regional escalation system recovery letter and is consistent with the Lincolnshire wide recovery plan. The scope and milestone plan are in place and a Programme Manager was appointed to provide dedicated support for 3 months. This programme provides a monthly progress report to Improvement Board and SRG on risks and issues.

This programme has three major works streams and is rated “amber” overall.

2.3.1 Urgent Care
Performance in Pilgrim A&E Department continues to be a concern. The Chief Operating Officer has appointed an additional Deputy Director to provide a dedicated focus on developing the future state for Pilgrim A&E. The operational teams have been re-aligned to focus on daily improvement in flow and performance. Key operational leads have been involved in developing a 30-day plan based upon the high impact actions.

2.3.2 Length of Stay
To support improvements in Length of Stay the SAFER bundle is being implemented which is being supported through the “Perfect Week” initiative commencing 1st February across the Lincolnshire system. The SAFER bundle is a national initiative to improve patient flow by:

S - Senior Review (Consultant review before midday)
A - All Patients have Estimated Date of Discharge
F - Flow of Patients (Wards to start to pull from Assessments Units by 10am)
E - Early Discharge (33% before midday)
R - Review (clinical review of patients with extended LOS over 14 days)

2.3.3 Planned Care

All projects are progressing and this work stream has been closed and is now being managed through normal management processes. ULHT has achieved RTT (referral to treatment time) performance for 5 consecutive months and 8 out of 9 Cancer standards during November. Risks remain but are being actively managed.

2.4 Financial Recovery (Amber/Red)
Senior Responsible Owner – Jason Burn, Interim Director of Finance

The financial recovery programme is progressing with a number of schemes now showing delivery against actual spend. Schemes are being managed and governed with a clear programme structure to ensure the escalation of issues and risks are timely and resolved wherever possible. The programme reports fortnightly to the Improvement Board. There are four overall main areas within the programme that are requiring significant focus:

2.4.1 - Nursing Workforce Utilisation

Progress has been made with actual changes affecting an expenditure reduction. The executive team have provided some focussed support in the form of “deep dive” meetings which has ensured pace and unblocked a number of issues.

2.4.2 - Medical Workforce Utilisation

Progress has been made in relation to medical workforce although there has not been an actual reduction in spend overall. However, there has been a reduction in price of agency doctors through re-negotiation and the demand is being reduced through improvements being made by clinical teams. An example of good practice is a £250k improvement in spend in integrated medicine by revising rotas and using doctors more efficiently.

2.4.3 - Income

Progress is being made in ensuring income is maximised including ensuring that the Trust receives the best practice tariff – this is a payment for delivering best practice care for the patient.

2.4.4 - Tactical

An expenditure and income position (Control totals) for the end of this financial year has been agreed with all business units. The Business Units are now managing to ensure that they deliver this. The Executive Team are providing additional support to areas where this is needed.

Plans are now being developed for 2016/17 financial year.

3. Governance Arrangements

The Portfolio Improvement Board is chaired by the Chief Executive with full executive attendance. This was also supported by the TDA Improvement Director until recently and ULHT has now appointed an Associate Director of Improvement.

The individual Senior Responsible Owners have reporting arrangements with the Improvement Hub which holds the master milestone plans and progress reports. An overview of progress, with corrective action for any plans not on trajectory, is submitted to the Trust Board on a monthly basis.

4. Conclusion

ULHT has an agreed Improvement Portfolio with a robust governance framework. The table below gives an overview of the current position for January 2016.

PROGRAMME OVERVIEW	Current Period RAG	Next Period RAG	Senior Responsible Owner (SRO)
Quality Improvement Programme	**A/G (Jan)**	**A/G (Feb)**	Michelle Rhodes
Workforce and Organisational Development	**A/R (Jan)**	**A/R (Feb)**	Ian Warren
Constitutional Standards	**Amber (Jan)**	**Amber (Feb)**	Mark Brassington
Financial Recovery	**A/R (Jan)**	**A/R (Feb)**	Jason Burn

5. Consultation

Not applicable

6. Background Papers

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

This report was written by Jan Sobieraj, Chief Executive (ULHT), who can be contacted on (01522) 512512 or jan.sobieraj@ulh.nhs.uk

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

Open Report on behalf of Healthwatch Lincolnshire

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**17 February 2016**
Subject:	**Healthwatch Lincolnshire Mental Health Report (November 2015)**

Summary:

This report sets out the final report from Healthwatch Lincolnshire on Mental Health Services, which was published in November 2015.

Since April 2013, Healthwatch Lincolnshire has been reviewing concerns raised by service users, patients and carers. Over the last 18 months mental health has consistently featured in the top reported themes for Lincolnshire residents and since the spring of 2014 we focussed on specific activities relating to mental health with the aim of identifying and exploring more deeply, some of the key areas of concern being highlighted.

Our report captures these key themes and in turn promotes the voice of the service user to support the awareness of mental health and the need for improvement of services. The overall findings did highlight some very good experiences of mental health services in Lincolnshire which is very encouraging. However, it also raised some areas of concern and as a result we included 25 observations, findings and suggestions.

Currently we are waiting for the outcome of the recent CQC inspection into LPFT services before any further steps can be taken.

Actions Required:

1. The Health Scrutiny Committee for Lincolnshire is invited to consider and comment on the Healthwatch Lincolnshire Mental Health report published in November 2015.
2. Following the outcome from the CQC inspection, the Health Scrutiny Committee for Lincolnshire may wish to decide to review improvements in mental health services, in relation to LPFT and the South West CCG demonstrating better outcomes for patients, users and their families.

1. Background

Our work was carried out in 3 stages from November 2014 until November 2015 with the engagement of 345 individuals feeding back their experiences and perceptions of mental health services.

Firstly, in spring 2014 a very broad piece of work was undertaken which looked at individual's views of services and support structures within mental health. We asked a small group of 23 people to complete a paper-based survey.

Secondly, we designed and distributed an in-depth structured survey. This survey looked at mental health services from the perspective of current service users and also those waiting to enter the assessment, diagnosis and treatment pathways. 126 people completed this questionnaire which was circulated to a range of groups including mental health support groups, home start centres and professionals working within the arena mental health.

Finally, during 2015 we invited 3 mental health organisations to gather the experiences and views of their service user groups. We asked that they share the results of this work as part of our Seldom Heard Voices programme. 196 people responded to this project through a series of survey and focus group activity.

In total, 345 individuals have been engaged with, and their voices form the basis of our findings.

2. Conclusion

Whilst we have identified 25 areas for improvement we can summaries these into the following areas:

- CAMHS and Transition to adult services
- Understanding and awareness of pathways and support networks
- Support and recognition (for mental health conditions)
- Training (for GP's and other frontline staff)
- Patient involvement (respecting feedback)
- General support for patients and carers
- In-patient services
- Discharge from hospital or care
- Missing persons
- Out of hours
- Self-harm
- Waiting times (and referrals)
- Perception of services
- Complaints

Following the completion and distribution of our November report, LPFT have provided responses to our findings.

3. Consultation

Not applicable

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Healthwatch Lincolnshire Service user, patient and carer views on mental health services – final report November 2015

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 Sarah Fletcher, Chief Executive, Healthwatch Lincolnshire, who can be contacted on 01205 820892 or sarah.fletcher@healthwatchlincolnshire.co.uk

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healthwatch Lincolnshire

Service User, Patient and Carer views on Mental Health Services

Final Report

November 2015

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Acknowledgements

Service users, patients and carers are at the heart of this report and it is to this group of people we have the biggest thanks to give. Agreeing to support our work was a big commitment and we recognise that without this support we would not be able to provide the rich feedback which gives validity and strength when representing the views of mental health users and their loved ones. We also recognise and value the support of the providers, commissioners and the community and voluntary sector without whom we would have not been able to access as many of the community.

Some Facts and Figures about Mental Health

A quarter of the population will experience some kind of mental health problem in the course of a year, with mixed anxiety and depression the most common mental disorder in Britain.

Women are more likely to have been treated for a mental health problem than men and about 10% of children have a mental health problem at any one time.

CAMHS failing parents with the eligibility criteria always changing.

Suicides rates show that British men are 3 times more likely to die by suicide than British women and self-harm statistics for the UK show one of the highest rates in Europe: 400 per 100,000 population.

Depression affects 1 in 5 older people.

Mental Health Foundation

Précis of Findings and Conclusions

The following provides an overview of some of the key areas for observation and development which can be found in full at the end of this report.

CAMHS and Transition to Adult Services. A lack of clarity is borne out by the questions and statements received from patients, parents and carers that indicate a complex pathway which is not effective. In addition, access to CAMHS and the transition between child and adult services is described as unclear and appears children do fall between the child and adult services.
Understanding and Awareness of Pathways and Support Networks. GPs and other health care providers supporting people with mental health conditions need to be more aware and be able to provide information about what support is available both clinically and within the community.
Support and Recognition. Patients accessing GPs and other support services highlighted the need for more support and recognition relating to their mental health concerns and its impact from their doctor or other health care professionals. For patients, recognition that mental health is a real concern for individuals was critical and felt they should not feel they are fobbed off or told to just live with it. This recognition should be for children, young people, adults and older people accessing support and ensure the removal of social stigma around mental health conditions.
Training. To ensure GP and other support services understand the Single Point of Access (SPA), the waiting times, referral processes and are able to relay them to the patients and carers. There needs to be clarification for the community on the role and purpose of the SPA and if it is a 'mental health only' single point of access.
Patient Involvement. Trusts and commissioners should receive regular feedback from community representatives and a varied selection of patients and carers.
General Support for Patients and Carers. This point was reiterated when respondents specifically considered carers. Carers considered referral to community support groups important especially in relation to reducing social isolation. Carers also felt that health and care staff did not understand their needs. In view of the Care Act 2014 all front line staff need additional training in the needs of carers, carer's assessment and community based support groups and services.
In-Patient Services. There appears to a high level of dissatisfaction with building-based community services. Hospital-based care was better received there were still significant issues relating to patient and carer perception. It is suggested that LPFT provide a greater range and variety of activities within these establishments and continue to review the impact inpatient services has on patients and loved ones.

Discharge from Hospital or Care. 80% of our respondents were unsatisfied with the discharge process from an inpatient setting. This replicates national concerns raised about unsatisfactory discharge and readmission rates. It also links strongly into our response to the Suicide Prevention Strategy.

Missing Person. We are concerned about the number of police calls to in-patients services at Pilgrim and PHC and we request more information and assurance from LPFT and commissioners that the reasons are within an acceptable tolerance.

Out of Hours. It was felt that there needed to be more access to help and support patients and families and carers particularly during 'out of hours' and at weekends. It was suggested that availability of CPNs and other support networks would be hugely beneficial.

Self-Harm. The number of respondents who had self-harmed and continued to self-harm raised questions and concerns about the recognition, support and prevention services for patients self-harming. Concerning was also the correlation of bullying and its impact on self-harm within our schools and colleges.

Waiting Times. Previous intelligence suggested there is a continuing problem with waiting times for mental health assessment. The findings of this work confirmed that waiting times were still an issue for patients who felt that capacity and timeliness of services was not satisfactory. When these issues are raised with the provider we have consistently been told that waiting times are within tolerance but this consistently has not been the feedback from patients. We would recommend transparent reporting.

Waiting Times and Referrals. In almost all the occasions where patients told us they had made a complaint, they were with reference to the complex referral backwards and forwards between GP and CMHT without any individual organisation taking responsibility for their care. LPFT/CCG should ensure there is a clear referral pathway and if this already exists, that all GPs and health professionals are clear on what it entails and adhere to it.

Perception of Services. With regard to special mental health support services many respondents highlighted services such as 24/7 telephone support, crisis team and counsellors as important in helping them with their illness. However we were concerned that the patient feedback we received doesn't consider STEP, Recovery College, HIPS, Green Light Team, day care and day hospital, DART, CAMHS and buddying service specialist psychological services as important.

Executive Summary

In 2014, Healthwatch Lincolnshire produced an interim mental health report for Lincolnshire. This led to the formation of an action plan and request for further information from commissioners and providers specifically where areas of development and improvement could be identified. This follow-up report is being presented by Healthwatch Lincolnshire as a final overview of results from our work to date.

Whilst this report provides a final overview of the evidence gathered by Healthwatch Lincolnshire and our partner organisations, we will continue to gather the views of patients, service users and carers relating to mental health services in the county. We will continue to share all intelligence Healthwatch Lincolnshire receives with the commissioners and providers of mental health services along with our national body, Healthwatch England, and other interested parties.

Since April 2013, Healthwatch Lincolnshire has been reviewing concerns raised by service users, patients and carers. Over the last 12 months mental health has consistently featured in the top reported themes for Lincolnshire residents and since the spring of 2014 we focussed specific activities relating to mental health with the aim of identifying and exploring more deeply, some of the key areas of concern being highlighted.

Our report captures these key themes and in turn promotes the voice of the service user to support the awareness of mental health and the need for improvement of services.

The key themes which came out of the work focused around the following areas:

Communication, Awareness and Recognition

Patients, carers and loved ones were impassioned when telling us that they wanted understanding, recognition and better communication around their mental health diagnosis and a real effort looking at new ways to eliminate stigma.

Community Based Services

Support networks and groups were probably seen as the most valuable services provided to patients and carers when dealing with mental ill health. The support includes providing information, reducing social isolation and providing a source of information that was integral to the recovery process.

Building-Based Services

There were some positive comments about ‘in-patient’ and ‘day-patient’ services. However, there were also themes that suggested good practice at some sites which was not replicated across all and this had a detrimental effect on the patient and loved ones.

Waiting Times, Transition and Pathways.

Clear pathways throughout the services were a priority for patients and carers and this was an area where they they felt let down. This was particularly true during the transition from child to adult services where patients felt they were passed between professionals with no one organisation taking responsibility for their care. Extensive waiting times for assessment and treatments also added to patient and carer concern and for many, this had a detrimental effect on their recovery.

Healthwatch will continue to keep a watchful eye over both the positives and challenges facing those dealing with mental health concerns within our county, whether they be the patients, carers and loved ones or those that work within that environment.

Introduction to Healthwatch

Healthwatch England is the national consumer champion in health and care. We have statutory powers to ensure the voice of the consumer is strengthened and heard by those who commission, deliver and regulate health and care services.

Healthwatch Lincolnshire came into effect on 1st April 2013 as an independent organisation and formed as a registered charity and Company Limited by Guarantee.

The Health and Social Care Act 2012 recognised the need for a local independent consumer champion for health and social care services to cover each of the 152 county councils or boroughs, with one overarching body, Healthwatch England. The Health and Social Care Act 2012 provided each Healthwatch with the following statutory powers:

- A duty of service providers and commissioners to respond to requests for information within 20 working days.
- A duty of service providers and commissioners to respond to recommendations within 20 working days.
- Make reports and recommendations about services known to commissioners, providers and regulators of health and social care services.
- A duty to allow entry to authorised statutory health and care facilities known as 'Enter and View' visits.
- A seat on the Health and Wellbeing Board to promote health improvements and tackle health inequalities.
- A process where recommendations to Healthwatch England about which special reviews or investigations may be required and where relevant to the Care Quality Commission.

Healthwatch Lincolnshire activities can be broken down into 3 core functions:

Influencing. We are here to listen to people's views and personal experiences of their health and care services and share the key messages we hear in order to help influence improvements in services.

Signposting. Signposting people to help them access advice, choice and information about their local health and care services

Watchdog. To ensure change is happening.

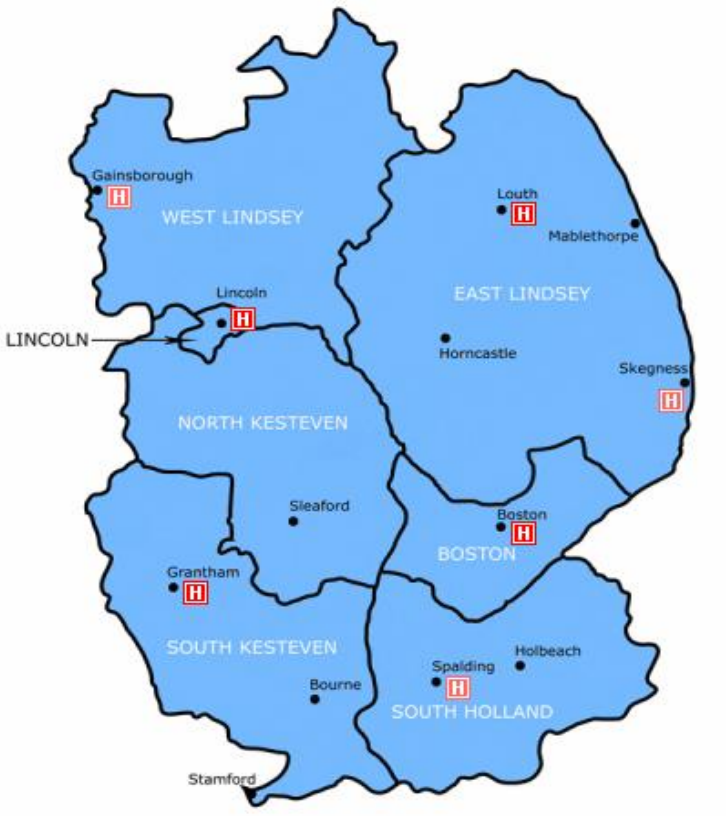
You can find out more about the work of Healthwatch Lincolnshire by visiting our website www.healthwatchlincolnshire.co.uk or contact us and a member of our team will be happy to discuss further.

A Brief Overview of Lincolnshire

Lincolnshire is England's fourth largest county (geographically). As a predominantly rural county with only one city, Lincolnshire is particularly challenged by its road networks having some of the largest number of B and C roads in the country. Transportation of patients to and from health and care services is a continual problem.

The 2011 census recorded a population of 713,653 residents (updated figures from Lincolnshire Research Observatory show an increase in our population to 724,500 by mid-2013).

A briefing by Lincolnshire Public Health Intelligence shows 101,300 people of all ages (16+) having a common mental disorder of which 56,300 having mixed anxiety and depressive disorder and 27,500 with generalised anxiety disorder. When apportioned by age group, prevalence of mental ill health is estimated to be highest in persons aged 45 - 54.



The number of residents who were born outside of the UK has more than doubled in the past 10 years with Lincoln, Boston and South Holland having the greatest proportion of foreign born residents.

Lincolnshire is still well below the national statistics of non-white population (14%), having 2.4% of its residents as non-white, the majority being younger and economically active.

The 2014 Health Profiles for Lincolnshire show that in comparison to England as a whole, the health of people in Lincolnshire is varied. For example, deprivation in the county is generally lower than the England average, but about 17.2% (21,300) of children live in poverty. They also show that priorities are obesity (Lincolnshire is showing worse than England average statistics), smoking and alcohol.

Lincolnshire health and care key organisations are currently working on reorganising and integrating health and care services across Lincolnshire. This work will provide services much closer to home, helping to ensure more people are treated locally and away from hospital and may result in future significant changes as well as financial savings.

Background to the Report

It is important to firstly recognise those people who have contacted Healthwatch Lincolnshire to tell us about their mental health experiences. Patients, families and carers themselves have identified concerns when trying to access mental health services and it is their voices that is the instrumental driver for this report. The volume of feedback we have consistently received from patients, service users and carers over the 2 years indicates that there are issues with access, diagnosis, treatments and ongoing support for people with mental health conditions.

From a national perspective there has been a great deal of recognition that not enough money is being spent on tackling the growing problem of mental health in children, young people and adults:

- *Mental health needs to be more of a priority, with targets for waiting times and more protection for funding, says England's chief medical officer. Dame Sally Davies said there were signs funding was being cut at a time when the cost to the economy was rising. Her annual report said mental illness led to the loss of 70 million working days last year - up 24% since 2009.*

- *Minister of State, Paul Burstow, quoted from No Health without Mental Health Implementation Framework. "At any one time, roughly 1 in 6 of us is experiencing a mental health problem. While that is a staggering figure in itself, mental health problems are also estimated to cost the economy an eye-watering £105 billion per year."*

- *In March 2013 the Department of Health stated "There's evidence that mental health services aren't meeting the needs of some groups of people. For example, only 1 in 6 older people with depression ever discusses it with their GP. So we're giving local Health and Wellbeing Boards a duty to reduce health inequalities in their area, including in mental health".*

- *The World Health Organisation report state that mental health problems account for 23% of the total 'burden of disease' in the UK; while the 'No health without mental health' report states at least 1 in 4 people will experience a mental health problem at some point in their lives, with 1 in 6 having a mental health problem at any one time (HM Government, No health without Mental Health (Feb 11).*

What is Mental Health?

A person who is considered 'mentally healthy' is someone who can cope with the normal stresses of life and carry out the usual activities they need to in order to look after themselves, can realise their potential and make a contribution to their community. However, your mental health or sense of 'wellbeing' doesn't always stay the same and can change in response to circumstances and stages of life. Mental illness is common but fortunately most people recover or learn to live with the problem, especially if diagnosed early.[1]

Mental ill-health represents a complex and multi-faceted public health problem and one which has wide-ranging social and economic implications, as well as stark consequences for physical health (HSCIC, Health Survey for England – General mental and physical health (www.hscic.gov.uk/catalogue/PUB13218/HSE2012-Ch4-Gen-health.pdf).

The Health and Social Care Act 2012 enshrined in law the principle of parity of esteem, whereby mental health must be given equal priority to physical health. However, according to the Centre for Mental Health, an independent mental health charity, there are many areas where parity of esteem has not yet been realised.

Nationally, the Care Quality Commission has found that too many health-based places of safety are turning people away because they are already full and some are refusing to help people who are intoxicated or exhibiting disturbed behaviour. Too many providers operate policies that exclude young people, people who are intoxicated and people with disturbed behaviour from all of their places of safety. The most common reasons for health care admissions directly due to alcohol are mental and behavioural disorders, alcoholic liver disease and ethanol poisoning.

Out of all alcohol-specific conditions, the highest numbers of admissions were caused by mental and behavioural disorders due to the use of alcohol (this includes a wide range of problems from acute drunkenness to chronic alcohol dependence, alcohol withdrawal, hallucinations, memory loss and other conditions) (**Lincolnshire Alcohol Health Needs Assessment 2014).**

'Mental health problems cost the UK economy an estimated £70bn annually.'
(Wellbeing in four policy areas' All Party Parliamentary group on Wellbeing Economics.)

[1] A health needs assessment for adults with a learning disability in Lincolnshire 2012 NHS Lincolnshire et al
[2] BBC Science

Methodology

Our work was carried out in 3 stages from November 2014 until November 2015 with the engagement of 345 individuals feeding back their experiences and perceptions of mental health services.

Firstly, in spring 2014 a very broad piece of work was undertaken which looked at individual's views of services and support structures within mental health. We asked a small group of 23 people to complete a paper-based survey.

Secondly, we designed and distributed an in-depth structured survey. This survey looked at mental health services from the perspective of current service users and also those waiting to enter the assessment, diagnosis and treatment pathways. 126 people completed this questionnaire which was circulated to a range of groups including mental health support groups, home start centres and professionals working within the arena mental health.

Finally, during 2015 we invited 3 mental health organisations to gather the experiences and views of their service user groups. We asked that they share the results of this work as part of our Seldom Heard Voices programme. 196 people responded to this project through a series of survey and focus group activity.

In total, 345 individuals have been engaged with and their voices form the basis of our findings.

The Interim Mental Health Report, Children and Young Peoples' Report and the Seldom Heard reports can all be found on our website at www.healthwatchlincolnshire.co.uk under the Public Documents section.

Overview of Key Findings for Part 1

Our first piece of work focussed broadly on a person's mental health and general wellbeing and tried to gather an overarching level of satisfaction from the patient perspective. This was complimented by the findings in our children and young people report 'Hear our Voice' published in December 2014 where mental health was a key driver in the wellbeing of young people.

One young person said:

'There is not enough emphasis on recognising mental health problems among young people. Many feel like they are all alone or do not want to bother others so the problem gets ignored resulting in more serious consequences.'

The findings from this first piece of work generated the following themes.

- GPs and other health care providers supporting people with mental health conditions need to be more aware and be able to provide information about what support is available both clinically and within the community.

- It was felt that there needed to be more access to help and support, particularly during 'out of hours' and at weekends. It was suggested that availability of CPNs and other support networks would be hugely beneficial.

- The number of respondents which had self-harmed and continued to self-harm raised questions around the recognition, support and prevention services for patients self-harming.

Self-harm and bullying were also a key and consistent component of the information school aged children and young people told us during our Children and Young People Report. We felt that our education system tells us that bullying is not tolerated in our schools within Lincolnshire, however, when we were seeing 93.6% of our children and young people saying they were bullied and being bullied within our schools and colleges, this could not be ignored or tolerated and we raised it within the report as a priority for development. This is a classic example of what we were being told from the providers and authorities not correlating to public experiences - *how many times have we heard "If only they had listened to us or taken note"*.

Overview of Key Findings for Part 2

Our survey, targeted at adults, was completed between late September and early November 2014, with 126 individuals feeding into it.

The findings within this phase highlighted some very good experiences of mental health support services in Lincolnshire which is encouraging for all concerned. However, it also highlighted some key areas of concern raised by service users, carers and loved ones which require consideration.

The findings from this piece of work generated the following themes.

- **Waiting Times.** Previous intelligence suggests there is a continuing problem with waiting times for mental health assessment. The findings from this piece of work confirmed that waiting times were still an issue for patients. Patients felt that capacity and timeliness of services was not satisfactory. When this has been raised with the provider we have been consistently told that waiting times are within tolerance but this has not been the feedback from patients. One patient told us they were given an 18 month waiting time for an assessment.

- **Discharge from Hospital or Care.** 80% of our respondents were unsatisfied with the discharge process. This replicates national concerns raised about unsatisfactory discharge and readmission rates.

- **Caring** for any ill or disabled relative can be stressful and a major commitment. The findings suggest there should be much more support offered for those families that are having to care for family members or friends with long-term or severe mental health conditions, particularly where the carer is an older person.

- **Patients accessing GPs and other support services** highlighted the need for more support and recognition from their doctor or other health care services. For patients, recognition that mental health is a real concern for individuals was critical and felt they should not be fobbed off or told to just live with it, which is a statement we heard on numerous occasions. This recognition should be for children, young people, adults and older people accessing support.

- With regard to **special mental health support services** many respondents highlighted services such as 24/7 telephone support, crisis team and counsellors as important in helping them with their illness. However we were concerned that patient feedback didn't consider STEP, Recovery College, HIPS, Green Light Team, day care and hospital, DART, CAMHS and buddying serviced specialist psychological services as important.

- Two of our respondents directly highlighted the need for more support for **ex-military** personnel. This suggests there may be a need to work with partner agencies to look at what services might need to be put to support services personnel.

Overview of Key Findings for Part 3 Seldom Heard Voices

Following our initial phases we continued our work around mental health and the theme was integral to our Seldom Heard Voices work. The full Seldom Heard Report is available on our website, however we have captured the findings related to mental health in this section http://www.healthwatchlincolnshire.co.uk/seldom-heard-voices-reports/.

We worked with 3 organisations to enable better access to people living with mental ill health they were, Shine, Peterborough & Fenland MIND and Rethink. Each organisation selected their own method of service user engagement which included face-to-face engagement and surveys. 95 mental health service users and 101 carers were consulted as part of this work. The following information is a summary of the feedback from these individuals.

The findings from this piece of work generated the following themes:

- Over half of respondents were **satisfied with waiting times and support from staff for mainstream primary care services** such as doctors, dentists, opticians and pharmacies but over 50% said their ability to book appointments was affected by their mental health. Nonetheless, patients did say they felt GPs did not have time to see the person, they just saw the diagnosis and that GPs in general, need to make more effort to understand mental health.

- 80% received an appointment letter within 3 months of contacting mental health services and a similar number had the appointment within a further 3 months. This means that some patients had to **wait up to 6 months from initial diagnosis with GP to see a specialist service**.

- A further 18% waited over 3 months for both appointment letter and actual appointment. However, **67% of these had their appointments changed and 38% of these had a second notification of change.** Those patients whose appointments are on a 4-weekly cycle or shorter were happier about the process than those on a 4 - 13 week or more cycle. 87% felt that 4 - 6 weeks was an acceptable time to wait to see a Psychiatrist.

- Overall **waiting times appear to cause most distress**. Service users have made comments such as *"there is a need for more frequent appointments"* and *"more could be done for us with more regular appointments"*.

- In the community it was generally felt that patients received high quality, responsive treatment from both CPNs and the Psychiatrist although there were problems around **cancellations and lack of communication with carers**. However, at Lincoln CMHT a number of patients felt that the service received was dismissive and of little use and at Spalding, carers indicated that appointments for those they care for were often cancelled due to **staff sickness**. This has been borne out by correspondence from LPFT to Healthwatch Lincolnshire stating they have seen unprecedented levels of staff sickness in some areas.

- 68% of carers felt that referrals to **voluntary/community sector support groups were extremely valuable**. The benefits identified included a reduction in social isolation providing an opportunity for peer support, gaining information and advice and an understanding that they weren't alone in dealing with particular problems.

"Without Upbeat my mental health would deteriorate dramatically"
"It is good to have somewhere to go and chat to like-minded people"
"I have found the Mindfulness group in Louth very helpful"

- Only 42% of service users in hospital felt they had been involved in the discharge process and only **50% of discharges were considered satisfactory**.

- Discharge in general, received a number of negative comments such as they were discharged too soon due to a lack of staff. One carer said *"they discharged my husband too soon - he was clearly still very ill, but they didn't have anyone to see him, so they just discharged him"*. Another comment said *"They discharged my son too soon. He was not well enough to live independently and the only reason he was discharged was because they had reached the limit of what they could offer him and, in addition, his CPN was frequently off sick"*.

- In respect of Boston CMHT and PHC, there was strong feeling that discharge came at the right time for those they care for with assurances of fast-track re-referral in case of relapse. They were consulted regarding discharge plans although 2 respondents felt that the package of support offered following discharge was poor.

- Overall there is a view that **waiting times for any kind of 'talking' therapy** such as counselling, CBT and other related therapies were too long throughout Lincolnshire. At least 3 carers are still waiting to receive counselling nearly 4 months after the initial referral was made.

- **Only 36% of the people feeding back said they were referred to a support services** or groups such as Kingfisher, Greenfingers or mindfulness, 60% of whom rated these very highly. However, over **70% were not given any information** about the managed care network or Shine - services which are funded directly by LPFT.

- Rethink also looked at some of the **building-based support** such as Holly Lodge, Long Leys Court, Witham Court and Beaconsfield Centre. These were generally **rated as poor by 50% of users.** It was felt there were very few activities for service users and service users tended to spend most time in the day rooms watching TV. Patient and carer feedback suggests significant improvements were needed in terms of staff attitude, communication, and facilities.

- Discovery House and Peter Hodgkinson Centre received praise from service users and carers who felt that services provided by Discovery House were of a very good standard, and delivered in a timely manner. At Peter Hodgkinson Centre respondents felt that in terms of intensive support, patients said ***"PHC is one of the best places in Lincolnshire. However, it is less suited to those who are not psychotic or severely mentally ill"*** and ***"the people in the PHC were great; they really helped me and seemed to know how I felt even though they weren't in my shoes"***.

For people with mental health conditions coping mechanisms with everyday situations are essential. Functions like telephoning for an appointment, having to make challenging or even basic decisions about their health or care needs, having to wait long times for an appointment with a professional when they need that help immediately, feeling suicidal and not knowing where or who to go to because ***"I can't get through to the crisis team"*** exasperate their illness. Some services were rated as excellent, others not so, and this rating was also linked to geographical delivery. This demonstrated that there are gaps and inequalities in mental health support services across our county. This service postcode lottery could result in life or death situations. The core themes that came out of seldom heard work were as follows:

- **Communication.** Adapt the methods of communication to meet the patient's or communities' needs was continuously referred to throughout the seldom heard work. Communication needs to be fit for purpose and achieve its purpose - if communication is failing our communities then this needs to be addressed at all levels and across all sectors.

- **Training.** Better awareness of specific disabilities and conditions; personal barriers for patients needs to be a priority, recognising that more materials and access to information for the patient and the clinician should lead to more educated choices being made.

- **Emotional and Mental Health Support.** Helping people manage their health, mental health and disability conditions on a daily basis. Across all areas limited or poor access to mental health services was seen as having a direct impact on people's wellbeing in the county.

- **The Wider Community.** Better use of voluntary and community services would help people manage their conditions on a daily basis. If statutory providers and commissioners invested more in voluntary and community services, it could help to alleviate pressures and save money in the long term.

Additional Information

Healthwatch Lincolnshire acknowledge that there are more sources of data and rich intelligence available which can balance any number of surveys or focus group feedback and as such, we have tried to draw some of this additional information together within this section.

CAMHS – Children and Adolescents' Mental Health

From Autumn 2013 reports in the media and Parliament highlighted the problems for young people having to travel hundreds of miles from home to receive inpatient treatment. Following this, the Chief Medical Officer focused one chapter of children's mental health in their 2013 Annual Report. As a result, the House of Commons Health Committee launched an inquiry into all areas of children's and adolescents' mental health and CAMHS services. The results of the inquiry and recommendations from the Health Committee can be read in their report published on 5 November 2014 (HC342) Children's and Adolescents' Mental Health and CAMHS http://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/inquiries/parliament-2010/cmh-2014/

Key agencies in Lincolnshire have come together to plan, develop and design a single approach to transform mental health and wellbeing services for Lincolnshire children and young people. The Lincolnshire Local Transformation Plan (September 2015) sets out multiple priories for service provision and ambitious aspirations for future provision that will require radical service transformation and ongoing joint working across agencies including schools and health and service users. The plan can be accessed via the Lincolnshire County Council's website or the following link http://lincolnshire.moderngov.co.uk/documents/s11757/Appendix%20A%20-%20CAMHS%20Transformation%20Plan.pdf

Healthwatch England have been conducting national enquiries and collating evidence relating to access for children's and adolescent mental health services (CAMHS). Problems relating to CAMHS services have been highlighted across the Healthwatch network. Provision of children and adolescent mental health services in Lincolnshire has been under national scrutiny.

During 2014 Healthwatch Lincolnshire carried out some work with children and young people which asked them about their experiences of health and care services. The work highlighted a number of concerns including the impact of self-harm, bullying and triggers for stress and depression. A copy of the full report 'Hear our Voice' can be downloaded from our website www.healthwatchlincolnshire/public-docs/2014.

What parents and young people told us?

- *"It is difficult to access CAMHS or know where to go to. Once in the service there appears to be no continuity with staff changing on a regular basis which is difficult for the young service users to comprehend"*.

- *"Our 17 year old who had been using the services of CAHMS was removed (because of age) from the service just before his 18th birthday without much of an explanation of where to go for further support"*.

- **October 2015.** A 14-year old who needed support was put on a children's ward at one of our Lincolnshire hospitals. The environment wasn't suitable and the clinical staff were unable to cope. The child's mother was unhappy about the way the staff dealt with the situation and the hospital called the police with the result that the patient was sectioned. The child was then taken out of county and mother was unable to see her child until next day after a journey which took four and half hours.

- **October 2015:** A young person with a mental health diagnosis had only 2 days medication left and tried to get appointment at GP surgery in Boston for a repeat prescription but was informed that there were no appointments for 3 weeks. The patient contacted their mentor at the Prince's Trust who telephoned the surgery on their behalf and got an appointment for the same day. The surgery said it was a cancellation, however, this raises concerns for us as there seems to be a lack of regard for this young person's medication needs and those professionals not taking young people seriously especially if they have mental health issues.

The lack of clarity is continually borne out by the questions and statements received from parents that indicate a complex pathway which is not supportive.

The following details a few questions raised by parents in October 2015 relating to CAMHS and mental health in Lincolnshire:

- *"What is the transition point to adult services, 18 or 25? And how is transition supported?"*

- *"Communication with carers once a child reaches 18 needs exploring."*

- *"Parental support is great once under their care". "Unacceptable lack of acute beds locally."*

- *"Where is early intervention and where is mental health support in schools and primary care for children?"*

- *"Lots of GPs need enhanced training in mental health including suicide prevention training for all."*

It is hoped that continually raising the profile of mental health for young people will improve outcomes for current and future users of services.

Healthwatch Lincolnshire Response to the LPFT Summit

A risk summit was called in response to concerns raised regarding the care offered by Lincolnshire Partnership NHS Foundation Trust (LPFT). The risk summit was an opportunity for organisations to outline their concerns and for the provider to respond.

Once issues were identified the whole health and social care system could agree actions and timelines to address these areas to be monitored.

All organisations present were requested to provide an overview of their findings. All contributed including Healthwatch. This is what we said:

> *Healthwatch have been aware of consistent concerns since 2013. Concerns are fed back to commissioners and the provider. Helpful ongoing dialogue and sharing of data and information between partners was described. The Healthwatch report on mental health services which was interim at December 2014 is now finalised. Long Leys Court is cited within the report. Patients have fed-back on staff attitude, risk management and carer and patient engagement. Healthwatch Lincolnshire supports the Trust and CCG action plan, however, felt that more focus on advice and education for patients and service users is needed.*

Freedom of Information Requests made by Healthwatch Lincolnshire

Healthwatch Lincolnshire recognises that mental health has an impact on more than one sector of the community and often on more than one service provider. As a result, we sought to look at some facts that would build a picture of where mental health impacts on other services.

In October 2015 we made Freedom of Information requests to look at the levels of impact mental health has on services. These were sent to Lincolnshire Police and the mental health provider Lincolnshire Partnership Foundation Trust (LPFT).

The requests made are as follows:

FOI to Lincolnshire Police. Police Call-Outs to NHS Mental Health Services (LPFT):
Over the last year, on how many occasions have your officers been called out to each of the LPFT hospital sites (Pilgrim Ward 12, Peter Hodgkinson Centre) breaking down all reasons for attendance at LPFT hospital premises. For example, how many call-outs were to PHC in 2015 (to date) for alarms, concern for safety and missing persons? How many of these were deemed an appropriate call-out?

FOI to NHS Mental Health Services (LPFT) . Call outs to Lincolnshire Police:
Over the last year, on how many occasions have your staff called for police officers to attend each of the LPFT hospital sites (Pilgrim Ward 12, Peter Hodgkinson Centre) breaking down all reasons for attendance at LPFT hospital premises. For example, how many calls from your staff to the police in 2015 (to date) were related to alarms, concern for safety patient safety on-site, staff safety on-site and missing persons? Were these call-outs attended?

Conclusions

It is acknowledged that upon receipt of any information relating to a FOI request the information provided remains the copyright property of the owner. In the interest of timeliness for the report, Healthwatch has requested permission to utilise the full data set as provided but in the interim, wishes to highlight issues raised as a direct result of the data being provided without specifics.

Lincolnshire Police, Hospital and Mental Health Trust Impact.

We recognise that on occasion our Acute and Mental Health Trust may require assistance from the Police as an emergency service to attend and support any number of incidents. However, we were particularly interested in how this featured when comparing the Acute Trust with the Mental Health In-Patient provision and their calls to Lincolnshire Police. Specifically we were interested in two areas - 'concern for safety' and secondly, we were interested in the number of times Police were called where individuals had gone missing from a service. The time period looked at was between 1 January 2015 and the point of making the FOI in late October 2015, nearly 10 full months.

For clarity the following provides a brief overview into the categorisation of a call taken in excerpt from the NSIR.

Concern for Safety within Public, Safety and Welfare.

Where a report is received where there is genuine and justifiable concern for a person's welfare or well-being and where the report does not outline any information which may indicate that the person is missing. It is the risk assessment of a call to the police which will determine the response. This category includes reports that a person has been found either collapsed or appears to be suffering from any illness or injury (including mental illness) or is trapped. It will also include those who have deliberately self-harmed.

Missing Person within Public, Safety and Welfare.

Where a report is received and is assessed as one of the following:

- *High Risk. The risk posed is immediate and there are substantial grounds for believing that the subject is in danger through their own vulnerability or mental state or the risk posed is immediate and there are substantial grounds for believing that the public are in danger due to the subject's mental state.*
- *Medium Risk. The risk posed is likely to place the subject in danger or they are a threat to themselves or others.*
- *Low Risk. There is no apparent threat or danger to either the subject or the public.*

We observed from the information received from Lincolnshire Police that the number of calls for Concern for Safety and Missing Persons featured highly in terms of total calls made across all categories to both the ULHT and Mental Health Trust sites. However, we noted specifically the information relating to the Mental Health In-patient facility at Peter Hodgkinson Centre (PHC Lincoln) and Ward 12 (Boston Pilgrim). We saw that on average, Concern for Safety across 3 ULHT hospital sites from January to October averaged 33% of total calls whilst Missing Person was averaged at 9% of all calls received during that period. This, when compared to the Mental Health Trust (LPFT) data was considerably different - from January to October Concern for Safety calls averaged at 17% of total calls and Missing Person averaged at 29% of all calls received during that period made by the PHC and Ward 12.

On the basis of the police data, we are concerned about the number of calls related to the inpatient setting of Peter Hodgkinson and Ward 12 at Boston including the significant number of Police call-outs to Missing Person. This was further supported by the data received from LPFT where on average, the percentage of all calls to the Police for missing persons equated to 48% across PHC and Ward 12 over 3 years. In addition, we noted that the data relating to missing persons at PHC bore no relation to the data received from Lincolnshire Police - Lincolnshire Police reported missing person calls 64% higher than what LPFT said they made. Where patients are supported within an in-patient facility, we would like to understand why the Police would be called to Missing Person reports to such a high level (29% of all calls made to the police from Ward 12 and PHC). Healthwatch would like to seek reassurance from LPFT around Missing Person calls, specifically whether there is an issue with the physical building when protecting patients from going missing or whether there is another underlying reason.

Healthwatch Lincolnshire Response to Suicide Prevention Strategy

LPFT have released their Draft Suicide Prevention Strategy for consultation. In light of the findings of our work, this is what Healthwatch Lincolnshire said:

> ***"Firstly we agree with the 2 final points made by Mark Housley, specifically in relation to the strategy seemingly being focussed on high risk groups and the question raised why the focus here was high risk - as opposed to all groups at risk. We also agreed that the plan did not seemingly seek to do anything different to tackle a culture in which mental illness, such as depression, is still taboo. We are aware within Healthwatch locally, this culture impacts on hard to reach groups such as the working male population and rural and isolated communities such as farming.***
>
> ***We fully support the recognition and intention to 'plug the gaps' (as it was phrased) for those in crisis and those who do not meet the thresholds for other services. We look forward to seeing the operational development of this as certainly within the work Healthwatch Lincolnshire has undertaken, crisis and Out of Hours pathways have been challenging, not only for patients and their loved ones, but also for services.***
>
> ***We noted risk emanating from an in-patient setting and its reported association with suicide and also noted that the National Confidential Inquiry saw the importance of optimising ward safety through the removal of ligature points and reducing absconsion. Given the recent Freedom of Information requests by Healthwatch Lincolnshire, we are concerned that the latter is an area which presents many challenges to the in-patient services along with other agencies such as the police and ambulance service. However, given the number of missing person calls from our in-patient units at Boston and Lincoln, we feel that any improvement in absconsion could quickly stop preventable suicides within the county.***
>
> ***We also note from our work in various health settings that the challenges around patient discharge into an appropriate and supported setting can be challenging and agree that achievement of that should be integral to the strategy and future improvement of services.***

We were pleased to see the acknowledgement and a will around training and development for staff and others that come into contact with those at risk and specifically those who deliberately self-harm. Through our own work, specifically around mental health, we found the need for recognition, understanding and support without prejudice to be crucial in the support of patient wellbeing and recovery and certainly the link between poor care experiences and declining health, was evident. Finally, we would like to note for consideration removal of the word 'endeavour' from the strategy document. Whilst we appreciate there is financial and capacity limit for all services and the intention to do the very best for patients, we still feel that the commitment would be stronger with its use."

Mental Health as a Secondary Consideration

When we think of mental health we often think of it in isolation so as to not lose the importance of an individual suffering from mental ill health. Nevertheless, we may sometimes lose sight of the occurrences where mental health is a secondary consideration and the core physical health diagnosis takes precedence. Over the last 12 months we have seen occurrences of this in the work we have undertaken and have provided some of the examples below:

Terminal illnesses, Waiting for Referral and Support.

We have heard that patients suffering from terminal and life-limiting conditions often suffer with mental health issues. However, this part of their care can often be missed or overlooked with the focus being the physical care and treatment of a patient. Whilst completing some recent work around hospice care patients, carers and loved ones told us that the support in the community and accessing psychiatric assessment was very limited and getting the support when they needed it was challenging.

One patient told us *"I have had to wait a long time for mental health support. It was 6 months before I had an initial appointment"*. This client has terminal cancer and feels this should be taken into consideration.

Other Health Conditions that lead to stress and depression such as aggressive alopecia or psoriasis are often seen as a secondary diagnosis, as are conditions such as epilepsy and more severe forms of the condition could be more prone to suicide.

People living with complex health and disabilities which cause social isolation can also experience mental health issues as a direct response to being isolated causing anxiety and depression.

People living in poverty, substandard accommodation, long-term unemployed and those facing reduced benefits are all key causes of stress and depression. More recently we have seen a link between working-age men and self-harm where unemployment and relationship breakdown have all been triggers for their behaviours and mental state.

Being homeless. One person told us *"As a professional, who has on numerous occasions tried to link clients in with mental health services, I am exasperated with the current set up of services. I work with rough sleepers and there is a reluctance from mental health services to engage with our client group unless in an absolute crisis. Very often people will rough sleep because of their poor mental health, yet because they are of no fixed address services will not engage with them"*.

Findings in Summary

After engaging with 345 patients and carers and undertaking additional background data collection, we have concluded our findings alongside which LPFT responses can be viewed.

We recognise and acknowledge that not all themes relate to one service provider and/or commissioner and with this in mind we will ensure that all relevant parties have an opportunity to receive and comment on the content. More specifically, we would hope the issues raised are acknowledged and that feedback around current activity and planned local and national initiatives will be included. This we hope will demonstrate how providers and commissioners provide the people of Lincolnshire with positive improvement in mental health, removing the stigma and providing proactive and joined up services for all. The table below outlines our final thoughts - we acknowledge the areas below are highlighted as issues of concern, however, this should in no way detract from the positive feedback and activity also described within the report.

No	Observations, Findings and Suggestions	Provider/Commissioner Feedback/Action/ Supporting Information
1	**CAMHS and Transition to Adult Services.** A lack of clarity is borne out by the questions and statements received from patients, parents and carers that indicate a complex pathway which is not effective. In addition, access to CAMHS and the transition between child and adult services is described as unclear and appears children do fall between the child and adult services.	There are differences in thresholds for access to the CAMHS and the adult services due to the commissioning of the services. LPFT are currently working on improving the transition pathway between CAMHS and Adult Services and this is due to be shared with Commissioners in Jan 16. This will enable better joint working between CAMHS and Adult Services where young people meet the criteria for adult services. There are various transition ages across paediatric care, mental health and physical healthcare - this issue has been acknowledged by the Commissioners. The CAMHS service is going through a transformation with the new model commencing in Apr 16, specifically for those requiring transition to adult services, the lead professional will adhere to the following process:

		• A lead person from each involved service will be identified to be responsible for the operational elements of the transition. • The young person will be identified and referred at least 6 months prior to their 18th birthday (18.5 years for LAC). • The young person (and where appropriate their parent or carer) will be involved in the planning and decision making and will be prepared in advance for the transition meetings; this will include the use of clear adolescent-friendly information to the young person abut the range of adult services. For those with complex or severe needs the Care Programme Approach (CPA) will be used. This will include a formal transition CPA meeting involving CAMHS and AMHS (plus any other appropriate services). For those not formally under the CPA the same principles of joint transition meetings will apply. The purpose of which are the completion of a transition treatment plan including both Risk and Crisis Contingency Planning. The frequency of joint/transition meetings will be agreed at these forums. A clinically appropriate number of appointments will be offered during this 'hand-over period'. The specific needs of more vulnerable individuals such as young people with learning or physical disability, LAC clients, homeless young people etc will be taken into account, addressed with other appropriate professionals involved, in order to create a plan that is holistic, seamless and inclusive.

2	**Understanding and Awareness of Pathways and Support Networks.** GPs and other health care providers supporting people with mental health conditions need to be more aware and be able to provide information about what support is available both clinically and within the community.	Work is currently underway to ensure local services are aware of what exists within their area. A local directly will be available from June 2016. This will be shared with GPs. In addition to this, GPs already have access to SHINE ambassadors who have a wealth of knowledge of non-clinical services in their local areas. All services within LPFTs Adult Community Division will have clear criteria that will be agreed with Commissioners, shared with GPs and published on the LPFT website.
3	**Support and Recognition.** Patients accessing GPs and other support services highlighted the need for more support and recognition relating to their mental health concerns and its impact from their doctor or other health care professionals. For patients, recognition that mental health is a real concern for individuals was critical and felt they should not feel they are fobbed off or told to just live with it. This recognition should be for children, young people, adults and older people accessing support and ensure the removal of social stigma around mental health conditions.	LPFT is committed to working with our colleagues in Primary Care and in support their education of mental health issues and services. This issue was highlighted to us through our patient and carer engagement workshops earlier this year and as a result, our new Clinical Strategy for 2016/17 highlights our ambition to provide support/training for Lincolnshire GPs to support mental health and learning disability awareness.
4	**Training.** To ensure GP and other support services understand the Single Point of Access (SPA), the waiting times, referral processes and are able to relay them to the patients and carers. There needs to be clarification for the community on the role and purpose of the SPA and if it is a 'mental health only' SPA.	The Single Point of Access (SPA) in LPFT has recently been changed to ensure that referrals are passed onto the appropriate services more efficiently. LPFT will ensure that these new arrangements are communicated to GPs and other referrers. The SPA continues to be the Single Point of Access for all LPFT services, in summary: mental health, learning disability and drug and alcohol services. Arrangements have been made for any referrals for social care needs received by the County Council to be passed to the LPFT SPA, for people whose social care needs can be met through LPFT services.
5	**Patient Involvement.** Trusts and commissioners should receive regular feedback from community representatives and a varied selection of patients and carers.	LPFT have plans for the establishment of 2 new groups in Boston and Skegness. LPFT, SWLCCG and

		Healthwatch Lincolnshire will hold quarterly meetings to ensure patient concerns are shared.
6	**General Support for Patients and Carers.** This point was reiterated when respondents specifically considered carers. Carers considered referral to community support groups important especially in relation to reducing social isolation. Carers also felt that health and care staff did not understand their needs. In view of the Care Act 2014, all front line staff need additional training in the needs of carers, carer's assessment and community based support groups and services.	**SWCCG.** Mental Health provider partners should consider a pathway tool which will inform and explain to patients, families and carers what mental health services are in Lincolnshire, how and when they should be accessed and include interim referrals to local self-help and support networks.
7	**Lincolnshire South West Clinical Commissioning Group.**	**Directory of Services.** SWLCCG Head of Engagement and Inclusion Officer to scope production of directory of services to support GPs and other health and care providers with their patients and service users.
8	**Lincolnshire South West Clinical Commissioning Group.**	Neighbourhood Teams and Primary Care Co-commissioning to be utilised as a vehicle for CCGs to engage GPs in developing a framework for supporting patients with long-term conditions in the community.
9	**Appointments.** Clinical Commissioning Groups CCGs need to consider ways to make it easier for mental health patients to have the confidence and ease of access to make and cancel an appointment.	
10	**In-Patient Services.** There appears to be a high level of dissatisfaction with building-based community services. Whilst hospital-based care was better received, there were still significant issues relating to patient and carer perception. It is suggested that LPFT provide a greater range and variety of activities within these establishments and continue to review the impact in-patient services has on patients and loved ones.	All inpatient wards have signed up to a triangle of care initiative which ensures carer's involvement. Wards continually seek Service User feedback and have "you said, we did" boards. Activity Hub has been developed at Lincoln.

11	**Discharge from Hospital or Care.** 80% of our respondents were unsatisfied with the discharge process from an in-patient setting. This replicates national concerns raised about unsatisfactory discharge and readmission rates. It also links strongly into our response to the Suicide Prevention Strategy.	Discharge processes will be one of the leading quality initiatives for the inpatient division in 2016. Linking up the care provided in community, through crisis teams and on patient wards is a priority for LPFT. We are aware of concerns raised by service users in relation to this and work with the Community Care Coordinators to prioritise our service users who become inpatients, by ensuring there is capacity within the teams to continue to have contract with service users, remain involved in their care throughout inpatient admission and continue to provide support in the community on discharge from inpatient services is underway. We hope to see a significant improvement in this in the latter half of 2016 and will attempt to measure service user satisfaction in the discharge process.
12	**Missing Person.** We are concerned about the number of police calls to in-patient services at Pilgrim and PHC. We request more information and assurance from LPFT and commissioners that the reasons are within an acceptable tolerance.	Meetings are taking place with the local police force to review our missing persons and AWOL protocols to ensure we are working closely together.
13	**Carer.** During patient/service user consultations, the identification of carers should be included as part of the consultation process.	LPFT will engage with the National Triangle of Care programme hosted by the Carers Trust. ULHT are keen to involve carers of people with mental health conditions in any redesign of their Carers Policy. LPFT could work with carer's support organisations such as Lincolnshire Carers and Young Carers Partnership and Carers Connect to see how any additional support to carers can be met. A fortnightly carers group runs at Discovery House in partnership with Rethink and the group has recently become a Healthwatch Hub.

14	**Complaints.** 90%+ of respondents said they were less than 'very satisfied' with the outcome of a formal complaint they have made.	This is a very disappointing and concerning statistic and whilst the report acknowledged that not all themes relate to one service provider and/or Commissioner, we are always mindful that we need to ensure that we identify what resolution complainants are seeking to manage the expectations of what can be achieved through the complaints process. We promote the NHS Complaints Advocacy Service, POhWER, to ensure that complainants are supported through the process. The high number of complainants not satisfied with the outcome of their complaint does not correlate with the number of referrals to the independent review stage of the Complaints Procedure to the Ombudsman which is also a concern as that suggests that people do not feel able to take this further. LPFT will look at reviewing the outcome of focus groups carried out with patients, carers and staff. One outcome from this work was the "Top Tips" for handling complaints. We will look at how we can work with service users and carers to achieve the best satisfaction possible from our complaints processes.
15	**Support for Ex-Military Personnel.** Our respondents directly highlighted the need for more support for ex-military personnel. There may be a need to work with partner agencies to look at what services might need to be put in place or perhaps more importantly the services which would provide more information and support before leaving, during the transition and beyond leaving the Forces.	Currently in place is a specific MOD inpatient unit at Boston Ward 12. The Trust is currently commissioned to provide a Veteran Liaison Service across the East Midlands. The Regional Lead sits within LPFT and is also the Veteran Liaison Champion (VLC) for Lincolnshire. The VLC is a single point of access for GPs, veterans, families and carers. The VLC will work in partnership with third sector organisations to ensure appropriate support is available and oversee the journey through mental health services. They will also support the

		Trust's internal teams to ensure that we carry out our duty of care as set out in the Armed Forces Covenant. The service has also developed in an in-reach programme with the Department of Community Mental Health at RAF Cranwell and Chilwell. This is to identify military personnel who will be discharged on medical grounds within the next 6 months and enable early referral to the appropriate services. This will enable a smoother transition into NHS services and allow the VLC to share information with servicemen and women about available resources prior to discharge to alleviate anxiety. The VLCs regularly attend public events to promote and disseminate information about available services and support and work in partnership with third sector and public organisations.
16	**Out of Hours:** It was felt that there needed to be more access to help and support patients and families and carers particularly during 'out of hours' and at weekends. It was suggested that availability of CPNs and other support networks would be hugely beneficial.	**SWCCG**: Seven day service/interface with other providers to be considered within quality schedules. **LPFT:** Crisis teams are currently available out of hours though this is a limited and stretched resource. A CAMHS Tier 3 plus service will be available from Apr 16 which includes a CRHT component. It is hoped that a peer support worker-led helpline will be available in 2016.
17	**Self-Harm:** The number of respondents who had self-harmed and continued to self-harm raised questions and concerns about the recognition, support and prevention services for patients self-harming. Concerning was also the correlation of bullying and its impact on self-harm within our schools and colleges.	**System Review:** LPFT are undertaking a whole system review of adult mental health services to meet current and future demand (this includes the remodelling of psychological therapy services). The review includes crisis home treatment, S136 services, step-down options (for community outcomes), SPA, discharge from hospital and complaints process.

18	**Lincolnshire South West Clinical Commissioning Group.**	A Joint Delivery Board has been established to oversee the provision of mental health and LD Services. Where service performance is below the expected trajectories, LPFT Contract Business Group will escalate this to the Board.
19	**Access and Transport.** When visiting a GP most journeys were less than 2 miles but when seeing specialist services there was a great deal more travel involved even though around three quarters of respondents had access to transport. Therefore ULHT/LPFT should provide more information about transport schemes such as community car schemes and call connect etc.	Information is available to the Local Authority in relation to transport links. http://www.lincolnshire.gov.uk/transport-and-roads/public-transport/community-transport LPFT will ensure local teams have relevant information in their waiting areas. In addition, part of the strategic vision for adult community mental health services is greater integration with primary care in line with the NHS 5-Year Forward View. If this is done effectively then this should reduce the amount of travelling required by service users accessing mental health services, as well as provide a more seamless pathway between primary and secondary care and promote Parity of Esteem within Primary Care.
20	**Mental Health in the Work Place.**	Lincolnshire Public Health confirmed they will work with LPFT to include support for employers (and employees) to recognise mental health in the workplace in the Lincolnshire Mental Health Promotion Strategy.
21	**Waiting Times.** Previous intelligence suggested there is a continuing problem with waiting times for mental health assessment. The findings from this work confirmed that waiting times were still an issue for patients and patients felt that capacity and timeliness of services was not satisfactory. When these issues are raised with the provider we have been consistently told that waiting times are within tolerance but this consistently has not been the feedback from patients. We would recommend transparent reporting.	LPFT closely monitors the waiting times and sets local targets for most of its services which are well within the national targets with the notable exception of waiting times for psychology. LPFT recognises, however, that any length of wait can be distressing for a person seeking help, so being within national targets (18 weeks in many cases) is still too long to wait. There are also some specialist services which have historical waiting lists and long waits for

		treatment, such as psychology services. LPFT is working to improve on these waiting times. For more information, LPFT provides detailed information of its waiting times in the Integrated Performance Report as part of the Board of Director's meeting papers, available on the LPFT website. The adult mental health services are facing increasing demands in the context of reduced resources year on year. In response to this challenge, LPFT has commenced a full transformational review of its community mental health services and will be engaging service users, carers, GPs, Healthwatch and others in this review.
22	**Waiting Times.** Whilst there was a mixed response to waiting times to see a specialist ie psychiatrist there was concern that 2 out of 3 appointments had been changed. A third of these had been changed for a second time. Lincolnshire Partnership Foundation Trust should, therefore, review its appointments system and investigate the reasons why this figure is so high.	Appointment data will be routinely reviewed as part of each division's management team governance work. This will enable patterns to be monitored and benchmarking with regards DNAs (did not attends) and provider cancellations/rearrangements.
23	**Waiting Times and Referrals.** In almost all the occasions where patients told us they had made a complaint, they were with reference to the complex referral backwards and forwards between GP and CMHT without any individual organisation taking responsibility for their care. LPFT/CCG should ensure there is a clear referral pathway and if this already exists that all GPs and health professionals are clear on what it entails and adhere to it.	Through the development of criteria it will be clear what adult community mental health services do and do not provide a service for. Within this there will also be a process for if there is disagreement between professionals as to which service (if any) a service user should be seeing. This process should be 'invisible' to the service user - not so as to not be transparent with them, but to ensure they are not caught up in professional disputes.

24	**Perception of Services.** With regard to special mental health support services many respondents highlighted services such as 24/7 telephone support, crisis team and counsellors as important in helping them with their illness. However, we were concerned that the patient feedback we received doesn't consider STEP, Recovery College, HIPS, Green Light Team, day care and day hospital, DART, CAMHS and buddying serviced specialist psychological services as important.	This does not equate to the feedback LPFT receive from people using the services listed as not "important". These are specific specialist services and it is unlikely that anyone who had not used these services would comment on them. Generally, the service user feedback for the Green Light, DART and CAMHS services has been very positive. We will continue to ensure we measure the effectiveness of our services and pathways, as well as experience of people using them. LPFTs hope that through the use of technology and improved feedback mechanisms we can not only get a greater response rate but more detailed response so as to continue to improve services.
25	**Crisis Care Concordat (Mental Health).** Consideration of where the Declaration Statement for Lincolnshire (signed Dec 14) sits within the overall commitment to improving mental health services in Lincolnshire.	Concordat partner organisations to consider whether the promises within the document to people experiencing mental health crisis are being met. LPFT is an active member of the Concordat Group. Action plan is reviewed regularly and is managed overall by SWCCG.

Conclusion

Healthwatch Lincolnshire wishes to recognise and thank those patients, carer's families and professionals who have supported this work over the last 12 months.

We believe the report provides value to a range of stakeholders and supports people who are passionate about providing the best possible service for those with mental ill health. We also believe that it is recognised that those who need help should be better supported within the community as much as possible, when they need it. We consider that people get involved because they want to tell people where services work well and when they don't.

During our work we have heard some heart-warming stories where people felt they owed their life to the professionalism of a service or staff member within our health service, however, we also heard many more experiences where services weren't well received and it is these, where it is hoped we can raise the profile, encourage and influence change no matter how small.

We recognise and acknowledge that no changes can truly be implemented by one provider or commissioner in isolation, instead we hope this will reinforce the need for a whole community response. We hope that monitoring organisations such as the Care Quality Commission, NHS England and Lincolnshire County Council recognise the work that is done well, but also recognise the areas where there are real challenges such as timeliness, quality of care and support and with this recognition it is hoped that they are able to influence a better joined up and supported approach for improvement.

As a local Healthwatch we welcome the positive work being carried out and will watch for developments and will also be very open to any future work we may be asked to do or get involved in, as part of developing Mental Health services for Lincolnshire. Mental Health after all, affects us all.

Distribution of this Report:

This report will be available to download from the Healthwatch Lincolnshire website, copies can also be available in other formats by request.

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

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

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**17 February 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

17 February 2016		
Item	**Contributor**	**Purpose**
United Lincolnshire Hospitals NHS Trust Improvement Portfolio	Jan Sobieraj, Chief Executive, United Lincolnshire Hospitals NHS Trust Michelle Rhodes, Director of Nursing, United Lincolnshire Hospitals NHS Trust	Update Report
Universal Health Ltd: Primary Care Practices in Lincoln, Metheringham and Gainsborough	Dr John Brewin, Chief Executive, Lincolnshire Partnership NHS Foundation Trust A Representative from Lincolnshire and District Medical Services Ltd	Status Report
Lincolnshire Partnership NHS Foundation Trust – Draft Clinical Strategy 2016-21	Chris Higgins, Deputy Director of Strategy and Business Planning, Lincolnshire Partnership NHS Foundation Trust	Consultation
Healthwatch Lincolnshire Mental Health Report (November 2015)	Sarah Fletcher, Chief Executive, Healthwatch Lincolnshire	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

16 March 2016		
Item	**Contributor**	**Purpose**
Lincolnshire Partnership NHS Foundation Trust - Adult Psychology Service – Developments in Provision	Dr John Brewin, Chief Executive, Lincolnshire Partnership NHS Foundation Trust (to be confirmed)	Status Report
Urgent Care – Constitutional Standards Recovery and Winter Resilience	Sarah Furley, Urgent Care Programme Director, Lincolnshire East Clinical Commissioning Group	Update Report
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
Arrangements for Consideration of Quality Accounts 2015-2016	Simon Evans, Health Scrutiny Officer	Status 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
United Lincolnshire Hospitals NHS Trust – Pharmacy Services	Colin Costello, Chief Pharmacist, United Lincolnshire Hospitals NHS Trust	Update Report
East Midlands Ambulance Service - Performance and Improvements	Andy Hill, General Manager – Lincolnshire, East Midlands Ambulance Service	
Lincolnshire Cancer Strategy	Sarah-Jane Mills, Director of Planned Care and Cancer Services at Lincolnshire West Clinical Commissioning Group	Update Report

18 May 2016		
Item	**Contributor**	**Purpose**
Lincolnshire Recovery Programme Board	Jim Heys, Locality Director NHS England – Midlands and East (Central Midlands) Jeff Worrall, Portfolio Director, NHS Trust Development Authority	Update Report

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
- Child and Adolescent Mental Health Services

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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