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

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A Meeting of the Health Scrutiny Committee for Lincolnshire will be held on Wednesday, 20 April 2016 at 10.00 am in Committee Room One, County Offices, Newland, Lincoln LN1 1YL

MEMBERS OF THE COMMITTEE

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

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

Healthwatch Lincolnshire: Dr B Wookey

AGENDA

Item	Title	Pages
6	**Urgent Care Update** *(To receive a report from Sarah Furley (Urgent Care Programme Director – Lincolnshire East Clinical Commissioning Group) which provides the Committee with an update on urgent care in Lincolnshire. Gary James (Accountable Officer – Lincolnshire East Clinical Commissioning Group) will be in attendance for this item)*	25 - 32
7	**Pharmacy and Medicines Optimisation Services at United Lincolnshire Hospitals NHS Trust** *(To receive a report from Colin Costello (Director of Pharmacy and Medicines Optimisation – United Lincolnshire Hospitals NHS Trust (ULHT)) which provides the Committee with details of the processes in place to ensure the delivery of the Hospital Pharmacy Transformation Programme (HPTP) and the commitment of ULHT to redesign infrastructure through the planned implementation of electronic prescribing systems by 2020. Colin Costello (Director of Pharmacy and Medicines Optimisation – United Lincolnshire Hospitals NHS Trust) will be in attendance for this item)*	33 - 36
8	**Emergency Planning - Exercise Black Swan** *(To receive a report from Cheryl Thomson (Public Health Programme Officer, Health Protection – Lincolnshire County Council) which provides the Committee with feedback on the lessons learnt following Exercise Black Swan, an annual multi-agency exercise run by the Local Resilience Forum (LRF). Cheryl Thomson (Public Health Programme Officer – Lincolnshire County Council) and David Powell (Head of Emergency Planning – Lincolnshire County Council) will be in attendance for this item)*	37 - 70
	LUNCH 1.00PM - 2.00PM	
9	**St Barnabas Lincolnshire Hospice** *(To receive a report from Chris Wheway (Chief Executive – St Barnabas Hospice Trust) which provides the Committee with an update on Palliative and End of Life Care which has been delivered by St Barnabas Hospice Trust since 1979 to improve end of life care for the people of Lincolnshire. Chris Wheway (Chief Executive – St Barnabas Hospice Trust), Jane Bake (Director of Service Innovation and Integration – St Barnabas Hospice Trust) and Michelle Webb (Director of Patient Care – St Barnabas Hospice Trust) will be in attendance for this item)*	71 - 82
10	**Community Pharmacy in 2016/17 and Beyond - Views of the Lincolnshire Local Pharmaceutical Committee** *(To receive a report from Simon Evans (Health Scrutiny Officer) which asks the Committee to consider the potential impact of the funding reductions to community pharmacies in Lincolnshire. Steve Mosley (Chief Officer – Lincolnshire Local Pharmaceutical Committee) will be in attendance for this item)*	83 - 90

Item	Title	Pages
11	**Work Programme** *(To receive a report from Simon Evans (Health Scrutiny Officer) which invites the Committee to consider its work programme for the coming months)*	91 - 96

Tony McArdle
Chief Executive
12 April 2016

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HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE
16 MARCH 2016

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, T M Trollope-Bellew, Mrs S M Wray and S Weller.

Lincolnshire District Councils

Councillors G Gregory (Boston Borough Council), J Kirk (City of Lincoln Council), T Boston (North Kesteven District Council), C J T H Brewis (South Holland District Council (Vice-Chairman)) and Mrs R Kaberry-Brown (South Kesteven District Council).

Healthwatch Lincolnshire

Dr B Wookey.

Also in attendance

Katrina Cope (Senior Democratic Services Officer), Simon Evans (Health Scrutiny Officer), Dr Tony Hill (Executive Director of Community Wellbeing and Public Health), Rob Harvey (Divisional Manager, Adult Community Health, Lincolnshire Partnership NHS Foundation Trust), Jane Marshall (Director of Strategy and Performance, Lincolnshire Partnership NHS Foundation Trust), Lynne Moody (Director of Quality and Executive Nurse, South Lincolnshire CCG), Tracy Pilcher (Chief Nurse, Lincolnshire East CCG) and Dr Tracey Swaffer (Head of Adult Clinical Psychology and Psychotherapies Service, Consultant Clinical Psychologist).

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

90 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

An apology for absence was received from Councillor D P Bond (West Lindsey District Council).

It was agreed that the Democratic Service Officer would contact District Councils highlighting the need to ensure continuity of membership was maintained from District overview and scrutiny representatives.

Councillor S Weller (East Lindsey District Council) joined the meeting at 10.10am as the replacement member for Councillor Mrs P F Watson (East Lindsey District Council).

91 DECLARATIONS OF MEMBERS' INTERESTS

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

92 CHAIRMAN'S ANNOUNCEMENTS

The Chairman thanked everyone for their messages of support during her period of absence. The Chairman also expressed her thanks to Councillor C J T H Brewis, Vice Chairman of the Health Scrutiny Committee for Lincolnshire for chairing the last meeting.

Further to the announcement above, the Chairman welcomed everyone to the Committee and made the following announcements:-

i) New Springwells GP Practice

The Committee was advised that the New Springwells GP Practice in Billingborough was the first GP practice in the County to have been given an outstanding rating by the Care Quality Commission, who had published their inspection report on 25 February 2016. The Committee was advised further that so far in Lincolnshire, 42 GP practices had received ratings under the CQC's revised rating system, introduced in October 2014. It was reported that the new Springwells GP Practice, situated in the South West Lincolnshire CCG area, provided services for 6,200 patients. The Chairman extended congratulations to the New Springwells Practice on achieving the outstanding rating and looked forward to other practices in Lincolnshire being awarded this rating.

ii) Carholme Court, Long Leys Road, Lincoln

It was reported that Lincolnshire Partnership NHS Foundation Trust was looking at options for developing a Psychiatric Intensive Care Unit at Carholme Court, which would be situated at the front of the St George's Hospital site on Long Leys Road, Lincoln. The Trust was planning to hold a community information event for local residents on 30 March between 5.30pm and 7.30pm.

The Chairman advised that a request would be made for volunteers to attend the event under the Work Programme item later on in the agenda.

It was also highlighted that a Psychiatric Intensive Care Unit (PICU) was a psychiatric inpatient ward, with higher staffing levels than on a normal acute ward. The PICUs would provide more intensive support to patients with complex needs who could not be managed on open psychiatric wards.

The Committee noted that the planning application was for the Trust to extend the current building, to potentially provide a ten-bed unit on the existing site.

iii) Dean Fathers, Chairman of United Lincolnshire Hospitals NHS Trust

The Committee was advised that on 2 March 2016, the United Lincolnshire Hospitals NHS Trust had announced the appointment of Dean Fathers as their new chairman. Dean Fathers was chairman of Nottinghamshire Healthcare NHS Foundation Trust and would be continuing in his role there.

It was highlighted that Dean Fathers was replacing Ron Buchanan, who was retiring at the end of February after two years with the Trust. Dean had started his two year term of office on 5 March 2016, and was looking forward to working with staff, partners, patients and carers to make a positive difference.

The Chairman advised the committee, that she would try and arrange a meeting with the new Chairman, Dean Fathers.

iv) Sue Noyes, Chief Executive, East Midlands Ambulance Service

The Committee was reminded that at the last meeting, it had been reported that Sue Noyes, the Chief Executive of the East Midlands Ambulance Service, would be leaving EMAS for personal family reasons in June 2016. It was reported that due to personal circumstances, Sue would now be leaving EMAS on 17 March 2016. The Committee extended their thanks to Sue for all her efforts over the last two and a half years; and the Chairman advised the Committee that she would be write to Sue to pass on the Committee's thanks.

The Committee was also advised that Pauline Tagg, the Chairman of EMAS, had started discussions with NHS Improvement about its future leadership arrangements. In the meantime, Richard Henderson, the Director of Operations, would become the Acting Chief Executive. It was highlighted that Richard Henderson had previously been the Divisional Manager in Lincolnshire.

v) Community Pharmacies in Lincolnshire

The Chairman advised the Committee that on a recent visit to her local pharmacy, she had obtained a leaflet asking for support for community pharmacies and it was agreed that the Health Scrutiny Officer would provide the Committee with additional information after the meeting.

The Chairman advised further that it was reported that on 17 December 2015, the Department of Health and NHS England had announced a reduction in funding for community pharmacies in England of £170 million (from £2.8 billion to £2.63 billion) for 2016/17. It was noted that the Department of Health and NHS England were consulting on how they were going to implement the budget reductions, with a view to any changes in service beginning from October 2016.

The Committee noted that on 15 March 2016, it was reported that the Lincolnshire Pharmaceutical Committee had been concerned that the reductions would lead to people with minor illnesses accessing GP surgeries or hospitals, when they could receive advice from pharmacies. It was highlighted that the reductions potentially could have a negative impact on the rest of the NHS.

The Committee noted further that in November 2014, in its response to the Health and Wellbeing Board's consultation on the Lincolnshire Pharmaceutical Needs Assessment the Health Scrutiny Committee had emphasised the importance of community pharmacies, as a means of treating patients with minor ailments, and preventing their attendance at accident and emergency departments or GP surgeries.

The Committee was advised that a national website (http://supportyourlocalpharmacy.org) operated by the National Pharmacy Association was urging members of the public to contact their local Members of Parliament to support local pharmacies.

vi) Accident and Emergency at Lincoln County Hospital

It was reported that there had been media reports of 'extreme pressures' on Accident and Emergency at Lincoln County Hospital, with one patient being quoted as saying she had had to wait up to eight hours for a paediatrician to see her six-week old baby; and patients suffering with minor ailments, including coughs and cold, were being urged to visit their local pharmacist, their GP, or to visit Lincoln's walk-in centre.

It was noted that pressure on Accident and Emergency departments was not unusual, however, this update and the previous item above relating to community pharmacies presented a worrying and contradictory picture.

It was agreed that this issue would be discussed further, as part of the work programme item later in the agenda.

vii) House of Commons Library Brief Paper – Structure of the NHS in England

The Committee was advised that a briefing paper had been prepared for the House of Commons Library, which had been published on 10 March 2016. The briefing paper was entitled the Structure of the NHS in England, and the Chairman advised that the Health Scrutiny Officer would circulate an electronic copy to all members of the Committee, as a useful background document on how the NHS works.

viii) Lynne Moody Director of Quality and Executive Nurse for South Lincolnshire CCG

On behalf of the Committee, the Chairman extended thanks to Lynne Moody, the Director of Quality and Executive Nurse at South Lincolnshire Clinical Commissioning Group, who was retiring at the end of the month. It was highlighted that Lynne had undertaken the role as one of the Committee's special advisors since 2009, when she had been employed by Lincolnshire Primary Care Trust. Lynne's help and advice had been invaluable, as she had enabled the Committee to ensure that its

work programme had been properly focussed. The Committee wished Lynne well in her retirement. The Chairman confirmed that she would be writing formally to Lynne, on behalf of the Lincolnshire Health Scrutiny Committee after the meeting.

93 MINUTES OF THE MEETING OF THE COMMITTEE HELD ON 17 FEBRUARY 2016

RESOLVED

That the minutes of the Health Scrutiny Committee for Lincolnshire held on 17 February 2016, be approved and signed by the Chairman as correct record.

94 ADULT CLINICAL PSYCHOLOGY AND PSYCHOTHERAPIES SERVICE

The Chairman welcomed to the meeting Jane Marshall, Director of Strategy and Performance, Lincolnshire Partnership NHS Foundation Trust, Rob Harvey, Divisional Manager Adult Community Mental Health, Lincolnshire Partnership NHS Foundation Trust; and Dr Tracey Swaffer, Head of Adult Clinical Psychology and Psychotherapies Service, Consultant Clinical Psychologist.

Before the start of the presentation, the Chairman asked the Director of Strategy and Performance, Lincolnshire Partnership NHS Foundation Trust, to clarify recent media interest with regard to patient waiting times, it had been reported that there were delays of 31 months to access pathways of care after being assessed for Psychology and Psychotherapies Services at Lincoln and Louth.

The Director of Strategy and Performance agreed that the length of time patients were kept waiting was not acceptable, and that it was a concern for the Trust to be in that position. The Director confirmed that the longest waits were in Louth and Lincoln, with individuals having to wait 31 months to access 18 session individual pathways of care. Reassurance was given that the service provided was a good quality service, and those patients that had experienced the journey through the service had made positive comments about the service they had received. It was noted that 94% of patients who accessed the service felt that they would recommend it to family and friends. Further details relating to waiting times were contained on page 26/27 of the report presented.

It was highlighted that patients that had been assessed, and were waiting further intervention were never actually left without support; they still had access to the service. It was reported that the eighteen week target on how the service was progressing was not the same as others as the clinicians providing the service were not doctors. The Committee was advised that for one to one clinical support, there was a longer waiting time, and that all options were being looked into to reduce the waiting time. Some of those patients were offered group work, and depending on the individual's needs, some had taken up the offer of group work, others had opted to wait for one to one sessions.

The Committee noted that guidance given was that anyone entering the service could be offered up to eighteen sessions, but quite often patients did not need that number of sessions.

The Committee was advised that Lincolnshire Partnership NHS Foundation Trust (LPFT) delivered its clinical services from four operational divisions. The Adult Clinical Psychology and Psychotherapies (ACPPS) was commissioned by South West Lincolnshire Clinical Commissioning Group, on behalf of the Lincolnshire CCG's to provide talking therapies to people who presented to services in Lincolnshire that had moderate to severe levels of Psychological need. It was highlighted that referrals to the service were received in the main from within the Trust such as Outpatient Psychiatry Clinics, Community Mental Health Teams and Improving Access to Psychological Therapies.

It was reported that in 2007, the Government had released a significant amount of money to provide increased access to psychological therapies for the general population across the country. The money had been invested in the development of a stepped care model of psychological intervention. An explanation of the stepped care model was shown on pages 24/25 of the report presented.

The Head of Adult Clinical Psychology and Psychotherapies Service, Consultant Clinical Psychologist provided the Committee with some background information with regard to the type of patient accessing the service; and details the stepped care model provided.

It was highlighted that from 2012 – 2014 there had been significant increase in referrals to the service by 17%, year on year. It was highlighted further that the Trust was also obliged to achieve cost improvement savings each year; this had meant that there had been a reduction in the number of psychology posts within the service.

Since 2012, the Committee noted the service had completed 4,686 episodes of care, which averaged 1,171 episodes per year. A definition of an episode of care was someone entering and then exiting the service, which could range from 18 sessions of individual therapy, 12 sessions of group based interventions, 8 sessions of formulation driven work to an assessment and formulation of treatment plan for others to implement.

The Divisional Manager Adult Community Mental Health, Lincolnshire Partnership NHS Foundation Trust explained that the current challenge for the service was the continued existence of lengthy waits to access Step 4 service. To try and address the waiting time, various measures had been put in place, which had focussed upon the development and delivery of new pathways of care that included:-

- Parameters around the number of sessions offered;
- Introduction of Group based Interventions;
- Re-design of referral pathways into the service;
- Adoption of emerging new therapies such as Acceptance and Commitment Therapy;

- Skill mixing of staff to offer different types of therapy; and
- Clear job planning and expectations for those individuals delivering the service.

In conclusion, the Trust advised that they were committed to continuing to look at innovative approaches to address waiting times, whilst ensuring that the continued provision of high quality psychological interventions to those with the greatest severity of need.

During discussion, the Committee raised the following points:-

- The timescale for how long a patient could access the service. The Committee was advised that guidance allowed for 18 sessions, per patients as part of their treatment, however, some patients would not require the 18 sessions;
- A question was asked whether the Trust could have anticipated the situation of long waiting times. It was reported that the Trust had tried to manage over a number of years, being aware of the pressure and trying to deal with it;
- The Committee reflected on the type of patient presenting at Tier 4: usually they were patients who had suffered extensive emotional and physical abuse, sometimes over a period of 20-30 years, and often from their childhood. Each patient needed to be treated differently and there was no policy of one size fits all. For some patients group therapy sessions would work.
- It was asked whether as a consequence of waiting for treatment, any patient had attempted suicide. The Committee was reassured that while patients were waiting, they still had access to the service, they were not left on their own, and support was always given during the waiting period. It was thought that this point needed to be included and clarified in a report such as the one presented, as the report presented indicated that patients whilst waiting were left on their own;
- Confidentiality and the use of group meetings. The Committee noted that not everyone entering the service felt that they wanted to share with others in a group, and opted for the one to one option. Others, as part of their recovery were able to share with others. Reassurance was given that people who had opted for group sessions were not exposed at all, only baseline information was shared with others, confidentiality was always maintained;
- There was also some reflection on the approaches to psychological therapies, in terms of a brief comparison of the cognitive/behavioural approach and the analytical Freudian approach. Following this it was further confirmed that a training session with regard to the mental services and treatments would be planned for all members of the Committee, this would then ensure a better understanding of the complex subject matter;
- Whether there had been any extra funding to deal with increasing cases of Post-traumatic stress. The Committee was advised that this particular sector were dealt with under the Armed Forces Covenant and that NHS England commissioned the service; and
- The cost improvement savings of 4% each year and the impact on the service. The Committee were advised that funding was an issue, but the service was

doing its best with the funds it had. Additional funding would always be welcomed. The Committee was advised further that the Trust were visiting other areas to see if they could provide the service better. Some members of the Committee felt that lobbying needed to be done to get extra funding. The Committee were reassured that the service was passionate about providing a good quality service;

- The need to ensure that when writing a report enough detail was included to make sure the reader could make the correct assumptions, particular reference was page 27, Summary and Conclusions, the wording could have been more positive if the two paragraphs had been changed round and then reference to the steps being taken to rectify the waiting times;
- The waiting times applicable for Louth and Lincoln. The Committee were advised that to help alleviate the waiting time, three new staff were being recruited, one for Louth; and two for Lincoln and that these positions would come into effect from 1 May 2016. It was hoped that the extra staff would have an impact and reduce the waiting list. The service would also be looking at the skill mix of staff, and where appropriate only applying specialist skills to the more complex cases. It was reported that that the Trust was exploring all the options, for example using alternative providers, as waiting times were not at an acceptable level; and
- The Committee agreed that a briefing paper would be prepared by the Director of Strategy and Performance providing more background on the content of the report, and a progress report should be presented to the Health Scrutiny Committee for Lincolnshire in six months' time.

RESOLVED

1. That a briefing paper be prepared by the Director of Strategy and Performance at Lincolnshire Partnership NHS Foundation Trust, providing more background on the content of the report, and a progress report be presented to the Committee for Lincolnshire in six months'.

2. That a training session on mental health approaches and treatments be arranged for members of the Health Scrutiny Committee for Lincolnshire.

95 ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH ON THE HEALTH OF THE PEOPLE OF LINCOLNSHIRE 2015

The Committee gave consideration to a report from the Dr Tony Hill, Executive Director of Community Wellbeing and Public Health, which provided the Annual Report on the Health of the People of Lincolnshire for 2015.

It was reported that it was a statutory duty of the Director of Public Health to produce an annual report on the health of the people of the area for which they are responsible. The report was an independent view of the state of the health of the people of Lincolnshire, with a series of recommendations on the action needed to be taken by a range of organisations and partnerships. The Committee noted that the previous year's annual report had focused on the major causes of premature mortality, which was when people died under the age of 75 years. That report had

highlighted three major findings, one of which was that the levels of mortality arising from liver disease were deteriorating. As a result of the increase in preventable liver disease, it was highlighted that the current report concentrated solely on this issue.

The annual report described what liver disease was, what the causes and stages were, and the patterns, facts and figures relating to liver disease. The Executive Director of Community Wellbeing and Public Health reported that the three main causes of liver disease were obesity, alcohol and hepatitis. The report highlighted that there was a need for some sustainable investment in liver disease prevention and treatment and the development of effective pathways of care for people with liver disease and its causes. The Committee were advised that in each chapter there were a series of recommendations on the action needed to be taken by a range of organisations and partnerships. It was noted that it was hoped that the next year's commissioning plans would address the needs highlighted in the annual report.

During discussion, the following issues were raised:-

- Budgetary constraints – The Committee noted that the Autumn Statement had reduced the amount of grant relating to public health and that this amount would continue to reduce year on year. Some preventative services had been de-commissioned, or reduced, however, it was hoped that by working in partnership with other organisations that some of the services would be maintained. Unfortunately, this information could not be shared with the Committee at this moment in time. The Committee noted that not all services de-commissioned by the County Council would therefore cease. The Committee were also advised that the NHS Five Year Forward view emphasised the need for prevention.
- The Committee were advised that the smoking cessation contract had been re-commissioned at considerable savings; significant improvement and better value for money. It was noted further that the weight management contract had been de-commissioned, as its role was for CCGs and NHS England;
- Page 10 of the Annual report document –Figure 1.1 provided the Committee with data relating to trends in United Kingdom (UK) deaths rate since 1970. It was noted that during the forty year period, all other major causes of premature deaths in the UK had fallen, but the death rates from liver disease had seen a continuous rise (figure 1.1 provided that data). It was reported that the death rate from liver disease was across all age groups had risen more than 400% since 1970. However, under the age of 65 years, this had increased by 500%. Concern was expressed that generally the general public were not taking liver disease seriously. Some members felt that it would have been useful to had some data relating to the effect on admissions to hospitals; and relative incidents;
- Page 12 – That the average age of death from liver disease was 59 years, compared with 82-84 for those with heart disease, lung disease or a stroke. The Committee noted that alcohol and obesity were significant contributory factors to liver disease. The Committee noted further that better clinical pathways needed to be developed for the treatment of liver disease;
- Reference was also made to the previous work carried out in 2011, by the Committee's Reducing Alcohol Harm in Lincolnshire Task and Finish Group.

The Committee considered whether it would be useful to review the content of that report, in light of the Director of Public Health's Annual Report;

- The Committee discussed the issues surrounding obesity, and the fact that the low fat diet had made matters worse, as the fat content was reduced, but, the sugar content in products was increased. The Committee were advised that a lot of work was being done by Public Health England to try and change the emphasis. To make a difference people needed to change their lifestyle;
- An update was received from two Councillors who had recently attended the Public Health Conference who had been advised that the reductions were not about savings but were as a result of priorities;
- Some discussion was had regarding whether anything could be done locally to publicise to young people the issues surrounding obesity and alcohol. Particular reference was made to the need for working with supermarkets. The Committee was advised that there was a national voluntary partnership working with retailers to try and change things. It was felt that trying to do work at a local level would have little effect and there were no resources available to do that type of work. It was felt that health in the workplace was a starting point. Some reference was made to binge drinking and the fact that in some countries the purchase of alcohol was not made from supermarkets, but from strictly controlled shops;
- Members expressed their thanks to the Executive Director of Community Wellbeing and Public Health for his annual report; and
- One member enquired whether there was a correlation in increased alcohol related issues and the relaxation of licensing laws. The Committee was advised that there was a correlation, as the amount of drinking had increased over the decade since licensing laws had been relaxed.

The Chairman, on behalf of the Committee extended her thanks to the Executive Director of Community Wellbeing and Public Health.

RESOLVED

1. That the Annual Report on the Health of the People of Lincolnshire, from the Director of Public health be noted.

2. That further consideration be given to the outcomes of the report of the Committee on Reducing Alcohol Harm in Lincolnshire.

96 PETERBOROUGH AND STAMFORD HOSPITALS NHS FOUNDATION TRUST - SEMINAR ON DELAYED TRANSFERS OF CARE

Consideration was given to a report from the Executive Director with responsibility for Democratic Services, which provided an update on the Peterborough and Stamford Hospitals NHS Foundation Trust – Seminar on Delayed Transfers of Care, held on 2 March 2016, to which Councillors Mrs J Renshaw and Mrs S Wray had attended.

The Health Scrutiny Officer presented the report and advised that there were several issues that had been raised at the seminar, which might merit further exploration.

However the Committee was advised that the Adults Scrutiny Committee was the responsible overview and scrutiny committee for the overall Better Care Fund arrangements, and the reducing delayed transfers of care would be a key element of the Better Care Fund in 2016/17. The Committee was advised further that it was due to receive a general update report from the Peterborough and Stamford Hospitals NHS Foundation Trust at its meeting planned for 20 July 2016, and it was likely that this update would include information on delayed transfers of care, if this was relevant to the Trust' overall performance.

It was highlighted that from the report presented, there were still capacity issues around Lincoln and parts of the South of the County.

Reference was also made to the limited capacity for care packages in the community, particularly in cases where people required four visits a day, in these cases people were not being discharged, as a result of their high needs. Assurance was given that what could be done was being done to get patients out to care in the community.

Other issues highlighted by the Committee included:-

- Page 33 - Paragraph 2 – reference was made to the suggestion that "step-down" facilities in Lincolnshire could be improved further with a number of available beds in nursing homes to assist patients being moved out of acute beds;
- The Committee extended their thanks to Councillors Mrs J Renshaw and Mrs S Wray for their report; and
- The Committee agreed that the Adults Scrutiny Committee be requested to look into delayed transfers of care and report its findings to the Health Scrutiny Committee.

RESOLVED

1. That the report presented be noted.

2. That the Adults Scrutiny Committee, given its role as the lead committee for scrutinising the Better Care Fund, be requested to look into delayed transfers of care and report its findings to the Health Scrutiny Committee.

97 ARRANGEMENTS FOR CONSIDERATION OF QUALITY ACCOUNTS 2015-16

Consideration was given to a report from the Executive Director with responsibility for Democratic Services, which invited the Committee to consider which draft Quality Accounts of which local providers of NHS-funded services did the Committee wish to make a statement on. Also the Committee was asked to consider the joint arrangements with Healthwatch Lincolnshire, who had indicated that they would like to work with the Committee on the Quality Accounts on the three main Lincolnshire based providers, and the Committee were requested to establish a working group for the Quality Account process. Finally the Committee was asked to comment of the

draft priorities for 2016/17 of the East Midlands Ambulance Service NHS Trust, who were seeking initial views in accordance with best practice.

Overall, following a short discussion, members felt that concentration should be made on areas applicable to Lincolnshire; and support was given to the working with Healthwatch with regard to the three areas as detailed in the report presented.

The Chairman asked for volunteers to assist in the Quality Accounts 2015-2016 process. The Councillors who volunteered were Councillors C J T H Brewis (South Holland District Council), J Kirk (City of Lincoln Council), S L W Palmer, Mrs S M Wray, Mrs J M Renshaw and Mrs C A Talbot.

RESOLVED

1. That the Health Scrutiny Committee for Lincolnshire make a statement on the draft Quality Accounts of the following local providers of NHS-funded services:-

    - Boston West Hospital;
    - East Midlands Ambulance Service NHS Trust;
    - Lincolnshire Community Health Services NHS Trust;
    - Lincolnshire Partnership NHS Foundation Trust;
    - Peterborough and Stamford Hospitals NHS Foundation Trust;
    - St Barnabas Hospice; and
    - United Lincolnshire Hospitals NHS Trust;

2. That agreement be given to working jointly with Healthwatch Lincolnshire and prepare a joint statement on the following three draft Quality Accounts:

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

3. That a working group for the Quality Account process be established comprising of Councillors C J T H Brewis, J Kirk, S L W Palmer, Mrs S M Wray, Mrs J M Renshaw and Mrs C A Talbot.

98 WORK PROGRAMME

The Committee gave consideration to its work programme for its forthcoming meetings.

The Health Scrutiny Officer advised that from the meeting, two items had come forward and they were:-

- Lincolnshire Community Pharmacies; and
- The Outcomes of the Committee's report on Reducing Alcohol Harm in Lincolnshire from 2011.

It was also confirmed that training would be planned for the Committee on mental health treatments, approaches and services.

The Committee were asked for volunteers to attend the Carholme Court, Long Leys Road, information event on 30 March 2016. Councillors J Kirk and Mrs J M Renshaw volunteered to attend the event and then report back to the Committee.

During a short discussion, the Committee raised the following potential items for inclusion on future agenda. These were as follows:-

- Recruitment and retention of GPs in Lincolnshire;
- Lincolnshire Medical School;
- Update from Queen Elizabeth's Hospital, King's Lynn.

RESOLVED

That the contents of the work programme, with the amendments as detailed above, be agreed.

The meeting closed at 1.40 pm

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

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

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**20 April 2016**
Subject:	**Boston West Hospital**

Summary:

This report provides information on Boston West Hospital. During 2014/15 Boston West Hospital admitted 2,980 patients, 95% of whom were NHS-funded. A further 590 patients were seen in the Hospital's outpatient department.

Carl Cottam, the General Manager of Boston West Hospital is due to attend for this item.

Actions Required:

(1) To consider and comment on the information presented on Boston West Hospital.

(2) To use the information presented as background information, which will make the Committee better informed to complete a draft statement on Boston West Hospital's Quality Account for 2016.

1. Background

Boston West Hospital is a private hospital operated by Ramsay Health Care UK, which undertakes a significant proportion of NHS-funded activity. The information in this report has been compiled from the Boston West Hospital Quality Account 2014/15 and the Care Quality Commission inspection report. The Hospital building is a purpose built facility which provides services for the assessment, diagnosis and

treatment of common medical conditions, and has a suite of outpatient and treatment rooms. A theatre undertakes a range of surgical procedures and endoscopic (diagnostic) investigations.

Boston West Hospital's vision is as follows: -

"*As a committed team of professional individuals we aim to consistently deliver quality holistic care for all our patients across a full range of care services. We believe we are able to achieve this by continually updating our key skills and knowledge enabling us to deliver evidence based clinical practice throughout the Hospital."*

The Hospital provides a wide range of services covering NHS and private day case facilities for the following specialties:

- Orthopaedic
- Ophthalmology
- General Surgery
- Pain Management
- Gynaecology
- Gastroenterology
- Urology
- Physiotherapy
- Cosmetic Surgery
- ENT

Boston West Hospital provides treatment for adult patients (excluding children below the age of 18 years), whether NHS-funded, privately insured or self-pay. A high percentage of Boston West's patients have come from the NHS sector, with patients choosing to use the facility through 'Choose and Book'. Boston West Hospital receives the standard NHS tariff for its NHS-funded patients. Boston West Hospital's services help to ease the pressure on other NHS facilities such as Pilgrim Hospital and Lincoln County Hospital. Boston West Hospital has worked closely with its NHS Clinical Commissioners, South Lincolnshire CCG, to ensure improved access for patients requiring day case surgery.

During 2014/15 Boston West Hospital, admitted a total of 2,980 patients, 95% of whom were NHS-funded. An additional 590 patients were seen per week in the Hospital's outpatient department by one of the consultants. Boston West Hospital offers consultant led care, meaning that all its patients are seen by a consultant at each step of their patient care pathway.

Care Quality Commission Inspection

The Care Quality Commission (CQC) published its most recent inspection report on Boston West Hospital on 23 October 2015. The overall rating for Boston West Hospital was good. The CQC's key findings were as follows: -

- "All clinical areas were clean. The hospital had reported no incidence of MRSA, clostridium difficile (C.diff.) or methicillin-sensitive staphylococcus aureus (MSSA) in the reporting period between January to December 2014.
- Best practice infection prevention and control practices were being followed.
- Nursing staffing was managed effectively to ensure patients received safe care with access to consultants obtained in a timely manner. Staffing levels were reviewed daily to enable team leaders in the clinical areas to flex their staffing, according to patient requirements. The hospital had not used any agency staff for the twelve months prior to our visit.
- The provider employed 1.6 whole time equivalent (WTE) consultants in the hospital; an anaesthetist and a surgeon. At least one of the employed consultants was present throughout the hospital's operating hours. A consultant anaesthetist was present in the hospital for both operating lists each day. This meant they could respond quickly in an emergency and reduce any risk to patients.
- The hospital had not reported any patient deaths between January 2014 and December 2014. There had been no transfer of care to a nearby trust for patients between January 2014 and December 2014.
- Staff followed guidance on fasting prior to surgery which was based on best practice. For healthy patients requiring a general anaesthetic this allowed them to eat up to six hours prior to surgery and to drink water up to two hours before.
- The hospital provided only day surgery, therefore meals were not provided. A selection of hot drinks and biscuits were available to patients once they had recovered from their procedure and prior to discharge.

We saw several areas of outstanding practice including:

- 100% of staff had completed all mandatory training and appraisals in 2014/15.
- The hospital had been awarded accreditation by the Joint Advisory Group (JAG) on gastrointestinal endoscopy and was the first independent hospital to achieve this.
- The hospital operated a 24 hour telephone helpline run by hospital staff, available to all patients post procedure or operation.

However, there were also areas of poor practice where the trust needs to make improvements. Importantly, the hospital should:

- ensure specialist personal protective equipment (PPE) in radiology, including lead aprons, is checked regularly.
- ensure requests to repair equipment are made, recorded and completed using standard processes and procedures."

<u>Quality Account Process</u>

One of the reasons for the inclusion of an item on Boston West Hospital on the Committee's agenda is to provide background information, so that the Committee will feel better informed to undertake the Quality Account process. Boston West Hospital's Quality for 2014/15 included the following priorities for 2015/16: -

"Patient Experience

"Patient experience continues to be a key focus to ensure we deliver the highest level of patient care at Boston West Hospital. Fostering an environment that enables us to learn from patient feedback is critical to the growth and development of our services.

"Our aim in 2015/16 is to improve the process for patients who do not attend the hospital for their appointment concentrating on key services. The process aims to reduce waits and provide a more streamlined process for those services with high demand, which in turn will provide patients with a better experience, looking specifically into the area of endoscopy.

"As feedback is important to us, we plan to review the way in which "HOT" alerts and informal patient feedback is addressed to ensure all feedback is addressed and lessons learned where possible to improve the services we offer our patients.

"In 2015/16 we aim to develop a Consultant Newsletter to ensure the clinicians are aware of our activity in relation to governance and quality sharing lessons learned from the wider Ramsay group and highlighting key information from clinical audit and national guidelines to promote best practice.

"Clinical Effectiveness

"Sharing our findings from governance information and learning lessons is key, in order to progress the effectiveness of the hospital. During 2015/16 we will be introducing display boards within each department which will highlight key governance activity and performance.

"We will also be sharing lessons with key clinical staff regarding adverse events and sharing lessons from the wider Ramsay group for learning.

"Patient Safety

"2014/15 has seen the theatre team build on their safety culture, with the sound implementation and ongoing review of the WHO checklist. Monthly clinical audits are completed to review clinical safety and effectiveness. The average compliance rate for these audits during 2014/15 was 98% and during 2015/16 we would like to build on these findings.

"We hope to continue this momentum and build on an already sound culture. During 2015/16 we have attached CQUIN activity to theatres which we hope will provide ongoing improvements and enhance the good work which is already evident, when looking back on the previous year."

Previous Engagement with Health Scrutiny Committee

The Health Scrutiny Committee has made statements on the draft Quality Accounts of Boston West Hospital in 2011, 2013 and 2014. On 25 January 2014, three

members of the Committee (Councillors Chris Brewis, Mrs Sue Ransome and Mrs Sue Wray) visited Boston West Hospital and they reported their findings subsequently to the Committee.

2. Conclusion

The Health Scrutiny Committee is invited to consider and comment on the information presented on Boston West Hospital. The Committee is then invited to use the information, which will make the Committee better informed to complete a draft statement on Boston West Hospital's Quality Account for 2016.

3. Consultation

This is not a consultation item.

4. Background Papers

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

This report was written by Simon Evans, Health Scrutiny Officer, who can be contacted on 01205 553607 or Simon.Evans@lincolnshire.gov.uk

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

Open Report on behalf of Lincolnshire East Clinical Commissioning Group

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**20 April 2016**
Subject:	**Urgent Care update**

Summary:

The purpose of this item is to update the Health Scrutiny Committee on urgent care in Lincolnshire.

Actions Required:

To consider and comment on the current position with regard to urgent care.

1. Background

The NHS constitution sets out that a minimum of 95% of patients attending an A&E department in England must be seen, treated and admitted or discharged in under four hours (the four hour A&E standard).

The target was introduced in 2004 and set at 98%. This was changed to 95% in 2010.

The four hour standard is only a crude measure of the health of the urgent care system and a broader range of information is provided in this paper to show how the Lincolnshire urgent care system is performing.

1.1 National context

The data for January 2016 from NHS England showed 88.7% of patients were dealt with in four hours and this is the worst monthly performance since the target came in in 2004. Other parts of the UK are also struggling with Scotland, Wales and Northern Ireland also missing the four hour A&E standard.

Nationally, in January 2016, overall attendances were up by more than 10% compared with the same time last year. There was also a sharp rise in emergency admissions and calls to NHS 111.

1.2 Local context

A&E attendances and performance

In Lincolnshire, the four hour A&E standard has been falling since the winter of 2014/15. The table below gives local performance which can be compared against both the regional and national performance.

Four Hour Standard 95%	Dec 2015	Jan 2016	Feb 2016
England	91.0%	88.7%	Not available
Midlands and East Region	91.0%	88.2%	86.9%
United Lincolnshire Hospitals NHS Trust	84.9%	82.7%	81.1%
Peterborough and Stamford Hospitals NHS Foundation Trust	91.6%	87.2%	81.1%
The Queen Elizabeth, Kings Lynn	90.6%	81.7%	79.8%

In order to give context for this performance, the following table gives the number of people who used A&E services during the month of January 2016 and the numbers of people who were not seen, treated and admitted or discharged in under four hours.

January 2016	Total A&E attendances	Total A&E attendances > 4 hours	Performance against the 95% standard
England	1,906,920	216,287	88.7%
Midlands and East Region	Not available		
United Lincolnshire Hospitals NHS Trust	13,367	2,309	82.7%
Peterborough and Stamford Hospitals NHS Foundation Trust	8,535	1,089	87.2%
The Queen Elizabeth, Kings Lynn	4,856	890	81.7%

Mirroring the national position, during March 2016, Lincolnshire experienced an increase in A&E attendances which increased by more than 10% compared with the same time last year. However throughout 2015/16, A&E attendances have only increased by 2.7% overall. This is equivalent to approximately 4,500 additional attendances in 2015/16 compared against 2014/15.

Emergency admissions

Unlike the national position, emergency admissions have reduced by nearly 1.5% in Lincolnshire. This is equivalent to approximately 900 less people being admitted to hospital in 2015/16 compared against 2014/15.

Bed Occupancy

NHS bed occupancy rates of higher than 90% can increase the risk of problems such as infections and quality of care. Bed occupancy continues to be high in United Lincolnshire Hospitals NHS Trust (ULHT) as previously reported. Since January 2016, bed occupancy rates have been between 92% and 95%. The actual numbers of beds available in acute hospitals varies day to day as a result of beds being opened and closed to meet surge in demand, staffing levels and infection control issues for example. To give context, in February 2016, ULHT had on average 1010 beds opened through that month.

Delayed Transfers of Care (DTOC)

Like the four hour standard, Delayed Transfers of Care (DTOC) are also a crude measure of the health of the urgent care system. Most importantly, delayed transfers of care have negative impacts on the people who become delayed, with significant implications for their independence. They also have an impact on wider service delivery and performance across the whole health and care system, but the immediate effects manifest themselves within hospitals. Delayed Transfers of Care reduce flow out of the A&E department and within the hospitals.

As reported in December 2015, DTOCs in terms of lost bed days were fairly stable until the summer of 2014; since that time, in Lincolnshire the number of lost bed days due to delays has increased.

The DTOC national target is to achieve a standard of less than 3.5% of available bed days being lost due to delays. The table below gives local acute hospital performance which can be compared against the regional performance. This data set is February 2016 only.

	Number of available bed days lost due to delays				% of Delays, i.e. no. of available bed days lost due to delays			
February 2016	NHS	Social Care	Both NHS & Social Care	**Total bed days lost**	NHS	Social Care	Both NHS & Social Care	**Total % of delays**
Midlands and East Region	23,794	9,148	3,416	36,358	65.4%	25.2%	9.4%	4.9%
United Lincolnshire Hospitals NHS Trust	1,249	150	61	1,460	85.5%	10.3%	4.2%	4.9%
Peterborough and Stamford Hospitals NHS Foundation Trust	937	257	28	1,222	76.7%	21.0%	2.3%	8.0%
The Queen Elizabeth, Kings Lynn	235	246	0	481	48.9%	51.1%	0.0%	4.2%

To give context, in February 2016, ULHT lost 1,460 beds days which is equivalent to 50 beds out of an average 1010 beds opened through that month. The actual number of people affected cannot be provided; however it is likely to in excess of 65 people.

Lincolnshire Community Health Services (LCHS) NHS Trust has also experienced significant DTOCs through 2015/16. The data is not available for the same timeframe as in the above table; however LCHS has been reporting a DTOC greater than 10% since June 2015 and in December 2015, LCHS had a DTOC rate of 13.56% from an average bed stock of 177 beds. As previously stated, caution needs to be taken with the actual numbers of beds available as it varies day to day.

Since October 2014 delayed days attributable to the Lincolnshire Local Authority have doubled and quadrupled in June 2015 and October 2015 respectively. It should be noted that despite this increase, NHS delays are at crudely 2 to 3 times greater than LA attributable delays across the county in all care settings.

Tackling the problem requires effective and mature systems thinking across health services, social services and the independent sector, each with individual responsibilities, resources and constraints. This plan is part of the Better Care Fund (BCF) 2016/17 and aims to recover the standard to 3.2% by October 2016 and maintain that position through the winter of 2016/17. Please note that the BCF DTOC metric is different to the NHSE metric for measuring DTOCs.

NHS 111 performance

Unlike the national position, the number of Lincolnshire NHS 111 calls has decreased by 1.5% during 2015/16. This is equivalent to approximately 2,700 less people calling NHS111 in 2015/16 compared against 2014/15. On average, every month in 2015/16, 15,000 people rang Lincolnshire NHS111.

The national standard for NHS 111 is that 95% of all calls will be answered within 60 seconds. The table below gives the performance of NHS 111 so a comparison can be made.

NHS 111	Nov 2015	Dec 2015	Jan 2016
England	89.6%	86.1%	86.4%
Midlands and East Region	92.3%	91.4%	88.4%
Lincolnshire NHS 111	95.5%	95%	94.2%
Cambridgeshire and Peterborough NHS 111	97.7%	95.4%	97.1%

Other urgent care services

The Walk In Centre, Urgent Care Centres and Minor Injury Units – these services consistently achieve in excess of 95% for the four hour standard to see, treat and admit or discharge in under four hours.

1.3 Lincolnshire's Constitutional Standards Recovery Plan

Since last reporting to the Committee, the urgent care recovery plan has now been focused on two distinct areas; a 30 day rolling programme of actions for Pilgrim Hospital and five priority areas agreed with the Emergency Care Improvement Programme (ECIP). ECIP had just started working with the Lincolnshire urgent care system at the time of the last report. They undertook diagnostic exercises through November and December and met with a number of key clinical, managerial and executive stakeholders. In February, a concordat was agreed by leaders from each part of the Lincolnshire system and the regional tripartite to demonstrate the overall commitment to the five priorities which are;

1. Emergency Care Flow
   - Development of "front door" services and early Comprehensive Geriatric Assessment
   - Early senior assessment in the Emergency Department
   - Review of pathways/criteria specifically short stay
   - Development of default to ambulatory care
   - Development of surgical ambulatory processes
   - Access to rapid access clinics

2. SAFER CARE BUNDLE & 'No Waits' process implemented on 5 wards per month (including community)
   - Senior Review
   - All patients have a Predicted Date of Discharge
   - Flow
   - Early discharge before 10am

3. Therapy Review/ Improvement
   - Assessment of current provision/ skills/ competencies
   - Review safe thresholds for transfer to non-acute environments/ home
   - Further development Early Supported Discharge

4. Amalgamation of existing discharge portals into a home first/ Discharge to Assess model (Transitional Care)
    - Ensure pathways developed and widely communicated with thresholds that accept patients
    - Ensure enablement resources are packaged around the patient
    - Patients must be managed actively through pathways
    - Goals set and managed
    - Ensure mental health support available

5. Perfect Week Programme
    - Ensure whole system engagement and response
    - Ensure metrics are clear from beginning
    - Staff engagement a priority encouraged by social movement approach
    - Executive Leadership and visibility required

These priorities are those that will best improve the performance of the Lincolnshire urgent care system, reduce waits and bed occupancy and so improve outcomes, including reducing mortality, for patients in our system.

The Lincolnshire workforce continues to contract; there are fewer staff in post and leavers continue to outweigh starters. In addition, a national framework has been put into place that is attempting to reduce the use of agency and locum staff and the large financial burden that this was placing on NHS trusts as "supply and demand" principles were driving ever increasing costs. Lincolnshire and the wider system is having to adjust to working within this framework and the adjustment to a level "playing field" has not been fully completed across the system as yet and some shifts remain empty.

2. Conclusion

This paper has aimed to describe the current state of the Lincolnshire urgent care system. Focusing solely on the acute hospital four hour A&E standard of 95% "masks" good performance in other services and does not acknowledge the interdependencies which impact on the acute trusts' ability to deliver the four hour A&E standard of 95%, e.g. DTOC.

In summary, increased demand is not driving the Lincolnshire urgent care system as A&E attendances have only risen with population growth and emergency admissions are reducing.

Urgent care is a complex system that "flexes" to accommodate surges in demand as it should but this also means that it requires dynamic solutions to meet ever changing problems.

All the performance measures detailed above and national performance (as a benchmark) have been considered when identifying a recovery trajectory for the Lincolnshire acute hospital four hour A&E standard of 95%. In addition, there is an emerging national view that not all NHS trusts will achieve the 95% four hour

standard during 2016/17. Lincolnshire's current trajectory is to achieve 85% consistently through Q1 2016/17 and 89% in Q4 2016/17. The other system measures will also be monitored, i.e. achieving 3.2% DTOC by October 2016.

It remains the aspiration of Lincolnshire clinicians and leaders to improve beyond this trajectory.

3. Consultation

This is not a direct consultation item.

4. Background Papers

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

Report to the Health Scrutiny Committee for Lincolnshire, 18 November 2015 - Urgent Care – Constitutional Standards Recovery and Winter Resilience

This report was written by Sarah Furley, who can be contacted on 01522 513355 ext. 5424 or sarah.furley@lincolnshireeastccg.nhs.uk

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

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**20 April 2016**
Subject:	**Pharmacy and Medicines Optimisation Services at United Lincolnshire Hospitals NHS Trust**

Summary:

Robust processes are in place at United Lincolnshire Hospitals NHS Trust (ULHT) to ensure the delivery of the Hospital Pharmacy Transformation Programme (HPTP) as required by the Lord Carter Review. The HPTP includes a work programme to ensure patients have rapid access to optimised medication, reducing delays to treatment, both for in-patients and at discharge.

This is being achieved through the dispensing for discharge project, with redesigned roles and skill-mix, using clinical pharmacy technicians to administer medication and prescribing pharmacists to optimise evidence-based drug treatment.

There is also a commitment from the Trust to redesign infrastructure through the planned implementation of electronic prescribing systems by 2020 to give further efficiencies and reduced delays to treatment and discharge prescriptions.

Actions Required:

The Health Scrutiny Committee for Lincolnshire is invited:

(1) To comment on the information presented, in particular in relation to the implementation of United Lincolnshire Hospitals NHS Trust's Hospital Pharmacy Transformation Programme (HPTP) as recommended by the Lord Carter Review; the work programme for improving delays to discharge through the dispensing for discharge scheme, supported with redesigned roles and skill-mix for clinical pharmacy technicians and prescribing pharmacists; the processes for development and implementation of the

electronic prescribing and medicines administration system (ePMA); and

(2) To determine whether the Committee is assured that the Trust is making every effort to avoid discharges being delayed as a result of the prescribing processes at discharge not facilitating a timely supply of medication.

1. Background

The Lord Carter Review now requires all acute Trusts to have in place by 2017 a Hospital Pharmacy Transformation Programme (HPTP) to improve productivity, procurement and efficiency of Hospital Pharmacy and Medicines Optimisation Services.

The Carter Review states:

> Trusts should, through a Hospital Pharmacy Transformation Programme (HPTP), develop plans by April 2017 to ensure hospital pharmacies achieve their benchmarks such as increasing pharmacist prescribers, e-prescribing and administration, accurate cost coding of medicines and consolidating stockholding by April 2020, in agreement with NHS Improvement and NHS England so that their pharmacists and clinical pharmacy technicians spend more time on patient facing medicines optimisation activities.

A project to deliver the Trust's Constitutional Standards was initiated in order to improve the way discharge prescriptions are managed and prevent delays. This involved moving the emphasis from supplying patients with prescriptions to take home at the point of discharge, to a supply process that ensures the prescription products are labelled as discharge prescriptions from the point of patient admission. These products are kept in the patients' bedside lockers, rather than on drug trolleys, and any new prescriptions are updated with new labelled products which are ready for discharge at the point of in-patient supply. Such a scheme is often referred to as 'dispensing for discharge'.

This dispensing for discharge process is now embedded in the HPTP and is being rolled out across all beds in the Trust, following a successful pilot on the wards on Level 6 at Pilgrim Hospital Boston.

Alongside this the Trust is investing in new roles for clinical pharmacy technicians to optimise patients' medication on the medical admissions wards. This includes actively managing the dispensing for discharge process to ensure patients get access to the correct medication as rapidly as possible and to reduce discharge delays. As part of this redesign of roles, clinical pharmacy technicians will be administering medication to patients on the wards and helping patients to self-administer as in-patients, giving control of medication back to patients during their stay in hospital.

The Trust is also investing in more pharmacist prescribers who will be able to apply expertise in therapeutics and prescribing, in order to optimise evidence-based therapeutic decisions, reduce prescribing errors and reduce delays with discharge prescriptions.
To support these changes and deliver further efficiencies in the prescribing process a business case has been submitted to the Trust for electronic prescribing and medicines administration (ePMA). The business case has been included in the Trust's digital strategy

and it is envisaged that the case will be funded and implemented in the 2017-18 round of funding in line with the requirements of the Carter Review to ensure implementation by April 2020.

A separate and bespoke ePMA system for cancer patients has been successfully implemented in 2015-16 by Pharmacy. This system enables improved scheduling of patients, more cost-efficient management of very high cost dose-banded cytotoxic chemotherapy and monoclonal antibodies for the treatment of cancers, and thereby leads to fewer delays for patients during their treatment and at discharge.

The Director of Pharmacy and Medicines Optimisation is the Trust lead for Hospital Pharmacy and Medicines Optimisation, reporting directly to the Medical Director, the Trust Executive and Trust Board to ensure delivery of the HPTP.

2. Conclusion

The Health Scrutiny Committee for Lincolnshire is invited to comment on the information presented, in particular in relation to the implementation of United Lincolnshire Hospitals NHS Trust's Hospital Pharmacy Transformation Programme (HPTP) as recommended by the Lord Carter Review; the work programme for improving delays to discharge through the dispensing for discharge scheme, supported with redesigned roles and skill-mix for clinical pharmacy technicians and prescribing pharmacists; the processes for development and implementation of the electronic prescribing and medicines administration system (ePMA); and to consider whether the Committee is assured that the Trust is making every effort to avoid discharges being delayed as a result of the prescribing processes at discharge not facilitating a timely supply of medication.

3. Consultation

This is not a consultation item for the Committee.

4. Background Papers

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

This report was written by Colin Costello, Director of Pharmacy and Medicines Optimisation, United Lincolnshire NHS Trust who can be contacted on 01522 573760 or colin.costello@ulh.nhs.uk

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Lincolnshire COUNTY COUNCIL Working for a better future		**THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE**	
Boston Borough Council	East Lindsey District Council	City of Lincoln Council	Lincolnshire County Council
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Open Report on behalf of Dr Tony Hill, Executive Director of Public Health

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**20 April 2016**
Subject:	**Emergency Planning – Exercise Black Swan**

Summary:

Following an invite to attend the Health Scrutiny Committee for Lincolnshire to feedback on the lessons learnt from Exercise Black Swan, this report and supporting documents present an overview of the exercise; the key learning achieved, and the level of assurance given to the Local Resilience Forum (LRF).

Exercise Black Swan was the LRF's annual multi-agency exercise held on 15 October 2015. The exercise focussed on the multi-agency planning and response to a severe pandemic influenza and presented a developing scenario throughout the day.

Clear aim and objectives were set for the exercise, and these were achieved throughout the day. The exercise identified areas of good practice as well as some lessons to be learnt, which have been captured in the Exercise Report.

Actions Required:

Members are asked to:

1. Consider and comment on the presentation and learning gleaned from the exercise.

2. Consider the level of assurance given to the Local Resilience Forum on the preparedness of the County to respond to an influenza pandemic

1. Background

A new influenza pandemic continues to be recognised as one of the six Tier 1 risks to the United Kingdom due to the impacts on public health and well-being, and on the likely disruption to 'normal' services resulting from the large numbers of infected people and the impact on staffing due to both illness of staff and the requirement to care for dependents who may fall ill.

Exercise Black Swan allowed participants to explore the response to a severe pandemic influenza within the Local Resilience Forum (LRF) command structure, acknowledging the regional and national implications of such an incident. The exercise also provided an opportunity to test the LRF Multi-Agency Pandemic Influenza Contingency Framework which was re-written in 2014 to reflect guidance from the World Health Organisation and the Department of Health.

Following evaluation of the exercise an assurance opinion of 'some improvement needed' was delivered to the LRF on the preparedness of the County to respond to a pandemic of influenza. The rationale for assigning this level of assurance relates to the main finding of the exercise, which is the requirement for a comprehensive review and re-write of the LRF's Multi-agency Pandemic Influenza Contingency Framework. Whilst the document provided exercise players with good information relating to the national management of an influenza pandemic, it does not offer tactical options to assist local commanders and responders in the continuation of critical functions within the County. A task and finish group has been set up to undertake this review, with a completion date of September 2016.

Despite this, the response to the scenario was robust, addressing not only the health and social care needs, but fully considering the wider consequences associated with the scenario.

Attendance by Health Scrutiny Committee Members

Five members of the Health of the Health Scrutiny Committee attended the event as observers on 15 October 2016: Councillors Mrs Christine Talbot, Chris Brewis, Mrs Rosemary Kaberry-Brown, Jackie Kirk and Mrs Sue Ransome.

2. Conclusion

In conclusion, the exercise report with recommendations has been presented to, and accepted by the Local Health Resilience Partnership, the LRF's Programme Management Board, and the Local Resilience Forum.

The Programme Management Board is monitoring the progression of the recommendations ensuring that the learning gleaned from the exercise is embedded into the management of future incidents and exercises.

The attached presentation provides members with an overview of the exercise review and the key lessons learnt.

3. Consultation

This is not a consultation item.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Exercise Black Swan Report

5. Background Papers

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

This report was written by Cheryl Thomson, who can be contacted on 01522 552345 or cheryl.thomson@lincolnshire.gov.uk

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Lincolnshire's Resilience Forum

PREPARING FOR EMERGENCIES
WHAT YOU NEED TO KNOW

Exercise Black Swan

Thursday 15th October 2015

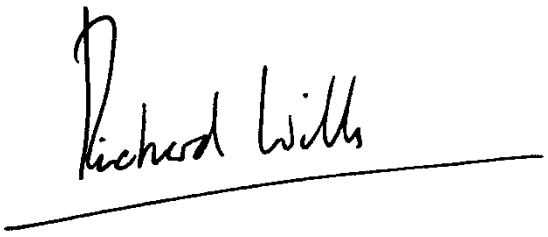
Exercise Report

FORWARD

Exercise Black Swan gave us an excellent opportunity to thoroughly test both our multi-agency, and individual organisational plans for dealing with an influenza pandemic. With attendance from many organisations within the Lincolnshire Resilience Forum, the discussions reiterated the fact that pandemic influenza is not just a health and social care emergency, and that the implications would be felt across all organisations both locally and nationally.

The exercise has provided a wealth of learning for individual organisations and the LRF as a whole which has been captured throughout this report and summarised in the recommendations table found in Appendix D. The aim of this report is to demonstrate a clear link between the lessons learnt from Exercise Black Swan, and changes to our plans and procedures moving forward.

I would like to thank all those involved in Exercise Black Swan, and hope you all have gained a better understanding of your roles and those of your organisation in the event of an influenza pandemic. Undertaking these exercises can only ensure that we are better prepared to deal with the consequences of such an incident.



Richard Wills
Executive Director for Communities, Lincolnshire County Council
Exercise Director, Exercise Black Swan

Report Prepared by:
Cheryl Thomson, Lincolnshire County Council, Public Health

Contents

Executive Summary

Exercise Black Swan was Lincolnshire Local Resilience Forum's (LRF) annual multi-agency exercise held on October 15th 2015. The exercise was designed and delivered by a multi-agency planning team, led by a representative from Lincolnshire County Council's Public Health Directorate. The exercise focussed on the multi-agency planning and response to a severe pandemic of influenza, presenting a developing scenario throughout the day. As the number of cases within the County increased, so did the demand for resources across all organisations taking part in the exercise. Participants were asked to identify how they would respond whilst ensuring the continuation of essential services in the County.

This report covers all aspects of the exercise, from the planning through to delivery and evaluation. It presents the key findings gleaned from testing the Multi-Agency Pandemic Influenza Contingency Framework (The LRF Framework), the multi-agency command functions and from the tactical support cells. It also highlights the strengths identified during the exercise, as well as areas for improvement. The report does not identify lessons to be learned from individual organisations unless these impact on the multi-agency response as a whole.

Clear aims and objectives were set for the exercise and these can be found in section 3 of the report. The exercise achieved these aims and objectives and delivers an assurance opinion of 'some improvement needed' on the preparedness of the multi-agency response to a pandemic influenza incident within Lincolnshire. A full breakdown of the Assurance Definitions can be found in Appendix B.

The exercise highlighted that the Multi-Agency Pandemic Influenza Contingency Framework currently sits as a strategic document, therefore lacking in tactical options for consideration by either the Strategic Coordinating Group (SCG) or the Tactical Coordinating Group (TCG) and specialist support cells. Specifically the LRF Framework does not offer tactical considerations which will be required when developing the tactical plan for dealing with an incident. A key recommendation from the exercise is to review the entire document ensuring it sits within the LRF suite of plans fulfilling its purpose as a tactical plan.

Despite this, the response to the scenario was robust, addressing not only the health and social care needs but fully considering the wider consequences associated with a pandemic. In fact many of the conversations throughout the day will greatly assist in the population of the reviewed framework. A full list of the recommendations generated from the exercise and subsequent evaluation can be found in Appendix D.

1. Introduction

A new influenza pandemic continues to be recognised as one of the six Tier 1 risks to the United Kingdom in the National Security Strategy and Strategic Defence and Security Review 2015[1]. Within Lincolnshire the risk also sits on the Community Risk Register (CRR) as one of the nine enduring risks faced by the County.

The World Health Organisation (WHO) defines a pandemic as *"the worldwide spread of a new disease".* This will occur when a distinctly different strain of the influenza virus will emerge with most people not having any immunity. The virus then spreads rapidly across the world causing an influenza pandemic. In the event of such an incident, large numbers of the population may become infected with varying degrees of symptoms. The pandemic may result in severe illness and mortality in certain age or patient groups, and has the ability to significantly impact not only the health and social care services, but the normal functioning of society as a whole.

As such, and following on from the cancellation of Exercise Cygnus, (a national exercise commissioned by the Cabinet Office (CO) due to take place in October 2014, of which Lincolnshire was one of 11 Local Resilience Forums selected to participate), the LRF agreed to support the delivery of a pandemic influenza exercise as the focus of the multi-agency major exercise in 2015. This report outlines all aspects of Exercise Black Swan, and details observations and lessons identified from the exercise. A summary of all the recommendations can be found in Appendix D.

Exercise Black Swan was a one day command post exercise (CPX) held on Thursday 15th October 2015 with a focus on the multi-agency response to a severe influenza pandemic in Lincolnshire. The exercise allowed participants to explore the response to the scenario within the LRF command structure and acknowledged the regional and national implications of such an incident. The exercise also provided an opportunity to test the LRF Multi-Agency Pandemic Influenza Contingency Framework (The LRF Framework).[2] This document was re-written to reflect the changes since the introduction of the Health and Social Care Act 2012, and to ensure that the local response is in line with the national response as identified in the UK Influenza Pandemic Preparedness Strategy 2011[3]. The framework was approved by the Programme Management Board (PMB) on 21st July 2014.

The exercise was supported by a multi-agency planning team, and on the day, a pre-identified exercise control team. Further, it provided an opportunity for multi-agency strategic and tactical commanders to interact with other agencies, and gain an overview of other organisations pandemic influenza plans.

[1] The National Security Strategy and Strategic Defence and Security Review 2015 can be found at: https://www.gov.uk/government/publications/national-security-strategy-and-strategic-defence-and-security-review-2015

[2] Lincolnshire's LRF Multi-Agency Pandemic Influenza Contingency Framework can be found on Resilience Direct in the All Hazards Plan at: https://www.resilience.gov.uk/RDService/home/1558/07.-Plans

[3] The UK Influenza Preparedness Strategy 2011 can be found at: https://www.gov.uk/guidance/pandemic-flu#uk-influenza-pandemic-preparedness-strategy-2011

2. Scenario

The scenario focussed on the management of a new subtype of the Influenza- A virus (H2N2). The fictional virus was identified in Thailand by the Centres for Disease Control and Prevention (CDC) in the months of June and July 2015. The virus had a clinical attack rate (CAR) in the region of 35% with a case fatality rate (CFR) of 1.3% over the course of the pandemic. The first confirmed UK cases of the H2N2 virus were identified in travellers returning from Thailand on 31st August 2015, and this therefore activated the UK response to the situation with week 1 being identified from 31st August to 6th September 2015.

An information pack[4] was sent to all participants two weeks in advance of the exercise containing:

- An agenda for the day
- Joining Instructions
- Participants Scene-setting manual
- SCG teleconference minutes containing the decision to stand up a multi-agency response
- Lincolnshire's communication plan
- Exercise Players List.

The participant's scene setting manual documented both the UK and the Lincolnshire response to the virus in the weeks preceding the exercise. The decision to supply the exercise participants with this detailed information was deliberate, recognising that in a real pandemic influenza situation key responders would have been following the progression of the virus internationally, nationally and locally prior to collectively deciding to implement a multi-agency response.

The morning session focussed on week 7 of the UK national response, and was held in real time. The impact on Lincolnshire as a County was low at this point however forecasts predicted a significant increase in numbers over the coming weeks. This allowed the morning session to focus on the business continuity aspects of the scenario, and focus on planning for the future impact on services.

The afternoon session included a 3 week time jump and was based on week 10 of the UK national response. During the time lapse, clinical cases had exponentially increased along with additional flu deaths, and equally staff absences had increased across all organisations as staff had either become unwell themselves, or were required to look after unwell dependants. Exercise participants were requested to respond to pre-scripted problems associated with this increase in numbers, whilst also identifying how to continue with 'business as usual' in the circumstances.

[4] A copy of all the pre-read information can be found on Resilience Direct at: https://www.resilience.gov.uk/RDService/home/61253/Exercise-Black-Swan

3. Aim and Objectives

The exercise was commissioned by the Lincolnshire LRF, with a commitment for Exercise Black Swan to be the major multi-agency exercise for 2015 ensuring that preparatory work undertaken for the cancelled Exercise Cygnus in 2014 was maximised by the planning team.

3.1 Exercise Aim

To assess the preparedness and response to an influenza pandemic in Lincolnshire.

3.2 Exercise Objectives

- To test LRF multi-agency capability and capacity to respond to a severe influenza pandemic
- Test category 1 and 2 responders and voluntary sector business continuity planning to maintain critical functions during a severe pandemic outbreak
- To rehearse key people in strategic and tactical lead responder and multi-agency coordination roles
- Engage with health, social care and education providers in considering the impacts of resilience for a severe influenza pandemic
- Test partner communications processes (with an emphasis on learning from recent exercised and emergency responses.)

Evaluation of the exercise identified that the aim and the objectives were met. In terms of an assurance opinion on the preparedness of the multi-agency response to a pandemic influenza incident within Lincolnshire, this has been assessed at the level of 'some improvement needed'. Whilst the response to the proposed scenario was robust, demonstrating a good understanding of roles within the command structure and a good ability for partners to work together identifying solutions to the problems posed; the assurance level is unable to be high due to the fact that the LRF Multi-Agency Pandemic Influenza Contingency Framework was deemed inadequate to support the response.

To enable the LRF to gain a level of assurance against the risk, clear definitions are required. This will support the development of exercises and plans in the provision of assurance to the LRF, and provide standardisation in the evaluation process overall. The definitions found in Appendix B provide a framework for the assessment of the preparedness of the multi-agency response to a pandemic influenza incident based on current LRF supporting documents and command and control arrangements.

To ensure exercises offer a standardised assessment of assurance against the specific risk / plan they are based on, it is recommended that the assessment definitions are adopted by the LRF, along with an agreed process for evaluation of multi-agency exercises / plans.

Recommendation 1:
The LRF to design and agree a standardised exercise evaluation / reporting framework incorporating the assignment of an assurance opinion based on agreed definitions.

4. Participating Organisations

126 delegates from 22 organisations attended the exercise as either participants or facilitating staff. Participants included representatives from the following organisations:
Lincolnshire County Council, Public Health England (PHE), representatives from the Clinical Commissioning Groups (CCG) in Lincolnshire, representatives from the 3 main NHS providers in Lincolnshire, Lincolnshire Police, Lincolnshire Fire and Rescue, East Midlands Ambulance Service, British Red Cross, members from the LRF Interfaith Group, and an Assistant Coroner in Lincolnshire.

5. Exercise Format

5.1 Exercise Style

Exercise Black Swan utilised a command post exercise format to test the operational aspect of the command and control process within the Lincolnshire LRF. This included the setting up of the County Emergency Centre (CEC) and the stand up of both Strategic and Tactical Co-ordinating Groups along with pre-identified tactical support cells.

This format was chosen for the exercise to ensure strategic and tactical commanders across organisations within the LRF were given the opportunity to not only test the pandemic influenza plan and the process for managing such an incident, but also provided the opportunity to test their own role both within the context of their own organisation and in the multi-agency setting.

By formally setting up the CEC, the exercise also supported a practical test of equipment and facilities and allowed further tests of new processes to be undertaken, an example of this being the use of Resilience Direct (RD) during a live incident.

In addition to the main body of the exercise, a separate Lincolnshire County Council (LCC) internal Business Continuity (BC) exercise was being run concurrently with the morning session using the same scenario. This exercise, whilst closely linked will be reported on separately.

Lincolnshire Fire and Rescue also activated their Fire Silver Cell to further test their pandemic influenza plans. A full report including their findings and any recommendations will be generated by Lincolnshire Fire and Rescue.

In addition to the Fire Silver Cell, Lincolnshire Fire and Rescue were represented in the multi-agency response at the Strategic and Tactical levels, and in the information cell, and the feedback generated has been included throughout this report.

5.2 Command Support Functions

To provide support to the SCG and TCG, the LRF in Lincolnshire has adopted the model of multi-agency specialist / tactical support cells. The objectives and representation within these cells will be dependent on the type and scale of the emergency.

For the scenario used in Exercise Black Swan, the following cells were activated:

- Outbreak Control Team
- Health and Social Care Cell
- Warning and Informing Cell
- Community Resilience Cell
- Excess Deaths Cell
- Information Cell
- Fire Silver Cell

These cells were populated by exercise participants, each performing a role relevant to their organisation that, in the event of an influenza pandemic, would support the County wide response to the incident. The exercise planning group identified leads for each cell with a specialist knowledge of the role that the cell would perform. These leads then ensured that each cell was populated appropriately to undertake the relevant functions. To facilitate this process, artificial SCG minutes were produced, during which the decision for the activation of the CEC was agreed along with the set-up of the relevant cells.

5.3 Exercise Timeframe and phases

To maximise the learning potential from the exercise, and to support the achievement of the exercise aim and objectives, three distinct phases were utilised.

Firstly, the pre-exercise phase commenced when the first cases of the virus were identified in Thailand in the months of June and July 2015 through to 14th October 2015, the day prior to the exercise. The planning team, recognising the importance of all exercise participants attending the day fully prepared, produced a comprehensive participant manual detailing the key events and the international, national and local decisions thus developing a timeline for the management of the incident. This allowed the exercise delegates to arrive and focus on the issues presented in the exercise, with some of the pre-work completed in advance.

The second phase took place in the morning session of the exercise and took was based in real time on the morning of the 15th October 2015. At this point the UK was in the seventh week of the national response, and numbers were beginning to rise putting some strain on services. Within Lincolnshire the first cases of the virus had been identified two weeks previously and numbers were still low in the County. The rationale for this timeframe is that the virus had been in the Country for enough time to allow for some modelling to take place, and some early predictions of the trend of

the virus could be given. This allowed the exercise to focus on the business continuity aspects of an influenza pandemic and to identify organisationally and collectively critical functions within the County and the resources required to maintain these.

The final phase was run in the afternoon of the exercise, and included a three week time jump. Fictionally exercise players were informed that they were now in the week commencing the 2nd November. By moving the scenario on three weeks, participants were able to focus on the pre-identified worst week in the pandemic. It allowed exercise participants to gain an understanding of the level of demand that would come with a pandemic over a protracted period of time with ever reducing resources.

5.4 Exercise artificialities

Exercise artificialities are inevitable in any exercise, and this was noted during both the planning and delivery of Exercise Black Swan.

The scenario focussed on a virus with an expectation of an initial 15 week wave. It is acknowledged that should a pandemic influenza incident occur, response arrangements would mirror that of the virus with both preparatory work commencing prior to the first cases of the virus entering the County, and recovery work continuing until services were returned to 'business as usual'. Exercise participants were asked to consider the entirety of the 15 week wave during a one day event which at times caused confusion.

It was also acknowledged that some decisions would have been made in advance of the 15th October 2015, and that by week 7 of the UK response, plans would be in place. However to ensure that delegates gained the most from the exercise, many of these key decisions were omitted from the preparation work allowing for discussions to take place during the exercise.

With a pandemic influenza incident impacting all areas of the Country, the planning team recognised that a national approach to the response would occur. Exercise Black Swan was Lincolnshire focussed, and whilst referenced the regional and national implications, the lack of this input was impactful on the delivery.

Where possible the afore mentioned constraints have been taken into account during the evaluation of the exercise and the generation of this report.

5.5 Exercise Risks

The delivery of any exercise contains a degree of risk, and Exercise Black Swan is no exception.

During the planning of the exercise, two risks were identified, the emergence of a real incident in the County, and a failure to apply learning from the exercise to future planning and response work in the County.

Organisations within the LRF in Lincolnshire horizon scan continuously to identify any new or emerging risks to the County, and equally to ensure that mitigations in place for existing and known risks are sufficient. In the event that a collective response is required, tried and tested processes are in place to ensure an appropriate response.

The planning of the exercise included appointing an Exercise Director. The Exercise Director is a senior member of the LRF, and in the event that the exercise required cancellation prior to the 15th October, or at any point during the day itself would, in consultation with the Exercise Control Team, take the decision to call a 'no duff' and cancel the exercise. Participants were made aware of these arrangements in advance of the exercise, and they were reiterated in the introductory sessions at the start of the day.

To ensure that maximum learning has been gained from the exercise, a full evaluation has taken place. This report is the result of the evaluation and contains a comprehensive review of both the exercise planning, and the relevant learning opportunities that were highlighted during the day. To ensure that this learning is applied to future exercises and incidents, a full list of recommendations has been compiled and can be found in Appendix D. This report will be presented to both PMB and the LRF, and due to the strong health and social care element of the exercise will also be taken to the Local Health Resilience Partnership (LHRP). Management of the recommendations will be through the PMB with escalation as required to the LRF.

Any exercise requires the commitment of organisations to ensure appropriate staff will be released from work commitments enabling participation in the exercise, and the success of this has been demonstrated by a high turnout of from 22 organisations within Lincolnshire. However it needs to be noted that in the week preceding the exercise 21 participants withdrew from taking part in the exercise requiring the exercise team to identify replacements at short notice. Many of these were performing key roles in the exercise, and the absence of the role would have been impactful on the exercise gaining the maximum learning. It is recognised that operational pressures will always take priority over exercising, however to ensure this learning is achieved, continued commitment is required from all organisations within the LRF.

Recommendation 2:
Include 'Late Withdrawal of Exercise Participants undertaking key roles' as a standard risk to LRF Exercise Risk Assessment.

6. Exercise Evaluation

Evaluation of the exercise was conducted by gathering information through the following methods:

Exercise Control Team:	Members of the Exercise Control Team had the opportunity to observe the exercise and ensure that play was proceeding within the boundaries of the exercise. All members of the Exercise Control Team had received a briefing prior to the 15th October 2015, and were asked to note any issues that arose during the day and ensure these were fed back to the Exercise Controller. The Exercise Control Team were also asked to complete a debrief form capturing any learning that came out of the day.
Exercise Evaluator:	A specific evaluator was identified for the observation and analysis of the SCG against the aim and objectives of the exercise. The findings of this evaluation have been fed back to the Exercise Controller for inclusion in this report.
Hot Debrief Sessions:	These sessions were conducted at the end of both the morning and afternoon sessions. Exercise participants were invited to discuss issues the key learning points identified from the session within the cells they had been working. One member of each cell was then asked to feed back to the group. These findings were then captured and have contributed to this report.
Participant Feedback:	At the end of the Exercise, feedback forms were available for participants to complete. These were then collated by the Exercise Control Team and the key learning points extracted.
Debrief Forms:	The formal debrief forms were sent out electronically to all exercise participants on the day following the exercise to allow all delegates the opportunity to feedback and inform the report. In total 64 responses were received. A copy of the debrief form can be found in Appendix B.

7. Lessons identified

7.1 Introduction

This section identifies the key observations and lessons learned from the exercise, and outlines recommendations for action as a result. A summary of the recommendations can be found in Appendix D. Following agreement, the PMB will monitor the completion of these actions by the appointed leads with the agreed timeframes.

During the planning stage of a large multi-agency exercise, many factors require consideration from the design of the exercise, ensuring appropriate population, exercise admin etc. The risk of omitting a small issue in the planning that could become impactful on the delivery of the exercise overall does exist. This could be easily resolved with the development of an Exercise Check List and associated time line which would ensure that not only are the key aim and objectives addressed, but equally the small details that ensure smooth running on the day itself.

Recommendation 3:
Develop an Exercise Check List and associated Time Line for the delivery of LRF multi-agency exercises.

The participating organisations in general had a clear understanding of their own response, and the expectations of the multi-agency group to respond to the incident presented to them. All participants had been sent a copy of the Multi-Agency Pandemic Influenza Contingency Framework in advance of the exercise, and in addition, copies were available on the Exercise Black Swan Resilience Direct page, with hard copies available on each cell table on the day. Delegates were also requested to have familiarised themselves with their own organisational plans for managing a pandemic influenza incident in advance of the exercise.

Evaluation of the exercise concluded that the aim and objectives have been achieved throughout the planning and delivery, and that the process generated a level of assurance for the LRF as well as clear learning points for future work.

7.2 Command and Control

For the multi-agency response to the scenario, the tried and tested command and control processes within Lincolnshire were utilised with the formal stand up of an SCG, TCG and an allocated Command Support Manager (CSM). Learning from previous incidents and exercises, the CSM left the SCG meetings after the initial briefing and any urgent business was discussed, ensuring a link between the operational cells and the SCG, and actively leading the battle rhythm of the exercise.

The exercise planning team provided pre-scripted minutes from a previous hypothetical SCG meeting for the morning session. These minutes included the strategic aims identified in the LRF's Pandemic Influenza Framework. Feedback post exercise indicated that these objectives were effective, but noted that resilience of the response was not included, and that discussions at strategic level highlighted the need to ensure appropriate consideration was given to this.

Recommendation 4:
Include resilience of the response as a strategic objective in the LRF Multi-Agency Framework and examine ways that this can be achieved i.e. via alternative working methods and ensuring a safe working environment (e.g. robust deep cleaning processes / the provision and training of appropriate PPE)

The LRF Multi-Agency Pandemic Influenza Contingency Framework clearly identifies that the SCG will be chaired by NHS England. Locally, when planning for the exercise, it became apparent that this would be difficult to implement in a pandemic situation due to the demands placed on NHS England regionally and nationally. The SCG chair role was therefore undertaken by the Director of Public Health for Lincolnshire (DPH). As co-chair of the LHRP, the relationship between the Local Authority DPH and the NHS relating to Emergency Planning, Resilience and Response (EPRR) is strong, and within Lincolnshire, the DPH is supported by a team of Public Health Consultants who would be able to provide resilience to this arrangement. It was also noted that physical attendance at SCG meetings may not always be possible from some organisations, and that remote attendance may be required in this instance to ensure the correct participants. The LRF has a protocol in place for partnership teleconferences, and this would be utilised if required.

At both strategic and tactical level, it was noted that the LRF Framework did not include tactical options for consideration. Feedback also highlighted that the LRF Framework, whilst recognising the significant impact a pandemic influenza would have on the health and social care sectors, is limited in terms of the impact on wider partners.

Recommendation 5:
Convene a task and finish group led by the LHRP operational sub-group to undertake a full review of the LRF Multi-Agency Pandemic Influenza Contingency Framework

The role of the LCC Tactical Commander was tested as part of the command and control aspect of the exercise. It is noted that in a pandemic influenza scenario, LCC would provide representatives from more than one directorate reflecting the wide range of services provided by the Council. The Tactical Commander role then becomes critical in pulling together all aspects of this work and providing the one update from LCC during TCG meetings. The role is a relatively new function undertaken in the Council, implemented as a recommendation following the Tidal Surge Response in 2013. As a result the role has yet to be tested during an incident response and those trained in undertaking the role have had limited opportunities to familiarise themselves with the realistic expectations required. It is noted that in a response situation to a 'real incident' the LCC Tactical Commander would be fully supported by a member of the LCC's Emergency Planning and Business Continuity Team, however this level of support could not be replicated during the exercise due to the team supporting the exercise control. This issue, coupled with the as yet unutilised role in an incident, resulted in a feeling of lack of clarity about what would be expected from the role. Generating an action card for the role would offer some initial direction for the commanders whilst the 'battle rhythm' of the incident became established.

Recommendation 6:
Develop an action card for the LCC Tactical Commander for the initial stages of an incident.

Pre-scripted minutes from ongoing SCG meetings during the time jump in the middle of the day were not provided, and delegates felt that this would have been useful in assisting the discussions in the afternoon. The decision had been made by the planning team not to provide this information, as some of the actions implemented in the morning session could impact on the discussions held in the afternoon, and this could not be foreseen. Thus a broad overview of the scenario was provided allowing for issues identified in the morning to be followed through if required.

The balancing act between providing too much information in an exercise and therefore constraining conversations, and too little information thus impeding clarity for the group is a difficult one to manage, and, when exercising a 15 week scenario in one day, artificialities will emerge. On reflection, the exercise may have benefited from concentrating on the one time period, allowing for detailed discussions to arise on the potential management over the coming weeks.

Feedback from the Exercise Evaluator identified that the SCG benefited from the wide range of organisations represented to ensure a good overview of the situation within the County was achieved. It was also highlighted that the meetings were managed at a strategic level, and when tactical discussions ensued, the meetings were brought back to a strategic level ensuring effective management and decision making.

It was noted that the TCG meetings did not follow a structured agenda, and that this may have hindered the generation of the tactical plan in the morning aspect of the exercise. The LRF Multi Agency Coordination Aide Mémoire contains a standing agenda for the SCG, and whilst it is recognised that this will be adapted to ensure it is fit for purpose for the incident requiring a response, it does provide a framework to check that key issues are addressed. It would be of benefit to include a draft TCG agenda in the Aide Mémoire for the initial meeting.

Recommendation 7:
Include a draft TCG agenda in the LRF Multi Agency Coordination Aide Mémoire.

The introduction of a second formal strategic meeting in both the morning and afternoon sessions was made by the SCG to enable the group to receive a tactical update from the TCG and supporting cells. Due to tight timeframes, work on the tactical plan was limited, however the SCG felt that formalising the actions both undertaken, and in the process of being undertaken to support the incident strategy was effective, and provided focus for the tactical group.

The TCG in the afternoon presented the SCG with a formal tactical plan with clear identified actions against each strategic objectives. This was well received, and identified as an area of good practice.

Recommendation 8:
Develop a template for the tactical plan based on strategic objectives for delivery to the SCG.

To ensure the training opportunity is maximised, exercises can attract a high number of delegates, and Exercise Black Swan was no exception. On a positive note, this raises the profile of one of the largest civil protection risks faced by the Country, and ensures strategic and tactical commanders are better prepared to respond if required, however it can make for a challenging working environment in the CEC. This was mitigated by ensuring cells with large numbers were housed in smaller rooms outside the main room (Lecture Room 1), which in turn can lead to a feeling of isolation from these cells, and these points of noise and isolation were highlighted in the feedback forms.

There are no easy solutions to the above raised points, however it is worth noting that the number of attendees in the CEC during an incident tends to be significantly lower that during exercises, and it is important to ensure that exercises do not create unrealistic expectations of the perceived work environment during a multi-agency response.

Communications between the SCG, TCG and tactical cells was identified as an area for improvement. This was particularly highlighted by the cells housed out of the main room (Lecture Room 1). It is noted that due to the artificiality of the exercise there was limited time between the strategic and tactical meetings, and therefore time for feedback to the tactical cells post meetings was reduced. It is recognised that the battle rhythm during a live pandemic influenza incident would be significantly different allowing for more interaction between responders. It is worth noting that some of the work carried out within the CEC however would be managed remotely thus highlighting the need for robust communication between the cells to be in place. Multi-Agency exercises and training opportunities continue to offer good opportunities for networking with colleagues from partner organisations who may be involved in a multi-agency responders and better understanding the roles and responsibilities of all responders.

The registration process for attendees in the CEC was tested for the first time in large numbers, and demonstrated the benefit of formally capturing the details of those arriving in the centre. It was noted that the booking in process was lengthy, in particular at the start of the exercise with delegates arriving in large numbers, however this process allows for more efficient centre management during exercises and incidents, and facilitates both health and safety and staff welfare arrangements.

7.3 Health and Social Care Cell

The health and social care cell included representation from the key providers of NHS funded services in Lincolnshire, Adult care and infection prevention from LCC and representatives from Nottinghamshire Foundation Trust representing prison health in HMP Lincoln. As such the cell became the largest in the response. Whilst this was useful due to the level of knowledge and expertise from the relevant organisations, it was noted that at times working in this cell was difficult with the level of noise being cited as a factor.

Due to the size of the group, the health and social care cell were situated in a stand-alone room, and this identified some silo working within the cells. An example of this being that initially the cell was unaware that a representative from the education service was situated on the Community Resilience Cell, and some links between the two groups took time to be established. Whilst taking into account the artificiality of the exercise process, and the limited time available to address the scenario, this could still be an issue replicated during a live incident and it is of equal worth to highlight that in a pandemic influenza incident, alternative methods of working may be explored to facilitate the resilience of the response. Communication therefore needs to be robust. Ensuring each cells aims and objectives, along with a cell member list are made available to all responding to the incident will improve communication.

The group noted the need to ensure all relevant partners were included in the response, identifying NSL, and 111 as key partners for involvement due to the roles they would play in a real scenario. Ensuring that independent providers of social care are also informed and involved in the process was highlighted, along with the suggestion that the Lincolnshire Care Association (LinCA) is involved in the planning process.

Recommendation 9:
Ensure LinCA is included in the consultation of the LRF multi-agency framework post review.

As the scenario progressed, the importance of deploying resources to support critical services in the health and social care sector increased. Discussions ensued about cross organisational working and how this could be achieved. It was gleaned that Lincolnshire Partnership Foundation NHS Trust (LPFT) were able to easily identify how many dual trained nurses would be available to support the response, but it was noted that information on the registered workforce in LCC (including nurses, doctors, pharmacists and occupational therapists) is not easily available within the organisation. Whilst this information may not be required from a single organisational response within LCC, the exercise re-emphasized the need to respond from a multi-agency perspective, and therefore highlighted the benefits of a skills review early in the response.

Recommendation 10:
Ensure that mutual aid considerations are included as a tactical option when reviewing the LRF Multi-Agency Pandemic Influenza Contingency Framework.

7.4 Outbreak Control Team

During the planning for Exercise Cygnus in 2014, discussions were held both locally and with the national planning team with differing opinions on whether a Scientific and Technical Advice Cell (STAC) would be called in a Pandemic Influenza incident, recognising that the specific role of the STAC is to provide specialist advice to the SCG. During a Pandemic Influenza incident, this advice would be given nationally via the Scientific Advisory Group for Emergencies (SAGE) initially to the Cabinet Office Briefing Room (COBR) and then disseminated to a local level, thus potentially negating the need for a STAC. The planning team however recognised that this

potentially left a knowledge gap locally, and therefore implemented an Outbreak Control Team as a tactical cell. The role of this cell was to provide advice where required, interpret scientific information on a local level and answer any queries that may arise from external sources.

The LRF multi-agency framework identifies that during the Detection and Assessment phases of a pandemic, PHE would lead a single Outbreak Control Team across the centre area, and therefore this model was replicated at a local level. Recognising that in reality this would include remote membership from some members due to geographical constraints and pressure of workload regionally, it was agreed that there would be benefit to bringing all relevant players together to generate discussion and identify local issues that may arise.

The team worked effectively throughout the exercise, filling the gap in planning provided in the LRF Framework, and it is recommended that this model be adopted as a tactical option when the LRF Framework is reviewed.

Recommendation 11:
Ensure the LRF Multi-Agency Framework contains the stand up of a local outbreak control team as a tactical option

7.5 Warning and Informing Cell

Similarly to the Outbreak Control Team, the warning and informing cell identified that a clear strategy for communications would be in force from the start of the UK response to the pandemic led by the News Coordination Centre at a national level. This is documented in the UK Pandemic Influenza Communications Strategy 2012[5].

It was also recognised that a local communications strategy would be discussed and requested by the SCG at the initial meeting, and therefore a Lincolnshire communications strategy closely reflecting the UK Pandemic Influenza Communications Strategy had been drafted in advance and circulated as part of the exercise pre-read information. Understanding the importance that social media now plays in any response, the role was fully embedded as part of the plan.

The cell identified the importance of establishing remote links with the communications leads in both NHS England and Public Health England early on in the exercise, to promote a good flow of information and to ensure that one single message was being disseminated.

Recognising that a pandemic influenza incident will be a health led incident, the Warning and Informing cell had strong but not exclusive representation from the Health Community. Sustainability of the health communication response was identified as a potential problem due to the small size of communications departments within each of the providers of NHS funded services.

[5] The UK Pandemic Influenza Communications Strategy 2012 can be found at: https://www.gov.uk/government/publications/communications-strategy-for-uk-flu-pandemics

To support this, and the LRF Warning and Informing response as a whole, a 'health' communications plan for use during a multi-agency response was suggested, with a focus on the undertaking of roles being competence rather than organisationally based. This will ensure that the Warning and Informing cell will always have appropriate representation from the health community.

Recommendation 12:
Develop a communications plan for the health community for use during a multi-agency response.

7.6 Community Resilience Cell

The link between the community resilience cell and the voluntary sector was explored in depth during the exercise. It was noted that the Memorandum of Understanding (MoU) between the voluntary sector and LCC on behalf of the LRF would be activated during a pandemic influenza incident, however that this MoU does not cover all organisations that might attend and assist.

The exercise identified that wider partners within the LRF were not familiar with the scope and limitations of the MoU, and as such some unrealistic expectations were identified about exactly what this would cover.

Recommendation 13:
Actively raise awareness of the capabilities of organisations who have signed up to the Voluntary Sector MoU amongst LRF partners.

Recognising the enormous benefit spontaneous volunteers would bring to the response, the question was asked with the cell about how and who would manage this aspect of the response. Following the East Coast Tidal Surge in December 2013, the 'After Action' report recommended that responsibility for the management and coordination of spontaneous volunteers be clarified, and work has been progressing on this area. A further LRF exercise 'Exercise Barnes Wallis' has since been held on Thursday 12th November and this tested the process in a simulated live scenario. The learning from this exercise will be captured in the report and disseminated amongst LRF partners providing the clarity requested.

The management of expectations from the cell would be a key piece of work that would be required at an early stage. As the scenario progressed and business continuity plans became stretched, the 'fall back' plan appeared to focus heavy reliance on the voluntary sector and 'community resilience' to support the delivery of critical services with unrealistic demands on this sector. Delegates in the cell identified that having a clear plan outlining what could be delivered by the cell early on in the response would support realistic planning of wider partners throughout the incident.

7.7 Excess Deaths Cell

With a case fatality rate of 1.3% and a clinical attack rate of 35%, the scenario presented a challenge for the management of excess deaths. Following on from Exercise Georgiana in 2013, significant work has been undertaken on the mass fatalities plan ensuring the learning gleaned from the exercise has been captured. The revised plan was utilised during Exercise Black Swan and, by working through the options available, plans to support the management of the excess deaths generated by the scenario were made.

Significantly the work undertaken with undertakers, crematoria managers and hospital mortuary staff to identify 'normal' and 'stretch' capacities provided the underlying basis for understanding the impact of the increased death rate and the available tactical options required. Identifying that 'normal' processes once enhanced and expanded through changes in working practices, could continue through the worse of the cycle as long as enhanced body storage facilities are established to hold the backlog was a key learning point from the exercise.

The pre-planning work undertaken by the mass fatalities planning team ensured that the cell was populated with appropriate members to assist in the preparation for the management of the increased death rate, and those with the ability to facilitate the operational process required. The addition of procurement representation would bring benefit to the cell, it was noted that by not having this representative in the cell, these areas were not discussed in depth.

The LRF Mass Fatalities and Excess Deaths plan provides a range of tactical options for dealing with an increase in demand for body storage when activated. The scenario allowed for these options to be discussed, with a view for identifying the most appropriate option to be put in place. Throughout the discussions, a further option was identified within the cell that would better focus on dealing with body storage issues.

Recommendation 14:
Include the additional discussed tactical body storage solution in the LRF Mass Fatalities and Excess Deaths plan.

7.8 Information Cell / Situation Report (SITREP)

In previous incidents and exercises the decision has been made to stand up a Procurement, Information, Resources and Logistics (PIRL) cell. For the purposes of the scenario used in Exercise Black Swan, many of the roles usually undertaken in this cell were naturally absorbed by other more appropriate tactical cells and therefore the PIRL cell morphed into the Information cell with the primary objective being to collate the information generated by the tactical cells and, using this information, populate the SITREP.

Exercise Black Swan offered the first opportunity to test the nationally agreed template for the SCG SITREP in Lincolnshire in either exercise or incident. The new format was agreed by the LRF and formally adopted in Lincolnshire in May 2015.

The population of this SITREP in the information cell proved problematic during the exercise due to a few factors. Firstly, as previously mentioned exercises produce artificial timelines and as such the time offered to generate this SITREP was not sufficient. This is always difficult to manage during exercises and it is recognised that the artificial time frame will have an impact on the ability to complete some tasks.

Secondly, it quickly became apparent that the information cell was not the correct platform to support the generation of the SITREP. The main source of information into the cell was from other tactical support cells, which does not reflect the reporting required in the national SITREP. Discussions during the evaluation phase of the exercise identified that the TCG would supply the relevant information required to comprehensively complete the SITREP, delivering an appropriately completed document to the SCG to form part of their overall picture of the incident within the County.

Recommendation 15:
The national SITREP adopted in Lincolnshire for the SCG is completed during the TCG meetings using the information supplied by the individual agency tactical commanders.

Leading on from this, further discussions were held regarding the most appropriate role to lead on this piece of work. The purpose of the Command Support Manager role is to ensure that all command support functions are co-ordinated, providing adequate support to SCG / TCG and Cell operations. Key to this role is to establish and maintain the 'battle rhythm' for the response, and along with the TCG commander generate the Common Operating Picture (COP). As such, having a clear understanding of the state of play from the individual agencies will ensure a good collective overview of the incident. The CSM is also required to attend all TCG meetings making ownership of the SITREP a natural part of the role.

Recommendation 16:
The function of SITREP generation is included in the Terms of Reference for the Command Support Manager role.

7.9 Resilience Direct

In addition to the new Sitrep, the LRF has agreed to adopt the use of Resilience Direct (RD) as the single information sharing platform for use during response and recovery from incidents. This policy has undergone a consultation process within the LRF and is now awaiting final sign off from the PMB.

Whilst RD has been utilised by partners for plan sharing, and meeting management, the first test of the facility during a live incident was during Exercise Black Swan. Overall, the process demonstrated the benefits that using one single platform will bring, however identified that for this to be effective, partners need to ensure that commanders responding to incidents are both signed up and trained to use RD. During Exercise Black Swan, some time was spent supporting commanders in accessing RD, and uploading documents, this increased the workload of those supporting, who equally had their own role to perform.

Recommendation 17:
The LRF supports multi-agency exercising of Resilience Direct quarterly, ensuring the system is tested regularly and familiarising users with the system.

8 Summary

Exercise Black Swan provided an excellent opportunity to provide the LRF with a level of assurance on the preparedness of the multi-agency response to a pandemic influenza incident within Lincolnshire by testing the LRF Multi-Agency Pandemic Influenza Contingency Framework, and testing the LRF command structure to a health led risk. The exercise provided participants with the chance to consider the longer term considerations associated with a pandemic influenza scenario, in particular the business continuity issues and the ability to ensure the resilience of the response. Delegates were enthusiastic throughout the response, engaging with the scenario and widening discussions where appropriate to ensure all elements were considered. Feedback from the day has been positive with delegates feeling as if it has been a useful experience and the evaluation of the exercise has demonstrated that the overall aim and objectives have been achieved.

Within the constraints of the exercise, valuable lessons have been learned. The exercise identified that further work is required on the LRF Multi-Agency Pandemic Influenza Contingency Framework to ensure that this document provides meaningful tactical options when activated, and it is recommended that a task and finish group led by the LHRP operational sub-group be set up to undertake this work. By undertaking the exercise within the County, the impact on local arrangements was explored as well as taking time to identify the critical services within the County. Recognising the national implications of a pandemic, the opportunity to interact with regional and national colleagues would have brought additional layers of learning to the LRF and this was lost with the cancellation of Exercise Cygnus.

The exercise also provided the opportunity to test the new national SITREP template, and the management of a live incident via Resilience Direct, both providing valuable learning on the integration of these processes in the overall command and control structure within the LRF. Inevitably exercise reports focus on areas where the need for improvement has been identified, however it should also be noted that Exercise Black Swan highlighted many areas of good practice within individual organisations and the multi-agency response as a whole, and this should be commended.

9 Acknowledgements

Many people contributed to both the planning and delivery of Exercise Black Swan, and the planning team would like to extend their thanks to all involved for their time and expertise. The planning team would also like to acknowledge the Exercise Cygnus national planning team from Public Health England for the use of their scientific data and scenario to assist in the planning. The ability to utilise the work undertaken in 2014 assisted greatly in the delivery of the exercise.

The success of an exercise can only be achieved with the full participation of delegates, and the planning team would like to especially thank all participants for their enthusiasm and engagement throughout the day.

Appendix A - Glossary of Terms

BC	Business Continuity
CAR	Clinical Attack Rate
CCG	Clinical Commissioning Groups
CDC	Centre for Disease Control
CEC	County Emergency Centre
CFR	Case Fatality Rate
CO	Cabinet Office
COBR	Cabinet Office Briefing Room
COP	Common Operating Picture
CPX	Command Post Exercise
CRR	Community Risk Register
CSM	Command Support Manager
DCLG	Department for Communities and Local Government
DH	Department of Health
DPH	Director of Public Health
EPRR	Emergency Planning, Resilience and Response
FCO	Foreign and Commonwealth Office
JESIP	Joint Emergency Services Interoperability Programme
LCC	Lincolnshire County Council
LCHS	Lincolnshire Community Health Service NHS Trust
LinCA	Lincolnshire Care Association
LHRP	Local Health Resilience Partnership
LPFT	Lincolnshire Partnership NHS Foundation Trust
LRF	Local Resilience Forum
MoU	Memorandum of Understanding
NCC	News Coordination Centre
OCT	Outbreak Control Team
PHE	Public Health England
PIRL	Procurement, Information, Resources and Logistics
PMB	Programme Management Board
RD	Resilience Direct
SAGE	Scientific Advisory Group for Emergencies
SCG	Strategic Coordinating Group
SITREP	Situation Report
STAC	Scientific and Technical Advice Cell
TCG	Tactical Coordinating Group
The LRF Framework	Multi-Agency Pandemic Influenza Contingency Framework
ULHT	United Lincolnshire Hospitals NHS Trust
WHO	World Health Organisation

Appendix B – Assurance Definitions

Effective	The critical review and assessment of the risk / plan gives a high level of confidence on the multi-agency co-ordination arrangements, management of the risk, and the ability for the LRF partners in Lincolnshire to effectively respond to an incident of this nature. The risk of the multi-agency response to the incident not being effective is low. Controls have been evaluated as adequate, appropriate and operating effectively. As a guide there will be a few low risk / priority recommendations arising from the review.
Some improvement needed	The critical review and assessment of the risk / plan gives a reasonable level of confidence on the multi-agency co-ordination arrangements, management of the risk, and the ability for the LRF partners in Lincolnshire to effectively respond to an incident of this nature. There are some improvements required in either the specific plan / multi-agency co-ordination arrangements, however overall the controls have been evaluated as adequate, appropriate and operating sufficiently so that the risk of the multi-agency response to the incident not being effective is medium to low. As a guide there are low to medium risk / priority recommendations arising from the review.
Major improvement needed	The critical review and assessment of the risk / plan identified numerous concerns on multi-agency co-ordination arrangements, the management of the risk, and the ability for the LRF partners in Lincolnshire to effectively respond to an incident of this nature. There are significant improvements required in either the specific plan or the multi-agency co-ordination arrangements and the controls in place have not been found to be operating effectively or are inadequate. Therefore, it is unlikely that the multi-agency response to the incident will be effective. As a guide there are numerous medium and a few high risk priority recommendations arising from the review.
Inadequate	The critical review and assessment of the risk / plan identified significant concerns on multi-agency co-ordination arrangements, the management of the risk, and the ability for the LRF partners in Lincolnshire to effectively respond to an incident of this nature, and has identified significant concerns requiring urgent attention. There are either gaps in the control framework managing the key risks or the controls have been evaluated as not adequate, appropriate and are not being effectively operated. Therefore the risk of the multi-agency response to the incident not being effective is high. As a guide there are a large number of high risks / priority recommendations arising from the review.

Appendix C – Debrief Form

EXERCISE BLACK SWAN

PARTICIPANT FEEDBACK

Please use this form to comment on the exercise.
Name (optional):.....
Organisation: .....

1. The scenario and supporting material generated useful discussions

Strongly Agree		**Agree**		**Disagree**		**Strong Disagree**	
Comments:							

2. The exercise generated important issues and lessons identified

Strongly Agree		**Agree**		**Disagree**		**Strong Disagree**	
Comments:							

3. The exercise identified the following gaps in planning

Comments:

4. The exercise identified the following gaps in training

Comments:

5. Highlight the main learning point you have gained as a result of the exercise

Comments:

6. Any further comments

Appendix D – Recommendations Table

No.	Recommendation	Lead for Action	Risk Priority Low/Medium/ High	Completion Date	Comments / Updates
1	Develop and agree a standardised exercise evaluation / reporting framework incorporating the assignment of an assurance opinion based on agreed definitions	LRF Exercise Group	Low	September 2016	
2	Include 'Late withdrawal of Exercise Participants undertaking key roles' as a standard risk to LRF Exercise Risk Assessment	LRF Exercise Group	Low	September 2016	
3	Develop an Exercise Check List with associated time line for the delivery of LRF Multi-agency exercises	LRF Exercise Group	Low	September 2016	
4	Include resilience of the response as a strategic objective in the LRF Multi-Agency Pandemic Influenza Contingency Framework and examine ways that this can be achieved i.e. via alternative working method and ensuring a safe working environment through robust deep cleaning process / the provision and training of appropriate PPE	Pandemic Influenza Framework Task and Finish Group	Medium	September 2016	
5	Convene a task and finish group led by the LHRP operational sub-group to undertake a full review of the LRF Multi-agency Pandemic Influenza Contingency Framework	Pandemic Influenza Framework Task and Finish Group	Medium	September 2016	

No.	Recommendation	Lead for Action	Risk Priority Low/Medium/ High	Completion Date	Comments / Updates
6	Develop an action card for the LCC Tactical Commander for the initial stages of an incident	LCC Emergency Planning and Business Continuity	Medium	September 2016	
7	Include a draft TCG agenda in the LRF Multi-Agency Coordination Aide Mémoire	LCC Emergency Planning and Business Continuity	Medium	September 2016	
8	Develop a template for the tactical plan based on strategic objectives	LCC Emergency Planning and Business Continuity	Medium	September 2016	
9	Ensure LinCA is included in the consultation of the LRF Multi-Agency Pandemic Influenza Contingency Framework post re-write	Pandemic Influenza Framework Task and Finish Group	Low	September 2016	
10	Ensure mutual aid considerations are included as a tactical option when reviewing the LRF Multi-Agency Pandemic Influenza Contingency Framework	Pandemic Influenza Framework Task and Finish Group	Low	September 2016	

No.	Recommendation	Lead for Action	Risk Priority Low/Medium/ High	Completion Date	Comments / Updates
11	Ensure the LRF Multi-Agency Pandemic Influenza Contingency Framework contains the stand up of a local outbreak control team as a tactical option	Pandemic Influenza Framework Task and Finish Group	Medium	September 2016	
12	Develop a communications plan for the health community for use during a multi-agency response	LHRP operational sub-group	Low	September 2016	
13	Actively raise awareness of the capabilities of organisations who have signed up to the Voluntary Sector MoU amongst LRF partners	LCC Emergency Planning and Business Continuity	Low	September 2016	
14	Include the additional discussed tactical body storage solution in the LRF Mass Fatalities and Excess Deaths plan	Mass Fatalities Planning Group	Low	September 2016	
15	Include the completion of the SITREP as an agenda item for TCG meetings	LCC Emergency Planning and Business Continuity	Low	September 2016	
16	Include the function of the SITREP generation in the Terms of Reference for the Command Support Manager role	LCC Emergency Planning and Business Continuity	Low	September 2016	

No.	Recommendation	Lead for Action	Risk Priority Low/Medium/ High	Completion Date	Comments / Updates
17	LRF partners to agree to supporting quarterly multi-agency exercising of Resilience Direct to promote familiarisation of the system	LCC Emergency Planning and Business Continuity	Low	March 2016	

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

Open Report on behalf of St Barnabas Lincolnshire Hospice

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**20 April 2016**
Subject:	**St Barnabas Lincolnshire Hospice**

Summary:

Palliative and end of life care seeks to improve the quality of life for patients with life limiting conditions. St Barnabas Hospice Trust was established in 1979 to improve end of life care for the people of Lincolnshire.

The Trust continues to be committed to improving and developing palliative and end of life care services for the people of Lincolnshire in partnership with other health and social care providers.

The Organisation is engaged in the Lincolshire Health and Care development programme both on the ground through neighbourhood team working and at senior level through established partnerships.

Actions Required:

To consider and comment on the content of this update report for St Barnabas Hospice Trust.

Definition of Palliative Care

Palliative[1] care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, (**this includes both cancer and *non cancer conditions)*** through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

[1] World Health Organisation definition of palliative care (2014)

Palliative care:

- provides relief from pain and other distressing symptoms;
- affirms life and regards dying as a normal process;
- intends neither to hasten or postpone death;
- integrates the psychological and spiritual aspects of patient care;
- offers a support system to help patients live as actively as possible until death;
- offers a support system to help the family cope during the patient's illness and in their own bereavement.
- uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated;
- will enhance quality of life, and may also positively influence the course of illness;
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

Background

St Barnabas Hospice Trust was created in 1979 by a small group of people to provide a haven of comfort and care, with total funds amounting to £270. By 1989, the reputation of the hospice and demand for the service had grown and the hospice purchased a building on Nettleham Road. This building continues to provide inpatient facilities for eleven patients.

In 2008 the inpatient unit underwent an extensive refurbishment programme and was re-opened in December 2008. An official opening ceremony was performed by Professor Mike Richards, CBE, and National Director for Cancer and End of Life Care, in February 2009.

Over the next few years the Trust expanded further and by 1994 had five day centres operating around Lincolnshire, i.e. Gainsborough, Sutton-on-Sea, Lincoln, Boston and Spalding. Further services we developed to include hospice at home, welfare support, and family support and bereavement services.

The aim of all of the services is to support the patient psychologically, physically and emotionally to enable them to achieve, within the limits of their illness, what is important to them. This is achieved through a combination of activities including nursing care and medical care, physiotherapy and occupational therapy, arts and crafts, complementary therapies, counselling and spiritual care.
St Barnabas currently employs approximately 350 staff and has over 1000 volunteers who help to provide support to patients and their families at all sites throughout the county. The Trust Shops and Fundraising Teams are required to raise in excess of £4 million to fund services.

Introduction

Nationally, over the next 10 years, not only is the incidence of cancer projected to rise by 30% in men and 12% in women, but dementia and chronic illnesses linked to lifestyle will also increase. It is estimated that by 2021 over one million people in the UK will be living with dementia – with a further half a million likely to have undiagnosed dementia. This increase in people living with, and dying from, multiple chronic conditions will have a significant impact on the families and communities who support them.

St Barnabas Hospice is a county-wide organisation that recognises the differing demographic and health challenges faced by communities within Lincolnshire. The ageing population and long-term health needs of those on the east coast being a specific example. We acknowledge that our services need to reflect local needs.

Our services

St Barnabas Hospice has the needs of the patients at the centre of everything we do. We seek to ensure that patients with palliative and end of life care needs, irrespective of their diagnosis, have access to and receive high quality support and care that is centred around them. Whether we are delivering care in the patient's home, nursing home or hospital we seek to improve their experience and enhance their quality of life.

The services and expertise we offer for people from the age of 18 years and upwards have been developed in a variety of care settings to support a wide range of needs from controlling pain and other distressing symptoms to accessing welfare benefits advice.

Palliative Care Co-ordination Centre

The Palliative Care Co-ordination Centre, based in in Lincoln, has a county-wide remit to co-ordinate care packages to support patients who have been diagnosed with any life-limiting illness, so that they can stay safely at home if that is their preferred place of care. The team consists of a number of co-ordination administrators and specialist palliative care nurses, who provide advice and support to patients, their families and clinical staff.

The co-ordination centre arranges care from a number of providers, including our own Hospice at Home teams, Marie Curie night care and Rapid Response services and, where healthcare or joint health and social funding has been allocated, private care agencies.

The choice of provider and the number of visits allocated depends on the patient's clinical needs and urgency of those needs. These needs are determined by regular assessment of the patient and their family circumstances, using a Responsive Needs Tool, developed by the Hospice and shared across all health and social care providers in Lincolnshire.

In order to achieve the patient's preferred place of care, the centre aims to provide the right level of care to the right patient at the right time. The PCCC is open 365 days per year, Monday to Friday 9am to 6pm, weekends and bank holidays 9am to 5pm.

During 2015/16 1,538 new referrals were received by the service. Over 225 of these patients lived alone, and required very complex packages of care to achieve their preferred place of care.

Hospice at Home

Hospice at Home is a service for people with an advanced, life limiting illness who choose to be cared for and to die in their own home.

Hospice at Home is a countywide service, operating 7 days a week. Care is provided by a team of experienced specialist registered nurses and healthcare support workers. All care is planned with the person and their relatives/carers working closely alongside community nursing teams to meet the needs of both the patient and the family.

As well as providing personal care for the patient a major part of our role is to manage physical and psychological symptoms, and provide advice and emotional, social and spiritual support to the patient, and those significant to them.

During 2015/16 1,715 patients have received care from Hospice at Home teams across Lincolnshire and 90% of patients were able to die in their preferred place of death.

Inpatient Unit

Our 11-bed specialist inpatient unit, located in Lincoln, is the only specialist palliative care inpatient unit in Lincolnshire.

The inpatient unit supports patients with complex physical or emotional care needs. The multi professional team work closely with patients, families and carers to manage complex symptoms.

Year to date 2015/16 there have been 145 admissions to the unit, the largest number of referrals are received from the community and the hospital specialist palliative care service.

Day Therapy

Our Day Therapy service welcomes anyone over the age of 18 years who has a life limiting illness, and aims to support people to live independently, through a model of palliative rehabilitation, advice and information and helps people to make informed choices about their future care.

Care is provided by a team of experienced specialist registered nurses, occupational therapists, physiotherapists, health and rehabilitation support workers, chaplains, complementary therapists and volunteers.

During 2015/16 780 referrals to the service were received.

Welfare Service

The Welfare Benefits Service is a team of experienced benefits advisors who provide confidential advice on all Personal Independent Payments (PIP), tax credits, grants and blue badges.

Many people do not receive payments to which they are entitled because they believe that their income or savings are too high. This is frequently not the case. Benefits advice can be given over the telephone, face to face by appointment at one of our sites across the County or, in exceptional circumstances we can visit you in your own home.

During 2015 the team received over 300 referrals per month and secured in excess of £7 million of benefits for patients and their carers.

Family Support Service

St Barnabas Family Support Service is a service providing emotional and psychological support to patients, their families and carers, together with support for those who have experienced bereavement.

The service consists of a small team of paid staff and approximately eighty volunteers who work throughout the county. Our volunteers all receive training and we have a team of fully qualified and some trainee counsellors.

The bereavement service facilitates several bereavement groups across the County. The purpose of these groups is to enable bereaved people to meet with each other in a safe and comfortable place with trained, experienced volunteer help at hand.

Support can also be offered according to need on an individual face to face or telephone basis from one of our trained listeners or by a member of our counselling team.

Groups are structured to enable support to be provided relevant to the individual and members are encouraged to move through from bereavement to friendship to companion groups at appropriate stages. Support is available through these groups for as short or as long a time as is required.

Currently there are 568 clients receiving support from the service.

Hospice in the Hospital – a partnership initiative

This Unit is a unique partnership between St Barnabas, United Lincolnshire Hospitals Trust and South-West Lincolnshire Clinical Commissioning Group. The unit provides six community hospice beds to serve South-West Lincolnshire community and is based within Grantham and District General District Hospital.

The care is provided by a nurse led team, supported by General Practitioners and other professionals.

The unit directly benefits local people who require end of life care in an in-patient setting, assessment and treatment of symptoms or palliative rehabilitation. Clinical treatment provided within this unit particularly benefits those patients who have frequent hospital admissions for symptom management as they will receive timely interventions and will be able to return home to the care of community teams for on-going support.

Since opening in September 2014 the unit has cared for 165 patients.

Service Developments

St Barnabas Hospice continues to be ambitious in developing and improving services, to ensure services evolve to meet patient and carer needs and to widen access to palliative and end of life care for all.

The priorities the Trust has established for the forthcoming year reflect local need and national guidance. The following national documents describe some of the critical outcomes and success factors for palliative and end of life care.

Ambitions for palliative and end of life care

The national palliative and end of life care partnership[2] has identified the ambitions and local actions that will support people's wishes. We fully support and endorse these ambitions and they form the basis of our strategy:

- Each person is seen as an individual and care is goal orientated and person-centred.
- There is fair access to care, irrespective of diagnosis or place of residence.
- Comfort, wellbeing and control our maximised taking a rehabilitative palliative care approach to self-management and empowerment, enabling people to maintain their independence and to live until they die.
- The care provided is integrated and co-ordinated, staff work with other providers to ensure the patient receives the right care at the right time from the right person in a timely manner.
- Care is delivered by well-trained, skilled, supported and resilient multi-professional teams.

Every Moment Counts[3]

This narrative document informs us from the perspective of patents, carers and families what person centred care means from the viewpoint of someone approaching the end of life and what really matters to them:

[2] Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020
http://endoflifecareambitions.org.uk/wp-content/uploads/2015/09/Ambitions-for-Palliative-and-End-of-Life-Care.pdf

[3] Every Moment Counts (2015) http://www.nationalvoices.org.uk/every-moment-counts-new-vision-coordinated-care-people-near-end-life-calls-brave-conversations

- We work for my goals and the quality of my life and death and I am respected as a whole person, not treated as an illness.
- I have honest discussions and the chance to plan and I am confident that staff are able to have difficult conversations.
- The people who are important to me are at the centre of my support and I can decide the people most important to me.
- My physical, emotional, spiritual and practical needs are met and I am helped to feel safe, in control, comfortable and dignified with as little fear as possible.

Commitment to Carers[4]

This document describes the critical role of carers in supporting patients. Caregivers may be prone to depression, grief, fatigue and changes in social relationships. They may also experience personal physical health problems and fatigue. Perceived caregiver burden has been associated with an increase in the use of primary care services by carers, premature institutionalisation and patient reports of unmet needs.

St Barnabas also recognises the importance of carers and is committed to embedding the priorities outlined in the Commitment to Carers document by developing direct supportive interventions for carers including strategies and support for psychological, spiritual and emotional wellbeing.

Delivering Our Ambitions

The table below identifies the actions we are taking, or will take, to continue the improvement of palliative and end of life care services in Lincolnshire, taking into account the documents referenced above. To deliver our ambitions we plan to:

Our Ambitions	Making this a reality
Continue to develop our understanding of each locality within Lincolnshire, listening to local communities, and our partners, so that our plans reflect and are responsive to the needs of local populations.	Develop local strategies for each locality – we are currently consulting on the first of these – East Lindsey. We have a programme of public engagement, including a *'listening volunteers'* project which supports the gathering of valuable patient and family feedback on their experience of end of life care in Lincolnshire.

[4] Commitment to Carers (2014) https://www.england.nhs.uk/wp-content/uploads/2-14/05/commitment-to-carers-may.14.pdf

Our Ambitions	Making this a reality
Support better access to palliative care services by providing care closer to people's homes, including care homes and to those who are in minority groups.	Working with other providers to support End of Life care in care homes and a specific project *'Hospice in your Care Home'*. We are working with HMP North Sea Camp to deliver Advance Care Planning training for the prison population who are approaching end of life.
Ensure that our staff and volunteers continue to receive education and training, using best practice evidence to support people's goals and, quality of life and death.	We have recruited a clinical practice educator supporting continuing professional development of the workforce. We are developing a training package to support staff to care for people with learning disabilities at the end of life. We are supporting our specialist nurses to undertake Non-medical prescribing.
Continue to work closely with families, GPs, community nurses, hospital teams and other agencies involved in the care and support of patients.	We have funded and recruited to a Matron in Palliative and End of Life Care who will work with the palliative care teams across the United Lincolnshire Hospitals Trust.
Work with partner organisation to actively explore new ways of working and opportunities to better co-ordinate care, including the use of technology.	Introduce a patient flow system 'Cayder', alongside the Lincolnshire Community Health Services to improve discharge from hospitals, better identify capacity and resources and provide timely responses. We are in the final stages of deploying EPaCCS (Electronic Palliative Care Co-ordination System) which will share pertinent end of life information across health (and eventually social care) providers to support seamless care, patient choice and unnecessary admission to acute care.
Offer specialist education and training opportunities for health and social care professionals.	We continue to provide a range of education and training – we have recently provided education to Lincolnshire County Council for both qualified Social Workers and Social Support Workers.
Share our estate and that of others to support partnership working and the local community caring for those with palliative and end of life care needs.	We are exploring opportunities to work differently and to share premises to benefit health professionals and patients locally.
Deliver rehabilitative palliative care through our day therapy services across local communities.	We are reviewing demand and capacity of our day therapy services and seeking opportunities to deliver day therapy services to the housebound and those in isolated communities.

Develop our services to better support the emotional, spiritual and psychological well-being of patients, their carers and families during the person's illness and into bereavement.	We are developing an integrated spiritual and wellbeing assessment to determine need and who is best placed to support the person, we are also training staff in Cognitive Behavioural Therapy and Mindfulness to support earlier, preventive psychological support and reduce the need to refer to mental health providers.
Encourage and develop the community's ability to discuss dying, death and bereavement in open, honest and more confident ways.	We are supporting Dying Matters week (May 16-22nd) across the county with various activities including death cafes in Lincoln and Skegness including a family open day to acknowledge the needs of parents with young children who are bereaved and the specialist support they require. That week we will also be launching an App – *'Good Goodbyes'* that promotes conversations about death and dying. A priority is the development of a Dementia Strategy for the organisations that aligns with the Lincolnshire Strategy – specifically enabling people to make advance care plans whilst they have capacity to make informed choices.
Improve public awareness of the difficulties people face and create a better understanding of the help that is available and to identify new ways to give the practical support, information and training that enables families, neighbours and community organisations to help.	We are working with local communities, third sector organisations and other social care providers to support the ownership of end of life care in local communities.

Conclusion

People, who face progressive life-limiting illness and those important to them, require different levels of health and social care at different times in their illness in order to live as well as possible, for as long as possible. Palliative and end of life care is important, our society is ageing with 10 million people in the UK over the age of 65.

As medical treatments continue to improve with many people surviving and living with continuing illness, including heart and respiratory disease, diabetes, and cancer. This has led to people experiencing a different set of health needs, frequently complex in nature. Today at least 15 million people in the UK have a chronic condition and the number of people with more than one chronic condition is growing rapidly.

St Barnabas Hospice prides itself in leading local, regional and national initiatives to improve end of life care outcomes locally. Despite the economic and demographic challenges we face we are confident that we can continue to achieve our ambitions for the maximum impact on patient care.

Consultation

This is not a consultation item.

Appendices

There are no appendices.

Background Papers

Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020 (2015) http://endoflifecareambitions.org.uk/wp-content/uploads/2015/09/Ambitions-for-Palliative-and-End-of-Life-Care.pdf

Every Moment Counts (2015) http://www.nationalvoices.org.uk/every-moment-counts-new-vision-coordinated-care-people-near-end-life-calls-brave-conversations

Commitment to Carers (2014) https://www.england.nhs.uk/wp-content/uploads/2-14/05/commitment-to-carers-may.14.pdf

This report was written by Michelle Webb, Director of Patient Care, who can be contacted on 01522 518200 or Michelle.Webb@stbarnabashospice.co.uk

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

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

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**20 April 2016**
Subject:	**Community Pharmacy in 2016/17 and Beyond – Views of the Lincolnshire Local Pharmaceutical Committee**

Summary

On 17 December 2015, the Department of Health began a consultation with the Pharmaceutical Services Negotiating Committee on how services would be delivered to meet the £2.63 billion funding cap set by the Department of Health for 2016/17.

The Health Scrutiny Committee is requested to consider the potential impact of the funding reductions on community pharmacies in Lincolnshire.

Steve Mosley, the Chief Officer of the Lincolnshire Local Pharmaceutical Committee, is due to attend for this item and present the views of Lincolnshire Local Pharmaceutical Committee, which are also contained within this paper.

Actions Required:

To consider the information presented on the Government consultation *Community Pharmacy in 2016/17 and Beyond* and to consider the potential impact on pharmacies in Lincolnshire, as presented by the Lincolnshire Local Pharmaceutical Committee.

1. Background

Introduction

On 17 December 2015 the Department of Health began a consultation with the Pharmaceutical Services Negotiating Committee (PSNC), a national organisation which promotes and supports the interests of all NHS pharmacies in England. The consultation, entitled *Community Pharmacy in 2016/17 and Beyond*, took the form of an open letter from

the Director General of Innovation, Growth and Technology at the Department of Health and the Chief Pharmaceutical Officer at NHS England, to the PSNC. Other national pharmacy bodies such as the Royal Pharmaceutical Society and the General Pharmaceutical Council were also copied into the letter, which is attached at Appendix A to this report.

Consultation Period

Originally the closing date for all responses to the consultation was 24 March 2016. The Department of Health has extended the closing date for the consultation on the Drug Tariff determinations to 24 May 2016. The consultation date for the Pharmacy Integration Fund element of the consultation closed on 24 March.

Further information on the consultation is available at the following link:

https://www.gov.uk/government/publications/putting-community-pharmacy-at-the-heart-of-the-nhs

Content of Letter

The letter advised that under the funding settlement for 2016-17 community pharmacies would receive no more than £2.63 billion, which represents a £170 million reduction (6.1%) from the £2.8 billion allocated in 2015-16. The reduction would be delivered through Drug Tariff amendments in the six months from October 2016.

Views of the Lincolnshire Local Pharmaceutical Committee

The impact on community pharmacy services across Lincolnshire will be significant, if they pass as described in the letter. Lincolnshire is under-served by community pharmacies compared to England as a whole. With 11,724 pharmacies across England in April 2015, there is one pharmacy per 4,600 population. In Lincolnshire, it is closer to one pharmacy per 6,100. Despite the fact that 40% of Lincolnshire residents are served by dispensing doctors due to the rural nature of the County, the 121 pharmacies that we do have dispense approximately 50% more prescription items than an average pharmacy in England. This means an arbitrary funding cut delivered via Drug Tariff adjustment will have a more punitive impact on Lincolnshire community pharmacies than the average pharmacy. Using the information in the letter and subsequent briefing documents published by the Department, the Lincolnshire Local Pharmaceutical Committee estimates that the average financial impact for a community pharmacy in England will be approximately £14,500. For a pharmacy in Lincolnshire this is likely to be £22,000.

That is a significant loss of funding for any small business to endure, especially being delivered across the six months of autumn and winter, typically the period of time NHS services are under their greatest strain. It will land not as a 6.1% cut, but a 12.2% cut just as pharmacies will be asked by their colleagues across primary care to support the winter pressures that traditionally arise. Lincolnshire Local Pharmaceutical Committee contends that the Department of Health should be actively investing in community pharmacy to take pressure of GPs, A&Es, Minor Injury clinics and Out-of-Hours Services.

The community pharmacy network in England costs the equivalent of £1, per person, per week and is the most accessible source of healthcare advice available to the public. The 121 pharmacies in Lincolnshire provide access to highly quality healthcare advice for 112 out of the 168 hours in a week, with no appointment needed. Commissioners of health and social care services need to build on that network and use it to provide services closer to peoples homes, utilising the expertise of the pharmacy team. By commissioning services to support urgent care, long term condition management, medicines optimisation and reduction of medicines waste we believe that community pharmacy can deliver savings to the NHS that equal or exceed those the Department seek to deliver through the proposed funding cuts.

3. Consultation

This item does not refer to direct consultation with the Health Scrutiny Committee for Lincolnshire. **This item provides information on a consultation undertaken by the Department of Health with the Pharmaceutical Services Negotiating Committee, and other representative organisations, which in the view of the Lincolnshire Local Pharmaceutical Committee is likely to have impacts on the level of pharmacy services in Lincolnshire**.

4. Appendices – These are listed below and attached at the end of the Report.

Appendix A	Letter from the Department of Health to Chief Executive of the Pharmaceutical Services Negotiating Committee – 17 December 2015.

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

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

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Department of Health

NHS England

Sue Sharpe
Chief Executive
Pharmaceutical Services Negotiating Committee
Times House
5 Bravingtons Walk
LONDON
N1 9AW

17 December, 2015

Dear Sue,

Community pharmacy in 2016/17 and beyond

We are at an important point in the development of the NHS in England. Spending on health continues to grow, and the Spending Review announced a £10 billion real terms increase in NHS funding in England between 2014/15 and 2020/21, of which £6 billion will be delivered by the end of 2016/17. The Five Year Forward View sets out a clear direction, building on the strengths of the NHS and rising to the challenges of the future. These include responding to changes in patients' health needs, expectations and personal preferences; rapid developments in treatment, technologies and care delivery; and transformational change through new models of care to improve patient outcomes.

The Five Year Forward View also described the need for greater efficiency and productivity, and in the Spending Review the Government re-affirmed the need for the NHS to deliver £22 billion in efficiency savings by 2020/21. Community pharmacy is a core part of NHS primary care and has an important contribution to make as the NHS rises to all of these challenges.

Through this letter we invite the PSNC as the body recognised under section 165(1)(a) of the NHS Act 2006 as representing all community pharmacies providing NHS pharmaceutical services in England, to enter discussions with the Department of Health, supported by NHS England, on changes to the community pharmacy contractual framework for 2016/17 and beyond, linked to the Spending Review. Given the potential impact of these proposals, in keeping with section 165(1)(b) of the NHS Act 2006, the Department will also consult with the organisations listed as copy recipients of this letter and others, including patient and public groups.

Pharmacy at the heart of the NHS

There is real potential for far greater use of community pharmacy and pharmacists: in prevention of ill health; support for healthy living; support for self-care for minor ailments and long term conditions; medication reviews in care homes; and as part of more integrated local care models. To this end we need a clinically focussed community pharmacy service that is better integrated with primary care. That will help relieve the pressure on GPs and Accident and Emergency Departments, ensure optimal use of medicines, better value and better patient outcomes, and contribute to delivering seven day health and care services.

Recent initiatives – such as clinical pharmacists in GP practices – will promote pharmacy and pharmacists in the short-term. However, we would like to take this further and bring pharmacy even closer into the wider primary care and community health system. We want pharmacists to bring their skills more to GP practices, care homes and urgent care, using those opportunities to improve and protect people's health, aligning with the emerging new models of care. So, alongside the funding discussion with the community pharmacy sector, the Department will consult on how best to introduce a Pharmacy Integration Fund to help transform how pharmacists and community pharmacy will operate in the NHS, bringing clear benefits to patients and the public.

Making efficiencies

As well as providing more effective patient and public friendly services, community pharmacy also has to play its part in delivering the efficiencies required by the Government's recently published Spending Review and to support the need for greater efficiency and productivity as outlined in the Five Year Forward View.

This will involve reductions in NHS funding for community pharmacies in England. For 2015/16, the funding commitment for pharmacies in England is £2.8 billion under the community pharmacy contractual framework (essential and advanced services). In 2016/17 this funding will be no higher than £2.63 billion. We anticipate that the funding reductions will take effect from October 2016, giving community pharmacies time to prepare for this change. Given the context of the Spending Review, and to facilitate a clear accountability framework, Department of Health Ministers will be responsible for all the proposals dealing with the necessary savings and the related reforms, and so the implementing measures in the Drug Tariff will be Ministerial determinations.

The 2016/17 funding quantum remains significant in a period when the NHS and public services have to become more efficient. The Government believes those efficiencies can be made within community pharmacy without comprising the quality of services or public access to them. In some parts of the country there are more pharmacies than are necessary to maintain good access. 40% of pharmacies are in a cluster where there are three or more pharmacies within ten minutes' walk. The development of large-scale automated dispensing, such as 'hub and spoke' arrangements, also provides opportunities for efficiencies. We want to work with pharmacy bodies and patient groups on how we can best maintain patient and public access whilst pursuing these efficiencies.

We will ensure that those community pharmacies upon which people depend continue to thrive. The Department will consult on the introduction of a Pharmacy Access Scheme, which would provide more NHS funds to certain pharmacies compared to others, considering factors such as location and the health needs of the local population.

The Department will also consult on how best to drive new models of ordering prescriptions and collecting dispensed medicines. The online journey for patients remains slow and awkward and we want patients to be offered more choice about how they access their medicines and advice. In future, patients should be able to choose to order their prescriptions on line and have them delivered to their home if they wish, or to 'click and collect' if they prefer. We will also be looking at steps to encourage the optimisation of prescription duration, balancing clinical need, patient safety avoidance of medicine waste and greater convenience for patients.

The Department will separately consult on changing the Human Medicines Regulations 2012 (HMR 2012) to allow all pharmacies to access the efficiency created by 'hub and spoke' dispensing, with the aim of making this legislative change by October 2016. This could help pharmacies to lower their operating costs and free up pharmacists to provide more clinical services and public health services. We welcome the views of the pharmacy sector on how best to support efficiency and patient service through these innovative dispensing arrangements.

Consultation process

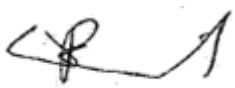
As indicated above, the budget for community pharmacy in 2016/17 is to be set no higher than £2.63 billion, with the reduction in funding expected to take effect from October 2016. We want to work closely with community pharmacy and others on the changes necessary to deliver these efficiencies. At the same time, we want to ensure we retain good access to pharmaceutical services through local community pharmacies and online services, and support the transformation to a more clinically focussed community pharmacy service that is better integrated with primary care,

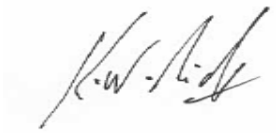
with pharmacists having a more prominent role across the NHS, exploiting opportunities to improve and protect people's health. We will also consider issues arising under the public sector equality duty, relevant duties of the Secretary of State under the NHS Act 2006 and the family test.

Consultation on these proposals will continue with the PSNC and others through to 24 March 2016. This will take the form of detailed discussions with the PSNC, together with engagement opportunities for the organisations listed as copy recipients and for others, including patient and public representatives. We will feedback from those engagement opportunities into the discussions with the PSNC, and so those discussions with the PSNC will be at the heart of this expanded consultation process. The proposals to further enable 'hub and spoke' dispensing through changing the HMR 2012 will be the subject of a separate consultation exercise in 2016.

These consultation processes are an important opportunity to help further develop the proposals and inform the decisions taken by Department of Health Ministers, which will shape community pharmacy's role in the NHS in future. We look forward to working together to transform community pharmacy for 2016/17 and beyond, to the benefit of patients and the public.

Yours sincerely





Will Cavendish
Director General, Innovation,
Growth and Technology
Department of Health

Keith Ridge
Chief Pharmaceutical Officer
Supporting NHS England,
Department of Health, and
Health Education England

Copy:

Pharmacy Voice (comprising the Association of Independent Multiple pharmacies, the Company Chemists Association and The National Pharmacy Association)
Royal Pharmaceutical Society
Association of Pharmacy Technicians UK
General Pharmaceutical Council

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

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

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**16 March 2016**
Subject:	**Work Programme**

Summary:

This item invites the Committee to consider and comment on its work programme.

Actions Required:

To consider and comment on the content of the work programme.

1. The Committee's Work Programme

The work programme for the Committee's meetings over the next few months is attached at Appendix A to this report, which includes a list of items to be programmed.

Set out below are the definitions used to describe the types of scrutiny, relating to the proposed items in the work programme:

Budget Scrutiny - The Committee is scrutinising the previous year's budget, the current year's budget or proposals for the future year's budget.

Pre-Decision Scrutiny - The Committee is scrutinising a proposal, prior to a decision on the proposal by the Executive, the Executive Councillor or a senior officer.

Performance Scrutiny - The Committee is scrutinising periodic performance, issue specific performance or external inspection reports.

Policy Development - The Committee is involved in the development of policy, usually at an early stage, where a range of options are being considered.

Consultation - The Committee is responding to (or making arrangements to respond to) a consultation, either formally or informally. This includes pre-consultation engagement.

Status Report - The Committee is considering a topic for the first time where a specific issue has been raised or members wish to gain a greater understanding.

Update Report - The Committee is scrutinising an item following earlier consideration.

Scrutiny Review Activity - This includes discussion on possible scrutiny review items; finalising the scoping for the review; monitoring or interim reports; approval of the final report; and the response to the report.

In considering items for inclusion in the Committee's work programme, Members of the Committee are advised that it is not the Committee's role to investigate individual complaints or each matter of local concern.

2. Conclusion

The Committee is invited to consider and comment on the content of the work programme.

3. Consultation

There is no consultation required as part of this item.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Health Scrutiny Committee Work Programme

5. Background Papers

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

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

APPENDIX A

HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE

Chairman: Councillor Mrs Christine Talbot
Vice Chairman: Councillor Chris Brewis

20 April 2016		
Item	**Contributor**	**Purpose**
Boston West Hospital	Carl Cottam, General Manager, Boston West Hospital.	Status Report
Urgent Care Update	Sarah Furley, Urgent Care Programme Director, Lincolnshire East Clinical Commissioning Group	Update Report
United Lincolnshire Hospitals NHS Trust – Pharmacy Services	Colin Costello, Chief Pharmacist, United Lincolnshire Hospitals NHS Trust	Update Report
Exercise Black Swan – Outcomes and Learning	David Powell, Head of Emergency Planning, Lincolnshire County Council Cheryl Thomson, Public Health Programme Officer, Health Protection, Lincolnshire County Council	Update Report
St Barnabas Lincolnshire Hospice	Chris Wheway, Chief Executive, St Barnabas Hospice Trust	Status Report
Community Pharmacies in Lincolnshire	Steve Mosley, Chief Officer, Lincolnshire Local Pharmaceutical Committee	Status Report

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

18 May 2016		
Item	**Contributor**	**Purpose**
Lincolnshire Partnership NHS Foundation Trust – Outcomes from Care Quality Inspection	Dr John Brewin, Chief Executive, Lincolnshire Partnership NHS Foundation Trust	Status Report

18 May 2016 – 2.30 – 4.00 pm
There will be a briefing meeting for Members of the Committee on the Sustainability and Transformation Plan and Lincolnshire Health and Care

15 June 2016		
Item	**Contributor**	**Purpose**
Lincolnshire Recovery Programme Board	Jim Heys, Locality Director NHS England – Midlands and East (Central Midlands) Jeff Worrall, Portfolio Director, NHS Trust Development Authority	Update Report
Recruitment and Retention of GPs in Lincolnshire	Dr Kieran Sharrock, Medical Director, Lincolnshire Local Medical Committee	Update Report

15 June 2016 – 2.00 – 3.30 pm
There will be a training session briefing meeting for the Committee on the Sustainability and Transformation Plan and Lincolnshire Health and Care

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

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

Items to be programmed

- Reducing Obesity for Adults and Children
- Dementia and Neurological Services
- Queen Elizabeth Hospitals, King's Lynn – General Update Report
- Lincolnshire Health and Care – Strategic Outline Case
- Child and Adolescent Mental Health Services
- Joint Strategic Needs Assessment
- Reducing Alcohol Harm in Lincolnshire – Update
- Child and Adolescent Mental Health Services

For more information about the work of the Health Scrutiny Committee for Lincolnshire please contact Simon Evans, Health Scrutiny Officer, on 01522 553607 or by e-mail at Simon.Evans@lincolnshire.gov.uk

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