Public Document Pack

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, 21 July 2021 at 10.00 am in the Council Chamber, County Offices, Newland, Lincoln LN1 1YL

MEMBERS OF THE COMMITTEE

County Councillors: C S Macey (Chairman), L Wootten (Vice-Chairman), M G Allan, R J Cleaver, S R Parkin, R P H Reid, Dr M E Thompson and R Wootten

District Councillors: S Woodliffe (Boston Borough Council), B Bilton (City of Lincoln Council), Mrs S Harrison (East Lindsey District Council), Mrs L Hagues (North Kesteven District Council), G P Scalese (South Holland District Council), Mrs R Kaberry-Brown (South Kesteven District Council) and Mrs A White (West Lindsey District Council)

Healthwatch Lincolnshire: Dr B Wookey

AGENDA

Item	Title	Pages
11	**Health Scrutiny Committee for Lincolnshire - Work Programme** *(To receive a report from Simon Evans, Health Scrutiny Officer, which invites the Committee to consider and comment on its forthcoming work programme)*	105 - 110

Debbie Barnes OBE
Chief Executive
13 July 2021

Please note: This meeting will be broadcast live on the internet and access can be sought by accessing Agenda for Health Scrutiny Committee for Lincolnshire on Wednesday, 21st July, 2021, 10.00 am (moderngov.co.uk)

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HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE
23 JUNE 2021

PRESENT:

Lincolnshire County Council

Councillors M G Allan, R J Cleaver, C S Macey, S R Parkin, R P H Reid, Dr M E Thompson, L Wooten and R Wootten.

Lincolnshire District Councils

Councillors S Woodliffe (Boston Borough Council), B Bilton (City of Lincoln Council), Mrs L Hagues (North Kesteven District Council), G P Scalese (South Holland District Council) and Mrs A White (West Lindsey District Council) and Councillor M A Whittington (South Kesteven District Council).

Healthwatch Lincolnshire

Dr B Wookey.

Also in attendance

Katrina Cope (Senior Democratic Services Officer) and Simon Evans (Health Scrutiny Officer).

The following officers/representatives joined the meeting remotely via Teams:

Mark Brassington (Director of Improvement and Integration and Deputy Chief Executive, United Lincolnshire Hospitals NHS Trust), Dr Kakoli Choudhury (Consultant in Public Health Medicine), Simon Evans (Chief Operating Officer, United Lincolnshire Hospitals NHS Trust), Simon Hallion (Managing Director Family Health), Dr Suganthi Joachim (Divisional Clinical Director - Family Health, United Lincolnshire Hospitals NHS Trust), Tracy Pilcher (Director of Nursing, Lincolnshire Community Health Services NHS Trust), Anna Richards (Associate Director of Communications and Engagement, United Lincolnshire Hospitals NHS Trust), Katy Thomas (Head of Health Intelligence), Professor Derek Ward (Director of Public Health), Chloe Scruton (General Manager Surgery, United Lincolnshire Hospitals NHS Trust) and Andrew Simpson (Consultant Urologist, United Lincolnshire Hospitals NHS Trust).

County Councillor C Matthews (Executive Support Councillor for NHS Liaison, Community Engagement, Registration and Coroners) attended the meeting as an observer.

HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE
23 JUNE 2021

1 ELECTION OF CHAIRMAN

RESOLVED

That Councillor C S Macey be elected as the Chairman of the Health Scrutiny Committee for Lincolnshire for 2021/22.

COUNCILLOR C S MACEY IN THE CHAIR

2 ELECTION OF VICE-CHAIRMAN

RESOLVED

That Councillor L Wootten be elected as the Vice-Chairman of the Health Scrutiny Committee for Lincolnshire for 2021/22.

3 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

Apologies for absence were received from Councillors Mrs S Harrison (East Lindsey District Council) and Mrs R Kayberry-Brown (South Kesteven District Council).

The Committee noted that Councillor M A Whittington (South Kesteven District Council) had replaced Councillor Mrs R Kayberry-Brown (South Kesteven District Council) for this meeting only.

An apology for absence was also received from Councillor S Woolley (Executive Councillor for NHS Liaison, Community Engagement, Registration and Coroners).

4 DECLARATIONS OF MEMBERS' INTEREST

No declarations of members' interest were made at this stage of the proceedings.

5 MINUTES OF THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE MEETING HELD ON 16 MARCH 2021

RESOLVED

That the minutes of the Health Scrutiny Committee for Lincolnshire meeting held on 16 March 2021 be agreed and signed by the Chairman as a correct record.

6 CHAIRMAN'S ANNOUNCEMENTS

Further to the Chairman's announcements circulated with the agenda, the Chairman brought to the Committee's attention the supplementary announcements circulated on 22 June 2021. The supplementary announcements made reference to: Covid-19 Data; Integrated Care Systems – Design Framework; and Quality Accounts 2020/21.

The Chairman advised the Committee of his intention to write to Councillor Chris Brewis thanking him for his long service on the Committee, having been the Committee's Vice-Chairman from 2013 to 2021.

RESOLVED

That the Supplementary Chairman's announcements circulated and the Chairman's announcements as detailed on pages 15 to 24 of the report pack be noted.

7 UNITED LINCOLNSHIRE HOSPITALS NHS TRUST - GENERAL UPDATE

The Committee gave consideration to a report from United Lincolnshire Hospitals NHS Trust (ULHT), which provided a general update on its services.

The Chairman invited the following representatives from ULHT to remotely present the report to the Committee: Mark Brassington, Deputy Chief Executive and Director of Improvement and Integration and Simon Evans, Chief Operating Officer.

The Committee received an update on the current position in relation to the services, which made reference to the following:

- That ULHT currently had one Covid-19 positive in-patient in Pilgrim Hospital, Boston. The Committee noted that to date the Trust had treated over 3,000 Covid-19 patients. The Deputy Chief Executive and Director of Improvement extended thanks to staff in hospitals and across Lincolnshire for their continued support and commitment throughout the pandemic. In contrast, it was noted that in Wave One the number of patients receiving treatment had peaked at 104; and in Wave Two the figure had risen to 253 patients being treated;
- The hospital hub had provided over 41,000 vaccinations to social care staff across Lincolnshire. It was noted that hospital hub had now closed;
- That complex clinics continued to operate to accommodate patients with more complex medical conditions who required closer monitoring;
- That the number of staff absences from work as a result of Covid-19 or having to isolate had reduced back to normal levels, which was a positive step forward for the Trust;
- There had been an increase in bed occupancy due to an increase in emergency demand, which had also impacted on other partners such as the ambulance service. It was also highlighted that there had also been an increase in the number of elective patients;
- That the Trusts waiting lists were being treated in order of clinical urgency, with clinicians applying priority status: priority one where patients were treated within 72 hours, and the Committee noted that currently there were no patients waiting in this priority group; and priority two where patients were treated within four weeks. The Committee noted that currently this waiting time was at six weeks. There was recognition by the Trust that there was more to be done to improve access. It was

highlighted that cancer patients were quickly prioritised and were receiving treatment within four weeks. It was highlighted further that the waiting list in Lincolnshire during the pandemic had peaked at just over 2,000 patients waiting, and that this figure had now been reduced to 937; and that there was a commitment to reduce the waiting list further; and

- That the Grantham restoration was going to plan and that services would be restored to as they were in May 2020 with two additional services: Chemotherapy and additional theatres (it was highlighted that there were currently two additional theatres but one of these was due to be removed). It was highlighted further that it was the intention to make Grantham Hospital, the principal elective surgery site.

Appended to the report at Appendix 1 was a copy of the Chief Executive's Report to United Lincolnshire Hospitals NHS Trust Board of Directors (1 June 2021) and Appendix 2 provided a copy of the Report to United Lincolnshire Hospitals NHS Trust Board of Directors (1 June 2021) on the Restoration of Services to Grantham Final Phase and Progress for the Committees consideration.

During discussion, the Committee raised the following points:

- Clarification around the opening times of the accident and emergency department at Grantham being only from 8.00am to 6.30pm, when the Urgent Treatment Centre provided 24/7 provision. The Committee was advised that a decision had to be taken to reduce the hours to support the overall delivery of services across Lincolnshire and that these would remain in place until the outcome of the Acute Services Review. It was noted that during Covid-19, there had been the Urgent Treatment Centre (UTC), with the restoration plan now coming to fruition, these staff had now returned to their usual roles, and as a result the system was unable to sustain 24/7 cover. Thanks were extended to the Lincolnshire Community Health Services staff who had maintained the UTC service at Grantham Hospital;
- Personal experience of attending the Lincoln A & E, and the number of people waiting (around 60 people). The Committee was advised that there had been an increase in number of people visiting A & E. The Committee noted that both Lincoln County Hospital and Pilgrim Hospital, Boston were still operating in a Covid-19, socially distanced way; and as such hospitals had to make provision to be able to separate any Covid-19 positive patients or potential Covid-19 positive patients from non-Covid-19 patients;
- Provision of medical beds at Grantham Hospital. Reassurance was given that an appropriate level of medical beds would be available to meet demand;
- The success of Moy Park. The Committee was advised that the provision of services at Moy Park had been extended for a further six months, to allow some of the services to be moved back into Grantham Hospital and for other services to be re-located;
- The possible cause for the increase in the number of patients visiting A & E departments. One reason highlighted was whether this could be because some residents were unable to gain access to their GP. It was reported that access to

primary care was increasing also. Reassurance was given that measures had been put in place to meet the increased demand at A & E departments. It was also highlighted that there needed to be further communication messages informing residents not to use A & E unless it was an emergency and to encourage residents to contact 111 or their GP. It was highlighted that residents were confused as to what services were available and how they were accessed;

- Reflection of what could have been done better during the pandemic. The Committee was advised of two areas which the Trust representatives felt could have been done better. The first item highlighted was identifying one of the hospital sites as a green site earlier; and the other was allowing staff to take annual leave during beginning of the pandemic, when Lincolnshire was not being affected as much as elsewhere, as most staff had a 100 day stretch without being able to take annual leave;
- Mobile breast screening service. The Committee was advised that the mobile unit moved around the county particularly on the east coast. Reassurance was given that the mobile unit would return to a hospital previously visited. The Committee noted that the provision of breast screening was a system approach and agreed by colleagues from Public Health. It was suggested that there needed to be more public awareness regarding this service;
- What the identified risks associated with finances were? The Committee was advised that for 2021/22, finances had been split into two parts, H1 (the first part of 2021/22) which included additional funding in response to Covid-19. It was highlighted that further work was then underway on mitigating the risks and on planning for the second half 2021/22 (H2). It was reported that it was anticipated that the NHS would return to a more normal financial regime in H2, following the revised financial arrangements during the Covid-19 pandemic. It was highlighted further that the return to the more normal financial regime would bring with it increased financial risk;
- The effect the new UTC at Lincoln had on reducing the number of patients into A & E. The Committee was advised that, so far the impact had been that patients were being treated more quickly, and that there was an ability to expand more clinical rooms to see more patients; and
- How the recruitment process was progressing and whether there was any overseas recruitment element? The Committee was advised that recruitment had been very positive; the Trust had the lowest number of vacancies they had seen for quite some time. This had been achieved by normal recruitment; and by being part of the national programme for the recruitment of health care support workers, with over 200 support works being recruited. The Committee was advised further that the overseas recruitment had been suspended in response to Covid-19 restrictions, but had recently been reopened. It was also noted that the development of the medical school at the University of Lincoln had also had a positive effect on recruitment. It was agreed that recruitment details would be forwarded on to members of the Committee following the meeting.

The Chairman on behalf of the Committee extended thanks to the ULHT representatives for their presentation.

RESOLVED

1. That thanks be extended by the Committee to staff for their efforts during the pandemic and in restoring services within United Lincolnshire Hospitals NHS Trust.

2. That the information presented by United Lincolnshire Hospitals NHS Trust as part of the general update be noted.

3. That a request be made for future reports from the Trust to focus on specific service areas such as cancer care.

8 UNITED LINCOLNSHIRE HOSPITALS NHS TRUST - CONSULTATION ON HOSPITAL UROLOGY SERVICES

The Chairman invited Mark Brassington, Deputy Chief Executive and Director of Improvement and Integration, Andrew Simpson Consultant Urologist, Chloe Scruton, General Manager Surgery and Anna Richards, Associate Director of Communications and Engagement, to remotely present the report to the Committee.

The Committee was advised that planned urology services were currently delivered from Lincoln County Hospital, Pilgrim Hospital, Boston, Grantham and District Hospital and County Hospital, Louth; and emergency urology admissions at the weekends went through one single site-alternating between Lincoln and Pilgrim hospitals. It was highlighted that there were emergency admissions at both Lincoln and Pilgrim hospitals during the week.

It was noted that ULHT were consulting patients on a proposal that Lincoln County Hospital in future received all emergency urology admissions seven days per week as they believed that this change would increase ULHT's capacity to perform planned surgery without disruption to patients, better meet the needs of ULHT's emergency cases and allow for more patients to seen and treated.

It was reported that at present, consultants and middle grade doctors within the urology service were required to perform planned surgery and be on-call for urgent surgical requirements at the same time. This was of concern as staff were becoming exhausted as they could be preforming planned surgery in the day and then be called out to perform an emergency surgery; this then impacted on the ability for the service to respond as quickly as it would like to emergency surgical needs; and it also caused the cancellation at short notice of planned surgeries, typically over 1,300 operations per year across ULHT every year for urology related procedures.

The Committee noted that the separation of duty to enable consultants to be either on-call or scheduled to perform planned surgery, would avoid the requirement to fulfil both duties at the same time. Full details of what was being proposed were shown on pages 45 to 47 of

the report pack and page 52 provided the Committee with a list of the benefits to patients of the proposal.

Detailed at Appendix 1 to the report was a copy of a document entitled Hospital Urology Services Consultation – Have Your Say *(United Lincolnshire Hospitals NHS Trust-2021)* for the Committee to consider. The Committee was advised that the consultation was due to close on 23 July 2021.

During discussion, the Committee raised the following points:

- Clarification whether the 1,900 cancelled procedures annually related to elective procedures. Confirmation was given that the figure related to elective procedures;
- Whether there was sufficient bed capacity to meet the increased demand in elective surgery at Grantham Hospital. Confirmation was given that there was sufficient bed capacity at Grantham Hospital; as more surgical procedures were planned to be carried out at Grantham Hospital;
- Operating theatre capacity at Grantham Hospital. The Committee noted that currently there were two additional mobile theatres at Grantham Hospital, one of which was due to be removed from the site, as the temporary contract for its hire was due to expire. The Trust was now looking into replacing the theatre with a more permanent modular unit which would be available for use later in the year;
- Some concern was raised that services were being removed from Pilgrim Hospital Boston. The Committee was advised that the proposal was subject to consultation. Reassurance was given that it was not the intention of the Trust to remove services from Pilgrim Hospital, Boston. The intention was to ensure that the best service possible was provided and that all sites had a role to play in providing that service. The Committee was advised that discussions had taken place with staff at Pilgrim Hospital, Boston and colleagues from Boston had welcomed the opportunity to work with the Lincoln site, as a specialist site, with the development of specialist knowledge and skills;
- That the consultation period had been extended to ten weeks;
- Whether there was a detailed impact assessment for the proposal. The Committee was advised that a quality impact assessment was being finalised and that once completed could be shared with the Committee;
- The level of response to the consultation and what the general theme was of the responses received so far? It was reported that so far 120 responses had been received and the responses had been divided, some were in favour of the proposal and understood the reasons for the changes, others had raised concerns regarding have to travel further for emergency treatment. It was also noted that the ambulance service had been supportive of the proposal; and
- Reference was made to page 45 of the report which stated under the proposed changes if a patient was to arrive at Pilgrim Hospital, Boston and it was deemed urgent, the patient would then be transferred by ambulance to Lincoln County Hospital. Some concern was expressed as to whether any consideration had been given as to how the patient would then be transferred to Pilgrim Hospital, Boston, to

collect their vehicle if it had been parked at Pilgrim. The Committee was advised that based on normal pathways the patient would be returned back to the home site.

The Chairman on behalf of the Committee extended his thanks on behalf of the Committee to the representatives for their presentation.

RESOLVED

That a draft response, based on the Committee's comments today, be submitted to the next meeting of the Committee on 21 July 2021 for consideration and approval.

9 UPDATE ON PILGRIM HOSPITAL, BOSTON, PAEDIATRIC SERVICE

The Chairman invited Mark Brassington, Deputy Chief Executive and Director of Improvement and Integration, Simon Hallion, Divisional Manager Family Health and Dr Suganthi Joachim, Divisional Clinical Director for Family Health to remotely present the report to Committee, which provided an update on the Paediatric Service, at Pilgrim Hospital, Boston.

Detailed at Appendix A to the report was a copy entitled "Proposal for the Next Stage Development of the Paediatric Assessment Unit (PAU) Model at Pilgrim Hospital Boston."

The Committee was reminded of the background to the original model agreed in August 2018, which sought to assess and discharge all children presenting at Boston within a twelve-hour time frame, with children requiring longer inpatient periods being transferred to Rainforest Ward at Lincoln County Hospital, by private ambulance.

It was noted that by the spring of 2019, however, the PAU was not always strictly following the twelve-hour model. It was noted further that the absence of an immediate High Dependency Unit-level ambulance transfer service meant that sicker children (non-intensive care) needed to receive the early phase of their care at Pilgrim Hospital, Boston. Over the intervening two-year period, a more sustainable longer-term model of care had been actively developed alongside the successful recruitment into both the medical and nursing teams.

It was reported that the ULHT Trust Board had supported a revised interim model for paediatric care at Pilgrim Hospital, Boston, moving the service towards a Short Stay Paediatric Assessment Unit, with an average length of stay below 24 hours. The remit of the unit would be to deliver both an assessment and short term observation function, with the option of some children with defined care plans remaining on in the unit beyond 48 hours.

In conclusion, the Committee was advised that the clinical teams believed that the described model delivered a short stay PAU that reflected national best practice and enabled children and young people to receive their full care needs at Pilgrim Hospital, Boston.

It was also highlighted that general public and patient engagement had been ongoing around the Pilgrim Hospital paediatric service over the last three years, including extensive patient involvement in adjustments to the service offer to reflect local need.

The Committee were invited to provide guidance on the level of public engagement required to make the current service model into a more permanent arrangement.

During discussion, the Committee raised the following points:

- Congratulations and support was extended to the improved service. The Committee was advised that there had been a high level of consultation with the local population and patients, which had been gratefully received as had the support of staff at Pilgrim Hospital, Boston. Particular thanks were extended to the SOS Pilgrim Group for the articulate way the needs of the local population had been presented;
- Whether the model to be adopted at Pilgrim Hospital, Boston would be replicated in other hospitals and by neighbouring hospital trusts. The Committee was advised that the model had been seen as good practice, and innovative in its approach. It was noted that the Trust was taking forward the learning from the service to the Lincoln County Hospital. It was agreed that further information would be obtained via the Clinical Commissioning Group regarding what paediatric services were in place for Lincolnshire patients requiring paediatric services from neighbouring hospital trusts; and
- The Support provided to children to help them with their stay in hospital. The Committee noted that the improved services at Pilgrim Hospital, Boston had enabled staff to support families in a more wrapped around way.

The Chairman on behalf of the Committee extended his thanks to the representatives for their presentation.

RESOLVED

1. That the report on the development of the paediatric service at Pilgrim Hospital, Boston over the last three years be noted; and that thanks be extended to staff for their effort in maintaining and restoring paediatric services over the last year.

2. That the Chairman be authorised to respond to United Lincolnshire Hospitals Trust, outlining the views of the Committee on:

   (a) The substance of the proposal for a short stay paediatric assessment; and
   (b) To support the proposal by the Trust for a twelve-week engagement period.

10 LINCOLNSHIRE COMMUNITY HEALTH SERVICES - GENERAL UPDATE

The Chairman invited Tracy Pilcher, Director of Nursing, Allied Health Professionals and Operation to remotely present the report to the Committee, which provided an update on

the restoration and recovery of services provided by Lincolnshire Community Health Services NHS Trust (LCHS) following the Covid-19 pandemic.

A copy of the report had been circulated to members of the Committee on 19 June 2021.

In guiding members of the Committee through the report, mention was made to:

- That all services had now been restored and were all back to pre-Covid-19 levels of performance; that Louth and Skegness Urgent Treatment Centres (UTCs) were now open 24/7, and that Gainsborough and Spalding had been restored as UTCs, providing a greater range of services;
- Same Day Primary Care Appointments; LCHS was currently working with system partners on a short-term proof of concept to support two GP surgeries; in Gainsborough and Lincoln. Details relating to the proof of concept were shown on page 4 of the report. The Committee was advised that activity was increasing across all UTCs and that the Skegness activity was continuing to increase as in previous years. The biggest demand being from 8am to 10pm with minimal activity overnight. A breakdown for each UTC for restoration and recovery was shown on pages 5 to 8 of the report;
- Community Hospitals – It was noted that as part of the restore programme a number of developments had been identified, including the piloting of an e-observation platform, further development of the direct admissions pathways for community hospital, as well as a review of the workforce models for community hospitals to support the wider out of hospital programmes of care. The Committee noted that 67% of services had been partially restored;
- LCHS Outpatient Services – This activity would be restored on the LCHS sites during June and July 2021;
- Butterfly Hospice – The service had been restored and was providing significant contribution to the palliative and end of life pathway for patients within Boston and surrounding area;
- Community Nursing – The Community nursing service was now fully restored; and that work was now ongoing in relation to embedding the new pathways of care, as well as supporting the increased number of patients with complex needs being cared for in the community. Full details of referrals and discharges were shown on page 11 of the report;
- Allied Health Professionals and Children's Services - It was highlighted that there had been challenges to fully restoring the services due to many of the Allied Health Professional services being stepped down during the first phase of Covid-19, in line with national policy, and staff being redeployed to support the wider organisational response;
- Specialist Services – The Committee noted that 62% of services had been restored;
- Post-Covid Syndrome Service – It was highlighted that since the commencement of this service , there had been 438 referrals, with 312 open referrals and 126 patients being discharged from the service; and

- Covid-19 Vaccination Programme – It was highlighted that delivery models had been developed to safely, rapidly and efficiently vaccinate eligible cohorts. It was noted that the Princess Royal Sports Arena, Boston and the Lincoln Showground were running well and were successfully delivery services in line with the national provider and operational specifications.

During discussion, the Committee raised the following points:

- An explanation of the assistance provided to GPs to enable them to have extra capacity;
- The number of Community Nursing vacancies in the county. The Committee was advised that there was a staff establishment of 320 fte community nurses across the county and that this figure had increased from 284 fte in the previous year, but there were still some vacancies. It was agreed that further information would be made available to members of the Committee, from which it would be established whether the Committee would need to look into this matter further;
- Post Covid-19 Syndrome and the associated mental psychological health issues. It was highlighted that someone with mild symptoms of Covid-19 in the first wave may not have been diagnosed as having Covid-19. As a result there was a cohort of people who had a range of symptoms who had not been tested for Covid-19 who were suffering from fatigue, and other symptoms. In these circumstances primary care would be requested to perform a range of diagnostic tests (in line with National Institute for Health & Care Excellence (NICE) guidance) before referring into the service. Any one referred experiencing mental or psychological issues would be referred to the Lincolnshire Partnership Foundation NHS Trust;
- The Trusts intended plans for the St Mary's Medical Centre premises in Stamford following its use as a vaccination centre. The Committee advised that this would be a matter for the CCG;
- Whether there were any plans to review the overnight medical cover arrangements at Louth and Skegness urgent treatment centres, as there was no doctor on duty overnight. The Committee was advised that there were two practitioners on duty overnight at Louth and Skegness, and that there was an on call doctor. The Committee noted that the model had been reviewed and had been signed off as a safe and effective model. There was an appreciation of the concerns and anxieties raised by staff and the public, but reassurance was given that there had been no incidents overnight; and it was highlighted that arrangements were continually being monitored; and
- What the capital investment was being used for in Skegness and Louth and when was work likely to commence? The Committee was advised that in Louth the refurbishment would be addressing environmental issues such as ventilation; and storage of medicines. At Skegness there would be more significant investment to look at the whole environment, to take into account ventilation; self-isolation provision and the provision of an additional waiting area; and a children's waiting area.

The Chairman extended thanks on behalf of the Committee to the Director of Nursing, Allied Health Professionals and Operation for her update.

RESOLVED

1. That the information presented by the Lincolnshire Community Health Services NHS Trust be noted and that thanks be extended to all staff involved in the Trust for their continued involvement in responding to Covid-19.

2. That the establishment of new urgent treatments centres in Gainsborough and Spalding during the last year be welcomed.

3. That the Committee's concerns about overnight medical cover at Louth and Skegness urgent treatment centres be recorded and that a further report concerning this matter be received at a future meeting.

11 NATIONAL GENERAL PRACTICE DATA FOR PLANNING AND RESEARCH - DATA COLLECTION

The Chairman invited Derek Ward, Director of Public Health and Katy Thomas, Head of Intelligence to remotely present the report to the Committee, which provided information on the National General Practice Data for Planning and Research (GDPR) data collection and local risks.

The Committee was advised that NHS Digital was changing the way it collected data from GP sites. It was noted that although the changes were predominantly around the process that was to be used, the issue had caused some concern. It was highlighted that the implementation date for the new process had been moved from 1 July to 1 September 2021.

The Committee was advised further that disruption to the national programme or substantial number of patients 'opting out' of data sharing with NHS Digital locally would hamper the national data flows for primary care. This would mean that data would be unusable for understating needs, fair and effective service provision and outcomes for the residents of Lincolnshire. It was noted that this would have implications for Lincolnshire County Council and the Director of Public Health in fulfilling their statutory duties to their best abilities; and for the Clinical Commissioning Group to commission and providers to provide high quality, appropriate and effective services for all, making the best use of collective resources. It was also highlighted that the increasing concern over data sharing might impact engagement with local programmes and agreements.

The report provided information on governance and safeguards; what was changing; what data was shared; and how data was shared by NHS Digital. It was highlighted that patients' names, addresses were not shared and all other data that could directly identify patients (such as NHS number, date of birth, full postcode) would not be included and would be replaced by unique codes before the data was shared with NHS Digital, which would ensure that patients could not be identified directly to the data.

It was further reported that data shared by NHS Digital was subject to robust rules relating to privacy, security and confidentiality; and that organisations using the data also had to have a clear legal basis to do so.

Dr B Wookey left the meeting at 12.41pm.

Councillor M G Allan left the meeting at 12.43pm.

During discussion, the Committee raised the following points:

- What level of patients opting out of data sharing would compromise the data collected. The Committee was advised that there was not a figure identified in this regard. To obtain complete data sets, the fewer patients that opted out the better the data would be;
- Whether anything could be done to encourage patients not to opt out. The Committee was advised that work was already ongoing with general practices to try and provide reassurances; and that more would need to be done nationally to alleviate any misunderstandings; and
- Support was extended by some members of the Committee for the need to be able to access the data to ensure that Lincolnshire had all the information required to do the best for Lincolnshire residents.

The Chairman extended his thank on behalf of the Committee to the representatives for their presentation.

RESOLVED

That the report presented be noted and that a further progress report be received at a future date.

12 HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE - WORK PROGRAMME

The Chairman invited Simon Evans, Health Scrutiny Officer, to present the report, which invited the Committee to consider and comment on its work programme as detailed on pages 68-70 of the report.

Potential items suggested included:

- Dentistry;
- G P Services;
- Mental Health Issues as a result of Covid-19;
- Acute Services Review;
- North West Anglian NHS Foundation Trust – Update; and
- Non-Emergency Patient Transport – Update.

RESOLVED

That the work programme presented be agreed, subject to inclusion/consideration of the items listed above.

The meeting closed at 1.04 pm.

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

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**21 July 2021**
Subject:	**Chairman's Announcements**

1. Secretary of State for Health and Social Care

The Rt Hon Sajid Javid MP was appointed the Secretary of State for Health and Social Care on 26 June 2021, following the resignation of the Rt Hon Matt Hancock MP. The ministerial team remains unchanged.

2. Health and Care Bill 2021

The Health and Care Bill 2021 was published on 6 July 2021, when it received its first reading in the House of Commons. The Bill comprises 135 clauses and 16 schedules, and is 232 pages in length. The Department for Health and Social Care has reported that measures in the Bill include:

- The NHS and local government coming together to plan health and care services around their patients' needs, and quickly implement innovative solutions to problems which would normally take years to fix, including moving services out of hospitals and into the community, focusing on preventative healthcare.
- The development of a new procurement regime for the NHS and public health procurement, informed by public consultation, to reduce bureaucracy on commissioners and providers alike, and reduce the need for competitive tendering where it adds limited or no value. This will mean staff can spend more time on patients and providing care, and local NHS services will have more power to act in the best interests of their communities.
- Supporting the introduction of new requirements about calorie labelling on food and drink packaging and the advertising of junk food before the 9pm watershed to level up health across the country. The pandemic has shown the impact of inequalities on public health outcomes and the need for government to act.

3. Lincolnshire Acute Services Review - Consultation

The Acute Services Review (ASR) pre-consultation business case has been approved by NHS England. Lincolnshire Clinical Commissioning Group (CCG) is now preparing the materials and the processes for a public consultation. The consultation documentation and processes will be submitted to the CCG's Board for approval.

4. Covid-19 Update

An update on the latest position with regard to Covid-19 will be circulated prior to the meeting.

5. Paediatric Services at Pilgrim Hospital – Short Stay Paediatric Unit

On 6 July 2021, the Board of Directors of United Lincolnshire Hospitals NHS Trust Board agreed to support a proposal to move to a twelve week public engagement exercise on the short-stay paediatric assessment unit at Pilgrim Hospital. This followed consideration by this Committee on 23 June 2021, when the Committee advised a twelve week engagement programme to seek public support for the revised model at Pilgrim Hospital.

6. Community Nursing Vacancies in Lincolnshire

In response to a question on the presentation from Lincolnshire Community Health NHS Trust (LCHS) at this Committee's last meeting on 23 June 2021, the following information was circulated on community nursing vacancies:

In the last year LCHS has increased its establishment of community nurses from 284 to 320 whole time equivalent (wte). The service has 28 whole time equivalent vacancies representing 8.5% of the total workforce, which compares to regional vacancy rates for community nursing of 8%. The table below shows the vacancy position reported In April 2021:

Staff Role	Model (wte)	Numbers in Post (wte) April 2021
Band 2	0	2.26
Band 3	65	62.2
Band 4	40	22.07
Band 5	145	127.97
Band 6	46	58.62
Band 7	24	19.36
Total	**320**	**292.48**

A report to the LCHS Board of Directors on 13 July 2021 (The Bi-Annual Safe Staffing Report June 2021) provides further information and includes the following:

> *"Team capacity is affected as there are significant numbers of staff on restricted duties short and medium term, either from pandemic, long term condition and MSK related conditions which is impacting significantly – one team alone Boston ICT has 11 restricted staff. This takes additional focus and effort on roster allocation and deployment.*
>
> *"Teams are reviewed daily at the morning safety huddle, deferred visits when required are monitored and temporary workforce is deployed to support the substantive workforce where available including low numbers of agency.*
>
> *"Positive recruitment to community nursing teams has continued and resulted in an overall vacancy rate of 8.5%, but with peaks in three teams of 15% - 25%, Skegness, Welland and Lincoln City North.*
>
> *"During the pandemic staff worked excess hours and due to fatigue and personal choice, the need to recover and holiday periods - this is now reducing availability. Of note is that the overtime hours current used equates to 50% of the vacancies.*
>
> *"The positive steps in recruitment are balanced with increased rates of referrals and rising associated activity - alongside some teams having 50% of registered staff that are newly recruitment to the Trust having been recruited during the pandemic. The Clinical Practice Education team is working with the workforce team to understand the support required by the staff to recover any induction gaps and understand development requirements.*
>
> *"The annual and overall turnover in community nursing is recorded at 13% slightly worse than the national average of 12% and the trust overall of 10%. Annual turnover rates are c20% in 4 teams – Skegness, Welland, Lincoln City South and Gainsborough.*
>
> *"Community nursing leaders describe the rising referrals, restricted staff duties, sickness absence and maternity leave, new staff with training and development needs as the reasons why the impact of successful recruitment is not yet fully appreciated in the teams.*
>
> *"The community nursing transformation programme whilst partially paused initially in the pandemic is now progressing. Successful recruitment has taken place resulting in the appointment 11 of the 12 WTE new posts of Community Clinical Practitioners with development programmes for the new roles underway. There are 5 new apprentice nurse roles in place and 5 registered nurses in development posts to become district nurses."*

This report is available in full at www.lincolnshirecommunityhealthservices.nhs.uk/about-us/our-trust-board/trust-board-papers

7. Lincolnshire Clinical Commissioning Group Annual Report and Accounts 2020-21

On 28 June 2021, Lincolnshire Clinical Commissioning Group published its annual report and accounts for 2020/21, which is available at the following link:

https://lincolnshireccg.nhs.uk/library/annual-report-1/annual-reports-2021/

8. Site Clearance Works – New Adult Mental Health Care Unit in Boston

On 5 July 2021, Lincolnshire Partnership NHS Foundation Trust has announced the beginning of site clearance works at Norton Lea in Boston. This five acre site will accommodate a new 19 bed inpatient unit for men and women, and will replace the existing Ward 12 at Pilgrim Hospital. This project is part of a £37 million programme to end dormitory accommodation across all Lincolnshire inpatient mental health units and provide all patients with their own en-suite bedrooms, with ground floor access to a courtyard and garden. The programme also includes the construction of two new wards at the Peter Hodgkinson Centre at Lincoln County Hospital, where work is already underway.

The plans are subject to planning permission from Boston Borough Council. A full planning application is in preparation and will be submitted by the Trust later this year.

9. Involvement Champion Programme

On 5 July 2021, Lincolnshire Clinical Commissioning Group (CCG) launched its *Involvement Champion* Programme, with the aim of strengthening the existing patient and public involvement channels within the CCG and wider NHS. The CCG is encouraging and supporting people to become trusted voices in their local area, so that they can help the CCG and wider NHS, reach as many people from different communities as possible, when involving people and communities in our work.

Involvement Champions will act as a point of contact between NHS Lincolnshire CCG and the group or community that they are a part of. They will present the views and feedback about health services from their communities and groups to the CCG so that the CCG can hear and act on the patient voice from the community we serve.

Further details on the programme and the application process may be found at:

https://lincolnshireccg.nhs.uk/get-involved/how-to-get-involved/become-a-ccg-involvement-champion/

10. Quality Accounts 2021

A report to the Committee on the Quality Accounts for 2021 is set out for information at Appendix A to these announcements.

APPENDIX A

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 Andrew Crookham
Executive Director - Resources

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**21 July 2021**
Subject:	**Quality Account Priorities for 2021-22**

Summary:

Most providers of NHS-funded services are required to publish by 30 June each year an account of the quality of their service for the previous year, and include in this account at least three priorities for improvement for the coming year. This document, referred to as the quality account, is shared in draft form with each local health overview and scrutiny committees (as well as local healthwatch organisations and clinical commissioning groups), who may make a statement on its contents, for inclusion in the published version.

On 16 March 2021, this Committee agreed to make statements on the draft quality accounts of two local providers: the East Midlands Ambulance Service NHS Trust and United Lincolnshire Hospitals NHS Trust. This report includes the three priorities for improvement from these two trusts, together with the Committee's statements on their documents.

1. Background

Providers of most NHS-funded services are required to publish by 30 June each year an account of the quality of their service for the previous year. This requirement does not extend to all providers, for example GPs and NHS dentists are not included. This document is referred to as the *Quality Account* and has been used by the Department of Health and Social Care since 2010. A *Quality Account* does not focus on finances, but represents an account of the quality (as opposed to an account of the finances) of a particular organisation. Overall financial information on a particular trust is found in their annual report.

Legal Framework for Quality Accounts

Where a Quality Account is required from a provider, each provider of NHS-funded services should submit their draft *Quality Account* to*:*

- their local health overview and scrutiny committee;
- their local healthwatch organisation; and
- their relevant clinical commissioning group.

The regulations define 'local' as the local authority area, in which the provider has their principal or registered office. Whilst there is a requirement for local providers to submit their draft *Quality Accoun*t to their local health overview and scrutiny committee, there is no obligation on such a committee to make a statement in response.

What is Contained in a *Quality Account*?

The content of a *Quality Account* is prescribed by regulations, with additional requirements set by NHS England and NHS Improvement. The *Quality Account* 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; and
  - general performance and the number of complaints.

What Should a Statement on a Quality Account Cover?

The Department of Health and Social Care has previously issued guidance to those making statements to focus on the following questions: -

- Do the priorities in the *Quality Account* reflect the priorities of local people?
- Have any major issues been omitted from the *Quality Account?*
- Has the provider demonstrated involvement of 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 issues, where the Committee has been involved?

The Health Scrutiny Committee is entitled to make 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.*

Quality Account Arrangements in 2021

On 16 March 2021, this Committee agreed to provide statements on the draft *quality accounts* of:

- East Midlands Ambulance Service NHS Trust
- United Lincolnshire Hospitals NHS Trust

This report provides information to the Committee on the priorities of above two providers, together with this Committee's statements. These two statements were drafted after working group meetings on 2 and 8 June 2021, comprising Councillors Carl Macey, Linda Wootten, Ray Wootten and Angela White.

This report also includes for information the Quality Account priorities for 2021-22 for the following provider trusts:

- Lincolnshire Community Health Services NHS Trust
- Lincolnshire Partnership NHS Foundation
- North West Anglia NHS Foundation Trust
- Northern Lincolnshire and Goole NHS Foundation Trust

2. Appendices

These are listed below and attached at the back of the report	
Appendix 1	East Midlands Ambulance Service NHS Trust – Quality Account Priorities for 2021-22 and Statement from the Health Scrutiny Committee for Lincolnshire
Appendix 2	United Lincolnshire Hospitals NHS Trust – Quality Account Priorities for 2021-22 and Statement from the Health Scrutiny Committee for Lincolnshire
Appendix 3	Lincolnshire Community Health Services NHS Trust – Quality Account Priorities for 2021-22
Appendix 4	Lincolnshire Partnership NHS Foundation Trust – Quality Account Priorities for 2021-22
Appendix 5	North West Anglia NHS Foundation Trust – Quality Account Priorities for 2021-22
Appendix 6	Northern Lincolnshire and Goole NHS Foundation Trust – Quality Account Priorities for 2021-22

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, Health Scrutiny Officer, who can be contacted on 07717 868930 or by e-mail at Simon.Evans@lincolnshire.gov.uk

APPENDIX 1

EAST MIDLANDS AMBULANCE SERVICE
QUALITY ACCOUNT PRIORITIES 2021-22

Priority 1 – Caring

We will improve the way in which we listen to and use feedback from our patients, carers and families to continually improve our services. We will do this by expanding our patient voice groups and ambassador roles in terms of both numbers and diversity, implementing revised patient feedback for ambulance services and developing a metric to capture compassion, kindness, dignity and respect in action. **(carried over from 2020/21)**

Priority 2 – Responsive

We will continue to promote the safe and appropriate use of alternatives to ED by ensuring that our staff have the necessary knowledge, skills, experience and confidence to do so. This will include ensuring that staff have digital access to shared records and to senior clinical support where required.

Priority 3 – Effective

We will improve our performance against the nationally reported Ambulance System Indicators and Clinical Outcomes, with a particular focus on cardiac arrest. We will do this through a robust audit programme, effective clinical leadership, sharing learning and implementing improvement strategies. **(carried over from 2020/21)**

Priority 4 – Well Led

We will continue to learn from when things go well as well as when they go wrong, ensuring that learning is shared both internally and externally to improve the quality of care we provide to our patients. We will work collaboratively with partners to identify and mitigate risks across the system and implement the Patient Safety Incident Response Framework once published.

Priority 5 – Safe

We will improve the timeliness of managing safeguarding referrals raised by our staff by fully automating the referrals process ensuring that relevant third parties are alerted in real-time.

Statement on the *Quality Account* for 2020/21
of the East Midland Ambulance Service NHS Trust

Introduction

The Health Scrutiny Committee for Lincolnshire reviews and scrutinises NHS-funded health services in the administrative county of Lincolnshire, which forms a substantial part of the Lincolnshire Division of the East Midlands Ambulance Service region.

Covid-19

The Committee recognises the significant impact of Covid-19 on emergency ambulance services and would like to record its thanks to all the EMAS staff, who have continued to provide emergency ambulance services during the challenges of the pandemic.

Progress on Priorities for 2020-21

The Committee welcomes the fact that Priority 1 *(Use of Patient Feedback)* has included the establishment of a Patient Voice Group in Lincolnshire. The Committee would like to see the membership of Lincolnshire group strengthened during the coming year and confirmation of the reporting arrangements between the patient voice groups and the EMAS Board, so the patient voices can be heard and acted on. This could be achieved by enabling patient voice groups to raise matters of concern directly with the EMAS Board.

The Committee notes that as part of Priority 2 (*Meeting Individual Needs of Patients*) there has continued to be an emphasis on reducing the rate of conveyance to A&E departments, for example, a non-conveyance rate of over 40% in February 2021. Robust clinical decision-making is key to the success of non-conveyance, so that both staff and patients can feel confident that the right treatment is being delivered in the right place at the right time. The Committee notes the 'missed opportunity' audits with their focus on patients taken to hospital unnecessarily. The Committee would like to see clinical audits of 'non-conveyed' patients, to provide reassurance that the treatment or advice they received out of hospital was appropriate to their clinical needs and wellbeing.

The Committee welcomes the piloting of cardiac arrest leaders in Lincolnshire as part of Priority 3 (*Ambulance Clinical Quality Indicator Performance*) activity. The Committee notes and supports the progress made with both Priority 4 (*Continuous Staff Learning and Innovation*) and Priority 5 *(Improving Serious Incident Investigations).*

Selection of Priorities for 2021-22

As stated in the section above, activity for Priority 1 *(Use of Patient Feedback)* should include strengthening patient voice groups; and the formal reporting arrangements should be considered, so that patient voice feedback is fully taken into account by the EMAS Board.

Promoting alternatives to inappropriate attendance at A&E is supported as part of Priority 2 (*Meeting Individual Needs of Patients*). However, the Committee believes that striving for targets could lead to patients who require attendance at A&E being inappropriately treated, and suggests clinical audits of 'non-conveyed' patients as a source of evidence. The Committee acknowledges that there has been a wealth of learning during the pandemic and would like to see this shared so staff can feel confident in their clinical decision-making and patients can feel assured they are being treated appropriately. Staff appraisals would be expected to support this.

The Committee strongly supports Priority 3 (*Ambulance System and Clinical Outcome Indicators*). Liaison with acute hospitals is key to delivering improvement, so that handover delays are minimised, both to transfer patients to the appropriate hospital clinician as well as to release ambulances.

The Committee supports Priority 4 (*Learning from Incidents*), but would like to see more detail on how the learning, particularly during the pandemic, is going to be shared in practice. The Committee strongly supports Priority 5 (*Managing Safeguarding Referrals*).

Lincolnshire

The Committee welcomes the inclusion of specific information on Lincolnshire initiatives, such as cardiac arrest leaders, who have improved rates of return of spontaneous circulation; and pathways co-ordinators, who work to avoid inappropriate attendances at A&E. Reviews of patients being harmed as a result of hospital handover delays and response times are also welcome. The Committee would like to explore these topics with representatives from EMAS in the coming year.

It is expected that consultation on the Lincolnshire Acute Services Review will begin during 2021-22. As any service changes are likely to affect the demands on ambulance services, the Committee would expect EMAS to be involved in discussions on any significant service re-designs.

Complaints and Compliments

The Lincolnshire Division has again recorded a reduced number of formal complaints, with a total of only eight. Both complaints and compliments are essential elements of patient feedback.

Non-Emergency Patient Transport

Although EMAS does not provide this service in Lincolnshire, the Committee notes the low level of complaints for the Trust's non-emergency patient transport services in Derbyshire and Northamptonshire.

Role of Community First Responders

The Committee would like the research, currently being undertaken by the University of Lincoln, on the role of community first responders in rural areas to be shared, as Lincolnshire has been supported for many years by the Lincolnshire Integrated Voluntary Emergency Service (LIVES), as well as services such as Lincolnshire Fire and Rescue.

Engagement with the Health Scrutiny Committee for Lincolnshire

The Committee received an information briefing in January 2021. In the coming year, the Committee like to receive a presentation on EMAS activities in the county, including some of the topics highlighted in this quality account.

Presentation of Information

Although the required content of a quality account is not designed for members of public, the Committee believes that the document is as accessible as possible, and the inclusion of a glossary is welcomed.

Conclusion

We look forward to continued engagement with the Trust in the coming year and acknowledge that impacts of Covid-19 will continue to present challenges to the service.

APPENDIX 2

UNITED LINCOLNSHIRE HOSPITALS NHS TRUST
QUALITY ACCOUNT PRIORITIES 2021-22

Priority 1 – Improving Respiratory Services

Our aim is to develop a Trust Wide Respiratory service that provides safe, effective and quality care; and which meets all local and national standards and guidelines. With an aim to bring our model of respiratory service in line with that of our peers, by investing in recruitment and retention of staff, training for all, service re-design and configuration to British Thoracic Society (BTS) standards. Respiratory was a quality priority for the Trust in 2020-21, however, we did not achieve all of the deliverables expected due to Covid-19 and respiratory remains as a quality priority for 2021-22 for the Trust.

Priority 2 – Developing a Safety Culture

The 'NHS Patient Safety Strategy: Safer culture, safer systems, safer patients' was published in July 2019 and provides the framework by which NHS organisations will use patient safety initiatives and responses to enable a transition from blame to learning. This approach will result in patient safety initiatives and responses that are primarily based on what can be learned rather than who should be held accountable. By building on the foundations of a patient safety culture and a patient safety system, the NHS can achieve its safety vision, which is to continuously improve patient safety. Safety culture remains a key priority for the Trust and will remain as a quality priority for 2021-2022.

Priority 3 –Improving Patient Experience

Communication is the most critical requisite within healthcare as it directly affects safety, quality, effectiveness and experience of care. We know that within our organisation our staff and our patients report instances of poor communication and that we could (and indeed should) do better. Communication is also about listening, and listening is about taking that patient voice and learning from it. Listening is not just understanding the words of the question a patient may have asked, but to understand why the question was asked in the first place. To be listening to our patient they have to have a voice and to do this we need to ensure as an organisation that voice is sought and heard throughout all we do.

Engaging and involving our patients as partners in care is central to patient-centred care. Involvement is a factor across the continuum of care and can be general day-to-day care through to key information giving and the opportunity to ask questions. Patient-centred care means ensuring we respect individual preferences, we listen, provide support, comfort and compassion and we involve family, friends and carers.

There is rich evidence that people who have experience of using services are uniquely placed to help plan and develop those services and demonstrates the importance and impact of working in partnership with people with lived experience. It also demonstrates how engaging with our patients and carers, learning from them and working with them leads to better outcomes for all involved.

Statement on United Lincolnshire Hospitals NHS Trust's *Quality Account* for 2020/21

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

Covid-19

The Health Scrutiny Committee would like to record its thanks to all the staff, who have continued to provide services during the last year, not only in direct response to the pandemic, but also in maintaining and restoring other services such as cancer care.

Progress on Priorities for Improvement for 2020-21

Given the impact of the pandemic, the Committee commends the Trust's progress on its five priorities for improvement for 2020-21. In relation to Priority 2 (*Safe Patient Discharge*), the Committee recognises the various planning and processes to be completed before discharge. However, there are some concerns that too many patient discharges are still being delayed by prescriptions not being ready; or the availability of patient transport.

Priorities for Improvement for 2021/22

We acknowledge the rationale for the selection of the three priorities for improvement for 2021/22, which support the Trust's five year integrated improvement plan. The following comments are put forward on each priority:

- *Priority 1 – Improving Respiratory Services* – The Committee welcomes the planned opening of the respiratory support units in both Boston and Lincoln in the coming year.
- *Priority 2 – Developing a Safety Culture* – The Committee stresses the importance of staff being able to raise safety (as well as other) concerns. The Committee notes the roles of the *freedom-to-speak-up guardian* and the *freedom-to-speak-up champions* and would like to see all staff, irrespective of status or rank, feeling confident to escalate concerns using the Trust's own processes in the first instance, rather than contacting people outside the organisation.
- *Priority 3 – Improving Patient Experience* – The Committee notes the Trust's commitment to improving communications with patients. One example is where letters inviting patients to appointments are not issued and appointments are missed. The Committee understands that alternatives to letters, such as telephone, email or text message, are being explored. However, improvements have included the approach whereby letters from consultants to GPs are copied directly to patients.

The Committee notes the wealth of data available to the Trust on the patient experience, which includes the patient panel, established in September 2020, on which the Committee will be seeking more information in the coming year.

Specific Issues

The Committee would also like to record its comments on the following specific topics:

- Grantham Green Site – The temporary conversion of Grantham Hospital to a green site was a success in maintaining the treatment of patients with cancer and other conditions requiring urgent care.
- Grantham A&E Overnight Closure – Grantham A&E has been closed overnight on a temporary basis since August 2016. The Committee would like to see resolution of this issue, as part of an overall plan for the hospital, and looks forward to consultation on the Lincolnshire Acute Services Review, on the longer term arrangements.
- A&E Services – The Committee recognises the extraordinary challenges faced by A&E services during the last year. Initiatives to minimise attendance at A&E by 'non-emergency' patients are acknowledged, but a challenge remains in ensuring that patients arriving by ambulance are transferred to the care of A&E staff as soon as possible.
- Outpatient Appointments at Community Hospitals – This topic emerged during the last year, but the Committee accepts that no substantial changes will be made to appointment provided by the Trust at community hospitals without consultation.
- Board Meetings – Holding public Trust Board meetings remotely has enabled many more members of the public to engage with the Trust. The Committee encourages this approach.

Care Quality Commission

While there have been no formal reports from the CQC since 2019, the Committee understands that regular meetings are taking place between the Trust and the CQC as part of the CQC's inspection arrangements during the pandemic.

Engagement with the Health Scrutiny Committee for Lincolnshire

During 2020-21, frequent engagement with the Health Scrutiny Committee for Lincolnshire has continued, with the focus largely on the Covid-19 pandemic and the restoration and maintenance of services. This has included the temporary arrangements, such as the Grantham hospital green site, which during the summer of 2019 attendance by clinicians at the Committee as part of the presentations on the *Healthy Conversation 2019* engagement exercise, which provided the Committee with a deeper understanding of the rationale for each preferred option.

We look forward to continued engagement with the Trust's senior managers, and where appropriate clinicians, in the coming year. This will be particularly important as the Trust, together with the rest of the local NHS, balances the challenges of responding to covid-19 with restoring care and treatment to non-covid-19 patients.

Presentation of the Document

We are again pleased to see a well presented document. For example, there is a clear indication as to whether the success measures for the actions supporting each priority have been achieved.

Conclusion

The Committee is grateful for the opportunity to make a statement on the draft Quality Account. The Committee looks forward to progress with the three priorities in the coming year and will continue to seek to engage the Trust at its meetings. The Committee would again like to record its thanks to all the Trust's staff and volunteers who have strived to respond to the challenges and maintain services during the pandemic.

APPENDIX 3

LINCOLNSHIRE COMMUNITY HEALTH SERVICES NHS TRUST
QUALITY ACCOUNT PRIORITIES 2021-22

Priority One – Patient Involvement and Patient Partners

This quality account priority seeks to reset and launch the patient voice work and will support establishing the patient partner framework within the trust. The programme of work is in three levels.

Level 1 - Panel member - receive regular information about the Trust, share their views via surveys

Level 2 - Service specific interest group - established around specific service lines. Developed to work in partnership, to progress specific projects, share views via surveys or consultation.

Level 3 – Patient partners - core group of trained panel members, who can take part in visits, sit on appropriate LCHS committee/meetings and participate on recruitment panels.

Immediately prior to the Covid-19 pandemic the Trust articulated a programme of work with a desire to improve and promote the patient voice and experience in delivery of our services. The developments contributed to creating an environment which improves the experiences of our patients, promotes listening and learning – providing greater understanding of how patients feel about care locally. Our key drivers are:

- Ensuring patient public involvement is increased and is robust
- To ensure learning from Covid19 continues to be embedded to support patient generated assurance and scrutiny to help shape future services
- Creating an environment in which the views of patients and the public are maximised through increased opportunities
- Creating an environment in which the patient voice can directly influence future developments and change the perspective of our learning
- Provide an opportunity for the trust to work towards understanding and addressing local inequalities

Priority Two – Embed the Principles of the Safety Culture (National Patient Safety Strategy)

Implementing this priority will ensure the trust takes proactive steps to respond to the recommendations made within the National Patient Safety Strategy specifically the embedding of the concept of the 'Just Culture Guide' and appropriate investigation of patient safety incident investigation. The focus on the National Patient Safety Strategy formally adopted and then embedded trough a quality account priority programme will ensure the 'Just Culture Guide' is formally adopted and built into Trust policies enabling improvement in the quality of incident reporting as one of the principles of improving safety culture. The trust is keen to ensure staff are equipped to respond to patient safety incidents and to undertake patient safety incident investigation and that learning from safety incidents continue to shape future service provision.

The National Patient Safety Strategy has been widely shared with clinical teams over the past months and a gap analysis will be included to refresh our current understanding on skills, capability, capacity within the organisation to assess Trust safety culture and deliver robust management of patient safety incident management and investigation. The Trust will adopt the NHS Improvement 'Just Culture Guide' and Human factors awareness. Investigation of incidents will be delivered under the new Patient Safety Incidences Response Framework. Training programmes adopting the framework applicable to all staff trust wide who are required to conduct incident investigation will be delivered. Trust wide awareness and stakeholder events will be planned and delivered.

Priority Three – Personalised Care and Support Planning

This priority will support the development of a clear vision and drive forward a consistent approach to Personalised Care and Support Planning (PCSP) across the trust's clinical services, aligned to and with all partners within the Lincolnshire health and care system. The development supports a consistent PCSP approach; ensuring patient goals and plans are developed in line with what matters to patients and outcomes are maximised in line with the national personalisation agenda. Supporting patients through PCSPs also supports the trusted assessment principles of "do once and share'', promotes the effectiveness of care by reducing duplication, maximising the plan for the patient and shared agreed outcomes and responsibilities for delivery of those outcomes.

PCSP from an individual's perspective is should be owned by the patient and shared with the right people. Where possible this should be held as a digital book with chapters that are unique to the patient.

Patient needs ("what matters to you") are identified with the patient following an initial conversation and subsequent series of conversations in which the person whose plan is being discussed actively participates. The conversations recognise a person's strengths and skills. Services 'wrap around' the patient to support the achievement of agreed outcomes including the development and use of standardised methods of patient reported evaluation. The plan is owned by the individual and is shared and contributed with and by the right people.

The approach is underpinned by an agreed definition of personalised care and support planning, which follows the 6-stage approach outlined by NHSE The Trust will use an agreed PCSP approach and documentation, allowing for appropriate variation which is clinically determined We will ensure that PCSPs are developed with patients and that this information is shared as appropriate with system partners in the pathway to enable seamless care. The scope of the programme will be all patients within community nursing, community therapy, specialist and transitional care services.

APPENDIX 4

LINCOLNSHIRE PARTNERSHIP NHS FOUNDATION TRUST
QUALITY ACCOUNT PRIORITIES 2021-22

Priority One – Involvement of Carers and Families

To improve the involvement of carers and families in patient/service user care (Adult Inpatient and Urgent Care Division). This is a new quality priority.

This priority builds on previous work to improve carer and family involvement in relation to the adult inpatient care pathways and particularly leave and discharge arrangements. There have been a number of serious incidents which highlighted the need for improved involvement to support better outcomes for patients/service users.

The Operations Performance and Governance Group will monitor and receive progress reports on improvements.

Priority Two – Dual Diagnosis Pathway – Alcohol and Substance Misuse and Mental Health

To develop and implement robust dual diagnosis (alcohol/substance use and mental ill health) pathway (Adult Community Division). This is a new quality priority.

Challenges faced by patients/service users who have a dual diagnosis can cause both physical and psychological harm to patients. Lincolnshire's dual diagnosis pathway has been found to fall short of the standard required to deliver safe and effective care that the Trust (and partner agencies) aspire to.
The Operations Performance and Governance Group will monitor and receive progress reports on improvements.

Priority Three – Patient Feedback

To make it easier for people who use our services to share their experiences of care by providing a range of methods to provide feedback across the services. This feedback will inform service development and improvement (Specialist Services Division). This is a new quality priority.

Service user and carer feedback on their experience of care is vital to support service improvement and development; however, the traditional way of using surveys to collect feedback can often mean groups, often the most disadvantaged and vulnerable, do not have the opportunity to provide feedback on their experiences. A single metric cannot provide a rounded picture of people's experience of care and we need to be creative in the ways we provide opportunities for people to give real time feedback, ensure they are listened to and be able to demonstrate their feedback has contributed to change.

The Operations Performance and Governance Group will monitor and receive progress reports on improvements.

Priority Four – Home Treatment Service Hubs for People Living with Dementia.

To deliver a home treatment service in Lincoln and Boston Hubs for people living with dementia (Older People and Frailty Division). This is a new quality priority.

This is important to prevent admission and support timely discharge by delivering care as close to home as possible for people living with dementia who require intensive support to maintain as much independence and autonomy as possible; and to provide person-centred care during transitions by providing a co-ordinated, multi-disciplinary approach.

The Operations Performance and Governance Group will monitor and receive progress reports on improvements.

APPENDIX 5

NORTH WEST ANGLIA NHS FOUNDATION TRUST
QUALITY ACCOUNT PRIORITIES 2021-22

Priority One – Mortality

To continue to improve position to re-gain top quartile status for the Hospital Standardised Mortality Ratio (HSMR) and Standardised Hospital Mortality Indicator (SHMI). The overarching aims are: to identify and understand the reasons behind relative risk alerts and to reduce HSMR to evidence good quality care; and to improve data quality and documentation of patient diagnosis groups, comorbidities and palliative care.

Priority Two – Digital Innovation for Quality

The overarching aims are: to improve quality measure outcome in more real time and improve data oversight; and to reduce labour intensive workload and enable more care hours back to direct patient care through the use of digital.

Priority Three – Clinical Risk and Patient Safety

The overarching aim is to implement the principles of the NHS Patient Safety Strategy Framework (PSIRF) to promote shared learning

Priority Four – Pressure Ulcers

The overarching aim is to reduction in hospital acquired pressure ulcers to promote quality of care and patient safety.

Priority Four – Sepsis Management

The overarching aim is to improve compliance with sepsis recognition and management.

Priority Five – Maternity (Safety)

The overarching aim is to maximise safety through the implementation of the Ockenden Recommendations.

Priority Six - Liberty Protection Safeguards - New Mental Capacity Act Guidance

The overarching aim is to implement the new Liberty Protection Safeguards legislation and processes replacing the Deprivation of Liberty Safeguards nationally.

Priority Seven – Patient Experience

The overarching aim is to enhance patient experience through the engagement of minority patient groups.

Priority Eight – Health Inequalities

The overarching aims are: to improve targeted health promotion that focus on Minority Ethnicity groups; to support improvement of Health inequalities in Women and Children; and to improve outcomes for women and babies who are from either a minority ethnic group or are vulnerable.

Priority Nine – Chaplaincy

The overarching aims are: to enhance patient experience through the use of volunteers within chaplaincy; to develop social media platform for chaplaincy services; to replicate the successful Peterborough City Hospital Volunteer Emergency Department Pastors and End of Life sitting service programme at Hinchingbrooke Hospital.

Priority Ten – Maternity (Patient Experience)

The overarching aim is to enhance women's birth experience.

Priority Eleven – Implementation of Integrated Urgent Treatment Centre

The overarching aim is to improve patient experience, safety and quality by streamlining patient flow in Peterborough City Hospital Emergency Department.

Priority Twelve – Infection Control

The overarching aims are: to reduce hospital acquired clostridium difficile infections; and to return to, and maintain, business as usual for the Infection Prevention and Control Team post pandemic

Priority Thirteen – Care Quality Commission Strategy

The overarching aims are: to embed the new Care Quality Commission strategy following its publication in May 2021; to improve internal governance process, the accuracy of data and the use of data from the Care Quality Commission insight report; and to complete outstanding actions on Care Quality Commission action plan from the Trust-wide inspection in 2019 and the Emergency Department inspection in December 2020.

APPENDIX 6

NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST QUALITY ACCOUNT PRIORITIES 2021-22

The Trust has agreed 5 quality priority areas for 2021/22:

Priority One - End of Life and Related Mortality Indicators
(Clinical Effectiveness & Patient Experience)

Priority Two - Deteriorating Patient and Sepsis
(Clinical Effectiveness & Patient Safety)

Priority Three - Increasing Medication Safety
(Patient Safety & Patient Experience)

Priority Four - Safety of Discharge
(Clinical Effectiveness, Patient Safety & Patient Experience)

Priority Five - Diabetes Management
(Clinical Effectiveness & Patient Safety)

The quality priorities for 2021/22 were set in harmony with the Trust's quality strategy longer term objectives. The priorities were also based on a comprehensive programme of consultation which involved the identification and formulation of a 'long-list' of prospective areas for priority focus. This was then consulted on with local residents and service users through the use of a survey made available by the Trust's communications and patient experience teams as well as CCG partners through their social media channels.

This analysis of service user feedback was then used for wider consultation within the Trust and with commissioners which resulted in a short-list of priorities for 2021/22. This was refined further by the Trust's Quality & Safety Committee and Trust Board.

Progress against these quality priorities will be monitored through the Trust's quality section of the Integrated Performance Report. This is a monthly report considered by the Executive-led Quality Governance Group for the oversight of management actions and also by the Non-Executive Director (NED) Chaired Quality & Safety Committee for assurance purposes. Assurance and performance against the Quality Priorities will also be monitored via the Trust Management Board, Quality & Safety Committee, Quality Governance Group and Operations Directorate performance.

Some of the above quality priorities and the underpinning measures to understand progress in each link to Trust performance indicators. In these instances, the Trust's Finance and Performance Committee will primarily oversee progress, with the Quality & Safety Committee seeking assurance on quality outcome measures related to Trust performance.
There are close links established between these oversight arrangements and the monthly performance meetings held with divisions, where divisions will be held to account for their performance.

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

Open Report on behalf of Lincolnshire Partnership NHS Foundation Trust and NHS England and NHS Improvement (Midlands)

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**21 July 2021**
Subject:	**Lincolnshire Child and Adolescent Mental Health Services Crisis and Enhanced Treatment Team**

Summary:

This report sets out an end-of-pilot evaluation for the Intensive Home Treatment service within the Child and Adolescent Mental Health Service (CAMHS) Crisis and Enhanced Treatment Team (CCETT) following the temporary closure of Ash Villa in October 2019 and implementation of the new community-based service.

This item has previously been considered by this Committee on 22 January 2020, 22 July 2020, and 17 February 2021.

Actions Requested:

(1) To consider the information in the evaluation of the pilot CAMHS Crisis and Enhanced Treatment Team.

(2) To consider whether to support the view that the CAMHS Crisis and Enhanced Treatment Team would be the new model of care in Lincolnshire on a permanent basis.

1. New Model of Care

A new model of care, in line with the principles of NHS England and NHS Improvement provider collaboratives was designed as an alternative provision to Lincolnshire Partnership NHS Foundation Trust's CAMHS inpatient ward Ash Villa, as this closed at the end of September 2019. The objective of the new model was to prevent unnecessary admission to out of area hospital beds and ensure that children and young people were repatriated back into the community in a timely manner where admission occurs. Whilst this is not exclusively for children and young people at risk of admission or actually admitted to general adolescent units, this will be the main focus as non-general adolescent unit beds (specialist eating disorders, psychiatric intensive care, low secure, learning disability beds) are out of scope from a financial perspective at this stage of the pilot. This would ensure that Lincolnshire children and young people would receive a service to support their needs in the absence of an inpatient facility.

Ash Villa was closed at the end of September 2019 due to a combination of staffing, estates and strategic factors. This closure led to a rapid mobilisation of an interim intensive home treatment team and an operational policy was pulled together in October and commenced on the 4 November 2019. The intensive home treatment team merged with the CAMHS crisis team on the 1 April 2020 to become the CAMHS Crisis and Enhanced Treatment Team (CCETT) to ensure a seamless service and improved journey for young people in crisis.

The data for this report has been taken from local sources as national data is underrepresenting inpatient usage and would overestimate the impact of the pilot. The key for all graphs analysed by month is that red is with Ash Villa and blue is with CCETT.

Previous Committee Consideration

Reports on this pilot have previously been submitted to this Committee on:

- 22 January 2020, which is available at Agenda for Health Scrutiny Committee for Lincolnshire on Wednesday, 22nd January, 2020, 10.00 am (moderngov.co.uk)
- 22 July 2020, which is available at: Agenda for Health Scrutiny Committee for Lincolnshire on Wednesday, 22nd July, 2020, 10.00 am (moderngov.co.uk)
- 17 February 2021 Agenda for Health Scrutiny Committee for Lincolnshire on Wednesday, 17th February, 2021, 10.00 am (moderngov.co.uk)

2. Covid-19 Impact

When the pilot was established, Covid-19 and the associated impact on mental health were unknown. Lincolnshire Partnership NHS Foundation Trust (LPFT) continues to monitor and assess the impact of Covid-19 on mental health and the associated increases activity on services. The national expectations are to see an average of 30% increase in demand. Figure 1 shows the number of referrals received by LPFT crisis services since 2017/19. In the last year there has been a 7% increase and in the last two years a 13% increase.

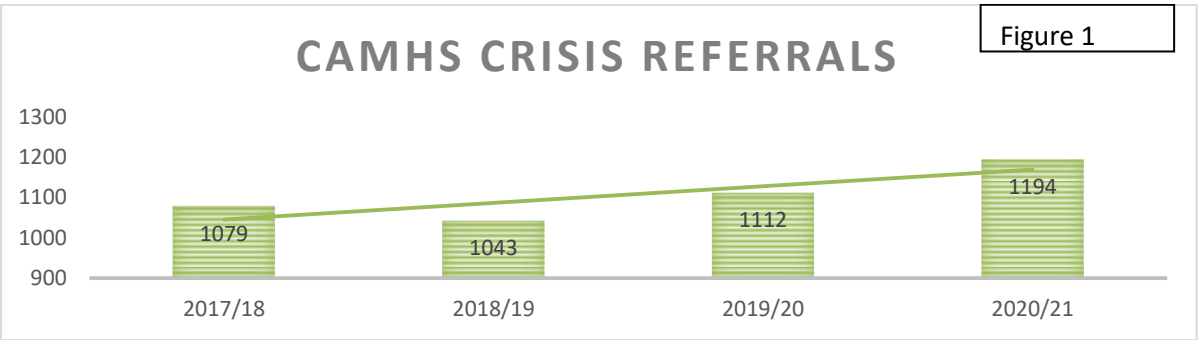
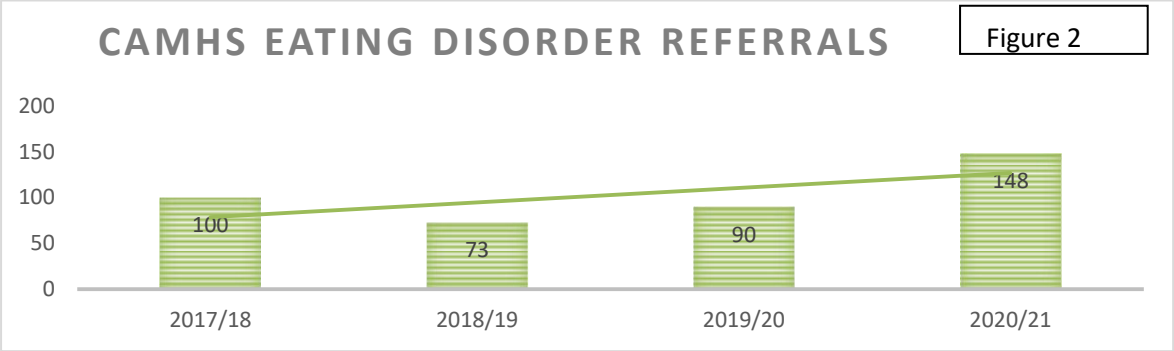


Figure 2 shows the eating disorder referrals into the CAMHS services since 2017/18. In the last year there has been a 39% increase in referrals and in the last two years a 51% increase. Presentations of eating disorder patients in this last year have been higher in acuity than normal resulting in an increase in crisis and home treatment interventions in this group of patients to avoid hospital admission.



3. Success Criteria for Lincolnshire CAMHS Crisis and Enhanced Treatment Team (CCETT)

The success criteria were agreed in advance by the provider and at the time commissioner, NHS England and NHS Improvement specialised commissioning team. They were designed to ensure that the pilot would improve experience, quality and be financially sustainable. The CCETT team successfully kept 97.7% of accepted referrals out of hospital during 2020/21.

Objective	Achieved?
Run at or below 61 occupied bed days per month on average for General Adolescent Units	☺
Have no increase in serious incidents	☺
To receive positive feedback from service users using the experience of service questionnaire and session rating scale	☺

4. Running a Community-based Service in Comparison to a General Adolescent Unit

Performance and Activity

Table 1	2018/19	2019/20	2020/21
Total Admissions General Adolescent Units	46	26	13

Table 2	2018/19	2019/20	2020/21
Mean Monthly Occupied Bed Days General Adolescent Units	168	146	61

The service has managed to avoid admission for 97% of children and young people who have been provided with home treatment in 2020/21.

Figure 3 shows the number of admissions each month into a general adolescent unit bed. This graph shows both Ash Villa Admissions and out of area admissions. Prior to Ash Villa's closure we averaged three general adolescent unit admissions a month. Since the enhanced community team (CCETT) commenced in November 2019, this has reduced to an average of 0.9 admissions a month from 3.4 a month which is a 74% reduction.

Figure 3

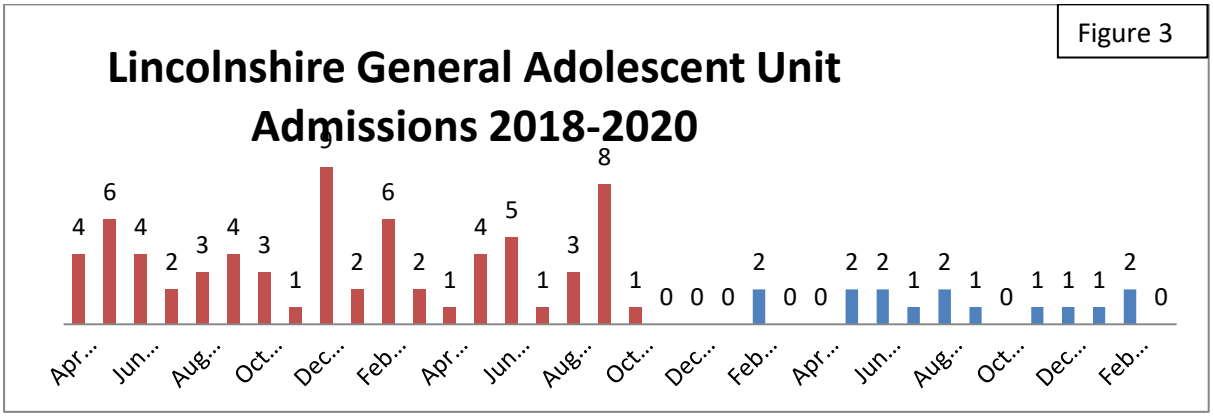


Figure 4 demonstrates that general adolescent unit occupied bed days have reduced by 53% from the 19 months prior to the closure of Ash Villa to the 17 months since the CCETT team has been in operation. In the 2020/21 financial year the service is just over its target of general adolescent unit occupied bed days a month, with 61 occupied bed days on average each month. It is clear from the trend line that general adolescent unit occupied bed days have reduced significantly over the last couple of years.

Figure 4

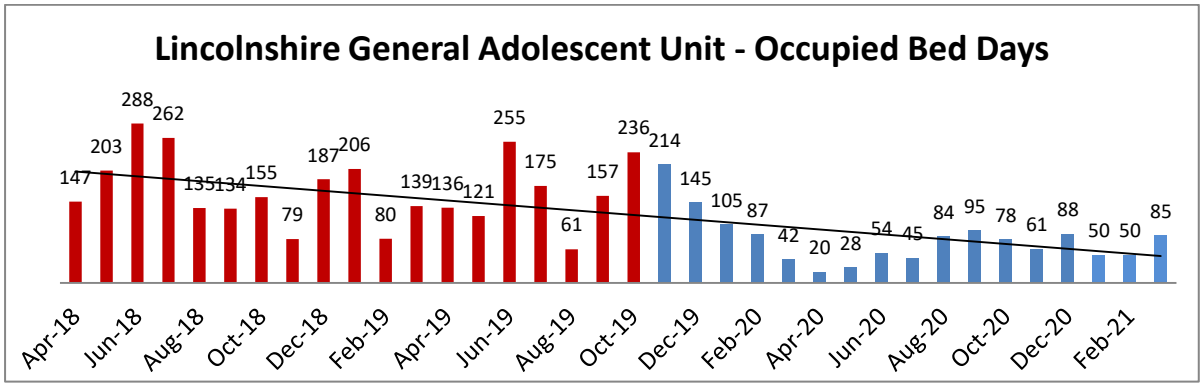


Figure 5 demonstrates that there has been a steady decline in the mean length of stay in GAU beds since Ash Villa closed. There were concerns that not having an inpatient unit may increase the median length of stay for young people as we would have less control in managing discharge. However, the teamwork with inpatient providers, children and young people and families to plan for discharge from the point of admission. The team have been successful at promoting the repatriation pathway and inpatient hospitals have felt confident in the intensive care packages that the team are able to offer. This in turn enables the hospital to discharge quickly and safely.

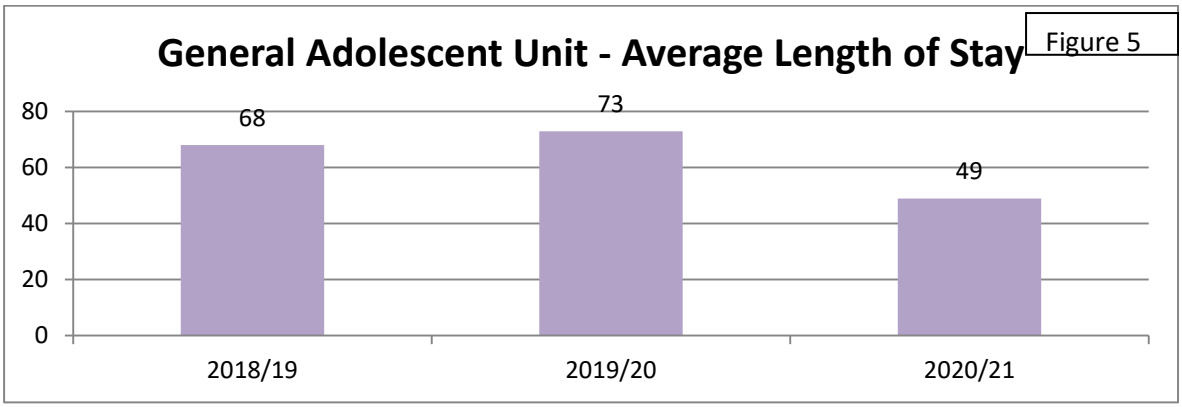


Figure 5

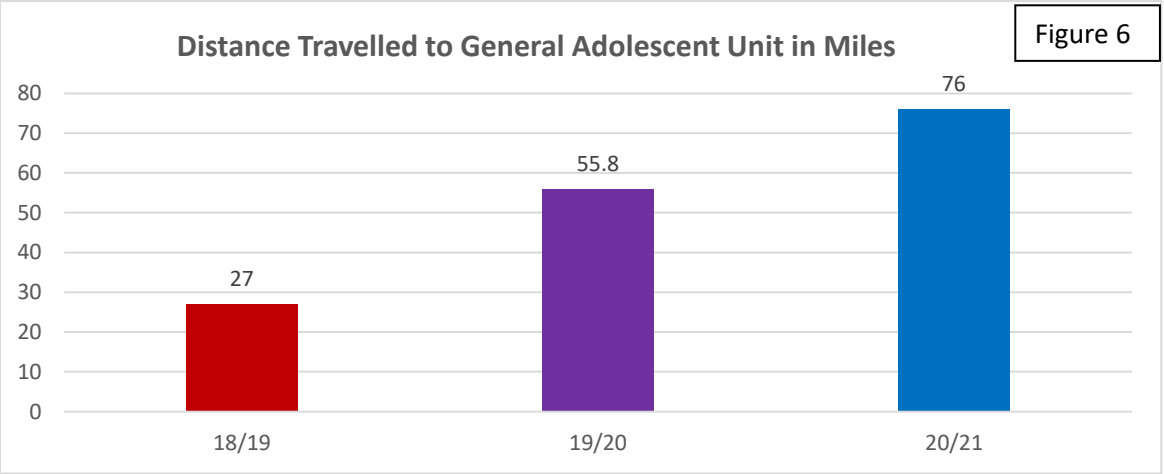
Data from figure 5 can also be compared to the national average length of stay for general adolescent units, which shows LPFT being very much comparable for both 2018/19 and 2019/20, whilst Ash Villa was open. However, a significant positive variance of 49 days for LPFT vs a national average of 71 days in 2020/21 shows the direct impact of CCETT which benefits the children and young people of Lincolnshire in not staying in inpatient care.

5. Equalities

Figure 6 shows the distance travelled in the period before Ash Villa closed was on average 55.8 miles. This was because most young people from Lincolnshire could be admitted to Ash Villa unless it was full and were allocated a bed out of area. This figure is, however, negatively distorted by six admissions, who lived fewer than three miles away from the unit, arguably showing an overuse of the service because it was locally convenient. Since the closure of Ash Villa, the distance children and young people have had to travel averages at 76 miles, which is an increase of 64% between 2018/19 and 20/21. Most young people are able to access beds in the East Midlands area. The significant point to note is that whilst this increase is not insignificant, from 2018/19 to 2020/21 the overall benefit to the population

of Lincolnshire by being able to avoid admissions by 71% and length of stay by 30%. This means that more people are benefiting from the closure of the service than are negatively impacted by increased travel.

Figure 6



There have been 0 admissions for children and young people diagnosed with learning disabilities and or autism since the start of the pilot, showing a success in line with the national Transforming Care programme, of which Lincolnshire was the top performing area in the country in 2019/20. Approximately 13% of referrals into the CCETT team in the last year have been for young people with a learning disability or autism or both. Figure 7 shows the monthly breakdown of referrals in 20/21 into CCETT.

Figure 7

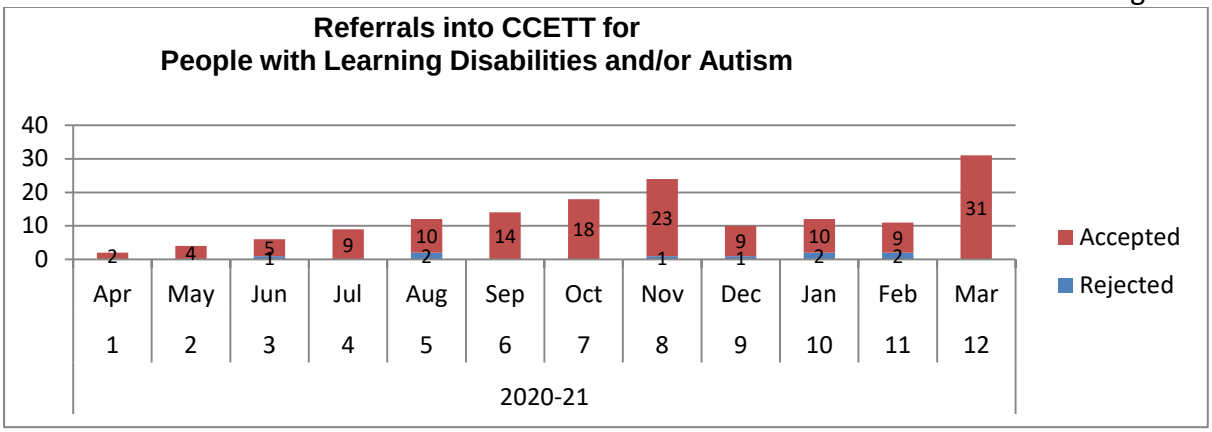
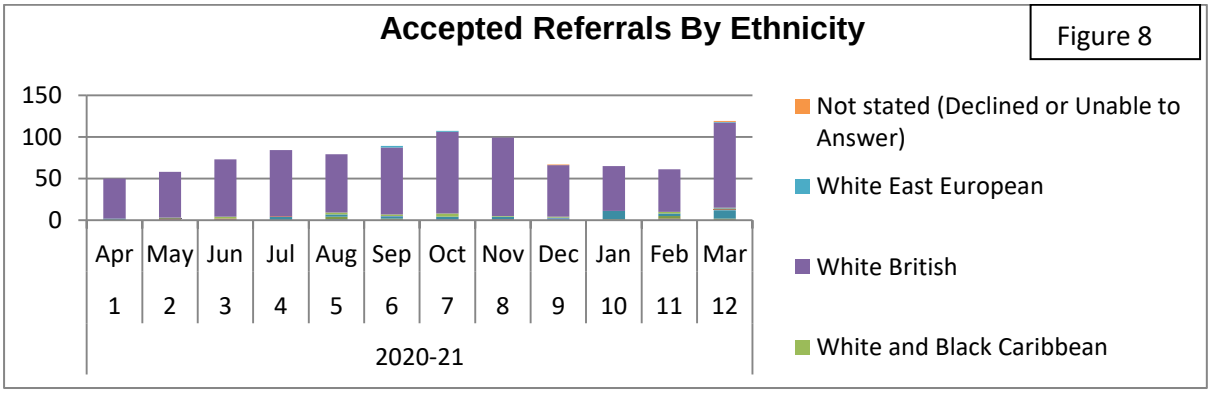


Figure 8, shows the ethnicity make up of referrals into the CCETT this is in line with Lincolnshire demographics.



6. Quality

Figure 9 represents serious incidents, usually categorised by unexpected or avoidable significant harm or death, have stayed at 0 during the whole of 20/21. This metric will be continuously monitored as the service would not be considered effective if there was an increase in serious incidents and the root causes analysis established that the closure of Ash Villa, or providing intensive support in the community were a factor in why incidents were occurring.

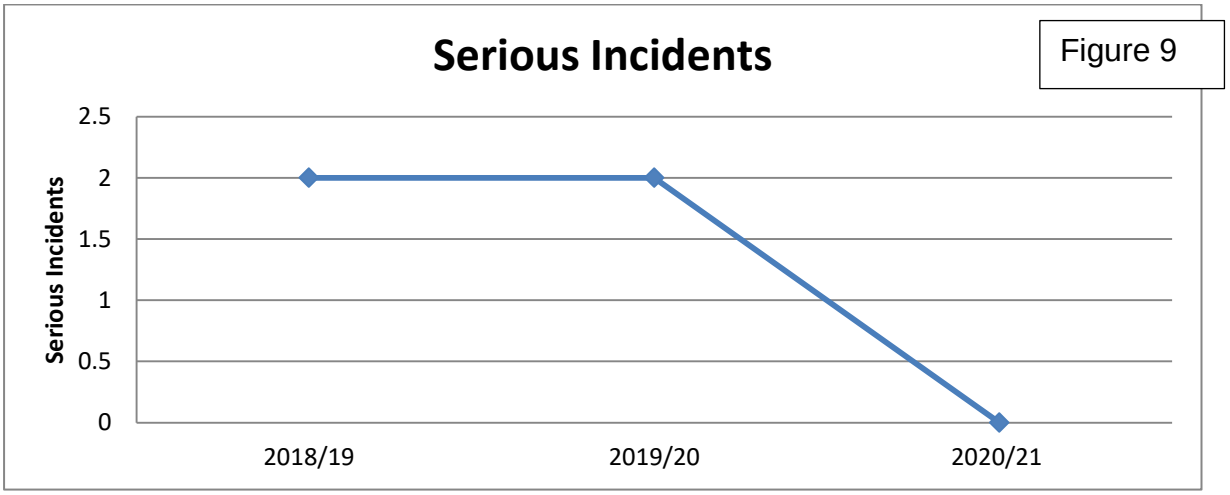
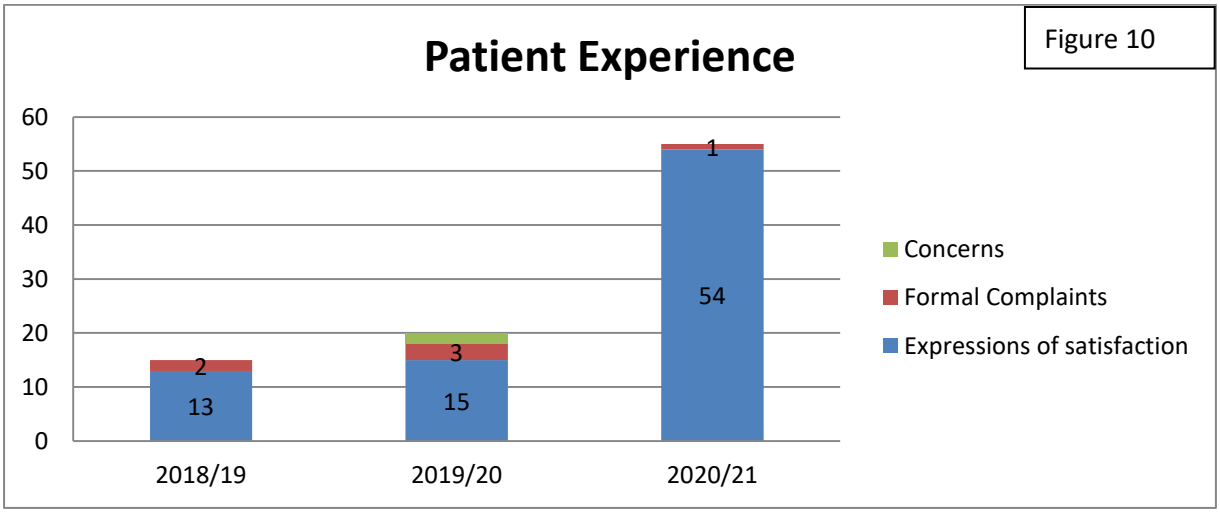


Figure 10 shows the new service has seen a reduction in complaints and concerns. The formal complaints across all 3 years relate to Ash Villa, with no complaints relating to the new service. Positive feedback has increased significantly as the service has developed and comes in greater volume than Ash Villa saw.



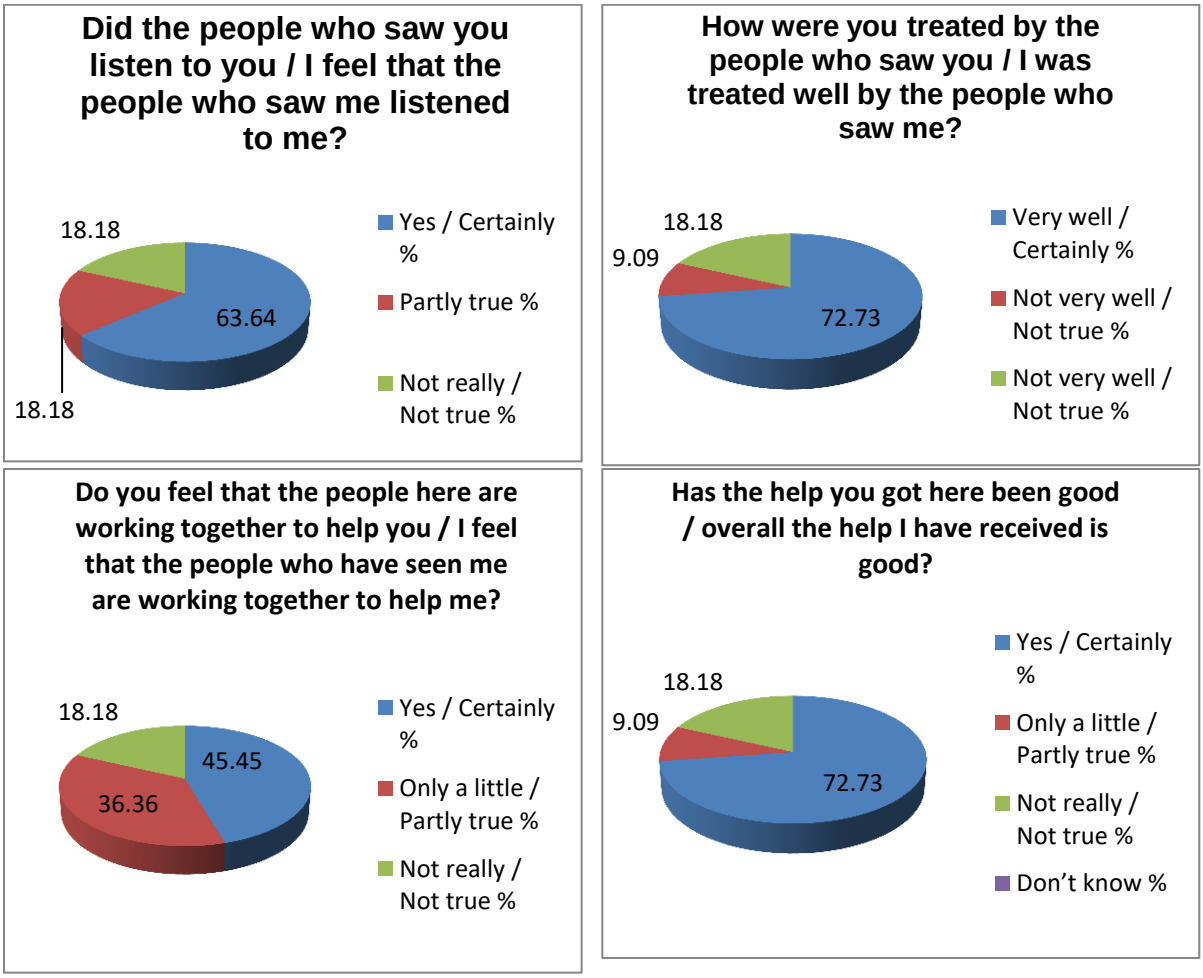
The following includes comments relating to LPFT services and has been unaltered from a consultation run by NHS England/Improvement in 2021 re the change of service from an inpatient to community service.

Questions	Comments
Community service – did you find the service helpful?	• Yes helpful (patient) • Patient experienced Ash Villa and community pilot – positive about both but extremely positive about the community option/not having to go anywhere (patient) • Flexible and responsive (professional) • Immediate response when needed (professional) • Sometimes helpful sometimes not. Not helpful that have to ring rather than text after 5pm but feels they were helped a lot (patient) • The team have been brilliant (carer)
Inpatient service – did you find the service helpful?	• Didn't find treatment helpful apart from art and activities (patient)
Anything that could have been better?	• More support for eating disorder/support around meals in particular (patient with reference to the community model) • Not having constant rotation of staff (patient re: community model) • Operating after 7pm as young people can struggle in the night (professional re: community service) • Improved transition to adult services (patient re: community services) • Earlier intervention (carer)

Questions	Comments
Preference for model – inpatient or community	• Strong preference for the community model (patient) • Prefer community but dependent on needs (patient) • Strong preference for the community model (professional) • No preference but thinks the distance to travel to an inpatient unit is too far (professional) • Depends on the patient (carer)

Feedback and pie charts from the experience of service questionnaire feedback forms. This shows more detail as to some of the feedback from service users and external professionals.

Stakeholder	Comments
Young Person	"They explained everything really well and it was very helpful" "the people were lovely and caring" "the staff listened to me and it felt like they actually wanted to help" "the people I worked with are nice and easy to get along with. One of the most helpful things was the reassurance I was given when I didn't know what to say and I wasn't forced to answer questions"
Parent/Carer	"G**** was absolutely amazing with him" "I would have liked a little more interaction so that I knew what was being discussed whist recognising the need for confidentiality. Not all teenagers will discuss what the sessions cover."
Professional	"I just wanted to say how amazing the work you're doing keeping children and young people out of hospital is. Thank you and keep it up."



7. Case Studies

Case Study 1

Following the national enforced lockdown in April 2020, the young person who is central to this case study (and will be referred to as 'Ben') presented with a significant increase in anxiety levels, negative perception of self and subsequent restricted eating which resulted in a significant weight loss and physical impairment which required admission to acute paediatrics in late April.

The initial assessment and subsequent intervention was provided by the CCETTs team at this time for the duration of circa twenty weeks. Intensive CCETT intervention initially entailed attending the paediatric ward twice daily in order to support the paediatric nursing team and promote re-feeding. This episode of care entailed formally assuming the Care Co-ordinator role under the Care Programme Approach and the convening of multiple professionals meetings, requesting indicated CCG Care, Education and Treatment Review assessment and attempting to work towards Ben and his family's wish to achieve discharge home to work further with the service in the community.

Ben and his family's goal to return home was initially met after achieving pre-identified physical health and weight gain parameters after a six-week paediatric admission. Daily CCETTs input continued both during the inpatient admission and following discharge home and included occupational therapy, cognitive behavioural therapy and additionally accessed dietetic input. However, Ben's relationship with food would not significantly alter and they subsequently required two further paediatric hospital admissions for further weight restoration purposes. Throughout the CCETTs team worked intensively and collaboratively with Ben's parents, the medical team, social care and the CCG in an attempt to collaboratively promote engagement in treatment and prevent the necessity for admission to a specialist eating disorder unit.

Collaborative care planning required on-going daily CCETTs intervention (both whilst on the ward and at home) and entailed the development and subsequent amendment of multiple bespoke plans of care to support Ben's re-feeding and psychological well-being. The later versions of which requiring the deployment of a team of suitably trained individuals within the team to provide least restrictive physical interventions to support three meals a day whilst remaining on the paediatric ward whilst under the parameters of the Mental Health Act, Section 2.

On initial receipt of the referral, it was being explicitly requested that Ben be transferred from the paediatric environment to a specialist mental health eating disorder environment. However, after working collaboratively with the ward, Ben and his family, it became evident that the young person and their family's goal-based outcome was to avoid mental health inpatient admission, achieve weight restoration and be able to return home where they may subsequently access and engage with specialist eating disorder service community provision locally. This outcome was subsequently achieved after 20 weeks of intensive CCETTs input (both within the home and hospital setting), which subsequently avoided the need for specialist eating disorder unit admission. However this was not initially supported by the Care, Education and Treatment Review process and achieved Ben's goal-based outcome to return to the consistency and familiarity of their home environment whilst accessing indicated on-going health and social care provisions.

The episode of care is demonstrative that an enhanced level of crisis support and intervention (thrice daily input at some stages) can support in achieving mental health stability and respond to the risks associated to an episode of mental crisis without the requirement of mental health hospitalisation.

The episode of care required an immediate identification of an acting Care Co-ordinator (CCETTs Clinical Lead) who subsequently quickly identified the necessity for multi-disciplinary mental health team involvement and subsequently assembled the team, which consisted of the consultant psychiatrist, two clinical leads, an occupational therapist and multiple CCETTs practitioners based both within the North and South of the county.

The Clinical Lead subsequently organised and facilitated weekly meetings with the Paediatric Team, organised staffing to attend and support within the paediatric environment and continued to work therapeutically with both the Ben and the family. Additionally within the acting Care Co-ordinator role multiple further liaisons were had with social care, the CCG, Mental Health Act legal teams, the Trust's Prevention and Management of Violence and Aggression team and secondary CAMHS services (Eating Disorder and Core Services) in order to identify to promote safe practice and the achievement of positive recovery outcomes for Ben.

The episode of care is demonstrative that an enhanced level of crisis support and intervention can support in achieving mental health stability and respond to the risks associated to an episode of mental crisis, without the requirement of mental health hospitalisation. Imperative to this was the responsive acceptance of an acting Care Co-ordination role and the actioning of indicated clinical responses/actions. Furthermore, the Multi-disciplinary make-up and involvement within the CCETTs team (psychiatry and occupational therapy) aided the achievement of the positive patient outcome.

Ben and family regularly expressed difficulties engaging with multiple clinicians from the team and different agencies at this time. Therefore, best attempts were made to limit the involvement of multiple clinicians and provide supportive intervention responsive to the wishes of the family (particularly within the home setting).

Lessons learnt being the timely arrangement of a CETR (by the CCG) and then outcomes of said formal reviews not accurately capturing the discussions and information presented in the meetings. Furthermore, the clinical case highlighting some disparities between clinical and safeguarding needs and demonstrated a need for improved multi-agency working practices, communication and subsequent actions (Health, social care and CCG's).

From a CCETTs perspective the episode of care highlighted the need for an increased number of clinicians to be trained in prevention and management of violence and aggression within both the CCETTs and the wider community CAMHS teams, should individuals further require physical intervention/assistance for re-feeding purposes (under either the safeguards of the Mental Health Act or parental consent). Furthermore, it identified the need for on-going specialist community teams to be more responsive and efficient in commencing their assessment process in order to assist a timelier move towards recovery after the initial severity of crisis has subsided.

Case Study 2

This involved a young person (who shall be referred to as Sarah) with a long history (three years plus) of accessing Community CAMHS for therapeutic intervention in relation to difficulties of a complex multi-trauma nature, presented with an increase in significant self-injurious behaviours (incidents of self-induced poisoning and lacerating limbs) resulting in six A&E attendances within a seven day period.

Subsequent inpatient admission was discussed and sought by the Community Consultant Psychiatrist for risk management purposes. There was limited opportunity to provide enhanced home treatment model of care aimed at maintaining safety and preventing admission, as inpatient admission had been promoted as a treatment option to the patient and family prior to referral to CCETTS.

A subsequent brief 4 inpatient admission ensued for risk management purposes. During the admission the CCETT's Clinical Lead provided regular in reach and communication to the ward as per the Repatriation Pathway and associated agreed timescales. The Clinical Lead subsequently assumed the role of Acting Care Co-ordinator, which promoted and subsequently appropriately planned for a safe and supportive discharge eleven days following admission in order to allow the provision of a collaboratively agreed episode of indicated home treatment as per a trauma pathway.

Early discharge supported and facilitated from the inpatient environment after a period of 11 days duration. Following discharge from the inpatient environment and implementation of the Repatriation Pathway and subsequent trauma pathway interventions, Sarah, has maintained their safety and not engaged in any further significant risk behaviours of concern.

The episode of care required an immediate identification of an acting Care Co-ordinator (CCETT's Clinical Lead) who subsequently quickly identified the necessity for collaborative working with both the patient, their family, the inpatient unit and the Community CAMHS teams within Lincolnshire.

The Clinical Lead subsequently organised and facilitated daily communications with the inpatient team in order to identify and to share previous clinical knowledge and safely plan for a timely supported discharge with on-going indicated crisis care, whilst also making subsequent CPA planning arrangements for post-discharge.

Sarah could possibly have been internally referred to CCETTS approximately two weeks earlier when initially voicing and presenting with risk ideation/intent of concern. It was apparent that referring to CCETTS (enhanced home treatment team) following previously promoting inpatient admission as a treatment option, that likelihood for successful home treatment which would reduce the need for inpatient admission was significantly impaired.

Therefore, considered that this case has highlighted the need for timely referrals to CCETTS and that potential inpatient admission may be best discussed and explored with patients and their families by the team who access assesses for inpatient admission (CCETTS).

The patient has reported that they would not wish to access a further inpatient admission and thus states a desire and consideration that they can maintain their safety in order to avoid such. Furthermore, said experience has resulted in greater co-ordination of said patients community mental health care and the safety/containment to engage in the indicated and required trauma pathway intervention, which is reflected by a significant reduction in the severity (and reported intent) of self-injurious behaviours.

8. Staff Experience

Feedback from clinical staff working within the CCETT team has indicated that they believe a community approach is more beneficial than an inpatient one, with the main theme being it gives greater opportunity to maximise independence and allow people to live their life in a way meaningful for them away from institutional settings, in line with the core principles of a recovery philosophy. They value having a multidisciplinary model that increases the access to specific therapies and treatments and being able to do this in a residential environment amongst family and still having access to their school and community adds value.

It is also a belief of team members that relationships with families and professionals are more consistent and supportive for families, who develop relationships with core staff members. This allows our staff to help and guide them through the challenges they are experiencing, rather than handing over the care of their child to a hospital setting, sometimes a long way from home. Staff are all aware that although sometimes admission is a necessary and where this will add to a person's quality of life is considered as part of a discussion around treatment options with children and young people and families.

Similarly when young people have been admitted, staff are of the belief that this model can give enhanced support on discharge in their transition home and this is able to be done in a more timely way due to the CCETT teams presence at ward rounds and Care Programme Approach reviews as they are able to be fully involved in discharge planning. Therefore, young people and families are less likely to feel abandoned by the local services, as their contact is consistent throughout the admission.

Staff are conscious that parents and carers may find treatment at home more challenging than hospital admission, as it can have a large impact on other areas of their lives, such as employment, family relationships and from a social perspective and always consider this with the families when discussing treatment options and supporting families in balancing the risks.

9. Finance

	2018/19	2019/20	2020/21
General Adolescent Unit Activity Costs (mean monthly total)	£92,354	£80,162	£33,825

Whilst the primary purpose of this pilot was a quality initiative to establish whether it was possible to provide an alternative to hospital in the community, it must be affordable. Fortunately, the cost of running the service, even with the requirement to fund a relatively low amount of general adolescent unit inpatient activity, makes it cost saving.

10. Assessment

The service has met the success criteria defined with NHSE/I prior to the implementation of the model. It is keeping the vast majority of children and young people in their usual place of residence in affordable way, and improving patient experience.

Added Value for non General Adolescent Unit Beds

Table 1 - Total Admissions	2018/19	2019/20	2020/21
Specialist Eating Disorder Units	7	14	5
Learning Disabilities Units	2	1	0
Low Secure Units	3	1	2
Psychiatric Intensive Care Units	2	2	2

Table 2 – Mean Monthly Occupied Bed Days	2018/19	2019/20	2020/21
Specialist Eating Disorder Units	56	130	80
Learning Disabilities Units	40	40	0
Low Secure Units	22	27	28
Psychiatric Intensive Care Units	44	27	54

Figure 11 shows that the number of specialist eating disorder admissions (SEDU) have also reduced. There were seven admissions in 18/19, 14 admissions in 19/20 and 20/21 there were five admissions. Eating disorder admissions from Lincolnshire had doubled between 2018/19 and 19/20 and eating disorder admissions across the country have continued to increase with bed placements becoming increasingly difficult to secure. It has been a great success therefore that in quarters 1 and 2 of 2020/21 there were no eating disorder admissions; and in quarters 3 and 4, there was a marked increase in the number of complex eating disorder presentations both locally and nationally. These often did not become known to services until they were in a very poor physical condition requiring immediate hospitalisation. The team has been working closely with the local general hospital to support patients to provide the appropriate care needs. This success in reducing eating disorder admissions has not been at the expense of increased admissions into general adolescent unit beds.

It is worth noting that psychiatric intensive care unit admissions have remained very similar between 2019/20 and 2020/21, with no learning disabilities general adolescent unit admissions and two low secure unit admissions since the CCETT service became operational.

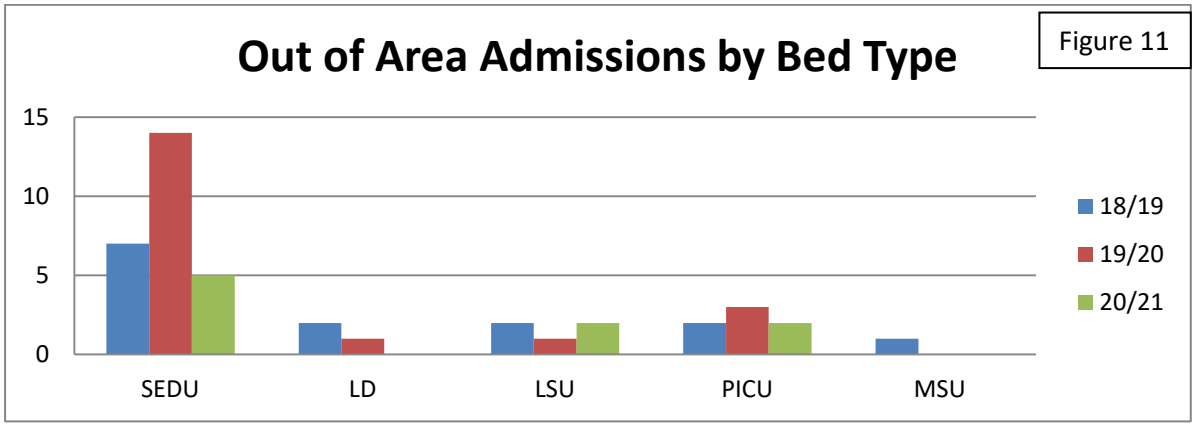


Figure 12 shows the total monthly admissions of young people into all bed types. In the 15 months prior to the introduction of the CCETT team there averaged 5 admissions per month. In the 14 months since the CCETT team commenced this has reduced to an average of 1.7 admissions of any bed type a month which is an 64% reduction in all admissions since the CCETT team commenced.

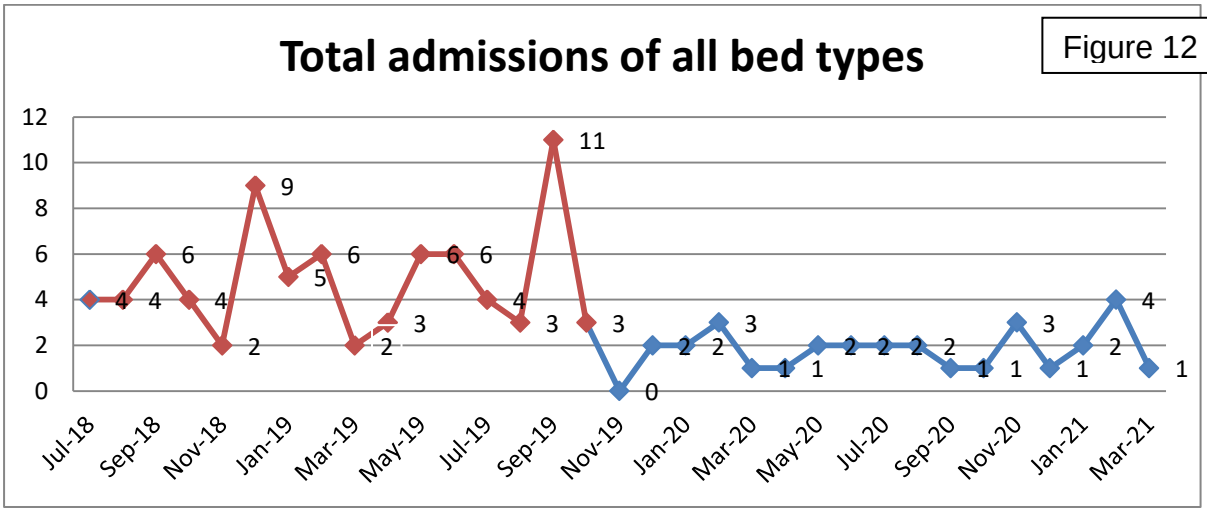
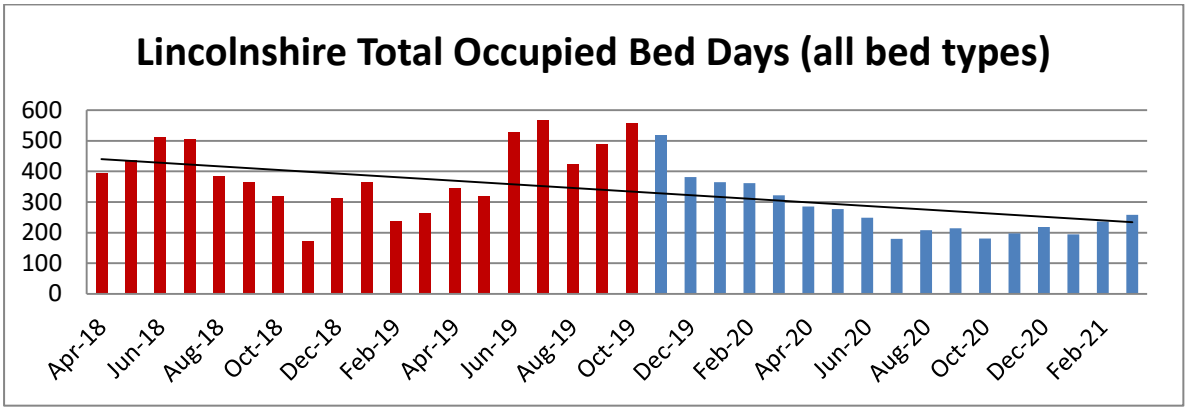
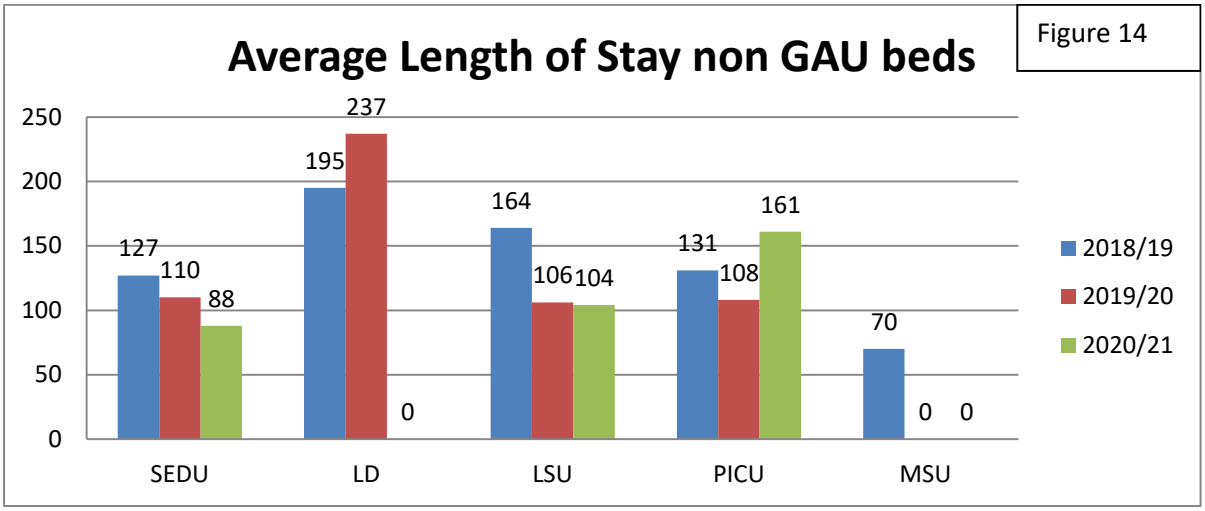


Figure 13 examines occupied bed days for all bed types. All occupied bed days have reduced significantly since the closure of Ash Villa with a 30.5% reduction when comparing the 19 months prior to closure (red line on graph) to the 17 months since closure (blue line on graph). Specialist eating disorder occupied bed days have also reduced due to the reduction in admissions. Psychiatric intensive care unit occupied bed days have increased slightly due to two long term patients with social needs that have been difficult to discharge.



With the increase in acuity now admitted to PICU due to the ability to keep most children and young people out of hospital that would have previously been admitted, Figure 14 is showing an increase in PICU length of stay by 23% between 2018/19 and 2020/21. However, over the same time period:

- Specialist Eating Disorder Units have seen a 30% reduction in length of stay
- Learning Disabilities units admissions have been reduced by 100% as has length of stay
- Low Secure Units have seen a 37% reduction in length of stay
- Medium Secure Unit admissions have been reduced by 100% as has length of stay



11. Conclusion

There is additional value above that was expected of the pilot due to the impact in reduction of bed use on GAU beds. This should be considered as part of the collaboratives over all commissioning strategy across the East Midlands, not just in relation to the establishment of community alternative to inpatient services but in the modelling of the total bed stock required.

Areas for Development

1. Workforce - enhancing the multi-disciplinary team through psychology and speech and language therapy and continuing to train all new starters in evidence-based home treatment approaches
2. Maintenance of the positive relationship with acute paediatric colleagues, whilst developing relationships with Emergency Department and Medical Admission Unit colleagues in relation to 16/17-year olds as the pathways are not currently similar and this puts a strain on staff from all organisations. This will include cross divisional work within LPFT with our acute hospital mental health liaison service and adult inpatient services, as well as the necessity to consider a system wide approach to supporting children and young people that require restraint to support with nutrition.
3. Review of the requirements for staffed 24/7 service rather than on call
4. Embedding CCETT staff within a children and young people specific single point of access for Lincolnshire as and when this is established
5. Ensuring access is equal through coproduction with populations of specific cohorts of children and young people, for example, autistic people, the eastern European community, children and young people with learning disabilities, and BAME children and young people and families
6. Developing a robust approach with Approved Mental Health Practitioners, on call CAMHS consultants and Section 12 approved doctors so that no child can be detained under the mental health act without CCETT involvement in the decision to treat at home. Without this application of the mental health act can be used without the full knowledge of therapeutic provision available, and the intensive nature of the service that can be provided in the community.

7. Constantly monitoring and reviewing the impact of the pandemic on demand for children and young people's services to ensure that we respond to the increase in the number of people needing a service. This requires close working with all of our partners in the wider system of health and care, including our primary care and social care colleagues.

12. Appendices

These are listed below and attached at the back of the report	
Appendix A	Lincolnshire Community Engagement Pilot

13. Background Papers

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

This report was written by Jane Marshall, Director of Jane Marshall, Director of Strategy, People and Partnerships, Lincolnshire Partnership NHS Foundation Trust, who can be contacted via Jane.Marshall3@nhs.net

APPENDIX A

Lincolnshire Community Pilot Engagement

The Health Scrutiny Committee for Lincolnshire considered a previous report on 22 July 2020 on the impact of the new model of care in place for Lincolnshire. The Health Scrutiny Committee asked that targeted engagement with the Lincolnshire public commence to consider whether to make the new model of care a permanent change. An update report was presented to the Health Scrutiny Committee in February 2021 which resulted in a request for a further report on completion of the engagement exercise which was ongoing at that time.

Engagement was carried out from 18 January 2021. An initial four-week period was allowed for responses, and the time was extended to encourage more responses. The survey sought to gather feedback from patients who might have experienced care in an inpatient setting or from the new community model and their parents/carers. The questionnaire was circulated to former patients, staff, charities that care for children and young people locally as well as patient groups. It was also circulated to other healthcare organisations.

Details of those providing feedback are detailed below with a summary of their responses.

Summary of Responses

There were nine individual responses in total.

Q1 Are you (please tick, more than one option can be selected if necessary):

Option	Total	Percent
Someone who has received care as an inpatient within a child and adolescent in-patient unit?	3	33.33%
A carer of someone who has received care as an inpatient within a child and adolescent in-patient unit?	1	11.11%
A professional who cares for people admitted to in-patient child and adolescent inpatient units?	0	0.00%
Someone who has received care from the new community model?	3	33.33%
A carer of someone who has received care from the new community model?	1	11.11%
A professional who has cared for someone in receipt of the new community model?	3	33.33%
Not Answered	0	0.00%

Overall summary of responses to other questions

Questions	Comments
Community service – did you find the service helpful?	• Yes helpful (patient) • Patient experienced AV and community pilot – positive about both but extremely positive about the community option/not having to go anywhere (patient) • flexible and responsive (professional) • Immediate response when needed (professional) • Helpful input from inpatient unit in Nottingham (carer) • Sometimes helpful sometimes not. Not helpful that have to ring rather than text after 5pm but feels they were helped a lot (patient) • The team have been brilliant (carer)
Inpatient service – did you find the service helpful?	• Didn't find treatment helpful apart from art and activities (patient) • Comment that was helpful although it was Hopewood rather than AV. Not needed to use pilot (carer)
Anything that could have been better?	• More support for ED/support around meals in particular (patient with reference to the community model) • Not having constant rotation of staff (patient re: community model) • A list of things in relation to the inpatient unit relating to need for more awareness of disability/LGBTQ issues, discharge planning and communication, use of restraint (patient) • Operating after 7pm as young people can struggle in the night (professional re: community service) • Comments about the need to be admitted a long way from home which restricted attendance at meetings (these were however secure units rather than GAU although also used AV briefly) (carer re: inpatient access) • Improved transition to adult services (patient re: community services) • Earlier intervention (carer)
Preference for model – inpatient or community	• Strong preference for the community model (patient) • Prefer community but dependent on needs (patient) • Community definitely (professional) • No preference but thinks the distance to travel to an inpatient unit is too far (professional). • Depends on the patient (carer) • No preference (patient) • No preference (carer)

Questions	Comments
Top 5 things	• Accessibility and responsiveness (patient) • Diagnosis. Getting help in time. (patient) • Staff awareness of different needs. Communication between teams (patient) • Empathy, time, skills, accessibility (timeliness), consistency (professional) • Being seen quickly, being admitted within an hour of home, experienced staff, flexibility of treatment, being able to attend MDTs each week (carer) • Caring, supportive, listening, understanding and flexibility of approach (patient) • Early intervention (carer)
Experience of inpatient unit	• Not positive – frequent admissions for issues that are not MH related which removes responsibility from the people around the child (professional) • Very dedicated and skilled staff (professional)
Experience of community offer	• Much better than the previous offer – really important to keep CYP in their community. Admission can make problems worse (professional) • Teams have been merged poorly creating a lack of consistency and support. Due to Covid difficult to shadow and learn the role. Staff trying their best in difficult circumstances (professional)
Preferred Model	• Community Model (professional) • Inpatient model (professional)
Further comments	• Keep the current model. Don't go back to inpatient care as the default. And more areas should be doing this based on the evidence and outcomes of the pilot (professional)

Questionnaire Questions

Q1 Are you (please tick, more than one option can be selected if necessary):

- Someone who has received care as an inpatient within a child and adolescent in-patient unit?
- A carer of someone who has received care as an inpatient within a child and adolescent in-patient unit?
- A professional who cares for people admitted to in-patient child and adolescent inpatient units?
- Someone who has received care from the new community model?
- A carer of someone who has received care from the new community model?
- A professional who has cared for someone in receipt of the newcommunity model?

If you have used services or are the carer of someone who has used services, please answer questions 2 – 5

Q2 Did you find the treatment helpful? If so, what was good about it?

Q3 Was there anything you think could have been better? If so, what do you think could have been better?

Q4 Do you have a preference for a community or in-patient model of treatment?

Q5 What are the top 5 things that are important to you in relation to your experience of children and adolescent mental health services?

If you are a professional or organisation involved in delivering services or representing the views of young people, please answer questions 6-9

Q6 What is your experience of the inpatient model of care in Lincolnshire?

Q7 What is your experience of the community model of care in Lincolnshire?

Q8 Do you have a preference for either model? If so, can you explain the reasons for your preference?

Q9 Do you have any further comments on the model of care in Lincolnshire?

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

Open Report on behalf of Lincolnshire Partnership NHS Foundation Trust

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**21 July 2021**
Subject:	**Older Adult Mental Health Services – Home Treatment Team**

Summary:

The Older Adult Services Home Treatment Team was established in October 2018 as a county-wide pilot providing a community facing service to older adult patients with functional mental illness, who would otherwise have been admitted to Brant Ward, Lincoln, which at that time was being refurbished. Subsequently, when Brant Ward was re-opened, the Home Treatment Team continued, with the service funded by the temporary closure of Rochford Ward at Pilgrim Hospital, which was not fit for purpose and would require capital investment for improvement.

This report provides the Committee with information on the Home Treatment Team, as well as engagement and consultation responses on the permanent closure of Rochford Ward.

Actions Requested:

To consider the information presented on the Older Adult Services Home treatment Team and the engagement and consultation responses on the proposed closure of Rochford Ward at Pilgrim Hospital, Boston.

1. Background

Older Adult Services – Functional Mental Health

Typically the term Older Adult Services refers to those services provided to patients over 65 years of age. Traditionally, these services have been divided into functional mental health (for example, depression and anxiety) and organic mental health services (for example, dementia). Prior to October 2018, there were two inpatient wards for functional mental health provided by Lincolnshire Partnership NHS Foundation Trust (LPFT). These wards were Brant Ward, Witham Court, Lincoln, and Rochford Ward, Pilgrim Hospital.

Refurbishment of Brant Ward, Witham Court, Lincoln

In October 2018 a project began to upgrade Brant Ward at Witham Court in Lincoln, to create single en-suite bedrooms and improve the ward living spaces. Witham Court is the main centre for older adult mental health in Lincolnshire and has a firm place within the Trust's future strategy. The work on Brant Ward was considered to be a good investment in order to meet Care Quality Commission standards and to future-proof this valuable service.

The Home Treatment Team was established in October 2018 as a county-wide pilot providing a community facing service to older adult patients with functional mental illness, who would otherwise have been admitted to Brant Ward. Brant Ward was re-opened in February 2020, providing 18 single en-suite bedrooms in a modern, accessible and therapeutic space.

Rochford Ward, Pilgrim Hospital

In February 2020, when Brant Ward was re-opened, the Home Treatment Team continued, with the service funded by the temporary closure of Rochford Ward at Pilgrim Hospital. The reason for this was that Rochford Ward was not fit for purpose, it was on the first floor, which restricted patients access to fresh air. Rochford Ward also had beds in dormitories, which was not conducive to mental health recovery and did not meet the Care Quality Commission standards for care environments, for example it was difficult to protect the privacy and dignity of patients in this setting. Re-provision of Rochford Ward would have required require capital investment and a move to a ward on the ground floor.

The closure of Rochford Ward meant that patients who needed an inpatient bed would need to travel to Lincoln, instead of travelling to Boston. However, the Home treatment Team would continue to work to reduce hospital admissions.

Previous Committee Consideration

All the above developments were reported to this Committee, with details available at the links listed:

- 17 April 2019
  https://lincolnshire.moderngov.co.uk/ieListDocuments.aspx?CId=137&MId=5365&Ver=4

- 22 January 2020
  https://lincolnshire.moderngov.co.uk/ieListDocuments.aspx?CId=137&MId=5530&Ver=4

- 22 July 2020
  https://lincolnshire.moderngov.co.uk/ieListDocuments.aspx?CId=137&MId=5536&Ver=4

2. Home Treatment Team Service and Consultation

Over the last three years Lincolnshire Partnership NHS Foundation Trust (LPFT) has carried out several engagement events working with patients, staff, governors, public, partner organisations and clinicians to consider and develop its Older People and Frailty Mental Health Services. This has included activities ranging from the co-production of a Carers Pathway for Older People; and their families using our services to the setting up of an Older People Advisory Group to work with staff and help shape services.

Events have taken place at a variety of locations across Lincolnshire and more lately online due to Covid-19 restrictions. (For a full list of engagement events see Appendix A)

People told us:

- They need to have services that work after 5.00pm and weekends.
- They prefer to be treated in their own home.
- They wanted us to involve carers and family in pathways of care.
- They wanted to avoid out of area admissions.
- They wanted us to get on with doing it!

What did we consult on?

We specifically asked for views on the plans for the Home Treatment service to provide a permanent county wide service. This means that Rochford Ward at Pilgrim Hospital will no longer be required. All patients will be cared for in accordance with needs but will have the option of home treatment team support if risks can be managed within a community setting but people will still have access to an inpatient bed if required.

What is the Home Treatment Team?

The team provides an alternative to hospital for older people with complex and severe mental health needs who can be managed safely in the community setting with enhanced and intensive bespoke support; available seven days a week. It is made up of a psychiatrist, mental health nurses, occupational therapy, physiotherapist and support workers, who provide practical assistance for people in our care.

What do they do?

They work closely with the patient, their family or carer and other professionals (such as the existing Older Peoples Community Mental Health Teams (CMHTs) to provide intensive support, assessment and treatment during periods of increased need; when the care of the CMHTs alone is not enough. The Home Treatment Team works with and supplements the existing community support to provide more intensive and frequent support, to work with the patient and family in their own home and community; to draw on their strengths and skills to improve and maintain their mental health and independence.

While under their care, patients can access the team seven days a week 8.00am – 8.00pm Monday to Friday and 10.00am – 6.00pm Saturday and Sunday.

The care they provide is short term, intensive and flexible to meet individual needs. The length of time will be agreed with the patient, their family, carers and the community mental health team.

The Home Treatment Teams Aims

The team will help patients manage and resolve this stage of their illness through assessment and treatment in their home as an alternative to hospital admission. They also support people being discharged from psychiatric hospital, helping them to continue their recovery at home.

The Home Treatment Service provides:

- An alternative to hospital for older people with severe and complex mental health needs.
- Close monitoring of patient's mental health.
- Support, education and advice for patients and their family/carer.
- Help with managing medication management.
- Help with personal care if this has been impacted on by the patient's mental health.
- Assessment of activities of daily living.
- Support with effective coping strategies.
- If the patient has a care team, the Home Treatment Team will work closely with them to make sure the patient has the best possible care.
- Where someone is not currently receiving Trust services but requires longer term support, the team will refer them to the most appropriate service(s) to meet their needs.

How did the Home Treatment Team begin?

A major refurbishment of one of our older adult mental health wards in Lincoln (Brant Ward), presented the opportunity to pilot a new home treatment model during October 2018 which delivers increased community support, enabling service users to stay at home safely. This has greatly reduced the need for people to be admitted to hospital and the number of beds required; enabling the provision of the enhanced community offer over seven days and extended hours of access. The service has received positive feedback from service users, carers, our partners and clinical staff.

The Home Treatment Team has evidenced that fewer people need to be admitted to hospital and thus we need fewer inpatient beds. For those people where home treatment has not proved effective, we are able to use the best of our inpatient wards for our patients.

Why do we need to make these changes?

Like many NHS organisations up and down the country, we are working hard to transform services so that they are better for patients, deliver the right care, in the right place, first time and improve value for money.

This is a difficult balancing act, especially in a large area such as Lincolnshire where many people's homes are spread across the countryside and in small villages. The development of increased community support aligns with national, regional and county priorities to provide greater support direct to people's own homes and communities and reduce the number of people unnecessarily admitted to hospital.

Why do we want to make the Home Treatment Service permanent?

The home treatment service has clearly demonstrated that there is no longer a need for the number of in-patient beds previously provided without the extended community support offered by the home treatment team. This means that the beds previously provided by Rochford Ward are no longer required. Furthermore, Rochford Ward does not meet essential quality standards for mental health wards, because it is based on the first floor and has no access to safe outside space. The ward has dormitory style bedrooms with issues of privacy, dignity and safety for patients. This is something which has also been identified by the Care Quality Commission in various national reports and during their inspection of Trust premises.

Given these outcomes and factors, Lincolnshire Partnership NHS Foundation Trust is proposing that Rochford Ward would no longer be used and instead we would only use the recently refurbished modern, accessible and therapeutic space at Brant Ward as the main older adult mental health unit for those fewer patients who do still need to be admitted to a hospital bed. This consultation gathered public, service user, staff and stakeholder views on this proposal.

3. Supporting Information:

Admission Avoidance

Since the commencement of the Older People Home Treatment Team, of the 394 referrals to the team only 28 (7%) of these patients required progression to in-patient admission. This represents a potential 93% of patients being able to be treated in the comfort and familiar surroundings of their own home and family.

Reduction in Out of Area Patients

For the six months prior to the introduction of the Home Treatment Team (April to September 2018) nine patients had to go out of area (an average of 1.3 per month). This compares with the 19-month period following the introduction of the team when only ten patients required access to out of area beds (an average of 0.5 per month).

Before the creation of the Home Treatment Team the average days out of area for older people was 23 days, compared to an average of 14.5 days whilst the team has been operating.

Patient Experience

The patient experience of the Older People Home Treatment Team has been consistently high. Based on the nationally utilised patient experience Friends and Family Test (FFT); the recommendation rate for the team has remained above 95%, within which the recommendations have been either extremely likely or likely to recommend the service (based on 203 responses). There has also been a reduction in the amount of medications required and used and a significant reduction in the number of patient incidents and improved clinical outcomes for patients and carers accessing Older Adult Home Treatment Service.

Consultation feedback from events held online on the 14, 18 and 20 January 2021 captured in common themes.

Carers Support

- *Carers need support with signposting – often carers don't know they are a carer; support with form filling and community groups.*
- *The HTT can support carers alongside the patient - carers interaction is not often enough; carers need intervention as much as the patients.*
- *Support carers to navigate inpatient elements – what happens on the ward and why? Support for carers when visiting the ward; more information.*
- *Carers involvement in care planning and discharges and MDT's.*
- *Technology support for carers.*
- *Developments in OP services for carers including Carers Leads, Leaflets, Accreditation, Triangle of Care, Co-produced Carers Pathway.*

Advanced Care Planning & Pathways

- *Patients to have a choice of home or hospital treatment.*
- *Receiving home treatment gives continued connections with the community for both patients and carers.*
- *Person centred care.*
- *Patients treated with dignity and respect.*
- *Carers to be involved in care and discharge planning.*
- *Joined up working is key so that patients and carers don't have to keep retelling their story.*

Communication of Services

- *There needs to be some mapping to bring all the services together across the county to model what works well to support patients and carers.*
- *Work needs to be done with GP's, so they are aware of the services in the county.*
- *Carer shared they weren't aware of Admiral Nurse service or their support.*
- *Within LPFT we now have the Dementia Support Service which is a signposting service to support carers.*
- *Having access about information of who carers can contact and even have support with a call.*

Development of a Dementia Home Treatment Team

- *DHTT has commenced for a 6-month pilot.*
- *Dementia patients do not recognise the time of day so could effectively need support 24 hours of the day.*
- *For elderly patients the thought of leaving their home and loved ones is very distressing. To be able to stay at home with support and keeping their independence and control through the support of OT's and physiotherapists helping to adapt to their environments, keeping routines the same through support and taking patients to appointments.*
- *A patient with dementia feels safer at home but unfortunately some carers don't always feel safe at home.*

LPFT working with community partnerships

- *Ensuring we are working with our community links and knowing what networks are in the county and how to signpost to them, this will help us to broaden our treatment plans.*
- *Links with community partnerships have improved since the introduction of the HTT.*
- *The ability to still relate to the external world, to continue to pursue things that have meaning and interest.*
- *There needs to be some mapping to bring all the service together across the county to model what works well to support carers.*

Transport and Technology

- *Challenges for rural areas with transport.*
- *People struggle with transport and having to use technology to organise transport for appointments.*
- *Difficult for people with a visual impairment.*
- *Can inhibit people accessing services?*
- *Better connectivity between different transport options to help patients to get to a range of appointments.*

PROPOSAL: To extend the Home Treatment service to provide a county wide service. This means that Rochford Ward at Pilgrim Hospital will no longer be required. All patients who would have been admitted here will in future be cared for in their own homes.

Agreement from the majority – no objections.

Feedback positive that people would like the HTT service to continue. No comments received regarding Rochford ward.
Ideally you would find a new space to replace Rochford Ward given the number of older people increasing to replace the unit but keep the HTT going as they are delivering fabulous work. I don't think it is tenable given the increasing aging population in Lincolnshire not to replace the ward eventually and you don't want the HTT to become a "sticking plaster".

HTT amazing service – huge well done with all the work you do!!

Online Survey 10 February – 31 March feedback report
Extract from full survey response on the proposal question.

9a - 9a. Proposal: For the home treatment service to provide a permanent countywide service. This means that Rochford Ward at Pilgrim Hospital will no longer be required. All patients will be cared for in accordance with their needs but will have the option to be cared for by the home treatment team if their care can be managed within a community setting. People will still have access to an inpatient bed if required.

Strongly Agree	50.00%
Agree	42.11%
Disagree	0.00%
Strongly Disagree	2.63%
Don't Know	5.26%

9b - 9b. Please tell us why you agreed or disagreed with the proposal and if you have any other suggested proposals. Word Cloud detects common themes from the open text.

9c - 9c. Please indicate below the impact that the proposal may have on you

Positive Impact	36.11%
No Impact	30.56%
Negative Impact	5.56%
Don't Know	27.78%

9d – 9d Please tell us the reason for your answer. Word cloud detects common themes from the open text.

4. Conclusion

The Committee is required to consider the information presented on the Older Adult Services Home treatment Team and the engagement and consultation responses on the proposed closure of Rochford Ward at Pilgrim Hospital, Boston.

5. Appendices

These are listed below and attached at the back of the report	
Appendix A	Older People and Frailty Services Engagement Work Plan

6. Background Papers

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

This report was written by Jane Marshall, Director of Strategy, People and Partnerships, Lincolnshire Partnership NHS Foundation Trust, who can be contacted via Jane.Marshall3@nhs.net

APPENDIX A

Older People and Frailty Services Engagement Work Plan

Date	Delivery Method	Audience	Activity
Engagement Events			
12th December 2017	Focus Group Having a Conversation	Service users, carers, families, providers and interested people in **Grantham**	Starting a conversation about how to improve services
14th December 2017	Focus Group Having a Conversation	Service users, carers, families, providers and interested people in **Skegness**	Starting a conversation about how to improve services
19th December 2017	Workshop	Staff	To engage with staff about the potential changes
3rd January 2018	Focus Group Having a Conversation	Service users, carers, families, providers and interested people in **Spalding**	Starting a conversation about how to improve services
8th February 2018	Focus Group Having a Conversation	Service users, carers, families, providers and interested people in **Lincoln**	Starting a conversation about how to improve services
14th March 2018	Focus Group Having a Conversation	Service users, carers, families, providers and interested people in **Boston**	Starting a conversation about how to improve services
12th April 2018	Focus Group Follow up – requesting a conversation about next steps and support for a cross county service.	Service users, carers, families, providers and interested people in **Lincoln**	Starting to shape feedback

Date	Delivery Method	Audience	Activity
Engagement Events			
8th May 2018	Focus Group Follow up – requesting a conversation about next steps and support for a cross county service.	Service users, carers, families, providers and interested people in **Grantham**	Starting to shape feedback
15th May 2018	Focus Group Follow up – requesting a conversation about next steps and support for a cross county service.	Service users, carers, families, providers and interested people in **Spalding**	Starting to shape feedback
3rd October 2018	Staff Carers Pathway	Staff	Looking at the Clinical Pathway
19th October 2018	3rd Sector Event	Providers/Groups	Feedback and information sharing
Summer 2018	Questionnaire	Carers	To develop the carers pathway
September – December 2018	Newsletters	Stakeholders	To update
21st November 2018	Carers Pathway	Carers, patients, providers, staff	Making the clinical pathway more user friendly

Date	Delivery Method	Audience	Activity
Conversations about the Home Treatment Team			
1st July 2019	Focus Group Having a Conversation	Service users, carers, families, providers, staff, third sector and interested people in **Grantham**	Feedback and information sharing
2nd July 2019	Focus Group Having a Conversation	Service users, carers, families, providers, staff, third sector and interested people in **Skegness**	Feedback and information sharing

Date	Delivery Method	Audience	Activity
Conversations about the Home Treatment Team			
30th July 2019	Focus Group Having a Conversation	Service users, carers, families, providers, staff, third sector and interested people in **Louth**	Feedback and information sharing
31st July 2019	Focus Group Having a Conversation	Service users, carers, families, providers, staff, third sector and interested people in **Lincoln**	Feedback and information sharing
8th August 2019	Focus Group Having a Conversation	Service users, carers, families, providers, staff, third sector and interested people in **Boston**	Feedback and information sharing
14th August 2019	Focus Group Having a Conversation	Service users, carers, families, providers, staff, third sector and interested people in **Spalding**	Feedback and information sharing

Date	Delivery Method	Audience	Activity
Consultation Events			
14th January 2021	Consultation Event	Service users, carers, families, providers, staff, third sector and interested people in **Older People & Frailty Services**	Feedback on proposal and information sharing
18th January 2021	Consultation Event	Service users, carers, families, providers, staff, third sector and interested people in **Older People & Frailty Services**	Feedback on proposal and information sharing
20th January 2021	Consultation Event	Service users, carers, families, providers, staff, third sector and interested people in **Older People & Frailty Services**	Feedback on proposal and information sharing

Date	Delivery Method	Audience	Activity
Older Adult Advisory Group Meetings			
11th September 2019	Older People Advisory Group	Service users, carers, staff and third sector	To act as a critical friend to the Older Adult Service
6th November 2019	Older People Advisory Group	Service users, carers, staff and third sector	To act as a critical friend to the Older Adult Service
22nd January 2020	Older People Advisory Group	Service users, carers, staff and third sector	To act as a critical friend to the Older Adult Service

The Older Adult Advisory Group meetings were postponed in March 2020 due to COVID-19 restrictions. These will commence again when restrictions have been lifted.

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 Andrew Crookham
Executive Director - Resources

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**21 July 2021**
Subject:	**Lincolnshire Partnership NHS Foundation Trust – General Update**

Summary:

This item provides a general update to the Committee on the activities of the Lincolnshire Partnership NHS Foundation Trust (LPFT). Attached is the Chief Executive's report to Board of Directors meeting of LPFT on 20 May 2021. The report to the next LPFT Board of Directors meeting on 29 July is being prepared and will be circulated when available.

Actions Requested:

To consider the information presented by Lincolnshire Partnership NHS Foundation Trust.

1. Background

This item provides a general update to the Committee on the activities of the Lincolnshire Partnership NHS Foundation Trust (LPFT). This is being achieved via the Chief Executive's reports to Board of Directors meetings of LPFT. The relevant report from the most recent meeting of the Board of Directors on 20 May 2021 is attached. The report to the next LPFT Board of Directors meeting on 29 July is being prepared and will be circulated when it is available.

2. Conclusion

The Committee is requested to consider the information presented by Lincolnshire Partnership NHS Foundation Trust.

3. Appendices

These are listed below and attached at the back of the report	
Appendix A	Chief Executive's Report to the Lincolnshire Partnership NHS Foundation Trust Board of Directors 20 May 2021, including as Appendix 1: • East Midlands Alliance for Mental Health and Learning Disabilities - Common Board paper

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, Health Scrutiny Officer, who can be contacted on 07717 868930 or by e-mail at Simon.Evans@lincolnshire.gov.uk

Lincolnshire Partnership
NHS Foundation Trust

Report to:	Board of Directors
Date of meeting:	20 May 2021
Section:	Strategy
Report title:	Chief Executive's Report
Report written by:	Sarah Connery
Job title:	Acting Chief Executive
Lead officer:	Sarah Connery
Action required:	For information
For assurance (Yes or No)**:**	Yes

Purpose of the Report

The report is intended to provide a high-level overview of key national and local issues that may impact on Trust strategy, annual plans and priority setting.

Key Issues, Options and Risks

1. REGULATORY

Care Quality Commission (CQC) Inspection 2020

The Trust continues to hold regular engagement meetings with the CQC providing an open and transparent relationship. The CQC only inspect against the standards of care we want to provide for our patients at all times and therefore it can be argued that we should strive to always be inspection ready. However, in preparation for a future re-inspection of our services, the Trust is reviewing its practices and putting in place a range of actions so that we can provide assurance we are providing the desired standard of care and leadership.

2. COVID-19

The Trust continues to follow the government roadmap as the nation moves towards the further easing of restrictions. The Trust welcomed the downgraded status of the pandemic from a level 4 to level 3 classification. However, the threat from Covid is still very much with us - and we continue to ask staff to act vigilantly, to follow guidelines and exercise good practice around infection prevention and control. As a result I am pleased to report there have been no outbreaks in the Trust since February 2021.

COVID Vaccination Programme

Vaccinations continue to be offered to staff and the Trust is making plans for future vaccination programmes that will be delivered later in the year.

3. NATIONAL

The Government has set the legislative programme for the year ahead, with the NHS front and centre, setting out the biggest reforms to the NHS in nearly a decade in the wide-ranging Health and Care Bill.

The Government has also announced plans to continue to support the vaccine roll out, provide additional funding for the NHS, focus on prevention and reform the Mental Health Act. There was a renewed commitment to bring forward "proposals on social care reform", later in the year however there was no detail on what these proposals would entail.

4. REGIONAL

East Midlands Alliance for Mental Health and Learning Disabilities

The Alliance continues to push forward on its collaboration work. An update on the progress to date is attached at Appendix A.

5. LINCOLNSHIRE

Integrated Care System

Work continues to progress the development of our Integrated Care System for Lincolnshire. Our focus is around how we will work together to best deliver the four aims namely: **integration** of **health** and **care services**; improving population **health** and reducing inequalities; supporting productivity and sustainability of **services**; and helping the NHS to support social and economic development.

We are still awaiting national guidance on some key areas such as for example, Provider Collaboratives and Governance infrastructure. Despite this we are making progress on all fronts to ensure we can realise our vision to provide better care for our population. Our focus has been around understanding population health and driving forward the Personalisation agenda.

The Mental Health, Learning Disability and Autism Partnership Group continues to meet monthly with strong engagement from such partners as the Police, the Local Authority and NHSE/I. We are in the process of agreeing our system objectives for 2021/22 as well as our longer term strategic vision for the system.

6. LPFT

Out of Area

Inappropriate Out of Area placements has remained at zero for Acute and Psychiatric Intensive Care, with good progress on length of stay for our wards. Cross divisional working and collaboration with the Local Authority on housing is continuing to enhance options to avoid admissions and supporting discharge.

Following the success of this programme, the focus is now turning to reducing the number of rehabilitation and other specialist out of area mental health placements.

Transforming Care: Learning Disabilities and Autism

Through collaborative development with the Lincolnshire CCG, investment has been agreed to expand the Transforming Care services in the Trust. This will include new specialist roles in the adult crisis and home treatment teams and the community forensic team, as well as significantly expanding the transforming care liaison team that will support the staff and teams across the trust to better support people with a learning disability and/or autism.

Community Mental Health Transformation

Following a successful bidding process, the Trust is now preparing to expand the community mental health transformation programme across another third of the county. This next stage

development will see the refocussing of our community mental health teams as specialist mental health services with patients with lower levels of need being transitioned into the new integrated place-based teams, primary care and community & voluntary services.

This will lead to our CMHTs having the capacity and capability to focus on a smaller number of people with the highest level of need and able them to provide a much more response service, leading to a maximum of a four week wait for treatment.

A task and finish group is now being established with our Clinical Directors and Associate Directors of Operations to redefine the criteria and transition points in and out of the CMHTs. It will take some time to fully implement this new way of working, but this is a key stage in the development of this programme of work.

New national investment in Lincolnshire's mental health services for children and young people

Following a joint bid, submitted by the Trust and Lincolnshire County Council's Children Service, the county has been successfully awarded significant new national funding to develop a new approach to supporting the mental health of children and young people (CYP) with complex needs. The funding from NHS England (Health and Justice) amounts to approximately £2.5million initially over the next three years and will provide a fantastic opportunity to shape our services to best meet the needs of children and young people in the county. This new approach will enable professionals across a number of partner agencies to work in a much more joined-up way to provide mental health care and support children and young people using trauma-informed practice. The new service will be phased in over the next three years to be fully implemented in 2023/24.

Maternal mental health hubs funding

NHS England is developing Maternal Mental Health Hubs across the country as part of their commitment to the NHS Long Term Plan. Lincolnshire has received funding and will be one of the 26 hubs offering maternal mental health, further expanding our perinatal offer.

Working in partnership with United Lincolnshire Hospitals NHS Trust (ULHT), this new investment will help us introduce new countywide support for women who have experienced birth trauma or loss, as well as expectant mothers who have a fear of labour (Tokophobia). It will offer women psychological support from a range of skilled staff and will be supported by a specialist mental health midwife.

International Nurses' Day

This month the Trust has celebrated international nurses' day recognising the invaluable contributions our nurses continue to make to our services. This year it has been particularly important to take the time to reflect on the work of our nursing workforce over the last year during the COVID-19 pandemic and the inspirational work they have done to support our local community. To celebrate the day the Trust shared a number of quotes and case studies from our nurses, as well as used this as an opportunity to promote nursing as a career in LPFT.

For our staff we have also been hosting a number of online webinars as part of our annual nursing conference. We have heard from important national and international speakers including Paula McGowan. Paula is a multi-award-winning activist who, following the avoidable death of her teenage son Oliver, has dedicated her life to campaigning for equality of Health and Social Care for Intellectually Disabled and or Autistic people.

Mental Health Awareness Week

This year's Mental Health Awareness Week took place between the 10 – 16 May, with this year's theme focusing on 'Nature'. Throughout the week the Trust has been sharing various resources on social media with a focus specifically on children and young people and the helplines available for all ages.

A number of services have also been sharing how getting out in nature can have a positive impact on people's mental wellbeing.

7. CELEBRATING SUCCESS

Staff Excellence Awards shortlist announced

After having to sadly cancel our 2020 staff excellence awards due to the pandemic, we are pleased to be able to celebrate our worthy finalists in a virtual ceremony that is taking place on 21 May.

We really hope that all those able to attend enjoy the ceremony and we look forward to recognising the amazing work that our staff do to provide great care each and every day.

Executive Analysis

I continue to be in awe of, and grateful for, all of the hard work that our staff continue to put in day in and day out to respond to Covid and to keep our services safe.

Our most pressing challenge is to ensure our people are rested and that they have the support they need to deliver on both the challenges and opportunities of recovery.

There are some real positive indicators of progress and investment being made in the Lincolnshire system, particularly around Mental Health, Learning Disability and Autism services. The Trust continues to work on our alliances, both within and beyond the Lincolnshire system, in order to deliver high quality sustainable services for the population.

Recommendation (action required, by whom, by when)

Directors are asked to receive and discuss this report.

Regulation, legislation and compliance

CQC Impact on key lines of enquiry:	Well-led
Financial Implications:	Non delivery of transformation programme and KPIs will have a direct impact of the funding for the Trust
Equality Analysis:	COVID continues to effect particular groups of staff and as such ensuring risk assessment and response plans are in place is essential.
Compliance Impact:	Compliance with Licence condition FT4 – NHS foundation trust governance arrangements

Risk Appetite

Risk assessment — **Not applicable** (delete as appropriate)

Risk Level > Key Elements v	**Avoid**	**Minimal**	**Cautious**	**Open**	**Seek**	**Mature**
Financial / VFM:					G	
Compliance/Regulatory:				G		

Innovation/Quality:					G	
Reputation:				G		
APPETITE	**NONE**	**LOW**	**MODERATE**	**HIGH**	**SIGNIFICANT**	
Explanation of variance from general (G) risk appetite						

The level of risk against each element should be indicated. Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes.

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Document Control – Version 5 – May 2019

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East Midlands Alliance for Mental Health and Learning Disabilities

Common Board paper

May 2021

Introduction

This paper provides an update to the Board on the progress made by the East Midlands Alliance since the previous common Board paper in November 2020. It also sets out the next steps on governance agreed by the Chairs and CEOs. The same paper will be presented to all six provider Boards in May or June.

Progress with joint work programme

Covid pandemic response

The weekly Alliance CEO meetings have focused on sharing experience, learning and approaches to the Covid pandemic, vaccination programme, working with BAME staff, broader staff support and plans for recovery.

Establishment of a learning collaborative on restraint and wider restrictive practice

The baseline review of each provider has been completed and baseline reports shared with each provider. A broader Alliance-wide report has been developed by the East Midlands Academic Health Science Network.

The Alliance level report contains a valuable summary of the issues and best practice identified alongside a set of recommendations to help us minimise restrictive practice and prevent the abuse of restraint.

Mental Health Safety Improvement Programme – East Midlands

The Alliance has agreed to work with the East Midlands AHSN to establish the East Midlands element of the national mental health safety improvement programme. The Mental Health Safety Improvement Programme (MHSIP) is commissioned by NHS England.

The Patient Safety Collaborative is part of the Academic Health Sciences Network (AHSN) and is the delivery arm for the patient safety programmes. The national delivery model for the MHSIP is led through sub regional formation of MH Patient Safety Networks supported by the Patient Safety Collaboratives within each AHSN footprint and is a mandated aspect of the commission.

The three priorities for the MHSIP in 2021/22 are:

- Suicide and deliberate self-harm
- Restrictive practice
- Sexual safety

The AHSN discussed the approach with the Alliance Medical and Nurse Directors at a workshop on 6 May. The national launch of the MHSIP is on 10 May.

The governance of the MHSIP will be linked to the more formal governance of the Alliance and the AHSN has asked the Alliance to support the identification of a chair for the programme and clinical chairs for the three priority workstreams.

Mental Health Clinical Networks in the East Midlands

The Alliance Medical and Nurse Directors met on 6 May to hear from the AHSN about the new Patient Safety Collaborative, to better understand the approach of the Clinical Networks hosted by NHS England and to consider actions to strengthen the link between the Alliance and those networks.

The group heard from the clinical and managerial leads for the East Midlands mental health clinical networks. The presentation was well received and helped to improve the understanding of the group on the nationally prescribed objectives and approach of the Clinical Networks. Some further work will be undertaken to share a further level of detail on the purpose, membership and schedule of meetings for the 26 networks in the East Midlands. This will enable the Medical and Nurse Directors to offer thoughts on the overall scope and opportunities for aggregation.

The Medical and Nurse Directors supported the programme of work set out and encouraged the Clinical Network leads to develop a greater focus on mental health data quality and actions to address health inequalities.

There are established separate Medical and Nurse Director forums in the East Midlands. The group agreed to meet quarterly as a joint Medical and Nurse Director forum to consider provider issues of common interest.

Demand and capacity model

Further work has been undertaken to develop an Alliance demand and capacity model for mental health. Further versions of the model have been issued to the providers for review and validation. The process to validate inputs and outputs is complete in most of the Alliance providers.

Provider specific reports have been issued to each Alliance member. The model also generates Alliance wide comparative information. A presentation of the model was made in March to the CEO group who agreed to extend the hosting period for the model with the North of England CSU to the end of June 2021. The extension will enable the validation process to be completed and further versions of the model to be released. It will also allow the Alliance time to identify a host from within the Alliance.

Research opportunity with the East Midlands Police Academic Collaboration

The Alliance has agreed to support the East Midlands Police Academic Collaboration in a research proposal to consider learning and evaluation from different policing and mental health approaches. The National Institute for Health Research (NIHR) called for expressions of interest by the end of

March 2021. If successful, the Alliance and Police Collaboration will be invited to submit a more detailed proposal later in the year.

Learning workshop with crisis alternative leads and police mental health leads

Linked to the joint police research opportunity referenced above, the Alliance proposed to the Chief Constable group in the East Midlands that we hold a joint workshop to share the models used in the region for joint mental health and police work, the successes and challenges. The Chief Constable group supported the workshop proposal, and it will take place on 9 June.

Use of technology to support seclusion processes

St Andrew's have been working with the Academic Health Science Network and their Patient Information System supplier to consider how technology could support the reminder and record keeping elements of the seclusion process. The outcome of the work will be shared with the rest of the Alliance later in 2021.

Regional provider collaboratives (New Care Models)

Two provider collaboratives have been given the green light to go live from 1 April 2021. NHS England transferred the leadership of CAMHS and Adult Eating Disorders in the East Midlands to provider collaboratives led by Northamptonshire Healthcare for CAMHS and Leicestershire Partnership for Adult Eating Disorders.

The new Alliance Executive Board will discharge the part two Board role for these Provider Collaboratives (and the Impact Forensic Provider Collaboration). These collaboratives are also looking at joint roles and common approaches to areas such as communications.

The Alliance held a joint Finance and Strategy Directors workshop with NHS England on Provider Collaborative financial responsibilities in February 2021. The workshop considered approaches to sharing risk across the three new Provider Collaboratives and future NHS England collaborative opportunities.

The Alliance Executive Board will also monitor progress with the Midlands Veterans High Intensity Service (HIS) that went live on 1 October 2020. This service covers the whole of the Midlands patch which is then sub-divided into three areas. The three HIS teams are multi-disciplinary and offer a variety of skills to the service. The Partnership is led by Lincolnshire Partnership Foundation Trust in collaboration with Coventry and Warwickshire Partnership Trust and Birmingham and Solihull Mental Health NHS Foundation Trust.

The HIS works collaboratively with providers with the aim to ensure veterans have access to:

- A crisis service, 24/7 crisis response, rolling out specialist community care to prevent avoidable admissions
- Therapeutic acute mental health inpatient care to provide stabilisation and rehabilitation in the least restrictive setting as close to home as possible
- Comprehensive continuous care coordination of care
- Family support and coordination of care.

Regional and local provider collaboration

The CEO group met with David Nicholson and Richard Mitchell to discuss and inform their work for the NHS England Midlands region on provider collaboration. A spectrum of options will be proposed from a Provider Leadership Board through to merging providers to create a single organisation.

The four options on the spectrum are:

- Provider leadership board
- Lead provider
- Shared provider leadership
- Single provider organisation

There was discussion about using the Single Oversight Framework as a mechanism to identify the strongest organisation in a system to take a lead. Higher performing systems would have more freedom to determine their own model with a lead provider relationship seen as sufficient, unless the local system chooses to go further. More challenged systems could be expected to act to bring together their providers as a single organisation.

The Alliance Strategy Directors shared approaches to ICS/STP level provider alliances at their meeting in March. The group discussed the ICS Mental Health Board and Learning Disabilities Board approach in Derbyshire and the lead provider model in Northamptonshire.

Chair and CEO meeting – 24 March

The Chairs and CEOs of the six providers met in March to discuss progress and next steps for the East Midlands Alliance. The CEOs provided an update on the breadth of joint work captured in this paper. The CEOs also set out proposals to move to a more formal Executive Board, with an independent Chair, based on a new Partnership Agreement.

The Chairs provided suggestions on the governance and restated the importance of the Alliance taking key decisions back to provider Boards with a common recommendation. It was agreed that a common Board paper would be prepared after each Executive Board meeting to include key decisions with recommendations to provider Boards.

The Executive Board will meet at least every two months and will undertake the part B strategic decision-making role for the provider collaborative boards in one forum (rather than separately multiple times). The first shadow Board will take place on 14 May, with a second meeting on 10 June to build momentum.

Recruiting an independent chair

A role description for the Indepdenent Chair has been shared with CEOs and Chairs for comment. The plan is to advertise for an independent chair in early summer with a view to them being in post later in the summer.

Joint Board development session

The Chairs and CEOs agreed to hold a joint Board development session focused on clarifying the roles and links between regional provider alliances, ICS level provider collaboration and provider Boards. The first of these joint Board development sessions will take place in June or July.

CEOs meeting with Claire Murdoch

The CEO group met with Claire Murdoch, the national NHS England lead for mental health and learning disabilities on 23 April. The CEOs discussed provider collaboration, the CQC, the role of mental health trusts on ICS Boards, the challenges of competitive premiums being paid to clinical staff and the progress of the Alliance in the East Midlands.

Partnership Agreement

A new Partnership Agreement, based on the three Agreements in place in the East Midlands for the provider collaboratives, has been developed. The new Partnership Agreement formalises the arrangements for joint Alliance working and the link to the three Provider Collaboratives. A further version of the Agreement will be shared at the first Alliance Board on 14 May for comment ahead of circulating a copy to each provider Board for review and approval.

Work programme for 2021/22

A work programme for 2021/22 will be agreed at the June Executive Board.

Recommendation

1. The Board is asked to note the update and progress made in collaborative working through the East Midlands Alliance.
2. The Board is asked to note the agreement to develop a more formal Executive Board with an independent Chair based on a new Partnership Agreement.
3. The Board is asked to note the planned Board development session.

Graeme Jones

7 May 2021

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

Open Report on behalf of Derek Ward, Director of Public Health, Lincolnshire County Council

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**21 July 2021**
Subject:	**Lincolnshire Pharmaceutical Needs Assessment 2022**

Summary:

Completion of a Pharmaceutical Needs Assessment (PNA) is a statutory duty for Health and Wellbeing Boards (HWBs) to undertake at least every 3 years. Due to the Covid-19 pandemic, the requirement to republish an updated PNA by 31 March 2021 was suspended. The HWB is now required to publish the PNA by 31 March 2022.

The production of the 2022 PNA for Lincolnshire has commenced, and a draft PNA is being prepared to go out for consultation between October and December 2021.

Actions Required:

The Health Scrutiny Committee for Lincolnshire is requested to:

(1) note that the process to produce a revised Pharmaceutical Needs Assessment by 31 March 2022 has commenced;

(2) receive the project plan timeline from the Lincolnshire PNA Steering Group on the production of the Lincolnshire Pharmaceutical Needs Assessment 2022; and

(3) initiate a working group to comment on the draft Pharmaceutical Needs Assessment during the statutory 60-day public consultation.

1. Background

The Pharmaceutical Needs Assessment (PNA) is a report of the present and future needs for pharmaceutical services. It is used to identify any gaps in current services or improvements that could be made in future pharmaceutical service provision. To prepare the report data is gathered from pharmacy contractors, dispensing GP practices, pharmacy users and residents, and from a range of other sources (commissioners, planners and others). The report also includes evidence and a range of maps that are produced from data collected as part of the PNA process.

The Health and Social Care Act 2012 transferred responsibility for developing and updating PNAs to Health and Wellbeing Boards (HWBs). The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 sets out the legislative basis for developing and updating PNAs.

Due to the pandemic, in June 2020 the Department of Health and Social Care suspended the statutory duty to produce a revised PNA by 31 March 2021. HWBs are now required to publish an updated assessment by 31 March 2022. Lincolnshire's current PNA, which was published in 2018, is available to view on the Lincolnshire Research Observatory.

Lincolnshire County Council Public Health Division is facilitating the process to prepare a revised assessment with external pharmaceutical expert resource being provided by the University of Lincoln. A PNA Steering Group (SG) has been convened to support the development of the PNA. The Steering Group has membership from the key stakeholders – community pharmacies (represented by the Local Pharmaceutical Committee), health services (represented by NHS Lincolnshire Clinical Commissioning Group, Public Health and the Local Medical Committee) and residents (represented by Healthwatch Lincolnshire). The PNA SG held its first meeting on 8 June 2021. At this meeting the Terms of Reference were agreed along with the Project Plan shown in Appendix A.

The PNA SG is currently undertaking several pre consultation engagement activities to help inform the drafting of the PNA document. Surveys are currently being undertaken with local community pharmacies and GP dispensing practices to ascertain current commissioning and provision of services. In addition, Healthwatch Lincolnshire is gathering the views of patients, service users and the public to seek their opinion on current pharmaceutical services.

The intention is to present the draft PNA to the HWB on 28 September 2021 for the Board to consider it prior to undertaking the statutory 60-day consultation exercise during October to December. The Health Scrutiny Committee for Lincolnshire is invited to initiate a working group during this time in order to feed into the consultation process on the draft PNA.

2. Consultation

A 60-day consultation is a mandatory component of the PNA process. The consultation follows the period of engagement and data gathering on health needs, service provision and views of residents on the existing levels of pharmacy provision. The proposed consultation will be on the findings of the draft PNA, approved by the HWB at is meeting in September.

It is anticipated that the consultation questions will broadly cover the following:

- To what extent do you agree or disagree with the assessment? (The findings on whether there are gaps or not in pharmaceutical provision)
- To what extent do you agree or disagree with the other conclusions contained within the draft PNA
- In your opinion, how accurately does the draft PNA reflect each of the following?
    - current provision of pharmaceutical services
    - current pharmaceutical needs of Lincolnshire's population
    - future pharmaceutical needs of Lincolnshire's population over the next three years
- Any other comments
- We will also collect some (optional) basic data about the respondent (in line with LCC guidance).

The Pharmaceutical Regulations mandate that the consultation must be for a minimum of 60 days. The planned dates for the consultation are from 4 October 2021 to 3 December 2021.

The regulations also list a range of stakeholders who must be consulted. A stakeholder list has been developed, in conjunction with the PNA SG, and used to help distribute the questionnaire. In addition to approving the draft PNA for consultation, the Board will also approve the consultation plan.

An Equality Impact Assessment has been produced and will be used to identify any vulnerable groups which may need to be targeted. The consultation will be an online survey on the Council's website and communicated through:

- Traditional and social media communications
- Newsletters and partner's communication networks
- Presentations – Healthwatch Lincolnshire have offered to host a Webinar
- Paper copies of the consultation will be available on request.

3. Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy

The PNA is undertaken in the context of the health, care and wellbeing needs of the local population, as defined in the Lincolnshire Joint Strategic Needs Assessment (JSNA). The JSNA, as well as defining the needs of the local population, also identifies a strategic direction of service delivery to meet those needs, and commissioning priorities to improve the public's health and reduce inequalities. The PNA should therefore be read alongside the JSNA.

Regulation 9 of the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations requires, when carrying out assessments for the purpose of publishing PNAs, to have regard of:

- the number of people in its area who require pharmaceutical services
- the demography of its area
- the risks to the health or wellbeing of people in its area

4. Conclusion

The draft PNA 2022 is currently being produced by the PNA SG. The draft PNA will be considered by the HWB for approval from consultation. Pending approval, it will be made available for the 60-day statutory consultation in early October 2022. The Health Scrutiny Committee for Lincolnshire is being invited to convene a working group as part of this process.

The results of the consultation will be considered by the PNA SG in January 2022 and the final PNA document will be presented to this committee and the HWB in February and March 2022 respectively. The final PNA must be published by 31 March 2022.

5. Appendices

These are listed below and attached at the back of the report	
Appendix A	Lincolnshire 2022 PNA Project Plan

6. Background Papers

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

The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013	http://www.legislation.gov.uk/uksi/2013/349/contents/made

This report was written by Alison Christie, Programme Manager, who can be contacted on alison.christie@lincolnshire.gov.uk

APPENDIX A - LINCOLNSHIRE 2022 PNA PROJECT PLAN

		Owner	May 2021	June 2021	July 2021	August 2021	September 2021	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022
Stage 1	Project Start/PH internal Working Group meets	**AC**	**18**										
Stage 1	**First Steering Group Meeting**	**AC**		***8***									
Stage 1	Produce Communication & Engagement Plan and complete initial EIA	**AC**											
Stage 1	Deadline for HWB papers	**AC**		**1**									
Stage 1	HWB meeting to receive paper on process & timescales	**AG/AC**		**22**									
Stage 1	HSC meeting to receive paper on process & timescales – for information	**AC**			**TBC**								
Stage 2	Data collation including questionnaires												
Stage 2	**Second Steering Group Meeting** to agree and lock down the data				***TBC***								
Stage 3	Complete draft PNA including recommendations					***13***							
Stage 3	Circulate draft PNA to Steering Group and NHSE					***16***							
Stage 3	**Third Steering Group Meeting**-agree draft PNA					***TBC***							
Stage 3	Prepare consultation – documentation, correspondence to statutory consultees, webpages	**AC**											
Stage 3	Deadline for HWB papers	**AC**					**6**						
Stage 3	HWB meeting to agree Draft PNA for consultation	**AG/AC**					**28**						
Stage 3	Statutory Consultation Exercise (61 days)							**4**		**3**			
Stage 3	Deadline for HSC papers	**AC**							**TBC**				
Stage 3	HSC meeting to review draft & input into consultation	**AG/AC**							**TBC**				
Stage 4	HWB meeting to provide a verbal update on the consultation exercise/key headlines	**AG/AC**								**7**			
Stage 4	Produce consultation report and draft final PNA												
Stage 4	Circulate draft Final PNA to Steering Group												
Stage 4	**Fourth Steering Group Meeting**-agree final PNA										***TBC***		
Stage 4	Deadline for HSC papers	**AC**										**TBC**	
Stage 4	HSC meeting to final draft & provide scrutiny comments to HWB	**AG/AC**										**TBC**	
Stage 4	Deadline for HWB papers	**AC**											**7**
Stage 4	HWB meeting to agree draft Final PNA for publication	**AG/AC**											**29**
Stage 4	Convene steering group (if needed) to receive/inform comments from HWB	**AG**											**30**
Stage 4	Amend final PNA for feedback from HWB	**AG**											**30**
Stage 4	Upload Final PNA onto Council or Observatory (TBC) website, and make 'live'	**AC**											**31**

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

Open Report on behalf of Andrew Crookham
Executive Director - Resources

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**21 July 2021**
Subject:	**United Lincolnshire Hospitals NHS Trust – Consultation on Hospital Urology Services**

Summary:

On 23 June 2021, the Committee considered a consultation on hospital urology services provided by United Lincolnshire Hospitals NHS Trust. The Committee agreed that a draft response would be submitted to this meeting of the Committee for consideration and approval, which would be informed on the Committee's comments made on 23 June 2021. The draft response is attached as Appendix A to this report.

Actions Requested:

To consider the draft response (which will be circulated as Appendix A to this report) to the consultation on hospital urology services provided by United Lincolnshire Hospitals NHS Trust, and subject to any amendments, approve it for submission by 23 July 2021.

1. Background

A consultation on hospital urology services provided by United Lincolnshire Hospitals NHS Trust (ULHT) was presented to this Committee on 23 June 2021, by representatives from the Trust.

Planned urology services are currently delivered from Lincoln County Hospital, Pilgrim Hospital, Boston, Grantham and District Hospital and Louth County Hospital; and emergency urology admissions at the weekends go through one single site, alternating between Lincoln County and Pilgrim Hospitals. There are emergency admissions at both Lincoln and Pilgrim Hospitals during the week.

In summary, the consultation document advises that ULHT is consulting patients on a proposal that Lincoln County Hospital in future receives all emergency urology admissions seven days per week. There would be increases in planned urology services at Grantham and District Hospital and Pilgrim Hospital, with a reduction of planned activity at Lincoln County. There would be no changes at Louth County Hospital. ULHT believes that this change would increase ULHT's capacity to perform planned surgery without disruption to patients; better meet the needs of ULHT's emergency cases; and see and treat more people.

On 23 June the Committee agreed that a response would be drafted for consideration by the Committee on 21 July. The Committee has also requested sight of the quality impact and equality impact assessments, which would also inform the Committee's response.

A draft response has been prepared, which is being circulated to the members of the Committee for comments. Once this draft has reflected the comments of members, it will be published and considered for approval on 21 July, and following approval, a final response will be submitted to ULHT by 23 July, the closing date for the consultation.

2. Conclusion

The Committee is invited to consider the draft response (to be circulated as Appendix A to this report) to the consultation on hospital urology services provided by United Lincolnshire Hospitals NHS Trust. Subject to any amendments, the Committee is requested to consider approving it for submission to ULHT by 23 July 2021.

3. Appendices

These are listed below and attached at the back of the report	
Appendix A **(TO FOLLOW)**	Draft Response to the Consultation on Hospital Urology Services Provided by United Lincolnshire Hospitals NHS Trust

9. 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, Health Scrutiny Officer, who can be contacted on 07717 868930 or by e-mail at Simon.Evans@lincolnshire.gov.uk

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

Open Report on behalf of Andrew Crookham
Executive Director - Resources

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**21 July 2021**
Subject:	**Proposals for Scrutiny Reviews**

Summary:

On 17 June 2021, the Overview and Scrutiny Management Board requested each overview and scrutiny committee to identify potential topics for in-depth scrutiny review, which would be undertaken by the two Scrutiny Panels, taking into account the prioritisation toolkit. The Overview and Scrutiny Management Board is due to consider suggestions at its meeting on 30 September 2021, with a view to making a decision on which reviews would be approved.

Actions Requested:

To consider the request from the Overview and Scrutiny Management Board for suggestions for scrutiny reviews and in responding to the Board, to be mindful of Section 6 of this report.

1. Background

One of the essential roles of overview and scrutiny is to carry out in-depth reviews where the outcomes can clearly influence and improve policy and service delivery for the people of Lincolnshire. In accordance with the Council's constitution, this role is undertaken by the two scrutiny panels, Scrutiny Panel A and Scrutiny Panel B.

These two scrutiny panels provide an opportunity for scrutiny councillors to consider a particular topic in great detail, for example by engaging with a range of individuals in less formal settings, which is not always possible in the formal setting of a committee meeting. Based on the evidence received, a report is compiled, with the panel making recommendations for possible improvement.

Scrutiny Panel A and Scrutiny Panel B will conduct each review in accordance with the following principles:

- Scrutiny panels should aim to collect a broad range of evidence on the particular review, interviewing interested parties, and engaging local communities, where this is feasible.
- Scrutiny panels should focus on developing realistic recommendations for improvement in relation to the topic under review.
- Scrutiny panels will submit their draft reports to the relevant overview and scrutiny committee for consideration, approval and onward referral as appropriate.

Scrutiny Panel A and Scrutiny Panel B will undertake in-depth scrutiny reviews in accordance with the terms of reference and timetable determined for each review by the Overview and Scrutiny Management Board.

2. Identifying Potential Scrutiny Review Topics

A Scrutiny Panel should only be set up when a suitable topic for a scrutiny review is identified by the Overview and Scrutiny Management Board using the Prioritisation Toolkit. Suggestions for scrutiny reviews may come from a variety of sources such as the scrutiny committees, other non-Executive Councillors, Executive Councillors, and senior officers.

When considering a potential topic for a scrutiny review, it is important that the Board ensures that the potential scrutiny review will not be duplicating any review work that is being undertaken by officers or external partners. The remit for the potential scrutiny review should be focused and not too broad, so that an in-depth review can be completed within a set timescale and will lead to achievable outcomes.

3. Role of Overview and Scrutiny Management Board

The Overview and Scrutiny Management Board is responsible for making decisions whether a scrutiny panel is merited, and in so doing the Board applies the guidance in the prioritisation toolkit attached at Appendix A.

Once a potential topic for a scrutiny review has been identified by the Overview and Scrutiny Management Board and assigned to a scrutiny panel, the terms of reference will be drafted by the Scrutiny Panel and submitted to the Overview and Scrutiny Management Board, if they have not already been approved by the Board. This does not prevent the panel from undertaking initial work on its topic.

4. Composition of Scrutiny Panels

Each scrutiny panel may comprise up to eight members including its chairman and vice chairman, who were appointed by the County Council on 21 May. The remaining members of each panel are appointed for each particular review, and there is an aim to make the membership politically inclusive. All non-executive councillors are eligible, with nominations for membership being sought from the leader of each political group.

5. Role of Overview and Scrutiny Committees – Approval of Final Report

As stated above, when each scrutiny panel completes its review, its draft report is submitted to the relevant overview and scrutiny committee for consideration and approval. Following its approval, the final report, including any recommendations, is submitted to the relevant decision-making body, which in most instances would be the Executive for matters relating to the County Council's executive functions. The relevant scrutiny committee is responsible for receiving the response to the review and for any future monitoring of recommendations.

6. The Timing of Suggestions

An in-depth scrutiny review would require significant input from colleagues in the NHS, who have been restoring and recovering NHS services as a result of the pandemic, as well as responding to its challenges. Therefore, it might be prudent at this stage to reconsider this topic at a later meeting, say 15 December 2021 or 19 January 2022, by which time, the NHS might be in a better position to contribute to a scrutiny review.

Furthermore, there were seven newly appointed members to this Committee in May 2021. Given the breadth of this Committee's remit, in effect the scrutiny of all NHS-funded services in Lincolnshire, as well as the complexity of some of the service areas, all members of the Committee will be better acquainted with the key topics affecting the NHS by the end of this calendar year.

7. Conclusion

Following the decision by the Overview and Scrutiny Management Board on 17 June 2021, this Committee is being asked to consider the request from the Overview and Scrutiny Management Board.

8. Appendices

These are listed below and attached at the back of the report	
Appendix A	Scrutiny Prioritisation - Prioritisation Toolkit

9. 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 Nigel West, Head of Democratic Services and Statutory Scrutiny Officer, who can be contacted on 01522 552840 or by e-mail at nigel.west@lincolnshire.gov.uk

APPENDIX A

Scrutiny Prioritisation

Prioritisation is a key tool for successful scrutiny. Selecting the right topics where scrutiny can add value is essential for scrutiny to be a positive influence on the work of the Council. Scrutiny committees must be selective about what they look at and need to work effectively with limited resources. Scrutiny activity should be targeted, focused and timely and include issues of corporate and local importance, where scrutiny activity can influence and add value.

The questions below are a guide to help members and officers consider and identify key areas of scrutiny activity for consideration.

Will Scrutiny input add value?

- Is there a clear objective for scrutinising the topic?
- What are the identifiable benefits to residents and the council?
- Is there evidence to support the need for scrutiny?
- What is the likelihood of achieving a desired outcome?
- Is the topic strategic and significant rather than relating to an individual complaint?
- Are there adequate resources to ensure scrutiny activity is done well?

Is the topic a concern to local residents?

- Does the topic have a potential impact for one or more section(s) of the local population?
- Has the issue been identified by Members through surgeries and other contact with constituents?
- Is there user dissatisfaction with service (e.g., increased level of complaints)?
- Has the topic been covered in the local media or social media?

Is it a Council or partner priority area?

- Does the topic relate to council corporate priority areas?
- Is there a high level of budgetary commitment to the service/policy area?
- Is it a poor performing service (evidence from performance indicators /benchmarking)?

Are there relevant external factors relating to the issue?

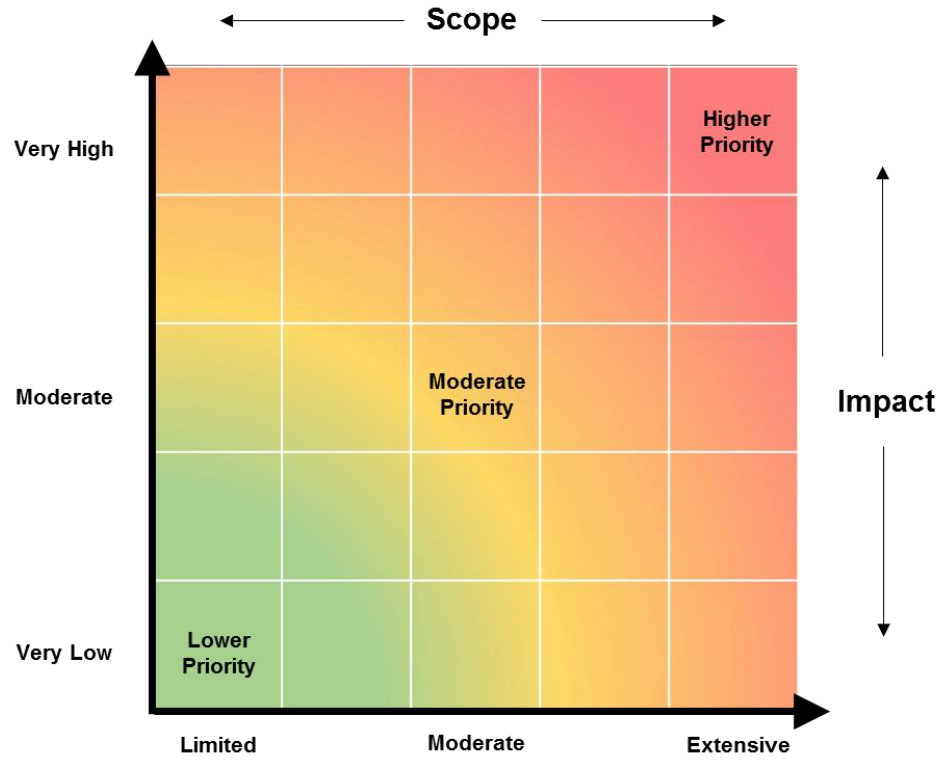
- Central government priority area.
- New government guidance or legislation.
- Issues raised by an internal or external audit or from formal inspections, etc.
- Key reports or new evidence provided by external organisations.

Criteria for not considering topics

- There is no scope for scrutiny to add value/make a difference or have a clear impact.
- New legislation or guidance is expected within the next year.
- The issue is being examined elsewhere - e.g., by the Executive, working group, officer group or other body.
- The objective of scrutiny involvement cannot be achieved in the specified timescale required.

Prioritisation Matrix

The prioritisation matrix shown below is a framework to aid in prioritising a number of scrutiny options or topics. Each topic should be assessed in terms of the impact it would have and the overall scope of the activity.



When considering the scope and impact of a Scrutiny item it is important to consider the following areas:

- People / Communities
- Assets / Property
- Financial
- Environmental
- Reputation
- Likelihood of Impact
- Resource Required
- Cost Effectiveness

Prioritisation tool

The prioritisation tool below can be used in deciding on whether an issue would warrant being considered by Scrutiny or the subject of a Scrutiny Review.

Does the topic affect a number of people living, working and studying in Lincolnshire?

Yes

Is the issue strategic and significant?

Yes

Can scrutiny add value? Is there evidence to support the need for scrutiny?

Yes

Will scrutiny topic be duplicating other work?

No

Is the topic likely to lead to effective outcomes?

Yes

Is the Council due to review the relevant policy area *(allowing scrutiny recommendations to influence the new direction to be taken)?*

Yes

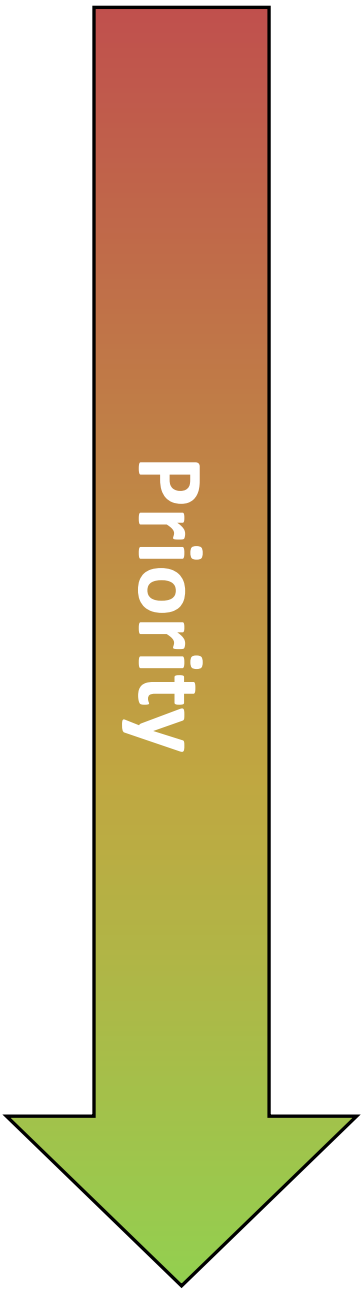
Are there adequate resources available to do the activity well?

Yes

Is the Scrutiny activity timely?

Yes

HIGH PRIORITY



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Open Report on behalf of Andrew Crookham
Executive Director - Resources

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**21 July 2021**
Subject:	**Health Scrutiny Committee for Lincolnshire - Work Programme**

Summary

This report sets out the Committee's work programme, and includes items listed for forthcoming meetings, together with other items, which are due to be programmed. The Committee is required to consider whether any further items should be considered for addition to or removal from the work programme.

Actions Required

To consider and comment on the Committee's work programme.

1. Background

At each meeting, the Committee is given an opportunity to review its forthcoming work programme. Typically, at each meeting three to four substantive items are considered, although fewer items may be considered if they are substantial in content.

2. Today's Work Programme

The items listed for today's meeting are set out below: -

21 July 2021		
	Item	*Contributor*
1	Lincolnshire Partnership NHS Foundation Trust: Lincolnshire Child and Adolescent Mental Health Services (CAMHS) Crisis and Enhanced Treatment Team	Jane Marshall, Director of Strategy, People and Partnerships Lincolnshire Partnership NHS Foundation Trust
2	Lincolnshire Partnership NHS Foundation Trust: Older Adults Mental Health Services	Jane Marshall, Director of Strategy, People and Partnerships Lincolnshire Partnership NHS Foundation Trust
3	Lincolnshire Partnership NHS Foundation Trust: General Update	Jane Marshall, Director of Strategy, People and Partnerships Lincolnshire Partnership NHS Foundation Trust
4	Lincolnshire Pharmaceutical Needs Assessment	Alison Christie, Programme Manager, Public Health
5	United Lincolnshire Hospitals NHS Trust – Finalising Response to Consultation on Urology	Simon Evans, Health Scrutiny Officer

3. Future Work Programme

Items to be Programmed

The following items are due to be programmed at forthcoming meetings:

- **The Lincolnshire Acute Services Review Consultation** – As reported in the Chairman's Announcements (item 4 of the agenda), the Lincolnshire Acute Services Review (ASR) pre-consultation business case has been approved, with consultation documentation now being prepared. If this consultation is launched during the autumn of 2021, it is anticipated that it will form a major part of the Committee's work programme, possibly over several meetings.

  The ASR consultation is expected to include proposals for change to the following four services:

  - Medical Services / Acute Medicine (Grantham)
  - Stroke Services
  - Trauma and Orthopaedics
  - Urgent and Emergency Care

- **Care Quality Commission Report: Protect, Respect, Connect – Decisions about Living and Dying Well During the Covid-19 Pandemic** – This item has been included in the Committee's work programme following a request from one of its members. As reported to this Committee on 23 June 2021, the Care Quality Commission published its report on this topic on 18 March 2021, which contained eleven recommendations. Three of these recommendations were directed at NHS providers.

- **NHS Continuing Healthcare** – On 11 November 2020, the Committee agreed to add NHS Continuing Healthcare to its list of items to be programmed. This followed a representation from a member of the public and the publication on 30 October 2020 of a report by the Parliamentary and Health Service Ombudsman (PHSO), entitled: *Continuing Healthcare: Getting It Right First Time*. This report made six recommendations, three of which were directed towards clinical commissioning groups.

- **Non-Emergency Patient Transport –** The Committee has requested an update on the outcomes of the current procurement exercise for a new contract for non-emergency patient transport which is due to begin from 1 July 2022.

Scheduled Items

Planned items for the Health Scrutiny Committee for Lincolnshire are set out in the following tables.

15 September 2021		
	Item	*Contributor*
1	Community Pain Management Service	Sarah-Jane Mills, Chief Operating Officer, West Locality, Lincolnshire Clinical Commissioning Group Tim Fowler, Assistant Director, Contracting and Performance, Lincolnshire Clinical Commissioning Group
2	North West Anglia NHS Foundation Trust (to be confirmed)	Management Representatives from North West Anglia NHS Foundation Trust
3	United Lincolnshire Hospitals NHS Trust: Nuclear Medicine	Senior Management Representatives from United Lincolnshire Hospitals NHS Trust
4		

13 October 2021		
	Item	*Contributor*
1	Dental Service Update (To be confirmed)	Representatives from NHS England and NHS Improvement Midlands
2	GP Practice – Developments and Challenges	Dr Kieran Sharrock, Medical Director Lincolnshire Local Medical Committee
3		
4		

10 November 2021		
	Item	*Contributor*
1	East Midlands Ambulance Service Update	Management from East Midlands Ambulance Service
2		
3		
4		

16 December 2021		
	Item	*Contributor*
1		
2		
3		
4		

Geographical Extent of Committee's Remit

There are no set criteria for this Committee in terms of how far it should extend its remit geographically. In terms of acute hospital trusts, the Committee's focus inevitably is on United Lincolnshire Hospitals NHS Trust, which in turn is scrutinised by only one health

overview and scrutiny committee. Many patients use acute hospitals in neighbouring counties, for example North West Anglia NHS Foundation Trust, which manages Peterborough City Hospital, for those in the south of Lincolnshire; and Northern Lincolnshire and Goole NHS Foundation Trust for many of those in the north of the county. All these non-Lincolnshire based trusts would be scrutinised by their local health overview and scrutiny committee or committees.

Traditionally, this Committee has received an annual update from North West Anglia NHS Foundation Trust (NWAFT) on the basis that there is extensive patient flow from the south of Lincolnshire to Peterborough; and furthermore NWAFT operates Stamford and Rutland Hospital, which is located in Lincolnshire. The patient flows to Northern Lincolnshire and Goole (NLAG) are significant but smaller than those to NWAFT, and an annual update from NLAG has not traditionally been sought. The Humber Acute Services Review (ASR) is likely to propose changes to services to Diana Princess of Wales Hospital, Grimsby, and Scunthorpe General Hospital. When consultation begins on the Humber ASR, which is not as advanced as the Lincolnshire ASR, it would be appropriate for consideration by this Committee.

In order to ensure that relevant acute hospital services for all residents in Lincolnshire are scrutinised by this Committee, it is proposed that when future items are brought to the Committee on a specific topic, for example cancer care, the Clinical Commissioning Group is requested, when appropriate, to provide information on those Lincolnshire patients being treated outside the county, for example at NWAFT or NLAG, as well as at United Lincolnshire Hospitals NHS Trust.

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, Health Scrutiny Officer, who can be contacted on 07717 868930 or by e-mail at Simon.Evans@lincolnshire.gov.uk

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