Health, public health and social care round-up: January 2015

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Summary

The health, public health and social care round-up summarises new policy, research and publications that are relevant to elected members and officers interested in health and social care. It is intended to be a digested read and provides links to the source documentation of major reports for further consideration. The briefings are organised in the following categories:

• major developments in January
• health and social care reform and finance
• public health reform and practice
• health and social care quality and practice.

Briefing in full

Major developments in January

New models of care continued to be high on the NHS agenda in January, with applications to be in the ‘vanguard’ for developing the models required by NHS England by 2 February. Unfortunately, the focus on NHS care models is in danger of detracting from the integration agenda. Age UK published a report showing the critical state of adult social care, its Director said, ‘for any policymakers to acknowledge the need for investment in the NHS while omitting to mention social care is not good enough’.

Pressures on A&E continued, with delayed discharges attributable to adult social care identified as a major factor.

The roles of competition and the private sector had a high profile, with the flagship private sector franchise at Hinchingbrooke hospital falling through when firm Circle
withdrew. Sir David Dalton, author of the recent report into the future of NHS providers, said that franchise arrangements would continue, but would be more likely to be led by an NHS organisation in future.

NHS Providers flexed their muscles by refusing to agree the new national tariff for 2015-16 – negotiations are set to continue.

Labour published its 10-year plan for the NHS, setting out a greater role for health and wellbeing boards, and for the NHS as preferred providers of health and social care. Labour promised no top-down structural reorganisation, but the Kings Fund has questioned whether the scale of the changes proposed could be achieved without restructuring.

The DH, NHS England, the CQC and local government leaders have responded to the report by Sir Stephen Bubb on Winterbourne View. A consultation on national standards for admission and discharge will follow shortly.

Health and social care reform and finance

New models of care

Health Service Journal (HSJ) reports that a number of community services providers are expressing an interest in being in the vanguard for the multi-speciality community provider (MCP) model. While the NHS Forward View indicates these should be formed by GP practices scaling up, community providers are confident they are well placed because they are already working across large populations. The proposals could involve joint ventures with GP practices, or buying out practices and employing GPs directly. HSJ also reports on NHS England Simon Stevens acknowledging there was a potential danger in the vertical integration model, led by acute hospitals, of sucking in resources and leading to less patient choice.

NHS England has appointed Samantha Jones, Chief Executive of West Hertfordshire Hospitals Trust, as Director of new care models. Jones has told HSJ that proposals will need to have meaningful clinical and patient involvement to be approved. NHS England also intends to work with local areas to tackle barriers such as the national tariff. Jones will be supported by Sir Sam Everington, Chair of Tower Hamlets CCG, on a part time basis. She will report to Ian Dodge, National Director for Commissioning Strategy.

NHS England supplementary planning information

In supplementary information to its planning guidance, NHS England indicates that CCGs need to be realistic about the savings realisable from reducing unplanned admissions under the Better Care Fund; they need to take into account actual performance to date, likely outturn and progress on contract negotiations with providers. The BCF had an expectation of reducing admissions by 3.5 percent, but admissions rose by over five percent in December. HSJ reports that targets in plans range from one to 16 percent.
Realistic provider plans

HSJ also reports that NHS England, Monitor and the NHS Trust Development Authority will work together to assure providers’ operational plans for 2015-16 against ‘misaligned’ or ‘unrealistic’ planning assumptions. GP referrals and non elective activity are running above levels agreed by commissioners and providers; Monitor has found that only thirty percent of strategic plans demonstrated clear sustainability.

Co-commissioning specialised services

Plans for CCGs and NHS England to co-commission services have been criticised by the Specialised Healthcare Alliance (100 patient-related groups) because CCGs will have competing local priorities which may divert funding from specialised services.

NHS Clinical Commissioners disputes the claim, but has separately criticised plans to fully transfer responsibility for renal dialysis and morbid obesity by April 2015, on the grounds that CCGs are not prepared. NHS England subsequently agreed to postpone the transfer.

Co-commissioning primary care

HSJ reports that around a third of CCGs (around 77) are bidding to take full responsibility for performance management and budgets of their member GP practices from April in ‘delegated commissioning’. 89 CCGs have applied for ‘joint commissioning’ (a committee of CCGs and NHS England area teams), and 25 have applied for the lowest level – ‘greater involvement’ – working with the local area team but with no decision making functions. There are regional variations, with neighbouring CCGs tending to opt for the same level of delegated powers. There is some correlation between those applying for full powers and deprived populations; it is possible this relates to the need to improve primary care in areas where it may be poorer.

HSJ indicates that CCGs are considering swapping GP board members with neighbouring groups for primary care decisions to safeguard against potential conflicts of interest. NHS England national guidance stipulates that CCGs must create decision making committees with a lay chair and lay and executive member majority rather than GPs.

A report by the Kings Fund and Nuffield Trust indicates that in a survey of nearly 300 GPs nearly half said they did not have sufficient time for existing duties, and doubted whether they could take on more responsibility for primary care. Few were interested in performance managing GP colleagues, and fewer were engaged in the work of the CCG than in last year’s survey. They report calls on CCGs to look at how they are attracting GP leaders.
Tariff for specialised services

NHS Providers is warning that the marginal rate for specialised services, in which providers are paid half the tariff once activity rises above agreed levels, may stop some from providing services. It also points to conflict of interest for NHS England, as jointly responsible for setting a tariff while also being a commissioner which will benefit from it.

No national tariff agreement for 2015-16

HSJ reports that NHS Providers has rejected proposals for the tariff for 2015-16 due to concerns about viability and sustainability. Pricing authorities must either refer proposals to the Competition and Markets Authority or consult the NHS again on revised prices. Monitor is working with NHS England to address this, and until agreement is reached the current (higher) tariff will continue. NHS Providers has said it did not take the decision lightly; it points to years of ‘unprecedented’ price cuts, and a lack of understanding of the problems facing providers in politicians and NHS system leaders. It indicates that its veto is one of the few ways it can raise concerns.

A&E pressures

January started with continued pressure on A and E. At least 15 hospitals declared a major incident because no beds were available, and planned operations had to be cancelled. HSJ reports that a single trust, University of North Midlands Trust (created when University Hospitals of North Staffordshire took over Stafford hospital in November) was responsible for 57 percent of the patients waiting for more than 12 hours in A&E – 100 patients. NHS England has pointed out that the £700 million winter pressures funding has resulted in 800 more doctors, 5000 more nurses and six thousand more beds.

Research into use of emergency services

Research by the London School of Economics and Political Science has found that when walk in centres are on the same site as A&E, between ten and 20 percent of patients go to the centre rather than A&E. The aim of the research is to advise on whether walk in centres are a cost effective alternative to A&E attendance. According to a report by Monitor, between 2000 and 2010 230 walk in centres opened, but more than 50 have closed since 2010.

Delayed transfers of care

The Government has allocated an additional £25 million to be spent by April 2015 to reduce social care attributable delayed discharges. These were 24 percent higher in November 2014 than in the previous year. The funding will go to the 65 councils with the greatest pressures. The Kings Fund has voiced concern that this is rewarding areas failing to get a grip with delayed discharges, while other commentators have indicated this is not enough to make a difference.
HSJ reports that Jeremy Hunt’s Monday meetings with the leaders of national organisations has now been extended to include Eric Pickles and Minister for Government Policy Oliver Letwin, and now focuses on delayed transfers of care due to social care.

**Age UK social care score card**

Age UK has analysed 22 existing data sets and identified a ‘calamitous’ and ‘rapid’ decline in adult social care. Findings include:

- spending fell by £1.1 billion from 2010-11 to 2013-14, taking into account NHS transferred funding
- numbers of people receiving home care fell by 32 percent since 2010, and day cases declined by 67 percent
- nearly a third of people with difficulty in carrying out essential tasks receive no formal help.

**Commissioning support units**

Three commissioning support units, which have worked together for eighteen months, are to formally merge in April. South, South West and Central Southern CSUs will be called South, Central and West CSU and will cover a population of ten million people over 37 CCGs in Sussex, Cornwall, Gloucestershire and Oxford.

Two CSUS were unsuccessful in their bid for full accreditation to provide support services. North West CSU and Yorkshire and Humber CSU cover 47 CCGs and employ 2,200 people. HSJ indicates that the future of these CSUs is not yet known. The following CSUs were successful: North of England, South East, Greater East Midlands and Arden, Midlands and Lancashire, North and East London, South, Central and West CSU, Central Southern CSU. The full results will not be known until 5th February.

**NHS England outsourcing primary care support**

NHS England has shortlisted three bidders for a ten year £1 billion contract to provide back office functions such as practice lists, administrating prescription payments, pensions and medical records and screening programmes. The organisations are:

- Capgemini global consultancy with South East CSU
- Capita with Anglian community enterprise
- Equitini finance and administration.

HSJ reports that CSUs were discouraged from applying because of conflict of interest – as part of NHS England.

**Circle pulls out of Hinchingbrooke contract**

The flagship private sector franchise provider, Circle, has pulled out of its ten-year contract to run Hinchingbrooke Healthcare Trust, citing unacceptable pressures on
the system which would require considerably more investment than it was contracted to provide.

Hours later the CQC announced that Hinchingbrooke had been rated as inadequate. Examples of poor practice included call bells and drinks repeatedly out of reach, and a patient soiling himself while waiting for support. There were particular concerns about A&E, medical and paediatric care, and leadership.

Circle has called the CQC’s conclusions unbalanced, and is to challenge the rating – Circle holds other healthcare contracts and its business activities could be damaged by the assessment.

The Daily Mail has suggested that members of the inspection team may have been biased against the private sector; this is strongly denied by the CQC, however it is to revise its policy for declaring potential conflicts of interest.

Hinchingbrooke has been placed on special measures, which will involve being buddied with a high performing trust. The trust and the NHS Trust Development Authority are expected to provide details of plans to transition the hospital back to NHS control in the coming weeks. Latest reports show Hinchingbrooke is £7.2million in the red.

**Challenge to NHS England procurement**

A consortium of NHS cancer services providers have lodged a challenge against NHS England’s decision to award a contract for PET CT scanning to independent organisation Alliance Medical.

**Monitor to investigate in Devon**

Monitor is to investigate the decision by Northern, Eastern and Western Devon CCG to name Royal Devon and Exeter Foundation Trust the preferred community provider without competitive tender. A complaint had been made by Northern Devon Healthcare Trust which had provided community services in eastern Devon since April 2011.

**Monitor urges CCGs not to automatically roll over community contracts**

Many community contracts come to an end in 2015-16, and Monitor has advised CCGs not to automatically renew existing contracts; if they decide not to tender contracts they should show how this is in the best interests of patients. CCGs have expressed concern that enforced competition will hamper integration and introducing new care models.

**Primary care and out of hospital services**

A report by market analysts Laing and Buisson suggests that the independent sector (private and voluntary) could be responsible for 50 percent of the community
services market by the end of the decade; currently the NHS is responsible for 69 percent of the £9.75 billion funding, but in future there will be increased opportunities for non-NHS providers to bid for larger ‘pathway’ based contracts. This outcome would be dependent on no political return to NHS favoured commissioning.

Labour ten-year NHS plan

Key features of the plan, introduced by Andy Burnham and Ed Milliband include:

- Health and wellbeing boards to manage year of care budgets for frail older people with health and social care needs, commissioning from an ‘accountable provider’ – NHS preferred provider. This model is intended to incentivise providers to provide health and social care services in people’s homes rather than hospitals and would require them to bear the costs if health deteriorates.
- 5000 additional home care workers employed in the NHS.
- Repealing the 2012 Health Act, replacing the competition framework with an NHS preferred provider framework, scrapping the roles of Monitor and the Competition and Markets Authority in NHS competition.
- Safeguarding the role of the voluntary sector through longer and stable arrangements.
- NHS 111 to be managed by the ambulance service to provide expertise that diverts people appropriately from A&E.
- Reducing NHS bureaucracy and restoring democratic responsibility to the Secretary of State – details are not given about how organisations such as NHS England, CSUs, the Trust Development Authority and the CQC may change, but Monitor is likely to have a new role in driving integration and for the financial viability of whole health economies.
- Shortening waits for accessing mental health talking therapies.

Seven-day services

NHS Employers has issued proposals for delivering seven-day services, including changes to medical contracts and payment for staff at weekends and evenings, proposals to stop the right of medical consultants to opt out of non emergency evening and weekend work and automatic pay progression, and cuts to non medical staff payments for evening and weekend working.

NHS England has employed financial consultancy firm Deloitte to examine the cost implications of seven-day services in acute, community, mental health and social care.

Public health

Fall in life expectancy

Public Health England has confirmed to HSJ that it is to investigate recently released data showing a sustained fall in life expectancy in older people in some areas.
Across England and Wales life expectancy at 85 fell for women in 2009-11, 10-12, and 11-13. Life expectancy for men at 85 rose, but at a much smaller amount than previously.

Health and social care practice and quality

Transforming care for people with learning disabilities: next steps

This is the response from the DH, NHS England, the CQC and local government leaders to the report by Sir Stephen Bubb on Winterbourne View. Main plans are:

- following a consultation, national standards for admission and discharge will be written into the NHS England standard contract and introduced from April 2015
- compliance will be monitored in 2015-16 and could be linked to financial penalties
- a right to request a ‘care and treatment review’ for people with learning disabilities/autism and families which has been shown to lead to swifter discharge in pilots
- a delivery board chaired by NHS England with a deputy chair from Adass.
- further consideration of closing hospital services, but alternatives need to be in place – further proposals to follow
- a taskforce deployed to focus on the North where progress has been slowest
- a feasibility study on a social investment fund to develop community services.

The latest figures from the second annual census showed 3230 people in hospital, just 300 fewer than in 2013.

Monitoring the use of the Mental Capacity Act Deprivation of Liberty Safeguards in 2013-14

This report by the CQC found a backlog of over nineteen thousand DoLS applications at the end of September 2014, compared with 359 in April. The backlog was caused by the Supreme Court ruling which extended the application of DoLS. The CQC expects local authorities to do what they can to address the backlog, including using triage tools created by Adass. The report points to significant regional variations in application rates, a lack of staff awareness of the Mental Capacity Act, and providers consistently failing to notify the CQC about applications.

How local authorities allocate resources to carers through carer personal budgets

This research by York University school for social care research examined how councils operated carer budgets in two regions. It found significant differences in the thresholds for accessing support, the extent to which professionals were allowed to exercise discretion, resource allocation systems for determining the size of budgets, and the extent to which carers’ assessments were outsourced, e.g. to carers’ centres. Councils differ in many ways – some use minimum number of hours spent caring, others a points based system, others use risk of breakdown as a criteria;
some base budgets on needs, others have a fixed sum. Most areas had a ceiling of either £200, £300 or £500 a year. The report suggests that the variation will lead to a postcode lottery when the Care Act is implemented in April.

**Guidelines for minimum staffing levels in A&E**

NICE has issued draft guidelines setting out minimum expectations for staffing levels in different situations in A&E; for example, one registered nurse to one cubicle for triage, two to one patient for cardiac arrest and major trauma. The guidelines also cover expectations for specialist training, e.g. nurses trained in specialist child care or mental health, and red flag events to trigger a review of nursing staffing such as people not receiving pain relief. The guidelines have been largely welcomed, although some have warned against the levels becoming the default position.

**Changes to the Mental Health Act 1983 code of practice**

Following consultation, the government has made major changes to the code of practice, including:

- five new guiding principles
- new chapters on care planning, human rights, equality and health inequalities
- consideration of when to use the MHA, the Mental Capacity Act and Deprivation of Liberty Safeguards
- new sections on physical healthcare, blanket restrictions, duties to support patients with dementia and immigration detainees
- updated chapters on the appropriate use of restrictive interventions
- further guidance on children and young people, and people with a learning disability or autism.

**Specialised drug fund**

NHS England has announced an additional £60 million to boost the fund following a review to evaluate the cost effectiveness of medicines available through the fund. It is forecasting £80 million savings through measures such as negotiated price reductions. Eight drugs have ceased to be available, a further eight have tighter conditions and four new treatments are added.

**Improving paediatric healthcare**

This study by the Royal College of Paediatrics and Child Health indicates that the NHS has failed to centralise paediatric inpatient units which it believes is necessary to improve care and tackle UK child mortality rates, which are significantly higher than in Europe. The increase in numbers of consultants has helped, but the number of units has continued to fall since 2011, with a wide range of paediatrician to patient ratios – from 28.7 per hundred thousand children to 47.8.

**Commons Health Committee into Quality of Health Services Ombudsman investigations into NHS complaints**
The Committee highlighted ongoing concerns from patient groups about the poor quality of ombudsman investigations. The Ombudsman began a transformation programme in 2012 but a timetable for improvement is needed and an independent process to benchmark quality.

**Food standards in hospitals**

This report from a panel commissioned by the DH was led by Dianne Jeffrey of Age UK looks at standards relating to patient nutrition and hydration, healthier eating across hospitals and sustainable food and catering services. When adopted, standards will form part of the legally binding NHS contract.

For more information about this, or any other LGiU member briefing, please contact Janet Sillett, Briefings Manager, on janet.sillett@lgiu.org.uk