Leicester
City Council

MEETING OF THE HEALTH AND WELLBEING SCRUTINY COMMISSION

DATE: TUESDAY, 14 JANUARY 2014
TIME: 5:30 pm
PLACE: THE TEA ROOM - FIRST FLOOR, TOWN HALL, TOWN HALL SQUARE, LEICESTER

Members of the Commission

Councillor Cooke (Chair)
Councillor Sangster (Vice-Chair)

Councillors Chaplin, Cleaver, Desai, Grant, Singh and Westley

Members of the Commission are invited to attend the above meeting to consider the items of business listed overleaf.

G. J. Carey

For Monitoring Officer

Officer contacts:
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Tel: 0116 2298813, e-mail: Graham.Carey@leicester.gov.uk
Anita Patel (Scrutiny Support Officer):
Tel: 0116 2298825, e-mail: Anita.Patel@leicester.gov.uk)
Leicester City Council, Town Hall, Town Hall Square, Leicester LE1 9BG

INFORMATION FOR MEMBERS OF THE PUBLIC

ACCESS TO INFORMATION AND MEETINGS

You have the right to attend Cabinet to hear decisions being made. You can also attend Committees, as well as meetings of the full Council. Tweeting in formal Council meetings is fine as long as it does not disrupt the meeting. There are procedures for you to ask questions and make representations to Scrutiny Commissions, Community Meetings and Council. Please contact Democratic Support, as detailed below for further guidance on this.

You also have the right to see copies of agendas and minutes. Agendas and minutes are available on the Council's website at www.cabinet.leicester.gov.uk or by contacting us as detailed below.

Dates of meetings are available at the Customer Service Centre, King Street, Town Hall Reception and on the Website.

There are certain occasions when the Council's meetings may need to discuss issues in private session. The reasons for dealing with matters in private session are set down in law.

WHEELCHAIR ACCESS

Meetings are held at the Town Hall. The Meeting rooms are all accessible to wheelchair users. Wheelchair access to the Town Hall is from Horsefair Street (Take the lift to the ground floor and go straight ahead to main reception).

BRAILLE/AUDIO TAPE/TRANSLATION

If there are any particular reports that you would like translating or providing on audio tape, the Democratic Services Officer can organise this for you (production times will depend upon equipment/facility availability).

INDUCTION LOOPS

There are induction loop facilities in meeting rooms. Please speak to the Democratic Services Officer at the meeting if you wish to use this facility or contact them as detailed below.

General Enquiries - if you have any queries about any of the above or the business to be discussed, please contact Graham Carey, Democratic Support on 0116 229 8813 or email graham.carey@leicester.gov.uk or call in at the Town Hall.

Press Enquiries - please phone the Communications Unit on 0116 252 6081

PUBLIC SESSION

AGENDA

1. **APOLOGIES FOR ABSENCE**

2. **DECLARATIONS OF INTEREST**

Members are asked to declare any interests they may have in the business on the agenda.

3. **MINUTES OF PREVIOUS MEETING**

The minutes of the meeting held on 26 November 2013 have been circulated and the Commission will be asked to confirm them as a correct record.

The minutes can be found on the Council's website at the following link:-

http://www.cabinet.leicester.gov.uk:8071/ieListDocuments.aspx?CId=737&MId=5793&Ver=4

4. **PETITIONS**

The Monitoring Officer to report on the receipt of any petitions submitted in accordance with the Council's procedures.

5. **QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE**

The Monitoring Officer to report on the receipt of any questions, representations and statements of case submitted in accordance with the Council's procedures.

6. **WORK PROGRAMME** **Appendix A (Page 1)**

The Scrutiny Support Officer submits a document that outlines the Health and Wellbeing Scrutiny Commission's Work Programme for 2013/14. The Commission is asked to consider the Programme and make comments and/or amendments as it considers necessary.

7. **CORPORATE PLAN OF KEY DECISIONS** **Appendix B (Page 13)**

The Commission is recommended to note the items that are relevant to its work in the Corporate Plan of Key Decisions that will be taken after 1 January 2014.

8. **EMAS - BETTER PATIENT CARE - PROGRESS REPORT** **Appendix C (Page 21)**

To consider a report from EMAS following attendance at a risk summit

organised by the Local Area Team for Derbyshire and Nottinghamshire, on behalf of the regulators and other key stakeholders. Since the risk summit, the Trust has been working on a Quality Improvement Plan (Better Patient Care) which sets the direction of the organisation for staff, clinical quality and responding to patients.

Clare Wade, Patient Safety and Experience Manager, EMAS, will attend the meeting to present the report and answer Members' questions.

9. NHS AND LEICESTER CITY COUNCIL COMPLAINTS Appendices D-H

To consider the complaints procedure and process, complaints data and actions taken following complaints for a number of organisations involved in the provision of health services.

There is a short covering report to introduce the following reports:-

Appendix D
(Page 25)

1) UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST (UHL)

Appendix E
(Page 27)

2) LEICESTERSHIRE PARTNERSHIP NHS TRUST (LPT)

Appendix F
(Page 35)

3) LEICESTER CITY CLININCAL COMMISSIONING GROUP (CCG)

Appendix G
(Page 41)

4) EAST MIDLANDS AMBULANCE SERVICE (EMAS)

Appendix H
(Page 51)

5) LEICESTER CITY COUNCIL

Appendix I
(Page 59)

Representatives of the various organisations will be in attendance to give a brief overview of the reports and to answer any Members' questions. At present the following have indicated they will be in attendance:-

UHL - John Adler, Chief Executive and Moira Durbridge, Director of Safety and Risk

LPT – Paul Miller, Chief Operating Officer

EMAS – Clare Wade, Patient Safety and Experience Manager

10. EXTERNAL 'FIT FOR PURPOSE' HEALTH SCRUTINY ARRANGEMENTS REVIEW — Appendix J (Page 69)

To consider the report of the external 'Fit For Purpose' review carried out by Ms B Cook on behalf to the Centre for Public Scrutiny.

Ms Cook will be at the meeting to present the report and answer Members' questions.

11. FRANCIS REPORT

To receive a verbal update on the Government's response to the Francis Report recommendations.

12. UPDATE ON 'CLOSING THE GAP' PERFORMANCE INDICATORS FOR CARERS — Appendix K (Page 83)

To receive the report of the Director Care Services and Commissioning, Adult Social Care on the steps being taken to improve the indicators relating to 'carer-reported quality of life' and 'the proportion of carers who reported that they had not been included or consulted in discussion about the person they cared for'.

The report was requested at the last meeting of the Commission following consideration of the Joint Health and Wellbeing Strategy 'Closing the Gap'.

13. NHS ENGLAND - COMMISSIONING REPORT — Appendix L (Page 89)

To receive a report on NHS England's Commissioning Intentions for 2014/15 which is being submitted to the Health and Wellbeing Board meeting on 30 January 2014. The Commission is invited to make comments and suggestions on the proposals which can then be submitted to Board.

The two NHS England publications below are also attached for information and as a background to the report.

Prescribed Specialised Services Commissioning Intentions 2014/15 – 2015/16 **(Appendix L 1 – Page 93)**

NHS Public Health Functions Agreement 2014 -15 **(Appendix L 2–Page 125)**

14. UPDATE ON MATTERS CONSIDERED AT A PREVIOUS MEETING — Appendices M-N

The following updates on matters considered at previous meetings of the Commission are submitted for information:-

Improving Mental Health Services in Leicester City

Copy of presentation attached. **Appendix M (Page 157)**

Congenital Heart Disease Review

The update reports listed below in relation to the Congenital Heart Disease Review. The documents highlighted in the update reports can be found at the following link:-

http://www.england.nhs.uk/category/publications/blogs/john-holden/

11th NHS England Bulletin – 11 November 2013 **Appendix N 1 (Page 165)**

12th NHS England Bulletin – 25 November 2013 **Appendix N 2 (Page 169)**

13th NHS England Bulletin – 10 December 2013 **Appendix N 3 (Page 173)**

14th NHS England Bulletin – 17 December 2013 **Appendix N 4 (Page 177)**

15. ANY OTHER URGENT BUSINESS

QUESTION

The Chair has agreed to receive a question from Councillor Singh under this item. The details of this are attached.

Health & Wellbeing Scrutiny Commission
PROPOSED DRAFT WORK PROGRAMME 2013/14

CURRENT / ONGOING / FUTURE ISSUES – Updated December 2013

DATE OF COMMISSION MEETING	PROPOSED TOPICS / ITEMS AND LEADS	ACTIONS / OUTCOMES
Standing Items - Accountability of Deputy City Mayor – lead for Health issues, Councillor Rory Palmer	1) The broad issues around the implementation of NHS & Public Health White Paper (Deb Watson/Rod Moore) 2) Public Health Work by the City Council & Health & Wellbeing Board (Deb Watson/Rod Moore) 3) Implementation of the Health and Social Care Act (Deb Watson / Tracie Rees) 4) Public Health Budget (Deb Watson / Tracie Rees/Rod Moore) 5) Commissioning Process for Patient Representative Body - HealthWatch (Tracie Rees) 6) Leicester City Council City Mayors Forward Plan (Cllr Palmer/Deb Watson / Tracie Rees) 7) Leicester City Clinical Commissioning Group (Simon Freeman/Richard Morris)	
9 April 2013, (agenda 26/03/13)	1) **Draft Work Plan 2013/14** (Cllr Cooke/Anita) – work in progress	**Action** - Discussed in private planning session 18th September to enable effective scrutiny
	2) **The Francis Report** – Implications for Health Scrutiny Commission and lessons to be learnt a) An overview of the Francis Report and the implications for the local authority (Rod Moore) b) Responses from LCCCG on the Francis Report (Richard Morris) c) Responses from UHL on the Francis Report (Stephen Ward)	**Actions:** a) Agreed, an external review of the council's scrutiny arrangements for scrutinising the provision of health services in the city. Agreed 'Fit For Purpose' Review to be led by CfPS expert advisor. b) To explore health commission members to receive mandatory training Liaise with John/legal re: constitution.

Appendix A

Health & Wellbeing Scrutiny Commission
PROPOSED DRAFT WORK PROGRAMME 2013/14

DATE OF COMMISSION MEETING	PROPOSED TOPICS / ITEMS AND LEADS	ACTIONS / OUTCOMES
		Actions (conti).. c) Discussed francis report and health scrutiny forward planning. d) Review engagement arrangements with partners involved in health scrutiny e.g. LLR Joint Committee and OSC (part of Fit for Purpose Review) e) To review the development and delivery plans of partner organisations/bodies in light of the Francis Report recommendations (ongoing)
	3**) LINKS** (Local Involvement Network for Patients) – The Emergency Pathways (Michael Smith/Sue Mason) 4) Regulations on new Health & Wellbeing Board – Implications for Health Scrutiny (Pretty Patel)	**Actions:** a) Private Policy meeting taken place b) Healthwatch to reassure the commission that the Emergency Pathways work will continue. c) Contact LPT re: views on LINKs treatment during Bradgate Unit visit (pending)
	5) **Healthwatch** and Scrutiny – Framework (Tracie /Jo Clinton)	**Action** – Healthwatch to bring a paper on draft protocol, setting out how it will actively

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Health & Wellbeing Scrutiny Commission
PROPOSED DRAFT WORK PROGRAMME 2013/14

DATE OF COMMISSION MEETING	PROPOSED TOPICS / ITEMS AND LEADS	ACTIONS / OUTCOMES
		engage with the scrutiny commission.
	7**) Councils Forward Plan**	Noted.
28th May 2013 (agenda 14/05/13)	**1) University Hospitals of Leicester (UHL)** 1a) UHL - Strategic Direction Presentation (Stephen Ward/John Adler) 1b) UHL Annual Quality Accounts (Sharon Hotson, UHL) 1c) UHL Unannounced Hospital Visits – feedback report (Richard Morris) 1d) Urgent Care Centre (A&E) at Leicester Royal Infirmary, to monitor progress on the pilot programme to refer non urgent cases to GP (Richard Morris)	**Actions:** 1a) The Strategic Direction report was noted. 1b) The Quality Accounts 2013/14 report noted and comments to be sent to UHL (done) 1b) HSC members invited to visit the hospital to see how services are provided (to be arranged). 1c) Report noted. HSC to receive further updates on future visits. 1d) Report noted. Further update to HSC in 6 months.
	2) NHS 111 Non-Emergency Helpline – Information/update report on plans for this emergency helpline to go live in Leicestershire on 25th June 2013 (Richard Morris)	**Action:** The report was noted and comments made by HSC to be taken into account by the West Leicestershire CCG when implementing the NHS 111 System (Richard to action).
	3) Public Health Structure – to include organisation chart, posts and functions, plus current areas of work, budgets and schedule of commissioning	**Action:** Private session to be arranged to discuss functions and commissioned services.

Health & Wellbeing Scrutiny Commission
PROPOSED DRAFT WORK PROGRAMME 2013/14

DATE OF COMMISSION MEETING	PROPOSED TOPICS / ITEMS AND LEADS	ACTIONS / OUTCOMES
	areas and timescales (Rod Moore)	Report noted.
	4) Healthwatch – Protocols of how HW will actively engage with and support the commission in its scrutiny of health issues (Vandna Gohill, VAL/ Jo Clinton)	Report noted.
	5) Drugs and Alcohol Scrutiny Review – draft report of findings for members of the commission to discuss/approve (cllr Sangster/Anita)	**Actions:** - Draft report and recommendations endorsed. Final report to go to OSC, then to the City Mayor. - Chair to discuss procedures and mechanisms for council to commission drug and alcohol services.
	6) Work Plan 6a) Draft Work Programme 2013/14 – update/suggestions from commission members (cllr Cooke/Anita) 6b) Summary of Work Completed 2012/13 – for information, commission contribution to Scrutiny Annual Report (cllr Cooke/Anita)	6a ongoing & 6b noted.
	7) City Mayor's Delivery Plan – Leicester City Council 2013/14, referred from Overview Select Committee for comments (Rod Moore)	**Actions:** - Chair to arrange private session for further discussion on the Plan. - HSC reserved the right to submit comments

DATE OF COMMISSION MEETING	PROPOSED TOPICS / ITEMS AND LEADS	ACTIONS / OUTCOMES
		at a later date. - HSC request progress report in 6 months - Joint scrutiny reviews with Adult Social Care SC is supported.
	8) Items for noting: a) Health & Wellbeing Board – minutes of last meeting b) Council's Forward Plan c) Glenfield Hospital Heart Unit Review – verbal update (cllr Cooke)	All noted.
17th July 2013 (agenda 25/06/13)	1) East Midlands Ambulance Service "Being the Best" Report (Karlie Thompson) 2) Update on Glenfield Hospital Heart Unit Review (Cllr Cooke) 3) 'Alcohol Awareness Social Marketing' consultation proposals (Julie/Rod) 4) Development Training Session for HSC members to cover the following: a) 'Better Understanding of the New Structures of the NHS' (Rod) c) Feedback from Derbyshire CfPS Workshop 8th July on 'Developing Relationships with Public Health England and NHS England, including lessons from the Francis Report' (Anita/Rod) 5) External Review of Health Scrutiny Arrangements (Cllr Cooke/Anita)	1) **Action:** Six monthly updates n order to monitor progress Re: detailed management performance criteria and data (Anita add to w/p) 2) **Action:** Update to September meeting. 3**) Action**: Feedback to September meeting 4c) **Action:** Proposal for Leicester to be offered as a venue for a future regional event (Anita to liaise with CfPS) **5) Action:** Engaged expert advisor from CfPS.

Health & Wellbeing Scrutiny Commission
PROPOSED DRAFT WORK PROGRAMME 2013/14

DATE OF COMMISSION MEETING	PROPOSED TOPICS / ITEMS AND LEADS	ACTIONS / OUTCOMES
6th August 13	1) Glenfield Heart Unit – NHS ENGLAND new review process to discuss. **SPECIAL MEETING ARRANGED FOR THIS ITEM ONLY**	**Actions:** HSC to monitor progress
3rd September 2013 (agenda 14/08/13)	1) Council's Procurement Plan – Health & Wellbeing Topics (Neil Bayliss) 2) Access for All Document – referred by Overview Select Committee to all scrutiny commissions for comments (Paul Lenard-Williams) 3) Alcohol Awareness – Project feedback (Julie) 4) LCCCG Response to Francis Report – Update (Simon Freeman) 5) UHL Emergency Floor Scheme Report – (Stephen/Mark) RE: to brief the Commission on UHL Emergency Floor scheme and the associated enabling scheme under which it is proposed to move temporarily some outpatient services from Leicester Royal Infirmary to Leicester General Hospital. 6) Leicestershire Partnership NHS Trust <u>7) Items for noting:</u> a) Glenfield Heart Unit NHS England Review – Update b) External Review of Health Scrutiny Arrangement – Update	**Item 1** – Further breakdown of Commissioning Contracts re: Public Health budgets to future meeting – Nicola Hobbs/Rod Moore **Item 2** – Deferred to future meeting **Item 3** – Project not started, deferred to future meeting. **Item 4** – An update to further responses by the CCG still to be reported to future meeting. **Item 5** – Noted and agreed in principle. **Item 6** – Viv Addey submitted a letter of representation on concerns about the number of recent suicides of people in Bradgate Unit calling for an independent inquiry into the failing. **Outcome:** HSC members voiced their concerns /disappointment for the failings at Bradgate Unit and at LPT.

Health & Wellbeing Scrutiny Commission
PROPOSED DRAFT WORK PROGRAMME 2013/14

DATE OF COMMISSION MEETING	PROPOSED TOPICS / ITEMS AND LEADS	ACTIONS / OUTCOMES
18th September 2013 **PRIVATE SESSION FOR HSC MEMBERS**	*Private session planned to discuss the work programme to enable effective scrutiny and give members the opportunity to shape and direct the commission's activities.* To be led by the Chair, assisted by Brenda Cook, expert health scrutiny advisor, and Anita Patel/Graham Carey	Notes taken and submitted to HSC meeting. Work plan to be updated / progressed as part of the Fit for purpose review outcomes.
15th October 2013 (agenda 01/10/13)	1) **Procurement & Commissioning Public Health Budget** – Further breakdown of Commissioning Contracts to better understand Public Health budgets and who provides services (Nicola Hobbs/Rod Moore) **2) Access for All** – Deferred from last meeting (Paul Leonard-Williams) 3) **Work Programme** – Update from 18th September private members session (Chair/Anita) 4) **Glenfield Heart Unit Review** Update - NHS England letter and Response from Cllr Cooke RE NHS England Review Team request to visit Joint Health Scrutiny (Chair/Anita) 5**) Leicestershire Partnership NHS Trust** – Update on Progress to improve services and feedback from minutes of last meeting RE Bradgate MHU. (tbc) 6) **'Fit for Purpose' Health Scrutiny Review –** Progress update (Chair/Anita) 7) **Alcohol Awareness Project** – feedback on progress (Julie/Rod) 8**) NHS 111 Service** – Update on progress (Dr Johri/Richard Morris)	1) Further reports on commissioning items to future meetings. 2) report noted 3) Updating work programme - in progress 4) Meeting with John Holden, NHS England Review team lead on 25th Oct 5) to be invited to October meeting to report progress. 6) In progress 7) report noted 8) NHS 111 Equality Impact Assessment report for local service – to Oct mtg.

Health & Wellbeing Scrutiny Commission
PROPOSED DRAFT WORK PROGRAMME 2013/14

DATE OF COMMISSION MEETING	PROPOSED TOPICS / ITEMS AND LEADS	ACTIONS / OUTCOMES
26th November 2013 (agenda 13/11/13)	1) Francis Report Recommendations - Progress Reports from UHL, LCCCG, LPT, LCC Public Health 2) Closing the Gap – Review of progress (Adam Archer/Rod) 3) Hospital Unannounced Visits – Reports from CCG (Richard Morris) 4) UHL Emergency Department Assessment Service and CQC planned inspection – Progress Reports (Mark / Richard) 5) Winter Care Plan Review – Update (Cllr Chaplin) 6) Bradgate Adult Mental Health Unit – LPT update report and CQC latest inspection report (Cheryl Davenport) 7) Oral Health in the City, Dental Health Policy and Strategy (Jasmine Murphy) 8) Health Visitors report (Rod/Jo) 9) Responses to Scrutiny Review Reports (MHR and VCS) from UHL, CCG, LPT and City Counciil 10) Congenital Heart Disease Review – Update (Chair) 11) East Midlands Regional Health Scrutiny Network – update (Chair) 12) External Scrutiny Review 'Fit for Purpose' by CfPS – update (Chair)	

Health & Wellbeing Scrutiny Commission
PROPOSED DRAFT WORK PROGRAMME 2013/14

DATE OF COMMISSION MEETING	PROPOSED TOPICS / ITEMS AND LEADS	ACTIONS / OUTCOMES
14th January 2014	1) East Midlands Ambulance Service "Being the Best" Progress Report 2) NHS Complaints Procedures – process of CCG, UHL, LPT, EMAS and Leicester City Council 3) Bradgate Mental Health Unit, LPT, CQC inspector to be invited to provide a progress report. 4) Closing the Gap, Performance Indicators on Carers, follow up information requested. 5) NHS 111, local Equality Impact Assessment document, for information. 6) Francis Report, Health Secretary of State response to Francis (CfPS), for information. 7) Overview of CCG Mental Health Scoping Document, for information. 8) Public Health Budgets and Commissioning 9) External 'Fit for Purpose' Health Scrutiny Review – update	
25th February 2014		
8th April 2014		
20th May 2014		

DATE OF COMMISSION MEETING	PROPOSED TOPICS / ITEMS AND LEADS	ACTIONS / OUTCOMES

Suggested Items for above Work Plan:

- Public Health Team – Structures, responsibilities, budgets and outputs
- Leicestershire Partnership NHS Trust – The Agnes Unit and Bradgate Unit (follow up)
- Better Care Together
- Health Variations – Public Health Team
- NHS Reconfiguration – G.P practices fit for purpose
- NHS Commissioning
- LPT/UHL – to review and monitor their performance data / complaints data
- Lead Commissioners of Health Services across the city – work plans
- Annual Reports – LOROs, UHL, ICAS, LPT NHS TRUST and HEALTHWATCH
- ICAS and HEALTHWATCH – Regular Reports
- Hospital Discharges
- Homelessness Strategy – Implementation
- Capital Programme – monitoring role
- Forward Plan – monitoring role
- Corporate Strategies – monitoring role
- Stickle Cell Anemia Services

DATE OF COMMISSION MEETING	PROPOSED TOPICS / ITEMS AND LEADS	ACTIONS / OUTCOMES
- BME groups – targeting of specific health services - HIV/AIDs Services - Mental Health Services for BME e.g. Aqwaabaa		

Leicester City Council

CORPORATE PLAN OF KEY DECISIONS

On or after 1 January 2014

What is the plan of key decisions?

Each month, the Council publishes a forward plan to show all the key decisions, which are currently known about, that are intended to be taken by the Council's Executive (City Mayor, Deputy City Mayor and Assistant City Mayors) over the next few months. Each plan runs from the first of each month.

What is a key decision?

A key decision is an executive decision which is likely:

- to result in the Council incurring expenditure which is, or the making of savings which are, significant having regard to the Council's budget for the service or function to which the decision relates; or
- to be significant in terms of its effects on communities living or working in two or more wards in the City.

In addition to the key decisions, the City Mayor and the Executive also take other non-key decisions. Details of these can be found at www.cabinet.leicester.gov.uk/mgdelegateddecisions.aspx?bcr=1

What information is included in the plan?

The plan identifies how, when and who will take the decision and in addition who will be consulted before the decision is taken and who to contact for more information or to make representations.

The plan is published on the Council's website.

Prior to taking each executive decision, please note that the relevant decision notice and accompanying report will be published on the Council's website and can be found at www.cabinet.leicester.gov.uk/mgdelegateddecisions.aspx?bcr=1

Corporate Plan of Key Decisions

On or after 1 January 2014

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1. A place to do business

What is the Decision to be taken?	LEICESTER TO WORK PHASE 2 To approve the project and funding.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Jan 2014
Who will be consulted and how?	Consultation as part of the Economic Action Plan with key stakeholders.
Who can I contact for further information or to make representations	AndrewL.Smith@leicester.gov.uk

What is the Decision to be taken?	FRIARS MILL WORKSPACE To approve the project and funding.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Jan 2014
Who will be consulted and how?	Consultation as part of the planning application and with key stakeholders.
Who can I contact for further information or to make representations	AndrewL.Smith@leicester.gov.uk

What is the Decision to be taken?	LEICESTER MARKET PHASE 2 Final approval and inclusion of the scheme in the capital programme.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Jan 2014
Who will be consulted and how?	Consultation undertaken as part of the planning process and with key stakeholders.
Who can I contact for further information or to make representations	AndrewL.Smith@leicester.gov.uk

2. Getting about in Leicester

What is the Decision to be taken?	BUS LANE ENFORCEMENT - AYLESTONE QUALITY BUS CORRIDOR Decision to implement Bus Lane Enforcement on the Aylestone Road corridor bus lanes.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Jan 2014
Who will be consulted and how?	Done as part of Aylestone Bus Corridor Scheme.
Who can I contact for further information or to make representations	AndrewL.Smith@leicester.gov.uk

What is the Decision to be taken?	CONNECTING LEICESTER STREET IMPROVEMENT SCHEME/S Approval of funding for second phase of Connecting Leicester street improvement projects.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Jan 2014
Who will be consulted and how?	Consultation through Connecting Leicester initiative and TRO process.
Who can I contact for further information or to make representations	AndrewL.Smith@leicester.gov.uk

3. A low carbon city

No key decisions are currently scheduled to be taken during this current period.

4. The built and natural environment

What is the Decision to be taken?	TOWNSCAPE HERITAGE INITIATIVE Scheme and funding approval.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Mar 2014
Who will be consulted and how?	Requirement for external consultation. Community engagement included in the project.
Who can I contact for further information or to make representations	AndrewL.Smith@leicester.gov.uk

What is the Decision to be taken?	RELEASE OF THE PROPERTY MAINTENANCE PROVISIONS 2013/14 Release of block fund from Capital Programme.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Jan 2014
Who will be consulted and how?	Not applicable.
Who can I contact for further information or to make representations	john.stevens@leicester.gov.uk

5. A healthy and active city

No key decisions are currently scheduled to be taken during this current period.

6. Providing care and support

What is the Decision to be taken?	DEVELOPMENT OF AN INTERMEDIATE CARE FACILITY To consider the options for the development of intermediate care facilities In Leicester.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Jan 2014
Who will be consulted and how?	N/A
Who can I contact for further information or to make representations	Ruth.Lake@leicester.gov.uk

What is the Decision to be taken?	REVIEW THE POTENTIAL OPTIONS FOR PROVIDING THE MOBILE MEALS SERVICE IN FUTURE To consider the outcome of a consultation exercise regarding the future of the Mobile Meals Services.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Jan 2014
Who will be consulted and how?	Formal consultation started with the existing service users on 9th July 2013.
Who can I contact for further information or to make representations	Tracie.Rees@leicester.gov.uk

What is the Decision to be taken?	THE REDESIGN OF ADULT SOCIAL CARE PREVENTATIVE SERVICES The re-design will inform future procurement activities.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Jan 2014
Who will be consulted and how?	Formal consultation will be required with existing Service Providers.
Who can I contact for further information or to make representations	Tracie.Rees@leicester.gov.uk

What is the Decision to be taken?	RESIDENTIAL CARE FEES REVIEW To consult with the providers of residential care on the level of fees to be paid for 2012/13, 2013/14 and 2014/15.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Jan 2014
Who will be consulted and how?	Consultation in progress with external providers.
Who can I contact for further	Tracie.Rees@leicester.gov.uk

information or to make representations	

What is the Decision to be taken?	THE FUTURE OF DOUGLAS BADER DAY CARE CENTRE To consider the outcome of a consultation exercise regarding the future of the service.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Jan 2014
Who will be consulted and how?	Formal consultation started with the existing service users on 17th September 2013.
Who can I contact for further information or to make representations	Tracie.Rees@leicester.gov.uk

What is the Decision to be taken?	REVIEW OF HOUSING RELATED SUPPORT FOR ADULT SOCIAL CARE USERS
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Jan 2014
Who will be consulted and how?	Formal consultation in progress with Service Users and Providers.
Who can I contact for further information or to make representations	Tracie.Rees@leicester.gov.uk

7. Our children and young people

What is the Decision to be taken?	CHILDREN IN CARE COUNCIL AND PLEDGE To provide an update on the Children in Care Council and Pledge.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Jan 2014
Who will be consulted and how?	None.
Who can I contact for further information or to make representations	Andy.Smith@leicester.gov.uk

8. Our neighbourhoods and communities

What is the Decision to be taken?	PROPOSALS FOR FUTURE USE OF LOWER HASTINGS STREET AND LOUGHBOROUGH ROAD HOSTEL BUILDINGS
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Jan 2014
Who will be consulted and how?	None required.
Who can I contact for further	julia.keeling@leicester.gov.uk

information or to make representations	

What is the Decision to be taken?	TRANSFORMING NEIGHBOURHOOD SERVICES PROJECT: CHANGES TO SERVICE DELIVERY IN SOUTH AREA PILOT Informed by the community engagement exercise undertaken in October, a decision is sought on the content of proposals for reconfiguring neighbourhood service delivery in the South of the city (4 wards) and on the consultation process.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Jan 2014
Who will be consulted and how?	Consultation with a range of stakeholders.
Who can I contact for further information or to make representations	Liz.Blyth@leicester.gov.uk

9. A strong and democratic council

What is the Decision to be taken?	SUPPORTING THE VOLUNTARY AND COMMUNITY SECTOR (VCS) To approve future arrangements for supporting the VCS, engaging with the VCS to support cohesion and to support volunteering in the city.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Feb 2014
Who will be consulted and how?	Public Consultation is running from 28.10.13 until 17.01.14.
Who can I contact for further information or to make representations	Miranda.Cannon@leicester.gov.uk

East Midlands Ambulance Service NHS Trust

BETTER PATIENT CARE PROGRAMME PROGRESS REPORT

1. Overview

On 8 October 2013, EMAS was requested to attend a risk summit by the Local Area Team for Derbyshire and Nottinghamshire, on behalf of the regulators and other key stakeholders. Since the risk summit, the trust has been working on a Quality Improvement Programme (Better Patient Care), which sets the direction of the organisation for our staff; raising our clinical quality; and responding to patients.

2. Overall Progress

Progress has been made in following areas:

- Implementation of the plan has now commenced using a programme management approach through the Trust Programme Management Office (PMO). This will ensure:
  - core processes are in place to give the Board and stakeholders confidence and assurance that the plans will be delivered on time and to a very high standard with exceptions highlighted
  - robust governance arrangements are in place to ensure staff are not burdened by excessive bureaucracy but are easily able to communicate progress and exceptions that require action
  - co-ordination with other major projects and ensure conflicts and constraints are managed
- Workstream leads have been identified and meetings have been held to agree actions to develop detailed plans for each workstream contained in the plan
- Project toolkits have been generated for the worksteams of the plan which will monitor the progress against the project plan, risks, issues and benefits
- Project toolkits have been created for each workstream
- Key performance indicators to be agreed against each workstream of the Better Patient Care plan which will help the trust define and measure progress towards the organisational goals and success criteria.

3. Update on Governance Arrangements

The following governance arrangements have been agreed:

- The Better Patient Care Board will meet twice a month and will be chaired by the Chief Executive
- Better Patient Care Delivery Group has been established and will meet weekly to review progress with the workstream leads
- Better Patient Care Delivery Groups will also be replicated in each county
- Additional support will be provided to the workstream leads
- EMAS Oversight Group (attendees EMAS, CCG, TDA and CQC) to meet fortnightly-this will be the forum where the trust is held to account regarding the implementation of the plan
- Escalation of any issues will be through the PMO to the workstream Executive leads and/or Better Patient Care Board

4. Workstream Progress

Responding to Patients
Additional Private Ambulance Services has been commissioned to support performance delivery elements of the plan. In addition Voluntary Ambulance Services will continue to provide additional resources on a daily basis. A GP has been assigned to the Emergency Operations Centre to provide additional support during weekends.

Our People
The Trust has confirmed its intentions to go forward with Listening into Action. Executive Directors are now aligned to each county including attendance at Urgent Care Boards. An engagement meeting has also been held with staff to go through the Better Patient Care plan and to obtain feedback

Our Leadership
An offer has been received from the Local Education and Training Board in terms of what they can do to support the trust around individual and team development

Clinical Safety
A Task and finish group has been established to review the future governance process for reviewing quality standards. At the first meeting the terms of reference for the Clinical Governance Group were reviewed and revised (including addition of lay representation, ensuring duties and relationships with other groups clearly defined). It was also agreed that a further sub group looking at clinical effectiveness will be established, that a work plan for the CGG would be developed to provide clarity regarding what reports are required on a regular basis for assurance.

The terms of reference of the serious incident review have been agreed and the external body to undertake the review has been identified.

Our Money:
Financial Governance has been strengthened including revised terms of reference for the Investment Committee to focus on Finance and Performance; finance restructure which includes dedicated financial support to Operational Divisions including the Emergency Operations Centre. An activity forecast for 2013/14 based on actual figures to end October has been prepared and shared with Commissioners. A workshop has been set up to review activity growth forecasts for 2014/15 and 2015/16.

Our Communications:
A staff engagement group has met and spent time talking with frontline and support service colleagues about Better Patient Care. Valuable feedback was gained on the Our Communications work stream. It led to the addition of a new action: 'to ensure EMAS colleagues who deliver engagement and public education work in addition to their day job are captured on a central database and supported by being able to access newly created resources, held centrally, to support EMAS community engagement work i.e. school talks, short educational videos, hot topic and key messages one-side etc.'

Recording this work centrally allows for identification of colleagues who are suited to different styles of engagement (i.e. school talks, Women's Institute, faith groups etc.) and allows EMAS to recognise and reward colleagues who go above and beyond what they are employed to do.

Being held to Account
Revised Board and committee arrangements which will assist in addressing issues identified at the recent risk summit to strengthen current corporate governance arrangements have been proposed and will be agreed by the Trust Board.

Estates
Activity has focused on identifying sites and partners for Community Ambulance Stations (CAS), with focus on Lincolnshire as a first phase. Melton ambulance station, where the Trust's lease expires, is due to close on the 6 January 2014 and staff will move to Oakham. As a result of feedback and suggestions from staff at Melton, a premises owned by Melton Borough Council (Phoenix House, Melton Mowbray), will be used as a CAS.

5. Next Steps for Better Patient Care:

The Better Patient Care programme will be supported to deliver the required benefits through a robust programme management framework. There has been a rapid period of readjusting existing programme management and governance arrangements to absorb the developing Better Patient Care plan. It is intended that this work will be finalised in line with the QIP submission in order to support implementation. The following next steps will be taken:

- Governance arrangements to be implemented and regular reporting established to provide assurance through the organisation and out to stakeholders
- Key Performance Indicators will be agreed to define and measure progress to ensure that planned activity delivers outcomes to improve the care we provide to our patients.

Leicester City Council

Appendix D

Cover Report for members of the Health & Wellbeing Scrutiny Commission meeting on 14th January 2014

Agenda Item: 'NHS Complaints and Leicester City Council Complaints'

1. Purpose

1.1 To inform commission members about how complaints are handled by local NHS providers and by Leicester City Council.

1.2 The Director of Information & Customer Access, Leicester City Council, plus representatives of the 4 major local NHS providers, University Hospitals of Leicester, Leicestershire Partnership NHS Trust, Leicester City Clinical Commissioning Group and East Midlands Ambulance Service, have been invited to submit reports and attend the meeting to provide an overview of their complaints process and discuss how they use the issues identified through complaints to improve quality and safety.

2. Background

2.1 The Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (known as the Francis Report) was critical of the health scrutiny function in Staffordshire, specifically referring to the "dismissive language" in a letter from Staffordshire Borough Council to a member of the public, which stated: "*that it is not the role of the Health Scrutiny Committee to pursue individual cases from members of the public"* and concluded with "*However, your letter will have alerted Members of the Health Scrutiny Committee to your concerns and general nature of these may be taken into account during any future discussions with the Trust*" (Paragraph 6,252 of the Francis Report).

2.2 In terms of complaints handling at overview and scrutiny committees, the Francis Report made the following general recommendation:

Overview and scrutiny committees and Local Healthwatch should have access to detailed information about complaints, although respect needs to be paid in this instance to the requirement of patient confidentiality. (Recommendation 119 of the Francis Report).

2.3 In September 2013, the Centre for Public Scrutiny advised councils that "scrutiny is not a way to resolve individual complaints", and that scrutiny should not ignore personal stories, but should have ways to test whether personal experiences are symptomatic of wider problems – amplifying the voices and concerns of the public where necessary to affect change". The CfPS Briefing for Council Scrutiny Guide also refers to the use of published information such as public board papers, media reports and statistics.

3. Recommendation

3.1 Commission members are asked to use the information provided to inform questioning and discussion about how NHS complaints and Leicester City Council complaints are listened to and learnt from. Commission members to identify what, if any, is the future role for health scrutiny in relation to an oversight of complaints.

Anita Patel, Health Scrutiny Support Officer, December 2013.

Anita.Patel@leicester.gov.uk

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: HEALTH AND WELLBEING SCRUTINY COMMISSION

REPORT FROM: DIRECTOR OF SAFETY AND RISK

DATE: 14TH JANUARY 2014

SUBJECT: UHL NHS TRUST COMPLAINTS PROCEDURES, DATA AND ACTIONS TAKEN

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1. INTRODUCTION

1.1 The purpose of this paper is to provide the City Council Health and Wellbeing Scrutiny Commission with a summary report of complaints activity and management at the University Hospitals of Leicester NHS Trust (UHL).

1.2 Complaints within UHL, however received, are managed within the NHS Complaints Regulations, 2009. Furthermore, the Trust seeks to ensure that the Parliamentary and Health Service Ombudsman's 'Principles of Good Administration' are followed. In summary these are:-

- Getting it right
- Being Customer Focused
- Being open and accountable
- Acting fairly and proportionately
- Putting things right
- Seeking continuous improvement

1.3 The Trust's policy is designed to ensure the patient remains at the centre of the process and that changes are made and embedded as a result of the lessons learned. It is acknowledged that many complainants might like assistance in writing complaint letters or at complaint meetings. POhWER is the local organisation that provides independent advocacy and advice in complaints handling and complainants are informed of this service and how to contact POhWER.

1.4 Feedback is actively and openly encouraged from all service users and concerns may be raised in a number of ways, including:-

- Directly with front line staff.
- Message to Matron.
- You help us learn.
- Patient Experience questionnaire.
- Postcard to Leicester.
- Free Phone: 08081 788 337.
- E-mail: pils@uhl-tr.nhs.uk.
- Web address: www.uhl-tr.nhs.uk/patients/support-and-advice/making-a-complaint
- In writing: The Firs, C/O Glenfield Hospital, Groby Road, Leicester, LE3 9QP
- Chief Nurse – public listening event.

2. PATIENT INFORMATION AND LIAISON SERVICE (PILS)

2.1 PILS is a central team who receive and administer all complaints, concerns, requests for information, comments and compliments, whether received from a patient, relative, G.P. or external organisations.

2.2 They endeavour to deal with all issues as quickly as possible, liaising with the relevant ward and departments within the Trust, and external organisations when appropriate.

2.3 Every complaint received is reviewed by a Patient Safety Manager who is a senior member of the team and who has a clinical background.

2.4 The issues are assessed/triaged for an appropriate investigation and response as follows:-

➢ **Triaged as green (10 working days from date of receipt)**

- Easy straightforward issues that would require a minimum level of investigation, fact finding and resolution.
- Clinical Management Groups (CMGs) may agree with complainant that they will not provide a written response but will speak with them directly to assure them of actions taken on how resolution has been achieved.
- CMG must inform Corporate Team (Administrator) of outcomes so that the complaint can be closed on Datix.

➢ **Triaged as amber (25 working days from date of receipt)**

- More complex issues, nearly always serious enough to warrant a face to face meeting. A full and detailed investigation and provision of an investigation report, with a covering letter, or detailed written response. These complaints will require an action plan which will be shared with the complainant and monitored by the CMG.

➢ **Triaged as Red (up to 45 working days from date of receipt)**

- The issues raised will be highly complex, multi-CMG or cross-organisational. They will require the highest level of investigations, and may also be reportable as a Patient Safety Incident. It may be appropriate that an independent review is undertaken either internally or by an external clinical expert.

2.5 Re-opened complaints are responded to within 25 working days and are closely monitored by the central team. CMGs whose performance is poor in terms of the numbers, themes or performance of complaints are required to account for their position and their plans at monthly performance meetings with Executive Directors.

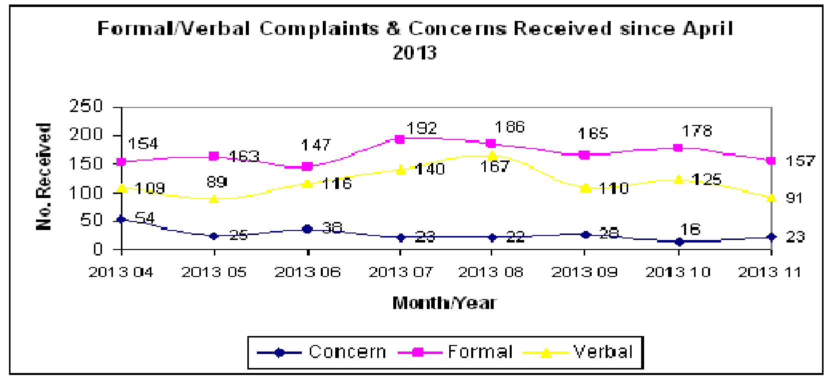
2.6 Multi-organisational complaints are assessed by the Corporate Patient Safety Team and managed in line with the *Protocol for the Handling of Local Inter-Organisational Complaints* (Revised 2010), ensuring that a single co-ordinated response is provided to the complainant. On receipt of a multi-organisational complaint PILS will acknowledge the complaint within 3 days and seek consent for the sharing of information with other organisations. A 'Lead Partner' (organisation subject to the primary focus of the complaint) is identified and carries out the responsibilities in accordance with the management protocol. All responses are quality checked to ensure;
- Accuracy and attention to detail
- Consistency
- All concerns have been addressed
- No conflicting information
- No apportionment of blame by one party of another party

3. DATA

3.1 For the year 2012/13 UHL received 1527 formal complaints. The overall activity for PILS during this year was 3668 contacts. This demonstrates an increase in total activity from the previous year, but a decrease in the number of formal complaints received.

3.2 It is acknowledged by the Department of Health that a high number of complaints is not necessarily a reflection of the quality of services provided. UHL encourages the patients and public to voice its views and express any concerns they may have.

3.3 The table below shows complaints activity from April to the end of November 2013:-



3.4 The following table provides complaint information for 2013 by subject:-

	2013 01	2013 02	2013 03	2013 04	2013 05	2013 06	2013 07	2013 08	2013 09	2013 10	2013 11	Total
Medical Care	29	30	31	38	35	19	36	38	37	47	43	**383**
Waiting times	20	18	24	20	28	29	30	34	34	34	21	**292**
Communication	18	19	15	13	22	24	20	12	13	17	11	**184**
Nursing care	14	20	22	19	15	20	16	15	15	13	15	**184**
Cancellations	14	9	22	13	14	10	24	19	12	11	12	**160**
Staff attitude	12	13	15	13	14	12	16	13	10	20	17	**155**
Discharge	6	4	11	7	7	4	14	7	4	5	12	**81**
Administration	6	3	2	2	5	2	4	14	8	2	6	**54**
Complications	3	2	4	2	3	6	5	9	6	8	6	**54**
Information	3	3	3	4	3	5	6	3	3	2	1	**36**
Medication	2	1	3	4	1	2	0	2	1	1	4	**21**
Hotel Services	2	0	1	0	1	2	1	5	6	2	0	**20**
Beds	1	2	2	4	3	0	1	0	2	0	1	**16**
Environment	2	1	0	0	1	1	1	2	1	5	1	**15**
Medical Records	1	0	0	4	1	0	1	1	1	2	4	**15**
Dignity/Privacy	1	1	3	1	1	1	2	1	1	1	1	**14**
Security	1	2	1	2	2	2	1	1	1	1	0	**14**
End of life care	0	1	1	0	2	3	3	1	2	0	0	**13**
Telephones	0	0	0	1	1	0	3	2	4	0	2	**13**
Car parking	0	1	1	2	0	1	3	1	0	1	1	**11**
Access	0	0	0	3	0	0	1	2	1	2	0	**9**
Confidentiality	1	2	0	0	1	1	0	2	0	0	2	**9**
Transport	0	1	1	1	1	0	1	0	2	2	0	**9**
Clinical Care (Other Staff)	2	0	0	0	1	1	0	1	0	0	1	**6**
Consent	0	0	0	0	1	1	1	0	1	1	0	**5**
Funding	0	2	1	1	0	0	1	0	0	0	0	**5**
Appliances/equipment	1	0	0	0	0	0	0	0	0	0	1	**2**
Equality and Diversity	1	1	0	0	0	0	0	0	0	0	0	**2**
Infection Control	0	0	0	0	0	0	1	1	0	0	0	**2**
Safeguarding issues	0	0	0	0	0	1	0	0	0	1	0	**2**
Totals:	**140**	**136**	**163**	**154**	**163**	**147**	**192**	**186**	**165**	**178**	**162**	**1786**
Complaints per 1000 admissions/attendances	1.4	1.5	1.7	1.5	1.6	1.5	1.9	2.0	1.7	1.7	1.6	1.7
IP	17923	16561	17365	17273	17722	16951	18246	16898	17544	18748	17796	19307

OP	68,996	63,530	62,313	69,118	66,855	65,133	71,158	64,076	69,024	75,220	68,675	74408
ED	13655	12865	14336	14415	14343	14145	13439	11517	11964	12254	11874	14487
TOTAL	10054	92956	94014	10086	98920	96229	10283	92491	98532	10622	98345	10812

3.5 The Trust sets a standard of 95% compliance with the 10, 25 and 45 working day response performance, and this is monitored on a monthly basis, both internally and with commissioners as part of the quality schedule.

3.6 UHL's current performance is 86% (10 working day), 85% (25 working day) and 81% (45 working days). The need to improve complaints performance is recognised and work is being undertaken with the relevant Clinical Management Groups to provide more timely responses to complainants. 100% of formal complaints are acknowledged within the required 3 working days.

3.7 In 2012/13, 24 UHL complaints were referred to the Parliamentary and Health Service Ombudsman (PHSO). Of these, only one was upheld which related to compensation for lost dentures. The trust is still waiting to hear the PHSO's decision regarding two of the 24 complaints.

3.8 Under the new approach, detailed in "More investigations for more people" (Parliamentary and Health Service Ombudsman announcement, April 2013), if the complaint meets some basic tests the Ombudsman will begin an investigation immediately and inform those involved. The Ombudsman's office hopes this will improve openness and transparency for all the parties involved in a complaint. They also hope that it will help healthcare providers to see and learn from more of the complaints that are notified each year, helping to identify opportunities to develop and improve services.

4. ACTIONS TAKEN/LEARNING FROM COMPLAINTS

4.1 Complaints provide a rich source of feedback and learning for organisations and the Trust is keen to listen, learn and improve as a result of complaints. Furthermore the recent Francis, Keogh and Berwick reports highlight the fundamental importance of using complaints as spur for learning and improvement.

4.2 Within UHL, reports on complaints are currently received by, and discussed at the monthly meetings of the Executive Quality Board, the Quality Assurance Committee and the Clinical Quality Review Group (with our CCG Commissioners). All complaints are reviewed and if they meet the relevant triggers they will be escalated and investigated as a serious untoward incident.

The following are examples of leaning from recent complaints:-

4.3 A complaint was received regarding an incident which was also a Never Event, where a child had to be returned to theatre from recovery for x-ray and removal of a retained needle. Following the serious incident investigation, a meeting was held with the patient's mother to discuss her complaint and the findings of the investigation. The policy relating to the management of swabs, needles and instruments in theatre has been revised to make the responsibilities for missing items and the importance of x-raying a patient whilst still in theatre clearer. This policy and the learning from the incident have been widely disseminated through a variety of routes including e-mails, meetings and newsletters. There was also an article about Never Events included on the intranet with details in a desktop box on screen when staff logged in to a computer.

4.4 A man complained about the discharge of his daughter on a Saturday, from Leicester General Hospital, taking a long time due to delays in provision of her discharge medication. The delays were due to a combination of issues i.e. a delay in the discharge

letter being written due to the workload of the doctors and a delay in the provision of medication. This was due to the Pharmacy at Leicester General Hospital closing at 14:00 at weekends. New ways of working for junior doctors are being trialled. The main aim of this is to try to prepare discharge letters the day before patients are due to go home, in order to assist with timely discharges. The provision of Pharmacy services across all sites is going to be reviewed to identify the service needs. The outcome of this review may include extending opening hours and staff availability on each of the UHL sites during evenings and weekends. The roll out of electronic prescribing will also assist with this process.

4.5 A patient complained that his operation was cancelled on the day of surgery after the anaesthetist had started to administer anaesthetic gas, as an implant required was not available. The patient was smaller than average and requires a smaller implant which was not part of the routine stock. At the Team Brief the equipment required was discussed but the surgeon had not realised that the implant he needed had to be specially ordered therefore did not identify this as an issue at this stage. As a result of this issue, theatre staff have created a list of prostheses routinely stocked. This has been attached to the shelf next to the equipment to assistant with the checking procedure.

4.6 A patient's daughter complained that their mother had missed doses of medication and that staff had reported they were unable to contact Pharmacy support out of hours. Following a review of this complaint, it was evident that there was a lack of knowledge about out of hours (OOH) Pharmacy provision amongst nursing staff. To address this:-

- Staff received feedback regarding OOH provision.
- A poster was designed and displayed to provide an on-going prompt.
- Electronic prescribing has been introduced on the ward.

4.7 A patient's brother complained that there was a lack of provision of equipment and wheelchairs for bariatric patients. On review of this complaint, it was identified that there was a lack of knowledge amongst nursing staff about what equipment is available within the hospital and how to access it. To address this:-

- Staff have been spoken to on an individual basis as a team.
- The Trust has formed a working group to improve services for this group of patients.

4.8 A complainant was unhappy with the standard of privacy and dignity afforded to them and wanted assurances regarding staff training. As a result of this complaint:-

- A five day Health Care Assistant (HCA) induction programme (for all new HCAs to the Trust) has been implemented.
- A four day HCA Development Programme (over three months) for HCAs who have been in post for at least one year has been implemented which also includes a project on improving patient experience.
- A new three day programme began on the 18th February 2013 in partnership with the Learning Disability Liaison Team for HCAs. The programme is designed to provide HCAs with the skills to provide quality care for those patients who require extra support during hospitalisation.

4.9 Concerns were received regarding the cancellation of a procedure due to a low haemoglobin level. Bloods had been taken at a pre-assessment appointment (21st December), however the patient was cancelled on arrival (3rd January 2013). A long wait during a pre-assessment appointment due to the doctor's availability. As a result of this complaint actions were taken to:-

- To amend the appointment letter to include waiting time expectations and advise patients that they may need to see an anaesthetist during their visit.

- To establish existing information accessibility/availability on the surgical wards (re: escalating unresolved concerns). To address the information provided (if insufficient) to relatives/patients.
- To address the information provided to bank nursing staff re: communicating to patients/relatives/professionals.
- To oversee the revised pre-assessment letter contents prior to it being implemented.

4.10 In the Women's and Children's CMG complaint themes are monitored on a weekly basis and reported back to the CBU and Divisional Quality Boards on a monthly basis. It has already been highlighted to the Boards that nursing and midwifery themed complaints have increased in Quarter 4. However as a result of this, the Division will be undertaking a total complaints review for Quarter 3 and 4 to identify whether there are any trends or themes within the subject themes.

In addition, the Division have re-written the Quality and Safety teaching package on the mandatory training days, targeting complaints identified as medical, nursing and staff attitude. Following the complaints review, if specific issues are identified, the Division will formulate an action plan with recommendations on how to reduce their incidence.

5. FUTURE PLANS

5.1 The long-awaited publication of the Clwyd-Hart review into the NHS hospitals complaint process was released on 28th October 2013 and sets out a number of recommendations to improve the complaints system. The government-commissioned inquiry, led by Labour MP Ann Clwyd and Professor Trish Hart, was a response to the Francis Report which detailed 13 specific recommendations that relate directly to complaints and their handling.

5.2 'Putting Patients Back in the Picture' sets out the reasons people complain, picks up on staff attitudes and concerns about resources and goes on to set out what patients want from a complaint system. The following recommendations are particularly relevant to UHL and are currently being reviewed:-

- i Trusts should provide patients with a way of feeding back comments and concerns about their care on the ward.
- ii Attention needs to be given to the development of appropriate professional behavior in handling complaints. This includes honesty, openness and a willingness to listen to the complainant, and to understand and work with the patient to rectify the problem.
- iii Staff need to record complaints and the action that has been taken and check with the patient that it meets their expectation.
- iv There should be NHS accredited training for people who investigate and respond to complaints.
- v Trusts should actively encourage both positive and negative feedback about their services. Complaints should be seen as essential and helpful information and welcomed as necessary for continuous service improvement.
- vi Every Chief Executive should take personal responsibility for the complaints procedure, including signing off letters responding to complaints, particularly when they relate to serious care failings.
- vii There should be Board-led scrutiny of complaints. All Boards and Chief Executives should receive monthly reports on complaints and the action taken, including an evaluation of the effectiveness of the action.
- viii Every Trust has a legislative duty to offer complainants the option of a conversation at the start of the complaints process. This conversation is to agree on the way in which the complaint is to be handled and the timescales involved.
- ix Hospitals should offer a truly independent investigation where serious incidents have occurred.
- x When Trusts have a conversation with patients at the start of the complaints process they must ensure the true independence of the clinical and lay advice and advocacy support offered to the complainant.
- xi Board level scrutiny of complaints should regularly involve lay representatives.

5.3 Following consideration of all the recommendations and noting the on-going work of external organisations, we propose that there are a number of recommendations which we can action within the Trust without delay. These include:-

- Increase the signage around the Trust for patients and relatives who wish to raise concerns;
- Improve feedback mechanisms at ward level;
- Deal with patient concerns early – ‘real-time’;
- Strengthen the sign-off arrangements for complaint responses;
- Early engagement with patient groups on complaints;
- Update complaints handling guidance for new CMGs.

5.4 However, other recommendations will require further consideration so the following is proposed:-

- Further, early collaboration with HealthWatch to consider this report and improving our complaints handling including reporting to the Board;
- Consider the establishment of an internal Complaints Review Panel with lay representation;
- Hold a ‘Putting Patients Back in the Picture’ LiA event with internal staff and external stakeholders;
- Consider UHL making pledges to our patients and public on complaint handling;
- Review the training needs re complaints handling within the Trust;
- Improved triangulation of complaints, patient experience and NHS Choices information;
- Consider a mechanism for independent advocacy of complaints / concerns.

5.5 Following discussion on this at the Executive Quality Board and Quality Assurance Committee, the Trust Board have agreed to a Trust Board Development Session on complaints handling in February 2014.

6. RECOMMENDATIONS

6.1 The City Council Health and Wellbeing Scrutiny Commission is invited to receive this report and note:-

i UHL’s current data and performance relating to complaints.
ii The learning and actions the Trust is taking.
iii The Trust’s on-going plans to strengthen and improve complaint management at UHL.

Moira Durbridge,
Director of Safety and Risk
December 2013

Appendix F

LPT report for Health & Wellbeing Scrutiny Commission Meeting

14 January 2014

Complaint Process

LPT's objective is to address all complaints within 25 working days, with the exception of those cases which are highly complex and /or require multi-agency involvement. Any extended timescale will only be agreed by the Customer Service Team in negotiation with the complainant and investigation Lead. NOTE: the timescale must be agreed by the complainant, it cannot be imposed.

Complaint letters received anywhere other than Customer Services Team, must be immediately faxed (within 1 working day of receipt) to Customer Services Team using the safe haven fax (0116 2950843) or securely emailed to **customerservices@leicspart.nhs.uk**

If the complaint is made verbally, staff must complete a 'Record of Concern/Verbal Complaint Form' which must be immediately faxed to the Customer Service Team using the safe haven fax. The Customer Service Team will seek verification of the record with the complainant. A copy of the verbal complaints form will be sent to the complainant by the Customer Services Team for accuracy checking and signature prior to being logged as a complaint.

If the Customer Services Team receives a complaint, the following steps will be taken:

Review

- Determine if it should be processed as a complaint by assesing if, among other things, it is merely asking for information or seeking finacial recompense, rather than seeking an explanation.
- Forward it to relevent service area (e.g. to Information Governance, Litegation Department etc) if the letter is found not be a complaint.

Acknowledge

- Determine if confidently issues arise and if consent is required (e.g. if complaint is being raised by a third party, and not by the service user)
- Acknowledge the complaint within 3 working daysof receipt enclosing a copy of the LPT leaflet and offer the complainant the opportunity to discuss, either by telephone or face to face, how the complaint is to be handled i.e written response or resolution meeting.

Investigation

- Identfiy key areas of concerns for which the complainant seeks a response. Agree with the complainant how the complaint will be investigated within what timescales and how the investigation findings will be fed bacl to the complainant (e.g by means of letter or a meeting)
- Identify the most appropriate lead where one or more division or organisations are involved, to ensure a co-ordinated approach to the investigation and response. Forward complaint to the appropriate division within 3 working days.

Investigation

- Identify any issues of potential discrimination that may require the advice/support of the Integrated Equality Service.
- Identify any issues of potential vulnerability that may suggest concerns in realtion to vunerable adults or children and obtin the advice/support of the Head of Safeguarding for these areas.

Investigation

- Identidy if any of the issues raised are also part of the incident reporting process and discuss with the Lead for Patient Safety.
- Identify any potential claim for compensation and liaise weith the Lead for Corporate Complaiance .

Log & Send

- When the above stages have been completed, the Customer Services Team will log the complaint, which will represent the start of the agreed time period in which a written response should be made to the complainant.
- The Customer Services Team will send the complaint by the most appropriate route to the relevent division. Information to be forwarded will include a copy of the Complaint Management Plan, copy of the letter of complaint and a copy of a draft response letterhead template.

Divisional staff

On receipt of the complaint details, if the designated division feels that they should not be the lead, or they consider that input from other division or agencies is required, they should notify the Customer Service Team within 1 working day.

The designated division lead will progress the complaint investigation within the service and ensure key staff are notified/involved as necessary. This will include allocating an Investigating Officer to investigate what went wrong and why, offering an apology where appropriate.

Where appropriate, key staff, shall be asked to provide statements to assist in the investigation. These statements shall clearly include:

- The name of the person making the statement;
- The individual’s position and how long in the post;
- The date the statement was made;
- The name of the complainant/service user;
- The individual’s response to all relevant points of the complaint;
- Signature of the individual giving the statement.

By the end of the designated investigation period the divisional investigation lead will produce and submit to the Customer Service Team:

A draft response, using the response letterhead template which will acknowledge where mistakes have been made if appropriate and will tell the complainant what will be done to put things right and/or reduce the possibility of this happening again in the future.

A completed complaint management plan template which identifies where any mistakes have been made and/or an opportunity for learning and what action will be taken to address and prevent reoccurrences.

Complaint Data

1. **Complaint Numbers**

During Quarters one (1/4/13-30/6/13) and two (1/7/13-30/9/13) 164 complaints were received, this was a 35% increase in complaints from the previous two quarters

Division	**Quarter Two 2013/14 (July-Sept 13)**	**Quarter One 2013/14 (Apr- Jun 13)**	**Quarter Four 2012/13 (Jan-Mar 13)**	**Quarter Three 2012/13 (Oct – Dec 12)**	**Quarter Two 2012/13 (July-Sep 12)**	**Quarter One 2012/13 (Apr-June 12)**
Adult Mental Health	40	49	23	22	27	23
Learning Disabilities	0	1	2	1	0	1
Community Health	30	20	30	6	30	21
Families, Young People and Children's	10	14	12	9	7	10
Enabling	0	0	1	1	2	0
Trust-Wide	**80**	**84**	**68**	**39**	**66**	**55**

2. **Timescales**

Of the 164 complaints received in quarters one and two 100% were acknowledged within three working days of receipt in line with 'The Local Authority Social Services and National health Service Complaints (England) Regulations 2009'

118 complaints were closed within agreed timescales, of these 61 were 'upheld' and 57 were 'not upheld'. 29 complaints are currently on-going within agreed timescales, 2 complaints are on hold, 1 awaiting consent and 1 awaiting further information and 15 complaints were withdrawn.

3. Complaint Themes

During quarter four the highest three categories for complaints Trust-Wide were;

- Staff Attitude
- Communication
- Patient Expectations

The top category has remained consistent over the last three quarters.

Category	Total
Aids & Appliances	2
Appointment - Cancellation(OP)	7
Appointment - Delay (IP)	1
Appointment - Delay (OP)	9
Attitude Of Staff - Allied Health Professionals	3
Attitude Of Staff - Medical	13
Attitude Of Staff - Nursing	18
Bed Moves / Transfers	1
Clinical Advice/Treatment	14
Communication/Info To Carers	6
Communication/Info to Patients	12
Confidentiality	2
Diagnosis Problems	1
Difficulty/Delay In Being Accepted by a Service	5
Difficulty/Delay In Contacting	3
Discharge Arrangements	8
Failure to Follow Procedures	2
Failure/Difficulty With Tests/	1
Inadequate/Incomplete Assessment	1
Incorrect Information Contained in Documentation	4
Information	2
Issues Around Standard Of Therapy Care	2
Loss of Personal Property	1
Medication Error/Issues	10
Nursing Care	7
Other Environmental Issues	1
Patient Expectations And Service Delivered	15
Patient Safety	7

Patient's Privacy & Dignity	5
Transfer Arrangements	1
TOTAL	**164**

4. Lessons Learned / Actions Taken as a Result of Complaints

As a result of complaints a number of lessons were learned and actions identified for example;

• Good practice to discuss medication changes with patients who are detained under the Mental Health Act as much as is possible before changes are made and explanations about legal rights under the Mental Health Act may need to be explained on a number of occasions to patients who are detained.

• Teams being reorganised during the out of hour's period to increase the capacity of the service and to ensure that all calls are prioritised appropriately and care is provided without delay. This is expected to be implemented by October.

• Reiterate to schools the importance of informing School Nurses of continence issues experienced by children on site.

Leicester City CCG Complaints Process

Stage one of the Complaints Process

1. Complainants can send a complaint to the Governance Officer at Leicester City CCG using several methods of communication. This includes, sending an e-mail to the designated complaints e-mail address (LCCCGComplaints@LeicesterCityCCG.nhs.uk), by post and also by use of the new online form on the Leicester City CCG website. It has been recognised that before complainants send an e-mail or any correspondence through to the CCG, they tend to call the CCG to discuss their complaint first. This is helpful for the CCG because it means we can identify and explain exactly what information is required for the complaint to be registered with the CCG. it will be highlighted that the complaint should be received in writing, and the complainant must include specific pieces of information such as their address and the GP practice they are registered with. They should, if possible, also provide consent for other health bodies to aid the investigation in to the complaint.

2. Clarity needs to be sought as to whether the patient is a city patient or is registered to a practice that belongs to one of the other two CCGs in Leicestershire. Currently, Leicester City CCG uses a postcode database as a search mechanism to establish which CCG should have responsibility for investigating the complaint.

3. Leicester City CCG also receives complaints that are more appropriate for the other two neighbouring CCGs or NHS England. Complainants need to provide verbal consent and a hard copy of their consent to ensure they are happy for Leicester City CCG to send the complaint to the correct organisation on their behalf. Leicester City CCG also explains to the complainants how they can address their complaint to the correct organisation themselves by providing the relevant addresses and telephone numbers.

Stage two of the Complaints Process

4. Once a complaint has been received by the CCG, and the complainant is recognised as a Leicester City CCG patient, the complaint is then logged into the system and an acknowledgement sent to the complainant within 3 working days, in line with the statutory NHS Complaints Regulations 2009. If explicit consent to investigate a multi-organisational complaint has not been provided, it is sought at this stage. Once consent has been obtained, an investigation in to the complaint can commence. The complaint is triaged to the relevant health bodies to help aid investigation, and the complainant receives an estimated timescale for the response.

5. Leicester City CCG aims to provide responses to complainants within 28 working days. However, this timescale may need to be amended to ensure all organisations taking part in the investigation have adequate time to investigate all of the concerns that have been raised thoroughly.

Stage 3 of the Complaints Process

6. As soon as the complaint is triaged it is then monitored by the Governance Officer, who will source additional information from the complainant if required. The Governance Officer then works to ensure that deadlines are on target and provides regular updates to the complainant if there are any changes to the response deadline.

7. Once the concerns highlighted have been investigated by all the relevant parties involved in the complaint, all of the information provided is compiled into one response, and this response is then quality assured and reviewed by a CCG Governing Body clinician if necessary.

POhWER

8. At Leicester City CCG, we have experienced that some complainants would like more support in making their complaint. Due to this, the CCG has incorporated the use of POhWER who are a free, independent and confidential service.

9. POhWER act as an advocate for the complainants, helping to formulate the complaint so that all the relevant information is included and guide the complainant through the system.

10. Complainants are made aware that they should not feel obliged to use POhWER if they do not wish to use them. However, we recommend POhWER because they are able to help complainants who need extra support, while they also help the CCG because they ensure the complainant includes all the facts needed to undertake a robust investigation.

Disputes

11. Leicester City CCG always provides information for the Health Service Ombudsman when the response is sent back to the complainant. This consists of a leaflet outlining what the complainant can do if they are not satisfied with the response that they have been provided with.

Reporting

12. Every month the Senior Management Team at the CCG receive an update in regards to the number of complaints received and any identified themes. Weekly updates are provided to the Quality team as they require this information to understand what experiences patients are having in regards to the services commissioned by the CCG. Weekly monitoring helps them to identify key trends and themes, but also how they can help to improve patient experience.

13. A monthly update is also provided to the Contracting Team at the CCG who analyse the data to understand the key themes that have been identified. This data helps them to monitor issues that are raised with services, and helps to develop them to ensure patients receive a high quality service.

14. The data from the complaints register is modified to ensure that patient confidential information is not included in the updates provided to colleagues at the CCG.

Review of Complaints Process

15. Leicester City CCG is currently undergoing a review of the Complaints Process, to ensure it is more streamline and robust. After having sight of the Francis Report and Clwyd Review, it is paramount that key recommendations are taken into consideration to ensure complaints are investigated fully and a robust process is followed to ensure responses are thorough and provide assurance to patients.

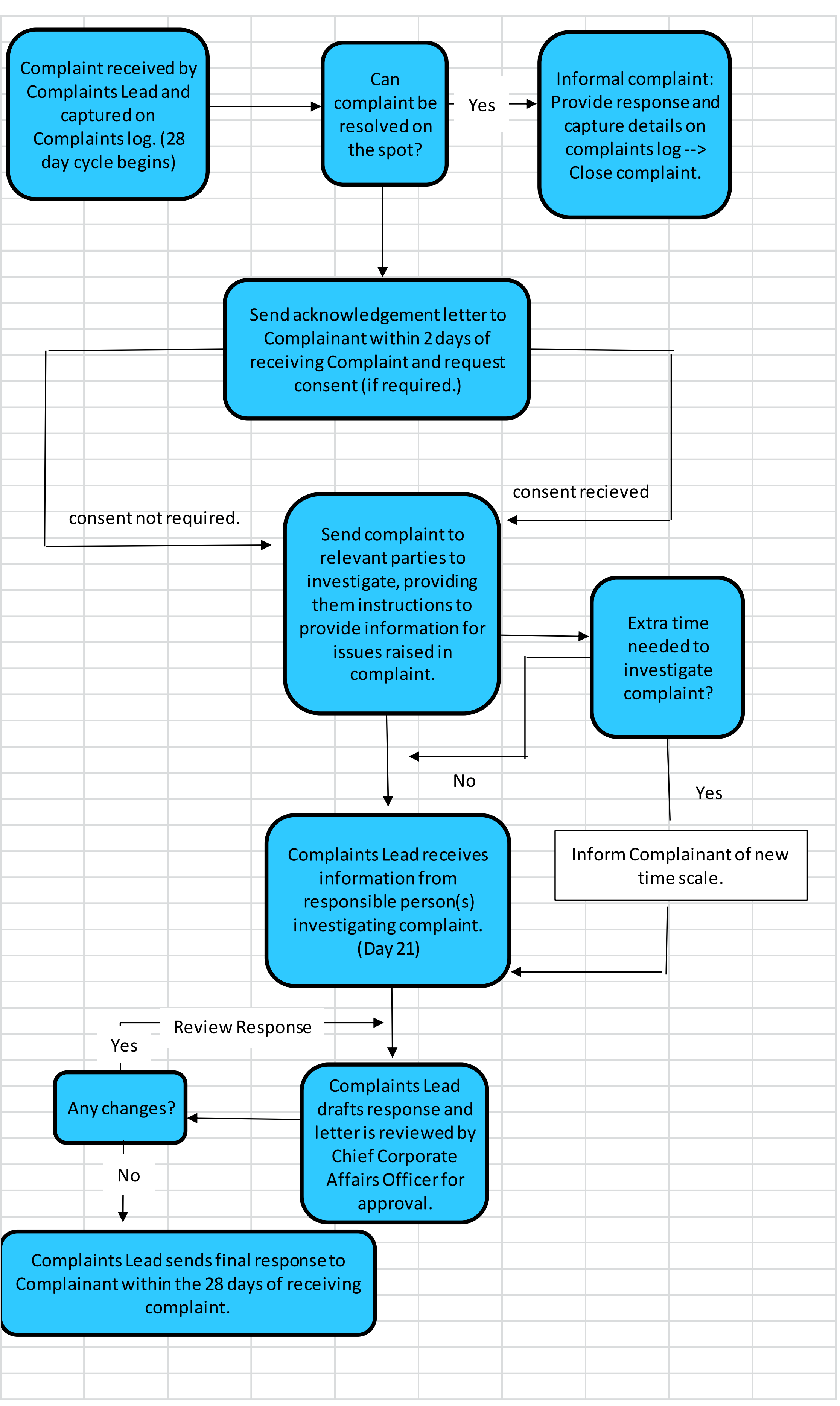
16. The process will be amended so that complainants have the opportunity to include some of the protected characteristics on the online complaints form, or in the acknowledgment letter sent back to them. This information will aid the CCG to analyse trends and patterns and key themes. The Clwyd Review in particular provides recommendations into the standards that might be best applied to the handling of complaints.

17. The complaints register will be analysed to ensure all the information is captured appropriately and to ensure timescales are reviewed to ensure each stage is given sufficient time for all the information to be pulled together. This will also allow enough time for letters to be approved appropriately before they are sent out, and for the information to be challenged by the organisation if clarity needs to be sought.

18. As soon as a response has been provided, patients will be given an opportunity to provide feedback so that we can ensure that the CCG are meeting their expectations. This can be done by introducing resolution meetings to iron out problems at a local level. This will give the organisation a chance to solve the

problem with the patient before escalating the complaint to the next stage and involving the Health Service Ombudsman.

Current CCG Complaints Process



Leicester City CCG: Information on Complaints

Number of Complaints Received in Quarter 1, 2 and 3

1. In quarter one; Leicester City CCG (LC CCG) received eleven complaints from the period of April 2013 to June 2013. Out of the eleven complaints, one was signposted to West Leicestershire CCG (WL CCG), and one was signposted to East Leicestershire and Rutland CCG (ELR CCG), and one was for NHS England. Therefore, LC CCG has been the lead for eight complaints in the first quarter.

2. In quarter two, Leicester City CCG received eighteen complaints from the period of July 2013 to September 2013. Out of the eighteen, ten have been for NHS England, and two of the complaints have been for West Leicestershire CCG (WL CCG). Therefore, LC CCG has been the lead for six of the complaints received.

3. In quarter three, LC CCG received twenty one complaints, of which, one was West Lincolnshire CCG, seven were for NHS England, one for East Leicestershire and Rutland CCG, and three for West Leicestershire CCG. Therefore, LC CCG has been the lead for nine of the complaints received.

Themes for the Complaints

4. Leicester City CCG will only investigate complaints in regards to the services commissioned by the CCG and services that are commissioned on behalf of the CCG by the other two neighbouring CCGs in Leicestershire and Rutland.

5. A common theme identified from the complaints handled by Leicester City CCG is in relation to concerns with University Hospitals of Leicester NHS Trust (UHL). Patients have complained that they have experienced delays in referral to treatment and appointments have been booked beyond the eighteen week time frame due to hospitals cancelling appointments and rescheduling them to later dates. In addition, another common theme identified from the complaints received in relation to UHL surrounds the general poor standards of hospital care received by patients.

6. Patients have also experienced difficulties in accessing patient transport provided by Arriva. Some have experienced unnecessary delays. This is a common trend and from analysing the complaints in the last three quarters, there is a common occurrence that patients are not receiving a good quality and satisfactory service from Arriva.

7. Another common theme is in relation to the Out of Hours Service. Patients have expressed that they have not been satisfied with the service provided during their

consultations with an Out of Hours GP. Patients have felt that they have experienced communication breakdowns with the GP during their consultation as they feel that their problems are not being addressed appropriately, and quality has not been at its best.

Data the CCG collects

8. The CCG will always ensure that the patient provides their GP practice an address before undertaking an investigation into a complaint. This is to ensure that the patient belongs to the CCG and so that the correct process can be undertaken.

9. The CCG is currently undergoing a review of the complaints process to include a process to collate data from some of the protected characteristics. The specific characteristics have not been agreed upon, but they are in the process of being finalised. This data will be used to help the CCG Quality team to analyse patient experiences and break them down in to smaller categories.

10. The table below shows the data the CCG collects when a complaint is recorded and processed. The data collected from the CCG is anonymised before it is shared with colleagues in the organisation to ensure that there isn't a breach of data protection.

11. As the CCG is undergoing a review of the complaints process, the way data is collected will also be reviewed to ensure that all the relevant aspects are captured.

Complaint Ref:	Date received:	Date of Complaint (letter):	Method of complaint and details:	Description of Complaint:	Date Acknowledgement Letter Sent (2 days from receipt):	Draft response required by (20 days from receipt):	Final response to be sent by (25 days from receipt):	Lead:	Final response sent:	Opened / Closed:
April - June 2013:										
July - September 2013:										
October - December 2013:										
January - March 2014:										

Action Taken

12. Within the CCG, particular teams are provided with a snapshot of a description of the complaints received. This is to ensure that contractually providers are delivering the services they should be, and to ensure that patients are experiencing the best quality of services commissioned by the CCG.

13. Weekly updates are provided within the CCG with the Quality team so that they can identify any key themes or trends and build upon experiences patients are having. This is a key element to ensure that patient experience is improved, and to also ensure that complaints are investigated robustly.

14. Data is shared within the three CCGs and other agencies such as UHL only when the complaint requires a multi organisational response, or if the complainant has sent their complaint to the wrong CCG.

15. The CCG is currently exploring many ways in which the complaints data can be used to improve services, and to ensure that information is captured and shared appropriately within the CCG. The CCG is looking to implement a new process by ensuring recommendations from the Francis Report and Clwyd Report on complaints handling is taken into consideration.

East Midlands Ambulance Service NHS
NHS Trust

Responding to Patient/ Public Concerns

1.0 Introduction

This paper outlines the way in which East Midlands Ambulance Service NHS Trust receives, acknowledges, investigates, responds to and learns from concerns raised by patients and the public.

Trust wide data relating to the number and nature of Formal Complaints (FCs) and Patient Advice and Liaison Service (PALS) concerns for the last 3 years is included along with a breakdown for the Leicester, Leicestershire and Rutland region.

Information relating to the number of cases referred to and upheld by the Ombudsman is also included for the last 3 years.

2.0 Policy

The Trust has in place a Complaints policy which outlines the duties, responsibilities, and process for managing both Formal Complaints (FCs) and PALS concerns. This underwent fundamental review in August 2013 in light of changes to the organisational structure and to ensure that recommendations from the Francis Report (February 2013) were adopted. Some of the changes made at this time included:

- Provision of a dedicated nhs.net email address to receive complaints via commissioners or other healthcare providers
- Process for escalating significant patient safety concerns to be reported and investigated as serious incidents
- Makes clear that PALS will where possible be resolved by the central team at first contact and not passed to Division unless required
- Inclusion of the revised flowchart for dealing with redress requests (making this a quicker and simpler process for claims under £1000)
- More robust process for monitoring completion of actions identified to address learning from complaints/ concerns
- Inclusion of requirement to seek clinical/ specialist advice in investigations where appropriate
- Change to advocacy arrangements
- Inclusion of requirement to consider reasonable adjustments in providing responses
- Quarterly Reports to be shared with stakeholders and made available on the public website

A further addition was made in October 2013 following concerns raised by the Derbyshire Heathwatch group regarding the Trust’s lack of a defined process for dealing with anonymous patient feedback.

The nature of the concern and the complainant’s wishes will determine whether the concern is dealt with through the FC process or the PALS process. The PALS process is a less formal process and is appropriate to address requests for information, explanation and less complex/ serious concerns. PALS cases are investigated by PALS Coordinators who are able to act as liaison with staff and managers in the Divisions to provide complainants with a response, usually verbally although written responses can be provided if required.

The FC process is used in more complex cases, where there are more serious concerns raised or where the complainant has requested at the outset that the formal process is followed. FCs are investigated by Investigation Officers who coordinate the investigation which may include formally interviewing staff, taking statements, reviewing clinical records and dispatch records. A written response from the Chief Executive is provided for all FCs.

On receipt of any concern an assessment is made against a risk matrix which identifies the most appropriate process for dealing with the concern. This is discussed and agreed with the complainant following an explanation of the routes available to them.

In either case the investigation is conducted by a member of the central team (a PALS Coordinator or an Investigation Officer) who works independently from the Divisions. They act as liaison with the complainant keeping them updated with investigation progress. Learning is identified along with any action required to prevent similar concerns in future.

If it is identified or suspected (either on receipt of a concern or during the course of the investigation) that there has been actual or potential serious harm as a result of failings on the part of EMAS the case will be escalated to serious incident status which means that the case must be reported to the commissioners and a full root cause analysis investigation undertaken to establish the cause, contributory factors and actions required to prevent a recurrence. If this is the case the complainant will be informed and if they wish can be involved in the investigation. They will receive feedback once the investigation has been concluded. The Trust has in place a Being Open policy which outlines when and how this should be done.

3.0 Process

3.1 Receipt

Complaints or concerns are received in a number of ways including by letter, email, telephone call and less frequently in person. Complaints or concerns may come directly from the patient or via a relative or advocate acting on their behalf. In addition complaints can be received via commissioners or other healthcare providers.

The table below shows the numbers of FCs and PALS received by the Trust as a whole and from Leicester, Leicestershire and Rutland during 2011/12 to 2013/14 year to date (to end November 2013).

Type of concern	2011/12		2012/13		2013/14 YTD	
	Trust	**Leics**	**Trust**	**Leics**	**Trust**	**Leics**
FC	255	67	229	43	118	23
PALS	1377	334	1393	238	883	177

3.2 Acknowledgement

Complaints fall under the Local Authority Social Services and National Health Services Complaints (England) Regulations 2009 (hereafter referred to as the Regulations).

The Regulations state that complaints should be acknowledged no later than three working days after the day on which the complaint is received. The Trust has set a key performance indicator of 100% achievement of this target, which is monitored on a monthly basis. There is no national standard for acknowledging PALS concerns but the Trust has set an internal target for acknowledging 100% of PALS within 1 working day.

The table below shows the performance against these targets from 2011/12 to 2013/14 year to date (to end November 2013).

Target	2011/12	2012/13	2013/14 YTD
FCs acknowledged within 3 working days	98.9%	100%	98.3%
PALS acknowledged within 1 working day	92.6%	99.1%	97.5%

It is of course not possible to acknowledge or respond to anonymous concerns. These are however logged, investigated (within the limitations of having restricted information), triangulated with other sources of patient feedback and where appropriate action taken in response to learning.

In the last 3 years we have only received 1 anonymous concern. This was from the Derbyshire area and related to inappropriate comments made by a member of staff and alleged that the staff member took photographs of the patient's home without consent. A reminder was issued to staff regarding the need to gain patient's consent for photography and when this is appropriate clinically.

3.3 Themes

The tables below show the numbers of FCs and PALS received by theme by the Trust as a whole and from Leicester, Leicestershire and Rutland during 2011/12 to 2013/14 year to date (to end November 2013).

Timeliness	2011/12		2012/13		2013/14 YTD	
	Trust	Leics	Trust	Leics	Trust	Leics
FC	141	37	128	26	50	9
PALS	563	151	695	107	350	69

Timeliness complaints may include concerns regarding the time taken to send an initial response, to call back to undertake further assessment, delay in providing back up response capable of transporting the patient to a solo responder in a car or delay in undertaking a patient transport service planned journey.

Quality of care	2011/12		2012/13		2013/14 YTD	
	Trust	Leics	Trust	Leics	Trust	Leics
FC	63	19	60	9	38	10
PALS	174	43	160	24	111	33

Quality of care complaints may include concerns regarding the assessment and/or treatment of the patient. This could include not transporting a patient to hospital or signposting patients to other services e.g. out of hours/ GP practice or urgent care centres.

Staff attitude	2011/12		2012/13		2013/14 YTD	
	Trust	Leics	Trust	Leics	Trust	Leics
FC	22	3	21	5	18	3
PALS	141	31	185	32	96	18

Attitude complaints may include concerns about the behaviour and/or actions of a member of staff or the way in which they have communicated.

Other	2011/12		2012/13		2013/14 YTD	
	Trust	Leics	Trust	Leics	Trust	Leics
FC	29	8	20	3	12	1
PALS	499	109	353	74	326	57

Other complaints may include concerns relating to administrative arrangements, communications, confidentiality, damaged or lost property, driving, environment, information requests and PTS eligibility.

3.4 Response

The Regulations allow NHS Trusts a period of 6 months to investigate and respond to a complaint (or agree a longer period with the complainant). There is no national target for responding to PALS concerns. However as a Trust EMAS is committed to providing timely resolution to patient and public concerns and as a result has set an internal target of responding to all FCs and PALS within 20 working days.

The table below shows performance against these targets from 2011/12 to 2013/14 year to date (to end November 2013).

Target	**2011/12**	**2012/13**	**2013/14 YTD**
FCs responded to within 20 working days	66%	74.4%	68.3%
PALS responded to within 1 working day	50%	52.6%	45.0%

Please note that the 45% for PALS relates to data from 12 August (when we moved to Ulysses)

There have been significant improvements to the timeliness of responses in recent months following a review of the capacity and management of the patient experience team. The table below shows year to date performance.

We aim to resolve as many PALS concerns as we possibly can at first contact. This is not always possible but in order to ensure that these less complex concerns are addressed in a timely manner the team have a set of Key Performance Indicators (KPIs) that are monitored on a weekly basis. The table below shows performance against these KPIs year to date.

PALS	**Target**	**April 2013**	**May 2013**	**June 2013**	**Jul 2013**	**Aug 2013**	**Sep 2013**	**Oct 2013**	**Nov 2013**
% closed at first contact	**50%**	8.22%	18.28%	21.69%	45.6%	45.6%	50%	37.1%	53.3%
% closed by 48 hours	**55%**					39.1%	49.5%	40.2%	57.5%
% closed by the 5th day	**60%**					57.1%	61.5%	43.9%	61.7%

3.5 Second Letters

EMAS aims to resolve all concerns to the complainants' satisfaction first time. This is however not always the case and some FCs and PALS will attract second letters. Sometimes this is because the response has prompted further questions or the complainant has identified new areas of concern. However sometimes this is because they are unhappy with the initial response. The number of and reason for second letters is therefore monitored as this can be an indicator of the quality of the service provided to complainants.

The table below shows the number of second letters received in relation to FCs from 2011/12 to 2013/14 year to date (to end November 2013). This data has only been collected for FCs this year.

Target	2011/12	2012/13	2013/14 YTD
FC second letters received	32 (13%)	33 (14%)	9 (14%)
PALS second letters received	not recorded	not recorded	not recorded

(5 PALS further letters in July/August recorded on Respond – We don't yet have further letters recorded on Ulysses)

The reasons for the 9 FC second letters received to date this year are as follows:

- because the original response raised further questions
- to identify new issues from the same incident
- because the complainant did not agree with the response
- for clarification of an issue in the original response

The Trust offers local resolution meetings as part of the complaints process. This enables complainants to meet with relevant staff, discuss their concerns and have face to face apologies and explanations. These can be arranged at a convenient time at the complainant's house or at any of the EMAS premises whichever the complainant prefers. We have as part of local resolution offered visits to our control room if appropriate so that complainants can see how the service works.

3.6 Redress

Complainants can make a claim for redress as a result of their complaint if they have suffered out of pocket expenses or feel that they are entitled to damages. All claims for redress are considered at a senior level and the rationale for approving or declining requests is shared with the complainant.

As at the end of November 2013 the Trust had received 13 claims for redress. These included: update below

- 4 x claims for damaged doors when crews gained access
- 2 x manholes damaged by ambulances
- 2 x due to delayed response
- 2 x due to clinical care
- 2 x lost property
- 1 x car damage sustained by a driver swerving to get out of the path of an ambulance on lights and sirens

Of the 13 claims 4 have been approved in full and 1 in part including 3 claims for broken doors and 2 claims for broken manholes (1 half payment approved due to condition of existing manhole).

1 was declined on the recommendation of the NHS Litigation Authority with a view to the complainant pursuing a clinical claim. The others were declined due to there being insufficient causal link between the loss or suffering experienced and the actions of EMAS.

3.7 Ombudsman

Any complainant who is dissatisfied with the Trust's response can take their case to the Parliamentary Health Service Ombudsman (PHSO). The table below shows the number of cases referred and upheld from 2011/12 to 2013/14 year to date (to end November 2013).

	2011/12	2012/13	2013/14 YTD
Number of cases referred to the PHSO	6	4	6 FCs 4 PALS
Number of cases upheld by the PHSO	1	0 1 case is still under investigation	0 7 cases still under investigation

4.0 Lessons Learned and Action Taken

Each concern raised by a patient or a member of the public is an opportunity for learning. Following each individual complaint actions are identified aimed at preventing a recurrence. The actions will vary depending on the nature of the concern raised but may include:

- Reviewing and revising existing policies and procedures
- Providing education, training or communications to staff
- Reviewing and reallocating resources

A record of all actions identified through FCs and PALS are kept by the patient experience team and these are monitored until evidence of closure is provided.

FCs and PALS data is triangulated with other sources of patient feedback including patient surveys and actions are identified to address recurring themes. Quarterly Integrated Patient Experience Reports are produced and presented at Trust Board in the public session. These are also available on the Trust website.

Below are some examples of specific actions taken in the last year in response to the main themes arising from patient feedback:

Timeliness

- "Being the Best" consultation being implemented to reconfigure EMAS estate and redesign service delivery model to improve response to all call categories
- Independent Review undertaken to provide clear evidence base for workforce profile required
- Increase in Community First Responder Schemes and Public Access Defibrillators
- Use of Third Party Private Providers
- Development of Resource Management Centre to optimize resource utilization including use of third party providers to support timely response
- Proactive sickness absence management and recruitment of clinical staff to support 'safe staffing'

- Guidance issued to frontline staff to support non-conveyance and reduce on-scene time where clinically indicated
- Ongoing work with Acute Trusts and Commissioners to address hospital turnaround delays. Welfare checks have been introduced for green call delays and where no contact can be made these calls are automatically upgraded as a safeguard

.

Quality of Care

- Revision of the Safe Carriage SOP to make staff responsibilities with regard to safely securing patients clear and clarify action to be taken if patients cannot be adequately secured.
- Introduction of a C Spine assessment and management training video podcast and flowchart.
- Third Party Quality Schedule Review process to monitor quality of services provided
- Spinal injury assessment and management being delivered face to face in Essential Education from 1 July 2013
- Maternity Update as part of Essential Education (EE) from 1 July 2013
- Development of Maternity SOP and red flags for use by Emergency Medical Dispatchers
- Regular audit of Patient Report Form completion undertaken with results fed back to individuals and themes identified with appropriate action plans to address these.
- Additional staff training in record completion and appropriate safety netting of non- conveyed patients.

Attitude

- Recruitment processes now include assessment of attitude/ behaviours
- EMAS is incorporating a behaviour and attitude module into its current Essential Education programme for 2013/14
- Introduction of a patient survey to be utilised following receipt of attitude related complaints with a random selection of patients attended by the relevant individual.

Other

- Improved process for ensuring relevant information regarding incidents shared with assisting emergency services.
- Introduced new process of testing communications with Community First Responders at the start of each shift.

5.0 Conclusion

EMAS values patient feedback and views every concern raised as an opportunity for learning and improvement. Significant progress has been made in the past year in both the quality and timeliness of investigating and responding to complaints. However, EMAS recognises that there is still room for improvement and is committed to further improving the quality of the service provided and responding sensitively and effectively when concerns are raised.

Appendix I

Health and Well Being Scrutiny Commission **31st December 2013**

Leicester City Council complaint management

Report author: Director, Information and Customer Access

1. Summary

This report summarises how complaints about Council service are dealt with. Reference is made to the Corporate, Social Care and FOIA processes.

2. The Corporate Complaint Process

General complaints to Leicester City Council are recorded on a corporate complaints system and allocated to Departmental Complaints Officers (DCOs) for allocating and monitoring responses.

Corporate complaints are classified as

- Stage 1 which are dealt with by the service area complained about. A complaint is acknowledged within 24 hours and responded to in full within 10 working days.
- Stage 2 which is used where a complainant is not satisfied with the response they receive at Stage 1. This stage is dealt with an independent officer from another service area. Complaints are acknowledged, as above, and responded to in 20 working days

After these two stages have been exhausted, the complainant may have recourse to refer their issue to one of two Ombudsman services (there is a specialist Ombudsman for Council tenancy matters).

All complaints are also classified by type (e.g. standard of Service, attitude of staff), and whether the complaint was justified or not. A service improvement narrative (where a complaint is justified,) is also recorded.

Complaints are identified mainly though Customer Services or other front of house points, such as the specialist telephone Contact Centres. However, any

Council officer may record a complaint and forward it to Customer Services or their service area DCO for recording and processing.

3. Adult, Young People and Children's Statutory Social Care Complaints

Separate procedures exist for complaints about the standard of social care provision.

Adult Social Care Complaints (Two Stage Process)

The Adult Social Care Statutory Complaints & Commendation process operates within a legislative framework and formal guidance is in place to support its practical implementation. The process is overseen by the Complaints Manager.

The complaint guidance defines and sets out such things as who is able to raise a complaint under the procedure, what time limits exist for raising a complaint, timescales for acknowledging and responding and more.

In principle there are two stages involved with the Adult Social Care Statutory Complaints process:

The first stage is a combination of processes working towards Local Resolution and this may include internal or independent investigation, mediation and conciliation, dependent on the circumstances. An assessment is made by the complaints manager and the investigation is usually, although not invariably, handled by a senior manager (Locality General Manager or above).

The response times for complaints at this stage vary from 5 to 65 working days according to the "grading" given to the complaint's level of seriousness by the complaints manager.

The second stage of the process is with the Local Government Ombudsman.

As the legislation that drives Adult Social Care Complaints is also shared by agencies within Health, there is a formal joint protocol in place to ensure that cross organisational complaints are addressed in a unified way. The purpose of the protocol is to draw together these agencies to provide one complaint response on behalf of all the organisations concerned. Representatives from the relevant agencies also meet on a quarterly basis to discuss any common issues arising and to review the effectiveness of the protocol that is in place.

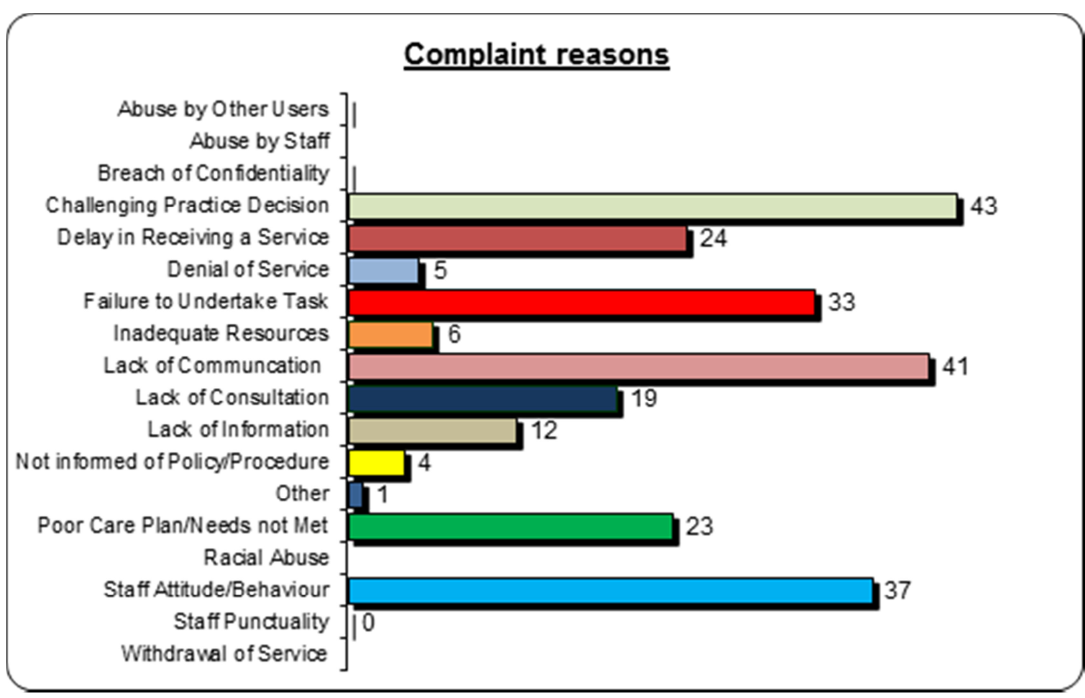
Adult Social Care also records and responds to those complaints that are logged under the corporate procedure.

Information management, monitoring and reporting

Adult Social Care senior managers are provided with monitoring information relating to complaints on a monthly basis and this is followed with a detailed annual report that is also made available publically.

Within the annual report detailed statistical information is provided with some analytical commentary on such areas as:

- How many complaints/commendations are received
- What/which service they are about
- Target response times and how they are being met
- How/how many complaints are concluded (e.g. upheld, partially upheld, not upheld)
- How complaints are received (email, post etc)
- Analysis by demographics, gender, ethnicity (i.e. who is accessing the complaint procedure/reporting concerns)
- Analysis by service area
- Customer feedback comments (in relation to managing the complaint itself)
- Reasons behind complaints (the chart below provides an example of what is recorded)



A policy is also in place to consider any complaints that may result in payments for maladministration identified by the Department (not by the Local Government Ombudsman).

A brief report on complaints and commendations information is also published in the Adult Social Care Annual Report together with a report on what we have done as a result of the complaints that we have received.

Learning lessons from customer feedback

An important part of the ASC complaint process is to ensure that valuable customer feedback is identified from complaints received and utilised to ensure that service improvements are made where appropriate.

At the point at which an outcome to a complaint is known, managers responding to complaints are asked to identify any areas of weakness or to highlight any potential service improvements, flagged up as a result of a customer's expression of dissatisfaction.

Managers are expected to make improvements where necessary for their own individual service area following specific information received from a complaint.

The Complaints Manager also actively reviews all complaints received (regardless of outcome) for specific periods of time and reports to senior managers on any trends or common themes emerging from these individual complaints. The Divisional Management Team is asked to consider this information and to propose and implement any appropriate actions identified. Adult Social Care and Safeguarding's Senior Management Team is now actively involved with implementing service improvements identified from this complaint monitoring information. The consideration that has been given to the lessons learnt and any actions arising are then reported back as part of this monitoring cycle to the Leadership Team, so that the Director is aware of the action taken.

As an example, some of the actions taken as a result of complaints received during the year have been:

- Held more open discussions within teams regarding customer feedback to encourage direct service improvements by team members.
- Made improvements to our communication with customers; making sure that we use plain English in the letters that we send out.
- Targeted staff training to make sure that there is a consistent approach in the way that we carry out community care assessments.
- Reviewed our message taking methods to make sure that the right people return calls in a timely way.

The Complaints Manager has also uses specific examples from complaints received at different team meetings to enable staff to fully understand the importance of good complaints handling and to learn from poor practice or mistakes.

Commendations are welcomed and the Director is made aware of individual efforts so that these can be acknowledged and formally recognised.

Children and Young Peoples' Social Care Complaints (Thee Stage Process)

The Children's Social Care Statutory Complaints & Commendation process operates within a legislative framework and formal guidance is in place to support its practical implementation. The process is overseen by the Complaints Manager. The Complaints Manager is part of the Safeguarding and Quality Assurance Unit of the Children's Social Care and Safeguarding Division and is responsible for managing the process for children's statutory complaints.

The complaint guidance defines and sets out such things as who is able to raise a complaint under the procedure, what time limits exist for raising a complaint, timescales for acknowledging and responding and more.

The statutory complaints procedure has three stages

Stage 1 – Local Resolution

Complaints are dealt with by managers at the point closest to service delivery.

Stage 2 – Formal Independent Investigation

Experienced, Independent Investigators who are not employed by Leicester City Council investigate the complaint and produce a report. The Regulations require the Investigator to be accompanied by an Independent Person who works alongside the Investigator to ensure that the process is transparent, open and fair.

A Service Director adjudicates on the findings.

Stage 3 – Independent Review Panel

A panel consisting of 3 Independent People reviews the Stage 2 investigation and the Department's response.

STATUTORY RESPONSE TIMESCALES FOR COMPLAINTS		
Stage 1	Stage 2	Stage 3
10 Working Days or up to 20 if the case is complex	25 Working Days Can be extended up to 65	30 Working days to set up panel following request. 20 Days for Director to respond to panel's findings

This is the end of the statutory complaints procedure. If complainants remain dissatisfied they can refer their case to the Local Government Ombudsman (LGO).

The Local Government and Public Involvement in Health Act 2007, which came into effect from 1st April 2008, introduced a number of changes to the Local Government Ombudsman's jurisdiction. One of these changes gives the LGO the power to investigate a complaint that has not previously progressed through the complaints procedure of the local authority concerned

In addition to the three formal stages, concerns can also be responded to as an Initial Enquiry. These are enquiries raised by a service user, or on behalf of a service user, which can either be resolved swiftly – by perhaps a phone call, or if the expressed preference is not to make a formal complaint. Initial Enquires also cover issues which need further clarification. There are no formal timescales for a response, although this is monitored by the Complaints Manager.

Alternative Dispute Resolution

Most service users want to resolve complaints quickly and don't always want to enter the formal investigation stage. Those whom are not satisfied with the response at any stage of the complaint are offered the opportunity to meet with the responding manager to try to resolve the issues. This meeting is chaired by the Complaints Manager.

The role of Complaints Manager has recently been extended to have a wider remit covering customer feedback and quality assurance. Consultation will take place with Children and Young People, Parents and Carers, Professionals and

community members to find out their experiences of the Services provided by the Division. This will be co-ordinated by the Complaints Manager.

This more complete picture will support us to identify services that receive repeat complaints and will help us to identify areas for improvement across the Division.

4. DPA and FOIA Complaints

Complaints about breaches of the Data Protection Act 1998 are not dealt with under the corporate complaints procedure but are logged with and investigated by the Information Governance Team.

Stage 1 is an investigation by the Information Governance Manager. (Target 20 working days)

Stage 2 is an investigation by an independent manager. (Target 20 working days)

Stage 3 Complainants are advised to contact the Information Commissioner's Office if they remain unhappy.

5. Monitoring and Reporting on Complaints

Complaints are recorded in the corporate Customer Relationship Management (CRM) system which holds a full history, including documentation, of any complaints received.

The Head of Customer Services leads a Departmental Complaints Officers Group, through which issues relating to complaints handling can be explored and resolved.

The CRM system is used by DCOs to flag any complaints which have deadlines due. There is also a specialist reporting tool which is used by DCOs to produce monthly reports for managers and directors within their service areas of any outstanding complaints and trends in issues being reported.

Recently, Customer Services have assumed a role to assist with this process and also to review the quality of complaints responses on a monthly basis. Customer Services also provide data on the ratio of Stage 2 to Stage 1 complaints. Work is underway to identify which services most often attract escalated complaints and also any trends in types of complaint being raised, eg service failure.

Figures for corporate complaints received during 2013 are attached at Appendix 1.

6. Vexatious Complainants

A procedure exists for investigating and designating a complainant as "vexatious". This is where, despite a DCO being satisfied that a complaint has been properly investigated and responded to the complainant persists in making the same complaint, attempts to change the substance of a complaint, is physically or verbally aggressive or threatening, or contacts Council officers repeatedly about the same subject.

A case conference will be convened by a lead DCO, and involve DCOs and officers from any other affected areas, plus an independent DCO. The details and recommendations are reviewed by the Director of Information and Customer Access who will confirm if the complainant should be designated vexatious or not.

7. Help and Support

There is extensive information and advice available on the Council intranet for those handing complaints, including sample phrases and forms to use to record complaints.

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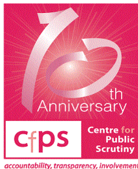
Appendix 1

Stage 1	2013						
Service	Received	Justified	% Justified	within SLA	% within SLA	SI identified	% SI identified
Access, Inclusion and Participation	9	2	22%	3	33%	2	22%
Assurance and Democratic Services	16	8	50%	13	81%	9	56%
Community Care Services	16	3	19%	11	69%	4	25%
Culture	235	139	59%	216	92%	34	14%
Environmental Services	239	67	28%	202	85%	7	3%
Finance	593	217	37%	509	86%	11	2%
Housing Services	1984	1173	59%	1575	79%	30	2%
Housing Strategy and Options	104	31	30%	90	87%	13	13%
Information and Support	116	68	59%	109	94%	59	51%
Learning Environment	0	0	0%	0	0%	0	0%
Learning Services	19	4	21%	13	68%	0	0%
Legal Services	19	14	74%	14	74%	8	42%
Older People's Services	6	1	17%	5	83%	1	17%
Personalisation and Business Support	4	0	0%	2	50%	1	25%
Planning and Commissioning	5	3	60%	1	20%	3	60%
Planning and Economic Development	66	12	18%	52	79%	2	3%
Regeneration, Transport and Highways	259	71	27%	238	92%	14	5%
Safer and Stronger Communities	5	3	60%	4	80%	1	20%
Social Care and Safeguarding	3	0	0%	0	0%	0	0%
Strategic Asset Management	7	4	57%	7	100%	5	71%
Total	3705	1820	49%	3064	83%	204	6%

Stage 2	2013						
Service	Received	Justified	% Justified	within SLA	% within SLA	SI identified	% SI identified
Assurance and Democratic Services	1	1	100%	0	0%	1	100%
Community Care Services	1	0	0%	0	0%	0	0%
Culture	15	4	27%	11	73%	2	13%
Environmental Services	30	1	3%	22	73%	0	0%
Finance	42	16	38%	38	90%	2	5%
Housing Services	141	64	45%	94	67%	3	2%
Housing Strategy and Options	13	4	31%	10	77%	3	23%
Information and Support	3	1	33%	2	67%	1	33%
Learning Environment	1	1	100%	1	100%	0	0%
Learning Services	1	0	0%	0	0%	0	0%
Legal Services	0	0	0%	0	0%	0	0%
Older People's Services	0	0	0%	0	0%	0	0%
Planning and Commissioning	1	0	0%	0	0%	0	0%
Planning and Economic Development	17	1	6%	10	59%	0	0%
Regeneration, Transport and Highways	22	2	9%	15	68%	0	0%
Strategic Asset Management	3	0	0%	2	67%	0	0%
Total	291	95	33%	205	70%	12	4%

Appendix J



Centre for Public Scrutiny

Review of Leicester City Council Health and Wellbeing Scrutiny Commission

Summary

This report has been produced by the Centre for Public Scrutiny (CfPS) at the request of Leicester City Council's Health and Wellbeing Commission (the Scrutiny Commission). It outlines a review of the methods of working and the skills of the Members of the Council's Health and Wellbeing Scrutiny Commission in response to the recommendations of the Francis Inquiry. The review was undertaken between September and December 2013.

The report makes a series of recommendations to Leicester City Council in response to the Francis Inquiry and best practice in health scrutiny. The recommendations aim to improve the effectiveness of the Scrutiny Commission and to ensure that it is fit for purpose in the current climate of economic and resource pressures within the public sector. The recommendations focus on:

- Improved public and community involvement
- Clarification of relationships
- Effective prioritisation of issues to scrutinise
- Member skills development

CfPS looks forward to working with the Scrutiny Commission to develop and sustain its effectiveness.

Background

The report by Robert Francis QC into the serious failings of care at Mid Staffordshire NHS Foundation Trust was published on 6 February 2013. Whilst the report attributed accountability for the failures at the Trust to the Trust Board, it also identified a systematic failure by a range of national and local organisations to respond to concerns about patient care. This included identifying the role of scrutiny locally and failings in how scrutiny had been undertaken. The recommendations from the Inquiry to the Secretary of State included some that were directly related to overview and scrutiny committees.

- 43 - Those charged with oversight and regulatory roles in healthcare should monitor media reports about the organisations for which they have responsibility.

- 119 - Overview and scrutiny committees and Local Healthwatch should have access to detailed information about complaints, although respect needs to be paid in this instance to respect for patient confidentiality.
- 147 - Guidance should be given to promote the co-ordination and co-operation between local Healthwatch, Health and Wellbeing Boards, and local government scrutiny committees.
- 149 - Scrutiny committees should be provided with appropriate support to enable them to carry out their scrutiny role, including easily accessible guidance and benchmarks.
- 150 - Scrutiny committees should have powers to inspect providers rather than relying on local patient involvement structures to carry out this role, or should actively work with those structures to trigger and follow up inspections where appropriate rather than receiving reports without comment or suggestion for action.

The Francis Report also highlighted what can go wrong when patients, their families and the public struggle to have their voices heard. Council scrutiny has a key role to play in the participation of patients and the public in health service provision and in strengthening their voice. It needs to establish ways to monitor data or information about the experiences of people who use health and care services, alongside ‘triggers to act’ when things seem to be going wrong. It should not duplicate what others are doing but should maintain a wide network of intelligence so that it can use its powers effectively to hold the NHS account - having a clear understanding about the quality, safety and value of healthcare services and challenging providers and commissioners when it seems that good outcomes elsewhere are not being matched locally.

All NHS bodies were required to produce action plans in response to the Francis report by the end of December 2013. These may provide scrutineers with information about how health services are adapting practice in response to the lessons learnt. All local authorities are also encouraged to consider the issues identified in the Francis report and whether there is a need to change their scrutiny practice to ensure effectiveness. Leicester City Council is therefore committed to ensuring that its health scrutiny provisions are fit for purpose now and in the future.

Methodology

The methodology of the review was agreed between the CfPS and Leicester City Council as follows:

- Discussion with the Chair and Members of the Commission
- Desk research considering the terms of reference and processes of the Commission
- 360^0 Feedback to be sought from key local stakeholder organisations
- Training and development needs self-assessment by members of the Commission
- Observation of a Commission meeting

It was agreed that the review report would make recommendations based on the insight gained from these activities.

Outcomes from review activity

i. Desk research and discussion with Chair and Members of the Commission

The research undertaken has identified the need to clarify and promote the role and principles of the Health and Wellbeing Scrutiny Commission. There is evidence that the public, some members of the voluntary and community sectors, independent and NHS providers, and other organisations may not understand the role of health scrutiny especially with the new arrangements. At a development meeting facilitated by CfPS, Commission Members agreed with the four principles of effective scrutiny, i.e.

- To provide a critical friend challenge to the executive policy makers and decision makers;
- To enable the voice and concerns of the public and communities to be heard;
- To carry out scrutiny by 'independent minded governors' who lead and own the scrutiny process;
- To drive improvements in services and find efficiencies.

The Members added two further local principles:-

- To prevent duplication of effort and resources;
- To seek assurances of quality from stakeholders and providers of services.

It was suggested that these might be included in the 'information for members of the public' section of Commission agendas.

Members of the Scrutiny Commission acknowledge their difficulties in prioritising issues for scrutiny. This appears to lead to long agendas and insufficient time to consider issues in detail. No evidence was identified of applying tools or recognised assessment methods to set priorities. For example, it is not current practice for the Commission to base its priorities on the main causes of death, ill health or health inequalities as identified by the local Director of Public Health or to assess where scrutiny can have most influence. Similarly, the Commission has not considered its potential role in looking at what changes are needed in the provision of health services due to population change in the future. The Chair and Members of the Commission have, however, developed a close working relationship with the local authority Public Health service and recognise the value that public health data may provide to priority setting and question development.

The research indicates that relationship between the Commission and Leicestershire County Council and Rutland Council has been relatively dormant in the past 12 months. The previous joint committee hasn't met recently and there have been no informal meetings between Chairs, although support officers do have regular email and telephone contact with each other. Members of the Commission stated that there were merits and economies in undertaking joint scrutiny with the Leicestershire, Leicester and Rutland Joint Health Scrutiny Committee to avoid duplication on major topics of interest where health trusts wished to consult all three Councils. By having one

discussion at a Joint Scrutiny Committee instead of a trust visiting all three local authorities could be beneficial to all concerned. It was suggested that a shared protocol might enable the re-establishment of joint working and could take into account the resource pressures experienced by all three local authorities.

The research undertaken indicates that the Scrutiny Commission does monitor local media reports, as referred to in recommendation 43 from the Francis Enquiry, and that information about local health services that is gleaned from the media is used to inform discussions in meetings and less formally with NHS representatives.

No evidence was found that the Scrutiny Commission had applied any available guidance to promote the co-ordination and co-operation between local Healthwatch, Health and Wellbeing Boards and its role. Whilst the long awaited national guidance for health scrutiny had not been published at the time of the research or the drafting of this report, guidance has been produced by CfPS which Leicester City Council and Leicester Healthwatch might find helpful in clarifying roles and building relationships. This is addressed further in the recommendations section.

ii. 360^0 feedback from partners and stakeholders

Feedback was invited from a number key stakeholders who have interacted with Leicester City Council's scrutiny functions in the past 12 months. A list of stakeholders contacted is attached as Appendix A. No attempt was made to contact either NHS England or the Care Quality Commission as CfPS was advised that there had been no contact between them and the Scrutiny Commission in the past year. The recommendations from the Francis Inquiry have led to changes in practice for both CQC and NHS England at a local level, resulting in changes to the CQC inspection methodology and the implementation of Quality Accounts by local NHS trusts and establishment of Quality Surveillance Groups by local area teams within NHS England. We would encourage the Scrutiny Commission to build relationships with CQC and NHS England to share insight and intelligence and to help the Scrutiny Commission to gain a clear picture of the state of health services within Leicester. It would be particularly beneficial for the Scrutiny Commission to develop a relationship with the local Quality Surveillance Group which will identify issues of concern with local services.

The feedback was collected using a standard telephone questionnaire and focussed on asking for information about the relationship between the organisation and the Scrutiny Commission, comments about their perception of the effectiveness of scrutiny, and up to 3 suggestions of actions that could improve scrutiny in Leicester City in the light of the Francis Report.

Common themes identified were:

- ✓ the strength of leadership provided by the current Chair;
- ✓ the respect and realism that the Scrutiny Commission provides to NHS organisations;

- ✓ the benefits of regular informal liaison between the Chair and NHS organisations which helps to create a 'no surprises' culture;
- ✓ some NHS participants stated that they were confused about the relationship between the Health and Wellbeing Board and the Scrutiny Commission and would welcome greater clarity;
- ✓ interest was expressed by the majority of respondents in participating in discussions to develop the Scrutiny Commission's work plan and in identifying priorities and timescales for scrutiny.

The main recommendations received from stakeholders were:

- to make use of the opportunity to take an overview of issues and see them within a wider context, e.g. to see winter planning issues within the wider Urgent Care agenda, and then scrutinise the issues of concern;
- the need to re-establish the joint committee with Leicestershire County Council and Rutland Council and ensure better liaison and joint scrutiny of services across all three authorities;
- the need for more sustained engagement with the local voluntary and community organisations, especially in priority and agenda setting;
- the need for more engagement of all Members of the Commission in scrutiny to enable the process to be led by the Scrutiny Commission as a whole;
- to work with partners to ensure there is a clearer understanding across organisations of the relationship between the CCG, Health and Wellbeing Board and Scrutiny Commission.

iii. Development needs self-assessment

Members of the Scrutiny Commission were invited to complete a self-assessment form aimed at identifying their development or training needs in 3 areas:

a) Community leadership
b) Knowledge
c) Scrutiny and challenge

Five completed forms were received and analysed. The outcomes identified similar areas for development.

a) Community leadership

All respondents were comfortable in taking a community leadership role in scrutiny of health and wellbeing issues and identified a level of confidence requiring no further training or development. However, it was suggested by one respondent that it would be helpful to have a development session for the current Scrutiny Commission Members to refresh their skills in this area. It was also suggested that every year the new Scrutiny Commission should attend training that included explaining the community leadership role.

b) Knowledge

All respondents recognised the challenges in understanding the new health and social care landscape and identified the need for training on understanding structures and relationships between organisations nationally, regionally and locally. Particular concern was highlighted about the need for more understanding about Healthwatch, the Health and Wellbeing Board, and the Clinical Commissioning Group and their relationships with the role of the Scrutiny Commission.

c) Scrutiny and challenge

Not all respondents identified the need for training or development around the competencies identified within the 'scrutiny and challenge' section. However, the majority asked for support in developing presentation skills and in improving their questioning and probing skills. There was also some identification that Members required training on the local priorities to address health inequalities and health improvement.

iv. Meeting observation

The aims for observing a meeting were as follows:

a) To understand how a member of the public attending a meeting would perceive how scrutiny was undertaken;

b) To consider the process of scrutiny and how local issues were scrutinised;

c) To gather data about how Members of the Scrutiny Commission interact with each other and with witnesses;

d) To observe the questioning skills;

e) To consider how effective the scrutiny process is at holding local NHS bodies to account.

A summary of the observation is attached as Appendix B.

The observation demonstrated that NHS stakeholders took the role of the Scrutiny Commission seriously and are prepared to actively participate in its work by fielding senior members of staff and through attendance by Chairs and Non-Executive Directors where considered appropriate. However, at times this may result in more NHS attendees than is required by the Scrutiny Commission resulting in more of a discussion amongst peers than scrutiny holding to account. It was clear that there was a longstanding relationship between some NHS representatives and some Commission Members which might at times seem more 'friendly' than challenging.

The agenda was very long (204 pages) with 7 agenda items and 9 additional update reports from a previous meeting. The meeting that was observed in part lasted for 3.5 hours. This suggests Commission may be trying to address too many issues in one meeting and would benefit from looking at models for prioritising its workload and different methods of scrutiny, such as mini scrutiny or 'scrutiny in a day'.

Whilst Healthwatch representatives are invited to participate as members of the Scrutiny Commission, there appears to be no additional input from the public or voluntary and community sector organisations in either the meeting or agenda setting process. This might be considered as a way to identify issues of local importance and their relative priority.

The meeting room was not set out to enable a member of the public with no local government experience to gain a clear understanding of the scrutiny process and at times members of the public would have been unable to hear the ongoing discussions and strength of questioning.

Conclusions

The review has identified both clear strengths within the Scrutiny Commission and themes for development. Most were identified by both the members of the Commission and the local stakeholders and there is a strong level of consensus.

Strengths of current practice include:

- ✓ the consistent and clear leadership by the Chair
- ✓ the apolitical approach to scrutiny that focuses on issues for local people rather than political issues
- ✓ the diversity of skills and expertise of the different members of the Scrutiny Commission
- ✓ the provision of dedicated officer support
- ✓ the commitment to working with NHS bodies and stakeholders

Areas for development include:

- the need for clarification about relationships with other parts of the local authority especially the Health and Wellbeing Board
- the length of the agenda, which may restrict the effective scrutiny of issues of importance
- the need for stronger engagement in the scrutiny process of all Scrutiny Commission members, to scrutinise as a group rather than as individuals
- the need to make use of local data, including public health data, and insight from local people to set priorities.

Recommendations

The following recommendations aim to address the issues raised through the review and to ensure that the Scrutiny Commission is fit for purpose in response to the Francis Inquiry.

a) Improving practice

Community Leadership

- the Commission needs to find a way to reduce the length of agenda's and maximise the time in meetings spent on scrutiny whilst still ensuring that Members have adequate information. Some other authorities provide information in the form of written briefings, whilst others provide short, verbal briefings organised at a time when councillors are available to attend and open to all Members;
- include the principles of effective scrutiny agreed by the Scrutiny Commission in the 'information for members of the public' section of agendas, to enable anyone observing or attending meetings to be clear about its role;
- clearly inform witnesses and stakeholders invited to attend Scrutiny Commission meetings why they are being invited and who should attend. If more representatives turn up, limit the number who are able to participate so that the discussions remain focussed on the issues identified by the Commission;
- develop and implement a consistent approach to prioritising items in the work plan and agendas. There are different approaches that might be used, e.g. identifying annual priorities based on public health data or local concerns, or both, or assessing issues against a set of criteria;
- consider using different approaches to scrutiny of different issues, e.g. appreciative inquiry, mini scrutiny and the CfPS Return on Investment models.

Involving and listening to local people

- Undertake further discussions with Healthwatch and Leicester Voluntary Action representatives about building local concerns into the work of the Scrutiny Commission. This might include looking at how service users views can be incorporated into the beginning of reviews, which is a practice used in some other authorities.
- It is recommended that the Scrutiny Commission considers building an opportunity for members of the public to ask questions at its meeting. Some local authorities have effectively enabled this through incorporating a 'question time' session within their agendas in addition to dealing with petitions. The inclusion of questions has been agreed with local NHS bodies so that the questions may be asked of the NHS representatives as well as the

Scrutiny Commission. This would enable Members of the Scrutiny Commission to hear some of the public's views.

Questioning and Listening

- Make more effective use of pre-meeting by considering reports, identifying lines of inquiry and key areas for questioning, and discussing how questions may be articulated. Use the review meeting to reflect on what went well and what could be improved in the future.
- Develop an approach to 'active listening' to what local people are telling individual councillors and the committee, to what anonymised complaints data shows, and to the stakeholders that present at meetings or act as witnesses.
- Work more effectively as a 'team' rather than as individuals in questioning and probing witnesses.

b) Working with other stakeholders

- The review highlighted that the Scrutiny Commission has not yet developed a working relationship with NHS England or the Care Quality Commission. This should be addressed and consideration given to the role of scrutiny in relation to Quality Surveillance Groups organised by the local area team of NHS England and to the new approaches to CQC inspection and implications locally. The Scrutiny Commission may also want to scrutinise services commissioned by NHS England such as community primary care services (including dental health) and specialised services.
- We recognise that establishing processes for joint working and joint committees can be challenging. However some issues need to be scrutinised jointly. It is recommended that the Scrutiny Commission reviews the experience of joint scrutiny with Leicestershire County Council and Rutland Council and establishes a joint protocol that establishes processes for stronger and more effective joint scrutiny before it is required.
- In response to the confusion amongst stakeholders that was identified in the 360^0 feedback, we recommend that Leicester City Council develops a common understanding between the Health and Wellbeing Board and the Health and Wellbeing Scrutiny Commission about roles and how each adds value and influence.
- We recommend that an annual work programme event is held that involves the voluntary, community and advocacy sectors to help inform the Scrutiny Commission about the state of health and health services in Leicester. This might take the form of an inquiry day or form part of a development session for Members.
- Build the use of local public health data, such as health inequalities into priority setting and approaches to questioning.

c) Member development

- It is recommended that one or more development sessions are held, open to all councillors, to present and discuss local public health data and priorities.
- Organise a development day for the existing Scrutiny Commission members to include, an overview of the NHS system, prioritisation skills, training on questioning and active listening skills and to look at how scrutiny in meetings can be outcome focussed.
- Recommend that there is mandatory training for all new health scrutiny councillors that includes how the system works, questioning skills, active listening, and how the Scrutiny Commission relates to other systems of accountability.
- Hold a development session for members of the Scrutiny Commission to discuss the implementation and implications of national guidance soon after it has been published.

It is recommended that Leicester City Council considers reviewing progress in the implementation of these recommendations twelve months after the acceptance of this report.

Centre for Public Scrutiny
December 2013

Appendix A

List of Stakeholders invited to provide 360^{0} feedback

Health and Wellbeing Board (Executive), Leicester City Council

Adult Social Care Scrutiny Commission, Leicester City Council

Public Health Department Leicester City Council

Partner authorities in the Joint Health Scrutiny Committee (Leicestershire County Council and Rutland Council)

Leicestershire University Hospitals NHS Trust

Leicestershire Partnership NHS Trust

Leicester City Clinical Commissioning Group

Local Healthwatch

Leicester University

Voluntary Action Leicester

Appendix B

Summary of meeting observation 18 November 2013

These notes summarise the outcomes of an observation exercise carried out on the first 2 hrs 15 minutes of the meeting of Leicester City Council Health and Wellbeing Commission on 18 November 2013. The observation focussed on the following four areas:

- Accessibility of the meeting and its content to members of the public
- Provision of information and focused agenda
- Questioning skills of Members of the Commission
- Evidence of influencing health outcomes

1. ***Accessibility to the public***

- The room was physically accessible and well lit
- There was no clear area for the public to be seated. Room set out with board room style table in the centre and sofa's against the walls. It was therefore unclear whether people sitting on the sofa's were members of the public or witnesses/presenters waiting to be called to the meeting at the table.
- The room acoustics were not good from the sofa without Members using microphones. Although microphones were provided not all speakers initially used them. Part way through the meeting the microphones started to pick up discussion from a meeting in another room so a decision had to be taken not to use them. This resulted in the observer being unable to hear some of the discussions.
- No indication whether an audio loop was provided was observed although the agenda does state that one was available.
- Copies of the agenda were available from the Democratic Services Officer. The agenda was 204 pages long and an additional item was added as representatives from the NHS attended resulting in a very long meeting.
- Speakers/witnesses were not always introduced and asked to speak clearly.
- The aims and functions of the committee were not explained at the beginning of the meeting and not included in the information for members of the public in the agenda.

2. ***Agenda***

- The agenda was extremely long and could not be taken chronologically so at times became confusing.
- Some NHS organisations were represented by 3 or 4 witnesses who all wanted to participate in discussions. This increased the length of discussions that might have been dealt with more succinctly with less NHS participants.

3. ***Questioning***

- Not all Members of the Commission actively participated in questioning.
- Some good strong questions that demonstrated Members as community leaders were asked. More follow up probing could have been undertaken.
- Some questions were prefaced by long statements which deflected the focus from the question asked. If the questions had been asked in a more focussed and succinct manner they might have had more impact and also made more effective use of the time available.
- It would be helpful to summarise the issues raised and actions expected at the end of each discussion.

4. ***Evidence of Influence***

- The level of seniority from NHS organisations attending the meeting might be seen as an indicator for how the role of the Commission is valued but not as a level of influence.
- It was clear that some of the questions made participants uncomfortable, especially about statistics, and that there was a likelihood that the Trust would look more closely at the issues raised and return to the Commission with more information.
- No evidence was shown from the discussion about oral health promotion about how the Commission's work might influence the improvement of oral health in Leicester.

Appendix K

HEALTH AND WELLBEING SCRUTINY COMMISSION BRIEFING

Carers Support

Lead Director: Tracie Rees

Useful information

- Ward(s) affected: All
- Report author: Mercy Lett-Charnock
- Author contact details: 454 2377

1.Purpose

1.1 To inform the commission about what is being done to improve the indicators relating to 'carer-reported quality of life' and 'the proportion of carers who reported that they had been included or consulted in discussions about the person they cared for'.

2. Background

2.1 As a result of the Health and Wellbeing Strategy progress report presented at the scrutiny meeting on 26th November a request was made for further information in relation to the 2 carer indicators that reflected reduced satisfaction.

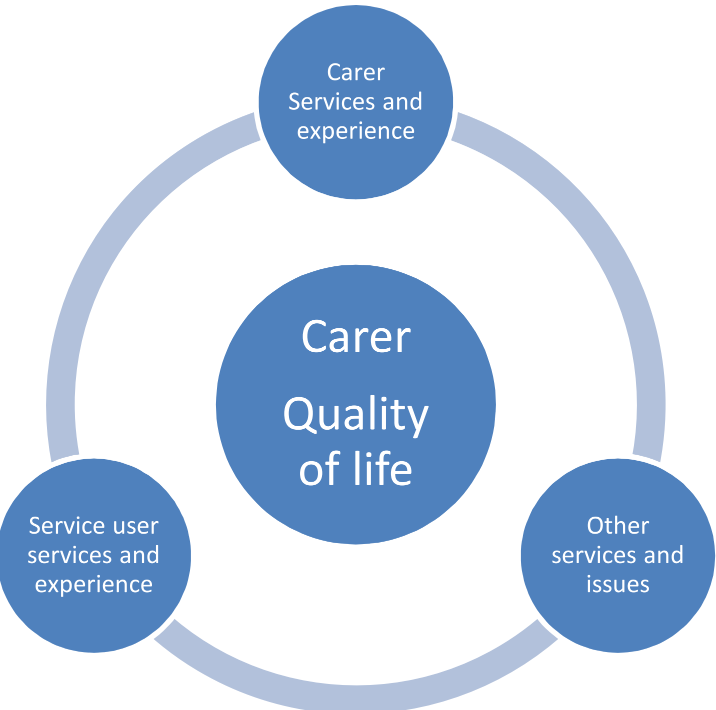
3. Report

3.1 The indicators referred to in the Health and Wellbeing Strategy progress report are as follows:

Indicator	Reporting frequency	Baseline	Latest data	Direction of travel	Notes
Carer-reported quality of life	Biennial	9/10 – 8.7	12/13 – 7.1	↓	Next survey 14/15
The proportion of carers who report that they have been included or consulted in discussion about the person they care for.	Biennial	9/10 – 70%	12/13 – 63.5%	↓	Next survey 14/15

3.2 The department recognises the downturn in performance and is looking at additional ways to address the needs of carers. However, it should be noted that carer satisfaction and quality of life are not solely due to direct carer services and how carers experience their treatment whilst in their caring role. The quality and quantity of service user provision as well as things outside of local authority control such as changes to welfare benefits, finances more generally and issues to do with GP or hospital provision also affect satisfaction. Carers when asked their views, often list non Council issues as a concern to them. This can be summarised as at Fig 1 below.

Fig 1.



3.3 Service user provision has been a concern for many carers particularly older carers who are reflecting that the change from traditional services to personal budgets has been hard to understand and in some cases stressful to deal with. Changes to the way in which individuals are choosing to spend their personal budgets to meet their social inclusion needs mean that some customers are choosing to spend less time out of the house than previously was the case and so carers may be getting less time as respite or to undertake tasks or activities than they used to. Changes to Health provision as well as Council provision are changing and where service users have received the same service for many years and are now experiencing change, this can be unsettling.

3.4 "Other" service issues raised by carers and carer organisations include perceived lack of support and advice from G.P's, impact of welfare reforms (and financial pressures generally) and issues around hospital discharge. Carers frequently raise these issues when consulted and in being asked about their general satisfaction are quite likely to consider these things as well

as local authority services and support.

3.5 The department is now 18 months into the carer strategy action plan and has begun to tackle some of the issues raised by carers – including work with Health colleagues to try to deal with areas outside of the Council remit. Progress includes:

- A Carers Joint Specific Strategic Needs Assessment, “The Needs of Carers in Leicester” has been produced. This will be reviewed over time but already identifies issues for carers in the City that support services can focus on in order to improve outcomes for carers. This information will inform future developments.
- The numbers of carers assessments undertaken has increased from 1,233 in 2011/12 to 1,810 in 2012/13 and additional staff training around carers assessments has been commissioned.
- In 2012/13 824 carers were provided with a carers personal budget (this is approximately 45% of those receiving a carers assessment) and the opportunity continues to be promoted in order to enable carers to access personalised support that best meets their needs.
- Five voluntary sector organisations have been awarded additional monies to provide carers breaks during 2013/14.
- Preventative services within the voluntary and community sector are being reviewed and consultation will shortly be undertaken on the findings. One of the recommendations is to invest additional monies into the sector for carers services.
- A significant commitment has been given to helping to identify carers and to support them through the provision of information and advice during the last year and in addition to the voluntary sector services information provision, a new information leaflet to help early identification of carers has been produced with and for carers.
- A carer training programme has been developed within the City Council which has delivered training to help carers undertake their caring role.
- An interagency pilot has been underaken to improve the pathways into services for young carers, to ensure they are identified and are able to fulfil their potential in terms of education and leisure.
- GP’s have been invovled in carer awareness along with practice manager staff to ensure an improved service for carers and better identification.
- Development of the carers charter and the launch on national carers rights day (November 2013) at the Curve will help inform carers of their rights and that support is available

3.6 It can be noted that as a result of some of these actions progress can be seen in the area of assessments and information (see figure below) although this is an area we continue to look to improve on and practice has been revised so that workers within the Single Point of Contact will complete carers assessments in future. This will provide carers with a quicker service and will maximise the number of assessments undertaken.

Indicator	Reporting frequency	Baseline	Latest data	Direction of travel	Notes
Carers receiving needs assessment or review and a specific carers service or advice and information	Quarterly	11/12 – 18.8%	12/13 – 26.5% 13/14 Q1 – 7.6%		

3.7 In relation to support and awareness raising for carers the department funds and supports Carers Forums facilitated by The Carers Centre, to provide information and gain feedback from carers to inform service development. This year forums for carers included:

- police and hate crime
- consultation on the council tax benefit changes
- consultation on the LCC budget proposals
- sessions developing the carers charter
- meeting with the police and crime commissioner
- consultation on the government personal health budget consultation paper
- trading standards door step crime
- working with health professionals
- working with social care staff
- carers information requirements

3.8 However, it is also acknowledged that carers need more in depth support and information. National research, local experience and feedback from carers tell us that training is an effective way to support carers to feel better able to cope with their role, to feel less isolated and to look after their own wellbeing. During the year the following work has been undertaken to support this:

- Training delivered to nearly 120 additional carers through training provided by voluntary sector organisations (funded specifically by LCC to do this)
- A new carer training programme (delivered in house) for 2013/14 (last year training was delivered to 123 carers)
- Training was commissioned from the Challenging Behaviour Foundation for joint sessions with carers and staff from different provider organisations
- Carers Action Group carers were provided with safeguarding training
- An e-learning package has been purchased and tailored to local needs so that all staff have access to information about the needs of carers

- Provided 42 front line staff with Carers Assessment training delivered by a local voluntary sector partner

3.9 Despite the progress there is a lot of work still to be done as highlighted by the satisfaction ratings (and issues raised directly by carers). There remain challenges as resources tighten and all people – not just carers, feel the pressure of financial/welfare and service changes nationally.

3.10 The indicator relating to carers being included or consulted in discussions about the person they care for is a specific point relating to current practice. There could be several reasons for the result that have more nuances than "not being included or consulted" reflects.

3.11 The carer not being involved by staff could be because the carer was involved in a safeguarding issue at the time and it wasn't therefore appropriate. Or it could be that another professional requests for example an extra domiciliary care call and in order to get that expedited the worker does an assessment without the carer. It is always expected that workers would consult carers where practicable and this will continue to be emphasised.

3.12 It is also possible that the carer didn't agree with the outcome and therefore reported they weren't involved e.g. the carer wanted the person they care for to go into residential care but it was felt this wasn't appropriate for the service user.

3.13 Consideration is being given to how the survey is undertaken in future as some of the above points are based on suppositions. It is felt that helping people complete the surveys in future may give more accurate responses and also enable more qualitative data to be collected enabling us to truly understand the reasons behind the responses. This may mean that where surveys aren't returned an offer of a visit is given.

Future

3.14 The carers strategy continues to be implemented and the impact of the Care Bill is being assessed in terms of actions required by the Council. A focused resource for carers (such as carer support officers) may be the way forward for the Council as pressures on care management time mean that carers cannot always be the first priority. This will be considered along with other options for carer support both within and outside the Council.

3.15 As many of the issues affecting carers relate to partner organisations, the joint working will continue and investment in the voluntary sector if agreed will help to support carers in the future.

NHS ENGLAND COMMISSIOINING INTENTIONS

Author: Peter Huskinson Director of Commissioning

Leicestershire and Lincolnshire Area Team NHS England. 0116 259 3439.

Purpose of Report:

To provide the Board with information on the NHS England Commissioning Intentions for 2014/15.

1. Background

This report summarises the Commissioning Intentions published by NHS England for the services which it is responsible for commissioning.

2. Recommendations

The Board is asked to note the contents of the report.

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3. Key Issues

NHS England is not producing Area Team specific Commissioning Intentions but a national set of principles and expectations to deliver equity of access to good quality services for the whole population.

4. Additional Information

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Background Papers: Appendix A: The Prescribed Specialised Services Commissioning Intentions 2014/15 – 2015/16

Appendix B: The NHS Public Health Functions Agreement 2014/15.

NHS England Commissioning Intentions Report.

1. Background.

The NHS publishes commissioning intentions, usually annually, to outline its plans and priorities for commissioning services in the coming year. These are usually published at the beginning of October to provide 6 months' notice to providers of expectations and potential contract changes. This process does not apply to Primary Care Contracts (General Practice, Pharmacy, and Dental & Optometry).

NHS England is responsible for the commissioning of a range of services on behalf of the population including, Specialised Services, Health & Justice, Health Services for Military Personal & Veterans, Public Health Services (screening immunisations & child health), General Practice, Dentistry, Pharmacy and primary Care Optometry.

As a single organisation NHS England will only issue one set of commissioning intentions for the services it also responsible for. Area Teams will not issue their own commissioning intentions, but may issue guidance to providers re local contracting arrangements or operational management.

2. Specialised Commissioning.

NHS England published details of its commissioning intentions for specialised services for 2014/15 and 2015/16, on 3rd October. Attached to this paper as appendix A. This document, entitled 'Prescribed Specialised Services Commissioning Intentions 2014/15-2015/16, serves as notice to all providers of specialised services in England, and will be supported by other, more technical guidance, which will outline clearly which specialised services will be commissioned by NHS England, and which are the responsibility of Clinical Commissioning Groups. These additional documents, most notably the Manual and Information Rules, will be published shortly. This is the first set of commissioning intentions to cover a two year period and is intended to allow commissioners and providers to work together to develop improved outcomes against a consistent framework.

The Commissioning Intentions provide a basis for robust engagement between NHS England's Area Teams and providers of specialised services, and are intended to drive improved outcomes for patients, and transform the design and delivery of care, within the resources available. The Area Team responsible for leading the work with providers within Milton Keynes is the Leicester & Lincolnshire Area Team.

The key messages from the document are:

- Stability in terms of range of services commissioned, need to review all 143 services and develop a commissioning framework for each.
- Clinical Reference groups now in place to provide a single source of advice to NHS England re the development & management of prescribed specialised services.
- Work underway to develop a 5 year strategy across the portfolio of services

- Right Care: seeking to develop collaborative commissioning arrangements across NHS England, CCGs and Local Authorities, exploring pathway commissioning (5 pathfinders, forensic care, paediatric care pathways, acute kidney injury, haemoglobinopathy, and back pain & sciatica.)
- Consistent standard approach to contracting including quality delivery and the measurement of improvement.

3. Public Health Commissioning.

On the 12th November NHS England and Public Health England (PHE) published the 'Public Health Functions Agreement (s7a) 2014/15. The documents confirm the scope of services covered, sets out the commissioning ambitions for 2014/15 and identifies the actions required to implement the associated revised service specifications for 2014/15. It is supported by a suite of over 30 documents, detailing the relevant public health programmes and service specifications. The overarching document is attached as appendix 2.

The NHS has a critical part to play in securing good population health. The Public Health Functions Agreement (S7A) for 2014/15 is an agreement between the Secretary of State for Health and NHS England. It enables NHS England to commission certain public health services, such as national immunisation programmes and will drive improvements in population health. It sets out outcomes to be achieved and arrangements for funding from the public health budget. The spirit of this agreement is a shared commitment from the Department of Health and NHS England, with the support of PHE, to protect and improve the public's health.

The key messages from the document are:

- Sets out the relationships and responsibilities of the various national bodies in commissioning the services identified.
- Outlines the changes to specific programmes including the roll out of flu immunisation to cover children aged 2-17, the evaluation of a meningococcal B (MenB) immunisation programme for infants and adolescents ,and continued expansion of the bowel cancer screening programme.
- Sets out the commitment to transfer children's public health services from pregnancy to age 5 to Local Authorities from 2015.
- The supporting documents set out the clear service specifications and outcome indictors for each programme.

4. Primary Care Contractors.

There is no requirement to issue, commissioning intentions for the 4 primary care contractor groups. The Regulations governing the relationship between NHS England, pharmacists, dentists and optometrists are regularly reviewed and amendments to the Regulations published on the NHS England website.

In terms of General Practice, an, annual contract re-negotiation is undertaken nationally, between the GPC and NHS Employers on behalf of NHS England. The key changes to the contract are outlined below:

- More personal care for older people aged 75 and over with a named accountable GP for people aged 75 and over.
- Contractual changes to monitor and report on the quality of out of hours services
- A scheme to support reducing unplanned admissions and to improve services for patients with complex health and care needs.
- Changes to the Quality & Outcomes Framework
- Wider choice of GP practice, enabling patients to register with practices outside of traditional boundary areas
- Introduction of the family & friends test for general Practice
- Increased on line access for patients
- Changes to enhanced services for extended hours, dementia care, annual health checks for people with learning disabilities, alcohol abuse and patient participation.
- Changes to payment processes, calculations and information sharing rules.

5. Health & Justice

Commissioning intentions for Health & Justice Services have not yet been published, but responsible Area Teams continue to work with all partners across the system to review existing commissioning arrangements.

6. Military & Veterans Health

Commissioning intentions for Health & Justice Services have not yet been published, but responsible Area Teams continue to work with all partners across the system to review existing commissioning arrangements.

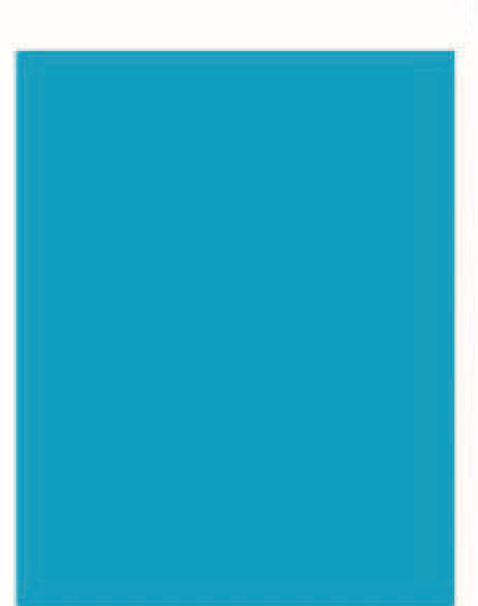
7. Additional Context

I should be noted that further work is to be done in relation to the Area Teams financial position and the requirement for extensive QIPP planning and this may present challenges across all services. In particular this will have a bearing on specialised services which are also being reviewed against new national service specifications. This is likely to result in consequential impact and changes across the health community. We will provide a further update on this one our position is clarified.

Appendix L 1

NHS England

Prescribed Specialised Services Commissioning Intentions 2014/15-2015/16



NHS England INFORMATION READER BOX

Directorate		
Medical	**Operations**	Patients and Information
Nursing	Policy	Commissioning Development
Finance	Human Resources	

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NHS England

Prescribed Specialised Commissioning Intentions

First published: October 2013

Updated: (only if this is applicable)

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Purpose

1. This document sets out to healthcare providers notice of NHS England's Commissioning Intentions for Prescribed Specialised Services for 2014/15 and 2015/16. They should be read in conjunction with the Strategic and Operational Planning Guidance, the NHS Standard Contract and the National Tariff Document (NTD) which are to be published later this year by NHS England and Monitor.

2. The commissioning intentions provide the context for constructive engagement with providers, with a view to achieving the shared goal of improved patient outcomes and service transformation within the fixed resources available. To support patient-centred care, NHS England is committed to securing alignment across all aspects of NHS commissioning. We shall be working with CCGs, partner NHS oversight bodies and local government to secure the best possible outcome for patients and service users within available resources. We expect all commissioners and providers to be flexible around the service improvements that can be made when opportunities for alignment are realised.

Context

3. Since the last published Commissioning Intentions in November 2012, much has changed. More than 1600 expert clinicians, in 75 service-specific Clinical Reference Groups (CRGs) have developed national service specifications and healthcare providers have assessed compliance with key elements. Many providers now hold a single contract with one area team covering all English patients treated; national clinical policies are in place and access to the Cancer Drugs Fund (CDF) and Individual Funding Requests (IFR) are consistently assessed through a standard operating procedure approach led by four regional teams.

4. Clinical Senates and Strategic Clinical Networks are working to support commissioners and providers in consideration of local challenges and Operational Delivery Networks (ODNs) are working to ensure coherent and co-ordinated cross-provider working to comply with commissioned pathways and standards.

5. Our 2014/15-2015/16 Commissioning Intentions build on the progress that has been made, with an emphasis on addressing the strategic challenges faced by NHS England in delivering improved outcomes for patients and communities within a fixed resource.

6. Significant achievements have been made through the collaborative work of commissioners and providers however it is clear that a step change is needed in our shared pursuit of effectiveness, efficiency and the engagement of patients and staff, if we are to achieve our aim to secure high quality care for all, both now and for future generations.

7. In 2014, NHS England's strategy 'A Call to Action' will set out a long term vision and the critical changes needed in the medium term. For health services to remain sustainable some key changes in support of our future direction of travel need to begin now and these are set out in our commissioning intentions.

The Scope of Prescribed Services

8. At a clinical level, major changes in the scope of services directly commissioned by NHS England are not intended for 2014/15, as we believe a period of stability is required after the major changes in 2013/14. The technical algorithm to align services between NHS England and Clinical Commissioning Groups' (CCGs) commissioner responsibility, "The Identification Rules"(IR), has been refined to improve its precision and will be further updated to align to the update of procedure codes for all NHS services . A summary of the impact of the Information Rules refinement will be provided in the coming weeks to aid forward planning by trusts and commissioners.

The Prescribed Specialised Services Manual

9. The Manual is the technical document that describes the 143 prescribed specialised services. It sets out which elements of services are commissioned directly by NHS England and which by CCGs. It provides details of each service to be commissioned and a rationale as to why a service is commissioned by NHS England and not by CCGs.

10. The Manual will be updated to include any changes in commissioning responsibility agreed by Ministers following receipt of recommendations from the Prescribed Specialised Services Advisory Group.

11. This document will also be updated to take account of any changes in service description and numbers of providers. All material changes will be highlighted.

Clinical Reference Groups

12. Clinical Reference Groups (CRGs) were introduced in 2012 to assist in the transition of prescribed services into NHS England and to support the development of commissioning and contracting products, such as service specifications and clinical commissioning policies. Their inclusion into the structures of NHS England was approved and 75 CRGs have been established for specialised services, with additional groups for Health and Justice, and Armed Forces commissioning. Membership of the CRGs is supported on a voluntary basis by the individual's host provider organisation, with four patient voice members appointed through national selection. The groups are supported by a lead commissioner with access to the Public Health, Pharmacy and Clinical Effectiveness Teams.

13. The CRGs continue to review and develop the clinical service specifications, introduce clinical access policies, define quality measures and build quality dashboards. This will form a key part in the development of the future specialised services commissioning strategy. As voluntary groups they need support from providers, area teams, regions and the national support centre team to develop their work.

14. CRGs are the primary source of clinical advice to NHS England around the development and management of the prescribed specialised services.

Patient & Public Engagement

15. In upholding the NHS Constitution, NHS England is committed to ensuring that patients are the priority in every decision that NHS England makes. Putting patients first needs to be a shared principle in all that we do. NHS England, through the area teams will ensure that this is demonstrated in the way care is provided and monitored through our formal contracting process with providers.

16. We expect all providers to demonstrate real and effective patient participation, both in terms of an individual's treatment and care, and on a more collective level through patient groups/forums; particularly in areas such as service improvement and redesign.

17. It is essential that all providers of specialised services demonstrate the principles of transparency and participation and offer their patients the right information at the right time to support informed decision making about their treatment and care.

18. Providers of specialised services should look to provide accessible means for patients to be able to express their views about, and their experiences of specialised services, making best use of the latest available technology and social media as well as conventional methods.

19. As well as capturing patient experience feedback from a range of insight sources, providers should demonstrate robust systems for analysing and responding to that feedback.

Strategic Direction

20. As part of the 'Call to Action', NHS England is developing a five year strategy for specialised services, which will be published in April 2014. This will address the service specific objectives for the next five years, overarching strategic objectives for the provision of a system of specialised healthcare as a whole and the impact of co-dependency between service areas.

21. Our strategic commissioning approach has six strands:

    1. Ensuring consistent access to effective treatments for patients in line with evidence based clinical policies, underpinned by clinical practice audit:

        - Any potential developments in access to treatments or services with resource implications will be considered and costed by the CRGs. These will then be assessed and evaluated by NHS England's Clinical Priorities Advisory Group and prioritised against NHS England's ethical framework.

National adoption alongside any consequent disinvestment will also be evaluated through the Clinical Priorities Advisory Group and ratified by NHS England's Quality and Risk Committee to ensure resources can be safely released to support innovative development.

2. A Clinical Sustainability Programme with all providers, focused on quality and value through:

    - achieving and maintaining compliance with full service specifications, and making changes to service provision where there is no realistic prospect of standards being met;
    - reviewing and revising service specifications to deliver a continuous incremental improvement in clinical outcomes, service quality, patient experience and value for money;
    - refreshing and focusing CQUIN schemes to directly contribute to improving outcomes with challenging, but achievable goals;
    - providing transparency in service quality through the continued development of service level quality dashboards and improvements in data flows.

3. An associated Financial Sustainability programme with all providers, focussed on better value through:

    - a two-year programme of productivity and efficiency improvement in service delivery which will commence during 2014/15 and will focus on converging local tariff pricing to match the most efficient services, with support and reward in line with commitment to levels of ambition, and shared ownership of risk:
    - agreed improvement goals to ensure that efficient services form part of lean, patient-focused pathways, and that treatment is commissioned by default in the most cost effective setting, adopting and spreading best practice across provider services;
    - securing the benefits of more widespread use of best value prices for drugs and devices with increased transparency of billing;
    - strategic collaboration with providers and other partners to achieve prevention and earlier intervention in specific services;
    - reducing the future burden of demand for prescribed services by managing demand and reducing rates of admission and readmission.

4. A systematic market review for all services to ensure the right capacity is available, consolidating services where appropriate to address clinical or financial sustainability issues.

5. Adopting new approaches to commissioning care where it promotes integrated care and clinical oversight for patients in particular services and care pathways:

   - We will select providers with a strong track record in clinical and financial sustainability programmes in 2014/15, to award prime contracts in 2015/16 for a network of care with other providers for selected priority services.
   - We will pilot five specific services initially partnering with CCGs to co-commission full pathways of care.

6. A systematic rules-based approach to in-year management of contractual service delivery, including:

   - transition from local to national data flows as the primary source of payment for services covered by national datasets;
   - the promotion and use of clinical utilisation review tools to identify and address bottlenecks in care and ensure the right treatment in the right settings;
   - the use of commissioner-led clinical threshold audit by the NHS England medical directorate peer review team;
   - the commissioning of clinical coding reviews where needed to establish potential unintended consequences of clinical practice that have not been subject to formal notification of change.

Operating Model for Prescribed Services

22. NHS England continues to build on the single operating model with the national support centre team, five Programmes of Care, CRGs, regional teams and the 10 area teams.

23. The 10 area teams that lead on specialised services contracting across England are:

    a. Birmingham and Black Country
    b. Bristol, North Somerset, Somerset and South Gloucestershire
    c. Cheshire, Warrington and Wirral
    d. Cumbria, Northumberland, Tyne and Wear
    e. East Anglia
    f. Leicestershire and Lincolnshire
    g. London
    h. South Yorkshire and Bassetlaw
    i. Surrey and Sussex
    j. Wessex

The Prescribed Specialised Services Manual

24. In line with the Health and Social Care Act 2012, Ministers take into account four factors when deciding which elements of specialised services should be prescribed and therefore directly commissioned by NHS England rather than by CCGs:

    a. The number of individuals requiring the provision of the service or facility;
    b. The cost of providing the service or facility;
    c. The number of persons able to provide the service or facility; and
    d. The financial implications for CCGs if they were required to arrange for the provision of the service or facility.

25. Ministers take advice from the Prescribed Specialised Services Advisory Group (PSSAG), a multi-disciplinary committee hosted by the Department of Health.

26. The Prescribed Specialised Services Advisory Group will make recommendations to Ministers who will consult with NHS England on any agreed recommendations. Any changes in commissioning responsibility will need to be reflected in the Manual, the Identification Rules and in allocation changes.

27. If NHS England becomes the responsible commissioner, commissioning products such as service specifications and policies will need to be developed. NHS England will also consider the funding priority of the service through the Clinical Priorities Advisory Group and a process for selecting providers. Any highly specialised services that become the commissioning responsibility of NHS England will be discussed at the Rare Disease Advisory Group (RDAG).

Commissioning through Evaluation (CtE)

28. Commissioning through Evaluation (CtE) has been developed by NHS England as an innovative approach to the commissioning of prescribed specialised services for which there is currently insufficient evidence of relative clinical and/or cost effectiveness to warrant routine commissioning. Commissioning through Evaluation is particularly pertinent to specialised and other lower volume procedures or services, where randomised controlled trial evidence is less prevalent, and where an alternative approach to evaluation therefore needs to be available to support commissioning policy decisions.

Strategic Clinical Service Review

29. NHS England directly commissions 143 specialised services and will be developing a commissioning framework for each service. For many of these services, it will be the first time that there has been a single national commissioner and it will be important to ensure that each framework takes into account factors such as patient need, required changes to service provision, technological advancement and the health care provider market. As each framework is developed, NHS England will decide how best to take

forward the procurement of services, in line with regulations and Monitor's final guidance when available. This process will take into account proportionality, best practice and equal treatment. If a competitive procurement process is needed, details will be advertised as required by the regulations in order that all potential providers are aware of the opportunity.

30. In line with the National Health Service (Procurement, Patient Choice and Competition) (No 2) Regulations 2013, and draft guidance issued by Monitor entitled 'Substantive guidance on the Procurement, Patient Choice and Competition Regulations', NHS England is committed to ensuring that when it procures health care services it satisfies the procurement objectives laid down in the regulations, namely to act with a view to: securing the needs of the people who use the services; improving the quality of the services; and improving the efficiency in the provision of services.

31. NHS England will develop its commissioning framework by prioritising those service lines which most urgently need to be reviewed and that are in the best interests of the people who use the services.

32. This prioritisation work will be informed by system wide strategic plans for the future of health care delivery and specialised service configuration in each region. Each prioritised programme of change will work within a consistent national framework and process. There may be some areas where a national approach to procurement is required due to the incidence of quality or capacity issues arising.

UK Strategy for Rare Diseases

33. The UK Strategy for Rare Diseases will be published by the end of December 2013. NHS England, in line with the three devolved health administrations, will be developing an implementation plan in response to the strategy. The plan will be developed through the Rare Diseases Advisory Group and will be published in February 2014.

Reinvestment Strategy for Cost Effectiveness

34. Commissioners will establish a transparent priority setting framework which enables decisions to be made about investment and reinvestment within a CRG, and between Programmes of Care.

35. A principle will be established for the identification of disinvestment for "better value reinvestment":

    a. In 2014-15 this framework will be developed and proposals will be consulted upon.
    b. In 2015-16 this framework will be implemented with a prioritised list of better value interventions.

36. Investments will only be approved where they demonstrate measurable outcome and value improvements and where cash has been released elsewhere.

Co-Commissioning, Trialling New Payment Approaches

37. Although the contracting focus for 2014/15 will be the consolidation of the single national operating model, NHS England is keen to promote innovation that benefits patients, providers and commissioners.

38. Where innovation can demonstrably contribute to improving outcomes, quality and saving money, area teams will work with providers over the next 18months to gain permission for local variations and agree risk/benefit share arrangements where appropriate. This will extend to innovative proposals from multiple providers working together.

Prime Contractor

39. Commissioners will lead a process to invite proposals over the coming 18 months for prime contractor delivery where this enables either consolidation and networking of specialist provision to achieve the national specification and standards, and/or prime contractor arrangements for a whole pathway of care or model of care where tiers of provision are closely networked. One example of this is neurorehabilitation, where such an approach could enable alignment of incentives and accountability for quality improvement and capacity management.

40. To support this process, tools and guidance will be developed including a national inter-provider contract, specification standards between hub and spoke and incentive structures.

Driving Value

41. The NHS faces a major challenge in that it cannot rely on additional funding to meet the needs of patients and drive quality improvement. If we are to protect the fundamental principles of the NHS, offering comprehensive services on the basis of clinical need, there has to be significant reform in the way that services are provided.

42. NHS England will focus on driving commercial terms to get better value for the taxpayer from suppliers and partners and we want accountability for all partners to reorganise care to improve outcomes and release cash savings.

43. Specialised services are provided at the end of a pathway of prevention and treatment. These are often the most expensive and scarce resources that the NHS is able to offer and therefore must be accessed following pathways of care that seek to actively prevent deterioration and provide levels of care appropriate to the needs and stage of disease. Alignment of the accountability, incentives and clinical leadership around improving outcomes across pathways and programmes, will drive better value.

44. Over the next two years, it is the intention of NHS England to focus on aligning and driving value from specialised services through three programmes:

    a. Getting value from commercial business

b. Enabling the right care, providers and pathways for outcomes and value
c. Reinvestment, with a view to delivering improved clinical outcomes for patients/service users.

Right Care

Collaborative Commissioning

45. Commissioning for NHS funded care is now spread across NHS England, CCGs and local authorities. Over the next two years there will be a drive on joint strategy, planning and collaborative commissioning to ensure there is alignment of our commissioning toward outcomes and how each party works to lead on pathway or programmes of care.

46. Strategies will be developed over the next year to show the future structure of care in each region and the changes in services ahead. The configuration of specialised services will have a critical impact on how services evolve in the acute and tertiary sector. Decisions about how specialised services are configured to meet national standards at best value must be planned, along with a broader strategy including clinical interdependencies. These plans will have an opportunity to drive value and improved outcomes.

Pathways

47. Commissioners will work together across the whole pathway to develop evidence based pathways, from prevention to specialised care, ensuring clarity in access across commissioning responsibilities. These pathways can be used in contracting with providers, aligning incentives and accountability for outcomes. It is anticipated that the model of engaging commissioners will be the basis of future whole pathway approaches. The development of this approach will allow the pathways selected to provide evidence of the impact on value of adopting recommended interventions and levels of capacity.

48. Five pathways will be established for adoption by 2015/16 and will be available for use by early adopters and networked providers. The five pathways are:

Specialised Programme of Care	Pathfinder
Mental Health	Forensic pathway
Women and children	Paediatric care pathways
Internal medicine	Acute Kidney Injury pathway
Cancer and blood	Haemoglobinopathy
Trauma	Back pain and sciatica

Effective & Focused Commissioning

49. The majority of specialised services form part of a patient pathway and it is important that patients can access more specialised care promptly and also, once clinically ready for discharge, they can move out to intermediate step down or more community based care settings. There are several specialities, such as neuro-rehabilitation, where patients may not be able to either access more specialised care or be discharged once clinically suitable.

50. Six principles, or 'rights', of effective commissioning form the foundation of NHS England's approach to specialised commissioning and these focus on ensuring patients receive the most appropriate care in the optimum care setting with the most effective use of specialised resources. These reinforce and build upon patients' rights under the NHS Constitution.

51. These principles are summarised below:

Right patient	In order for patients to receive optimum care, they need to be assessed and referred appropriately.
Right provider	Ensuring patients are referred to the most appropriate provider will support achievement of 18 weeks as well as the most effective use of resources.
Right treatment	The national service specification compliance process, together with the implementation of national clinical policies, will ensure that only the most effective treatments are commissioned from compliant providers, supported by outcome based evidence.
Right place	Patients should receive their treatment in the optimum care setting. This means that patients should receive care within designated centres that meet national clinical standards, and that delayed admission and discharge into and out of specialised care should be considered a priority for action.
Right time	This recognises the importance of early referral and prompt treatment, with a particular emphasis on compliance with national waiting times and delayed discharges.
Right price	The development of local and national tariffs that represent best value for money whilst ensuring appropriate levels of reimbursement is fundamentally important.

52. NHS England is committed to commissioning specialised patient care at the optimum time and in the most appropriate care setting. Specialities where there are known to be delayed admissions or discharges will be identified and national work undertaken to both identify and resolve barriers in order to streamline referrals and discharges. This will involve working with CCGs and local authority colleagues in supporting pre-

discharge planning initiatives and through appropriate incentives with providers to facilitate prompt discharge.

53. This will not only result in improved equity of access for patients, but will also ensure a more effective and focused use of resources.

Strategic Clinical Networks

54. Commissioners will support Strategic Clinical Networks and Academic Health Science Networks to develop work plans which focus on strategic care models and pathway development for key health needs. This will enable integration of care and a shift toward earlier intervention and treatment. Specialised commissioning will benefit from this work particularly where there is a direct link to specialised care such as in obesity, kidney care and cancer.

Clinical and Operational Delivery Networks

55. NHS England has recognised that clinical networks are an NHS success story and have been responsible for some significant sustained improvements in the quality of patient care and the outcomes of treatment. We should build on this progress, moving beyond transition and stability, toward delivery of real value and transformation through strong governance, improvement planning and aligned incentives and supports.

56. Operational Delivery Networks (ODNs) are focused on coordinating patient pathways between providers over a wide area to ensure access to specialist resources and expertise. For more information about Operational Delivery Networks, go to: http://www.england.nhs.uk/wp-content/uploads/2012/07/way-forward-scn.pdf

57. ODNs focus on operational delivery; they ensure outcomes and quality standards are improved and that evidence based networked patient pathways are agreed.

58. They focus on an operational role, supporting the activity of providers in service delivery and improvement in delivery of a commissioned pathway. They have a key focus on the quality and equity of access to service provision. This will allow for more local determination, innovation and efficiency across the pathway. ODNs support the delivery of ‘right care’ principles by incentivising a system to manage the right patient in the right place at the right time.

59. ODNs will be fully established in 2014/15 and all acute providers who provide specialised services under the scope of the ODN will be required to join networks for quality improvement. Networks will operate under a governance framework which develops an annual improvement plan across all members, and publishes results of the network’s achievements annually. These will identify how value has been measured and improved for the benefit of the patient and commissioners.

60. These networks will have a host organisation and an agreement with NHS England which sets out the roles and responsibilities of all parties. NHS England is able to seek the advice of ODNs in undertaking strategic service reviews. NHS England will retain a

register of all ODNs and members, together with the annual improvement agreements and annual reports from the ODN on delivery.

61. The governance model for the ODNs comprises of the following:

    a. An agreement with the commissioner (s) which includes open book financial arrangements:
        i. Roles and responsibilities of the host in managing resources and governance
        ii. Terms of Reference of the Board
        iii. Members Agreement
        iv. Host and Board Service Level Agreement
        v. Information governance agreements
        vi. Financial and quality incentive agreements

62. An ODN may have a combination of individual provider, prime contractor, alliance, and joint ventures within its auspices.

63. If at any point an entire ODN responds as a prime contractor to an invitation from commissioners, this would change the nature of the ODN into a provider entity with a contract for services with the commissioner.

64. ODNs will not automatically translate into a prime contractor, and indeed commissioners will manage choice and competition processes in such a way that any invitation to submit proposals is fair and transparent. The ODN however may identify this as an opportunity where there is alignment of commissioning intentions and provider development and consolidation.

65. NHS England recognises that there is still a degree of transition required for ODNs to embed fully within provider contracts, until the tariff and reference costs solutions take effect. The transitional funding approach, which utilised 0.1% of CQUIN monies, will continue throughout 2014/15, whilst future funding options are developed for 2015/16.

66. Due to the nature of the care pathways that are commissioned by specialised services, over time we expect many more to be delivered in an ODN model as reflected in our service specifications. Providers should consider utilising existing ODN structures and consider how these could be aligned to ensure greater efficiency and cross fertilisation of skills, service development and expertise.

Contracts

Standard Contract

67. NHS England has been engaging with stakeholders to inform the development of a revised NHS Standard Contract for use in 2014/15 and this will be published during December 2013. It is likely that there will be considerable continuity with the current

contract, in terms of both structure and content. There will also be some significant revisions, to reflect stakeholder feedback and other important developments, including implementation of recommendations from the Francis report and from NHS England's review of incentives, rewards and sanctions, which will be completed by the end of October 2013.

68. The 2014/15 Standard Contract will be used for all new contracts agreed for specialised services from 1 April 2014 onwards. Where existing contracts do not expire at 31 March 2014, these will be updated for 2014/15 using Deeds of Variation which will be produced by NHS England early in 2014. Forms of contract other than the NHS Standard Contract will not be used.

69. An online system for completing the NHS Standard Contract (the eContract) was made available for the first time in February 2013 and an improved, more robust system will be available for use for 2014/15. The eContract approach has significant benefits, for instance in enabling the tailoring of contract content to reflect the specific range of services being commissioned. We anticipate that use of the eContract approach will become the norm for specialised services contracts for 2014/15.

Single Provider Contract

70. The intention for 2014/15 is that NHS England should normally only hold (or be party to) one NHS Standard Contract with any provider, which includes the five areas of direct commissioning with contract schedules for each area team.

Consistent Contracting

71. 2013/14 was a year of collaboration between NHS England, CCGs and providers to implement the NHS England single national operating model whilst seeking to maintain service and financial stability.

72. Area teams will continue to work with providers to ensure local practice is transitioned to the single national operating model, including:

    a. clear and consistent identification of prescribed specialised services at all providers using the nationally published tools and grouper;
    b. the eradication of differential prices charged by the same provider to NHS England based on a patient's place of residence by individual providers. There will be a single stated price per service line in each provider contract;
    c. the implementation of mandatory currencies. This should be accompanied by the production of monitoring information for the baseline year in the mandatory currency, and continued monitoring in the previous currency alongside mandatory currencies, to assure the accuracy of locally set prices against the new currencies given the quantum involved;
    d. standardised simplified indicative activity plans and non-tariff price lists, including drugs and devices, providing clarity and transparency.

e. a nationally standardised approach and documentation for coding and counting change proposals to better evaluate and assess the wider system impact of those proposals;
f. transparency about the application of Section 75 rules and evidenced consideration of “most capable provider” in commissioning and funding decisions.

73. In conjunction with full Payment by Results, NHS England will negotiate marginal rates and capped resource contracts or service lines, which will seek to manage within a fixed commissioning budget and recognise provider cost.

Implementing Commissioning Policies

74. NHS England commissions according to agreed policies and service specifications, which identify where treatments, devices and services are routinely commissioned. Commissioning policies that specify treatment thresholds and criteria act within the NHS contract as group prior approvals for treatment. In some cases, additional audit requirements may be required with regard to individual prior approval by commissioners. Where policies and specifications make clear that treatments, devices and services are not routinely commissioned or where treatment thresholds and criteria have not been adhered to interventions will not be funded.

CQUIN

75. CQUIN arrangements for 2014/15 will be focused on an updated national menu of schemes with associated measures. To reflect an appropriate return for the level of investment, CQUIN measures will be based on achievement of significant levels of improvement, which may require the deployment of provider resources.

76. A CQUIN indicator for adoption across all specialised services providers will be developed. This incentive will only be offered to providers for initiatives which are proven to offer continuous improvement toward best practice, benchmarked utilisation, appropriate care and quality indicators. An example would be the adoption of utilisation management systems across providers and pathways.

77. A national review group drawn from commissioners and CRG leads will establish the indicator for adoption across all specialised providers. The CRGs will be guided by a set of principles in developing the specific CQUINs for their area to ensure these incentives are delivering greater value for the NHS.

CQUIN on Drugs and Devices Excluded from Tariff

78. National tariff pay and price adjustments are not automatically applied to drugs and devices excluded from tariff i.e. NHS England will pay actual costs. These costs are also excluded from the tariff efficiency deflator arrangements. NHS England is committed to consistently adopting the national rules as published in all contracts and therefore will be excluding excluded drug and device budgets from the contract value to which CQUIN applies for all NHS England contracts in 2014/15 and onwards.

Commissioning Resources

79. Specialised services will, as in 2013/14, be funded directly by NHS England. NHS England will set budgets at an area team level for all prescribed specialised services activity undertaken by providers in their geographical area. Allocations will be based on historic baselines adjusted for 2014/15 planning requirements.

80. High quality specialised services will be effectively managed within these finite resource envelopes by NHS England and providers working together.

81. Each area team will be responsible for ensuring the financial and quality performance of the contracts it holds. Growth and efficiency savings will be applied to contracts in line with the 2014/15 planning guidance. This will apply to all elements of the contract but not drugs and devices excluded from tariff.

Financial Sustainability Programme

82. Prices for specialised services are currently subject to wide variation. This does not provide equitable funding to trusts, and could lead to significant financial instability when a single national price is set for a non-tariff service. The financial sustainability programme aims to ensure that local tariff prices for specialised services converge to levels that at least 25% of providers are already achieving and are compliant with national standards of care. In recognition that unit costs may be impacted by the consistency of adoption of the national service specifications, a target range, rather than a specific price level, is being developed. Where current provider non-tariff prices are above the target range, a trajectory for reductions through locally agreed service redesign will be agreed and will inform the contract prices and contractual service improvement programme.

83. During 2014/15 a key element of the programme will be to develop a national benchmark understanding of best practice pricing and standards compliance. This will be shared with providers. Commissioners and providers will identify early areas of opportunity and agree goals for change in the 2014/15 contract. This will ensure early progress on convergence is made whilst more extensive benchmarking is undertaken.

84. In 2014/15 providers will have the opportunity to contribute toward the development of a national pricing framework which manages risks and benefits. This framework will fully apply to all providers in 2015/16. NHS England will work with CRGs, providers, the Payment by Results development team and Monitor to develop a programme of work to deliver national currencies and prices for specialised services. NHS England is open to proposals from provider networks during 2014/15 where alignment of pricing between members retains funding within the best practice range.

Specialist Top Up Payments

85. Specialised top up payments will continue to be paid solely to those providers who are on the list of providers eligible for top up in the National Tariff Document (NTD) guidance, (as defined by the Specialist Top Up Group), and for those services outlined

in the guidance. There will be no extension to other services which now form part of the prescribed list.

86. In future the list of eligible providers will be informed by the strategic clinical service review.

Identification Rules

87. The Identification Rules (IR) is a technical toolkit that enables identification of the 143 prescribed specialised services and supports the detail of the Manual and clinical service specifications.

88. The Identification Rules consist of two elements:

    a. A software version of an informatics rule set that enables automated identification of specialised activity from standard inpatient and outpatient data flows.
    b. A guidance document that outlines how specialised services can be identified in non-standard data flows.

    Note: both elements need to be used together.

89. The current version of the Identification Rules is in the process of being updated to address anomalies/omissions reported by stakeholders. NHS England intends to publish a document during early October 2013, outlining the changes to the 2014/15 version of the Identification Rules. NHS England is committed to promoting a stable financial environment by keeping any changes to a minimum, and this revision will aim to address only those changes that are essential.

90. The intention for the 2014/15 commissioning process is that there will be no deviations from the reported Identification Rules and NHS England will utilise contract sanctions where the quality of data is proven to be deficient.

91. A development time line is currently being developed to look at opportunities to incorporate the Identification Rules within the HRG grouper and the replacement for the Secondary Usage Service (SUS) for the future.

Dialysis Away from Base in England

92. The 10 area teams responsible for the commissioning of specialised services will fund dialysis away from base for all English patients who require treatment from a dialysis provider within an area team's catchment area. Payment for dialysis away from base will be made to the dialysis providers by their area team. Further guidance for commissioners, providers and patients is being developed.

Individual Funding Requests

93. During 2013/14, the responsibility for Individual Funding Requests (IFR) for specialised treatments transferred to four regional teams which manage the process on behalf of the 10 area teams working to a single NHS England "Individual Funding Requests Policy and Standard Operating Procedure". The current management process, the policy and Standard Operating Procedure will be reviewed and revised for 2014/15, strengthening national consistency. A training programme for panel members, commissioners and potentially for providers will be available.

Cancer Drugs Fund

94. The Cancer Drugs Fund will continue during 2014 and will continue to be managed as part of the prescribed services single operating model. The single national consistent policy for the management of the Cancer Drugs Fund will continue and be refreshed as required. This will be operationally managed on a regional footprint by four of the area teams responsible for prescribed services.

95. Trusts must have a process in place to ensure that the Cancer Drugs Fund application is made as part of the decision-making process i.e. patients should be registered prior to the commencement of treatment, except in exceptional circumstances, and in any event within 48 hours of commencing treatment. Failure to do so may result in withholding of payments.

96. Invoices must be submitted within three months of use of the drug. All Cancer Drug Fund drugs will be funded at cost; no additional charges will be accepted and no gain sharing will be allowed with drugs funded via the Cancer Drugs Fund. From April 2014 the Cancer Drugs Fund audit will be undertaken from returns to the Systemic Anti-Cancer Therapy (SACT) database. All trusts will be expected to make complete submissions to SACT for all chemotherapy.

Drugs & Devices

Commissioning and Procurement

97. Significant variation is experienced in the prices that commissioners pay for a range of drugs and devices that are provided to patients but are not covered by tariff. These drugs and devices are directly 'passed through' to the commissioner as the responsibility of NHS England.

98. The NHS is not obtaining best value from the opportunity to procure these at scale, with standard terms. It is estimated that savings of up to £400m over five years would accrue from this "at scale" approach. Commissioners will therefore establish a national procurement framework for excluded drugs and devices which provides for a national transparent price list that will be the maximum payable by

commissioners. This price list will not include administration costs and prescribing costs of aligned therapies will not be chargeable.

99. Excluded drugs and devices have historically been passed through as a charge to commissioners without a national standard framework which ensures best value for the NHS. It is acknowledged nationally that significant benefits can be obtained from better procurement. This national process proposes a four regions approach with two tranches of drug procurement over an estimated two year period. Currently homecare drugs are not included within this procurement framework. NHS England is currently working very closely with the Commercial Medicines Unit (CMU) in the Department of Health.

Payment

100. Drugs as detailed in the current NHS England excluded drug list will be commissioned in line with NHS England commissioning policies and NICE Technology Appraisals (TA). NICE approved drugs/ devices recommended within a NICE Technology Appraisal, that are excluded from tariff, will be automatically funded from day 90 of its publication. Some approved drugs and devices may be funded before this time at the discretion of NHS England. Trusts are expected to meet the requirements of NICE Technology Appraisals and be able to demonstrate compliance through completion of innovation scorecard returns.

101. Those excluded drugs and devices that are not NICE approved or endorsed within a national clinical commissioning policy can be considered via an Individual Funding Request, if there is evidence that the patient has clinically exceptional circumstances in comparison with other patients with the same condition presenting at the same stage of the disease. However, where the intervention relates to a cohort, a business case will be required and a national policy will be developed.

102. Excluded drugs/devices recommended within a NICE Interventional Procedures Guidance (IPG) and/or guideline will not be routinely funded unless endorsed within a national clinical commissioning policy.

103. Budgets for excluded drugs and devices will be set on an annual basis. This will be based on the provider’s assessment of need through horizon scanning, and agreed through a confirm and challenge meeting with the provider. It is not anticipated that new excluded drugs and devices will be funded in-year unless approved by NICE and/or anticipated funding requirements have been previously identified.

Post-transplant immunosuppressants

104. It is expected that from April 2014 all post-transplant immunosuppressants and inhaled antibiotics for cystic fibrosis will be commissioned directly from trusts; patients receiving these treatments via GPs in primary care should be repatriated to secondary care.

Chemotherapy Drugs

105. Chemotherapy drugs could be considered for funding via the Cancer Drugs Fund by application to the national chemotherapy panel.

106. All trusts will be required to provide Systemic Anti-Cancer Therapy (SACT) data for all patients at each cycle of chemotherapy. This in turn will support the audit of drugs within the Cancer Drugs Fund.

107. From April 2014 all 42 fields of SACT data are mandated for each cycle of chemotherapy delivered. Trusts are expected to audit activity data quarterly and demonstrate that over 90% of activity data maps to the SACT data submitted per month. Trusts must have an action plan agreed with commissioners to address any shortfall in SACT data fields and findings of the audit of activity compared to SACT data submissions.

108. Only those drugs which are defined as a priority within a recognised chemotherapy regimen will be funded as part of the pass through arrangements. It does not include drugs which are provided for symptoms that arise post chemotherapy (e.g. anti-emetics, unless given to all patients as part of the standard regimen) and it does not include longer-term use of non-chemotherapeutic agents such as bisphosphonates. In addition, hormone therapies, unless specifically identified as excluded by the national Payment by Results team or by agreement with NHS England, are considered in tariff.

109. Procurement costs related to chemotherapy will be agreed in line with national principles.

Financial Assumptions

110. Excluded drugs and device costs charged to NHS England will be reflective of actual product costs to providers. NHS England will reserve the right to audit provider costs to demonstrate compliance with this term. Where national procurement terms have been adopted and commercial best price obtained. The cost of these drugs should represent good value for money to commissioners.

111. NHS England will maintain a central repository of prices for all excluded drugs and devices which is updated as national procurements are implemented. This will represent the maximum that commissioners will pay. If trusts obtain better value than this national price then the trust should be offered the national funded level on the condition that it joins the national programme so that the national programme achieves this benchmark level. Gain share opportunities will be considered where they are in line with national principles and endorsed by commissioners.

112. All existing gain sharing arrangements should be identified by 31 October 2013 to the area team pharmacy lead and will be reviewed against national principles developed by the Medicines Optimisation CRG.

113. Where agreement cannot be reached on share of gains or proposals offer limited value, the full value of best price and best prescribing practice will be passed through in line with national guidance.

114. Where drugs and devices are used outside of commissioned services, as defined as nationally commissioned by NHS England, any consequential costs that are incurred will not be funded. This includes the costs associated with the entire treatment.

115. Non-excluded drugs prescribed concurrently with the excluded drugs are not chargeable as these are covered within national tariff.

116. No additional charges above cost will be accepted. The only exception to this will be for those specifically identified in 2014/15 Payment by Results guidelines, explicitly agreed with NHS England and specifically agreed within the contract. Any on cost or additional charges previously added to drug costs must be identified to the area team pharmacy lead by 31 October 2013 and will be subject to review.

117. It is expected that all drugs subject to discounts, rebates or other such Patient Access Schemes (PAS) agreed as part of a NICE Technology Appraisal review will be charged to NHS England at full net cost unless by prior approval.

Performance Monitoring

118. All providers will be required to fully populate the national IVIG data base to ensure patient safety. This includes indication, dose, administration and outcome. Invoices for IVIG will be matched to the national database entries.

119. Excess treatment costs related to National Institute for Health Research sponsored trials will be prioritised in accordance with NHS England's interim commissioning policy which can be found at:http://www.england.nhs.uk/wp-content/uploads/2013/04/cp-06.pdf

120. A monthly report on drugs and devices expenditure will be required as set out in the Information Schedule of the NHS Standard Contract. Validation of the use of excluded drugs and devices will be requested by NHS England where there is a reported overspend. This will normally be in the form of an audit. Any use of a drug/device outside the agreed criteria without express authority from NHS England will not be funded. Validation queries will be raised on a monthly basis in line with national payment timetables. Where further action is required validation meetings will be convened on a quarterly basis.

Devices

121. There appears to be significant variation in the recharge to commissioners for excluded devices. A national framework will be established during 2014/15 which identifies the best value and price for funding. This will be informed by procurements at a regional and national level that represent value for money. As this price list is

established by NHS England this will be utilised to challenge and inform agreed budgets.

Service Specifications

122. During 2013 NHS England, via the four regional and 10 area teams has undertaken work with the provider community to assess compliance with service specifications. This work has informed an approach to the formal introducing of these specifications which sees:

    - a significant number of specifications moving from the developmental to the mandatory part of contracts in-year, where providers have demonstrated compliance with service specifications;
    - the development of provider action plans to achieve compliance with specifications within a defined time period. These provider action plans are supported by a 'derogation'. A derogation is a licence to operate outside of a national service specification for a time-limited period;
    - a number of services where local and/or regional analysis has highlighted that commissioner-led work is required to achieve compliance with service specifications (e.g. due to a provider landscape with more providers than can support minimum numbers of cases identified in the specification). In these cases a derogation has been used, but without the requirement for a provider action plan;
    - a small number of specifications require further work prior to introduction;

123. Area teams will be performance monitoring the delivery of provider derogation action plans through routine contract monitoring mechanisms. NHS England will utilise contract sanctions where there is significant or persistent non-delivery against these plans.

124. Where commissioner-led service review work is required, this will be undertaken as part of the specialised services work plan. The pace and timing of this work will be communicated at a later stage once assessment of the requirement has been undertaken, identifying the scale at which each of these service reviews would most appropriately be undertaken.

125. NHS England does not expect service specifications to drive any inflation in the overall expenditure on specialised services.

Service Developments

126. NHS England has an interim generic policy on service developments which can be found at **http://www.england.nhs.uk/wp-content/uploads/2013/04/cp-02.pdf**

127. Any service development will be funded from within the existing quantum of specialised services and will be prioritised within the specialised commissioning

strategy. Commissioners will decide, with the advice of the CRGs, which service developments should be implemented.

128. NHS England will not support any service developments which are not aligned to our strategic priorities or developments. This includes the following:

    a. Services that are not defined as prescribed specialised services;
    b. Services that have been confirmed through policy as not routinely commissioned;
    c. Services which are not able to demonstrate clinical, patient and cost improvement;
    d. In year service developments, unless explicitly required by commissioners;

New Market Entrants

129. Discussions have taken place with Monitor to agree a programme of work that reviews all 143 specialised service lines and implements a programme of market assessment over a two to three year period. This will allow NHS England to prioritise the work over a number of years and enables us to share our strategic decision-making framework with Monitor proactively.

130. NHS England intends to move towards a 'fair playing field' for NHS and independent sector providers.

131. For 2013/14 there will be no new market entrants for specialised commissioning across the country unless there are clinical safety or capacity issues. It is unlikely that this position will change significantly in 2014/15 unless the outcome of the review of service lines identified above indicates capacity expansion is required or where market testing a service will bring clinical and/or financial benefits.

132. It will be important that we link the review of current provision and capacity with the implementation of the specifications and the development of the national strategy to ensure that we can demonstrate that we have a consistent and transparent way of addressing new market entry on a national basis.

Service Specific Issues

Mental Health

Secondary Commissioning

133. It is intended that all secondary commissioning of Specialised Mental Health Services will cease from 1 April 2014 and NHS England will contract directly with providers for specialised mental health services. This will help moving in the direction of travel to support Monitor's fair playing field review.

Currencies and Pricing

134. It is intended that NHS England move to all inclusive pricing for Specialised Mental Health Services particularly in respect of observations

135. Information for Payment by Results (PbR) development for Specialised Mental Health Commissioning will be required and incorporated into the Information Schedule.

136. There will be on-going work in 2014/15 and 2015/16 in the development of currencies for high, medium and low secure services. It is anticipated that pilot sites will be established in April 2014 to test the currency, care packages and outcome measures.

Access to Services

137. Standardised Access Assessments will be developed by the relevant specialised mental health CRGs for introduction during the period of these commissioning intentions.

Offender Personality Disorder Programme

138. We continue to support the implementation of the Offender Personality Disorder Programme, commissioning and decommissioning services to improve access and treatment outcomes in line with agreed funding.

Winterbourne View Concordat

139. The work with CCGs and providers will continue to ensure the Winterbourne View Concordat actions are implemented.

Child and Adolescent Mental Health Services (CAMHS) Tier 4

140. Following the Child and Adolescent Mental Health Services Tier 4 review, it is expected that the recommendations to procure appropriate quality, access and capacity will be implemented.

High Secure Services

141. A capacity review for high secure services will be carried out to inform a high secure commissioning plan. Work will continue with providers to align policies and procedures that directly impact on patients.

142. An additional 0.5% efficiency is expected from high secure providers with continued involvement in the benchmarking cost exercise to ensure delivery of future Quality, Innovation, Productivity and Prevention (QIPP).

Innovative Radiotherapy

143. Working with the Department of Health, NHS England is supporting the establishment of a Proton Beam Therapy (PBT) service in England by 2018. During 2014/15 we anticipate a phased increase in access to Proton Beam Therapy through the current overseas programme, whilst equipment is procured for the future centres planned in Manchester and London.

144. Intensity Modulated Radiotherapy (IMRT) is now available in more than 50 sites throughout England and we will require all providers to reach and maintain access to inverse planned IMRT at 24% or more of all radical treatments in each site. This is in line with the Government's commitment.

145. Intensity Modulated Radiotherapy and Proton Beam Therapy are only two examples of innovative radiotherapy and NHS England is therefore working in partnership with Cancer Research UK, clinical leaders and industry partners to develop and communicate NHS England's broader ambitions around equitable access to the most clinically and cost effective radiotherapy treatments as part of its broader strategy work.

146. Work will be undertaken during 2014/15 in collaboration with providers to secure sustainability in workforce and other aspects of service delivery to maintain IMRT services.

Paediatric Cardiology

147. During 2013-14 NHS England is conducting a new review to consider the whole lifetime pathway of care for people with congenital heart disease with the aim of bringing forward an implementable solution by the end of June 2014. This is expected to be a standards driven approach, building on the standards developed by Safe and Sustainable and the ACHD advisory group. All providers are encouraged to respond to the consultation on the standards (expected to take place in 2013/14) and to actively participate in the review. All providers are expected to work collaboratively with other centres in patients' best interests.

148. Until the new standards have been agreed and adopted, the Safe and Sustainable standards remain valid, and all specialist paediatric surgical centres are expected to work with the relevant area team to undertake a baseline assessment of that unit's position against the standards, and to develop an agreed plan for working towards the standards.

149. All specialist congenital heart disease providers should ensure that families, staff and referrers are kept informed of the progress of the review, the unit's participation in the review, and of local plans to enhance quality and safety.

150. It is widely acknowledged that the uncertainty which has been caused by recent developments is one of the greatest risks to the current delivery of the service. NHS England has developed a dashboard to provide early warning of any emerging concerns. All providers are expected to participate in this process.

Genetics

151. NHS England will be considering the future configuration of genetic laboratory services during 2014/15 with the intention of securing specialist testing and analysis skills; associated staffing and facilities; identifying opportunities to achieve efficiencies through economies of scale, and ensuring a strong provider platform upon which to take forward emerging and exciting advances in genomic medicine. Led by a multidisciplinary steering group, a range of options will be considered, with supporting descriptions of levels of service available to test with a wide range of stakeholders before a formal procurement is undertaken.

152. The Genomics UK led 100k genomes project is also expected to get underway during 2014/15, and NHS England will be working with commissioned providers to support the identification of potential participants and to ensure the programme links effectively to clinical pathways.

Haemophilia Tendering

153. The current national frameworks for the supply of blood clotting factor products expire in 2014 the first of these, for recombinant factor VIII, on 31 March 2014. NHS England is working with the Haemophilia CRG, the UK Haemophilia Centre Directors' Organisation (UKHCDO) and the Commercial Medicines Unit (CMU) to make sure that new national supply arrangements are in place through a competitive tendering exercise. All centres using blood clotting factor products for NHS patients will be expected to purchase factor products in line with these agreed national arrangements in order to support this national initiative.

PET/CT

154. The two national independent sector contracts for PET/CT, which deliver approximately 50% of PET/CT scanning in England, are due to expire at the end of March 2015. NHS England is currently looking at the most appropriate re-procurement model to ensure continued access to PET/CT services. It is envisaged that a tendering process will need to commence in 2013/14 and will run through 2014/15.

Appendix L 2

NHS public health functions agreement 2014-15

Public health functions to be exercised by NHS England

November 2013

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NHS public health functions agreement 2014-15

Public health functions to be exercised by NHS England

Prepared by Public Health Policy and Strategy Unit, Department of Health

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Introduction

The NHS has a critical part to play in securing good population health. This agreement between the Secretary of State for Health and NHS England enables NHS England to commission certain public health services that will drive improvements in population health.

Local government has responsibility for taking steps to improve the public's health, supported by the independent expertise of Public Health England (PHE) which is an executive agency of the Department of Health (DH). NHS England has a specific role and DH is the overall steward of the system. Direct commissioning of public health services by NHS England provides the public with evidence-based, safe and effective services, supported by information and expert advice from PHE.

This agreement sets out outcomes to be achieved and arrangements for funding from the public health budget. The spirit of this agreement is a shared commitment to protect and improve the public's health. DH, NHS England and PHE share the vision of working in partnership to achieve the benefits of this agreement for the people of England. In line with the Government's strategies for the NHS and the public health system, we aim to:

- improve public health outcomes and reduce health inequalities, and
- contribute to a more sustainable public health, health and care system

A. General

Legal framework

A1. This agreement sets out the arrangements under which the Secretary of State for Health delegates to NHS England responsibility for certain elements of public health functions, which add to the functions exercised by NHS England under the National Health Service Act 2006 ("the 2006 Act"). This agreement is made under section 7A of the 2006 Act as inserted by the Health and Social Care Act 2012 ("the 2012 Act).

A2. NHS England was established as the National Health Service Commissioning Board ("NHS CB"), by section 1H(1) of the 2006 Act as inserted by the 2012 Act.

A3. Pursuant to this agreement, NHS England will exercise functions of the Secretary of State under sections 2, 2A, 2B and 12 of the 2006 Act so as to provide or secure the provision of the services listed in Table 1, column 2, from 1 April 2014 to 31 March 2015. Where NHS England exercises these functions, they may be referred to in this document as "NHS public health functions".

A4. The provision of the services listed in Table 1 are steps which the Secretary of State considers appropriate for the purpose of protecting the public in England from disease or other dangers to health, and are therefore to be provided and arranged pursuant to the Secretary of State's duty under section 2A of the 2006 Act. In addition, with the exception of screening programmes and cancer screening programmes, the provision of the services listed in Table 1 are steps the Secretary of State considers appropriate to improve the health of the people of England and are therefore to be provided or arranged pursuant also to the Secretary of State's power under section 2B of the 2006 Act.

A5. This agreement follows that made for the financial year 2013-14 as part of continuing arrangements that are intended to provide stability for commissioners and providers. Similar agreements under section 7A of the 2006 Act are expected to be made for future financial years. In order to assist planning, this agreement for 2014-15 sets out some shared expectations for future years. The Government intends to take steps to transfer commissioning responsibilities for children's public health services from pregnancy to age 5 to local authorities from 2015.

A6. This agreement is intended to include functions of the Secretary of State mentioned in paragraph A3 within the framework of other responsibilities of NHS England. By virtue of section 13Z4 of the 2006 Act (interpretation), references in the statutory provisions listed in that section to its functions include functions exercisable under section 7A arrangements. The effect is that these provisions, including the provisions on NHS England's general duties as to improvement in quality of services and reducing inequalities, apply to the functions exercised by NHS England under this agreement as they do to its other functions.

A7. This agreement is separate from and in addition to the objectives set for NHS England by virtue of the Mandate published by the Secretary of State under section 13A of the 2006 Act ("the Mandate").

A8. Furthermore, this agreement applies only to the exercise of Secretary of State public health functions referred to in paragraph A3 above and does not apply to other functions of NHS England including in particular:

a) arranging the provision of services under NHS England's primary care functions, that is arrangements made under the following provisions of the 2006 Act:
    - sections 83, 84 and 92 (primary medical services)
    - sections 99, 100 and 107 (primary dental services)
    - section 115 and 117 (primary ophthalmic services)
    - sections 126 and 127 (pharmaceutical services)
    - sections 134 and 127 (pharmaceutical services),

b) arranging the provisions of services under regulations made under section 3B of the 2006 Act (specialised and other services), and high secure psychiatric services (section 4 of the 2006 Act),

c) NHS England's responsibilities for emergency preparedness or emergencies, including arrangements made under section 252A of the 2006 Act, and

d) NHS England's responsibilities in relation to clinical commissioning groups, including functions under Chapter A2 of Part 2 of the 2006 Act.

A9. This agreement is not intended to be a contract in law and should not be regarded as giving rise to contractual rights or liabilities. The Secretary of State for Health and NHS England will jointly aim to resolve any possible dispute that might arise in relation to this

agreement as quickly as possible with the processes outlined in this agreement.

A10. In this agreement, references to DH are to the parts of the Department other than PHE.

A11. Part C of this agreement sets out requirements for and evidence underpinning each service to be commissioned (referred to as “service specifications”). PHE has responsibility for keeping service specifications under review as part of its role in offering scientifically rigorous and impartial advice, evidence and analysis to support NHS England’s functions. NHS England and the Secretary of State may jointly agree to update the provisions of Part C (the service specifications) of this agreement as described below (paragraph A50).

A12. The Secretary of State for Health and NHS England may be referred to in this document as “the parties” where this is convenient.

Accountability

A13. The parties believe that accountability under this agreement should reflect the two high level outcomes set out in the Public Health Outcomes Framework ‘Healthy Lives, Healthy People: Improving Outcomes and Supporting Transparency’, first published in January 2012. This agreement therefore focuses on achieving positive health outcomes for the population and reducing inequalities in health through provision of the services listed in Table 1. NHS England is accountable to the Secretary of State for how well it performs its responsibilities under this agreement, and how well it drives improvement through the services listed. The key deliverables set out in this agreement should be the main measures of that performance. The key deliverables are matched as far as possible to measures used in the Public Health Outcomes Framework.

A14. In exercising the Secretary of State’s functions under this agreement, NHS England will :

a) seek to improve or at least maintain the national level of annual performance for each key deliverable and supporting indicator wherever a previous level of performance is shown as a baseline in Table 2, or

b) seek to achieve the highest practicable national level of performance in relation to each key deliverable shown in Table 2 , Table 3 or Table 4.

NHS England is accountable to the Secretary of State for these key deliverables. NHS England will seek to sustain local levels of performance where these are above the national level of annual performance.

A15. As indicated in paragraphs A6 and A7, NHS England is accountable for the exercise of statutory functions and for the objectives set by virtue of the Mandate. Under this agreement, NHS England is accountable in particular for the matters described in paragraphs A16 to A23 and A26 to A29 below. The parties note that the main measures of performance for these accountabilities will be drawn from management information available to NHS England, without additional reporting burdens. NHS England will use reasonable endeavours to obtain the data necessary to measure local levels of performance for the purposes described in paragraphs A14 and A18. Information in relation to quality of services is expected to address clinical effectiveness, patient safety and patient experience.

A16. Part C of this agreement contains service specifications which set out the evidence underpinning each service to be commissioned. NHS England will have inherited a variety of practice in commissioning resulting in unacceptable variations in the local provision of services. The parties expect further work by NHS England will be needed to bring these consistently into line with the service specifications. In line with paragraph A13, achieving this will reduce health inequalities and support improvements in population health. Consequently, NHS England will work with partners to undertake a review of existing commissioning to be completed by 31 March 2014. Where arrangements in any part of England are not in accordance with the service specifications in Part C, NHS England will set out the steps and timescale ('pace of change') to bring services consistently into line with the service specifications. NHS England will provide the steering group (mentioned in paragraph A33) with its draft report on pace of change and have regard to any views expressed. A final report will be provided to the Senior Oversight Group (mentioned in paragraph A31 below) no later than 31 March 2014.

A17. Full national implementation of commissioning in accordance with the service specifications in Part C should be no later than 31 March 2015. It is recognised that there may be exceptional circumstances in some cases and a clear timetable and rationale for any exceptions will need to be provided as part of the draft report and final report.

A18. The parties expect over time that NHS England will reduce the range of variation in local levels of performance, while improving or at least maintaining the national levels of performance described in paragraph

A14. Before 31 March 2014, NHS England will take steps to identify all cases of unacceptable or low local levels of performance by providers. This will be included as part of the review of current commissioning arrangements mentioned in paragraph A16 and A17. Unacceptable or low local levels of performance will be determined having regard to any written advice that may be given by PHE, including acceptable levels of performance that may be stated in service specifications. It may be convenient to use the term 'performance floors' for the minimum levels of performance that are acceptable. NHS England will state in the draft report and final report a set of measurable objectives for sufficient and sustainable changes in providers' performance to reduce the national range of variation. The objectives for 2014-15 may take into account an assessment of the resources required and available to undertake such improvement actions.

A19. Both the Secretary of State and NHS England have statutory duties relating to equality and as to reducing health inequalities. Consistent with those duties, NHS England should apply fresh information, evidence and methodologies to support accountability under this and future section 7A agreements in relation to equality and reducing health inequalities. This will include the use of information on variations in services between different areas and populations. NHS England will be accountable for achieving and demonstrating a greater understanding of effective interventions to narrow health inequalities.

A20. Actions are being taken forward by NHS England in response to the Francis Report (Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry) to transform the care people receive. Where not otherwise required by service specifications, NHS England will seek to ensure that the views of service users and others, including parents and carers, will be sought and taken into account in designing, planning, delivering and improving services that are provided pursuant to this agreement. In relation to this agreement, as indicated in paragraph A34(b), we expect the oversight group to review how the public and patients' voices are used both to develop insight to improve outcomes and reduce inequalities, and to help address under-performance.

A21. Where not otherwise required, in relation to any complaints relating to a service or services provided pursuant to this agreement, NHS England will ensure that information is shared appropriately with regulatory bodies and other organisations in the public health, health and care systems ("other bodies"), and that the fullest attention is given by NHS England to complaints whether received in the first place by NHS England or other bodies.

A22. Transparency is an organising principle. Where NHS England takes steps to remedy the level of performance or quality of any service provided pursuant to this agreement, it will provide information setting out remedial steps (an "improvement plan") and work with providers to ensure that objectives in the improvement plan are achieved in a timely manner..

A23. For the purposes mentioned in paragraph A31, NHS England is expected to develop financial reporting so that, in line with its other obligations including those mentioned in paragraphs A50, the oversight group can review quarterly information on the use of funding with a breakdown showing expenditure as described in paragraph A49. NHS England will provide information to the steering group about any incentivisation of providers through rewards or sanctions.

A24. The parties acknowledge the delivery challenges represented by the safe and effective implementation of planned changes represented by the key deliverables in Table 3 and Table 4. As indicated in paragraphs A34(b) and A53(b), these delivery challenges will be kept under review by the oversight group and the steering group.

A25. The parties recognise that key deliverables (described in Tables 2, 3 and 4) which are terms of this agreement may be delivered by a combination of the performance by NHS England of functions under this agreement and the exercise of its other functions, including primary care functions. An example is the commissioning of childhood immunisations through primary care contracts. For purposes of accountability, the Secretary of State and NHS England recognise that the funding provided under this agreement in accordance with paragraph A44 below is intended to provide the resources necessary to achieve the key deliverables of this agreement having regard to contributions expected to be made by the exercise of NHS England's other functions.

Specific programmes

A26. The Joint Committee on Vaccination and Immunisation (JCVI) has recommended that all children aged 2 years old to under 17 years old are vaccinated against seasonal flu on an annual basis. Once fully implemented, childhood flu immunisation will be the largest immunisation programme in England. Due to the significant scale and challenge of delivering this programme, a phased implementation began in 2013-14, with provision for all 2 and 3 year olds along with geographical pilots in a number of areas to test delivery in primary schools, to enable learning about delivery to inform more substantive implementation in 2014-15 and beyond. DH, NHS England and PHE

have a shared ambition for the next phase of implementation - to offer vaccine to all children between 2 and 4 years old and all secondary school aged children (11-16 year olds). Specific provisions for phased implementation in 2014-15 are set out in Table 4. NHS England is accountable for the key deliverables in Tables 2, 3 and 4.

A27. Following consideration of advice from the JCVI, it is possible that there may be a commitment by the Secretary of State to undertake population-based evaluation of use of meningococcal B (MenB) vaccine in infants and/or adolescents starting in 2014-15 or 2015-16 to investigate uncertainties in scientific evidence about the vaccine's effectiveness. Such an evaluation could involve, for example, national and/or regional temporary MenB immunisation programmes in England. If such an evaluation is undertaken, NHS England is expected to work with PHE to ensure that there would be sufficient capacity within the NHS to support development and/or delivery of such a population based evaluation. The senior oversight group will review the position once JCVI's advice has been received in November 2013.

A28. As mentioned in paragraph A5, the Government intends to take steps to transfer commissioning responsibilities for children's public health services from pregnancy to age 5 to local authorities from 2015. Arrangements are being developed through a task and finish group of the Children's Health and Wellbeing Partnership, of which both NHS England and DH are members. In relation to this agreement, NHS England is expected to continue its engagement with partners and planning for safe and effective transfer of commissioning arrangements, acknowledging the challenge that adaptation of plans may be necessary as steps proceed. NHS England is expected to explore, in particular, opportunities for sign-off of commissioning plans for 2014-15 with local authority Chief Executives. DH will retain responsibility for system assurance and due diligence for the transfer of responsibilities to local government.

A29. PHE will continue to be responsible in 2014-15 for the roll out of the bowel scope screening programmewhich will contribute towards the Mandate objective for England to become one of the most successful countries in Europe at preventing premature deaths.. . The Secretary of State's commitment is to have this programme rolled out to 60% of England by the end of March 2015, and to the rest of England by the end of 2016. NHS England will work with PHE to help deliver the involvement of screening centres sufficient to meet the 60% commitment and to support preparatory steps in other bowel cancer screening centres to implement by the end of 2016. The expectation has been that PHE would retain responsibility until after full roll out has been achieved, but NHS England might be requested to take responsibility for commissioning from 2015-16. The steering group

(mentioned in paragraph A33) expects to consider information about progress from the bowel scope screening delivery board.

Oversight and assurance

A30. The parties' commitment to partnership recognises the role of joint oversight and close collaboration in driving improvements in population health. PHE plays a key role as the national expert voice and centre of advice for public health, contributing to joint oversight and in day to day collaborative relationships with NHS England.

A31. NHS England and the DH will jointly convene meetings of an oversight group which will be chaired by the DH Director General for Public Health. The oversight group is currently known as the NHS public health functions senior oversight group. The oversight group:

a) will review planning, performance, risks and mitigating actions in relation to functions exercised under this agreement, which may be both nationally and in relation to any specific area, service or population group of concern to NHS England or the Secretary of State,

b) will secure arrangements for effective partnership working to deliver improvements in population health, and

c) may make reports and recommendations to the Secretary of State and NHS England, including recommendations in relation to proposed updates or variations of this agreement.

A32. Membership of the oversight group will include the PHE Chief Executive and otherwise will be determined by the chair of the oversight group with the consent of the NHS England Chief Operating Officer.

A33. The oversight group is expected to meet at least quarterly. The oversight group will determine its own working arrangements, including the functions of any subgroups. There is currently one subgroup. The NHS public health steering group, chaired by the NHS England Director of Partnerships, reports to and advises the oversight group. The steering group is expected to implement arrangements for effective partnership working and make every effort to resolve operational issues between bodies.

A34. The oversight group is expected to review:

a) matters described in paragraph A31(a)

b) information provided by NHS England and PHE in relation to paragraphs A16 to A23 and A26 to A29, including the pace of change mentioned in paragraph A16,

c) the quality of services delivered pursuant to this agreement, including any serious incidents or serious complaints, and steps taken to improve the quality of services, and

d) any prospective changes under this agreement, including those described in paragraphs A31(c) and A35.

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A35. The oversight group, or as appropriate the steering group, will discuss implementation plans at a formative stage so as to inform programme decisions by the Secretary of State on a prospective:

a) new or changed service that would be requested to be commissioned by NHS England under the functions mentioned in paragraph A3,

b) request for roll-out of a service development by NHS England following a pilot phase, or

c) pilot for a service, or an extension to a service, that in future would be requested to be commissioned by NHS England under these functions.

A36. The oversight group is expected to consider the views of NHS England on the exercise of functions by NHS England under this agreement having regard to its other functions including those mentioned in paragraphs A6 to A8. For example, in connection with a prospective variation, the most appropriate times to implement planned changes under this agreement in relation to a commissioning cycle.

A37. The oversight group and the steering group will consider in each quarter the availability of new evidence and data in relation to key deliverables and baselines identified in Table 2, including the availability of any new or updated baselines. Any such proposed changes may be given effect by written agreement as described in paragraph A51 below, or may otherwise be the subject of guidance as described in paragraph A38.

A38. In order to exercise NHS public health functions more effectively, the oversight group or the steering group may make decisions as to guidance which may inform the carrying out of the provisions of this agreement.

Information

A39. To fulfil the purposes of this agreement. DH, PHE and NHS England should each have the same timely and objective information available to them. Achieving the best information flows, nationally and locally, requires full collaboration with each other, and with bodies such as the Health and Social Care Information Centre.

A40. DH, PHE and NHS England will share information to enable effective joint planning of service delivery and service improvement. This means that information will be shared at formative stages. For example, PHE should share its understanding of emerging evidence and the work of its advisory committees in relation to prospective changes in services or new services that may be commissioned under a future section 7A agreement.

A41. NHS England and PHE will share performance information in relation to services. NHS England will as far as is practicable share with the Health and Social Care Information Centre all information it collects, or requires providers to collect, in the exercise of its functions pursuant to this agreement. NHS England will also ensure that relevant unpublished information is shared on a timely basis with PHE and DH for the purpose of assisting the Secretary of State to exercise his functions. PHE should similarly share relevant unpublished information. NHS England will agree arrangements with PHE for the supply or exchange of relevant information and analyses.

A42. It is necessary that public health experts and officials responsible to the Secretary of State, including the Government's Chief Medical Officer, receive information in relation to matters of expert, clinical or Parliamentary concern at the earliest possible time. NHS England will without delay inform DH in writing of any significant concerns it has in relation to the delivery of services by providers, including reports of serious failings or incidents, or major risks. This includes matters described in paragraph A21

A43. NHS England will work with DH and PHE to support: development of:

a) baseline data for Table 2 where this is currently not available,

b) detailed data to enable effective contract management of providers in relation to the purposes of this agreement mentioned in paragraph A13, and

c) excellent data quality and completeness in relation to items mentioned in Table 2 and management information as mentioned in paragraph A15.

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Finance

A44. The Secretary of State agrees to pay NHS England the sum of £1,929m from the public health budget for the purposes of performing functions pursuant to this agreement during the financial year 2014-15 (in addition to the funding referred to in paragraph A46). This is ringfenced funding that may be used only for expenditure attributable to the performance of functions pursuant to this agreement.

A45. This does not preclude NHS England from choosing to allocate additional resources to prioritise public health spend within its overall resource limit(s).

A46. Additional funding of £394m from the public health budget for services provided through primary care is included within the total allocation of resources to NHS England under sections 223B and 223D of the 2006 Act. This funding and that referred to in paragraph A44 amount to £2,323m allocated to NHS England from the public health budget for the financial year 2014-15 for the delivery of the services listed in Table 1.

A47. The revenue resource limit for NHS England for the year 2014-15, as specified in the Mandate has been set so as to take into account the funding provided under this agreement under paragraph A44.

A48. NHS England will report to the oversight group any expected underspending of the funding allocated under paragraph A44 so that DH can take account of this in HM Treasury carry forward arrangements. Any sum underspent which is made available as part of section 7A funding for the following financial year may also only be used for expenditure attributable to the performance of functions pursuant to this agreement or a similar future agreement.

Reporting

A49. NHS England will report annually to the Secretary of State in relation to this agreement, on its achievement of the key deliverables listed in Tables 2, 3 and 4. NHS England will report to the Secretary of State after the end of each financial year on the use of the funding allocated

under paragraph A44 above and if different to the amount of funding allocated, then NHS England will report the total expenditure attributable to the performance of functions pursuant to this agreement. This annual report will include a breakdown showing expenditure for each programme category or programme listed in Table 1.

A50. NHS England's duty to make an annual report on how it has exercised its functions (section 13U of the 2006 Act) applies to the functions exercised under this agreement. NHS England may include the specific report required under paragraph A49 as part of that annual report or as a separate document provided no later than the date on which that annual report is laid before Parliament.

Variation

A51. This agreement may be varied by the Secretary of State and NHS England by written agreement. The oversight group is expected to review plans and may make a recommendation about such a variation.

A52. A planned variation to this agreement is expected in relation to the extension of the seasonal influenza vaccination programme to children of secondary school age (12 to 16) as described in Table 4. The planned variation may also address associated or consequential changes for other programmes

A53. The nature of this agreement, and the intention to provide stability for commissioners and providers, implies that unplanned variations to this agreement will never be routine. The circumstances in which an unplanned variation to this agreement may be considered include:

a) a new threat to the health of the people of England, or an unexpected new opportunity to protect their health,

b) a new assessment of operational implications in relation to a programme mentioned in Table 3 (key deliverables for implementing change),

c) a change of evidence or advice in relation to a service specification

A54. The parties note that if only limited or proportionate actions are required to respond to any of the circumstance described in paragraph A53, they will consider whether an unplanned variation can be agreed within NHS England's existing operational capacity and financial resources. If such agreement is not possible, an unplanned variation (that is, any variation other than a variation described in paragraph A52) may, among other things, provide for either or both of:

a) lower expectations of performance in other services while actions are implemented in relation to matters mentioned in paragraph A53(a) or (b) (for example, implementation of a new vaccination programme),

b) an amount of additional funding where the Secretary of State considers that there are exceptional circumstances that makes the additional funding necessary. Under section 13B of the 2006 Act, if the Secretary of State varies the amount of money specified under section 223D(2) (total revenue resource use), the Secretary of State must revise the Mandate accordingly..

Dispute resolution

A55. As indicated in paragraph A9, any dfferences should be resolved quickly and constructively. The following provisions are intended to resolve any dispute in relation to:

a) the exercise of functions under this agreement,

b) any aspect of collaboration in relation to this or future agreements under section 7A of the 2006 Act.

A56. At their discretion, an authorised senior representative of NHS England, DH or PHE may at any time declare a dispute under this agreement by a written notice to the chair of the oversight group that provides information about the dispute and how resolution of the matter has been attempted and failed. The day when the chair is notified is the "date of notification". The chair will have joint responsibility with the Chief Operating Officer of NHS England to resolve the dispute and may delegate responsibilities to named individuals.

A57. Any dispute remaining unresolved after a maximum of 5 working days from the date of notification shall be reported to the Chief Executive of NHS England, the DH Director General Policy, Strategy & Finance, and the DH Permanent Secretary. They shall take steps to resolve the dispute within no more than 10 working days from the date of notification.

A58. If the matter is not resolved in accordance with paragraph A57, the matter must be referred to the Secretary of State for final determination. The Secretary of State must, after consultation with NHS England, appoint a person independent of DH, PHE and NHS England to consider the dispute and make recommendations, within a period specified by the Secretary of State on appointment. The Secretary of State must make a final decision within 10 days of

receiving the recommendations. DH and NHS England agree to be bound by the decision of the Secretary of State and to implement any decision within a reasonable period.

A59. This agreement is without prejudice to the exercise of the Secretary of State's powers in respect of NHS England, including his powers in relation to the failure by NHS England to discharge, or to discharge properly, any of its functions (section 13Z2 of the 2006 Act).

B. Tables

B1. Table 1 is mentioned first in paragraphs A3 and A4.

Table 1: List of services by programme category

Programme category or programme	Services
Immunisation programmes	Pertussis pregnant women immunisation programme
	Neonatal BCG immunisation programme
	Respiratory syncytial virus (RSV) immunisation programme
	Immunisation against diphtheria, tetanus, poliomyelitis, pertussis and Hib
	Rotavirus immunisation programme
	Meningitis C (MenC) immunisation programme
	Hib/MenC immunisation programme
	Pneumococcal immunisation programme
	DTaP/IPV and dTaP/IPV immunisation programme
	Measles, mumps and rubella (MMR) immunisation programme
	Human papillomavirus (HPV) immunisation programme
	Td/IPV (teenage booster) immunisation programme
	Seasonal influenza immunisation programme
	Seasonal influenza immunisation programme for children
	Shingles immunisation programme
Screening programmes	NHS Infectious Diseases in Pregnancy Screening Programme
	NHS Down’s Syndrome Screening (Trisomy 21) Programme
	NHS Fetal Anomaly Screening Programme

	NHS Sickle Cell and Thalassaemia Screening Programme
	NHS Newborn Blood Spot Screening Programme
	Newborn Hearing Screening Programme
	NHS Newborn and Infant Physical Examination Screening Programme
	NHS Diabetic Eye Screening Programme
	NHS Abdominal Aortic Aneurysm Screening Programme
Cancer screening programmes	Breast Screening Programme
	Cervical Screening
	Bowel Cancer Screening Programme
Children's public health services (from pregnancy to age 5)	Healthy Child Programme and Health Visiting (universal offer)
	Family Nurse Partnership (nationally supported targeted offer)
Child Health Information Systems	Child Health Information Systems
Public health care for people in prison and other places of detention	Public health services for people in prison and other places of detention, including those held in the Young People's Secure Estate
Sexual assault services	Sexual assault referral services

B2. As described in paragraphs A13 and A14, the key deliverables shown in Tables 2, Table 3 and Table 4 should be the main measures of how well NHS England performs its responsibilities under this agreement, and how well it drives improvement through the services listed in Table 1. Baseline data in Table 2 normally shows a previous level of performance (that is, rather than a target or required level of performance). It should also be noted that paragraph A18 describes arrangements in relation to 'performance floors' for local levels of performance, and that service specifications in Part C may further describe requirements for quality and performance. .

B3. As described in paragraph A13, the key deliverables shown in Table 2 are matched as far as possible to measures used in the Public Health Outcomes Framework. This refers to the document 'Improving outcomes and supporting transparency: a public health outcomes framework for England 2013-16' as updated in July 2013. Other references and sources are shown in the table. 'To be confirmed' is shown where the parties anticipate suitable baseline data becoming available.

Table 2 Key deliverables for services

Key deliverables (shown in bold) and supporting indicators	**Baselines**	**Year, or time period**
Immunisation programmes **Pertussis vaccine uptake for pregnant women** Health Protection Report Vol.7. No.40 http://www.hpa.org.uk/hpr/archives/2013/hpr4013.pdf	50%	Lower estimate of coverage achieved in first 9 months of the programme to June 2013
Population vaccination coverage (as defined in Public Health Outcomes Framework indicator 3.3)		
3.3i: Hepatitis B vaccination coverage (1 and 2 year olds)	To be confirmed	
3.3ii: BCG vaccination coverage (aged under 1 year)	To be confirmed	
3.3iii: DTaP/IPV/Hib vaccination coverage (1, 2 and 5 year olds)	94.7% at age 1 96.1% at age 2 To be confirmed at age 5	2011-12

3.3iv: MenC vaccination coverage (1 year olds) 3.3v: PCV vaccination coverage (1 year olds) 3.3vi: Hib/MenC booster vaccination coverage (2 and 5 year olds) 3.3vii: PCV booster vaccination coverage (2 year olds) 3.3viii: MMR vaccination coverage for one dose (2 year olds)	93.9% 94.2% 92.3% at age 2 88.6% at age 5 91.5% 91.2%	2011-12 2011-12 2011-12 2011-12 2011-12
3.3ix: MMR vaccination coverage for one dose (5 year olds) 3.3x: MMR vaccination coverage for two doses (5 year olds) 3.3xi: Td/IPV booster vaccination coverage (13-18 year olds) 3.3xii: HPV vaccination coverage (females 12-13 year olds) 3.3xiii: PPV vaccination coverage (aged 65 and over) 3.3xiv: Flu vaccination coverage (aged 65 and over) 3.3xv: Flu vaccination coverage (at risk individuals from age six months to under 65 years, excluding pregnant women)	92.9% 86.0% To be confirmed 86.8% 68.3% 73.4% 51.3%	2011-12 2011-12 2011-12 academic year 2011-12 2012-13 2012-13
Flu vaccination coverage (children aged two and three)	To be confirmed	
Screening programmes **Access to non-cancer screening programmes (as defined in Public Health Outcomes Framework indicator 2.21)** http://www.screening.nhs.uk/kpi/data-collection 2.21i: HIV coverage: percentage of pregnant women eligible for infectious disease screening who are tested for HIV, leading to a conclusive result 2.21ii :Syphilis, hepatitis B and susceptibility to rubella uptake: The percentage of women booked for	 98.1% To be confirmed	 2012-13

antenatal care, as reported by maternity services, who have a screening test for syphilis, hepatitis B and susceptibility to rubella leading to a conclusive result		
2.21iii: The percentage of pregnant women eligible for antenatal sickle cell and thalassaemia screening for whom a conclusive screening result is available at the day of report	98.0%	2012-13
2.21iv: The percentage of babies registered within the local authority area both at birth and at the time of report who are eligible for newborn blood spot screening and have a conclusive result recorded on the Child Health Information System within an effective timeframe	92.3%	2012-13
2.21v: The percentage of babies eligible for newborn hearing screening for whom the screening process is complete within 4 weeks corrected age (hospital programmes - well babies, all programmes - NICU babies) or 5 weeks corrected age (community programmes – well babies)	97.5%	2012-13
2.21vi The percentage of babies eligible for the newborn physical examination who were tested within 72 hours of birth	To be confirmed	
2.21vii: The percentage of those offered screening for diabetic retinopathy who attend a digital screening event	80.2%	2012-13
NHS Abdominal Aortic Aneurysm Screening Programme **The proportion of men eligible for abdominal aortic aneurysm screening to whom an initial offer of screening is made.**	To be confirmed	
Cancer screening programmes **Cancer screening coverage (as defined in Public Health Outcomes Framework indicator 2.20)**		
2.20i: The percentage of women in a population eligible for breast screening at a given point in time who were screened adequately within a specified period	76.9% coverage aged 53-70	Published in 2012

2.20ii: The percentage of women in a population eligible for cervical screening at a given point in time who were screened adequately within a specified period Bowel cancer screening programme **FOBt (faecal occult blood testing) Screening Uptake (all rounds)** Source: NHS Cancer Screening Programmes	75.3% coverage aged 25 to 64 55.8%	Published in 2012 Start of programme to end-August 2013
Children's public health services (from pregnancy to age 5) **The Government's commitment to increase the number of health visitors by 4,200 against a May 2010 baseline of 8,092 and to transform health visiting services by April 2015.** Health Visiting Minimum Data Set **The Government's commitment to more than double the April 2011 number of places on the FNP programme to at least 16,000 by April 2015.** **Low birth weight of term babies (as defined by the Public Health Outcomes Framework indicator 2.1)** 2.1: Percentage of all live births at term with low birth weight **Breastfeeding (as defined in Public Health Outcomes Framework indicator 2.2)** 2.2i: Breastfeeding initiation 2.2ii: Breastfeeding prevalence at 6-8 weeks after birth **Excess weight in 4-5 year olds (as defined in the Public Health Outcomes Framework indicator 2.6)** 2.6i: Percentage of children aged 4-5 classified as overweight or obese	9,133 FTE qualified health visitors (ESR and non-ESR)] 11,475 FNP places as at 1 April 2013 2.85% 74.0% 47.2% 22.6%	March 2013 2010 2011-12 2011-12 school year 2010-11
Hospital admissions caused by unintentional and deliberate injuries in under 18s (as defined in the Public Health Outcomes Framework indicator 2.7) 2.7: Crude rate of hospital emergency admissions		

caused by unintentional and deliberate injuries in age 0-17 years, per 10,000 resident population. **Infant mortality (as defined in the Public Health Outcomes Framework indicator 4.1 - shared indicator with NHS Outcomes Framework 1.6i)** 4.1: Crude rate of infant deaths (persons aged less than 1 year) per 1,000 live births **Tooth decay in children aged five (as defined in the Public Health Outcomes Framework indicator 4.2)** 4.2: Rate of tooth decay in children aged 5 years based on the mean number of teeth per child sampled which were either actively decayed or had been filled or extracted – decayed/missing/filled teeth (dmft) **Maintain and extend coverage of local delivery of the Healthy Child Programme, moving towards delivery of the full service specification.**	To be confirmed 4.2 deaths per 1,000 live births To be confirmed	2011
Child health information systems **Maintain coverage of local delivery of Child Information Systems, with a plan to implement defined minimum standards as far as possible by April 2015 and encourage future attainment.**		
Public health care for people in prison and other places of detention		
People entering prison with substance dependence issues who are previously not known to community treatment (as defined in the Public Health Outcomes Framework indicator 2.16) 2.16: Proportion of people assessed for substance dependence issues when entering prison who then require structured treatment and have not already received it in the community	To be confirmed	

The proportion of individuals in secure environments that engage in structured drug and alcohol treatment interventions who at the point of departure from that establishment either: • successfully completed a treatment intervention in custody and did not represent to treatment (either in custody or the community) within 6 months of release; or • successfully engaged in community based drug and alcohol treatment interventions following release; or • where they were transferred to another prison/YPSE, successfully engaged in structured drug and alcohol treatment interventions at the receiving establishment.	To be confirmed To be confirmed To be confirmed	
Sexual assault services **Assure improvement in local delivery of sexual assault referral centres as described in Table 3. .**		

B4. Table 3 is first mentioned in paragraph A14.

Table 3: Key deliverables for implementing change

Key deliverables (shown in bold)
Immunisation programmes **Implement as far as reasonably practicable the planned new MenC immunisation programme for university entrants.** **Develop the extension of the seasonal influenza vaccination programme to children as described in Table 4, including vaccination coverage for children aged four that is as high as reasonably practicable.**
Children's public health services (from pregnancy to age 5) As described in paragraphs A5 and A28, arrangements in relation to transition of children's public health services from pregnancy to age 5 are being developed through a task and finish group of the Children's Health and Wellbeing Partnership, of which both NHS England and DH are members. **Develop plans, nationally and for each local area, for transferring commissioning responsibilities for children's public health services from pregnancy to age 5 to local authorities, on the basis of effective partnership with local authorities so far as this is reasonably practicable.**
Sexual assault referral services **NHS England will provide by 31 March 2014 an improvement plan. The plan will set out a review of the current commissioning arrangements and aim to standardise the core offer to the victim in 2014-15, and to commission services fully in accordance with the service specification no later than 2015-16. The core offer should include roll-out of the provision of HIV starter prophylaxis in all SARCs in 2014-15 in accordance with the service specification. The improvement objectives for 2014-15 may otherwise take into account an assessment of the resources required and available to undertake such improvement actions.**

B5. Table 4 is first mentioned in paragraph A26.

Table 4: Phased implementation of the extension of the seasonal influenza vaccination programme to children

Key deliverables (shown in bold)
In 2014-15, NHS England will: **a) make provision of childhood flu vaccination for all 2 and 3 year olds;** **b) make provision for 4 year olds;** **c) continue delivery to primary school aged children (5-11 year olds) in the current pilot areas; and** **d) commence delivery of childhood flu vaccination to as many children of secondary school age as reasonably possible in the light of the circumstances below.** The best uptake of vaccination among 5-16 year olds is likely to be achieved through a school-based programme. However, it is recognised that the capacity of school nursing services (where appropriate locally working with specialist immunisation services) is not currently adequate to enable the programme to be offered to all children in this way. Work is being undertaken jointly by DH and NHS England, and with PHE, [Health Education England] and professional bodies to: • support the development of sustainable long-term solutions, • ensure the availability of sufficient appropriately-trained staff, and • work with local government to develop the associated commissioning arrangements for school nursing to deliver the programme. NHS England will also work with PHE to undertake an assessment of the commissioning capacity to deliver a programme of this scale. NHS England will work towards delivery of childhood flu vaccination to as many children of secondary school age as reasonably possible in 2014-15. However, it is recognised that full coverage may not be achievable within one year. The partners therefore intend to enter into negotiations following on the outcome of the assessments of workforce and commissioning capacity, with a view to agreeing by way of a variation to this agreement by April 2014, the extent to which the programme can be rolled-out and the expected uptake rates for vaccination in 2014-15.

C. Service specifications

C1. This part of the agreement includes the service specifications listed in Table 4 which are published as separate documents.

Table 4 : List of service specifications

Number		**Publication date**
	Immunisation programmes:	
1	Neonatal Hepatitis B immunisation programme	Nov 2013
1A	Pertussis pregnant women immunisation programme	Nov 2013
2	Neonatal BCG immunisation programme	Nov 2013
3	Respiratory syncytial virus (RSV) programme	Nov 2013
4	Immunisation against diphtheria, tetanus, poliomyelitis, pertussis, and Hib	Nov 2013
5	Rotavirus immunisation programme	Nov 2013
6	Meningitis C immunisation programme	Nov 2013
7	Hib/MenC immunisation programme	Nov 2013
8	Pneumococcal immunisation programme	Nov 2013
9	DTaP/IPV and dTaP/IPV immunisation programme	Nov 2013
10	Measles, mumps and rubella (MMR) immunisation programme	Nov 2013
11	Human papillomavirus (HPV) programme	Nov 2013
12	Td/IPV (teenage booster) immunisation programme	Nov 2013
13	Seasonal influenza immunisation programme (2014-15 programme)	Nov 2013
13A	Seasonal influenza immunisation programme for children (2014-15 programme)	Nov 2013
14	Shingles immunisation programme	Nov 2013

	Screening programmes	
15	NHS Infectious Diseases in Pregnancy Screening Programme	Nov 2013
16	NHS Down's Syndrome Screening (Trisomy 21) Programme	Nov 2013
17	NHS Fetal Anomaly Screening Programme	Nov 2013
18	NHS Sickle Cell and Thalassaemia Screening Programme.	Nov 2013
19	NHS Newborn Blood Spot Screening Programme	Nov 2013
20	NHS Newborn Hearing Screening Programme	Nov 2013
21	NHS Newborn and Infant Physical Examination Screening Programme	Nov 2013
22	NHS Diabetic Eye Screening Programme	Nov 2013
23	NHS Abdominal Aortic Aneurysm Screening Programme	Nov 2013
	Cancer screening programmes	
24	Breast Screening Programme	Nov 2013
25	Cervical Screening	Nov 2013
26	Bowel Cancer Screening Programme	Nov 2013
	Other programmes	
27	Children's public health services (from pregnancy to age 5)	Nov 2013
28	Child Health Information Systems (CHIS)	Nov 2013
29	Public health services for people in prison and other places of detention, including those held in the Children & Young People's Secure Estate	Nov 2013
30	Sexual assault services	Nov 2013

NHS
Leicester City
Clinical Commissioning Group
Improving Mental Health services in Leicester City
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Appendix M
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The key priorities outlined in the existing CCG clinical commissioning strategy:

2012/13
1. Implement the Year 1 LLR wide Dementia Strategy actions. 2. Review, respecify and recommission the IAPT service. 3. Improve access to emergency and acute mental health services.
2013/14
1. Implement the Year 2 LLR wide Dementia Strategy actions and improve diagnosis rates and treatment. 2. Deliver the new IAPT service increasing access to 18%. 3. Contract manage the IAPT service to ensure outcomes are being met. 4. Monitor outcomes for emergency and acute mental health services to ensure outcomes are being met.
2014/15
1. Implement the Year 3 LLR wide Dementia Strategy actions. 2. Delivery of the IAPT service increasing access to 20%. 3. Contract manage the IAPT service to ensure outcomes are being met. 4. Monitor outcomes for emergency and acute mental health services to ensure outcomes are being met.

Objectives of the scoping document

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- What services do we commission?
- What does each service provide?
- Does each service provide mental health care efficiently and effectively?
- Where are the service gaps & any unmet need?
- What options are available for future commissioning of mental health services?

Methodology

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Clinical Commissioning Group

Overview of service → Estimate of need & prevalence → Actual activity compared to need → Benchmarked activity vs. peer population → Analysis & findings

GP survey: themes

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Concerns around the **quality/lack of communication/information** from Secondary Care/LPT (In-Patient & Community Crisis services) back to Primary Care

Concerns around **access/referral** in to Crisis Team and Home Treatment service (CRHT)

Concerns around aspects of the **CRHT** service

Concerns around lengthy Patient **Waiting Times**

Positive experience of the **“Open Mind” (IAPT)** service (Except Waiting Times)

Key findings

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Primary Care	Community Care	Acute Care
• Long waiting times for IAPT • Limited alternatives to IAPT • Access for vulnerable groups • Evaluation of Mental Health Nurse Pilot with 6 practice needed.	• Provision & effectiveness of CMHT/CRHT/AOT teams require review • Liaision psych service could be pivotal to integrating care pathways • Limited services available for sub/post acute care	• Alternatives to acute admission required • High bed occupancy • Pathway requires systemic redesign • 'Out of area' usage remains high

Future work programmes/ commissioning intentions

Primary care based services

- Reduce referral to treatment time for IAPT services using a demand vs. capacity analysis
- Consider commissioning of alternatives to IAPT, targeted to vulnerable groups/unmet need
- Evaluate pilot of the MH nurse specialist role

Community based services

- Full commissioner review of current CRHT provision
- Expand role of the liaison psychiatry service in line with national best practice models
- Evaluate non-bedded and bedded admission avoidance services to prevent admissions to acute care

Acute services

- Full commissioner review of the efficacy of the clinical pathway within LPT inpatient facilities
- Further review (nationally and internationally) of non-hospital based services as an alternative model of care

Post acute services

- Consider commissioning of step down facilities (non-bedded) to decrease length of acute episode & increase flow across the system
- Consider commissioning of locked rehabilitation beds in the City to prevent costly out of area placements

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Discussion

News

The new Congenital Heart Disease review: 11th update – John Holden

11 November 2013 - 21:55

Your feedback

The main topic you've been commenting on has been the scope of the review, which was discussed by our Board's Task and Finish Group on 29 October 2013. They considered a recommendation from our Clinical Advisory Panel, who in turn had the benefit of over 40 contributions from public, patient and other stakeholders.

One of the lessons we learnt was that in our desire to talk plain English (proposing which services are "in" or "out" of scope") we over–simplified and, as often seems to be the case, set some hares running about what we were up to. So we realised quite quickly that the approach needs to be more than just "in or out" – for example we needed to describe how we will take account of services which have a dependency with CHD but aren't solely for CHD patients. The notes of the Board Task and Finish Group and the Clinical Advisory Panel meetings will be published shortly. But to cut to the chase, our Task & Finish Group agreed that the heart of the review should be the whole lifetime pathway of care for people with congenital heart disease (CHD):

- Improving quality of care for people with suspected or diagnosed CHD (including congenital heart arrhythmias or arrhythmias in the context of congenital heart disease) along the whole patient pathway:

- Fetal and neonatal diagnosis of CHD
- Specialist obstetric care (including both the care of women whose unborn child has suspected or confirmed CHD, and care of pregnant women with CHD)
- Care for babies children and young people
- Transition from children's services to adult services
- Care for adults
- End of life care.
- Extracorporeal life support (ECLS) for children and young people including cardiac and respiratory ECMO
- Care and support for families suffering bereavement and/or poor outcomes following surgery or other intervention for CHD

- The review covers all care for CHD commissioned by the NHS for people living in England

In addition there are some conditions which while not CHD receive their care wholly or mainly from congenital heart services. Though we won't set standards for these conditions, patients with these conditions should be able to participate in the review because whatever happens to CHD services will affect them. This includes:

- children and young people with acquired heart disease
- children and young people with inherited heart disease

There are some services which are not CHD specific but which are nonetheless used by congenital heart patients. The standards for these services won't be set as part of the new CHD review, but the use of these services by CHD patients will be considered by the review, including definition of patient pathways and referral routes. Patients and specialists from these services should be able to participate in the review; this includes:

- neonatal, paediatric and adult intensive care, transport and retrieval services;
- other interdependent clinical services (e.g. other tertiary paediatric services);
- mechanical circulatory support for adults (e.g. cardiac ECMO and VAD);
- complex tracheal surgery;
- heart transplant and bridge to transplant for children and young people; and
- heart transplant for adults.

Services which are explicitly out of scope of this review are:

- adults with inherited heart disease;
- adult respiratory ECMO;
- local maternity services; and
- pulmonary hypertension services.

Patients, families and their representatives

The Health Scrutiny Committee for Lincolnshire, which I attended on 18 September 2013, has provided an extract of their minutes, which you can read here. The Committee invited me to attend again on 20 November 2013, however I could not justify another visit so soon when there are many other engagement priorities. I promised to send a written update in advance of their 20 November 2013 meeting – I will publish the update here.

On 9 October 2013, Professor Sir Bruce Keogh and Michael Wilson attended the All Party Parliamentary Group (of MPs and peers) to discuss the new CHD review. They provided a brief overview using slides, enclosed here. There were no minutes of the meeting but we took our own informal note which is attached here. There was not enough time at the APPG to answer every question, so we have written this letter to attendees to answer their outstanding queries.

On 4 November 2013 I attended the North East Regional Health Scrutiny Meeting (the chairs of local government Overview and Scrutiny Committees), in Gateshead. I will share a note of the discussion when it becomes available.

The meeting of the new CHD review patient and public group, chaired by Professor Peter Weissberg (British Heart Foundation) will be held on Tuesday 12 November 2013 in London. A list of those organisations invited to attend is here.

Clinicians and their organisations

The meeting of the new CHD review provider executives' group, chaired by Chris Hopson (FT Network) will be held on Tuesday 19 November 2013 in London, you can view a list of the organisations invited to this meeting here.

The meeting of the new CHD review clinicians' group, chaired by professor Deirdre Kelly, will be held on Friday 22 November 2013 in London, you can view a list of the organisations invited to this meeting here.

Professor Kelly is also overseeing the process of bringing to a conclusion the work on additional standards for children's congenital heart services and is working with the adult congenital heart disease advisory group to make a joint recommendation on a single combined set of standards (for consideration and full consultation by the congenital heart services Clinical Reference Group). A note of the recent Standards Alignment Working Group meeting held on 21 October 2013 is attached here.

NHS England and other partners

Our Programme Board meets on 13 November 2013 in London. The papers for that meeting (including the draft minutes of the last discussion on 21 October 2013) are attached here.

NHS England's Board met on Friday 8 November 2013, and amongst other things considered an update from each of its sub-committees and groups. Item 7e on the agenda was an update on the work of the "Task and finish group on the new CHD review". The Board papers have been available on the NHS England website since 1 November 2013 and the link to the paper is here. The meeting was broadcast live on the internet and a recording will be available shortly on YouTube, with a link from the NHS England website.

News

The new Congenital Heart Disease review: 12th update – John Holden

25 November 2013 - 18:15

Your feedback

In the last couple of weeks we've had a series of face to face meetings with three different engagement groups, which have helped us to understand what's important to them, and how we work together in a way that's challenging, honest, and productive. I gave the same "Update" presentation to all three groups – you can see it here. There will be notes of the meetings in due course and I have given a flavour of each of the three meetings further down this blog. The general point I'd want to make is that every meeting had a mix of general discussion, constructive suggestions and direct criticism – about the current (and previous!) processes, timetable, next steps, weariness, case for change, patient safety, and so on. From our perspective this is invaluable and the challenge now is to use what we've learnt to improve what we do. All three groups said they'd like to meet again in the new year.

One issue that I've been asked to highlight in my blog is the use of pulse oximetry – a simple test on new-borns which can help pick up heart problems that might otherwise go undetected. The National Screening Committee (part of Public Health England) is currently running a consultation on the evidence for using this technique. Although their work is separate from NHS England's review, we're very interested in better detection of heart problems, so I'm drawing this to your attention in case you wish to respond. The link is here to the UK NSC policy on Congenital heart disease screening in newborns. There is a "comments form" to complete, but I'm told by those running the consultation that it's not essential to use this. Responses should be sent to screening.evidence@nhs.net by 13 December.

Patients, families and their representatives

On 12 November Michael Wilson and I attended the Patients & Public Group, which brings together local and national charities. The meeting was chaired by Peter Weissberg from the British Heart Foundation, and NHS England's "Patient Voice" team helped to facilitate the event. I felt that we had a really productive session, in large part because attendees were very open about what they wanted out of it, and what wasn't working for them. The slide pack for the meeting – which includes questions added during the meeting – is attached here. Amongst other things we tried a live twitter feed, which didn't generate a lot of tweets but did give us an insight into how we can reach out beyond the confines of a meeting room in London. We will keep learning from this and other events to help improve our engagement. Bill McCarthy, NHS

England's national policy director, joined us for the group discussion and Q&A. Amongst other things, the Group highlighted:

- Managing the risk of occasional practice – especially (but not only) in the care of adults
- The need for clarity, when setting standards, about the minimum number of cases for surgeons or interventional cardiologists, about case mix (of complexity, and adults/children), and what number of clinicians is required in a centre to ensure safe cover and a resilient service
- The perversity of any proposals which would require patients to travel past a congenital centre to be treated elsewhere – i.e. not for good clinical reasons, but simply to "make up the numbers"
- The potential for "sub specialisation" – whether every centre should undertake every procedure
- What exactly would it mean to have a national congenital heart service operating to national standards?

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The Patient Safety team in NHS England are currently recruiting a number of patient and public voice (PPV) representatives to sit on six Patient Safety Expert Groups and on the national Patient Safety Steering Group. For further information and application packs for these roles please see the Patient Safety First website.

The six Expert Groups are:

- Mental Health
- Primary Care
- Surgical Services
- Children and Young People
- Medical Specialties
- Women's Health

The closing date to apply for either/or both the Steering Group and the Expert Groups is 9am, 2nd December 2013. Interviews for the national Patient Safety Steering Group only will be held on the 9th January 2014.

Clinicians and their organisations

The draft minutes of the Clinical Advisory Panel meeting on 15 October are available here. The minutes will be formally agreed at the next meeting of the Panel.

On 19 November Michael Wilson and I attended the Provider Group, which brings together the Chief Executives or other senior leaders of hospitals providing congenital heart services. The meeting was chaired by Chris Hopson from the Foundation Trust Network. Amongst other things, the Group highlighted:

- Their interest in the substance of the issue (the pattern of service provision) and not just the process of review
- The importance of commissioning services which are sustainable and resilient to events – specifically, but not only, the financial implications.
- Whether all options really are "on the table" and up for debate – for example might one or only a few congenital centres undertake the most complex work?
- The risk of "chronic stagnation" – and therefore the importance of accelerating change where this was appropriate.
- Providers' legitimate desire to help co-design the options for implementing change, without pre-judging the outcome of the review
- The importance of keeping workforce, training and research in mind whilst planning the future pattern of service provision

On 22 November, Michael Wilson and I attended the Clinicians' Group, which brings together clinicians representing English providers of congenital heart surgery or cardiology intervention; Welsh, Scottish and Northern Irish representatives; and relevant professional colleges and societies. The meeting was chaired by Professor Deirdre Kelly who also chairs the work to align service standards. Professor Sir Bruce Keogh, NHS England's national medical director, joined us for the group discussion and Q&A. Amongst other things, the Group highlighted:

- The need to explain simply and persuasively the case for change
- Support for the scope of the review and bringing adults' and children's standards together – but not going "back to square one" on standards which are largely uncontentious
- How will any proposals for change survive the inevitable challenges/objections?
- The need to make rapid progress – surgeons in some centres are under great pressure and yet delivering great results – this is not sustainable
- Reconfiguration has an unavoidable cost (double running etc) – any expectation of "cost neutrality" will be unacceptable
- How to "future proof" the service?

NHS England and other partners

A list of dates of future meetings of the Task & Finish Group, Programme Board, and NHS England's main Board meeting in public, is attached here.

This blog is published fortnightly on a Monday. Planned publication dates are as follows:

- 9 December
- 16 December
- no blog on 30 December due to the Christmas holidays
- 6 January
- 20 January
- etc.

We have been asked whether it would be possible to issue an email alert whenever a new blog is published. We are happy to oblige, but we're conscious that some of you won't want any more emails So, we will compile a mailing list based on our current records, and will send out alerts every fortnight with an option for you to "unsubscribe". If you don't think you're on the mailing list, but you'd like to be, please let us know at england.congenitalheart@nhs.net.

News

The new Congenital Heart Disease review: 13th update – John Holden

10 December 2013 - 13:43

Your feedback

We often get questions about Patient & Public representation on the CHD clinical reference group (CRG). It's become a bit of a *cause celebre* – there is a concern that some people who wished to be patient representatives on this CRG were excluded. This has been investigated, and NHS England is satisfied that there was no process failure and that no applications which had been correctly submitted were overlooked. However, this debate reinforces what we already knew, that patient and public representatives very much want to be involved in the work of NHS England, especially in those clinical reference groups which are dealing with services where major change could result. This was discussed at our recent Programme Board (see below), which includes Mr James Palmer, who is National Clinical Director for Specialised Commissioning, and Giles Wilmore, who is Director for Patient & Public Voice. It was agreed by the Programme Board that for those CRGs where this is a particular issue, we should take the opportunity to strengthen patient and public representation, with eight members rather than the usual four. So, NHS England will shortly announce a process to add another four patient and public members to the existing four on the congenital heart CRG (and the same approach will be adopted on a few other CRGs: Neurosciences; Chemotherapy; and PET-CT).

Patients, families and their representatives

We are holding an event in Birmingham on 8 January to which we are inviting local authorities and local Healthwatch for those areas which currently host a congenital heart centre. The intention is to raise awareness amongst all these authorities and to provide an opportunity for all to discuss and debate. We will be discussing the outline plan for the event in advance, but our working plan is that it should cover the following items:

- Update on the new review – what has been done, what is in plan, what the timelines are and the plan of the year ahead.
- Summary of the outputs from clinical, provider and patient engagement groups, how we are responding to the "difficult issues".
- Opportunity for questions from the floor and identify any items of particular concern for attendees

One of the topics I would like to discuss is the timing of local elections and the implications of "purdah" (restrictions on local authority activity during the pre-election period) for any engagement or consultation that would otherwise take place, since this presents a risk to our review's timetable.

We are making separate arrangements to engage with the wider local authority community in England.

The date of our next Patient & Public Group meeting has been set for **21 January 2014**. Further details to follow.

Clinicians and their organisations

NHS England's analysts have been working on refreshing the data and analysis which underpins our understanding of the services currently being provided, and which may be required in future. I first provided a summary in blog 7 (23 September) and since that time the specification has been refined in the light of feedback from clinicians and others. We have been working with clinicians to define which procedures and diagnoses are relevant and have identified a list of relevant procedures. This work will provide us with a basic data set, including the most recently available data on volume of activity by procedure (for both adults and children, at all providers), and will help shape assumptions about future demand in the light of demographic change, clinical developments and other factors. An update of where we are with this work is attached here, amendments to the original specification have been shown as successive updates to the end of the note so you can follow the trail. This initial analysis is focused on the demand for specialist inpatient congenital heart disease care; at a later stage we will be carrying out a full capacity and impact analysis also. The enclosed slide pack aims to provide an overview of the review's analytical programme. We welcome views from all stakeholders on the proposed analytical work and the procedures and diagnoses in question. If you have any comments on this work please submit them to our email address – england.congenitalheart@nhs.net

On 19 November Michael Wilson and our review's lead analyst Jo Glenwright met representatives of NICOR – the National Institute for Cardiovascular Outcomes Research. NICOR run the Congenital Heart Disease Audit using patient information collected by the Central Cardiac Audit Database (CCAD). NICOR are experts in using this data and producing outcomes analyses. They discussed whether the information collected could be used to further understand the relationship between certain factors and patient outcomes –whether, for example, there is any association between certain outcomes and type of procedure, patient ethnicity, distance from surgical centre, access to related services, and number of procedures carried out by a surgical centre. It was agreed that NICOR would investigate this, but also recognised that there are serious concerns that existing data on patient outcomes is limited, and any analysis could only show association not causality (and there may be some complicated inter-relationships), and the amount of data may be insufficient to give reliable (statistically significant) answers. Given these limits there are risks to be addressed in interpreting any results. The agreed next steps are that NHS England will formally describe the data questions it is most interested in, and NICOR will

respond. We will publish our formal request to NICOR, their response, and any subsequent analysis.

The date of our next Provider Group meeting has been set for **15 January 2014**. The date of the next Clinicians' Group meeting has been set for **30 January 2014**. Further details on both meetings to follow.

NHS England and other partners

The new CHD review Programme Board met on 13 November; a DRAFT note of the meeting is here. The note will remain draft until ratified at the next Programme Board meeting (due 16 December).

MPs and peers (members of the House of Lords) ask questions of health ministers, and the answer (or the transcript when there is a debate) is published in Hansard. See here for a question relating to the new CHD review which was answered recently.

We are now overdue publishing the notes of one or two of our recent meetings. I want to avoid any excess delay so I will produce a short blog next week (Monday 16 December) to sweep up any outstanding items, so you have something to read whilst roasting chestnuts over an open fire etc. There will then be no further blog in December but I will resume again in January – most likely on 13 January (this is a change from earlier plans).

News

The new Congenital Heart Disease review: 14th update – John Holden

17 December 2013 - 15:06

Your feedback

Thank you for your comments, questions and challenges about the review during 2013, all of which have been gratefully received.

As promised last week, this is just a short blog to publish a few things that are overdue and I didn't want to leave until the new year. In particular, there are notes of the three engagement meetings we held, with our patient and public group, our clinicians group, and our providers group (see separate items below). To help make sense of the different discussions, we have also produced a draft summary which draws out some of the common themes.

Patients, families and their representatives

I wrote to the Chair of the Health Scrutiny Commission for Lincolnshire, and to the Chair of Yorkshire and Humber Joint Health Overview & Scrutiny Committee, to provide each with a short update on the progress of the review. This update was instead of me attending their meetings in person again, which they had requested. Copies of the correspondence are here – Lincolnshire: 31 Oct, Lincolnshire: 20 Nov and here – Yorkshire & Humber: 09 Dec, Yorkshire & Humber: 10 Dec

On 12 November 2013 Bill McCarthy, Michael Wilson and I attended the Patients & Public Group – a draft note of the meeting is here.

Clinicians and their organisations

On 19 November 2013 Michael Wilson and I attended the Provider Group – a draft note of the meeting is here.

On 22 November Bruce Keogh, Michael Wilson and I attended the Clinicians' Group – a draft note of the meeting is here.

The next meeting of the Clinical Advisory Panel is scheduled for Wednesday 18 December 2013 and the agenda and papers for the meeting are enclosed.

NHS England and other partners

I enclose a draft note of the Task & Finish Group which took place on 29 October 2013. The note will remain draft until it is agreed when the Group meets again in January.

Leicester
City Council

SECOND DESPATCH

HEALTH AND WELLBEING SCRUTINY COMMISSION
14 JANUARY 2014

ITEM OF URGENT BUSINESS

Further to the agenda for the above meeting which has already been circulated, please note the following:-

15. ANY OTHER URGENT BUSINESS

As the issue to which the following question relates arose too late for inclusion in the agenda for this meeting, the Chair has agreed to consider it under Any Other Urgent Business:

Councillor Singh submits the following question:-

“Will the Chief Executive of University Hospitals of Leicester NHS Trust make a full statement to this Commission on the financial position affecting the current budget of UHL, the organisational fiscal controls in place and the steps undertaken to support the budget deficit to safeguard the current and future health service provisions to patients and the public.”

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