healthwatch Lincolnshire

Service User, Patient and Carer views on Mental Health Services

Final Report

November 2015

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Acknowledgements

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

Some Facts and Figures about Mental Health

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

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

CAMHS failing parents with the eligibility criteria always changing.

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

Depression affects 1 in 5 older people.

Mental Health Foundation

Précis of Findings and Conclusions

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

CAMHS and Transition to Adult Services. A lack of clarity is borne out by the questions and statements received from patients, parents and carers that indicate a complex pathway which is not effective. In addition, access to CAMHS and the transition between child and adult services is described as unclear and appears children do fall between the child and adult services.

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

Support and Recognition. Patients accessing GPs and other support services highlighted the need for more support and recognition relating to their mental health concerns and its impact from their doctor or other health care professionals. For patients, recognition that mental health is a real concern for individuals was critical and felt they should not feel they are fobbed off or told to just live with it. This recognition should be for children, young people, adults and older people accessing support and ensure the removal of social stigma around mental health conditions.

Training. To ensure GP and other support services understand the Single Point of Access (SPA), the waiting times, referral processes and are able to relay them to the patients and carers. There needs to be clarification for the community on the role and purpose of the SPA and if it is a 'mental health only' single point of access.

Patient Involvement. Trusts and commissioners should receive regular feedback from community representatives and a varied selection of patients and carers.

General Support for Patients and Carers. This point was reiterated when respondents specifically considered carers. Carers considered referral to community support groups important especially in relation to reducing social isolation. Carers also felt that health and care staff did not understand their needs. In view of the Care Act 2014 all front line staff need additional training in the needs of carers, carer’s assessment and community based support groups and services.

In-Patient Services. There appears to a high level of dissatisfaction with building-based community services. Hospital-based care was better received there were still significant issues relating to patient and carer perception. It is suggested that LPFT provide a greater range and variety of activities within these establishments and continue to review the impact inpatient services has on patients and loved ones.

Discharge from Hospital or Care. 80% of our respondents were unsatisfied with the discharge process from an inpatient setting. This replicates national concerns raised about unsatisfactory discharge and readmission rates. It also links strongly into our response to the Suicide Prevention Strategy.
Missing Person. We are concerned about the number of police calls to in-patients services at Pilgrim and PHC and we request more information and assurance from LPFT and commissioners that the reasons are within an acceptable tolerance.
Out of Hours. It was felt that there needed to be more access to help and support patients and families and carers particularly during 'out of hours' and at weekends. It was suggested that availability of CPNs and other support networks would be hugely beneficial.
Self-Harm. The number of respondents who had self-harmed and continued to self-harm raised questions and concerns about the recognition, support and prevention services for patients self-harming. Concerning was also the correlation of bullying and its impact on self-harm within our schools and colleges.
Waiting Times. Previous intelligence suggested there is a continuing problem with waiting times for mental health assessment. The findings of this work confirmed that waiting times were still an issue for patients who felt that capacity and timeliness of services was not satisfactory. When these issues are raised with the provider we have consistently been told that waiting times are within tolerance but this consistently has not been the feedback from patients. We would recommend transparent reporting.
Waiting Times and Referrals. In almost all the occasions where patients told us they had made a complaint, they were with reference to the complex referral backwards and forwards between GP and CMHT without any individual organisation taking responsibility for their care. LPFT/CCG should ensure there is a clear referral pathway and if this already exists, that all GPs and health professionals are clear on what it entails and adhere to it.
Perception of Services. With regard to special mental health support services many respondents highlighted services such as 24/7 telephone support, crisis team and counsellors as important in helping them with their illness. However we were concerned that the patient feedback we received doesn't consider STEP, Recovery College, HIPS, Green Light Team, day care and day hospital, DART, CAMHS and buddying service specialist psychological services as important.

Executive Summary

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

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

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

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

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

Communication, Awareness and Recognition

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

Community Based Services

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

Building-Based Services

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

Waiting Times, Transition and Pathways.

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

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

Introduction to Healthwatch

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

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

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

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

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

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

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

Watchdog. To ensure change is happening.

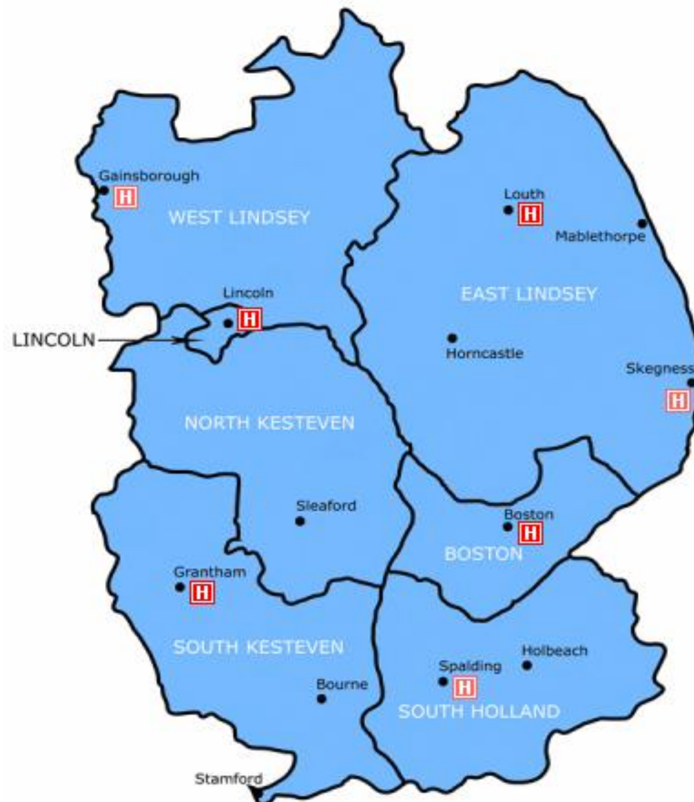
You can find out more about the work of Healthwatch Lincolnshire by visiting our website www.healthwatchlincolnshire.co.uk or contact us and a member of our team will be happy to discuss further.

A Brief Overview of Lincolnshire

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

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

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



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

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

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

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

Background to the Report

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

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

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

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

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

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

What is Mental Health?

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

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

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

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

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

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

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

[2] BBC Science

Methodology

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

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

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

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

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

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

Overview of Key Findings for Part 1

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

One young person said:

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

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

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

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

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

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

Overview of Key Findings for Part 2

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

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

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

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

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

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

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

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

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

Overview of Key Findings for Part 3 Seldom Heard Voices

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Additional Information

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

CAMHS – Children and Adolescents' Mental Health

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

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

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

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

What parents and young people told us?

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

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

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

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

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

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

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

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

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

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

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

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

Healthwatch Lincolnshire Response to the LPFT Summit

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

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

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

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

Freedom of Information Requests made by Healthwatch Lincolnshire

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

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

The requests made are as follows:

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

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

Conclusions

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

Lincolnshire Police, Hospital and Mental Health Trust Impact.

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

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

Concern for Safety within Public, Safety and Welfare.

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

Missing Person within Public, Safety and Welfare.

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

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

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

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

Healthwatch Lincolnshire Response to Suicide Prevention Strategy

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

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

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

Mental Health as a Secondary Consideration

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

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

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

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

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

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

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

Findings in Summary

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

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

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

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

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

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

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

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

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

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

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

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

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Conclusion

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

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

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

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

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

Distribution of this Report:

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

Report Authors:

Sarah Fletcher, Chief Executive Officer
Nicola Tallent, Senior Community Engagement Officer
Tim Barzycki, Adult & Children Social Care Engagement Officer
Dean Odell, Data Analyst
Angela Bentley, Centre Manager

Healthwatch Lincolnshire
Unit 12
1 – 2 North End
Swineshead
BOSTON
PE20 3LR
01205 820892

Please visit our website http://www.healthwatchlincolnshire.co.uk/
Follow us on Twitter@healthwatchlincs
Facebook: https://www.facebook.com/healthwatchlincolnshire

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