Health, public health and social care round-up: March 2016

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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 March
- health and social care reform and finance
- public health
- health and social care quality and practice.

Briefing in full

Major developments in March

Financial and quality concerns about the NHS and adult social care continued to dominate in March, with reports from the Public Accounts Committee and a number of think tanks questioning sustainability and the potential for efficiency savings across both sectors. See forthcoming LGiU policy briefing on reports from the Institute of Public Care and the National Audit Office. Prior to the budget there was support from NHS leaders for greater investment in adult social care. This was not forthcoming, but the suggestion that the NHS should fund adult social care to support people leaving hospital could be gaining some traction.

Further details on sustainability and transformation plans emerged, with, so far, only two areas confirmed with a local authority lead for the STP footprint – Manchester and Birmingham/Solihull.
New care models are taking shape – in March, the most ambitious developments were moves to establish the primary and acute provider organisation in South Somerset. The organisational complexities needed to establish new models will, hopefully, be offset in time by improved outcomes and financial sustainability.

The BMA announced the intention to pursue strike action against the imposed junior doctor contract. In April, there will be a 48-hour strike, for the first time without emergency cover. Earlier opinion polls suggest that withdrawing emergency cover will result in reduced public sympathy.

Health and social care reform and finance

Sustainability and transformation plan (STP) updates

Simon Stevens has announced an update on STPs. There will be 44 STP ‘footprints’ across the country with populations varying from 300,000 to 3 million. Most areas had announced their ‘single leader’, subject to NHS England and Monitor approval. In a small number of areas no leader was available – either because leaders are too busy with other tasks, relationships are too poor, or leaders are not of sufficient calibre. NHS England is working to appoint someone independent to take on the role. Stevens defended the exercise against criticisms about the ambiguity, difficulty and tight timescale of the strategic planning process. He pointed to a need for a ‘trade off’ between speed and depth of process, and pointed to the plans bringing key people together to have ‘a difficult conversation’; he also indicated that planning and joint working involved ‘shades of grey’ and ‘ambiguity’.

STP footprints

Health Service Journal (HSJ) reports that NHS England has approved nine of the 44 leaders of STP footprints. Of these:

- two are council chief executives (Manchester and Birmingham/Solihull)
- three are CCG chief officers (Lancashire/South Cumbria, Buckinghamshire/Oxfordshire/Berkshire West and Leicester/Leicestershire/Rutland)
- four are hospital trust chief officers (North Central London, Devon, Frimley, West Yorkshire).

The largest footprints will be Greater Manchester; West Yorkshire; Merseyside/Cheshire/Warrington/Wirral; and North West London all with populations over two million. The smallest footprints are Shropshire/Telford and Wrekin; and North Cumbria, both with populations of less than 500,000.

Local government concern about STPs

The LGA has agreed to write to the health secretary expressing concern about how STPs are working. It says that areas around the country report being kept out of planning. It also warns that handing leadership of the plans to one individual undermines local accountability and sidelines health and wellbeing boards. In addition the different planning requirements for STPs and the Better Care Fund
(BCF) was creating duplication, and the fast timescale was not allowing proper engagement. The Chair of the Community Wellbeing Board said that local government was being ‘left out in the cold’ and not involved in the integration agenda. For example, the North East STP footprint did not cover the area of the North East combined authority.

**Warning against ‘trendy’ plans in STPs**

HSJ reports that the head of new joint regulator NHS Improvement, Jim Mackey, has warned local NHS organisations not to build STPs around ‘trendy’ new organisational structures or contracting models. He pointed to the Cambridgeshire CCG older people’s services contract which collapsed after eight months (see below) as an example, saying that when he first heard read about it he didn’t understand how it would work.

**How CCG leaders view health and wellbeing boards**

A survey of NHS Clinical Commissioners members, shared with HSJ, found mixed views about the value of HWBs.

- 46 percent did not think HWBs were able to deliver real change.
- Nearly a third thought they did not provide an environment conducive to local decision making.
- 75 percent associated HWs with partnership working, and two thirds saw them as a place for open discussion.
- 57 percent saw HWBs as an equal partnership.

**New care models**

**South Somerset**

Three GP practices with a total registered list of 12,500 people are to be taken over by a company owned by the local hospital foundation trust as part of a move to an integrated primary and acute provider organisation. The practices will become part of Symphony Healthcare Services, a new subsidiary company of Yeovil District Hospital FT. South Somerset is one of nine vanguards working to establish primary and acute care systems (PACS) integrating GP and hospital services. The practices will continue to technically exist and have individual contracts, but these will be held by nominee GPs from the Symphony Health Services board. HSJ reports that other GP practices will have the option of following this path or to become a co-owner of another new entity, South Somerset Primary Healthcare, which will partner with Symphony to set up a third new body which will become the local accountable care organisation by being given a single outcomes based budget to provide care for the local population. The takeover arrangements can be reversed if the vanguard fails.

**Wolverhampton**

Royal Wolverhampton Trust will take over running three GP practices as part of a pilot to integrate primary and secondary care. This vertical integration model will cover 23,000 patients, approximately 20 per cent of the local population. Practices will be subcontracted to provide services, and the 12 GPs will transfer to be
employed by the trust which will provide additional staff to increase integrated services in the community.

**Reading and West Berkshire**
Four CCGs and two foundation trusts have signed a memorandum of understanding with intention to establish an accountable care system to move towards a more preventative model of care, improve outcomes and become more financially sustainable. This will not involve a new organisation or provider. The intention is to involve the four local councils, GPs and the ambulance trust.

**Multispeciality community provider pilots**
HSJ reports that NHS England’s new care model team has provided £500k to 15 rapid test sites piloting an integrated care model for primary care, similar to the multispeciality community provider model vanguards but with smaller populations, typically 30 to 50 thousand, rather than the average vanguard of 186 thousand. The pilots involved multidisciplinary workforces, a capitated budget, and provision of urgent appointments.

**Collapse of £700m contract - investigation**
Cambridgeshire and Peterborough CCG commissioned West Midlands Ambulance Service to review the circumstances that led to the Uniting Care Partnership (a limited liability partnership made up of two local foundation trusts) withdrawing from a contract after just eight months. The review found that the provider expected to be paid substantially more than had been agreed in the bid. Just one month into the contract, the provider asked for an extra £34.3million for the year, and despite negotiation a £10million gap remained. Uniting Care had agreed during the bidding process that it would work within the contract conditions and not ask for additional funding. Also, the business case for the FTs forming a limited company, submitted to Monitor, were not shared with the CCG. There were also shortcomings in the risk management element of the tendering process, and the DH also failed to recognise any problems with this. A review by NHS England is due shortly and is likely to have an impact on how CCGs conduct tenders.

**Commissioning of specialist mental health services devolved**
NHS England is to devolve control of services such as secure mental health, tier four child and adolescent mental health services, and eating disorder units to selected local areas to tackle disconnected commissioning and reduce patients being sent long distances from their homes for treatment. This could mean that CCGs, trusts and independent providers could band together to make local or regional bids.

**Public accounts committee report on GP capacity**
The PAC has accused the DH and NHS England of being complacent about the increased demand on GP services and rising public expectations, and the ability of general practice to cope with this. It warns that access to general practice varies considerably across the country, with greater availability in older, white and affluent
areas. The report also identifies extreme workload pressures and low morale leading to clinicians leaving general practice. It concludes that neither the DH or NHS England have sufficiently good data to make informed decisions about general practice. It calls for improved data, a policy to encourage GPs to remain in the profession, and a strategy to improve access for ethnic minorities. The DH has responded that improvements will come from the new GP contract, and that GP recruitment has increased.

**Sustainability and financial performance of acute hospital trusts**

The Commons Public Accounts Committee reports that the government is doing too little to address growing hospital deficits and has no convincing plan for closing the £22bn efficiency gap by 2020-21. The Committee also believes that the data used by Lord Carter to identify efficiency savings was flawed which casts doubt on the potential to deliver savings. The Committee accepted evidence that the four per cent efficiency targets set by Monitor and NHS England were unrealistic and have caused long term damage and points, but despite this the DH believes that some trusts should have even tougher targets. It recommends a new payment and contracting system and more action to tackle the volume of agency staff payments; it asks the DH, NHS England and NHS Improvement to report on progress in September.

**A perfect storm: an impossible climate for NHS providers finances?**

This Health Foundation report found a significant association between poor financial performance and both spending on agency staff and the proportion of income received by the national tariff. Providers with financial problems are more likely to be rated inadequate by the CQC, and operate from fewer hospital sites. Staff are also less likely to recommend their hospital to family and friends. It warns that the financial situation of the NHS in England is likely to get worse without urgent and concerted action to reduce reliance on agency staff. Potential productivity savings – the £5billion identified by Lord Carter’s review – are less than a quarter of the £22billion savings required by 2020/21.

**Hospital success regime – network model**

HSJ reports that the chief executive of Basildon and Thurrock University Hospitals Foundation Trust is to lead a new leadership team overseeing three hospital trusts with a combined prospective overspend of £216m by 2018-19. This is a new group network model under NHS England’s success regime. The hospitals will work as a network with a flexible workforce.

**Proposals to restrict access to NHS services**

A group of CCGs in the Midlands is to consult on wide-ranging restrictions to NHS services in order to close a £25million funding gap. These include restricting access to knee and hip operations, stopping hearing aids for mild hearing loss, restricting access to some treatments for patients who have unhealthy lifestyles, restricting chiropody to people with long term conditions, restricting IVF, vasectomies and...
female sterilisation. The CCGs are also seeking feedback on possible changes to primary care, community services and continuing healthcare, such as reducing opening hours of minor injuries unit and capping CHC payments.

HSJ points to other CCGs already limiting services for financial reasons: East Essex CCG no long routinely provides gluten free foods, vasectomies and female sterilisation; North Staffordshire CCG restricted access to publicly funded hearing aids for the first time in NHS history.

Potential for NHS to purchase social care

HSJ reports that Lord Darzi, former Health Minister and now non executive director of NHS Improvement, has asked the NHS Improvement board why NHS providers should not look at providing adult social care services in order to reduce pressure on their services and lower their costs. The NHS Improvement chief executive said that in some areas the business case for homecare provision had been drawn up.

Think tank Respublica has recommended that the NHS should pay for care home places where people are involved in delayed discharge. They claim it would free up hospital beds while bringing vital investment in the care sector, which is currently facing huge problems. The think tank has previously warned that 37,000 beds could be lost in the coming years because of low council fees.

Support for social care from clinical leaders

Fourteen doctors’ leaders from the royal colleges and other organisations wrote to the chancellor prior to the Budget, asking for further investment in adult social care to prevent bed blocking and the knock on effects of poorer clinical outcomes for patients (infections and falls) and cancelled appointments and operations. The letter suggested bringing forward the additional £700m from the BCF to this year rather than 2017.

Revised care and support guidance for the Care Act

Updated measures in the revised statutory guidance include:

• More detail on the role of principal social workers to be lead practitioners and challenge management decisions on care. This includes quality assuring social work practice, supporting effective supervision, advising management on complex or controversial cases, and developing the safety, quality and consistency of social work practice.
• Clarification on how practitioners can comply with safeguarding legislation, including considering the need for a criminal investigation, and considering whether safeguarding enquiries should be made when people are self-neglecting.
• Additional information on financial abuse.
• More detailed explanation on potential conflict of interest with advocacy providers.
POLICY BRIEFING

• Clearer guidance on cross-border arrangements.

LGA Care Act stocktake

Community Care reports that the latest stocktake of Care Act implementation found that the number of adult safeguarding cases doubled in the first six months, between April and October. This strongly suggests that safeguarding caseloads have increased substantially since the Act introduced a national statutory threshold for investigation. There are concerns that this may not just reflect changes due to the Act, but to quality problems in adult social care – in March the CQC identified 30 per cent of services as requiring improvement. The stocktake, which is used by the LGA and DH to monitor progress on the Act also found:

• an expected additional 56,000 social care assessments, up from 1.65 million the previous year
• a predicted 37 per cent increase in carers assessed as eligible for services and a 48 per cent increase in carers receiving council-funded services
• a 2 per cent increase in independent advocacy (the impact assessment estimated 7 per cent leading to concerns that not all eligible people are being offered advocacy
• only 29 per cent believed they had sufficient resources to implement the Act in 2016-17 and beyond – down from 81 per cent confidence for 2015-16.

Year one of the Care Act

Independent Age commissioned a review of all local authority websites in England. The survey found that 70 per cent of council websites did not provide people with all the information required by the Care Act, and 23 per cent did not have up-to-date information on assessments and eligibility. One in seven did not provide information for carers, including the circumstances in which they have a right to an assessment. The charity also undertook an online survey of people’s experience of the Act. 39 per cent of councils had not provided full, satisfactory answers to phone enquiries, and two-thirds of carers said they had not received a carer’s assessment since the Act came into force. The charity concluded that lack of information was leading to people with social care needs and carers not receiving timely assessments and support.

Making a House a Home – Disabled Facilities Grant

A report by the Local Government Ombudsman based on 130 complaints about the DFG found that lack of communication between housing and social care was a key factor in unacceptable delays and wrong decisions. It recommends that clear protocols between housing and adult social care should be established for home adaptations, and that this is particularly important in two-tier councils. It also recommends that councils develop better links with the voluntary sector for cases where people are not eligible for DFG.

Carers strategy: call for evidence
The DH is seeking views to develop a new national strategy for carers and wants to hear from carers, people who have someone to care for them, business, social workers, and the NHS by 30th June.

**Junior doctor strike**

The BMA’s junior doctors committee announced an escalated strike of 48 hours on 26th and 27th April to include the withdrawal of emergency care; consultants, nurses and other staff will provide emergency cover.

Jeremy Hunt has said that there is no point in further negotiation because of the stance taken by the BMA. He also told an HSJ meeting that the new contract was ‘right for doctors’ and ‘much safer’ and that the BMA waged ‘a massive and totally irresponsible campaign of misinformation’.

HSJ reports on a leaked document from the BMA’s lawyers which warns the union’s planned legal action against the government for allegedly not undertaking an impact assessment under the Equality Act will not prevent the government from imposing the contract. Lawyers advised that the application for a judicial review would be a ‘last throw of the dice’ with the main potential for the BMA to secure further improvements to the contract. The judicial review application would also be hugely expensive.

**Public health**

**Chancellor introduces sugar tax**

In his budget speech the Chancellor set a new levy on the soft drinks industry from April 2018. Most of the prospective £520m raised in the first year will be used to boost sports activity for children and young people. Drinks that contain more than five grams of sugar per 100ml will be subject to a main rate charge, with a higher rate for drinks with more than eight grams per 100ml. Firms will be encouraged to reformulate drinks with less sugar and to reduce portion sizes.

**New Healthy Towns programme**

Simon Stevens has identified the locations of ten healthy new towns, an initiative announced in the Five Year Forward View. The programme will be run with Public Health England and aims to join up design of the built environment with health and care services, particularly tackling obesity. Initiatives could include digitally enabled primary care services, green spaces, and dementia friendly street design. NHS England plans to bring in clinicians, designers and technology experts to help shape the areas over the next six months, including, apparently, a project manager for each scheme. The areas are:

- Whitehill and Bordon, Hampshire – 3350 new homes
- Cranbrook, Devon 8,000 new homes
- Darlington 2,500 residential units
- Barking Riverside, East London 10,800 new homes
Health and social care practice and quality

**NHS England plans for 2016/17 assessment and improvement framework**

NHS England is inviting suggestions on proposals for implementing the Ofsted-style ratings of CCGs required by the Health Secretary. The document sets out 54 assessment indicators grouped in four categories: better health, better care, sustainability and leadership. The framework relates to agreement and delivery of STPs; the framework will also look at how the NHS operates through place-based partnerships.

**NHS provider safety**

The DH has published a league of trusts deemed to be open and transparent and to learn from their mistakes, based on safety reporting and the NHS staff survey. The ranks go from ‘outstanding’, through ‘good’, ‘significant concerns’ and ‘poor reporting culture’.

From April all deaths in England and Wales will be investigated by independent medical examiners in order to improve patient safety, tackle inaccurate death reporting and tackle worrying trends. Around 300 senior doctors will be appointed to review cases, and can refer deaths to a coroner for investigation. Early pilots found that one in four hospital death certificates were inaccurate and one in five cause of death were wrong.

**Cutting red tape in adult social care**

The Cabinet Office’s Cutting Red Tape review asked more than 200 care home providers about the bureaucratic burdens they faced. The review found duplication of paperwork requirements between council contract monitoring and CQC inspection, inconsistencies about council and CCG requirements and confusion about the respective role of CCGs and councils. In response the DH has accepted the review’s findings and has pledged to provide a statement clarifying different roles, and to work with others to reduce red tape, including exploring the primary authority option in which one council takes over contracting responsibility on behalf of others. The DH will report on progress in six months.

**Nurses maintained on the immigration shortage occupation list**

A report by the Migration Advisory Committee criticised the DH, Health Education England, and NHS trusts for not seeing obvious warning signs about a growing
shortage of nurses over many years. The committee also blamed the organisations for being too focused on saving money, and an over-reliance on EU nurses; it said that the shortage would continue – due to cuts HEE has only commissioned 331 extra nurse training places for 2016-17, a tenth of what is needed. In light of this the committee ‘reluctantly’ recommended that nursing should be kept on the immigration shortage occupation list, with an annual cap of 3,000 to 5,000 a year. The committee also found that predictions by HEE that supply would meet demand by 2019 do not factor in the needs of the care sector, and that the median pay for nurses at £31,000 is £7,500 below that of other graduate occupations.

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