Leicestershire County Council

HEALTH AND WELLBEING BOARD: 5 DECEMBER 2013

POSITION STATEMENT BY THE CHAIRMAN

Local Health and Care Economy Matters

1. Matters affecting local services include two key quality and performance issues:
   - The performance of the local emergency care system including A+E performance at University Hospitals of Leicester;
   - The implementation of the quality improvement programme for adult mental health services in response to the Care Quality Commission Warning Notices issued to Leicestershire Partnership Trust in July.

2. Both of these matters are the subject of escalation with local commissioners, NHS England and the Trust Development Authority. In the case of emergency care, a weekly oversight meeting is in place chaired by NHS England dealing with operational delivery of the agreed actions to improve and sustain performance across the urgent care system. In the case of the Bradgate Unit, a multi-agency Assurance and Oversight Group remains in place while further assurance is received (e.g. pending the outcome of the CQC follow up visit and the delivery of agreed priority areas in the quality improvement programme).

3. It is anticipated that the outcome of the CQC's follow up inspection at the Bradgate Unit will be published in early December. Meanwhile UHL has been selected as one of the next group of acute Trusts to undergo the new Chief Inspector of Hospitals inspection.

4. In addition to the above matters, members of the Board should also note that
   - The planned consultation in relation to the Community Services in Ashby will now take place between January and March 2014;
   - The planned consultation in relation to Minor Injury and Illness services in East Leicestershire and Rutland is scheduled to run between February and April 2014.
   - Winter plans have been submitted in the last month by all local NHS agencies. UHL's board report on this matter in October suggested on the basis of recent bed modelling there is there is a shortage of acute medical beds of around 74, with 26 too few assessment beds.

     Following the modelling work, UHL are increasing assessment beds at LRI by 16 beds and expanding the respiratory beds at Glenfield for winter period by 15.

Additional Community Support is being put in place from October, this should increase capacity to manage up to 40 additional patients at home as well as an additional 24 patients in community hospital beds

Integration and Planning for 2014/15 – 2015/16

5. Recommended Reading– the **King's Fund Integrated Care Bulletin** – sign up to receive this and other health and wellbeing resources at http://www.kingsfund.org.uk/forms/get-latest-news-fund

6. Since the last meeting of the Health and Wellbeing Board the first **Integration Pioneers** have been announced by the government. A listing of the successful submissions and the key elements of their proposals, which focus on how to provide more coordinated care around the needs of patients across a wide range of health and social care services, can be found at this weblink.https://www.gov.uk/government/news/integration-pioneers-leading-the-way-for-health-and-care-reform--2

7. On October 17 2013 NHS England issued correspondence entitled "next steps on implementation the **integration transformation fund** which described in more detail the composition/sources of the fund and how it will be distributed, along with the conditions on which the fund will be allocated, e.g. the local evidence required and the intent to award some of the fund based on performance indicators. http://www.local.gov.uk/documents/10180/5572443/Next+steps+on+implementing+the+Integration+Transformation+Fund/4e797e4b-0f1a-4d53-a87d-6a384a86792d

8. Subsequently a **joint planning letter** has been issued by Monitor, the Trust Development Authority, NHS England and the Local Government association (http://www.hsj.co.uk/Journals/2013/11/12/m/z/q/4-Nov-2013-Joint-planning-letter.pdf) which indicates that all elements of the health and care system will be expected to produce a 2 year view of their "annual" plans by the end of March 2014. The intention is that these fit together as integrated plans across the local health and care system and they will need to include, amongst many other policy elements, the implications of the 2015/16 integrated transformation fund, which local authority and NHS commissioners have to tackle in advance, as part of this year's planning round.

9. NHS England has confirmed that CCGs need to join together to plan across a larger population base than an individual CCG area, which in the case of our local position is the Leicester, Leicestershire and Rutland health and care economy, per our existing Better Care Together arrangements.

10. A refreshed **NHS Mandate** has also been published in November for the period 2014/15 – 2015/16 and a separate paper is provided as part of the Board's agenda today summarising the implications of this document.

11. **Healthwatch Leicestershire have published a response to the Mandate** which is accessible at this weblink :-

http://www.healthwatchleicestershire.co.uk/about/docs/healthwatch-leicestershire-response-government-nhs-mandate

Government Response to the Francis Report

12. On November 19 the government published a response to the inquiry into the care failings at Mid Staffordshire Hospital, partially accepting all but nine of the recommendations of the Francis Report.

13. Three of the rejected recommendations relate to the regulation of healthcare assistants. The government has also decided against adopting in full Francis's recommendations in relation to a statutory duty of candour and making it a criminal offence to obstruct healthcare professionals from exercising a duty of candour, as recommended by Mr Francis.
14. However, the government plans to address both of these issues by strengthening professional codes of conduct.

15. The response confirms the government's plans to press ahead with a scheme to prevent failed managers from working in health and social care again. The Care Quality Commission will police a fit and proper persons test and get new powers to investigate whether an individual is fit to hold a director level position.

    A full statement on the announcement and its implications can be found at Appendix 1

"A review of the hospitals complaints system, putting patients back in the picture"

16. This review was commissioned by the Prime Minister and Secretary of State for Health, Jeremy Hunt, after the Francis report into care failings at Mid Staffordshire NHS Trust The review was co-chaired by the Rt. Hon Ann Clwyd MP and Professor Tricia Hart, Chief Executive, South Tees Hospitals NHS Foundation Trust and examined how complaints about care in NHS hospitals made by patients, their carers and representatives are listened to and acted on by hospitals.

17. The review included holding 8 engagement events and providing email and telephone access to submit evidence from which 2,500 responses were received. The majority described problems with the quality of treatment or care in NHS acute hospitals. The review panel also heard from people who had not complained because they felt the process was too confusing or they feared for their future care. While the review concentrated on acute care the themes and issues are relevant to other care settings. The recommendations cover 4 main themes
    - improving the quality of care
    - improving the way complaints are handled
    - ensuring greater independence in the complaints procedures
    - whistleblowing

A more detailed breakdown of the recommendations and action proposed for NHS organisations and their Boards is given at Appendix 2.

Full report at this weblink:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/255615/NHS_complaints_accessible.pdf

The New GP Contract

18. Agreement has been reached between the BMA's General Practitioners Committee (GPC) and NHS Employers (on behalf of NHS England) on changes to the General Medical Services contract for 2014/15. Key changes include:
    - Named GP for over 75s
    - GPs to get more responsibility for out of hours (oversight not provision)
    - Reduced emergency admissions to replace quality and productivity indicator in Quality Outcomes Framework (QOF)
    - £290m of QOF pay to be diverted to core GP contract
    - Choice of GP practice from October 2014
    - Friends and family test to be rolled out to GP practices (mandatory)
    - Practices must offer access to patient records and other online services from April 2014
    - GP seniority pay scheme to be phased out

    Appendix 3 provides a more detailed briefing of the changes – source is by Primary Care Commissioning www.pcc-cic.org.uk

Reforming Urgent and Emergency Care

19. In January 2013 NHS Medical Director Professor Sir Bruce Keogh announced a comprehensive **review of the NHS urgent and emergency care system** in England. Stage 1 of this review has now concluded with the publication of this report in mid-November.http://www.nhs.uk/NHSEngland/keogh-review/Documents/UECR.Ph1Report.FV.pdf

20. The report proposes a new blueprint to make care more responsive and personal for patients, as well as deliver better clinical outcomes and enhanced safety. In the report, Keogh characterises the current system as follows:
    - Under "intense, growing and unsustainable pressure," driven by rising demand from a population that is getting older;
    - A confusing and inconsistent array of services outside hospital;
    - High public trust in the A&E brand;
    - 40 per cent of A&E patients are discharged requiring no treatment;
    - Up to one million emergency admissions were avoidable last year;
    - Up to 50 per cent of 999 calls could be managed at the scene;
    - When treating two of the nation's two biggest killers – heart attacks and strokes –survival rates have improved significantly by taking patients to specialist centres.

21. The proposals which are intended to be delivered over a 3- 5 year period will create two distinct “streams” of care and redesign services nationally to better serve these streams:

22. For those people with urgent but non-life threatening needs provide highly responsive, effective and personalised services outside of hospital. These services should deliver care in or as close to people’s homes as possible, minimising disruption and inconvenience for patients and their families.

23. For those people with more serious or life threatening emergency needs we should ensure they are treated in centres with the very best expertise and facilities in order to maximise their chances of survival and a good recovery.

24. Phase two of the review will focus on developing the proposals further and testing the assumptions about clinical standards, skill mix/workforce and finances/commissioning. A further report will be published in the Spring of 2014.

Reconfiguration in the NHS

25. A useful briefing has been developed by healthcare expert legal advisers Mills and Reeve which examines the challenges commissioners and their partners face in progressing proposals to reconfigure NHS services, in particular with regard to the duty to consult and potential for legal challenge. A copy can be found at this weblink

    http://www.mills-reeve.com/files/Publication/1c71458e-6a71-4b88-95df-a7a575500263/Presentation/PublicationAttachment/f3a0da0b-1fbd-4081-952d-b51f14505974/Reconfiguring%20services%20briefing_October%202013.pdf

Report from the King’s Fund “Health and wellbeing boards: one year on”

26. Health and wellbeing boards have made good progress in establishing themselves but face a critical year which could define whether they develop into system leaders or are relegated to a side show according to The King’s Fund second survey of boards. This report, based on a survey of nearly half of the 152 health and wellbeing boards, shows that local authorities have brought strong leadership to establishing the Boards and report good relationships with CCGs. Most have prioritised public health inequalities allaying concerns about the transfer of this remit to local authorities. However, there is little sign they have begun to grapple with immediate issues such as reconfiguration and integrated care with the latter only mentioned by 9 respondents. Access the Report at this link.

New Self-Assessment Tools for Health and Wellbeing Boards

Assessing Joint Health and Wellbeing Strategies

27. A new tool for health and wellbeing boards to self-evaluate their local Joint Health and Wellbeing Strategy (JHWS) contains ten questions boards can use to test to see if their strategy meets the highest standards of good practice.
http://www.nhsconfed.org/priorities/latestnews/Pages/practical-new-tool-for-health-and-wellbeing-boards-launched.aspx

Assessing the overall performance and maturity of health and wellbeing boards.

28. Health and Wellbeing Boards are challenged to develop complex and innovative approaches that require new ways of working. This online tool is just part of the national development “offer” to councils and will help ensure that boards are performing at the highest possible standard." The self-assessment tool will help boards to assess their performance and develop plans to transform services and outcomes for local people. It offers HWBs an opportunity to evaluate their position using a maturity model, describing characteristics of a ‘young', ‘established', ‘mature' and ‘exemplar' HWB, against six dimensions for an effective partnership.
http://www.local.gov.uk/documents/10180/11493/Health+and+wellbeing+system+improvement+programnme+development+tool+-+September+2013/e1acf67f-6be8-4a99-90b5-45ecec4d11e9

APPENDIX 1

GOVERNMENT ANNOUCEMENT ON THE RESPONSE TO THE INQURY INTO CARE FAILINGS AT MID STAFFORDSHIRE FOUNDATION TRUST

STATEMENT: NEW ERA FOR PATIENTS AND NHS AS GOVERNMENT ACCEPTS RECOMMENDATIONS OF MID STAFFORDSHIRE INQUIRY

More openness, greater accountability and a relentless focus on safety will be the cornerstones of an NHS which puts compassion at its heart, Health Secretary Jeremy Hunt announced today. The plans, set out in the Government's response to the Inquiry into the failings at Mid Staffordshire NHS Foundation Trust, build on the cultural change already taking place in the wake of the hospital scandal.

The Government has already instigated a number of changes following the Inquiry's report published in February, most notably introducing a new hospital inspection regime and legislating for a *duty of candour* on NHS organisations so they have to be open with families and patients when things go wrong.

Today's response builds on this and sets out a detailed response not only to the Inquiry but also to five expert independent reports on safety, complaints, bureaucratic burdens, support workers and trusts with the worst mortality rates. The response also comes as new figures show that, following the Inquiry's report and Government action to date, hospitals are already planning to hire more than 3,700 extra nurses over the coming months.

Key proposals for consultation to be announced today would see all NHS organisations and professional staff obligated to be open with patients when things go wrong. If a hospital had not been open with patients and their families following a patient safety incident, its indemnity cover for that compensation claims could be reduced or removed. This would give a strong financial incentive to hospitals to be open about patient safety incidents.

Similarly, the General Medical Council, the Nursing and Midwifery Council and the other professional regulators will introduce a new explicit and consistent professional duty of candour for doctors, nurses and other health professionals, making clear a requirement to be open with patients and families, whether the incident is serious or not. Health professionals will have to be candid with patients about all avoidable harm and the guidance will make clear that obstructing colleagues in being candid will be a breach of their professional codes. Speaking up quickly may also be considered to be a mitigating factor in a conduct hearing and this will further encourage individual candour. Inspired by normal practice in the airline industry, "near misses" of serious harm will also be subject to a professional duty of candour, fostering an NHS culture in which reporting and learning from mistakes is the norm.

Health Secretary Jeremy Hunt said: "I do not simply want to prevent another Mid Staffs. I want our NHS to be a beacon across the world not just for its equity, but its excellence. I want it to offer the safest, most compassionate and most effective care available anywhere - and I believe it can. Today's measures are a blueprint for restoring trust in the NHS, reinforcing professional pride in NHS frontline staff and

above all giving confidence to patients. I want every patient in every hospital to have confidence that they will be given the best and safest care and the way to do that is to be completely open and transparent."

New changes in response to the independent recommendations include:

- **Safe staffing:** from next April, all hospitals will publish staffing levels on a ward-by-ward basis together with the percentage of shifts meeting safe staffing guidelines. This will be mandatory and will be done on a monthly basis. By the end of next year this will be done using models approved independently by NICE.
- **Boards will review the evidence for their staffing numbers in public** at least once every six months.
- **A new national safety website** will publish all the information relevant to safety in every hospital in the country on a monthly basis, so that patients have the same information about their hospitals that the system has.
- **A new national patient safety programme** across England will spread best practice and build safety skills across the country. NHS England will start the programme in April 2014 and will bring together frontline teams, experts, patients, commissioners and others to tackle specific patient safety problems, develop and test solutions, and learn from each other to improve safety.
- **Five thousand *patient safety fellows*** will be trained and appointed by NHS England within five years, to be champions, experts, leaders and motivators in patient safety. The fellows could be anyone, from a frontline nurse to a senior manager, who has demonstrated a commitment to and success in delivering quality improvement.
- **Quarterly complaints reporting and better complaints information:** Trusts will report quarterly on complaints data and lessons learned and the Health Service Ombudsman will increase significantly the number of cases she considers. In addition, all hospitals will be required to set out clearly how patients and their families can raise concerns or complain, with independent support available from their Healthwatch or alternative organisations.
- **Better reporting of safety incidents:** Experts will be asked to advise the Government on how to improve reporting of safety incidents, including whether the statutory duty of candour on organisations should cover incidents of death and severe harm, or death, severe and moderate harm.
- **A new criminal offence for wilful neglect:** the Government will legislate at the earliest available opportunity to make it an offence to wilfully neglect patients - so that organisations and staff, whether managers or clinicians, responsible for the very worst failures in care are held accountable.
- A new **Fit and Proper Person's Test** which will enable the Care Quality Commission to bar unsuitable senior managers who have failed in the past from taking up individual posts elsewhere in the system.
- **Time to care:** Every national NHS organisation has signed a compact to reduce the national bureaucratic burden on frontline organisations and frontline staff dramatically, freeing up hospitals to focus on their local populations and freeing up time for staff to care for patients.
- A new **Care Certificate** to ensure that Healthcare Assistants and Social Care Support Workers have the fundamental training and skills needed to give good personal care to patients and service users. The Chief Inspectors will

ensure that employers are using the Disclosure and Barring Service to prevent unsuitable staff from being re-employed elsewhere.

- **Every hospital patient should have the names of a responsible consultant and nurse above their bed.** And as announced last week as part of the agreement with GPs, starting with over-75s from next April, there will be a named accountable clinician for out-of-hospital care for all vulnerable older people.

In total, the Government has accepted 281 out of 290 recommendations; including 57 in principle and 20 in part (meaning the recommendation has been accepted with some differences or new ideas relating to how it will be delivered). Progress against the report as a whole will now be reported to Parliament on an annual basis to ensure rapid progress against delivering the recommendations.

NOTES TO EDITORS

Explore the recommendations in full and government response to each at: http://francisresponse.dh.gov.uk/

Since the initial response to the inquiry in March, progress includes:

- The Care Quality Commission has appointed three **Chief Inspectors** of hospitals, adult social care and primary care.
- In the Care Bill, the Government has introduced **a new criminal offence for care providers that supply or publish certain types of information that is false or misleading**. This offence will also apply to directors and senior managers where an organisation has committed the offence, rather than just organisations.
- **Expert inspections of hospitals with the highest mortality rates**, led by the NHS Medical Director, revealed unacceptable standards of care. Eleven hospitals were placed into 'special measures' **to put them back on a path to recovery and then to excellence**.
- Inspection of eighteen Trusts has begun, and will be completed by Christmas. By the end of 2015 the CQC will have inspected all acute Trusts.
- The Care Quality Commission has consulted on a **new system of ratings** with patient care and safety at its heart.
- Legislation to introduce a responsive and effective **failure regime** which looks at quality as well as finance is progressing through Parliament.
- The Government is legislating to give **greater independence to the Care Quality Commission.**
- The Care Quality Commission has conducted a major consultation on a new set of **fundamental standards:** the inviolable principles of safe, effective and compassionate care that must underpin all care in the future.
- The **fundamental standards will enable prosecutions of providers** to occur where patients have been harmed because of unsafe or poor care, without the need for an advance warning notice. This will ensure that the current regulatory gap identified in the Inquiry is filled.
- NHS England has published guidance to commissioners, *Transforming Participation in Health and Care*, on **involving patients and the public** in decisions about their care and their services.

- The **Health and Safety Executive** has brought a prosecution against Mid Staffordshire Foundation Trust for the death of a patient during the period of the failings at the Trust. This case is awaiting sentence.
- For the first time, NHS England has **published clinical outcomes by consultant** for ten medical specialties and has also begun to publish data on the Friends and Family Test.
- **New nurse and midwifery leadership programmes** have been developed from which 10,000 nurses and midwives will have benefitted by April 2015. *Compassion in Practice* has an action area dedicated to building and strengthening leadership.
- **New approaches to nurse training,** where nurses work as healthcare assistants, are being piloted.
- A new fast-track **leadership** programme to recruit clinicians and external talent to the top jobs in the NHS in England has been launched, including time spent at a world-leading academic institution.
- By the end of the year, 96 per cent of **senior leaders and all Ministers at the Department of Health will have gained frontline experience in health and care settings**.

In addition to the Francis Inquiry the government has responded to the following independent reports:

- *Review into the Quality of Care and Treatment Provided by 14 Hospital Trusts in England,* led by Professor Sir Bruce Keogh, the NHS Medical Director in NHS England.
- *The Cavendish Review: An Independent Review into Healthcare Assistants and Support Workers in the NHS and Social Care Settings*, by Camilla Cavendish.
- *A Promise to Learn – A Commitment to Act: Improving the Safety of Patients in England*, by Professor Don Berwick.
- *A Review of the NHS Hospitals Complaints System: Putting Patients Back in the Picture* by Rt Hon Ann Clwyd MP and Professor Tricia Hart.
- *Challenging Bureaucracy*, led by the NHS Confederation.

APPENDIX 2

FULL LIST OF RECOMMENDATIONS FROM THE NHS COMPLAINTS REVIEW

Theme 1 - Improving the Quality of Care

- Staff providing basic care should be adequately trained, supported and supervised. Action: Trusts, professional bodies and representative organisations, HEE, clinical leaders and managers.

- There should be annual appraisals linked to the process of medical revalidation which focus on communication skills for clinical staff and dealing with patient concerns positively. This goes hand in hand with ensuring that communication skills are a core part of the curriculum for trainee clinical staff. Action: HEE, professional bodies and representative organisations, clinical leaders and managers.

- Trusts should ensure that there is a range of basic information and support available on the ward for patients, such as a description of who is who on the ward and what they do; meal times and visiting times; and who is in charge of care for the patient. Care should be taken to ensure that differences in language, culture and vulnerability are taken account of in this. Action: Trusts, clinical leaders and managers, clinicians and practitioners

- Patients should be helped to understand their care and treatment. While written information is helpful, it is always important to discuss diagnoses, treatments and care with a patient. Patients frequently need to revisit topics already addressed. Where appropriate, their relatives, friends or carers may be included in discussions. Action: Trusts, professional bodies and representative organisations, HEE, clinical leaders and managers, clinicians and practitioners, patients.

- Trusts should provide patients with a way of feeding back comments and concerns about their care on the ward including simple steps such as putting pen and paper by the bedside and making sure patients know who to speak to if they have a concern – it could be a nurse or a doctor, or a volunteer on the ward to help people. Action: Trusts, education and training organisations, clinical leaders and managers, clinicians and practitioners, patients.

- Hospitals should actively encourage volunteers. Volunteers can help support patients who wish to express concerns or complaints. This is particularly important where patients are vulnerable or alone, when they might find it difficult to raise a concern. Volunteers should be trained. Action: Trusts, volunteer organisers

Recommendations for Trusts and Boards

- Trust Chief Executives and Board members should be supported so they have the necessary skills in effective communication, seeking and using patient feedback, routinely throughout their organisation and are equipped to ensure their organisation learns from that feedback. Action: NHS Leadership Academy and NHS Confederation.

- PALS should be re-branded and reviewed so it is clearer what the service offers to patients and it should be adequately resourced in every hospital. Action: DH.

- Every Trust should ensure any rebranded patient service is sufficiently well sign-posted and promoted in their hospital so patients know where to get support if they want to raise a concern or issue. Action: Trusts.

- The CQC should include complaints in their hospital inspection process and analyse evidence about what the Trust has done to learn from their mistakes. Action: CQC.

Theme 2 - Improvements in the way complaints are handled

- Attention needs to be given to the development of appropriate professional behaviour in the handling of complaints. This includes honesty and openness and a willingness to listen to the complainant, and to understand and work with the patient to rectify the problem. Action: Trusts, professional bodies and representative organisations, clinical leaders and managers, clinicians and practitioners.

- Staff need to record complaints and the action that has been taken and check with the patient that it meets with their expectation. Action: Trusts, professional bodies and representative organisations, education and training organisations and clinical leaders and managers, clinicians and practitioners.

- Complaints are sometimes dealt with by junior staff or those with less training. Staff need to be adequately trained, supervised and supported to deal with complaints effectively. Actions: Trusts, education and training organisations, clinical leaders and managers.

- There should be NHS accredited training for people who investigate and respond to complaints. Action: Trusts, HEE.

- 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. Action: Trusts, HEE, clinicians and practitioners.

- It needs to be clearly stated how whistle-blowers are to be protected and gagging clauses should not be allowed in staff contracts. Action: DH.

- The development of the 'cultural barometer' should continue. This will determine if a workplace is suffering from a problem with staff attitudes or organisational approach. Action: NHS England and DH.

- The independent NHS Complaints Advocacy Service should be re-branded, better resourced and publicised. It should also be developed to embrace greater independence and support to those who complain. Funding should be protected and the service attached to local HealthWatch organisations. Action: Local Authorities.

- HealthWatch England should continue to bring together patients and representative groups, and lead the Healthwatch network in the public campaign to improve complaints' systems in health and social care. Some funding should be made available to help organisations to participate fully in this important work. Action: Healthwatch England, DH.

Recommendations for Trusts and Boards

- 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. Action: Trusts.

- 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. These reports should be available to the Chief Inspector of Hospitals. Action: Trust Chief Executives and Boards.

- There should be a new duty on all Trusts to publicise an annual complaints' report, in plain English, which should state what complaints have been made and what changes have taken place. Action: DH.

- 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. Action: Trusts.

- Where complaints span organisational boundaries, the Trusts involved should adhere to their statutory duty to cooperate so they can handle the complaint effectively. Action: Trusts.

- Further work should be done to explore how we look for the right skills in the recruitment of Chief Executives and Board members. They need to be capable of ensuring that their Trust is a learning organisation. Action: NHS Leadership Academy.

- Commissioners and regulators should establish clear standards for hospitals for complaints handling. These should rank highly in the audit and assessment of the performance of all hospitals. Action: CCGs, CQC.

- There should be proper arrangements for sharing good practice on complaints handling between hospitals, including examples of service improvements which result from action taken in response to complaints. Action: DH, Trusts.

- Regulators and the PHSO should work more closely to co-ordinate access for patients to the complaints system, and to detect failings in clinical or other professionals or Trusts. Action: PHSO.

- We welcome the ongoing discussions on making a Duty of Candour a statutory requirement and recommend that a Duty of Candour is introduced. Action: DH.

Theme 3 - Greater Independence in the Complaints Process

- Hospitals should offer a truly independent investigation where serious incidents have occurred. Action: Trusts.

- 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. Action: Trusts.

- Patient services and patient complaints support should remain separate so patients do not feel they have to go through PALS first before they make a complaint. Action: Trusts.

- Patients, patient representatives and local communities and local HealthWatch organisations should be fully involved in the development and monitoring of complaints systems in all hospitals. Action: Trusts.

- Board level scrutiny of complaints should regularly involve lay representatives. Action: Trusts.

Theme 4 Whistle-Blowing

- Clear guidance for staff on how they should report concerns, including access to the Chief Executive on request. Action: DH.

- A board member with responsibility for whistle-blowing should be accessible to staff on a regular basis. Action: Trusts.

- A legal obligation to consider concerns raised by staff, and to act on them if confirmed to be true. Action: Trusts.

- In assessing the complaints systems of hospitals the CQC should investigate the ease with which staff can express concerns and how whistleblowing is responded to where it has taken place. Action: CQC.

- The CQC itself should designate a board-member with specific responsibility for whistleblowing, and ensure that it acts on intelligence received from whistle-blowers. Action: CQC.

APPENDIX 3

BRIEFING ON THE CHANGES TO THE GP CONTRACT FROM 2014

More personal care for older people and those with complex health needs

Named, accountable GP for people aged 75 and over - as part of a commitment to more personalised care for patients with long-term conditions, all patients aged 75 and over will have a named, accountable GP with overall responsibility for their care.

Out-of-hours services - there will be a new contractual duty to monitor and report on the quality of out-of-hours services and support more integrated care, e.g. through record sharing.

Reducing unplanned admissions - there will be a new enhanced service to improve services for patients with complex health and care needs and to help reduce avoidable emergency admissions. This will replace the Quality and Outcomes Framework (QOF) quality and productivity domain and the current enhanced service for risk profiling and care management and will be funded from the resources released from these two current schemes. The key features of the scheme will be for GP practices to:

- Improve practice availability, including same-day telephone consultations, for all patients at risk of unplanned hospital admission
- Ensure that other clinicians and providers (e.g. A&E clinicians, ambulance services) can easily contact the GP practice by telephone to support decisions relating to hospital transfers or admissions
- Carry out regular risk profiling, with a view to identifying at least two per cent of adult patients – and any children with complex needs – who are at high risk of emergency admissions and who will benefit from more proactive care management
- Provide proactive care and support for at-risk patients through developing, sharing and regularly reviewing personalised care plans and by ensuring they have a named accountable GP and care coordinator
- work with hospitals to review and improve discharge processes;
- undertake internal reviews of unplanned admissions/readmissions.

QOF (Quality Incentive Scheme) reform - a number of indicators will be retired from the clinical (worth 185 points), public health (33 points) and the patient experience (33 points) domains. Most of the funding released – around £290m - is to be reinvested into weighted capitation (“global sum”) payments.GP practices are expected to continue to provide the relevant interventions, where clinically appropriate, but they will have greater scope, working with patients and carers, to flex care to meet the needs of individual patients. NHS England will continue to collect and publish data, where possible, on the relevant interventions and outcomes in order to support practices in promoting ongoing quality improvement.

QOF thresholds - the QOF threshold increases that were previously due from April 2014 will be deferred for one year to allow a stronger focus on implementing the new arrangements for more proactive care management.

Remote care monitoring - this enhanced service will cease from 31 March 2014 and the associated funding recycled into global sum payments. Remote care monitoring will continue to be promoted in other ways.

Empowering patients and the public

Choice of GP practice - from October 2014, all GP practices will be able to register patients from outside their traditional boundary areas without a duty to provide home visits. Area teams will need to arrange in-hours urgent medical care when needed at or near home for patients who register with a practice away from home.

Friends and family test - there will be a new contractual requirement from December 2014 for practices to offer all patients the opportunity to complete the friends and family test and to publish the results.

Patient online services - GP practices will be contractually required from April 2014 to promote and offer patients the opportunity to book appointments online, order repeat prescriptions online and gain access to their medical records online. The current enhanced service for patient online services will cease and the associated funding transfer into global sum payments.

Extended opening hours - the extended hours enhanced service will be adapted to promote greater innovation in how practices offer extended access.

Patient participation - the patient participation enhanced service will be adapted to promote greater innovation in how practices seek and act on patient insight and feedback, including the views of patients with mental health needs.

Transparency of GP earnings - the GPC will join a working group with NHS England and NHS Employers to develop proposals on how to publish – from 2015/16 onwards – information on GPs' net earnings relating to the GP contract (with the first published data based on 2014/15 earnings). Publication of this information will be a future contractual requirement.

Fairer funding

Giving greater weight to deprivation factors - work is ongoing between the GPC and NHS Employers to identify whether it is possible to update the existing deprivation factors in the Carr-Hill formula from April 2014 to ensure that the formula reflects the most up to date information on deprivation and to develop changes to the formula to be implemented from April 2015 to give greater weight to deprivation.

Seniority pay - the seniority pay scheme will be closed to new entrants from 1 April 2014 and will be abolished entirely from 1 April 2020. Current expenditure will be reduced using a phased approach, reinvesting the released resources into global sum payments. NHS England and the GPC will monitor the funding released during 2014/15 and will agree how to reduce funding by 15 percent a year in light of their findings.

MPIG - As planned, from April 2014 MPIG payments will be reduced by one-seventh every year for the next seven years, with funding recycled into global sum

payments. Separate arrangements are to be put in place for area teams to review their outlier practices.

Other improvements to quality of patient care

Diagnosis and care for people with dementia - the existing enhanced service will be changed to promote more personalised care planning and allow greater professional judgement in which patients should be offered assessment to detect possible dementia.

Annual health checks for people with learning disabilities - the scope of this service will be extended to young people aged 14-17, to support transition to adulthood and to introduce health action planning.

Alcohol abuse - the existing enhanced service will be changed to incorporate additional assessment for depression and anxiety.

Information sharing - from 1 April 2014 GP practices will be contractually required to:

- Include the NHS number as the primary patient identifier in all clinical correspondence
- Provide an automated upload of their summary information on at least a daily basis to the summary care record, or have a published plan in place to achieve this by 31 March 2015
- Use the GP2GP facility to transfer patient records between practices, or have a published plan in place to achieve this by March 2015

NHS Employers and the GPC have agreed joint work during 2014/15 to review how to deliver consistent access to the detailed patient record for other care providers, e.g. out of hours, A&E and NHS 111.

PMS contracts - area teams are being encouraged to reflect the changes, as appropriate, in local PMS agreements to promote an equitable approach across all practices, once the relevant changes to legislation and guidance are in place.

Annual contract uplift - decisions on uplift will be made following recommendations from the Doctors and Dentists Pay Review Body in February 2014.

Further information - the NHS Employers website www.nhsemployers.org/gms provides details of the agreement documents and will in due course contain implementation guidance. The Department of Health is preparing the necessary amendments to legislation and, when finalised, these will be published on the NHS England website.

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