Lincolnshire COUNTY COUNCIL
Working for a better future

HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE
15 FEBRUARY 2017

PRESENT: COUNCILLOR MRS C A TALBOT (CHAIRMAN)

Lincolnshire County Council

Councillors R C Kirk, S L W Palmer, Miss E L Ransome, Mrs S Ransome, Mrs J M Renshaw, Mrs S M Wray, R L Foulkes and Mr P Keeling

Lincolnshire District Councils

Councillors P Gleeson (Boston Borough Council), Mrs P F Watson (East Lindsey District Council), J Kirk (City of Lincoln Council), C J T H Brewis (South Holland District Council (Vice-Chairman)), Mrs R Kaberry-Brown (South Kesteven District Council) and P Howitt-Cowan (West Lindsey District Council)

Healthwatch Lincolnshire

Mr P Keeling

Also in attendance

Liz Ball (Executive Nurse, South Lincolnshire CCG), Andrea Brown (Democratic Services Officer), Clare Credland (Integrated Clinical Services Lead, Lincolnshire Community Health Services NHS Trust), Simon Evans (Health Scrutiny Officer), Gary James (Accountable Officer, Lincolnshire East CCG), Sharon Jeffreys (Chief Commissioning Manager, South West Lincolnshire CCG), Allan Kitt (Chief Officer South West Lincolnshire CCG), Blanche Lentz (Lincolnshire Divisional Manager, East Midlands Ambulance Service NHS Trust), Jane Marshall (Director of Strategy and Performance, Lincolnshire Partnership NHS Foundation Trust), Sarah McKown (Head of Clinical Services, Lincolnshire Community Health Services NHS Trust), Linda Sanderson (Trust Manager, Butterfly Hospice), Neil Scott (Lincolnshire Assistant Divisional Manager, East Midlands Ambulance Service NHS Trust), Yvonne Slater (Chair of Trustees, Butterfly Hospice), Dr John Stephenson (Associate Medical Director, East Midlands Ambulance Service NHS Trust) and Chris Weston (Consultant in Public Health (Wider Determinants))

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

70 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

Apologies for absence were received from Councillor T M Trollope-Bellew and Dr B Wookey.

The Chief Executive reported that under the Local Government (Committee and Political Groups) Regulations 1990, he had appointed Councillor R L Foulkes and Mr P Keeling to the Committee in place of Councillor T M Trollope-Bellew and Dr B Wookey respectively, for this meeting only.

71 DECLARATIONS OF MEMBERS' INTERESTS

Councillor Mrs S M Wray advised the Committee that she was one of the founders of the Butterfly Hospice which was to be considered by the Committee at Agenda Item 6 – *The Butterfly Hospice, Boston*.

Mr P Keeling, Healthwatch representative, advised the Committee that he was a former Chairman of the Butterfly Hospice which was to be considered by the Committee at Agenda Item 6 – *The Butterfly Hospice, Boston*.

Councillor S L W Palmer advised the Committee that he was a LIVES First Responder and, when activated, was under the employment of the East Midlands Ambulance Service NHS Trust (EMAS), both of whom would be addressing the Committee at Agenda Item 5 – *East Midlands Ambulance Service Update and Performance* and Agenda Item 8 – *LIVES (Lincolnshire Integrated Volunteer Emergency Services) Status Report and Update.*

Councillor Mrs C A Talbot advised the Committee that she continued to be a patient of Nottingham University Hospitals NHS Trust but also under the care of a team at United Lincolnshire Hospitals NHS Trust.

Councillor Mrs P F Watson advised the Committee that she continued to be a patient of United Lincolnshire Hospitals NHS Trust.

72 CHAIRMAN'S ANNOUNCEMENTS

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

i) Congenital Heart Disease – Launch of Consultation

On 9 February 2017, NHS England launched the national consultation on Congenital Heart Disease services. The consultation would continue through the local government purdah period to 5 June 2017. The Chairman intended to discuss the arrangements for the Committee's response to the consultation as part of the Work Programme item. The overall length of the NHS England consultation materials was in excess of 200 pages.

The Chairman also reported that the General Meeting of the East Midlands Councils was considering this item at its meeting on 15 February 2017 which included a recommendation that all health overview and scrutiny committees in the East Midlands also make a robust response to the consultation.

It was noted that only two health scrutiny committees in the East Midlands had not provided a response therefore it was important that there was a united voice on this issue across the region.

The Chairman confirmed that no response had been received, from the Secretary of State for Health, to the letter asking why the Department had allowed a consultation during Purdah.

ii) East Midlands Ambulance Service - Care Quality Commission Inspection

The Care Quality Commission (CQC) had undertaken an inspection of East Midlands Ambulance Service (EMAS) in November 2015. For three days from 21 February 2017, the CQC would carry out a follow-up inspection to review areas of concern identified during their last inspection. The inspection would concentrate on those areas where the CQC had identified concerns including the Warning Notices, which had sought improvement in areas such as staff resourcing; response times; and hospital handover delays.

Progress with recommendations in the November 2015 CQC inspection was not covered in detail in the report at item 5 which would focus on response times in Lincolnshire.

iii) Louth Ambulance and Fire Station

Lincolnshire Fire and Rescue and the East Midlands Ambulance Service had decided to share an operational base on Eastfield Road in Louth from August 2017. A new ambulance and fire station would be located on the site of the existing fire station. This was a good example of collaboration between two blue light services.

iv) West Lindsey District Council Health Commission

The Chairman referred to a letter dated 26 January 2017, from Councillor Sheila Bibb, Chairman of West Lindsey District Council's Health Commission, and Manjeet Gill, Chief Executive of West Lindsey District Council. The letter explained the role of the West Lindsey Health Commission. The Chairman confirmed that the letter had been acknowledged and an explanation of the role of the Health Scrutiny Committee for Lincolnshire included. This also emphasised the importance of each district council representative on the Committee.

v) Referral to the Secretary of State – Grantham and District Hospital

On 10 February 2017, the Chairman wrote to the Rt Hon Jeremy Hunt MP, Secretary of State for Health, to pursue a response to the Committee's referral in relation to Accident and Emergency Services at Grantham and District Hospital, which had been received by the Department of Health on 20 December 2016. Whilst aware that the letter was under consideration by the Secretary of State and national organisations within the NHS, the Chairman remained disappointed that a written acknowledgement had not been received.

The Board of United Lincolnshire Hospitals NHS Trust met on 7 February 2017 and agreed to extend the opening times of Grantham Accident and Emergency Department by one year, from 8.00am until 6.30pm rather than opening at 9.00am. These arrangements would be reviewed in three months.

vi) Clinical Commissioning Groups Council Meeting

On 1 February 2017, the Chairman attended the Clinical Commissioning Group Council Meeting to present information on how the County Council's revised overview and scrutiny arrangements would work in the new Council term. The Health Scrutiny Officer also attended this meeting and was thanked by the Chairman for preparing the report presented to this meeting.

vii) Lincolnshire West Clinical Commissioning Group

On 7 February 2017, the Chairman met with Richard Childs (Chairman); Dr Sunil Hindocha (Chief Clinical Officer); and Sarah Newton (Chief Operating Officer) of Lincolnshire West Clinical Commissioning Group. On behalf of the Committee, the Chairman had written to Sarah Newton, prior to her imminent retirement, to thank her for her contributions to the Committee over the last few years.

viii) Visit to Butterfly Hospice in Boston

On 9 February 2017, the Chairman visited Butterfly Hospice in Boston, which would be considered by the Committee at Item 6 of the agenda. The Chairman was pleased to see how the six-bed inpatient facility was working and to form a view on the Hospice's plans for the future.

ix) MRI Scanner – Stamford and Rutland Hospital

Further to the announcement made at the meeting of the Committee in January 2017, the Chairman reported that the first patients had been offered appointments for the new MRI scanner at Stamford and Rutland Hospital on Monday 6 February 2017. Appointments were available every weekday from 7.30am to 8.00pm. Peterborough and Stamford Hospitals NHS Foundation Trust was preparing a briefing on this and other topics, such as progress on the merger with Hinchingbrooke Health Care, which would be circulated with the agenda for the March meeting.

x) United Lincolnshire Hospitals NHS Trust – Five Year Strategy Working Group

On 24 January 2017, the United Lincolnshire Hospitals NHS Trust Five Year Strategy Working Group met and gave further consideration to the ULHT Five Year Strategy.

xi) Delayed Transfers of Care Working Group

The Delayed Transfers of Care Working Group met on 2 February 2017. After consideration of the information, the Working Group concluded that it would be best that this topic be considered in the new Council term. The outcomes from the meeting had been recorded and circulated and the content would be considered as part of the work programme.

73 MINUTES OF THE MEETING OF THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE HELD ON 18 JANUARY 2017

RESOLVED

That the minutes of the meeting of the Health Scrutiny Committee for Lincolnshire held on 18 January 2017 be approved and signed by the Chairman as a correct record.

74 EAST MIDLANDS AMBULANCE SERVICE UPDATE AND PERFORMANCE

Consideration was given to a report by Blanche Lentz (Lincolnshire Divisional Manager, East Midlands Ambulance Service NHS Trust) which summarised the key areas of demand and performance within East Midlands Ambulance Service with particular reference to the Lincolnshire Division.

Blanche Lentz (Lincolnshire Divisional Manager, EMAS), Neil Scott (Lincolnshire Assistant Divisional Manager (EMAS) and Dr John Stephenson (Associate Medical Director, EMAS) were in attendance for this item.

The national performance standards, set for calls to ambulance services, was explained to the Committee as follows:-

- Red 1 – immediately life threatening calls – 7 minute response time from call received (target 75%) and 19 minute response time for conveying resource to scene (target 95%);
- Red 2 – life threatening calls – 8 minute response time from call received (target 75%) and 19 minute response time for conveying resource to scene (target 95%);
- Green 1 – serious but not life threatening calls – 20 minute response time from call received (target 85%);
- Green 2 – serious but not life threatening calls with no serious clinical need – 30 minute response time of 30 minutes of call received (target 85%);
- Green 3 – non-life threatening non-emergency call – telephone assessment within 20 minutes of call received (target 85%);
- Green 4 – non-life threatening non-emergency call – telephone assessment within 60 minutes of call received (target 85%).

The contractual arrangements for the Trust during 2016-17 provided an expected performance against Red1, Red2 and Red19. With approval from the Clinical Commissioning Groups in the East Midlands, the contractual targets had been set at a lower level than the national performance standards. Although EMAS was only required to meet response time performance across the Trust as a whole it was stressed that the local expectation was an increase in performance.

Nationally ambulance services were struggling with performance against the national trajectory and standards set and during quarter 3 of 2016/17, the Lincolnshire Division (including North and North East Lincolnshire) did not meet these standards. Ambulance Services across England continued to struggle with demand and the ability to meet the nationally set targets. Future changes set by the Ambulance

Response Programme nationally would also impact this position as the service migrated to the new method of coding and response by 2017-18.

In relation to Red Conversion rates for Quarter 3 performance at Clinical Commissioning Group level, the percentage was split between red and green calls. The Red Conversion rate provided a comparison between calls for the very unwell which necessitate a response within eight minutes, compared to calls for the moderately unwell where a response in excess of eight minutes was accepted.

The expected and forecast level to meet national performance standards was 42% of emergency calls and had an acuity level which necessitated an eight minute response. The increased red conversion rate above the level was a marker of increased acuity of 999 calls. The red conversion rate had steadily increased to a level of 58% in December 2016 which was significantly above the expected level for efficient delivery of service (42%). Analysis of these figures showed a steady increase in 111 red conversion over a twelve month programme.

Both *Hear and Treat* (HAT) and *See and Treat* (SAT) had increased with a concurrent decrease in *See, Treat and Convey,* which showed a reduction in conveyance to hospital over Quarter 3.

Hospital Handover Times for Quarter 3 indicated significant pressure with the highest proportion of one-two hour and two plus delays at Lincoln County Hospital. It was reported that 6,543 hours in total were lost during Quarter 3 due to turnaround delays at Lincolnshire Division or adjacent hospitals.

The staffing position had improved throughout Quarter 3 with an increase in rostered staff from circa 90% to 97%. Staff sickness remained the lowest across the wider Trust.

Following the CQC report and identified areas of improvement, the Trust had provided enhanced incident investigation training to Band 6 managers in order to provide a robust service when untoward incidents were reported. This was also concurrent with increased education of frontline staff on the definition of an untoward incident and what action was required to report them.

Statutory and Mandatory training and appraisals for frontline staff continued to be delivered and the Trust were confident that all would be complete by the end of the financial year. The skill mix of qualified ambulance staff had also been improved following an extensive and progressive recruitment campaign.

Incident commanders had also undertaken further training at the National Ambulance Resilience Unit to improve and enhance the response to a major incident scenario.

Plans were in development to move to an all-electronic patient report form service during 2017/18 in line with the forward vision set by NHS Digital. Medicines management compliance had been reviewed and the process changed which had resulted in the lowest recorded number of medication errors across all divisions of EMAS.

The ambulance fleet was continually updated and the Lincolnshire Division had recently taken delivery of 10 new ambulances which continued to provide Lincolnshire with quality and visually upgraded vehicles.

Engagement with partners and agencies continued to build as noted:-

- United Lincolnshire Hospitals NHS Trust had collaborated on an improved handover process for emergency departments which would continue into 2017/18. Support was also provided to ULHT during the current temporary overnight closure of Emergency Department services at Grantham Hospital;
- Lincolnshire Partnership NHS Foundation Trust (LPFT) have worked with EMAS to develop a number of ongoing work streams including the establishment of the mental health triage car which continued to provide assistance to patients where the default of an emergency department was not appropriate for their current condition. In addition, work was ongoing to develop a frequent caller project;
- The working relationship with Lincolnshire Community Health Services NHS Trust (LCHS) was extremely close and had resulted in continued development and enhancement of the Clinical Assessment Service to improve access to the Urgent Care system; and
- Police and Fire colleagues regularly shared learning and training through the national JESIP Programme and through collaborative working in Lincolnshire Resilience Forums. Financial efficiency and quality improvement through the shared premises programme "blue light campus".

The operational restructure of EMAS was also reported which was intended to provide an enhanced clinical leadership response to critically ill patients whilst providing greater face-to-face management for frontline clinicians.

The response times were further explained to the Committee for ease of consideration of the report:-

1. The clock was initially started when the call connected to the switchboard prior to being answered;
2. Initial discussion with the call handler would ascertain if the patient was conscious or breathing;
3. If yes, an extra minute was allocated to find out what the problem may be, therefore the start time is either 0 seconds or 60 seconds;
4. The clock would stop (for RED1 or RED2 calls) when a responder with a defibrillator reached the patient; and the clock would stop for a RED19 call was when an ambulance arrived capable of conveying the patient to hospital.

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

- It was acknowledged that the use of emergency ambulances to take patients home, following hospital treatment did occur in some cases, however, it was

not to be promoted. A third party provider was responsible for patient transport in Lincolnshire. An exception to this was where a person wished to return home to die then the ambulance would undertake that journey with the patient to ensure clinical safety;

- Ten new ambulances had been allocated to the Lincolnshire Division, the older vehicles had also been retained. In addition, all maintenance work was done within the divisions rather than one central place in the East Midlands which had further reduced 'vehicle off the road' times;
- When ambulances were engaged, an email was sent by EMAS to GPs, coroners and any other required professionals. However, there was no way to guarantee that these emails had been read. The method of communication was that emails were sent to one central point and redistributed to health professionals. It was then noted that the email had been delivered whereas there was no confirmation that the previous method of faxing information had been delivered;
- The standard mobile network across the county was currently used with the existing Toughbooks gathering information as and when signal was available. Radios for the emergency services were to be replaced on a rolling programme from 2019 and it was expected that the Toughbooks would link to the data provided by the radios;
- It was suggested that the triage car, based in Lincoln, would not travel to the south of the county if there was an issue with, for example, a drugs overdose. In some of these cases, police officers had transported these patients to the nearest appropriate unit, generally in Lincoln. It was acknowledged that there had been reports of incidents of this type which, when investigated fully, were found not to be as initially reported. The triage car worked only between the hours of 4.00pm and 2.00am and some of these incidents had occurred out of those hours. It was agreed that the police should not be transporting patients, however it was stressed that there was only so much resource available and that, on occasion, ambulance crews were called, inappropriately, to incidents of assaults;
- Appendix C to the report showed the number of vehicles at hospital over quarter 3 but the figures had a number of parameters attached to them and further clarity was requested. The Committee asked that consideration be given to the presentation of these figures in future reports to ensure that the figures were clear;
- After patients had been passed to Accident and Emergency staff at hospitals, crews were allowed 15 minutes to restock, tidy and clean the ambulance and take a comfort break ready for the next call. Crews in the Lincolnshire Division took less than 15 minutes overall. Staff were able to observe patients undergoing resuscitation, for ongoing development, should authorisation be given which meant crews may be at an Accident and Emergency site for over an hour. Staff were encouraged to stay and watch procedures as this contributed to 'on-the-job' training;
- Despite the performance figures and report presented, one Member of the Committee expressed thanks to EMAS and highly commended the crews, having had personal experience over recent weeks. The crews and hospital staff had worked non-stop to provide the most appropriate care and the

Committee were asked to recognise the endeavours of the staff, in this challenging time;

- Concern was noted that the performance levels had been reduced as Commissioners were aware that national standards could, and would, not be met. By setting local performance requirements as part of the contract, EMAS had been given realistic targets;

At 11.20am, Councillor Miss E L Ransome left the meeting.

- The time difference between a LIVES first responder arriving at a scene and a professional, including an explanation of the impact on the system and reporting, was requested;
- Full training was provided to all crews on the Toughbooks, however those who identified the need for further training were given extra support. Staff within the hospitals would also be available for further support and by the end of 2017 it was expected that all crews would be using this equipment, which was mandatory;
- The Hospital Ambulance Liaison Officer (HALO) was not a funded role within the hospital but an ambulance manager who had been given that title. This was an attempt to turn crews around faster and this officer would liaise with the nurses in charge. The Committee was asked to note that this role was in support of the hospital but that the person in this role was an ambulance manager who should be otherwise supporting ambulance staff;
- Although a regional service, the 'drift' from Lincolnshire into neighbouring counties had been a major concern over the last year. It was reported that this had reversed in Quarter 3 which meant Lincolnshire had been in a much better position than in previous quarters.

At 11.37am, Councillor Mrs P F Watson left the meeting.

The Chairman thanked EMAS representatives for their attendance and presentation and requested that an update be added to the Committee's work programme for the meeting scheduled for Wednesday 20 September 2017.

RESOLVED

1. That the report and content be noted; and
2. That a further update be added to the Committee's work programme for 20 September 2017.

At 11.40am, Councillor J Kirk left the meeting.

75 THE BUTTERFLY HOSPICE, BOSTON

Consideration was given to a report by Lincolnshire Community Health Services NHS Trust and Butterfly Hospice which provided information on the Butterfly Hospice in Boston. The Hospice opened to patients in 2014 and the report also included information about the planned future developments for the Hospice.

At 11.46am, Councillor J Kirk re-entered the meeting.

Sarah McKown (Head of Clinical Services, Lincolnshire Community Health Services NHS Trust), Clare Credland (Integrated Services Lead, Lincolnshire Community Health Services NHS Trust), Linda Sanderson (Butterfly Hospice Trust Manager) and Yvonne Slater (Chair of Trustees, Butterfly Hospice) were in attendance for this item.

Sarah McKown (Head of Clinical Services, Lincolnshire Community Health Services NHS Trust) introduced the report which noted that in the Hospice's full year (2015) 106 patients had been admitted. Admissions had increased to 161 for 2016.

At 11.50am, Councillor Mrs P F Watson re-entered the meeting.

Following a meeting with 600 Boston residents in September 2000 to discuss the need for palliative care in the local area, a Trustee Board was formed for the Butterfly Hospice Trust. The Trust was now both a registered charity and a private limited company as this status meant that individual Trustees and employees could not be liable for business debts. Initial fundraising had resulted in £1.2m being raised, which meant the Hospice could be built and, in March 2009, NHS Lincolnshire committed to commission twenty-two additional community inpatient beds across Lincolnshire for service users identified as end of life. The building opened in 2011 and six inpatient beds were commissioned by Lincolnshire East Clinical Commissioning Group (LECCG) and a three year partnership agreement put in place between the Butterfly Hospice and Lincolnshire Community Health Services NHS Trust (LCHS) in August 2014.

Care was delivered with a nurse-led model with GP input. LCHS provided the nursing care and the Butterfly Hospice Trust agreed to raise the funds to cover all operational and maintenance costs associated with the building. Chefs and housekeeping staff were also employed and WiFi had also been installed for the benefit of patients and visitors.

Key principles of care were followed by the Hospice to ensure End of Life Care Service Users:-

- Were treated with dignity and respect at all times;
- Received effective symptom management whatever the diagnosis;
- Had choice and control over where they would prefer to die; and
- Were in the company of people who cared about them when they died.

The expected outcomes of the Hospice were explained:-

- Increased quality of life for Service Users through the reduction of distressing symptoms;
- Increased Service User and Carer/family satisfaction of the service;
- Increased numbers of Service Users who would achieve their Preferred Priorities of Care (PPoC);
- Increased numbers of Service Users who would achieve their Preferred Priorities of Death (PPoD);

- An Advanced Care Plan to be in place for all Service Users;
- Increased numbers of non-cancer Service Users accessing services;
- Reduced numbers of deaths in acute hospitals; and
- Reduced strain and anxiety of Carers in the short term.

The referral criteria for the Butterfly Hospice were noted:-

- The referring clinical professional shall have answered "no" to the 'surprise question' of *"Would you be surprised if this Service User were to die in the next six-twelve months?"* from the Prognostic Indicator Guidance, the Gold Standard Framework;
- Service Users wishing to return to their home or usual residence, e.g. care home;
- Service Users shall be registered with a Lincolnshire East GP Practice; and
- The Service User had needs identified under one of the following two categories:-
    - Palliative and End of Life/Terminal Care; and
    - Respite Care.

Meetings were held on a quarterly basis between the management teams of the Butterfly Hospice Trust, Lincolnshire Community Health Services NHS Trust and Lincolnshire East CCG to review quality issues and Key Performance Indicators (KPIs). Current KPIs included:-

- Patient, family and carer experience and satisfaction;
- Reduction in transfers to acute providers;
- Increased numbers of non-cancer patients accessing the service;
- Case management and recognition of GSF;
- Preferred place of death and care;
- Length of stay 14 days, review of longer stays and bed occupancy; and
- Staffing turnover and sickness.

Between 11 and 17 patients had been admitted every month with an average length of stay at 10/11 days with admissions from either acute hospitals or the patient's own home. Patients continued to be predominantly cancer patients for both respite and terminal care and the main referrers from allied health care professionals, community nursing teams and Macmillan and specialist nursing staff. The Committee noted that fewer patients were referred from GPs and only very small numbers of referrals considered inappropriate.

The number of deaths ranged between three and ten per month. The number of discharges and deaths were reported monthly and those figures included whether the Hospice was the preferred place. Where it was not possible to ascertain the patient's wishes, this was reported separately.

The Hospice was pleased to report that they were in receipt of frequent accolades and had not received any formal complaints or been required to escalate any serious incidents.

Challenges and risks for the future included:-

- Bed occupancy – promotion of the services available to health professionals to raise professional awareness was constantly required;
- A two-bedded room was available in addition to four single rooms which could not, on occasion, be fully utilised due to single sex accommodation requirements;
- GPs had been identified who did not utilise the GSF which identified a potential risk of suitable patients not being notified of the services available which impacted on the utilisation of beds;
- Momentum needed to continue to raise the profile of the Hospice via collaborative work to ensure a sustainable future;
- The current contract was scheduled to end on 31 August 2017 and meetings had been arranged to progress contracting arrangements and agree future requirements;
- Criteria for Admission – Consideration was being given to the current restrictions due to GPs in locality to provide flexibility if needed for patients out of area; and
- Workforce Model – work was ongoing to ensure a sustainable and appropriate skills mix in order to meet the needs of the service and to create resilience within the team. Active recruitment was underway.

The Butterfly Hospice also received income from four shops, two of which were based in Boston, one in Spalding and another in Skegness.

The aspirations of the Hospice were to build a further wing which would provide a range of day services and complementary therapies. It was anticipated that the capital appeal for funds would commence in October 2018. The website was also being updated to enable online ticket sales for events in addition to the ability to make donations online. Development of existing fundraising events continued and the Trust had employed a full-time Fundraising and Events Manager in addition to a part-time Corporate Grants and Trust Officer.

There was potential for growth in the service in line with pathways offered in other inpatient services. Single intervention pathways were developed for use in Community Hospitals and interventions, including pre-planned infusions or assessments could be safely delivered in the Hospice with the appropriate acute/community arrangements, treatment plans and staff skill mix in place.

The Hospice also planned to continue partnership working with a view to increasing opportunities within Integrated Neighbourhood Teams and assurance of sustainable provision for local patients.

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

- It was confirmed that Lincolnshire Community Health Services NHS Trust provided the clinical care for the Hospice;

- In relation to bed occupancy, it was agreed that when looked at in a statistical form, it would appear that the Hospice was never at full occupancy. However, it was explained that the Hospice was full most of the time. Should two beds become free, due to the death of a patient or the patient being discharged to home, this could show a 66% occupancy on any one day but earlier in the same day occupancy could be 100%;
- Despite being fully utilised every day, Nurses within the Hospice regularly consulted the waiting list and palliative care list at Pilgrim Hospital to proactively offer any beds which became available;
- GP referrals were uncommon as each patient who needed this type of care was considered during palliative care meetings between GPs, community and Macmillan nurses and was the main source of referral;
- The proposal for future developments was not to increase the bed space within the Hospice but to provide additional facilities including a staff room and shower facilities; a family room to enable families to stay overnight; a larger dining area; and rooms to provide services to the community, for example, pre-planned infusions;
- Joint work was ongoing with St Barnabas Hospice to consider the public perception in relation to hospices and how that perception could be changed;
- The income from the four shops was not restricted and was used where needed. All monies, whether from shops, fundraising, corporate sponsorship or individuals was used for overheads and whatever was left was used for chefs and housekeepers, etc.;
- Although income had increased significantly over the last year, the Committee was assured that there would be no capital appeal for expansion started unless the Hospice and Commissioners were confident that there was enough income to run those services;

At this point of the proceedings Mr P Keeling, Healthwatch Representative, declared that he was a former Chairman of the Butterfly Hospice and was currently the Chief Executive of the Respite Association.

- There appeared to be a huge gap in services for respite care provision and it was suggested that hospices may be able to amend their constitutions to include the provision of respite care;
- Social media was important for the promotion of the Hospice and to provide information for residents who were entitled to the care provided but who were unaware of its' existence and/or that the care was without charge;
- LCHS were working with a number of care homes within Lincolnshire as well as other partners, including United Lincolnshire Hospitals NHS Trust (ULHT), Lincolnshire Partnership NHS Foundation Trust (LPFT) and social care to ensure that they were also aware of what the Hospice could offer and if any of their patients was suitable for a place;
- Continued promotion of the Hospice as an option for acute providers was ongoing.

The Chairman gave thanks for the presentation and advised that the Committee was reassured that wraparound care was also available to patients and families.

RESOLVED

1. That the report and contents be noted; and
2. That visits to the Butterfly Hospice for the Committee be arranged.

76 LEARNING DISABILITY SERVICES

Consideration was given to a report from Jane Marshall (Director of Strategy and Performance, Lincolnshire Partnership NHS Foundation Trust (LPFT)) which provided information on the proposed options on the future model of Learning Disability Services for the people of Lincolnshire.

Jane Marshall (Director of Strategy and Performance, Lincolnshire Partnership NHS Foundation Trust), Allan Kitt (Accountable Officer, South West Lincolnshire Clinical Commissioning Group) and Sharon Jeffreys (Chief Commissioning Manager, South West Lincolnshire Clinical Commissioning Group) were in attendance for this item.

Jane Marshall (Director of Strategy and Performance, LPFT) introduced the report by giving the background to the proposed options. Section 242 of the Health and Social Care Act 2016 was a statutory requirement for NHS bodies to consult with Overview and Scrutiny Committees, patients, public and stakeholders when consideration was given to a proposal for the substantial development of the health service or a substantial variation in the provision of a service. Prior to 2015, learning disability services in Lincolnshire consisted of Long Leys Court (Lincoln), a unit of 16 beds with eight assessment and treatment beds and eight rehabilitation beds. Community services included a dispersed range of health professionals located across the county.

In June 2015, Long Leys Court was closed temporarily following safety concerns of the unit. The decision was taken by Lincolnshire Partnership NHS Foundation Trust (LPFT) with the Clinical Commissioning Group and in partnership with the patients and carers/families of people within the unit at the time. The temporary closure meant that the progress with the national Transforming Care programme was accelerated to enable a new model of care to be introduced.

Since 1 April 2016, a new fully developed integrated community service had been running effectively which had stopped waiting times between professionals, ensured most patients were treated at home and provided equal services across the county. The service was delivered across Lincolnshire by a total of five multi-professional teams. Four community hubs were also aligned with the Clinical Commissioning Groups with satellite bases around the county to reduce travel and to ensure local service delivery.

Following the successful implementation of the new model of care, LPFT believed that there was no longer a requirement for an inpatient unit such as Long Leys Court. To ensure the best service was available to Lincolnshire residents, a consultation with stakeholders was required on the options for providing inpatient beds for the small number of people who needed that level of care.

The improvements to learning disability services had originally been planned to be part of the Lincolnshire Health and Care public consultation, however due to the successful implementation of the new service model, both the Transforming Care Board and Senior Managers from the service provider felt that it would be appropriate to carry out a focussed consultation with immediate effect.

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

- The Transforming Care Agenda clearly stated that all patients must undergo a full review to decide if admission to hospital was required and, if deemed necessary, that this be as short a stay as possible. Patients were previously hospitalised because they had a learning disability and this was not now the case as it was more beneficial for patients of this type to remain at home;

At 12.45pm, Councillor B W Keimach left the meeting and did not return.

- In relation to the small percentage of patients placed out of county, at the present time, it was reported that one Lincolnshire patient had been admitted to a specialist ward in Mansfield, one in Hull and another with a private provider in Lincolnshire;
- Since the closure of Long Leys Court and the implementation of the Transforming Care Agenda, 90% of potential admissions had been avoided. Although this was challenging for staff there was a sense of achievement that people had been able to remain at home;
- It was suggested that the use of closed questions within the consultation would restrict a full response. It was explained that the questions had been constructed in such a way so as to enable people with learning disabilities to answer them. Comments and suggestions from the Committee to improve these questions were welcomed but the Committee was asked to respect the notion that, for those people with learning difficulties, a different approach to the questions may be required.

In summing up, the Chairman asked the Committee to consider the proposed length of the consultation and if the suggested eight week consultation was appropriate or whether this should be kept in line with the Sustainability and Transformation Plan and be 13 weeks.

RESOLVED

1. That the report and contents be noted; and
2. That the length of the consultation be recommended by the Committee to remain parallel with the Sustainability and Transformation Plan and be open for 13 weeks.

The Chairman adjourned the meeting for lunch at 12.45pm and asked the Committee to reconvene at 2.00pm.

NOTE: At 2.00pm, the Chairman reconvened the meeting. On return, the following Members and Officers were in attendance:-

Lincolnshire County Council

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

Lincolnshire District Councils

Councillors P Gleeson (Boston Borough Council), Mrs P F Watson (East Lindsey District Council), J Kirk (City of Lincoln Council), C J T H Brewis (South Holland District Council (Vice-Chairman)), Mrs R Kaberry-Brown (South Kesteven District Council) and P Howitt-Cowan (West Lindsey District Council)

Healthwatch Lincolnshire

Mr P Keeling

Also in attendance

Liz Ball (Executive Nurse, South Lincolnshire CCG), Andrea Brown (Democratic Services Officer), Simon Evans (Health Scrutiny Officer), Nikki Silver (Chief Executive Officer, LIVES), Dr Simon Topham (Clinical Director, LIVES) and Chris Weston (Consultant in Public Health (Wider Determinants))

77 LIVES (LINCOLNSHIRE INTEGRATED VOLUNTEER EMERGENCY SERVICES) STATUS REPORT AND UPDATE

Consideration was given to a report from Nikki Silver (Chief Executive Officer, Lincolnshire Integrated Volunteer Emergency Services (LIVES)) which provided a status report and update on services provided by LIVES.

Nikki Silver (Chief Executive Officer, LIVES) and Dr Simon Topham (Clinical Director, LIVES) were in attendance for this item.

Dr Simon Topham (Clinical Director, LIVES) introduced the report which explained that LIVES was a charity in its 48th year of operation and which held the charitable objectives noted below:-

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

Responders were organised into operational groups based on a response time of approximately six minutes under normal driving conditions. There were over 160 responder groups across Lincolnshire with around 700 active LIVES Community First Responders and LIVES Medics. The service had responded to almost 21,000 emergency calls in 2016 which was an increase of approximately 15% on the previous year. It was expected that this would continue to increase.

LIVES appointed its first Chief Executive Officer in recognition that the organisation had reached a level where strategic development was required to respond to the ever-growing demand for health and care within a resource-limited NHS.

On receipt of a 999 call within a responder's area, East Midlands Ambulance Service NHS Trust (EMAS) would despatch an emergency ambulance with a response category determined by the AMPDS computer-based triage system. At the same time, the EMAS Community First Responder (CFR) desk would activate the LIVES responder 'on-duty'. The responders were dispatched using a response 'isochrones map' determined by an ability to get to the patient within six minutes. The schema leads to the responder:-

- Clearing and controlling the airway of an unconscious patient;
- Providing resuscitation and defibrillation;
- Giving oxygen therapy;
- Controlling any bleeding;
- Taking observations; blood pressure, blood glucose, temperature, respirations and pulse;
- Being the 'eyes and ears' of the ambulance service and feeding back information to control if the situation is not as initially expected;
- Making the patient feel more comfortable and at ease; reassuring worried relatives and taking charge of the situation; and
- Using local knowledge to ensure that the ambulance can find the location quickly.

Responders made the biggest impact on calls coded by the AMPDS system as RED1 or RED2 calls which had been deemed "serious and/or life threatening". Examples of RED calls were:-

- Signs of cardiac arrest;
- Unconsciousness and collapse;
- Chest pains (for example, heart attack and acute angina);
- Breathing difficulties (for example, asthma);
- Diabetic emergencies (for example, hypoglycaemia);
- Fitting or convulsions (for example epilepsy);
- Stroke;
- Anaphylaxis (severe allergic reaction); and
- Choking.

More experienced volunteers also respond to traumas and some to road traffic collisions and made the early assessment if additional resources were required.

LIVES medics had been voluntarily providing advanced pre-hospital emergency care since the inception of the charity in the early 1970s. These members were qualified healthcare professionals; doctors, nurses, paramedics and technicians who freely offered their spare time to respond to 999 calls when available. Medics may attend the following types of incidents:-

- Life-threatening medical emergencies;
- Cardiac arrest;
- Paediatric emergencies;
- Road traffic collisions;
- Major trauma;
- Major incidents; and
- Respond to requests for on-scene advanced clinical support.

It was reported that 18.8% of EMAS RED calls were attended by a LIVES CFR. Although the contribution to EMAS performance had reduced over the last year, the actual number of calls attended had increased by 3,628. Work was ongoing with NHS commissioners to understand the reason for this.

In 2016, LIVES responders achieved a ROSC (return of spontaneous circulation) rate of 31.8% in patients attended. This was a significant improvement on the national average of 10-13% and could be attributed to a number of factors including geographic reach, responder availability and a focus on training to ensure volunteers were well equipped.

LIVES was dependent on generating income to enable volunteers to deliver this level of response. Delivery of LIVES services cost in excess of £1m. Lincolnshire CCGs provided £307k of funding under a contract to deliver the CFR service although no funding was received for medic response or the new CAS response. This income was generated through fundraising and commercial activities.

Two grants had been awarded, totalling £29k, to fund the development of a Cycle Response Unit (CRU) in the Lincoln shopping centre and also to facilitate the delivery of CPR training to secondary schools in the area.

Disappointingly, LIVES was unsuccessful in securing a grant from the LIBOR funds distributed by the Chancellor of the Exchequer in the Autumn Statement. These grants were available to military and emergency services charities and, despite the submission of a bid for £850k to fund monitoring equipment for volunteer medics, this had been rejected due to concerns around additionality due to the close working with the NHS and the size of the grant in proportion to the turnover of the organisation. The Chief Executive was currently meeting with MPs in Lincolnshire to secure support for a future funding bid.

As a progressive organisation, ongoing development projects included:-

- Clinical Assessment Service;
- Lincoln Cycle Response Unit;
- Ongoing development of volunteers;

- Pilot of LIVES volunteers on the CFR dispatch desk at EMAS;
- A pilot of a smartphone APP for dispatch of responders;
- Introduction of telemedicine and advanced monitoring capability for medics; and
- LIVES 2017/18 CQUIN proposal to train and equip responders to undertake near patient urine testing.

An additional element of the work of LIVES was the commitment to education and sharing skills both with healthcare colleagues and the wider community. Two key developments included providing CPR training to schools, youth and community organisations and to provide full training to those volunteers content with providing a Level 1 response only.

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

- The Committee was disappointed that the bid for a LIBOR Grant had been unsuccessful and it was explained that this may be due to profile. LIVES was the only organisation of its kind in the country and it was suggested that more detail was required within future bids to ensure decision-makers understood what exactly the service provided;
- Although there were other community co-responder schemes throughout the country, the level of service provided in Lincolnshire was very different;
- Following a meeting with EMAS, LIVES had requested data to enable a comparison of the calls responded to by LIVES rather than EMAS;
- It was confirmed that any funding received was not used to pay responders, these were very much volunteers. The funding was for equipment and training to ensure the best and safest level of service was given;
- The motivation for LIVES was to provide support to communities and not to alleviate pressure from EMAS although any pressure taken from EMAS in this current climate was acknowledged as a bonus;
- Responders were trained to different levels depending on their own personal drive. Some responders had become 'train the trainers' which would help people to retain skills and remain competent;
- The impact of the service needed to be better promoted and it was intended that LIVES would contact every parish; district, town; and county councillor in addition to all county MPs to provide detailed information on what they do;
- An application was also being prepared to bid for the Coastal Community Fund as the coastal area was an area which needed further recruitment and coverage;

At 2.57pm, Mr P Keeling left the meeting and did not return.

- The Road Traffic Act allowed medics who were required to travel some distance to be 'blue light' trained but there was no provision for responders to do the same. This type of training and equipment could cost in the region of £3500 for each responder which was prohibitive although it was being considered for some areas which were regularly gridlocked;

- A suggestion was made to make arrangements to celebrate the 50th Anniversary of LIVES in 2019 and to continue to raise the profile across the county. This could include contacting past fundraisers to take part. Responders and volunteers were intent on helping their communities, however it was agreed that more needed to be done to celebrate the achievements and to promote the continued endeavours of LIVES.

The Chairman encouraged discussions with the seven Lincolnshire MPs and also suggested requesting an opportunity to give a presentation in London, to the Chancellor of the Exchequer, prior to the next round of LIBOR bids. The Chairman also suggested to the Committee that a letter be written to the Chancellor of the Exchequer to express the Committee's disappointment that the bid submitted by LIVES for LIBOR funding had been rejected.

RESOLVED

1. That the report and comments be noted; and
2. That the Chairman, on behalf of the Committee, write to the Chancellor of the Exchequer to express disappointment at the rejection of the bid for LIBOR funding.

78 WORK PROGRAMME

Consideration was given to a report by the Health Scrutiny Officer which gave the Committee the opportunity to consider its work programme for the coming months.

During consideration, the Committee was also asked to consider the Outcomes of the Delayed Transfers of Care Working Group, which had been circulated to the Committee prior to the meeting.

The Chairman also invited volunteers for a working group to discuss the planned Consultation by NHS England on Congenital Heart Disease Services prior to the next meeting of the Committee on 15 March 2017. NHS England would be in attendance at the next meeting, hence the need to hold this meeting in the next two to three weeks. Councillors J Kirk, C J T H Brewis, S L W Palmer, P Howitt-Cowan, Mrs R Kaberry-Brown agreed to join the Chairman on this working group and a date was agreed for Wednesday 1st March 2017 at 10.00am. An appointment and relevant paperwork would be provided in due course.

RESOLVED

1. That the work programme be agreed;
2. That the conclusion of the Delayed Transfers of Care Working Group to hold a detailed review in the new council term be supported;
3. That the Congenital Heart Disease Consultation Working Group, with the Members noted above, be arranged for Wednesday 1st March 2017 at 10.00am.

The meeting closed at 3.30 pm