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

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A Meeting of the Health Scrutiny Committee for Lincolnshire will be held on Wednesday, 16 March 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: 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	**Annual Report of the Director of Public Health on the Health of the People of Lincolnshire 2015** *(To receive a report from Dr Tony Hill (Director of Public Health – Lincolnshire County Council) which provides an independent statutory report to Lincolnshire County Council on the health of the people of Lincolnshire to raise the issues of importance to the health population of Lincolnshire. Dr Tony Hill (Director of Public Health – Lincolnshire County Council) will be in attendance for this item.* ***Please note: Appendix A to the report has been circulated electronically****)*	29 - 30
7	**Peterborough and Stamford Hospitals NHS Foundation Trust - Seminar on Delayed Transfers of Care** *(To receive a report from Simon Evans (Health Scrutiny Officer) which provides information from Councillors Mrs J M Renshaw and Mrs S M Wray following their attendance at a Seminar on Delayed Transfers of care held on 2 March 2016 and hosted by Peterborough and Stamford Hospitals NHS Foundation Trust)*	31 - 34
8	**Arrangements for Consideration of Quality Accounts 2015-16** *(To receive a report from Simon Evans (Health Scrutiny Officer) inviting the Committee to make arrangements for the Quality Accounts process for 2016)*	35 - 42
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)*	43 - 48

Tony McArdle
Chief Executive
8 March 2016

HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE
17 FEBRUARY 2016

PRESENT: COUNCILLOR C J T H BREWIS (VICE-CHAIRMAN IN THE CHAIR)

Lincolnshire County Council

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

Lincolnshire District Councils

Councillors 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), Mrs R Kaberry-Brown (South Kesteven District Council) and D P Bond (West Lindsey District Council)

Healthwatch Lincolnshire

Dr B Wookey

Also in attendance

Liz Ball (Deputy Chief Nurse – United Lincolnshire Hospitals NHS Trust), Mark Brassington (Chief Operating Officer – United Lincolnshire Hospitals NHS Trust), Dr John Brewin (Chief Executive – Lincolnshire Partnership NHS Foundation Trust), Andrea Brown (Democratic Services Officer), Simon Evans (Health Scrutiny Officer), Chris Higgins (Deputy Director of Strategy and Business Planning - Lincolnshire Partnership NHS Foundation Trust), Gary James (Accountable Officer - Lincolnshire East CCG), Jane Marshall (Director of Strategy and Performance - Lincolnshire Partnership NHS Foundation Trust), Jan Sobieraj (Chief Executive - United Lincolnshire Hospitals NHS Trust) and Chris Weston (Consultant in Public Health, Public Health Intelligence)

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

81 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

The Vice-Chairman, Councillor C J T H Brewis, welcomed the Committee and advised that the Chairman would not be in attendance at the meeting and that he would, therefore, be in the Chair. Councillor Brewis had requested that Councillor T M Trollope-Bellew act as Assistant to the Chairman for this meeting only.

Apologies for absence were received from Councillors Miss E L Ransome (Lincolnshire County Council), Mrs C A Talbot (Lincolnshire County Council) and Mrs S M Wray (Lincolnshire County Council).

The Chief Executive reported that under the Local Government (Committee and Political Groups) Regulations 1990, he had appointed Councillor C E D Mair to the Committee in place of Councillor Miss E L Ransome.

82 DECLARATIONS OF MEMBERS' INTERESTS

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

83 CHAIRMAN'S ANNOUNCEMENTS

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

i) United Lincolnshire Hospitals NHS Trust – Appointment of Chairman

Councillor Mrs C A Talbot had attended a Stakeholder Event at Pilgrim Hospital in Boston on 21 January 2016 to meet candidates seeking to become the new Chairman of United Lincolnshire Hospitals NHS Trust (ULHT). It was understood that the formal interviews took place on 28 January 2016 and an announcement was expected shortly.

ii) New Maternity and Gynaecology Unit – Pilgrim Hospital Boston

On 9 February 2016, United Lincolnshire Hospitals NHS Trust (ULHT) announced that a new purpose-built modular maternity and gynaecology unit would be 'arriving' at Pilgrim Hospital in Boston this week. ULHT had invested £5.2 million in to Pilgrim Hospital for creation of new wards to replace the existing maternity and gynaecology wards.

The new unit would be an extension to the main hospital and had been built at a factory near Beverley, Yorkshire and would take approximately 10 days to construct on site. This innovative method of construction was an off-site build to reduce the construction time and disruption to patients.

iii) Britain Imbalanced – Why Now is the Time to Tackle Obesity in Britain

The Chairman referred members to a report authored by Olympic rower, James Cracknell, which was published on 10 February 2016 by the Policy Exchange Thinktank and which received some national media attention. The report, entitled *Britain Imbalanced – Why Now is the Time to Tackle Obesity in Britain*, made a number of recommendations including the introduction of a tax on sugary drinks. Additionally, the report recommended that children aged 4-11 should be measured although the report argued against issuing "fat-shaming" letters to parents as these were often counter-productive. The emphasis, therefore, should be on improvements

to a child's wellbeing and reduced portion sizes. The Chairman looked forward to further developments in the national debate on reducing obesity.

iv) Sue Noyes, Chief Executive – East Midlands Ambulance Service NHS Trust (EMAS)

On 15 February 2016 it was announced that the Chief Executive of the East Midlands Ambulance Service (EMAS), Sue Noyes, would be leaving EMAS later this year. The decision had been made due to personal and family reasons but Sue had been requested to stay until June 2016 to continue to lead EMAS through the introduction of phase three of its quality improvement programme, *Better Patient Care – Driving Forward for 2016*.

The Chairman of EMAS, Pauline Tagg, would be discussing the future leadership arrangements with the EMAS Board and the NHS Trust Development Authority (TDA).

v) East Midlands Health Scrutiny Network – 17 February 2016

A meeting of the East Midlands Health Scrutiny Network was taking place at Leicester City Hall at the same time as this Committee. The Chairman advised that the meeting was to cover the approaches of health scrutiny committees in the region to topics such as health inequalities; the integration of health and social care; and commissioning and reconfiguration.

It was regretful that the meeting coincided with this Committee meeting and therefore there would be no representation from Lincolnshire present. Feedback would be sought from the network meeting and attendance at future network meetings would be considered.

vi) Peterborough and Stamford Hospitals NHS Foundation Trust – Seminar on Delayed Transfers of Care – 2 March 2016

On 2 March 2016 Peterborough and Stamford Hospitals NHS Foundation Trust would be holding a seminar on delayed transfers of care. The Trust had stated that it had complex discharge arrangements, as its patients were from different local authority areas, and were to explore the complexity with representatives of health scrutiny committees to provide improved outcomes for patients. The Trust had, therefore, extended a formal invitation to the members of the Committee to attend the seminar. Members were asked to advise the Health Scrutiny Officer of their intention to attend.

84 MINUTES OF THE MEETING OF THE COMMITTEE HELD ON 20 JANUARY 2016

The Committee asked that formal thanks to the Democratic Services Officer for the clear, concise and detailed minutes of the last meeting be recorded.

RESOLVED

That the minutes of the meeting of the Health Scrutiny Committee for Lincolnshire held on 20 January 2016 be approved and signed by the Chairman as a correct record.

85 LINCOLNSHIRE PARTNERSHIP NHS FOUNDATION TRUST (LPFT) DRAFT CLINICAL STRATEGY 2016-2021

A report by Jane Marshall (Director of Strategy – Lincolnshire Partnership NHS Foundation Trust (LPFT)) was considered which set out the Lincolnshire Partnership NHS Foundation Trust (LPFT) Draft Clinical Strategy 2016-2021.

Dr John Brewin (Chief Executive – Lincolnshire Partnership NHS Foundation Trust), Jane Marshall (Director of Strategy and Performance – Lincolnshire Partnership NHS Foundation Trust (LPFT) and Chris Higgins (Deputy Director of Strategy – Lincolnshire Partnership NHS Foundation Trust (LPFT) were in attendance for this item.

Members were given an overview of the draft clinical strategy, which was intended to translate the organisation's Mission into the deliverable objectives and actions through a series of agreed priorities and would sit centrally to the governance framework, informing the development of Divisional plans, dependent sub-strategies and the Trust's overarching Integrated Business Plan.

The Strategy was the result of work completed since the summer of 2015 during which time staff, patients and carers, commissioners, partners, Governors and the public had been consulted about their views on what should be done to improve clinical services. The aim was to implement a new clinical strategy for 2016/17 and beyond which reflected the ambition to provide the best possible care but also a strategy co-created with service users but which remained aligned to national policy and best available evidence.

Current clinical priorities had been derived from feedback, local delivery objectives and national policy. The clinical priorities were:-

- *More people will have good mental health;*
- *More people will have a positive experience of care and support;*
- *More people with mental health and 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.*

Members of the Committee had held a working group on 12 November 2015 to discuss the draft Clinical Strategy following which a joint statement, from the

Committee and Healthwatch Lincolnshire, was presented to the Committee at its meeting on 16 December 2015 for approval. Dr Brewin formally thanked the Committee for their support and input into the strategy.

The Draft Clinical Strategy was expected to be presented to the Board of Directors of Lincolnshire Partnership NHS Foundation Trust in March 2016 for final approval.

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

- A substantial proportion of the population were likely to suffer some mental health problems at some point in their lives and concern was noted about the isolation of young people as a result of social media;
- The veteran's service within the LPFT was working with patients to consider expansion in to community services and engagement with communities was broadening to assist with this. Team models were being considered to provide the right level of support;
- It was reported that there was a bespoke Ministry of Defence (MOD) unit on one of the wards in Boston which was for ex-servicemen requiring inpatient care. The Trust were in constant dialogue with groups who were part of a network supporting veterans and members of the armed forces at a community level;
- Recent press coverage had implied that some chemical therapies were not effective and focus should be talking therapies. In response it was agreed that talking therapies did have a good evidence base for keeping people in their own lives by the Steps to Change programme in addition to the Improving Access to Psychological Therapies (IAPT) strategy. Chemical based therapies were now being questioned and the availability of a wider range of therapies more specific to individual patients were increasing. Chemical based therapies may still be the best option for some patients but it was acknowledged that these would not be used as frequently as in recent years;
- The comments received by Healthwatch Lincolnshire from patients were largely based around their dissatisfaction with the support from the community after discharge and the wider issue of the relationship with primary care and the support which GPs could give. There appeared to be a wide ignorance of mental health within GP practices and primary care generally despite the increased need for mental health support. These points made in relation to access, discharge and transition were agreed as was the fact that 90% of mental health work was undertaken within a primary care setting. At present, the Trusts' cooperation with primary care needed to improve, with the emphasis on integrated working while consideration was being given to the availability of treatment;
- Trust representatives advised that they were to attend a Task & Finish Group to discuss how to address these issues as part of the Lincolnshire Health and Care (LHAC) programme;
- It was reported that 10% of the budget must be removed within the next three years from back office functions. The Trust were required to show that they were working as efficiently and productively as possible;

- Discussions were being held with local gyms in relation to 'social prescribing', for example members of the armed forces struggling with PTSD (Post Traumatic Stress Disorder) as patients who engaged in physical activity to help maintain their fitness levels to help avoid slipping into a deeper depression;
- Page 35 of the report referred to "Increased Prevention" within the Key Financial Challenge box. It was agreed that the language used within the report could be clearer but that this particularly referred to changing the approach 'upstream' and giving patients access to treatment programmes earlier in order to prevent a higher level of treatment at a later time. It was agreed that consideration would be given to make this section of the Clinical Strategy clearer;
- The discrepancy between age groups was highlighted, for example up to 64 years of age, a wide range of services were available, but after 65 years mental health services had traditionally focussed on dementia only. It was acknowledged that the world had moved on, in particular with dementia and early onset dementia which required the services to be shaped to meet the needs of individuals rather than being based on age alone. Further work with commissioners was needed as services had been historically commissioned based on age;
- Page 39 of the report, under the national 'Must Do's', had *"Achieve Financial Balance"* at the top of the list. Members questioned whether this should be the main priority when patient care should be the top priority. It was explained that this order had followed the national list but it could be changed in the local strategy. It was also stressed that there was a difficulty finding a balance to achieve good quality care within the current financial constraints;
- In relation to support for patients suffering with drug and alcohol issues, it was explained that the line between cause and effect was not always clear and that some of the patients treated under alcohol services were often the most vulnerable people in society. It was, therefore, inappropriate to favour one group over another and important to treat everyone with need in the same way to avoid wider consequences for other parts of the health system and community;
- It was difficult to differentiate between the broad spectrum of conditions presented and if a person was in need whether they had the right to treatment. It was difficult to balance the right thresholds for accessing care;
- The Managed Care Network was starting to see community groups and organisations reaching more people. Investment by the Trust was resulting in the same amount of money leading to services for more people and more initiatives of this type were being considered to make more services available;
- Although there were issues with patients being admitted to units far from home, it was suggested that they were admitted to ensure they received the specialist treatment needed rather than being in a hospital close to home which did not have those specialisms. Within Lincolnshire there was a broad range of services but it was noted that there was a particular shortage of beds for eating disorders and perinatal care. However, the Trust had an excellent relationship with the Nottinghamshire unit where Lincolnshire patients were admitted. There was no Psychiatric Intensive Care Unit (PICU) within the

county, but it was hoped to establish one at Lincoln County Hospital within the year;

- Often by choice, people with severe mental illness did not want to engage with a health professional, but the Trust remained assertive in actively contacting these patients to advise them of the risks of not accepting help;
- An event at Carholme Court was planned for 24 February 2016, where the community team would host an open evening providing case studies, discussions and details of services offered. Eating disorders was a good example of a range of conditions, information for which would be available;
- It was suggested that the emphasis on reducing childhood obesity was having a detrimental effect on some children who were developing eating disorders for fear of becoming overweight;
- Development of Neighbourhood teams within the LHAC and in GP practices would see a broad range of mental health workers within those teams. It was proposed to have a suite of people within each of those teams to enable GPs to focus on the work they need to do;
- The Committee asked if it would be possible to have training of the cause and effect of mental health issues. LPFT confirmed that they would be pleased to deliver a training programme for the Committee which would cover a broad range of areas.

RESOLVED

1. That the comments of the Committee on the draft Clinical Strategy be considered by Lincolnshire Partnership NHS Foundation Trust; and
2. That a training session be arranged for the Committee, to be delivered by representatives of Lincolnshire Partnership NHS Foundation Trust, to raise the Committee's awareness of mental health, including the various services and treatments available.

86 UNIVERSAL HEALTH LTD: PRIMARY CARE PRACTICES IN LINCOLN, METHERINGHAM AND GAINSBOROUGH

A report by Jane Marshall (Director of Strategy and Performance – Lincolnshire Partnership NHS Foundation Trust (LPFT)) was considered which provided an update on the four GP Practices recently awarded the contracts by NHS England to Universal Health Ltd.

Jane Marshall (Director of Strategy and Performance – Lincolnshire Partnership NHS Foundation Trust) and Dr John Brewin (Chief Executive – Lincolnshire Partnership NHS Foundation Trust) were in attendance for this item of business.

Members were advised that the GP Practices referred to were the Arboretum and Burton Road Surgeries in Lincoln, Pottergate Surgery in Gainsborough and Metheringham Surgery. Universal Health Ltd, a consortium of Lincolnshire Partnership NHS Foundation Trust (LPFT) and Lincolnshire and District Medical Services (LADMS), were awarded four Alternative Provider Medical Services (APMS) contracts in 2015 with effect from 1st April 2015 (and from 1st July 2015 in the case of

the Burton Road Surgery). There were 11,000 registered patients across the four practices.

Both clinical and non-clinical staff teams within the surgeries had ensured that the services offered continued seamlessly during the transfer of the contracts to Universal Health Ltd. Due to the shortages there were challenges in recruiting nursing and medical staff particularly to the role of General Practitioner (GP) and the costs incurred with using locum medical cover to ensure services continued. It was reported that this was not uncommon across Lincolnshire as challenges with the ongoing stability of primary care continued.

Universal Health Ltd was a Joint Venture company created by LPFT and LADMS in late 2014 and established a new provider vehicle to transfer, stabilise and transform services. Any potential profit made by this company would be reinvested in local services. Universal Health Ltd had a formal Board governance structure with director and non-executive director portfolios and also held separate financial accounts.

The challenges and risk presented for these contracts were:-

- The recruitment and retention of skilled, primary care trained staff to build resilience and capacity in the system. The recruitment of these staff was becoming increasingly difficult due to the changing workforce profile, for example a large number of GPs were expected to retire in the coming years. The medical staff at these particular practices were Salaried Doctors rather than GP Partners. Innovate options were required to ensure that these staff were supported to stay in general practice;
- The surgeries were open to new patients who needed to register with a GP. Those patients who were not currently registered with a GP were being encouraged to choose these surgeries due to the capacity for them to take on new patients onto the registered list;
- Staff working in the surgeries had been through a period of disruption and change over 12 months as well as future uncertainties. Priorities for Universal Health Ltd were to retain good staff and offer opportunities for new staff;
- The service offer would be developed to offer alternative services in primary care for patients. This would include, for example, including Physiotherapists within the clinical team to assess and advise patients who required this service.

It was reported that Burton Road Surgery and Metheringham Surgery had been inspected by the Care Quality Commission in December 2015 and formal reports would follow.

As the mobilisation and initial stabilisation phases were almost complete, opportunities for transformation and integration of additional services were being pursued.

At this stage of the proceedings, Councillor Mrs P F Watson asked the Committee to note that the joint Chief Executive of Universal Health Ltd, Dr Neil Parkes, was her GP and a personal friend.

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

- Some GP practices operated a strict 10 minute rule for each appointment but it was felt that this was inappropriate for someone presenting with a mental health issue. Appreciation was noted that GPs needed to manage their time to the best of their ability but this could present an issue to these patients. There was work ongoing to align the mental health offer to the patient as much as possible but it was acknowledged that this was a difficult balance to reach;
- National discussions were helping to destigmatise mental health and, although there had been improvements, it was a slow process but projects such as this one was helping with that process;
- For these practices, the majority of people requesting an appointment was within two days depending on their particular need;
- Further information was requested about LADMS and it was explained that this was a joint venture and not just within these four surgeries. LADMS was similar to a GP federation and was a membership organisation with the ability to bid for additional work to provide to health organisations, such as out-of-hours cover, sexual health services, etc. The Committee would be sent a brief of the organisation to assist with their understanding of LADMS;
- The four practices had salaried GPs rather than partners and it was asked if this was a risk or a benefit to the practices. The GPs received a salary for their service rather than a being a partner whose role was to run the practice as a business working with commissioners to develop services. It was, however, difficult to recruit either type of GP which, in turn, increased the risk in being able to provide continuity of care. Progress had been made in permanently recruiting to these posts and in particular, GPs with special interest in other areas of care, for example mental health;
- Although there was a risk of a higher turnover in GPs, it was noted that some GPs wanted to be salaried as they believed that this type of role enabled them to have a better work life balance;
- The condition 'Bipolar' was explained to the Committee as previously being known as Manic Depression where patients have varying episodes of mania and depression;
- It was stressed that the four surgeries referred to in the report operated as any other GP practice and were not a new primary care service. This item was being considered by the Committee due to the proposal of NHS England, in 2014, to close one of the practices, the Burton Road Surgery;
- Some large practices had taken on other business in addition to their general practice, for example, minor operations or psychiatric rotations. The funding stream for this type of work would need to be done through a commissioning service but, as a general principle, consideration was being given to expand those service within practices;
- A suggestion was made that, if the committee was seeking to look at the broadening of the services provided by primary care, a presentation from the Local Medical Committee (LMC) may be beneficial to the Committee.

RESOLVED

1. That the report and comments be considered; and
2. That a further update be scheduled for a future meeting of the Health Scrutiny Committee for Lincolnshire.

87 UNITED LINCOLNSHIRE HOSPITALS NHS TRUST IMPROVEMENT PORTFOLIO

At this point of the proceedings, Councillor G Gregory advised the Committee that he had rotated to Sherwood Forest Hospitals NHS Trust and was no longer a paid employee of United Lincolnshire Hospitals NHS Trust (ULHT). He therefore no longer had a pecuniary interest to declare for any item of business relating to the ULHT.

A report by Jan Sobieraj (Chief Executive – United Lincolnshire Hospitals NHS Trust) was considered which provided an update on progress against the ULHT Improvement Portfolio and gave an overview of action being taken where risk and issues had been identified. The governance arrangements which had been put in place were also described.

Jan Sobieraj (Chief Executive – United Lincolnshire Hospitals NHS Trust), Mark Brassington (Chief Operating Officer – United Lincolnshire Hospitals NHS Trust) and Liz Ball (Deputy Chief Nurse – United Lincolnshire Hospitals NHS Trust) were all in attendance for this item of business.

Members were advised that the four key recovery work streams included Quality Improvement, Workforce and Organisational Development, Constitutional Standards and Financial Recovery.

Quality Improvement Programme (Rating – Amber/Green)

An update on the main areas of concern where significant issues were:-

Safeguarding (Amber rating) – Additional safeguarding training had been established to provide sufficient capacity to deliver training to all relevant staff. Compliance had significantly improved although some clinical areas had experienced difficulty in releasing staff to attend training due to site pressures and demands. At the end of December 2015 compliance for Safeguarding Level 1 Core Learning was 80% against a trajectory of 95% by 31 March 2016. Work was ongoing to explore the possibility of providing an e-learning package to complement face to face training. The RAG [red, amber, green] rating had remained the same since the previous update in October 2015.

Hospital at Night (Green rating) – This model had been implemented to improve care to deteriorating patient during the night. Focus was now on the implementation of the recommendations from Health Education for East Midlands (HEEM) and phase 2 of the project was being developed to maintain a focus on improving these services further. The RAG rating had improved from Amber since the previous update in October 2015.

Control of Infection (Amber rating) – A full review of housekeeping, cleaning capability and capacity was commenced in December 2015. When the findings of this review had been received, a business case would be developed.

A major outbreak of the norovirus was effectively managed during December and January with 199 symptomatic patients affecting 16 wards, 11 of which were closed during the peak. The RAG rating had remained the same since the previous update in October 2015.

Training and Appraisal (Amber/Green rating) – It was reported that this project had now moved to the Workforce Improvement Programme and would be discussed within that section of the report.

Out-Patients (Amber/Green rating) – Environmental improvements had been made in Lincoln Out-Patient Department with Clinic Room standards being introduced to ensure that all areas were clean, tidy and equipped for use. The booking system for follow-up patients had been improved and there was now a full understanding of the number of patients waiting for follow-up appointments with "time critical" patients clearly identified. Work was ongoing to deal with the capacity shortfalls in order to provide sufficient appointments. The RAG rating had remained the same since the previous update in October 2015.

It was reported that the Chief Executive was the chair of the Lincolnshire Wide Quality Improvement Programme Board, in addition to the internal ULHT Quality work, which was attended by all stakeholders and had a focus on Lincolnshire Wide Frailty Services, Safeguarding CAMHS, Adult Mental Health and Paediatric Commissioning. The next meeting would begin to focus on 2016/17 priorities.

Workforce and Organisational Development (Amber/Red)

The programme scope outlined 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 the Improvement Board. A Senior Programme Manager was appointed and the Workforce Programme Board met fortnightly with monthly reporting to the Improvement Board and Workforce & OD Committee.

The focus for the revised work streams for the programme was:-

Nursing Workforce Utilisation (Amber/Red rating) – Monitor and the Trust Development Authority (TDA), in October 2015, 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. A dedicated team had also been established to undertake a bank service review to support delivery of the agency cap.

Progress had been made with changes affecting an expenditure reduction and had been achieved by utilising the workforce more effectively. Key performance indicators had been developed to enable areas requiring improvement to be monitored. Members of the Executive Team were also providing more focussed support and challenge to ensure pace be maintained and issues unblocked.

Medical Workforce Utilisation (Amber/Red rating) – The agency cap, previously noted, was also applied to medical agency usage. Progress had been made in relation to controls for agency usage and plans to ensure the existing workforce was used effectively. Medical Teams were actively involved and had reduced overall expenditure by approximately £600k per annum following a reorganisation of medical rotas.

Recruitment and Retention (Amber rating) – A CQC Compliance Note was currently in place for Nurse Staffing Levels and monitoring systems were in place on wall wards with active recruitment taking place to reduce the vacancy rate. There was local active engagement with the University and students and apprenticeships were now in place. Open days were being held to attract school leavers.

Further recruitment was undertaken in January 2016, when a team travelled to Manila and successfully recruited 131 candidates. These candidates were now being processed through the formal HR checks. In addition, six registered nurses arrived in Boston from the European Union on 6th February 2016. More overseas recruitment drives were being planned.

A comprehensive marketing and communications plan was also being developed to retain the existing workforce.

The RAG rating for these areas had changed from Amber/Red for Recruitment and Amber/Green for Retention to an overall rating of Amber since the update in October 2015.

Electronic Staff Record (ESR) (Amber rating) – This system was expected to improve central management and reporting of workforce details. The ESR Supervisor Self Service was being rolled out across the organisation and would enable line managers to access real time information for all staff in respect of contract details, core learning compliance, annual leave and absence rates. The RAG rating had remained the same since the previous update in October 2015.

Training and Appraisal (Amber/Green rating) – The Core Learning Compliance was reported as 78% and Appraisals at 67% at the end of December 2015. The focus was to maintain and improve compliance over the winter period with a view to delivering 95% compliance by 31 March 2016.

Constitutional Standards (Amber)

The programme scope outlined 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 was consistent with the

Lincolnshire wide recovery plan. The scope and milestone plan were in place and a Programme Manager had been appointed to provide dedicated support for three months. The programme provided a monthly progress report to the Improvement Board and SRG on risk and issues.

The programme had three major work streams and had an overall "Amber" RAG rating which had remained the same since the previous update in October 2015:-

Urgent Care – It was noted that performance within Pilgrim A&E Department continued to be a concern. As a result, the Chief Operating Officer had appointed an additional Deputy Director to provide a dedicated focus on developing the future state for Pilgrim A&E. Operational teams had been realigned to focus on daily improvement in flow and performance and key operational leads had been involved in developing a 30-day plan based upon high impact actions.

Length of Stay – The SAFER Bundle was being implemented, to support improvements in Length of Stay, and this was being supported through the "Perfect Week" initiative which commenced on 1st February 2016 across the Lincolnshire system. The SAFER bundle was a national initiative to improve patient flow by:-

S – Senior Review (Consultant review before midday)
A – All patients had an Estimated Date of Discharge (EDD)
F – Flow of Patients (wards to start to pull from Assessment Units by 10am)
E – Early Discharge (33% before midday)
R – Review (clinical review of patients with extended length of stay over 14 days)

Planned Care – All projects were progressing and this work stream closed and managed through normal management processes. ULHT had achieved Referral to Treatment Time (RTT) performance for five consecutive months and eight out of nine Cancer standards during November 2015. Risks remained, however, but were now actively managed.

Financial Recover (Amber/Red rating)

The financial recovery programme was progressing with a number of schemes now showing delivery against actual spend. Schemes were being managed and governed with a clear programme structure to ensure the escalation of issues and risks were timely and resolved wherever possible. The programme reported fortnightly to the Improvement Board. Four main areas within the programme required significant focus:-

Nursing Workforce Utilisation – Progress had been made with actual changes effecting an expenditure reduction. The Executive Team had provided some focussed support in the form of "deep dive" meetings which had ensured pace and unblocked a number of issues.

Medical Workforce Utilisation – Progress had been made in relation to the medical workforce although it was reported that there had not been an actual reduction in spend overall. There had been a reduction in the price of agency doctors through

renegotiation with the demand being reduced through the improvements made by clinical teams. A £250k improvement in spend within integrated medicine by revising rotas and using doctors more efficiently was reported as an example of good practice.

Income – Progress was also being made in ensuring income was maximised by ensuring that the Trust received the best practice tariff. It was explained that this was the tariff for delivering best practice care for the patient.

Tactical – An expenditure and income position (Control totals) for the end of this financial year had been agreed with all business units who were managing the delivery of this. The Executive Team were providing additional support to areas where this was required.

Finally, in relation to governance arrangements, it was explained that the Portfolio Improvement Board was chaired by the Chief Executive with full executive attendance. This was further supported by the Improvement Director of the Trust Development Authority (TDA) and a newly appointed Associate Director of Improvement.

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

- In 2015 140 nursing students had qualified from Lincoln University but only 60 had chosen to be employed by ULHT and, although the Trust would not expect the full cohort to stay in Lincolnshire, it was felt that 60 was too low. So far this year out of 200 students, 118 had applied to the general advert with some appointed to specific wards, which had been a marked improvement;
- As the numbers would still be insufficient, international recruitment had been undertaken. During this recruitment, the Trust had been very honest with applicants about Lincolnshire and the nature of the county and the city of Lincoln itself to minimise the number of nurses taking jobs in Lincolnshire and then leaving for alternative locations;
- Although the checks and balances were ongoing, some already had General Medical Council (GMC) registrations to be able to work in the UK and it was anticipated that some would be able to start work sooner as a result;

At this point of the proceedings, Councillor S L W Palmer asked that it be noted that he had an outstanding serious complaint with United Lincolnshire Hospitals NHS Trust.

- Although safeguarding training was Amber rated this was due to acknowledgement by ULHT that further improvement was required. There were opportunities for more online training which would reduce the time away from the wards. Cascade training was suggested but this was not possible for safeguarding due to statutory obligations of this training. The requirement was that this training be delivered by skilled and experienced trainers in this area;
- Control of Infection was also Amber rated but it was anticipated that it would move to a Green rating soon. The delay had been as a result of the recent

norovirus but the Committee were assured that this area had made significant improvement;

- Workforce issues were expected to take a number of years to resolve. Although attrition rates had reduced to an average of 9.68% the Trust were looking to further reduce this and, if successful, the current situation would not worsen. The reality for the next five to seven years was that ULHT would not have the required level of nurses and midwives. Creative thinking about the roles of staff within the Trust was underway to ascertain how to utilise time and skills better;

At this point of the proceedings, Councillor P F Watson advised that she was a cancer patient receiving care from United Lincolnshire Hospitals NHS Trust.

- Concern was raised regarding the process for a consultant declaring a patient medically fit to leave and it was asked whose responsibility it was to notify the GP about any future requirements of that patient. ULHT were aware of this issue and work was ongoing to improve the situation. It was explained that every outpatient appointment follow-up letter would be sent to the GP, usually within one week of the outpatient appointment. A key piece of this work was to look to develop a single system for patient records;
- The Committee challenged the appointment of a Consultant Nurse for Control of Infection and the cost involved. The role had been created following a restructure of that team and utilising the money within that team. The role was to give kudos to infection control to ensure compliance across the Trust;
- There remained a number of vacancies for radiographers, midwives ad physiotherapists and the challenge was to make these roles attractive to professionals to attract them to Lincolnshire;
- There were some services which required more resilience and help from other Trusts would be sought, but this would be a slow process as a mutual agreement benefiting both parties would have to be reached to be a longer term solution. At present ULHT had a good relationship with University Hospitals of Leicester NHS Trust (UHL);
- It was noted that performance was a concern rather than care and performance of teams. In terms of timeliness, it was acknowledged that greater improvements were required but that these would be challenging and not resolved quickly. The Committee were assured that lots of work was ongoing to improve performance and to make the workforce more resilient;
- A lot of progress was reported within the system of complex discharges with the focus on having discharge hubs in place across all hospital sites. It was confirmed that there were currently 70 people in beds across the Trust who were medically fit for discharge but needed a number of a requirements in place before they could be safely discharged. As a result, work was ongoing as to how to better utilise community hospitals;
- The report in relation to the review of housekeeping was expected within a few weeks, following the assessment of the norovirus. It was confirmed that the Trust employed in-house cleaners who were now responsible to the Ward Sister. The review looked at the cleaning schedule and the correct allocation

at different times of the day. During the winter, additional money had been allocated for cleaning due to the heavy footfall within A&E;

- Although the NHS worked 7 days per week, it was acknowledged that staff were already providing 24/7 cover. It was stressed, however, that elective care was not reliant on medical staff only and was a team effort, including porters and Health Care Assistant, for example. The wider impact on the system had not been considered during these national debates and there were cost implications;
- Clarification was given that the term 'junior doctors' did not only apply to newly qualified doctors but also applied to doctors up to a Consultant level;
- Hospital capacity on the East Coast and in the south of Lincolnshire had implications for Delayed Transfers of Care due to the lack of capacity in community hospitals. Despite the situation not worsening, it was acknowledged that significant improvements were still required;
- Work had been undertaken to review nursing shift patterns and offer flexible working although this needed to be tailored to ensure care provision was at a sufficient level and robust. These arrangements were reviewed on a six-monthly basis to ensure that any changes in personal circumstances were considered whilst ensuring full staff coverage. Work was also ongoing with the internal nurse bank and also the provision of new technology which allowed staff to book bank shifts remotely;

At 12.48pm, Councillor R C Kirk left the meeting and did not return to the morning session.

- Nurse demand had fundamentally changed over the years and this was the reason why the Nursing and Midwifery Council (NMC) had been more rigorous to ensure the profession remained respected, however there were restrictions in recruitment and training. The Trust could develop its own nurse training programme but it would be at a huge cost. The aim was to make ULHT attractive to school leavers;
- Although ULHT worked in partnership with the University these restrictions were set nationally which made it difficult to look at new ways of working;
- The 'agency cap' was the process whereby the Government sought to limit the price paid to agency and locum staff, so that ideally Trusts would work collectively to keep costs down, but patient safety remained the primary consideration. Out of 241 Trusts it was reported that ULHT were in the worst five for breaching this cap therefore the focus must be on improving this situation as the Trust were under scrutiny;
- Each request for an additional agency nurse was approved by the Director of Nursing and each request considered on merit balancing quality and safety of the patient;
- A Sustainability and Transformation Plan was required for Lincolnshire as a result of the NHS Planning Guidance 2016/17 – 2020/21, to address the *Five Year Forward View*. Without this and a clear way forward, the Trust could face administration but it was advised that this was some way in the future and only if improvements were not being made. It was suggested that the Committee

might wish to consider the Sustainability and Transformation Plan, prior to its final submission in June 2016.

The Chairman thanked officers for their frank and honest answers and looked forward to welcoming them to a future meeting for a further update.

RESOLVED

1. That the report and comments be considered and a further update from the Trust be submitted to a forthcoming meeting; and
2. That consideration be given to including Lincolnshire's Sustainability and Transformation Plan, prior to it submission in June 2016.

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

Lincolnshire County Council

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

Lincolnshire District Councils

Councillors 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), Mrs R Kaberry-Brown (South Kesteven District Council) and D P Bond (West Lindsey District Council)

Healthwatch Lincolnshire

Dr B Wookey

Also in attendance

Andrea Brown (Democratic Services Officer), Simon Evans (Health Scrutiny Officer) and Chris Weston (Consultant in Public Health, Public Health Intelligence)

88 HEALTHWATCH LINCOLNSHIRE MENTAL HEALTH REPORT (NOVEMBER 2015)

A report by Sarah Fletcher (Chief Executive – Healthwatch Lincolnshire) was considered which set out the final report from Healthwatch Lincolnshire on Mental Health Services published in November 2015. The report captured the key themes and promoted 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) and Dr Brian Wookey (Board Member – Healthwatch Lincolnshire) were in attendance for this item of business.

Members were advised of the process involved which enabled Healthwatch Lincolnshire to produce this report. The work was carried out in three stages from November 2014 until November 2015 with 345 individuals providing feedback on their experiences and perceptions of mental health services.

A broad piece of work had been undertaken during Spring 2014 which considered individual's views of services and support structures available within mental health. A small group of 23 people were also asked to complete a paper-based survey.

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

During 2015, three mental health organisations were invited to gather the views of their service user groups and asked that these views be shared as part of the Seldom Heard Voices programme. 196 responses to the project were received through a range of surveys and focus group activity.

Based on the feedback received, 25 areas for improvement were summarised in to the report:-

- 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; and
- Complaints.

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

- Concern was raised about mental health patients being arrested or dealt with by the police as a result of their actions. The police were not always trained to deal with mental health patients and, for example, should patient possess a

weapon with intent to harm themselves only, the police tended to be unaware of the patient's intent and were obliged to remove the weapon and make the area safe. Unfortunately, in the main instances the individual did not receive the help that they needed, as the police were not always trained to identify and respond to those with mental health issues;

- The transition of young people to adulthood was a concern to the Committee and it was felt that within the new transition service designs more recognition for additional support was required. Also the age limit for transition into adulthood should be case specific as the mental age of some may be different to the actual age;
- Access for families to the correct service remained a challenge. Departments and telephone numbers changed regularly and therefore leaflets were regularly out of date which could exacerbate a challenging situation for a family;
- It was stressed that Healthwatch did not deal with individual cases and that the example used was an illustration to raise the issues to the Committee. It was suggested that feedback from the provider Trust on the actions taken as a result of this report be requested by the Committee;
- The responses received to the areas within the report from providers and what actions they would take were included. However, until the CQC report on Lincolnshire Partnership NHS Foundation Trust (LPFT) was published and the Clinical Strategy implemented, time would have to be given to LPFT to put some of those actions in place. The intention was that Healthwatch would monitor the progress every three months;
- The Committee were advised that senior management representatives of LPFT could not be present to address these issues and answer the concerns of the Committee;
- The Committee were seriously concerned about the content of the responses from patients and families. Healthwatch Lincolnshire confirmed that had any positive feedback been received then that would have also been included in the report but, in this case it was not. Additionally, it was asserted by Healthwatch Lincolnshire that services were not being delivered to the level required. However, recognition was given to the staff delivering the services as there was some good support available but, sadly, the length of time patients waited for treatment or diagnosis could mean the difference between life or death;

At 2.50pm, Councillor R C Kirk returned to the meeting.

- It was suggested that a letter, on behalf of the Committee, be sent to Lincolnshire Partnership NHS Foundation Trust to advise that this report had been considered and the Committee was sufficiently concerned to advise LPFT of their views.

RESOLVED

1. That the report and comments be noted;
2. That, following the outcome from the Care Quality Commission Inspection, the Committee review the improvements in mental health services provided by

Lincolnshire Partnership NHS Foundation Trust, and commissioned by South West Lincolnshire Clinical Commissioning Group; and

3. That a letter be sent to Lincolnshire Partnership NHS Foundation Trust, from the Committee, to advise that this report had been considered and the Committee was sufficiently concerned to advise LPFT of their views.

89 WORK PROGRAMME

The Committee considered its work programme for forthcoming meetings.

Members were advised that the meeting scheduled for Wednesday 16th March 2016 would continue in to the afternoon.

It was agreed to add an item to the work programme for the May or June meeting of the Committee – Lincolnshire Sustainability and Transformation Plan (STP).

The Health Scrutiny Officer would seek to facilitate mental health training, which would be delivered by Lincolnshire Partnership NHS Foundation Trust.

In relation to the request for Members to attend the Seminar on Delayed Transfers of Care at Peterborough and Stamford Hospitals NHS Foundation Trust on 2 March 2016, Councillors J Kirk and Mrs J M Renshaw expressed an interest in attending on behalf of the Committee.

RESOLVED

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

The meeting closed at 3.09 pm

Lincolnshire COUNTY COUNCIL Working for a better future		**THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE**	
Boston Borough Council	East Lindsey District Council	City of Lincoln Council	Lincolnshire County Council
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Open Report on behalf of John Brewin, Chief Executive, Lincolnshire Partnership NHS Foundation Trust

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**16 March 2016**
Subject:	**Adult Clinical Psychology and Psychotherapies Service**

Summary:

This report includes information on the Adult Clinical Psychology and Psychotherapies service that is operated by Lincolnshire Partnership NHS Foundation Trust (LPFT). The service provides psychological interventions to those individuals who access secondary mental health care.

Actions Required:

To receive, consider and comment on content of report

1. Introduction

Lincolnshire Partnership NHS Foundation Trust (LPFT) delivers its clinical services from four operational divisions. The Adult Clinical Psychology and Psychotherapies Service (ACPPS) sit within the Adult Community Mental Health Division along with Community Mental Health Services, Community Forensic Services, Eating Disorder Services and IAPT (Improving Access to Psychological Therapies), a service for the treatment of common mental health problems. This paper will give the Health Scrutiny Committee a briefing in regard to the service and what it delivers, some of the challenges it has faced and the action the service has taken to address these.

2. Purpose of the Service

The ACPPS is commissioned by South West Lincolnshire CCG, on behalf of the Lincolnshire CCGs to provide talking therapies to people who present to services in Lincolnshire that have moderate to severe levels of psychological need. Referrals to the service are received in the main from within the Trust such as Outpatient Psychiatry Clinics, Community Mental Health Teams and IAPT services. It delivers NICE [*the National Institute for Health and Care Excellence*] guideline recommended treatment pathways and principles where possible, yet also draws from emerging evidence of new ways of working, that are recommended for patients who have complex psychological needs.

3. What are Talking Therapies?

Talking therapies involve the formation of a formal relationship between a professional and a patient, that involves a set of procedures that are intended to form a therapeutic alliance, explore the nature of their psychological problems, and encourage new ways of thinking, feeling or behaving.

There are many types of psychological interventions to draw upon for instance Cognitive Behavioural Therapy (NICE guideline recommended therapy for individuals who have symptoms associated with depression and anxiety), Dynamic Psychotherapy (insight fostering), EMDR[1] (NICE guideline recommended therapy for individuals who have symptoms associated with post-traumatic stress disorders - PTSD), and Cognitive Analytic Therapy (therapy with practice based evidence for working with ingrained relational difficulties). Essentially the work that is delivered is based upon research evidence and outcome studies as well as trained clinical judgement. The underpinning thread that links the patients who access the ACPPS is a personal history that involves the consistent and significant exposure to traumatic events, often in early life and also across the patient's life span. The interventions provided are therefore aimed at developing insight, in which the emphasis of the work is upon developing a greater understanding of personal motivations underlying the individual's thoughts and feelings, and action based work in which the focus of the intervention is upon changing how the patient thinks and acts.

4. What is Stepped Care?

In the 2007, the Government released a significant amount of money to provide increased access to psychological therapies for the general population across the UK. The money has been invested in the development of a stepped care model of psychological intervention which seeks to provide the least restrictive of those interventions currently available, but is still likely to provide significant mental health gain. Therefore movement through the stepped care model is dependent upon the level of intervention intensity that the patient needs in order to achieve psychological change.

Step One (Generally delivered by the patient's GP)

- General patient population
- Watchful Waiting
- Contact with non-specialist in mental health on infrequent basis

[1] Eye Movement Desensitization and Reprocessing

Step Two (Generally delivered by IAPT Services – Psychological Well Being Practitioners)

- Mild to moderate difficulties
- 6 – 8 30 minute individual sessions
- 4 x 90 minute group based sessions
- Guided self help

Step Three (Generally delivered by IAPT Services – Cognitive Behavioural Therapists)

- Mild to moderate difficulties
- 12 x 1 hour (up to 20 if needed) individual sessions
- 12 x 1hour group based sessions

Step Four (Generally delivered by Clinical Psychologist or Dynamic Psychotherapists)

- Moderate to severe difficulties
- 18 sessions x 1 hour (25 x 1 hour if Dynamic Psychotherapy) individual sessions
- 12 x 2 hour group based sessions (up to 18 months in group therapy if Dynamic Psychotherapy)

Essentially the ACPPS offers psychological interventions to those patients who have deeply held dysfunctional or maladaptive beliefs about themselves and their world, which have led to a significant impact upon their daily functioning. These beliefs are formed as a reaction to adverse life events, and are pervasive and lead to significant emotional distress

5. Service Challenges

Capacity and Demand

From 2012 – 2014 there was a significant increase in referrals to the service by 17% year on year. Further to this the Trust is obliged to achieve a 4% cost improvement saving each year and this has meant a reduction in psychology posts within the service.

Although the introduction of a new internal referral pathway of care has reduced the number of referrals into the service during the last year, the level of need that patients present has not diminished.

Since 2012, the service has completed 4,686 episodes of care, averaging 1,171 episodes per year. An episode of care is someone entering and then exiting the service and can range from 18 sessions of individual therapy, 12 session of group based interventions, 8 sessions of formulation driven work to an assessment and formulation of treatment plan for others to implement.

Historical waits

The current significant challenge for the service is the continued existence of lengthy waits to access the Step 4 service; these have been in situ for over a decade. Capacity modelling has consistently shown that the service is able to manage, within a timely fashion, the referrals that come into the service; what is not possible, is to clear the backlog of patients who are waiting and continue to accept new referrals into the service without the development of significant waiting times.

6. What have we done to address it?

To try and address, this the service has put in place various measures, these have focused upon the development and delivery of new pathways of care that include:

- Parameters around the number of sessions offered
- Introduction of Group Based Interventions
- Re-design of referral pathways into the service
- Adoption of emerging new therapies such as Acceptance and Commitment Therapy
- Skill mixing of staff to offer different types of therapy
- Clear job planning and expectations for those individuals delivering the service

The impact of this on the delivery of clinical care to patients is consistently assessed, and the current outcome rates demonstrate a statistically significant improvement in symptoms for those patients who receive an intervention from the ACPPS Clinical Psychologists. Further to this 94% of patients who accessed the service felt that they would recommend it to family and friends.

In its continued effort to improve access to the service, the Trust is looking at innovative approaches to how it uses the workforce, increased access to self-help advice and the offer of interim therapeutic support while people are waiting to see a psychologist.

Current Waiting Times

There are extensive waits to access the Adult Clinical Psychology Service, for just over 800 people. As of 1 March 2016, the longest waits are in Louth and Lincoln, with individuals waiting 31 months to access 18 session individual pathways of care. The shortest wait of twelve months for 18 session individual pathways of care is in Grantham and Sleaford. The average waiting time for the 18 session individual pathway of care is 24 months. Waiting times for group based interventions are shorter; with the longest waits being 25 months in Louth and the shortest being 12 months in Grantham and Sleaford. The average waiting time for a group based intervention is 21 months. The waiting times for groups will reduce again, as group based interventions are planned across the region over the next three months. Whilst there are not any national figures for waiting times for Tier 4 services available, the picture of lengthy waits is known to be similar in Derbyshire.

Location		Waiting Times in Months	
East CCG		*Individual 18 session Therapy*	*Group Based Therapies*
	Boston	25	24
	Louth	31	25
	Skegness	27	23
South CCG			
	Spalding	23	23
	Stamford	20	19
South West CCG			
	Grantham & Sleaford	12	12
West CCG			
	Lincoln	31	21
	Gainsborough	24	24

7. Summary and Conclusion

The Trust is committed to continue its proactive approach to addressing waiting times and ensuring the continued provision of high quality psychological interventions to those with the greatest severity of need.

Reassuringly, although there are long waits to access the service, all feedback methods that are used to evaluate it demonstrate consistent recovery rates and significant patient satisfaction when the service is received.

8. Consultation

This is not a consultation item.

9. Background Papers – No background papers as defined in Section 100D of the Local Government Act 1972 were used in the preparation of this report.

This report was written by Dr Tracey Swaffer, Head of Adult Clinical Psychology and Psychotherapies Service, Consultant Clinical Psychologist, who can be contacted on 01522 340160 or at Tracey.Swaffer@lpt.nhs.uk.

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Lincolnshire COUNTY COUNCIL		THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE	
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Open Report on behalf of Dr Tony Hill,

Executive Director of Community Wellbeing and Public Health

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**16 March 2016**
Subject:	**Annual Report of the Director of Public Health on the Health of the People of Lincolnshire 2015**

Summary:

The *Annual Report on the Health of the People of Lincolnshire from the Director of Public Health* is an independent statutory report to Lincolnshire County Council. The report raises issues of importance to the health of the population of Lincolnshire.

Actions Required:

The Health Scrutiny Committee is requested to receive the *Annual Report on the Health of the People of Lincolnshire from the Director of Public Health* and consider the recommendations included in each chapter.

1. Background

It is a statutory duty of the Director of Public Health to produce an annual report on the health of the people of the area he/she serves. It is a statutory duty on the local authority for that area (in this case the Council) to publish that Report. The report attached at Appendix A is the latest report of the Director of Public Health for Lincolnshire. The report is not an annual account of the work of the Public Health Team, but an independent professional view of the state of the health of the people of Lincolnshire, with recommendations on the action needed by a range of organisations and partnerships. Last year the annual report on the health of the people of Lincolnshire focused on the major causes of premature mortality, that is people who die under the age of 75 years. The report highlighted three major findings, one of which is getting worse, this is liver disease.

Concern about the increase in preventable liver disease is so great that this year's report concentrates solely on this issue. We describe liver disease, its stages and causes, its patterns and associations, its facts and figures. Following that, the three main causes; obesity, alcohol and hepatitis, are covered in a chapter each. We finish with some recommendations, but chief among them must be that we see some sustained investment in liver disease prevention and treatment and the development of effective pathways of care for people with liver disease and its causes. This reflects the joint contributions of prevention and treatment to conditions where progress has been made and maximises our chances of success. It is to be hoped that next year's commissioning plans will address these needs.

2. Conclusion

The statutory annual report of the Director of Public Health on the health of the people of Lincolnshire has now been prepared and the Health Scrutiny Committee for Lincolnshire is asked to receive a presentation and note the recommendations included in each chapter.

3. Consultation

This is not a consultation item.

4. Appendices

These are listed below and published as a supplement to the Agenda Pack.	
Appendix A	Annual Report of the Director of Public Health on the Health of the People of Lincolnshire 2015 Please note that this appendix has been circulated electronically and can be found on the Committee pages as a supplement to the agenda pack at:- http://lincolnshire.moderngov.co.uk/ieListDocuments.aspx?CId=137&MId=4541&Ver=4

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 Dr Tony Hill, who can be contacted on 01522 552902 or tony.hill@lincolnshire.gov.uk

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

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**16 March 2016**
Subject:	**Peterborough and Stamford Hospitals NHS Foundation Trust – Seminar on Delayed Transfers of Care**

Summary:

On 2 March 2016, Peterborough and Stamford Hospitals NHS Foundation Trust held a seminar at Peterborough City Hospital on Delayed Transfers of Care. Two members of the Health Scrutiny Committee for Lincolnshire attended, Councillors Mrs Judy Renshaw and Mrs Sue Wray. This paper includes their report.

Actions Required:

(1) To consider and comment on the information presented on the Delayed Transfers of Care Seminar held by Peterborough and Stamford Hospitals NHS Foundation Trust on 2 March 2016, including the report by Councillor Mrs Judy Renshaw and Councillor Mrs Sue Wray.

(2) To determine if any further action is required by the Committee.

1. Background

Seminar for Health Overview and Scrutiny Committee Members

On 2 March 2016, Peterborough and Stamford Hospitals NHS Foundation Trust held a seminar on delayed transfers of care at Peterborough City Hospital. Representatives were invited from the Health Scrutiny Committee for Lincolnshire, as well as other health overview and scrutiny committees in the Trust's catchment. Approximately half of the Trust's patients are from Peterborough. Lincolnshire provides about one quarter of the patients, with a

further quarter coming from Cambridgeshire, Rutland and Northamptonshire combined.

As part of the invitation, the Trust had stated that it was in an interesting position with patients coming from a wide population and across different local authority areas and community health providers. This leads to a degree of complexity to their discharge arrangements. The Trust wanted to explore this topic with members of health overview and scrutiny committees, so there would be more understanding of the context, in which the Trust was working, particularly in relation to delayed transfers of care.

Councillors Mrs Judy Renshaw and Mrs Sue Wray attended the seminar, and their report, which is based on the presentation given at the seminar.

Background to Delayed Transfers of Care

The definition of a delayed transfer of care is when:

- a clinical decision has been made that a patient is ready for transfer; AND
- a multi-disciplinary team decision (involving the NHS body and the local authority) has been made that a patient is ready for transfer; AND
- the patient is safe to discharge/transfer.

There are several ways of measuring delayed transfers of care. Here are some examples:

(1) The number of delayed days as a cumulative figure for the month, which is measured by
    - local authority;
    - provider trust;
    - responsible organisation (NHS, Social Care or both);
    - reason for the delay.

(2) The number of patients with a delayed transfer of care as a monthly snapshot taken at midnight on the last Thursday of each month, which is measured by
    - local authority;
    - provider trust;
    - responsible organisation (NHS, Social Care or both);
    - reason for the delay.

(3) The average daily rate of delayed transfers of care for NHS organisations in England, acute and non-acute, per 100,000 population aged 18 and over, by local authority with social services responsibility. This is based on the snapshot figure in (2) above.

(4) The number of delayed days as a percentage of total available bed days in a hospital or hospital trust. In April 2015, NHS England urged that sufficient discharge management and alternative capacity such as discharge-to-assess models were in place to reduce the delayed transfer of care rate to 2.5%. This would form a stretch target beyond the 3.5% standard set in the NHS planning guidance.

Report from Councillors Mrs Judy Renshaw and Mrs Sue Wray

It was reported to the seminar that the number of delayed transfers of care on 26 February 2016 at Peterborough City Hospital was equivalent to one acute ward of 34 beds. This figure was based on patients from across all the Trust's local authority areas.

At the seminar, the Trust focused on the delayed transfer of care measured by available bed days lost, as described in (4) above, and highlighted certain issues for the discharge of Lincolnshire patients from Peterborough City Hospital on the basis of this measure. It was suggested that "step-down" facilities in Lincolnshire could be improved. For example, Cambridgeshire and Peterborough City have twelve beds in nursing homes, which enable patients to be moved out of acute hospital beds. The Trust stated that eight similar beds in Lincolnshire would help reduce the number of delayed transfers for Lincolnshire's patients.

It was also suggested that the Committee might wish to seek to encourage discussions between the Trust and Lincolnshire organisations to further pursue this matter.

Better Care Fund

It should be noted that that the Better Care Fund, which requires Clinical Commissioning Groups and local authorities in every single area to pool budgets and to agree an integrated spending plan for how they will use their Better Care Fund allocation, should be borne in mind by the Committee.

For 2016/17, as part of the Better Care Fund arrangements, each local area is required to develop a local action plan for managing delayed transfers of care, including a locally agreed target. All local areas will need to establish their own stretching local delayed transfer of care target, agreed between the CCG, the local authority and relevant acute and community trusts. This target should be reflected in CCG operational plans. The metric for the target should be the average delayed transfers of care (delayed days) per 100,000 population (attributable to either NHS, social care or both) per month. This would be based on the cumulative number of days measure [(1) above] rather than the snapshot figure [(2) above].

In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with the relevant acute and community trusts and be able to demonstrate that the plan has been agreed with the providers given the need for close joint working on the delayed transfer of care issue.

2. Conclusion

Several issues have been raised at the seminar, held by Peterborough and Stamford Hospitals NHS Foundation Trust, which could merit further exploration by the Health Scrutiny Committee for Lincolnshire. However, it should be noted that the Adults Scrutiny Committee is the responsible overview and scrutiny committee for the overall Better Care Fund arrangements and gave consideration to this topic on 24 February 2016.

The Health Scrutiny Committee is due to receive a general update report from Peterborough and Stamford Hospitals NHS Foundation Trust on 20 July 2016 and could request that the Trust include information on delayed transfers of care as part of this report. In the meantime, the Committee could seek reassurance that discussions are taking place between the Trust and Lincolnshire organisations on this topic.

3. Consultation

There is no consultation required as part of this item.

4. Background Papers

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

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

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

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

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**16 March 2016**
Subject:	**Arrangements for Consideration of Quality Accounts 2015-2016**

Summary

The Health Scrutiny Committee for Lincolnshire is invited to make arrangements for the *Quality Account* process for 2016. In particular, the Committee is invited to consider a series of questions. Firstly, the Committee is asked to consider on which draft *Quality Accounts* of which local providers of NHS-funded services does the Committee wish to make a statement.

The Committee is also asked to consider the joint arrangements with Healthwatch Lincolnshire, which has indicated that it would wish to work with the Committee on the Quality Accounts of the three main Lincolnshire based providers (Lincolnshire Community Health Services NHS Trust; Lincolnshire Partnership NHS Foundation Trust; and United Lincolnshire Hospitals NHS Trust). The Committee are requested to establish a working group for the *Quality Account* process.

Finally, the Committee is asked to comment on the draft priorities for 2016/17 of the East Midlands Ambulance Service NHS Trust, which is seeking initial views in accordance with best practice.

Actions Required:

(1) To determine which of the following local providers of NHS-funded services on whose draft *Quality Account* the Health Scrutiny Committee for Lincolnshire would wish to make a statement (Section 4 of the report):

- Boston West Hospital
- East Midlands Ambulance Service NHS Trust
- Lincolnshire Community Health Services NHS Trust

- Lincolnshire Partnership NHS Foundation Trust
- Northern Lincolnshire and Goole NHS Foundation Trust
- Peterborough and Stamford Hospitals NHS Foundation Trust
- St Barnabas Hospice
- United Lincolnshire Hospitals NHS Trust

(2) To consider whether to work jointly with Healthwatch Lincolnshire and prepare a joint statement on the following three Quality Accounts:

- Lincolnshire Community Health Services NHS Trust;
- Lincolnshire Partnership NHS Foundation Trust; and
- United Lincolnshire Hospitals NHS Trust

(3) To consider whether establish a working group for the *Quality Account* process for 2016.

(4) To provide some initial comments on the draft priorities of the East Midlands Ambulance Service, which are attached at Appendix A.

1. Legal Framework for Quality Accounts

The legal framework for *Quality Accounts* became effective on 1 April 2010, and has been amended since that time to reflect changes in NHS organisational structures and to further prescribe the content of each *Quality Account*. Each significant provider of NHS-funded services is required to submit their draft *Quality Account* to*:*

- their local Health Overview and Scrutiny Committee;
- their local Healthwatch Organisation; and
- their relevant Clinical Commissioning Group.

The definition of 'local' is the local authority area, in which the provider has their principal or registered office. Five providers of NHS–funded health care have their registered office in Lincolnshire.

Role of the Health and Wellbeing Board

The regulations do not include a formal role for health and wellbeing boards. However, providers may share their draft *Quality Account* with their local health and wellbeing board for comments, if they wish. NHS England has emphasised that any involvement of health and wellbeing boards is discretionary.

2. What is a *Quality Account*?

The content of a *Quality Account* is prescribed by regulations. It must include:

- three or more **priorities for improvement** for the coming year;

- an account of the progress with the **priorities for improvement** in the previous year; and
- details of:

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

In addition foundation trusts are required by Monitor (the financial regulator of foundation trusts) to prepare a Quality Report, which in effect must incorporate all the required elements of a *Quality Account*, together with additional requirements set by Monitor.

It should be noted that statements prepared should not be limited to a response to the content of the draft *Quality Account*, but should in addition reflect the views of the Committee on the quality of services provided during the course of the year by the provider.

3. What Should a Statement on a *Quality Account* Cover?

The Department of Health has previously issued guidance to bodies making statement on *Quality Accounts,* which encourages these organisations to focus on the following questions: -

- Do the priorities included in the *Quality Account* reflect the priorities of the local population?
- Have any major issues been omitted from the *Quality Account?*
- Has the provider demonstrated that they have involved patients and the public in the production of the *Quality Account*?
- Is the *Quality Account* clearly presented for patients and the public?
- Are there any comments on specific local issues, which Healthwatch / the Health Scrutiny Committee have been involved with?

4. Previous *Quality Account* Arrangements 2010 - 2015

From the first year of the introduction of Quality Accounts in 2010 until 2012, the Health Scrutiny Committee for Lincolnshire and the Lincolnshire Local Involvement Network worked jointly. Healthwatch Lincolnshire was established on 1 April 2013 and a joint arrangement operated for 2013, 2014 and 2015.

A working group arrangement has always been adopted, whereby representatives of the provider organisation present their draft *Quality Account* to a working group of Committee members and representatives from Healthwatch Lincolnshire. The output from the working group is a statement (up to 1,000 words) on the draft *Quality Account*, which has to be included in the final published version of the *Quality Account.*

The main points for 2015 were as follows:

- The first draft *Quality Account* was received on 10 March 2015 (The East Midlands Ambulance Service NHS Trust) and the last one was received on 12 June 2015 (St Barnabas Hospice), a period of three months. This 'phased' approach is beneficial and does not overwhelm the working group with too many *Quality Accounts* in a short period of time.
- Healthwatch Lincolnshire had indicated that it would not participate in preparing statements on the draft *Quality Accounts* of Northern Lincolnshire and Goole NHS Foundation Trust and Peterborough and Stamford Hospitals NHS Foundation Trust on the basis that the Healthwatch organisations in the respective areas would be preparing statements.
- Two working group meetings took place, each considering two draft *Quality* Accounts.
- The Health Scrutiny Committee and Healthwatch Lincolnshire prepared joint statements on four draft *Quality Accounts.*
- The Health Scrutiny Committee had indicated that it would prepare statements on the draft *Quality Accounts* of Northern Lincolnshire and Goole NHS Foundation Trust and Peterborough and Stamford Hospitals NHS Foundation Trust. Statements were not submitted owing to the limited time available.
- Healthwatch Lincolnshire indicated that it would prepare a statement on the draft *Quality Account* of Boston West Hospital and accordingly made a statement, but the Health Scrutiny Committee declined to do so.

4. Which Providers Should be Involved?

Lincolnshire Based Providers

It should be noted that the regulations enable the "relevant overview and scrutiny committee" to make a statement on the *Quality Account* of a local provider. This is defined as the overview and scrutiny committee of the local authority in whose area the provider has its registered or principal office". The following providers have headquarters in Lincolnshire and therefore they would be required to include a statement on their *Quality Account*: -

- Lincolnshire Community Health Services NHS Trust
- Lincolnshire Partnership NHS Foundation Trust
- Boston West Hospital (Ramsay Healthcare)
- St Barnabas Hospice
- United Lincolnshire Hospitals NHS Trust

There is regular engagement between the Health Scrutiny Committee and three of the above providers (Lincolnshire Community Health Services NHS Trust; Lincolnshire Partnership NHS Foundation Trust; and United Lincolnshire Hospitals NHS Trust). Boston West Hospital and St Barnabas Hospice are due to present items to the Committee on 20 April 2015.

Providers with Head Offices Outside Lincolnshire

The following providers do not have their registered office in Lincolnshire, but have in the past voluntarily agreed to the inclusion of a statement on their draft *Quality Account:*

- East Midlands Ambulance Service NHS Trust
- Northern Lincolnshire and Goole NHS Foundation Trust
- Peterborough and Stamford Hospitals NHS Foundation Trust

Each of the above trusts provides a significant number of services to Lincolnshire residents. The Health Scrutiny Committee is requested to consider on which of the above three providers' draft *Quality Account* it would wish to make a statement.

6. Working with Healthwatch

The Health Scrutiny Committee for Lincolnshire has worked jointly with Healthwatch Lincolnshire for the last three years. Healthwatch has indicated that it would wish to continue working with the Committee on three *Quality Accounts:*

- Lincolnshire Community Health Services NHS Trust
- Lincolnshire Partnership NHS Foundation Trust
- United Lincolnshire Hospitals NHS Trust

Healthwatch has indicated that it would be working with other Healthwatch organisations in the East Midlands on the preparation of a joint statement on the draft *Quality Account* of the East Midlands Ambulance Service NHS Trust.

Healthwatch Lincolnshire has again indicated that it will not be preparing statements on the draft *Quality Accounts* of Northern Lincolnshire and Goole NHS Foundation Trust and Peterborough and Stamford Hospitals NHS Foundation Trust on the basis that the Healthwatch organisations in the respective areas would be preparing statements.

7. Working Group Arrangements

If the Committee were to adopt a working group arrangement, it is requested that the Committee indicate whether it they would wish to volunteer for this activity. This would involve meeting three or four times in total during April, May and early June.

8. East Midlands Ambulance Service NHS Trust

The East Midlands Ambulance Service NHS Trust (EMAS) is seeking comments on its draft priorities for 2016/17. These are set out in Appendix A. There will still be an opportunity to consider the full EMAS *Quality Account,* when it is available.

9. Conclusion

The Committee is invited to make arrangements for the *Quality Account* process for 2015-16.

10. Consultation

This is not a consultation item. However, as part of the annual *Quality Account* process, the Health Scrutiny Committee for Lincolnshire is entitled to make a statement up to 1,000 words on the content of each local provider's draft *Quality Account*. This process is detailed throughout this report.

11. 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

East Midlands Ambulance Service NHS Trust

Draft Quality Account Priorities for 2016/17

Priority Classification	Priority Description
Clinical Effectiveness	Priority 1 Cardiac arrest – return of spontaneous circulation (ROSC) and survival outcomes. EMAS has continued to focus its attention upon the improvement of successful ROSC rates in cardiac arrest. During 2016/17: • To continue to develop and improve our cardiac arrest outcomes. • To see our Ambulance Quality Indicators and outcomes around stroke, chronic obstructive pulmonary disease, and asthma improve. • Increase the presence of frontline clinical supervision to all active resuscitation attempts.
Patient Safety	Priority 2 Sepsis is a worldwide public health issue. In developing nations, sepsis accounts for nearly 80% of deaths. Sepsis kills far more citizens than AIDS, prostate cancer and breast cancer combined. It is the leading cause of death and has a high mortality in the developed world. • To identify and treat sepsis within our patients. • Ensure the formalisation of the Trust Sepsis Lead, including documented objectives and performance measures. • Appoint divisional Sepsis champions (1 per division) on a volunteer basis. • Develop a robust action plan to achieve element J which will ensure the availability of waveform capnography on a minimum of 95% of front line operational resources (Double Crewed Ambulances and Fast Response Vehicles). • Work with a partner Acute Trust to explore the increased pre-hospital use of intravenous antibiotics in the treatment of sepsis. This will require cross boundary working and collaboration across Clinical Commissioning Groups and other key stakeholders. • To improve patient outcomes whilst seeing a reduction in the maternal related incidents in the Trust.

Priority Classification	Priority Description
Patient Experience	Priority 3 Having signed up to the National Mental Health Crisis Concordant, we will work collaboratively with local commissioners and relevant stakeholders to implement the agreed priorities within the mental health action group. • To build on mental health pathways in all divisions. • To embed Parity of Esteem in the Trust for all patients and to ensure Patients presenting with mental health conditions receive an appropriate response and are signposted to the appropriate service. • To improve awareness of mental health conditions in our Trust. • This will require cross boundary working and collaboration across Clinical Commissioning Groups and other key stakeholders.
Patient Safety	Priority 4 • To identify the common themes of all maternity related incidents and to reduce patient related incidents. • Reduction in severity of all maternity related incidents within our care. • To receive an improvement on aspects of clinical care from maternity units. • To educate all operational workforce in maternity related training.
Patient Safety	Priority 5 To explore the usage of alternative pathways in the division by using the pathfinder leads to develop the pathways in the Trust and in each commissioning region.

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:	**16 March 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

16 March 2016		
Item	**Contributor**	**Purpose**
Adult Clinical Psychology Service – and Psychotherapies Service	Jane Marshall, Director of Strategy and Performance, 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
Peterborough and Stamford Hospitals NHS Foundation Trust – Report on Delayed Transfers of Care Seminar	Councillor Mrs Sue Wray and Councillor Mrs Judy Renshaw	Position Statement
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
Lincolnshire Partnership NHS Foundation Trust – Outcomes from Care Quality Inspection	Dr John Brewin, Chief Executive, Lincolnshire Partnership NHS Foundation Trust	Status Report

20 April 2016		
Item	**Contributor**	**Purpose**
Urgent Care – Constitutional Standards Recovery and Winter Resilience	Sarah Furley, Urgent Care Programme Director, Lincolnshire East Clinical Commissioning Group	Update Report
United Lincolnshire Hospitals NHS Trust – Pharmacy Services	Colin Costello, Chief Pharmacist, United Lincolnshire Hospitals NHS Trust	Update Report
Exercise Black Swan – Outcomes and Learning	David Powell, Head of Emergency Planning, Lincolnshire County Council Cheryl Thomson, Public Health Programme Officer, Health Protection, Lincolnshire County Council	Update Report
St Barnabas Hospice – Palliative Care and End of Life Care	Chris Wheway, Chief Executive, St Barnabas Hospice Trust	Status Report

18 May 2016		
Item	**Contributor**	**Purpose**
East Midlands Ambulance Service - Performance and Improvements	Andy Hill, General Manager – Lincolnshire, East Midlands Ambulance Service	
South Lincolnshire Clinical Commissioning Group Update	Caroline Hall, Acting Chief Officer, South Lincolnshire Clinical Commissioning Group	Update Report
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

15 June 2016		
Item	**Contributor**	**Purpose**

20 July 2016		
Item	**Contributor**	**Purpose**
Peterborough and Stamford Hospitals NHS Foundation Trust – General Update	To be confirmed.	Update Report

21 September 2016		
Item	**Contributor**	**Purpose**
Lincolnshire Cancer Strategy	Sarah-Jane Mills, Director of Planned Care and Cancer Services at Lincolnshire West Clinical Commissioning Group	Update Report

Items to be programmed

- Reducing Obesity for Adults and Children
- Dementia and Neurological Services
- Queen Elizabeth Hospitals, King's Lynn – General Update Report
- Lincolnshire Health and Care – Strategic Outline Case
- Dentistry
- Lincolnshire West CCG Update on Delegated Commissioning
- Child and Adolescent Mental Health Services
- Joint Strategic Needs Assessment

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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