All PSNC members can attend this meeting and may speak with the permission of the Chairman.

PSNC Service Development Subcommittee Agenda

for the meeting to be held on Tuesday 14th May 2013

at Old England Hotel and Spa, Bowness on Windermere, Cumbria, LA23 3DF

starting at 3.30pm

Members: Stephen Banks, David Evans, Elisabeth Hopkins, Indrajit Patel, Adrian Price, Alan Robinson, Omar Shakoor, Gary Warner (Chairman)

1. Apologies for absence

Apologies for absence have been received from Adrian Price.

2. Minutes

The minutes of the meeting held on 12th March 2013 were shared with the subcommittee and are available to download from PSNC's website.

3. Matters arising

4. Work Plan

The 2013 work plan is set out at **Appendix SDS 02/05/13** for consideration by the subcommittee.

ACTION / RATIFICATION

5. Development of future medicines optimisation services

The Royal Pharmaceutical Society (RPS) published 'Medicines Optimisation: helping patients make the most of medicines' at the start of May. This guidance provides four guiding principles to help front-line professionals in England support patients to improve their quality of life and outcomes from better use of medicines:

1. aim to understand the patient's experience;
2. make sure choice of medicine is made on the best available evidence;
3. ensure medicines use is as safe as possible; and
4. make medicines optimisation part of routine practice.

The principles have been developed with health professionals, patients, lay representatives and patient groups, and importantly they are endorsed by NHS England, the Academy of Medical Royal Colleges, the Royal College of General Practitioners, the Royal College of Nursing and the Association of the British Pharmaceutical Industry.

NHS England will be developing a medicines optimisation strategy over the coming months, which will be led by Clare Howard, Deputy CPhO, at NHS England. It is likely that the RPS principles will be used by NHS England as its starting point in the development of its medicines optimisation strategy.

Alastair Buxton will give a presentation on options for the future development of community pharmacy medicines optimisation services, following which the subcommittee will be asked to provide their thoughts and views on the best options to pursue in the short term.

6. Dementia

The Prime Minister has set out his Dementia challenge to accelerate delivery of major improvements in dementia care and research by 2015. This year the focus is on action to improve dementia awareness, with a commitment to change being encouraged by all healthcare providers and professionals. DH has been asked to explore how pharmacy might engage in the dementia awareness programme and their potential role in dementia.

The subcommittee is asked to consider the information and questions set out in **Appendix SDS 03/05/13**.

7. The Francis Report – implications for community pharmacy

At the end of March 2013 DH published their initial response to the Francis Report – 'Patients First and Foremost'. The document sets out a collective commitment and plan of action for the whole health and care system and everyone who works in it. Actions set out in the document include:

- new Ofsted-style ratings for hospitals and care homes overseen by an Independent Chief Inspector of Hospitals and Chief Inspector of Social Care;
- a statutory duty of candour for organisations which provide care and are registered with the Care Quality Commission;
- a review by the NHS Confederation on how to reduce the bureaucratic burden on frontline staff and NHS providers by a third;
- a pilot programme which will see nurses working for up to a year as a healthcare assistant as a prerequisite for receiving funding for their degree; and
- nurses' skills being revalidated, as doctors' are now, and healthcare support workers and adult social care workers having a code of conduct and minimum training standards.

PSNC needs to consider the implications to community pharmacy of the Francis Report and the Government's initial response. A summary of the key points from the Government response is set out **Appendix SDS 04/05/13** for consideration by the subcommittee.

8. Rural Working Group

a) Appointment of Chairman

Following the resignation of David Gill, the office of Chairman to the Rural Working Group is vacant. An email has been sent to all members of PSNC, to ask for expressions of interest. So far, an expression of interest has been received, from Ian Cubbin.

There was no deadline set for receipt of expressions of interest, and further expressions of interest may be received up until the time the Service Development Subcommittee nominates the chair.

The subcommittee is asked to nominate a chair.

b) Minutes of the Rural Working Group

The confidential minutes of the last Rural Working Group are set out at **Appendix SDS 05/05/13** for information.

c) Appointment of Members

The term of office of the members of the Rural Working Group ended in January 2013. All LPCs have been asked to nominate members, for the Service Development Subcommittee to consider. Under the terms of reference, one member is to be appointed from each PSNC region in which there is a significant level of rural dispensing.

Uncontested regions

Yorkshire & Humber	Phil Bratley
South Central	Olivier Picard

South West	Sue Taylor

The subcommittee is asked if it wishes to appoint these three members.

Contested regions

East Midlands & South Yorkshire	Avril McDermott & Robert Severn
South East Coast	Mike Keen & Martin Mandelbaum
West Midlands	Joanne McMurray & Les Yeates

Brief details of each nominee are set out at **Appendix SDS 06/05/13**; this appendix is confidential. The subcommittee is asked to appoint one member in each region.

Other regions

North Eastern Region – it is understood that the region is holding a meeting and will nominate a member within the next few days. Details will be emailed to members of the subcommittee to ask if the nominee should be appointed.

No nominations have been received from East Anglia; East of England, London North Thames, London South Thames, North West or Mersey (Ian Cubbin was the appointee last year, and has expressed interest in the Chairman's position). It is proposed that a further invitation is sent to each of the LPCs, other than those in the two London regions.

REPORT

9. Procurement, Competition and Choice in the new healthcare landscape

A summary of the Monitor Fair Playing Field Review and how the Procurement, Patient Choice and Competition Regulations implement the Government's policy of encouraging competition is set out in **Appendix SDS 07/05/13** for information.

10. Changes to the GMS Contract in 2013/14

A summary of the changes to the GMS contract, which DH has determined to impose on GMS contractors, is set out in **Appendix SDS 08/05/13** for information.

11. Urgent and Emergency Care Services

NHS England has announced a wide ranging review of urgent and emergency care services in England, and following the problems with the roll out of NHS 111, a Parliamentary inquiry, a working party and an NHS England review into the service have all been announced. The roll out of NHS 111 has been put back until autumn but the service is still being supported by NHS England. Further details are set out in **Appendix SDS 09/05/13**.

A meeting between DH, NHS 111 and the pharmacy bodies is due to take place on 8th May 2013; Barbara Parsons will provide a verbal report on the discussions at the subcommittee meeting.

12. Public Health Services

At the beginning of April 2013 the responsibility for the majority of public health services transferred to Public Health England (PHE), with commissioning of most services passing to local authorities and a minority being commissioned by NHS England.

An update on recent public health policy developments, including a summary of new and amended documents which have recently been issued is set out in **Appendix SDS 10/05/13**.

13. New Medicine Service (NMS)

Following the last meeting of the subcommittee, NHS England and DH confirmed an extension of the NMS to the end of September 2013. Future commissioning of the service will be a matter for NHS England.

The researchers undertaking the DH funded evaluation of the service have worked to increase the number of pharmacies involved in the research in order to improve patient recruitment to the study. They have also requested an extension to the study which is expected to be granted by DH. Assuming this occurs, the study will continue to the end of February 2014.

14. Developing consultation and communication skills for pharmacists and pharmacy technicians

In March 2013 the Modernising Pharmacy Careers (MPC) programme (now part of Health Education England), hosted a meeting to start work on developing and assuring the consultation skills of pharmacists and pharmacy technicians to support medicines optimisation and the delivery of public health messages.

The meeting, which was chaired by Professor Christopher Cutts, Director of CPPE and Clare Howard, Deputy CPhO, NHS England, was attended by stakeholders across a range of different pharmacy sectors and job roles, including Christine Burbage and Alastair Buxton.

Participants discussed their visions and aspirations for developing consultation skills in pharmacy professionals. In breakout sessions, participants shared ideas about what they thought the 'perfect model' for learning, experience and assessment of consultation skills would look like, then discussions turned to possible barriers to achieving the perfect model, and, finally, considered how such barriers could be overcome.

This work came about as a result of proposals issued by Health Education England's Modernising Pharmacy Careers professional board in 2012 to help strengthen and develop the confidence and skills of pharmacists and pharmacy technicians post registration. The proposals included the need to enhance the skills of pharmacy professionals in working with patients, other healthcare professionals and members of the public to improve the safety, value and effectiveness of medicines through medicines optimisation and to enhance their skills in the delivery of public health interventions.

Following the initial brainstorming meeting, a Task and Finish Group and Reference Group have been set up to progress this piece of work. The Task and Finish Group will make recommendations for a national model for enhancing the consultation and communication skills of pharmacists and pharmacy technicians. Meetings of the group will take place over the coming months, with delivery of outputs planned for the autumn.

The first meeting of the Task and Finish Group was held in late April and members reviewed the first draft of consultation skills competencies for pharmacy professionals. This document had been created with reference to the relevant sections of the RCGP competencies for GPs. The document is set out in **Appendix SDS 11/05/13** and for the time being should be treated as being confidential. If Committee members have comments on the competencies, these should be passed to Alastair Buxton, who will feed them back to the MPC team.

15. RPS Commission on Future Models of Care

In mid-April the RPS English Pharmacy Board launched a Commission on the Future Models of Care. The Commission will bring together expertise from across pharmacy, the wider healthcare sector, and patients and the public to develop practical ideas about how future models of care can be delivered through pharmacy over the next few years.

The report of the Commission, to be made in autumn 2013, will suggest how policy makers, commissioners and the pharmacy profession can put into practice such new models of care. The Commission is being chaired by Dr Judith Smith, Director of Policy at the independent charitable research foundation, the Nuffield Trust. The terms of reference for the review are to:

- make the case for change in relation to the role that pharmacy can play in the delivery of care;
- articulate the benefits to patients of involving pharmacists in the delivery of a wider range of services;
- identify the range of models of care involving pharmacy that are starting to emerge in the UK and overseas;
- examine what has helped or hindered the development of such models of care;
- identify what needs to be done to enable and support the spread of such models of care; and
- consider the implications of the commission's findings for policy and practice in the English NHS and more widely.

It is hoped that the 'non-pharmacy' input into the review will support a wider dissemination of the eventual findings than would be possible for an inward looking exercise within the profession, however the bulk of the information on current innovation in pharmacy needs to come from the profession itself.

PSNC has already had a one-to-one session with Judith Smith to explain our vision for future service development and we will be contributing further views and examples of innovative practice as part of the evidence gathering process. PSNC has also encouraged LPCs to submit examples of innovative services that have developed in their area over the last two to three years. Further information on the Commission can be found at www.rpharms.com/futuremodels.

16. EPS

An EPS status report and a copy of a letter recently sent to the EPS Senior Responsible Owner, Beverley Bryant, on the transmission of Schedule 2 and 3 Controlled Drugs via EPS are set out at **Appendix SDS 12/05/13** and **Appendix SDS 13/05/13** for information.

17. Information Governance

A brief summary of Dame Fiona Caldicott's independent review of information governance within the NHS in England is set out at **Appendix SDS 14/05/13**.

18. Any other business

Appendix SDS 02/05/13

2013 Work Plan for the Service Development Subcommittee

The 2013 work plan for the Service Development subcommittee covers all items agreed at the November 2012 planning meeting.

Key for RAG coding
Red – needs attention / not started / high risk
Amber – underway / in progress
Green – completed / no further attention

Target Plans	Target date	Comment / Update on progress	R/A/G
In 2013 PSNC will develop recognition of the value and potential of community pharmacy service provision in meeting the health needs of our population. We will support development of strong and productive relationships with the NHS Commissioning Board at local and national level. We will ensure that developments in technology support the community pharmacy service and will work to ensure that regulations and their administration meet contractor needs. • PSNC will work to develop models for service delivery in all four domains (medicines optimisation, minor ailments, public health and supporting independent living) ensuring they support the achievement of elements of the health and social care outcomes frameworks. Medicines optimisation services may focus on a specific patient cohort where day to day care of the patient's LTC is managed by the patient in partnership with their pharmacy. • PSNC proposals for the four domains will include robust and manageable quality and outcome measures, where possible aligning with those for other primary care service providers, notably GPs. • PSNC will seek to ensure the continued commissioning of NMS, and make progress towards the integration of tMUR and NMS as fully funded Essential services. • PSNC will seek to persuade the NHS CB and / or Public Health England to develop national standard specifications for a range of services in order to facilitate the commissioning of services at a national or local level.			
Review the management of common long term conditions in order to assess which could be most appropriately managed within community pharmacy.	March	The results of this review will be discussed at the May meeting of the subcommittee.	Green
Develop a business case and supporting documentation / resources to support the commissioning of medicines optimisation services.	August	The presentation and discussion on options for future medicines optimisation services to be undertaken at the May meeting will inform the next steps on developing a business case and associated resources.	Amber
Develop a business case and supporting documentation / resources to support the commissioning of public health services.	November	This work will be commenced in due course.	Red

Develop a business case and supporting documentation / resources to support the commissioning of services to support independent living.	November	This work will be commenced in due course. A project to support the identification of carers is being investigated with a carers' charity.	Red
Develop a business case and supporting documentation / resources to support the commissioning of self-care/minor ailment services.	August	Current information on this topic is being compiled to create a business case which can be used at a local or national level.	Amber
Continue to collaborate with DH on building the case for the re-commissioning of NMS.	Ongoing	Following submission of the PharmOutcomes NMS evaluation, discussions with DH and NHS England resulted in an agreement to extend the service for six months.	Amber
Continue to collaborate with the DH appointed academic team evaluating NMS to support the provision of timely information to assist in future negotiations on the extension of the service.	Ongoing	Alastair Buxton and Gary Warner attended a meeting of the NMS Evaluation Advisory Group in February, where an update on the progress of the research was provided. AB has also had a bilateral meeting with a member of the research team to provide assistance on recruiting more pharmacies to the research. Regular contact with the research team is being maintained and assistance has been provided to them on the organisation of a stakeholder event in June.	Amber
Continue to develop contacts at the NHS CB and PHE and discuss development of standard service specifications once appropriate individuals are in post.	Ongoing	Initial discussions have been held with our new contacts at NHS England. Sue Sharpe and Alastair Buxton are meeting with one of the pharmacy leads shortly, but it is still unclear at what point the commissioning development team will be in a position to have substantive discussions. Close relationships are continuing to be maintained with NHS Employers, who will continue to have a role in negotiating changes to the contract on behalf of NHS England. Contact with a number of PHE's senior team has been initiated and will be pursued over the next few weeks.	Amber
• PSNC will work to ensure amending regulations and implementation of changes for administration of pharmacy services are effective for contractors and LPCs (working with LIS). • PSNC will work to ensure that Market Entry and PNA regulations are implemented effectively (working with LIS).			
See the LIS work plan for action points related to the above issues. If problems with implementation are identified SDS will consider the appropriate action to be taken in partnership with LIS.			
• PSNC will work to ensure implementation of EPS will incorporate full protection of risks to contractors, including protecting patient choice, and be managed to avoid any distortion of the market (working with LIS).			
Work closely with DH to ensure patient choice is protected during the implementation of EPS Release 2.	Ongoing	Guidance has recently been issued to LPCs on the NHS re-organisation. A particular concern is the loss of the duty on PCTs to proactively monitor use of the EPS	

		nomination functionality however NHS England will continue to be obliged to respond to complaints.	Amber
Monitor the implementation of EPS closely to identify problems arising and support sharing of lessons learned to feed into discussions with DH on ensuring the system works effectively for pharmacies.	Ongoing	Continuing to work to collate feedback. A few new issues have arisen linked to changes in the message broker used by some system suppliers – however there is consistency in the majority of issues that are being reported.	Amber
Work with DH to agree guidance to support minimising the risk of system failures occurring and their impact and ensure that there is recognition in the funding arrangements of changes in business risk.	Ongoing	Discussions are on-going on business continuity guidance and the funding linked to this. It is hoped that this will be resolved soon.	Amber
• PSNC will support LPCs to develop their relationships with Local Authorities, Health & Wellbeing Boards and Clinical Commissioning Groups, and promote the commissioning of community pharmacy services at a local level (working with LIS).			
The LIS workplan contains a range of activities to support LPCs in line with the above action point. LIS will oversee the development of support materials and resources as appropriate and will seek the input of SDS on service related matters.			

Dementia

Background

In 2009, Living Well with Dementia – A National Dementia Strategy was published, setting the standard for improving the lives of people with dementia, their families and carers. The strategy focuses on raising awareness, encouraging early diagnosis and providing high quality treatment and care.

Initiatives were introduced to reduce the inappropriate prescribing of antipsychotic drugs with an aim to reduce by two thirds this type of prescribing, and treatment using these medicines has become less common. The RPS issued a call to action on this topic and developed The right prescription – a call to action aimed at reducing inappropriate use of antipsychotics.

The Dementia Action Alliance was formed in 2010, and over 480 organisations have joined, including some pharmacy companies. Members of the alliance publish an action plan based on a common set of seven outcomes setting out what they will do to improve things for people with dementia and their carers up to 2014.

In 2012, the Prime Minister set out his challenge on dementia, an ambitious programme of work intended to accelerate delivery of major improvements in dementia care and research by 2015, building on the achievements of the National Dementia Strategy.

The document acknowledges that dementia is one of the biggest challenges currently being faced, and recent data shows that:

- 800,000 people are living with dementia in England;
- One in three people aged over 65 will have dementia by the time they die;
- Life expectancy is increasing, so an increasing number of people will be affected;
- Research knowledge lags behind other major diseases such as heart disease and cancer;
- The current cost of dementia to the economy is approximately £23bn per annum;
- Diagnosis rate in England is 45% - over 50% of dementia sufferers are undiagnosed;
- By 2040 the number of people affected is expected to double – and the costs treble;
- Dementia is the greatest health concern for people over 55.

The PM's challenge on dementia focuses on four main areas:

- Driving improvements in health and care. From April 2013, NHS Health Checks for the over 65s commissioned by Local Authorities include a dementia awareness element and referral where necessary;
- Increasing public understanding through national awareness campaigns which will run annually until 2015;
- Creating dementia friendly communities that understand how to help and improve social inclusion and quality of life for people with dementia. A key part of this programme is the introduction of dementia friends and champions with an aim to create one million 'dementia friends';
- Better research.

Guidance for local NHS services on improving dementia diagnosis rates has been developed by DH working with NHS England. In April 2013 NICE published a quality standard on the care of people with dementia, along with a dementia commissioning guide. Making commissioning decisions based on NICE guidance and standards along with other NICE accredited evidence can help commissioners use their resources effectively to commission services in line with the CCG outcome indicator set and other national outcomes frameworks which will improve the quality of health and social care for people with dementia.

The Alzheimer's Society, which is closely involved with the DH Awareness campaigns and the PM's challenge, is calling on commissioners to ensure appropriate services are available and is urging support for dementia friendly communities to reduce the social isolation of patients with dementia, their families and carers. In April, the Society published its annual report *Dementia 2013: The hidden voice of loneliness* which showed:

- 38% of people with dementia over 55 and 62% of those who live on their own feel lonely (compared to 24% over 55s);
- 70% had stopped doing things due to lack of confidence;
- 63% felt anxious or depressed;
- 54% of the general public believe that people with dementia have a bad quality of life.

Recent activity

DH held a meeting on dementia towards the end of last year following an email from PSNC to Keith Ridge. The meeting was attended by Barbara Parsons, and discussion points were:

1. The progress report on the Prime Minister's Challenge on Dementia is published on the DH website. However there is no mention of pharmacy in the Challenge or report. Why was no evidence found for inclusion or research identified to put forward for funding, possibly around medicines optimisation. There is significant funding attached to the Challenge to improve dementia care and research by 2015 and it was agreed that suitable research issues should be identified and put forward;
2. The inclusion of dementia awareness and signposting to memory clinics within the NHS Health Check programme for the over 65s from April 2013 was highlighted; community pharmacies have now been commissioned to carry out the service in some areas;
3. Individual pharmacy companies have already made commitments - Tesco pharmacy became the first national pharmacy chain to partner with the Alzheimer's Society, and Lloydspharmacy actions are recorded by Dementia Action Alliance and are available on their website;
4. The RPS has developed webinars and toolkits for the Dementia Action Alliance;
5. Dementia commissioning packs have been available since 2010 but there are no locally commissioned community pharmacy services linked to dementia on the PSNC services database;
6. There has been a national campaign to raise awareness, including use of TV adverts;
7. Pilots of dementia clinical networks were launched in September 2012. Dementia is included in one of the strategic clinical networks which will be established and supported by NHS England from 2013. Community pharmacists (and their staff) are one of the wide ranging healthcare professionals involved in the care of these patients and should be included in the network. (One report of pharmacy involvement has now been received);
8. It was agreed that the RPS would lead on this work as it covers all sectors of the profession;
9. Jeremy Hunt and Norman Lamb have recently completed a regional tour to raise awareness of the need to deliver change in dementia, and have asked everyone to make a commitment to change, which may include:
    - Joining the Dementia Action Alliance;
    - Signing up to the Dementia Care and Support Compact;
    - Signing up to become a dementia friend (see below);
    - Improving diagnosis rates;
    - Reducing inappropriate prescribing of anti-psychotics; and
    - Driving public involvement in dementia research.

Gul Root, Principal Pharmaceutical Officer at DH, has also been approached by colleagues at NHS England to explore how pharmacy might engage in the dementia awareness programme and has had great interest expressed by Dr David Geddes (Head of Primary Care Commissioning, Operations Directorate) in how community pharmacy might engage in this agenda.

Dementia Friends

The Alzheimer's Society has set up an initiative to create a network of one million Dementia Friends across England by 2015. The initiative aims to give people an understanding of dementia and the small things they can do that make a difference to people living with dementia – from helping someone find the right bus to spreading the word about dementia.

People can volunteer to be a Dementia Friends Champion, who following a one day training session, are able to run Dementia Friends information sessions of around one hour. To become a Dementia Friend a person has to attend a Dementia Friends information session and register as a Dementia Friend with the Alzheimer's Society. People should then turn their understanding of dementia into a practical action, such as:

- Behaving patients with someone showing signs of dementia;
- Signposting people affected by dementia to more information and support;
- Volunteering with an organisation to support people with dementia;
- Helping your workplace to be more dementia friendly; telling other people about Dementia Friends or spreading the word through social media.

Having staff trained as dementia friends in community pharmacies has been identified as a key target:

- there is keenness for the existing HLP health champions to become dementia friends. Plymouth is a dementia friendly city and it is intended that each HLP will be a hub for dementia with a trained dementia friend included as part of their core quality criteria;
- the Pharmacy and Public Health Forum is supportive of community pharmacy engaging in the early dementia awareness programme, in much the same way as it is doing for the early cancer awareness programme. The Forum would be keen to see a dementia friend in every pharmacy, supporting and signposting people with early symptoms of dementia, their relatives and friends, appropriately;
- The representative pharmacy organisations, who are members of the Forum could play an important role in promoting the concept of a dementia friend in every pharmacy, through their normal communication channels with co-ordinated messages.

The subcommittee is asked to consider the following questions:

- Should the decision to train a member of staff as a dementia friend be one for each individual contractor to take on an ad hoc basis?
- Should the approach be contractual and each pharmacy must have one?
- If so, how would this be funded?
- What other services to improve the care of people with dementia should be considered?

The Francis Report – implications for community pharmacy

In late March DH published 'Patients First and Foremost' the initial Government response to the report of the Mid Staffordshire NHS Foundation Trust Public Enquiry.

In an accompanying letter to Chairs of NHS Trusts, Jeremy Hunt, Secretary of State for Health said:

'This is a call to action for every individual and organisation within the health and care system, to reflect on our behaviours and priorities. I know that many of you are delivering outstanding care, and this should not be taken as a negative reflection on the hard work that many in your organisations are doing to respond to the many pressures facing the NHS. However there are lessons for all of us to learn from the appalling events at Stafford Hospital, and it is important that we do so.'

The response is divided into five areas, designed to improve the care that people receive from the NHS:

1. Preventing problems;
2. Detecting problems quickly;
3. Taking action promptly;
4. Ensuring robust accountability; and
5. Ensuring staff are trained and motivated

The recommendations of the Inquiry focussed on acute hospitals and so too does the response to the Inquiry, however, DH states that many of the messages from the Inquiry are equally relevant to other health and care settings. Issues such as the culture of care and the vital importance of listening to and being open with patients, their families and advocates apply across the health and care system.

A summary of the main points in the documents and the actions listed by DH are set out below:

1. Preventing Problems

- A Chief Inspector of Hospitals will be appointed by CQC to lead inspection and highlight where standards are not being met.
- Time to Care – DH will ensure that paperwork, box ticking and duplicatory regulation and information burdens are reduced by at least one third.
- The Health and Social Care Information Centre will act as a single national hub for collecting information, and it will have a duty to seek to reduce the information burden on the service year on year.
- The Berwick Review - Prof Don Berwick, former adviser to President Obama, is working with NHS England to ensure a robust safety culture and a zero tolerance of avoidable harm is embedded in the DNA of the NHS.

2. Detecting Problems Quickly

- The CQC Chief Inspector of Hospitals will make assessments based on judgement as well as data. The Chief Inspector will be supported by expert inspectors (rather than generalists) who have 'walked the wards, spoken to patients and staff, and looked the board in the eye'.
- The Chief Inspector will become the nation's whistle-blower – naming poor care without fear or favour from politicians, institutional vested interests or through loyalty to the system rather than the patients that it serves.
- A 'comply or explain' approach to known good practices will be used in inspections. So, where there are well-established practices that benefit patients, inspectors will expect to see these being used across hospitals or a valid explanation given if this is not the case.

- The CQC will be given the power to conduct ratings at the earliest opportunity and will work with the Nuffield Trust to develop these proposals further. This will ensure that there is a single version of the truth about how hospitals are performing, not just on finance and targets, but on a single assessment that fully reflects what matters to patients.
- A Chief Inspector of Social Care will be appointed who will adopt a similar approach to social care and will be charged with rating care homes and other local care services, promoting excellence and identifying problems.
- Publication of information at a department, specialty, care group and condition-specific level. Initially this will see an extension of the transparency on surgical outcomes from heart surgery, to cardiology, vascular surgery, upper gastro intestinal surgery, colorectal surgery, orthopaedic surgery, bariatric surgery, urological surgery, head and neck surgery and thyroid and endocrine surgery.
- Implementation of penalties and possibly additional legal sanctions at corporate level for organisations that are found to be massaging figures or concealing the truth about their performance.
- Create a statutory duty of candour on providers to inform people if they believe treatment or care has caused death or serious injury, and to provide an explanation.
- A ban on clauses intended to prevent public interest disclosures.
- Complaints Review - a review of best practice on complaints to ensure that when problems are raised, they are heard, addressed and acted upon, and seen as vital information for improvement rather than irritations to be managed defensively.

3. Taking Action Promptly

- CQC, working with NICE, commissioners, professionals, patients and the public, will draw up a new set of simpler fundamental standards which make explicit the basic standards beneath which care should never fall.
- Introduction of a time limited hospital failure regime for quality as well as finance.

4. Ensuring Robust Accountability

- The Health and Safety Executive to be able to apply criminal sanctions where the Chief Inspector identifies criminally negligent practice in hospitals.
- Faster and more proactive professional regulation - as part of the implementation of the Law Commission's review, DH will seek to legislate at the earliest possible opportunity to overhaul 150 years of complex legislation into a single Act that will enable faster and more proactive action on individual professional failings.
- Introduction of a national barring list for unfit NHS managers.

5. Ensuring Staff are Trained and Motivated

- Healthcare Assistant training and practice for up to a year to be undertaken before people undertake NHS funded nursing degrees.
- Introduction of revalidation for nurses.
- Publication of a Code of Conduct and minimum training for Healthcare Assistants.
- Introduction of a barring system for Healthcare Assistants
- The NHS Leadership Academy will initiate a major programme to encourage new talent from clinical professionals and from outside the NHS into top leadership positions.
- Frontline experience for D staff - within four years, every civil servant in the Department will have sustained and meaningful experience of the frontline with Senior Civil Service and Ministers leading the way.

Implications for community pharmacy

Some of the actions and issues raised in the Government response and the Francis report that could be applied to community pharmacy are detailed below in order to stimulate discussion. The subcommittee is

asked to consider these points and provide feedback on whether they are appropriate issues for community pharmacy to consider. The subcommittee is also asked to suggest other issues which should be considered as a result of the Francis report. Some of the points are areas where action has already been taken by community pharmacy, but where additional effort may be required to meet the vision included in the Francis report.

1. Development of (quality) standards for services (fundamental, enhanced and developmental standards).
2. Development of evidence based standard procedures, e.g. for provision of medicines optimisation services.
3. Increased patient safety incident reporting and appropriate feedback following reporting.
4. Development of outcome measures for services.
5. Development of risk management standards.
6. Improving complaints handling processes and learning from complaints.
7. Being alert to concerns raised by patients about other services, and taking necessary action to raise these concerns on behalf of patients.
8. Embedding a culture within community pharmacy that supports the raising of concerns and open discussion about care and system failures in order to improve future patient care.
9. Implementing the duty of candour and ensuring that is part of the culture of community pharmacy practice (bur recognising the need to tackle decriminalisation of dispensing errors).
10. Enhancing the caring culture within community pharmacies.
11. Enhancing team working in primary care and between primary care and secondary care, in particular to support transfer of care for individual patients.
12. Access to shared clinical records to facilitate improved patient care.
13. Building robust follow up of patients into community pharmacy services.
14. Creation of system to support collation of real-time performance information on community pharmacy services.

As previously stated, many of the recommendations within the Francis report focus on secondary care services, but some of these ‘hospital specific issues’ may map across to support community pharmacies provide to care homes.

Procurement, Competition and Choice in the new healthcare landscape

Monitor review - A fair playing field for the benefit of NHS patients

On 21 May 2012, the Secretary of State wrote to Monitor asking it to undertake "an independent review of matters that may be affecting the ability of different providers of NHS services to participate fully in improving patient care". His letter also set out the Government's aim that "NHS services are commissioned from the best providers, with competition based on quality".

Monitor considered the provision of NHS-funded care as a playing field on which the players are the wide variety of health care providers offering or seeking to offer services to NHS patients. If the playing field were fair, there would be nothing to prevent providers with the best services from reaching patients, regardless of the type of provider. Monitor sought to understand whether there are any systematic distortions in the playing field preventing this from happening. Throughout their work they treated all types of provider equally; with no assumption that certain types of provider might be better able to meet the needs of patients than other types. PSNC's response to the review is available on the website.

Playing field distortions

The review concentrated on distortions to the playing field that have, or potentially have, a significant impact on patients and are beyond the control of providers affected by them.

All of the providers that made comments to the review experience aspects of the playing field that they believe are unfair distortions. However, as Monitor's core duty is "to protect and promote the interests of people who use health care services", it weighed the evidence according to its impact on patients.

It found three types of distortion:

1. **Participation distortions**. Some providers are directly or indirectly excluded from offering their services to NHS patients for reasons other than quality or efficiency. Restrictions on participation disadvantage providers seeking to expand into new services or new areas, regardless of whether the providers are public, charitable or private. Participation distortions disadvantage non-incumbent providers of every type.
2. **Cost distortions**. Some types of provider face externally imposed costs that do not fall on other providers. On balance, cost distortions mostly disadvantage charitable and private health care providers compared to public providers.
3. **Flexibility distortions**. Some providers' ability to adapt their services to the changing needs of patients and commissioners is constrained by factors outside their control. These flexibility distortions mostly disadvantage public sector providers compared to other types. These are not relevant to pharmacy contractors and so are not discussed further in this briefing.

Participation distortions

Commissioners play a critical role in ensuring patients' care needs are met as well and as efficiently as possible. With limited resources to meet the population's growing health care needs, commissioners need to be increasingly rigorous in identifying the highest quality, most efficient and best coordinated care available.

During the course of the Review, Monitor found widespread examples of commissioners failing to consider alternative providers where that might have been appropriate. Similarly, it found examples of commissioners running unnecessarily complex procurement processes. In such cases, commissioners give incumbents an advantage over alternative providers, whether public, private or charitable, and patients may finish up with a poorer service than they could have received. PSNC made comments to Monitor about such distortions to competition, faced by pharmacy contractors, and the concerns about

commissioning by CCGs when their member practices have a competing interest.

Monitor's recommendations on participation distortions aim to complement current changes and support commissioners so that they can deliver benefits to patients without disrupting patient care. Specifically, the recommendations are intended to develop:

- a more stable and supportive commissioning environment, to help commissioners think and act strategically;
- better evidence, case studies and tools for commissioners, to help them identify the best solutions for patients; and
- better aligned incentives for commissioners, with a greater voice for patients.

Cost distortions

Monitor learned of many circumstances in which some types of provider face externally imposed costs that do not fall on others.

Monitor found two cost issues that affect patients and which are not currently being addressed: differences in access to rebates for VAT and the variation in cost of capital faced by different types of provider. PSNC commented on the effect of the cost of capital for pharmacy contractors but in relation to the VAT treatment of some services provided by pharmacies, there are advantages compared with other providers.

Several of the cost distortions raised by providers are already being tackled, and Monitor suggested complementary measures in some cases. The remaining cost issues that providers raised turned out, on examination, not to affect patient services, and they recommend making no changes in these areas.

Cost distortions not being addressed

VAT - Current VAT rules represent a material playing field distortion. Under the 'Contracted Out Services' scheme, public sector providers claim VAT rebates worth a substantial amount in total on contracted out services, such as legal or laundry services. However, it appears that they may no longer be eligible for all of this rebate because of changes in the healthcare sector. Private and charitable providers cannot claim VAT rebates on any of their contracted out services and this sometimes affects their decisions about supplying services. Monitor recommended that the Government reviews whether certain public providers remain eligible for VAT refunds and considers extending rebates to services provided by the charitable sector, where they would be eligible and that the Government re-invests any resulting net saving in the NHS.

Cost of capital - Many providers raised the differential cost of capital faced by different providers. Private and charitable providers borrow (and in the case of private providers, raise equity) at rates that reflect the lender's risk of not recovering the capital. Public providers, however, do not. It was helpful to pharmacy contractors that Monitor recommended that risk is priced into the cost of capital for all providers.

Cost distortions already being addressed

Pensions - Private and some charitable providers serving the NHS cannot generally offer continued access to the NHS Pension Scheme to staff transferring to them from a public provider. Instead, these providers must offer a broadly comparable private pension, which costs them more than the NHS Scheme costs public employers. These additional pension costs deter some providers from bidding for contracts. PSNC in its response to the review highlighted that pharmacy contractors and their staff cannot access the NHS pension scheme.

The Government has made a commitment to allow NHS staff who are members of the NHS Pension Scheme to retain their membership if they are transferred to a non-public health care employer. However, to remove this distortion fully, all staff working in NHS-funded health care services should have access to the NHS pension scheme, not just those currently working for the public sector. Monitor recognises this presents practical challenges but recommended that the Government works to overcome them.

Clinical negligence indemnity - The Clinical Negligence Scheme for Trusts (CNST), overseen by the NHS Litigation Authority, is open only to public sector providers. Contributions for CNST indemnity do not fully reflect the risks of individual providers, which creates a distortion among providers in the Scheme that have different levels of risk but pay the same rate for their indemnities. There may also be distortions between public providers in the Scheme and other providers who cannot gain access to it. PSNC made the point that pharmacy contractors are unable to access the scheme.

The review indicates that the Government has already laid regulations to open the CNST to charitable and private providers. Monitor recommended that the Department of Health and the NHS Litigation Authority also improve the pricing of risk within the CNST and minimise barriers to joining and leaving the Scheme for all types of provider.

Education and training - Responses to Monitor's initial request for evidence suggested that the requirement to provide education and training for clinical staff disadvantaged public providers because independent sector providers are able to recruit trained staff without incurring the costs of training them. However, since the aggregate funding of provision of education and training appears to match the aggregate costs, this is not a distortion between types of provider. Nevertheless, the current system for funding undergraduate and postgraduate education and training does create a distortion amongst providers within the public sector. This system pays more per trainee to some large, established public sector hospitals than to other public sector hospitals.

Health Education England is responsible for reforming clinical training arrangements to ensure funding reflects the underlying costs, which should remove this distortion. PSNC made the point in its response that there is not always equitable access to training for clinical staff (although the development of LETBs may address this). We commented that LETBs may be swayed by large NHS employers. We also raised the point that there is little standardisation of training requirements across PCT areas, and this was undermining mobility of the pharmacy workforce.

Further Discussions

Following submission of PSNC's comments to the review, we were invited to attend, to discuss PSNC's concerns in more detail. We emphasised that there was real concern amongst pharmacy contractors that when CCGs are responsible for commissioning, pharmacy contractors may not be commissioned, where the CCGs GP practices are direct competitors. We were also able to share recent examples of direction of prescriptions, and other anti-competitive activity.

Procurement, Patient Choice and Competition Regulations

During the passage of the Health and Social Care Bill, the Government responded to concerns about the future application of choice and competition in the health service by committing to retain the existing non-statutory administrative rules (The Principles and Rules for Cooperation and Competition), that concern procurement for clinical services, and place them on a firmer, statutory footing. On 13 February 2013, as part of the arrangements the Government laid the National Health Service (Procurement, Patient Choice and Competition) Regulations 2013.

The Regulations imposed requirements on NHS England and CCGs to ensure good practice in procurement of health care services; to ensure protection of patients' rights to make choices regarding their NHS treatment; and to prevent anti-competitive behaviour by commissioners.

Where a commissioner advertises an invitation to providers, it would be required to publish a notice on a website maintained by NHS England, but there was no requirement to advertise where the commissioner is satisfied that the services are capable of being provided only by a particular provider.

There was a prohibition on anti-competitive behaviour which is against the interests of users of NHS services. There would also be a prohibition on the award of contracts where there are conflicts between the interests of commissioning and providing services, and commissioners would be required to establish and apply transparent, proportionate and non-discriminatory criteria for making commissioning decisions. There would be a requirement to publish a record of all contracts.

Monitor was provided with powers to investigate and take enforcement action in relation to breaches of the requirements imposed on commissioners, and this included the power to declare contracts that were in contravention of the requirements as ineffective. Monitor also had power to issue directions to commissioners.

These regulations were opposed, and particular concern was raised about the apparent power of Monitor to require commissioners to undertake competitive tendering, and the possibility that Monitor may interfere with contracts that had been agreed. As a result of the challenges, the Government hastily reviewed them and on 11 March, revised Regulations were laid which revoked the earlier set.

The changes to the regulations made clear that:

- there is no requirement to put all contracts out to competitive tender. Commissioners are able to offer contracts to a single provider where only that provider is capable of providing the services;
- Monitor has no power to force the competitive tendering of services; and
- Competition should not trump integration - commissioners are free to use integration where it is in the interest of patients.

The Regulations place requirements on commissioners to ensure accountability and transparency in their expenditure. In particular:

- to record the rationale for their decisions and how they have met their duties as to quality, effectiveness and the promotion of integration;
- to publish details of the contracts that they have awarded;
- to not award contracts where conflicts or potential conflicts of interest have, or appear, to affect the integrity of the decision; and
- not to engage in anti-competitive behaviour unless to do so is in the interest of patients. Behaviour in the interests of patients may include services being provided in an integrated way or co-operation between providers in order to improve the quality of services. Questions of anticompetitive terms or conditions would not be considered in isolation from the objective of improving quality and efficiency, and securing the needs of patients.

These regulations also establish the framework under which Monitor will exercise its duty to protect and promote the interests of people who use health care services. The regulations provide the following powers:

Powers of investigation - Monitor may investigate a complaint received by it that a commissioner has failed to comply with a requirement imposed by the above regulations or by specified regulations in The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012.

An important feature is that Monitor may on its own initiative investigate whether a commissioner has failed to comply the regulatory prohibition on anti-competitive behaviour. This means that a complaint from a patient is not required to trigger an investigation.

Commissioners are required to provide Monitor with such information in its possession as Monitor may specify for the purposes of an investigation.

The power of Monitor includes:

(a) power to require the commissioner to provide an explanation of such information as it provides; and

(b) in relation to information kept by means of a computer, power to require the information in legible form.

Declaration of ineffectiveness - Monitor may declare that an arrangement for the provision of health care services for the purposes of the NHS is ineffective where it is satisfied that in relation to that arrangement, a commissioner has failed to comply with some of the requirements imposed by the regulations, where the failure is sufficiently serious.

Power to give directions - Monitor may direct a commissioner:

(a) to put in place measures to prevent failures to comply with a requirement imposed by the regulations;

(b) to put in place measures for the purpose of mitigating the effect of such failures;

(c) to vary or withdraw an invitation to tender to prevent or remedy a failure to comply with specified requirements;

(d) to vary an arrangement for the provision of health care services made in consequence of putting the provision of services out to tender to remedy a failure to comply with a requirement imposed by the regulations;

(e) to vary an arrangement for the provision of healthcare services to remedy a failure to comply with specified regulations;

(f) to otherwise remedy a failure to comply with a specified requirement.

However, Monitor may not direct a commissioner to hold a competitive tender for a contract.

Undertakings - Monitor may accept an undertaking from a commissioner to take action of a kind mentioned in its powers to give directions, and within such period as is specified.

Guidance - Monitor has a duty to publish guidance for commissioners on compliance with the Regulations and how it intends to exercise its enforcement powers. Monitor must consult and must obtain the approval of the Secretary of State before the guidance is published.

NHS England will also publish guidance in early 2013 to help CCGs understand and work within the Regulations, including in relation to conflicts of interest. NHS England and Monitor are working closely together so that their guidance is consistent and will bring the guidance together through a resource for the NHS called the Choice and Competition Framework.

The regulations can be accessed at www.legislation.gov.uk/uksi/2013/500/made.

In a recent HSJ interview with David Bennett, chief executive of Monitor, he rejected claims that the new competition regulations could lead to a sharp increase in competitive tendering for NHS services. He said "Fortunately for the patients of England, we have a duty to do whatever we do with a focus on what's in their best interests. We would be mad to enforce those rules in a way that leaves commissioners spending all their time running competitive processes because they're terrified they're going to get into trouble if they don't".

Mr Bennett noted that there were 211 CCGs, each with an estimated 60 to 600 contracts, while Monitor would have only around 40 employees investigating competition issues. "We're going to have to prioritise and we're going to be extremely clear about how we will prioritise what we do. We will be focusing on areas where we think opportunities to improve the service delivered to patients have been missed in a serious way".

David Bennett and Catherine Davies (Monitor Cooperation and Competition director) told HSJ competition regulation would be largely "complaints driven", and its assessment of complaints would hinge on whether the commissioner had acted in a reasonable way. They suggested this would begin by looking at the commissioning plan the CCG had developed with its HWB.

Monitor's steps would be to ask, have they gone through a process? Have they established a commissioning plan that sets out what they want to do? Is the conclusion they've reached a reasonable conclusion given the steps they've followed?

Mr Bennett also indicated that in some cases it might be reasonable for commissioners not to run a competitive process for a service, because they did not feel they were able to accurately measure the quality of their existing provider. "It's fair to say that the quality metrics in community and mental healthcare are poorer than they are in acute services. So if a commissioner says my focus in the next year is on getting a much better grip on the quality of care my patients are being provided by the current provider, we would say that sounds like quite a sensible thing to do".

Since the publication of the report of the Fair Playing Field Review, and the Regulations, DH has accepted Monitor's proposal, set out in its Fair Playing Field review, to undertake more work on commissioning of GP services. Monitor's report says questions were raised during the course of the Review about the extent to which the commissioning of general practice and associated services in particular is operating in the best interest of patients.

Issues raised included:

- the rules for setting up a general practice;
- the different contractual terms under which practices operate;
- the perceived reluctance of PCTs to commission new services against the wishes of existing local practices and Local Medical Committees;
- perceived conflicts of interest that may in future prevent clinical commissioning groups from commissioning services from new entrants; and
- concerns about a lack of choice of general practitioners for patients.

The report proposed that 'Monitor should issue a call for evidence by June 2013 to help determine the extent to which the commissioning and provision of general practice and associated services is operating in the best interests of patients'.

Whilst this review is primarily about patients accessing medical services, there is a reference to perceived conflicts of interest that may in future prevent CCGs from commissioning services from new entrants – and Earl Howe said: "We are committed to making sure that patients can access services delivered by the best possible providers. We are constantly working to improve the quality of care that patients receive and creating a fairer playing field will help to do this".

PSNC will continue to input into any reviews that may be relevant to the commissioning of pharmacy contractors by CCGs.

Changes to the GMS contract in 2013/14

Following negotiations between the GP Committee (GPC) of the BMA and NHS Employers, the Department of Health (DH) consulted on proposals to change the primary medical care contractual arrangements in December 2012. DH said the proposed changes were intended to maintain current levels of investment in general practice, whilst promoting continuous improvement in the quality of GP services.

The GPC and other medical stakeholders raised a wide range of objections to the changes proposed by DH, but in March this year DH determined that the changes would be implemented by NHS England, with a number of amendments being made following feedback from the GPC and others. The main changes to the service elements are amendments to QOF and the introduction of new Enhanced services.

New Enhanced services

Four new Enhanced services are being introduced into the contract, funded by the retirement of the QOF organisational measures. The new services are:

1. The identification and case management of patients identified as seriously ill or at risk of emergency hospital admission. This will be undertaken by risk profiling and stratification of their registered patients on at least a quarterly basis. For patients identified by this process the practice should coordinate the care management of those patients who would benefit from more active case management. It is likely that the CCG will have a significant interest in this service and may coordinate the work across its practices.

2. Undertaking a proactive approach to the timely assessment of patients who may be at risk of dementia. This will be based on an opportunistic offer of assessment to at-risk patients who are aged 60 and over with CVD, stroke, peripheral vascular disease or diabetes; patients aged 40 and over with Down's syndrome and other patients aged 50 and over with learning disabilities; and patients with long term neurological conditions which have a known neurodegenerative element, for example, Parkinson's disease.

3. Undertaking preparatory work in 2013/14 to support the subsequent introduction in 2014/15 of remote care monitoring arrangements for patients with long term but relatively stable conditions. This will involve agreement with the CCG which long term condition is to be the local priority for remote care monitoring in 2014/15. The appropriate test or bodily measurements required to support the stable management of the chosen condition will be agreed alongside how the tests and measurements will be accessed or fed in by patients. The options by which patients will receive results of the tests or measurements, other than by face to face consultations, will be identified, e.g. video call, telephone, text, email or letter. Practices will then discuss the opportunity to use this service in the following year with appropriate patients.

4. Enabling patients to use electronic communications for booking of appointments and requesting repeat prescriptions. NHS England intends to develop the service in 2014/15 to take into account the Government's commitment for implementing secure online communication and viewing medical records (including test results and letters).

The latter service is of most immediate interest to LPCs and community pharmacy, as contractors will want to understand the local process to be used for the ordering of repeat prescriptions and the ramifications this may have for current pharmacy practice and the potential for this development to prompt changes in GP practice procedures or behaviour related to collection of repeat prescriptions.

LPCs may wish to highlight this development to their contractors, so contractors can ascertain whether local GP practices plan to implement the service.

The other services are not likely to have such an immediate impact on community pharmacy, but the widespread adoption of risk profiling and stratification of patients, especially if this is conducted at a CCG level, may provide opportunities for promotion of community pharmacy medicines optimisation services such as MUR and NMS and their more effective integration into local care pathways (e.g. using risk stratification data to prompt GP referrals to the MUR service for certain patients). LPCs may want to keep an eye on such developments in order that they can highlight to CCGs the support community pharmacy can provide to high risk patients.

The dementia service will sit alongside other local initiatives to support the early identification and management of people with dementia, such as the introduction of a dementia element to the NHS Health Check service, which local pharmacies may be providing. There has been comment in the medical press that suggests that this service is less favoured by some GPs, due to the potential workload it may impose on practices.

The introduction of remote care monitoring arrangements will be phased over two years, so there may be minimal immediate implications for community pharmacy, but LPCs and contractors will be able to see the potential for community pharmacy to be involved in supporting the provision of such monitoring. This was also noted by Deborah Jaines, Head of Outcomes and Primary Care in NHS England's commissioning development directorate, when she commented at the recent PSNC Community Pharmacy Conference that she was keen to explore the opportunities for extension of remote care monitoring into community pharmacy.

Quality and Outcomes Framework (QOF)

DH proposed a number of changes to the Quality and Outcomes Framework (QOF) in order to secure further health improvements for patients. These included implementing all the NICE recommendations for changes to QOF (NICE became responsible for managing an independent and transparent approach to developing the QOF clinical and health improvement indicators from April 2001); raising thresholds for existing indicators in line with the 75th centile of achievement to ensure more patients receive evidence-based care; setting up a Public Health Domain in the QOF, as originally proposed in the 2010 Public Health White Paper; and removing the remaining organisational indicators that represent basic standards that all practices will be expected to meet as part of CQC registration.

A summary of the QOF, including the new and amended indicators is available on the NHS Employers website. The new indicators relate to management of heart failure, hypertension, diabetes, COPD and rheumatoid arthritis.

Urgent and Emergency Care Services

NHS England reviews

At the beginning of the year, NHS England announced a wide ranging review of the model of urgent and emergency care in England in order to improve these services in the future, as the existing model of care is seen to be clinically and financially unsustainable.

The review, led by Sir Bruce Keogh (NHS England Medical Director), is looking at how emergency care is currently provided, how it works with other NHS providers such as GP practices, community care and NHS 111, and is assessing transfer processes between different providers. It aims to make proposals for the best way of organising care to meet the need of patients and to develop a national framework to ensure high quality consistent standards of care. The review is part of plans to offer more seven day services within hospitals and NHS England also wants to improve public understanding of the best place to go for care.

Local commissioning is seen to be at the heart of the review and the proposals will support CCGs in shaping services for the future. Emerging principles will be published for consultation soon.

NHS England has also recently announced an urgent review of the NHS 111 urgent care phone service, the sustainability of the current model of service into 2014, and an appraisal of the likely market of providers. NHS England has admitted that patients have been 'let down' by the unacceptable failure of some NHS 111 services and questions have been raised as to whether the service should have been commissioned nationally rather than locally, or at least managed and co-ordinated nationally.

NHS 111

NHS 111, the free-to-call non-emergency medical helpline service, should have been introduced across the country by April 2013 to improve access to NHS urgent care services. By now, it should have replaced the telephone triage and advice services provided by NHS Direct and local GP out-of-hours services in the majority of the country, with those services being finally discontinued nationwide by June 2013. But several factors have caused problems:

1. A chaotic roll-out, with half the services due to launch in April 2013 delayed until the autumn, and some areas, such as Worcestershire, starting the NHS 111 service and then returning to previous arrangements for at least two months to ensure patient safety is not compromised;
2. The inability of NHS 111 to cope with the number of calls it was receiving and the length of time taken to respond, with unacceptable delays over the Easter period and many abandoned calls;
3. Patients, unable to get the advice they need, have been turning to A&E;
4. An increase in 999 ambulance calls with a 50% rise in A&E attendance in some areas due to NHS 111 activity;
5. Fears over patient safety with serious cases not being identified, and eight serious incidents reported, although none led to serious patient harm;
6. Concerns have also been raised about the quality of advice and the lack of specialist advice, as most calls are handled by non-medical staff using algorithms.

The principle of ensuring that patients are transferred in one step to the healthcare professional who can deal with their problem has meant that algorithms refer mainly to GP or A&E and this has been strongly criticised by GPs, who have called for the service to be scrapped, and pharmacy bodies, which have requested changes to the algorithms to allow greater referral to pharmacies.

Concern has been raised that the NHS 111 service has led to shifts in demand which have reduced accessibility and quality of urgent and emergency care for those who need it most – the very opposite of the intended effect.

Increased demand for A&E, ambulances and GP surgeries, and reports of inappropriate dispatch of ambulances by NHS 111 have resulted in a Parliamentary inquiry to review emergency care, the NHS 111 service and the impact it is having on emergency services.

The NHS Commissioning Assembly has convened a working group of CCG representatives, NHS England and the NHS 111 central team. The group is working together to help identify what needs to be done locally and nationally in order to resolve current issues and advise NHS England and commissioning CCGs about the best course of action. Full appropriate governance arrangements will be put in place across NHS England and CCGs to manage the way forward for this service.

NHS England is still committed to the roll out of the service, delayed now until autumn to give time to correct problems, and will continue to support CCGs to work with their local providers in order to ensure the NHS 111 service continues on a sounder footing.

A meeting between the national pharmacy bodies and DH has been arranged for 8th May to discuss NHS 111. With A&E performance plummeting in April and the majority of trusts missing their 95% target of patients being seen within four hours, A&E is seen as a major NHS pressure point and reducing A&E attendance is a priority for many areas. One of the main discussion points will be to consider changes to the Directory of Services to increase the use of appropriate pharmacy referral to divert patients from A&E and GP practices and thus reduce NHS costs.

Public Health Update

Public health services are important for community pharmacy as they are included within the contractual framework and formed the majority of the Enhanced services previously commissioned by PCTs.

From April 1st the statutory duty for health improvement moved from the NHS to local government. Public Health England (PHE), the Local Government Association (LGA) and the Department of Health (DH) have jointly produced a public health supplement to the NHS Constitution. This contains information on those circumstances where the revised NHS Constitution can apply to local authorities (LAs) and to PHE. A meeting to discuss community pharmacy's public health role with PHE is being arranged.

Transitional arrangements allowed for public health services to be transferred from PCTs to LAs and most LPCs have reported that this has been achieved. Over the next 12-18 months, LAs will be reviewing the services and deciding which are most relevant to their local Pharmaceutical Needs Assessment (PNA), and national priorities such as the Public Health Outcomes Framework. Some public health services will also be commissioned by NHS England.

NHS England

The NHS has a critical part to play in securing good population health and NHS England has been enabled to commission certain public health services as part of the system design to drive improvements in population health. These services are set out in Public health functions to be exercised by the NHS Commissioning Board (2012) and include immunisation programmes, such as seasonal 'flu, and screening programmes, including cancer. Service specifications are available for each of the listed services, and key deliverables for implementing change include changes to the immunisation programme, to include rotavirus, shingles, and extension of the seasonal influenza programme.

Changes to the National Immunisation programme for 2013-14

The first announcement of changes to the programme linked to the key deliverables was made in May 2013 in a variation to the public health functions document and a letter from DH, PHE and NHS England. These are:

- Rotavirus (from July 2013) - the introduction into the childhood immunisation schedule of a vaccine to protect babies under four months against rotavirus. It is estimated that the rotavirus vaccine will halve the number of vomiting and diarrhoea cases caused by rotavirus and there could be 70% fewer hospital stays as a result;
- Shingles (from September 2013) - the introduction of a shingles vaccine for people aged 70 years (routine cohort) and 79 years (catch-up cohort) to protect against herpes zoster. A vaccination programme will prevent nearly 40% of the 30,000 cases seen every year in people over 70;
- Childhood 'Flu - the existing 'flu immunisation programme will be extended over a number of years to include all children aged two to 16 inclusive. In autumn 2013, immunisation by a nasal flu vaccine will be offered to a limited age range of pre-school-aged children with nationwide roll-out in 2015. Full details will be given in the annual flu immunisation letter; and
- Meningitis C (from June 2013) - changes to the current schedule for administering the vaccine, with the second priming dose currently given at four months to be replaced by a booster dose given in adolescence. The four month dose will cease from 1 June 2013.

The relevant service specifications have also been developed or amended and there are opportunities here for community pharmacy to extend their vaccination services.

Update to the Public Health Outcomes Framework 2013-2016

The Framework, published last year, sets out the desired outcomes for public health and how they will be measured, along with the broad range of opportunities to improve and protect the nation's health and

wellbeing across its life course and to reduce inequalities in health that still persist by improving the health of the poorest fastest. It focuses on two outcomes:

- Increased healthy life expectancy by taking account of the health quality as well as the length of life; and
- Reducing differences in life expectancy and healthy life expectancy between communities, through greater improvements in more disadvantaged communities.

The outcomes have four domains:

- Improving the wider determinants of health;
- Health improvement;
- Health protections; and
- Healthcare public health and preventing premature mortality.

The indicators in the framework have been introduced to act as a stimulus to encourage public health delivery partners, which includes community pharmacy, to make significant improvements in services and share best practice more widely, with benchmarking intended to have a strong impact on improving public health outcomes and thus a direct effect on protecting and improving the nation's health.

The framework has recently been updated, with a number of minor changes. The main change which will include pharmacy are the changes to the definition of indicators for the successful completion of drug treatment into two subgroups, opiate users and users of other drugs, with the indicator being the number of users who left drug treatment successfully (free of dependence) who do not re-present within 6 months as a proportion of the total number of users in treatment.

Public Health England Priorities 2013/14

PHE has recently published its priorities for 2013/14 and announced that it will work closely with partners to develop its ambitions for the next three years to transform the public health system and create a genuine improvement in the public's health. This is PHE's first major publication since taking up its full responsibilities as an executive agency of the Department of Health on 1 April 2013.

Accepting that local action will drive sustainable change in the public's health, PHE are committed to taking action nationally where necessary and Public Health England: our priorities for 2013/14 sets out five main priorities:

1. Helping people to live longer and more healthy lives by reducing preventable deaths and the burden of ill health associated with smoking, high blood pressure, obesity, poor diet, poor mental health, insufficient exercise, and alcohol;
2. Reducing the burden of disease and disability in life by focusing on preventing and recovering from the conditions with the greatest impact, including dementia, anxiety, depression and drug dependency;
3. Protecting the country from infectious diseases and environmental hazards, including the growing problem of infections that resist treatment with antibiotics;
4. Supporting families to give children and young people the best start in life, through working with health visiting and school nursing, family nurse partnerships and the Troubled Families programme;
5. Improving health in the workplace by encouraging employers to support their staff, and those moving into and out of the workforce, to lead healthier lives.

To underpin these outcomes-focused priorities PHE will:

- promote the development of place-based public health systems; and
- develop its capacity and capability to provide professional, scientific and delivery expertise to its partners.

15 local PHE centres will be responsible for assuring that services, advice and expertise are tailored to local need, working with LAs, and will deliver health protection services directly. They will also work with NHS England to support its role in commissioning key services, including national public health programmes.

Four regions, co-terminous with those of NHS England, will support the local public health system, maintain an overview on implementation of the Public Health Outcomes Framework and be responsible for the development of the wider public health workforce. Centres and regions will be supported by eight knowledge and intelligence teams, and experts in public health.

PHE also produces a bulletin which provides public health news and information for local authorities and public health professionals – the first was produced at the end of April and included its priorities.

Pharmacy and Public Health Forum

The Forum now reports to PHE and Richard Parish, the Forum chair, has recently been appointed as a non-executive member of the PHE Advisory Board. Professor John Newton, who chaired the evidence base task group, is the Chief Knowledge Officer for PHE. Three Task Groups have now either completed their work or are on track to complete by the set deadline, which will leave the Supporting the roll out of HLPs, Workforce implications and Business Support task groups to continue their work.

HLP Evaluation launch

The evaluation was launched on the 22nd April 2013 and the key findings were:

- Early results seen in Portsmouth can be replicated in other areas of the country as the benefits of the scheme were shown not to be dependent on levels of local health need and deprivation;
- The HLP concept was consistent with increased service delivery and improved quality measures and outcomes;
- 21% of people surveyed wouldn't have done anything if they hadn't accessed a service or support in the HLP so would have missed out on the benefit of getting advice to improve their health and wellbeing;
- 60% of peopled surveyed would have otherwise gone to a GP;
- Public feedback was positive with 98% saying they would recommend the service to others and 99% were comfortable to receive the service in the pharmacy;
- More people successfully quit smoking in HLPs than non-HLPs or prior to becoming a HLP;
- The number of people who accessed sexual health services and were provided with additional sexual health advice was greater than in non-HLPs;
- The acceptability of community pharmacy as a location for clients to receive an alcohol service and the relatively high levels of activity seen in HLPs compared with non-HLPs showed that HLPs could have an important contribution to this harm reduction service;
- HLPs were effective at delivering increased support for people taking medicines for long term conditions, through both Medicines Use Reviews and the New Medicine Service. Activity was higher for both services in HLPs than non-HLPs or before HLP implementation in all but one site; and
- Pharmacies were also positive about the scheme; with 70% of the contractors surveyed saying it had been worthwhile for their business.

Duncan Selbie, Chief Executive of Public Health England, highlighted the results from the HLP evaluation in his weekly message following the evaluation launch:

'Pharmacies have a major role to play in helping improve the public's health, with 1.8 million people visiting a pharmacy each day. On Monday, the evaluation of the Healthy Living Pharmacy Programme was launched at the Royal Pharmaceutical Society. Led by a collaboration of all the national pharmacy bodies and supported by the Department of Health and the public health organisations, there are now 508 Healthy Living Pharmacies in England. The results are really impressive. The public 'strongly' approved of the pharmacies which have signed up, with over 98% saying they would recommend them. Results have been

equally encouraging in Stop Smoking services, with the Healthy Living Pharmacies delivering a significant improvement in the number of quits. The public and patients have also been much more positively engaged in other lifestyle areas where advice and support have been given by pharmacy Health Champions accredited by the Royal Society for Public Health'.

The national total of HLPs, both Pathfinder and non-Pathfinder is now 525, with 17 HLPs recently accredited in Stockton-on-Tees.

EPS Update

Deployment status

Seven pharmacy systems now have EPS Release 2 full roll-out approval, AAH Proscript Link, Cegedim Nexphase, Cegedim Pharmacy Manager, Helix Health, Positive Solutions Analyst, RX Systems Proscript and the Lloyds Compass system. Pharmasys is working towards achieving compliance – since PharmaSys has been acquired by Helix Health, PharmaSys customers have had the option of transferring to the EPS R2 compliant Helix Health system while PharmaSys is still passing through the approval process.

Four GP systems, EMIS Web, InPractice Vision, TPP SystmOne and Microtest Evolution 11 have been granted EPS Release 2 roll-out approval. EMIS users need to migrate from the EMIS legacy solutions, EMIS LV and EMIS PCS to EMIS Web before being able to access Release 2. The pace of deployment of TPP SystmOne is expected to continue to be slow until aspects of the system's functionality are enhanced. CSC have confirmed that the iSOFT system will be withdrawn from the market over the next year, GPs currently using this system will need to switch to an alternative product to access EPS Release 2.

Authoritative information on the Release 2 development status of GP and pharmacy systems can be found on the HSCIC website (www.hscic.gov.uk/eps).

EPS Release 2 Deployment Statistics (Extracted 26th April 2013)	
EPS R2 enabled GP practices	732
EPS R2 enabled pharmacies	**9,589**
Number of R2 prescription messages to date	**4,888,569** prescriptions containing **11,355,474** items have been dispensed
Number of patient nominations set	**1,788,625**

Changes in NHS organisational responsibilities

National Level: Responsibility for EPS is transferring from the Department of Health to NHS England. The new senior responsible owner for the project is Beverley Bryant, Director of Strategic Systems and Technology at NHS England.

Local Level: Feedback from an LPC survey in March suggested that in many localities, planning to transition EPS support functions from PCTs to the new NHS organisations was at an early stage. To date, few problems have been reported to the office, and those that have been reported have related to challenges finding out who to contact locally. CFH are also reporting that few problems have been reported to their Implementation Leads. We will be surveying LPCs again within the next couple of weeks to get up-to-date evidence on the status of local support for EPS.

EPS risks and issues

Process for Authorising GP Deployments post-1st April

Prior to 1st April 2013, only PCTs that had been authorised through Secretary of State Directions could direct their GPs to start issuing electronic NHS prescriptions. A list of GPs that have been authorised to start issuing electronic prescriptions under the old governance arrangements can be found on the NHS England website.

Subject to final approval from NHS England, with effect 1st April 2013, for a GP practice to deploy EPS Release 2 they are required to submit an application form to the relevant NHS England area team to request authorisation to use electronic prescriptions. This form may be submitted by the GP practice directly, through its CCG or through the local support organisation responsible for providing GP IT support services on behalf of the CCG (e.g. CSU or Health Informatics Service). To ensure dispensing contractors are

given sufficient notice of GP go lives, the applications should be submitted at least 8 weeks from the following Monday (as a minimum) before the proposed go-live date. Also, to ensure a standard deployment model, based on experience to date, is implemented and that pharmacies affected by a deployment can access pre-requisites such as tokens and smartcards, the application form requires the applying organisation to confirm a number of points including that relevant LPCs have been engaged as part of the deployment process.

If the proposed implementation date included in the application provides less than 8-weeks' notice, if the applying organisation has not confirmed that relevant LPCs have been engaged or is not able to confirm that smartcards and dispensing tokens (FP10DTs) are available for all relevant pharmacies affected by the planned go live, the area team will reject the application. Without approval from the area team, the GP practice will be unable to obtain an 'end point' for EPS Release 2; an 'end point' is a technical switch that is required to operate EPS Release 2 and is set for each practice centrally.

The process will enable a GP practice to go-live for up to two weeks after the planned date, however if the GP practice has not used EPS Release 2 by then, its end point will be removed and the practice must re-apply for authorisation through the same process, giving at least 8-weeks' notice of the new planned date.

Information on planned deployments can be accessed online via an EPS Release 2 deployment map or via a downloadable list published in Excel; both resources are updated weekly by the HSCIC (www.hscic.gov.uk/eps). A tailored weekly email has started to be sent from the HSCIC to LPCs providing details of pharmacies in a locality that may be affected by a planned go-live.

Controlled Drugs

PSNC co-ordinated a letter to the new EPS SRO, Beverley Bryant, from PSNC, PV, RPS, the DDA, RCGP, GMC and the Patients' Association on the transmission of Controlled Drug via EPS. A response is awaited.

NCSO & EPS

A possible solution has been identified to address concerns about missing out on making NCSO endorsements if prescriptions are submitted for reimbursement close to the point of dispensing rather that the end of the month. The idea being discussed is a 'reimbursement amendment message' that could be used to correct a previously submitted endorsement. The idea is technically possible but agreement needs to be reached on a change to the technical specification.

Delayed Prescriptions

This continues to be a problem. There are a range of possible reasons for this, for example the GP not having issued the prescription, the prescription being post-dated so it has not yet left the GP system or if it is a repeat dispensing prescription, the next issue may not have been pulled down from the spine via the automatic scheduling functionality as expected. Whilst rare, there may also be technical reasons that have delayed the arrival of an electronic prescription.

To support troubleshooting in pharmacy and GP practices, Connecting for Health have developed a simple, "Where is my prescription?" application that can be used to confirm the location of a prescription passing through the EPS Service. This has passed through compliance testing and the HSCIC are undertaking some final assurance work in a live environment – the application is expected to be publicised widely in the near future.

Spine Housekeeping

A recently reported problem is instances of contractors not sending reimbursement claims within 6 months - if a claim is not sent within 6 months, the claim is removed as part of spine housekeeping and cannot be sent electronically to NHS Prescription Services. In the EPS Compliance Specification, it was suggested (a should versus must requirement) that pharmacy systems include alerts so that users know when a dispensed prescription is about to reach the reimbursement claim deadline – however, not all PMR systems

chose to include alerts in their system. Reasons for dispensed prescriptions not being claimed include prescriptions being marked as dispensed before they were handed out (and not claimed as patient hasn't collected) and problems with the design of some systems where there is not an easily accessible report of dispensed but not claimed items.

Background information on EPS R2 can be found online at www.psnc.org.uk/EPS.

EPS roles and responsibilities

To prevent duplication of effort and gaps in contactor support, there is a need for improved co-ordination between the pharmacy bodies on EPS. An initial meeting took place in June 2012 involving PSNC, Pharmacy Voice and the RPS to discuss each organisation's roles and responsibilities in relation to NHS IT.

At that meeting, it was discussed that PSNC's role, as the recognised representative of contractors on NHS matters is to take responsibility for policy relating directly to IT support for NHS community pharmacy service provision including agreeing the IT requirements (i.e. functional requirements) for NHS services, negotiating funding for IT required to support NHS services and acting as the interface between pharmacy contractors and the various NHS IT projects. At the same time, there was recognition that there were other roles that would be better placed with other organisations such as engagement with pharmacy system suppliers and work to support interoperability between systems.

Susan Grieve at DH has made clear to Pharmacy Voice representatives that it is PSNC's role to lead on policy discussions. To try and improve co-ordination in relation to EPS, PSNC has been working with Pharmacy Voice to detail each organisation's responsibilities in relation to EPS and consider how we can improve communication between the organisations. This work began in February.

PSNC has made it clear that as the recognised representative of contractors on NHS matters, PSNC has the lead role in working with DH and the HSCIC to agree policy related to EPS including the EPS functional specification/ requirements, RA policy and problems that are inherent in the NHS controlled architecture for EPS. We see Pharmacy Voice as having a key role in supporting this work including supporting gathering evidence of problems experienced by contractors and helping collate evidence of views on policy issues.

Appendix SDS 13/05/13

Letter to Beverley Bryant on EPS and Controlled Drugs

Beverley Bryant
Senior Responsible Owner
Electronic Prescription Service
NHS England
Quarry House
Leeds

7th May 2013

Dear Beverley,

Transmission of Schedule 2 and 3 Controlled Drugs via EPS
Our organisations collectively represent key stakeholders in the Electronic Prescription Service; patients, GPs and pharmacists.

For over 10 years, there has been awareness that barriers to the electronic transmission of Controlled Drug (CD) prescriptions could compromise patient safety. There is now clear evidence that this is a significant clinical risk in practice. Where a patient has nominated a pharmacy and is being prescribed a Controlled Drug, it can create a situation where prescribing is split over a mix of paper and electronic prescriptions. This is leading to instances of patients visiting a pharmacy expecting to collect their prescriptions but only being able to access medication that was prescribed electronically. In many cases this is an inconvenience, as the patient may need to visit their GP Practice to collect the paper prescription and make a further trip to the pharmacy; however on some occasions it is not clear to the patient or pharmacy that a CD was prescribed, creating a significant clinical risk. Proposed workarounds to this problem such as asking patients not to nominate a pharmacy are not in the interests of patients and act to increase inequality. Many of the patients being prescribed Controlled Drugs are amongst the most vulnerable.

This problem is also blocking the realisation of a range of benefits from the service. It is acting as a barrier to GPs utilisation of the service; it is reducing efficiency, both within pharmacies and at NHS Prescription Services, and by continuing to issue paper-based forms for these items, the NHS is not benefitting from the increased security offered by the EPS Service, for example unlike with paper forms, there is no scope for patients to fraudulently amend electronic prescriptions.

Over the past 10 years this issue has been raised regularly and it has been suggested that this problem has been a high priority for the EPS Programme Board. Despite this there has been no visible progress. As the number of GP practices using the service rises, so too does the impact of this problem. Given the status of EPS Release 2 deployment, we believe that there is now an urgent need for changes to be made to the regulations to permit the transmission of Controlled Drug prescriptions electronically.

We would be grateful for more information on the steps being taken by NHS England to ensure that this problem is resolved urgently.

Yours sincerely

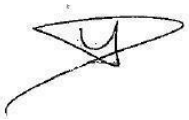
Dr Laurence Buckman Chairman
General Practitioners Committee,
British Medical Association

Matthew Isom
Chief Executive
Dispensing Doctors'
Association

Sue Sharpe
Chief Executive
Pharmaceutical Services
Negotiating Committee

All PSNC members can attend this meeting and may speak with the permission of the Chairman.






Rob Darracott Chief Executive Pharmacy Voice	**Dr Clare Gerada** Chair Royal College of General Practitioners	**Howard Duff** Director for England Royal Pharmaceutical Society	**Katherine Murphy** Chief Executive The Patients Association

CC: Rachel Habergham, EPS Programme Head, Health and Social Care Information Centre

Appendix SDS 14/05/13

NHS Information Governance Update

Dame Fiona Caldicott has published her independent review of information governance within the NHS in England, Information: To Share or Not to Share? Key recommendations in her report include:

- Individuals should have a right to access their care records without charge. The Department of Health Information Strategy set a target that individuals should be able to gain electronic access to their own care records where they request it, starting with GP records by 2015 and social care records as soon as IT systems allow. The review recommended extending this right of access within the next decade to cover hospital records, community records and personal confidential data held by all organisations within the health and social care system. The review also highlighted the importance of putting in place a clear plan for implementation to ensure that this happens.
- An audit trail of everyone who has accessed a patient's personal confidential data should be made available in a suitable form to patients via their health and social care records.
- For the purposes of direct care, relevant personal confidential data should be shared among registered and regulated health and social care professionals who have a legitimate relationship with the individual. The health and social care professional regulators must agree upon and publish the conditions under which regulated and registered professionals can rely on implied consent to share personal confidential data for direct care. Where appropriate, this should be done in consultation with the relevant Royal College. This process should be commissioned from the Professional Standards Authority.
- Organisations should pay closer attention to the appropriate transfer of information when people move across institutional boundaries, such as leaving hospital.
- Regulatory, professional and educational bodies should ensure that information governance, and especially best practice on appropriate sharing is a core competency of undergraduate training; and information governance, appropriate sharing, sound record keeping and the importance of data quality are part of continuous professional development and are assessed as part of any professional revalidation process.
- DH should recommend that all organisations within the health and social care system which process personal confidential data, including but not limited to local authorities and social care providers as well as telephony and other virtual service providers, appoint a Caldicott Guardian and any information governance leaders required, and assure themselves of their continuous professional development. The report does not exclude the possibility of small organisations sharing Caldicott Guardians or information governance staff to develop expertise and ensure consistency.
- In order to encourage openness and transparency, every health and social care organisation should publish a description of what personal confidential data it discloses, to whom and for what purpose. This information should already exist within the Data Protection Act privacy notices and data sharing agreements that organisations have produced.

The report recommends the addition of an additional principle to the 1997 Caldicott Principles:

'The duty to share information can be as important as the duty to protect patient confidentiality: Health and social care professionals should have the confidence to share information in the best interests of their patients within the framework set out by these principles. They should be supported by the policies of their employers, regulators and professional bodies'.

The Health Secretary has responded to the Caldicott review, stressing the need to strengthen patient privacy on confidential data use, and to respect the relationship of trust between the patient and medical professional which will be key to enabling information and technology to have a transformational effect on healthcare. DH will make a full response to the review in the summer. Dame Fiona Caldicott will also be

chairing an independent panel to oversee and scrutinise implementation of the review's recommendations, and provide advice on information governance issues.

Possible impact on pharmacy Information Governance Toolkit Assessments

If DH agrees with the review's recommendations, they may request amendments to some of the current IG requirements, e.g. introducing checks on the competency of IG leads and the possibility of strengthening self-assessments.

The report states:

"The Information Governance Toolkit is an online resource that allows NHS organisations and other bodies to assess themselves against the Department of Health's information governance standards and policies. In practice, there is no independent audit of the self-assessments submitted and it is questionable how well they reflect actual information governance practice in organisations, particularly given the obligations to publish the results. Version 8 of the toolkit had required both supporting evidence of the self-assessment score to be submitted and for the scoring and evidence for some of the requirements to be internally audited. As a consequence, there was a marked decline in the results. Additionally, the Department of Health subsequently initiated a 'deep dive' assessment of the scoring of five of the requirements in a number of acute trusts, looking at the efficacy of the internal audit process. The quality of the audit was found to be variable and the consistency of scoring across organisations to be poor.

The Review Panel concludes that Information Governance Toolkit self-assessments could be strengthened, and their profile raised, by inclusion of declarations in the Statements of Internal Control accompanying the annual quality reports of NHS organisations or for non-NHS organisations, in the annual report or performance report, signed off by the organisation's board or equivalent body."